Tracking Health Reform

What the Evolution of 1332 Waivers Tells Us about Their Innovative Potential

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Abstract Section 1332 of the Affordable Care Act (ACA) provides states unprecedented flexibility to alter federal health policy. The authors analyze state waiver activity from 2019 to 2023, applying a comparative approach to understand waivers proposed by Georgia, Colorado, Washington, Oregon, and Nevada. Much of the waiver activity during this period focused on reinsurance programs. During the Trump administration, the most innovative waiver application was from Georgia, which sought to restructure and decentralize its individual market, moving away from the framework established by the ACA. While the Biden administration suspended Georgia's efforts, Democratic-led states have focused implementing waiver programs supporting and expanding on the ACA. This has included adopting public-option insurance plans offered by private insurers and expanding eligibility for qualified health plans for previously ineligible groups. The authors' analysis offers insights into contemporary health politics, policy durability, and the role of the administrative presidency.

Keywords 1332 waivers, Affordable Care Act, single payer

State innovation waivers, established under section 1332 of the Affordable Care Act (ACA), provide states with alternative strategies for improving access to affordable health insurance. These "1332 waivers," enacted by Congress during the Obama administration, first went into effect during the Trump administration and have subsequently expanded in scope during the Biden administration.

This article explores 1332 waiver activity from 2019 to 2023. Taking a comparative approach, we focus largely on the actions of Georgia,

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Colorado, Washington, Oregon, and Nevada to illuminate the shifting use of these waivers. With one exception (Georgia), much of the waiver activity during the Trump administration revolved around reinsurance programs. Although such initiatives were valuable, they did not realize the innovative promise of the waiver program that its architects envisioned. The early years of the Biden administration saw Democratic-leaning states seek more potentially significant reforms through waivers. However, we find that even as there has been a shift in states' efforts to innovate using 1332 waivers, they still have had more of a *potential* impact than an *actual* impact on state policy.

The Trump administration sought to spur conservative state activity by loosening the guardrails constraining 1332 waivers after the failures of congressional Republicans to repeal the ACA in 2017 (Tolbert and Pollitz 2018). But waivers did not prove to be a viable alternative to repeal for Republicans. Despite the regulatory changes, only Georgia pursued a waiver under the loosened regulatory guardrails, and as we highlight below, this effort was suspended after opposition from the Biden administration. In contrast, during the Biden administration, Democratic state policy makers have actively sought to expand and build on the ACA, including the creation of variations on the "public option" (which we call a "pseudo-public" option) and expanding eligibility for purchasing insurance on marketplaces. For Democratic-led states, this successful waiver activity could offer a model for future reforms.

How Innovative Are 1332s?

During congressional debate over the ACA, the role of 1332 waivers was largely overlooked, although John McDonough (2014) contended "the law's biggest impact on state innovation" was likely to be the newly created waiver program. The architect of 1332s, Senator Ron Wyden (D-OR), argued that the waivers had substantial innovative potential:

> [Every state] can innovate. They can go out and look at fresh approaches to address our health care challenges. That would include doing health reform without an individual mandate . . . with Section 1332 of the health reform bill. . . . [We want] to send a message to all the States all across the country that we invite them to come up with the kind of fresh, creative ideas that are going to help us hold health care costs down. . . . I hope some of those States will take a look at section 1332 that, in my view, ought to be attractive to elected officials all across the political spectrum.

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(https://www.congress.gov/congressional-record/volume-156/issue-47/senate-section/article/S1923-9)

Although the ACA provided unprecedented authority to states compared to other waiver programs, 1332 waivers have not yet lived up to their innovative promise (McDonough 2014). An earlier analysis of waiver activity found most state action has been focused on reinsurance programs (Wright et al. 2019). Such programs are useful, but they still fall short of the "fresh, creative ideas" for health care cost control envisioned by Wyden.

Waiver Activity during the Trump Administration

Reinsurance is a long-established insurance strategy for protecting against costly insurance claims by setting a threshold after which a third party pays claims. This early approach to 1332 waivers was popular among states seeking to stabilize their health insurance Marketplaces as the ACA's Transitional Reinsurance Program was designed to end in 2016 (CMS 2020b), which occurred during a time when marketplace premiums increased substantially (Holahan et al. 2017).

