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Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform

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Abstract States have long been the testing ground for new models of health care and coverage. Section 1332 of the Affordable Care Act, which takes effect in less than two years, throws open the door to innovation by authorizing states to rethink the law's coverage designs. Under State Innovation Waivers, states can modify the rules regarding covered benefits, subsidies, insurance marketplaces, and individual and employer mandates. States may propose broad alternatives or targeted fixes, but all waivers must demonstrate that coverage will remain as accessible, comprehensive, and affordable as before the waiver and that the changes will not add to the federal deficit. This issue brief describes how states may use State Innovation Waivers to reallocate subsidies, expand or streamline their marketplaces, replace or modify the mandates, and otherwise pursue their own brand of reform tailored to local market conditions and political preferences.

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OVERVIEW

The Affordable Care Act (ACA) establishes a new national paradigm for health coverage while leaving room for considerable experimentation by states. Indeed, building on a long history of state innovation with coverage, payment, and delivery models, the ACA is fueling far-reaching campaigns by governors to reform state health care systems across payers and providers. The door to innovation will be thrown open even further in 2017, when section 1332 of the ACA invites states to find alternative ways to meet the coverage goals of the law while staying within its fiscal constraints.

Developed with bipartisan support that continues to this day, section 1332, known as State Innovation Waivers, authorizes states to request five-year renewable waivers from the U.S. Departments of Health and Human Services (HHS) and the Treasury of the ACA's key coverage provisions, including those related to benefits and subsidies, the exchanges (also known as marketplaces), and the individual and employer mandates.[1]

Depending on their policy and political priorities, states may propose waivers to pursue broad alternative approaches to expand coverage or targeted fixes intended to smooth the rough edges of the ACA. Some ACA provisions, such as guaranteed issue, may not be waived and all applications must demonstrate that coverage remains as accessible, comprehensive, and affordable as before the waiver and that the proposed changes will not contribute to the federal deficit.

In this brief, we examine the requirements of section 1332 and explore how states might utilize the waivers. We do so with limited guidance from HHS, whose only regulations to date relate almost entirely to the application process.[2] Thus, our exploration is based on the statutory language, considerable experience with exchanges and Medicaid waivers, and interviews with policy experts and state officials (Appendix A).

THE BASICS

What May Be Waived?

States may propose alternatives to four pillars of the ACA:

- **Benefits and Subsidies.** States may modify the rules governing covered benefits, as well as the subsidies that are available through the marketplaces. States seeking to reallocate premium tax credits and cost-sharing reductions may receive the aggregate value of those subsidies to implement their alternative approaches.
- **Marketplaces and Qualified Health Plans.** States may replace their marketplaces or supplant the plan certification process with alternative ways to provide health plan choice, determine eligibility for subsidies, and enroll consumers in coverage.
- **The Individual Mandate.** States may modify or eliminate the requirement that individuals maintain minimum essential coverage.
- **The Employer Mandate.** States may modify or eliminate the requirement that large employers offer affordable coverage to their full-time employees.

FAIR PLAY RULES MAY NOT BE WAIVED

States may not waive the ACA's nondiscrimination provisions, which prohibit carriers from denying coverage or increasing premiums based on medical history. States are also precluded from waiving related "fair play" rules that guarantee equal access at fair prices for all enrollees.

Waiver Guardrails

State Innovation Waivers must satisfy four criteria:

- **Comprehensive Coverage.** States must provide coverage that is "at least as comprehensive" as coverage absent the waiver.
- **Affordable Coverage.** States must provide "coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable" as coverage absent the waiver.
- **Scope of Coverage.** States must provide coverage to "at least a comparable number of residents" as would have been covered without the waiver.
- **Federal Deficit.** The waiver must not increase the federal deficit.

Coordination with Other Waivers

HHS is required to coordinate and consolidate the 1332 waiver process with waiver processes for Medicaid, Medicare, the Children's Health Insurance Program, and other federal laws relating to the provision of health care services. Such consolidation of waivers allows for better alignment of coverage programs and may create some flexibility in how waiver packages are assessed.

Taken together, these provisions confirm the ACA's central policy goal—ensuring that every American has access to affordable and meaningful coverage—while giving states considerable flexibility to decide how best to achieve this within their borders. Ultimately, the extent of that flexibility will be defined by statute, regulation, and most notably, through the lens of the administration reviewing the 1332 waiver requests.

