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BACKGROUNDER

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State Innovation: The Key to Affordable Health Care Coverage Choices

Doug Badger and Edmund F. Haislmaier

Abstract

Obamacare's rigid and centralized federal regulation of the nongroup market is failing. Premiums have risen, choices have contracted, and enrollment in individual policies continues to fall. Section 1332 of the Obamacare statute provides states with very limited authority to escape Obamacare's mandates and test new approaches to undoing some of this damage. Several states have successfully used a waiver to change market conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care. Waivers alone, however, are not enough. Congress should enact legislation to empower states to establish consumer-centered approaches that reduce health care costs and increase choices. To make incremental progress towards this goal, the Trump Administration can simplify the unnecessarily restrictive waiver progress established by the Obama Administration in order to provide near-term relief to consumers without new federal spending.

The federal government's takeover of the individual and small-group health insurance markets came with the promise of lower premiums, more insurance options, better coverage, and a substantial reduction in the number of people who lack insurance.

Instead, it has produced skyrocketing premiums,[1] insurance-company monopolies and duopolies,[2] burdensome cost-sharing requirements,[3] a shrinking individual health insurance market,[4] and a negligible effect on the number of uninsured.[5]

Over the past two years, however, several states have used the waiver authority in section 1332 of the Obamacare statute to deviate from some of the statute's suffocating requirements. Actuarial

Key Points

- Section 1332 of the Obamacare statute permits states to seek waivers from certain Obamacare health insurance regulatory mandates.
- Two states that obtained waivers for 2018 have seen premiums fall for the lowest-cost Bronze policies by 5.1 percent to 38.7 percent. Premiums for such plans rose by 16 percent nationwide.
- The seven states that will have waivers in 2019 estimate that premiums will be 7 percent to 30 percent less than without the waiver—without new federal spending.
- Waivers alone, however, cannot overcome Obamacare's rigidities, which continue to increase costs and limit choices.
- Congress should enact the Health Care Choices Proposal, which repeals Obamacare entitlements and provides states with resources and authority to establish consumer-centered approaches that reduce costs and increase choices.
- In the interim, the Trump Administration can simplify the restrictive waiver process established by the Obama Administration to provide near-term relief to consumers without new federal spending.

This paper, in its entirety, can be found at **http://report.heritage.org/bg3354**

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

studies commissioned by those states indicate that these changes will reduce premiums and increase enrollment in non-group coverage, a result that would defy overall Obamacare premium and enrollment trends.

Significantly, states are achieving these favorable outcomes without the expenditure of additional federal funds. Instead, under their 1332 waivers, they repurpose federal money that would have been paid directly to insurance companies in the form of premium subsidies, using it instead to pay medical bills for residents in poor health.

These findings suggest that the most effective means of undoing the detrimental effect of Obamacare's federal regime of subsidies, penalties, and regulations while ensuring that everyone can access private coverage is to provide states with the resources and flexibility to achieve that goal, rather than lashing them to a failing Washington-dominated system.

Policymakers should take two key steps to build on these successes and further help consumers:

1. Further undo Obamacare's damage by enacting the Health Care Choices Proposal.[6] Under the proposal, current federal entitlement spending on Obamacare's rigid structure of insurance subsidies and Medicaid expansion would be reprogrammed into state block grants, with broad flexibility for states to develop more consumer-centered approaches to meeting the needs of the poor and the sick, while keeping coverage affordable for other enrollees.

2. Make incremental progress towards the goal of transitioning away from Obamacare's Washington centric approach by simplifying the unnecessarily restrictive wavier process established by the Obama Administration. The limited statutory flexibility offered under section 1332 waivers is inadequate for the task of providing full relief, but improving that process would allow states to begin the transition to a reformed system without spending new federal money. The Centers for Medicare and Medicaid Services (CMS) should make it easier to provide near-term relief from the burdens of Obamacare.

Current Restrictions on Section 1332 Waivers Impair State Innovation

Section 1332 of the Obamacare statute permits states to seek waivers from certain federal health insurance regulatory requirements.[7] Under this provision, a state can request the CMS's permission to receive a portion of federal premium and cost-sharing reduction subsidies that the federal government otherwise would pay directly to insurance companies on behalf of eligible individuals.

