Article from

Health Watch

May 2016
Issue 80

Section 1332 Waivers: Coming Soon to a State Near You?

By Greg Fann

When I sampled 10 actuaries and told them I was writing an article about Section 1332 waivers, I was met with 10 blank stares. If I conduct the same experiment a year from now (of course after filtering out avid *Health Watch* readers), will I get the same result? I don't know the answer to that question; as we actuaries like to say, it depends. This article provides an introductory view of the nature and requirements of Section 1332 waivers and discusses the potential developments of Section 1332 and what this might mean for health actuaries in the coming years.

BACKGROUND

Section 1332 of the Patient Protection and Affordable Care Act (ACA) created opportunities for waivers[1] in commercial markets that allow states to bypass some of the marketplace requirements, mandates and tax penalties constructed by the ACA. It is fair to say that these marketplace waivers are analogous to Section 1115 (of the Social Security Act) waivers that allow Medicaid rules to be waived. At first glimpse, this is a tremendous game changer given the varying state decisions on Medicaid expansion and the development of exchanges, not to mention the provocative vocal viewpoints expressed by some state leaders regarding the economic implications of the ACA. The prospect of states being able to muddle with the ACA marketplaces has been described as "breathtaking" and "state innovation on steroids."[2]

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Why then is this opportunity still somewhat under the radar and not top of mind for actuaries? There are two primary reasons. First, Section 1332 waivers cannot be implemented until 2017. Chatter has been light in the five years since ACA inception, but it is picking up in 2016 after federal guidelines were promulgated in December 2015. Second, there are severe limitations about what actually can be waived, and these limitations thwart major changes to the principles of expanded coverage and affordability. In other words, those that seek radical changes to the ACA are not going to be able to accomplish their objectives through Section 1332 waivers.

WAIVER REQUIREMENTS

For a Section 1332 waiver to be considered, state legislation needs to be passed, a public hearing and comment period need to occur, and a formal waiver application process needs to follow. A Section 1332 waiver requires discretionary approval from the Secretary of Health and Human Services and the Secretary of the Treasury and is predicated on meeting these four requirements, frequently referred to as *guardrails:*

1. **Comparable scope of coverage:** The waiver must provide coverage to a comparable number of state residents absent the waiver in each forecasted year.
2. **Affordable:** The waiver must provide coverage as affordable as coverage absent the waiver. The affordability measure is net out-of-pocket spending, which includes premium contributions, cost sharing and spending on non-covered services impacted by the waiver. The measure will apply to the average enrollee as well as enrollees with high medical costs relative to income.
3. **Comprehensive coverage:** The waiver must provide coverage that is as comprehensive as coverage absent the waiver. The state must demonstrate how the benefits offered are as comprehensive as the state's benchmark plan.
4. **Deficit neutral:** The waiver must be federal deficit neutral in each year of a 10-year budget period. This is a stricter requirement than 1115 waivers, which allow deficit neutrality over the life of the waiver.

In addition to having to meet the first three requirements as measured on an average enrollee basis, waiver applications are also evaluated based upon the impact to vulnerable residents. These populations include individuals who are low income, elderly, and have significant health issues.

WHAT CAN BE WAIVED?

The ACA "community rating" (old-school term, the new lingo is "fair play") framework of guaranteed issue policies without pre-existing condition limitations or the application of health status as a rating variable cannot be modified, but several key components (not an exhaustive list) of the ACA requirements can be waived:

1. **Qualified Health Plan requirements:** States can waive the network, quality and "single risk pool" requirements associated with Qualified Health Plans.
2. **Essential health benefits/actuarial value requirements:** States can modify the benefit requirements but must comply with the comprehensive coverage requirement.
3. **Exchange/marketplace requirements:** States could privatize their exchanges and retain the same federal funding amounts available through the public exchanges.
4. **Subsidies:** States can reallocate how federal funds available absent the waiver can be used to provide affordable coverage.
5. **Mandates:** States can waive the mandates and penalties; alternatively, they could apply something similar to the Medicare Part D late enrollment penalty or other responsibility mechanisms in the individual market.

