Looking Toward the Future: Health Policy Priorities and Actions in the First Year of the Biden Administration

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INTRODUCTION

In 2020, the Patient Protection and Affordable Care Act (ACA), the landmark piece of health legislation signed into law on March 23, 2010, celebrated its tenth anniversary. This major reform of the healthcare system expanded access to both public programs and the commercial healthcare markets – and thereby to healthcare – while creating a minimum standard of benefits and providing new opportunities for subsidized coverage. Throughout the previous decade, it was threatened by judicial challenges and legislative repeal, but the law withstood these threats and now is firmly entrenched in our nation's care delivery system.

The outcome of the 2020 election combined with the Supreme Court's decision in *California v. Texas* upholding the constitutionality of the ACA, have led to a new focus on reinforcing and expanding upon the law starting at the top from the new administration. That came at the same time as the impacts and lessons from the COVID-19 pandemic have highlighted needs and provided opportunities to address remaining barriers to healthcare that have become particularly acute during this healthcare crisis. Within that context, in the first year of the Biden administration, there has been an increased focus on access to healthcare, affordability of health coverage and equity in care delivery through the dual coverage pathways of private insurance and Medicaid as well as the public health system. The administration has issued executive orders, sought legislative changes - such as via the American Rescue Plan Act and the Build Back Better Act - updated market rules, and made funding investments aimed at promoting those health policy priorities. This paper explores the actions since the start of the current federal administration to advance its key healthcare priorities and what may come next in those areas.

PART I: PRIVATE INSURANCE

AFFORDABILITY

Recent Action

With a focus on addressing the impact of the COVID-19 pandemic in all facets of the country, the sweeping American Rescue Plan Act of 2021 (ARPA) was the administration's first attempt to enhance the affordability of health coverage. Most notably, ARPA includes what are currently temporary provisions to expand the Premium Tax Credits (PTCs) for commercial health insurance coverage through the Marketplace.

Under the ACA, the amount of PTCs for which individuals are eligible is based on income, with individuals' premium contributions limited to a set percentage of their income and PTCs available to cover the remainder of the premium for the Second-Lowest Cost Silver Plan (the benchmark plan). For both the current year and for 2022, ARPA decreases the percentage of income individuals are expected to contribute for the benchmark plan, as reflected in the chart below. In doing so, ARPA not only makes the benchmark plan more affordable, but also increases the amount of the PTC an eligible individual can use to purchase a different plan on the Marketplace. Unlike with PTCs in general, the amount of these reduced expected contributions are not indexed but will remain the same for those two years.

Income (Percent of Federal Poverty Level [FPL])	Maximum Individual Contribution (Percent of Income)	
	Original (indexed to 2021)	American Rescue Plan Act (2021 and 2022)
Up to 133% FPL	2.07%	0%
133% to 150% FPL	3.10% to 4.14%	0%
150% to 200% FPL	4.14% to 6.52%	0% to 2%
200% to 250% FPL	6.52% to 8.33%	2% to 4%
250% to 300% FPL	8.33% to 9.83%	4% to 6%
300% to 400% FPL	9.83%	6% to 8.5%
Over 400% FPL	n/a	8.5%

Notably, for the first time, ARPA reduces the expected individual contribution of the lowest income individuals eligible for PTCs - those up to 150% of the Federal Poverty Level (FPL) - to zero percent, meaning those individuals are currently eligible for no-cost insurance with reduced cost sharing. In the past, individuals could obtain zero-dollar coverage via PTCs by buying down to Bronze plans with PTCs based on Silver benchmark plans. However, by purchasing the Bronze coverage instead of the benchmark plan or another Silver plan, those individuals forfeited cost sharing reductions (CSRs) for which they were also eligible, but which are only available for Silver-level coverage. Now these individuals can get no-cost coverage at the Silver level, maintaining their CSR.

