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MERCATUS GRADUATE POLICY ESSAY

SECTION 1115 WAIVERS: AN INCREASING PART OF THE
MEDICAID PROGRAM

by Kelly Ferguson



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Abstract

The Medicaid program, made law in 1965, now constitutes the largest intergovernmental grant in the United States.¹ Intergovernmental grants are transfers of funds from one level of government to another and are often used in the United States to achieve nationwide social goals by providing financial support to implement those goals at the state or local level. This paper examines whether political affiliation in federal and state governments affects the likelihood that a state will be approved by the federal government for a Section 1115 Medicaid waiver, which is designed to allow states to advance the stated goals of Medicaid while being given some flexibility beyond federal Medicaid rules. My analysis of waiver approval times from 1994 through 2016 found evidence that a state may have its waiver approved more quickly if the legislature or governor belongs to the same party as the president. This finding casts doubt on the ability of a state government to use Section 1115 waivers to reform its Medicaid program free of political influence from the federal government.

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¹ CBO (Congressional Budget Office), "Outlays in 2011 for Federal Grants to State and Local Governments" (Washington, DC: CBO, March 2013).

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List of Acronyms in Alphabetical Order

ACA	Affordable Care Act
CBO	Congressional Budget Office
CMS	Centers for Medicare and Medicaid Services
DSH	Disproportionate Share Hospital
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
GAO	General Accounting Office
GDP	gross domestic product
HDHP	high deductible health plan
HHS	Department of Health and Human Services
HIFA	health insurance flexibility and accountability
HIP (1.0 and 2.0)	Healthy Indiana Plan 1.0 and 2.0
HSA	health savings account
IGT	intergovernmental transfer
NCPA	National Center for Policy Analysis
NCSL	National Conference of State Legislatures
NGA	National Governor’s Association
OMB	Office of Management and Budget
PAS	political affinity score

Introduction

The Social Security Act became law in 1935, during the first years of the New Deal. The legislation established a range of social welfare programs and was an unprecedented expansion of the federal government's role into functions such as old-age insurance; aid for the blind; and women and children, public health, and unemployment insurance. Several of the federal programs established by the 1935 law² were designed as formula grants³ to the states, which are noncompetitive grants that bind the federal government to reimbursing a portion of each state's program expenses. In turn, the state operates the program according to federal law.

In 1962, President John F. Kennedy signed a sweeping welfare reform bill, which added Section 1115 to the Social Security Act.⁴ The section, titled "Demonstration Projects," allows the Secretary of the Department of Health and Human Services (HHS) in charge of these programs to waive federal guidelines and disburse federal funds for states engaged in "experimental, pilot, or demonstration" projects that the HHS Secretary deems to "promote program objectives."⁵ When Medicaid was added to the Social Security Act as Title XIX in 1965, it was designed to assist the states in providing medical care to low-income individuals in their states. The new Medicaid law included Section 1115, so that interested states could apply to the HHS Secretary to conduct pilot projects in their Medicaid program. In the 50 years since Medicaid's inception, Section 1115 waivers have morphed from a little-known provision into a key feature of the Medicaid program. One-fifth of Medicaid spending in 2001 occurred through demonstrations,

² See preamble of the Social Security Act of 1935, 42 U.S.C. ch 7, <https://www.ssa.gov/history/35act.html#PREAMBLE>.

³ Grants.gov, "What Is a Formula Grant?," *Grants.gov Community Blog*, July 13, 2016, <https://blog.grants.gov/2016/07/13/what-is-a-formula-grant/>.

⁴ Public Welfare Amendments of 1962, Pub. L. No. 87-543 (1962).

⁵ *Ibid.*, 64.

and demonstration spending represents one-third of Medicaid spending today.⁶ Looking forward, there is reason to believe that Section 1115 waivers and the flexibility they offer will continue to be attractive to states as the Affordable Care Act (ACA) continues to be implemented. The ACA offers states an increased matching rate to extend Medicaid coverage to childless adults making 138 percent or less of the federal poverty level (FPL). This “expansion population” was previously not eligible for coverage without a Section 1115 waiver. This expansion means that the Medicaid program is a key part of the Obama administration’s efforts to reduce the number of uninsured, and state governments are taking advantage of the Section 1115 waiver program to expand coverage to childless adults while tailoring the expanded program to political, fiscal, and policy considerations within the state. To date, of the 32 states that have expanded Medicaid since the passage of the ACA, 9 have used or are using waivers to do so.⁷ Because this flexibility is a potentially powerful tool for both state and federal governments, it is important for program integrity that the federal government is basing waiver decisions on objective, consistently applied criteria. My thesis addresses two potential sources of biased decision-making:

- (1) Does the political party of the state government applying for a waiver affect the federal government’s decision-making? For example, would the Centers for Medicare and Medicaid Services (CMS) be more likely to approve a waiver from a state governed by Democrats if a Democrat-appointed administrator was in charge of the CMS? Conversely, would the head of CMS under President George W. Bush have been less likely to approve a waiver coming from a Democratic state government?

⁶ Katherine Iritani, “Medicaid Demonstrations: More Transparency and Accountability for Approved Spending Are Needed” (Testimony before the Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives, Washington, DC: General Accounting Office, June 24, 2015).

⁷ Mary Beth Musumeci and Robin Rudowitz, “The ACA and Medicaid Expansion Waivers” (Issue Brief, Kaiser Family Foundation, Washington, DC, November 2015), <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

- (2) If a state's waiver program runs contrary to the policy goals of an administration, is an administration less likely to approve or renew it?

Research Question

This research project will study waivers granted between 1994 and the 2016, in an effort to understand whether the administrations in that time period were more likely to approve a waiver that had been submitted by a state government belonging to the same political party as the president. The project also includes a case study of Indiana's Section 1115 waiver, Healthy Indiana Plan (HIP), and how different administrations received HIP.

The Political Economy of Medicaid

Political economy offers an interdisciplinary approach to social science, focusing on the relationships and interactions between economic, political, legal, sociological, and other environments.⁸ Whereas a strict public interest theory might posit a general welfare-maximizing legislature and executive branch, a political economy perspective recognizes that the supply of, demand for, and final outcome of policy all influence each other and that economic and social constraints further limit the decision set of policies. Viewing policy developments through this framework can explain policy outcomes by applying economic modeling to the political process, thus recognizing that political goods and economic goods are both being exchanged in the political process and that political players vie for these goods in an environment of scarcity by acting in their self-interest while facing a degree of uncertainty.

⁸ "Political Economy," *American Heritage Dictionary of the English Language*, n.d., <http://www.thefreedictionary.com/political+economy>.

Medicaid as Intergovernmental Grant

Understanding the political economy of Medicaid requires study of the program's design and history. Medicaid became law in 1965, when Congress added Title XIX to the Social Security Act, "Grants to States for Medical Assistance Programs." As such, Medicaid was and is a joint effort between the federal government and the 50 states, plus the District of Columbia and many US territories. Although the federal government cannot force states to participate, all 50 states do, and states administer their Medicaid programs within federal guidelines on eligibility, cost sharing, and benefits. Health care services for Medicaid recipients are typically provided by private providers who agree to accept Medicaid insurance. Providers then bill the state Medicaid program for services rendered. The CMS, an agency within HHS, then reimburses the state a percentage of the state's total Medicaid expenses.

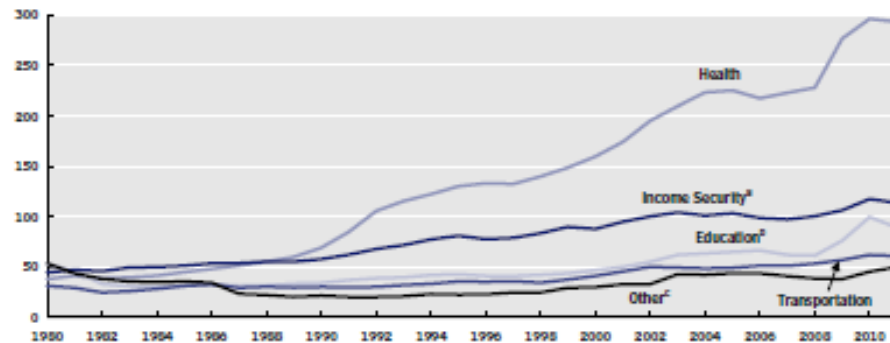
This style of grant is one of a few that is termed *intergovernmental grants*. Whereas many of these grant programs exist across the federal government, Medicaid has grown into the largest outlay of intergovernmental grant funds by far. The Congressional Budget Office (CBO) demonstrates how far Medicaid spending has outpaced other intergovernmental grant programs over the past 30 years (figure 1).⁹

Figure 1: Outlays for Federal Grants to State and Local Governments, by Budget Function, 1980 to 2011
Billions of 2011 dollars

⁹ CBO, "Federal Grants to State and Local Governments," March 2013.

Outlays for Federal Grants to State and Local Governments, by Budget Function, 1980 to 2011

(Billions of 2011 dollars)



Source: CBO (Congressional Budget Office), “Federal Grants to State and Local Governments,” March 2013, 26.

This alarming trend is projected to increase, largely because of the Medicaid expansion for childless adults.¹⁰ Federal Medicaid spending is projected by the CMS’s chief actuary to have been more than \$347 billion in 2015, reaching nearly \$1 trillion by 2024.

