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Section 1332 State Innovation Waivers: Waiving Goodbye to Cooperative Federalism and Hello to Collaborative Federalism

Brittany Hynes[*]

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INTRODUCTION

> *"The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in State governments are numerous and indefinite."*

The above statement was made by James Madison in response to an uproar concerning the danger of leaving a portion of authority to the

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[*] J.D. Candidate 2019, University of Miami School of Law. First and foremost, I wish to thank Professor Frances Hill not only for her insight and guidance, but also for the inspiration behind this Note. Thank you to the University of Miami Business Law Review for selecting this Note for publication and to the Executive Board for their commitment and thoroughness. Finally, for her unwavering support and faith, I am immensely appreciative of my mother, Holly Beer.

several states through the United States Constitution. His concept of states' power was and is appropriate to this day. States are in more promising positions to decide what is best for the improvement and prosperity of their own state. An accurate example would be the power of the states to implement their own state-innovated plans through healthcare waivers. The federal government views state flexibility as a critical tool in carrying out the Medicaid program.[1] States have been responsible for directing payment and service delivery reform that stabilizes Medicaid's versatile objectives of reconstructing access, providing quality care, and controlling costs.[2]

However, there is consistent controversy in how the lines of this flexibility are drawn.[3] There have been debates concerning whether the federal government is too lenient or strict in approaching state waiver requests.[4] Also, private suits have disputed certain state actions, such as rate reductions and various expenditure reforms that are thought to hinder accessibility.[5] In these situations, the legislative and regulatory structure promotes state flexibility but maintains procedural constraints and substantive restraints.[6]

The federal government commonly confirms its approval for more state flexibility in response to the tension.[7] For instance, Congress rectified the Medicaid Act to broaden the range of state power in numerous program operations.[8] In March 2017, the Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS") issued a letter to United States governors declaring the federal government's alliance with the states to boost the principle and efficiency of the Medicaid program for low-income beneficiaries.[9] This letter invites states to develop plans based on beliefs that mirror the state's culture.[10]

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1 *See generally Methods for Assuring Access to Covered Medicaid Services*, 80 Fed. Reg. 67,576, 67,578 (Nov. 2, 2015) (to be codified at 42 C.F.R. § 447); *see also* Brietta Clark, *Medicaid Access & State Flexibility: Negotiating Federalism*, 17 HOUS. J. HEALTH L. & POL'Y 241, 243–44 (2017).

2 *Id.*

3 *See* Clark, *supra* note 1, at 243–44 (citing Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,576, 67,578 (Nov. 2, 2015) (to be codified at 42 C.F.R. § 447)).

4 *See* Laura D. Hermer, *On the Expansion of "Welfare" and "Health" Under Medicaid,* 9 ST. LOUIS U. J. HEALTH L. & POL'Y 235, 257–58, 263 (2016).

5 *See generally* Brietta R. Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration is Undermining its Own Health Reform Goals*, 55 HOW. L.J. 771, 846–51 (2012).

6 Clark, *supra* note 1, at 244.

7 *Id.* at 319, n.241.

8 *Id.* at 244.

9 *Id.* at 291, n.140.

10 *Id.*

Part I of this Comment explores the overall function and process of waivers. It also identifies the concept of state flexibility through waivers. Part II examines the shift in health care delivery law, which went from a cooperative federalism to a collaborative federalism approach. Part III takes a closer look into states that have utilized their flexibility in developing innovation health care systems through 1332 waivers. It discusses the specific details of Alaska's, Oregon's, and Hawaii's unique programs, and it illustrates how the authority they gained through waivers has allowed them to stabilize the state's health care market. Part IV concludes by considering the opportunities that are afforded through 1332 waivers.

I. THE BIRTH OF WAIVERS

Modern administrative law developed in reply to the common delegation of expansive lawmaking authority to administrative agencies.[11] This gives agencies the power to create policies that Congress deliberately decided not to create.[12] However, there is a form of delegation of expansive lawmaking power that seems to be commonly overlooked: the extensive, unrestricted power of agencies to govern whether rules established by Congress should be discarded.[13] Instead of making law that Congress has not, this power allows agencies to waive laws made by Congress.[14]

The politically controversial Patient Protection and Affordable Care Act ("ACA") was designed to "improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, and rural populations."[15] Nevertheless, some states chose not to expand Medicaid, leaving millions of Americans without health coverage because their incomes exceeded the federal Medicaid limit but fell under the premium tax credit threshold.[16] These states also experienced an increase in hospital uncompensated care costs.[17]

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[11] *See* David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 266 (2013).
[12] *Id.* at 267.
[13] *Id.*
[14] *Id.*
[15] Patient Protection and Affordable Care Act, H. R. 3590-470, § 5001 (2010).
[16] Rachel Garfield, Anthony Damico & Kendal Orgera, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,* KAISER FAMILY FOUND. (June 12, 2018), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.
[17] *See* Becca Aaronson, *Without Medicaid Expansion, Hospitals Seek Long-Term Solution*, THE TEXAS TRIBUNE (Feb. 14, 2014), www.texastribune.org/2014/02/14/without-medicaid-expansion- hospitals-seek-long-term; *see also* Jeffrey Young, *Hospitals In States*

Luckily, permitting health coverage through Section 1115 waivers to expand Medicaid can seal this gap and lower hospital uncompensated care costs.[18] Section 1115 of the Social Security Act ("SSA") permits states to propose waivers to the Secretary of the U.S. Department of Health and Human Services ("HHS") for authorization of "[e]xperimental, pilot, or demonstration projects that promote the objectives of the Medicaid."[19] These demonstrations give states greater discretion to create and better their programs.[20] The goal is to establish and assess state-specific policy techniques to enhance serving Medicaid communities.[21] Waivers give states the chance to enact amendments that surpass conventional medical care and concentrate on "evidence-based interventions," encouraging improved health results, and enhancing quality of life.[22]

CMS conducts a case-by-case analysis of each plan to detect whether its objectives coordinate with those of Medicaid.[23] CMS also examines whether projected waiver expenses are suitable and compatible with federal guidelines.[24] Also, the demonstrations are required to be "budget neutral" to the federal government;[25] so, federal Medicaid expenses cannot exceed federal spending without the demonstration.[26] Waivers are commonly approved for a primary five-year term and, contingent upon the populations served, may be lengthened for to an added three to five years.[27]

For years, states applied for Section 1115 waivers solely to offer Medicaid premium assistance to compensate ineligible parents of children eligible for the Medicaid and Children's Health Insurance Program ("CHIP") or employer-based coverage.[28] Nonetheless, with substantial federal funding given to the states by the ACA, the role of Section 1115

That Won't Expand Medicaid Left With More Unpaid Bills, HUFFINGTON POST (Sept. 24, 2014), www.huffingtonpost.com/2014/09/24/medicaid-expansion-hospitals5876980.html.

