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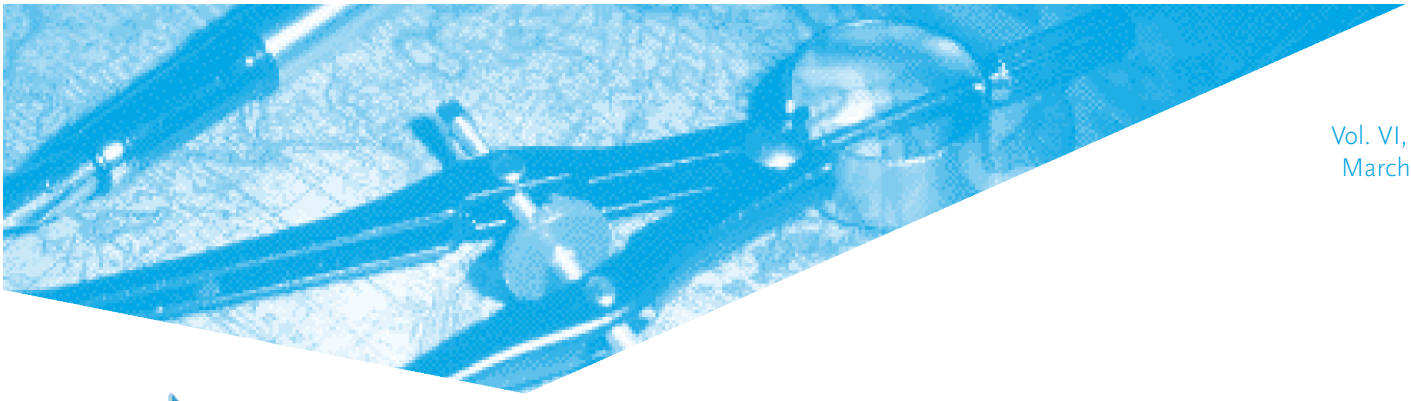

issue brief

Uncharted Territory: Current Trends in Section 1115 Demonstrations

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Introduction

Under section 1115 of the Social Security Act, the Secretary of Health and Human Services has the authority to waive many provisions in the Medicaid and State Children's Health Insurance Program (SCHIP) statutes. Section 1115 demonstrations have long been an important vehicle for states to not only expand health insurance coverage, but also provide a launching pad for changes to their underlying programs. In the early days of Medicaid managed care, section 1115 was a useful vehicle for implementing mandatory managed care enrollment for large segments of state's eligible populations. States would then use section 1115 authority to redirect the ensuing savings into coverage expansions.

The 1115 demonstrations have traditionally been the vehicle through which states have made innovations in their Medicaid programs. In recent years, states have explored the use of section 1115 to test more innovative financing strategies and coverage vehicles in their publicly funded health care programs. This has occurred, in part, as a result of the new guidelines for a section 1115 model known as the Health Insurance Flexibility and Accountability (HIFA) initiative which was issued by the Centers for Medicare and Medicaid Services (CMS) in 2001.

The HIFA initiative built on section 1115 by giving states enhanced waiver flexibility to expand coverage while streamlining benefits packages, creating public-private partnerships, and increasing cost-sharing for optional and expansion populations covered under Medicaid and SCHIP. HIFA also provided states with new methods to meet budget neutrality requirements. Although states can still use the HIFA guidelines, in many instances they are moving beyond this model to embrace new benefit designs, purchasing strategies, and financing arrangements.

This issue brief builds on previous SCI publications by examining new directions in recent section 1115 demonstration approvals and proposals. It is important to note, however, that the recently passed Deficit Reduction Act of 2005 provides states new authority to make changes in benefit design and cost-sharing through the state plan amendment process, as opposed to submitting waivers, and could change the face of waivers going forward. Whether states in the future will rely on the new federal changes or continue to use 1115 demonstrations as a vehicle for reforming their Medicaid programs remains to be seen.

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Related Resources:

The State Coverage Initiatives (SCI) program has published two issue briefs on HIFA, examining both early and subsequent demonstration approvals:

- Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States, August 2002; and,
- HIFA at Age Two: Opportunities and Limitations for States, December 2003.

Both are available at www.statecoverage.net/publications

Section 1115 Waiver Authority

Section 1115 can be a powerful tool for program transformation, eligibility expansion, or both. In addition to permitting states to administer their programs differently than what is otherwise required, section 1115 contains a provision that allows states to use Medicaid and SCHIP funds for "costs not otherwise matchable."

