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2-23-98

THE WHITE HOUSE

WASHINGTON

February 12, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: PHIL CAPLAN
SEAN MALONEY

SUBJECT: Children's Health Insurance Program Waivers

The attached memo from Chris Jennings seeks your guidance on whether to grant waivers under the two prongs of the new Children's Health Initiative Program (CHIP), and sets out possible options for doing so. As you know, CHIP allows states to expand coverage either through new non-Medicaid block grants, or by expanding their Medicaid programs. The non-Medicaid block grant option has fewer benefit requirements than does the Medicaid option. Even so, certain states that choose the non-Medicaid option are expected to request waivers of CHIP's requirements. Other states that choose the Medicaid option, will likely seek Medicaid/CHIP waivers. Still others will want to expand their existing Medicaid waivers, previously granted by the Administration, to encompass CHIP.

Two issues are presented. First, what sort of waivers, if any, should be granted to states under CHIP's new non-Medicaid block grant option. Second, what sort of waivers, if any, should be granted to states under CHIP's Medicaid option.

I. Non-Medicaid block grant waivers. *All of your advisers agree* that for non-Medicaid block grant programs, waiver decisions should be deferred for one year. The consensus among your advisers is that, because CHIP is a new program, states should have at least a year's worth of experience, followed by an evaluation, before waivers are granted.

Approve (recommended option) ✓ Disapprove ___ Discuss ___

II. Medicaid/CHIP Waivers. With respect to Medicaid/CHIP waiver requests, your advisers present three options:

Option 1 -- Defer new Medicaid/CHIP waivers until after one year's program evaluation; allow expansions of existing Medicaid waivers but require that they adhere to CHIP's non-Medicaid block grant requirements. *HHS* favors this option; it believes CHIP sets a benefits floor that we should not fall below and waiver negotiations could delay program implementation/coverage for 5 million uninsured kids. Democrats and children's health advocates would prefer this option; Governors would react strongly and negatively to it.

Option 2 -- Permit Medicaid/CHIP waivers (either existing or new) if states' programs are *generally* consistent with CHIP's non-Medicaid block grant requirements. *NEC and DPC* support this option. They believe it's a good balance, preserves CHIP's standards, and removes an important disincentive for states to use the Medicaid option. *NEC/DPC* would further allow states to drop modestly below certain CHIP requirements (*e.g.*, permitting cost sharing for those at 133% versus 150% of the poverty level). Base Democrats and advocates, who feel their support for CHIP's less-than-Medicaid requirements was conditioned on no new flexibility in Medicaid, will oppose this option. Governors would prefer it to Option 1, but will still seek greater flexibility.

Option 3 -- Permit new Medicaid/CHIP waivers if states' programs are *generally* consistent with CHIP's non-Medicaid block grant requirements (like Option 2 above); but permit states' existing Medicaid waivers to expand but without adhering to CHIP non-Medicaid black grant requirements. *OMB* and *Treasury* support this option. They think allowing approved waivers to encompass CHIP would help waiver-holding states avoid significant coordination problems. Such states may feel the Administration "reneged" if we don't permit them to extend approved waivers to CHIP. Base Democrats and children's advocates would strongly oppose this option; so too some Republicans, who would see it as an attempt to steer states into Medicaid. Governors would support it.

Option 1 (HHS) ___ (defer new waivers; allow existing if CHIP-consistent)

Option 2 (DPC/NEC) ✓ (allow new & existing if generally CHIP-consistent)

Option 3 (OMB/Treasury) ___ (allow new if CHIP-consistent; permit existing without changes)

Discuss ___

- Under Options 2&3, permit modest cost sharing flexibility

  Approve ✓ Disapprove ___ Discuss ___

THE WHITE HOUSE

WASHINGTON

January 21, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Chris Jennings CJ

SUBJECT: Waivers and the Children's Health Insurance Program

cc: Bruce Reed, Gene Sperling, Jack Lew, Josh Gotbaum, Elena Kagan

This memo seeks your guidance on how much, if any, additional flexibility should be given to states in the Children's Health Insurance Program (CHIP) through the use of §1115 waivers. Although waivers have been instrumental in modernizing and reforming welfare and Medicaid, questions have been raised about the feasibility and advisability of granting waivers for the new children's health care program so soon after its enactment.

Despite acknowledging the great amount of flexibility given to the states in the new CHIP grant program, the Governors asked — soon after the law's enactment — if additional flexibility would be given through waivers. HHS's interim response was that it would be difficult to review and evaluate the merits of waiver proposals until we had some experience with the implementation of the new law. Your advisors agreed that this was the appropriate, initial response, but we also underscored that this was not necessarily our final position.

The National Governors Association (NGA) immediately responded by formally requesting that we affirm states' ability to seek new CHIP grant program §1115 waivers. Since then, two other issues have been raised: (1) Will we approve new Medicaid §1115 waivers in the Medicaid option within CHIP, and (2) Will we allow states with current Medicaid §1115 waivers to expand those programs through CHIP (even though some have provisions below the CHIP minimums).

All of your advisors agree that the HHS Secretary does have the authority to grant waivers for CHIP, whether administered through a new non-Medicaid grant program or through Medicaid. They also generally agree that the CHIP waiver policy need not conform to existing waiver policy. However, they (HHS, OMB, Treasury, NEC/DPC) disagree on whether and under what circumstances HHS should approve waivers in CHIP.

Because HHS is holding state conferences this month on CHIP and the annual NGA conference is in February, it is important that we receive direction from you in short order on this issue. This memo, developed in collaboration with HHS and OMB, outlines these issues, provides policy options for your consideration, and summarizes where your advisors stand on these options.

BACKGROUND

Your Administration has given states unprecedented flexibility for their health care programs. Since 1993, we have granted 15 comprehensive Medicaid waivers that test approaches not allowed in Medicaid like experimenting with premiums and cost sharing for low-income populations, waiving benefits, and accelerating enrollment in managed care. States have also used waivers to expand coverage to millions of Americans. In addition, with the Administration's strong support, the Balanced Budget Act secured much greater administrative flexibility for the Medicaid program (e.g., eliminated the need for a waiver for a managed care program, repealed the Boren amendment, and reduced cost-based reimbursement requirements for community health centers). In so doing, we eliminated the need for many time-consuming waivers that we heretofore required from states.

The BBA also created CHIP, which has fewer Federal guidelines than any other health insurance program that the Government oversees. Unlike Medicaid, CHIP allows states that opt to expand through a new, non-Medicaid grant program to cap the number of children covered (i.e, no entitlement requirement); to limit programs to parts of the state; to not cover Medicaid's EPSDT (Early, Periodic, Screening, Detection and Treatment) benefit; and to charge beneficiaries long-sought-after (although limited) cost-sharing. Alternatively, states may expand using the enhanced Federal match through the now more flexible Medicaid program. However, states choosing this option must follow Medicaid rules (e.g., no benefits changes or cost sharing).

Although extremely flexible, CHIP includes standards for accountability, benefits, and cost sharing limits; these were secured by you and Congressional Democrats. Accountability provisions include limits on the type of state contribution (e.g., no provider taxes and donations) and provisions to prevent "crowd out" (substitution of the new coverage for existing coverage). For the new non-Medicaid grant program, we developed a benefit standard that simultaneously ensures that it is valuable but provides great flexibility to states in benefits design. Cost-sharing is allowed in the grant program but limited to moderate premium and copayment schedules for those below 150 percent of poverty and to 5 percent of family income for those above 150 percent. As under current law, states electing the Medicaid option must follow Medicaid rules for benefits (including EPSDT) and cost sharing (for children, none is allowed).

Despite the flexibility in CHIP, some states have indicated that they want §1115 waivers. There are three types of waivers that states are seeking. First, several states want to waive provisions for non-Medicaid, CHIP grant programs (e.g., California wants to impose greater cost sharing above the CHIP limits). Second, others want to waive Medicaid provisions within CHIP's Medicaid option since states choosing the Medicaid option must use all Medicaid rules (e.g., Missouri wants to waive the Medicaid requirement to cover non-emergency transportation). Third, most states that already have Medicaid §1115 waivers want to expand those programs to more children to receive CHIP's higher matching rate — even though some include provisions that are significantly below the new CHIP minimums (e.g., Arkansas has higher cost sharing requirements than allowed in CHIP). It is important to note that the provisions that states want most to waive are the benefits and cost sharing minimums we worked to secure before signing off on the budget agreement.

CONSENSUS RECOMMENDATION: DEFERRING NON-MEDICAID CHIP WAIVERS

Your advisors have achieved consensus on one of the major issues. For CHIP non-Medicaid grant programs, we believe the Administration should consider waiver applications only after a state has had at least a year's worth of experience, followed by an evaluation of its children's health insurance program. As we gain experience with the new CHIP grant program, we will have a better understanding of what types of CHIP demonstrations are appropriate and will develop guidelines at that point.

We believe that deferring approvals for waivers of the already extremely flexible CHIP is advisable because this enables us to see how the program you signed into law last summer will work. Granting waivers now would place great pressure on us to weaken the accountability and benefits standards that we secured in the Balanced Budget negotiations that base Democrats and advocates think are too modest anyway. Having said this, waiver policy for CHIP may well be advisable after we have had time to learn about the program's strengths and weaknesses.

If you agree, we will inform Governors of this policy in a response to their letter. While we believe that Governors will be disappointed with this position, they will likely appreciate that our policy is temporary and that we open up the prospect for waivers soon after they implement their children's health programs.

Decision

_____Agree on deferring non-Medicaid grant program waivers until plans in place for one year

_____Let's discuss

ISSUE: POLICY FOR MEDICAID WAIVERS

The other types of waivers, about which there is disagreement amongst your advisors, concern the Medicaid option within CHIP. We all agree that our Medicaid waiver policy should be modified to acknowledge the fact that the Congress did pass legislation that explicitly outlines new guidance on balancing the need for greater flexibility with the need for accountability. However, we differ on how our policy should be modified to reflect this policy change and, more specifically, the extent to which we would hold Medicaid waivers to the CHIP standard.