The focus on reinsurance generated tension within the Trump administration, however. In one of his first communications to the nation's governors, Health and Human Services Secretary Tom Price singled out reinsurance programs as an opportunity for 1332 waiver use by states (HHS 2017). This coincided, however, with Trump administration actions to destabilize the ACA's Health Insurance Marketplace by decreasing federal funding for enrollment, navigators, outreach, and advertising, which reduced insurer participation, increased premiums, and reduced enrollment (Cox et al. 2016).

Since 2017, 16 of the 17 approved 1332 waivers have included a reinsurance component (table 1), reflecting a rare area of bipartisan responses to the ACA (table 2). But subsequent waiver activity has grown increasingly more partisan.

The partisan divisions surrounding 1332 activity began after congressional Republicans failed to enact legislation to repeal and replace the ACA. As Timothy Jost argues, "With its 1332 waiver guidance, the Trump administration is attempting to accomplish through administrative fiat changes in the ACA that Republicans repeatedly tried and failed to bring about through legislation in 2017" (Jost 2018).

In October 2018, the Trump administration released 1332 waiver guidance that significantly loosened the guardrails for states (HHS 2017). This

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Table 1 State Waiver Activity, 2016–2023

State	Status	Date of federal action	Policy design
Alaska	Approved	2017, 2022*	Reinsurance
Colorado	Approved	2019, 2021*	Reinsurance
	Approved	2022	Colorado Option
Delaware	Approved	2019	Reinsurance
Georgia	Approved	2020	Reinsurance
	Suspended		Transition away from FFM
Hawaii	Approved	2016, 2021*	Waive SHOP provisions
Maine	Approved	2018, 2022*	Reinsurance
Maryland	Approved	2018	Reinsurance
Minnesota	Approved	2017, 2022*	Reinsurance
Montana	Approved	2019	Reinsurance
New Hampshire	Approved	2020	Reinsurance
New Jersey	Approved	2018	Reinsurance
North Dakota	Approved	2019	Reinsurance
Oregon	Approved	2017, 2022*	Reinsurance
Pennsylvania	Approved	2020	Reinsurance
Rhode Island	Approved	2019	Reinsurance
Virginia	Approved	2022	Reinsurance
Wisconsin	Approved	2018, 2021*	Reinsurance
Washington	Approved	2022	Expanded access to SBM and QHP
California	Withdrawn	2017	Undocumented access to SBM
Iowa	Withdrawn	2017	Iowa Stopgap Measure
Oklahoma	Withdrawn	2017	Reinsurance
Idaho	Deemed incomplete; pending	2019 2022	100%–138% FPL to credits to purchase QHP Reinsurance
Massachusetts	Deemed incomplete	2017	Waive CSR
Ohio	Deemed incomplete	2018	Waive individual mandate
Vermont	Deemed incomplete	2016	Waive SHOP provisions

Note: FFM = federally facilitated marketplace; SHOP = small business health options program; SBM = state-based marketplace; QHP = qualified health plan; FPL = federal poverty level.
*Renewal of existing waiver.

included allowing states to count ACA-noncompliant plans when calculating rates of insurance coverage, permitting states to analyze waiver impacts on the total population (rather than on particularly high-risk subpopulations), and offering subsidies to encourage the use of ACA-noncompliant insurance plans. The Centers for Medicare and Medicaid Services (CMS) released a set of waiver concepts concurrently with the

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Table 2 Executive Partisanship at Time of First Approval and Renewal of Section 1332 Waiver

	Republican governor	Democratic governor
Republican president	AK; GA; ME; MD; MT; NH; ND; WI	CO; DE; HI; MN; NJ; OR; PA; RI
Democratic president	AK*	CO*; HI*; ME*; MN*; OR*; VA; WA; WI*

*Renewal of existing waiver

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revamped guidance, suggesting the types of waiver applications that the administration would welcome. This included using waivers to redirect federal subsidies away from ACA Marketplace plans and toward short-term health plans and plans for older adults, regardless of income, all while discouraging Medicaid expansion or the creation of a public option (CMS 2018).

However, only one state, Georgia, submitted a nonreinsurance waiver application in the wake of the Trump regulatory changes. In March 2019, the Georgia General Assembly passed a law, the Patients First Act, authorizing the state to apply for a waiver, with support from 133 Republicans (with three Republican lawmakers opposing) and six Democrats (with 84 Democratic lawmakers opposing) (https://www.legis.ga.gov/legislation/20192020/184300.pdf). After passage, Governor Brian Kemp called it "a Georgia-centric system that encourages innovation and enhances health outcomes for families" (Office of the Governor 2019b). The proposed program comprised two parts, with the first focused on adopting a reinsurance program that the state estimated would result in a 10% reduction in individual marketplace premiums statewide (Office of the Governor 2019a).

