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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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Acronyms List

ACA	Patient Protection and Affordable Care Act
APTC	Advance Premium Tax Credit
CMS	Centers for Medicare and Medicaid Services
CHIP	Children’s Health Insurance Program
CSR	Cost Sharing Reduction
EHB	Essential Health Benefits
ESI	Employer-Sponsored Insurance
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
HHS	U.S. Department of Health and Human Services
IRC	Internal Revenue Code
MAGI	Modified Adjusted Gross Income
QHP	Qualified Health Plan

Executive Summary

In this paper, we recommend changes to the statutory and regulatory environments of the Patient Protection and Affordable Care Act (ACA) to allow states to pursue targeted, intermediate, and comprehensive reforms to strengthen their health insurance markets.

When Congress passed the 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 ACA. 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 lives 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 plans 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 federal administration should reflect the fact that state governors have and can continue to achieve better outcomes for their citizens than is possible from 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. Although 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.

Medicaid was created “[f]or the purpose of enabling each State, **as far as practicable under the conditions in such State**, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services **to help such families and individuals attain or retain capability for independence** or self-care....”²

Non-elderly, non-disabled people become Medicaid-eligible for very personal, and often unfortunate reasons—unemployment, divorce, and violence in the home, to name a few. Medicaid should provide eligible individuals with the same access to quality care as those around them; it should be considered part of, not separate from, the rest of the health insurance system; and it should help people “attain...independence,” rather than keep them dependent on it long term. Creating the expectation that the individual and family will return to full employment and receive and contribute to their coverage the same way their neighbors do should be intrinsic to the Medicaid program. CBO estimates, however, that the Medicaid expansion in the ACA actually reduces incentives to work and therefore decreases the amount of work hours and labor supply.³

State Innovation Waivers and the Affordable Care Act's Section 1332

State Innovation Waivers found in Section 1332 of Title 1 of the ACA are commonly called “1332 waivers.” These waivers were included in the Affordable Care Act to provide flexibility for states to experiment with different methods of offering health insurance—so long as these methods meet the stated goals of the ACA. Waivers must be approved by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury, if they modify the Internal Revenue Code. To be approved, a waiver must satisfy four broadly written requirements. The law’s waiver provision is credited to U.S. Sen. Ron Wyden (D-OR), who actively pushed for an amendment based on his previous health care legislation.⁴

Due to the ACA’s fiscal scoring, the start date for 1332 waivers was delayed to 2017. Sen. Wyden and then-U.S. Sen. Scott Brown (R-MA) introduced a bipartisan bill—endorsed by President Obama—that would have moved up the waiver start date, but the bill was never enacted.⁵ Even after the passage of the ACA, lawmakers were interested in making 1332 waivers available to states before the 2017 start date.

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.”⁶ The law permits states to submit a single application for obtaining an Innovation Waiver for any and all of these federal health care programs,⁷ 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.

States, stakeholders, and policy experts have debated the metes and bounds of 1332 waiver authority since the waivers were enacted. Some analysts see great flexibility and broad discretion for states to innovate under the statute, while others read a much narrower authority for states to experiment.⁸ The Obama Administration recently adopted the latter perspective, announcing a restrictive interpretation of State Innovation Waivers in its December 2015 guidance (December Guidance), and enthusiasm for the potential of the innovation waivers has waned markedly since.⁹

Statutory Authority

Section 1332 of the Affordable Care Act provides that “[a] State may apply to the Secretary for the waiver of **any or all** of the requirements...with respect to health insurance coverage....”¹⁰ Accordingly, states may pursue different levels of reform and seek waivers ranging from targeted and small to intermediate to comprehensive. Under this provision, states may change some of the most noteworthy parts of the ACA, including the individual and employer mandates. States could also regain authority over health insurance requirements and the essential health benefits package.

Under Section 1332, states may seek waivers for four important categories of ACA requirements: Parts I and II of Subtitle D; Section 1402 of Part I of Subtitle E; and Sections 36B, 4980H, and 5000A of the Internal Revenue Code. The substance of these statutory provisions is discussed below.

Part I of Subtitle D of the ACA

Part I of Subtitle D defines Qualified Health Plans (QHPs) and individual, small-group and large-group markets; imposes Essential Health Plan Benefits (EHB) and special rules regarding abortion services; imposes annual limits on total cost sharing; and creates actuarial value standards for “metal level” plan categories and catastrophic plans. Part I also defines eligibility for enrollment in catastrophic plans and imposes aggregation rules for small and large employers.¹¹

Part II of Subtitle D of the ACA

Part II of Subtitle D provides authority to create health benefit exchanges, including Small Business Health Options Programs (SHOP) and individual exchanges. It identifies products that may be sold through the exchanges, describes exchange functions, and addresses eligibility, including Medicaid eligibility and enrollment facilitation by exchanges. Part II brings within federal authority several areas traditionally regulated by states, such as the financial integrity and solvency of the on-exchange health insurance marketplaces, certification of plans and requirements to submit justifications for premium increases, and limitations on exchange contracting rules (including limitations regarding insurance issuers operating exchanges for the state). Part II also creates a new category of free brokers for exchange-based health insurance (Navigators), and imposes a single risk pool for health insurance offered inside and outside of an exchange, which requires each insurer operating on and off an exchange to treat all of its enrollees as one group when setting premiums. Part II imposes mental health parity for QHPs and requires health insurance plans to reward quality through market-based incentives and quality improvement activities, e.g., patient safety and hospital readmission measures.¹²

Section 1402 of Part I of Subtitle E of the ACA

Section 1402 of Part I of Subtitle E requires reduced cost-sharing for eligible individuals enrolled in QHPs. This section prescribes cost-sharing rules and their application, including how benefits in addition to the EHB are considered, and provides special rules for pediatric dental plans, Native Americans, and people not lawfully present in the United States.¹³

Sections 36B, 4980H, and 5000A of the Internal Revenue Code

The fourth category of ACA requirements that states may waive with State Innovation Waivers consists of several controversial sections of the Internal Revenue Code and is of great interest to the states. These sections of the Internal Revenue Code define the eligibility rules for the Advanced Premium Tax Credit (APTC) subsidies, including the rules for individuals with access to affordable ESI. They contain the individual and employer mandates, and also include the Modified Adjusted Gross Income (MAGI) methodologies.

Key provisions of each section are listed below.

- **Section 36B** establishes the premium assistance tax credit, including the amount of assistance available and the connection to the second-lowest-cost “silver plan.” This section sets the income tiers as a percent of the federal poverty level (FPL) and defines the sliding scale for percentages of premiums that individuals must pay. Section 36B defines key terms relating to income and families, including the MAGI and the “poverty line,” and key terms relating to subsidies, including “applicable taxpayer” and “coverage month,” exceptions for minimum essential coverage, and special rules for employer-sponsored minimal essential coverage. This section also creates special rules for pediatric dental coverage and for individuals not lawfully present, and it prescribes how credits and advanced credits should be reconciled.
- **Section 4980H** describes employers’ shared responsibility for providing health coverage, and defines “large employer” and “full-time employee.” It imposes taxes on large employers that do not offer coverage and provides exemptions for some employers.
- **Section 5000A** imposes the individual mandate to maintain essential coverage and prescribes the tax for failure to maintain such coverage. It defines important terms relating to the calculation of the MAGI, including income and family size. It also creates exemptions from the tax, e.g., for unaffordable coverage, religion, individuals who are not lawfully present in the U.S., individuals who are incarcerated, and how individuals may be exempt from the tax base due to hardships in personal situations. Section 5000A also defines minimum essential coverage under government-sponsored programs, employer-sponsored plans, plans in the individual market, grandfathered health plans, and other coverage.

Four Statutory Hurdles Facing State Innovation Waiver Applications

The ACA restricts State Innovation Waivers in four key ways. Each statutory requirement must be satisfied before the federal government will approve a State Innovation Waiver application. The requirements address costs, health care coverage, and the values of insurance plans. Typically, the secretary of HHS is responsible for approving most waiver applications, but the secretary of treasury must approve any waiver request that would affect tax revenue or the meaning of the Internal Revenue Code.

