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Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage

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Section 1115 of the Social Security Act permits the Secretary of the Department of Health and Human Services (DHHS) to waive certain portions of the federal Medicaid Act for a five-year demonstration project, if the demonstration is budget neutral to the federal government. Once the budget neutrality test is met, the Secretary, through the Health Care Financing Administration (HCFA), can grant a state's request to alter Medicaid eligibility standards, benefit rules, payment provisions, and other rules.[1]

In short, Section 1115 waivers offer a way to design coverage expansions using Medicaid funding.

Typically, the 1115 waiver is used to expand coverage to an otherwise uninsured group. HCFA's records show that about 1.5 million people are now included in expansion populations across the country. The catch: budget neutrality. Put simply, the costs of covering the "expansion population" must be offset by other programmatic changes in Medicaid that lower the overall spending.

Why an 1115 Waiver?

Obtaining the federal government's approval of a proposed 1115 waiver takes time, patience, and an attention to design and financing details. Four main reasons motivate states to pursue this route.

First, only an 1115 waiver allows a state to access federal Medicaid funds to cover expansion populations who otherwise could not qualify for the program, including poor adults who are single or have grown children, and children above Medicaid's eligibility ceilings. Efforts to open the State Children's Health Insurance Program (SCHIP) to parents, and the growing use of "income disregards" in Section 1931 Medicaid expansions, still only reach adults with minor or dependent children at home. It takes an 1115 waiver to access federal funds for other adults.

Second, only an 1115 waiver allows a state to offer a tailored package of benefits, rather than the full Medicaid benefits, to a targeted expansion population. As a result, Section 1115 waivers have been approved to offer focused benefit packages to HIV-positive individuals (to get them started on drug regimens before they become symptomatic and disabled), and to middle-income women of childbearing age (to allow them access to family planning benefits and avoid unwanted pregnancies).

Third, tapping into federal Medicaid funds enables states to serve more people. While matching rates vary by state, the federal government will pay at least 50 percent of the expenditures in an approved 1115 waiver (up to 80 percent), which constitutes quite an advantage over purely state-funded programs. The size of the coverage expansion is thereby enhanced through access to federal funds.

Fourth, unlike a regular Medicaid eligibility group, states have the opportunity in an 1115 waiver to cap enrollment, or to create a time-limited program. Therefore, an 1115 waiver allows a state to avoid an open-ended entitlement, which can scare governors and state legislatures. In all,

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[1] While HCFA has substantial latitude in granting 1115 waivers, a few limitations (particularly with respect to eligibility) apply. For example, HCFA may not grant a state an exemption from covering Medicaid-eligible pregnant women and children.

at least 14 states have used 1115 waivers to extend coverage to approximately 1.5 million adults and children.

None of this is possible, however, unless the state can prove that its proposed demonstration is "budget neutral." .

Financing & Budget Neutrality

HCFA cannot approve an 1115 waiver proposal that would result in a higher level of federal spending than otherwise would have been the case under the state's Medicaid program. This requires comparing, over the five-year proposed waiver period, the "with waiver" costs (what the federal government would spend upon approval of the 1115 waiver) against the "without waiver" costs (what HCFA would spend assuming the status quo). This, in turn, requires the state to make projections of the "with waiver" and "without waiver" expenditures, and then defend the credibility of all of its assumptions. These assumptions, and the underlying methodologies, are actively negotiated between the state and HCFA during the course of the 1115 waiver review process.

The state's projections for these expenditures are tested by HCFA's Office of the Actuary and the Office of Management and Budget (OMB). Each must certify that an 1115 waiver application is budget neutral for the federal government over the five-year demonstration period. It is not necessary, however, for a waiver to be budget neutral in each individual year; some waivers have substantial deficits in years one and two that are offset by savings in subsequent years.

States have used various approaches for 1115 coverage expansions while meeting the federal budget neutrality test.

