




The Affordable Care Act's 1332 Waiver: An Avenue for Short-Run Adjustment, Innovative Change, or Political Acceptance?

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By Michael Gusmano, John Kaelin, and Thomas Gais

Although the Congress repeatedly failed to repeal and replace the Affordable Care Act (ACA) in 2017, ACA policies have changed extensively over the past year. December's tax bill eliminated the financial penalties enforcing the individual mandate, starting in 2019. The Trump administration used its executive powers to slash ACA advertising spending and shrink the ACA enrollment period, and it ceased making cost-sharing reduction payments to insurers. These changes did not appear to have a big impact on ACA's 2018 enrollments, which were only slightly below the previous year's total, but there has been a decline in the number of participating insurers, and premiums increased in many rating areas.¹

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It is still too early to know the longer-term effects of these changes, much less anticipate future developments. They do, however, suggest that states are implementing the ACA in a dynamic, uncertain environment even after the act escaped wholesale replacement. To deal with these and future changes, or to modify policies that would make state ACA programs more effective, or more to their political liking, state governments may turn to the ACA's Section 1332 State Innovation Waivers. The 1332 waivers are not the only way in which states can modify ACA policies, and their role has been limited to date. But the waivers have potential as a means for widespread policy change, and that potential may grow. As of this writing, there are bipartisan proposals in the Congress to expand the authority under the ACA's section 1332 provision to foster even more state innovation.

This paper discusses the 1332 waiver — its origins, powers and limitations, and uses

¹ Ashley Semanskee, Gary Claxton, and Larry Levitt, "How Premiums Are Changing In 2018," *Health Reform*, Kaiser Family Foundation, Updated November 29, 2017, <https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/>.

thus far — and how it may be used to address major challenges facing the ACA. We note, for example, a shift in the purposes of planned 1332 applications before and after the 2016 elections, a shift that suggests a new and challenging function for waivers — not simply to allow states to adopt different pathways to common policy goals, but to respond effectively and quickly to rapid changes in healthcare markets. We discuss the practicality and implications of this shift along with ways in which 1332 waivers may be used to serve other purposes, including how they may be used in combination with other waivers and instruments to bring about comprehensive reforms in the delivery of healthcare. We also discuss the prospects for 1332 waivers in the coming years, their potential roles in adapting the ACA to changing and diverse circumstances, and ways in which the waiver process may be improved.

Waivers as a Policy Tool

Program waivers are a congressional delegation of authority to the federal executive branch to permit selective deviations from the law. Since the Clinton presidency, states have requested and received hundreds of Medicaid waivers, and many have been used to restructure state Medicaid programs in the hope of expanding access, improving quality, or reducing cost.² The primary, though not exclusive, authorization for demonstration

waivers comes from Section 1115 of the Social Security Act. Approved by Congress in 1962, this provision authorized the federal executive branch to experiment with alternative state approaches to program delivery. The 1115 waivers were intended to be a tool for policy learning and required formal evaluations.

Section 1332 of the Affordable Care Act permits a state to apply for a state innovation waiver. As with other waiver categories, the purpose of 1332 waivers is to provide states with the flexibility to develop innovative methods for achieving the goals of the legislation. In the case of the 1332s, the waivers only apply to commercial insurance, including most prominently those offered through state and federal marketplaces created by the ACA; they are not supposed to change the Medicare, Medicaid, or the Children's Health Insurance (CHIP) programs. However, as we discuss below, they may be combined with 1115 and other waivers to bring about more comprehensive health system reform changes within a state.³

States have been allowed to submit state innovation waivers since January 1, 2017. Based on the list of provisions that may be subject to the waiver, many core features of the ACA could, if approved by the U.S. Department of Health and Human Services (DHHS), be changed through a Section 1332 waiver. These include the creation of health insurance exchanges, ACA certification standards for qualified health plans, ACA requirements

² Carol S. Weissert and William G. Weissert, "Medicaid Waivers: License to Shape the Future of Fiscal Federalism," in *Intergovernmental Management for the 21st Century*, eds. Timothy J. Conlan and Paul L. Posner (Washington, DC: Brookings Institution Press, 2008): 157-75.

