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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 waiver, 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 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

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**

1115 waivers. Using these waivers, a state could address the access and affordability needs of its residents through strategies such as modifying eligibility criteria, expanding benefits, or easing requirements for remaining eligible.

ACA Section 1332 Waivers

The ACA aims to make affordable health insurance available to as many people as possible. To reach that goal, the law sets out a structure of marketplaces, benefit plans, subsidy schedules, and individual and employer obligations. The ACA also builds in opportunities for states to be flexible with that structure, including a broad State Innovation waiver.

The State Innovation waiver is described in Section 1332 of the ACA.¹ Beginning in 2017, an ACA Section 1332 waiver would allow states to opt out of requirements regarding any of the following:

- The creation of health benefit marketplaces (i.e. in Connecticut, Access Health CT);²
- The establishment of qualified health plans that meet certain standards and are available for purchase in the marketplaces;³
- Federal subsidies, in the form of cost sharing reductions and premium tax credits, for eligible individuals purchasing qualified health plans in a marketplace;⁴ and
- The requirement that most individuals purchase or otherwise secure coverage and that employers of a certain size either offer coverage to their employees or contribute to a subsidy fund.⁵

Each of these is a fundamental element of the coverage expansion section of the ACA. That the law allows them to be waived indicates openness to state experimentation with alternative solutions.

Section 1332 of the ACA requires the United States Secretary of Health and Human Services to coordinate the waiver process. A state may submit a single application for waivers of the ACA and the Medicare, Medicaid and Children's Health Insurance Program (CHIP) laws (described in the next section). Acceptance of one coordinated waiver application would allow a state to craft its public health coverage as a coherent whole and may simplify the process of making the case for federal deficit neutrality, a critical component of any waiver process.

Medicaid Section 1115 Waivers

Federal law requires a state to have an approved Medicaid state plan to operate its Medicaid program. A state plan includes income and asset eligibility standards, required and optional benefits, application and redetermination processes, methods for paying providers, and more. States are required under federal Medicaid law to make program services available statewide and not offer different services for people with specific diagnoses or conditions. Section 1115 of the Social Security Act allows states to waive some of the federal requirements placed on states.

Although Medicaid Section 1115 waivers have become a basic policy tool for many states' Medicaid programs, there is little formal guidance regarding what may be waived under Section 1115. The statute simply says that the Secretary of Health and Human Services "may waive compliance with *any of the requirements of section ... 1396a* [the Medicaid state plan]" if, in the judgment of the Secretary, doing so is "likely to assist in promoting the objectives" of the program.⁶ Using an 1115 waiver, states have:

- Increased income eligibility limits for Medicaid;
- Expanded eligibility by creating new eligibility categories for people with certain health conditions or demographic characteristics;
- Added benefits or a specialized care delivery model for a specific population of recipients;
- Launched a pilot program in just one area of the state;
- Promoted care coordination using closed or narrow networks; and
- Experimented with varying levels of premiums and cost sharing for enrollees.

Section 1115 waivers: Some state examples

Massachusetts has had a comprehensive Medicaid waiver in place since 1997; it governs eligibility and services for most of its non-elderly members. This waiver was the engine for several waves of coverage expansion, brought additional financial support to safety net providers, and was the vehicle for implementing key provisions of the state's 2006 reform law, including the premium subsidies that became the model for the Affordable Care Act.

Rhode Island's Global Consumer Choice Waiver, now known as the Rhode Island Comprehensive Demonstration, governs its entire Medicaid program. The state agreed to a firm cap on total federal Medicaid contributions over the term of the waiver, in exchange for broad flexibility in designing the program and delivering services.

Arkansas's Private Option Demonstration allows the state to use Medicaid funds to provide assistance to adults who were made eligible by the ACA's Medicaid expansion to purchase a private Qualified Health Plan through the state's marketplace.

Sources:

MA: Stephanie Anthony et al., *The MassHealth Waiver: 2009-2011... and Beyond*. Massachusetts Medicaid Policy Institute, February 2009.

RI: Rhode Island Comprehensive Section 1115 Demonstration Fact Sheet, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-fs.pdf> (accessed 7/30/15);

AR: Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration Fact Sheet, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-fs.pdf> (accessed 7/30/15).