State waiver programs must operate within narrow bounds established by the statute. They must operate inside what are commonly referred to as "guardrails." These guardrails require a state to demonstrate that "at least a comparable number

1. Average premiums doubled between 2013 and 2017. See U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "Individual Market Premium Changes: 2013–2017," May 23, 2017, https://aspe.hhs.gov/pdf-report/individual-market-premium-changes-2013-2017 (accessed September 20, 2018). Premiums rose by double digits in 2018. See U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," October 30, 2017, https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2018-federal-health-insurance-exchange (accessed September 20, 2018).
2. U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," p. 1.
3. HealthPocket, "Average Market Premiums Spike Across Obamacare Plans in 2018," October 27, 2017, https://www.healthpocket.com/healthcare-research/infostat/2018-obamacare-premiums-deductibles (accessed September 20, 2018).
4. Ashley Semanskee, Larry Levitt, and Cynthia Cox, "Data Note: Changes in Enrollment in the Individual Health Insurance Market," Kaiser Family Foundation, July 31, 2018, https://www.kff.org/health-reform/issue brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/ (accessed September 20, 2018).
5. Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation *Issue Brief* No. 4743, July 26, 2017, https://www.heritage.org/sites/default/files/2017-07/IB4743_0.pdf.
6. Health Policy Consensus Group, "The Health Care Choices Proposal: Policy Recommendations to Congress," June 19, 2018, https://www.healthcarereform2018.org/wp-content/uploads/2018/06/Proposal-06-19-18.pdf (accessed September 20, 2018).
7. Section 1332 Public Law 111–48, codified at 42 U.S. Code 18052, https://www.law.cornell.edu/uscode/text/42/18052 (accessed September 20, 2018).

of residents" would have health coverage under its proposal as under existing law, that the coverage would be "at least as comprehensive" and cost-sharing requirements "at least as affordable" as under current law, and that the waiver "would not increase the federal deficit."[8] Section 1332 also imposes certain procedural strictures on states seeking waivers. A state must pass a law seeking a waiver, but may do so only after following processes that the Secretary of Health and Human Services (HHS) establishes, even if the state has authorized its governor to apply for waivers in the absence of legislative action.[9]

The CMS issued final regulations implementing these requirements in February 2012.[10] The agency supplemented these regulations with sub-regulatory guidance in December 2015.[11] The guidance erects much higher barriers against state waivers. Even if a state, for example, can show that a "comparable number" of people would have coverage under its program, the CMS could deny the waiver on the grounds that an insufficient number of "vulnerable" people would have insurance. The guidance does not spell out what it means by "vulnerable," creating ambiguity that the agency can use to refuse waiver requests.[12]

This encrustation of statutory, regulatory, and sub-regulatory plaque has restricted the flow of state innovation to a trickle. Few states have submitted section 1332 waiver applications. The most ambitious and far-reaching reform proposals have either been rejected or withdrawn after languishing in the CMS approval process.[13]

Where Section 1332 Is Working: Risk Mitigation Waivers Are Lowering Premiums

State risk-mitigation waivers are an exception to this rule, according to analysis of projected 2019 and actual 2018 premiums. As of the date of publication, three states had implemented such waivers in 2018, four others had won approval to launch their programs in 2019, and one state withdrew its application.[14]

Although these waivers differ from state to state, they follow the same general pattern: States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.

