State Health Reform and the Role of 1115 Waivers

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This article summarizes the status of State health reform and includes a table of major initiatives undertaken by each State. The Health Care Financing Administration's (HCFA's) role in reviewing State waiver proposals is analyzed, and the author examines why States are likely to continue to seek section 1115 waivers, absent Federal health care reform. The often conflicting roles and responsibilities of Federal and State policymakers in health reform are explored.

OVERVIEW OF STATE HEALTH REFORM

With the demise of Federal health reform, all eyes again turn to the States as laboratories of innovation. For the past decade, States have led the health reform debate through their experiments with a wide array of reforms. Historically, State activity has not been limited to Medicaid but has included broader actions to meet the needs of the uninsured, such as:

- Convening health reform commissions and task forces and initiating studies.
- Experimenting with programs that subsidize insurance costs for small businesses.
- Creating State and privately funded children's health plans.
- Reforming insurance laws to eliminate or reduce practices that exclude or deny affordable coverage; for example, for those with preexisting conditions.
- Establishing high-risk pools and sometimes subsidizing the premiums of those deemed "uninsurable."
- Launching State-supported purchasing alliances.
- Testing the feasibility of medical individual retirement accounts and using tax incentives for health coverage.
- In a handful of States, enacting comprehensive statewide reform of health care service delivery and financing, including the requirement that employers participate in the cost of employees' health coverage or pay taxes in lieu of that coverage.

But States have also focused attention on Medicaid program reforms, such as:

- Expanding and redefining Medicaid coverage and increasing the use of managed care within the program.
- Seeking section 1115 waivers to expand coverage of Medicaid to include more of the uninsured and to make other program changes.

In recent years, virtually every State has engaged in one or more of these initiatives, often supported through grants from the Robert Wood Johnson Foundation and other philanthropies and facilitated by the approval of waivers of current Medicaid rules by HCFA.

Table 1 summarizes five of the most frequently discussed approaches to health reform and identifies which States are currently pursuing those reforms. In the table, insurance reform includes a range of reforms from the establishment of "bare bones" or basic benefit plans to rating reforms, small group reforms, and community rating. Only Maine, New Jersey,

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Table 1

Summary of Major State Health Reform Initiatives: February 1995

States	Insurance Reform	State Purchasing Alliances	1115 Waiver	Universal Coverage Law	Expanded Coverage for Children
Alabama	X	X			
Alaska	X				
Arizona	X		X		
Arkansas	X				X
California	X	X			X
Colorado	X				X
Connecticut	X				X
Delaware	X		Submitted		
Florida	X	X	X	X	X
Georgia	X				
Hawaii			X	X	
Idaho	X				
Illinois	X		Submitted		
Indiana	X				
Iowa	X	X			
Kansas	X				
Kentucky	X	X	X	Incremental	
Louisiana	X		Submitted		
Maine	X			Study underway	X
Maryland	X				
Massachusetts	X	X	Submitted	X	X
Michigan					X
Minnesota	X	X	Submitted	X	X
Mississippi	X	X			
Missouri	X	X			
Montana	X			Study underway	
Nebraska	X	X			
Nevada	X				
New Hampshire	X		Submitted		
New Jersey	X				
New Mexico	X	X			
New York	X				X
North Carolina	X	X			
North Dakota	X				
Ohio	X		X		
Oklahoma	X	X			
Oregon	X		X	X	
Pennsylvania					X
Rhode Island	X		X		X
South Carolina	X	X	Planning phase approved		

See note at end of table.

Table 1—Continued

Summary of Major State Health Reform Initiatives: February 1995

States	Insurance Reform	State Purchasing Alliances	1115 Waiver	Universal Coverage Law	Expanded Coverage for Children
South Dakota	X				
Tennessee	X		X		
Texas	X				
Utah	X			Incremental	
Vermont	X			Study underway	X
Virginia	X				
Washington	X	X		X	X
West Virginia	X				
Wisconsin	X				
Wyoming	X				

SOURCE: Riley, T., National Academy for State Health Policy, 1994.

New York, and Vermont have implemented some form of comprehensive community rating, however.

