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Making the Health Insurance Flexibility and Accountability (HIFA) Waiver Work through Collaborative Governance

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I. INTRODUCTION

The Health Insurance Flexibility and Accountability ("HIFA") waiver, introduced in August 2001, has recently drawn criticism from health advocates and government officials. Critics have expressed concern that state HIFA waiver programs may abuse the Medicaid system by using unspent federal State Children's Health Insurance Program ("SCHIP") dollars to reduce overall benefit levels, increase cost-sharing, cover childless adults rather than children, and limit enrollment in public programs. Although these criticisms are noteworthy and merit discussion, this paper aims to put the HIFA waiver into a more positive perspective. Specifically, one could view the HIFA waiver as a vehicle to implement collaborative governance schemes. Collaborative governance approaches to designing health coverage expansion programs under the HIFA waiver may address at least some of the concerns expressed by advocates and the General Accounting Office ("GAO").

It should be noted that this paper does not necessarily support the waiver's specific benefit and cost-sharing standards set by the Department of Health and Human Services ("DHHS"). Nor does it address the specific HIFA waiver programs states have already devised. Rather, this paper focuses on the HIFA waiver's increased programmatic flexibility offered to states and its emphasis on public-private coordination to expanding health coverage. These two HIFA waiver characteristics offer states and other health care stakeholders an opportunity to collaboratively design and implement politically, economically, and socially viable solutions to reduce the number of uninsured. This paper focuses on the need for collaborative solutions, using the HIFA waiver as a vehicle for designing and implementing those solutions.

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Collaborative governance should be an essential component in any HIFA waiver proposal due to a health care system that is moving away from a federal, hierarchical program design and implementation and moving toward a more local, collaborative approach. After providing essential background information about the HIFA waiver in Part II, this paper will introduce the collaborative governance model in Part III. Part IV of this paper will provide several reasons why HIFA waiver proposals compel collaboration among stakeholders. In particular, collaborative governance should be an essential component of HIFA waiver proposals because current stakeholder projects and coalitions show health system reform necessitates collaboration. Collaboration may overcome barriers to health expansion program success, such as stakeholder buy-in, notice, and state access to private health coverage information.

Furthermore, collaboration within the context of the HIFA waiver process may maximize the strengths of current collaborations, such as providing: access to greater and more stable funding sources; access to a facilitator that can collect and distribute data; and an avenue for accountability. Part V of this paper discusses challenges in ensuring collaborative governance success under the HIFA waiver and provides some suggestions for meeting those challenges. Such challenges include: involving health care consumer advocates; designing a program that is local enough to achieve stakeholder support; and convincing government agencies to adopt and support collaborative models in HIFA waiver initiatives. This paper concludes that if states were to adopt a truly collaborative approach when designing and implementing programs under the HIFA waiver, there may be hope in expanding and improving health coverage, since collaboration is the most appropriate mechanism to address the complexity of health system reform.

II. HIFA WAIVER BACKGROUND

The new HIFA waiver, introduced in August 2001, is a type of Medicaid and SCHIP section 1115 waiver.[1] "Section 1115, as applied to Medicaid, essentially allows [DHHS] to provide federal Medicaid matching funds to a state that is providing coverage that does not meet federal minimum standards or that extends beyond available federal options."[2] The HIFA

1. *See also* 42 U.S.C. § 1315(a)(1) (2000) (stating that "the Secretary may waive compliance with any of the requirements of section . . . 1396a of this title . . . to the extent and for the period he finds necessary to enable such State . . . to carry out such project"). Section 1396a of the Social Security Act outlines "State plans for medical assistance," and discusses or references eligibility, service and cost-sharing criteria. 42 U.S.C. §§ 1396a(a)(10)(A) (2000), (a)(14) (2000).

2. CINDY MANN, THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE NEW

waiver emphasizes public-private health insurance integration or coordination and offers states greater flexibility with respect to benefit design and cost-sharing levels.[3] The primary goal of the HIFA waiver is to encourage states to find innovative ways to expand health insurance coverage within current federal spending levels.[4] Although states are free to expand coverage to any income group, the waiver encourages states to focus on individuals with incomes below 200% of the federal poverty level ("FPL").[5] HIFA demonstration projects may cover the following population categories: mandatory (i.e., children under age six and pregnant women up to 133% of the FPL); optional (i.e., such as children covered in Medicaid or SCHIP above the mandatory levels and parents covered under Medicaid); and expansion (i.e., childless and non-disabled adults).[6]

In the same spirit as the SCHIP legislation, the HIFA waiver encourages states to coordinate public insurance coverage with private insurance coverage.[7] In particular, the HIFA waiver requires states to implement premium assistance programs, even if only as a pilot program.[8] Premium assistance programs use public funds to subsidize enrollee purchase of private coverage by enrollees rather than directly enrolling them in

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MEDICAID AND CHIP WAIVER INITIATIVES 11 (2002), http://www.kff.org/content/2002/4028/4028.pdf.

3. CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH CARE FINANCING ADMIN., HEALTH INSURANCE FLEXIBILITY ACCOUNTABILITY DEMONSTRATION INITIATIVE, *at* http://cms.hhs.gov/hifa/default.asp [hereinafter HCFA HIFA Article]. "Section 1115 of the Social Security Act authorizes the executive branch of the Federal government to waive statutory and regulatory provisions of major health and welfare programs under the Social Security Act, including Medicaid and [S]CHIP." JEANNE LAMBREW, THE KAISER COMM'N ON MEDICAID & THE UNINSURED, SECTION 1115 WAIVERS IN MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: AN OVERVIEW 1 (2001), http://www.kff.org/content/2001/4001/4001.pdf#pathways.

4. HCFA HIFA Article, *supra* note 3.

5. *Id.* Currently, 200% of the federal poverty level is equivalent to a family of three earning $2,503.33 per month. WIS. DEP'T OF HEALTH & FAMILY SERVS., FEDERAL POVERTY LEVEL GUIDELINES (FPL) (effective May 2002), *at* http://www.dhfs.state.wi.us/medicaid1/fpl/fpl.htm.

6. CTRS. FOR MEDICARE & MEDICAID SERVS., *Guidelines for States Interested in Applying for a HIFA Demonstration, at* http://cms.hhs.gov/hifa/hifagde.asp [hereinafter HIFA Guidelines].

7. *Id.* SCHIP legislation encourages coordination between public and private health insurance programs. *See, e.g.*, 42 U.S.C. § 1397bb(b)(3)(C) (2000) (stating that states should submit a plan to DHHS describing how the state's proposed SCHIP program will "not substitute for coverage under group health plans"); 42 U.S.C. § 1397bb(c)(2) (2000) (stating that states should submit a plan to DHHS describing how the state will coordinate the SCHIP program with "other public and private health insurance programs").

8. THE KAISER COMM'N ON MEDICAID & THE UNINSURED, THE NEW MEDICAID AND CHIP WAIVERS 22-23 (2002) (on file with author) [hereinafter KFF CHIP Waiver Article].

Medicaid or SCHIP-funded programs.[9] The HIFA waiver's feature of public-private partnership through premium assistance programs supports the notion that expanding health care coverage to the working poor is a complex endeavor, because many of these workers have access to some form of health insurance.[10] Thus, there may be some conflict between the private and public programs. However, health coverage offerings in the low-income workplace are increasingly unaffordable or unavailable altogether, particularly for part-time and other "peripheral" workers.[11] The risk of un-insurance is "spreading up the income ladder and deep into the ranks of those with full-time jobs."[12] Premium assistance programs potentially provide greater continuity of coverage for low to moderate-income workers. Even though the amount of public subsidy provided in premium assistance programs may fluctuate with the amount of private coverage available to low-wage workers, workers could maintain some level of health coverage despite a change in their employment status.[13]

Unlike the previous Medicaid and SCHIP section 1115 waivers, the HIFA waiver promotes premium assistance programs by eliminating specific cost effectiveness tests.[14] However, each state must monitor such programs to ensure costs are not "significantly" higher than costs would be if an enrollee were insured directly through a public program.[15] In addition, DHHS will be more flexible with respect to benefits and cost-sharing in

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9. *Id.* at 22; EDWIN PARK & LEIGHTON KU, CTR. ON BUDGET & POLICY PRIORITIES, ADMINISTRATION MEDICAID AND SCHIP WAIVER POLICY ENCOURAGES STATES TO SCALE BACK BENEFITS SIGNIFICANTLY AND INCREASE COST-SHARING FOR LOW-INCOME BENEFICIARIES 3 (2001).

10. John V. Jacobi, *Symposium: Medicaid Expansion, Crowd Out, and Limits of Incremental Reform,* 45 ST. LOUIS U. L.J. 79, 112 (2001).

11. *Id.* at 112-13.

12. John M. Broder, *Problem of Lost Health Benefits is Reaching Into the Middle Class,* N.Y. TIMES, Nov. 25, 2002, http://www.nytimes.com/2002/11/25/national/25INSU.html.

13. Jacobi, *supra* note 10, at 115.

14. PARK & KU, *supra* note 9, at 9.

15. *Id.* Under the pre-HIFA section 1115 demonstration waivers, if states implement premium assistance programs, they are required to prove enrollment in employer-based coverage is cost effective and that the beneficiaries have the same benefits and cost-sharing protections that they would have in the regular Medicaid program. KFF CHIP Waiver Article, *supra* note 8, at 4 App.. A premium assistance program is determined to be "cost effective" if the cost of the premium assistance is no greater than the cost of covering the enrollee under the regular Medicaid or SCHIP program. PARK & KU, *supra* note 9, at 9. If the private health insurance coverage fails to provide the same benefits provided under the Medicaid program, then the state must pay for wrap-around benefits in the premium assistance program. *Id.* It should be noted, however, that even under HIFA waiver demonstration projects, the entire project (of which the premium assistance program is a part) must meet budget neutrality requirements. HIFA Guidelines, *supra* note 6. That is, over the life of the project, federal funding must not increase over what would have been spent under current program requirements. *Id.*

premium assistance programs, which means states do not have to provide wrap-around coverage as they have in the past.[16]

The HIFA waiver allows states more discretion in establishing benefit and cost-sharing structures for optional and expansion populations, but not for mandatory populations.[17] With mandatory populations, states must continue to follow the cost-sharing and benefit guidelines specified in Title XIX of the Social Security Act.[18] The HIFA waiver lowers the benefit

16. Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, in Madison, Wis. (Feb. 23, 2001) (indicating that cost-effectiveness is measured by comparing the cost of a BadgerCare participant enrolled in a HMO with the cost of wrap-around coverage and extra administrative costs provided in the HIPP program). *See also* KFF CHIP Waiver Article, *supra* note 8, at 23.

17. HIFA Guidelines, *supra* note 6. Although pre-HIFA section 1115 waivers would have allowed states more flexibility in adjusting benefit and cost-sharing structures, a dearth of such proposals is more likely a reflection of the Clinton Administration's emphasis on preservation and enhancement of beneficiary access to quality services, as well as lower rates of health care inflation in the 1990s. *See* LAMBREW, *supra* note 3, at 3 (noting that while the Clinton Administration encouraged state section 1115 demonstration, it rejected proposals that did not promote its' policy objectives of extending medical savings accounts to low-income persons and using beneficiary cost-sharing to replace state spending).

18. HIFA Guidelines, *supra* note 6. Current Medicaid law requires states to provide certain benefits to mandatory populations and limits beneficiary cost-sharing. *Id.* For example, to be eligible for federal funds, states are required to provide Medicaid coverage "for most individuals who receive Federally assisted income maintenance payments, as well as for related groups not receiving cash payments." CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID ELIGIBILITY, *at* http://cms.hhs.gov/medicaid/eligibility/criteria.asp [hereinafter CMS Medicaid brochure]. These mandatory groups include: (a) low income families with children, as described in section 1931 of the Social Security Act (SSA), who meet certain eligibility requirements in the State's AFDC plan in effect on July 16, 1996 (for example, in Wisconsin, a family would fall in this category if their income ranged from $311/month for one individual to $1099/month for eight individuals, or between 45% to 59% of the Federal Poverty Level (FPL); (b) Supplemental Security Income (SSI) recipients; (c) infants born to Medicaid-eligible pregnant women; (d) children under age six and pregnant women whose family income is at or below 133% of the FPL and to children under age nineteen who were born after Sept. 30, 1983 and are in families with incomes at or below the FPL; (e) recipients of adoption and foster care assistance under Title IV-E of the SSA; (f) certain Medicare beneficiaries; and (g) certain individuals transitioning off Medicaid. *Id.;* RACHEL CARABELL & RICHARD MEGNA, LEGISLATIVE FISCAL BUREAU, MEDICAL ASSISTANCE AND BADGERCARE, INFORMATIONAL PAPER #43, 4 (2001); 42 U.S.C. § 1396a(10)(a)(i) (2000). States may also receive federal matching funds for covering other "categorically needy" and "medically needy" groups. CMS Medicaid brochure, *supra* note 18; 42 U.S.C. § 1396a(10)(a)(ii) (2000). The optional categorically needy groups share characteristics of the mandatory groups, "but the eligibility criteria are somewhat more liberally defined." CMS Medicaid brochure, *supra* note 18. The categorically needy group includes: (a) infants up to age one and pregnant women not covered under the mandatory rules with income below 185% FPL; (b) certain aged, blind, or disabled adults with higher incomes than those in mandatory populations but still below the FPL; (c) low-income children under age twenty-one; (d) low-income institutionalized individuals or those who would be institutionalized but receive care under home and community-based waivers; (e) recipients of State supplementary payments; (f) low-income TB-infected persons; and (g) low-income, uninsured women who need treatment for breast and cervical cancer. *Id.* The optional

standards available to optional Medicaid groups, which includes: optional categorically needy and optional medically needy.[19]

Traditionally, Medicaid law has required that the following types of services be provided to optional categorically needy groups:

(a) hospital services;
(b) physician services;
(c) medical and surgical dental services;
(d) nursing and home health services;
(e) family planning services and supplies;
(f) rural clinic services;
(g) laboratory and x-ray services;
(h) pediatric and family nurse practitioner services;
(i) federally-qualified ambulatory services;
(j) nurse-midwife services; and
(k) early and periodic screening diagnosis and treatment ("EPSDT") services for individuals under age twenty-one.[20]

Optional medically needy populations are required to receive only the following services:

(a) prenatal care and delivery for pregnant women;
(b) ambulatory services for those under eighteen or entitled to institutional care;
(c) home health to those entitled to nursing facility care; and
(d) if the state plan includes services in institutions for mental diseases, the state must offer a number of similar services as offered to the categorically needy population.[21]

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medically needy group extends eligibility to "qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups." *Id.* As a result, those who are in the medically needy group can "spend down" to Medicaid eligibility "by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan." *Id.* Benefits for those that qualify for Medicaid under the medically needy category may not be as extensive, though in Wisconsin the benefits provided to the medically and categorically needy populations are essentially the same. CARABELL & MEGNA, *supra*, at 3.

