Politics and Policy of Health Reform

The Devolution of Health Reform? A Comparative Analysis of State Innovation Waiver Activity

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Abstract Section 1332 of the Affordable Care Act (ACA) establishes state innovation waivers, which if approved allow states to waive certain ACA requirements, provided that insurance coverage remains comparable to the ACA with respect to affordability, benefit design, and enrollment, without increasing the federal deficit. The Trump administration has encouraged states to pursue these waivers, but the administration's haphazard approval process raises numerous questions about the malevolence and/or incompetence behind the administration's inconsistent behavior. The authors analyzed the thirteen 1332 waiver applications that states have submitted since January 2017, and they discuss the progress of states that are pursuing but have not submitted a 1332 waiver application and report on conversations with four states in the early stages of considering a 1332 waiver application. They found that most states are using or considering 1332 waivers to implement reinsurance programs rather than pursuing more sweeping reforms. Given evidence that such reinsurance programs both are more likely to gain federal approval and appear effective at stabilizing Health Insurance Marketplace premiums, they expect this trend to continue.

Keywords 1332 waiver, Trump administration, federalism, Affordable Care Act, health reform

Until recently, section 1332 of the Affordable Care Act (ACA) was an underappreciated—even unfamiliar—aspect of the ACA health reform. The provision, included at the insistence of Senator Ron Wyden (D-OR), permits states to pursue their own innovative approaches to health reform,

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provided they comply with a series of "guardrails." These guardrails are designed to ensure that state policies are comparable to the ACA with respect to the affordability of insurance, comprehensiveness of benefits, and number of persons covered, without increasing the federal deficit (McDonough 2014). In short, these section 1332 state innovation waivers were a frank acknowledgment of the role of states as laboratories of democracy within our federalist system of government, and a vehicle permitting progressive states to pursue health reforms of their own that would go further than those under the ACA (e.g., Vermont's push for single payer).

With a Republican president in the White House, more conservative states have begun considering the use of 1332 waivers to pursue alternatives to the ACA that likely would not have been approved by the administrations of Barack Obama or Hillary Clinton because they are more restrictive and arguably fail to meet the guardrail provisions (Singer 2017). In March 2017, just weeks after he took office as the new secretary of the Department of Health and Human Services (HHS), Tom Price wrote a letter to every governor encouraging them to consider applying for a 1332 waiver. Secretary Price highlighted the legal constraints of such a waiver but suggested "State Innovation Waivers that implement high-risk pool/state-operated reinsurance programs may be an opportunity for states to lower premiums for consumers, improve market stability, and increase consumer choice" (Price 2017).

With 13 states (Alaska, California, Hawaii, Iowa, Maine, Maryland, Massachusetts, Minnesota, Ohio, Oklahoma, Oregon, Vermont, and Wisconsin) having pursued 1332 waivers since 2017—the first year in which the law authorized them to do so—it is increasingly important to understand the political and policy dynamics surrounding state innovation waiver activity across the country. Before deciding to apply for a waiver, states must consider multiple factors, including the extent of constituent support for the waiver, the ability to pass the required state legislation authorizing use of the waiver, the costs associated with the application process, and the limited window in which to submit an application that can be approved before rates need to be set for open enrollment.

In this essay, we report on a comparative analysis of these 13 states to identify common themes and important differences in both the content of each state's respective waiver and the contextual factors and processes that led to each state's decision to pursue the waiver. Additionally, we identified several states that discussed pursuing a 1332 waiver but have not formally begun the waiver process. We compare and contrast the dynamics in these states with those of the 13 states that pursued a 1332 waiver. Finally, we

discuss the implications of these efforts for the future of health reform in the context of federalism and congressional efforts to amend the 1332 waiver process and abolish the guardrails.

States That Pursued 1332 Waivers since 2017

We begin by considering the states that pursued a 1332 waiver since 2017. Provided they remain within the guardrails, states can use 1332 waivers narrowly to implement incremental tweaks to perceived flaws (e.g., in the Health Insurance Marketplace) or more broadly to design innovative state-based reform efforts (Howard and Benshoof 2015). Of the 13 states that have pursued a 1332 waiver, only 4 of them have been approved (Alaska, Hawaii, Minnesota, and Oregon). The other 9 were either withdrawn (California, Iowa, and Oklahoma), rejected by the Trump administration (Massachusetts and Ohio), or placed on hold (Vermont) or are still pending approval (Maine, Maryland, and Wisconsin). Three of the four approved 1332 waivers established reinsurance programs, while the fourth was used to waive compliance with the ACA's small business health options program (SHOP) provisions in Hawaii.

