

FACT SHEET

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Cover Missouri Project: Report 5

The Quiet Medicaid Revolution: State Waiver Activity in the Early 2000s

Budget pressures and rising health care costs have forced many states to curtail spending on Medicaid. Among other things, states are reducing or eliminating Medicaid benefits, capping program enrollment, and imposing premiums and other costs on beneficiaries. To make many of these changes, states have obtained waivers from federal Medicaid law. The Health Insurance Flexibility and Accountability (HIFA) waiver gives states broad authority to design and finance their State Children's Health Insurance Programs (SCHIP) and Medicaid programs. HIFA offers a streamlined application process and an expedited federal review process. Within the past four years, nearly half of the states have gained federal approval to significantly modify their Medicaid programs. Several additional states are developing waiver proposals and are contemplating making further reforms to Medicaid. This fact sheet highlights excerpts from a research report by the same name that discusses state waiver activity in-depth.

Overview of State Waiver Activity

Coverage Expansions – HIFA stipulates expansions must target low-income and uninsured individuals but does not stipulate the size or nature of the expansion. The structure of a coverage expansion appears to be broadly interpreted by federal officials. While the bulk of recently approved waivers include at least some planned expansion, many of the newly approved waivers focus on maintaining coverage and controlling Medicaid costs. At least one recent modification to a proposal entailed a reduction in coverage. Several HIFA states have not achieved their planned coverage goals because of budget problems.

Coverage Expansions and Budget Neutrality – Under a general Section 1115 waiver, states receive no additional federal funding. If a state elects to expand coverage as part of its waiver, it must be budget neutral to the federal government. Depending upon the comprehensiveness of a state's Medicaid program, finding federal savings to offset the cost of an expansion can pose a number of difficult policy choices. Sample strategies to achieve budget neutrality include: shifting from a Medicaid fee-for-service system to managed care; redirecting disproportionate share hospital (DSH) payments to Medicaid; reducing the cost of providing coverage to current Medicaid or SCHIP enrollees by capping enrollment; restricting benefits and imposing new premiums or cost-sharing; and raising new funds to support the demonstrations.

Enrollment and Spending Caps

In the most recent wave of waiver applications, states have proposed several ways of controlling spending, including capping enrollment and limiting spending on enrollees.

Enrollment Caps – Many of the recently approved Medicaid demonstrations give states the ability to cap enrollment as a way to curtail program spending. Enrollment caps have primarily applied to waiver expansion populations, but limits on existing enrollees in optional eligibility categories have also been approved in at least two states. Challenges presented by enrollment caps include eliminating an individual's guarantee to coverage under Medicaid, basing enrollment on a first come basis rather than on existing conditions or income basis and preventing Medicaid dollars from going to the most vulnerable individuals, especially to those individuals experiencing a sudden onset of a costly illness.

Per Enrollee Spending Limits – Some waiver proposals call for putting limits on how much is spent on program enrollees. Various strategies are planned, but all have the primary goal of controlling Medicaid expenditure growth.

Cost-Sharing

Many of the newer state waiver proposals intend to make broad use of cost-sharing in their demonstrations. Health care cost-sharing comes in several forms and includes premiums, coinsurance, co-payments, and deductibles. Enrollees, however, are protected from excessive cost-sharing through a maximum out-of-pocket liability similar to the protections provided under SCHIP. Medicaid regulation limits how much enrollees are required to contribute toward their health insurance. Yet, in an effort to lower program costs and to make enrollees prudent consumers of health care, several of the recent state waiver applications have sought to significantly change Medicaid cost-sharing rules.

The intended goals of cost-sharing include assisting individuals to make informed health choices and to use care prudently. Medicaid program costs would, as a result of appropriately utilized medical services, decline. At the same time, research suggests that even modest levels of cost-sharing may reduce access to care and use of prescription drugs, particularly for low-income and chronically ill individuals. Research on the effects of co-payments has been limited, but co-payments will disproportionately affect those with poor health status and those with chronic conditions.

Extent of Medicaid Privatization

Several states sought to privatize Medicaid through the waiver process. Underlying this approach is a belief that private market forces will do a better job managing costs and quality than the government. The extent to which states have pursued privatizing Medicaid varies greatly, ranging from implementing premium assistance programs to developing a competitive program that is largely consumer directed.

Premium Assistance Programs – Typically under premium assistance programs a state directly subsidizes an individual's employer-sponsored insurance (ESI) premiums. States are interested in the ability to leverage private dollars to help finance health insurance for low-income workers who are unable to afford their share of an ESI premium. Premium assistance is also sometimes viewed as a way to help low-income workers maintain health coverage for themselves and their families. Premium assistance has been available under Medicaid and SCHIP for some time but has had limited success because of the federal regulations governing the programs. The HIFA statute addresses this by granting states considerable latitude in their premium assistance design. While the HIFA statute requires that states have a premium assistance component, there is extensive variation in the extent to which they have been used. Premium assistance programs are in their infancy, and their role as a cost-effective strategy to provide coverage to the low-income population remains a question.

Market-Oriented Medicaid Program – Several states are currently considering a complete overhaul of the program and creating a competitive Medicaid market. Instituting a competitive Medicaid program to deliver health care to enrollees is, as of this writing, untested but has several potential advantages. Most prominently, it would allow states to more accurately budget state Medicaid expenditures as well as control program costs. Additionally, giving enrollees health care choices offers the potential of making enrollees smarter health care consumers, eliminating unnecessary care and reducing program costs. However, while a major driving force behind these initiatives is the desire to save money, or at the very least control Medicaid costs, recent research suggests that Medicaid is no more costly than private insurance. Specifically, over the last few years Medicaid costs per beneficiary have been lower than that of private insurance. A shift to a competitive Medicaid program would assuredly drive up state administrative costs. The success of privatizing Medicaid also hinges in large part on the ability to accurately adjust premiums for risk. Risk adjustment methods, however, are still in the development phases and thus may not be sufficiently advanced enough to support a fully privatized program.

Summary

HIFA and general Section 1115 waivers offer state governments the opportunity and flexibility to strike a compromise between budgetary commitments and public health care costs. While individual waivers differ in approach and scope, each of the 24 recipient states offers a case study in the positives and negatives associated with redesigning Medicaid. All indications suggest that health care costs will continue to rise in the future. Additionally, Medicaid, both as a program and as expenditure, will continue to challenge policymakers to confront the questions of health care quality, quantity, and cost.

About This Fact Sheet

The information presented here is taken from *Cover Missouri Project: Report 5: The Quiet Medicaid Revolution: State Waiver Activity in the Early 2000s* written by John Holahan, PhD, Director, and Teresa A. Coughlin of The Urban Institute's Health Policy Research Center in Washington, DC. Report 5 is part of a series of research papers about the uninsured in Missouri prepared by The Urban Institute and published by the Missouri Foundation for Health.

The complete report is available online at www.mffh.org. Printed copies of this Fact Sheet are available upon request while supplies last. Please contact the MFH Health Policy staff at info@mffh.org or toll-free at 1-800-655-5560.



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