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Medicare and Medicaid Programs; Guidance on Section 1332 Waivers for State Innovation, Comments Due

Section 1332 of the Patient Protection and Affordable Care Act (ACA) provides the Secretary of Health and Human Services and the Secretary of the Treasury with the discretion to approve a state's proposal to waive specific provisions of the ACA (State Innovation Waiver), provided the proposal meets certain requirements. State Innovation Waivers are available for effective dates beginning on or after Jan. 1, 2017, and may be approved for periods up to five years and can be renewed.

A State Innovation Waiver must meet four requirements:

1. Provide coverage to a comparable number of residents of the state as would be provided absent the waiver;

2. Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided absent the waiver;

3. Provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and

4. The proposal will not increase the Federal deficit.

The Secretaries reserve the right to suspend or terminate a waiver (in whole or in part) any time before the date of expiration if the Secretaries determine that the state materially failed to comply with the terms and conditions of the waiver.

A state is required to provide actuarial analyses and actuarial certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to support the state's estimates that the proposed waiver will comply with the requirement. **The Departments did not request comments on this Guidance.**

Key Provisions:

Coverage: To meet the coverage requirement, a comparable number of state residents must be forecast to have coverage under the waiver, as would have coverage absent the waiver.

Coverage refers to minimum essential coverage (if the individual shared responsibility provision is waived under a State Innovation Waiver, to something that would qualify as minimum essential coverage but for the waiver).

Coverage condition generally must be forecast to be met in each year the waiver would be in effect. Assessment of whether the proposal covers a comparable number of individuals takes into account the effects across different groups of state residents, especially vulnerable residents (low-income, elderly, and those with or developing serious health issues). Analysis of whether the coverage requirement is met takes into account whether the proposal sufficiently prevents gaps/discontinuations of coverage.

Affordability: To meet the affordability requirement, health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver.

Affordability refers to state residents' ability to pay for health care, and may generally be measured by comparing residents' net out-of-pocket spending for health coverage and services to their incomes.

Out-of-pocket expenses include both premium contributions (or equivalent costs for enrolling in coverage), and any cost sharing such as deductibles, co-pays, and co-insurance associated with coverage. Spending on health care services not covered by a plan may also be considered if they are affected by the proposal.

The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. The condition generally must be forecast to be met for each year waiver applies. Waivers will be evaluated not only based on how they affect affordability on average, but also on how they affect the number of individuals with large health care spending burdens relative to their incomes. Evaluation of waiver will consider the effects across different groups of state residents—in particular, vulnerable residents. Reducing affordability for vulnerable groups would cause a waiver to fail this requirement—even if the waiver maintained affordability in the aggregate.

A waiver would also fail the affordability requirement if it reduces the number of individuals with coverage that provides a minimal level of protection against excessive cost sharing. Specifically, a waiver that reduced the number of people with insurance coverage that provides both an actuarial value equal to or greater than 60 percent and out-of-pocket maximum that complies with section 1302(c)(1) of the ACA would not satisfy this requirement.

The waiver application must include information on estimated individual out-of-pocket costs by income, health status, and age groups, absent the waiver and with the waiver. Among such information should be the expected changes in premium contributions and other out-of-pocket costs, and the combined impact of changes in these components. The application should also identify any types of individuals for whom affordability of coverage would be reduced by the waiver.

Comprehensiveness: To meet the comprehensiveness requirement, health care coverage under the waiver must be forecast to be at least as comprehensive overall for residents of the state as coverage absent the waiver.

Comprehensiveness refers to the scope of benefits provided by the coverage, as measured by the extent to which coverage meets the requirements for Essential Health Benefits (EHBs) or Medicaid/CHIP standards as appropriate. Impact

on all state residents is considered, regardless of the type of coverage they would have absent the waiver.

Waiver must not decrease the number of individuals with coverage that satisfied the requirements of EHB, the number of individuals with coverage of any one category of EHB, or the number of individuals with coverage that includes services authorized under the state's Medicaid/CHIP programs.

As with the other requirements, assessment of whether the proposal meets the comprehensiveness requirement also takes into account the effect the proposal has on vulnerable residents.

Deficit Neutrality: Under the deficit neutrality requirement, the projected federal spending net of federal revenues under the waiver must be equal to or lower than projected federal spending net of federal revenues in the absence of the waiver.

The estimated effect on federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (excluding user fees) that would result from the proposed waiver.

Effect on federal spending includes all changes in Health Insurance Marketplace financial assistance and other direct spending, such as changes in Medicaid spending that result from the changes made through the State Innovation Waiver. Projected federal spending under the waiver also includes all administrative costs to the federal government associated with the waiver.

Waivers must not increase the Federal deficit over the period of the waiver (which may not exceed five years unless renewed) or in total over the 10-year budget plan submitted by the state as part of the State Innovation Waiver application. A waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement.

Other Provisions:

Impact on Other Program Changes: Assessment of whether a State Innovation Waiver proposal satisfies 1332's criteria takes into account the impact of changes to ACA provisions made by the waiver proposal.

Assessment does not consider the impact of policy changes that are contingent on further state action, such as legislation that is proposed but not yet enacted. Assessment does not include the impact of changes contingent on other federal determinations, including approval of other federal waivers. Savings accrued under either proposed or current 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed waiver meets the deficit neutrality requirement.

Funding Available to States: The amount of federal funding provided to states to implement their waiver is the Secretaries' annual estimate of the federal cost (including outlays and foregone revenue) for marketplace financial assistance provided pursuant to the ACA that would be claimed by participants in the Marketplace in the state in the absence of the waiver.

Operational Considerations: Certain changes that would affect the Federal-facilitated Exchange platform or the Internal Revenue Service administrative process may make a waiver proposal not feasible.

For example, waivers that would require changes to the calculation of Exchange financial assistance, nonstandard enrollment period determinations, customized plan management review options, or changes to the design used to display plan options are generally not presently feasible due to operational limitations. In addition, a waiver that would require the IRS to administer different sets of rules in different states would not be feasible.

States contemplating a waiver that requires operational changes may consider establishing their own platform administered by the state. States contemplating a waiver proposal that includes a modified version of a federal tax provision may consider waiving the provision entirely and relying on a tax program administered by the state.

Public Input on Waiver Proposals: A State Innovation Waiver must provide a minimum length of public notice and comment period of at least 30 days. Waiver applications must be posted online by the states in a manner that meets national standards to assure access to individuals with disabilities.

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