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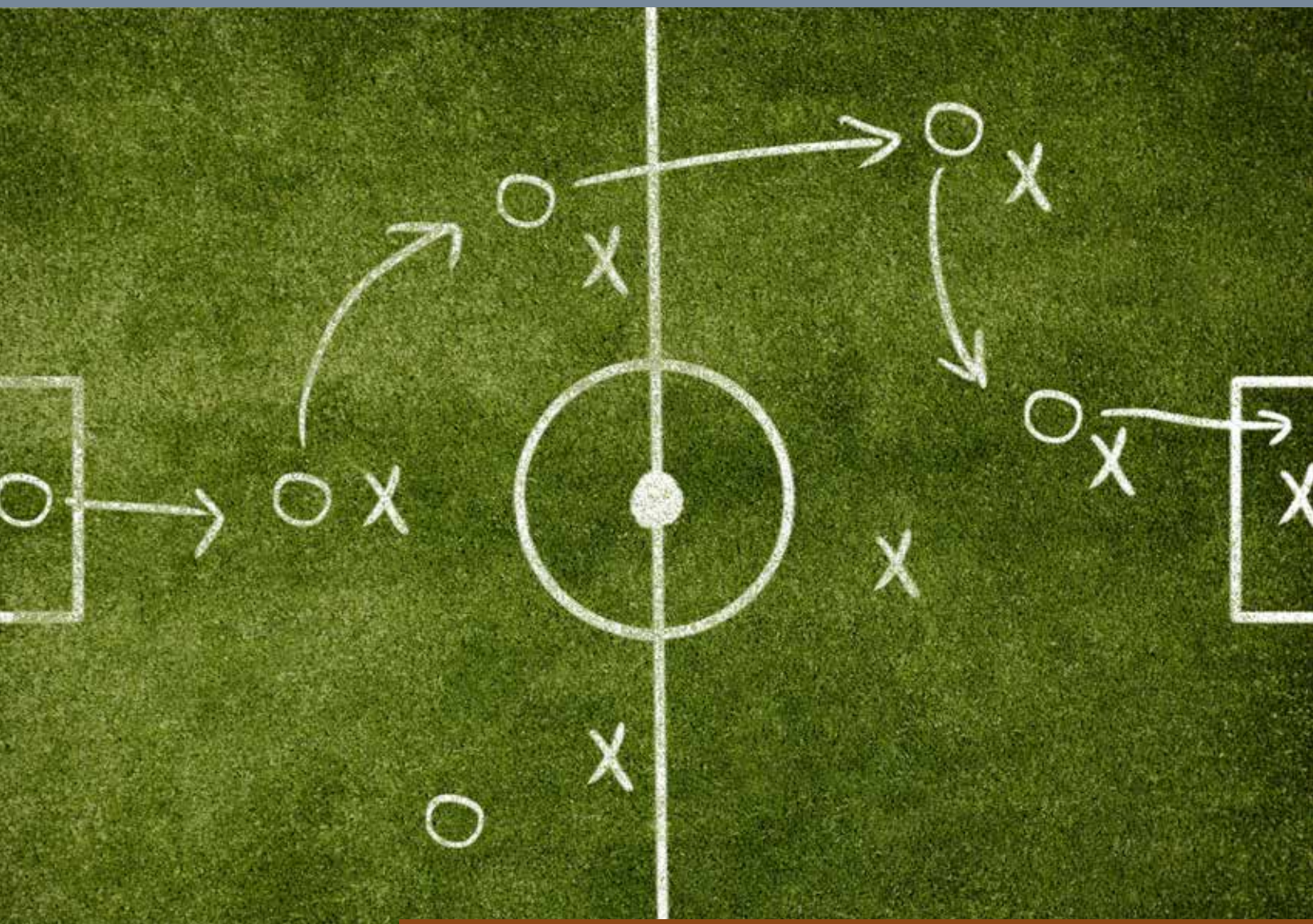

Understanding the Rules:
Federal Legal Considerations for State-Based Approaches to Expand Coverage in California

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About the Author

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Introduction

Since the implementation of the Affordable Care Act (ACA) in 2014, the uninsured rate in California has dropped by nearly half, from 16% in 2013 to 9% in 2015. However, 2.9 million Californians remained uninsured.[1] And although California policymakers and the California ACA marketplace, Covered California, have nimbly responded to federal threats, plan choice and affordability are nonetheless concerns for many people with coverage. In continuing California's tradition as a national leader on health policy, state policymakers, advocates, and other stakeholders are exploring state-based approaches to expand or improve coverage in California. Some of the approaches under discussion to increase coverage include creating a single-payer system to provide universal coverage, improving the affordability of Covered California products to expand enrollment in the individual market, and expanding Medi-Cal to include undocumented Californian adults. A public option to improve choice and competition among marketplace plans has also been discussed. This paper examines the ways these state-based policy approaches intersect with federal law.

There are myriad ways California might seek to expand coverage as well as address other issues such as consumer choice and health care affordability. Many of these are private, market-based approaches or could be advanced through existing state taxation or health insurance regulatory authority.[2] This paper is not a comprehensive inventory of such options. Instead, it identifies four approaches designed to expand coverage that have been proposed legislatively or discussed among state policymakers. These approaches interact, to varying degrees, with federal programs and federal laws. This paper explores those interactions to illuminate legal issues that the state and stakeholders would need to consider under each of the following proposed options:

- **Single-payer system.** To expand coverage to all state residents while maximizing state purchasing power and reducing system administrative costs, California would create a state-run, comprehensive, universal, single-payer health care system. The single-payer system would provide comprehensive coverage to those who are currently insured as well as those who are uninsured by merging Medicare, Medi-Cal, and marketplace funding, and potentially employer health care contributions as well.
- **Improved marketplace affordability.** To make coverage in the individual market under Covered California more affordable, the state would create a new program to help subsidize premiums and/or cost sharing for a segment of enrollees. The state could also create a reinsurance program designed to reduce premiums for individual market coverage.
- **Medi-Cal expansion to undocumented adults.** To expand access to coverage, the state would allow Californian adults not eligible for Medi-Cal because of their immigration status to enroll in state-only funded Medi-Cal.
- **Public option.** To ensure consumer choice and enhance plan competition — and potentially improve affordability for Covered California beneficiaries throughout the state — California would create a state-sponsored public coverage alternative that would be available statewide through Covered California and offered alongside other marketplace plans.

Approach

Because coverage financing and program rules are a complicated patchwork with deep federal involvement, California's actions are constrained by and must be informed by federal requirements. There is a chicken-and-egg problem: Proposing state policy solutions absent a deep understanding of federal constraints is fraught, yet it is hard to navigate federal constraints without having a specific proposal in mind. This paper presents illustrative examples intended to spark further refinement going forward. Medicare, Medicaid, and marketplace coverage must meet statutorily and regulatorily specified standards. Federal requirements governing Medicare and Medicaid benefits will come into play to the extent that California either changes the way in which current beneficiaries receive services or seeks to use federal dollars to expand services. If California seeks to alter the terms of employer-sponsored health benefits, the federal Employee Retirement Income Security Act of 1974 (ERISA) is relevant.

The proposals examined, and the assumptions made, are designed to explore how different policy approaches interact with federal law. The underlying assumptions

about policy design for each approach are described below; changes to these assumptions could affect this analysis and the manner in which federal law might or might not constrain implementation.

This paper does not analyze state legal constraints, because the legislature (and/or ballot initiatives) can alter state laws. Nor does this paper analyze the various public policy implications, positive and negative, that the proposals might have, for example, on provider access or the state budget. Rather, it examines feasibility solely through a federal legal and regulatory lens.

Key Federal Laws and Authorities

Below is an overview of the key federal laws and authorities examined in this paper. For many of the policy proposals analyzed here, only some of these federal laws are relevant.

Medicare. Title XVIII of the Social Security Act, the Medicare statute, creates an entitlement to coverage for individuals age 65 or older who have worked the equivalent of 10 years in the United States and for people with disabilities.[3] Medicare is run by the federal government and funded through federal Medicare trust funds. Services are available through fee-for-service or managed care networks, at the beneficiary's choice. The secretary of the Department of Health and Human Services (HHS) has authority to waive Medicare provisions under Section 402(b) of the Social Security Amendments of 1967 and Section 1115A of the Social Security Act.

Medicaid. Title XIX of the Social Security Act, the Medicaid statute, creates an entitlement to coverage for eligible low-income individuals and to funding for states, which share in Medicaid financing with the federal government. The Medicaid statute sets various minimum eligibility, benefit, coverage, financing, and administrative standards that states that choose to participate must honor in administering their programs. States implement changes that are consistent with federal law by amending their Medicaid state plan.[4] If states wish to deviate from federally required standards to test new ways to design coverage and deliver care, states can seek demonstration authority (referred to as "waivers") under Section 1115 of the Social Security Act.

