MAXIMUS

"Continuing the Conversation: Opportunities for State Innovation in Health Insurance Programs"

Webinar Transcript

Bruce Caswell: Good afternoon, I'm Bruce Caswell, President of MAXIMUS, and welcome to our second event to help health policy readers understand and consider their options around the Section 1332 of the Affordable Care Act. Our first event with four different panelists was held on February 6. You can view the recorded video and transcript on our website at maximus.com/webinars. We also have a white paper and issue brief on Section 1332 that are posted on our website. We have a very exciting hour-plan today, so let's get started. Moderating today's webinar will be Krista Drobac. Krista is a Partner at Sirona Strategies, she has nearly 20 years of experience in Federal and State Government and in Public Affairs and was previously the Director of the Health Division at the National Governors Association, and a Senior Adviser at the Center for Medicare and Medicaid Services. Krista provides strategic advice on a broad range of state and federal, legislated and regulatory issues around Medicaid, Medicare, Delivery System Reform, and the Affordable Care Act, public health and other areas. She'll begin with a brief recap of Section 1332: The State Innovation Waiver Provisions, and will introduce our four panelists. They will each provide a short overview of their perspectives, and then Krista will pose a number of questions to the panel. We'll also take questions from those of you who have logged in to the webinars, so if you have questions please type them into the questions panel on the webinar toolbar, or email them to webinars@maximus.com. Krista I'll pass it on to you.

Krista Drobac: Great. Thanks so much, Bruce. Thanks to MAXIMUS for holding this important webinar. I'm going to start with a short overview of the State Innovation Waiver Program that's in Section 1332, which we all call 1332 waivers, and then I'm going to turn to each of our panelists, John McDonough, Len Nichols, Stuart Butler, and Grace-Marie Turner, for their perspective, and then we're going to open up for questions. I'll start with some questions, but we hope that all of you will also participate by sending in your questions. I'm going to introduce our panelists as we go forward, but first, let me give you the very high level basics of the 1332 waivers. These waivers were really put in place to offer flexibility on certain provisions of health reform. If you look at them, there are a lot of things that can be waived. You can waive the Qualified Health Plans, the Metal Levels. You can waive whether or not you're going to have an Exchange. You can even waive the Premium Tax Credits, and they don't have to be purchased through the Exchange. You can waive the Reduced Cost Sharing, the Reduced Copays and Deductibles and overall out-of-pockets that are provided to lower-income individuals. You can also waive the Minimum Essential Coverage, the Business Tax Credits, the Employer Mandate. There are lot of -- and what I mean when I say Minimal Essential Coverage, I mean we're also talking about the Individual Mandate. Really, there are a number of things that can be waived by State, but interestingly, there are also a lot of things that can't be waived, which I think is

the reason that it's so important that we have webinars like this, so that there's a greater understanding of the opportunities that really do exist for flexibilities. The things that can't be waived, among which are the Insurance Reforms -- so a state could not allow an insurer to discriminate based on preexisting condition. MLR, the rate bands -- so you can't decide that you're going to allow insurers to rate-up older people. They have to comply with the ACA rate bands. You can't waive a risk adjustments. You couldn't allow an insurer to start implementing lifetime limits anymore. That's another thing that be waived -- and parents can still keep their kids on their insurance up to the age of 26. A couple other limitations, you can't use this waiver to waive Medicaid or CHIP, although you can combine a 1332 waiver with an 1115 waiver in a single application. It can be -- they can be used in conjunction. Finally -- there are things that can be waived and can't. Finally, there are some conditions that have to be met in order for CMS to approve the waiver. There has to be at least as much coverage. You have to be able to show CMS that you could achieve the same coverage levels. It has to be as affordable -- qualified individuals aren't going to pay any more than they would have in the Exchange -- and the coverage has to be available to at least as many people. If you're getting rid of some of these mandates, or waiving the Premium Tax Credits, you still have to make sure that as many people can access the coverage as before, and it has to be at least as cost-effective. These are some pretty high-bar, but there are some things that the 1332 waivers can be used for, and obviously, we encourage states to look closely at that. Let's hear a little bit about some additional history of 1332, what it was meant for, and some of the areas that states can really take advantage of this waiver program. The first panelist that we're going to hear from is John McDonough. He's a Professor of Public Health Practice in the Department of Health Policy and Management at Harvard, their School of Public Health, and he's also the Director of the School Center for Executive and Continuing Professional Education. In 2010, he was the Joan Tisch Distinguished Fellow in Public Health at Hunter College in New York City. Between 2008 and 2010, John was right in the thick of it, trying to pass this bill as the Senior Adviser of National Health Reform to the Senate Committee-- the Senate Health Committee which is what we have here -- but the House Education Labor and Pensions Committee. John, you wrote a paper recently that gave the history of how Section 1332 came to be and what states might be able to do with it and what congress envision they would do with it. Could you give us a short recap of the ways that the waivers enhance State Health Policy options?