18 *See* Anne McKenzie, *Section 1115 Waivers, the Future of Medicaid Expansion*, 27 HEALTH L. 12, 12 (2015).

19 *See About Section 1115 Demonstrations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

20 *Id.*

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *About Section 1115 Demonstrations*, MEDICAID, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

26 *Id.*

27 *Id.*

28 Garfield et al., *supra* note 16; *see also* Social Security Act of 1935, 42 U.S.C. § 1396d(a) (2018); *see also* 42 U.S.C. § 1396e (2018); *see also Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, CMS (Dec. 10, 2012), www.cms.gov/CCIIO/Resources/Files/Down loads/exchanges-faqs-12-10-2012.pdf.

waivers was fundamentally transformed.[29] The ACA took away the states' requirement to acquire waivers to cover low-income Americans because it raised the federal poverty level ("FPL") income percentage, so these adults are now covered by federal Medicaid.[30] Now, states are able to use additional federal funding under the ACA to carry out the expansion in ways that vary from federal law.[31]

When the ACA was first enacted in 2010, the federal government ran into issues when it attempted to link states' current Medicaid funding to the required expansion obligation under the ACA.[32] The federal funding provided to states through Medicaid programs becomes a significant portion of states' budgets.[33] Section 2001 of the ACA demanded states to abide by the recent Medicaid coverage requirements.[34] If states did not comply, then they would lose all federal funding.[35] In response to the federal government's coercion, twenty-six states, various citizens, and the National Federation of Independent Business ("NFIB") filed a suit against the Secretary of HHS challenging the constitutionality of the Medicaid expansion provision.[36]

In *NFIB v. Sebelius*, the U.S. Supreme Court found that the federal government was restricted from pressuring states into expanding by threatening to strip them of existing Medicaid funding.[37] This decision led the Centers for Medicare and Medicaid Services ("CMS") and the National Health Law Program to conclude that limited Medicaid expansion was not authorized under Section 2001.[38] So, states were provided two options: (1) completely expand Medicaid to encompass all

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[29] Robin Rudowitz, Samantha Artiga & MaryBeth Musumeci, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, KAISER FAMILY FOUND. (Feb. 5, 2014), http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-l115-medicaid-demonstration-waivers.

[30] *Id.*

[31] *Id.*

[32] *See* 42 U.S.C.A § 1396(c) (2014); *see also National Federation of Independent Business v. Sebelius,* SCOTUS BLOG, www.scotusblog.com/case-files/cases/ national-federation-of- independent-business-v-sebelius.

[33] Nat'l Fed'n of Indep. Bus. v. Sebelius*,* 132 S. Ct. 2566, 2581 (2012).

[34] *Id.* at 2582; 24 U.S.C. § 1396(c) (2012).

[35] Sebelius, 132 U.S. at 2582.

[36] *Id.* at 2572.

[37] Garfield et al., *supra* note 16 at 2608 (explaining that although the Medicaid expansion provision of the ACA was found to violate the Constitution by commandeering states with the threat of losing their Medicaid funds, the individual mandate was found to be a valid exercise of Congress's taxing power).

[38] *Frequently Asked Questions on Exchanges and Market Reforms*, CMS (Dec. 10, 2012), www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf [hereinafter *FAQs on Exchanges*].

individuals below 138 percent of the FPL; or (2) not expand at all.[39] Roughly half of the states expanded.[40]

In 2012, CMS released a "FAQs on Exchanges, Market Reform, and Medicaid," which explained the alternative option of expanding by requesting a Section 1115 waiver to command premium assistance or to ratify a state-tailored plan.[41] Section 1115 power permits states to afford premium assistance in forms that do not satisfy federal requirements and to make modifications to their Medicaid programs to enhance care and reduce costs.[42]

For example, some states are privatizing Medicaid to bridge the Medicaid gap.[43] Privatization engages the use of federal funding to buy private insurance instead of Medicaid, allowing individuals that were eligible for Medicaid to be eligible for private insurance.[44] This is a desirable method for states that wanted flexibility to control their health programs in conformance with their demands as opposed to Medicaid objectives.[45]

In 2012, the federal government afforded $432 billion for federal and state Medicaid programs.[46] Consequently, by 2014, the number of

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39 *See* 42 U.S.C. § 1396a(c)(14)(1) (explaining that Medicaid expansion expands eligibility to 133 % of the poverty level and allows 5% of income to be disregarded, effectively establishing the eligibility income as 138%).

40 *Where each state stands on ACA's Medicaid expansion*, ADVISORY BD. COMM. (Jun. 14, 2013), www.advisory.com/daily-briefing/2012/11/09/medicaid map-1ightbox/0; Dorn, S. et. al., *What is the Result of States Not Expanding Medicaid?* (Aug. 7, 2014), www.urban.org/UploadedPDF/ 413 192-What-is-the-Result-of-States-Not- Expanding-Medicaid.pdf.; Jeffrey Young, *Hospitals In States That Won't Expand Medicaid Left With More Unpaid Bills*, HUFFINGTON POST (Sept. 24, 2014), www.huffingtonpost.com/2 014/09/24/medicaid-expansion-hospitals n 5876980.html.

41 *Frequently Asked Questions on Exchanges and Market Reforms*, *supra* note 38.

42 Rudowitz et al., *supra* note 29.

43 Sarah Kliff, *Privatizing the Medicaid expansion: 'Every state will be eyeing this.'* WASH. POST. (Mar. 8, 2013), www.washingtonpost.com/blogs/wonkblog/ wp/2013/03/08/ privatizing-the-medicaid-expansion-every-state-will-be-eying-this.