There are two questions. The first is whether we grant new waivers to states that expand CHIP coverage through Medicaid. States have indicated that they are interested in expanding coverage through the Medicaid option, but since the law allows no flexibility from Medicaid rules, they want waivers, particularly in the area of cost sharing. The second question is whether we allow states that already have Medicaid §1115 waivers to expand those programs, without change, to get the CHIP allotment and higher match. The following are the options proposed by your advisors.

OPTION 1 (HHS): Defer new Medicaid CHIP waivers (with minor exceptions) and allow expansions of existing Medicaid waivers if consistent with CHIP standards for non-Medicaid grant programs. HHS recommends that we apply the same policy for new Medicaid and non-Medicaid, grant program waivers. It would hold off on approving any new Medicaid waiver under CHIP until we have at least a year's experience plus an evaluation. (The only exception would be for waivers for small, incidental provisions that have little or no effect on most children — like Missouri's desire to waive the Medicaid requirement for non-emergency transportation.) For states that have waivers already, HHS would allow them access to the new enhanced matching dollars only if they met CHIP's non-Medicaid grant program standards.

Although HHS/OMB have, in years past, approved a number of Medicaid waivers that have less generous benefits than even the new CHIP grant program, HHS believes the new law set a floor that we should not fall below. They fear that once we open the door to waivers, we will have a difficult time maintaining these standards. In addition, they are concerned that waiver negotiations will delay implementation of new programs in a number of states. Rapid implementation is one critical component to covering our target 5 million uninsured children.

If you choose this option, the Democrats and children's health advocates will applaud our decision to respect the rules enacted in the widely praised new health insurance program for children. However, Governors — who are hoping that we will allow some type of Medicaid waivers — will surely react strongly and negatively to this policy.

OPTION 2 (NEC/DPC): Allow Medicaid CHIP waivers (new or old) if generally consistent with CHIP standards for non-Medicaid grant programs. This option would allow new waivers through the Medicaid option of CHIP if those waivers were consistent with the standards provided under the new CHIP grant model. In other words, states choosing the Medicaid CHIP option could waive Medicaid rules as long as the benefits, cost-sharing and other accountability provisions are in line with the CHIP grant program standards. Existing (old) Medicaid §1115 waiver programs could also receive the higher matching rate, but they too would have to meet CHIP standards; in a number of cases, this would mean they would have to strengthen some of their benefits/cost-sharing protections to access these additional dollars. Although a few states would have to reduce cost sharing requirements to comply with CHIP, we believe that the higher matching rate available under CHIP would be sufficient to offset these costs.

DPC/NEC believes that this option strikes an appropriate balance by maintaining the integrity of the CHIP program and the Balanced Budget Act and giving the new standards time to be tested. It also removes an important disincentive for states to use the Medicaid option in CHIP. Many states would prefer to use their already-in-place Medicaid programs because it is administratively simple. Moreover, having a seamless Medicaid program serving both poor and children of working parents has obvious advantages. However, allowing any new Medicaid waivers through CHIP will be criticized by our base Congressional Democrats, some Republicans, and advocates. They believe that their support for the flexibility in the non-Medicaid CHIP program was conditional on no new flexibility in Medicaid. The Governors would like this approach better than the HHS option, but they could be counted on to say that it is still not flexible enough.

Within this option, NEC/DPC also recommends that the Secretary have the authority to approve Medicaid CHIP waivers that may be modestly below those standards provided for in the new CHIP grant program. While we strongly believe that the CHIP standards should be the guiding principle for Medicaid waivers, we also recognize that it is unwise and unrealistic to treat the new law's standards as "lines in the sand" that can never be crossed regardless of a waiver's merits. One good example is in the area of cost sharing.

In both previous Medicaid waivers and our internal policy positions, we have allowed limited cost sharing that exceeds the CHIP grant program standards. Such cost sharing can appropriately increase beneficiaries' cost sensitivity in using health services and decrease possible employer insurance dropping problems, since such a policy would more accurately mirror marketplace coverage. While we recommend providing this additional flexibility authority, we also believe that waivers of the CHIP grant standards for children not be granted below 133 percent of poverty -- the level your Administration advisors had previously concluded (during the balanced budget discussions) achieved the balance between appropriate and excessive cost-sharing.

While some might point out that it is inconsistent to allow flexibility below CHIP standards for Medicaid and not the grant option, we believe that the advantages of this approach far outweigh this criticism. First, the CHIP standards were designed for the grant program — not Medicaid. Second, Medicaid waivers are quite variable and have never been publicly held by Democrats and advocates to the same standards as legislated changes to public programs. And thirdly, as described above, having an additional incentive to administer the children's health program through Medicaid is desirable.

Giving HHS the authority to allow any cost sharing flexibility in Medicaid will likely anger base Congressional Democrats and some moderate Republicans. They will argue (as does HHS) that once we sanction higher cost sharing below 150 percent of poverty, decisions will be perceived as arbitrary, making it difficult to say no to states that demand even greater flexibility. We believe these are valid concerns and should be seriously considered. However, we are also well aware of states (such as Wisconsin) who will be requesting cost-sharing levels just under 150 percent (i.e., 143 percent of poverty) that we would find difficult to oppose on purely policy grounds.

OPTION 3 (OMB & TREASURY): Allow new CHIP Medicaid waivers if consistent with CHIP standards for non-Medicaid, grant programs, but allow existing Medicaid waivers to expand with no change. For states requesting *new* Medicaid waivers, OMB/Treasury agree with DPC/NEC option that the CHIP standards should guide approval of such waivers (also allowing for greater cost sharing for families no less than approximately 133 percent of poverty). This policy should be re-evaluated after states gain experience with their programs, at the same time the Administration is re-considering non-Medicaid, grant program waivers.

For states with waiver programs already approved (since the 1994 NGA waiver agreement), OMB and Treasury recommend that we recognize their history and different situation and not hold them to the CHIP standards. We anticipate that these 11 states will want to expand their current waiver programs under CHIP; OMB and Treasury think they should be permitted to do so with no changes. Although this option provides only a few more states with additional flexibility in cost-

sharing or benefits under CHIP than the DPC/NEC option, it helps these states avoid significant coordination problems by sanctioning CHIP programs consistent with approved waiver programs. In addition, lower income children in these states might pay more in premiums than the higher income children newly eligible under CHIP. Waiver states will consider the Administration to have reneged if we don't permit them to carry their waivers to CHIP. This option excludes pre-NGA agreement waivers (e.g., Tennessee) since states have been held to a higher standard since then.

Allowing existing Medicaid waivers into CHIP unchanged will surely be noticed and strongly opposed by base Democrats and children's advocates. They believe that some of the waivers that we have approved to date, such as Tennessee and Arkansas, have gone too far by allowing states to impose "excessive" cost sharing on low-income beneficiaries and waive EPSDT. Ironically, this policy may also be criticized by some Congressional Republicans, who think that many of our CHIP implementation decisions are steering states toward the Medicaid option. It would, however, be the most acceptable option to the NGA and the relevant (existing waiver) states.

Decisions

Medicaid Waivers

_____OPTION 1: Defer new Medicaid waivers in CHIP (with minor exceptions)
Allow existing waivers to expand through CHIP if consistent with CHIP standards for non-Medicaid, grant programs

_____OPTION 2: Allow new & existing Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs

_____OPTION 3: Allow new Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs
Allow existing waivers (post-NGA agreement) to expand through CHIP with no program changes even if they fall significantly below new CHIP grant standards

_____Let's discuss

Cost Sharing Flexibility

_____OPTION 1: Hold all Medicaid waivers to the cost sharing in CHIP for non-Medicaid, grant programs

_____OPTION 2: Authorize the Secretary to approve, within limits, Medicaid waivers in CHIP with cost sharing below CHIP standards for non-Medicaid, grant programs

_____Let's discuss

STATES WITH MEDICAID 1115 WAIVERS (Chronological Order)

STATE	Approved	Eligibility Limit	Benefits for New Eligibles	Cost Sharing: New Eligibles
Arizona	10/82	Existing eligibles	Medicaid benefits	None
Oregon	3/93	People < 100% PL	Prioritized benefits	Premiums: $6 to 28 No copays or deductibles
Hawaii	7/93	People < 300% PL, plus assets test	No long-term care	Premiums: $142 - 168 Copays: $5
Maryland	10/93 10/96	Children 133-185% PL Existing eligibles	No inpatient, outpatient, emergency room, some EPSDT; no long-term care Medicaid benefits	Copay: $5 None
Rhode Island	11/93	Children < 250% PL	Medicaid benefits	Premiums: From 185-250% PL: $1.50 - $10.75 No copays or deductibles
Tennessee	11/93	People up to 400% PL, with enrollment cap	Medicaid benefits	Premiums: $14.25 to 475 Deductibles: $250 / $500 Coinsurance: 2 to 10%
Florida	*9/94*	*People < 250% PL*	*Excludes some EPSDT, transportation, some long-term care and mental health*	*Premiums: $90 - 550 / mo* *Deductibles: Up to $500* *Copays: $10-200 or 20%*
Ohio	1/95	People < 100% PL	Medicaid benefits	None
Massachusetts	4/95	People < 200% PL	Medicaid benefits	Premiums: Variable Deductibles:$100 / $250 Copays: $5 / 10
Minnesota	4/95	Children < 275% PL	Medicaid benefits	Premiums: $4 to 104 / mo No copays or deductibles
Delaware	5/95	People < 100% PL	Medicaid w/ small changes	None
Vermont	7/95	People < 150% PL	No transportation, long-term care	Premiums: Above 25% PL: $5 to $20 every 6 months Copays: $3 for dental
Kentucky	*10/95*	*Existing eligibles*	*Medicaid benefits*	*None*
Oklahoma	10/95	Existing eligibles	Medicaid benefits	None
Illinois	*7/96*	*Existing eligibles*	*Medicaid benefits*	*None*
Alabama	12/96	Existing eligibles	Medicaid benefits	None
New York	7/97	Home relief pop.	Medicaid benefits	None
Arkansas	8/97	Children < 200% PL	No EPSDT, limited long-term care & mental health	Copays: $10 outpatient; 20% inpatient ; $5 for drugs

Italics indicated approved but not implemented. States above the line were approved prior to NGA 1994 agreement.

