

# Comparing Section 1332 and Section 1115 Waiver Authorities

Waivers can provide an opportunity for states to advance program objectives that are not otherwise permissible under federal law. Section 1115 of the Social Security Act (the Act) is the broadest waiver authority available for Medicaid and the State Children's Health Insurance Program (CHIP) and is being used by states to implement a wide variety of changes to eligibility, benefits, and delivery systems. Section 1115 waivers can be broad, encompassing most of a state's Medicaid program, or used for more modest program changes, like altering benefits or cost sharing. Section 1332 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) is a new waiver authority that will allow states, beginning in 2017, to make changes to health insurance exchanges, qualified health plans, premium tax credits and cost-sharing subsidies, as well as the individual and employer mandates. Guidance released the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Treasury (Treasury) in December 2015 provides some indication of the potential scope and limitations of Section 1332 waivers and their interaction with Medicaid and CHIP.

This issue brief provides an overview of these two types of waiver authority, including details on what can be waived, the application and approval process, and the waiver requirements. (See Appendix Table 1 for a detailed side-by-side comparison.)

## Section 1332 Waivers

Section 1332 of the ACA established a new type of waiver to allow states to experiment with alternative ways to meet the coverage goals of the ACA. Specifically, beginning on or after January 1, 2017, HHS and Treasury may waive provisions of the statute which deal with the exchanges, qualified health plans, premium tax credits and cost-sharing subsidies, and the individual and employer mandates. Section 1332 waivers cannot be used to change Medicaid, although states may wish to coordinate changes across programs (this is discussed in greater detail in Box 1). A Section 1332 waiver must provide coverage that is as comprehensive and as affordable to enrollees, cover as many individuals, and not raise the federal deficit. Depending on the structure of the Section 1332 waiver, projected federal spending on tax credits and cost-sharing reductions would be passed through to the state for each year. Section 1332 waivers will initially be approved for up to five years and can be renewed. Finally, they are required to be deficit neutral. As of August 2016, no state has received approval for a Section 1332 waiver, although a number have expressed interest. States that have publicly released applications are discussed below.



## Requirements and approval process for Section 1332 waivers

Under the statute, Section 1332 waivers must meet certain requirements, often referred to as guardrails, which were described in more detail in guidance released in December 2015 (CMS 2015, Treasury and HHS 2015). Specifically, these waivers will be assessed using the following criteria:

1. **Under the waiver, a comparable number of residents must have minimum essential coverage as would have been covered in the absence of the waiver.**<sup>1</sup> To satisfy this requirement, the level of coverage is assessed for all state residents, regardless of their coverage source. In addition, assessment of the waiver will also examine whether the proposal prevents gaps or discontinuations of coverage.
2. **Coverage under the waiver must be as affordable overall for residents as it would have been in its absence.** This will be assessed by comparing residents' net out-of-pocket spending for health coverage and services (i.e., both premiums and any cost sharing) to their incomes. Any spending on health care services that are not covered by the plan may be taken into account if that spending is affected by waiver. In addition to assessing affordability on average, the waiver will also be assessed on how it affects individuals with large health care spending burdens. Finally, the waiver will not satisfy the affordability guardrail if it reduces the number of people with coverage that has a 60 percent actuarial value and meets the annual out-of-pocket maximum established in the ACA.
3. **Health care provided under the waiver must be just as comprehensive as what it would have been without the waiver.** This factor will be measured by the extent to which coverage meets the requirements for essential health benefits (EHBs). Specifically, the waiver cannot reduce (a) the number of individuals with coverage that satisfies EHB requirements; (b) the number with coverage in any one category of EHB; or (c) the number of individuals with coverage that includes the full set of services covered under Medicaid and CHIP.
4. **Section 1332 waivers must also be federal deficit neutral over both the period of the waiver and a ten-year budget window.** Specifically, projected federal net spending under the waiver must be equal to or lower to what it would have been without the waiver. On the revenue side, this includes all changes in income, payroll, and excise tax revenues, and any other forms of revenue (such as user fees) that may result from the waiver; on the spending side, this includes all changes in exchange spending, any changes in Medicaid spending, as well as any administrative costs. Importantly, however, it does not include any savings accrued under the state's current or proposed Section 1115 waivers. The amount of federal money provided to the states is determined annually based on the amount of federal spending that would have otherwise been expected in the given calendar year.

