

medicaid and the uninsured

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ASSESSING THE ROLE OF RECENT WAIVERS IN PROVIDING NEW COVERAGE

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EXECUTIVE SUMMARY

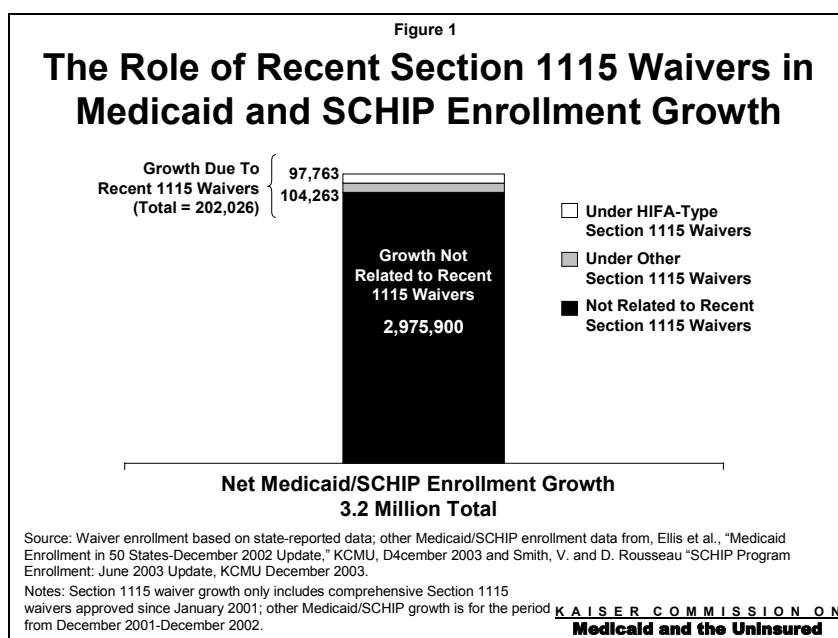
Growth in the number of Americans who lack health insurance has renewed debate over different approaches for extending coverage to the uninsured. Recently, Section 1115 Medicaid and State Children's Health Insurance Program (SCHIP) waivers have been promoted as a way to reduce the number of uninsured people without increasing public program spending. This brief reports enrollment data from states with recently approved Section 1115 waivers and examines how enrollment compares to projected coverage gains. It also provides insight into the characteristics of the waivers that have led to the most gains in coverage and discusses how these gains compare to the overall growth in Medicaid enrollment.

States must obtain a waiver to cover adults without dependent children who are not elderly, disabled, or pregnant through Medicaid or to cover populations other than uninsured children through SCHIP. Waivers also are needed to change some of the conditions of coverage provided to Medicaid and SCHIP beneficiaries, for example, by reducing mandatory benefits or increasing cost sharing beyond federal standards. A longstanding component of federal waiver policy is that waivers that expand coverage must be "budget neutral" for the federal government, meaning that a state must demonstrate that federal costs under the waiver would not be any more than costs without the waiver. A state does not need a waiver to expand Medicaid coverage to children, parents, pregnant women, elderly people or people with disabilities. It can exercise these options by amending its Medicaid state plan, unless it is seeking to also change aspects of the coverage offered to these individuals in ways that are not otherwise allowed under federal Medicaid rules. Since "state plan amendment" changes implement options authorized by federal law, they are not required to be budget neutral.

The Department of Health and Human Services (HHS) launched the first of its major Section 1115 waiver initiatives, the Health Insurance Flexibility and Accountability (HIFA) initiative, in August 2001. The goal was to "increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources."¹ Consistent with the federal government's budget neutrality waiver policy, no new federal funds were made available for waiver expansions. States can finance new waiver coverage either by redirecting federal SCHIP or Disproportionate Share Hospital (DSH) payments—financing mechanisms available under waivers prior to HIFA—or by offsetting new coverage costs with reductions in coverage for current beneficiaries—a new financing strategy available under HIFA.

¹ Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative," September 17, 2002, <http://www.cms.gov/hifa/default.asp>.

In light of the growing number of uninsured people, it is important to look at the extent to which recent waivers have expanded coverage. In addition, because some HIFA-type waivers include significant reductions in coverage for current beneficiaries, it is important to examine which types of waivers have led to coverage gains and under what conditions waivers hold promise as a strategy for extending coverage to the uninsured. This analysis finds that recent waivers have expanded coverage in important ways in a few states, but, overall, the number of people who have gained new coverage under recent waivers has been quite limited, well below projections and small compared to overall growth in Medicaid enrollment (Figure 1).



Specifically this analysis finds:

- Section 1115 waivers approved since January 2001 have resulted in a net gain in coverage of about 200,000 people (Table 1).** Since January 2001—the time period HHS typically uses when describing the impact of waivers—12 comprehensive waivers and waiver amendments (including nine HIFA-type waivers) have been approved. To date, the net gain in coverage from these waivers has been about 200,000 people who were previously ineligible for Medicaid, SCHIP or state-funded coverage.² This includes nearly 300,000 new enrollees in New York (the state with the largest number of people gaining new coverage through a recent waiver) and factors in the 192,000 people who Tennessee reports have lost coverage as a result of recent waiver changes.

Table 1
Net Gains in New Coverage From Recent Section 1115 Waivers*

Non-HIFA Type Waivers	104,263
HIFA-Type Waivers	97,763
TOTAL	202,026

*Comprehensive Section 1115 waivers approved since January 2001.

² See Appendix A for the sources and details of the state enrollment data. This analysis focuses on broad, comprehensive waivers, as distinguished from the more targeted waivers approved under the "Pharmacy Plus" and "Independence Plus" Section 1115 initiatives.