State purchasing alliances include only those alliances that have been created and/or funded by the State and therefore do not include the many private, more localized alliances.

States identified with "universal coverage laws" are those that have enacted laws aimed at securing health insurance coverage for all citizens and include those States that have developed a more phased or "incremental" approach as well as those that have recently enacted laws requiring a study of how to achieve universal reform.

"Expanded coverage for children" includes initiatives that are State financed. Although States have expanded Medicaid to serve large numbers of children, pursuant to recent Federal eligibility reforms, a number of States have also developed their own children's health plans, often in collaboration with privately financed initiatives such as the Blue Cross Associations' Caring programs, which exist in 16 States. An additional 14 States have State-funded programs to provide health care for children not otherwise eligible for Medicaid (Butler, Mollica, and Riley, 1993).

Finally, the table lists those States that have secured or are seeking section 1115 waivers to allow them to overhaul Medicaid programs. Generally, States seeking these waivers do so in order to expand coverage of the uninsured while assuring budget neutrality. Most waivers include revisions to financial and other eligibility standards to make more of the uninsured eligible, expansion of the use of managed care, and modification of coverage of certain health clinics and of disproportionate-share payments to hospitals (Rosenbaum and Darnell, 1994).

Although much attention has been given to recent State interest in 1115 waivers, these waiver requests must be understood in light of the considerable activity of State health reformers over the last decade. Early reforms by States focused largely on insurance reform and efforts to assist small employers and individuals to afford coverage. Some States sought more comprehensive reforms aimed at achieving universal access to coverage and care. But those approaches to reform have been stymied by two critical factors. First, absent congressional action to create changes in the Employee Retirement Income Security Act (ERISA), States have insufficient authority

to generate revenues and enact reforms that cover all. Specifically, ERISA prohibits States from regulating or, it would appear, taxing self-insured companies whom ERISA exempts from State mandates. As only about 24 percent of health care is paid by private health insurance that is regulated by the State (U.S. General Accounting Office, 1993), States cannot "level the playing field" by applying reforms equally to those insurers who are regulated by the State and those who are not. Even if these impediments were removed by Congress, States still face the fury of multistate businesses, which strenuously object to different coverage requirements imposed by different States, and to consumer advocates who worry about portability and continuity of coverage should States be given a free hand in determining what coverage will be available in each jurisdiction.

Second, States have an insufficient financing base to fully achieve reform. With ERISA prohibitions, efforts to generate revenues from self-insured businesses fail, and there is little enthusiasm in States to support any kind of broad-based tax increases.

Indeed, most States must balance their desire to develop health reform against the continuing struggle to reduce the cost of government. Because Medicaid today comprises 18 percent (on average) of total State spending (National Association of State Budget Officers, 1994), bringing down its costs and improving its efficiency are high priorities for State governments. Finally, as the new Congress convenes with promises of further reductions in Federal programs, States must consider the impact of those reductions on their expenditures and service demands.

It is in this environment of restrained authority over health care reform and financing and growing concern over State budgets that Medicaid reform finds its audience. Absent Federal reform, States have few tools available to them to address the growing problem of health care costs and increased numbers of uninsured. Although many States can do more with existing programs and policies, the States in the vanguard of reform have little more they can achieve without Federal reforms. Medicaid has become the primary vehicle, then, for State-based reform.

States have been creative in maximizing the use of the Medicaid program, in part because its financing is shared between the Federal and State governments so that, on average, for every $43 a State puts up, Federal financial participation is $57. The amount of Federal participation varies by State.

Medicaid was enacted in 1965 to provide health coverage for the Nation's poor in a partnership between the State and Federal governments. Although the program now provides comprehensive coverage for more than 1 in 10 Americans, last year covered about one-third of all births, and is run efficiently by the States with an administrative expense of less than 4 percent of total outlays, it has not yet achieved its promise of full health coverage of the poor. Many in Congress are quick to criticize the program, blaming the States for its problems. Indeed, Medicaid today serves only about 60 percent of the poor, pays providers significantly less than they receive from private payers, and its services are not always available (Rosenbaum and Darnell, 1994).

