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MEDICAID SECTION 1115 WAIVERS

Flexible Approach to Approving Demonstrations Could Increase Federal Costs

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The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committe on Finance
United States Senate

Dear Senator Moynihan:

This report, prepared at your request, examines the financing arrangements for four approved section 1115 Medicaid demonstration waivers.

As arranged with your office, unless you publicly announce its contents earlier, we will make no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services; the Administrator, Health Care Financing Administration; the Director, Office of Management and Budget; and other congressional committees. Copies of this report will also be made available to others upon request.

If you or your staff have any questions, please call me at (202) 512-7123. Major contributors to this report are listed in appendix VI.

Sincerely yours,

William J. Scanlon
Associate Director
Health Financing Issues

Executive Summary

Purpose

In what amounts to an ambitious experiment to determine whether the Medicaid program can add several million new beneficiaries without increasing federal costs, the administration has approved requests for 11 demonstration waivers authorized under section 1115 of the Social Security Act. The cost of extending Medicaid coverage to uninsured individuals under these demonstrations is said to be offset by the reinvestment of managed care savings. The administration has asserted that approval for such a major restructuring hinges on budget neutrality, that is, federal costs over 5 years must be no more than if the state had opted to continue its smaller, prewaiver Medicaid program. (A glossary at the end of this report defines budget concepts and other program terminology.) In fact, some states suggest that the net result will be lower costs—even though managed care savings are being reinvested. Eleven more states have pending waivers and other applications are anticipated.

Because a significant number of states may eventually restructure and operate their Medicaid programs under "comprehensive" 1115 demonstration waivers,[1] the Ranking Minority Member of the Senate Committee on Finance asked GAO to examine the financing arrangements for applications approved since 1992, concentrating on the potential net impact on federal Medicaid expenditures. GAO focused its review on section 1115 waivers in Tennessee, Florida, Oregon, and Hawaii, but also closely monitored other approved and pending waivers.

Background

To constrain rising health care costs, states are increasingly turning to mandatory enrollment of some or all Medicaid beneficiaries in managed care delivery plans—arrangements that limit a beneficiary's choice of physicians and hospitals. In many cases, these managed care plans are prepaid a fixed amount per enrollee. This financing arrangement—known as "capitation"—has demonstrated the ability to lower service utilization, which in turn can hold down costs. In order to implement mandatory managed care programs, states must obtain a waiver of certain Medicaid requirements. The waiver authority that gives states the greatest flexibility—it allows the executive branch to waive most federal Medicaid requirements for demonstration projects likely to assist in promoting program objectives—is section 1115 of the Social Security Act.

Since 1992, 22 states have asked to use this demonstration authority to restructure their Medicaid programs. As of September 1995, 5 of the 11

[1]The administration refers to section 1115 waivers that seek to restructure state Medicaid programs as "comprehensive" to distinguish them from other, less ambitious 1115 demonstrations.

section 1115 waivers approved by the administration were being implemented—those for Tennessee, Hawaii, Oregon, Rhode Island, and Minnesota. (App. III summarizes the status of all approved and pending waivers.) The common thread present in what have been coined comprehensive 1115 waivers—complex, sometimes controversial proposals often tied to broader health care reforms—is (1) the switch from a fee-for-service to a managed care approach to delivering health benefits to traditional beneficiaries and (2) the use of anticipated savings plus other funding streams to expand coverage to groups previously ineligible for Medicaid. In return for extending coverage, the federal government has increased states' flexibility to use managed care as a cost-containment strategy. Only a few states have applied for 1115 waivers without also proposing to expand coverage.

The transformation of Medicaid through 1115 waivers is being facilitated by a new federal flexibility in assessing the budget neutrality of such demonstrations, particularly the administration's openness to new methods to estimate what the continuation of a state's existing Medicaid program would have cost. By redefining the terms of budget neutrality, the administration has made it easier for states to demonstrate that the waiver will cost less than the existing Medicaid program. Each state with an approved waiver has a 5-year expenditure cap on the federal share of its demonstration. As spelled out in the waiver agreement, yearly expenditure targets may be exceeded, but total spending over the 5-year period of the demonstration must be at or under the overall cap.

According to waiver applications, states are relying on a mix of funding sources to pay for extending Medicaid to some portion of their uninsured. Analytically, these funding sources can be grouped into two major categories:

- redirected resources obtained by eliminating or reducing existing programs, such as Medicaid's Disproportionate Share Hospital Program (DSH),[2] public health programs, or optional Medicaid coverage expansions, and
- expected savings, primarily from different forms of managed care delivery but also from other Medicaid reimbursement reforms or reductions in benefits.

The extent of reliance on a particular funding source varies from state to state and, contrary to the conventional wisdom, managed care savings

[2]DSH compensates hospitals that serve the uninsured and a large Medicaid clientele.

predominate in only one of the four waiver applications we examined. In addition, many states collect user fees—the premiums charged to new program enrollees. Finally, in a few cases, state funds used to subsidize insurance programs for low-income residents are being folded into the waiver.

Results in Brief

Contrary to the administration's assertion, the approved spending limits for demonstration waivers in Oregon, Hawaii, and Florida are not budget neutral and could increase federal Medicaid expenditures. Only Tennessee's 1115 waiver agreement should cost no more than the continuation of its smaller, prewaiver program and, in fact, should result in savings. Overall, the net additional federal funding is small in relation to demonstration spending allowed under federal expenditure caps—likely less than 3 percent. However, federal Medicaid expenditures could grow significantly if the administration continues to show a similar flexibility in reviewing state 1115 financing strategies. Five waivers have been approved since Florida's in late 1994, and the large backlog of pending waivers includes three states with large Medicaid programs—New York, Illinois, and Texas.

Additional federal dollars are available along with other funding sources identified in state waiver applications. GAO believes that the potential for additional federal funding serves as a hedge against the many challenges and uncertainties states face in implementing these ambitious demonstrations—including changing economic conditions, the accuracy of cost-containment assumptions, the availability of anticipated funding identified in waiver applications, and the lack of reliable cost data on the uninsured. The three states in GAO's sample currently implementing demonstrations are already reacting to these challenges. How they adjust to differences between expectations and actual experience in a changing political landscape will determine whether they live within or exceed their 1115 waiver funding caps.

Principal Findings

Waiver Agreement Spending Limits Could Increase Federal Costs

To determine whether the four approved waivers were budget neutral, GAO compared (1) the estimated cost of the traditional Medicaid

program—absent the demonstration—with (2) each state's capped budget under its waiver funding agreement.

Projecting growth in each state's traditional Medicaid program was challenging because of the lack of consistently generated, state-specific forecasts. Lacking such data, GAO relied on the only available forecasts—the Office of Management and Budget's national projections, on a current services basis, of how the traditional Medicaid program would grow over the 5-year duration of 1115 waivers.[3] GAO then examined state-specific information to identify any reasons why growth in future expenditures for the traditional program should exceed expectations of average growth nationwide. Using this methodology, the waiver expenditure caps negotiated by the administration exceeded the expected costs of continuing the traditional Medicaid program in three states—Oregon, Hawaii, and Florida. GAO saw no support in state-specific data to justify the differences. Only Tennessee's 1115 demonstration is budget neutral.

Administration officials told GAO that, since some states' Medicaid expenditures had been growing faster than the national average, the budget neutrality of each proposed waiver should be evaluated independently in order to capture these variations. However, neither the negotiating record nor other state-specific data analyzed by GAO justified higher than average future funding for Florida, Oregon, or Hawaii. Even in the case of Florida, whose program had been growing faster than the national average, the state's own estimates showed that key factors contributing to past growth were not expected to be sustained.

Access to Additional Funding Has Not Eliminated Cost Pressures

Rather than precise funding road maps, state financing strategies to pay for expanded coverage under an 1115 waiver are outlines subject to the test of reality. The uncertainties states face in implementing these ambitious waivers make it difficult to predict the extent to which the "cushion" provided by access to additional federal dollars will be needed to supplement the redirected funds and program savings outlined in the waiver applications. During the first year of implementation, these uncertainties have played out in different ways for the three states in GAO's

[3]A current services forecast provides a policy-neutral benchmark that only reflects medical inflation, normal growth in the eligible population, and changes in utilization for the entire Medicaid program.

review that are currently implementing waivers.[4] For diverse reasons, all three states are reacting to pressures to reduce waiver expenditures.

Oregon: Unlike Tennessee, Hawaii, and Florida, coverage expansion plans in Oregon rely predominately on managed care savings. Increased managed care savings resulting from significantly higher enrollment in fully capitated plans allowed the state to spend less than the federal expenditure cap—despite the enrollment of a greater-than-estimated number of uninsured residents. These optimistic first-year results, however, have not dampened the concern of state officials about future waiver costs. Under the waiver agreement, federal matching funds for newly eligible individuals are linked to the number of traditional eligibles, a major component of which experienced a numerical decline in 1994. Should this decline continue, fewer new eligibles would qualify for federal matching funds. State concerns also stem from (1) higher-than-expected costs of new eligibles; (2) a number of new, non-health-related, spending priorities; and (3) the impact of a 1991 tax limitation initiative. Oregon began implementing a number of cost-containment measures such as new eligibility rules in October 1995. The state is still waiting for the administration to approve a reduction in benefits and premiums for newly eligible enrollees.

Hawaii: Only Hawaii exceeded its federal waiver funding cap for the first year—costs that must be offset in later years. Any advantage from the current slowdown in medical inflation was offset by the surge in newly eligible individuals who signed up for coverage under the waiver. The state attributes this higher-than-expected enrollment to Hawaii's current economic slowdown and to individuals who dropped private insurance in favor of less expensive coverage through the waiver. Hawaii is taking a number of steps—including increasing premium contributions from new enrollees and using stricter eligibility standards—to lower its waiver costs.

Tennessee: After maintaining open enrollment for a full year and achieving about 80 percent of its coverage expansion goal, Tennessee abruptly cut off enrollment as a result of a budget crisis that it attributes, in part, to the 1115 waiver. In contrast to Hawaii, Tennessee's first year demonstration costs were well below its federal spending cap and on a par with the cost of its significantly smaller prewaiver program—even though the demonstration added several hundred thousand previously uninsured individuals. Moreover, the state has lowered its waiver spending estimates

[4] In 1994 and again earlier this year, Florida's legislature refused to authorize implementation of the waiver.

for future years. According to administration officials, lower-than-expected expenditures may be linked to problems in identifying state matching funds. They told GAO that Tennessee's elimination of its DSH program could have served as a major source of funding for coverage expansion; however, the state also discontinued the hospital tax that served as the source of state match with the onset of waiver implementation. Primarily because of the steep price discount that the state required from participating managed care plans, Tennessee's waiver expenditure cap may have provided more money than the state actually needed to expand coverage.

Section 1115 Medicaid waivers were approved during a period of economic recovery and a slowdown in medical inflation. The recession of the early 1990s coupled with rapid medical price increases serves as a reminder of the risks posed by fixed-cost agreements in variable-cost environments. While states have benefited from recent economic trends, the potential for a resurgence in medical inflation, a recession, and a large increase in the number of traditional and/or newly eligible beneficiaries could create problems for three states currently implementing waivers—Tennessee, Oregon, and Hawaii. Moreover, the political environment has already changed considerably since many of these waivers were first conceived and approved. National health care reform no longer appears imminent, and even reform-minded states have retreated from earlier, broader goals. A new cost-consciousness—unrelated to current economic conditions—has emerged. Clearly, 1115 waivers will continue to evolve, perhaps in unanticipated ways, as they are implemented.

Recommendations

GAO is making no recommendations in this report.

Agency Comments

In commenting on a draft of this report, the Department of Health and Human Services and the Office of Management and Budget disagreed with GAO's conclusion that the waiver funding caps for Oregon, Hawaii, and Florida are not budget neutral. GAO continues to believe that the administration's waiver funding caps for these states may result in increased federal spending. A detailed discussion of the administration's comments and GAO's response appears in chapter 5. The administration's comments are reprinted in appendix V.

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Abbreviations

CPI	Consumer Price Index
DSH	Disproportionate Share Hospital Program
ERISA	Employee Retirement Income Security Act of 1974
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
OMB	Office of Management and Budget
PCCM	primary care case management
PPO	preferred provider organization
PPPM	per person per month
SFY	state fiscal year

Introduction

Financed jointly by the federal government and states, Medicaid is the nation's health care lifeline for two statutorily defined groups of low-income residents—families, primarily women and children; and the aged, blind, and disabled.[5] In reality, Medicaid is not 1, but rather 56 separate programs that differ dramatically across states.[6] While federal statute mandates who is eligible for coverage and the broad categories of services that must be provided, each participating state designs and administers its own program by (1) setting certain income and asset eligibility requirements, (2) selecting which optional groups and services to cover, and (3) determining the scope of mandatory and optional services. As a result of this flexibility, Medicaid is not available to everyone who is poor. In 1993, Medicaid provided health care coverage to less than half of those with incomes below the poverty level.[7] The Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS) monitors each state program for compliance with federal regulations. (App. II contains more background information on the Medicaid program.)

The $130 billion Medicaid program is at a crossroads. Between 1985 and 1993, Medicaid costs tripled and the number of beneficiaries increased by over 50 percent. Current projections suggest that program costs will double over the next 5 to 7 years. To constrain rising health care costs, states are increasingly turning to mandatory enrollment of some or all Medicaid beneficiaries in managed care delivery plans—arrangements that limit a beneficiary's choice of physicians and hospitals. In many cases, these managed care plans are prepaid a fixed amount per enrollee. This financing arrangement has demonstrated the ability to lower service utilization, which in turn can hold down costs.

In order to implement mandatory managed care programs, states must obtain a waiver of certain Medicaid requirements. The waiver authority that gives states the greatest flexibility is section 1115 of the Social

[5]The federal government matches state expenditures according to a prescribed formula based on state per capita income, providing, on average, 58 cents for every dollar spent. Federal matching for individual states varies from a minimum of 50 percent to a maximum of 83 percent of total Medicaid costs.

[6]All 50 states plus the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have Medicaid programs.

[7]Throughout this report, "poverty level" refers to the federal poverty guidelines, which are used to establish eligibility for certain federal assistance programs. The guidelines are updated annually to reflect changes in the cost of living and vary according to family size. Guidelines are uniform across the continental United States and slightly higher for Alaska and Hawaii. For example, in 1994 the poverty level for a family of four in the continental United States was $14,800, while in Hawaii it was $17,020.

Security Act. Section 1115 allows the executive branch to waive most federal Medicaid requirements for demonstration projects likely to assist in promoting program objectives.[8] Since 1992, 22 states have asked to use this demonstration authority to restructure their Medicaid programs. The common thread present in what have been termed "comprehensive" 1115 demonstration waivers is (1) the switch from a fee-for-service to a managed care approach to delivering health benefits and (2) the use of anticipated savings plus other funding streams to expand coverage to groups previously ineligible for Medicaid.

Medicaid Programs Restructured Under Redefined Budget Neutrality Policy

Eleven states with 1115 waivers approved since 1993 have undertaken an ambitious experiment to demonstrate that the Medicaid program can actually save money while simultaneously expanding coverage.[9] The administration has entered into 5-year budget commitments that allow each state to reinvest managed care savings and redirect other funds in order to expand coverage to currently uninsured individuals. Compared to expenditure trends for the predemonstration program, states suggest that the net result of waivers will be lower costs—even though managed care savings are being reinvested. Eleven more waivers are pending, and all but a few applicants are pursuing a similar managed care cost-containment/coverage expansion strategy. Only Illinois, Oklahoma, and Kentucky (the state's 1995 demonstration application) propose using 1115 waiver authority to reduce both state and federal Medicaid expenditures without expanding coverage.[10]

The use of 1115 waivers to restructure state Medicaid programs has been facilitated by a new federal flexibility in assessing the budget neutrality of such demonstrations—particularly, the administration's avowed openness to "new methodologies" to estimate what the continuation of a state's existing Medicaid program would have cost. By redefining the terms of budget neutrality, the administration has made it easier for states to demonstrate that waivers will cost less than their existing Medicaid programs. The administration asserts, nonetheless, that all approved 1115

[8]Demonstration projects have made significant contributions to the development of Medicaid policy, including early experiments with prospective payment for inpatient care and school-based services for young children.

[9]In 1982, Arizona was granted an 1115 waiver to initiate a statewide managed care program. Previously, the state had not participated in Medicaid. For a description of Arizona's Medicaid program, see Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, Oct. 4, 1995).

[10]Kentucky's 1993 demonstration application was one of the first to be approved. Because of the state legislature's concern about the adequacy of funding to extend eligibility to certain uninsured residents, the state submitted a new 1115 waiver application in 1995 that omits any coverage expansion.

waivers are budget neutral and that the demonstration authority is not being used to expand entitlement spending.

Oregon First to Request 1115 Medicaid Demonstration Waiver

Oregon's 1991 application—a major component of a broader reform of its health care system—was the first request since 1982 to operate a comprehensive, statewide demonstration program. After a year of review, the Bush administration rejected the application on the grounds that the state's proposed benefits package might violate the Americans With Disabilities Act. A report prepared for the National Governors' Association criticized the handling of Oregon's application, noting that the review process did not give due weight to the state role in Medicaid, had a "chilling" effect on innovative proposals, and imposed budget neutrality requirements that were too narrow.[11] The Clinton administration subsequently announced plans to streamline and expedite the review process for 1115 waivers.

Oregon revised and resubmitted its waiver application in late 1992 and the following March became the first state in over 10 years to obtain approval for a comprehensive 1115 demonstration. Since then, 10 additional waivers have been approved. Another 11 states have applications pending, and others have expressed interest in submitting requests for 1115 waivers. States with approved and pending waivers account for about 49 percent of the nation's Medicaid beneficiaries and 52 percent of total Medicaid expenditures.[12] As of July 1995, however, only five states—Oregon, Hawaii, Tennessee, Rhode Island, and Minnesota—had begun implementation. Appendix III summarizes the status of all approved and pending comprehensive 1115 demonstrations submitted since 1992.

[11]John Luehrs, Flexibility and Waiver Authority for Health Care Reform: A Primer for States, Health Policy Studies, Center for Policy Research, National Governors' Association (Washington, D.C.: 1992).

[12]Throughout this report, Medicaid beneficiary/recipient statistics include all enrolled individuals in the 50 states and the District of Columbia regardless of whether they received services during the year.

1115 Waivers Remove Roadblocks to Managed Care

Requirements intended to preserve quality by protecting a Medicaid beneficiary's freedom to choose a provider have limited states' ability to mandate enrollment in HMO-style managed care.[13] HMO-style health plans are prepaid a fixed amount based on the number of enrollees rather than reimbursed after each service is rendered. Such prepayment on a per capita basis is often referred to as "capitation." A convergence of trends—spiraling Medicaid expenditures coupled with a stronger interest on the part of mainstream HMOs in serving the Medicaid population—has given impetus to as well as facilitated the adoption of a managed care cost-containment strategy by states. And rather than turning to physician gatekeeper arrangements that dominated past managed care experiments, many states are using the flexibility gained under 1115 Medicaid waivers to adopt capitated alternatives.