19. "All mandatory and most optional groups are 'categorically eligible.' A different and more limited set of benefits can be provided to the optional 'medically needy' group." KFF CHIP Waiver Article, *supra* note 8, at 8 n.9.

20. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID SERVS., http://cms.hhs.gov/medicaid/mservice.asp [hereinafter CMS Medicaid Service Brochure].

21. *Id.* Specifically, "if the State plan includes services either in institutions for mental diseases or in intermediate care facilities for the mentally retarded (ICF/MRs), it must offer either of the following to each of the medically needy groups: the services contained in 42 C.F.R. sections 440.10 through 440.50 and 440.165 (to the extent that nurse-midwives are authorized to practice under State law or regulations); or the services contained in any seven of the sections in 42 C.F.R. 440.10 through 440.165." *Id.* Sections 440.10 through 440.70 include such services as inpatient and outpatient hospital services, laboratory and x-ray

In contrast, the HIFA waiver only requires states to provide the optional population with basic services, such as hospital and physician services, lab and x-ray services, and well-baby and well-child care.[22] Beyond these basic services, states have the flexibility to design the benefit package to parallel one of the following types of plans:

(a) the benefit package that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State;
(b) the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to Federal employees under 5 U.S.C. section 8903(1);
(c) the plan offered to the state's employees;
(d) a benefit package actuarially equivalent to one of the aforementioned plans; or
(e) a plan approved by the Secretary of DHHS.[23]

For expansion populations, the HIFA waiver will provide states even greater flexibility in designing the benefit package.[24] The primary restrictions on state flexibility with regard to expansion populations are that the state must provide these people a basic primary care package (i.e., health care services usually furnished by a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician) and the additional costs of the expansion must not increase federal expenditures (i.e., be budget neutral).[25]

As for cost-sharing, the HIFA waiver grants states broad authority to impose premiums, enrollment fees, deductibles and co-payments with regard to optional and expansion groups. Cost-sharing for mandatory groups continues to be limited to current Medicaid law.[26] Except for optional children, however, no cost-sharing limits will exist for optional and

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services, nursing facility and home health services, physician and other medical professional services (such as chiropractors). 42 C.F.R. §§ 440.10 -.70 (2002).

22. HCFA HIFA Article, *supra* note 3, at 3.

23. *Id.*

24. *Id.*

25. *Id.*

26. KFF CHIP Waiver Article, *supra* note 8, at 22; HIFA Guidelines, *supra* note 6. Current Medicaid law prohibits states from imposing enrollment fees or premiums on categorically needy individuals for any services and ties such fees to gross income for medically needy populations. 42 C.F.R. § 447.51(a) (2001). Current Medicaid law permits states to charge either nominal deductibles, coinsurance, co-payment or similar charges on categorically and medically needy people, except for services furnished: (a) to children under eighteen; (b) to pregnant women (and the services are related to the pregnancy); (c) to institutionalized individuals; (d) in an emergency; (e) for family planning purposes; and (f) to HMO enrollees. 42 C.F.R. § 447.53(b) (2001). It should be noted that states can apply to CMS to waive the "nominal" cost-sharing requirement for non-emergency services furnished in a hospital emergency room. 42 C.F.R. § 447.54(b) (2001).

expansion groups.[27] For optional children, "total cost-sharing must not exceed five percent of family income."[28] This cost-sharing limit on optional children does not include family premiums; that is, "if a state covered the entire family, the premium to enroll the family would not be counted towards the five percent cap on cost-sharing that would apply to each child in the family."[29] It should be noted that DHHS will use premium collections and other offsets to reduce overall program expenditures before the state can claim federal matching funds.[30] In exchange for following the HIFA waiver guidelines, states are promised an efficient review process of their waiver proposal.[31]

In essence, the HIFA waiver promises states more flexibility than previous section 1115 waivers to ensure the sustainability of the private health insurance system, while creating programs to reduce the number of uninsured.[32] However, this flexibility recently raised concern among government officials, leading to a critical report by the GAO.[33] The GAO report focused on the questions: whether DHHS is acting outside the authority of SCHIP by allowing states to use their unspent SCHIP funds to cover uninsured adults; whether DHHS' authority under section 1115 of the Social Security Act takes precedence over SCHIP's statutory objectives; and whether the public is being adequately informed with regard to waiver

27. KFF CHIP Waiver Article, supra note 8, at 22.

28. *Id.* This five percent cap is similar to the cost-sharing cap for children enrolled in separate child health insurance programs (not Medicaid expansion programs) through SCHIP. *See, e.g.*, 42 C.F.R. § 457.560(a) (2001); 42 C.F.R. § 457.500(c) (2002).

29. KFF CHIP Waiver Article, *supra* note 8, at 22.

30. HCFA HIFA Article, *supra* note 3, at 7.

31. *Id.* at 1

32. *Id.*

33. GENERAL ACCOUNTING OFFICE, REP. NO. GAO–02-817, MEDICAID AND SCHIP DEMONSTRATION WAIVERS 2 (2002) [hereinafter GAO REPORT]. Senators Baucus and Grassley requested the GAO to conduct a study of DHHS' waiver approval process. Letter from Tommy G. Thompson, Secretary, DHHS, to Senator Max Baucus (May 6, 2002), *at* http://www.healthlaw.org/pubs/waivers/thompson.response.pdf. General use of section 1115 waivers has also raised concerns. Because section 1115 waivers avert Congressional approval, the executive branch can advance its policy agenda through these waivers. LAMBREW, *supra* note 3, at 2-3. For example, the Clinton Administration explicitly sought proposals to "preserve and enhance beneficiary access to quality services," but discouraged proposals that would expand the use of medical savings accounts (MSAs) to low-income people, or proposals that would increase beneficiary cost-sharing to replace state spending. *Id.* The Bush Administration, however, is emphasizing public-private health insurance coordination and permitting cost-sharing proposals through the HIFA waiver. KFF CHIP Waiver Article, *supra* note 8, at 18. A former General Accounting Office Comptroller stated that use of section 1115 demonstration to accomplish an administration goal "without consultation and concurrence of the Congress does appear to be inappropriate." Lambrew, *supra* note 3, at 2.

program proposals.[34] Specifically, the GAO argued that covering childless adults is inconsistent with the objectives of SCHIP, which was enacted to expand health coverage to low-income, uninsured children, and was therefore outside its section 1115 authority. It argues that Section 1115 should promote "the objectives of the particular title of the Social Security Act in which the waived program requirements or expenditure limitations appear."[35]

The GAO also noted the inadequacy of public notice and comment in the HIFA waiver proposal process of some of the states.[36] For example, advocates in Utah complained that they had, "little or no opportunity to formally comment on and influence the waiver proposal."[37] Arizona did not release copies of its HIFA waiver proposal to the public until after it was approved by DHHS.[38] Therefore, the GAO recommended that Congress amend SCHIP to specify that its funds should not be used to cover childless adults, clarify which statutory objectives take precedence (those of Title XXI or section 1115 authority), and require DHHS to improve the public notification and input process at the federal level so interested parties can review and comment on waiver proposals before approval.[39]

In response to the GAO's criticisms, DHHS noted that: allowing states to cover uninsured adults under SCHIP meets the broad objectives of SCHIP legislation, which is to cover those previously uninsured;[40] section 1115 provides DHHS considerable legal flexibility and therefore it is within the agency's authority to determine how SCHIP funds should be used;[41] and public notice is adequate because HIFA waiver information is posted on DHHS's website, and DHHS requires states to solicit public input in the

34. GAO REPORT, *supra* note 33, at 5.

35. *Id.* at 17, 31. It should be noted that Senator Chuck Grassley, ranking member of the Committee on Finance, stated that he plans to clarify that SCHIP funds "are meant to insure children, not childless adults." Press Release, Senator Chuck Grassley, Welfare, Medicaid, and SCHIP (Nov. 8, 2002), *at* http://grassley.senate.gov/releases/2002/p02r11-08.htm.

36. GAO REPORT, *supra* note 33, at 27.

37. *Id.*

38. *Id.* at 28.

39. *Id.* at 31.

40. *Id.* at 5.

41. *Id.* at 16. Specifically, DHHS argues that "the language of section 1115 permits approval of demonstration projects based on the overall purposes of all the listed Social Security Act programs (rather than segregating each program)." *Id.* The GAO disagrees with this interpretation of section 1115. *Id.* at 17. Specifically, "HHS's interpretation of section 1115 effectively eliminates the distinctions among the programs authorized under the identified titles of the Social Security Act and would allow the agency to waive requirements or authorize otherwise impermissible expenditures under one program to promote the objectives of any other program." *Id.*

waiver development process.[42] Clearly there is disagreement between GAO and DHHS about whether DHHS is stepping outside its congressional authority in the HIFA waiver approval process. It is beyond the scope of this paper to analyze which interpretation of section 1115 and SCHIP legislation is correct. However, there is agreement among some health policy experts that using Medicaid and SCHIP funding to expand health coverage is a viable way to close the uninsured gap.[43] These experts suggest expanding Medicaid and SCHIP to "cover a broader range of participants."[44] The remainder of this paper will operate under the assumption that DHHS is acting within its congressional authority by permitting states that apply for HIFA waivers to cover childless adults with SCHIP funds.

In addition to criticism by government officials, health care consumer advocates have expressed fear that state programs developed under the HIFA waiver will actually decrease coverage. Specifically, these critics worry that the HIFA waiver's flexibility, coupled with current state budget crises, will result in benefit cuts, higher cost-sharing for optional and expansion groups, or imposition of enrollment caps.[45] Even if states did expand coverage to additional groups, the advocates worry that this coverage could be severely limited.

The HIFA waiver only requires that expansion groups receive basic primary care, sustaining such groups' lack of access to medical specialists and inpatient hospitalization.[46] Furthermore, increased cost-sharing by optional and expansion groups could discourage those groups from accessing medically necessary services. Critics of increased cost-sharing point to research that indicates that cost-sharing "reduces utilization of

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42. *Id.* at 25, 54.

43. Press Release, The National Academies News, Bold Initiatives Aim to Solve Key Health Care Problems; Demonstration Projects Lay Foundation for Systemwide Reform (Nov. 19, 2002), *at* http://www4.nationalacademies.org/news.nsf/isbn/0309087074?OpenDocument [hereinafter National Academies Press Release] (stating that a committee of health policy experts appointed by the Institute of Medicine believe that several states should undertake model projects that would aim to provide universal coverage). Currently, the U.S. has over 41 million people without health insurance. *Id. See also* Robert Pear, *Panel, Citing Health Care Crisis, Presses Bush to Act,* N.Y. TIMES, Nov. 19, 2002, http://www.nytimes.com/2002/11/20/health/20HEAL.html.

44. National Academies Press Release, *supra* note 43.

45. PARK & KU, *supra* note 9, at 1; MANN, *supra* note 2, at 1; NAT'L HEALTH LAW PROGRAM, WHAT IS HIFA AND WHY SHOULD WE BE CONCERNED?, http://www.healthlaw.org/waiver.shtml [hereinafter NHELP Brochure]. Specifically, with regard to benefit cuts, optional beneficiaries, such as children above age six and disabled individuals not receiving Supplemental Security Income (SSI), may lose essential benefits like long-term care or EPSDT services. PARK & KU, *supra* note 9, at 5-6.

