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June 22, 2006

Adequate Health Care Task Force
Illinois Public Health Institute
James R. Thompson Center
100 W. Randolph, Suite 6-600
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Dear Adequate Health Care Task Force Members:

During the May 23, 2006 Adequate Health Care Task Force (AHCTF) meeting, Navigant Consulting was asked to respond to three questions related to the stakeholder proposal summaries and the state coverage summaries. We have provided the questions and responses in the attached pages.

Sincerely,

A handwritten signature in black ink that reads "Gwyn Davidson". The signature is written in a cursive style with a large, stylized "G" and "D".

Gwyn Davidson
Associate Director, Navigant Consulting, Inc.

1. *When reviewing the Maine Dirigo Health State Summary, the Task Force members and Navigant Consulting discussed the role of federal financial participation (FFP), often referred to as the federal match, in program financing. The Task Force requested that Navigant Consulting provide more information about how the Medicaid or State Children's Health Insurance Program (SCHIP) federal match could make it more or less affordable to finance an approach.*

States pay for Medicaid and SCHIP programs using a combination of federal and state funds. The amount of federal Medicaid and SCHIP funds varies by state according to a federal medical assistance percentage (FMAP) that is higher for low-income states, and vice versa. For example, in Federal Fiscal Year 2007, the highest state Medicaid FMAP is 75.89 (Mississippi) and the lowest is 50.00 (Illinois, California, Colorado, among others). This means that for every Medicaid dollar Mississippi and Illinois spend, the federal government will pay 75.89 and 50.00 cents, respectively. State SCHIP federal matching rates are slightly higher to encourage participation; Illinois' Federal Fiscal Year 2007 SCHIP FMAP is .65.

Expanding coverage through Medicaid or SCHIP programs allows states to access federal matching funds. While using federal Medicaid and SCHIP funds reduces the amount of state general funds needed to finance a coverage initiative, these additional funds come with significant "strings" attached. In expanding Medicaid or SCHIP, states must comply with federal regulations regarding benefit package content and eligibility, among other program design components. Given these regulations, it may be more difficult to target specific populations or benefits¹. Most states enacting health reform have generally built into their approaches options to expand Medicaid and SCHIP, considering carefully the tradeoffs between enhanced federal funding and ongoing state responsibilities.

2. *According to Item #7, page 2 of the Oregon Family Health Insurance Assistance Program State Summary, the "projected benefit costs of this program are approximately \$50.5 million for federal fiscal year (FFY) 2006." The Task Force requested that Navigant Consulting clarify if the \$50.5 million represents federal or state costs.*

The \$50.5 million is state costs. Payments made by the Oregon Family Health Insurance Assistance Program are matched by federal Medicaid and SCHIP funds. For Federal Fiscal Year 2007, the federal government will pay 61.07 cents and 72.75 cents of every Medicaid and SCHIP dollar Oregon spends, respectively.

¹ States generally cannot cover single, childless, non-disabled adults under Medicaid or SCHIP and the national Deficit Reduction Act of 2005 disallowed the use of SCHIP funds for this population. While states may expand Medicaid to this population using a waiver (see Question #3), the expansion would have to be budget neutral, requiring a corresponding reduction in costs for current Medicaid-covered populations.

- 3. In response to the group's discussion about the different state approaches to program design and financing presented in the state summaries, the Task Force asked that Navigant Consulting provide information on the different Medicaid waivers that a state can use to implement a health care reform initiative.*

State Medicaid and SCHIP programs must comply with specific federal regulations to receive federal matching funds. For example, Medicaid programs must offer the same benefits to individuals across the state (i.e., statewideness and comparability of services) and allow beneficiaries freedom of choice of providers. Some state health care reform initiatives require that a state request a federal waiver of one or more of these regulations – for example, a state would need a waiver of the “comparability of services” provision to expand coverage using a limited benefit package. Requesting a waiver is a time-intensive, formal process that requires designating the proposed initiative as a “waiver program,” complying with federal regulations regarding waivers and evaluating and renewing the program on a periodic basis.

A state may implement a health care reform initiative without a waiver if it does not use federal Medicaid or SCHIP funding, or if the initiative does not require a waiver of federal Medicaid regulations. New York, for example, implemented the Healthy New York program, a state-reinsured health insurance product that every health maintenance organization must offer, without the assistance of a Medicaid or SCHIP waiver.

