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New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility?

By Cindy Mann and Samantha Artiga

Executive Summary

Many of the changes adopted in Medicaid in recent years reflect broader market trends. A few recent state Medicaid initiatives have emerged, however, that take the program into new directions. States have expressed a number of objectives in developing these approaches, including offering beneficiaries greater choice, promoting personal responsibility and healthier behaviors among enrollees, and, in some cases, relying more heavily on the private marketplace. In addition, states have sought to shape their initiatives in ways that could help them better predict and limit their exposure to costs.

These initiatives are different in important ways, but they share a common element that has often been overlooked as other aspects of these plans are debated: they restructure the program in ways that allow states to place new limits on their responsibility for certain costs and medical care. This brief examines how these approaches change financial risk and responsibility for states, the federal government, beneficiaries, and providers.

New Initiatives to Limit State Costs and Responsibilities

- ***Defined contribution.*** Florida has a Section 1115 waiver that converts the acute care side of its Medicaid program from a defined benefit to a defined contribution approach. Under a defined benefit approach (i.e., regular Medicaid program rules), a state must cover a certain set and scope of benefits. By contrast, under a defined contribution approach, the state's obligation is limited to a pre-determined premium or allotment level for each person. Under Florida's waiver, the state will offer participating plans risk-adjusted premiums (i.e., "the defined contribution") and allow the plans discretion to design benefits within certain state standards and to control utilization. Adults (including those with a disability or chronic illness, but not pregnant women) will also be subject to an annual maximum benefit limit. The state's goal is to attract a sufficient number of plans that will offer varying benefit packages that meet the diverse needs of Florida's beneficiaries, but the state assumes no residual responsibility if the defined contribution, the annual benefit cap, or the plans' benefit packages are insufficient to meet medical needs that arise over time. Like most section 1115 waivers, federal funding under the waiver is limited by a per person cap.

1330 G Street NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
Website: www.kff.org

- ***Capitated payments and broad new flexibility.*** Under a new waiver in Vermont, federal funding is subject to an overall ("global") cap as well as per person caps. The state has new authority to limit its responsibilities and exposure to costs by reducing benefits, increasing cost sharing, and capping enrollment, subject to some requirements. Currently, the state does not have plans to make these changes, but the fiscal incentives built into the waiver could encourage such action, because the state can use federal Medicaid funds it does not spend on Medicaid services for other purposes.

- ***"Tiered" benefits.*** A few states (Idaho, Kentucky, and West Virginia) have changed their programs under the new authority provided by the Deficit Reduction Act of 2005 to create "tiered" benefits. The general approach is to divide enrollees into groups and provide different benefit packages to each group. People assigned to a healthier group will have more limited coverage than people in other groups. States adopting this approach limit their liability because, to some degree, benefit package assignments, rather than actual medical need, set the outer boundaries for state costs. Those with health care needs that exceed the limits of coverage for their assigned group may not be covered for the medical care they need.

New Risks States May Bear Under these Approaches

Although these new approaches could insulate states from certain costs, they may also expose them to other costs and new fiscal pressures.

- ***States are at risk for costs beyond waiver caps.*** In all section 1115 waivers, like the waivers in Vermont and Florida, the federal government imposes caps on federal funding to help ensure that the federal government will not bear any new costs as a result of the waiver. Although it is not possible to know now whether Vermont or Florida will be constrained by these caps over the course of their waivers, the caps mean that the states, rather than the states in combination with the federal government, bear the risk of higher-than-projected costs. If Florida, for example, finds that over time it cannot attract plans or satisfactorily meet beneficiary needs at the expenditure levels matched under its waiver caps, it will not be able to draw down additional federal funds to address these issues. Similarly, if Vermont's economy weakens and many more people need Medicaid coverage, the state will not receive any additional federal funds above its global cap to help defray the added cost associated with new enrollment.

- ***Spending at the average can result in some overspending.*** States that rely on any type of defined contribution approach in which people (or health plans on their behalf) receive a pre-determined amount of funds run the risk that they will set the level of their contribution too low for some people and too high for others. Spending for Medicaid beneficiaries is highly skewed (as it is for most large insured groups). Therefore, any design in which a state pays an amount that is average or even significantly below average for a group will result in the state paying a far higher amount for many individuals than the cost of services that those individuals are likely to consume. The average per person expenditure for Medicaid nationwide in fiscal year 2001 was $3,838. If that contribution were provided on behalf of all beneficiaries, the payments would be "too high" for eight out of ten enrollees. Risk

adjustment can help, but risk adjustment methodologies are often not very sophisticated and difficult to apply on an individual basis.

- ***States and localities may need to respond to their residents' unmet health care needs.*** A basic question is whether states or local communities will be compelled to step in if these new approaches result in people not getting needed care or new health care needs arise. If they do, they may be picking up costs outside of the Medicaid program without the benefit of federal matching funds. Many states expanded Medicaid over the years to help them finance care and services that they or local communities had been providing to their residents with state or local dollars. The new limits in Medicaid could have implications for financing of other state and local programs.

Impact on the Federal Government

New Ability to Limit Federal Costs

From a budgetary standpoint, the federal government appears to fare the best under these new arrangements.

- ***Limits applied by states carry over to the federal government.*** When states limit their risks under Medicaid, they limit the federal government's exposure as well. For example, if a tiered benefit approach limits a state's obligations because some people are assigned to more narrow coverage, it will similarly limit the federal government's obligations. And, unlike the states, the federal government is not positioned to feel nearly as much pressure to "come to the rescue" of enrollees or providers if the system falls short of people's needs.

- ***Waiver caps limit federal exposure to costs.*** The federal government also limits its liability through the budget neutrality waiver caps. With per person caps, like those in the Florida waiver, the federal government no longer shares the risk of higher-than-anticipated per person costs, although it remains at risk for enrollment-driven costs. Global caps, like the one approved in Vermont's waiver, protect the federal government from higher enrollment costs as well. These caps also enable the federal government to know its outer boundaries for program spending in the state.

Financial Risks for the Federal Government

The federal government could, however, incur some new costs under these approaches.

- ***Caps can sometimes lead to higher federal spending.*** Caps are set based on historical spending, adjusted by projected rates of growth in health care costs. Historical spending, however, is not always a good indicator of future costs and projected trend rates for health care spending often turn out to be far from the mark. The General Accounting Office (GAO, now called the Government Accountability Office) has found waiver financing to sometimes lack consistent and objective criteria. If the federal government agrees to waiver caps that are above what it might have spent under regular program rules, the waiver could result in higher federal spending levels, as appears to be the case for Vermont.

Impact on Beneficiaries

Potential Improvements for Beneficiaries

Under some of these new approaches, beneficiaries may realize some gains or avoid some losses that might otherwise come about:

- ***Avoiding other reductions.*** Policymakers have sometimes pointed to these new initiatives as a way to avoid taking other steps to control costs, like eliminating an optional eligibility category or optional benefits.

- ***Emphasizing healthy behaviors.*** All of the new approaches seek to encourage healthy behaviors and, in some cases, increase personal responsibility, although they plan to do so in different and largely untested ways. For example, some offer "reward credits" for participating in healthy activities, while one state uses a "stick" approach of reducing benefits if individuals do not fulfill certain broad responsibilities related to their health or to their children's health.

