Using the State Innovation Waiver to Fill Obamacare's Coverage Gaps in Connecticut

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I. INTRODUCTION

While much attention has been focused on the coverage gaps in states that opted to not expand their Medicaid programs under the Affordable Care Act (ACA),[1] far less attention has been paid to the coverage gaps that persist in States celebrated as Obamacare success stories, such as Connecticut. Even in Connecticut, an early adopter of the Medicaid expansion, the cost of marketplace coverage for those just above the Medicaid eligibility threshold can be prohibitive.[2] Connecticut residents whose income put them at the dividing line between marketplace coverage and Medicaid eligibility face a high risk of changes to their coverage and costs when their income fluctuates, a concept known as "churn."[3] Churning leads to gaps in coverage and disruptions in health care access.

Section 1332 of Article I of the ACA, which allows states to apply for a state innovation waiver, provides a potential solution to this problem. Connecticut could apply for a Section 1332 waiver to use the federal funding allocated for marketplace tax credits and cost sharing reductions to fund a state program to address coverage needs of low-income individuals at the margin of Medicaid and the marketplace.

This paper proceeds in four parts. Section I provides an overview of the ACA's coverage expansions and the gaps that exist even in Medicaid expansion states. Section II describes the ACA's state innovation waiver

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[1] As of September 2016, 19 states had opted out of the Medicaid expansion: Alabama, Florida, Georgia, Idaho, Kansas, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin and Wyoming. Rachel Garfield & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Oct. 19, 2016), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update.

[2] This population would likely be eligible for tax credits towards their premiums, but the cost of coverage also includes out-of-pocket costs for services—deductibles, copayments and coinsurance. In 2016, maximum out-of-pocket costs for the lowest premium (bronze) plan, which is not eligible for cost-sharing reductions, ranged from $6,850 for individuals and $13,700 per family. *Standard Bronze Plan – 60% - Schedule of Benefits*, ACCESS HEALTH CT, http://ct.gov/hix/lib/hix/I_Standard_Bronze_Plan_60.pdf (last visited May 9, 2016).

[3] For further discussion of churn, see Benjamin D. Sommers et al., *Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact*, 33 HEALTH AFF. 700 (2014).

option. Section III analyzes how the waiver would fill Connecticut's coverage gaps. Finally, Section IV discusses some potential pitfalls and other issues for policymakers to consider.

II. ACA COVERAGE EXPANSIONS AND THE GAPS THAT PERSIST

The Affordable Care Act not only mandates that most people have health insurance coverage, but also endeavors to make coverage accessible in three main ways: (1) requiring employers with over fifty employees to offer insurance;[4] (2) creating health insurance marketplaces where consumers can compare and purchase insurance with premium and cost-sharing assistance (collectively called subsidies) for households between 100% and 400% of the federal poverty level (FPL);[5] and (3) expanding Medicaid to all adults at or below 138% FPL.[6] The system was designed to give everyone access to affordable coverage, including the very poor under Medicaid, the near-poor through subsidized coverage in the marketplaces, and the employed through the employer mandate. See Figure 3 for a chart outlining the various government-administered coverage categories in Connecticut.

In order to expand Medicaid coverage to the very poor, the ACA fundamentally altered Medicaid's scope by shifting it beyond its original focus on the "deserving poor." The Medicaid program, which was signed into law in 1965, was a federal-state partnership designed to cover medical expenses for aged, blind, and disabled individuals as well as parents and dependent children receiving public assistance.[7] The program is voluntary for states, but all states have participated since the early 1980s.[8] The Medicaid expansion provision of the Affordable Care Act was intended to cover low-income adults who were previously excluded from the program.

The Medicaid expansion has been one of the most effective ways of reducing the uninsured,[9] but it has also been considered one of the most

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[4] Jennifer Tolbert, *The Coverage Provisions in the Affordable Care Act: An Update*, KAISER FAM. FOUND. 10–11 (Mar. 2015), http://files.kff.org/attachment/issue-brief-the-coverage-provisions-in-the-affordable-care-act-an-update.

[5] *Id.* at 1. See Figure 1 for federal poverty level chart. Premium tax credits are available to U.S. citizens and legally residing immigrants who do not have access to affordable coverage through an employer, Medicaid, Children's Health Insurance Program or Medicare. Tolbert, *supra* note 4, at 13. The tax credits limit how much a consumer pays for coverage to a certain percentage of their income (between 2% and 9.6% in 2015) and are calculated based on the second-lowest cost Silver plan. *Id.* Cost sharing reductions are available to individuals eligible for premium tax credits with incomes between 100% and 250% FPL. *Id.* The cost sharing reductions lower deductibles, copayments and other out-of-pocket costs, but to take advantage of these, consumers must purchase a silver plan (the second lowest cost metal category). *Id.*

[6] *Id.* at 1. To support the Medicaid expansion, the federal government is financing it at 100% from 2014 through 2016, with the federal match phasing down to 90% in 2020 and thereafter. *Id.* at 16.

[7] Julia Paradise et al., *Medicaid at 50*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED 1 (May 2015), http://files.kff.org/attachment/report-medicaid-at-50.

[8] *Id.*

[9] *See infra* p. 5.

controversial provisions of the ACA. A legal challenge to the expansion was, in part, the issue that sparked the first Supreme Court ruling on the law.[10] The opponents of the Act prevailed and the Court's holding essentially made the Medicaid expansion optional.[11] As a result, a number of states have opted not to participate.[12] Subsequently, almost three million people in nineteen states have no coverage because their annual income is too high to qualify for traditional Medicaid (where the median eligibility limit is 44% FPL for parents; in most cases childless adults are ineligible), but are too poor to qualify for subsidized marketplace coverage, which begins at 100% FPL.[13]

In Connecticut, the first state to adopt the Medicaid expansion,[14] Medicaid and the Children's Health Insurance Program (CHIP)[15] are administered by the State Department of Social Services under the umbrella of the HUSKY Health Program. The HUSKY Program offers a comprehensive benefit package that covers preventive and primary care, specialist services, hospital care, behavioral health, dental services and prescription medications.[16] Medicaid members do not have to pay cost sharing and receive some additional services not offered by private coverage, including non-emergency transportation to health appointments.[17] There are four categories of HUSKY: A, B, C, and D, each of which carry different eligibility criteria, as outlined in Figure 2 and Figure 3.

The ACA's coverage provisions have shown results. Nationwide, the non-elderly uninsured rate dropped from 16.6% in 2013 to 14% in the second quarter of 2014, with eleven million uninsured adults gaining coverage in 2014.[18] States that expanded Medicaid have seen more significant drops in their levels of uninsured, averaging a 4.3 percentage point drop between 2013 and the second quarter 2014, compared to a reduction in the uninsured rate of only 2.5 percentages points in states that opted out of the Medicaid expansion.[19] Connecticut reported that its uninsured rate fell by half (from 7.9% to 4%) after the first open enrollment

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[10] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566 (2012).

[11] *Id.*

[12] *See supra* note 1 and accompanying text.

[13] Garfield & Damico, *supra* note 1.

[14] Press Release, U.S. Dep't. of Health & Human Serv., Conn. First in Nation to Expand Medicaid Coverage to New Groups under the Affordable Care Act (June 21, 2010), http://www.ct.gov/dss/lib/dss/pdfs/2010newsrelease/connecticut_first_in_nation_6.21.10.pdf.

[15] The CHIP program is also administered jointly between the states and federal government and provides low-cost or free coverage to children in families that earn too much to qualify for Medicaid. *The Children's Health Insurance Program (CHIP)*, HEALTHCARE.GOV, https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program (last visited May 9, 2016).

[16] *Benefit Overview*, CONN. HEALTH CARE FOR CHILDREN AND ADULTS, http://www.huskyhealth.com/hh/cwp/view.asp?a=3573&q=421554&hhNav=| (last visited May 9, 2016).

[17] *Id.*

[18] *See* Tolbert, *supra* note 4, at 19.