Some of the most interesting features of the new round of section 1115 demonstrations are in the budget neutrality agreements. Budget neutrality is a requirement that applies to all section 1115 programs. While not formally required by law, budget neutrality has evolved as a policy requirement: Medicaid waivers cannot cost the federal government any more than the state's standard Medicaid program. The budget neutrality test involves a comparison of actual demonstration expenditures with a negotiated "without waiver" budget ceiling.[1] States with SCHIP waivers can use unspent SCHIP funds in what is called "allotment neutrality." As will be seen in this issue brief, some of the recent section 1115 approvals introduce new concepts into the construction of budget neutrality agreements.

Recent Waiver Activity

An examination of recent section 1115 demonstrations reveals a marriage of state and federal policy and financial priorities. For example, in some cases the demonstrations are a vehicle for states to "lock in" financing arrangements that have supported their programs, while giving CMS assurances that certain financial practices will come to an end and federal exposure will be limited. States are still interested in expanding coverage when possible, but in some cases there is a greater interest in accomplishing this through employer-based coverage rather than directly through the state's Medicaid or SCHIP program. And while HIFA for the first time explicitly defined the flexibility that CMS envisioned for changes to the Medicaid benefit package for certain populations, states are now exploring using section 1115 authority to test the use of the defined contribution concept in Medicaid. Notwithstanding, the Deficit Reduction Act will now give states greater flexibility to make changes without a waiver.

Financing Arrangements

Many demonstrations are unique because of the financing agreements that are a part of their budget neutrality terms and conditions. A number of states described in this brief pursued new waivers to preserve federal revenue by shifting financing arrangements. Many of the new financing provisions allow states to shift resources currently funneled through hospitals for free care to individuals or programs aimed at reducing the number of uninsured.

California

California's budget neutrality agreement establishes a $766 million per year Safety Net Care Pool. Essentially, the funds in the pool replace money that the state had been able to draw under a previous section 1915(b) selective provider contracting waiver. A delicate balance was struck in setting up the financing. The new 1115 demonstration preserves funding that was set to expire under the previous waiver, securing the state's federal financing to some degree.

According to the terms and conditions for the demonstration, the safety net care pool can be used for coverage of the uninsured and support of safety net hospitals. As part of the agreement with CMS, California will be required to demonstrate that the matching funds for the safety net care pool arise from legitimate sources—including certified public expenditures by public health care providers—and allowable intergovernmental transfers. In addition, $180 million annually of the pool is "at risk" if the state fails to meet pre-negotiated milestones.

The specific milestones, and the amount of the pool to which they are related, vary by year. During the first year of the demonstration, which began on September 1, 2005, the state was required to enact managed care legislation by September 30, 2005, in order to be eligible for $90 million in federal matching funds.[2] The state would then be required to submit a state plan amendment related to managed care by May 31, 2006 in order to be eligible for another $90 million in federal matching funds. The second year milestones, which each allow the state up to $60 million in federal matching funds, are submission of managed care state plan amendments and waivers, submission of managed care contract and rate revisions, and enrolling beneficiaries in managed care beginning September 1, 2006.[3] During the remaining three years of the demonstration, there are no new milestones, but the special terms and conditions stipulate that $180 million of the $766 million can be used only for health care coverage for the uninsured.

Therefore, to the extent that the state distributes all of the pool funds to safety net hospitals in the first two years, as was the practice under the previous section 1915(b) waiver, they will need a strategy for transitioning the payments to coverage. In this manner, the demonstration establishes a vehicle for California to continue to access funds that might have otherwise been lost, but only in exchange for meeting benchmarks established by CMS.

Florida

Florida's sweeping Medicaid reform plan, scheduled to begin July 1, 2006, also preserves certain payments that would likely cease without the demonstration. Because of increased enrollment in managed care, the state stands to lose some $600 million in special payments to hospitals that are connected to fee-for-service utilization. The

Table 1: Examples of how Section 1115 Can Be Used

	Under Medicaid	Under Section 1115
Enrollment Caps	When a state includes a group of individuals in its state plan, all members of that group are entitled to coverage, regardless of the state's budget situation.	The Secretary can give a state permission to limit the number of individuals who are made eligible.
Variation Across State	A state's program must be operated uniformly in all geographic areas	There can be variation in the program across the state.
Different Benefit Packages	All eligibility groups must receive a uniform benefit package	Different benefit packages can be provided to different groups of eligible individuals.
Coverage for Non-Categorical Adults	Coverage can only be provided to individuals who meet income eligibility criteria *and* who fit into a statutory category (i.e., children; pregnant women; parents; and the aged, blind, and disabled).	States may cover non-disabled, non-pregnant adults without dependent children.

