United States General Accounting Office
Washington, DC 20548

January 5, 2004

The Honorable Charles Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

Subject: *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals*

States provide health care coverage to about 60 million low-income uninsured adults and children largely through two federal-state programs—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid, established in title XIX of the Social Security Act, generally covers low-income families and elderly and disabled individuals, and SCHIP, established in title XXI of the act, covers children in families whose incomes, although low, are above Medicaid's eligibility requirements. In 2001, the Secretary of Health and Human Services announced a new initiative—the Health Insurance Flexibility and Accountability Initiative (HIFA)—under which states could expand coverage to uninsured populations using Medicaid and SCHIP funds. HIFA encourages states to develop coordinated public and private health insurance coverage options and to target program resources to uninsured individuals with incomes below 200 percent of the federal poverty level (FPL). Authority for this initiative comes from section 1115 of the Social Security Act, which allows the Secretary to waive many of the statutory requirements of Medicaid or SCHIP in the case of experimental, pilot, or demonstration projects that promote program objectives. Within the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) has the lead role in reviewing HIFA waiver applications.[1]

[1]Although CMS has lead responsibility for administering Medicaid and SCHIP, throughout this report we refer to HHS as the primary program entity because section 1115 waiver authority resides with the Secretary, and other HHS entities are also involved in the review process.

In a July 2002 report, we raised legal and policy concerns about the need to clearly establish purposes and populations for which SCHIP funds may be spent.[2] Our specific concerns related to HHS's approval of a HIFA waiver for Arizona, which proposed using unspent SCHIP funds to cover childless adults. We reported that, in our view, approving a waiver to use SCHIP funds for expanding coverage to childless adults was inconsistent with SCHIP's statutory objective to expand health coverage to low-income children. Because the SCHIP statute requires that unused funds be redistributed to states that have spent their allotments, states' coverage of childless adults using SCHIP funds decreases the funding available in future years for reallocation to states with unmet SCHIP needs.[3]

We also reported that HHS had approved HIFA waivers for Arizona and California to use SCHIP funds to cover parents of SCHIP- and Medicaid-eligible children without regard to cost-effectiveness, even though the SCHIP statute provides that families may be covered only if such coverage is cost-effective—that is, only if covering the family costs no more than covering the eligible children. We suggested that Congress consider specifying in statute that SCHIP funds are not available to cover childless adults and recommended that HHS deny any pending or future state proposals to spend SCHIP funds for such coverage. We also suggested that Congress consider establishing which statutory objectives should take precedence: those of the SCHIP statute, which authorizes family coverage only if cost-effective, or those of section 1115, which allows certain statutory provisions—such as cost-effectiveness tests—to be set aside.

After receiving our July 2002 report, you wrote to the Secretary of HHS to express concern about the agency's justification for using SCHIP funds to provide health coverage for childless adults.[4] In your letter, you indicated that the Secretary should not continue to approve waivers that divert SCHIP funds set aside by Congress for children to insure childless adults. You also indicated that if these approvals

[2]U.S. General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

[3]Congress in 1997 appropriated a fixed amount for SCHIP—approximately $40 billion in federal matching funds over 10 years (fiscal years 1998 through 2007). Annual allotments are made to states for use over a 3-year period, and the Secretary is required to determine an appropriate procedure for redistributing the unused SCHIP funds to those states that have already spent their SCHIP allotments. Pub. L. No. 108-74, 117 Stat. 892, signed into law on August 15, 2003, made SCHIP allotments for fiscal years 1998 through 2001 available for a longer period (for example, 1998 and 1999 allotments will be available through 2004). It also allows states that do not spend their entire 2000 and 2001 allotments within a 3-year period to keep half the unspent amounts, while the other half is redistributed to states that have spent their entire allotments (for example, half a state's unspent 2001 allotment shall remain available to that state through the end of fiscal year 2005).

[4]Letter to the Honorable Tommy G. Thompson from Max Baucus, Chairman, and Charles E. Grassley, Ranking Member, Senate Committee on Finance, August 6, 2002.

continued, you intended to take legislative action to prevent them, which you have subsequently done.[5]

This report responds to your request that we update our analysis of states' HIFA waiver proposals reviewed and approved by HHS after July 2002. This report provides information on HHS's approvals of states' proposals to use SCHIP funds to extend health insurance coverage to childless and other groups of adults, including whether such proposals were subject to a cost-effectiveness test, and outlines the status of other HIFA waiver applications that HHS has reviewed but not approved. Our analysis covers states' HIFA waiver proposals considered by HHS from July 2002 through December 2003.[6] For approved waivers, we analyzed the waiver applications as submitted by the states; HHS decision memorandums and approval letters; waiver applications as approved; waiver terms and conditions; and, when available, the states' plans (called operational protocols) for how the waivers will operate. We also discussed these waiver approvals with officials at CMS. We conducted our work from January through December 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Despite SCHIP's statutory objective of expanding coverage to low-income children, HHS has continued to approve HIFA waivers that allow states to use SCHIP funds to cover childless adults. From July 2002 through December 2003, HHS approved three states' proposals to use SCHIP funds for childless adults. Without requiring the states to meet the statutory cost-effectiveness test, the agency also approved four states' proposals to use SCHIP funds to cover parents or guardians of SCHIP- or Medicaid-eligible children. Unless Congress and HHS take actions in response to the matters for congressional consideration and recommendations to HHS presented in our July 2002 report, it appears likely that HHS will continue to allow states to use SCHIP funds for childless adults, and for parents and guardians, without regard to whether this use is cost-effective.