Waivers can be categorized into different types; we have provided a brief description of each type below, along with examples of some state waiver approaches; additional information can be found on the Centers for Medicare and Medicaid Services' webpage: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp#TopOfPage.

Section 1115 Research and Demonstration Waivers: These five-year waivers allow states to test health care theories, policy innovations and service approaches that further the objectives of the Medicaid program and provide potential learning opportunities for other states. States have used these waivers to expand coverage, redesign their Medicaid benefit packages, implement family planning services and make other program design changes. To obtain federal waiver approval, a state must prove that its demonstration project will be budget neutral, that is, that federal Medicaid spending under the waiver will not exceed what the federal government would have spent in the absence of the waiver.

The federal government established a special 1115 waiver category through the Health Insurance Flexibility and Accountability Act of 2001 (HIFA). The HIFA waiver option encourages states to use unspent SCHIP allotment and existing Medicaid funds to cover additional populations under 200 percent of the federal poverty level (FPL), with an

emphasis on employer-based coverage options. Many states have used these waivers to expand coverage to parents of SCHIP children or other special populations, such as working adults at a percentage of the federal poverty level. To obtain HIFA waiver approval, a state must prove that its demonstration will be SCHIP-allotment neutral, that is, that federal SCHIP spending under the waiver will not exceed the State's federal SCHIP allotment.

Through the KidCare Parent Coverage 1115 HIFA waiver, for example, Illinois has expanded health care coverage for parents of Medicaid and SCHIP children up to 185 percent of the FPL. Other Section 1115 waivers as they relate to the state summaries presented at the May Adequate Health Care Task Force meeting include:

- For Dirigo Health, Maine used an existing 1115 HIFA waiver to expand Medicaid eligibility to additional single, childless adults and parents of Medicaid-eligible children.
- As part of its statewide reform plan, Massachusetts intends to renew its current 1115 HIFA waiver to increase eligibility for children of low-income employees who receive insurance subsidies.
- Wisconsin proposes to renew the State's Section 1115 waiver to create a single, comprehensive health care safety net program (BadgerCare Plus) for families. This program would merge the family medical assistance program, BadgerCare (the State's SCHIP program) and the Healthy Start Program.
- Oregon used a Section 1115 HIFA waiver for the Family Health Insurance Assistance Program to provide subsidies to low- and middle-income families to purchase health insurance through their employer or through the private market.

In 2005, CMS created Section 1115 Katrina Waivers to assist states in providing Medicaid and SCHIP coverage for evacuees who have been displaced as a result of Hurricane Katrina.

Other Waivers: Through Section 1915(b) Managed Care/Freedom of Choice waivers, the Centers for Medicare and Medicaid Services waives Medicaid requirements for statewideness, comparability of services and freedom of choice — as such, states often use these waivers to require Medicaid recipients to enroll in managed care programs, or to implement selective contracting initiatives. Section 1915(c) Home and Community-Based Services waivers allow states to develop Medicaid-financed home- or community-based alternatives to traditional long-term care (such as hospitals, nursing facilities or intermediate care facilities for persons with mental retardation). Combined 1915(b)/(c) waivers allow states to limit freedom of choice and at the same time target eligibility for the program and provide home- and community- based services.

Our preliminary assessment suggests that Illinois Medicaid could potentially expand its program using a waiver program, or through an amendment to its State Plan. If the State chooses to amend its State Plan, Illinois would have to continue to fund those expansions on an on-going basis unless it filed another amendment to the State Plan to cut back on the expansion. Alternatively, Illinois could expand coverage using a Medicaid waiver program assuming it would be able to maintain budget neutrality. While other states have used unspent SCHIP and disproportionate share hospital funding to cover additional populations, Illinois has already used up both of these funding sources. In the past, some states have moved SCHIP participants into Medicaid to make more of SCHIP funding available, however, the federal government is currently prohibiting this approach.

Many of the coverage proposals presented to the Task Force involve a Medicaid or SCHIP expansion that requires a federal waiver. The Navigant Consulting team will review these proposed waivers as part of our evaluation of each coverage proposal. As the topic of waivers is complex, we could offer a supplemental presentation on waivers and their uses if the Task Force chooses.