

## State HIFA Waiver Plans

State	HIFA waiver (Y/N)	Application Date/ Approval Date	Goal	Key Components	Funding	Benefit change to existing groups
Arizona	Yes	<b>Approved 12/12/01</b>  Effective dates: 11/1/01 and 10/1/02	<b>Expansion:</b> Extend coverage to parents with incomes between 100% and 200% FPL; non-parents (continuation from previous 1115 waiver) with incomes up to FPL.	Benefits will equal those under the Medicaid demonstration acute care package. <b>Cost sharing for parents:</b> Identical to SCHIP program (above 150% premiums not to exceed \$25/month for family and total cost sharing capped at 5% of family income) <b>Cost sharing for non-parents:</b> Will be the same as the state's Medicaid program. <b>Enrollment freeze:</b> State may lower eligibility standards, suspend determination and enrollment or discontinue program depending on SCHIP funds available.	SCHIP funds.	No change.
California	Yes	<b>Approved 1/29/02</b>	<b>Expansion:</b> Enroll parents, caretakers and legal guardians with incomes under 200% FPL into state's separate SCHIP program. Estimated at 300,000 when fully implemented.	Parents will receive the same benefits as children in SCHIP. Includes health, vision and dental. <b>Cost sharing:</b> Pay \$5 for outpatient health and vision benefits; higher for dental benefits; Copayments capped at \$250 per year per household; premiums are \$10 per parent per year for families below 150% FPL and \$20 per parent for above 150%.	SCHIP funds.	No change.
Colorado	Yes	Submitted 5/31/02  <b>Approved 9/27/02</b>	<b>Expansion:</b> Enroll approximately 13,000 pregnant women 134% to 185% FPL in SCHIP program.	<b>Enrollment cap:</b> Program capped on the lesser of the annual appropriations made by the Colorado Assembly or available federal allotment <b>Cost sharing:</b> No enrollment fee; copayments for families with incomes over 150% FPL <b>Benefits:</b> Complete benefit package consistent with private insurance available to most Coloradans.	SCHIP funds.	No change.

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Connecticut I	No	Submitted 02/02	<b>Expansion of drug benefit:</b> prescription drug benefit for elderly and disabled; ConnPACE.	<b>Annual fee:</b> \$25 per member. <b>Coverage:</b> Enrollees up to 233% FPL would pay \$12 per prescription, enrollees over 233% FPL would pay \$20; cannot be enrolled in Medicaid.	Funded by reduction of long term care services; delay in spend down to Medicaid.	No change.
Connecticut II	No	Submitted 02/02	Deter spend down and transfers of wealth toward Medicaid eligibility for Long Term Care.	Waiver to federal law so that penalties following significant transfer of assets would begin on first day of Medicaid LTC eligibility and not the first day of the month of the transfer.	Increase use of private payers.	Effect all with exceptions for those with dementia and other hardships.
Delaware	Yes	Submitted 5/16/02	<b>Expansion:</b> Delaware Healthy Adult Program will offer comprehensive benefits to certain uninsured adults with incomes at or below 200% FPL and will be phased in as funding permits.	<b>First phase:</b> Target uninsured individuals transitioning off Medicaid into DHAP for 12 months after 12 the months of extended Medicaid coverage. After 10/02, individuals newly eligible for optional Medicaid groups will be enrolled in DHAP/DHCP. This will include pregnant women between 133% and 200% FPL, uninsured adults at or below 100% FPL, and Section 1931* adults between 65% and 75% FPL Medicaid will cover pregnant women up to 133%FPL, as will infants up to 185% FPL and Section 1931 adults under 65% FPL. Infants between 185% and 200% FPL will be enrolled into DHCP. <b>Cost sharing:</b> Monthly premiums for families over 100% and at or below 133% FPL will be \$10; \$15 for families greater than 133% and under 166% FPL, and \$25 for families over 166% and below 200 %. \$10 co-payment for improper use of ER <b>Expenditure cap:</b> Limited to State's SCHIP allotment and annual state appropriations. Benefits: similar to those offered State employees	SCHIP funds and possibly tobacco settlement money.	Individuals who are receiving benefits in an optional Medicaid group will keep benefits until participation is terminated. Uninsured adults receiving care under the Diamond State Health Plan (previous 1115 waiver) will keep benefits until participation is terminated.

\* Section 1931 adults refers to adults that have a dependent child living with them, have income sources that would have qualified them for AFDC under the state plan in effect July 16, 1996, and meet certain deprivation requirements (absent parent) of said state plan.

