Understanding the Section 1332 option

- The basic premise is to propose a "Super Waiver" under Section 1332 of the ACA
- This waiver requires the state to provide a system that
    - Covers at least as many people as the ACA would have
    - Provide coverage that is similarly affordable
    - Has no net impact on the federal budget
- No states have pursued this to date, but some are thinking about it
- It appears that a state could consider **ALL** federal funds under the ACA including premium tax credits and CSR in the individual exchange and the federal spend on a full expansion for low-income adults. You might also be able to pull in the federal spend on the tax-exemption for employer-based insurance (if you did away with that) and the federal spend on existing Medicaid and CHIP programs (as long as those populations still get equivalent coverage)

Here are a few "out-of-the-box" proposals to consider to get the creativity flowing:

1. Hybrid Medicaid Expansion Option

- This is a **limited time Full Expansion Model** that focuses on Premium Assistance & the Market
- Create Two Expansion programs:
    - Adult Medicaid 1 - Adults below 100% FPL
        - Coverage and benefits TBD, could also be Premium Assistance approach
    - Adult Medicaid 2 - Adults between 100-138% FPL get covered through the Exchange using a Premium Assistance option
        - Benefits mirror exactly those that would have been provided through the Exchange, including cost-sharing reductions
    - Timed to end in 2017 when the Medicaid landscape changes

2. Tax Recovery Option

- This is an **aggressive Super Waiver** option. The state works with the federal government to determine the total amount of federal spend that they would expect for the State of Utah under Full Expansion
- The state then creates a system of tax credits for businesses and families that is pegged to total up to this amount
- The tax credit creates incentives for :
    - Businesses to provide coverage to low-income adults (or othe targeted population)
    - Low-income individuals to purchase private health insurance
- The tax credits could be structured in several different ways, but the principle design element should be to maximize the number of people getting covered

3. Iowa Model

- As I understand it, this is a **partial expansion** of Medicaid for low-income adults (below 100% FPL)
- Iowa experiences some significant savings by reducing/eliminating current programs for adults over 100% FPL. This money is sufficient to fund the state's share of the FMAP for the expansion adults.
- For those above 100% FPL, they are transitioned to the Exchange where they can purchase a private policy and receive premium tax credits
- For those below 100% FPL, the program is a Premium Assistance program
    - Using Section 1937, those who are eligible receive a subsidy to help them purchase a "Benchmark Plan" (similar to the state employee benefit plan)
    - Some modifications are necessary to ensure that they have access to required benefits, such as Mental Health parity
- Another key feature of the Health Iowa Plan is their approach to patient engagement
    - Require sliding scale premiums that are put into a Health Responsibility Account
    - Patients are required to have some "skin in the game" by being responsible for spending their own money (from the Account) for specific services

4. Low-Income Health Network

- This is a **Non-Expansion Model** that takes advantage of federal funding for people over 100% FPL and plows any state savings back into the low-income adult population
- Adults over 100% FPL enroll in QHPs are receive APTC/CSR through the Exchange
- This creates some savings to the state (PCN population) and to the health care system (higher enrollment should reduce uncompensated care)
- The state works with local provider networks to create a basic primary care package at negotiated rates with participating clinics
- The package would need to include
    - Primary care visits
    - Pharmacy benefits
    - Behavioral health
- There are multiple options for designing the package:
    - Sliding scale premiums & some insurance component
    - No premiums or insurance component; only reduced cost of services
- State general fund *could* be used to help subsidize the premiums or cost of care
    - Not clear if you could figure out a way to draw down federal match, although it may be possible under a 1915-type waiver or a modification of the current PCN program
    - This could also be considered the "next generation" solution for the High Risk Pool

5. Full Family Program

- This is a **Super Waiver** proposal that focuses on the family as the unit for coverage instead of the individual.

- Under this model, each family is evaluated for a “family income” which determines the level of benefits available.
- The first consideration is the availability of employer-sponsored group insurance:
    - Families who have the option of getting insurance through an employer would receive a sliding scale subsidy (and possibly extra or wrap-around coverage depending on the income level)
    - This maximizes pooling the total available resources including public and private and also helps simplify the churning problem
- For families who cannot (assumed to be temporarily) get group coverage, they are enrolled in family policies. This could be structured in a couple of ways:
    - They could all be sent to the exchange where they shop for QHPs using pre-determined sliding scale subsidy & cost-sharing reduction funding
    - Or the program could establish a managed care contract for the lowest income families, then an option for them to transition to private insurance in the next tier, and the highest tier families are all enrolled in private family coverage.