A waiver may be granted only if the secretary of HHS or treasury finds that a State Innovation Waiver will:

- (A) provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title and offered through Exchanges established under this title as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS) based on sufficient data from the State and from comparable States about their experience with programs created by the ACA and the provisions of the ACA that would be waived;

(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.¹⁴

These requirements are broadly written and require more interpretation from the administration or Congress. Since the ACA was passed, states and members of Congress have requested more instruction on how the administration understands and interprets these requirements.¹⁵

Application Process

Although 1332 waivers will not take effect until 2017, states may begin the waiver application process before then. Indeed, because any waiver request must be submitted with ample time allowed for implementation,¹⁶ a state that has not already submitted a waiver application is unlikely to receive federal approval in time for the waiver to start in January 2017.

As part of the application process, states must issue public notice, receive public comment, and hold public hearings on any waiver application. Only after public notice, comment, and hearings may a state submit its waiver request, along with the required additional materials.

In the application, states must provide comprehensive information about the proposed waiver, detailed information about the plan that will supplant part of the ACA, proof that the state has the legal authority to execute that plan, and an explanation of how the state's plan satisfies all four statutory requirements. A state's waiver application must include actuarial and economic analysis demonstrating that any approved waiver will not contribute to the federal deficit during a 10-year budget window. States must provide HHS with all data, assumptions, methodology, and other information used for econometric modeling of the waiver's impact on finances and individuals. The CMS actuary will determine the value of coverage offered by the state to ensure compliance with the statute's comparable coverage and enrollment requirements. A state must also explain how implementing the proposed waiver could affect the administrative burden on individuals, the state, and the federal government, as well as how the waiver could impact other areas of the ACA.

Upon receiving a state's waiver request, the federal government has a 45-day review period to ensure that the application has all the necessary components. If the waiver application is complete, the secretary of HHS will then have 180 days to approve or deny the waiver request, and seek additional information from the state if necessary.¹⁷

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.¹⁸ 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.¹⁹ Such flexibility would allow states to apply savings in Medicaid or Medicare to insurance reforms.

Some states have also wanted flexibility to use the federal health insurance exchange to administer State Innovation Waivers. Nearly 40 states currently use the federal infrastructure to manage health insurance exchanges. Some of this infrastructure, however, would not be available to a state that uses 1332 waivers and could increase the cost of a waiver. The technology platform used to run the federal program got off to a disastrous start and still suffers from technological problems. As a result, states will not be allowed to use the federal platform in State Innovation Waivers, because the technology cannot currently be tailored for individual states.²⁰ This could increase costs and make it harder for waivers to be deficit neutral.

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, 2015.²¹ 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 statute requires that a State Innovation Waiver “will provide coverage to at least a comparable number of its residents as the provisions of this title would provide....”²² The December Guidance states that, “[f]or this purpose, ‘comparable’ means that the forecast of the number of covered individuals is no less than the forecast of the number of covered individuals absent the waiver.”²³ The Guidance, however, goes on to state:

Assessment of whether the proposal covers a comparable number of individuals also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including **low-income residents**.... Reducing **coverage** for these types of vulnerable groups **would cause a waiver application to fail this requirement**, even if the waiver would provide coverage to a comparable number of residents overall.²⁴

The December Guidance's statement "...to cover a comparable **number...of low-income residents...**" lacks clarity and creates uncertainty for applicant states because the Guidance does not define "low-income." Some suggest that this language may give flexibility to the states to define "low-income" for themselves. If so, a state might ask whether "low income" means:

- Medicaid eligible (which could be below 100 percent FPL in a state that did not adopt the expansion option)?
- CHIP eligible (CHIP originally defined a target low-income child as up to 200 percent FPL or 50-percentage points above Medicaid; states can now set virtually any income level)?
- 100 percent of poverty?
- 138 percent of poverty (the upper limit for the new expansion adults)?
- 200 percent of poverty (the upper limit for the Basic Health Plan)?
- Some other income level?

It is unlikely that the Obama Administration intends to offer states such broad authority inasmuch as the December Guidance also prohibits changing the terms of a state's Medicaid coverage and requires that Medicaid policies be held constant. In other words, Medicaid is untouchable. Thus, the December Guidance contradicts the flexibility allowed by the statute, which specifically anticipates a state filing a single application using both Section 1332 and Section 1115 authority simultaneously.

The dramatic and unforeseen growth in Medicaid enrollment as a result of the ACA makes the administration's requirement to maintain current Medicaid policies a difficult pill for states to swallow for several reasons:

1. The December Guidance would treat states inequitably because some states have already used Section 1115 waivers to make policy changes while other states would be precluded from doing so. Six states expanded coverage under Section 1115 authority, which allows them to deviate from the Medicaid statute. Some of these waivers, for example, include permission to impose higher premiums and cost-sharing. Other states, including those that have already expanded Medicaid and those that have not, may also be interested in using Section 1115 authority to change Medicaid policies. But these states would be precluded from doing so under the December Guidance. As a result, states may be discouraged from pursuing reforms that could improve their programs and reduce costs.
2. CMS and some states are interested in making Medicaid look more like health insurance. In the new massive Medicaid managed-care regulation, for example, CMS justifies a number of new requirements for states on the grounds of "alignment" of Medicaid with various ACA provisions. States that might be interested in other alignment strategies such

as eliminating retroactive eligibility, using premium assistance, and conforming Medicaid income standards and methodologies to those used in the marketplaces would not be able to do so.

3. Although research is limited, it is widely held that a significant number of individuals will change coverage status over time. One study found, for example, that children move between Medicaid and CHIP eligibility.²⁵ Adopting new policies could mitigate this “churn” and reduce administrative and medical costs. CMS, however, would not allow such policy changes to count toward savings that could be used to meet the deficit neutrality requirement in the waiver. Under the December Guidance, states get no credit for these cost reductions.

4. Some evidence suggests that the newly eligible childless adult population is older, less healthy, more likely to become Medicaid-eligible due to a disability, and likely to cost more to cover than adults with dependent children.²⁶ States may want to adopt a variety of new intervention strategies to target the adults with chronic health conditions that could, over time, improve health outcomes and reduce Medicaid costs. According to the December Guidance, CMS would not recognize such savings generated from lower Medicaid spending.

5. A number of states have expressed interest in policies that would provide incentives for increasing work for Medicaid-eligible adults, which would generate Medicaid savings over time. Medicaid is a means-tested program. Medicaid eligibility is linked to the national, state, and local economic environments. Even as the nation emerged from the recession of 2009, but before the ACA’s Medicaid expansion, Medicaid enrollment stayed well above the historical average. Although there are few longitudinal studies on the use of Medicaid as a long-term source of coverage among the non-disabled populations, one study on child enrollment in Medicaid indicates that a child’s length of stay on Medicaid is linked to his/her parents’ education level. More than half of children whose parent lacks a high school education stay for five years.²⁷ Earnings are linked to education. More than 60 percent of children whose family income is at or below 100 percent FPL stayed on Medicaid for five years. Some states are interested in adopting strategies that would help individuals and families raise their income sufficiently that they would no longer be Medicaid-eligible. Under the December Guidance, CMS would not allow such savings from Medicaid to be counted in “with waiver” 1332 calculations.

6. Medicaid and CHIP cover over one-quarter of the population under age 65. In poorer states, the two programs may cover up to half of the population. Overwhelmingly, enrollees will be young, healthy individuals (about half of Medicaid enrollees and nearly all CHIP enrollees are children). By combining the Medicaid and CHIP populations with employer coverage or marketplace coverage, the trajectory of premium increases could be lowered. But if states are not allowed to count Medicaid savings, of which at least half will be credited to the federal government, it will be substantially more difficult to demonstrate deficit neutrality.

7. CMS has awarded nearly \$1 billion to states under the State Innovation Model (SIM) Initiative Grants. This initiative, established by the ACA, provides financial and technical support to states for developing and testing models of multi-payer health care payment and service delivery. States must implement a proposal capable of creating statewide health transformation for the majority of care within the state. There is an expectation that payment and service delivery reforms should ultimately bend the cost curve. As states move to implement these models in their Medicaid programs, it would make little sense for CMS not to recognize those savings in a 1332 waiver application as a return on investment with taxpayer dollars.

8. In 2010, California became the first state to receive approval for a “Delivery System Reform Incentive Payment” (DSRIP) program as part of its Section 1115 Demonstration. This program is designed to assist the 21 public hospitals in California developing infrastructure and new models of care, and improve the patient experience.