John McDonough: Yes. Thanks, and I'm happy to be here with everybody. I actually tried in my paper to get people to call it a Wyden waiver rather than a 1332, but I think I failed at that. That's okay. Senator Ron Wyden was the individual most responsible for the inclusion of this in the Affordable Care Act, and it has opened up a door for thinking about a lot of different options for what states might do with this, and the biggest one -- the one that got the most attention over the past several years was Vermont's intended effort to establish a state-single-payer system which ended this past December when Governor Peter Shumlin withdrew from that process. Prior to that, when they were both feet ahead, the notion of getting a 1332 and making that a central feature of creating a state-single-payer was very high under a list of must-do's. That was the one state that everybody looked and said, "Okay, this one is coming." Other states could continue that. I have a hunch that we won't see many of those following, at least in the near future. Another option is something called the Basic Health Program or the Basic Health Plan which is modeled on a feature of the Washington State Health System for about 20 years and that Senator

Maria Cantwell got this into the ACA. A state can create a Basic Health Program option within the ACA by getting approval from the Department of Health and Human Services, but it can only benefit people up to 200 percent of the Federal poverty level. Theoretically, one could use a 1332 waiver to try to go higher up the income ladder, that's like 250 or even 300 percent of the federal poverty line. We know that some states have talked about that including, for example, Minnesota, but no one at this point is publicly out there looking very hard and moving forward to try to do it. Another opportunity would be doing something that was highly controversial during the passage of the Affordable Care Act which is whether it will include a public plan option within every state or federal health insurance exchange, kind of like a Medicare fee for service option. Ultimately, that was not included and is not part of ACA. However, it seems that there is nothing that would prevent a state from using 1332 to try to create such an option today. However again, I don't see any states that are actively considering this because I think there are many obstacles that are much more formidable than just getting a 1332 to do that. Another option is using a 1332 to more securely enable a Private Insurance Medicaid Expansion such as we see in Arkansas, Iowa, Indiana, Ohio, Michigan and other states clearly considering that. There is some concern that Arkansas model which was the first might not in the long run be able to survive the requirements for Federal Budget Neutrality, and the notion is that if you could use 1332 and align them together, align the 1332 with a Medicaid 1115 waiver, then you might be able to more securely achieve the Budget Neutrality that is acquired from both waivers. The big question for that of course is CMS has not come up with any substance of policy-based regulations, so -- whether the opportunity to get waiver applications jointly, actually, it's simply just a submission requirement. You can put them in the same Manila envelope when you file. Whether in fact, you can use the savings from one waiver to help finance another side of the waiver, gives something that again, there's speculation -- and I hope that that will come, but that's not certain. Then of course, there's the notion that this could be an accelerant for all kinds of state innovations. The ones that I've listed above can't be kind of large in terms of their scope, but we might actually see, and perhaps in the early days, a host of smaller things of states want to do that are little twists to their system that they can get through the process because it doesn't lower benefits or cost -- or raise cost-sharing, or collapse into some of the other guardrails. I think actually probably, up to the last one, that maybe the one that we see moving, the past that stand out, the ones that will come early. Next slide please. Here are just a few points, and then I will be quiet and let my fellow experts weigh in. The first thing is a lot of people are saying, "Well, this is a great avenue for conservative states to get some room to maneuver around some of the requirements of ACA that aren't necessarily that popular," and I guess my observation looking at it is if I think that the guardrails, the requirements to get a 1332 are kind of tough and stiff, and I'm not sure that when states fully appreciate the difficulty of achieving all of those requirements, that 1332 is going to be as attractive as some people might think. That's just speculation on my part, but it just seems to me, pretty straightening. Second thing is a lot of people who are interested in 1332 because if you get one, you can theoretically dry down a significant amount of the dollars coming in for the states through the Affordable Care Act that would otherwise go in other directions and directed in a way that enables some larger states also form such as Vermont's single-payer. The one cautionary note I'd put on that is Vermont actually took a really hard look at that. They had three studies that were done in 2011, 13 and 14. I wrote about this in a paper I have this week in the New England Journal of Medicine on the demise of Vermont single payer. The track records are -- suggests that in terms of the amount of money at stake might be able to

dry down -- that there's less there than meets the eye. The original 2011 study that got everybody so excited is just that the starting level of money coming in to Vermont would have been $420,000,000. A later study in 2013 kind of brought that down and estimated that it's $467,000,000, and then the third one that was done led by the Shumlin Administration, with some consultants, estimated the value of a 1332 waiver at a $106,000,000, and that was based on -- the last one was based on some various extensive conversations and interactions with the US Treasury Department, so probably is closer to reliable and -- the other to estimates. That's an important things to keep in mind. The third thing I've already mentioned, which is how far can you go in terms of merging Federal Waiver Application? Is it simply a process merger, or is it a substance and policy merger where can you blend the elements together including use of potential dollars on each side? That leads then to my fourth thing in this report, and which is an open question of whether or not before-- the Obama Administration at the end 2016, whether CMS will issue substance of regulations to match the process regulations that they already issued a couple of years ago. A very important question, but particularly important because the future of 1332 will be pretty much shaped by who occupies the White House in January 2017, and that I think more than anything, is going to a be quite stateful and important in terms of where we see policy world going in terms of 1332 legwork. I'll stop there, and thank you very much.

