THE KAISER COMMISSION ON
Medicaid and the Uninsured

Appendix

Side-by-Side Comparison of HIFA Guidance and Medicaid and CHIP Statutory Provisions

Note: This presentation of HIFA waiver policy is based on guidance issued by the Center for Medicare and Medicaid Services in August 2001, the "Report on the Health Insurance flexibility and Accountability (HIFA) Initiative: State Accessibility to Funding for Coverage Expansions" issued by CMS, dated October 4, 2001, and various presentations by CMS staff in the fall and early winter following release of the HIFA guidance. Further clarification of some of the policy questions raised by the guidance is expected from CMS.

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Waiver Financing

	Medicaid Statute	CHIP Statute	HIFA Waiver Guidelines
Financing	States and the federal government jointly finance Medicaid. The federal government matches state spending on an open-ended basis, and payments are made for all individuals meeting eligibility requirements, including all individuals covered under optional coverage categories.	States and federal government jointly finance CHIP; the federal matching rate is higher for CHIP than for Medicaid. Federal CHIP funds are capped and allotted to states based on a formula. States that use CHIP to expand Medicaid can receive federal Medicaid matching funds for the expansion if they spend all their CHIP funds.	States and the federal government will jointly finance waivers. Waivers must be budget neutral with respect to the federal funds that would have been spent under the state's program without a waiver. Federal financial payments are capped on a per person basis over the life of the demonstration. The federal financial ceiling is calculated based on (1) a base year per capita spending estimate for each mandatory and optional group included in the waiver and (2) a growth rate (either the Medical Consumer Price Index or a state-specified Medicaid growth rate); the product of these factors is multiplied by the number of mandatory and optional individuals actually enrolled under the waiver. Costs of coverage for expansion populations are not included in the calculation of the federal cap. The federal per person payment amount is not adjusted over the course of the waiver if costs rise above projections.

Mandatory Groups

	Medicaid Statute	CHIP Statute	HIFA Waiver Guidelines
Eligibility	As a condition of participating in Medicaid, states must cover: • SSI-linked blind, disabled, and elderly • Pregnant women & children age 0-5 up to 133% FPL • Children age 6 up to age 18 up to 100% FPL • Families with children with incomes and resources below July 1996 cash assistance levels (on average, 41% FPL)	There are no "mandatory" or "optional" groups in CHIP. States may cover "targeted low-income children," generally defined as children whose family income exceeds the Medicaid applicable income level, but not by more than 50 percent; or 200 percent of the poverty line, whichever is higher. States may *not* cover children who: • Are eligible for Medicaid; • Have health insurance coverage; • Reside in a public institution; • Is a member of a family eligible for coverage under a State health plan (for public employees) States must cover lower income children before covering higher income children.	States must cover all mandatory populations as specified under Medicaid law.
Enrollment Cap	States must serve all individuals who apply and meet eligibility rules.	For children in a CHIP-funded Medicaid expansion, a state must enroll all eligible children who apply even after it depletes its CHIP allotment. (States can claim regular Medicaid matching funds if it spends its full CHIP allotment.) For children in a separate program, states may impose enrollment caps and waiting lists.	Medicaid statutory rules continue to apply.

Mandatory Groups (continued)

Benefits	States must provide all "mandatory benefits" and may cover as many "optional" benefits as they choose. Children must be provided all screening and medically necessary services under the "EPSDT" mandatory benefit. Services include preventive, acute, long-term, and custodial care. Benefits must be comparable for most groups. Limits can be applied as long as benefits are sufficient with respect to amount, duration, and scope to reasonably achieve their purpose.	For children in a Medicaid expansion, Medicaid rules apply. For children in a separate program, states must provide, at a minimum, one of five benefit packages: • Benefit package for HMO plan with largest commercial, non-Medicaid enrollment in state; • Standard BC/BS PPO option offered under FEHBP; • Health plan available to state employees; • Benefit package actuarially equivalent to one of the above; • Secretary-approved coverage (should include inpatient & outpatient hospital, physician, lab & x-ray, and well-child care).	States are required to continue to provide the benefit package specified in their Medicaid state plan as of the date of the HIFA application.
Cost sharing	Cost sharing is limited to nominal amounts: $2 deductible per month, copayment of $.50-3.00, or coinsurance of 5% of state's payment rate. No cost sharing allowed for children and pregnant women or for emergency and family planning services.	For children in a Medicaid expansion, Medicaid rules apply. In a separate program, children with incomes below 150% of poverty cannot be charged more than nominal amounts. Total annual cost sharing (including premiums, co-payments, etc.) for all CHIP children in a family may not exceed 5% of family income.	Medicaid statutory rules continue to apply.

Mandatory Groups (continued)

Premiums	For most mandatory groups, states may not charge premiums.	For children in a Medicaid expansion, Medicaid premium rules apply. For children in a separate program, states may charge premiums based on an income-related sliding scale. Total annual cost sharing (including premiums, co-payments, etc.) for all CHIP children in a family may not exceed 5% of family income for the year.	Medicaid statutory rules continue to apply.
Premium Assistance	States can use Medicaid funds to purchase employer coverage but must assure cost sharing does not exceed Medicaid limits and provide wrap-around benefits if employer plan is more limited than the applicable Medicaid benefit package.	States may use federal CHIP funding to provide premium assistance if it is cost-effective, meaning it does not cost more than if the state had covered the child under its regular CHIP program. Benefits and cost sharing in the private plan must meet CHIP requirements or wrap-around assistance and benefits must be provided.	States are encouraged to use Medicaid and CHIP funding to provide premium assistance to help people purchase private health insurance, and required to at least have a premium assistance study or pilot program. For mandatory groups, Medicaid statutory rules continue to apply. For other groups, states will be allowed more flexibility (not specified) with respect to benefit standards and cost sharing.

