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## HIFA: Finding the Flexibility

### Summary

The Health Insurance Flexibility and Accountability (HIFA) demonstration initiative announced by the U.S. Department of Health and Human Services (HHS) on August 4, 2001, provides states with an opportunity to expand health insurance coverage to more individuals. HIFA emphasizes statewide approaches that maximize the use of private health insurance coverage and that integrate Medicaid and State Children's Health Insurance Program (SCHIP) funding. Based in part on an NGA proposal to restructure Medicaid, HIFA signals new flexibility for states to design their programs. The HIFA guidance<sup>i</sup> issued by the Center for Medicare and Medicaid Services (CMS) promises an expedited review for proposals that meet the guidance parameters, although no new review process is specified. This *Issue Brief* examines some key parameters outlined in HIFA and discusses implications for the design of state programs.

### Eligibility

HIFA does not make adjustments to benefits or eligibility for mandatory Medicaid populations. The HIFA guidance identifies two populations that may be covered:

- **Optional populations.** These populations may be covered under either Title XIX (Medicaid) or Title XXI (SCHIP) state plans at the state's option, regardless of whether they are currently covered. Optional populations in Medicaid include children, families, and pregnant women with income above federal minimum income levels.<sup>ii</sup> Disabled and elderly individuals with income above Social Security income levels and the medically needy are also part of this population. All children covered through SCHIP are optional populations, as are parents in an SCHIP premium assistance or family coverage program coverable under the state plan.
- **Expansion populations.** Expansion populations are those individuals not previously covered under Medicaid or SCHIP. Expansion populations primarily include childless adults; pregnant women over age 19 and above 185 percent of the federal poverty level (FPL); and some small subgroups, such as nonrelative caretakers and noncustodial parents. HIFA provides more flexibility to cover these populations.

Another eligibility parameter set by HIFA is to focus on the uninsured population below 200 percent of FPL. The HIFA guidance defines "income" as gross income, excluding income sources that cannot be counted pursuant to other statutes (such as Agent Orange payments.) This guideline continues a precedent to establish upper eligibility levels the current administration used in its first approval of a SCHIP section 1115 demonstration for Minnesota.<sup>iii</sup> Many states have traditionally used eligibility levels higher than 200 percent of FPL, used net or countable income, or disregarded a portion of income for eligibility determinations. Therefore, states will need to consider the following issues in designing their HIFA demonstrations:

- **Size of the expansion.** Depending upon the population the state targets for coverage, a gross income limit of 200 percent of the FPL may not be adequate. For example, states trying to expand coverage to pregnant women above 185 percent of the FPL may find that few of those women have net income above 185 percent of the FPL and gross income below 200 percent of the FPL.
- **Coordinating eligibility.** Using gross income may split eligibility within families unless the program is carefully designed. Parents subject to a gross income test may not be eligible for coverage, while their children are eligible under a net income test. In addition, eligibility determination will be more complex. For example, a state that currently collects only information about the amount of a family's

take-home pay would also need to get information about the amount of gross wages from the family. This additional step can cause confusion for a family, and subsequently delay the application process. States may also need to alter their eligibility systems since HIFA permits only statutorily-excluded income to be deducted from gross income. Currently, states may use additional deductions for net income determinations.

- **Insured individuals.** HIFA demonstrations are intended for individuals with no insurance. However, some states are also concerned about providing additional coverage for the underinsured or for those who cannot afford private insurance. These individuals may already be receiving Medicaid coverage under the state's plan since Medicaid permits coverage of insured individuals. If coverage for this population is the sole purpose of the HIFA waiver, then states will need to explore coverage of this population outside of HIFA.

The HIFA guidance indicates that states that want to raise eligibility to levels higher than 200 percent of the FPL should demonstrate that high coverage rates already exist below 200 percent of the FPL and that coverage above 200 percent of the FPL will not induce people to drop private coverage. However, no guidance is provided as to how these factors should be demonstrated or what criteria will be used to evaluate state data.

### **Benefits**

For optional and expansion populations, states can alter their usual Medicaid benefit package to more closely resemble the private market. Although several states with existing section 1115 demonstrations offer an altered Medicaid benefit package, HIFA now provides guidelines for these packages.

