kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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COVERAGE GAINS UNDER RECENT SECTION 1115 WAIVERS: A DATA UPDATE

by Samantha Artiga and Cindy Mann

Executive Summary

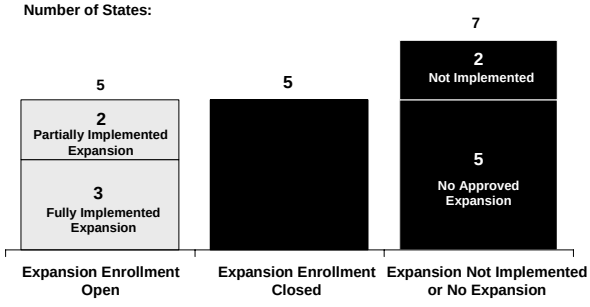
Recently, waivers have been promoted as a way to expand the number of people covered within existing resources and cited as a model for Medicaid reform. Some recent waivers have included coverage expansions, but increasingly, in light of fiscal pressures, states have also looked to waivers to as a way to reduce state costs. To assess the extent to which recent waivers have helped reduce the number of uninsured people, the brief updates data on the number of people that have gained new coverage under recent Section 1115 waivers (i.e., those approved since January 2001).[1] Other work will examine broader implications of recent waivers, including cost reductions. This analysis finds:

Five of the seventeen waivers approved between January 2001-April 2005 had implemented expansions that were enrolling newly eligible people as of April 2005. Between January 2001 and April 2005, 17 states had comprehensive Section 1115 waivers or waiver amendments approved. Twelve of these waivers included an expansion, and ten of the twelve were at least partially implemented as of April 2005. Only five, however, were still enrolling newly eligible people (Figure 1).

There has been a net gain in coverage of 426,329 people under recent waivers. There was a total coverage gain of 672,887 people. Over two-thirds of this gain (68% or 462,169 people) stemmed from New York, reflecting the significant size of the state's overall Medicaid program and total population (Figure 2). Enrollment declines in Oregon and Tennessee partially offset the gains, reducing them by 37% or 246,558 people. (This analysis does not include coverage losses from the most recent waiver amendment in Tennessee, under which the state currently is disenrolling an additional 226,000 people.)

Figure 1

Status of Coverage Expansions in Recent Section 1115 Waivers



Source: KCMU and Georgetown University Analysis
Notes: Current as of April 2005; includes waivers approved January 2001-February 2005. Some waivers amend pre-existing waivers. Some waivers with closed enrollment have held brief open enrollment periods since enrollment was initially closed.

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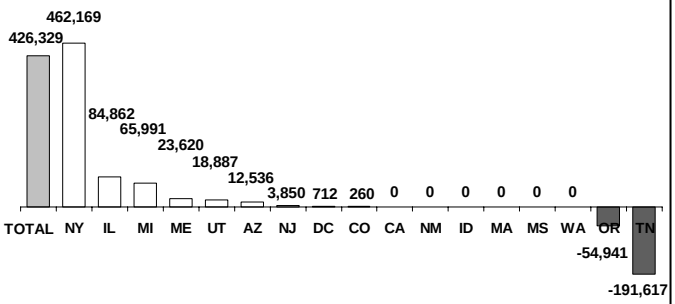
Figure 2

Net Coverage Changes Under Recent Section 1115 Waivers



Notes: Section 1115 waiver coverage based on enrollment data from comprehensive Section 1115 waivers approved since January 2001 as of Winter of 2005.
Source: Waiver enrollment based on state-reported data.

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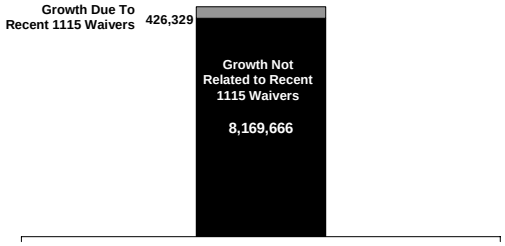
[1] This brief updates data from, Mann, C., Artiga, S., and J. Guyer, "Assessing the Role of Recent Waivers in Providing New Coverage, Kaiser Commission on Medicaid and the Uninsured, December 2003.

Coverage growth under recent waivers represented only a small fraction of total recent Medicaid growth. While recent waivers extended coverage to 426,329 previously uninsured people, total Medicaid enrollment grew by some 8.6 million people in recent years (Figure 3).

