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MEDICAID

Statewide Section 1115 Demonstrations' Impact on Eligibility, Service Delivery, and Program Cost

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SUMMARY

The growth of Medicaid, which accounted for $142 billion (federal and state) in 1994, is outpacing even Medicare. This is happening at a time when many states are feeling pressured financially and are seeking ways to provide care to their uninsured populations. In response, states are, one by one, reinventing their Medicaid programs, using the authority of section 1115 waivers. This phenomenon illustrates the difficulty of controlling Medicaid costs under the current program structure.

MEDICAID CONSUMES GROWING SHARE OF FEDERAL BUDGET. In 1994, federal and state governments spent $104 billion more on Medicaid than they did a decade previously. Currently, Medicaid consumes about 6 percent of all federal outlays--3 times the share devoted to Food Stamps and 5 times the share devoted to Aid to Families With Dependent Children.

STATES SEEK SECTION 1115 WAIVERS TO CONTAIN COSTS AND EXPAND COVERAGE. Section 1115 waivers free states from certain Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to individuals not normally eligible for Medicaid. Since 1993, the Health Care Financing Administration (HCFA) has approved for implementation 10 statewide demonstration waivers: Oregon, Hawaii, Kentucky, Tennessee, Rhode Island, Florida, Ohio, Massachusetts, Minnesota, and Delaware. Another 13 states either have submitted applications or have held discussions with HCFA about statewide demonstrations.

While HCFA has agreed to waive Medicaid's restrictions on states' use of managed care, the terms and conditions of section 1115 waivers do require states to operate alternative quality assurance systems and collect medical encounter data so they can monitor service use and access. Several states are also expanding their Medicaid programs by providing benefits to individuals who would not normally qualify for them. According to the documents states submitted to obtain waivers, almost 3 million new beneficiaries could be added in the 10 states with waivers approved since 1993.

SECTION 1115 DEMONSTRATIONS COULD INCREASE FEDERAL SPENDING. Our analysis suggests that some approved statewide section 1115 demonstrations may not be budget neutral and that the granting of additional waivers merits further scrutiny for the following reasons: (1) The administration is allowing states to apply the federal share of Medicaid savings from managed care to finance coverage of additional populations not included under Medicaid law. (2) The administration's method for determining budget neutrality may allow states access to more federal funding than they would likely receive without the waiver. (3) The Congress may find it difficult to scale back section 1115 demonstrations if they prove more costly than forecast.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the implications of states' efforts to reinvent their Medicaid programs through the authority granted under section 1115 waivers. Our April 1995 report on Medicaid spending pressures provides details on this subject.[1] In it, we examine (1) federal and state Medicaid spending trends, (2) states' efforts to contain Medicaid costs and expand coverage through waivers of certain federal requirements, and (3) the potential impact of the waivers on federal spending.

As you know, the growth of the Medicaid program, on which federal and state governments spent $142 billion in 1994, outpaces that of most major items in the federal budget, including Medicare. Without some modification, spending could double in the next 5 to 7 years. Medicaid is also the fastest growing component in most state budgets at a time when states are feeling pressured by many financial constraints and when many are looking for ways to provide care to their uninsured populations.

In response, states are one by one reinventing their Medicaid programs under the authority of section 1115 waivers. Named for section 1115(a) of the Social Security Act, these waivers free states from certain Medicaid restrictions on the use of managed care delivery systems. They also allow states to expand Medicaid-financed coverage to individuals not normally eligible for Medicaid. For example, Tennessee's waiver program, in operation since January 1994, has expanded coverage to an additional 438,000 individuals who were not previously eligible under the state's traditional Medicaid program.

In essence, requiring states to obtain federal waiver approval in order to pursue their managed care strategies is burdensome and may hamper their cost containment efforts. Furthermore, allowing the waiver process to be used to expand coverage to hundreds of thousands of additional individuals without the consultation and concurrence of the Congress appears inappropriate. The result of these waivers could lead to a heavier financial burden on the federal government.

