Medicaid and SCHIP Section 1115 Research and Demonstration Waivers

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Summary

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to waive certain statutory requirements for states to conduct research and demonstration projects that further the goals of Titles XIX (Medicaid) and/or XXI (the State Children's Health Insurance Program; SCHIP). States use the Section 1115 waiver authority to cover non-Medicaid and SCHIP services, limit benefit packages, cap program enrollment, among other purposes.

As of July 1 2008, there were 94 operational Medicaid and SCHIP Section 1115 waiver programs in 43 states and the District of Columbia. In FY2006 (the most recent data available), Section 1115 waiver federal expenditures (for Medicaid and SCHIP) totaled approximately $42.4 billion. Section 1115 waiver programs represented approximately 24% of all federal Medicaid spending in the 50 states and the District of Columbia for FY2006 (19% for SCHIP), and provided coverage to approximately 11.5 million enrollees—2.5 million of whom were eligible only for a targeted benefit package such as family planning or pharmacy benefits. FY2006 waiver expenditure and enrollment estimates from the Centers for Medicare and Medicaid Services (CMS) based on state-reported data, and are subject to change. Between FY2001 (the earliest year for which CRS has access to Section 1115 expenditure estimates) and FY2005, federal Medicaid waiver expenditures as a percentage of total Medicaid spending were steady at approximately12-14%. In FY2006, there was a substantial increase in federal waiver spending as a percentage of total Medicaid spending (i.e., almost 60% increase over the FY2005 totals). While there are several plausible explanations for this increase (e.g., ramp up of new and renegotiated waivers, prior period adjustments, etc.) because waiver financing arrangements are negotiated over a 5-year budget window it is hard to determine if the jump in federal expenditures represents a step increase in overall federal waiver spending, or a one-time increase that will be mitigated over the budget authority window. Analysis of future waiver expenditure trends will help to clarify this question. Estimates do not include state experience under the 5 month temporary Katrina waivers (described below).This report provides background information on the waiver authority, and will be updated when new data are available.

Contents

Background 1
Section 1115 Waiver Authority.. 1
Program Types... 3

Contacts

Author Information... 5

Background

Medicaid, authorized under Title XIX of the Social Security Act, is a federal-state program providing medical assistance for low-income individuals who are aged, blind, disabled, members of families with dependent children, or who have one of a few specified medical conditions. The Balanced Budget Act of 1997 established SCHIP under a new Title XXI of the Social Security Act. SCHIP builds on Medicaid by providing health insurance to uninsured children in families with income above applicable Medicaid income standards.

Section 1115 Waiver Authority

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to conduct research and demonstration projects under several programs authorized by the Social Security Act including Medicaid and SCHIP. Section 1115 also authorizes the Secretary to waive certain statutory requirements for conducting these projects without congressional approval. For this reason, the research and demonstration projects are often referred to as Section 1115 "waiver" projects. Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902 (including but not limited to what is known as, freedom of choice of provider, comparability of services, and state-wide access).[1] The Secretary may also use the Section 1115 waiver authority to provide Federal financial participation (FFP) for costs that are not otherwise matchable under Section 1903 of the Social Security Act. For SCHIP, no specific sections or requirements are cited as "waiveable." Section 2107(e)(2)(A) of the Social Security Act states that Section 1115 of the act, pertaining to research and demonstration waivers, applies to SCHIP. States must submit proposals outlining terms and conditions for proposed waivers to CMS for approval before implementing these programs.

In recent years, there has been increased interest among states and the federal government in the Section 1115 waiver authority as a means to restructure coverage, control costs, and increase state flexibility. Under current law, states may obtain waivers that allow them to provide services to individuals not traditionally eligible for Medicaid (or SCHIP), cover non-Medicaid (or SCHIP) services, limit benefit packages for certain groups, among other purposes. Whether large or small reforms, Section 1115 waiver programs have resulted in significant changes for Medicaid and SCHIP recipients nationwide, and may serve as a precedent for federal and state officials who wish to make statutory changes to these healthcare safety net programs.

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations on how a state may operate a waiver program. For example, one provision restricts states from establishing waivers that fail to provide all mandatory services to the mandatory poverty-related groups of pregnant women and children; another provision specifies restrictions on cost-sharing under waivers. Other features of the Section 1115 waiver authority include:

- *Federal Reimbursement for Section 1115 Demonstrations*. Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or SCHIP) state plan

[1] Freedom of choice refers to a requirement that Medicaid beneficiaries have the freedom to choose a provider. Comparability refers to a requirement that services be comparable in amount, duration, and scope for persons in particular eligibility groups. A waiver of the statewideness requirement allows states to provide services in only a portion of the state, rather than in all geographic jurisdictions.

for purposes of federal reimbursement. Project costs associated with waiver programs are subject to that state's FMAP (or enhanced-FMAP)[2].

