

Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process

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Abstract Executive federalism emphasizes collaboration between the executive branches at the national and state levels to transform grant programs through the implementation process. In this regard, Medicaid demonstration waivers loomed large during the presidencies of Bill Clinton and George W. Bush. This article documents and compares the volume and substance of section 1115 Medicaid waiver activity under the two presidencies. From the perspective of policy performance, Medicaid demonstration waivers provide modest support for the view that states serve as laboratories for policy learning in the health care arena. More broadly, the waivers have not yielded a major solution to the problem of the uninsured and are unlikely to do so. At the same time, they have not (as some have suggested) been a subterranean force for the erosion of Medicaid. To the contrary, these waivers have often enhanced health services for low-income people; above all, they have helped preserve Medicaid as an entitlement by undercutting support for those seeking to convert the program into a block grant. From the perspective of the democratic process, we find that Congress has been a more significant player in shaping waivers than the executive federalism model suggests. While the decision processes surrounding Medicaid waivers often fall short of democratic standards with respect to transparency and opportunities for public input, they still compare favorably to certain alternatives.

Intergovernmental grants are a major policy tool and do much to define American federalism. In historical terms, these grants have increasingly

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become a story of health policy. At the birth of Medicaid in 1965, health initiatives consumed 6 percent of all federal grants to state and local governments. By 2006, this share had grown to nearly one-half of all such grants, with Medicaid alone accounting for close to 45 percent (White House Office of Management and Budget 2006). Medicaid, an open-ended entitlement program, insures over 50 million Americans and costs the national and state governments (which share the expense) well over \$300 billion annually.

Traditionally, students of federal grant programs have focused on policy changes forged by Congress and the courts. At times, however, grant programs undergo major transformation through the implementation process. Change via this process has been so striking over the last two decades that Gais and Fossett (2005) have described the phenomenon as the rise of “executive federalism.” This intergovernmental pattern emphasizes collaboration between the executive branches at both the federal and state levels to modify the implementation of grant programs. Executive federalism, in part, rests on the adroit use of such familiar tools as administrative rule making, executive orders, and comprehensive management strategies (the orchestration of appointments, procedures, and contracts). It also involves the use of program waivers—a congressional delegation of authority to the executive branch to permit selective deviations from the law. By persuading the federal bureaucracy to approve their waiver requests, states gain new freedom to shape who gets what, when, and how from grant programs.

This article takes a partial step toward addressing the implications of executive federalism and waivers for policy performance and democratic process by examining the experience with demonstration waivers under Medicaid and the State Children’s Health Insurance Program (SCHIP) during the presidencies of Bill Clinton and George W. Bush.

More specifically, we seek to enhance understanding in three ways. First, we document and compare the volume and substance of Medicaid waiver activity under the two presidencies. Second, we probe the implications of these demonstration waivers for policy performance—the degree to which they have altered or promise to alter the substance of Medicaid outputs and outcomes. While this issue could be studied from myriad perspectives, we limit our focus to the following questions: To what degree have these waivers allowed states to serve as laboratories for policy learning? And to what extent are they a force for the erosion of benefits to low-income people? Since we focus on Medicaid demonstration waivers, it seems natural to explore whether these demonstrations support the com-

mon assertion that American federalism allows states to innovate and test policies, thereby enabling other governments to make informed decisions on whether to adopt them. The other performance question reflects the cogency and importance of Hacker's (2004) thesis that, over the last three decades and in the absence of large-scale legislative action, a "hidden politics of social policy retrenchment" has prevailed in the United States. Ostensibly, waivers represent just the kind of subterranean administrative tool that might function in this way. The degree to which they do so, if at all, deserves attention.

Third, we explore waivers from the perspective of democratic process. Does heavy reliance on waivers tamp transparency, inhibit participation in the policy process, undercut the role of legislative bodies, or otherwise vitiate democratic norms? Optimally, this question should be examined at both the national and state levels. For present purposes, however, we focus on transparency and congressional involvement in the waiver processes of the federal government.

This article's findings derive from extensive archival research, open-ended interviews with ten individuals highly knowledgeable about the waiver process, and a site visit to Maine.¹ We would like to emphasize that this article is an exercise in proposition generation rather than hypothesis testing. Only a few studies have explicitly probed federalism and waivers (e.g., Gais and Fossett 2005; Schneider 1997; Weissert and Weissert 2006). Comprehensive data sets that could fully illuminate the implications of waivers are not readily available. Sufficient evidence does exist, however, to offer five core propositions that can animate and orient subsequent research.

The Rise of Medicaid Waivers

Although Medicaid law and regulations afford states substantial discretion to design their programs, many states have craved the additional flexibility that waivers provide. Two kinds of waivers—demonstration and programmatic—dominate the Medicaid arena. The primary, though

1. The archival work included an extensive review of the scholarly literature, public documents, print media, and pertinent Web pages of government agencies and nonprofit groups. We conducted the interviews over the telephone and in person. While we promised anonymity to our sources, their general positions appear in the appendix. Parenthetical citations of responses (e.g., "Interview A") correspond to the listings in the appendix. The site visit to Maine resulted from one of the authors serving as a reviewer for an innovations award program. The state had been heavily involved in negotiations with the national government over a waiver.

not exclusive, authorization for demonstration waivers comes from section 1115 of the Social Security Act, which became law in 1962, prior to Medicaid. Endorsed by President John F. Kennedy, the provision gives the executive branch authority to experiment with alternative state approaches to program delivery (Rosenberg and Zaring 1995). It explicitly envisions these 1115 waivers as a tool for policy learning by requiring that state initiatives be formally evaluated. Originally targeted at various social welfare programs, section 1115 subsequently came to play a huge role in Medicaid. In contrast, programmatic waivers principally derive from section 1915 of the Social Security Act. Authorized by Congress in 1981, this provision gave the federal bureaucracy the authority to approve state waivers in two main substantive areas—the design of alternative health care delivery and reimbursement systems (mainly managed care) and the provision of services in a home- or community-based setting rather than in a nursing home or hospital. Unlike the 1115 waivers, these programmatic initiatives do not require formal evaluation.

While the implications of both demonstration and programmatic waivers deserve attention, this article focuses on the 1115 initiatives. These waivers provide states with more opportunities to seek comprehensive changes in Medicaid programs. They more explicitly proceed under the banner that states can be laboratories for policy learning. Moreover, they have occupied center stage in the Clinton and Bush administrations.

Demonstrations Prior to Clinton

Prior to 1993, the federal government used 1115 authority to approve approximately fifty Medicaid waivers (Vladeck 1995: 218). Waiver processes during this period tended to reflect a top-down approach, with the national government driving the topical agenda and stressing the research component and limited duration of the demonstrations. In 1982 and 1983, for instance, the Health Care Financing Administration (HCFA) used multiple waiver authorities (including section 1115) to test various hypotheses about the efficacy of managed care for Medicaid in six states (see, e.g., Freund 1984; Freund et al. 1989). Only one of the 1115 waivers during this period, Arizona's managed care program, typified the kind of comprehensive, enduring reforms that flourished during the Clinton years.

As the 1980s unfolded, the White House Office of Management and Budget (OMB) and the concept of "budget neutrality" increasingly dominated the waiver process. The OMB had grown concerned that HCFA and the states might use demonstration waivers to launch innovations that

would drain the federal treasury. Historically, the bureaucracy had neither promulgated guidelines on waiver costs nor built the capacity to project and track these costs with any precision. No statutory provision required HCFA to do so. In 1983, however, the OMB insisted that HCFA adhere to the principle of budget neutrality in its waiver reviews (Andersen 1994: 227). This principle averred that the activities carried out under the waiver should cost the national government no more than if the state had continued to operate its current Medicaid program. The growing strength of the OMB in the waiver review process, in terms of cost neutrality, contributed to a sharp decline in the number of Medicaid demonstrations approved during the latter part of the 1980s (Dobson, Moran, and Young 1992: 79). While smaller programmatic waivers under section 1915 proliferated, the states found the national government less and less receptive to 1115 proposals. State policy makers increasingly chafed over Medicaid restrictions, with one governor going so far as to claim that the administration of George H. W. Bush had “put its courage in the closet” concerning state experimentation (Roberts 1992).

The Clinton Administration Opens the Door

The Clinton administration wasted no time in signaling that a new day had dawned for 1115 waivers. Speaking to a meeting of the nation’s governors on February 1, 1993, President Clinton deemed the waiver process “Byzantine and counterproductive” (Friedman 1993). He asserted that “for years and years and years, governors have been screaming for relief from a cumbersome process by which the federal government has micro-managed the health care system affecting poor Americans. We are going to try to give them . . . relief” (ibid.). Clinton ordered HCFA to consult with the National Governors Association and within sixty days develop plans to streamline the waiver process (ibid.).