[19] *Id.*

period in 2014; over 250,000 people who enrolled in insurance through Medicaid or the marketplace.[20]

While low-income people in states that opted out of the Medicaid expansion face a well-recognized coverage gap, individuals in states that opted into the Medicaid expansion also face a significant gap at the border of Medicaid and marketplace coverage. Individuals in this gap are at a high risk of disruptions in coverage and costs when their income fluctuates, a concept known as "churn."[21] Individuals receiving coverage through Medicaid and marketplace plans must report changes in their income during the year.[22] If a marketplace member's income drops, they could qualify for a subsidy or even Medicaid coverage; if their income increases, their subsidy could be reduced or eliminated altogether. Similarly, if a Medicaid recipient's income increases, they could become ineligible for Medicaid and eligible for subsidized marketplace plans, with out-of-pocket costs and reduced benefits.[23] Marketplace members' failure to report changes in income could result in additional tax liabilities or credits at the end of the year, as they must reconcile the tax credits to actual earned income when filing their tax returns.[24] The lower bands of marketplace coverage include particularly vulnerable recent immigrants whose income is technically low enough to make them eligible for Medicaid, but they are barred from Medicaid by federal law until they have been in the country five years.[25] (In 2009, this group represented about 4,800 people in Connecticut.[26])

Because Medicaid and marketplace plans may provide very different sets of benefits and healthcare provider networks, moving between plans produces gaps in coverage and disruptions in the continuity of care, as patients may have to find new providers and substitute treatments when they change plans.[27] The steep cost sharing in the marketplace plans put coverage out of reach for some low income people; therefore losing eligibility for

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[20] Press Release, Access Health CT, Conn. Statewide Insurance Rate Cut in Half (Aug. 6, 2014) http://4155l2gg5ga3d1m572z1uo2qov.wpengine.netdna-cdn.com/wp-content/uploads/2015/10/2014_08_06- AHCT-Cuts-uninsured-in-half.pdf.

[21] Benjamin D. Sommers et al., *Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact*, 33 HEALTH AFF. 700, 700–01 (2014).

[22] *FAQ: Affordability – What Happens If My MAGI Changes During the Year?*, ACCESS HEALTH CT, http://learn.accesshealthct.com/faqs/ (last visited May 9, 2016).

[23] Note that Connecticut parents with earned income, including many on HUSKY A, are eligible for one year of transitional medical assistance in accordance with *Rabin vs. Wilson Coker*, 362 F.3d 190 (2d Cir. 2004).

[24] *See FAQ: Affordability, supra* note 22, at 1.

[25] Lawfully present immigrants who have been in the U.S. less than five years can get subsidized coverage through the insurance marketplace but are ineligible for Medicaid. *Key Facts about the Uninsured Population,* KAISER FAM. FOUND. (Sept. 29, 2016), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[26] Brief for Appellee at 1, 17, Pham v. Starkowski, 300 Conn. 412 (2010) (No. 18582), 2010 WL 5813146.

[27] Sommers et. al., *supra* note 21.

Medicaid or subsidized coverage may result in a person losing coverage altogether.

For example, a single 30-year old male living in Hartford County and making $24,000 is at 202% of the federal poverty level, making him "too rich" for to qualify for Medicaid (for which eligibility ends at 138% FPL), but eligible for a premium tax credit if he purchases the lowest premium bronze plan through the marketplace. While the bronze plan will have relatively low monthly premiums (starting at less than $28), the member must reach an annual deductible ranging from $3,500 to $6,200 before the plan's benefits kick in (at an estimated annual cost of between $3,836 and $6,536 per year when the premium is added to the deductible).[28] Meanwhile, if the male purchases a more expensive silver plan, he will pay more in monthly premiums (at least $132 per month), but will be eligible for a premium tax credit plus cost-sharing subsidies resulting in a deductible ranging from $500 to $2,750 (at an estimated annual cost of $2,084 to $4,334).[29] Based on the Massachusetts Institute of Technology's Living Wage Calculator, a person living in Hartford County and making $24,000 can only afford to pay $2,520 per year toward their medical expenses given other living expenses.[30] In other words, even a young person with robust subsidies may not be able to afford the most affordable plans available through Access Health CT (Connecticut's marketplace).

In a Medicaid expansion state like Connecticut, being a poor and uninsured adult bears little difference to being a poor and uninsured adult in a state without expanded Medicaid. Going without coverage has been shown to result in negative health consequences. Without insurance, people tend to delay treatment and receive less preventive care, resulting in more serious illnesses.[31] It also results in risk of medical debt and other negative outcomes such as using up savings, having difficulty paying for non-medical necessities, borrowing money, and anxiety leading to delayed or forgone

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[28] Cost information obtained using Access Health CT enrollment tool available at www.accesshealthct.com. (last visited May 8, 2016).

[29] *Id.*

[30] Amy K. Glassmeier, *Living Wage Calculation for Hartford County, Connecticut*, MASS. INST. OF TECH., http://livingwage.mit.edu/counties/09003 (last visited May 9, 2016).

[31] INST. OF MED. OF THE NAT'L ACAD., COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, HEALTH INSURANCE IS A FAMILY MATTER, (2002); *see also* Jack Hadley, *Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income*, 60 MED. CARE RES. AND REV. 3S (2003); Pamela Farley Short et al., *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, THE COMMONWEALTH FUND 9 (November 2003), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2003/nov/churn--churn--churn--how-instability-of-health-insurance-shapes-americas-uninsured-problem/short_churn_688-pdf.pdf; *But see* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG J. MED. 1713, 1718–21 (2013).

care.[32] Finally, loss of insurance results in the uninsured seeking costly emergency department visits and hospitalizations due to forgone preventive measures—care for which hospitals may never receive payment (called uncompensated care).[33]

Churning between Medicaid and the health insurance marketplace plans may be a significant problem. At the March 2016 board meeting of Access Health CT, staff reported that the churn rate between Medicaid and private insurance was approximately 4–10% on a monthly basis.[34] However, a national study estimated Connecticut's rate of continuous eligibility in Medicaid and marketplace plans at 70% over six months and only 52% over twelve months. This means that almost half of recipients may lose eligibility over the course of the year.[35] Further, the study's authors note that while churn rates were likely to be high in all states, they were likely to be higher in states with more generous Medicaid eligibility criteria and with higher per capita incomes and lower poverty rates, resulting in a larger share of the population at the upper end of Medicaid eligibility.[36] Connecticut satisfies these criteria, which points to a likelihood of high churn rates.

Recent changes to Connecticut's Medicaid program will likely exacerbate the churning problem. Despite its embrace of the Medicaid expansion,[37] Connecticut, like many other states, has struggled to balance its budget since the economic downturn of 2008. The Medicaid program has been a major cost-center for the state because caseloads have increased in Medicaid categories for which the state receives less than 100% federal reimbursement.[38] In February 2015, Connecticut Governor, Dannel Malloy,

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[32] Rachel Garfield & Katherine Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security Among Newly Insured Adults*, KAISER FAM. FOUND. 15 (June 2015), http://files.kff.org/attachment/issue-brief-how-does-gaining-coverage-affect-peoples-lives-access-utilization-and-financial-security-among-newly-insured-adults.

[33] *See* Peter J. Cunningham, *Medicaid/SCHIP Cuts and Hospital Emergency Department Use*, 25 HEALTH AFF. 237, 245 (2006); Mary E. Rimsza et al., *Impact of Medicaid Disenrollment on Health Care Use and Cost*, 119 PEDIATRICS e1026, e1030–31 (May 2007); Stephen Zuckerman et al., *Missouri's 2005 Medicaid Cuts: How Did They Affect Enrollees and Providers?* 28 HEALTH AFF. w335, w343–44 (2009).

[34] Conn. Health Insurance Exchange Board of Directors Mins. for Mar. 17, 2016 Meeting, 4 (2016), http://www.ct.gov/hix/lib/hix/APPROVED_03172016_Minutes_Connecticut_Health_Insurance_Exchange.pdf. BOARD OF DIRECTORS OF THE CONNECTICUT HEALTH INSURANCE EXCHANGE, MEETING MINUTES (Mar. 17, 2016).

According to the staff of the Exchange, more detailed reporting on churn is forthcoming.

[35] Sommers, *supra* note 21, at Appendix Exhibit 2.

[36] *Id.* at 704–05.

[37] Connecticut was an early adopter of the Medicaid expansion, extending coverage to adults earning up to 56% of the federal poverty level beginning April 1, 2010 as an interim step to the full expansion. *See supra* note 14.

