HEALTH ACCESS CALIFORNIA

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Section 1332 of the Affordable Care Act

Options & Opportunities for California

Introduction

Under Section 1332 of the Affordable Care Act, California and other states have the opportunity to apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver of key provisions of the ACA. A "1332 waiver" allows states to pursue innovative approaches to achieve the primary goals of the ACA. The proposal should cover at least the same number of people and provide the same level of benefits, affordability, and consumer protections. It cannot increase the federal deficit.

Under a 1332 waiver, states can waive some, but not all, ACA provisions with respect to:

- The Exchange marketplace and subsidies for coverage
- Some insurance market rules but not all
- The individual mandate
- The employer responsibility requirement (but not other federal rules related to employer-provided health benefits, such as ERISA)

A 1332 waiver does not waive Medicaid rules, but may be combined with a Medicaid waiver. California has taken important steps to not just implement but improve upon the ACA, and a 1332 waiver is a new tool to take additional steps. Health Access has identified the following broad areas of reform where a 1332 waiver could facilitate potentially worthwhile changes:

- Inclusivity, specifically allowing undocumented Californians to buy unsubsidized plans through Covered California.
- Streamlined enrollment and reduced churn and disruption for consumers by aligning coverage and other rules between programs, especially Covered California and Medi-Cal.
- Improved affordability, from premiums to cost-sharing to better benefits (some of the most exciting possibilities, but ones that require that savings or a state funding source would need to be identified to satisfy the federal requirement regarding the federal deficit.)
- Broader system transformations such as a revamped employer mandate requirement or single-payer health care are theoretically possible through a 1332 waiver but face the same political and practical obstacles that previously existed.

The paper outlines barriers and challenges for ideas under the waiver. But despite those barriers, Health Access believes there are important priorities that can be advanced through a 1332 waiver.

Part I: First, Do No Harm

Federal guidance issued December 16, 2015 (CFR 78131) substantially narrows the options and opportunities for states contemplating Section 1332 waivers.[1] It does this in part through imposing administrative obligations on states and in part through requirements that may be sensible from a federal budgeting perspective but are limiting from a state perspective. While Health Access supports the intent to disallow state waivers that undermine affordability, comprehensiveness of benefits, and other important protections of the ACA, from a California perspective some of these limitations and requirements of the recent federal guidance prevent innovation that would improve on the ACA.

Federal guidance requires specific state legislation authorizing a state to apply for a Section 1332 waiver. Covered California does not have existing statutory authority to apply for a waiver; nor would the California Department of Health Care Services, even within its broad authority, be able to apply without authorizing state legislation.[2]

While supportive of pursuing a 1332 waiver, Health Access proposes the following principles to guide discussion of 1332 waiver options:

- No consumer should be worse off in terms of affordability, benefits or consumer protections
- The health care safety net should not be harmed
- Lowest-income first

Part II: Barriers and Challenges: Federal Guidance on Section 1332

The principles based on "first, do no harm" are consistent with the recent federal guidance, which pointedly and repeatedly says that any Section 1332 waiver will be evaluated for its "effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues."[3] With respect to coverage, affordability, and comprehensiveness of benefits, the guidance says in unambiguous terms that waiver proposals that reduce coverage, affordability, or comprehensiveness of benefits for vulnerable residents will be denied.

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[1] December 2015 federal guidance: https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf
[2] As the sole state agency with oversight for Medicaid, the Department of Health Care Services can, and does, apply for various Medicaid waivers under its broad statutory authority. In some instances, as with the 1115 Waiver renewed in December 2015, implementing legislation is required. What is different about the requirements for a 1332 waiver is that state statute is required *before* the application rather than after an agreement is made with the federal government.
[3] The term "elderly" is not defined, so it is unclear in this context whether it refers to the over-65 population (a tiny sliver of the exchange enrollment), or the 50-64 population, many of whom face significant affordability challenges because of the ACA's age rating structure and geographic rating.

The federal guidance specifically limits 1332 waivers to those states, like California, that operate their own exchange. The federal guidance says that "the Federal platform cannot accommodate different rules for different states," thus closing the door on not only those states which rely on the Federal exchange but also those that use it for part of their exchange infrastructure. For many states, this element of the guidance alone closes the door on a 1332 waiver.