While the federal bureaucracy’s 1115 review process continued to draw fire from various governors throughout the 1990s, HCFA undoubtedly responded to the president’s directive. Of particular importance, HCFA (1994) published a notice in the *Federal Register* promising several steps to expedite 1115 reviews. The notice affirmed that the agency would establish a well-defined schedule with target dates for reaching a decision on state waiver requests. It promised to maintain, “to the extent feasible, a policy of one consolidated request for further information” when a state submitted a proposal (ibid.: 23,960). The Health Care Financing Administration pledged to expand preapplication consultation and to provide more

technical assistance to the states. To reduce delay, proposals would receive concurrent, rather than sequential, review from HCFA, the OMB, and any other pertinent federal agencies. Moreover, HCFA vowed to commit the internal resources needed for a “sound and expeditious review” (*ibid.*; no small matter in the face of an increased volume of waiver submissions and relatively constant staffing levels).

The 1994 public notice also announced that HCFA planned to abandon the stringent approach to budget neutrality that had done so much to stymie 1115 waiver approvals. The Health Care Financing Administration promised to examine the cost neutrality of a demonstration project over its entire life, not on a year-by-year basis (the prior practice). The agency also expressed openness to state ideas on how to calculate baseline projections for future Medicaid expenditures and, more generally, on how to assess cost neutrality. This more flexible stance soon sparked criticism from fiscal watchdogs. Appearing at a congressional hearing in 1995, for instance, U.S. Comptroller General Charles A. Bowsler warned that “waivers could lead to a heavier financial burden on the federal government” (Pear 1995). He complained that HCFA had interpreted the budget neutrality requirement so loosely as to make it almost meaningless (*ibid.*).

George W. Bush: Variations on a Waiver Theme

Upon taking office in 2001, the Bush administration moved quickly to change the name of HCFA to the Centers for Medicare and Medicaid Services (CMS) and announced its receptivity to state ideas for reinventing Medicaid. The new administration continued some practices present under Clinton. Like HCFA, CMS flexibly interpreted the budget neutrality of waiver proposals and soon came under criticism from the U.S. General Accounting Office (GAO 2004b) for its permissiveness. The Centers for Medicare and Medicaid Services did not seek to terminate the comprehensive demonstrations launched under Clinton.

But CMS also pursued new directions on 1115 waivers. It developed a boilerplate application form to reduce the transaction costs for states submitting waiver proposals. CMS also made it easier for states to use two additional pots of federal money to fund their 1115 initiatives. One was Medicaid’s disproportionate share hospital program. The federal government had long permitted states to use certain Medicaid funds to subsidize hospitals that provided disproportionate amounts of charity care. Now, CMS stressed that states could use 1115 waivers to reprogram this hospital subsidy to fund insurance for individuals. In essence, the federal

government made these disproportionate share moneys more fungible. The agency also gave states more discretion over SCHIP funds. The 1997 authorizing legislation for this program had explicitly permitted states to apply for waivers to cover the parents of SCHIP children. The Centers for Medicare and Medicaid Services took this one step further by inviting waivers that redeployed SCHIP moneys that states had failed to spend on children to insure childless adults.

To a greater degree than Clinton, the Bush administration also articulated 1115 waiver themes that it would welcome. Announced in 2001, the Health Insurance Flexibility and Accountability (HIFA) initiative signaled to states that CMS would be open to proposals for Medicaid eligibility expansions that sought to thin coverage through more constricted service packages and greater enrollee cost sharing. This initiative also strongly encouraged states to submit 1115 proposals that enlarged private health insurance options for the low-income uninsured, such as using Medicaid funds for premium assistance to employers. In addition to HIFA, CMS announced a Pharmacy Plus demonstration initiative in January 2002 to provide states with the opportunity to cover the drug costs of low-income seniors and the disabled who did not meet current eligibility criteria.

The Volume and Substance of Demonstration Waivers

To what degree did the orientations of the Clinton and the Bush administrations toward Medicaid demonstration waivers fuel the submission and approval of these waivers? To address this question, we assembled an archival data set of all 1115 waiver proposals considered from January 1993 through August 2006 from submission to final disposition (approval, disapproval, withdrawal). Limits to HCFA and CMS historical records make it possible that we overlooked certain waivers and that our findings therefore underestimate 1115 activity, but we believe that any such discrepancy is slight.

Table 1 points to a torrent of waiver activity from January 1993 through August 2006. During this period, forty-eight states and the District of Columbia submitted 195 Medicaid proposals. The number of 1115 requests ranged from none, in the case of Nebraska and Pennsylvania, to 13, in the case of Minnesota (including 3 renewal requests). The great majority of states submitted multiple proposals. Table 1 also indicates that states submitting proposals stood a good chance of getting them approved. By the end of August 2006, forty-four states and the District of Columbia had

Table 1 1115 Demonstration Waivers Submitted and Approved, January 1993–August 2006

Administration	States Submitting	States Obtaining Approval	Waivers Submitted	Waivers Approved (Including Holdovers and Renewals)
Bill Clinton	39 (plus District of Columbia)	30 (plus District of Columbia)	89 ^a	66
George W. Bush	46 (plus District of Columbia)	39 (plus District of Columbia)	106	83
Total	48 (plus District of Columbia)	44 (plus District of Columbia)	195	149

^aThis number excludes fifteen holdover waiver proposals submitted under the presidency of George H. W. Bush.

obtained approval for 149 waivers. One should note that the 66 waivers endorsed during the Clinton years included 15 holdover requests from the prior administration. Of the 89 proposals (including renewals) submitted during the Clinton years, 57 percent won HCFA's blessings by January 2001. Ostensibly, this rate increased under the Bush administration with CMS endorsing 72 percent of all waiver proposals it had received as of August 2006 (excluding approval of 7 holdover requests from the Clinton years). But this rate is distorted by the substantial volume of Hurricane Katrina waivers. If we exclude them from the analysis, the approval rate under Bush does not differ much from that under Clinton.

States seeking waivers typically became involved with federal officials in negotiations, which varied in duration. For instance, it took Tennessee officials only five months to win endorsement of comprehensive reform in 1993 and Florida only one and one-half months in 2005. In contrast, Missouri went back and forth with HCFA for over three years before winning the agency's blessings in 1998. Over one-third of all waiver proposals submitted did not make it through the process. In only nine cases (five under Clinton and four under Bush) did the bureaucracy explicitly disapprove 1115 requests. More commonly, states withdrew their proposals or simply let them lapse in the face of difficult negotiations or reconsideration (at times brought on by a new governor) as to whether they wanted the waiver in the first place. A few states, such as Illinois in the mid-1990s, declined to implement approved waivers. The great majority of states, however,

carried out the waivers and, in the case of more comprehensive demonstrations, repeatedly sought renewals.

Substantively, state waiver proposals ranged from highly incremental to transformative. At one extreme, New Hampshire submitted a proposal in 1993 called Project Tooth, which sought to expand dental services to “disfigured” welfare recipients who had signed up for jobs programs. At the other, Tennessee during that same year submitted TennCare—a bold, comprehensive innovation, which sought major expansions in coverage through managed care and other measures. While varying in the footprints they sought to leave, most 1115 proposals pursued significant changes when viewed from the perspective of the number of individuals affected or the originality of the methods they wanted to test.

To analyze trends in waiver substance under Clinton and Bush, we assessed the primary thrust of each approved demonstration. While many proposals featured multiple elements, in nearly all cases the central idea or inspiration of the waiver could be derived. This analysis allowed us to sort 127 waivers approved from January 1993 through March 2006 into the ten categories that appear in table 2. The overall approval numbers differ slightly from those in table 1, because we excluded renewals.²

As table 2 suggests, the hallmark of the Clinton years stems primarily from the approval of seventeen comprehensive waivers that moved large numbers of Medicaid enrollees into managed care, usually with eligibility expansions. Minnesota, Maryland, Missouri, New York, Oregon, Tennessee, and other states markedly transformed their programs in this way.

Clinton administration waiver approvals also exceeded those of the Bush administration in two other categories. During the 1990s, HCFA approved eight waivers of smaller scope to enhance the health of pregnant women and children (e.g., by expanding Medicaid eligibility to pregnant substance abusers). Under Clinton, HCFA also approved more long-term care waivers (e.g., to foster understanding of case mix and quality in nursing homes).

Waiver activity under the Bush administration, to some extent, manifests continuity from the Clinton years. The Centers for Medicare and Medicaid Services spent considerable time negotiating renewals of the major managed care demonstrations of the 1990s. These renewed waivers typically featured alterations in the original program design. In one

2. We excluded renewals because they would, in a sense, artificially inflate the numbers in certain substantive categories, especially the managed care expansions originally approved under Clinton and repeatedly resubmitted by the states.

