UNITED STATES of CARE

Waiver Options for the Bridge Plan Task Force

The creation of a "Bridge Plan" is an innovative solution that has great potential for Oregon. As the Bridge Plan Task Force (BPTF) assesses the best goals and pathways for the plan to meet that potential, it is critical to design a **flexible coverage program that works for Oregon long-term.** The BPTF is charged with making a recommendation to state agencies on the best waiver route that maximizes federal funds and minimizes costs to the state and enrollees, and **we believe the 1332 state innovation waiver meets those goals while also creating a long-term solution that helps even more Oregonians.** Additionally, the BPTF should seek a program designed to allow for further expansion and eventually meet the needs of all Oregonians struggling to afford high-quality, affordable health care.

Potential Impacts of Waiver Pathways on a Public Health Insurance Option

A waiver should allow for the appropriate flexibility to create a coverage program that best fits the needs of the Bridge Plan population, while also allowing for a pathway to expand coverage to additional Oregonians through a public health insurance option in the future. *The BPTF should consider the benefits of the different types of federal waivers, outlined below, as they are developing their proposal and related recommendations for the Bridge Plan. We also encourage the BPTF to consider whether to seek approval for multiple waivers in tandem, which can allow for flexibility to cover additional populations in the future and can better support streamlined enrollment across coverage programs.*

- **1332 State Innovation Waiver: A 1332 waiver would design the most flexible option for expanding eligibility for coverage beyond 200% FPL through a public health insurance option. A 1332 waiver would present the state with more flexibility to leverage pass-through funding to invest in other state coverage programs.** We believe 1332 waivers bring great opportunity and potential, and that Oregon can learn from the experiences of Nevada and Colorado, who have used 1332 waivers to expand coverage and improve affordability for their residents. Specific benefits of 1332 waivers are highlighted in the overview table, below.

- **1331 Basic Health Program:** Creating a Basic Health Program (BHP) under Section 1331 of the ACA may mean Oregon receives less federal funding or has federal limitations to cover future additional populations, beyond those with incomes between 138-200% FPL, through a public health insurance option. In addition, a BHP creates a separate risk pool for individuals covered under the BHP, which may have implications for the individual market risk pool in the Marketplace.
- **1115 Medicaid Demonstration Waiver:** 1115 waivers primarily focus on providing additional flexibility for states to design and improve their Medicaid programs. Oregon currently operates its Medicaid program through an 1115 waiver, which implemented the Coordinated Care Organization (CCO) community-based infrastructure for the Oregon Health Plan. An 1115 waiver on its own would likely not provide the flexibility to align innovative waiver provisions to support expanded access to care across coverage programs and markets.

Overview of Waiver Options

	1332 Waiver: State Innovation Waiver	1331 Waiver: Basic Health Program	1115 Waiver: Medicaid Demonstration Waiver
Purpose and Goals	Section 1332 of the ACA provides states with an option to seek a State Innovation Waiver to pursue innovative strategies to provide high quality, affordable health care coverage while retaining the ACA statute's basic protections. ★ **The goal of 1332 waivers is to provide states with flexibility to develop their own approaches to providing more choice, competition, and affordability.** **States currently leveraging this pathway:** A number of states have received approval for reinsurance waivers under Section 1332. Colorado is currently seeking federal approval for an amendment to its existing 1332 waiver in conjunction with its public option plan, scheduled to be implemented in January 2023. If Colorado's 1332 waiver amendment is approved, federal pass-through funding will be reinvested in state-level funds to provide financial assistance to undocumented Coloradans and	Section 1331 of the ACA enables states to create a Basic Health Program (BHP). BHPs are intended as an alternative program for low-income beneficiaries who would otherwise be eligible to purchase plans on the marketplace. The key benefits of a BHP are improved State capacity for delivering more affordable care while increasing continuity of care for those who fluctuate above the Medicaid/CHIP income thresholds. **States leveraging this pathway:** **Minnesota:** • Minnesota BHP Blueprint • Minnesota Financial Report **New York** • New York Essential Plan Blueprint • New York's Essential Plan 2019 Report (most recent)	Section 1115 of the Social Security Act allows HHS, through CMS, to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Under Section 1115, CMS may waive certain provisions of the Medicaid statute to give states additional flexibility to design and improve their Medicaid programs. **States leveraging this pathway (Spotlight on Oregon Health Plan):** • Oregon's current 1115 demonstration, the Oregon Health Plan, received initial approval in 1994 and has been continuously extended with modifications every 5 years. • Oregon's Medicaid program infrastructure under the Coordinated Care Organization model is implemented under the waiver. • The current demonstration extension is set to expire on June 30, 2022. A 5-year extension is currently under CMS review.

