State innovation and Medicare expansion waivers: considerations for employers
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The Center for Consumer Information & Insurance Oversight — SECTION 1332: STATE INNOVATION WAIVERS,

Similar to the Section 1332 waivers, 1115 waivers

In order to finance the waivers, the federal

Ibid.

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Section 1332 of the ACA created a process whereby states could request a waiver of certain provisions under the ACA for plan years beginning after 1 January 2017. State Innovation Waivers must provide coverage to a comparable number of residents of the state, they cannot increase the Federal deficit, public input for the initiatives must be obtained and waivers are initially approved for five years. They must also contain a detailed list of provisions the state wishes to waive as well as the rationale and detailed analysis of the proposal, a 10-year budget plan, a copy of state legislation providing the state authority to implement the proposal and a detailed timeline.

Section 1332 does not change existing waiver authority for provisions in other federal health programs such as Medicaid or Medicare (including waiver authorities under Section 3021 specific to the Center for Medicare and Medicaid Innovation or under Section 1115 related to Medicaid and the Children’s Health Insurance Program (CHIP)), although states may apply for such waivers as part of the coordinated application process to be developed by the Secretary of Health and Human Services.

Section 1115 of the Social Security Act allows for the waiver of certain welfare programs and gives states the flexibility to improve Medicaid and CHIP while also promoting the objectives of these programs. Similar to the Section 1332 waivers, 1115 waivers are approved for a five-year period and are renewable. Section 1115 Demonstration Waivers, as they are called, can be narrow — focusing on specific services or populations or comprehensive. A comprehensive waiver more broadly impacts a state’s programs through changes in eligibility, overall benefits, cost sharing and provider payments. In order to finance the waivers, the federal Government enforces budget neutrality by placing caps on federal funds during the waiver period. States have a variety of reasons for seeking an 1115 waiver, including an expansion of Medicaid coverage or modifying their delivery systems.

Amid uncertainty over how insurance markets will be affected by a failure to repeal the Patient Protection and Affordable Care Act (ACA), state legislators are looking for long-term solutions. Even before the Senate’s rejection of a full repeal of the ACA, some states had already begun taking health care into their own hands. Anticipating a repeal of the employer mandate, some states proposed their own “pay or play” legislation, while others were considering single-payer systems.1 The American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA), as proposed, would have done more than reduce federal spending and roll back the Medicare program. Those bills also delegated to the states a significant amount of power and autonomy with respect to their health care programs. The BCRA called for a loosening of the statutory waiver requirements under the ACA that permit states to experiment with different health care coverage models. The State Innovation Waiver, allowable under Section 1332 of the Patient Protection and Affordable Care Act, encourages states to develop innovative strategies for their health care systems that take into account particular state circumstances while still satisfying the ACA’s mandate. The repeal-and-replace proposals would have provided states filing and implementing Innovation waivers with $26 billion in funding, as well as streamlined approval requirements for the Department of Health and Human Services (HHS), and unlimited renewals every eight rather than five years. Recently floated compromise proposals continue the theme of transferring more autonomy to the states. In addition to State Innovation Waivers, Section 1115 of the Social Security Act provides states with an opportunity to develop and test programs, generally under Medicaid, that are not otherwise permitted under federal law, provided the state meets certain requirements with respect to budget transparency and evaluation.

1 California, Wisconsin, Illinois


4 Ibid.
This summary aims to provide an overview of Section 1332 and Section 1115 waivers, including some market-based considerations as well as state waiver goals and the challenges with which they are confronted. For the time being, the ACA remains the law of the land, and employers must continue to comply with its requirements, such as the employer shared responsibility requirements and the IRS forms 1094 and 1095 reporting requirements. In separate letters dated March 2017, the Secretary of Health and Human Services highlighted both Section 1332 and Section 1115 waivers as opportunities for states to advance changes in their health care systems. Although they may provide states with the “flexibility to develop innovative healthcare models that will improve patient access to care, increase affordability and choices offered, lower premiums, and improve market stability,” waivers are not void of checks and balances. Despite the Administration’s favorable attitude toward the use of waivers (as reflected in the statements by Health and Human Services and provisions in the legislative proposals) to craft programs that reflect a state’s priorities, considerable emphasis is still placed on public involvement and the administrative process.

The HHS Secretary is given the authority to approve experimental, pilot or demonstration projects that promote the objectives of Medicaid or CHIP under Section 1115 of the Social Security Act 42 USC Section 1315. The purpose of granting this flexibility is to demonstrate and evaluate policy approaches such as expanding eligibility to individuals not otherwise eligible for Medicaid or CHIP; providing services not typically covered or using innovative service delivery systems that improve care, increase efficiency or reduce costs. The demonstrations must be “budget-neutral” to the federal Government.

