

medicaid
and the **uninsured**

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**NEW DIRECTIONS FOR MEDICAID SECTION 1115 WAIVERS:
POLICY IMPLICATIONS OF RECENT WAIVER ACTIVITY**

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EXECUTIVE SUMMARY

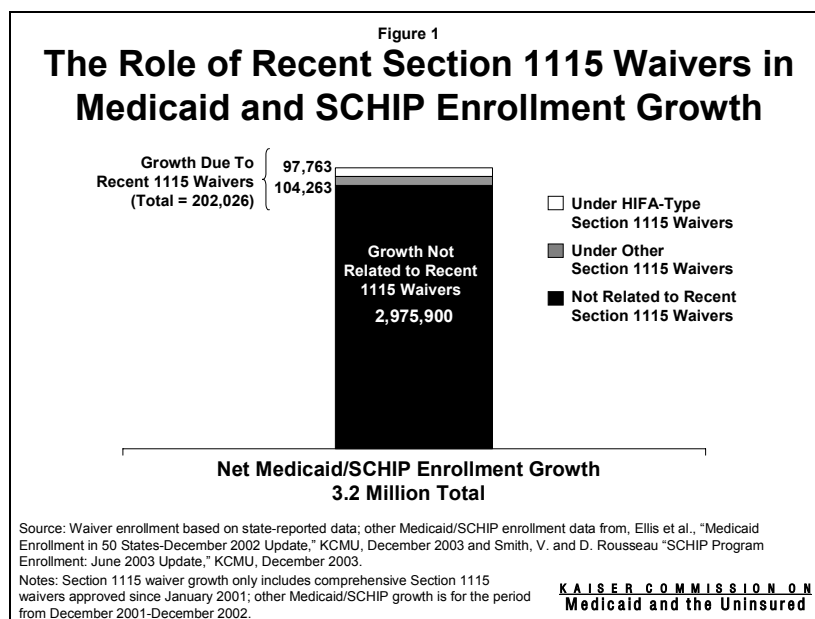
Medicaid finances health coverage for low-income families and elderly and disabled people. Often poorer and sicker than the privately insured, Medicaid enrollees rely on the program for preventive, medical, and long-term care services. The federal government and the states jointly fund Medicaid, with the federal government paying 50% to 77% of the costs, depending on the state. States administer the program guided by a combination of federal standards and state options that qualify them to receive federal matching funds.

Section 1115 waivers give states federal approval to alter the way they provide coverage and/or deliver services to the low-income population outside of the federal standards and options and still receive federal matching funds. That is, they allow states to use federal Medicaid funds in ways not otherwise allowed under federal law. States have used waivers to test and try a variety of changes affecting program coverage and costs throughout the 40-year history of the Medicaid program. For example, in the mid-1990's a number of states relied on waivers to require beneficiaries to enroll in managed care, a service delivery option that later became available to states without a waiver. Tennessee, Oregon, New York and others used waivers to significantly expand coverage to new groups, using managed care savings or redirected Disproportionate Share Hospital (DSH) funds to meet budget neutrality requirements of the federal government.

Waivers have been used in good and bad economic times both to try new ways to provide coverage for the low-income population as well as to try alternative approaches to contain costs. Over the past few years, as states have faced significant budget shortfalls and increasingly difficult fiscal situations, new federal waiver guidelines offered states increased programmatic flexibility through waivers and new financing mechanisms to meet budget neutrality requirements. This combination of severe fiscal pressure on states and increased flexibility has led to a new round of waiver activity. Recent waiver activity has focused on reducing coverage to relieve state fiscal pressures, affecting enrollment, benefits, and affordability of coverage and care. Most recently, a few states have begun considering waivers that would make broader structural changes to the Medicaid program with the goal of limiting costs.¹

Seventeen states have had comprehensive Section 1115 waivers approved since January 2001. This brief provides an overview of this recent waiver activity and reviews the implications for coverage and access to care:

- It is difficult to achieve new coverage through waivers without additional federal financial support.** The Administration’s 2001 Health Insurance Flexibility and Accountability (HIFA) waiver initiative promoted the use of section 1115 waivers to “increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources.”² Providing expanded program flexibility without additional federal resources has not created much new coverage—overall, a net gain of about 200,000 people nationwide as of Fall 2003 (Figure 1). In the first few years following the HIFA waiver initiative, some states obtained waivers to expand coverage. However, several of these waivers were never or only partly implemented. In a few states where new coverage was offered, enrollment was later closed due to state fiscal pressures or federal financing caps. In two states (Oregon and Tennessee), the changes made through waivers led to net coverage reductions. Without additional federal financing, increased programmatic flexibility does not appear to be sufficient to support ongoing substantial coverage expansions.



- Through recent waivers, states have made changes in eligibility, enrollment, benefits, and premiums and cost sharing (Table 1).** In some cases, these waivers have focused solely on reducing—rather than expanding—coverage to limit or reduce spending. Enrollment caps have resulted in coverage being provided on a first come, first serve basis. New premiums and enrollment fees have contributed to significant coverage losses and/or created barriers to obtaining coverage, particularly among those with the lowest incomes. Limited benefits and higher cost sharing requirements have made it difficult for some beneficiaries, particularly the lowest income beneficiaries, to obtain care and, in some cases, have shifted costs onto health care providers.
- Waiver flexibility is not necessarily sufficient to prevent other program cutbacks.** Reductions made under recent waivers have sometimes been sought to stabilize the program and prevent other coverage reductions. However, some states that have used waivers to

reduce spending have still needed to pursue additional program cutbacks to address their budget problems.

Table 1: Key Features of Recent Waiver Activity

Features	Implications	Examples
Eligibility expansions to adults without dependent children	<ul style="list-style-type: none"> Allows states to cover groups excluded from Medicaid under federal law Size, scope, and implementation limited by availability of state funds and federal budget neutrality requirements Coverage and/or care may be limited by enrollment caps, premiums, limited benefits, and/or cost sharing 	DC, ME, MI, NM*, NY, OR, UT
Enrollment caps	<ul style="list-style-type: none"> Eliminates guarantee to coverage for those who qualify Enrollment based on first come first serve, not income or health needs Allows states to quickly reduce program costs by freezing enrollment 	CO, MA, MI, NJ, NM*, OR, UT
Reduced benefits; new or increased premiums and/or cost sharing	<ul style="list-style-type: none"> Limits access to coverage and/or care Potential for unmet medical needs and increased uncompensated care Reduces state/federal program costs 	NM*, OR, UT, WA*
“Premium assistance” with limited or no benefit or cost sharing standards and no wraparound coverage	<ul style="list-style-type: none"> Potential to improve access to providers through employer-based plans, but availability of these plans is limited for the eligible population Cost sharing and coverage restrictions could limit access Potential to contain state/federal costs, but may not be cost effective 	ID, IL, MI, OR, UT <i>(ID, IL, and MI allow people to choose premium assistance or direct coverage)</i>
Different benefits and cost sharing for different groups within a state	<ul style="list-style-type: none"> Allows states to selectively limit benefit packages May enable states to retain or expand coverage, but some individuals may not be covered for needed services or able to afford higher cost sharing Increases administrative complexity Confusion could dampen participation among eligible people and providers 	MI, OR, TN, UT

**Denotes that the waiver has not been implemented as of February 2005.*

As of February 2005, enrollment in the Michigan and New Jersey expansions was closed. Enrollment in Utah’s Primary Care Network expansion was also closed although enrollment in its premium assistance expansion remained open. Enrollment in Oregon’s OHP Standard program, which covers previously eligible parents and other adults with incomes below poverty, was closed. In Maine, an enrollment freeze has been announced but not yet implemented.