Approved Waivers

The purpose of the reinsurance programs in Alaska, Minnesota, and Oregon is to attempt to stabilize the Health Insurance Marketplace in cases where there are a limited number of insurers who then assume the risk for what is often a disproportionately sick segment of the state's population. Alaska's 1332 waiver, which was approved in July 2017 without any significant obstacles, established a reinsurance program that reimburses insurers for individuals' medical claims if they have 1 of 33 high-cost conditions (Beaton 2017).

Oregon's 1332 waiver is similarly centered on a reinsurance program, passed by the legislature in July 2017 (Cauchi 2018). Oregon's reinsurance program reimburses 50% of claims between an administratively set minimum for an individual and a cap of $1 million (Straight and Brown 2017). The proposal was submitted to HHS in August 2017 and was approved in October 2017 (Straight and Brown 2017).

The process was more complicated in Minnesota. In September 2017, HHS partially approved Minnesota's 1332 waiver, granting the state permission to waive the single-risk-pool requirement in the market section of the ACA but denying the request to "receive funding equal to the amount of

the forgone federal funds and assistance that would have been provided without the waiver" (Verma 2017). In essence, the Centers for Medicare and Medicaid Services (CMS) denied aspects of Minnesota's waiver related to its basic health plan (MinnesotaCare), with the net result representing a loss of $161 million (Brooks and Snowbeck 2017).

Approximately 2 weeks later, Governor Mark Dayton wrote to HHS to voice his disapproval with the decision to deny the federal funding provision of the waiver application (Dayton 2017). Nevertheless, he signed the waiver into law on October 16, 2017 (Dayton 2017). In Minnesota, the reinsurance program works by reimbursing insurers between 50% and 80%, as set by the Minnesota Comprehensive Health Association, of the cost of an individual's medical claims that reach at least $50,000 during the year but do not exceed $250,000 (Minnesota State Law H.F. no. 5, §4). Evidence suggests that the reinsurance program has stabilized the marketplace in Minnesota and while premiums increased in 2018, they are estimated to be 20% lower than they would have been in the absence of the waiver (Blewett 2017).

The heart of the Hawaii waiver—which was the first in the nation to be approved, in January 2017—was somewhat different from the waivers focused on reinsurance. Hawaii sought its 1332 waiver to secure approval to halt its SHOP exchange and operate a pre-ACA insurance program for all businesses in the state. Under a 1974 Hawaiian law known as the Prepaid Health Care Act, the state implemented an employer mandate for all employees working more than 20 hours per week and provided premium assistance to small employers. Hawaii's waiver eliminates SHOP and uses the federal funds that would have been spent as employer incentives on SHOP as pass-through funds to support the state's premium assistance fund (CMS 2016; Ige 2016). This is the lone example of an approved 1332 waiver that is used to extend insurance coverage beyond the limits of the ACA.

Withdrawn Waivers

Three states, California, Iowa, and Oklahoma, ultimately withdrew their 1332 waiver applications. Interestingly, two of these states proposed reinsurance programs on the same timeline as the approved Oregon waiver. This was the case in Iowa, where a reinsurance program was included as one component of the so-called Iowa Stopgap Measure, as well as in Oklahoma, where reinsurance was the sole focus. The Oklahoma reinsurance program would have covered 80% of costs for individuals with medical claims

ranging from $15,000 to $400,000 (Cline 2017b). However, it appears that the Trump administration purposely delayed the waiver approval process during the spring and summer of 2017 to exacerbate problems in the marketplace as Congress debated efforts to repeal and replace the ACA (Ario 2017). According to a letter from Oklahoma HHS secretary Terry Cline, the failure to receive timely HHS approval precluded the state's ability to implement the reinsurance program prior to the 2018 open enrollment period, forcing Oklahoma to withdraw its application (Cline 2017a).