Florida demonstration establishes a Low Income Pool that essentially replaces the disappearing hospital payments, reserving up to $1 billion annually for safety net providers.

As is the case with the California pool, a portion of the Florida pool— $300 million—is at risk if the state does not meet specified milestones. These milestones include provisions related to evaluation and improvement of the health care delivery system serving the uninsured and adhering to timeframes and deliverables for the other waiver provisions.

Iowa

Another demonstration that coincides with the phasing out of a financing arrangement is the IowaCare program. The genesis of Iowa's reform was a need to preserve approximately $65 million in federal revenue generated through intergovernmental transfer (IGT) funding mechanisms which fell under CMS scrutiny.[4] The resulting section 1115 demonstration eliminated the IGTs but in exchange created an innovative expansion program that allows the state to both preserve the federal funds and limit its exposure to any increased cost associated with the expansion.

In return for discontinuing some financing mechanisms for safety net providers, Iowa received approval to allow federal matching funds for expenditures associated with serving non-elderly adults, including childless adults, with incomes up to 200 percent of the Federal Poverty Level (FPL) when those services are obtained through the specific providers.

The state identified approximately $100 million in unmatched state and county health care expenditures for this expansion. Benefits are limited to a set of services provided by specific entities. The state can cap enrollment for the covered population (eliminating the entitlement), and may implement cost sharing requirements for the limited set of benefits.

Another component of the expansion provides federal matching funds for non-elderly adults in the state's four mental health institutions (IMDs). The IMD component represents an exception to a long-standing federal prohibition of Medicaid payments for services to non-elderly adult patients residing in an IMD. Many states use Disproportionate Share Hospital (DSH) funding to offset uncompensated care in their state institutions, but Iowa's program did not include such provisions when DSH reforms were enacted in the 1990s, precluding the state from using more than a nominal amount of DSH funds for this purpose. The IMD expansion approved by CMS is a temporary measure that is phased out over the term of the waiver. After the phase-out, however, the funding will remain available to support community based mental health services or for costs associated with a Prepaid Inpatient Health Plan, which manages and delivers behavioral health services.

The waiver also includes provisions for home and community based services for children with serious mental illness, as well as provisions that allow pregnant women in families earning up to 300 percent of FPL to spend-down in order to qualify for services. Under the demonstration, the state agreed to an aggregate expenditure cap for the waiver population with no adjustment for enrollment growth—except for a small population of mentally ill children—over the term of the waiver.

Table 2: Recent Section 1115 Medicaid Waivers

State/Waiver name	Expansion populations	Key Features
California Medi-Cal Hospital Uninsured Care	• Not specified, however, in the final three years of the waiver, $180 million per year is reserved for expanding coverage to the uninsured per the terms and conditions of the waiver.	• Preserves $766 million annual of federal matching funds for Safety Net Care Pool for the uninsured and safety-net hospitals • Includes $180 million in annual contingencies tied to managed care enrollment expansion and coverage for the uninsured • Requires the state to demonstrate legitimate certified public expenditures or intergovernmental transfers as sources of non-federal match
Florida Medicaid Reform	• No new populations, however, individuals with incomes at or below 200 percent FPL who lose eligibility but who retain balances in an enhanced benefit account will be able to maintain eligibility for the purpose of exhausting accumulated funds	• Preserves $1 billion in a Low Income Pool to provide services to the uninsured or underinsured • Low Income Pool includes $300 million in annual contingencies tied to assessment and improvement of safety net for uninsured • Replaces the Medicaid defined benefit with a defined contribution • Allows managed care plans to establish amount, duration and scope of benefits • Establishes Enhanced Benefit Accounts to influence consumer utilization
Iowa IowaCare	• Childless adults and parents of Medicaid and SCHIP with income up to 200 percent FPL receiving services through a limited provider network	• Preserves $65 million in federal funds for safety net providers • Limits expansion population and benefits to a defined provider network • Allows federal stop-gap funding for IMDs with phase-out • Eliminates IGT and UPL arrangements, and prohibits new provider taxes • Budget neutrality determined on an aggregate cap basis
Massachusetts MassHealth (extension of existing waiver)	• Not specified, however, per the terms and conditions the Safety Net Care Pool (SNCP) may be used to expand coverage to the uninsured	• Discontinues $636 million in annual MCO supplemental payments and $370 million in hospital IGTs • Establishes a $1.23 billion SNCP to reduce the rate of uninsurance • Establishes allowable uses of SNCP to include non-hospital medical services and expenditures related to insurance products • Requires the state to demonstrate legitimate certified public expenditures or intergovernmental transfers as sources of non-federal match
New Mexico[a] State Coverage Insurance	• Childless adults and parents of Medicaid and SCHIP children with incomes up to 200 percent FPL	• Creation of a new subsidized insurance product for uninsured small businesses • Purely employer-based expansion model
Oklahoma SoonerCare/ Employer/Employee Partnership for Insurance Coverage	• Childless adults and parents of Medicaid and SCHIP children with income up to 185 percent of the FPL who work for participating small businesses	• Employer-focused expansion amendment • Use of accumulated savings for an employer-based program
Vermont Global Commitment to Health	• Not specified, but per the terms and conditions of the waiver, savings achieved through the financing model may be used to address uninsurance	• Establishes a global cap of $4.7 billion over the 5 year demonstration. • Financing mechanism allows a state agency to function much like an MCO and receive capitated payments for enrollees • Allows the state to retain savings, (the difference between capitated rates and actual cost of services) for state directed health initiatives

