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Returning Health Care Power to the States

The Affordable Care Act's Section 1332 Waiver for State Innovation

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Executive Summary

When Congress passed the Patient Protection and Affordable Care Act (ACA), it transferred significant regulatory power from the states and placed the health insurance coverage of millions of Americans under the direct authority of the federal government. But Congress also provided states the power to innovate and improve on the ACA through a statutory provision, Section 1332, which provides states with power over some of the most controversial parts of the law. Beginning in 2017, for example, states may choose to waive "all or any requirements" of the ACA's new provisions related to the federal tax code.

Section 1332 implicitly recognizes that states could do a better job meeting the objectives of the ACA than the federal government. Congress intended for states to innovate and experiment using Section 1332, and the ACA expressly grants states latitude to pursue alternative plans: "[a] State may apply to the Secretary for the waiver of ***any or all*** of the requirements…with respect to health insurance coverage…" (emphasis added).

To take advantage of Section 1332's "Waiver for State Innovation," alternative state plans must meet four conditions:

1. Coverage must be at least as comprehensive as the Essential Health Benefits package and offered through exchanges;

2. Provide coverage and cost-sharing protections against excessive out-of-pocket spending for individuals;

3. Provide coverage to at least a comparable number of residents; and

4. Will not increase the federal deficit.

State Innovation Waivers may be used for states to pursue a range of reforms. Some states, like Ohio, have already enacted laws encouraging broad innovation and experimentation. States also could use Section 1332 to take smaller steps to target specific problems, such as the so-called "Family Glitch," or to resolve other inequities by realigning conflicting income and standards methodologies. The

waiver process could also enable states to eliminate the individual mandate, develop better ways to sell health insurance, terminate the federal statutory prescription of metal tiers and coverage benefits, and promote market competition by giving individuals more choices to meet their needs.

Unfortunately, the Obama Administration released guidance in December 2015 that discourages states from pursuing State Innovation Waivers. The administration's guidance conflicts in part with the ACA, complicates waiver approval, and imposes arbitrary restrictions on states.

For states to innovate in health care, they need commitment from the federal government to work cooperatively with state reform efforts, and new guidance that frees states from federal overreach so that they can effectively focus on the needs of their residents.

Recommendations

1. The next presidential administration should rescind the Obama Administration's December Guidance, which deviates from the text and intent of the ACA. The Guidance deviates dramatically from the current fiscal practices used in the Section 1115 demonstration program. The December Guidance limits the ability of states to make Medicaid a more cost-effective program with better health outcomes in the long term.

2. The executive branch should release additional guidance on how deficit neutrality will be calculated. The new guidance should allow *any* savings from moving healthy individuals in Medicaid and the Children's Health Insurance Program (CHIP) into private sector markets as a result of state action, whether economic, administrative, or policy, to be counted and offset any higher costs. There cannot be a wall between Innovation Waivers and Medicaid waivers that prevents savings in one area from applying to another area.

3. The executive branch should release additional guidance to clarify that Section 1332 authority and Section 1115 authority can be used in combination, and that a state can file a single application using both authorities under a single definition of deficit neutrality.

4. Congress should amend the statutory requirement in Section 1332 to provide coverage at least as comprehensive as the Essential Health Benefits package. The current requirement in Section 1332 is inconsistent with the inherent authority itself and is anticompetitive. As an alternative, Congress should consider permitting states to use each of the five original benchmark options under the CHIP and the Deficit Reduction Act of 2005 for all children and adults who are covered by Medicaid, CHIP, or tax subsidies.

5. Congress should amend the statutory requirement in Section 1332 regarding cost coverage and cost-sharing protections against excessive out-of-pocket spending. There are multiple definitions of "affordability" that create and reflect inequities among individuals and families depending on their source of coverage. As CHIP funding declines, Congress should have a coherent plan for integrating coverage of children with their parents' coverage and recognize that affordability reflects the cost of covering all members in a family. Congress should consider closer alignment with private sector employer-sponsored insurance and alternative mechanisms of protecting individuals against catastrophic losses.

6. State governors of both parties should continue to push for flexibility from the federal government in regulating their state health insurance markets. New guidance from the administration should reflect the fact that state governors have and can continue to achieve better outcomes for their citizens than a one-size-fits-all rule drafted in Washington, D.C.

