

January 2017

MI

ISSUE BRIEF



STATE WAIVERS: A FEDERALIST RX FOR OBAMACARE ILLS

Yevgeniy Feyman

Adjunct Fellow

Contents

Executive Summary.....	3
Introduction.....	4
A Federalist Prescription for Health-Care Reform....	5
Conclusion.....	6
Endnotes.....	7

Executive Summary

The Trump administration and the majority Republican Congress have committed to repealing and replacing the Affordable Care Act (ACA). Part of their challenge during the transition will be dealing with the distortions that Obamacare has created and doubled down upon health insurance and, indeed, the entire health-care system.

Luckily, the ACA does have a provision that can enable states, in tandem with the federal government, to partially work through the transition while moving the country toward a health-care system that offers more choices and competition and is more affordable. Recent legislation proposals correctly expand upon this provision by putting states at the forefront of an ACA replacement strategy.

Key Findings:

- Section 1332 of the ACA provides for “state innovation waivers” that allow states to waive many elements of the law, including the individual mandate and the law’s subsidy structure.
- If a waiver is granted, a state receives essentially a block grant of funding that it otherwise would have received through the waived element(s). The catch: the state must provide at least equivalent financial protection to individuals, cover at least as many people as the ACA would, and be “deficit neutral.”
- 1332 waivers alone cannot replace the ACA, but in tandem with parallel waiver provisions in the Medicaid program, they can help usher in a replacement that will rebalance state and federal government power.



Introduction

The incoming Trump administration and the new Republican Congress are committed to repealing and replacing the Affordable Care Act (ACA). The details will be complicated, and Congress will have to carefully consider how to address the ACA's ongoing failures while moving toward a more stable health-care system.

Making this transition easier is a provision in the ACA itself. The law provides a basic (through restrictive) framework for giving states more flexibility to manage their health-care dollars and tailor interventions to their populations. Republicans can build on Obamacare's real coverage gains while offering a superior framework for patient and consumer choice, competition, and affordability. In fact, the key to transforming health care is to give states greater control over federal health-care subsidies—and even expand that flexibility into other federal funding streams.

The ACA represented a large expansion of federal authority of health care. Nevertheless, several key provisions rely on states, localities, and nongovernment entities for implementation. The exchanges, for instance, could be run by states instead of by the federal government. The expansion of Medicaid is entirely contingent on decisions by the states. Even some provisions unrelated to insurance expansion (such as providers setting up or joining Accountable Care Organizations) are voluntary and are subject to various local regulations and adoption.

The ACA also built on the success and popularity of so-called 1115 waivers, which allow states to waive or modify provisions of the Medicaid program (such as income eligibility thresholds), subject to various restrictions, including deficit neutrality. The ACA introduced “state innovation waivers” (or 1332 waivers, named after the section of the law that created them), which allow states to waive many elements of the law, including the individual mandate and the law's subsidy structure.¹ The law also makes provisions for a single review process for these waivers and new 1115 waivers.

In exchange, states receive essentially a block grant of money that they otherwise would have received through the waived mechanisms. For instance, waiving the law's subsidy structure entitles a state to subsidies that its individual citizens would otherwise receive. The key is that alternative coverage must provide at least equivalent financial protection (in terms of minimizing out-of-pocket health-care expenditures) to such individuals and must cover at least as many people as would the ACA without the waiver.

Obamacare waivers have been floated as vehicles for ideas ranging from single-payer reforms² to private insurance for individuals eligible through the ACA's Medicaid expansion.³ Reforms that take a consumer-directed approach would typically require a combined 1115/1332 waiver that offsets spending on one population (likely the Medicaid population) with lower spending on the other (the exchange population).

Intuitively, this latter approach should never have been a major question. After all, both waivers require deficit neutrality, and a program that relies on both waivers to avoid increasing the federal deficit should be evaluated on its overall effect on the federal budget. But guidance from the Centers for Medicare & Medicaid Services and the Department of Health and Human Services (HHS) and the Treasury⁴ limited the scope of these waivers. One waiver's effect on the deficit, according to the guidance, would not be considered when evaluating another waiver's effect. With this guidance, 1332 waivers became much less attractive to Democratic- as well as Republican-led states.

A Federalist Prescription for Health-Care Reform

Before the 2016 election, making changes to 1332 waivers to override poorly designed guidance or to amend bad legislation was largely a nonstarter. A new administration can rewrite guidance for the implementation of 1332 and 1115 (Medicaid) waivers.

This will not by itself cure the problems of the Affordable Care Act; Congress would need to pass a full replacement. Nevertheless, as repeal-and-replace efforts move forward, one idea should have bipartisan appeal: different states should have the freedom to pursue different strategies that might better suit the needs of their residents. While there needs to be appropriate reporting requirements and congressional oversight to ensure that vulnerable populations are protected, states should be allowed to have greater control of federal subsidies encouraged to undertake more ambitious state-level health-care reforms.