- **About 98,000 people have gained new coverage through HIFA-type waivers.** Nine of the 12 waivers approved since January 2001 are HIFA-type waivers or waiver amendments. These waivers have resulted in enrollment of about 98,000 of the 200,000 people who gained new coverage. If enrollment decreases resulting from one of these waivers (Oregon) were factored in, the net gain from HIFA-type waivers would be considerably lower.

These enrollment numbers are well below most state projections made at the time the waivers were approved and the number HHS cites when describing progress in covering the uninsured. Most recently, HHS reported that Medicaid and SCHIP waivers and state plan amendments have expanded coverage to 2.27 million people.³ Several factors account for the different numbers. The net gain in coverage reported here counts the number of people who have actually gained or lost coverage as a result of implemented waivers, based on state-reported enrollment data. The HHS estimate is based on state-projected coverage gains, and it includes about one million people estimated to have gained coverage through optional state expansions that did not require waivers. The HHS estimate includes projections for states that have not implemented waivers or that have only implemented a portion of their waivers and does not factor in coverage losses that have resulted from recent waivers. Further, the projections relied on by HHS represent different time periods—in some states, projected enrollment is for the first year of the waiver, while in other states it is for a later year or for multiple years. Finally, the HHS estimate includes some people who were previously insured through public coverage.

The small number of people gaining new coverage through recent waivers nationwide suggests that, in the current environment, waivers have only a limited ability to expand coverage. Additional programmatic flexibility, itself, has not resulted in a significant amount of new coverage and may have negative impacts on coverage and access to care. New resources appear to be required to significantly expand coverage.

- **Most waiver-related coverage gains are under waivers that rely on federal DSH or SCHIP funds.** These financing mechanisms are not new. They redirect federal funds toward new coverage, but hold limited potential for expansions since federal DSH and SCHIP funds are capped. Not all states have available funds to redirect toward coverage.
- **Enrollment results are mixed under waivers that utilize the new HIFA financing approach.** The three states—New Jersey, Oregon, and Utah—that utilized the HIFA financing approach of offsetting expansion costs with coverage reductions for existing enrollees have had mixed enrollment results. New Jersey’s waiver covered a closed group of low-income parents; enrollment in the waiver program is not open to other parents. Utah’s waiver extended a limited benefit package to about 17,500 of the 25,000 adults the state projected it would enroll, and the state has since closed enrollment into the program. In Oregon, a state that is experiencing significant fiscal problems, even with some reliance on SCHIP funds (in addition to the offsetting coverage reductions), enrollment losses appear to exceed coverage gains.
- **The impact of new flexibility on the adequacy and affordability of benefits should be considered.** Further analysis is needed to assess how new benefit, cost sharing, and

³ Testimony of The Honorable Thomas A. Scully, Hearing before the Committee on Energy and Commerce, The U.S. House of Representatives, “Challenges Facing the Medicaid Program in the 21st Century,” October 8, 2003.

enrollment cap policies under some recent waivers have affected beneficiaries, providers, and coverage rates.

When considering the impact that recent waivers have had on coverage gains, it is also useful to look at the waiver numbers in context:

- **Gains in coverage under waivers are a small portion of total Medicaid and SCHIP enrollment growth.** Total Medicaid and SCHIP enrollment grew by about 3.2 million people in 2002.⁴ Most of this enrollment growth occurred because more people became eligible for Medicaid due to the downturn in the economy. The entitlement feature of the program coupled with guaranteed federal funding allowed Medicaid to cover more people as the need for public coverage increased. This growth in Medicaid enrollment helped keep the number of uninsured people from rising even higher during the recent economic downturn. Overall, waivers played a very limited role in this coverage growth.

⁴ Ellis, E et al., "Medicaid Enrollment in 50 States: December 2002 Data Update," KCMU, December 2003; Smith, V. and D. Rousseau, "SCHIP Program Enrollment: June 2003 Update," KCMU, December 2003.

BACKGROUND

Overview of Section 1115 Waiver Policy

In exchange for federal financial participation, states administer the Medicaid and the State Children's Health Insurance Program (SCHIP) programs subject to certain federal standards. These standards set the basic rules regarding eligibility, benefits, and cost sharing, while leaving states broad discretion to provide additional coverage or benefits, to establish their service delivery systems, and to set the rates they pay their providers. To the extent that a state is looking to use federal Medicaid or SCHIP funds in ways that are not permitted under federal requirements and options, it may apply for a waiver of the federal rules as part of a "research and demonstration" project under Section 1115 of the Social Security Act. This provision of the law authorizes the Secretary of the Department of Health and Human Services (HHS) to let states use federal Medicaid and SCHIP funds in ways that are not otherwise allowed under the federal rules as long as the Secretary determines that the initiative is a research and demonstration project that "furthers the purposes" of the programs.

Section 1115 waivers are not new; they have been used in Medicaid and in other programs authorized by the Social Security Act for decades.⁵ At various times over the past 40 years, waivers have been promoted for one purpose or another. Much of the waiver activity in the early years, following the adoption of Section 1115, had to do with the administration of welfare programs. In the 1990's, a growing number of states began to turn to waivers to implement managed care in their Medicaid programs, and, in some cases, these managed care waivers included coverage expansions. (In 1997, federal law was changed to allow states to require most beneficiaries to enroll in managed care without having to seek a federal waiver.)

A state does not need a waiver to expand coverage to children, parents, pregnant women, elderly people or people with disabilities. It can exercise such options by submitting a Medicaid "state plan amendment." States do, however, need a waiver if they want to cover adults without dependent children (including those with chronic illnesses, such as HIV, that do not meet federal disability standards) or change some of the conditions of the coverage provided, for example, by charging premiums to individuals with somewhat higher incomes.