Table 2 Substance of Approved 1115 Waivers, January 1993–August 2006

Main Focus	Number Approved in Clinton Administration	Number Approved in Bush Administration	Total	Percent of All Waivers
Managed Care	17	1	18	14
Broad System Reform	1	2	3	2
Adult/General Eligibility Expansions	4	16	20	16
Health Care for Children/ Pregnant Women	8	0	8	6
Employer-Based Expansion	1	3	4	3
Family Planning	8	11	19	15
Katrina Waivers	0	26	26	20
Long-Term Care	14	5	19	15
Patient Cost Sharing	0	2	2	2
Prescription Drug	0	5	5	4
Other	3	0	3	2
Total	56	71	127	

Note: The numbers exclude renewals of ongoing waivers. Waivers often contain multiple features with respect to delivery mode, cost sharing, and eligibility. This typology reflects the primary thrust of the approved waiver.

category, family planning, the volume of waiver approvals after 2000 approximated those under Clinton. However, as table 2 indicates, the Bush administration also ushered in significant substantive changes. The Bush waiver initiatives substantially flowed from the core themes enunciated in its HIFA and Pharmacy Plus demonstration initiatives.

The most striking development suggested by table 2 is one that the drafters of the original 1115 provision in 1962 almost certainly never envisioned. This involved the emergence of 1115 demonstrations as a primary tool for responding to national disasters. The single largest category of approved waivers (about one in five overall and some 35 percent of those endorsed under Bush) granted states the opportunity to extend Medicaid eligibility to individuals adversely affected by Hurricane Katrina. Ultimately, twenty-five states plus the District of Columbia applied for and obtained these waivers. Waiver states not only included those at or near the geographic center of the storm but more remote jurisdictions as well, including Idaho, Montana, and Rhode Island. The Katrina waivers represented an extraordinary development. To be sure, the Clinton administra-

tion had used a major demonstration waiver to meet an emergency when it bailed out a financially troubled Los Angeles County health system in the late 1990s, but HCFA at least went through the motions of treating this initiative as a demonstration and had it evaluated by the Urban Institute (Zuckerman and Lutzky 2001). The Katrina waivers paid some lip service to the research objectives of the 1115 waivers, but the Katrina evaluations typically consisted of states briefly reporting the number of people served and the mechanisms they employed (e.g., uncompensated care pools). Whether this expansive reading of 1115 statutory authority could have withstood court challenge, had it occurred, is an open question.

In sum, the 1115 Medicaid demonstrations under Bill Clinton and George W. Bush departed significantly from practices prior to 1993. Not only did the sheer number of waivers mushroom, they tended to be broader in scope and to involve more Medicaid dollars. The demonstrations also became less self-conscious exercises in research and evaluation shaped by federal officials. Instead, the waivers to a greater degree reflected the bottom-up preferences of states, with research benefits considered secondary. Rather than terminate the waivers after assessing their further research potential, state and federal officials renewed them if they liked the programmatic outcomes. Certainly, the Clinton and Bush administrations differed in the degree to which they provided centralized thematic direction, but even though CMS under Bush sent strong signals to the states on the substance of waiver proposals, it did not return to the restrictive, centrally dominated approach of the 1980s.

Demonstration Waivers and Policy Learning

The outpouring of 1115 waivers since 1992 naturally raises questions of their implications for health policy. One pertinent issue revolves around whether these demonstrations support their formal rationale—that states can be laboratories for policy learning. The waivers ostensibly seek to promote what Peterson (1997: 1087–1089) calls substantive learning, which rests on a reasoned consideration of evidence of what works that draws on pertinent social-science methods. Peterson also points to another kind of learning, which he calls “situational.” This form of learning pays more attention to the lessons that officials draw from broader political, economic, and social contexts often in the absence of systematic analysis. As a rule, situational learning focuses less on how well an initiative works than on whether it can be enacted and sustained politically (see also Bennett and Howlett 1992; Heclo 1994).

Ideally, at least four conditions would need to be met for 1115 waivers to spawn substantive policy learning. First, evaluators would need to use respected analytic methods to produce accessible and valid information concerning the nature and consequences of 1115 activities in a state. Second, key policy makers and other stakeholders at the national and state levels would need to be aware of this evidence. Third, these actors would need to correctly interpret the implications of this information for policy choices in their own jurisdictions. Fourth, policy makers would need to attempt to act on the knowledge gained from a waiver evaluation to shape health care policy. In the more obvious cases, they would seek to emulate the practices of a demonstration state with appropriate customization to their jurisdictions. Alternatively, they would eliminate a policy option from consideration on grounds that a waiver indicated it would not yield desirable outcomes. We cannot calibrate the precise degree to which these conditions apply to Medicaid demonstration waivers. Enough evidence exists, however, to view the states as policy laboratories through three lenses: technical evaluation, state horizontal, and national vertical.³

The Technical Evaluation Lens

The technical evaluation lens focuses on the degree to which federal and state officials undertake serious formal efforts rooted in social-science methodology to assess demonstrations, draw pertinent lessons, and disseminate relevant findings. Viewed through this lens, the catalytic role of 1115 waivers as vehicles for policy learning appears quite limited. One obstacle to policy learning—the absence of an easily accessible central archive of 1115 studies—has been relatively constant across several presidential administrations. A GAO (1988) report noted this problem, and as 1115 waivers multiplied, the challenge of dealing with it grew. Those who wish to access waiver studies on individual states typically face daunting transaction costs. Also, neither HCFA nor CMS has ever comprehensively promulgated abstracts concerning the core findings of each demonstration study.

Beyond hindering access to research findings, the bottom-up 1115 process presents myriad problems from the perspective of rigorous evaluation design. Random assignment to treatment and control groups, carefully controlled multistate comparisons, before and after testing, and other

3. We make no claim that these lenses constitute the full set of policy learning models. For additional types, see especially Oliver (2001: 282–288).

components of sophisticated evaluation are difficult to achieve given the dynamics of the 1115 process.⁴ While most demonstrations cannot feasibly feature these elements, they can still yield carefully crafted studies that fuel policy learning (e.g., Artiga et al. 2006). Even when one applies less-stringent methodological standards to the 1115 demonstrations, their limits from the technical evaluation perspective seem evident. These limits became salient under Clinton and even more so during the Bush administration.

Under Clinton, HCFA certainly assigned the evaluation component of the 1115 waivers a lower priority than had been the case in the past. The guidelines promulgated in the *Federal Register* in 1994 conveyed that HCFA would be flexible and not compel states to present exacting research designs in their 1115 waiver proposals. The agency acknowledged that policy complexities and “unanticipated events” made a one-best-way approach to methodology infeasible. While adopting a more permissive approach, however, HCFA still hoped for some knowledge gains. In 1993, HCFA’s director of research and demonstrations asserted that a streamlined waiver process featuring a more “laissez-faire approach” dominated by the states could still lead to valuable research (Antos 1993: 182). So, too, HCFA administrator Bruce Vladeck (1995: 220) reaffirmed the role of 1115 waivers in testing “good ideas” to “determine their real-world effects” and underscored that HCFA would contract with independent evaluators to assess state efforts. During the Clinton years, top HCFA officials tended to be curious about the policy lessons they might learn from the 1115 waivers. The agency contracted with well-qualified organizations (at times collaborating with private foundations) to sponsor a number of informative studies.⁵

Nonetheless, the mounting numbers of demonstrations, a steadily growing workload on other fronts, and declining research budgets meant that HCFA stood little chance of hiring an independent contractor to evaluate each 1115 waiver. Instead, the agency turned increasingly toward state self-evaluations. This approach essentially let states submit their own assessments to HCFA on the efficacy of their 1115 waivers. While some

4. For general discussions of the utility of waivers for research purposes, see Andersen (1994) and Dobson, Moran, and Young (1992). One interview subject (D) noted that demonstrations are undertaken to show that an initiative can establish itself and generally function. He suggested that they implied a less-rigorous approach to evaluation.

5. In 1998, for example, the Robert Wood Johnson Foundation teamed with the federal bureaucracy to galvanize the approval and rigorous evaluation of three cash-and-counseling waivers. These waivers sought to empower Medicaid recipients of home- and community-based care. They are described in more detail later in this article.

states took this obligation seriously, these self-assessments often failed to generate high-quality findings that could foster policy learning (Interview D).

The Bush administration downplayed the research component of 1115 waivers more than the Clinton administration did. Political appointees at CMS were especially concerned not to embarrass the states by releasing findings that might point to deficiencies in their waiver programs (Interview E). They shifted resources out of the CMS Office of Research, Development, and Information and continued the trend toward state self-evaluations rather than independent assessments performed by contractors (Interview D). Also, CMS did not put much pressure on the states to present evaluation plans in their waiver proposals or, subsequently, to implement them. States varied greatly in the attention they paid to evaluation. For instance, Illinois, South Carolina, and Wisconsin submitted Pharmacy Plus demonstration proposals to CMS that contained fairly extensive descriptions of evaluation methodology. In contrast, Florida officials submitted a pharmacy proposal that devoted only two paragraphs to evaluation. The CMS approved all of these waiver requests (GAO 2004b).