[38] Benjamin D. Sommers et al., *New Evidence on The Affordable Care Act: Coverage Impacts of Early Medicaid Expansions*, 33 HEALTH AFF. 78, 85 (2014). Even though the federal government reimburses states that participate in the ACA Medicaid expansion at a rate of 100%, the marketing around the expansion has increased enrollment numbers in groups who were eligible even without the ACA eligibility expansions. *Id.* at 79. The federal government reimburses a state's normal Medicaid reimbursement rate for these previously eligible individuals, resulting in a net cost to the state. *Id.* In Connecticut, this rate is 50%. Arielle Levin Becker, *Spending and Enrollment Up, But Medicaid Per-Person Cost is Down*, CT MIRROR (Jan. 15, 2016), https://ctmirror.org/2016/01/15/spending-and-

proposed eliminating Medicaid coverage for approximately 34,200 HUSKY A adults: affected parties included pregnant women and parents of Medicaid children with incomes between 138% and 201% FPL.[39] This was done with the intent to reduce state expenditures.[40] Without access to Medicaid, these adults are eligible for subsidized insurance through the health insurance marketplace.[41] Governor Malloy's proposal raised serious questions among advocates about whether low-income parents could afford marketplace coverage even with the subsidies.[42] To support their position, advocates cited low enrollment numbers among uninsured people, under 200% FPL.[43] Despite these concerns, the legislature and Governor ultimately agreed on a compromise that eliminated eligibility for an estimated 23,700 non-pregnant adults of minor children with incomes in excess of 155% FPL for an anticipated savings of $2.4 million in FY 16 and $43.5 million in FY 17.[44]

The early results of these eligibility changes were not promising. According to a February 2016 report, 18,903 non-pregnant HUSKY A adults were ultimately identified as having household incomes above 155% FPL.[45] A large subset of these adults (17,688) qualified for Transitional Medical Assistance, allowing them to retain their HUSKY A coverage until August 1, 2016.[46] The remaining 1,215 individuals were scheduled to lose coverage on September 1, 2015,[47] but of those, 570 continued to qualify for Medicaid because they were pregnant, had a qualifying disability, or earned less income than they originally reported.[48] Only 171 individuals (14%) enrolled in marketplace coverage.[49] The ACA's state innovation waiver option offers

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enrollment-up-but-medicaid-per-person-cost-is-down. Note, while caseloads have grown, per member per month Medicaid costs have actually leveled off. *Id.*

[39] See Figure 1 for federal poverty level chart.

[40] OFFICE OF FISCAL ANALYSIS BUDGET SHEETS FOR HUMAN SERVICES SUBCOMM., FY 2016-2017 BIENNIAL BUDGET PROPOSAL, at 10 (Ct. 2015), https://www.cga.ct.gov/ofa/Documents/year/GOVBS/2015GOVBS-20150226_Human%20Services%20Subcommittee%20Budget%20Sheets%20Agency%20Hearing%20Phase%20FY%2016%20and%20FY%2017.pdf.

[41] *Id.*

[42] *See* Arielle Levin Becker, *As Medicaid Cut Looms, Critics Warn of More Uninsured,* CT MIRROR (June 9, 2015), https://ctmirror.org/2015/06/09/as-medicaid-cut-looms-critics-warn-of-more-uninsured.

[43] *Testimony Opposing Reduced Appropriations for the Department of Social Services: Testimony to the Appropriations Comm.*, H.B. No. 6824 (Conn. 2015) [hereinafter *H.B. No. 6824 Testimony*] (testimony of Connecticut Voices for Children), http://www.ctvoices.org/sites/default/files/022715_approps_hb6824_noreducedappropsdss.pdf.

[44] CONN. GEN. ASSEMBLY OFFICE OF FISCAL ANALYSIS, STATE BUDGET FOR FY 16 & FY 17, at 341 (2015), https://www.cga.ct.gov/ofa/Documents/year/BB/2016BB-20151007FY%2016%20and%20FY%2017%20Connecticut%20Budget.pdf. Note that 155% FPL includes a 5% income disregard.

[45] Dep't of Soc. Services, *Husky A Parent Transition*, CONN. GEN. ASSEMBLY 1–5 (Feb. 19, 2016), https://www.cga.ct.gov/med/council/2016/0219/20160219ATTACH_HUSKY%20A%20Transitions%20.pdf.

[46] *Id.* at 5. *See supra* text accompanying note 23.

[47] Dep't of Soc. Services, *HUSKY A Parent Transition*, *supra* note 45, at 9.

[48] *Id.* at 13.

[49] *Id.* The 474 individuals, who did not enroll in marketplace coverage, could have enrolled in insurance through another channel, such as employer coverage.

an opportunity for Connecticut to cover this population at little or no state cost.

II. SECTION 1332 STATE INNOVATION "SUPER WAIVER"

A. Literature Review

ACA architect Professor John McDonough and others have referred to section 1332 as a "super waiver" for its potential as a game changer in federal and state health policy.[50] This low-profile provision of the ACA has broad appeal across the ideological spectrum, garnering interest from Senator Bernie Sanders and Arkansas republicans alike, because it permits states to waive a variety of key provisions of the law within certain parameters.[51]

There is a gap in literature in this area, and much of what exists was authored prior to the December 2015 release of the waiver guidance. McDonough authored the seminal paper in this area, which provides thorough background on the legislative development of the waiver and examples of potential uses.[52] McDonough provides a good starting point for further exploration, but he does not examine the opportunities or constraints of section 1332 or its regulations. Similarly, Heather Howard and Galen Benshoof provide a background on the law and outline some categories of innovation, but do not explore any of these in-depth.[53] In contrast, Elizabeth Weeks Leonard focuses on ACA-opponents' apparent ambivalence to section 1332 waivers, despite the fact they would allow states to waive out of some of the ACA provisions they have bitterly criticized.[54] While this note does not focus on this tension, Weeks Leonard provides context for analyzing some states' decision-making. Meanwhile, Marea B. Tumber identifies the federal Employee Retirement Income Security Act (ERISA), which preempts state action, as a barrier to innovation under section 1332.[55] In contrast, the present analysis focuses on Medicaid and individual coverage sold through the marketplace and not employer-sponsored insurance. Similar to the present analysis, Kimberly S. Min focuses on a particular use for the waiver: supporting Vermont's proposed single payer

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[50] John E. McDonough, *Wyden's Waiver: State Innovation on Steroids*, 39 J. HEALTH POL. POL.'Y & L. 1, 11–12 (2014).

[51] *Id.* at 5, 8–10.

[52] *Id.*

[53] Heather Howard & Galen Benshoof, *State Innovation Waivers: Redrawing the Boundaries of the ACA*, 40 J. HEALTH POL. POL.'Y & L. 1203 (2015).

[54] Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation*, 46 U. RICH. L. REV. 781 (2012).

[55] Marea B. Tumber, Note, *The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Healthcare Reform?*, 10 U. MASS. L. REV. 388 (2015).

system. [56] This note, however, focuses on addressing a specific gap in coverage rather than overhauling a state insurance system as Vermont, Colorado and other states have proposed. Finally, Robert B. Leflar examines how the waiver could be used to support "nontraditional federally funded alternatives" to Medicaid, like the one developed by Arkansas, which offers subsidized private insurance to low-income residents in lieu of expanded Medicaid. [57] In contrast, this note seeks to propose how a public plan could be designed to cover the lowest income people currently eligible for private coverage through the marketplace.

B. Background

Beginning in 2017, section 1332 of Article I of the ACA authorizes the U.S. Secretaries of Health and Human Services and Treasury to grant states waivers from certain provisions of the Act if they meet certain coverage and cost standards.[58] Under this section, states may waive the following ACA provisions for plan years beginning on or after January 1, 2017: the establishment of qualified health plans, including the essential health benefits, cost-sharing limits and standard metal tiers; minimum federal standards for plans offered in the marketplaces and the basic functions of the marketplaces; cost sharing reductions for low- and modest-income people in marketplace plans; premium tax credits; the individual mandate and related penalty; and the employer penalty.[59] States may not waive the ACA's guaranteed issue and related rating rules (*i.e.*, the prohibition on insurers denying coverage or increasing premiums based on medical history).[60]

Section 1332 gives states fairly broad authority to waive provisions of the ACA, but provides four "guardrails" to protect against cuts in the number of people covered, comprehensiveness of benefits, erosion of affordability, and impact to the federal deficit. In order to gain the approval of the

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[56] Kimberly S. Min, *Waiver for State Innovation: A Call for Increased Success or a Projected Failure?*, 26 HEALTH L. 32 (2013).

