

Health Policy Brief

State health coverage innovation and Section 1332 waivers: Implications for states

Produced by the Deloitte Center for Health Solutions and the Deloitte Center for Regulatory Strategies



Executive summary

Although states and the federal government have implemented most Affordable Care Act (ACA) provisions, a few are scheduled to go into effect in the coming years. One such provision is Section 1332 State Innovation Waivers,¹ (1332) which allows states to pursue alternative and innovative strategies for ensuring that residents have access to high-quality, affordable health insurance as long as they meet certain requirements. Within the constraints of Section 1332, states have numerous options for revamping their current approaches to providing health coverage to individuals and families. If approved, the waivers can go into effect beginning January 1, 2017. To implement reforms next year and take advantage of realizing innovative alternatives for health care coverage, states should consider acting now.

New guidance from the US Departments of Health and Human Services (HHS) and Treasury released at the end of 2015 indicates that waiver proposals from states using the federally facilitated health insurance exchange might not be considered feasible at this time because “the Federal platform cannot accommodate different rules for different states.”² Instead, these states may want to consider establishing their own exchange platform and then apply for a 1332 waiver.

This health policy brief presents a number of potential waiver-associated coverage alternatives, including those being discussed by some states. While some options are mutually exclusive, states may include multiple innovative concepts in their applications. It is important to note that, even with the new HHS and Treasury guidance, the analysis required to support a 1332 waiver application may require states to leverage actuarial, policy, technology, and data expertise.

What are Section 1332 waivers?

During ACA congressional negotiations, Section 1332 waivers were envisioned as a way for a state to achieve ACA coverage goals by pursuing alternative approaches that might better suit its specific health care market needs.

States can apply for Section 1332 waivers in 2016 as long as they allow sufficient time for proposal review and implementation. If a state’s application is approved, the waiver can go into effect beginning January 1, 2017.

When developing their alternative approaches to health care coverage, states must address certain requirements; specifically, that coverage:

- Be at least as comprehensive and affordable as coverage provided without a waiver;
- Be held by a comparable number of the state’s residents as coverage provided without a waiver; and
- Not increase the federal deficit.

Section 1332 waivers were championed by Oregon Senator Ron Wyden, who filed a health reform proposal with Utah Senator Robert Bennett in 2007 called the Healthy Americans Act. The Wyden/Bennett bill contained a provision to foster state innovation. The Senate amendment inserting Section 1332 into the ACA borrowed much of the state innovation language from the Healthy Americans Act.³ If a state can show that its state law would more effectively accomplish the ACA’s coverage, affordability, and regulatory goals, the law gives states the flexibility and autonomy to try new approaches.

In 2012, HHS and Treasury issued a final rule⁴ outlining the new Section 1332 review process and timeline; in late 2015 they released additional guidance which indicates that waivers might not be viable at this time for states that rely on the federally facilitated health insurance exchange platform. Instead, these states may consider waiving the provision entirely and relying on a state-administered tax program.

What innovative approaches to providing health insurance coverage may states consider taking?

Within the constraints of Section 1332, states have many options for revamping their current approaches to providing health coverage to individuals and families. What follows are a number of alternatives that some states are considering. While some options are mutually exclusive, states can include multiple innovative concepts in their application.

Privatize their health insurance exchange

A state could choose to leave the federally facilitated exchange (or its own state-based exchange) and use a privately built and administered health insurance exchange (or multiple private health insurance exchanges) to connect state residents (both with and without premium subsidies) with health plans offered on those exchanges.ⁱ The state might consider using its public assistance eligibility system or a separate eligibility system to determine an individual's or family's eligibility for – and to set the level of – subsidy and cost-sharing reductions. Note that the late-2015 HHS and Treasury guidance indicates that waiver proposals which affect processes of the federally facilitated exchange platform by states using that platform might not be considered feasible at this time because “the Federal platform cannot accommodate different rules for different states.”

Eliminate the individual mandate penalty

A state could choose to eliminate the ACA's individual tax penalty for non-participation in a health coverage plan and replace it with some type of “user fee” or other method to enforce personal responsibility for non-participants who need health coverage.

Eliminate the employer mandate

A state may decide to modify or eliminate ACA-imposed penalties on large employers that do not offer affordable coverage to their full-time employees. States that opt for this approach must find alternative revenue-generating or cost-cutting provisions to achieve budget neutrality. The December 2015 guidance states that because the Internal Revenue Service (IRS) “is not generally able to administer different sets of rules in different states,” states considering waiver proposals that include a modified version of a federal tax provision may consider waiving the provision entirely and instead rely on a state-administered tax program.