Krista Drobac: Great. Thanks, John. Before we hear from the other side of the aisle, we're going to here from Len Nichols who is another advocate for the Affordable Care Act. Len is -- has been the Director of the Center for Health Policy and Ethics and a Professor of Health Policy at George Mason University since 2010. He's been intimately involved in health reform debates, policy developments, and communication with the media and policymakers for more than 20 years. He was previously Senior Adviser for Health Policy at the Office of Management Budget -- and Budget in the Clinton Administration, so he's been a veteran of two health reforms and efforts. Len, you've given a lot of thoughts to what will it take to make states own health care reform. Can you give us some highlights of your current thinking?

Len Nichols: Sure, Krista, and I'm glad to be here with this distinguished panel, and you. It's really a great team. The first map you may be looking at is one you're probably familiar with, and that is it reflects the current decisions or some continuing conversations about the decision to expand Medicaid. The color code here is dark blue, has decided to expand or they implemented it. The light blue is, according to the Kaiser Family Foundation, still talking about it, which means either the governor or one branch of the legislature isn't very well-looking still. The yellow shading and then the orange are those who have said no, and I want you to sort of reflect -- not so much the individual states, but their regional reality that this map reflects, and that is the south pretty much -- except for my home, save Arkansas, I will point out -- and in the Midwest, had pretty much said no. You might think, "That's just a rare thing, and it's due to the current demise of partisanship -- bipartisanship," so what I want to do now is go to the next slide and show you a map from 1965 when Medicaid Program was created. Now, some of you on the webinar may remember, Medicaid was attached to Medicare pretty much at the end of the debate literally near midnight, the night before they loaded back in 1965, and it was understood by Wilbur Mills and the chairman of the Ways and Means Committee and the President Lyndon Johnson, but it's not entirely clear how many other members of congress were actually aware this thing had been stuck

in there. The Medicaid Provisions -- think about it. They passed the law at the end of July of 65, the program started in January of 66. There was no way they had detailed regs on how to run a Medicaid program that basically said that first year, whatever you're doing to take care of the poor, we'll pay half and then we'll figure out what to do over time. Whatever you're going to pay, take care of the poor, we'll pay half, led to exactly 26 states creating a Medicaid Program that first year, precisely the same number of states as Expanded Medicaid into the ACA option. Not quite the same states -- dark blue here has been at the first year, gray is at the second year, and the other colors reflect later on. The point here is not quite the same states, but similar regions -- the south again, being the single most salient region in the lane. What I want to point out is that Virginia, that very light blue, came in 69, and along with Colorado and Tennessee four years later. The dark red --North Carolina, Florida, Alabama, Mississippi, Arizona -- they came in after Virginia, five years in. Arizona by the way, didn't start until 82, and I noted -- and I note, they still don't have daylight savings time. The point is our country is large and diverse, and our country has different priorities, and the states are reflected of those priorities, and it's kind of I would say folly to assume we're going to be able to dictate the same program across the country, which is exactly why Senator Wyden tried so hard to get this provision in the law. John will probably remember that he wanted the provision to be activated earlier than 2017. I think he wanted it to be activated at the beginning, but -- that is 2014 -- but the majority of them trusted and support that because they were afraid of giving too much freedom, but I think it's fair to say we're now in a situation where the only way we're going to get the whole country to embrace a form of reform is to give more state flexibility. The point is these maps is really to say we've always had variability across the states, we've always allowed a lot of variability, and particular in the Medicaid Program, and that's how you allow folks to tailor the programs to fit their own local priorities. As far as, I would say, as to how to think about going forward in a way while many supporters of the law won't be disappointed, that Chief Justice Robert created that opportunity for states to not expand the Medicaid, at the same time I would say, his legal genius led to the reality that if you do expand Medicaid, you are choosing to embrace the law on your own time, and therefore you own it, just like when they created Medicaid in the first place back in the 60s. I think the most exciting thing about 1332; it allows states to think about, "Okay, how could I change my Medicaid Program?" because you all know -- everybody knows -- the fundamental barrier to expanding Medicaid and embracing the full opportunity to Affordable Care Act is folks are nervous, in fact maybe even scared, about how much Medicaid cost. They think it's not functioning all that well in a lot of context in a lot given states. They would like to fundamentally change the program, and that's hard to do under existing law, even under existing waiver authority, but would be more possible under something like 1332 where you can combine a Medicaid waiver with other waivers to get you to have more freedom. I think that fundamentally, what the law -- what the provision does is it gives us an opportunity to embrace the states where they are, as opposed to where we would like them to be maybe and therefore, enable us all to look forward, and I look forward to this discussion, becoming much more robust, which I think it will once the spring court rules on Burwell and the next election happens.