Reacting to quality-of-care, marketing, and other problems that surfaced in a number of Medicaid managed care programs, the Congress enacted provisions in 1976 with the general goal of encouraging HMOs to provide public clients a quality of care comparable to that available to private clients.[14] At the time, HMOs were the prevalent form of managed care. One provision discouraged the creation of HMOs serving only Medicaid beneficiaries by requiring that at least a certain percentage of the patients be privately insured. The participation of private-paying patients, who presumably have a choice of health plans, was instituted as a proxy for quality. A second provision added in 1981 allows recipients to terminate enrollment in an HMO at any time. From the beneficiary's perspective, these provisions offer protection against enrollment in an HMO seeking excessive profit at the expense of quality. From the HMO's perspective, however, unrestricted freedom to disenroll makes it difficult to plan financially and

[13]Though no commonly accepted definition exists for the term "managed care," a number of features are typically associated with it: (1) provider networks with explicit criteria for selection, (2) alternative payment methods and rates that often shift some financial risk to providers, and (3) utilization controls over hospital and specialist physician services. Despite the confusing nomenclature used to distinguish a variety of managed care plans—HMO, PPO, PCCM—most include one or more of these common cost-control features. Health maintenance organizations (HMO), the most tightly controlled type of managed care plans, require patients to use affiliated physicians who may be salaried, paid on a per capita basis (often referred to as "capitated"), or reimbursed for each service. Typically, a patient's care, especially referrals to specialists and hospitalization, is coordinated by a primary care physician—often called a "gatekeeper." Preferred provider organizations (PPO) provide enrollees with a financial incentive—lower cost-sharing (co-payments)—to receive care from a network of providers that are normally reimbursed at a discounted rate. Finally, many state Medicaid programs have conducted experiments using a primary care case management (PCCM) approach in which physician gatekeepers must authorize a patient to see a specialist or obtain hospital care. Gatekeeper physicians may be partially capitated or paid for each service delivered. For a description of the evolution and use of the term managed care, see Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

[14]These provisions were incorporated in subsection (m) of the Social Security Act, which was added to section 1903 (42 U.S.C. 1396b(m)).

therefore renders the enrollment of Medicaid recipients less attractive. This provision added to the hesitancy of many mainstream HMOs to participate in Medicaid, further restricting states' ability to experiment with fully capitated health plans.[15]

In 1993, about 4.8 million beneficiaries, or about 12 percent of the Medicaid population, were enrolled in some type of managed care.[16] Though a number of voluntary and mandatory managed care options are available to states, the enrollment of Medicaid beneficiaries has lagged behind national trends. Without an 1115 waiver, states essentially have three managed care options:

- voluntary enrollment in an HMO, in which case the beneficiary must also have a choice of obtaining services on a fee-for-service basis and be allowed to disenroll at will;
- mandatory enrollment in an HMO, provided the beneficiary can choose from among a number of competing HMOs, with disenrollment allowed on a monthly basis (or every 6 months if an HMO meets certain federal requirements); and
- voluntary or mandatory enrollment in a physician gatekeeper system in which either the physician's charges are partially capitated or the physician is reimbursed under fee-for-service.

The last two options require waivers of Medicaid provisions that have been widely provided under section 1915(b) of the Social Security Act. As of July 1994, 37 states operated 1915(b) waiver programs. These programs were primarily substate (that is, in a limited geographic area), voluntary, and involved physician gatekeepers rather than HMOs. Until 1993, only two states—Arizona and Minnesota—operated mandatory HMO managed care programs under the authority of an 1115 waiver.[17] Table 1.1 delineates the additional flexibility available under an 1115 waiver compared with 1915(b) authority.

[15]Other factors that dissuaded HMOs from participating in the Medicaid program included (1) inability to offer incentives, such as lower out-of-pocket costs or better benefits, to encourage beneficiaries to enroll; (2) lack of experience in marketing to individuals as opposed to large employers; and (3) a widespread perception that Medicaid beneficiaries were costly and had difficulty adjusting to HMO restrictions.

[16]This percentage is calculated using the number of individuals enrolled in Medicaid. Occasionally, a slightly higher percentage is reported that is based only on beneficiaries who actually receive services during the year.

[17]As noted earlier, Arizona's program operated statewide. In contrast, Minnesota's 1115 waiver primarily covered the urban counties surrounding Minneapolis.

Table 1.1: Comparison of Managed Care Flexibility Available Under 1915(b) Versus 1115 Waivers

Section 1915(b) program waivers[a]	Section 1115 demonstration waivers
HMOs must still meet federal requirement for more than 25 percent private enrollment	HMOs may enroll Medicaid patients exclusively
Full range of mandatory services must be offered	Benefit package may be modified[b]
Enrollment “lock-in” limited to 1 month[c]	Enrollment “lock-in” may be extended to 12 months
No restrictions on access to family planning providers	Access to family planning providers may be restricted

[a]When originally enacted in 1981, section 1915(b) expressly allowed waiver of section 1903(m) HMO provisions in the Social Security Act. The following year, the law was amended to eliminate the authority to waive these provisions.

[b]To date, only Oregon has been permitted to modify the benefit package for traditional Medicaid eligibles. Other states have been permitted to offer a modified package only to those newly eligible under the demonstration.

[c]The lock-in is 6 months for an HMO meeting certain federal qualifications.

1115 Coverage Expansion Goals and State Medicaid Baselines Vary

Though all approved 1115 waivers expand eligibility, the nature and extent of coverage expansion varies. Waivers use income standards to define and, in effect, limit who is eligible, but states further restrict the number of individuals that can actually obtain coverage through explicit enrollment caps, other barriers, and even premiums. Because of greater than anticipated enrollment, several states are taking additional steps to limit the number applying for coverage.

Most states are adding groups who were previously ineligible for Medicaid—single adults and childless couples. However, it is important to recognize that some categories of newly eligible individuals in one state may already be enrolled in Medicaid in another because of differences in the qualifying income levels established by states for families and optional coverage expansions allowed by statute.[18] Moreover, states may have previously provided health coverage to some new eligibles outside of Medicaid—that is, through state-funded programs. For example, Kentucky’s planned expansion under its now suspended 1993 waiver includes both previously ineligible individuals and individuals who could have been included in Medicaid at state option. In Rhode Island, Hawaii,

[18]One such option is section 1902(r)(2) of the Social Security Act, 42 U.S.C. 1396(b)(r)(2), which enables states to liberalize financial criteria for certain individuals not receiving cash assistance. Women and children and the aged, blind, and disabled may qualify for Medicaid coverage in this way. No precise upper limit on income exists under this option. Thus, at least one state has established financial criteria sufficiently liberal to cover individuals with incomes up to 300 percent of the federal poverty level.

and Minnesota the expansions either are limited to or include individuals who could have been Medicaid- eligible at state option. Both Hawaii and Minnesota offered state-funded coverage to many included in their waivers.[19]

Table 1.2 summarizes the coverage expansion goals of seven states with approved 1115 waivers. Generally, expansion goals are stated in terms of the number of newly eligible individuals expected to be covered under the waiver at the end of the 5-year period of each demonstration. Enrollment in year 1 may be less than the 5-year enrollment goal, since states typically anticipate reaching "full enrollment" gradually. State goals should be viewed as targets subject to a number of constraints, especially financing. Some waivers indicate that the state will limit enrollment if funding proves to be inadequate. At least one state, Tennessee, has already done so.

[19]These programs are the General Assistance and State Health Insurance Programs in Hawaii and MinnesotaCare in Minnesota.

Table 1.2: Coverage Expansion Goals and Cost-Sharing Arrangements for Seven Approved 1115 Demonstration Waivers

	Implemented					Not implemented	
	Tennessee	Oregon	Hawaii	Rhode Island	Minnesota	Kentucky	Florida
Poverty level criterion (no individual/family with income above this limit qualifies for coverage)[a]	No upper limit	100% of poverty level	300% of poverty level	250% of poverty level	275% of poverty level (children only)	100% of poverty level	250% of poverty level
Estimated enrollment, year 5	500,000	96,400[b]	77,000	7,000	135,000	201,000	1,100,000
Enrollment, year 1	400,425 (actual, 7/7/95)	69,666 (average, 12/31/94)	63,500 (actual, 7/95)	716 (actual, 5/31/95)	47,000 (actual, 7/95)	Suspended by state	145,558 (estimated)
Percentage of poverty level at which premium payments begin	100% of poverty level[c]	[d]	100% of poverty level[e]	185% of poverty level[f]	70% of poverty level	No premiums	Enrollee with any income must pay a premium
Income level at which enrollee pays full premium	400% of poverty level[c]	[d]	201% of poverty level[e]	Over 250% of poverty level	Over 275% of poverty level	No premiums	Over 250% of poverty level
Average monthly premium for a family of 4 at 150% of poverty level	$27.35	[d]	$140[e]	No premium at this poverty level[f]	$36	No premiums	Approximately $21[g]

[a]For example, in Oregon a family of four whose income exceeds $14,800 would not be eligible for coverage under the waiver, while in Minnesota the income standard is $40,700.

[b]Because of the employer mandate, the state expected the number of new eligibles to decline to this lower level by the fifth year of the waiver as some low-income individuals shift to private insurance.

[c]Participants are also expected to contribute co-payments for most services and annual deductibles up to a maximum.

[d]In June 1995, Oregon requested HCFA approval to begin charging premiums as of October. As of late October, HCFA officials had not responded to this request. Under the proposed changes, all new eligibles are expected to pay a premium. The maximum premium for a family of four or more at 100 percent of the poverty level would be $28.

[e]Hawaii implemented these cost-sharing arrangements on August 1, 1995. During the preceding 12 months, out-of-pocket costs for new eligibles were lower: (1) only individuals at and above 133 percent of the poverty level were required to pay premiums, (2) individuals at or above 296 percent of the poverty level were required to pay the full premium, and (3) the monthly premium payment for a family of four was only $51.40.

[f]Rhode Island offers two cost-sharing options—a premium and a point-of-service co-payment. To date, most enrollees have selected the point-of-service co-payment option. According to a state official, the two options are designed to be actuarially equivalent, that is, the net cost to enrollees is the same. Premium shares for demonstration eligibles are stratified by age and represent 3 percent of the total premium amount. A family of four consisting of a mother, one infant, and two children between 185 and 250 percent of the poverty level would pay a monthly premium of about $14.50.

[g]The total premium is actually $42, but Florida assumes that enrollees and their employers will split the cost. An enrollee would be responsible for any portion of the total premium not paid by the employer.

At one end of the expansion continuum, Tennessee's waiver program has no eligibility income limit and requires only those enrollees above 400 percent of the poverty level to pay the full premium. Tennessee set an original enrollment cap of 500,000 on new eligibles and excluded individuals who were insured before a certain cutoff date to forestall a migration from private insurance.[20] The state lowered its cap in December 1994, in effect limiting the expansion to the approximately 400,000 previously uninsured individuals already enrolled.[21] In contrast, Oregon's expansion goals are less ambitious because, in part, the employer mandate was expected to cover low-income workers. The waiver expands eligibility up to 100 percent of the poverty level, requires no premiums from participants, and has no explicit enrollment cap. In order to address budgetary constraints, the legislature enacted several changes that the state began implementing on October 1, 1995. However, HCFA has yet to approve Oregon's request to require premiums of some newly eligible participants.

Some 1115 waivers, such as Hawaii's, target individuals who were already covered by state-funded expansion programs outside of Medicaid.[22] Consequently, Hawaii did not anticipate much additional enrollment as a result of its waiver. Unlike Hawaii, Minnesota's waiver application did not include single adults and childless couples covered under state-funded MinnesotaCare. State officials told us that requesting a federal match for this group would have created a budget neutrality problem because of the cost. Instead, the approved waiver shifts children covered under MinnesotaCare into Medicaid—a group that could have been included in the program at state option. Finally, Rhode Island's expansion group is limited to pregnant women and children who could also have been covered at state option without an 1115 waiver.

[20]Tennessee established an overall cap on program participation—1.3 million the first year (1 million traditional Medicaid recipients and 300,000 previously uninsured individuals) and 1.5 million in subsequent years (1 million traditional recipients and 500,000 previously uninsured individuals). In effect, however, the cap only applied to the enrollment of the previously uninsured, since traditional Medicaid recipients and those whose medical conditions make them uninsurable would continue to be enrolled if the overall cap is reached.

[21]On December 31, 1994, Tennessee closed enrollment to previously uninsured individuals who do not qualify for Medicaid or are not considered uninsurable. Applications pending at that time were processed.

[22]Some individuals covered by Hawaii's state-funded expansion had been ineligible for Medicaid, while others could have been included at state option.

Treatment of Low-Income Populations Under Waivers Is Controversial

Embedded in many comprehensive 1115 demonstrations is a controversial philosophical shift in the way publicly supported health care is provided to the poor—a shift (1) inherent in the adoption of managed care delivery systems and (2) visible in the treatment of those newly eligible under the demonstration. The cumulative effect of these changes is to place more responsibility on the individual beneficiary. Advocacy groups for the poor[23] and waiver states disagree on the extent to which low-income beneficiaries can shoulder these responsibilities.

Advocacy groups typically see Medicaid beneficiaries, as well as many of the working poor to whom coverage is being extended, as a vulnerable, high-risk, and sicker segment of the population. They are concerned about the ability of the poor to access services in a managed care system. As noted earlier, some critics of managed care argue that it creates a "perverse incentive" to deliver fewer or less costly services than may be needed. Advocacy groups also worry that managed care will (1) further reduce the historically low Medicaid reimbursement levels, (2) diminish quality of care, and (3) curtail access to providers that have traditionally served the poor. Finally, they see a disincentive for the poor to participate in waiver programs when premiums, though subsidized, are high relative to income. States, on the other hand, point out that the waivers require them to implement significant quality assurance programs such as collecting and analyzing encounter data and conducting annual satisfaction surveys. They contend that access and quality were never optimal under a fee-for-service delivery system in which choice was guaranteed but not necessarily available and high emergency room use was an underlying symptom of access problems. Finally, states generally see employment as a proxy for health and evidence for distinguishing between the newly eligible working poor and the more vulnerable beneficiaries typically enrolled in Medicaid.

The "mainstreaming" of new eligibles—that is, the attempt to treat them as if they were purchasers of private insurance—is perhaps the hallmark of most state 1115 demonstrations.[24] For the newly insured, states have attempted to break Medicaid's psychological link with welfare by

[23]In June 1994, the National Association of Community Health Centers filed a lawsuit to stop the implementation of comprehensive 1115 demonstrations. The Association noted that it was acting to ensure that the rights of vulnerable populations are protected—not to thwart state efforts to improve health care delivery. In a press release announcing the lawsuit, the Association argued that beneficiaries were being "forced to enroll in managed care plans that are under no compulsion to meet federal safeguards designed to ensure access, services, and quality control."

[24]Since 1986, states have had greater leeway in adopting a streamlined eligibility process for Medicaid recipients who do not receive cash assistance. Most states have adopted one or more of the available alternatives.

establishing eligibility criteria and enrollment mechanisms distinct from those that apply to traditional beneficiaries, many of whom qualify for Medicaid by virtue of receiving cash assistance. For example, most waivers eliminate the asset test, often criticized as intrusive and expensive to administer, and rely instead on a gross income test.[25] Moreover, rather than the frequent redeterminations of eligibility associated with Medicaid, many newly eligible individuals are enrolled for periods ranging from 6 to 12 months. In some states, enrollment of new eligibles is not handled by the agency that administers Medicaid. In fact, Florida plans to hand this task over to insurance agents—further underscoring the similarity to a private insurance product. In general, application forms are simpler and in some states can even be mailed. Newly eligible individuals usually receive the full acute care benefit package available to traditional Medicaid recipients. Only in the case of Florida is the benefit package more restrictive. Finally, many states require individuals with incomes above the poverty level to contribute toward the cost of health care coverage by charging premiums, co-payments, and deductibles.

For the traditional Medicaid population, the major change associated with 1115 waivers is the wholesale movement from fee-for-service to some type of managed care—even in rural areas and, often, even for those who are aged, blind, or disabled.[26] For some, such as low-income families in Oregon and Minnesota who were already enrolled in mandatory managed care programs, the change may be imperceptible. Under most 1115 waivers, eligibility requirements are unchanged and benefits remain the same or are more generous. For example, Tennessee lifted service restrictions on its Medicaid benefit package. Only Oregon altered benefits to help finance coverage expansion. The redefined package, commonly

[25]Certain of these changes result in the loss of coverage for a small number of individuals who would qualify for Medicaid were the demonstration not in place. For a more extensive discussion of the impact of eliminating the asset test, see Sara Rosenbaum and Julie Darnell, Medicaid Section 1115 Demonstration Waivers: Approved and Proposed Activities as of November 1994, Center for Health Policy Research, The George Washington University (Washington, D.C.: Nov. 1994), p. 3.

[26]Tennessee and Florida include the aged, blind, and disabled in their transition from fee-for-service to managed care. HCFA approved Oregon's request to add this population to the state's waiver program beginning in January 1995. Hawaii anticipates seeking HCFA approval to include these populations at a later date.

known as the “prioritized list,” eliminates some costly health services while adding a broad array of preventive care.[27]

Waiver Designs Often Reflect State Context and Health Reform Goals

A notable feature of the growing number of 1115 waivers is their divergent techniques for using Medicaid as a springboard to achieve some degree of reform in state health care systems. Numerous states that have submitted waiver applications are recognized leaders representing diverse approaches to health care reform. Though many waivers were conceived when national reform appeared imminent, the recent retrenchment from broader reform goals suggests that Medicaid waivers have become a more important component of state health care reform. Appendix IV compares several states across a range of indices that are relevant to understanding the diversity evident in waiver designs.

The 1115 waiver is health care reform in Tennessee. The state’s emphasis on managed care promises to increase penetration by that delivery system in a region long resistant to such a change while at the same time significantly reducing the number of uninsured. The success of this policy hinges on the adoption of a stringent cost-containment strategy with regard to health care financed through the waiver.

In contrast to Tennessee’s nascent reform program, Florida’s as yet unimplemented waiver represents a logical progression from earlier small market reforms intended to provide access to affordable insurance for the working poor. The state hopes to use its waiver to achieve a dramatic enrollment expansion in the state’s voluntary, small business-oriented purchasing cooperatives and a significant reduction in its estimated 24-percent uninsured rate. Florida stands alone in the extent to which it distinguishes between traditional and newly eligible Medicaid recipients. While the former are required to choose between different forms of managed care, newly eligible recipients may select any health plan offered by state-supported purchasing cooperatives with the sole proviso that the enrollee is responsible for any difference between the subsidy and the plan premium. Florida’s 1992 health reform legislation established a goal of

[27]The process for establishing the revised benefit package was controversial because the state developed a method to rank, or prioritize, services in descending order from most to least useful. Independent actuaries set cost estimates for individual services on the list. Each legislative session, state legislators “draw the line” according to the amount of funds appropriated for the program, thereby defining the list of available services. State officials believe the use of the prioritized list will ensure continuous coverage for demonstration enrollees despite funding fluctuations, which states historically remedy by eliminating coverage for optional groups and services. Examples of services not included are aggressive cancer treatment that will not result in a 5-percent probability of a 5-year survival (hospice care, comfort care, and treatment of symptoms are still covered); medical treatment for a sore throat or diaper rash; and cosmetic services.

universal coverage, and the legislature promised to revisit the choice of a voluntary over a mandatory approach unless there was a significant reduction in the number of uninsured.

In Minnesota, Oregon, and Hawaii, the waiver is only one element of a much more ambitious reform agenda—an agenda that some state officials believe has been brought into question since the 1994 health care debate. All three states have universal coverage as a goal. Hawaii already has a limited exemption from the requirements of the Employee Retirement Income Security Act of 1974 (ERISA)[28] that allows it to require employers to offer health insurance to their workers. Oregon's Medicaid waiver is also built around an ERISA exemption to permit enactment of an employer mandate. Obtaining that exemption is now considered unlikely. In contrast, Minnesota had been attempting to finance universal coverage with an individual mandate, though state officials told us that this approach is no longer considered a possibility. Both Hawaii and Minnesota have relatively small uninsured populations and, prior to the 1115 Medicaid waiver, had already taken steps to address this problem through the establishment of state-funded coverage expansions. All three states have significant managed care penetration. Moreover, Oregon and Minnesota have a decade of experience with Medicaid managed care.

Financing of Waivers Is Most Contentious Issue

An important element of the administration's commitment to streamline and expedite the review of 1115 waivers was the promise to maintain the principle of waiver budget neutrality "more flexibly than has been the case in the past." Despite this commitment, a number of factors have contributed to a lengthening of the process, including extensive negotiations over financing.[29] In fact, both administration and state officials told us that budget neutrality is often the most contentious issue.

[28]Public Law 93-406, 88 Stat. 829 (classified as amended at 29 U.S.C. 1001 et seq.). ERISA prevents states from mandating that employers provide health benefits. Concurrent with the original passage of ERISA, Hawaii enacted comprehensive health reform requiring all employers to provide full-time employees a standard health package and pay for a substantial portion of the premium. Some dependents, part-time workers, and certain other individuals were not covered by the mandate. After several large employers successfully argued that ERISA precluded such a mandate, the Congress grandfathered Hawaii's statute by granting an exception to ERISA requirements.

[29]Five waivers were submitted between November 1992 and mid-1993 and each was approved before the end of 1993. The shortest approval took 3 months and the longest 7 months. In 1994, however, only one of nine waivers pending was approved for implementation. Additional factors that have lengthened the review process include (1) the complexity of and variation found in state applications, (2) concerns raised over the rapid approval and implementation of Tennessee's waiver, and (3) the growing backlog of waivers submitted.