The reason for Iowa's withdrawal was similar, though the Stopgap Measure is a special case. Conceived of in response to the possibility that Iowa might have no participating insurers on the marketplace in 2018, Iowa proposed one of the most aggressive uses of the 1332 waiver to date. The Stopgap Measure would have abolished the marketplace and instead offered a single, standardized off-exchange health insurance plan with an actuarial value equivalent to an ACA Silver plan. The rationale behind this was to reduce administrative complexity and permit Iowa to offer per-member per-month premium credits to all Iowans (not just those with incomes between 100% and 400% of the federal poverty level [FPL]), based on age and income. By giving everyone access to premium credits, the hope was to entice younger, healthier people at higher incomes (i.e., >400% FPL) back into the marketplace. However, this expansion of subsidy eligibility would have necessitated providing lower-income individuals with smaller subsidies than they would have received under the ACA. Thus, many felt the waiver violated the affordability and coverage guardrails—coverage would not be as affordable for lower-income individuals under the Iowa Stopgap Measure as it was under the ACA, and consequently, fewer of these individuals would be covered.

Additionally, the Stopgap Measure proposed creating a reinsurance program that would have applied once an insured individual reached $100,000 or more in claims in a year. Specifically, the reinsurance would have covered 85% of costs for claims between $100,000 and $3,000,000 (for individuals between $1,000,000 and $3,000,000 the state would have covered 25% of costs and the Federal High-Cost Risk Pooling Program would have covered 60%). Above $3,000,000 the Stopgap Measure would have covered 100% of costs (40% covered by the state and 60% covered by the Federal High-Cost Risk Pooling Program) (Reynolds and Gregg 2017b).

Iowa submitted its finalized application in August 2017 (Reynolds and Gregg 2017b). A month later, Iowa was notified by HHS that its application was complete and would be approved or denied within 180 days—

effectively by March 2018 (Pate 2017b). On October 5, HHS asked Iowa to answer more specific questions about its 1332 waiver application, which the state responded to the following day (Iowa Insurance Division 2017). Then, on October 19, HHS informed Iowa that the state's method of calculating federal funding was problematic for budget neutrality (Pate 2017a). Specifically, CMS informed Iowa that the federal government could provide only an amount of funding equal to what it would have provided absent the waiver. In other words, there would be no additional funding if marketplace enrollment increased in response to implementation of the waiver (Jost 2017b). Iowa's inability or unwillingness to make up the difference with state funds likely explains why the waiver was ultimately withdrawn on October 31 (Jost 2017a).

The official justification from the state to HHS was that Iowa was withdrawing the 1332 waiver application because "Section 1332 Waivers are not designed to fix collapsing individual health insurance markets" (Reynolds and Gregg 2017a). This is a curious rationale, given that the precise motivation for the waiver application was the implementation of the Stopgap Measure in the face of a potentially collapsed individual health insurance market. However, in light of the details regarding HHS's interpretation of budget neutrality, it seems clear that Iowa was ultimately criticizing the agency and the waiver process more than the intended "design" of 1332 waivers. Indeed, it was also rumored that Trump himself told CMS administrator Seema Verma to deny Iowa's 1332 waiver application in an effort to exacerbate the marketplace problems in Iowa as evidence of Obamacare's "failure" (Kodjak 2017).

Finally, California took the 1332 waiver in a very progressive direction, seeking to provide access to coverage for as many as 390,000 undocumented immigrants via the Covered California state health insurance exchange (Mukherjee 2016). Notably, these individuals would not have been eligible to receive any federal subsidies. The waiver would merely have allowed them to purchase insurance via the Health Insurance Marketplace. However, when Donald Trump won the presidential election on a platform that included a strong anti-immigrant position, the state opted to withdraw the waiver application, anticipating that it had no chance of being approved (Mukherjee 2017).

Waivers Determined Incomplete

Three states submitted waiver applications to the federal government only to have CMS deem them incomplete for a variety of reasons. For example,

Massachusetts planned to establish a Premium Stabilization Fund using federal pass-through dollars for a state-based version of cost-sharing reduction (CSR) payments but was informed by HHS that the waiver application was not submitted early enough to permit 120 days of federal review and receipt of a decision in time for open enrollment, so the application was rejected (Hansard 2017). Vermont, the first state to submit a 1332 waiver application, sought to waive the SHOP requirement and permit employers to continue direct enrollment via health insurers (similar to Hawaii). However, HHS notified the state that its waiver was incomplete, and the state has neither pursued nor withdrawn the waiver (Dickson 2016; Families USA n.d.). Lastly, Ohio's application would have waived the individual mandate in the state, even after congressional action had removed the penalty associated with the mandate. CMS determined the waiver was incomplete because it did not provide a description of why the state wanted to waive the individual mandate (CMS 2018).

