Report on Health Reform Implementation

# Wyden's Waiver: State Innovation on Steroids

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*Editor's note: The two essays in this issue's Report on Health Reform Implementation section emerged from a workshop, generously funded by the Robert Wood Johnson Foundation, that was held in Chicago, Illinois, in January 2014. The purpose of the workshop was threefold: first, to increase communication and learning between state-level policy practitioners and health policy researchers; second, to address key ACA implementation issues that states are currently grappling with; and third, in response to these issues, to identify useful policy instruments and strategies for dissemination across the states. With these goals in mind, we asked several policy practitioners in different states to submit questions on current implementation challenges that might benefit from the insights of a policy researcher. We then identified researchers with significant expertise in applicable areas to respond to a small selection of these important questions. Andrew Allison's question on whether Arkansas should take advantage of the ACA's "Waiver for State Innovation," and John McDonough's response, is an example of the work that came out of this productive process. They represent the first of three sets of essays, which will be published in this section in future issues. We welcome any feedback on the process or the issues.*

**Abstract** Section 1332 of Title I of the Affordable Care Act offers to state governments the ability to waive significant portions of the ACA, including requirements related to qualified health plans, health benefit exchanges, cost sharing, and refundable tax credits. It permits state governments to obtain funding that otherwise would have gone to residents and businesses through the ACA and to use those funds to establish, beginning in 2017, an alternative health reform framework within statutory limitations. Section 1332 also permits states to apply in a coordinated fashion for waivers from

*Journal of Health Politics, Policy and Law*, Vol. 39, No. 5, October 2014
DOI 10.1215/03616878-2744824 © 2014 by Duke University Press

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Medicare, Medicaid, the Children's Health Insurance Program, and "any other federal law relating to the provision of health care items or services." This article reviews the statutory provisions and related regulations of this new and unprecedented state waiver authority, as well as the legislative history of section 1332. Finally, it reviews the limited activities thus far by states contemplating use of this provision and considers ways this authority may be considered for use by states in the future. Section 1332 has the potential to instigate a new, varied, and unprecedented array of state health sector innovations from both sides of the political divide over health care reform.

Over time, the Affordable Care Act (ACA) will be known for many things. The law includes a treasure chest of policy innovations, most of them unknown and uncelebrated beyond small circles that pay close attention to their respective arenas. Thus far, the ACA has not been known as a stimulus for state health policy innovation. That reputation is undeserved as we see, for example, the federal Centers for Medicare and Medicaid Services (CMS) approve new and unorthodox waivers to states such as Arkansas, Iowa, and Michigan to draw these otherwise recalcitrant states into the ACA's Medicaid expansion orbit. Arguably, the law's biggest impact on state innovation will be section 1332 in Title I, the "Waiver for State Innovation." Inattention to this section thus far may be connected to a key design feature: no state can implement one until January 1, 2017, at the earliest. Right now, most states have far more on their minds than 2017. In coming years, section 1332 will become far more recognized—and controversial.

## Section 1332, the Waiver for State Innovation

Let's start with the statute (Public Law 111-148): Section 1332 (codified as 42 U.S.C. 18052) begins, "A state may apply to the Secretary [of the US Department Health and Human Services] for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning or after January 1, 2017."

Paragraph (2) details the four elements of the ACA from which states may seek a 1332 waiver:

**Title I. Subtitle D. Part 1.** The requirement to establish qualified health plans that include coverage of minimum essential benefits, specified standards, and coinsurance limits.

**Title I. Subtitle D. Part 2.** The creation of government or nonprofit Health Benefit Exchanges.

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**Title I. Subtitle E. Section 1402.** Reduced cost sharing for lower-income individuals and families enrolled in qualified health plans.

**Title I. Subtitle E. Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.** IRS regulations relating to refundable tax credits for premiums, shared responsibility for employers, and penalties for failure to maintain minimum essential coverage.

Paragraph (5) introduces an important element: "Coordinated Waiver Process—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII [Medicare], XIX [Medicaid], and XXI [Children's Health Insurance Program] of the Social Security Act, *and any other Federal law relating to the provision of health care items or services* [emphasis added]. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions." This is a broad statutory invitation for states to consider many sorts of unprecedented changes to health care policy within their borders, including by name the touchiest of political terrains, Medicare.

There are strings attached (§§(b)(1)):

> The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—
>
> (A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;
>
> (B) will 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;
>
> (C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and
>
> (D) will not increase the Federal deficit.