8. Congress authorized the payment of cost-sharing reduction subsidies in section 1402 of Public Law 111–48, codified at 42 U.S. Code 18071, https://www.law.cornell.edu/uscode/text/42/18071 (accessed September 20, 2018), but never appropriated money for this purpose. In October 2017, the Administration halted these payments to insurance companies. News release, "Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments," U.S. Department of Health and Human Services, October 12, 2017, https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html (accessed September 20, 2018).
9. 42 U.S. Code 18052(b)(2) and (a)(4)(B)(ii).
10. Department of Health and Human Services, "Application, Review, and Reporting Process for Waivers for State Innovation," *Federal Register*, Vol. 77, No. 38 (February 27, 2012), p. 11700, https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf (accessed September 20, 2018).
11. Department of Health and Human Services, "Waivers for State Innovation," *Federal Register*, Vol. 80, No. 241 (December 16, 2015), p. 78131, https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf (accessed September 20, 2018).
12. The guidance lists several categories of "vulnerable residents," including "low-income individuals, elderly individuals and those with serious health issues or who have a greater risk of developing serious health issues." Ibid., p. 78132. The guidance does not, however, define these terms.
13. For a more complete discussion of the section 1332 waiver program and a review of waiver applications submitted during 2017, see Doug Badger and Rea S. Hederman, Jr., "Stabilizing the ACA's Individual Markets: Why State Innovation Is Key," Mercatus Center, February 27, 2018, https://www.mercatus.org/publications/affordable-care-act-individual-markets-state-innovation (acessed September 21, 2018).
14. Centers for Medicare and Medicaid Services, "The Center for Consumer Information & Insurance Oversight: Section 1332: State Innovation Waivers," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html (accessed September 21, 2018).
15. Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Alaska: State Innovation Waiver Under Section 1332," July 11, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf (accessed September 21, 2018).

Alaska was the first state to obtain a section 1332 waiver to implement this type of approach.[15] The state sought a waiver of Obamacare's "single-risk-pool" requirement, under which people who are likely to file large medical claims must be pooled with those who might never see a doctor. This Obamacare mandate has touched off a vicious cycle, in which insurers must charge high premiums, repelling the healthiest customers but not the sickest, resulting in premiums that are increasingly affordable only to those who receive federal subsidies.[16]

Alaska instead proposed to move customers with one of 33 medical conditions into a separate pool. Their medical claims would be funded in part by a portion of federal premium-subsidy payments diverted to the pool. Non-federal funding sources include ceded premiums (meaning, in the case of an enrollee whose claims costs the insurer transfers to the pool, the insurer must also transfer to the pool some portion of the premium it received from that enrollee), state assessments on insurers, and state general fund contributions. Based on an actuarial analysis commissioned by the state in support of its waiver application, the state concluded that it would reduce premiums and increase enrollment in the individual market at no additional cost to the federal government.

Projected 2019 Premium Effects. Table 1 displays the estimated effects of pending, approved, and withdrawn 1332 risk-mitigation waiver applications on 2019 premiums and enrollment, based on actuarial analyses submitted by each state.[17]

The first two columns display the state and the status of its waiver application. For example, Alaska's waiver application was approved in July 2017 and is in effect for the current plan year. Maine's application has been approved for 2019, while Oklahoma withdrew its application.

The next three columns present the amount of money, including federal premium subsidy money and money from non-federal sources (such as ceded premiums, state assessments on insurers, and state general revenue funding) that each state proposes to devote to its risk-mitigation program in 2019. Minnesota, for example, plans to use $151.0 million in premium subsidy money and add $147.2 million in non-federal funding for total risk-mitigation spending of $298.1 million.

The next two columns represent actuarial projections of the waiver effects on 2019 average non-group premiums and enrollment. Minnesota projects that average premiums for individual policies will be 19.7 percent lower in 2019 than they would be without the waiver, and that enrollment will be 13.3 percent higher than in the absence of the waiver.

The final two columns present the percentage of federal premium subsidies that would be diverted to the risk-mitigation pool and the total (federal and non-federal) size of the risk-mitigation pool as a percentage of total non-group premiums. Maine, for example, would divert 10.9 percent of federal premium subsidies into its risk-mitigation pool, and total federal and non-federal contributions to the pool would equal 20.9 percent of total premiums for the non-group market.

The first and most obvious observation is that actuaries forecast that every state waiver program would have substantial favorable effects on premiums. The waivers, according to independent actuarial analyses, would result in average non-group 2019 premiums ranging from 7.0 percent (Oregon) to 30.0 percent (Maryland) lower than without the waiver.