Oates¹¹ has noted that in a federal system, intergovernmental grants can be an important tool for a national government to achieve social policy goals across its subnational jurisdictions. However, the nature of the grant and the nature of the goal create different incentives which primarily determine the effectiveness of a grant program. On one hand, environmental regulation is cited by Oates as an area where central management from the national government may be best positioned to mitigate the externalities of pollution and to work toward a socially optimal level of pollution.¹² On the other hand, Oates points out that other social problems in a federal system may be best addressed not by decentralizing per se, but by instituting federal–state partnerships so that all states have the resources and incentives to undertake policy experiments that are positioned not only to solve social programs in the experimenting state, but also to be

¹⁰ Christopher J. Truffer, Christian J. Wolfe, and Kathryn E. Rennie, “2015 Actuarial Report on the Financial Outlook for Medicaid” (Office of the Actuary, Centers for Medicare and Medicaid Services, 2015).

¹¹ Wallace Oates, “An Essay on Fiscal Federalism,” *Journal of Economic Literature* 37, no. 3 (1999): 1120–49.

¹² Oates, “An Essay on Fiscal Federalism.”

potentially scaled up for use in other states. This aspect of federalism is named by Oates as laboratory federalism,¹³ drawing from the remarks of Supreme Court Justice Louis Brandeis in 1932.¹⁴ The concept of laboratory federalism appears to influence the thinking behind the decision to include Section 1115 in the 1962 welfare reform bill. At the time, the *New York Times* editorial board wrote: “. . . the law does permit experimentation by the states and localities in improved methods for balancing relief needs and costs. It empowers the Secretary . . . to waive requirements for state-wide uniformity where he is convinced that pilot projects may be constructive.”¹⁵

In theory, the Section 1115 program is designed to allow states to experiment with their Medicaid program for benefit of Medicaid enrollees both in state and, by extension of lessons learned, nationwide. Pilot projects conducted under the Section 1115 program that show better outcomes for enrollees, lowered program costs, or both, could potentially garner positive results that inform future planning on either a state or national level, creating a positive externality.

Medicaid in Practice

The Medicaid program (without factoring in any waivers) is financed by a federal–state arrangement that allows each state to report their Medicaid expenditures to CMS and to receive reimbursement for a predetermined percentage of those expenses. The reimbursement is called the Federal Matching Assistance Percentage (FMAP). Generally, the FMAP formula provides a 50 percent FMAP for the wealthiest states and provides roughly 75 percent for the poorest states.¹⁶ As a consequence, as Brian Blase has noted, “The federal Medicaid reimbursement

¹³ *Ibid.*, 1132.

¹⁴ Michael S. Greve, “Laboratories of Democracy: Anatomy of a Metaphor,” *Federalist Outlook* (blog), American Enterprise Institute, May 2001.

¹⁵ “Decency Wins in Welfare,” editorial, *New York Times*, July 24, 1962.

¹⁶ Brian Christopher Blase, “Three Papers Toward a Better Understanding of State Medicaid Programs and Program Efficiency” (PhD dissertation, George Mason University, Fairfax, VA, 2013).

allows state politicians to increase state government spending while passing at least half of the cost to taxpayers outside their jurisdiction.”¹⁷ The incentive for each state to maximize its federal share manifests itself in a plethora of creative financing schemes to maximize the share reimbursed by the federal government, which can then be spent on any state budget item and does not have to be reinvested into the state Medicaid program. In Congressional testimony from 2004, Kathryn Allen of the General Accounting Office (GAO) described some of these schemes and their effects on the federal–state partnership:

Taking advantage of statutory and regulatory loopholes, some states, for example, have made large Medicaid payments to certain providers, such as nursing homes operated by local governments, which have greatly exceeded the established Medicaid payment rate. These state expenditures would enable states to claim large federal matching payments. Once states receive the returned funds, they can use them to supplant the states’ own share of future Medicaid spending or even use them for non-Medicaid purposes.¹⁸

Besides contributing to ever-increasing Medicaid spending, there is evidence that the ability to divert Medicaid funds results in relatively worse care delivered to its vulnerable beneficiaries. Recent work by Baicker and Staiger examines the Medicaid Disproportionate Share Hospital (DSH) program, which is a funding source targeted at hospitals serving the poor and uninsured. Baicker and Staiger find that state DSH payments were correlated with improvements in care and decreased mortality rates, but that this correlation was much weaker in states that were using a payment scheme called an intergovernmental transfer (IGT) to maximize a DSH payment. In this case, the IGT worked by allowing public hospitals to charge higher rates

¹⁷ Ibid., 7.

¹⁸ Kathryn Allen, “Intergovernmental Transfers Have Facilitated State Financing Schemes” (Testimony before the Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives, General Accounting Office, March 18, 2004), <http://www.gao.gov/new.items/d04574t.pdf>.

to draw down an increased DSH payment from the federal government. The state could then take some of this payment back from the public hospital.¹⁹

As Barrilleaux and Miller point out, and consistent with a framework of political economy, the demand for Medicaid-provided services, the supply of those services, and state and federal policy regarding those services all influence each other.²⁰ Within each state, social, economic, and political factors influence Medicaid policy. In fact, Barrilleaux and Miller's research concludes that the demand for Medicaid services in a state was more influenced by the supply of physicians already practicing in the state than on unemployment.²¹ This result suggests that interest group politics, and state spending decisions responding to those politics, can and do affect Medicaid policies on the state and federal level.

Beaulier and Pizzola took a case study approach to the political economy of Medicaid, examining five different states that have pursued Medicaid reform since 2000.²² They argue that, although many state reforms (including Section 1115 reforms) were ostensibly designed to achieve cost savings and introduce market principles into the state's Medicaid program, cost savings have not been as forthcoming in these Medicaid reforms as promised. Beaulier and Pizzola's work recognizes that promising reforms have to survive a grueling political battle if they are to be enacted or implemented at all.²³

¹⁹ Katherine Baicker and Douglas Staiger, "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality," *Quarterly Journal of Economics* 120, no. 1 (February 2005): 345–86.

²⁰ Charles J. Barrilleaux and Mark E. Miller, "The Political Economy of State Medicaid Policy," *American Political Science Review* 82, no. 4 (December 1988): 1089–107.

²¹ *Ibid.*

²² Scott Beaulier and Brandon Pizzola, "The Political Economy of Medicaid: Evidence from Five Reforming States" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, February 2012).

²³ *Ibid.*

Medicaid Waivers as Flawed Solution

Beaulier and Pizzola discuss that both endogenous factors (federal Medicaid law) and exogenous ones (state political environment) constitute the political economy of Medicaid policy. Political economy could potentially prove a fruitful approach to studying Medicaid waiver policy, given that the approval process sometimes deviates from required guidelines. The nonpartisan GAO has documented chronic problems with the waiver process, finding through multiple sustained investigations that many waivers are not conducted under required budget-neutral guidelines.²⁴ The HHS has maintained a budget neutrality policy for these waivers since the 1980's,²⁵ and because waivers are often used to expand coverage and services, the budget neutrality requirement is needed to serve as a constraint on waiver spending. A 2013 report examined 10 Section 1115 waivers and found that 4 of the 10 demonstrations were deemed budget neutral by HHS using poor accounting techniques. "For example, HHS approved a spending limit for Arizona's demonstration using outdated information on spending—1982 data that [were] projected forward—that reflected significantly higher spending than what the state's Medicaid program had actually cost. For Texas, HHS approved a spending limit using a base year that included billions in costs the state had not incurred. The GAO found limited support and documentation for the higher-than-benchmark limits HHS approved."²⁶ For these four demonstrations alone, the GAO estimated that using HHS benchmark rates as its budget neutrality process required would have saved the federal government \$21 billion. The same GAO reports that raised these concerns about the budget neutrality for waivers also noted that many

²⁴ Iritani, "Medicaid Demonstrations: More Transparency Needed"; Kathryn Iritani, "Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency" (Washington, DC: General Accountability Office, June 2013); Kathryn Iritani, "Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns" (Washington, DC: General Accountability Office, August 8, 2014); Katherine Iritani, "Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives," Report to Congressional Requesters (Washington, DC: General Accounting Office, April 2015).

²⁵ Iritani, "Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency."

²⁶ *Ibid*, highlights page. <https://www.gao.gov/products/GAO-13-384>

waiver decisions, including the decisions for which the GAO found accounting deficiencies, were conducted without significant public input or without meaningful explanation from HHS about how the agency had reached its decisions. The GAO's health care director wrote:

After examining HHS's approach for approving spending limits of recently approved demonstrations, we have three main concerns regarding the budget neutrality policy and process. First, HHS's policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented. Second, the policy and processes lack transparency regarding criteria and the supporting evidence required to justify deviations from historical spending and established benchmark growth rates. We recognize that forecasting spending during changing economic times is challenging and a state's circumstances may warrant such deviations. Nonetheless, we believe that approved spending limits that are based on baselines and growth rate expectations that greatly deviate from HHS's current benchmarks should be well-supported and documented. HHS's policy is currently silent as to when deviations are allowed and does not require that reliable evidence be provided to justify deviations. Transparency around the basis for spending limit decisions is important not only for assurances of the ongoing fiscal integrity and sustainability of the program, but also for assurances of consistency of approvals among states. Third, the policy as implemented allows methods for establishing spending limits that we believe are inappropriate for such purposes, such as allowing states to include hypothetical costs in the baseline for spending limits. The second and third concerns parallel those we have raised in earlier reports. In 2008, because HHS disagreed that changes to the budget neutrality policy and review process were needed, we suggested that Congress consider requiring increased attention to fiscal responsibility in the approval of section 1115 Medicaid demonstrations and require the Secretary of Health and Human Services to improve the demonstration review process by, for example, clarifying the criteria for approving spending limits and documenting and making public the basis for such approvals. Thus far Congress has not acted on this suggestion.²⁷

The GAO's work on this issue suggests that certain features of how the program operates in practice may be inimical to the program's intent. A federal agency that is reluctant to apply agreed-upon standards and cannot explain satisfactorily to the public what standards were applied is not an agency that state governments can confidently look to as a partner in efforts to innovate within their Medicaid programs.

