NCSL Information and Expert Analyses on Section 1332 Waivers

State-Run Health Exchanges:

prepared for the Colorado Health Insurance Exchange Oversight Committee

by Richard Cauchi, NCSL Program Director - Health Insurance, Costs and Pharmaceuticals

July 15, 2015

Table of Contents

1 – Governing Magazine – **"With Innovation Waivers, States Can Go Their Own Way on Obamacare"-** September 2014

> "There's a continuum in discussions of health care," Sanders says. "On one end, there's the drive toward a single-payer model. On the other end is a consumer-focused, individualized care system that provides more choices, more flexibility, and is transparent in terms of price and quality." – Sen. David Sanders (R-AR)

2- JAMA Forum**: Why Section 1332 Could Solve the Obamacare Impasse** by Stuart Butler, PhD – April 2015

> "… a provision of the ACA is now attracting attention as a way out of this mess. It provides not only what is essentially an exit strategy for Republican states but also, paradoxically, a way for supporters of the ACA to preserve the law. - Stuart Butler, PhD, Heritage/Brookings (Journal of the American Medical Association)

3a - Health Affairs Blog: **Section 1332 Waiver Activity Heating Up In States** – June 2015
3b –Section 1332 Waivers and The Future Of State Health Reform – December 2014

> **"…**A better name for this program might be Waivers for State Responsibility, because they don't exempt states from accomplishing the *aims* of the ACA, but give them the ability (and responsibility) to fulfill the aims in a different manner while staying between certain guardrails.

4 – Rhode Island – 1332 Waiver authorization (enacted law, June 30, 2015)

5 – Minnesota 2015-26 legislation "preparing for a Minnesota innovation waiver under section 1332 of the Affordable Care Act" Text of S 813; H1181 – pending; carryover to 2016

6 - NCSL and Interpretation of Section 1332: States must enact a law
6A- Arkansas: "Section 1332 Waivers and the Future of Arkansas Healthcare Innovation" – for the Arkansas Health Insurance Marketplace Board & Legislative Oversight Committee – April 6, 2015 [PDF] Excerpts

7 - Wyden's Waiver: State Innovation on Steroids. John E. McDonough (PDF)

Section 1332 Materials previously provided to Colorado Committee on April 29, 2015

8- "Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform- The Commonwealth Fund (Copy provided by NCSL on 4/29/2015 briefing – text at www.commonwealthfund.org/publications/issue-briefs/2015/apr/innovation-waivers-and-health-reform

9 - NCSL Presentation slides (#s 30-33)

GOVERNING
THE STATES AND LOCALITIES

Health & Human Services

With Innovation Waivers, States Can Go Their Own Way on Obamacare

States can eventually drop major portions of the health law if they plan to maintain the same level of coverage at the same cost to the federal government.

by Chris Kardish | September 2014

Arkansas state Sen. David Sanders wants to use a federal waiver to transform his state's health-care system. The Associated Press

At a time when most Republicans are more focused on dismantling the Affordable Care Act (ACA), Arkansas Republican state Sen. David Sanders is focused instead on reshaping the existing law along conservative lines. Sanders wants to use a provision under the ACA to transform the entire health-care system in Arkansas.

“There’s a continuum in discussions of health care,” Sanders says. “On one end, there’s the drive toward a single-payer model. On the other end is a consumer-focused, individualized care system that provides more choices, more flexibility, and is transparent in terms of price and quality.”

It is the latter end of the continuum that Sanders wants to build in Arkansas. He plans to use an ACA waiver that provides an unparalleled level of flexibility -- albeit within some major parameters -- to get it. Arkansas already has an existing waiver under the health reform law that has allowed it to privatize its Medicaid system. But the additional waiver, known as the section 1332 or state innovation waiver, would allow Arkansas and other states starting in 2017 to drop major portions of the law, including the individual mandate or the insurance exchange requirement, if they have a viable plan that maintains at least the same level of coverage at the same cost to the federal government. As long as states can do that, which is no small feat, they can take the federal money they would have received and use it how they see fit.

In other words, blue states, for example, could decide if they’d like to create a public option for the insurance exchanges that would otherwise be dominated by private or nonprofit players. Massachusetts could decide to use federal money to create cheaper plans for people who straddle the income line for Medicaid. States such as Maryland or Oregon could use the waiver to enhance their own efforts to better control spending and provide more coordinated care.

The waiver, which also provides for states to make changes to Medicare and the Children’s Health Insurance Program, is a “broad statutory invitation for states to consider many sorts of unprecedented changes to health-care policy within their borders,” says health policy expert John McDonough of Harvard University.

McDonough points to Vermont, where officials want to create the country’s first single-payer system. Vermont was the first state to announce its intention to seek a 1332 waiver. The annual costs of the plan, though, will be more than the estimated $275 million being offered by the feds under the ACA. It will cost about $1.8 billion a year more, McDonough says.

Arkansas' Sanders is being cagey about specific policy proposals that his plan might include, but he says he's going to submit a bill in the 2015 legislative session that would authorize state officials to pursue the waiver. If that sounds a bit premature, just consider how long it might take to craft a proposal that could meet federal muster and grant enough time to win over reluctant interest groups on the political front.

The lack of specificity from Arkansas is causing some concern. Observers want more details: Is Arkansas talking about vouchers or health savings accounts for all? "When you start to throw around words like 'consumerism,'" says Judy Solomon, vice president for health policy at the Center on Budget and Policy Priorities, "is this something that's evidence-based or are we just engaging in what I would call wishful thinking about incentives and how they really drive people to make their decisions?"

No matter what it does, Arkansas likely won't be the only conservative state looking into a 1332 waiver. "Once we get over the anti-Medicaid expansion phase of ACA implementation," says McDonough, "many Republican health folks are going to start thinking about their own versions of health system transformation, and 1332 could be an important part of the pathway."

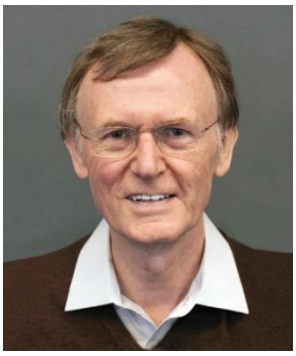
Chris Kardish | Staff Writer

---

ckardish@governing.com | @ckardish

SOURCE: http://www.governing.com/topics/health-human-services/gov-innovation-obamacare-waivers.html
Reprint by NCSL - Accessed 7/9/2015

JAMA Forum: Why Section 1332 Could Solve the Obamacare Impasse



By Stuart Butler, PhD *on* April 28, 2015

Stuart Butler is a Senior Fellow in Economic Studies at the Brookings Institution.
Until 2014 he was Director of the Center for Policy Innovation
at The Heritage Foundation, a conservative think-tank

The Affordable Care Act (ACA) continues on its painful journey. Major technical problems remain in the statute, such as the "family glitch," in which lower-income workers are offered employer coverage but their families are not and are also ineligible for exchange subsidies.

The congressional leadership wants to repeal the ACA rather than fix it, but lacks the votes to override a veto. Many Republican states have refused to implement the ACA's Medicaid expansion. And in the pending *King v Burwell* case, the US Supreme Court could strike down subsidies in federal exchanges, leading to chaotic gridlock.

But a provision of the ACA is now attracting attention as a way out of this mess. It provides not only what is essentially an exit strategy for Republican states but also, paradoxically, a way for supporters of the ACA to preserve the law.

The Opportunity for States

Section 1332 of the ACA, known as "State Innovation Waivers," allows states, starting in 2017, to apply to the federal government for 5-year renewable waivers from key provisions of the legislation. For instance, states could request changes to or exemptions from the individual and employers mandate, the market exchanges, the exchange subsidies, the Essential Health Benefits requirements, and other provisions. Moreover, states can combine waivers from ACA provisions with waivers from Medicaid provisions (so-called 1115 waivers), Medicare, the state Children's Health Insurance Program, and waivers available through "any other Federal law relating to the provision of health care items or services."

The opportunity for states to transform the ACA within their borders is breathtaking. It's little wonder that a former top aide to the late Senator Edward Kennedy describes Section 1332 as "state innovation on steroids."

Section 1332, however, is not a blank check for states to ignore the whole intent of the ACA, even assuming the White House or the next administration were open to that. It has important fine print. To obtain a waiver, a state's proposal must retain important protections, such as guaranteeing that health plans accept an applicant regardless of their health status or other factor. The proposal's coverage must be "at least as comprehensive" and cover "at least a comparable number of its residents" as the ACA, and insurance must be as affordable. Any state plan must also be budget neutral for the federal government.

