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Big Waiver Under Statutory Sabotage

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INTRODUCTION

The Affordable Care Act's State Innovation waiver allows federal agencies to suspend the most controversial parts of the statute for states to pursue alternative paths, while keeping the federal funding provided by the statute. This "big waiver" provision has the potential to enable states to pursue transformative health reforms, while preserving the affordability and universal coverage aims of the federal statute. Big waivers like this one carry theoretical promise, which largely depends on the strength of the federal statute's baseline infrastructure. This Essay considers early implementation of the State Innovation waiver as a test for big waiver theory – and for cooperative federalism in health reform.

The fragmentation of the Affordable Care Act through litigation, legislation, and executive challenge has complicated both the State Innovation waiver's intended implementation, and the theoretical promises of big waiver. Most recently, the administering agency's new guidance stretches the ACA's already-sizeable waiver beyond its statutory guardrails, even changing its aspirational title from "State Innovation" to "State Relief and Empowerment." The embrace of the ACA's big waiver by an administration hostile to the enduring statute suggest that the threats of big

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waiver swallowing its housing statute are real, and that the waiver may be wielded not as an instrument of innovation, but one of further fragmentation.

I. THE PROMISE OF THE ACA'S BIG WAIVER

The Patient Protection and Affordable Care Act[1] (better known as the "Affordable Care Act" or "ACA") "tackled the affordability of care largely by engaging third-party payers (insurers) and expanding access to care, rather than directly addressing the price of care."[2] While the ACA made a large amount of new federal law on health insurance, it simultaneously provided for the unmaking of that new law by statutory waiver. In particular, the ACA's "Waiver for State Innovation" allows administrative waiver of the individual and employer mandates, insurance subsidies, coverage regulations, and health insurance exchange rules for states who want to replace the ACA with their own reforms.[3] By suspending the core reforms of the statute, the ACA's state flexibility waiver is a paradigm of the phenomenon Judge Barron and Professor Rakoff have termed "big waiver."[4] As such, enactment of the ACA's State Innovation waiver embodied all promise, and peril, of big waiver theory.[5]

A. The ACA's Waiver for State Innovation

In 2009, the ACA cobbled together reforms across numerous dimensions of the health care system, aimed primarily at making health care more affordable by making health insurance more accessible for the segment of the population not covered by employer plans, Medicare, or Medicaid.[6] The

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 20, 21, 25, 26, 28, 29, 36, 42 U.S.C.); OFFICE OF THE LEGISLATIVE COUNSEL, 111TH CONG., COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010).

2. Elizabeth McCuskey, *Access, Affordability, and the American Health Reform Dilemma, Part II: The Affordable Care Act's First Seven Years*, OXFORD HUMAN RIGHTS HUB (Mar. 28, 2017), http://ohrh.law.ox.ac.uk/access-affordability-and-the-american-health-reform-dilemma-part-ii-the-affordable-care-acts-first-seven-years/[https://perma.cc/KM74VEUN]. *See* Amy Goldstein, *Priority One: Expanding Coverage*, *in* WASHINGTON POST STAFF, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW – THE AFFORDABLE CARE ACT – AND WHAT IT MEANS FOR US ALL 73 (2010).

3. 42 U.S.C. § 18052. *See generally* Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L. J. 1100, 1127-41, 1164-66 (2017).

4. David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 278 (2013).

5. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1127-41.

6. *See* Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption against Preemption*, 89 TEMP. L. REV. 95, 131-40 (2016). The ACA also contains numerous cost-reduction measures to the Medicare program and quality-based reforms that aspired to reduce the economic drain of preventable health conditions. But those reforms tend to reduce the costs of *care* around the margins, rather than targeting the cost and availability of *insurance* to pay for that care.

statute represented the first comprehensive federal reform of the health care system and had, as its primary goal, the achievement of universal coverage under meaningful, affordable policies.[7] Toward this goal, the ACA knitted together rules requiring individuals to have health insurance or pay a tax (the "individual mandate") with rules about the insurance available to satisfy that mandate.[8] The ACA broadened individuals' access to the existing sources of insurance by building exchanges in the individual market and subsidizing coverage there, as well as expanding the Medicaid program to cover those who could not afford the subsidized coverage, requiring medium- and large-size employers to offer their employees insurance, and infusing coverage with protections like guaranteed issuance, prohibitions on preexisting condition exclusions, and essential health benefits.[9]

Despite its federal, preemptive, and comprehensive nature, the ACA embraced cooperative federalism on various levels.[10] The statute offers several provisions for "State Flexibility to Establish Alternative Programs,"[11] including "basic health programs for low-income individuals not eligible for Medicaid,"[12] and multi-state plans.[13] On a grander scale, the ACA's waiver for "State Innovation" offers a mechanism for states to pursue more ambitious and wholesale alternatives.[14] The State Innovation waiver can suspend the statute's provisions on:

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7. *See, e.g.*, Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 130 (2011) (identifying five aims of the ACA and describing "near-universal coverage" as the "central" aim and "fairness, quality, and affordability of health insurance coverage" as a second aim).

8. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1115-16.

9. *See id.* at 1115-1117. *See also Summary of Coverage Provisions in the Patient Protection and Affordable Care Act*, HENRY J. KAISER FAM. FOUND. (July 17, 2012), http://kff.org/health-costs/issue-brief/summary-of-coverage-provisions-in-the-patient [https://perma.cc/F8N6-R49T].

10. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1157-64. *See also* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L.REV. 1693 (2018); Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1760 (2013) ("[T]he ACA offers something for everyone, . . . [it] includes . . . a federal-only model in the statute's Medicare reforms; a cooperative-federalism model in the statute's Medicaid expansion and health insurance exchange provisions; a new 'hybrid' federalism model, created in the ACA's implementing regulations, that allows states to take the lead but allows the federal government to perform certain tasks that benefit from centralization or economies of scale across groups of states; and a state-only model that expressly leaves certain functions entirely in state hands.").

11. 42 U.S.C. § 18051 (2018).

12. *Id.*

13. *Id.* §§ 18053–18054.

14. *Id.* § 18052. The statute calls this waiver provision the "Waiver for State Innovation;" many people still refer to it as the "Section 1332 waiver," referencing citation to the Act, rather than the codified section. *E.g.*, Ctr. for Consumer Info. & Ins. Oversight, *Section 1332: State Innovation Waivers*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers.html [https://perma.cc/D8DX-GAF7].

(1) the individual mandate;[15]
(2) the employer mandate;[16]
(3) qualified health plan and essential benefits provisions in the individual market;[17]
(4) individual market risk-pooling and exchange rules;[18]
(5) cost-sharing provisions;[19] and
(6) premium assistance subsidies.[20]

These waivable pillars constitute the majority – but not the entirety – of the reforms to the commercial insurance market. Notably, the waiver authority does not extend to the popular coverage regulations including guaranteed issue, preexisting condition, and dependent coverage protections or the requirement that preventive health services be covered without cost-sharing.[21] And the State Innovation waiver does not cover the public programs essential to universal coverage, like Medicare and Medicaid.[22] Medicaid is subject to its own much smaller waiver provisions predating the ACA.[23]

Administrative implementation of the State Innovation waiver is an exercise in bounded discretion. The Secretary of the Department of Health and Human Services (HHS) administers the State Innovation waiver and has delegated his waiver authority to the Center for Medicare and Medicaid Services (CMS).[24] CMS may only grant state waiver applications after determining that the state's proposed alternatives will provide coverage that is "at least as comprehensive as" the exchange plans' essential health benefits,

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15. 42 U.S.C. § 18052(a)(2)(D) (referencing 26 U.S.C. § 5000A, the "Requirement to maintain minimum essential coverage" provision also known as the individual mandate).

16. *Id.* § 18052(a)(2)(D) (referencing 26 U.S.C. § 4980H, the "Shared responsibility for employers regarding health coverage" provision also known as the employer mandate).