- ***Providing access to new providers or additional benefits.*** Florida anticipates that its new system will bring in plans and providers that may not have participated in Medicaid, potentially offering beneficiaries new choices and broader access. In addition, both the Florida plan and the tiered benefit approach could result in additional benefits for some beneficiaries. These advantages, however, may be limited or offset by other aspects of the initiatives. In the context of a defined contribution, if the plans under Florida's system pay higher rates to attract new providers, the trade off for beneficiaries may be a more narrow benefit plan or tighter utilization controls. In a tiered benefit system, while some people could have broader plans others would be assigned to more limited plans.

New Risks for Beneficiaries

While there may be some potential improvements for beneficiaries, they will likely be at risk for new costs and unmet needs:

- ***The defined contribution approach puts beneficiaries at risk if the premium payment is insufficient.*** When beneficiaries are no longer guaranteed a particular scope of benefits and the state's obligation is defined primarily by a pre-determined dollar amount, beneficiaries will bear the risk if, over time, the premium payment is insufficient to entice plans to offer coverage that meets their health care needs.

- ***People with higher levels of medical need could bear a greater risk of uncovered health needs.*** Under Florida's plan, adults are at risk for the cost of medical care above the benefit caps. With tiered benefits, where different groups of people are assigned to different benefit packages, people with above-average needs for their particular group are the ones most likely to have medical needs beyond the limits or coverage of their assigned plan.

- ***Capped federal funding also increases risks for beneficiaries.*** Caps on federal funding for Medicaid benefits, combined with new flexibility granted to states to keep their costs below the caps, put beneficiaries at risk of reduced benefits, tighter limits on utilization of services, and/or higher cost sharing. Under Vermont's waiver, for example, some eligible beneficiaries could be put on a waiting list. The structure of the Vermont waiver further increases the chance that this kind of action might occur because, in effect, it sets up competition between Medicaid and non-Medicaid uses for the fixed amount of federal funds.

Impact on Health Plans and Providers

Some new health plans may emerge or may be strengthened as plans compete for business under the new designs, and providers could see reimbursement levels rise relative to current Medicaid payment rates. This new market and these payment levels may be unstable, however, particularly if funding levels do not keep up with costs. Some observers have noted that, over time, a "shake down" in plan participation might occur.

More fundamentally, if states and the federal government limit their contributions for health care coverage for the low-income population, funding available for their care will be reduced relative to what might have been committed under regular Medicaid program rules. Safety-net providers, such as health centers, public hospitals, and children's hospitals may be particularly disadvantaged under these new systems given their reliance on Medicaid financing and their traditional role serving the uninsured and underinsured.

In addition, certain features of these new approaches, such as benefit limits or caps that could disrupt a patient's treatment, could create ethical and legal dilemmas for providers.

Conclusion

States have a strong interest in being better able to predict and limit their Medicaid costs. These costs, however, often grow for reasons beyond their control. New approaches that limit state responsibility for medical care generally do not make the need for such care or the costs of such care disappear. It appears that other stakeholders, particularly beneficiaries and, in some cases, health plans and health providers, will bear much of the risk no longer assumed by state Medicaid programs. Further, states may end up incurring costs without the benefit of federal financial participation. Moreover, should these new approaches take hold, the long-term impact on the Medicaid program's ability to cover people who otherwise would be uninsured could be substantial. In some cases, these approaches depart from traditional notions of insurance and remove explicit incentives built into the Medicaid program that were intended to encourage and support state efforts to expand and strengthen coverage.

I. Introduction

Medicaid has been experiencing significant change at both the state and federal levels driven largely by rising health care costs, declining workplace coverage, and state and federal interest in reducing program spending. Waivers have contributed to these changes, and the recently enacted Deficit Reduction Act of 2005 (DRA) further alters the landscape by providing states a new array of program options.

While most of the changes that have been adopted by states follow or reflect changes occurring more broadly in the health care marketplace, a few of the most recent state initiatives move into new directions. The details vary although the objectives often overlap: these initiatives often seek to promote personal responsibility and healthy behaviors among Medicaid's enrollees, and some are trying to rely more heavily on the private marketplace with the goals of driving down costs and offering beneficiaries greater choice. Over the next period of time, it will be important to closely examine how these initiatives unfold and how well they meet these and other goals.

In addition, it will be important to consider how costs and risks are distributed under these new approaches. One feature that is common to all of these initiatives, but that is often overshadowed by other aspects of the plans, is that in one way or another they seek to impose new limits on state responsibility for certain costs and medical care. If Medicaid is restructured in ways that circumscribe state responsibility for some health care costs, those costs generally will not disappear. A key question is who will bear these costs? This issue brief examines these new Medicaid designs and assesses how they might change financial risk and responsibility for states, the federal government, beneficiaries, and providers.

II. Background

Risks and Responsibilities under Basic Program Rules

Medicaid program costs – including higher-than-expected costs, as well as savings that accrue from successful cost containment measures – are shared by the states and the federal government. Within this shared financing arrangement, each level of government has different responsibilities and levers with which it can exert control over Medicaid spending.

States decide whether or not to participate in Medicaid; they all do because Medicaid provides them substantial federal funding to provide health care services for their residents and helps them defray costs that they would otherwise bear with state or local funds. Once in the program, a state takes on certain financial obligations, which stem from two basic federal requirements: as a condition of receiving federal Medicaid funding, states must cover certain groups of people (called "mandatory" populations), and they must provide most individuals with certain benefits. States can broaden the scope of their programs by choosing to cover "optional" populations or by providing "optional" benefits. In general, once a state decides to cover a service it has to offer it to all beneficiaries statewide. The new DRA benefit option, which is described below, alters some of these rules with respect to certain groups of Medicaid beneficiaries.

State obligations for children are considerably stronger than for adults with respect to both eligibility and benefits. The minimum eligibility levels for children are much higher than for adults, and federal law guarantees children a comprehensive benefit package, known as the Early Periodic Screening, Diagnostic and Treatment benefit ("EPSDT"). [1]

As long as a state complies with the requirements of the program, the federal government commits to paying 50 – 76 percent of coverage costs.[2] The financing rules are explicitly designed to encourage and support state decisions to invest in coverage. When a state expands or improves coverage (for example, by increasing provider payment rates to promote access or by adding an optional population), the federal government automatically contributes its share of the new cost. New investments, however, still require states to pay their share of costs; states do not have a "free ride" when they cover more people or broaden their benefit package.

Options for States to Contain their Costs

States can control their expenditures in a variety of ways. They can limit eligibility (to the minimum "mandatory" standards), and, for adults, they can limit benefits and restrict the scope of coverage for a particular medical service within federal guidelines (e.g., by setting a limit on the number of covered hospital days in a year). They also can improve or dampen participation rates by making it easier or more difficult for people to apply for or retain their coverage. These state decisions are influenced by many considerations. In practice, most states cover a broad array of optional services, because those services are often important to beneficiaries and they can help contain the cost of other required services.[3] Coverage of prescription drugs, for example, is optional, but prescription drugs can lower the cost of hospital care, which is a required service. In addition, some states cover optional services and optional populations under Medicaid because otherwise states or localities might pay for this care with state and local funds.