Marketplace. Title I of the ACA created marketplaces, such as Covered California, to expand access to private insurance coverage. The ACA also created premium tax credits that help pay premiums for individuals with incomes up to 400% of the federal poverty level (FPL) who are enrolled in qualified health plans (QHPs) and do not have access to other affordable coverage. The ACA established a maximum out-of-pocket amount for coverage,[5] and it permits individuals with incomes up to 250% of the FPL who purchase coverage through the marketplace to receive reduced cost sharing. The ACA also establishes minimum benefit standards, or essential health benefits, for the individual market, including marketplace coverage.

ERISA. ERISA is a federal law that sets standards for private-sector employers that establish employee benefit plans. Certain ACA requirements are incorporated into ERISA and apply to employee benefit plans that cover health care. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA, although ERISA does not prevent states from regulating health insurance issuers and the products they sell to employee benefit plans.[6]

Because coverage financing and program rules are a complicated patchwork with deep federal involvement, California's actions are constrained by and must be informed by federal requirements.

Obtaining Waivers of Federal Health Care Law

Several authorities exist whereby the federal government can waive otherwise applicable laws and program standards for Medicaid, Medicare, and the ACA. (Note that ERISA is not included here as its provisions are not waivable by administrative action). We note that granting waivers is at the discretion of an administration. By longstanding practice, once an administration has approved a waiver of particular provisions, it treats that waiver as a precedent and will generally approve similar waiver requests, but policy approaches can vary across administrations. However, without congressional action, an administration is never legally obligated to approve a waiver request. The current administration's position on coverage expansions supported by federal dollars is not likely to be favorable, which could make it difficult to secure federal authority, where necessary.

The authorities described below include different standards for their approval and thus are used by states with varying degrees of frequency. Examples of relevant authorities are as follows:

Medicare 402(b) waivers. Medicare demonstration waivers granted by the secretary of HHS under Section 402(b) of the Social Security Amendments of 1967 permit Medicare payments to be made at variance with the standard Medicare payment rules for approved projects that aim to increase the efficiency and economy of the provision of Medicare health services.[7] Outside of the standard payments authorized by the Medicare Act, 402(b) Medicare demonstration projects are also funded by the Medicare trust funds. To date, this authority has been used rarely.

Medicaid Section 1115 waivers. Section 1115 of the Social Security Act gives the secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the secretary may waive certain provisions of the Medicaid law (i.e., those contained in Section 1902 of the Social Security Act) to enable states to meet their policy goals, subject to evaluation and monitoring requirements. Though not delineated in statute or regulations, budget neutrality requirements apply to ensure that the federal government does not spend more on the demonstration (or waiver) than it would spend in the absence of the waiver.[8] Many states operate some or all of their Medicaid programs under Section 1115 authority.

Medicare and Medicaid Section 1115A. Section 1115A of the Social Security Act created the Center for Medicare & Medicaid Innovation (CMMI) to test "innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care" for those individuals who receive benefits through Medicare and certain other federal health care programs.[9] For example, CMMI has exercised the Section 1115A authority to partner with states to support multipayer health care payment and delivery system reforms. CMMI's State Innovations Models initiative has given states flexibility to test new delivery-system reform approaches, such as those that rely on Medicare participation.[10] Although Section 1115A is a new authority, the Centers for Medicare & Medicaid Services (CMS) continues to advance new models and approaches, though it is somewhat of an open question as to how the current administration will approach the authority.

Affordable Care Act, Title I Section 1332 waivers. Section 1332 of the ACA permits states to apply for a State Innovation Waiver to pursue strategies for providing their residents with access to high-quality, affordable health insurance as an alternative (in whole or in part) to standard marketplace coverage. States can apply for waivers of selected marketplace requirements, including those governing essential health benefits and tax credits, if they meet four guardrails to retain the basic protections of the ACA. Coverage provided under a 1332 waiver must (1) be at least as comprehensive as coverage provided absent the waiver, (2) provide coverage and cost-sharing protections so that coverage is at least as affordable as coverage absent a waiver, (3) provide coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and (4) not increase the federal deficit.[11] States could repurpose premium tax credits (and cost-sharing reductions [CSRs] if appropriated[12]) under a 1332 waiver. If a state's 1332 proposal reduced federal premium tax credit spending, the state could receive pass-through funding in the amount of the savings to the federal government. For example, in the three states with approved reinsurance waivers (Alaska, Minnesota, and Oregon), the states reap the federal savings for their policies that reduce premiums, which in turn lowers tax credits and thus federal expenditures. The 1332 authority is the newest of the federal waiver authorities, effective starting in 2017, so there is less information about what types of initiatives will be approved under this authority. Further, the current administration's reluctance to approve waivers that support ACA implementation could be a limiting factor on future approvals.

POLICY APPROACH #1

Single Payer

Overview

This section analyzes the federal ramifications associated with creating a state-based single-payer infrastructure. Although there are various ways the state could structure a single-payer system, this analysis considers the Healthy California Act, SB 562 (2017-2018 session), the most current single-payer proposal under consideration by California state policymakers.[13]

The Healthy California Act would create a new Healthy California program to administer a comprehensive, universal, single-payer health care coverage system. The proposal is intended to eliminate segmentation of the health insurance market and instead create a single coverage program for individuals eligible for Medicare, Medi-Cal, employer-sponsored coverage, and individual insurance, as well as the currently uninsured.[14] Key features are as follows:

- The state would create a new authority to operate a single-payer system for all state residents, administered by a new Healthy California board, which would be an independent entity not affiliated with any existing agencies or departments.
- Federal financing that supports existing federal programs (including Medicaid, Medicare, ACA tax credits, and other federal funds and subsidies) would be merged into the Healthy California fund to pay for coverage. Although employer contributions to health coverage are not expressly addressed in the current draft of Senate Bill (SB) 562, the spirit of the proposal suggests a goal of redirecting contributions to the Healthy California fund rather than towards the employer's health care benefit plans.
- Healthy California would provide enrollees with a broad range of benefits, encompassing those provided by existing public programs and deemed medically appropriate by the enrollee's health care provider, with no premiums or cost sharing.[15]
- Healthy California would permit enrollees to choose health care services from any participating provider, who would be paid on a fee-for-service basis until another payment methodology is established by the Healthy California board. Health plans and insurers would be prohibited from offering benefits or services for which coverage is offered under the Healthy California program.
- Care coordination services would be provided to all enrollees, including administrative tracking and medical recordkeeping services.
- The Healthy California board would apply for any necessary federal waivers so that Healthy California members could receive all benefits through Healthy California, financed with federal program funding that might have otherwise supported their care. The legislation also directs the board to seek authority for Healthy California to receive and deposit all federal payments under those programs.

Of the four policy approaches analyzed in this paper, the single-payer proposal interacts with the most federal laws because it relies on existing federal program financing and thus raises a number of legal questions.[16] That said, although a goal of Healthy California is to promote administrative simplicity, SB 562 is drafted in a manner that also appears designed to skirt some of the thorniest legal issues by acknowledging the ongoing role of federal health care programs even in a single-payer environment. In particular, although the legislation directs the Healthy California board to seek waiver authority to ensure that "federal payments are paid to Healthy California in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs,"[17] the legislation also specifies that the Healthy California board "may apply for coverage for, and enroll, any eligible member under" Medi-Cal, CHIP, or Medicare.[18] Indeed, the legislation further directs the board to maximize enrollee eligibility for such federal programs.[19]

Therefore, while the legislation seeks to establish a system in which enrollees receive all Healthy California benefits through the program, it also appears to acknowledge that the state may nevertheless need to maintain compliance with existing federal eligibility, benefit, and enrollment rules. This includes verifying income upon initial enrollment and at regular renewal intervals to ensure that the state can claim available federal funding through Medi-Cal, marketplace subsidies, or Medicare. It is unclear from the legislation the extent to which Medi-Cal will continue as is, but it appears likely that Medi-Cal could operate in the background of Healthy California (e.g., enrollees

may think of themselves as enrolled in Healthy California, but, for purposes of accessing federal financing, would be enrolled in Medi-Cal). Similarly, the legislation clearly envisions repurposing marketplace tax credits to support Healthy California enrollment and also gives the Healthy California board the option of enrolling its participants who are eligible for Medicare into Medicare Parts A, B, and D (whether through fee-for-service Medicare or Medicare Advantage plans and whether administered by other entities or Healthy California itself) so that the federal government could continue to cover the cost of their care, with premiums and copays assumed by Healthy California.[20]

Medicaid Issues

Recognizing the importance of Medicaid financing and the various requirements that attach to that financing, SB 562 appears to (1) direct the state to seek broad waivers to secure maximum flexibility to implement a seamless single-payer system and (2) authorize a hybrid solution that relies on continued compliance with, at a minimum, traditional Medicaid eligibility and enrollment rules so that the state could continue to access federal Medicaid matching funds. The legislative authorization for such a hybrid approach may be an acknowledgment of the need to balance the goal of simplicity with the difficulty of securing approval for, and implementing, a more radical departure from existing federal requirements. That balance necessarily involves trade-offs. This section explores how the degree of continued compliance with key federal Medicaid requirements could influence waivers that the state needs.

