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The Opportunities and Constraints of the ACA's State Innovation Waivers

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The federal government is authorized to approve ''Waivers for State Innovation'' starting in 2017 under Section 1332 of the Affordable Care Act (ACA). Under this authority, the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury can provide federal funding for innovative state health care programs that depart from many of the requirements in the ACA.

Congress created Section 1332 waivers to encourage States to pursue ''fresh, creative'' ideas for health care reform.[1] With decades of experience operating Medicaid programs and regulating private health insurance, States are well-positioned to develop innovative approaches, and State officials understand the unique priorities, conditions, and challenges facing their State in a way that federal officials do not. By giving the Secretaries broad authority to waive some of the most important requirements in the ACA, Section 1332 allows a State to implement health care reform that is fundamentally different than the ACA's patchwork of mandates, subsidies, market regulation, and expanded Medicaid coverage.

Although Section 1332 presents an exciting opportunity for state-level health care reform, the significant constraints it places on state innovation have been largely overlooked by policymakers and commenters eager to tout the promise of these waivers. The limits in Section 1332 unnecessarily restrict States pursuing comprehensive reform and effectively prevent States from using Section 1332 to implement smaller-scale innovation.

[1] 156 Cong. Rec. S1969 (daily ed. March 24, 2010) (statement of Sen. Ron Wyden).

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Opportunities for Large-Scale Innovation

Section 1332 gives the Secretaries broad authority to waive some the ACA's most central requirements, including those governing the individual mandate, the employer mandate, Qualified Health Plans, Exchange operations, premium tax credits, and cost sharing subsidies.[2] States can develop and implement a waiver program in which these ACA rules are supplanted with rules that the State negotiates with the Centers for Medicare & Medicaid Services (CMS) and/or Treasury, financed with direct federal payments to the State up to the amount that would otherwise be paid to individuals in the State for tax credits and subsidies to purchase Exchange coverage.[3] Although Section 1332 itself does not permit the waiver of Medicaid or Children's Health Insurance Program (CHIP) rules, States can combine a Section 1332 waiver with a Section 1115 demonstration

[2] *See* ACA § 1332(a)(1)-(2).
[3] *See id.* § 1332(a)(3).

 ISSN 1068-1213

project.[4] Section 1115 has long given the Secretary of HHS the ability to waive Medicaid and CHIP rules for a demonstration project if it furthers the objectives of the program.

The broad scope of Section 1332's waiver authority allows States to pursue health care reform that is dramatically different than the ACA's reform. States can use the federal funds that support affordable Exchange coverage to finance a state health care system that wholly supplants the federal approach, if that state system meets certain coverage requirements described below. And the availability of joint Section 1332-Section 1115 waivers means that these state programs can also encompass Medicaid enrollees and access federal Medicaid dollars to support the program.

For example, Vermont considered using Section 1332 to implement a single payer system, *i.e.*, to provide Vermonters with coverage through a single, government-operated health care plan. Although cost concerns eventually led Vermont to abandon this proposal, the fact that Section 1332 can be used to help finance a single payer system illustrates the breadth of opportunities available under the provision.

Policymakers and commentators have touted the promise of Section 1332 waivers, stressing the latitude that Section 1332 gives to States to experiment with alternative coverage models. In an effort to hasten their availability, legislation was introduced in Congress to make Section 1332 waivers available starting in 2014, instead of 2017.[5] More recently, Section 1332 has been floated as one potential mechanism for dealing with the fallout if the Supreme Court rules in favor of the plaintiffs in *King v. Burwell*.[6]

Unnecessary Constraints on State Innovation

Although Section 1332 holds great promise for the certain types of far-reaching reforms, it also significantly limits how a State can innovate. Specifically, Section 1332 waiver programs must:

1) ''provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) and offered through Exchanges'';

2) ''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'';

3) ''provide coverage to at least a comparable number of its residents'' as the ACA provisions would cover; and

4) ''not increase the federal deficit.''[7]

These limits unnecessarily constrain innovation. Requiring that benefits be ''at least as comprehensive as'' the ACA's ''essential health benefits'' prevents States from testing even modestly less generous or different benefits packages, regardless of how the State uses the savings achieved from allowing narrower coverage. A similar requirement applicable to the Medicaid expansion has been very challenging for a number of States that have expanded or considered expanding, as it requires a comparison to a detailed, exhaustive set of benchmark benefits, and various supplementation and substitution of benefits, with little flexibility to experiment with different approaches, such as consumer-driven health plans or differentiated packages of benefits based on need.

Section 1332 also prevents States from pursuing smaller-scale reforms. States will be unable to implement waiver programs that focus on innovation with respect to benefits, increased cost sharing, or anything that might increase federal costs. In addition, States likely cannot experiment with providing wider access to government-sponsored or subsidized coverage—if a State cannot offer less generous benefits and cannot allow increased cost sharing, it is unlikely to find a cost-neutral way to cover more people than the ACA allows.

In addition to the substantive barriers they create, the limits in Section 1332 increase the administrative burdens for States pursuing a Section 1332 waiver. As many States can attest, obtaining CMS approval for a Section 1115 demonstration with new or creative policy ideas can be an arduous process, even though the only statutory condition for waiving Medicaid rules under Section 1115 is that the demonstration ''is likely to assist in promoting the objectives of'' Medicaid and/or CHIP. For Section 1332 waivers, the federal government must satisfy itself that much more specific and onerous standards have been met, *i.e.*, that the program will cover a comparable number of beneficiaries as would be covered under the ACA, and that beneficiaries will receive coverage ''at least as comprehensive'' as essential health benefits, with ''cost sharing protections against excessive out-of-pocket spending that are at least as affordable'' as they would be under the ACA. To make matters even more challenging, States seeking approval for state innovation waivers may need approval from both CMS and Treasury, which may have different policy priorities and goals.

Prospects for Innovation

If Congress is serious about fostering state innovation, it should amend Section 1332 to provide States with more flexibility, particularly with respect to benefits and cost sharing. CMS and Treasury should similarly consider regulatory changes that would minimize the burdens on States seeking to implement a Section 1332 program, and they should interpret and implement Section 1332 in a way that honors Congress' intent to encourage innovation. CMS and Treasury are entitled to conduct robust oversight of federally-funded Section 1332 programs—the agencies should demand measurable goals for health care quality, outcomes, and cost effectiveness, and they should require regular reporting and active monitoring to analyze whether those goals are being advanced. But if policymakers really want to maximize the ''fresh'' and ''creative'' ideas coming out of States, they need to give States sufficient flexibility to be fresh and creative.

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[4] 31 C.F.R. § 33.102; 45 C.F.R. § 155.1302.

[5] *See* Empowering States to Innovate Act, S. 248 (introduced Feb. 1, 2011).

[6] *See* Lanhee J. Chen, *Why Not 50 Different Affordable Health-Care Plans?*, Wall St. J., March 12, 2015; Stuart M. Butler, Let the states fix Obamacare, http://www.brookings.edu/blogs/health360/posts/2015/03/20-aca-five-years-let-states-fix-obamacare-butler (March 20, 2015).

[7] ACA § 1332(b)(1).

  HCPR ISSN 1068-1213