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[5]Since our July 2002 report, several legislative proposals have been introduced that expressly prohibit the Secretary from using section 1115 waiver authority to make SCHIP funds available for childless adults. As of December 2003, however, none of these proposals had been enacted into law. See Beneficiary Access to Care and Medicare Equity Act of 2002, S. 3018, 107th Cong., § 706, placed on Senate Legislative Calendar on October 2, 2002; Health Care Coverage Expansion and Quality Improvement Act of 2003, S. 10, 108th Cong., § 801, introduced in the Senate on January 7, 2003; and Personal Responsibility, Work, and Family Promotion Act of 2003, H.R. 4, 108th Cong., § 602, reported in S. Rep. 108-162, at 182 (2003). A prior version of the Jobs Growth Tax Relief Reconciliation Act of 2003 also contained a provision that would have prohibited the agency from spending SCHIP funds on childless adults. See H.R. 2, 108th Cong., § 383 of Engrossed Amendment as Agreed to by Senate, discussed in H.R. Conf. Rep. No. 108-126 at 169 but not enacted in Pub. L. No. 108-27, 117 Stat. 752.

[6]HHS also reviews non-HIFA section 1115 waivers, including some with provisions similar to those proposed under HIFA, such as Tennessee's TennCare II and Utah's Primary Care Network. We did not include non-HIFA applications in this review. HHS approved one additional HIFA waiver that we also omit: a waiver for Maine, approved September 13, 2002, that would cover childless adults but would not use SCHIP funds. The Maine waiver instead uses funds from its Medicaid disproportionate share hospital allocation for this coverage.

HHS reviewed a draft of this report and reiterated its position responding to our July 2002 report. HHS continues to believe that using section 1115 waiver authority to approve spending SCHIP funds to cover childless adults is appropriate because this practice helps low-income Americans who do not have health insurance. We believe that in allowing states to use unspent SCHIP funds for their own adult populations, HHS is reducing the unspent SCHIP funds available for future redistribution to states that have exhausted their allotments for covering uninsured low-income children. HHS has not, in our view, adequately explained how the objectives of the SCHIP statute are promoted by insuring childless adults or by covering populations besides children without regard to cost-effectiveness.

Background

Medicaid and SCHIP are the nation's largest health-financing programs for low-income people, accounting for about $250 billion in federal and state expenditures in fiscal year 2002. To receive federal funding—which reimbursed states, on average, for about 57 percent of their Medicaid expenditures and 70 percent of SCHIP expenditures in fiscal year 2002—states must meet certain statutory requirements. Medicaid is an open-ended entitlement program: as long as the federal government has approved a state's Medicaid plan, the federal government will pay its share of the state's expenditures to cover eligible populations; the number of enrollees in the state's program cannot be limited. SCHIP, in contrast, is not open-ended. Congress in 1997 appropriated a fixed amount for SCHIP, specifically, $40 billion in federal matching funds over 10 years (fiscal years 1998 through 2007). Annual allotments are made to states for use over a 3-year period, and the Secretary of HHS is required to determine an appropriate procedure for redistributing unused funds to states that exhaust their allotments. As of the end of fiscal year 2002, few states had spent their full SCHIP allotments, and Congress in 2003 passed legislation allowing the states to retain their unspent funds for a longer period.[7] At the same time, however, SCHIP enrollment has been growing. CMS estimates that 3.4 million children were covered through SCHIP in fiscal year 2000, compared with more than 5.3 million children in fiscal year 2002.

Under the authority of section 1115, HIFA gives states considerable flexibility to increase cost sharing and reduce benefits for some Medicaid and SCHIP beneficiaries to help fund coverage for additional uninsured populations within existing program resources. The initiative allows states to provide different benefit packages to different groups of people covered under the waiver. To be considered, HIFA proposals must be statewide and seek to coordinate coverage with private health insurance options for low-income uninsured individuals—for example, through premium assistance programs that would pay a portion of covered individuals' premiums to purchase employer-based insurance. Typically, waivers are approved for 5 years.

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[7]The Congressional Research Service reports, for example, that as of the end of fiscal year 2002, 29 states (including the District of Columbia) had spent less than half their available SCHIP funds. See Congressional Research Service, *CRS Report to Congress: SCHIP Financing Issues for the 108th Congress* (Washington, D.C.: Library of Congress, Aug. 15, 2003).