The biggest hurdles associated with maintaining federal Medicaid funding while implementing a single-payer system are the federal requirements that tie federally matched expenditures to the services provided to Medicaid-enrolled individuals. Eligibility would have to be identified and services tracked by enrollee so that the state can claim federal matching funds for allowable expenditures. Healthy California — acting under the authority of the Department of Health Care Services (DHCS) (if DHCS continues to exist) or as a new single-state agency administering Medi-Cal — could essentially run these eligibility and financial tracking requirements in the background (i.e., in a manner invisible to Healthy California enrollees) to promote simplicity for the consumer and limit the waivers needed while meeting various federal requirements for federal matching funds.[21] To the extent that Healthy California would either stand "in the shoes" of the DHCS (e.g., through interagency agreements) or formally function as the single state Medicaid agency as required by federal law, following all existing laws and regulations that govern the administrative functions of the Medicaid agency, minimal federal Medicaid waivers would be needed.[22]

Indeed, SB 562 explicitly provides that the Healthy California board may apply for coverage for, and enroll, any eligible member in Medi-Cal.[23] Because Healthy California would rely on pooling federal funds from Medi-Cal, marketplace subsidies, and Medicare, it would need to conduct some initial eligibility screening to assess income and other factors to determine which federal dollars could be claimed for which enrollees. Therefore, screening for Medi-Cal would be expected to be done as part of the initial enrollment process (and at regularly scheduled renewals), even if it was not transparent to applicants that Healthy California was conducting eligibility determinations related to Medi-Cal (or other federal programs).[24] Although the legislation is not explicit about how the program would be administered and how funding would be tracked, the most straightforward approach would be for Healthy California to track claims for Medi-Cal-enrolled individuals, even if enrollees were receiving their Medi-Cal services through a broader, state-administered, universal coverage program. The Medi-Cal tracking would not need to be transparent to enrollees, who would be treated as all other Healthy California enrollees, some of whom also would be supported by other federal program funding.[25]

On the other hand, to the extent that Healthy California does not wish to determine Medi-Cal eligibility and/or track expenditures on a person-by-person basis, it would need to seek a Section 1115 waiver. The discussion that follows illustrates several ways through which the state could seek to implement the program without following all federal Medicaid eligibility, enrollment, and financing rules, through waiver authority:

- **Eligibility and enrollment.** If the state does not wish to establish eligibility upon enrollment, it could seek a waiver of certain Medicaid eligibility rules and then conduct a post-eligibility review of income and other factors to properly attribute enrollees' costs to Medi-Cal (or other federal programs).
- **Financing.** If the state does not wish to track expenditures on a per-enrollee basis, the state would

need to negotiate capped funding with CMS, perhaps based on historical spending plus a trend rate adjustment, or to design and obtain approval for a sampling methodology that would assure CMS that it was not overpaying for Medi-Cal enrollees relative to the entire Healthy California pool.[26] Sampling methodologies would carry some administrative burden but would avoid complicating the enrollment process. Depending on the terms that California would negotiate with the federal government, the state could be at risk for spending over any capped amount (perhaps through an approach similar to a per capita cap).

The benefit and cost-sharing structure for Healthy California appears to not require federal waiver authority. As drafted, Healthy California benefits are intended to be at least as generous as federal Medicaid mandatory benefit standards require,[27] and Healthy California does not intend to charge cost sharing so would not be in conflict with Medicaid's limits on premiums or copayments. If cost estimates lead to refinement of the proposal in a manner that restricts benefits or adds out-of-pocket costs, additional legal considerations would come into play.[28] Although the current administration's waiver policy remains somewhat untested, it is likely to entertain waivers to limit some benefits or increase cost sharing, although federal law does impose some guardrails to prevent high cost sharing. Provider rates, as envisioned, also would appear to meet Medicaid's access requirements, and thus no additional authority would be required.

It is impossible to detail all federal Medicaid requirements that might be implicated based on the design of a single-payer system, but two examples illustrate provisions that could require waivers if the state wished to deviate from federal law. Even though these waivers are significant and potentially controversial, in most cases the changes they seek are less far-reaching than the eligibility, financing, and administrative issues described above. For example, the legislation is silent about retroactive coverage (e.g., the federal requirement that Medicaid pays for any Medicaid-covered costs incurred up to three months prior to a beneficiary's application date, so long as the beneficiary would have been eligible for coverage during the three months prior to application when the bill was incurred).[29] There is precedent for waiving this provision, at least for some Medicaid populations; moreover, retroactive eligibility would appear to be less important over time in a system moving towards universal coverage. To take another example, although the legislation envisions that Healthy California enrollees would have access to all providers, the legislation does not specify that — as under federal Medicaid law — Healthy California enrollees must have access to federally qualified health centers (FQHCs) and rural health clinics, which must be paid a favorable rate under Medicaid law. To the extent that the state does not intend to incorporate these Medicaid requirements into the administration of Healthy California, it would need to seek waivers of requirements regarding access to, and payment of, FQHCs. Such waivers are not common and are controversial, but they are legally allowable.

Finally, because the single-payer system depends on drawing down federal Medicaid dollars, federal financing rules governing allowable sources of the nonfederal share (including rules regarding intergovernmental transfers, certified public expenditures, and provider taxes) would continue to apply. California would need to continue to comply with these Medicaid financing requirements, which are not waivable.

Marketplace Issues

To fund Healthy California, the legislation envisions repurposing premium tax credits, which are currently available to assist individuals with incomes up to 400% of the FPL in purchasing QHPs offered through Covered California. To do this, California would need to seek authority from the HHS and the Department of the Treasury for a 1332 waiver. A 1332 waiver would be necessary to eliminate the Covered California marketplace in favor of coverage through Healthy California and allow Healthy California to repurpose premium tax credit dollars.

A 1332 waiver also would be necessary to allow the state to circumvent several other ACA requirements. For example, the ACA creates a right of any "qualified individual" to enroll in a QHP;[30] to the extent that Healthy California would replace Covered California and thus eliminate existing QHPs, a waiver would be needed. In addition, California would need to seek 1332 authority to waive compliance with the ACA Small Business Health Options Program (SHOP) requirements, which govern Covered California for Small Business and are designed to help small businesses provide health coverage to their employees. Covered California for Small Business would no longer be needed once Healthy California was launched.

Given the comprehensiveness of benefits and cost-sharing limitations in SB 562, and the cost-control mechanisms envisioned by the legislation, the authors' assessment is that Healthy California could satisfy the four 1332 waiver guardrails described in the text box on page 5. However, as noted, waivers are discretionary, and CMS has not yet approved significant changes to premium tax credit funding for policies other than reinsurance, so securing the authority described could be difficult. Finally, since this proposal doesn't offer coverage through a private insurance plan, it would not need to meet the rating and other consumer protection requirements implemented by the ACA;[31] since these provisions cannot be waived under a 1332 waiver, the structure of Healthy California thus avoids a potential legal issue.

Medicare Issues

As discussed above, under SB 562, federal financing that supports existing federal programs would ideally be merged into the Healthy California program, which would create a new, centralized authority to operate a single-payer system, administered by the state and providing a broad range of benefits (encompassing those provided by existing public programs including Medicare) with no premiums or cost sharing. However, SB 562 also takes into consideration that if Medicare payments cannot be redirected to the Healthy California fund, the Healthy California board might enroll those eligible for Medicare into Medicare Parts A, B, and D (including via Medicare Advantage plans).[32]

Financing

Redirecting Medicare trust fund dollars to the Healthy California fund might require federal legislative action as well as federal regulatory and administrative steps.[33]

Standard Medicare payments. The Medicare statute authorizes payments necessary to fund statutorily mandated Medicare services,[34] which have been limited to payments made to Medicare-enrolled providers and suppliers for medically necessary covered services as well as to Medicare Advantage organizations under Part C and prescription drug plan sponsors under Part D to provide Medicare benefits. It is unlikely that any of the standard provisions of the Medicare Act would be read to permit payments to a state health fund, meaning that the waivers described below (or congressional action) would be required to achieve this goal.