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Markets and Populations Impacted; Statutory Requirements	States can develop 1332 waivers for the individual and Small Business Health Options Program (SHOP) exchanges. A 1332 waiver cannot change the conditions of Medicaid coverage. To be approved, states must demonstrate that certain "guardrails" are met. To do so, states must show that, absent a waiver, the plan will still: • Cover the same number of people • Provide as affordable coverage • Be as comprehensive Additionally, states must demonstrate a fourth "guardrail" that shows their 1332 waiver is deficit-neutral to the federal government within a ten-year budget window (see more detail under "limitations"). ★ **Impact on vulnerable populations: In addition to assessing the broad impacts of the waiver, the assessment of the first three guardrails will specifically take into account the impacts on the state's most**	A Basic Health Plan primarily impacts Marketplace plans, as those under 200% FPL must be enrolled in a BHP rather than a qualified health plan (QHP) on the marketplace. Nationally, those with incomes under 200% FPL represent ~50% of those in the marketplace. Under a BHP, states may provide coverage to individuals who are citizens or lawfully present non-citizens who do not qualify for Medicaid, CHIP, or other minimum essential coverage with income between 133-200% FPL. Lawfully present individuals with incomes below 133% FPL but do not qualify for Medicaid, may also enroll in BHP coverage. A BHP supports continuity of coverage for a population that frequently experiences churn between Medicaid and marketplace insurance thresholds (those with incomes between 133-200% FPL) Specific requirements that BHPs must meet, include: • A benefits package that includes at least the 10 Essential Health Benefits (EHBs)	1115 waivers primarily impact the Medicaid and CHIP programs. There are certain requirements states must meet for the federal government to approve an 1115 waiver: • The state must demonstrate that the waiver is "likely to assist in promoting the objectives of the Medicaid program." • The demonstration must remain budget neutral to the federal government, meaning the share of money the federal government spends on the state's Medicaid program under the waiver is the same amount as would be spent absent a waiver. • The state must conduct periodic evaluations of the waiver to confirm it is meeting the goals outlined in the waiver application and remains budget neutral.

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	vulnerable populations, including low-income individuals, elderly populations, and individuals with or at risk of developing serious health conditions.	• Premium and cost-sharing amounts are limited to what individuals would have paid if they received coverage from a QHP on the marketplace.	
Flexibility in the Program Design	The state retains flexibility for 1332 waivers as long as the above guardrails are met.	The state has flexibility in the design of plan structure, benefits, and cost-sharing (can offer more generous levels than Marketplace coverage.) Further, states can offer additional services, such as coverage of health-related social determinant needs, through a BHP. States must utilize a single streamlined application for enrollees. States have the option to use an open enrollment model (akin to Marketplace) or a continuous enrollment model (Medicaid). States can also use 12-month continuous eligibility. The BHP offers states stability in federal funding if approved. If all program requirements are met, states are entitled to receive funding and there are no budget neutrality requirements.	States have the flexibility to define eligibility levels for the population identified to be covered under the waiver, in addition to flexibility in benefit design. 1115 demonstration projects are generally broad in scope, operate statewide, and affect a large portion of the state's Medicaid population. However, 1115 waivers can also focus on specific services or populations, including family planning, and expanding substance use disorder treatment benefits, among others.
Federal Funding Available to States	★ **States receive "pass-through" funding from the**	States with a BHP receive federal funding equal to 95% of the advanced premium tax credit and	Spending that can be authorized under an 1115 waiver includes: • Supplemental payments

