Waiver World: A Guided Tour of 1115 and 1332 Waivers

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Overview

I. Foundation and Context

II. Section 1115 of the Social Security Act

III. Section 1332 of the Affordable Care Act

IV. Discussion
POLICY BRIEF | October 2015

How Waivers Work: ACA Section 1332 and Medicaid Section 1115

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Introduction

Many health care programs, including Medicaid and Affordable Care Act (ACA) health insurance marketplaces, operate according to federal law. Using waivers, states can gain federal approval to increase their flexibility within that law. States have long used Medicaid Section 1115 waivers to manage their Medicaid programs. The ACA introduced the State Innovation waivers, also known as a Section 1332 waiver, which can be used to waive many health insurance marketplace requirements.

This brief outlines how Medicaid Section 1115 and ACA Section 1332 waivers work and what states should consider when designing these waivers. For consideration of how a particular state could use waivers to improve health care affordability and access, see our companion issue brief, “Using Waivers to Improve Health Care Affordability and Access to Coverage in Connecticut.”

What is a Waiver?

A waiver is a special permission from the federal government to a state to disregard—or waive—provisions of federal law. Waivers may be granted to allow states to experiment with alternative ways to achieve the objectives of federal law and still receive federal matching funds. State and federal officials negotiate the specific terms of a waiver. Waivers usually impose financial constraints, reporting duties and other requirements on the state.

A state can use waivers as a policy tool in designing and administering health care programs. Two waivers that allow broad changes are ACA Section 1332 waivers and Medicaid Section 1115 waivers. States may use waivers to make health insurance more accessible and affordable for their low income residents. In designing a waiver, states should consider:

- What aspects of the law may be waived
- Approval criteria
- Timing of waiver approval process
- Financing
- Public input requirements

States may use waivers to make health insurance more accessible and affordable for their low income residents by:

- Simplifying the health care system through administrative reforms and/or publicly-financed coverage.
- Making Medicaid available to more people.
- Using Medicaid funds to purchase private insurance.
- Streamlining eligibility processes.

However, recent HUSKY reductions may partly reverse Connecticut’s insurance coverage gains. In addition, recent affordability research shows that while insurance facilitates access to health care, insurance doesn’t guarantee access.

Connecticut has addressed cost concerns in several ways. A multi-payer initiative to reform
I. Foundation and Context
Why Focus on 1115 and 1332 Waivers?

- Breadth and potential to re-shape health care programs to meet State (and Federal) objectives
- Capture federal funds for new state-initiated ideas
- **Section 1115** – A Demonstration project is approved if “…in the judgment of the Secretary, it is *likely to assist in promoting the statutory objectives of the Medicaid or CHIP program.*” 42 CFR 431.404; See also, Section 1115(a) of the SSA
- **Section 1332** - Insurance and exchange regulation under ACA may not align with your state client policy goals; Section 1332 option may help
II. Section 1115 of the Social Security Act
Medicaid Legal Framework
States “elect” to participate

Federal Roles
- Federal Courts
- Congress (policy)

Oversight Agency
- CMS
  - Regulations
  - State manuals
  - Policy letters
  - Audits

State Roles
- State Courts
- State Legislature (policy)

Governing Documents
“Jointly-Administered”

State Plans
Title XIX and XXI

Waivers
Title XIX and XXI
- 1915(c) HCBS Waivers
- 1115 Title XIX/XXI Demonstration Projects

Designated State Agency
- Regulations
  - Bulletins
  - Billing rules
  - Contracts

Single State Agency
- Approve or deny

FFP claims
Audit responses

State
Legislature
(policy)

Medicaid recipients
Providers/Plans

Disallows
Defers

Regulations
- State manuals
- Policy letters
- Audits

3

providers/Plans

Medicaid recipients

Disallows
Defers

FFP claims
Audit responses

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FFP claims
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“Traditional” Examples of Section 1115 Opportunities

Statewide-ness – Section 1902(a)(1): To enable the State to operate the Demonstration on a less-than-statewide basis.

Amount, Duration and Scope of Services – Section 1902(a)(10)(B): To enable the State to provide benefit packages to Demonstration populations that differ from the State plan benefit package.

Eligibility Expansion – via financial eligibility streamlining; or establishing higher income standards; or limiting asset “tests.”
Newer Section 1115 Opportunities

• **Delivery System Reform**
  – Delivery System Transformation Initiative (DSTI)
  – Delivery System Reform Incentive Payments (DSRIP)
  – Designated State Health Programs (DSHP)

• **Financing mechanisms**
  – Re-deploying some or all of the State’s Disproportionate Share Hospital (DSH) allotment
  – Expenditure authority for existing state costs; aka, CNOM
  – Provider taxes, savings (utilization mngmt, APMs)
  – Medicare/Medicaid (“Dual”) blended payment methods
Weighing the options …

Expanded State Plan options; e.g.,
  – ACA Adult coverage to 138% FPL
  – HCBS options – 1915(c),(i),(j),(k)
  – Managed Care plans

But…what if SP option parameters are at odds with your State’s idea?