Placing waiver authority in the hands of one federal agency may also create unnecessary delay in implementing beneficial program changes on the state level. For example, as this paper's empirical analysis section will show, the median number of days for a waiver to be

²⁷ Ibid.

approved across our study period is 182 days, or six months. Depending on the proposed reform, six months can be significant. For example, the state of Pennsylvania initially expanded Medicaid to childless adults using a waiver, which was approved in August 2014 and implemented in January 2015. In February 2015, the governorship had changed hands, and the new governor, Tom Wolf, announced plans to undo the waiver and cover the expansion population under a State Plan Amendment. A Medicaid State Plan is a contract to administer a state's Medicaid program, and amending this plan generally consists of technical changes, not exceptions to federal Medicaid requirements.²⁸ Governor Wolf's administration was able to do this because the ACA included these childless adults inside the program, meaning that no waiver was needed to provide them Medicaid coverage. In just seven months, the Wolf administration had notified the expansion population, moved that population into different managed care plans from those the waiver had allowed, and completed the transition from waiver Medicaid expansion to traditional Medicaid expansion. Requiring innovative ideas to go through federal approval may delay needed reforms at the state level.

Finally, whereas Section 1115 was designed to foster experimentation that would inform future Medicaid policies throughout the country, it is not clear that the lessons learned from Section 1115 demonstrations are being applied outside the state where the demonstration was conducted. A 2009 study by Kevin Esterling looked at Congressional hearings conducted on the Medicaid program between 2000 and 2003, and it found that state-level policy expertise garnered from programs like Section 1115 waivers was only informative to federal policymakers who were already sympathetic to the state's programmatic decisions.²⁹ Where programmatic interests

²⁸ American Action Forum, "Breaking Down Barriers to Medicaid Innovation: Rethinking Medicaid Waiver Approval," Research (American Action Forum, Washington, DC, August 14, 2014).

²⁹ Kevin M. Esterling, "Does the Federal Government Learn from the States? Medicaid and the Limits of Expertise in the Intergovernmental Lobby," *Publius* 39, no. 1 (Winter 2009): 5.

were not aligned (Esterling uses a hearing on intergovernmental transfers as an example³⁰), federal policymakers were measurably more engaged with other witnesses who were equally as knowledgeable about the policy issue being discussed. Esterling names this phenomenon a “failure of federalism,” and specifically argues that federal legislative preferences dominate in the Medicaid federal–state partnership, despite the option for states to use waiver authority. Given the concerns addressed by the GAO on the outcomes of the waiver process and the lack of analysis in the literature about how the process unfolds, using political economy to analyze the waiver process will be an important contribution to the literature on this topic.

Theory

Public Choice

Public choice applies the economic way of thinking to political science. Nobel laureate James Buchanan was one of the first to develop this theory, and among his seminal contributions to public choice theory were the economic analytic tools that he and other members of the Austrian school favored to assess the non–market exchange that happens in a political setting.³¹

- (1) *Methodological Individualism*—whereas the preponderance of mainstream political economic theory tends to evaluate the government as a monolithic unit, public choice theory uses the individual as the basic unit of economic analysis. This means that every person making a decision with respect to Medicaid waivers is acting purposively to advance his or her self-interest. Self-interest absolutely can—and does—include altruistic and public good motives; but we cannot assume that anyone

³⁰ Ibid.

³¹ James Buchanan, *The Collected Works of James M. Buchanan*. Vol. 1, *The Logical Foundations of Constitutional Liberty* (Indianapolis, IN: Liberty Fund, 1999), <https://www.libertyfund.org/books/the-logical-foundations-of-constitutional-liberty>.

acts solely out of public welfare motives, even if he or she is acting as a public official.

(2) *Political Exchange*—political exchange differs from market exchange in a number of ways. The most relevant for the purpose of this paper is that political exchange involves all members of the community inside the polity, whereas market exchange only involves willing exchange participants and the proactive decision they make to engage in trade.

A straightforward public interest theory would posit that CMS officials, who evaluate waivers under the supervision of the Secretary of Health and Human Services, evaluate waivers as the text of Section 1115 requires, using their individual and collective judgment to determine if a waiver will meet program objectives in a more cost-effective or outcome-effective way than if the state were strictly complying with federal Medicaid requirements. Yet, both the GAO³² and academic literature³³ have indicated that waivers are expensive, that waiver decisions are not transparently made, and that programmatic lessons learned from successful waivers are cherry-picked by lawmakers, held up as paragons for the preferred policies of Congress, and ignored when they contradict Congressional will.

In his “Political Theory of Intergovernmental Grants,” Philip Grossman develops a vote-maximizing model of grant distribution and finds in empirical analysis that the political affiliation and popularity of a state legislature was a statistically significant predictor of how much money in federal grants the state received per capita.³⁴

³² Iritani, “Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency.”

³³ Esterling, “Does the Federal Government Learn from the States?”

³⁴ Philip J. Grossman, “A Political Theory of Intergovernmental Grants,” *Public Choice* 78, no. 3/4 (1994): 295–303.

Buchanan's framework of methodological individualism and politics as market exchange helps explain Grossman's conclusions. The work of these two scholars explains the suboptimal performance of the waiver program more convincingly than a public interest theory would. According to public choice theory, federal lawmakers and bureaucrats will administer the waiver program with a view toward the political incentives they face and the options available to them to maximize their political payoff. Multiple administrations have come under criticism by the nonpartisan watchdog GAO for a lack of transparency in waiver decisions, as well as for an inability to adhere to budget neutrality guidelines. Exploring how waivers are approved through a public choice lens may yield valuable conclusions about the causes of program flaws.

For purposes of this project, I will apply public choice to examine federal and state incentives in the waiver process. On a state level, it is reasonable to assume that state officials are interested in preserving as much of the federal match as possible, while garnering flexibility to expand coverage, to introduce cost sharing, or to promote managed care plans inside their Medicaid program. On a federal level, it is reasonable to assume that CMS officials are interested in mitigating any increase to the federal contribution that may result from a waiver. But given HHS's documented inability to consistently and transparently apply a budget neutrality standard to waiver applications at a cost of billions per poorly analyzed waiver, we have to look for another motivation. Grossman's political model of vote maximization serves as a guidepost to consider how federal *and* state lawmakers may use intergovernmental grant funds to support themselves and their political allies. The analysis of this paper will measure how political payoff affects waiver decisions by measuring the political affiliation of states applying for waivers and the administrations deciding whether to grant waivers. I hypothesize that an

administration will be more cooperative in granting the waiver application of a state whose legislature or governor share its political party.

Methods and Data Analysis

The CMS website has a database³⁵ of all the Section 1115 waivers for which a formal application has ever been made, dating to 1982 when Arizona was granted the first waiver. The analysis will only include waivers approved after 1994, for two reasons:

- (1) There are two sources available for political affiliation of state legislatures *after* 1992: both Ballotpedia.org and the National Conference of State Legislatures (NCSL) keep political affiliation data, but while the NCSL database goes back to 1970, Ballotpedia.com has this information only from 1992 onward.³⁶ Restricting the analysis to years in which two sources of this information are available is designed to fortify the credibility of the data.
- (2) The waiver application process became a negotiation process in the beginning of the Clinton administration, when the new president signaled his willingness to use waiver authority to achieve broad-based reform. President Bill Clinton's position on the matter was bolstered in federal court, when a lawsuit challenging the administration's stance on waiver flexibility was decided in the administration's favor.³⁷ This series of events set the stage for the environment in which political motivations could more easily manifest themselves into the Section 1115 waiver process.

³⁵ Centers for Medicaid and Medicare Services (CMS), "Demonstrations and Waivers" (CMS, n.d.), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html.

³⁶ "State Legislatures," Ballotpedia, https://ballotpedia.org/State_Legislatures.

³⁷Gloria Nicole Eldridge, "The Medicaid Evolution: The Political Economy of Medicaid Federalism" (PhD dissertation, University of Texas at Austin, 2007).

Waivers can have one of six statuses: approved, pending, disapproved, expired, withdrawn, and terminated. The analysis will consider only approved waivers, for a number of reasons that are explained subsequently. A review of the dataset reveals that only three waivers are currently listed as disapproved or withdrawn, and none are listed as terminated. Thirty entries are pending as of July 31, 2016, but because a final decision has not yet been made on those waivers, total time to approval cannot be analyzed. The database lists 40 approved waivers, and within those waivers, some have more than one original waiver application. However, each approved waiver contains multiple iterations of the same waiver program, which may have been renewed multiple times and is now simply in its current iteration. Therefore, the dataset actually contains 269 observations.³⁸

This dataset ($n = 269$) is composed of 77 original waiver applications and 192 renewal applications, all of which were approved permanently. The dataset included roughly 80 temporary approvals, which were granted for a variety of reasons and were not included in the analysis. Because temporary approvals were granted for different periods of time, ranging from 2 weeks to 18 months, and for a variety of reasons on the part of both the state and the federal government, temporary approvals do not represent the dynamic between state and federal governments as well as permanent approvals do, which are granted for 5 years.

