Report on Health Reform Implementation

State Innovation Waivers: Redrawing the Boundaries of the ACA

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JHPPL *seeks to bring this important and timely work to the fore in Report on Health Reform Implementation, a recurring special section. Thanks to funding from the Robert Wood Johnson Foundation, all essays in the section are published open access.*

—Colleen M. Grogan

Abstract In the federalist spirit of the rest of the Affordable Care Act (ACA), section 1332 of the law authorizes new optional waivers for state innovation. These waivers, 1332 waivers, as they have become known, offer states the flexibility to refashion their coverage systems, provided that their reforms stay within important boundaries set by statute. A year and a half out from the earliest effective date—January 1, 2017—some states have already begun the planning and engagement process required as part of the waiver application. This article discusses possible waiver strategies aimed at exchange sustainability, coverage expansion, delivery system reform, and more. States have the option to make small, targeted fixes or bring more sweeping changes to their health landscapes. Though the application process is involved and states must still accomplish

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the aims of the ACA, 1332 waivers give them the opportunity to tailor the law to local politics, markets, and health systems.

Keywords waivers for state innovation, 1332 waiver, Affordable Care Act (ACA), state health reform

Overview

Last year, in the pages of this journal, John McDonough sparked a conversation around section 1332 of the Affordable Care Act (ACA). His analysis has become one of the most cited articles about section 1332's state innovation waivers, which he predicted would be "the law's biggest impact on state innovation" (McDonough 2014). And it's no wonder—1332 waivers have the power to bring sweeping changes to states' coverage landscapes, even potentially reaching into their delivery systems.

But how should states think about these new opportunities? Now, with several states actively pursuing 1332 waivers (Howard and Benshoof 2015) and the effective date in sight, we turn our attention to possible state approaches to these waivers. First, we will describe the timeline and role of the federal government and then the scope of 1332 waivers. Finally, we propose a new framework consisting of five overarching strategies for state consideration.

Minimal Federal Guidance

According to statute (42 U.S. Code 18052), 1332 waivers may take effect as early as January 1, 2017 (which is why they are also known as 2017 waivers). But the timeline is heavily dependent on both the applicant state and the federal government. States must adhere to a process laid out in regulation by the US Department of Health and Human Services (HHS) in 2012 (US Department of Health and Human Services 2012). This includes legislative authorization, stakeholder engagement, actuarial analysis, and more. In four states, legislatures are not scheduled to meet in 2016, lending more urgency to this year's sessions (Howard and Benshoof 2014).

HHS is expected to release additional guidance on 1332s.[1] Until then, though, states have only the statute and process regulations as formal signposts.

1. In July 2015, CMS created a resource hub for states, refreshing earlier process guidance and providing a central point of contact: www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html.

Even after potential guidance is released, most of the final details of 1332 proposals will be negotiated directly between a state, HHS, and the US Department of the Treasury. As a result, first-mover states will help frame the debate, as Arkansas did with its alternative Medicaid expansion model.

What Can and Cannot Be Waived

States can request waivers of four major provisions of the ACA—the individual mandate, the employer mandate, benefits and subsidies, and exchanges and qualified health plans (QHPs). They may not waive fair-play provisions such as guaranteed issue, the requirement that insurers take all qualified applicants. For states, the bedrock appeal of 1332 waivers is the financing. They can cash out the value of federal spending on tax credits and cost-sharing reductions (CSRs) and redirect those funds toward an alternative affordability framework.

However, a 1332 waiver is not a "get out of ACA free" card—waiving one or more of the pillars does not exempt a state from accomplishing the goals of the ACA. It must still cover a comparable number of people, offer coverage that is at least as affordable and comprehensive as traditional implementation, and crucially, not increase the federal deficit. Thus, if states wish to increase spending in a particular area, they must also come up with an offset in another area, whether through increased state spending or decreased federal spending.

In theory, any state could craft an acceptable waiver application by staying within these critical guardrails. Practically, however, states relying on the federal marketplace portal are at a distinct disadvantage (this group includes supported state-based marketplaces, partnerships, and federally facilitated marketplaces). For now, HealthCare.gov is one size fits all and is unable to accommodate customized state-by-state tweaks to eligibility and enrollment mechanisms that could underpin a state's innovation waiver.