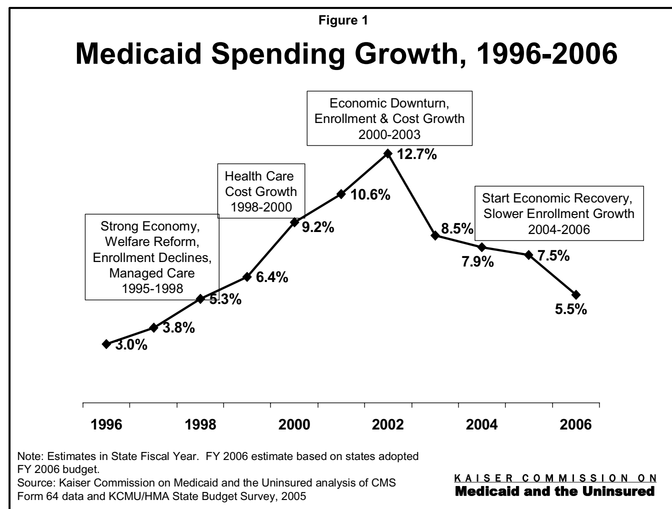
Beyond these basic choices, states have other ways to contain (and, to some degree, shift) Medicaid costs. Perhaps most fundamental is that states set the rates they pay Medicaid providers and the prices they pay for Medicaid services, such as prescription drugs. Until the DRA, however, states had very limited ability to impose cost sharing on beneficiaries–either as a way to shift costs or to control utilization. States have long had other tools to control utilization. For example, they can establish prior authorization procedures, utilization reviews, disease management programs, and pay-for-performance and other payment arrangements that encourage or discourage certain practice patterns.[4]

In addition, states have broad discretion in designing their service delivery systems. States typically contract with private health plans to deliver most of the services provided through Medicaid. In 2004**,** 61 percent of Medicaid beneficiaries nationwide –mostly children and nondisabled adults– were enrolled in some form of managed care.[5] These arrangements allow states both to manage care and to limit their risks and financial exposure. Through capitated managed care payment arrangements, states can achieve greater predictability of costs and potentially shift some of the risk of higher-than-anticipated costs onto health plans.

Medicaid Spending Levels and Growth Rates

Through these options and an array of management tools, states have been able to keep Medicaid costs, on a per person basis, below private sector costs.[6] On a per person basis, Medicaid has been growing more slowly than the private sector, and in the past few years, the overall Medicaid growth rate has dropped considerably (Figure 1).

States' ability to control their Medicaid costs, however, is constrained – in part because of federal minimum requirements but largely because Medicaid costs are driven by overall health care costs and other factors beyond states' control. If underlying hospital or prescription drug costs rise, a new and effective cancer drug comes on the market, or a hurricane hits or a flu epidemic breaks out, state Medicaid programs will be affected. And, as the population ages and if employer-based coverage continues to decline, Medicaid enrollment will grow.



Waivers and New State Plan Options under the DRA

Waivers and, more recently, new options available under the DRA, alter some of these basic program rules. "Section 1115" waivers allow states to change their Medicaid programs in ways that depart from federal standards and the options otherwise available to states.[7] Over the last decade, a number of states relied on Section 1115 waivers to cover populations that they could not cover under regular Medicaid options (i.e., childless adults) or to require beneficiaries to enroll in managed care (which, due to a federal legislative change enacted in 1997, states can now do without a waiver). With the onset of state fiscal pressures in 2001, waiver activity focused more on increasing beneficiary cost sharing and, in some cases, reducing benefits or capping enrollment, as well as ways to maximize federal funding. A few states continued to rely on waivers to expand coverage.

The DRA, which was enacted in February 2006, made a number of significant changes in Medicaid program rules aimed at reducing federal Medicaid expenditures. It accomplishes this objective largely by offering states some new program options that previously had only been available through a Section 1115 waiver.[8] The DRA provides states with expanded flexibility to impose cost sharing on children and adults. It also eliminates the concept of "mandatory" and "optional" benefits for certain enrollees by allowing states to offer "benchmark or "benchmark-equivalent" plans instead. States have very broad flexibility to design these benchmark plans and to offer different plans to different groups of people (for example, based on health status, county of residence, or place of employment). The new option, however, is limited mostly to children and low-income parents, and, while children may be enrolled in these benchmark plans, they must still be provided with full EPSDT benefits as "wraparound" coverage.[9] Guidance

issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicaid program, potentially broadens the use of these benchmark plans by permitting states to enroll groups that are exempt from these new rules (e.g., children and adults eligible based on disability) into benchmark plans on a voluntary basis.[10] The benchmark plan option also only applies to eligibility groups established in a state as of the date of DRA enactment. Because the aim of the DRA was to reduce federal spending, the law does not allow states to use the benchmark plan option to expand coverage.

The lines between what can and cannot be done under the DRA and the relative advantages or constraints of making changes through the DRA options versus waivers are just beginning to be sorted out. Waivers are still available post-DRA, and they potentially offer states the opportunity to go beyond the limits Congress decided upon when it enacted the DRA.[11] Unlike the DRA options, waivers alter the federal and state financial relationship for program funding. All Section 1115 waivers impose some sort of cap on federal funding as part of the federal government's policy to assure that waivers do not result in new federal costs.[12] In addition, some waivers have permitted other types of financing arrangements that would not have been permitted (or that are being phased out) under regular Medicaid rules.[13]

III. New State Approaches

In recent years, some states have expressed interest in having greater ability to not just reduce or better manage their Medicaid costs but to be able to more accurately predict costs and limit their exposure to costs. Most recently, a few different approaches have emerged that exert new levels of control over state Medicaid spending. To date, these approaches have been adopted in just a few states. Florida and Vermont have redesigned aspects of their programs through Section 1115 waivers. A few other states – West Virginia, Kentucky, and Idaho – first considered waivers but then, after enactment of the DRA, adopted their changes as a "state plan amendment' under the new flexibility permitted by DRA.

Defined Contribution

Florida's recently approved waiver essentially converts the acute care side of the state's Medicaid program from a defined benefit to a defined contribution approach.[14] This approach limits the state's obligation to a pre-determined dollar amount rather than to the cost of a certain set and scope of medical services. Through this initiative, the state is seeking to "introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost."[15] Under the waiver, which will be implemented as a pilot in two counties, beneficiaries (including people with disabilities) will choose among private plans that decide to participate.

Participating plans will be offered risk-adjusted premiums for each member they enroll. In exchange, plans must cover certain benefits but, for adults, they have discretion to vary the amount and scope of benefits within certain limits and to either add or exclude certain benefits, as compared to Florida's pre-waiver benefit package. For example, plans could adopt more restrictive prescription drug formularies or decide to cover or exclude services like physical or occupational therapy.[16] Benefit packages must meet the state's sufficiency standards (for

different target groups of beneficiaries) and will be reviewed by the state to determine if "the overall level of services provided is appropriate for the premium received." [17]

All adults except pregnant women will be subject to a new annual maximum benefit limit. Once expenditures for a beneficiary reach the limit, neither the state nor the managed care plan will be responsible for further costs. Children will be required to enroll in the new system, but plans must offer children the full range of Medicaid ("EPSDT") services as a condition of their participation. Utilization control mechanisms (applied to children as well as adults) are left to the plans' discretion. Florida's waiver also anticipates an "Enhanced Benefit" system to provide incentives for healthy behaviors, and it received capped federal funding under the waiver for a "Low-income Pool" "to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations."[18]

In exchange for the new flexibility in program design, Florida has agreed to be bound by a per capita (i.e., per person) "budget neutrality" waiver cap on federal funds. The state will receive up to but no more than a pre-set amount of federal dollars for the people enrolled (calculated over the course of the five-year waiver). The federal per person cap varies by beneficiary group and rises annually by an average of eight percent to accommodate projected medical inflation. For the first two years of the waiver, when it is being implemented on a pilot basis, approximately nine percent of Florida's Medicaid beneficiaries will be enrolled. The cap on federal dollars under the waiver, however, has been applied statewide, affecting 89 percent of all of Florida's Medicaid enrollees.[19]

Capitated Payments within an Aggregate Cap and Program Flexibility

Vermont has an approved waiver under which a state agency will receive a set amount of federal funds for each person enrolled in Medicaid.[20] The waiver also imposes an overall "global" cap on the total amount of funds that the federal government will provide to the state, similar to a block grant. Federal funding for the next five years is set by the waiver terms; it will not grow based on actual costs.