Section 1115 waivers can be comprehensive, encompassing most or all of a state's Medicaid population. They can also focus on particular groups, such as people with HIV/AIDS, pregnant women, or unemployed childless adults. There are 56 Medicaid and CHIP Section 1115 waivers currently approved nationwide. Forty-three states plus the District of Columbia have Medicaid and CHIP 1115 waivers in effect or pending approval. Connecticut does not have a Medicaid or

CHIP Section 1115 waiver, though it has executed some expansions through its Medicaid state plan.*

How Waivers Work

When pursuing waivers, states must work within certain constraints outlined in federal law. Each waiver comes with its own requirements.

Approval Process and Criteria: ACA Section 1332 Waivers

Section 1332 gives discretion to the Secretary of the U.S. Department of Health and Human Services (DHHS) to approve or reject a state's Innovation waiver application. In the case of waivers for tax credits or the individual and employer mandates, the Secretary of the Treasury also must approve the waiver. While the language in the ACA allows for the possibility of broad experimentation, it is not without limits. A state must demonstrate to the federal agencies that its plan will:

- Provide coverage that is at least as comprehensive as the essential health benefits under the law;
- Provide coverage that is at least as affordable as what the subsidies and cost sharing protections under the law provide;
- Cover a comparable number of people; and
- Not increase the federal deficit (the "deficit neutrality" requirement).

Approval Process and Criteria: Medicaid Section 1115 Waivers

The DHHS Secretary must approve Medicaid Section 1115 waivers as well. In practice, the Centers for Medicare and Medicaid Services (CMS) reviews waiver requests on the Secretary's behalf and conducts extensive negotiations with a state before granting approval. The main criterion for approval is that the demonstration promotes the objectives of the Medicaid program, giving CMS wide latitude in approving waivers. Though budget neutrality (see below) is not technically required by law or regulation, it has become a standard requirement of all 1115 waivers.

Timing: ACA Section 1332 Waivers

ACA Section 1332 waivers may take effect starting on January 1, 2017.⁷ We expect the waiver design and approval process will take many months or even years, based on Medicaid Section 1115 and other waiver experiences. Section 1332 waivers may be granted for an initial period of up to five years, with subsequent extensions possible.

Timing: Medicaid Section 1115 Waivers

Medicaid Section 1115 waivers can begin at any time. As mentioned above, Medicaid waivers take many months or even years to prepare the application, negotiate with federal agencies, and gain approval. Like ACA Section 1332 waivers, Medicaid Section 1115 waivers may be granted for an initial period of up to five years, with subsequent extensions possible.

Financing: ACA Section 1332 waivers

A state may choose to design its Section 1332 waiver so that individuals and small employers

* Connecticut also has 10 waivers under Section 1915(c), which allows states to provide long term services and supports in the home or community to individuals who are eligible to receive care in an institutional setting.

do not receive subsidies through the mechanisms established in the ACA (tax credits and cost sharing reductions). In that instance, Section 1332 directs the federal government to pay the state the amount that would have been paid for these subsidies. There is no information yet about how the federal pass-through of subsidies would be calculated, nor are there specifics of how deficit neutrality will be evaluated.

Medicaid Section 1115 waivers

The constraining element in Section 1115 waivers is budget neutrality: federal expenditures in a waiver demonstration may not exceed what they would have been absent the waiver.

Demonstrating compliance with this constraint requires a calculation based on hypotheticals and projections. The state and federal negotiators project what Medicaid spending would be without the waiver (the “without waiver base”). Federal spending with the waiver must be at or below the without waiver base.

Details of the budget neutrality calculation are at the heart of negotiations between a state and DHHS over a waiver, as the parties discuss what should be included in the base, at what trend rate spending should be projected into the future, and how the state will reallocate funds or realize savings to pay for expansions in the demonstration proposal. The DHHS Secretary, represented by officials from CMS, has broad discretion in granting waivers, and negotiations can become lengthy and very technical. The federal Office of Management and Budget (OMB) usually advises CMS on budget neutrality issues. There are often political elements to the negotiations, and CMS may introduce its own policy objectives into the process as well.