Even with these limitations on state plans, section 1332 could lead to state health plans in the future that change the ACA beyond recognition. A Republican state like Arkansas, Utah, or Texas, for instance, could use the section to take the federal money for Medicaid expansion as a block grant and turn it into subsidies for families to buy private coverage. These or other states could also end the mandates on individuals and employers, perhaps using government-encouraged auto-enrollment for insurance to meet the ACA's coverage projections.

Meanwhile, states like Vermont, Oregon, and Hawaii could design waivers to create a form of single-payer health system.

Room for Maneuvering

The so-called guardrails associated with section 1332 could also be looser than they seem. For instance, since the US Supreme Court in 2012 struck down the requirement on states to expand Medicaid, the "comparable number" waiver stipulation for coverage in a nonexpansion state like Texas is much less onerous for the state. In addition, the definition of federal budget neutrality could get rather metaphysical, depending on how baseline is defined—in other words, the amount of federal spending that would occur in the future without a 1332 waiver. Again, for a state like Texas or Florida, the baseline could be calculated only on the basis of projected exchange plan subsidy costs (because these states have not expanded Medicaid). But if such states declared that in principle they want to expand coverage to the Medicaid-eligible population, albeit in another way, then the baseline could include the extra projected spending. If so, nonexpansion states could propose a budget-neutral waiver that uses billions of "new" federal dollars to construct a market-based health plan.

The political ramifications of this wide flexibility under section 1332 are immense. For instance, Republican opponents of the ACA, recognizing that the foreseeable congressional makeup means outright repeal of the ACA is not feasible even if Republicans win the White House in 2016, would have a strategy for states to exit much of the ACA. Meanwhile liberals in other states would have a tool to move closer to their dream of a single-payer system. And the White House could claim that even in the Republican states with sweeping waivers, the ACA had been fully implemented. Moreover, the 1332 waivers would allow many of the technical problems of the ACA to be fixed at the state level without going to Congress.

A Solution for *King v Burwell*

If the Supreme Court decides in favor of the plaintiff in the *King v Burwell* case, striking down subsidies in states with federal exchanges, the ruling could also trigger a critical role for section 1332. Because 1332 does not even require exchanges and permits states to use the money for federal subsidies in quite different ways, it could be possible for states with federal exchanges today to finesse a *King* decision by using 1332. Republican states currently with federal exchanges could use the money for subsidies to empower residents to buy coverage in other ways. Democratic supporters of the ACA could redesign their exchanges or move in a different direction without needing to pursue legislation from Congress.

The wrinkle in this scenario right now is that section 1332 does not go into effect until 2017. But if the *King v Burwell* ruling results in millions of Americans losing affordable coverage, it would be the kind of crisis that produces a political deal in Congress. In return for agreeing to change the law to permit exchange subsides to continue at least temporarily in federal exchanges, Congress could insist on making 1332 take effect immediately and allow states to develop plans for waivers before a subsidy extension ends. It would be in the White House's interest to agree to that. Republicans would avoid a potential backlash from physicians, hospitals, and newly uninsured constituents and allow many states effectively to take an exit ramp from the ACA.

The Republican Congress might also be able to force the White House to agree to changes in 1332 to make the Administration less able to block waivers, making the procedure less politically risky for Republicans. One way to do that would be to make certain types of waivers subject to automatic approval unless the Administration can show technical flaws. Another, as I proposed some years ago, would be for states to apply for fast-track congressional approval of waivers cleared by a federal-state commission.

With all these possibilities, it is little wonder that there's growing interest in section 1332.

Source: http://newsatjama.jama.com/2015/04/28/jama-forum-why-section-1332-could-solve-the-obamacare-impasse/
Reprint by NCSL – accessed 7/6/2015

Health Affairs Blog

Following the ACA
Associated Topics: Costs and Spending, Insurance and Coverage

Section 1332 Waiver Activity Heating Up In States

Heather Howard and Galen Benshoof

June 24, 2015

Editor's note: *This post describes recent state activity regarding ACA Section 1332 State Innovation Waivers. It updates a December 5, 2014* Health Affairs *Blog post by the authors.*

This week, the health policy world is focused on the pending Supreme Court decision in *King v. Burwell* and potential state reactions to a ruling for the plaintiffs. A few states are actively planning strategies for maintaining subsidies for their residents in the event of an adverse ruling, but for most, the process is rife with challenges both political and operational. Though *King* looms, don't lose sight of other recent state action on the Affordable Care Act (ACA) front.

In particular, interest in Section 1332 waivers continues to heat up. As we've previously written, 1332 waivers offer states an opportunity to fashion a new coverage system customized for local context and preferences, while still fulfilling the aims of the ACA. The statute requires interested states to pass authorizing legislation as a first step, in order to apply for and ultimately implement waiver-based reforms.

Here is recent movement on 1332s:

- Last week, the **Rhode Island** legislature adopted a budget that included authorization for the state to pursue a Section 1332 waiver.
- The **California** Senate passed SB4 authorizing the state to apply for a 1332 waiver in order to allow undocumented immigrants to purchase private coverage on the exchange.
- **Hawaii** approved legislation last month to "[narrow] the scope of work of the State Innovation Waiver Task Force to facilitate the development of an Affordable Care Act waiver in a timely manner."
- **Minnesota** passed legislation instructing the newly-created Task Force on Health Care Financing to consider opportunities under Section 1332.
- In **New Mexico,** the legislature considered the creation of an Innovation Waiver Working Group. The state's Office of the Superintendent of Insurance established a temporary task force to examine the issue.
- The Governor of **Arkansas** has signaled that the future of the state's innovative "private option" Medicaid expansion depends on a 1332 waiver. In April, 1332-related legislation was recommended for study in the Senate Insurance and Commerce and the Arkansas Health Reform Legislative Task Force committees.

Virtually all of this activity took place within the last few months, and we anticipate more state signals no matter how the Court rules in *King.* State officials across the ideological spectrum see significant

potential for 1332 waivers, though they have a lot of work to do in order to obtain a waiver and launch reforms on January 1, 2017, the earliest possible effective date.

Section 1332 Waivers and The Future Of State Health Reform

Heather Howard and Galen Benshoof

December 5, 2014

Editor's note: *This post is part of a series of several posts stemming from presentations given at "The Law of Medicare and Medicaid at Fifty," a conference held at Yale Law School on November 6 and 7.*

The Affordable Care Act (ACA) turbocharges state innovation through a number of provisions, such as the creation of the Center for Medicare & Medicaid Innovation, funding for states to establish customized insurance exchanges, and Medicaid reforms such as health homes and projects geared toward the dual eligible population. Yet another component of the law holds even more potential for broad reform. Buried in Section 1332 of the law is a sparkplug for innovation called the State Innovation Waivers program.

Also known as 2017 waivers or Wyden waivers, 1332s offer wide latitude to states for transforming their health insurance and health care delivery systems. According to the statute, states can request that the federal government waive basically every major coverage component of the ACA, including exchanges, benefit packages, and the individual and employer mandates. But the cornerstone of 1332 waivers is the financing. To fund their reforms, states can receive the aggregate amount of subsidies—including premium tax credits, cost-sharing reductions, and small business tax credits—that would have otherwise gone to the state's residents. Depending on the size of the state, the annual payment from the federal government for alternate coverage reform could reach into the hundreds of millions or even billions of dollars.

A better name for this program might be Waivers for State Responsibility, because they don't exempt states from accomplishing the *aims* of the ACA, but give them the ability (and responsibility) to fulfill the aims in a different manner while staying between certain guardrails. State reforms must ensure "affordability," cover a "comparable" number of people as statutory ACA implementation would have, and not increase the federal deficit.

Little Federal Guidance But Significant Interest And Potential Interest From States

So far, the Health and Human Services and Treasury Departments have issued general guidance on the application process, but little on the substance of 1332s (see Tim Jost's *Health Affairs* Blog post for more). How HHS and Treasury define affordability and comparability, and which computational models they use to assess budget neutrality, will shape how states can use these waivers.

Nevertheless, Vermont has already signaled its intention to apply for a 1332 waiver to implement a single-payer system within the state. In Hawaii, the legislature created a task force to explore how the state could better provide individual insurance coverage through a 1332 waiver, with fruitful discussions already underway. Minnesota has also expressed interest in a waiver to build on the state's Basic Health Plan to smooth out the coverage continuum for low-income residents and support the state's broader delivery system reforms. Some states may seek a waiver to fix problems with the ACA such as the family glitch.

