

medicaid and the uninsured

March 2009

THE ROLE OF SECTION 1115 WAIVERS IN MEDICAID AND CHIP: LOOKING BACK AND LOOKING FORWARD

EXECUTIVE SUMMARY

Over the years, Section 1115 waivers have provided important opportunities for states to test new coverage approaches in Medicaid, but have also raised some issues. This brief reviews the experience of Section 1115 Medicaid and CHIP waivers and offers a range of options the new Administration could consider for waivers in the future. It focuses on comprehensive Section 1115 waivers that states have used as a vehicle for coverage and/or cost control changes.

Overview of Section 1115 Waiver Authority

Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive provisions of major health and welfare programs authorized under the Act, including certain requirements of Medicaid and CHIP. Under Section 1115, the Secretary can allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules, as long as the Secretary determines the initiative is a “research and demonstration project” that “furthers the purposes” of the program. The Secretary’s waiver authority is very broad, but there are some program elements the Secretary does not have authority to waive, such as the federal matching payment system for states. Although not set in statute or regulation, under longstanding policy, waivers must be budget neutral for the federal government to prevent increased federal spending through demonstrations. This means that federal costs under a waiver must not be more than federal costs would have been for that state without the waiver. The federal government enforces budget neutrality by establishing a cap on federal funds under the waiver.

Looking Back: Experience with Section 1115 Medicaid and CHIP Waivers

While there is great diversity in how states have used waivers, a series of waiver themes has emerged that generally reflects the political and economic climate of each period. From Medicaid’s beginning in 1965 through the early 1990s, there were many waivers, but most were small in scope. Beginning in the 1990s, there was a significant spurt in waiver activity, and, since then, waivers have become even more numerous and wider in scope.

- *Broad Expansion Waivers (Mid-1990s-2001).* In the mid-90s through the early part of this decade most waivers focused on expanding coverage. Many began as state efforts to implement broader managed care systems than were permitted under federal law. States used savings from mandatory managed care or redirected DSH funds to offset expansion costs, and flush economic times during the mid- to late-90s helped support expansion efforts. Two of the largest waivers approved during this time (Oregon Health Plan and TennCare) also restructured coverage for existing beneficiaries in ways that were considered very controversial at the time.
- *CHIP Waivers (2001 Forward).* In July 2000, based on research showing that covering parents benefited their children, under President Clinton, the administration issued waiver guidelines permitting waivers to expand coverage to parents using CHIP funds under certain

conditions. The guidelines also permitted CHIP waivers to cover pregnant women, but prohibited CHIP waivers to cover childless adults. In 2001, under President Bush, the administration newly permitted the use of CHIP funds to cover childless adults. However, the Congress barred future CHIP waivers for childless adults under the Deficit Reduction Act of 2005, and, in 2007, the administration stopped renewing CHIP adult coverage waivers.

- *HIFA Waivers (2001 Forward)*. In August 2001, under President Bush, the Administration announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative, which promoted the use of waivers to expand coverage within “current-level” resources and offered states increased flexibility to reduce benefits and charge cost sharing to offset expansion costs. However, states had limited interest and success in expanding coverage under HIFA, and waivers instead began to increasingly focus on cost control as the nation moved into an economic downturn. Expansions that did move forward under HIFA waivers were generally limited, particularly when compared to the larger expansions of the 1990s and overall enrollment growth in the regular Medicaid program over the period.
- *Reform Waivers (2005 Forward)*: Beginning in 2005, some broad waivers were approved that restructured Medicaid financing and other key program elements, for example, by setting a global cap on federal funds and allowing a state to shift new authority to private managed care plans to determine benefits and cost sharing. These waivers stemmed from continued federal emphasis on and interest in some states in controlling and increasing predictability of program costs as well as ideas about reshaping Medicaid to promote personal responsibility and reflect private market trends. However, during this same period, Massachusetts obtained a waiver that provided instrumental support for its broad efforts to provide universal coverage without significantly restructuring its Medicaid program.
- *Emergency Waivers*. Beyond these themes, waivers have also helped states quickly provide Medicaid support during emergency situations, for example, by enabling a vastly streamlined enrollment process in New York in the wake of the September 11th attacks and by assisting states in providing temporary Medicaid coverage to certain groups of Katrina survivors.

Because waivers have been used in a variety of ways and for an array of purposes, they have had varying impacts on beneficiaries. For example, some waivers have enabled states to cover previously uninsured individuals, including adults who could not otherwise be covered under Medicaid. However, waivers have limitations as a coverage expansion tool, and waiver expansions are often limited in size and/or scope because of budget neutrality requirements. As waivers increasingly focused on cost control and restructuring in recent years, some contributed to losses in coverage and/or access problems for some beneficiaries.

Although waivers are intended to be research and demonstration projects, for many years, there has been a limited focus on waiver evaluations. In the early- to mid-1990s, there were several large federally-funded, multi-state evaluations. However, as the volume of waivers increased and research budgets became tighter, efforts shifted toward state-specific, state-funded evaluations and public access to evaluation findings became more limited.