The federal guidance specifies that savings from any federal program must remain within that program: this means that a state could not blend together savings from a Medicaid waiver and the 1332 waiver to create a single payer program or a voucher program without accounting separately for the savings to each federal program. Savings from redesigning exchange coverage cannot be used, per this federal guidance, to fund a Medicaid expansion or Medicaid redesign. "Therefore, the assessment (of the impact of the waiver proposal) would not take into account changes to Medicaid or CHIP that require separate Federal approval," such as the savings from a proposed Section 1115 waiver. While this is sensible from a federal budget perspective, it is very constraining from a state perspective.

The other constraint imposed by the recent federal guidance is that the Internal Revenue Service is unwilling to administer federal taxes differently in different states. A state seeking a waiver that involves changing federal tax rules should be prepared to administer those taxes using its own state tax administrative apparatus or to create an alternative approach that does not otherwise violate federal rules. The IRS dictum that federal taxes cannot vary by state creates a major administrative barrier to altering a number of provisions that could be waived under a 1332 waiver. Federal tax provisions that can be altered pursuant to a 1332 waiver include:

- The individual mandate: the federal income tax penalty for not carrying insurance
- The exclusion of employer-paid health benefits from federal tax liability
- The advanced premium tax credit, one of the two sources of subsidy for exchange enrollees
- The employer responsibility penalty, also a federal tax penalty.

Even in a state like California with well-established state administrative apparatuses for personal income tax withholding and collection of various employer and corporate taxes, the burden of administering variations on the ACA federal tax structures should not be taken lightly. In a state that lacked a personal income tax or a corporate tax, the need to create a new tax infrastructure for the purposes of a 1332 waiver might well be too onerous.

A state can waive the individual mandate entirely and use a different approach to accomplishing the same objective. For example, a state could waive the requirement for the Advanced Premium Tax Credit and use that funding to provide subsidies through a mechanism used in other federal income tax credits—perhaps like a state EITC. Hawaii has a unique employer obligation that is exempt from ERISA: Using a 1332 waiver to preserve this employer obligation may make sense in Hawaii, where

this requirement is a well-established element of its health care system as well as its economy.[4] But in states where ERISA continues to govern employer-paid health benefits, waiving the employer responsibility requirement and creating an alternative structure for an employer mandate would require considerable creativity and might run into state-specific limitations.

Part III: California-Specific Challenges and Opportunities

Adding to the challenges created by the federal guidance are the challenges specific to California. The most challenging of these is the requirement for a two-thirds vote of the Legislature, and signature of the Governor, to increase taxes. Converting a tax imposed by the federal government into a tax imposed by state government requires a two-thirds vote of the Legislature as well as the signature of the Governor, because it requires state law to impose the tax. This is true of payroll taxes, whether imposed on employers or workers. In short, a 1332 waiver does nothing to address the daunting barrier of a 2/3 vote threshold to support the financing of a single-payer system or other major health system redesigns. Some changes through the state budget take a simple majority vote but require sufficient revenue to sustainably fund improvements in affordability or benefits.

A number of proposals below would therefore require additional funding to be consistent with the principle of "do no harm" and another key federal guidance on not reducing affordability or comprehensiveness of benefits for vulnerable populations. Additional state funding is a challenge in California, as in other states. Some have suggested taking money from existing state programs that serve vulnerable populations or protect the safety net for the remaining uninsured, robbing Peter to pay Paul. Most such proposals either yield trivial funding or push costs to other parts of the system. For these reasons and others, they are undeserving of further consideration.

Improving the ACA: Not Everything Requires a Waiver!

Many ACA improvements do not require a 1332 waiver and California, through legislation or through the actions of Covered California, has already taken a number of worthy ideas far down the path. Examples of improvements that can be made or strengthened without a waiver include active purchasing, standard benefit designs, anti-discrimination measures, limits on cost sharing, and additional transparency measures. What follows is not an exhaustive list of options for Section 1332 waivers, but an attempt to explore ideas, mostly suggested by others (see links at the end of this document for details).