17. *Id.* § 18052(a)(2)(A) (referencing provisions on "Establishment of Qualified Health Plans" (§§ 18021 et seq.)).

18. *Id.* § 18052(a)(2)(B) (referencing provisions on "Consumer Choices and Insurance Competition Through Health Benefit Exchanges" (§§ 18031 et seq.)).

19. *Id.* § 18052(a)(2)(C) (referencing 42 U.S.C. § 18071, "Reduced cost-sharing for individuals enrolling in qualified health plans").

20. 42 U.S.C. § 18052(a)(2)(D) (referencing 26 U.S.C. § 36B, "Refundable credit for coverage under a qualified health plan").

21. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1132.

22. *Id.*

23. *See* 42 U.S.C. §§ 1315, 1396n (2012); Sidney D. Watson, *Out of the Black Box and into the Light: Using Section 1115 Medicaid Waivers To Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213, 214 (2015); Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 29 (2013).

24. *See* 42 U.S.C. § 18052(a)(1) (2012) (authorizing Secretary of HHS); Delegation of Authorities, 76 Fed. Reg. 53,903, 53,903–04 (Aug. 30, 2011) (delegating to CMS in conjunction with the Department of the Treasury).

"at least as affordable as" coverage accounting for ACA subsidies, and will cover "at least a comparable number of [state] residents" as the ACA would.[25] A state may receive pass-through funding with its waiver, but the plan must be budget-neutral for the federal government.[26] And, the state must promise that it has, or will enact law the law it described in its application.[27] These so-called "guardrails" on the waiver process are built to ensure that state plans still serve the underlying goals of the ACA, albeit with different law.[28] In other words, "State flexibility to change the ACA is significant, but it isn't unlimited."[29]

Congress wrote the ACA to reach full implementation on January 1, 2014, when the individual and employer mandates were to take effect, the exchanges were to open, the subsidies were to become available, and the Medicaid expansion was to begin.[30] The State Innovation waiver applications, however, did not become available until the plan year starting January 1, 2017,[31] ostensibly giving the states three years of experience with the federal statutory infrastructure before proposing their own alternatives.

Some states sought modest waivers in 2017, largely girding against market instability in a year of potential turmoil, as discussed below in Part III.A. On October 24, 2018, HHS and the Department of Treasury issued new guidance on the State Innovation waiver,[32] renaming it and reinterpreting the statute to permit state variations that could actually diminish the comprehensiveness of coverage, as well as the number of residents covered by those variations.[33] The new guidance encourages state waivers that expand private-market options, including using ACA subsidies for non-

25. 42 U.S.C. § 18052(b)(1).

26. *Id.*

27. *Id.* § 18052(b)(2).

28. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1164-66. *See also see also* Heather Howard & Galen Benshoof, Health Affairs Blog Post, *1332 Waivers and the Future of State Health Reform*, 15 YALE J. HEALTH POL'Y L. & ETHICS 237, 237 (2015) ("guardrails").

29. Justin Giovannelli & Kevin Lucia, "States See Opportunities for Flexibility in the ACA's Innovation Waiver Program," COMMONWEALTH FUND (Sept. 25, 2017), https://www.commonwealthfund.org/blog/2017/states-see-opportunities-flexibility-acas-innovation-waiver-program?redirect_source=/publications/blog/2017/sep/aca-innovation-waiver-program-flexibility.

30. *See* Rosenbaum, *supra* note 7, at 130.

31. 42 U.S.C. § 18052(a)(1).

32. State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018) (to be codified at 45 C.F.R. pt. 155).

33. *See* Katie Keith, "Feds Dramatically Relax Section 1332 Waiver Guardrails," HEALTH AFFAIRS BLOG (Oct. 23, 2018).

compliant plans and other erosions of the statute's core infrastructure, rather than encouraging transformative experiments within that infrastructure.[34]

B. THE PROMISES OF BIG WAIVER

The State Innovation waiver gives HHS the power to "substantially revise and not [just] modestly tweak" the core provisions in the statute and thus typifies the phenomenon of "big waiver."[35] Plus, the ACA adds some incentives for states to aim for transformative waivers. First, the structure of the ACA's waiver – that CMS must justify denials and report them to Congress – "indicates Congress's approval of waivers with broad effects."[36] And second, the ACA creates a process for "coordinating" the State Innovation waiver with a Medicaid waiver in a single application, along with other federal health laws that contain waivers.[37] The State Innovation waiver is, by any measure, significant in its scope.

Statutes frequently provide agencies the power to "modify" limited provisions, or to "handle an unusual application" or "exceptional case."[38] This kind of ubiquitous enforcement discretion, however, does not capture the capacious essence of the State Innovation waiver. Instead, the theory of "big waiver" poses that waivers which strike at the "heart of the statutory framework – the express provisions of it that seem most central to its effective operation as a regulatory mechanism" represent a unique legislative technique whose "operation is also clearly more legally consequential than" either little waivers or enforcement discretion.[39] The State Innovation is a paradigm "big" waiver.[40]

Scholars have foretold both promising and perilous aspects of statutory big waiver.[41] Barron and Rakoff's defense of big waiver highlighted its potential to break legislative gridlock by creating an escape hatch for substantive provisions, as well as to make legislation flexible enough to

34. *See* Christina Cousart & Trish Riley, "Administration Proposes Significant Policy Changes for State Insurance Markets through new 1332 Waiver Guidance," NASHP.org (Oct. 23, 2018). *See also* Timothy S. Jost, "Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State," COMMONWEALTH FUND BLOG (Oct. 30, 2018).

35. Barron & Rakoff, *supra* note 4, at 278.

36. *Id.* at 282 n.54

37. 42 U.S.C. § 18052(a)(5).

38. Barron & Rakoff, *supra* note 4, at 277.

39. *Id.* at 291.

40. *See id*. at 281.

41. *E.g.*, Abbe R. Gluck et al., Essay, *Unorthodox Lawmaking, Unorthodox Rulemaking*, 115 COLUM. L. REV. 1789, 1818 (2015); Martin A. Kurzweil, *Disciplined Devolution and the New Education Federalism*, 103 CAL. L. REV. 565, 567–68 (2015); Zachary S. Price, *Politics of Nonenforcement*, 65 CASE W. RES. L. REV. 1119, 1137 (2015); *see also* David Russell, *Administrative Balance*, 71 ARK. L. REV. __ (forthcoming 2019) [http://perma.cc/HDJ4-TD4F].

withstand changing circumstances and unforeseen events.[42] Through big waiver, a statute may get updated without going through the pain of enacting new legislation.[43] From a federalism perspective, big waiver may encourage state experimentation by providing a federal regulatory safety net, expert coaching, and necessary funding.[44] It may also encourage discourse between federal agencies, with nationwide perspective and substantive expertise, and state policymakers, with perspective on the needs of discrete populations and markets.[45] That is, it may "foster a more engaged federalism debate between federal and state agencies."[46]

The ACA's big waiver for State Innovation, in particular, also holds promise for meaningful experimentation in health reform, balancing the goals of universal, affordable, comprehensive coverage with state-by-state variations on how best to pursue those goals.[47]

On the other hand, big waiver can diffuse accountability for essential policy decisions.[48] Big waiver also can subject a statutory scheme to political risks after enactment due to its outsized reliance on the administering agency.[49] And, of course, a big waiver improperly calibrated can "swallow the statute's regulatory protections entirely,"[50] potentially tearing down the statutory infrastructure.

The State Innovation waiver has been available for less than two years, which is hardly enough time to judge conclusively whether it fulfills big waiver's promises or succumbs to its pitfalls. Instead, a multi-front political effort to fragment and undermine the ACA has produced less-than-ideal conditions for observing the statutory waiver because this fragmentation has altered the baseline rules and intended implementation of the statute itself.

