

# Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States

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*The Health Insurance Flexibility and Accountability (HIFA) demonstration initiative is a significant milestone in the evolution of the states' ability to use section 1115 of the Social Security Act. Section 1115 gives the Secretary of the U.S. Department of Health and Human Services (HHS) the discretion to let states modify Medicaid and the State Children's Health Insurance Program (SCHIP) by waiving certain portions of Titles XIX and XXI.*

Through section 1115, the federal government has encouraged states to conduct research and demonstration projects of innovative coverage models using existing federal financial resources.<sup>1</sup> Over the years, states have used 1115 waivers to tailor their Medicaid and SCHIP programs to their unique political and economic environments.

Some have pursued the waivers to restructure their Medicaid delivery systems to managed care, for example, while others have used them to expand eligibility to new populations.

The HIFA initiative builds on section 1115 by giving states enhanced waiver flexibility to streamline benefits packages, create public-private partnerships, and increase cost-sharing for optional and expansion populations covered under Medicaid and SCHIP.<sup>2</sup> It also allows states to have waivers approved more quickly than was previously possible, provided that applications are submitted within the parameters for HIFA specified by the Centers for Medicare and Medicaid Services (CMS). This issue brief describes what HIFA is, what it allows states to do, how states are using it, and how it may evolve in the future.

## Origins of HIFA

Although some states have used section 1115 waivers to define benefits packages in the past, the degree to which they have been permitted to do so has depended on the Secretary of HHS. Historically, states generally have found the amount of flexibility granted through HHS to be limiting.

Early in the course of the Bush administration, the National Governors' Association (NGA) unveiled a health reform proposal asking the federal government to grant states broader flexibility in designing benefits and impose cost-sharing requirements under Medicaid and SCHIP.<sup>3</sup> With two former governors in top federal positions (Bush and HHS secretary Tommy Thompson), the political environment was ripe for a change in federal policy that would be responsive to states' needs.

HIFA grew out of the NGA proposal. Through it, the federal government has given states the authority to design and manage their public coverage programs in ways that were not previously permitted—by allowing them to limit enrollment, modify benefit designs, impose greater cost-sharing limits, extend coverage to single adults and couples, and build on employer-sponsored insurance (ESI) more easily. As with other 1115 demonstration waivers, HIFA projects are approved for an initial five-year period from the date of implementation.

In return for flexibility, states are expected to extend coverage to more people. In addition, initiatives must be statewide and seek to develop coordinated private and public health insurance coverage options to the low-income uninsured.

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Importantly, HIFA allows states to expend unused Title XXI allotments for expanding to populations beyond children, including parents, single adults, and couples. (Previously, states had been required to cover children up to 200 percent of the federal poverty level (FPL) before SCHIP could be used for other purposes.) In addition, states can cover these groups under Title XIX as long as budget neutrality can be demonstrated.

States are allowed under HIFA to tailor benefits packages for optional and expansion populations, but not for mandatory populations—which is ostensibly the group most in need. But some advocates have pointed out that the difference between mandatory, or “core,” populations and expansion populations is not necessarily the same as that between lower and higher income groups. Some individuals that fall under expansion populations—such as childless adults—can be quite poor and unable to afford the potential cost-sharing increases that HIFA allows the state to impose. Moreover, critics of the initiative contend that the pared-down benefits it permits represent an erosion in coverage for vulnerable populations.

Still, a number of states are pursuing HIFA because they believe it will enable them to give more people some coverage rather than having to drop certain beneficiaries entirely in order to meet budgetary challenges.

## What Does HIFA Allow States to Do?

Several parameters under HIFA differ from those under the original 1115 waiver process.

### *Enrollment limits*

The most significant tool that HIFA makes available to states is the ability to impose enrollment limits. Enrollment can be controlled on either an expenditure or enrollment basis. This feature, which appears to reflect the gubernatorial experience of Secretary Thompson with Wisconsin’s

BadgerCare program, transforms the nature of expansion initiatives from entitlements with unknown limits to expansions that can be managed as budget changes necessitate. Enrollment limits are also a response to the political reality that state legislatures may be unwilling to entertain programmatic expansions in difficult economic times without the option to cap enrollment.