Optional Groups

	Medicaid Statute	CHIP Statute	HIFA Waiver Guidelines
Eligibility	States may cover any optional group, including: • Children above federal income minimums (100% or 133% FPL) • Pregnant women above 133% FPL • Adults in families with children above federal minimum (on average 41% FPL) • Disabled and elderly above SSI income levels • Working disabled people • Elderly nursing home residents • Medically Needy (those with high medical expenses related to income)	N/A	States may cover existing as well as new optional groups (non-mandatory groups that can be covered in a state's Medicaid or CHIP programs without waiver authority) under the waiver. There is no upper eligibility level, but states are encouraged to focus efforts to individuals below 200% FPL.
Enrollment Cap	States must serve all individuals who apply and meet the eligibility rules.	N/A	States may be able to impose enrollment caps and waiting lists for optional groups.
Benefits	For most groups, states must provide all "mandatory benefits" and may cover as many "optional" benefits as they choose. Children must be provided all screening and medically necessary services under the "EPSDT" mandatory benefit. Services include preventive, acute, long-term, and custodial care. Benefits must be comparable for most groups. Limits can be applied as long as benefits are sufficient with respect to amount, duration, and scope to reasonably achieve their purpose.	N/A	States must provide, at a minimum, one of the five benefit packages specified in Title XXI (CHIP) law.

Optional Groups (continued)

Cost Sharing	Cost sharing is limited to nominal amounts: $2 deductible per month, copayment of $0.50-3.00 or coinsurance of 5% of state's payment rate. States may impose higher cost sharing for the working disabled on a sliding scale based on income. No cost sharing is allowed for children, pregnant women, and elderly nursing home residents or for emergency and family planning services.	N/A	States have broad flexibility to design cost sharing. For children, total costs (excluding premiums for family coverage) cannot exceed 5% of family's income; no limits apply to other groups.
Premiums	For Medically Needy individuals, states may impose premiums up to $19 per month, depending on family size and income. For working disabled, states can set premiums on a sliding scale based on income. For other groups, states may not charge premiums.	N/A	States have broad flexibility to charge premiums. For children, total costs of premiums and cost sharing cannot exceed 5% of family's income (premiums for family coverage are not subject to the cap). No limits apply to other groups.
Premium Assistance	States can use Medicaid funds to purchase employer coverage but must assure cost sharing does not exceed Medicaid limits and provide wrap-around benefits.	N/A	States are encouraged to use Medicaid and CHIP funding to provide premium assistance to help people purchase private health insurance, and required to at least have a premium assistance study or pilot program. For mandatory groups, Medicaid statutory rules relating to benefits and cost sharing continue to apply. For other groups, states will be allowed more flexibility (not specified) with respect to benefit standards and cost sharing.

Expansion Groups

	Pre-HIFA Medicaid Waiver Policy	Pre-HIFA CHIP Waiver Policy	HIFA Waiver Guidelines
Eligibility	In the past, states have been granted waivers to cover "expansion" groups.	States may seek waivers to use enhanced CHIP matching funds to cover additional children, pregnant women, or parents in Medicaid or CHIP. Parents and pregnant women can only be covered if children are covered at least up to 200% FPL and state adopts measures to promote enrollment of children. CHIP funds cannot be used to cover childless adults.	States may cover individuals who are excluded from Medicaid or CHIP eligibility categories and can only be covered under Section 1115 waiver authority. For Medicaid, this group includes childless adults at any income level; for separate CHIP, it includes all groups other than "targeted low-income" children. There is no upper eligibility level, but states are encouraged to focus efforts on individuals below 200% FPL.
Enrollment Cap	States have generally not been permitted to cap enrollment. TN's enrollment cap applies to a limited group of individuals who could not have otherwise been covered under Medicaid.	Enrollment caps in CHIP-funded Medicaid expansions are not addressed by pre-HIFA waiver policy. For children in separate programs, states may impose enrollment caps and waiting lists without a waiver.	States may be able to impose enrollment caps and waiting lists for expansion groups.
Benefits	In general, the Medicaid benefits package and rules on the scope of benefits apply, unless a specific mandatory benefit is waived. Benefit waivers have been granted.	In general, CHIP rules apply, unless a specific rule is waived.	States can limit coverage to basic primary care services (must include physician services; otherwise not defined).
Cost sharing	In general, Medicaid cost sharing rules apply, unless a specific cost sharing waiver is granted. Cost sharing waivers have been granted.	In general, CHIP cost sharing rules apply, unless a specific waiver is granted.	States have broad flexibility to design cost sharing.
Premiums	In general, Medicaid premium rules apply, unless a specific waiver is granted. Premiums have been allowed by waiver.	In general, CHIP premium rules apply, unless a specific waiver is granted.	States have broad flexibility to charge premiums.

Expansion Groups (continued)

Premium Assistance	At least one state (Massachusetts) has been granted section 1115 authority to do premium assistance for some of the individuals covered under its waiver. Benefits must meet a benchmark identified in the waiver.	Premium assistance is not addressed by pre-HIFA waiver policy.	States are encouraged to use Medicaid and CHIP funding to provide premium assistance to help people purchase private health insurance, and required to at least have a premium assistance study or pilot program. For mandatory groups, Medicaid statutory rules continue to apply. For other groups, states will be allowed more flexibility (not specified) with respect to benefit standards and cost sharing.