46. PARK & KU, *supra* note 9, at 8-9.

health care services" and has "a disproportionate effect on low-income populations."[47] Finally, premium assistance programs would result in higher costs to the government due to public funds substituting private funds (i.e., "crowd out"). In particular, since the HIFA waiver eliminates the cost-effectiveness requirement, employers with numerous low-wage employees may be tempted to reduce their premium contribution knowing that states could then increase premium funding to make up for the loss in employer contribution.[48]

With concerns similar to those raised in the GAO Report, advocates question whether the HIFA waiver is the appropriate vehicle to modify federal statutory standards for coverage under Medicaid and SCHIP.[49] Specifically, they wonder whether the criteria that DHHS will use to operate programs under the HIFA waiver will satisfy Medicaid's purpose of providing adequate coverage to vulnerable populations.[50] They also wonder how beneficiary interests will be represented in a waiver approval process that promises the states a quick turnaround.[51] Moreover, the HIFA waiver does not require states to reinvest the savings from these actions to expand health coverage to additional people.[52] "A state could use part of all of the savings to offset existing Medicaid and SCHIP obligations or to finance other budget items, such as constructing roads or providing tax cuts."[53] To address some of these concerns, some consumer advocates suggest relieving states from making the choice between cutting back on Medicaid and expanding coverage, and instead encourage the federal government to provide states with additional financial resources and incentives.[54]

The concerns expressed in the GAO Report and by consumer advocates are legitimate and should be taken very seriously. However, if states were to apply a collaborative governance model to HIFA waiver proposal development and implementation, they could reconcile many of the issues raised by these groups. Collaborative governance structures that involve all local health care stakeholders and include support by state agencies could design programs that expand health coverage through learning and consensus. This process might require more time and resources up front, but the final product could be more satisfactory to all involved.

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47. *Id.* at 7.
48. *Id.* at 9-10.
49. MANN, *supra* note 2, at 25-26; NHELP Brochure, *supra* note 45.
50. MANN, *supra* note 2, at 26.
51. *Id.*
52. PARK & KU, *supra* note 9, at 3.
53. *Id.*
54. *Id.* at 11.

III. THE COLLABORATIVE GOVERNANCE MODEL

Collaborative governance is one way to improve the quality, ability to implement, and legitimacy of government agency initiatives, such as rulemaking or program development.[55] Collaborative governance recasts outside stakeholders as potential contributors and equal partners to the rulemaking or program creation process, rather than a threat to agency ideas.[56] Specifically, collaborative governance has the following features:

(a) a problem-solving orientation, requiring information sharing and deliberation among knowledgeable parties;
(b) participation by interested and affected parties in all stages of the decision-making process, which may also facilitate effective problem solving;
(c) development of temporary rules subject to revision, contingent upon the findings of continuous monitoring and evaluation;
(d) replacement or supplementation of traditional oversight mechanisms with new allocations of authority because parties are interdependent and accountable to each other; and
(e) the agency acting as a facilitator of multi-stakeholder negotiations and viewing regulatory success as contingent on the contributions of other participants.

These conditions result in mutual learning among stakeholders, produce more innovative solutions that can adapt to changing conditions and encourage greater stakeholder adoption and compliance. Negotiated rulemaking and environmental permitting projects offer some examples that encompass many of the ideas behind collaborative governance.[57]

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55. Jody Freeman, *Collaborative Governance in the Administrative State,* 45 UCLA L. REV. 1, 22 (1997).

56. *Id.*

57. Briefly, "negotiated rule making is a consensus-based process, usually convened by an agency, through which stakeholders negotiate the substance of a rule." *Id.* at 34. The idea of negotiated rulemaking or "regulatory negotiation" ("reg-neg"), grew in the early 1980's as a way to decrease the amount of time to develop regulations, improve the substance and acceptability of rules, and reduce the number of judicial challenges to the rules. Matthew J. McKinney, *Negotiated Rulemaking: Involving Citizens in Public Decisions,* 60 MONT. L. REV. 499, 501 (1999). Congress institutionalized the idea of negotiated rulemaking with the adoption of the Negotiated Rulemaking Act (NRA) in 1990. Freeman, *supra* note 55, at 36. The Act sets statutory guidelines for using reg-neg, such as announcing the formation of a negotiating committee in the Federal Register, but also "allows for great flexibility and encourages experimentation and innovation by federal agencies." McKinney, *supra,* at 503; Freeman, *supra* note 55, at 37. The Act also emphasizes public participation and communication between stakeholders. McKinney, *supra,* at 503. For a more discussion of negotiated rulemaking, please refer to Freeman, *supra* note 55, at 36-40; McKinney, *supra,* at 505-08 (describing the Montana Negotiated Rulemaking Act). In an environmental permit process, the EPA may approve a single permit to control total emissions rather than a separate permit for each type of emission (e.g., air and water emissions). Freeman, *supra*

Collaborative governance can be contrasted with other administrative processes such as interest representation and civic republicanism. Both interest representation and civic republicanism often neglect adequate public participation.[58] Interest representation is characterized by: (a) constrained agency discretion through competition among interest groups in rule-making; (b) rule construction based on bargains and trade-offs made between the agency and stakeholders; (c) viewing agency officials as insiders and other stakeholders as outsiders; (d) adversarial relationships, with stakeholders seeking to maximize their interests by winning on important issues; and (e) the agency acting as a neutral and reactive arbiter among stakeholders, seeking compromise in response to pressure from outsiders.[59]

In civic republicanism, government agency decisions are made by relying on expert administrator deliberation, rather than competition among interest groups.[60] Civic republicans believe that public policy should be "made by enlightened, empowered bureaucrats acting in the 'public interest,' an interest that can be subverted by private bargaining in the interest representation regime."[61] Civic republicans view public participation as obstructing reasoned deliberation of expert administrators who should be policed by executive, congressional and judicial oversight.[62] Thus, both interest representation and civic republicanism juxtapose the government agency with outside stakeholders when making, implementing, and enforcing rules.

The traditional notice and comment process in rulemaking illustrates the limits of interest representation and civic republicanism. Under the notice and comment process, the agency acts as an expert administrator when initially developing the proposed rule.[63] "Only after the Notice of Proposed Rule Making ("NPRM") do parties supply detailed arguments about the technical and practical difficulties of implementing a rule, instead of much earlier when the information might be more valuable to the agency in formulating the proposed rule."[64] Thus, the government agency may not have all the necessary information to formulate a practical rule that outside

note 55, at 55. This allows companies to exchange a decrease in one type of pollutant for an increase in another type, so long as the company promises "superior environmental performance" overall. *Id.*

58. Freeman, *supra* note 55, at 18-22.
59. *Id.* at 18-19.
60. *Id.* at 20.
61. *Id.*
62. *Id.*
63. *Id.* at 13.
64. *Id.* at 12.

stakeholders can, and want to, implement.[65] Furthermore, traditional rulemaking with notice and comment processes often ignores finding solutions to the regulatory problem at hand. Instead it forces stakeholders to take extreme positions on the rule with the anticipation that the agency will "split the difference" between competing positions.[66] Hence, "parties miss opportunities to engage constructively with each other in a sustained way,"[67] because the government agency typically consults with each stakeholder one at a time.[68]

Due to its emphasis on problem-solving, collaborative governance could help negotiating parties shift their focus from a narrow issue to the root of the problem, thereby fostering learning and compromise. According to one researcher, learning takes place "when parties redefine their projects and obligations as their joint experience outpaces their initial understanding."[69] Collaborative governance cultivates such learning among opposing stakeholders. "When actors jointly explore problems they modify their perceptions of problems and interests. The outcome is thought to be a positive sum where – compared to following one's own strategic interest – collaborative interactions or discussions which lead to jointly defined interests can provide mutual gain to parties without them feeling like they have given up some important part of their self-interest."[70] Thus, collaborations could improve the amount and quality of the information shared between stakeholders.[71]

The problem-solving nature of collaborative governance also mandates face-to-face negotiations between stakeholders, which helps stakeholders resist being extreme or unrealistic.[72] The collaborative scheme forces parties to make hard compromises on issues which government agencies otherwise would have to resolve alone.[73] Creative solutions, capable of implementation, often result from these negotiations and compromises.[74] Although the solutions achieved through a collaborative process may not be

65. *Id.*

66. *Id.*

67. *Id.* at 11.

68. McKinney, *supra* note 57, at 500.

69. Christine Overdevest, OMCs and Learning Literature 4 (Oct. 23, 2001) (quoting Charles Sable) (unpublished manuscript, on file with author).

70. *Id.* at 10.

71. Freeman, *supra* note 55, at 54; McKinney, *supra* note 57, at 536 (noting that two state-level reg-neg cases demonstrate "the critical importance of joint fact-finding and mutual education").

72. Freeman, *supra* note 55, at 54.

73. *Id.*

74. Freeman argues that the compromised solution is likely to be more implemented and sustained because the various stakeholders helped create it. *Id.* at 27, 54.

ideal for a particular interest, participants may perceive the process of collaboration as more fair and just, and therefore, more successful than traditional interest representation or civic republican models. According to Thibaut and Walker, "people seek to maximize their personal involvement in decisional processes and gauge the fairness of processes by the degree of that participation."[75]

Despite the benefits of collaborative governance schemes, such schemes face criticism and may not be applicable in every situation. Concerns about collaborative governance can be lumped into three categories: (a) fear of collusion; (b) questions about public accountability; and (c) resource intensity. One of the primary concerns with collaborative processes is collusion.[76] Advocates fear that collaboration may exacerbate the weaknesses of interest representation by providing an opportunity for the agency and industry to propose solutions that undermine the public interest.[77] "Too much cooperation between government and regulated parties could lead to unhealthy relationships in which both regulated parties and government officials gain at the expense of the public interest."[78] This fear is fueled by the fact that most community groups do not have the knowledge-base or financial resources to participate in collaborative groups, thereby making negotiations unbalanced.[79]

A related concern is the lack of public accountability in collaborative solutions, particularly due to sub-delegation and unfettered agency discretion.[80] Accountability is a basic tenet in administrative law. However, the fundamental problem of administrative law is "trying to design a system of checks that will minimize the risks of bureaucratic arbitrariness and overreaching, while preserving for the agencies the flexibility they need to act effectively."[81] One can measure accountability using three factors: the degree to which the public can influence a decision

75. Mark R. Fondacaro, *Toward a Synthesis of Law and Social Science: Due Process and Procedural Justice in the Context of National Health Care Reform*, 72 DENV. U. L. REV. 303, n.92 (1995).

76. Freeman, *supra* note 55, at 83.

77. *Id.* at 56, 83.

78. Jack M. Beermann, *Privatization and Political Accountability*, 28 FORDHAM URB. L.J. 1507, 1537 (2001).

79. Freeman, *supra* note 55, at 56, 83.

80. *Id.* at 83-87.

81. WEST LEGAL DIRECTORY, ADMIN. LAW AND PROCEDURE, http://www.wld.com/conbus/weal/wadmin1.htm. *See also* A.L.A. Schecter Poultry Corp. v. United States, 295 U.S. 495, 542 (1935) (finding unconstitutional a law giving the President of the United States, rather than Congress, powers to make codes for the rehabilitation and expansion of trade or industry); Carter v. Carter Coal Co., 298 U.S. 238, 311 (1936) (finding that delegating the power to fix maximum hours of labor to coal producers rather than the government violates the due process clause of the Fifth Amendment).

through political activity; the degree to which the public can discern who is responsible for a decision; and the degree to which information regarding activities is available.[82] Interest representation and civic republicanism rely on judicial review as a means to ensure agency legitimacy.[83] In comparison, collaborative governance schemes that rely on agency compliance with performance-based standards, such as the goal of expanding health coverage, make detection of regulatory violations more difficult.[84]

Potentially, stakeholder self-monitoring creates difficulties in accessing information. The sub-delegation of monitoring activities to a private organization blurs the determination of who is responsible for program decisions while also reducing the ability of agencies to compare data and determine whether progress is being made. For example, Massachusetts has delegated much of the mental health administration within its Medicaid program to a private entity. This delegation has created a gap in information, making it difficult for meaningful oversight of the mental health program because "data across contractors are not comparable, and the amount of information available from the current managed care company, and from the Division of Medical Assistance, is far too limited to allow healthy public debate about the wisdom of the program."[85]

A third concern regarding collaborative governance is the amount of resources that are necessary for its proper implementation. One researcher notes that collaborative governance can be very resource-intensive for all involved in the process.[86] For example, the collaborative process of negotiated rulemaking "requires the participants to review additional documents and generate ideas, proposals, and perhaps data – all of which takes time."[87] Furthermore, the time it often takes to reach consensus can drain an agency and other stakeholders' resources and morale. Even for industry representatives, "the pressure to show short-term profit discourages executives from making large investments of company time and resources in uncertain [consensus-based] processes that cannot

82. Beermann, *supra* note 78, at 1509.

83. Freeman, *supra* note 55, at 82.

84. Beermann, *supra* note 78, at 1535. There are measurability, time lag and attribution problems with relying on performance-based standards such as "expanding health care coverage." But these problems are not insurmountable. For an interesting discussion of this issue, *see* MARK SCHACTER, INST. ON GOVERNANCE, WHAT WILL BE, WILL BE: THE CHALLENGE OF APPLYING RESULTS-BASED THINKING TO POLICY 10 (2002), http://www.iog.ca/publications/resultsandpolicy.pdf.

85. Manjusha P. Kulkarni et al., *Public Health and Private Profit: A Witch's Brew,* CLEARINGHOUSE REV. 629, 641-42 (Jan.-Feb. 2002).