Transparency related to 1115 research also declined during the Bush administration. The political leadership of CMS had most state self-evaluations forwarded directly to them. They did not routinely share these assessments with the professional staff of the Office of Research, Development, and Information, let alone the more general policy community (Interview E). When CMS used independent contractors to evaluate state demonstrations, it was less willing than HCFA had been to clear and expedite the release of these studies to the public (Interview F).

In sum, the technical evaluation lens provides limited support for the states-as-policy-laboratories model. This is not to gainsay that CMS contracted for valuable studies during the Clinton and Bush years. As insightful as many of these analyses were, the fact remains that the federal government and the states did not systematically partner to assure rigorous evaluation of the 1115 demonstrations, the synthesis of major findings, and the vigorous dissemination of these results to other states and the broader policy community. To the degree that 1115 waivers facilitate policy learning from the technical evaluation perspective, such learning probably has less to do with the diffusion of research findings from one state to the next than with a stovepipe effect whereby officials within the waiver state review information and extract lessons. To the degree that states experience substantial turnover of top executives and staff, this form of learning may also decay.

The State Horizontal Lens

The horizontal lens focuses on the extent to which state policy makers across the country obtain useful information about the 1115 initiatives of particular states in the absence of a robust formal system for fostering evaluation and disseminating research findings. Professional associations (e.g., the National Association of State Medicaid Directors), the trade media, journals, foundations, think tanks, and others transmit considerable information about waivers across state boundaries. This information usually lacks the depth and sophistication of more formal analysis, but it may still facilitate substantive and situational learning.

Readily available evidence does not permit us to assess this lens in much depth. The policy diffusion literature provides some support for the view that such learning occurs. Volden (2006), for instance, has shown that in the case of SCHIP, states have emulated the successful practices of other states (i.e., approaches that lower the proportion of low-income, uninsured children). With respect to 1115 waivers, the proliferation of major managed care initiatives during the Clinton years provides the strongest evidence of policy diffusion. Medicaid managed care enrollments increased approximately ninefold during the 1990s with coverage reaching approximately 55 percent of all Medicaid beneficiaries by the end of the decade. By this point, nearly all states offered some form of managed care to some group of enrollees. One study suggests that officials were “highly discriminating” in learning from the managed care initiatives of other states as their programs evolved throughout the decade. Policy makers learned, for instance, to shun approaches that ran sharply against the grain of local provider sentiment and practice (Hurley and Zuckerman 2003: 241).

The diffusion of comparable program initiatives among states does not, of course, necessarily mean that states are learning from each other. Under Bush, for instance, many states introduced 1115 coverage expansions for parents and childless adults. However, this primarily reflected a response to signals emanating from CMS rather than a response to cues and information from other states.

The National Vertical Lens

States can serve as laboratories for the federal government in two major ways. National policy makers may use insights from state initiatives to design and shape federally run programs. During the New Deal, for

instance, President Franklin Roosevelt's advisers drew heavily on the experience of such innovative states as Wisconsin in assembling federal social programs. To the degree that this dynamic applies to Medicaid demonstrations, we expect national policy makers to scrutinize the implications of state practices for Medicare, the Veterans Administration medical system, and other federally operated programs. States may also serve as laboratories in shaping federal policy toward the states. National policy makers could mandate that all states adopt certain practices that appeared to work well in state demonstrations. Alternatively, 1115 waiver activity could fuel devolution as national policy makers gain more confidence in the states and particular innovations thereby prompting statutes that give states a longer menu of options.

On the whole, the experience under the Clinton and Bush administrations provides modest support for the national vertical model. The most vivid case of such learning by national policy makers involved cash-and-counseling demonstrations that HCFA approved in the late 1990s in Arkansas, Florida, and New Jersey. Medicaid ordinarily provides personal care services (e.g., help in bathing) to the disabled and elderly by contracting with home health care organizations. The 1115 waivers permitted the three states to give money directly to enrollees or proxies they designated to purchase needed services themselves (including hiring their relatives to care for them). With financial support and encouragement from the Robert Wood Johnson Foundation, the federal government contracted with Mathematica Policy Research Incorporated to design and implement an uncommonly rigorous evaluation of the demonstrations. The approach featured random assignment of Medicaid recipients to the traditional agency model and to the experimental cash-and-counseling alternative. Ultimately, the evaluation studies pointed to the superiority of the beneficiary-driven approach on a range of fronts (see, e.g., Carlson et al. 2005). These findings encouraged Congress to insert provisions in the Deficit Reduction Act of 2005 that gave states more authority to use cash and counseling without obtaining waivers.

The major managed care demonstrations initiated under Clinton also provided some support for the national vertical model of policy learning. Prior to the 1990s, state managed care initiatives had a checkered past. Fraud and other forms of implementation failure had surfaced with a vengeance in California and elsewhere (Thompson 1981: 127–128). The experience with the Medicaid demonstrations under Clinton provided evidence that managed care could work reasonably well and helped to create

a climate for statutory change (Interview H). The Balanced Budget Act of 1997 ostensibly opened the door for more managed care in both Medicaid and Medicare without resorting to waivers, but the new law also showed the limits to federal learning. Efforts to draft implementing regulations for the managed care provisions of this law dragged on for over five years. Federal requirements continued to make the adoption of managed care through normal channels unattractive to many states. By and large, states continued to rely on 1115 waivers to sustain their managed care initiatives. Managed care also did not make much headway in Medicare, which overwhelmingly remained a fee-for-service program.

Beyond the cash-and-counseling and managed care examples, evidence of specific changes in federal law linked to 1115 waivers is scant. To be sure, waivers approved under President Bush presaged certain statutory changes. The Pharmacy Plus demonstrations preceded the new Medicare drug program. So, too, the waivers of the early 2000s, which permitted greater enrollee cost sharing and more restricted service packages, anticipated certain provisions of the Deficit Reduction Act of 2005 that gave states greater latitude to adopt these modifications without waivers. We find no evidence that the Medicare prescription drug program and these components of the Deficit Reduction Act reflect bottom-up learning from 1115 projects. As noted earlier, CMS political appointees under Bush did not place a premium on learning from the demonstrations. Moreover, most of the initiatives approved under Bush had not been in operation long enough to pry lessons from them. In essence, CMS acted more as a teacher of the states than as a student of them. The Bush administration held strong views on how to improve Medicaid (e.g., thinning insurance, increasing privatization). The administration invited states to submit waivers targeted toward these ends less because it thought it could learn from the demonstrations than because it wanted states to adopt its approach. “Try it, you’ll like it” might well have been the motto.

While the available evidence provides limited support for the proposition that between 1993 and 2006 states served as laboratories for the national government with respect to specific policies, learning may have occurred at a more general level. Clearly, the cumulative experience with 1115 demonstration waivers (and for that matter their 1915 counterparts) has testified to national policy makers that many states have the capacity and commitment to shape their Medicaid programs in creative ways. This has, at times, prompted Congress and the executive branch to devolve greater Medicaid authority to the states. One should note, however, that

devolutionary steps have been modest and have often been accompanied by new federal mandates.⁶

Policy Laboratories in Perspective

While additional research is needed to fathom more fully possible patterns of state horizontal learning, the available evidence points to the following proposition:

P1 Medicaid 1115 waivers provide limited support for the model of states as policy laboratories. The waiver process frequently features the federal government as a teacher of the states with limited interest in learning from them.

To a degree, the Medicaid demonstration waivers support the view that states function as policy laboratories. The 1115 process has occasionally yielded sophisticated evaluations, and some horizontal learning may well have occurred, especially in the case of managed care. Federal policy makers at times learned lessons from waivers that encouraged them to modify laws (e.g., cash and counseling) or generally devolve more authority to the states. But the preponderance of evidence supports those who hold a more skeptical view of the role of states as laboratories (e.g., Oliver 2001; Peterson 1997; Sparer and Brown 1996). The 1115 process did not consistently yield well-designed studies of state demonstrations and the vigorous dissemination of research findings. Nor did the national government appear consistently inclined or able to soak up lessons from the waivers. While officials in waiver states drew lessons from their demonstrations, these lessons probably reflected stovepipe learning with minimal knowledge transfers to other states.

Waivers and the Preservation of Medicaid

In addition to implications for policy learning, the degree to which waivers vitiate or enhance the access of low-income people to quality health care deserves attention. More specifically, do the waivers comprise one more example of subterranean administrative efforts to foster social program erosion?