[57] Robert B. Leflar, *Red-State Health Reform: Threading the Political Needle*, 24 ANNALS OF HEALTH L. 410, 410 (2015).

[58] 42 U.S.C. § 18052 (2010).

[59] 42 U.S.C. § 18052; 31 C.F.R. pt. 33 (2012); 45 C.F.R. pt. 155 (2012).

[60] Deborah Bachrach et al., *Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform*, COMMONWEALTH FUND 2 (Apr. 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/apr/1811_bachrach_innovation_waivers_rb_v2.pdf. The statute requires state legislation authorizing the waiver request. It specifies that waivers cannot be implemented until January 1, 2017 and may extend up to five years. 42 U.S.C. § 18052. The proposal is subject to public notice and comment both prior to submission at the state level and once the Secretaries have received it. 42 U.S.C. § 18052; 31 C.F.R. §§ 33.112–33.116; 45 C.F.R. §§ 155.1312–155.1316. Following approval, states must also hold a public forum to solicit comments six months after the implementation date and annually thereafter. 31 C.F.R. § 33.120; 45 C.F.R. § 155.1320. The regulations also specify reporting and evaluation requirements. 31 C.F.R. §§ 33.124–33.128; 45 C.F.R. §§ 155.1324–155.1328. The waiver application must include sufficient actuarial analyses, data and assumptions for the Secretaries to determine whether the application satisfies the guardrails. 31 C.F.R. § 33.108; 45 C.F.R. § 155.1308.

Secretaries of Health and Human Services and Treasury, a state's proposal must: (1) provide coverage that is as least as comprehensive as the coverage offered through the marketplace based on the essential health benefits; (2) provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as marketplace coverage; (3) provide coverage to at least as many people as the marketplace prior to the waiver; and (4) must not increase the federal deficit.[61]

In December 2015 guidance, the Secretaries of Health and Human Services and Treasury elaborated on the guardrail requirements. The guidance specified that "vulnerable residents" cannot be negatively impacted by changes to the number of individuals covered, comprehensiveness of coverage and affordability.[62] It stated that a waiver proposal that negatively impacts vulnerable residents would be rejected.[63] The guidance defines vulnerable residents to include individuals who are low-income, elderly, have serious health issues or are at risk of developing them.[64]

To date, states have examined a number of proposed uses of the 1332 waiver. For example, Colorado voters considered a ballot measure on whether to replace the ACA with single-payer system under a 1332 waiver in 2016.[65] The California legislature considered a bill to open the state's unsubsidized marketplace plans to undocumented immigrants.[66] Vermont officials have discussed waiving the small business marketplace requirement.[67] The Governor of Arkansas proposed using the waiver to bolster the state's private coverage efforts by strengthening employer-sponsored insurance.[68] Previously, Arkansas officials had expressed an interest in using the waiver to strengthen its private alternative to Medicaid.[69] Minnesota's Health Care Financing Task Force issued a draft report in January 2016 which suggested a number of possible uses for a 1332 waiver:

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[61] 42 U.S.C. § 18052.

[62] Waivers for State Innovation, 80 Fed. Reg. 78131, 78132 (proposed Dec. 16, 2015) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155).

[63] *Id.*

[64] *Id.*

[65] Rachana Pradan, *One state's unlikely Obamacare replacement plan: Single-payer*, POLITICO (Nov. 12, 2015, 5:25 AM), http://www.politico.com/story/2015/11/obamacare-colorado-single-payer-health-care-215780.

[66] S.B. 10, 2015–2016 Reg. Sess. (Ca. 2016).

[67] Lawrence Miller & Justin Johnson, *VT Health Connect, Exchange Options for 2017*, VT. HEALTH CONNECT 50 (Nov. 2, 2015), http://www.leg.state.vt.us/jfo/jfc/2015/2015_11_13/Vermont%20Health%20Connect%20Exchange%20Options%20FINAL%20110215.pdf.

[68] *Manatt on Health Reform: Weekly Highlights*, MANATT, PHELPS & PHILLIPS (Dec. 22, 2015), https://www.manatt.com/health-reform-weekly-highlights-12-22-15.aspx.

[69] *See* Andrew Allison, *Report on Health Reform Implementation: Arkansas's Alternative to Medicaid Expansion Raises Important Questions about How HHS Will Implement New ACA Waiver Authority in 2017*, 39 n. 5 J. HEALTH POL., POL'Y & L. 1090 (2014). This effort may have been stymied by federal guidance precluding states from offsetting additional costs in Medicaid 1115 waivers with savings in 1332 waivers and vice-versa. *See* Waivers for State Innovation, 80 Fed. Reg. 78131, 78132 (Dec. 16, 2015) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155).

enabling adults to use advance premium tax credits and cost sharing reductions to subsidize their purchase of dental insurance through the marketplace;[70] fixing the so-called "family glitch";[71] and improving affordability of coverage and smoothing premium and cost-sharing cliffs for individuals between 200% and 275% FPL by expanding that state's Basic Health Program.[72] Hawaii will use the waiver to resolve some conflicts between the ACA and that state's employer mandate.[73] Similarly, Massachusetts is considering the waiver as a solution for reconciling its pre-ACA small group market reforms with the ACA, as well as to create new options to increase small business and individual consumer choice and a state-based approach to the individual mandate.[74]

Unlike Colorado's broad overhaul and Hawaii and Massachusetts' harmonizing efforts, this note proposes tailoring the waiver to fill Connecticut's coverage gap at the border of Medicaid and subsidized marketplace eligibility. This is analogous to Minnesota's proposal to expand its Basic Health Program, which covers a similar population. However as will be discussed, Connecticut is ineligible for the Basic Health Program option.

III. USING A WAIVER TO FILL CONNECTICUT'S COVERAGE GAP

A. The Problem

The adults in the HUSKY A category of Medicaid, whose eligibility was recently subject to state budget cuts, exemplify the challenges people who fall in the margin between Medicaid and the marketplace face. During the debate over cuts to HUSKY A, opponents of the cuts raised several concerns around affordability and access to needed services. One of the most significant obstacles to enrolling in insurance through the marketplace is the price of coverage.[75] Opponents of the cut were concerned about whether this group would purchase marketplace coverage, given that it offers less robust benefits (especially with regard to mental health, substance abuse and dental

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[70] MINN. HEALTH CARE FIN. TASK FORCE, *Health Care Financing Task Force Final Report* 12 (Jan. 28, 2016), http://mn.gov/dhs-stat/images/final-materials-final-report_01-28-2016.pdf

[71] *Id.* at 17. Family glitch is a widely-recognized defect in the ACA tax credit system that prevents individuals from accessing marketplace subsidies where their employer offers employee coverage that meets the affordability threshold for an individual but not a family. Thus, while employee-only coverage may be considered affordable, covering the whole family on the employer's plan is not, but the family is precluded from accessing Medicaid and marketplace tax credits and cost sharing reductions. *Id.*

[72] *Id.* at 22. *See* discussion *infra* Section III.B.

[73] EXEC. CHAMBERS OF GOVERNOR DAVID Y. IGE, HAWAI'I'S PROPOSAL TO WAIVE CERTAIN PROVISIONS OF THE PATIENT PROTECTION & AFFORDABLE CARE ACT (2016), https://governor.hawaii.gov/wp-content/uploads/2014/12/Hawaii-ACA-Section-1332-Waiver-Proposal-June-15-2016.pdf.

[74] MASS. HEALTH CONNECTOR, *Section 1332 Innovation Waiver – Summary of Preliminary Policy Direction* (Dec. 9, 2015), https://betterhealthconnector.com/wp-content/uploads/SIW-Summary-of-Preliminary-Policy-Direction-120915.pdf.