CONSOLIDATING 1332 AND 1115 WAIVERS: ARKANSAS

Arkansas' section 1115 expansion waiver, also known as the private option, authorizes the state to use Medicaid funds to purchase qualified health plan (QHP) coverage on the marketplace. While the Government Accountability Office challenged the program's budget neutrality, the expansion has been enormously successful. Nearly 200,000 newly eligible adults enrolled in coverage through QHPs in the Arkansas marketplace, which substantially increased its size and helped drive down premium costs. As premiums go down, federal costs related to tax credits likewise decrease. Such savings do not count toward budget neutrality, however, because they are not savings to the Medicaid program. Under a consolidated 1115 and 1332 waiver, one could envision HHS permitting states to demonstrate budget neutrality across waivers. Arkansas Governor Asa Hutchinson recently alluded to a 1332 waiver as playing a role in the future of the private option.

POSSIBLE WAIVER STRATEGIES

State Innovation Waivers create a fresh opportunity for states to pursue their own brand of reform tailored to local market conditions and political preferences. As one commentator noted, "Without even changing the law, 1332 could change the ACA almost beyond recognition."[3] The possibilities are far ranging, but all are subject to the coverage and fiscal guardrails discussed above. There is considerable interest in the waivers across the political spectrum, although few state officials have identified a particular path forward. The most compelling ideas may emerge after state officials and key stakeholders come together and—through the public and transparent process required under section 1332—forge consensus. Interviews with policy experts and state officials suggest the following areas of interest.

Rethinking Subsidies for Marketplace Plans

The ACA seeks to make coverage affordable for those above Medicaid income-eligibility levels through a combination of subsidies that includes premium tax credits and cost-sharing reductions. State officials at both ends of the political spectrum question whether the law's subsidy rules strike the right balance. Some are concerned that cost-sharing levels are too high and will impede access to care. Others would welcome health plans with greater cost-sharing and lower premiums to attract younger and healthier populations. Both approaches seek to minimize "subsidy cliffs" (dramatic drops in subsidy amount as income rises) and establish more graduated subsidies.

For example, a state may pursue a consolidated 1332 and Medicaid waiver to smooth the subsidy cliff faced by individuals moving from Medicaid to the marketplace. It could align premiums for higher-income Medicaid enrollees with those of lower-income marketplace enrollees and, in doing so, could redeploy the aggregate value of tax credits and cost-sharing reductions to increase subsidies for those with more modest incomes and develop more graduated subsidies.

Alternately, some states may pursue the addition of high-deductible, lower-premium plans with greater cost-sharing than is currently allowed in the marketplaces and use the savings to offer health savings accounts to ease cost burdens on low-income individuals—similar to what Indiana has implemented for its Medicaid enrollees. While this may increase the number of individuals covered and decrease premiums if the overall risk pool is improved, the waiver application would need to meet the requirement that coverage be at least as affordable as coverage absent the waiver. The same concerns would apply to states interested in allowing value-based purchasing models that increase cost-sharing for lower-value services or lower-quality plans. Such waiver approaches would have to address how the benefits to some consumers would be balanced against the increased costs to others. States also must be mindful that current spending on subsidies will influence the amount available through a 1332 waiver.

PRECEDENT FOR REDEPLOYING FEDERAL SUBSIDIES: THE BASIC HEALTH PROGRAM

Under the Basic Health Program (section 1331 of the ACA), states may receive 95 percent of the aggregate value of subsidies that otherwise would have gone to individuals with incomes up to 200 percent of the federal poverty level who are eligible to purchase marketplace coverage and use those funds to offer more affordable coverage. The method for calculating the aggregate federal funding available under this approach suggests how HHS might calculate the funding available to states under State Innovation Waivers. Under Basic Health Program (BHP) regulations, HHS develops rate cells, breaking down the potentially eligible population by age range, geographic area, coverage category, household size, and income level. The payment rate is calculated by taking the sum of 95 percent of the tax credits and cost-sharing reductions–adjusted for risk and other factors–multiplied by the projected number of enrollees within each rate cell. The aggregate amount the state receives is equal to the sum of the payment amounts for each rate cell, reconciled retrospectively based on actual enrollment, coverage category, household size, and income level.

Notably, come 2017, section 1332 will allow states to accomplish the goals of the BHP with 100 percent of the aggregate subsidy amount, rather than 95 percent as authorized for the BHP.

Reforming the Marketplaces

The marketplaces play a central role in the ACA, though some states have done little to support them (ceding control to the federal government) while others are broadening their role. Section 1332 allows for either approach, although states currently using the federal marketplace may be limited in their ability to modify its provisions unless and until the federal marketplace can accommodate more state-specific policies. These states may eliminate the federal marketplace entirely, however, as long as their waiver applications address the law's coverage and fiscal goals.