TO: Rob

Issues Not Addressed in the HHS Paper

1. **State table:** States listed by provisions inconsistent with Title XXI (draft attached)

2. **Discussion of our "bottom line"**: What are we willing to waiver?

- Benefits
- Cost sharing
- Funds for adults
- Funds for uninsured children already eligible for Medicaid (Gorton amendment)
- Medicaid coordination requirements
- 200% / + 50% rule
- **Public employee coverage**
- Coverage for children inadequately covered
- Crowd out requirements
- Reporting requirements

If we accept HHS's recommendation -- to allow Medicaid 1115s if they meet benefits and cost sharing requirements, we implicitly are allowing all of the other provisions in this list to be waived.

3. **Group coverage issues:** There is a question about whether the legislation allows states to cover children through group coverage without a waiver. Regardless, issues include:

- **Plan-by-plan benefits and cost sharing determinations**: Since Federal funds may only be used for qualifying plans, each families' employer's plan will have to be reviewed to see if it qualifies.

- **Different benefits for families receiving assistance**: The cost sharing protections and the prohibition on covering abortion make it likely that employers' plans will need to be modified to qualify. This could create problems for the employers' benefits managers as well as equity concerns from other employees not receiving the same benefits.

- **Lower employer contribution**: New employers in a state in which low-wage workers have access to premium assistance may set up plans with contributions that are lower than they would otherwise have been. In a state decides to work with employers to determine eligibility, there is a risk that the employer will only agree to modify its benefits if it can change its contribution (e.g., go from 80% / 20% to 60% / 40% with an understanding that the premium assistance of 30% will allow the employee pay less).

- **Dropping of coverage by co-workers and new employees**: Most states will probably adopt "fire walls" or requirements that children must be uninsured for a certain time period (e.g., 6 months) in order to be eligible. This means that if there are two families in a firm with the same income, one of which purchases ESI and the other doesn't, the family that purchased ESI cannot be eligible for assistance unless they drop that coverage and their children remain uninsured for the required period of time. Will families who currently pay their full share think it worth it to expose their children to being uninsured for the time period so that they can get the exact same coverage at a lower price? What happens if a family changes jobs?

DRAFT
HHS RECOMMENDATIONS ON SECTION 1115 WAIVERS UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND UNDER MEDICAID
November 7, 1997

The new State Children's Health Insurance Program ("Title XXI") strikes a balance between providing States with broad flexibility in program design and protecting beneficiaries through basic Federal standards. States have substantial flexibility in choosing to expand Medicaid, create a separate State program or some combination of these two approaches. At the same time, the new law ensures that States provide a meaningful benefit package, limit cost-sharing, maintain their current Medicaid programs and provide accountability.

The goal of the new Title XXI law is to provide comprehensive and affordable health insurance coverage for uninsured children below 200 percent of poverty. While we want to encourage States to try a broad array of approaches to meeting this goal, we also need to uphold the principles for which the Administration vigorously negotiated during the Congressional debate.

Several sections of the new Title XXI law provide the Secretary of HHS with the authority to vary or waive provisions of the new law (referred to as variances throughout the paper). The areas where the Secretary may grant variances are benefits, family coverage and administrative costs. In addition, Title XXI permits the Secretary to use Section 1115 waiver authority to waive statutory requirements of the new law. (The general purpose of section 1115 waivers is to test innovative alternative methods of carrying out the basic intent of programs under the Social Security Act.)

Section 1115 waiver authority also can be used to waive provisions of State Medicaid programs. This can occur in two instances with respect to children's coverage: (1) waivers requested by States wishing to use Medicaid as a vehicle to expand coverage with funds authorized under the new State Children's Health Insurance Program at enhanced match; and (2) waivers requested by States wishing to expand coverage for children under their traditional Medicaid authority at regular match. The key distinction between these two situations is that under the first situation, the State would receive an enhanced matching rate using new funds while under the second situation, the State would receive its regular matching rate using traditional Medicaid funds.

This paper discusses guiding principles for consideration of waivers of statutory requirements and provides recommendations on the extent to which waivers of statutory requirements should be granted in four circumstances: (1) Secretary-approved variances from Title XXI provisions; (2) Section 1115 waivers for State Title XXI programs (non-Medicaid expansions); (3) Section 1115 waivers for States that use Title XXI funds to expand through Medicaid; and (4) new Section 1115 Medicaid waivers at regular match with no Title XXI funds.

GUIDING PRINCIPLES FOR CONSIDERING WAIVERS

The following are a set of guiding principles for considering waivers of statutory requirements of Title XXI and Medicaid.

- We should ensure that all uninsured children covered by our programs have meaningful, comprehensive quality health coverage, including well-baby and well-child care.
- We should ensure that coverage is affordable for low-income children (i.e., limited cost-sharing).
- We should ensure that States cover lower-income children before they cover higher-income children.
- We should ensure that States cover as many individuals as permitted under the law, consistent with the goal of ensuring comprehensive, affordable coverage. One group needing special focus is children with special needs.
- We should ensure that these funds supplement, not supplant, current public or private coverage, consistent with the law.
- We should ensure that States are accountable for new child health funds.
- Using the tremendous flexibility provided under the new law, we should encourage States to craft a broad range of approaches to covering uninsured children. We should not, however, significantly modify the areas in which Congress was clear in its intention (e.g., benefits and cost-sharing).
- We should evaluate the effectiveness of Title XXI in extending coverage to low-income uninsured children before we consider section 1115 waivers. States should have experience operating their new programs before they test alternative approaches.
- We should continue to ensure that current State Medicaid programs, which include comprehensive EPSDT benefits, will be maintained as a strong safety net for Medicaid-eligible children.

I. SECRETARY-APPROVED VARIANCES FROM TITLE XXI PROVISIONS

Issue: What types of variances can we expect the Secretary to permit under Title XXI?

Title XXI allows the Secretary to consider States' requests for variances from the general Title XXI rules in three areas: (1) offering health benefits other than those specifically described in the law; (2) exceeding the 10 percent limit on administration, outreach and direct services when the State provides cost effective coverage of children through community health delivery systems; or (3) providing family coverage through a group health plan or insurance coverage. The statute provides only minimal guidance on how the Secretary is to evaluate requests for variances from the law.

(1) Health Benefits. Title XXI generally requires States to offer a health benefits coverage package equal to a benchmark or benchmark-equivalent package. The law also permits the Secretary to approve a health benefits coverage package, upon application by a State, that she determines provides "appropriate" coverage for targeted low-income children.

We recommend that the Secretary deem the "grandfathered" benefit packages in New York, Florida and Pennsylvania as meeting the coverage requirements. In addition, we recommend that the Secretary deem that each State can use its traditional Medicaid benefit package for mandatory eligibles as meeting the coverage requirements. Deeming these benefit packages as "appropriate" coverage will ensure that coverage is comprehensive and ease the burden that States would otherwise face because of the requirement to obtain an actuarial assessment of the value of alternative benefit packages. This approach allows States to know in advance that we would allow such coverage. We would recommend that the Department not attempt to define additional packages as "appropriate" coverage.

(2) 10 percent limit. Under the new law, the Secretary may waive the 10 percent limitation on expenditures not used for Medicaid or child health assistance. The law specifies that the 10 percent limitation may be waived if a State demonstrates to the satisfaction of the Secretary that the coverage provided meets the minimum benefit requirements, is cost-effective on an average per child basis and is provided through a community-based health delivery system (e.g., public hospitals or Federally Qualified Health Centers.

We recommend that the Secretary develop guidance for defining coverage that is cost-effective and that is provided through a community-based health delivery system. This would assist States in understanding the types of waivers that would be acceptable.

(3) Family Coverage. Under Title XXI, the Secretary may allow payment to a State for the purchase of family coverage if the State establishes that it is cost-effective and it would not substitute for existing coverage. It is clear that criteria need to be developed for this particular variance option in the law. In addition, a question has arisen as to whether this waiver requirement applies only when a State is providing coverage to an eligible child through a family

policy (e.g., a policy that covers more than the child) or whether it also applies when a State subsidizes dependent coverage offered through an employer health plan (e.g., provides a voucher that can be used for separate dependent coverage offered by employers).

(a) Waiver required for group health plan coverage.

We recommend that States be required to obtain a waiver in cases where they wish to provide child health insurance through employer-provided group health plans. Most importantly, this will provide greater protection against "crowding out" of private coverage and contributions caused by employers dropping -- or reducing contributions toward -- dependent coverage because of the availability of public coverage. In addition, waivers will provide the Department with more discretion and control. States may view this, however, as a restrictive reading of the statute, and key Congressional staff will find it controversial because they believe a waiver is not needed for States to provide funding for employer-based coverage for children. It also is potentially unnecessary because HHS has authority to shape State plans that use employer-provided coverage through the normal State plan approval process. It is important to note that the decision on this issue also depends on the number of requirements we place on States to describe how they are reducing "crowd out" of private and public coverage.

(b) Criteria for family coverage waiver

We recommend that the Secretary specify a set of criteria for cost-effective coverage and coverage that would not substitute for existing coverage.

II. 1115 WAIVERS FOR STATE TITLE XXI PROGRAMS (NON-MEDICAID EXPANSIONS)

Issue: Should the Secretary consider Section 1115 waivers of Title XXI?

There are two distinct categories that need separate consideration: (1) waivers in the first two years of operation of a State child health plan; and (2) waivers in the third and succeeding years of operation of a State child health plan. In prior communications, the Administration has indicated that it is reasonable for States to have experience operating their Title XXI programs before seeking waivers.

(1) Waivers in the first two years of a State Child Health Plan

We believe that the only waivers that should be permitted in the first two years of implementation should be those to improve administrative coordination between Title XXI and Medicaid. This would allow States to remove barriers to smooth program administration (e.g., keeping track of funds on a fiscal year basis for reporting instead of quarterly reporting as required under the law) but would ensure that policies contained in Title XXI were followed as the program is implemented. We believe that there is enough flexibility in current law for States to achieve many

of their goals without a waiver. For example, many States have not realized that a waiver is not necessary to raise income eligibility levels because they can use income disregards under the current State flexibility in the law.