Waivers Currently Pending

Finally, three other states, Maine, Maryland, and Wisconsin, have submitted 1332 waiver applications that are currently pending CMS review at the time of this writing (Wisconsin Office of the Commissioner of Insurance 2018; Maine Bureau of Insurance 2018; Maryland Health Benefit Exchange 2018). In all three cases, the states are seeking the waiver to establish a reinsurance program, which has been explicitly encouraged by HHS and appears to be an effective strategy for stabilizing the marketplaces. However, given the Trump administration's previous decisions to both approve and disapprove similar waiver applications without a clear rationale from one state to the next, the fate of the Maine, Maryland, and Wisconsin waivers is not easy to predict.

States Exploring the 1332 Waiver Process

A handful of other states have publicly considered applying for a 1332 waiver but have not yet submitted their application as of this writing. Authorizing legislation has been enacted in Idaho, Kentucky, Louisiana, New Hampshire, New Jersey, Rhode Island, and Texas (Howard 2018). Of these states, public drafts of 1332 waivers have been released by Idaho, Louisiana, New Hampshire, and New Jersey, all of which propose to establish reinsurance programs (Idaho Department of Insurance 2018; Louisiana Department of Insurance 2018; New Hampshire Insurance

Department 2017; New Jersey Department of Banking and Insurance 2018). Authorizing legislation was also passed in Montana and Nevada before being vetoed by the governor in each state (Howard 2018). Other states have not proposed legislation but have had some level of conversation within the executive branch. We spoke with contacts in four states that considered a 1332 waiver to some degree: Georgia, Idaho, Pennsylvania, and New Hampshire. These conversations provide a fuller picture of the factors that may be motivating and/or hindering states from moving forward with a 1332 waiver.

While no specific details exist to outline what a 1332 waiver might look like for Georgia, the Georgia Health Policy Center has published a report recommending that the state consider using a 1332 waiver to establish a reinsurance program for the purpose of stabilizing the individual health insurance marketplace, drawing on the successful experiences of Alaska and Minnesota (Georgia Health Policy Center 2017). The only outspoken supporter of that process is the chair of the Senate Health and Human Services Committee, Senator Renee Unterman (R-GA), who is interested in using innovation waivers to address accessibility to care and the opioid and behavioral health crises (Yu 2017). However, there appears to be little support in the state legislature for moving forward with a 1332 waiver application at this time, given the uncertainties and complexities of the process. According to another Republican state senator in Georgia, the General Assembly missed the narrow window of opportunity to pursue a 1332 waiver for 2018 because they assumed that congressional Republicans would repeal the ACA (A. Miller 2017). To date, of course, only the individual mandate penalty has been repealed. Georgia may consider a 1332 down the road, but there appears to be little appetite at this time.

By contrast, Idaho is much further along with its discussion, having indicated that it plans to apply for both a 1115 and a 1332 waiver to increase access and affordability in the insurance market and provide Medicaid coverage to Idahoans with complex medical problems. Idaho's draft waiver application, submitted in February 2018, outlined three main objectives: increase enrollment in the marketplace, provide affordable health care to citizens with incomes below 100% FPL, and stabilize insurance premiums and control the insurance risk pool (Idaho Department of Insurance 2018). The 1115 waiver would move high-cost individuals from the exchange and enroll them in Medicaid, and the 1332 waiver would allow anyone below 100% FPL to purchase subsidized insurance on the exchange.

The process of developing this draft required outreach to various stakeholders, such as insurance companies, state legislators, and pharmaceutical companies. The insurance companies supported the waiver application

because it would stabilize their market and lessen their financial risk. Many state leaders also supported the waiver application as a way to demonstrate compassion to Idahoans. Even opposition legislators were eventually convinced to support the waiver application because to purchase insurance on the Idaho exchange, a person would be required to have taxable income, which incentivizes people to work. However, the pharmaceutical industry continues to vehemently oppose the application because they feel that this plan would cause Medicaid to be a program exclusively for the sick, and pharmaceutical companies do not want to be reimbursed at Medicaid rates.

