kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

June 2003

SECTION 1115 MEDICAID AND SCHIP WAIVERS: POLICY IMPLICATIONS OF RECENT ACTIVITY

Medicaid, which provides health coverage and long-term care services to low-income families, the elderly, and people with disabilities, is jointly funded by the federal government and states. 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.[1] Section 1115 of the Social Security Act gives the Secretary of the Department of Health and Human Services (HHS) authority to waive aspects of the law to permit states to undertake "research and demonstration" projects that further the purposes of Medicaid and SCHIP.[2] 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, in August 2001, the Administration released new waiver guidelines, called the Health Insurance Flexibility and Accountability Initiative (HIFA), encouraging states to submit waivers. This new initiative, combined with state fiscal pressures, have led to an increase in the number of states seeking Section 1115 waivers. Many of these recent waivers stake out new ground in terms of the scope of changes in coverage that they permit. Following is a brief overview of recent Section 1115 waivers and a discussion of key issues.[3] Note that this brief only addresses Section 1115 waivers that make changes in eligibility, benefits, or cost sharing for a broad group of people; more narrowly drawn waivers, such as Pharmacy Plus or Independence Plus waivers are not covered in this brief.[4]

COMPONENTS OF RECENT SECTION 1115 WAIVERS

Restructuring of Coverage

Like previous Section 1115 waivers, recent waivers allow states to adopt eligibility, benefits, or cost sharing rules that do not meet federal requirements or options. However, recent waivers are significantly different from earlier waivers, which often utilized savings derived from managed care and resulted in large expansions. Recent waivers are not necessarily focused primarily on expanding coverage and, because states no longer have access to managed care savings, when they do expand coverage they must rely on different financing mechanisms. HIFA guidelines allow states to cap enrollment, reduce benefits, and increase cost sharing for some groups of existing Medicaid beneficiaries and to use savings from these changes to finance coverage for other people. HIFA guidelines also encourage states to redirect federal SCHIP funds to cover populations other than low-income children, including adults without dependent children. The HIFA initiative does not preclude states from pursuing non-HIFA waivers, and some recent non-HIFA waivers also utilize these financing methods.

Increasingly, in light of fiscal pressures, states are using both HIFA and non-HIFA Section 1115 waivers to reduce state spending by making significant programmatic changes for current beneficiaries and by using Medicaid or SCHIP funds to refinance existing coverage. However, it appears HHS will not approve a HIFA waiver if it consists solely of reductions; it must include at

least some amount of a planned expansion. For example, Delaware's proposed HIFA waiver was recently denied based on the decision that it did not include an expansion.

Emphasis on Premium Assistance With Little or No Coverage Standards

Recent waiver activity also reflects a new focus on "premium assistance," where states use Medicaid or SCHIP funds to subsidize private insurance. All HIFA waivers are required to include at least a feasibility study of premium assistance. Without a waiver, states can provide premium assistance through Medicaid, but the premium assistance must be cost effective and states must assure that enrollees have access to Medicaid-covered services either through the private policy or as a "wraparound" benefit. States must also cover premiums or cost sharing obligations under the private insurance plan that exceed federal Medicaid standards. Recent waivers have permitted states to subsidize private coverage (both employer-based coverage and coverage available through the individual market) that does not meet federal benefit or cost sharing rules, without having to supplement the coverage.

FINANCING OF RECENT SECTION 1115 WAIVERS

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 demonstration must not result in greater federal Medicaid or SCHIP spending than would have been spent without the demonstration. 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.

As previously mentioned, many earlier waivers relied on savings that were derived from managed care to implement expansions in coverage. However, today, such savings are no longer available to states. In general, under recent waivers, states are utilizing two types of financing mechanisms (or a combination of both) to offset the cost of any new expansion and achieve budget neutrality:

- **Reducing coverage for existing beneficiaries.** Many of the recent waivers lower the cost of coverage for existing beneficiaries by capping enrollment, limiting services, and/or imposing new premium and cost sharing obligations.

