

**THE PROMISE AND PERIL OF EXECUTIVE FEDERALISM:
THE CASE OF MEDICAID DEMONSTRATION WAIVERS**

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Intergovernmental grants are a major policy tool and do much to define American federalism. As the 21st century dawned, the national government operated over 650 grant programs for states and localities. By 2005, these grants totaled over \$425 billion in federal outlays and, through matching requirements, fueled substantial expenditures by state governments from their own coffers (U.S. Office of Management and Budget 2005). 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 via the implementation process.

The administrative process as a vehicle for reshaping federal grant programs has loomed especially large under the presidencies of Bill Clinton and George W. Bush. Developments have been so striking in this regard that Gais and Fossett (2005) have described the phenomenon as “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 and “comprehensive management strategies” (the orchestration of appointments, procedures, and contracts). But it also involves program waivers -- a congressional grant of authority to the executive branch to permit selective enforcement of a 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.

The rise of executive federalism in general and waivers in particular raise a host of important research questions related to American governance that have yet to be

addressed fully.¹ One cluster of questions focuses on *performance* – the degree to which waivers for better or worse alter the substance of policy outputs and outcomes. A second cluster targets the implications of waivers for *democratic processes* – whether reliance on waivers reduces transparency, inhibits participation in the policy process, undercuts the role of legislative bodies, or yields related adverse effects.

This paper 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 more precisely the degree to which a gusher of substantively diverse waivers has profoundly transformed the basic character of Medicaid under the two presidential administrations. We explore whether these waivers enhance efforts to serve the disadvantaged or are instead subterranean vehicles fostering program erosion. Second, we assess the degree to which these waivers allowed states to serve as vital laboratories for policy learning. Third, we probe the democratic dimension of waiver processes in the national government, specifically, the level of transparency and of congressional involvement. The next three sections of this paper present evidence with respect to each of these foci. A penultimate section draws on this evidence to proffer five core propositions concerning Medicaid waivers, executive federalism, and health policy. This paper’s findings derive from extensive archival research and 10 open-ended interviews with individuals who have substantial knowledge of the waiver process.²

¹ While few studies have explicitly focused on federalism and waivers, Schneider (1997), Weissert and Weissert (2006), and Gais and Fossett (2005) have cast valuable light on the subject.

² 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 phone and in person with individuals who worked in the federal bureaucracy, congress, think tanks, private foundations, and universities.

The Rise of Medicaid Waivers

Medicaid offers open-ended grants to the states to provide health insurance to low-income people. In historical terms, intergovernmental grants have increasingly become a story of health policy and Medicaid. At the birth of Medicaid in 1965, health initiatives consumed six percent of all federal grants to state and local governments. By 2005, this share had grown to nearly half of all such grants with Medicaid alone accounting for some 45 percent (U.S. Office of Management and Budget 2005). As of 2005, Medicaid insured over 50 million Americans and cost the national and state governments (which share the expense) well over \$300 billion annually.

Although Medicaid law and regulations afford states substantial discretion to design their programs, many of them have craved the additional flexibility that waivers provide. Two general kinds of waivers have loomed especially large in the Medicaid arena – *demonstration* and *programmatic*. The primary, though not exclusive, authorization for demonstration waivers comes from Section 1115 of the Social Security Act. Approved by Congress in 1962 at the urging of President John F. Kennedy, the provision gives the executive branch the authority to endorse 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 evaluated using appropriate methodologies. 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 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 paper focuses on the 1115 initiatives. These waivers provide states with more opportunity to seek comprehensive changes in their 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 administrative presidencies of Bill Clinton and George W. Bush.

Demonstrations Prior To Clinton

Estimates of the number of 1115 Medicaid waivers prior to the Clinton years vary. Strictly defined, there appear to have been about 50 (Vladeck 1995). But this figure does not capture the volume of demonstrations emanating from diverse statutory sources outside the conventional 1115 mode. For instance, Dobson and associates (1992) found that the federal government authorized 172 Medicaid demonstrations during the 1980s. Waiver processes prior to 1993 tended to reflect a top-down approach with the national government driving the topical agenda and stressing the research component of the projects. In 1982 and 1983, for instance, the Health Care Financing Administration (HCFA) used multiple waiver authorities (including section 1115) to invite states to test various hypotheses about the efficacy of managed care for Medicaid. In response, six states applied for and received waivers. Each participating state had the discretion to shape important features of their proposals, but they did so as part of a centrally structured comparative study. The demonstration led to the publication of an eight-volume final report in the late 1980s as well as books and journal articles (e.g., Freund 1984, 1989). Only one of the 1115 waivers during this period, Arizona's comprehensive

managed care program, typified the kind of initiatives that became common during the Clinton years.