Political affiliations of federal and state governments are measured from both the day of waiver application and of waiver decision; when a waiver was submitted between an election and the seating of the new legislature and governor (usually between November and January), political affiliation is noted as the affiliation of the new governor and legislature—under the

³⁸ This analysis does not consider disapproved or withdrawn denials because only three were found in the CMS database. The challenges of constructing a meaningful comparison with such a small sample, as well as the possible theoretical implications of having so few disapprovals and withdrawals, led me to exclude those three waivers from the analysis and to use number of days to approval as the variable of interest.

assumption that an election’s outcome influences a waiver negotiation before the new government is seated.

The political affiliations are used to calculate a political affinity score (PAS), which can range from 0 to 6. A score of 0 indicates that neither a state’s governor nor either body of the legislature belonged to the same party as the president on the day that a waiver application was submitted or the day a waiver was approved. Conversely, a score of 6 means that all three of these governmental bodies matched the party of the administration on both the day of submission and the day of approval. In other words, there are 6 potential points of political alignment for this analysis; a score of 0 means there is no political alignment during the time of waiver consideration, a score of 6 means there is complete political alignment during such time, and a score from 1 to 5 means there is some alignment. Tables 1–3 give examples for hypothetical waivers with PASs of 0, 3, and 6. The PAS represents one independent variable of the analysis; I will also measure whether the party of the governor alone affects the speed of waiver decisions. The dependent variable in this analysis is the number of days it takes for each waiver to be approved.

Table 1: Sample Waiver with Political Affinity Score of 0

	Lower house of legislature	Upper house of legislature	Governor
Day of waiver application	Different party from president	Different party from president	Different party from President
Day of waiver decision	Different party from president	Different party from president	Different party from president

Table 2: Sample Waiver with Political Affinity Score of 3

	Lower house of legislature	Upper house of legislature	Governor
Day of waiver	Same party as	Same party as	Different party from

application	president <input checked="" type="checkbox"/>	president <input checked="" type="checkbox"/>	president
Day of waiver decision	Same party as president <input checked="" type="checkbox"/>	Different party from president	Different party from president

Table 3: Sample Waiver with Political Affinity Score of 6

	Lower house of legislature	Upper house of legislature	Governor
Day of waiver application	Same party as president <input checked="" type="checkbox"/>	Same party as president <input checked="" type="checkbox"/>	Same party as president <input checked="" type="checkbox"/>
Day of waiver decision	Same party as president <input checked="" type="checkbox"/>	Same party as president <input checked="" type="checkbox"/>	Same party as president <input checked="" type="checkbox"/>

Results

Table 4: Summary Statistics

Median days to waiver approval: 182	Average days: 691	Average days with outliers removed: 237
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Table 4 shows summary statistics from the dataset. When the median of a dataset and the mean of that dataset diverge drastically, it usually is an indication of outliers in the dataset. And indeed, there are three waivers in the dataset that took five to seven times longer than the average waiver to be approved: Missouri’s 1994 application, Montana’s 2008 application, and Mississippi’s 2011 application. These waivers are included in the analysis, with an adjusted figure reported alongside the nonadjusted one as needed so that the reader can see what the average approval time is for each PAS both with and without the outlier included. However, because these three outliers are so much larger than the rest of the observations, the median

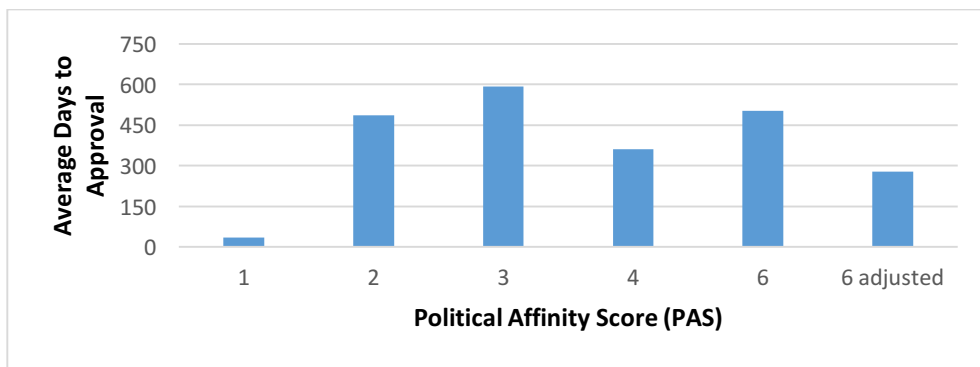
figure of 182 is a more meaningful marker than the average figure of 691 to determine how long the “typical” waiver should take to be approved. Tables 5 shows summary statistics for waiver approvals during the Clinton administration. Figure 2 demonstrates the relationship between political affinity scores and waiver approval times and figure 3 demonstrates the relationship between governor political affiliation and waiver approval times.

Clinton Administration Waivers: January 1994–January 2001

Table 5: Clinton—Specific Summary Statistics

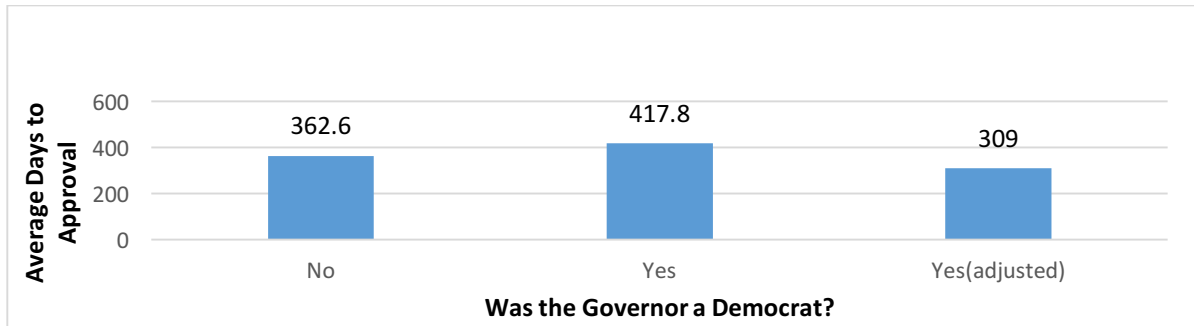
Median days to waiver approval	335
Average days to waiver approval	425

Figure 2: Political Affinity Scores and Waiver Approval Times under the Clinton Administration



Note: Twenty-three waivers were approved during the Clinton administration from 1994 to 2001. Of these, 1 had a political affinity score (PAS) of 1, 5 had a PAS of 2, 2 had a PAS of 3, 10 had a PAS of 4, and 5 waivers had a PAS of 6. After removing the 1998 Missouri waiver, which is an extreme outlier with 1,399 days to approval, 4 waivers have a PAS of 6.

Figure 3: Governor Affiliation and Waiver Approval Times under the Clinton Administration



During the Clinton administration, 23 Section 1115 waivers were approved. The average approval time was 425 days (roughly 14 months), and the median approval time was 335 days (roughly 11 months). Of the 23 waivers, none had a PAS of 5 and only one waiver, a 1998 application from Wisconsin, had a PAS of 1. Figure 2 shows results for the PAS, including an adjusted figure for the waivers with a PAS of 6. One of those waiver applications was submitted by Missouri and took nearly four years to be approved. On figure 2, 6 (adjusted) indicates the results for the PAS 6 waivers with the Missouri waiver removed as an outlier. With the exception of the PAS 3 waivers, time to approval does decrease as PAS increases. Specifically, PAS 6 (adjusted) waivers and PAS 4 waivers were approved in below-average time.

Examining governor party affiliation under the Clinton administration yields similar findings (figure 3). After adjusting for the Missouri outlier, results show that Democratic governors had waiver applications approved approximately 55 days more quickly on average than Republican governors did.

Bush Administration Waivers: January 2001–January 2009

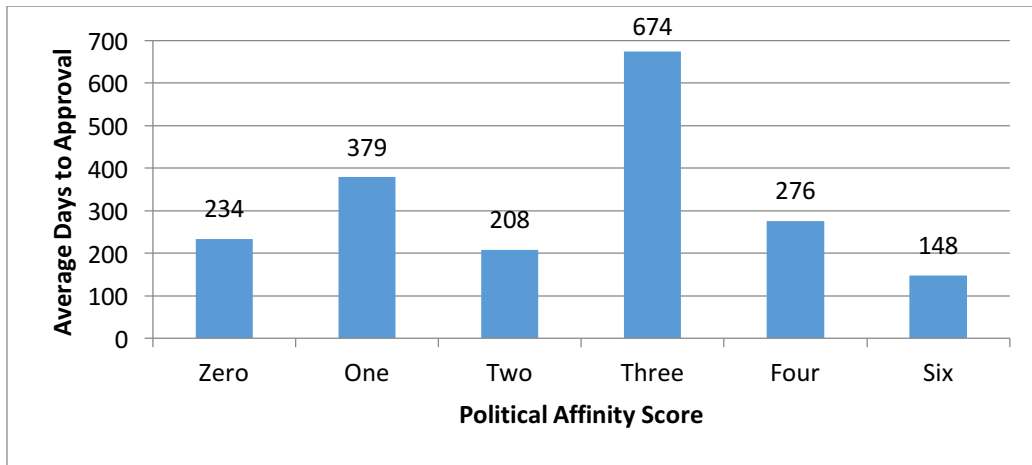
Below, table 6 shows summary statistics for waiver approvals during the Bush administration. Figure 4 demonstrates the relationship between political affinity scores and waiver approval

times and figure 5 demonstrates the relationship between governor political affiliation and waiver approval times during this period.