Accompanying these changes in financing is new flexibility that permits the state to curtail coverage and cap enrollment for many of the groups of people covered under Medicaid. In explaining the reasons for seeking the waiver, Vermont's Governor Douglas cited state fiscal problems and the desire for more flexibility to change the Medicaid program without federal review. The goals, according to the state, are to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services, 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens, and 3) foster innovation in health care by focusing on health care outcomes.[21]

One of the most notable—and perhaps least understood—aspects of the waiver is that the state can retain federal dollars (within the capped payments) that exceed the amount the state actually spends for the people covered under the program. "Excess" funds could come about if the actual cost of serving the people enrolled is below the level of the per person amounts the federal government will provide the state, either because the per person payments turn out to be high

relative to actual costs or because the state uses its authority under the waiver to lower per person costs (for example, by restricting utilization).[22] This financing arrangement is similar to private sector financing where private managed care companies retain, as profit, that portion of their premiums that exceeds the cost of covering enrollees under their plans. It is quite unlike financing under regular Medicaid program rules, where states receive federal payments only when they provide Medicaid services to Medicaid beneficiaries. While some waivers in the past have explicitly allowed states to retain program savings if they apply those savings to Medicaid expansions, Vermont's model is unique in that it allows federal Medicaid funding to be diverted for other purposes, in effect allowing it to fund state budget shortfalls.[23] After approval of the waiver, Vermont enacted new health care legislation, and it appears that Vermont may decide to use some portion of the "excess" funds for new coverage as well as for other state purposes.

"Tiered" Benefits

A few states have been developing "tiered" benefits, although the particular designs and, in some cases, objectives, vary considerably. Kentucky and Idaho have each received approval under the DRA to essentially divide Medicaid enrollees into groups and provide different benefit packages to each group. The stated goals of the Kentucky design are to improve the health status of enrollees, ensure that people receive the right care in the right setting at the right time, and ensure the solvency of the Medicaid program.[24] Through its changes, Idaho is seeking to "redesign its program so it provides vital services, while promoting prevention and personal responsibility for Idaho participants."[25]

In general, Medicaid redesigns that rely on tiered benefits assign people deemed to be part of a healthier group to a more limited benefit package and provide those who are expected to have more extensive medical needs (e.g., individuals who are eligible for Medicaid based on a disability) broader coverage. This coverage might be the same as what was available before the "tiered" approach was adopted or it could include benefit enhancements.[26] Some movement across groups and benefit package assignments may be permitted, but predictability in spending is predicated on the assumption that at least a considerable portion of people will stay with their benefit package assignment for some period of time, regardless of their actual medical needs.[27]

West Virginia also has an approved DRA state plan amendment that tiers benefits for children and parents. Its stated goals are to "emphasize personal empowerment and responsibility" and to "ensure that participants receive the right care at the right time by the right provider through care coordination."[28] Unlike Kentucky and Idaho, West Virginia's tiering is not based on people's anticipated health needs but rather on their behavior. Children and parents (parent eligibility in West Virginia is quite limited; family income must be below 37 percent of the federal poverty line) will be enrolled in an "Enhanced" plan if they (or in the case of the children, their parents) sign a member agreement and comply with its requirements. These requirements include broad responsibilities such as, "I will do my best to stay healthy," "I will go to health improvement programs as directed," and "I will use the hospital emergency room only for emergencies."[29] Physicians will be responsible for monitoring their patients' compliance and reporting on compliance to the state.

People who do not sign the West Virginia agreement or who the state determines have failed to meet the agreement will be enrolled in a more limited "Basic" plan, which excludes coverage for certain care such as diabetes care and mental health services. The West Virginia state plan amendment contains conflicting information about how children's benefits will be affected. It states that children may be enrolled in the "Basic" plan, which excludes coverage of broad classes of medical care but also lists "EPSDT" as a covered service. Children account for three quarters of those who are subject to the new system.[30]

Florida also adopts the concept of tiered benefits although implements it in yet a different way. Instead of being assigned to a benefit package, under Florida's system, people will choose a benefit package based on available offerings. The state anticipates that participating plans will offer different benefit packages that will focus on the needs of different populations.

IV. Changes in Responsibilities and Risks for States

New Ability for States to Limit Their Costs

Each of these approaches gives the states new ability to limit their responsibilities for certain costs. Florida's approach is perhaps most direct. The waiver fundamentally redefines the state's financial obligations, because, for adults, the state is largely relieved of its responsibility to provide a particular scope of services. Instead, the state's financial commitment is restricted to its "defined contribution," which is translated by the plans into a benefit package with a maximum benefit amount and potential benefit limits, particularly on optional services. Under the waiver, the state does not retain responsibility or assume any residual risk (with respect to non-pregnant adults) if beneficiaries' health care needs exceed what the plans offer.

Vermont's waiver permits the state to limit its responsibilities and its exposure to costs because it now has the ability to simply not serve Medicaid-eligible people or to restrict the coverage provided. Currently, the state does not have plans to make these changes, but the fiscal incentives built into the waiver could encourage such action because the state can retain federal funds it does not spend on Medicaid services and, in effect, use those funds for other purposes.[31]

A tiered benefit design limits a state's financial risks because people's coverage – and the state's exposure to costs – is limited by the person's benefit package assignment. Under regular program rules, the scope of coverage is generally the same for all beneficiaries (subject to the special rules for children), but an individual is only covered for a particular service if that service is medically necessary for that person. For example, if an otherwise healthy Medicaid beneficiary develops a disc problem, treatment is likely to be covered under most state Medicaid programs – but only if the person is found to actually need that service. States can limit their costs under tiered benefit plans because the tiers set new limits on coverage. Savings are achieved to the extent that some people are assigned to more limited benefit packages that do not cover medical needs that would have previously been covered. Under a tiered plan, the otherwise healthy adult who develops a disc problem and needs treatment might not have coverage for that treatment if he or she is enrolled under the state's more limited Medicaid benefit package (for "healthy" adults). Under these designs, a state's ability to predict and limit costs will be related to how quickly and easily it allows people to override benefit limits through authorization procedures or to switch to a broader benefit package when health problems arise.

Financial Risks for States

While these new approaches provide new methods for states to limit their exposure to Medicaid costs, states may also face some added financial risk under these arrangements.