Eliminating the marketplaces may be an especially attractive option in smaller states where only limited numbers use them. States may choose to replace them with a system that offers vouchers for eligible individuals to purchase coverage from any lawful seller of ACA-compliant coverage. Alternately, states may leverage the rapid growth of Web brokers and private exchanges to outsource marketplace functions to one or more competing Web-based sellers. The federal marketplace already allows a version of this approach, but states may want to move beyond what is currently allowed by the statute.

Other states may want to enhance their marketplaces' scale and leverage by using a 1332 waiver to offer coverage options for additional populations or even to serve as the sole provider of

coverage. (Vermont state officials contemplated but ultimately did not pursue this approach, citing fiscal constraints.) States may take incremental steps in this direction by, for instance, adding state employees or other large purchasing pools to their marketplaces.

Waivers focused on reforming the marketplaces are likely to have little impact on the coverage guardrails, though states should be mindful of how changes affect access to coverage across different populations.

CONTEMPLATING THE OPTIONS POSED BY 1332

In Hawaii, a longstanding and popular employer mandate, the Prepaid Health Care Act, has led to a high coverage rate (92%) among state residents. Efforts to reconcile Prepaid Health Care Act and ACA provisions have created challenges for Hawaii and motivated the legislature to establish a task force focused on 1332 waiver possibilities. The task force has not yet made any substantive recommendations but has engaged stakeholders in a review of options–a process that could be a model for other states wanting to ensure that all options are considered in a public and transparent way.

Replacing or Modifying the Individual and Employer Mandates

With some exceptions, the ACA penalizes individuals who do not have minimum essential coverage or employers that do not offer such coverage. Arguably the least popular provisions in the law, the individual and employer mandates may be prominently featured in states' 1332 waiver applications. Possible alternatives to the individual mandate include implementing penalties for late enrollment (similar to Medicare), reducing opportunities for enrollment (e.g., multiyear waiting periods if open enrollment is missed), or establishing automatic enrollment. On their own, waivers of the individual mandate would not impact the comprehensiveness of coverage, though they could reduce the number of individuals covered, decrease affordability, and increase federal costs (if premiums rise as a result). Much would depend on how effective the mandate alternative is at maintaining scope of coverage and a balanced risk pool.

As an alternative to the employer mandate, states may implement a "play or pay" requirement in which employers must pay a flat percentage of payroll in benefits or taxes. With the relatively low enrollment in the Small Business Health Options Program (SHOP), many states may welcome the flexibility to experiment with new approaches to serving the small business community. While waivers of the employer mandate might have little impact on coverage, they might have a significant fiscal impact: such a waiver would reduce the penalty revenue to the federal government and therefore raise the federal deficit, absent some other waiver component to offset it.

Targeted Fixes

In the earlier sections, we reflect on some of the more expansive ideas that have emerged around 1332 waivers. In this final section, we look at more targeted approaches. By targeted, we do not mean small or unimportant, but rather approaches that focus on a narrow slice of the law, such as undoing the ACA requirement that small-group rating rules apply to businesses with 51 to 100 employees. Other targeted reforms that were suggested in our interviews include:

- **Filling Coverage Gaps.** States might address coverage gaps, such as the "family glitch," which makes dependents ineligible for tax credits if they are offered employer coverage, regardless of whether that coverage is affordable.

- **Advancing State Reform Priorities.** States might provide incentives for health care quality improvement by reallocating subsidies to favor plans with higher quality ratings, as is currently done in Medicare Advantage.
- **Grace Periods.** States might replace the ACA's three-month grace periods for nonpayment with the one-month grace periods that are common in states for plans outside the marketplace.
- **Aligning Rules.** States might alter the rules on issues such as the definition and verification of income to align exchange, Medicaid, and other program rules.
- **Simplifying Regulations.** States might want to preserve federal reforms, such as cost-sharing reductions, but replace complex federal recordkeeping rules.

SMOOTHING THE LAW'S ROUGH EDGES

The Minnesota Department of Human Services has identified several opportunities for better aligning coverage rules across subsidy programs, including:

- *Income counting.* Income is counted differently under Medicaid, the state's BHP, and the marketplaces.
- *Eligibility verification.* Verification rules are not entirely consistent across Medicaid and the marketplaces.
- *Implementation of a consistent enrollment effective date.* The ACA and the Social Security Act use different enrollment start dates for Medicaid, QHPs, and the BHP.
- *Definition of American Indian.* The definition of American Indians differs for purposes of Medicaid and marketplace coverage.