In addition to looking at broad effects, the assessment of each of the first three guardrails will also take into account the effects on the state's most vulnerable residents, including low-income individuals, the elderly, and those with serious health conditions or at risk of developing serious conditions. Furthermore, these guardrail requirements must be met during each year of the waiver and include an assessment of the spillover effects on Medicaid and CHIP (Box 1).



**BOX 1: Assessment of the Effect of a Section 1332 Waiver on Medicaid and CHIP**

A Section 1332 waiver may not change the conditions of Medicaid coverage. However, the assessment of whether the waiver meets the first three guardrails will take into account broader effects on the state's health care system, while holding state Medicaid and CHIP policies constant. Although not defined in great detail, the guidance makes clear that spillover effects on Medicaid will be considered.

**Coverage:** Changes in Medicaid enrollment may result from a Section 1332 waiver. Any change in Medicaid enrollment will be considered when evaluating the number of residents with coverage.

**Affordability:** A waiver would not be approved if it reduced the number of people with coverage that meets the premium and cost sharing limitations under Medicaid.

**Comprehensiveness:** A Section 1332 waiver cannot decrease the number of individuals with coverage that includes the full set of services covered under Medicaid or CHIP.

As with Section 1115 waivers, Section 1332 waivers will be negotiated between the state and the HHS Secretary. In addition, the Secretary of the Treasury may be a party to the negotiations if the waiver provisions fall under the jurisdiction of the Internal Revenue Service (IRS). Section 1332 waivers are also subject to requirements similar to 1115 waivers affecting applications and public processes. If states choose to submit both a Section 1115 and a Section 1332 waiver, the process should be coordinated and states can, but are not required to, submit a single application. In addition, as part of the application, states are required to submit analysis and supporting data that show the state meeting each of the coverage guardrails as well as federal deficit neutrality requirements. Section 1332 waivers must be reviewed within a 180-day time period, although the Centers for Medicare & Medicaid Services (CMS) may delay review by requesting more information if the application is incomplete. While Section 1332 waivers require routine quarterly and annual reports to CMS and cooperation with outside evaluators, there is no state evaluation requirement.

## Operational limitations of Section 1332 waivers

The December 2015 guidance also put forth some operational limitations. At the time of the guidance, federal exchange and IRS were unable to accommodate different rules in different states. For example, the guidance specified that waivers changing the premium tax credit calculation, open enrollment period, or plan management reviews were not feasible in states relying on the federally facilitated exchange. As such, only states operating their own exchanges would be expected to pursue 1332 waivers.



## Examples of proposed Section 1332 waivers

Two states have submitted applications for Section 1332 waivers—Vermont submitted an application in March 2016 and Hawaii submitted an application in August 2016. Neither state has received approval. California has publicly released an application, although a larger number of states have expressed interest (Lucia et al. 2016).<sup>2</sup> The states that have developed waivers have done so in relatively modest ways and largely to maintain the status quo within their state.