Krista Drobac: Great. Thanks so much, Len. Now, we'll turn to the other side of the aisle, and I'd like to ask Stuart Butler for his thoughts. Stuart is a Senior Fellow at the Brookings Institution, and prior to joining Brookings, he spent 35 years at the Heritage Foundation as the Director of the Center for Policy Innovation, and earlier, as the Vice-President for

Domestic and Economic Policy Studies. He's also currently an Adjunct Professor at Georgetown's McCourt School of Public Policy and a Visiting Fellow at the Convergence Center for Policy Resolution. Stuart is a member of the Editorial Board of Health Affairs. Stuart, you've been blogging over the past few months about the State Innovation Waiver under 1332. Please take us through your perspectives.

Stuart Butler: Thanks very much, Krista. Well, I was certainly no fan of the Affordable Care Act in general, but in section 1332, Wyden waiver just very consistent with I think a lot of work that I did and others, to really try to frame what would a National Health System -- a national system would look like in America. I think if you stop in that perspective, you have to go to what Len said, that one can imagine living in the United State as opposed to the country I come from, the UK or Germany. America is a large and diverse country. When we try to set up any kind of system like it, a complex health system, we have to recognize that in different parts of the country, both technically and philosophically. People might want to reach the general objective in different ways. I think what we see now is the opportunity with the Affordable Care Act, distribution of it, is that we check very well -- we spend gold national levels as John have cited earlier with regards to this section of the -- of coverage, of targets, of affordability and so forth. Then if we set up an American-style federal-state vision of a national system, we would envision different states achieving those national goals in different ways. 1332 doesn't like you to do this? That has been emphasized. It keeps the objectives in place, the so-called guardrails of the goal, but then is -- as everybody said, it allows a state to propose to the Federal Government a propriety of possible range of getting there, by gaining some redemptions or waivers instead of features of the -- for the rest of provisions of the Affordable Care Act, such as the mandates, some individuals, employers, such as using the stocks and the tax credits differently, having exchanges or not having exchanges. And as John said, to combine this particular waiver with other waivers -- in other words, viable from Medicaid, CHIP, Medicare -- indeed, as the provision said, any other federal law that has an opportunity for waivers. To my mind, "Yes, I'm no big fan of the Affordable Care Act but the provision does allow us to achieve the kind of national system that I think is in line with the federal nature of the United States. Let’s move to the next slide, I think it does something also very important. Just a political opportunity to address the impasse that we are now facing in the United States, that there's really global warfare against each of the Affordable Care Act. Nobody is really happy with it on all the side of the aisle -- and changing -- everybody wants some kind of changes, and I think it is a political opportunity now to allow republicans and democrats to actually live with the Affordable Care Act by causing it to evolve in very different directions. I think you could have a situation – and can have a situation where one might say -- from the Republican side, "Okay, we'll keep this thing called the Affordable Care Act, but if in our states, we can move it down the direction very different from the rest of the Affordable Care Act laid out." Then in attempt, it is shaping the Affordable Care Act. As already been mentioned, there are enormous opportunities to do that. A more conservative state can afford the same as -- like a private option in Medicaid, it can introduce very different market -- approaches to Health Care. On the other hand -- well, they might --may not have been successful, this time, it can move -- other states can move forward with various forms of approaches more in line with the single payer approach. It does allow this diversity that would otherwise not be possible. Then I think in addition, it does allow us to find a solution to the King versus Burwell if there is a decision in favor of the plaintiff. I think that's -- you will likely to see republicans in the Congress being more

than to look at a combination of extending and assisting subsidies in those federal exchanges, providing that there are other things that are changed in the law, and I think 1332 and some revisions of that section could be a very effective way of dealing with this political fallout. For example, advancing the date of that section to now, which is a little earlier too, and others wanted to have it in existence today. Well, I think asking for legislation to address if some states can start moving right now, that would March 2017. I think allowing some fast track waivers so that certain categories of alternative innovative design of the Affordable Care Act in certain sections would get fast track waivers, where it would be presumed to be accepted, unless there are some technical objection put forward by the. I think it's also -- the guardrail that John mentioned, I also -- I think maybe a little bit more flexible than might first seen, a comparable number for example. Well, if a state is not currently expanded Medicaid, such as Texas, it's -- the bigger question was to what the comparable number actually is that have to be achieved? Is it the -- well, before Medicaid expansion or after Medicaid expansion? I think there is an opportunity for conversation there, and are they finally near yet of a budget neutrality. It's hard to say that the federal expenditure should well be under the Affordable Care Act in states. It's hard to project anyway. Do you make it -- do you consider it before or after an expansion of Medicaid? I think there is a lot of room to maneuver between republicans and democrats to utilize this 1332 to the head of the political quandary that everybody is in. I think finally, the bottom line, I think that 1332 does give an opportunity for both sides of the aisle to extract themselves out of the Affordable Care Act on pass to get it --to things that need to be fixed and to give options for states that want to go a different way to do so under the general structure of the ACA.