The second, more controversial part of the application would have fundamentally overhauled the state's individual marketplace through a framework known as the Georgia Access Model. Specifically, it would have ended the state's participation in Healthcare.gov, created a geographically decentralized system of private brokers and insurers, allowed nonqualified health plans to be sold by the brokers, and withdrawn all federal support for navigators, outreach, education, and marketing. Advocates in the state and across the nation raised concerns that the waiver would increase premiums and result in tens of thousands of Georgians losing health insurance (table 3) (Straw and Levitis 2021; Young and Levitis 2020).

Even with loosened guardrails and a sympathetic administration, the Georgia Access Model faced a challenging approval process. Amid concerns over the program's legality (Straw 2020), Georgia's application was

Table 3 Waiver Approval by Year

Year	No. of approvals	States
2016	1	HI
2017	3	AK; MN; OR
2018	4	ME; MD; NJ; WI
2019	5	CO; DE; MT; ND; RI
2020	3	GA; NH; PA
2021	3	CO; HI; WI
2022	6	AK; CO; ME; MN; OR; VA; WA

delayed twice after CMS requested additional data on projected churn and coverage losses (CMS 2020a; Kemp 2020). Following an extended review period, the Trump administration approved the Georgia Access Model just a few days before the 2020 election (CMS 2020c).

Waiver Activity during the Biden Administration

Blocking the Georgia Access Model

In an executive order issued following his inauguration, President Biden directed all agencies to reconsider and review previous rules and policies that limited health care access, including "waivers under Medicaid and the ACA that may reduce coverage" as well as policies that would undermine Marketplaces, Medicaid, and the ACA (White House 2021). With this order as its lodestar, the Biden administration has focused its use of 1332 waivers on expanding access of previously ineligible populations to purchase qualified health plans (QHPs) and supporting the creation of state-based pseudo-public options.[1]

First, though, the Biden administration moved quickly to stop the already approved Georgia Access Model. Within 10 days of her Senate confirmation, Biden's CMS administrator, Chiquita Brooks-LaSure, requested additional actuarial and economic analyses from Georgia. Federal requests focused on updating the state's Marketplace enrollment data, which was key to understanding the number of individuals at risk of losing coverage if the Access Model were to be approved and implemented (Brooks-LaSure 2021c).

Georgia officials argued that the data request violated the terms and conditions outlined in the approved waiver (Thomas 2021b) and began the

1. QHPs, as defined by the ACA, are insurance plans that are eligible to be purchased on state or federal health insurance exchanges because they meet regulatory requirements set forth in statutory and regulatory text, including providing essential benefits and limiting cost sharing.

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process of implementing the Access Model (Thomas 2021a). The state-federal standoff escalated as Brooks-LaSure threatened suspension of the waiver if Georgia continued to ignore the data request, a threat that was fulfilled when the Georgia Access Model was formally suspended in April 2022 (Brooks-LaSure 2022a). If the Biden administration had formally terminated the approved Georgia waiver application, it would have likely resulted in the state suing the federal government. But because the Biden administration requested additional data, it added costs and a pretext for suspending the waiver that functionally ended Georgia's efforts.

Support for a Public Option

While the Biden administration blocked the Georgia waiver, it also partnered with states to change the use of 1332 waivers to support and expand on the ACA; indeed, this is how the Biden administration's CMS understands the reason for the establishment of 1332 waivers.

As of July 2023, the Biden administration has approved eleven 1332 waivers, eight of which were renewal applications of Trump-approved reinsurance programs. One of the three remaining Biden-approved new applications was a new reinsurance program in Virginia. The two remaining approved applications are the most ambitious use of 1332 waivers to date. In Colorado, the state has been approved to create a public option, with expanded access and financial subsidies for previously ineligible populations to purchase QHPs. Washington had previously created a public option, although without the use of a 1332 waiver, but it has similarly expanded access to QHPs.[2]

Colorado's public option, the Colorado Option Standardized Health Benefit Plan, was approved by the Biden administration in June 2022 and has the potential to be the most impactful use of 1332 waivers to date. Although the precise meaning of the term "public option" is fluid (Oberlander 2019), it generally entails the creation of a government-administered insurance plan that is available to purchase in competition with private insurance plans. We call the Colorado Option (and similar efforts by other states) "pseudo-public" because each state uses private insurance carriers to offer lower-cost and more regulated insurance products. To date, no state