II. THE FRAGMENTATION OF THE ACA

The promise of big waiver depends in large part on the existence and enforcement of the statute itself. The ACA never reached its full intended enforcement due to litigation, legislation, and executive attacks that

42. *Id.* at 309-11.

43. *Id.*

44. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1166. *See also* Gluck, *Unorthodox*, *supra* note 38 (arguing that waivers "give the agency space to allow for special types of policy experimentation").

45. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1164.

46. *Id.*

47. *See id.* at 1162-64.

48. *See* Gluck, *Unorthodox*, *supra* note 41 ("at least some of the time, these [waiver] delegations also derive from a desire to shift accountability for difficult decisions or costs outside of the federal government").

49. *Cf.* Kurzweil, *supra* note 41, at 628 (describing political risks flowing from the "disciplined devolution model" of big waiver).

50. McCuskey, *Agency Imprimatur*, *supra* note 3, at 1139.

fragmented its infrastructure during the building phase and beyond. Crucial for the purposes of this Essay, fragmentation has targeted each piece of the statute subject to the State Innovation waiver: the individual mandate, the employer mandate, qualified health plan and essential benefits provisions in the individual market, the individual market risk-pooling and exchange rules, the premium assistance subsidies, and the cost-sharing reductions.[51] While the ACA has thus far survived intact, it has scars. The uncertainty generated by the attacks in all three branches of government has further undermined the ACA and the climate for states considering waivers for alternative programs.[52]

A. Fragmentation by Litigation

The ACA has faced constant attack from litigation challenges targeting the individual mandate, Medicaid expansion, employer mandate, premium subsidies, cost-sharing assistance, and, ultimately the constitutionality of the entire statute. The challenges to the individual mandate and Medicaid expansion started almost immediately after enactment of the ACA. In *National Federation of Independent Business v. Sebelius*,[53] the Supreme Court upheld the individual mandate as an appropriate use of Congress's taxation power, but fragmented the Medicaid expansion by holding that it could not be enforced as a mandatory Medicaid rule. *NFIB*'s revision to the ACA forever altered the statute's intended uniformity and universal coverage strategy by permitting states to refuse this piece of the coverage puzzle and to negotiate for diluted and questionably-legal modifications to it.[54] Although the State Innovation waiver cannot suspend Medicaid law, recalcitrant states' ability to refuse coverage for residents who cannot afford subsidized insurance on the exchanges fragmented the ACA's universal coverage strategies and cost considerations.[55]

The employer mandate remains in full effect, but delayed enforcement and litigation attacks diluted some of its intended uniformity. Most notably, the Supreme Court in *Burwell v. Hobby Lobby Stores, Inc.*[56] held that part of the preventive services mandate could not be enforced against secular, for-profit employers whose owners had religious objections to contraception, even if those beliefs were medically erroneous.[57] HHS under the Obama

51. *See* Part I.A., *supra*.
52. *See* Larry Levitt, *Is the Affordable Care Act Imploding?*, 317 JAMA 2051 (2017).
53. 567 U.S. 519, 589 (2012).
54. *See* Huberfeld et al., *supra* note 23, at 29; Watson, *supra* note 23, at 214.
55. *See* Watson, *supra* note 23, at 214.
56. 134 S. Ct. 2751 (2014).
57. *Id.* at 2782.

administration already had established an accommodation for *religious*, *non-profit* organizations with religious objections.[58] *Hobby Lobby* exempted a much larger swath of employers from the regulation and the line on these exemptions is still being challenged.[59]

Litigation challenged the availability of the premium assistance tax credits, designed by the ACA to make policies sold in the individual market exchanges more affordable to those who previously had foregone insurance due to its cost.[60] In *King v. Burwell,*[61] the Supreme Court upheld the ACA's provision for these premium credits, interpreting sloppy drafting by Congress in light of the statute's broader purpose: "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter."[62] Thus, the premium assistance credits remain in effect, but the pendency of the *King v. Burwell* litigation during the opening of the exchanges certainly added uncertainty to the process.

The cost-sharing reduction (CSR) payments in the ACA, designed to defray the impact of exchange plans' deductibles on individuals' medical costs, met litigation attack after the ACA's implementation. In *House v. Burwell,*[63] members of the U.S. House of Representatives sued the Secretaries of HHS and Treasury, alleging that the CSR payments they administered constituted unappropriated funds prohibited by the Constitution.[64] The district court granted the requested injunction against paying the CSR payments, but stayed the injunction pending appeal.[65] On appeal, several states intervened to support the CSR payments.[66] Ultimately, the House and HHS settled the appeal,[67] but the administration issued a memo prohibiting

58. *See* 45 CFR §§ 147.131(b)(4), (c)(1); 26 CFR §§ 54.9815–2713A(a)(4), (b) (cited in *Hobby Lobby,* 134 S. Ct. at 2782).

59. *See e.g.*, Zubik v. Burwell, 136 S. Ct. 1557, 1562 (2016).

60. *See Premium Assistance Tax Credit*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/premium-tax-credit/.

61. 135 S. Ct. 2480 (2015).

62. *Id.* at 2496.

63. 185 F. Supp. 3d 165 (D.D.C. 2016).

64. *Id.*

65. *Id.*

66. *See* Timothy Jost, *Latest Motion in House v. Price Has a Significant Impact on the Future of CSR Payments*, HEALTH AFFAIRS BLOG (Aug. 2, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170802.061363/full/.

67. *See* Timothy Jost, ACA *Round-Up: Court Blocks New Contraceptive Coverage Rules; CSR Case Settlement; Final Tax Bill Released; Open Enrollment Closes*, HEALTH AFFAIRS BLOG (Dec. 16, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171215.665944/full/.

the payment of CSRs to insurers.[68] In the interim, the CSR's uncertain fate wrought havoc on the individual market plans for 2017's open enrollment.[69]

Litigation threats to the ACA thus far cast temporary shadows of uncertainty over many of its provisions, but ultimately had little direct impact on the provisions subject to State Innovation waivers for commercial insurance markets.[70] That could soon change. In *Texas v. U.S.*, twenty states under Republican governors sued HHS, arguing that a legislative change to the individual mandate starting in 2019 renders the *entire* ACA unconstitutional – and these plaintiffs found a federal district court judge who agrees with them.[71] This current litigation warrants a transition to discussing fragmentation by legislation, before returning to its potential impacts on the climate for state waiver.

B. Fragmentation by Legislation

Opponents of the ACA won the 2016 presidential election, as well as control of both houses of Congress just months before the State Innovation waiver became available. This political turn of course ushered in a period of attempted legislative repeal, and then fragmentation. Among the provisions subject to the State Innovation wavier, thus far only the individual mandate has taken a direct hit through legislation, though the weakened mandate and the threat of broader legislative repeal have rippled throughout the commercial markets.

One of the first legislative shots to the ACA's stability came softly in 2014, when Congress stopped funding for a temporary "risk-corridor" program intended to encourage insurers to participate in the exchanges by "shielding them from the risk of pricing and selling new individual product

68. Memorandum from Eric Hargan to Seema Verma (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf. Insurers found a way to incorporate the CSR amount into premiums, however, in a nuanced and complex process known as "silver-loading" because it rolls the CSR amount into the "silver" level plan premiums. *See* '*Silver-loading' helped save the ACA's exchanges in 2018. Now, the Trump admin may ban it*, ADVISORY.COM (April 17, 2018, 7:30 AM), https://www.advisory.com/daily-briefing/2018/04/17/exchanges-silver-load.

69. Rabah Kama et al., *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums*, KFF.ORG (Oct. 27, 2017) https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/. (Explaining that the CSR challenge created "substantial uncertainty" for insurers trying to set rates for exchange plans during open enrollment).

70. The impact of *NFIB v. Sebelius* on the ACA's implementation as a whole, however, remains significant. *See* Nicole Huberfeld, NFIB v. Sebelius *at 5*, 12 U. ST. THOMAS J.L. & PUB. POL'Y 48 (2017).