- **California.** The state wants to allow individuals ineligible to purchase qualified health plans because of their immigration status, to purchase plans on the exchange without premium tax credits or cost sharing reductions (California 2016).
- **Hawaii.** The proposal seeks to maintain the state’s Prepaid Health Care Act which requires most employers to provide health insurance and has higher standards for employer-sponsored coverage than are required under the ACA. The waiver seeks to replace the ACA’s employer mandate and the Small Business Health Options Program (SHOP) exchange with the state’s preexisting program (Hawaii 2016).
- **Vermont.** Due to technical difficulties with the website, employers and employees were not able to enroll through the state’s SHOP exchange, and instead were encouraged to enroll directly through insurance carriers. The state wishes to continue this direct enrollment approach in the small group market by eliminating the requirement to have a SHOP website for enrollment and premium processing (Vermont 2016).<sup>3</sup>

Other states discussing Section 1332 waivers include Colorado and Minnesota, although neither has put forth a formal application. Additional states, such as Arkansas and Kentucky, have raised the idea of combining Section 1332 waivers with Section 1115 waivers, but it is not clear whether they will pursue this avenue given the December guidance that removed the potential to count savings from one waiver toward another in order to meet the budget and deficit neutrality requirements (Lucia et al. 2016).

## Section 1115 Waivers

Section 1115 of the Act provides broad authority to the HHS Secretary to approve demonstrations that are likely to assist in promoting the objectives of the Medicaid or CHIP program. Under Section 1115, the HHS Secretary can waive almost any Medicaid state plan requirement under Section 1902 (which describes state Medicaid program requirements and options for coverage) to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program. The HHS Secretary can also permit federal financial participation for costs not otherwise matchable, allowing states to cover services and populations not included in the Medicaid state plan. Section 1115 waivers can be comprehensive, covering the entirety of a state’s Medicaid program, or narrow, such as those that allow otherwise non-eligible adults access to family planning services.



Section 1115 predates the enactment of Medicaid as a vehicle for testing new approaches in a variety of federally funded programs and was used infrequently for policy experimentation for many years after Medicaid's enactment. Since 1994, however, states have sought Section 1115 waivers more frequently to alter eligibility, benefits, and delivery systems. For example, states used these waivers to provide targeted benefits to individuals with HIV/AIDS, mandate enrollment in a specific capitated managed care plan, and increase cost sharing for certain populations. A number of significant programmatic changes to the Medicaid statute have been made following their implementation under Section 1115 waivers, including managed care and the use of home and community-based services.

## Requirements and approval process for 1115 waivers

The specifics of Section 1115 waivers are worked out through negotiations between states and CMS and are detailed in the waiver's special terms and conditions. Unlike state plan amendments, Section 1115 waivers require advance approval through an open-ended negotiation process, which can take several months or years. This is partly because Section 1115 waivers are often comprehensive in nature, whereas state plan amendments typically address a discrete aspect of a state's program; for a comprehensive waiver, each program element must be separately discussed and negotiated. Furthermore, the open-ended nature of the negotiations allows waivers to be more tailored to states' needs as opposed to state plans that are more standardized, but have a more streamlined approval process. Section 1115 waivers are initially approved for five years and are renewed for three to five years at a time.

Demonstration waivers are, by their nature, subject to a great deal of secretarial discretion and states are afforded a great deal of flexibility in what they propose. However, at a minimum, states must assure budget neutrality, obtain meaningful public input, as well as conduct an evaluation and provide periodic reports to CMS.

**Budget neutrality.** Section 1115 waivers are required to be budget neutral, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver. Although not defined by federal statute or regulations, this requirement has been in practice for many years. If federal costs exceed the budget neutrality limit (in the aggregate), then states are liable for the additional spending and CMS reserves the right to terminate the demonstration. Over time, CMS has allowed states to calculate budget neutrality in multiple ways, although in most states, it is determined on a per capita basis. In addition, Section 1115 waivers can be used to allow a state to use savings generated by one initiative to pay for other changes, such as eligibility expansions, as long as the waiver as a whole is budget neutral over the approval period.

**Meaningful public input.** There are public process and transparency requirements at both the state and federal level for Section 1115 waivers. A state must solicit significant public input by using multiple methods for public notification (such as electronic mailing lists and notices in newspapers) and having a 30-day comment period prior to submitting the proposal to CMS. At the federal level, CMS must post all waiver application-related documents and correspondence on Medicaid.gov and also hold a public comment period (CMS 2012).



