

1115 Ways to Waive Medicaid and SCHIP Rules

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OVERVIEW — *This issue brief explores the history and context of the Section 1115 Medicaid waiver authority, discusses the Health Insurance Flexibility and Accountability (HIFA) initiative under way in the Bush administration, and considers some of the potential impacts that HIFA could have on state budgets and access to health care for low-income families. Finally, it considers the future of Section 1115 waivers as a vehicle for modifying Medicaid and the State Children's Health Insurance Program.*

1115 Ways to Waive Medicaid and SCHIP Rules

The use of the term “waiver” in relation to the Medicaid program has been evolving almost since Section 1115 was added to the Social Security Act in 1962.¹ In the early days, waivers were typically research or demonstration pilot projects designed to test a variety of new ideas on a small scale.² Later, waivers tested the effectiveness of managed care service delivery and the potential cost savings that could be achieved by converting state Medicaid programs from the fee-for-service model. In more recent years, the savings resulting from managed care waivers have been used to finance a range of health coverage expansions to new populations. Throughout its existence, the demonstration authority established under Section 1115 has been one of the most sought-after vehicles for enhancing states’ access to federal matching funds.

BACKGROUND

The provision found at Section 1115(a) of the Social Security Act has been used and interpreted in a variety of ways. Allowing for a great deal of secretarial discretion, the relevant parts of the provision read as follows:

- (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI or XIX...in a State or States...
- (1) the Secretary may waive compliance with any of the requirements of section...1902...to the extent and for the period he finds necessary to enable such State or States to carry out such project, and
- (2)(A) costs of such project which would not otherwise be included as expenditures under section 1903...shall be regarded as expenditures under the state plan.³

With respect to the Medicaid program (and now SCHIP), the Section 1115 demonstration authority has undergone many changes over the years. In the 1970s and 1980s, the administration attempted to adhere to the fundamental demonstration nature of the provision, which caused states frustration in designing projects that would test a new concept and not replicate another state’s proposal. In addition, the (nonstatutory) “budget neutrality” requirements established by the Office of Management and Budget during the Carter administration added an additional level of complexity. Budget neutrality requires federal spending to be no higher under the waiver than it would have been without the waiver. Therefore, until 1994, Arizona was the only state to receive approval for a statewide Medicaid demonstration waiver.⁴

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In the 1990s, at the request of the states and through negotiations with the National Governors Association, the Clinton administration publicly indicated its intent to provide more flexibility in designing and financing Section 1115 demonstrations. This new flexibility was in large part a response to states' frustration with federal welfare rules under Aid to Families with Dependent Children (AFDC) and the desire to reform their programs prior to the enactment of national welfare reform. On September 27, 1994, the Department of Health and Human Services (DHHS) published a public notice in the *Federal Register* announcing that the administration would (a) grant waivers with the same or related policy innovations in multiple states, (b) approve demonstration projects ranging in scale from reasonably small to statewide or multistate, and (c) consider joint Medicare-Medicaid demonstrations.⁵ While the guidance did not outline specific policies, it signaled the goal of a more open and consultative review and negotiation process and gave many states the opportunity to replicate the same welfare reform strategy.

The notice also indicated that demonstrations would be approved for a duration of at least five years (in order to "give new policy approaches a fair test")⁶ and clarified that budget neutrality could be calculated over the duration of the demonstration rather than on an annual basis. In addition, the administration signaled a willingness to give states access to a broader variety of funding sources—including redirecting payments for disproportionate share hospitals and experimenting with the cost-saving ability of managed care—to finance Section 1115 demonstrations in Medicaid.

The result was a barrage of proposals from states and 17 comprehensive Medicaid demonstration approvals between 1994 and 1999.⁷ Although the federal government originally indicated that the review process might be completed within 120 days, the time frame did not anticipate the complexity of the negotiations, particularly around budget neutrality. While the department has been widely criticized for taking too long—an average of 10 months—to approve the states' proposals, today there are 8.2 million individuals receiving coverage under a Section 1115 demonstration, accounting for nearly one-fifth of all Medicaid spending.⁸

The Bush administration has continued the philosophy of state flexibility by creating the Health Insurance Flexibility and Accountability (HIFA) initiative, announced by DHHS in August 2001. As DHHS Secretary Tommy Thompson stated, "Our goal is to give governors the flexibility they need to expand insurance coverage to more Americans through innovative approaches, including the kind of health insurance options available in the private sector."⁹ Through, for example, increased flexibility to design benefit packages, the administration has indicated that the HIFA initiative will provide incentives for states to modify Medicaid and SCHIP programs to better fit their budgets and policy goals.