Optional populations can be offered one of the SCHIP benefit packages.<sup>iv</sup> States have wide discretion in designing benefits for optional populations by using SCHIP coverage options for “actuarially equivalent” and “Secretary-approved” benefit packages. For example, Wyoming designed a benefit package for its SCHIP population that received HHS Secretary approval rather than using one of the SCHIP benchmark packages. HIFA specifies that the benefits for optional populations, at a minimum, must include inpatient and outpatient hospital services; physician surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including immunizations. Since optional populations tend to be children, disabled, and elderly, states should carefully consider how to modify health benefits while meeting the needs of these more vulnerable populations. If benefits are reduced from current levels, states should be prepared for negative reactions from enrollees and advocates. When modifying benefits, states tend to put limits on utilization rather than eliminating a specific benefit.

States have even wider flexibility in designing benefit packages for expansion populations under HIFA and are only required to include basic primary care. However, single-benefit proposals will not likely be approved.<sup>v</sup>

### **Cost Sharing**

HIFA permits cost sharing (e.g., premiums and copayments) for both optional and expansion populations. Again, many states are using cost sharing in their section 1115 statewide demonstrations and in SCHIP. For purposes of HIFA, the guidance clarifies that cost sharing attributable to children cannot exceed 5 percent of family income. It does not impose any other limits. States planning to impose cost sharing will need to consider how it can be imposed while maintaining program affordability. While cost sharing may be used (e.g., to encourage appropriate use of primary care services in place of more expensive emergency room treatment), states may want to monitor whether new cost-sharing requirements impact participation rates and utilization of services among targeted populations.

### **Premium Assistance**

The HIFA demonstration initiative strongly encourages states to integrate Medicaid and SCHIP funding with private insurance options. States planning to expand coverage using HIFA may want to design their programs to include assistance for individuals to pay premiums for coverage offered by their employers

or for private individual coverage. This is beneficial because employer contributions help lower the cost of coverage to the state and federal governments. In addition, some individuals may be more inclined to enroll in the program if they can obtain their coverage through private sources.

Designing premium assistance programs is challenging. While several states have implemented premium assistance programs, either through their Medicaid Health Insurance Premium Payment (HIPP) programs or through SCHIP, enrollment numbers are small and administration is complex. It is difficult to ensure that benefits and cost sharing meet Medicaid or SCHIP standards. Likewise, many employers are reluctant to participate in government programs that may increase their management burdens. Another complication is that many individuals in the targeted income range may be employed, or employed in the same job, for only short periods of time. Further, there is little consensus on how much public programs “crowd-out” private coverage by inducing employers to reduce their contribution levels or discontinue health benefits.

The HIFA guidance removes the cost-effectiveness tests in the HIPP and SCHIP laws. It signals that there is more flexibility in benefit packages and cost sharing when premium assistance programs are used. However, HIFA does not provide any additional guidance as to what this flexibility may entail or how to successfully structure these programs.

Key issues states should address in their waiver applications related to premium assistance include:

- **Minimum benefits.** Although HIFA promises more flexibility for premium assistance programs, definitions are still needed for the minimum benefit package to be offered and the process for ensuring those benefits. It appears this process under HIFA may be simplified by checking that required benefits are present in the employer plan since HIFA does not require a certain level of coverage (number of visits or dollar amount) for each benefit. If wrap-around coverage will be offered, this process should also be described.
- **Cost sharing.** States will need to discuss their process for ensuring the 5-percent cap on cost sharing for children. Many states have implemented processes for SCHIP children, so those processes may be adapted for HIFA. Additionally, the HIFA application template asks for information about cost sharing limits for other participants in premium assistance programs. These amounts will vary widely among employer health plans, so one possible way to address this may be to set an overall family maximum.
- **Crowd-out.** The state will need to examine any existing data on the impact of Medicaid and SCHIP to determine appropriate steps to prevent substitution of coverage. The SCHIP regulation requires a six-month period without insurance prior to enrolling in a premium assistance program, but HIFA does not apply this requirement. States should provide a monitoring plan with HIFA waiver applications that describes how they will monitor substitution of coverage.

### **Financing and Budget Neutrality**

Financing is another challenging aspect of the HIFA demonstration initiative. Demonstration projects are required to be budget neutral. They cannot result in higher costs to the federal government over the life of the project (generally five years) than would have been spent in the absence of the demonstration. States will need to find savings in their programs to finance expansion populations.<sup>vi</sup> There are several sources of financing from SCHIP and Medicaid that may be available to states.