INITIAL STATE ACTIVITY

Three states—Hawaii, Massachusetts and Vermont—have active proposed waivers that seek to preserve pre-ACA employer coverage mandates and characteristics. Minnesota, Ohio and Rhode Island have passed legislation authorizing the waiver application, and a Health Care Financing Task Force in Minnesota has proposed a comprehensive list of recommendations,[3] some of which require Section 1332 waiver approval.

Arkansas and New Mexico are considering Section 1332 legislation. Notably, the Arkansas intent would be to continue the "private option" that allows Medicaid recipients to access the marketplace with Medicaid funds through a Section 1115 waiver that expires Dec. 31, 2016.

Early discussions are underway in three other states. California had a public meeting in February 2016.[4] Colorado seeks to use Section 1332 to develop a single payer system, an experiment that was recently abandoned in Vermont due to lack of funding. Kentucky may be the most interesting state to watch with a charismatic new governor who, during the campaign, had mentioned the possibility of reversing Medicaid expansion and demolishing one of the better-performing state exchanges, and has continued to maintain a strong health care focus after taking office. A combined innovative "super waiver" utilizing both Section 1115 and Section 1332 is a noteworthy and distinct possibility in Kentucky, but it is not likely to be developed and approved in 2016.

ROLE OF ACTUARIES

Approval of a Section 1332 waiver will require actuarial involvement, namely a requirement of an actuarial certification. The certification is required to support the state's estimate of the first three waiver requirements; arguably, actuarial input could also be crucial to some of the assumptions in the deficit neutrality calculation, but it is not required in the guidance. The calculations to determine waiver compliance are necessarily complex and are required by the guidelines to be constructed "using generally accepted actuarial and economic analytic methods such as micro-simulation."[5] Detailed documentation of the actuarial work product is also required with the waiver application. The promulgated guidance for each of the four requirements contains this paragraph: "The state should also provide a description of the model used to produce these estimates, including data sources and quality, key assumptions, and parameters. The state may be required to provide micro data and other information to inform the Secretaries' analysis."[6]

OPPORTUNITIES FOR STATES

States can apply to implement simple targeted corrections that allow specific state initiatives to function efficiently or seek major changes in how federal funds are applied. A sampling of ideas is included here:

- **Family glitch.** Individuals with access to affordable employer-sponsored coverage are not eligible for premium and cost-sharing subsidies through the marketplaces. The affordable definition is based on the required premium contribution relative to the employee's household income. The affordability test is based on employee-only coverage and not family coverage. This results in some families not having affordable employer-sponsored coverage and also not being eligible for premium and cost-sharing subsidies. This unfortunately impacts several million low-income people. While there are calls to address the "glitch," there is not a clear legislative path for a correction at the federal level. States could use a Section 1332 waiver to redefine affordability on a family basis.
- **Subsidy cliffs.** What sounds like a scenic lookout to explore on the San Diego coast is not a fun place to visit and is an unfortunate problem with unintended misaligned incentives. Unlike the individual income tax calculations that are generally graduated, the subsidy calculations in the ACA have some sharp break points, where earning additional income becomes punitive. Section 1332 waivers could be used to smooth these cliffs. States could also use a Section 1115 waiver in conjunction to smooth the cliff at the Medicaid/marketplace income threshold.
- **Broader market appeal.** The mandated age ratios and distribution of premium tax credits resulting from the premium subsidy calculation create a market that is more favorable to older enrollees.[7] A waiver could allow the state to reallocate the subsidy dollars to be more attractive to a younger demographic. More broadly, a state can fund its reform effort by redirecting the federal financial assistance from cost-sharing reduction payments and small business tax credits as well as premium subsidies. The government-sponsored promotion of individual health insurance to young adults in the initial years of ACA

implementation has been creative and somewhat successful, while concern lingers that market sustainability relies upon continued enrollment of this group to maintain a stable population and balanced risk pool. High premiums and cost sharing with little realized value could drive young adults out of the market. A Section 1332 waiver could be used to reallocate federal dollars to attract a younger market through financial incentives rather than aggressive marketing promotions. States may also elect to provide subsidized coverage above 400 percent of federal poverty level; this is allowable given that the budgetary impact is compliant with the four guardrails.