Table 6: Bush—Specific Summary Statistics

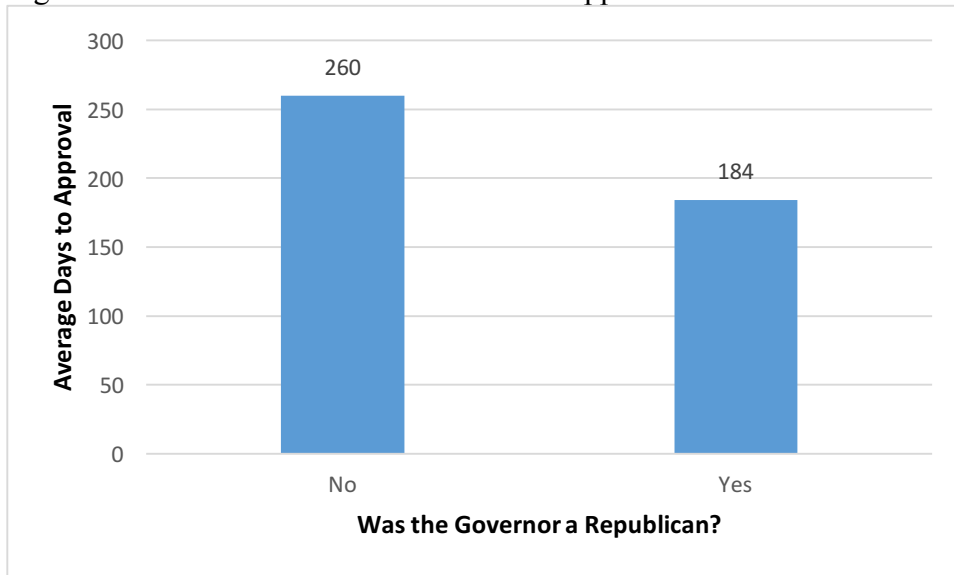
Median days to waiver approval	179
Average days to waiver approval	222

Figure 4: Political Affinity Scores and Waiver Approval Times under the George W. Bush Administration



Note: Eighty waivers were approved during the Bush administration, 2001–2009. Twenty-three waivers had a PAS of 0, 1 had a PAS of 1, 31 had a PAS of 2, 6 had a PAS of 3, 10 had a PAS of 4, 0 had a PAS of 5, and 9 had a PAS of 6.

Figure 5: Governor Affiliation and Waiver Approval Times under the Bush Administration



During the George W. Bush administration, 80 waivers were approved. The Bush administration’s waiver decisions as judged by PAS are far less predictable than those of the Clinton administration—but like the Clinton administration, the Bush administration’s CMS was quicker to grant waiver approvals to states with a PAS of 6 than to any other PAS.

Republican governors applying for a Section 1115 waiver also fared better under the Bush administration than did their Democratic counterparts; Republican-led waivers were approved 76 days more quickly than Democratic-led waivers. Republican waivers were approved in an average of 184 days, while Democratic waivers were approved in an average of 260 days.

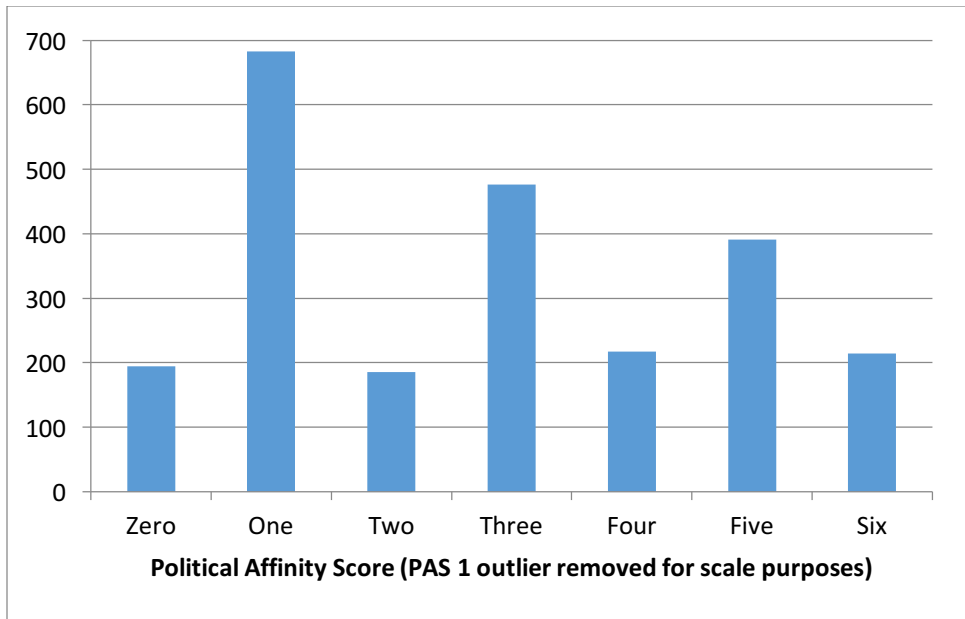
Obama Administration Waivers: January 2009–January 2016

Table 7 shows summary statistics for waiver approvals during the Obama administration. Figure 6 demonstrates the relationship between political affinity scores and waiver approval times and figure 7 demonstrates the relationship between governor political affiliation and waiver approval times during this period.

Table 7: Obama—Specific Summary Statistics

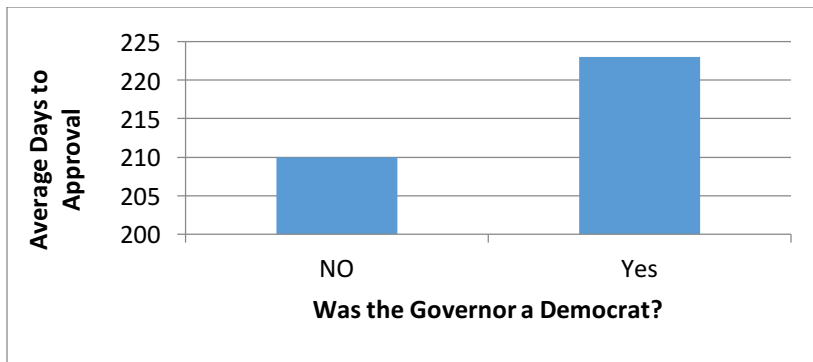
Median days to approval	169
Average days to approval	222

Figure 6: Political Affinity Scores and Waiver Approval Times in the Obama Administration



Note: A total of 166 waivers were approved during the Obama administration. Of these, 48 had a PAS of 0, 2 waivers had a PAS of 1, 32 had a score of 2, 33 had a PAS of 4, 3 had a PAS of 5, and 45 had a PAS of 6. A 2011 Mississippi waiver is removed from the calculations, as an extreme outlier at 1,363 days to approval, for scaling purposes.

Figure 7: Governor Affiliation and Waiver Approval Times during the Obama Administration



Under the Obama administration, 163 waivers were approved, which are more than the two previous administrations approved combined.

The behavior of the Obama administration toward waiver applications tells a different story than that of the two previous administrations. Not only did the Obama administration approve significantly more waivers, but it did so just as quickly as the Bush administration, with similar figures for mean and median approval time.

President Clinton’s administration took much longer on average to approve a waiver—likely because the Clinton administration was the first to allow a broad use of waivers and probably experienced a learning curve in reviewing and negotiating waivers.

The Obama administration also did not demonstrate an apparent favoritism toward Democratic waivers, either as measured by PAS or governor’s party. It was possible that the ACA transparency regulations had been effective in forcing CMS to justify its waiver decisions more objectively, reducing the opportunity to show favoritism. It was also possible that President Obama interacted with governors in a way that was fundamentally different from his two predecessors, who both served as governors themselves. However, from the perspective of political economy, it was also possible that the frequency and speed of waiver approval from the

Obama administration reflected a policy preference to expand coverage as quickly as possible, recognizing that coverage would be politically difficult for a state government to take away once granted.

Case Study: Healthy Indiana Plan

In November 2006, during the George W. Bush administration, Indiana Governor Mitch Daniels announced his plan for statewide health care reform. The governor's plan called for a Medicaid waiver to expand coverage to adults earning less than 200 percent FPL, to be paid for by federal funds and a cigarette tax increase.³⁹ Consistent with the Health Insurance Flexibility and Accountability (HIFA)⁴⁰ guidance issued at the beginning of the Bush administration, HIP patterned its coverage after a high-deductible, health savings account (HSA) model. HIP also required some cost sharing on the part of HIP enrollees, who would have a choice of three high deductible health plans (HDHP), all with a deductible of \$1,100. The state contributed to the HSA for poorer recipients.