The affordability provisions in ARPA also target those at higher income levels. Some individuals who are income-eligible for PTCs do not receive them because the benchmark plan premiums do not exceed their expected contribution. Those individuals receive no premium assistance, even to purchase more expensive coverage which may be a better fit for their needs. Under ARPA, some of those individuals may see their expected contribution drop below the cost of the benchmark plan, making them eligible for a PTC. This is most likely to impact younger individuals (who have lower age-rated premiums) at relatively higher incomes within the eligibility for PTCs (and, therefore, higher expected contributions). They will have the option of using their new PTCs to purchase more expensive coverage with lower cost sharing, which is particularly meaningful for this population that is not eligible for CSRs based on their income.

ARPA also temporarily extends eligibility for premium assistance to those whose incomes previously exceeded the income cutoff for PTC eligibility. Under the ACA, 400 percent of the FPL is the income eligibility cutoff for PTCs. However, under ARPA, for 2021 and 2022, those with incomes over 400 percent of the FPL are eligible for PTCs if their cost of coverage is more than 8.5 percent of their income. The amount of their PTC will be equivalent to the amount that their benchmark plan premium exceeds 8.5 percent of their income. This eliminates the ACA's "subsidy cliff," which disproportionately impacts older individuals with incomes just over 400 percent FPL because of age rating.

These changes to the PTCs have a significant impact on the affordability of coverage, particularly for those at the lowest end of the income range and those just over the ACA eligibility cutoff that were previously faced with the full cost for coverage, regardless of its price. The expectation is that the increased affordability will result in fewer uninsured individuals, increased access to care and lower burden of medical debt for families and providers during the pandemic.

The increased PTCs also have the potential to improve affordability more broadly in states with Section 1332 Waivers aimed at affordability. The federal funding for Section 1332 Waiver programs is based, in part, on savings accrued in lower PTCs resulting from the waiver. Waivers that lower the cost of PTCs,

such as reinsurance program waivers that lower the cost of coverage throughout the individual market by subsidizing high-cost claims, receive the amount that – without the waiver – would have been spent in increased PTCs to fund the waiver program (known as pass-through funding). With increased amounts of funding and eligibility for PTCs outlined above, the amount of pass-through funding available based on PTCs is also increased. For the 15 states with reinsurance program waivers, that means increased funding available to fund high-cost claims across the market and, as a result, even further decreased premiums for all individual market enrollees. In those states, the impact of the increased PTCs is much broader than for those individuals that receive them since the reinsurance program funded by the savings in PTCs benefits the entirety of the individual market.

What Is Next?

The ARPA expansion of PTCs is temporary. However, there is an ongoing effort to extend them, most recently via the Build Back Better Act. The framework that was released by the White House and draft of the legislation that was released from and heard in the House of Representatives' Rules Committee in late October included both the decreased personal contribution (with an extended pause on indexing those amounts) and the extended eligibility for PTCs through 2025.

This too would impact states more broadly via the opportunity for increased pass-through funding for Section 1332 Waivers noted above. The timeline of the waiver process would make it nearly impossible at this point for any state that does not already have a 1332-funded reinsurance program in place to reap the market wide affordability benefits of the ARPA PTC provisions. However, the extension of the provisions may incentivize more states to seek Section 1332 Waivers, including to support reinsurance programs, therefore expanding the broader impacts of the change.

Looking beyond ARPA and the Build Back Better Act, the administration is also expected to tackle long-standing affordability challenges. Arguably the largest affordability gap in the country is in states that have not expanded Medicaid. The administration's efforts to ensure that population has access to affordable healthcare is outlined below. Another concern that has long been discussed is the so-called "family glitch." Individuals who have access to "affordable" employer-based coverage currently cannot access premium tax credits, even if they are income-eligible for them. The determination of access to affordable coverage for an entire family is based on the cost of employee-only coverage. Therefore, even if the cost of family coverage through an employer exceeds the affordability threshold, family members do not have access to premium subsidies if the employee-only coverage is affordable. This "glitch" could be adjusted by tying the determination of affordability for each individual to the employment-based coverage that would cover that person. The family glitch is not addressed in the Build Back Better Act, though it was included in prior efforts to build upon the Affordable Care Act.