44 Rudowitz et. al., *supra* note 29; *Premium Assistance in Medicaid and CHIP: An Overview of Current Options and Implications of the Affordable Care Act,* KAISER FAMILY FOUND. (Mar. 2013), https://www.kff.org/medicaid/issue-brief/premium-assistance-in-medicaid-and-chip-an-overview-of-current-options-and-implications-of-the-affordable-care-act/.

45 *See Medicaid Expansion Through Premium Assistance: Arkansas, Iowa, and Pennsylvania's Proposals Compared*, KAISER FAMILY FOUND. (Apr. 4, 2014), http://kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared.

46 *2013 Actuarial* Report *on the Financial Outlook for Medicaid*, HHS (2013), http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/ Downloads/medicaid-actuarial-report-2013.pdf.

uninsured Americans was reduced by approximately 10.3 million.[47] Also, an added 8 million individuals were covered by Medicaid, leading to nearly $5.7 billion reduction in uncompensated hospital costs.[48]

Similar to Section 1115 waivers, Section 1332 of the ACA is a catalyst for innovation called the Waiver for State Innovation program.[49] Under this statute, since the beginning of 2017 states can ask the federal government for a five-year waiver of nearly every considerable coverage element of the ACA.[50] The pillar of these waivers is the financing, which allows states to receive all subsidies that would have gone to the state's residents in order to fund their reforms.[51]

Section 1332 of the ACA allows a state to apply for a State Innovation Waiver to seek innovative approaches for presenting access to economical, high-quality health insurance to its residents while maintaining the fundamental protections of the ACA.[52] States may waive provisions pertaining to the essential health benefits and metal tiers of coverage, as well as the correlated restraints on cost sharing for covered benefits.[53] States may adjust the premium tax credits and cost-sharing cuts, such as seeking an cumulative payment of what individuals would have otherwise collected in premium tax credits and cost-sharing cuts.[54] In addition, states may revise or replace the marketplaces by altering or removing the individual or employer mandates.[55]

To receive a 1332 waiver, a state must file an application with the Secretary of HHS that includes proof supporting its suitability for the waiver.[56] The Secretary can find that the state is equipped only if the

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47 *ASPE Issue Brief: Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014*, HHS (Sept. 4, 2014), http://www.aspe.hhs.gov/health/reports/2014/UncompensatedCare/UncompensatedCare.pdf.

48 *Id.*

49 Patient Protection and Affordable Care Act of 2010, PUB. L. NO. 111-148, § 1332, 124 Stat. 120, 203 (2010).

50 Heather Howard & Galen Benshoof, *1332 Waivers and the Future of State Health Reform*, 15 YALE J. HEALTH POL'Y L. & ETHICS 237, 237 (2015).

51 *Id.*

52 *Section 1332: State Innovation Waivers*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 2, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html.

53 Jennifer Tolbert & Karen Pollitz, *Section 1332 State Innovation Waivers: Current Status and Potential Changes*, KAISER FAMILY FOUND. (July 6, 2017), https://www.kff.org/health-reform/issue-brief/section-1332-state-innovation-waivers-current-status-and-potential-changes/.

54 *Id.*

55 *Id.*

56 42 U.S.C. § 18052; *see also* Katherine Hayes & Sara Rosenbaum, *Waivers for State Innovation,* HEALTH REFORM GPS (Mar. 21, 2011), www.healthreformgps.org/resources/waivers-for-state-innovation/.

alternative program encompasses as many benefits that are covered by the ACA's fundamental health benefits plan,[57] affords as many cost constraints as the ACA,[58] and covers as many individuals as the ACA.[59] Furthermore, the states must present a 10-year budget plan to show that the alternative program would not further the federal deficit.[60]

Upon receipt of an application, the Secretaries of HHS and Treasury must initiate a shared review within 45 days and make a decision within 180 days on whether to approve the waiver.[61] If the waiver is granted, then the state no longer has to (1) order individuals to purchase coverage or incur a tax penalty,[62] (2) require employers with a minimum of 50 full-time employees to provide health insurance to employees or incur a fine,[63] (3) establish mandatory exchanges,[64] and (4) provide healthcare plans meeting only the minimum essential coverage standards.[65] Nevertheless, these states still secure the premium tax credits and subsidies from the federal government.[66] States can then use this funding to achieve alternative plans, rather than disbursing it to the insured.[67]

The ACA allows for an integration of the waiver process by which states can request for 1115 and 1332 waivers in a single application.[68] This mixed waiver process provides states with more flexibility.[69] But, while approving combined waiver requests, the Secretary may not waive any

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[57] 42 U.S.C. § 18052(b)(1)(A).

[58] 42 U.S.C. § 18052(b)(1)(B) (provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide); *see also* § 18022(c)(3).

[59] 42 U.S.C. § 18052(b)(1)(C) (provide coverage to at least a comparable number of its residents as the provisions of this title would provide).

[60] 42 U.S.C. § 18052 (" . . . application shall . . . contain . . . a 10-year budget plan for such plan that is budget neutral for the Federal Government . . . [so that it] will not increase the Federal deficit.").

[61] *Id.*; *see also* Katherine Jett Hayes, *Essential Benefits,* HEALTH REFORM GPS (Jan. 12, 2012), www.healthreformgps.org/resources/essential-benefits/.

[62] 26 U.S.C. § 5001A(a), 1501(b) (2012).

[63] 26 U.S.C. § 218a-b, 4980H, 1513(c)(7) (2012); *see also Summary of New Health Reform Law*, KAISER FAMILY FOUND. (Apr. 15, 2011), www.kff.org/healthreform/upload/8061.pdf.

[64] 42 U.S.C. § 18031(b)(1) (2012).

[65] *See* 42 U.S.C. § 300gg-6(a); *see also* Patient Protection and Affordable Care Act: Standards Related to Essential Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,838, 12,860 (Apr. 26, 2013); *see also Section 1332: State Innovation Waivers, supra* note 52.

[66] *See* Hayes, *supra* note 61.

[67] *See id.*

[68] *See* Howard & Benshoof, *supra* note 50, at 237.