There was great variation across states in terms of the impact of recent waivers on coverage. Differences in the coverage changes reflect differences in waiver design, state implementation decisions, and enrollment limits. Waiver-related gains accounted for 9%-12% of total caseload in Maine, Utah and New York, 5% in Illinois and Michigan, and 2% or less in four states (Arizona, New Jersey, District of Columbia, and Colorado). Losses exceeded gains in one state (Oregon) and another state (Tennessee) experienced only enrollment losses.

Figure 3

The Role of Recent Section 1115 Waivers in Medicaid Enrollment Growth



Notes: Section 1115 waiver coverage based on enrollment data from comprehensive Section 1115 waivers approved since January 2001 as of Winter of 2005; other Medicaid growth is for the period December 2000 through June 2004.
Source: Waiver enrollment based on state-reported data; Medicaid enrollment data from Kaiser Commission on Medicaid and the Uninsured Medicaid enrollment update, forthcoming.

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In sum, recent waivers resulted in a net gain in coverage of 426,329 people nationwide, with most of these gains resulting from New York's waiver. The impact of recent waivers on coverage varied significantly across states, with some states experiencing gains and two states experiencing net declines. Overall, the waiver coverage gains represent a small portion of recent overall growth in the Medicaid program nationwide as well as in the waiver states.

The relatively limited coverage gain under recent waivers reflects the difficult budget situations in most states, which sometimes precluded embarking on coverage expansions, and the lack of additional federal funds under waivers. States with waivers become subject to caps on federal financing and are at risk for costs that exceed the cap. To work within this financing arrangement, states often have to limit the number of people they enroll in their expansion, and, in some cases, the scope of coverage they provide. Overall, the experience with recent waivers suggests that the increased flexibility allowed through waivers, without added federal financing, has limited ability to generate and support substantial, ongoing coverage expansions.

I. Introduction

Medicaid serves many roles in the health care system, providing health coverage and long-term care assistance to millions of Americans, filling in gaps in Medicare coverage, and supporting safety-net providers. In 2003, Medicaid covered over 39 million children, parents, and pregnant women in low-income families and 12 million elderly and disabled people. While Medicaid helps stitch together the holes in the health care system, substantial needs remain. Since the economic downturn in 2001, family incomes have shifted downward and the share of Americans with employer-sponsored insurance has declined for four consecutive years.[2] The number of uninsured has grown by over five million since 2000, and now more than one in six of the nonelderly population lacks insurance (18%).[3] Medicaid helped offset some of the recent decline in employer-sponsored insurance, preventing even higher growth in the uninsured.[4]

States have many options under Medicaid to expand coverage to the uninsured and, over time, all states have taken advantage of at least some of these options. In the past, some states have also used Medicaid waivers to expand coverage to groups of people that could not be covered under regular program options and/or to alter the benefits or cost sharing for the newly covered groups in ways that are not permitted under regular program options.

Recently, waivers have been promoted as a way to expand the number of people covered within existing resources and cited as a model for Medicaid reform.[5] Some recent waivers have included coverage expansions, but increasingly, in light of fiscal pressures, states have also looked to waivers to as a way to reduce state costs.[6]

To assess the extent to which recent waivers have helped reduce the number of uninsured people, the Kaiser Commission on Medicaid and the Uninsured collects state enrollment data for coverage expansions under recent Section 1115 waivers and waiver amendments (i.e., those approved since January 2001). This brief updates state-reported waiver enrollment data, using data from Winter 2004, where available.[7] The data are used to determine the number of people who gained "new" coverage or lost coverage as a result of recent waivers or waiver amendments. Because this analysis seeks to determine net gains in new coverage, the data exclude individuals who were enrolled under the waiver but who would have been eligible for coverage prior to the recent waiver (either under Medicaid or a fully state-funded coverage program).[8] (See Appendix A for more details on data.)

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[2] Hoffman, C., Carbaugh, A., and A. Cook, "Health Insurance Coverage in America: 2003 Data Update," Kaiser Commission on Medicaid and the Uninsured, November 2004.
[3] Ibid
[4] Ibid
[5] Leavitt, M., "Medicaid: A Time to Act," address to the World Health Care Congress, Washington, DC, February 2005.
[6] Artiga, S. and C. Mann, "New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity," Kaiser Commission on Medicaid and the Uninsured, March 2005.
[7] This brief updates 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.
[8] Some waivers refinance one or more state-funded coverage programs, allowing the state to claim federal matching funds for coverage previously financed with state funds. This can bring needed fiscal relief to states, but the people who move from state-funded coverage to federally-financed coverage were not uninsured before the waiver.