ACCESS

Recent Action

Access to quality health insurance is another pillar of the ACA and has also been a focus of the administration since taking office. In connection with the ACA's package of commercial health insurance consumer protections - including the requirement that health plans let all-comers enroll regardless of health status or other factors and the prohibition on pre-existing condition exclusions – the law also created a limited time period during which consumers can enroll in coverage each year unless their life circumstances change. Specific to the COVID-19 pandemic, President Biden's January 28th Executive Order on Strengthening Medicaid and the Affordable Care Act called on Secretary Becerra of the Department of Health and Human Services (HHS) to consider establishing a Special Enrollment Period (SEP) for uninsured and under-insured Americans to seek coverage through the Federally Facilitated Marketplaces (FFMs).

In a follow-up to the executive order, ARPA created such a SEP starting on February 15, 2021 through August 15, 2021 in FFM states. Many State-based Marketplaces (SBMs) followed suit, allowing residents

in both FFM and SBM states to enroll in coverage during that period of the public health emergency if they were not already covered. Importantly, this allowed individuals who were newly eligible for more affordable coverage by virtual of the enhanced and expanded PTCs, as outlined above, to enroll in coverage now that they were newly able to afford it. Enrollment in FFM states increased by over 2.8 million individuals during the SEP.

More broadly, via Part 3 of the Notice of Benefit and Payment Parameters (NBPP) for 2022, the administration also lengthened the duration of the annual Marketplace Open Enrollment Period. From the start of the Marketplaces for plan year 2014 until the enrollment period for plan year 2018, the annual OEP during which enrollees could newly enroll in coverage or change coverage was November 1st through January 15th. However, in 2017, the former administration shortened the OEP to six weeks – November 1st through December 15th. The NBPP for 2022 reverts back to the original timeline and ten-week duration of the OEP starting with enrollment for plan year 2022 and going forward, with the goal of providing a longer time period each year when individuals may consider and enroll in coverage regardless of their personal circumstances.

What Is Next?

In its rulemaking thus far, the administration has made it clear that it intends to address the Marketplace grace period for non-payment of Marketplace premiums. The grace period provides enrollees receiving advance premium tax credits (APTC) extra time to catch up on missed premium payments before losing coverage. Specifically, the administration has expressed concern that the three-month grace period available to those appealing APTC eligibility is unclear and it intends to clarify it.

POLICY RESETS

Recent Action

In addition to proactively addressing remaining policy needs, the current administration has taken aim at policies from the previous administration, particularly those impacting consumer information and assistance. One major change is the enhanced focus on Navigators. Under the previous administration, funding for customer assistance steadily declined, as well as funding for Navigators and assister organizations. These roles have served an essential function, assisting consumers with Marketplace enrollment and/or technical assistance in eligibility and plan selection to ensure accessible plan enrollment through Healthcare.gov or state-based marketplace websites. In August 2021, CMS announced there would be $80 million dollars directed towards Navigator organizations, a huge increase from the $10 million dollars allocated annually between 2018 and 2020. Additionally, the previous administration eliminated the requirement that there be a minimum of two Navigators per state, and one be a community-based non-profit and maintain a presence in the state. To date, these standards have not been reinstated but the increase in funding is meant to begin to fill the gaps for enrollment assistance, especially during the COVID-19 pandemic where more and more individuals have questions about insurance and may be eligible for subsidies.

The increased Navigator and assister support will be partially funded by an increase in the Marketplace user fees which had been reduced. The final amounts for 2022 will be 2.75 percent for FFM and 2.25 percent for SBMs on the Federal Platform.

Another change aimed to assist consumers is ensuring consumers in every state maintain access to the centralized shopping portal, the Marketplace. The first Notice of Benefit and Payment Parameters for 2022, issued under the prior administration, allowed states to forgo the Marketplace and provide enrollment only via private direct enrollment entities. However, in the third part of the NBPP, released in September 2021, the Centers for Medicare and Medicaid Services (CMS) finalized the proposal to repeal this option, meaning states will not have the option to bypass a centralized marketplace portal using a private entity.

What Is Next?

The administration is also seeking to reintroduce the standardized insurance plans for FFMs. Originally, insurers selling coverage through HealthCare.gov were encouraged to adopt standard plan designs established by CMS. This was not required and was eliminated by the previous administration. Likewise, adoption of standardized plans at the state level has been slow thus far. In 2022, only eight states and the District of Columbia have adopted standardized plans, with Colorado set to do so in 2023.