2. The state of Washington created the Cascade Select plan through legislation in 2019. The Washington approach shares several key characteristics with plans in Colorado and Nevada, including a standard benefit design, reduced deductibles, access points for more first-dollar services, limits on provider reimbursement as a cost-savings mechanism, state-mandated quality goals, and requirements for hospital participation. The initial Cascade Select program was adopted without a waiver, but the state used a section 1332 to expand eligibility for financial subsidies for undocumented immigrants, as discussed below.

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has created a *fully* public insurance program; rather, their "public" options take a hybrid approach.

The ACA did not include a public option, as President Obama and progressive Democrats had initially wanted, but a public option was a centerpiece of the Biden campaign's health policy platform (Hacker 2021). Three states are currently pursuing state-based pseudo-public options through 1332 waivers: Colorado, Nevada, and Oregon (table 4).

Colorado laid the groundwork for its public option during the Trump administration, with the adoption of a reinsurance program starting in 2020 (Polis 2019). The state worked in tandem with the reinsurance program to pursue additional reforms, and the legislation creating the Colorado Option was passed in 2021. The Colorado Option would use a 1332 waiver to promote "access, affordability, and racial health equity" (Hoskins n.d.) through a public option model, albeit one that relied extensively on private insurers (CHA 2021). Any Coloradan who purchases insurance on the individual market or is employed by a firm with fewer than 100 employees is eligible to select a Colorado Option plan.

The Colorado Option introduced several new requirements for private insurance carriers in the state. These regulations included requiring all insurance carriers that offer insurance products on either the individual or the small-group markets to include a state-standardized benefit plan with the same benefit and cost-sharing limitations, and provider networks that are "culturally responsive and representative of the population" (CDRA 2021). For the 2024 year, there were 11 insurers that filed to participate in the small-group and individual markets, each insurer also offering other non–Colorado Option products (CDRA 2023). If insurance carriers cannot meet network requirements, the state can require participation from hospitals and providers to ensure adequate availability of culturally responsive networks. The state projects that over the first five years of the Colorado Option, enrollment would increase by 15.1% compared to the 2021 individual market enrollment figures, an increase of 32,735 Coloradans enrolled in the individual market.

Overlaying these regulations for insurers and providers is a mandatory premium-reduction plan, with mandatory reduction targets that insurance carriers need to meet during each of the first three years of the program. With the 2021 premium rates as the baseline, the premium for each Colorado Option plan is required to decrease by 5% each year from 2023 to 2025. This would result in a 15% reduction in premiums (compared to 2021) in the first three years of the program. Premiums in subsequent years must not outpace national medical inflation (https://leg.colorado.gov/bills/hb23-1224). However, preliminary rate filings indicated that only one

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Table 4 Comparison of Public Options by States

	Colorado	Washington	Nevada
Eligibility	Anyone who purchases insurance on the individual market	Anyone not eligible for Medicare or Medicaid and not offered ESI	Eligibility as defined by ACA
Insurer participation	All private insurers offering individual or small-group plan must offer public-option plan	Private insurers have option to offer public option; state is responsible for selecting plans to offer	All private insurers who offer a Medicaid managed care plan in the state must offer a public-option plan; state is responsible for selecting plans to offer
Benefit design	Standard benefit design and cost sharing, but not premiums	Standard benefit design and cost sharing, established by state insurance commissioner	State will not require standard benefit design and cost sharing, as long as it is an ACA-qualified health plan with coverage consistent with one gold-tier plan and one silver-tier plan
Cost savings	Mandatory premium reductions, achieving 15% reduction over three years	Covered benefits provided by licensed physicians and facilities may not exceed 160% of Medicare reimbursement; primary care services may not be less than 135% of Medicare reimbursement	Premiums must be 4% lower than county average in first year, achieving 16% lower than county average within four years; premiums cannot increase above CPI

Note: ESI = employer sponsored insurance; ACA = Affordable Care Act; CPI = consumer price index.

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insurer participating in the Colorado Option would be able to meet the premium reduction target (CDRA 2023). The threat of public hearings held by the Colorado Insurance Commissioner became irrelevant when state officials were able to reach an agreement with the participating insurers and providers to meet premium goals by reducing provider reimbursement rates (Kim 2023).