- Waivers can further increase complexity in the Medicaid program.** Through recent waivers, some states have established different benefits and cost sharing for different groups of beneficiaries. Tiered benefits and cost sharing enables states to selectively limit benefit packages for existing and/or new groups of beneficiaries. This can help enable states to preserve or expand coverage but can lead to individuals lacking coverage for needed services or being unable to afford cost sharing requirements. Further, tiered structures are more complicated for states to administer and have led to reports of dampened provider participation due to increased program complexity and of individuals not seeking care because of confusion surrounding their coverage.

- **In exchange for the increased flexibility provided through waivers, states must accept a cap on federal financing.** Under longstanding federal policy, waivers must be “budget neutral” for the federal government, meaning that a waiver must not result in greater federal Medicaid spending than would have occurred without the waiver. As such, states that obtain waivers must agree to a budget neutrality cap on federal financing. The cap is the mechanism the federal government uses to enforce budget neutrality. It limits a state’s access to open-ended federal financing, putting the state at risk for costs that exceed the cap and creating the potential for the state to experience additional fiscal stress over time.

Much of the recent round of waiver activity has been directed toward limiting coverage and spending, although some recent waivers have led to people gaining coverage or retaining coverage that otherwise might have been lost to due budget pressures. Medicaid is already a lean program, spending less per person than private insurance after adjusting for age and health status.³ To the extent that recent waivers have achieved savings they have done so largely by narrowing or eliminating coverage through benefit reductions, higher premiums and cost sharing, and enrollment caps for low-income beneficiaries. Given the limited resources and poor health of many beneficiaries, these changes have adversely affected some beneficiaries’ coverage and access to care and, in some cases, increased pressures on their providers. In light of the scope of changes that have been made, the more far-reaching waiver initiatives that a few states are considering, and the lessons that can be learned from waivers in the context of the broader debate over Medicaid restructuring, it is important that they be carefully considered, evaluated, and publicly debated.

I. INTRODUCTION

Medicaid provides coverage for preventive, medical, and long-term care services for low-income families, the elderly, and people with disabilities and is jointly funded by the federal government and states. On average, the federal government contributes 57% of funds, while states pay the remaining 43%. The State Children's Health Insurance Program (SCHIP), enacted in 1997, is also jointly funded by the federal government and states and provides coverage for additional low-income children. States administer their Medicaid and SCHIP programs subject to requirements and options established by federal law. Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services (HHS) authority to waive some of these requirements to permit states to undertake "research and demonstration" projects that further the purposes of Medicaid and SCHIP.⁴ These waivers allow states to use federal Medicaid and SCHIP funds in ways that are not otherwise allowed under federal law.

Section 1115 waivers are not new to Medicaid and SCHIP. However, federal initiatives to promote waivers⁵ and state fiscal pressures have led to an increasing number of waivers in recent years. In the past, most Medicaid Section 1115 waivers included some expansion of coverage. Recently, states have obtained waivers that focus on reducing coverage to relieve state fiscal pressures through changes to enrollment, benefits, premiums, and cost sharing. The waiver planning currently underway in a few states would result in broader structural changes to the Medicaid program. This brief provides an overview of recent, approved Section 1115 waivers and discusses their implications for coverage and access to care.⁶

II. OVERVIEW OF RECENT SECTION 1115 WAIVERS

Between January 2001 and March 2005, 17 states had comprehensive Section 1115 waivers and waiver amendments approved (Table 2).⁷ Some states had more than one waiver or amendment approved during this time period. A number of waivers and amendments also are pending.⁸

**Table 2:
Approved Comprehensive Section 1115 Waivers, January 2001-March 2005**

	Key Features	Imple- mented?
AZ	Allows state to use SCHIP funds to expand eligibility for parents, for whom the state can cap enrollment, and to refinance existing (Medicaid-financed) childless adult coverage. An amendment for a small pilot premium assistance program is pending.	Yes
CA	Allows state to use SCHIP funds to expand eligibility for parents. (State is currently developing a new waiver.)	No
CO	Allows state to use SCHIP funds to expand eligibility for pregnant women.	Yes
DC	Allows DC to redirect Disproportionate Share Hospital (DSH) funds to expand eligibility for childless adults between ages 50-64.	Yes
ID	Allows state to provide premium assistance for private coverage with no minimum benefit or cost sharing benchmarks to SCHIP-eligible children as an alternative to direct coverage, at the option of the beneficiary.	Yes
IL	Allows state to use Medicaid and SCHIP funds to expand eligibility for parents and to refinance some state-funded health programs. The state can also provide premium assistance for private coverage with minimal benefit and no cost sharing benchmarks for some beneficiaries as an alternative to direct coverage, at the option of the beneficiary.	Partially
ME	Allows state to redirect allocated but unspent DSH funds to expand eligibility for childless adults.	Partially
MA	Amendment to original MassHealth waiver allows state to cap enrollment for certain adults, including some adults with disabilities, some parents, and HIV-positive adults. A pending amendment would allow the state to narrow the disability determination standard and process, making it more difficult for individuals to qualify on the basis of disability. Original MassHealth waiver was recently renewed, and renewal altered some financing terms.	Yes
MI	Allows state to use SCHIP funds to expand eligibility to very low-income childless adults. Some of these adults were previously covered through a state-funded program. Adults have the choice of limited direct coverage or premium assistance for private coverage with minimal benefit and no cost sharing benchmarks. An amendment allowed the state to eliminate inpatient hospital coverage for childless adults in exchange for eliminating their copay for emergency room care and lowering their copay for prescription drugs.	Yes
MS	Outside of its waiver, the state planned to eliminate coverage for 65,000 elderly and disabled Medicaid beneficiaries (mostly dual eligibles) on October 1, 2004; this elimination was delayed by court order. The waiver allows the state to provide reduced Medicaid benefits to two subsets of the 65,000 beneficiaries affected by the coverage elimination: (1) 12,000 individuals who are dual eligibles that have one of four specific diagnoses and (2) 5,000 individuals who were not dual eligibles (i.e., not eligible for Medicare). The remaining 48,000 beneficiaries lose all coverage.	Yes
NJ	Allows state to reduce benefits for some parents already enrolled in Medicaid in order to finance coverage for a closed group of 12,000 parents whose applications were pending approval when the state reduced parent eligibility in June 2002.	Yes
NM	Allows state to use SCHIP funds to expand eligibility for parents and other adults, providing a limited benefit package (with premiums and cost sharing). An employer contribution is required, or individuals must pay both employer and employee costs.	No
NY	Allows state to expand eligibility for parents and to redirect DSH funds to cover other adults, providing nearly full benefits without premiums or cost sharing.	Yes
OR	Allows state to reduce benefits, increase cost sharing, and cap enrollment for previously eligible parents and other adults. Subject to availability of state funds, allows state to modestly expand eligibility for children and pregnant women; to more broadly expand coverage for parents and other adults, for whom enrollment can be capped; and to use SCHIP funds to refinance and modestly expand a preexisting state-funded premium assistance program. An amendment allows the state to make further changes in benefits for previously eligible poor parents and other poor adults, so long as a core set of services, which does not include hospital care, is covered. The amendment also allows the state to modestly expand SCHIP and FHIAP eligibility.	Partially
TN	2002 waiver allows state to significantly revise the preexisting TennCare waiver by restricting eligibility and benefits for some groups of children and adults. Waives the Early and Periodic Screening, Diagnostic, and Treatment benefit for some optional children. A 2005 amendment allows the states to eliminate coverage for over 300,000 adult enrollees. Pending proposed amendment changes would make further changes in premiums, copays, and benefits and give the state broad authority to make other changes if spending exceeds spending targets.	Partially
UT	Allows state to expand eligibility for parents and other adults, subject to an enrollment cap. They receive a benefit package limited to primary care services with an enrollment fee and copays. Also permits increased cost sharing and modest benefit reductions for previously eligible lower-income parents. An amendment allows the state to provide premium assistance for private coverage with no benefit or cost sharing benchmarks to parents and other adults who would be eligible for the expansion but who have access to employer-sponsored insurance. A second amendment lowered the enrollment fee for primary care services coverage for very low-income adults.	Yes
WA	Allows state to charge premiums for some children previously eligible for Medicaid.	No