Final rate approvals for the 2019 plan year suggest that Maryland may have underestimated the premium effect of its risk-mitigation waiver. According to a table released by the state's insurance administration in September 2018, insurers had requested premium increases for 2019 averaging 30.2 percent.[18] Insurers filed those requests prior to CMS approval of Maryland's waiver application. Average final rates for 2019 were actually 13.2 percent *lower* than 2018 premiums. Thus, 2019 premiums for Maryland's non-group market will be 43.4 percent lower (a

16. Edmund F. Haislmaier and Doug Badger, "How Obamacare Raised Premiums," Heritage Foundation *Backgrounder* No. 3291, March 5, 2018, https://www.heritage.org/health-care-reform/report/how-obamacare-raised-premiums (accessed September 21, 2018).
17. Data compiled from actuarial and budget analyses included in state waiver applications: Centers for Medicare and Medicaid Services, "The Center for Consumer Information & Insurance Oversight," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html (accessed September 21, 2018).
18. News release, "Governor Larry Hogan Announces Health Insurance Premium Rate Decreases," Maryland Insurance Administration, September 21, 2018, http://www.mdinsurance.state.md.us/Pages/newscenter/NewsDetails.aspx?NR=2018201 (accessed September 24, 2018)

TABLE 1

Estimated Effects of 1332 Waivers on Average 2019 Non-group Premiums and Enrollment

State	Waiver Status	Risk Mitigation Amounts (millions)			Waiver Effects		Risk Mitigation as a Percentage of …	
		Federal	*Non-Federal*	*Total*	*Premiums*	*Enrollment*	*Federal APTC**	*Total Premium*
AK	Implemented	$56.00	$8.10	$64.10	–19.8%	7.1%	21.7%	19.3%
MN	Implemented	$151.00	$147.20	$298.10	–19.7%	13.3%	30.0%	22.6%
OR	Implemented	$34.60	$60.40	$95.00	–7.0%	1.6%	7.0%	7.4%
OK	Withdrawn	$271.00	$54.00	$325.00	–28.7%	18.8%	33.4%	28.4%
MD	Approved	$303.60	$158.40	$462.00	–30.0%	5.8%	35.5%	30.9%
ME	Approved	$34.70	$70.00	$104.70	–9.5%	1.8%	10.9%	20.9%
NJ	Approved	$218.00	$105.80	$323.80	–15.1%	2.8%	19.2%	13.8%
WI	Approved	$172.50	$27.50	$200.00	–10.6%	0.8%	12.5%	10.4%

* Advanced premium tax credit.
SOURCE: Centers for Medicare and Medicaid Services, "The Center for Consumer Information & Insurance Oversight—Section 1332: State Innovation Waivers," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html (accessed September 24, 2018).

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13.2 percent decrease, as opposed to a 30.2 percent increase) than without the waiver, a figure that is larger than the 30 percent actuarial forecast that appears in Table 1.[19]

Lower premiums, in turn, would induce more people to buy individual policies, resulting in higher enrollment. Those estimated changes range from 0.8 percent (Wisconsin) to 13.3 percent (Minnesota) in states whose waivers have been implemented or approved.

These premium and enrollment effects are directly opposite to broader Obamacare market trends. Enrollment in individual coverage has been declining since 2016.[20] This coverage decline, evidenced in both Obamacare-compliant and non-compliant policies, has continued through the first quarter of 2018. In December 2015, 17.7 million people had individual policies.[21] As of March 2018, 14.4 million people had individual policies, a drop of around 2 million (12 percent) from March 2017.[22] The most precipitous drop has been among those purchasing policies—both Obamacare-compliant and non-compliant—outside the health insurance exchanges. That number fell by 2.3 million (38 percent) between March 2017 and March 2018.[23]

19. Arriving at a point estimate of the waiver's premium effect is, of course, a bit more complicated than that. There is certainly no guarantee that Maryland insurance regulators would have approved the 30.2 percent premium hikes insurers sought, even if the CMS had denied the state's waiver request. It is also worth noting that the premium effects of the waiver in 2020 and beyond are difficult to predict. Maryland has proposed to reduce non-federal contributions to the reinsurance program in 2020. A reduction in reinsurance payments would almost certainly dampen the program's premium effects. All of this points to the need to provide states with maximum flexibility to design and amend their market-stabilization programs over time. The 1332 waiver process, along with its other infirmities and deficiencies, may not easily accommodate such adjustments.
20. Edmund Haislmaier, "Obamacare Is Shrinking the Individual Health Insurance Market," Heritage Foundation *Commentary*, May 17, 2018, https://www.heritage.org/health-care-reform/commentary/obamacare-shrinking-the-individual-health-insurance-market.
21. Ibid.
22. Semanskee, Levitt, and Cox, "Data Note: Changes in Enrollment."
23. Ibid.