86. McKinney, *supra* note 57, at 500-01.

87. *Id.*

guarantee results."[88] One government official commented that state agencies are not very excited about having open meetings in which, like collaborations, debate of a proposal can be quite lengthy.[89]

One response to the critiques of collaborative governance is to allow the government to continue to play a critical role in collaborations. For instance, agencies could retain the authority to withdraw from the negotiated agreements, and improprieties in the decision-making process could be challenged through petitions for judicial review, at least with regard to agency rulemaking.[90] Certain collaborative governance schemes, like negotiated rulemaking, are subject to open meetings law and negotiations must be made public record.[91] One researcher has noted that with respect to sub-delegation, accountability may not be an impediment to privatization as long as the private company is given detailed, comprehensive instructions by a governmental agency, and that agency remains accountable for the successes and failures of that private entity.[92] Hence, as long as the government agency maintains a significant role in the collaborative regime and checks and balances exist within the system, fears about collusion and accountability should be diminished.

However, traditional forms of accountability should not be the central focus of successful collaborative endeavors.[93] Instead, the public must change the way it views accountability. Under a collaborative governance model, agencies require flexibility and should withdraw from negotiated agreements sparingly. If the agency is too proscriptive or threatening in relation to the other stakeholders, participants will never engage in prolonged negotiation to achieve consensus or have a sense of ownership of the agreement.[94] Consequently, one should establish alternative forms of accountability that foster flexibility in program development and implementation. In a collaborative governance environment, Congress could authorize legislation approving agency departure from statutory limits if stakeholders agreed to certain conditions, which would rein in agency abuse of discretion.[95] These conditions could include items such as a promise of superior performance, that there be no risk of adverse effects, or

88. Freeman, *supra* note 55, at 76.

89. Telephone Interview with Jim Edge, State Contact for the Oregon HIFA Waiver Proposal (Aug. 6, 2002).

90. Freeman, *supra* note 55, at 87-89. *See* discussion *infra* note 179 and accompanying text.

91. Freeman, *supra* note 55, at 89.

92. Beermann, *supra* note 78, at 1517.

93. *See* Freeman, *supra* note 55, at 95-96.

94. *Id.* at 92; McKinney, *supra* note 57, at 536.

95. Freeman, *supra* note 55, at 90.

that there be reliable monitoring mechanisms.[96] The key to legislation that is conducive to collaboration is to not "preordain solutions," but rather to leave open the methods of achieving the statute's goal.[97] Under this scheme, collaborations could act as information-gathering entities and act as a critical resource for legislators when deciding future legislation.[98]

As for the resource intensity that collaborative governance models require, proponents point toward the long-term benefits and potential savings that such models create.[99] For example, in a Montana collaborative governance initiative, participants met for over twenty months negotiating rules around game farms, and another four months seeking ratification from each of the stakeholders' constituency.[100] As a result, there was essentially no opposition to the proposed rules.[101] Thus, if the ultimate goal in creating rules or programs is to see implementation of those rules or programs, then the amount or resources spent on achieving that goal should become less relevant. In essence, the goal for stakeholders in a collaborative governance model becomes the development of a high quality rule or program.[102] "Even if producing such [collaborative] solutions requires a more up-front investment of resources than informal rule making, the resulting rules may ultimately reduce the cost of legal challenge and resistance to implementation."[103]

Despite all the rhetoric about collaborative governance, it may not apply in every circumstance. In fact, since the early 1980's, less than one percent of all administrative rules promulgated by the federal government have used negotiated rulemaking.[104] One researcher has noted that the existence of a controversial, complex issue that is of high priority to identifiable stakeholders creates an ideal condition for the application of collaborative governance.[105] The HIFA waiver, particularly with its features of agency flexibility and public-private partnership around the complex issue of health system reform, presents such a condition. States could apply a collaborative governance model under the HIFA waiver by facilitating stakeholder design and implementation of a health coverage expansion program. Such collaboration would consist of consumer groups, providers,

96. *Id.*
97. *Id.* at 95.
98. *Id.* at 93.
99. *See, e.g.*, McKinney, *supra* note 57, at 501.
100. *Id.* at 515.
101. *Id.*
102. Freeman, *supra* note 55, at 26-27.
103. *Id.* at 26.
104. McKinney, *supra* note 57, at 503.
105. *Id.* at 530.

insurers, businesses, and government seeking to solve the problem of a complete lack of insurance and underinsurance by designing, implementing, and monitoring a consensus-based solution. The solution, however, would be subject to revision, depending on changes in the market or regulatory environment. Members of the collaboration would be accountable to each other, ensuring that the devised solution met its goals of health coverage expansion. Finally, the state agency would act as the facilitator of the collaboration, "providing technical resources, funding, and organizational support when needed."[106] Applying collaborative governance to HIFA waiver program development may actually achieve HIFA's goal of expanding health care coverage.

IV. APPLYING THE COLLABORATIVE GOVERNANCE MODEL TO HIFA WAIVER INITIATIVES

The HIFA waiver's emphasis on flexibility and public-private partnerships should encourage states to incorporate collaborative governance models when developing HIFA waiver proposals. Specifically, the HIFA waiver is flexible with respect to state program design and requires each state to "develop coordinated private and public health insurance coverage options to low income uninsured."[107] The general goal of the HIFA waiver – to expand health insurance coverage – helps maintain agency accountability and provides a framework in which the collaboration can work, but also allows states to experiment with methods to achieve that goal.[108] Researchers have suggested that greater flexibility in the Medicaid program may help states cover more uninsured low-income workers.[109] The HIFA waiver's flexibility to adjust benefit and cost-sharing levels to meet local interest and needs, and public-private coordination requirements, could nurture collaborative approaches to program design and implementation. Because parties have more freedom to find a consensus-based solution, the collaborative approach is ideal.

State adoption of collaborative approaches in developing HIFA waiver

106. Freeman, *supra* note 55, at 22.

107. HCFA HIFA Article, *supra* note 3, at 1.

108. *Id.* Of course, there are federal resource constraints with implementing HIFA waiver programs. *See supra* text accompanying notes 4, 25. It should be noted at the outset that some may question the federal government's role entirely in health coverage expansion, since health care reform has devolved to the state level. *See, e.g.*, Louise G. Trubek, *Public Interest Lawyers and New Governance: Advocating for Healthcare,* 2002 WIS. L. REV., 575, 594. However, the Medicaid program is a federal-state initiative, and federal dollars significantly support the program. *See* CARABELL & MEGNA, *supra* note 18, at 1. Plus, federal involvement can facilitate data collection and learning among states.

109. Randall R. Bovbjerg et al., *Medicaid Coverage for the Working Uninsured: The Role of State Policy,* HEALTH AFFAIRS, Nov.-Dec. 2002, at 241.

proposals is important for three primary reasons. First, public-private collaboration at local levels is an essential element in the controversial and complex endeavor of health system reform. Second, collaborative models could overcome barriers to successful program implementation. In particular, collaboration could increase stakeholder buy-in, provide notice to stakeholders about the proposed health reform ideas, and help states gain access to private health coverage information. Third, collaborative governance in HIFA waiver proposals could maximize the benefits experienced by current community collaborations. These benefits include: access to greater and more stable funding sources, access to a facilitator that can collect and distribute data, and an avenue for accountability. Each of these reasons will be discussed, using examples of collaborative efforts from Wisconsin, San Diego, Michigan, Illinois, and Oregon to illustrate the successes and failures of attempted stakeholder coordination.

A. Health System Reform Demands Collaboration Between Local, Public-Private Entities

The HIFA waiver's emphasis on agency flexibility and public-private coordination may be a response to what is already happening or should happen in health system reform. Namely, expanding health care coverage is too complex an endeavor for one stakeholder to achieve alone and therefore coalitions emerge. The few programs that have been proposed thus far under HIFA demonstrate the complexity and controversy behind the issue of expanding coverage to the uninsured and underinsured.[110] States that have proposed to reduce benefits or raise consumer cost-sharing levels saw protests by provider and consumer groups.[111] States that explored premium assistance programs drew the attention of insurers and employer groups.[112] Thus, health system reform efforts affect many powerful interest groups, such as insurers, employers, consumer groups, and providers.[113]

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110. *See, e.g.*, GAO REPORT, *supra* note 33, at 28 (noting that advocates and providers in Utah "expressed concern about reduced optional benefits and increased cost sharing for current beneficiaries, the planned enrollment fee and co-payments, and lack of specialty services and inpatient hospital coverage for the waiver expansion population"); KAISER DAILY HEALTH POL'Y REPORT, *States Should Not Use Unspent CHIP Money to Cover Uninsured Adults, USA Today Editorial States* (Aug. 15, 2002), http://www.kaisernetwork.org/daily_reports.

111. *See, e.g.*, GAO REPORT, *supra* note 33, at 28.

112. ARIZ. HEALTH CARE COST CONTAINMENT SYSTEM, FEASIBILITY STUDY OF AN EMPLOYER-SPONSORED INSURANCE PILOT PROGRAM IN ARIZONA 7 (2002) (on file with author).

113. WIS. DEP'T OF HEALTH & FAMILY SERV., BADGERCARE PROPOSAL 50, 51 (Dec. 22, 1998) (noting the various interested parties with whom DHFS met to discuss the BadgerCare

All of these stakeholders agree that the complex issue of the uninsured must be resolved.[114] And in response to this unified interest, stakeholder coalitions, at both the state and national levels, developed.[115] Broad participation in such coalitions is only likely to increase as the economy weakens. For example, employers who may not concern themselves with the rates of insurance outside their own organization, have recently expressed concern about the rates of those without insurance. These employers noted that "paying for the uninsured is making health care even more expensive for private employers and government programs."[116] It is during difficult economic times that employers are more likely to express interest in and participate in health reform efforts.[117]

Many current health reform coalitions may have formed because state Medicaid agencies have recognized the importance of collaboration in addressing the issue of the uninsured. For example, Wisconsin, one of the eleven states that won "State Planning Grant" funding from DHHS to study the uninsured, stated in its final State Planning Grant report[118] that building community partnerships is an effective strategy in collecting data to study the uninsured problem. This allows the State "to obtain valuable

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proposal, including physicians, businesses, consumer advocates, and managed care organizations) (on file with author).

114. Milt Freudenheim, *Next Big Health Debate: How to Help Uninsured,* N.Y. TIMES, Aug. 27, 2002, at C1 (stating that employers, labor unions, Congressional leaders, consumers and insurers all believe resolving the uninsured issue is important), http://www.nytimes.com/2002/08/27/business/27CARE.html.

115. *Id.* (discussing the National Coalition on Health Care (NCHC)). NCHC members include corporations, labor unions, small business, and the nation's major religious, consumer and health care provider organizations. NAT'L COALITION ON HEALTH CARE, WHO WE ARE, http://www.nchc.org/principles.html. NCHC members hope to achieve universal coverage. *Id. See also* UTAH DEP'T OF HEALTH, COVERING KIDS, *Covering Kids State Projects Utah, at* http://www.coveringkids.org/projects/state.php3?StateID=UT (noting how Utah plans to increase health insurance to children by increasing coordination between public and private entities statewide); City of Milwaukee, BadgerCare Coordinated Network Mission Statement (Oct. 1, 2001) (on file with author) (stating that the Network's goal is to provide easy access to publicly funded resources through collaboration and coordination with community organizations and local and state government agencies) [hereinafter BadgerCare Coordinated Network Mission Statement]; SHARON SILOW-CARROLL ET AL., THE COMMONWEALTH FUND, EXPANDING EMPLOYMENT-BASED HEALTH COVERAGE: LESSONS FROM SIX STATE AND LOCAL PROGRAMS 41 (2001) (describing a collaboration in Muskegon County, Michigan that consisted of patient, provider and community representation to expand employment-based coverage); see www.cmwf.org.

116. Freudenheim, *supra* note 114.

117. Peter Swensen & Scott Greer, *Foul Weather Friends: Big Business and Health Care Reform in the 1990's in Historical Perspective,* 27 J. OF HEALTH POL., POL'Y & L. 605, 615 (2002).

118. Dennis Chaptman, *State Wins Funds to Find Out Who Lacks Health Insurance, Why,* MILW. J. SENTINEL, Sept. 22, 2000, http://www.jsonline.com/news/state/sep00/insure23092200.asp.

information and gain perspective on issues of the uninsured from a community or local viewpoint."[119] The State acknowledged that "particular groups of uninsured face barriers to health insurance coverage for a variety of reasons that, perhaps, could be most effectively addressed at the local level or through pooling of resources and State-local partnerships." In addition, the State of Utah, which also received a State Planning Grant, revealed that its planning process to address the uninsured involved "widespread representation from all sectors of Utah that have an interest in the uninsured issue," including private citizens, providers, agencies, advocacy groups, business, and academia.[120] Thus, it appears that at least some states recognize that the problem of the uninsured cannot be resolved without additional stakeholder support.

State recognition of the need for public-private collaboration might reflect a shift in responsibility for health care reform from the federal level to local levels (the movement down) and from government to private entities (the movement out). The movement down from federal to state level governance has been occurring for the past few decades, with welfare reform being the "hallmark of this process of devolution."[121] The movement down has also affected health care reform efforts, although researchers disagree as to the extent of or reasons behind relinquishment of federal power.[122] There is agreement, however, that states play a significant

119. WIS. DEP'T OF HEALTH & FAMILY SERVS., WIS. STATE PLANNING GRANT FINAL REPORT TO THE SEC'Y 59 (2001), http://www.dhfs.state.wi.us/medicaid1/state-grant/SPG-final.pdf.

120. UTAH DEP'T OF HEALTH, DIV. OF HEALTH CARE FINANCING, 1115 DEMONSTRATION WAIVER REQUEST FOR THE PRIMARY CARE NETWORK OF UTAH 16 (2002) (on file with author).