A longstanding component of federal Section 1115 waiver policy is that waivers that expand coverage must be "budget neutral" for the federal government.⁶ A state seeking to expand coverage through a waiver must show that federal costs under the waiver would not be any more than the federal costs in that state without the waiver. Over the years, states have relied on various approaches to establish budget neutrality. When states were implementing managed care waivers, some states used the anticipated savings from such arrangements to offset the cost of a coverage expansion. Several states redirected some of their Disproportionate Share Hospital (DSH) funds toward new coverage, and following the

⁵ Section 1115 waiver authority is the broadest but not the only source of waiver authority in Medicaid. Federal Medicaid law also allows for more targeted waivers to promote managed care and to provide people at risk of institutionalization with home and community-based long term care services.

⁶ Budget neutrality is not required by federal statute. In the early years of Section 1115 waivers, additional federal funds were made available to states undertaking Section 1115 research and demonstration projects.

enactment of SCHIP, states were permitted to redirect unexpended SCHIP funds to cover parents or pregnant women.⁷

The Health Insurance Flexibility and Accountability Section 1115 Waiver Initiative

In August 2001, HHS launched a major new Section 1115 waiver initiative, the Health Insurance Flexibility and Accountability (HIFA) initiative. The goal of HIFA was to “increase the number of individuals with health insurance coverage within current level Medicaid and SCHIP resources.”⁸ The HIFA initiative continues the tradition of requiring budget neutrality and permits states to offset coverage expansions in ways that have been allowed in the past—by redirecting SCHIP or DSH funds.⁹ HIFA guidelines also broadened the possible uses of SCHIP funds, allowing states to use them to cover adults without dependent children. Further, the HIFA model permits states to use savings achieved from reducing coverage below federal minimum standards for people already eligible for Medicaid to offset the cost of new coverage. States may also lower the cost of an expansion by scaling back benefits, charging higher cost sharing, or capping enrollment for the newly eligible groups covered by the waiver.

The other central component of the HIFA initiative was an emphasis on premium assistance—using Medicaid or SCHIP funds to subsidize health coverage purchased through employers or on the individual market. Premium assistance is already an option for states under Medicaid without a waiver, as long as the state determines that providing the premium assistance is cost-effective and the state fill in the gaps in benefits and cost sharing between the private coverage and federal Medicaid standards. HIFA allows states to provide premium assistance without supplementing private policies that fall short of federal standards.¹⁰

The post-HIFA experience with waivers has been affected by a number of factors. Since 2001, state revenues have been declining at record-setting rates, private and public health care costs and unemployment rates have been rising, and employer-based coverage has been contracting. While some states have moved forward to expand coverage for the uninsured, most are more focused on containing costs to reduce gaping state budget shortfalls.

GAINS IN NEW COVERAGE THROUGH WAIVERS

Section 1115 Waiver Activity Since January 2001

When HHS describes coverage gains due to waivers, it considers waivers approved since January 2001, including, but not limited to, HIFA-type waivers. Between January 2001 and December 2003, 12 comprehensive waivers and waiver amendments have been approved (Table 2). According to recent state enrollment data, there has been a net gain in new coverage of about 200,000 people as a result of these waivers. These enrollment numbers represent

⁷ Health Care Financing Administration (now Centers for Medicare and Medicaid Services), “State Children’s Health Insurance Program (SCHIP) Section 1115 Demonstration Policy,” July 31, 2000. In addition, HHS has considered waiver expansions that cover groups that could be covered under Medicaid without a waiver to be “pass throughs.” The state does not have to find offsetting savings to cover such groups (since they could be covered without a waiver), but it does still need to bring the group under a financing “cap,” which HHS uses to enforce its budget neutrality agreements with states.

⁸ Centers for Medicare and Medicaid Services, “Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative,” September 17, 2002, <http://www.cms.gov/hifa/default.asp>.

⁹ States also can continue to rely on “pass throughs” to establish budget neutrality (see footnote 7).

¹⁰ Alker, J., “Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity,” KCMU, October 2003.

those people who were covered under a waiver expansion and who were not previously eligible for Medicaid, SCHIP, or a state-funded coverage program. (See Appendix A for sources and details of state enrollment data.)

Table 2
Net Gains in New Coverage Under
Comprehensive Section 1115 Waivers Approved Since January 2001

State	Number Gaining New Coverage (State Enrollment Data)	Implementation Status of Waiver Expansion
Non-HIFA-Type Waivers		
District of Columbia	1,416 as of September 2003	Implemented February 2003
New York	294,464 as of September 2003	Implemented October 2001
Tennessee	-191,617 as of June 2003	No expansion included in waiver
<i>Non-HIFA-Type Subtotal</i>	104,263	
HIFA-Type Waivers		
Arizona	10,504 as of September 2003	Implemented October 2002
California	0	Not implemented
Colorado	253 as of September 2003	Implemented October 2002 Enrollment closed May 2003
Illinois	40,309 as of September 2003	Partially implemented October 2002
Maine	16,248 as of September 2003	Partially implemented October 2002
New Jersey	10,756 as of April 2003	Implemented March 2003 for a closed group of parents
New Mexico	0	Not implemented
Oregon	2,120 as of September 2003	Partially implemented February 2003 ¹¹
Utah ¹²	17,573 as of September 2003	Implemented July 2002 Enrollment closed November 2003
<i>HIFA-Type Subtotal</i>	97,763	
Total	202,026	

The largest new coverage gains came from New York's waiver, which was submitted in June 2000 and approved in June 2001.¹³ Given the size of the state's population, New York's waiver has brought in a relatively large number of new enrollees—nearly three times the combined total gains in coverage realized from all of the other recent waivers. While the number of New York's

¹¹ An expansion from 170-185% of poverty for pregnant women and children was implemented in February 2003; the state began receiving federal matching funds for and expanded eligibility from 170-185% of poverty for its previously fully state-funded premium assistance program in November 2002.