In DSRIP, states procure a Section 1115 waiver that allows the state to reward providers for implementing successful delivery system and payment reform projects. This is a hospital-based effort and is financed by redirecting supplemental payments that have traditionally been available to hospitals for the provision of uncompensated care. States pool a portion of their existing uncompensated care funds (and supplement with additional resources at times) to target and reward specific quality improvement goals.²⁸

Since California’s initiative, eight more states have implemented DSRIP programs. Another six states have developed DSRIP proposals. CMS has approved these waivers with the explicit requirement that service delivery reform and payment reform will lower the cost of providing care for the Medicaid populations. Collectively, tens of billions of dollars will be invested in these programs by the time they end. They are designed to be replicated by other states. CMS would be shortsighted not to allow savings in Medicaid reform to be used to offset other costs in order to ensure deficit neutrality.

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 of a regulation that went through the rigors of the Administrative Procedures Act (APA). 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' ability 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 authors of ACA 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. 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.

Section 1115 Budget Neutrality

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. Demonstration Projects must also be evaluated.

Budget neutrality is generally the most complex part of the approval process for a Demonstration Project. The five-year baseline is the federal cost without a waiver. Then, the five-year federal cost with the waiver is determined. If, at the end of the Demonstration period, the cumulative federal cost with the waiver does not exceed the without-waiver projection, it is budget neutral. States make up the shortfall between projected costs and actual spending once all federal funds are used. States, therefore, may make adjustments during the Demonstration period to reduce costs. For example, states that had expanded eligibility to a new population group were allowed to cap enrollment during the Demonstration period to reverse enrollment growth and thereby avoid further costs.

Budget neutrality may be calculated in the aggregate, such as Vermont's Global Commitment waiver, or on a per-capita basis. Under a per-capita cap, the state is not at risk for enrolling more people than under the original forecast, but is at risk if the cost per person exceeds the original

estimates. Accordingly, the state will typically produce data by Medicaid Eligibility Groups (MEGs) and further disaggregate spending based on age, sex, geographic area, and other variables. State and federal officials will ultimately agree on trend rates to forecast future spending. Trend rates are based on national and state-specific data.

Deficit Neutrality and the ACA

The ACA was designed to reduce the number of Americans without health insurance through a three-pronged approach—expand Medicaid eligibility, offer subsidies to purchase private individual coverage through exchanges, and maintain employer-sponsored health insurance. The CBO’s scoring reflects the fundamental understanding that policy changes among any one of these three prongs will affect the others. On March 11, 2010, CBO wrote to then-Senate Majority Leader Harry Reid with an estimate of the direct spending and revenue effects of H.R. 3950, the “Patient Protection and Affordable Care Act”—the foundation for the ACA signed into law just two weeks later.²⁹ Table 3 of the Reid letter provides the estimated effects of the insurance coverage provisions contained in H.R. 3590.³⁰ Without the ACA, health insurance coverage in 2010 and 2016 would be distributed as follows:

	2010	2016
Medicaid & CHIP.....	40 million.....	35 million
Employer.....	150 million.....	162 million
Non-group & Other.....	27 million.....	29 million
Uninsured.....	50 million.....	52 million
Total Population	267 million.....	277 million

CBO estimated that with the ACA the distribution of health insurance coverage in 2016 would be as follows:

	2016
Medicaid & CHIP.....	51 million
Employer.....	158 million
Non-group & Other.....	24 million
Exchanges.....	22 million
Uninsured.....	22 million

In the spring of 2016, CBO issued *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, a report that documents federal spending growth on health insurance.³¹ “CBO also released a series of baseline projections for various federal programs, including Medicare, Medicaid, and tax subsidies for individual private insurance purchased through the federal and state marketplaces. These baselines are used to score legislation, making them a vital resource to the public as well as to the Congress.”³²

Now that 2016 is actually here, CBO estimates that health insurance coverage for the population

under age 65 is distributed as follows:

2016

Medicaid & CHIP.....	68 million
Employer.....	155 million
Non-group (purchased outside Marketplace).....	9 million
Marketplace.....	12 million
Basic Health Program.....	1 million
Medicare ³³	9 million
Other Coverage.....	5 million
Uninsured.....	27 million
 Total Population.....	 272 million

Coverage in 2016 looks vastly different than the original CBO estimates provided in March 2010. Instead of adding 16 million people to Medicaid and CHIP—as CBO originally predicted—enrollment in these programs has 33 million more people than CBO estimated. “In 2010, Medicaid and CHIP covered 40 million non-elderly people. Enrollment in these programs...was expected to drop to 35 million people under CBO’s 2010 (pre-ACA) projections.”³⁴ In other words, Medicaid and CHIP enrollment has nearly doubled in six years.

The difference in enrollment is even more shocking when we consider that CBO’s original estimate of future Medicaid enrollees assumed that every state would expand Medicaid. Thus far, only 32 states have expanded Medicaid, and six of those have done so through Section 1115 waivers. CBO estimates that only 11 million people were made eligible for Medicaid by the ACA, meaning that the states are financing a substantial percentage of the increase in enrollment at regular match rates. Other differences in the CBO projections include:

- 10 million fewer people covered by the exchanges (marketplaces) than CBO projected;
- Five million more people covered by employers than there were in 2010; but three million fewer people covered by employers than CBO projected for 2016;
- 27 million uninsured in 2016—five million more than the original CBO estimate;
- Total population grew by five million people, half of the 10 million that CBO forecasted;
- Percentage of uninsured is 11, rather than eight, as originally forecast.

CBO estimates that 244 million people or 90 percent of all U.S. residents now have health insurance coverage and that the 90-percent level will be maintained throughout the 2016-2026 period.³⁵ The number of people without insurance has dropped to 27 million, and the number of uninsured is projected to remain constant over the same period. Where people obtain their

coverage is of particular interest, and is displayed in Table 1 of the Federal Subsidies baseline.³⁶ According to Table 1, CBO estimates that people under age 65 will receive coverage through the following sources in 2016 and 2026:

	2016	2026
Total Population Under Age 65.....	272 million	280 million
Employment-Based Coverage	155 million	152 million
Medicaid and CHIP.....	68 million	71 million
Non-group Coverage and the Basic Health Program		
Subsidized through Marketplaces	10 million	14 million
Unsubsidized through Marketplaces	2 million	4 million
Purchased Outside Marketplaces	9 million	7 million
Basic Health Program	1 million	1 million
Medicare	9 million	9 million
Other Coverage	5 million	6 million
Uninsured	27 million	28 million

ACA Increases Deficit

Table 5 of the CBO Report details the effects of the insurance coverage provisions of the ACA on the federal deficit from 2016 to 2025. The gross cost of coverage will total \$1.805 trillion during that period, which will be partially offset by an increase of \$461 billion in revenues, resulting in a net cost of \$1.344 trillion.³⁷

Outlays

Subsidies for Coverage through Marketplaces and Related Spending and Revenues.....	\$803 billion
Medicaid and CHIP Outlays.....	\$993 billion
Small Business Tax Credits.....	\$9 billion
Gross Cost of Coverage Provisions	\$1,805 billion

Revenues

Penalty Payments by Uninsured People	-\$37 billion
Penalty Payments by Employers.....	-\$155 billion
Excise Tax on High-Premium Insurance Plans	-\$59 billion
Other Effects on Revenues and Outlays.....	-\$210 billion

Net Cost of Coverage Provisions

	\$1,344 billion
--	-----------------

The source of coverage—ESI, Medicaid/CHIP, or marketplace subsidies—has profound implications for outlays and revenues. States face several challenges as they model their baseline with and without a waiver. States must present evidence that a waiver does not increase the federal deficit and covers a comparable number of people. By attempting to separate Medicaid finances from

other Section 1332 finances, the December Guidance makes modeling even more challenging. Other challenging factors in the economic simulations of deficit neutrality may include:

- On a per-capita basis, federal costs are less for a person enrolled in Medicaid than marketplace subsidies;
- The majority of subsidies are paid on behalf of individuals with income at or below 250 percent of FPL;
- A person moving from part-time employment to full-time employment could increase ESI and lower Medicaid costs; and
- Increasing ESI could result in a loss of revenue through lower penalties paid by employers and through increased deductions for coverage.