ⁱ For the employer view on private insurance exchanges, please see Deloitte's paper, “Private insurance exchanges: Outlook is good” at <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/private-health-insurance-exchanges.html>.

Align and coordinate with Medicaid

A state might change its commercial health coverage market in ways to more closely align and coordinate with Medicaid:

- A state could combine Medicaid and premium assistance into a single private marketplace where the only differences between Medicaid and the premium subsidies are the funding source and the amount of cost-sharing. A state could base the income level on an individual's previous year's income unless there has been a large change.
- A state could choose to modify the premium subsidy calculation in a manner that minimized the "cliff" for those who churn to below and above 138 percent of the federal poverty level (FPL) (or 100 percent FPL for non-expansion states).
- The state could group families that currently have some members in Medicaid/Children's Health Insurance Program (CHIP), other members in Medicaid's private health coverage program, and others in a subsidized coverage program, regardless of funding source.
- A state could better align exchange, Medicaid, and other program rules through:
 - Changing income policy so that income that is currently counted differently under Medicaid, the state's Basic Health Program (BHP), and the exchanges, would now be treated the same across all three.
 - Modifying verification rules so that they are consistent across Medicaid and the insurance marketplaces.
 - Implementing a consistent enrollment-effective date, since the ACA and the Social Security Act use different enrollment start dates for Medicaid, Qualified Health Plans (QHPs), and the BHP.
 - Modifying the definition of American Indian so that it is the same for Medicaid and marketplace coverage.

State innovation waivers and Medicaid

Section 1115 of the Social Security Act⁵ gives the Secretary of HHS authority to waive certain provisions, including certain Medicaid requirements, and allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. This includes testing and implementing new enrollment and coverage approaches that do not meet federal program rules.

The ACA created new Section 1115A requirements as well as Section 1332 waiver authorities. Section 1115A authorizes the Secretary to waive provisions of Medicare, Medicaid, and CHIP law; establishes the Center for Medicare and Medicaid Innovation (CMMI); and provides \$10 billion through FY2019 to test, evaluate, and expand different service delivery and payment models to slow cost growth while preserving or enhancing quality of care. Section 1332 provides authority for state innovation waivers of non-Medicaid provisions of the new law related to exchanges, benefits, and cost-sharing protections and includes provisions to coordinate the Section 1115 and Section 1332 waiver processes. Notably, the Administration in December 2015 provided guidance stating that savings accrued under either a current or proposed Section 1115 waiver would not be factored into the federal government's assessment of whether a Section 1332 waiver meets the ACA's deficit-neutrality requirement.

Early approaches: Hawaii and Vermont

Hawaii is interested in using the Section 1332 waiver to reconcile the ACA and the state's Prepaid Health Care Act, an employer mandate that was in effect prior to the ACA's passage.⁶ The Prepaid Health Care Act, which requires employers to provide coverage for eligible employees, is a popular provision that has led to 92 percent of the state's residents obtaining health care coverage. Efforts to reconcile the Prepaid Health Care Act and ACA provisions created challenges for Hawaii, which resulted in the legislature establishing a task force focused on 1332 waiver possibilities. The task force has engaged stakeholders to review options publicly and transparently – a process that could serve as a model for other states. Hawaii operated its own health insurance exchange platform for 2014 and 2015 but used the federally facilitated exchange for 2016. Based on the Administration's December 2015 guidance, depending upon the changes the state seeks, Hawaii might face obstacles pursuing a 1332 waiver while using the federally facilitated exchange platform.

Vermont explored the possibility of using the 1332 waiver to implement a single-payer system in the state called Green Mountain Care. Proponents of the plan wanted to redirect ACA subsidies, supplemented with state funds, to finance a gold-level benefit plan for residents. Cost concerns eventually ended the initiative, but Vermont remains an example of the diverse types of coverage strategies that states may consider.⁷

Offer a public option

A state could consider providing coverage for all residents by decoupling employment from health insurance coverage and relying on private insurance coverage only for supplemental health services. A state government or quasi-government agency could organize health care coverage and contracting of provider payments. The state could use a single eligibility and enrollment process to determine how much the government would subsidize care and the amount of an individual or family's contribution toward their care. This public option would require state or other non-federal funding beyond ACA-provided subsidies and tax credits since it covers all residents regardless of financial resources; however, those individuals would no longer have to pay health insurance premiums or cost-sharing through their employer or directly to commercial health insurance carriers.

