



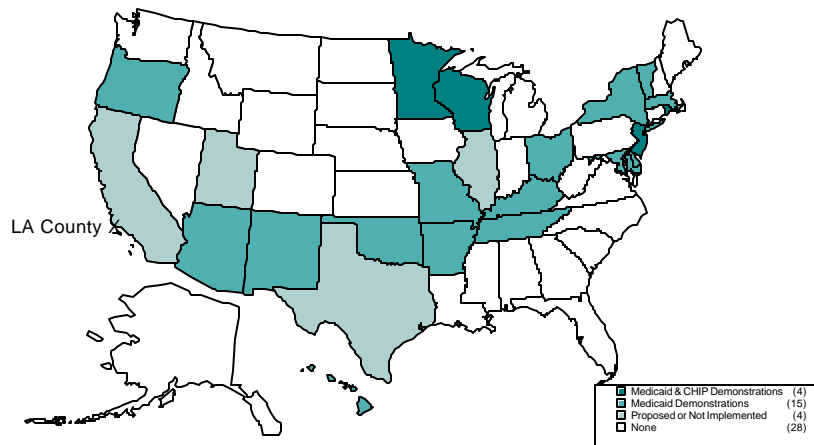
# SECTION 1115 WAIVERS IN MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: AN OVERVIEW

## Introduction

Perhaps the most powerful health policy tool that the executive branch possesses is its ability to restructure Medicaid and the State Children's Health Insurance Program (CHIP) through §1115 demonstrations. Section 1115 of the Social Security Act authorizes the executive branch of the Federal government to waive statutory and regulatory provisions of major health and welfare programs under the Social Security Act, including both Medicaid and CHIP. To date, there are 18 major Medicaid §1115 demonstrations and 4 approved CHIP demonstrations (see figure 1). About \$27 billion Federal dollars are spent through Medicaid demonstrations – one-fifth of total Federal Medicaid spending. Both the Bush Administration and the nation's governors have indicated a high degree of interest in expanding the use of the §1115 authority to secure basic changes in publicly-sponsored health insurance programs.

This Policy Brief provides an overview of §1115 and its implications for Medicaid and CHIP. Following a description of the law and its history, this Brief reviews the ways in which §1115 has been used over the years and discusses the major issues that arise in the design, implementation, and oversight of §1115 demonstrations.

**Figure 1: Medicaid & CHIP 1115 Demonstrations**



## Background on §1115 Demonstration Authority

Section 1115 of the Social Security Act<sup>i</sup> was enacted in 1962 – prior to the creation of Medicaid – to permit the Secretary of Health and Human Services (HHS) to authorize any demonstration project which “in the judgement of the Secretary is likely to assist in promoting the objectives” of numerous state grant programs under the Social Security Act. Section 1115 thus authorizes demonstrations in several programs, not just Medicaid and CHIP. For example, the law that replaced Aid to Families with Dependent Children (AFDC) with the Temporary Aid to Needy Families (TANF) program was preceded by more than 40 statewide §1115 welfare reform demonstrations that made significant modifications to AFDC, many of which were reflected in final legislation.<sup>ii</sup> Medicaid §1115 demonstrations stand out because of the large amount of Federal funding involved.

Section 1115 is unprecedented in its sweep. While many Federal programs have tightly circumscribed demonstration authority, §1115 gives the Secretary of HHS very broad authority to modify virtually all aspects of programs without prior Congressional review or approval or public involvement.<sup>iii</sup> Courts have shown great deference to the Secretary to exercise “judgement” in approving §1115 demonstrations means that he or she has nearly unreviewable authority to determine when a §1115 demonstration proposal is consistent with the objectives of the particular program that is the subject of the demonstration.<sup>iv</sup> Congress has only rarely intervened to limit the Secretary’s authority to design or approve demonstrations.<sup>v</sup>

The inherent legal power of §1115 has been enhanced over the decades because demonstration standards have not been subject to formal rulemaking. Unlike more limited demonstration programs (e.g., §1915(b) of the Social Security Act), HHS has never issued regulations setting forth formal standards or procedures for the design, approval, implementation and oversight of §1115 demonstrations. Instead, HHS has articulated its Federal demonstration policies in various *Federal Register* notices,<sup>vi</sup> Medicaid operations manuals,<sup>vii</sup> review guides,<sup>viii</sup> approval letters and conditions of approval, and informal letters to and communications with state agency officials, other public officials, advocates and researchers. While permissible, aggressive and unilateral use of this authority by the executive branch has been criticized. For example, a former General Accounting Office Comptroller stated that use of §1115 demonstration to accomplish an administration goal “without consultation and concurrence of the Congress does appear to be inappropriate.”<sup>ix</sup>

While in theory, the objective of §1115 is to test unique approaches to program design and administration, in reality, once a state demonstration has been approved, numerous states have sought approval to conduct nearly identical demonstrations. As a result, §1115 has become a means for achieving general program changes outside of the legislative process. Indeed, many of the changes that have taken place in Medicaid and other programs over the decades have been presaged by §1115 demonstrations. This has blurred the line between Congressional and Administration control over program changes.

## §1115 Demonstrations: Federal and State Goals, Approval, and Oversight

### Federal Goals and Parameters for §1115 Demonstrations

The specific waivers of Federal law that any administration grants in §1115 demonstrations tend to reflect that administration’s policy priorities. From the beginning of the Medicaid program through the early

1990s, there were many approved demonstrations, but they were small in scope and primarily driven by state rather than Federal interest. The exception was Arizona's 1982 statewide demonstration. Arizona created its entire Medicaid program through a §1115 demonstration that allows it to deliver virtually all of its services through managed care.<sup>x</sup> Although some states submitted comprehensive §1115 demonstrations to the first Bush Administration (e.g., Oregon), it did not approve them.

In contrast, the Clinton Administration actively promoted states' use of §1115 demonstrations. It clarified the §1115 approval process and stated that it explicitly sought proposals to "preserve and enhance beneficiary access to quality services."<sup>xi</sup> It also placed a heavy emphasis on state flexibility in administering the program – a priority that sometimes conflicted with its stated goal of preserving and enhancing beneficiary access. Most of the demonstrations it approved between 1994 and 1997 focused on low-income families and people for whom the affordability of care was a problem. After 1997, there was a shift in focus towards populations with serious and chronic health problems who face barriers to adequate health care (e.g., persons with HIV/AIDS) (see "A Brief Overview of Existing 1115 Demonstrations"). The Administration generally discouraged and denied proposals that were inconsistent with its policy priorities (e.g., a plan to extend medical savings accounts to low-income persons, use of cost sharing from beneficiaries to replace state spending).<sup>xii</sup>