Idaho has not expanded Medicaid, foregoing an estimated $3.3 billion in federal Medicaid funding as a result. However, to receive these matching funds, the state would have to spend $246 million (Dorn, McGrath, and Holahan 2014). Governor Butch Otter's administration hoped to include this amount as savings toward its 1332 waiver application's cost neutrality. Leaders in Otter's administration said they had a close relationship with Secretary Price when Idaho submitted its application to HHS, but they are less confident about their proposal since his replacement. They report having recently spoken to Seema Verma, who they say is eager to help and wants to allow Idaho to file for a waiver without having expanded Medicaid, but was concerned about the larger implications of making such an exception. Legislation authorizing the state to pursue the dual waivers cleared the state House Health and Welfare Committee. However, House leaders were unable to corral enough votes, and the bill has been pulled from the House floor and sent back to the committee, where nothing happened before the end of the 2018 legislative session in March. A new governor will take office in January 2019, and it is unclear what direction the state's new administration will go with respect to the waivers. (Since this article was written, Idahoans voted to approve Proposition 2, which would expand Medicaid, during the 2018 midterm elections. However, the proposed expansion is now being challenged in court.)

New Hampshire is a unique case. The state expanded Medicaid through a "private option" in which people enroll in private plans on the marketplace using Medicaid funds. These individuals enroll the same way as other exchange enrollees, but Medicaid funding is used to reduce cost sharing and make these programs affordable. However, New Hampshire's government recognized that there were too many insurance carriers for a state with such a small population and worried about retaining all the carriers. The state's policy makers also noticed a trend in increased spending among marketplace plans, likely because Medicaid expansion was causing higher utilization. Thus, New Hampshire published a draft of its 1332 waiver proposal in July 2017 that proposed creating a reinsurance program

administered by the New Hampshire Health Plan with the hopes of reducing market premiums and lowering rates (New Hampshire Insurance Department 2017).

New Hampshire wanted to implement the 1332 waiver quickly so it could set its new insurance rates before open enrollment in the fall of 2017. In retrospect, its policy makers did not have enough time to properly create the reinsurance program and, coincidentally, all the insurance carriers recontracted with the state, so its primary concern was mitigated. New Hampshire's 1332 proposal did not consider the legislative and administrative challenges related to this unique design, such as separating the program from the exchange (creating a new department, hiring staff, etc.). Its policy makers are considering pursuing a waiver in the future because its Medicaid expansion is due for reauthorization by the end of 2018 and the state may decide to separate Medicaid from its individual market.

The policy makers in New Hampshire with whom we spoke generally found CMS and HHS to be helpful throughout the application process. They also communicated regularly with their counterparts in Alaska, which successfully initiated a reinsurance program. Through their contacts in Alaska, they hired a contractor to help them navigate the complex language and idiosyncrasies of the 1332 waiver process.

Like other states, Pennsylvania is concerned about the impact of increased insurance rates on its citizens (T. Miller 2017). Pennsylvania officials began to consider how a state innovation waver may stabilize its market after they finalized the state's insurance contract for 2018 and the rate more than doubled due to uncertainty regarding CSR payments. In January 2017, then-commissioner Teresa Miller noted in a letter to congressional leadership that Pennsylvania did not intend to apply for a waiver; however, many innovation initiatives were in the works (Miller et al. 2017). Based on the success of reinsurance programs in other states, Pennsylvania has considered using a 1332 waiver to establish a reinsurance program for 2019.

State Innovation Waivers and the Future of Health Reform

A number of themes emerge from our analysis of the early days of 1332 waivers, providing some indication of the role they are likely to play in the future of health reform. Foremost among these is that, as long as the Trump administration is in office, states are likely to continue to pursue these waivers to implement modest reforms rather than sweeping overhauls of the health care system. The dominant trend to date has been to use a 1332

waiver to stabilize the individual health insurance marketplace by establishing a state-level reinsurance program. While Hawaii received approval to waive the ACA's SHOP requirement, a similar effort in Vermont has not progressed. Moreover, the Iowa Stopgap Measure—by all accounts the most ambitious of the 1332 waiver applications to date—was withdrawn, either due to a lack of time for proper implementation prior to open enrollment according to the state or, according to other sources, because President Trump instructed HHS to deny the application with the goal of hastening the collapse of Iowa's marketplace and further dismantling Obamacare (Leonard 2017).

A closely related point is that these reinsurance programs appear to be effective at stabilizing the marketplace and controlling the growth in premium costs. That is, there is evidence from Alaska, Minnesota, and Oregon to support this approach to 1332 waivers in other states. Even Iowa's reinsurance program, which was never implemented, was projected to substantially lower premiums (Nowak, Rao, and Lui 2017). And, from the informants we talked to in states that have submitted or are considering submitting a waiver application in 2018, a focus on reinsurance programs is common.