- **Waiver caps shift costs in excess of the caps onto states.**

  When these new approaches are implemented through waivers, states are subject to federal "budget neutrality" rules, which are aimed at preventing the federal government from incurring new costs. All approved Section 1115 waivers cap the amount of federal dollars the states will receive over the course of the waiver, placing the states at risk for costs that exceed the caps.

  Florida's cap is set on a per person basis, placing the state at risk for per person costs that exceed the caps but not for costs associated with higher-than-anticipated enrollment. If the state finds over time that it cannot attract plans or satisfactorily meet beneficiary needs at the per-person level of expenditures allowed under the cap, it will not be able to draw down additional federal funds to address these issues. As noted, Florida's waiver caps extend to nearly 90 percent of the entire Medicaid population in the state even though its waiver will be implemented initially on a pilot basis in two counties and affect only 9 percent of enrollees. The statewide caps could create added fiscal pressures for the state and may push the state to make other changes in the program or move more quickly to implement the defined contribution approach beyond the pilot counties.

  Vermont's waiver puts the state at risk for all costs – enrollment and per person health care costs– that exceed the caps negotiated under its waiver. While the waiver offers the state broad options to reduce coverage and limit enrollment that could help prevent Medicaid costs from exceeding the caps, federal funding caps – particularly "global" caps– inevitably create risks for states. The federal government no longer fully shares the risk of unexpected health costs. Vermont's aggregate cap is set at a relatively generous level, but other states, especially states with much larger Medicaid programs, may not be able to negotiate a cap with these terms because of the potential cost to the federal government.[32]

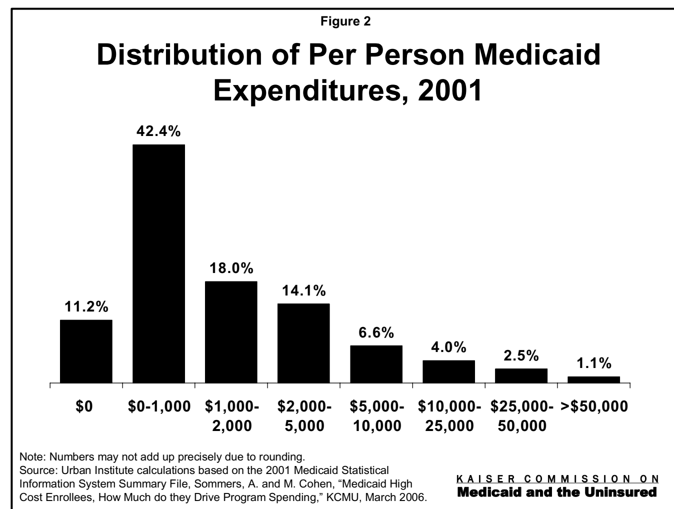
- **The ability to divert funds for other purposes can create Medicaid shortfalls.**

  The fact that Vermont can use federal Medicaid funds for non-Medicaid purposes under its waiver was a major attraction for some state policymakers, but this aspect of the waiver may eventually lead to a funding problem for the state. If, over time, Vermont policymakers tap heavily into the state's capped federal funding for other state priorities and Medicaid costs rise for any number of reasons, Vermont's Medicaid program could face a funding shortfall. Once funds are diverted to other purposes, it may be difficult to redirect them back to Medicaid.[33]

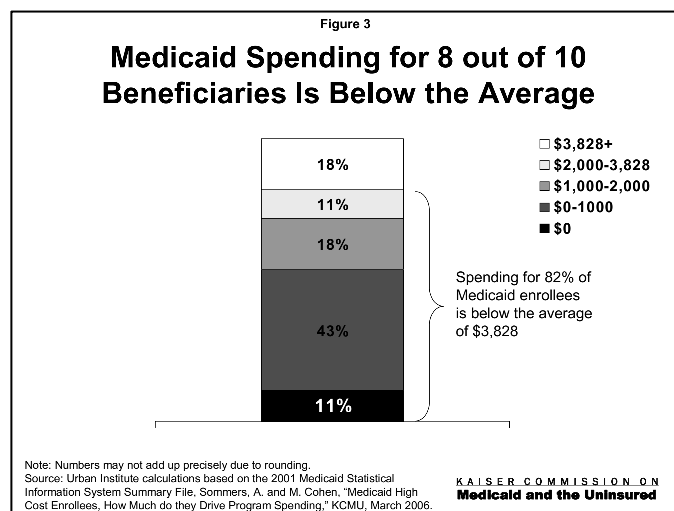
- **Setting defined contribution levels can lead to higher costs.**

  Moving to a defined contribution approach (including an approach in which individuals are provided a set amount of funds in a "personal account" or through vouchers that they can use to purchase services or coverage) may actually lead to overspending for certain groups of individuals. Spending for Medicaid beneficiaries is highly skewed (as it is for most large insured groups). Most people need only a small amount of services while a few require a much greater amount of medical care.

  A recent analysis shows that, in federal fiscal year 2001, more than half of all Medicaid beneficiaries consumed less than $1,000 in services, while 3.6 percent of beneficiaries had expenditures over $25,000 (Figure 2).[34] Any design in which a state pays to each individual, or on behalf of each individual, an amount that is average or even significantly below average for the group will be paying a far higher amount for many individuals than the cost of the services that those individuals are likely to consume. The average per person expenditure for Medicaid nationwide in fiscal year 2001 was $3,838. If that contribution were provided on behalf of all beneficiaries, the payments would be "too high" for eight out of ten enrollees (Figure 3).



  Risk adjustment could help states temper this mismatch. Risk adjustment is used by many states when they set their Medicaid managed care rates; it helps states determine an appropriate rate for broad groups of people where the risk of the high cost cases is spread over the group. Methodologies, however, are generally not very sophisticated, and individual risk adjustment is far more difficult and generally untested in state Medicaid programs.[35] States often lack adequate data necessary to make these adjustments, and particular issues arise with respect to newcomers to the program and people whose health status changes.



  In light of these challenges, states face a dilemma. A state concerned about access can compensate for limited risk adjustment capabilities by setting its premium contribution or

personal accounts at a relatively high level, but doing so exacerbates the problem of spending "too much" for those who end up not using many health care services.

- **Reducing Medicaid obligations does not necessarily reduce or eliminate residual state or local responsibilities.**

  Perhaps the most basic question regarding states' risks under these new approaches is whether states can, in fact, put new boundaries on their responsibilities for certain health care costs. State Medicaid programs grew over the years, in part, because residents needed medical care, health care providers needed a reliable payment source to serve those residents and to remain solvent, and states and localities needed federal matching funds to help pay for care. If any of these new approaches create holes in the system or new health care needs arise, local communities or the state may be compelled to address the problem. If they do, they may be picking up costs without the benefit of federal matching funds. As such, the new limits in Medicaid could have significant implications for the financing of other state and local programs.

  The early experience with Medicare's new prescription drug benefit is instructive. It shows that even when a health care responsibility clearly no longer lies with the state, states often must and will respond to residents' needs. When the initial Medicare drug plan implementation left many people without access to the drugs they needed, more than half the states stepped in and provided payment for drugs.[36] Similarly, if holes in the Medicaid system lead to unmet need, states or localities may feel the need to step in. If they do, however, they may not have the benefit of federal matching funds.