Although it is still unclear how and to what extent HIFA will be utilized by the states, the announcement of the new and expedited waiver

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review process, in a time when Medicaid spending has been increasing by an average of 13 percent, has generated a great deal of discussion about the future of Medicaid and the State Children's Health Insurance Program (SCHIP) and the potential impact on the availability of coverage and access to care for the programs' low-income beneficiaries.

HIFA

The initial DHHS guidance on the HIFA initiative included four major themes to set HIFA waivers apart from the Section 1115 demonstrations of the past.¹⁰ HIFA does the following:

- Specifically targets individuals with incomes below 200 percent of the federal poverty level (FPL). (In 2002, 200 percent of FPL is \$36,200 for a family of four.)
- Requires that states include some form of integration of Medicaid/SCHIP funding with private health insurance funding (for example, through employer-subsidized coverage).
- Maintains existing Medicaid mandatory coverage requirements.
- At the same time, encourages states to find new approaches to increase the number of individuals with health insurance—within current-level Medicaid/SCHIP funding—by providing flexibility to limit benefits and increase cost sharing for beneficiaries.

The announcement of HIFA was in large part a response to the National Governors Association's proposal to restructure the Medicaid program¹¹ and provide greater access to federal matching funds. While HIFA does not include any new funding, the Bush administration has continued the trend toward permitting states to use more of their SCHIP allotments (\$11 billion is projected to be remaining at the end of fiscal year 2002¹²) by expanding coverage to parents or other adults and, in some cases, refinancing existing Medicaid coverage at the higher SCHIP matching rate. At the same time, HIFA can be seen to encourage states to look for ways to trim their programs and enrollment levels without appearing to roll back eligibility.

To date, only two states, Arizona and California, have received approval for actual HIFA waivers (see boxes on this and the following page).

In addition, the Centers for Medicare and Medicaid Services (CMS) has approved three other, non-HIFA Section 1115 demonstrations that reflect the new DHHS approach to waivers. Utah's recently approved demonstration

Arizona – AHCCCS and KidsCare

On December 12, 2001, Arizona was the first state to receive approval under HIFA's streamlined review process. The demonstration will expand coverage to parents with incomes between 100 and 200 percent of the FPL. The demonstration will also refinance, with SCHIP funding, Medicaid coverage of childless adults with incomes below 100 percent of the FPL. To satisfy the private insurance coordination requirement, the state conducted a study to assess the feasibility of implementing an employer-sponsored insurance program; the study was completed in May 2002 and is under review at the Centers for Medicare and Medicaid Services. If implemented, Arizona's demonstration could expand coverage to as many as an estimated 25,000 uninsured parents.

has perhaps been the most “HIFA-like” concept proposed thus far. It provides a coverage expansion to adults with incomes below 150 percent of the FPL but provides this optional population with a very limited set of benefits (primary and preventive care only) and includes a \$50 enrollment fee and other cost sharing for newly eligible individuals. The expansion is financed by reductions in benefits and new cost sharing for some current enrollees in both mandatory and optional coverage groups. The state may also cap enrollment at a later date.¹³ Because the state did not elect to pursue an employer-based coverage component as part of the demonstration and because the demonstration reduces benefits to a mandatory Medicaid population, Utah’s waiver did not qualify as a HIFA demonstration under the DHHS guidelines. (See below for further discussion on the ESI requirement.)

Illinois received approval to provide an estimated 368,000 low-income seniors with prescription drug coverage under Medicaid, and Tennessee received approval to restructure eligibility and benefits for current TennCare enrollees.¹⁴ Several other states, including New Mexico, Washington, and Oregon currently have statewide Section 1115 demonstration proposals under consideration, either through HIFA or through the traditional route, and several more states are in the development stages.

It is not clear from the HIFA guidance that has been released thus far whether coverage expansions will continue to be required. Regardless, it seems clear that states will have the ability to place limitations on their programs, including reduced benefits, higher levels of cost sharing than permitted under the Medicaid and SCHIP statutes, and removal of the Medicaid entitlement through enrollment caps or other means.