But the roots of Medicaid's shortcomings can be traced largely to a failed partnership between the Federal and State governments. No process exists for States to negotiate the scope of the program. Rather, Congress enacts requirements in the law and expects the States to pay a part of them,

arguing that without Federal standards States would not provide needed coverage.

Congress created an entitlement program and enacted rigid, welfare-based eligibility requirements for it. That is, under current law, an individual or family deemed eligible for Medicaid is entitled to a wide range of medically necessary services. States must generally provide the same scope and duration of services to all eligible groups and must provide all services mandated by the Federal Government. The Federal Government even requires that certain professions be reimbursed by Medicaid. Thus, financially strapped States, which must produce balanced budgets, have little discretion over services and providers covered and often have been forced to find savings through limiting provider reimbursement or limiting the scope of eligible beneficiaries. Congress argues that, left on their own, States would sacrifice program goals for their budget objectives.

To receive Medicaid, individuals must either meet prescriptive asset and income tests to qualify for a welfare program or prove that they have spent so much ("spend-down") on health care so as to become poor, although they do not actually qualify for a welfare check. Because welfare is limited to those who qualify under Aid to Families with Dependent Children or Supplemental Security Income (SSI), and Medicaid is available primarily to those groups, the program is not now available to many low-income persons. Forty percent of the poor do not qualify for Medicaid (Rosenbaum and Darnell, 1994).

Certainly States have discretion to establish the rate of welfare payments and to determine whether or not to allow those who "spend down" to qualify for Medicaid. Because of that discretion, there is variation in eligibility from State to State and resentment from some in Congress that some States are too restrictive in coverage. Much of the variation in coverage has been minimized by the congressional mandates of the 1980s, however. But because States must provide the full range of Medicaid benefits to broad groups of eligibles, they have had few acceptable options to limit their financial exposure. And because the Medicaid program has grown to become the first or second largest part of State budgets, States grow increasingly concerned about those costs.

When States have found ways to increase revenues for the underfinanced Medicaid programs, those mechanisms often have been deemed "loopholes" in the law, and HCFA and the Congress have worked to close them. The rage of "Medicaid maximization" during the recession of the 1980s and more recent use of provider taxes and donations and disproportionate-share hospital payments to providers with large concentrations of low-income beneficiaries are examples of such State activities. To be certain, some States were overzealous in their attempts to gain more Federal financial participation and went far beyond efforts to enhance the Medicaid program, using these financing schemes to bail out strapped State budgets.

Far from being a partnership, however, State and Federal relations concerning Medicaid are often strained. Little negotiation occurs about how the Federal-State "partnership" should work. Some argue that the Medicaid program requires a complete overhaul because it has not been systematically reviewed and fundamentally altered since its inception. Others, notably States, fear what they see as the heavy hand of the Congress and seek instead to use waivers of Federal regulations to experiment with ways to redesign the Medicaid program. And, while the new Republican Congress in its Contract with

America promises to end unfunded mandates, it is still unclear how the Medicaid program will be treated.

RISE OF 1115 WAIVERS

Throughout the 1980s, States began to reform their Medicaid programs by expanding their use of managed care. These initiatives were taken largely through the provisions of section 1915 waivers that allow States to limit beneficiary freedom of choice of providers and to build managed-care systems for Medicaid beneficiaries. From those early efforts, States became aware of the potential of managed care to improve access, retain quality, and reduce costs of the program. But the 1915 waiver authority was limited.

Arizona's use of section 1115 waiver authority to create a statewide Medicaid managed-care program gained attention, and States began to consider this research and demonstration authority as a vehicle for more expansive reforms. As States became increasingly involved in health reform, and as the cost of Medicaid grew while still leaving out large segments of the poor, States grew more sophisticated in their deliberations of how to restructure the Medicaid program to serve more of the poor and to better control escalating costs.