The transparency of the waiver approval process has diminished over the years. In the mid-1990s, efforts were made to establish public process policies at the federal and state level by providing regular notice of waivers in the Federal Register with a comment period and requiring states to describe processes used to obtain public input as part of their waiver proposals.

However, commitment to these practices faded over the years and recent analysis by the Government Accountability Office (GAO) concluded that the Centers for Medicare and Medicaid Services has failed to consistently provide an opportunity for the public to learn about and comment on pending waivers at the federal level and that there is significant variation in opportunities for public input at the state level.

Looking Forward: The Role of Section 1115 Medicaid and CHIP Waivers in the Future

Because many aspects of waiver policy are shaped by each administration, there are a number of key issues for the new Administration to consider about the role of waivers in the future:

As under previous administrations, the new Administration can use waiver authority to promote initiatives that are consistent with its priorities for Medicaid and health care more broadly. For example, through waiver guidelines it can articulate the kinds of waivers it will encourage and approve as well as communicate limits on changes that will be permitted under waivers. Further, it could develop a waiver template for a specific waiver approach or approaches that it seeks to encourage among the states.

To facilitate states' ability to use waivers to expand coverage, the Administration could revisit waiver budget neutrality rules. As a result of budget neutrality, states that use waivers to expand coverage to groups who cannot otherwise be covered under Medicaid (such as childless adults) must identify savings or redirect existing resources to offset expansion costs. Under current policy, states are restricted to identifying savings within Medicaid or CHIP. To help support coverage expansions through waivers, the Administration could revise the rules to allow states to use federal savings from other programs (such as Medicare or SSI) as offsets, expand the period of time used to assess budget neutrality, or identify preferred waiver designs for which it might relax budget neutrality requirements.

Consistent with the Administration's goal of increasing government transparency, it could increase opportunities for the public to review and comment on waiver activities. For example, it could make all waiver documents, including financing arrangements, publicly accessible and provide an opportunity for public review and comment prior to waiver approvals being finalized. Further, to help assure public input at the state level, it could return to earlier policies that required states to describe processes used to obtain public input and identify or require processes it determines are sufficient for obtaining input, such as holding public hearings and making the waiver proposal readily accessible to the public.

The Administration could strengthen and support waiver evaluations to enhance waivers' role as research projects. This could be achieved by funding timely federal waiver evaluations and making the findings readily available to the public policy community.

Conclusion

For many years, Section 1115 waivers have been an important element of the Medicaid and CHIP programs that have facilitated state innovation but also raised some important issues. Because waivers often reflect each administration's priorities, the new Administration has an opportunity to encourage and shape the use of waivers to help support its priorities and goals for Medicaid and the broader health care system as well as to increase the transparency of the waiver approval process and strengthen the role of waivers as research and demonstration projects.

INTRODUCTION

Medicaid, the nation's publicly financed health and long-term care coverage program for low-income people, covered 59 million people in 2005, including 45 million children and adults in low-income families and 14 million elderly and disabled individuals. Medicaid plays many important roles in the U.S. health care system, covering some of the poorest and sickest individuals who would otherwise go uninsured and serving as a major source of financing within the overall health care system.

For many years, Section 1115 waivers have been used in the Medicaid program, and to a lesser degree in the Children's Health Insurance Program (CHIP), to provide states an avenue to test and implement coverage approaches that do not meet federal program rules. While these waivers have facilitated important program evolutions over time, some have also raised issues. This piece reviews experience with the use of waiver authority to date and discusses issues for the new Administration to consider about the role of waivers in the future. (This paper only addresses comprehensive Section 1115 waivers and focuses on their use as a vehicle for coverage and/or cost control changes. It does not address more narrowly drawn Section 1115 waivers such as family planning or pharmacy plus waivers, nor 1915 freedom of choice or home and community based services waivers.)

OVERVIEW OF WAIVER AUTHORITY

In exchange for federal matching funds, states administer their Medicaid and CHIP programs subject to federal standards and options. The federal rules provide a base for the program that reflects Congressional intent about minimum standards to be met in return for federal funds and the options provide states broad discretion over how they administer their programs. If a state wants to operate its Medicaid or CHIP program in a way that does not meet federal standards and still receive federal matching funds, it must obtain a waiver of the federal rules from the Secretary of Health and Human Services (HHS).

Under Section 1115 of the Social Security Act, the Secretary of HHS can waive provisions of major health and welfare programs under the Social Security Act, including certain requirements of Medicaid and CHIP. This provision authorizes the Secretary to allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under the federal rules, as long as the Secretary determines that the initiative is a "research and demonstration project" that "furthers the purposes" of the program. While the Secretary's waiver authority is very broad, there are some elements of the program that the Secretary does not have authority to waive, such as the federal matching payment system for states.¹

While not set in statute or regulation, a longstanding component of Section 1115 waiver policy that has been utilized and applied across administrations is that waivers must be budget neutral for the federal government. This means that federal costs under a waiver must not be any more than federal costs would have been for that state without the waiver, as calculated by the administration. The federal government enforces budget neutrality by establishing a cap on federal funds under the waiver, putting the state at risk for any costs beyond the cap.