402(b) waivers. The parameters of 402(b) are fairly vague and, although they could be read to permit a transfer of Medicare trust fund payments to a state trust fund that serves Medicare enrollees,[35] Section 402 as a whole largely considers demonstrations relating to provider payments and managed care payments;[36] no past 402(b) demonstrations have involved the routing of Medicare payments to a state-based health care program.

1115A waivers. CMMI waivers under Section 1115A of the Social Security Act might be another way to redirect Medicare trust fund payments to Healthy California. CMMI's broad authority appears to allow CMS to authorize a demonstration in which Medicare funds are directed to the state and paid to providers via the state's own payment system. Some precedent exists for this type of Section 1115A demonstration: The Maryland All-Payer Model[37] permits the Maryland Health Services Cost Review Commission (HSCRC) to set the rates for Medicare payments to hospitals in a way that does not reduce quality and decreases spending by an agreed upon amount,[38] regardless of numerous statutory Medicare payment rules[39] — which are waived under the demonstration. Although Medicare funds are not redirected to HSCRC and are instead paid by Medicare Administrative Contractors according to HSCRC-determined rates, CMMI could presumably redirect Medicare funding to the state in future demonstrations.[40] Additionally, the ability to set the rates at which Medicare payments are made to providers could itself permit Healthy California to achieve many of its goals (e.g., ensuring that certain benefits are covered, eliminating cost sharing by establishing provider rates as payments in full), even without redirecting Medicare payments into the Healthy California fund.

Eligibility and Enrollment

To the extent that the Healthy California board would choose to require those eligible for Medicare to enroll in Medicare as a condition of Healthy California coverage, Healthy California seeks to require mandatory enrollment in Medicare Parts A, B, and D,[41] administered either as it is now by Medicare Administrative Contractors, Medicare Advantage Organizations, and Part D prescription drug plan sponsors, or by Healthy California itself.[42] No Medicare law expressly prohibits states from requiring Medicare enrollment.[43] However, because Medicare is voluntary and because enrollees must pay premiums[44] for Medicare Parts B and D and Medicare Advantage plans (and Medicare Part A for certain individuals), the de facto requirement of SB 562 that Californians eligible

for Medicare pay Medicare premiums may be subject to legal challenge by individuals not wishing to enroll in Medicare and pay such premiums.[45]

Benefits and Coverage

As drafted, SB 562 appears to assume that all Healthy California beneficiaries would receive a robust package of benefits that includes all Medicare-covered services as well as services not covered by Medicare, without any premiums or cost sharing. Non-Medicare benefits like those proposed to be covered under SB 562 may be covered without legislative action, but they would require waivers where original Medicare coverage is involved and would have to meet supplemental benefits requirements where Medicare Advantage plans are involved.

- Under original Medicare, non-Medicare benefits may be covered as part of a Medicare demonstration project under a Medicare 402(b) waiver. Specifically, Section 402 waiver authority permits Medicare demonstration projects involving grants to public agencies (i.e., Healthy California) to pay for non-Medicare services that would result in more economical provision and more effective use of Medicare services.[46] The broad language of Section 1115A, which permits CMMI to test "innovative payment and service delivery models" that either reduce costs or improve quality of care[47] could also be read to permit CMMI demonstration projects in which non-Medicare benefits are offered. The Next Generation accountable care organization (ACO) demonstration and its Telehealth Expansion Waiver, Post-Discharge Home Visit Waiver, and Three-Day Skilled Nursing Facility Waiver[48] exemplify a CMMI demonstration that permits the offer of services not traditionally covered by Medicare.

- Under Medicare Advantage, non-Medicare benefits may be covered as supplemental benefits. The additional non-Medicare benefits proposed under SB 562 might be covered as mandatory supplemental benefits given the intent of the bill to provide an identical package of benefits to all enrollees.[49] However, not all non-Medicare benefits are eligible to be covered as supplemental benefits,[50] so Healthy California would have to structure its benefits package to ensure that ineligible benefits are not offered,[51] or it would have to offer the additional benefits outside of Medicare Advantage.

ERISA Issues

To fully integrate individuals currently covered under group health plans regulated by ERISA into Healthy California, including channeling the employer financing of those plans into Healthy California, would likely require federal statutory changes.[52]

SB 562 defers specifics on financing to future development of a revenue plan, but the spirit of the proposal suggests that its likely goal is to require employer contributions to be directed to the Healthy California fund rather than towards the employer's health care benefit plans. ERISA generally preempts state laws that "relate to" employee benefit plans[53] offered by employers.[54] A pure single-payer system, which would involve terminating all existing ERISA plans and requiring employers to contribute to a state-administered health program fund, would likely be found to constitute the impermissible and preemptable regulation of an employer health benefit plan absent the grant of a federal legislative exemption from ERISA. Although not contemplated in the bill, an alternative pay-or-play approach that would not require termination of ERISA plans but would require employers to pay to finance health care provided through Healthy California or in coordination with Healthy California may not be preempted if structured appropriately, but it would likely be tested in the courts. (For more on the pay-or-play approach, see Appendix A).

ERISA Exemptions

If it seeks to termination ERISA plans, Healthy California would likely need federal legislation to receive an exemption from ERISA preemption. Congress has only exempted one state health program from ERISA preemption by statute and has expressed an unwillingness to do so again: Hawaii enacted its Prepaid Health Care Act in 1974, the same year that ERISA was enacted.[55] The Hawaii law requires most employers to provide health coverage to most employees. It regulates employee benefit programs in contradiction of ERISA and is preempted.[56] However, in 1983, Congress amended ERISA to create a limited exception for Hawaii, allowing it to continue to enforce its law as it existed in 1974. Hawaii still is not permitted to amend the law except to further the "effective administration" of the law as it existed in 1974.[57] Furthermore, in creating this exception Congress said it "should not be considered a precedent" for exempting any other state law from ERISA preemption.[58] No other state's employee benefit laws have been exempted from ERISA.

Note on the Pay-or-Play Option

California could potentially adopt a pay-or-play system in which the state requires employers that do not contribute a minimum amount to their health care benefit plans to contribute to the Healthy California program. Strictly speaking, a pay-or-play system is not compatible with a single-payer system because employers could choose to "play" by offering their own coverage rather than "paying" into the single-payer fund. Aside from falling short of the single-payer goal by permitting the existence of multiple payers, another issue raised by the pay-or-play approach is that the benefits and cost sharing associated with plans offered by these multiple payers would not be uniform. For these reasons, the pay-or-play option is not analyzed at length here. A discussion of the pay-or-play option is included in Appendix A.

POLICY APPROACH #2

Improved Marketplace Affordability

Overview

To make individual market coverage more affordable, the state could create a new affordability program for coverage purchased through Covered California. Currently, premium tax credits are available for eligible enrollees with incomes up to 400% of the FPL. California consumers with incomes between 138% of FPL up to 250% of the FPL can enroll in enhanced cost-sharing reduction (CSR) plans that reduce out-of-pocket costs.[59] There are various ways to structure such a proposal, depending on the desired target population, including the following:

- Increasing premium subsidies for Covered California consumers with incomes below 400% of the FPL
- Extending premium tax credits to consumers with incomes above 400% of the FPL
- Lowering cost sharing for those enrolled in Covered California with premium tax credits by increasing the value of CSRs for individuals and families with incomes under 250 percent of the FPL and/or offering lower cost sharing to those earning above 250 percent of the FPL

The state could also create a reinsurance program designed to reduce premiums for individual market coverage. This would improve affordability for enrollees not receiving premium tax credits.

As described below, federal requirements are triggered primarily if California seeks federal funding for these proposals.

Medicaid Issues

Using state-funded dollars to increase subsidies to improve the affordability of Covered California coverage does not invoke Medicaid in any way. However, to the extent that the state wishes to use Medicaid dollars to provide a premium or cost-sharing wrap for lower income individuals enrolled through Covered California, the state could pursue a 1115 waiver to do so. Massachusetts and Vermont have such authority through Section 1115 waivers, but those were granted by the prior administration. In light of the Trump administration's positions regarding various Medicaid and marketplace policies, it is unlikely that it would grant a waiver for this purpose.

Any such proposal would have to be budget neutral to the federal government, meaning that the state would likely need to find efficiencies elsewhere in the Medi-Cal program to offset the cost of the affordability wrap.

Marketplace Issues

Nothing in these proposals requires waiving federal law or federal approval *if* the state, rather than the federal government, is providing the additional funding for these purposes. Using state funding, California can increase premium subsidies and make affordability support available to additional populations, subsidize cost sharing, and create reinsurance programs, provided the state does not rely on the IRS structure to do so.

