Vol. IV, No. 6
November 2003

STATE COVERAGE INITIATIVES

issue brief

HIFA at Age Two: Opportunities and Limitations for States

by Theresa Sachs

In August 2001, the Secretary of the U.S. Department of Health and Human Services (HHS) unveiled the Health Insurance Flexibility and Accountability (HIFA) initiative, which was intended to create "a new, simpler process for states to propose and implement creative ideas to help uninsured residents."[1] Since then, the Centers for Medicare and Medicaid Services (CMS) has approved eight HIFA demonstrations, several of which were approved after publication of a General Accounting Office (GAO) report that was sharply critical of the initiative.

States continue to express interest in HIFA, and it remains a preferred section 1115 approach of CMS. However, severe budgetary pressures have constrained states' abilities to pursue large eligibility expansions under HIFA.

The HIFA initiative has clearly expanded the limits of federal flexibility in considering state proposals to cover the uninsured. This issue brief examines the evolution of HIFA since its inception more than two years ago. It explores how states have used the HIFA initiative, the limits that have been placed on it by federal policy decisions, and the policy issues that remain unresolved. Finally, the brief discusses factors that may influence HIFA in the future.

The HIFA Approach and Guidelines

The HIFA initiative is a section 1115 demonstration approach designed to increase the number of low-income Americans with health insurance and promote employer-sponsored insurance (ESI) as a coverage vehicle. (For background information on section 1115 of the Social Security Act, visit www.statecoverage.net/pdf/issuebrief802.pdf.) In exchange for meeting these federal policy objectives, HHS gives states the ability to limit benefits and increase cost sharing, and provides relief from the usual requirements for developing coverage models that build on ESI.

In addition, HIFA allows states to use State Children's Health Insurance Program (SCHIP) funds in new ways, such as to cover childless adults. Although there have been various congressional efforts to prevent HHS from allowing states to use SCHIP funds for childless adults, to date none have been successful.[2]

Though not a stated purpose of HIFA, states have also found it possible to use it to maximize federal reimbursement by obtaining matching funds for previously state-only funded health coverage programs.[3] This is probably what continues to appeal to states about HIFA despite their current budget difficulties. CMS has issued guidelines for HIFA demonstrations, available at: www.cms.gov/hifa/hifagde.asp. There is also a CMS-designed application template, available at www.cms.gov/hifa/hifatemp.pdf. For proposals that meet the HIFA guidelines, CMS promises an expedited review process. However, virtually every proposal to date has included some elements that required policy decisions outside the scope of the HIFA guidance, thereby requiring more time for federal review.

In August 2002, the State Coverage Initiatives program published an issue brief examining HIFA during its early stages. A number of proposals under review at that time have since been approved, so it is now easier to see the true extent of what is possi-

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for SCI, an initiative of The Robert Wood Johnson Foundation.

ble under HIFA. An April 2003 brief evaluated states' experiences with benefit design using HIFA and non-HIFA waivers. Both publications are available online at www.statecoverage.net/publications.htm.

HIFA Activity to Date

Since introducing HIFA, HHS has approved eight HIFA demonstrations. The states of Arizona, California, Colorado, Illinois, Maine, New Mexico, New Jersey, and Oregon have received approvals under the initiative. Although most HIFA demonstrations have been implemented, there are two notable exceptions: California and New Mexico.

In the case of Oregon, the HIFA approval is actually an amendment to the existing Oregon Health Plan demonstration, which was approved in 1993. CMS is currently reviewing requests for new HIFA demonstrations from Arkansas and Michigan. (Michigan had submitted a HIFA proposal on March 1, 2003, but subsequently halted action on that plan.)[4] In addition, CMS is reviewing HIFA amendments from Illinois and Oregon.[5] A proposal from Delaware was disapproved on March 19, 2003.[6] A list of approved and pending HIFA demonstrations can be found in Table 1 on page 3.