Standardized health plans can make it easier for consumers to compare plans and select the one that best suits their needs. They also ensure access to quality coverage via the coverage design and requirements. For example, standardized plan designs may require plans to exempt certain services from their deductibles. Some states have also considered using standardized plans as a way to combat health disparities by eliminating cost-sharing requirements for conditions that disproportionately effect underprivileged groups.

The Biden administration also plans to reintroduce federal network adequacy reviews in the Qualified Health Plan (QHP) process as noted in the 3rd NBPP. The federal review of QHP network adequacy was eliminated via the NBPP for 2019, deferring to state review.

Strong network adequacy standards are critical to ensuring insured individuals have access to healthcare providers via their insurance coverage. Additionally, strong standards ensure that insured individuals have meaningful access to care, including the ACA-mandated Essential Health Benefits that all QHPs must offer.

1332 WAIVERS

Recent Action

The new administration has also made changes to Section 1332 State Innovation Waivers to ensure they promote meaningful access to affordable, comprehensive coverage.

Section 1332 of the ACA allows states to seek State Innovation Waivers of certain ACA provisions.

ACA Sections that may be Waived under Section 1332	
Subtitle D, Part I	Sections 1301-1304: Qualified Health Plan (QHP) and Essential Health Benefits requirements; Requirements for QHP carriers; Special rules related to abortion services; Insurance-related definitions
Subtitle D, Part II	Sections 1311-1313: Exchange (Marketplace) requirements
Subtitle E, Part 1	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H and 5000A: Premium tax credits; Individual coverage requirement; Large employer coverage requirement

In order to receive a Section 1332 Waiver, states must demonstrate that the waiver meets comparability requirements:

- It will provide coverage to at least a comparable number of the state's residents as would be provided without the waiver;
- It will provide coverage and cost-sharing protections that are at least as affordable as would be provided without the waiver;
- It will provide for coverage that is at least as comprehensive as would be provided without the waiver; and
- It will not increase the federal deficit.

The first Section 1332 Waiver was granted to Hawaii in 2016 (effective January 1, 2017) to allow it to maintain its longtime employer coverage system. Since then, all additional Section 1332 Waivers that have been approved have been granted, at least in part, to support state-based reinsurance programs. As noted above, these programs subsidize high-cost claims to lower premiums across the market funded, in part, with federal pass-through funding from the savings accrued in PTCs by virtue of the premium savings. As outlined in greater detail below, Georgia's waiver includes a reinsurance program as well as a second phase that would eliminate the Marketplace in the state.

As outlined above, the changes recently made to PTCs have the additional impact of increasing Section 1332 pass-through funding for states' waiver programs. This will make more federal funding available for waiver programs, possibly encouraging more states to seek Section 1332 Waivers, as explored in further detail below. Pass-through funding across the Section 1332 Waiver states increased by $452 million, ranging from $7 million to $139 million per state, for 2021 as a result of the changes.

More directly, via Part 3 of the NBPP for 2022, the administration rescinded changes that made the waiver guardrails more flexible. Before leaving office, the prior administration enshrined its 2018 guidance on Section 1332 Waiver requirements in the first part of the NBPP for 2022. In follow-up rulemaking this summer, the new administration rescinded those changes and the 2018 guidance, instead reverting to prior interpretations included in the 2015 Section 1332 Waiver Guidance. The impact of those latest changes is to ensure that assessments of guardrail compliance are based on those *enrolled* in affordable, comprehensive coverage, instead of just having *options* for such coverage, and the heightened compliance standards outlined below:

- **Comprehensiveness guardrail:** Coverage under a waiver must be at least as comprehensive overall for all residents as it would be without the waiver—with "comprehensiveness" referring to the scope of benefits in relation to Essential Health Benefit (EHB) requirements, the state's EHB benchmark plan and, in some cases, Medicaid and CHIP coverage. The waiver must not reduce the number of people in the state with coverage that meets the comprehensiveness standards. Specific focus will be given to the impact on vulnerable and underserved residents.
- **Affordability guardrail:** Coverage under a waiver must be at least as affordable for all state residents as coverage without the waiver—with "affordability" referring to residents' ability to pay for healthcare expenses and measured by comparing expected out-of-pocket spending for coverage and services to income. Specific focus will be given to individuals with large healthcare spending burdens relative to their income. Waivers also must not reduce the number of individuals with a cost-sharing protections.
- **Coverage guardrail:** The waiver must provide minimum essential coverage (MEC) to a comparable number of people as would have MEC without the waiver, with the impact on all state residents considered (including those enrolled in public programs). Specific focus will be given to the impact on vulnerable and underserved residents as well as any impact on gaps in coverage or discontinuation of coverage. The assessment will look at the number of people that are enrolled in coverage.
- **Deficit neutrality guardrail:** The projected federal spending net of federal revenues under the waiver must be equal or lower than it would be without the waiver. All changes in tax and other forms of revenue and financial assistance, other direct spending, and administrative costs will be considered.

The change to the waiver guardrails is not likely to have an impact on the most common type of waiver today – those that support state-based reinsurance programs. Those programs lower the cost of coverage and, by doing so, increase enrollment, without impacting benefits or the federal deficit. However, the change may impact the sorts of more unique waivers that could be sought going forward. It will ensure that the focus of Section 1332 Waivers remains to promote the key tenets of the ACA in innovative ways and that waivers that arguably undermine those tenets will not be approved.

What Is Next?

All eyes are currently on Georgia, which is the latest state to be granted a Section 1332 Waiver. In addition to creating a state-based reinsurance program, the waiver– which faces legal challenge – has a second phase that would eliminate the state Marketplace. Under the Georgia Access Model, residents would instead search for and enroll in coverage using a decentralized system relying on web-brokers and insurers, which would also be selling plans not compliant with the ACA, such as short-term limited-duration insurance.

The Departments of Health and Human Services and Treasury noted in the preamble to the NBPP that they "reserve the right to further evaluate an approved waiver and suspend or terminate an approved waiver, in whole or in part, any time before the date of expiration, if the Secretaries determine that the state materially has failed to comply[,]" including with the Section 1332 guardrails. While the Departments have recently taken a second look at all Section 1332 Waivers, Georgia's waiver, which was approved based on the more flexible interpretations of the guardrails, is the only one that, thus far, has been flagged for concerns.

To that end, the Departments requested additional information about Georgia's waiver last June with the goal of ensuring the waiver continues to satisfy the Section 1332 guardrails in light of the increases in Marketplace enrollment and expected impact of ARPA. Thus far, the state has refused to respond to the information request; however, the Departments opened a 60-day public comment period on the waiver on November 9, 2021. Following their review of comments, the Departments will determine whether the waiver continues to meet federal requirements. If the Departments finds the waiver does not meet federal requirements, the administration could seek to terminate the waiver. Notably, the review may be impacted by a unique term in Georgia's waiver. While Section 1332 Waivers all include a provision granting the federal government authority to suspend or terminate a waiver, only Georgia's included language that limited such actions to if the state "materially failed to comply" with the STCs or failed to meet the waiver guardrails.

Despite the future of Georgia's waiver being in question, if the increase and expansion of PTCs are extended under the Build Back Better Act, more states are likely to consider the amount of funding available to them under waivers and more waivers could be sought. Of course, under the new guardrail interpretation, those waivers would need to meet the more stringent application of the guardrails. Most likely, there will be additional reinsurance program waiver applications. However, with increased funding available, states may have the ability to be more innovative in their approaches.

PART II: MEDICAID

1115 WAIVERS

Recent Action

In its first year in office, the Biden administration also reset the approach to Section 1115 Medicaid Demonstration Waivers, looking with more scrutiny at waiver proposals that could result in restricting

benefits for eligible populations. Section 1115 of the Social Security Act allows states to waive certain federal Medicaid requirements and to use federal Medicaid matching funds for ”costs not ordinarily matchable”.

The prior administration approved a number of waivers that included “community engagement” requirements, or requirements that beneficiaries work or participate in qualified activities to receive benefits. This was a deviation from previous administrations that had long held that such eligibility requirements undermined access to care. Eleven states have received approval of such waivers, many of which are now subject to legal challenges. A number of those states - including Kentucky and Arkansas - are appealing court decisions against their waivers at the federal level.