1332 waivers may also appeal to states with alternate Medicaid expansions, such as Arkansas and Iowa. So far, these so-called private option expansions, which enroll Medicaid-eligible individuals into private coverage, operate through Section 1115 waivers, which predate the ACA. But states may find the budget neutrality requirements of 1115 waivers to be overly restrictive. The ACA calls for a streamlining of the waiver process, whereby states can ask for 1115 and 1332 waivers in one application. As John McDonough wrote earlier this year, this combined waiver process could give states much more flexibility. For example, an 1115 waiver proposal that would not be independently budget-neutral could become acceptable in conjunction with a

related 1332 waiver proposal. States will have greater ability to craft applications that meet the needs of their intended reforms.

The Potential Chilling Effect of King v. Burwell On 1332 Waivers
(Section removed as no longer applicable)

The Pressures of The Calendar

In the past, President Obama expressed support for legislation moving up 1332 waivers, which the statute authorizes to take effect January 1, 2017, to give states more time to innovate. That timing hasn't been changed, but 1332 waivers still give the administration the opportunity to engage more states in reforms during the president's final years in office, in spite of a hostile Congress. Anticipated regulations from HHS and Treasury will signal the extent of state flexibility.

Before 2017, states will need to build in sufficient time for legislative and stakeholder engagement, as well as negotiations with the federal government over the contours of a waiver proposal. The handful of states with biennial sessions have even less time, as their legislatures would need to pass authorization next year, in 2015. For innovative state-level reform, the clock is ticking.

Source: http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/

Heather Howard is director of two Robert Wood Johnson Foundation-funded programs: the State Health Reform Assistance Network provides technical assistance to states implementing the Affordable Care Act and the State Health and Value Strategies program supports state efforts to enhance the value of health care by improving population health and reforming the delivery of health care services. She is also a lecturer in public affairs at Princeton's Woodrow Wilson School (WWS) and a faculty affiliate at the Center for Health and Wellbeing. She most recently served as the commissioner of New Jersey's Department of Health and Senior Services, a cabinet level agency with a budget of approximately $3.5 billion.

Reprint by NCSL; accessed 7/2015

RHODE ISLAND
H 5900, Signed into law June 30, 2015
Art18
RELATING TO HEALTH REFORM ASSESSMENT AND HEALTH BENEFIT EXCHANGE

[excerpt of text]

. . . . .

42-157-5. Regional purchasing, efficiencies, and innovation. -- To take advantage of economies of scale and to lower costs, the exchange is hereby authorized to pursue opportunities to jointly negotiate, procure or otherwise purchase exchange services with or partner with another state or multiple states and to pursue a Federal Affordable Care Act 1332 Waiver.

42-157-6. Audit. -- (a) Annually, the exchange shall cause to have a financial and/or performance audit of its functions and operations performed in compliance with the generally accepted governmental auditing standards and conducted by the state bureau of audits or a certified public accounting firm qualified in performance audits.

(b) If the audit is not directly performed by the state bureau of audits, the selection of the auditor and the scope of the audit shall be subject to the approval of the state bureau of audits.

(c) The results of the audit shall be made public upon completion, posted on the department's website and otherwise made available for public inspection.

42-157-7. Exchange advisory board. -- The exchange shall maintain an advisory board which shall be appointed by the director. The director shall consider the expertise of the members of the board and make appointments so that the board's composition reflects a range and diversity of skills, backgrounds and stakeholder perspectives.

42-157-8. Reporting. -- HealthSource RI shall provide a monthly report to the chairpersons of the house finance committee and the senate finance committee by the fifteenth day of each month beginning in July 2015. The report shall include, but not be limited to, the following information: actual enrollment data by market and insurer, total new and renewed customers, number of paid customers, actual average premium costs by market and insurer, number of enrollees receiving financial assistance as defined in the Federal Act, as well as the number of inbound calls and the number of walk-ins received. The data on inbound calls shall be segregated by type of call.

Source: RI Legislative site:
http://webserver.rilin.state.ri.us/billtext15/housetext15/article-018-sub-a-as-amended.htm

2015 MN S 813	**Author:** Marty **Version:** Amended **Version Date:** 03/16/2015 *Pending; Carried over to 2016*

SF 813

1st Engrossment - 89th Legislature (2015 - 2016) Posted on 03/17/2015

A bill for an act relating to health; preparing for a Minnesota innovation waiver under section 1332 of the Affordable Care Act; developing a health care system that best serves Minnesotans; requiring a cost analysis; appropriating money.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. SECTION 1332 WAIVER COST AND BENEFIT ANALYSIS.

Subdivision 1. Contract for analysis of proposals.

In preparation for a section 1332 waiver request, the commissioner of management and budget shall contract with the University of Minnesota School of Public Health and the Carlson School of Management, to conduct an analysis of the costs and benefits of up to three specific proposals that seek to create a better health care system which would increase access, affordability, and quality of care in comparison to the current system.

Subd. 2. Plans.

After consulting with interested legislators, the commissioner of health shall submit to the University of Minnesota the following proposals:

(1) a free-market insurance-based competition approach;

(2) a universal health care plan designed to meet the following principles:

(i) ensure all Minnesotans receive quality health care;

(ii) cover all necessary care, including all coverage currently required by law, complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;

(iii) allow patients to choose their own providers; and

(iv) use premiums based on ability to pay; and

(3) a third alternative may be submitted by the commissioner that offers a different approach.

Subd. 3. Proposal analysis.

(a) The analysis of each proposal must measure the impact on total public and private health care spending in Minnesota that would result from each proposal. "Total public and private health care spending" means spending on all medical care, including dental care, prescription drugs, medical equipment and supplies, complete mental health services,

chemical dependency treatment, long-term care, and home care services as well as all of the costs for administering, delivering, and paying for the care. The analysis of total health care spending shall include whether there are savings or additional costs compared to the existing system due to:

(1) increased or reduced insurance, billing, underwriting, marketing, and other administrative functions;

(2) timely and appropriate use of medical care;

(3) market-driven or negotiated prices on medical services and products, including pharmaceuticals;

(4) shortages or excess capacity of medical facilities and equipment;

(5) increased or decreased utilization, better health outcomes, increased wellness due to prevention, early intervention, and health-promoting activities;

(6) payment reforms;

(7) coordination of care; and

(8) non-health care impacts on state and local expenditures such as reduced out-of-home placement or crime costs due to mental health or chemical dependency coverage.

(b) The analysis must also estimate for each proposal job losses or gains in health care and elsewhere in the economy due to implementation of the reforms.

(c) The analysts shall work with the authors of each proposal to gain understanding or clarification of the specifics of each proposal. The analysis shall assume that the provisions in each proposal are not preempted by federal law or that the federal government gives a waiver to the preemption.

(d) The proposals must be submitted to the University of Minnesota analysts within 30 days after final enactment of this legislation. The analysis shall be completed by August 1, 2016.

Sec. 2. APPROPRIATION.

$..... is appropriated in fiscal year 2015 from the general fund to the commissioner of management and budget to contract with the University of Minnesota to conduct an economic analysis of costs and benefits of section 1332 waiver health care system proposals specified in section 1.

Sec. 3. EFFECTIVE DATE.

Sections 1 and 2 are effective the day following final enactment.

Source:
https://www.revisor.mn.gov/bills/text.php?number=SF813&version=1&session=ls89&session_year=2015&session_number=0&su=0

NCSL and Interpretation of Section 1332

States must enact a law

From the state legislative perspective, Section 1332 provides an important, first time opportunity to define and set broad ACA-related policy. Because the federal statute requires the filing of state legislation:

> (a)(1)**(B)(i) "a comprehensive description of the State legislation and program to implement a plan..."**

A separate subsection specifies a new state law, or an existing law that is inclusive of all major provision in a new state waiver application.

> **(2)(D)(b) GRANTING OF WAIVERS**
>
> > **(2) REQUIREMENT TO ENACT A LAW ---**
> >
> > **(a) IN GENERAL --- A law described in this paragraph is a State law that provides for State actions under a Waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).**

See accompanying PCG Appendix E from Arkansas for section-by-section analysis

--Richard Cauchi, NCSL – compiled 7/14/2015

Appendix E

Interpretation of Section 1332

Text and PCG Comments: Affordable Care Act Section 1332

(a) APPLICATION.—
(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—
(A) be filed at such time and in such manner as the Secretary may require;
(B) contain such information as the Secretary may require, including—
(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and (ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and (C) provide an assurance that the State has enacted the law described in subsection (b)(2).