Benefits and Cost Sharing

HIFA gives states new authority to modify the benefit package for optional and expansion populations. For optional Medicaid and SCHIP populations, states may choose from the SCHIP benchmark benefit packages outlined in the statute. These choices include a category called “Secretary-approved coverage,” which essentially allows the state to propose any benefit package as long as it includes a list of basic services.¹⁵ For expansion populations, states have even greater flexibility to establish limits on the types of providers and services that are available. The first significant example of the department’s willingness to restrict benefits across the board is Utah’s waiver, which limits benefits for its expansion

California – Healthy Families

In January 2002, California received its long-awaited approval for a waiver to expand coverage to parents of children enrolled in SCHIP. Originated as a SCHIP demonstration proposal, the waiver will enable California to use its SCHIP allotment to expand coverage to parents who have children enrolled in Medi-Cal or Healthy Families and incomes up to 200 percent of the FPL. The state anticipates that 275,000 parents would qualify for health coverage under the demonstration, if it is implemented. California, at the request of CMS, is conducting a feasibility study to determine whether or not to implement an ESI program.

population to routine physician services and pharmacy coverage. The state will not provide coverage for hospital care (other than emergencies), specialty care, mental health care, or substance abuse services. In addition, Utah has also limited benefits for its existing mandatory coverage population.¹⁶

Another significant departure from previous policy is the new flexibility with regard to cost sharing. With the exception of the nominal levels for mandatory Medicaid populations and a 5 percent cap on optional Medicaid and SCHIP children, there are no specific limitations on cost sharing under HIFA. For example, Utah will charge a \$50 annual application fee and \$5 copayments for physician services and prescription drugs. The only limit on the amount of cost sharing for the expansion population is a \$1,000 out-of-pocket maximum per person per year, which amounts to at least 13 percent of an individual's income at the highest income level (150 percent of the FPL).

While providing minimal levels of benefits and charging significant cost sharing is an understandable strategy in difficult financial times, analysts argue that it will not likely have a positive effect on the overall health care system. Many analysts argue that, in order to have a positive influence on the uninsured, coverage must be both available and affordable. For example, several studies have shown that providing a small tax credit to subsidize the purchase of individual coverage will do little to help reduce rates of uninsurance. Individual coverage cannot really be considered to be "available," maintain analysts, if it is too expensive for the average working individual to afford.¹⁷ On the other hand, states argue that there is a value to providing limited coverage to those who would not otherwise be eligible. Providing primary and preventive care is often cited as a means of reducing emergency room visits. The question of whether some coverage to an expansion population is better than no coverage at all will continue to be a point of debate.

Working with the Private Sector

In the August announcement of the HIFA initiative and the subsequent report released in October 2001, DHHS indicated a strong emphasis on working with the private sector as a means of more effective program financing. Widely being discussed as a good strategy to control costs and reach more of the working poor—who often do not have access to health insurance through their employers—is the merging of public and private funding to purchase health coverage. This blending of public and private funds could take many forms. Discussions on Capitol Hill and in the health policy community have centered around the pros and cons of premium assistance for employer-subsidized coverage (ESI) and tax credits for the purchase of insurance coverage in the individual market, but the outcome will most likely be a combination of several approaches and funding sources.

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To date, the DHHS policy has been to require states applying for HIFA waivers to have proposals to “integrate, or at a minimum, coordinate Medicaid and SCHIP funding with private health insurance options.”¹⁸ In order to make it easier for states to pursue ESI, HIFA provides increased flexibility beyond what was codified in the SCHIP final regulations in relation to premium assistance programs. DHHS has removed the SCHIP benchmark benefit standard (which many employer benefit plans do not meet), removed the limits on cost sharing, and scaled back almost completely the cost-effectiveness test established in the statute. However, despite this increased flexibility, states have not strongly pursued premium assistance programs through HIFA so far. This could be due in part to the administrative complexity of setting up premium assistance programs as well as states’ concern about substituting existing private coverage with publicly funded coverage and their general lack of experience in interacting with the private insurance market.

Overall, the decision to require that all HIFA waivers have a private coverage component has created confusion as to which waivers being approved are HIFA waivers and which are “regular” Section 1115 demonstrations. For example, the two states with approved HIFA demonstrations, Arizona and California, did not originally intend to pursue ESI in their demonstrations; however in order to meet the HIFA requirement, the states negotiated short ESI feasibility studies in exchange for an expedited approval process. Utah did not agree to pursue establishing a premium assistance program, so it cannot technically be considered a HIFA demonstration, although the waiver is otherwise consistent with the goals of the HIFA initiative. It is noteworthy that, so far, the only states that are actually testing the viability and effectiveness of merging public and private funding sources as a more efficient means of reaching the uninsured are those seven states whose approved SCHIP plans include a premium assistance component.¹⁹

HIFA and SCHIP: Expanding Coverage or Buying out the Base?