Difference Scenarios that Affect Medicaid Expenditures

As noted, even though the Obama Administration will not allow a state to change Medicaid policies in conjunction with a State Innovation Waiver, Medicaid enrollment could still decline due to external factors. Consider the following scenarios in which this decline may occur:

Scenario A: Medicaid enrollment increases due to a decline in the state's economy that is heavily dependent upon oil and gas production. Three years later, the state's economy improves, private sector hiring increases, which increases earnings as well as employer-based coverage, and the number of people eligible for Medicaid declines.

Scenario B: A state, which exceeds the national average of insurance coverage with 93 percent of its residents covered by insurance, has incorrectly enrolled individuals into Medicaid due to problems determining Medicaid eligibility. Two years later, the system's problems were fixed and the state once again performed its required Medicaid eligibility redeterminations, resulting in the removal of 10 percent of the Medicaid population from the rolls. Because the state invested in assisting individuals to enroll in the marketplace, 93 percent of its residents still have coverage, but there are now fewer **low-income** residents.

Scenario C: The difference between Medicaid eligibility and tax subsidies eligibility is \$10 per month for a single individual. Because the social determinants for long-term stays on Medicaid are related to education and income, a state invests in education, employment, and training programs and targets individuals enrolled in the Supplemental Nutrition Assistance Program (SNAP) and Transitional Medicaid Assistance (TMA). As a result, earnings increase and monthly enrollment declines 1 percent per month for 24 months. The percentage of individuals who stay on Medicaid for three years falls by 10 percent and the percentage of individuals who stay on Medicaid for five years declines by 20 percent.

Each of these scenarios could reduce Medicaid spending while maintaining overall coverage. Under the December Guidance, however, a State Innovation Waiver could fail if a state increases

job opportunities for Medicaid recipients that result in those recipients obtaining coverage other than Medicaid. No state should be penalized if it increases the number of residents with health insurance coverage but the number of low-income residents on Medicaid declines. Costs would shift from Medicaid to the private insurance market with possible tax subsidies and therefore from state budgets to the federal budget. But greater federal revenues due to higher earnings would also be realized.

A significant number of individuals will likely move between Medicaid and private coverage. The December Guidance administrative requirement that ignores Medicaid savings conflicts with the intent of the ACA and does not account for cost shifts that occur as individuals and families move among coverage sources. It may be impossible to demonstrate deficit neutrality in a comprehensive State Innovation Waiver if some types of Medicaid savings are not allowed to be counted as people move from Medicaid to private coverage.

New Guidance Needed to Avoid Repeating History

Federal “waiver history” has been largely a bureaucratic contest of wills. The dispute over budget neutrality in Section 1115 Demonstration Projects, for example, has been waged between the Government Accountability Office (GAO) and HHS for more than 20 years through Democratic and Republican administrations alike. It took 17 years for the federal government to approve the first statewide, comprehensive Medicaid demonstration project in Arizona under Section 1115 authority—and it took another 10 years to approve the second. To avoid repeating that tragic history, new guidance on Section 1332 waivers is needed.

In November 1995, GAO issued a report to then-U.S. Sen. Daniel Patrick Moynihan (D-NY), the Ranking Minority Member on the U.S. Senate Committee on Finance, *Medicaid Section 1115 Waivers Flexible Approach to Approving Demonstrations Could Increase Federal Costs*. GAO found that 22 states had requested approval to use Section 1115 to restructure their Medicaid programs since 1992 and that by September 1995, half had been approved and five of those 11 had been implemented—Tennessee, Hawaii, Oregon, Rhode Island, and Minnesota. GAO examined four of these states in depth and concluded that only one met the budget neutrality test. GAO warned, “[t]he use of 1115 waivers to restructure state Medicaid programs has been facilitated by a new federal flexibility in assessing the budget neutrality of such demonstrations—particularly the administration’s avowed openness to ‘new methodologies’ to estimate what the continuation of a state’s existing Medicaid program would have cost.”³⁸

In April 2014, GAO issued its *2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap and Duplication and Achieve Other Financial Benefits*. Among its findings, GAO stated that, “[f]ederal spending on Medicaid demonstrations could be reduced by billions of dollars if the Department of Health and Human Services were required to improve the process for reviewing, approving, and making transparent the basis for spending limits approved for Medicaid demonstrations. GAO’s work between 2002 and 2013 has shown that HHS approved several demonstrations without ensuring that they would be budget neutral to the federal government.”³⁹ Given the historical disagreements between GAO and CMS about how budget neutrality should be calculated, new guidance could help ensure that similar disputes over

Section 1332 waivers are avoided. Significantly, GAO had the benefit of looking at these waivers with 20-20 hindsight, while CMS had to act on the waiver applications and project future costs. The chief actuary of CMS has acknowledged the inherent difficulty in predicting future health care spending, observing in the *2014 Actuarial Report on the Financial Outlook for Medicaid*: “[p]rojections of health care costs are inherently uncertain. For Medicaid, such projections present an even greater challenge as enrollment and costs are very sensitive to economic conditions.”⁴⁰ The projected spending in the annual reports themselves exemplify the difficulty of estimating future costs. Between the 2013 and 2014 reports, for example, the actuaries lowered their projected spending for 2022 by 7.9 percent. The 10-year projections for the years 2013 through 2022 were lowered by 5.3 percent or \$341.6 billion.⁴¹

In light of such inherent complexities and challenges, new guidance on Section 1332 waivers will be needed to avert the fate of the Section 1115 waiver program.

Deficit Neutrality Even More Complicated than Budget Neutrality

Establishing deficit neutrality will be an even greater challenge than budget neutrality because it will likely involve multiple programs and revenue streams as well as spending. Exacerbating that challenge, Section 1332 waivers require 10 years of projections while Section 1115 waivers require only five.

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 (EITC), 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 that 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 State 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. The statute states:

Section 1332(a)(5) Coordinated Waiver Process.--The Secretary **shall** develop a process for coordinating and **consolidating** the State waiver processes applicable under the provisions of this section, and the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, **and any other Federal law** relating to the provision of health care items or services. Such process **shall** permit a State to submit a **single application** for a waiver under any or all such provisions (emphasis added).⁴²

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. Section 1332 does not grant new authority to waive provisions of Title XIX, since authority to waive provisions of Medicaid already exists under Title XI. 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.

Under Section 1115 of the Social Security Act, the secretary of HHS has broad authority to approve “...any experimental, pilot, or demonstration project which in the judgment of the Secretary, is likely **to assist in promoting the objectives...**” (emphasis added) of various titles under the Social Security Act.⁴³ Title XIX, which provides the authority for the Medicaid program, is included among those covered titles. These demonstration projects are popularly referred to as “waivers,” as compliance with the requirements of the law for certain parts of the Act are “waived” by the secretary.

The secretary’s authority under Section 1115 predates Medicaid. Title XIX was created in 1965, three years after Title IX. The objective of Title XIX is found in Section 1901:

For the purpose of enabling each State, **as far as practicable under the conditions in such State**, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are

insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services **to help such families and individuals attain or retain capability for independence** or self-care....⁴⁴

The Social Security Act acknowledges that the capacity to support a Medicaid program varies from state to state and that the program is not intended to promote long-term dependency on public assistance. States may pursue a range of program reforms, including changes to covered populations, benefits, and the service delivery system that control costs and fraud and can help recipients leave Medicaid for better coverage. These 1115 waivers are either research and demonstration waivers or comprehensive reform waivers.

Obtaining Medicaid Waivers

A Medicaid state plan describes how the Medicaid program operates in a state and is generally organized around five major areas—eligibility, benefits, service delivery system, payments, and financing. A state plan is a compilation of all policies adopted since the beginning of a state’s Medicaid program. Through the 1115 demonstration-approval process, a state requests permission to deviate from its own state plan for the population covered by the waiver. CMS ultimately issues a letter to the respective state official that includes a set of Special Terms and Conditions (STCs). These STCs specify which federal requirements are waived. All other requirements, expressed in laws, regulations, and policy statements not expressly waived or identified as not applicable, apply to the 1115 demonstration.⁴⁵

Waivers can encompass a relatively small portion of a state’s Medicaid program for a short period of time. For example, demonstrations have been used in times of large-scale emergencies such as for New York during the post-9/11 period. More than 30 states received waivers to cover Medicaid enrollees who were displaced by hurricanes Katrina and Rita. Examples of waivers that have been approved for limited geographic areas can also be found in Columbus, New Orleans, and St. Louis.

