

Congress of the United States
Washington, DC 20515

November 29, 2018

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Steven Mnuchin
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Charles Rettig
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Secretary Azar, Administrator Verma, Secretary Mnuchin, and Commissioner Rettig:

We write to request further information regarding the Administration's October 22, 2018 guidance on Section 1332 of the Affordable Care Act (ACA). We are concerned that this guidance is unlawful, will raise costs for older and vulnerable Americans, and will eliminate protections for individuals with pre-existing conditions. As such, we are writing to request more information about the basis of the guidance as well as the process for promulgating it.

Congress enacted Section 1332 (State Innovation Waivers) of the ACA to provide states with the flexibility to experiment with health insurance reforms that could improve the well-being of their residents, but with a clear statutory directive to maintain the levels of benefits, affordability, and coverage provided to state residents by the ACA.

To ensure that any waiver achieves these goals, Congress enacted four strict statutory "guardrails" that waiver applications must meet in order to be approved by the Secretaries of Health and Human Services (HHS) and the Department of the Treasury (Treasury). Under Section 1332, states must demonstrate to the Secretaries of HHS and Treasury that their waivers:

1. "will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) [essential health benefits] and offered through Exchanges..."
2. "will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;"
3. "will provide coverage to a comparable number of its residents as the provisions of this title would provide; and"
4. "will not increase the Federal deficit."¹

¹ Section 1332(b)(1) of the ACA (emphasis added).

4. “will not increase the Federal deficit.”¹

The statutory text is clear that coverage provided under a state waiver must meet all four guardrails simultaneously: comprehensiveness, affordability, number of people covered, and deficit neutrality. This is clear not only from the plain text of the statute, which employs the conjunctive “and” rather than the disjunctive “or,” but also from the legislative history pertaining to the enactment of Section 1332. The author of the Section 1332 provision, Senator Ron Wyden, made clear that states would have to improve upon or at least maintain the levels of coverage and benefits afforded under the ACA in order to qualify for a waiver:

Exchanges are a new pathway to creating a competitive marketplace for the first time for health care in this country. Massachusetts led the way, opening the door to showing Federal legislators the potential for insurance exchanges when Massachusetts enacted its own health reform law. Many other States lead the way with innovation in health care, including States like Oregon and Vermont. That is why I have authored and championed in the Senate Finance Committee section 1332, the waiver for State innovation. If States think they can do health reform better than under this bill, and they cover the same number of people with the same comprehensive coverage, they can get a waiver exempting them from the legislation and still get the Federal money that would have been provided under the bill.²

On October 22, 2018, CMS and Treasury issued guidance for Section 1332 waivers that creates new standards for approving waivers that are wholly inconsistent with Congressional intent. Under the previous administration’s guidance, states needed to show the proposed waiver will provide comprehensive, affordable coverage to a comparable number of their residents as under the ACA, consistent with the plain language of 1332.³ The new 2018 guidance allows states to simply show that a comparable number of residents have *access* to “meaningful” coverage, regardless of whether they actually have it or not, thereby allowing the Secretary to approve waivers that do not provide coverage that is as affordable or as comprehensive as under the ACA.⁴ It also allows states to reduce coverage in the early years of the waiver, even though there is nothing in the statute that suggests that this type of loose interpretation was intended.

¹ Section 1332(b)(1) of the ACA (emphasis added).

² Statement of Senator Ron Wyden, Congressional Record, S13853 (Dec. 23, 2009) (emphasis added).

³ Department of Health and Human Services and Department of the Treasury, *Waivers for State Innovation*, 80 Fed. Reg. 78131 (Dec. 16, 2015).

⁴ Department of Health and Human Services and Department of the Treasury, *State Relief and Empowerment Waivers*, 83 Fed. Reg. 53575 (Oct. 22, 2018).

The interpretation disregards both the plain text of the statute, as well as the congressional intent behind Section 1332, which was to allow states to innovate to expand coverage, affordability, and comprehensiveness of benefits. Having “access” to coverage is not the same thing as having coverage, and the Administration’s attempt to read “access” into the statute is transparently motivated by an ideological opposition to the benefits and protections afforded by the ACA.