- **Using unspent SCHIP or Disproportionate Share Hospital (DSH) funds**. Some waivers use unspent SCHIP funds to cover parents as well as adults without dependent children. Others have redirected DSH funds to cover new populations.

As part of the waiver negotiations, 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. In general, the cap for a Section 1115 waiver limits the amount of federal funds a state can receive for all persons covered under the waiver based on the projected per person costs of those groups who were covered by the state prior to the waiver. States do not receive any additional funds for the expansion groups covered by the waiver. (Note that Pharmacy Plus Section 1115 waivers are financed through a global cap instead of a per capita cap; see *The Financing of Pharmacy Plus Waivers*.)[5]

RECENT WAIVER ACTIVITY

The programmatic restructuring allowed by HIFA, along with state fiscal pressures, have led to an increasing number of states seeking Section 1115 waivers. Since August 2001, ten waivers have been approved, two waiver applications are pending, and one application has been denied (as of April 2003, Table 1).[6] (These are not all technically "HIFA" waivers.)

Table 1: Section 1115 Waivers Submitted Since August 2001, as of April 2003

State	Implemented	Key Features
Approved		
AZ	Yes	Allows state to use SCHIP funds to expand eligibility for parents, subject to an enrollment cap, and to refinance existing (Medicaid-financed) childless adult coverage. (An amendment for a small pilot premium assistance program is pending.)
CA	No	Allows state to use SCHIP funds to expand eligibility for parents.
CO	Yes	Allows state to use SCHIP funds to expand eligibility for pregnant women.
IL	Partially[7]	Allows state to use Medicaid and SCHIP funds to expand eligibility for parents and to refinance some state-funded health programs. Also allows the state to subsidize premiums for private coverage (with no benefit or cost sharing benchmarks other than coverage of physician visits and inpatient hospital services) for some beneficiaries as an alternative to direct coverage, at the option of the beneficiary.
ME	Partially[8]	Allows state to redirect allocated but unspent Disproportionate Share Hospital (DSH) Medicaid funds to expand eligibility for childless adults.
NJ	Yes	Allows state to reduce benefits for some parents with incomes at or below 133% of poverty who were already enrolled in Medicaid when the state scaled back parent eligibility from 200% to below 37% of poverty in June 2002. (These parents remained covered after eligibility was reduced.) Permits state to use the savings from the benefit reduction to finance coverage for up to 12,000 parents whose applications were on file at the time the state reduced parent eligibility.
NM	No	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.
OR	Partially[9]	Allows state to reduce benefits, increase cost sharing, and cap enrollment for previously eligible parents and other adults with incomes below poverty and to further limit their benefits in the future; to modestly expand eligibility for children and pregnant women, subject to availability of state funds; to make a broader expansion for parents and other adults, subject to availability of state funds and an enrollment cap; and to use SCHIP funds to refinance and modestly expand a preexisting state-funded premium assistance program, also subject to availability of state funds.
TN	Yes	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 optional children.
UT	Yes	Allows state to expand eligibility for parents and other adults, providing a limited benefit package with enrollment fees and copayments, subject to an enrollment cap. Permits increases in cost sharing and benefit reductions for previously eligible lower-income parents. (Premium assistance amendment pending.)
Pending		
AR		Proposes to use an employer tax, SCHIP funds, and beneficiary cost sharing to expand eligibility for a limited benefit package to uninsured, non-pregnant, employed adults and spouses, whose employers choose to participate in the waiver program.
WA		Proposes enrollment caps, new premiums, and some cost sharing for previously eligible groups, including children; reducing benefits for the Medically Needy; and using SCHIP funds to refinance a preexisting state-funded coverage program for adults and to potentially expand enrollment in that program.
Denied		
DE		Proposed a reduction in benefits and increase in cost sharing for some current beneficiaries, including some pregnant women and infants. Also would have allowed the state to use SCHIP funds to cover a second year of Transitional Medical Assistance (TMA) for low-income families; the state was already providing this coverage with Medicaid funds.