- *Financing and Budget Neutrality*. Unlike regular Medicaid, CMS waiver guidance specifies that waiver costs are *budget neutral* to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program under current law program requirements.[3] For example, costs associated with an expanded population (e.g., those not otherwise eligible under Medicaid), must be offset by reductions elsewhere within the Medicaid program. Several methods are used by states to generate cost savings for the waiver component: (1) limiting benefit packages for certain eligibility groups; (2) providing targeted services to certain individuals so as to divert them from full Medicaid coverage; and (3) using enrollment caps and cost-sharing to reduce the amounts states must pay.
- *Financing and Allotment Neutrality*. Under the SCHIP program, a different budget neutrality standard applies. States must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program *and* for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment (i.e., original allotments and funds made available through the redistribution of unspent SCHIP funds). This policy limits federal spending to the capped allotment levels.
- *Application and Approval Process.* There is no standardized process to apply for a Section 1115 demonstration, but CMS has issued program guidance that impacts the approval process. States often work collaboratively with CMS to develop their proposals. Project proposals are subject to approval by CMS, the Office of Management and Budget (OMB), and the Department of Health and Human Services (DHHS), and may be subject to additional requirements such as site visits before the program may be implemented under the agreed upon terms and conditions.
- *Duration.* Waiver projects are generally approved for a five-year period, however, states may seek up to a three-year extension for their existing waiver program under the same special terms and conditions (STC), and an additional extension(s) under revised STC for the continuation of a waiver project operating under an initial three-year extension.[4]
- *Relationship of Medicaid/SCHIP Demonstration Waivers to Other Statutes*. Section 1115 waiver projects may interact with other program rules outside of the Social Security Act; for example, employer-sponsored health insurance as described by the Employee Retirement Income Security Act (ERISA), or alien

[2] Section 1903 describes the conditions under which federal financial participation is available. Section 1115(a)(2) stipulates that expenditures under a waiver are eligible for matching under Section 1903. The same federal reimbursement rules apply to SCHIP waiver projects. As with SCHIP state plan expenditures, SCHIP Section 1115 waiver programs are reimbursed at an enhanced federal matching rate.

[3] An exception was made by the Secretary for the Katrina waivers (i.e., all tests of budget *and* allotment neutrality were waived).

[4] The approval process associated with each type of extension is defined in statute at Section 1115(e) and at Section 1115(f) respectively.

eligibility as contained in immigration law. In cases like these, the Secretary does not have the authority to waive provisions in these other statutes.[5]

- *Program Guidance.* The Secretary can develop policies that influence the content of demonstration projects and prescribe approval criteria in three ways: (1) by promulgating program rules and regulations;[6] (2) through the publication of program guidance (e.g., waivers must be budget neutral);[7] and (3) waiver policy may also be implicitly shaped by the programs that have been approved (e.g., CMS approval of benefit specific waivers). Legislative action may be required if Congress chooses to further shape the Secretary's authority over the content of the demonstration programs, dictate specific Section 1115 waiver approval criteria, or otherwise limit the Secretary's waiver authority.

Program Types

As of July 1 2008, there were 94 operational Medicaid and SCHIP Section 1115 waivers in 43 states and the District of Columbia. In FY2006 (the most recent data available), Section 1115 waiver federal expenditures (for Medicaid and SCHIP) totaled approximately $42.4 billion. Section 1115 waiver programs represented approximately 24% of all federal Medicaid spending in the 50 states and the District of Columbia for FY2006 (19% for SCHIP), and provided coverage to approximately 11.5 million enrollees.[8] Of the 11.5 million total Medicaid and SCHIP waiver enrollees, 2.5 million were only eligible for a targeted benefit package such as family planning benefits. There are several types of operational waiver programs including:

- *Comprehensive demonstrations.* These demonstrations provide a broad range of services that are generally offered statewide. Many of the comprehensive waivers operate under combined title XIX and title XXI authority and are financed with federal Medicaid and SCHIP matching funds. Several also include a family planning and/or Health Insurance Flexibility and Accountability (HIFA) component (see below). In FY2008, there were 32 operational comprehensive state reform waivers in 26 states.[9] FY2006 state-reported enrollment estimates for these waivers totaled approximately 8.1 million,[10] at a federal cost of approximately $38.4 billion. The SCHIP-financed portion of these waivers

[5] For example, states may not provide benefits to qualified aliens as a part of a Section 1115 eligibility expansion without adhering to the five-year ban on alien access to federal assistance as required by the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193).

[6] Program rules and regulations that meet specified rulemaking criteria are legally binding. To date, CMS has *not* shaped Section 1115 waiver-related policy through program rules and regulations.

[7] Unlike program rules and regulations, program guidance is not legally binding. Rather, program guidance provides a framework for the process by which states may obtain approvals and the principles under which states may operate their programs. Program guidance contains authoritative interpretation and clarification of statutory and regulatory requirements. To date the Secretary has only used guidance to shape Section 1115 waiver policy.

[8] Estimates do not include state experience under the 5 month temporary Katrina waivers (described below).