³ Cheryl Fish-Parcham and Andrea Callow, "How Could a 1332 Waiver Affect Medicaid and CHIP?," *FamiliesUSA* Short Analysis, January 2016, <http://familiesusa.org/product/how-could-1332-waiver-affect-medicaid-and-chip>.



related to essential health benefits (EHB), cost-sharing reduction payments and premium tax credits (with alternative funding available), and employer and individual mandates.

While the law allows states to modify, replace, or eliminate several ACA requirements, it also imposes important constraints, most of which relate to the expected effects of state proposals. For 1332 waivers to be approved, coverage must be at least as comprehensive as the ACA's EHBs, it must be at least as affordable, it must cover a comparable number of people, and the waiver may not increase the federal deficit. It is important, however, to recognize that the operational definitions of "comprehensive," "affordable," "comparable," and deficit neutrality are subject to negotiation between the states and DHHS (more specifically, the Department's Centers for Medicare & Medicaid Services, or CMS). Recent history suggests that the executive branch will exercise significant discretion over these issues. For example, they may accept optimistic estimates of budget implications that, in reality, allow states to increase federal spending.⁴ As a result, negotiations between the executive branch and the states may have a profound impact on the consequences of 1332 waivers for access, coverage, and cost.

From the beginning, the standards for satisfying the statutory requirements of 1332 were rigorous, and subsequent guidance increased that rigor. In 2015, the Obama administration issued guidance on 1332 waivers for states.⁵ The guidance stated:

- Coverage and affordability impacts are considered with respect to subgroups, including vulnerable persons and those with large healthcare spending burdens, and separately for each year of the waiver.
- States may not use savings generated through separate Medicaid 1115 waivers. Also, federal deficit neutrality must be achieved in each year of the waiver, as opposed to calculating neutrality over the life of the waiver, as Medicaid 1115 waivers do.

⁴ Frank J. Thompson and Michael K. Gusmano, "The Administrative Presidency and Fractious Federalism: The Case of Obamacare," *Publius: The Journal of Federalism* 44, 3 (2014): 426-50.

⁵ *Federal Register* 80, 241 (December 16, 2015): 78131-5, <https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf>.

- The federal government’s website, Healthcare.gov, will not accommodate state-specific rules. States using federally facilitated exchanges and proposing 1332 waivers that would require changes in the exchange platform should consider establishing their own platform administered by the state.

This level of rigor and its effects in creating practical obstacles to utilizing 1332s were highlighted at a hearing in September of 2017 by the Senate Health, Education, Labor & Pensions (HELP) Committee. Several witnesses pointed out the difficulty of submitting and gaining approval for a 1322 waiver. Extended federal timelines to review and approve waivers were cited as one of several barriers to state flexibility and innovation by state officials.⁶

Some of these barriers may be addressed by administrative actions, though the Congress is also considering two bills that would streamline the 1332 waiver process. The Alexander-Murray bill, cosponsored by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), is a bipartisan effort to reinstate, through 2019, the cost-sharing reduction (CSR) payments ended by President Trump. Because Congress did not restore these payments to insurers in time for the 2018 premium rate cycle, rates increased sharply in most states. (Ironically, the higher premium rates triggered larger federal tax credits, allowing many consumers to purchase low or zero premium policies.)

Along with offering a short-term fix to the CSR problem, the Alexander-Murray bill includes provisions designed to speed up the waiver process. If adopted, the bill would eliminate the requirement for states to enact legislation before submitting a waiver application. It would also require CMS to expedite the review process. The National Association of Insurance Commissioners (NAIC) has stated that the provisions of the bill

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would reduce the administrative burden faced by states when applying for 1332 waivers. The bill would also allow states to develop plans for coverage that offer “comparable affordability” instead of restricting state plans to those that are “at least as affordable” as the ones offered by ACA. This change could allow states to offer plans that are less affordable for some consumers if they reduce the costs faced by the highest risk patients. The bill also modifies the “deficit neutrality” requirement and permits states to count savings generated by 1115 waivers to offset additional spending for programs funded by the 1332 waiver. To date, states have been prohibited from combining 1332 waivers with 1115 Medicaid waivers for the purpose of considering “broad reforms that span both their