KEY ISSUES RAISED BY RECENT WAIVER ACTIVITY

As in previous waivers, under recent waivers, states accept a per capita cap on federal financing. The cap limits the state's access to open-ended federal financing, putting the state at risk for costs that exceed the cap, other than costs associated with increased enrollment of pre-waiver groups. This creates the potential for the state to experience additional fiscal stress over time. Additionally, like previous waivers, recent waivers enable states to expand Medicaid eligibility to new groups for which they cannot otherwise receive federal matching funds, such as adults without dependent children, and to use SCHIP funds to cover parents and pregnant women. However, while recent waivers incorporate some of the same features of earlier waivers, they also include new features that have significant new implications (Table 2).

Table 2: Key Features of Recent Waiver Activity

Features of Recent Waivers	Implications
Enrollment caps for *existing* Medicaid beneficiaries	Elimination of the individual entitlement to coverage and potential denials of or delays in coverage for eligible people
Reduced benefits and new or increased premiums and/or cost sharing for existing beneficiaries	Reduced access for some existing beneficiaries Potential increase in uncompensated care
Narrow benefit packages and significant premiums and/or cost sharing for new beneficiaries	New coverage, but potential access barriers for new beneficiaries, including some with significant medical needs
Use of Medicaid and SCHIP funds for premium assistance that subsidizes coverage that does not meet federal minimum standards, without supplementing the coverage	Potentially greater access to providers who might not otherwise take Medicaid or SCHIP payment, but potential access barriers due to limited benefits, cost sharing, and other coverage restrictions
Use of SCHIP funds for adults without dependent children	Helps to pay for coverage expansions, but reduces funding for children in future years since SCHIP funds are capped
Different benefits and cost sharing obligations for different groups of beneficiaries within a state	Increased administrative complexity Potential confusion among beneficiaries and providers that could dampen participation among people and providers

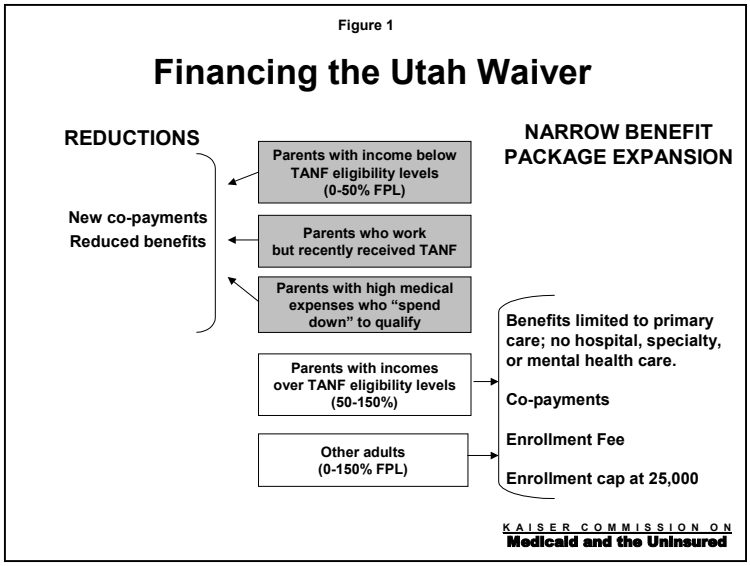
It is evident from the implications stemming from recent waivers that waivers raise a variety of difficult and complex issues and questions. While they can result in expansions in Medicaid and SCHIP eligibility, a number of these waivers alter the most basic elements of Medicaid and SCHIP. Key issues that are emerging in recent comprehensive Section 1115 waivers are discussed in greater detail below.

Elimination Of The Individual Entitlement To Medicaid. Under waivers, states have been granted authority to cap enrollment for groups covered under an expansion, and, in some cases, for previously eligible groups, eliminating their individual entitlement to Medicaid. For example, in Oregon, the state can freeze enrollment for some poor parents and other adults who were entitled to Medicaid prior to the recent waiver. Under the Utah waiver, the state can cap enrollment for newly eligible parents and other adults, including those with incomes below poverty. Unlike the scale-backs in eligibility that are allowed under current law, which limit

coverage based on income, enrollment caps result in Medicaid coverage being provided on a "first come, first serve" basis. While scale-backs in eligibility assure that the lowest-income beneficiaries maintain access to coverage, enrollment caps are not tied to income and, thus, do not provide this protection; instead, coverage is based on when an individual applies.