[a] New Mexico's Waiver was approved in August 2002 but implemented in July 2005.

Vermont

Vermont's demonstration introduces a unique concept in financing. Under the demonstration, entitled Global Commitment, the Vermont Agency for Human Services is authorized to pay the Office of Vermont Health Access as if it were a managed care organization (MCO). That is, one state agency will pay another state agency a monthly premium for each Medicaid beneficiary (long term care recipients and SCHIP enrollees are excluded). The exact premium will be set within a range that must be established by an independent actuary under contract with the Office of Vermont Health Access.

Premium payments will be made based on the number of enrollees under the demonstration. Therefore, the amount of money the State of Vermont may draw down from CMS each year will automatically adjust for increases or decreases in enrollment. However, since the demonstration is under a concurrent aggregate cap ($4.7 billion over the five-year waiver period), if enrollment grows beyond what can be supported within the cap, then the premium payments would also be capped. This scenario is highly unlikely because, based on the current program and previously existing section 1115 demonstration, the aggregate cap exceeds the maximum amount the state is projected to spend in the next five years. CMS assumed in formulating the budget neutrality cap that administrative costs would account for 9 percent of spending. However, this is high compared to the typical 3 to 5 percent administrative costs for state Medicaid agencies. SCHIP funds, long-term care, and DSH are excluded and therefore will continue outside the budget neutrality cap.

Medicaid Consumer-Directed Health Purchasing

Momentum appears to be gathering to pilot various forms of consumer-directed models in Medicaid. These reforms fundamentally would alter the role of the state, the state's expectations of Medicaid beneficiaries, and the behavior of every participant in the system. Depending on their design, consumer-directed health purchasing programs would create new opportunities and risks for Medicaid beneficiaries.

For more information, see "Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing," available at www.statecoverage.net/publications.

One important element of Vermont's demonstration is that the premium assumptions and incentives are likely to create savings. According to the special terms and conditions for the demonstration, any difference between the premium payments and the actual cost of providing and administering the benefit package is counted as savings and can be used to finance a range of public health and health care services for uninsured and underinsured Vermonters, including programs that are currently only funded with state dollars.

Even though the aggregate cap gives the state authority to spend more than its own projections, the authority is not boundless. The aggregate cap will hold, regardless of any new financing strategies that could be developed by states in the coming years. In this way, CMS is assured that even if states develop financing initiatives similar to previous DSH and upper payment limit (UPL) programs, Vermont will only be able to draw down federal funds up to the level of the cap. The cap will also hold regardless of enrollment increases. However, the state retains the option to end the demonstration if it appeared such a move were in its best interests. If this were to occur, the state would have to revert to operating the program without the flexibility and new program design established under the waiver.

Massachusetts

Massachusetts is another example of a state that was required to renegotiate certain funding mechanisms used to draw federal matching for payments to safety net providers, which offset the cost of care for the underinsured and uninsured. In this case, Massachusetts was seeking a three-year extension of a 1115 waiver originally approved in 1995, called MassHealth.[5]

Although the state requested an extension with no program changes, CMS used the request to initiate several program changes. The MassHealth program was using a complex set of mechanisms to pay for charity care and to maximize federal reimbursement to its safety-net providers. These included supplemental payments to managed care organizations (MCOs), which CMS approved in the original waiver application, as well as certain UPL and DSH payments to public hospitals.