Key Elements of a HIFA Demonstration

In order to be considered a HIFA demonstration, a proposal MUST:

- Include a coverage expansion;
- Include a public-private coordination component;
- Set a goal and include a methodology for monitoring changes in the rate of uninsurance;
- Promise to meet maintenance of effort (if a state-funded program is being federalized); and
- Meet a test of budget neutrality (for Medicaid funds) or allotment neutrality (for SCHIP funds).

A HIFA proposal may NOT:

- Reduce services to mandatory Medicaid eligibles
- Provide coverage to individuals with incomes above 200 percent FPL (with certain exceptions).

Under HIFA, a state MAY:

- Reduce benefits and/or increase cost sharing, including the ability to provide only a primary care benefit package to certain populations;
- Impose enrollment caps;
- Federalize a state-funded program (provided maintenance of effort is met);
- Use unspent SCHIP funds to finance increased coverage; and
- Divert DSH funds to finance increased coverage.

HIFA Precedents

To date, many HIFA approvals have set important precedents in the areas of financing, ESI implementation, use of unspent disproportionate share hospital (DSH) funding, denial of services for refusal to pay cost sharing, and the definition of an expansion population. None of these items were explicitly addressed in the HIFA guidance, but rather were the result of policy evolution as CMS considered each proposal.

Financing: In an important financing precedent, several states received approval to use SCHIP funds to cover childless adults through their HIFA demonstrations. This element, which was not explicitly addressed in the HIFA guidance, was first approved for Arizona on December 12, 2001. Arizona's experience likely spurred other states to submit similar proposals.

The ability to use SCHIP funds for childless adults is groundbreaking. Previously, the only ways to cover childless adults and still meet budget neutrality requirements was to either generate enough Medicaid savings to cover their costs or to redirect DSH funds.[7] Using DSH funds for coverage is not always a feasible option, given each state's public policy climate and the potential for disruption of hospital finances.

Another financing precedent, though not as important because of the low likelihood of replication, was CMS's approval of Arizona's request to use SCHIP funding (with its higher match rate) for a population that was previously included in an approved Medicaid demonstration. At the time Arizona submitted its proposal, the earlier approval had not yet been implemented. Most experts believe it unlikely that CMS would approve refinancing a long-standing Medicaid demonstration group with SCHIP monies (a similar request from Delaware was disapproved), and doubtful that another state would fit Arizona's profile.

Other important financing decisions have been associated with providing federal financial participation (FFP) for previously state-only funded programs. The HIFA guidance is somewhat contradictory on the subject of using FFP for these programs,[8] first saying that FFP will not be available for such programs, but then saying that if the program is being expanded, a maintenance-of-effort requirement will apply. Thus far, three states have received approval for FFP for previously state-funded programs: Arizona, Illinois, and Oregon. Maintenance-of-effort is not defined in the guidance, but CMS has developed an operational definition evident in the terms and conditions of approved HIFA demonstrations (see endnote 4).

In Arizona, the expansion population that had been included in the previous Medicaid demonstration had also been a state-funded program before the Medicaid approval. Illinois is receiving FFP under its demonstration for three previously state-funded programs: a premium rebate program for children in the state's SCHIP income range who were precluded from SCHIP participation because they were not uninsured as the SCHIP program requires; the Illinois Comprehensive Health Insurance Program, which is the state's high-risk insurance pool; and a program that provides services to hemophilia sufferers.

Like other states, Illinois is subject to a maintenance-of-effort requirement for spending on these programs. However, the programs are not being expanded under the demonstration, with the exception of the hemophilia program, which is now required to include primary care services pursuant to the CMS special terms and conditions for the demonstration.[9] In addition, the Oregon HIFA amendment to the Oregon Health Plan demonstration provides FFP for a previously state-funded premium assistance program known as the Family Health Insurance Assistance Program (FHIAP).