Waiver Strategies

Due to wide variation across states—in terms of regulatory responsibility, market size, and much more—they may have very different priorities for their waiver applications. Broadly, we see five possible approaches.

1. Expand the Enrollment Base to Promote Sustainability

Low-population states and others with small individual markets are still determining the best way to ensure ongoing sustainability of their new exchanges.

One strategy could be to expand the base of enrollment. For example, states could bring in new groups to the exchange, such as state government employees, in order to boost the number of covered lives (Bachrach, Ario, and Davis 2015). Or states could open up their exchanges to more immigrants (currently, certain groups of immigrants are allowed to purchase QHPs on exchanges and receive tax credits and cost-sharing reductions, while other groups are barred from access).

States seeking to attract higher-income young adults, who may not be as likely to sign up as other populations (Mangan 2015), may consider appealing to them with high-deductible, low-premium plans with savings accounts (Bachrach, Ario, and Davis 2015). More healthy enrollees lead to lower premiums for everyone, which in turn strengthens the stability of the exchange.

Finally, states could turn to individuals who would otherwise be eligible for the new Medicaid expansion. Indeed, Arkansas may seek to maintain its alternate expansion through a 1332 waiver, gaining additional advantages that an 1115 waiver alone cannot provide (Wheaton and Pradhan 2015). Enrolling healthy individuals below 138 percent of the federal poverty level (FPL) into QHPs could be particularly well suited for a state-based marketplace (SBM), helping to satisfy self-sustainability requirements by increasing economies of scale.

2. Streamline Operations

While the previously discussed pathways to sustainability centered on expanding the base of enrollment for exchanges in order to ensure sufficient funding for robust operations, some states may not have the ability or the will to add new groups, and instead could seek to attain sustainability by slimming down their exchanges.

States with overly high per-member spending could use their existing SBM platform only for comparison shopping and local customer service, while forgoing the typical attribution and calculation of the advanced payment of premium tax credits (APTC). Instead, as Hawaii is considering (Hawaii State Innovation Waiver Taskforce 2015), health insurance carriers could work within state guidelines to provide affordable coverage directly, using a mechanism for determining eligibility different from the exchange-based infrastructure. Such a model could be run through the carriers themselves, the state Medicaid apparatus, or state tax departments.

Other options include waiving the requirement that the exchange operate a call center, often one of the biggest slices of the budget (Sun and Chokshi

2015). Some states may seek to dissolve their SHOP, the small business insurance exchange. And states could go so far as to eliminate their individual exchange infrastructure entirely and rely instead on an outside vendor (Bachrach, Ario, and Davis 2015).

3. Facilitate Delivery System Reform

Health care delivery, payment, and coverage systems are all intertwined, and tweaks to choice architecture and behavioral incentives in one area can have ripple effects in another. Some exchanges have begun exploring their leverage within coverage by publicly displaying the quality ratings for insurance plans. Yet many consumers do not fully understand these ratings or why they matter (McGee 2013).

With this in mind, exchanges could turn from the nudge to the hammer by linking APTC availability to quality scores. Under this scenario, individuals eligible for tax credits would be able to unlock their full benefit only by enrolling in a plan scoring high enough on the quality scale. This would push more people into high-quality plans and encourage more carriers to offer such plans, improving coverage and care across the health system.

States could promote better health and smarter utilization of health care services by reducing cost sharing for populations with serious health conditions. Recent studies show that high levels of cost sharing for the unhealthiest group of enrollees might actually cause harm, as well as fail to produce desired savings for public and private payers (Frakt 2015). Cost-sharing customization could fit with states' current efforts to provide high-quality care, keep costs in check, and keep their residents as healthy as possible.

Generally speaking, better alignment across programs and higher rates of coverage, both possible through 1332 waivers, can help states facilitate their desired delivery system reforms. That is also true of plan enrollment optimization, which we discuss next.