121. Trubek, *supra* note 108, at 580-81 (indicating that "[r]ather than a mere anomaly, welfare reform is regarded as the 'maturation of a generation-long trend that fundamentally transformed community governance'"). Welfare reform denotes the switch from Aid to Families with Dependent Children (AFDC), which relied on federal subsidies and a centralized administrative system, to a state-based block grant system under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, the aim of which is to move people off welfare and into jobs. *Id.;* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2114 (1996). Professor Trubek attributes the move from federal to state control to the distrust in federal agencies that occurred as a result of social unrest and political pressures brought about by inflation in the 1970s. Trubek, *supra* note 108, at 580.

122. Trubek, *supra* note 108, at 581 (stating that some early critics of the 1996 welfare reform have been won over); John D. Blum, *Leveraging Quality in Managed Care: Moving Advocates Back into the Box,* 2002 WIS. L. REV., 617-19 (noting that the "recent shifts in authority downward do not reflect a belief in state governments' abilities, but rather reflect an ongoing belief on the part of federal law-makers that the national government needs to be released of some of its obligations" and that "it seems reasonable to argue that government power in health care, while somewhat diffused, has resided, and continues to reside, at the national level.").

role in health policy and serve as interesting laboratories for health reform efforts.[123] For example, states traditionally have played an integral part in health care policy and delivery, due in part to their role as guarantor of health and welfare under the Tenth Amendment.[124] Health insurance and medical malpractice issues have traditionally been a state level concern, and recent Supreme Court cases support that notion.[125] But welfare reform, coupled with the federal government's inability to expand health coverage, has bolstered the role of the state in health care reform efforts.[126] SCHIP was tied to welfare reform by enabling state development of programs that would encourage low-income mothers to move off welfare and into jobs without fear of losing health coverage.[127] Since the passage of SCHIP, all states, commonwealths, and territories have implemented health coverage programs under SCHIP in an effort to expand coverage and reform health care.[128]

States have reformed the health system by involving private stakeholders, which illustrates the movement out. "The movement out is a series of systems that link public and private organizations and is related to what is often called 'privatization' – an increased reliance on the private institutions of society to satisfy public needs."[129] For example, Wisconsin formed its original BadgerCare proposal as a result of a coalition of religious groups, direct service providers, and nonprofit organizations that gathered to analyze the State's welfare reform proposal.[130] Another Wisconsin collaboration of providers and consumers, the Collaboration for

123. Blum, *supra* note 122, at 620; Louise G. Trubek, *Symposium: Barriers to Access to Health Care,* 12 HEALTH MATRIX 157, 166 (2002).

124. U.S. CONST. amend. X.

125. *See, e.g.*, FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 515 (4th ed. 2001); Pegram v. Herdrich, 530 U.S. 211, 236-37 (2000) (noting that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose" and stating that it is not the federal role or intent under ERISA to apply a malpractice standard to HMOs); Rush v. Moran, 536 U.S. 355, 372-379 (2002) (stating that a state's external review law is saved from ERISA preemption under ERISA § 514(b) because it regulates insurance, using the McCarran-Ferguson Act factors as a guidepost, and does not provide an alternative remedy to that available under ERISA § 502(a)).

126. Trubek, *supra* note 123, at 158 (stating that "[t]he public policy vacuum created by the failure of the Clinton plan is being filled by state-based initiatives that provide coverage and access for low-income people.").

127. *See, e.g.*, Louise G. Trubek, *The Health Care Puzzle, in* HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA 147 (Joel F. Handler & Lucie White eds. 1999).

128. GABRIELA ALCALDE, NAT'L CONFERENCE OF STATE LEGISLATURES, EXPLORING A NEW OPTION: SECTION 1115 DEMONSTRATION WAIVERS UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM 3-7 (2001).

129. Trubek, *supra* note 123, at 167.

130. *Id.* at 148.

Healthcare Consumer Protection ("CHCP"), helped shape patients' rights legislation in the state.[131] New Mexico designed an employer-based solution to expand health coverage through a collaboration of health care groups, state and local government, business organizations, and advocacy organizations.[132] Finally, groups like the Kaiser Family Foundation and the Urban Institute make data available about health reform efforts across states, which helps states learn from one another and encourage further experimentation.[133]

Some researchers attribute the reliance on more private actors for public program guidance as an indication that the current policy regime no longer works.[134] Others state that collaborations among public and private actors may "reflect a serious desire to carry out major change."[135] Regardless of the reason behind public-private coordination efforts, both state and federal governments have come to rely on various health care stakeholders for health program information and implementation. This reliance illustrates the difficulty a single public entity has in developing health coverage expansion programs in a civic republican or interest representation regime. As a result, stakeholder coalitions become necessary to develop feasible and acceptable programs. One could argue that the HIFA waiver allows these coalitions to continue and grow by encouraging partnership between public and private stakeholders, such as through premium assistance programs, and offering flexible conditions in which these coalitions can develop innovative solutions to expanding health coverage.

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131. *Id.* at 591-92.

132. STATE OF NEW MEXICO, NEW MEXICO STATE COVERAGE INITIATIVE PLANNING GRANT 5 (May 2001-Dec. 2001) [hereinafter NEW MEXICO GRANT REPORT] (on file with author).

133. Trubek, *supra* note 123, at 171-74; Interview with Don Schneider, Chief of Coordination of Benefits Section, DHFS, in Madison, Wis. (Aug. 16, 2002) [hereinafter Don Schneider Aug. 16 Interview] (noting that groups like Kaiser Family Foundation ("KFF") cropped up because they wanted to focus on research and provide data to entities to make policy). As health coverage expansions occurred, both state and the federal governments needed information and groups like KFF had the data. Don Schneider Aug. 16 Interview, *supra* note 132. *See also* URBAN INSTITUTE, ASSESSING THE NEW FEDERALISM PROJECT MISSION STATEMENT (2001), http://www.urban.org/Content/Research/NewFederalism/AboutANF/AboutANF.htm (last visited Sept. 26, 2002) (stating that the Assessing the New Federalism project is a multi-year project to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care and welfare reform programs).

134. Charles Sabel, *The Changing Shape of Government,* 28 FORDHAM URB. L.J. 1319, 1351 (2001) (noting that in the public school system, "the way you on the outside know they say that [the system is not working] is because all of a sudden you get coalitions, quite surprising coalitions, of very disgruntled insiders whose professional honor, whose sense of dedication, whose sense of humanity, and whose sense of disgust are triggered, teaming up with people on the outside to try new things"); Trubek, *supra* note 108, at 586.

135. Trubek, *supra* note 108, at 586.

B. Overcoming Barriers to Program Success

State collaboration with other health care system stakeholders in HIFA waiver proposal development may overcome obstacles that often diminish the success of health coverage expansion programs. These obstacles include: stakeholder buy-in to program design and implementation, notice to stakeholders, and access to private health coverage information.

1. Buy-in

There are several examples of how collaboration among stakeholders increases buy-in and the impact of that buy-in on program success. One example, the San Diego Financially Obtainable Coverage for Uninsured San Diegans ("FOCUS") program, is a premium assistance program targeted at lower-income employees in small businesses.[136] FOCUS arose out of a community-based forum that discussed health care access issues.[137] The forum included representatives from provider organizations, local government, and health insurers, among others.[138] "Since a group comprising of hospitals, insurers, and other community members *developed* FOCUS, local providers agreed to serve FOCUS enrollees at reduced rates and brokers agreed to participate without commissions."[139] The designers of FOCUS declined to make the program publicly-based because wrapping FOCUS services around Medicaid or SCHIP would have been too administratively burdensome.[140] Thus, financing FOCUS with private resources allowed more flexibility in designing the program.[141]

FOCUS recipients receive a "reasonably generous" benefit package with minimal cost-sharing that includes: physician office visits for a $5 co-payment; 100 percent hospitalization coverage; outpatient prescription drugs ($5 generic/$15 brand name co-payments); urgent care services for a $5 co-payment; emergency room services for a $50 co-payment; home health services; and limited mental health and chemical dependency coverage.[142] Employees share in the cost of the premium, which amounts to $10 to $194 per month, depending on income and family size.[143] FOCUS

136. SILOW-CARROLL ET AL., *supra* note 115, at 44. Small business is defined as fifty or fewer employees and low-income is defined as incomes up to 300% of the Federal Poverty Level. *Id.*

137. *Id.* at 43.

138. *Id.*

139. *Id.* at vii (emphasis added).

140. *Id.* at 44-45.

141. *Id.*

142. *Id.* at 44-45. In addition, there are no deductibles or lifetime maximums, and the annual co-payments are capped at $1,500 per individual and $3,000 per family. *Id.*

143. *Id.*

demonstrates that given flexibility in program design, collaborators will not necessarily reduce benefits or increase recipient cost-sharing. Rather, the program achieves cost-savings through stakeholder buy-in. Specifically, providers have agreed to lower reimbursements, brokers do not charge commissions for enrolling businesses in the program, and the plan administrator donates one-third of its typical administrative costs.[144]

Another example of collaboration creating a health coverage expansion program buy-in is the Access Health program in Muskegon County, Michigan. Access Health covers approximately 500 people and targets working uninsured people who make $10 per hour or less.[145] The program was designed through a "community decision-making process" that involved employers and providers.[146] The HMO community was not involved in the design process, so when program planners approached them with the benefit package, HMOs declined to offer the package for the price that employers were willing to pay.[147] Thus, Access Health became an independent nonprofit organization that contracts directly with providers.[148]

Access Health is financed by employers, employees, and community match (consisting of federal, local government, community, and foundation funds).[149] This allows it to be flexible in its design and to respond to changes in the health care marketplace. For example, after Access Health was implemented, program officials learned that they could benefit more employees if they extended eligibility to businesses with more than nineteen employees.[150] "Such flexibility ensures that even if the target population changes, programs will be able to adapt and continue to provide health insurance to low-income workers."[151] The Muskegon community views the program as successful, and has attributed much of the program's success to community involvement (including the medical community) in developing the program.[152] Patients, providers, and other community members continue their involvement in Access Health through a community board.[153] "Program officials noted that because the program ideas originated in the community, the creative structure of the program

144. *Id.*
145. *Id.* at 37.
146. *Id.* at 36.
147. *Id.*
148. *Id.*
149. *Id.* at 38.
150. *Id.* at 40.
151. *Id.*
152. *Id.* at 40-41.
153. *Id.* at 41.

was acceptable to the community.[154]

In Illinois, the Illinois KidCare Rebate program provides another example of how collaboration under flexible conditions can create stakeholder buy-in. In designing its KidCare Rebate program in 1998, Illinois used a taskforce consisting of legislators, governor's office staff, providers, insurers, local government officials, and advocates in order to determine eligibility criteria, benefit design, and cost-sharing structures.[155] The taskforce also worked with employer groups.[156] Initially, the program, a type of premium assistance program, was funded completely by the state without federal matching funds (covering children from low-income families).[157] As a result, the state had flexibility with regard to benefit and cost-sharing levels,[158] similar to the flexibility now provided under the HIFA waiver. According to one state official, the taskforce reached a compromise that allowed for lower benefit levels (i.e., physician visits and hospital inpatient services) but minimized beneficiary cost-sharing.[159] To date, there have been no complaints from stakeholders about the program and the program covers 5,779 children.[160] The State is expanding the KidCare Rebate program to cover optional categories of parents and children through a HIFA waiver.[161] Interestingly, even the GAO found that Illinois interest groups did not complain about public notice issues during the Illinois HIFA waiver application process.[162]

The success of the Illinois KidCare Rebate program is contrasted with the low enrollment numbers of Wisconsin's premium assistance program. Wisconsin's Medicaid expansion program, BadgerCare, has a premium assistance component labeled the Health Insurance Premium Purchase ("HIPP") program.[163] This program was developed under a section 1115

154. *Id.*

155. Telephone Interview with Jane Longo, Chief of KidCare Bureau, Illinois Dep't of Public Aid (Sept. 11, 2002).

156. *Id.*

157. *Id.;* STATE OF ILL., ILLINOIS HIFA WAIVER APPLICATION 24, attach. D (2002), http://www.cms.hhs.gov/hifa/hifapend.asp [hereinafter Illinois HIFA Application].

158. Interview with Jane Longo, *supra* note 155.

159. *Id.*

160. *Id.;* Illinois HIFA Application, *supra* note 157, at 24, Attach. D.