If California were instead to seek federal funding to support these initiatives, the state would need to apply for a 1332 waiver to access federal funding. California would need to propose a provision or provisions of the federal law that the state wants to waive in order to either repurpose federal funding or demonstrate savings under a 1332, as well as meet the four guardrails described in the text box on page 5. For the affordability initiatives other than reinsurance, California would need to demonstrate a policy that would reduce federal premium tax credits to receive funding under a waiver.

Reinsurance. Reinsurance lowers premiums in the individual market by paying a portion of high-cost claims so insurers do not have to bear the risk of those claims or price products to assume higher cost claims. Three states have received 1332 reinsurance waivers (waiving the single risk pool provision[60]) to receive federal funding. These waivers require the state to generate funds (outside of only taxing marketplace plans[61]) for the federal government to provide pass-through funding. Because state-financed reinsurance programs lower premiums, the federal costs of the premium tax credits also go down, and the federal government passes those savings on to the state. To date, states with reinsurance waivers have planned to use pass-through funding from those waivers to partially offset the state cost of the reinsurance program; however, a state contribution remains necessary to access the federal funds.[62]

Increasing premium or cost-sharing subsidies. If California sought federal financing for increasing premium tax credits or CSRs, it would need to demonstrate how the state's proposal would save federal funds. The administration would review the proposal looking for policies that either (1) lower federal costs in some way or (2) repurpose the federal funding in a way that also met the four guardrails already described — including coverage requirements and deficit neutrality. As of this writing, CSRs are not appropriated, so the administration would permit California to use only federal tax credit funding, and not CSRs, in its calculations. Unless an additional proposal were included, it is difficult to determine a way that the state could demonstrate savings simply by providing affordability support as envisioned in this proposal. No state has been able to do this to date. Iowa proposed changes to the tax credit structure to increase tax credits for higher income individuals by reducing tax credits for lower income individuals, but ultimately withdrew its waiver request before CMS formally ruled on whether the waiver would meet 1332 standards. In fact, since the affordability changes would likely increase enrollment in Covered California and tax credits compared with the status quo,[63] attempting to address affordability through a 1332 waiver, in conjunction with a reinsurance proposal, could encounter challenges from a federal deficit neutrality perspective.

POLICY APPROACH #3

Medi-Cal Expansion to Undocumented Adults

Overview

To expand access to coverage for Californians not eligible for Medi-Cal because of their immigration status, California could create a state-only funded eligibility expansion for people who otherwise meet Medi-Cal eligibility criteria. This approach builds on California's recent expansion of Medi-Cal to all low-income children regardless of immigration status.[64] This approach could include the following key features:

- The coverage expansion would leverage the Medi-Cal infrastructure, including the state's existing eligibility and enrollment process; benefit structure; claims payment systems; and administrative, oversight, and management capabilities.
- The state would contract with existing Medi-Cal managed care organizations (MCOs) to deliver care for this population and would negotiate rates with plans.
- The plans would leverage the Medi-Cal provider network; Medi-Cal rates would apply and, indeed, providers would be unlikely to know the immigration status of their patients.

Medicaid Issues

Federal Medicaid dollars cannot be used to pay for services for undocumented immigrants, with the exception of emergency Medi-Cal services and labor and delivery. This is not a waivable prohibition. Since federal approval is not possible, the inability to access Medicaid funding for this proposal simplifies this analysis. Because federal Medicaid laws are not applicable, California could set benefit and eligibility criteria that are different from those of its current Medi-Cal program.

Financing and administration. The structure of the state's program would determine whether it impacts the state's — or individual hospitals'— access to federal funds that are tied to the uninsured (e.g., Medicaid disproportionate share hospital [DSH] funding). If services were to be delivered through Medi-Cal MCOs that are paid a capitated rate for individuals made eligible through the expansion, there could be an interaction with DSH payments to hospitals.[65]

The availability of state-funded services for these populations would not impact the state's continued ability to claim federal Medicaid funding for restricted scope Medi-Cal services that are currently paid by Medicaid, so long as the state complies with applicable federal laws on claiming those services. The state would do this by separately tracking spending for immigrants.

Provider network and contracting. This approach to expand coverage for undocumented immigrants would leverage existing Medi-Cal plans to deliver services to the expansion population. Again, because federal Medicaid dollars are not supporting the services, no additional federal approval would be required.

Marketplace Issues

The current proposal does not envision leveraging the Covered California infrastructure, unlike California's submitted (and later withdrawn) 1332 waiver proposal to enable undocumented immigrants to purchase coverage through Covered California.[66] There are no marketplace-related federal legal barriers to implementing a Medi-Cal coverage expansion.

POLICY APPROACH #4

Public Option

Overview

A public option could be designed in various ways, depending on the state's goal. Although many details of a California public option approach remain unclear, the authors of this report assume that California's primary goal is to ensure that robust coverage options are available in all counties and expand competition within Covered California in areas where issuer participation is thin.[67] To advance those goals, California could contract with local Medi-Cal managed care plans to create a state-sponsored product that it could offer as a QHP available for purchase through Covered California. Some health plans doing business with Medi-Cal are already participating in Covered California, but participation is neither statewide nor assured.

One aim of this approach would be to promote continued marketplace stability because the state would ensure that a state-sponsored product was available across the state and over the long term under Covered California. The public option might additionally enhance the ability of Covered California enrollees to maintain coverage when they move within California and might increase provider continuity for Californians whose eligibility shifts between Medi-Cal and Covered California. These benefits would depend on how the program was designed and implemented, however.

The public option could include the following key features:

- The state would offer a new public coverage alternative in the marketplace that would be available statewide through contracts with MCOs that participate in Medi-Cal. This could necessitate the state contracting with multiple carriers given regional variation in participation of Medi-Cal MCOs.
- Qualified enrollees would receive the premium tax credit subsidy.
- The state would use the Medi-Cal infrastructure to conduct other administrative, oversight, and management functions for the new product.[68]
- The state product would be required to meet Covered California standards (i.e., benefits, network adequacy, quality, and other QHP requirements as certified by Covered California). The product would also be required to meet state insurance requirements as certified by the Department of Managed Health Care or Department of Insurance.
- The state would contract with Medi-Cal MCOs to deliver care. To distinguish this offering from the status quo, where some Medi-Cal MCOs already participate in Covered California, the state could consider providing additional encouragement or compulsion to induce plan participation in the public option.[69] One option would be to tie the Medicaid and marketplace contracts together in a way that would require plans to participate in both programs or provide preferential treatment in the procurement process (e.g., additional bonuses on a request for proposal for plans that participate in Medi-Cal and the marketplace public option). Alternatively, California could create a contracting requirement to spur participation (e.g., Medi-Cal MCOs would have to bid for the public option). There could be other incentives, such as California sharing the risk on behalf of the public option or providing reserves.

These types of initiatives would not require federal approval.

Medicaid Issues

Although the public option approach anticipates relying on Medi-Cal managed care plans and the Medi-Cal infrastructure for paying claims, oversight, and so on, it would not rely on federal Medicaid dollars to finance the coverage or operate the program. The subsidy would be through the marketplace premium tax credits. As such, there are no federal Medicaid issues to address or federal approvals to secure.

Marketplace Issues

As the state develops its public option proposal, different structural decisions will influence whether the state would need to seek 1332 waiver authority to implement the proposal.

Payment of premium tax credits. The most straightforward approach would be for premium tax credits to be paid to the public option plan (rather than to the state), which would not require any additional authority if the plan meets California standards for ACA marketplace participation.

State-licensed entity. Federal law requires that tax credits can be paid only to QHPs and that only state-licensed issuers can be QHPs.[70] As long as the public option is a state-licensed issuer, no additional federal authority would be needed. If California designed a public option that did not meet existing state licensing requirements — an approach whose implications for consumer protections, market stability, and competition would have to be carefully weighed — a 1332 waiver of the requirement that tax credits are paid only to QHPs would be necessary to establish a public option.[71]

Plan certification. To use premium tax credits, the state would either have to seek federal authority to waive the requirement that the public option must qualify as a QHP to be offered through Covered California, or the state-sponsored public option must be certified as a QHP, which entails meeting certain requirements described below (e.g., guaranteed availability). If the public option plan cannot meet these requirements, then a 1332 waiver would be required to secure authority for the premium tax credits to be paid to the public plan.

To the extent that California holds the public option to the same standards that other Covered California plans are held to — which is a reasonable assumption given well-established state policy — it is likely that little federal authority would be needed to implement the public option described here.