### *Flexibility in benefit design*

HIFA’s benefit design flexibility is quite broad for expansion populations and less so for optional groups. For optional populations, the CMS template provides that states can offer one of the Title XXI benefit packages, including the largest commercial HMO package in the state, the federal employees’ plan, the state employees’ plan, or an actuarial equivalent of one of the three. However, the template also allows states to submit a different package that is subject to the Secretary’s approval. For expansion groups, the required design is a basic primary care package, which does not necessarily include an inpatient benefit.

### *Cost-sharing*

Cost-sharing requirements under HIFA remain “nominal” for mandatory populations, but not for optional and expansion populations, provided that expenditures attributable to children do not exceed the statutory limit of 5 percent of family income imposed by Title XXI. In theory, co-payments can be a substantial portion of the cost of care, particularly for adults.

HIFA may allow states to require patients to make co-payments as a condition of receiving care, although CMS has not yet made a determination on this. Under Medicaid today, providers are not allowed to deny service when people don’t make a co-payment.

### *Single adults and couples*

HIFA provides the first explicit path to provide coverage to non-categorically linked populations that doesn’t involve either savings or payment diversions. Currently, in order to be Medicaid-eligible, an adult must be a parent of an eligible child or must be elderly, blind, or disabled (the law defines

these categorically eligible groups). Under HIFA, single adults and childless couples—who have not been eligible for Medicaid up to now—may be targeted in expansion programs. States probably cannot expand these populations to higher income levels than they do for children.

Because Medicaid did not previously cover adults without a categorical linkage, some states have implemented programs offering insurance to these groups using state-only dollars. Under HIFA, there is an ability to leverage these state-only programs in order to expand coverage. Although HIFA requires state maintenance of effort, with the addition of federal funding, states may find that an expansion population can be added to their program at no net cost to them. Arizona, the first approved HIFA waiver, covers previously state-funded populations under a section 1115 waiver amendment and a population expansion under HIFA.

### *Employer-sponsored insurance (ESI)*

HIFA strongly emphasizes state coordination with private health insurance coverage, principally through premium assistance for the purchase of ESI. Until HIFA, states either had to demonstrate the cost-effectiveness of purchasing premiums under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 on a case-by-case basis, or they had to meet a complex test for family coverage purchased under Titles XIX or XXI. The narrowness of these programs and the administrative complexity that they created for employers and states led to very low participation.

In an effort to remedy this, HIFA allows states to pursue broad, statewide ESI initiatives. In fact, CMS is most likely to approve HIFA applications that offer expanded coverage to individuals with access to ESI. CMS has required states whose plans did not initially include building on private coverage—such as Arizona and California—to explore the role of ESI in their expansions.

One of the most difficult potential policy questions facing CMS is whether they will allow families with children who are Medicaid eligible to enroll in ESI options without full Medicaid benefits.

### *HIFA waiver submission and approval*

CMS has recently issued the clearest statement to date on the procedure for the section 1115 waiver process,<sup>4</sup> as well as a 14-page template for the HIFA waiver application that covers both Titles XIX and XXI.<sup>5</sup> Prior to HIFA, the application process was burdensome, and most section 1115 waiver and demonstration proposals were about the size of a large phone book. CMS has also released a budget neutrality template in conjunction with the application template.

### **State Experiences with HIFA**

To date, a number of states, including Arizona, California, Michigan, and New Mexico, have submitted HIFA applications; as of this writing, Arizona and California have been approved.<sup>6</sup> Utah received approval in February 2002 for their section 1115 waiver proposal, which, while not technically a HIFA initiative, is certainly in its spirit. (See box on page 5.) Washington state has also filed an 1115 waiver proposal with goals similar to those outlined in HIFA.

#### *Arizona*

Arizona secured the first statewide managed care section 1115 demonstration waiver and also the first waivers submitted and approved under HIFA. In September 2001, Arizona submitted three proposals to CMS:

- A HIFA waiver to enroll adults and couples under Title XXI with incomes up to 100 percent FPL;
- A HIFA waiver to enroll parents of eligible children (under Titles XIX and XXI) with incomes between 100 and 200 percent FPL; and
- An amendment to their existing section 1115 demonstration to allow coverage of these populations once the Title XXI allotment is exhausted.

Arizona's HIFA waivers were approved in December 2001. Arizona was faced with expanding coverage up to 100 percent FPL for all Arizonans pursuant to an initiative measure, and the state had already made a considerable investment in state-funded populations. For these reasons, the HIFA waivers and the amendment to the section 1115 waiver offered two major benefits: they allowed the state to leverage federal dollars while expanding Title XIX coverage, and they enabled it to use its full Title XXI allotment.