- Managed Care Savings

  A common method is to re-invest the savings, achieved by moving the Medicaid population into managed care, in expanded eligibility to cover people who could not qualify for Medicaid. In its application for an 1115 waiver to institute a Medicaid managed care program, Delaware dedicated the projected savings to cover 13,000 new beneficiaries. Hawaii, Tennessee, Minnesota, Vermont, and other states have also used projected savings from Medicaid managed care contracting to expand coverage under their 1115 waivers.

  Managed care contracting has been particularly common in the 1115 process: at least 15 states applied for 1115 authorization to operate or expand their managed care programs. However, this technique may be harder to defend in coming years. As capitated premiums increase at rates that parallel less managed forms of care, it may be harder for a state to defend to HCFA and OMB assumptions premised on large managed care savings.

- Reallocation of Disproportionate Share Hospital (DSH) Funds

  DSH is a special Medicaid program to subsidize certain health care providers that serve a disproportionately large volume of Medicaid and indigent patients. Because these providers cannot cost shift this care to private pay patients (due to the high volume of Medicaid and indigent patients they serve) DSH exists as a federally approved subsidy to keep them open.

  Thus, DSH payments are based, in part, on charity care provided to people who lack health insurance. If more people were insured, then less DSH funds would be needed. This argument underlies a few 1115 waivers: the "without waiver" projections included DSH payments to providers of indigent care, and the "with waiver" projections assumed a coverage expansion with less indigent care, achieving overall budget neutrality. Under its 1115 waiver, Missouri relied on DSH monies to fund its expansion for adults of SCHIP-eligible children. The state's DSH allocation is reduced by the premium amount of each enrolled adult. Similarly, Massachusetts relied on DSH monies and the diversion of uncompensated care pool dollars to fund MassHealth, the state's expansion for children, pregnant women, unemployed and/or disabled adults, and others.

- Pay Now, Save Later

  The HIV waivers and family planning waivers described earlier rely on a different model for budget neutrality to extend coverage to an expansion population. The theory behind an HIV waiver goes something like this: the asymptomatic HIV-positive person cannot qualify for Medicaid now, since he/she is not disabled. If we pay for medications to keep him/her healthy, we will avoid the deterioration of the person's health. Otherwise, eventually the person will show up for Medicaid with severe, expensive needs (including hospitalization).

  Thus, the "without waiver" projections assume high-cost expenditures in the later years of the five-year period, while the "with waiver" projections assume early, less costly preventive care.

  The same principle applies to family planning waivers, where early expenditures on pregnancy prevention care for non-Medicaid eligible women are designed to prevent pregnancies (and Medicaid eligibility under pregnancy-related eligibility groups).

- Controlling Enrollment, Benefits and Cost Sharing

  In addition to reducing Medicaid spending on existing eligibles, states have also tried to control expenditures for the expansion population and to maintain the budget neutrality of their 1115 waivers. Both Hawaii and Tennessee received amendments to their 1115 waivers to institute enrollment caps. Other states have opted to use beneficiary cost-sharing measures (e.g., deductibles, copayments, and premium contributions) to help reduce "with waiver" expenditures to achieve budget neutrality.

  Oregon's well-known "prioritized list" 1115 waiver eliminates coverage for treatments that may not be efficacious or low priority, to reinvest those savings in a coverage expansion. Enrollment caps and cost-sharing provisions, however, cannot be instituted for some Medicaid mandated coverage groups (e.g., pregnant women under 133 percent of the federal poverty level (FPL)).

- Combination Rationales
  Several states have multi-faceted waivers that span more than one demonstration area. For example, Massachusetts' 1115 waiver integrates multiple indigent care and hospital programs, includes a managed care initiative, and provides employer subsidies for health insurance. In addition, New Mexico obtained approval for an 1115 waiver in a Medicaid-expansion SCHIP program that reflects managed care savings along with recipient cost-sharing measures.