As the 1980s unfolded, the waiver process increasingly came to be dominated by the Office of Management and Budget (OMB) and the concept of “budget neutrality.” OMB had grown concerned that HCFA and the states might use demonstration waivers as launching pads for 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 do so. In 1983, however, OMB persuaded HCFA to defer to the principle of “budget neutrality” in its waiver reviews. 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 muscle of OMB in the waiver review process under the banner of cost neutrality contributed to a sharp decline in the number of demonstration waivers approved after 1983 (Andersen 1994; Dobson et al. 1992). While smaller programmatic waivers under Section 1915 proliferated, the states found the national government less and less receptive to their 1115 proposals. As the administration of George H.W. Bush drew to a close in 1992, the fate of an Oregon 1115 waiver request sent clear signals in this regard. In a highly publicized process, which featured extensive hearings throughout the state, Oregon officials had won approval from the legislature for a plan that would extend Medicaid eligibility to new groups while simultaneously eliminating certain benefits through a prioritization process. When the federal bureaucracy rejected the proposal, Oregon Governor Barbara Roberts (1992), a Democrat, charged that the Bush

administration had “put its courage in the closet” concerning state experimentation with health care reform.

Bill Clinton And George W. Bush Open The Door

The Clinton Administration wasted no time in signaling that a new day had arrived for 1115 waivers. Speaking to a meeting of the nation’s governors on February 1, 1993, President Clinton deemed the processes associated with waiver approval “Byzantine and counterproductive.” He went on to say: “For years and years and years, governors have been screaming for relief from a cumbersome process by which the federal government has micromanaged the health care system affecting poor Americans. We are going to try to give them...relief.” Clinton told his audience that he had ordered HCFA to consult with the National Governors Association and develop plans to streamline the waiver process within 60 days (Friedman 1993).

While the federal bureaucracy’s 1115 review process continued to draw fire from various governors throughout the 1990s, HCFA undoubtedly took steps to make it less onerous to the states. Of particular importance, HCFA (1994) published a notice in the *Federal Register* in September 1994 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. HCFA pledged to expand pre-application consultation and provide more technical assistance to the states. To reduce delay, proposals would receive concurrent, rather than sequential, review from HCFA, OMB, and any other pertinent federal agency. Moreover, HCFA vowed to commit the internal resources needed for a “sound and expeditious review” (no small matter in the face of an increased volume of

waiver submissions and the propensity of congress to hold the agency's staffing levels constant).

The 1994 public notice also announced that HCFA planned to abandon the stringent approach to estimating budget neutrality that had done so much to stymie 1115 waiver approvals. In this regard, HCFA promised to assess 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. HCFA's more flexible stance did not mean that the agency rubber-stamped state calculations. Testifying before congress in early 1995, Sally Richardson, Director of the Medicaid Bureau within HCFA, said that reaching agreement with an 1115 waiver applicant on cost neutrality was often "the most difficult and time-consuming part of the approval process" (U.S. Senate Committee on Finance 1995, p.4). Nonetheless, HCFA became more permissive, so much so that some oversight actors sounded alarms. Appearing at a congressional hearing in 1995, for instance, Comptroller General Charles A. Bowsher warned "waivers could lead to a heavier financial burden on the federal government." He complained that HCFA had interpreted the budget neutrality requirement so loosely as to make it almost meaningless (Pear 1995).

Upon taking office in 2001, the second Bush Administration opened the door to 1115 waiver proposals even wider. The White House 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. Like HCFA, CMS flexibly interpreted the budget neutrality of waiver proposals and soon came under criticism from the General Accounting Office (2004) for its approach. Simultaneously, CMS took the review process

beyond practices of the Clinton years by permitting states to use two additional pots of federal money to fund their 1115 proposals – Medicaid’s disproportionate share hospital program and unspent SCHIP monies. The federal government had long permitted states to use certain Medicaid funds to subsidize hospitals that provided “disproportionate” amounts of charity care. CMS now stressed that states could use 1115 waivers to reprogram this hospital subsidy to fund insurance for individuals. The agency also gave states more discretion over SCHIP monies by permitting waivers that redeployed these funds to provide insurance to childless adults. In addition to these fiscal maneuvers, CMS developed a boilerplate application form designed to reduce the transaction costs to states of submitting waivers proposals.

Demonstration Waivers Proliferate

To what degree did the more receptive orientations of the Clinton and second Bush Administrations fuel state waiver requests? To address this question we assembled an archival data set designed to track all 1115 waiver proposals considered from 1993 through March 2006 from their 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 the level of 1115 activity. But we believe that any such discrepancy is slight.

Table 1 indicates that the more receptive orientations of the Clinton and second Bush administrations unleashed a torrent of 1115 waiver proposals. During the period from 1993 through March 2006, 48 states and the District of Columbia submitted 190 Medicaid demonstration proposals. The number of 1115 proposals ranged from zero in the case of Nebraska and Pennsylvania to 13 in the case of Minnesota (including three renewal requests). The great majority of states submitted more than one proposal during

this period. Both the number of states transmitting demonstration requests and the overall volume of submissions rose during the second Bush Administration. The increases are all the more remarkable given that they cover only the first five and a quarter years of that presidency.