Background

The Patient Protection and Affordable Care Act (ACA) expands health insurance coverage through a three-part approach: Medicaid, tax credit subsidies in the individual market, and Employer Sponsored Insurance (ESI). The majority of Americans, 155 million, receive coverage through ESI. Medicaid is the second-largest source of coverage, with Medicaid and CHIP providing coverage to 68 million people—or one-quarter of the U.S. population under age 65—while the new ACA exchanges cover only 12 million people. Indeed, Medicaid and CHIP now cover 17 million *more* people and the exchanges cover 10 million *fewer* people than the Congressional Budget Office (CBO) had originally projected. CBO's projections were based on the statutory requirement that all states expand Medicaid under the ACA, but the U.S. Supreme Court struck that provision, making state participation in the Medicaid expansion optional.[1]

The ACA created new federal regulations for health insurance by creating Essential Health Benefits (EHBs) in 10 different categories. Only Qualified Health Plans (QHPs) could be sold on the federal and state marketplaces. These regulations replaced state laws and regulations that governed a state's health insurance market. Now, instead of states being able to offer insurance that meets the needs of their population, states have no choice but to require insurance that meets the new federal requirements. People now no longer choose plans that best fit their needs, but instead must choose a plan that meets federal standards.

The next president will face many challenges on health care from the fate of the ACA to CHIP. Next year, a new Congress will need to work with whoever is elected president to develop a coherent strategy in response to the decline in CHIP funding, which expires in 2016 under current law. While parents have been receiving ACA coverage and subsidies, many children have remained covered by Medicaid and CHIP. State waivers may become even more important to states if no federal agreement is reached on CHIP and children could lose health coverage. With many insurers pulling out of the ACA exchanges, it seems likely that health care will be a key issue in the next few years.

What Are State Innovation Waivers?

State Innovation Waivers found in section 1332 of Title 1 of the ACA are commonly called "1332 waivers." These waivers allow states more flexibility to design health care plans to best serve their respective populations by removing many mandates and regulations put into place by the ACA.

Section 1332 provides states with a great deal of power to alter provisions of the ACA and other federal health programs to fit their state's needs. A State Innovation Waiver, for example, could be used to change not only the ACA but also some parts of Medicare, Medicaid, CHIP, and "any

other Federal law relating to the provision of health care items or services."[2] The law permits states to submit a single application for obtaining an Innovation Waiver for any and all of these federal health care programs,[3] and allows states to use a waiver that combines the ACA and other federal programs like Medicaid. States can address the health care needs of their population through one waiver, instead of piecemeal.

The ACA restricts State Innovation Waivers in four key ways. A waiver may be granted only if the Secretary of Health and Human Services (HHS) or Treasury finds that a State Innovation Waiver will:

> (A) provide coverage that is at least as comprehensive as the coverage that would be received under the ACA;
>
> (B) provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as those provided under the ACA;
>
> (C) provide coverage to at least a comparable number of the state's residents as would be covered under the ACA; and
>
> (D) not increase the Federal deficit.[4]

States Push for Flexibility

States have pushed for flexibility in designing their health care programs since well before Congress enacted the ACA. Since the ACA's passage, both Republican and Democratic governors have expressed interest in seeking State Innovation Waivers. The bipartisan National Governors Association urged the Obama Administration to make the waivers as flexible as possible.[5] Many governors want the administration to interpret the four statutory requirements so as to give states greater latitude in designing their plans and waiver requests. For example, some governors have argued that administrative savings accrued when a state provides services instead of the federal government should be applicable to the entire waiver instead of just one section. Some states have sought unified budget flexibility that would allow a waiver to be budget neutral if the total of all the provisions would not increase the deficit.[6] Such flexibility would allow states to apply savings in Medicaid or Medicare to insurance reforms.

Impact of December Guidance

The Department of Health and Human Services and the Department of the Treasury released guidance on State Innovation Waivers on December 11, 2015.[7] That "December Guidance" addresses the four Section 1332 requirements related to coverage, affordability, comprehensiveness, and deficit neutrality. Unfortunately, the guidance sharply curtails the flexibility of the State Innovation Waivers by establishing stringent restrictions that go far beyond the four requirements outlined in the law. These arbitrary restrictions prove inconsistent with the text of the statute regarding how other federal programs would be treated under a Section 1332 waiver application, and go beyond historical examples of other federal guidance on waivers, such as providing states with samples of what the federal government is likely to approve, and templates for facilitating a

streamlined approval process. Instead, the December Guidance exceeded restrictions that historically have been attached to waivers when it informed states that *any* policy change to Medicaid would cause a waiver application to fail.