(2) Waivers in the third and succeeding years of a State Child Health Plan

We recommend that the Secretary continue the policy of approving program administration waivers that are designed to improve coordination between Medicaid and Title XXI and that we reconsider our position on additional, more substantive waivers for the third and succeeding years of a State Child Health Plan. This policy allows more time for experience with the new program.

III. SECTION 1115 WAIVERS FOR STATES THAT USE THEIR TITLE XXI FUNDS TO EXPAND THROUGH MEDICAID

Issue: Should the Secretary consider Section 1115 waivers of Medicaid in cases where States want to use Title XXI funds and enhanced matching to expand Medicaid?

There are two distinct categories that warrant separate consideration in determining the extent to which the Secretary will grant Section 1115 Medicaid waivers for child health expansions. The first category is States with currently approved section 1115 Medicaid waivers. These include both States that have implemented their waivers and potentially those with approved waivers that have not yet been implemented. (We would not include States with approved waivers that have taken no steps to implement those waivers.) The second category is States without existing waivers. These include States that have applied for waivers, but have not received approval.

(1)States with approved Section 1115 Medicaid waivers.

We recommend permitting these States to expand coverage consistent with their current waivers, but State programs would be required to meet at least the Title XXI standards on benefits and cost-sharing for the new expansion populations. This policy would ensure that Title XXI funds are used to provide comprehensive coverage. We believe States will support the fact the they would not have to change their underlying waiver. We also believe that all of the State section 1115 waivers except Maryland would meet the benefit requirements, but a handful would not meet the cost-sharing requirements. Preliminary analysis indicates that the following five States would not meet the cost-sharing requirements: Arkansas, Hawaii, Minnesota, Oregon and Tennessee. Attached is a chart summarizing the States that have approved and pending section 1115 waivers.

(2) States that do not have approved Section 1115 Medicaid waivers.

We recommend that for States that currently do not have approved section 1115 Medicaid waivers the Secretary not approve any new section 1115 Medicaid waivers for children's programs or expansions using the new funding and enhanced match for two years. After two

years, we would reevaluate our position. We believe that the Medicaid system, as it currently is structured, was what Congress intended as on option for states and that we should not allow any new changes to the Medicaid program, particularly in benefits. This overrides the concern that some have that States may then choose not to go the Medicaid route because of the more comprehensive benefit package.

The decision on these two issues (States with approved section 1115 Medicaid waivers and those without approved section 1115 waivers) is a compromise. For States with approved section 1115 waivers, we would grant new waivers if they meet at least the Title XXI standards for the new expansion populations. For States without approved waivers, we would not grant any new section 1115 waivers through Medicaid for two years. We believe the new program sets a new floor in terms of benefits and cost-sharing for children that was negotiated between Congress and the Administration and that we should not change that floor at this time. The Democrats and advocates may be concerned with our position for States with approved section 1115 waivers for Medicaid, but would support our position on States without approved waivers.

IV. NEW SECTION 1115 WAIVERS AT REGULAR MATCH WITH NO TITLE XXI FUNDS

Issue: Should the Secretary continue to grant section 1115 waivers at regular match?

Some States may seek section 1115 waivers in their Medicaid programs, at regular FMAP, for demonstration purposes that include expansions of coverage for children, particularly if the State fully uses its allotment under Title XXI. States also may be pursuing such waivers in conjunction with waivers for adults, particularly those coming off welfare so that States can use one system for all people and States can purchase services and develop contracts for a larger population.

We recommend that the Secretary approve section 1115 waivers for children with regular match only if the waivers are for expansions and for insignificant changes that do not affect the standard of comprehensive coverage. This would ensure comprehensive coverage is provided without excessive cost-sharing. This would help States like Missouri that want to expand coverage for children using enhanced match first and then use an 1115 waiver to expand coverage above this category including both children and adults using regular match.

STATES THAT HAVE IMPLEMENTED 1115 WAIVERS (15)

Alabama - 5/97
Arizona - 10/82
Arkansas - 9/97 (children only)
Delaware - 1/96
Hawaii - 8/94
Maryland - 6/97
Massachusetts - 7/97
Minnesota - 7/95
New York - 10/97
Ohio - 7/96
Oklahoma - 4/96
Oregon - 2/94
Rhode Island - 8/94
Tennessee - 1/94
Vermont - 1/96

STATES WITH APPROVED 1115 WAIVERS/PENDING IMPLEMENTATION (3)

Florida - no legislation (Amendment under review, children only)
Illinois - proposed implementation 8/98
Kentucky - proposed implementation 11/97

STATES WITH PENDING APPLICATIONS FOR 1115 WAIVERS (8)*

Georgia
Louisiana
Missouri
New Hampshire
New Jersey
Texas
Utah
Washington

*Most of the States with pending applications for 1115 waivers are for expansions for children. These States likely will want to pursue waivers using the enhanced match provided under Title XXI rather than regular match under Title XIX.

1115 Waivers under CHIP

Provision	Option 1	Option 2	Option 3	Option 4	Recommendation
XXI waiver for health benefits	Secretary would define a set of minimum benefits and allow variances above this minimum	For all states, "grand fathered" benefits packages in NY, FL, PA deemed as meeting coverage requirements	State's Medicaid benefits package for mandatory eligibles deemed as meeting requirements of "appropriate coverage"		Options 2 and 3.
XXI waiver on 10% limit	States could waive 10% limit, consistent with statutory requirements	Secretary to develop guidance for defining coverage that is cost-effective and that is provided through a community-based delivery system.			Option 2
XXI waiver for family coverage (a) waiver for group health plan coverage	Waiver requirement should only apply in States providing or subsidizing coverage through a family health insurance plan	States should obtain a waiver in all cases where it would provide child health insurance through employer-provided health plans.			Option 2

(b) Criteria for family coverage waiver	Secretarial criteria based on guidance for cost-effective coverage and coverage that would not substitute for existing coverage	States could offer a package less generous (different standards on benefits or cost-sharing) than "benchmark equivalent plan," while meeting cost-effectiveness standard			Option 1
1115 Waivers for Title XXI for non-Medicaid expansion in first year of a State Child Health Plan	No waivers for first 2 years of implementation	Waivers immediately	No waivers in first 2 years of implementation except to improve administrative coordination		Option 3
1115 Waivers for Title XXI for non-Medicaid expansion in third and succeeding years of a State Child Health Plan	Waivers that make program less generous to eligible individuals in order to cover more children or reduce "crowd out" of private coverage	Waivers that would expand coverage to children beyond those identified as eligible under Title XXI	Waivers that are designed to improve the coordination between Medicaid and Title XXI	Reconsider position after two years.	Option 3 and 4

115 Waivers for Title XXI for Medicaid expansions n states with pproved 1115 Waivers	States could expand Medicaid and receive enhanced match under Title XXI under same terms and conditions of current waivers for new expansion population	Medicaid waivers for new child health expansions, but State programs should meet at least the Title XXI standards (benefits and cost sharing) for new expansion populations	Medicaid waivers for new child health expansions only if they bring their existing waiver program standards into compliance with minimum standards in Title XXI as well as applying these standards to new programs.	No 1115 Medicaid waivers that use Title XXI allotment to expand through Medicaid for one year.	Option 2
1115 Waivers for Title XXI for Medicaid expansions in states without approved 1115 waivers	Medicaid waivers for Title XXI expansions through Medicaid that are consistent with standards (benefits and cost-sharing) required for Title XXI separate child health insurance program	No 1115 Medicaid waivers for child health expansions through Medicaid for two years. Reevaluate after two years.			Option 2
1115 Waivers of Medicaid at regular match	No 1115 waivers for children only programs at regular match	1115 waivers for children only programs at regular match with no restrictions	1115 waivers for children only programs at regular match only if they meet: a) Title XXI standards; b) Medicaid benefit package; or c) for expansions and insignificant changes.		Option 3 c

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DRAFT

SECTION 1115 WAIVERS UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND UNDER MEDICAID

October 28, 1997

This paper discusses the merits of granting waivers of various provisions of the new State Children's Health Insurance Program ("Title XXI") and Medicaid ("Title XIX"). A key issue is the extent to which waivers of statutory requirements should be granted. Many of these issues were only recently were the subject of an intense legislative debate that resulted in a bipartisan compromise.

Several sections of the new law or Medicaid provide the Secretary of HHS with the authority to vary or waive statutory requirements. Title XXI has three specific provisions that would allow the Secretary to consider variances from the law for States that want to: (1) offer benefits other than those described in the law; (2) exceed the 10 percent limit on administration, outreach and direct services when the State provides cost effective coverage of children through community health delivery systems; or (3) provide family coverage through a group health plan or insurance coverage. In addition, Title XXI permits the Secretary to use Section 1115 waiver authority to waive provisions of the new law.

Section 1115 waiver authority also can be used to waive provisions of State Medicaid programs. This can occur in two instances with respect to children's coverage: (1) waivers requested by States wishing to use Medicaid as a vehicle to expand coverage with funds authorized under the new State Children's Health Insurance Program at enhanced match; and (2) waivers requested by States wishing to expand coverage for children under their traditional Medicaid authority at regular match. The key distinction between these two situations is that under the first situation, the State would receive an enhanced matching rate using new funds while under the second situation, the State would receive its regular matching rate using traditional Medicaid funds.

This paper first provides some background on the Title XXI program and on Section 1115 waivers. It then examines the circumstances under which the Secretary may grant the variances as specified in Title XXI, and then discusses the options identified related to using the 1115 authority in Titles XXI and XIX.

Background on Title XXI

The new State Children's Health Insurance Program provides about $24 billion over five years to expand coverage to a defined set of children (generally children in families below 200 percent of poverty but not eligible for Medicaid).

The basic intent of Title XXI is to provide certain low-income children with health insurance coverage financed by Federal and State monies. The key elements are:

- The eligible children are children with family income under 200 percent of the poverty level. These children also cannot have insurance coverage from any other source -- Medicaid or private insurance.

- The benefits provided are intended to be comprehensive.