Though a policy of budget neutrality has been in effect since the early 1980s, previous 1115 Medicaid demonstrations were usually small-scale experiments targeted at specific populations (for example, pregnant drug-users on Medicaid) or implemented in a limited geographic area.[30] As a result, the potential impact on state and federal expenditures was more circumscribed and the task of devising a cap to ensure cost neutrality was less challenging.[31] Oregon's 1991 waiver application was the first of a new breed of "comprehensive" 1115 demonstrations—complex proposals that were sometimes controversial and often tied to broader health reform agendas. HCFA officials told us that the number, scope, and complexity of such comprehensive demonstrations in effect elevated the importance of budget neutrality while making it more difficult to evaluate and enforce.

In a memo preceding promulgation of a more flexible approach to budget neutrality, HHS officials recognized the incentive for states to shift costs to the federal government and the need to constrain such behavior. Nonetheless, they outlined several arguments for a less strict approach. For example, they pointed out that the federal government might want to (1) share in the risks and costs of testing innovations that were ultimately in its own interest; (2) set the stage for health reform by supporting changes that should not wait even if they are somewhat more costly; and, finally, (3) provide some fiscal relief to states overburdened by the rising number of uninsured, increasing charity care requirements, and federally mandated expansions. Most importantly, the memo recognized that whatever policy was adopted needed to be clear and consistently applied.

There are two key aspects to the administration's revised budget neutrality policy. First, states are allowed to demonstrate budget neutrality over the life of the waiver rather than on a yearly basis, allowing more time to recoup any associated start-up costs. Second, recognizing the difficulty in estimating the costs of continuing the prewaiver program over the period of the demonstration and the inherent element of judgment in undertaking such an estimate, the administration announced that it was open to state suggestions on the development of a new baseline methodology. According to HHS and Office of Management and Budget (OMB) officials who share responsibility for implementing this revised policy, there are

[30]Past insistence on budget neutrality had effectively limited the scope of 1115 waivers to small, substate demonstrations. The only prior use comparable to recent statewide waiver applications was the 1982 initiation of a managed care program in Arizona, a state that previously had not participated in Medicaid.

[31]Minnesota obtained an 1115 waiver in 1982 to move low-income families and elderly recipients in the Minneapolis area and one rural county into HMOs. Budget neutrality was addressed by requiring that the capitation rate be structured at 90 to 95 percent of fee-for-service costs for these beneficiaries.

three critical steps in determining baseline costs: (1) selecting a base year, (2) developing a trend factor for growth from the base year to the first year of implementation, and (3) developing a trend factor for baseline costs over the period of the waiver. The method used to develop baseline costs is important because it is the benchmark against which the administration assesses waiver costs. The higher the baseline, the easier it is for a state to demonstrate cost neutrality.

Monitoring and Enforcing Budget Neutrality

The final waiver agreement consists of a set of terms and conditions that, among other things, spells out how budget neutrality will be monitored and enforced. Although there are important state-specific variations, the administration has taken two basic approaches to enforcement. Tennessee and Florida have an aggregate cap on the amount of federal matching funds available for their demonstrations, while all other states have a per capita limit. The federal government will not match state expenditures above the specified caps. Table 1.3 highlights the important differences in what the expenditure caps cover and how they work in the four states whose budget neutrality agreements we assessed.

Table 1.3: Methodology for Enforcing Budget Neutrality Expenditure Limits

State	Methodology
Aggregate cap	
Tennessee	Expenditure limit is on total Medicaid program, including long-term care, which is not part of the demonstration; expenditures for traditional and new eligibles are matched up to the cap.
Florida	Expenditure limit only applies to acute care costs and DSH; expenditures for traditional and new eligibles are matched up to the cap.
Per capita limit	
Hawaii	Expenditure limit applies to acute care costs of traditional Medicaid population; expenditures on new eligibles are not matched, but program savings can be applied to cover their costs.
Oregon	Expenditure limit applies to acute care costs of traditional Medicaid population and new eligibles, but a formula limits the number of those newly eligible for which federal matching funds are available.

Aggregate caps are the most straightforward and uniform of the two approaches. In Tennessee and Florida, the federal government agreed to an explicit expenditure limit on demonstration costs. With the exception of certain recipient growth in Florida, the federal government will not

match any costs above this cap. For states that use the per capita approach, the federal government agreed to a cost-per-recipient limit. For Hawaii, this cost limit is based on per capita fee-for-service costs from 1993 trended forward to the first year of the demonstration. If, as the state anticipates, the switch to managed care produces savings over fee-for-service rates, they can be applied to the costs of those newly eligible. In Oregon, the agreement specifies per capita cost limits for both traditional and newly eligible enrollees. However, the number of new eligibles is limited to an agreed-upon percentage of traditional Medicaid enrollment. With the exception of Tennessee, no state is held at risk for growth in the Medicaid population caused by an economic downturn. Florida has an escape valve from its aggregate cap if growth in the Medicaid population exceeds projections by 3 percent or more.

Objectives, Scope, and Methodology

We reviewed the financing arrangements for approved 1115 Medicaid demonstration waivers in several states, with a focus on (1) the relationship between the waiver and other state health reform initiatives, (2) the planned sources of funding available to finance expanded coverage, (3) the potential net impact of these waivers on federal Medicaid expenditures, and (4) the actual waiver expenditures of states with the most implementation experience. Although our study focused on 1115 waivers in Tennessee, Florida, Oregon, and Hawaii, we closely monitored other pending waivers, which we use as examples throughout this report. For a detailed description of our methodology, see appendix I. Our review was conducted from August 1994 through August 1995 in accordance with generally accepted government auditing standards.

Theory Behind Expanding Medicaid Coverage Without Increasing Program Expenditures

Although the administration has adopted a more flexible approach toward budget neutrality, it contends that all approved comprehensive 1115 demonstrations are in fact budget neutral. Before addressing this issue in the next chapter, this chapter describes and categorizes waiver funding strategies—strategies that states say will result in coverage expansion without increasing expenditures beyond what their smaller, prewaiver Medicaid programs would have cost. In fact, compared to the cost of continuing the existing Medicaid program, many states project that the demonstrations could actually save money. State officials estimate that the four 1115 demonstrations whose financing we examined in detail could add up to 2 million previously uninsured individuals while yielding savings of about $6 billion over 5 years.

Table 2.1: State Projections of 5-Year Savings Under 1115 Waivers

Dollars in billions

	Tennessee	Florida	Oregon	Hawaii
State share	$1.6	$.845	$.017	$.429
Federal share	3.2	0.0	.029	.005
Total	**$4.8**	**$.845**	**$.046**	**$.434**

Planned Sources of Funding for 1115 Medicaid Waivers

States rely on a similar mix of funding sources that, analytically, can be grouped into two major categories: (1) Medicaid resources redirected from existing programs, such as the Disproportionate Share Hospital Program (DSH),[32] and (2) expected savings, primarily from different forms of managed care delivery. In addition, many states collect user fees—the premiums charged to new program enrollees. Finally, in a few cases, state funds used to subsidize insurance programs for low-income residents are being folded into the waiver. Based on a review of waiver applications and discussions with HCFA and state officials, table 2.2 (1) summarizes the planned funding sources for expanded coverage in four states over the 5-year terms of the demonstrations and (2) highlights the relative importance of the various categories of funding.

[32]DSH compensates hospitals that serve the uninsured and a large Medicaid clientele.

Table 2.2: Planned Sources of Funding for Expanded Coverage Over the 5-Year Terms of 1115 Demonstrations

	Tennessee	Florida	Oregon	Hawaii
Redirected	**Major $$$**	**Important $$**	**No role**	**Major $$$**
	DSH	DSH		DSH
	Public health programs	Medically Needy Program		
Program savings	**Important $$**	**Major $$$**	**Major $$$**	**Important $$**
	Managed care	Managed care	Managed care	Managed care
		Reimbursement reform	Priority list	
			Employer mandate	
Other	**Less important $**	**Less important $**	**Less important $**	**Less important $**
	Premiums	Premiums	State-funded programs	Premiums
				State-funded programs

Note: This categorization is based on expected funding sources before states started implementing their waivers. Chapter 4 addresses the extent to which state expectations have been realized.

Comparing the major funding sources across states can be tricky. For example,

- Hawaii's waiver application never quantified expected managed care savings,
- Tennessee's waiver application identified premiums but not DSH as a financing source, and
- Florida quantified its funding sources but omitted premiums because they will be used to offset state costs.

Despite these obstacles, a few generalizations can be made about the magnitude and relative importance of core, coverage expansion funding. The conventional wisdom that 1115 expansions are financed largely by managed care savings is misleading. In at least two states with approved waivers, funds redirected from DSH and other programs play a more significant role. On the other hand, states with relatively small DSH allotments rely to a greater extent on managed care or other forms of savings. Finally, premiums are a less important and more uncertain source of funding.

Funds From DSH and Other Programs Play Major Role

Based on a review of waiver applications and discussions with HCFA and state officials, DSH and other redirected funds in Tennessee's and Hawaii's demonstrations appear to be a more important coverage expansion financing source than either expected managed care savings or any capitation discount obtained from managed care organizations.[33] As shown in table 2.3, both states had relatively large DSH programs at the time their waivers were approved. The theory behind eliminating or greatly reducing DSH payments to hospitals is that fewer uninsured will translate into less uncompensated care.[34] Compared to other financing sources, DSH appears to be the most tangible and assured source of financing.

Table 2.3: DSH Allotment as a Percentage of Medicaid Expenditures in Fiscal Year 1993 for Four Waiver States

Dollars in millions

	DSH allotment	Percentage
Tennessee	$430	16.1
Hawaii	44	11.5
Florida	240	4.8
Oregon	21	2.2

Source: The Urban Institute.

Tennessee's waiver also proposes to redirect funds from two additional sources—public health programs and DSH-like payments, referred to as local government charity care. As with DSH, state officials believe that routine access to health care by those currently uninsured should decrease the funding needed for programs such as those for communicable disease control and maternal and child health.

Florida's 1115 waiver caps enrollment at about 1.1 million previously uninsured individuals—less than half of the state's uninsured population. Since hospitals would continue to face significant levels of uncompensated care, the state was reluctant to redirect all of its DSH

[33]Our recent report on Tennessee's 1115 waiver program, Medicaid: Tennessee's Program Broadens Coverage, But Faces Uncertain Future (GAO/HEHS-95-186, Sept. 1, 1995), focuses primarily on the financial aspects of the demonstration. It challenges the state's estimate of the discount obtained from participating managed care organizations, noting that Tennessee's rate-setting methodology understated historical Medicaid costs by approximately 25 percent. See chapter 4 for a discussion of Tennessee's waiver expenditures for the first year of the demonstration and the influence of DSH on the level of state spending.

[34]Under Tennessee's waiver agreement, DSH was technically eliminated, since the state was relieved of the obligation of making payments to hospitals. However, Tennessee's level of DSH funding in fiscal year 1993 is built into the waiver expenditure cap and actually grows in future years. For further details, see chapter 3.

funds. Consequently, Florida's finance plan only shifts growth in its DSH resources toward coverage expansion. Because of the relative modesty of its DSH payments, Florida was forced to search for an alternative funding source. The state decided to eliminate Medically Needy Program coverage and to reallocate those funds to help subsidize the purchase of private health insurance. A state is not required to offer a Medically Needy Program under Medicaid. Because the Medically Needy Program pays for health services only after individuals have already incurred large liabilities, Florida considers the program to be similar to DSH. That is, it reimburses hospitals for bills that otherwise might go unpaid. Together with DSH, redirected funds are only about one-third of the financing identified in Florida's waiver.

Savings Anticipated, Primarily From Managed Care

States with relatively smaller DSH allotments like Oregon and Florida rely to a much greater extent than Tennessee and Hawaii on program savings to finance coverage expansion. Those expected savings, however, represent more than just the transition to managed care. Though all 1115 waivers anticipate managed care savings, there appears to be little unanimity on how quickly savings can be achieved or on what type of managed care delivery system is the most efficient.

Without substantial DSH funding, Oregon's expansion goals, as outlined in the waiver, rely almost exclusively on program savings. In addition to managed care efficiencies, the state also anticipates lower Medicaid costs under the waiver as a result of adopting its redefined benefit package, known as the prioritized list, and an employer mandate. The mandate would reduce state costs by requiring employers to provide health insurance coverage to low-income workers initially covered under the waiver. State estimates suggest that about 85 percent of the financing for expanded coverage is attributable to the combination of switching to managed care delivery arrangements and using the prioritized list. Although the state attributes a specific amount of savings to the list, its officials told us that, in fact, it is difficult to distinguish such savings from managed care efficiencies.

About two-thirds of Florida's financing also relies on program savings. However, almost half of those savings would result from proposed reimbursement reforms. Unlike Medicaid physician fees, other medical services in Florida have had a built-in inflation adjustment. Under the reimbursement reforms, price increases for services rendered by HMOs, pharmacies, and clinics, and on an outpatient basis at hospitals, will be

lowered by limiting them to increases in the Consumer Price Index plus a declining number of percentage points with each subsequent year.

Lack of Consensus on Managed Care Savings

Despite the common thread of reliance on anticipated managed care savings as a funding strategy, state definitions of just what constitutes managed care and their approaches toward achieving those savings differ. Thus, Tennessee uses a reimbursement strategy in the form of a capitation discount to achieve immediate savings. In contrast, Oregon offers relatively generous capitation payments but expects control over utilization of services to reduce the rate of future cost increases. These differing strategies reflect each state's decision on how best to balance the need for savings against (1) the extent and maturity of the state's managed care infrastructure and (2) concerns about enrollee access, quality, and choice.

Demonstrations typically rely on a mix of different types of managed care delivery, though one is often predominant: HMO-style systems in Oregon, PPOs in Tennessee, and physician gatekeeper arrangements in Florida. Table 2.4 shows the actual enrollment of beneficiaries in Tennessee and Oregon, and Florida's projection of enrollment if the state implements its approved waiver. The high penetration of HMOs in Oregon, with enrollment of almost one-third of the state's population, facilitated the state's decision to rely on this type of managed care delivery system. In Tennessee and Florida, enrollment in HMOs is significantly lower—6 percent and 18 percent of each state's residents, respectively. HMOs and PPOs participating in the 1115 demonstration in all three states are reimbursed on a per capita basis, referred to as a capitation payment. Physician gatekeepers, on the other hand, are often paid on a fee-for-service basis, though some are partially capitated. What differentiates managed care from fee-for-service is not only the method of reimbursement but the attempt to control the utilization of services. Although gatekeepers in Florida would be paid for each service delivered, enrollees must get prior authorization to see a specialist. PPOs in Tennessee, on the other hand, have 3 years to employ physician gatekeepers to help control the length of inpatient hospital stays and the utilization of other services.[35]

[35]As of February 1995, about one-half of enrollees had been assigned to primary care physicians. While one Tennessee PPO, accounting for almost 50 percent of total enrollment, allows specialist visits without prior authorization, most others require preauthorization.

Table 2.4: Percentage Enrollment in Different Types of Managed Care Delivery Systems

	HMO-style	PPO	Physician gatekeeper	Partially capitated plans[a]
Tennessee	33%	67%	0%	0%
Oregon	91%	0%	4%	5%
Florida	33%	0%	67%	0%

Note: Enrollment data for Tennessee and Oregon are actual data as of May and August 1995, respectively. Florida, which has not yet implemented its waiver, provided enrollment projections in its waiver application.

[a]A plan that is capitated for a range of services that does not include inpatient hospitalization.

Tennessee's approach to managed care reflects the strategy used by large employers. The state asked for and received a substantial capitation discount from participating HMOs and PPOs.[36] Tennessee acknowledges that its shift from fee-for-service to capitation is unlikely to result in significant utilization savings at the outset, since most traditional and newly eligible recipients are enrolled in PPOs that lack gatekeepers rather than in more structured HMO-style managed care arrangements. Despite the belief that utilization savings will be lower during this initial phase-in period, substantial capitation discount savings still accrue to the state. Tennessee officials noted that PPOs in turn often obtain significant pricing discounts from their providers. Our recent report on the Tennessee demonstration notes that a primary concern about the future of the demonstration is the poor financial performance of participating managed care plans and the willingness of physicians to contract with those plans.[37] The demonstration's viability, we concluded, may hinge on the continued willingness of the health care community to participate in the program in spite of the low reimbursement levels. Although analysis of access to and quality of health care under the waiver has been limited because of problems in collecting data on enrollee visits to providers, beneficiary surveys and advocacy groups both indicate that access is a problem.

[36]According to the state's waiver application, a key element in establishing rates for managed care organizations in Tennessee is the assumption that per capita costs can be reduced from historic levels because more people will have health care coverage. The reduction recognizes that prior to the waiver, some of the cost of uncompensated care in the state's health care system was shifted to other payers. Skeptical that a reduction in uncompensated care would eliminate a cost shift that had become "institutionalized," the state discounted the initial capitation rate under the waiver by about 25 percent, which it characterized as an attempt to capture about one-half of uncompensated care charges statewide. The dollars "saved" through the discount help to finance expanded coverage.

[37]GAO/HEHS-95-186, Sept. 1, 1995.

In contrast to Tennessee's steep, up-front, capitation discounts, Oregon took a longer range approach that emphasizes access and quality. Concerned about the adverse impact of its already low Medicaid fee-for-service rates on the delivery of services, Oregon's initial capitation rates represent an increase over comparable fee-for-service rates prior to the 1115 demonstration. According to state officials, this increase contributed to the decision of a large number of HMOs to participate in the demonstration. As a result, about 91 percent of the recipients covered under Oregon's 1115 waiver are enrolled in some type of fully capitated HMO—over three times more than the state's original estimate.[38] Oregon assumes that more highly structured managed care will better control the utilization of services and that over time health care costs will rise at a slower rate than under the old fee-for-service reimbursement system.

Finally, there appears to be a wide spectrum of opinion among 1115 waiver states about the extent of savings from alternative managed care structures. Florida assumes that a physician gatekeeper arrangement, which preserves recipient choice, will produce the greatest managed care savings and anticipates that the majority of its Medicaid population will select this option. Only one-third of the state's Medicaid population is expected to enroll in fully capitated HMOs, the system that Oregon considers to be the most cost-effective form of managed care delivery. The gradual erosion of savings in Kentucky, which employs physician gatekeepers under a 1915(b) waiver, suggests that state enforcement and oversight of such managed care arrangements are critical. According to state officials, emergency room use has risen again after an initial decline. Kentucky's 1115 waiver application envisioned an eventual transition to more highly structured forms of managed care.

Newly Insured Asked to Contribute Toward Costs

Although the waiver proposals we reviewed rely primarily on redirected funds and expected program savings to finance coverage expansions, many state financing strategies incorporate new money raised by charging premiums to certain enrollees. Such premiums appear to make a modest contribution toward overall financing, ranging from a high of about 15 percent to as little as 1 percent of the core funding strategies we discussed. Moreover, at least one state's application recognized that not all premiums are likely to be collected.

[38]This estimate includes all new eligibles as well as both low-income families and the aged, blind, and disabled. The state's original estimate of enrollment in fully capitated health plans excluded the latter group since it was not initially scheduled to be part of the demonstration.

The 1115 waivers in Tennessee, Florida, and Hawaii require most recipients with incomes above the poverty level to pay premiums on a sliding scale. In addition, Florida expects a minimal premium contribution from individuals below the poverty level if they have any income. Expected premiums in Tennessee are about 8 percent of the combined total of redirected funds and the capitation discount. In Florida, premiums account for about 15 percent of the funds the state says it needs to provide insurance to a target group of about 1.1 million. Officials in Hawaii told us that premiums expected from newly eligible beneficiaries represent only about 1 percent of coverage expansion funding. Under the approved waiver agreements, a substantial portion of the premiums collected in Tennessee and Florida can be counted as state match, with no reduction in federal expenditures. In Hawaii, the state and federal governments share equally in the cost offset represented by individual premiums. Table 2.5 provides hypothetical examples of the different types of arrangements used to allocate premiums.

Table 2.5: Hypothetical Examples of Premium Allocation Agreements Under Approved Waivers

	Cost of coverage	Federal match rate	Federal share	State share	Enrollee's premium contribution
State A (no enrollee premium)	$100	50%	$50	$50	0
State B (only state benefits from premiums)	100	50%	50	40	$10
State C (premium revenue divided between federal and state governments)	100	50%	45	45	10

Two States Fold Subsidized Insurance Programs for Low-Income Residents Into Waivers

Hawaii and Minnesota are folding existing state subsidized insurance programs for low-income residents into their waiver programs and, in the process, bringing along the state dollars that financed them.[39] These program dollars now qualify for federal match.[40] While some individuals in these state-sponsored expansions were eligible for Medicaid under optional programs for pregnant women and children authorized in the late 1980s, others were not.