161. Press Release, Dep't of Health & Hum. Servs., HHS Approves Illinois Plan to Expand Health Insurance Coverage to Reach as Many as 300,000 Uninsured Residents (Sept. 12, 2002), http://www.hhs.gov/news/press/2002pres/20020912a.html. The state will use unspent SCHIP dollars to expand the KidCare Rebate program to cover parents at higher income levels. *Id.*

162. GAO REPORT, *supra* note 33, at 27.

163. WIS. DEP'T OF HEALTH & FAMILY SERVS., BADGERCARE AT A GLANCE: PROGRAM DESCRIPTION (May 2002) http://www.dhfs.state.wi.us/badgercare/html/glance_1.htm [hereinafter BadgerCare Brochure].

waiver prior to HIFA,[164] so it contains a cost-effectiveness test and provides wrap-around services equal to BadgerCare coverage.[165] As of May 2002, only seventy-six families participated in the HIPP program[166] (although this was an increase from thirty-four families in February 2001).[167] Wisconsin's Department of Health and Family Services has noted that it is difficult to meet the cost-effectiveness test in the HIPP program due to the costs of providing wrap-around coverage and extra administrative costs involved in following up with employers about their health plans.[168] In addition, enrollment in HIPP programs remains low "primarily because many employer health plans do not meet SCHIP's benefit requirements and because employers must contribute a substantial portion of the premium to qualify."[169]

As evidenced by the success of FOCUS, Access Health, and Illinois' KidCare Rebate program, it could be argued that flexibility in benefit design and cost-sharing structures, such as that available in the HIFA waiver, increases stakeholder buy-in of the health coverage expansion program. For example, both FOCUS and Access Health were funded mostly with private dollars, removing many of the program design restrictions that often accompany public funding. "When states develop initiatives that operate under federal programs such as Medicaid or [SCHIP], they gain continuing access to federal matching funds that finance half or more of the costs, but must comply with numerous federal regulations and reporting requirements."[170]

The downside to rejecting federal funding sources is the limitation of funds (and therefore limited program scale) in addition to increasing vulnerability to financial and political crises.[171] Yet removal of some of the benefit coverage and employer premium contribution standards has increased the number of people eligible for premium assistance programs,

164. CTRS. FOR MEDICARE & MEDICAID SERVS., DIV. OF STATE CHILDREN'S HEALTH INS., STATE CHILDREN'S HEALTH INSURANCE PROGRAM ("SCHIP") APPROVED AND UNDER REVIEW DEMONSTRATION PROJECTS TABLE (January 6, 2003) http://www.cms.hhs.gov/schip/1115waiv.pdf.

165. BadgerCare Brochure, *supra* note 163.

166. *Id.*

167. Interview with Don Schneider, *supra* note 16.

168. *Id.* (indicating that cost-effectiveness is measured by comparing the cost of a BadgerCare participant enrolled in a HMO with the cost of wrap-around coverage and extra administrative costs provided in the HIPP program).

169. John Holahan et al., *Health Policy for Low-Income People: States' Responses to New Challenges,* HEALTH AFFAIRS (Web Exclusive), W187, W199 (May 22, 2002), *at* http://www.healthaffairs.org/WebExclusives/2104Holahan2.pdf.

170. SILOW-CARROLL ET AL., *supra* note 115, at vii.

171. *Id.*

thereby decreasing administrative costs in such programs.[172] In addition, flexibility in benefit design and cost-sharing strategies addresses some of the employer concerns surrounding premium assistance programs. For example, employers in New Jersey expressed apprehension of the state's premium assistance programs because of employers' inability to meet federal requirements related to cost-sharing and benefit packages.[173]

Equally important, however, is that the FOCUS, Access Health, and KidCare Rebate programs demonstrate that collaboration among stakeholders in program development contributes to stakeholder buy-in. Each of these three programs used a collaboration of stakeholders to develop the health coverage expansion program, and all three programs noted few complaints from stakeholders but rather quite substantial cooperation in making the program succeed. The FOCUS program relies on provider acceptance of reduced reimbursement and the absence of broker commissions. Program officials have attributed this local support to stakeholder involvement in developing the program.[174]

It is interesting to note the lack of HMO support in the Access Health program. Program officials did not approach HMOs until after the program was designed.[175] As a result, the program created a nonprofit to directly contract with providers, bypassing the need for HMO involvement.[176] Finally, involving advocates in the design of KidCare Rebate minimized the unrest among the advocacy community surrounding the program. Advocates found it more acceptable to trade fewer benefits for more limited cost-sharing because they helped design the program.[177]

2. Notice to Stakeholders

DHHS requires each state to solicit public input in the development of section 1115 waivers.[178] This public input may include: formal notice and comment, public forums, legislative hearings, placement of information on

172. INST. FOR HEALTH POL'Y SOLUTIONS, COMMENTS ON PROPOSED IMPLEMENTING REGULATIONS FOR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (HCFA-2006-P) 4 (2000), http://www.ihps.org/.

173. INST. FOR HEALTH POL'Y SOLUTIONS, COORDINATING STATE CHILDREN'S HEALTH INSURANCE PROGRAMS WITH EMPLOYER-BASED COVERAGE: DESIGN AND IMPLEMENTATION OF PREMIUM ASSISTANCE PROGRAMS 15 (1999), http://www.ihps.org/.

174. SILOW-CARROLL ET AL., *supra* note 115, at 7.

175. *Id.* at 36.

176. *Id.*

177. Interview with Jane Longo, *supra* note 155.

178. Letter from Dennis Smith, Dep't of Health & Human Servs., Ctr. for Medicare & Medicaid Servs., to State Medicaid Directors, SMDL #02-007 (May 3, 2002) *at* http://cms.hhs.gov/states/letters/smd50302.asp (last visited July 10, 2002) [hereinafter DHHS Public Notice Letter].

the state website with a link for public comments, distribution of draft waiver applications for comment, public presentations, newspaper notices, or a special commission with broad representation.[179] Other than a special commission (which fits most closely within the collaborative governance model), each of the suggested ways to involve public participation fosters interest representation rather than collaboration when designing proposed program standards.[180] As noted earlier, traditional public input mechanisms, such as notice and comment, may expose government agencies to interest representation and adversarialism when unveiling a proposed health coverage program under section 1115 waivers. Consequently, to satisfy the HIFA waiver's public input requirement, but also to achieve a higher quality and more legitimate solution, states could take advantage of HIFA's emphasis on public-private partnership and apply a collaborative governance model when designing HIFA waiver programs. Also, using collaborative governance to achieve public notice may address the GAO's criticism that some states lack adequate public notice in their HIFA waiver proposals.[181] The GAO has noted that the methods that states can use to satisfy public notice in waiver proposal development "do not necessarily guarantee consensus on a state's planned waiver."[182]

One method states could use to solicit public input in developing a

179. *Id.*

180. One difference between public input during administrative rulemaking processes and program design under a section 1115 waiver is that the former is subject to judicial review for noncompliance under the Administrative Procedure Act (APA), whereas the latter is arguably not subject to such review. For example, rulemaking is performed in the shadow of the Administrative Procedure Act, which requires an agency to notify the public when promulgating rules. 5 U.S.C. § 553(b) & (c) (2002). The Act gives persons suffering "legal wrongs because of agency action" the right to judicial review. 5 U.S.C. § 702 (2002). "Agency action" includes the "whole or a part of an agency rule." 5 U.S.C. § 551(13) (2002). However, at least at the federal level, designing programs or standards for section 1115 waivers are arguably not subject to judicial review under the APA because such action is discretionary. 5 U.S.C. § 701 (2002) (stating that the judicial review chapter of the APA does not apply to agency action that is committed to agency discretion by law). Under 42 U.S.C. § 1315 (discussing section 1115 waivers or "demonstration projects"), the Secretary "*may* waive compliance" with certain provisions of the SSA. 42 U.S.C. § 1315 (2002) (emphasis added). It should be noted, however, that even with challenging a regulation due to lack of public notice under rulemaking, a plaintiff may still have to show an actual injury. *See, e.g.*, Paul A. Garrahan, *Note: Failing to See the Forest for the Trees: Standing to Challenge National Forest Management Plans*, 16 VA. ENVTL. L.J. 145, 168 (1996) (citing the Supreme Court who noted, "a regulation is not ordinarily considered 'ripe' for judicial review under the APA until the scope of the controversy has been reduced to more manageable proportions, and its factual components fleshed out, by some concrete action applying the regulation to the claimant's situation in a fashion that harms or threatens to harm him" in Lujan v. Nat'l Wildlife Fed'n, 497 U.S. 871, 891 (1990)).

181. GAO REPORT, *supra* note 33, at 27.

182. *Id.*

waiver proposal is to "form[] a special commission with broad representation including recipients, families, private providers and public interest representatives."[183] As noted earlier, this method most closely resembles a collaborative governance model. This collaborative governance scheme is similar to the method used by Oregon when it developed its HIFA waiver. The State of Oregon convened a committee of twenty-five different stakeholders who designed the HIFA waiver proposal.[184] All committee meetings were open to the public and it took about one year to reach a compromise proposal.[185] The committee decided not to have a wrap-around coverage feature in the program.[186] According to one state official, while consumer advocates on the committee did not like that idea, the advocates saw the compromise solution as better for Oregon. Therefore it may be presumed that the program has stakeholder support.[187] This, this collaborative governance model is likely to facilitate approval of the waiver proposal by DHHS.[188] By incorporating a consensus-based collaboration scheme among stakeholders, state HIFA waiver programs may not only result in stakeholder buy-in, but it may also satisfy a federal notice requirement.

3. Access to Private Health Coverage Information

As noted earlier, the HIFA waiver requires states to include a premium assistance program in its proposal, even if it only amounts to a pilot program.[189] In order to successfully operate premium assistance programs, states need "detailed information from potentially participating employers regarding costs, benefit package, employer share of costs and employee eligibility" in the employer's health plan.[190] Federal law requires states to collect information with regard to premium assistance programs to determine the extent of substitution of private coverage for public coverage (i.e., "crowd out") and whether those programs increase access to

183. DHHS Public Notice Letter, *supra* note 178.

184. Interview with Jim Edge, *supra* note 89.

185. *Id.*

186. *Id.*

187. *Id.*

188. *Id.* This assumption was confirmed by Kathleen Farrell of the Department of Health & Human Services (DHHS), who agreed that collaboration may facilitate approval of waiver proposals. Telephone Interview with Kathleen Farrell, HIFA Waiver Project Officer, DHHS (Sept. 11, 2002).

189. *See supra* text accompanying note 8.

190. CONN. HEALTH POL'Y PROJECT, PREMIUM ASSISTANCE PROGRAMS: WHAT ARE THEY AND COULD THEY HELP CONNECTICUT FAMILIES WITHOUT HEALTH INSURANCE? 1 (revised 2002), http://www.cthealthpolicy.org/pubs/premium.htm [hereinafter Connecticut Health Policy Project].

coverage.[191] Wisconsin's BadgerCare program requires such information in order to verify initial and continued employee eligibility in the program.[192] Therefore, access to employer health plan information is important for a state to verify whether a person is eligible for a Medicaid expansion program and to have an impact on un-insurance rates.

The ability to access employer health plan information illustrates a larger problem facing states with regard to employer health plan regulation. Due to ERISA preemption, states are often left in a regulatory vacuum when attempting to coordinate and understand public and private health insurance.[193] State law that explicitly imposes burdens on ERISA plans, such as reporting to state agencies about their coverage, "is likely to be preempted by ERISA because it relates to ERISA plans."[194] State collaborations that include employer health plan groups may fill this regulatory gap, eliminating the need for an ERISA amendment that would require employers to furnish states with health plan information.[195] Rather, employer buy-in of the health coverage expansion program, similar to the buy-in demonstrated by providers and brokers in the FOCUS and Access Health programs, may encourage employers to freely provide such information to states so that states can track program accomplishments.

Not only is state access to employer health plan information important, but so is employer access to information about the health coverage expansion program. For example, one of the biggest challenges to the FOCUS program in San Diego is getting information about the program to

191. 42 C.F.R. § 457.810(d) (2002). A recent study of SCHIP enrollment found that "growth in children's public coverage was not solely from the ranks of the uninsured, but that some substitution of public for private coverage occurred." BRADLEY C. STRUNK & JAMES D. RESCHOVSKY, CTR. FOR STUDYING HEALTH SYSTEM CHANGE, TRACKING REPORT NO. 4, WORKING FAMILIES' HEALTH INSURANCE COVERAGE, 1997-2001 3 (2002), www.hschange.org. Some degree of substitution of SCHIP coverage for employer coverage is inevitable and not necessarily bad. Private insurance premiums pose a substantial financial burden on most low-income working families, and substituting public coverage reduces this burden. *Id.*

192. WIS. DEP'T OF HEALTH & FAMILY SERVS., BADGERCARE EMPLOYER VERIFICATION OF INSURANCE COVERAGE (EVIC) FORM, http://www.dhfs.state.wi.us/badgercare/pdfs/evicformsample.pdf.

193. Peter D. Jacobson, *Regulating Health Care: From Self-Regulation to Self-Regulation?*, 26 J. OF HEALTH POL., POL'Y & L. 1165, 1171 (2001); Trubek, *supra* note 123, at 167.

194. PAT BUTLER, ERISA COMPLICATES STATE EFFORTS TO IMPROVE ACCESS TO INDIVIDUAL INSURANCE FOR THE MEDICALLY HIGH RISK, STATE COVERAGE INITIATIVES, ISSUE BRIEF 4 (Aug. 2000), http://www.statecoverage.org.

195. *See, e.g.*, Barbara J. Zabawa, *Breaking through the ERISA Blockade: The Ability of States to Access Employer Health Plan Information in Medicaid Expansion Initiatives*, 5 QUINNIPIAC HEALTH L.J. 1, 2, 33 (2001) (discussing methods states can use to access employer health plan information without an amendment to ERISA).

small businesses.[196] "Experts on premium assistance programs emphasize that small employers need more than just financial support," but also information to purchase insurance effectively and efficiently.[197] FOCUS relies on collaboration with brokers, chambers of commerce, economic development councils, and business improvement districts to help educate small businesses and spread the word about the program.[198] Increasing program participation by employers spreads more policy risk, reduces adverse selection, and keeps premium rates down.[199] Furthermore, the HIFA waiver permits states to design the benefit package for optional groups based on the benefit package offered by an HMO that has the largest commercial, non Medicaid enrollment in the state.[200] Collaboration between public and private entities would enhance state access to private health plan information, allowing for more informed decisions when designing the HIFA waiver benefit plan.