The Clinton Administration was even more explicit in describing its goals for CHIP §1115 demonstrations. It encouraged demonstrations that would expand coverage to children, incorporate innovative outreach strategies, and improve the quality of care. To the extent that a state has already extended coverage to children in families with income up to 200 percent of poverty (\$29,260 for a family of three in 2001), it could apply for a demonstration to use CHIP funds to cover uninsured parents, which could increase enrollment of uninsured children.<sup>xiii</sup> The CHIP guidance indicates that the past Administration would not approve demonstrations that would reduce benefits or increase cost sharing.<sup>xiv</sup>

While Federal priorities have significantly affected the direction of §1115 demonstrations, states still determine the specific design and breadth of demonstration efforts. This is because no Administration can compel a state to apply for a particular type of demonstration. Moreover, as recent history shows, the negotiation between the Federal and state executives over approval often yields a *quid pro quo*: states will include in their demonstrations some Federal priority (e.g., expanding coverage) in return for approval of their own priority (e.g., keeping Medicaid disproportionate share hospital (DSH) dollars, implementing mandatory managed care).<sup>xv</sup> Thus, tradeoffs are made to reconcile the often-different goals for §1115 demonstrations.

## Why States Seek Approval for Medicaid and CHIP Demonstrations

Both Medicaid and CHIP provide states with considerable discretion over issues of program design, administration, and eligibility. Nonetheless, states have sought demonstration approval. Three main reasons why states have sought demonstrations include:

- **Reducing the Federal requirements that apply to program participation under Medicaid and CHIP.** States have sought waivers of Medicaid laws related to benefits, cost sharing, use of managed care, provider participation and compensation, among others. Many of these requirements have been the subject of intense Congressional deliberation. Nonetheless, it is relatively typical for administrations to waive some of these requirements on a demonstration basis, allowing states to continue to receive Federal matching payments through such demonstrations.

- **Increasing access to Federal payments for populations who otherwise would be ineligible for coverage under Medicaid or CHIP.** Federal funding for Medicaid and CHIP eligibility is limited to certain groups recognized in the statute. States may seek, through demonstrations, to extend Federal funding for coverage for other groups of individuals who are not eligible under current law (e.g, low-income non-elderly, non-disabled adults without children, who as a category are ineligible for Medicaid regardless of the extent of their poverty).
- **Redirecting Federal funding from one area to another.** Because §1115 demonstrations aim to be budget neutral, they constitute a re-direction of existing Federal funding away from one existing expenditure and towards a newly recognized one. For example, a state might seek approval to cease payments to disproportionate share hospitals (i.e., hospitals that serve a disproportionate share of low-income and Medicaid patients) to extend Medicaid coverage to low-income, uninsured adults. Although waivers could result in savings without reinvestment, it is usually in the states' best interest to find a way to apply the Federal savings from the demonstration towards an existing or new state expenditure.

## **Budget Neutrality of Demonstrations**

To date, one constant across administrations is the emphasis on the budget neutrality of demonstrations. While not required in statute, the budget neutrality requirement for §1115 was initially adopted by the Carter Administration, has been maintained by succeeding administrations, and was explicitly described in 1994.<sup>xvi</sup> Budget neutrality means that total Federal Medicaid expenditures under a §1115 demonstration can be no greater than they would have been in the absence of the demonstration for comparable services for the same beneficiaries. Budget neutrality is calculated by creating a “without waiver” baseline, which is a projection of per capita Federal Medicaid spending on relevant services and populations in the absence of the demonstration. The “without waiver” baseline serves as a limit on the “with waiver” spending, or projected spending for services and populations within the proposed demonstration. These estimates focus exclusively on Medicaid costs for the five-year life of the demonstration.

While budget neutrality is conceptually straight forward, it is often the most contentious part of the demonstration approval in practice. This is because of its components and consequences. Determining what are appropriate dollars and/or services in and outside of the demonstration, what base year to use, and what are the appropriate trend factors for the with- and without-waiver baselines all involve some measure of discretion. States clearly have a financial interest in creating the most generous budget neutrality agreement possible, while the administration – particularly the Office of Management and Budget (OMB) – tends to take the position that agreeing to states' terms may create a demonstration that is not budget neutral and drains the Federal Treasury.

With CHIP §1115 demonstrations, there is a different standard for budget neutrality. CHIP by law has an aggregate annual cap (called an allotment) on Federal expenditures for (1) enhanced matching payments for states that expand through Medicaid or (2) total expenditures for states that expand through non-Medicaid programs. For CHIP demonstrations, “budget neutrality” means that states' demonstration spending cannot exceed the unused amount of the states' annual CHIP

allotment.<sup>xvii</sup> Since most states have not spent their entire allotment on children, there is not only room for additional spending, but Federal spending could increase since, without the demonstrations, many states would otherwise not spend their entire allotments in each year – at least in the near term.<sup>xviii</sup>

## **The Demonstration Approval and Oversight Process**

All §1115 demonstration proposals must go through a Secretarial review process and are monitored differently than ordinary state plan amendment changes. In previous administrations, a stronger emphasis was placed on approval than on monitoring. High standards for approval were viewed as necessary given magnitude of the changes to law and the dollars involved in §1115 demonstrations. However, states have expressed concern over both the standards and the lengthy approval process, triggering interest by the new Administration in streamlining them. The processes used by past administrations are described below.

### **1. Application and Approval**

States begin the process by submitting a demonstration proposal to the Centers for Medicare & Medicaid Services (CMS) (formerly known as the Health Care Financing Administration or HCFA) within HHS. Because the development of an application is time consuming, some states submit concept papers and/or meet with CMS staff to review their ideas and obtain guidance on shaping the demonstration and their applications. Although there is no formal application, most states use a special review guide developed by CMS to structure their proposals. Key elements to include are: environment for reform (e.g., state legislative support, public input); administrative issues (e.g., plan for developing additional needed personnel); eligibility issues (e.g., family and income definitions, effect on currently eligible persons); coverage/benefits; delivery system (e.g., assurance of provider participation in managed care); access issues (e.g., outreach, enrollment, marketing); quality of administration and service delivery; financing issues; implementation plan; and evaluations and reporting.<sup>xix</sup>

Once the application is submitted, the administration assembles a “waiver review team” comprised of HHS and OMB staff. This team meets to review the application, develop a list of additional questions (if any) it has for the state, and prepare for meetings with state officials about the demonstration. It includes agencies outside of CMS since most waivers include interactions with other programs (e.g., mental health services). When reviewing proposals, the team in recent years has been likely to pay particular attention to beneficiary protections, the soundness of delivery system infrastructure, quality assurance and budget neutrality. Unlike state plan amendments, there is no time frame for approval of initial §1115 demonstration proposals, although strict time limits apply to requests for continuation and extension of certain demonstration projects.<sup>xx</sup> One study found that the median approval time was six months during the 1990s.<sup>xxi</sup> In some cases, this approval process took years to complete. Sometimes, this resulted from long series of questions posed by the demonstration review team to states – some of which were viewed by states and others as extraneous. In other cases, the delay resulted from a change in the state executive branch’s or legislature’s interest in demonstration approval.