State Legislation & Law is Required

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:
(A) Part I of subtitle D.
(B) Part II of subtitle D.
(C) Section 1402.
(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

PCG Comment: This means that the state can obtain waivers on the ACA requirements starting in 2017 related to the legal definition of Qualified Health Plans (QHPs), Essential Health Benefits (EHBs), Advance Premium Tax Credits (APTCs), Cost Sharing Reductions (CSRs), the individual mandate, employer responsibility payments, and the functions of an Exchange. HHS will not review the application unless the state has enacted a law authorizing its alternative program (see also (b)(2) as noted in comment #6 below).

(3) PASS THROUGH OF FUNDING.—With respect to a State Waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such Waiver, shall be paid to the State for purposes of implementing the State plan under the Waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

Funding to State

PCG Comment: This means that the state can, under a section 1332 Waiver, be federally funded up to the aggregate amount of dollars that otherwise (without the waiver) would have been paid out for the state as Advance Premium Tax Credits, Cost Sharing Reductions (CSRs), and small business tax credits. The pass through amount will be calculated annually by HHS, not the state.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—
(A) IN GENERAL.—An application for a Waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).
(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate gate regulations relating to Waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input; (ii) a process for the submission of an application that ensures the disclosure of—
(I) the provisions of law that the State involved seeks to waive; and
(II) the specific plans of the State to ensure that the Waiver will be in compliance with subsection (b);
(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

PCG Comment: The 2/27/12 HHS regulations address the procedural issues enumerated above; they do not impose any substantive restrictions or conditions on HHS granting of waivers beyond those stated in Section 1332. There is nothing in Section 1332 or the regulations that limits waivers to states that have state-based exchanges, or any exchange at all, if the state proposes a plausible alternative approach to providing coverage under the waiver and can demonstrate to HHS that all conditions are met.

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the Waiver; and (v) a process for the periodic evaluation by the Secretary of the program under the Waiver.
(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for Waivers under this section.
(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 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 of such provisions.

PCG Comment: The 2/27/12 HHS regulations say that HHS will coordinate with IRS regarding any Section 1332 Waiver applications that involve IRS; the state need not separately apply to IRS or deal with separate requests for additional information from IRS.

(6) DEFINITION.—In this section, the term ''Secretary'' means—
(A) the Secretary of Health and Human Services with respect to Waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and
(B) the Secretary of the Treasury with respect to Waivers relating to the provisions described in paragraph (2)(D).
(b) GRANTING OF WAIVERS.—
(1) IN GENERAL.—The Secretary may grant a request for a Waiver under subsection (a)(1) only if the Secretary determines that the State plan—
(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;
(B) will provide 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;
(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and
(D) will not increase the Federal deficit.

PCG Comment: The state must demonstrate to HHS, to HHS's satisfaction, that the coverage that will be provided under the waiver is at least as comprehensive as that offered under the ACA; as affordable; covers at least as many persons; and will not increase the Federal deficit. All of the conditions must be demonstrated to be met, in HHS's view, in advance.

State Law Requirement

(2) REQUIREMENT TO ENACT A LAW.—
(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a Waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

PCG Comment: As noted previously, the state law must be enacted in advance, before HHS will consider any waivers.

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the Waiver with respect to the State.
(c) SCOPE OF WAIVER.—
(1) IN GENERAL.—The Secretary shall determine the scope of a Waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).
(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.
(d) DETERMINATIONS BY SECRETARY.—
(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.
(2) EFFECT OF DETERMINATION.—
(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a Waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such Waiver.
(B) DENIAL OF WAIVER.—If the Secretary determines a Waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.
(e) TERM OF WAIVER.—No Waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such Waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

PCG Comment: These provisions all relate to the scope and duration of the waiver, as well as state options to terminate the waiver.

Section 1332 Waivers and the Future of Arkansas Healthcare Innovation

Prepared for the Arkansas Health Insurance Marketplace Board and Legislative Oversight Committee

April 6, 2015

Table of Contents

I. Executive Summary 1

II. Introduction to Section 1332 Waivers for State Innovation 3
Background 3

III. Federal Regulations Governing Section 1332 Waivers 5
Provisions that May Be Waived Under Section 1332 5

State Public Notice Requirements 9

Federal Public Notice and Approval Process 10

Monitoring and Compliance 10

State Reporting Requirements 11

IV. Opportunities to Leverage Section 1332 to Advance Market Innovation 12
Leveraging Section 1332 Waiver Authority to Integrate Coverage 16

V. Implementation of Section 1332 Waiver 27
Creation of a Workgroup and Preliminary Planning 28

Passage of Authorizing Legislation 29

Drafting, Submission, and Negotiation of the Waiver 29

Operational Planning and Implementation 31

Appendices

Appendix A 32
Acronym List

Appendix B 33
Explanation of Metal Levels

Appendix C 34
Federal Poverty Level Guidelines

Appendix D 35
Letter from Senator Sanders to Chairwoman of the Arkansas Health Insurance Marketplace Board of Directors

Appendix E 38
Interpretation of Section 1332

Appendix F 42
Final Rule: Application, Review, and Reporting Process for Waivers for State Innovation

I. Executive Summary

State Innovation Waivers are authorized under Section 1332 of the Affordable Care Act (ACA), and, therefore, are commonly referred to as "1332 Waivers." These waivers will allow state-specific variations to health insurance marketplace rules in much the same way that "1115 Waivers" currently permit Medicaid rules to be waived to demonstrate program improvement.

This report on the role Section 1332 Waivers might play in shaping future Arkansas healthcare reforms has been drafted at the direction of the Policy Innovations Committee of the Arkansas Health Insurance Marketplace (AHIM) Board. The request was prompted by a legislative inquiry into how 1332 Waiver authority could be leveraged to establish new approaches to healthcare access, cost, and quality in Arkansas.

The Arkansas "Private Option" has already leveraged a federal Medicaid 1115 Waiver to employ marketplace Qualified Health Plans as the delivery system for the state's Medicaid expansion, which was launched January 1, 2014. That waiver is due to expire December 31, 2016. At the same time, the AHIM Board has identified January 1, 2017 as the target launch date for the state-operated individual marketplace. These timelines notably align with the January 2017 date by which states may begin operating programs authorized under Section 1332.

The four sections of this paper that follow this Executive Summary are intended to:

- Identify the provisions of the Affordable Care Act that may be waived, and the conditions upon which they may be waived, under Section 1332.
- Document key events that prompted the request that this report be completed.
- Provide options and examples of waiver concepts that appear permissible under the law in order to facilitate a general policy framework of what is possible and feasible.
- Assess how 1332 Waiver provisions might be used to change program integration approaches between the marketplace and other coverage sources, such as Medicaid and employer-sponsored health insurance, in Arkansas.
- Identify key activities and timelines to be considered, should Arkansas decide it wishes to pursue a program alternative under Section 1332 for launch in 2017.

Amid this information, this report reaches three important conclusions:

1) **Section 1332 Waivers give states broad latitude to design a health insurance marketplace that operates under a different set of rules than the Affordable Care Act.** This is the case as long as the program alternative can be shown to provide as much coverage to as many people at no higher cost.

2) **Section 1332 Waivers have the potential to redraw the boundaries among major health benefit coverage sources, such as the marketplace, Medicaid, and employer-sponsored health insurance.** This appears possible because rules governing eligibility for marketplace premium assistance and reduced cost sharing may be waived under Section 1332. This is especially notable for Arkansas as it considers legislative renewal of the Private Option, among other possible healthcare access innovations.

3) **It will be difficult to implement a program alternative authorized under a 1332 Waiver if planning does not begin in earnest in early 2015.** This is the case given an implementation process that would involve passage of a state law, federal waiver approval, and establishment of comprehensive new business operations to run the program, all within the context of an Open Enrollment period for the state-based individual marketplace that would commence for plan year 2017 on October 15, 2016.

Section 1332 Waivers are new territory in state and federal healthcare policy. No such waiver has been applied for, denied, or approved as of the date of this writing. Interpreting and negotiating what is permissible under Section 1332 will gain its first precedents in the months ahead. This paper serves to help assess options and plan activities should Arkansas wish to be the first, or among the first, to submit an application.

II. Introduction to Section 1332 Waivers for State Innovation

Background

The Affordable Care Act (ACA) established a specific framework for health insurance marketplaces, Medicaid, and employer-sponsored health insurance. But one section of the law – Section 1332 – provides an opportunity for states to waive major provisions of the ACA in order to create program alternatives that are more responsive to state-specific coverage needs. Under the law, these alternative programs, if approved by the federal government, may begin operation as early as January 1, 2017. Approvals may involve review by both the federal Department of Health and Human Services (HHS) and the Treasury Department.