C. Collaborative Governance in HIFA Waiver Proposals Maximizes the Benefits of Collaboration

The HIFA waiver offers a unique opportunity to maximize the benefits of collaboration because HIFA would keep both federal and state governments involved. As one discovers from the collaborative governance schemes used by FOCUS and Access Health, involving federal and state governments in the collaborative project has several advantages: (a) access to greater and more stable funding sources; (b) access to a facilitator that can collect and distribute data; and (c) an avenue for accountability.

1. Access to Greater and More Stable Funding Sources

As noted earlier, one disadvantage of not coordinating a health coverage expansion program with Medicaid or SCHIP is lack of access to larger, more stable funding sources. The designers of the FOCUS program, for example, financed the program with private funds in order to maintain flexibility. Specifically, the designers found the wrap-around coverage requirement administratively burdensome. In addition, part of the success of the Illinois KidCare program compared to the Wisconsin HIPP program

196. SILOW-CARROLL ET AL., *supra* note 115, at 46.

197. PETER HARBAGE ET AL., HEALTH POL'Y R&D, THE CALIFORNIA PACADVANTAGE PREMIUM PROGRAM 23 (March 2002), http://www.healthcareoptions.ca.gov/nov01/CPPP%20328021.pdf.

198. SILOW-CARROLL ET AL., *supra* note 115, at 45.

199. *See generally id.* at 46; Connecticut Health Policy Project, *supra* note 190, at 3 (describing barriers to implementation that a Connecticut premium assistance program might encounter).

200. *See supra* text accompanying note 23.

can be attributed to the lack of wrap-around coverage in the former program. The HIFA waiver provided the flexibility in benefit design and cost-sharing levels that the program developers in the FOCUS and KidCare programs needed, but were unable to receive prior to the HIFA waiver. Consequently, future collaborations might be able to design a program like FOCUS, but with access to federal and state funds.

2. Access to a Facilitator that can Collect and Distribute Data

Involving government agencies in program design would also secure a facilitator that can collect and distribute data. Because states are required to submit HIFA waiver proposals to the federal government, the state agency automatically acts as a facilitator of the collaboration. Collaborative governance requires a flexible government agency that is engaged in the negotiation process through facilitating broad participation by stakeholders and providing information and technical resources when needed.[201] State gathering and disseminating of data is an essential function in collaborative governance schemes and is a "shift from management skills on the part of public servants to enablement skills, the skills of activating, orchestrating, and modulating these complicated relationships and networks."[202] Information gathered from collaborative initiatives will help stakeholders learn from one another, and help design future legislation.[203] Government agency involvement is crucial to the learning process that occurs in collaborative governance schemes because government is a significant stakeholder in the health care system and has valuable perspectives to share with other stakeholders.

3. An Avenue for Accountability

State agency facilitation of HIFA waiver collaborations would also help dispel concerns about accountability. As discussed in Part III, one of the biggest concerns about collaborative governance is a lack of accountability.[204] Traditional notions of accountability have included controlling government agency discretion through notice and comment and other requirements embodied in the Administrative Procedure Act.[205]

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201. Freeman, *supra* note 55, at 22.

202. Lester M. Salamon, *The Changing Shape of Government,* 28 FORDHAM URB. L.J. 13, 19, 1340 (2001).

203. *See* Freeman, *supra* note 55, at 93-94.

204. *See, e.g.*, Jack Beerman, *Public Oversight of Public/Private Partnerships,* 28 FORDHAM URB. L.J. 1357, 1358 (2001) [hereinafter Beerman Remarks].

205. Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction,* 28 FORDHAM URB. L.J. 1611, 1671-72 (2001).

Although it may be difficult to challenge an agency's HIFA waiver program proposal in court,[206] judicial review is only one form of accountability.[207] While it is true that collaborative governance schemes give private stakeholders substantial discretionary authority in designing programs, accountability within these structures is still possible. The federal government offers a clear objective through the HIFA waiver of "encourag[ing] new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources."[208] Collaborations that assemble around this clear objective are more likely to develop strategies to meet the objective.[209]

The federal government has also set minimum standards on what groups should be targeted, benefits that must be covered, and limits on recipient cost sharing.[210] Because the state agency is the facilitator of the collaboration and submits the HIFA waiver proposal to the federal government, the state maintains responsibility for the proposed project and has the information concerning the project, which should be available through public records law.[211] Furthermore, collaborative governance demands a shift in thinking about how to achieve accountability, particularly in light of the complex nature of social welfare program design.[212] Accountability can be achieved through "agency and community

206. *See supra* note 180.

207. Freeman, *supra* note 55, at 95, 97 (discussing alternatives to traditional accountability mechanisms, such as government cultivating the capacity of nongovernmental stakeholders); *see* Beerman Remarks, *supra* note 204, at 1357-58 (discussing political accountability).

208. HCFA HIFA Article, *supra* note 3, at 1.

209. DAVID MITCHELL, CONTROL WITHOUT BUREAUCRACY 107 (McGraw Hill 1979).

210. HCFA HIFA Article, *supra* note 3, at 3-4.

211. *See, e.g.*, WIS. STAT. § 19.35 (2002) (giving individuals the right to inspect records). "Record" is defined as "any material on which written, drawn, printed, spoken, visual or electromagnetic information is recorded or preserved, regardless of physical form or characteristics, which has been created or is being kept by an authority." WIS. STAT. § 19.32(2) (2002). Examples of an "authority" are "a state or local office, elected official, agency, board, commission, committee, council, department or public body corporate and politic created by constitution, law, ordinance, rule or order." WIS. STAT. § 19.32(1) (2002).

212. Freeman, *supra* note 55, at 95; Salamon, *supra* note 205, at 1672 (stating that "instead of thinking of accountability as responsibility to a single dominant unit of government that authorizes a program, third-party government institutionalizes and legitimizes multiple perspectives on the goals and purposes of programs"); Barbara L. Bezdek, *Contractual Welfare: Non-Accountability and Diminished Democracy in Local Government Contracts for Welfare-To-Work Services,* 28 FORDHAM URB. L.J. 1559, 1609 (2001) (arguing that one way to increase accountability in welfare contracts is to include citizens experienced with TANF and other work-related programs in collaborative schemes, such as a Community Congress). Professor Bezdek notes that the complex interactions

participation in corporate decision-making bodies, third-party certification or auditing of corporate practices, and increased monitoring by and disclosure directly to, communities as well as agencies."[213] Thus, a collaborative governance scheme created around a HIFA waiver proposal could achieve accountability by ensuring that all stakeholders are adequately represented with the ability to voice their concerns on health reform proposals, and that the information gathered at collaborative meetings would be disclosed to the public. Achieving adequate consumer advocate involvement in developing a HIFA waiver proposal, however, is one of several challenges to ensuring success of HIFA waiver collaborative governance schemes.

V. ENSURING THE SUCCESS OF HIFA WAIVER COLLABORATIVE GOVERNANCE SCHEMES

Although it could be argued that states should apply collaborative governance schemes when developing HIFA waiver proposals, there are some significant challenges to ensuring that the collaborations are effective. These challenges include: (a) involving consumer representatives in collaborative efforts; (b) designing a program that is "local" enough to achieve stakeholder support; and (c) convincing governmental agencies to adopt and support collaborative models. Each of these challenges is discussed below, as well as some suggestions on how to meet these challenges.

A. Adequate Consumer Representation

One of the primary threats to the legitimacy of health reform proposals created under collaborative governance schemes is the absence of some stakeholder voices, particularly those representing consumers.[214] While it is imperative that all stakeholder voices are involved in health reform proposal development, including various providers, employers, insurers, regulators, and medical/pharmaceutical device manufacturers, consumers often have the fewest resources to be effective participants in collaborative efforts.[215] "Consensus-based processes, especially those that envision continued engagement and responsibility for oversight, require a

between welfare policy and the swirling changes in wage work support the need for expanding stakeholder involvement in discussing welfare policy. *Id.*

213. Freeman, *supra* note 55, at 95.

214. *Id.* at 81.

215. *Id.* at 76 (stating that "[e]ven if they wished to embrace collaboration, however, chronically understaffed public interest groups cannot afford to participate in multiple negotiations over multiple policy issues and at the same time continue to fight their traditional battles in courts and legislatures.").

tremendous commitment of resources."[216] Furthermore, informal collaborative models have "historically worked against [consumer advocate] interests."[217]

As noted in Part III, one of the primary objections to collaborative governance is fear of collusion among stakeholders.[218] Yet, health care consumer advocate participation in HIFA waiver proposal development is essential. Consumer advocates could guard against removal of the most essential services in the new expansion programs while ensuring that the savings from eliminating nonessential services are used to expand coverage to new groups. Consumer advocate participation in public-private collaboration helps guarantee that any cost sharing mechanism is realistic for low-income people. Thus, consumer advocate participation is a critical component to the success of collaborative governance structures. However, it may be difficult to bring consumer groups to the table, either because they lack resources or are suspicious that such collaborative efforts can really work in their favor.

State agency facilitation of these collaborative groups is essential to securing adequate representation of consumer interests.[219] At the very least, state agencies could appoint a consumer advocate for underrepresented groups to participate in these collaborative efforts.[220] To strengthen the technical and financial resources of consumer advocacy groups in these new governance structures, "agencies could build institutional capacity by promoting connections between universities and community groups or by investing directly in community organizations."[221] Capacity-building reinforces the state agency's role as facilitator of collaborations. Building institutional capacity may enhance the consumer interest and increase the knowledge base of consumer advocates with respect to participating in collaborative health reform efforts. For example, there is a dearth of community-based consumer advocates who are interested in or understand private health insurance issues.[222] Yet, consumer advocate knowledge of

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216. *Id.*

217. *Id.* at 75 (referring to lawyers involved in environmental advocacy and how collaboration has historically worked against them).

218. *See supra* text accompanying notes 76-79.

219. Freeman, *supra* note 55, at 81.

220. *Id.* at 82.

221. *Id.* at 81-82.

222. Telephone Interview with Alice Weiss, Director of Health Policy, National Partnership for Women and Families (Aug. 28, 2002). Proportionately, the number of private health insurance ombudsman programs pales in comparison to the number of Medicare or Medicaid programs. Telephone Interview with Jackie Fox, Private Sector Coordinator, Families USA Health Assistance Partnership Project (July 22, 2002). Specifically, there are forty official ombudsman programs (20 that actually provide advocacy

private health insurance issues would be particularly useful in the design of premium assistance programs under the HIFA waiver. State agencies can strengthen consumer representation by providing educational resources to consumer advocates about private health insurance matters, thereby creating a more balanced discussion between stakeholders.

The study of community organization as applied to health behavior and education might provide a theoretical framework that state agencies could use to help mobilize consumer interest in health reform collaborations. Health education scholars emphasize that to maximize community interest and involvement in an issue, the change agent must "start where the people are."[223] That is, the agent must allow the community to identify its needs and concerns.[224] In the area of health reform, there are many consumer-based community groups that have already identified health coverage expansion as a central concern. For example, in Wisconsin, groups such as the Citizen Action Health Care Task Force,[225] BadgerCare Coordinating Network,[226] and the Dane County HealthWatch[227] meet regularly to discuss health coverage access issues. State agencies could tap into these existing groups in their capacity-building efforts and recruit members to participate in HIFA waiver collaborations.

In addition to state agencies, law school clinics could increase the number of consumer advocates interested in participating in health reform collaborations. Although this solution may not address immediate HIFA waiver proposals, it does offer a solution for future collaborative governance schemes. Law school clinics that focus on health care advocacy may broaden future lawyers' views on their role in achieving justice through collaborations. One clinical law professor notes:

> Lawyers and law students, working with leaders from other disciplines

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services) for the 126 million people with private health insurance; twenty-five to thirty official ombudsman programs for the 60 million people on Medicaid; and 1500 SHIP (State Health Insurance Assistance Programs) programs to assist the approximately 60 million people on Medicare. *Id.*

223. Meredith Minkler, *Improving Health Through Community Organization*, HEALTH BEHAVIOR & HEALTH ED. 270 (Karen Glanz et al., eds. 1990).

224. *Id.* at 271.

225. *See, e.g.*, Press Release, Wis. Citizen Action, Citizen Action Says No to Privatizing Medicare, *at* http://wica.fp.execpc.com/no_to_privatizingmed.htm (discussing a coalition comprising of senior citizens, physicians, nurses, labor, health care advocates and farmers).

226. BadgerCare Coordinated Network Mission Statement, *supra* note 115.

227. ABC FOR HEALTH, HEALTHWATCH COMMITTEES, *at* http://www.abcforhealth.org/projects/hw/index.asp (stating that the mission of the HealthWatch Committee of Dane County is to "advocate for and with low-income families in south-central Wisconsin on issues relating to access and quality of health care services, with a particular emphasis on Medicaid managed care.").

> and backgrounds, including representatives from empowered grassroots organizations, can learn by observing and interacting with expert problem solvers. Additionally, they may learn to be sensitive to more collaborative, facilitative forms of lawyering, in which they must adapt to teamwork, group decision-making, and identifying and solving problems directed by others.[228]

As argued in Part IV, health reform proposals demand collaboration between health system stakeholders. Health advocacy clinics could teach law students about our health care system by combining individual consumer representation with participation in community collaborations. "Individual cases . . . can inform lawyers of more systemic problems that may be at work in the community."[229] Individual case representation gives students a valuable health care stakeholder perspective (in addition to their own consumer status) that can be offered at stakeholder negotiations. Part IV noted that community collaborations already exist around health system reform, illustrating the movements down and out. Consequently, health advocacy clinics should be able to find a number of collaborations that can involve law students. Through these community collaborations, future consumer advocates could learn about the health care system from other stakeholder perspectives, preparing them to be effective advocates for health reform collaborations.