[75] *See* KAISER FAMILY FOUNDATION, *supra* note 25.

services[76]), for a higher price than Medicaid (which generally does not charge premiums, deductibles, or copayments).[77] Thus, even someone who qualified for the most generous premium tax credits and cost-sharing reductions would still pay significantly more for less comprehensive coverage than they would on Medicaid.

The Connecticut Health Foundation provided examples to illustrate this point: (1) a family of two at 180% FPL ($28,674 in 2015), with annual medical expenses of only $300 will still pay $1,582 in annual premiums and cost sharing and (2) a family of two making 201% FPL ($32,019) with annual medical costs of $12,000 would pay $5,268 in premiums and cost sharing. [78] In both cases the families would receive covered services for free on Medicaid. The Foundation estimated that under the original proposal[79] 20–30% of those slated to lose Medicaid coverage would not enroll in the marketplace plans, and those who did enroll might delay care to avoid out-of-pocket costs.[80] Opponents of the cut cited a similar budget cut in Rhode Island, where Medicaid coverage was eliminated for individuals between 138% and 175% FPL, who were also eligible for subsidized coverage through that state's insurance marketplace. Four months after losing coverage, only 11% had enrolled in the state's marketplace.[81]

Experts' dire coverage predictions for those losing Medicaid coverage in Connecticut may be coming true. The initial HUSKY A adults' uptake of marketplace insurance was only marginally higher than the Rhode Island experience. As previously discussed, after the first (and relatively small) round of cuts, about 14% of those who lost Medicaid coverage in August

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[76] As Connecticut Voices for Children noted in its testimony to the Appropriations Committee regarding the HUSKY A cuts, "HUSKY coverage is tailored to the needs of low-income families . . . access to behavioral health services is limited or too expensive under many commercial plans. There is tremendous concern that individuals whose mental health conditions are controlled with psychiatric medications will forgo those drugs if they have to pay even nominal amounts. It is very likely that many of these parents, struggling to pay rent, utilities, food, clothing, and other essential items for their children, will forgo paying for their own health insurance coverage, rather than skimp on supports for the family as a whole." *See H.B. No. 6824 Testimony*, *supra* note 43, at 4.

[77] MARY FITZPATRICK & ALEX REGER, *Copays and Deductibles in Medicaid and Health Insurance Plans*, OFFICE OF LEGISLATIVE RESEARCH 1 (Jun. 25, 2015), https://www.cga.ct.gov/2015/rpt/pdf/2015-R-0160.pdf.

[78] Rachel Gershon et al., *How Proposed HUSKY Cuts will Harm Low Income Families*, CONN. HEALTH FOUNDATION 2–3 (Mar. 15, 2015), http://www.cthealth.org/wp-content/uploads/2015/03/2015-HUSKY-Parents-Brief-Final.pdf. Note that cost-sharing reductions are only available to those purchasing a silver plan, not the lowest-premium bronze plan. However, the most generous cost sharing reductions (two-thirds) are available to households making 200% FPL or less. *See* 42 USC § 18071 (2012).

[79] The original proposal was broader than what was adopted in June 2015; it would have eliminated coverage for pregnant and non-pregnant adults in the 138%-201% FPL range. *See* OFFICE OF FISCAL ANALYSIS BUDGET SHEETS FOR HUMAN SERVICES SUBCOMM., *supra* note 40. The final proposal cut eligibility for non-pregnant adults above 155% FPL. *See* CONN. GEN. ASSEMBLY OFFICE OF FISCAL ANALYSIS, *supra* note 44. *See* Figure 1 for federal poverty level chart.

[80] *See* Gershon et al., *supra* note 78, at 3.

[81] *Id.*

2015 enrolled in the marketplace within five months.[82] This may confirm predictions that the bulk of those who lose their HUSKY A benefits are unlikely to enroll in marketplace plans. Further, those who do enroll are likely to do so because they have medical needs, resulting in adverse selection, which can drive up claims and premiums, making the market less attractive to insurers and the healthy consumers needed to dilute risk.[83]

B. Policy Solution

1. Create a new program for the low-income marketplace

Connecticut could address the problems of affordability and churn by using a state innovation waiver to create a new program for non-pregnant adults and children between 138% and 201% FPL, the lower end of eligibility for the marketplace. Under the waiver rules, the state could divert the federal marketplace subsidies earmarked for these individuals to cover the cost of administering the program. This plan would permit Connecticut to cover those individuals who are ineligible for Medicaid but cannot afford marketplace coverage (such as childless adults just above the income threshold for HUSKY D) and the up to 18,900 HUSKY A parents[84] set to lose coverage. It would also provide an affordable option for thousands of very low-income recent immigrants who are not eligible for Medicaid.[85]

Marketplace plans exclude, severely limit, or levy significant out-of-pocket costs for services that Medicaid provides in order to meet the needs of low-income families, such as medically necessary prescriptions, transportation to appointments, dental, behavioral health and substance abuse services.[86] This new program could be designed with lower cost-sharing, more robust benefits, and a provider network similar to that offered in Medicaid in order to reduce the impact of moving between the new program and Medicaid.

2. Federal funding

By creating a new coverage category under the 1332 waiver, the state would receive the value of 100% of the subsidies each covered individual would have received in the marketplace.[87] Currently Connecticut is

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[82] *See* Dep't of Soc. Services, *HUSKY A Parent Transition*, *supra* note 45, at 9. In addition, 52 individuals enrolled but later cancelled or were disenrolled for failure to pay premiums. *Id.*

[83] Cynthia Cox et al., *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, KAISER FAMILY FOUND. 1 (Aug. 17, 2016), http://files.kff.org/attachment/Issue-Brief-Explaining-Health-Care-Reform-Risk-Adjustment-Reinsurance-and-Risk-Corridors.

[84] This is a revised estimate as of February 2016. *See* Dep't of Soc. Services, *HUSKY A Parent Transition*, *supra* note 45, at 5.

[85] *See supra* p. 7; KAISER FAMILY FOUNDATION, *supra* note 25; Brief of Appellee at 1, 17, Pham v. Starkowski, 300 Conn. 412 (2010) (No. 18582), 2010 WL 5813146, at *1, *17.

[86] *See H.B. No. 6824 Testimony*, *supra* note 43.

[87] 42 USC § 18052(a)(3) (2012).

reimbursed for about 50% of its costs for non-expansion Medicaid.[88] The new program could be configured in such a way so that the federal funding covers more than half, if not 100% of the costs. Given the limited availability of cost and demographic data for individuals in the 138% to 201% FPL range, it is difficult to estimate the potential cost or savings to the state of implementing this plan. But what follows is a simplified estimate based on the small group of HUSKY A parents who enrolled in the marketplace from July through October 2015 upon losing their coverage.[89]

The per capita costs of the HUSKY A program have recently averaged between $314 and $349 per member per month.[90] The first wave of those transitioning from HUSKY A to the marketplace, 160 non-pregnant adults between 155% and 201% of FPL, qualified for an average monthly marketplace tax credit of $584.77.[91] By comparing the average monthly costs (between $314 and $349) to this monthly tax credit, it appears the state could reasonably design a plan for which federal subsidies would exceed the cost of the program by between $235.77 to $270.77 per member per month, resulting in a savings to the state over the current (non-expansion) Medicaid program, for which the state typically recoups half of its costs. In addition, the state could realize lower monthly costs by covering this population in a waiver program than in the marketplace, where the total (unsubsidized) premiums for the first wave of HUSKY A parents averaged $723.06 per member per month versus a cost of less than $350 per member per month in Medicaid.[92]

There are policy levers available to the state to adjust the cost of the proposed waiver program. These levers include adjusting the ages and income ranges of those covered by the waiver. For example, older adults pay the highest premiums in the marketplace of any age group, but because the subsidy is a percentage of their premium, older adults qualify for the largest subsidies in the marketplace. However, older enrollees tend to utilize more services and therefore cost more on a monthly basis.[93] Meanwhile, young

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[88] Dep't. of Social Services, *Board of Directors Meeting January 21, 2016*, CONN.'S OFFICIAL ST. WEBSITE 74 (Jan. 21, 2016), http://www.ct.gov/hix/lib/hix/PRESENTATION01212016.pdf.

[89] Access Health CT, *Board of Directors Meeting November 15, 2015*, CONN.'S OFFICIAL ST. WEBSITE 15 (Nov. 19, 2015), http://www.ct.gov/hix/lib/hix/FinalPresentation.pdf.

