A Comparison of States' Use of 1331 Waivers to Create a Basic Health Plan

- Section 1331 of the Affordable Care Act (ACA) gives states the ability to pursue an innovative approach to high-quality health care coverage by creating a Basic Health Plan for people with incomes between 138 and 200% of the federal poverty level (FPL). The goal of a 1331 waiver is to provide sustainable and affordable coverage for this population, many of whom "churn" between Medicaid and private insurance due to income fluctuations.
- To receive approval from the Department of Health and Human Services (HHS), states must apply using the Basic Health Program Blueprint form. The blueprint allows the state to explain the program design choices, describes operations and management, and details compliance with federal rules.
- The Centers for Medicare and Medicaid Services (CMS) and the Department of the Treasury calculate the amount of "pass-through" funding given to the state, equal to 95% of the amount of the premium tax credits that would have been provided to beneficiaries if they were enrolled in qualified health plans through the Marketplace. The remaining 5% must be covered with state funds.

What Other States can Learn

- States can use a 1331 waiver in conjunction with a Section 1332 innovation waiver to provide opportunities for health care innovation to develop additional affordable health insurance options.
    - Minnesota submitted a Section 1332 waiver, in conjunction with its 1331 waiver, in 2017 to establish a reinsurance program.
    - New York will submit a Section 1332 waiver in 2023 to raise the income eligibility cap of their current Basic Health Plan (Essential Plan) from 200% to 250% of the federal poverty level (FPL) and transition the program's operating authorization from a 1331 to 1332 waiver.
- A recently updated federal rule finalized by CMS in December 2022 provided updates to the Basic Health Plan federal funding methodology for program year 2023. For the first time, the finalized rule also included a "Section 1332 Waiver Factor" to make up for any loss in Basic Health Plan funding when paired with a Section 1332 waiver designed to lower costs. States looking to pursue 1331 waivers in conjunction with existing or proposed 1332 waivers, such as currently exists in Minnesota, should be aware of this to ensure their Basic Health Plans receive adequate federal funding.

A Comparison of State 1331 Waivers

	New York	Minnesota	Oregon
Overview and Goals	New York used the 1331 Basic Health Program (BHP) waiver to create the Essential Plan in 2015 for people with incomes 138-200% FPL. There are minimal cost sharing requirements for some enrollees based on income. For dental and vision coverage, there is no co-pay. Out of pocket costs range from $0-$2,000, depending on the plan. The BHP was intended to be a more affordable coverage option for those that alternate or "churn" between income eligibility for Medicaid and private insurance. The Essential Plan shifted Medicaid funding for lawfully present immigrants from state only to federally funded. As of 2023, there are 14 Essential Plan insurers throughout New York.	MinnesotaCare, a public health insurance program, was originally created in 1992. In 2013, Minnesota passed legislation that allowed the state to apply for a 1331 Waiver and establish MinnesotaCare as a Basic Health Plan (BHP) under the ACA that provides enrollees with low-cost and high-quality coverage. MinnesotaCare is open to all Minnesotans who do not have access to Medicare, Medicaid or other forms of health insurance with incomes between 138-200% FPL. MinnesotaCare utilizes a sliding scale premium, with certain demographics being exempt from cost-sharing. MinnesotaCare contracts with nine different insurers, ensuring that each county has the choice between two and six different plans.	Oregon is in the process of designing and implementing a Basic Health Program for low-income residents, known as the Bridge Plan. The Bridge Plan will cover adults with incomes between 138-200% of the federal poverty level (FPL). There will be little to no cost to enrollees and will offer the same core benefits as their state Medicaid program. The Bridge Plan will provide coverage through the state's current Medicaid Coordinated Care Organizations (CCOs) and be accessible through Oregon's Health Insurance Marketplace.
Status	Approved by CMS on March 27, 2015.	Approved by CMS on December 15, 2014.	The Oregon Health Authority (OHA) expects to submit the state's waiver application for CMS approval by August 2023.
Timeline	★ Authorizincluded in the 2014-2015 state budget,	★ Authorization included in the 2013-2014 state budget,	★ Authorizing legislation signed into law March 17,