Under the Arizona waivers, expansion populations will receive the full Medicaid benefit package through the state's contracted health plans, with the co-payment structure now in place. Parents with incomes between 100 percent and 200 percent FPL will be subject to the premium and co-payment schedule established for SCHIP.

#### *California*

California's approved HIFA waiver allows the state to use its Title XXI allotment to expand eligibility to parents under 200 percent FPL and three groups in eligibility transition, including:

- Individuals in a Medi-Cal or a Healthy Families (SCHIP) eligibility re-determination who are potentially eligible for the other program, but for whom a final determination has not yet been made, and
- Medi-Cal eligibles who are not yet enrolled.

To prevent gaps in coverage for these groups, up to two months of eligibility are extended under the HIFA waiver.

The state had previously proposed their eligibility expansion plan as a regular section 1115 waiver, which had not yet been approved more than a year after submission. After the state converted the waiver to the HIFA format, it gained approval in about 10 days.

In total, the California initiative will serve 275,000 newly eligible individuals. Expenditures and enrollment will be capped at the available SCHIP allotment. The benefit package offered is the state

employee package. Cost-sharing is consistent with Title XXI requirements. Like Arizona, California will conduct a 16-month study to determine the feasibility of implementing an ESI pilot program.

#### *Washington*

Washington state's waiver proposal seeks the most far-reaching changes and flexibility that any state has asked for from the federal government to date. Washington's proposal was submitted as a section 1115 waiver but will likely be resubmitted under HIFA. The application requested broad authority to reduce benefits, increase cost-sharing, and impose enrollment caps on mandatory and optional populations. The most unique feature of Washington's proposal is that it sought the authority to implement a range of program changes on an as-needed basis, rather than at the start of the waiver period. Specifically, Washington asked:

- To be able to reduce benefits when needed down to a floor for mandatory and optional coverage groups;
- To use its unspent Title XXI allotment to expand coverage through the state's Basic Health Plan by adding up to 20,000 parents, single adults, and couples;
- To impose cost-sharing up to the Title XXI maximums on all mandatory, optional, and expansion populations (excluding preventive services);
- To waive Early and Periodic Screening, Diagnostic and Treatment for higher income children; and
- To impose enrollment limits on optional as well as expansion populations.

CMS responded to Washington's proposal with a request for additional specificity in proposed benefit changes, cost-sharing, and the eligibility groups to which those changes will apply. CMS also made clear that they would require Washington to submit a formal amendment for their approval if the state planned any future changes in benefits and/or cost-sharing. Finally, CMS suggested that the state add HIFA features to its proposal so it could be considered under HIFA.

## HIFA Mechanics

States applying for a HIFA waiver are asked to complete nine sections of the template with information on income limits, eligibility groups, benefit packages, and so on. In total, eight attachments are required. Most sections are self-explanatory, but the areas on budget neutrality can be complex.

### Budget neutrality

By far the most complicated part of applying for a HIFA waiver, as is the case with section 1115 waivers, is demonstrating budget neutrality. In order to have a budget neutral proposal, a state must show that expenditures under the waiver are no greater than expenditures in the absence of the waiver. CMS provides two budget neutrality templates for the HIFA application: one for Title XXI and one for Title XIX. Both require states to estimate costs “with waiver,” but only the template for Title XIX requires them to submit five years of historical data.

**Title XXI.** States that intend to use only their unused Title XXI allotments are in a fortunate position, because for them the test of budget neutrality is allotment neutrality. In other words, as long as a state does not exceed its SCHIP allotment, the budget neutrality test is met. Anticipated but unallocated redistributed dollars under Title XXI cannot be factored into the Title XXI budget neutrality test. Because HIFA permits states to use unobligated Title XXI funding that otherwise would revert back to the federal government, presumably these dollars could be used once they are allocated. Given their ability to limit enrollment through HIFA, states may wish to use their SCHIP funds (with the favorable match rates) to expand coverage to selected populations.

**Title XIX.** If the HIFA application is under Title XIX, the budget neutrality test and negotiation process appears to be the same as it is with any section 1115 waiver. However, there is a template and guidelines to assist states in addressing the five main components of budget neutrality.