Adequacy Of Coverage For Existing And New Beneficiaries. As noted, some waivers reduce the benefits provided to already-eligible beneficiaries, sometimes for the purpose of reducing costs in order to finance a coverage expansion for new groups of beneficiaries. In addition, some waivers provide limited benefits with cost sharing above federal standards to new beneficiaries to reduce the cost of an expansion and to help the state meet federal budget neutrality requirements. For example, Utah reduced benefits and increased cost sharing for 17,600 parents, including parents with incomes below 50% of poverty ($7,630 for a family of three in 2003), parents transitioning from welfare to work, and medically needy parents. It used these "savings" to provide a significantly reduced benefit package with relatively high cost sharing to newly eligible parents (with incomes between 50-150% of poverty) and other adults (with incomes between 0-150% of poverty) (Figure 1). These parents and most of the other adults are charged a $50 enrollment fee; all of the new enrollees have benefits that are limited to primary care services. Hospital care (other than the emergency room) and specialty services, including mental health services, are not covered.

Figure 1



These types of limited benefit packages with higher costs for existing and new beneficiaries allow coverage expansions to occur without new state or federal spending, but also raise questions about whether waivers assure adequate and affordable coverage. For example, in Utah, newly eligible parents and other adults might not enroll in coverage if they cannot afford the enrollment fee. Further, parents who had their benefits reduced and newly eligible parents and other adults might delay or fail to obtain necessary care if they cannot afford to pay the required cost sharing or the cost of uncovered services.

Increased Reliance On Private Coverage With Lower or No Standards For That Coverage. Many of the recent waivers include a premium assistance component in which Medicaid and/or SCHIP funds are used to subsidize the purchase of private group or individual coverage. The waivers allow subsidies for coverage that does not meet minimum federal benefit or cost sharing rules and do not require the states to supplement that coverage. Subsidized coverage also may have other features common to private plans that are otherwise prohibited under Medicaid, such as preexisting condition exclusions.

It is too early to know how much new coverage will result from premium assistance initiatives given low-wage workers' limited access to employer-based coverage. People with 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. The loss of benefit and cost sharing standards, however, raises questions about whether subsidized coverage will provide adequate coverage at affordable costs for the target population. For example, in Oregon, some poor parents and adults whose coverage is limited to premium assistance could have a $500 deductible and a preexisting condition waiting period as long as six months. The lack of coverage standards also 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.

Waivers Expansions Are Sometimes More Limited Than They Appear. Although HHS currently is requiring waivers to include some amount of a planned expansion, waivers do not always actually result in a large number of people gaining new coverage for several reasons:

- ***Expansion Is Not Implemented.*** Approved waiver expansions are sometimes not implemented or are not implemented in full because they are subject to the availability of state funds. For example, California's expansion to low-income working parents, which was approved in January 2002, has not been implemented due to state budget problems. Illinois' parent expansion was authorized up to 185 percent of poverty, but in the first year of the waiver, the state could only afford to expand to 49 percent of poverty; the state is hoping to further increase the parent expansion over the next several years.

- ***Coverage Reductions Offset Implemented Expansions.*** In some states that use waivers to reduce coverage as well as to expand coverage, state budget problems are leading them to only implement a portion of an expansion even as they move forward with all of the reductions. In these cases, waivers may authorize a significant expansion but, in fact, result in reduced Medicaid coverage and spending. For example, Oregon's waiver allows it to cap enrollment, reduce benefits, and increase cost sharing for poor parents and other adults who were eligible for Medicaid prior to the recent waiver; to implement a small expansion for pregnant women and children; to modestly expand (and refinance) an existing state-funded premium assistance program; and to adopt a significant expansion for parents and other adults. The state is moving forward with its approved reductions, the premium assistance refinance, and the smaller expansions, but it has not implemented the broader eligibility expansion for parents and other adults (Figure 2).