LOOKING BACK: EXPERIENCE WITH SECTION 1115 WAIVERS

The following sections review and discuss the types of changes that states have made through Section 1115 waivers over the years as well as aspects of waiver evaluations and the waiver approval process.

Scope, Purpose, and Impact of Waivers

While there is great diversity in how states have used waivers, a series of broad waiver themes has emerged that generally reflects the political and economic climate of each period. From Medicaid's beginning in 1965 through the early 1990s, there were many approved waivers, but most were small in scope.² Beginning in the 1990s, there was a significant spurt in waiver activity, and, since then, waivers have become even more numerous and wider in scope. As of July 2008, there were 32 comprehensive Section 1115 waivers operating in 26 states.³ While all 32 are classified as comprehensive statewide waivers, they range from waivers that allow large, significant program changes to those that authorize smaller changes with less significant impacts.

- *Broad Expansion Waivers (Mid-1990s-2001).* In the mid-1990s through the early part of this decade most waiver activity focused on expanding coverage.⁴ In some cases, these expansions focused on childless adults who could not otherwise be covered in Medicaid, while others expanded coverage to optional Medicaid groups but in ways that required waiver authority.⁵ Many waivers approved during this time began as state efforts to implement broader managed care systems than were permitted under federal law.⁶ States used savings from mandatory managed care systems or redirected Disproportionate Share Hospital (DSH) funds to offset the cost of their expansions, and flush economic times during the mid- to late-90s helped support expansion efforts.⁷ Two of the largest waivers approved during this time were TennCare in Tennessee and the Oregon Health Plan (OHP). These waivers expanded coverage but also restructured coverage for existing beneficiaries in ways that were considered very controversial at the time.⁸ TennCare and OHP made significant progress in reducing the uninsured rate in these states, but, in recent years, the programs have undergone significant cutbacks due to state budget pressures.
- *CHIP Waivers (2001 Forward).* In July 2000, based on research showing that covering parents benefited their children, under President Clinton, the administration issued federal CHIP waiver guidelines permitting waivers to expand coverage to parents using CHIP funds under certain conditions.⁹ The guidelines also permitted CHIP waivers to cover pregnant women, but explicitly prohibited CHIP waivers to cover childless adults. Between 2001 and 2002, six states obtained CHIP waivers to expand family coverage pursuant to these guidelines.¹⁰ In 2001, under President Bush, as part of its broader Health Insurance Flexibility and Accountability waiver initiative (HIFA, discussed below) the administration newly permitted the use of CHIP funds to cover childless adults, and a number of states moved forward with HIFA CHIP waivers to cover adults.¹¹ However, the Congress barred future CHIP waivers for childless adults under the Deficit Reduction Act of 2005. In 2007, the administration announced that it would no longer renew CHIP adult coverage waivers, and did not renew some of these waivers that it had previously approved.¹²

- *HIFA Waivers (2001 Forward)*. In August 2001, under President Bush, the administration announced the HIFA waiver initiative, which promoted a streamlined approval process for states using waivers to expand coverage within “current-level” resources and offered states increased flexibility to reduce benefits and charge cost sharing to help finance the expansions.¹³ HIFA also required states to incorporate elements of premium assistance (i.e., using Medicaid or CHIP funds to subsidize the purchase of private coverage) into their waivers. However, states had limited interest and success in expanding coverage under HIFA, and waivers instead began to increasingly focus on cost control as the nation moved into an economic downturn.¹⁴ Some states either did not implement expansion components of their waivers and/or used waivers solely to reduce program costs by reducing benefits or increasing costs for already-eligible individuals.¹⁵ Expansions that did move forward under HIFA waivers were generally limited, particularly when compared to the larger expansions that occurred in the 1990s and overall enrollment growth in the regular Medicaid program over the period.¹⁶
- *Reform Waivers (2005 Forward)*: Most recently, since 2005, some broad waivers have been approved that restructure Medicaid financing as well as other key elements of the program. These waivers stemmed from continued federal emphasis on and interest in some states in controlling and increasing predictability of program costs as well as broader ideas about reshaping Medicaid coverage to promote personal responsibility and reflect private market trends.
 - In 2005, driven by a combination of state fiscal problems and state desire for increased flexibility to make program changes, Vermont obtained its Global Commitment waiver, which places all of its federal funding for acute care services under a global cap.¹⁷ In exchange for the cap, the waiver allows the state to use federal Medicaid funds to refinance a broad array of non-Medicaid health programs and gives the state new flexibility to reduce benefits, increase cost sharing, and cap enrollment for many beneficiaries.¹⁸ The state also obtained a second waiver that places a global cap on federal funding for long-term care services. Together, the waivers create a fixed dollar limit on the total amount of federal Medicaid funds available to the state, putting the state at risk for any costs beyond the cap. However, the cap the state received under the Global Commitment waiver is very generous, and, in fact, according to the General Accountability Office (GAO), higher than supported by the state’s historical spending.¹⁹ Because the cap is generous and the state is allowed to refinance existing programs, the waiver also provided an influx of federal financing that has enabled the state to use the waiver to expand coverage as part of its broader health reform efforts.²⁰
 - Also in 2005, Florida obtained a waiver to shift its Medicaid program from a defined benefit program to the direction of a defined contribution approach, in which beneficiaries choose from private managed care plans that are paid risk-adjusted premiums and have new authority to determine benefits and cost sharing, subject to state approval.²¹ Through the waiver, the state is seeking to improve predictability of Medicaid spending and reduce the rate of spending growth.²² It also is seeking to increase consumer choice, market competition among private health plans, participation in private coverage, and to promote healthy behaviors.²³ The waiver does not expand coverage to any new groups.