If California decided to design the public option in a way that did not meet Covered California requirements, some policy approaches could require federal approval, others might be able to be resolved within the state, and some are not waivable. These parameters are described below. The authors again note that the current administration has not approved 1332 waivers for these provisions.

- **Meeting network adequacy standards.** Since the federal government has deferred network adequacy requirements to the states in its regulations, a deviation in network adequacy would be a state legal and regulatory issue, not a federal one.

- **Meeting federal health insurance requirements.** Certain basic federal health insurance requirements are not waivable under 1332 waiver authority. As long as the public option is a QHP, it could not deviate from the federal requirements (e.g., guaranteed issue, modified community rating with no discrimination for health status, and no annual and lifetime limits).

- **Prohibition on mandatory or restricted enrollment.** Under the ACA, California could not require some individuals to choose the public option,[72] although this provision is waivable under 1332. The public option also could not generally be available only to select individuals, but there are limited exceptions to this requirement. For example, a plan can have its enrollment restricted if it has limited network or financial capacity; CMS has in the past relied on this "network capacity" exception to permit states to design plans with limited enrollment.[73]

- **Complying with essential health benefit standards, coverage, and meeting actuarial value coverage.** As long as the public plan offered at least the essential health benefits, no waiver of federal law would be required.

- **Meeting actuarial requirements, including offering both metal tiers (silver and gold).** Federal law permits QHPs to offer coverage based on only five tiers (bronze, silver, gold, platinum, and catastrophic) and also requires plans to offer, at a minimum, both silver and gold options. The metal-level tiers are distinguished by actuarial value, and limiting the number of options promotes consumers' ability to compare plans. The public plan option is not expected to deviate from these requirements, but a 1332 waiver would be necessary if it did.

- **Quality and other marketplace reporting.** Most of these requirements are established at the state level and are subject to state discretion, beyond the eligibility reporting requirements for those who receive tax credits.

Conclusion

California has a variety of paths available by which it could expand coverage or bolster consumer plan choice across the state. As summarized in Table 1, the four approaches — a single-payer system, improved marketplace affordability, Medi-Cal expansion to undocumented adults, and a public option — vary in terms of their dependence on federal action. Not surprisingly, the proposal for a single-payer system, which has sweeping ambitions in terms of altering the current financing and coverage arrangements, would need to navigate numerous federal legal constraints. Regardless of the path California chooses, a clear understanding of the role of federal laws and regulations, the constraints federal requirements impose on state-based solutions, and the routes for federal approval are important to understand as California considers its options.

Table 1. Comparison and Summary of Policy Approaches

	POLICY GOALS	KEY FEDERAL AUTHORITIES INVOKED	POTENTIAL PATHWAYS TO FEDERAL APPROVAL Granting waiver approval is at the discretion of an administration.
1. Single-payer system. Create a state-run single-payer health care coverage and health care cost-control system that would provide comprehensive coverage to those who are currently insured, as well as those who are uninsured, by merging Medicare, Medi-Cal, and marketplace funding, and potentially employer health care contributions as well.	▸ Expand coverage to all state residents. ▸ Maximize state purchasing power. ▸ Reduce system administrative costs.	▸ Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act ▸ Title I of the Affordable Care Act ▸ The Employee Retirement Income Security Act of 1974 (ERISA)	▸ California could operate Medicaid in the background of Healthy California to avoid seeking any Medicaid waivers, provided California follows all federal Medicaid requirements. A Medicaid Section 1115 waiver would be necessary if California did not wish to determine eligibility and/or track expenditures on a person-by-person basis. Additional waivers could be required if budgetary pressures lead to a reduction in benefits or an increase in cost sharing for beneficiaries. ▸ Center for Medicare & Medicaid Innovation (CMMI) and/or Medicare 402(b) waivers would be necessary to transfer Medicare trust fund dollars to the state or to mandate and administer enrollment into Medicare. ▸ An Affordable Care Act Title I 1332 waiver would be necessary for repurposing tax credit funding to pay for coverage that would meet existing marketplace benefit requirements. ▸ Since the Employee Retirement Income Security Act of 1974 (ERISA) preempts certain state laws for employee benefit plans, California would encounter barriers to any requirement that employers contribute to Healthy California rather than to current plans. Because ERISA is not waivable, federal legislation would be required to address this challenge. ▸ As an alternative to a pure single-payer system, a pay-or-play option might be possible if California follows the guidelines in *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, 546 F. 3d 639 (9th Cir. 2008), but it is likely to be challenged.

Table 1. Comparison and Summary of Policy Approaches, *continued*

	POLICY GOALS	KEY FEDERAL AUTHORITIES INVOKED	POTENTIAL PATHWAYS TO FEDERAL APPROVAL Granting waiver approval is at the discretion of an administration.
2. Improved marketplace affordability. Create a new program to subsidize premiums and/or cost sharing for coverage purchased through Covered California. The state could also create a reinsurance program designed to reduce premiums for individual market coverage.	▶ Make individual market coverage more affordable.	▶ No federal authority invoked unless federal funding sought.	▶ A Medicaid Section 1115 waiver would be needed if California seeks Medicaid funding to support marketplace affordability improvements. ▶ An Affordable Care Act Title I Section 1332 waiver would be needed if California were to seek federal tax credit funding. ▶ An Affordable Care Act Title I Section 1332 waiver would be needed if California were to seek federal funding for a state-run reinsurance program.
3. Medi-Cal expansion to undocumented adults. Allow Californian adults not eligible for Medi-Cal because of their immigration status to enroll in state-only funded Medi-Cal.	▶ Expand access to coverage for adults ineligible for Medi-Cal because of their immigration status.	▶ No federal authority invoked; no federal Medicaid funding permitted.	N/A
4. Public option. Create a state-sponsored public coverage alternative that would be available statewide through Covered California and offered alongside other marketplace plans.	▶ Ensure consumer choice. ▶ Enhance marketplace plan competition. ▶ Potentially improve continuity for Californians whose eligibility shifts between Medi-Cal and Covered California.	▶ Title I of the Affordable Care Act	▶ An Affordable Care Act Title I Section 1332 waiver would be needed if California seeks to modify marketplace rules. ▶ No federal authority necessary if all marketplace requirements are met by the public option.

Appendix A. Single Payer and Pay-or-Play Option

Strictly speaking, a pay-or-play system is not compatible with a single-payer system because employers could choose to "play" by offering their own coverage rather than "paying" into the single-payer fund. Aside from falling short of the single-payer goal by permitting the existence of multiple payers, another issue raised by the pay-or-play approach is that the benefits and cost-sharing associated with plans offered by these multiple payers would not be uniform. However, a pay-or-play system (a) could cause some employers to pay into a single-payer fund; and (b) could require all employers to pay into a single-payer fund if they opted to not provide coverage s to all of their employees.

Although the pay-or-play option is controversial, a 9th Circuit opinion[74] suggests that, under narrowly defined circumstances that meet certain requirements, ERISA may not always be found to preempt state laws requiring employers who do not contribute a minimum amount to their own health care benefit plan to contribute an amount to a health care program administered by a government agency. The fates of challenges to future statewide pay-or-play approaches may differ, and they would be influenced by the specific details of future Healthy California proposals relating to employer plans that are not currently known.

The chances that Healthy California's employer proposal would escape ERISA preemption could be improved if the proposal resembled the health care program at issue in *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, 546 F. 3d 639 (9th Cir. 2008), which was a pay-or-play option that exhibited the following eight traits[75]:

1. The program does not mandate a particular set of rules, structure, or benefits for employers — it should only mandate that they contribute a certain monetary amount.

2. The program should require employers to pay a certain amount of money on behalf of employees in a simple way that would not require a complex administrative scheme that would constitute a benefit plan.

3. The program should allow employers offering ERISA plans to leave those plans unchanged and must not require employers not offering ERISA plans to do so.

4. The program being funded by employer contributions should be open to all residents regardless of employment or whether employers contribute.

5. The program should not be established or maintained by, or controlled by (e.g., benefits offered) an employer.

6. Employers should not be permitted to contract with the government to administer the program for their employees.

7. The program should apply uniformly to all employers (and not apply only to ERISA plans or to employers with ERISA plans).

