Health Advocate

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Section 1332 Waivers for State Innovation and Medicaid

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Key Resources

CMS Guidance on Section 1332 (December 2015)

CMS Frequently Asked Questions for Section 1332 (July 2015)

Final Regulations on Section 1332 (February 2012)

Coming in May's *Health Advocate*:

Medicaid Managed Care Regulations

Background

Section 1332 is a provision of the Affordable Care Act that, starting in 2017, allows states to request waivers of Marketplace requirements in order to implement "State Innovations" in the Marketplace. For example, a state might use an innovation waiver to expand the minimum coverage requirements for health plans. Section 1332 is conceptually similar to Medicaid's section 1115 authority, which allows states to request waivers of some Medicaid requirements to implement innovative demonstrations. In December 2015, CMS issued guidance clarifying how section 1332 can be used, including how it can interact with Medicaid. Multiple states have processes underway to evaluate or implement section 1332 projects.

Section 1332 confers broad authority on the Secretaries of Health and Human Services and Treasury to waive a wide range of provisions in the Marketplace, including requirements addressing: the "Essential Health Benefits" covered by plans; affordability standards such as premium credits and out-of- pocket limits; plan marketing and benefit design requirements; choice of providers and essential community providers; enrollment periods; individual mandate penalties; and calculation of minimal essential coverage. Note that section 1332 authority is not inherently good or bad—it might be used to strengthen or weaken requirements. (See discussion of "Guardrails" below.) The Secretaries have full discretion in deciding which section 1332 waiver requests to approve or deny.

Section 1332 is a Marketplace authority and cannot waive any Medicaid requirements. However, the Affordable Care Act allows states to submit a "coordinated" application that includes both section 1332 (Marketplace) and 1115 (Medicaid) waivers. The recent CMS guidance underscores the legal requirement that even though these applications may be reviewed in tandem for administrative simplicity, "each waiver will be evaluated independently according to applicable Federal laws." Therefore, all Medicaid requirements continue to be in full force, regardless of whether a Medicaid demonstration is filed "in coordination" with a section 1332 project.

December 2015 Guidance

The ACA sets out four basic "guardrails" for use of section 1332 authority. The December 2015 Guidance elaborates on these limits:

Guardrail 1: The section 1332 project must cover a number of people comparable to existing coverage. States cannot use section 1332 to reduce the number of individuals who receive coverage. The guidance clarifies that this test applies to each year of the project and considers the impact of coverage on all state residents, including Medicaid enrollment. (See also Partial Expansion discussion below.) The comparable coverage protection must also consider the potential for project to have a disparate impact on subpopulations or create breaks in continuity of coverage for enrollees.

Guardrail 2: The section 1332 project must not reduce affordability of coverage. States cannot use section 1332 to make coverage less affordable for enrollees. The guidance clarifies that this means a section 1332 project cannot increase out-of-pocket insurance costs for enrollees. However, an important exception is that the guidance does appear to allow a state to include expenses enrollees pay for non-covered services in that out-of-pocket cost calculation. For example, if a state wanted to use section 1332 to add vision services to the benefits package, this could be permissible; even though adding the benefit might slightly increase the premiums for insurance, thus increasing out-of-pocket costs for insurance, it might decrease the total out-of- pocket spending for consumers if you factor in what they were paying out-of-pocket to obtain vision services outside of their insurance. In other words, their insurance cost may go up $20 per year, but the new vision coverage saves them $50 per year in paying for vision services. The affordability protection also must consider disparate impacts on subpopulations.

Guardrail 3: The section 1332 project must provide benefits at least as comprehensive as existing benefits. States cannot use section 1332 to reduce the comprehensiveness of the benefits package. The guidance clarifies that this test considers the impact on benefits for all populations in the state, including Medicaid beneficiaries. This means a section 1332 project should not reduce the scope of benefits for Medicaid enrollees. (See further discussion in Partial Expansion section below.) The comprehensiveness protection also must consider disparate impacts on subpopulations.

