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Frequently Asked Questions About ACA Section 1332 Waivers and Medicaid

By Jessica Schubel

The Centers for Medicare & Medicaid Services (CMS) is encouraging states to use State Innovation waivers (known as “section 1332 waivers”) available under the Affordable Care Act (ACA) in conjunction with Medicaid waivers to change how they provide coverage to low- and moderate-income people.¹ This primer provides background on 1332 waivers, explains why they can’t be used to change Medicaid, and discusses alternative ways states can achieve some (though not all) of the goals they’ve identified for 1332 waivers.

Section 1332 Waiver Basics

What is a section 1332 waiver?

Section 1332 waivers, named for the section of the ACA that created them, allow states to modify how they implement key elements of the ACA and to adopt alternatives that depart from some of its standards and requirements, provided that they meet rigorous standards, or “guardrails.”

What are the requirements for a section 1332 waiver?

States must satisfy four guardrails specified in statute to obtain 1332 waiver approval. First, coverage must be “at least as comprehensive” as marketplace coverage. In addition, coverage and protections against excessive out-of-pocket spending under the waiver must be as affordable as marketplace coverage, and a comparable number of people must have coverage under the waiver as would have had coverage without it. Finally, the waiver can’t increase the federal deficit. Together, these guardrails ensure that waivers don’t leave state residents worse off than they would be without the waiver and don’t benefit a single state at the expense of increased federal costs.

Has the Trump Administration changed these requirements?

No. The four guardrails are laid out in statute and can’t be changed without new legislation. The Trump Administration did issue guidance that aims to change how the guardrails are interpreted,

¹ Centers for Medicare & Medicaid Services, “Speech: Remarks by Administrator Seema Verma at the CMS National Forum on State Relief and Empowerment Waivers,” April 23, 2019, <https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-cms-national-forum-state-relief-and-empowerment-waivers>.

weakening the coverage, affordability, and comprehensiveness tests compared to earlier guidance issued by the Obama Administration.² But to date, no waivers have been approved based on the revised interpretation of the guardrails, and such waivers could be challenged in court if they fail to meet the statutory requirements.

What can and can't be waived in a section 1332 waiver?

Under section 1332, states can waive some — but not all — of the ACA's marketplace coverage provisions. These include, for example: federal marketplace subsidies, essential health benefit requirements, minimum federal standards for marketplace plans, marketplace functions, and enrollment and claims data requirements.

Many important components of the ACA cannot be waived. For example, section 1332 waivers can't be used to waive the ACA's prohibition against insurers denying coverage or charging higher premium rates to people with pre-existing health conditions, its requirement to cover certain preventive medical care at no charge to enrollees, or its requirement to cover adult dependents up to age 26. Nor can a state use a 1332 waiver to eliminate an array of ACA provisions that bar discrimination against people based on health status, disability status, race, age, sex, or other factors.

Are states using section 1332 waivers?

Yes. Most states with approved 1332 waivers are using them to facilitate reinsurance programs, which aim to reduce premiums in the individual market by providing payments to health insurers to help offset the costs of enrollees with large medical claims.³ A few states are using section 1332 waivers for other purposes. For example, Hawaii is using a section 1332 waiver to forgo setting up a Small Business Health Options Program, the marketplace for small businesses otherwise required under the ACA. No state has yet to receive approval for a 1332 waiver making major changes to subsidy eligibility, benefit standards, or marketplace operations.

What is pass-through funding?

If a state's 1332 waiver is projected to reduce federal costs, then the state may be able to receive "pass-through" payments from the federal government up to the amount of the federal savings. Pass-through funding is limited to the amount of premium tax credits, cost-sharing reductions, and small-business tax credits that the federal government *would have* provided to the state's residents absent the section 1332 waiver, minus the amounts for those items that the federal government actually will provide. The federal government recalculates each state's pass-through funding annually, using the most up-to-date information available on enrollment, premiums, enrollee characteristics, and other factors. That means the amount of pass-through funding a state ultimately receives may be different from the amount it anticipated in its waiver application.