- The benefits can be provided through a number of alternative approaches at the option of the States. The States may choose to: (1) use their existing Medicaid program; or (2) establish a health insurance program using either the Federal Blue Cross Blue Shield plan, a health insurance plan widely available to State employees, the HMO product in the State with the largest number of non-Medicaid covered lives, or the State can develop an "actuarial-equivalent" plan. In addition, there is the option for the State to request a Secretarially approved plan. Finally, three States -- Florida, New York, and Pennsylvania -- have the benefits of their current child health plans labeled in the law as comprehensive.

- The cost sharing requirements were specified separately from the benefit package, and they are in general consistent with cost-sharing for the medically needy under Medicaid.

- The Federal funding is not open-ended. Each State has a specific allotment, and the allotment, if not used in a three year period, is re-allocated to the other States.

The new Title XXI law provides substantial flexibility to States in determining how to expand coverage to new populations of children. States have substantial flexibility in establishing the benefits package for children under the new law. They also can use more liberal income and resource standards in their new State children's health programs than allowed under Medicaid. At the same time, Congress indicated a strong interest in being able to measure the effectiveness and efficiency of the program. This is demonstrated in clear language about performance measures and strategic objectives, annual reports and State evaluations.

Despite the substantial flexibility granted in the new law, many States will likely still seek variances or waivers from statutory provisions, although they may not realize that waivers may not be needed for certain items. The areas expected to generate the greatest interest in additional flexibility are in the benefits package and cost sharing. A number of States also may want to use existing private group health plans as a mechanism to provide child health coverage, an option

which may require a variance under the new law. States also may want waivers of provisions in Title XXI in order to coordinate their new child health programs with their existing Medicaid programs.

Background on Section 1115 Medicaid waivers

The general purpose of section 1115 waivers is to test innovative alternative methods of carrying out the basic intent of programs under the Social Security Act. Typically, these waivers are supposed to be research and demonstration waivers that must include a research and evaluation design. In addition, current policy requires that section 1115 waivers must be budget neutral. The section 1115 waivers are already available to States under the Medicaid program, and now States may apply for section 1115 waivers under the recently enacted Child Health Insurance Program (Tittle XXI).

States have used the section 1115 waivers under Medicaid to facilitate State health reform demonstration efforts, many of which have focused on expansion of coverage to children. Under these section 1115 waivers, a number of specific Medicaid provisions have been modified, permitting such controversial policies as increased beneficiary cost sharing for expansion populations and reduced benefits.

To date, 15 States have implemented section 1115 Medicaid waivers. Another 3 States have received approval for waivers, but have not yet implemented them. (Florida is included in this category, although there is no enabling State legislation.) In addition, 8 States have applications pending for 1115 waivers. The Arkansas waiver and a Florida amendment to its overall section 1115 waiver are exclusively for children.

As part of their section 1115 Medicaid waiver process, 5 States have reduced benefits. The Maryland KidsCount Program, implemented in 1993, had the most significant benefits reductions: inpatient, outpatient, emergency room and some EPSDT expanded services were excluded. Massachusetts has also modified the benefit package to exclude EPSDT and transportation for one small subgroup of children. Arkansas excludes EPSDT treatment, child health management services, and non-emergency transportation. The Oregon Health Plan has developed a benefit package based on a prioritized list of diagnosis-specific benefits that is used to determine coverage. Most, if not all of Oregon's excluded benefits on that list would otherwise be part of the Medicaid package. New York excludes dental coverage.

In addition, 5 of the 18 States with approved section 1115 waivers have cost-sharing requirements for beneficiaries that would exceed limitations in the new Title XXI requirements. (Title XXI requires that for children in families with income at or below 150 percent of poverty, the cost-sharing must be consistent with Medicaid nominal levels. For children in families with incomes above 150 percent of poverty, the cost-sharing must be based on an income-related sliding scale and the annual aggregate for all children in the family cannot exceed 5 percent of the family's income.) Arkansas requires copayments of $10 for most outpatient services. Florida

requires coinsurance of 20 percent for all services in the indemnity plan, which could easily exceed the limits. Hawaii imposes premiums of $147 per month on all individuals over 100 percent of poverty. Minnesota's copayments for children in a family over 150 percent of income could exceed the 5 percent limit if they had several inpatient visits. Tennessee imposes monthly premiums on a family of three above poverty beginning at $24.50, which is higher than permitted under Medicaid.

I. SECRETARY-APPROVED VARIANCES FROM TITLE XXI PROVISIONS

Issue: What types of variances can we expect the Secretary to permit under Title XXI?

Title XXI allows the Secretary to consider States' requests for variances from the general Title XXI rules in three areas: (1) offering health benefits other than those described in the law; (2) exceeding the 10 percent limit on administration, outreach and direct services when the State provides cost effective coverage of children through community health delivery systems; or (3) providing family coverage through a group health plan or insurance coverage. The statute only provides minimal guidance on how the Secretary is to evaluate requests for variances from the law.

(1) Health Benefits. Title XXI generally requires States to offer a health benefits coverage package equal to a benchmark or benchmark-equivalent package. However, the law also permits the Secretary to approve a health benefits coverage package, upon application by a State, that she determines provides "appropriate" coverage for targeted low-income children.

Options:

- **Option #1.** The Secretary of HHS will identify a set of minimum benefits and allow variances above this minimum level.

  Pro: Provides States with additional flexibility.

  Provides a clear bottom line for States.

  Con: Congress specified what it intended to be the minimum benefit package.

  Many argued for a comprehensive benefit package during the Congressional debate of the new law, and only accepted the benchmarks in the law as a compromise position.

  Even if a minimum set of benefits are identified, some States will propose even less generous packages anyway. It is likely that the result will be a State-by-State review.

  The effort of specifying a minimum benefit package may not be worthwhile.

- **Option #2.** For all States, the Secretary will deem the "grand fathered" benefit packages in New York, Florida and Pennsylvania as meeting the coverage requirements. (Cost-sharing requirements must be met.)

  Pro: These States' benefit packages for children are comprehensive.

  Eases the burden States otherwise would face because of the requirement to obtain an actuarial assessment of the value of alternative benefit packages.

  Con: States would find this desirable, but not sufficient flexibility.

  Some would oppose as potentially allowing reduced benefits option.

- **Option #3.** The Secretary may deem the State's Medicaid benefits package for mandatory eligibles as meeting the requirements of "appropriate" coverage.

  Pro: Medicaid is a comprehensive benefits package.

  Eases the burden States otherwise would face because of the requirement to obtain an actuarial assessment of the value of alternative benefit packages.

  Con: Provides insufficient flexibility for States to design their own packages.

Recommendation: Options 2 and 3.

(2) 10 percent limit. Under the new law, the Secretary may waive the 10 percent limitation on expenditures not used for Medicaid or child health assistance. The law specifies that the 10 percent limitation may be waived if a State demonstrates to the satisfaction of the Secretary that the coverage provided meets the minimum benefit requirements, is cost-effective on an average per child basis and is provided through a community-based health delivery system.

Options:

- **Option #1.** States may be allowed to waive the 10 percent limit, consistent with statutory requirements.

  Pro: State flexibility.

  Con: No assurance that a sizeable portion of the children will receive comprehensive coverage.

- **Option #2.** The Secretary should develop guidance for defining coverage that is cost-effective and that is provided through a community-based health delivery system.

Pro: Would provide additional time for consideration of the types of waivers that would be acceptable.

Con: States may want waivers to be granted immediately.

Covering start-up costs may not be "cost effective" on a per eligible basis as required by the law.

Recommendation: Option 2.

(3) Family Coverage. Under Title XXI, the Secretary may allow payment to a State for the purchase of family coverage if the State establishes that it is cost-effective and it would not substitute for existing coverage. It is clear that criteria need to be developed for this particular variance option in the law. In addition, a question has arisen as to whether this waiver requirement applies only when a State is providing coverage to an eligible child through a family policy (e.g., a policy that covers more than the child) or whether it also applies when a State subsidizes dependent coverage offered through an employer health plan (e.g., provides a voucher that can be used for separate dependent coverage offered by employers).

(a) Waiver required for group health plan coverage.

Options:

o **Option #1.** Limit waiver requirement only to situations in which the State is providing or subsidizing coverage through a family health insurance plan. This would mean that States could subsidize dependent coverage offered through an employer plan without a waiver.

Pro: Makes a limited reading of the waiver requirement. States that want to use voucher approaches would not need to apply for this type of waiver.

Would be less controversial with Congress. Some in Congress feel that their intent was to allow States to subsidize employers to cover dependent children without a waiver.

Any concerns with group health plan approach (e.g., greater potential for crowd out) can be addressed through state plan approval process. A separate waiver is not needed.

Cons: Limiting waiver requirement to "family policies" may increase the risk of crowd out. Some health insurance analysts are concerned that the potential for crowd out is greater under schemes that subsidize employer coverage than under stand-alone private health insurance arrangements. A waiver could be required for any State arrangement that provides coverage through employer plans.

- **Option #2.** States may be required to obtain a waiver in cases where they wish to provide child health insurance through employer-provided group health plans.

  Pros: Potential to reduce crowd out.

  Provides more Federal discretion (e.g., cost-effectiveness standard).

  Would not be subject to the 90 day limit on approving child health plans.

  Cons: States may view as a restrictive reading of statute by States and key Congressional staff will find it controversial because they believe a waiver is not needed.

  Potentially unnecessary because HHS has authority to shape State plans that use employer-provided coverage through the normal State plan approval process.

Recommendation: Option 2.

(b) Criteria for family coverage waiver

Options:

- **Option #1.** The Secretary will specify a set of criteria for cost-effective coverage and coverage that would not substitute for existing coverage.

  Pro: Assures comprehensive coverage.

  Con: States may oppose the lack of flexibility in the benefit package.

- **Option #2.** States may offer a package that is less generous (different standards on benefits or cost-sharing) than the "benchmark equivalent plan," while meeting the cost-effectiveness standard.

  Pro: States will support the flexibility.

  Con: This is inconsistent with our goals of ensuring comprehensive coverage.

Recommendation: Option 1.