[4] Joel Ario and Spencer Manasse, Lessons from Hawaii's Trailblazing ACA 1332 Waiver Proposal, Manatt, December 18, 2015. https://www.manatt.com/health-law/Lessons-from-Hawaiis-Trailblazing-ACA-1332-Waiver.aspx.

SUGGESTED 1332 WAIVER REFORMS

Immigrant Inclusivity

SB10 (Lara) would allow undocumented immigrants to buy coverage through Covered California using their own money. The specific proposal would allow non-qualified health plans that mirrored QHPs into the California exchange for this express purpose. Nothing in the recent federal guidance appears to preclude this approach, though Federal approval is not guaranteed.

A simpler approach, allowing undocumented immigrants to purchase existing coverage through Covered California, is prohibited due to two precise provisions of federal law--requiring exchanges to verify citizenship or lawful immigration status—that cannot be waived even with a 1332 waiver.

SB10 would not provide subsidies to undocumented immigrants. If in the future California is able to fund subsidies through a state-version of advanced premium tax credits or cost sharing reductions that would be a worthy discussion and could be an important pilot program to demonstrate the value of such measures. But even without subsidies, removing the prohibition on purchasing coverage through Covered California would be an important step to immigrant inclusion. While undocumented immigrants could buy coverage as individuals through other avenues, the exclusion in Covered California creates problems. Separate drinking fountains were wrong: separate paths to coverage are equally wrong. Inclusion, the principle that all Californians should have the same opportunities, regardless of immigration status, is an important element of this proposal.

Although the current proposal does not fund subsidies through advanced premium tax credits or other cost sharing reduction measures, this approach would be especially helpful in allowing Covered California to be a one-stop shop for mixed-status families, a common circumstance, especially in California, where family members often have different immigration status. Even if different family members qualified for different subsidy levels or some family members did not qualify for subsidies at all, a one-stop-shop approach would go a long way to reducing barriers to enrollment. In California and other states with a CHIP expansion above 138% FPL, families commonly face mixed *coverage* status, where the children are eligible for Medicaid or CHIP but the parents are eligible for coverage through the exchange. There is ample evidence that making the parents eligible for coverage increases the likelihood that otherwise eligible children will be enrolled in coverage.[5] The same principle applies when family members have different immigration status.

For purposes of seeking federal approval, the proposal would still abide by the spirit of President Obama's promise that no federal dollars would go to fund coverage of undocumented immigrants—

[5] M. Yamauchi, et. Al, "Does Health Insurance Continuity Among Low-Income Adults Impact Their Children's Insurance Coverage," Maternal and Child Health Journal, February 2013. http://www.ncbi.nlm.nih.gov/pubmed/22359243.

this would be unsubsidized coverage, and by 2017 the exchanges will be self-sufficient and no longer federally supported.

Aligning Coverage, Aligning Rules

California, like some other states, has a lack of alignment between its Medicaid program and the state exchange rules. For example, California's CHIP program eligibility extends to 266% of the federal poverty level (FPL), but adults between 139-266% FPL are not eligible for Medicaid; and if they lack job-based coverage, they can enroll in Covered California. This results in a fair number of mixed coverage families, with the kids on Medi-Cal and the parents in Covered California. Similarly, when women enrollees in Covered California with incomes up to 321% FPL become pregnant, they are eligible for zero cost Medi-Cal as well as Covered California: Does it make sense, especially from a continuity of care perspective, to shift to Medi-Cal for the perinatal period and back to Covered California once the baby turns three months old?

California has a bifurcated delivery system and coverage system. Commercial coverage, including Covered California, relies primarily on commercial carriers (and private doctors and hospitals), and Medi-Cal managed care relies heavily on the Local Initiatives and County Organized Health Systems. The Local Initiatives as well as the County Organized Health Systems, a foundational element of the health coverage safety net, are California's own, home-grown public options. These public health plans are generally county-based and serve most of the urban counties in California—from Los Angeles, Orange, Riverside, San Bernardino and Ventura to the Bay Area counties. Some of these public plans have more than a million Californians enrolled in coverage, more than the population of some states. These public plans were designed to provide Medicaid managed care and to strengthen the safety net of health providers that relies heavily on county hospitals and community clinics. These providers are on the front lines of state-based delivery system reforms through our Medicaid waiver, and as such uniquely configured to achieve "triple aim" (or quadruple aim—including equity) objectives: better care, at lower cost, for improved health outcomes.[6]

With that much at stake, could a 1332 waiver be used to allow consumers who choose to receive coverage from these public plans to continue to do so?