When a demonstration is approved, CMS issues an award letter, 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 terms and conditions address numerous issues in demonstration design and operation, such as eligibility standards, contracts with managed care organizations, quality assurance, budgetary terms, evaluation, and demonstration reporting.<sup>xxii</sup> These terms and conditions are binding but can be superceded by changes in underlying Federal law. Demonstrations are approved for a five-year duration and must be reviewed prior to their extension.

## 2. Monitoring and Evaluation

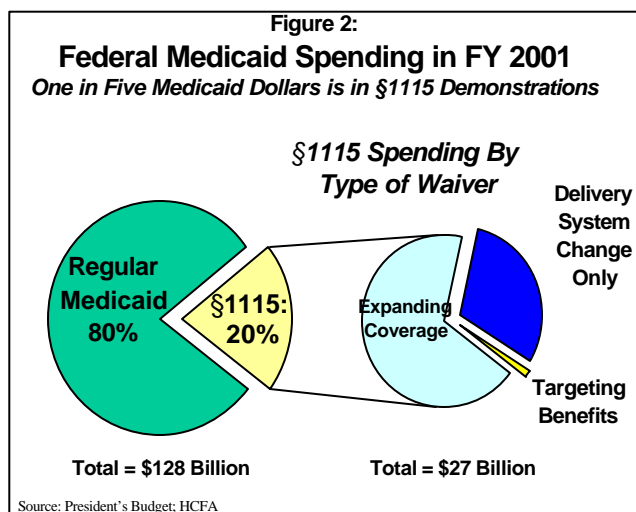
Once implemented, demonstrations are monitored through review of regular reports, communications, and site visits. CMS assigns one program officer from its central office to each demonstration; this individual maintains primary management oversight, along with regional office staff. CMS has funded several independent evaluations by private contractors to assess the impact of certain approved demonstrations on service delivery systems, costs, and quality of care. Individual-state evaluations have been completed for Arizona and Oregon. In addition, CMS has sponsored two major, five-state evaluations (one of Hawaii, Rhode Island, Tennessee, Oklahoma and Maryland whose final report is due shortly and another of Los Angeles, Kentucky, Minnesota, New York, and Vermont).<sup>xxiii</sup>

Public access to information on demonstration approval and monitoring is limited. Public input is required in developing the demonstration application. However, the final terms and conditions, budget neutrality agreements, and demonstration renewal information are not available on the CMS website, as are state plan amendments.

### A Brief Overview of Existing §1115 Demonstrations

Eighteen states have implemented statewide, comprehensive §1115 demonstrations in Medicaid that modify their delivery system, expand health insurance coverage, or both (see figure 3). Los Angeles County, California, also operates its health system through a §1115 demonstration. In addition, a number of states have received approval for demonstrations targeted at specific services or populations, most notably family planning services, care for people with HIV/AIDS and prescription drug discounts for Medicare beneficiaries (see descriptions below).

According to the President's budget, the Federal government will spend \$27 billion in fiscal year (FY) 2001 through Medicaid demonstrations (see figure 2).<sup>xxiv</sup> More than 20 percent of total Federal Medicaid spending is governed by §1115 demonstrations' terms and conditions rather than usual Medicaid rules. When Medicaid spending on long-term care is excluded (since very few demonstrations include long-term care), demonstration spending comprises one-third of Federal Medicaid spending.<sup>xxv</sup> This is over five times the amount the Federal government spends annually on CHIP. The amount of Medicaid demonstration spending exceeds the discretionary funding for 23 of the 27 Federal agencies, including the FY 2001 discretionary budgets for the Departments of Agriculture, Justice, Labor and Veterans Affairs.<sup>xxvi</sup> If demonstration spending were to remain constant as a share of total spending, it would total over \$170 billion from 2002 through 2006, and over \$400 billion over the next 10 years.<sup>xxvii</sup> To put this amount in context, projected Medicaid §1115 demonstration spending over the next ten years is one-third higher than the Congressional allocation and nearly three times the President's allocation for a Medicare prescription drug benefit.



Section 1115 demonstrations also affect a significant number of Medicaid (and soon CHIP) beneficiaries. Several million beneficiaries get their health care through demonstrations, and nearly 2 million uninsured have gained access to health care through Medicaid demonstrations.<sup>xxviii</sup>

**Figure 3:  
MAJOR MEDICAID AND CHILDREN'S HEALTH §1115 DEMONSTRATIONS**

<b>STATE</b>	<b>ELIGIBILITY / BENEFITS EXPANSION</b>	<b>YEAR IMPLE- MENTED</b>	<b>FED. SPENDING THROUGH §1115 *** (Millions, FY 2001)</b>
<b>MEDICAID</b>			
<b>Demonstrations for Delivery System Changes Only</b>			
Arizona		1982	\$1,670
<i>California: LA County (Not Statewide)</i>		1996	\$246
Kentucky		1997	\$2,290
Maryland		1997	\$1,021
Ohio		1996	\$2,287
Oklahoma		1996	\$900
<b>Subtotal</b>			<b>\$8,414</b>
<b>Demonstrations Including Health Insurance Expansions**</b>			
Arkansas	Children	1997	\$49
Delaware	Adults	1996	\$105
Hawaii	Adults	1994	\$283
Massachusetts	Adults & Pregnant Women*	1997	\$1,918
Minnesota	Parents & Childless Adults	1995	\$1,437
Missouri	Parents	1999	na
New Mexico	Children	1999	na
New York	Adults	2001	\$10,509
Oregon	Adults	1994	\$545
Rhode Island	Parents	1994	\$70
Tennessee	Adults	1994	\$3,227
Vermont	Adults	1996	\$151
Wisconsin	Parents	1999	na
<b>Subtotal</b>			<b>\$18,294</b>
<b>Demonstrations for Targeted Benefits</b>			
12 States	Family Planning	1990s	\$308
Maine, D.C.	HIV*	2000 / 2001	\$7
Maine, Vermont	Prescription drug discount	2000 / 2001	\$0
<b>Subtotal</b>			<b>\$315</b>
<b>TOTAL FEDERAL MEDICAID FUNDING THROUGH §1115</b>			<b>\$27,023</b>
<b>STATE CHILDREN'S HEALTH INSURANCE PROGRAM</b>			
New Jersey	Parents & Pregnant Women	2001	na
Rhode Island	Parents & Pregnant Women	2001	na
Wisconsin	Parents	2001	na
Minnesota	Parents	2001	na

Sources: Health Care Financing Administration, 2000; The Urban Institute 2000, Center for Health Services Research & Policy, 2001.

\* Massachusetts received approval in January 2001 for an HIV waiver; its spending is not included

\*\* These states almost all have delivery system and/or targeted benefit expansions as well.