[69] *See generally Meeting 2 Draft Minutes,* STATE INNOVATION WAIVER TASK FORCE (Oct. 2014), http://govemor.hawaii.gov/wp-content/uploads/2014/12/Meeting-2_Meeting-Minutes- Approved.pdf.

non-healthcare federal law that is not within the Secretary's power.[70] Innovation waivers cannot be used to alter Medicaid program guidelines.[71] When a state receives a waiver, it is required to document how it is managing the 1332 waiver requirements yearly.[72]

Looking to the federal government's financial assistance and accelerated and joint review process, a 1332 waiver appears designed to serve states with broad support by creating innovative plans to permit states to spare time and cost in enacting reforms.[73] The goal of a 1332 waiver is not only to provide "deference to a state's sovereignty or diversity," but also to welcome an improved functioning system by being more economical.[74] Although Section 1332 affords states broad power to waive provisions of the ACA, it supplies four "guardrails" to protect against reductions in the amount of individuals insured, scope of benefits, destruction of affordability, and effect on the federal deficit.[75] For approval of a waiver, a state's plan must: (1) afford coverage that is at least as extensive as the coverage provided through the marketplace based on the essential health benefits; (2) afford coverage and cost sharing protections against unreasonable out-of-pocket expenses that are at least as inexpensive as marketplace coverage; (3) afford coverage to at least as many individuals as the marketplace without the waiver; and (4) cannot increase the federal deficit.[76]

In addition to these substantive safeguards, Section 1332 also provides several procedural safeguards.[77] Even if the state's proposal satisfies the substantive protections, the Secretary of HHS and Secretary of the Treasury have the authority to reject waivers.[78] A waiver cannot be approved for longer than five years and can be revoked if the Secretaries find that the plan is not meeting the requirements.[79] Furthermore, prior to applying for a waiver, a state must pass legislation ratifying the state's proposal to afford coverage through the waiver, providing certainty of

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[70] *See generally* 42 U.S.C. § 18052 (2012); *see also* Application, Review, and Reporting Process for Waivers for State Innovation, 77 Fed. Reg. 11,700, 11,700 (Apr. 27, 2012).
[71] *See* Tolbert & Pollitz, *supra* note 53, at 2.
[72] *See id.*
[73] *See* Kimberly S. Min, *Waiver for State Innovation: A Call for Increased Success or a Projected Failure*, 26 HEALTH L. 32, 32 (2013).
[74] *Id.* at 34.
[75] 42 U.S.C. § 18052 (2012).
[76] *Id.*
[77] Jason Levitis & Stuart Butler, *Elements of a Compromise on State Innovation Waivers*, BROOKINGS (Sept. 19, 2017), https://www.brookings.edu/blog/up-front/2017/09/19/elements-of-a-compromise-on-state-innovation-waivers/.
[78] *Id.*
[79] *Id.*

comprehensive support among the state.[80] Collectively, these protections are designed to guarantee that the extensive authority provided by waivers does not compromise the cost of health care, federal budget restraint, or the policy principle.[81]

In 2015, HHS and the Treasury Department issued guidance on their interpretation of the law's rules for waivers to afford comparable coverage, breadth, budget neutrality, and affordability.[82] This guidance stated that "vulnerable residents" are not to be adversely impacted by revisions.[83] It specified that if a waiver proposal adversely affects "vulnerable residents," then the proposal would be rejected.[84] The guidance defines vulnerable residents to encompass people who are low-income, elderly, have severe health problems or are at risk of developing severe health problems.[85] However, this guidance is not legally-binding and can easily be altered by later administrations. On his first day in office, President Trump issued an executive order indicating that states would be afforded expanded discretion in relation to ACA implementation.[86]

II. THE SHIFT TO COLLABORATIVE FEDERALISM

Because waivers under the ACA grant states more flexibility and power to design state-specific healthcare plans, the federal-state interaction seems to be shifting from cooperative federalism to collaborative federalism. States are no longer simply receiving federal orders. Now, states are creating the appropriate program guidelines and molding health policy from the bottom up.

The Medicaid Program was long viewed as an example of cooperative federalism by scholars and the courts.[87] Cooperative federalism supports the idea that the states' powers and the federal government's powers are

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[80] *Id.*

[81] *Id.*

[82] *See* Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,132 (Dec. 16, 2015) (to be codified at 31 C.F.R. § 33 and 45 C.F.R. § 155).

[83] *Id.*

[84] *Id.*

[85] *Id.*

[86] *See* Tolbert & Pollitz, *supra* note 53, at 2.

[87] *See* Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL'Y 266, 267–68 (2011) (viewing our current structure of health policy as an example of cooperative federalism that "entrusts large swaths of its implementation to the states."); *see also* Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism,* 79 N.C. L. REV. 663, 668 (2001); *see also* Douglas v. Indep. Living Ctr. of S. Cal., Inc. (Indep. Living Ctr.), 132 S. Ct. 1204, 1208 (2012); *see also* Nat'l Fed'n of Indep. Bus., 132 S. Ct. at 2629 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

complementary to each other.[88] Medicaid was described as "a cooperative federal-state program"[89] because Congress was relying on a federal regulatory agency to develop certain standards for the state agencies to follow.[90] Instead of permitting a federal agency to execute a uniform health-care structure for the nation's poor, Congress afforded states the freedom to modify Medicaid grants to match the specific demands of each state if they abided by regulations set by federal law.[91] In sum, Medicaid is a quintessential illustration of federal-state cooperation in supporting the country's general welfare.[92]

Two prevailing themes arose from this cooperative vision of health administration.[93] First, state power is crucial evidence to rebut alleged federal coercion.[94] For instance, Justice Ginsburg's dissent in *NFIB* rejected the finding that Medicaid expansion tied with the traditional Medicaid program was coercive and emphasized the ample sovereignty states maintain under the Act.[95] On the other hand, the second theme highlights the value of federal law in regulating states' flexibility.[96] To health proponents, beneficiaries, and providers, the role of the federal government in drawing the lines of the states' power is just as crucial.[97] For example, Medicaid devises privileges to those whom meet certain criteria.[98] Individuals who are denied insurance may seek legal remedies in the courts.[99] Additionally, the statute allows Medicaid beneficiaries to choose a provider, which precludes the states from barring compensation to providers without evidence of considerable quality of care concerns or provider status termination stemming from Medicaid fraud.[100]

States have gone from nothing more than beneficiaries of federal mandates to agents heavily shaping the pertinent program guidelines and constructing health protocol from the ground up.[101] Certain areas lack federal mandates or regulations that precisely specify the ways that states