II. Background

The federal government and states jointly fund Medicaid, with the federal government paying 50%-77% of the costs, depending on the state. States administer the program guided by a combination of federal standards and state options. Section 1115 waivers allow states to use federal Medicaid funds in ways not otherwise allowed under federal law.[9]

Waivers have been used by states over the course of the Medicaid program's history to try new ways to provide coverage and to adopt new approaches to contain costs. In the mid-1990's, a number of states relied on waivers to require beneficiaries to enroll in managed care, an option that later became available to states without a waiver. States such as Tennessee and New York coupled their managed care initiatives with significant coverage expansions.

In 2001, the Secretary of Health and Human Services released new waiver guidelines, called the Health Insurance Flexibility and Accountability (HIFA) initiative, which encouraged states to look to Section 1115 waivers as a way to expand coverage within "current-level" resources.[10] Waivers do not offer states new federal funding for coverage expansions. Under longstanding federal policy, waivers must be budget neutral for the federal government. This means that federal costs under a waiver cannot be more than projected federal Medicaid costs without the waiver. Accordingly, if a state plans to expand coverage through a waiver to a group it could not have covered without a waiver, it must find savings to offset any new federal costs associated with the expansion.[11]

In the past, states have identified managed care-related savings or they have redirected Disproportionate Share Hospital Payments (DSH) to cover expansion costs. Soon after the State Children's Health Insurance Program (SCHIP) was enacted, the Administration also allowed SCHIP waivers, which permitted states to use unspent SCHIP funds to cover parents or pregnant women.[12] Under the HIFA initiative, states were offered two additional ways to offset the cost of a coverage expansion. They could use SCHIP funds to cover adults without dependent children and they could reduce the cost of covering existing beneficiaries by capping enrollment, limiting benefits, and or imposing new premium and cost sharing obligations.

Regardless of the type of offset used or even whether a waiver includes a coverage expansion, all Section 1115 waivers include budget neutrality caps. These financing caps limit the amount of federal funds available to a state under the waiver, providing assurance to the federal government that waiver expenditures will not exceed projections over the course of the waiver. States must either keep their costs below the caps or finance the excess cost with state-only dollars.

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[9] Lambrew, J., "Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview," Kaiser Commission on Medicaid and the Uninsured, July 2001.

[10] Centers for Medicare and Medicaid Services, "Health Insurance Flexibility and Accountability Demonstration Initiative," http://www.cms.hhs.gov/hifa/default.asp.

[11] Under long-standing policy, waiver expansions that cover groups that could be covered under Medicaid without a waiver are considered *"pass throughs,"* and states do not have to find offsetting savings for their coverage.

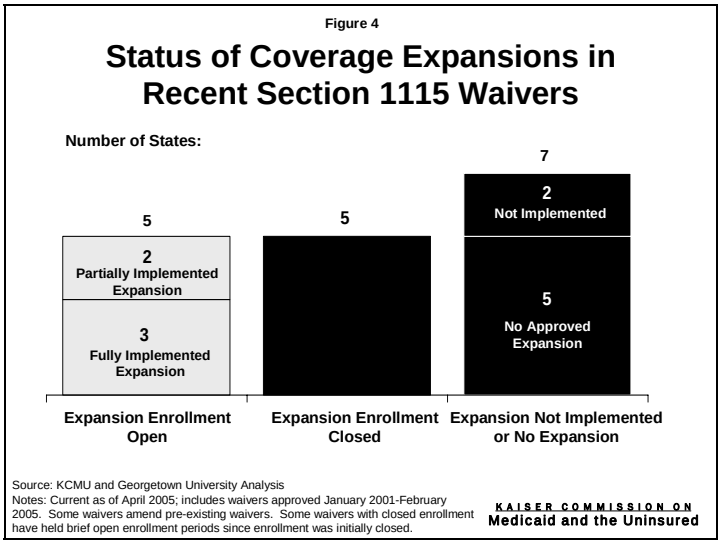
[12] Centers for Medicare and Medicaid Services, "Guidance on Proposed Demonstration Projects Under Section 1115 Authority," July 31, 2000.