Krista Drobac: Great. Thanks so much, Stuart. Finally, we're going to here from Grace-Marie Turner. Grace-Marie is the President of the Galen Institute, a Public Policy Research Organization that she found in 1995 to promote and inform debate over free-market ideas for health reform. She's been instrumental in developing and promoting ideas for reform to transfer power over healthcare decisions to doctors and patients. She speaks and writes extensively about incentives to promote a competitive, patient-centered marketplace in the health sector. She has received the 2007 Outstanding Achievement Award for Promotion of Consumer Driven Health Care from Consumer Health World, and she serves on the Board the Association of Private Enterprise Education. Grace, you've been a vocal proponent of free-market alternative to help insurance coverage. Could you provide us some of the highlights of -- from your point of view?

Grace-Marie Turner: I believe that actually the 1332 waiver does provide an opportunity for some of the kinds of free-market options that the state would feel that has really indicated that they would be interested in pursuing. Well, thank you very much, Krista, for moderating, and I also want to thank Bruce and your team at MAXIMUS for putting the call together. I think this is -- it's really important to have this conversation because there really is agreement about this particular provision which may seem like a posted stamp, but it really has a lot of opportunities to begin to move in the direction of the right kind of health reform that really does account for the differences between states and individual preferences. John mentioned early on that the requirements of 1332 are pretty tough to meet right now, and I do think that the opportunity, should the petitioners prevail, and the King V. Burwell feud where we expect to have a decision probably by the end of June, that that could provide an opportunity to really begin to move forward with giving the states

more flexibility, that the congress has really pledged in a number of different ways, through op-eds, through a lot of comments that leaders in congress have made, that they want to provide safety net coverage for the people in the 37 states that are currently under the federal -- operating in the Federal Exchange, to make sure there is continuity of coverage. I think we've got some feedback here, and I don't know where that might be coming from. Does anybody else here it, or is it just me?

Krista Drobac: Yeah. Could everybody mute their phones please?

Grace-Marie Turner: Let's see …

Krista Drobac: I'll send out a note on the chat here.

Grace-Marie Turner: Okay. The -- but there's opportunity because that would require legislation, as Stuart said. In order to continue to provide those subsidies, if King prevails, because they would have been -- the court would have been decided that the IRS acted illegally, and allowing federal subsidies to flow through exchanges that were not established by states. That then provides an opportunity to look at what other things might not -- might need to be changed in the law in order to provide the kind of flexibilities to allow people to purchase more affordable coverage. I think that giving -- that this could be used as a platform for congress to provide more flexibility and the design of insurance products to the state give them more freedom from some of the mandates and the coverage requirement, so that whatever 1332 says right now could be adjusted with consultation, not only with the governors, but also with members on both sides of the aisle -- and I think that Senator Wyden would certainly be the leader in this because he wants to make this provision work. If it's something that could be used as a vehicle to give states more flexibility, then I believe that you would begin to see those 37 states look at the ACA in a different way. If they began to see that this gives us the opportunity to begin to provide coverage for our citizens, but not fitting into the boxes of gold -- of platinum and gold, silver, bronze, but letting us decide and letting the citizens decide what kind of coverage we -- they need. Allowing 1332 to be adjusted in whatever post-King legislation might be passed could perhaps give states more flexibility and meeting the coverage target, redesigning benefits, offering alternative distribution that can instance for the subsidies, et cetera. I think you've seen the states having -- sort of beginning to talk about that already and having this opportunity to use some of those flexibility, well I think really gives him the opportunity, as Len said, to begin to think of the ACA as a partner rather than in many cases -- letting -- see it as an enemy. This is -- using this platform allows us to move forward. Next slide please. Happen next -- yeah. States in particular as we know have been talking for a long time about what a Medicaid -- block grants for Medicaid because they feel they really could provide better services or economically if they didn't have to jump through so many hoops to meet all of the requirements of Medicaid and the long and sometimes torturous process of getting the 1115 waivers approved. They really already want some way that they can have more control over the funds to be able to distribute them in new ways. Allowing that money to be combined not only with Medicaid but also with CHIP money provides a tremendous amount of resources for the states. When you think about individuals in those states, they may have parents on the ACA subsidies, and they have a child on CHIP and another child on Medicaid. Extremely cumbersome, extremely difficult, not only for that family, but for the state to administer. Allowing this as an

opportunity to begin a kind of harmonization of these existing healthcare programs I think would be -- they would see this as an important opportunity. To show that there's already a lot of thinking about this, Paul Ryan, now Ways & Means Chairman, has proposed something called Opportunity Grants, and this would be an opportunity for states to combine more than a dozen existing programs such as food stamps,, Temporary Assistance for Needy Families, Section 8 Housing, Child Care Development, Weatherization Assistance, Community Development Block Grants -- a lot of those into a uniform grant that would then be targeted to the individual so that people can get the services they need rather than once again, having to jump through so many hoops, trying to fit into all of these boxes, and perhaps still not getting the services that they need. I see this as an important opportunity. It may need to be adjusted. There are lot -- conversations already going on with the states, and hopefully, we can see this as a bipartisan effort, and I think that this call shows that that sentiment is there to begin to think about this as the opportunity to -- dare I say, make the ACA work by giving states more of the kind of control and authority over allocation of these resources so that they can really tailor them to the resources of their state and the needs of their states. I will end there, Krista, so we can begin to take questions.