In this statement I will present a more detailed look at Medicaid's growing expenditures, describe states' efforts to obtain section 1115 waivers, and summarize the expenditure forecast of programs operating with waivers.

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

MEDICAID CONSUMES GROWING SHARE OF FEDERAL BUDGET

In 1994, federal and state governments spent $104 billion more on Medicaid than they did a decade previously. Currently, Medicaid consumes about 6 percent of all federal outlays--3 times the share devoted to Food Stamps and 5 times the share devoted to Aid to Families With Dependent Children. The Congressional Budget Office projects Medicaid's annual growth rate at over 10 percent for the next several years. Medicaid has also grown rapidly in size. In 1994, Medicaid served more than 35 million beneficiaries, which was an increase of more than 13 million beneficiaries since 1984.

Creative financing approaches used by states to leverage additional federal dollars contributed to the cost growth in recent years. Part of each approach involved making payments to hospitals that served a disproportionate share of Medicaid and other low-income patients. These federal and state payments exploded from a few hundred million dollars in 1989 to over $17 billion in 1992. Although legislation has limited the growth of these payments to disproportionate share hospitals since 1993, the gaming of these payments in some states has both increased the level and affected the distribution of current and future Medicaid spending. States now seek section 1115 waivers, which can allow disproportionate share payments to be built their programs' baselines and then to be redirected to other uses. There is a risk that these waiver agreements will allow the statutory limits on disproportionate share payment growth to be implicitly exceeded in some states.

Other factors also worked to increase Medicaid costs: more beneficiaries, medical inflation, and higher utilization of services. Although many of the new beneficiaries were pregnant women and children made eligible by congressional mandates enacted since 1984, the addition of this group played a less significant role in increasing Medicaid costs because these individuals are relatively inexpensive to serve. While medical inflation is currently much lower than before, the number of elderly and individuals with disabilities receiving Medicaid benefits continues to grow rapidly. While this is a relatively small group, it accounts for a large share of program cost--about two-thirds of Medicaid dollars go to one-fourth of the beneficiaries.

STATES SEEK SECTION 1115 WAIVERS TO CONTAIN COSTS AND EXPAND COVERAGE

To deal with pressures to contain costs while confronting the problem of the uninsured, a number of states are turning to section 1115 waivers. These waivers address states' needs in two ways: they allow states greater flexibility to test such cost containment strategies as capitated managed care, and they allow states to expand program eligibility beyond traditional Medicaid populations. Since 1993, the Health Care Financing Administration (HCFA), which

oversees the Medicaid program, has approved for implementation 10 statewide demonstration waivers: Oregon, Hawaii, Kentucky, Tennessee, Rhode Island, Florida, Ohio, Massachusetts, Minnesota, and Delaware.[2] However, only four states--Oregon, Hawaii, Tennessee, and Rhode Island--have statewide demonstration programs operating, and only Tennessee's and Oregon's programs have been in operation for a full year.[3] Another 13 states either have submitted applications or have held discussions with HCFA about statewide demonstrations.

These section 1115 waivers allow states to contract with managed care organizations that enroll few or no private patients. In other words, the "75-25 rule" has been waived. This rule stipulates that, to serve Medicaid beneficiaries, 25 percent of a plan's total enrollment must consist of private-paying patients. The principle behind this restriction is that a health plan's ability to attract private enrollees can serve as one assurance of quality.

The waivers also permit states to require beneficiaries to enroll in their health plans for longer periods than Medicaid typically requires. Allowing beneficiaries to choose to disenroll, as normally permitted by Medicaid, makes managed care organizations' planning for financial stability difficult and, therefore, makes the enrollment of Medicaid beneficiaries less attractive.

Medicaid's restrictions on states' use of managed care reflect historical concerns over quality. In the 1970s, reports on quality of care problems in Medicaid managed care prompted the Congress to enact certain provisions to improve quality assurance. States believe that the 75-25 rule and Medicaid's prohibition against locking enrollees into a plan for an extended period unduly hamper their efforts to contract with managed care networks. While HCFA has agreed to waive some of the traditional requirements aimed at ensuring managed care quality, the terms and conditions of section 1115 waivers require states to operate quality assurance systems and to collect medical encounter data to make evaluations of service use and access possible.