III. FINDINGS

A. Overall Waiver-Related Coverage Gains and Losses

Between January 2001 and April 2005, the Secretary approved 17 comprehensive Section 1115 waivers or waiver amendments. Twelve included an approved expansion, and, as of April 2005, ten of these expansions had been at least partially implemented.[13] Only five of these waivers, however, were still enrolling newly eligible people (Figure 4).

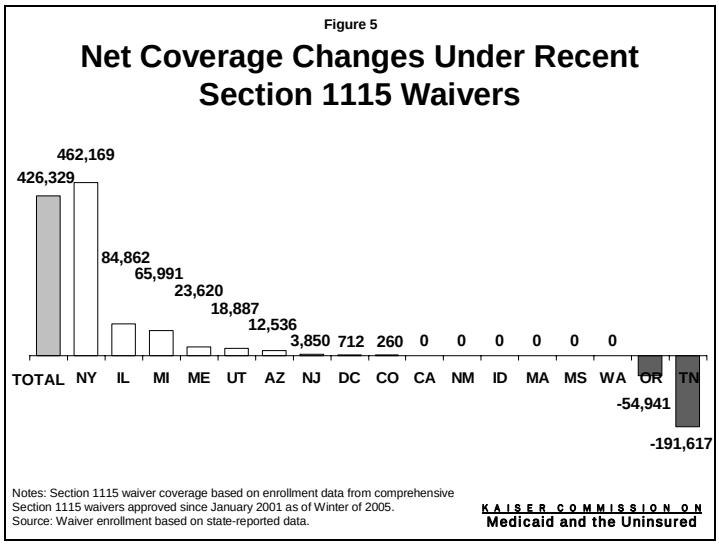
Figure 4



Nationwide, recent waivers resulted in a net gain in new coverage of 426,329 people. There was a total gain in coverage of 672,887 people. Over two-thirds (68% or 462,169 people) of this gain stemmed from New York (Figure 5). Enrollment declines in Oregon and Tennessee partially offset the gains, reducing them by 37% or 246,558 people. (This analysis does not include coverage losses from the most recent waiver amendment in Tennessee, under which the state currently is disenrolling an additional 226,000 people.)

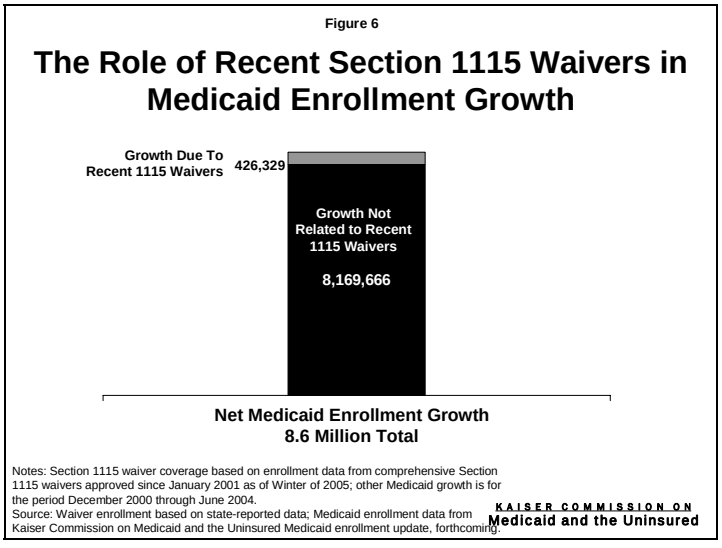
[13] A state with an approved waiver is not required to implement the waiver, or to implement all aspects of the waiver.

Figure 5



Coverage growth under recent waivers represented only a small fraction of total recent Medicaid growth. Between December 2000 and June 2004, total Medicaid enrollment grew by 8.6 million people. Much of this growth occurred because more people became eligible during the recent economic downturn. The existing Medicaid structure, with its open-ended federal financing, enabled the program to expand to meet the needs of the increasing number of people who became eligible as they lost jobs and experienced income declines. Waiver-related gains were responsible for a very small portion of total new enrollment (Figure 6).