Table 1 also indicates that states submitting proposals stood a good chance of getting them approved. By the end of March 2006, 44 states and the District of Columbia had obtained approval for 146 waivers. It deserves note that the 66 waivers endorsed during the Clinton years included 15 holdover requests from the prior administration. Within three months of taking office, HCFA reversed the first Bush Administration by signing off on the highly innovative and controversial 1115 proposal from Oregon. By early 1995, HCFA had approved an additional 14 holdovers. Of the 89 proposals (including renewals) submitted during the Clinton years, 57 percent of them had won HCFA's blessings by January 2001. This rate increased under the second Bush Administration with CMS endorsing 72 percent of all waiver proposals by the end of March 2006 (excluding approval of seven holdover requests from the Clinton years).

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

	States Submitting	States Obtaining Approval	Waivers Submitted	Waivers Approved (including holdovers and renewals)
Clinton Administration	39 (plus D.C.)	30 (plus D.C.)	89*	66
George W. Bush Administration	46 (plus D.C.)	39 (plus D.C.)	101	80
	48	44	190	146

Total	(plus D.C.)	(plus D.C.)
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*This number excludes 15 holdover waiver proposals submitted under the presidency of George H. W. Bush.

The flurry of 1115 waiver activity under Clinton and Bush did not mean that HCFA and CMS rubber-stamped state proposals. The process of approval often involved intense negotiation. For instance, the second Bush Administration adopted a hard-nosed bargaining posture on certain fiscal practices states used to meet federal matching requirements. CMS viewed certain state practices (e.g., taxes on providers that the state found a way to reimburse, convoluted intergovernmental transfers) as fiscal gimmicks designed to draw down federal dollars while involving little real expenditure of state funds. CMS' general efforts to fight this fiscal manipulation spilled over into the 1115 process. When Maine proposed a waiver to expand coverage that would count premiums paid by employers for certain Medicaid recipients as part of the state match, CMS expressed skepticism and deferred action on the request indefinitely. In other cases, such as Massachusetts, the agency used the state's renewal request to eliminate certain "suspect" funding sources the state had previously used for its match.

Some negotiations went easier than others. For instance, it took Tennessee officials only five months to win approval for comprehensive reform in 1993 (TennCare) and Florida only a month and a half in 2005. In contrast, Missouri went back and forth with HCFA for over three years before winning the agency's blessings in 1998. Over a third of all waiver proposals submitted from 1993 through March 2006 did not make it through the process. In only eight cases (five under Clinton and three under Bush) did the bureaucracy explicitly disapprove 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 gubernatorial administration) 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.

The Substance Of The Demonstrations

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 footprint they sought to leave, most 1115 waivers pursued significant changes when viewed from the perspective of the number of individuals affected or the originality of the methods proposed.

To analyze trends in the substance of waivers under Clinton and Bush, we assessed the primary thrust of each approved waiver. To be sure, many waivers featured myriad elements. But in nearly all cases the central idea or inspiration of the waiver could be derived. This analysis allowed us to sort 124 waivers approved from 1993 through March 2006 into the ten different categories that appear in Table 2. The overall approval numbers differ slightly from those in Table 1 because we excluded renewals.³

As Table 2 suggests, the hallmark of the Clinton years primarily derives from the approval of 17 comprehensive waivers designed to move large numbers of Medicaid enrollees into managed care usually with eligibility expansions. Minnesota, Maryland,

³ 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.

Missouri, New York, Oregon, Tennessee and other states markedly transformed their programs in this way. Clinton waiver approvals also exceeded those of George W. Bush in two other categories. HCFA during the 1990s approved eight waivers of smaller scope focused on enhancing the health of pregnant women and children. In 1993, for instance, Maryland, Massachusetts, and New York all won endorsement of 1115 proposals seeking to expand eligibility to pregnant substance abusers. HCFA under Clinton also approved more long-term care waivers than CMS under Bush did (14 compared to five). In 1998, for instance, HCFA signed off on proposals from Arkansas and New Jersey designed to enhance the control of chronically impaired recipients over the services they received in a home or community-based setting rather than a nursing home.

Waiver activity under the second Bush Administration manifests some continuity from the Clinton years. CMS spent considerable time approving renewals of the major managed care demonstrations of the 1990s. These renewal requests often sought alterations in the original program design (in the case of Oregon and Tennessee, significant retrenchment). In one category, family planning, the volume and nature of waiver approvals after 2000 mirrored those under Clinton. But, as Table 2 indicates, the Bush Administration also ushered in significant substantive changes in some cases sending signals of a new push-the-envelope-to-the-limit approach.

The Bush waiver initiatives substantially flowed from five core themes that the administration articulated upon taking office: (1) expansion of the federal role in providing prescription drugs for seniors, (2) a willingness to trade eligibility expansions for a thinning of coverage in terms of more constricted service packages and greater enrollee cost sharing, (3) enhanced incentives for employers to provide insurance to low-income enrollees, (4) the promotion of recipient choice, personal responsibility, and

market forces, and (5) the shifting of financial risk to the states. While demonstration waiver activity under Bush tended to reflect these themes, the most striking development – one that the drafters of the original 1115 provision almost certainly never envisioned – involved the emergence of the principle that demonstration waivers ought to be a primary tool for responding rapidly to national disasters.