[90] Dep't of Soc. Services, *Updated Review of Medicaid Financial Reports and Trends*, CONN.'S OFFICIAL ST. WEBSITE 8 (Jan. 8, 2016), https://www.cga.ct.gov/med/council/2016/0108/20160108 ATTACH_Medicaid%20Trends%20Presentation.pdf. This per member per month average covers the quarters ending December 2013 through September 2015. *Id.* Note that this per member per month cost includes pregnant women, who tend to utilize more services, but would not move into the waiver program under this proposal. In contrast, the monthly cost does not account for childless adults who tend to be sicker than those with dependents and would be included in the proposed program. *See* figure 1 for federal poverty level chart.

[91] *See* Access Heath CT, *supra* note 89.

[92] *Id.*

[93] Larry Levitt et al., *The Numbers Behind the "Young Invincibles" and the Affordable Care Act.* KAISER FAMILY FOUND., (Dec. 17, 2013), http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/.

people tend to be healthier and have lower premiums but therefore qualify for lower premiums subsidies.[94] If the state just wanted to cover the adults cut from HUSKY A, it would formulate a waiver to cover qualifying parents between 155% and 201% FPL, but if it covered childless adults, children and pregnant women, it could go as low as 138% FPL and as high 400% FPL, the income limit for federal subsidies.

In making the policy decision around income range, the state will probably need to engage an actuarial consultant with the ability to model utilization, per member per month costs, and corresponding federal reimbursements in these income ranges. The state will also need to consider the size of the population the waiver program will cover. The first wave of the HUSKY A eligibility cut only resulted in about 53% of those projected to lose eligibility actually losing it.[95] This means that a substantially smaller portion than estimated might actually be eligible for the marketplace and for this proposed program. It does not make actuarial or administrative sense to create a program that will serve only a few thousand people.

Lowering benefit levels and increasing out of pocket costs will reduce the overall cost of the plan. However, adjusting benefit levels and costs so that they are too similar to the marketplace plans will undermine the goal of creating a more robust program aligned with the needs of low-income families. In order to make running plan worthwhile, it should look more like Medicaid than the commercial plans in the marketplace. One way to lower costs independent of benefits and cost sharing is to lower health provider payments. In general, private health insurance plans reimburse providers at higher rates than their costs in order to compensate for the cost shift from underpayments from government programs.[96] However, provider reimbursements in the marketplace plans are reportedly lower that most commercial rates. They are close to or below Medicare rates, leading some providers to opt-out of the marketplace plan networks.[97] Reducing reimbursement rates too much in the waiver program could result in inadequate provider networks, where members must change their providers upon entering the plan and face long waits and geographic barriers to accessing medical services.

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[94] *Id.*

[95] *See* Dep't of Soc. Services, *HUSKY A Parent Transition*, *supra* note 45, at 13. Note that extending this program above 201% FPL to cover more of the existing marketplace tax credit recipients would help to mitigate the ACA requirement that recipients repay a portion of their tax credits if their income goes up and their tax credit is not adjusted down, creating an unexpected expense at tax time.

[96] For example, according to the Connecticut Hospital Association, private health insurance reimburses at 131% of the actual cost of care, while Medicare reimburses at 92% and Medicaid reimburses at 72%. Conn. Hosp. Ass'n, *Hospital 101 Handout*, CHIME, 2 (Feb. 2012), http://www.chime.org/CHA/assets/File/newsroom/publications/CHA_Hospital101_DRAFT_v6.pdf.

[97] Roni Caryn Rabin, *Doctors Complain they will be Paid Less by Exchange Plans*, KAISER HEALTH NEWS (Nov. 19, 2013), http://khn.org/news/doctor-rates-marketplace-insurance-plans/.

3. Covering the whole family

By removing some parents from HUSKY A, Connecticut has bifurcated eligible children's coverage from that of their parents. This note proposes adding income eligible children to the waiver program along with their parents. There are advantages to keeping parents in the same coverage category as their children, including consistent coverage across a whole family and a simpler enrollment process. A 2005 study found that children living in states with separate Medicaid and CHIP programs (splitting some children into a separate program from their parents) were 45% more likely to drop out than children living in states with combined programs.[98] Dividing the family into separate coverage programs is confusing and may discourage families from spending the time to renew their coverage.[99] For this reason, if Connecticut decides to create a coverage program using the 1332 waiver, it should use a family-based approach so that parents and children have the same benefits, provider networks, and enrollment procedures.

Connecticut may also be able to use the 1332 waiver to address the ACA's "family glitch," which limits families' access to federal subsidies when they are offered unaffordable employer-sponsored insurance (ESI). Where an employee is offered coverage that meets the federal affordability standards for employee-only coverage but exceeds these standards for the family plan, the spouse and dependents are legally precluded from accessing marketplace tax credits and cost sharing reductions.[100] Some of the parents slated to lose HUSKY A coverage maybe affected by the family glitch.[101] Minnesota considered applying for 1332 waiver authority to amend the definition of affordability for ESI so that it considers the cost of dependent/family coverage for affordability purposes.[102] By incorporating a similar provision into its waiver proposal, Connecticut should be able to address the family glitch, making affected families eligible for subsidies, which will be used to fund their coverage in the new waiver program. This change would result in a cost to the federal government (in the form of additional marketplace subsidies), and thus must be offset by savings created by the waiver in order to pass the federal budget neutrality test required by the waiver guardrails.

4. Satisfying the guardrails

In tinkering with its policy levers, Connecticut will need to ensure that it satisfies all the statutory "guardrails," conditions that must be met in order

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[98] Benjamin D. Sommers, *The Impact of Program Structure on Children's Disenrollment from Medicaid and SCHIP*, 24 HEALTH AFFAIRS 1611, 1616 (2005).

[99] *Id.*

[100] *See* MINN. HEALTH CARE FIN. TASK FORCE, *supra* note 70.

[101] *See* RACHEL GERSHON ET AL., *supra* note 78, at 2.

[102] *See* MINN. HEALTH CARE FIN. TASK FORCE, *supra* note 70, at 17–18.

for the Secretaries to approve a waiver.[103] Based on the basic cost assumptions outlined above in section III(B)(2), Connecticut should be able to meet the first three criteria, including the special protections for "vulnerable residents" specified in the federal guidance.[104] If Connecticut is unable to design a program that is as comprehensive as the exchange plans, with the same or better cost sharing protections that covers at least as many people, including vulnerable residents, then it is unlikely to adequately fill the coverage gaps left by churning and will not provide care tailored to the needs of the low income population.

With regard to the fourth guardrail, the federal guidance broadly defines deficit neutrality, requiring a comparison of the net of federal expenses and revenue with and without the waiver.[105] The deficit neutrality test requires states to account for changes in federal spending and revenue including premium tax credits, cost sharing reductions, revenues from tax penalties on individuals, and changes in Medicaid spending that result from the 1332 waiver (but not separate Medicaid waivers).[106] States must also account for any additional federal administrative costs attributable to the waiver.[107]

Connecticut would likely have to account for some loss of revenue from tax penalties on individuals who are eligible for but do not enroll in marketplace coverage. It might have to account for a corresponding uptick in enrollment in the 1332 program (and therefore the cost of the federal subsidies) over existing enrollment in the marketplace plans. It is unclear whether the state could use federal savings from removing people from Medicaid (HUSKY A) to offset any additional costs because the decision to move them off was not a result of approval of the 1332 waiver, but an independent decision made prior to submitting the waiver. A second group affected by the HUSKY A cut lost eligibility in 2016, just prior to the earliest date coverage could become available under the waiver.

This temporal gap also raises a concern about continuity of coverage. When they lost HUSKY A coverage on August 1, 2016, the group became eligible for subsidized exchange coverage. If the proposed waiver is approved and the program is implemented, sometime after January 2017, this same group will be eligible for a third coverage category. This is essentially state-produced churn. From the standpoint of continuity of coverage and cost neutrality, it might have been advantageous to extend HUSKY A for this group through the implementation date of the waiver, and then transition them into the new waiver program. Making the transition contingent on the waiver's approval may have enabled Connecticut to

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[103] *See supra* II (B).

[104] *See supra* II (B).