This report was drafted at the request of the Policy Innovation Committee of the Arkansas Health Insurance Marketplace (AHIM) Board and documents the scope of what is waivable in order to clarify possible 1332 options that Arkansas may wish to consider moving forward. In a letter dated July 28, 2014, AHIM Legislative Oversight Committee Chair, Senator David Sanders, asked AHIM to draft a report identifying alternative marketplace establishment options that may be allowable under a 1332 Waiver. The timing of AHIM's proposed launch of a state-based individual marketplace is also January 1, 2017, so 1332 alternatives are integral to AHIM business-planning needs. Senator Sanders's letter was referred to the AHIM Policy Innovations Committee. Since then, the following actions have occurred:

- At the Policy Innovation Committee's August 7, 2014 meeting, Public Consulting Group, Inc. (PCG) provided the committee with a high-level overview of possible program initiatives, including 1332 Waivers, which could be pursued to advance policy goals that the committee had previously identified.

- At the August 11, 2014 AHIM Board meeting, PCG presented an overview of Section 1332 Waivers. This included briefing materials that described all components required for a complete 1332 Waiver application.

- On August 26, 2014, PCG provided the AHIM Executive Director with a Policy Innovations Chart that included broad program options potentially achievable under a Section 1332 Waiver.

- At the November 20, 2014 Policy Innovation Committee meeting, PCG provided a detailed analysis of each provision of ACA Section 1332. At this meeting, the Board directed PCG, in its role as the Board's professional services contractor, to author a report intended to address the Legislative Oversight Committee's request for a 1332 options paper.

This document is that report and a starting point for Arkansas's conversations about the role of 1332 Waivers in future state healthcare innovations. It includes the following sections:

Section III – Federal Regulations Governing Section 1332 Waivers provides an analysis of the provisions that can be waived, along with information regarding the procedures of the application submission process and ensuing state and federal public comment and hearing periods.

Section IV – 1332 Opportunities provides a set of waiver options to help provide a framework for establishing marketplace alternatives. Key to this section is analysis of how 1332 Waiver authority might be used to impact the future direction of Medicaid-marketplace program integration efforts, such as the existing "Private Option."

Section V – Implementation of a 1332 Waiver provides information about both the activities and key timeline milestones that must be considered. This section acknowledges the Arkansas-specific issues that would influence a 1332 Waiver implementation work plan, particularly coordination with the individual state-based marketplace launch in 2017 and end date of the Private Option Section 1115 Waiver on December 31, 2016.

III. Federal Regulations Governing Section 1332 Waivers

Provisions that May Be Waived Under Section 1332

Section 1332 (a)(2) states that the following passages of the Affordable Care Act and Internal Revenue Code of 1986 are potentially waivable, beginning in 2017:

Subtitle D, Part I	Sections 1301-1304: Qualified Health Plan and Essential Health Benefits requirements
Subtitle D, Part II	Sections 1311-1313: Marketplace requirements
Subtitle E, Part 1	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H, and 5000A: Premium tax credits and individual and employer-shared responsibility

The sections referenced above include the fundamental components of health insurance marketplace features. These will be detailed in *Section III*, and will touch upon some of these salient provisions:

Qualified Health Plans	**Essential Health Benefits**
Premium Tax Credits	**Cost-Sharing Reductions**
Individual Mandate	**Employer-Responsibility Payment**

The final rules and regulations around the design, development, and implementation of Section 1332 Waivers for state innovation are codified in 31 Code of Federal Regulations (CFR) Part 33. The rule states that the Secretary of HHS may authorize a waiver for state innovation that would begin on or after plan year January 1, 2017. (*Section IV* of this paper will delve more deeply into the timing of activities, deliverables, and milestones that would need to occur in order for Arkansas to submit a quality waiver application.)

Arkansas can coordinate Section 1115 and 1332 Waivers to achieve programmatic integration.

The rules also make another important point in clarifying that states may choose to submit a single application to HHS under Section 1332, but the state may also choose to submit its 1332 Waiver in coordination with and under one or more of the existing waiver processes applicable under titles XVII, XIX, and XXI of the Social Security Act.[1] This permits Arkansas to reconsider program integration approaches between Medicaid and the marketplace that are as fundamental as eligibility criteria defining the service boundaries between the two programs.

Logistics of the Application Submission

31 CFR Part 33 states that the application submitted to the Secretary of HHS must be done in an electronic format. The Secretary will then begin a review of the application package for completeness, which must be done within 45 days of submission. Once HHS has determined that the application is indeed complete, a 180-day review and decision-making period will ensue.

Application Criteria

Completeness
As 31 CFR Part 33 states, an application for initial approval of a Section 1332 Waiver will not be considered complete unless the application meets all of the following conditions[2]:

- Provides written evidence of the state's compliance with the public notice requirements set forth in 31 CFR Part 33;
- Provides a comprehensive description of the state legislation and program to implement a plan that meets the requirements of a waiver under Section 1332;
- Provides a copy of the enacted state legislation that provides the state with the authority to implement the proposed waiver;
- Provides a list of the provisions of the law that the state seeks to waive, including a description of the reason for the specific requests; and
- The analyses, actuarial certifications, data, and assumptions are provided to the Secretary.

Arkansas would need to pass and enact state legislation authorizing waiver implementation prior to submitting an application.

[1] 31 CFR 33.102(a)

[2] 31 CFR 33.108(f)

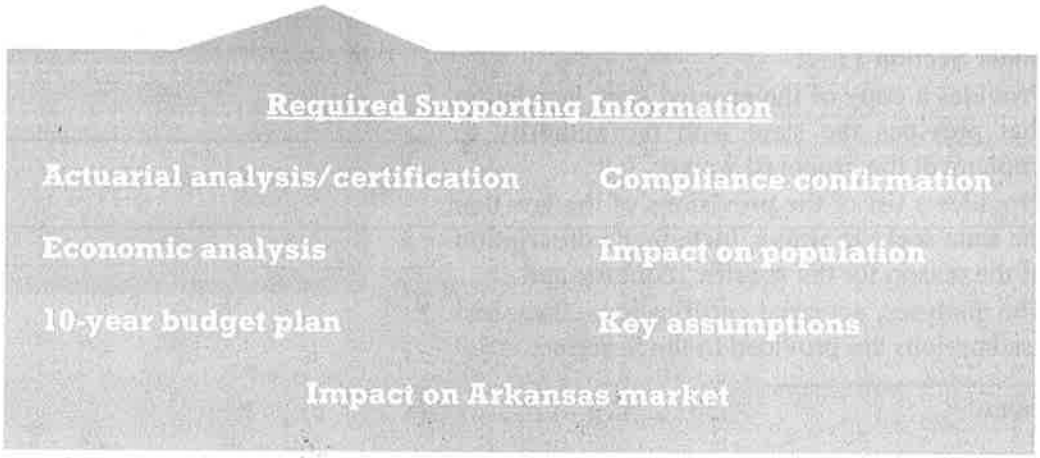
Principles
The CFR specifies that the healthcare coverage proposed by the state in its waiver application package must meet the three essential principles (outlined below) in order to be accepted and ultimately approved by HHS.

1) **Comprehensive Coverage:** The requirement here is that the coverage proposed in the waiver application must be at least as comprehensive as the coverage offered through the marketplace. The thinking is that the term "comprehensive" refers to the benefit package, and that the plans offered in this new healthcare delivery system via a 1332 Waiver provide comparable benefits and protections to consumers looking to purchase quality healthcare.

2) **Affordability:** The regulations for 1332 Waivers also require that the healthcare coverage provide cost-sharing protections against excessive out-of-pocket spending, so that the plans offered to consumers are at least as affordable as those offered under the regulations codified in the ACA. There are a number of affordability requirements in the ACA, but one that states and issuers would need to consider when pricing these plans is the maximum out-of-pocket for both individuals and families. Any form of new coverage that enters the healthcare delivery system due to the implementation of programs proposed through a 1332 Waiver must meet the affordability requirement of the minimum essential coverage guidance, which states that healthcare coverage is considered "affordable" if it does not cost more than 9.5% of an individual's income.

3) **Access to Coverage:** The healthcare coverage proposed in the 1332 Waiver application package must be offered to at least a comparable number of residents, as codified in the ACA.