*Aggregate or per capita.* In all likelihood, budget neutrality will be a per capita test for most states pursuing ESI or other coverage expansions. This means that states are not at risk for increased caseload in their Medicaid populations, only for the spending amount per client. Under an aggregate limit, which measures total federal expenditures, the state is at risk for total expenditures, even if spending increased due to Medicaid caseload growth.

*Trend rate.* A trend rate is used in budget neutrality to project expenditures under the waiver. The HIFA template gives states a choice of either a state-specific Medicaid trend rate, the President’s budget trend rate, or the Medical Care Consumer Price Index. If a state chooses a state-specific Medicaid trend rate, negotiations around the rate are likely to take some time.

*Disproportionate Share Hospital (DSH).* To maintain budget neutrality, states have the option of using their disproportionate share dollars. However, if DSH dollars are used to finance the expansion, DSH is limited to the lesser of the allotment or base year spending. In other words, unspent DSH allotment dollars cannot be used in the same way that the Title XXI unspent allotment can.

*Services.* States need to consider the services that fall under the aggregate or per capita limitation as they negotiate terms for budget neutrality. States pursuing expansion programs typically exclude long-term care, for example.

*Populations.* One of the most important aspects of budget neutrality is the definition of which populations are “scored” for budget neutrality purposes. As a general rule, CMS has allowed states to add populations to both the “with” and “without” waiver spending estimates if a population could be covered under a state plan change such as Section 1902(r)(2)<sup>7</sup> and/or 1931(d).<sup>8</sup> This results in no “score” against budget neutrality. It is only those populations that cannot be brought into coverage through a state plan amendment (single adults and childless couples) that “score.”

The estimates that states submit with their applications are a good faith demonstration that their waiver is likely to meet a budget neutrality test. However, it is the calculations performed according to the terms negotiated on each component of the test, and not the estimates themselves, that form the ultimate basis of budget neutrality.

### Evaluation

Unlike section 1115 waiver applications, HIFA does not require a formal evaluation plan, although CMS does intend to independently assess the HIFA initiatives. Instead, HIFA requires measurement and monitoring of rates of uninsurance, private coverage (to keep track of crowd-out), and take-up of Medicaid, Medicare, and other health insurance. The state must also identify the sources of data for this information.

### Timing and Processing

HIFA waivers are processed within CMS by the Center for Medicaid and State Operations. CMS intends that HIFA applications will be evaluated and processed more quickly than those for regular section 1115 waivers, but the time to approval is still measured in weeks and months, not days. Unlike the process for regular section 1115 waivers, the federal sign-off for HIFA waivers is streamlined because the Executive Branch has agreed on the principles for approval in advance. Under a regular section 1115 waiver, roughly 19 parties within CMS, the Department of Health and Human Services, and the Office of Management and Budget must sign off on a waiver approval.

## Utah's 1115 Waiver in the Spirit of HIFA

Utah's recent 1115 waiver is not through HIFA, but is similar in spirit. Under the Utah waiver, the state will reduce some benefits to current Medicaid eligibles (including some Temporary Aid to Needy Families [TANF] parents) and reallocate the savings to expand coverage to 25,000 uninsured individuals (parents, single adults, and couples) with incomes under 150 percent FPL.

The benefit package for this expansion population does not include inpatient hospitalization but offers physician office visits, immunizations, emergency care, lab, x-ray, medical equipment and supplies, basic dental care, hearing and vision screening, and prescription drugs.

Optional Medicaid groups (excluding children and pregnant women) will receive a benefit plan comparable to private insurance rather than the full Medicaid package. Cost-sharing for optional groups will increase from \$2 to \$3 a visit and from \$1 to \$2 for prescription drugs. Significantly, Utah changed its statutes so that private insurers could offer a primary care limited benefit plan. This means that Utah will be able to purchase the primary care benefit through the private market rather than through a public program. While the Utah waiver was submitted under section 1115 rather than HIFA (probably because of the benefit reductions for TANF parents), similar state proposals could probably be handled through HIFA.

### Michigan

Michigan's waiver application is one of the most comprehensive HIFA submittals to date. In it, the state proposes to replace all current coverage of optional parents with two new plan designs. For parents with incomes at or below 50 percent FPL, the plan is similar to a commercially available plan. It imposes co-payments of \$5 on office visits and \$25 on non-emergency use of the emergency room. For parents with incomes between 51 percent and 100 percent FPL, the plan increases co-payments to \$10 and offers \$500 per day of inpatient coverage up to five days. Both parent plans include mental health and substance abuse coverage, but only through the public system.