The 1115 Process

Unlike other waivers,[2] there is no prescribed format for an 1115 application. States should include detailed information about the proposed program design (including the proposed benefits, eligibility, cost sharing and delivery system), project administration and management, evaluation plan, and supporting budget/cost information. States also should cite compelling policy reasons for proposing the coverage expansion.

After a state submits its 1115 application, HCFA may request clarifications or further information. Given the complicated nature of many 1115 proposals, some states have submitted "Concept Papers" for HCFA that refine their 1115 applications prior to formal submission. In this way, many potential concerns are resolved before HCFA conducts its formal review.

The review process typically involves several HCFA policy directors, the HCFA Office of the Actuary, and OMB personnel. Each waiver is assigned a project officer at HCFA who guides the waiver through various offices represented on an ad hoc task force. The median time of HCFA review and approval during the 1990s for waivers and amendments was six months, though review time ranged between two and 25 months. States varied widely in terms of their implementation timeframe: the median time between HCFA's approval and the state's implementation date of an 1115 waiver was also six months, though it ranged between one month and four years. As a good rule of thumb, states should assume that the process will take at least two years from design to implementation.

Although somewhat rare, approval may be granted in two stages: a conceptual phase and an implementation phase. This approach allows states to work out technical issues during the review period, and in so doing, shortens the rollout time for a proposed expansion. Maine sought and won initial authorization to expand its Medicaid program for low-income individuals with HIV in 1999. HCFA granted approval contingent on the state's ability to secure a drug price discount on HIV medications, thereby making the waiver budget neutral. Thus, the state was able to proceed with its waiver application and with its negotiations with drug manufacturers at the same time.

Operational Attractiveness for States

The 1115 waiver allows states to integrate various programs that deliver health services to the indigent. For example, Hawaii's QUEST program consolidates patients formerly covered by Medicaid, General Assistance, and the State Health Insurance Program into a single purchasing pool for capitated health care. New York also incorporated many Home Relief beneficiaries in its Medicaid managed care contracting under an 1115 waiver. These states benefit from a more integrated service system and from simplified administration.

Through the 1115 process, many states have been able to develop and pilot innovative service delivery systems. For example, New York is developing a capitated program that provides intensive medical and case management services for HIV-infected Medicaid beneficiaries. These Special Needs Plans (SNPs) should offer patients greater continuity of care and enhanced access to specialist providers. The approach will also limit the state's risk for HIV-related fee-for-service claims.

An 1115 waiver provides states with greater operational flexibility. Massachusetts similarly won authorization under an 1115 to create incentives for employers to provide health insurance benefits for workers under 200 percent FPL, including provisions for the state to provide financial support for the employees' insurance premiums with Medicaid funds.

The 1115 waiver may exempt states from the statewide requirements of the State Plan. For example, the HIV SNPs in New York will be allowed to operate in the five boroughs of New York City and in Buffalo, while HIV-infected beneficiaries in the remainder of the state will continue to use fee-for-service Medicaid. Kentucky and Oklahoma took advantage of a statewide exemption in their 1115 waivers and phased in their managed care programs in limited areas. HCFA also granted California's request for such an exemption, thereby allowing state and local authorities to restructure the public health system in Los Angeles County.

Relation to 1915(b) Waiver and 1931 Expansions

Other recently enacted provisions of federal law may temper the popularity of 1115 waivers. In particular, many states have applied for Section 1915(b) waivers to execute mandatory enrollment managed care programs for selected Medicaid populations without reinvesting the savings in coverage expansions. Additionally, states now have the option to expand family coverage to parents of minor or dependent children under income and resource disregards authorized by Section 1931 of the Social Security Act, a product of the welfare reform law of 1996.