- At the end of 2008, Rhode Island received approval for a waiver that, like Vermont, capped all federal funding for the program at a fixed dollar amount and provided the state substantially increased flexibility to make program changes. However, unlike Vermont, which has separate caps for acute care and long-term care services, Rhode Island’s waiver places acute care and long-term care services under a single global cap. Moreover, while Vermont received a generous cap, Rhode Island’s cap is lower than the amount it had requested and significantly lower than recent spending projections that account for increased enrollment due to the economic downturn.²⁴

However, during this same period, Massachusetts obtained a Medicaid waiver that helped support its broad efforts to provide universal coverage without significantly restructuring its Medicaid program. The waiver, approved in 2005, allowed the state to redirect Medicaid financing, including DSH funds, to create a Safety Net Care Pool, which serves as the primary source of funding for a new subsidized coverage program called Commonwealth Care.²⁵ Over half of the newly insured in Massachusetts, or about 175,000 adults, are covered through Commonwealth Care.²⁶

- *Emergency Waivers.* Beyond these waiver themes, waivers have also helped states quickly provide Medicaid support during emergency situations. For example, in the wake of the September 11th attacks, a waiver was used to create Disaster Relief Medicaid (DRM) in New York because the attacks had damaged New York City’s Medicaid computer systems making it difficult to process applications at a time when many people needed assistance.²⁷ DRM was a temporary program that used a vastly simplified, expedited application process and expanded eligibility, including eligibility for childless adults and recent legal immigrants. Nearly 350,000 New Yorkers enrolled in DRM over its four-month time period.²⁸ Similarly, when Hurricane Katrina led to the displacement of tens of thousands of people from their homes, a waiver initiative was designed to assist states in providing temporary Medicaid coverage to certain groups of evacuees. Some 32 Katrina waivers were approved that provided temporary coverage to over 100,000 people.²⁹

As waivers increasingly focused on cost control and restructuring in recent years, some led to losses in coverage and/or created new challenges for beneficiaries. For example, as noted, in the 1990s, Oregon obtained a waiver to create its Oregon Health Plan, which resulted in a significant coverage expansion. However, as a result of budget pressures due to the economic downturn, in 2002, it obtained a waiver amendment that increased premiums and cost sharing and reduced benefits for some already-eligible poor adults. In the first year following these changes, program enrollment fell by roughly half or about 50,000 people.³⁰ Research found that most of these disenrollees became uninsured and the state experienced increases in emergency department visits by uninsured individuals.³¹ Florida’s more recent waiver, which focuses on increasing the role of consumer choice and market competition among private managed care plans, has resulted in significant confusion among beneficiaries. About 30% of waiver enrollees were not aware they were enrolled in the waiver and needed to choose a plan. Further, more than half of those who were aware they needed to choose a plan reported difficulty choosing a plan.³² Analysis of the Florida changes has also pointed to some access problems among beneficiaries, particularly for prescription drugs.³³

Waivers have limitations as a coverage expansion tool, reflecting that the primary intended purpose of waiver authority is not coverage expansion. Although a number of states have used waivers to expand coverage, waivers are limited in their ability to serve as a broad coverage expansion vehicle. Longstanding policy requires that Section 1115 waivers be budget neutral for the federal government to prevent increased federal spending under demonstrations. This means that a waiver may not result in greater federal Medicaid or CHIP spending than would have occurred in the state without the waiver. As a result of budget neutrality, states that use waivers to expand coverage to groups who cannot be covered under Medicaid without a waiver (such as childless adults) must identify offsetting savings or redirect existing resources to cover the expansion costs.³⁴

States have limited capacity to generate savings or redirect resources, particularly during economic downturns. When states are able to identify resources for an expansion, they often must limit the size and scope of the expansion through enrollment caps and/or limited benefit packages to stay within budget neutrality limits. For example, Utah has a waiver expansion that is limited to 25,000 adults and only covers primary and preventive care. Further, waiver expansions are often vulnerable to cutbacks during economic downturns. For example, as noted above, in 2002, Oregon made a number of cutbacks in its waiver to address budget pressures that resulted in significant coverage losses. Similarly, Tennessee, which had also expanded coverage through a waiver in the 1990s, made large reductions in its waiver coverage following the 2001 economic downturn.