8. The program should provide employers with a "meaningful alternative" to establishing or modifying their ERISA plans by ensuring that the "pay" side of the pay-or-play decision gives employers some actual benefit (e.g., employer payments might serve as credits for *their employees* towards receipt of coverage under the program).[76]

Even if the proposal were to meet these requirements, it would not likely escape litigation, because the 9th Circuit's pay-or-play holding in *Golden Gate Restaurant Ass'n* and guidelines are somewhat controversial[77] and potentially even in conflict with a 4th Circuit opinion in a similar case.[78]

Endnotes

1. Reflects population under 65 years old. Fronstin, "California's Uninsured."
2. For example, in light of the elimination of the financial penalty for individuals to maintain health coverage to purchase health insurance, Pub. L. No. 115-97, Section 11081, California could impose its own tax penalty for individuals who do not maintain qualifying coverage. This paper does not examine that issue here as there are no substantive federal legal barriers.
3. An entitlement program is one in which individuals who meet certain eligibility criteria are guaranteed specific benefits as established in legislation.
4. Seeking a state plan amendment is a procedural step the state must take to alter its program within allowable statutory and regulatory standards (e.g., changes to benefits, cost sharing, provider rates). Although it is a procedural hurdle, CMS does not have discretion to deny state plan amendments that adhere to Medicaid standards. Thus, this analysis focuses on policy changes that will require the state to seek waivers of Medicaid requirements (where the federal government does have discretion) and does not specify all instances where the proposed policies could require state plan changes.
5. The maximum out-of-pocket limit applies beyond marketplace coverage to large-group, small-group, and individual market coverage.
6. ERISA, Section 514(a), 29 U.S.C., Section 1144(a).
7. Social Security Amendments of 1967, Pub. L. No. 90-248, Section 402, 42 U.S.C. Section 1395b-1.
8. For more information about Section 1115 waivers, see "Section 1115 Demonstrations," Center for Medicaid and CHIP Services, CMS, www.medicaid.gov.
9. "About the CMS Innovation Center," Centers for Medicare & Medicaid Services, June 23. 2017, innovation.cms.gov; "State Innovation Models Initiative: General Information," Centers for Medicare & Medicaid Services, October 31, 2017, innovation.cms.gov.
10. Section 1115A(b)(2) gives the secretary of HHS authority to select models to be tested, including "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State."
11. Section 1332(b)(1) of the ACA, codified at 42 U.S.C. Section 18052(b)(1). For more information about 1332 waivers, see: "Section 1332: State Innovation Waivers," Center for Consumer Information and Insurance Oversight, CMS, www.cms.gov.
12. As of this writing, CSRs funding is not appropriated, so the authors refer primarily only to premium tax credits when describing dollars available under a 1332 waiver.
13. SB 562, "The Healthy California Act," Introduced by Senators Lara and Atkins, California Legislature, Amended May 26, 2017, leginfo.legislature.ca.gov.
14. For more discussion about considerations that arise when considering single-payer proposals, see "Key Questions When Considering a State-Based, Single Payer System in California," California Health Care Foundation, November 2017, www.chcf.org.
15. The current draft of SB 562 does not explicitly address whether long-term care benefits — currently available to Med-Cal eligible enrollees — would be available to all without cost sharing.
16. Note, too, that SB 562 prohibits the legislation from becoming operative until the secretary of California HHS gives written notice that the Healthy California trust fund has the reserves to fund the costs of implementing the act.
17. SB 562, Chapter 7, Article 1, Section 100650(b)(1), (2).
18. SB 562, Chapter 7, Article 1, Section 100650(e). Federally matched health care programs are defined as Medi-Cal and CHIP.
19. SB 562, Chapter 7, Article 1, Section 100650(f), (g), (h).
20. SB 562, Chapter 7, Article 1, Section 100650(e), (f)(1), (h), (i).
21. Tracking expenditures also may be necessary if the state wishes to claim Medicaid drug rebates under Section 1927 of the Social Security Act.
22. Social Security Act Sections 1902(a)(4) and (5) and 42 C.F.R. 431.10 outline the requirement for the Medicaid single-state agency.
23. SB 562, Chapter 7, Article 1, Section 100650(e).
24. The Medicaid statute and regulations specify eligibility and enrollment standards to facilitate simplified eligibility processing and to ensure that eligible Medicaid beneficiaries are promptly enrolled if they are determined to be eligible for Medicaid. In addition, screening would be needed to determine eligibility for marketplace premium tax credits as well; the methodology for determining eligibility for both programs is already aligned (i.e., there is already a combined application/eligibility determination process in Covered California).
25. Because it appears that Healthy California would use a centralized administrative infrastructure to administer the program (regardless of how it operates the eligibility and financial claiming elements described here), cost-allocation methodologies would be necessary to ensure that Medicaid dollars support only Medicaid beneficiaries and functions. The state already uses cost allocation for other health care programs and federal approval is not required, although the state should have auditable cost-allocation methodologies in place. OMB Circular A-87, The White House Office of Management and Budget, last updated May 10, 2004, www.whitehouse.gov.
26. HHS has the authority under Section 1115 to set a per capita cap on Medicaid spending as well as to place a global cap on total Medicaid expenditures by a state (as it has done

in the past for Vermont and Rhode Island; those waivers are no longer in effect). HHS does not have authority to waive the requirement that states pay their share of expenditures or the Federal Medical Assistance Percentage claiming rules. Therefore, even under a per capita or global cap established under a waiver, the state would continue to be required to develop a methodology to track spending for the Medicaid-eligible population.

27. SB 562, Section 100630(b)(34)(B) specifies that in addition to benefits enumerated earlier in the section, covered benefits for members shall include "all health care services required to be covered under" Medi-Cal (and other federal health programs) without regard to whether the member would otherwise be eligible for or covered by the program or source referred to.

28. One particular area to monitor is long-term care due both to its expense and because of potentially conflicting language in the current version of SB 562. To meet federal requirements, long-term services and supports would need to be covered for all Medi-Cal recipients for whom the services are medically necessary. How this would be funded and administered is not clear. To the extent that long-term care services are no longer provided to Medicaid-eligible beneficiaries who meet level of care criteria to qualify for such services, a waiver of Section 1902(a)(10)(B) of the Social Security Act would be required to enable the state to use Medicaid financing for coverage that does not meet all otherwise applicable Medicaid requirements.

29. Social Security Act Section 1902(a)(34).

30. ACA Section 1312(d)(3)(C).

31. See Title XXVII of the Public Health Service Act.

32. This analysis focuses on SB 562's primary goal of routing Medicare funding directly to the Healthy California fund, with some discussion of the secondary option of having Medicare eligibles enroll in Medicare Parts A and B and a Medicare prescription drug plan under Part D. Although one of the general goals of SB 562 includes eliminating premiums and cost sharing, the current draft of SB 562 does not discuss whether these goals would continue to apply if the Healthy California board decides to enroll Medicare eligibles into Medicare Parts A, B, and D (except with respect to Part D, where the current draft does contemplate engaging in premium assistance at the low-income benchmark premium amount or a greater level of cost-effective premiums for those in Medicare Advantage Prescription Drug [MAPD] plans). SB 562, Chapter 7, Article 1, Section 100650(i). This analysis does not include discussion of other options that SB 562 does not clearly contemplate (e.g., that Healthy California itself would become a Medicare Advantage organization or prescription drug plan sponsor).

33. Susan Phillip and Marian Mulkey, "Key Questions When Considering a State-Based, Single-Payer System in California," California Health Care Foundation, page 13, www.chcf.org.

34. See Social Security Act 1817(h) (Part A: "The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses . . ."); Social Security Act 1841(g) (Part B/D: "The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with Section 201(g)(1). The payments provided for under part D, other than under Section 1860D-31(k)(2), shall be made from the Medicare Prescription Drug Account in the Trust Fund. The payments provided for under Section 1860D-31(k)(2) shall be made from the Transitional Assistance Account in the Trust Fund.").

35. Cf., *Blue Cross Asso. v. Harris* 664 F2d 806 (10th Cir. 1981). (HHS has the power to award Medicare demonstration projects to other than standard intermediaries or statutorily defined "carriers" and can contract with "public agencies.")

36. See, for example, Medicare Preferred Provider Organization Demonstration and M+C Alternative Payment Demonstrations authorized under 402(b). Government Accountability Office Report to the Ranking Minority Member, Committee on Finance, U.S. Senate: Medicare Demonstration Preferred Provider Organizations, GAO-04-960, available at: www.gao.gov.

37. Authorized under Section 1115A(b)(2)(B)(xi).

38. Under the terms of the Maryland All-Payer agreement, Medicare will pay rates that are at least 6 percent less than the all-payer rates, and the demonstration is required to generate Medicare hospital inpatient savings of $330 million over five years.

39. Including rules under IPPS, OPPS, Readmissions Reduction Program, Hospital Acquired Conditions Program, Hospital Value Based Purchasing, EHR penalty.

40. Although it did not involve a single-payer or all-payer system, the HealthPath Washington Medicare and Medicaid Integration Demonstration did involve Medicare funds being paid to the State of Washington under ACO authority.