\*\*\* Source: Budget of the United States Government, FY 2002, Analytical Perspectives (April 2001); table 14-4.

Note: Only the LA county waiver costs are net increases in Federal spending; the rest are budget neutral.



## Managed Care and Delivery System Demonstrations

Many of the demonstrations now in place began as state efforts to implement broader managed care systems than Federal law permitted. Prior to the Balanced Budget Act (BBA) of 1997, states could not require that beneficiaries join a managed care plan to receive Medicaid services (known as mandatory managed care). Although changes enacted in the BBA ease states' use of mandatory managed care, the revised Federal statute still imposes certain requirements and limitations that in some cases are more constraining than allowed in demonstrations. As a result, most states with §1115 demonstrations approved before 1997 have elected to continue operating their programs on a demonstration basis. Areas in which state demonstrations typically permit greater flexibility than Federal law include the scope of mandatory enrollment,<sup>xxxix</sup> standards that apply to participating managed care organizations, and beneficiary protections (such as disenrollment rights).

Past administrations also approved sub-state demonstrations that modify Federal requirements related to payment and delivery of care. The most notable of these is the Los Angeles demonstration. In 1995, California received a §1115 demonstration to restructure the Los Angeles County Department of Health Services system of 6 public hospitals and 45 health centers. The demonstration, which was extended for another five years in January 2001, is designed to transform the county's large, hospital-based public medical care system into an integrated system that coordinates services and relies more on primary and outpatient care. It is the only Medicaid §1115 demonstration that explicitly increases Federal costs, according to the President's budget document.<sup>xxx</sup>

There has also been interest – but few approved demonstrations – in the area of integrated care for individuals dually eligible for both Medicare and Medicaid (known as “dual eligibles”). These individuals comprise about 19 percent of Medicaid beneficiaries but account for 35 percent of total Medicaid costs.<sup>xxxi</sup> In 1995, the New England states formed a consortium that submitted concept papers to CMS on ways to better manage the delivery of care to these individuals.<sup>xxxii</sup> The primary goal was to combine Medicare and Medicaid funding for dual eligibles which would allow managed care organizations to deliver a broad array of health and social services.<sup>xxxiii</sup> Because of concerns about budget neutrality, the challenge of coordinating Medicare and Medicaid waivers, and passage of legislation giving states more options (e.g., an expansion of the PACE and SHMO programs<sup>xxxiv</sup>), none of the New England demonstrations were approved. However, small programs were implemented in Minnesota and Wisconsin and dual eligibles in Arizona and Tennessee receive services through their broader §1115 demonstrations.<sup>xxxv</sup> And, in 2001, there has been renewed state and administration interest in these types of demonstrations.

## Health Insurance Expansion Demonstrations

Since the mid-1970s states have received approval for demonstrations to extend Medicaid coverage to previously uninsured persons. The number of demonstrations that included coverage expansions grew dramatically in the mid-1990s as state and Federal attention increasingly focused on Medicaid's potential role in reducing the number of Americans without health insurance. In some cases, these coverage expansions focused on groups that could not otherwise be enrolled in Medicaid (e.g., childless adults). In others, they expanded to groups that could be insured at state option, but not in the same way (e.g., in mandatory managed care).

Because of the large cost of health insurance expansions, these demonstrations invariably included mandatory managed care systems and/or alterations in provider payment rules, most notably the reduction or elimination of disproportionate share hospital (DSH) payments. In the late 1980s and early 1990s, some states paid hospitals large, excess DSH payments, received a Federal matching payment for the payment, and got a part or all of the excess Federal payment back through provider taxes, donations, or intergovernmental transfers. This practice was limited by laws and regulations that began taking effect in 1994. Some affected states realized that they could use §1115 waivers to capture Federal DSH dollars – which would have gone away under the new laws and regulations – to redirect towards coverage expansions in a budget neutrality agreement.

Examples of health coverage expansion waivers include:

- **Tennessee:** The §1115 demonstration granted to Tennessee to create TennCare is, arguably, the most aggressive use of the demonstration authority to date. Created in 1994, TennCare originally expanded subsidized health coverage to all uninsured and uninsurable people up to 400 percent of poverty (\$58,520 for a family of three in 2001) and allowed those with income above this level to buy into the program. This was possible through an aggregate (rather than per capita) budget neutrality agreement that allowed the state to both (a) provide services to virtually all beneficiaries through managed care; and (b) capture Federal DSH funding (the State faced the prospect of losing almost half a billion annually).<sup>xxxvi</sup> TennCare has been modified several times and restricted eligibility, due to provider managed care participation problems, concerns about access to care, and state financial problems. However, the number and percent of uninsured in the state has fallen since 1993<sup>xxxvii</sup> and studies have shown that access to care has improved.<sup>xxxviii</sup>
- **Minnesota:** In 1995, Minnesota received approval for its Medicaid demonstration program known as MinnesotaCare. It builds on basic Medicaid coverage to provide comparable insurance coverage with nominal premiums and cost sharing to individuals with income up to 275 percent of poverty (\$40,232 for a family of three in 2001). Eligibility is restricted to those without access to employer-based insurance and who have generally been uninsured for at least 4 months (with exceptions). It was funded primarily by a move to mandatory managed care. One study found that while the rate of uninsured in the U.S. rose from 1990 to 1998, it remained constant in Minnesota and decreased for its children and low-income population.<sup>xxxix</sup>

## Targeted Benefit/Coverage Demonstrations

Since 1997, the number of states applying for approval to expand coverage has declined. This decline, in part, resulted from reforms in Medicaid and the enactment of CHIP that created new coverage expansion options that do not require demonstration approval.<sup>xi</sup> In addition, the new options regarding mandatory managed care and the

decline in the availability of disproportionate share hospital funds decreased states' ability to conduct major, budget-neutral expansions.