II. 1115 WAIVERS FOR STATE TITLE XXI PROGRAMS (NON-MEDICAID EXPANSIONS)

Issue: Should the Secretary consider Section 1115 waivers of Title XXI?

States should operate their Title XXI programs following the requirements set in law for a period of time and before they consider ideas on how to modify certain elements so that they could achieve the same outcomes but in a more efficient and effective manner. The section 1115 waivers would then be used to implement these alternative ideas in the future.

In a set of questions and answers, the Administration has indicated that, while it would not refuse to entertain requests for Section 1115 waivers of Title XXI, it was not clear how such requests should be evaluated. They believe it is reasonable for States to have experience operating their Title XXI programs before seeking waivers.

There are two distinct situations that need separate consideration: (1) waivers in the first two years of operation of a State child health plan; and (2) waivers in the third and succeeding years of operation of a State child health plan.

(1) Waivers in the first two years of a State Child Health Plan

Options

- **Option #1: No waivers during first two years of implementation** -- No section 1115 waivers of Title XXI would be approved until a State has two years of experience operating its child health plan. **(Note: This moratorium does not apply to Secretarial variances described above.)** Some argue that it will be difficult to draw the line on granting some types of waivers, but not others. In addition, this policy would treat all States the same.

  Pros: This would provide time for States to gain experience operating their Title XXI programs.

  A no waiver policy might facilitate more rapid consideration of State plans, because there would be fewer policy decisions to make.

  Cons: States will oppose because they want the flexibility to design programs that meet their unique needs.

  Some States might choose not to develop a children's health insurance program unless they can get a waiver of some of the rules under Title XXI.

- **Option #2: Grant waivers in the first two years of implementation** -- section 1115 waivers of Title XXI will be approved during the first two years a State had an approved Child Health Plan.

  Pros: This would provide States with the flexibility that they desire.

Some States will argue that they should not have to wait one year since they have been operating a separate children's program for a number of years.

Cons: States would not be able to develop a baseline against which we can measure the effect of a change to assess the usefulness of the new option in promoting efficiency and effectiveness.

Some in Congress would oppose this.

o **Option #3: No waivers in the first two years of implementation except to improve administrative coordination between Medicaid and Title XXI, as described by pages 10 through 12. (Note: This moratorium does not apply to Secretarial variances.)**

Pro: This would allow States to remove barriers to smooth program administration (e.g., keeping track of funds on a fiscal year basis for reporting instead of quarterly reporting as required under law, as well as other technical problems in the law) but would ensure that the policies contained in Title XXI were followed as the program is implemented.

Con: States may want waivers in the first year, including waivers that would provide for new coverage for children with higher incomes (e.g., Some States want to expand to 300 percent of poverty), although States may be able to do this without a waiver, due to flexibility under the law with respect to income and resources.

Recommendation: Option 3

(2) Waivers in the third and succeeding years of a State Child Health Plan

The following options are provided for consideration:

o **Option #1: Less Generous Approaches** -- Approve State section 1115 waivers of legal requirements with the result that the program would be less generous to eligible individuals in order to cover more children or reduce "crowd out" of private coverage.

One type of restriction States may consider is limiting the number or scope of benefits that are required under Title XXI. (Note: a section 1115 waiver is not the only means for a State to receive approval to offer reduced benefits. The Secretary has discretion under the variance authority discussed above to approve a benefits package other than one described in the law.)

States also may consider increasing the cost-sharing that is permitted for Title XXI

Pro: Permitting less generous coverage to Title XXI eligibles would permit the available money to be spread more widely so more children would be covered.

It could reduce "crowd out" of private insurance.

Waivers of Medicaid cost-sharing limits have been in place for years under some of the section 1115 waiver process for non-mandatory Medicaid eligibles.

Con: This type of waiver could undermine Congress' intent to require a meaningful benefit package and minimal cost-sharing requirements to the lowest-income uninsured children.

Although the Title XXI dollars could be used to cover more children, the dollars would not be used for their targeted purpose -- to cover the lowest income uninsured children.

It creates a slippery slope.

o **Option #2: More Generous Approaches** -- Approve Title XXI section 1115 waivers of legal requirements with a result that would expand coverage to children beyond those identified as eligible under Title XXI. For example:

One approach that States may consider is increasing the eligibility of qualified children to higher income levels.

Another type of expansion that States may consider is covering children who have "inadequate" coverage. This could be limited to children under 200 percent of poverty to address the "crowd out" issue since those with higher incomes are most likely to have other coverage.

Another type of expansion that States may consider is covering more people (e.g., pregnant women).

Pro: These flexibilities could be used by a State that would otherwise be unable to use all of its allotment for eligible children. Some States may not be able to spend all of the funds in their allotments on the children specified in Title XXI, because they already have generous State programs for children.

State flexibility.

Con: Some States wanting to do more to cover lower-income children may be concerned that this would limit the money that would be reallocated after three years, although States already at higher incomes in terms of coverage would disagree.

As eligibility is expanded to higher income children or adults, "crowd-out" concerns increase. (Anti-discrimination rules and third-party liability rules may reduce crowd out.)

Slippery slope -- if waivers are granted in one area, it may become difficult not to grant waivers in other areas.

Not needed because States have flexibility to expand to higher income levels through income disregards under Title XXI.

It is not at all clear that a waiver that expands coverage to more people, but includes a reduced benefit package, is "more generous."

o **Option #3: Improved Administrative Coordination** -- Approve State 1115 waivers that are designed to improve the coordination between Medicaid and title XXI.

One type of waiver would be to allow fiscal year reporting rather than quarterly reporting process as provided under the law. This would reduce the States' administrative burden in terms of reporting.

Another type of waiver would be for States that want to fix a technical problem. For example, there are technical drafting problems for Tennessee and Rhode Island that would prevent these States from expanding coverage under the law.

Pro: Every attempt should be made to ease the administration of this new program and not increase the burden on States. Current law may be very burdensome on States.

Could be used to waive certain issues if technical amendments are not passed in a timely fashion.

Con: Not a consistent policy on granting of waivers in the first two years.

Using waivers to extend coverage well beyond statutory boundaries may be seen as too much legislation by discretion.

Option #4. Reconsider position after two years.

Pro: Allows more time for experience with the new program.

Con: States may want a clear policy on section 1115 waivers.

Recommendation: Option 3 and 4.

III. SECTION 1115 WAIVERS FOR STATES THAT USE THEIR TITLE XXI FUNDS TO EXPAND THROUGH MEDICAID

Issue: Should the Secretary consider Section 1115 waivers of Medicaid in cases where States want to use Title XXI funds to expand Medicaid?

Some States with Title XIX waivers approved and implemented want to get enhanced match under Title XXI to expand coverage beyond current coverage levels through existing programs. As noted on page 3, five States (Arkansas, Florida, Hawaii, Minnesota and Tennessee) have 1115 waivers with cost-sharing requirements that exceed the Title XXI limit. In addition, Maryland has a unique situation of the most significantly reduced package, although this is a time-limited waiver. The question has been raised whether existing waivers should be approved for enhanced match under Title XXI and on whether 1115 waivers for children should conform with the new law. A decision also needs to be made about States with no existing approved waivers that may want to generally take the Medicaid approach, but make modifications such as a reduced benefit package under Medicaid.

The following are a number of important considerations for approving 1115 waivers.

Pros:

States are in very different programmatic positions: some States are operating under existing Section 1115 Medicaid waivers, some States have developed State-only child health programs, while others have done very little in the area. The Section 1115 waiver process provides an opportunity to address differences in States. For example, States that already have used Section 1115 to extend coverage might want to build on those programs (which might not otherwise meet the requirements of the new law).

States may be reluctant to use the Medicaid option to extend coverage if they cannot get waivers in certain areas, such as benefits and cost sharing. Under the Act, States have much greater flexibility if they create a separate child health program to extend coverage than if they use Medicaid. During the legislative debate, many strongly advocated making Medicaid a viable option for States to extend child health coverage. A key advantage of using Medicaid is that the children would have an individual entitlement when funds are exhausted under Title XXI. States would have to keep covering children at regular matching rates.

Cons:

The child health provisions in the Act were the subject of intense negotiations. Many fought hard for substantive provisions in areas such as benefits, cost sharing, maintenance of effort, and accountability. Providing waivers in these areas (under Medicaid or under separate child health programs) could be viewed as renegotiating the deal already made.

Congress had an opportunity to provide for additional flexibility for States wanting to extend coverage to children through Medicaid and chose not to do so. The Act provides States with substantial flexibility when extending coverage through a Title XXI separate child health program, but does not extend that flexibility to States that choose to extend coverage through Medicaid. (It can be argued that Congress was aware of section 1115 and believed that it could be invoked to provide States with sufficient flexibility.)

Some believe that States were given too much flexibility in the Act and that the Act should be interpreted strictly to ensure that children receive comprehensive coverage. These advocates strongly support the protections and provisions in the Medicaid program and tend to oppose Medicaid waivers. If DHHS were to grant waivers, they would be severely criticized for granting section 1115 Medicaid waivers to States that use their Title XXI allotment to expand through Medicaid. This would be particularly true if States were permitted to offer Medicaid coverage that was less protective of children than would be possible under a Title XXI separate child health insurance program.

Most States believe that they were losers in the legislative debate over the requirements for child health insurance programs. They wanted additional flexibility and several States already have indicated that they intend to seek that flexibility through waivers. Most, if not all States, would be expected to seek waivers. This could substantially slow the process of getting State child health programs established. It also could lead to a situation where States attempt to bargain with DHHS to determine whether they can get more flexibility under Medicaid or under a separate program.

Options

There are several options in determining the extent to which it will grant Section 1115 Medicaid waivers for child health expansions. There are at least two distinct situations that warrant separate consideration. The first category is States with approved section 1115 Medicaid waivers. These include both States that have implemented their waivers and those with approved but not yet implemented waivers. The second category is States without existing waivers. These include States that have applied for waivers, but have not received approval. (See attachment.)