71. *See, e.g.*, Lawrence Gostin, "Texas v United States: The Affordable Care Act Is Constitutional and Will Remain So," JAMA FORUM (Dec. 17, 2018). Complaint available at https://www.texasattorneygeneral.gov/files/epress/Texas_Wisconsin_et_al_v._U.S._et_al_-_ACA_Complaint_(02-26-18).pdf.

they had never sold before."[72] The federal government ended up owing billions of dollars to insurers, and the insurers have sued to enforce those payments in pending litigation.[73]

On a larger scale, Republican legislators introduced several so-called "repeal-and-replace" bills in 2017, proposing substantial changes to the statute under the auspices of the budgetary reconciliation process.[74] All of these efforts failed to pass, several of them in dramatic fashion.[75] But the real threat of repeal, heightened by the haste with which several bills were introduced, still injected tumult into the insurance markets.[76]

Following a period of relative calm after the close of the budget reconciliation deadline, in December 2017, Congress passed a tax reform bill that included removal of the individual mandate's tax penalty.[77] This legislative move on the individual mandate actually leaves the mandate provision technically intact, but makes the dollar amount of the penalty "zero" beginning in 2019.[78] Shortly after passing the tax bill, Republicans introduced a bill targeting repeal of the employer mandate, though that effort stalled.[79] After Democrats regained a majority of the House in the November 2018 midterm elections, the threat of wholesale legislative repeal has faded for a time.[80]

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72. Katie Keith,"Litigation Update: Challenges To Kentucky's Medicaid Waiver, Cost-Sharing Reductions, And Risk Corridors," HEALTH AFFAIRS BLOG (Jan. 25, 2018).

73. *Id.*

74. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1140-141, 1164-67 (detailing some of these efforts). *See also* Dylan Scott & Sarah Kliff, "Why Obamacare repeal failed, and why it could still come back," VOX.COM (Jul. 31, 2017), https://www.vox.com/policy-and-politics/2017/7/31/16055960/why-obamacare-repeal-failed.

75. *See* Susan Cornwell, *Republicans fail again to kill off Obamacare in the Senate*, REUTERS.COM (Sept. 25, 2017), https://www.reuters.com/article/us-usa-healthcare/republicans-fail-again-to-kill-off-obamacare-in-senate-idUSKCN1C00BT; Dan McLaughlin, *How Republicans Went Wrong on Health Care*, NATIONAL REVIEW (July 28, 2017) (arguing that, in the saga of failed repeal bills, "defeat had many fathers"), https://www.nationalreview.com/2017/07/republican-health-care-bill-defeat-understanding-failure/.

76. *E.g.*, Margot Sanger-Katz, *The Upshot: How Failure of the Obamacare Repeal Affects Consumers*, N.Y. TIMES (Sept. 26, 2017), https://www.nytimes.com/2017/09/26/upshot/how-the-failure-of-obamacare-repeal-affects-consumers.html.

77. *See* Timothy Jost, *The Tax Bill and the Individual Mandate: What Happened, and What Does it Mean?*, HEALTH AFFAIRS BLOG (Dec. 20, 2017), 10.1377/hblog20171220.323429.

78. *Id. See also* Annie L. Mach, THE INDIVIDUAL MANDATE FOR HEALTH INSURANCE COVERAGE: IN BRIEF, CONG. RESEARCH SVC. (March 19, 2018), https://fas.org/sgp/crs/misc/R44438.pdf.

79. *See* Robert Pear, *Individual Mandate Now Gone, G.O.P. Targets the One for Employers*, N.Y. TIMES (Jan. 14, 2018), https://www.nytimes.com/2018/01/14/us/politics/employer-mandate.html.

80. *See* Sean Sullivan, *Republicans abandon the fight to repeal and replace Obama's health care law*, WASH. POST (Nov. 7, 2018); Donald Moulds, et al., *The Midterm Election Results Have Big Implications for Health Care*, COMMONWEALTH FUND BLOG (Nov. 7, 2018).

But the removal of the individual mandate's tax penalty has many ramifications for the ACA. The individual mandate has long been thought necessary to stabilize insurance risk pools by bringing healthy people into the mix.[81] The individual mandate thereby supports guaranteed-issue, pre-existing condition protections, and community-ratings (forcing insurers to cover anyone who can pay and to not charge sick people more than healthy ones), because without a mandate, people could forego paying premiums while healthy, then wait until they got sick to start buying insurance.[82] Without a mandate, presumably many healthy people will not have sufficient incentive to join the risk pool, leaving insurers with sicker and more costly pools from which to draw premiums.[83] Thus, repeal of the penalty "undoubtedly [will] do harm . . . to insurance markets . . . . The effect will vary from state to state, but premiums will increase in the individual market across the board, and increase dramatically in some states," with insurers potentially abandoning states with smaller individual markets.[84]

The tax bill's zero-out of the individual mandate penalty has set up a dual litigation-executive challenge in the *Texas v. U.S.* case. Plaintiff states' legal theory is this: *NFIB v. Sebelius* upheld the individual mandate's constitutionality as a tax, therefore now that the tax penalty in the mandate is removed, the mandate itself has no constitutional basis and renders the rest of the statute unconstitutional with it.[85] This is a legally dubious constitutional argument that also seems to ignore *NFIB v. Sebelius*'s holding about severability in the ACA.[86] And yet, the Department of Justice on behalf of defendants, responded to the states' request for preliminary injunction by espousing plaintiffs' arguments that the individual mandate is unconstitutional and that the guaranteed-issue and community-rating

81. *See* David M. Cutler & Jonathan Gruber, *The Affordable Care Act is Constitutional*, 156 ANNALS INT. MED. 660 (2012) (explaining the "three-legged stool" theory). *See also* Avik Roy, *How the Heritage Foundation, a Conservative Think Tank, Promoted the Individual Mandate*, FORBES (Oct. 20, 2011, 8:26AM), https://www.forbes.com/sites/theapothecary/2011/10/20/how-a-conservative-think-tank-invented-the-individual-mandate/#cc9726861877.

82. Cutler & Gruber, *supra* note 81.

83. Robert Pear*, Without the Insurance Mandate, Health Care's Future May Be in Doubt*, N.Y. TIMES, Dec. 18, 2017.

84. Jost, *The Tax Bill*, *supra* note 77.

85. *See* Abbe Gluck & Nick Bagley, *Strange Bedfellows in the Texas Lawsuit over the Affordable Care Act*, TAKE CARE BLOG (June 14, 2018). https://takecareblog.com/blog/strange-bedfellows-in-the-texas-lawsuit-over-the-affordable-care-act.

86. *See, e.g.*, Brief of Amici Curiae Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, Ilya Somin, and Kevin C. Walsh in Support of Intervenors, *Texas v. U.S.*, No. 4:18-cv-00167-O (Dkt. 121) (N.D. Tex. June 14, 2018), https://theincidentaleconomist.com/wordpress/wp-content/uploads/2018/06/Texas-v.-US-Law-Profs-Amicus-Br.pdf.

provisions must fall with it.[87] The extraordinary position taken by the DOJ caused rifts within its staff, and implicates the Constitution's Take Care Clause, which obliges the executive branch to defend and enforce federal laws with only limited exceptions.[88]

Which brings us to attacks on the ACA from the executive branch.

C. Nullification by Executive Non-Enforcement

Although neither legislative nor litigation efforts to break the ACA thus far have succeeded, the statutory infrastructure and implementation were altered irreparably during its infancy and to the present day.[89] Since January 2017, when the executive branch turned over to those opposed to the ACA, numerous executive actions have undermined the statute, amplifying the effects of litigation and legislation attacks.