Demonstrations can also effectively serve as a state’s entire program as in Arizona and Tennessee. Typically, demonstrations are approved for a five-year period and can be extended (usually for three years) and renewed. Arizona’s demonstration, for example, dates back to 1982. Similarly, TennCare and MassHealth were first approved in the 1990s.

According to the first CMS Report to Congress, *Transparency in the Review and approval of Medicaid and Children’s Health Insurance Program (CHIP) Section 1115 Demonstrations*, there were 55 active demonstration projects operating in 38 states in September 2015.⁴⁶ Of these, 34 were comprehensive, eight were targeted “to select populations or geographic areas, and 13 provide only family planning services to individuals not otherwise eligible for Medicaid.”⁴⁷ According to an April 2014 GAO report, \$70 billion in federal funds or about one-fourth of federal Medicaid outlays were spent under Section 1115 authority in 2013.⁴⁸

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. By 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.

EHB must include items and services within at least the following 10 categories:⁴⁹

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance abuse disorder services including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services including oral and vision care.

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 benefit

package could inject competition into the market and lower prices.

Under Medicaid, states are required to cover certain mandatory services and are allowed to claim Federal Financial Participation (FFP) for additional optional services (described in Appendix B). For children, states are required to provide early and periodic screening, diagnostic, and treatment (EPSDT) benefits that are medically necessary. The EPSDT benefit includes all mandatory and optional benefits and comprehensive health care services “ranging from preventive and acute care to potentially long-term care for serious physical, mental, and developmental conditions. EPSDT benefits are considered to be more comprehensive than any commercial benefit package.”⁵⁰ For example, a state might limit an adult to one set of eyeglasses per year, but a child would have no such limitation.

CHIP was created in 1997 to provide coverage to targeted, low-income children who did not have access to affordable health insurance. In general, these children were in families with income above Medicaid-eligibility levels but whose families could not afford private insurance because they were low-income.

States were given flexibility to expand Medicaid as their CHIP program (M-CHIP), create a separate CHIP program, or create a combination program in which lower-income children were enrolled into Medicaid and higher-income children were enrolled into a separate CHIP program. Only eight states and the District of Columbia chose to adopt the Medicaid expansion option. The remaining states operate separate CHIP programs or combinations.⁵¹

In choosing the separate CHIP option, states can select from five benefit options:

- (1) benchmark coverage with benefits that are the standard Blue Cross/Blue Shield preferred-provider option offered to federal employees;
- (2) the state employee’s coverage plan;
- (3) the HMO plan that has the largest commercial, non-Medicaid enrollment within the state;
- (4) secretary-approved coverage; or
- (5) benchmark-equivalent coverage, with benefits actuarially equivalent to one of the benchmarks.⁵²

A state that chose the Medicaid expansion option must follow all Medicaid rules including providing the EPSDT benefit and cost-sharing rules, which allow only limited cost sharing. In separate CHIPs, states are allowed to charge for premiums, deductibles, copayments, and coinsurance, but the total combined costs cannot exceed 5 percent of total family income. Premiums and cost sharing vary significantly by state in CHIP with some charging income-based premiums and others having no premiums.

The Deficit Reduction Act of 2005 adopted the benchmark plan approach as well, this time for a new adult eligibility group. Because these different programs were created at different times, states, individuals, families, and health plans face a scramble of different rules for eligibility, cost sharing and benefits. Children may be in different programs than their parents.

Section 1332 is inherently inconsistent as it permits the EHB to be waived but under the four guardrails, it also requires “...coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title....”⁵³

Permitting states to offer a benchmark plan to all nondisabled children and adults in Medicaid and the marketplace would require a statutory change because eligibility groups have been added at different points in time. Previous eligibility groups were “grandfathered” into old benefit packages. The EPSDT benefit for children could still be included as a supplemental benefit.

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 plans options under the CHIP and the Deficit Reduction Act of 2005 for all children and adults who 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 the 9.5 percent ESI affordability threshold.

The CHIP program was created in 1997 for low-income children in families that did not have access to health insurance through traditional Medicaid. These families made too much money to qualify for Medicaid but not enough to be able to purchase private coverage. States were permitted

to cover children up to 200 percent FPL or 50-percentage points higher than their eligibility for Medicaid. Thus, in today's environment, children in a family may be covered by Medicaid or CHIP while their parents are covered by private insurance purchases with tax subsidies. CHIP gives flexibility to states in designing benefits, premiums, and cost sharing within certain limitations. Families cannot pay more than 5 percent of income on coverage for the children in the family, for example. Federal law also prohibits states from requiring a family to pay a premium for the children's CHIP coverage if the family income is less than 150 percent FPL.

Significantly, however, funding for the CHIP program will start to run out for some states in 2017. If there is no funding for CHIP, a child who loses CHIP coverage is then eligible for coverage with their parents through an exchange. Children who go on exchanges due to the loss of CHIP make it harder to craft a waiver that meets the guidance requirements.

The ACA requires the secretary of HHS to "...review the benefits and cost sharing in qualified health plans (QHP) and certify those plans that offer benefits and cost sharing that are at least comparable to the Children's Health Insurance Program."⁵⁴ On November 25, 2015, the secretary released the results of the review (see Appendix C for state-by-state comparisons), which include:

Comparison of Cost Sharing and Benefits

HHS reviewed the second-lowest-cost silver plan (SLCSP) in the largest rating area in each state to compare it to CHIP in that state and determined that CHIP and marketplace coverage offer beneficiaries different levels of financial protection and benefits, reflecting the programs' different purposes and structure as established in statute. The review found that the average out-of-pocket spending in the SLCSP was higher than out-of-pocket spending in CHIP for CHIP-eligible children in all states reviewed, on a per-child basis under CHIP and under SLCSP with financial assistance. In addition, the Actuarial Value (AV) of CHIP exceeds the AV of the SLCSP in every state reviewed except Utah, where the CHIP and SLCSP AVs are equivalent. This finding indicates that families are expected to pay for a larger percentage of expected covered health care costs in QHPs than CHIP in all but that state. When premiums are taken into account, Utah's average out-of-pocket spending in the SLCSP was higher than out-of-pocket spending in CHIP.

HHS also reviewed benefit comparisons and determined that benefit packages in CHIP are generally more comprehensive for "child-specific" services (such as dental, vision, and habilitation services) and for children with special health care needs as compared to those offered by QHPs. CHIP coverage of "core" benefits (such as physician services, laboratory, and radiological services) is similar between CHIP and QHPs.

Certification

Accordingly, and based on this review, the secretary is not certifying any QHPs as comparable to CHIP coverage at this time. Because the allotments provided under section 2104 of the Act are sufficient to provide coverage to all children who are eligible to be

targeted low-income children at this time and in the foreseeable future, the requirement at 2105(d)(3)(B) of the Act that requires states to establish processes to enroll children in certified QHPs does not apply.⁵⁵

The secretary's comparison of CHIP to QHPs is significant because states used the flexibility in the CHIP program to design their CHIP programs that are far more generous than federal law requires. The secretary's certification does not support the concern of some that if states have flexibility there will be a "race to the bottom." Instead, state-designed CHIP plans often have superior benefits compared to QHPs.

The richer benefits of CHIP make it harder to get a waiver that meets the December Guidance. Once again, we find that Section 1332 promises state flexibility, but then takes it away by requiring states "...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." As CHIP funding expires, the new Congress and the new president would do well to review the history and lessons of both the ACA and CHIP. With the history of CHIP as a guide for how states will likely use flexibility, the Section 1332 limitation on coverage and cost sharing is unnecessarily restrictive and should be revisited.

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.⁵⁶ 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 1996.⁵⁷

The National Governor’s 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.⁵⁸ 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 1332.⁵⁹

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 is possible from a one-size-fits-all rule drafted in Washington, D.C.