As a condition of extending the waiver, CMS required the supplemental payments to MCOs to be discontinued by July 1, 2006. Although hospital intergovernmental transfers (IGTs) were not part of the original waiver, during the waiver negotiations, CMS required the state to discontinue IGTs to three hospitals that were used to generate federal match, and to restructure the funding to a CMS approved mechanism, such as certified public expenditures. In FY 2005 the MCO supplemental payments amounted to approximately $636 million and hospital payments were approximately $370 million.

The waiver extension also established a Safety Net Care Pool, "for the purpose of reducing the rate of uninsurance," funded with approximately $575 million of the state's DSH allocation and an amount equal to the 2005 supplemental MCO payments. Consequently, the state was allowed to preserve access to the affected federal funds but needed to identify alternative sources for the non-federal share. The budget neutrality agreement establishes a cap of approximately $1.23 billion per year with no growth allowance, allowing CMS to limit its exposure to the increasing costs of providing health care for the uninsured.

The state is using the Safety Net Care Pool and other elements of the waiver to restructure its methods of financing care for the uninsured and is taking an aggressive approach to reducing the rate of uninsurance within the state. CMS allowed considerable flexibility with respect to the types of expenditures that can be made from the Safety Net Care Pool. While nearly all of the state's existing Uncompensated Care Pool (UCP) is paid to hospitals and community health centers, the Safety Net Care Pool may be used for various purposes in addition to inpatient and outpatient hospital costs associated with care for the uninsured.

The reform of the MassHealth program is part of a larger reform process undertaken by the state. The Massachusetts legislature is currently considering several bills to address the issue of the uninsured. Proposals include easing insurance regulations to allow insurance providers to offer low cost plans, an individual mandate requiring every person to have health insurance coverage or face penalties, and employer mandates to provide coverage or pay through a payroll tax or other assessment. This type of legislation, if passed, along with the waiver's flexible Safety Net Care Pool provisions and its employer insurance assistance provisions, could result in significant changes to care delivery for the uninsured.

Defined Contribution and Individual Accounts

Some of the new demonstrations have ventured into the territory of transforming a portion of the Medicaid program from a defined benefit to a defined contribution structure. That is, instead of an entitlement to a set of benefits, beneficiaries in the waiver population are guaranteed a specific level of funding. Additionally, another new element being explored is the introduction of financial incentives designed to influence beneficiary behavior through the creation of individual accounts.

In fact, a critical component of the Deficit Reduction Act is the Health Opportunity Accounts provision which provides funds to allow ten states to establish these accounts, similar to health savings accounts.

Previously, the only financial tool for influencing beneficiary behavior was the imposition of co-payments. There are a number of concerns about the use of co-payments in the Medicaid program, including access to care issues and strict limits on amounts that can be charged. In addition, co-payments have been largely ineffective because providers cannot deny services on the basis of non-payment. The Deficit Reduction Act includes a provision that gives states the option to allow providers to condition receipt of items or services upon payment of applicable cost-sharing by the recipient.

Several states – Florida, South Carolina, Kentucky and West Virginia – have all proposed some version of an individual account. Some states have designed a model where the amount under the beneficiary's control is a defined contribution to cover most services received by the beneficiary. Others have proposed accounts to be composed of funds or credits that are "earned" based on the beneficiary displaying desired behaviors. Another proposal would allow the consumer to use the accumulated funds or credits for a variety of purposes ranging from meeting cost sharing requirements to purchasing health related services not covered by Medicaid.

At the time this publication went to print, many states were awaiting a thorough analysis of the Deficit Reduction Act by CMS. Consequently, some states that have not formally submitted their 1115 requests may revise their proposals to reflect the new flexibility granted to the states by Congress.

Florida

Florida is one state that has moved ahead with a demonstration approved by CMS in October 2005. The state's plan is to pay a risk-adjusted premium for all their beneficiaries' health care needs. The recipient may choose from state-approved plan options, which are available through various health maintenance organizations and provider networks. These plans, designed for different eligibility groups, are required to provide Medicaid mandatory benefits and most optional benefits in exchange for the premium, but services can vary in amount, duration, and scope. Thus a Medicaid recipient will be required to decide which plan best suits his or her health care needs, and then would be subject to the service limitations and cost-sharing requirements of that particular plan. The various target eligibility groups are likely to have a different mix of benefits. Plans may also vary by geographic area.