[105] Waivers for State Innovation, 80 Fed. Reg. 78131, 78133 (Dec. 16, 2015) (to be codified at 31 C.F.R. pt. 33 and 45 C.F.R. pt. 155).

[106] *Id.*

[107] *Id.*

account for the federal Medicaid savings when documenting deficit neutrality as part of its waiver application.

5. Why not the basic health program?

Creating a coverage program for those on the eligibility border between Medicaid and the marketplace to mitigate churn is not a new idea. Minnesota and New York have used another provision of the ACA, the Basic Health Program (BHP) option, to address this problem. [108] Similar to the waiver proposal outlined here, under the BHP the federal government diverts a portion of marketplace subsidies (95%) to fund a state program for individuals with incomes at or below 200% of FPL who would otherwise qualify for subsidized marketplace coverage.[109] Analyses of the BHP option provides insights into the effects of a similar 1332 waiver program: according to one national analysis, if the BHP were integrated with Medicaid so that the same benefits packages served everyone at or below 200% FPL, the amount of churning between Medicaid and marketplace plans would decline by 16%.[110]

Connecticut examined the BHP option as a way to mitigate churning between Medicaid and the marketplace, considered legislation and convened a work group in 2012,[111] prior to the release of the federal BHP regulations. To date, Connecticut has not implemented the BHP option. State officials have cited a variety of concerns, including whether providers who serve this population would see drops in their payments if enrollees moved from higher-reimbursing commercial exchange plans to the state-administered BHP; whether the creation of the BHP would spur adverse selection;[112] and whether the cost of administering the BHP would exceed federal reimbursement.[113] These concerns are also relevant to the waiver proposal and would have to be addressed before it is implemented.

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[108] Medicaid and CHIP Learning Collaboratives, *Basic Health Program (BHP) Learning Collaborative: BHP Planning & Implementation - State Experiences to Date* (Sept. 2015), https://www.medicaid.gov/basic-health-program/downloads/bhplc-state-experiences.pdf.

[109] STAN DORN & JENNIFER TOLBERT, THE ACA'S BASIC HEALTH PROGRAM OPTION: FEDERAL REQUIREMENTS AND STATE TRADE-OFFS 1–2 (2014), http://files.kff.org/attachment /the-acas-basic-health-program-option-federal-requirements-and-state-trade-offs-report. The Basic Health Program option for states was authorized by section 1331 of Article I of the ACA and became available in 2015. *Id.*

[110] *See* MATTHEW BUETTGENS ET AL., CHURNING UNDER THE ACA AND STATE POLICY OPTIONS FOR MITIGATION 6 (2012) http://www.urban.org/sites/ default/files/alfresco/publication-pdfs/412587-Churning-under-the-ACA-and-State-Policy-Options-for-Mitigation.PDF. (Noting that implementing a BHP would essentially push the churn threshold up to 200%, but employer sponsored insurance is more prevalent as income goes up, so the magnitude of churning would be lower).

[111] Basic Health Plan Work Group, CT STATE INNOVATION MODEL PROGRAM MANAGEMENT OFFICE, http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2742&q=334030 (last visited May 9, 2016).

[112] *See* COX ET AL., *supra* note 83.

[113] *An Act Establishing a Basic Health Program: Hearing on HB 5450 Before the Human Services Comm.*, 2012 Leg. Sess. (Conn. 2012) (statement of Benjamin Barnes, Office of Policy and

The major stumbling block to Connecticut's implementation of a BHP came with the program's final regulations, published in March 2014. The regulations appear to preclude Connecticut's participation by requiring states to contract with multiple managed care organizations (often health insurance companies who are paid a monthly fee for each member from which the cost of services are debited) to administer the program.[114] Connecticut has abandoned this model in favor of contracting with a single entity to manage the plan and paying a fee for individual services (dubbed "managed fee for service").[115]

In contrast, the regulations and guidance for section 1332 do not contain a similar program administration restriction. Using a 1332 waiver to implement Connecticut's own version of the BHP has other advantages. It provides more flexibility for Connecticut to design a program that meets the needs of low-income populations and provides coverage stability when their incomes fluctuate. It also offers a more generous federal reimbursement rate to serve this population than the BHP option.

IV. POTENTIAL PITFALLS AND OTHER POLICY CONSIDERATIONS

Using the 1332 waiver to create a new coverage category carries a number of potential drawbacks. Most obvious to state budget writers is the risk of underestimating the cost of providing coverage to this group, for example, if federal subsidy levels are lower than projected or the group has higher medical costs than expected. This could result in costs that exceed the federal reimbursement and create the need for the state to contribute funding in order to satisfy the guardrails. If this were to occur, the state could adjust the plan design to bring expenditures down. Given these policy levers and the fact that in the basic calculations outlined in section III(B)(2), the subsidies for the HUSKY A group exceeded their corresponding Medicaid costs by 68–75%, it seems unlikely that the waiver program would cost the state more than keeping the same population on Medicaid, where costs are only reimbursed at 50%.

There is also a possibility that creating a waiver program situated between Medicaid and the marketplace on the income continuum will open more gaps than it closes. It is certainly possible that in order to reduce costs, the state must reduce benefits, increase cost sharing, or reduce health provider reimbursements, making it difficult for plan members to access

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Management); *id.* (statement of Stephen Frayne, Connecticut Hospital Association); *id.* (statement of the Connecticut Association of Health Plans).

[114] See 42 C.F.R. §§ 600.410, 600.415, 600.420 (2016), which have been interpreted to require a state to contract with multiple managed care organization to administer the BHP.

[115] Since 2012, Connecticut has administered its medical coverage for Medicaid and CHIP programs under a self-insured fee-for-service arrangement through a contract with a single non-risk administrative services organization (ASO). Dep't of Soc. Services, *Board of Directors Meeting*, *supra* note 88, at 90–92.

health providers. If the waiver program does not offer a relatively seamless transition from Medicaid, it could create new hurdles for low-income families. In designing a program, the state should endeavor to reduce costs using methods that have the least impact on continuity of coverage. Some continuity concerns can be addressed by having the same contractor that administers the Medicaid and CHIP programs also administer the waiver program using the same parameters, so that the consumer can move between programs relatively seamlessly.

Policymakers must also be aware of the impact creating a new program will have on the marketplace. In order to attract insurance carriers, offer competitively priced insurance products, and smooth out volatility in the risk pool, the marketplace must secure a critical mass of healthy members. If it turns out that creating a waiver program removes too many healthy members from the marketplace or causes unintended adverse selection,[116] it could disrupt Connecticut's successful marketplace. The impact on the marketplace should be considered when creating actuarial models for the eligibility and benefits structure of this new program. The impact on the marketplace can be minimized by creating a relatively narrow waiver program, perhaps only serving those previously eligible for HUSKY A and others in the same income range, as this note suggests.

V. CONCLUSION

Connecticut should adopt a 1332 waiver program to cover non-pregnant adults and children between 138% and 201% FPL, including those adults pushed off HUSKY A in 2015 and 2016. This program must provide a benefit package tailored to the health and affordability needs of low-income households while minimizing cost sharing. Creating such an option will result in more people with continuous access to health coverage, improved access to preventive services, better management of chronic conditions and health outcomes, and reduced financial stress due to lack of insurance. The waiver program would also provide more continuity of coverage and care for those households who experience a high degree of income fluctuation. In turn, these households will be less likely to fall through administrative

[116] *See supra* note 83.

and coverage gaps associated with moving between Medicaid and the commercial marketplace plans.

POSTSCRIPT

As of August 2017, Alaska, Hawaii, Minnesota and Vermont have filed 1332 waivers.[117] Alaska's waiver would fund a reinsurance program for the individual market.[118] Hawaii's waiver to reconcile the ACA with the state's employer mandate was approved in December 2016.[119] Massachusetts submitted an application and then withdrew upon learning that it was not necessary to accomplish its goals.[120] California also filed and later withdrew its waiver, which would have permitted certain immigrants to purchase insurance through the marketplace, in January 2017.[121]

Meanwhile, Congressional Republicans and President Trump have considered several proposals to "repeal and replace Obamacare," but have not taken aim at section 1332. In fact, President Trump's executive order easing the ACA's requirements, which he signed on his first day in office, requires agency heads to "waive . . . any provision or requirement of the Act that would impose a fiscal burden on any State . . ."[122] and instead "exercise all authority and discretion available to them to provide greater flexibility to States and cooperate with them in implementing healthcare programs."[123] This language may be referring to section 1332 or similar provisions that enable state action. On March 13, 2017, Thomas Price, the new Secretary of Health and Human Services, wrote a letter to Governors touting section 1332 as a way to adapt the ACA to fit individual state needs.[124] The letter described the waiver program consistent with the existing statute and encouraged states to use it in implementing high-risk pools and state-operated reinsurance programs, as proposed by Republicans in an attempt to control costs and stabilize the individual insurance market.