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88 Clark, *supra* note 1, at 256.
89 *See* Indep. Living Ctr., 132 S. Ct. at 1208.
90 Weiser, *supra* note 87, at 668.
91 Clark, *supra* note 1, at 256 ("Rather than authorizing a federal agency to administer a uniform national health-care system for the poor, Congress offered States the opportunity to tailor Medicaid grants to their particular needs, so long as they remain within bounds set by federal law." (quoting Nat'l Fed'n of Indep. Bus., 132 S. Ct. at 2629)).
92 *See id.*
93 *Id.* at 257.
94 *Id.* at 256.
95 *Id.*
96 *Id.*
97 Clark, *supra* note 1, at 256.
98 *Id.*
99 *Id.* at 258.
100 *Id.*
101 *See id.* at 260.

should make certain types of choices. Consequently, states are supposed to create the specifics of the program model and interpret the substance of the same federal regulations that purportedly restrict state flexibility.[102] When viewed in this light, the relationship between federal and state power regarding health care is better described as collaborative.

Even though Section 1115 waivers have provided states the chance to embrace this type of control, the deviating balance of power towards the states is demonstrated by the federal-state relationship occurring under the ACA.[103] Since the emergence of the ACA, the federal government manifested a readiness to bargain with states desiring even more freedom in the execution of private and public coverage reforms.[104] Even though opponents regard the considerable amount of funding at risk as proof of coercion, the truth is that states are proficient at finagling federal dollars to better benefit their own concerns.

Under this collaborative federalism model, state flexibility is greater than a confined area cut out for states in a law governed by federal mandates. Instead, the federal government progressively respects its relationship with the state as active and considers state flexibility as crucial to the federal government's motive for states to propel health policy. This view encompasses a more equal partnership in which both the federal government and the states are heavily engaged in molding the principles guiding more specific features of program design.[105] It may have been the view that states were used for the function of achieving federal goals;

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[102] Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J. F. 1, 16 (2017) ("The Obama Administration's willingness to grant broad Medicaid waivers has allowed the states to adopt policies that align with their interests. Similarly, subsidies for individual plans purchased through the health-care exchanges come out of federal funds, even as states were given the option of running the exchanges themselves.").

[103] *See* Clark, *supra* note 1, at 244.

[104] Cristina M. Rodriguez, *Negotiating Conflict Through Federalism: Institutional and Popular Perspectives*, 123 YALE L.J. 2094, 2094 (2014) (describing "the contours of our federal system [as] under constant negotiation, as governments construct the scope of one another's interests and powers while pursuing their agendas" and arguing that "federalism does not consist of a fixed set of relationships.").

[105] *See* Heather K. Gerken, *Federalism as the New Nationalism: An Overview*, 123 YALE L.J. 1889, 1893 (2014) ("Too often federalism scholars have treated sovereignty and autonomy as if they were the only form of state power, as if the states and national government were in a zero-sum policymaking game. They've neglected the different but equally important form of state powers that are at the heart of the nationalist school's work on federalism. The power states enjoy as national government agents. The power states exercise in driving national policy and debates. The power states wield in implementing and integrating federal law.").

however, it is becoming more common that states are viewed as the ones in power by leveraging federal funds toward essential state objectives.[106]

Before the start of the ACA, the federal government's progressively generous granting of waivers was viewed as confirmation of flourishing state discretion in Medicaid.[107] Now, under the ACA, there is a substantial contention that states acquired even more power. Because the Supreme Court made Medicaid expansion voluntary and the Act alone rendered state-operated coverage exchanges optional, the Obama Administration relied on states for the ACA to prosper. The federal government could not fulfill its desire to expand health care accessibility without the states. Thus, the need for each other's support became equal between the federal and state governments.

The development of a more balanced partnership between the states and the federal government does not end with negotiations concerning whether to obtain federal terms and funding. It persists as states explore distinct and advanced ways to provide and finance health care.[108] While older federalism models oppose federal control of health care, collaborative federalism indicates that states may be liberated through federal spending programs. The belief is that states accept considerable federal funding, allowing them to explore financing methods and approaches to health care delivery to enhance health care for their citizens through methods they otherwise could not. In addition, this collaborative framework may have finally encouraged Republican-led states to adopt the Medicaid expansion.

III. THE GLACIAL PACE OF STATE INNOVATION WAIVER APPROVAL

To date, only eight states—Alaska, Hawaii, Minnesota, Oregon, Maine, Maryland, New Jersey, and Wisconsin—have submitted

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106 *See generally* Deborah Bachrach et al., *Medicaid at a Crossroads: What's at Stake for the Nation's Largest Health Insurer,* STATE HEALTH REFORM ASSISTANCE NETWORK (Robert Wood Johnson Foundation) (Feb. 2017), http://www.statenetwork.org/wp-low-content/uploads/2017/02/State-Network-Manatt- Medicaid-at-a- Crossroads-February-2017.pdf (describing the modernization and payment reforms led by the states with critical funding from the federal government).

107 *See* Elizabeth Weeks Leonard, *Crafting a Narrative for the Red State Option*, 102 KY. L.J. 381, 397 (2013–2014) (describing the "evolution of the Medicaid waiver process and other flexible options are part of a larger trend of federal-state negotiations over program design and implementation.").

108 *See* Clark, *supra* note 1, at 260.

successful 1332 waiver applications.[109] And, although its waiver was approved, Minnesota did not receive full approval of its original application.