Table 2
Substance of Approved 1115 Waivers*
January 1993-March 2006

Main Focus**	#Clinton	# Bush	Total	Percent of All Waivers
Managed Care/Eligibility Expansion	17	1	18	15%
Broad System Reform	1	2	3	2%
Adult/General Eligibility Expansions	4	16	20	16%
Children/Pregnant Women Health	8	0	8	6%
Employer Based Expansion	1	3	4	3%
Family Planning	8	10	18	15%
Katrina Waivers	0	24	24	19%
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	68	124	

*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.

The single largest category of approved waivers (close to one in five overall and some 35 percent of those endorsed under Bush) sought to help states cope with Hurricane Katrina. Ultimately, 23 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. Through these waivers, states could extend Medicaid eligibility to individuals adversely affected by the storm whether they remained in the states hit by Katrina or evacuated to other jurisdictions.

Other waiver activity more faithfully reflected the stated themes of the Bush Administration. In January 2002, CMS announced a Medicaid Pharmacy Plus Initiative to provide states with the opportunity to cover the drug costs of low-income seniors and the disabled who did not meet the state's current eligibility criteria. Some 15 states submitted proposals and five received approval before major Medicare reform extended prescription drug coverage to seniors.

Upon taking office, the Bush Administration also launched a Health Insurance Flexibility and Accountability (HIFA) initiative to facilitate the creative financing of eligibility expansions via the Medicaid program and employers. CMS promised to be receptive to 1115 proposals that would thin Medicaid coverage via enrollee cost sharing and more limited benefit packages.⁴ The 16 waivers in Table 2 fostering eligibility expansions for adults largely reflect this initiative. Most commonly, these waivers allowed states to use SCHIP funds to cover the parents of children enrolled in that program or to insure childless adults. In the vast majority of cases, the states did not accept the Bush Administration's invitation to thin coverage. They generally adhered to

⁴ We borrow the concept of "thinning" from Moran (2005).

service package already embedded in Medicaid or SCHIP and did not markedly increase enrollee cost sharing.

While most state initiatives did not feature a major thinning of insurance, CMS sent clear signals that it stood ready to endorse such action. In 2002, CMS approved a much publicized waiver from Utah that took the concept of a thin benefit package to the realm of the razor thin. Utah's 1115 waiver extended coverage to uninsured parents and other adults with incomes up to 150 percent of poverty. It financed this expansion by trimming the benefit package and imposing certain cost sharing on current Medicaid enrollees (e.g., poor parents receiving welfare payments). The newly "insured" group of adults obtained a benefit package that covered only primary care and not hospital services except for emergency room use. To cover these enrollees in the event they needed hospital care, state officials negotiated an informal agreement with hospitals to offer them a set amount of charity care. It also 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 in the event they became acutely ill.

CMS 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. The Oregon waiver 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.

Table 2 indicates that only three 1115 demonstrations under Bush primarily emphasized the role of private employers in extending insurance to low-income

individuals. In 2006, for instance, Arkansas obtained approval for a Safety Net Benefit Program to provide a circumscribed benefit package through employers to 50,000 uninsured adults with incomes at or below 200 percent of poverty. The state pledged to contract with private insurance companies to offer this option to employers.

The most sweeping systemic reforms of the second Bush Administration involved Florida and Vermont. These two waivers possessed elements not present in the major managed care demonstrations of the Clinton years. The Florida Medicaid Reform waiver of 2005 emphasized enrollee choice, privatization, and market dynamics. More specifically, the initiative asked Medicaid recipients in two of the states 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 plan that the enrollee selected. Florida permitted recipients to opt out of Medicaid and use the premium subsidy to participate in an employer insurance plan. The Florida initiative also promoted “personal responsibility” by pledging to put money in individual health benefits accounts if enrollees engaged in certain healthy 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, was much less precise than the Florida proposal. Through a new organizational arrangement within state government, Vermont officials promised to consider adopting an array of options consistent with Bush Administration themes – health savings accounts, premium subsidies to employers, expanded home and community based services, and much more. But Vermont did not

clearly commit itself to any of these measures. What the waiver did do, however, was accept a kind of global budget cap on federal spending in exchange for enhanced flexibility. CMS agreed to pay a capitation amount for all Medicaid service in the state over the waiver period. Vermont would be at risk for managing costs within this limit. If its expenditures exceeded the agreed upon federal contribution per recipient, the state would have to absorb the added cost. If state officials could keep expenditures per beneficiary down, they could use the savings for certain other purposes. Through this waiver, the Bush Administration achieved a highly whittled down version of an objective it had tried and failed to achieve via the legislative process – the conversion of Medicaid to a block grant.

In sum, 1115 demonstrations under Clinton and Bush assumed many substantive guises. This outpouring naturally raises the question of their implications for health policy in the United States – whether they in some sense represent a step forward or a force for program erosion. But before addressing this issue, another dimension of waiver performance deserves consideration. Unlike the 1915 programmatic waivers, the 1115 initiatives paid explicit homage to the idea that states could be vital laboratories for policy learning. To what extent have they functioned in this way?