Supporting Documentation
Additionally, the waiver application must include the following supporting information in order to be considered complete:



Journal of Health Politics, Policy and Law Advance Publication, published on May 19, 2014

Report on Health Reform Implementation

Wyden's Waiver: State Innovation on Steroids

John E. McDonough
Harvard University

Abstract Section 1332 of Title I of the Affordable Care Act offers to state governments the ability to waive significant portions of the ACA, including requirements related to qualified health plans, health benefit exchanges, cost sharing, and refundable tax credits. It permits state governments to obtain funding that otherwise would have gone to residents and businesses through the ACA and to use those funds to establish, beginning in 2017, an alternative health reform framework within statutory limitations. Section 1332 also permits states to apply in a coordinated fashion for waivers from Medicare, Medicaid, the Children's Health Insurance Program, and "any other federal law relating to the provision of health care items or services." This article reviews the statutory provisions and related regulations of this new and unprecedented state waiver authority, as well as the legislative history of section 1332. Finally, it reviews the limited activities thus far by states contemplating use of this provision and considers ways this authority may be considered for use by states in the future. Section 1332 has the potential to instigate a new, varied, and unprecedented array of state health sector innovations from both sides of the political divide over health care reform.

Over time, the Affordable Care Act (ACA) will be known for many things. The law includes a treasure chest of policy innovations, most of them unknown and uncelebrated beyond small circles that pay close attention to their respective arenas. Thus far, the ACA has not been known as a stimulus for state health policy innovation. That reputation is undeserved as we see, for example, the federal Centers for Medicare and Medicaid Services (CMS) approve new and unorthodox waivers to states such as Arkansas, Iowa, and Michigan to draw these otherwise recalcitrant states into the ACA's Medicaid expansion orbit. Arguably, the law's biggest impact on state innovation will be section 1332 in Title I, the "Waiver for State

Journal of Health Politics, Policy and Law, Vol. 39, No. 4, August 2014
DOI 10.1215/03616878-2744824 © 2014 by Duke University Press

Published by Duke University Press
Published by Duke University Press

Journal of Health Politics, Policy and Law

Innovation." Inattention to this section thus far may be connected to a key design feature: no state can implement one until January 1, 2017, at the earliest. Right now, most states have far more on their minds than 2017. In coming years, section 1332 will become far more recognized—and controversial.

Section 1332, the Waiver for State Innovation

Let's start with the statute (Public Law 111-148): Section 1332 (codified as 42 U.S.C. 18052) begins, "A state may apply to the Secretary [of the U.S. Department Health and Human Services] for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning or after January 1, 2017."

Paragraph (2) details the four elements of the ACA from which states may seek a 1332 waiver:

> **Title I. Subtitle D. Part 1.** The requirement to establish qualified health plans that include coverage of minimum essential benefits, specified standards, and coinsurance limits.
>
> **Title I. Subtitle D. Part 2.** The creation of government or nonprofit Health Benefit Exchanges.
>
> **Title I. Subtitle E. Section 1402.** Reduced cost sharing for lower-income individuals and families enrolled in qualified health plans.
>
> **Title I. Subtitle E. Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.** IRS regulations relating to refundable tax credits for premiums, shared responsibility for employers, and penalties for failure to maintain minimum essential coverage.

Paragraph (5) introduces an important element: "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 existing waiver processes applicable under titles XVIII [Medicare], XIX [Medicaid], and XXI [Children's Health Insurance Program] of the Social Security Act, *and any other Federal law relating to the provision of health care items or services* [emphasis added]. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions." This is a broad statutory invitation for states to consider many sorts of unprecedented changes to health care policy within their borders, including by name the touchiest of political terrains, Medicare.

Published by Duke University Press

There are strings (§§(b)(1)):

The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide 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;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

A few other salient details: for a state to act, its application must be backed up by a law, and a state may pass a law anytime it pleases to withdraw from the 1332 waiver program. The HHS secretary has the authority to determine whether or not to grant a waiver and must promulgate regulations to implement this section. No waiver can last longer than five years, and waivers can be renewed by the state and the secretary.

How Did Section 1332 Happen?

The architect and achiever of section 1332 is Senator Ron Wyden (D-OR), the recently installed chairman of the Senate Finance Committee (SFC) following the departure of Senator Max Baucus (D-MT), President Obama's choice as ambassador to the People's Republic of China. This succession is ironic for many reasons, among them Baucus and Wyden's competition in 2008 and 2009 to be the US Senate's intellectual leader on national health reform.[1]

1. This account is based on (a) the author's firsthand knowledge of the process as a staff member on the Senate Committee on Health, Education, Labor, and Pensions between 2008 and 2010 and (b) recent interviews with key congressional staff members who wish to remain anonymous.

Journal of Health Politics, Policy and Law

Wyden's contribution came first in 2007 with the Healthy Americans Act, a legislative reform blueprint far more radical than the ACA that would have engineered a rapid transition from employer-sponsored insurance into employer-subsidized insurance. For most, Wyden's plan would have guaranteed that if you liked your current coverage, you could *not* keep it. Included in his plan was a waiver for states to devise alternative reform plans. Baucus had no room on his SFC stage for a rival plan and did his best, with success, to marginalize both Wyden and his plan. But Wyden had a seat as the fourth ranking Democrat on Baucus's committee, and a hard-to-suppress voice as well.

Before the SFC began its markup of Baucus's health reform legislation in September 2009, the last of the five key congressional committees to do so,[2] Wyden asked Baucus to include two amendments: first, a right for American workers who were offered unaffordable employer coverage to take the employers' share of premium and use those dollars to buy coverage through an exchange; and second, a waiver for state innovation lifted nearly word-for-word from his Healthy Americans Act. Facing business and labor opposition, Baucus did not want to give Wyden the first amendment, and so gave ground on the second. That is how the Wyden waiver got into the health reform law.

That is not the end of the story. In late September into October 2009, as Senate and Obama administration staff merged the health reform bills produced by the SFC and the Health, Education, Labor and Pension Committee (HELP) to produce a new version for full Senate consideration, the Congressional Budget Office (CBO) privately warned staffers about Wyden's waiver: if the provision were allowed to begin in 2014, as written in the SFC version, CBO predicted the administration would be unable to estimate a reliable federal budget neutrality benchmark, lacking at least several years of experience with state exchanges, tax credits, and the rest of the ACA's paraphernalia. Thus, if the legislation permitted waivers as early as 2014, the CBO would give the legislation a substantially more expensive "score," estimated at an added $4.1 billion over ten years. Since keeping the cost of the bill as low as possible was a top priority, the date on which waivers could start was changed to 2017. That is what went to the Senate floor for final passage as part of the Patient Protection and Affordable Care Act on December 24, 2009.

2. The other four committees were the Senate Committee on Health, Education, Labor, and Pensions; the House Committee on Ways and Means; the Energy and Commerce Committee; and the House Committee on Education and Labor.

Published by Duke University Press

Beginning in early January 2010, key Democratic House and Senate members and staff negotiated merging the House health reform legislation approved, without state waivers, on November 7, 2009 with the Senate bill approved on Christmas Eve. In rooms all over Capitol Hill and in the Executive Office Building, armies of staff reconciled literally thousands of issues, including the Wyden waiver, and haunted by a rapidly advancing clock.

In December, Senator Bernie Sanders (D-VT) got interested in section 1332, wanting to advance his home state's ambition to create its own single-payer system and pressing negotiators to return the implementation date to 2014. He convinced the CBO to state in writing that if waivers were granted to no more than two states per year between 2014 and 2016, and if an effective "clawback" provision were included to compel states to reimburse the federal government for any overpayments in connection with the waiver, they would consider the provision budget neutral even though starting in 2014. Beginning his advocacy too late to amend the Senate bill approved on December 24, he pushed hard in January, receiving firm resistance from key House leaders, especially Rep. Henry Waxman (D-CA), then chairman of the House Energy and Commerce Committee, who wanted no waiver at all. Also in January, a letter to Senate Majority Leader Harry Reid signed by Democratic senators, among them Wyden, Sanders, Barbara Boxer (D-CA), and Mary Landrieu (D-LA), asked that section 1332 not be eliminated despite House expressions of opposition.

On January 19, 2010, Senate Democrats lost the ability to thwart partisan filibusters when Republican Scott Brown won the Massachusetts special election to fill the seat formerly held by the late Senator Edward Kennedy, abruptly ending House-Senate negotiations on a merged bill. Passage by the House of the Senate's Patient Protection and Affordable Care Act (PPACA), with only limited budget-related amendments permitted in a follow-up bill, became the sole path to health reform's enactment. On March 23, 2010, President Obama signed the Senate's PPACA into law, including section 1332.