The mandatory premium reductions are essential to the Colorado Option to help fund a second innovation: creating state subsidies for previously ineligible populations to access QHPs (https://leg.colorado.gov/bills/hb21-1232). The mandatory premium reductions and reinsurance program combined to generate federal savings, a portion of which was then passed on to the state. In August 2023, the Biden administration announced that Colorado would receive $245 million in shared savings for the state to further reduce premiums in the reinsurance program and provide subsidies for undocumented immigrants to purchase Colorado Option plans (CDRA 2023).

Colorado is currently the only state to receive federal approval for a public option, but other states have followed their lead. Nevada and Oregon both passed legislation authorizing their states to submit waiver applications for public options, although they too rely extensively on private insurance. The Democratic governor of Nevada, Steve Sisolak, signed a public option into law in June 2021. Reflecting the program's complicated nature, the law included a long implementation runway, giving state officials until 2024 to submit their application, with the public option to be implemented in 2026. The law would require all health insurers offering Medicaid managed care plans to submit "good faith" bids to the state; these bids must include ACA-compliant insurance plans (NDHHS n.d.).

Like Colorado, Nevada's pseudo-public option imposes additional regulations on private plan offerings. This includes a mandatory 4% lower premium for a plan that is part of Nevada's public option, compared to the average premium for all other insurance products offered on the exchange in each county. Premium reductions of 4% are required for the public option plans for each of the first three years, resulting in premiums that are 12% lower than the average cost of the other plans offered on the marketplace in each Nevada county. Nevada projects that implementation of their version of the public option would produce cost savings of up to $400 million during the first five years of the program, with an additional 50,000 Nevadans enrolled in a public option plan (NDHHS 2022).

However, Sisolak's loss to Republican challenger Joe Lombardo in 2022 has complicated implementation. Lombardo has largely been quiet on his health policy plans, but he did call the public option "bullshit" during a

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Republican governor candidate forum (Golonka 2021). In his first State of the State speech in 2023, Lombardo stated: "At a minimum this law needs to be substantially revised, or better yet repealed, so we can refocus on the real problem which is getting eligible but uninsured Nevadans the coverage they need" (Office of the Governor 2023).

Although Oregon has not signed a public option plan into law, in 2021 the legislature enacted a law directing the Oregon Health Authority to analyze potential options. The initial reports and analysis have largely mirrored Colorado's pseudo-public option plan, with a 1332 waiver as the centerpiece of expansion (Ario, Karl, and Zhan 2022).

Expanded QHP Eligibility

In addition to approving state public option plans, the Biden administration has approved 1332 waivers that expand eligibility to QHPs for previously ineligible populations. Again, these efforts have leveraged waivers to expand the scope of accessing health insurance markets introduced by the ACA.

The idea of using 1332 waivers to expand access for previously ineligible groups predates the Biden administration. In 2016 California applied to provide a new health insurance product available for purchase on the state's health insurance exchange for individuals who are ineligible for a QHP because of immigration status, even though they would remain ineligible for subsidies. After Trump's election, the state withdrew the application, with legislators citing concerns over the new administration using data collected through the exchange to deport undocumented individuals (Ibarra and Terhune 2017). Similar to the creation of a state-based public option, Washington and Colorado have led the way in expanding eligibility to purchase QHPs for previously excluded populations.

Both states included two interconnected programmatic designs that focused on broadening coverage, particularly to immigrant populations, and extending subsidies to more people to make purchasing insurance more affordable. First, each state has rescinded federal restrictions on purchasing QHPs through exchanges. In the case of Washington, 41% of the state population that is "not lawfully present" (Altman 2022)—meaning undocumented immigrants—is uninsured.[3] The Washington waiver creates a new

3. Section 1312(f)(3) of the ACA prohibits people considered "not lawfully present" from purchasing QHP coverage on the ACA Marketplace. Immigrants who can purchase such coverage under existing federal law include lawful permanent residents/green card holders; refugees and asylees; those granted temporary protected status; and survivors of domestic violence, trafficking, and other serious crimes, among others.

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coverage pathway called Cascade Care Savings, beginning in 2024. The program will allow previously ineligible individuals with incomes below 250% of the federal poverty level (FPL) to access state financial subsidies and purchase QHPs on the state Marketplace. Additionally, the waiver allows mixed-status families, where members within a family have different immigration statuses, to purchase insurance coverage together as well as individuals who fall within the ACA's "family glitch" (Inslee 2022).[4] The state projects that of the estimated 242,000 Washingtonians who are uninsured and who fall below 250% FPL, 29% would be eligible to access the Cascade Care Savings program (Altman 2022).