A Note on Budget Neutrality and Provider Payment Rates (Medicaid Section 1115 Waivers)

The budget neutrality cushion is the difference between “without waiver” projected spending – also called the budget neutrality ceiling – and projected spending with the waiver in place. When there is a cushion, the state may ask in the waiver negotiations to apply it to program innovations the state may want to include in the demonstration.

“Without waiver” spending is calculated as the product of total member months enrolled for a base population (that is, those who are eligible for Medicaid without a waiver) and per-member-per-month (PMPM) spending for the base population. These factors are projected from a base year into the future using a trend based either on historical program enrollment and costs, or on the underlying Medicaid growth rate in the President’s federal budget proposal (whichever is lower).* The trends are intended to account for population growth and price increases over the life of the waiver.

Other things being equal, a higher “without waiver” base allows for a larger budget neutrality cushion. Changes in payment rates to Medicaid providers made while a waiver is in effect would apply to both the without waiver and with waiver populations and would therefore not affect budget neutrality.

* Anthony, Stephanie, Robert W. Seifert and Jean C. Sullivan. The MassHealth Waiver: 2009-2011 ... and Beyond. Massachusetts

Public Input: ACA Section 1332 Waivers

Successful design and execution of a health care reform initiative requires the measured input of parties that will be affected by the changes. In the case of public policy initiatives to make health care more affordable, these parties include (at a minimum) the low- and moderate-income individuals whose coverage and out-of-pocket costs would be affected; insurers, who have financial interests as well as expertise to contribute; health care providers, who have revenue and delivery system concerns; and government agencies that provide coverage and services to the target population.

The ACA acknowledged the importance of public input by including extensive requirements for public notice and comment in the Section 1332 waiver process. In their response to comments on proposed regulations, the Departments of Treasury and Health and Human Services refer to “the Secretaries’ desire to implement a state waiver process that promotes transparency, facilitates public involvement and input, and encourages sound decision making at all levels of government.”⁸ The 2012 regulations lay out a process for state public notice requirements “sufficient to ensure a meaningful level of public input for the application for a Section 1332 waiver.” The regulations require that a comprehensive description of the waiver proposal be made available; a public notice and comments period, and public hearings are also required. The regulations also mandate a federal public notice and approval process, allowing for a public comment period for completed waiver proposals that have been submitted to the federal government.⁹

Public Input: Medicaid Section 1115 Waivers

Prior to 2010, a recurring criticism of the Section 1115 waiver process was that there was not a formal application process or criteria for decision making, no guidelines for negotiation and deliberation or receiving public input, evaluating demonstrations, and so on.¹⁰ The ACA added Section 1115(d) to the Social Security Act to address these concerns. The law requires the Secretary to issue regulations ensuring meaningful public input into the development of state demonstrations and in the federal review and approval of state applications and renewals. It also requires periodic evaluations and implementation reports that include standards related to the goals of the demonstration, the demonstration’s impact on cost and coverage, and the state’s plans to ensure compliance with Medicaid law. These regulations were issued in February 2012; all demonstration applications and renewals are now subject to these rules.¹¹

Conclusion

ACA Section 1332 and Medicaid Section 1115 waivers can be powerful tools for improving care and containing costs in a state’s health care system. In designing their waiver strategy, policy makers should consider what aspects of the law may be waived; criteria and process for approval; timing of the waiver approval process; financing; and public input requirements.

Endnotes

¹ ACA § 1332, 42 U.S.C. 18052

² Part II of subtitle D of Title I of the Affordable Care Act.

³ Part I of subtitle D of Title I of the Affordable Care Act.

⁴ Section 1402 of the Affordable Care Act and Section 36B of the Internal Revenue Code of 1986, respectively.

⁵ Sections 5000A and 4980H of the Internal Revenue Code of 1986, respectively.

⁶ Section 1115 of the Social Security Act, 42 U.S.C. 1315

⁷ ACA § 1332(a)(1), 42 U.S.C. §18052(a)(1)

⁸ 77 Fed. Reg. 11707 (February 27, 2012)

⁹ 31 C.F.R. §§ 33.112 - 33.116

¹⁰ One example of multiple critiques is in U.S. Government Accountability Office (2013). Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency.

¹¹ 42 C.F.R. §§ 431.400 - 431.428

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