- **Premium risk transfer.** The ACA subsidy formula puts the premium risk on the burden of taxpayers. Subsidy-eligible enrollees purchasing the benchmark plan are insulated and only responsible for a percentage of their income, regardless of the premiums in the market. The remaining amount is the responsibility of the federal government. This has created an unusual leveraging situation where plans priced lower than the benchmark cost younger enrollees more than older enrollees at the same income level.[8] Similar to the broader market appeal aspiration, states can use a Section 1332 waiver to convert the premium risk to the enrollees, using either a fixed-dollar contribution or a percentage-of-premium concept (both more in line with employer contributions in the group market), but changes must be budget neutral to the tax credit approach in the ACA.
- **Basic Health Plan replacement/alternative.** States could use a Section 1332 waiver to develop a program similar to a Basic Health Plan (authorized in Section 1331) with much more flexibility. Additionally, states can receive 100 percent of the federal funding allotment rather than the 95 percent allowed for a Basic Health Plan.

Notably, states that have not developed their own exchange should be aware of the operational limitations on the federally facilitated exchange. The *healthcare.gov* platform is not designed to accommodate state flexibility with tax credits or income adjustments. States that are serious about innovation should consider the current inherent limitations of abandoning their state exchange or remaining on the federal platform.

PRESIDENTIAL ELECTION YEAR DYNAMICS

Given the late timing of the guidance, the strict requirements, and the logistics and time frame required to get a waiver up and running, it seems unlikely that any states, other than the three states with existing minor proposals, will have waivers approved by the Obama administration. The next president may increase the waiver flexibility and offer more choices for states. The December 2015 guidance is not binding; it can be easily changed by a future administration.

All candidates except Hillary Clinton envision federal health legislation significantly different from the ACA and may have little interest in approving Section 1332 waivers. That being said, outright repeal may be an uphill battle and waivers that suit the new president's policy goals may be a potential outcome. Clinton actually references Section 1332 on her campaign website without mentioning it by name, stating she "will work with interested governors, using current flexibility under the Affordable Care Act, to empower states to establish a public option choice."[9]

CONCLUSION

Section 1332 provides opportunities for states to adjust some of the ACA difficulties within their borders and tailor the federal requirements to the states' needs. This will allow corrections to some of the unintended consequences, particularly addressing the rough edges and unfortunate coverage gaps in the individual market. States that seek to pursue innovations for Section 1332 waivers will need actuaries to opine on the waiver impact to enrollment, benefit richness/selection and affordability. Will states proceed with Section 1332 waiver implementation? We will have to wait and see. If they do, it will be yet another pioneering actuarial opportunity to harvest from the fields of ACA implementation. We should be ready for the challenge. ■

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ENDNOTES

1 Section 1332 waivers are sometimes referred to as state innovation waivers or Wyden waivers because Sen. Ron Wyden was the initial supporter of the waiver idea in a prior legislative proposal.

2 *http://www.brookings.edu/blogs/health360/posts/2015/04/29-aca-section-1332-waiver-butler*

3 *http://www.mn.gov/dhs/images/final-materials-final-report_01-28-2016.pdf*

4 *http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/Agenda%20-%20February%2023%202016%20Section%201332%20Wavier%20Meeting.pdf*

5 *https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf*

6 *https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf*

7 *https://www.soa.org/Professional-Interests/Health/hlth-detail.aspx.* See Publications: *Health Watch*—May 2014.

8 *http://www.theactuarymagazine.org/the-true-cost-of-coverage/*

9 *https://www.hillaryclinton.com/issues/health-care/*