⁶ “Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: Health Care Stakeholders,” U.S. Senate Committee on Health, Education, Labor & Pensions Hearing, September 14, 2017, <https://www.help.senate.gov/hearings/stabilizing-premiums-and-helping-individuals-in-the-individual-insurance-market-for-2018-health-care-stakeholders>.

Medicaid program and subsidized marketplace coverage.”⁷ Lifting this prohibition could lead to more radical state-level changes for addressing the goals of the ACA.

The proposed Collins-Nelson bill, cosponsored by Senators Susan Collins (R-ME) and Bill Nelson (D-FL), would also encourage states to develop new 1332 waiver proposals for specific purposes. The bill calls for \$2.25 million in funding for 2018 and 2019 for states that obtained 1332 innovation waivers in order to develop reinsurance programs.

Why Are States Pursuing 1332 Waivers?

States have been developing and proposing 1332 waivers to solve several different problems; in fact, state motivations are evolving. Before the 2016 election, much of the conversation around 1332s was about going beyond the ACA and overcoming remaining gaps in healthcare reform. Vermont was planning to use the 1332 waiver as part of its broader effort to adopt a single-payer reform.⁸ California was going to submit a 1332 waiver that would have allowed undocumented immigrants to purchase insurance through the California marketplace. Hawaii received approval for a 1332 waiver to extend its employer mandate program and align it with the ACA; it was the only state to have won approval for a 1332 waiver under President Obama.⁹

Since then, 1332 waivers have been approved in only a handful of cases and most have been of limited scope, though some of the more recent 1332 waiver proposals and ideas could lead to significant changes in the ACA’s marketplaces. In March 2017, former DHHS Secretary Tom Price sent a letter to state governors encouraging them to submit 1332 waiver requests.¹⁰ In May, CMS Administrator Seema Verma reinforced the message by making a checklist available to states for 1332 waivers.¹¹ Yet Alaska, Minnesota, and Oregon

Before the 2016 Election



Vermont

Planned to use the 1332 waiver as part of its broader effort to adopt a single-payer reform.



California

Planned to submit a 1332 waiver to allow undocumented immigrants to purchase insurance through the California marketplace.



Hawaii

Received approval for a 1332 waiver to extend its employer mandate program and align it with the ACA. The only state to have won approval for a 1332 waiver under President Obama.

⁷ Heather Howard and Dan Meuse, “New Section 1332 Guidance A Mixed Bag For States,” *Health Affairs Blog*, February 29, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20160229.053456/full/>.

⁸ John E. McDonough, “Wyden’s Waiver: State Innovation on Steroids,” *Journal of Health Politics, Policy and Law* 39, 5 (2014): 1099-111.

⁹ Sarah Lueck and Jessica Schubel, *Understanding the Affordable Care Act’s State Innovation (“1332”) Waivers* (Washington, DC: Center for Budget and Policy Priorities, Updated September 5, 2017) <https://www.cbpp.org/research/health/understanding-the-affordable-care-acts-state-innovation-1332-waivers>.

¹⁰ Howard and Meuse, “New Section 1332 Guidance A Mixed Bag For States”; also see letter from U.S. DHHS Secretary Thomas E. Price to state governors, March 13, 2017, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.

¹¹ “Centers for Medicare and Medicaid Services (CMS) Issues Section 1332 State Innovation Waiver Checklist,” U.S. CMS Press Release, May 16, 2017, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-16.html>.

have been the only states to receive 1332 waivers since the 2016 elections; all three waivers established state-funded reinsurance programs designed to prevent large premium increases and stabilize the ACA marketplace. Several other states have proposed waivers, but they have not been approved. Vermont submitted a 1332 waiver to permit small employers to enroll directly through insurers rather than use a SHOP internet portal; Oklahoma proposed a reinsurance program, though later withdrew it when it was clear that it would not be approved in time for the 2018 enrollment cycle; and Massachusetts sought to establish a “premium stabilization fund” in lieu of cost reduction payments, though DHHS determined that the submission arrived too late for approval before the 2018 cycle. Several other states — including Maine, Ohio, Rhode Island, and Texas — have also adopted legislation authorizing the submission of a 1332 waiver, while Idaho and Washington are considering legislative proposals.