(1)States with approved Section 1115 Medicaid waivers. A number of States have already expanded coverage to children through expansions to their Medicaid programs under a Section 1115 waiver. These States may wish to use the new program funds (and receive an enhanced matching rate) to extend their existing waiver programs to reach new eligibles. Due to the maintenance of effort requirement, these States could not receive an enhanced match for current children eligible under section 1115 waivers in effect prior to April 15, 1997. In some cases, these programs meet all of the Medicaid benefit and coverage rules and would be easily approvable under the new law. In other cases, the State has received a waiver of benefits, cost sharing and other Medicaid provisions and

would need to have that waiver extended to the new Title XXI population. In several cases, the benefits and cost sharing currently being provided by these waiver programs fall below the standards that the Act applies to Title XXI separate child health programs (i.e., they are below the standards that were negotiated as part of the Act).

Three States (Florida, Illinois and Kentucky) have received Section 1115 Medicaid waivers to expand coverage to children but have not yet implemented their programs. In at least one case, the waiver was granted some time ago and the State has indicated they may not want to pursue the expansions (at least under the existing waiver terms). In other cases, the waivers are newly granted and the States intend to implement in the near future.

- **Option #1: Expand Medicaid and receive enhanced match under Title XXI under the same terms and conditions that exist under their current waivers for the new expansion population.**

  Pro: Permits continuity of existing program.

  Permits States to quickly participate in new program.

  Maintains existing policy on waivers.

  Con: Permits some States to meet standards that are below those negotiated for Title XXI.

  Would be strongly criticized by those who support beneficiary rights.

- **Option #2: Medicaid waivers for new child health expansions, but State programs would be required to meet at least the Title XXI standards (benefits and cost sharing) for the <u>new</u> expansion populations.**

  Pro: This would ensure that Title XXI funds are used to provide comprehensive coverage.

  States would support the fact that they would not have to change their underlying waiver.

  Most State section 1115 waivers would qualify as meeting the Title XXI benefit requirements except Maryland. Preliminary analysis indicates that the following five States would not meet the cost-sharing requirements: Arkansas, Florida, Hawaii, Minnesota, and Tennessee.

  Con: This could create a two-tiered system, although the States currently are operating the Medicaid program and the waiver program, too. The higher income children could have lower out-of-pocket expenditures than lower income children.

It may be difficult for States to maintain two different cost-sharing arrangements for the two groups of children (although some States have different cost-sharing arrangements for their expansion populations than for the traditional Medicaid eligibles).

- **Option #3: Medicaid waivers for new child health expansions that bring their existing waiver program standards into compliance with the minimum standards required for Title XXI separate child health insurance programs as well as applying these standards to their new programs.**

  Pro: For States currently at a lower standard than Title XXI, it brings States up to standards contemplated by Title XXI.

  Establishes more consistency across States in requirements for child health insurance.

  Consistent with principles in Title XXI.

  Allows States to expand coverage without creating a new program. (This is consistent with Secretary's goal to minimize administrative burdens.)

  Con: Disrupts current programs -- some States will have to modify their benefits or cost-sharing. Will be seen as intrusive by States and as reneging on an agreement.

  States that have to modify their cost-sharing will lose revenue.

  In effect, this allows the Medicaid benefits to be reduced to the benchmark plan or its actuarial equivalent.

- **Option #4: No new 1115 Medicaid waivers to States that use their Title XXI allotment to expand through Medicaid for two years. Reevaluate after two years.**

  Pro: Consistent with new Act's denial of flexibility for Medicaid expansions.

  Clear policy.

  Con: May disrupt current programs.

  States would either need to change their existing waiver programs or establish a new, inconsistent program for Title XXI children.

  May be criticized by States as inflexible.

  Would encourage States to expand through Title XXI rather than Medicaid

(depending on Title XXI policy).

Recommendation: Option 2.

(2) States that do not have approved Section 1115 Medicaid waivers. Although most States have not used Section 1115 to expand their Medicaid programs for children, several suggest that they would like to do so. These States often look at the programs that other States have negotiated and use those as precedents for their applications. At least two States filed for waivers prior to passage of Title XXI but decisions have yet to made on them.

- **Option #1: Medicaid waiver for Title XXI child health expansions through Medicaid that are consistent with standards (benefits and cost-sharing) required for Title XXI separate child health insurance program.** In effect, this option would establish the Title XXI standards as a floor for new Medicaid waivers.

  Pro: Provides States with the same flexibility in Medicaid as is available under a Title XXI separate child health insurance program. This would make expansion through Medicaid more attractive to States.

  If option 3 (above) is chosen for the States with existing waivers, this option would establish consistent policy for Section 1115 Medicaid waivers that would apply for all States.

  Continues to show flexibility while maintaining principles that we fought for during the negotiations over Title XXI.

  Con: May be seen as intrusive and inflexible by States.

  Would be criticized by supporters of beneficiary rights.

  May be seen as inconsistent with terms of new law; Congress had an opportunity and chose not to extend benefit and other terms in Title XXI to Medicaid expansions.

  Could "water down" the Medicaid benefits and cost-sharing protections for children, enabling all States to easily reduce current protections to the minimum standards under Title XXI.

  In effect, this allows the Medicaid benefits to be reduced to the benchmark plan or its actuarial equivalent.

- **Option #2: No new 1115 Medicaid waivers for child health expansions through Medicaid for two years. Reevaluate after two years.**

Pro: Clear policy.

If option 4 (above) is chosen, would be consistent policy.

Would be praised by supporters of beneficiary rights.

Con: Would be seen as inflexible by States. Would be strongly criticized.

Recommendation: Option #2.

IV. NEW SECTION 1115 WAIVERS AT REGULAR MATCH WITH NO TITLE XXI FUNDS

Issue: Should the Secretary continue to grant section 1115 waivers at regular match?

Some States may seek section 1115 waivers in their Medicaid programs, at regular FMAP, for demonstration purposes that include expansions of coverage for children, particularly if the State fully uses its allotment under Title XXI. States also may be pursuing such waivers in conjunction with waivers for adults, particularly those coming off welfare so that States can use one system for all people and States can purchase services and develop contracts for a larger population.

Options

- **Option #1: No section 1115 waivers for children only programs with regular match.**

  Pro: Congress made clear their intent for coverage of children through enactment of Title XXI, although they did not repeal section 1115 waivers. Allowing waivers may be viewed as overturning their intent.

  Con: The newly enacted BBA does not explicitly prohibit the granting of section 1115 waivers for children.

  States may want to cover additional children with higher incomes at regular match, if they use their Title XXI funds. This is the case with Missouri's plan for children.

  HCFA already approved Arkansas' waiver.

- **Option #2: Grant Section 1115 waivers for children only programs with regular match (No restrictions.)**

  Pro: States would support this continued flexibility to vary from the traditional Medicaid requirements.

States may want to use Medicaid waivers to expand coverage to children who would not be eligible for Title XXI (e.g., children with incomes above Title XXI limits; subsidizing children with inadequate coverage).

Con: This would not achieve the goal of ensuring comprehensive coverage for children.

- **Option #3: Grant Section 1115 waivers for children only programs with regular match only if it meets either: (a) Title XXI standards; (b) the Medicaid benefit package; or (c) only for expansions and for insignificant changes that do not affect the standard of comprehensive coverage.**

  Pro: Assures that children's benefit and cost-sharing provisions meet Title XXI standards.

  States may want to use Medicaid waivers to expand coverage to children who would not be eligible for Title XXI (e.g., children with incomes above Title XXI limits; subsidizing children with inadequate coverage).

  Con: States would object to this limit on their flexibility.

Recommendation: Option 3(c).

STATES THAT HAVE IMPLEMENTED 1115 WAIVERS (15)

Alabama - 5/97
Arizona - 10/82
Arkansas - 9/97 (children only)
Delaware - 1/96
Hawaii - 8/94
Maryland - 6/97
Massachusetts - 7/97
Minnesota - 7/95
New York - 10/97
Ohio - 7/96
Oklahoma - 4/96
Oregon - 2/94
Rhode Island - 8/94
Tennessee - 1/94
Vermont - 1/96

STATES WITH APPROVED 1115 WAIVERS/PENDING IMPLEMENTATION (3)

Florida - no legislation (Amendment under review, children only)
Illinois - proposed implementation 8/98
Kentucky - proposed implementation 11/97

STATES WITH PENDING APPLICATIONS FOR 1115 WAIVERS (8)

Georgia
Louisiana
Missouri
New Hampshire
New Jersey
Texas
Utah
Washington

Provisi	Option 1	Option 2	Option 3	Option 4	Recommendation
CXI w r for ealth b fits	Secretary would define a set of minimum benefits and allow variances above this minimum	For all states, "grand fathered" benefits packages in NY, FL, PA deemed as meeting coverage requirements	State's Medicaid benefits package for mandatory eligibles deemed as meeting requirements of "appropriate coverage"		Options 2 and 3.
CXI w r on 10% mit	States could waive 10% limit, consistent with statutory requirements	Secretary to develop guidance for defining coverage that is cost-effective and that is provided through a community-based delivery system.			Option 2
CXI wa r for mily c rage) waiv r for group alth pl coverage	Waiver requirement should only apply in States providing or subsidizing coverage through a family health insurance plan	States should obtain a waiver in all cases where it would provide child health insurance through employer-provided health plans.			Option 2

(b) Criteria for family coverage waiver	Secretarial criteria based on guidance for cost-effective coverage and coverage that would not substitute for existing coverage	States could offer a package less generous (different standards on benefits or cost-sharing) than "benchmark equivalent plan," while meeting cost-effectiveness standard			Option 1
1115 Waivers for Title XXI for non-Medicaid expansion in first year of a State Child Health Plan	No waivers for first 2 years of implementation	Waivers immediately	No waivers in first 2 years of implementation except to improve administrative coordination		Option 3
1115 Waivers for Title XXI for non-Medicaid expansion in third and succeeding years of a State Child Health Plan	Waivers that make program less generous to eligible individuals in order to cover more children or reduce "crowd out" of private coverage	Waivers that would expand coverage to children beyond those identified as eligible under Title XXI	Waivers that are designed to improve the coordination between Medicaid and Title XXI	Reconsider position after two years.	Option 3 and 4