Mixed Coverage Families: Kids on Medi-Cal, Parents in Covered California

About 70% of Covered California enrollment has income 138-250% FPL, and 95% are adults ages 18-65. In California, children are eligible for CHIP/Medi-Cal up to 266% FPL. So there are lots of

[6] California Association of Public Hospitals and Health Systems and Safety Net Institute, *California's Delivery System Reform Incentive Program 2010-2015*, October 2015. http://caph.org/wp-content/uploads/2015/10/CA-DSRIP-2010-2015-Successes-to-Build-On.pdf.

families with parents in Covered California and kids in Medi-Cal (an estimated 600,000-700,000 kids plus their parents).

Is there some way to unify families without making kids pay higher premiums or lose their entitlement—and without completely disrupting the safety net and Local Initiatives and County Organized Health Systems (LI/COHS), as the Basic Health Plan would have—and with no state general fund costs? Could we have a distinct Medi-Cal program aligned with Covered California for the kids? And is that best achieved through a Medicaid waiver or waiver amendment rather than a 1332 waiver?

The federal guidance makes clear that a section 1332 waiver could not be used to move kids into Covered California because it would increase their premiums and cost sharing while providing less comprehensive benefits. While CHIP kids do pay premiums and cost sharing, those premiums and copays are far more modest than the most affordable Covered California plans—and Medi-Cal benefits are more comprehensive than the commercial coverage offered through Covered California. Aligning coverage for mixed families should not result in reducing affordability or benefits.

Could a 1332 waiver allow the LI/COHS to offer coverage through Covered California without marketing in the outside market? And would it be just for parents of CHIP kids? Or *all* enrollees? Health Access would support requiring the LI/COHS to play by the same market rules as other QHPs, except for offering coverage outside the exchange. The proposal is not to waive important consumer protections but rather to allow the public plans to offer non-QHPs which would play by the same market rules except for offering coverage in the off-exchange market.

Pregnant Women: 138-321% FPL

Under existing rules, women who get pregnant and who want zero cost coverage can move from Covered California to Medi-Cal—and then come back to Covered California 3 months after the baby is born. A woman can also choose to stay enrolled in Covered California and pay her premiums and cost sharing for that coverage.

Is there a way to make the pregnancy experience more consumer friendly without losing the Medi-Cal entitlement or zero costs of the Medi-Cal program? Again, does this require a 1332 waiver, a Medicaid waiver, neither or both? Similar to the proposal for mixed status families, the proposal is not to waive important consumer protections but rather to allow the public plans to offer non-QHPs in the off-exchange market while following the same market rules.

Aligning Rules between Medi-Cal and Covered California

Medi-Cal and Covered California count income differently and have other notable differences. Part of the reason for lack of alignment on income counting is that advocates won a more consumer-

friendly rule for Medi-Cal based on a point-in-time estimate of income than was allowed by the IRS for premium subsidies. Though it leaves consumers facing a temporary drop in income at a distinct disadvantage, the IRS has a dim view of point-in-time measures preferring a measure based on the full tax year. Not only does Medi-Cal base eligibility on income at a point in time, but it allows enrollment for up to a year.

Is it possible to align these rules while winning the most consumer friendly version? If so, how much would that cost? And what is the benefit in terms of helping people get covered and stay covered?

The recent federal guidance further complicates a proposal in this area for two reasons: First, the guidance makes clear that savings must remain within each program and second, the guidance requires a state administrative apparatus for any changes to federal subsidies through the APTC.

Improve Affordability

This category includes a number of proposals to improve affordability for consumers, either through reducing share of premium or extending or otherwise improving cost sharing reduction subsidies. Assuming we do not intend to make anyone worse off than they are today, which is consistent with the federal guidance on vulnerable populations, all of these proposals will require additional state funding or finding federal savings that can be redirected to help improve affordability.