Clearly, 1115 waivers have not succeeded in galvanizing universal cov-

6. For instance, the Deficit Reduction Act of 2005 mandated longer look-back periods for asset divestiture and greater citizen documentation requirements for Medicaid eligibility.

erage in particular states. However loosely interpreted, the dictum that Medicaid waivers should be budget neutral to the federal government virtually assures this outcome. In a more incremental way, however, many of the waivers bolstered access to health services for low-income people. The managed care demonstrations launched under Clinton often facilitated the more cost-effective delivery of Medicaid services while expanding eligibility to new groups. Some of these waivers, such as those in Oregon and Tennessee, could not, over time, resist the retrenchment brought on by economic downturns, changes in political leadership, the potency of the antitax movement, and related factors (Hurley 2006; Oberlander 2006). But other innovative states, such as Minnesota, have continued to use their comprehensive waivers to reduce the ranks of the uninsured.

Moreover, waiver negotiations have at times sparked states to think more creatively about coverage expansions. In 2005, for instance, Massachusetts attempted to renew a comprehensive waiver it had initially launched during the Clinton years. The Centers for Medicare and Medicaid Services indicated it would not approve an extension unless the state ceased to use certain provider funding sources as part of its Medicaid match. The resulting negotiation between federal and state officials ushered in a major reform that preserved CMS approval for a revised waiver and triggered passage of a broader law designed to extend health insurance coverage to all Massachusetts residents (Keough 2006; Sachs, Walls, and Friedenzohn 2006).⁷

Still, the prospect that waivers might galvanize Medicaid retrenchment cannot be dismissed. Through various actions, the Bush administration has signaled its willingness to sign off on waivers that seem likely to reduce the access of low-income individuals to quality health care. Its HIFA initiative invited states to thin coverage by restricting benefit packages and imposing greater cost sharing on Medicaid enrollees. A few states accepted the invitation. In 2002, for instance, CMS approved a much-publicized waiver proposal from Utah that took the concept of a thin benefit package and made it razor thin. Utah's waiver extended coverage to uninsured parents and other adults with incomes up to 150 percent of the federal poverty level. It financed this Medicaid expansion by

7. The Centers for Medicare and Medicaid Services viewed certain fiscal practices states used to meet their matching requirements as gimmicks designed to attract federal dollars while involving little real expenditure of state funds. These included taxes on providers that states found a way to reimburse and intergovernmental transfers of funds that created the appearance rather than the substance of state fiscal effort. For further discussion, see Thompson (1998) and Coughlin, Bruen, and King (2004). State requests for waiver renewals during the Bush years have often prompted negotiations over this matter (Sachs, Walls, and Friedenzohn 2006).

trimming the benefit package and imposing certain cost sharing on current enrollees (e.g., poor parents on welfare). The newly “insured” group of adults obtained a benefit package that covered primary care but no hospital services except emergency-room use. State officials negotiated an informal agreement with hospitals to offer enrollees a set amount of charity care in the event that they needed it. These officials promised the new Medicaid beneficiaries that case managers in the Utah Department of Health would try to connect them with specialists willing to provide free care.

The Centers for Medicare and Medicaid Services also indicated its openness to hefty hikes in enrollee cost sharing. An Oregon waiver significantly boosted costs to recipients, among other things imposing a \$250 co-payment on those receiving hospital care. It also allowed providers to deny services to enrollees who failed to pay and imposed strict penalties for delinquent premium payments. Arkansas and Washington won approvals for waivers that imposed new cost sharing requirements on enrollees without extending eligibility to new groups.

On balance, however, what is striking about 1115 waiver activity under Bush is the degree to which states obtaining HIFA waivers declined to impose significant enrollee cost sharing or trim standard benefit packages. An analysis of ten HIFA states concluded that coverage expansion, not cost control, primarily motivated their requests. While these states collectively fell short of their enrollment target of 820,000, they increased the number of insured by an estimated 300,000 (Coughlin et al. 2006).

Beyond the HIFA waivers, questions persist as to whether the two most sweeping, systemic demonstrations of the Bush years in Florida and Vermont might precipitate Medicaid retrenchment. The Florida Medicaid Reform waiver of 2005 emphasized privatization, market dynamics, and a shifting of responsibility and risk to enrollees. The initiative asked Medicaid recipients in two of the state’s most populous counties to choose among competing provider organizations that would offer varying service packages. The state would pay a risk-adjusted premium to the plans the enrollees selected. Florida also permitted recipients to opt out of Medicaid and use a premium subsidy to participate in an employer insurance plan. It promoted “personal responsibility” by pledging to put money in individual health benefits accounts if enrollees engaged in certain health-promoting behaviors (to be defined subsequently by a board). Medicaid beneficiaries could use the money deposited in their accounts to purchase health care services. Through competition among plans, transparency concerning their performance, and enrollee choice, Florida officials claimed

that the waiver would inject much-needed efficiencies into the Medicaid program.

The Vermont waiver, Global Commitment to Health, ostensibly raises the specter of the 1115 process opening the back door to Medicaid block grants. This waiver proposal promised to consider a menu of options consistent with Bush administration themes—health savings accounts, premium subsidies to employers, and much more. But Vermont officials made no explicit commitment to any of these measures. What the waiver did do, however, was to accept a kind of global budget cap on federal spending in exchange for enhanced flexibility. The Centers for Medicare and Medicaid Services agreed to an administrative arrangement whereby one Vermont agency would pay a monthly premium for certain Medicaid enrollees to another state agency that would act as if it were a managed care organization. Vermont would be at risk for managing the costs of this new approach within a negotiated five-year cap on federal outlays. The state would have to cope on its own if its outlays exceeded the cap. If state officials could keep expenditures beneath the cap, they could use any savings for certain other purposes. Having failed to persuade Congress to convert Medicaid to a block grant, the Bush administration turned to waivers in the hope it could encourage this conversion one state at a time.

Do the Florida and Vermont waivers pose a serious threat to the preservation of Medicaid benefits for low-income people? The Florida case presents the more serious case in this regard partly because of the greater number of people affected. Florida's privatized, market-oriented approach presents many possible implementation pitfalls—bewildered enrollees compelled to make uninformed choices, inadequately risk-adjusted premiums that prompt private agents to shun the neediest Medicaid recipients, and more. These and related snafus could reduce take-up of the eligible population into the Medicaid program and undercut the quality of care that beneficiaries receive. Of course, Florida officials may rise to the occasion and sidestep these pitfalls, but the implementation challenges of the waiver will require officials to achieve an uncommon level of administrative capacity, commitment, and skill for this to occur. In contrast, the Vermont waiver seems less threatening to health care benefits. The state negotiated a generous cap on expenditures with CMS (Sachs, Walls, and Friedenjohn 2006). In the unlikely event that the state expenses rise beyond that figure, officials can take solace in the fact that the waiver will expire within five years.

On balance the experience with 1115 waivers since 1993 suggests the following proposition:

P2 The degree to which 1115 waivers open the door to Medicaid retrenchment largely depends on presidential priorities, but even under the Bush administration, waivers have not been a major tool for program erosion.

Medicaid 1115 waivers are in the tool kit of the administrative presidency for use as the White House strives to alter policy outcomes via the implementation process. As such, conservative presidents may well attempt to use them as a vehicle for retrenchment. Under Bush, CMS was willing to approve Medicaid waivers that would thin coverage, privatize risk, and promote block grants, but the efficacy of waivers as an administrative tool ultimately depends on state cooperation. Ultimately, only a few states sought waivers that might curtail Medicaid enrollments and benefits appreciably.

The implications of 1115 waivers for the preservation of Medicaid go beyond the substance of particular demonstrations. They also involve the policy feedbacks of administrative action. Hacker (2004: 248) aptly notes that barriers to major policy transformation heighten the appeal of retrenchment (in his terms, “conversion”) via administrative means. The case of 1115 waivers suggests how the use of administrative vehicles for change can occasionally make dramatic policy change even less likely.⁸

Medicaid narrowly dodged major retrenchment when in 1995 President Clinton vetoed legislation that would have converted the program from an open-ended entitlement to a block grant. The proliferation of 1115 waivers makes it more difficult to open that policy window again. The critical role of the nation’s governors as Medicaid power brokers largely accounts for this. In general, the governors have a straightforward preference with respect to Medicaid. They want more flexibility to run the program, and they want the federal government to pay more of the costs. In 1995, the tenacious leadership of Speaker of the House Newt Gingrich, the ideological fervor for a devolution revolution stoked by dramatic Republican gains in the 1994 election, a slowing of Medicaid budget increases in the states, and unhappiness with HCFA stringency in approving waivers prompted several prominent governors to endorse a block grant (Smith 2002: 46–48).