A. Hawaii—The Pioneer of 1332 Waivers

On December 30, 2016, Hawaii became the first and only state to have its 1332 waiver application approved.[110] Specifically, Hawaii sought and was later permitted to waive the requirements of the ACA's Small Business Health Options Program ("SHOP").[111] SHOP's obligations directly conflicted with the state's Prepaid Health Care Act.[112] The Prepaid Health Care Act, ratified in 1974, requires the state's employers to afford more generous insurance than is demanded under the ACA.[113] Hawaii was also authorized to waive the requirement that the small business tax credits be available only through SHOP.[114]

B. Alaska's Model

Alaska submitted a 1332 waiver application at the end of 2016 requesting federal pass-through funding to partially finance the Alaska Reinsurance Program ("ARP").[115] The ARP fully or partially reimburses insurance providers for acquired claims for high-risk individuals diagnosed with certain health conditions, such as HIV/AIDS, cancer, and multiple sclerosis.[116] Because Alaska subsidized the costs of individuals with high-cost diagnoses, it was able to lower the rising cost burden on the state's market risk pool.[117] Accordingly, Alaska's insurance rates in 2017, which were anticipated to increase more than forty percent, were approximately only seven percent higher than the insurance rates for 2016.[118]

The approval of Alaska's application demonstrates a method that other states could follow to reduce premiums in their marketplaces and better

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[109] *Section 1332: State Innovation Waivers, supra* note 52 (explaining that the waivers for Maine, Maryland, New Jersey, and Wisconsin were approved in July 2018 and just became effective on January 1, 2019).
[110] *See id.*
[111] *Id.*
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Section 1332: State Innovation Waivers*, *supra* note 52.
[116] Dane Meuse & Heather Howard, *How States are Addressing Uncertainty with 1332 Waivers* HEALTH AFFAIRS (June 9, 2017), https://www.healthaffairs.org/do/10.1377/hblog 20170609.060512/full/.
[117] *Id.*
[118] *Id.*

allocate the costs of the very ill.[119] The approval of this waiver will not alter the way individuals with pre-existing conditions receive care. These individuals will still enroll in the same plans and pay the same premiums as those who are healthy, receive all benefits, and, if eligible, collect premium credits and cost sharing cuts.[120] Nevertheless, the costs of their claims will be compensated out of a pool funded by a broader set of payers, which reduces individual insurance premiums for everyone and stabilizes the marketplace.[121] The pool is funded partly by an evaluation across the vast state-regulated coverage system, which includes the group market, and receives federal funding through the waiver.[122]

The objective of Alaska's reinsurance system is to reduce premiums in the individual market. Because the premiums are lower than they would be otherwise, the federal government does not have to reimburse as much to low- and middle-income individuals through premium tax credits.[123] Under the ACA, low- and middle-income families can receive premium tax credits for the disparity between the total cost of premiums in marketplace plans and a percentage of their income.[124] Because reinsurance decreases the total cost of premiums in Alaska, the federal government salvages money.[125]

Through Alaska's waiver, federal savings are refunded to the state reinsurance program, balancing the individual market for years to come, reducing premiums, and mitigating the considerable fiscal pressure that Alaska is currently enduring.[126] In fact, in August 2018, Alaska's individual market provider announced that it filed for an average rate decrease of 3.9 percent, which is in addition to the 22.4 percent average decrease in premiums for 2018.[127] Alaska also predicts that an additional 1,485 people will enroll in Alaska's individual market as a result of the reinsurance system's outcome in reducing premiums.[128]

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[119] Cheryl Fish-Parcham, *Alaska's Reinsurance 1332 Waiver: An Approach that Can Work* FAMILIES USA (Aug. 2017), http://familiesusa.org/product/alaska-reinsurance-1332-waiver-approach-can-work.
[120] *Id.*
[121] *Id.*
[122] *Id.*
[123] *Id.*
[124] *Id.*
[125] Fish-Parcham *supra* note 119.
[126] *Id.*
[127] Louise Norris, *Alaska health insurance marketplace*, HEALTHINSURANCE.ORG (Dec. 17, 2018), https://www.healthinsurance.org/alaska-state-health-insurance-exchange/#rates
[128] *Id.*

C. Oregon Follows on the Trail

On October 18, 2017, the Trump Administration approved Oregon's 1332 waiver application.[129] The state requested waiver of Section 1312(c)(1)[130] for a period of five years starting in 2018.[131] Oregon established a state reinsurance program.[132] While this waiver does not affect any other provision of the ACA, it produces reduced market-wide index rate, which decreases premiums and federal disbursement of advance premium tax credits.[133]

The Oregon Reinsurance Program is structured to stabilize the individual market, cut rates, and invite insurance providers to provide plans in more areas of the state.[134] Identical to the motive backing Alaska's program, Oregon is utilizing reinsurance to disperse the risk of high-cost claims so that all insurance providers take an identical portion of the risk of costly claims.[135] In fact, rates for individual plans in 2018 were six percent lower than they would be if there was no reinsurance program.[136] The Acting Director of Oregon's Division of Financial Regulation emphasized that, without the program, there may have been counties suffering due to no plans provided through Oregon's Health Insurance Marketplace, and it was exacerbated due to more individuals buying their own insurance in 2018.[137]

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129 *See Section 1332: State Innovation Waivers, supra* note 52.

130 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 § 1312(c)(1) (2010) ("A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.").

131 Richard Cauchi, *Innovation Waivers: State Options and Legislation Related to the ACA Health Law*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org /research/health/state-roles-using-1332-health-waivers.aspx (last updated Dec. 14, 2018).

132 *Id.*

133 *Id.*

134 *DCBS announces federal approval of 1332 State Innovation Waiver Application*, OREGON.GOV: OREGON NEWSROOM (Oct. 20, 2017), https://www.oregon.gov/newsroom /Pages/NewsDetail.aspx?newsid=2368.

135 *Id.*

136 *Id.*

137 *Id.* ("We are pleased that CMS has quickly approved Oregon's 1332 State Innovation Waiver application enabling Oregon to establish its reinsurance program," said Acting DCBS Director Jean Straight. "The Oregon Reinsurance Program will provide much needed stability to Oregonians who purchase insurance on their own.").

IV. THE POTENTIAL SUCCESS FOR COLLABORATIVE FEDERALISM BY WAIVER

As with nearly anything vulnerable to variability, the instability among numerous state ACA exchanges has considerable downfalls for health insurance providers. Some providers are facing obstacles in selling profitable exchange plans because of high enrollment among sick individuals and low enrollment among health individuals.[138] The negative impact of the instability flows over onto health care providers, pharmaceutical companies, and device manufacturers.[139] When health insurance is unavailable or too expensive, fewer individuals are likely to be covered; thus, fewer individuals are able to buy health care services.[140] Nonetheless, if states execute favorable waiver programs, then opportunities can emerge for practically everyone in the health care industry.[141]

To the extent that Section 1332 waivers permit states to develop reinsurance programs that overturn the instability in exchanges, all will be improved.[142] Although it is uncertain whether merely enacting reinsurance programs is sufficient to stabilize individual markets in the states, HHS promoted the reinsurance waiver model founded on one year of involvement in Alaska.[143] It is argued that Alaska is unique due to its small population, so it is unclear how such reinsurance programs will operate in other states.[144] Specifically, reinsurance programs might not have ample funding to cancel out other market forces that push premiums to increase.[145] Such determinants may include healthy individuals refusing to

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[138] Andrew L. Bab, Jennifer L. Chu, Mark Goodman, Maura Monaghan, Kevin Rinker & Jacob Stahl, *How Section 1332 Waivers Could Impact Health Care Reform*, LAW 360: EXPERT ANALYSIS (July 24, 2017, 11:32 AM), https://www.law360.com/articles/946530/how-section-1332-waivers-could-impact-health-care-reform.