Each of these proposals also requires a state administrative apparatus that does not exist today and that may or may not be practical or cost-effective to create. One possibility is to waive the federal Advanced Premium Tax Credits and use the pass-through federal funding to create a state subsidy program, administered by some combination of Covered California funding and assessments on the plans. This might allow better alignment with the Medi-Cal rules and other possible changes—though not without expense and additional bureaucratic burdens.

How many people are we talking about? The University of California Berkeley Labor Center estimates about 440,000 uninsured Californians not subsidy eligible for various reasons: this includes 50,000 kids and 270,000 adults below 400% FPL.[7] The number of people affected by each of these proposals, and the dollars involved, will depend on the exact proposal.

Fixing the Family Glitch

As interpreted by the IRS, employer based coverage is required to be affordable for the worker, not the family. And affordable means coverage does not cost more than 9.5% of wages/salary for 60%

[7] Laurel Lucia, Miranda Dietz, Kan Jacobs, Xiao Chen, and Gerald Kominski, *Which Californians Will Lack Health Insurance Under the ACA*, UC Berkeley Labor Center, January 29, 2015. http://laborcenter.berkeley.edu/which-californians-will-lack-health-insurance-under-the-affordable-care-act/. The number of uninsured who are ineligible because of immigration status (1.3 million) or who are eligible but not enrolled in Medi-Cal (550,000-950,000) is far greater—and both populations are lower income.

minimum value coverage. In a change that partly mitigated the impact of the family glitch interpretation, the IRS required large employers to offer coverage to children of workers but did not require an employer contribution. Too many employers contribute zero to dependent coverage, making it unaffordable for families. The family glitch also affects spouses who do not have coverage from another source.

If CHIP sunsets, the number of children affected might grow dramatically. Since California now includes CHIP kids in the Medi-Cal entitlement, this might not be the case in California. But if CHIP *funding* sunsets, this Administration or another Governor might try to reduce eligibility for kids on Medi-Cal. Then the family "glitch" would be become even worse.

Estimates specific to California are outdated: the UC team is working on additional estimates, and their rough ballpark counts 50,000-75,000 uninsured kids, with incomes above 266% FPL and roughly an equal number of spouses.[8]

For the kids, coverage is cheap but coverage will still cost something. For spouses, coverage would cost what adult coverage costs.

Under the federal guidance, California would be required to administer tax subsidies or otherwise reduce premiums for those affected by the family glitch. But Covered California does not administer premiums: it chose instead to rely on a combination of the plans collecting the individual share and the federal government administering the APTC. This is a considerable (and expensive) administrative barrier. It is possible that the plans might administer differential premiums, as they do now for both Covered California and importantly for employer-based coverage. But this would still require some sort of new administrative apparatus at the state level for a duty now administered by the Internal Revenue Service.

Alternatively, California could require employers to provide affordable coverage to the entire family, including both children and spouses. This would require a waiver of the employer responsibility requirement and new employer obligations—and imposing those employer obligations faces various hurdles including ERISA, which cannot be waived under Section 1332.

And under a new President, the IRS could revisit its interpretation of the law (which is contrary to the federal law on its face).

"Smoothing" of premium subsidies between 138% FPL and 400% FPL

From Medi-Cal to Covered California, the jump in premiums is steep and abrupt, from zero cost to roughly $50-$70 per month for silver (for $18,000 income, single person). Consumers with incomes

[8] An earlier estimate by UC found 144,000 adults and kids affected, but that was prior to the requirement imposed by the IRS that employers offer coverage, with or without an employer contribution, to dependent children under age 18.

between 300%-400% FPL have incomes above the functional subsidy level (which varies depending on age and region) and therefore face a similar bump in premium costs. Otherwise, the cost curve is smooth from 138-400%FPL. The cost of a proposal for further smoothing and the number of people affected are unknown. To clarify, any proposal along these lines could only improve affordability for those above Medicaid levels.

To administer "smoothed" subsidies the state would need to create a state-level administrative structure. Covered California does not even pay premiums to plans so this would need to be part of that administrative structure.

Again, a new President might be able to accomplish some of these things administratively through re-interpreting the federal tax law. This, in turn could help mitigate some of the bureaucratic burdens of administering a premium subsidy smoothing proposal.