A few other salient details: for a state to act, its application must be backed up by a law, and a state may pass a law anytime it pleases to withdraw from

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the 1332 waiver program. The HHS secretary has the authority to determine whether or not to grant a waiver and must promulgate regulations to implement this section. No waiver can last longer than five years, and waivers can be renewed by the state and the secretary.

## How Did Section 1332 Happen?

The architect and achiever of section 1332 is Senator Ron Wyden (D-OR), the recently installed chairman of the Senate Finance Committee (SFC) following the departure of Senator Max Baucus (D-MT), President Barack Obama's choice as ambassador to the People's Republic of China. This succession is ironic for many reasons, among them Baucus and Wyden's competition in 2008 and 2009 to be the US Senate's intellectual leader on national health reform.[1]

Wyden's contribution came first in 2007 with the Healthy Americans Act, a legislative reform blueprint far more radical than the ACA that would have engineered a rapid transition from employer-sponsored insurance into employer-subsidized insurance. For most, Wyden's plan would have guaranteed that if you liked your current coverage, you could *not* keep it. Included in his plan was a waiver for states to devise alternative reform plans. Baucus had no room on his SFC stage for a rival plan and did his best, with success, to marginalize both Wyden and his plan. But Wyden had a seat as the fourth-ranking Democrat on Baucus's committee, and a hard-to-suppress voice as well.

Before the SFC began its markup of Baucus's health reform legislation in September 2009, the last of the five key congressional committees to do so,[2] Wyden asked Baucus to include two amendments: first, a right for American workers who were offered unaffordable employer coverage to take the employers' share of premium and use those dollars to buy coverage through an exchange; and second, a waiver for state innovation lifted nearly word-for-word from his Healthy Americans Act. Facing business and labor opposition, Baucus did not want to give Wyden the first amendment, and so gave ground on the second. That is how the Wyden waiver got into the health reform law.

1. This account is based on (a) the author's firsthand knowledge of the process as a staff member on the Senate Committee on Health, Education, Labor, and Pensions between 2008 and 2010 and (b) recent interviews with key congressional staff members who wish to remain anonymous.

2. The other four committees were the Senate Committee on Health, Education, Labor, and Pensions; the House Committee on Ways and Means; the Energy and Commerce Committee; and the House Committee on Education and Labor.

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That is not the end of the story. In late September into October 2009, as Senate and Obama administration staff merged the health reform bills produced by the SFC and the Health, Education, Labor and Pension Committee (HELP) to produce a new version for full Senate consideration, the Congressional Budget Office (CBO) privately warned staffers about Wyden's waiver: if the provision were allowed to begin in 2014, as written in the SFC version, CBO predicted the administration would be unable to estimate a reliable federal budget neutrality benchmark, lacking at least several years of experience with state exchanges, tax credits, and the rest of the ACA's paraphernalia. Thus, if the legislation permitted waivers as early as 2014, the CBO would give the legislation a substantially more expensive "score," estimated at an added $4.1 billion over ten years. Since keeping the cost of the bill as low as possible was a top priority, the date on which waivers could start was changed to 2017. That is what went to the Senate floor for final passage as part of the Patient Protection and Affordable Care Act on December 24, 2009.

Beginning in early January 2010, key Democratic House and Senate members and staff negotiated merging the House health reform legislation approved, without state waivers, on November 7, 2009, with the Senate bill approved on Christmas Eve. In rooms all over Capitol Hill and in the Executive Office Building, armies of staff reconciled literally thousands of issues, including the Wyden waiver, and were haunted by a rapidly advancing clock.

In December, Senator Bernie Sanders (D-VT) got interested in section 1332, wanting to advance his home state's ambition to create its own single-payer system and pressing negotiators to return the implementation date to 2014. He convinced the CBO to state in writing that if waivers were granted to no more than two states per year between 2014 and 2016, and if an effective "clawback" provision were included to compel states to reimburse the federal government for any overpayments in connection with the waiver, they would consider the provision budget neutral even though it started in 2014. Beginning his advocacy too late to amend the Senate bill approved on December 24, he pushed hard in January, receiving firm resistance from key House leaders, especially Rep. Henry Waxman (D-CA), then chairman of the House Energy and Commerce Committee, who wanted no waiver at all. Also in January, a letter to Senate Majority Leader Harry Reid signed by Democratic senators, among them Wyden, Sanders, Barbara Boxer (D-CA), and Mary Landrieu (D-LA), asked that section 1332 not be eliminated despite House expressions of opposition.