Alaska, Minnesota, and Oregon’s waivers established reinsurance programs. Such programs provide subsidies to insurers to absorb the financial burden of high-risk or high-cost individuals, thereby lowering the overall risk profile for the general risk pool. The lower risk among enrollees is then expected to lead insurers to keep premiums down and remain in the ACA markets. Because reinsurance systems cut premiums in the individual market, the programs reduce the amount of money the federal government provides in premium tax credits. Under the Alaska, Minnesota, and Oregon waivers, the federal savings are returned to the states’ reinsurance programs via “pass-through funding” that allows states to obtain the savings from the lower federal premium tax credits.

Pass-through funds are limited by federal deficit neutrality rules under section 1332, so each state must generate sufficient state funding to satisfy the requirements of the new reinsurance program. In Alaska, the costs of claims by enrollees with high-cost conditions are paid out of a pool financed by other payers in the system. In Minnesota, the reinsurance program has been funded by state appropriations from Minnesota’s Health Care Access Fund and General Fund. Oregon plans to rely primarily on federal pass-through funding; if that funding is insufficient after an enrollment cycle, it would reduce its payments to insurers in future cycles.

After the 2016 Election

Approved Waivers



**Alaska
Minnesota
Oregon**

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Proposed Waivers



Vermont

Submitted a 1332 waiver to permit small employers to enroll directly through insurers rather than use a SHOP.

Massachusetts

Sought to establish a “premium stabilization fund” in lieu of cost reduction payments; DHHS determined that the submission arrived too late for approval before the 2018 cycle.



Oklahoma

Proposed a reinsurance program, though later withdrew it when it was clear that it would not be approved in time for the 2018 enrollment cycle.



Although some of the other state waiver proposals have focused on reinsurance, some of the more recent 1332 proposals have sought to make more extensive changes in the ACA. Iowa's plan, later withdrawn, was one example. On August 21, 2017, Governor Reynolds and Lieutenant Governor Gregg of Iowa submitted a 1332 Waiver Request to CMS for the Iowa Stopgap Measure, a proposal that sought to stem the state's short-run crisis in the ACA market while also calling for a major restructuring of the state's ACA. According to the state, Iowa's individual marketplace was in a state of crisis because all but one insurer had left the market, and Medica, the only remaining insurer, announced that it would increase premiums by 56 percent in 2018. In their proposal to CMS, the state claimed that the departure of healthy individuals and meager enrollments among young people led to skyrocketing premiums in the individual market, though some of these problems may stem from the fact that the state allowed 85,000 people to keep non-ACA compliant health plans in 2014. As younger and healthier people signed up for the noncompliant plans, the ACA-compliant plans disproportionately drew people who were older and sicker than insurers anticipated.¹²

To reduce this plan-selection effect, Iowa proposed to create one standard silver level plan — 68 to 72 percent of actuarial value — in the individual marketplace. The same plan would be offered by all insurers. It would cover all essential health benefits and Iowa state-mandated benefits. In addition, Iowa proposed to use federal cost-sharing reduction payments to fund a reinsurance program and premium tax credits, the eligibility of which would be determined by the state. The Iowa program would include a continuous coverage

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requirement for “consumers who seek a special enrollment period.” The continuous coverage requirement was designed to provide “additional motivation for consumers to enter the market at open enrollment and ensure a large risk pool.” The Iowa Stopgap Measure would have been used to fund advance premium tax credits and cost-sharing reduction payments to insurers. Unlike the Alaska and Minnesota reinsurance programs, Iowa did not propose to use any state funds to finance the program. The initiative would have been fully funded with pass-through payments from the federal government, money that the federal government would otherwise pay to Iowans as advance premium tax payments (APTC) and cost-sharing reimbursements (CSR).