Changing circumstances after that year sapped gubernatorial support for such action. Through the Medicaid waiver process, governors could

8. We underscore that the Medicaid demonstration waivers do not constitute a definitive test of Hacker’s (2004) thesis of program erosion. He bases his argument on an impressive body of evidence concerning a much broader range of policies.

increasingly have their cake and eat it, too; they gained impressive new power to shape their state programs without having to forego the national government's open-ended funding commitment. Hence, Bush could muster little support for his legislative proposal to convert Medicaid to a block grant, even though most governors came from his party and the Republicans controlled both houses of Congress. Ironically, the triumph of the Bush administrative presidency in facilitating 1115 waivers undermined prospects for more major policy retrenchment. This dynamic suggests the following proposition:

P3 Medicaid 1115 waivers have helped preserve the status of that program as an entitlement by providing an outlet for pressures from the states (especially their governors) for greater flexibility.

This proposition does not gainsay that conservative policy makers can forge legislation that chips away at Medicaid coverage. Indeed, the Deficit Reduction Act of 2005 imposes citizen documentation requirements on applicants and program beneficiaries that may well trigger enrollment declines. It highlights, however, the persistent difficulties of converting Medicaid from an entitlement into a block grant.

Waivers and Democratic Governance at the National Level

Executive federalism via waivers not only has implications for health policy performance, it also possesses ramifications for democratic governance (Bolton 2003; Gais and Fossett 2005). Two questions loom especially large. First, do 1115 processes achieve sufficient transparency and provide adequate opportunity for public comment prior to action on a waiver request? Second, do waiver processes undermine the rule of law and appropriate checks and balances by relegating the courts and legislative bodies to the policy sidelines? Ultimately, these questions should be addressed at both the federal and state levels. This section takes an initial step by focusing on the national government.

Transparency and Opportunities for Voice: Toward Erosion

Public bureaucracies can make it more or less difficult for stakeholders to get timely information and voice their views to administrators. This realization prompted Congress to approve the Administrative Procedures

Act in 1946, which requires agencies under many circumstances to issue notices of proposed rule making in the *Federal Register* and to solicit public comment. The federal bureaucracy faces no requirement to conform to this process in the case of Medicaid waivers. But HCFA in the early Clinton years decided to use the *Federal Register* to pursue a double-barreled approach to transparency and public notice—one barrel targeting the national government and the other the states. In 1994, HCFA decided to put periodic notices in the *Federal Register* concerning all new 1115 proposals and the status of those under review (i.e., approved, disapproved, withdrawn, pending). It also promised to develop a list of organizations that would be notified whenever a state submitted a waiver request. The Health Care Financing Administration promised to take no action on an 1115 proposal for at least thirty days to allow time for comment.

The agency also evinced concern about transparency and public input at the state level. The Health Care Financing Administration required a state to describe in writing the processes used to solicit public comment on an 1115 proposal and promised to rule on the acceptability of the process within fifteen days after receiving the description. To help states clear this hurdle, HCFA specified five practices, any one of which would incline it to sign off on a state's processes. States could hold public hearings on the 1115 proposal, form a commission that held such hearings, obtain state legislative approval of the waiver proposal, provide formal notice and opportunity for comment via the state's administrative procedures act, or publish a waiver notice in the newspapers. The Health Care Financing Administration went on to specify a remedy if it disapproved a state process. In this event, a state could obtain HCFA endorsement if it published a waiver notice in the newspaper with the widest circulation in each city with a population of at least one hundred thousand. If the state had no city of this size, it could meet the requirement by publishing the notice in the newspaper with the largest circulation.

The Health Care Financing Administration's commitment to transparency and public input at two levels of the federal system waned over time. In 1998, the agency abandoned its practice of publishing periodic notices in the *Federal Register* and decided that states under its supervision would be primarily responsible for assuring adequate public notice.⁹ While the

9. We suspect, although we cannot verify, that several factors pushed the Health Care Financing Agency to drop the practice. These included a major reorganization of the agency, the turnover of key personnel including its director, and heavy workload pressures related to the Y2K computer transformation and the drafting of regulations for the Balanced Budget Act of 1997 (Smith 2002).

Bush administration did not abandon the guidelines that HCFA had promulgated for the states, it relaxed federal oversight of them. In streamlining the waiver process, CMS deleted the requirement that states describe their efforts to obtain public input. Instead, states could now check a box on a form indicating that they had done so.

The degree to which states fostered transparency and opportunities for public comment from January 1993 through August 2006 remains an open question. A review of waiver proposals and anecdotal information suggests that most states complied with the 1994 federal guidelines. In 2002, however, the GAO took CMS to task for permitting some states to skirt federal requirements. Arizona officials had, for instance, refused to release copies of a waiver for an adult coverage expansion to groups requesting it. Frustrated at the state level, these groups filed a freedom of information request with CMS in November 2001 to obtain the proposal. Two months later, CMS notified them that it would respond to their request “as soon as possible.” Meanwhile, the agency had already approved the Arizona waiver in December 2001. In response to criticism, CMS sent a letter to state Medicaid directors in May 2002 reaffirming its commitment to enforcing the 1994 guidelines concerning public notice. The agency also worked to improve Web access to waiver documents.

Judicial Deference and Congressional Attentiveness

Executive federalism via Medicaid waivers also raises issues of judicial and legislative control over administrative discretion. States seeking to cut benefits provided under waiver authority have occasionally run into adverse court rulings. Moreover, the courts have indicated that they would not tolerate arbitrary and capricious waiver practices. In general, however, the federal courts have shown great deference to HCFA, CMS, and the states on waivers (Bolton 2003).

Congress, in contrast, has evinced substantial interest in demonstration waivers. The ebb and flow of congressional oversight and statutory intervention over two decades indicates that the story of 1115 waivers is not one of congressional passivity and impotence in the face of an aggressive executive branch. This pattern emerged in two major phases — permissiveness and then resistance. The permissive phase started before the Clinton administration took office and lasted through 2000. During this period, Congress spent considerable time monitoring 1115 activity and prodding the bureaucracy to make it easier for states to obtain waivers. These pro-

penalties initially surfaced when the Reagan and the George H. W. Bush administrations put the brakes on 1115 authorizations in the 1980s. Faced with a disinterested executive branch, Congress increasingly wrote demonstration projects into statutes (Dobson, Moran, and Young 1992: 80). Congress typically ordered HCFA to solicit proposals from the states and to select the best one, but in certain cases, such as a respite-care pilot project in New Jersey, Congress earmarked the demonstration for that state. On occasion, Congress intervened in renewal decisions. For instance, HCFA staff in the late 1980s decided not to renew the On Lok demonstration, which had provided innovative long-term-care services, on the grounds that its continuation would yield little new knowledge. Congress, however, intervened to continue the project (Andersen 1994: 245–246).

The outpouring of waivers under Clinton and the Republican takeover of Congress in 1995 precipitated intense oversight of the waiver process. During 1995 and 1996, congressional committees repeatedly summoned administrative officials to testify. Congress conducted at least five sets of major hearings on Medicaid that dealt at least partly with 1115 waivers (U.S. House Committee on Commerce 1996a, 1996b, 1996c; U.S. Senate Committee on Finance 1995, 1997). A Senate hearing in March 1995 focused exclusively on the subject, and Congress also asked the GAO (1995a, 1995b) to prepare reports on the waivers. Some of the oversight reflected a genuine effort to learn more about the 1115 demonstrations, but most of the hearings developed the theme that the waiver approval process was still hopelessly bureaucratic and that only a Medicaid block grant could unleash state creativity. Committee chairs invited a gaggle of officials to testify about HCFA delays in approving 1115 waivers from such major states as Florida, Illinois, and New York. Appearing before Congress in June 1995, for instance, Illinois Governor Jim Edgar complained that “HCFA has delayed and delayed and delayed” in responding to his state’s waiver request (U.S. House Committee on Commerce 1996a: 23–24). “The bureaucrats ask questions. We rush to respond. And then we wait and wait. The bureaucrats then ask more questions” (*ibid.*). Edgar concluded that HCFA would rather “fiddle and quibble” than act promptly (*ibid.*). In taking HCFA to task at these hearings, members of Congress frequently resorted to such visual props as huge stacks of paper (three feet high in one case) representing a state’s correspondence with the agency over an 1115 waiver request. On one occasion, the committee chair had these stacks brought into the room in a wheelbarrow.

President Clinton’s veto of a Medicaid block grant and his subsequent insistence that Medicaid and welfare reform be decoupled brought these

“show trial” hearings to a close by mid-1996. This did not, however, signal an end to congressional interest in waivers. Members of Congress continued to do casework for state officials if they needed assistance in dealing with HCFA. Beyond this, Congress enacted prowaiver statutory measures. A provision approved in 1997 mandated that state renewal requests automatically be granted for three years if the federal bureaucracy failed to act within six months. Another measure in 2000 clarified that, despite any changes in federal law (e.g., concerning managed care), states could continue to operate their programs under Medicaid waiver authority at least until they came up for renewal (Smith 2002: 302–303).