Guardrail 4: The section 1332 project must be deficit neutral for the Federal budget. States cannot implement section 1332 projects that increase costs to the Federal government. While this is analogous to section 1115's budget neutrality test, it is a much broader standard, since section 1115 requires neutrality in the Medicaid budget, while section 1332 requires neutrality in the entire Federal budget. This means there is more flexibility in the section 1332 context to design a creative budget neutrality theory. For example, a benefit might increase Federal Marketplace subsidy expenditures by one million dollars, but achieve deficit neutrality by increasing productivity resulting in two million dollars of increased tax revenues. The guidance clarifies that the section 1332 project must be budget neutral for the duration of the approved waiver (initially up to 5 years) and the 10-year budget submitted with the application. The section 1332 project is also "less likely" to be approved if it increases costs in any particular year, making it harder for states to design projects that frontload costs and achieve savings in the later years. Federal administrative costs, such as changes that need to be implemented to make the waiver work, are factored into the calculation.

No Cross-Subsidization

Two additional standards that are confirmed in the guidance merit special attention. First, the guidance confirms that states cannot "cross-subsidize" Medicaid and the Marketplace using section 1332 authority. For example, CMS cannot approve a "coordinated" waiver that achieves overall cost-neutrality by increasing costs in the Marketplace by four million dollars while saving five million dollars in Medicaid. In other words, savings in Medicaid cannot be used to fund expenditures in the Marketplace, and vice-versa. This is an important policy to underscore, because misunderstanding of the statute by many industry stakeholders led to public messaging that this type of cross-subsidization could or should be allowed. However, CMS was entirely constrained by the statute, which requires full and independent compliance with Medicaid standards, and thus under the law CMS had no alternative other than to prohibit cost-subsidization with Medicaid. This policy is significant in that it will limit the ability of states to use section 1332 as a vehicle to merge Medicaid programs into the Marketplaces.

Note, however, this does not reduce a state's flexibility to do other things with money that flows from Marketplace innovations. For example, if a state develops a Marketplace innovation that will save the Federal government two million dollars in premium subsidies, that money is considered "pass through funding" that the state can use to fund the state's innovation. The prohibition on cross-subsidization discussed above is focused on cross-subsidizing between federally-funded Medicaid and the Marketplace.

Partial Expansion

The 2012 *NFIB* decision allows states to avoid losing Medicaid funding if they choose not to expand Medicaid. After that decision in 2012, some states were interested in implementing partial expansion. The theory was that the states would implement Medicaid expansion only up to 100% FPL (instead of 138% as required by the ACA), and thereby shift the costs of insuring the population from 100%-138% entirely on to the Federal government, which would pay the full cost of subsidizing that population in the Marketplace. However, CMS clarified in 2012 guidance that they would not approve such partial expansions "through 2016." There has been some speculation that CMS might revisit that policy in 2017 when section 1332 authority begins.

Although the CMS guidance does not directly address partial expansion, the guidance appears to narrow the possibility of partial expansion through section 1332. As discussed above, the guidance establishes a test for comparability of number of insured individuals that factors in Medicaid, and would thus prohibit a section 1332 project that reduced the number of individuals currently enrolled in Medicaid. Likewise, the affordability and comprehensiveness of coverage requirements bar reducing the affordability or benefits for a Medicaid enrollee. These policies would make it impermissible, for example, for a state to move Medicaid enrollees that are between 100-138% FPL from Medicaid expansion into the Marketplace through a section 1332 waiver. CMS's approach here is very sensible; while a partial expansion policy would have been problematic in 2012, it would be exponentially more disruptive in 2017, since over 30 states that have already expanded Medicaid would have a financial incentive to drop the coverage for populations between 100-138% FPL (and move those individuals to Marketplaces).

Odds and Ends

One of the uncertainties regarding section 1332 authority has been how it could be operationalized in federally facilitated Marketplaces (FFMs). While CMS's policy is still under development, the guidance makes clear that there will be limits on how FFM states can use section 1332 due to limitations on what the federally facilitated platform and IRS subsidy calculation systems can do at this time.

In a positive development, CMS specified in the guidance that the mandatory section 1332 notice and comment periods must be at least 30 days at both the state and federal levels, matching (at least) the 30-day standard in the section 1115 transparency process.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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