V. Impact on the Federal Government

New Ability to Limit Federal Costs

From a budgetary standpoint, the federal government appears to fare the best under these new program designs. To the extent that these approaches permit states to limit their risks under Medicaid, the federal government similarly limits its exposure. Florida's defined contribution approach, for example, limits the federal government's exposure to Medicaid costs to the same degree that it limits Florida's exposure to these costs. And, unlike the states, the federal government is not positioned to feel nearly as much pressure to "come to the rescue" of enrollees or providers if the system falls short of meeting people's needs.

The changes implemented through waivers also allow the federal government to limit and predict the outer boundaries of its liability through the budget neutrality caps that are imposed as part of each waiver. In 2003—partly as a way to constrain growth in federal spending—the Bush Administration proposed converting the Medicaid program into one in which at least a portion of federal Medicaid payments to states would be subject to overall global caps like the one approved in Vermont's waiver.[37]

Financial Risks for the Federal Government

While these new program designs allow the federal government to contain federal Medicaid spending and, in some cases, explicitly limit its cost exposure, they could also end up costing the federal government more than it would have otherwise spent at least in some states or for some populations.

- **Waiver caps might not assure the federal government "budget neutrality."**

  Federal waiver caps are predicated on historical spending, adjusted by a trend rate that allows the caps to grow by a set percentage each year of the waiver. These are necessarily imprecise measures and often turn out not to be good predictors of actual costs. Other considerations also can play a role when waiver caps are set; financing negotiations within the waiver context have been criticized by states and the GAO as lacking transparency and consistency across states.[38] As a result, a cap may be set too low in some states and too high in others, when measured against the costs that would have been incurred without the waiver.

  If the federal government agrees to a cap that is above what it might have spent under regular program rules, the waiver could result in higher federal spending levels. For example, an analysis of the global cap in Vermont's waiver suggests that it is set well above the level the federal government would have spent on Medicaid services for Medicaid beneficiaries in that state. To put the Vermont financing terms in context, if all federal Medicaid spending grew at the same rate allowed under the Vermont waiver, it is estimated that the federal government would spend an additional $105 billion over five years compared to currently projected levels.[39]

- **New initiatives could lead to federal Medicaid spending for non-Medicaid purposes**

  The federal government has an interest in knowing that the funds provided to states for Medicaid services are used for appropriate purposes, as indicated by concern among federal policymakers over some state Medicaid financing practices. Waivers that allow states to divert funds for non-Medicaid purposes to refinance state programs, or to retain funds that have been raised through financing practices that are no longer permitted under federal rules result in federal funds being spent in ways that are either not clear or that have been disallowed in other contexts. These practices can result in increased federal spending. Florida's waiver, for example, includes a "Low-income Pool" that essentially allows the state to maintain and even increase federal funding it had been receiving under a financing practice that is being phased out in other states. The waiver does not specify with any detail the allowable uses of these pool funds.

VI. Impact on Beneficiaries

Potential Improvements

Under some new program designs, beneficiaries—or some groups of beneficiaries—may realize gains or avoid some losses that might otherwise come about.

- **Avoiding cuts in eligibility or benefits.**

  Although it is hard to know for sure what might have happened in the absence of a waiver or program change using new DRA options, state policymakers have sometimes pointed to their Medicaid redesign efforts as a way to avoid taking other steps to control costs, such as eliminating an optional eligibility category or optional benefits.

- **Promoting healthy behavior.**

  All of the new approaches have a stated goal of encouraging healthy behaviors, although they plan to do so in different and largely untested ways. In Florida, the state expects that "individual health outcomes will improve as people take an active role in managing and understanding their health care needs."[40] In West Virginia, the state anticipates that people will respond positively to the potential of a significant reduction in coverage by taking whatever steps are required under their "Member Agreement." Additionally, several of the new state approaches include a type of "reward account," in which individuals can receive credits for certain healthy behaviors that can go toward uncovered health care costs.

- **More choice of plans and providers and added benefits.**

  Some of the new approaches also seek to provide Medicaid beneficiaries with a broader choice of health plans and providers. Medicaid programs have sometimes had trouble attracting a sufficient number of providers, in part, because states may pay below market rates. One of the goals of Florida's redesign is to provide beneficiaries with new plan choices that could result in beneficiaries gaining access to a broader group of providers. These new program designs might also provide people access to benefits that are not currently covered under their state's Medicaid program. In Florida, at their discretion, health plans may cover medical services that have not been covered in the past. As part of its tiered benefit design, Idaho is planning to expand home and community-based service options for people with disabilities.[41]

  These potential improvements, however, are likely to be accompanied by other changes that result in higher costs or unmet needs for at least some beneficiaries. A defined contribution system is a "zero sum" approach –plans will operate within the context of a fixed premium payment. If plans attract new providers through higher rates or if they decide to cover additional services, other benefits could be restricted or all services might be subject to tighter controls to keep costs within the limits of the state's contributions. In a tiered benefit system, the trade-off may be between groups of beneficiaries. Some people could have access to a broader array of benefits while others could lose benefit coverage.

New Risks for Beneficiaries

Because these new approaches are designed to not just manage risk but to limit the government's assumption of risk and responsibilities, risk will be shifted elsewhere and beneficiaries are very likely to bear some, if not a major portion, of these risks. Risk could arise in different ways depending on the design of the particular initiative.

- **In the "defined contribution" approach, beneficiaries are at risk for uncovered health needs if the premium payment is insufficient.**

  Under a system like the one being piloted in Florida, where plans can vary the level or scope of services, the consequences of inadequate premium payments will be borne primarily by beneficiaries.[42] To some degree, beneficiaries may have unmet needs under the current system if the state Medicaid program pays plans or providers low rates. However, the beneficiary is still entitled to defined benefits so the consequences of underfunding fall partly on health plans and providers. In addition, when plans and providers are required to provide a defined set and scope of benefits, they have a clear incentive to manage care and costs and/or to push for higher payment rates. In a defined contribution system that offers plans new discretion to drop, limit, or tighten access to benefits, plans may still seek to efficiently manage care and to increase the state's level of contributions, but they also have other opportunities to limit their costs that could directly impact beneficiaries' access to needed services.

- **People with higher levels of medical need could bear increased risks.**

  Florida is planning to individually risk adjust premiums, with the goal of providing premiums that will reflect individuals' health care needs. However, as noted, individualized risk adjustment will be challenging. If plans are not secure with the accuracy of the risk adjustment, they may be particularly reluctant to market to and serve people with high medical needs since they could have health care costs that exceed their premium levels. Florida's annual maximum cap on benefits for adults offers plans added protection against particularly high costs, since the health plans are not responsible for costs beyond the cap. However, this feature shifts risks to beneficiaries; individuals with high medical expenses that exceed the cap will be at risk for all health needs and costs beyond the cap.

  Similarly, tiered benefits could result in greater risks and unmet needs for those with above-average medical needs. Tiered benefit systems generally group people together based on an assessment of their medical needs and assign each group to a benefit package that the state has determined generally fits those needs. Individuals who require medical care that extends beyond the limits of the coverage provided to their group will not be covered for that care. States can mitigate the risk for beneficiaries by allowing people to move between benefit packages or to receive authorization for services whenever they have a need for medical care that exceeds the limits of their tiered coverage, but this would negate the purpose of the tiered plans. If it is permitted, beneficiaries needing care are likely to experience delays in accessing care and states and health plans will incur new administrative costs.