With the ACA’s expansion of Medicaid, several states used 1115 waivers to expand in nontraditional ways. For example, six states[6] that expanded Medicaid required some form of premium or monthly contribution to enroll in coverage. Some states used the expansion funds to provide premium assistance to lower-income individuals to purchase coverage in the state’s ACA Marketplace and/or employer-sponsored coverage. Some of the states used the waivers to charge premiums to the expansion population beyond what is otherwise permitted under federal law.

On 13 March 2017, then-HHS Secretary Thomas Price wrote governors to indicate that his agency was committed to improving the ACA-expanded Medicaid through swifter processing of waiver applications, using Section 1115 demonstrations to approve “meritorious innovations that build on human dignity that comes with training, employment and independence,” and aligning Medicaid and private insurance policies for non-disabled adults (by, for example, implementing cost-sharing models). These expanded authorities have encouraged several states[7] to seek waivers adding work requirements for non-disabled adults. Such waivers had been denied in the past by the Obama Administration but look to be approved under the current Administration’s loosened requirements. On 7 November 2017, Seema Verma, the Administrator of the Centers for Medicare and Medicaid Services (CMS), in a speech before the National Association of Medicaid Directors, signaled that CMS would now be open to the approval of such waivers.

“The ACA moved millions of working-age, non-disabled adults into a program that was created to care for seniors in need, pregnant mothers, children and people with disabilities, stretching the safety net for some of our most fragile populations, many of whom are still on waiting lists for critical home-care services while states enroll millions of newly-eligible able-bodied adults. The ACA also gave states a higher federal reimbursement than they do for our most vulnerable citizens. If the match rate is a reflection of the value we place on caring for our neediest citizens, this is backward. While many responded to this expansion with celebration, we shouldn’t just celebrate an increase in the rolls, or more Medicaid cards handed out. For this population, for able-bodied adults, we should celebrate helping people move up, move on and move out. We have a moral responsibility to do more than just give them a card, we have a responsibility to give them care.”[8]

Additional new waiver requests include a monthly income verification to prove ongoing eligibility, a lockout for failure to promptly renew and, even, drug testing. Most of these variations are aimed at the expansion populations (i.e., those with income that permitted them to enroll in Medicaid with the expansion of eligibility to 138% of the federal poverty line).


Encouraging expansion waivers under the current Administration

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State innovation waivers

address a top priority

On 13 March 2017, then-Secretary Price again addressed governors in a letter discussing President Donald Trump’s January 20 Executive Order aimed at minimizing the national economic burden of the ACA and encouraging states to utilize Section 1332 waivers. To date, only three state innovation waivers have been approved (Hawaii, Alaska, and Minnesota).

The first state innovation waiver was approved on 30 December 2016, for the state of Hawaii under the Obama Administration. In its waiver request, Hawaii sought a waiver from hosting or participating in a Small Business Health Options Program (SHOP) exchange. Since 1974, Hawaii has required employers to provide health insurance for their employees and dependents under the Hawaii Prepaid Health Care Act. Many provisions required under Hawaii law, such as the number of hours to be deemed eligible for coverage and the maximum employee contributions employees allowed were more conservative then permitted under the ACA. As such, the Hawaii waiver was approved.

The approach taken by Alaska has become a model for other states. Faced with a 42% increase in individual health insurance premiums for 2017, Alaska created the Alaska Reinsurance Program (ARP) to help stabilize the individual market. Initially, this program was funded by the State Legislature assessment on all health insurers and covered claims for individuals diagnosed with one or more of 33 conditions. As a result, the individual premiums increased 7.3% instead of 42.8%. Given the success of the program, Alaska applied for and was granted a state innovation waiver on 7 July, 2017 for 2018-2022. Alaska projected what the federal government would have spent in Advances Premium Tax Credits absent the reinsurance program and requested the projected savings to help fund the reinsurance program. It is anticipated the additional funding will further stabilize the individual health insurance market by continuing to lower premiums and allow for more individuals to obtain health insurance coverage.

After the Alaska approval, Section 1332 waivers containing reinsurance programs aimed at stabilizing premiums in the individual insurance market have been submitted by Iowa, Minnesota, Oklahoma and Oregon. The Minnesota Waiver was approved on 22 September 2017, but with less federal funding than the state had requested. At the time of this as this writing, the Governor of Minnesota has appealed the decision and the future of the program is unclear. Oklahoma submitted a waiver application on August 18 with a request for an expedited approval by September 25 for a program to take effect 1 January 2018. The public comment period was open until September 23. As of September 29, the waiver had not been approved, so Oklahoma withdrew its application. The application for Iowa, submitted in August 2017, was similarly withdrawn in October. The application for Oregon, also submitted in August 2017, to waive the ACA’s single-risk-pool requirement in order to set up a reinsurance program in the state with the goal of reducing premiums for individual market enrollees was approved by CMS in October. However, the Oregon waiver was approved on 18 October 2017.