Krista Drobac: Great. Thank you. We are going to take questions from you all, but we also have some questions that we've thought about ourselves. In order to encourage audience participation, I'm actually going to take an audience -- a question from the audience first. John, this is directed at you. The question is what did Vermont learn about Federal Budget Neutrality Calculations under 1332 from their conversations with the Treasury Department?

John McDonough: Well, I was not a part into that. I know that they went on, and I heard some of the bottom lines, but I didn't have extensive detail or have information on what actually happened in the conversation as much as -- I think they went into the conversations with perhaps a bit of exuberant enthusiasm from the initial estimates that suggested that they could get more than $400,000,000 a year in federal revenues that would otherwise could go into the state, and at the end of the day, the treasury, and they came to their realization that they're probably talking close to around $100,000,000, which is obviously not an insignificant amount of money for a state particularly the size of Vermont. Nonetheless, it just -- there was a lot less there than they expected, and that came from understanding at least how the current treasury officials would do the calculation, with the experience was already beginning to show in terms of the costs, so the Federal Treasury for the ACA. It was a reality check moment that said, "This is not quite as great a deal as we had initially envisioned and hoped for."

Krista Drobac: Imagine that this is a really big question for states. How do we tackle the budget neutrality aspects, and what are the perspectives of the government officials that are going to be looking at this? Does anyone else have any kind of tips for states that might be thinking about doing a 1332 waiver and how to present it? Maybe Len, giving your OMB background, you might have some good advice.

Len Nichols: What I'm about to say -- I don't think rises to the level of advice, but I would offer some things to think about -- just because the truth is, the administration hasn't put out the detailed instructions on regulations on how to go about this, and that's -- I would just

say, one of the problems Vermont have. They were kind of flying blind and they were -- if I understand what John has told us correctly, they were focused just on 1332 from the ACA. Whereas, I think states' thinking more expansively like I and Stuart and Grace-Marie are encouraging, would -- it would draft 1115, an SCHIP, and theoretically, I don't know why you couldn't -- given this -- the language and statute, you can wrap a Medicare waiver in there too and really get all the funds to give you far more freedom. That would be the advice I would take or will suggest to states. Don't go in just looking for what the feds would have spent on the ACA per se, but look at the total federal expenditure on healthcare in your state, and that gives you far more degrees of freedom to play with..

Krista Drobac: Great. Thank you. I'm going to mix these questions up a little bit. Grace-Marie, I'd like to ask you, so what generally are some of the ways that Republican Governors can use 1332 while still avoiding the accusations of accommodating Obamacare?

Grace-Marie Turner: I think that the way they would do that is by trying to build on programs that they already have been proposing, and in some case, implementing. For example in Indiana, Governor Pence began a program, the Healthy Indiana Program, to provide access to health insurance using the Medicaid waiver platform, but also some state money, to provide access to people up to about I think 200 percent of poverty. There was the Medicaid Private Option that Stuart was talking about earlier, that Governor Jeb Bush initiated in Florida. Missouri has obviously been trying to be creative in providing private options for Medicaid through its waiver application for the Medicaid expansion under the ACA. There are number of things that states has been proposing. They have -- many of them have run into considerable obstacles, such that other states have been sort of disinterested in pursuing them because they don't have the same head start. I think you would be -- you would see that the leading states would be those who already have an idea; perhaps even a program in place that they could build on as an opportunity to move forward. The Healthy Indiana Program for example could be used as a way of expanding access to coverage through -- for those individuals in the state who are currently getting subsidies through the ACA. They already have distribution mechanisms, there are -- for the funds, they already know how to do that, they already know how to collect funds from individuals, some of those technical -- pardon me -- details had been worked out. You'd see those states beginning to lead, but then others, seeing their successes, I think would begin to follow, and they would see that there is more of an opportunity for creativity, particularly in harmonizing and integrating those several program.

Krista Drobac: Stuart, I'm anticipating that you probably have gotten some calls from Republican governors wondering how this might work for them, or a Republican staff, and obviously, you don't need to reveal who they are, but I'm imagining they're leaning on you for advice, as well as Grace-Marie. What would you -- if I was a Republican governor wanting to do something this -- what would you advise?