Premiums have similarly risen sharply since Obamacare regulations took full effect in January 2014. Average premiums more than doubled between 2013 and 2017.[24] HHS reports that premiums for the lowest-cost plan available to a 27-year-old in states using the healthcare.gov platform rose by an additional 17 percent in 2018.[25]

Actuaries project that both trends will be reversed in states with approved risk-mitigation waivers.

Second, it appears that the overall size of the risk-mitigation program (including both federal and non-federal funding sources) may bear some relation to its premium effect. At 7.4 percent of total premium, Oregon's is the (proportionately) smallest risk-mitigation program and has the weakest effect on premiums (–7.0 percent). Maryland intends to devote 30.9 percent of premium to risk mitigation, projecting to yield a 30.0 percent reduction in premium. That same general pattern prevails in other states.

That is not to suggest a linear relationship. It is likely that the optimal percentage will vary from state to state based on differences among states in the extent to which Obamacare shifted high-cost patients into the non-group market. Those are additional reasons why it is desirable for states to have broad flexibility to experiment and to adjust their programs over time.

What is common to all of these arrangements is that they target public resources to those who incur the largest medical claims. By segmenting the load imposed by these policyholders from the broader insurance pool, plans are able to offer more favorable rates to all customers in the non-group market.

This data exposes one of Obamacare's core structural problems. The law's architects assumed that they could shift a significant number of high-cost enrollees into the market and compensate by enrolling a far greater number of healthy people into that same market. Their theory relied to a great extent on the individual mandate, which they assumed would coerce relatively healthy people to buy policies. That strategy has clearly failed. While Obamacare expanded the non-group market by 50 percent—from 11.8 million individuals in 2013 prior to implementation to 17.7 million at its peak in 2015—those new customers were disproportionately older and in poorer health. Consequently, premiums soared and enrollment has been falling since 2015. States that obtain waivers to escape this framework can undo some of the damage that Obamacare inflicted on their individual markets.

Critically, these waivers do *not* involve the expenditure of additional federal funds or the creation of a federal reinsurance program. Unlike the transitional reinsurance program, which was in effect from 2014 through 2016,[26] and recent proposals in Congress to expend federal money on reinsurance programs,[27] section 1332 waivers are budget-neutral for the federal government.[28] Stabilizing markets with new federal spending on a new federal program is utterly unnecessary. States can use the 1332 waiver to achieve favorable results without adding to the federal deficit.

Actual 2018 Premium Effects: Alaska, Oregon, and Minnesota. The premium and enrollment effects in Table 1 reflect actuarial projections. Tables 2 and 3 examine premium effects in Alaska, Oregon, and Minnesota, the three states that are operating risk-mitigation programs in 2018.[29]

24. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Individual Market Premium Changes: 2013–2017," Data Point, May 23, 2017,
25. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf (accessed September 21, 2018).
26. Section 1341 of Public Law 111–48, codified at 42 U.S. Code 18061.
27. S. 1835, introduced September 19, 2017, https://www.congress.gov/115/bills/s1835/BILLS-115s1835is.pdf (accessed September 21, 2018).
28. 42 U.S. Code 18052(a)(2)(B)(ii) requires that waiver applications include "a 10-year budget plan…that is budget neutral for the federal government." 42 U.S. Code 18052(b)(1)(D) provides that the Secretary may only grant waivers that "will not increase the federal deficit." It is unclear from the text of the statute how these two provisions interact.
29. There are several reasons why we chose Bronze plans, rather than Silver plans, as the point of comparison. First, the Trump Administration discontinued cost-sharing reduction subsidy payments to insurers in October 2017, as discussed in footnote 8. These payments, which Congress had never appropriated, compensated insurers for the cost of reducing cost-sharing payments by enrollees with incomes between 100 percent and 250 percent of poverty who enrolled in Silver plans on the exchanges. To compensate for the loss of cost-sharing reduction money, insurers received approval from insurance commissioners in most states to drastically increase premiums for Silver plans sold on health insurance exchanges. These premium increases did not affect Bronze plans. Second, Bronze plans are the choice of most people who do not qualify for premium subsidies. Consequently,they are the plans purchased by the most price-sensitive consumers; those who cannot rely on the federal government to offset premium increases and must pay any additional cost out of their own pockets.