As the state acknowledged in its application letter, the Iowa 1332 waiver was radical, in part because the 1332 waivers were not intended for crisis management. In its response to Iowa's proposal, CMS was concerned about its broader age and income categories for setting premiums, as they would require older people to pay higher premiums than

¹² Timothy Jost, “Iowa Submits 1332 Waiver Request, Claiming It Is Necessary To Avoid An Individual Insurance Market Collapse,” *Health Affairs Blog*, June 12, 2017, <http://healthaffairs.org/blog/2017/06/12/iowa-submits-1332-waiver-request-claiming-it-is-necessary-to-avoid-an-individual-insurance-market-collapse/>.

they would have under the ACA. The federal government was also concerned that the Iowa plan would have made insurance less expensive for people over 400 percent of the federal poverty line, but more expensive for individuals with lower incomes. In response to this latter concern, Iowa submitted a supplement to its application in which the state would offer “additional cost sharing credits to individuals with incomes between 133-150 percent of the federal poverty level (FPL).” The state supplement argued that the proposed federal pass-through funds would pay for the additional \$14 million needed to provide these cost-sharing credits.¹³ In late October, however, Iowa withdrew its proposal and remarked that the 1332 waiver process was “unworkable” and “not designed to fix collapsing individual health insurance markets....”¹⁴

Another type of waiver proposal encompasses Medicaid as well as ACA exchanges and must therefore include both 1115 and 1332 waiver submissions. The “Idaho Health Care Plan” is still in the state comment period, but if its 1332 and 1115 Medicaid waivers were enacted and approved, it would produce an extensive restructuring of the ACA and Medicaid. Because Idaho has not expanded its Medicaid program, there “remains a

Table 1 Current Models for 1332 Waivers

Complementary 1332 and 115 Waivers That Restructure Medicaid and ACA	Modifications of ACA via 1332 to Stabilize and Improve Markets	Comprehensive Commercial Market Redesign Under 1332
<p>Example: Idaho (proposed) Expand Medicaid eligibility to chronically ill persons below 400 percent of Federal Poverty Level (FPL) and expand federal tax credit eligibility to persons below 100 percent of FPL</p>	<p>Examples: Alaska, Minnesota, Oregon Reinsurance programs separate out costs for higher cost, higher risk individuals, thereby reducing the overall risk profile for the general risk pool.</p>	<p>Example: Iowa (withdrawn) Single plan (no metal levels) offered; subsidy structure redesigned; reinsurance program included.</p>
<p>Key Considerations Unclear whether CMS/DHHS will award pass-through of federal savings from a state’s decision not to expand Medicaid.</p>	<p>Key Considerations How is the reinsurance funded? Should reinsurance be based on health conditions of individuals or costs? How much is funded by carriers? Does reinsurance actually stabilize markets?</p>	<p>Key Considerations How does the program impact the risk pool generally? Are healthy individuals incentivized to purchase coverage? Is coverage more affordable? How complex is this design to implement?</p>
Medicaid		Commercial

¹³ “IOWA STOPGAP MEASURE SUPPLEMENT 1: Cost Sharing Credits for Persons with Income From 133-150 Per cent of the Federal Poverty Level,” n.d., <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Iowa-Stopgap.pdf>.

¹⁴ Letter from Iowa Insurance Commissioner Doug Ommen to U.S. Department of Treasury Secretary Steven Mnuchin and U.S. DHHS Acting Secretary Eric D. Hargan, October 23, 2017, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/IA-Letter-Withdraw-1332-Waiver.PDF>.

significant number of working Idahoans living under 100 percent of the Federal Poverty Level (FPL) who do not have access to affordable coverage....”¹⁵ Idaho’s proposal would avoid expanding Medicaid to cover these people and instead offer them premium tax credits and cost-sharing reductions that would “make coverage more affordable” when they purchase insurance on the private markets. However, the tax credit would only be available to persons who report earned income, thereby creating a work requirement for eligibility for federal subsidies. Idaho’s plan would also require a 1115 Medicaid waiver, which would permit people with certain medically complex diagnoses to get Medicaid coverage for the duration of their illness, a provision that would extract high-cost individuals from the private individual market and thus reduce insurance premiums within that market.