These trends appeared to change the nature, as well as the volume, of §1115 Medicaid demonstrations. A diverse set of demonstrations emerged with one common theme: filling gaps in insurance coverage either by insuring selected populations or by expanding coverage for and access to selected services. Examples of these types of waivers include:

- **Family planning waivers:** As of July 2001, 14 states were operating statewide demonstrations that extend family planning services to low-income women.<sup>xii</sup> Eight of these states make services available to women who lost Medicaid at the end of a post-partum period; the length of coverage ranges from two to five years. One state makes family planning services available for two years to women who lose Medicaid for any reason. Five states have gone a step further, basing eligibility solely on income rather than on previous Medicaid enrollment. These demonstrations are assumed to be budget neutral because it is estimated that for every \$1 spent on publicly funded family planning services, \$3 is saved on Medicaid prenatal and newborn care.<sup>xiii</sup> Medicaid pays for over one-third of all births in the U.S.<sup>xiii</sup>
- **HIV/AIDS demonstrations:** In May 2000, Maine received approval to conduct a demonstration to extend health coverage for people with HIV who do not otherwise qualify for Medicaid because their disease has not progressed to the point where they are considered disabled and thus eligible for Medicaid. This demonstration achieves budget neutrality by structuring coverage to permit early access to cost-effective antiretroviral therapy as a strategy for reducing Medicaid costs associated with AIDS treatment. Massachusetts and the District of Columbia received approval for similar demonstrations in January 2001 (they are not yet implemented). Medicaid is the largest single payer of care for people with AIDS, spending an estimated \$4.3 billion in FY 2001 to cover over 50 percent of all persons and up to 90 percent of all children with AIDS.<sup>xiv</sup>
- **Prescription drug demonstrations:** In November, 2000, Vermont received approval for an amendment to its §1115 program to allow all Medicare beneficiaries and certain low-income adults, irrespective of income, to access the Medicaid discounts for prescription drug coverage. Although beneficiaries would not get insurance for drug expenditures, they would benefit from Medicaid's pharmacy discount and rebate program. Maine received approval for a similar demonstration in January 2001. However, the Pharmaceutical Manufacturers of America of Association sued Vermont and, on June 8, 2001, the United States Court of Appeals for the District of Columbia Circuit ruled that HHS lacked the authority to grant the waiver of the rebate program since it was extending the rebate to non-Medicaid recipients. Maine's demonstration may be vulnerable as well. Medicaid will pay an estimated 17 percent of all prescription drugs expenditures nationwide this year,<sup>xv</sup> making it the single largest purchaser of prescription drugs.

It appears that the Bush Administration will change demonstration policy with regard to targeted benefit / coverage waivers. The press has reported that the Administration will only approve extended family planning coverage in the context of a comprehensive demonstration proposals and will deny the 9 pending family planning waivers. Details of this policy change are not yet known.<sup>xvi</sup>

## CHIP Demonstrations

The Federal CHIP legislation explicitly authorizes the Secretary to waive provisions of the law to conduct §1115 demonstrations. Within the last year, the Clinton Administration issued policy guidance and began to approve demonstrations in CHIP. Three states were authorized to conduct CHIP demonstrations in January 2000.<sup>xvii</sup> New Jersey's demonstration covers uninsured parents of Medicaid and CHIP-eligible children and pregnant women with income up to 200 percent of poverty (\$29,260 for a family of three in 2001). Rhode Island's demonstration covers uninsured parents with incomes between 100 and 185

percent of poverty and pregnant women with incomes between 185 and 250 percent of poverty (up to \$36,575 for a family of three in 2001). Wisconsin began to receive CHIP enhanced payments for its parents' coverage through its BadgerCare Medicaid demonstration program. And, the Bush Administration approved a CHIP waiver for Minnesota to cover certain parents at the enhanced CHIP matching rate.<sup>xlviii</sup>

## Future Directions and Key Issues in §1115

The Bush Administration has stated its intent to both promote and streamline the practice of using §1115 to permit broad restructuring of Medicaid and CHIP. In a recent press release, it wrote, "The Bush Administration has made a commitment to states to give them more power in determining the nature of their programs by granting waivers from Federal rules."<sup>xlix</sup> In addition, the HHS budget submission states that it will explore options with states to "increase State flexibility and ensure that Medicaid and CHIP are being effectively used to promote health insurance coverage."<sup>l</sup> As of mid-June 2001, the Administration has not yet made any public changes to §1115 demonstration policy. It has approved an amendment to New York's Medicaid demonstration and Minnesota's CHIP demonstration.<sup>li</sup>

The general health policy environment also may be a catalyst for change. After years of low rates of health expenditure increases, health care inflation has returned, raising concern about both health spending and the number of uninsured – which may increase in the slowing economy. Medicaid costs, too, are beginning to grow as a result of general cost inflation, greater enrollment, creative state financing strategies ("upper payment limit" arrangements), and the high cost of prescription drugs.<sup>lii</sup> The Supreme Court's 1999 decision in *Olmstead v L.C.* has also been cited by both the Congressional Budget Office<sup>liii</sup> and state officials as a cost factor because of its implications for Medicaid spending on community services for persons with serious disabilities. These factors, coupled with renewed interest on the part of Federal and state officials, may yield a rapid change in §1115 policy and practice.

### Financing §1115 Demonstrations: Will Budget Neutrality Change?

As a growing number of states experience budget problems (in part, because of high Medicaid costs), they may seek demonstrations to reduce state spending and/or increase Federal funding. The higher Medicaid baseline, recent practice of overpaying public hospitals and nursing homes through the upper payment limit, and 1997 repeal of provider payment protections (known as the Boren amendment) may create new opportunities for savings. Alternatively, states could look to §1115 demonstrations to reduce their benefits and/or coverage below Federal minimums and either keep the savings or reinvest them in replacing state with Federal dollars for some other type of state service. In addition to seeking demonstrations, states may press for changes in how budget neutrality in Medicaid is defined. For example, the National Governors' Association (NGA) recommends that states be permitted to use savings in Medicare, Supplemental Security Income (SSI) and other programs that result from demonstrations to offset the demonstrations' Medicaid costs.<sup>liv</sup>

States may also pursue demonstrations in CHIP to increase Federal funding. Unlike Medicaid demonstrations, CHIP demonstrations are not budget neutral in the sense that they result in greater Federal spending than would be the case in the absence of the demonstration (constrained by state allotments). In addition, CHIP provides a higher Federal matching rate and, in non-Medicaid CHIP plans, fewer Federal requirements. Thus, states may seek approval of the type of demonstrations outlined by the previous administration. They may also seek to broaden CHIP demonstration parameters and/or shift Medicaid-eligible populations into CHIP – which would increase Federal costs and possibly reduce the scope of benefits for children.<sup>lv</sup>

The Bush Administration has not, thus far, announced a change in the budget neutrality policy.<sup>lvi</sup> Even if it does not change it, it could come under criticism. As early as 1995, the General Accounting Office and some members of Congress raised concerns about the current budget neutrality approach, arguing it was

neither effective nor enforceable.<sup>lvii</sup> These issues could be exacerbated if there is a rapid increase in the number and types of demonstrations.

## Subsidizing Private Employer-Based Insurance through CHIP?

The new Administration has committed to promoting the use of CHIP funds to subsidize employer-based insurance for children and their parents.<sup>lviii</sup> An existing demonstration authority within CHIP allows states to provide CHIP coverage for children through employers. However, few states have taken advantage of it, arguing that the requirements of this demonstration authority are too restrictive (e.g., assuring that benefits and cost sharing meet CHIP standards). Waiver policy could further reduce the employer contribution; loosen the benefit and cost sharing requirements; and/or modify the provisions against subsidizing children who already have insurance. This type of policy could be constructed to benefit all involved: families could be able to afford private group insurance that has the same benefits as CHIP; states could pay less if the employer makes a contribution; and employers could offer coverage with a lower contribution. However, questions may arise as to whether families are getting the level of health insurance that Congress specified and whether public dollars are “crowding out” private dollars -- effectively subsidizing low-wage businesses that might have offered insurance anyway.