III. KEY FEATURES OF RECENT WAIVERS

A. Financing

As in previous waivers, recent waivers do not provide states with any new federal funds to expand coverage. Under longstanding federal policy, waivers must be “budget neutral” for the federal government, meaning that the waiver must not result in greater federal Medicaid or SCHIP spending than would have occurred without the waiver. Therefore, states that use waivers to expand coverage must finance the expansions by creating savings in their programs or by redirecting existing Medicaid or SCHIP resources.

Many earlier waivers relied on savings from managed care to implement coverage expansions. Today, such savings are largely not available to states since most states with capacity to rely on managed care have already made those changes. Under recent waivers, states that expanded coverage generally relied on several types of financing mechanisms to offset the cost of the expansion, including two new approaches promoted in the Administration’s 2001 HIFA waiver guidelines.⁹

- Reducing the cost of coverage for existing beneficiaries. Under an approach explicitly endorsed by HIFA, three recent waivers offset the cost of an expansion by reducing coverage for existing beneficiaries. These waivers capped enrollment, limited services, and/or imposed new premium and cost sharing obligations on previously eligible groups of people. Savings from these reductions may then be used to cover new groups; however, states’ implementation of these reductions is not contingent upon implementation of the expansion.
- Using SCHIP or Disproportionate Share Hospital (DSH) funds. Some waivers redirect federal DSH funds or use unspent federal SCHIP funds to cover new populations. HIFA broadened the possible uses of SCHIP funds under waivers to include adults without dependent children; previously they could only be used for parents and pregnant women. This use of SCHIP funds to cover adults without dependent children has led to some new coverage but has also raised concerns because SCHIP funds are capped. Waivers, therefore, can reduce the federal funding available to cover children in other states. In addition, the Government Accountability Office (GAO) has questioned whether HHS has used its waiver authority in a manner consistent with the SCHIP statute.¹⁰
- Pass through financing. Under longstanding policy, waiver expansions that cover groups that could be covered under Medicaid without a waiver are considered “pass throughs.” States do not have to find offsetting savings to cover such groups, but their waiver payments still are brought under the budget neutrality cap (discussed below).

Whether or not a Section 1115 waiver includes an expansion component, states must agree to a budget neutrality cap on federal financing. The cap is the mechanism the federal government uses to enforce the budget neutrality agreement. It limits the state’s access to open-ended federal financing, putting the state at risk for costs related to the waiver that exceed the cap. This creates the potential for the state to experience additional fiscal stress over time.¹¹

The waiver cap can be set on either a per capita or global basis. In general, comprehensive Section 1115 waivers have relied on per capita caps, which limit the amount of federal funds a state can receive for persons covered under the waiver based on pre-set per person costs. Under this type of cap, federal matching funds adjust for enrollment but not for higher-than-projected per-person costs. Alternatively, a global cap, like those relied on in the Pharmacy Plus waivers, places a total limit on federal funding for waiver-related expenditures.¹² This type of cap does not adjust for enrollment or for health care cost increases. Under either type of cap, states cannot receive federal funds for waiver-related costs that exceed the cap.

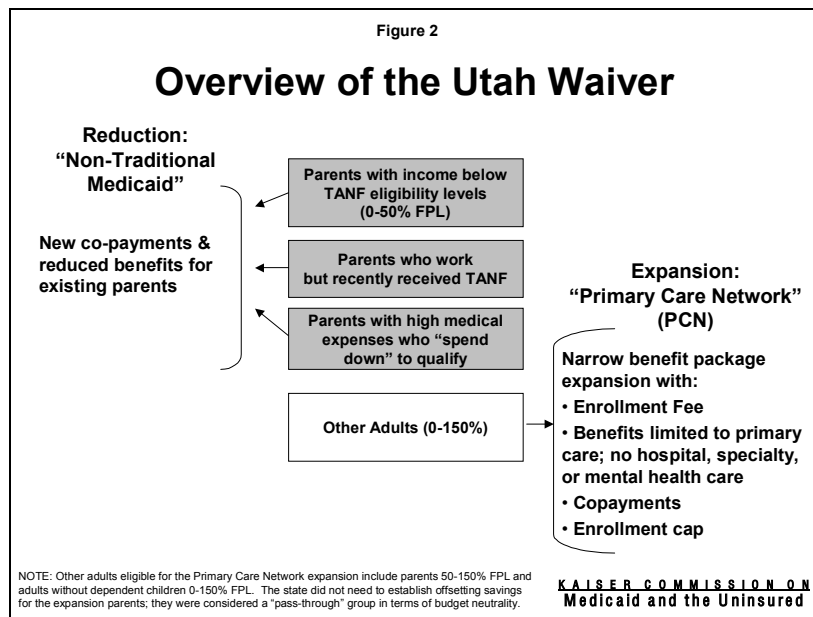
B. Programmatic Changes

Some recent waivers do not look much different than waivers that have been approved in the past. For example, New York's Family Health Plus waiver amendment (which was submitted to CMS before January 2001 but approved after that date) extended Medicaid eligibility for parents and other adults, keeping the Medicaid benefit package and cost sharing rules largely intact. Other recently approved waivers, however, make significant program changes.

As in the past, recent waivers have been used to impose premiums or cost sharing above levels allowed under regular program rules. Typically, these changes were associated with coverage expansions that brought new groups of people into Medicaid whose incomes were considerably above traditional Medicaid eligibility standards. Some of the more recent waivers increase costs for much lower income people. Additionally, some recent waivers allow states to make other changes in coverage such as capping enrollment and/or limiting benefits below federal standards. States have made such changes to offset the cost of a coverage expansion and/or to reduce the cost of an expansion. In a few states, the purpose of the changes was to lower state Medicaid costs with no associated coverage expansion.

Utah and Oregon are two states that have used waivers to make significant programmatic changes:

- In 2002, Utah increased cost sharing and modestly reduced benefits for 17,600 parents with incomes below 50% of poverty (about \$154 per week for a family of three in 2005). It used the savings from these changes to expand eligibility for other poor and near-poor adults, including adults without dependent children. The newly eligible adults are subject to an enrollment fee and an enrollment cap of 19,000 adults.¹³ They have significant cost sharing requirements and benefits limited to primary care—they are not covered for inpatient hospital services (other than through the emergency room), specialty care, or mental health services (Figure 2). The state closed new enrollment into the expansion in November 2003, when the cap was reached.¹⁴ The coverage reductions imposed on previously eligible parents remain in place.