**Periodic reporting and evaluation.** The ACA strengthened federal requirements for evaluations of Section 1115 demonstrations (42 CFR 431.424). The terms and conditions of the waivers include requirements for the evaluation, although the specific research questions and design are settled through a subsequent approval process. Evaluations are required to be publicly available. CMS may also conduct evaluations on a demonstration to examine the impact; states must also cooperate with any federal evaluation that occurs. Finally, states must provide quarterly and annual reports on their waiver enrollment and spending.

## Examples of Section 1115 waivers

Section 1115 waiver authority has been used in a number of ways over the years, including to expand eligibility, require managed care enrollment, restructure hospital and safety net financing, or alter benefits or cost sharing.

**Eligibility expansion.** States have used Section 1115 waivers to expand eligibility, both to optional groups with limits (such as enrollment caps) that they may not otherwise be able to apply, and to groups not eligible for Medicaid. Prior to passage of the ACA, a few states used Section 1115 waivers to expand Medicaid eligibility to adults without dependent children. More recently, six states (Arkansas, Iowa, Indiana, Michigan, Montana, and New Hampshire) have used Section 1115 waivers to extend coverage to the new adult group with certain limitations, for example on benefits (MACPAC 2016).

**Managed care enrollment.** Although states can implement managed care in their Medicaid program without waivers, a number of states have used Section 1115 waivers to require mandatory enrollment into managed care, including managed long-term services and supports.

**Supplemental payments.** Because supplemental payments are not permitted under capitated managed care, states have pursued Section 1115 waivers to continue these payments as they transitioned to managed care. Currently, nine states use Section 1115 waivers to create dedicated uncompensated care pools that provide payments to hospitals and other safety net providers. Additionally, under Section 1115 waivers, seven states (California, Kansas, Massachusetts, New Hampshire, New Jersey, New York, and Texas) have established Delivery System Reform Incentive Payment (DSRIP) programs to support provider-led efforts to change the delivery of care, improve quality of care, and promote population health (MACPAC 2015).

**Benefits.** States have used Section 1115 waivers to change the benefits provided to enrollees. Many waivers that expanded coverage to new populations offer the same services as provided in the state plan, but others limit services, such as in Utah where only primary care services are provided to enrolled adults. States have also used Section 1115 waivers to provide additional benefits to particular groups, such as family planning services. Finally, states have used these waivers to alter the delivery of services, for example, through the use of Medicaid funds for premium assistance toward purchasing health insurance on the exchanges.

**Cost sharing.** In addition, states have used Section 1115 waivers to change the cost-sharing structure through the use of enrollment fees, premiums, and copayments.<sup>4</sup> For example, a number of states use waiver authority to impose copayments for non-emergency use of the emergency room. States have also



used Section 1115 waivers to establish accounts similar to health savings accounts or to incentivize healthy behaviors.

## CHIP and Section 1115 waivers

Waivers under CHIP are subject to the same application and transparency requirements as Section 1115 Medicaid waivers. However, instead of being budget neutral, Section 1115 waivers in CHIP are required to be allotment neutral, meaning that spending on the waiver cannot exceed the state's capped allotment. In the early 2000s, a number of states used Section 1115 waivers to provide coverage to pregnant women, parents, and childless adults using their CHIP funds (Artiga and Mann 2007). Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111–3), CHIP-funded coverage for non-pregnant adults, including parents, was phased out. CHIPRA did, however, allow states to cover low-income pregnant women under CHIP through a state plan amendment. Since then, most states have transitioned their CHIP-funded waiver coverage to other funding sources; however, Virginia still uses a Section 1115 waiver to cover pregnant women and implement premium assistance in CHIP.