The second moderately resistant phase of congressional oversight and statutory intervention commenced with the presidency of George W. Bush. This period provided an interesting test case for executive federalism. Starting in 2003, the Republicans controlled both houses of Congress and the presidency. Under unified party government, legislative leaders usually lack the electoral incentive to embarrass or confront the executive branch and tend to trust it more (Huber and Shipan 2002). Moreover, the Republicans demonstrated an unusual degree of party discipline in furthering much of the president’s agenda. Given these circumstances and Congress’s favorable disposition toward waivers, one would predict minimal formal oversight and overwhelming deference to the executive branch on 1115 initiatives. This is not, however, the picture that emerges. To be sure, Congress did not stage highly visible hearings on the waivers, and CMS broadly interpreted its authority to act, but the Senate Finance Committee was far from passive. It requested several reports from the GAO (2002, 2004a, 2004b) on the bureaucracy’s practices and in at least two cases prevailed when the executive branch proved indifferent to its concerns.

The first episode involved the Bush administration’s practices with respect to 1115 waivers that reprogrammed unspent SCHIP funds to insure childless adults. Asked by the Senate Finance Committee to investigate, the GAO (2002) concluded that these waivers violated the law by diverting funds from children and their parents. Upon receiving the report, Senators Charles Grassley, the ranking Republican on the Senate Finance Committee (Iowa), and Senator Max Baucus, the ranking Democrat (Montana), wrote Secretary of Health and Human Services Tommy Thompson asking him to desist from approving these waivers. The Centers for Medicare and Medicaid Services, however, continued to endorse them (GAO 2004a). In the face of executive branch recalcitrance, Congress inserted provisions in the Deficit Reduction Act of 2005 that prohibited CMS from granting any new 1115 waivers that reallocated SCHIP funds in this way.

This legislation also provided Congress with another modest victory in its skirmishes with the executive branch. As indicated previously, the Bush administration had used the 1115 waiver process to allow states to extend coverage to Katrina survivors. In doing so, it resisted claims from Senators Grassley and Baucus that the executive branch lacked the statutory authority to authorize these waivers. Despite resistance from the White House, Congress wrote provisions into the Deficit Reduction Act that explicitly authorized and reshaped the Katrina waivers (Park 2005). Acting more generously than the White House preferred, the law temporarily required CMS to pay the state share of the Medicaid match for services to this target group.

Overview of the Democratic Process

The experience with Medicaid waivers under Bill Clinton and George W. Bush suggests the relevance of two propositions.

P4 The processes for approving 1115 Medicaid waivers indicate that executive federalism should not be equated to executive-branch autonomy. Congress emerges as a watchful, mostly consenting, but at times contentious adult in the waiver process.

Medicaid waivers place the executive branch at center stage in the decision-making process. Top officials, especially under the Bush administration, at times pushed statutory interpretation to the limit in approving waivers, but the exercise of formal authority in this way does not automatically equate to executive branch power. To a considerable degree, the demonstrations reflect the preferences of a Congress that goes to some lengths to stay informed about them.

P5 Decision processes related to 1115 waivers often fall short of democratic standards, but they may still compare favorably to major alternatives.

The 1115 waiver process does not meet pristine standards of democratic process. Transparency often suffers. Major program decisions get made within the bureaucracy rather than in congressional committee rooms and on the floors of the House and Senate. Formal notice of waiver action via the *Federal Register* no longer occurs. Although the national bureaucracy has established guidelines requiring states to provide opportunities for public comment about pending waivers, it does not vigorously monitor states to assure their compliance.

While the 1115 process suffers limitations as an exercise in democratic process, however, it takes on a more positive guise when compared to three alternatives. First, the 1115 process features greater transparency than the one associated with the approval of countless 1915 programmatic waivers. The more incremental, targeted 1915 initiatives seldom attract much public attention and face no requirement to serve as demonstrations. While 1115 waivers have often failed to generate broadly disseminated evaluations, their status as demonstrations usually triggers the transmission of more information to stakeholders than is the case with programmatic waivers. Second, routine administrative venues for approving modifications in state Medicaid programs are often less transparent and open to public input than the 1115 process (Rudowitz and Schneider 2006). In the absence of waivers, states can modify their Medicaid programs by submitting amendments to their state plans. This process will become even more important in the wake of the Deficit Reduction Act of 2005, which grants states new authority to refashion their programs. Third, one should guard against Panglossian versions of congressional decision making when noting the limits to the democratic character of waiver processes. The increasing propensity of Congress to roll major program changes into massive omnibus budget acts often leaves key stakeholders and the public in the dark until well after the bill has become law (Quirk and Binder 2005).

Conclusion

The concept of executive federalism developed by Gais and Fossett (2005) frames an important research agenda related to policy and democratic process in the health care arena. Waivers in particular deserve more scholarly attention. Our study has more precisely documented the transformation of Medicaid wrought by an outpouring of 1115 demonstrations during the administrations of Bill Clinton and George W. Bush. Forty-four states won approval for close to 150 waivers from the beginning of 1993 through mid-2006. We have assessed these demonstrations from two perspectives related to policy performance. The evidence provides modest support for the view that 1115 waivers effectively use the states as laboratories for policy learning. While such learning occurs at times, it falls far short of optimal levels. This study also finds that Medicaid 1115 waivers have not been a major force for subterranean program erosion through the implementation process. While the Bush administration certainly invited waiver proposals that would serve that purpose, most states declined to

submit them. Moreover, the flood of waivers increasingly washed away political support for the conversion of Medicaid from a federal entitlement to a block grant. These findings tend to reinforce the views of those who have recently highlighted political forces that, seemingly against the odds, sustain Medicaid (e.g., Brown and Sparer 2003; Grogan and Patashnik 2003).

In addition to focusing on certain dimensions of policy performance, this study has taken an initial step toward assessing them from the perspective of democratic process at the national level. In this regard, concerns that the waivers spawn the emergence of an autonomous executive branch seem somewhat overblown. Clearly, negotiations between officials in federal and state bureaucracies drive the waiver process, but Congress still emerges as an interested and potent player in the waiver process. Demonstration processes do fall short in achieving high levels of transparency and opportunities for public input. Their deficiencies, however, appear less acute when compared to those embedded in other administrative and even legislative vehicles for altering Medicaid.

While we have made headway in understanding Medicaid 1115 waivers, an important research agenda awaits. Additional evidence should be assembled to test more definitively our five core propositions. In this regard, we need more in-depth analysis of state decision processes that prompt waiver initiatives and shape their evolution. The role of 1115 demonstrations in fueling more general changes in Medicaid via horizontal policy learning deserves particular scrutiny. So, too, the degree to which waiver processes in the states feature meaningful legislative involvement, transparency, and public voice should be compared to those present in other policy arenas for shaping Medicaid, such as the state plan amendment process (see, e.g., Grogan and Gusmano, forthcoming).

This and related research will provide a platform for comparing the demonstration and program waivers. The 1915 program waivers have also transformed Medicaid. Work by Weissert and Weissert (2006) suggests that these waivers may more exclusively be a subterranean, executive branch affair at the national and state levels. They may also feature a brand of executive federalism built more on bureaucratic discretion. The 1115 waivers fit a model that emphasizes the ability of presidents and governors to achieve important policy ends through the implementation process. We suspect that the 1915 waivers will feature greater bureaucratic autonomy in which collaborating professionals at the federal and state levels in consultation with advocacy groups drive the waiver process.