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On January 19, 2010, Senate Democrats lost the ability to thwart partisan filibusters when Republican Scott Brown won the Massachusetts special election to fill the seat formerly held by the late Senator Edward Kennedy, abruptly ending House-Senate negotiations on a merged bill. Passage by the House of the Senate's Patient Protection and Affordable Care Act (PPACA), with only limited budget-related amendments permitted in a follow-up bill, became the sole path to health reform's enactment. On March 23, 2010, President Obama signed the Senate's PPACA into law, including section 1332.

That is not the end of the story. During the course of his run for the presidency in 2011 and 2012, Republican Mitt Romney made repeated statements guaranteeing that his new administration would issue waivers to states to excuse them from complying with the ACA. "On his first day in office, Mitt Romney will issue an executive order that paves the way for the federal government to issue Obamacare waivers to all fifty states," stated his campaign website (Kaplan 2012; see also Haberkorn 2011). Romney staffers never provided a credible response when asked how he would accomplish this before the statutory start of state innovation waivers in 2017.

Lastly, in November 2010, Senators Wyden and Brown cosponsored bipartisan legislation to advance the start date for section 1332 waivers from January 1, 2017, to January 1, 2014 (Office of Senator Ron Wyden 2010). About three months later, the legislation received an unexpected endorsement from President Obama, a move that produced no discernible impact on the bill's prospects (White House Press Office 2011). Despite bipartisan pedigree and the president's endorsement, the legislation received no further attention and was not refiled (Dobias 2011).

## Final Regulations to Implement Section 1332

In section 1332, the HHS secretary was directed to promulgate implementation rules within 180 days after its signing. A proposed rule was issued on March 14, 2011, and the final rule was issued on February 27, 2012. Notably, the final rule was issued on the same day as new final rules were issued by CMS governing future section 1115 Medicaid waivers (see Jost 2012). Both sets of rules establish public accountability and transparency requirements for new and renewed waivers. Section 1115 is the older and more familiar kid on the block, a waiver process that made possible and energized many key state health reform initiatives going back to the early 1980s; Wyden's 1332 waiver is the new kid—and the

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interaction between these two may prove a novel and potent concoction that generates even newer innovations.

The final 1332 rule pertains only to processes, albeit important ones. It establishes procedures by which states can submit initial applications and lays out the content of those applications and the required processes for public hearing, notice, and comment, as well as standards for postaward reporting and monitoring. The required content in any application must address six major areas:

1. The provisions of federal law that a state seeks to waive
2. How the innovation waiver will meet the ACA's goals of coverage expansion, affordability, comprehensiveness of coverage, and costs
3. An implementation timeline, and including a budget plan that must not increase the federal deficit
4. Actuarial certifications and economic analysis
5. An analysis of the waiver's impact on provisions of the ACA that are not waived, such as how a proposed waiver program would impact access to health services when citizens leave the state, and how it will deter waste, fraud, and abuse
6. Plans for periodic reports, quarterly and annually, that track affordability, comprehensiveness of coverage, numbers of persons covered, and the impact on the federal deficit

Though a section 1332 waiver must be tied to an explicit authorization in a state law, "a State does not have to enact a new law in support of a section 1332 waiver if the State already has a law in place" (77 Fed. Reg. 11700). Of keen interest to states will be the opportunity to merge multiple waiver requests into a single application, including waivers associated with Title XVIII (Medicare), Title XIX (Medicaid), and Title XXI (Children's Health Insurance Program). The 1332 regulations are included in two sets—one issued by the HHS and a parallel set issued by the Department of the Treasury—because implementation authority is shared between the two. The formula to determine the appropriate payment to a 1332-waivered state ("the amount in tax credits and cost-sharing reductions that would have been paid had the state not received a waiver") "will be determined annually by the Secretaries, on a per capita basis, taking into consideration the experience of other states for participation in an Exchange and tax credits and cost-sharing reductions provided in such other states" (77 Fed. Reg. 11702).

Is this all there is—all process and no substance? In the supplementary information accompanying the final rule, two nonspecific comments

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suggest more will come. First: “We appreciate the comments submitted on standards for approval and will consider them as we develop the substantive component of the waiver approval process” (77 Fed. Reg. 11705). And this second one: “One commenter asked how HHS will determine the total amount of Federal funding under an approved waiver. *Response.* We will provide additional information on this issue as we move closer to the date on which section 1332 waivers could be effective and regulations regarding the underlying provisions are promulgated” (77 Fed. Reg. 11711).