B. Designing Locally-Based Programs

Another challenge for implementing successful HIFA waiver proposals through state-based collaborations will be designing a program that meets the needs of different localities within each state. For example, Wisconsin learned through its State Planning Grant initiative that "each locality, whether it be a county, city, provider network or some other entity, faces its own unique challenges with regard to issues of the uninsured."[230] The successful FOCUS and Access Health programs described earlier served geographic areas much smaller than an entire state. The success of these smaller programs may relate to their ability to provide increased experimentation and greater transparency and accountability to local stakeholders.[231] Furthermore, narrowing the geographic focus of a proposed

228. Andrea M. Seielstad, *Community Building as a Means of Teaching Creative, Cooperative, and Complex Problem Solving in Clinical Legal Education,* 8 Clinical L. Rev. 445, 495-496 (2002).

229. *Id.* at 493.

230. WIS. DEP'T OF HEALTH & FAMILY SERVS., STATE PLANNING GRANT REPORT, *supra* note 119, at 59.

231. Trubek, *supra* note 108, at 599-600.

program may increase the ability to achieve adequate stakeholder representation and program buy-in. It may be difficult for a state to facilitate a collaboration that could agree on a single program that will satisfy the varying health coverage needs across the state.

One way the states could overcome this difficulty is by submitting multiple HIFA waiver proposals. The state could convene several collaborations in different areas across the state so that each locality's unique health coverage needs are addressed. One DHHS official confirmed that multiple submissions of HIFA waiver proposals by state region is a valid use of the HIFA waiver.[232] Although multiple HIFA waiver proposal submissions may be administratively burdensome for state agencies, more tailored programs to each state region may have a better chance of meeting the HIFA waiver's goal of expanding health coverage.

C. Government Agency Adoption and Support of Collaborative Governance Models

Although collaborative governance could satisfy public notice requirements under the HIFA waiver, there are other methods of public notice that employ fewer resources and thus may be more attractive to both state and federal governments. Forming a special commission with broad representation is only one of several methods that states can use to achieve public notice.[233] Other methods, such as public presentations, forums, or newspaper notices take less agency time and resources. Collaborative methods that require consensus take much longer and may create difficulty in achieving closure.[234] For example, even in the Access Health program, which was designed at the county level, the "community almost gave up at one point prior to implementing Access Health because it was unclear that local stakeholders would ever agree on how to solve the problem of the uninsured."[235] The small number of negotiated rulemaking applications by government agencies also demonstrates the unpopularity of collaborative devices.[236] Surveys of government agencies indicate that the lack of popularity of negotiated rule-making stems from the belief that other methods of public notice achieve the same result as collaborative governance schemes.[237] "Negotiated rulemaking merely adds formalities (e.g., publication of notice regarding committee appointment, use of a

232. Interview with Kathleen Farrell, *supra* note 188.
233. *See supra* text accompanying notes 178-79.
234. Telephone Interview with Alice Weiss, *supra* note 222.
235. SILOW-CARROLL ET AL., *supra* note 115, at 7.
236. *See supra* text accompanying note 102.
237. McKinney, *supra* note 57, at 509-10.

facilitator, and so on) to regular rulemaking which informally accomplishes the same end."[238] Specifically, the surveyed agencies stated that informal conferences and consultations obtained stakeholder viewpoints and advice with respect to contemplated rulemaking.[239]

However, such informal consultations may foster adversarialism among stakeholders and fail to achieve the benefits of collaborative governance. Collaboration allows stakeholders to learn from one another about the complex health system during the *development* of program proposals, rather than just respond to proposals created by the agency. The success of the collaborations, described in previous sections, hinged on stakeholder learning and compromise during program development. Thus, although collaboration may be more time consuming and perhaps more frustrating for government agencies to employ, the quality of the program designed through a collaborative process may be far superior to programs designed using other public involvement methods.

One might wonder whether the HIFA benefit level and cost-sharing standards would have faced less opposition from consumer advocates and providers had DHHS developed those standards using a collaborative governance mechanism. Instead, DHHS and the federal Office of Management and Budget worked on the HIFA waiver guidelines without public input.[240] DHHS could incorporate collaborative governance into HIFA waiver (or future waiver) guideline development, thereby achieving more stakeholder buy-in and setting an example for states to follow when they design their waiver proposals.[241]

Furthermore, DHHS could support state-based collaborative efforts by requiring states to develop HIFA waiver proposals under a collaborative governance model. Since many of the HIFA waiver's objectives could benefit from public-private collaboration, DHHS would send a clear message to states by limiting the public input requirement to only the collaborative model, rather than the civic republicanism or interest representation models. Alternatively, DHHS could track how states achieve public input. Currently, a state verifies with DHHS whether it "has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration" by checking a box on the

238. *Id.* at 509.

239. *Id.* at 509-10.

240. Telephone Interview with Therese Klitenic, Health Insurance Specialist, Centers for Medicare and Medicaid Services (Sept. 4, 2002).

241. By employing collaborative governance schemes at the federal level, DHHS may also be able to satisfy its duty to solicit public comment on waiver proposals, as it vowed to do in its' 1994 Federal Register notice. KFF CHIP Waiver Article, *supra* note 8, at 12; GAO REPORT, *supra* note 33, at 4.

HIFA waiver application.[242] DHHS does not track the types of public input methods used and the success of those methods. Since states like New Mexico, Illinois and Oregon have employed collaborative governance schemes at some point during the development of their HIFA waiver proposals, it would be interesting to study the success of those programs compared to states that use less collaborative approaches to achieve public input.[243] If data could show that programs designed under a collaborative governance approach are more successful at expanding health coverage, then more states might adopt such approaches when attempting to reform the health system.

VI. CONCLUSION

Health care costs are soaring higher than any other economic category as measured by the Consumer Price Index, and this impacts all health care stakeholders.[244] Medicaid programs are not immune to rising costs, and under difficult economic conditions, states are unlikely to throw more money at an already enormous program.[245] Yet solving the growing uninsured problem is equally important, and many health policy experts view expanding Medicaid and SCHIP as a means to achieve universal coverage.

The HIFA waiver is one vehicle that states could use to develop such expansion programs. The HIFA waiver encourages states to expand health coverage through flexibility in benefit design and public-private partnership, while also under budget neutral conditions, at least with respect to federal funds. Advocates are concerned that the combination of HIFA waiver budget neutrality, flexibility in structuring benefit and cost-sharing levels, and tight state budgets will lead to programs that reduce benefits, raise cost-sharing levels, or limit the number of people eligible for the

242. DEP'T OF HEALTH & HUM. SERVS., SAMPLE HIFA WAIVER APPLICATION 2 (2001), *at* http://cms.hhs.gov/hifa/hifatemp.pdf; Interview with Kathleen Farrell, *supra* note 188.

243. NEW MEXICO GRANT REPORT, *supra* note 132; Telephone Interview with Jane Longo, *supra* note 155; Telephone Interview with Jim Edge, *supra* note 89.

244. Victoria Colliver, *Big Surge in the Cost of Health Care; 4.9% Increase in Past Year Exceeds Overall Inflation Rate,* S.F. CHRON., Aug. 17, 2002, *available at* http://sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2002/08/17/BU126675.DTL. Nationally, health care costs jumped nearly five percent over the past year, and this increase was attributed to higher labor costs, skyrocketing prescription drug and hospital expenses, and increased use of medical services. *Id.*

245. Robin Toner & Sheryl Gay Stolberg, *Decade After Health Care Crisis, Soaring Costs Bring New Strains,* N.Y. TIMES, Aug. 11, 2002, *available at* http://www.nytimes.com/2002/08/11/health/11HEAL.html; Raymond Scheppaeh, Remarks at the AAHP Conference on Expanding Coverage for the Uninsured (Sept. 12, 2002) (notes on file with author).

program.[246]

However, there is hope that states can expand health coverage under a collaborative governance approach, as demonstrated by several health coverage expansion initiatives like FOCUS, Health Access, and Illinois KidCare. These collaborative efforts could serve as models for HIFA waiver proposals. As these examples show, true collaboration requires commitment, learning and compromise, which may be a hard sell to groups that are accustomed to an interest representation environment and that often lack resources to adequately bargain in collaborative groups. Yet with proper state and federal support of collaborative governance, as well as better training of future health care advocates (such as through law school clinics), an increased number of underrepresented groups may feel comfortable collaborating with other health system stakeholders. Indeed, all stakeholders would benefit from all-inclusive collaboration, because the health system is too complex for stakeholders to reform on their own.

Many attribute the failure of President Clinton's health reform proposal to the lack of a collaborative approach in developing the proposal.[247] "Top-down social engineering by Washington's central planners is now intuitively rejected as an anachronism, a hopelessly inefficient throwback to the bygone era of the Machine Age."[248] The complexity of the U.S. health care system demands government agencies to adopt networked or collaborative governance approaches rather than hierarchical approaches (such as civic republicanism) to reform health care.[249]

Moreover, collaborative governance under budget neutral conditions does not have to result in poorer quality programs. Public-private collaboration could establish greater continuity of coverage for low-income people.[250] Specifically, collaboration may help Medicaid-based programs keep up with private health insurance market changes, causing less traumatic change when people shift from public to private coverage. Furthermore, by working together, stakeholders may stumble on ideas that actually improve health within the confines of current funding levels. For example, collaborators may find that improving the quality of care for one

246. *See, e.g.*, NAT. HEALTH LAW PROGRAM, WHAT IS HIFA AND WHY SHOULD WE BE CONCERNED (2002), *available at* http://www.healthlaw.org/waiver.shtml.

247. Michael Rothschild, *Why Health Care Reform Died,* WALL ST. J., Sept. 22, 1994, *available at* http://www.binomics.org/text/resource/articles/ar_026.html; Michael Levin-Epstein, *How We Got it Anyway: The Clinton Health Plan Never Died,* MANAGED CARE, Oct. 2000, at 5, *available at* http://www.mangedcaremag.com/archives/0010/0010.clinton.html.

248. Rothschild, *supra* note 247.

249. Levin-Epstein, *supra* note 246 (observing that "[t]here is no one in Washington smart enough to write a health care plan that will solve everybody's problem.").

250. Jacobi, *supra* note 10, at 115.

health condition may free up health care dollars to expand coverage to other individuals.[251]

Alternatively, stakeholder buy-in may be strong enough to support a fee on insurers or businesses, or donation of stakeholder resources (as the brokers and providers did in the FOCUS program) in order to expand coverage. The flexible conditions under the HIFA waiver attempt to foster innovative ways to expand coverage with greater efficiency, which is a laudable goal in a country that spends more per capita on health care without improved performance on health status measures.[252] Increasing Medicaid budgets is not necessarily a better alternative to expanding health coverage and improving health, as some advocates suggest.[253] With mounting evidence of poor patient quality, such as that discussed by the Institute of Medicine's Report on patient safety,[254] much can still be done to improve population health within current health care resources.

Health system stakeholders have a wealth of information to offer each other in a collaborative scheme. The HIFA waiver's flexibility and emphasis on public-private coordination offers states a perfect opportunity to learn *with* other stakeholders and the best chance of closing the health coverage gap.

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251. For example, in Asheville, North Carolina, the city as an employer offered free medications and supplies to diabetic employees in exchange for employee attendance of a health class and monthly check in with a pharmacist. *See* Ceci Connolly, *In N.C., Improving Worker Health – and Cutting Costs,* WASH. POST, Aug. 20, 2002, at A01, *available at* http://www.washingtonpost.com/ac2/wp-dyn/A37834-2002Aug19.html. The project has saved the city money, as well as reduced emergency room and staff demands in area hospitals. *Id.* Such savings could be applied to health coverage expansion programs.

252. Gerard Anderson & Peter Sotir Hussey, *Comparing Health System Performance in OECD Countries,* HEALTH AFFAIRS, May/June 2001, at 227-29. Specifically, compared to other countries belonging to the Organization for Economic Cooperation and Development (OECD), the U.S. spent the most on health care as a percentage of Gross Domestic Product (13.6% in 1998), but performed relatively poorly on infant mortality, child mortality, and potential years of life lost and was similar to the median OECD country on life expectancy and disability-adjusted life expectancy at age sixty. *Id.*

253. PARK & KU, *supra* note 9, at 11 (stating that to relieve states from making the choice between cutting back on Medicaid and expanding coverage, "the federal government could instead provide states additional financial resources and incentives.").

254. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM, (LINDA T. KOHN ET AL., eds., 2000), *available at* http://books.nap.edu/html/to_err_is_human/Exsum.PDF. According to the Institute of Medicine report, between 44,000 and 98,000 Americans die each year as a result of medical errors. *Id.* at 1. This costs the nation between $17 billion and $29 billion, not even counting errors that occur outside the hospital system. *Id.* "Errors are also costly in terms of opportunity costs. Dollars spent on having to repeat diagnostic tests or counteract adverse drug events are dollars unavailable for other purposes." *Id.* at 2. As a result, the IOM report states "it would be irresponsible to expect anything less than a 50% reduction in errors over five years." *Id.* at 3.