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	federal government that is equal to the amount of funding the state would have received for premium tax credits and cost-sharing reduction amounts without a waiver. States have the flexibility to reinvest this funding in programs that meet the needs of their specific populations. CMS and the Treasury Department calculate the amount of pass-through funding for each state on an annual basis based on rates with and without a waiver, total premiums, advanced premium tax credits, and other information. See note under "limitations" for how increased enrollment affects pass-through funding.	the cost-sharing reduction amounts that would have been provided to eligible individuals enrolled in marketplace plans. Prospective federal funding is paid to states every quarter. Retrospective adjustments are also used to federal BHP payments to better reflect population risk-adjusted funding for each program year. Funding is an entitlement if qualifications are met and is not subject to CMS discretion.	for uncompensated care or delivery system reform • Eligibility and benefit expansions • State-funded programs to supplement Marketplace premium tax credits • Designated state health program funding (to reduce state funding contributions) The approval of an 1115 waiver will not impact a state's federal Medicaid match percentage.

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State Process, Timeline, and Opportunities for Input	Before submitting a waiver application, states must provide public notice and implement a comment period (including public hearings) at the state level. • The state comment period must be open for 30 days and include 2 public hearings, at a minimum. • States with one or more federally recognized tribes within their borders must conduct a separate process for meaningful consultation with the tribes.	The state's BHP blueprint must be signed by the governor before being sent to CMS for approval. The state must identify agencies and/or officials who are responsible for the operation. The State must provide an opportunity for public comment on the BHP Blueprint before submission. While there is not a specified period of time for state comment, Minnesota opened its comment period for one month, and New York opened its comment period for two weeks. The state must seek public comment on any significant subsequent revisions before submission of those revisions to the Secretary for certification. The process of seeking public comment must include federally recognized tribes. States are required to submit annual reports to CMS 60 days before the end of the operational year.	Under federal regulations, there are specific requirements to make 1115 applications and approvals publically available at the state and federal levels. States must provide at least a 30-day public notice and comment period for applications of new demonstrations and extensions of existing demonstrations. The state may choose to modify the waiver application following the state comment period.
Federal Approval Process, Timeline, and Opportunity for Input	HHS and Treasury are responsible for reviewing and approving waiver applications.	**Initial Approval Process:** • States must submit a blueprint to CMS. • Unlike 1332 waivers, 1331	CMS is responsible for reviewing completed waiver applications. Following the completion of the

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	Upon receipt of a 1332 waiver application, HHS and Treasury work with states on the review and approval process: • The Departments will conduct a preliminary review within 45 days of submission and will provide written notice that the application is or isn't complete; • HHS and Treasury implement a public notice and comment period; • The final decision is issued no later than 180 days after the determination that an application is complete. **Waiver Timeline:** • 1332 waivers last 5 years and states can request continuations and/or amendments.	waiver approvals are not subject to the discretion of CMS - if all BHP requirements are met, the plan will be approved. • HHS, through CMS, is required to certify the plan meets all requirements in a "timely manner." **Annual Review:** Each year HHS will conduct a review of state performance to ensure adherence to the blueprint and ensure financial adherence. **Waiver Timeline**: • Blueprint to remain in effect until: ○ It is replaced with a new blueprint submitted by the state and approved ○ The state terminates the program ○ The Secretary determines the	state comment period, the state will submit the application to CMS: • Within 15 days of receipt of the application, CMS will determine whether the application is complete. • If the application is deemed complete, CMS will send the state a written notice informing the state of the start of the 30-day federal public comment period. • If CMS determines the application is not complete, CMS will share with the state any missing components of the applications. CMS is not permitted to decide on a waiver application until, at a minimum, 15 days after the close of the federal comment period. **Waiver Timeline:** • 1115 demonstrations span 5-year periods, in which time an evaluation is required to be conducted to identify if the goals and objectives of the waiver are met. • Demonstrations may be renewed on a 3-5-year basis. CMS has approved