The inability of states to count changes to Medicaid policy in a waiver is a significant barrier to reform, because Medicaid has enrolled twice as many people as CBO originally projected for 2016. The "comparable coverage" provision of the December Guidance goes beyond the statute and presents a major hurdle for states, since the Guidance splits Medicaid waivers and 1332 waivers into separate groups and savings from Medicaid cannot offset other costs.

The December Guidance informs states and other interested parties about the views of the Obama Administration, but it does not carry the same legal weight as a regulation that went through the rigors of the Administrative Procedures Act. Fortunately, this means that the Guidance can be amended or even rescinded by this—or any future—administration by releasing new or updated guidance.

Recommendation 1

The Obama Administration's December Guidance should be rescinded by regulatory action by the next presidential administration. The Guidance deviates from the text and intent of the ACA, deviates dramatically from the current fiscal practices used in the Section 1115 demonstration program, and limits the states' abilities to make Medicaid a more cost-effective program with better health outcomes in the long term. The Obama Administration policy in the December Guidance of keeping 68 million lives, more than half of whom are healthy children, separate from the rest of the insurance market thwarts the objective of the ACA's Section 1332.

Deficit Neutrality Needs Clarification

Securing approval for a Section 1332 waiver requires a state and the federal government to agree upon deficit neutrality. Costs and revenues *with* the waiver will be compared to costs and revenues *without* the waiver. If, at the end of the waiver period, the cumulative federal cost with the waiver does not exceed the without-waiver projection, it is budget neutral.

History suggests that even the first step of establishing a baseline without the waiver will be a difficult challenge. CBO and CMS do not even agree on baseline spending for Medicare and Medicaid at the national level. Generating state-specific baselines that include Medicaid spending, CHIP spending, and federal spending on tax credits will be even more complicated than a baseline that reflects only Medicaid spending.

Although not required by statute or regulation, the longstanding policy of the federal government has been to require that Section 1115 Demonstration Projects be budget-neutral over a five-year period, though not in each individual Demonstration year. Historically, budget neutrality has required a state to generate savings in order to pay for new costs to the program. For example, a number of states have adopted different forms of managed care to produce savings. Although there may be start-up costs in the first year or two in a Demonstration period, savings will accrue over time and be budget-neutral during the entire Demonstration period.

Deficit neutrality should include the fiscal impact on federal outlays beyond health care. Medicaid is a doorway to participation in other income-related programs, including the Supplemental Nutrition Assistance Program (SNAP), the Earned Income Tax Credit, housing assistance, and child care assistance. Thus, in many cases, individuals on Medicaid also receive other sources of federal assistance, which increases federal spending and the deficit. As individual earnings increase, federal spending on these other benefit programs will decrease, and states should be credited with reducing total federal outlays and increasing federal revenues, including payroll taxes.

Medicaid coverage and future spending will look very different among states that have expanded Medicaid eligibility and those that have not. Accordingly, building deficit-neutral baselines that include coverage and outlays will need to accommodate different starting points for each state. These baselines should take into account the additional federal spending that accrues to Medicaid enrollees due to more SNAP and other transfer programs.

The executive branch should release additional guidance on how deficit neutrality will be calculated. Such guidance should specifically include:

- Impact on federal outlays, including reductions in spending on Medicaid and other public assistance programs;

- Impact on federal revenues, including through increased full-time employment; and

- State adjustments from national trend rates.

Recommendation 2

The executive branch should release additional guidance on how deficit neutrality will be calculated. The new guidance should allow *any* savings from moving healthy individuals in Medicaid and the Children's Health Insurance Program into private sector markets as a result of state action, whether economic, administrative, or policy, to be counted and offset any higher costs. There should not be a fiscal wall between Innovation Waivers and Medicaid waivers that prevents savings in one area to apply to another area.

Two Authorities, One Application, One Deficit Neutrality

The ACA requires the Secretary of HHS to accept a single application from a state that combines Section 1332 authority with Section 1115 authority. As Section 1332 already gives states the authority to include Medicaid in a 1332 waiver, it would be redundant for a state to submit a separate Section 1115 waiver. A state may want to include waivers of Medicaid policy as part of a Section 1332 waiver in order to generate savings to meet the deficit-neutrality requirement. In fact, it may be almost impossible to make a comprehensive Section 1332 waiver deficit neutral without reforming Medicaid to create savings.

Recommendation 3

The executive branch should release additional guidance to clarify that Section 1332 authority and Section 1115 authority can be used in combination and that a state can file a single application using both authorities under a single definition of deficit neutrality.