Section 1931 allows states to increase "income disregards" when determining Medicaid eligibility for low-income parents. Income disregards are the family/individual income that is not included in determining eligibility. This provision effectively grants states the freedom to

[2] There are two other common waivers. One is a 1915(b) or "freedom of choice" waiver, which is commonly used to start a managed care program without expanding eligibility to new groups. The other is a 1915(c) or "home- and community-based services" waiver, which is used to offer community services to people with disabilities in order to prevent them from being institutionalized.

cover parents at any level of income. (See May 2000 Issue Briefs by Birnbaum and Wheatley.) In contrast to the 1115 waiver, the 1931 expansions need not be budget neutral, and they do not require approval of a waiver.

On the downside, Section 1931 expansions only reach parents of minor or dependent children, and they create an entitlement to the full Medicaid program for all qualified individuals, which creates a more open-ended financial exposure for the state.

One New Idea: A Commercial Benchmark Program

The lesson of SCHIP offers another model for a coverage expansion. Hypothetically, a state could design an 1115 waiver with the following three-step approach. First, a state may be contemplating a Section 1931 expansion to cover parents. This would cover adults with minor and dependent children up to some income level (using income disregards), say 135 percent FPL. This Section 1931 expansion could only offer the Medicaid benefit design: full retroactive coverage for up to three months before the month of application, full Medicaid benefits (that exceed commercial benefits in areas such as long-term care and transportation), probably no cost sharing (premiums, copayments), and an open-ended enrollment entitlement. Still, the state's hypothetical Section 1931 plan expansion, which does not require a waiver, could serve as the "without waiver" expenditure projection in a budget neutrality test, since it could be achieved by a plan amendment rather than a waiver.

Second, a state could propose, in an 1115 waiver, to instead cover these parents in a commercial insurance product, much like a SCHIP benchmark plan. This would generate savings by not providing retroactive coverage, not providing benefits typically excluded from commercial plans (e.g., nursing home care), and/or including modest cost sharing (e.g., $5 copayments).

Third, the savings that would result would then be reinvested in a coverage expansion that would reach single adults, childless couples, and couples whose children are grown, all of whom could not be covered under a Section 1931 state plan. This coverage expansion could have a defined enrollment to appease governors and state legislatures concerned about creating new Section 1931 entitlements.

The commercial benchmark model would be the "with waiver" projections – more people covered through a product that looks more like the insurance available to working populations (albeit probably with lower cost-sharing requirements).

This approach, which has not yet been formally presented to or approved by HCFA, would trade off savings (achieved through narrower benefits, no retroactive eligibility and modest cost sharing) for a demonstration that reaches a higher number of insured individuals. While certainly not ideal to many people who prefer Medicaid's benefits, retroactivity, and free care, a state plausibly could assert that it could not cover more people without deriving savings somewhere. Moreover, both the precedent of commercial benchmark plans in SCHIP, and the notion of serving near-poor adults in an employment-like insurance product, might advance this concept.

Conclusion

Section 1115 waivers remain a vibrant opportunity for coverage expansions, especially to reach those adults and children who cannot under any circumstances qualify for Medicaid. The catch, of course, is deriving savings somewhere in Medicaid to pay for the coverage to the expansion population. Findings savings is not always easy – it depends on sometimes unpopular managed care approaches, DSH reductions, narrower benefits, or employer purchasing models – but absent savings the coverage expansion cannot meet the budget neutrality test of an 1115 waiver.

References

Gage LS, von Oehsen WHE. 1995. Managed Care Manual: Medicaid and State Health Reform. Deerfield, IL: Clark, Boardman, Callaghan.

For more information on specific state 1115 waivers, please refer to HCFA's Comprehensive State Health Reform Demonstrations web site: *http://www.hcfa.gov/medicaid/ord-1115.htm*.

Birnbaum, M. "Expanding Coverage to Parents through Medicaid Section 1931." Issue Brief. *State Coverage Initiatives*, May 2000.

Wheatley, B. "State Approaches to Expanding Family Coverage." Issue Brief. *State Coverage Initiatives*, May 2000.

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