Figure 6



B. Gains and Losses Across States

There was great variation across states in terms of the impact of recent waivers on coverage gains or losses. Differences in the coverage changes reflect differences in waiver design, state implementation decisions, and, in one case, enrollment limits stemming from the budget neutrality requirements that limit federal funding. Waiver-related gains accounted for 9%-12% of total caseload in Maine, Utah and New York, 5% in Illinois and Michigan and 2% or less in four states (Arizona, New Jersey, District of Columbia, and Colorado) (Table 1). Losses

exceeded gains in one state (Oregon) and another state (Tennessee) experienced only enrollment losses.

Table 1:
Net Coverage Changes Under Recent Section 1115 Waivers,
Waivers Approved Between January 2001-April 2005

State	Net Waiver Coverage Gains/Losses as of Winter 2005	Total Medicaid Enrollment as of June 2004	Waiver Coverage as a Percent of Total Medicaid Enrollment
NY	462,169	3,952,243	12%
IL	84,862	1,661,909	5%
MI	65,991	1,366,332	5%
ME	23,620	240,505	10%
UT	18,887	204,438	9%
AZ	12,536	836,034	2%
NJ	3,850	776,588	1%
DC	712	135,360	1%
CO	260	382,777	0%
CA	0	6,387,674	0%
NM	0	381,921	0%
ID	0	154,600	0%
MA	0	944,783	0%
MS	0	579,242	0%
WA	0	831,409	0%
OR	(-54,941)	376,656	-15%
TN	(-191,617)	1,345,131	-14%
Total	**426,329**	**20,818,574**	**2%**

States with Coverage Gains

New York's waiver, Family Health Plus, experienced the biggest gains, largely reflecting the significant size of the state's overall Medicaid program and total population. The waiver was submitted in June 2000 and was approved in June 2001, before the HIFA guidelines were released. The waiver provides nearly the full range of Medicaid benefits to newly eligible parents and childless adults. Similar to other waivers approved in the 1990s (including New York's earlier waiver), expansion costs were offset with a combination of DSH funds and savings from existing managed care arrangements (Table 2).

Illinois, Michigan, Maine, and Arizona also experienced sizeable coverage gains. These expansions were financed with redirected DSH or SCHIP funds. Illinois, Maine, and Arizona extended new coverage to adults (parents in Illinois and Arizona and adults without dependent children in Maine).[14] Except in Michigan, benefits are comparable to the benefits provided to other adults in the Medicaid program. Michigan originally extended a fairly broad set of benefits to adults without dependent children, although, under a more recent waiver amendment, these benefits have been scaled back and no longer include inpatient hospital care. Further, enrollment in Michigan's expansion was closed after it reached its enrollment cap. Maine also closed enrollment into its expansion because it reached its budget neutrality cap under the waiver and, therefore, could not access additional federal matching payments to support additional coverage.

[14] Illinois and Arizona also refinanced coverage previously provided with SCHIP funds.

Table 2:
Net Coverage Changes, Implementation Status, and Financing Mechanisms for Recent Section 1115 Waivers, Waivers Approved Between January 2001-April 2005

State	Net Coverage Gains/Losses as of Winter 2005	Waiver Includes Expansion?	Expansion Implemented?	Expansion Enrollment Open as of April 2005?	Financing Mechanisms	
					Benefit Reductions/ Cost Sharing Increases for Previously Eligible Groups	Redirected Federal DSH/SCHIP Funds
NY	462,169	✓	✓	✓		✓
IL	84,862	✓	Partially	✓		✓
MI	65,991	✓	✓	X		✓
ME	23,620	✓	Partially	X		✓
UT	19,559	✓	✓	X[15]	✓	
AZ	12,536	✓	✓	✓		✓
NJ	3,850	✓	✓	X	✓	
DC	712	✓	✓	X		✓
CO	260	✓	✓	✓		✓
CA	0	✓	X	N/A		✓
NM	0	✓	X	N/A		✓
ID	0	X	N/A	N/A	N/A	
MA	0	X	N/A	N/A	N/A	
MS	0	X	N/A	N/A	N/A	
WA	0	X	N/A	N/A	N/A	
OR	(-54,941)	✓	Partially	✓	✓	
TN	(-191,617)	X	N/A	N/A	N/A	
Total	**426,329**	**12**	**Fully: 7 Partially: 3**	**5**	**3**	**9**