4. Enroll Consumers in Optimal Plans

Many states are still struggling to enroll their residents in plans that minimize out-of-pocket spending. As just one example, it appears that 77 percent of HealthCare.gov enrollees eligible for cost-sharing reductions ultimately enrolled in silver plans, the only way to receive this assistance, meaning that 23 percent left money on the table (Sprung 2015). So far such data are mostly unavailable for SBMs, but we do not expect their experiences to be substantially different.

CSRs can substantially diminish out-of-pocket spending for certain enrollees, extending the actuarial value (AV) of a silver plan from 70 percent all the way up to 94 percent at lower-income levels. However, the power of CSRs is dampened for individuals from 201 percent to 250 percent FPL—producing just 73 percent AV in silver. This small bump in assistance may not have been enough to persuade many from enrolling in bronze plans instead. Unfortunately, due to low levels of health insurance literacy (Levitt 2014), some enrollees were not familiar with the challenges attending a high deductible typical of bronze plans (Stiffler 2015). Others below 250 percent FPL may have spent more to obtain gold or platinum plans, not understanding the logic of how silver might be better (we have heard from exchanges that such confusion is not uncommon).

Using 1332 waiver authority, states could address one or all of these problems by (1) making coverage more appealing to the remaining uninsured, (2) increasing affordability for lower- and middle-income enrollees, and (3) minimizing the potential for enrollment in suboptimal plans. To accomplish this, a state could allocate a greater proportion of its tax credits to people more in need, reducing the amount available to those earning closer to four times the poverty line, the cutoff for APTC eligibility. They could also use that offset to enhance the power of CSRs for income levels where it is weakest.

To direct shoppers toward optimal plans, states could make the bronze tier unavailable below 201 percent or 250 percent FPL. Or they could go the other way, attaching CSRs to metal levels other than silver. Exchanges could offer more actuarial levels by calculating the subsidy formula, using the total cost of a policy instead of the premium only (Mayhew 2015).

However, behavioral research shows that more choice is not always better (Frakt 2013). Moreover, actuarial level, metal tier, and cost-sharing reductions do not interact intuitively. An exchange could scrap the metal system, where, confusingly, a silver plan is markedly more valuable than a gold plan for somebody near the poverty line and where a gold plan appears more inherently desirable than a silver plan in general (Ubel, Comerford, and Johnson 2015).

Instead, states could offer plans by a limited number of AV levels, bolstered by an out-of-pocket cost calculator. Most dramatically, an exchange could simply offer one option, whether that plan is sponsored by the state government or private carriers.

5. Smooth the Sharp Edges of the Law

The ACA's reforms touch a number of different federal programs and also create new ones, without perfect alignment around when and how

beneficiaries shift in and out. As a result, some transitions can be very detrimental to beneficiaries. For example, eligibility cliffs create unwanted incentives to limit income and unpleasant surprises for those whose income does increase (Sommers and Rosenbaum 2011). At some income levels, an additional dollar earned could result in hundreds or even thousands of dollars in additional out-of-pocket spending on coverage (Wu 2013).

As the Minnesota Department of Human Services (2015) wrote in its February 2015 report to the state legislature, a 1332 waiver could "reduce sharp differences in out-of-pocket costs as people move from one affordability program to another by creating one standardized sliding scale." States could use a 1332 waiver to ease the effect of transitioning eligibility from Medicaid to the marketplace and between subsidy levels on the marketplace, so that individuals and families experience a predictable, gradual phasing out of financial assistance.

Other misalignments within the law include differences in methods used to calculate income and define eligibility (Center for Budget and Policy Priorities 2014; Brooks 2014). Through 1332 waivers, states could use the same definitions and time frames in order to reduce administrative hassle and make the enrollment process much smoother for consumers and agencies alike.

Moving Forward

States that want to be operational on January 1, 2017, will need to be on a path by fall 2015. But given that the statute does not preclude multiple bites at the apple, states may want to pursue several 1332 waivers as their needs dictate. They may apply for smaller, simpler 1332 waivers at first and return with broader requests in the near future. Many of the targeted fixes in these broader strategic areas would work well as stand-alone reforms, though states could gain additional benefits by stacking them or combining them with other waivers and initiatives in order to harness the full potential of aligned coverage, payment, and delivery system reform.

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