## Eligibility Expansions: Medicaid Versus CHIP, Poor Versus Sick?

Recent higher health care costs and a slowing economy may result in a deterioration in private insurance coverage and benefits. States may soon seek permission to fill these gaps through both Medicaid and CHIP. Current legislative proposals offer insight into the shape that state demonstrations might take. Some legislative proposals would expand Medicaid eligibility for more of the poorest uninsured and encourage CHIP expansions for higher-income individuals.<sup>lix</sup> Others would target Medicaid coverage expansions for populations with special health needs (e.g, children with disabilities<sup>lx</sup> and people with HIV/AIDS<sup>lxi</sup>) irrespective of income.

Focusing Medicaid coverage expansions on persons with significant health needs may make sense, since Medicaid provides benefits and services not found in conventional insurance. On the other hand, making Medicaid more like a high-risk pool, while enrolling average-health people in CHIP, could undermine support for Medicaid. Coupling Medicaid's lower matching rate and more generous benefits with an exclusively sicker population will lead to spiraling costs and an even greater financial incentive for states to focus on CHIP. This major policy question, which has large financial and policy implications, will likely get played out in the §1115 demonstration context as well as the legislative process.

## Medicaid and CHIP Benefits: Who Will Get What?

A related question in Federal policy concerns the scope of Medicaid's benefit requirements. The NGA has proposed to allow states to impose cost sharing on all optional benefits; tailor Medicaid benefits for populations eligible at state option;<sup>lxii</sup> and reduce the commitment to comprehensive benefits required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children.<sup>lxiii</sup> In addition to potential waivers of benefit requirements for current Medicaid-eligible populations, some states may seek to establish a “partial benefits package” for persons who need coverage for certain forms of assistance. For example, states with pharmacy assistance programs for low-income seniors above Medicaid eligibility may petition for Medicaid payment for those and additional seniors – a policy that the new Administration has endorsed through a legislative proposal known as the “Immediate Helping Hand”.<sup>lxiv</sup>

Proposals to modify the Medicaid benefit package raise complex issues. Most of Medicaid spending today is for optional services, meaning that states could eliminate coverage for the benefit altogether. States also, for most benefits and populations, can determine the amount, duration and scope of coverage (e.g., states can limit prescription drug coverage to three filled medications per month, or adult hospital coverage to a week). What states need waivers for is imposing cost sharing or restricting

benefits to subgroups of beneficiaries such as children or pregnant women. While cost sharing can reduce unnecessary utilization, it can cause access problems for low-income populations (the average Medicaid beneficiary's income is well below the poverty level). It also disproportionately affects sick people who are higher users of health care services. Limiting benefits to subgroups of Medicaid enrollees also poses challenges. For example, the line between a "regular" Medicaid child and one with special health needs is often hard to draw. A child with asthma may not be defined as having "special needs" but would incur high treatment costs that could consume a large fraction of the family's income if a state restricted services covered for non-disabled children.

Partial benefits packages raise similar questions. Covering only chemotherapy for an uninsured man with prostate cancer may mean that he stops therapy if he cannot afford the cost of caring for its side effects. However, providing a supplemental service such as prescription drugs to a person who already has Medicare may be viewed as good health policy. Congress appears to have rejected this partial benefit approach for persons with severe illnesses when it enacted the Breast and Cervical Cancer Prevention and Treatment Act of 2000.<sup>ixv</sup> The Act allows states to extend Medicaid to women with diagnosed breast and cervical cancer, but prohibits states from limiting benefits to only those that are necessary to treat the cancer itself. This decision on Congress' part may reflect the inherent difficulties in deciding which benefits and services might be needed to treat illness.

### **The Approval and Renewal Process: Different or Just Faster?**

While there is uncertainty about the future substantive direction of §1115 waivers, it seems clear that the process for demonstration approval will change. The Secretary of HHS, in a speech to the NGA, stated, "You will no longer have to wait months, a year or even longer to get action on a demonstration request. No more frustrating delays, waiting to implement your innovative ideas. No need to badger the department."<sup>ixvi</sup>

However, details of how demonstration application review will be expedited have not been announced. By definition, §1115 is a demonstration authority and requires deliberations regarding the merits of demonstrations. Thus, while improving the processing of applications for new or renewed demonstrations may be appropriate, concerns may be raised about perceived automatic approval of states demonstration requests.

It is also not clear whether the review criteria, public process, and/or monitoring of demonstration activity will change. The review criteria for demonstrations are generally known, and they are described on the CMS webpage and in its guide.<sup>ixvii</sup> The content of the review, weight given to different elements of the demonstration, and composition of the review team itself could change, since these are determined through the administration's discretion. It is also unknown if and how public involvement in demonstration development and approval will change. The past Administration required states to solicit public input before submitting a demonstration proposal. States are also supposed to consult with Indian tribes when developing demonstrations that affect them. However, it did not make publicly available the state application, its questions to states, and the final terms and conditions. The new Administration, whose budget documents emphasize the importance of fiscal integrity and accountability, may improve the review process and available information as well as reduce application review time.

## **Conclusion**

At a time of rapid changes in the health system, §1115 offers a means of tackling challenges in insurance coverage and service delivery for low-income and vulnerable populations. Previous administrations have made extensive use of this broad demonstration authority to modernize the Medicaid program. It is likely that this active use of §1115 will continue and grow in the coming years, as the complexities of the legislative reform process continue to slow progress towards fundamental reforms. At the same time, the balance of power between Congress and the executive branch raise questions

about the extent to which §1115 can be used as a substitute to legislative reform. This basic issue, as well as numerous others, undoubtedly will be the subject of ongoing debate in the coming years.

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## Notes

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<sup>i</sup> 42 U.S.C. §1315

<sup>ii</sup> Greenberg M; Savner S. (November 1996). *Waivers and the New Welfare Law: Initial Approaches in State Plans*. Washington, D.C.: Center for Law and Social Policy.

<sup>iii</sup> Certain provisions of Medicaid law state specifically that they cannot be modified through waivers, including: the statutory Federal matching rate, quality assurance responsibilities, cost sharing for certain populations, and policies related to Qualified Medicare Beneficiaries and related groups, among other provisions. See “Review Guide for Section 1115 Research and Demonstration Waiver Proposals for State Health Care Reform.”