The controversy surrounding Oregon's 1115 proposal brought further attention to those waivers. As part of a comprehensive approach to assure that all citizens had access to similar benefits, Oregon enacted legislation that would establish a standard benefit to be available to all Oregonians and proposed to redesign their Medicaid program to provide such a standard benefit to all those living in poverty. To do so, Oregon proposed that it be allowed to design the benefit package based upon a "prioritized list" of health services and greatly expanded its use of managed care for Medicaid beneficiaries. Oregon argued that it is better to provide all of the poor with a solid benefit of effective services than to provide only some of the poor the comprehensive benefits currently afforded by Medicaid. Further, Oregon proposed to resolve a major problem plaguing Medicaid—low rates of reimbursement to providers—by assuring through its waiver that providers would be paid for the costs they incurred.

The Oregon waiver request was subjected to intensive review by the Federal Government, rejected by the Bush administration, and negotiated, finally revised, and approved by the Clinton administration. The approval process was a costly and onerous one, prompting the Clinton administration to negotiate with the National Governors' Association and develop a set of principles to improve the process for future State applicants while still assuring a careful Federal review.

Since the Oregon proposal, a total of six States have sought and received 1115 waivers for comprehensive health reforms. A seventh State, South Carolina, has received approval for a planning phase to develop the framework of its waiver application and meet certain milestones before a formal waiver will be authorized.

States seek these waivers for a variety of reasons. For some, such as Oregon, Hawaii, and Florida, the waiver is part of a comprehensive plan to establish universal coverage and is a piece of a broader initiative that includes efforts to increase private sector coverage as well. For others, such as Rhode Island, the waiver is a first step toward reform, providing more managed care, expanding coverage for some uninsured, providing the capacity to buy low-cost coverage for certain individuals not eligible for Medicaid, and developing a clear

set of anticipated health outcomes. Rhode Island has clearly used the waiver to integrate public health principles and expand coverage of preventive services. Each of these waivers anticipates Medicaid cost savings through managed care, which are then used to finance expanded eligibility.

For some, such as Tennessee, the 1115 waiver was also seen as a vehicle through which a State could retain dollars that had been spent on disproportionate-share hospital payments. When the Federal Government restricted State capacity to draw down additional Federal dollars, States that had invested heavily in those initiatives were eager not to lose those investments. States such as Tennessee had maximized the use of disproportionate-share payments—payments made to hospitals with large amounts of indigent care—by using State payments to public hospitals to match Medicaid. Because the disproportionate-share payments were driven by a formula payment and not based upon actual billing, some States were able to realize what the Federal Government perceived as a windfall. The Omnibus Budget Reconciliation Act (OBRA) of 1993 limited future disproportionate-share payments to the actual costs of uncompensated inpatient care. Thus, if States such as Tennessee sought an 1115 waiver prior to implementation of OBRA 1993, they could include all the disproportionate payments or their equivalent costs in the base upon which their waiver costs would be calculated. Because an approved 1115 waiver locks the Federal Government into paying for the current base of expenditures plus inflation for 5 years, some States seek 1115 waivers hoping to lock in current spending. Whether or not such a "lockin" of Federal funds under waivers will continue depends on the outcome of the current congressional debate.

With these waivers, States have already been able to cover hundreds of thousands of new eligibles—people who were previously uninsured. States are interested in pursuing the 1115 waiver process, then, because it provides an opportunity to experiment with new, more flexible benefit packages and eligibility criteria that are established by the State, not the Congress, to:

- Bring in large numbers of previously uninsured.
- Institute beneficiary cost sharing.
- Develop new provider networks and reimbursement strategies.
- Restrain and make predictable program growth in order to afford increased payments to providers and/or additional coverage of uninsured.
- Potentially lock in Federal financial participation for 5 years or more. As the new Congress seeks to make significant reductions in Federal outlays, waivers may provide some predictability of program growth.

As Arizona's 1115 waiver, approved for 5 years, is now in its 15th year, waivers are viewed as having more permanence than only for the period of the demonstration. If a waiver were achieving its goals of increasing access, assuring quality, and restraining costs after the 5 years of a demonstration, HCFA would be hard pressed to require the State to return to its former Medicaid program. Yet no formal process exists for transition of successful waivers to permanent policy except, it would seem, by seeking legislative authorization.