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² Sarah Lueck, "Commentary: Trump Administration Rules on Health Waivers Weaken Pre-Existing Condition Protections," Center on Budget and Policy Priorities, November 2, 2018, <https://www.cbpp.org/health/commentary-trump-administration-rules-on-health-waivers-weaken-pre-existing-condition>.

³ Sarah Lueck, "Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums," Center on Budget and Policy Priorities, April 3, 2019, <https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums>.

Can section 1332 waivers change Medicaid?

No. Section 1332 waivers are *not* “superwaivers”: they do not give states any new authority over Medicaid, the Children’s Health Insurance Program (CHIP), or Medicare. And while a state could submit section 1332 and Medicaid waiver applications simultaneously, the federal government will evaluate them independently, under the separate standards and requirements that apply to each type of waiver.

Moreover, states can’t use savings from section 1115 Medicaid waivers — named for the section of the Social Security Act that authorizes them — to meet 1332 waiver deficit neutrality requirements. States have expressed interest in calculating budget neutrality across Medicaid and 1332 waivers as a way, for example, to offset costs of a 1332 waiver with savings from a Medicaid waiver. But the 2018 Trump Administration 1332 waiver guidance reaffirms that the Administration will assess the 1332 deficit neutrality requirement without taking into account budget savings accrued under proposed or current Medicaid waivers.

What are some of the differences between 1332 waivers and Medicaid 1115 waivers?

There are many differences between the two waivers. First, the standards for approval are different. A Medicaid 1115 waiver can be approved if it is “... likely to assist in promoting the objectives of [Medicaid].”⁴ 1332 waivers are required to meet the four guardrails described above.

Related, the purpose of a Medicaid 1115 waiver is to serve as an experiment, pilot, or demonstration project that includes hypotheses to be tested and evaluated. Section 1332 waivers aren’t demonstration projects, and there’s no requirement for evaluations; instead, the state must provide actuarial and other analysis up front demonstrating that the guardrails will be met.

Additionally, the Health and Human Services (HHS) Secretary has authority to approve a Medicaid 1115 waiver, whereas a section 1332 waiver must be approved by the secretaries of both the Treasury Department and HHS. Finally, while both types of waivers require public comment at both the state and federal levels, there are key differences in the public comment process as well as application requirements, summarized in Table 1.

⁴ Recent federal court decisions affirmed that a central objective of the Medicaid program is to provide health coverage to low-income people.

TABLE 1

Comparing the Application Process for 1332 and Medicaid 1115 Waivers

Requirement	1332 Waiver	Medicaid Waiver
Application Elements	<ul style="list-style-type: none"> • Program description • Requested waiver authorities • 10-year budget plan (with supporting actuarial certifications and economic analyses) • Authorizing state legislation • Evidence that the waiver meets the coverage, affordability, and comprehensiveness guardrails • Explanation of waiver's effect on individuals, insurers, employers, other ACA provisions, and efforts against fraud, waste, and abuse • Evidence of compliance with public notice requirements • Reporting plans 	<ul style="list-style-type: none"> • Program description • Requested waiver and expenditure authorities • Financing and budget neutrality information • Description of proposed health care delivery system, eligibility requirements, covered benefits, and cost sharing • Estimated annual enrollment and spending with and without the waiver • Current enrollment data and enrollment projections with and without the waiver • Other expected modifications to Medicaid or CHIP • Description of research hypotheses that will be tested and plan to evaluate them • Written documentation of state's compliance with public notice requirements
State Public Comment Period	No less than 30 days	30 days
Number of State Public Hearings	No number specified	At least 2 hearings – one must be telephonic or have web capability
Timeline for Federal Government to Determine Application Complete	45 days from submission	15 days from submission
Federal Public Comment Period	No less than 30 days	30 days
Final Federal Determination	180 days from determination of complete application	No timeframe specified
Federal Department in Charge of Waiver Review and Approval	Department of Treasury and Department of Health and Human Services	Department of Health and Human Services

Can states use section 1332 waivers to substitute for Medicaid expansion?