¹² Utah is not technically considered a "HIFA" waiver although it follows the basic HIFA model.

¹³ New York's actual waiver expansion enrollment is somewhat lower than reported here because the number includes some legal immigrants who are covered with state-only funds.

new enrollees is large compared to other states' waiver gains, it represents a relatively small portion—less than one percent—of New York's Medicaid program, which served 3.6 million people as of December 2002.¹⁴

In contrast to New York's waiver, Tennessee's waiver has resulted in a loss in coverage. Tennessee's longstanding waiver (called "TennCare") was modified substantially through amendments approved in May 2002. The waiver changed TennCare eligibility in a number of ways, but no new groups of people were covered as a result of these changes. The state reports that over 190,000 people lost coverage pursuant to these waiver changes and the process undertaken to implement the changes.

HIFA-Type Waivers

As seen in Table 2, nine of the twelve approved waivers are HIFA-type waivers. (Utah's waiver is not formally considered a HIFA waiver because it did not have a premium assistance component at the time it was initially approved and because it included some benefit changes that exceeded the HIFA guidelines. However, Utah has since added a premium assistance piece and, in general, its waiver follows the HIFA approach for financing coverage expansions.) About 98,000 people have gained new coverage as a result of these nine waivers (Table 2). (If Utah's waiver is not included in this count, the number of people gaining new coverage through HIFA waivers drops to 80,190, and the net gain in coverage from non-HIFA-type waivers grows to 121,836.)

It is important to note that new coverage under two of these waivers (Illinois and Maine) is phasing in. If these states continue with their phase-ins, enrollment gains will likely grow over time. On the other hand, three states (Colorado, New Jersey, and Utah) have stopped enrolling new people under their waivers; over time, their waiver enrollment numbers are expected to fall through attrition.¹⁵

In addition, Oregon has seen significant enrollment losses since implementing its waiver changes, although these losses are not factored into the enrollment data reported here because it is difficult to determine the exact number of people who have lost coverage as a direct result of the waiver changes. Oregon's waiver authorized reductions as well as expansions in coverage. Due to state budget pressures, the state has only implemented a small portion of the approved expansions, while moving forward with the approved reductions, including increased and new premiums for some parents and other adults who were previously eligible for Medicaid coverage.¹⁶ Oregon reports that, as of September 2003, about 2,100 people had gained new coverage, but about 32,000 people had disenrolled because they did not pay the premiums. While it is not possible to know how many people dropped out of the program because they could not afford the premiums (some may have found other coverage or may have moved out of

¹⁴ Ellis, E et al., "Medicaid Enrollment in 50 States: December 2002 Data Update," KCMU, December 2003.

¹⁵ Utah is continuing to enroll people in its recently implemented premium assistance program, but enrollment is quite limited. As of November 20, 2003, 15 people were enrolled.

¹⁶ Poor parents and other adults are subject to monthly premiums ranging from \$6-\$20, based on income. Some of these beneficiaries paid premiums before the recent waiver; however, their premiums increased under the waiver.

state), studies that have examined the impact of premiums on low-income people have shown that even relatively low premiums can have a significant negative effect on participation.¹⁷

ACTUAL ENROLLMENT VERSUS PROJECTIONS

The number of people reported by states as gaining new coverage as a result of waivers is, overall, and for most individual states, far below projections (Table 3). The projections were made at the time the waivers were first approved (the sources are typically the formal waiver application or approval documents; sources are identified for each state in Appendix A).

Table 3
Enrollment Data Compared to Enrollment Projections for
Comprehensive Section 1115 Waivers Approved Since January 2001

State	Number of People Projected to Gain Coverage (State Estimates)	Number Gaining New Coverage (State Enrollment Data)	Expansion Implemented?
Non-HIFA-Type Waivers			
District of Columbia	1,200 in the first year	1,416 as of September 2003	Yes
New York	619,000 when fully implemented	294,464 as of September 2003	Yes
Tennessee	No gains projected	-191,617 as of June 2003	N/A
HIFA-Type Waivers			
Arizona	21,250 in the first year	10,504 as of September 2003	Yes
California	275,000 in the third year	0	No
Colorado	13,000 over a four-year period	253 as of September 2003	Enrollment closed
Illinois	29,000 in the first year 300,000 when fully implemented	40,309 as of September 2003	Partially
Maine	11,480 in the first year	16,248 as of September 2003	Partially
New Jersey	12,000 parents with applications pending in June 2002	10,756 as of April 2003	Enrollment closed
New Mexico	40,000 in the fifth year	0	No
Oregon	60,000 in the second year	2,120 as of September 2003	Partially
Utah	25,000 in the second year	17,573 as of September 2003	Enrollment closed

The enrollment numbers also are well below the number HHS cites when describing progress in covering the uninsured. Most recently, HHS reported that Medicaid and SCHIP waivers and

¹⁷ Hudman, J. and M. O'Malley, "Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations," KCMU, March 2003; Ku, L., "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 2003; State Planning Grant Consultant Team, "Income Adequacy and the Affordability of Health Insurance in Washington State," June 2002.

state plan amendments have expanded coverage to 2.27 million people.¹⁸ Several factors account for the different numbers.

The state enrollment data presented here were reported by each of the waiver states and represent the number of people with new coverage due to recent Section 1115 waivers who were enrolled at a recent point in time—generally, as of September 2003. Coverage losses due to recent waiver changes that have been reported by Tennessee have been factored into the data, and people who were previously eligible for Medicaid, SCHIP, or state-funded coverage have not been included since they have not gained new coverage as a result of waivers. In contrast, the HHS estimate is based on state-projected coverage gains through waiver expansions and it includes one million people estimated to have gained coverage through optional state expansions that did not require waivers.¹⁹ The waiver coverage gains cited by HHS include projections for states that have not implemented their waivers or that have only implemented a portion of their waiver. Also, the state projections represent different time periods; in some cases, projected enrollment is for the first year of the waiver, while in other cases it is for a later year or for multiple years (the time periods for the projections are noted in Table 3). The HHS estimate is based on the sum of these projections. The numbers also are different because, in some cases, enrollment has been lower than projected in states that have implemented their waivers. Finally, the HHS estimate does not factor in losses in coverage due to recent waiver changes and it includes some people who were previously insured through public coverage. (See Appendix B for a fuller explanation of these factors.)