The review and approval process to secure a waiver from HCFA is a rigorous one in which conditions are often imposed. But States tend to perceive the 1115 waiver as a worthy pursuit, for it provides them with the authority they have felt lacking to structure their Medicaid programs in a way

that will serve more of the uninsured, protect the poorest of the poor, and provide more control over budget increases.

It is likely that more States will seek 1115 waivers in the face of a proposed Medicaid cap. Governors have historically resisted block granting of Medicaid, which would give them much wanted discretion over program design, because they fear an entitlement for which the Federal liability would be limited but the States' would not. If Medicaid Federal spending is capped but the States' obligation is not, States will be left with enormous expenses they cannot meet. Moreover, the Congress could enact major changes in Medicaid that would restrict what the program could pay for, similar to recently announced proposals to limit what the Federal SSI program could support. As a result, States are turning to the 1115 waiver program as a vehicle to secure a more predictable future and more control over the program and to assure their role as equal partners in the Medicaid program, not just as partial payers of the bill.

Perhaps because of their experiences with 1115 waivers, governors have recently seemed more receptive to block grants and the opportunities they provide for State discretion potentially even beyond that allowed by Medicaid waivers.

IMPACT OF 1115 WAIVERS

State Medicaid agencies experience significant change both through the 1115 waiver process itself and through the program redesigns the waiver allows. That is, many State agencies that move aggressively to managed care using 1915 waivers will experience some of the same new demands as 1115 States. It is the conversion from fee for service that accounts for the administrative change necessary to turn from a claims payment operation to one of managed-care contracting. But unlike 1915 waivers, 1115 waivers are usually more complex to design and construct. They require a clearly articulated research and demonstration component, and they require the State to think differently in order to accommodate non-Medicaid eligibles within the program. Thus, the planning and administrative requirements to support an 1115 waiver request are significant. States often engage outside consultants, whose costs often run to the hundreds of thousands of dollars, to help them through the process.

The 1115 process has broader and significant implications that change the scope of the Medicaid program and require increased sophistication of Medicaid agencies. The waiver allows Medicaid to move beyond its role as a payer to think broadly about the health system and how Medicaid can be the base for coverage for the uninsured. For the first time, the 1115 waiver process allows States to achieve their long-sought-after goal of breaking from a welfare-based system to a system of health coverage for all, or at least for all who are now uninsured. As such, considerable work needs to be done to determine how to make the eligibility determination easier and to break it from the welfare model. Although no State has yet sought to wholly redesign eligibility and eliminate completely the asset and resource testing for all current beneficiaries, States are learning much from procedures being developed to make eligible the poor who were previously excluded from Medicaid. Indeed, in Oregon, new eligibles may submit applications by mail, freed from onerous resource and asset testing requirements.

States also need to develop methods to include cost-sharing provisions for new eligibles. But because the waiver is only a demonstration, Medicaid agencies still

need to continue much of their current Medicaid operation and retain some parallel functions. This is particularly true if States do not include all their Medicaid population in the waiver design.

Because most States use 1115 to expand Medicaid eligibility to more of the poor, financed by savings accrued from converting from a fee-for-service system to managed care, it is this transition to managed care that has the greatest impact on States.

First, States need to assure that sufficient managed-care capacity exists or can be developed and must negotiate with plans for coverage of these new enrollees. Such negotiation and the development of effective contracts with plans take skills often not found in a traditional Medicaid program. Waivers also require strict compliance with budget neutrality provisions and require considerable financial expertise to develop appropriate capitation rates for Medicaid beneficiaries, many of whom are perceived to be high risk and costly by managed-care plans. Careful consideration of special-needs populations needs to be assured. If those populations are to be included as eligible beneficiaries, and not "carved out" of managed care, plans must have the capacity to meet those needs. In some instances the Medicaid program has developed more capacity than private sector plans to meet special needs. For example, the social services and benefits provided under Medicaid, such as mental health services, are often in excess of services provided by traditional commercial plans. Oversight and training of commercial plans need to be assured if these populations are to be guaranteed the level and types of services they require and have received under traditional fee-for-service Medicaid.