That is not the end of the story. During the course of his run for the presidency in 2011 and 2012, Republican Mitt Romney made repeated statements guaranteeing that his new administration would issue waivers to states to excuse them from complying with the ACA. "On his first day in office, Mitt Romney will issue an executive order that paves the way for the federal government to issue Obamacare waivers to all fifty states," stated his campaign website (Kaplan 2012; see also Haberkorn 2011). Romney staffers never provided a credible response when asked how he would

accomplish this before the statutory start of state innovation waivers in 2017.

Lastly, in November 2010, Senators Wyden and Brown cosponsored bipartisan legislation to advance the start date for section 1332 waivers from January 1, 2017, to January 1, 2014 (Office of Senator Ron Wyden 2010). About three months later, the legislation received an unexpected endorsement from President Barack Obama, a move that produced no discernible impact on the bill's prospects (White House Press Office 2011). Despite bipartisan pedigree and the president's endorsement, the legislation received no further attention and was not refiled (Dobias 2011).

Final Regulations to Implement Section 1332

In section 1332, the HHS secretary was directed to promulgate implementation rules within 180 days after its signing. A proposed rule was issued on March 14, 2011, and the final rule was issued on February 27, 2012. Notably, the final rule was issued on the same day as new final rules were issued by CMS governing future section 1115 Medicaid waivers (see Jost 2012). Both sets of rules establish public accountability and transparency requirements for new and renewed waivers. Section 1115 is the older and more familiar kid on the block, a waiver process that made possible and energized many key state health reform initiatives going back to the early 1980s; Wyden's 1332 waiver is the new kid—and the interaction between these two may prove a novel and potent concoction that generates even newer innovations.

The final 1332 rule pertains only to processes, albeit important ones. It establishes procedures by which states can submit initial applications and lays out the content of those applications and the required processes for public hearing, notice, and comment, as well as standards for postaward reporting and monitoring. The required content in any application must address six major areas:

(1) The provisions of federal law that a state seeks to waive
(2) How the innovation waiver will meet the ACA's goals of coverage expansion, affordability, comprehensiveness of coverage, and costs
(3) An implementation timeline, and including a budget plan that must not increase the federal deficit
(4) Actuarial certifications and economic analysis
(5) An analysis of the waiver's impact on provisions of the ACA that are not waived, such as how a proposed waiver program would impact

access to health services when citizens leave the state, and how it will deter waste, fraud, and abuse

(6) Plans for periodic reports, quarterly and annually, that track affordability, comprehensiveness of coverage, numbers of persons covered, and the impact on the federal deficit

Though a section 1332 waiver must be tied to an explicit authorization in a state law, "a State does not have to enact a new law in support of a section 1332 waiver if the State already has a law in place" (77 Fed. Reg. 11700). Of keen interest to states will be the opportunity to merge multiple waiver requests into a single application, including waivers associated with Title XVIII (Medicare), Title XIX (Medicaid), and Title XXI (Children's Health Insurance Program). The 1332 regulations are included in two sets—one issued by the HHS and a parallel set issued by the Department of the Treasury—because implementation authority is shared between the two. The formula to determine the appropriate payment to a 1332-waivered state ("the amount in tax credits and cost-sharing reductions that would have been paid had the state not received a waiver") "will be determined annually by the Secretaries, on a per capita basis, taking into consideration the experience of other states for participation in an Exchange and tax credits and cost-sharing reductions provided in such other states" (77 Fed. Reg. 11702).

Is this all there is—all process and no substance? In the supplementary information accompanying the final rule, two nonspecific comments suggest more will come. First: "We appreciate the comments submitted on standards for approval and will consider them as we develop the substantive component of the waiver approval process" (77 Fed. Reg. 11705). And this second one: "One commenter asked how HHS will determine the total amount of Federal funding under an approved waiver. *Response.* We will provide additional information on this issue as we move closer to the date on which section 1332 waivers could be effective and regulations regarding the underlying provisions are promulgated" (77 Fed. Reg. 11711).

Though the ACA's section 1332 states: "The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection," in the final 1332 rule "there is no minimum time specified between the submission of an application and the start date of the waiver" (77 Fed. Reg. 11703).

One final bit of good news for states: "The Departments estimate that it will take 400 hours for a State to develop and submit a complete section 1332 waiver application, at a cost of $18,668" and "the Departments

Journal of Health Politics, Policy and Law

estimate that it will take a State 80 hours annually to periodically review the waiver's implementation, at a total cost of $3,734" (77 Fed. Reg. 11713). Departments estimate a full cost of $31,922, or 684 hours, for all state annual recordkeeping and reporting requirements in connection with the proposed rule (77 Fed. Reg. 11714). That is $46.77 per hour (author's calculation).

What Will or Might or Could States Do with a Wyden Waiver?

Answering the question, what will/might/could happen, begins in Vermont. The Green Mountain State's current governor, Peter Shumlin, first elected in November 2008, made a high-profile campaign promise to pursue establishment of a state single-payer health care system. In 2010, the governor and legislature commissioned academic experts to produce a report on how to achieve a single-payer system. That report, *The Vermont Option: Achieving Affordable Universal Health Care,* prepared by Harvard's William Hsiao, Steven Kappel of Policy Integrity, and the Massachusetts Institute of Technology's Jonathan Gruber, identified section 1332 as an important tool to enable the state to achieve its goal: "Under this section, the state could obtain the federal premium and cost-sharing subsidies to fund a single payer system. . . . [I]t seems likely that the state could be able to align the benefit packages and administration, given the broad nature of the statutory language" (Hsaio et al. 2011:107–8).

In a 2011 law, Vermont state government stated its intention to establish the first state-level single-payer system in the nation through the creation of "Green Mountain Care" (2011 Vt. Acts and Resolves 48). The Vermont Health Benefit Exchange, operated by the state as part of the ACA, was designed purposefully to evolve to assume single-payer coverage and financing responsibilities beginning in 2017. Vermont officials intend to be the first to file for a 1332 waiver, and they recognize that their vision would be less feasible absent section 1332. A report on single-payer financing released in January 2013 pegged the monetary value of a 1332 waiver to the state at $267 million in 2017 (ranging between $211 million and $292 million). The estimate was generated by summing the value of premium tax credits and cost-sharing reductions that would have been provided to eligible state residents under the ACA and then subtracting the combined value of individual and employer penalties, the insurer tax, and the excise tax on high-cost health plans (University of Massachusetts Medical School and Wakely Consulting Group 2013).

Published by Duke University Press

Journal of Health Politics, Policy and Law

Though 2017 seems far off, it is not. Political considerations demand that the state move expeditiously to approve a financing plan and initiate the waiver process. The Vermont governor's term runs for only two years, and a change in the state's chief executive in 2014 or 2016 could be fatal for its single-payer ambition. Also, 2016 will be the final year of the Obama administration, under which sympathetic HHS/Treasury reviews are a better bet than the verdict from an unknown new administration in 2017. Waiver negotiations for Medicaid 1115 waivers, far less complex than the 1332 variety, often last a year or longer, and the state would need substantial time to establish a new and unprecedented single-payer infrastructure.[3]

Beyond Vermont, no other state is publicly exploring opportunities embedded in section 1332. Legislative and administration officials in Minnesota have discussed how a 1332 waiver could provide enhanced financial flexibility to implement the Basic Health Program (BHP) opportunity found in the ACA's Section 1331 that permits Medicaid-like coverage—similar to Washington state's Basic Health Plan (Dorn 2011)—for eligible individuals up to 200 percent of the federal poverty level.[4] Massachusetts officials also have discussed the 1332 waiver option in their deliberations over the BHP opportunity.

Interest also appears from Arkansas, a more conservative state that won Obama administration approval for an alternative ACA Medicaid expansion to enroll low-income uninsured persons into exchange-sponsored private health plans instead of Medicaid. Iowa is also moving this way as other conservative states watch closely. The Arkansas and Iowa alternative currently is built on the chassis of an 1115 waiver that requires federal budget neutrality so that the program will not cost the federal government more in Medicaid costs than no waiver. Arkansas officials worry that the narrow 1115 budget neutrality imperative will constrict their ambition to achieve broader system-wide savings that may be less robust on the Medicaid side of the ledger.

With a 1332 waiver, by contrast, Arkansas could mix private sector and Medicaid savings to thread a larger budget neutrality needle. As other conservative states consider participating in the ACA's Medicaid expansion, creativity involving section 1332 may expand. Further, if the Arkansas/Iowa approach succeeds and expands via 1332 authority, states now refusing to establish their own health insurance marketplaces may find new and compelling motivation to do so. Also, a Republican president in 2017 might want

3. Based on confidential conversations with Vermont state officials and others.

4. A proposed rule to govern the Basic Health Program option was issued by CMS on September 25, 2013 (78 Fed. Reg. 59121).