Colorado similarly expanded QHP eligibility by eliminating immigration status as a qualifying circumstance for state Marketplace participation (https://leg.colorado.gov/sites/default/files/2020a_215_signed.pdf), thereby opening it up to noncitizens. Eligibility is limited to those who fall below 300% FPL and who reside in Colorado. State residency requirements include owning a business in the state, being gainfully employed in the state, or residing in Colorado for 90 consecutive days. State estimates indicated that the eligibility expansion would result in more than 10,000 residents gaining insurance.

The second programmatic innovation that facilitated expanding access to QHPs in these two states was the creation of new dedicated funding sources to provide financial subsidies to undocumented immigrants. For example, Colorado's expansion of subsidies for formerly ineligible people is funded through several revenue streams. The largest has been the use of federal pass-through funds from the previously approved reinsurance program, with more than $57 million earmarked for use as state subsidies. In addition to the federal pass-through funds, Colorado implemented a fee for insurance carriers and hospitals to fund coverage expansion. Without a 1332 waiver to accrue federal pass-through funds, Washington has appropriated $50 million in state funds for state-based subsidies, with $5 million earmarked for populations previously deemed ineligible (Inslee 2022).

Lessons

Several important lessons emerge from the evolution of 1332 waivers since 2019. First, much of 1332 waivers' potential to impact health care currently remains unfulfilled, although recent developments suggest a more dynamic use of waivers going forward.

4. The ACA's "family glitch" was addressed by the Biden administration with new rules issued in 2023 (Keith 2022).

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Despite more than one-third of all states having an approved waiver as of 2023, the unfulfilled promise of 1332s has more to do with the types of reforms that have been enacted. During the Trump administration, nearly all activity was focused on reinsurance. Before Colorado's implementation of a pseudo-public option, nearly all other nonreinsurance waivers failed to receive approval or were never implemented. We highlighted Georgia's attempts to radically alter its individual market above, yet earlier nonreinsurance waivers from California, Iowa, Idaho, Massachusetts, Ohio, and Vermont were also all deemed incomplete or rejected by federal authorities. These waiver applications failed for various reasons (e.g., projections that reforms would violate regulatory guardrails, states submitting incomplete data, etc.), but partisan changes in the presidency and governors recast the dynamics of executive federalism and altered the durability of waiver programs (KFF 2020).

The loosening of the regulatory guardrails during the Trump administration did encourage Georgia to submit its Access Model, but it did not result in applications from other Republican-controlled states. There are many reasons for such inaction by conservative states. Sweeping conservative reforms through a waiver are not a costless endeavor; they require administrative resources, expertise, capacity, and an inclination toward health policy, which conservative states have not shown (Grumbach 2018). Additionally, some conservative states have a history of attempting to undermine the ACA by failing to implement a state-based exchange or adopt the Medicaid expansion. Even among Republican-led states that have adopted the Medicaid expansion, a different waiver program, section 1115, has been key for many of these states to adopt the expansion. These "waiver states" have introduced a series of changes to Medicaid, including increased cost sharing, premiums, and work requirements (Grogan, Singer, and Jones 2017).[5]

Also, approval and implementation of nonreinsurance waiver applications requires political alignment between state and federal officials, and enough time to allow for policy durability (Thompson and Burke 2007). In the case of Georgia, while the Trump administration approved their waiver, the Biden administration managed the implementation. The newly misaligned politics of the Georgia Access Model resulted in the federal government bogging the implementation process down with additional data requests and ultimately suspending the program.

5. The Biden administration withdrew all work requirement waiver programs in both expansion and nonexpansion states in January 2021.

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The durability of reforms adopted through 1332 waivers is influenced by the role of the administrative presidency. Trump was particularly focused on expanding the presidency's administrative powers, shaping health policy through executive orders and regulation (including changes to 1332 guardrails) (Thompson, Wong, and Rabe 2020). The election of a Republican to the presidency in 2024 could have implications for the durability of the more ACA-supportive waiver programs established during the Biden administration.