Demonstration Waivers And Policy Learning

Federal policy requires that each 1115 waiver feature an evaluation component. Ideally, at least four conditions would apply for demonstration waivers to facilitate policy learning. First, evaluators would produce accessible and valid information concerning the nature of 1115 activities in a state and their implications for program performance. Second, key policymakers and other stakeholders at the national and state levels would be aware of this evidence. Third, these actors would correctly interpret the implications of

this information for policy choices in their own jurisdictions. Fourth, policymakers would seek to use the knowledge gained from these waivers to shape health care policy. In the more obvious case, 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 waiver evidence indicated it would *not* yield desirable outcomes. We cannot calibrate the precise degree to which these conditions apply to Medicaid demonstration waivers. But sufficient evidence exists to examine the states as policy laboratories through three lenses – technical evaluation, state policy, and national policy.

The Technical Evaluation Lens

The technical evaluation lens focuses on the degree to which federal and state officials undertake serious efforts rooted in social science methodology to assess the demonstrations, draw appropriate lessons, and disseminate pertinent findings. Viewed through this lens, the catalytic role of 1115 waivers as vehicles for policy learning appears quite limited.

Evaluation purists might, of course, view this as a foregone conclusion. From the perspective of rigorous evaluation design, the whole bottom-up 1115 process presents myriad problems. Random assignment to treatment groups, carefully controlled multi-state comparisons, pre- and post-testing, and other components of a sophisticated evaluation are implausible given the dynamics of the 1115 process.⁵ On balance, however, this perspective seems too pessimistic. While far from a springboard for rigorous experimental and quasi-experimental research, waivers can yield carefully crafted studies that fuel policy learning (e.g., Artiga et al. 2006). The limited efficacy of

⁵ For general discussions of the utility of waivers for research purposes, see Andersen (1994) and Dobson et al. (1992).

1115 initiatives from the technical evaluation perspective derives from sources other than the imposition of stringent methodological standards.

One obstacle to policy learning has been relatively constant across several presidential administrations -- the absence of an easily accessible central repository of 1115 studies. A General Accounting Office report released in 1988 noted this problem and, as 1115 waivers multiplied, the challenge of dealing with it grew. Those who wish to access waiver studies produced for individual states typically face daunting transaction costs. Nor has HCFA or CMS ever comprehensively promulgated abstracts concerning the core findings of each demonstration study. The federal bureaucracy has faced little pressure to invest in such an information system. Congressional staffers associated with pertinent committees could not recall a single time when they had asked for a state-specific 1115 report. One evaluation specialist in the executive branch thought it would be a waste of time to do so, given the quality of many of those studies.

While accessibility has been a persistent problem, the Clinton and Bush Administrations differed in other ways. HCFA under Clinton certainly assigned the evaluation component of 1115 waivers a lower priority than had been the case in the past. HCFA guidelines (1994) assured states that they did not need to present exacting research designs in their 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). So, too, HCFA Administrator Bruce Vladeck (1995, p. 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 manifested a genuine curiosity 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.

Nonetheless, the proliferation of demonstrations, a steadily increasing workload on other fronts, and limited resources meant that HCFA stood little chance of hiring an independent contractor to evaluate each 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 demonstrations. While some states took this obligation seriously, these self-assessments often failed to generate high quality findings that could foster policy learning in other jurisdictions.

The second Bush Administration downplayed the research component of 1115 waivers more than Clinton had. Political appointees at CMS were especially concerned not to embarrass the states by releasing findings that might point to deficiencies in their waiver programs. 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. Nor did CMS 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. CMS approved all four requests (U.S. General Accounting Office 2004).

Transparency related to 1115 research also declined during the second 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. 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.

In sum, the technical evaluation model provides very limited support for the states-as-policy laboratories model. This is not to gainsay that CMS has contracted for valuable studies during the Clinton and Bush years. But insightful as many of these analyses have been, the fact remains that the federal government and the states do not systematically partner to assure 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, it probably has less to do with the horizontal diffusion of research findings from one state to the next than with stove pipe learning whereby officials *within* the waiver state review information and extract lessons.

The State Policy Lens

The state policy lens focuses on the extent to which policymakers at this level of the federal system obtain useful information about the 1115 initiatives of other states in the absence of robust formal evaluation. Professional associations (e.g., the National Association of State Medicaid Directors), the trade media, foundations, think tanks, and

other actors transmit considerable information about waiver activities across state boundaries. This information generally lacks the depth and sophistication of more formal analysis, but frequently conveys important insights. Given these information networks, state policymakers stand a chance of extracting sensible lessons from 1115 demonstrations in other states and many probably do so.

The policy diffusion literature supports the view that states at times operate as policy laboratories. Volden (2006), for instance, has shown that in the case of SCHIP, states have emulated the successful practices of other states (i.e., practices that lower the proportion of low-income, uninsured children). He notes “policymakers tend to adopt policies found in states with similar partisan and ideological leanings, those with similar demographics, and those facing similar budgetary situations” (p. 295). 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 by approximately nine-fold during the 1990s with coverage reaching approximately 55 percent of all Medicaid beneficiaries by the end of the decade. As of 2000, nearly all states offered some form of managed care to some group of enrollees. States appear to have been “highly discriminating” in learning from the managed care initiatives of other states as their efforts evolved throughout the decade (Hurley and Zuckerman 2003). 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 to parents and childless adults. However, this primarily reflected a response to signals emanating from CMS rather than cues and information from other states.