Improved Premium Subsidies, especially for those over age 50 in geographic regions with high insurance premiums or high cost of living to keep premiums under 8% or 9.5% of income

In some regions in California, health insurance premiums are high enough, especially for those over age 50, that consumers with incomes above 400% FPL find that premiums take up more than 8% of their income. While consumers with unaffordable premiums can get an exemption from the individual mandate, it would be even better if they could get affordable coverage—but that requires additional subsidies.

State funding for subsidies and a new state administrative apparatus would be required to administer an adapted APTC and to pay premiums to the plans. Again, the number impacted and dollars needed are unknown.

As noted above, any improvements in the federal APTCs would necessitate a change in federal law—a heavy lift but worthwhile for California. High cost states like California and New York were disadvantaged by the composition of the Senate Finance Committee in drafting the ACA and would have benefitted from a conference compromise that accounted for the reality that health care costs are higher in some regions than others. States like California still need a solution other than a punitive excise tax that punished employers and workers in high cost areas.

Improved cost sharing reduction subsidies

Under existing federal law, consumers with incomes 100-250% FPL are eligible for "cost sharing reduction subsidies," (CSRs) which reduce their copays/coinsurance/deductible depending on their income. It would be good if cost sharing reduction subsidies were available higher up the income scale than 250% FPL. Additional funding from either state sources or federal waiver savings would be required.

Would it be possible for the plans to administer different CSRs, with different cost sharing, if the exchange could determine eligibility (assuming the funding or savings is identified)?

Again, doing this at the federal level probably takes a change in federal law but this doesn't mean advocates shouldn't make the case. Advocacy organizations sought improved affordability throughout the course of the debate over the ACA: while the law in its current form was the most expansive possible at the time, from the perspective of California-based consumer advocacy groups there was more to do on both cost sharing reduction assistance and premium assistance.

Mandatory enrollment in cost sharing reduction subsidies

Under federal guidance, the consumer must voluntarily select the product with the lower deductible: Not everyone does this, much to our chagrin. A tiny fraction of consumers enrolled through Covered California pick platinum with worse cost sharing and higher premiums, for example. About 13% of the total enrollment of Covered California is consumers below 250% FPL who pick bronze with a $1 monthly premium in many regions but a $6,500 deductible. Bronze is $70-$100 per month cheaper than silver in most regions (the exact difference varies by age and region but the principle that bronze is cheaper applies to everyone).

What about making involuntary the selection of a cost sharing reduction subsidy-just as the income from Social Security is involuntary and depends on prior earnings: that is, someone with an income below 200% FPL or 250% FPL can get a CSR product whether they like it or not? In a high cost housing market like the Bay Area or parts of Los Angeles, premiums compete against rent money for people below 250% of poverty.

Repayment Rule: lower repayment owed if misestimate income

Consumers with incomes estimated to be below 400% FPL who end up with incomes over 400% FPL face the penalty of repaying the entire subsidy. While few consumers go from below 250% FPL to over 400% FPL in a single year, it does happen and it is a big shock that does not improve consumer opinion of the ACA. The ACA originally capped the amount taxpayers would repay but the cap was eliminated as a "pay-for" before 2014. A proposal could reinstate the cap, or provide another mechanism to limit sticker shock.

"Super" Platinum Plan for Small Business

Pre-ACA, some small employers offered benefits that were more than 90% actuarial value (AV, which represents the percentage of total average costs for covered benefits that a plan will cover). Section 1332 would allow CA to waive the requirement limiting coverage to the four AV tiers and offer a richer benefit to employees of small businesses that chose to offer richer coverage. This

includes not only non-profits but also small businesses run by affluent professionals (architects, engineers, attorneys, even doctors).

Essential Health Benefits

Most of the impetus for changes on essential health benefits seems to come from those wanting to offer substandard benefits on the grounds that less comprehensive coverage is more "affordable" in the sense that premiums would be lower if benefits were less meaningful. You get what you pay for.

In clarifying that the federal government will deny a 1332 waiver that makes benefits less comprehensive, particularly for vulnerable populations, the federal guidance essentially closes the door on proposals to reduce benefits—which is for the best.