- Oregon’s most recent waiver and waiver amendments, approved in 2002 and 2004, allowed the state to cap enrollment, reduce benefits, and increase premiums and cost sharing for previously eligible poor parents and other adults. (In the mid-1990s, the state expanded coverage to these adults through a waiver.) The new waiver changes also authorized several coverage expansions. To date, the state has implemented the enrollment cap, reduced benefits, and imposed the new premium and cost sharing requirements, but it has only implemented a small portion of the approved expansions (Figure 3).¹⁵

Figure 3

Waiver Changes in Oregon

	Changes Allowed Under Waiver:	Number Affected:
Implemented Reductions	OHP Standard: Changes for some parents and other adults <100% FPL : <ul style="list-style-type: none"> • Enrollment closed • Increased premiums and cost sharing • Reduced benefits 	Over 100,000 adults affected in February 2003 (Enrollment dropped to 46,520 as of October 2004, largely due to new premium policies)
Implemented Expansions	Children & pregnant women 170-185% FPL Premium assistance program 170-185% FPL	3,748 enrollees as of October 2004
Expansions that Have Not Been Implemented	Parents 100-185% FPL Other adults 100-185% FPL Subsequent expansion for children and premium assistance program 185-200% FPL	N/A

Note: Oregon has not yet implemented its approved expansion for parents and other adults due to state funding constraints. Copayments for poor parents and other adults were eliminated in June 2004, following a court ruling.

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Recent waiver activity also reflects HIFA’s focus on “premium assistance,” where states use Medicaid or SCHIP funds to subsidize private insurance.¹⁶ Without a waiver, states can provide premium assistance through Medicaid, but the premium assistance must be cost effective, states

must assure that enrollees have access to Medicaid-covered services either through the private policy or as a “wraparound” benefit, and states must cover premiums or cost sharing that exceed federal Medicaid standards. Recent waivers have permitted states to subsidize private coverage (both employer-based and individual coverage) that does not meet federal benefit or cost sharing rules, without supplementing the coverage.

IV. ISSUES AND IMPLICATIONS OF RECENT WAIVERS

Table 3 identifies features of recent waivers and some of their implications for beneficiaries, providers, and states.

Table 3: Key Features of Recent Waiver Activity

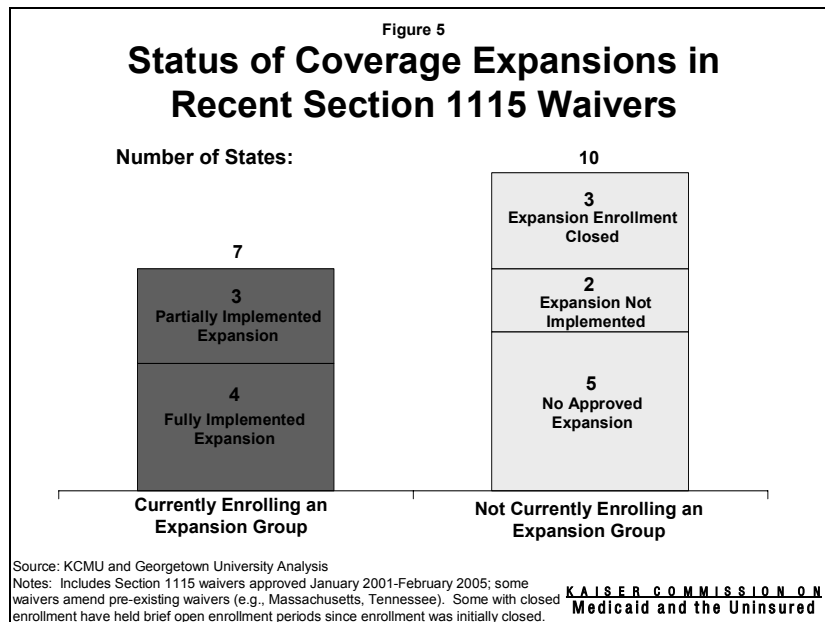
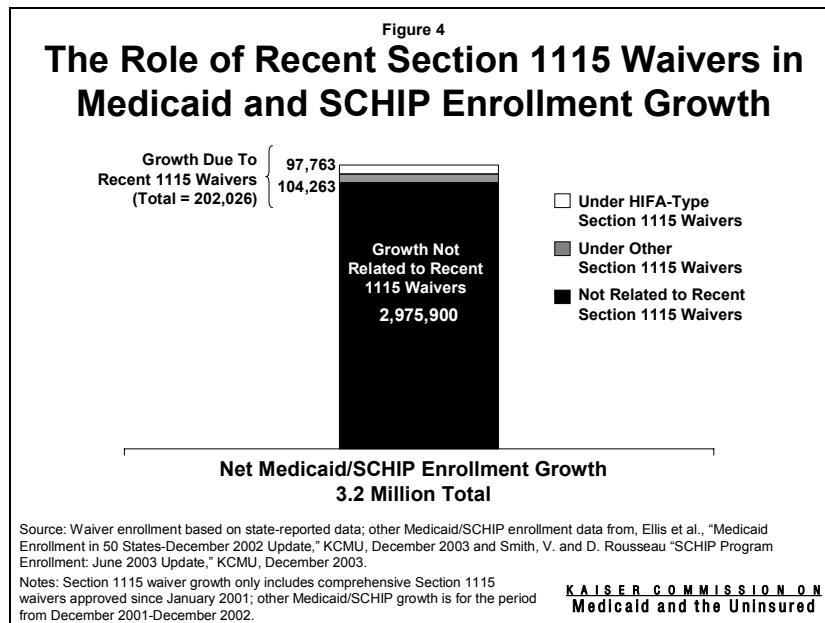
Features	Implications	Examples
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Enrollment caps	<ul style="list-style-type: none"> Eliminates guarantee to coverage for those who qualify Enrollment based on first come first serve, not income or health needs Allows states to quickly reduce program costs by freezing enrollment 	CO, MA, MI, NJ, NM*, OR, UT
Reduced benefits; new or increased premiums and/or cost sharing	<ul style="list-style-type: none"> Limits access to coverage and/or care Potential for unmet medical needs and increased uncompensated care Reduces state/federal program costs 	NM*, OR, UT, WA*
“Premium assistance” with limited or no benefit or cost sharing standards and no wraparound coverage	<ul style="list-style-type: none"> Potential to improve access to providers through employer-based plans, but availability of these plans is limited for the eligible population Cost sharing and coverage restrictions could limit access Potential to contain state/federal costs, but may not be cost effective 	ID, IL, MI, OR, UT <i>(ID, IL, and MI allow people to choose premium assistance or direct coverage)</i>
Different benefits and cost sharing for different groups within a state	<ul style="list-style-type: none"> Allows states to selectively limit benefit packages May enable states to retain or expand coverage, but some individuals may not be covered for needed services or able to afford higher cost sharing Increases administrative complexity Confusion could dampen participation among eligible people and providers 	MI, OR, TN, UT

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**As of February 2005, enrollment in the Michigan and New Jersey expansions was closed. Enrollment in Utah’s Primary Care Network expansion was also closed although enrollment in its premium assistance expansion remained open. Enrollment in Oregon’s OHP Standard program, which covers previously eligible parents and other adults with incomes below poverty, was closed. In Maine, an enrollment freeze has been announced but not yet implemented.

A. Eligibility

As noted, the recent HIFA waiver initiative encouraged states to use waivers to expand coverage within existing resources. As of Fall 2003, recent waivers had resulted in a net gain in coverage of about 200,000 people, far less than projected waiver coverage gains and a fraction of overall recent Medicaid and SCHIP enrollment growth (Figure 4).¹⁷ Most of the new coverage resulted from one waiver—New York’s Family Health Plus expansion for parents and childless adults. Even though most approved waivers include an expansion component, actual coverage growth has been limited because expansions were not always fully implemented and some expansions were capped and are no longer open to new people (Figure 5 and Appendix A). In addition, some limit coverage to certain subgroups within the expansion population, and others refinanced existing coverage. In two states, waivers resulted in net coverage reductions.