Among the executive actions aimed at weakening the markets served by the ACA, the administration dramatically cut funding to support services for the individual market exchanges, particularly the navigator program to help qualified individuals sign up for policies, and ending advertisement for the exchanges almost entirely, as well as shutting down the exchange website for maintenance during peak open enrollment season.[90] The administration also has authorized the sale and subsidization of short-term and association plans that circumvent most of the ACA's core protections, potentially draining healthy people from the insurance exchange risk pools, and thereby making

87. *See* Federal Defendants' Memorandum in Response to Plaintiffs' Application for Preliminary Injunction, *Texas v. U.S.*, No. 4:18-cv-00167-O (Dkt. 92) (N.D. Tex. June 7, 2018) https://www.justsecurity.org/wp-content/uploads/2018/06/ACA.Azar_.filing.pdf.

88. *See, e.g.*, Ian Samuel & Leah Litman, *The Establishing Shots of a Heist: The Trump DOJ Meets the Affordable Care Act*, TAKE CARE BLOG (June 7, 2018) https://takecareblog .com/blog/the-establishing-shots-of-a-heist-the-trump-doj-meets-the-affordable-care-act; Katie Keith, *Defending the ACA Versus Enforcing the ACA in Texas v. United States*, HEALTH AFFAIRS BLOG (Aug. 8, 2018), 10.1377/hblog20180808.552397.

89. *See, e.g.*, Julie Rovner, *Timeline: Despite GOP's Failure to Repeal Obamacare, the ACA Has Changed*, WASHINGTON POST (April 5, 2018). https://www.washingtonpost.com/national/health-science/timeline-despite-gops-failure-to-repeal-obamacare-the-aca-has-changed/2018/04/05/dba36240-38b1-11e8-af3c-2123715f78df_story.html?utm_term=.fb291c3699e7.

90. *See* Ken Alltucker, *Trump administration slashes funding for Obamacare outreach program*, USA TODAY (July 10, 2018) https://www.usatoday.com/story/news/nation/2018/07/10/obamacare-cuts-mean-groups-have-less-sign-up-customers/773728002/; Sarah Kliff, *Trump is slashing Obamacare's advertising budget by 90%*, VOX.COM (Aug. 31, 2017) https://www.usatoday.com/story/news/nation/2018/07/10/obamacare-cuts-mean-groups-have-less-sign-up-customers/773728002/; Phil Galewitz, *Sunday Hours: Obamacare Website To Be Shut Down For Portion of Most Weekends*, KAISER HEALTH NEWS (Sept. 22, 2017) https://khn.org/news/hhs-to-close-insurance-exchange-for-12-hours-on-sundays-during-enrollment/.

exchange plans more expensive.[91] And, of course, it ended the CSR payments, as described above.

A new lawsuit filed by four cities alleges that the administration has been "waging a relentless campaign to nullify and ultimately sabotage" the ACA in violation of the Administrative Procedure Act and the Constitution's Take Care Clause.[92] The complaint includes the actions just described, as well as a litany of others alleged to have eliminated "protections that the ACA guarantees," deterred people from enrolling in exchange plans, "driving up costs" in the individual market, "working to decrease enrollment" in the exchanges, and refusing to defend the ACA.[93]

This death-by-one-thousand-cuts attack on the ACA has spillover effects even in the portions of the law not directly altered. For example, the employer group "has its own crisis because of increased cost-shifting and the growing ranks of the under-insured"[94] spurred in part by some states' rejection of the Medicaid expansion, and the widespread uncertainty over the operation of the exchanges, availability of subsidies, and risk-corridor payments to exchange insurers.

The ACA encountered delayed enforcement under a friendly administration,[95] and now concerted under-enforcement under a hostile administration. The politics and theories of administrative non-enforcement have a rich scholarly discourse,[96] which offer valuable context to the ACA's current state of non-enforcement, or – as some have put it – executive

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91. *See* Vanessa Romo, *4 Cities' Lawsuit Calls Drumpf Efforts To Undermine Obamacare Unconstitutional*, NPR .ORG (Aug. 2, 2018); Dylan Scott, *Trump's new plan to poke holes in the Obamacare markets, explained,* VOX.COM (Feb. 20, 2018) https://www.vox.com/policy-and-politics/2018/2/20/17031640/short-term-insurance-trump-obamacare.

92. *See* Complaint for Declaratory and Injunctive Relief, *City of Columbus v. Trump*, No. 18-cv-2364 (Dkt. 1) (Aug. 2, 2018).

93. *Id.*

94. Nicholas Terry, *State Law Reactions to Trumpcare*, THE WEEK IN HEALTH LAW PODCAST (Aug. 16, 2018), https://play.google.com/music/listen?u=0#/ps/I7jdil4fgte7nlmwoozui2cyavq.

95. Timothy Stoltzfus Jost & Simon Lazarus, *Obama's ACA Delays—Breaking the Law or Making It Work?*, 370 NEW ENG. J. MED. 1970 (2014) (discussing the Obama administration's delayed enforcement of parts of the Affordable Care Act).

96. Aaron L. Nielson, *How Agencies Choose Whether to Enforce the Law: A Preliminary Investigation*, 93 NOTRE DAME L. REV. 1517, 1518 (2018); Patricia L. Bellia, *Faithful Execution and Enforcement Discretion*, 164 U. PA. L. REV. 1753, 1769 (2016); Jeffrey A. Love & Arpit K. Garg, *Presidential Inaction and the Separation of Powers*, 112 MICH. L. REV. 1195, 1199-1200 (2014); Zachary S. Price, *Enforcement Discretion and Executive Duty*, 67 VAND. L. REV. 671, 697 (2014); Daniel T. Deacon, Note, *Deregulation Through Nonenforcement*, 85 N.Y.U. L. REV. 795, 796 (2010); Daniel Stepanicich, Comment, *Presidential Inaction and the Constitutional Basis for Executive Nonenforcement Discretion*, 18 U. PA. J. CONST. L. 1507, 1510-11 (2016).

sabotage.[97] For the purposes of this Essay, non-enforcement or sabotage of the statute poses potentially the most damage for the State Innovation waiver because the incentives for the waiver presume enforcement, and the realities of the waiver process depend on the will of the executive branch. As do the market conditions that determine whether the ACA's individual market exchanges can properly function.

By potentially shifting ACA funding to states who wish to pursue private-market strategies with non-ACA compliant coverage, the "State Relief and Empowerment" guidance administratively implements some of the failed legislative proposals of 2017.[98]

Beyond the existential threat posed by *Texas v. U.S.*, as of this writing the picture of ACA provisions subject to the Section 1332 waiver includes:

Waivable Provision	In Effect?	Fragmentation
(1) Individual Mandate	✘	Legislatively stripped of tax penalty as of 2019.
(2) Employer Mandate	✓	Litigation expanded exemptions for employer objections to women's preventive service coverage; premiums increased by market uncertainty.
(3) Exchanges: qualified health plan & essential benefits provisions	✓	Administratively undermined by short-term, off-exchange plans and by new waiver guidance.

97. *E.g.*, Abbe Gluck, *President Trump admits he's trying to kill Obamacare. That's illegal*, VOX.COM (Aug. 3, 2018); Elizabeth McCuskey, *Health Reform: Sabotage Edition*, PRAWFSBLAWG (Sept. 29, 2017).

98. *See* Timothy S. Jost, *Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State*, COMMONWEALTH FUND BLOG (Oct. 30, 2018).

(4) Individual market risk-pooling and exchange rules	✓	Administratively undermined by short-term off-exchange plans, curtailing consumer supports, risk-corridor payment withdrawal, withdrawal of executive support, and new waiver guidance.
(5) CSR payments	✘	Administratively terminated.
(6) Premium assistance tax credits	✓	Litigation challenge created period of uncertainty, but upheld.