Florida is implementing its demonstration in a two-county pilot with mandatory participation for Temporary Assistance for Needy Families (TANF) related eligibility groups and the aged and disabled. Within a year, pending legislative approval, the pilot will expand to three additional counties. The CMS terms and conditions require the state to transition some voluntary eligibility groups – foster care children, individuals with developmental disabilities, and children with special health care needs – to mandatory enrollment beginning in year three, assuming adequate plans are available to meet their needs. Other groups (the institutionalized, hospice-related, and the dually Medicaid/Medicare eligible) are to transition later with the goal of state-wide mandatory managed care implementation for most Florida Medicaid recipients over the term of the waiver. Only Florida's "Medically Needy" and those with retroactive eligibility are planned to continue in the traditional Medicaid fee-for-service delivery system. Expansion to additional geographic areas requires legislative approval. Adding the dually eligible, hospice related groups, or the Medically Needy requires legislation and CMS approval of a waiver amendment. Given the size and related cost of the population, the eventual mandatory enrollment of dual eligibles in Medicaid managed care plans is a significant feature of this demonstration.

South Carolina

South Carolina submitted its demonstration proposal to CMS in October 2005. The state's 1115 waiver application outlines a plan in which beneficiaries would purchase health coverage using a Personal Health Account. At the time this publication was printed the state was awaiting more specific interpretations of the Deficit Reduction Act to inform officials on how they may want to alter the waiver submission.

The demonstration would include all Medicaid beneficiaries except dual eligibles and foster care children. Expansion groups would include parents of Medicaid children whose account is sufficient to purchase family coverage and individuals who have lost eligibility but retain an account balance. Such individuals may remain eligible for up to 12 months.

The South Carolina demonstration represents what officials in the state refer to as a hybrid between defined benefit and defined contribution. Carriers would be required by the state to provide a certain level of coverage; however, the individual plans would have some flexibility with the additional benefits offered outside the mandatory coverage areas. According to the proposal, any savings in the account could be used by the beneficiary to purchase non-covered services. Accounts would provide a guaranteed level of funding based on age, gender, and health status.

Enrollees may choose from several service delivery models: prepaid plans, a "medical home network" (shared risk arrangement with a preferred provider organization and an administrative services organization), or employer-sponsored insurance. Fee-for-service would remain available to children with disabilities whose primary care provider does not participate in a network.

In addition to the standard account arrangements, there will be a self-directed care demonstration within the waiver. Enrollees in this portion of the demonstration would use the funds in the account to purchase a major medical

plan (similar to the high deductible health plan that would be used in non-Medicaid health savings accounts). Other services would then be paid for directly from the account.

West Virginia

In West Virginia's proposed Healthy Rewards Accounts, an individual would receive a deposit of credits into an account that then become available for consumer directed health decisions. The intent is to discourage certain behaviors (i.e., missed appointments, use of emergency rooms for non-emergency care, purchase of drugs not on the state's preferred drug list) and encourage healthy behaviors such as well child checkups and vaccinations, prenatal care, and tobacco cessation. Accounts would be debited for undesirable behaviors and credited for desirable behaviors. Balances in the account carry forward and are available to use for services or items not covered by the Medicaid program.

Employer-based Coverage

In many of the newly-approved and proposed demonstrations, enrollment in employer-sponsored insurance (ESI) remains a priority, or at least an option. However, since ESI availability is limited for the populations typically enrolled in demonstrations, it is unclear whether the principal reason for this has to do with the potential for significant savings, or is based on a philosophical preference for employer-based coverage. One of the stated purposes of the HIFA initiative was to encourage the formation of public-private partnerships to decrease the number of uninsured.

In states like Florida (approved) and South Carolina (proposed), where the program design involves a defined contribution methodology, the amount allocated to beneficiaries can be used to enroll in ESI. Presumably, there will be a strong incentive on the part of the enrollee to do so, because the difference between the allocated amount per person and the cost of coverage is deposited into an account that will be controlled by the beneficiary. In previous demonstrations that used ESI, the enrollee did not share in any savings that were realized. It will be interesting to see whether ESI take-up rates increase with the introduction of this element.

In addition to Florida and South Carolina, several other states are focusing on an ESI alternative to direct public coverage. New Mexico and Oklahoma have demonstrations under way that focus on employer-based coverage. Louisiana and Kentucky have submitted proposals, while Idaho and Montana have developed concept papers.