Utah's waiver has attracted considerable attention both because it provides a very limited benefit package to its expansion group and because of how it offset its waiver expansion costs. Although not technically considered a "HIFA" waiver, Utah relied on the new HIFA-endorsed financing approach of reducing benefits and increasing cost sharing for existing beneficiaries to keep its expansion to parents and other adults budget neutral for the federal government. The state also kept the costs of its expansion low by limiting the benefits covered for its expansion population (for example, it does not cover specialty or hospital care other than emergency room use)[16] and by charging an annual enrollment fee and copayments. Under the waiver, enrollment in the "Primary Care Network" expansion is limited to 19,000 adults. The state first reached this

[15] Enrollment under Utah's main waiver expansion is closed. Utah does still enroll people in its premium assistance waiver program, but enrollment is very limited. As of April 2005, 70 people were enrolled.

[16] While inpatient hospital and specialty care are not covered, the state made informal agreements with the hospitals and specialty care providers to provide some donated or charity care.

cap and closed enrollment in November 2003. Since then, the state has held several brief open enrollment periods. Enrollment has been closed since January 2005.

Utah's waiver also includes a premium assistance expansion, called "Covered at Work," which provides subsidies for the purchase of private coverage to certain adults with access to employer-sponsored coverage. Under the waiver terms, the state can enroll up to an additional 6,000 people in Covered at Work, but as of April 2005, only 70 people were covered in this program.

New Jersey, the District of Columbia, and Colorado had more limited coverage gains. New Jersey's waiver originally expanded coverage to a closed group of 12,000 parents. Since implementation, enrollment has dropped off over time due to attrition. Colorado's enrollment is also limited because enrollment in its expansion for pregnant women was closed for over a year (between May 2003 and July 2004). It has been open since July 2004 and, thus, is expected to grow over time. The District of Columbia expanded coverage to a very narrow eligibility group—adults without dependent children between ages 50 and 64 with incomes below 50% of the federal poverty level. It closed enrollment into its expansion in November 2003. The smaller size of the District of Columbia's population combined with the narrow eligibility criteria and closed enrollment explain its more limited coverage gain.

States with Coverage Losses

Oregon's recent waiver activity builds on an earlier effort in Oregon to significantly expand coverage by providing a "prioritized" list of health benefits. Its more recent waiver and waiver amendment, approved in 2002 and 2004, came about largely as a result of Oregon's significant state budget pressures, exacerbated by a rollback in a tax increase adopted to address the state's considerable revenue shortfall.

The new waiver allowed the state to cap enrollment, reduce benefits, and increase premiums and cost sharing for previously eligible parents and other adults with incomes below 100% of the federal poverty line (about $16,090 per year for a family of three in 2005). It also authorized several coverage expansions—for pregnant women and children from 170% to 200% of poverty, for enrollees in its previously state-funded premium assistance program from 170% to 200% of poverty, and for parents and other adults from 100% to 185% of poverty. To date, the state has implemented the enrollment cap and it has reduced benefits and imposed the new premium and cost sharing requirements on previously eligible poor adults.[17] However, it has only implemented a small portion of its approved expansions—for pregnant women and children from 170% to 185% of poverty and in its premium assistance program from 170% to 185% of poverty. The larger adult expansion has not been implemented.

Following implementation of its waiver changes, Oregon experienced significant enrollment declines among the previously eligible poor parents and other adults. Research conducted by a state-sponsored collaborative has shown that these declines were largely driven by the increased

[17] The cost sharing requirements were later eliminated following a court order.

premiums and stricter premium payment rules instituted under the waiver.[18] These losses far outweighed the gains in new coverage that occurred for pregnant women and children and in its premium assistance program. As such, the state experienced an overall net loss in public coverage of about 55,000 people.

Tennessee's 2002 waiver amendment also resulted in a net loss in coverage. Like Oregon, Tennessee's recent waiver activity affects a longstanding waiver that originally expanded coverage. The 2002 waiver amendment modified "TennCare" eligibility in a number of ways, for example, by eliminating coverage for some adults with incomes over the poverty level. The state reports that over 190,000 people lost coverage pursuant to these waiver changes and the process undertaken to implement the changes.

Further, under a subsequent waiver amendment approved in March 2005, Tennessee currently is diesnrolling an additional 226,000 adults. This coverage loss is not reported in the enrollment data because the reductions are in the process of being implemented. These reductions will increase Tennessee's waiver-related losses and potentially reduce the overall nationwide enrollment gains.