- **Capped federal funding also increases risks for beneficiaries.**

  Budget neutrality waiver caps can limit the federal government's exposure to costs, and, as discussed above, shift costs onto states. To the extent that a state's program design effectively limits the state's exposure (for example, through broad new flexibility to reduce benefits, increase cost sharing or cap enrollment), the state may be protected but, again, the risk shifts to beneficiaries (and potentially to plans and providers, depending on the program design). For example, if a state were to use options to reduce benefits, increase cost sharing, or cap enrollment to stay within its budget neutrality cap, some beneficiaries, potentially those with the greatest health care needs or the lowest incomes, might not be able to obtain needed health care and some eligible individuals might not be able to enroll in coverage.

VII. Impact on Health Plans and Providers

It is difficult to draw broad conclusions as to how health plans and health care providers will fare under these new arrangements, in part, because the different program designs will have different consequences for plans and providers. Further, different types of plans and providers will have different interests and concerns. Fundamentally, however, if states and the federal government limit their contributions to health care coverage for the low-income population, funding available for the provision of health care for this population will be reduced (relative to what might have been committed under regular Medicaid program rules). In recent years, hospitals, nursing homes and other major health providers have objected strongly to capped financing arrangements and to other measures that would bring further pressure to a program that many providers believe is already underfunded.[43]

In the short term, some new plans may emerge or be strengthened as plans compete for business under some of the redesigned programs, and some providers may see reimbursement levels rise relative to current Medicaid payment rates. However, the new market may be particularly unstable. Some observers have noted that over time a "shake down" in plan participation might occur.[44] If state contributions do not keep up with medical inflation or allow for sufficient return for the plans, plans might leave the market. In addition, under current Medicaid managed care arrangements, states often must guarantee plans a certain share of the market to sustain their participation. Under the Florida model, the state is hoping that many different plans will compete for enrollment. This may lead to plans entering and exiting the market.

Safety-net providers, such as community health centers and public hospitals whose mission is to serve all comers, may be particularly disadvantaged under these new systems. They might face more competition from other plans or they might not be included in the networks that develop to compete for business under the new systems. Currently, Medicaid is a significant source of revenue for these institutions.[45] At the same time, to the extent that these new systems create new holes in the coverage system, safety-net institutions may find they have greater demands on their resources given their traditional role serving the uninsured and the underinsured. For example, although direct causation could not be established due to limits on the study design, Oregon researchers found a significant increase in emergency room use after the Oregon Health Plan reduced benefits and experienced a significant fall off in enrollment due to increased premiums.[46]

In addition, some aspects of these new approaches create particular problems for providers. A cap on benefits that cuts off coverage mid-treatment could create ethical and perhaps even legal dilemmas for the treating physician or hospital. The West Virginia Chapter of the American Academy of Pediatrics has voiced its concern over the role pediatricians are expected to play under their state's new Medicaid redesign. Providers and health plans will be responsible for monitoring their patient's compliance with the new Member Agreements and reporting on compliance to the state.[47] Noncompliance could result in a significant loss of coverage for their patients.

VIII. Conclusion

New approaches that limits state responsibilities for certain medical care generally do not make the need for such care or the costs of such care disappear. It appears that other stakeholders, particularly beneficiaries and, in some cases health plans and health providers, will bear much of the risks no longer assumed by state Medicaid programs. Beneficiaries will likely face new costs and a greater risk of unmet health needs, which could increase strains on providers as well as other state programs. If states and localities need to step in to respond to their residents' unmet health care needs outside of Medicaid, they would not benefit from federal matching dollars. In some cases, these approaches depart from traditional notions of insurance and remove explicit incentives built into the Medicaid program that were intended to encourage and support state efforts to expand and strengthen coverage. Should these new approaches take hold, the long term impact on the Medicaid program's ability to cover people who otherwise would be uninsured could be substantial.

Prepared by Cindy Mann of the Center for Children and Families at the Georgetown University Health Policy Institute and Samantha Artiga of the Kaiser Commission on Medicaid and the Uninsured.

ENDNOTES

[1] Federal benefit guarantees for children, known as the Early Periodic Screening Diagnostic and Treatment ("EPSDT") benefit, requires states to cover all medically necessary services that a particular child may require if it is a service that can be covered under Medicaid even if that service is not covered for adults. Social Security Act, Title XIX, sec. 1905(r) (5); see also, Centers for Medicare and Medicaid Services, at http://www.cms.hhs.gov/medicaid/epsdt/default.asp.

[2] Federal matching rates vary relative to a state's per capita income; states with lower per capita incomes pay a lower share of their Medicaid program costs.

[3] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Benefits: Online Database,* state benefit tables, http://www.kff.org/medicaid/benefits/state_main.jsp.

[4] The Deficit Reduction Act of 2005 provides states with additional tools and options to lower costs. Kaiser Commission on Medicaid and the Uninsured, *Deficit Reduction Act of 2005: Implications for Medicaid,* February 2006.

[5] Centers for Medicare and Medicaid Services, *Medicaid Managed Care Overview*, http://www.cms.hhs.gov/MedicaidManagCare/ and Kaiser Family Foundation StateHealthFacts.org, http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi.

[6] Jack Hadley and John Holahan, *Is Health Care Spending Higher under Medicaid or Private Insurance?, Inquiry*, 40 (2003/2004): 323-42.

[7] "Section 1115" refers to the section of the Social Security Act that allows the Secretary of Health and Human Services to grant approvals for research and demonstration projects that "further the objectives" of the program. The Medicaid statute includes other more narrowly-defined waiver authorities, including waivers to allow home and community based long term care services and managed care arrangements. For a discussion of recent waiver activity, see Samantha Artiga and Cindy Mann, *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, March 2005 and Teresa A. Coughlin, et al, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs*: 25 (3), April 2006.

[8] Kaiser Commission on Medicaid and the Uninsured, *Deficit Reduction Act of 2005,* op cit.

[9] Deficit Reduction Act of 2005, Section 6044(a) and Jocelyn Guyer, Cindy Mann, and Joan Alker, *The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families*, Georgetown University Center for Children and Families, March 2006.

[10] Centers for Medicare and Medicaid Services, State Medicaid Director Letter #06-008, March 31, 2006, http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf.

[11] Following the enactment of the DRA, Senator Grassley, Chairman of the Senate Finance Committee, expressed his view that waivers should not be used to override Congressional decisions made in the DRA in a set of questions addressed to the Secretary of Health and Human Services. Finance Committee Hearing, "The President's Fiscal Year 2007 Budget Proposal," Questions Submitted for the Record to Secretary Leavitt, February 16, 2006.

[12] Under longstanding waiver practice, the federal government requires all Section 1115 waivers to be "budget neutral" to the federal government and imposes caps on the federal funds that will be provided to the state over the course of the waiver to enforce the budget neutrality agreement. See HHS HIFA guidelines at http://www.cms.hhs.gov/HIFA/02_Guidelines.asp; Cindy Mann and Joan Alker, *Federal Medicaid Waiver Financing: Issues for California,* Kaiser Commission on Medicaid and the Uninsured, July 2004; and Theresa Sachs, *HIFA at Age Two: Opportunities and Limitations for States,* State Coverage Initiatives, Vol. 4, #6, November 2003.

[13] Andy Schneider and Peter Harbage, *Medi-Cal Hospital Waiver Implementation, The 3 Waivers: Medicaid Hospital Financing in California, Iowa, and Massachusetts,* The California Endowment and the California HealthCare Foundation, August 23, 2005.