In states that have not expanded Medicaid, adults with incomes above 100 percent of the poverty line can enroll in subsidized coverage through the ACA marketplaces. Those with incomes below 100 percent of the poverty line cannot, and they often fall into a “coverage gap,” ineligible for both Medicaid and marketplace subsidies.

Some states have talked about addressing their coverage gaps using section 1332 waivers as an alternative to Medicaid expansion. It’s not entirely clear what approach states are considering, but it might include extending federal subsidies to people with incomes below the poverty line to purchase marketplace coverage.

But such an approach likely couldn’t meet the 1332 guardrails. If a state sought to extend subsidies to people with incomes below 100 percent of the poverty line without making other changes, its proposal would run afoul of the deficit neutrality guardrail, since the federal government would be spending more than without the waiver. Meanwhile, if a state cut subsidies for people with incomes above the poverty line to pay for subsidies below 100 percent of the poverty line — especially subsidies robust enough to actually let low-income adults afford coverage — it would likely run afoul of the coverage and affordability guardrails, since many people with incomes above the poverty line who would have affordable coverage without the waiver would lose it.

Are section 1332 waivers a way for states to receive enhanced federal funding without fully expanding Medicaid?

Some states have sought to only partially expand Medicaid — limiting coverage to people with incomes below the poverty line, rather than up to 138 percent of the poverty line — while receiving the ACA’s enhanced federal matching rate for expansion (a 90 percent federal match, compared to standard match rates of 50 to 76 percent). CMS recently announced that it won’t allow states to receive the ACA’s enhanced federal matching rate for a partial expansion. Instead, states can only receive their regular Medicaid match for a partial expansion.⁵

Section 1332 waivers do not offer an alternative path for states to obtain the ACA enhanced match rate for partial expansion. To pursue this approach through a 1332 waiver, a state would need to take up the ACA’s expansion of Medicaid to qualify for enhanced match for those with incomes below the poverty line, then seek permission to move people with incomes between 100 and 138 percent of the poverty line into marketplace coverage instead. But such a proposal would fail the deficit neutrality guardrail, as confirmed in CMS’ recent letter to Idaho regarding its section 1332 waiver application.⁶ As CMS noted, marketplace coverage is more expensive than Medicaid coverage, and because the federal government pays the full cost of ACA marketplace subsidies but

⁵ Jessica Schubel, “Trump on Partial Medicaid Expansion: Right Decision, Wrong Reasons,” Center on Budget and Policy Priorities, July 30, 2019, <https://www.cbpp.org/blog/trump-on-partial-medicaid-expansion-right-decision-wrong-reasons>.

⁶ Centers for Medicare & Medicaid Services, “Determination of Incompleteness Letter to Idaho’s Department of Insurance,” August 29, 2019, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Idaho-Notice-of-Preliminary-Determination-of-Incompleteness.pdf>.

only 90 percent of the cost of Medicaid expansion, it would cost the federal government more to cover low-income people through the marketplace than through Medicaid.⁷

The proposal would likely also fail the coverage guardrail, because some people with incomes between 100 and 138 percent of the poverty line would lose coverage as a result of the waiver. Compared to the marketplace coverage available to near-poor adults, Medicaid offers significantly lower premiums and cost sharing and the option to enroll at any time during the year, instead of just during open enrollment. In addition, people who have an offer of employer-sponsored coverage are still able to enroll in Medicaid if they are otherwise eligible, but such an offer would disqualify them from claiming a premium tax credit for marketplace coverage if the employer coverage is deemed “affordable,” forcing people either to enroll in employer coverage with premiums that may be much higher than they would be expected to pay in the marketplace — or go uninsured. Due at least in part to these factors, the uninsured rate among near-poor adults in non-expansion states (where this group can enroll in subsidized coverage through the marketplaces) is twice the uninsured rate in expansion states (where they can enroll in coverage through Medicaid).

Alternatives to Section 1332 Waivers to Accomplish State Goals

Do states have options to provide Medicaid coverage through private plans?