<sup>iv</sup> Rosenblatt R; Law S; Rosenbaum S. (1997). *Law and the American Health Care System*. New York, NY: Foundation Press. Chapter 2 (J) and (M)). There have been certain exceptions, however. In *Crane v Mathews*, 417 F. Supp. 532 (N.D. Ga., 1976) a Federal court enjoined Georgia’s §1115 Medicaid cost sharing demonstration on the grounds that the demonstration involved research on human subjects had not been reviewed for its impact in accordance with Federal human subject protection rules. In 1982 the Reagan Administration removed §1115 demonstrations from the scope of the human subject protection regulations. Rosenbaum S. (1993). “Mothers and Children Last: The Oregon Medicaid Experiment,” *American Journal of Law & Medicine*. In 1994, the Clinton Administration was enjoined from approving California’s welfare reform demonstration on the ground that the Secretary’s approval was arbitrary and capricious and without a factual basis regarding the objectives of the AFDC program that the demonstration would further. *Beno v Shalala* 30 F. 3d 1057 (9<sup>th</sup> Cir., 1994).

<sup>v</sup> In 1982, Congress significantly reduced the Secretary’s authority to waive Medicaid cost sharing protections under §1115. §1916 f of the Social Security Act; 42 U.S.C. §1396o(f), added by §131(b), P.L. 97-248 (Tax Equity and Fiscal Responsibility Act of 1982). In 1997 and again in 2000 Congress amended §1115 to limit the Secretary’s authority to review and disapprove or modify certain “statewide comprehensive demonstration projects” and in addition limited the Secretary’s authority over the procedures used to review proposals that involve the “extension” of a previously approved “waiver projects.” §4757 of the Balanced Budget Act of 1997, P.L. 105-33; §703(a) of the Medicare, Medicaid and CHIP Benefits Improvement Act of 2000, P.L. 106-554. In 2000 Congress prohibited the Secretary from waiving the Federal payment requirements for Federally qualified health centers. §702 of the Medicare, Medicaid and CHIP Benefits Improvement act of 2000.

<sup>vi</sup> Office of the Secretary of Health and Human Services. (September 27, 1994). “Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures.” *Federal Register*, 59(186): 49249.

<sup>vii</sup> State Medicaid Manuals contain information throughout on §1115 demonstration issues. They can be accessed at [www.hcfa.gov/pubforms/progman.htm](http://www.hcfa.gov/pubforms/progman.htm).

<sup>viii</sup> Health Care Financing Administration. (nd). “Review Guide for Section 1115 Research and Demonstration Waiver Proposals for State Health Care Reform.” Available at: [www.c-c-d.org/revge.html](http://www.c-c-d.org/revge.html)

<sup>ix</sup> Pear R. (1995). “GAO Says White House is Expanding Medicaid Coverage.” *The New York Times*.

<sup>x</sup> McCall N; Wrightson W; Paringer L; Trapnel G. (1994). “Managed Medicaid Cost Savings: The Arizona Experience.” *Health Affairs*. 13(2): 234-245.

<sup>xi</sup> Office of the Secretary of Health and Human Services. (September 27, 1994). “Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures.” *Federal Register*, 59(186): 49249.

<sup>xii</sup> Conversations with Federal officials.

<sup>xiii</sup> Ku L; Broaddus M. (September 5, 2000). *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*. Washington, DC: Center on Budget and Policy



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Priorities. Lambrew JM. (May 2001). *Health Insurance: A Family Affair: A National Profile and State-by-State Analysis of Uninsured Parents and Their Children*. New York: The Commonwealth Fund.

<sup>xiv</sup> Health Care Financing Administration. (July 31, 2000). Letter to State Health Officials. Available at: [www.hcfa.gov/init/ch73100.htm](http://www.hcfa.gov/init/ch73100.htm).

<sup>xv</sup> From conversations with Federal officials.

<sup>xvi</sup> Office of the Secretary of Health and Human Services. (September 27, 1994). "Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures." *Federal Register*, 59(186): 49249.

<sup>xvii</sup> Health Care Financing Administration. (July 31, 2000). Letter to State Health Officials. Available at: [www.hcfa.gov/init/ch73100.htm](http://www.hcfa.gov/init/ch73100.htm). Note that states draw Federal matching payments for eligible expenditures on children first from allotment amounts carried over from previous years and/or from allotment amounts reallocated from other states that have not used them before using the annual allotments. In most states, this results in a large percentage of the annual allotments remaining unspent in a given year.

<sup>xviii</sup> The Balanced Budget Act of 1997 provided more CHIP funding in the early years than the late years of the program, and the annual appropriation ends altogether in 2007.

<sup>xix</sup> Health Care Financing Administration. (nd). "Review Guide for Section 1115 Research and Demonstration Waiver Proposals for State Health Care Reform." Available at: [www.c-c-d.org/revge.html](http://www.c-c-d.org/revge.html)

<sup>xx</sup> §1115(e) and (f) of the Social Security Act.

<sup>xxi</sup> Milligan C. (May 2001). *Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage*. Washington, DC: Academy for Health Services Research and Health Policy State Coverage Initiatives Issue Brief.

<sup>xxii</sup> Rosenbaum S; Darnell J. (May 1997). *Statewide Medicaid Managed Care Demonstrations under Section 1115 of the Social Security Act: A Review of the Waiver Applications, Letters of Approval and Special Terms and Conditions*. Washington, DC: The Kaiser Commission on the Future of Medicaid.

<sup>xxiii</sup> Health Care Financing Administration. (2000). *Active Projects Report: Research and Demonstrations in Health Care Financing*. Washington, DC: U.S. Department of Health and Human Services.

<sup>xxiv</sup> *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2002*. Washington, DC: U.S. Government Printing Office. Table 14-4.

<sup>xxv</sup> This estimate is derived by applying the FY 1998 percent of non-long-term care Medicaid spending (from Kaiser Family Foundation's *Medicaid Enrollment and Spending Fact Sheet*, February 2001) to the President's Budget's projection of total Federal Medicaid spending for FY 2001.

<sup>xxvi</sup> *Budget of the United States Government, Fiscal Year 2002*. Washington, DC: U.S. Government Printing Office. Table S-6. Discretionary Budget Authority by Agency.

<sup>xxvii</sup> Estimated by taking demonstration spending (from *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2002*. Washington, DC: U.S. Government Printing Office. Table 14-4); dividing it into the FY 2001 current services Federal Medicaid spending (*Analytical Perspectives, Budget of the United States Government, Fiscal Year 2002*. Washington, DC: U.S. Government Printing Office. Table 14-11) and applying it to FY 2002 through 2006 current services spending projections. For FY 2007-2011, Federal Medicaid spending was projected multiplying the FY 2006 projected spending by the average annual growth rate for FY 2002 through 2006 (both from Table 14-11 of *Budget's Analytical Perspectives*).

<sup>xxviii</sup> National Economic Council / Domestic Policy Council. (January 2001). *Clinton Administration's Health Care Accomplishments*. Washington, DC: The White House. Available at National Archives.