Despite the limited number of 1332 waiver proposals, states have already formulated quite different submissions, ranging from efforts to use the ACA to restructure healthcare for low-income individuals, including Medicaid; to ideas for market redesigns that focus on the ACA exchanges, plans, and subsidies; and to smaller changes such as adding a reinsurance program in order to stabilize the healthcare market (Table 1). Although the waiver process has not yet yielded many approvals, this first year record does suggest that states are considering a wide range of policy changes.

Implications of 1332s for Stabilization, Access, Costs, and Politics

If there is one constant about the Affordable Care Act, that is its persistent exposure to change. The ACA is enmeshed in a highly dynamic healthcare system, and changes in that system can greatly affect the program’s implementation and the impacts of different policies and administrative strategies. As Ezekiel Emanuel noted, “There is no final reform.”¹⁶ The ACA’s effectiveness is also influenced by its economic and social context.

As we noted in last year’s five-state report on ACA implementation, ACA effectiveness varies substantially not just among states but also among localities. If the ACA is to improve its performance, states must adjust policies and administrative approaches to local as well as state circumstances.¹⁷ Finally, the ACA obviously involves politically divisive issues that are seen differently across states and over time. If the ACA is to be a nationally supported healthcare policy, it may need adjustments to fit within very different state and local political cultures.¹⁸

¹⁵ Idaho Department of Insurance, “Idaho’s Draft Application Pursuant to Section 1332 of the Patient Protection & Affordable Care Act, Encouraging Waivers for State Innovation,” Revised November 1, 2017, <https://doi.idaho.gov/DisplayPDF?id=Draft1332Application&cat=publicinformation>.

¹⁶ Ezekiel Emanuel, *Reinventing American Health Care: How the Affordable Care Act Will Improve our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System* (New York: PublicAffairs, 2014): 258.

¹⁷ Michael A. Morrisey, Alice M. Rivlin, Richard P. Nathan, and Mark A. Hall, *Five State Study of ACA Marketplace Competition: A Summary Report* (Washington, DC: Center for Health Policy, Brookings Institution, and Albany: Rockefeller Institute of Government, 2017), http://www.rockinst.org/ACA/pdf/2017-02-09-Brookings_ACA_Summary.pdf.



These three points suggest that the ACA is not now and probably can never be a final, fixed policy. To be effective, the ACA must change, and it must adjust to different states' healthcare, economic, demographic, and political circumstances. The real questions then are how change can take place; who should have a say; and according to what criteria, rules, and procedures.

One approach to accommodating change and variation is simply to devolve more decisions to states, an approach found in parts of the repeal and replace bills of last year, particularly the Graham-Cassidy proposal, which would have, among many other things, permitted states to alter ACA protections for persons with preexisting conditions. The virtue of devolution is that states can act quickly and in ways that respond precisely to their judgments as to what is needed. One problem of devolution, however, is that states may use their flexibility to veer away from the basic purposes of the national program. To date, attempts at ensuring common purpose and performance accountability in block grants to states have not been particularly successful.¹⁹

The 1332 State Innovation Waivers offer a different model of intergovernmental change. Instead of devolution, waivers are a form of cooperative federalism, in which the federal and state governments must agree on specific modifications, usually after considerable negotiation and in accordance with certain fixed criteria (such as comparable coverage and deficit neutrality). Both governments have leverage over one another — states implement many elements of the program, while the federal government controls considerable funding — and if the experience of recent Medicaid waivers is applicable, the negotiations can modify the positions of both levels of government.²⁰

¹⁸ For a discussion of one state using a 1115 waiver to expand Medicaid in a way that fits within a conservative political culture, see Carol S. Weissert, Benjamin Pollack, and Richard P. Nathan, "Intergovernmental Negotiation in Medicaid: Arkansas and the Premium Assistance Waiver," *Publius: The Journal of Federalism* 47, 3 (2017): 445-66; and Joseph W. Thompson, Craig Wilson, and Leah Ramirez, *Arkansas: Baseline Report* (Albany: Rockefeller Institute of Government, June 2015), http://www.rockinst.org/ACA/states/Arkansas/2015-06-Arkansas_Baseline.pdf.