[39]While Tennessee had no means-tested, subsidized insurance programs, the state did fold its high-risk pool for otherwise uninsurable residents into its 1115 demonstration. Hawaii had no high-risk pool, and Minnesota and Florida elected to maintain separate programs for the uninsurables outside of their waivers.

[40]Minnesota officials told us that they planned to continue extending MinnesotaCare coverage of single adults and childless couples by using state funds freed up through the 1115 waiver's shift of children in MinnesotaCare into Medicaid.

Previously, states chose to expand coverage outside of Medicaid for a number of reasons. First, men, single adults, and childless couples were generally ineligible for Medicaid unless they were elderly or disabled. Second, such programs made it easier for states to provide coverage to entire families. Third, freed from Medicaid rules, states were able to offer more modest benefits and to require participants to pay premiums, co-payments, and deductibles. At least one state, Minnesota, cited another rationale for its self-funded program, MinnesotaCare. State consultants concluded that the lack of an employer mandate would result in the migration of children from private insurance to Medicaid. Eligibility rules in MinnesotaCare were designed to prevent such a migration. Thus, MinnesotaCare enrollees must have been uninsured for the 4 months immediately preceding enrollment and may not have had access to employer-subsidized health insurance for the previous 18 months. HCFA allowed Minnesota to maintain these barriers in its approved 1115 waiver.

Three of Four Demonstration Waivers Are Potentially Not Budget Neutral

Contrary to the administration's assertion that approved Medicaid 1115 waivers are budget neutral, net federal spending in the four states we examined could potentially exceed projected without-waiver program costs over the 5-year duration of the demonstrations. The net additional federal funding available in these four states is small in relation to allowable demonstration spending. However, overall federal Medicaid expenditures could grow significantly if the administration shows a similar flexibility in reviewing the large backlog of pending waivers.

Administration officials told us that, since some states' Medicaid expenditures were growing faster than the national average in the past, the budget neutrality of each proposed waiver should be evaluated independently in order to capture these variations. Such an approach is difficult because of the lack of consistently generated, state-specific forecasts. Lacking such data, we relied on the only available forecasts—national projections of how the current Medicaid program would grow over the 5-year duration of waiver programs.[41] At the same time, we reviewed waiver applications and talked with state officials to identify factors suggesting whether a state's Medicaid expenditures would indeed exceed the national norm. We found no evidence to support the high budget caps agreed to by the administration.

Spending Limits Inconsistent Under Four Approved Waivers

Medicaid 1115 waiver programs are popular because they allow the administration to grant states significant program flexibility. Since the 1980s, OMB has used its budget neutrality policy to ensure that states were not given access to additional federal funding at the same time they were provided with greater program flexibility. Rather than applying a uniform methodology to measure the budget neutrality of waiver applications approved since 1993, the administration has allowed considerable variation in growth of baseline costs from state to state.

According to the administration, each of the waiver programs is budget neutral, even though the individual growth rates vary significantly. The results of the administration's flexible, state-specific approach are shown in table 3.1, which summarizes the rates of increase allowed in the four agreements—Florida, Tennessee, Oregon, and Hawaii. Also included in the table are the administration's projected rates of growth for Medicaid on a nationwide, current services basis over roughly the same time period.

[41]Since we were evaluating the administration's budget neutrality assessments, we used OMB's national Medicaid projections rather than those produced by the Congressional Budget Office.

Table 3.1: Allowed Growth Rates Under Four Approved 1115 Waiver Agreements

Numbers in percent

	Year 1	Year 2	Year 3	Year 4	Year 5	Average
OMB FY94 projection[a]	**14.5**	**15.4**	**13.0**	**12.2**	**11.2**	**13.3**
Tennessee	16.4	8.3	7.5	5.7	5.1	8.5
Oregon[b]	11.2	36.9	20.6	6.3	11.5	16.8
Hawaii[b]	30.5	15.2	13.3	14.4	14.4	17.4
OMB FY95 projection[a]	**10.6**	**12.2**	**12.3**	**12.2**	**11.7**	**11.8**
Florida	16.3	15.6	15.4	14.8	14.2	15.3

[a]Each year the president's budget contains OMB's projection of expected growth in the Medicaid program on a nationwide, current services basis. States are grouped under the OMB projection for the fiscal year in which their waiver was approved.

[b]Oregon's and Hawaii's rates of growth depend on an estimated number of individuals enrolled as defined in the waiver agreements. Actual rates of growth will vary depending on program enrollment. See appendix I for a detailed explanation of our methodology for arriving at these figures.

Table 3.1 shows that in three out of four states, the waiver agreements permit growth above what OMB projected for the Medicaid program as a whole at the time the waivers were approved. The growth patterns among states also vary. The growth rates of Tennessee, Florida, and Hawaii are the highest in the first year of their waiver. While Florida's growth rate declines gradually in each subsequent year, both Tennessee's and Hawaii's drop dramatically in the second year and then decline more slowly in the remaining years of their demonstrations. In Oregon, however, the highest rate of growth is in the second and third years, with dramatically lower increases in the last two.[42]

Given the unique state setting of each Medicaid program, some variation in the rate of Medicaid growth among states is to be expected. However, even though OMB was predicting overall lower growth in Medicaid, state waiver applications did not identify future trends to justify their higher-than-average growth rates over the course of the demonstrations. Instead, states used a variety of arguments primarily based on history and options available under current statute to convince the administration that their particular situation warranted a high rate of growth.

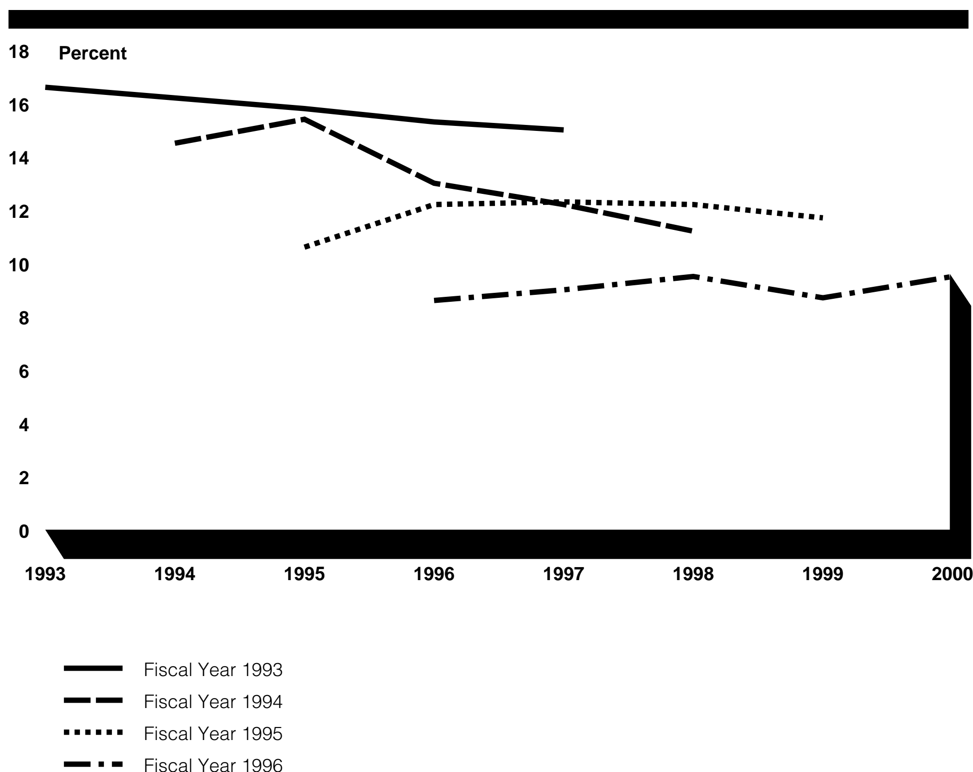
[42]Oregon's estimates of expenditure growth assume high enrollment in the early years, as individuals who were previously ineligible for coverage move into the program. The estimates also assume that during the last 2 years the state will implement its employer mandate, resulting in a decrease in the number of individuals enrolled in the program and lower costs. In addition, by the fourth year of the waiver, managed care is expected to restrain medical costs.

HCFA and state officials admit that, in some states, continued Medicaid growth at historical rates is unsustainable because of the great strain it places on state budgets. Moreover, several of the primary contributors to the growth of state Medicaid budgets over the past 5 years are no longer present. For example, some states' use of targeted provider taxes and donations contributed to the rapid rise in DSH funding between 1989 and 1993, but recent legislation strictly limits—and in some cases caps—such growth. It also appears unlikely that states will be asked to absorb major new federally mandated expansions of populations and benefits—a practice that contributed to high growth rates in the past.[43]

As shown in figure 3.1, the assumption that higher historical rates of Medicaid growth will continue runs contrary to the administration's own projections of nationwide Medicaid growth on a current services basis. Each successive projection since 1993 shows a decline in the rate of growth in Medicaid. In addition to pointing to the history of recent rapid growth in Medicaid expenditures, states used the so-called "hypotheticals" argument to justify higher baselines. They argued that groups who were hypothetically eligible for Medicaid coverage under existing law, but had not been included in a state's Medicaid plan, should be considered part of the state's baseline population for the purpose of determining budget neutrality. Including hypotheticals raises baseline costs, making budget neutrality easier to achieve.

[43]No major federal mandates have been added since 1991.

Figure 3.1: OMB Projections of Medicaid Current Services Outlays



The Hawaii, Kentucky, Minnesota, Rhode Island, and Ohio waiver agreements allow hypothetical populations to be included in the baselines. To date, the inclusion of hypotheticals has been limited to those individuals who would actually be covered by the demonstration and who are optionally eligible for Medicaid under section 1902(r)(2) of the Social Security Act.[44] Hawaii and Minnesota have covered some of this population outside the Medicaid program in the past through state-only funded programs.[45] A Hawaii Medicaid official estimated that including the 1902(r)(2) population added approximately $56 million to the state's waiver baseline over the 5-year life of the program—about 4 percent of total waiver agreement funding. In Kentucky, Rhode Island, and Ohio, however, hypotheticals were not covered by any state-funded program.

[44]Under section 1902(r)(2) of the Social Security Act states were essentially given the option to expand coverage of women, children, the elderly, and the disabled by employing less restrictive eligibility methodologies.

[45]Some individuals eligible for Medicaid under section 1902(r)(2) have been covered under Hawaii's General Assistance or State Health Insurance Program and under MinnesotaCare in Minnesota.

In each waiver we reviewed that included hypotheticals in the baseline, state officials mentioned cost containment as a primary consideration in seeking 1115 demonstration authority. It is questionable, therefore, that these states would have added optional eligibility groups to their Medicaid programs without the waiver.

Nationwide Medicaid Expenditure Forecasts Used to Assess Budget Neutrality

The complexity of and variation in individual state programs makes it difficult to assess budget neutrality without a consistent frame of reference.[46] Lacking state-specific Medicaid expenditure forecasts, we used OMB's current services projections of growth in Medicaid for the nation as a whole. A current services projection is policy neutral and only reflects medical inflation, normal growth in the eligible population, and changes in utilization for the entire Medicaid program.

To determine if the four approved waivers were budget neutral, we first estimated the cost of continuing the traditional Medicaid program—absent the demonstration—in each state. This estimate—referred to as "without-waiver spending"—was developed by adjusting for inflation in the following manner: We adjusted the cost of providing Medicaid in the year prior to waiver implementation at the rate specified by OMB in its forecast of future Medicaid current services outlays. We compared this without-waiver spending estimate to total projected costs under the waiver expenditure caps negotiated by each state and the administration. The difference between our without-waiver projection and the waiver expenditure cap in each state is the basis for our conclusion of whether an agreement is budget neutral. When the difference was positive, we examined state-specific information to determine if there was any identifiable reason why the waiver expenditure cap should exceed our without-waiver spending projection and still be regarded as budget neutral.

We applied this methodology to the two types of waiver spending caps agreed to by the administration, aggregate and per capita expenditure limits. For states that use the aggregate cap—Tennessee and Florida—the

[46]Reliable HCFA Medicaid expenditure data that are sufficiently flexible to analyze waiver programs are limited. For example, one HCFA report contains auditable expenditure data by service category; however, expenditures on these services cannot be related to eligible individuals. On the other hand, a different report on expenditures by eligibility category omits items such as DSH and capitation payments. Moreover, these data are unreliable because components may not sum to report totals or may rely on estimated amounts. Finally, auditable expenditure reports do not allow for the separation of acute care services for recipients covered by the waiver programs from those who are not part of the demonstration. In a number of states, waivers exclude participation by aged, blind, and disabled beneficiaries. Since 1115 waivers often segment the Medicaid population and services in ways or time periods not reflected in HCFA reports, budget neutrality analysis often relies on other state databases.

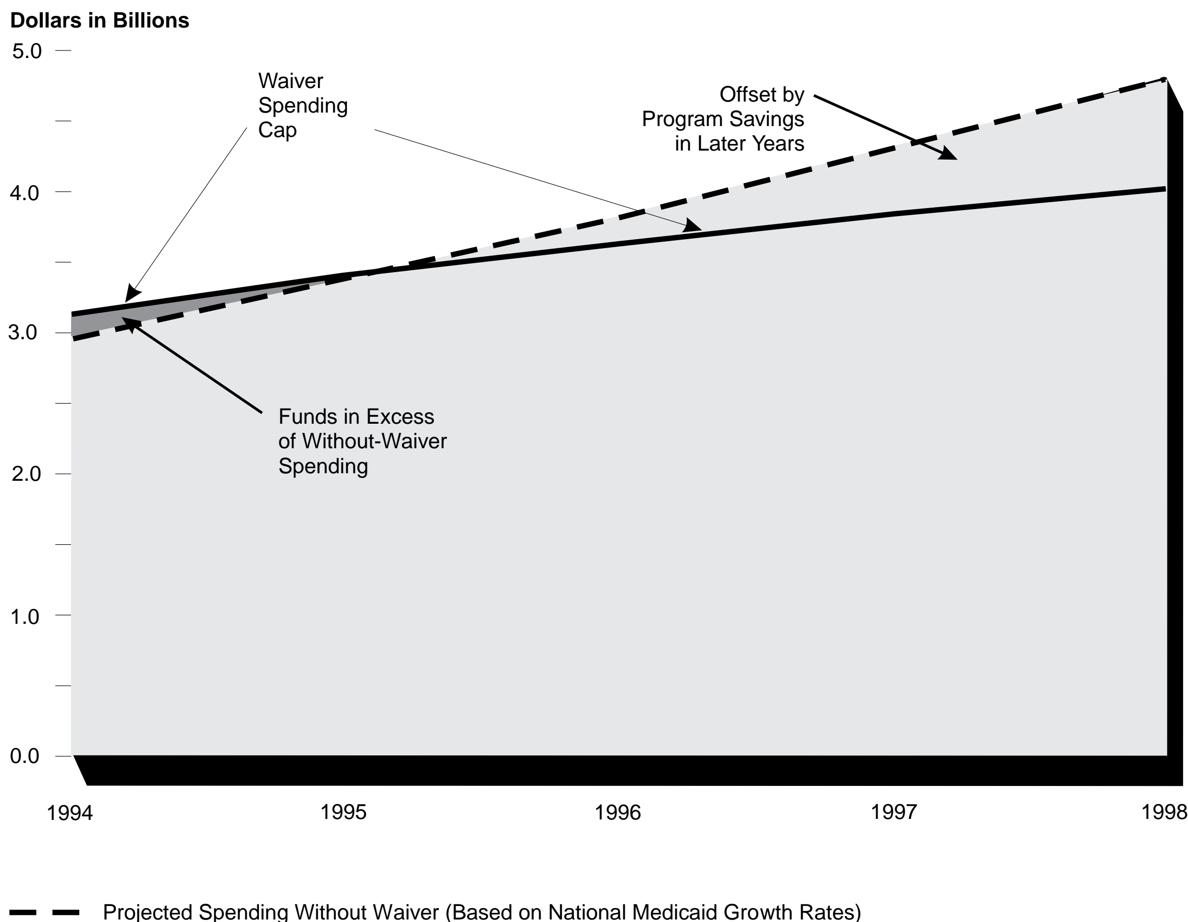
waiver funding limits are specified in the terms and conditions approving the demonstration. For states with per capita limits—Hawaii and Oregon—the spending cap depends on the actual number of enrollees in the waiver program. To assess the potential budget neutrality of these per capita agreements, we used enrollment projections developed by each state and submitted to HCFA in conjunction with approval of the waiver. If actual enrollment proves to be higher than these initial projections, then the waiver agreement funding limit will generally be higher and the state will have access to more funds than we projected. Conversely, if enrollment falls below these projections, fewer additional resources would be available.[47]

Tennessee

For the Tennessee demonstration, the administration specified an aggregate federal funding cap, with any spending above that cap ineligible for federal match. The relatively low rates of growth under this spending limit mimic the growth caps used in the President's 1993 health care reform proposal. The waiver agreement expenditure cap covers all aspects of Tennessee's Medicaid program, whether or not the associated populations are being moved into managed care. Figure 3.2 shows a comparison of Tennessee's waiver agreement spending cap and our without-waiver projection of spending. Our without-waiver estimate was derived by increasing actual expenditures in the year prior to implementation of the demonstration at the national current services growth rate projected by OMB. When compared with our without-waiver spending projection, Tennessee's waiver expenditure cap is budget neutral. Savings in subsequent years make up for initial demonstration costs that exceed projected without-waiver spending.

[47]In both Oregon and Hawaii, actual enrollment for the first year of the waiver was higher than estimated.

Figure 3.2: Tennessee: Comparison of Waiver Agreement Spending Cap and Projected Spending Without Waiver



While the Tennessee waiver agreement is budget neutral using the current services methodology, the administration's treatment of DSH funds raises another issue. After the first year of the waiver, DSH funding disappears as a budget item since it is built into the baseline that increases at the agreed-to rates of growth on overall Medicaid spending.[48] However, DSH

[48]According to HCFA, Tennessee's DSH payments were not allowed to grow in the first year of the waiver program—state fiscal year (SFY) 1994. Holding DSH payments constant results in an overall Medicaid funding increase of 19.6 percent for the remaining elements of the state's Medicaid program in SFY 1994. On the other hand, simply comparing SFY 1993 Medicaid expenditures, including DSH, with the level permitted under the waiver agreement in SFY 1994 results in an overall increase of 16.4 percent.

funding in Tennessee and a number of other states is capped by law because it is more than 12 percent of the state's total Medicaid expenditures. In such states, DSH funding is only permitted to grow when it falls below this 12-percent cap.

Under the waiver agreement, Tennessee's DSH funding is allowed to grow after the first year of the waiver, even though it exceeds the 12-percent limit.[49] Consequently, Tennessee is eligible for approximately $250 million in DSH growth that would not have been allowed without the waiver. Without this additional DSH funding, net savings to the state and the federal government under the Tennessee waiver agreement would have been higher.

Since the Tennessee agreement, the administration has separated DSH funding from other aspects of waiver program funding. This approach allows the cap on DSH growth to be enforced. Moreover, HCFA officials told us that if DSH funding is growing at a slower rate than the other program elements covered by the waiver, then that lower growth rate is applied to any DSH growth.

