Despite an overwhelming focus on national-level health system reform, states remain an important part of the equation. To enable states to innovate, waivers from federal program requirements—especially those of Medicare and Medicaid—often are necessary. In a paper in Health Affairs, Winter 1992, Allen Dobson and colleagues of Lewin-VHI reported on the history and progress of state waivers; this Peer Review revisits this important topic. First, Joe Antos, head of the Health Care Financing Administration (HCFA) Office of Research, clarifies some of the issues from HCFA’s perspective. Next, Governor Howard M. Dean of Vermont describes his state’s experience with waivers. To close the section, Dobson and colleagues offer their comments.

Waivers, Research, And Health System Reform
by Joseph R. Antos

In the Winter 1992 issue of Health Affairs, Allen Dobson, Donald Moran, and Gary Young consider how federal waiver programs were used during the 1980s to support innovation in the Medicare and Medicaid programs and what improvements might be desirable in the management of waivers for broad health system reform in the 1990s. They do not address whether states can, or should, take the lead in health system reform through statewide demonstrations.

Dobson and colleagues find in their review of waiver activity that the early 1980s represented the most active period for demonstrations, with a substantial drop in demonstration sites after 1983. Thereafter program waivers were responsible for a growing share of waiver sites. The authors are concerned that this decline in demonstration activity, and a perceived narrowing of the range of demonstration priorities, could seriously hamper policy making in the 1990s.

This Peer Review provides a broader perspective on the contribution of health services research (including waiver programs) to health policy formulation and offers an alternative interpretation of the past decade of federal support for health policy innovation. Obviously, research and demonstration priorities depend on the pressing health financing issues of the day and the interests of both the administration and Congress. Nonetheless, in my view, federal health services research and demonstration activities have contributed directly to policy formulation of national significance in the past and promise to provide a strong basis for health system reform in the future.

Waivers And Policy Innovation

Demonstration waivers and program waivers represent two different stages in the policy development process. Demonstration waivers permit experimentation with a variety of Medicare and Medicaid program in-
novations. They are intended to provide information about such innovations; they are thus time limited and include evaluation of the experiment as an integral component. Program waivers, in contrast, provide administrative flexibility for states to institute managed care and noninstitutional long-term care services in their Medicaid programs. Since they permit implementation of well-established reforms, program waivers are routinely renewed after they have been granted and do not involve evaluation.

The two kinds of waivers have very different purposes, involve very different approval processes, and cannot be considered equivalent. Moreover, waiver activity alone does not fully encompass either federal policy development activities or federal support for state administrative flexibility. Both demonstration and research activities contribute to new policy development, and both must be considered. Similarly, states are provided with the administrative flexibility to implement Medicaid program changes through two nonlegislative approaches: program waivers and state plan amendments (a nonwaiver mechanism routinely used to implement a wide variety of eligibility, coverage, and reimbursement decisions left to state discretion).

Dobson and colleagues do not distinguish clearly between federal activities that support policy development and those that promote administrative flexibility. It is beyond the scope of this paper to consider the history of federal support for state flexibility in administering Medicaid. However, the proper or acceptable role of the states in this regard is a policy decision, which does not necessarily depend on past trends toward greater or less state autonomy. I focus instead on the pattern of federal support for developing new health policies.

**Federal Support For Innovation**

**Difficulties of measurement.** Dobson and colleagues use counts of waiver sites and their associated expenditures as indicators of federal support for innovation, which can be misleading. This is not the same as the number of waivers, to which the authors frequently refer. A single-site demonstration could involve more than one waiver of program rules. A multiple-site demonstration could involve only one waiver.

The number of demonstration sites is not related to the policy significance of demonstrations or even to the number of policy changes being tested through demonstrations. The amount of benefit dollars flowing through a demonstration can also be a misleading indicator of significance, since it has no necessary relationship to total program costs for the services in question. Broadening the perspective to encompass both research and demonstrations complicates this already complex measurement problem.

The real problem is that there is no one way to measure demonstration activity. The measurement problem grows if one is trying to assess policy significance and political commitment to innovation, rather than to simply quantify activity levels. In my view, the policy significance of a project depends on its potential impact on larger issues of health financing and service delivery. The analysis must go beyond demonstrations to include research, and beyond activity measures to consider policy impact.

The judgment as to how well the federal government has supported health policy innovation, then, is a judgment about the adequacy of federally supported health services research and demonstrations, which are primarily sponsored by two agencies, the Health Care Financing Administration (HCFA) Office of Research and Demonstrations (ORD) and the Agency for Health Care Policy and Research (AHCPR).