Ultimately, diffusion models underestimate learning because they tend to ignore policy dogs that do not bark. When a state fails to enact some change adopted by other jurisdictions, it need not reflect ignorance of practices in other states, an inability to distill the right lessons, and an unwillingness to pursue change. It may constitute rich policy learning whereby state officials have concluded that the innovation will not work in their jurisdictions. In the case of the managed care waivers, for instance, states learned to be leery of approaches that ran against the grain of local provider sentiment and practice (Hurley and Zuckerman 2003).

National Policy Lens

States can serve as laboratories for national policy in two major ways. Federal policymakers may use insights from state initiatives to design and shape *federally run programs*. During the New Deal, for instance, President Franklin Roosevelt's advisors 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 would expect national policymakers to scrutinize the implications of state practices for Medicare, the Veterans Administration medical system, and other federally run programs. States may also serve as laboratories shaping *federal policy toward the states*. In this regard, national policymakers could mandate that all states adopt certain practices that appeared to work well in state demonstrations. Alternatively, 1115 waiver activity could fuel devolution as congress and the executive branch gain more confidence in the states and modify Medicaid law to afford them more options.

On the whole, the experience under Clinton and Bush provides modest support for the view that federal policymakers have successfully translated lessons from the 1115 waivers into law. To be sure, certain long-term care demonstrations from the Clinton

years encouraged congress to insert provisions in the Deficit Reduction Act of 2005 to foster movement of enrollees out of nursing homes into a home or community-based setting (“money follows the person”) and to give beneficiaries more control over the services they received (“self-directed cash and counseling”). So too, the major managed care demonstrations facilitated statutory change. 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 such states as California and Florida. The experience with the 1115 demonstrations under Clinton provided evidence that managed care could work reasonably well. This pattern increased the comfort of national policymakers with this approach and undercut the arguments of opponents thereby creating a climate for policy change. The Balanced Budget Act of 1997 ostensibly opened the door for more managed care in both Medicaid and Medicare. States appeared to win discretion to adopt managed care through the regular plan amendment process rather than the 1115 demonstrations. But the Balanced Budget Act also shows 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 and many continued to rely on their 1115 waivers. Nor did managed care make much headway in Medicare, which overwhelmingly remained a fee-for-service program.

Beyond the long-term care and managed care examples, there is not much evidence of specific changes in federal law linked to learning from the 1115 demonstrations. To be sure, waivers approved under President Bush presaged certain statutory changes. The pharmacy plus demonstration waivers preceded the adoption of the new Medicare drug program. So too, the waivers of the early 2000s permitting greater

enrollee cost sharing and more restricted service packages anticipated certain provisions of the Deficit Reduction Act of 2005. This new law gave states greater latitude to adopt these modifications through the state plan amendment process. But the dynamics underlying these policy developments hardly reflect bottom-up learning by federal lawmakers based on the experience of 1115 waiver states. As noted earlier, CMS political appointees under Bush have not placed 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. Ultimately, the Bush approach emphasized centrally driven enticement. Leaders in the executive branch had clear views from the start on what ought to be done. Until they could get their objectives written into law, they used the 1115 process to persuade states to adopt these policy changes. The experience states gained with the initiatives might in turn prompt them to be more supportive of the administration's efforts to etch these practices into law.

While the available evidence provides limited support for the proposition that 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 waivers (and for that matter their 1915 counterparts) has shown national policymakers that many states have the capacity and commitment to shape their Medicaid programs in creative ways. This has fueled the propensity of congress and the executive branch to devolve greater authority to the states. But on the whole devolutionary steps have been modest and often accompanied by new federal mandates. The Balanced Budget Act of 1997 freed states much less than its proponents originally thought it would. In addition to giving states new options, the Deficit Reduction Act mandates eligibility requirements related to citizenship documentation and look-back periods for

asset divestiture. It remains to be seen whether this law will obviate the need for states to seek waivers to design the programs they prefer.

Waivers And Democratic Governance At The National Level

Executive federalism via waivers not only has implications for the substance of health policy and learning, 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 a formal decision on the waiver? Second, do waiver processes vitiate the rule of law and appropriate checks and balance by relegating the courts and legislative bodies to the policy sidelines? This section addresses these questions in the context of the national government. Our focus in no way ignores the need to consider processes at the state level as well. Indeed, we currently have research in progress to that end.

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 rulemaking 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 targeting the national government and the other the states. In 1994, HCFA announced its intention 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. HCFA promised to take no action on an 1115 proposal for at least 30 days to allow time for comment.

The agency also evinced concern about transparency and public input at the state level. HCFA 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 15 days of 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 request, provide formal notice and opportunity for comment via the state's administrative procedures act, or publish a waiver notice in the newspapers. HCFA went on to provide a specific 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 100,000 people. If the state had no city of this size, it could meet the requirement by publishing a notice in the newspaper with the largest circulation in the state.