On 8 September 2017, citing the uncertainty of the federal Government continuing the Cost Sharing Reduction (CSR) payments, the state of Massachusetts submitted a 1332 application that establishes a premium stabilization fund in lieu of CSR payments. As outlined in the application:

“Under the waiver, CSR payments will be waived, and in their place the Commonwealth will stabilize premiums via direct issuer reimbursement, an approach that would eliminate the need for a rate revision and any related consumer-facing changes to coverage costs. Federal APTC/PTC savings that accrue due to the stabilization program will be shared with the Commonwealth in the form of “pass-through” funding to help pay for the stabilization program.”

On 23 October 2017, CMS ruled the Massachusetts application incomplete, as its comment period would extend beyond the beginning of open enrollment for 2018. As of this writing, there have been no additional state waivers approved, and on October 12, Trump announced that the federal Government would discontinue any future CSR payments to insurers.

For states that have yet to consider waivers as a means to align their Medicaid programs with private insurance policies, there is currently a national trend toward increased premiums and a palpable uncertainty about the future of the ACA’s individual mandate. The White House has been forthcoming with its desire to let the ACA fail rather than take action to reassure insurers and stabilize markets. Higher premiums seem to make sense to insurers who are confident there will be no enforcement of the individual mandate.

The current trend in legislative proposals toward state autonomy in health care markets is spurred, in part, by a desire to develop policies and programs that reduce the number of uninsured individuals. Medicaid covers nearly 70 million Americans, and the ACA has had the far-reaching effect of transforming the way states think about their Medicaid policy goals. That those that are weighing the pros and cons of improving or enhancing their Medicare programs are not only seeking to increase enrollment, they are looking to transform the delivery of health care and increase its value within their borders. Funding is also a consideration, as state total spending and Medicaid enrollment tend to reflect economic and policy changes. However, in states with ACA Medicaid expansions, federal support has allowed states to pursue innovative strategies without the same fiscal challenges of non-expansion states.

For a brief period this summer, it appeared as though every county in the country was set to have at least one health insurer on the ACA Marketplace. Consumers residing in counties without a Marketplace insurer are unable to purchase marketplace plans with premium tax credits (PTCs) and cost-sharing reduction subsidies (CSRs). Under the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, employer-provided group health plans are required to follow the ACA’s requirements that benefits not be subject to annual or lifetime limits. However, that provision only applies to those benefits defined as “essential health benefits.” Under Treasury regulations, essential health benefits (EHBs) are defined as “(c)of the EHB benchmark plans applicable in a State.”

State innovation and Medicare expansion waivers: considerations for employers

Market considerations

Under ACA regulations, there are 10 EHBs that apply uniformly throughout the country. Therefore, employer plans that offer any of those benefits may not put annual or lifetime limits on those benefits. However, the AHCA contained a provision by which a state could alter the EHBs in the state through a streamlined waiver process. If that or a similar provision were enacted, it could have repercussions for employers. If any state were to alter those required benefits, any large employer could choose that state as its benchmark. For example, if a state eliminated the requirement to provide maternity benefits, any employer could choose that state’s EHB benchmark for its plan. That in turn would permit the employer to apply annual and lifetime limits to the provision of maternity benefits in its plan. If a state were to eliminate all 10 EHBs, any employer plan could apply annual and lifetime limits to all benefits provided in its plan.

Just as every state is unique with varying health and welfare needs, so too are state waivers independently reviewed and approved based on the facts and circumstances presented in each application. However, there are some common features of Medicare waivers that states have adopted as they look to stabilize their respective health care markets. Specifically, the flexibility offered by sections 1115 and 1332 waivers to develop innovative health care solutions has prompted states to consider market-based features that promote individual responsibility and gradually decrease reliance on government programs. Waiver requests also commonly propose premium amounts, based on a sliding scale, that take into account incomes at or below the federal poverty level (FPL). A simplified application process and health savings accounts (HSAs) are also key components of many waiver requests, as states have shifted their focus toward preventative health care and discourage reliance on emergency facilities. In Oregon, emergency department visits and preventable hospital admissions have plummeted along with overall Medicaid spending as a result of a successful waiver program.21

Despite the common themes in waiver applications, state waivers will impact employers to varying degrees. Because waivers grant states greater flexibility to regulate health care, at least some states may require funding in excess of or to supplement federal assistance, including more state tax revenue from employers. Demands may also be placed on employers to report on certain members of its workforce. As of September 2017, six states, Arkansas, Indiana, Kentucky, Maine, Wisconsin and Utah, have pending Section 1115 waiver requests that would require employment as a condition for eligibility for some Medicaid-eligible employees. Further, some waiver requests seek eligibility and enrollment restrictions that include drug testing and benefit restrictions that would apply to populations beyond Medicaid expansion adults.22