What about adult dental and adult vision benefits?

Could California use a 1332 waiver to make adult dental and adult vision mandatory in the individual and small group market? The ACA includes limited oral health parity, but only for children—from a public health and fiscal standpoint, adults should have access to oral health care and a mandate would help distribute that cost. What would be the premium impacts if these were mandated benefits? For kids, the cost went from $30 PMPM (per-member, per-month) to $3PMPM when California went from standalone pediatric dental to embedded or mandatory dental benefits. Adult costs might be higher because of historic lack of coverage in individual and small group markets. Such a proposal might need to allow various provisions such as waiting periods for services and other protections against adverse selection.

The recent federal guidance does not appear to preclude adding adult dental and adult vision: the impediment is the cost of adding a benefit mandate. Perhaps a path to explore is a softer mandate to offer rather than a mandate to cover.

Market Rules

Put the Entire Individual Market into Covered California

Are upper income consumers currently purchasing non-mirrored products to get broader networks or additional benefits? Does the apparent need to serve upper income consumers with broader networks or additional benefits undercut product standardization?

Would including the entire individual market in Covered California facilitate transitions among coverage sources? Facilitate enrollment?

To answer these questions, it would be important to know how large the off-exchange market is and what type of consumers are buying off-exchange products.

Auto-enrollment into individual coverage when a consumer loses other coverage?

Would it be possible to "automatically" enroll a Covered California enrollee in Medi-Cal when their income drops? How "automatic" can this be? Both are state programs with a common application: it seems that it should be feasible, if technically challenging.

What about automatically enrolling consumers into Covered California/Medi-Cal when they lose employer-based coverage? This comes with multiple challenges, including the reality that lots of people go from one source of employer coverage to another. But in a multi-payer system helping consumers go from one coverage source to another will be an ongoing challenge.

What about automatic enrollment from Covered California (or Medi-Cal) into Medicare: Can CMS talk to itself?

Process/Timeline

If legislation passes in 2016 and is signed by the Governor in September, that timeline would allow four months for California to submit a waiver and potentially get an answer from the current Obama Administration, before a new President takes office on January 20, 2017. The ACA says that a 1332 waiver cannot go into effect before 2017, but it could be approved in 2016 to be ready on January 1, 2017. Federal guidance does not appear to prohibit a state from having multiple 1332 waivers, each of different complexity and on a different timetable.

The requirement for specific authorizing legislation and the intersection with the provision of the California Constitution that legislation take effect on January 1 of the year after it is signed into law means that if California waits until 2017 to adopt legislation, then the waiver would be in effect in 2018 at the earliest or perhaps in the year 2019 when there will be a new Governor.

Conclusion

California can use the 1332 waiver to pursue additional progress in implementing and improving upon the Affordable Care Act, despite real obstacles contained in both the new federal guidance and the state's own laws. Advocates believe there are a range of proposals to make it easier for people to get on and stay on coverage—from immigrant inclusivity to aligning rules of different programs--and that we should explore ways to raise the savings or money to improve affordability in our high

cost-of-living state. Furthermore, California should take advantage of the opportunity to seek a 1332 waiver during the President's last year in office.

Resources and Further Background

December 2015 Federal Guidance (CFR 78131): https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf

Final Federal Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf

Federal Application: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html.

Commonwealth Fund Brief: http://www.commonwealthfund.org/publications/issue-briefs/2015/apr/innovation-waivers-and-health-reform

Center on Budget and Policy and Priorities: http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers

ITUP: http://itup.org/wp-content/uploads/2015/09/ITUP-Report-ACA-Section-1332-Opportunities.pdf and from Covered California board meeting materials, please look at pages 64-80: http://board.coveredca.com/meetings/2015/10-08/Reports%20and%20Research%20-%20Master_October%208,%202015.pdf

Robert Wood Johnson Foundation: http://statenetwork.org/2016/01/17/1332-waivers-resource-library/

The primary author of this discussion draft is Beth Capell for the Health Access Foundation, who expects to release a revised version in February 2016. We welcome your input, suggestions, and thoughts. For more information, contact Health Access California, www.health-access.org.