	New York	Minnesota	Oregon
	signed into law on March 31, 2014 ★ Program began January 1, 2016	signed into law on May 18, 2013 ★ Program began January 1, 2017	2022
Target Population	New Yorkers ages 16-64 years old that do not qualify for Medicaid due to income or immigration status. "Alessia" immigrants that were once covered by state funded Medicaid are now covered under the Essential Plan. The Essential Plan has four separate plans based on income. Plan 1 requires income levels of 150% – 200% of the Federal Poverty Level (FPL), Plan 2: 138-150% FPL, and Plans 3 and 4: up to 138% FPL. The Essential Plan started enrolling people in 2016 and currently covers over 1 million New Yorkers. (1,102,838 in 2022).	All Minnesotans with an income between 138%-200% FPL who do not have access to Medicaid, other government forms of health insurance, or private health insurance. It also covers lawfully present non-citizens who meet income criteria. MinnesotaCare offers a fully state funded program for DACA recipients. However, the program does not cover other undocumented noncitizens. MinnesotaCare started enrolling people in 1993 and currently covers 107,943 Minnesotans.	Oregon residents ages 19-64 whose incomes are between 138-200% FPL, who are eligible for premium tax credits but are not eligible for Medicaid. This population includes lawfully present immigrants who earn less than 138% FPL but who are ineligible for Medicaid because they have resided in the United States for fewer than five years. The Bridge Plan is expected to cover approximately 110,000 Oregonians once fully implemented.
Covered Services	As of 2021, a list of covered services and cost sharing is here. Dental and Vision services are covered at no cost and without co-pays. Essential Plans 3 & 4 include additional benefits such as orthotic services, orthotic footwear,	A list of covered services here. The most generous coverage is extended to pregnant people and children under the age of 19. Dental coverage may be available but limited for nonpregnant adults.	A list of covered services is not yet available. The Bridge Plan plans to minimally cover all 2021 CCO-covered Medicaid benefits, including adult dental coverage, pending sufficient federal revenue to support initial capitation rates.

	New York	Minnesota	Oregon
	non-emergency transportation, and non-prescription drugs.	A list of services that are not covered can be found here.	
Cost Sharing Requirements	The New York Essential Plan does not require cost sharing or premiums for all plans. However, prior to changes made in 2020, Essential Plan 1 did have a $20 premium. There is no cost sharing in all plan levels for preventative care.	Cost-sharing requirements can be found here but do not apply to children under age 19 or people who belong to a federally recognized tribe.	The proposed Bridge Plan will have no cost sharing requirements. There will be no premiums or out of pocket costs for enrollees.
Enrollment Periods	Enrollment for the Essential Plan is open all year for eligible people.	Enrollment for MinnesotaCare is rolling, allowing people to consistently have the option to apply for coverage regardless of when they become eligible.	Enrollment for the Bridge Plan, once fully implemented, will be rolling. The Basic Health Program will be implemented in multiple phases. ★ Implementation Phase 1 (July 2024): After federal approval of the Blueprint, OHA will transition people who will be found ineligible for Medicaid due to redeterminations to the Bridge Plan. ★ Implementation Phase 2 (January 2025): Within 24 months after the implementation of Phase 1, the Bridge Plan will be available to all other eligible Oregonians to enroll.
Federal Pass-through Funding	According to the 2022 Executive	According to the 2022 Minnesota	Initial actuarial results expect federal

	New York	Minnesota	Oregon
	Budget federal pass-through funding amounts to ★ 2021- $4.4 billion ★ 2022- $5.5 billion ★ 2023- $5.6 billion ★ 2024- $5.5 billion ★ 2025- $5.4 billion	Department of Human Services (DHS) Forecast federal pass-through funding amounts to: ★ 2022- $575 million ★ 2023- $653 million ★ 2024- $597 million ★ 2025- $590 million ★ 2026- $600 million ★ 2027- $599 million	pass-through funding to amount to approximately $865 million per year. The state will continue to monitor revenue/cost projections as the estimated 55,000 eligible Oregonians currently in the Medicaid population begin to transition during the PHE unwinding.
State Funding	According to the same 2022 Executive Budget, state funding for Essential Health Plan ★ 2021- $67 million ★ 2022- $65 million ★ 2023- $62 million ★ 2024- $62 million ★ 2025- $62 million In April 2021, the state budget established a $200 million Essential Plan Quality Pool to promote high quality of care. These funds will strengthen provider networks, incentivize providers based on performance, and ensure provider access for all Essential Plan members.	According to the same 2022 Forecast state funding for the BHP (excluding enrollee premiums) amounts to: ★ 2022- $55 million ★ 2023- $52 million ★ 2024- $81 million ★ 2025- $48 million ★ 2026- $50 million ★ 2027- $73 million	Initial analysis estimate required state funding for initial implementation of the Bridge Program will amount to $103.3 million between 2023-2025.
Market Impact	The uninsured rates have decreased to 5.2% in 2019 since the Essential Plan was enacted.	Minnesota has a total uninsured rate of 5.1%, significantly lower than both the national average (10.2%) and comparable states.	A simulation of Oregon's individual market suggested the market would remain relatively stable following the creation of the Bridge Plan. The