Florida

As in Tennessee, the Florida waiver agreement has an aggregate cap on demonstration expenditures.[50] The cap only applies to the acute care and DSH portions of the state's Medicaid program. Florida relied heavily on an historical argument to justify its higher-than-average rates of growth under the waiver, even though some state officials later told us that it was unlikely that such growth could be sustained.[51] Figure 3.3 compares

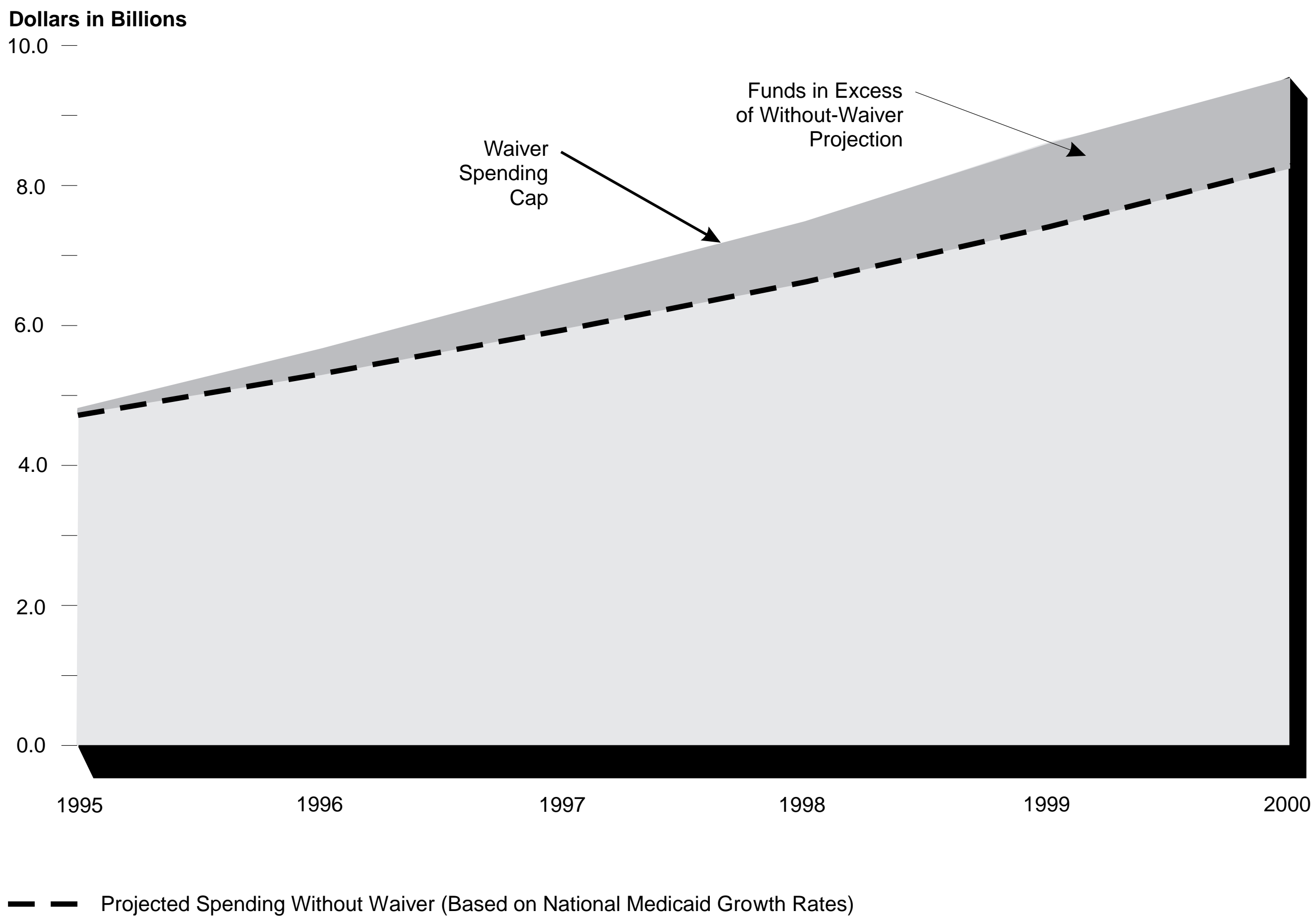
[49]In contrast, our assessment of the budget neutrality of Tennessee's waiver agreement held DSH payments constant until they would have constituted less than 12 percent of total Medicaid expenditures. Thus, our approach is consistent with statutory DSH limits.

[50]The waiver agreement includes a circuit-breaker provision that allows Florida to eclipse the waiver agreement cost cap in the event that the state's traditional Medicaid population exceeds projections by 3 percent or more.

[51]A Florida official told us that the state's 1115 waiver was presented to the legislature at about the same time the application was submitted to HCFA. This official was skeptical that the legislature would sustain the past rates of growth in Medicaid in order to finance coverage expansion under the waiver. A more likely scenario, he said, is that the legislature would choose to let Medicaid grow at a slower rate than in the past. The Florida legislature adjourned in both 1994 and 1995 without agreeing to implement the waiver program. During the 1995 session, the Governor's waiver bill was never reported out of subcommittee. In its place, the legislature considered alternatives that differed considerably from the waiver approved by the administration in September 1994. No consensus emerged, and the governor planned to call a special legislative session during the summer of 1995. According to a Florida official, the state budget approved by the legislature already moves money from social services programs to prison construction—including managed care savings accrued under the state's more limited 1915(b) and voluntary HMO programs. Managed care savings are an important source of funding for expanded coverage.

estimated waiver agreement spending and spending without the waiver. Our without-waiver estimate was derived by increasing actual expenditures in the year prior to implementation of the demonstration at the national current services growth rate projected by OMB. The comparison shows that the waiver spending cap exceeds our without-waiver estimate, with the difference equaling $4.5 billion in state and federal funding.

Figure 3.3: Florida: Comparison of Estimated Waiver Agreement Spending Cap and Projected Spending Without Waiver



We also analyzed the extent to which Florida's coverage expansion goals depend on this $4.5 billion in excess funding. Our analysis shows that Florida's enrollment plans would have to be scaled back without the excess funds provided under the waiver agreement. If the funding limits for Florida's waiver agreement had been based on national projections of growth in the Medicaid program, both DSH and the state's Medically Needy Program would have grown at slower rates. As a result, almost $1 billion less than the amount needed to meet the state's expansion goals would have been available. As shown in table 3.2, the $4.5 billion in excess funding potentially available under the waiver more than covers that shortfall. We believe that the difference between the excess funds available and the shortfall—about $3.5 billion—provides a backup if state assumptions about managed care savings or other funding sources prove faulty.

Table 3.2: Comparison of Florida's Expansion Cost Estimates and Budget Neutral Growth in Without-Waiver Program

Dollars in billions

Budget projection	Amount
Expansion costs	$5.864
Funds available to expand coverage assuming budget neutral growth in DSH and Medically Needy Program	4.869
Shortfall	.995
Funds in excess of our without-waiver spending projection	4.527[a]
Backup: difference between excess funds and shortfall	3.532

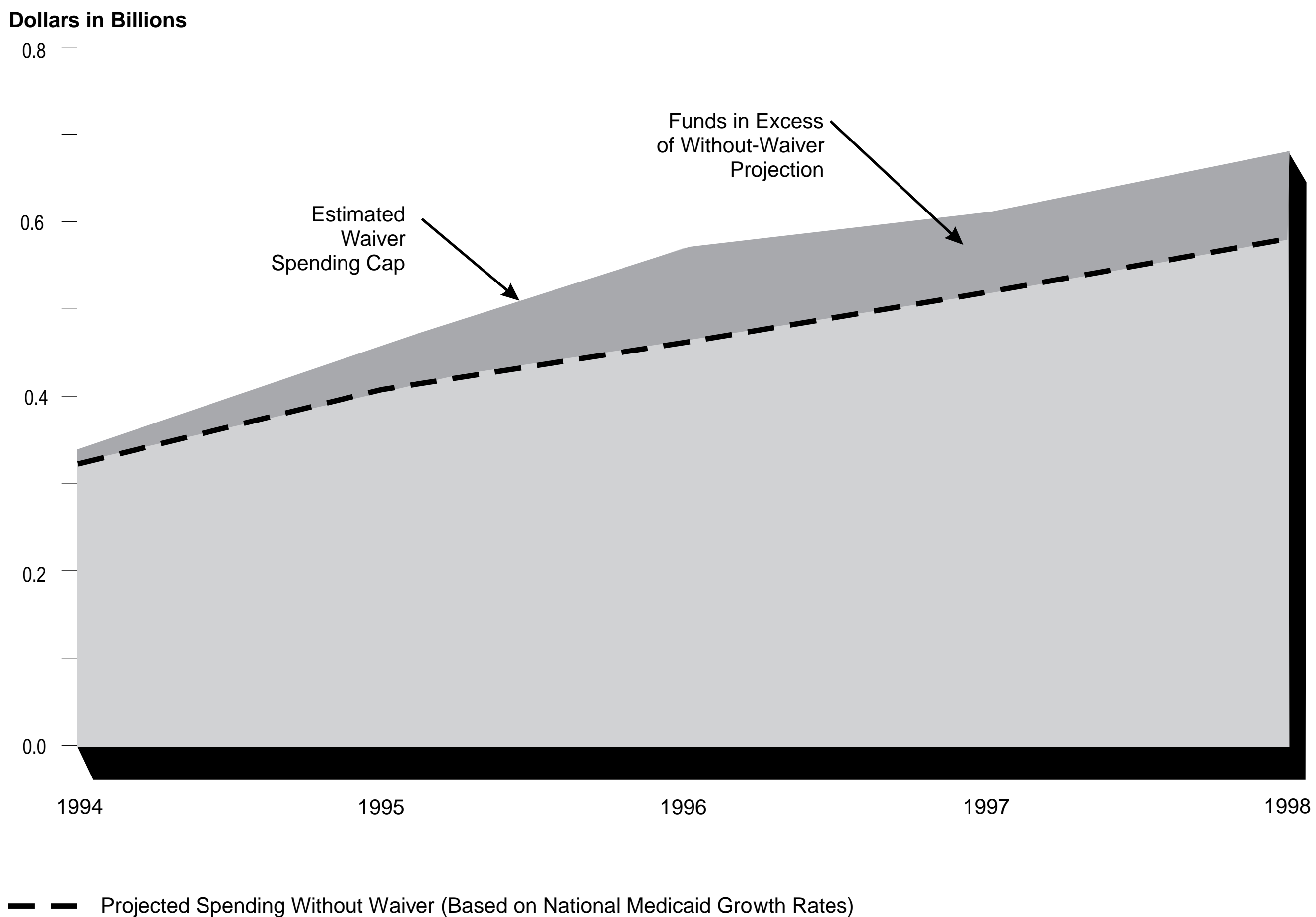
[a]The federal share is about $2.5 billion (55 percent), and the remainder consists of state matching funds.

Oregon

It is more difficult to apply our methodology to states with per capita waiver agreements, like Oregon. As implied by the term "per capita," estimating both the waiver agreement spending cap and without-waiver expenditures requires assumptions about enrollment. Moreover, in Oregon, the mix of benefits changed in the transition from traditional fee-for-service Medicaid to the demonstration, making it more difficult to arrive at a base-year cost. In addressing these methodological challenges, we used the projected enrollment in the waiver agreement to estimate spending, and we derived a base-year cost from state reports. We discussed our methodology with Oregon officials, who agreed that it was appropriate. Figure 3.4 compares estimated waiver agreement spending and spending without the waiver. Our without-waiver projection was derived by increasing base-year estimated expenditures at the national

current services growth rate projected by OMB. The comparison shows that the Oregon waiver spending ceiling exceeds our without-waiver projection.

Figure 3.4: Oregon: Comparison of Estimated Waiver Agreement Spending Cap and Projected Spending Without Waiver

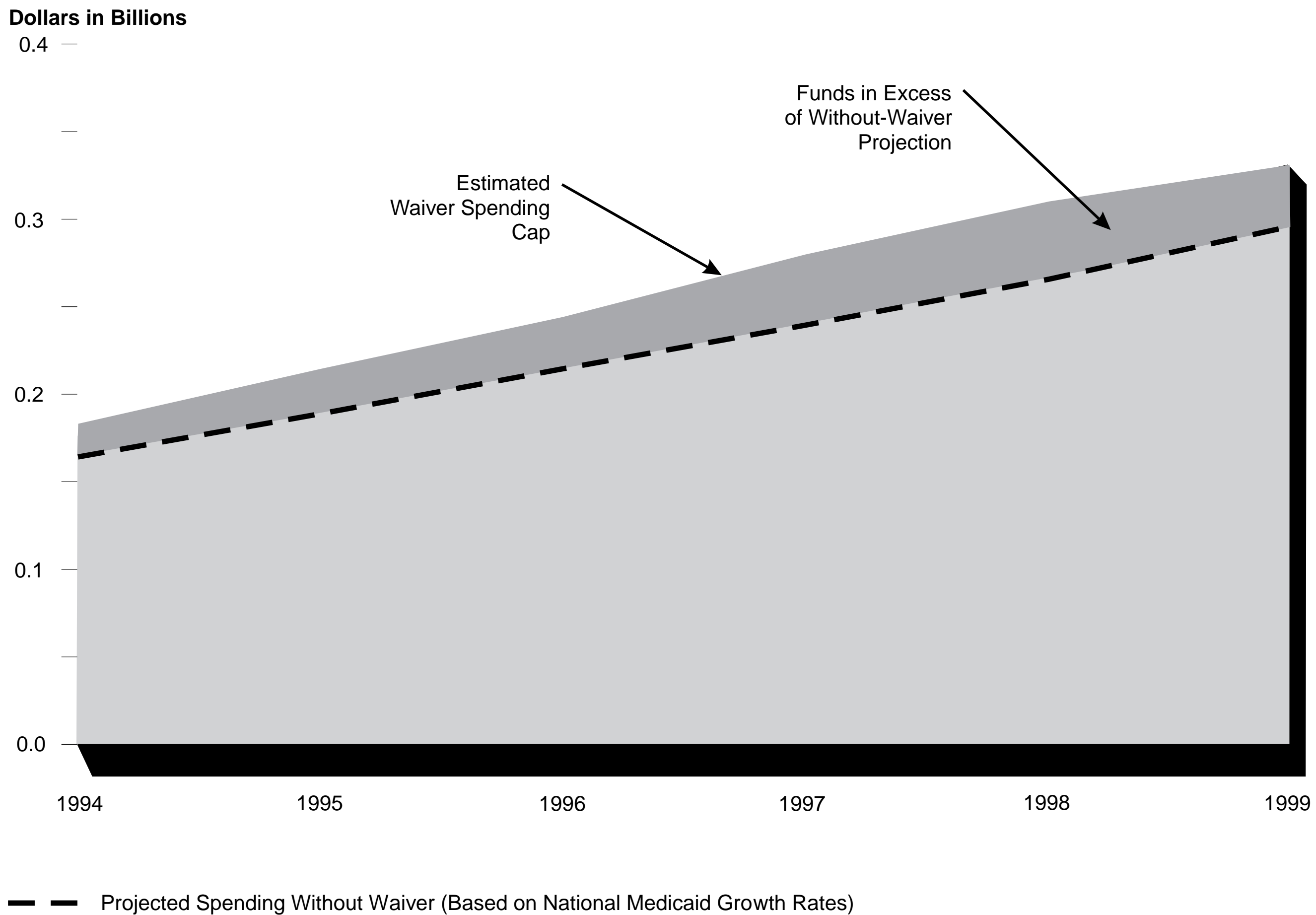


Hawaii

The Hawaii waiver expenditure cap is also based on per capita costs. As with the Oregon spending limit, all the pieces needed to calculate the projected waiver costs were not included in the waiver agreement documents. HCFA and Hawaii have agreed to use 1993 as the base year to calculate budget neutrality, but have not yet agreed on per capita costs for the various eligible populations. Our analysis was further complicated by

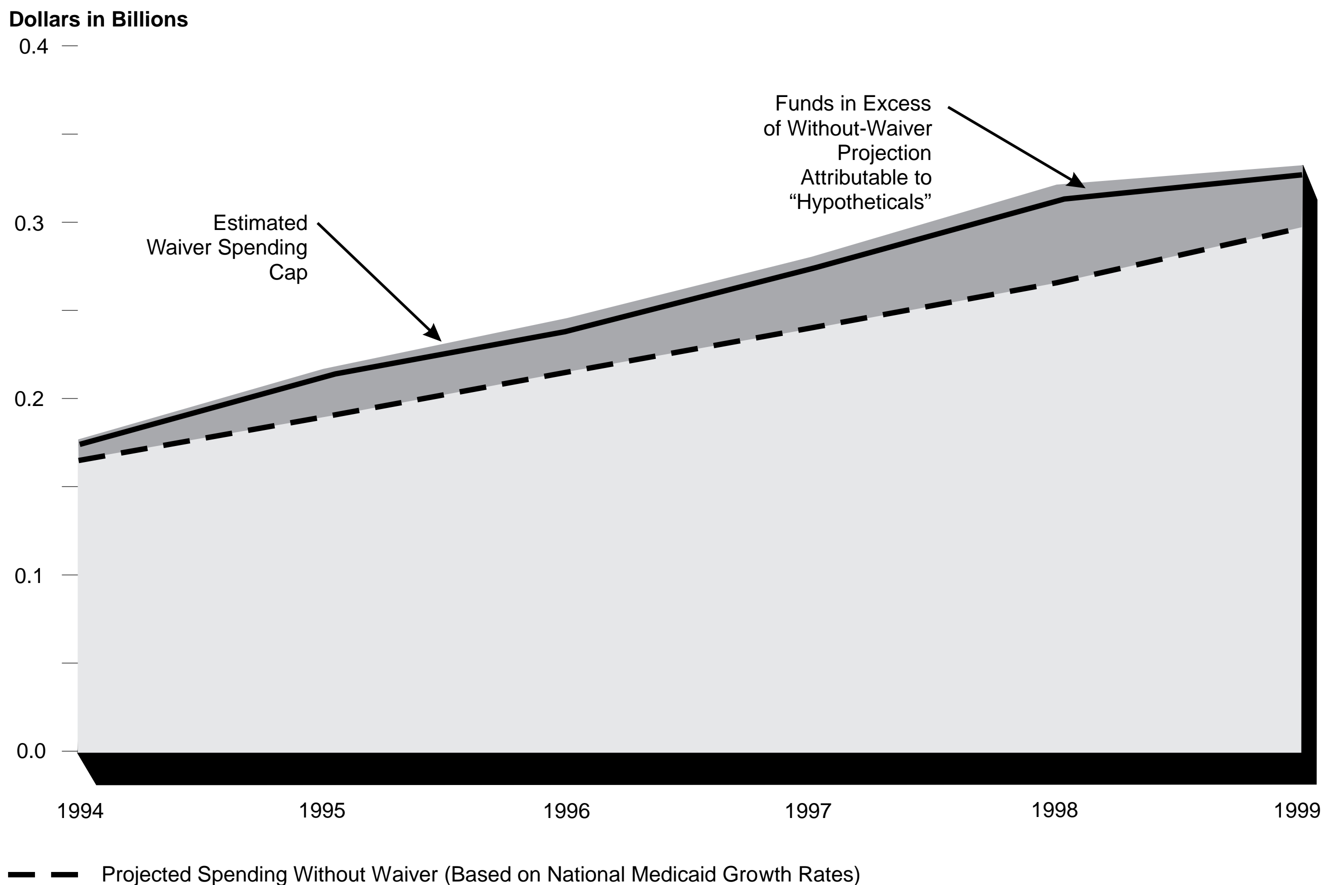
the fact that Hawaii has not yet completed its final enrollment count for the base year. To make our calculation of program costs, we used a preliminary state average per capita cost and an estimate of the base-year enrollment from waiver documents. According to state officials, these were the best figures available. Figure 3.5 compares estimated waiver agreement spending and spending without the waiver. Our without-waiver projection was derived by increasing base-year estimated expenditures at the national current services growth rate forecast by OMB. The comparison shows that the waiver expenditure cap exceeds our without-waiver spending projection.

Figure 3.5: Hawaii: Comparison of Estimated Waiver Agreement Spending Cap and Projected Spending Without Waiver



Of the four waiver agreements we analyzed, only Hawaii's included a hypothetical population in its baseline. As illustrated by figure 3.6, our analysis shows that the inclusion of this hypothetical population—made up of children that had previously been covered by state-only funded programs and who were eligible for Medicaid under section 1902(r)(2)—did not significantly affect the cost of implementing the waiver over its 5-year life.[52]

Figure 3.6: Impact of Including "Hypothetical" Populations in Hawaii's Program Baseline



[52]Kentucky also included the optional 1902(r)(2) population in its waiver agreement baseline. Because this population is so much larger in Kentucky than it is in Hawaii, it would have had a significant impact on the cost of Kentucky's demonstration program. Kentucky's legislature refused to permit implementation of the state's approved waiver.

State Variation Does Not Justify Waiver Agreement Expenditure Caps

In responding to our work on budget neutrality, the administration said that the characteristics of individual states—primarily historical trends—justified waiver growth limits higher than projected national average program growth. However, none of the four waiver applications we analyzed in detail offered a rationale for the expected higher-than-average rates of growth in expenditures, enrollment, or medical inflation. OMB officials also told us that the four state Medicaid programs we analyzed in detail had been growing faster than the national average. Table 3.3 compares the national average with growth in Medicaid spending from 1988 to 1993 for Florida, Tennessee, Oregon, and Hawaii.