Though the ACA’s section 1332 states, “The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection,” in the final 1332 rule “there is no minimum time specified between the submission of an application and the start date of the waiver” (77 Fed. Reg. 11703).

One final bit of good news for states: “The Departments estimate that it will take 400 hours for a State to develop and submit a complete section 1332 waiver application, at a cost of $18,668” and “the Departments estimate that it will take a State 80 hours annually to periodically review the waiver’s implementation, at a total cost of $3,734” (77 Fed. Reg. 11713). Departments estimate a full cost of $31,922, or 684 hours, for all state annual record-keeping and reporting requirements in connection with the proposed rule (77 Fed. Reg. 11714). That is $46.77 per hour (author’s calculation).

## What Will or Might or Could States Do with a Wyden Waiver?

Answering the question, what will/might/could happen, begins in Vermont. The Green Mountain State’s current governor, Peter Shumlin, first elected in November 2010, made a high-profile campaign promise to pursue establishment of a state single-payer health care system. In 2010, the governor and legislature commissioned academic experts to produce a report on how to achieve a single-payer system. That report, *The Vermont Option: Achieving Affordable Universal Health Care,* prepared by Harvard’s William Hsiao, Steven Kappel of Policy Integrity, and the Massachusetts Institute of Technology’s Jonathan Gruber, identified section 1332 as an important tool to enable the state to achieve its goal: “Under this section, the state could obtain the federal premium and cost-sharing subsidies to fund a single payer system. . . . it seems likely that the state could be able to align the benefit packages and administration, given the broad nature of the statutory language” (Hsaio et al. 2011:107–8).

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In a 2011 law, Vermont state government stated its intention to establish the first state-level single-payer system in the nation through the creation of "Green Mountain Care" (2011 Vt. Acts and Resolves 48). The Vermont Health Benefit Exchange, operated by the state as part of the ACA, was designed purposefully to evolve to assume single-payer coverage and financing responsibilities beginning in 2017. Vermont officials intend to be the first to file for a 1332 waiver, and they recognize that their vision would be less feasible absent section 1332. A report on single-payer financing released in January 2013 pegged the monetary value of a 1332 waiver to the state at $267 million in 2017 (ranging between $211 million and $292 million). The estimate was generated by summing the value of premium tax credits and cost-sharing reductions that would have been provided to eligible state residents under the ACA and then subtracting the combined value of individual and employer penalties, the insurer tax, and the excise tax on high-cost health plans (University of Massachusetts Medical School and Wakely Consulting Group 2013).

Though 2017 seems far off, it is not. Political considerations demand that the state move expeditiously to approve a financing plan and initiate the waiver process. The Vermont governor's term runs for only two years, and a change in the state's chief executive in 2014 or 2016 could be fatal for its single-payer ambition. Also, 2016 will be the final year of the Obama administration, under which sympathetic HHS/Treasury reviews are a better bet than the verdict from an unknown new administration in 2017. Waiver negotiations for Medicaid 1115 waivers, far less complex than the 1332 variety, often last a year or longer, and the state would need substantial time to establish a new and unprecedented single-payer infrastructure.[3]

Beyond Vermont, no other state is publicly exploring opportunities embedded in section 1332. Legislative and administration officials in Minnesota have discussed how a 1332 waiver could provide enhanced financial flexibility to implement the Basic Health Program (BHP) opportunity found in the ACA's section 1331 that permits Medicaid-like coverage—similar to Washington State's Basic Health Plan (Dorn 2011)—for eligible individuals up to 200 percent of the federal poverty level.[4] Massachusetts officials also have discussed the 1332 waiver option in their deliberations over the BHP opportunity.

Interest also appears from Arkansas, a more conservative state that won Obama administration approval for an alternative ACA Medicaid expansion

3. Based on confidential conversations with Vermont state officials and others.

4. A proposed rule to govern the Basic Health Program option was issued by CMS on September 25, 2013 (78 Fed. Reg. 59121).

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to enroll low-income uninsured persons into exchange-sponsored private health plans instead of Medicaid. Iowa is also moving this way as other conservative states watch closely. The Arkansas and Iowa alternative currently is built on the chassis of an 1115 waiver that requires federal budget neutrality so that the program will not cost the federal government more in Medicaid costs than no waiver. Arkansas officials worry that the narrow 1115 budget neutrality imperative will constrict their ambition to achieve broader system-wide savings that may be less robust on the Medicaid side of the ledger.