ESI Implementation: The HIFA guidance states that, "Under the HIFA demonstration initiative, the administration strongly encourages state proposals that would further integrate, or at a minimum coordinate, Medicaid and SCHIP funding with private health insur-

ance options."[10] CMS has operationalized this element of the guidance to mean that HIFA demonstrations should include a premium assistance component, whereby Medicaid and/or SCHIP funds are used to pay an individual's share of an ESI premium when he or she has access to ESI.[11] As the HIFA initiative evolved, CMS set a number of policy precedents in this area.

The Illinois HIFA demonstration, approved on September 13, 2002, was the first in which a state was allowed to give optional Medicaid beneficiaries an informed choice between ESI and direct state coverage. Unlike premium assistance under Medicaid statutory rules, in this case individuals choosing to receive their coverage through ESI would not receive wraparound benefits from Medicaid for services not covered in their employers' plans. They would also be subject to the cost-sharing requirements in their ESI plan.

This provision also extends to SCHIP children, with an important caveat: If the employer's plan does not include immunizations, the state is required to cover this benefit. The beneficiary has the right to revert to direct state coverage on demand. The Oregon approval on October 15, 2002, took that concept even further, in that mandatory Medicaid beneficiaries are permitted to make an informed choice between ESI and direct state coverage.[12]

New Mexico set another ESI precedent when CMS approved its demonstration on August 23, 2002. CMS permitted the state to use an ESI model exclusively in its demonstration, with no expansion of direct coverage. Although this program has not yet been implemented, it still sets an important precedent for states wishing to leverage private resources and avoid expansions of their Medicaid and SCHIP programs. Arkansas's proposal, currently under CMS review, uses a similar model.

Unspent DSH funding: The Maine HIFA demonstration, approved September 13, 2002, represented a departure from CMS's previous policy on unspent DSH funds. Historically, CMS has allowed states to use funds that would otherwise be paid as DSH[13] to be redirected to purchase coverage for the uninsured. However, there has been a longstanding policy caveat that a state could only spend what they would have otherwise used under their approved state plan. This means that, in order to use DSH in a demonstration, funds would need to be diverted from hospitals that would have otherwise received the payments.

Maine gained approval to use previously unspent DSH in its demonstration. However, CMS required that the following condition be met: The state must submit a state plan amendment (SPA) adding the payments to the state plan, and show that the payments could legally be made to hospitals under statutory provisions that limit the amount of DSH payments to specific facilities.

CMS issued simultaneous approvals of the SPA and the demonstration proposal. This is an important precedent because it suggests a willingness on the part of the federal government to treat unspent DSH allotments more like unused SCHIP allotments—which states have been able to access previously—in the context of a HIFA demonstration, provided the applicable statutory requirements are met.

Denial of services: CMS's decision to permit providers in Oregon to deny services to individuals based on non-payment of copayments was another significant first. Although this authority is not given in the list of waiver and "cost not otherwise matchable" authorities that CMS included in the approval letter, CMS expressed its approval of this provision by referencing the state's proposal in the terms and conditions for the demonstration.

Table 1: Health Insurance Flexibility and Accountability (HIFA) Demonstrations

State	Approval Date	Expansion Population	State-Funded Program Included?	Precedents/Additional Design Features
AZ	12/12/01	◆ Childless adults with income up to 100% FPL ◆ Parents of Medicaid and SCHIP children with income between 100% and 200% FPL	Y	◆ SCHIP funding for childless adults ◆ Refinancing at enhanced FMAP of previous section 1115 demonstration population
CA	1/25/02 (not yet implemented)	◆ Parents/legal guardians of SCHIP children with income up to 200% FPL	N	N/A
CO	9/27/02	◆ Pregnant women with income between 133% and 185% FPL	N	N/A
IL	9/13/02	◆ Parents of Medicaid and SCHIP children with income up to 185% FPL (beginning with 54% FPL with intention of incremental phase-in)	Y	◆ Informed choice between ESI and direct coverage ◆ Federalization of high-risk pool ◆ Federalization of hemophilia program
ME	9/13/02	◆ Childless adults with income up to 100% FPL	N	◆ Use of unspent DSH
NM	8/23/02 (not yet implemented)	◆ Childless adults and parents of Medicaid and SCHIP children with income up to 200% FPL	N	◆ Design of ESI component; no direct state coverage
NJ	1/31/03	◆ Parents with income between 100% and 133% FPL	N	◆ Use of Medicaid eligibility SPA to create "expansion"
OR	10/15/02 (amendment to existing demonstration)	◆ Individuals with income up to 185% FPL, some of whom were previously covered in a state-funded premium-assistance program	Y	◆ Denial of service for refusal to pay cost sharing