Yes. States do not need a 1332 waiver to provide Medicaid coverage through private health plans similar to those that provide coverage in the ACA marketplaces.

First, states have the option to deliver benefits through private managed care plans. Of the 32 states that had implemented the ACA’s Medicaid expansion as of July 1, 2018, 27 were using private health plans to cover the newly eligible adults.⁸

Second, states can even enroll their Medicaid expansion populations directly into marketplace coverage, as Arkansas does through an 1115 waiver (New Hampshire and Iowa previously had similar waivers but have since ended them). States taking this approach are required to ensure that Medicaid expansion enrollees are provided with all Medicaid benefits and cost-sharing protections to which they’re entitled, either through a marketplace plan or a “wrap” through the state’s Medicaid program.

“Private option” waivers ensure that Medicaid expansion and marketplace enrollees have the same plan options. A downside is that they generally cost the state more than a traditional expansion,

⁷ *Ibid.*, and Jessica Schubel, “Partial Medicaid Expansions Fall Short of Full Medicaid Expansion with Respect to Coverage and Access to Care,” Center on Budget and Policy Priorities, June 27, 2019, <https://www.cbpp.org/research/health/partial-medicaid-expansions-fall-short-of-full-medicaid-expansion-with-respect-to>.

⁸ Kathleen Gifford *et al.*, “State Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019,” Kaiser Family Foundation, October 2018, <http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019>.

because, as noted above, commercial health plans generally cost more than Medicaid.⁹ This was a key factor in New Hampshire’s decision to end its private option waiver and transition its Medicaid expansion populations into managed care.¹⁰

Do states have options to reduce churn and smooth transitions between Medicaid and marketplace coverage?

Yes. States do not need a 1332 waiver to improve coordination between Medicaid and marketplace coverage.

States have several options available to help reduce churn and smooth transitions between Medicaid and marketplace coverage. Income fluctuations are especially prevalent in near-poor populations, often causing people to “churn,” or move frequently between Medicaid and the marketplace. This churn can result in disruptions in coverage and the continuity of care, including the use of medications and the need to change doctors. Churning is also associated with increased use of the emergency room and worsening self-reported quality of care and health status.¹¹

One approach to reduce churn is to improve information sharing between the marketplace and Medicaid. For example, if the marketplace has already verified an enrollee’s citizenship status, that information should be conveyed to Medicaid during the account transfer process.

Another option is to provide 12 months of continuous Medicaid eligibility for children, adults, or both. Under this approach, Medicaid coverage is guaranteed for 12 months regardless of changes in family circumstances, such as income or household size changes. At the end of the 12-month period, the state redetermines the individual’s eligibility. Twelve months of continuous eligibility provides a stable source of coverage, helping to improve continuity of care. This approach is an option under the Medicaid state plan for children. States need a Medicaid 1115 waiver to implement it for adults, as Montana and New York are currently doing.

Finally, states could consider implementing a Basic Health Program (BHP), another coverage option created under the ACA. BHP is a coverage program for people with incomes between 138 percent and 200 percent of the poverty line who would otherwise be eligible for federal subsidies to purchase marketplace coverage.¹² BHP enables states to provide more affordable coverage to near-poor people while improving continuity of care for people whose income frequently fluctuates above Medicaid’s threshold by reducing the negative effects of churn. Currently over 700,000 people in Minnesota and New York are enrolled in BHP.

⁹ Lisa Clemans-Cope, John Holahan, and Rachel Garfield, “Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence,” Kaiser Family Foundation, April 13, 2016, <https://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/>.

¹⁰ New Hampshire State Legislature Premium Assistance Program Commission, “Final Report of House Bill 1696,” November 17, 2017, <http://www.gencourt.state.nh.us/statstudcomm/reports/1288.pdf#page=53>.

¹¹ Benjamin Sommers *et al.*, “Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful for Many,” *Health Affairs*, October 2016, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455>.

¹² People who are lawfully present non-citizens and have income below 138 percent of the poverty line but are unable to qualify for Medicaid due to their non-citizen status are also eligible for BHP.