Table 3.3: Recent Medicaid Spending Trends in Four Waiver States

Numbers in percent

	1988-1993 trend
Florida	25.8
Tennessee	20.9
Oregon	20.4
Hawaii	17.5
National average	**19.4**

Note: Trends and growth in expenditures exclude growth in DSH.

This analysis shows that, with the exception of Florida, these states were not growing significantly faster than the national average. In fact, the trend in Medicaid expenditures in Hawaii suggests that it might be appropriate for its waiver program to grow more slowly than the national average.

Federal mandates have contributed significantly to variations in state Medicaid growth rates over the last 8 years. According to a 1994 Urban Institute study, states with historically more restrictive Medicaid programs grew very rapidly during the period 1988 to 1992, with much of the growth attributable to newly eligible adults and children coming into the program under federal mandates.[53]

Such new mandates were at least partially responsible for escalating costs in Florida, a state whose Medicaid growth rate from 1988 to 1993 was significantly higher than the national average. Thus, previously ineligible adults, children, elderly, and disabled individuals accounted for more than 30 percent of the increase in Medicaid spending between 1989 and 1990. According to state officials, the establishment of an optional Medically

[53]Theresa Coughlin and others, "States' Responses to the Medicaid Spending Crisis: 1988 to 1992," Journal of Health Politics, Policy, and Law, Vol. 19, No. 4 (Winter 1994).

Needy Program—which totaled $98 million by 1993—also contributed to state expenditure growth. More significantly, it had the unintended consequence of helping to greatly expand enrollment of low-income families. Florida officials explained that an outreach program designed to increase participation in the Medically Needy Program uncovered many low-income families eligible for Medicaid. Enrollment of low-income families rose nearly 24 percent per year from 1990 to 1993, with associated expenditures more than doubling from just under $500 million to nearly $1.2 billion. Finally, state officials told us that the recession in 1991 also contributed to growth in the number of low-income families enrolled in Medicaid.

Although these factors contributed to the sharp rise in Florida's Medicaid expenditures in the early 1990s and resulted in waiver growth rates significantly higher than the national average, even Florida officials do not expect a continuation of past trends. Actual experience appears to support their predictions. For example, while the waiver agreement estimated that acute care expenditures would grow at 17 percent in 1994, the base year, actual spending increased by only 12 percent without implementation of the waiver. Moreover, Florida officials told us that enrollment growth among low-income families has leveled off at around 4 or 5 percent over the past 18 months. The Florida waiver agreement estimates that low-income family enrollment growth will fluctuate between 2 and 3 percent over the life of the waiver.

Three Waivers Provide Access to Significant Additional Funding

While the administration contends that each of the waiver agreements we reviewed is budget neutral, our analysis of both national and state-specific data shows that most of the agreed-upon rates of growth are too high. As a result, the agreements provide these states with access to significant additional federal Medicaid funding.[54] Table 3.4 compares the waiver agreement spending caps and our without-waiver expenditure projections (based on national Medicaid growth rates), aggregated over the 5-year duration of the programs. The $1.9 billion in net additional federal funds should not be interpreted as a precise prediction of the amount of additional funds available under these four waivers; rather, it reflects the significant magnitude of the differences between the two projections.

[54]States are not obligated to spend up to the limits placed on them by the agreements. Moreover, the federal government will only provide funds to match actual state expenditures.

Table 3.4: Comparison of Four Section 1115 Waiver Agreement Expenditure Caps and Projected Without-Waiver Spending

Dollars in billions

	Estimated waiver agreement spending	Projected without-waiver spending	Additional funds	Federal share
Tennessee	$20.9	$22.2	($1.3)	($0.9)
Florida	37.2	32.7	4.5	2.5
Oregon	2.7	2.3	0.4	0.2
Hawaii	1.3	1.1	0.2	0.1
Net additional funds			**$3.8**	**$1.9**

Despite Lower Inflation, State Demonstrations Face Cost Pressures

We analyzed preliminary financial results from 1115 demonstrations in Tennessee, Oregon, and Hawaii—three states with significant waiver implementation experience. The data suggest that waivers will continue to evolve as states attempt to balance coverage expansion goals against systemic cost-containment pressures. Changing political/fiscal realities in all three states and the potential for an acceleration in the rate of medical inflation underscore the challenges in implementing fixed-cost agreements in a variable-cost environment.

Enrollment of previously uninsured individuals in both Oregon and Hawaii surpassed state estimates. Oregon was able to meet greater than expected demand without exceeding its waiver agreement expenditure cap. Hawaii, however, projects demonstration spending will be about 23 percent higher than permitted by its waiver agreement—costs it will have to offset in future years if it is to live within the expenditure cap. After maintaining open enrollment for a full year and achieving about 80 percent of its coverage expansion goal, Tennessee abruptly cut off enrollment because of a budget crisis it attributes to the demonstration. In contrast to Hawaii, Tennessee's first-year demonstration costs were 14 percent below its waiver agreement spending cap. While Tennessee's waiver program covered several hundred thousand previously uninsured individuals, total expenditures were on a par with its significantly smaller prewaiver program.

Despite the slowdown in medical inflation, all three states face pressures to contain future waiver costs. Oregon and Hawaii have announced a number of initiatives to do so, including higher cost sharing and new eligibility rules. Since resources up to a state's waiver funding cap are available until the end of the demonstration, expenditures to date may not be a reliable indication of demonstration costs—particularly if medical inflation accelerates.

Oregon: First-Year Enrollment and Cost Experience

Greater than anticipated managed care savings allowed Oregon to offer insurance to about 50 percent more new enrollees than anticipated during 1994—without breaching the waiver funding agreement.[55] Though the exact amount of the cap is in dispute, HCFA data show that waiver

[55] Oregon's first year of waiver implementation—February to December 1994—only covers 11 months.

expenditures of $347 million were about $34 million less than the administration's estimate of the waiver agreement ceiling.[56]

As shown in table 4.1, actual 1994 expenditures were remarkably close to the 1993 cost estimates that formed the basis of the federal-state financing agreement—within about $600,000. However, as this table also demonstrates, traditional Medicaid beneficiaries were less expensive than the state estimated. Table 4.2 provides our analysis of costs for traditional Medicaid beneficiaries and those newly eligible under the waiver on a per-person-per-month (PPPM) basis.[57] On average, traditional eligibles cost 25 percent less than anticipated. Those newly eligible, however, cost 36 percent more. Oregon officials attribute the higher costs of new eligibles, in part, to the fact that many are sick when they apply for coverage. Thus, hospitals are signing up individuals for health benefits under the waiver as soon as they are admitted. Currently, eligibility for benefits commences with the submission date rather than with the subsequent approval of the application. Until the newly eligible individual is enrolled in a managed care plan, providers are reimbursed on a fee-for-service basis, further increasing state costs.

Higher costs for newly eligible individuals, however, were offset by additional managed care savings of $38 PPPM for each traditional Medicaid recipient. In part, state officials credit increased savings to the fact that all but 8 of 36 counties are served by fully capitated, HMO-style health plans. As a result, about 91 percent of waiver enrollees, rather than the estimated 28 percent, are receiving services from what the state believes is the most cost-effective form of managed care.[58] We also believe that the current ebb in medical inflation contributed to lower than expected costs.

[56]The waiver agreement specifies the maximum allowable costs for each of three categories of both traditional and newly eligible enrollees. It does not specify a methodology if, as was the case, enrollment differs from projections, that is, when there are fewer beneficiaries in a more expensive category or more in a less costly classification.

[57]The aged, blind, and disabled were not part of the demonstration until February 1995. Thus, enrollment/cost statistics for traditional Medicaid recipients only reflect low-income families.

[58]This estimate includes the aged, blind, and disabled. Excluding this group, the percentage of total enrollees in fully capitated health plans is slightly higher—92 percent. Compared with new eligibles and low-income Medicaid families (3 percent), a higher percentage of the aged, blind, and disabled (10 percent) are enrolling in the physician gatekeeper option and thus lowering the percentage participating in fully capitated plans.

Table 4.1: Comparison of 1994 Actual and Estimated Costs and Enrollment Under Oregon's 1115 Waiver

Dollars in millions and enrollment in thousands

	Costs			Enrollment		
	Actual	Estimated	Difference	Actual	Estimated	Difference
Traditional Medicaid	$224.6	$286.8	($62.2)	181.9	173.5	8.4
New eligibles	122.3	60.7	61.6	69.7	46.8	22.9
Total	**$346.9**	**$347.5**	**($.6)**	**251.6**	**220.3**	**31.3**

Table 4.2 Comparison of Estimated Versus Actual PPPM Costs for Traditional and Newly Eligible Beneficiaries Under Oregon's 1115 Waiver

	Actual costs	Estimated costs
Traditional Medicaid	$112	$150
New eligibles	$160	$118

Some Cost Concerns Spring From Details of Waiver Agreement

Despite greater-than-expected managed care savings in Oregon, state officials are concerned about the financial implications of current cost/enrollment trends. The concern stems from the fact that the traditional Medicaid population determines the funding base for covering new eligibles. Under the per capita cost agreement, federal matching funds for new eligibles are tied to a fixed ratio of new to current eligibles. Thus, for every four current eligibles, Oregon can claim a federal match for one new eligible in the first year of the waiver.

In the first year, unexpected enrollment by new eligibles and higher-than-anticipated costs for this group was accompanied by a drop in the number of low-income families—the major component of the coverage expansion funding base.[59] Should these trends continue, fewer federal dollars than needed would be available to meet future waiver costs. In mid-1995, Oregon officials asked HCFA for approval to implement a number of cost-reduction initiatives. As of October 1995, Oregon had received approval to change waiver eligibility rules[60] and delay full implementation of mental health services. HCFA has yet to approve the state's request to

[59]Oregon officials attributed the large number of new eligibles to higher-than-anticipated participation rates rather than to an increase in the number of uninsured state residents. The waiver intentionally simplified eligibility and enrollment in order to encourage participation. The cost controls now under consideration (asset tests and co-payments) are intended to reduce participation rates.

[60]Oregon's proposed changes apply only to those newly eligible under the waiver. Eligibility would be based on 3 months' rather than 1 month's income, with liquid assets limited to $5,000. In addition, full-time college students would no longer be able to enroll.

reduce benefits[61] and require premiums/some co-payments for newly eligible individuals. In addition, state officials told us that greater-than-anticipated managed care efficiencies may allow them to reduce the capitation rate.

Other State Fiscal Concerns

Other, more general, fiscal concerns in Oregon stem from the impact of a 1991 tax initiative, new state priorities that reflect the outcome of the 1994 elections, and uncertainty about the fate of the employer mandate. Under the tax initiative, any shortfall in education funding that results from a mandated reduction in the property tax rate must be offset by general revenues. Funding for the 1115 waiver also comes from general revenues—rather than from a dedicated tax paid by a specific group. Similarly, a number of new priorities, such as prison construction, may further increase the competition for state funds.

The employer mandate plays an important role in Oregon's waiver finance plan. Oregon estimates that the mandate, originally scheduled to be phased in during the last 2 years of the waiver, would reduce both the number of traditional Medicaid beneficiaries and newly eligible individuals covered under the waiver. In addition, program costs will be reduced for low-wage workers who obtain employer-provided coverage but have incomes below the poverty level. For these individuals, Medicaid will only pay for costs not covered by the employer-provided insurance.

Growing business opposition to the mandate coupled with a political realignment in the state legislature creates considerable uncertainty about the future of this funding source. In 1993, the legislature postponed implementation of the mandate, potentially increasing state costs in the process. Although state legislation requires that the mandate be repealed unless the Congress grants Oregon an exemption to ERISA by January 1996, the legislature recently sent the Governor a bill that would have repealed the mandate outright. He vetoed the bill in July 1995. According to state officials, the administration has indicated that no adjustments will be made to the waiver financing agreement if the employer mandate is not implemented. And without the mandate, waiver costs will increase, forcing the state to make up the difference or to develop additional

[61]The funding line for covered services would be moved from line 606 to line 581 of the prioritized list of benefits. Examples of services that would no longer be covered include (1) certain urinary tract and yeast infections, such as thrush in infants; (2) painful menstruation and pelvic discomfort; (3) chronic bronchitis; and (4) surgical correction of deformities and injuries of the limbs or feet that may result in greater mobility or function. The state attributes the low priority attached to these services to the availability of over-the-counter medicine, to the fact that individuals get better on their own without medical intervention, or to uncertainty over the benefits of medical treatment.

cost-containment strategies. In 1994, Oregon estimated that the employer mandate accounted for about 16 percent of the funds necessary to finance coverage expansion under the waiver.

Hawaii: First-Year Enrollment and Cost Experience

Hawaii believed that state-funded programs subsumed under the waiver had already identified most of those newly eligible—the so-called gap group that included those who were not eligible for Medicaid and those who were either dependents or part-time workers not covered by the state's limited employer mandate.[62] During the first year of operation, however, Hawaii enrolled about 36,000 newly eligible individuals who had not participated in the former state-funded programs. According to state officials, a significant number of these new recipients are hypothetically eligible at state option under section 1902(r)(2) —pregnant women or children—who had not enrolled in the previous state-funded program but instead were covered by private insurance; the state believes these individuals dropped private insurance in favor of less expensive coverage through the waiver. These officials also attributed the unexpected high enrollment to Hawaii's current economic slowdown. Table 4.3 compares estimated and actual enrollment under the waiver for both traditional and new eligibles. Hawaii officials project that as a result of this higher-than-expected enrollment, the waiver will exceed the federal budget limit for 1994-95 by approximately 23 percent—$47 million.

Under the waiver agreement, higher costs in one year can be offset by lower costs in another—as long as expenditures over the 5-year life of the waiver do not exceed the cap. Hawaii officials told us that the state expects waiver costs to be slightly under the cap for the full 5 years of the program as a result of state efforts to reduce program expenditures. The following changes in eligibility standards and premiums were effective on August 1, 1995: (1) the point at which enrollees will be charged the full premium will be reduced from 296 percent of the federal poverty level to 201 percent, (2) individuals eligible for coverage under the employer mandate but who meet demonstration income requirements will be disenrolled, (3) self-employed individuals will be required to pay a minimum of 50 percent of the premium—regardless of their stated income,

[62]Hawaii is the only state to require employers to provide health insurance to their workers. Its expansion of health insurance coverage through the 1974 Prepaid Health Care Act was built on a tradition of employer-based health benefits. Under the act, employers pay most of the health insurance premiums. Employees must elect the insurance unless they have comparable coverage from another source. Employers who provide an extensive benefits package that meets standards described in the law are not required to cover dependents. Employers offering a more limited, state-approved, benefits package must then pay at least half the cost of dependent coverage. See Health Care in Hawaii: Implications for National Reform (GAO/HEHS-94-68, Feb. 11, 1994).

and (4) parental income will be taken into consideration when determining the eligibility of students under age 21. The state suspects that these last two groups either understate income or do not appropriately account for parental income. Officials in Hawaii told us that premium collections are keeping pace with expectations.

Table 4.3: Comparison of 1994 Actual and Estimated Enrollment Under Hawaii's 1115 Waiver

	Enrollment		
	Actual	Estimated	Difference
Traditional Medicaid	71,899	61,000	10,899
New eligibles[a]	63,490	27,100	36,390
Total	**135,389**	**88,100**	**47,289**

[a]Actual enrollment for new eligibles includes 22,675 individuals hypothetically eligible at state option under section 1902(r)(2) who were not previously covered by Medicaid and who will be counted as traditional eligibles for purposes of budget neutrality.

Tennessee: First-Year Enrollment and Cost Experience

During its first year of waiver implementation, Tennessee enrolled about 418,000 previously uninsured or uninsurable individuals. Although its waiver application proposed an open enrollment period once a year, the state actually accepted and processed enrollment requests throughout 1994. Moreover, Tennessee liberalized a restriction that had disqualified participation by individuals with access to insurance as of March 1993 by moving the effective date to July 1994. In late December 1994, however, the state unexpectedly announced an end to open enrollment for individuals not traditionally eligible for Medicaid.[63] Enrollment—including both traditional Medicaid and new eligibles was about 39,000 less than the state's 1994 enrollment cap of 1.3 million. Tennessee also informed HCFA that the enrollment cap for the remainder of the demonstration would be 1.3 million rather than 1.5 million beneficiaries. State officials attributed the freeze in enrollment of new eligibles to a budget crisis caused, in part, by demonstration costs.

HCFA reports indicate that the state spent about $443 million (14 percent) less than allowed under the waiver agreement cap.[64] Nonetheless, Tennessee covered several hundred thousand newly eligible individuals while increasing expenditures by less than half a percent from SFY 1993 to

[63]Tennessee officials indicated that applications received but not approved as of the date of the announcement would be processed.

[64]In Tennessee, the first year's cap on federal expenditures applied to the period July 1993 through June 1994 even though the demonstration did not begin until midway through that time period (Jan. 1994).

SFY 1994. Table 4.4 compares SFY 1993 enrollment and expenditures with those in SFY 1994, the first year in which the waiver became effective. Moreover, as shown in table 4.5, the state is now projecting lower waiver expenditures that could increase federal savings over earlier estimates. In the first 3 years alone, lower expenditures could more than double the state's previous estimate of savings due to the waiver.

Table 4.4: Comparison of Enrollment/Expenditures Under Tennessee's Prewaiver Medicaid Program and the 1115 Demonstration

Dollars in billions

	Enrollment	Expenditures
Prewaiver Medicaid Program—SFY 1993		
Traditional eligibles	777,431	
New eligibles	0	
Total[a]	**777,431**	**$2.702**
1115 waiver—SFY 1994		
Traditional eligibles	758,192	
New eligibles	361,264	
Total[b]	**1,119,456**	**$2.703**

[a]As of June 1993.

[b]Enrollment as of August 10, 1994.

Source: HCFA and state reports.

Table 4.5: Comparison of Tennessee's Waiver Agreement Spending Limits, First-Year Costs, and Revised Expenditure Projections

Dollars in billions

	SFY				
	1994 (actual)	**1995**	**1996**	**1997**	**1998**
Agreement	$3.146	$3.407	$3.663	$3.872	$4.069
Expenditures	2.703[a]	2.982	3.135		
Difference	0.443	0.425	0.528		

Note: The state did not issue revised estimates for SFYs 1997 or 1998.

[a]Data as of June 30, 1995.

Source: HCFA and state reports.

Both the (1) gap between 1994 waiver expenditures and the federal cap on spending and (2) projected reduction in waiver expenditures to well below the amount permitted under the state's 1115 financing agreement may be linked to problems in identifying state matching funds for DSH. HCFA officials told us that, from the outset, they anticipated Tennessee would

have difficulty in drawing down federal funds up to the maximum allowed under the waiver agreement.[65] They pointed out that although the Tennessee DSH program was available to provide a major source of funding for coverage expansion, the state discontinued its hospital tax with the onset of waiver implementation. This tax had been a source of state match for federal DSH funds. Undoubtedly, the shortfall in premiums collected from newly eligible enrollees and counted as part of state matching funds also contributed to Tennessee's financing problems.

Tennessee Encounters Problems in Collecting Premiums From Enrollees

Tennessee has encountered serious problems in collecting enrollee premiums. Initially, the state estimated that it would collect about $21 million in premiums during the first 6 months of the waiver as new eligibles gradually signed up for the program; premiums would increase up to $117 million in the last year when full enrollment had been achieved. However, for the first 6 months, Tennessee only collected $2.4 million, forcing it to find other sources of state matching funds.

Lower-than-expected premium revenues in Tennessee are due, in part, to a series of administrative glitches. Even though enrollment of the uninsured began in January 1994, initial premium notices were not mailed until June 1994. The notice informed enrollees that premium booklets would be mailed soon for monthly payments beginning with July. Then, the state contractor failed to mail up to 80,000 premium booklets, an error that was not discovered until November 1994. In February 1995, the state sent letters to nearly 60,000 households notifying them of past due premiums totaling $31 million. Approximately 62,000 individuals—about 15 percent of new eligibles—had been disenrolled from the program as of June 1995 and upwards of 20,000 more were within the 30-day notification period for termination. Another 17,000 families were placed on payment plans to address overdue premiums.