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Illinois I	Yes	Submitted 2/15/02  <b>Approved 9/12/02</b>	<b>Expansion:</b> Insure 235,000 parents currently uninsured whose families have income less than 185% of FPL. Also individuals who are medically uninsurable up to 185% FPL. Complete program will be phased in.	<b>Eligibility:</b> Family must have eligible child enrolled in Medicaid or KidCare; Plan enrolls parents into Medicaid or Medicaid look-alike; offers premium support model for private insurance (KidCare Rebate). <b>Families under 133%</b> are eligible to choose from any option; <b>Over 133%</b> can use cash support to buy private insurance or drop private coverage and enroll in state's insurance plan after 90 days; <b>Cost sharing:</b> state's insurance program would have same copayments as KidCare; families above 150% pay premiums of \$15 for one person, \$25 for two, \$35 for four and \$40 for five or more.	SCHIP funds.	No change.
Illinois II	No	<b>Approved 1/28/02</b>	<b>Expansion:</b> Prescription drug benefit for the elderly with incomes up to 200% FPL using a capped amount of Medicaid dollars designated for the elderly from the federal government.	<b>Cost sharing:</b> Seniors with incomes above FPL pay \$25 per year; \$3 per prescription for legend drugs; If over \$1750 in one year, beneficiary must pay 20% for each additional prescription.	State will forgo unlimited Medicaid matching funds and receive federal block grant instead. The state theorizes that with the benefit less elderly will "spend down" and qualify for Medicaid reducing the annual rate of growth of Medicaid spending on the elderly.	No overt change; rearrangement of Medicaid financing could cause state to reduce provider payments or discourage participation.

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Maine	Yes	Submitted 7/25/01  <b>Approved 9/13/02</b>	<b>Expansion:</b> Phase in expansion plan of childless adults up to 100% FPL initially, then increased to 125% FPL.  Implementation 10/1/02.	<b>Expenditure cap:</b> Limited to amount of future State Legislature appropriations. Eligibility level can be raised or lowered depending on program expenditures. <b>Benefit:</b> Benefits will be the same as the State's approved Medicaid plan (Maine Care).	Medicaid funds (unspent disproportionate share allocations).	No change.
Maryland	No	Submitted 11/15/01	<b>Demonstration:</b> Project to evaluate the effectiveness of crowd-out provisions among potential MCHP enrollees below 200% FPL Continuation of six month waiting period of new eligibles.	Other information gathered during the project seeks to find evidence of an increased use of medical services during the initial months of enrollment due to delay in seeking of treatment. The final study will show whether increased MCHP enrollment rates are a result of insuring more uninsured children or a substitution effect from the private market.	Included in SCHIP state budget.	No change.
Michigan	Yes	Submitted 3/02  Application withdrawn by Governor 7/29/02  <b>Inactive as of 9/17/02</b>	<b>Expansion:</b> Project expanding MICHild to MIFamily. New populations include pregnant women 186% to 200% FPL, people with disabilities up to 350%, and parents or guardians currently enrolled in MICHild with incomes between 51% and 100% FPL. Program will expand access to 220,000 people.	<b>Eligibility:</b> Established four expansion groups for four different plans with four different eligibility requirements. Plan A is reserved for pregnant women with incomes between 186% and 200% FPL, Parents covered in benefit plans B and C, at or below 50% and 51% to 100% respectively with plan B offering less cost sharing. Single adults with incomes at or below 35% FPL will be eligible for Plan D benefits statewide; Childless adults from 36% to 100% FPL will receive Plan E benefits in counties that choose to participate in the program. <b>Cost sharing:</b> Co-pays for office visits, emergency room visits and prescription drugs for plans B,C,D; <b>Benefits:</b> Limited inpatient benefit for plans C, covered for A,B; none for D,E; All plans offer some sort of mental health and substance abuse coverage. <b>Other components:</b> Establishes voucher system for MIFamily beneficiaries to encourage usage	SCHIP funds.	Some changes to eligible groups; redefining Caretaker/Relative Group coverage in TANF related category and turning into parent category. Caregivers may seek eligibility under childless adult programs. County programs will be phased in over five years meaning that not all counties will be offering plans until the end of five years and certain groups currently