ISSUES

Characteristics of Waivers that have Resulted in Coverage Gains

As seen in Table 4, flexibility alone has not resulted in much new coverage. Three states used the HIFA financing approach of offsetting expansion costs with waiver-approved coverage reductions for existing enrollees. New Jersey's waiver resulted in the enrollment of a closed group of low-income parents who had already filed applications for coverage with the state; no new parents can enroll in the waiver program. Utah's waiver has expanded coverage to about 17,500 of the 25,000 parents and other adults the state projected to enroll, and the state recently closed enrollment. In Oregon, even with some reliance on SCHIP funds (in addition to offsetting coverage reductions), enrollment losses likely exceed coverage gains. This is largely due to the fact that the state has moved forward with the reductions approved under the waiver, including increased and new premiums for some previously eligible groups, but has only implemented a small portion of its approved expansions.

In addition to examining the enrollment results of these waivers, it is important to consider other aspects of the new flexibility in terms of the adequacy and affordability of benefits. Utah's waiver benefits, for example, are quite limited, particularly with respect to people with serious medical needs, as the waiver covers primary care but not specialty or hospital care. Oregon has increased and added new premiums for people with incomes below poverty, and New

¹⁸ Testimony of The Honorable Thomas A. Scully, Hearing before the Committee on Energy and Commerce, The U.S. House of Representatives, "Challenges Facing the Medicaid Program in the 21st Century," October 8, 2003.

¹⁹ HHS provided an explanation of its projections to Senator Baucus; see Secretary's Responses to Questions from Senator Baucus, Hearing before the Committee on Finance, U.S. Senate, February 27, 2003, "Examining the Administration's Fiscal Year 2004 Health Care Priorities", Hearing record, at page 43; <http://finance.senate.gov/hearings/89348.pdf>.

Mexico's waiver (which is not yet implemented) would charge people with incomes below poverty copayments as high as \$25 for some services. Some states with premium assistance waiver programs have been allowed to use Medicaid and SCHIP funds to finance insurance plans available in the private market, even if the scope of benefits is considerably below federal standards or the cost sharing requirements are well above the limits imposed by federal law. In addition, some states, including Oregon, Utah, and the District of Columbia, have obtained waiver authority to freeze or cap Medicaid enrollment, essentially eliminating the entitlement nature of the program for some groups of people. (The waivers in Utah and the District of Columbia allow caps for newly eligible groups; Oregon's waiver allows the state to apply a cap to some parents and other adults who were eligible for Medicaid prior to the recent waiver.)

Table 4
Financing Mechanisms of Comprehensive
Section 1115 Waivers Approved Since January 2001

State	Number of People Gaining New Coverage (State Enrollment Data)	Benefit Reductions or Increased Cost Sharing for Groups Eligible Prior to the Waiver	Redirected Federal SCHIP or DSH Funds
Non-HIFA-TYPE Waivers			
New York	294,464		✓
D.C.	1,416		✓
Tennessee	Not Applicable		
HIFA-Type Waivers			
Illinois	40,309		✓
Utah	17,573	✓	
Maine	16,248		✓
New Jersey	10,756	✓	✓
Arizona	10,504		✓
Oregon	2,120	✓	✓
Colorado	253		✓
California	0		✓
New Mexico	0		✓

The states with the largest enrollment gains due to waivers are New York, Illinois, Utah and Maine. Of these states, only Utah reduced coverage for existing beneficiaries to cover other people, as permitted under HIFA. New York, Maine, and Illinois all relied on federal DSH or SCHIP funds, not benefit reductions or new cost sharing, to finance their expansions.²⁰ These financing mechanisms were available before HIFA, although HIFA guidelines gave states the new ability to use SCHIP funds to cover adults without dependent children, as was permitted in Arizona and New Mexico.

²⁰ New York also relied on "pass through" waiver financing for parents covered under the waiver. (See footnote 7 for a description of "pass through.")

SCHIP is a particularly attractive funding source because of its enhanced matching rate (and therefore lower state funding contribution). However, both SCHIP and DSH funds are capped and states' ability to rely on these funding sources varies considerably. Moreover, some questions have been raised about the propriety of allowing states to use SCHIP funds to cover adults without dependent children, given that SCHIP was legislatively designed to broaden coverage for children.²¹

It is too early to analyze enrollment gains achieved through premium assistance programs, which is another focus of the HIFA initiative. To date, state adoption of premium assistance programs has been limited.²² As part of their HIFA waivers, Arizona and Colorado agreed to study the feasibility of implementing a premium assistance program. Both states issued reports citing practical impediments to implementing a program. Arizona has since filed an amendment to add a premium assistance program under its waiver, which is pending. Five states (Illinois, New Mexico, Oregon, Tennessee and Utah) received approval for new or expanded premium assistance programs as part of their recent waivers. To date, only Oregon and Utah have implemented their programs. Oregon primarily refinanced an existing state-funded program and added a small expansion in eligibility. Utah's program is the only new program that has been implemented; it was implemented very recently, and, as such, it may be too new to offer much insight into how well the approach is working in the state.