Spending HSA funds wisely and seeking preventive care were two ways that HIP enrollees could lower their premiums and build up the funds in their HSA account, known in Indiana as a POWER account.⁴¹ These “consumer-driven” aspects of the plan were a deliberate part of the reform proposal.⁴² Governor Daniels promoted the plan as “a start to give many more people protection and peace of mind while fostering more personal responsibility to make good

³⁹ Jane Jankowski, “Protection, Prevention, Peace of Mind: Governor Introduces Plan for a Healthier Indiana,” Governor Daniels Press Calendar (Indianapolis, IN: Office of the Governor, November 17, 2006), http://www.in.gov/serv/presscal?PF=gov2&Clist=1_3_4_6_11_16_61&Elist=87673.

⁴⁰ See Nina Owcharenko Schaefer, “How States Can Expand Private Coverage with HIFA Waivers,” Heritage Foundation, December 16, 2002, <http://www.heritage.org/research/reports/2002/12/how-states-can-expand-private-coverage-with-hifa-waivers>.

⁴¹ Linda Gorman, “Medicaid Block Grants and Consumer-Directed Health Care” (Issue Brief no. 102, National Center for Policy Analysis, Dallas, TX, September 15, 2011), http://www.mspolicy.com/PolicyPlaybook/Health_Care/Medicaid_Block_Grants_Paper.pdf.

⁴² Jankowski, “Protection, Prevention, Peace of Mind: Governor Introduces Plan for a Healthier Indiana.”

decisions. . . .” According to his office, “Because participants will control how they spend their preventive and POWER accounts, they will have more interest in finding services at the best possible price and search for better information about those services.”⁴³

The governor’s press release showcased support for his plan from diverse organizations all across the state of Indiana, and perhaps more important, featured praise from Michael Leavitt, the secretary of Health and Human Services, to whom CMS officials report. Said Secretary Leavitt, “I certainly share the values and vision expressed so well by Governor Daniels. I applaud his commitment and creativity to help address the compelling issue of the uninsured. I am enthusiastic about working with him to develop his ideas into action through flexibility now available through Medicaid and exploring the possibility of a *budget neutral waiver* [emphasis added]. We intend to move aggressively on the proposal.”⁴⁴ Enabling legislation was passed in the Indiana legislature on a bipartisan basis in April 2007,⁴⁵ and the formal waiver application was submitted to CMS on July 3, 2007. By December of that year, CMS had approved the waiver, amounting to a 164-day window between application and approval.

Besides earning the public support of the Bush administration, HIP drew plaudits from some right-leaning scholars, such as Linda Gorman of the National Center for Policy Analysis (NCPA), who wrote approvingly of the program in 2011: “HIP retention rates have been higher than in Indiana’s regular Medicaid program. Fewer than 3 percent of members left because they failed to pay monthly contributions. Of those who enrolled in the first six months, 36 percent had funds to roll over and 71 percent met the preventive care requirements. There are preliminary

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Seema Verma, “Healthy Indiana Plan,” *Better Government Competition: 2011*, Pioneer Institute, July 19, 2011, <http://bgc.pioneerinstitute.org/healthy-indiana-plan/>.

indications that emergency room use has declined despite the fact that early enrollees may have had greater than average medical problems.”⁴⁶

When Indiana applied to renew the waiver on December 27, 2011, it submitted a report to CMS detailing the progress that HIP had made against seven mutually agreeable goals. However, with respect to Medicaid policy, the ground had shifted seismically between the time of the initial waiver application and the time for renewal. The ACA, which became law in March 2010, required state Medicaid programs to extend traditional Medicaid coverage to adults at or below 138 percent FPL; this made HIP and waivers like it obsolete in the eyes of the administration, even though the incentives in HIP were fundamentally different from those in traditional Medicaid. Once the US Supreme Court ruled in 2012 that the Medicaid expansion was optional for states, the political burden was shifted onto states like Indiana that used waiver authority to expand coverage to childless adults.

These states now had to decide whether to take the federal government’s offer of a generous FMAP for the expansion population or to leave state-crafted, waiver-enabled reforms in place. In September 2013, CMS granted Indiana a one-year extension of HIP 1.0, writing to the state that CMS’s intention was “to not disrupt the coverage currently afforded in Indiana as the state continues to consider its coverage options.”⁴⁷ Letters containing the same language were sent to at least two other states with Section 1115 waivers coming up for renewal as the traditional Medicaid expansion began, suggesting that CMS was sending a signal to those governments that their waiver would not be approved for another full round of demonstration

⁴⁶ Gorman, “Medicaid Block Grants and Consumer Directed Health Care.”

⁴⁷ Alexandra Gates, Robin Rudowitz, and Samantha Artiga, “Healthy Indiana Plan and the Affordable Care Act” (Kaiser Family Foundation, Washington, DC, December 18, 2013), <http://kff.org/medicaid/fact-sheet/healthy-indiana-plan-and-the-affordable-care-act/>.

without significant changes.⁴⁸ Indeed, protracted negotiations with CMS continued for another year, until July 2014. In July, Governor Mike Pence submitted a two-pronged waiver application, offering a compromise version of HIP (called HIP 2.0) while citing a prerogative to keep the existing waiver program in place to preserve coverage for the childless adults who had come to rely on HIP 1.0. In January 2015, HIP 2.0 was approved, and it largely took the same form as HIP 1.0, with the following changes:

- The HIP 1.0 enrollment cap was lifted.
- Eligibility was increased from 100 percent FPL to 138 percent FPL.
- Cost sharing began to be based on a flat rate, not on a percentage of income.
- Benefits were split into a HIP Basic and HIP Plus plan, allowing for different degrees of cost sharing and risk bearing for Indiana residents at different levels of poverty.⁴⁹

However, many right-leaning organizations—some of which had supported HIP 1.0—did not support the version of HIP that emerged from negotiations with Obama’s CMS. Writing in *Forbes* magazine, researchers from the Foundation for Government Accountability argued that “Medicaid reform does not require creating a new entitlement for working-age, able-bodied adults without children, which is the main policy objective of Obamacare and HIP 2.0.”⁵⁰

Kentucky, Arizona, and Ohio are three states that have expanded Medicaid coverage to childless adults in some form and whose governors are looking to Indiana as a model for their

⁴⁸ Cindy Mann, letter to Dr. Joe Parks, Medicaid Director of the State of Missouri, July 21, 2014, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mo/Gateway-to-Better-Health/mo-gateway-to-better-health-ext-appvl-ltr-07212014.pdf>; Cindy Mann, letter to Mary Dalton, Medicaid Director of the State of Montana, December 24, 2013,

<https://dphhs.mt.gov/Portals/85/hrd/documents/1115/June2013/MtBasicMedicaidDemoExtensionCMSApprovalLetter.pdf>.

⁴⁹ “Correcting Recent Misinformed Claims about HIP 2.0: HIP Response to Forbes Article” (Indiana Family and Social Services Administration, December 22, 2015), http://www.in.gov/fssa/hip/files/HIP_Response_to_Forbes_Article.pdf.

⁵⁰ Josh Archambault, Jonathan Ingram, and Christie Herrera, “Indiana’s Mike Pence Shouldn’t Embrace Obamacare’s Medicaid Expansion—He Should Walk Away,” *Forbes*, May 16, 2014, <http://www.forbes.com/sites/theapothecary/2014/05/16/did-2016-gop-contender-indiana-governor-mike-pence-just-embrace-obamacares-medicaid-expansion-2/#72e5e36e2f8b>.

states to pursue more market-driven coverage.⁵¹ As such, the HIP 2.0 waiver continues to be a contentious political issue with nationwide implications. In 2016, CMS made an emergency request of the Office of Management and Budget (OMB) to allow it to evaluate the impact of HIP 2.0 on beneficiaries' access to care. The OMB granted this request in April.⁵² In the Indiana case, CMS officials took the rare step of hiring their own evaluators to judge whether program objectives were being met, even though the state of Indiana had contracted with the Lewin Group, an independent auditor, for that same purpose.⁵³ The Lewin Group's July 2016 report included details of a July 2015 evaluation meeting with stakeholders across Indiana that was mostly positive.⁵⁴ The Lewin Group further noted that the HIP 2.0 program was making progress against the goals of reducing the uninsured, increasing preventive care in the Medicaid population, promoting personal responsibility, and encouraging HIP 2.0 recipients to transition off of public assistance.

Conversely, Center for Budget and Policy Priorities, a left-leaning think tank, published a cautionary article warning other states against pursuing the HIP model. On August 1, 2016, Judith Solomon wrote of the Lewin Group report that "An evaluation of HIP 2.0's first year shows it has not worked as the state intended in some important respects, likely due in part to its complexity. For example, the evaluation casts serious doubt on whether Indiana's use of accounts similar to health savings accounts, which Kentucky seeks to replicate, meets the state's

⁵¹ Virgil Dickson, "CMS Gets Green Light to Evaluate Indiana's Alternative Medicaid Expansion Plan," *Modern Healthcare*, April 1, 2016, <http://www.modernhealthcare.com/article/20160401/NEWS/160409983>.

⁵² *Ibid.*

⁵³ Maureen Groppe, "Pence: U.S. Evaluation of State's Alternative Medicaid Plan Is Unfair," *Indianapolis Star*, December 3, 2015, <http://www.indystar.com/story/news/2015/12/03/us-evaluation-indianas-alternative-medicaid-program-unfair-pence-says/76725598/>.