The small number of people gaining new coverage through recent waivers reflects the limitations of waivers as a coverage expansion tool. Longstanding federal policy requires waivers to be “budget neutral” for the federal government. With no new federal resources and states facing significant budget restraints, new coverage opportunities under waivers are quite limited.

New waiver flexibility may have helped some states sustain coverage during the economic downturn, but it also appears that flexibility is not necessarily sufficient to prevent other program cutbacks. At least one state that implemented a waiver that offered substantial new flexibility with respect to premiums, benefits, and cost sharing still needed to freeze enrollment and make significant additional eligibility and benefit reductions to address its budget shortfall.¹⁸ In contrast, states have reported that the temporary fiscal relief provided through the temporary increase in the federal Medicaid matching rate did help them avert coverage losses.¹⁹

B. Enrollment Caps

Medicaid provides a guarantee that all eligible people can enroll. As in Medicare, waiting lists are not permitted in Medicaid. Under recent waivers, however, states have been granted authority to cap enrollment. The scale-backs in eligibility that are allowed under current law without a waiver limit coverage based on income, assuring that the lowest-income beneficiaries are able to access coverage. By contrast, enrollment caps result in Medicaid coverage being provided on a “first come, first serve” basis.

Some recent waivers allow enrollment caps to be applied to adults who were already covered under Medicaid while others permit caps for only newly covered groups. Caps have been allowed for groups that can only be covered through a waiver (i.e., adults without dependent children) as well as for groups that states can cover under regular Medicaid program rules (e.g., parents). To date, no recent waivers have capped enrollment for any “mandatory” eligibility group. Nonetheless, since “optional” groups include people with very low incomes (often below poverty) and people with disabilities and chronic illnesses, the caps affect particularly vulnerable groups of people.²⁰ Examples of enrollment caps in recent waivers include:

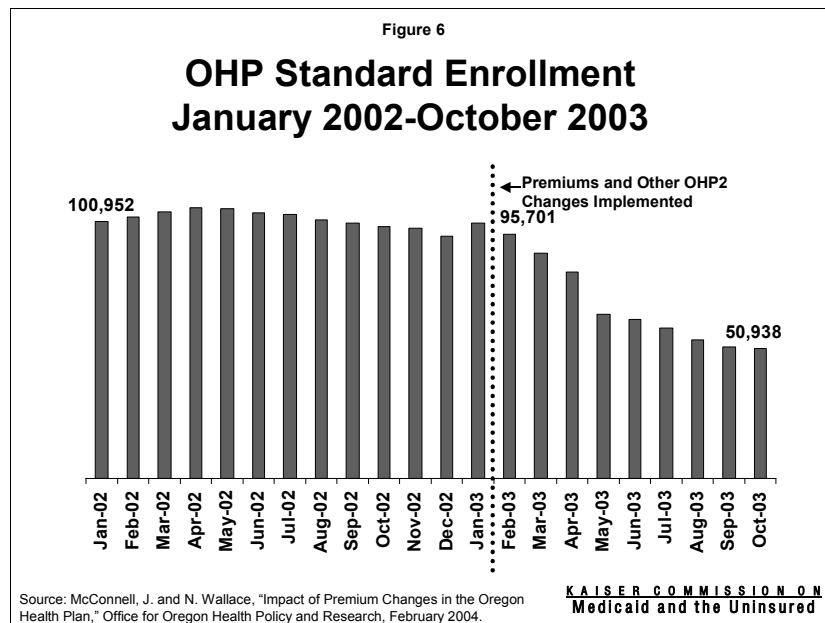
- Caps for previously eligible groups. Oregon used new waiver authority to close enrollment for some previously eligible parents and other adults with incomes below the federal poverty level. Massachusetts has received approval to close enrollment for a number of previously eligible groups of adults, including low-income adults with HIV and people with disabilities. Enrollment for these groups, however, remains open at this time.
- Caps for newly eligible groups. Colorado was granted authority to cap enrollment for newly eligible pregnant women. Under this authority, it closed enrollment after seven months; it then reopened enrollment a little over one year later. Utah closed enrollment for newly eligible parents and other adults into its Primary Care Network expansion after 16 months,²¹ and Michigan closed enrollment for newly eligible childless adults after six months.²²

C. Affordability and Adequacy of Coverage

Medicaid is designed to meet the needs of people with very limited incomes and those who are generally sicker than the population served by private coverage. As such, Medicaid provides a comprehensive benefit package to children and has minimum coverage standards for adults. It also limits the extent to which individuals can be charged premiums, copayments, or other costs. In the past, as some states expanded Medicaid to somewhat higher income groups, they sought waivers to impose premiums and copayments on these new coverage groups. Recently, states have used waivers to charge higher costs and or to provide limited benefits, sometimes for groups at very low incomes, including those with no income.

Impact of premiums/enrollment fees. A significant body of existing research has found that premiums can limit low-income people’s participation in publicly-funded coverage and that participation falls off sharply as premium amounts increase.²³ Early findings from states with recent waivers that charge premiums or enrollment fees are consistent with this research:

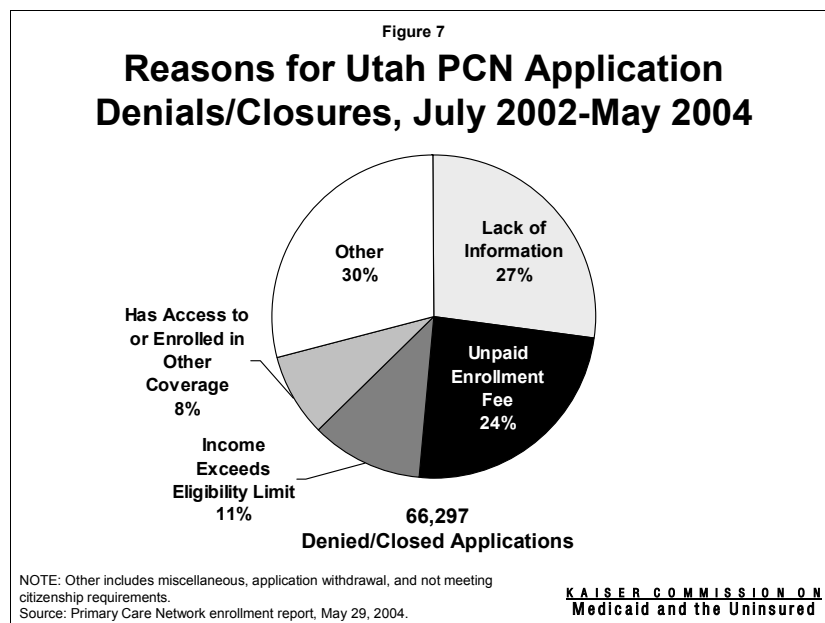
- Oregon increased premiums to \$6-\$20 for poor parents and other poor adults, including those with no incomes, and imposed stricter premium payment policies. Following these changes, enrollment among those subject to premiums dropped by nearly half or 50,000 people (Figure 6).²⁴ Coverage losses occurred among all income groups subject to the premiums, but were greatest for the lowest income individuals.²⁵ Survey results find that over two-thirds of those who lost coverage became uninsured.²⁶



- Utah charges an annual enrollment fee for parents (with incomes 50-150% of poverty) and other adults (with incomes 0-150% of poverty) who are eligible for its Primary Care Network (PCN) expansion. When the waiver was initially implemented in July 2002, the fee was \$50 for all eligible adults. In light of the difficulties some individuals were having paying the enrollment fee, in July 2003, the Utah state legislature reduced the fee to \$15 for those

receiving general assistance welfare payments. One year later, in July 2004, the legislature reduced the fee to \$25 for all other adults with incomes below 50% of poverty (\$92 per week for an individual in 2005).