V. Conclusion

Recent waivers resulted in a net gain in coverage of 426,329 people nationwide, with most of these gains resulting from New York's waiver. The impact of recent waivers on coverage varied significantly across states, with some states experiencing gains and two states experiencing net declines. Overall, the waiver coverage gains represent a small portion of recent overall growth in the Medicaid program nationwide and in the waiver states.

The relatively limited coverage gain under recent waivers reflects the difficult budget situations in most states, which sometimes precluded embarking on coverage expansions, and the lack of additional federal funds under waivers. States with waivers become subject to caps on federal financing and are at risk for costs that exceed the cap. To work within this financing arrangement, states often have to limit the number of people they enroll in their expansion, and, in some cases, the scope of coverage they provide. Overall, the experience with recent waivers suggests that the increased flexibility allowed through waivers, without added federal financing, has limited ability to generate and support substantial, ongoing coverage expansions.

Prepared by Samantha Artiga of the Kaiser Commission on Medicaid and the Uninsured and Cindy Mann of the Georgetown University Health Policy Institute. The authors greatly appreciate the time and effort of the state officials who provided the enrollment data used in this brief and thank them for their assistance. They also thank Barbara Lyons and Diane Rowland for their valuable comments and assistance.

[18] 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 Oregon Health Policy and Research, March 2, 2005; McConnell, J. and N. Wallace, "The Impact of Premium Changes in the Oregon Health Plan," The Office for Oregon Health Policy and Research, February 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.

Appendix A: State Enrollment Data Descriptions and Sources

	Description	Point-in-Time	Source
AZ	KidCare Parents and SOBRA Parents.	February 1, 2005	*Eligibility and Enrollment Report for February 1, 2005*, http://www.ahcccs.state.az.us
CA	Waiver has not been implemented.		
CO	Newly eligible pregnant women 133-185% FPL.	August 2004*	Communications with a state official, February 25, 2005.
DC	Newly eligible adults age 50-64 below 50% FPL.	January 31, 2005	Communications with a state official, February 9, 2005
ID	Waiver did not include an expansion.		
IL	Newly eligible parents between 39-133% FPL.	December 31, 2004	Communications with a state official, March 8, 2005
ME	Newly eligible adults without dependent children below 100% FPL. State officials report that these enrollment data may overstate newly eligible enrollees. The state estimates that some portion may have been eligible under a pre-existing disability coverage category.	March 2, 2005	Communications with a state official, March 8, 2005
MA	Waiver did not include an expansion.		
MI	Newly eligible adults without dependent children below 35% FPL. Some eligible adults had access to a state voucher program prior to the waiver. However, these adults are included because the voucher program did not provide coverage; individuals had to apply for the assistance at the time they needed care.	February 25, 2005	Communications with a state official, February 28, 2005
MS	Waiver did not include an expansion.		
NJ	Enrolled parents who had applications on file when enrollment under a previous expansion was closed in June 2002, who were determined eligible for coverage.	December 31, 2004	Communications with a state official, March 16, 2005
NM	Waiver has not been implemented.		
NY	Newly eligible parents and adults without dependent children in Family Health Plus.	December 2004	United Hospital Fund analysis of New York Department of Health Enrollment Reports
OR	Enrollment gains for 3,557 pregnant women 170-185% FPL and 492 premium assistance program enrollees 170-185% FPL. Enrollment losses (58,990) for parents and other adults (0-100% FPL) in OHP Standard between February 2003 and February 2005.	February 2005	Communications with a state official, March 2, 2005
TN	In 2002, Tennessee restricted its eligibility standards and required beneficiaries to reapply for Medicaid to "redetermine" eligibility. About 47,000 people lost coverage because they were no longer eligible under the new eligibility standards, and about 144,000 were diesnrolled because they did not complete the redetermination process.	June 2003	*TennCare Waiver: CMS Quarterly Progress Report Second Quarter, April-June 2003,* August 2003
UT	Primary Care Network and Covered at Work Enrollees. Does not include 672 individuals formerly covered by the state-funded Utah Medical Assistance Program.	February 26, 2005	*PCN-CAW Enrollment Report, 2-26-05*
WA	Waiver did not include an expansion.		

* More recent enrollment data are not available because the state recently implemented a change in its data system and, at the time of data collection, was unable to retrieve the data.

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