In addition to implementing widescale managed care, several states are also greatly increasing the scope of their programs by providing benefits to individuals who would not normally qualify for them. According to the states' initial waiver proposals, a

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[2]Listed in order of waiver approval.

[3]See Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, Mar. 23,1995) for a discussion of the barriers to obtaining and implementing a section 1115 waiver.

total of almost 3 million new beneficiaries could be added in the 10 states with waivers approved since 1993. If similar coverage expansions are approved for more and bigger states, the federal government (as well as the states) could be providing health insurance for millions more beneficiaries.

SOME STATES' SECTION 1115 DEMONSTRATIONS COULD INCREASE FEDERAL SPENDING

Section 1115 waivers, while freeing states to implement managed care cost containment strategies, could in the long run undermine efforts to contain federal expenditures. Our analysis disputes the administration's assertion that all the approved statewide section 1115 demonstrations are budget neutral. It suggests that the granting of additional section 1115 waivers merits further scrutiny for the following reasons:

-- The administration is allowing states to apply the federal share of Medicaid savings from managed care to finance coverage of additional populations not included under Medicaid law. The administration and states assume that the enrollment of the Medicaid populations in capitated managed care will save states enough money to cover additional low-income people at no extra cost to the federal government. Even if the proposed demonstrations will not require new federal dollars, the administration's approval of coverage expansions means that anticipated Medicaid cost savings (from more aggressive use of capitated care) will not be used to reduce federal spending. At issue is whether or not the federal treasury should benefit from these savings and eligibility be made available for new groups only after congressional debate and legislative action.

-- The administration's method for determining budget neutrality may allow states access to more federal funding than they would have received without the waiver. Our examination of four states' proposed demonstrations suggests that claims of budget neutrality for these states may not be sustainable in all cases. While Tennessee's demonstration project may be budget neutral, the demonstrations in Florida, Hawaii, and Oregon may require increased financial commitment from the federal government. Relative to overall Medicaid spending, the amount of new federal dollars spent in states with approved section 1115 waivers is small. However, the methods used by the administration to assess the budget neutrality of pending and future waiver proposals may greatly affect federal Medicaid spending in the years to come.

-- The Congress may find it difficult to scale back section 1115 demonstrations if they prove more costly than forecast. A demonstration waiver, granted for a limited period, may be a shortsighted approach to reducing states' uninsured populations. If at the end of 5 years the demonstrations have cost much more than estimated, the Congress may face the choice of increasing federal funding or relying on the states to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers.

CONCLUDING OBSERVATIONS

Over 35 million Americans--not only poor mothers and children, but also poor elderly, blind, and disabled individuals--depend upon health care made possible by the Medicaid program. However, the program's projected double-digit spending growth rate imperils efforts to bring the federal deficit under control. Consistent with the Subcommittee's interest in constraining federal spending, states believe they need the flexibility to manage their respective programs. Requiring states to obtain waiver approval to aggressively use managed care strategies may hamper their cost containment efforts. Yet, because current program restrictions on managed care were designed to reinforce quality assurance, in the absence of these restrictions, continuous oversight of managed care systems is essential to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses. Finally, we believe that the potential for increased federal spending under future statewide demonstrations warrants close scrutiny of the section 1115 waiver approvals.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or the other Subcommittee members may have.

For more information on this testimony, please call William J. Scanlon, Associate Director, at (202) 512-4561. Other major contributors included James Cosgrove, Hannah Fein, Walter Ochinko, and Alfred Schnupp.

APPENDIX I

RELATED GAO PRODUCTS

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, Apr. 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, Mar. 23, 1995).

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

Health Care Reform: Potential Difficulties in Determining Eligibility for Low-Income People (GAO/HEHS-94-176, July 11, 1994).

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

Medicaid: Data Improvements Needed to Help Manage Health Care Program (GAO/IMTEC-93-18, May 13, 1993).

Medicaid Formula Alternatives (GAO/HRD-93-18R, Mar. 31, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

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