¹⁹ Carl W. Stenberg, "Block Grants and Devolution: A Future Tool?," in *Intergovernmental Management for the 21st Century*, eds. Timothy J. Conlan and Paul L. Posner (Washington, DC: Brookings Institution Press, 2008): 263-85.

²⁰ Weissert, Pollack, and Nathan, "Intergovernmental Negotiation."

Although not a panacea for the problems facing the ACA or the potential loss of insurance coverage due to the repeal of the individual mandate, 1332 state innovation waivers have the potential for stabilizing the insurance marketplaces. To date, few innovation waivers have been approved and all have focused on relatively conservative reinsurance programs. Some states, such as Iowa, have argued that the review process for 1332 waivers is too long and arduous to be a good vehicle for addressing fast-changing problems faced by state marketplaces.

Whether this criticism is well-founded or not is still unclear; Iowa, after all, only gave CMS two months to review its 1332 waiver proposal before withdrawing it. Nonetheless, the wide range of potential waiver proposals suggests that it may make sense for the federal government to create different processes for various types of waivers. Proposals that closely resemble waivers already approved may be expedited, so long as the new proposals clearly indicate the similarities and differences. Rapid reviews might also be permitted when the proposed changes are comparatively marginal and short term such as a request to establish a reinsurance program for two years.

Other improvements in the waiver process might also be considered. One area is generating credible evidence from policy changes. The 1332 waivers do not require evaluations and, in some cases, rigorous evaluations would be difficult to design and implement. But if the federal government were authorized to require evaluations when it considers the potential evidence to be especially valuable, evaluations could be administered flexibly, in a way that fits the nature of the waiver. Where, for example,

states try to stabilize their markets with reinsurance programs and other statewide fixes, strong research designs with comparison groups may not be feasible. But other research designs could be valuable, such as implementation studies that show how states have put the new policies into effect, or performance analyses that show changes in intermediate and final outcomes before and after implementation. Where possible and appropriate, the federal government might insist on rigorous impact studies, including randomized control trials, where an expected marginal improvement might be introduced on a small, selective scale. Even if such analyses are

infrequent, they would add a great deal to the sparse body of evidence on the effects of variants in ACA policies.

The challenges of the 1332 waiver process and requirements notwithstanding, the adoption of the tax bill by the Congress may increase the appetite for more aggressive uses of 1332 waivers by the states. The elimination of the individual mandate, coupled with the loss of CSR payments, threatens to destabilize some marketplaces around the country and lead to sharp increases in health insurance premiums. If Congress adopts legislation to streamline the waiver process and loosen restrictions on deficit neutrality or

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the combination of 1332 and 1115 waivers, this could increase the number and change the character of 1332 waiver submissions.

That prospect raises many policy and research questions. How will the federal government handle these proposals? Will it respond expeditiously and flexibly, yet still maintain the basic purposes of the ACA? Will waivers become a politically popular approach to changing policies, since they allow state elected officials to demand specific accommodations from Washington? Will states use waivers to bundle a coherent set of interrelated policies, or will they submit incremental changes that may or may not fit together well? Will particular waiver proposals diffuse among states, producing widespread change? And how much evidence and learning are generated from waiver experiences, and how do states respond to and use the information?

Just as the Rockefeller Institute and Brookings Institution's ACA Implementation Research Network monitored the first years of ACA implementation, these later developments should be tracked carefully in order to see the new ways in which healthcare policies are developed, approved, and diffused across the states — and to understand the waiver process more generally as an increasingly important policy process in American government.

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