kaiser commission on medicaid and the uninsured
KEY FACTS
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MEDICAID SECTION 1115 WAIVERS: CURRENT ISSUES

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

Section 1115 waivers provide a mechanism for states to use federal funds in ways that do not conform to federal standards. Section 1115 waivers have been used throughout the 40-year history of the Medicaid program. They can serve as useful tools for states to demonstrate new ways to provide coverage and deliver services to the low-income population.

In recent years, there has been a growing amount of waiver activity reflecting a combination of new federal waiver initiatives and state fiscal pressures. Increased flexibility available through waivers has been promoted as a way for states to cover more people without increasing program costs. Recent waiver expansion efforts have been quite limited and some recent waivers have altered core elements of Medicaid affecting enrollment, benefits, and affordability of coverage and care. Increasingly, waiver activity has focused on reducing coverage to relieve state fiscal pressures.

WHAT IS A SECTION 1115 WAIVER?

The broadest source of federal waiver authority is Section 1115 of the Social Security Act. Section 1115 gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs under the Social Security Act, including Medicaid and SCHIP, without a statutory change. States can obtain "comprehensive" Section 1115 waivers to make very broad changes in eligibility, benefits, or cost sharing in Medicaid. Currently, 27 states and DC have approved comprehensive Section 1115 waivers. Some have not been implemented, many were adopted primarily to move beneficiaries to mandatory managed care (which states can now do for certain beneficiaries under program options without a waiver), and others make more fundamental program changes.

There are also more narrowly drawn waivers. Some Section 1115 waivers focus on specific services or populations such as family planning services or people with HIV. There are other more targeted waivers under Medicaid such as Section 1915 waivers that permit states to enroll Medicaid beneficiaries in mandatory managed care or to provide home and community based services to people who would otherwise need nursing home care.

Section 1115 waivers are intended to test and evaluate innovative coverage approaches. By law, Section 1115 waivers are to be used for "research and demonstration" projects that "further the objectives" of the program. Over the years, states have used Section 1115 waivers to test new coverage and delivery approaches. For example, in the 1990s, some states used waivers to test whether managed care worked well for Medicaid enrollees and led to cost savings; some then used savings to expand coverage. These waivers were accompanied by large formal evaluations and paved the way for legislative changes that gave states the option to implement certain managed care arrangements without seeking a waiver.

In 2001, the Administration released a new Section 1115 waiver initiative. The Health Insurance Flexibility and Accountability (HIFA) waiver initiative encouraged states to seek Section 1115 waivers to expand coverage within existing resources and offered states increased waiver flexibility. At the time HIFA was established, states began facing serious fiscal problems. This combination of new flexibility and increasing fiscal pressures has led some states to use recent waivers as tools to reduce program spending rather than to expand coverage.

WHAT KINDS OF CHANGES REQUIRE WAIVERS?

Section 1115 waivers allow states to use federal Medicaid and SCHIP funds in alternative ways. Under waivers, states can change eligibility, benefits and cost-sharing in ways that do not meet federal standards and still receive federal matching funds. A state does not need a waiver to expand Medicaid to children, parents of dependent children, pregnant women, or elderly or disabled people; it can do so under regular program options. However, waivers are needed to:

- Cap enrollment in Medicaid,
- Reduce benefits or increase premiums or cost sharing beyond federal standards,
- Cover adults without dependent children who are not elderly, disabled, or pregnant through Medicaid,
- Cover groups other than uninsured children using SCHIP funds.

HOW ARE WAIVERS FINANCED?

Longstanding federal policy requires Section 1115 waivers be budget neutral for the federal government. Federal costs under a waiver cannot be more than projected federal Medicaid costs without the waiver. States that use waivers to expand coverage must create offsetting savings or redirect existing federal funds to finance the expansion. To assure budget neutrality, under the terms of a waiver, federal funds for services financed under the waiver are capped for the period of the waiver. States must keep their spending below the caps or assume the full cost of services above the caps.