[139] *Id.*

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] *See generally* Press Release, U.S. Dept. of Health and Human Services, Readout of Secretary Price's Visit to Anchorage, Alaska (Aug. 19, 2017) (on file with the Health and Human Services News Release 1991–2016 Archive) ("Secretary Price listened to how HHS resources help CITC provide effective, community-based services to Alaska Natives of all ages. For example, at the Claire Swan Early Head Start Child Care Center, Secretary Price saw how Head Start resources can be used to provide child care services that are strongly grounded in the cultural, linguistic, and social needs of Alaskan families.").

[144] Timothy Jost, *Alaska Reinsurance Plan Could Be Model For ACA Reform*, HEALTH AFFAIRS (June 16, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160616.055420/full/.

[145] Robert E. Moffit, *States Are Offering Relief From Rising Health Care Costs*, THE HERITAGE FOUND. (May 24, 2018), https://www.heritage.org/health-care-reform/commentary/states-are-offering-relief-rising-health-care-costs-heres-how ("[H]ealth care

buy coverage through the exchanges and unpredictability as to if the federal government will continue financing cost sharing reductions.[146]

Instead of simply using 1332 waivers to create reinsurance programs, states can also utilize the waivers to request more extensive reform. Because states may not have the needed expertise to form large-scale innovations to their health care systems, health care companies may be able to provide proficiency in achieving state goals.[147] In addition, companies that are prepared to create innovative designs to offer coverage, provide care, or sell products may discover exceptional opportunities to develop or invest in states that adopt 1332 waivers.[148]

Nonetheless, slight legislative reform to the language and procedures in Section 1332 could lead to bipartisan approval.[149] Changes could transform the innovation waiver procedure into a more useful program to the states while ridding of many drawbacks of the current structure.[150] For example, if the regulations were relaxed for determining pass-through funding, it would allow states to distribute more of the federal dollars saved through their waivers, and then states would be able to make more widespread and cooperative reforms to their health care structures and the subsidization of care for low- and middle-income families.[151]

Under the current law, pass-through funding is currently subject to two individual caps.[152] Each cap individually limits the amount that can be compensated.[153] First, Section 1332(a)(3) provides that pass-through funding is equivalent to the number of federal marketplace subsidies that would be made without the waiver but are relinquished under the waiver.[154] Second, Section 1332(b)(1)(D) requires that a waiver does not

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costs and insurance premiums are also dependent upon the competitiveness of state health insurance markets, as well as the extent to which Medicare and Medicaid affect those markets, as well as the penetration of employer-sponsored health insurance.").

[146] *See id.*; *see also* Steven Chen, *If The Trump Administration Terminates Cost-Sharing Reduction Payments*, HEALTH AFFAIRS (Aug. 15, 2017), https://www.healthaffairs.org /do/10.1377/hblog20170815.061550/full/.

[147] *See* Jessica Schubel & Sarah Lueck, *Understanding the Affordable Care Act's State Innovation ("1332") Waivers*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www. cbpp.org/research/health/understanding-the-affordable-care-acts-state-innovation-1332-waivers#_ftnref6 (last updated Sept. 5, 2017) ("Premera, [Alaska's] only individual-market insurer, recently proposed a rate decrease of more than 20 percent for 2018, largely due to the reinsurance program.").

[148] *Id.*

[149] Levitis & Butler, *supra* note 77.

[150] *Id.*

[151] *Id.*

[152] *Id.*

[153] *Id.*

[154] *See* 42 U.S.C. § 18052 (2015).

increase the federal deficit.[155] Under this restraint, if the full amount of savings would result in increasing the deficit, then the pass-through funding is reduced to sustain deficit neutrality.[156] This calculation is illustrated in the Alaska waiver approval letter.[157] The waiver was projected to generate premium tax credits savings of approximately $50.5 million in 2018.[158] However, the waiver also requires federal costs, including a $700,000 cut in individual mandate payments and a $1.5 million cut in user fees paid to the federal-aided marketplace.[159] These effects net out to federal savings of nearly $48.4 million in 2018, and this amount—not the premium tax cut savings—is the determined amount of federal pass-through funding.[160]

Capping pass-through funding is crucial to avoid violating the deficit neutrality guardrail.[161] Nevertheless, it is not apparent why capping pass-through funding at relinquished marketplace subsidy expenses is also fundamental.[162] Under current law, only marketplace subsidy savings may be allotted to the state, and all other savings must be given up.[163] This procedure decreases the appeal and practicability of waivers, which meet the guardrail requirements and are otherwise enticing.[164]

For example, a waiver that develops a state program that decreases health coverage premiums in both the individual and group markets will generate marketplace subsidy savings that may be passed through to the state.[165] However, decreasing premiums for employer-funded health insurance would also decrease the cost of the individual tax exclusion for employer-funded insurance.[166] Thus, both federal individual income tax and payroll tax receipts would increase.[167] The current regulation impedes these exclusion savings from being distributed to the state through pass-through funding, consequently decreasing help for the state plan to cut premiums.[168] Also, waivers that would decrease the cost of tax exclusion

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155 *Id.*
156 Levitis & Butler, *supra* note 77.
157 *See generally Alaska Approval letter signed STC,* CTRS. FOR MEDICARE & MEDICAID SERVS. (July 11, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Alaska-STCs-signed-by-Treasury.pdf.
158 *Id.* at 8.
159 *Id.* at 8.
160 *Id.* at 8.
161 Levitis & Butler*, supra* note 77.
162 *Id.*
163 *See* 42 U.S.C. § 18052 (2015).
164 Levitis & Butler*, supra* note 77.
165 *Id.*
166 *Id.*
167 *Id.*
168 *Id.*

for employer health insurance by transitioning people to the individual market would be similarly burdened.[169]

