EXPERT VOICES

The ACA's Section 1332 Waivers:
Will We See More State Innovation in Health Care Reform?

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While the Affordable Care Act continues to be politically polarizing, my experience with stakeholders from across the health reform landscape is that they are focused on effectively implementing the law and on making incremental – not radical – changes to it. The question is how such change might happen given the deep national divisions about what corrections are needed. One answer lies in section 1332 of the ACA, which invites states to be "laboratories of democracy" in experimenting with ACA reforms that do not have enough support to pass Congress but could garner backing at a state level.

THE BOTTOM LINE

1. The ACA's Section 1332 waivers offer states an opportunity to customize health reform, starting as soon as 2017.
2. Narrow interpretation of the statute's protective guardrails has limited state action to date, but this guidance can be relaxed by the next administration, which could spark bolder state experiments.

What Could States Do?

Section 1332 authorizes states to request five-year renewable waivers from the U.S. Departments of Health and Human Services (HHS) and the Treasury to modify four pillars of the ACA, with changes beginning as early as 2017. First, states may modify the rules governing covered benefits, premium tax credits and cost-sharing subsidies. Second, they may replace or modify their ACA Marketplaces by providing health plan choice, subsidy eligibility determination, and enrollment in other ways. Finally, states may modify or even eliminate the ACA's individual and/or employer mandates.

In designing new approaches, states must satisfy four statutory "guardrails" by providing coverage that is at least as (1) comprehensive and (2) affordable to (3) at least as many residents as would have been covered without the waiver, all (4) without increasing the federal deficit. Substantive guidance on how reform proposals will be judged against these guardrails, released in late 2015, was decidedly more restrictive than some states had hoped. Among the significant limitations was the requirement to consider coverage and affordability impacts in each waiver year separately, as well as for population subgroups such as the poor, elderly and chronically ill. The guidance also bars states from using savings generated through a separate Medicaid expansion waiver to offset costs in a 1332 waiver. Finally, states wishing to use different rules for Marketplace functions or subsidies will have to make all necessary operational arrangements themselves rather than rely on HHS and the Department of the Treasury.

What Are States Doing So Far?

These limitations have largely discouraged states from proposing sweeping reforms. To date, only three states have published draft waivers, and each was narrowly drawn to resolve unique issues that put the state at odds with certain ACA provisions. The first phase of a Massachusetts proposal to maintain certain rating practices in its merged small group and individual market was approved by HHS on other grounds, obviating the need to file its 1332 waiver this year.[1] Similarly, Vermont's draft waiver to continue relying on direct enrollment through carriers rather than building a Small Business Health Options Program (SHOP) portal was rendered moot by new HHS guidance delaying the mandatory change to an online portal until 2019.[2] That leaves only Hawaii, which has formally asked to maintain its 40-year-old employer mandate rather than implement a SHOP that would offer less generous coverage and potentially decrease employer-based coverage. Hawaii's unique situation may make its waiver the only one to gain approval in 2016.

Two other states have recently passed legislation to pursue 1332 waivers. California hopes to allow undocumented immigrants to purchase Marketplace policies without subsidies,[3] and Alaska is interested in using its state-funded reinsurance program to reduce Marketplace premiums.

Looking Ahead

A new administration could take its own shot at federal reform. If that does not happen, however, or if the attempt fails, state experimentation is likely to receive renewed attention in 2017 and beyond. Indeed, the newly-adopted Democratic platform places added emphasis on supporting state innovations.

For 1332 waivers to be a game changer, the next administration would need to encourage state engagement by providing more leeway for broad innovations, starting with revisions to the 2015 guardrail guidance. Notably, that guidance was "sub-regulatory" and can easily be revised.

The many progressive and conservative "corrections" to various ACA provisions discussed since the law passed suggest a robust spectrum of possible waiver ideas. Ultimately, state innovations will depend on how the guardrails are interpreted as well as on political considerations.

Changing Benefits and Subsidies.
The ACA seeks to make coverage affordable through a combination of low premium/high cost sharing plans and a sliding scale of subsidies that minimize both premium contributions and cost sharing obligations for low-income consumers. Critics on both ends of the political spectrum question whether the law strikes the right balance. In Minnesota, for example, Democratic officials concerned that cost sharing levels are too high for low-income individuals advocate restoring MinnesotaCare, a pre-ACA program that offered low premiums and low cost sharing for enrollees with incomes up to 275 percent of the federal poverty level. Some Republican leaders, on the other hand, want the state Marketplace to offer higher deductible plans to reduce premiums for people who are young, healthy and/or ineligible for premium subsidies due to higher incomes. Both approaches address real needs, but have very different impacts.