[9] States include Alabama, Arizona, Arkansas (two programs), California (two programs), Delaware, Florida (two programs), Hawaii, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Montana, New York (two programs), Oklahoma, Oregon, Rhode Island (two programs), Tennessee, Texas, Utah, Vermont (two programs), Washington, and Wisconsin.

[10] In states where multiple demonstration populations are covered under a comprehensive waiver (e.g., the project includes a family planning component, a pharmacy-only component, an SCHIP and/or a HIFA component, etc.), enrollee counts reported include enrollees for whom the state reports expenditures associated with this population under the comprehensive demonstration waiver project number.

extended coverage to approximately 475,376 enrollees at a federal cost of $330 million. FY2006 enrollee estimates for the limited benefits offered under a FP component totaled approximately 104,990.

- *Family planning demonstrations (FP)*. In FY2008, there were 22 states with stand-alone FP waivers to provide a limited benefit package including family planning services and supplies for certain individuals of childbearing age.[11] FY2006 enrollment estimates for stand-alone FP waivers totaled 2.4 million at a federal cost of approximately $1.4 billion. Just over 1,000 of FY2006 enrollees were SCHIP-eligible with care financed out of the SCHIP allotments.
- *SCHIP and HIFA Waivers*. Of the 20 states with SCHIP waivers in FY2008, 14 have SCHIP waivers that were granted under the HIFA initiative.[12] HIFA demonstrations are designed to encourage states to extend Medicaid and SCHIP to the uninsured, with an emphasis on approaches that maximize private health insurance coverage and target populations with incomes below 200% of the federal poverty level (FPL). Under HIFA, states were encouraged to finance program expansions using unspent SCHIP funds to, for example, extend coverage to one or more categories of adults with children (typically parents of Medicaid/SCHIP children, caretaker relatives, or legal guardians), and/or pregnant women. Four states (i.e., Arizona, Michigan, New Mexico, and Oregon) have approval to cover childless adults under their HIFA waivers. The Deficit Reduction Act of 2005 prohibits new waivers that would use SCHIP funds to provide coverage to nonpregnant, childless adults. Recently the Administration has not renewed existing waivers that permitted coverage of adults through SCHIP.[13] In addition to expanding coverage to new populations under SCHIP, some states use the SCHIP Section 1115 authority for other purposes including modifying cost-sharing rules (e.g., New Mexico), and requiring periods of no insurance prior to SCHIP enrollment (e.g., Alaska and New Mexico). As of FY2006, approximately 925,196 enrollees accessed services under SCHIP and HIFA demonstrations at a federal cost of $675 million.
- *Specialty services and population demonstrations*. These demonstrations generally include programs that provide cash to enrollees so that they may directly arrange and purchase services that best meet their needs. In addition, they include waivers to provide pharmacy benefits to persons with specific conditions, such as HIV/AIDS. As of FY2008, there were 20 such operational

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[11] States with stand-alone FP demonstrations in FY2008 included Alabama, Arkansas, Colorado, Florida, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin. In addition, there are six states that operated family planning programs as a part of their comprehensive demonstration projects (i.e., Arizona, Delaware, Maryland, Missouri, New York, and Rhode Island). Enrollment counts and expenditure estimates associated with these six programs are included under the totals for the states' comprehensive demonstration projects.

[12] States include Alaska, Arizona (HIFA), Arkansas (HIFA), California (HIFA), Colorado (HIFA), Hawaii, Idaho (HIFA), Illinois (HIFA), Michigan (HIFA), Minnesota (HIFA), Missouri, Nevada (HIFA), New Jersey (HIFA), New Mexico (2 programs one is a HIFA waiver), Oregon (HIFA), Rhode Island, Texas, Utah (HIFA), Virginia (HIFA), and Wisconsin. Delaware, the District of Columbia, Louisiana, and Maine were granted HIFA waivers under Medicaid authority. Enrollment and expenditure data reported here exclude HIFA waiver programs counted as a part of the Comprehensive waiver group, but include HIFA waivers granted under the Medicaid waiver authority.

[13] For more information on SCHIP adult coverage waivers see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

- programs in 15 states and the District of Columbia.[14] In FY2006, these demonstrations covered approximately 37,473 individuals at a federal cost of approximately $441 million. Federal costs for Pharmacy-only demonstrations totaled $1.5 billion in FY2006.
- *Katrina/Multi-state Demonstrations.* In response to the Hurricane Katrina disaster, CMS allowed states to provide temporary eligibility for specified Katrina evacuees so that such individuals could obtain state plan services in a host state (i.e., a state that has been granted an emergency Section 1115 waiver). Between September 2005 and March 2006 CMS approved 32 Katrina waivers that extended coverage to an estimated 118,602 individuals at a federal cost of $1.63 billion.

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[14] States include Alabama, Arkansas (3 waivers), California, Colorado, District of Columbia, Florida, Georgia, Maine, Maryland (2 waivers), Massachusetts, New Jersey, Oregon, Rhode Island, (2 waivers), South Carolina, and Vermont (2 waivers).