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[117] Section 1332: State Innovation Waivers. CENTER FOR MEDICARE & MEDICAID SERVICES (last visited Aug. 15, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html.

[118] Manatt Health, *1332 State Innovation Waivers Under the Trump Administration*, STATE HEALTH REFORM ASSISTANCE NETWORK 21 (Apr. 12, 2017), http://www.statenetwork.org/wp-content/uploads/2017/04/1332-Waiver-Webinar-4-12-17__Final.pdf.

[119] *Id.*

[120] *Id.*

[121] California Letter to Withdraw 1332 Application. CENTER FOR MEDICARE & MEDICAID SERVICES (last visited Aug. 15, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Application-Withdrawal-Request-01-18.pdf.

[122] Exec. Order No. 13,765, 82 Fed. Reg. 8351 at § 2 (Jan. 20, 2017).

[123] *Id* at § 3.

[124] Letter from Thomas Price, Sec'y of Health and Human Services, to State Governors (Mar. 13, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.

The American Health Care Act (AHCA), passed by the U.S. House of Representatives in May 2017 leaves section 1332 intact.[125] Some U.S. Senate proposals contemplate expanding section 1332 to enable states to waive additional provisions.[126] Some of the waivable provision of the ACA, such as the advance premium tax credits and cost sharing reductions, continue to be debated as of August 2017. Changes to these provisions would impact the funding source for the coverage program this note proposes. In any case, it is possible that section 1332 may generate more interest and opportunities during the current push for state flexibility.

[125] *Summary of the American Health Care Act*, KAISER FAMILY FOUND. 9 (May 2017), http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act

[126] *Compare Proposals to Replace the Affordable Care Act*, KAISER FAMILY FOUND. (Jul. 2017), http://www.kff.org/interactive/proposals-to-replace-the-affordable-care-act/.

APPENDIX

Figure 1.

Federal Poverty Level by Percentage and Household Size

		Number of Household Members			
		1	**2**	**3**	**4**
Percentage of Federal Poverty Level	**50%**	$5,940	$8,010	$10,080	$12,150
	75%	$8,910	$12,015	$15,120	$18,225
	100%	$11,880	$16,020	$20,160	$24,300
	138%	$16,394	$22,108	$27,821	$33,534
	155%	$18,414	$24,831	$31,248	$37,665
	175%	$20,790	$28,035	$35,280	$42,525
	201%	$23,879	$32,200	$40,522	$48,843
	250%	$29,700	$40,050	$50,400	$60,750
	263%	$31,244	$42,133	$53,021	$63,909
	300%	$35,640	$48,060	$60,480	$72,900
	323%	$38,372	$51,745	$65,117	$78,489
	400%	$47,520	$64,080	$80,640	$97,200

Figure 2.

Connecticut's HUSKY Health Program: Medicaid and Children's Health Insurance Program Eligibility Categories

Category	Eligibility description[127]	Income eligibility[128]	Average per member per month cost for quarter ending September 2015[129]	Enrollment as of November 2015[130]
HUSKY A (Medicaid)	Children under age 19 Parents/caretaker relatives Pregnant Women	Up to 201% FPL Up to 155% FPL[131] Up to 263% FPL	$318	442,680
HUSKY B	Children's Health Insurance Plan for children under age 19 whose families earn too much to qualify for HUSKY A	201-323% FPL[132]	$166.99	15,362
HUSKY C (Medicaid)	Individuals age 65 and older; Disabled individuals; blind individuals	Based on state's family cash assistance benefit.	$2,399	94,830
HUSKY D (ACA Medicaid Expansion)	Low income childless adults age 19-64 who do not receive Medicaid	Up to 138% FPL	$623	184,641

[127] Dep't of Soc. Services, *Board of Directors Meeting*, *supra* note 88, at 58, 60.

[128] Income eligibility is based on federal poverty level (FPL) and includes 5% income disregard, effectively making income limits 5% higher than required by statute. MARY FITZPATRICK, OFFICE OF LEGISLATIVE RESEARCH, OLR BACKGROUNDER: MEDICAID ELIGIBILITY 2 (2015).

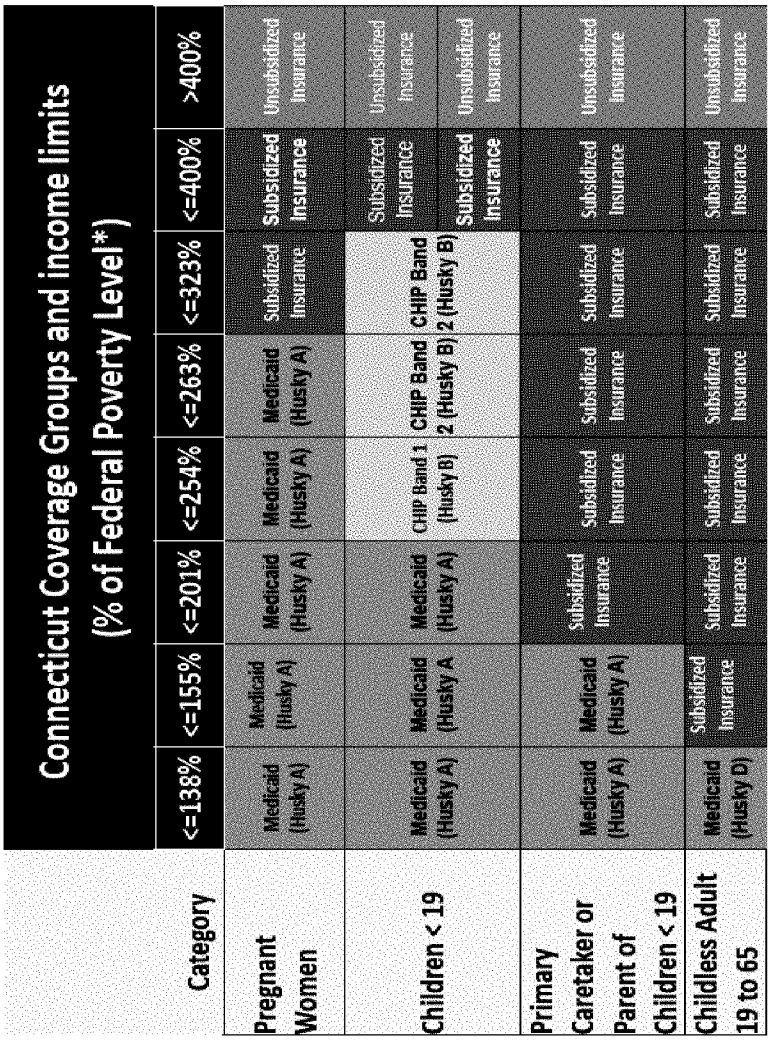
[129] The per member per month cost is borne by the federal and state government. Dep't of Soc. Services, *Updated Review of Medicaid Financial Reports and Trends*, *supra* note 90, at 8–9.

[130] Dep't of Soc. Services, *Board of Directors Meeting*, *supra* note 88, at 90.

[131] As discussed, effective September 1, 2015, HUSKY A eligibility was reduced by lowering the income limit for non-pregnant adults (i.e. parents or caretakers) from 201% FPL to 155% FPL; current enrollees with earned income from employment who become ineligible will receive transitional medical coverage until August 1, 2016. FITZPATRICK, *supra* note 128, at 7.

[132] Dep't of Soc. Services, *Board of Directors Meeting*, *supra* note 88, at 61.

Figure 3.[133]



[133] For the original source of this figure, see Dep't of Soc. Services, *Board of Directors Meeting*, *supra* note 88 at 61.