Essential Health Benefits Should be Amended by Congress

Through the ACA, Congress requires individuals to purchase health insurance coverage, and it specifies 10 Essential Health Benefits (EHB) that must be included in coverage offered by Qualified Health Plans (QHPs) sold on the federal and state Marketplaces. With this defined benefit requirement, Congress restricted the choices of millions of Americans to purchase what *they* may consider to be adequate affordable protection against potential financial losses. Moreover, these defined benefits surpass what Medicaid required in the past for adults and provides less flexibility for the states to establish the benefits for children under CHIP.

Whether the ACA has helped to lower the cost of health care overall remains a subject of dispute. What is clear, however, is that after six years of actual experience, there are five million *more* people without insurance and 10 million *fewer* individuals covered by QHPs than originally projected for 2016. There is no doubt that many Americans, even those eligible for generous subsidies, are declining coverage because, for them, it is not affordable. The ability of QHPs to compete based on price is limited because of the EHB. Allowing greater variation in the benefits package could inject competition into the market and lower prices.

Recommendation 4

The statutory requirement in Section 1332 to provide coverage at least as comprehensive as the Essential Health Benefits package should be amended by statute. This provision of Section 1332 is inconsistent with the inherent authority itself and is anticompetitive. As an alternative, Congress should consider permitting states to use each of the five original benchmark options under the CHIP and the Deficit Reduction Act of 2005 for all children and adults who are covered by Medicaid, CHIP, or tax subsidies.

Multiple Definitions of Affordability and Multiple Programs Create Inequities

The ACA provides multiple definitions of "affordability" depending on a person's income, family size, and the source of coverage. Because different subsidy programs were created at different times, states, individuals, and families face different rules for eligibility, premiums, cost sharing, and benefits. As a person's income increases, that person is responsible for paying a larger percentage of income, up to 9.5 percent of income for employer provided health insurance, for coverage. There are no subsidies for an individual with income in excess of 400 percent of FPL. A family with ESI may not be eligible for any type of subsidy and will pay more for their coverage as a percentage of income than a family that does not have ESI, because a family that purchases insurance on an exchange has a lower affordability threshold than the 9.5 percent of ESI.

In general, federal law places an individual with income at or below 138 percent FPL into Medicaid for which no premium can be charged for coverage. For someone who makes just $10 per month more and is at 139 percent FPL, such an individual is eligible to purchase coverage through an exchange with tax credit subsidies. The ACA considers coverage "affordable" for someone at 139 percent FPL if the person is willing to pay 2 percent of income toward the premium, much lower than 9.5 percent ESI affordability threshold.

Recommendation 5

The statutory requirement in Section 1332 to provide cost coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide should be amended by statute. There are multiple definitions of "affordability" that create and reflect inequities among individuals and families depending on the source of coverage. As CHIP funding declines, Congress should have a coherent plan for integrating coverage of children with their parents and recognize that affordability reflects the cost of covering all members in a family. Congress should consider closer alignment with private sector employer-sponsored insurance and alternative mechanisms of protecting individuals against catastrophic losses.

Increased Flexibility for the States

Governors of both parties want more flexibility from the federal government to pursue state-specific reform. The December Guidance ignores this request for flexibility and instead limits the usefulness of waivers. Past flexibility has allowed HHS to work with states to produce more effective outcomes by allowing some experimentation with Medicaid and welfare.

Welfare reform illustrates how states and the federal government can be effective partners with states experimenting with alternatives to provide better care for their residents. In 1988, Congress enacted the federal Family Support Act of 1988. This legislation attempted to implement work requirements for many welfare participants. Unfortunately, the law actually made it harder for states to run their own work programs.[8] As a result, the majority of states received waivers from HHS to allow experimentation with work programs and the welfare program before enactment of the bipartisan reform bill in 1996.[9]

The National Governors Association (NGA) has asked HHS for more flexibility under the ACA. NGA sent a letter regarding State Innovation Waivers to the Secretary of HHS outlining its request for further clarification on the waivers.[10] As previously discussed, the December Guidance rejected the call for flexibility on budget neutrality and the Medicaid program. Governors are still interested in State Innovation Waivers. Although governors may disagree on some policy specifics, the NGA is very interested in working together on Medicaid reforms and gaining a better application of Section 1332.[11]

Recommendation 6

State governors of both parties should continue to push for flexibility from the federal government in regulating their state health insurance markets. New guidance from the administration should reflect the fact that state governors have and can continue to achieve better outcomes for their citizens than a one-size-fits-all rule drafted in Washington, D.C.