The enrollment fee has been unaffordable for many individuals, particularly those with the lowest incomes, according to state data and interviews conducted as part of a case study of the Utah waiver experience.²⁷ As of May 2004, nearly a quarter of total PCN application denials and closures were due to unpaid enrollment fees (Figure 7).²⁸ Another 57% of denials and closures were due to lack of information or other reasons, and it is unclear whether some of these denials or closures might also stem from the enrollment fee. For example, an individual might not complete an application form after determining that he or she cannot afford the fee. During July through September 2003, when many enrollees were required to pay the annual fee to retain coverage, over a quarter (27%) of enrollees disenrolled.²⁹ A survey of disenrollees found that 29% of respondents indicated financial barriers to their reenrollment.³⁰ Additional analysis revealed that nearly 80% of those who cited a financial barrier to reenrollment had become uninsured.³¹

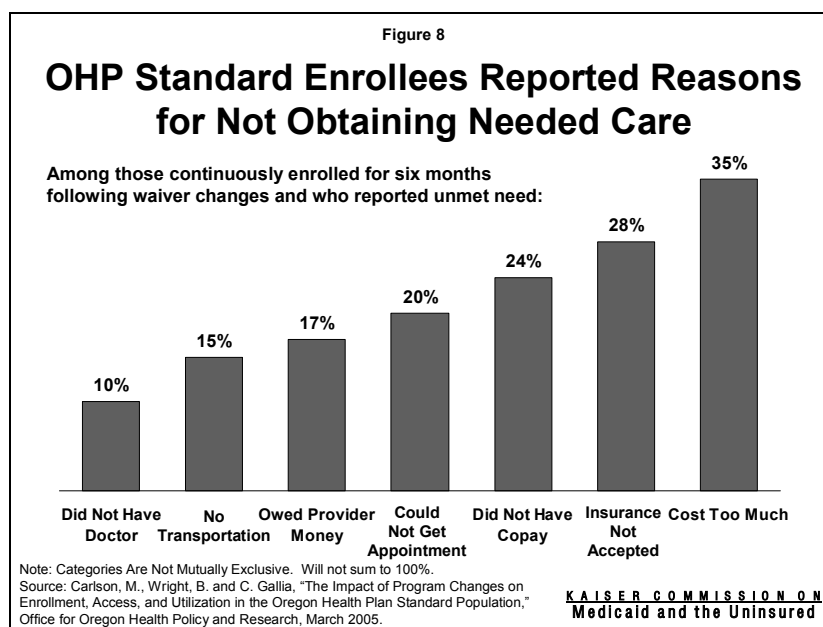


- Washington’s waiver, approved in February 2004, allows the state to charge premiums for about 30% of the children covered by Medicaid in the state. The state estimated that the premiums would cause 20,000 children or 10% of those who would be subject to premiums to disenroll from coverage.³² These premiums have not been implemented.

Impact of Limited Benefits and Increased Cost Sharing Requirements. Under some recent waivers, states have reduced benefits and increased cost sharing for existing beneficiaries and provided limited benefit packages to new beneficiaries. Consistent with existing research,³³ early experiences from the states find that these changes have led to problems accessing necessary care:

- Under its 2002 waiver, Oregon increased cost sharing and eliminated benefits, including mental health and substance abuse services, durable medical equipment, and dental and vision services for existing poor parents and other adults.³⁴ This reduced coverage is called OHP Standard. Both the increased cost sharing and eliminated benefits appear to have created significant challenges for some individuals.

In focus groups, respondents described difficulty affording copayments and having to forgo or delay necessary care.³⁵ As one woman remarked, “Being able to afford \$2 is a lot of money when you have absolutely nothing.” Respondents also faced substantial difficulties accessing care due to the elimination of benefits, particularly mental health care. Some said that their health and quality of life were deteriorating due to the loss of counseling services.³⁶ A survey of beneficiaries conducted by a state research collaborative had similar findings. Among beneficiaries who had their benefits reduced and cost sharing increased, over a quarter reported unmet health care needs, nearly half reported not filling prescriptions due to cost, and over a third reported unmet mental health care needs.³⁷ Among those who reported unmet health care needs, over a third reported that they could not obtain the care because it cost too much, about a quarter did not have the copay, and 17% reported that they owed the physician money (Figure 8).³⁸ Cost sharing was later eliminated for OHP Standard enrollees, in June 2004, following a court ruling.



- As noted, Utah’s Primary Care Network expansion for poor and near poor adults only covers primary care; it does not include coverage for hospital or specialty care. The state set up informal arrangements for beneficiaries to seek donated and charity hospital and specialty care. Enrollees are likely benefiting from their access to primary care and the state’s efforts to help individuals access donated hospital and specialty care have helped some people, but health care providers, advocates, and other key stakeholders have reported instances where beneficiaries experienced significant problems accessing specialty care.³⁹

The cost of the Primary Care Network expansion was offset with savings from increases in copayments and modest reductions in benefits for previously eligible parents. Early analysis of the impact of the new copayments has somewhat mixed findings. The state undertook a comprehensive analysis that included analysis of utilization data, focus groups, and a survey. When it compared actual utilization of services with modeled expectations, it found that the copayments did not have a statistically significant impact on utilization in most cases, although there were statistically significant decreases in utilization for some services, such as prescription drugs.⁴⁰ However, in the state’s accompanying survey, over a third (36%) of respondents agreed that copayments “seem small, but are actually a huge problem” and nearly 30% agreed that they cause “serious financial difficulties.”⁴¹ Reanalysis of the state’s utilization data, conducted by the Center on Budget and Policy Priorities (CBPP) using different methods and assumptions for modeling projected utilization, consistently found that the copayments led to decreased utilization of services, including hospital admissions, physician visits, prescription drugs, and outpatient hospital clinic visits.⁴²

D. Premium Assistance

Many of the recent waivers include a small premium assistance component, in part, reflecting HHS policy that “HIFA” waivers generally must include a premium assistance component.⁴³ The waivers permit the use of federal Medicaid and SCHIP funds to subsidize private plans that may not meet minimum federal benefit or cost sharing standards or that may have other features that are otherwise prohibited under Medicaid, such as preexisting condition exclusions. For example:

- Oregon’s 2002 waiver refinances and expands a premium assistance program that the state had previously operated with state-only funds. Under the waiver, some poor parents and adults are only eligible for premium assistance, while others are offered the choice of premium assistance or direct coverage. Subsidized plans may have a deductible up to \$500 and can have a preexisting condition waiting period lasting for as long as six months. Utah also offers only premium assistance to some parents and other adults. Utah has no minimum benefit or cost sharing benchmarks for this Medicaid-funded coverage.
- Idaho gives some children the choice of premium assistance or direct coverage with no minimum benefit or cost sharing requirements for subsidized coverage. Illinois also offers some parents and children the choice of premium assistance or direct coverage. The only benefit or cost sharing benchmarks for the subsidized coverage are that physician visits and inpatient hospital services must be covered but there are no minimum standards with respect to the scope of the services that must be offered. Additionally, Michigan offers some adults the choice of premium assistance or direct coverage without any benefit or cost sharing benchmarks for subsidized private coverage other than coverage of inpatient hospital care, physician services, and prescription drugs.