1115 Waivers for Title XXI for Medicaid expansions in states with approved 1115 waivers	States could expand Medicaid and receive enhanced match under Title XXI under same terms and conditions of current waivers for new expansion population	Medicaid waivers for new child health expansions, but State programs should meet at least the Title XXI standards (benefits and cost sharing) for new expansion populations	Medicaid waivers for new child health expansions only if they bring their existing waiver program standards into compliance with minimum standards in Title XXI as well as applying these standards to new programs.	No 1115 Medicaid waivers that use Title XXI allotment to expand through Medicaid for one year.	Option 2
1115 Waivers for Title XXI for Medicaid expansions in states without approved 1115 waivers	Medicaid waivers for Title XXI expansions through Medicaid that are consistent with standards (benefits and cost-sharing) required for Title XXI separate child health insurance program	No 1115 Medicaid waivers for child health expansions through Medicaid for one year. Reevaluate after one year.			Option 2
1115 Waivers of Medicaid at regular match	No 1115 waivers for children only programs at regular match	1115 waivers for children only programs at regular match with no restrictions	1115 waivers for children only programs at regular match only if they meet: a) Title XXI standards; b) Medicaid benefit package; or c) for expansions and insignificant changes.		Option 3 c

October 15, 1997

The Honorable Donna Shalala
Secretary, Department of Health and Human Services
200 Independence Avenue, SW, Room 615-F
Washington, DC 20201

Dear Secretary Shalala:

The undersigned groups concerned about implementation of the State Child Health Insurance Program are grateful for the high priority the Administration has placed on swift implementation of the law to provide the best possible health coverage for as many uninsured children as possible. While many of us are also communicating with the Department separately on a broad range of issues, we write together to convey some of our shared priorities for interpretation and implementation of the bill.

1. **Waivers under Section 1115.** We applaud the Department's stance that waivers of Title XXI's requirements will not be granted under Section 1115 until states develop a track record under the new statute. Section 1115 should not be used to waive newly enacted statutory provisions almost before their ink has dried. Early and aggressive use of Section 1115 would repudiate recent legislative decisions about the appropriate balance between state flexibility and minimum, federal safeguards. Section 1115 is intended, not to permit states to escape from statutory safeguards with which they disagree, but to permit "experimental, pilot, or demonstration project[s]," which are difficult to justify before significant implementation of this new statute, which already grants states considerable flexibility.

2. **A sensible relationship between Medicaid and other child health insurance programs.** A state that creates or expands a non-Medicaid program must screen children for potential Medicaid eligibility and, if eligible, they must be enrolled in Medicaid, under Section 2102(b)(3)(B). Such children's enrollment into Medicaid should be built into the application process for non-Medicaid programs, without requiring families to submit a new application to the Medicaid agency. Denying health coverage pending submission of a separate Medicaid application would contradict Title XXI's purpose by needlessly keeping children uninsured and would violate the statutory requirement that states must "ensure" Medicaid enrollment of Medicaid-eligible children.

3. **General Medicaid rules should apply when a state uses enhanced federal matching funds to expand Medicaid.** Congress clearly intended that, so long as the children involved have the targeted levels of family income, states should be able to expand Medicaid coverage without changing any Medicaid rules. Requiring separate rules for children receiving enhanced match would introduce needless complexity without advancing any compelling public policy goals. Congress sought to make it easier, not harder, for states to cover uninsured children.

4. **Immigrant children.** States should have the discretion to use their state matching funds to cover otherwise eligible immigrant children, regardless of their date of entry into the United States. As noted in comments from the National Immigration Law Center and the Center on Budget and Policy Priorities, state matching funds for children's coverage under the new bill are not subject to immigration status restrictions under the 1996 federal welfare law.

5. **Affordability**. If health coverage and health care are not affordable to low-wage, working families with uninsured children, the most central goals of the recent legislation -- helping low-income, uninsured children receive essential health coverage and care -- will not be achieved. Accordingly, in a non-Medicaid program, maximum premium payments per child with family income below 150% of poverty should not exceed roughly $3-5 per child. Otherwise, premium payments would not be "consistent with" Medicaid family premium maximum payments under 42 CFR 447.52 as required by Section 2103(e)(3)(A)(i). Similarly, the 5% cap on annual cost-sharing for children with incomes above 150% should apply to all payments for all children in a family, and the full range of preventive services included in a well-baby or well-child exam should be exempt from cost-sharing.

6. **Benefits**. HCFA should assure that covered benefits meet the unique health needs of children, including children with disabilities and other special needs. For example, a state employee health plan should not be viewed as "generally available" and therefore a benchmark plan unless it is actually used by a significant number of public employees.

7. **Public participation**. HCFA should move aggressively to encourage public participation, in both the federal and state implementation of the CHIP program. We were disappointed that the state plan template included no specific guidance to states about the importance of public participation and failed to establish rigorous standards of appropriate participation. We encourage you to incorporate more exacting standards into your next round of guidance or regulation. Also, HCFA should make state plans easily available to the public, preferably as soon as they are received.

We look forward to working together to pursue our common goals and make the most of this extraordinary opportunity to improve children's health coverage.

Sincerely,

Center on Budget and Policy Priorities
Children's Defense Fund
Families USA
National Health Law Program
National Immigration Law Center
National Center on Youth Law

c.c. Nancy-Ann Min DeParle
Deborah Chang
Earl Fox
Sally Richardson
Rick Fenton
Chris Jennings

NATIONAL GOVERNORS' ASSOCIATION

George V. Voinovich
Governor of Ohio
Chairman

Thomas R. Carper
Governor of Delaware
Vice Chairman

Raymond C. Scheppach
Executive Director

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Telephone (202) 624-5300

September 22, 1997

The Honorable William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

On behalf of the National Governors' Association, we would like to thank you for your leadership on children's health. Your dedication, together with the commitment of members of Congress from both parties, resulted in legislation that will make possible the single most dramatic expansion of health insurance coverage for children in thirty years. Governors share this dedication and commitment, and they have long been leaders in promoting insurance coverage for children. We welcome the opportunity to build on existing state efforts to extend health insurance coverage to millions of currently uninsured children and look forward to successfully implementing the new program.

Successful implementation will require close cooperation between the federal government and state governments. We appreciate the efforts already made by your administration to help states quickly implement the new children's health program created through the Balanced Budget Act. In particular, the Health Care Financing Administration (HCFA) is to be commended. HCFA officials have worked tirelessly to provide states with the information they need to move forward.

However, we have real concerns about some of the preliminary guidance that HCFA has given to states. For example, in a document responding to frequently asked questions regarding the new children's health program, HCFA poses the question, "May a state apply for a Section 1115 waiver of the Title XXI requirements?" The statute answers that question with an unambiguous "yes." Yet the response in the document concludes as follows: "Without experience in implementing Title XXI, it would be very difficult for HCFA to review and evaluate the merits of any waiver proposal." HCFA is sending a strong signal to states not to pursue the waiver option in state plan submissions.

As we begin the process of collaboration needed to ensure successful implementation, this response heightens state concerns that HCFA will use its administrative and regulatory powers to restrict the state flexibility set forth in the Balanced Budget Act. Congress gave states the authority to seek waivers, and states should be free to pursue that option. As a former Governor, we know that you support state flexibility to craft innovative programs through the waiver process.

During your presidency, your administration has granted seventy-eight welfare waivers to forty-three states. Since January 1993, at least sixteen comprehensive health care demonstration projects have been approved, in addition to dozens of smaller Medicaid demonstrations and welfare reform-related

Although in the past you have undoubtedly heard Governors express concerns about the length of the waiver approval process, the ability to pursue a waiver is critical to states. Waivers provide a way to pursue creative solutions to state-specific challenges.

We greatly appreciate the significant flexibility regarding program design already included in the new children's health program. Yet there will always be states that develop new programs that do not precisely meet the models envisioned in Washington, D.C. For those few states, waivers will be necessary to ensure that efficient, effective programs can be implemented. Importantly, Missouri, the first state to submit a plan application under the new program, is requesting a Section 1115 waiver of the new program to cover more people with its allocation.

The Balanced Budget Act is clear on the subject of waivers in the children's health program. Governors ask that this waiver flexibility be preserved, without second-guessing by HCFA. We request your help in ensuring that the new law is implemented as written, so we can begin extending health insurance coverage to millions of children in need.

Sincerely,

Governor George V. Voinovich
State of Ohio

Governor Thomas R. Carper
State of Delaware

Governor Lawton Chiles
State of Florida

Governor Michael O. Leavitt
State of Utah

Approved Medicaid 1115 Waivers With Provisions Inconsistent with Title XXI Children's Health Insurance Program Requirements

State	Benefits	Cost Sharing	Public Employees*	Group Coverage*	Other
Alabama			✔		
Arizona			✔		
Arkansas	✔	✔	✔		
Delaware			✔		
Florida		✔	✔		
Hawaii			✔		
Illinois			✔		
Kentucky			✔		
Maryland	✔		✔		
Massachusetts	✔	✔	✔	✔	
Minnesota		✔	✔		
New York	✔		✔		
Ohio			✔		
Oklahoma			✔		
Oregon	✔		✔	✔	
Rhode Island			✔		
Tennessee		✔	✔		
Vermont		✔	✔		

Italics indicated not yet implemented

* Assumes that no states exclude public employees; as far as I know, based on preliminary information

Approved Medicaid 1115 Waivers With Provisions Inconsistent with Title XXI Children's Health Insurance Program Requirements

State	Benefits	Cost Sharing	Public Employees*	Group Coverage*	Other
Alabama			✔		
Arizona			✔		
Arkansas	✔	✔	✔		
Delaware			✔		
Florida		✔	✔		
Hawaii			✔		
Illinois			✔		
Kentucky			✔		
Maryland	✔		✔		
Massachusetts	✔	✔	✔	✔	
Minnesota		✔	✔		
New York	✔		✔		
Ohio			✔		
Oklahoma			✔		
Oregon	✔		✔	✔	
Rhode Island			✔		
Tennessee		✔	✔		
Vermont		✔	✔		

Italics indicated not yet implemented

* Assumes that no states exclude public employees; as far as I know, based on preliminary information