The New Mexico demonstration, approved under the HIFA guidelines in 2002 and implemented in 2005, creates a new insurance product with incentives for employers and low-income individuals to purchase coverage. Under the program, the state contracts with managed care organizations for a standard benefit package for small businesses that previously did not offer coverage. State and federal funds offset the cost of coverage, making the insurance product more affordable to both employers and employees.

The Oklahoma program is somewhat different. It also targets a specific pool of small businesses (< 25 employees), including those that already offer coverage to their employees. Rather than creating a new insurance product, the state will subsidize existing coverage that employers can purchase on the open market. Oklahoma will also create a public coverage product for self-employed individuals, workers who are ineligible for or whose employers do not offer a health plan, and unemployed individuals who are actively seeking work. The Oklahoma program was enacted as a HIFA amendment to the existing SoonerCare section 1115 demonstration.

Louisiana's demonstration (proposed but not yet approved as of press time) includes LaChoice, an insurance subsidy for uninsured small businesses. Under LaChoice, small businesses that have not offered insurance for six months or more would be eligible to purchase a comprehensive insurance policy. If approved, the demonstration would give the state the authority to subsidize the cost of coverage for employees in families with income below 200 percent FPL. No subsidy would be given for higher income employees, but they could still be part of the LaChoice insured group. The program is meant to make it possible for small businesses to access insurance in the group market at a more affordable cost. Also, the state would be able to reduce the number of uninsured individuals without having to provide them with direct coverage at full cost.

Louisiana, like California, Massachusetts, and Florida, includes a pool component for coverage of the uninsured. Under Louisiana's pool, local parishes may use funds to either provide coverage or to increase access to primary care. It is expected that in cases where parishes decide to provide health insurance coverage, it may be in the form of premium assistance for ESI. Given the devastation wrought by Hurricanes Katrina and Rita, it is unknown exactly what shape the various initiatives may take, or if their implementation will be delayed because of a lack of local and state funding.

New Benefit Packages

State experimentation with different benefit packages is not a new trend; however, states are still exploring this area, trying to determine what appropriate benefit packages should look like for changing populations. Oregon's implementation of the Oregon Health Plan (OHP) prioritized list in 1998 was the first state initiative to address the complex issue of determining appropriate benefits for Medicaid eligible populations. Utah perhaps has pushed the envelope the farthest with the CMS approval of the 1115 waiver in 2002 allowing the state to implement a limited benefit Medicaid program, the Primary Care Network (PCN), which has solely provided primary and preventative care services to adults up to 150 percent FPL. With the PCN waiver up for reauthorization in 2007, it will be interesting to see if the program remains intact or is modified based on experience thus far.

Since the implementation of the PCN program, several other states have attempted to provide new benefit packages through the Medicaid program. In 2005, Maryland received approval for an amendment of the state's existing 1115 waiver to create a primary care program for an expansion population. Beyond the prioritized list, Oregon established two benefit packages for varying populations (OHP+ and OHP Standard). As mentioned earlier, both West Virginia and Kentucky have also proposed different benefit packages based on eligibility requirements.

In developing benefit packages for new programs, particularly targeted at employed adults, some states intentionally looked to mirror those available in the commercial market. This was the case for both New Mexico and Oklahoma's programs, which provide more streamlined coverage compared to traditional Medicaid. In fact, Oklahoma's O-EPIC benefits are less than other packages available in the private sector.

Future Factors to Consider

A number of environmental factors may influence both the success of the new wave of demonstrations, and the shape of future demonstrations. In the context of this discussion, the question still remains regarding how large of an impact the Deficit Reduction Act will have on future waivers. The Act also changes states ability to use SCHIP funds to cover childless adults. Furthermore, with the reauthorization of SCHIP scheduled by 2007, it is possible that there will be additional changes to the program that will impact states' options for financing coverage expansions. Lastly, because CMS has stated publicly that it will continue to scrutinize certain financing arrangements, it is possible that more states will avail themselves of the opportunity to use demonstration authority to preserve some funding streams, as has been the case in states like Florida, Iowa, and California.