How States Might Use Section 1332 and Section 1115 Waivers

As states better understand how millions of people move through the health insurance system there is interest in pursuing insurance reform through State Innovation Waivers in conjunction with Section 1115 Demonstration Projects. Thus far, states have approached reform in varying degrees and levels. Some states have attempted narrower reforms that targeted a specific provision of the ACA like the small-business exchange. Other states may prefer comprehensive reforms to their entire health insurance programs, while still others may pursue a middle road of intermediate reform measures such as fixing the “Family Glitch.”

Targeted Reform—Hawaii, Massachusetts, and Vermont

Hawaii, Massachusetts, and Vermont have proposed using Section 1332 authority to waive provisions of the ACA. In their waiver descriptions, the three states have described a robust health insurance market prior to enactment of the ACA. They have each explained how federal law threatens to disrupt what the state has created, with Vermont citing the burdensome online enrollment process for small businesses.⁶⁰ All three have warned against how the ACA could undermine the small-employer market in particular, resulting in a loss of coverage and higher federal costs. These states have also reported the following problems associated with operating SHOP exchanges:

- start-up costs and maintenance too expensive for small markets.
- systems too complex and susceptible to errors.
- small employers ultimately buying the same coverage, wasting money unnecessarily on outreach, marketing, and education efforts.

- no competition among carriers. Commercial plans were discouraged from participating due to federal requirements related to premium fees and additional filings and reporting requirements.

To address these problems and concerns, Hawaii, for example, currently seeks a federal waiver for provisions in Section 1301, 1304, 1311, and 1312 of the ACA in order to maintain its “Prepaid Employee Coverage Marketplace.”⁶¹ According to Hawaii, the ACA disrupted 40 years of success in the small-group market, and the secretary of HHS should consider:

- SHOP does not add value or incentives to employers and has served only to increase small-business costs.
- Besides maintaining the benefits for employees required by Prepaid, Hawaii requests a SHOP waiver to ensure the effective cooperation among insurers, employees, employers, and state agencies that has enjoyed an exemplary level of compliance without adding significantly to administrative costs.
- Creating the ACA-required infrastructure for SHOP is not cost effective but joining the federal platform for the SHOP exchange is not feasible because the federal exchange cannot accommodate Prepaid’s coverage mandates.⁶²

Similarly, Massachusetts seeks specific, targeted measures that will allow the state to return to its previous health insurance reforms. For instance, Massachusetts had merged the non-group and small-group markets in 2007, which created a more stable market, but the federal government now threatens to separate those merged markets, risking instability and pricing disruption.

The commonwealth anticipates that fully transitioning the current merged market to the federal definition of a merged market will cause significant market disruption and instability in pricing. An analysis in 2013 indicated that 181,000 small employer enrollees could see premiums increase by more than 10 percent under the rating factors transition. Of these enrollees, 6,000 could face premium increases of more than 30 percent.⁶³

The commonwealth therefore seeks a specific State Innovation Waiver to escape the requirement under Section 1312(c) of the ACA in order to maintain its merged market under a single risk pool.

Vermont has also sought relief from the SHOP provisions of the ACA. In its proposal, Vermont describes its environment in which only two health insurance issuers offer individual and small-group coverage.⁶⁴ Vermont proposes to eliminate the various federal requirements for the small-group exchange under Section 1311 to maintain a SHOP internet portal, and instead hopes to maintain the current process of direct enrollment through insurance carriers.

All three of these proposals seek relief from federal burdens and serve as important reminders that:

- Insurance markets are local, not national;
- The ACA has increased some prices and costs; and
- Exchanges or marketplaces are merely means of acquiring health insurance, the cost of which should be compared to other means.

Intermediate Reform—Fixing the Family Glitch

The ACA was designed in part to avoid the migration from employer coverage to taxpayer subsidies. In July 2011, prior to the IRS rule on affordability, the Employment Policies Institute released *An Offer You Can't Refuse: Estimating the Coverage Effects of the 2010 Affordable Care Act*, describing how price-sensitive workers covered by ESI might react to the ACA.⁶⁵ The authors found that nationally 74.29 percent of workers have ESI. They estimated that the ACA could significantly change the percentage of workers with ESI in either direction, ranging from a drop in coverage to 65.89 percent of workers to an increase to 78.62 percent of workers. The report also estimated that it would cost taxpayers up to \$5 billion in gross subsidies for every one million workers who switch from being an ESI policy holder to receiving APTC/CSR subsidies. The institute estimated that the “crowd out” effect could increase federal subsidies from \$19 billion in the least dynamic case to \$66.5 billion in the most dynamic case—signaling a clear federal interest in maintaining ESI.

Whether the ACA has helped to lower the cost of health care overall remains disputed. For millions of individuals, generous subsidies through the tax code and Medicaid have made coverage more “affordable.” But there has been no relief for millions of Americans who are caught in the so-called “Family Glitch.” Section 1401 of the ACA, “Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan,” created a new section 36B in the Internal Revenue Code. This section provides for sliding-scale premium assistance for taxpayers beginning at 100 percent of FPL, phasing out at 400 percent. The taxpayer’s share of the premium begins at 2 percent of household income up to 133 percent of FPL. The premium increases by income level until reaching 9.5 percent of household income at 300 percent FPL.

An individual is not eligible for the tax credit and cost-reduction subsidies, however, if anyone in the family is offered “affordable” coverage through employer-sponsored insurance. “Affordable” ESI is defined as 9.5 percent of the employee’s income for **self-only** coverage. This means that in 2016, an employee with an income of \$60,750 in a family of four would have to spend \$5,771 on her own coverage before her coverage would be considered “unaffordable.” The cost of coverage for other family members would be in addition to the employee’s share, and may not be affordable for the family. Individuals are liable for penalties imposed on dependents who do not maintain “minimum essential coverage.”

States could use a Section 1332 waiver to fix the so-called Family Glitch by converting the tax credit into a subsidy to purchase family coverage from the employer and eliminating the penalty for not having minimum essential coverage for other family members.

Intermediate Reform—Aligning Income Standards

Eligibility requirements for the APTC/CSR subsidies, Medicaid, and CHIP are based on an individual or family income as compared to the FPL. The FPL is determined by income and family size (see Appendix D). New IRS sections 36B and 5000A created by the ACA define how income methodologies under MAGI should be applied when determining the APTC/CSR subsidies. The ACA also required states to adopt MAGI for Medicaid and CHIP, but some differences remain, including:

- Income – Medicaid eligibility is determined on current monthly income, while APTC/CSR eligibility is determined on prior year or projected annual income.
- Household size – APTC/CSR subsidy eligibility is determined according to tax dependents, and while Medicaid eligibility generally follows the same rule, the program may also count additional people living in the household.
- Pregnant women – Medicaid eligibility counts an unborn child in family size, while APTC/CSR eligibility does not.

Sections 36B and 5000A requirements may be waived through Section 1332 authority. Medicaid income methodologies may be changed through Section 1115 authority. Aligning income methodologies may help reduce administrative costs caused by the so-called “churn” of individuals moving between types of coverage. For example, Medicaid provides coverage to a pregnant woman through 60 days postpartum, after which she will lose Medicaid coverage (in most states, Medicaid provides eligibility for pregnant women at higher income levels than adults). The infant, however, is automatically eligible for Medicaid for one year.

Fixing the Family Glitch is an intermediate-level reform that would fix a part of the ACA that touches on several different facets of the law. It would also change the ACA instead of returning to a previous form of insurance as some of the targeted reforms.

Comprehensive Reform

States should be allowed to use a combination of a Section 1332 waiver and a Section 1115 Demonstration Project to pursue broad, free-market reform initiatives—comprehensive reform. Comprehensive reforms would seek to change multiple health programs at the same time. Ohio, for example, called for comprehensive reform measures in its 2015 budget for fiscal years 2016 and 2017.⁶⁶

In a state that has expanded Medicaid, a person at 138 FPL relies on Medicaid while a person at 139 percent FPL typically purchases private insurance through the ACA’s exchange. The difference in income between these two people may be just \$10 per month, but their obligations and participation in the health insurance system differ significantly. A state might use a combination of a Section 1332 waiver and a Section 1115 Demonstration Project to combine those eligible for a tax credit subsidy and those eligible for Medicaid and CHIP into a larger risk pool. Companies

could then compete to cover this combined pool that is larger, younger, and healthier than the pool typically found in the exchanges. This type of reform would move many people from government coverage to private coverage.