- **Managed care savings.** Existing statewide 1115 demonstrations most commonly obtain savings through managed care. This funding source is likely to be limited due to rising premium costs and the fact that most states are already using managed care to the maximum extent feasible.
- **Redirecting Medicaid disproportionate share hospital (DSH) payments.** States could use allotted DSH funding because the need to pay hospitals for services to indigent patients is reduced when health insurance is provided.

- **Benefits savings.** To the extent a state offers benefits more closely resembling private coverage options or eliminates coverage for ineffective treatments, the savings could be used to finance expansion populations.
- **Premiums paid by or on behalf of enrollees.** Premiums paid by enrollees potentially reduce state (and federal) costs. However, some states' SCHIP experience indicates that premiums do not generate much revenue and are offset by administrative costs. An unanswered question is whether CMS would consider savings obtained from the employer contribution in a premium assistance program as savings for the purposes of budget neutrality since the employer contribution reduces both state and federal costs.<sup>vii</sup>

SCHIP monies are a major funding source states may use for HIFA. When SCHIP funds are used, "allotment neutrality" rather than budget neutrality applies. Instead of obtaining savings to finance coverage expansions, a state may spend the unspent portion of its SCHIP allotments up to the annual allotment cap, as well as currently redistributed funds. This approach has an additional advantage. States would receive the SCHIP enhanced federal matching payments for expansion populations covered using the SCHIP allotment, although costs for optional Medicaid populations would be matched at the state's usual Medicaid matching rate. For many states this may be a promising source of funding for expansions. However, under law, SCHIP allotments decrease significantly beginning in 2002 and, in combination with increasing enrollment of SCHIP children, may become a less viable funding source in the future.

### Conclusion

HIFA offers states the opportunity to expand coverage to previously uninsured individuals and provides new flexibility in the benefits that can be offered and in the cost sharing that can be imposed. At the same time, several issues need clarification from CMS. These issues include what criteria will determine when a state will be given flexibility to set eligibility levels above 200 percent of income and what additional flexibility will be available for premium assistance programs. Some parameters of the HIFA demonstration initiative are unclear, so it remains to be seen whether the promise of expedited review can be realized. CMS plans to release a set of questions and answers for states to use as guidance in preparation of HIFA waiver applications, although monitoring what is approved in other states might be equally as useful a tool. States that are considering developing a HIFA waiver are encouraged to contact CMS first to determine if the HIFA process is suitable for the state's goals for expansion.

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### ENDNOTES

<sup>i</sup> The HIFA guidance may be found at the CMS Web site at <[www.hcfa.gov/medicaid/hifademo.htm](http://www.hcfa.gov/medicaid/hifademo.htm)>.

<sup>ii</sup> Federal minimum income levels are 133 percent of the FPL for pregnant women and children under age 6, 100 percent of the FPL for children between the ages of 6 and 17, and equal to section 1931 standards for 18-year-olds. Coverage is also required for families with income and resources that would have qualified them for AFDC on July 16, 1996. HIFA requires states to continue to cover "mandatory" Medicaid eligibility groups and maintain the Medicaid eligibility levels for children that were in effect on June 1, 1997.

<sup>iii</sup> On June 13, 2001, Minnesota received approval to cover parents of eligible children with gross income at or below 200 percent of the FPL. The state had initially proposed coverage to 275 percent of the FPL.

<sup>iv</sup> Benchmark benefit packages permissible under SCHIP are: coverage the same as the standard Blue Cross/Blue Shield preferred provider option available under the Federal Employee Health Benefits Program; coverage available to state employees in the state involved; and the benefit plan with the largest commercial enrollment in the state that is offered through an HMO. States may also provide coverage that is actuarially equivalent to one of benchmark packages or HHS Secretary-approved coverage.

<sup>v</sup> Basic primary care for expansion populations is defined as health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. States have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services.

<sup>vi</sup> Because optional populations can be covered under the Medicaid state plan, they are treated as a pass through for budget-neutrality purposes. Their costs are included in the projection of federal Medicaid spending in the absence of the demonstration ("without waiver spending") that is established as a limit on the projected spending under the demonstration ("with waiver spending").

<sup>vii</sup> States cannot receive federal matching payments for expenditures financed by premiums paid by or on behalf of enrollees. This *Issue Brief* was written by Cynthia Shirk, under contract to NGA, with support from the David and Lucile Packard Foundation.

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