Definition of expansion population: New Jersey's HIFA demonstration, which was approved January 31, 2003, used a new approach for defining its expansion population. HIFA demonstrations must expand health insurance coverage in the state. New Jersey met this requirement by submitting an SPA that applied a more stringent income eligibility standard to new applicants than to current beneficiaries.

Therefore, the beneficiaries were "grandfathered" into the program but no new applicants above the stricter income standard could become eligible. Individuals who did not meet the new eligibility requirement were then considered the expansion population for the purposes of the HIFA demonstration. It remains to be seen whether CMS would permit a state to use such an approach to meet the maintenance of effort requirement for receiving FFP for a state-funded program. Maintenance of effort was not an issue in New Jersey.

Limits on HIFA Flexibility

While HIFA is arguably a flexible vehicle for states to cover the uninsured, there are limits. Just as HIFA's possibilities can be best comprehended by examining approved demonstrations, so, too, can its constraints be understood most fully by evaluating states' experiences.

Financing: Although CMS has approved new uses of SCHIP funds, there have been limits. The specific elements that were not approved, and the states in which the issues arose, are as follows:

- Use of SCHIP funds to cover individuals with insurance (Illinois and Oregon);
- Use of SCHIP funds to cover children of state employees in a separate state child health program (Illinois);
- Use of SCHIP funds to cover adults in a demonstration at higher income levels than children in SCHIP (Illinois);
- Use of SCHIP funds to cover individuals who are otherwise eligible for Medicaid (Illinois, Oregon); and
- Use of SCHIP funds to cover individuals otherwise eligible for Medicare (Illinois).

In addition, CMS has placed limits on the types of previously state-only funded programs that can be eligible for FFP. For example, Illinois was not permitted to receive funding for a dialysis program because it offers a narrow benefit. On the other hand, they received permission to receive federal funding for a state-funded hemophilia program, but only if the state agreed to provide primary care to participants. Illinois was also not allowed to receive FFP for a state-funded program for nonqualified aliens based on the statutory prohibition against providing FFP for such individuals.

Cost Sharing: The HIFA guidance suggests a great deal of flexibility in the area of cost sharing, particularly for optional and expansion populations. In fact, the guidance suggests that there is no cap on cost sharing for optional adult populations (children are treated differently). However, CMS requested that New Mexico cap out-of-pocket expenses for adults who would be covered under the demonstration, based on a concern that the proposed premiums and cost-sharing amounts could be prohibitive for some individuals. States will need to consider the administrative requirements around complying with the cap and whether to place the burden of tracking expenses against the cap on the state or on beneficiaries.

In a proposal that was initially submitted as a non-HIFA section 1115 proposal, re-submitted as HIFA and then withdrawn, Washington state had requested cost-sharing provisions that exceeded HIFA standards. Specifically, the state requested authority to impose cost sharing higher than nominal limits on mandatory eligibles, and had also asked permission to impose premiums on transitional medical assistance (TMA) eligibles. In both instances, CMS had given feedback that the statute does not permit this level of cost-sharing, even under a demonstration. Washington has withdrawn its earlier proposal and replaced it with a non-HIFA section 1115 proposal focused on cost sharing.