Stuart Butler: Well, I think Grace-Marie's absolutely on target for this. It's a question concerning -- looking at what states -- Republican states were already trying to do or putting in place, as she mentioned Indiana and elsewhere, and saying in effect, 1332 is a loophole in the Affordable Care Act, which then would allow these more Republican or Conservative state and districts to go ahead with the funding available through the

Affordable Care Act. What the state is actually doing is moving in that very independent direction. As I said back at the beginning of the remarks, that as we think about what the national system looks like. I think it's really more an issue of how do you frame it -- as you said, how do you tell the state doing what's to do using the Affordable Care Act without the last government being accused of putting into place Obamacare. I think that 1332 didn't appear to be doing that, and that's what I would advise Republican states to do. I think that John said in the beginning is health history of this section really was designed to that kind of variety. Now, we're sort of rebuilding that sort original in chunks of 1332, and are now using to deal with both the political and technical problems.

Krista Drobac: Great. Thank you.

John McDonough: Krista?

Krista Drobac: Yes.

John McDonough: This is John McDonough. Can I just add one little point?

Krista Drobac: Absolutely. Please do.

John McDonough: I think it's worth noting there's a little irony here in that. My reading, my understanding, my sense of 1332 is it's going to be a lot easier for a state to jump in with both feet if they in fact have their own state health insurance marketplace / exchange, and it's going to be a lot tougher and more difficult to figure out how to make a goal of this if you're relying on a federally facilitated marketplace. Of course, when we were writing the ACA in congress, we very much anticipated that most states would absolutely want their own exchange, and it's only in the political backlash against Obamacare that we saw things going very much in the other direction. I think that's something to keep in mind. It's just practically speaking a lot tougher to make this work if you have a federal as opposed to a state-based exchange.

Krista Drobac: John, let's stay with you for a second, and maybe Len can also weigh in on this. What are some of the smaller policy goals that can be accomplished? For example, reducing turn -- I know we've all been worried about people going back and forth between programs, or -- in creating consistent networks. What are the -- some of the smaller things that can be done?

John McDonough: Well, small is obviously always in the eye of the beholder. I would think -- I mean, trying to think from a Conservative point of view on something. One of the phenomena that we're seeing quite robustly over the past several years, and I think to some extent surprising how strong it's been, is the development and growth of these private health insurance exchanges outside of the ACA exchanges. I could see from an ideological point of view, a Conservative state saying, "We might like to have our own exchange, but we don't want it to be a government thing. We'd like to give it to one or several of these private exchanges and let that kind of marketplace work itself out." I haven't really dug deep into that idea, but that's seems to me to be something that's it's not turning the world upside down, it -- but it seems to me like it's something that might actually

be able to thread several needles to get to a waiver that might actually lead to something different from a policy perspective happening.

Len Nichols: I would just weigh-in on what is the problem churn? The problem with churn is that people incoming to real world and real life, there is overtime, is like lose one job, get a better job, whatever, and they bounce from being Medicaid eligible to both the not Medicaid eligible under the ACA, they would bounce from Medicaid into the marketplace and then back out again in a normal year, and there's a big number of people who we expect to have that happen. Well, the simple way to solve that problem is to have them not have to switch what kind of plan they're on, but fundamentally, you just alter the cost-sharing degree they are responsible for. In essence, a sliding scale would work seamlessly to enable you to have one kind of plan and clearly in the states that are reluctant to expand Medicaid as is, in part of what they want very much is for those plans to be more like private insurance, but you could just have a different copay or a different percentage they have to pay every month to be insured when they're on Medicaid, when they're not, and therefore, there wouldn't be a churn problem because they'd never had to switch plans. I think that is totally consistent with the goals of many Republicans that I've talked to and also consistent with the provision of 1332.

Krista Drobac: Thank you. We have one -- another one question from the audience, and then I'd like to turn after that to the question of King V. Burwell. I think that's an important question to get everyone's perspective on, and we have about nine minutes. Len, I think this is actually sparked by something that you said. Is there -- do you have any idea when CMS may release the guidance on 1332 and how prescriptive it might be? I know they never liked to tell anyone when they're going to do things, but obviously, they've got to get it done quickly if people are going to have time -- and maybe John, you may have some thoughts on this too.

Len Nichols: Well, as you know, Krista, we've all been asking them for months now, and they all say, "Sometime in the future, but not soon," and I would say two things. If you take the normal pace of -- that was anticipated by the law, and that is 2017 is the year you can entertain a proposal for 1332. Every state Medicaid director, or state leader I've ever talked to, and you talked to more than I have -- I guess you would collaborate this -- you need about a year to prepare a big time labor application for your own state, to get all your data and all your debts in order. That means the regs need to be in the state's hands in January of 16. I think that's actually the timetable that would be -- if you will, normal. I think King V. Burwell, if it is decided for the plaintiffs as Stuart and Grace-Marie had mentioned, I think a lot of stuff's going to happen really fast, and I wouldn't be surprised if that -- those regs didn't -- get moved forward in time. I would expect January 16 at the latest, and perhaps sooner if King V. Burwell goes that way.

Krista Drobac: Alright. Well, let me -- go ahead, John. Sorry.