Published by Duke University Press

Journal of Health Politics, Policy and Law

to encourage states to establish their own marketplaces to diminish traditional Medicaid.

From the 2014 opportunity horizon, a Wyden waiver may enhance these state health policy options:

A state-based single-payer financing plan. If Vermont policy makers can find a feasible financing plan, no easy task, the state may be the first to seek a 1332 waiver for the most dramatic form of U.S. health reform imaginable.

A Basic Health Program option as part of ACA. The BHP opportunity does not require a 1332 waiver, though the waiver could allow states to pursue a more expansive BHP program. Massachusetts officials have discussed using a 1332 waiver to implement a BHP expansion up to 300 percent of the federal poverty line even though the ACA's BHP section limits such expansions to 200 percent. Moreover, states employing the BHP option must share their savings with the federal government, while a similar 1332 expansion might require no such shared savings.

A public plan option within a state health benefit exchange. Establishing a Medicare-like public plan option within the health benefit exchanges was the sine qua non of health reform for many progressive groups in 2008–9 during the ACA legislative debate, failing when Senate Democrats could not attract sixty votes with it. As recently as November 2013, the CBO continues to score a federal public option as a federal budget saver; a section 1332 waiver could enable some state or states to put it to a real-life test (CBO 2013: 16).

A private insurance-based Medicaid expansion. Finally, as some Republican governors search for a politically acceptable formula to join the ACA's Medicaid expansion, section 1332 waivers may provide flexibility to make this path more achievable. As Arkansas officials believe, combining section 1332 and section 1115 waivers could offer more degrees of freedom to calculate budget neutrality beyond the confines of standard Medicaid math.

An accelerant for other state innovations. Oregon has established coordinated care organizations to deliver medical care and coverage for Medicaid enrollees that includes responsibility for population health outcomes (Oregon Health Authority, n.d.). Maryland has received federal approval to overhaul its "all-payer" Medicare waiver to hold hospitals accountable for total costs and to move toward global payments and population health responsibility (Maryland Department

Published by Duke University Press

of Health and Mental Hygiene 2014). In 2012, Massachusetts established a global health spending target at the rate of state economic growth (Commonwealth of Massachusetts, n.d.). Any of these—and other—reforms may be strengthened with the incorporation of a 1332 waiver.

One question is whether the Obama administration will issue further section 1332 regulations to define substance as well as process, offering guidance on comprehensiveness, affordability, coverage, and budget neutrality. Given President Obama's embrace of Senator Wyden's legislation to permit 1332 waivers as early as 2014, the administration may want to encourage 1332 possibilities. Some observers worry that any substantive rules will only narrow the universe of ideas; still others fear that a failure by the Obama administration to issue further rules would allow the next administration in 2017 to define the substance of 1332 in unpredictable and, perhaps, unfavorable directions. As of this writing, the Obama administration shows no signs of moving to craft a second set of 1332 rules.

More than anything, federal waiver processes are about money. A key part of each waiver negotiation is establishing a financial baseline acceptable to federal and state participants; just as important is an agreement on trend, the rate at which federal financing can grow in subsequent years. The success of prior 1115 waivers, such as those granted in the 1990s to Tennessee (TennCare) and Massachusetts (MassHealth), involved favorable and generous determination of trend by the Clinton administration.

Also vital to the future of section 1332 waivers will be Senator Wyden, the new chairman of the Senate Finance Committee. The senator keeps an eye on matters relating to section 1332 and was consulted by the Obama administration during the writing of the 2012 regulations. In a 2011 congressional budget deal, Wyden was surprised and upset when negotiators, including former SFC chairman Baucus, repealed the modest "employee free choice voucher" he had secured in the ACA during its final Senate passage (Lichtblau 2011). As SFC chairman, Wyden is well placed to prevent any similar damage to section 1332 in the period leading up to 2017, assuming Democrats retain majority control of the Senate. In either case, he can be expected to be vigilant.

Conclusion

Section 1332 has the potential to be a significant and unpredictable game changer in future directions in federal and state health care policy. As the

Journal of Health Politics, Policy and Law

pendulum swings between the federal government and states in health policy innovation, we can anticipate, and already observe, states pressing ahead with new policy agendas. The Wyden waiver just may be a new "super waiver" in the hands of states exploring the next frontiers of health system innovation and reform.

▪ ▪ ▪

John E. McDonough is professor of practice at the Harvard School of Public Health. Between 2008 and 2010, he served as a senior adviser on national health reform to the US Senate Committee on Health, Education, Labor and Pensions. Between 2003 and 2008, he was executive director of Health Care for All, Massachusetts's consumer health advocacy organization. From 1998 through 2003, he was associate professor at the Heller School at Brandeis University. From 1985 to 1997, he was a member of the Massachusetts House of Representatives where he cochaired the Joint Committee on Health Care. His articles have appeared in the *New England Journal of Medicine*, *Health Affairs*, and other journals. He has written *Inside National Health Reform* (2011), *Experiencing Politics: A Legislator's Stories of Government and Health Care* (2000), and *Interests, Ideas, and Deregulation: The Fate of Hospital Rate Setting* (1998). He holds a doctorate in public health from the University of Michigan and an MPA from the Kennedy School of Government at Harvard.

References

CBO (Congressional Budget Office). 2013. "Choices for Deficit Reduction: An Update." December. www.cbo.gov/sites/default/files/cbofiles/attachments/44967-DeficitReduction.pdf.

Commonwealth of Massachusetts. n.d. "Health Policy Commission." www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ (accessed Mary 16, 2014).

Dobias, M. 2011. "State-Based Health Bill Loses Speed." *Politico*, September 7. www.politico.com/news/stories/0911/62854.html.

Dorn, S. 2011. "The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States." March. Washington, DC: Urban Institute. www.urban.org/uploadedpdf/412322-Basic-Health-Program-option.pdf.

Haberkorn, Jennifer. 2011. "How Romney's Waivers Would Work." *Politico*, October 12. www.politico.com/news/stories/1011/65798.html.

Hsaio, William, Steven Kappel, Jonathan Gruber et al. 2011. "Act 128: Health System Reform Design. Achieving Affordable Health Care in Vermont." February 17.

Published by Duke University Press

Journal of Health Politics, Policy and Law

www.leg.state.vt.us/jfo/healthcare/FINAL%20REPORT%20Hsiao%20Final%20Report%20-%2017%20February%202011_3.pdf.

Jost, T. 2012. "Implementing Health Reform: State Innovation and Medicaid Waivers." *Health Affairs Blog*, February 23. healthaffairs.org/blog/2012/02/23/implementing-health-reform-state-innovation-and-medicaid-waivers/.

Kaplan, K. 2012. "Romney Says He'll Undo Obama Healthcare Reform on Day 1. Can He?" *Los Angeles Times*, October 30. articles.latimes.com/2012/oct/30/news/la-heb-president-romney-affordable-care-act-20121030.

Lichtblau, R. 2011. "Lobbyists Won Key Concessions in Budget Deal." *New York Times*, April 12. www.nytimes.com/2011/04/13/us/politics/13lobby.html.

Maryland Department of Health and Mental Hygiene. 2014. "Maryland Submits Proposal to Modernize All-Payer System." January 10. dhmh.maryland.gov/SitePages/Medicare%20Waiver%20Modernization.aspx.

Office of Senator Ron Wyden. 2010. "Wyden, Brown Introduce Bill to Move Up Date for Health Care Law's State Waiver Provision." November 18. www.wyden.senate.gov/news/press-releases/wyden-brown-introduce-bill-to-move-up-date-for-health-care-laws-state-waiver-provision.

Oregon Health Authority. n.d. "Coordinated Care Organizations." https://cco.health.oregon.gov/Pages/Home.aspx (accessed March 16, 2014).

University of Massachusetts Medical School and Wakely Consulting Group. 2013. "State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis." January 24. www.umassmed.edu/uploadedFiles/CWM_CHLE/About/Vermont%20Health%20Care%20Financing%20Plan%202017%20-%20Act%2048%20-%20FINAL%20REPORT.pdf.

White House Press Office. 2011. "Fact Sheet: The Affordable Care Act: Supporting Innovation, Empowering States." February 28. www.whitehouse.gov/the-press-office/2011/02/28/fact-sheet-affordable-care-act-supporting-innovation-empowering-states.

Published by Duke University Press