Unresolved Issues

Although HIFA approvals have shed light on CMS's policy priorities, some issues remain unresolved. One important matter, which is a key component of the pending Arkansas proposal, is whether proceeds from an employer tax earmarked for the demonstration can be used as the state share in a demonstration. According to the financing mechanism outlined in Arkansas's proposal, employers would make payments to the state for the state's share of covering low-income employees through a limited benefit package. Thus, the state would use employer funds as state match to leverage the FFP. CMS has not yet made a formal ruling on this issue. The agency's decision will go a long way toward defining the extent of future flexibility that is allowable under HIFA.

Some interesting issues were raised in a state proposal that was later withdrawn prior to any formal CMS decision. In its March 1, 2002, submission, Michigan asked for federal funding for a system of county programs for indigent care. The demonstration structure would have permitted different income eligibility levels in different counties. Because Michigan requested that review of its proposal be suspended, it's not clear whether CMS would have permitted such an approach.

Another issue raised by Michigan's withdrawn HIFA proposal was whether the state could have extended coverage to individuals with disabilities with incomes up to 350 percent of the federal poverty level (FPL). CMS was reportedly actively considering this request, even though it would appear to violate the HIFA guidance prohibition on covering populations with incomes above 200 percent FPL, unless the state already has significant coverage at that income level.

Future Factors to Consider

Future developments will undoubtedly continue to shape the evolution of HIFA. Some factors that may influence it are addressed in this section.

State budget shortfalls: States have been in dire fiscal straits since the release of HIFA. According to a recent survey by the Kaiser Commission on Medicaid and the Uninsured, states are beginning "what is for some the fourth consecutive year of fiscal stress."[14] In response to fiscal pressures, all 50 states and Washington, D.C., implemented Medicaid cost-containment measures in 2003 and plan to use additional spending constraints in 2004. It remains to be seen whether states will see HIFA as an opportunity to help them control their budgets, or if they will instead pursue other cost-containment measures.

Congressional interest: Some in Congress are critical of CMS's approval of state proposals to use SCHIP funds for childless adults. If there were to be a successful attempt to prohibit future approvals, this would curtail the number of expansion opportunities available to states under HIFA.

State interest in leveraging employer dollars: As budgets continue to be stretched, states may be more interested in approaches like those of New Mexico and Arkansas that involve partnering with employers. Given CMS's insistence on ESI components in HIFA demonstrations, this interest may spur creative approaches.

Medicare/Medicaid reform: The legislative debate on Medicare reform could have far-reaching impacts on state Medicaid programs, depending on the outcome of questions about whether Medicaid agencies will get any relief from the high cost of providing drug coverage to individuals eligible for both Medicaid and Medicare. In addition, earlier this year, HHS proposed to modify the Medicaid program in ways that would have granted a great deal of new flexibility without waivers, but with a capped allotment funding design. Although this proposal never became the subject of legislation, it was clearly important to CMS and HHS. If Congress takes action to revisit this proposal, states may rethink whether to pursue section 1115 demonstrations to modify their Medicaid and SCHIP programs.

Continuing evaluation and analysis: In July 2002, the GAO issued a report that was sharply critical of HIFA. A follow-up to that report is scheduled for publication by the end of 2003. GAO's chief concern is the use of SCHIP funds to purchase coverage for childless adults. (The report can be accessed at www.gao.gov; it is report GAO-02-817.)

The GAO recommended that Congress consider amending the SCHIP statute to prevent future use of SCHIP funds for this purpose, and that HHS institute a formal process for public input into decisions on demonstration proposals. The report did not appear to slow the pace of HIFA approvals, but it remains to be seen whether a second report would increase congressional pressure to impose limits on HIFA through legislative avenues.

In addition, CMS has contracted with the Urban Institute to perform an evaluation of the development and early implementation of HIFA, and to develop an evaluation design to be used in subsequent examinations. Results are expected in December 2003. The Urban Institute will also conduct a larger-scale follow-up evaluation.

Conclusion

An analysis of HIFA approvals paints a picture of evolving policymaking. CMS has been most likely to limit states' proposals in order to protect vulnerable populations or to be consistent with core policy principles and legal and regulatory constraints. While HIFA activity may have slowed somewhat, several proposals are still under review that will undoubtedly provide more clarity.