Deficit Reduction Act

The Deficit Reduction Act is expected to reduce federal Medicaid spending by $4.3 billion over five years, although there are some elements that would allow states to add services or eligibility groups. Moving forward, the new law gives states additional flexibility through the state plan amendment process. Theoretically, this means that changes to state programs could be made more quickly and efficiently because states will be able to make changes through an amendment to their Medicaid state plan rather that through a waiver. Most importantly, because state plan amendments do not require states to demonstrate savings, states will not have to operate under budget neutrality requirements. While this may provide incentive for states to pursue new expansions, they will still have to come up with general matching funds in order to implement them.

The major Deficit Reduction Act provisions of interest for states include:

- Benefit and Cost-Sharing Flexibility: States will be able to impose new cost-sharing obligations on beneficiaries, including on pharmacy services. Although some groups will still be protected from some cost sharing, no group will be exempt from cost sharing for non-preferred prescription drugs. In addition, states will be able to establish "benchmark" plans for certain groups in Medicaid, much like the benchmark option that has existed in the SCHIP program.

- Family Opportunity Act: States have the option to amend their Medicaid state plan to allow families of disabled children to "buy into" Medicaid if their income is less than 300 percent FPL.

- Health Opportunity Accounts: The Deficit Reduction Act provides $64 million to allow ten states to establish a "Health Opportunity Account" option in Medicaid. This option would operate like a health savings account (HSA) and represents another move toward a defined contribution model in certain circumstances.

- Managed Care Organization Taxes: The Deficit Reduction Act changes the section of the law that defines the classes of providers than can be taxed by states. States often use provider taxes to generate federal revenue. Previously, Medicaid MCOs were considered a class unto themselves. Under the Deficit Reduction Act, if states want to tax MCOs they will not be able to single out Medicaid MCOs.

SCHIP and Program Reauthorization

The Deficit Reduction Act includes a provision which prohibits the Secretary of Health and Human Services from approving any new demonstrations that allow the use of SCHIP funds for services provided to non-pregnant, childless adults. Several states have already received approval of such proposals, and this practice has previously been criticized by the Government Accountability Office. Furthermore, the Deficit Reduction Act prohibits states from using redistributed funds to cover parents.

The funding formula by which states receive a capped allotment is sure to be a hot topic in the reauthorization debate. Several redistributions have been made in the past, pointing out the imbalance in how allotments are determined. The new limitations imposed by Congress will clearly affect the discussions leading to the reauthorization of the program.

Conclusion

The recent section 1115 demonstrations feature a number of innovations, including the testing of a defined contribution model, the encouragement of healthy behaviors through the introduction of various versions of individual accounts, and the granting of some new financing flexibility for coverage of the uninsured. In addition, the demonstrations serve as a mechanism for CMS to impose some limitations on states' financing strategies while allowing states to maintain current funding levels. However, the continued receipt of federal funding is often contingent upon expanding coverage to the uninsured in some form. These new state strategies will yield different experiences and new data will be available about the overall impact of the waivers on enrollees, providers, and the state. Just as states' experience with HIFA and other demonstration models has shaped the current section 1115 proposals, the results of these new waivers will likely inform future activity.

About the Authors

Theresa Laper Sachs, a principal with Health Management Associates, is an expert on design and financing of Medicaid and SCHIP waiver programs with 18 years of experience in publicly funded health care at the local, state, and national levels. Prior to joining HMA, her experience included seven years at the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) where she specialized in

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Endnotes

1 This ceiling is flexible in that states are typically given credit for eligibility expansions that could have been accomplished under the state plan without seeking waiver authority. In addition, depending upon the type of budget neutrality cap, states can be held harmless for caseload growth for populations that can be covered under the state plan. Lastly, states can in some cases count unspent disproportionate share hospital funds toward meeting budget neutrality

2 The state did not meet the deadline for the Year 1milestone.

3 The populations affected include some elderly and individuals with disabilities who will be required to enroll in managed care, as well as families and children in 13 counties that do not presently have mandatory managed care enrollment.

4 The Iowa General Assembly website discusses the reform and provides links to Iowa's waiver documents and supporting material. http://staffweb.legis.state.ia.us/lfb/medicaid/medicaid.htm.

5 MassHealth provides coverage for a number of eligibility groups, including the uninsured, the unemployed, working and non-working disabled, low-income workers and families, individuals with HIV, and women with breast or cervical cancer. MassHealth also includes incentives for both employers and employees to participate in employer sponsored health insurance.

6 The waiver terms and conditions allow for "other non-hospital medical service expenditures for the uninsured/SNCP population (e.g. clinic, FQHC, physician), infrastructure expenditures...and any expenditures related to new insurance products that may be developed by Massachusetts and approved by CMS."

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