HCFA'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 provide the arena for public notice and comment. While the second Bush Administration did not gainsay 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 the processes they used for obtaining 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 1993 through March 2006 remains an open question. A review of waiver proposals and anecdotal information suggests that most states met the requirements set forth in 1994 federal guidelines. In 2002, however, the General Accounting Office 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 page 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 line 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. 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 persistently prodded the bureaucracy to make it easier for states to obtain waivers. These propensities initially surfaced when Reagan and first Bush Administration put the brakes on 1115 authorizations in the 1980s. Faced with a disinterested executive branch, demonstration projects became an exercise in congressional federalism as congress increasingly wrote demonstration authority into law. Over half of the demonstration waivers in the last half of the 1980s emanated from congressional mandates rather than the executive branch (Andersen 1994; Dobson et al. 1992). In authorizing waivers, congress usually 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, it earmarked the demonstration for that state. On occasion, congress intervened in renewal decisions. For instance, it overturned a decision by HCFA staff in the late 1980s not to renew the On Lok demonstration, which had provided innovative long-term care services.

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 1996, 1996a, 1996b; U.S. Senate Committee on Finance 1995, 1997). A senate hearing in March 1995 focused exclusively on the subject. Congress also asked the General Accounting Office (1995,

1995a) 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 from such states as Florida, Illinois, and New York to testify about HCFA delays in approving waiver requests. 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 proposal. “The bureaucrats ask questions. We rush to respond. And then we wait and wait. The bureaucrats then ask more questions.” Edgar concluded that HCFA would rather “fiddle and quibble” than act promptly (U.S. House Committee on Commerce 1996, pp. 23-24). In taking federal administrators 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 HCFA over a waiver request. At times, 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. But this did not bring 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 pro-waiver statutory measures. A provision approved in 1997 put pressure on HCFA to act in a timely fashion by mandating 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 come up for renewal (Smith 2002).

The second *moderately resistant phase* of congressional oversight and statutory intervention commenced with the presidency of George W. Bush. This period provides an interesting test case for executive federalism. Starting in 2003, the Republicans controlled all three branches of government for the first time in over 70 years. 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 generally demonstrated an unusual degree of party discipline in furthering much of the president's agenda. Given these circumstances and congress' 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 concerning waiver practices. But the Senate Finance Committee in particular requested several reports from GAO (2002, 2004, 2004a) on the bureaucracy's waiver practices. Furthermore, in at least two cases congress stood its ground and at least belatedly prevailed when the executive branch proved indifferent to its concerns.

The first episode involved Bush Administration 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. CMS, however, continued to endorse waivers that used SCHIP funds to cover childless adults (U.S. General Accounting Office 2004a). In the face of executive branch recalcitrance, congress inserted a provision in the Deficit Reduction Act of 2005 that prohibited CMS from granting any new 1115 waivers that reallocated SCHIP funds in this way.

The Deficit Reduction Act 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 inserted specific 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 Katrina victims.

OVERVIEW: CORE PROPOSITIONS

What general conclusions emerge from this investigation of Medicaid demonstration waivers from the perspective of health policy and democratic governance? Five propositions emerge.

1. Medicaid 1115 waivers may well have fostered a better balance among access, quality, and cost in the delivery of services to the disadvantaged, but they are unlikely to yield a major solution to the problem of the uninsured. While considerable uncertainty shrouds the precise implications of the 1115 waivers for health care services to low-income people, a strong case exists that many of the demonstrations made a positive contribution. By helping to fuel the diffusion of Medicaid managed care, the waivers

probably facilitated the more cost-effective delivery of services to enrollees compared to leaving them in traditional fee-for-service systems. So, too, many waiver states used the 1115 process to expand eligibility to new groups without slashing services to those already enrolled in the program. Even when CMS invited states to subsidize enrollment expansions by thinning coverage, most waiver states refrained. While states that pursued 1115 coverage expansions under Bush frequently fell short of their enrollment targets, they increased the number of insured significantly (Coughlin et al. 2006). Moreover, some waivers served as launching pads for particularly bold and innovative approaches to extending coverage. Some of these, such as initiatives in Oregon and Tennessee, could not over time resist the retrenchment brought on by economic downturns, changes in political leadership, the potency of the anti-tax movement, and related factors (Hurley 2006; Oberlander 2006). But other innovative states, such as Minnesota, have continued to use their 1115 waivers as a major tool to reduce the ranks of the uninsured. Among states, Minnesota had the lowest rate of uninsured in 2004 at just under nine percent (U.S. Census Bureau 2005).

While in these and other ways 1115 waivers emerge as an implementation success story, they stand little chance of galvanizing universal coverage. However loosely interpreted, the dictum that Medicaid waivers be “budget neutral” to the federal government virtually assures this outcome. To the degree that 1115 waivers can propel states toward insurance for all, it will probably be in a catalytic capacity linked to negotiations over waiver terms. For instance, tough-minded CMS bargaining with Massachusetts officials concerning the renewal of that state’s 1115 waiver prompted state policymakers to adopt a plan that went well beyond the waiver to require all of its

residents to obtain health insurance. The extent to which the Massachusetts plan will in fact cut the percentage of uninsured to nominal levels remains to be seen.