				of private or employer sponsored insurance.		receiving benefits will lose them.
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Minnesota	Yes	Submitted April 15, 2002  <b>Inactive as of 9/17/02</b>	<b>Expansion:</b> Expand family planning services to citizens up to 275% FPL and comprehensive benefits with some cost sharing for adults without children to 175% FPL. Also enrollees 15-50 years old transitioning off MinnesotaCare and Medical Assistance programs for 24 months.	Phase 1 & 2 (approved August 2000): Minnesota Prepaid Medical Assistance Project Plus (PMAP+) enrolled all AFDC eligibles, needy children and pregnant women into prepaid MCOs, Medicaid covers pregnant women and children up to 275% FPL who were previously enrolled in MinnesotaCare. Some parents and caretakers are covered through the SCHIP program.  Phase 3: <b>Expenditure Cap:</b> Cap is equal to state's SCHIP allotment plus reallocated funds minus the amount spent on SCHIP children. <b>Cost sharing for childless adults:</b> 10% for inpatient hospital up to \$1,000, \$10,000 per year maximum; prescription drugs \$3; \$25 for eye exams and 50% co-pay for restorative dental.	SCHIP funds and savings related to implementation of the family planning segment of this demonstration	No change
Montana	N/A	Not yet submitted; draft letter requesting expedited waiver submitted 4/1/02	Waiver to decrease benefits to existing beneficiaries.	Several waivers to decrease benefits and increase cost sharing in order to maintain current level of benefits to medically needy population. <b>Waiver 1:</b> Waiver of the federal requirement of comparability of Medicaid benefits would allow retention of optional benefits to elderly, disabled and other medically fragile populations while eliminating optional benefits for able bodied adults. <b>Waivers 2 &amp; 3:</b> Cost sharing increased from under \$2.00 to 5% coinsurance on all Medicaid services. Allow cost sharing of \$25 to \$50 per emergency room visit to deter non-emergency usage of emergency rooms. <b>Waiver 4:</b> Waiver would require clients to	Decreasing benefits and increasing cost sharing in order to prevent more drastic cuts in all Medicaid programs, specifically those serving medically fragile populations.	Drastic changes to able-bodied beneficiaries. Plan yet to be developed.

				show payment for incurred medical services before being eligible for Medicaid (spend down). Current practice requires incurred expenses but no evidence of payment.		
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New Jersey	Yes	Submitted 7/15/02	Expansion of insurance coverage to approximately 12,000 parents of SSCHIP or Medicaid children with incomes at or below 200% FPL.	<b>Benefit:</b> package for the health insurance plan is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the state of New Jersey. <b>Cost sharing:</b> Premiums and co-pays required for families with incomes over 150% FPL. \$5 co-pays on regular visits, lab work and brand name prescriptions. \$35 co-pay for emergency room visits.	Savings generated from standardization of the parent service package to Plan D of NJ FamilyCare will finance new coverage.	NJ FamilyCare parents receiving full Medicaid benefits will now receive the HMO benefit plan. Coverage for children will not change.
New Mexico	Yes	Submitted 4/02  <b>Approved 8/23/02</b>  Objection letter filed 4/23/02 by Senator Bingaman	<b>Expansion:</b> of uninsured adults through employer sponsored program, approximately 40,000. Phase I New Mexico State Coverage Initiative (SCI) for 2/03 implementation; and Phase II plan to be submitted no than September 30, 2002, reallocating resources for existing Medicaid programs into SCI for family coverage and non-traditional workers, benefits to be decided by a Medicaid Reform Committee in 2003.	<b>Eligibility:</b> Targets childless working adults 19-64 with incomes up to 200% FPL who do not have access to insurance. Also to parents of Medicaid and SCHIP children between 37% to 200% FPL. <b>Participation:</b> In a multi-stage process, state will release RFP to MCOs to bid on SCI plan; Enrollment brokers & MCOs will market to employers that do not offer coverage or those employees who cannot afford premium sharing of coverage offered. State will process applications, capitation payments etc. <b>Cost sharing:</b> Employer premium sharing will be \$75 per month per enrollee, employees up to 100% FPL will pay nothing, between 101% and 150% FPL \$20 per month, 151% to 200% FPL \$35 per month. Other co-pays are applicable but are not to exceed twice the client's total annual premium. Participating employers must also insure 75% of all employees. <b>Benefits:</b> All benefits in selected MCO plans will be the same. Includes mental health, hospital, pharmacy, physician etc.	SCHIP funds.	No benefit change.