Appendix Positions of the Ten People Interviewed in 2006

Interview A: U.S. Senate Committee Staff

Interview B: U.S. Senate Committee Staff

Interview C: U.S. Government Accountability Office Staff

Interview D: Evaluation Staff, Department of Health and Human Services

Interview E: Evaluation Staff, Department of Health and Human Services

Interview F: Staff, Center for Budget and Policy Priorities

Interview G: Former Medicaid Official, State of New Jersey

Interview H: Staff, Robert Wood Johnson Foundation

Interview I: Staff, Rutgers Center for State Health Policy

Interview J: Staff, Maine Dirigo Health Program (in addition to site visit)

References

- Andersen, E. 1994. Administering Health Care: Lessons from the Health Care Financing Administration's Waiver Policy-Making. *Journal of Law and Politics* 10:215–262.
- Antos, J. R. 1993. Waivers, Research, and Health System Reform. *Health Affairs* 13 (2): 178–183.
- Artiga, S., D. Rousseau, B. Lyons, S. Smith, and D. S. Gaylin. 2006. Can States Stretch the Medicaid Dollar without Passing the Buck? Lessons from Utah. *Health Affairs* 25:532–540.
- Bennett, C. J., and M. Howlett. 1992. The Lessons of Learning: Reconciling Theories of Policy Learning and Policy Change. *Policy Sciences* 25:275–294.
- Bolton, J. R. 2003. The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program. *Columbia Journal of Law and Social Problems* 37:91–179.
- Brown, L. D., and M. Sparer. 2003. Poor Program's Progress: The Unanticipated Politics of Medicaid Policy. *Health Affairs* 22 (1): 31–44.
- Carlson, B. L., S. Dale, L. Foster, R. Brown, B. Phillips, and J. Schore. 2005. *Effect of Consumer Direction on Adults' Personal Care and Well-Being in Arkansas, New Jersey, and Florida*. Mathematica Policy Research, Inc. May 16. aspe.hhs.gov/daltcp/reports/adultpcw.htm.
- Coughlin, T. A., B. K. Bruen, and J. King. 2004. States' Use of Medicaid UPL and DSH Financial Mechanisms. *Health Affairs* 23 (2): 245–257.
- Coughlin, T. A., S. K. Long, J. A. Graves, and A. Yemane. 2006. An Early Look at Ten State HIFA Waivers. Web exclusive, *Health Affairs*, April 25. content.healthaffairs.org/cgi/reprint/25/3/w204.

- Dobson, A., D. Moran, and G. Young. 1992. The Role of Federal Waivers in the Health Policy Process. *Health Affairs* 11 (4): 72–94.
- Freund, D. A. 1984. *Medicaid Reform: Four Studies of Case Management*. Washington, DC: American Enterprise Institute.
- Freund, D. A., L. F. Rossiter, P. D. Fox, J. A. Meyer, R. E. Hurley, T. S. Carey, and J. E. Paul. 1989. Evaluation of the Medicaid Competition Demonstrations. *Health Care Financing Review* 11 (2): 81–97.
- Friedman, T. L. 1993. President Allows States Flexibility on Medicaid Funds. *New York Times*, February 2.
- Gais, T., and J. Fossett. 2005. Federalism and the Executive Branch. In *The Executive Branch*, ed. J. D. Aberbach and M. A. Peterson, 486–524. New York: Oxford University Press.
- Grogan, C., and M. Gusmano. Forthcoming. *Healthy Voices, Unhealthy Silence: Advocacy and Health Policy for the Poor*. Washington, DC: Georgetown University Press.
- Grogan, C., and E. Patashnik. 2003. Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads. *Journal of Health Politics, Policy and Law* 28:821–858.
- Hacker, J. S. 2004. Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States. *American Political Science Review* 98:243–260.
- Health Care Financing Administration. 1994. Medicaid Program; Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policy and Procedures. *Federal Register* 59:23,960.
- Heclo, H. 1994. Ideas, Interests, and Institutions. In *The Dynamics of American Politics*, ed. Lawrence C. Dodd and Calvin Jillson, 366–392. Boulder, CO: Westview.
- Huber, J. D., and C. R. Shipan. 2002. *Deliberate Discretion? The Institutional Foundations of Bureaucratic Autonomy*. New York: Cambridge University Press.
- Hurley, R. E. 2006. TennCare: A Failure of Politics, Not Policy: A Conversation with Gordon Bonnyman. Web exclusive, *Health Affairs*, April 26. content.healthaffairs.org/cgi/reprint/25/3/w217.
- Hurley, R. E., and S. Zuckerman. 2003. Medicaid Managed Care: State Flexibility in Action. In *Federalism and Health Policy*, ed. J. Holahan, A. Weil, and J. M. Weiner, 215–248. Washington, DC: Urban Institute Press.
- Keough, R. 2006. The Politics of Passage. *Governing* 19 (9): A9–A11.
- Oberlander, J. 2006. Health Reform Interrupted: The Unraveling of the Oregon Health Plan. Web exclusive, *Health Affairs*, December 19. content.healthaffairs.org/cgi/reprint/26/1/w96.
- Oliver, T. R. 2001. State Health Politics and Policy: Rhetoric, Reality, and the Challenges Ahead. In *The New Politics of State Health Policy*, ed. R. B. Hackey and D. A. Rochefort, 273–291. Lawrence: University Press of Kansas.
- Park, E. 2005. Failing to Deliver: Administration's Medicaid Waiver Policy Excludes Many Katrina Survivors and Provides No Guarantee of Full Federal Funding. September 29. www.cbpp.org/9-29-05health.htm.

- Pear, R. 1995. GAO Says White House Is Expanding Medicaid Coverage. *New York Times*, April 5.
- Peterson, M. A. 1997. The Limits of Social Learning: Translating Analysis into Action. *Journal of Health Politics, Policy and Law* 22:1077–1114.
- Quirk, P. J., and S. A. Binder. 2005. Congress and American Democracy: Assessing Institutional Performance. In *The Legislative Branch*, ed. P. J. Quirk and S. A. Binder, 525–550. New York: Oxford University Press.
- Roberts, B. 1992. Bush Blows It on Health Care. *New York Times*, August 11.
- Rosenberg, J. M., and D. T. Zaring. 1995. Managing Medicaid Waivers: Section 1115 and State Health Care Reform. *Harvard Journal of Legislation* 32:545–556.
- Rudowitz, R., and A. Schneider. 2006. *The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and Look at the Deficit Reduction Act*. Washington, DC: Kaiser Commission on the Future of Medicaid and the Uninsured.
- Sachs, T., J. Walls, and I. Friedenzohn. 2006. Uncharted Territory: Current Trends in Section 1115 Demonstrations. *Stateside: Academy Health* 1 (2): 1–9.
- Schneider, S. K. 1997. Medicaid Section 1115 Waivers: Shifting Health Care Reform to the States. *Publius* 27:89–109.
- Smith, D. G. 2002. *Entitlement Politics: Medicare and Medicaid, 1995–2001*. New York: Aldine de Gruyter.
- Sparer, M. S., and L. D. Brown. 1996. States and the Health Care Crisis: Limits and Lessons of Laboratory Federalism. In *Health Policy, Federalism, and the American States*, ed. R. F. Rich and W. D. White, 181–202. Washington, DC: Urban Institute Press.
- Thompson, F. J. 1981. *Health Policy and the Bureaucracy: Politics and Implementation*. Cambridge, MA: MIT Press.
- . 1998. The Faces of Devolution. In *Medicaid and Devolution: A View from the States*, ed. F. J. Thompson and J. J. DiIulio Jr., 14–55. Washington, DC: Brookings Institution.
- U.S. General Accounting Office (GAO). 1988. *HCFA Research: Agency Practices and Other Factors Threaten Quality of Mandated Studies*. GAO/PEMD-88–9. Washington, DC: GAO.
- . 1995a. *Medicaid: Spending Pressures Drive States toward Program Reinvention*. GAO/HEHS-95–122. Washington, DC: GAO.
- . 1995b. *Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future*. GAO/HEHS-95–186. Washington, DC: GAO.
- . 2002. *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concern*. GAO-02–817. Washington, DC: GAO.
- . 2004a. *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*. GAO-04–166R. Washington, DC: GAO.
- . 2004b. *Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns*. GAO-04–480. Washington, DC: GAO.
- U.S. House Committee on Commerce. 1996a. *Transformation of the Medicaid Program—Part 1*. Washington, DC: U.S. Government Printing Office.

- . 1996b. *Transformation of the Medicaid Program—Part 2*. Washington, DC: U.S. Government Printing Office.
- . 1996c. *Transformation of the Medicaid Program—Part 3*. Washington, DC: U.S. Government Printing Office.
- U.S. Senate Committee on Finance. 1995. *Medicaid “1115” Waivers*. Washington, DC: U.S. Government Printing Office.
- . 1997. *Welfare and Medicaid Reform*. Washington, DC: U.S. Government Printing Office.
- Vladeck, B. 1995. Medicaid 1115 Demonstration Waivers: Progress through Partnership. *Health Affairs* 14 (1): 217–220.
- Volden, C. 2006. States as Policy Laboratories: Emulating Success in the Children’s Health Insurance Program. *American Journal of Political Science* 50:294–312.
- Weissert, C. S., and W. G. Weissert. 2006. Medicaid Waivers: License to Shape the Future of Fiscal Federalism. Paper presented at the Annual Meeting of the American Political Science Association, Philadelphia, PA, September 1–3.
- White House Office of Management and Budget. 2006. *Historical Tables: Budget of the United States Government, Fiscal Year 2007*. Washington, DC: U.S. Government Printing Office.
- Zuckerman, S., and A. W. Lutzky. 2001. *The Medicaid Demonstration Project in Los Angeles County, 1995–2000: Progress, but Room for Improvement*. Final report submitted under contract to the Centers for Medicare and Medicaid Services. Washington, DC: Urban Institute.