Budget neutrality rules are not legally required or established by regulation, but have been a longstanding waiver policy. Under current policy, states are limited to identifying offsetting savings within Medicaid or CHIP. As such, even if a waiver results in federal savings to another program such as Medicare or the Supplemental Security Income (SSI) program, those savings cannot be used to offset expansion costs. During the 1990s, states largely relied on managed care savings to offset expansion costs and some resulted in large coverage gains. Today, such savings are largely not available to states since most states with capacity to rely on managed care have already made those changes.

The 2001 HIFA initiative explicitly endorsed a new approach of creating savings by reducing coverage (for example, by reducing benefits or increasing cost sharing) for already-eligible beneficiaries. Only a few states used this financing approach, and their waivers resulted in marginal coverage expansions.³⁵ Most waiver-related coverage gains that occurred after 2001 were under waivers that redirected federal DSH or CHIP funds to cover new populations, financing mechanisms that were available prior to HIFA.³⁶ However, these resources are also limited since they are capped and not all states have funds available to redirect toward coverage. Further, as previously noted, the Deficit Reduction Act of 2005 prohibited any future CHIP waivers to cover childless adults and, in 2007, under President Bush, the administration announced that it would no longer renew CHIP adult coverage waivers.

Currently, almost all states are facing budget shortfalls due to the economic recession, which hit just as states were beginning to recover from the previous recession and move forward with program expansions and restorations of previous Medicaid cuts. Given that states already made

significant program cuts during the last recession and the current fiscal crisis, they likely have very limited ability to obtain savings or redirect existing resources toward new coverage.

Waivers' Role as Research and Demonstration Projects

Although waivers are intended to be research and demonstration projects, for many years, there has been a limited focus on waiver evaluations. As mentioned, Section 1115 waivers are intended to be research and demonstration projects to test and learn about new approaches to program design and administration. As such, federal law requires that the waivers be formally evaluated. In the early- to mid-1990s as an increasing number of states sought waivers, there was some formal evaluation, including several federally-funded multi-state evaluations conducted by independent contractors.³⁷ These findings provided important lessons about the impact of managed care on Medicaid populations, eventually paving the way for changes in the Balanced Budget Act of 1997 that gave states new authority to implement managed care arrangements without a waiver.

However, as the volume of waivers increased and research budgets became more constrained, focus turned away from federally-funded, multi-state waiver evaluations. Instead, the federal Medicaid agency, formerly known as the Health Care Financing Administration (HCFA) and, later, the Centers for Medicare and Medicaid Services (CMS), began to rely more on state-specific, state-funded evaluations, and CMS lightened the pressure on states to present detailed evaluation plans in their waiver proposals or to implement them.³⁸ Public access to evaluation findings also became more limited as state evaluations were submitted directly to CMS.³⁹ Further, when CMS used independent contractors for evaluation, the agency was slow to release the findings or did not release the findings at all.⁴⁰ Although all states have been required to complete evaluations of their waivers, not all evaluation findings are publicly available, and there is no comprehensive summary of evaluation findings available, which limits the ability for researchers, policymakers, and other stakeholders to identify and examine lessons learned from the waiver experiences to date.

The Waiver Approval Process

Waivers essentially are approved through a series of negotiations between a state and HHS. Section 1115 provides broad authority to the Secretary of HHS to approve “research and demonstration” projects that are determined in the view of the Secretary to further the purposes of the program without any Congressional review or approval. As noted earlier, while the Secretary’s waiver authority is very broad, there are some elements of the program that the Secretary does not have authority to waive, and, in fact, the GAO raised questions about whether, under President Bush, the administration overstepped its statutory authority in waiving certain federal program requirements under some recent waivers.⁴¹ There are no specific federal requirements for state review of waivers, and many states do not have any provisions requiring state legislative approval.⁴² As such, the role of state legislatures in the waiver approval process varies widely across states, with some authorizing legislation for waivers and others having little or no involvement in the process.

CMS begins to consider a waiver once a state submits a waiver application, although states often discuss waiver ideas with CMS or submit waiver concept papers before submitting an application. Prior to 2001, there was no formal application, but most states used a special review guide to structure their proposals. In 2001, under HIFA, a waiver application template was created; states were not required to use the template, although most did. However, use of the template appeared to cease in recent years. Staff from CMS reviews the waiver application, usually with the involvement of other HHS agencies and the Office of Management and Budget. During this time, significant negotiation may occur between the state and HHS, including around the waiver's financing.

If a waiver is approved, CMS issues an award letter to the state, which lists the specific sections of the Social Security Act and applicable regulations that are being waived or modified, as well as the terms and conditions of the approval. The approval also includes the budget neutrality agreement. Waivers are initially approved for a five-year period and then must be renewed to continue operations. In some cases, waivers have been continually renewed for many years, essentially becoming permanent program changes even though they have never been reviewed or approved by the Congress.