One of the questions observers have raised about the current approach to waivers is the way in which the SCHIP allotments are being used to finance new coverage for populations other than children and to refinance existing Medicaid coverage.

The debate over allowing SCHIP dollars to be used for populations other than children began during the Clinton administration. As it became clear that states were going to have trouble spending all of their SCHIP allotments during the time period prescribed in the statute, the administration began to consider the merits of financing parent coverage expansions with SCHIP funds. The states had long argued that the requirements for the “family coverage waiver” contemplated in the statute were too difficult to meet and that the Section 1115 waiver authority would be a

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more effective (albeit not necessarily quicker) vehicle for expansion to parents. After a great deal of debate, the somewhat controversial decision was made to consider states' proposals to use a portion of their SCHIP allotments to expand coverage to parents of SCHIP children and pregnant women, provided that the state is already "covering children up to age 19 with family incomes up to at least 200 percent of the federal poverty level (FPL), the target income range under the SCHIP law."²⁰

The subsequent question then became whether the federal government should also agree to assist those states that had been penalized by the design of the SCHIP statute because they had expanded children's Medicaid coverage to higher income levels before the enactment of SCHIP. The concept of "buying out the base"—refinancing existing Medicaid coverage with enhanced federal matching funds—has been hotly debated.

One side argues that the SCHIP funds should be reserved only for coverage of children, and states should be encouraged to expand eligibility levels as high as possible in order to maximize coverage and the corresponding enhanced matching funds. Another side argues that there was clearly too much money allotted to the SCHIP program when the law was crafted in 1997,²¹ and a better use of the surplus would be to help out states by supplementing their existing Medicaid matching rates for good deeds such as covering parents, pregnant women, and even childless adults. Many states and analysts have put forth the argument that this approach is consistent with the SCHIP statute in that making parents eligible for health coverage will result in more children enrolled in the program. Still another side agrees that there was clearly too much money allocated to SCHIP but would discourage states from further expanding coverage so that the excess funds will revert back to the treasury to be used for other purposes, such as a tax cut.

Ultimately, the Clinton administration determined that the SCHIP allotments would be best used to finance health coverage—expansions or not—and states were permitted to refinance portions of their existing Medicaid programs with SCHIP dollars.²² Wisconsin and Rhode Island had SCHIP waivers approved at the end of the Clinton administration, and Minnesota's proposal was approved in June 2001.²³ While these three states were not necessarily required to do a major coverage expansion in exchange for the increased access to enhanced matching funds, they were strongly encouraged to pursue additional program improvements, such as removing assets tests and providing 12 months of continuous eligibility, with their state legislatures. The waiver approvals gave this group of states the chance to access more of their SCHIP allotments and finally made up for the design of the SCHIP statute.

The debate has continued with HIFA, as the Bush administration has approved a demonstration in Arizona to refinance coverage of childless adults with SCHIP funds. Critics argue that the theory of covering adults in order to bring more children into SCHIP does not hold for childless

adults, and questions have been raised as to whether providing enhanced matching funds for covering childless adults is beyond the scope of the SCHIP statute.

Public Notice Process

The 1994 guidance also included a section entitled “State Notice Procedures” that laid out a detailed set of options for states to ensure public input into the decision-making process for demonstrations. Public input is generally to be sought prior to submitting a waiver proposal to DHHS for review and can be in many forms, ranging from holding public hearings to debate and enactment of state enabling legislation to a simple notice of the demonstration proposal in newspapers of general circulation that includes instructions on how to receive a copy of the proposal and where to send comments. States are to provide adequate time (30 days) for the public to provide comments and are to keep a record of comments received to be submitted to DHHS for review.²⁴

It has been noted many times over the years that the opportunity for public input often seems to be more a formality than a reality. The *Federal Register* notice does not explicitly require the states to follow a public notice procedure; rather, it uses the phrase, “the Department *expects* states to *ordinarily* [emphasis added] follow one of the processes.” Analysts have raised the concern that this language does not make the notice legally binding on states.