**Funding patterns.** Exhibit 1 shows the level of funding for research and demonstrations in HCFA and in AHCPR at various times over the past fourteen years, compared with the level of HCFA-sponsored demonstration funding over the same period. This exhibit separately reports the administrative costs of demonstrations, as appropriated annually, and their associated service costs.

Total research and demonstrations appropriations dropped after 1980, hovering around $50 million during the mid-to-late 1980s. Appropriation levels rose sharply
during 1990-1993, reflecting substantial increases in AHCPR’s funding over that period. HCFA’s research and demonstrations budget reached a plateau of about $36 million in the early 1990s. Funding for demonstrations mirrored this pattern.

While these funding patterns are generally consistent with the demonstration activity levels reported by Dobson and colleagues, Exhibit 1 shows that an exclusive focus on demonstration activities understates the full scope of federally supported health services research. Demonstration activities represent a large portion of HCFA’s research and demonstrations appropriation but only a small part (10-20 percent) of total federal appropriations in this area.

Service dollars. Since demonstrations directly test changes in health service delivery and financing, the appropriated budget associated with research and demonstrations is dwarfed by the service dollars involved. The lower portion of Exhibit 1 illustrates this point for 1990 and 1993.

By this measure, demonstration activities would clearly dominate other health services research activities. However, while all of the demonstration projects in Exhibit 1 are innovative and significant for policy, large demonstrations are not necessarily more important than smaller ones.

For example, the Arizona Health Care Cost Containment System (AHCCCS)-Arizona’s Medicaid—is conducted as a demonstration because of its strong managed care orientation. In 1993 this program accounts for $650,000 from the research and demonstrations budget and $927 million in service dollars (federal share). Although AHCCCS is an innovative project, it is also an operating program, which accounts for its high service costs. Smaller demonstrations, such as the Medicaid pregnant substance abusers demonstration or the cataract surgery negotiated pricing demonstration, have as much policy significance but involve a smaller scope of operation and far lower service costs. Clearly, the degree of innovation in a demonstration is not measured by the cost of services running through it.

This distinction between expenditures and policy significance can be easily overlooked. Dobson, Moran, and Young compare the service costs of the all-payer hospital demonstration in 1980 with the service expenditures of demonstrations in 1992. They take this as an indication of a lowered commitment to innovation over that period. A more plausible interpretation is that the 1983 enactment of the prospective payment system (PPS) for Medicare hospital services reduced the viability of, and may
have obviated the need for, the all-payer demonstration. It is likely that the advent of PPS effectively limited the Medicare demonstrations program to working in areas involving less program expenditure than inpatient hospital services, areas less amenable to projects of very large scale.

The reforms. Exhibit 2 lists major Medicare and Medicaid reforms adopted over the past decade and the research and demonstration projects that contributed to their adoption or implementation. Nearly every major reform of the 1980s is listed, because nearly every major reform has had a strong impact in Research and Demonstrations On Major Health System Reforms, 1978-1992

<table>
<thead>
<tr>
<th>Major reform</th>
<th>Impact in 1992</th>
<th>Research studies</th>
<th>Demonstrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital capital PPS (law passed in 1987, effective 1991)</td>
<td>$6 billion</td>
<td>Capital versus operating cost variation Capital and total cost models Payment adjustment design</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Care Financing Administration.
Note: HMO is health maintenance organization; AAPCC is adjusted average per capita cost; DRG is diagnosis-related group; AHCCCS is Arizona Health Care Cost Containment System, which is Arizona’s Medicaid program.

The 1992 impact is the total expenditure for Medicare services affected by major reforms. Total Medicare benefit costs in 1992 are $130.2 billion.
research/demonstration basis.

Services accounting for over 85 percent of Medicare expenditures and substantial portions of the Medicaid program have been directly affected by the policies listed in Exhibit 2. The program impact of research and demonstrations is even greater than the exhibit implies. It does not list the scores of less significant program changes adopted over the 1980s that were dependent in large part on research studies or demonstrations. Nor does it list projects that have led us away from misguided or ineffectual policies.

The record shows major research and demonstration impacts across Medicare and Medicaid. These impacts are felt throughout the health care system as well. Viewed in this light, federal support for research and demonstrations has had a leveraging effect on the health care system far out of proportion to the actual dollars invested.