CONCLUSION

State Innovation Waivers involve a delicate balancing act: providing states with considerable latitude to experiment with alternative coverage mechanisms while also requiring that they continue to meet the coverage and affordability goals of the Affordable Care Act. Combined with Medicaid waivers, they may provide states with the opportunity to move beyond the politics of the ACA and pursue their own reforms. Indeed, if state policymakers agree on the value of having accessible, affordable, and meaningful health care coverage for all, then 1332 waivers offer a way to achieve these goals while reinforcing states' leadership role in regulating their insurance markets and serving as the laboratories of health reform.

Appendix A. List of Interviewees

Stuart Butler, Ph.D., Senior Fellow, Economic Studies, Brookings Institution

Devon Green, Special Counsel for Health Care Reform, Vermont Agency of Administration

Gordon Ito, Insurance Commissioner, Hawaii Department of Commerce and Consumer Affairs, and Vice Chair, Hawaii State Innovation Waiver Task Force

Scott Leitz, Chief Executive Officer, MNsure (Minnesota Health Insurance Marketplace)

Robin Lunge, Director of Health Care Reform, Vermont Agency of Administration

John McDonough, Dr.P.H., Professor, Department of Health Policy and Management, and Director, Center for Executive and Continuing Professional Education, Harvard University School of Public Health

Len Nichols, Ph.D., Director, Center for Health Policy Research and Ethics, and Professor of Health Policy, College of Health and Human Services, George Mason University

Marie Zimmerman, Medicaid Director, Minnesota Department of Human Services

Notes

1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

2 U.S. Department of the Treasury and U.S. Department of Health and Human Services. Final Rule. "Application, Review, and Reporting Process for Waivers for State Innovation." *Federal Register* 77, no. 38 (Feb. 27, 2012):11700, http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf.

3 S. M. Butler, "Why the GOP Needs an Alternative to the Obamacare Repeal Strategy," *Health360* (blog), Brookings Institution, Jan. 28, 2015, http://www.brookings.edu/blogs/health360/posts/2015/01/28-gop-obamacare-repeal-strategy-alternative-butler.

About the Authors

Deborah Bachrach, J.D., a partner with Manatt, Phelps & Phillips, has more than 25 years of experience in health policy and financing in both the public and private sectors and an extensive background in Medicaid policy and health care reform. She works with states, providers, plans, and foundations in implementing federal health reform and Medicaid payment and delivery system reforms. Most recently, Ms. Bachrach was Medicaid director and deputy commissioner of health for the New York State Department of Health, Office of Health Insurance Programs. She has previously served as vice president for external affairs at St. Luke's-Roosevelt Hospital Center and as chief assistant attorney general and chief of the Civil Rights Bureau in the Office of the New York State Attorney General. Ms. Bachrach received her B.S. from the University of Pennsylvania, Wharton School, and her J.D. from New York University School of Law.

Joel Ario, J.D., a managing director at Manatt Health Solutions, has two decades of experience leading health insurance reform efforts at the state and federal government levels. He provides strategic consulting and policy analysis to assist state governments, health plans, hospitals, foundations, and other stakeholders in understanding and navigating the health reform landscape, with a particular emphasis on the role of public and private exchange-based marketplaces. Mr. Ario previously served as director of the Office of Health Insurance Exchanges at HHS, where he led HHS efforts to develop the regulatory framework for exchanges. Prior to his federal service, Mr. Ario was Pennsylvania Insurance Commissioner from 2007 to 2010 and Oregon Insurance Commissioner from 2000 to 2007. Mr. Ario received his B.A. from St. Olaf College, M.Div. from Harvard Divinity School, and J.D. from Harvard Law School.

Hailey Davis, M.P.H., a manager at Manatt Health Solutions, provides policy analysis, project implementation support, and other strategic business services to foundations, health care providers, payers, and other health care stakeholders. Her services focus primarily on the implementation of the Affordable Care Act, state marketplaces, and Medicaid managed care. Prior to joining Manatt, she served as a program analyst in the HHS Office of the Inspector General Office of Evaluation and Inspections. In this position she conducted national and statewide evaluations of HHS programs and served as a member of the Healthcare Reform Strategy Work Group. Ms. Davis received her B.A. from the University of Texas and her M.P.H. from Columbia University.

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