This issue has come up again more recently in response to the HIFA guidance. The guidance indicated that the administration is committed to an expedited review process for waivers that meet the HIFA provisions and included an application template to help states apply for the waivers. While the template includes a section to certify that states have conducted a public notice of the demonstration proposal, observers have noted that there does not appear to be any requirement for consideration of public comments at either the state or the federal level. This is a concern because of the significant changes being proposed and because the expedited and closed nature of the new review process make it difficult to fully understand the potential impact of these demonstrations on low-income families.

FINANCING AND THE FUTURE

Particularly since September 11, the economy has been a major cause for concern across the board. Nearly all states have reported shortfalls in their budgets, a major problem, considering that all but one state is constitutionally required to operate with a balanced budget.²⁵ On June 5, the governors released an updated report that found that states face a budget shortfall of \$40 billion to \$50 billion in state fiscal year 2002 and that they have used \$15 billion in “rainy day funds” and an additional \$15 billion in cuts in an attempt to close the spending gap.²⁶

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However, even in these trying economic times, analysts predict that states will not ultimately make major cuts in their Medicaid and SCHIP programs as a means of balancing their budgets. Rather, they are more likely to use strategies—through the waiver process or otherwise—such as trimming optional benefits, eliminating outreach, reinstating burdensome enrollment procedures, and cutting provider payment rates to make up some of the loss. The availability of federal matching funds provides a strong incentive for states to maintain Medicaid and SCHIP coverage.²⁷

As has been the case over the past 40 years, states and federal governments, researchers, advocates, and consumers continue to question the role of Section 1115 demonstrations in operating Medicaid programs. Many of the elements of states' approved 1115 demonstrations continue to go unchecked under the protection of what now seem to be open-ended demonstration periods. In fact, many states' Section 1115 demonstrations have effectively *become* the states' Medicaid programs. This raises the question as to whether legislative modifications to problematic aspects of the Medicaid and SCHIP statutes are needed to preserve the congressional oversight role. For example, prior to welfare reform, the Clinton administration was criticized for "using Section 1115 not to conduct selected welfare experiments but instead to achieve broad-scale policy changes that are normally regarded as the exclusive purview of the Congress."²⁸

On the other hand, as noted by Sara Rosenbaum in a 1999 discussion of the role of Section 1115 waivers, many of the elements of states' approved 1115 demos were codified in the Balanced Budget Act of 1997, and "the changes were more far-reaching in a number of respects than otherwise might have been the case in the absence of the running start created by the Section 1115 process."²⁹

HIFA has provided states with a "running start" down a new path. The route is yet to be determined, but it will undoubtedly have a lasting impact on the role of public financing of health programs, the relationship between state and federal governments, and the nature of access to health care for low-income Americans.

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ENDNOTES

1. P.L. 87-543, section 122.
2. In the 1980s, small substate demonstrations were approved in Minnesota, California, and New Jersey. See Sara Rosenbaum et al., "Section 1115 Medicaid Waivers: Charting a Path for Medicaid Managed Care Reform," in *Access to Health Care: Promises and Prospects for Low-Income Americans*, Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., 1999, 181; accessed, June 7, 2002, at http://www.gwhealthpolicy.org/medicaid_publications.htm.
3. Social Security Administration, "Demonstration Projects," in *Compilation of the Social Security Laws, Including the Social Security Act, As Amended, and Related Enactments*, vol. I,

January 1, 2001; accessed June 12, 2002, at http://www.ssa.gov/OP_Home/ssact/title11/1115.htm.

4. Arizona's statewide "demonstration," which constitutes the states' entire Medicaid program, was granted in 1982 and has been in operation ever since.

5. U.S. Department of Health and Human Services (DHHS), "Medicaid Program: Demonstration Proposals Pursuant to Section 1115(a) of the Social Security Act; Policies and Procedures," *Federal Register*, 59, no. 186 (Tuesday, September 27, 1994): 49249.

6. DHHS, "Medicaid Program."

7. States with approved demonstrations include Arkansas, California (Los Angeles County), Delaware, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin. See Cindy Mann, "The New Medicaid and CHIP Waiver Initiatives," Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., February 2002, 14; accessed June 10, 2002, at <http://www.kff.org/content/2002/4028>.

8. Theresa Sachs, telephone interview with author, May 29, 2002.

9. U.S. Department of Health and Human Services, "HHS to Give States New Options for Expanding Health Coverage: New Initiative Promotes State Innovations to Expand Access for the Uninsured," press release, August 4, 2001; accessed May 28, 2002, at <http://www.hhs.gov/news/press/2001pres/20010804.html>.