Conclusion

The ACA completed a controversial federal takeover of the health care system. Since the law took effect, ACA mandates have increased the cost of health insurance and there is now growing concern about insurance affordability as many health insurers continue to abandon the ACA exchanges. As these concerns mount, the ACA's health insurance scheme grows increasingly unstable. The next president will have to address this instability or risk greater collapse of an already fragile insurance system. The flexibility for state innovation afforded by Section 1332 waivers is by no means a perfect solution, but these waivers can help states regain some control of and return some stability to their health insurance markets. States have a better track record of managing their own insurance markets and should have the opportunity to again create a more competitive, responsive, and effective health care system. Unfortunately, the Obama Administration's December Guidance has discouraged state efforts and innovation. Unless and until the ACA is repealed or replaced, new federal guidance is needed to restore flexibility to the states. The ACA acknowledges the need for states to experiment and find insurance solutions for their citizens, but in order for states to fully engage in the reform effort, they must have a commitment from Washington that their waiver requests will be well received. Thus far, the states have no such assurance. As a general rule, federally mandated one-size-fits-all schemes rarely succeed, and the federal takeover of America's health care system is certainly no exception.

About the Authors

Rea S. Hederman Jr. is Executive Vice President and Chief Operating Officer of The Buckeye Institute. At Buckeye, Hederman manages the organization's team, operations, research, and policy output. He also oversees the Economic Research Center.

Prior to that, he was a Director of the Center for Data Analysis (CDA) at The Heritage Foundation, where he served as the organization's top "number cruncher." After joining Heritage in 1995, he was a founding member of the CDA, in 1997, when it was created to provide state-of-the-art economic modeling, database products, and original studies. Hederman oversaw Heritage's technical research on taxes, healthcare, income and poverty, entitlements, energy, education, and employment, among other policy and economic issues, and was responsible for managing its legislative statistical analysis and econometric modeling for Heritage policy initiatives.

In 2014, Hederman was admitted into the prestigious Cosmos Club as a recognition of his scholarship. He graduated from Georgetown Public Policy Institute with a Master of Public Policy degree and holds a Bachelor of Arts degree in history and foreign affairs from the University of Virginia. Hederman resides with his wife, Caryn, who is an attorney, and their three sons in Powell, Ohio.

Dennis G. Smith is a Principal in the Washington, D.C. office of Dentons. His practice focuses on health policy at the federal, state, and local levels. His experience includes serving at senior levels of government, as well as in the private sector.

Smith is an experienced and highly successful health policy executive, having served most recently as Secretary of the Department of Health Services for the State of Wisconsin. Appointed by Gov. Scott Walker, he was responsible for an $8 billion budget with 5,500 employees. Smith introduced a number of service delivery and payment reforms in the state's Medicaid program.

In July 2001, Smith was appointed by President George W. Bush to serve as Director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services (CMS). He served under Secretaries Tommy Thompson and Michael Leavitt until April 2008. By that time, Medicaid served more than 35 million people at a cost of more than $350 billion. During his tenure, he was the lead federal negotiator for a variety of successful waivers that redesigned Medicaid programs in states, including Indiana, Florida, Massachusetts, and Vermont. He led federal efforts to expand options for states to serve individuals with disabilities in their own homes and communities with a special emphasis on self-direction. He also served as Acting Administrator of CMS from December 2003 to March 2004.

Endnotes

1. National Federation of Independent Business v. Sebelius, 567 U.S. ___, 183 L.Ed.2d 450, 132 S.Ct. 2566 (2012).

2. 42 United States Code, Section 18052 Paragraph (5).

3. 42 United States Code, Section 18052 Paragraph (5).

4. 42 United States Code, Section 18052 (b).

5. Letter from the National Governors Association to Secretary of HHS Sylvia Burwell, October 27, 2015, at http://www.nga.org/cms/home/federal-relations/nga-letters/health--human-services-committee/col2-content/main-content-list/section-1332-state-innovation-wa.html

6. National Governors Association, "NGA Recommendations Regarding 1332 State Innovations," October 2015, at http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1510LtrHHSTreasuryAttachment.pdf.

7. Government Publishing Office, Federal Register Vol. 80, No. 241, December 16, 2015, at https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf

8. Robert Moffitt, "A Primer on Welfare Reform," Focus, 2008,Vol. 26, 15-25.

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11. Louis Jacobson, "New Head of Governor's Group Talks Future of States," Governing, March 28, 2016, at http://www.governing.com/topics/politics/gov-scott-pattison-national-governors-association.html