Implementing Fixed-Cost Agreements in a Variable-Cost Environment

Though the three waivers discussed in this chapter were approved during a period of economic recovery and a slowdown in medical inflation, the recession of the early 1990s coupled with rapid medical price increases serve as a reminder of the risks posed by fixed-cost agreements in variable-cost environments. While states have benefited from recent economic trends, the potential for a resurgence in medical inflation, a

[65]In retrospect, a line item in Tennessee's waiver budget—"additional state funds required"—may have been a clue to the existence of a state funding shortfall.

recession, and large numbers of traditional and/or new eligibles could create problems for Tennessee, Oregon, and Hawaii.

In Tennessee, the 1115 agreement provides the state with a fixed budget to serve both traditional Medicaid and newly eligible recipients. Though the state appears to have a tight lid on cost increases, it is already under pressure to raise capitation rates that most providers consider unrealistically low. A slowdown in economic growth and the associated increase in Medicaid enrollment due to rising unemployment could further exacerbate the state's current budget crisis and provide additional ammunition to already aggrieved providers.

Increased medical inflation and a recession could pose a somewhat different dilemma for Oregon and Hawaii. Under the terms of their waiver expenditure caps, these two states are not at risk for changing economic conditions that could increase the number of traditional Medicaid beneficiaries. Thus, the limit on demonstration costs floats upward with enrollment, permitting increased federal and state Medicaid expenditures. If increased state costs associated with covering more traditional beneficiaries is accompanied by an acceleration in medical price increases, however, the additional budget resources required could threaten Oregon's and Hawaii's coverage expansion plans.

Conclusions and Agency Comments

Comprehensive 1115 Medicaid demonstrations have given states flexibility to test innovative approaches for the delivery of publicly funded health care services. While the waivers were intended to give states program flexibility, it is not clear whether the administration's decision to simultaneously provide budgetary flexibility is consistent with the current emphasis on reducing the federal budget deficit. Under the four approved waivers we analyzed, the federal government is potentially at risk for a net increase of about $2 billion in Medicaid expenditures. While Tennessee's waiver agreement meets the test of budget neutrality, those of Florida, Oregon, and Hawaii do not. The agreements in these three states represent the antithesis of the budgetary certainty that the Congress appears to be moving toward in social program spending.

We believe the granting of additional section 1115 waivers merits close scrutiny for several reasons. First, the potential budget impact of 1115 waivers may increase if the administration continues to show budgetary flexibility in its review of additional state proposals. The administration has granted a number of additional waivers since Florida's, the most recently approved waiver whose budget neutrality agreement we examined in detail. Moreover, the number of pending waivers continues to grow and now includes New York, whose Medicaid expenditures represented about 16 percent of national program costs in fiscal year 1993. Second, given the priority attached to reducing the deficit, it may be appropriate to consider whether or at what point taxpayers should benefit from managed care savings that are currently being reinvested to expand Medicaid coverage to millions of additional individuals.

Finally, though comprehensive 1115 Medicaid waivers were approved during a period of economic recovery and a slowdown in medical inflation, the recession of the early 1990s coupled with rapid medical price increases serve as a reminder of the risks posed by fixed agreements in variable-cost environments. The combination of higher medical inflation, a recession, and large numbers of traditional and newly eligible Medicaid enrollees could pose equally unattractive alternatives for both the federal government and states: (1) increasing funding or (2) reducing benefits/denying coverage to hundreds of thousands of people newly enrolled under the waivers. Consequently, we question whether demonstration waivers granted for a limited period are the best approach to reducing states' uninsured populations.

Agency Comments

The Department of Health and Human Services and OMB disagreed with our conclusion that the waiver funding caps for Oregon, Hawaii, and Florida are not budget neutral. We continue to believe that the administration's waiver funding caps for these states may result in increased federal spending.

We do not believe that our methodology is the only appropriate method to estimate budget neutrality baselines, and agree that using a tailored, state-specific approach would be more appropriate. We did tailor our methodology to the specific services covered by the demonstrations and did reflect current DSH rules. We saw no evidence, however, that the administration itself adopted this approach. The only state-specific data evident in the negotiating record were historical trends, which were clearly not expected to continue. The acute and long-term care cost projections cited in the administration's comments are not consistent with OMB's published forecast of overall growth in the Medicaid program.

While OMB characterized its own approach to budget neutrality as "ad hoc," we adopted a consistent and uniform methodology that challenges the administration to support its contention that these demonstrations should grow at such high rates. To date, the administration's own methodology remains shrouded in generalities. We believe that potential program cost increases of hundreds of millions of dollars should be based on a more clearly specified methodology.

Second, contrary to the administration's assertion, state variation in Medicaid programs and expenditures was a central component of our assessment of budget neutrality. After using OMB's national forecasts to project without-waiver expenditure trends, we examined the waiver negotiating record and asked state officials to identify why future state Medicaid expenditures should exceed the national norm. As noted, we found no state-specific evidence to support the high budget caps agreed to by the administration. Even in the case of Florida, whose Medicaid program had been growing faster than the national average, the state's own estimates show that key factors contributing to past growth were not expected to be sustained.

OMB maintains that "it is more appropriate to use a current law rather than a current services baseline for adjudicating budget neutrality." Yet, it points out that "the President's budget does not differentiate between the two." We do not question OMB's authority to estimate the baseline, including anticipated behavioral changes in mandatory programs where

such changes are allowable under current law. We do question whether in this case such an adjustment is appropriate, based on our review of state practices in these programs. The only explicit use of current law evident in the waiver approval process is OMB's decision to include those hypothetically eligible for Medicaid under current law within their baseline. Of the four states we reviewed, OMB's approach only affected the baseline for Hawaii, as is reflected in figure 3.6. Since no attempt was made in Hawaii's or in other states' waivers to suggest that they would have expanded Medicaid eligibility to hypothetical groups if their 1115 demonstrations had not been approved, we chose not to include hypotheticals in the baseline.

Finally, the administration questioned the basis for our estimate of expenditures under the waiver funding agreements for Oregon and Hawaii, states with per capita funding limits. We asked and were told by administration officials that no estimates had been made of potential expenditures under those caps. Consequently, we worked closely with state officials to develop such estimates. State Medicaid officials reviewed and agreed with our methodology, described in detail in appendix I.

Objectives, Scope, and Methodology

To examine the financing arrangements for approved 1115 Medicaid demonstration waivers in several states, we focused on (1) the relationship between the waiver and other state health reform initiatives, (2) the planned sources of funding available to finance expanded coverage, (3) the potential net impact of these waivers on federal Medicaid expenditures, and (4) the actual waiver expenditures of states with sufficient implementation experience.

Although our study concentrated on four states, we closely monitored other pending waivers, which we use as examples throughout this report. Two criteria guided our sample selection: (1) whether the state was engaged in other major health reform initiatives and (2) whether it had begun implementing its approved waiver. At the time we selected our sample, only three states—Tennessee, Oregon, and Hawaii—had commenced implementation. Though its waiver had not yet been ratified by the state legislature, we included Florida in our sample since it was the first state with a large Medicaid program to gain federal approval of an 1115 waiver.

During our review we (1) analyzed data contained in HCFA expenditure reports, state 1115 waiver applications, correspondence between HCFA and state officials concerning the demonstrations, and reports prepared by state agencies and other interested parties, such as advocacy groups; (2) interviewed state legislators and officials responsible for the state Medicaid program and for other health reform initiatives; (3) discussed the waivers with affected parties, such as health plans, providers, and advocacy groups; and (4) interviewed HCFA, HHS, and OMB officials responsible for reviewing and approving waiver applications. We also reviewed the literature on state health care reform and Medicaid managed care.

To determine the potential impact of Medicaid 1115 waivers on federal Medicaid spending, we developed and applied a consistent framework that compares spending limits approved in each waiver with a benchmark based on current services budgeting concepts. The framework consisted of (1) determining base-year costs, for the existing fee-for-service Medicaid system in that state and inflating these costs at national projected current services rates to give us our without-waiver spending estimate; (2) determining the total waiver program cost limits, based on the waiver agreements; and (3) comparing the two costs.

Common Aspects of Our Multistate Analysis

The four waiver agreement cost limits we analyzed were different in several respects. Nevertheless, we applied some common rules and assumptions.

- We used the OMB national current services growth rate in effect at the time a waiver was approved to project without-waiver spending. For example, HCFA approved the Oregon waiver in March 1993, so we analyzed the agreement using the fiscal year 1994 projection OMB made in February 1993.
- We applied projections made for federal fiscal years to associated state fiscal years or calendar years, depending on the starting point of the programs.
- In cases where the total waiver agreement cost depended on program enrollment—the states that used a per capita cost limit—we used the states' enrollment estimates included either in the waiver application or in answers to subsequent HCFA questions prior to approval.
- The OMB projections of Medicaid current services outlays cover the entire Medicaid program, not just the populations and services associated with the waiver programs. By applying these growth rates to the waiver programs, we are assuming that the rates of growth for the waiver programs and the entire Medicaid program as a whole would not be significantly different.

Tennessee

The Tennessee waiver agreement has an aggregate cap on total program cost. The agreement documents specified the base-year cost and the rate at which this cost would be allowed to grow under the waiver, giving us the total potential program cost.

Because Tennessee has a high Disproportionate Share Hospital Program (DSH) allotment and the base-year cost included DSH, we did not simply adjust the base-year cost for inflation using the OMB current services rates to develop our without-waiver spending projection.[66] To be consistent with statutory DSH limits, we held Tennessee's DSH payments constant until they would have constituted less than 12 percent of total Medicaid expenditures. At that point, we allowed DSH payments to grow at the same rate as the rest of the Medicaid program. We adjusted the remainder of the program for inflation at the rates specified in OMB's projection for fiscal year 1994 current services outlays.

[66]DSH is limited by statute to 12 percent of total Medicaid program funding. States with DSH allotments higher than 12 percent were capped at their existing DSH levels and prohibited from any increase in DSH until they fell below 12 percent.

The net effect of holding DSH constant was that our without-waiver projection grew more slowly than it would have if we had allowed the whole program to grow at the OMB rate. Table I.1 shows the waiver agreement funding limit, our without-waiver estimate, and the difference.

Table I.1: Comparison of Tennessee Waiver Agreement Spending Cap and Projected Without-Waiver Spending—Year by Year

Dollars in billions

	1994	1995	1996	1997	1998
Waiver spending cap	$3.146	$3.407	$3.663	$3.872	$4.069
Percent growth	16.4	8.3	7.5	5.7	5.1
Without-waiver spending	$3.032	$3.433	$3.853	$4.325	$4.808
Percent growth	14.5	15.4	13.0	12.2	11.2
Difference (savings)	$0.114	($0.025)	($0.191)	($0.453)	($0.740)

Florida

Like Tennessee, the Florida waiver agreement has an aggregate cap on program costs.[67] However, this waiver only includes the acute care and DSH segments of the Medicaid program. The waiver agreement documents specified the base-year costs and the rate at which the program would be allowed to grow, giving us the total potential program cost.

To estimate without-waiver spending, we adjusted for inflation the waiver agreement base-year cost at the rate OMB projected Medicaid current services outlays would grow beginning in fiscal year 1995.[68] Because Florida has a low DSH allotment, we allowed DSH to grow at the same rate as the rest of the program. Table I.2 shows the waiver agreement, our without-waiver projection, and the difference.

[67]The waiver agreement includes a circuit-breaker provision that allows Florida to eclipse the waiver agreement cost cap in the event that the state's traditional Medicaid population exceeds projections by 3 percent or more.

[68]OMB's fiscal year 1995 projection did not include an estimate of current services growth for the year 2000. Because there was little variation in the projection from year to year, we used the 1999 figure for 2000.

Table I.2: Comparison of Florida Waiver Spending Agreement Cap and Projected Without-Waiver Spending—Year by Year

Dollars in billions

	1995	1996	1997	1998	1999	2000
Waiver spending cap	$4.950	$5.723	$6.605	$7.582	$8.658	$9.8872
Percent growth	16.3	15.6	15.4	14.8	14.2	14.2
Without-waiver spending	$4.706	$5.282	$5.931	$6.653	$7.430	$8.297
Percent growth	10.6	12.2	12.3	12.2	11.7	11.7
Difference-excess funds	$0.061	$0.442	$0.675	$0.929	$1.228	$1.193

The Florida waiver program was scheduled to begin in the fourth quarter of 1995 and end after the third quarter of 2000. To calculate our without-waiver projection and the waiver agreement spending cap, we assumed the program would run for a full year in 1995 and 2000, but only counted 25 percent of 1995 and 75 percent of 2000 for our calculation of additional funds. We did this to avoid skewing the increases in the first and last years of the program.

Oregon

The Oregon waiver agreement includes per capita cost limits, rather than an aggregate program cost cap. The agreement specifies per capita cost limits for individual eligibility groups, with a limit on the number of new eligibles.[69] Consequently, our analysis represents the waiver agreement limit based on a fixed set of enrollment assumptions, including both the number and distribution of health plan enrollees. We calculated the program cost using the agreed-upon per capita costs for each eligible population and the enrollment estimates provided by the state.[70]

The waiver agreement documents for Oregon did not include a base-year cost that we could adjust for inflation at the current services rates to

[69]The waiver agreement stipulates that the federal government will match state funds spent to provide coverage for newly eligible enrollees. However, the federal government will only provide matching funds for a limited number of new eligibles—based on the fixed ratio of current-to-new eligibles specified in the waiver agreement.

[70]We could not calculate the maximum waiver agreement limit with any other estimate of enrollment because, to date, HCFA and Oregon have not agreed on a specific methodology for determining the maximum allowable number of newly eligible enrollees in each category that will qualify for federal matching funds.

calculate without-waiver spending. Consequently, we constructed a base-year cost that approximated the cost of providing traditional Medicaid services to those individuals who would be eligible for the Oregon waiver program using data supplied by the Oregon Office of Medical Assistance Programs.[71] Then, we adjusted this base-year cost for inflation using OMB's fiscal year 1994 current services projections to arrive at our without-waiver projection for Oregon. Table I.3 shows the results of these calculations.

Table I.3: Comparison of Oregon Waiver Spending Agreement Cap and Projected Without-Waiver Spending—Year by Year

Dollars in billions

	1994	1995	1996	1997	1998
Waiver spending cap	$0.348	$0.476	$0.574	$0.610	$0.680
Percent growth	11.2	36.9	20.6	6.3	11.5
Without-waiver spending	$0.328	$0.413	$0.467	$0.524	$0.582
Percent growth	14.5	15.4	13.0	12.2	11.2
Difference-excess funds	$0.019	$0.063	$0.107	$0.086	$0.098

The Oregon waiver program was in operation for 11 months in 1994. To account for this, we multiplied the waiver agreement and our without-waiver projection by eleven-twelfths. As there was only a 1-month difference, we did not extend our analysis into a sixth year (in this case, 1999) as we did with Florida and Hawaii.

Hawaii

Like the Oregon agreement, the Hawaii waiver agreement is per capita based, where the limit on total program spending is flexible—depending on the number of traditional Medicaid eligibles enrolled—but the cost per person in each eligibility group is fixed. However, with Hawaii, HCFA cost sharing is based only on the number of traditional eligibles—including hypotheticals; newly eligible individuals are not counted in calculating the federal match.

In order to make our comparison, we used a preliminary estimate of the base-year per capita cost and constructed a base-year enrollment figure using actual enrollment figures for fiscal year 1992 and a state estimate for fiscal year 1994. To calculate the total waiver agreement cost, we adjusted

[71]This exercise generally gave us the cost of providing Medicaid services to the waiver population on a fee-for-service basis. A segment of the Oregon Medicaid population was already involved in a Medicaid managed care experiment; we assumed that this experiment would continue unchanged and grow at the same rate as the rest of the program.

the product of the base-year per capita cost and the state's projected enrollment by the waiver agreement inflation rate. The waiver agreement inflation rate is the Consumer Price Index (CPI) for health care in Honolulu plus 4 percentage points. However, because the Bureau of Labor Statistics does not make CPI forecasts, we used an OMB nationwide projection as a proxy for health care inflation in Honolulu.[72]

To project without-waiver spending, we multiplied the base-year per capita cost figure by the base-year enrollment estimate and adjusted the total for inflation at the rate specified by OMB's fiscal year 1994 current services projections. Table I.4 shows the results of these calculations.

Table I.4: Comparison of Hawaii Waiver Agreement and Projected Without-Waiver Spending—Year by Year

Dollars in billions

	1994	1995	1996	1997	1998	1999
Waiver spending cap	$0.188	$0.216	$0.245	$0.280	$0.321	$0.367
Percent growth	30.5	15.2	13.3	14.4	14.4	14.4
Without-waiver spending	$0.165	$0.190	$0.215	$0.241	$0.268	$0.298
Percent growth	14.5	15.4	13.0	12.2	11.2	11.2
Difference-excess funds	$0.012	$0.026	$0.027	$0.032	$0.040	$0.025

Hawaii's waiver program started in mid-1994, and the demonstration is scheduled to be completed in mid-1999. In creating table I.4, we annualized the 1994 and 1999 figures and, as we did with Florida, we multiplied the amount of additional funds by the fraction of the year the program was (or will be) in operation.

[72]In a previous report, we found that per capita health care expenditures in Hawaii, while lower than those in the nation as a whole, were growing at roughly the same rate as the rest of the nation. See Health Care in Hawaii: Implications for National Reform (GAO/HEHS-94-68, Feb. 11, 1994).

Overview of Medicaid

Financed jointly by the federal government and states, Medicaid is the nation's health care lifeline for two statutorily defined groups of low-income residents—families, primarily women and children; and the aged, blind, and disabled. The federal government matches state expenditures according to a prescribed formula, providing, on average, 58 cents of every dollar spent. In 1993, Medicaid expenditures for the 39 million beneficiaries enrolled in the 50 states and the District of Columbia totaled $130 billion, up dramatically from just a decade ago.

In reality, Medicaid is not one, but 56 separate programs that differ dramatically across states.[73] While federal statute mandates who is eligible for coverage and the broad categories of services that must be provided, each participating state designs and administers its own program by (1) setting certain income and asset eligibility requirements; (2) selecting which optional groups and services to cover; and (3) determining the scope of mandatory and optional services, for example, by limiting the number of covered hospital days per year. As a result of this flexibility, Medicaid is not available to everyone who is poor. In 1993, Medicaid provided health care coverage to less than half of those with incomes below the poverty level. HCFA, within HHS, monitors each state program for compliance with federal regulations.

Medicaid costs have escalated sharply—tripling between 1985 and 1993, while the number of beneficiaries increased by over 50 percent. Expenditure growth outpaced changes in the Consumer Price Index as well as national health and Medicare spending. Currently, Medicaid accounts for about 6 percent of all federal outlays and 19 percent of state spending. Medicaid nearly equals state expenditures for elementary and secondary education combined, generally the largest segment of state budgets.

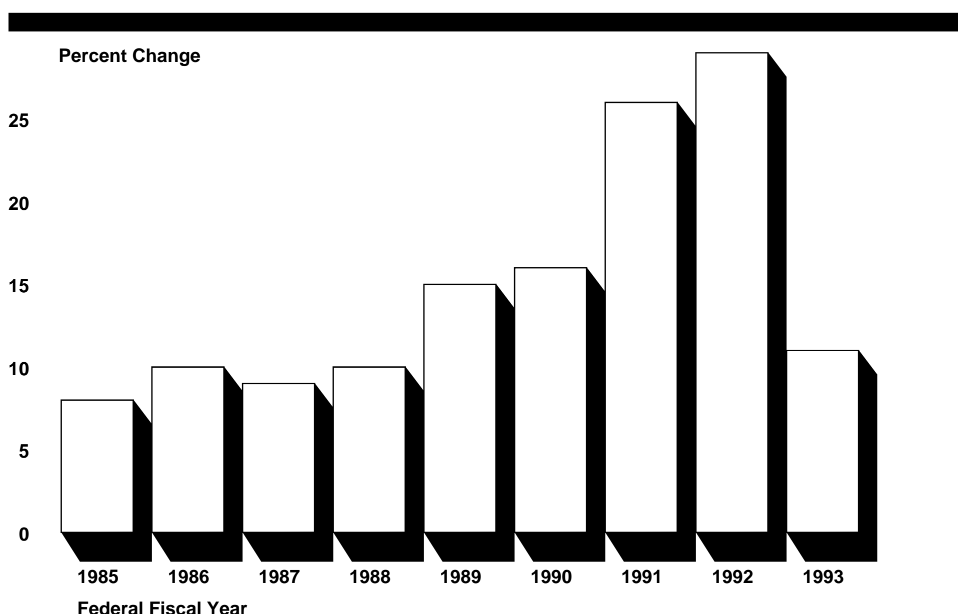
A number of factors contributed to this rapid cost growth. Between 1984 and 1990, the Congress mandated coverage for certain low-income groups—primarily pregnant women, children, and Medicare beneficiaries—and allowed coverage of others at state option.[74] Medical price inflation, higher provider reimbursements, utilization growth, and an increase in the number of eligibles due to the national recession also played a role. The relative importance of each factor depends on the time

[73]All 50 states plus the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have Medicaid programs.