Figure 2

Waiver Changes in Oregon: Reductions Offset Expansions

	Allowed Under Waiver:	Implemented:
Reductions	Changes for some parents and other adults <100% FPL:	
	• Authority to cap enrollment	✓
	• Increased premiums and cost sharing	✓
	• Reduced benefits	✓
Expansions	Parents 100-185% FPL	**No**
	Other adults 100-185% FPL	**No**
	Children and pregnant women 170-185% FPL	✓
	Premium assistance program 170-185% FPL	✓

NOTE: Oregon has not yet implemented its approved expansion for parents and other adults due to state funding constraints.

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- ***Expansion Does Not Benefit Everyone In The Expansion Group.*** Waiver expansions also do not necessarily make new coverage available to all individuals in an expansion group due to enrollment caps or limitations on who can participate. For example, New Mexico's waiver would expand coverage to adults with incomes below 200 percent of poverty, but, if implemented, would primarily benefit only those people in the expansion group who have an employer who would agree to pay a share of the required premiums.

- ***Expansion Does Not Provide "New" Coverage.*** In some cases, rather than providing new coverage to uninsured individuals, waivers refinance existing coverage. In Oregon, Utah, and Illinois, for example, some individuals who are identified as "newly eligible" under the waiver were previously eligible for fully state-funded programs.

Reduced Funding For Children In Future Years. Use of SCHIP funds to cover parents and other adults could lead to reduced enrollment of children in SCHIP in future years. (Under SCHIP law, federal funds that a state does not spend to cover children are reallocated to other states that may need those funds to cover children; because SCHIP funds are capped, waivers reduce the amount of SCHIP funds that will be reallocated to other states to cover children.) While parent coverage has been shown to increase children's coverage, the recent use of SCHIP funds to cover adults without dependent children has raised concerns about reducing funding available in future years without improving children's coverage.

Reduced Beneficiary Protections. Many recently approved waivers have eliminated some beneficiary protections or left unclear which beneficiary protections continue to apply under the waiver. For example, 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, including the right to apply for coverage without delay, to receive a prompt eligibility decision, and to appeal denials of coverage.

Patchwork Coverage And More Complicated Rules. Medicaid is often criticized as being a complex program that is difficult for potentially eligible people, providers, as well as policymakers, to understand. The recent waiver activity has made the program even more complex because of the loss of many of the federal minimum standards that imposed some degree of uniformity across states. Further, many 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. These new differences across states and within states raise questions about the value of having some uniform national standards and coverage goals and whether the more complicated benefit and coverage rules will dampen participation among eligible people and providers.

Increased Flexibility Does Not Prevent Program Cutbacks. Under recent waivers, states have been granted wide flexibility in eligibility, benefits, and cost sharing, beyond the scope previously seen. In light of current fiscal pressures, some states have turned to this increased flexibility as a way to reduce state spending by making significant programmatic changes for existing beneficiaries and/or by refinancing existing coverage. However, increased flexibility may not be enough to stabilize state fiscal situations or to prevent significant program cutbacks. At least one state that has implemented a waiver still has needed to make significant cuts to address its budget shortfall. Oregon's waiver resulted in a major restructuring of its Medicaid program, decreasing its Medicaid coverage and spending. However, the state still implemented other program cutbacks outside of the waiver, including eliminating its Medically Needy program. Further, one month after reducing coverage for parents and other adults under the waiver, the state made further major reductions in their benefits by eliminating their prescription drug,[10] mental health, durable medical equipment and dental coverage. Experiences such as this suggest that states may need more than flexibility to address their fiscal problems and that

flexibility may not be enough to shield existing coverage from cuts.