How Waiver Coverage Gains Compare to Overall Medicaid Growth

The early experience with recent waivers shows that nationwide only a relatively small number of people have gained new coverage through these initiatives. The waivers have provided valuable services to the people gaining new coverage, but these people represent only a tiny fraction of overall Medicaid and SCHIP enrollment, which, in 2003, is estimated to be 54 million people.²³ Compared to overall recent growth in Medicaid and SCHIP enrollment by 3.2 million people in 2002, the waiver expansion numbers are quite small (Figure 2).²⁴

Most of this enrollment growth occurred because more people became eligible for Medicaid as the downturn in the economy lowered incomes and caused people to lose employer-sponsored coverage. The entitlement feature of the program coupled with guaranteed federal funding allowed Medicaid to cover the additional people who needed and qualified for coverage. According to the Census Bureau, the growth in Medicaid and SCHIP enrollment offset a significant portion of the drop in employer-based coverage in 2002, helping to reduce the number of people who were uninsured during that year.²⁵

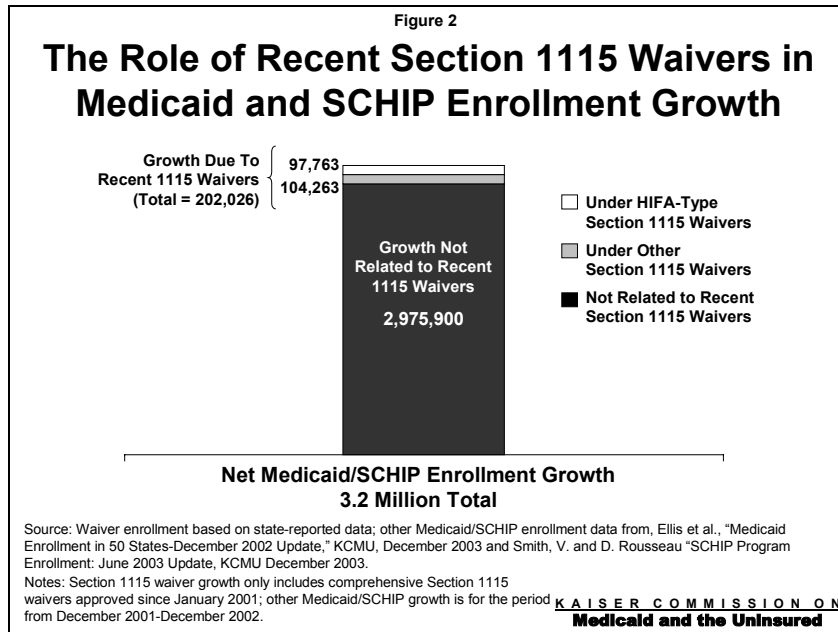
²¹ General Accounting Office, "Medicaid and SCHIP: Recent HHS Approval of Demonstration Waiver Projects Raise Concerns," July 2002, GAO-02-817.

²² Alker, J., "Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity," KCMU, October 2003.

²³ Congressional Budget Office, "Fact Sheet for CBO's March 2003 Baseline Medicaid and the State Children's Health Insurance Program," March 11, 2003, <http://www.cbo.gov/factsheets/medicaid.pdf>.

²⁴ Ellis, E. et al., "Medicaid Enrollment in 50 States: December 2002 Data Update," KCMU, December 2003; Smith, V. and D. Rousseau, "SCHIP Program Enrollment: June 2003 Update," KCMU, December 2003.

²⁵ U.S. Census Bureau, "Health Insurance Coverage in the United States: 2002," Current Population Reports, September 2003.



At the same time, however, the downturn in the economy makes it difficult for states to manage their share of the growing cost of the program. States have been taking action to reduce their Medicaid spending, and, increasingly, some states have turned to eligibility reductions as a way to curb state spending. A recent survey of the states shows that the federal initiative to temporarily increase states' federal Medicaid matching rate has helped many states avert taking actions that would result in coverage losses.²⁶ However, that same survey and several other analyses of state fiscal pressures show that coverage under Medicaid and SCHIP continues to be at risk.

CONCLUSION

Overall, the number of people who have gained new coverage under recent waivers has been quite limited, particularly when compared to overall growth in Medicaid and SCHIP enrollment. Medicaid's potential for covering people, particularly in an economic downturn, and the limited impact waivers have had on coverage gains suggest that strategies to strengthen and support states' ability to maintain and expand their Medicaid programs may hold more promise for reducing the number of uninsured Americans than waivers. Waivers have a role to play in the Medicaid and SCHIP programs, but their impact on coverage and access to care, as well as efforts to reduce the number of uninsured Americans raise many questions that require further analysis.

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²⁶ Smith, V. et al., "States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2003," KCMU, September 2003.

**APPENDIX A:
SOURCES AND DETAILS OF STATE ENROLLMENT AND PROJECTION DATA**

Arizona

- Enrollment data are for “KidCare Parents” and “SOBRA Parents” and are from *Eligibility and Enrollment Report for September 1, 2003*, <http://www.ahcccs.state.az.us/statistics>.
- Projection from the *Arizona Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal-Phase II*, September 18, 2001, <http://www.cms.gov/hifa/azhifa.asp>. The time period of the projection was confirmed through communications with a state official.

California

- No enrollment data are reported because the waiver has not been implemented.
- Projection from the *California Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, January 16, 2002 and Centers for Medicare and Medicaid Services, *California Health Insurance Flexibility and Accountability (HIFA) Initiative Fact Sheet*, May 23, 2002, <http://www.cms.gov/hifa/cafactsh.asp>. The time period of the projection is based on the *States Responses to Health Care Financing Administration Questions Regarding Section 1115 Proposal*, March 2001, http://www.mrmib.ca.gov/MRMIB/HFP/Parent_HCFA_Waiver_Resp.html.