[74]See Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995), p. 27.

period selected. For example, in 1993 the Kaiser Commission reported that enrollment, inflation, and increased use of services each accounted for about one-third of the increase in expenditures from 1988 through 1991.[75] The Urban Institute has attributed part of the cost growth to increased enrollment resulting from the sharp downturn in the economy during that time period.[76]

Figure II.1: Growth in Medicaid Expenditures, 1985-1993



As shown in figure II.1, growth in Medicaid expenditures soared in 1991 and 1992. The most important cost driver during this period was creative financing techniques typically adopted by some states to increase DSH payments. DSH provides supplemental payments to hospitals serving a large number of Medicaid and other low-income patients, thereby partially offsetting costs not covered by either Medicaid, state charity care programs, or private insurance. In 2 years, DSH grew from just under $1 billion to over $17 billion and represented about $1 out of every $7 Medicaid spent on medical services. This rapid growth can be traced to several legal but nonetheless questionable practices, including the use of

[75]The Medicaid Cost Explosion: Causes and Consequences (Baltimore, Md.: The Kaiser Commission on the Future of Medicaid, Feb. 1993).

[76]Theresa A. Coughlin and others, “State Responses to the Medicaid Spending Crisis: 1988 to 1992,” Journal of Health Politics, Policy, and Law, Vol. 19, No. 4 (Winter 1994).

rebated provider taxes to gain federal match under DSH.[77] In some cases, a portion of the federal matching funds was redirected to state general revenues and spent on programs other than Medicaid. This swapping and redirecting of revenues contributed greatly to Medicaid cost escalation. In response to these practices, the Congress placed restrictions on DSH in 1991 and 1993, effectively capping the program and tying increases to the overall growth in state Medicaid programs.

[77]For more detail on these state financing practices, see Medicaid: States Use Illusory Approaches to Shift Program Costs to the Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

Summary of Approved and Pending 1115 Medicaid Demonstration Waivers Submitted Since 1992

	Submission	Approval	Implementation/status
Approved demonstrations			
Oregon	Nov. 1992	Mar. 19, 1993	Feb. 1994
Hawaii	Apr. 1993	July 16, 1993	Aug. 1994
Kentucky	May 1993	Dec. 9, 1993	Suspended—not approved by state legislature; new waiver proposal submitted June 22, 1995
Tennessee	June 1993	Nov. 18, 1993	Jan. 1994
Rhode Island	July 1993	Nov. 1, 1993	Aug. 1994
Florida	Feb. 1994	Sept. 15, 1994	Not approved by state legislature in session ending May 1995
Ohio	Mar. 1994	Jan. 17, 1995	State has decided not to implement
Massachusetts	Apr. 1994	Apr. 24, 1995	Awaiting state legislative approval; expected implementation in Jan. 1996
Minnesota	July 1994	Apr. 27, 1995	July 1, 1995
Delaware	July 1994	May 17, 1995	Approved by state legislature; scheduled to begin Jan. 1996
Vermont	Feb. 1995	July 31, 1995	Jan. 1, 1996
Provisionally approved			
South Carolina	Mar. 1994	Nov. 18, 1994	In Apr. 1995, state abandoned waiver and shifted to a voluntary managed care strategy
Pending			
New Hampshire	June 1994		On hold, new proposal expected
Missouri	June 1994		Amendment submitted Mar. 24, 1995
Illinois	Sept. 1994		HCFA reviewing financing issues
Louisiana	Jan. 1995		Finance plan rejected
Oklahoma	Jan. 1995		HCFA reviewing proposal
New York	Mar. 1995		HCFA reviewing proposal
Kansas	Mar. 1995		HCFA reviewing proposal
Kentucky	June 1995		HCFA reviewing proposal
Utah	July 1995		HCFA reviewing proposal
Alabama	July 1995		HCFA reviewing proposal
Texas	Sept. 1995		HCFA reviewing proposal

Note: Information in table is as of October 6, 1995.

Differing State Health Reform Contexts

	Tennessee	Florida	Kentucky	Oregon	Hawaii	Minnesota	U.S. total
Access to insurance[a]							
Uninsured (percent of nonelderly), 1993[c]	15.6%	**24.1%**	14.7%	17.2%	13.7%[b]	12.7%	18.1%
Insured by employer (percent of nonelderly), 1993[c]	58.7%	52.8%	58.7%	**63.9%**	**68.8%**	**66.7%**	60.8%
Medicaid coverage (percent of nonelderly), 1993[c]	**16.0%**	**13.3%**	**18.4%**	9.3%	9.4%	11.3%	12.8%
Individuals in poverty (percent of total population), 1993	**19.6%**	**17.8%**	**20.4%**	11.8%	8.0%	11.6%	15.1%
State health care reform agenda							
Universal coverage goal	No	Yes	No	Yes	Yes	Yes	
Universal coverage financing mechanism	Not applicable.	Voluntary—to be reconsidered if no evidence of significant decline in uninsured.	Not applicable.	Employer mandate to begin in 1997 if voluntary participation falls short of goals.	Employer mandate enacted in 1974.[d]	Individual mandate had been considered; no consensus on an alternative has emerged.	
Legislatively established state health reform policy organization	No	Agency for Health Care Administration (1992)	Health Care Policy Board (1994)	Health Services Commission (1989)[e]	No	Health Care Commission (1992)	
Small group insurance reforms	Yes	Yes	Yes	Yes	No	Yes	
Publicly sponsored health purchasing cooperative	No	Yes	Yes	No	No	Yes	
High-risk insurance pool	Yes	Yes	No	Yes	No	Yes	

(continued)

	Tennessee	Florida	Kentucky	Oregon	Hawaii	Minnesota	U.S. total
Coverage expansions pursued by state prior to 1115 waiver							
State subsidized insurance programs for lower income residents	No	No	No	No	Yes, individuals up to 300% of poverty level.	Yes, families with children up to 275% of poverty level and individuals up to 125% of poverty level.	
Optional Medicaid coverage to pregnant women and infants over 133% of poverty level	Up to 185% of poverty level.	Up to 185% of poverty level.	Up to 185% of poverty level.	No	Up to 185% of poverty level.	Expanded beyond 185% of poverty level; see next row.	
Optional Medicaid coverage expansion under 1902(r)(2)	No	No	No	No	No	Yes, pregnant women up to 275% of poverty level and children up to age 1.	
Managed care penetration							
HMO enrollment (percent of population), 1993	5.7%	**17.6%**	6.6%	**31.5%**	**22.3%**	**30.1%**	17.4%
Previous Medicaid managed care experience							
Type of program	Substate managed care waiver under 1915(b). Renewal denied in 1992.	Voluntary HMO enrollment since 1981, and substate physician gatekeeper program under 1915(b) implemented in 1991.[f]	Statewide managed care program under 1915(b) implemented in 1986.	Substate managed care program under 1915(b) implemented in 1985.	Substate managed care waiver under 1915(b) implemented in 1983.	Voluntary HMO enrollment starting in late 1970s and substate managed care program under 1115 waiver implemented in 1985.	
Managed care enrollment as percent of Medicaid population, 1993	2.7%	**17.3%**	**45.8%**	**22.7%**	3.2%	**18.1%**	12.4%
Managed care approach	HMO and physician gatekeeper	HMO and physician gatekeeper	Physician gatekeeper	HMO and partially capitated health plans	HMO	HMO	

(continued)

	Tennessee	Florida	Kentucky	Oregon	Hawaii	Minnesota	U.S. total
Categories of traditional Medicaid population enrolled	Women and children	Primarily women and children, but a small number of aged, blind, and disabled[f]	Women and children	Women and children	Women and children	Women, children, and elderly	
1115 waiver managed care approach							
Managed care enrollment as percent of Medicaid population, 1995	100%	Not yet implemented	1115 not implemented, but 1915(b) enrollment is 57%	Approximately 80%[g]	84%	Approximately 33%	
Categories of traditional Medicaid population enrolled	Women, children, aged, blind, and disabled	Women, children, aged, blind, and disabled	Women and children	Women, children, aged, blind, and disabled	Women and children	Women, children, and aged.	
Managed care approach	Capitated HMOs and PPOs	Traditional eligibles: choice of capitated HMO or physician gatekeeper. New elgibles: choice of indemnity and HMO plans offered by state-sponsored health alliances.	Physician gatekeeper, phasing into capitated plans.	Capitated HMO-style plans, some partially capitated plans, and some physician gatekeeper programs.	Capitated HMOs and PPOs	Capitated HMOs	

(Table notes on next page)

[a]Numbers in bold indicate that amount is greater than the national average.

[b]Unlike most of the country, Hawaii is experiencing an economic downturn and an associated rise in unemployment and the number of uninsured. In 1992, Hawaii's percentage of uninsured was reported to be 8.1 percent—the lowest in the nation.

[c]Data are from Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1994 Current Population Survey, Issue Brief Number 158 (Washington, D.C.: Feb. 1995).

[d]Hawaii was the first state to attempt universal coverage with its passage of the Prepaid Health Care Act in 1974, which implemented a limited employer mandate. Because this act was passed before ERISA, Hawaii is the only state granted an exemption under ERISA. In addition, the state established publicly funded programs to insure individuals not covered by the employer mandate.

[e]Prepares prioritized list for legislative consideration, that is, ranks health services from most to least important.

[f]Florida has had authority to implement its 1915(b) waiver program statewide since 1993, but as of August 1995 the program was still limited to specific geographic areas of the state. It expects to enroll all traditional medicaid recipients (with the exception of those beneficiaries who are also eligible for Medicare) in either the voluntary HMO program or its physician gatekeeper program by June 1996. A small number of aged, blind, and disabled beneficiaries have been enrolled in the state's voluntary HMO program since 1981. However, as of August 1995, the enrollment of this population in the physician gatekeeper program was limited to two pilot areas.

[g]Though Oregon's goal is to transition all recipients into managed care, 20 percent remain in fee-for-service because there are no appropriate providers in their area or the most appropriate provider is not on the network of any participating managed care plan.

Comments From the Department of Health and Human Services

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 6 1995

The Honorable Charles A. Bowsher
Comptroller General of the
United States
Washington, D.C. 20548

Dear Mr. Bowsher:

Enclosed are the Administration's comments on your draft report, "Medicaid: Flexible Approach Used in Approving 1115 Waivers Could Increase Federal Costs." The comments represent the tentative position of the Administration and are subject to reevaluation when the final version of this report is received.

These comments reflect the position of the Office of Management and Budget as well.

The Administration appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Donna E. Shalala

Enclosure

Comments of the Administration
on the General Accounting Office Draft Report,
"Medicaid: Flexible Approach Used in Approving
1115 Waivers Could Increase Federal Costs"

OVERVIEW

This Administration is committed to working in partnership with the states to test new approaches to the Medicaid program. We share states' interest in developing innovative delivery systems, improving quality of care, and expanding coverage to uninsured Americans. Section 1115 demonstrations provide a unique mechanism for testing these approaches.

However, we must balance our commitment to restructuring the Medicaid program with our responsibility to Medicaid beneficiaries and American taxpayers. We fulfill this responsibility, in part, by ensuring that demonstration programs are budget neutral. To ensure budget neutrality, we limit Federal matching payments to the amount of projected Medicaid payments the Federal government would have made without the demonstration. To develop this limit, we start with the state's actual Medicaid expenditures after an agreed-upon base year, and forecast expenditures over the life of the waiver, using projected growth rates.

While the Administration has sought to provide states greater flexibility under demonstrations, it has consistently imposed a budget neutrality requirement. Indeed, in several cases, the Administration has insisted that states delay implementation or reduce eligibility expansions in their programs in order to decrease with-waiver costs and ensure budget neutrality. For example, the Administration informed Minnesota that its program was not budget neutral as submitted and the state had to scale it back to be approved. (GAO incorrectly reported that Minnesota officials did not request Federal matching payments for an expanded population because it would not be budget neutral.)

We disagree with GAO's methodology for determining budget neutrality, and therefore disagree with its conclusion that budget neutrality limits for Florida, Oregon and Hawaii may result in increased Federal spending. We believe GAO uses an inappropriate methodology--a uniform methodology for every state that ignores state variation. Although GAO finds great variation and complexity in the demonstration programs and spending, its methodology does not account for such variation in budget neutrality. We believe that GAO's report does not properly caveat its conclusions and this is a major weakness in its methodology. We believe that each demonstration is budget neutral and provides both the Federal and state governments a degree of protection against rising Medicaid expenditures.

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Finally, as GAO noted, states can choose between aggregate and per capita methods for enforcing budget neutrality. Such options strike a balance between fiscal control and risk to states for uncontrollable circumstances. The aggregate method places states at risk for enrollment growth as well as inflation and utilization changes. Under a per capita method, the state and the Federal Government continue to share the risk for enrollment growth, which could be due to a recession or other circumstances beyond the state's control. While GAO describes the aggregate method as "the most straightforward and uniform" approach, we note that Tennessee and Florida are the only states to have chosen this method. To date, all other demonstration states have chosen to use a per capita enforcement mechanism, rather than assume the entire financial risk for enrollment changes that they cannot control. Below are more detailed comments on budget neutrality issues.

STATE VARIATION

GAO's introductory chapters underscore the differences across states' Medicaid programs. We concur with their finding that state demonstration proposals exhibit a wide variety of approaches to Medicaid restructuring and that states have undertaken a wide variety of health care reforms. This diversity stems, in part, from the differences across state Medicaid programs and state health care systems. We would emphasize that the differences across states should produce valuable information and lessons about the potential consequences and implications of using Medicaid as a vehicle for reforming health care delivery and financing systems and improving access and coverage.

GAO correctly characterizes the variation in state experiences and innovative approaches. However, GAO does not account for this variation in its analysis of budget neutrality issues. Specifically, after pointing out the complexity and uniqueness of each state's program and indicating that state Medicaid spending growth varies dramatically, GAO supports using one standard (national Medicaid current services growth rates) to determine budget neutrality.

By contrast, the Administration has crafted without-waiver baselines that promote fairness and state flexibility by accounting for state by state variation. Because there is no stable estimate of state-specific baselines to forecast future trends, the Administration looks at state historical trends, evaluates the robustness of the state data, and compares them to aggregate national growth rate projections. We work with states to develop an

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adaptation of national rates and state experience that best project state spending over the demonstration period. The growth rates must be appropriate to the populations and services included in the demonstration, special circumstances that are unique to the state, and known trends within the state's Medicaid program.

USE OF NATIONAL GROWTH RATES

We do not believe that GAO's use of aggregate national Medicaid growth rates as the only appropriate method to estimate budget neutrality baselines is correct because these rates reflect growth in spending for Medicaid populations and services that are not included in the demonstrations. We believe that using these national growth rates exclusively to construct baselines for the demonstrations amounts to comparing "apples to oranges".

To illustrate this problem, consider that aggregate national Medicaid growth rates reflect spending growth for long term care as well as acute care, while Medicaid demonstrations most often include only acute care. The Administration (President's Budget 1994) projected that in 1994, over the period analyzed by GAO, acute care spending would grow 17.3 percent on average, while long term care spending would grow 13.2 percent--4 percentage points less than spending for acute care alone. The President's Budget 1994 projected total benefit spending to grow at about 14 percent over the same period, about 3 percentage points less than acute care growth. (The Congressional Budget Office's baseline reflects similar differences.) In our view, it is incorrect to use growth rates that apply to a different universe of spending. The Administration addresses these issues by calculating budget neutrality with projected growth rates *specific* to the services and populations covered under the demonstration, using the best data available. In some cases that data would be national growth rates and in other cases, state historical rates. The growth rate used may vary by eligibility category as well.

USE OF CURRENT SERVICES BASELINE

GAO uses as a standard for Federal budget neutrality a current services baseline, which it defines to include expenditures needed to finance the program, assuming no change in the laws and policies that are in place at the state level today. A current services baseline is inappropriate for adjudicating budget neutrality. In considering demonstration proposals, the Federal Government determines budget neutrality against a current law baseline -- the basis also used to project baseline Federal expenditures. Current law permits states to engage in program expansions and contractions. Therefore, in our view, establishing a state-specific budget neutrality baseline must involve some judgment regarding states' likely behavior under current law. Although GAO's use of a national current services

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baseline also reflects implicit judgments regarding a state's future behavior (i.e., that it will not change its program), GAO does not discuss the pros and cons of a current services versus current law approach.

We also note that GAO applies the current services standard to the national Medicaid baseline, which is a current law baseline (the President's Budget does not differentiate between the two, essentially applying a current law approach to estimates of current services baseline expenditures). Thus, GAO does not construct a true current services baseline for their analysis.

COMPARATIVE ISSUES

We believe GAO should provide more detail on how it calculated the budget agreement growth rates and estimates in Table 3.1 and Appendix I for the per capita states, and we question GAO's reconstruction of the demonstration budget agreements for these states. In order to adequately assess GAO's work, however, more information is needed concerning the specific background information upon which these estimates are based. Access to GAO's supplemental data would be particularly helpful since our independent estimates of these agreements differ from those developed by GAO. For example, our estimate of Oregon's waiver agreement is approximately $95 million below GAO's estimate. Our estimate of the Hawaii waiver agreement causes the total dollar gap between the waiver agreement and GAO's benchmark to drop by about two-thirds.

In addition, we do not believe GAO's analysis is appropriate because it used two different sets of enrollment projections when comparing per capita demonstration states to the current services baseline. The aggregate national current services baseline reflects assumptions about national Medicaid population growth that are inappropriate for individual states. To recreate the budget neutrality agreements, GAO used enrollment estimates furnished by the states. The baseline estimates used by GAO are not accurate for states whose budget neutrality agreements are on a per capita basis, such as Oregon and Hawaii. For these demonstrations, the amount of spending allowed by the budget agreement will vary, depending on actual Medicaid enrollment. GAO's methodology does not adequately take this factor into account.

Major Contributors to This Report

Michael Gutowski, Assistant Director, (202) 512-7128
Walter Ochinko, Senior Health Policy Analyst, (202) 512-7157
Cheryl Williams, Senior Health Policy Analyst
Mark Ulanowicz, Health Policy Analyst

Glossary

Term	Definition
Budget Neutrality	An assessment of whether the cost of expanding coverage to additional recipients under an 1115 Medicaid waiver is equal to or less than the cost of continuing the original Medicaid program serving only those traditionally eligible.
Current Services	A cost projection that assumes Medicaid spending will continue unchanged except for increases resulting from medical inflation, normal growth in the eligible population, and changes in utilization of medical services.
Terms and Conditions	The culmination of negotiations between a state and the administration over an 1115 demonstration application in which the administration specifies the provisions of the Social Security Act that are being waived and any special conditions upon which implementation of the waiver is contingent, including how budget neutrality will be measured and enforced over the life of the demonstration.
Waiver Funding Agreement	The portion of the terms and conditions governing an 1115 demonstration that spells out the limit (cap) on federal matching funds available during the demonstration.
Disproportionate Share Hospital Program (DSH)	A program that provides supplemental payments to hospitals serving a large number of Medicaid and other low-income patients, thereby offsetting costs not covered by either Medicaid, state charity care programs, or private insurance. Eliminating or limiting payments from this program is a major funding source for coverage expansion under 1115 waivers in states with high DSH allotments.
Managed Care	An umbrella term encompassing types of health insurance coverage with some insurer control over the use of services and restrictions on the choice of physicians and hospitals. In the context of Medicaid, it includes arrangements in which the insurer is paid a single fee, in advance, for each beneficiary rather than the state reimbursing providers after the fact for each service provided.

New Eligibles

Primarily lower income, uninsured individuals not traditionally eligible for Medicaid who are being provided health care coverage under 1115 waivers.

Traditional Eligibles

The specified categories of persons eligible for Medicaid according to statute: low-income families, primarily women and children; and the aged, blind, and disabled, depending on their financial status.

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