To encourage greater competition among insurance carriers, the Section 1332 waiver could:

- Eliminate metal tiers;
- Eliminate exclusivity of using a marketplace;
- Use any and all of the benchmarks available through Medicaid and CHIP; and
- Merge the individual market with the small-group market.

A state might also submit a Section 1115 Demonstration Project to make Medicaid work more like private insurance. Some states have taken this approach already. Arkansas and Indiana, for example, have applied some private sector insurance approaches to some Medicaid enrollees. Kentucky has recently released a new Section 1115 Demonstration Project proposal, “Helping to Engage and Achieve Long Term Health (HEALTH).”⁶⁷ Kentucky HEALTH proposes to “empower individuals to improve their health and gain employer sponsored coverage or other commercial health insurance coverage....”⁶⁸

Broad-brush Medicaid reforms could promote the concept that Medicaid coverage is a type of insurance in which individuals must take more proactive roles. To introduce elements of insurance into Medicaid, a state could use a Section 1115 Demonstration to:

- Narrow the differences in benefits and cost sharing between Medicaid and CHIP and what is available in private coverage (see CMS chart on comparability of pediatric coverage at Appendix C).⁶⁹
- Begin coverage on the first day of the month after the individual has picked a health plan and, when applicable, has paid the premium. Under current practices, a substantial percentage of Medicaid enrollees are “auto enrolled” into available plans. This does not prepare them to exercise their role in shopping among plans. Kentucky has proposed such an approach, beginning premiums even for individuals below the poverty line starting at \$1 to create a sense of personal responsibility and educate individuals about how insurance works.
- Waive retroactive eligibility – Medicaid eligibility can be established 90 days prior to application. Private insurance typically begins the month following application.
- Vary premiums by length of stay on Medicaid. Premiums would start as nominal but increase over time.
- Increase use of ESI by waiving Section 1906 provisions that make the use of premium support difficult.

- EPSDT benefits for children could be preserved either through each individual health plan or through a separate contract with the state.

Comprehensive reform plans could lower the cost of private health care plans. Although the ACA gave a legal definition of “affordable,” in reality, individuals decide what is “affordable” for themselves and how much financial risk they are willing to take. The lower-than-expected take-up rates, for example, demonstrate that millions of Americans have declined to purchase coverage even with the subsidies provided by the ACA.

As stated earlier, CBO had projected there would be 10 million more people covered in exchanges in 2016 than has turned out to be the case. Lower enrollment of young healthy individuals has undoubtedly been a factor in insurance carriers requesting substantially higher rates for 2017. Some carriers will stop offering coverage altogether, citing their losses and the instability of the individual market and the lack of healthy individuals in the individual market risk pool.

Moving 68 million people into the private health insurance pool will help lower premiums and stabilize the private health insurance market. Savings from changing Medicaid policies are imperative for a state to be able to meet the deficit-neutrality requirement. Moreover, requiring states to demonstrate budget neutrality within Medicaid and deficit neutrality in State Innovation Waivers introduces greater complexity than the statute requires. Combining a Section 1332 waiver with a Section 1115 Demonstration Project could help market forces truly lower the cost of health care and insurance.

Conclusion

Federal and state policymakers now have six years of ACA history to consider as they work to craft new health reform measures. Coverage under the ACA did not turn out as expected or projected by CBO. Few analysts foresaw the dramatic rise in Medicaid enrollment under the ACA.

Fortunately, the ACA explicitly grants the states broad authority to modify certain ACA requirements inasmuch as Section 1332 provides that “[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).” But for states to take full advantage of this authority, and for the necessary changes to occur more quickly than in previous cases, there must be a clear commitment from federal authorities that sensible, responsible waivers will be granted.

Recommendations

This paper recommends improving the statutory and regulatory environment so that power will be restored to the states to pursue the reforms that are right for them. Our recommendations include:

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. 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 lives 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 cannot be a wall between Innovation Waivers and Medicaid waivers that prevents savings in one area to apply 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. 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 plans options under the CHIP and the Deficit Reduction Act of 2005 for all children and adults who covered by Medicaid, CHIP, or tax subsidies.
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. Concerns that increased flexibility on coverage requirement would lead to inadequate coverage are unfounded based on HHS review of the CHIP program.
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 federal administration should reflect the fact that state governors have and can continue to achieve better outcomes for their citizens than is possible from a one-size-fits-all rule drafted in Washington, D.C.

About the Authors



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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.

Appendix A: Sample of Medicaid Waivers⁷⁰

Here are some of the Medicaid requirements that are currently waived as contained in a sample of Section 1115 Demonstrations (this list is not exhaustive and references that would identify an individual state have been removed):

Amount, Duration, Scope of Services	Section 1902(a)(10)(B)
	42 CFR 440.240 and 440.230

to enable the state to offer different or additional services to some categorically eligible individuals, than to other individuals, based on differing care arrangements in the Spouses as Paid Caregivers Program.

to permit the state to offer coverage through managed care organizations (MCOs) and PIHPs that provide additional or different benefits to enrollees, than those otherwise available to other eligible individuals.

Comparability	Section 1902(a)(10)(B)
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to enable the state to impose targeted cost sharing on individuals in a specified eligibility group.

Cost Effectiveness	Section 1902(a)(4)
	42 CFR 435.1015(a)(4)

to permit the state to offer premium assistance and cost-sharing reductions that are determined to be cost effective using state-developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

Cost sharing for Non-emergency Use of the Emergency Department	Section 1969(f)
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to enable the state to require a graduated co-payment up to \$25 for all demonstration populations, for non-emergency use of the emergency department.

Freedom of Choice	Section 1902(a)(23)(A)
	42 CFR 431.51

to enable the state to restrict the freedom of choice of providers through mandatory enrollment of eligible individuals in managed care organizations.

Methods of Administration

**Section 1902(a)(4)
insofar as it incorporates 42 CFR 431.53**

to relieve the state of the requirement to assure transportation to and from medical providers for demonstration populations.

Payment to Providers

Section 1902(1)(13) and Section 1902(a)(30)

to the extent necessary to permit the state to provide payment to providers that is not more than the rates paid by an employer-sponsored insurance plan providing primary coverage for services such that payment by the ESI plan (plus any payment from the individual's account and remaining cost sharing due from the individual under the ESI plan from the beneficiary) serves as payment in full and the state has no further payment obligation to the provider.

Premiums

Section 1902(a)(14) and Section 1916

to enable the state to charge premiums at levels not more than 2 percent of household income.

Reasonable Promptness

Section 1902(a)(8)

to the extent necessary to enable the state to start enrollment on the first day of the month in which an individual makes their initial contribution.

Retroactive Eligibility

**Section 1902(a)(34)
42 CFR 435.914**

to enable the state to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made.

Statewideness/Uniformity

Section 1902(a)(1)

to enable the state to provide benefits through contracts with managed care entities that operate only in certain geographical areas of the state.

Waivers from these policy provisions of Title XIX have already been granted and are present in active Section 1115 Demonstration Projects. The ACA provides that the secretary shall permit states to file a single application. It is undisputed that a state must describe which provisions of Title XIX it seeks to waive. At issue is whether states can use the authority that has already been granted.

Appendix B: Medicaid Mandatory and Optional Services⁷¹

“States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. ... States must cover certain ‘mandatory benefits,’ and can choose to provide other ‘optional benefits’ through the Medicaid program.”

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Benefits

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services-1915(i)
- Self-Directed Personal Assistance Services-1915(j)
- Community First Choice Option-1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary*
- Health Homes for Enrollees with Chronic Conditions – Section 1945

Appendix C: Comparison of CHIP Coverage to Second Lowest Silver Qualified Health Plans⁷²

(Excerpts from November 25, 2015 Certification of Pediatric Coverage Offered by Qualified Health Plans)

Marketplace Coverage and Cost Sharing

“Marketplace coverage provides financial assistance to eligible individuals and families purchasing private insurance products to reduce out-of-pocket spending, such as premiums, co-pays, and deductibles. In addition, total out-of-pocket expenditures in QHPs are limited to \$6,600 for an individual plan and \$13,200 for a family plan in 2015. QHPs use actuarial value to reflect plan generosity as related to the amount the consumer could be expected to pay in deductibles, co-insurance, and copayments. AV is commonly used as a measure of the percentage of expected health care costs for covered services that a health plan will pay.”