10. For a more detailed description of the elements of HIFA, see Cindy Shirk, "HIFA: Finding the Flexibility," Issue Brief, National Governors Association, Washington, D.C., October 24, 2001; accessed June 10, 2002, at <http://www.nga.org/cda/files/102401HIFA.pdf>. See also Jennifer M. Ryan, "Health Insurance Family Style: Public Approaches to Reaching the Uninsured," National Health Policy Forum Issue Brief 767, Washington, D.C., September 2001; available at [http://www.nhpf.org/pdfs/8-767+\(web\).pdf](http://www.nhpf.org/pdfs/8-767+(web).pdf).

11. National Governors Association, policy position on health reform; accessed June 10, 2002, at http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_1431,00.html.

12. Centers for Medicare and Medicaid Services, "Report on the Health Insurance Flexibility and Accountability (HIFA) Initiative: State Accessibility to Funding for Coverage Expansions," U.S. Department of Health and Human Services, Washington, D.C., October 4, 2001, 2.

13. Mann, "New Medicaid," 30. (There is no fact sheet available for Utah's waiver at this time.)

14. For more information about the specific provisions of these waivers, see Centers for Medicare and Medicaid Services, "Comprehensive State Health Reform Demonstrations," U.S. Department of Health and Human Services; accessed June 10, 2002, at <http://www.hcfa.gov/medicaid/1115>.

15. The basic services must include inpatient and outpatient hospital services, physician surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and age-appropriate immunizations.

16. Mann, "New Medicaid," 30.

17. For more information on this topic, see Stan Dorn and Jack A. Meyer, "What Health Coverage Would Laid-Off Workers Obtain under Recent Tax Credit Proposals?" *Covering America*, Economic and Social Research Institute, Washington, D.C., no. 2, March 2002; Lisa Duchon and Cathy Schoen, "Experience of Working-Age Adults in the Individual Insurance Market," Issue Brief, Commonwealth Fund, Washington, D.C., December 2001; and Leslie Jackson and Sally Trude, "Stand-Alone Health Insurance Tax Credits Aren't Enough," Issue Brief 41, Center for Studying Health Systems Change, Washington, D.C., July 2001.

18. Health Care Financing Administration, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," U.S. Department of Health and Human Services, Washington, D.C., August 4, 2001, 3; accessed June 10, 2002, at <http://www.hcfa.gov/medicaid/hifa>.

19. States with approved SCHIP premium assistance programs are Massachusetts, Wisconsin, Mississippi, Maryland, Virginia, New Jersey, and Wyoming.
20. For further information, see Health Care Financing Administration, SCHIP waiver guidance letter to state health officials, July 31, 2000; accessed June 12, 2002, at <http://www.cms.hhs.gov/schip/ch73100.asp>.
21. Frank Ullman, Brian Bruen and John Holohan, "The State Children's Health Insurance Program: A Look at the Numbers," Urban Institute, Washington, D.C., March 1998, 2.
22. The refinancing was initially limited to populations with incomes over 100 percent of the FPL.
23. New Jersey also received approval for a SCHIP Section 1115 demonstration during the Clinton administration, but the state's proposal did not include a refinancing of existing coverage. New Jersey's demonstration includes an expansion of coverage to parents of SCHIP children and a premium assistance program for employer-sponsored insurance.
24. DHHS, "Medicaid Program," 49250-51.
25. John Holohan, Joshua M. Wiener, and Amy Westpfahl Lutzky, "Health Policy for Low-Income People: States' Responses to New Challenges," *Health Affairs* web exclusive, May 22, 2002, 5; accessed May 23, 2002, at http://www.healthaffairs.org/webexclusives/holohan_web_excl_052202.htm.
26. National Governors Association, "State Fiscal Woes Continue," press release, May 16, 2002; accessed June 10, 2002, at http://www.nga.org/nga/newsRoom/1,1169,C_PRESS_RELEASE^D_3751,00.html.
27. Holohan, Wiener, and Lutzky, "Health Policy."
28. Sara Rosenbaum, Julie Darnell, Patricia Seliger Keenan, and Lois Simon, "Section 1115 Medicaid Waivers: Charting a Path for Medicaid Managed Care Reform," chap. 9, in *Access to Health Care: Promises and Prospects for Low-Income Americans*, Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., 1999, 193; accessed June 7, 2002, at <http://www.kff.org/content/1999/2137>.
29. Rosenbaum et al., "Section 1115."