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		blueprint no longer meets standards for certification	10-year extensions on a limited basis.
Application Requirements	The final regulations specify what information needs to be included in a waiver application, including: • The list of provisions the state seeks to waive; • Data and information demonstrating the waiver meets the four guardrails; • Actuarial analyses; • A 10-year budget plan that is deficit-neutral to the Federal government; • Analysis of the impact of the waiver on health insurance coverage in the state; • A description and copy of the authorizing legislation, and • A detailed plan and timeline for implementation.	The BHP Blueprint outlines all major provisions of the application process. These include submission of the state's plans regarding Content, Funding, and Transparency. Content: States must include 14 major content areas within the Blueprint which outline the state's plan for: 1. Minimum plan benefits 2. Competitive contracting plan 3. Standardized contract requirements 4. Enhanced plan availability 5. Ensuring/promoting coordination with other insurance affordability programs 6. Premium setting 7. Cost-sharing 8. Disenrollment procedures/consequences for failure to pay premiums 9. Standards for eligibility 10. Enrollment/disenrollment policies and coverage consistency plans 11. Fiscal policy and accountability measures 12. Process for selecting Trust Fund trustees and their duties or qualifications	There are a number of requirements that must be included in the submission of a new 1115 waiver application, including (but not limited to): • A comprehensive program description of the demonstration, including the goals and objectives of the project; • A description of the proposed delivery system, eligibility requirements, benefit coverage, and cost-sharing requirements for individuals impacted under the waiver that differ from the state's current program; • An estimate of the expected change in annual enrollment and, in annual aggregate expenditures, including historic enrollment or budgetary data; • Current enrollment data and enrollment projections expected under the waiver for covered beneficiaries; • Other components of the state's Medicaid program and/or CHIP that would be modified; • The specific waiver and

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		13. Insurances for program integrity 14. Operational assessment for agency readiness Funding plan: 1. Enrollment/cost projections for the first 12 months and secured funding should it go beyond the initial trust fund means 2. Demonstration that federal funds will only go towards reduced premiums, cost-sharing, or enhanced benefits Transparency: Must be made available online	expenditure authorities needed for approval; ● Evaluation plan to identify that the goals of the waiver are being met, and ● Written documentation of the state's compliance with the public notice requirements A similar application process is required for extensions of existing demonstrations and must include specific information related to any modifications to the waiver requested in the extension application.
Limitations	1332 waivers must be budget neutral to the federal government within a ten-year budget window. This calculation includes federal spending for premium tax credits, cost-sharing reductions, administrative costs, and changes in Medicaid spending (holding current policies constant). **Important note:** If states experience increased enrollment because of their waiver, their level of pass-through funding decreases due to the increased enrollment's subsequent increase in premium tax credits flowing to the state,	BHP premiums cannot exceed the benchmark plan. Cost-sharing must be at least as generous as the equivalent platinum-level plan for enrollees under 150% FPL and gold for enrollees between 150-200% FPL. **Marketplace risk pool implications:** BHPs create a separate risk pool from Marketplace and Medicaid populations. Depending on the health status of the BHP-eligible population, this may increase or	1115 demonstrations must be "budget neutral" to the federal government, meaning that, during the course of the demonstration project, the amount of money the federal government will spend on the state's Medicaid program will not be more than what the federal spending would be without the waiver. Budget Neutrality is identified over the period of the demonstration (typically 5 years) and is based on projected Medicaid spending alone.

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	which impacts current budget neutrality requirements.	decrease premiums for those remaining in the marketplace.	
Optionality for People to Choose Preferred Coverage Option	★ **A 1332 waiver permits Oregon to provide eligible individuals with incomes between 138-200% FPLwith a choice between a Bridge Plan offered through CCOs and affordable coverage on the Marketplace that leverages federal pass-through funding.**	• A 1331 waiver **does not permit Oregon to provide eligible individuals with incomes between 138-200% FPL with choice of coverage;** eligible individuals must enroll in the Bridge Plan through CCOs.	• Eligible individuals between 138-200% FPL covered under the 1115 demonstration **do not have the option to choose** between the Bridge Plan offered through the Medicaid waiver and Marketplace coverage.
Additional Resources	• CCIIO: State Innovation Waivers landing page (includes regulations, guidance, and state resources) • SHVS 1332 Waiver Tracker (Updated November 2021) • Congressional Research Service: State Innovation Waivers FAQ (January 2021)	State Health & Value Strategies>Manatt: Revisiting the Basic Health Program CMCS: Basic Health Program BHP Blueprint Document	Kaiser Family Foundation Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State