⁵⁴ "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report" (Lewin Group, July 6, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>.

goal to promote the efficient use of healthcare, including encouraging preventive care and discouraging unnecessary care.”⁵⁵

For its part, CMS has continued to argue that its own evaluation is necessary because other states may pursue the same reforms. This logic assumes that a reform pursued under a waiver must be approved by CMS every time a state wants to pursue it, with limited agency on the part of the state government to decide for itself which states have the best models to follow.

Governor Pence was selected as the vice presidential candidate by Republican presidential candidate Donald Trump, and, as a result, he did not run for reelection as governor of Indiana. Regardless, the story of HIP 1.0 and HIP 2.0 demonstrates that Section 1115 state waivers are not immune from Washington influences. When George W. Bush was in office, members of his cabinet were publicly and emphatically receptive to a waiver proposal that aligned with the president’s policy goals as stated in the HIFA guidance. Once the administration changed parties, Governor Pence found that extending the HIP model to more childless adults would not be received as warmly in Washington.

The intent and philosophy behind the ACA was that traditional Medicaid coverage, without the penalties and increased cost sharing that HIP required, is an entitlement for childless adults making up to 138 percent FPL. The shifting policy views on the federal level introduced a significant hurdle for Governor Pence, who sought to balance state preferences with the new federal entitlement program. CMS’s request of the interim report from OMB suggests that Medicaid waiver proposals like HIP will face a skeptical audience in the foreseeable future. As James Capretta wrote in a 2015 piece on Medicaid reform, “. . . the Obama administration has

⁵⁵ Judith Solomon, “Indiana Medicaid Waiver Evaluation Shows Why Kentucky’s Medicaid Proposal Shouldn’t Be Approved” (Center for Budget and Policy Priorities, Washington, DC, August 1, 2016), <http://www.cbpp.org/sites/default/files/atoms/files/8-1-16health.pdf>.

made it clear that it will grant waivers only to states that are pursuing goals the administration favors.”⁵⁶ The Bush administration’s enthusiastic reception of the HIP proposal in 2006 suggests that this favoritism is not limited to the Obama administration. As such, policymakers who are truly interested in devolving power to the states should consider reforms of Section 1115 and the authority it grants the federal government.

Policy Implications

The preceding analysis found that the executive branch has tended to show more deference to waiver proposals from governors belonging to its party. Further, the history of the Healthy Indiana Plan (1.0 and 2.0) suggests that approved reforms on the state level may face difficulty being reauthorized if future administrations come into office with fundamentally different goals. The difficulty is compounded if the administration is successful in passing those different policy goals into federal law. For states to truly be empowered to pursue the reform that works best for their residents, federal policymakers should consider changes to the Section 1115 process itself.

Broadly, there are two options: (a) to reform the Section 1115 Waiver process and (b) to replace the waiver process.

Reform the Section 1115 Waiver Process

As previously discussed, the General Accountability Office has documented longstanding flaws in the waiver process, as early as 1995.⁵⁷ Several reports in the past few years have suggested increased public input into the waiver process⁵⁸ or Congressional action to “improve” the waiver

⁵⁶ James Capretta, “Health Care Reform from the Bottom UP,” *Real Clear Policy*, September 3, 2015, http://www.realclearpolicy.com/blog/2015/09/03/health_care_reform_from_the_bottom_up_1409.html.

⁵⁷ William J. Scanlon, “Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs” (Washington, DC: General Accounting Office, November 1995).

⁵⁸ Kathryn Allen, “Medicaid Demonstration Waivers: Lack of Opportunity for Public Input during Federal Approval Process Still a Concern” (General Accountability Office, Washington, DC, July 24, 2007).

process or curb HHS's authority in the process.⁵⁹ Section 10201 of the 2010 ACA amended Section 1115 to require the HHS secretary to develop regulations to allow for federal and state stakeholders to have a chance to review and comment on proposed waivers during reviews. The ACA regulations also called on the HHS secretary to require periodic reporting from states, so that CMS and the public at large could monitor whether demonstration activities are furthering their intended goals and improving outcomes and access with minimal negative impact on the beneficiary.⁶⁰ The very database used for this paper was made more navigable, user friendly, and informative by those same regulations.

The ACA transparency regulations are consistent with recommendations that the GAO has been making for years and continues to make in its reports. A June 2014 report on an Arkansas Section 1115 waiver explained, "In 2008, because HHS disagreed that changes to the budget neutrality policy and review process were needed, we suggested that Congress consider requiring the Secretary of HHS to improve the demonstration review process by, for example, better ensuring that valid methods are used to demonstrate budget neutrality and documenting and making public the basis for such approvals."⁶¹ These words reflect GAO recommendations for the Section 1115 program across the past decade and continue to be part of the GAO's recommendations even after transparency and reporting for waivers were boosted under ACA transparency rules. GAO's recommendations have long centered on improving the process, in hopes that a better process can help curb costs and keep all stakeholders satisfied with waiver outcomes. However, it remains to be seen if any process reform will overcome the basic incentives of HHS authorities to use their authority to approve waivers for outcomes beyond

⁵⁹ Marjorie Kanof, "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns" (General Accounting Office, Washington, DC, January 2008).

⁶⁰ Mary Beth Musumeci and Robin Rudowitz, "The ACA and Medicaid Expansion Waivers" (Issue Brief, Kaiser Family Foundation, Washington, DC, November 2015), <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

⁶¹ Iritani, "Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns."

what Congress intended, as their ultimate boss in the secretary’s office—or the Oval Office—may exhort them to do.

It is important to consider that in this case, program transparency does not only serve to expose favoritism on the part of the federal government. Clear, consistent criteria that are communicated to all of the states is important so that states interested in reforms are not forced to navigate a process with no clear timeline, standards, or visibility into what a successful waiver process looks like. States’ budgets, staff resources, expertise, and political capital are finite resources and a successful federal-state partnership should not overly burden these states’ assets. However, recent work by the National Governor’s Association (NGA) suggests that states are still struggling with how to navigate federal Section 1115 negotiations.

The NGA’s Center for Best Practices recently published a toolkit called *The Future of Medicaid Transformation: A Practical Guide for States*⁶². Frederick Isasi, director of the Center for Best Practices health division, remarked that “Governors, more than just about any other group, feel the pressure of our inefficient and poorly performing health care system, and they are developing powerful innovations around the country to transform the system. At the center of these transformational efforts are the very complex and poorly understood negotiations between leadership at CMS and the White House and states.”⁶³

I was able to ask Isasi if the ACA transparency regulations had made any headway in simplifying the waiver process for states. He replied that the requirements for public input were welcomed by states, but also that there was “a lot about how this works that has not been well understood, and the negotiations have been very much state by state, and states still come to us

⁶² Hemi Tewarson, Frederick Isasi, and Hilary Kennedy, “The Future of Medicaid Transformation: A Practical Guide for States,” Toolkit (National Governors Association Center for Best Practices, Washington, DC, July 22, 2016).

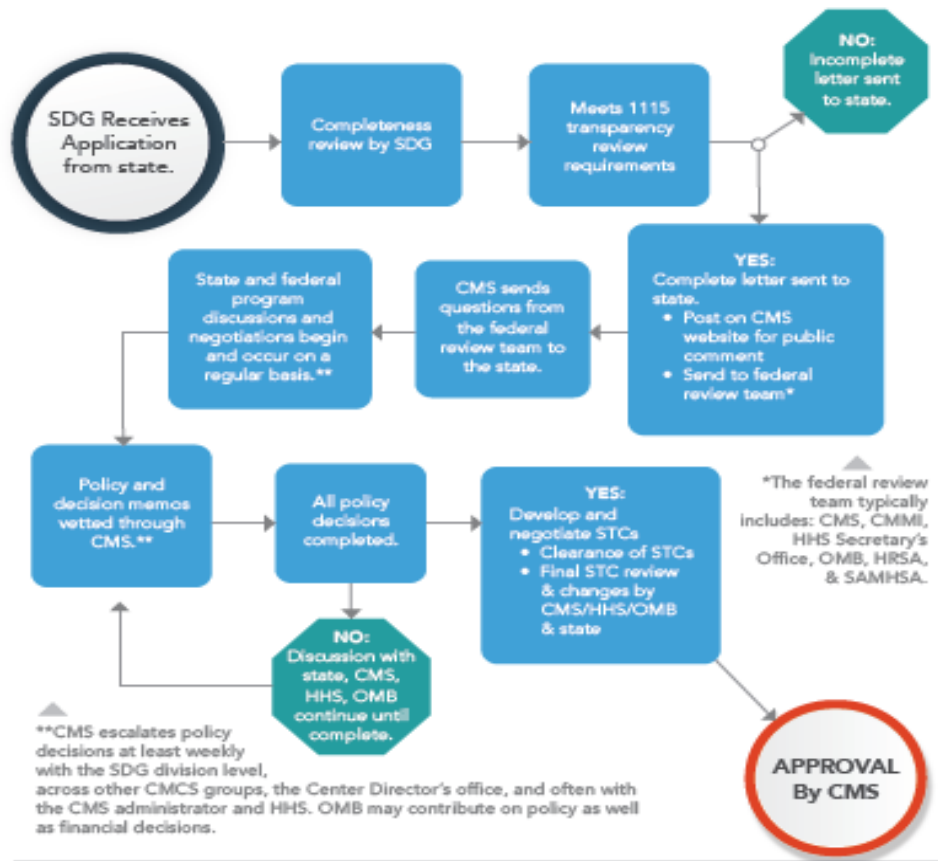
⁶³ Remarks from Frederick Isasi, National Press Club, Washington, DC, August 3, 2016, <https://www.nga.org/cms/news/2016/nga-releases-medicaid-toolkit-at-press-event>.

with questions about ‘Well, if we want to do this, would it work?’ I think there isn’t a lot of transparency, and the point of this [project] is to provide transparency about ‘What is CMS looking for? What kinds of questions do they ask you? What do you have to do to demonstrate, prove? What are the kinds of analyses you have to do?’ There hasn’t been a lot of transparency around that—I think that’s what [the toolkit] is intended to do.”⁶⁴ Much of the benefit of the toolkit to states consists in basic information about the decision trees at the federal level that undergird waiver decisions. Figure 8 shows the internal CMS process for waiver reviews as reported by the NGA toolkit. What is most noteworthy about the diagram is not the content itself, but the fact that, according to NGA officials, the publication of the toolkit in August 2016 was the first time they knew of that this information had been in print.