	New York	Minnesota	Oregon
	The Essential Plan reduced out of pocket cost by an average of $1,600 compared to enrolling in qualified health plans. 97% of people that are eligible for the Essential Plan are enrolled.	Similarly, there has been a notable decrease in uninsured rates since the BHP was enacted in its current form in 2015. While health spending has steadily increased over time, a very small portion of health costs can be attributed to MinnesotaCare. In fact, MinnesotaCare costs far less per capita than both Medicaid and private insurance coverage.	exit of the Bridge Plan eligible population from the market could lead to a reduction in average premium subsidies for those remaining in the individual market, may cause approximately 1,800 people to drop coverage and another subset of enrollees to shift to less generous coverage.
Stakeholder Engagement	The New York Department of Health started a workgroup in development of 1331 waivers. New York engaged groups such as consumer advocates, federally recognized tribes, health care associations, insurers, and provider groups. There were stakeholder meetings and public and written comments. Most comments focused on affordability, eligibility, enrollment, and provider rates. More information can be found here. The state comment period opened December 11, 2014 and closed January 12, 2015.	Minnesota DHS accepted public comments during two designated comment periods. Similarly, Minnesota DHS reached out to federally recognized tribes for comments. However, no comments were received. Two comment periods: ★ First Comment Period: ○ January 25, 2016 to February 24, 2016 ★ Second Comment Period: ○ October 19, 2016 to November 18, 2016 More information on stakeholder engagement within Minnesota DHS can be found here.	The Joint Task Force on the Bridge Health Care Program accepted written public comment relating to the design of the program on an ongoing basis. The Task Force also held time for public testimony at each meeting. Written comment submitted by members of the public through December 13, 2022 are available in appendix D here. The state waiver comment period opened May 1, 2023 and closed July 1, 2023. The Task Force recommended OHA conduct consumer focus groups to gather additional feedback before implementation and include

	New York	Minnesota	Oregon
			consumer representation in ongoing Bridge Plan governance.
Helpful Resources	Essential Plan BHP Blueprint 2015 Annual Report to Legislature and Governor Essential Plan Fact Sheet	MinnesotaCare BHP Blueprint MN House BHP Brief MinnesotaCare Fact Sheet 2021	DRAFT: Bridge Plan BHP Blueprint Bridge Plan Task Force Final Recommendations and Committee Materials USofCare Summarizes the Bridge Plan Task Force Preliminary Recommendations

Other innovative 1331 waivers that states are exploring

Kentucky

- ★ Kentucky has explored the possibility of pursuing a waiver to create a Basic Health Plan (BHP). This initiative is currently on hold.
  - In 2021, both houses of the legislature passed — and Governor Andy Beshear signed — a joint resolution establishing a work group to assess the feasibility of implementing a bridge insurance program, or Basic Health Plan.
  - In 2022, the Kentucky General Assembly approved $4.5 million in state funds and $4.5 million in federal funds as part of the 2022-24 state budget to set up the Basic Health Plan; however, the budget also requires the state to seek legislative approval prior to submitting a 1331 waiver blueprint for federal approval.
  - Initially, the state intended to launch the program in November of 2023 for coverage to begin on January 1, 2024, subject to CMS approval.
- ★ Proposed program design;
  - Expand coverage to U.S. citizens and lawfully present residents with the goals increasing access to and competition among plans, decreasing churn, and providing a flexible benefit package with cost-sharing requirements that fit the state's needs.