There is considerable interest in premium assistance as a strategy to prevent employers from dropping private coverage for low-income workers and to lower state coverage costs. People who have access to employer-based coverage may like the option of receiving assistance to purchase that coverage, and subsidized private coverage might expand access to providers who

do not accept Medicaid payments. Premium assistance may also reduce program costs if an employer is contributing toward the cost of the private plan. Overall, however, the impact of premium assistance has been quite limited. Low-income workers often do not have access to employer-based insurance with significant employer contributions. Enrollment under the premium assistance programs implemented under recent waivers has been very low.⁴⁴ For example, only 70 adults were enrolled in Utah’s premium assistance program as of February 26, 2005.⁴⁵

The loss of benefit and cost sharing standards in waiver-based premium assistance programs raises questions about whether subsidized coverage will provide adequate coverage at affordable costs for the target population. Plans with limited benefits, high deductibles, and/or copayments may result in more limited access for low-income families. Further, the lack of standards (and the lack of data on claims or utilization of services) raises questions about whether state and federal policymakers will be able to assess what services people are actually using and how federal Medicaid and SCHIP funds are being spent. It also is unclear whether this approach will be cost-effective given that Medicaid is a lower-cost approach to providing coverage compared to private insurance once the poor health status of Medicaid beneficiaries is taken into account.⁴⁶

E. Tiered Coverage

Medicaid is sometimes described as a complex program that is difficult for potentially eligible people, health care providers, as well as policymakers, to understand. Waivers could be used to make the program less complicated and easier to enroll in and administer, but a number of recent waivers have made the program more complex.

Several recent waivers provide different benefits and cost sharing to different groups of people within a state; without a waiver, within a given state, groups of beneficiaries generally must be treated similarly (although children may be treated more favorably than adults). This tiered benefit and cost sharing enables states to selectively limit coverage for some groups. This may enable states to preserve coverage for some groups or to expand coverage. However, it may lead to some individuals lacking coverage for needed services or being unable to afford higher costs.

In addition, tiered systems can create implementation challenges. A study in Oregon found that “clinic administrators reported widespread confusion among both providers and patients about changes in OHP [Medicaid] coverage and cost sharing.”⁴⁷ This study also found that some providers are hesitant to accept beneficiaries because they are uncertain about their coverage and that some beneficiaries are hesitant to seek care because they are unclear about which benefits are covered and how much they might be required to pay. Utah had to “revamp all orientations” to explain its different coverage programs. Educating beneficiaries about the different coverage programs has been difficult, creating confusion and frustration among beneficiaries and increasing responsibilities for state staff.⁴⁸

An additional complication for agencies, individuals, and providers in states with different benefits and cost sharing for different groups is that individuals’ eligibility for the different benefits and their cost sharing obligations can change if their incomes change. It is not uncommon for low-income people to experience frequent changes in income—for example, due

to a new job or additional hours of employment. These changes could result in more paperwork, higher administrative costs, and further confusion.

F. Beneficiary Protections

Many recently approved waivers have eliminated some beneficiary protections or left unclear which beneficiary protections continue to apply under the waiver. In other waivers, the status of key beneficiary protection rules is unclear. Tennessee’s pending waiver amendment would significantly alter procedural protections otherwise guaranteed to Medicaid beneficiaries. In some cases, notice and grievance and appeal rights would be curtailed. These types of policies take on added significance when states also create more complicated rules and eligibility categories, which can increase the likelihood of error.

In New Mexico, adults in the expansion group would receive a “commercial-like” benefit package that would be marketed through employers. It is not clear whether beneficiaries under this waiver would continue to be protected by Medicaid managed care rules and related patient protections. In some waivers that combine SCHIP and Medicaid funding, it is not clear whether the underlying rules for the SCHIP program or for the Medicaid program apply; this can make important differences in terms of a number of beneficiary safeguards.

V. CONCLUSION

States are making significant programmatic changes through Section 1115 waivers. Much of this recent round of waiver activity has focused on limiting spending by curtailing coverage, limiting benefits, and increasing costs imposed on beneficiaries, although some recent waivers have enabled people to gain coverage or retain coverage that may otherwise have been lost due to budget pressures. These changes have had adverse impacts on coverage, people’s ability to receive needed care, and pressures faced by providers and the waivers’ limits on federal funding may create new fiscal pressures for states over time. They have also further increased program variability within and across states.

States continue to face challenges financing and operating their Medicaid programs stemming from rising health care costs, years of slow state revenue growth, and the added cost pressures associated with an aging population. At the same time, Medicaid played an important role during the most recent economic downturn by offsetting much of the decline in employer-based coverage and keeping millions of people (mostly children) from becoming uninsured. The experience with recent waivers shows that increased programmatic flexibility may not be the solution for addressing state fiscal problems while maintaining access to needed care. Because Medicaid is a low-cost program that already offers states an array of options to contain costs, the savings that can be gleaned through waivers without reducing needed coverage are limited. Further, without new federal resources, recent waivers have not been particularly effective vehicles for reducing the number of uninsured. In light of the breadth and scope of the changes being made through waivers, the changes sought through waivers and the trade-offs for the low-income, elderly, and disabled population should be carefully evaluated and publicly debated.

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Appendix A:
Status of Coverage Expansions in Recent Section 1115 Waivers as of February 2005

	State	Waiver includes expansion?	Expansion implemented?	Enrollment open?
Total	17	12	Fully: 7 Partially: 3	7
Fully implemented expansion & enrollment open: 4 states	AZ	✓	✓	✓
	CO	✓	✓	✓
	DC	✓	✓	✓
	NY	✓	✓	✓
Partially implemented expansion & enrollment open: 3 states	IL	✓	Partially	✓
	ME	✓	Partially	✓
	OR	✓	Partially	✓
Fully implemented expansion & enrollment closed: 3 states	MI	✓	✓	X
	NJ	✓	✓	X
	UT	✓	✓	X
Expansion not implemented: 2 states	CA	✓	X	N/A
	NM	✓	X	N/A
No expansion: 5 states	ID	X	N/A	N/A
	MA	X	N/A	N/A
	MS	X	N/A	N/A
	TN	X	N/A	N/A
	WA	X	N/A	N/A

Source: KCMU and Georgetown University analysis.

Notes: Includes comprehensive Section 1115 waivers approved since January 2001; some waivers amend pre-existing waivers (e.g., Massachusetts, Tennessee). Some states with closed enrollment have held brief open enrollment periods since enrollment was initially closed. While enrollment in Utah's "Primary Care Network is closed, enrollment its premium assistance expansion remains open; 70 people were enrolled as of February 5, 2005. Enrollment in Maine's expansion is scheduled to close.

ENDNOTES

¹ See Office of the Secretary of Administration and the Office of the Secretary of Human Services, “Saving Medicaid, The Douglas Administration’s Plan for Saving the Vermont Medicaid System,” January 19, 2005; Bush, J., Governor, “Florida Medicaid Modernization Proposal,” January 11, 2005; Stephan, J.A., Commissioner, New Hampshire Department of Health and Human Services, “New Hampshire’s GraniteCare, Recommendations to Modernize Medicaid,” November 10, 2004; and Sanford, M., Governor, “South Carolina Medicaid Choice: A Waiver Concept to Bring a Consumer Directed, Market Based Environment into Medicaid,” (undated). Each of these are “concept papers” in various stages of development; they are not formal waiver submissions and, therefore, subject to considerable change as they are considered.

² Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” <http://www.cms.hhs.gov/hifa/default.asp>.

³ Hadley, J. and J. Holahan, “Is Health Care Spending Higher Under Medicaid or Private Insurance,” *Inquiry*, 40:323-342 (Winter 2003-2004).