CONCLUSION

Section 1115 waivers have been part of the Medicaid program for some time, but the Administration's initiatives to promote waivers and state fiscal pressures have pushed waivers and the programmatic restructuring they offer to the forefront of the Medicaid policy debate. Section 1115 Medicaid and SCHIP waivers, including the new HIFA waivers, allow states to make significant changes in eligibility, benefits, or cost sharing that would not otherwise be allowed under federal law, and many of the changes being made under recent waivers affect key features of Medicaid and SCHIP. These changes will have significant implications for the low-income population, state Medicaid and SCHIP programs, and other key stakeholders.

- **Waivers do not provide states new resources to expand coverage.** As such, recent waivers have offset any expansions in Medicaid or SCHIP eligibility by reducing coverage for existing beneficiaries or by redirecting existing Medicaid or SCHIP resources from other purposes. It is important to examine whether the benefits of the expansions that have been adopted outweigh the impact of the reductions made in order to finance them.

- **It is unclear whether coverage provided under waivers is adequate or affordable for existing and new beneficiaries.** Under waivers, many existing and new beneficiaries are receiving more limited benefit packages with higher cost sharing than allowed under current law. This occurs through reductions in coverage for existing beneficiaries, through the creation of narrow benefit packages for new beneficiaries, and through the elimination of coverage standards for private coverage subsidized through premium assistance. It is still unclear whether beneficiaries will be able to afford these higher cost sharing requirements and how they will obtain care for uncovered services.

- **Waivers do not necessarily result in a large number of people gaining new coverage.** Although a number of approved waivers authorize significant expansions, these waivers do not necessarily result in a large number of people gaining new coverage because the expansions are not always implemented or because of an enrollment cap. Further, reductions implemented under a waiver may offset or exceed the implemented expansion, the expansion may not benefit all individuals in the expansion group due to eligibility limitations, and/or the expansion may refinance existing state-funded coverage rather than provide new coverage.

- **Waiver flexibility does not prevent program cutbacks.** In light of state fiscal pressures, some states have turned to waiver flexibility to reduce state spending by making significant programmatic changes for existing beneficiaries and/or refinancing existing coverage. However, flexibility may not be the answer for stabilizing state fiscal situations or preventing significant program cutbacks. At least one state that has implemented a waiver still has made additional cuts to their Medicaid program to address its budget shortfall.

Prepared by Samantha Gill and Jocelyn Guyer of the Kaiser Commission on Medicaid and the Uninsured and Cindy Mann of the Georgetown University Health Policy Institute.

ENDNOTES

[1] Schneider, A. and R. Garfield, *Medicaid as a Health Insurer: Current Benefits and Flexibility*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, http://www.kff.org, forthcoming.
[2] 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 initiatives are permissible as long as they further the broader objectives of the Social Security Act.
[3] For a more detailed description of waiver guidelines and the policy implications of waivers, see the Kaiser Commission on Medicaid and the Uninsured (KCMU) report, *The New Medicaid and CHIP Waiver Initiatives*. For more details on the specific features of recently approved or pending waivers, see the KCMU Report, *Waivers at a Glance*, or KCMU State Waiver Fact Sheets (all available at http://www.kff.org).
[4] See Guyer, J., *The Financing of Pharmacy Plus* Waivers, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, http://www.kff.org, May 2003, for information on Pharmacy Plus waivers.
[5] Ibid.
[6] Additionally, two states, Michigan and Minnesota, submitted waiver applications, but these applications currently are inactive.
[7] Illinois has only implemented a portion of its approved expansion for parents; it expanded parent eligibility from 38% FPL to 49% FPL, but is approved to expand up to 185% FPL. Also, it is only offering a premium assistance option to one of several groups for which it has received approval to make this offer.
[8] Maine is approved to expand eligibility for childless adults up to 125% FPL; it implemented an expansion up to 100% FPL for the first year of the demonstration.
[9] Oregon implemented the portion of the waiver that refinanced and expanded its state premium assistance program on November 1, 2002; the cost-saving coverage reductions and pregnant women and children expansion authorized by the waiver were implemented on February 1, 2003; the planned expansion for parents and other adults has not yet been implemented.
[10] Prescription drug coverage was later restored for this population.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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