There are important steps that regulators and policy-makers can and should immediately take to unshackle the short-term waiver environment:

1. Undo the Obama administration's guidance on commingling 1332 and 1115 funding. Perhaps the most important step is to make clear to states that the administration will be agnostic about how deficit neutrality is achieved, so long as it is achieved across federal funding streams. This means that the various agencies responsible should explicitly acknowledge that for the purposes of 1332 and 1115 waivers (and any other potential waivers) that are submitted for approval in tandem, deficit neutrality will be evaluated across all waived programs.

This step can be achieved by a new guidance, although a lasting change to restore more power to the states would require federal legislation.

Importantly, new guidance within the ACA's mandates regarding deficit neutrality should clarify that there will be some flexibility in exchange for coverage gains. For instance, a state that replaces the individual mandate with an auto-enrollment approach (where individuals are automatically enrolled into a health-insurance plan and must actively opt out if they choose to) may lead to less funding for the federal government in the form of penalty payments by uninsured individuals. States should be held harmless in these situations, whereby the state's waiver proposal would not be rejected simply because it *increases* the number of individuals with health insurance.

2. Develop standardized waivers for fast-track approval. An oft-raised concern regarding Medicaid's 1115 waivers was that the Obama administration did not always negotiate in good faith and often took a long time to evaluate waiver proposals. To improve predictability for states, HHS should develop standardized waiver frameworks for states that have clear guidelines as to how deficit neutrality, cost, and coverage requirements will be evaluated. As long as these requirements are met, approval will be fast-tracked.

For instance, if a state chooses to expand Medicaid, the coverage for individuals above 100% of the federal poverty level and below 138% (the ACA's limit) could be provided on the individual market, through private health plans. This would likely require a combination of an 1115 and 1332 waiver, as health insurance for the Medicaid-eligible population under the ACA may cost more on the private market than under conventional Medicaid. However, a state might reduce subsidies for other enrollees (those above 138% of the federal poverty level) in the individual, non-Medicaid market (in a way that didn't affect enrollment) to offset that increased cost. For instance, reducing subsidies to those who already receive relatively little assistance (those between 300% and 400% of the federal poverty level) would likely have little effect on total enrollment.

A standardized 1332 waiver that replaced the individual mandate with auto-enrollment or a continuous coverage requirement⁵ could also be offered as an option for fast-track approval.

3. Permit 1332 waivers to waive a greater share of ACA's regulations. This change does require legislation, and such legislation should be a priority. The existing framework permits states to waive the individual and employer mandates, benefit and subsidy structures, and exchange regulations. However, employer-market reforms (such as those that ban lifetime and annual limits on coverage and, by extension, prohibit employers from contributing to individual-market health-care coverage for their employees) and requirements that restrict how much insurers can vary their rates by age cannot be waived by administrative action. All these regulations should be on the table for states to waive.

A reform that enables such waivers would permit insurers to offer plans that are less expensive to younger, healthier individuals on states' exchanges. This would, in turn, lead to healthier and more stable risk pools that keep premium growth slower and encourage insurers to remain in the market. In a similar vein to the ACA's 1332 waivers, the Patient Freedom Act of 2017, recently released by Senators Bill Cassidy, Susan Collins, Shelley Moore Capito, and Johnny Isakson, takes a state-focused approach to replacing the ACA by devolving decisions regarding the future path of health insurance to the states.

Conclusion

While addressing overarching flaws in the ACA at a federal level is the ultimate goal, Congress should remember that there are 50 states whose elected officials and electorates have varying policy preferences and local challenges. In short, what works for one state may not work (or be appropriate) for another. Bundling and block-granting funding streams for Medicaid and private insurance that are currently separate should garner immediate bipartisan support.

Longer-term, the one-size-fits-all approach to federal programs is ill suited to a federalist system of government. Instead, block grants should encompass a growing share of federal funding to states to help address their needs.

Endnotes

- ¹ Patient Protection and Affordable Care Act, Public Law 111-148, U.S. Statutes at Large 124 (2010).
- ² Vermont's abortive attempt to establish a single-payer system would have partially relied on 1332 waivers as a funding mechanism. Notably, this approach failed after estimates of needed tax revenue became politically unrealistic.
- ³ Rachel Dolan, "Medicaid Private Option for All?" Health Affairs Blog, July 2, 2015.
- ⁴ Department of the Treasury and Department of Health and Human Services, "Waivers for State Innovation," Federal Register 80, no. 241 (Dec. 16, 2015): 78131.
- ⁵ A continuous coverage requirement would maintain protections against risk-rating for individuals with preexisting conditions only if they maintain continuous health-insurance protections. Economically speaking, this approach is a bigger "stick" than the current individual penalty for not carrying health insurance.