Upon taking office, the Biden administration immediately set out to reverse these types of waiver approvals. President Biden’s Executive Order on Strengthening Medicaid and the Affordable Care Act directed Secretary Becerra to review policies and waivers for compatibility with the goal of protecting and strengthening Medicaid and making high quality healthcare accessible and affordable for every American. As part of this review, CMS sent letters in February to states with approved Medicaid waivers to let them know of this review process. This was followed by letters specifically withdrawing waivers from states that set work requirements for Medicaid eligibility due to the coverage and access risks that did not match the administration’s health policy goals, specifically during the pandemic. By August 2021, the federal government rescinded work requirement waivers from nine of the 11 states for which they had been previously approved, with the remaining two states either preparing to withdraw their demonstrations or in discussions with CMS for waiver modification.

The shift in approach to Medicaid waivers has been a significant course correction from the previous administration. It has expanded beyond work requirement waivers, and it has not been without state pushback. In April 2021, CMS rescinded a Medicaid waiver extension for the state of Texas which was approved during the final days of the prior administration. This Section 1115 Waiver provided federal funding for the state to reimburse hospitals for uncompensated care and to require Medicaid recipients to enroll in Managed Care Organizations (MCOs). The waiver extension request had been exempted from the public notice process by CMS for a ten-year extension, and the approval was rescinded once the under the new administration because of the lack of a public comment period. The state sued CMS for this action and in August, a preliminary ruling found the decision to revoke the waiver was “arbitrary and capricious.” Despite the legal roadblocks, the federal government has continued to revoke the approvals of most waivers that implement Medicaid work requirements, most recently in the state of Ohio.

What Is Next?

Texas was the first state to submit a legal challenge against the revocation of waiver approvals, but other states will likely follow suit. In the future, it is likely that CMS will only approve waivers that are targeting increasing access and coverage as opposed to waivers that seek to promote other goals such as implementation of work requirements.

MEDICAID EXPANSION

Recent Action

Action was taken via ARPA to provide greater access to Medicaid by incentivizing the 12 states that have not yet adopted the Medicaid expansion to do so. Individuals below 133% of the FPL were expected to be eligible for Medicaid nationwide prior to the Supreme Court decision that made Medicaid expansion optional. Therefore, under the ACA they were not made eligible for PTCs. As such, in states that did not expand Medicaid, most of those individuals have no affordable coverage options.

In an interesting twist, the ARPA incentive is tied to funding for the *non-expansion* population. If a state decides to newly implement expansion, they will receive a temporary increase of five percentage points in

federal match funding for their non-expansion populations. Like all other expansion states, they will also receive a 90 percent Federal Medical Assistance Percentage (FMAP) for the expansion population.

By tying the FMAP funding increase to states' non-expansion population—which account for the majority of state Medicaid costs—the incentive is more valuable than if it were tied to the expansion population. The federal match increase will be available for two years from the date a state expands coverage, which may be enough to incentivize the remaining twelve states (or the voters of those states) to expand Medicaid.

Slowly "holdout" states continue to adopt expansion. CMS announced this past summer that an estimated 190,000 residents of Oklahoma are now presumed eligible for Medicaid. This comes one year after voters in Oklahoma approved expansion. In just one month, from when the state started taking applications on June 1, 2021, to the benefit period beginning on July 1, 2021, 120,000 Oklahomans have applied and were determined eligible for Medicaid. It is estimated that the additional funding from ARPA will provide the state with $500 million over two years.

Missouri also recently adopted expansion, opening up Medicaid to an estimated 275,000 more eligible residents. In two months (August -October 2021) Missouri received 17,000 applications for Medicaid. It is estimated that the ARPA funding will result in an estimated $968 million in additional federal funding over the next two years.

What Is Next?

As states continue to consider the longstanding and new incentives, the Build Back Better legislation seeks to build on ARPA efforts to address the coverage gap in non-expansion states with an alternative approach. Under the bill, in states that maintain the coverage gap, individuals in that gap would be eligible for subsidized coverage through the Marketplaces for 2022 through 2025. Individuals would be newly and temporarily eligible for both premium tax credits and cost-sharing reductions.