John McDonough: Yeah. This is John. I just -- I think I may have a little difference of interpretation with my friend Len. My reading over it is that states can apply anytime they want, and -- but that the waiver can't start until January 1st, 2017. You can apply anytime you want, but it's obviously a very lengthy process, and particularly for the first one out of

the gate -- unless the first one's out of the gate are fairly minute and discreet in terms of their policy breakthroughs.

Len Nichols: I think you're right, but I think without guidance, John, they would be shooting in the dark. I think that guidance is really important to making that first application.

John McDonough: Wouldn't be the first time though, Len. I mean remember, the Children's Health Insurance Program, they started it, and then they wrote the regs after it was out.

Len Nichols: Well, that's true but it's a little bigger deal. Anyway, we should move on.

Krista Drobac: Alright. I'd like to ask the $6,000,000 question about the Supreme Court decision on King V. Burwell and how 1332 waivers might relate to that. I'd like to start with Grace-Marie, go to Stuart, then John, and then we'll end with Len. Grace-Marie, do you want to kick us off?

Grace-Marie Turner: Just quickly. I believe that congress, as I said earlier, really is committed to making sure if King should prevail, that subsidies do continue for the millions of people in the 37 states who are currently receiving them in order to afford their health insurance coverage, and that then provides an opportunity for congress to say how they are going to continue those subsidies and what new options they are going to be giving to both individuals and to the states so that I think 1332 can be seen as a platform -- and I know that congressional staff and members are already talking about this, they're thinking about it, they're talking to governors about what do you need to make this work, because they see this as an opportunity not only to continue those subsidies, but also to begin to chart a different course for giving people more freedom for the kind of health insurance that they want, giving states more authority over the kinds of health insurance that people would be able to buy, and then building that flexibility into some of the public programs that are existing. I think 1332 could be the platform, but I see this post-King legislation really is a vehicle.

Krista Drobac: Great. Stuart?

Stuart Butler: I totally agree with that -- this is Stuart -- that a decision for the plaintiff will accelerate a lot of the complications we just had, including the regulations. It will allow an opportunity to advance the date, specifically knowing that some standard states that need some guidance as to what to do. It -- a deal that involve extending current subsidies in the federal exchange states with making these changes -- making explicit for example that yes, you can mix different waivers as law – as it currently says -- but also mix the funding and the budgets for these different waivers into one sort of large budget neutral federal access. That means that some of the things that Len was saying, it turns to taking the subsidies, many people, instead of going into Medicaid, that direct support from the federal government to enroll in private plans or in employer-based coverage. All these sorts of things can be modifications to Section 1332. I think very quickly and I – an ideal opportunity. That would allow exactly the kind of variation and opportunities that we will be talking about, having to proceed that very quickly. There's no question that a decision for the plaintiff in King versus Burwell will cause a lot of turbulence. Certainly politically and

technically, but I think it does open up the opportunity to really put 1322 into overdrive so that we can achieve the kind of variety that would allow both people on the liberal and conservative side to feel comfortable with saying, "Well, maybe ACA wasn't perfect, but it's allowed me to do what we really wanted to do in the state to achieve objectives that nearly all Americans share."

Krista Drobac: Great. John?

John McDonough: Very briefly, I would just say that the thing about the post-King decision if King wins is that what we're asking is a congress that is run by party that is rebuilt ACA fifty something times, they have to agree on what to do. That would -- that says to me there is a core of Republicans who are never going to agree to spend this kind of money. They -- I believe like Grace-Marie and Stuart, there are plenty of Republicans who are willing to cut a reasonable deal, but it's going to take democratic votes to pass that revised legislation. Therefore, in a way, it presents us with a unique opportunity to revisit this whole conversation on a bipartisan basis. That's why I'm consciously optimistic even if King wins, that we can have an adult conversation, and I think that adult conversation can lead to the kinds of flexibility that a lot of states can embrace, then we can move forward.

Grace-Marie Turner: Hear hear. I agree, love.

Krista Drobac: John. Do you want to finish us off, and then we'll turn it back to Bruce.

John McDonough: Yeah. Note of caution. The suggestion by my friend Stuart, that things could happen very fast. A big difference between 1115 Medicaid waivers and a 1332 waiver. 1332 waiver Budget Neutrality is written into federal law. It is part of the statute. 1115, it's a rule. It's a common practice of 1115 waivers. As long as there's a requirement for budget neutrality, the notion that anything is going to go fast I think is just a little bit too much wishful thinking from what I see in terms of how these things move forward.

Krista Drobac: Alright. Well, on that note, Bruce, I'm going to turn it back over to you.

Bruce Caswell: Excellent. Thank you, Krista. On behalf of MAXIMUS, I'd like to thank Krista, John, Len, Stuart and Grace-Marie. It's been a great discussion on the state innovation waiver, and we really appreciate your time and your expertise. Thanks as well to all of you who participated today. We'll be posting the slides and the transcript of today's session on our website at www.maximus.com/webinars, and we encourage you and your colleagues to review that. Stay tuned for us to continue the conversation, and feel free to email help@maximus.com if you have any more questions. And with that, we conclude today's webinar. Thanks again.