With a 1332 waiver, by contrast, Arkansas could mix private-sector and Medicaid savings to thread a larger budget neutrality needle. As other conservative states consider participating in the ACA's Medicaid expansion, creativity involving section 1332 may expand. Further, if the Arkansas/Iowa approach succeeds and expands via 1332 authority, states now refusing to establish their own health insurance marketplaces may find new and compelling motivation to do so. Also, a Republican president in 2017 might want to encourage states to establish their own marketplaces to diminish traditional Medicaid.

From the 2014 opportunity horizon, a Wyden waiver may enhance these state health policy options:

*A state-based single-payer financing plan.* If Vermont policy makers can find a feasible financing plan, no easy task, the state may be the first to seek a 1332 waiver for the most dramatic form of US health reform imaginable.

*A Basic Health Program option as part of ACA.* The BHP opportunity does not require a 1332 waiver, though the waiver could allow states to pursue a more expansive BHP program. Massachusetts officials have discussed using a 1332 waiver to implement a BHP expansion up to 300 percent of the federal poverty line even though the ACA's BHP section limits such expansions to 200 percent. Moreover, states employing the BHP option must share their savings with the federal government, while a similar 1332 expansion might require no such shared savings.

*A public plan option within a state health benefit exchange.* Establishing a Medicare-like public plan option within the health benefit exchanges was the sine qua non of health reform for many progressive groups in 2008–9 during the ACA legislative debate, failing when Senate Democrats could not attract sixty votes with it. As recently as November 2013, the CBO continues to score a federal public option as

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a federal budget saver; a section 1332 waiver could enable some state or states to put it to a real-life test (CBO 2013: 16).

*A private insurance-based Medicaid expansion.* Finally, as some Republican governors search for a politically acceptable formula to join the ACA's Medicaid expansion, section 1332 waivers may provide flexibility to make this path more achievable. As Arkansas officials believe, combining section 1332 and section 1115 waivers could offer more degrees of freedom to calculate budget neutrality beyond the confines of standard Medicaid math.

*An accelerant for other state innovations.* Oregon has established coordinated care organizations to deliver medical care and coverage for Medicaid enrollees that includes responsibility for population health outcomes (Oregon Health Authority, n.d.). Maryland has received federal approval to overhaul its "all-payer" Medicare waiver to hold hospitals accountable for total costs and to move toward global payments and population health responsibility (Maryland Department of Health and Mental Hygiene 2014). In 2012, Massachusetts established a global health spending target at the rate of state economic growth (Commonwealth of Massachusetts, n.d.). Any of these—and other—reforms may be strengthened with the incorporation of a 1332 waiver.

One question is whether the Obama administration will issue further section 1332 regulations to define substance as well as process, offering guidance on comprehensiveness, affordability, coverage, and budget neutrality. Given President Obama's embrace of Senator Wyden's legislation to permit 1332 waivers as early as 2014, the administration may want to encourage 1332 possibilities. Some observers worry that any substantive rules will only narrow the universe of ideas; still others fear that a failure by the Obama administration to issue further rules would allow the next administration in 2017 to define the substance of 1332 in unpredictable and, perhaps, unfavorable directions. As of this writing, the Obama administration shows no signs of moving to craft a second set of 1332 rules.

More than anything, federal waiver processes are about money. A key part of each waiver negotiation is establishing a financial baseline acceptable to federal and state participants; just as important is an agreement on trend, the rate at which federal financing can grow in subsequent years. The success of prior 1115 waivers, such as those granted in the 1990s to Tennessee (TennCare) and Massachusetts (MassHealth), involved favorable and generous determination of trend by the Clinton administration.

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Also vital to the future of section 1332 waivers will be Senator Wyden, the new chairman of the Senate Finance Committee. The senator keeps an eye on matters relating to section 1332 and was consulted by the Obama administration during the writing of the 2012 regulations. In a 2011 congressional budget deal, Wyden was surprised and upset when negotiators, including former SFC chairman Baucus, repealed the modest "employee free choice voucher" he had secured in the ACA during its final Senate passage (Lichtblau 2011). As SFC chairman, Wyden is well placed to prevent any similar damage to section 1332 in the period leading up to 2017, assuming Democrats retain majority control of the Senate. In either case, he can be expected to be vigilant.

## Conclusion

Section 1332 has the potential to be a significant and unpredictable game changer in future directions in federal and state health care policy. As the pendulum swings between the federal government and states in health policy innovation, we can anticipate, and already observe, states pressing ahead with new policy agendas. The Wyden waiver may just be a new "super waiver" in the hands of states exploring the next frontiers of health system innovation and reform.

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