Comparison of Cost Sharing and Benefits

“HHS reviewed the second-lowest-cost silver plan (SLCSP) in the largest rating area in each state to compare it to CHIP in that state and determined that CHIP and Marketplace coverage offer beneficiaries different levels of financial protection and benefits, reflecting the programs’ different purposes and structure as established in statute. The review found that the average out-of-pocket spending in the SLCSP was higher than out-of-pocket spending in CHIP for CHIP-eligible children in all states reviewed, on a per-child basis under CHIP and under SLCSP with financial assistance. In addition, the AV of CHIP exceeds the AV of the SLCSP in every state reviewed except Utah, where the CHIP and SLCSP AVs are equivalent. This finding indicates that families are expected to pay for a larger percentage of expected covered health care costs in QHPs than CHIP in all but that state. When premiums are taken into account, Utah’s average out-of-pocket spending in the SLCSP was higher than out-of-pocket spending in CHIP.

“HHS also reviewed benefit comparisons and determined that benefit packages in CHIP are generally more comprehensive for ‘child-specific’ services (such as dental, vision, and habilitation services) and for children with special health care needs as compared to those offered by QHPs. CHIP coverage of ‘core’ benefits (such as physician services, laboratory, and radiological services) is similar between CHIP and QHPs.”

Comparing CHIP and SLSCP in 36 States⁷³

State	CHIP offers EPSDT benefits	Plan AV ⁷⁴		Average Premium + Cost ⁷⁵	
		SLCSP	CHIP	SLCSP	CHIP
Alabama		0.62	0.94	\$1,455	\$175
Arkansas		0.78	0.94	\$896	\$ 65
Colorado		0.65	0.95	\$1,178	\$68
Connecticut		0.71	0.96	\$1,756	\$154
Delaware		0.84	1.00	\$805	\$129
Florida (ages 0-1)	X ⁻⁷⁶	0.92	1.00	\$787	\$-
Florida (ages 1-5)		0.79	1.00	\$781	\$116
Florida (ages 6-18)		0.76	0.98	\$871	\$140
Georgia (ages 0-5)	X ⁻⁷⁷	0.59	1.00	\$1,133	\$-
Georgia (ages 6-18)	X ⁻⁷⁸	0.60	1.00	\$1,170	\$221
Idaho	X	0.85	0.99	\$647	\$163
Illinois	X	0.70	0.97	\$1,252	\$314
Indiana		0.72	0.98	\$1,102	\$225
Iowa		0.72	1.00	\$1,292	\$151
Kansas	X	0.71	1.00	\$1,009	\$152
Kansas		0.76	1.00	\$956	\$152
Kentucky		0.66	0.98	\$1,037	\$23
Louisiana	X	0.59	1.00	\$1,597	\$322
Maine	X	0.83	1.00	\$824	\$115
Massachusetts		0.77	1.00	\$1,422	\$225
Michigan		0.84	1.00	\$756	\$46
Mississippi		0.83	1.00	\$848	\$-
Missouri	X ⁻⁷⁹	0.62	1.00	\$1,492	\$829
Montana		0.70	1.00	\$1,111	\$5
Nevada	X ⁻⁸⁰	0.82	1.00	\$765	\$91
New Jersey	X/ ⁻⁸¹	0.73	0.98	\$1,557	\$321
New York		0.74	1.00	\$1,396	\$326
North Carolina		0.81	0.99	\$802	\$43
North Dakota		0.87	0.99	\$638	\$8
Oregon	X/ ⁻⁸²	0.52	1.00	\$1,598	\$-
Pennsylvania		0.59	0.99	\$1,869	\$646
South Dakota	X	0.68	1.00	\$1,202	\$-
Tennessee		0.67	0.94	\$1,103	\$64
Texas		0.76	0.91	\$814	\$75
Utah		0.83	0.83	\$750	\$247
Virginia		0.88	0.98	\$754	\$21
Washington	X	0.48	1.00	\$1,969	\$252
West Virginia	X ⁻⁸³	0.67	0.96	\$1,441	\$245
Wisconsin	X/ ⁻⁸⁴	0.67	0.97	\$1,409	\$146
Wyoming		0.81	0.97	\$830	\$32

Appendix D: U.S. Department of Health and Human Services 2016 Poverty Guidelines⁸⁵

Table A

2016 Federal Poverty Level—Annual								
Family Size	100%	133%	138%	139%	200%	250%	300%	400%
1	\$11,880	\$15,800	\$16,394	\$16,513	\$23,760	\$29,700	\$35,640	\$47,520
2	\$16,020	\$21,307	\$22,108	\$22,268	\$32,040	\$40,050	\$48,060	\$64,080
3	\$20,160	\$26,813	\$27,821	\$28,022	\$40,320	\$50,400	\$60,480	\$80,640
4	\$24,300	\$32,319	\$33,534	\$33,777	\$48,600	\$60,750	\$72,900	\$97,200
5	\$28,440	\$37,825	\$39,247	\$39,532	\$56,880	\$71,100	\$85,320	\$113,760
6	\$32,580	\$43,331	\$44,960	\$45,286	\$65,160	\$81,450	\$97,740	\$130,320
7	\$36,730	\$48,851	\$50,687	\$51,055	\$73,460	\$91,825	\$110,190	\$146,920
8	\$40,890	\$54,384	\$56,428	\$56,837	\$81,780	\$102,225	\$122,670	\$163,560

Table B

2016 Federal Poverty Level—Monthly								
Family Size	100%	133%	138%	139%	200%	250%	300%	400%
1	\$990	\$ 1,317	\$1,366	\$ 1,376	\$1,980	\$2,475	\$2,970	\$3,960
2	\$1,335	\$1,776	\$1,842	\$1,856	\$2,670	\$3,338	\$4,005	\$5,340
3	\$1,680	\$2,234	\$2,318	\$2,335	\$3,360	\$4,200	\$5,040	\$6,720
4	\$2,025	\$2,693	\$2,795	\$2,815	\$4,050	\$5,063	\$6,075	\$8,100
5	\$2,370	\$3,152	\$3,270	\$3,294	\$4,740	\$5,925	\$7,110	\$9,480
6	\$2,715	\$3,611	\$3,747	\$3,774	\$5,430	\$6,788	\$8,145	\$10,860
7	\$3,061	\$4,071	\$4,224	\$4,255	\$6,122	\$7,652	\$9,183	\$12,243
8	\$3,408	\$4,532	\$4,702	\$4,736	\$6,815	\$8,519	\$10,223	\$13,630

Table C

2016 Monthly Contribution for QHP Coverage by Federal Poverty Level							
Family Size	100%	133%	150%	200%	250%	300%	400%
	2.03%	2.03%	4.07%	6.41%	8.18%	9.66%	9.66%
1	\$20.10	\$26.73	\$55.60	\$126.92	\$202.46	\$286.90	\$382.54
2	\$27.10	\$36.04	\$74.98	\$171.15	\$273.01	\$386.88	\$515.84
3	\$34.10	\$45.36	\$94.36	\$215.38	\$343.56	\$486.86	\$649.15

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75. Premium+Cost Sharing OOP dollars represent total amounts, per child, paid for by the family. In order to correctly determine the premium paid, premiums were estimated for all family members. An adjustment factor derived from this comparison was then applied to the child only premiums within the family. That is, if a subsidy calculation resulted in only 75% of the theoretical premium for the family being paid by the family (with a 25% subsidy), and then this 75%/25% split was applied to the child-only premium.
76. EPSDT provided only for children in Florida's Medi-Kids program (kids ages 1-4) or CMSN (children ages 0-19 with special healthcare needs).
77. State provides all EPSDT benefits except non-emergency transportation.
78. State provides all EPSDT benefits except non-emergency transportation.
79. State provides all EPSDT benefits except non-emergency transportation.
80. State provides all EPSDT benefits except non-emergency transportation.
81. NJ offers EPSDT only in the plan offered to lower-income children (under 200% FPL).
82. OR offers EPSDT only in the plan offered to lower-income children (under 200% FPL).
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