Waiver requests that condition Medicaid eligibility on meeting a work requirement were previously unheard of but may be supported by then-Secretary Price’s March 17 letter, which relies on Section 1115 authority to approve proposals that require “training, employment, and independence.”23 Such proposals would generally predicate Medicaid eligibility on a beneficiary’s verified participation in approved activities, such as employment, job searches or job training programs, for a specified period of time, in order to qualify for health care coverage. Stakeholders will be watching to see whether CMS approves state requests containing work requirements, as doing so would indicate a major policy shift with respect to Medicaid’s general purpose of promoting health care coverage and access. For many employers, work requirements and other conditions for Medicaid eligibility could also mean increased reporting requirements, including mandatory employment verification and certification of job training, of which the quality and duration may be at issue.

In contrast with those states that are adding work requirements for individuals to be eligible for Medicaid, other states are looking to assess employers whose employees enroll in Medicaid or other public-provided coverage rather than employer coverage. Massachusetts recently enacted such legislation. A similar provision was introduced earlier this year in Oregon (SB 997) but as of this date has not made it out of legislative committee.

The Massachusetts provision enacted in the summer of 2017 provides that in 2018 and 2019 employers with at least five employees will be liable for this new assessment. The assessment will be applicable with respect to any non-disabled employee who receives health insurance coverage through MassHealth (i.e., Medicaid) or subsidized coverage through the ACA Marketplace in Massachusetts. The assessment will be 5% of the employee’s wages, up to a maximum of $750. The law provides that the state department of unemployment assistance, in consultation with the Division of Medical Assistance and the Commonwealth Health Insurance Connector Authority, will issue regulations to implement this provision. Therefore, it is unclear how burdensome the administration of this provision will be on employers. However, based on a study by the Kaiser Family Foundation, it would appear that the $750 maximum cost of the assessment will still likely be less than the cost that an employer would bear for providing coverage to an employee.

These requirements may result in financial impact for some employers who try to assist some of their employees in gaining coverage from governmental sources. In many instances, employees eligible for Medicaid or Tricare may find participation in these programs more cost-effective than options provided under employer-offered health coverage. As employers assess the implications of the Massachusetts provisions, they will undoubtedly also consider the benefit of having their employees covered along with the potential for improved health outcomes that could reduce employee absenteeism. Therefore, even though the states may start looking to assess employers whose employees are enrolled in public-provided coverage, it may still be an effective strategy for some to educate employees about public options that may be available to them.

Considerations for multistate employers

Multistate employers may find themselves in an interesting position when reviewing state-level healthcare reform. Whether a local health insurance marketplace is state-run or operated in collaboration with the federal Government, Multistate employers are likely to find themselves dealing with changes sparked by waivers on a state-by-state basis such as variations of the employer mandate and Medicaid eligibility. These changes would impact not only their health benefits and reporting requirements, but could also form the basis of business decisions impacting growth and expansion plans. Meanwhile, states with approved waivers must still offer solutions that meet the requirements of the ACA, including minimum essential coverage, affordability and budget neutrality. The bottom line is that each state in which an employer operates could require a different approach. Moreover, unionized workforces are likely to present unique challenges in those states with approved work requirements and certain eligibility and enrollment restrictions.

Ernst & Young LLP contacts

Ann Bradshaw
Partner
+1 713 750 4953
ann.bradshaw@ey.com

Alan Ellenby
Executive Director
+1 312 879 2468
alan.ellenby@ey.com

Belinda Sharp
Senior Manager
+1 965 405 8915
belinda.sharp@ey.com

Olivia Ybarra-Stoddard
Manager
+1 214 756 1458
olivia.ybarra@ey.com

Conclusion

States are increasingly looking to waivers as a means to expand or otherwise customize the ACA to best address their state’s unique circumstances. While there is still a great deal of uncertainty surrounding the individual market, states and employers will generally benefit from proposed measures to stabilize markets and combine programs that create innovative health care opportunities, as the number of states with pending 1332 and 1115 waivers is likely to continue to rise. The coming months will yield greater insight into the Trump Administration’s authority and agenda with respect to waiver approvals, including work requirements (which have been historically rejected) and other eligibility restrictions that are likely to shape future waiver application requests. As the health care landscape continues to shift and evolve beyond the current Administration’s term, the extent to which transparency, public input and evaluation provide the requisite checks and balances on potentially discriminatory programs is also likely to be challenged as states seek renewal of their waiver programs.
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