There has been significant variation across waivers in the length of the approval process, and the process has oftentimes been perceived as lengthy and burdensome by states.⁴³ Further, reflecting that waivers are a product of state-by-state negotiations with HHS, waivers have sometimes resulted in decisions that are inconsistent across states and with other program policies. For example, as part of their 2005 waivers, both Massachusetts and Vermont received approval to provide new subsidized coverage to adults. Under its waiver, Massachusetts received approval to provide federally-matched subsidies to adults up to 300 percent of the federal poverty level. Vermont also sought to provide subsidies up to 300 percent of poverty, but CMS denied the state's request and limited the federally-matched subsidies to 200 percent of poverty.⁴⁴ As such, Vermont is paying for the subsidies between 200 and 300 percent of poverty with state-only funds, while Massachusetts is able to receive federal match for its subsidy contributions at these income levels.⁴⁵ Further, the 2005 Massachusetts waiver allowed the state to maintain levels of financing that were flowing through mechanisms that had been disallowed in the regular Medicaid program.⁴⁶ Similarly, in 2008, the GAO concluded that the spending base used to determine the budget neutrality limit for Florida's waiver included supplemental payments that HHS had previously determined to be inflated and inaccurate.⁴⁷

The transparency of the waiver approval process has diminished over the years, leaving limited opportunity for the public to monitor and provide input on waivers. In 1994, the federal Medicaid agency, then known as HCFA, established public process policies for waivers at both the federal and state level. HCFA provided regular notice in the Federal Register of all new 1115 waiver proposals and the status of those under review.⁴⁸ It also provided a 30-day comment period before taking action on a waiver.⁴⁹ However, commitment to this practice faded over time, and Federal Register notices ceased in the late 1990s.⁵⁰ Under President Bush, CMS (which replaced HCFA in 2001) did not provide any regular notice of waiver proposals at the federal level and did not adhere to the 30-day comment period, limiting opportunities for public monitoring and input on waivers at the federal level.⁵¹ It posted some waiver documents on its

website, but there was no consistency in the timing and content of these postings, and in some cases, documents were only posted after a waiver had been approved.⁵²

The 1994 HCFA policy also required states to describe in writing what processes they used to solicit public comment on an 1115 proposal at the state level, and specified certain practices that it would deem sufficient, such as holding public hearings, obtaining state legislative approval, or publishing a waiver notice in a widely-circulated newspaper.⁵³ HCFA maintained these requirements after it stopped publishing notice of waiver proposals in the Federal Register in the late 1990s.⁵⁴ However, CMS' 2001 HIFA initiative eliminated this requirement and simply allowed a state to check a box stating it had provided opportunity for public input.⁵⁵ Following these changes, states' waiver applications often included lists of actions taken to solicit public input on the proposal, but these lists did not necessarily convey how meaningful or effective the actions were.

In 2002, the GAO concluded that CMS failed to consistently provide an opportunity at the federal level for the public to learn about and comment on pending waiver proposals and found significant variation in opportunities for public input at the state level.⁵⁶ In 2007, the GAO examined the approval process for waivers in Florida and Vermont and again determined that HHS did not provide an opportunity for public input at the federal level or provide access to the states' proposals prior to approval.⁵⁷ The GAO also found that, although the states provided opportunities for public input, stakeholders in both states and at the national level felt they lacked access to necessary information and/or sufficient time to review and comment on the proposals.⁵⁸

LOOKING FORWARD: THE ROLE OF SECTION 1115 WAIVERS IN THE FUTURE

Because many aspects of waiver policy are shaped by each administration, there are a number of key issues for the new Administration to consider about the role of waivers in the future:

The Administration will have significant ability to affect the shape and purpose of waivers moving forward. As in previous administrations, the waiver policies developed by the new Administration will reflect and help support its overall priorities for Medicaid. It also will be important for the Administration to consider how waivers might coordinate with or support broader changes that could occur in Medicaid and the overall health care system as part of any national health care reform efforts. Through waiver guidelines or templates, the Administration can articulate the kinds of waivers it will encourage and be likely to approve. As such, the Administration could use waivers to help support efforts to reduce the number of uninsured Americans by encouraging and prioritizing waivers that focus on expanding coverage and that supplement health reform efforts. The Administration can also communicate limits on the type and scope of program changes it will allow under waivers. For example, under the Deficit Reduction Act of 2005, the Congress established new minimum benefit and cost sharing standards for the program that provided states increased flexibility. Waiver policy could disallow changes that go below this recently established floor of benefit and cost sharing standards.

To support broader use of waivers to expand coverage, the Administration could revisit waiver budget neutrality rules. A number of states have used waivers to expand coverage to previously uninsured individuals, including childless adults who cannot otherwise be covered through Medicaid. However, the budget neutrality requirement applied to state waiver requests, which requires states to offset expansion costs with Medicaid or CHIP program savings or by redirecting existing Medicaid or CHIP resources, limits states' ability to expand coverage under waivers. Waiver budget neutrality rules are a longstanding policy, but are not legally required or established by regulation. As such, the Administration could revise the rules to help facilitate states' ability to use waivers to expand coverage. For example, it could allow states to use federal savings from other federal programs outside of Medicaid (such as Medicare or SSI) to offset expansion costs, it could expand the period of time (currently the five-year waiver period) used to assess whether a program is budget neutral, or it could even relax the budget neutrality requirements for a specified waiver design that the Administration seeks to encourage, for example, to test a specific type of coverage expansion. Further, the Administration could waive the requirement for a state to demonstrate budget neutrality if the state's proposed changes have consistently been shown to be budget neutral in other states. For example, family planning waivers have repeatedly been shown to be budget neutral across numerous states, but states newly applying for a family planning waiver must still demonstrate budget neutrality.