III. BIG WAIVER UNDER STATUTORY SABOTAGE

The ACA's State Innovation waiver could allow states to wholly transform their health insurance markets by sanctioning alternative programs and, more importantly, by funding those alternative programs with the money allocated by the ACA's existing provisions.[99] As the National Conference of State Legislatures has advised, "Section 1332 waivers offer states an opportunity to fashion a new health insurance coverage system customized for local context and preferences, as long as they fulfill the aims of the ACA."[100] Before the ACA, states unquestionably had the power to enact transformative reforms without waivers, but very few did so successfully. State experimentation often is not feasible, or palatable, without an infusion of federal funding.

The question posed here is how the ACA's big waiver provision has fared in an atmosphere of uncertainty about the statute itself and executive hostility to it.

A. Waiver Applications for Market Stabilization

Faced with volatile markets, uncertain funding, and rising premiums in the individual market, states have for the most part pursued waivers that touch only a fraction of the State Innovation waiver's possible scope. In the first year of the waiver, with the threat of full-scale repeal lingering until days before open enrollment, waiver activity was rather limited. The handful of states that applied for State Innovation waivers for 2017 largely pursued

99. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at

100. Colleen Becker, *State Health Insurance Innovations through Section 1332 Waivers*, 26 LEGIS BRIEF (June 2018), NCSL.ORG, http://www.ncsl.org/research/health/state-health-insurance-innovations-through-section-1332-waivers.aspx.

small-scale market stabilization efforts.[101] Alaska, California, Hawai'i, and Vermont filed waiver applications in 2016, before the change in administrations.[102] CMS granted Hawai'i's waiver request related to its state fund for the small-business exchange required by the statute, in recognition of Hawai'i's special status under ERISA.[103] CMS denied Vermont's application for an alternative to the small-business exchange based on incomplete actuarial support.[104] California withdrew its waiver application seeking to allow undocumented immigrants to shop on the exchange without subsidies days before the inauguration.[105] Also days before the inauguration in January 2017, CMS accepted Alaska's application.[106]

Along with its efforts to undermine the ACA, the new administration issued an Executive Order on January 20, 2017 which signaled its intention to prioritize state flexibility in health reform "to the maximum extent permitted," pending legislative efforts at repeal.[107] The Order did not cite the State Innovation waiver – or any piece of the ACA – but it did instruct HHS to exercise "all authority and discretion available . . . to *waive*" any provision creating a fiscal burden on any state.[108] The new Secretary of HHS then explicitly encouraged state governors to apply for State Innovation

101. *See* Jennifer Tolbert & Karen Pollitz, *Section 1332 State Innovation Waivers: Current Status and Potential Changes*, KFF.ORG (July 6, 2017).

102. *See, e.g.*, Ctr. for Consumer Info. & Ins. Oversight, *supra* note 14.

103. Ctr. for Consumer Info. & Ins. Oversight, *Fact Sheet: Hawai'i Innovation Waiver*, CENTER MEDICARE & MEDICAID SERVICES (Dec. 30, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Hawaii-1332-Waiver-Fact-Sheet-12-30-16-FINAL.pdf [https://perma.cc/9GXA-RMTU].

104. Letter from Sylvia M. Burwell, Sec'y, Health & Human Servs., to Peter Shumlin, Governor, Vt. (June 9, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Vermont-Notice-of-Preliminary-Determination-of-Incompleteness-.pdf [https://perma.cc/AXF6-8DRA] (providing Notice of Preliminary Determination of Incompleteness to the Governor of Vermont).

105. Letter from Peter V. Lee, Exec. Dir., Covered Cal., to Kevin J. Counihan, Dir. & Marketplace Exec. Officer, U.S. Dep't of Health & Human Servs. (Jan. 18, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Application-Withdrawal-Request-01-18.pdf [https://perma.cc/34W8FUC2] [hereinafter Letter from Peter V. Lee].

106. Letter from Sylvia M. Burwell, Sec'y, U.S. Dep't of Health & Human Servs., to Bill Walker, Governor, Alaska (Jan. 17, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SMB-Letter-Gov-Walker-1332.pdf [https://perma.cc/8YXB-KMCB] [hereinafter Letter to Walker].

107. Exec. Order No. 13,765, 82 Fed. Reg. 8351, 8351 (Jan. 20, 2017).

108. *Id.*

waivers.[109] Minnesota submitted a waiver application shortly after receiving the Secretary's invitation.[110]

From March to September, 2017, the legislative efforts to repeal the statute as the 2017 October open enrollment period neared stirred chaos and uncertainty about whether the ACA's Exchanges would be funded and enforced at all.[111] To deal with this chaos, Iowa and Minnesota submitted waiver applications aimed at market stabilization, followed by Oregon and Oklahoma.[112] Minnesota requested pass-through funding for a reinsurance program, similar to what Alaska had requested and extending to the state's "Basic Health Program," as well.[113] In July 2017, CMS granted Alaska's reinsurance waiver.[114] Buoyed by this opportunity to patch their chaotic markets before the October open enrollment, other states sought to negotiate similar waivers.[115]

But CMS delayed ruling on several other waivers until late September – days before insurers had to submit their prices for the exchange open enrollment periods. CMS granted Minnesota's reinsurance waiver, but denied its request to pass funding through to its Basic Health Program.[116] Oklahoma had to withdraw its reinsurance waiver application after CMS missed its September 25 deadline for responding, rendering the proposed program "effectively inoperative" for the upcoming plan year.[117] Massachusetts submitted a waiver application in September 2017 seeking to pass through CSR and premium assistance payments to a state Premium

109. *See* Letter from Thomas E. Price, Sec'y, U.S. Dep't of Health & Human Servs., to State Governors (Mar. 13, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf [https://perma.cc/TPT9-TL8A].

110. *See* Letter from Mark Dayton, Governor, Minn., and Minn. Legislators, to Steven Mnuchin, Sec'y, U.S. Dep't of the Treasury, and Thomas E. Price, Sec'y, U.S. Dep't of Health & Human Servs. (May 5, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf [https://perma.cc/A7ZR-ENNJ] (application and cover letter thanking the Secretary for his letter to state governors and requesting "swift review" of Minnesota's application for a waiver on its state reinsurance program).

111. *See* Rabah Kamal, et al., "How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums," KFF.ORG (Oct. 27, 2017).

112. *See* Kaiser Family Foundation, "Tracking Section 1332 State Innovation Waivers," KFF.org (Aug. 23, 2018).

113. *Id.*

114. Letter from Governor Bill Walker to Lina Rashid, Senior Policy Advisor, CMS (July 31, 2017) (accepting final terms and conditions of waiver approval), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-InnovationWaivers/Downloads/Alaska-STCs-signed-by-Treasury.pdf

115. *See* Alison Kodjak, "Administration Sends Mixed Signals on State Health Insurance Waivers," NPR (Oct. 19, 2017).

116. Kaiser Family Foundation, *Tracking Section 1332 State Innovation Waivers*, KFF.ORG (Aug. 23, 2018).

117. Letter from Terry Cline (OK Sec'y of HHS) to Steven Mnuchin (U.S. Sec'y Treas.) and Thomas E. Price (U.S. Sec'y HHS) (Sept. 29, 2017), https://www.ok.gov/health2/documents/Oklahoma%201332%20Waiver%20Withdrawal%209.29.17.pdf.

Stabilization Fund, but CMS deemed the application incomplete and responded that there was insufficient time to implement it for the upcoming plan year, given the requirements of public comment.[118] And finally CMS granted Oregon's reinsurance waiver on October 18, 2017.[119]

Iowa submitted a slightly more ambitious waiver in late August 2017, seeking to establish a reinsurance program, reallocate CSR and premium assistance payments from low-income enrollees to all individual market enrollees, alter the enrollment periods and assistance-qualification standards and procedures, and offer only silver-level plans on the exchange.[120] The waiver presented several problematic requests and lacked some actuarial support; nonetheless, the state withdrew its application three months later with the comment that the State Innovation "Waivers in the Affordable Care Act are unworkable."[121]

Thus, in 2017, State Innovation waivers focused almost entirely on reinsurance programs to simply stabilize premiums in the exchanges. Considering the full scope of waivable provisions, this is a pretty modest, though very important, experiment.