[14] Florida Medicaid 1115 Reform Special Terms and Conditions, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage. Florida's Governor Jeb Bush has publicly described his waiver plan as a "defined contribution plan." *Congressional Quarterly*, January 30, 2006.

[15] Florida Agency for Health Care Administration, "Florida Medicaid Reform: Application for 1115 Research and Demonstration Waiver," updated on October 19, 2005, p. 5.

[16] Neither the waiver nor the state's implementation plan for the waiver requires coverage of all currently covered optional services; state legislation enacted to implement the waiver may require optional services be covered but not any particular scope of coverage.

[17] Centers for Medicare and Medicaid Services, Florida Medicaid 1115 Reform Special Terms and Conditions, Section IX, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage; Florida Medicaid Reform Implementation Plan, http://ahca.myflorida.com/Medicaid/medicaid_reform/implementationplan/implementationplan_11-29-05.pdf .

[18] Centers for Medicare and Medicaid Services, Florida Medicaid Section 1115 Reform, Special Terms and Conditions, Section XV, 91, p. 24.

[19] Joan Alker, *Understanding Florida's Medicaid Waiver Application,* Winter Park Health Foundation, September 2005, p. 4.

[20] Centers for Medicare and Medicaid Services, Vermont Medicaid Section 1115 Reform Special Terms and Conditions, http://www.ahs.state.vt.us/OVHA/docs/RvVT_STCS.pdf. The waiver indicates that Vermont can pay itself a premium for each Medicaid beneficiary to whom it provides care. However, according to the state, the Vermont Agency of Human Services will pay a lump sum premium to the Office of Vermont Health Access each month to provide acute care to the state's Medicaid beneficiaries. The use of a monthly lump sum premium payment raises the question of whether the state is instead receiving an amount that is "pre-set" regardless of actual Medicaid enrollment. Jocelyn Guyer, *Vermont's Global Commitment Waiver: Implications for the Medicaid Program*. Georgetown University Center for Children and Families, for the Kaiser Commission on Medicaid and the Uninsured, April 2006.

[21] State of Vermont, Summary Overview, Global Commitment to Health Medicaid 1115 Demonstration Waiver, November 3, 2005.

[22] The larger the gap between the capitated premium payments Vermont receives under the waiver and the cost of delivering care to Medicaid beneficiaries, the greater the "excess." Vermont's ability to retain "excess" may be limited by a requirement that the premium payment must be "actuarially sound." However, it appears that there is sufficient room in the concept of "actuarial soundness" to allow for these excess funds and, moreover, to foster competition for federal Medicaid funds between Medicaid beneficiaries and other state priorities. Jocelyn Guyer, *Vermont's Global Commitment Waiver,* op cit.

[23] Under the waiver, Vermont may use "excess' payments to finance any of about 50 state-funded programs. This could free up state funds to be used in any way the state chooses and was a major selling point for state policymakers when the waiver terms were considered. Jocelyn Guyer, *Vermont's Global Commitment Waiver,* op cit.

[24] Birdwhistell, M. and S. Turner, "KyHealth Choices: Governor Fletcher's Medicaid Reform Initiative," slide presentation, April 27, 2006.

[25] Idaho Department of Health and Welfare, "Modernizing Medicaid: Prevention, Wellness, Responsibility," Program Overview, http://www.healthandwelfare.idaho.gov/site/3629/DesktopDefault.aspx?tabid=3629.

[26] Many of the details of the Kentucky and Idaho plans are not known at this time. The Kentucky plan is evolving and will involve many different components, including a new long-term care service initiative. CMS has announced the approval of Idaho's DRA state plan amendment, but the actual state plan amendment document is not yet available.

[27] In both Kentucky and Idaho, the opportunity to "opt out" of an assigned plan is required under federal law for some groups of beneficiaries because both states have chosen to include groups exempted from benchmark coverage under the DRA. As noted above, CMS has permitted states to enroll exempt groups in benchmark plans if enrollment is voluntary.

[28] West Virginia Department of Health and Human Services, "State Plan Amendment Could Revamp Medicaid," Press Release, May 3, 2006.

[29] West Virginia's State Plan Amendment, http://www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf.

[30] *What Will West Virginia's "Medicaid Redesign" Mean for Children?* Georgetown University Center for Children and Families, May 2006.

[31] See footnote 22 on potential limits to these "excess" funds.

[32] Jocelyn Guyer, *Vermont's Global Commitment Waiver,* op cit.

[33] Some states have experienced this tension with the Temporary Assistance to Needy Families (TANF) block grant when they spent TANF funds for child care and other state priorities. When the downturn occurred, some states had limited available TANF funds for TANF cash assistance. See Douglas J. Besharov and Caeli A. Higney. *Federal and State Child Care Expenditures (1997-2003),* Maryland School of Public Policy Welfare Reform Activity, May 2006.

[34] Fewer people have very low expenditures when considering only those people enrolled full-year but the spending was still quite skewed. About one out of five had expenditures below $1,000, nearly half had expenditures below $5,000, and 3.3 percent had expenditures of $25,000 or more. Anna Sommers and Mindy Cohen, *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?,* Kaiser Commission on Medicaid and the Uninsured, April 2006.

[35] Charles Milligan, Cynthia Woodcock, and Alice Burton, *Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing,* State Coverage Initiatives, Academy Health, January 2006.

[36] Kaiser Commission on Medicaid and the Uninsured, *The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation,* February 2006.

[37] Jocelyn Guyer, *Bush Administration Medicaid/SCHIP Proposal,* Kaiser Commission on Medicaid and the Uninsured, May 2003.

[38] General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns,* July 2002, GAO-02-817, General Accounting Office, *Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns*, June 2004, GAO-04-480, and Government Accountability Office, *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs*, November 8, 1995.

[39] Jocelyn Guyer, *Vermont's Global Commitment Waiver,* op cit.

[40] Florida Agency for Health Care Administration, "Florida Medicaid Reform: Application for 1115 Research and Demonstration Waiver," updated on October 19, 2005, p. 3.

[41] Idaho Department of Health and Welfare, "Modernizing Medicaid: Prevention, Wellness, Responsibility," op cit.

[42] In a defined contribution system the real value of the premium payment may erode over time. Florida's waiver does not require any adjustment in contribution or premium levels over the five-year course of the waiver.

[43] For a letter to members of Congress from the American Hospital Association opposing caps on Medicare and Medicaid spending, see http://www.aha.org/aha/advocacy-grassroots/advocacy/hillletters/content/040604hilletopposecuts.pdf.

[44] Charles Milligan, Cynthia Woodcock, and Alice Burton, *Turning Medicaid Beneficiaries into Purchasers of Health Care,* op cit.

[45] Marsha Regenstein and Jennifer Huang, *Stresses to the Safety Net: The Public Hospital Perspective,* Kaiser Commission on Medicaid and the Uninsured, June 2005.

[46] Bill J. Wright, et al, *Impact of Changes to Premiums, Cost-Sharing and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan,* The Commonwealth Fund, July 2005.

[47] Olga Pierce**,** ***Analysis: Medicaid plan hurts kids,*** United Press International, Wednesday, May 31, 2006.

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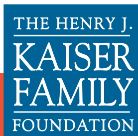

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