Consistent with the Administration's goal of increasing government transparency, it could increase opportunities for the public to review and comment on waiver activities. Given the significant program changes that can occur under waivers, the transparency of the waiver approval process is important. As noted by the GAO, public input is important at the federal level because waivers "represent federal policy that may have influence beyond a single state."⁵⁹ Adequate public input also provides visibility and transparency for all affected and interested parties, at both the state and federal level, including the Congress.⁶⁰ Further, at the state level, early knowledge of waiver changes among stakeholders such as providers, community organizations, and advocates can help with planning the implementation process.

There are a number of straightforward actions the Administration could take to help improve public notice of and input on waivers at both the federal and state level. For example, it could post on the CMS website all submitted waiver documents within a specified timeframe, including waiver concept papers, waiver applications, final waiver approvals (including approval letters, terms and conditions, and budget neutrality calculations), and waiver progress reports. Additionally, as noted, significant negotiation can occur between a state and CMS during the waiver application review process that can lead to changes in the waiver. As such, to allow for meaningful public input, there would also need to be an opportunity for the public to review and comment on a waiver, including its financing and budget neutrality limits, before the approval is finalized.

To help assure adequate access to and input on waiver developments at the state level, the Administration could return to earlier policies that required states to describe processes used to solicit public comment on a waiver proposal and identify or require processes deemed sufficient for obtaining input, such as holding public hearings and making the waiver proposal, including its proposed financing arrangements, readily available to the public. The Administration also could require states to provide information that gives insight into the effectiveness of the

processes used, such as levels of attendance at public events or how the proposal was modified to reflect public comments.

The Administration could strengthen and support waiver evaluations to increase waivers' role as research projects. Waivers are intended to be research and demonstration projects that provide lessons for policymakers and other stakeholders about covering the low-income population. To effectively fulfill this role, waivers need to be evaluated and waiver evaluation findings need to be accessible to researchers, policymakers, and other stakeholders. The Administration could strengthen the evaluation component of waivers by funding timely federal waiver evaluations and making the findings readily available to the public policy community. Additionally, while all states have been required to complete evaluations of their waivers, currently, these evaluation findings are not all publicly accessible. The Administration could facilitate access to these evaluation findings by posting the evaluation reports on the CMS website and potentially summarizing evaluation findings to identify some broad lessons learned from waiver experiences to date.

CONCLUSION

For many years, Section 1115 waivers have been an important element of the Medicaid and CHIP programs. While waivers can facilitate state innovation, they have also raised some important issues. Waivers often reflect each administration's priorities since they are essentially a product of negotiations between a state and the administration and approved under broad authority granted by the Social Security Act to the Secretary of HHS for programs authorized by the act, including Medicaid and CHIP. As such, it will be important for the new Administration to consider what types of waivers it might encourage and whether it will limit changes allowed under waivers, how it might increase the transparency of the waiver approval process, how waiver financing rules can be used to support coverage expansions and other health care priorities, and what steps it could take to support and strengthen waiver evaluations.

This brief was prepared by Samantha Artiga of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

ENDNOTES

¹ Section 1115(a)(1) only authorizes the Secretary to waive Medicaid provisions included in section 1902 of the Act. See also, Perkins, J., “Federal Authority to Approve Medicaid Demonstration Projects,” National Health Law Program, July 2005 and National Health Law Program, “Restrictions on the Scope of Medicaid Waivers Under 1115 of the Social Security Act.”

² Lambrew, J., “Section 1115 Waivers in Medicaid and the State Children’s Health Insurance Program: An Overview,” Kaiser Commission on Medicaid and the Uninsured, July 2001. Note that an exception was Arizona’s 1982 waiver, which allowed the state to implement its Medicaid program under a waiver and deliver virtually all services through managed care.

³ Baumrucker, E., “Medicaid and SCHIP Section 1115 Research and Demonstration Waivers,” CRS Report for Congress, Congressional Research Service, September 11, 2008. States include Alabama, Arizona, Arkansas, California, Delaware, Florida, Hawaii, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Montana, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Washington, and Wisconsin.

⁴ Ibid.

⁵ Ibid

⁶ Ibid

⁷ Lambrew, J., op cit. and Mann, C., “The New Medicaid and CHIP Waiver Initiatives,” The Kaiser Commission on Medicaid and the Uninsured, February 2002.

⁸ Ibid.

⁹ State Health Official Letter, July 31, 2000, Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/smdl/downloads/sho073100.pdf>

¹⁰ Artiga, S. and C. Mann, “Family Coverage Under SCHIP Waivers,” Kaiser Commission on Medicaid and the Uninsured, May 2007.