About the Author

Theresa Sachs is a corporate manager with EP&P Consulting, a Washington, D.C.-based firm that assists state agencies with health reform and Medicaid operations. Formerly Ms. Sachs was a technical director at CMS, where she worked on HIFA and other section 1115 policy issues. She can be reached at tsachs@eppconsulting.com or 202.628.1134.

Endnotes

1 Department of Health and Human Services, "HHS to Give States New Options for Expanding Health Coverage: New Initiative Promotes State Innovations to Expand Access for the Uninsured," (HHS Press Release), August 4, 2001.

2 Language that would prevent HHS from approving section 1115 demonstrations that would use SCHIP funds for childless adults was introduced during debate on the Tax Relief and Reconciliation Act, and in conjunction with reauthorization of the Temporary Assistance to Needy Families program. So far, this provision has not been enacted into law.

3 The HIFA maintenance-of-effort requirement provides that, when federalizing a previously state-funded program, state expenditures under the demonstration must continue to meet or exceed previous state expenditures. Because federal funds are being added to the demonstration, it is not possible to meet maintenance of effort without a coverage expansion.

4 In a July 26, 2002, press release, then-Gov. Engler halted action on the proposal pending the outcome of several ballot initiatives. The current proposal was submitted under the administration of Michigan's new Gov. Granholm.

5 CMS, Center for Medicaid and State Operations, HIFA Status Report, obtained via e-mail on September 29, 2003.

6 Letter from Thomas A. Scully, CMS Administrator, to Vincent P. Meconi, Delaware Health and Human Services Secretary, dated March 19, 2003.

7 Medicaid budget neutrality policy separates demonstration participants into two groups: those who could be covered under the Medicaid state plan, if the state plan were made more liberal, and those who could be covered only under a demonstration. These are referred to as categorical and non-categorical populations. Childless, non-disabled adults fit into the latter category because there is no Medicaid category of eligibility that would include them. CMS does not require states to identify sources of savings to cover the cost of categorical eligibles, but for non-categorical eligibles the state must either identify a source of savings elsewhere in the demonstration, or divert DSH funds for this purpose.

8 Page 8 of the guidance states, "As the purpose of the HIFA waiver is to create new coverage options, states will not be permitted to receive additional federal match for previously state-only health service programs under a waiver. Federal financial participation will not be claimed for any existing state-funded program. If a state is seeking to expand participation or benefits in a state-funded program, a maintenance-of-effort requirement will apply." www.cms.gov/hifa/hifagde.asp, accessed October 14, 2003.

9 CMS, Special Terms and Conditions, KidCare Parent Coverage Demonstration, p. 10.

10 CMS, Guidelines for States Interested in Applying for a HIFA Demonstration, pp. 4–5.

11 The earliest HIFA demonstrations, Arizona and California, were not required to offer a full premium assistance component, but rather were allowed to conduct feasibility studies. Other HIFA states—except Colorado, where the only expansion population is pregnant women—were required to address this requirement more fully.

12 Although HIFA precludes offering reduced benefits to mandatory Medicaid eligibles, the Oregon HIFA amendment is related to the pre-existing Oregon Health Plan demonstration, which had already set the precedent of reducing benefits to mandatory eligibles.

13 DSH funding, which is governed by statutory allotments to each state with a DSH program, covers uncompensated care delivered in hospitals serving a disproportionate percentage of Medicaid and low-income patients. States have flexibility in how they set up their DSH programs.

14 Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2003—Results from a 50-State Survey*, September 2003, p. 1.

AcademyHealth
Advancing Research, Policy and Practice

1801 K Street, NW, Suite 701-L
Washington, DC 20006
tel: 202.292.6700
fax: 202.292.6800
e-mail: SCI@academyhealth.org
web: www.statecoverage.net

Nonprofit
Organization
U.S. Postage
PAID
Permit No. 3999
Washington, DC