⁶⁴ Ibid.

Figure 8: NGA Toolkit and Internal Process for Section 1115 Review

Figure 8: Internal CMS Process for Review of Section 1115 Waiver Applications



CMMI: Center for Medicare & Medicaid Innovation
 HHS: Health and Human Services
 HRSA: Health Resources and Services Administration
 OMB: Office of Management and Budget
 SAMHSA: Substance Abuse and Mental Health Services Administration
 SDG: State Demonstrations Group

Source: Hemi Tewarson, Frederick Isasi, and Hilary Kennedy, "The Future of Medicaid Transformation: A Practical Guide for States," Toolkit (National Governors Association Center for Best Practices, Washington, DC, July 22, 2016), 54.

Whereas the NGA toolkit is only the beginning of a plan to roll out more technical assistance and information exchange among the states, it remains to be seen if these efforts will empower every state to negotiate confidently with CMS.

As of 2017, states will have a new source of flexibility from the federal government under Section 1332 of the ACA. This section allows states to command control of the subsidies

and credits granted to qualifying residents under the health insurance exchanges.⁶⁵ Combining this funding with other sources, such as Section 1115 funding, could prove a powerful lever for states to shift the locus of their health care systems away from the ACA model and toward preferred alternatives, such as the Healthy Indiana Plan. Section 1332 waiver authority would also empower states to change the many health insurance regulations enacted by the ACA and give insurers more leeway to tailor insurance offerings toward the consumers of that state. Although the Section 1332 authority is broader and therefore has more potential for states to enact meaningful reform, it is still a waiver authority that must be negotiated with the federal government and that therefore carries all the attending challenges described previously.

Replace the Waiver Process

An alternative to expanding state flexibility under waiver authority is to devolve a capped amount of funding to the states, ending the open-ended FMAP and allowing states to spend the limited funding however they see fit. These proposals are of two main types: block grants and per capita cap.

(a) *Block Grants*: A Medicaid block grant would give a fixed amount to each state to spend however it sees fit. The block grant has been a popular proposal among right-leaning scholars as well as Republican officials on all levels of government. In 2009, during the waning days of the Bush administration, the state of Rhode Island was approved for a Section 1115 waiver closely resembling a block grant. The federal government agreed to give the state \$12.75 billion for five years of Medicaid funding, as well as allowing the state to undertake

⁶⁵ Capretta, "Health Care Reform from the Bottom UP."

changes in its Medicaid program with expedited approval or no approval required from CMS.⁶⁶ Rhode Island's "global waiver" came with more funding than the federal government would have otherwise provided and so cannot serve as an ideal model for states looking to pursue a block grant.⁶⁷ However, more scalable block grant proposals can be found in the budget resolutions that Republican House and Senate members have passed in the past few years. A 2015 House Budget Committee proposal would repeal the ACA, including the Medicaid expansion, and make a fixed payment to each state that would rise each year to keep up with inflation and population growth.⁶⁸ The proposal would cut nearly \$1 billion over the next decade, according to House Republicans.

Critics of block grant proposals argue that block grants leave the vulnerable populations served by Medicaid at risk of going without needed care if the block grant funding runs out prematurely.⁶⁹ Robert Greenstein of the Center for Budget and Policy Priorities further argued in response to the 2015 House Budget proposal that block granting would shift the Medicaid program from an entitlement to another budget item, subject to cuts that would undermine the social safety net.⁷⁰

James Capretta offers two points that help address critiques of the Medicaid block grant. First, the Medicaid program covers disparate populations. The majority of program enrollees nationwide are children and their nondisabled parents. The rest of the enrollees are disabled or elderly and often need a holistic approach to their care that may require an interdisciplinary team

⁶⁶ Kerry Weems, letter to Gary Alexander, Secretary of the Department of Human Services, State of Rhode Island and Providence Plantations, January 16, 2009, <http://www.ohhs.ri.gov/medicaid/pdf/GlobalWaiverFinal1-09.pdf>.

⁶⁷ Mike Shields, "Rhode Island and the Medicaid 'Global Waiver,'" *Kansas Health Institute*, May 2, 2011, <http://www.khi.org/news/article/rhode-island-and-medicaid-global-waiver>.

⁶⁸ Virgil Dickson, "GOP's Medicaid Block-Grant Plan Won't Happen While Obama's in Office," *Modern Healthcare*, March 19, 2015, <http://www.modernhealthcare.com/article/20150319/NEWS/150319877>.

⁶⁹ Robert Greenstein, "Ryan and Block-Granting the Safety Net," *Off the Charts: Policy Insight Beyond the Numbers*, December 3, 2015, <http://www.cbpp.org/blog/ryan-and-block-granting-the-safety-net>.

⁷⁰ *Ibid.*

to address social, financial, and other wellness needs beyond strictly clinical care. Depending on the different mixes of these distinct patient groups within a state, a state may choose to pursue different kinds of reform for these populations' different needs.⁷¹ Governors who acknowledge these realities up front and present proposals to credibly address the disparate populations are more likely to earn the buy-in from the state-level stakeholders that they need to successfully reform their state's Medicaid program.

This leads to Capretta's second point, which is that block grant proposals appear more attractive once specific details can be offered from state leadership about how the block grant would be structured, in what form the safety net would remain intact, and what the potential benefits could be. Here, the case of the Healthy Indiana Plan is instructive. As Governor Pence sought to extend HIP 1.0 into HIP 2.0 and faced criticism for the expansive nature of the program, the Indiana Family and Social Services Administration protested in response that "due to the nature of the federal Medicaid program, the State must work within the limitations of the current program, which is why Governor Pence continues to support the block granting of Medicaid to the states."⁷²

(b) *Per Capita Cap*: Similar to a block grant, a per capita capped Medicaid grant provides a fixed amount of federal funding to each state. Unlike a block grant, the federal government sets a cap on how much it will pay states per enrollee. Future payments could be determined by factoring in a predetermined growth rate and accounting for increased or decreased enrollment per state. Unlike a block grant, a per capita cap would factor in enrollment increases caused by economic downturns or enrollment decreases caused by population loss. Population considerations can be critical when population shocks occur; for example, Louisiana lost 150,000

⁷¹ Capretta, "Health Care Reform from the Bottom UP."

⁷² Indiana FSSA, "Correcting Recent Misinformed Claims about HIP 2.0."

residents from 2000 to 2010, largely because of Hurricane Katrina in 2005. Some Louisianans died, but thousands more moved out of their city or out of the state. A per capita capped grant could account for these shifts.⁷³

Of course, there are challenges in designing this kind of grant. As previously mentioned, there are very different Medicaid populations within a state program, and the base payment for a state's enrollees should be set while accounting for each enrollee's different needs. Also, choosing the most appropriate index for determining the per capita amount from year to year is not a straightforward issue. For example, a recently introduced bill by Senate Republicans would peg cap increases to gross domestic product (GDP) plus 1 percentage point.⁷⁴ However, GDP may not accurately reflect growth in enrollees' healthcare spending. The same criticism is true of using an inflation index.⁷⁵

Conclusions

The financing of Medicaid lacks incentives for federal and state governments to constrain program spending. Further, my analysis of the political affiliations of state governments applying for waivers showed evidence that the Clinton and Bush administrations approved Section 1115 Medicaid waivers more quickly for governments of their own party. A study of the Healthy Indiana Plan 1.0 and 2.0 shows that waiver flexibility does not exempt states from the whims of federal policymakers, who are inclined to steer waiver programs toward their own preferred policies, regardless of a state's intent. These findings suggest that a different approach may be

⁷³ Campbell Robertson, "Smaller New Orleans after Katrina, Census Shows," *New York Times*, February 4, 2011, New York edition, sec. U.S.

⁷⁴ Timothy Jost, "The Sessions-Cassidy Bill: An ACA Alternative Spelled Out In Legislative Language," *Health Affairs Blog – Following the ACA*, June 1, 2016, <http://healthaffairs.org/blog/2016/06/01/the-sessions-cassidy-bill-an-aca-alternative-spelled-out-in-legislative-language/>.

⁷⁵ Robin Rudowitz, Rachel Garfield, and Katherine Young, "Overview of Medicaid Per Capita Cap Proposals" (Issue Brief, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, Washington, DC, June 2016).

needed to give states meaningful flexibility to pursue the social goals for which the Medicaid program was intended. Block grants and per capita caps are two widely suggested proposals that have promise to do just that.

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