## Coordination between waivers

Because of the potential for overlap between the two waiver authorities, CMS is required to coordinate Section 1115 and Section 1332 waiver requests. In addition, as discussed above, an assessment of a Section 1332 waiver requires an examination of its effect on Medicaid. However, CMS has offered little guidance about what specific policy changes it will approve under Section 1332 and how those changes may interact with Medicaid. As of May 2016, HHS and Treasury were still in the process of developing procedures for coordinating the review and approval of waiver proposals (GAO 2016).

## Conclusion

As discussed above, states cannot combine savings under Section 1115 and Section 1332 waivers into a single budget-deficit neutrality test. This clarification, along with the further definition of the guardrails, has been characterized by some as limiting states' flexibility under the statute. As such, it is not clear how many states will pursue Section 1332 waivers and whether any of the reforms will lead to changes in Medicaid or CHIP. Furthermore, given the timing of their implementation (January 2017), the change in administration at the federal level may alter the parameters in which states can seek these waivers.



## Appendix

**TABLE 1.** Comparison of Section 1332 and Section 1115 Waiver Provisions

Features	§1332	§1115
General requirements	<ul style="list-style-type: none"> <li>• Comparable number of people are covered (with no decrease in Medicaid or CHIP enrollment) (1332(b)(1)(C))</li> <li>• Coverage that is at least as affordable as judged through an aggregate test of average out-of-pocket spending (1332(b)(1)(B))               <ul style="list-style-type: none"> <li>– Additional tests for low-income and vulnerable groups to provide a minimum level of protection against excessive cost sharing</li> </ul> </li> <li>• Coverage that is at least as comprehensive as the EHB (1332(b)(1)(A))               <ul style="list-style-type: none"> <li>– Cannot reduce the number of people with plans that meet EHB requirements; with coverage in each particular EHB category; or with full Medicaid or CHIP benefits</li> </ul> </li> </ul>	<p>“Likely to assist in promoting the statutory objectives” of the Medicaid or CHIP program (42 CFR 431.404)</p> <ul style="list-style-type: none"> <li>• increase and strengthen overall coverage of low-income individuals in the state;</li> <li>• increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;</li> <li>• improve health outcomes for Medicaid and other low-income populations in the state, or;</li> <li>• increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks</li> </ul>
Provisions that can be waived	<p><b>Subtitle D—Part 1 of ACA</b>—HHS Secretary may waive:</p> <ul style="list-style-type: none"> <li>• §1301—requirements for qualified health plan issuers</li> <li>• §1302—essential health benefits, cost-sharing limitations, metal tiers and corresponding actuarial values, catastrophic plans, and child-only plans</li> <li>• §1304—definitions related to markets and employer size</li> </ul> <p><b>Subtitle D—Part 2 of ACA</b>—HHS Secretary may waive:</p> <ul style="list-style-type: none"> <li>• §1311—exchange establishment and requirements (e.g., plan certification), enrollment periods,</li> <li>• §1312—risk pool, maintaining outside market, state benefit mandates, limits coverage to citizens and lawful residents</li> <li>• §1313—financial integrity</li> </ul> <p><b>Section 1402 of ACA</b>—HHS Secretary may waive cost-sharing reductions, including eligibility and the manner of the reduction</p> <p><b>Internal Revenue Code (IRC)</b>— Treasury Secretary may waive:</p> <ul style="list-style-type: none"> <li>• §36B—premium tax credits, including the amount, the expected</li> </ul>	<p><b>§1115(a)(1)</b>—Secretary may waive any of the requirements under §1902. Examples include: statewideness, comparability (e.g., to provide benefits to a subset of enrollees); freedom of choice (e.g., to limit providers to managed care)</p> <p><b>§1115(a)(2)(A)</b>—Secretary may waive requirements under §1903 (also referred to as waivers through expenditure authority) that are not otherwise matchable. Examples include: managed care requirements of 1903(m)(2)(a); premium assistance cost-effectiveness requirements</p>