In 2018, with cessation of the CSR payments and the repeal of the individual mandate penalty assured and premiums for the upcoming plan year expected to rise, states again sought waivers aimed at stabilizing the individual market premiums. New states joined the reinsurance fold, with Maine, Maryland, New Jersey, and Wisconsin all securing versions of the reinsurance or premium stabilization fund waivers.[122] Congress's refusal to appropriate any money for ACA market stabilization in its March 2018 budget likely will further encourage states to consider waivers.[123]

Ohio's Insurance Department submitted an application to waive whatever was left of the individual mandate, likely because the state legislature had pre-committed to seeking waiver of the mandates long before Congress

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118. Kaiser Family Foundation, "Tracking Section 1332 State Innovation Waivers," KFF.org (Aug. 23, 2018).

119. *Id.*

120. *See* Timothy Jost, *Iowa Waiver Application Presents Crucial Decision Point for Administration*, HEALTH AFFAIRS BLOG (Aug. 24, 2017).

121. Letter from Doug Ommen (IA Ins. Com'r) to Steven Mnuchin (U.S. Sec'y Treas.) and Eric D. Hargan (Acting U.S. Sec'y HHS) (Oct. 23, 2017).

122. Kaiser Family Foundation, *Tracking Section 1332 State Innovation Waivers*, KFF.ORG (Aug. 23, 2018). *See also* Heather Howard, *More States Looking to Section 1332 Waivers*, STATE HEALTH & VALUE STRATEGIES (Aug. 22, 2018), https://www.shvs.org/more-states-looking-to-section-1332-waivers; Colby Itkowitz, *The Health 202: meet the unicorn of health-care policy*, WASHINGTON POST (July 31, 2018).

123. *See* Susannah Luthi, *Insurance market stabilization out: a look at Congress's spending omnibus*, MODERN HEALTHCARE (March 21, 2018), http://www.modernhealthcare.com/article/20180321/NEWS/180329973.

passed the Tax Bill.[124] CMS deemed the application incomplete, because it contained none of the statutorily-required explanations of the comparable comprehensiveness and affordability in the state proposal – nor did it actually include "a description of any program implementing a waiver plan" or even "the reason that the state is seeking" the waiver.[125]

At the close of 2018, a total of eight states had received State Innovation waivers and an additional eight had applied, but not received waivers due to timing or incomplete information.[126] These waivers "modestly tweak" the ACA's requirements, bearing the hallmark of "little waiver."[127] Yet they do so in ways crucial to the survival of the statute, thus fulfilling some of big waiver's promise to make its statute flexible enough to withstand dramatic shifts in circumstance.

B. Waiting in the Wings

This small number of states applying for waivers in the program's initial two years belies a wave of pre-application activities in state legislatures. Nineteen states have enacted laws related to pursuit of State Innovation waivers, some advising pursuit of a waiver and some, like Ohio's, binding their executives to apply.[128] In the first four months of 2018 alone, thirteen state legislatures considered *new* bills about State Innovation waivers.[129] Colorado and Virginia enacted state laws authorizing application for a waiver to offer catastrophic plans to all state residents, lifting the age and hardship limitations from the ACA.[130] A second Colorado bill authorizing a reinsurance program waiver application is pending.[131] Likewise, Hawaii, Idaho, Louisiana, Missouri, and Oklahoma introduced legislation on reinsurance waivers.[132]

Connecticut has gone further toward big waiver in its pre-application legislation. Connecticut has introduced legislation with a state-level individual mandate, reinsurance program, and a task force on seeking a

124. OHIO REV. CODE ANN. § 3901.052 (West Supp. 2017).

125. Letter from Randy Pate (CMS Deputy Administrator) to Jillian Froment (Director, OH Dept. of Ins.) (May 17, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Ohio-Notice-Preliminary-Determination-Incomplete.pdf.

126. *See* Kaiser Family Foundation, *Tracking Section 1332 State Innovation Waivers*, KFF.ORG (Aug. 23, 2018).

127. *See* Barron & Rakoff, *supra* note 4.

128. *See* Richard Cauchi, *Innovation Waivers: State Options and Legislation Related to the ACA Health Law*, NCSL.ORG (Aug. 22, 2018), http://www.ncsl.org/research/health/state-roles-using-1332-health waivers.aspx#1332_Legislation.

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.*

waiver, as well as a Medicaid public option.[133] Indiana has given nearly blanket authorization for its governor to seek and implement "a state plan of innovation that meets the waiver requirements established under federal law."[134]

Outside of the waiver context, several states have recently enacted state-level individual mandates to compensate for the rollback of the federal mandate and to maintain adequate risk-pooling in their individual markets.[135] States with new mandates include New Jersey (which has a State Innovation waiver for market stabilization), Vermont, and Washington, D.C., along with Massachusetts, whose mandate dates back to 2005.

States, of course, do not need a waiver to impose their own individual mandates. But they may need waivers to pursue some of the more ambitious and transformative reforms currently being debated in state legislatures, such as state single-payer systems and Medicaid-based public options.[136] Those waivers, presumably, would be closer to the scale of the "big" waiver that the ACA built. But no state currently has either committing legislation or an application for such a waiver.

Uncertainty about the baseline conditions year-to-year, or month-to-month, is not a particularly conducive environment for bold experimentation.[137] In health insurance reform, the real-world effects of experimentation can be felt keenly and swiftly by constituents. It makes sense that in a time of regulatory uncertainty and resulting market volatility, states would seek limited waivers that work to plug holes in their markets and gird against further instability.

C. Fulfilling the Promise of Big Waiver

In the earliest stages of its implementation, the ACA's State Innovation waiver did relatively little to embrace the theoretical promises of big waiver: offering flexibility for a regulatory regime to withstand upheaval, updating a statute's pillars without resort to legislation, and encouraging state experiments in the service of the statute's goals.[138] As Congress proved in

133. Cauchi, *supra* note 128.

134. *Id.*

135. *See* Alex Pappas, *Liberal states impose new individual mandate ahead of ObamaCare rollback*, FOXNEWS.COM (July 6, 2018) https://www.foxnews.com/politics/liberal-states-impose-new-individual-mandate-ahead-of-obamacare-rollback.

136. *See* Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 NEW ENG. J. MED. 5 (Jan. 4, 2018). *Cf.* Heather Howard & Galen Benshoof, Health Affairs Blog Post, *1332 Waivers and the Future of State Health Reform*, 15 YALE J. HEALTH POL'Y L. & ETHICS 237, 237 (2015); John E. McDonough, *The Demise of Vermont's Single-Payer Plan*, 372 NEW ENG. J. MED. 1584, 1585 (2015).

137. *Cf.* Kristen Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 801–02 (2014).

138. *See* Barron & Rakoff, *supra* note 4, at 309-11.

2017, it is not particularly agile at revising existing law or making new law – at least when it comes to health care. The ACA waivers granted in the same period illustrate the nimbleness contemplated by big waiver theory in that they allowed states to adapt to chaos in their insurance marketplaces, as legislative rewriting failed. Still, it was not the "bigness" of the waiver that enabled this flexibility, but rather the important tweaks to funding for reinsurance in the individual markets. And while the reinsurance waivers in a handful of states may have stabilized those markets for a few years, these waivers have done almost nothing to shore up the rest of the statute against sustained attack.

More profoundly, big waiver may encourage state experimentation[139] and discourse between federal agencies and state policymakers, offering federal substantive expertise and nationwide perspective, as well as state-level population needs and creativity.[140] While some of the eight state waivers thus far have involved the kind of detailed communication between agencies and states on actuarial projections and logistics, the process has already been fraught, at times, with delay and opacity from HHS, frustrating hopeful states. HHS's words of encouragement have not always matched the agency's actions. The State Innovation waiver, as enacted, holds considerable promise for meaningful state experimentation in health reform.[141] That potential, however, remains untapped.