TABLE 2

Monthly Bronze Plan Premiums in Alaska and Oregon in 2017 and 2018 for a 40–Year-Old Non-Smoker

State	2017 Bronze Premiums		2018 Bronze Premiums		
	Range	*Lowest*	*Range*	*Lowest*	*Change in Lowest*
Alaska	$703–$741	$703	$431–$455	$431	–38.7%
Oregon	$234–$426	$234	$222–$340	$222	–5.1%

SOURCE: Healthcare.gov, https://data.healthcare.gov (accessed September 24, 2018). BG3354 ☎ heritage.org

In 2018, the national average premium for the lowest-priced Bronze plan for a 40-year-old non-smoker *increased* by 16.1 percent.[30] As Table 2 shows, premiums for the equivalent plans *decreased* by 38.7 percent in Alaska and by 5.1 percent in Oregon. That decline, however, was not limited to the lowest-cost Bronze policies. The range of premiums for Bronze plans also dropped substantially. Alaskans paid between $703 and $741 for such coverage in 2017, a figure that fell to between $431 and $455 this year. Oregonians also saw the range of premiums narrow from between $234 and $426 to between $222 and $340. Premiums for the most expensive Bronze coverage in Oregon were 20.2 percent lower in 2018 than in 2017.

Comparable data are not available for Minnesota, because it is not a healthcare.gov state. The state's Commerce Department, however, publishes average small-group and non-group premium changes by insurers. These data serve as the basis for Table 3.

Prior to implementation of Minnesota's section 1332 waiver, all five carriers that remained in the market in 2018 increased their premiums by large margins. Average premiums for four of the five carriers more than doubled between 2015 and 2017, while rates for the fifth (Medica Insurance Company) rose by 82 percent. During the first year in which the waiver was in effect, four of the companies reduced their average premiums by 0.4 percent to 38.0 percent, while the fifth (Blue Plus) raised its premiums by 2.8 percent. Rate filings for 2019 suggest that all five carriers will cut their average premiums by nontrivial amounts (between 3.0 percent and 12.4 percent), suggesting that the effects of the waiver may not be a one-time event. If those proposed rate changes are approved, it will mean that average premiums for all five insurers will be lower in 2019 than they were in 2017.

These data strongly suggest that the section 1332 risk-mitigation waivers that are already in effect are enabling insurers to resist premium increase trends that have characterized the Obamacare markets. They also suggest that the optimal size of risk-mitigation funding may vary by state and that it may take time for each state to determine its own optimal level. In short, states that obtained 1332 waivers to deviate from the Obamacare framework achieved favorable effects on premiums.

Policy Implications

Under Obamacare, the federal government commandeered individual health insurance markets with disastrous results. Section 1332 opens the door a crack to state innovation; risk mitigation waivers are a unique section 1332 success story. However, on their own, section 1332 waivers are not sufficient to undo Obamacare's damage.

To start with, the waiver process entails a significant amount of uncertainty for states. For instance, under the terms of the currently approved section 1332 waivers, the amount of federal funding contributed to a state's risk mitigation program is effective-

30. The national average monthly premium for the lowest-cost Bronze plan in 2017 was $292: Kaiser Family Foundation, "2017 Health Insurance Marketplace Calculator," November 3, 2016, https://www.kff.org/interactive/subsidy-calculator-2017/ (accessed September 21, 2018). In 2018, that rose to $339: Kaiser Family Foundation, "Health Insurance Marketplace Calculator," November 3, 2017, https://www.kff.org/interactive/subsidy-calculator/ (accessed September 21, 2018).