Colorado

- Enrollment data are for newly eligible pregnant women and were reported through communications with a state official, November 3, 2003.
- Projection from the *Colorado Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, May 14, 2002 and Centers for Medicare and Medicaid Services, *Special Terms and Conditions for Colorado Adult Prenatal Coverage in CHP+*, September, 27, 2002, both at <http://www.cms.gov/hifa/cohifaapc.asp>. The time period of the projection is based on Attachment F of the application and was confirmed through communications with a state official.

District of Columbia

- Enrollment data are for newly eligible adults between ages 50-64 and were reported through communications with a District of Columbia official, October 24, 2003.
- Projection from *District of Columbia Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, October 19, 1999; Centers for Medicare and Medicaid Services, *Special Terms and Conditions for District of Columbia Medicaid Section 1115 Proposal for Childless Adults Ages 50-64*, March 7, 2002, and Centers for Medicare and Medicaid Services, *District of Columbia Section 1115 Waiver Fact Sheet*, February 3, 2003, <http://www.cms.gov/medicaid/1115/dc1115ca.asp>. The time period of the projection was confirmed through communications with a state official.

Illinois

- Enrollment data are for newly eligible parents with incomes between 39-90% FPL; the data do not include previously eligible parents with incomes below 39% FPL or enrollees covered by the waiver who were previously eligible for the state-funded ICHIP, Hemophiliac, and Rebate programs. Enrollment data from *Illinois Parent Coverage Waiver Health Insurance Flexibility and Accountability 1115 Demonstration Project Quarterly Progress Report July 1, 2003-September 30, 2003*.
- Projection and the projection time period from communications with a state official, December 5, 2003.

Maine

- Enrollment data are for newly eligible adults without dependent children and were reported through from communications with a state official, November 3, 2003. State officials report that these enrollment data may overstate newly eligible enrollees. The state estimates that some portion of the adults covered may be eligible under the pre-existing disability coverage category.
- Projection and the projection time period from the *Maine Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, July 25, 2001 (Transmitted to the Centers for Medicare and Medicaid Services February 21, 2002), <http://www.cms.gov/hifa/mehifamcca.asp>.

New Jersey

- Enrollment data are for parents who had applications on file when enrollment under the earlier expansion was closed in June 2002, who were determined eligible for coverage. The data were reported through communications with a state official, October 1, 2003.
- Projection from the *New Jersey Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, July 25, 2001, <http://www.cms.gov/hifa/njhifa1.asp>.

New Mexico

- No enrollment data are reported because the waiver has not been implemented.
- Projection and the projection time period from the *New Mexico Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, April 3, 2002, <http://www.cms.gov/hifa/nmhifasci.asp>.

New York

- Enrollment data are for newly eligible parents and adults without dependent children and are from United Hospital Fund analysis of New York Department of Health Enrollment Reports, October 2003. Actual waiver expansion enrollment is somewhat lower than reported

because the reported number includes some legal immigrants who are ineligible for federally-funded Medicaid coverage, but who are covered with state-only funds.

- Projection and projection time period from the *New York State request for a Section 1115 Waiver Amendment*, June 30, 2000, <http://www.cms.gov/medicaid/1115/ny1115pp.asp>.

Oregon

- Enrollment data are for the following implemented expansion groups: pregnant women 170-185% FPL, children 170-185% FPL, and Family Health Insurance Assistance Program (FHIAP) enrollees 170-185% FPL. The data do not include FHIAP enrollees with incomes below 170% FPL, who were eligible for state-funded FHIAP coverage prior to the waiver. The data were reported through communications with a state official, October 3, 2003.
- Projection is from the *State of Oregon 1115 Waiver Amendment Application and Oregon Application Template for Health Insurance Flexibility and Accountability Section 1115 Demonstration Proposal*, May 31, 2002. The projection and the projection time period were confirmed through communications with a state official.

Tennessee

- As part of its waiver changes, Tennessee made changes in eligibility standards and required existing beneficiaries to reapply for Medicaid coverage to “redetermine” eligibility for coverage. About 47,000 people lost coverage because they were found to be no longer eligible for coverage, while about 144,000 were disenrolled because they did not complete the process used to determine whether people continued to be eligible; this led to a total loss of coverage for over 190,000 people. Enrollment data from *TennCare Waiver: CMS Quarterly Progress Report Second Quarter, April-June 2003*, August 2003.

Utah

- Enrollment data are for newly eligible parents and other adults; the data do not include the 1,058 enrollees who were previously insured through the state-funded Utah Medical Assistance Program (UMAP). It is likely that additional parents and other adults covered under the waiver expansion would have been eligible for the UMAP and, therefore, were not newly eligible for coverage as a result of the waiver. According to the state enrollment report, nearly 7,500 enrollees had incomes below the UMAP income-eligibility standards. However, to be eligible for UMAP, individuals also had to meet certain medical condition requirements; therefore, it is not possible to determine how many of the 7,500 enrollees would have been eligible for the UMAP. As such, only those individuals who were previously covered by the UMAP are excluded from the waiver expansion enrollment data. Enrollment data from the *Primary Care Network Enrollment Report as of 9/27/03*.
- Projection and the projection time period from the *1115 Demonstration Waiver Request for the Primary Care Network of Utah*, November 15, 2001 and Centers for Medicare and Medicaid Services, *Special Terms and Conditions for the Primary Care Network*, August 20, 2002; all materials available at <http://www.cms.gov/medicaid/1115/ut1115pcn.asp>.

**APPENDIX B:
FACTORS CONTRIBUTING TO THE DIFFERENCE BETWEEN STATE-REPORTED WAIVER
EXPANSION ENROLLMENT DATA AND HHS ESTIMATED COVERAGE GAINS**

The following factors provide insight into why state-reported enrollment in waiver expansions is much lower than HHS' estimated coverage gains:

- **The HHS estimate includes people who gained coverage under optional state expansions that do not require waivers.**

When HHS reports enrollment gains, it typically combines enrollment gains achieved through waivers with gains achieved through "state plan amendments." When states expand coverage under an option available under federal law, they submit a state plan amendment. No waiver is required for these expansions, and, as long as the state is properly exercising the option, federal approval is routine. It appears that the HHS figure includes about one million people HHS estimates have gained coverage as a result of state plan amendments.²⁷ (This report does not analyze the number of people who actually have gained new coverage through state plan amendments.)

