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Insuring the Poor Through Section 1115 Medicaid Waivers

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Prologue:

Medicaid, the federal/state program of health insurance for the poor and disabled, accounted for 20 percent of states' spending in 1994, according to the National Governors' Association. Of the program's more than thirty million nonelderly beneficiaries, one-quarter are in managed care plans. That number has grown recently because of states' use of Section 1115 waivers, which are designed to allow states to develop “innovative solutions to a variety of health and welfare problems,” as long as these solutions do not add to the federal spending share. So far eight states have gained approval from the Health Care Financing Administration to implement 1115 statewide demonstrations. As of this writing, five states hav actually implemented their programs. These states are using various managed care models, ranging from primary care case management plans to staff-model health maintenance organizations (HMOs). In this paper John Holohan and his colleagues estimate the potential impact of these demonstrations on the number of poor persons who gain coverage and the impact on federal and state spending. Medicaid is currently under attack by budget-conscious lawmakers, who seek to gain as much as $ 190 billion in savings from the program over the next five to seven years. Many believe that more widespread use of managed care in Medicaid will enable the program to hold down the rate of increase in its costs, thereby easing pressure on the federal budget. “Given the absence of federal action on health care reform,” the authors write, “using Medicaid as a building block for reform is a positive development. “ Holohan is director of the Health Policy Center at The Urban Institute in Washington; Teresa Coughlin and Leighton Ku are senior research associates there, and Shruti Rajan is a research associate. Debra Lipson is associate director of the Alpha Center, also in Washington.

Abstract: With the demise of health care reform at the national level, much of the attention has shifted to state-level efforts. Recently, several states have begun looking to the Medicaid program as a way to solve their health care problems. A principal way in which states are implementing health care reform is through the Section 1115 research and demonstration Medicaid waiver program. The 1115 waiver authority provides states considerable flexibility to restructure their Medicaid programs to offer health care to new populations and thus has great potential for covering large segments of the uninsured population. While it shows great promise, however, there are many obstacles states must overcome both in implementing and in maintaining an 1115 program.

Topics:
Medicaid | Managed care | Premiums | Uninsured | Payment | Costs and spending | Disproportionate-share hospitals | Medicaid eligibility | Access to care | Health care providers

NOTES

Qualified Medicare beneficiaries are aged and disabled Medicare beneficiaries whose income is at or below 100 percent of poverty and whose resources are at or below 200 percent of the Supplemental Security Income (SSI) limit. Medicaid is required to pay Medicare premiums and cost sharing for these persons.

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Tennessee's creation of TennCare was triggered by the state's inability to enact a broad-based hospital tax for its disproportionate-share program, as required by 1991 federal legislation. It used a waiver program to retain the federal funds for disproportionate-share hospital payments that otherwise would have been lost. More recently, the Omnibus Budget Reconciliation Act (OBRA) of 1993 provided that disproportionate-share payments to any individual hospital could not exceed that hospital's Medicaid underpayments and uncompensated care costs. Disproportionate-share hospital payments were so large in some states that they could not meet this criterion at current spending levels and would, therefore, lose federal revenue without approval of a waiver program.

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With the rapid development of Section 1115 waiver programs by many states, it seems clear that states are indeed attracted to this mechanism. The discussion in this section largely pertains to very broad expansions of coverage to low-income groups.

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There are many reasons why many persons may remain uninsured after reform. These include the following: The scope of the reform may be modest, enrollment may be capped, outreach may be weak, participation may be voluntary, or premiums may be viewed as too high.

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