TABLE 1. (continued)

Features	§1332	§1115
	family contribution, benchmark, applicable taxpayer, and definition of minimum essential coverage (including affordability test for ESI) <ul style="list-style-type: none"> <li>• §4980H –employer mandate, including employer size and full-time definition</li> <li>• §5000A—individual mandate, including payment calculation, applicable individuals and exemptions</li> </ul>	
Provisions that cannot be waived	<ul style="list-style-type: none"> <li>• Insurance market reforms (e.g., preexisting conditions, age rating)</li> <li>• Self-insured plans</li> </ul>	<ul style="list-style-type: none"> <li>• Matching rate (§1903)</li> <li>• Cost sharing can be waived under the strict requirements of §1916(f)</li> </ul>
Spending that can be authorized	<ul style="list-style-type: none"> <li>• Projected federal spending on federal tax credits or cost sharing reductions are passed through to the state for spending under the §1332 waiver state plan each year (§1332(a)(3) of ACA)</li> <li>• Projected savings in future years cannot be spent in prior years</li> </ul>	<ul style="list-style-type: none"> <li>• Supplemental payments for uncompensated care or delivery system reform</li> <li>• Eligibility and benefit expansions</li> <li>• State-funded programs to supplement exchange premium tax credits</li> <li>• Designated state health program funding (to reduce state contributions)</li> </ul>
Length of waiver	5 years; can be extended	5 years initially; extensions of 3 to 5 years
Budget requirements	Federal deficit neutral—spending on the waiver (net of off-setting tax revenues) must not increase the federal deficit over the period of the waiver (not to exceed 5 years) or within a 10-year period, as certified by the CMS actuary <ul style="list-style-type: none"> <li>• Includes federal spending for premium tax credits, cost sharing reductions, administrative costs, and changes in Medicaid spending (holding current policies constant)</li> <li>• Includes changes in federal revenue from income, payroll, excise tax revenues, and any other forms of revenue (such as user fees) that may result from the waiver</li> </ul>	<ul style="list-style-type: none"> <li>• Budget neutral—spending on the waiver must not exceed projected federal spending without the waiver (note this is not in statute, but long-standing policy)</li> <li>• Budget neutrality is established over the period of the demonstration (typically a 5-year period) and is based on projected Medicaid spending alone</li> <li>• States can renew demonstrations beyond 5 years, but must rebase Medicaid spending projections to reflect more recent cost trends (CMS 2016c)</li> </ul>

**Notes:** Section 1115 waivers allow for expenditures at the regular matching rate, not enhanced matching rates. CHIP waivers are also possible and are subject to the same application and transparency requirements as Section 1115 Medicaid waivers. Instead of being budget neutral, CHIP Section 1115 waivers are required to be allotment neutral.

**Sources:** 42 CFR 431.400–428, 31 CFR 33.100–128, 45 CFR 155.1300–1328, Treasury and HHS 2015, CMS 2016c.

## Endnotes

- <sup>1</sup> Minimum essential coverage (MEC) is any insurance that meets the ACA's personal responsibility requirement for having coverage. For example, exchange plans, employer-sponsored insurance, and most Medicaid coverage (except for limited benefit plans) are considered MEC.
- <sup>2</sup> Massachusetts was looking to maintain its pre-ACA merged market for individual and small-group coverage using Section 1332 waiver authority (Massachusetts 2016). However, CMS determined that the existing market structure satisfied the ACA's requirements and that a waiver was unnecessary (CMS 2016a).
- <sup>3</sup> CMS released guidance in April 2016 extending the option for state-based SHOPS to use direct enrollment as a transitional measure for plan years beginning in 2017 and 2018. It is not clear whether Vermont will continue to pursue a Section 1332 waiver in light of this guidance (CMS 2016b).
- <sup>4</sup> Under Section 1115 authority, the Secretary can waive premium requirements; however Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

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