<sup>xxix</sup> Federal law prohibits mandatory enrollment of dual Medicare/Medicaid eligibles and special needs children. These prohibitions can be overridden through §1115.

<sup>xxx</sup> Department of Health and Human Services Press Release. (January 17, 2001). *HHS Agrees to Approve Waiver Extension to Strengthen Health Care Services in LA County*.

<sup>xxxi</sup> Health Care Financing Administration. (September 2000). *A Profile of Medicaid Chartbook 2000*. Washington, DC: U.S. Department of Health and Human Services.

<sup>xxxii</sup> See New England Consortium website: [www.neconsotrium.org](http://www.neconsotrium.org).

<sup>xxxiii</sup> See testimony by State Medicaid Directors at the hearing before the Senate Special Committee on Aging, April 29, 1997).

<sup>xxxiv</sup> Social health maintenance organizations (SHMOs) are HMOs that combine Medicare services with some long-term care and social services. Program of All-Inclusive Care for the Elderly (PACE) is a

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program that targets older people who are nursing-home eligible for integrated Medicare, Medicaid, and additional community-based services – all paid for through combined Medicare/Medicaid capitation payment.

<sup>xxxv</sup> Anthony SE; Schroer C; Silow-Carroll S; Meyer JA. (October 2000). *Medicaid Managed Care for Dual Eligibles: State Profiles*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

<sup>xxxvi</sup> Conover CJ; Davies HH. (February 2000). *The Role of TennCare in Health Policy for Low-Income People in Tennessee*. Washington, DC: The Urban Institute, Assessing the New Federalism Project, Occasional Paper Number 33.

<sup>xxxvii</sup> U.S. Census Bureau, Health Insurance Historical Table 6. Available at [www.census.gov](http://www.census.gov).

<sup>xxxviii</sup> Moreno L; Hoag SD. (January / February 2001). "Covering The Uninsured Through TennCare: Does It Make A Difference?" *Health Affairs* 20(1): 231-239.

<sup>xxxix</sup> Minnesota Department of Health, Health Economics. (April 2000). *Characteristics and Trends Among Minnesota's Uninsured Population*.

<sup>xl</sup> Legislative and regulatory changes now allow states to optionally expand coverage to: parents of children eligible for Medicaid; people with disabilities who work; uninsured, low-income women with breast cancer; and certain foster care children aging out of Medicaid eligibility.

<sup>xli</sup> Alan Guttmacher Institute. (July 1, 2001). *Medicaid Family Planning Waivers*. Washington, DC: Alan Guttmacher Institute State Policies in Brief.

<sup>xlii</sup> Benson Gold R. (February 2001). "Title X: Three Decades of Accomplishment," *The Guttmacher Report on Public Policy* 4(1)

<sup>xliii</sup> Kaiser Commission on Medicaid and the Uninsured. (August 1999). *Medicaid: A Primer*. Washington, DC: The Henry J. Kaiser Family Foundation.

<sup>xliiv</sup> Department of Health and Human Services. (February 2001). *Fact Sheet: Medicaid and Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection*.

<sup>xlv</sup> Health Care Financing Administration, Office of the Actuary, National Health Expenditure Projections, Table 11: Prescription Drug Expenditures Aggregate and Per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980-2010.

<sup>xlvi</sup> Kaufman M; Vedantum S. (July 20, 2001). "Broader Family Planning Services Rejected." *The Washington Post*.

<sup>xlvii</sup> Department of Health and Human Services Press Release. (January 18, 2001). *HHS Approves First CHIP Waivers*.

<sup>xlviii</sup> Department of Health and Human Services Press Release. (June 13, 2001). *HHS Approves Minnesota Plan to Insure Parents Through Medicaid, SCHIP*.

<sup>xlix</sup> Department of Health and Human Services Press Release. (April 5, 2001). *Secretary Thompson Announces Florida Medicaid Changes Approved*.

<sup>i</sup> Department of Health and Human Services Fiscal Year 2002 Budget.

<sup>ii</sup> Department of Health and Human Services Press Release. (May 30, 2001). *Secretary Thompson Announces Approval of Medicaid Waiver for New York State*. The Administration has approved a number of amendments to CHIP and 1915(b) and 1915(c) waivers.

<sup>iii</sup> Bruen B, Holahan J. (February 2001). *Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

<sup>iiii</sup> Congressional Budget Office. (January 2001). *The Budget and Economic Outlook: Fiscal Years 2002-2011*. Washington, DC: CBO.

<sup>lv</sup> National Governors' Association. (February 2001). *Policy Resolution HR-16.2.5: Budget Neutrality*. Available at [www.nga.org](http://www.nga.org).

<sup>lv</sup> National Governors' Association. (February 2001). *Policy Resolution HR-15-8: Waiver Authority*. Available at [www.nga.org](http://www.nga.org).

<sup>lvi</sup> Note: there is some question about whether the New York and Minnesota approvals are indeed budget neutral. New York had been petitioning for an exemption from budget neutrality.

<sup>lvii</sup> General Accounting Office (1995). *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs*. GAO/HEHS-96-44.

<sup>lviii</sup> Department of Health and Human Services. (April 2001). *Fiscal Year 2002 Budget*. Washington, DC; p. 62.

<sup>lix</sup> FamilyCare Act of 2001 in S. 6 in the 107<sup>th</sup> Session.

<sup>lx</sup> Family Opportunity Act, HR 4825, S 2274 in the 106<sup>th</sup> Session.

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<sup>lxi</sup> Early Treatment for HIV Act, HR 1591; S 902 in the 106<sup>th</sup> Session.

<sup>lxii</sup> National Governors' Association. (February 2001). *Policy Resolution HR-32: Health Reform Policy*. Available at [www.nga.org](http://www.nga.org).

<sup>lxiii</sup> National Governors' Association. (February 2001). *Policy Resolution HR-16.3.5: Allow States to Manage Costs in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program by Providing Services within Their State Medicaid Plan and Selecting Less Costly Alternatives for Diagnosis and Treatment without Risking Quality..* Available at [www.nga.org](http://www.nga.org)

<sup>lxiv</sup> *Budget of the United States Government, Fiscal Year 2002*. Washington, DC: U.S. Government Printing Office. Pp. 97-98.

<sup>lxv</sup> P.L. 106-354.

<sup>lxvi</sup> Tommy Thompson, Secretary of the Department of Health and Human Services. (February 25, 2001). Speech to the National Governors' Association.

<sup>lxvii</sup> Health Care Financing Administration. (nd). "Review Guide for Section 1115 Research and Demonstration Waiver Proposals for State Health Care Reform." Available at: [www.c-c-d.org/revge.html](http://www.c-c-d.org/revge.html); also see [www.hcfa.gov/medicaid/hpg6.htm](http://www.hcfa.gov/medicaid/hpg6.htm).

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