The revised 2018 guidance also increases costs for Americans with pre-existing conditions, seniors, and women by expanding the use of “junk” short-term plans, contrary to congressional intent. Under the 2018 guidance, states will be able to count short-term, limited-duration insurance (STLDI) as “health insurance coverage” for the purposes of meeting the requirement that a comparable number of people are covered under the waiver. These junk plans are not required to cover basic, essential health care, such as prescription drugs, maternity care, substance use disorder treatment, and mental health services. These plans may also discriminate against people with pre-existing conditions, older Americans, and women by excluding needed benefits, charging them higher premiums, and even denying coverage altogether. Allowing junk plans such as STLDI to be counted as “coverage” is contrary to Section 1332(a)(2), which does not permit states to waive any of the ACA’s protections for pre-existing conditions.⁵ Shockingly, under the new 1332 guidance, states can provide federal taxpayer dollars to subsidize these plans.

We believe this sub-regulatory guidance exceeds the Secretaries’ statutory authority. Outside of the notice-and-comment rulemaking process, it interprets the guardrails in Section 1332 to allow states to increase consumers’ costs, reduce coverage, and undermine protections for individuals with pre-existing conditions. It is contrary to the plain language of the statute, and it appears to be part of the Administration’s ideologically motivated efforts to sabotage the ACA.

In order to assist the Committees in understanding how HHS and Treasury arrived at this guidance, please provide the following information to the Committees by December 13, 2018:

1. Please provide all documents and analyses conducted by the IRS, CMS, HHS, or Treasury relating to any of the following questions:
 - a. Whether it is consistent with Section 1332 of the ACA to read the comprehensiveness and affordability guardrails as satisfied if the waiver application makes coverage that is comprehensive and affordable “available” to a comparable number of residents, even if such residents do not actually have such coverage.

⁵ Section 1332(a)(2) of the ACA.

- b. Whether it is consistent with Section 1332 of the ACA to read the comprehensiveness and affordability guardrails as satisfied if the waiver application makes coverage that is comprehensive and affordable “available” to a comparable number of residents, despite the statutory language requiring that the state waiver “will provide” insurance coverage that is at least as comprehensive and affordable as under the ACA.
 - c. Whether it is appropriate for a sub-regulatory guidance document to adopt a definition of “coverage” from a part of the law outside of the ACA, which includes STLDI, despite Section 1332(a)(2), which does not permit states to waive any of the individual market reforms contained in Subtitle C of the ACA.
 - d. Whether it is appropriate to read the word “access” into the comprehensiveness and affordability guardrails, thereby allowing states to reduce benefits and increase costs for residents in comparison to ACA.
 - e. Whether it is consistent with Section 1332 of the ACA to allow approval of a state plan that does not provide coverage to “at least a comparable number of its residents” by allowing a “temporary reduction in coverage,” so long as it makes it up in aggregate over the waiver term.
 - f. Whether the law permits HHS and Treasury to consider whether a 1332 waiver increases access to private market coverage over public programs in determining whether grant such waiver.
 - g. Whether the law permits HHS and Treasury to approve 1332 waivers that provide for individuals enrolled in STLDI to receive Advanced Premium Tax Credits (APTC).
- 2. Please provide any documents and communications pertaining to the potential impact of the 1332 guidance, including its impact on individuals with pre-existing conditions, and including any actuarial or fiscal impact analyses from CMS, the Office of Tax Analysis, and the Office of Management and Budget.
 - 3. Please provide a comprehensive list of all agency personnel at Treasury, IRS, HHS, or CMS who were involved in any way in promulgating, reviewing, or finalizing the Section 1332 guidance.
 - 4. Why did the Departments decide to promulgate 1332 guidance rather than go through notice of proposed rulemaking (NPRM)?

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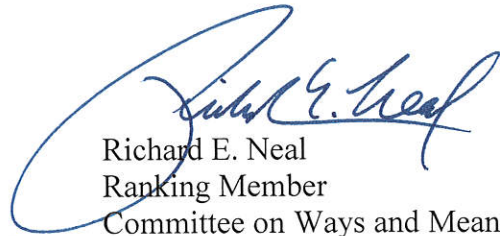
- a. Please provide all analyses conducted by the IRS, CMS, HHS, or Treasury relating to the question of the legality or appropriateness of making the proposed changes via guidance rather than an NPRM.
5. Please provide all documents and communications between Treasury, IRS, HHS, and CMS employees, and employees of the Executive Office of the President, including the Office of Management and Budget, referring or relating to the 1332 guidance.

Thank you for your attention to this matter. We look forward to your response in the near future.

Sincerely,



Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce



Richard E. Neal
Ranking Member
Committee on Ways and Means