Under current law, there are forces that would seem to discourage more ambitious 1332 waivers. For example, not only was Iowa's Stopgap Measure withdrawn, yielding no precedent for such efforts in other conservative states, but there are also potential issues with major reform initiatives in progressive states. For example, if states choose to pursue a single-payer option via a 1332 waiver, they may very well run into issues under the Employee Retirement Income Security Act of 1974 because of the impact such an approach would have on employers (Tumbler 2016). However, Republicans in the US Senate are reportedly drafting legislation that would not only eliminate the requirement for state legislatures to approve the 1332 waiver application process but also essentially eliminate the guardrail provisions (Dickson 2017). If this were to occur, states may suddenly reconsider proposals like the Iowa Stopgap Measure that would significantly overhaul their health insurance system. (Since this article was written, the Trump Administration during the fall of 2018 issued new guidance on the use of 1332 waivers—which they now call "State Relief and Empowerment Waivers"—that strongly suggest CMS will approve a wide variety of state waivers, including those that violate the guardrail provisions.)

Meanwhile, the Republican tax reform bill included a provision that repeals the tax penalty associated with the individual mandate, effective January 1, 2019. This has the effect of reducing expected revenues to the

federal government (i.e., no one will be paying a penalty for not having insurance), and as others have described, this makes it easier for states to ensure that their 1332 waiver complies with the budget neutrality guardrail (Anderson 2018). Similarly, when the Trump administration decided to eliminate cost-sharing reduction (CSR) subsidies to insurers, the insurers simply passed their increased costs back to the federal government by raising the premiums of their Silver plans to draw down a larger advance premium tax credit for consumers. However, tax credit eligibility is greater than CSR eligibility, meaning that this is going to increase the costs to the federal government and that states will have more money to work with while remaining budget neutral to the federal government (Anderson 2018).

Finally, the advancement of policy through the waiver process emphasizes the importance of executive federalism, state innovation, and policy diffusion in the Trump era. That is, the near future of health reform hinges less on what Congress does and more on what types of new programs states are creating, how they are seeking to amend or abolish certain aspects of the ACA, from whence these ideas are originating, and how they are spreading from state to state throughout the country. The challenge of advancing health policy at the state level is compounded by an unpredictable federal government. On the one hand, the Trump administration has pursued a wide range of legislative and administrative policies that have the effect of undermining the ACA, such as repealing the tax penalty associated with the individual mandate, encouraging states to impose work requirements for Medicaid, and allowing a more expansive use of short-term insurance plans (Jones et al. 2018). Yet, the Trump administration has at times shown a degree of restraint, including rejecting Kansas's request to impose lifetime limits on Medicaid benefits and warning states that have not expanded Medicaid that they cannot establish a work requirement such that people's new incomes will make them ineligible for Medicaid even though they are still very poor.

The Trump administration's approach to 1332 waivers epitomizes this dynamic of unpredictability and occasional restraint (Thompson, Gusmano, and Shinohara 2018). For example, it is unclear why Oregon and others were allowed to make changes that stabilize rather than explode their ACA marketplaces, while Oklahoma was pushed to abandon its plan even though the timing and scope of the proposals were similar. We know of no compelling rationale for these inconsistencies beyond an administration trying to find its way with an unpredictable president and an early major personnel change at the head of the HHS. While it is difficult, if not impossible, to know whether these inconsistencies reflect administrative incompetence and/or malevolent sabotage, the inconsistency itself

is entirely consistent with the back-and-forth on health reform by Trump's campaign throughout the 2016 election (Graham 2017).

Just as they have been with respect to the 1115 waivers (Grogan, Singer, and Jones 2017), states are paying close attention to one another to learn about both policy and politics. Leaders in Georgia, Idaho, Pennsylvania, and New Hampshire told us that they had spoken with officials in Alaska, Minnesota, and Oregon to identify factors that have contributed to the success of reinsurance programs in those states. Leaders are also looking at the experiences of states that had 1332 waivers explicitly or implicitly rejected, such as Oklahoma, as cautionary tales about roads to avoid going down with the Trump administration. Our findings suggest that they should learn that states have had the most success, both in gaining federal approval and with respect to the effects of the waiver itself, when limiting their use of 1332 waivers to establish reinsurance programs. By contrast, larger undertakings have not been—and likely will not be—approved.

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