Similarly, many states would like to smooth the continuum between Medicaid and Marketplace coverage – but drive toward that goal in quite different ways. Conservative states such as Indiana, for example, have sought to increase Medicaid cost sharing to Marketplace levels, while liberal states such as New York want to decrease Marketplace cost sharing to Medicaid levels. Waivers that increase cost sharing must be scrupulously attentive to affordability, while those seeking lower cost sharing will face the challenge of maintaining deficit neutrality. In addition, the 38 states relying on the federal Marketplace platform would face new operational challenges in adopting a customized subsidy structure.[4]

Redoing the Exchanges.
States have been weighing a wide range of alternative approaches to the ACA's exchange Marketplaces – from privatizing them to expanding their leverage. Waivers to reform the role of public exchanges must be mindful of how such changes affect access across different populations.

On the privatization side, Oregon recently rejected bids from three commercial vendors to transition from Healthcare.gov to a privatized eligibility and enrollment service.[5] Idaho offers a different model for minimizing dependence on the federal government by using Medicaid to determine eligibility for both Medicaid and Marketplace subsidies and then contracting with a commercial vendor to enroll consumers in qualified health plans.[6] Other states have discussed a bifurcated system in which consumers determined to be eligible for subsidies are given a voucher to purchase coverage from any carrier, broker or other entity authorized to sell ACA-compliant coverage. And the Council for Affordable Health Care recently proposed "Next Generation Exchanges" that would give subsidy-eligible consumers access to at least one private exchange option in every state.[7]

On the public side, Covered California is using its market leverage to drive delivery system reform by trimming poor performing providers from its Marketplace networks.[8] Although Vermont ultimately decided not to make its Marketplace the sole provider of coverage statewide, other states may take incremental steps in this direction by adding state employees or other large purchasing pools to their Marketplaces. Public exchanges could also play a key role in state efforts to build multi-payer alliances for payment reform.

Replacing the Individual Mandate.
The individual mandate is the least popular provision in the law, but experts agree that eliminating it would drive healthy people out of the insurance market, reducing coverage and increasing premiums. To avoid violating the coverage and affordability guardrails, states wanting to waive the individual mandate will need another way to keep healthy people in the insurance pool. Options include penalties for late enrollment (similar to Medicare), multiyear waiting periods if open enrollment is missed, or automatic enrollment. These approaches require customized enrollment functions and will be more challenging for states relying on Healthcare.gov.

Repealing the Employer Mandate.
In contrast, the employer mandate could be eliminated without a significant impact on the scope or cost of coverage,[9] but this step would raise the federal deficit by reducing the penalty revenue from large employers. States would need to have other features in their 1332 waiver to offset this lost revenue or cut federal costs elsewhere. One option is a "play or pay" requirement for employers to pay a flat percentage of their payroll in benefits or taxes.

Conclusion

As the dust eventually settles from the 2016 elections, both parties may find it attractive to unleash health reform at the state level. Section 1332 innovation waivers could be just the ticket, and relaxed guardrail guidance could encourage some states to take up bolder reforms. However, it is also possible that most states will opt to continue the status quo or pursue only narrow changes, if only because the ACA's success in expanding coverage is raising the political price that could be paid for disrupting health coverage.

1 https://betterhealthconnector.com/wp-content/uploads/CMS-Letter-Grants-MA-Merged-Market-Flexibility-052016.pdf

2 https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/1332-and-SHOP-Guidance-508-FINAL.PDF

3 White JB, "Gov. Jerry Brown Agrees to Seek Health Insurance for Undocumented Immigrants." *The Sacramento Bee*, June 10, 2016.

4 Manatt Health Solutions, "1332 State Innovation Waivers: Getting off the Ground." July 2015.

5 Gray C. "Oregon Will Stick with Healthcare.gov Despite New Charges for Website Use." *The Lund Report*, May 25, 2016.

6 Leavitt Partners. "The Your Health Idaho Marketplace: A Model for State Based Adoption." September 24, 2015. http://leavittpartners.com/category/white-papers/

7 Council for Affordable Health Coverage, "Exchange Enrollment: An Opportunity for Reform." June 7, 2016.

8 "Covered California's Board Adopts Prescriptions for A Better Health Care System," http://news.coveredca.com/2016/04/covered-californias-board-adopts.html, April 7, 2016.

9 Blumberg LJ, Holahan J and Buettgens M. "Why Not Just Eliminate the Employer Mandate?" The Urban Institute, May 2014.