Executive power at the state level is also important in shaping waiver durability. Although the outcome for Nevada and its implementation of a public option is still unknown, the state's newly elected Republican governor may create implementation challenges. Language in the law signed by his Democratic predecessor requires Nevada to apply for a waiver, but doing so without support from the governor's office—or submitting a shoddily constructed application—could place the Biden administration in a bind (https://www.leg.state.nv.us/Session/81st2021/Bills/SB/SB420_EN.pdf). A public option fits with the policy goals of the Biden administration, but supporting a waiver that is not supported by the current governor may be too much of a risk.

A related challenge to implementation arises from federal opposition. Waivers are examples of executive federalism, with minimal input from legislative bodies, but congressional Republicans have opposed the shift in waiver use undertaken by the Biden administration. For example, after Colorado received federal approval for its expanded eligibility for QHPs, all of the state's Republican members of Congress—Representatives Ken Buck, Lauren Boebert, and Doug Lamborn—introduced the No Federal Tax Dollars for Illegal Aliens Health Insurance Act (https://www.congress.gov/bill/117th-congress/house-bill/8441). Although passage is unlikely, the opposition of congressional Republicans to waiver activity has a twofold impact: first, it draws attention to a normally overlooked policy process; second, members of Congress can hold committee meetings, conduct investigations, or evaluate the use of 1332 waivers.

In addition, states have had an easier time using 1332 waivers to support the ACA than to undermine it. Legislative language in the ACA outlining the guardrail provisions for the waivers establishes a high threshold that reforms must meet, although we would expect different CMS leaders, appointed by Democratic or Republican presidents, to interpret these guardrails differently. Stabilizing markets was an important goal that seemed daunting in the formative years after the ACA's passage, even if market stabilization itself is unlikely to be lauded as a vanguard of

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innovation. The courts will likely play a central role in adjudicating waiver applications that seek to undermine the ACA. Georgia's application is the first (and so far the only) instance resulting in litigation. Initially, the litigation was to stop its implementation, but Georgia could still go to the courts after the Biden administration suspended implementation. If 1332 waivers become more politically contested (for example, the use of section 1115 waivers to adopt work requirements during the Trump administration), courts will take on a much more central role in the durability of waiver programs. Legal challenges mark a newfound complexity for states to manage through the 1332 process.

Georgia's waiver experience clearly highlights the ways in which undermining the ACA comes into conflict with regulatory limits. Even after the Trump administration loosened the interpretation of the legislative guardrails, the administration's own CMS found them unacceptable. Part of the challenge for Georgia officials in developing and implementing the Access Model before the change in administration were demands for addendums and additional analyses before they approved the waiver in November 2020. If the Access Model had been more entrenched, it would have been more difficult for the newly inaugurated Biden administration to suspend the program.

To date, Democratic-led states have had no such issues operating and maneuvering within the guardrails during the Biden administration. The current waiver policies that Washington, Colorado, Oregon, and Nevada have pursued have more easily fit within the parameters set by the ACA.

If Democratic-led states continue to pursue policies that build on the ACA, such as delivery systems or payment reforms, it is likely they could operate within the guardrails. Such states may of course face new regulatory challenges in the future, particularly if they pursue more substantial and far-reaching reforms. Implementing a single-payer program or a true public option (where the state creates a government-operated health plan to compete with private plans) would be much more challenging to accomplish. And Democratic-led states could well face more political challenges in pursuing 1332 waivers under future Republican presidential administrations.

Conclusion

The innovative promise of 1332 waivers to reform US health care remains aspirational; to date, such waivers' potential has exceeded their actual impact. Still, the Biden administration and Democratic-led states have put

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their stamp on the program. Waiver programs in Washington and Colorado may suggest a new chapter in waiver use, with other states following in their footsteps. The pseudo-public option and expanded eligibility for exchanges could be emulated by more Democratic-led states and viewed as models for reform—as long as a Democrat is in the White House. While it is likely that Georgia would have implemented its Access Model had President Trump been elected to a second term in 2020, the future of 1332 waivers for Republican-led states is less clear. The failures of federal Republicans to put their stamp on reform may spur additional focus and energy devoted to state-based reforms, with 1332 waivers as a linchpin of this approach. Yet Republican-led states have shown little interest in pursuing 1332 waivers, even with loosened guardrails and a sympathetic president. The challenges that Georgia encountered could deter future Republican leaders from pursuing a similar waiver, even with a Republican in the White House. In sum, the role of 1332 waivers in shaping US health care reform in the coming years remains highly uncertain.

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