Demonstration waiver needed:
  – Income standard higher than 138%
  – Budget constraints require HCBS caseload limits
  – Targeted case management via selective contracting
  – Beneficiary cost sharing - variations
  – Provider incentive payments and “CNOM”
Design Development and Analysis

Within External Parameters? *e.g.*,
- No less generous benefits for mandatory populations;
- Voluntary for Medicare beneficiaries; plan choices
- Independence of health plan enrollment processes;
- Legislature’s and consumers’ policy tolerance

Administrative Feasibility? *e.g.*,
- Can existing eligibility and MMIS systems accommodate changes? Increases in staff levels or vendor costs?
- Can provider groups participate without daunting adjustments?

Projecting service volume, caseload, pricing impacts
- Does Agency have sufficient market influence; other tools?
Basic Elements of Section 1115 Applications

• Share a Concept Paper with HHS/CMS
• Show that your “idea”, your proposal, promotes goals of Medicaid: *access, cost efficiency, quality outcomes*
• Engage with stakeholders and the general public
• Develop a detailed program description with all needed waiver and expenditure authorities identified
• Negotiate CMS approval, which includes:
  • Special Terms and Conditions (STCs) for waivers and spending
  • Protocol Document – how to operate/implement the program
  • Ensure Budget Neutrality
Section 1115 Waiver: Launched

- Does the federally approved Demonstration program or STCs or other conditions require further state level legislation?
- Plan time to secure policy leaders’ endorsement of the final Demonstration project features, as needed
- Establish an ongoing Stakeholder Communications Plan
- Implementation planning and resource gathering
- Sustainability: Waiver Extension => Reform mainstreamed
  - Renewals and Amendments
  - Sustaining financing and federal support
We want to hear from you…
III. Section 1332 of the Affordable Care Act
Section 1332 Focus: Individual and Small Group Markets

Before 2010:
Few consumer protections; Many states tried reform to varying effect

2010 – 2014 and beyond:
Implementation of ACA reforms
Section 1332: Opportunities

Flexibility to waive requirements of certain federal laws

- Establishment of Exchanges and Qualified Health Plans
- Premium Tax Credits*
- Cost-Sharing Subsidies*
- Individual Mandate
- Employer Mandate
- Small Business Credits*

* Availability of pass-through funds to the state
Section 1332: Limitations

Does not include explicit authority to waive

- Nondiscrimination (ACA s. 1557)
- Medicaid and Medicare provisions
- Market protections (guaranteed issue, etc.)
- Some Exchange operation requirements
- Others
Calculating Pass-through

• Amount that would have been paid in federal financial assistance
• Does not include administrative costs
• Determined by the HHS and Treasury Secretaries
Section 1332 Waiver: Process

• State develops waiver proposal, with input from public (including a public comment period)

• State submits waiver to HHS (and, if there are pass-through funds involved, Department of Treasury)

• State negotiates with HHS and Treasury

• HHS and Treasury approve or deny waiver
Group Exercise
State Experience

- California
- Hawai’i
- Vermont
Section 1332: Requirements

• State authorizing legislation required
• States must show that the resulting system will not increase the federal deficit and…
  – Be at least as comprehensive as…
  – Be at least as affordable as…and
  – Cover as many people as…
    …would have happened absent the waiver
When considering comprehensiveness, affordability, and scope of coverage:

• Consider impact on all residents of the state, regardless of coverage type
• Forecast for each year
• Vulnerable subsets of the population considered
• Only consider changes already in place
• Include actuarial analysis and certification, economic analyses, data, and assumptions
Guardrail: Comprehensiveness

Coverage that is **at least as comprehensive** for the state’s residents

Comparing to EHB benchmark and Medicaid/CHIP standard
Guardrail: Affordability

Coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable

Looking at out-of-pocket expenses and covered services, relative to income
Guardrail: Number of People Covered

Provide coverage to at least a comparable number of the state’s residents

Includes gaps in coverage and discontinuation of coverage
Guardrail: Federal Deficit Neutrality

Projected Federal spending net federal revenues must be equal to or lower than those absent waiver

<table>
<thead>
<tr>
<th>Spending</th>
<th>Revenues</th>
</tr>
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<tbody>
<tr>
<td>• Federal financial assistance;</td>
<td>• Income, payroll, excise tax;</td>
</tr>
<tr>
<td>• Medicaid spending;</td>
<td>• User fees</td>
</tr>
<tr>
<td>• Administrative costs</td>
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Additional items may be considered on both the spending and revenue side.
A state can submit a single application for 1332 and other waivers (including 1115) BUT

Waivers will be evaluated separately
  – Savings earned under one waiver cannot be applied to the other
  – Changes made to Medicaid cannot be applied until approved
Operational Considerations

- Federally-facilitated Exchanges will have limited ability to implement waiver changes, e.g., Different enrollment periods.

- The IRS will also have limited ability to implement waiver changes, e.g., Changes to eligibility for premium tax credits.
Resources

How Waivers Work: ACA Section 1332 and Medicaid Section 1115
http://www.cthealth.org/publication/how-waivers-work/

Using Waivers to Improve Health Care Affordability and Access in Connecticut
http://www.cthealth.org/publication/waivers-affordability-access/
Thank you!

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http://commed.umassmed.edu/centers-programs/
center-health-law-and-economics