As States convert Medicaid to managed care, traditional relationships with providers must change. Instead of a payer and regulator of providers, Medicaid agencies now need to see themselves as partners with health plans, negotiating for services required by their beneficiaries. Contracts between State Medicaid agencies and plans and those, in turn, between plans and providers are critical components of assuring quality care and must be skillfully negotiated. Medicaid agencies must also become aggressive payers negotiating with plans for comprehensive care for their clients at capitated payments that will meet the cost of care and assure compliance with the budget neutrality requirements of the waiver. Establishing those rates is a difficult task, made more complicated as more and more beneficiaries enroll in managed care, thereby diminishing the fee-for-service base from which capitation rates have been historically set.

Other traditional functions of Medicaid such as claims processing, provider audits, surveillance and utilization review, fraud investigation, and enrollment are fundamentally altered or eliminated. But new functions are required as well, such as more comprehensive, outcomes-based quality assurance, ratesetting and capitation design, culturally sensitive education and enrollment that maximizes consumer choice, and consumer grievance systems. Systems for monitoring and data collection that guarantee accountability and provide needed and reliable documentation for ratesetting also must be put in place. Data must be reliable, and policymakers must be skilled in using those data appropriately.

Under these 1115 waivers, States must redirect their Medicaid agencies to take on new functions, collect and analyze more and better data, and reach and serve a newly entitled population of beneficiaries. To do so, they often turn to consultants for help and find that considerable training needs exist within their own staffs. Efforts to reorganize, retrain staff, hire consultants, and purchase needed computer and actuarial

assistance are difficult in a civil service system that is generally unionized and operates within constrained State budgets. States may underestimate the time, training, and other investments that Medicaid conversion to managed care and administration of 1115 waivers may require. States are justifiably proud that they administer the complex and massive Medicaid program with an average administrative cost of 4 percent. However, as Medicaid takes on the new challenges inherent in most 1115 waiver proposals to increase access and retain quality, needed and useful administrative costs may need to be incurred. If not carefully tracked and justified, these additional costs could have political implications in the future, particularly given the importance the Federal Government holds to the standard of assuring budget neutrality and cost savings within the waiver programs.

Through 1115 waivers, States and the Federal Government are changing their historic relationships with each other, providing States more authority to direct the program and changing fundamental aspects of the Medicaid program itself. Some skeptics of the waiver programs raise concerns that the poorest of the poor are now served by the traditional Medicaid program and that those individuals could see services erode as Medicaid expands to cover more of the uninsured. Some fear that States, motivated by cost constraints, will restrict needed services. They caution that managed care cannot achieve projected savings over time and worry that existing safety net providers will be lost as Medicaid moves too quickly to managed care. Issues of how budget neutrality can be sustained are often raised, particularly in light of studies that question the true savings that can be realized by managed care.

The Medicaid program has been a principal payer for long-term care and for assisting people with physical and mental disabilities and chronic illnesses such as acquired immunodeficiency syndrome. Increasingly, States are turning their attention to these populations and seeking waivers to include them in managed-care settings. But is there sufficient experience among managed-care entities to meet the needs of these special populations? Finally, waivers beg the question of what is the appropriate locus for health reform. Is it sound policy to use the Medicaid program as a base for covering the uninsured?

States respond that they are aware of these concerns and address them within their own policy deliberations and with HCFA during negotiation over the waiver approval. Moreover, waivers provide a vehicle for an incremental approach to health reform, absent major Federal action. They provide the laboratories of innovation from which policymakers may draw conclusions and build larger scale reforms. Indeed, waivers allow States considerable discretion but retain a strong requirement for Federal oversight and generally include conditions from the Federal Government that States must satisfy. Finally, the waiver authority is rooted in research and demonstration and requires an outside evaluation of every waiver.

As HCFA and the States build their waiver programs they, together, venture into uncharted territory. Lessons are being learned that make clear the need for flexibility and revisions to make these incremental health care reforms succeed. But in the final analysis, both the State and Federal governments and the outside evaluators with whom they contract have a singularly important responsibility to evaluate the waivers against the tests of equity, quality, and effectiveness for the citizens for whom the waivers promise coverage and access to quality care.

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