¹¹ Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” August 2001. See also Mann, C., “The New Medicaid and CHIP Waiver Initiatives,” op cit. for an overview of the HIFA guidelines.

¹² Baumrucker, E., “Medicaid and SCHIP Section 1115 Research and Demonstration Waivers,” op cit.

¹³ Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” August 2001. See also Mann, C., “The New Medicaid and CHIP Waiver Initiatives,” op cit. for an overview of the HIFA guidelines.

¹⁴ Artiga, S. and C. Mann, “New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity,” Kaiser Commission on Medicaid and the Uninsured, March 2005.

¹⁵ Ibid.

¹⁶ Mann, C., Artiga, S., and J. Guyer, “Assessing the Role of Recent Waivers in Providing New Coverage,” Kaiser Commission on Medicaid and the Uninsured, December 2003.

¹⁷ Guyer, J., “Vermont’s Global Commitment Waiver: Implications for the Medicaid Program,” Kaiser Commission on Medicaid and the Uninsured, April 2006.

¹⁸ Ibid.

¹⁹ Government Accountability Office, “Medicaid Demonstration Waivers Recent HHS Approvals Continue to Raise Cost and Oversight Concerns,” January 2008, GAO-08-87.

²⁰ “Vermont Health Care Reform Plan,” Kaiser Commission on Medicaid and the Uninsured, December 2007.

²¹ Artiga, S., “Florida Medicaid Reform: Early Findings and Current Status,” Kaiser Commission on Medicaid and the Uninsured, October 2008.

²² Ibid.

²³ Ibid.

²⁴ Solomon, J. and J. Alker, “Rhode Island’s Medicaid Waiver: A Bad Deal for the State,” Center of on Budget and Policy Priorities and Georgetown University Health Policy Institute Center for Children and Families, January 2009.

²⁵ “Massachusetts Health Care Reform: Two Years Later,” Kaiser Commission on Medicaid and the Uninsured, May 2008.

²⁶ Ibid.

²⁷ Perry, M., “New York’s Disaster Relief Medicaid: Insight and Implications for Covering Low-Income People,” Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund, August 2002.

²⁸ Ibid.

²⁹ Baumrucker, E., op cit.

³⁰ Mann, C. and S. Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program,” Kaiser Commission on Medicaid and the Uninsured, June 2004.

³¹ Ibid.

³² Coughlin, T., et al, “Florida’s Medicaid Reform: Informed Consumer Choice?,” *Health Affairs*, Web Exclusive, October 15, 2008; Alker, J., Hoadley, J. and J. Thompson, Georgetown University Health Policy Institute, “Florida’s Experience with Medicaid Reform: Was had been learned in the first two years?,” Jessie Ball DuPont Fund, October 2008; and Artiga, S., “Florida Medicaid Reform: Early Findings and Current Status,” Kaiser Commission on Medicaid and the Uninsured, October 2008.

³³ Ibid.

³⁴ States do not need to identify offsetting savings for waiver expansions to groups that could be covered under Medicaid without a waiver as an optional group (such as parents); these groups are referred to as “pass thrus.”

³⁵ Mann, C., Artiga, S. and J. Guyer, “Assessing the Role of Recent Waivers in Providing New Coverage,” Op cit.

³⁶ Ibid.

³⁷ Thompson R.J. and C. Burke, op cit.

³⁸ Thompson R.J. and C. Burke, op cit.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Government Accountability Office, “Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act,” July 24, 2007, B-309734.

⁴² National Health Law Program and National Association of Community Health Centers, “Role of State Law in Limiting Medicaid Changes, April 13, 2006.

⁴³ Mann, C., “The New Medicaid and CHIP Waiver Initiatives,” op cit.

⁴⁴ “Vermont Health Care Reform Plan,” op cit.

⁴⁵ Ibid.

⁴⁶ Massachusetts Medicaid Policy Institute, “The MassHealth Waiver,” Issue Brief, April 2005.

⁴⁷ Government Accountability Office, “Medicaid Demonstration Waivers, Recent HHS Approval Continue to Raise Cost and Oversight Concerns,” January 2008, GAO-08-87.

⁴⁸ Mann, C., “The New Medicaid and CHIP Waiver Initiatives,” op cit. and Thompson, F.J. and C. Burke, “Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process,” *Journal of Health Politics, Policy, and Law*, Vol. 32, No. 6., December 2007.

⁴⁹ Ibid.

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Government Accountability Office, “Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern,” July 24, 2007, GAO-07-694R.

⁵³ Thompson R.J. and C. Burke, op cit.

⁵⁴ Ibid.

⁵⁵ Ibid.

⁵⁶ Government Accountability Office, “Medicaid and SCHIP: recent HHS Approvals of Demonstration Waiver Projects Raise Concerns,” July 12, 2002, GAO-02-817.

⁵⁷ Government Accountability Office, “Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern,” op cit.

⁵⁸ Ibid.

⁵⁹ Government Accountability Office, “Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern,” op cit.

⁶⁰ Ibid.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This report (#7874) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.