Introduce ACA premium subsidy alternatives

A state might also use the 1332 waiver process to modify the premium assistance tax credits provided to lower-income individuals under the ACA. Specifically, it could:

- Expand who receives the subsidy by increasing the income limit above 400 percent of the FPL;
- Use a premium (or voucher) approach, in which the state would pay enrollees a fixed dollar amount to buy insurance and enrollees would be responsible for the remaining cost;
- Have enrollees pay a fixed percentage of the total premium, with the state paying the rest; and
- Make tax credits available to other individuals, such as families who are prevented from receiving a credit on the exchange if one spouse is available for eligible employer coverage.

As explained above, the December 2015 guidance indicated that states considering waiver proposals that include a modified version of a federal tax provision may consider waiving the provision entirely and relying on a tax program administered by the state.

These subsidy alternatives are common approaches in the employer insurance market and may be more familiar than a tax credit or a voucher approach. However, any expansion of tax credits or cost-sharing subsidies must remain budget-neutral to the federal government.

While Section 1332 waivers are available for states to try different coverage approaches, their goals must align with the ACA's intent to expand coverage and make it affordable. No Section 1332 waiver can be granted for a plan that would weaken these outcomes as determined by HHS and Treasury. At a minimum, a 1332 waiver must:

- Be federal deficit-neutral over a 10-year budget period;
- Provide coverage "at least as comprehensive as" under the ACA;
- Ensure that as many or more individuals will have health coverage than as under the ACA; and
- Implement affordability standards equal to or greater than the ACA.

Other important ACA elements that cannot be waived include insurance marketplace protections such as:

- Guaranteed issue, which requires insurance companies to sell a health plan to any applicant – an individual or a group – regardless of the applicant's health status or other factors;
- A ban on pre-existing condition exclusions, which prohibits health insurance companies from not covering a person with a pre-existing condition or charging an individual who has a pre-existing more for coverage;
- Annual/lifetime cap on benefits, as the ACA prohibits health plans from putting annual or lifetime dollar limits on most benefits; and
- The rules of the small, large, or self-insured groups for employees: states could seek to expand the firm size for Small Business Health Options Program (SHOP) participation or eliminate the program, but they cannot change the rating and other market rules that govern insurance sold in the small group market.

The Basic Health Program

The Basic Health Program (BHP) is an ACA component that allows states to experiment with alternative coverage models and, potentially, reduce churn between Medicaid and QHPs. The BHP provides states with the option to establish a health benefits coverage program for lower-income individuals as an alternative to exchange coverage under the ACA. The voluntary BHP permits states to create affordable options for individuals with incomes that are too high to qualify for Medicaid but are in the lowest income category of residents who would be eligible to purchase coverage through the exchange. CMS issued final rules on the BHP in spring 2014, which can be found at: <http://www.medicaid.gov/basic-health-program/basic-health-program.html>.

Section 1332 guidance to date

The 2012 final rule⁸ on State Innovation Waivers released by HHS and the Treasury initially received limited attention, as it is likely states were focused on other ACA provisions rather than one that was not going into effect until 2017. As states later began to review the 1332 regulations, some stakeholders expressed confusion about the application process and the types of waivers most likely to be approved. The Departments released additional guidance in December 2015.

The December 2015 guidance focused on the requirements that states must meet, the application review process, the amount of pass-through funding, certain analytical requirements, and operational considerations. The guidance clarified that states must consider and report the waiver's potential impact on coverage for all state residents – especially vulnerable populations such as low-income individuals, the elderly, and individuals with serious health condition – regardless of the type of coverage they would have without the waiver. Under the deficit-neutrality requirement, states must estimate how the waiver would impact federal revenue, including all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees). The Secretaries' assessment of a state's proposal and whether it is budget-neutral will not consider changes in the Medicaid program caused by a 1115 waiver program, whether current or proposed. However, changes in Medicaid and CHIP that would result directly from the Section 1332 waiver will be considered.⁹

Application requirements

Before a state submits an innovation waiver application to HHS and Treasury it must take several steps to indicate its interest. At a minimum, the state must have:

- A public hearing for policymakers to consider the innovation the state hopes to pursue;
- A public comment period to solicit and allow a meaningful level of input from individuals, businesses, insurers, and other impacted stakeholders;ⁱⁱ and
- An enacted state law specifically granting the state authorization to pursue and implement the innovation(s) once federal waiver approval is finalized.