2. Medicaid 1115 waivers have helped preserve the status of that program as an entitlement by providing an outlet for pressures from the states for greater flexibility. The waivers have helped stem the erosion of the American welfare state. Hacker (2004) has argued that over the past three decades and in the absence of large-scale legislative reform, “subterranean” processes have significantly eroded social benefits in the United States and led to the privatization of risk. Ostensibly, waivers represent just the kind of “hidden” administrative tool that might function in this way. But while Hacker persuasively documents his case in several policy areas, 1115 waivers point in the opposite direction. They suggest that implementation measures not broadly understood by the general public at times inoculate social programs from more serious attack.

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 very 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 the federal government to pay more of the costs. In 1995, the tenacious leadership of 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 nationally renowned governors to endorse a block grant (Smith 2002).

But changing circumstances after that year sapped gubernatorial support for such action. Through the Medicaid waiver process, governors could increasingly have their cake and eat it too; they gained impressive new power to shape the program without having to forego the national government's open-ended funding commitment. Hence, George W. Bush could muster little support for his proposal to covert Medicaid to a block grant even though most governors came from his party and the Republicans controlled both houses of congress. Paradoxically, the triumph of the Bush administrative presidency in facilitating 1115 waivers undermined its prospects for broader legislative change.

3. Medicaid 1115 waivers provide modest support for the model of states as policy laboratories. While some policy learning occurs, it often does not comport to imagery of the laboratory model. To a degree the Medicaid 1115 waivers support the proposition that states function as valuable policy laboratories. States drew some pertinent lessons from the practices of other states especially in the case of managed care. In the most general sense, the waivers encouraged the national government to trust states and devolve more options to them. But viewed through other lenses, the states did not operate very well as laboratories. 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 to learn many specific policy lessons from state waivers.

When learning did occur, much of it departed sharply from the states-as-policy-laboratories model. For instance, officials in many waiver states at times learned a great deal from implementing and assessing waivers in their particular jurisdictions. The lessons they distilled led to revisions in their programs as they applied for renewals. But

valuable as such “stove-pipe” learning can be, it does not feature the kinds of horizontal knowledge transfers to other states embedded in the laboratory model. So too, some of the federal initiatives, especially under Bush, viewed the national government as teacher of the states rather than the reverse. The Bush Administration had strong views on how to improve Medicaid (thinning insurance, offering more choice, privatization, relying on employer insurance, and more). It invited states to submit waivers targeted toward these ends less because it thought it could learn from the demonstrations than because it wanted the states to adopt the administration’s approach. “Try it, you’ll like it” might well have been the motto.

4. The processes leading to approval of 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 these processes. Medicaid waivers place the executive branch at center stage in the decision-making process. Top officials, especially under the second Bush Administration, at times pushed statutory interpretation to the limit in approving waivers. But the exercise of formal waiver authority 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. Nor has congress failed to push back via statutory action when the executive branch has aggressively interpreted its prerogatives.

5. 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 democratic standards. 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. Unlike the practice in other

major administrative arenas, the federal bureaucracy no longer publishes an advance notice of waiver activity in the *Federal Register*. The national bureaucracy has established guidelines requiring states to go through some process of informing the public about waivers, but it does not assure that they comply.

While the 1115 process suffers from 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 a higher level of transparency than that associated with the approval of countless 1915 programmatic waivers. More incremental and targeted, the 1915 waivers seldom attract much public notice or attention. Unlike the 1115 initiatives, they face no requirement to serve as demonstrations. While the 1115 waivers have often failed to demonstrate much of anything, their formal status as tools for policy learning triggers the transmission of more information to stakeholders than tends to be the case with programmatic waivers. Second, routine administrative venues for approving modifications in state Medicaid programs appear to be less transparent than the 1115 process. 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. The federal bureaucracy provides less notice of pending action on these amendments than it does on 1115 waivers. Nor does it monitor state amendment processes to encourage openness and opportunities for public comment. 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) suggests and frames an important research agenda related to public policy and democratic process. Waivers in particular deserve more scholarly attention. While we have made headway in understanding Medicaid 1115 waivers, important issues remain to be addressed. Above all, the nature of state decision processes affecting the design, submission, approval, and evolution of waivers deserves attention.

Whether viewed through the lens of performance or democratic process, we fully anticipate that findings on the role of waivers and executive federalism will vary appreciably from one policy arena to the next. In fact, we expect this to be the case within Medicaid itself. In the aggregate the 1915 program waivers have also done much to transform the Medicaid landscape. Work by Weissert and Weissert (2006) suggests that these waivers may be more exclusively an executive branch affair at the national and state levels. They probably feature lower levels of transparency and invite much less legislative attention than their 1115 counterparts. A more in-depth comparison of programmatic waivers with the 1115 initiatives would also cast light on an issue that has so far received minimal attention in discussions of executive federalism – the degree to which waivers point to the potency of elected executives as opposed to bureaucratic autonomy. The 1115 waivers fit a model that emphasizes the ability of presidents and governors to achieve important policy ends through the administrative process. We suspect that the 1915 waivers will to a greater degree be a story of bureaucratic autonomy

where collaborating professionals at the federal and state levels in consultation with advocacy groups drive the waiver process.

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