The Medicaid coverage gap has long been a priority area for ACA supporters, and it is likely that the administration will continue to seek ways to address it permanently regardless of the outcome of the Build Back Better Act. This could include increasing the amount of federal matching reimbursement or making expansion a requirement of approval of a Medicaid waiver.

OTHER PUBLIC PROGRAM FUNDING INVESTMENTS

Recent Action

State efforts to allocate funding in a way that meaningfully invests in Home and Community Based Services (HCBS) and makes strategic investments in long-term care are not new. However, the COVID-19 pandemic exacerbated this need and illuminated current gaps. ARPA provides relief for Medicaid HCBS programs via scheduled, enhanced federal financing participation to offset state expenditures, and offered states the opportunity to invest the influx of funds from ARPA in a way that will provide long-term improvements for all involved.

Section 9817 of ARPA provides enhanced federal funding for Medicaid HCBS in addition to certain behavioral health services through a one-year, 10 percent increase to the share of state HCBS Medicaid spending that is paid for by the federal government. These increased FMAPs will be in place from April 1, 2021 through March 31, 2022, and states must spend the enhanced FMAP funding by March 31, 2024. This increase in federal matching funds will result in new, time-limited dollars that can be invested in certain Medicaid HCBS and behavioral health services.

In May 2021, CMS released a letter to all state Medicaid Directors containing guidance for implementing this ARPA provision, including reporting and spending plan requirements. The key areas of consideration for states underscore CMS's priorities related to these funds: sustainability, flexibility and equity.

What Is Next?

The extent to which this funding will make a long-term impact on HCBS is yet to be determined, but the unprecedented funding has allowed states to think creatively and carefully examine the investments being made in their long-term care supports.

The next step is state implementation, into which we are already getting early insight. States began submitting proposed spending plans this past summer, with many states breaking the spending into phases to maximize funding while also providing adequate time for public input and comment on how best to serve the affected communities. Some states have already received conditional or partial approval of proposed spending plans. The following state examples provide insights the ways these funds may make a difference on the ground in states.

Washington State: Washington outlined their spending plan for the ARPA funding, and plans to allocate funds to address high priority immediate needs, as well as long term planning as follows:

- **Long Term Support Services:** $264 million dollars directed towards rate increases; behavioral health transitional support; cost of living increases for personal needs allowance; provider rate increases; and rental subsidies for clients
- **Intellectual & Developmental Disabilities:** $178 million dollars for supportive living and provider rate increases; hourly wage increase; and the phase in of 5 three-bed, state operated living alternatives
- **Community Behavioral Health:** $81 million dollars to support provider rates and expand substance use services and short-term behavioral health housing support

Washington submitted their spending plan in June 2021, and the state is presently engaged in an ongoing dialogue with the CMS related to the funding planning- including working to provide additional information to CMS requested in the partial approval letter and recent addendum.

Massachusetts: Massachusetts has broken out the funding initiatives into "rounds." Massachusetts issued a Request for Information (RFI) in April 2021 to gather public input on its proposed areas for investment (of the estimated over $400 million in potential new dollars), soliciting comment on the following four areas:

- **Topic Area 1:** Access to HCBS services and supports
- **Topic Area 2:** Technology and infrastructure investments to strengthen HCBS
- **Topic Area 3:** Initiatives that provide opportunities to promote HCBS and emphasize high-quality, person-centered care
- **Topic Area 4:** HBCS workforce development, including recruitment and retention strategies

Massachusetts is balancing CMS's tight timeline for spending plan submission while ensuring adequate public input. The initial spending plan submitted to CMS in June 2021 focused on investing approximately $100 million in immediate, time-limited, across-the-board payment enhancements to stabilize the HCBS workforce. Providers will receive enhanced payments from July through December 2021 and will be required to spend at least 90 percent of enhanced payments to support direct care and support staffing.

The Round 2 spending plan addresses "new investments totaling approximately $44 million in long-standing commitment to equitable rebalancing long-term services and supports and behavioral health services towards community living by diverting and/or transitioning individuals away from facility-based settings."

The state is presently working on the Round 3 spending plan, as well as providing the additional information requested by CMS in the July 2021 partial approval letter and August 2021 addendum.