- **The projections do not reflect the fact that several states have not implemented some or any of their waiver expansions.**

HHS projections include enrollment estimates for states that have not implemented their waiver expansions and that have no current plans to implement their expansions.²⁸ California is the state with the largest projected enrollment (275,000 people in the third year of the waiver) that has not gone forward with its expansion due to state budget pressures. New Mexico also has not implemented its expansion; the approved waiver was submitted by the former Governor and the current Governor has not decided whether to implement it.

Among the seven states with HIFA-type waivers that were implemented, five implemented only a portion of their planned expansions, generally as a result of state budget pressures. Three states (Colorado, New Jersey, and Utah) have stopped enrolling people under their expansions, while two other states (Illinois and Maine) appear to be moving ahead with phased-in implementation of their waiver expansions. Arizona is the only state that has fully implemented its waiver expansion and that has not imposed a cap on enrollment.

- **The HHS projection is based on state projections that cover different time periods, including both one-year and multi-year projections.**

The time periods corresponding to the state projections are noted in Table 3. Several state projections represent estimated enrollment in the first year of waiver operations, while other state projections are based on estimated enrollment several years into a waiver program's operations. For example, Maine's estimate is for enrollment in the first year of the waiver, while New Mexico's estimate is for the number of people that will be enrolled in the fifth year of the waiver program. In one state, the projection represents multi-year cumulative projected enrollment—Colorado estimates that a total of about 13,000 people will be

²⁷ Secretary's Responses to Questions from Senator Baucus, Hearing before the Committee on Finance, U.S. Senate, February 27, 2003, "Examining the Administration's Fiscal Year 2004 Health Care Priorities", Hearing record, at page 43-44 <http://finance.senate.gov/hearings/89348.pdf>.

²⁸ Ibid.

enrolled over the four-year life of the waiver. HHS' estimate combines these estimates without accounting for the different time periods.²⁹ The state enrollment data reported here represent the number of people with new coverage who were enrolled at a recent point in time—generally, as of September 2003.

- **Costs imposed on beneficiaries and/or limited benefit packages that were approved as part of some waivers may also be contributing to lower-than-projected enrollment.**

Utah's waiver, for example, required all newly eligible people, including those with little or no income to pay a \$50 annual enrollment fee. This has reportedly caused some people to not enroll or to drop coverage at renewal, prompting social service agencies to pay the fees for some enrollees and the Legislature to lower the fee to \$35 for some people. In addition, the benefits provided under some of the waivers are quite limited and carry significant co-payment requirements, factors that may also lower participation particularly for people with significant illnesses or disabilities who may decide not to pay a premium or enrollment fee because the program does not meet their needs.

- **Losses that have occurred as a result of waiver changes are not included in the HHS projection.**

Tennessee has a longstanding waiver, which was significantly amended in May 2002. As part of the waiver changes, the state made changes in eligibility standards and required existing beneficiaries to reapply for Medicaid coverage to "redetermine" eligibility for coverage. According to a state report submitted to the federal government, about 47,000 people lost coverage because they were found to be no longer eligible for coverage, while about 144,000 were disenrolled because they did not complete the process used to determine whether people continued to be eligible; this led to a total loss of coverage for over 190,000 people.³⁰ These losses are not factored into the HHS projection.³¹ The enrollment data reported here include the coverage losses reported by Tennessee but not other losses resulting from waivers for which there are no reliable data.

- **The projections include people in some states who were insured prior to the waiver.**

HHS' projection includes (for some waivers) people who already had publicly-funded coverage prior to the recent waiver. Some waivers included a refinance of one or more state-funded coverage programs, allowing the state to claim federal matching funds for coverage previously financed with state funds. These arrangements can bring needed fiscal relief to states, but the people who moved from state-funded coverage to federally-financed coverage were not uninsured before the waiver and did not gain new coverage as a result of the waiver. Illinois, Oregon, and Utah all moved some groups of people who had been previously insured through state-funded coverage into their federally-financed waivers, and

²⁹ Ibid.

³⁰ State of Tennessee Bureau of TennCare, "TennCare Waiver: CMS Quarterly Progress Report, Second Quarter, April-June 2003," August 2003.

³¹ Secretary's Responses to Questions from Senator Baucus, Hearing before the Committee on Finance, U.S. Senate, February 27, 2003, "Examining the Administration's Fiscal Year 2004 Health Care Priorities", Hearing record, at page 43-44 <http://finance.senate.gov/hearings/89348.pdf>.

it appears these people are included in the HHS estimate.³² (Each of these states also expanded coverage to some newly eligible groups.) The HHS estimate also appears to include about 89,000 people covered through managed care and home and community-based waivers under sections 1915(b) and 1915(c) of the Medicaid legislation.³³ There were no expansions in coverage under these waivers since they extended or renewed existing programs. The enrollment data presented here do not include people previously covered by state-funded programs or 1915 programs, since they are not gaining new coverage.

³² Ibid. Also, Arizona used its waiver to refinance a federally-financed group; it moved a Medicaid group into SCHIP to gain the higher federal matching rate. Oregon's waiver covers some people who were already eligible for Medicaid; their coverage was reduced under the most recent waiver. HHS has stated that it has not counted groups previously eligible for Medicaid or SCHIP in its projections, but it appears that for Arizona and Oregon these groups have been included in the projections.

³³ Ibid.