Some recent waivers use different financing approaches than previous waivers. In the past, some states used managed care savings or redirected federal Disproportionate Share Hospital (DSH) funds to implement coverage expansions to groups that cannot be covered without a waiver. Some states also used savings realized by refinancing fully state-funded coverage with federal Medicaid matching payments. Today, savings from managed care generally are not available to states since most have already utilized these savings. Recent waivers that have sought to expand coverage to new groups are relying on redirected federal SCHIP or DSH funds and refinancing mechanisms, as well as an approach endorsed by HIFA that allows states to achieve "savings" by limiting coverage and/or imposing new costs on existing beneficiaries.

WHAT ARE CURRENT ISSUES AROUND WAIVERS?

Recent waivers have resulted in limited coverage gains, reflecting the absence of additional federal financing. States have had limited ability to fund expansions given their difficult fiscal situations and the lack of additional federal funds under waivers' budget neutrality requirements. Of the 17 Section 1115 waivers approved since January 2001, 12 included an expansion, but 2 were not implemented, 2 were only partially implemented, and 5 that were implemented were later closed under waiver-authorized enrollment caps. In most cases, implemented expansions covered a small number of people, sometimes with very restricted benefits. In a few cases, recent waivers resulted in coverage losses rather than gains. As of Fall 2003, recent waivers had resulted in a net gain in coverage of about 200,000 people, far less than projected coverage gains and a fraction of recent Medicaid enrollment growth.

Increasingly, states are using waivers to contain or reduce spending by altering core program elements. Under waivers, some states have altered many of Medicaid's key elements affecting benefits, affordability of coverage and care, and enrollment (Figure 1). Such changes have generally not resulted in enough savings to finance substantial coverage expansions. Rather, states have increasingly used these changes as a way to reduce coverage and relieve state fiscal pressures. However, waiver flexibility does not appear to be sufficient for addressing fiscal problems; some states that have used waivers to reduce spending have had to pursue additional program cutbacks to address their budget problems.

Figure 1

Examples of Changes to Key Elements of Medicaid through Recent Waivers

Waiver Features	Implications
Limited benefits and/or new or increased premiums and/or cost sharing	•Limits access to coverage and/or care •Potential increase in unmet needs and uncompensated care •Reduces state/federal program costs
Different benefits & cost sharing for different groups within a state	•Allows states to "target" benefit packages •Increased administrative complexity •Confusion could dampen participation among people & providers
Enrollment caps	•Eliminates guarantee to coverage •Enrollment based on first come first serve, not income or need •Potential increase in number of uninsured and levels of uncompensated care •Allows states to quickly reduce program costs
Eligibility expansions to adults without dependent children	•Allow states to cover groups excluded from Medicaid under federal law •Size, scope, and implementation limited by availability of state funds and budget neutrality requirements •Coverage and/or care may be limited by enrollment caps, premiums, limited benefits, and/or cost sharing

Some recent waiver changes have eroded coverage and protections for beneficiaries. Waivers permit states to impose enrollment caps and to provide more limited benefits with higher out-of-pocket costs than allowed under federal rules. In some cases the scope of benefits is very limited, for example, without coverage for hospital care. Enrollment caps enable states to predict expansion expenditures and limit program spending, but they eliminate Medicaid's guarantee to coverage, which requires enrollment of all eligible people who apply. Enrollment changes to a "first come, first serve" basis rather than an entitlement based on income or need. Limited benefits and increased beneficiary costs reduce state and federal program costs, but they may not be adequate or affordable for covered individuals given that they are often sicker and poorer than the privately insured population. Enrollment drop-offs and problems accessing care due to limited benefits and increased costs can result in unmet need and impose additional strains on providers.

CONCLUSION

Although waivers provide states with the opportunity to test alternative coverage approaches using federal Medicaid funds, recent waivers have focused more on reducing program spending. Waivers, however, are not the solution for addressing state fiscal pressures stemming from weak revenues, rising health care costs, and population needs. Further, without additional financing, recent waivers have not been particularly effective vehicles for reducing the number of uninsured. Waivers can be useful for testing innovation and can sometimes be used to expand coverage, but waivers can also have negative consequences for individuals and providers and may create new fiscal pressures for states over time. Given that some recent waivers are making fundamental changes in Medicaid, the trade-offs for the low-income, elderly and disabled population should be carefully evaluated and considered and publicly debated.

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