

There are currently several types of waivers that states can use to increase flexibility in their Medicaid program and health insurance Marketplace. Below are summaries of the most common types of waivers, the various authorities each waiver includes, and resources for more information on each type.

Medicaid and CHIP Waivers

1115 Waivers

An [1115 waiver](#) is the broadest type of waiver available under Medicaid. Officially, these waivers are to be used by states to create demonstration projects intended to improve Medicaid and/or CHIP programs, and they must include a formal evaluation of impact. Under an 1115, states may propose to waive many of the key provisions of the Medicaid statute, including but not limited to: which individuals are covered; which benefits must be provided; how much individuals may be charged for premiums and copayments; and how providers will be paid. An 1115 waiver can be very broad or very narrow, depending on the state's goals. All 1115 waivers are currently required to be budget neutral to the federal government, meaning the state will receive no more federal funding than it would have received without the waiver. State submit its 1115 waiver request to CMS for review and approval; they are typically approved for an initial 5 year period and can then be extended another 3 years if requested and approved. [Federal transparency rules](#) -- which require public input at the state level and again during the CMS review -- apply to all new 1115 waivers and renewals of existing waivers. See NACHC's [1115 waiver website](#) and [issue brief](#) on 1115 waiver transparency for more information.

1915(b) Waivers

A [1915\(b\)](#) waiver allows a state to require Medicaid patients to participate in managed care for some or all of their benefits (except for family planning). It is known as a "freedom of choice waiver" because it permits the state to waive the statutory requirement granting patients the freedom to choose any provider who accepts Medicaid. Historically, CMS has held that states that implement a 1915(b) waiver meet the statutory requirement that FQHCs are a required benefit as long as at least one Managed Care Organization (MCO) *in each service area* contains at least one FQHC in its network. Under [guidance published in April 2016](#), effective July 2017, *each MCO* must include at least one FQHC in its network, regardless of how many other MCOs are in the service area. The majority of states currently have [1915\(b\) waivers in effect](#). CMS has a standard template for states to submit these waivers, and they are typically approved for an initial two years, and can be extended every two years. Of note, there are no transparency requirements.

1915(c) waivers

A [1915\(c\)](#) waiver permits states to offer home and community based services (HCBS) to limited groups of enrollees as an alternative to institutional care. This waiver also enables the state to cap who receives HCBS services and to waive a few other Medicaid statutes, including some income requirements. To be eligible for HCBS, patients must qualify for care in an institution. 1915(c) waivers are required to be budget neutral. They are submitted to CMS for approval and are typically approved for 3 years with the possibility of a 5 year extension. Of note, there are no transparency requirements. Click [here](#) for more information regarding the general outline of 1915(c) waivers.

Follow this [link](#) to learn about existing Medicaid and CHIP Waivers by state.

Marketplace Waivers

1332 Waivers

A [1332 waiver](#), otherwise known as a “State Innovation Waiver,” allows states to waive ACA provisions related to the Health Insurance Marketplaces and the individual and employer mandates. However, these waivers cannot be used to waive the basic protections of the ACA (e.g., prohibition on lifetime caps, nondiscrimination provisions, guaranteed access to fair prices for all enrollees). All 1332 waivers must:

- provide coverage that is at least as comprehensive and affordable as would be provided absent the waiver;
- cover a comparable number of state residents as would be covered absent a waiver; and
- not increase the federal deficit.

Section 1332 waivers cannot be used to waive statutory provisions in the Medicaid, Medicare, CHIP, or the Public Health Service Acts; however, they can be coordinated, and submitted in conjunction with, waiver requests involving these programs. There are requirements for meaningful public input on the proposals both during the [state development process](#) and the [Federal review process](#). State Innovation Waivers are to be approved for five-year periods, and can be renewed. Read NACHC’s [issue brief](#) on 1332 waivers and health centers to learn more.

General Summaries of Medicaid and CHIP waivers

- [CMS waiver website](#)
- [MACPAC waiver website](#)
- [MACPAC Medicaid 101 waiver overview](#)
- [Kaiser Family Foundation on Waivers](#)