Connecticut: Connecticut has indicated that its top priority for the funding is to enhance its HCBS workforce, and the state is seeking to allocate funds to key items aimed at mitigating the increased need

for care as well as caregiver burn-out. The following are examples of initiatives in Connecticut that will address the known needs of the state via ARPA funds:

- **Temporary Workforce and Provider Stabilization:** $95.5 million dollars to develop an incentive-based program to help with recruitment and retention of provider staff, and a one-time funding to offset COVID-19-related impacts on provider networks
- **Provider Rate Increases:** $80.7 million dollars to level the playing field and improve patient access to care, as well as target investments in identified services
- **Support for Family Caregivers:** $10.8 million dollars to provide tools and resources for families caring for older adults and relatives with disabilities
- **Capacity Building & Training:** $2.2 million dollars to establish a statewide "train the trainer" program for all HCBS providers to prevent racial inequality in care delivery, as well as capacity-building to expand medication-assisted treatment for substance use.

Connecticut submitted its spending plan, which includes the full details of the ways it plans to strengthen, expand, and enhance the HCBS program, in July 2021. The state received partial approval of the initial spending plan in August 2021, with further details and reporting need to grant full approval.

This social experiment of unprecedented funding support for HCBS will be interesting to follow for years to come, particularly how much the direct financial support to workers and recipients made a measurable impact on the quality of care received.

PART III: HEALTH EQUITY

Recent Action

The current administration has also made health equity a central focus of its policy priorities, starting with the executive order Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. This executive order sought to promote "a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality." It calls for a comprehensive review of all federal agencies to determine whether the agencies' programs and policies fit with the executive order's definition of equity. This focus on equity has covered federal health policy as well.

Specific to health policy, the administration has integrated a health equity focus in its response to the COVID-19 pandemic, which has necessitated recovery solutions that are equitable in addition to being effective. These solutions include equitable vaccine distribution and increased testing for underserved communities. The Biden administration has also created a COVID-19 Health Equity Task Force which pledged to combat the health and social disparities that put groups at differing risk of contracting the COVID-19 virus. This task force has put forth numerous recommendations to ensure equity in the pandemic response, which include investing in equitable access to quality health and the creation of a permanent health equity infrastructure in the White House. Additionally, its recommendations have led to tangible investments into health equity solutions, such as a recent commitment of $785 million from ARPA funding to support equity-based projects. These include funding community-based organizations that are building vaccine confidence in underserved communities, supporting Tribal communities in COVID-19 relief efforts, and bolstering public health systems' ability to treat high risk patients.

What Is Next?

Moving forward, actions related to health equity are likely to continue and expand. In the context of the work of the COVID-19 Health Equity Task Force, hospitalizations and deaths within racial minority populations have declined over the last year with vaccination rates for these populations reflecting the rest of the population as a whole. In its final report, the Task Force issued the following recommendations

for prioritizing health equity in the continued recovery from the COVID-19 pandemic and in future health policy actions.

- Investments in community led health equity solutions
- Creating a data ecosystem that fosters equity-driven decisions
- Greater accountability for health equity outcomes
- Investments in a representative healthcare workforce to increase equitable access to care
- Creation of a permanent health equity infrastructure in the White House.

CONCLUSION

The current administration entered office during an unprecedented time in healthcare as it continues to deal with the ongoing COVID-19 pandemic and waited in limbo for the outcome of the latest legal challenge to the ACA, which has become the foundation for the nation's health care system. Empowered by the affirmation of the validity of the ACA and clear evidence of the harm created by the remaining challenges within our healthcare system during this time of intense healthcare needs, the new administration has prioritized healthcare policy since taking office as it seeks to increase access to healthcare, improve affordability of health coverage and create equity in care delivery. It has leveraged both private insurance and Medicaid and included both proactive initiatives and attempts to course correct from prior policy decisions that do not fit within its vision and mission.

Beyond the changes already in place, the statements and actions of the last year foreshadow what is likely to come in health policy over the coming years. There is no doubt that those efforts will include both supporting and building upon the foundation of the ACA to strengthen its provisions and complete its mission of ensuring access affordable healthcare across the American population.