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**Improving The Process**

The federal waiver process has been the subject of growing criticism in recent years. The tenor of this criticism is that the demonstration waiver process is too complex and time consuming, requires overly rigorous evaluation standards, and is not easily accessible by states. As partners with the federal government in the management of the Medicaid program, states have felt that the waiver process has limited unduly their right to test and evaluate new health care approaches. States are increasingly interested in revamping existing health care programs while continuing to receive federal matching money, and they recognize that demonstration waivers are the only vehicle to do so—short of legislation granting states broader authority.

**Full disclosure.** The most essential improvement to streamline the waiver process would be to establish fair ground rules and expectations for demonstration proposals. Prospective sponsors of demonstration projects must be able to determine in advance of the waiver approval process what kinds of ideas are welcome and what standards they must meet. The federal government has an obligation to establish acceptable boundaries if it chooses to take an active role in shaping the kinds of demonstrations it will approve, and it should be similarly clear if it chooses a more laissez-faire approach.

This full disclosure of expectations should extend to funding and research design issues as well. The issue of budget neutrality has raised much controversy, and as Dobson, Moran, and Young indicate, requires careful reconsideration and clarification. Similarly, evaluation standards should be established, at least in general terms, to assure that the level of analytic rigor that is expected will be communicated to demonstration sponsors. If the policy and technical expectations can be clearly and publicly established, there is no reason why the approval process itself cannot be streamlined.

**Other improvements.** Other steps to improve the waiver process include increasing technical support in the early development of demonstration proposals, addressing such areas as evaluation design and data collection, and improving the exchange of information arising from demonstrations. To be meaningful, these informational activities must go beyond simple waiver-tracking systems to encompass thoughtful analyses of issues cutting across various demonstrations.

**The ERISA question.** Dobson, Moran, and Young, and others, have suggested an additional, more difficult step to improve the utility of health care reform demonstrations: expanding waiver authorities to the Employee Retirement Income Security Act (ERISA). A number of states, including Florida and Vermont, are considering health care reform projects that may require this expanded authority. Powerful forces are opposed to such expansions, however, and such expanded authorities may not be compatible with the breadth of state health reform demonstrations that would be encouraged by the federal government.

We need not wait for congressional action, however, to improve the waiver process. If we can clarify the policy goals, streamline the process, and make better use of results, we will have accomplished a great deal. These activities can be initiated without legislation, although they would require
some additional funding. These will not be easy actions to take, but they are essential if we are to exploit more fully the opportunities that exist to test and evaluate health policy innovations using demonstrations.

The opinions expressed are those of the author and do not necessarily reflect those of the Health Care Financing Administration.

NOTES


3. Other agencies sponsoring health services research include the Department of Defense, the Department of Veterans Affairs, and the Agency for Health Care Policy and Research.

4. Other potentially controversial proposals include mandatory participation requirements in some demonstrations, strengthening existing Medicare waiver authorities, and providing states protection from federal antitrust prosecution.

New Rules And Roles For States
by Howard M. Dean

The need for fundamental reforms in America’s health care system has reached critical mass. President Clinton’s election provides renewed focus and energy to the debate at the federal level, further reinforced by the emphasis on health care issues in the 1992 congressional elections. The details of the Clinton plan had not been finalized as of this writing, but the basic goals are clear: (1) to implement short-term measures to curb the growth in health care spending; and (2) to create a framework for fundamental, long-term change in the financing and delivery of health care. These reforms will bring about changes in existing programs that states finance and administer, particularly in Medicaid. In addition, the reforms will require significant new administrative and regulatory measures, which will leave states with new responsibilities. Whatever the final design, there will be a new federal/state relationship with regard to governance of the health care system.

The paper by Allen Dobson and colleagues is particularly timely given these developments. Their analysis of the federal waiver process for state innovations under Medicare and Medicaid was spurred in part by the controversy associated with Oregon’s Medicaid waiver request (which was finally granted in March 1993 by the Clinton administration). They also note states’ growing interest in securing the broad waiver authority needed to implement health reform beyond the boundaries of Medicaid. Vermont is one of several states that may need extensive waivers to implement its health reform strategy. Now, the scope of state flexibility under a future national program is a central concern in the deliberations of the Clinton health care task force.

The lessons gained from previous experience with the federal waiver process must be considered if the president’s health reform legislation is to provide workable, sustainable strategies to improve the health care system for all Americans. I focus my comments primarily on the opportunities and challenges in recrafting the federal/state relationship—an essential element in the structure of a reformed health care system.

Impact of waivers on state innovation.
As Dobson and colleagues note, “An important drawback of enforced national-level program uniformity is that it limits experimentation with potential reforms.” The history of the waiver process is characterized by the fundamental tension between promoting and restraining change. States have been limited in trying new approaches based on a

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