Michigan's proposal would also cover childless adults with incomes up to 36 percent FPL. Benefits do not include inpatient coverage and require co-payments with a tiered co-pay for prescription drugs.

Three additional expansion groups are included in Michigan's proposal:

- Pregnant women from 186 percent to 200 percent FPL with a full Medicaid benefit;
- Disabled individuals up to 350 percent FPL with a full Medicaid benefit; and

- Childless adults with incomes between 36 percent and 100 percent FPL in counties that choose to offer a plan.

Each of the coverage groups can obtain a voucher equal to the cost of their plan to use toward purchasing employer-sponsored coverage. Because counties can choose to offer a plan, Michigan's proposal can result in differences across the state. Yet the HIFA template suggests that initiatives must be statewide. As of this writing, Michigan's proposal is still under review; it's not clear whether it will approve a plan that is not statewide.

### New Mexico

New Mexico's recently submitted HIFA proposal—called the State Coverage Initiative—would provide private health insurance for up to 40,000 adults (parents, single individuals, and couples) with incomes under 200 percent FPL. Under the plan, managed care organizations that respond to a state's request for proposal will provide a standardized benefit package, which is slightly more limited than the typical commercially available package, to the newly covered groups. Rather than a traditional "premium-assistance" program, New

Mexico's plan offers employers and employees specific coverage options. There are several unique features of New Mexico's proposal:

- It requires a \$75 dollar employer contribution;
- It requires employees with incomes between 101 percent and 150 percent FPL to pay a \$20 premium and those with incomes between 151 percent and 200 percent FPL to pay a \$35 dollar premium;
- The state and federal governments will subsidize the remainder of the estimated \$210 cost of private coverage; and
- Co-payments are not nominal (generic drugs \$10; named brand \$25; physician visits \$5, \$10, or \$20 on a sliding scale).

New Mexico will allow managed care organizations to market coverage directly to employers and employees. The state is also considering the use of insurance brokers as another marketing avenue. New Mexico's proposal also includes the following provisions to prevent crowd-out:

- Employers will be required to offer 75 percent of their employees' coverage.
- Employees must not currently have coverage.
- Brokers will receive differential fees in order to provide incentives for marketing other commercial products before the subsidized plan.
- Managed care plans will market their commercial products before the State Coverage Initiative to employees who did not enroll because of the required premium contribution.
- The product is more limited than commercially available insurance and thus less attractive.

### Conclusion

HIFA allows states to design benefits similar to private health insurance, to build on the existing employer-based market, to adopt cost-sharing significantly higher than the nominal amounts allowed under current law, and to expand coverage without creating new entitlements.

As state budgetary pressures continue to mount, states will no doubt pursue creative approaches that will push the restructuring

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allowed under HIFA. How CMS will balance the coverage expansions proposed under HIFA against the concerns some stakeholders have about the initiative remains to be seen. 🏠

## Endnotes

- <sup>1</sup> For more information, see <http://www.statecoverage.net/pdf/issue-brief501.pdf>.
- <sup>2</sup> Optional populations are groups that can be covered under a Medicaid or SCHIP state plan (i.e., they do not require an 1115 waiver to receive coverage). Expansion populations are individuals who can only be covered by Medicaid or SCHIP under an 1115 waiver (e.g., childless, non-disabled adults under Medicaid). Mandatory populations are groups that a state is required to cover in its Medicaid state

plan (e.g., children under age six, pregnant women up to 133 percent FPL).

- <sup>3</sup> For more information, see [http://www.nga.org/nga/legislativeUpdate/1,1169,C\\_POLICY\\_POSITION^D\\_1431,00.html](http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_1431,00.html).
- <sup>4</sup> For more information, see <http://cms.hhs.gov/hifa/hifagde.asp>.
- <sup>5</sup> For more information, see <http://cms.hhs.gov/hifa/hifatemp.pdf>.
- <sup>6</sup> In addition, Colorado, Delaware, Illinois, Maine, Minnesota, and Oregon have submitted HIFA applications. See <http://cms.hhs.gov/hifa/hifaadem.asp> for approved waivers and <http://cms.hhs.gov/hifa/hifapend.asp> for pending waivers.
- <sup>7</sup> Allows states to expand coverage for children, elderly, and the disabled.
- <sup>8</sup> Allows coverage of parents of eligible children.

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