In fact, the double constraint seems to have added to the derailment of New Hampshire's potentially valuable waiver.[170] New Hampshire was drafting a reinsurance waiver—similar to Alaska's waiver—to reduce premiums in 2018.[171] When other states requested a waiver, they determined that the federal pass-through funding would afford a wide portion of the funding for the reinsurance program.[172] Nonetheless, when New Hampshire's analysts calculated the amount, they found that pass-through funding would offset less than thirty percent of its reinsurance program in 2018.[173]

A significant reason for this small federal share seems to be the design of New Hampshire's Medicaid program and how it cooperates with the dual cap on pass-through funding.[174] New Hampshire expanded Medicaid eligibility under the ACA by enrolling the state's expansion population in individual market coverage through a premium support model.[175] A state reinsurance program would cut premiums among the individual market, including the sector aiding the expansion population.[176] Under the ACA's regulations for Medicaid expansion, the federal government covers ninety percent or more of the premiums for the expansion population.[177] So, a reinsurance program would produce considerable Medicaid savings without affecting coverage for Medicaid beneficiaries.[178] However, due to pass-through funding being capped at marketplace subsidy savings, Medicaid savings typically may not be passed through to the state.[179]

On the other hand, an approach to addressing the dual cap constraint would be to modify the language in Section 1332(a)(3) to alternatively cite to overall net federal savings under the waiver.[180] Therefore, all federal budget effects currently considered for intentions of deficit neutrality

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169 *Id.*
170 Cauchi, *supra* note 131.
171 *See New Hampshire's Proposal to Waive Certain Provisions*, NEWHAMPSHIRE.GOV (July 10, 2017), https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf.
172 *See* Levitis & Butler, *supra* note 77.
173 *New Hampshire's Proposal to Waive Certain Provisions*, *supra* note 171.
174 Levitis & Butler, *supra* note 77.
175 *Id.*
176 Levitis & Butler, *supra* note 77.
177 Waiver for State Innovation, 42 U.S.C. § 18052 (2017).
178 *Id.*
179 *Id.*
180 Tara O'Neill Hayes, *Proposed Reforms To The ACA's 1332 Waivers*, AM. ACTION FORUM (Nov. 20, 2017), https://www.americanactionforum.org/insight/proposed-reforms-acas-1332-waivers/.

would also be contemplated for intentions of pass-through funding.[181] The Section should simply state that if the Secretary finds that there would be a decrease in the federal deficit throughout the duration of the waiver period, then the Secretary shall afford a method that the amount of such reduction is given to the states to carry out its plan under the waiver.[182]

This proposition would alter how a waiver's indirect impact on Medicaid and other federal programs is treated.[183] Presently, indirect impacts are not considered for purposes of pass-through funding.[184] This proposition would make these indirect savings weigh evenly for both guardrail and pass-through funding purposes.[185] For instance, if a waiver generates savings from the tax exclusion, Medicare, and Medicaid without directly reforming these programs, then the accumulated savings would be taken into account for deficit neutrality and pass-through funding.[186]

Also, an expedited review procedure for waivers that are similar to waivers that have already been approved would also be beneficial.[187] A waiver that is substantially alike to an approved waiver has a much lower risk of being adverse.[188] In addition, the HHS and the Treasury are presumably capable of producing projections faster by regenerating their fiscal analysis and modeling as opposed to building from nothing, specifically in situations where the fulfillment of the guardrails is not impacted by any disparities among the states.[189] For example, Alaska's application was filed in December 2016, indicated as complete in January 2017, and approved in July 2017—approximately 180 days later.[190] Oklahoma filed its application in July 2017.[191] The Secretaries would have needed to act in far fewer than 180 days for Oklahoma's waiver to be approved in time for premiums to be adjusted for 2018.[192] Instead, Oklahoma withdrew its waiver request because the federal administration did not approve it by September 25, 2017, even though it indicated it would do so.[193]

Oddly enough, such fast acting appears both possible and suitable. The HHS and the Treasury have already interpreted state reinsurance programs

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181 *See id.*
182 Levitis & Butler*, supra* note 77.
183 *Id.*
184 *Id.*
185 *Id.*
186 *Id.*
187 O'Neill Hayes, *supra* note 180.
188 *Id.*
189 Levitis & Butler, *supra* note 77.
190 Cauchi, *supra* note 131.
191 *Id.*
192 Levitis & Butler, *supra* note 77.
193 Cauchi, *supra* note 131.

and how they affect state markets, guardrails, and premium tax credits.[194] Duplicating the Alaska research for Oklahoma appears somewhat clear-cut. Although the duration of the expedited review does not have to be clearly specified, a general obligation that the Secretaries decide on an accelerated basis would suffice. However, there is optimism that this may be occurring without a definite provision of the waiver approval procedures, as illustrated by the approval of Oregon's waiver request in approximately 50 days.[195]

A final potentially valuable change to the current waiver approval procedure would be to increase the HHS and Treasury staff to help states and assess waiver applications. Analyzing waiver proposals and projecting waivers' impacts usually adds up to evaluating an entirely new health care system, which demands advanced economic inquiry and modeling.[196] Yet both HHS and the Treasury have minimal employee positions concentrated on the waiver program.[197] In contrast, HHS has numerous personnel devoted to the Section 1115 waiver program.[198] Congress could expedite the waiver application process by supplying the Departments with adequate resources to help states seeking waivers and assess completed applications.[199]

CONCLUSION

Collaborative federalism through Section 1332 waivers stabilizes expansive state authority with critical safeguards for health coverage and federal funding. Vast support for this system exists to advocate state innovation and acclimatization to each state's unique health care demands. Nonetheless, revisions of Section 1332 could make it more practical and, therefore, more appealing to the states.

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194 *See id.*

195 *Id.*

196 *See* Sullivan Benefits, *HHS Promotes ACA Section 1332 Waivers*, ACA COMPLIANCE BULL. (Mar. 13, 2017), https://www.sullivan-benefits.com/wp-content/uploads/HHS-Promotes-ACA-Section-1332-Waivers-3-27-17.pdf.

197 Levitis & Butler, *supra* note 77.

198 *Id.*

199 *Id.*