TABLE 3

Average Rate Changes for Non-Group Health Insurance in Minnesota, by Insurer

Company Name	2016 Average Rate Change	2017 Average Rate Change	2018 Average Rate Change	2019 Proposed Rate Change
Blue Plus	45.0%	55.0%	2.8%	–11.8%
Group Health	31.3%	53.0%	–7.5%	–7.4%
Medica Insurance Company	15.6%	57.5%	–0.4%	–12.4%
PreferredOne	39.0%	63.0%	–38.0%	–3.0%
UCare	27.3%	66.8%	–13.3%	–7.0%

SOURCE: Minnesota Department of Commerce, "Health Insurance Rates," https://mn.gov/commerce/consumers/your-insurance/health-insurance/rates/ (accessed September 24, 2018).

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ly recalculated each year. That is because the federal funding is supposed to equal the difference between what the federal government is projected to spend with, and without, the state's program, and those projections change from year to year based on a variety of factors.

For the most part, states that have sought waivers to repair and rationalize broken markets have met with frustration.

Oklahoma, for example, attempted to use the 1332 waiver process to advance an innovative "blueprint" to reform its markets that included risk mitigation, but went far beyond that.[31] Citing rising premiums, low participation in the exchanges, and persistently high rates of uninsurance, the state proposed to alter the Obamacare credit structure, allow premiums to more accurately reflect insurance risk, and give subsidized consumers direct control over their subsidies. Instead of income-related subsidies that rise dollar-for-dollar with premiums and are paid directly to insurance companies, Oklahoma proposed flat, age-related subsidies that would be distributed to all eligible individuals through health savings accounts. Consumers would pay premiums out of these accounts, reserving any balance for out-of-pocket medical expenses.

Iowa similarly proposed to establish flat credits that would vary by income and age. As in Oklahoma, recipients would be entitled to the full value of the credit, retaining any amounts that exceed premiums. The proposal also included a risk-mitigation component to moderate premiums.

Despite the Trump Administration's receptivity to 1332 waivers,[32] both proposals withered on the vine. Unlike risk-mitigation waivers, which retain most of Obamacare's regulations and mandates, Oklahoma and Iowa sought a consumer-centered restructuring of the program itself, dooming the proposals from the start. Although the Administration can make useful changes to render the waiver process more state-friendly, it is difficult to imagine modifications that would permit sweeping state innovation along the lines that Oklahoma and Iowa sought. Innovations of that magnitude require more.

Recommendations

Obamacare's rigid and centralized regulation of the non-group market is failing. Premiums have risen, choices have contracted, and enrollment in non-group policies continues to fall. The law rendered states virtually powerless to repair this damage. Congress should enact legislation to empower states to establish consumer-centered approaches that reduce health care costs and increase choices. Congress should reject efforts to give states more

31. Oklahoma Secretary of Health and Human Services, "A New Horizon: Recommendations for Oklahoma's Modernized Health Insurance Market," March 2017, https://www.ok.gov/health2/documents/1332%20Waiver%20Concept%20Paper_FINAL.pdf (accessed September 21, 2018).
32. Letter to governors from HHS Secretary Tom Price and CMS Administrator Seema Verma on section 1332 waivers, March 2017, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf (accessed September 21, 2018).

money in the name of providing "market stability," as states have shown they can stabilize their markets through section 1332 waivers without new federal money. In the interim, the Trump Administration should provide regulatory relief by rolling back Obama-era restrictions to make it easier for states to pursue the limited range of innovations permitted under section 1332 of the Obamacare statute. Congress should:

Enact the Health Care Choices Proposal. In June 2018, a group of state and national think tanks, grassroots organizations, and health policy experts developed a proposal to enable and encourage state innovation.[33] The Health Care Choices Proposal would reverse the Obamacare polarity. In place of rigid federal constraints from which waivers could provide limited relief, the proposal would rely on states to devise ways to assist the sick and needy, without pricing coverage out of the reach of healthy and middle-income families. The proposal would repeal Obamacare's federal entitlements to premium assistance and Medicaid expansion and replace them with grants to states to stand up consumer-centered programs. Instead of asking Washington's permission for some limited flexibility, states would use federal resources to finance approaches that best serve the needs of their residents.