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Oregon	Yes	Submitted 5/31/02  <b>Approved 10/15/02</b>	Extension of current 1115 waiver; create OHP2 (Oregon Health Plan 2) made of three parts. Expansion to 60,000 uninsured.	<b>OHP Plus:</b> Provides OHP benefits to Medicaid eligible adults and pregnant women and children up to 185% FPL; Nominal copayments for drugs and ambulatory visits; Option to join assistance program. <b>OHP Standard:</b> Limited benefits to adults not eligible for Medicaid under a mandatory category up to 185% FPL; Enrollment would be capped including those currently receiving Medicaid; Varied copayments and premiums; Required to participate in employer sponsored insurance with assistance if available. <b>Family Health Insurance Assistance Program:</b> premium assistance for families with incomes up to 185% FPL; Smallest benefit package; Varied copayments and premiums depending on income; 25% cost-sharing on prescription drugs and no out-of-pocket maximums; \$500 annual deductible per enrollee.	New co-pays generated from groups previously exempted.	Reduction in benefits to current Medicaid expansion groups.
Tennessee	No	Submitted 2/12/02  <b>Approved: 5/31/02</b>  Effective Date: 7/1/02	<b>Expansion and redesign:</b> Modify existing TennCare with a managed care program with three distinct products and six eligibility categories (two Medicaid and four demonstration eligibles).	<b>TennCare Medicaid:</b> Medicaid eligibles and new group of uninsured women diagnosed with breast and cervical cancer, as determined by the CDC. (Groups A & B) <b>TennCare Standard:</b> <b>Eligibility:</b> No access to group health care; incomes below 250% of FPL (Group C); “medically eligible” (i.e. uninsurable) in any income category (Group D) Group E: Medicare enrollees who do not have Medicaid coverage enrolled in TennCare as of 12/31/01 will qualify for pharmacy benefits only. Group F: TennCare uninsured children as of 12/31/01; under the age of 19 and with family incomes below 200% FPL. <b>Cost sharing:</b> All groups in TennCare above FPL will pay premiums on a sliding scale basis; all beneficiaries will pay for prescription drugs. <b>Benefit design:</b> TennCare will be administered through contracted MCOs and BHOs; only one enrollment period over 12 months; Non-Medicaid enrollees must re-enroll every year. <b>TennCare Assist (Group G):</b> Incomes below 250% of FPL and employed, have access to insurance would provide premium assistance (not funded until	State appropriations/ federal Medicaid match.	New cost sharing for all beneficiaries (prescription drugs. Many groups with coverage now will lose eligibility under new plan if lawmakers do not appropriate \$100 million; if not 420,000 could lose benefits on 1/1/03.

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Utah	No	Approved 2/9/02	<b>Expansion:</b> provide primary care coverage to adults (25,000= 16,000 parents and 9,000 childless adults) that do not qualify for Medicaid incomes ranging from 0-150% of FPL and may be covered by existing state program.	<p><b>Adult expansion population:</b> coverage benefits include routine physician care, pharmacy coverage, emergency hospital care. No specialty care, mental health services or substance abuse services.</p> <p><b>Cost sharing expansion population:</b> \$5 physician services and pharmaceuticals, 5% of lab services over \$50, \$50 application fee, \$1,000 out of pocket maximum per person per year State may cap enrollment on expansion population.</p> <p><b>Exempted cost sharing populations with full Medicaid services:</b> 150 high risk pregnant women not previously eligible, children, the elderly, the disabled, and previously covered pregnant women.</p>	Not using SCHIP funds, Funded through benefit reductions and new cost sharing from some groups currently covered (parents receiving TANF with incomes 50% below FPL, parents who recently left TANF, and medically needy adults).	<p><b>Cost sharing:</b> Current beneficiaries will be required to pay a \$50 annual enrollment fee; \$100 per hospital admission; \$3 physician visits; \$2 prescription; 5% of lab fees over \$50; 20% of dental services; total out of pocket expenses limited to \$500 <i>per person</i> per year.</p> <p><b>Reduction in current services for adults:</b> mental health, vision, dental, hearing, occupational therapy, home health care and podiatric services.</p>

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Washington	Yes	Application re-submitted 8/12/02	<b>Expansion:</b> Basic Health coverage for parents of Medicaid children and other adults.	<p><b>Enrollment freeze:</b> Freeze on optional programs enrollment when state fiscal trigger points necessitate it. Current enrollees not effected. Mandatory programs and enrollment not effected.</p> <p><b>Cost sharing for optional groups:</b> Small premiums: \$10 for clients between 100% and 150% FPL, \$15 for clients between 150% and 200% PFL, and \$20 for clients above 200%FPL. No premium for under 100% FPL. Three person family maximum amount of \$30, \$45, and \$60. Total cost sharing not to exceed 5 percent of family's income. Excludes Medicaid clients over 100% FPL. Medical coverage will be terminated if premium payments are more than three months in arrears. If terminated there is a three month waiting period before reenrollment, at which point all delinquent payments will be due. There is no retroactive Medicaid eligibility once reenrolled.</p> <p><b>Co-Payments for all Medicaid groups:</b> Only in two circumstances A. Brand name drugs when generic is available; but not when medically necessary (\$5) B. Emergency room usage when not appropriate (\$10)</p> <p><b>Benefit redesign:</b> Medicaid adults in optional programs with incomes over FPL; benefit changed to be more in line with state's Basic Health program (unlike full-scope Medicaid services) that includes a premium not to exceed 5% of total income.</p>	SCHIP funds.	<p>Medicaid mandatory eligibility groups still entitled to full scope coverage; Optional groups will now have cost sharing if over FPL.</p> <p>Elimination of hearing, vision, and non-emergent dental in certain optional groups. No co-payments for American Indian or Native Alaskans.</p>