41. SB 562, Sections 100650(g)-(h).

42. SB 562, Sections 100650(c).

43. In fact, some federal laws essentially require (or did essentially require) certain individuals to enroll in Medicare. For example, individuals receiving Social Security or Railroad Retirement Board benefits are automatically enrolled in Medicare Part A and Part B. Those eligible for Part A were strongly incentivized to enroll in Part A by the fact that the former minimum essential coverage requirement was satisfied by Part A enrollment.

44. SB 562, Section 100650(i) contemplates that Healthy California will make a de minimis premium payment for Part D plan enrollment (at the low-income benchmark premium amount or, in some cases, a slightly higher premium amount for those enrolled in MAPD plans). However, Section 100650(i) does not discuss making premium payments under Medicare

Parts A and B or making more than a de minimis premium payment for Medicare Advantage or Part D plans. Separately, Section 100650(f) could be read as requiring the Healthy California board to decrease or eliminate Medicare premiums and cost sharing, but it is unclear (1) whether this section does indeed call for the decrease of elimination of Medicare premiums and cost sharing and, if so, (2) whether this proposal is part of the primary effort to redirect Medicare funds to Healthy California or if it is intended to be part of one of the fallback plans to keep Medicare intact.

45. Note also that although 402(b) waivers address only those Medicare requirements relating to payments to providers (making it unlikely that this Section 402 can be used to waive other Medicare requirements, including those dealing with eligibility and cost sharing), more flexibility exists in the language of Section 1115A, particularly via its authorization of all-payer payment models.

46. 42 U.S.C. Section 1395b–1(a)(1)(B).

47. Section 1115A(b) of the Social Security Act. For more information about 1115A authority and the CMS Innovation Center, see "About the CMS Innovation Center," Centers for Medicare & Medicaid Services, June 23. 2017, innovation.cms.gov and "State Innovation Models Initiative: General Information," CMS.gov: Centers for Medicare & Medicaid Services, October 31, 2017, innovation.cms.gov.

48. Although telehealth, home visit, and skilled nursing facility benefits are existing Medicare benefits, these waivers relax the rules associated with each benefit to expand and modify these benefits. For example, Medicare telehealth benefits were traditionally limited to rural settings, but this waiver permits Medicare to cover nonrural uses of telehealth. See "Benefit Enhancements" section at: innovation.cms.gov.

49. See 42 CFR Section 422.102.

50. Medicare Managed Care Manual, Ch. 4, Section 30.4 includes a list of services ineligible from being offered as supplemental benefits, which appears to include items and services that Medicare has determined to be medically unnecessary (e.g., cosmetic procedures, pap smears/pelvic exams more frequently than 24 months).

51. See Medicare Managed Care Manual, Ch. 4, Section 30.4 ("Items and Services Not Eligible as Supplemental Benefits").

52. Phillip and Mulkey, "Key Questions."

53. An employee benefit plan is "any plan . . . which . . . is . . . established or maintained by an employer . . . for the purpose of providing for its participants . . . through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits." 29 U.S.C. 1002(l).

54. 29 U.S.C. Section 1144(a); *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983) (a law "relates to" an employee benefit plan if it has "a connection with or reference to such a plan").

55. Haw. Rev. Stat. Section 393-1 et seq.

56. *Standard Oil Co. of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1981), aff'd 454 U.S. 801 (1981).

57. 29 U.S.C. Section 1144(b)(5).

58. Pub. L. No. 97-473 Section 301(b), 96 Stat. 2605, 2612 (1983).

59. The authors note that as of this writing, the Trump administration has eliminated CSR payments to plans. However, eligible enrollees in enhanced (CSR) plans are still charged lower cost sharing for services as they are legally entitled to these cost reductions.

60. Section 1312(c)(1) of the Patient Protection and ACA (P.L. 111-148).

61. Funding must come from outside of the insurers in the marketplace to reduce premiums, because if the funding came solely from the insurers participating in the marketplace it would not have the intended effect of reducing premiums. It is permissible to tax all plans and include marketplace plans, although that would reduce the amount of savings generated.

62. The federal pass-through amounts are based on the total expected spending on reinsurance, and in order to achieve federal savings, some state spending is necessary to lower premiums and thus achieve savings. To date, states have received different levels of federal support for their programs under the approved waivers. For example, Alaska received about 80 percent of the total reinsurance program funding and Oregon an estimated 33 percent under their 1332 waivers.

63. Deficit neutrality under 1332 waivers is calculated by assessing the effect on the federal deficit; increasing the enrollment in premium tax credits would increase federal spending, www.federalregister.gov.

64. See SB 4, approved by the governor October 9, 2015 (leginfo.legislature.ca.gov) and SB 75, Section 34, approved by the governor June 24, 2015 (leginfo.legislature.ca.gov).

65. Federal DSH audit rules define uninsured inpatient and outpatient revenue as "Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for inpatient and outpatient hospital services they receive. This amount does not include payments made by a State or units of local government, for services furnished to indigent patients." See 42 C.F.R. 447.299(c)(12). Therefore, if the state pays capitated rates for the coverage expansion, the coverage expansion would appear to constitute a source of third party coverage, which could interact with hospital-specific DSH caps, meaning that the state may be limited in its ability to pay DSH at previous levels to individual hospitals. The state's overall DSH allotment would not be impacted, however, and the state could redirect DSH funding to hospitals with room under their DSH caps. If the state simply pays providers out of a pool of dollars dedicated to support services for people who are participating in the eligibility expansion, the state could avoid this result. In addition, the precise interaction with uncompensated care funding included in California's existing 1115 waiver is dependent on program design and is not addressed here.

66. In that proposal, the state had planned to offer mirror plans with the same issuers providing the same benefits, cost sharing, and networks and meeting all QHPs. The primary difference would have been that undocumented individuals eligible under the 1332 waiver would not be eligible for premium tax credits or CSRs. California's December 16, 2016, Section 1332 proposal is available at: www.cms.gov. To expand Covered California coverage to undocumented immigrants, California sought a waiver of Section 1311(d)(2)(B)(i) of the ACA, which prohibits exchanges from making available any health plan that is not a QHP. This authority would have permitted the state to offer mirrored health plans through the exchange to the target population. The waiver of this provision is necessary due to the requirement that QHPs are only available to qualified individuals (Section 1312(a)), a term that can only refer to a "citizen or national of the United States or an alien lawfully present in the United States" as specified in Section 1312(f)(3) of the ACA. Such a waiver would not be needed for the Medicaid eligibility expansion described above.

67. This proposal does not anticipate that undocumented consumers would be permitted to access tax credits to buy into the public option.

68. The Medicaid statute requires states to establish a single state agency to administer their Medicaid programs (See Social Security Act Sections 1902(a)(4) and (5) and 42 C.F.R. 431.10). Depending on how a public option is designed, the single state agency could remain DHCS, which would execute a memorandum of understanding with Covered California. Or, the single state agency could be switched to Covered California (perhaps with memoranda of understanding back to DHCS for purposes of services for other populations).

69. It is assumed that different Medicaid MCOs would participate in different parts of the state.

70. ACA Section 1301(a)(1)(C).

71. A challenging state-level issue, would be how to maximize participation by current public plans, including County Operated Health Systems, some of which are not currently state licensed for Medi-Cal. This and other potential issues are beyond the scope of this paper.

72. ACA Section 1312(d)(3).

73. CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, question 14, (2012), www.cms.gov.

74. *Golden Gate Restaurant Ass'n v. City & County of San Francisco*, 546 F. 3d 639 (9th Cir. 2008).

75. Traits gleaned from *Golden Gate Restaurant Ass'n v. City & County of San Francisco*.

76. Under the Healthy San Francisco program, when employers choose the "pay" option, their covered employees receive either discounted services under the program or city-managed medical reimbursement accounts, which yield an indirect benefit to the employers. San Francisco, CA, ADMIN. CODE Section 14.1(b)(7) (2006); ESR Reg. 4.2(a).

77. For example, Professor Edward Zelinsky argued that the fact that Healthy San Francisco permits employers to make a payment to the city in a way that yields benefits to their employees (see previous footnote) militates in favor of ERISA preemption and not against it — because the employers are essentially buying an ERISA plan from the city. Edward Zelinsky, Golden Gate Restaurant Association: *Employer Mandates and ERISA Preemption in the Ninth Circuit* (Cardozo Sch. of Law, Jacob Bums Inst. for Advanced Legal Studies, Working Paper No. 219, 2008).

78. See *Retail Industry Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007) (finding a Maryland statute to be preempted where it required certain large employers to spend either 8 percent of total payroll costs on employee health insurance or pay the shortfall to the state; the fact that the "pay" option yielded no benefit for employers made the law tantamount to an impermissible direct requirement that employers spend 8 percent of total payroll on employee health insurance).