The proposal would put in place some conditions for the grants. First, every individual who receives subsidies from the federal government (including Medicaid and Children's Health Insurance Program), would be given new freedom to spend that money on the coverage arrangement of their choice—vastly expanding their options. States, additionally, would have to use a portion of their federal allotment to establish risk-mitigation programs. The proposal would also require states to spend a specified portion of their federal grants on subsidizing private, commercially available insurance coverage for people with low incomes. States could not use the money to expand Medicaid or consign low-income people to state-contracted managed care plans.

The proposal would release states from Obamacare requirements on essential health benefits, single-risk pools, medical loss ratio, and the 3:1 limit on age rating. Nullifying these mandates and providing states with new flexibility would reduce premiums, allow premiums to more accurately reflect medical risk, and, in combination with risk mitigation, assure that the sick get the coverage they need without saddling the healthy with unfairly high premiums.

Most important, the proposal would replace the Washington-knows-best approach to health policy with one that invests states with the policy initiative, something the section 1332 waiver process cannot accomplish. The block grant approach provides certainty for state (and federal) governments by putting spending on a budget that can't be increased, as is the case today, if a state or insurer decides to spend more money. The block grant also gives states greater certainty in projecting the amount of federal funding that will be available to them over time. And it helps consumers because it gives new freedom to people to control their federal subsidy and direct it to their choice of a wide range of private coverage arrangements. Regardless of the approach a state chooses to implement, an individual can claim the value of the benefits and use it on the private coverage arrangement of their choice.

Do not create a new federally funded reinsurance program. States have shown they can take steps under Section 1332 to stabilize their markets without new federal money. It is utterly unnecessary to spend new federal money in the name of market stabilization.

Revise the Section 1332 Waiver Process. Instead of providing new federal money or creating new federal programs, policymakers should revise the section 1332 waiver process. This would allow policymakers to make incremental progress toward the goal of transitioning from Obamacare's Washington-centric approach to state-based health care reform. Obama Administration limits and statutory limits on the section 1332 process should be relaxed or removed during that transition. There already are a variety of proposals to do just that, including one from Senate HELP Committee Chairman Lamar Alexander.[34] CMS should start by rescinding the December 2015 guidance, which imposes restrictions on state innovation that go beyond the already excessive stat-

33. Health Policy Consensus Group, "The Health Care Choices Proposal: Policy Recommendations to Congress."

34. See for example letter from Senator Lamar Alexander to HHS Secretary Alex Azar and CMS Administrator Seema Verma, June 15, 2018, https://www.alexander.senate.gov/public/_cache/files/bfa4ef5a-0cf4-4478-95f3-31abfcae3bdb/6.15.18-state-innovation-waiver-letter-to-azar-and-verma.pdf (accessed September 21, 2018).

utory restrictions, creating burdens that are costly and time-consuming. In many cases, states have withdrawn their applications rather than see the process through to its conclusion. CMS should replace this process with a streamlined approach and develop model waivers organized around the principle of reducing premiums for private coverage in the broader non-group market, increasing choices for consumers. Such changes—while insufficient to the larger task of needed reform—would support states' near-term efforts to address Obamacare's damage to their broken private markets as part of a transition to the broader solution.

Conclusion

Obamacare's inflexible regime of subsidies, penalties, and regulations have roiled health care markets, restricted consumer choices, and priced coverage out of the reach of many families. Washington's foray into the individual market has proven disastrous. Congress should enact legislation that gives patients, through the states, more control over health care policy decisions rather than bureaucrats in Washington. The Health Care Choices Proposal would facilitate state-based reforms that will make health insurance affordable again, regardless of income or medical condition. As a transition to this reform, the CMS should rescind the section 1332 waiver guidance and put in place a new guidance that affords states greater latitude to adopt reforms that can help pave the way.

*—**Doug Badger** is a Visiting Fellow at The Heritage Foundation and Senior Fellow at the Galen Institute. **Edmund F. Haislmaier** is Preston A. Wells Jr., Senior Research Fellow in Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*