⁴ For many years, it has generally been the practice that Section 1115 waivers must promote the objectives of the program for which requirements are being waived—in this case, Medicaid or SCHIP. However, in response to a recent GAO report, which suggested that some recent Section 1115 SCHIP waivers do not further the purposes of SCHIP, HHS has taken the stance that the waiver initiatives are permissible as long as they further the broader objectives of the Social Security Act. GAO, “Medicaid and SCHIP: Recent HHS Approval of Demonstration Projects Raise Concerns,” July 2002, GAO-02-817.

⁵ Since 2001, the Administration has promoted several waiver initiatives including HIFA, Pharmacy Plus, and Independence Plus. See <http://www.cms.hhs.gov/medicaid/waivers/>.

⁶ This brief only addresses Section 1115 waivers that make changes in eligibility, benefits, or cost sharing for a broad group of people; more narrow waivers, such as Pharmacy Plus or Independence Plus, are not addressed. Waivers also have significant financial implications for states, which are beyond the scope of this paper; see Mann, C. and J. Alker, “Federal Medicaid Waiver Financing: Issues for California,” Kaiser Commission on Medicaid and the Uninsured, July 2004.

⁷ This timeframe is used because it is the one the Department of Health and Human Services typically uses when describing recent waiver activity, Statement by Tommy G. Thompson Secretary of Health and Human Services Regarding “Cover the Uninsured Week,” News Release, May 10, 2004, <http://www.hhs.gov/news/press/2004pres/20040510.html>.

⁸ CMS’ information on pending waivers is at <http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp>. Some waivers or waiver amendments, however, are not posted; Maryland, for example, has a pending waiver submitted in October 2003 that is not reported on the CMS site; Letter from Nelson J. Sabatini to Dennis Smith, Director, Center for Medicaid and State Operations, October 9, 2003.

⁹ Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” <http://www.cms.hhs.gov/hifa/default.asp>.

¹⁰ GAO, “Medicaid and SCHIP: Recent HHS Approval of Demonstration Projects Raise Concerns,” July 2002, GAO-02-817.

¹¹ Mann, C. and J. Alker, “Federal Medicaid Waiver Financing: Issues for California,” Kaiser Commission on Medicaid and the Uninsured, July 2004

¹² See, Guyer, J., “The Financing of Pharmacy Plus Waiver: Implications for Seniors on Medicaid of Global Caps,” Kaiser Commission on Medicaid and the Uninsured, May 2003, <http://www.kff.org/medicaid/4111-index.cfm>.

¹³ The state also can provide subsidies for private coverage for up to an additional 6,000 adults.

¹⁴ Since enrollment was closed in November 2003, the state has held several brief open enrollment periods.

¹⁵ Copayments for OHP Standard beneficiaries were later eliminated, in June 2004, following a court ruling.

¹⁶ Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” <http://www.cms.hhs.gov/hifa/default.asp>.

¹⁷ Mann, C., Artiga, S. and J. Guyer, “Assessing the Role of Recent Waivers in Providing New Coverage,” Kaiser Commission on Medicaid and the Uninsured, December 2003.

¹⁸ Oregon’s waiver resulted in a major restructuring of its Medicaid program that led to significant decreases in coverage and spending. However, the state still implemented other program cutbacks outside of the waiver, including eliminating its Medically Needy program. The state is planning further reductions.

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- ¹⁹ Smith, V., Rudowitz, R., and M. O'Malley, "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2004, Results from a 50-State Survey," Kaiser Commission on Medicaid and the Uninsured, October 2004.
- ²⁰ Schneider, A. et al, Chapter 1: Medicaid Eligibility, *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002.
- ²¹ Enrollment in the state's premium assistance program, Covered at Work, remains open.
- ²² Since initially closing enrollment, these states have held brief open enrollment periods but then re-closed enrollment.
- ²³ Hudman, J. and M. O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, March 2003; Ku, L., "Charging the Poor More for Health Care: Cost Sharing in Medicaid," Center on Budget and Policy Priorities, May 2003.
- ²⁴ McConnell, J. and N. Wallace, "The Impact of Premium Changes in the Oregon Health Plan," The Office for Oregon Health Policy and Research, February 2004; Mann, C. and S. Artiga, "The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program, Kaiser Commission on Medicaid and the Uninsured, June 2004.
- ²⁵ Ibid
- ²⁶ Carlson M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," The Office for Health Policy and Research and the Office of Medical Assistance Programs, March 2005; Mann, C. and S. Artiga, "The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program, Kaiser Commission on Medicaid and the Uninsured, June 2004.
- ²⁷ Case study of the Utah waiver experience, Kaiser Commission on Medicaid and the Uninsured, forthcoming.
- ²⁸ Primary Care Network enrollment report, May 29, 2004.
- ²⁹ Office of Health Care Statistics, "Utah Primary Care Network Disenrollment Report, July-August 2003," Utah Department of Health, August 2004.
- ³⁰ Ibid
- ³¹ Ibid
- ³² "Section 1115 Demonstration Waiver Application," Washington State Department of Social and Health Services, July 21, 2003.
- ³³ Hudman and O'Malley.
- ³⁴ Some of the eliminated benefits were optional benefits that could be eliminated without a waiver; however, the state needed a waiver to eliminate these benefits for only some groups of beneficiaries. The increased copayments were eliminated in June 2004, following a court ruling.
- ³⁵ Perry, M. et al, "The Impact of Medicaid Reductions in Oregon: Focus Group Insights," Kaiser Commission on Medicaid and the Uninsured, December 2004.
- ³⁶ Ibid
- ³⁷ Carlson and Wright.
- ³⁸ Ibid
- ³⁹ A Case Study of the Utah Waiver Experience, Kaiser Commission on Medicaid and the Uninsured, forthcoming.
- ⁴⁰ Office of the Executive Director, Utah Department of Health, "Medicaid Benefits Change Impact Study," 2003 Utah Public Health Outcome Measures Report, December 2003.
- ⁴¹ Ibid.
- ⁴² The state used econometric models to examine trends in health care use with and without the copayments. The state baselines produced by these models estimated that, even without any copayments or other policy changes, utilization of physician and inpatient hospital services would decline significantly. According to CBPP, "The models that UDOH employed make use of a quadratic (i.e., squared) function in generating their baseline. Use of such a function is unusual in this type of model, and it is the inclusion of the quadratic function that produced the curious estimate that, in the absence of any policy changes, utilization would fall dramatically and at an accelerating pace. Because the reliance on a quadratic function produced this highly unusual estimate of a sharp drop in utilization, the drop in utilization that actually followed the introduction of the copayments is interpreted as being almost entirely unrelated to the copayments." In contrast, the CBPP analysis assumes that utilization would have either continued to rise or flatten out if copayments had not been imposed. Ku, L., Deschamps, E., and J. Hilman, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," Center on Budget and Policy Priorities, November 2004.

⁴³ Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” <http://www.cms.hhs.gov/hifa/default.asp>.

⁴⁴ Alker, J., “Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity,” Kaiser Commission on Medicaid and the Uninsured, October 2003.

⁴⁵ Utah Department of Health, Primary Care Network and Covered at Work Enrollment Report as of February 26, 2005.

⁴⁶ Hadley, J. and J. Holahan, “Is Health Care Spending Higher under Medicaid or Private Insurance?” *Inquiry*, Vol. 40, No. 4, Winter 2003/2004.

⁴⁷ Hines, P. et al, “Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers in Multnomah and Washington Counties,” The Office for Oregon Health Policy and Research, December 2003; Mann, C. and S. Artiga, “The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon’s Medicaid Program,” Kaiser Commission on Medicaid and the Uninsured, June 2004.

⁴⁸ A Case Study of the Utah Waiver Experience, Kaiser Commission on Medicaid and the Uninsured, forthcoming.

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