Overall, the theoretical promises of "big waiver" remain largely unrealized in the chaotic first two years of the ACA's experiment, underscoring the reality that finding a replacement for the ACA's commercial insurance infrastructure is no easy task.

Some intrepid states have signaled they may be up to that task sooner rather than later. Chaos at the federal level has spawned nascent efforts by states to replace the fragmented ACA infrastructure with their own single-payer systems. As of this writing, nineteen state legislatures have introduced single-payer bills, though only Vermont has enacted one.[142] Practically, to fund and enforce a state-level single-payer system will require at least a State Innovation waiver to suspend the ACA's commercial market rules, as well as pass-through funding from its exchange and subsidy provisions.[143] If states

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139. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1166. *See also* Gluck, *Unorthodox*, *supra* note 41, at (arguing that waivers "give the agency space to allow for special types of policy experimentation").

140. *See id.* at 1164.

141. *See id.* at 1162-64.

142. *See* Erin Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA and State Single-Payer Health Care*, (manuscript and data compilation on file with author).

143. *See, e.g.*, Douglas Hervey, et al., *State Single Payer And Medicaid Buy-In: A Look At California, New York, And Nevada*, HEALTH AFFAIRS BLOG (June 30, 2017),

do pursue these big waivers, administrative discretion will play a crucial role in determining whether state plans fit within the comprehensiveness, affordability, and budgetary guardrails in the State Innovation waiver.[144] Administrative and political will at the federal level to give imprimatur and pass-through funding to this type of experiment may play an even more directive role, such that states seeking transformative flexibility may wait for more favorable political climate to go "big."[145]

The new "State Relief and Empowerment" guidance,[146] however, signals both an administrative retreat from the promises of big waiver theory, and a pivot toward its perils. As the name change from "Innovation" to "Relief and Empowerment" implies, the administration views the waiver as a way to "relieve" states from the statute's requirements, and shifts the aim from novel experiments to simply giving states greater authority to work around the federal regulations.[147]

CMS Administrator Seema Verma explained that the new guidance intends to "empower[] states to address the problems caused by the ACA by . . . giving them broader flexibility to waive ACA regulations" and "get out from under the onerous rules imposed by the ACA."[148] Verma blamed the lack of ambitious waivers in 2017 on the requirement that a state provide projections of how many people would "take up" comprehensive coverage under its plan – including among vulnerable populations.[149] Under the relaxed standard of the new guidance, states need only show that a comparable number of people would have "access" to comprehensive coverage on the whole.[150]

While the new guidance eliminates some administrative burdens on states seeking waivers, it narrows the focus of waivers to private-market reforms

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10.1377/hblog20170630.060852; McDonough, *supra* note 136, at 1585 (detailing Vermont's plan and noting the necessity of a State Innovation – "1332" – waiver to its feasibility); STATE OF VERMONT, GREEN MOUNTAIN CARE: A COMPREHENSIVE MODEL FOR BUILDING VERMONT'S UNIVERSAL HEALTH CARE SYSTEM 4, 34-36 (2014), http://hcr.vermont.gov/sites/hcr/files/pdfs/GMC%20FINAL%20REPORT%20123014.pdf (same). *See also* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 78 OHIO ST. L. J. 843 (2018).

144. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1166-67.

145. Giovannelli & Lucia, *supra* note 29.

146. State Relief and Empowerment Waivers, 83 Fed. Reg. at 53,575.

147. *Compare* INNOVATION, MERRIAM WEBSTER ("the introduction of something new; a new idea, method, or device) *with* EMPOWERMENT, MERRIAM WEBSTER ("the granting of the power, right, or authority to perform various acts or duties").

148. Seema Verma, *New State Relief and Empowerment Waiver Guidance Gives States Tools to Help Fix Broken Health Insurance Markets*, CMS.GOV BLOG (Oct. 22, 2018).

149. *See id.*

150. *See id. See also* Katie Keith, *Feds Dramatically Relax Section 1332 Waiver Guardrails*, HEALTH AFFAIRS BLOG (Oct. 23, 2018).

and explicitly prioritizes private coverage over public – including short-term and association plans in the favored "private" mix.[151] While the ACA's combined Medicaid and State Innovation waiver application process remains available, CMS will no longer consider "savings accrued under either proposed or current Section 1115 Medicaid or CHIP demonstrations" in "the assessment of whether a proposed State Innovation Waiver meets the deficit neutrality requirement"[152] – a deterrent to state system-wide reform proposals.[153] CMS also has promised to release "Waiver Concepts" to initiate discussions, signaling that states need not drive innovation and that CMS already has preferred models for waivers in mind.

The State Relief and Empowerment version of the ACA's waiver thus raises big waiver's inherent perils: diffusion of accountability from legislative to administrative enforcers, subjecting the statute to political whim, and threatening to undermine the statute's core provisions. Legislative expansions of the waiver provision failed to pass in Congress,[154] but the new administrative guidance implements some aspects of the failed legislation.[155] The ACA authorizes HHS to grant state waivers only on finding that the state proposal would result in coverage as comprehensive, affordable, and available to "a comparable number of people" as that provided under the statute's rules.[156] Yet under HHS's new interpretation of the statute, the Relief and Empowerment guidance allows waivers that make coverage of any kind technically "available" to a similar number of people, though that coverage would not be as comprehensive or affordable as under ACA rules.[157] And, by encouraging states to count in "coverage" those non-compliance short-term plans that exclude coverage for preexisting conditions and other key benefits and use health status underwriting, the guidance takes a further step toward allowing waiver to swallow the statute's core protections.

The effects of the State Relief and Empowerment guidance, like the State Innovation waiver itself, remain to be seen and depend largely on states' initiative. The portions of the State Relief guidance that ostensibly overreach

151. State Relief and Empowerment Waivers, 83 Fed. Reg. at 53,575.

152. *Id.*

153. *See, e.g.*, *See* Christina Cousart & Trish Riley, *Administration Proposes Significant Policy Changes for State Insurance Markets through new 1332 Waiver Guidance*, NASHP.ORG (Oct. 23, 2018).

154. *See* McCuskey, *Agency Imprimatur*, *supra* note 3, at 1164-65 (describing failed legislative proposals to super-size the waiver provision).

155. *See* Timothy S. Jost, *Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State*, COMMONWEALTH FUND BLOG (Oct. 30, 2018).

156. *See* 42 U.S.C. § 18052.

157. State Relief and Empowerment Waivers, 83 Fed. Reg. at 53,575.

the statute will be subject to litigation challenge if they result in waivers granted beyond the statutory guardrails.[158]

CONCLUSION

The ongoing fragmentation of the ACA by opposition in litigation, legislation, and executive undercutting has rendered the State Innovation waiver an urgent tool for patching the holes left in states' insurance markets. The cloud of uncertainty posed by constant attack may keep states thinking "small" in their prophylactic waiver requests, rather than catalyzing states to harness the "big" scope of the ACA's "big waiver" to pursue transformative reforms in a time of uncertainty in federal health policy.

The first two years of the ACA's State Innovation waiver, implemented by an administration hostile to the statute, saw the promises of big waiver theory largely unrealized, but its perils also largely avoided. The new State Relief and Empowerment guidance, however, makes it easier for the agency to suspend the statute's core protections for state waivers, while discouraging the combined public and private reforms that aim for system-wide innovation. It remains to be seen whether the ACA's fragmentation ultimately may be a catalyst of its State Innovation waiver, or an effect of it.

158. *See, e.g.*, McCuskey, *Agency Imprimatur*, *supra* note 3, at 1158-62 (detailing reviewability and review of Section 1332 waiver decisions through litigation.). *Cf.* Stewart v. Azar, 313 F. Supp. 3d 237 (D.D.C. 2018) (sustaining challenge to Medicaid waiver granted beyond statutory authority).