Once these pre-steps are completed, the state must submit an application to HHS and Treasury to begin the waiver evaluation period. The application must include:

- Ten-year budget plan (must be deficit-neutral to the federal government);
- Implementation timeline;
- Program/initiative overview (including a list of ACA provisions the state is seeking to waive, including rationale);
- Description and copy of state legislation providing state authority to seek and implement a 1332 waiver;
- Explanation of how the requested waiver will help meet goals of coverage, affordability, robust benefits (at same or higher level than under the ACA): the explanation must include date, assumptions, and targets on how the waiver will achieve these goals;
- Economic and actuarial analysis of the waiver's cost and benefits; and
- Description of the waiver's impact on employers, insurers, consumers, and other groups that would be impacted.

HHS and Treasury will conduct a review within 45 days of an application's submission. If the agencies certify the application as complete, federal public notice and comment periods will start. These comment periods are required before a waiver approval can be finalized. HHS and Treasury will issue a final decision no later than 180 days following an application's submission.

ii States with at least one federally recognized Indian tribe must conduct a separate process to ensure that meaningful input is received from tribe members.

Analysis required for a 1332 waiver application

The analysis required to support a state's 1332 waiver application calls for actuarial, policy, technology, and data expertise to examine cost (federal and non-federal), number of individuals covered under alternative proposals, and overall economic impacts, specifically:

- A fiscal comparison of current ACA program affordability with the state's proposed alternative(s) to ensure that total out-of-pocket expenses for members are equal to or less than the pre-waiver coverage;
- A comparison of the populations covered in the waiver with those eligible for pre-waiver coverage; and
- A budget-neutrality calculation that clearly shows the 1332 waiver will not expend more federal funds than would have been expended in the pre-waiver period (with health cost trends taken into effect over the course of the waiver).

The state will need to estimate the pre-waiver funding available under traditional ACA programs (e.g., tax penalties for the individual mandate, penalties under the employer mandate, total premium tax credits, and cost-sharing reductions) to demonstrate comparability between pre- and post-waiver benefits and affordability. This process likely will require actuarial support, possibly including Actuarial Certifications. The state will need to conduct the same comparison for plan design and model coverage to estimate the "take-up" rate of a new model and whether the covered population total is at least as large as without the waiver. In addition, the state will need to determine the commercial market implications (e.g., economic analysis, quantification of the uninsured population, and impact on Medicaid populations).

Since the 1332 waiver requires budget neutrality, a state will need to compare federal expense without the waiver (WOW) and with the waiver (WW). WOW strategies will depend on how broad the state's assumptions are allowed to be. The WW will require significant assumptions (and agreement with CMS on those assumptions) both for the programs and populations covered in the waiver, and for the downstream impact on programs and populations outside the waiver. As 10-year assumptions may be difficult to project and support, it will be important for the state to determine its liability should it not achieve budget neutrality.

A final consideration

As the United States moves closer to the next presidential election, the health care landscape will continue to shift and evolve. Beginning in 2017, an Administration other than the Obama Administration will have stewardship over the ACA and its various provisions, including Section 1332 State Innovation Waivers, for the first time. States should be aware that – depending on where they are in the application process at the start of 2017 – approvals may depend on the goals of the new Administration.

Endnotes

1. Public Law 111-148: Section 1332 (codified as 42 U.S.C. 18052)
2. Waivers for State Innovation, 31 CFR 33, December 16, 2015
3. John E. McDonough, "Wyden's Waiver: State Innovation on Steroids," *Journal of Health Politics, Policy and Law*, May 19, 2014
4. Application, Review, and Reporting Process for Waivers for State Innovation, 31 CFR 33, February 27, 2012
5. 42 U.S.C. 1315
6. Deborah Bachrach, Joel Ario and Michael Kolber, "Thinking Ahead, 1332 State Innovation Waivers," December 2014
7. Robin Lunge, Green Mountain Care, "Vermont's universal and unified health system, and the federal waiver for state innovation," October 29, 2014
8. Application, Review, and Reporting Process for Waivers for State Innovation, 31 CFR 33, February 27, 2012
9. Waivers for State Innovation, 31 CFR 33, December 16, 2015



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