At the time of our July 2002 report, HHS had approved two HIFA waivers, Arizona's and California's. Arizona's HIFA waiver allows the state to cover previously uninsured low-income adults, including those with no children. Coverage of childless adults with incomes at or below 100 percent of FPL was implemented in November 2001. Coverage of parents of children enrolled in Medicaid or SCHIP with family incomes from 100 to 200 percent of FPL was implemented in January 2003. According to CMS, as of July 1, 2003, combined state and federal SCHIP spending on childless adults covered in Arizona's waiver totaled more than $214 million, and coverage for parents totaled about $12.8 million. California's HIFA waiver, which had not been implemented as of December 2003, would allow that state to use SCHIP funds to cover the parents of children who are enrolled in Medicaid or SCHIP.

Five Approved HIFA Waivers Use SCHIP Funds to Cover Uninsured Adults

From July 2002 through December 2003, HHS approved five states' waiver proposals that would use SCHIP funds to provide health care coverage for adults, including three that would cover childless adults. Specifically, HHS approved HIFA waiver proposals from Illinois, New Mexico, and Oregon to use unspent SCHIP funds to cover uninsured adults who have no children, as well as parents of Medicaid- or SCHIP-eligible children. Two other approved HIFA waiver proposals—New Jersey's and Colorado's—do not cover childless adults but do cover other groups of adults. New Jersey's HIFA waiver uses SCHIP and Medicaid funds to cover uninsured parents and relative caretakers of children covered by Medicaid or SCHIP, and Colorado's HIFA waiver used SCHIP funds along with state tobacco settlement funds to expand coverage to pregnant women not otherwise eligible for Medicaid.[8] Table 1 presents more specific information on covered populations and the expected sources of funding.

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[8]On November 1, 2003, Colorado suspended its waiver because budget constraints forced it to close its SCHIP program to new enrollment, and under the terms and conditions of its waiver, the state could not close enrollment in SCHIP while the waiver demonstration program was in effect.

Table 1: HIFA Waivers Approved from July 2002 through December 2003

State and approval date	Approved coverage expansion and funding sources			
	Projected population[a]	SCHIP	Medicaid	Other
New Mexico August 23, 2002[b]	Approximately 40,000 individuals: 11,000 childless adults 29,000 parents of Medicaid or SCHIP children	$246.8 million total: $193.3 million federal share $53.5 million state share		
Illinois September 13, 2002	Approximately 300,000 individuals: Up to 1,000 adults who are uninsurable because of their medical conditions (including childless adults) Up to 43,000 children Up to 268,000 parents of Medicaid or SCHIP children	$889.1 million total: $577.9 million federal share $311.2 million state share	$209.0 million total: $104.5 million federal share $104.5 million state share	State general revenues
Colorado September 27, 2002	13,000 pregnant women (Closed to new enrollment in May 2003 and suspended on Nov. 1, 2003)	$64.0 million total: $41.6 million federal share $22.4 million state share		Tobacco settlement funds
Oregon[c] October 15, 2002	Approximately 581,000 individuals (535,000 current plus 46,000 expansion eligibles): 99,900 childless adults 10,000 pregnant women 234,400 parents of Medicaid or SCHIP children 236,700 children	$379 million total: $272 million federal share $107 million state share	$12.9 billion total: $9 billion federal share $3.9 billion state share	
New Jersey January 31, 2003	12,000 uninsured parents and relative caretakers of children covered by Medicaid or SCHIP	$134 million total: $87.1 million federal share $46.9 million state share	$866.8 million total: $433.4 million federal share $433.4 million state share	State general revenues and tobacco settlement funds

Source: HHS.

[a]Populations to be covered and projected numbers of enrollees over 5 years of the HIFA waiver, with the exception of Colorado, whose waiver was approved for 4 years. On November 1, 2003, Colorado suspended its waiver because budget constraints forced it to suspend new enrollment in its SCHIP

program, and under the terms and conditions of its waiver, the state could not close enrollment in SCHIP while the waiver demonstration program was in effect.

[b]Not yet implemented.

[c]The projected population and funding sources and amounts for Oregon represent the HIFA waiver combined with the existing statewide waiver program known as the Oregon Health Plan. Expansions approved under the HIFA waiver in October 2002 have been implemented only in part (see enclosure I for details). According to CMS officials, Oregon's proposal would use Medicaid funds to cover pregnant women.

Four of the five approved HIFA waivers allow states to cover eligible parents and guardians of children in Medicaid or SCHIP, and three include a provision that would require parents and guardians with access to employer-sponsored health insurance to enroll in premium assistance programs.[9] For three of these HIFA waivers, the states will also directly cover certain eligible parents and guardians who do not have access to employer-sponsored insurance.

In approving the four waivers covering parents and guardians, HHS did not require the states to demonstrate that their waivers met the SCHIP statutory cost-effectiveness test.[10] As we reported in July 2002, in creating SCHIP, Congress authorized states to cover health benefits for entire families—parents or custodians and their children—if it was cost-effective to do so. The cost-effectiveness test for family coverage specifies that the expense of covering adults as well as children in a family must not exceed the cost of covering the eligible children. Under these circumstances, achieving cost-effectiveness appears possible only when the cost to SCHIP of covering a family is subsidized by employer contributions or other state funds. In our view, this statutory test demonstrated congressional priority for covering children before their parents. We reported in 1999 that some states and advocacy groups were nevertheless seeking increased flexibility to tailor their SCHIP programs to cover uninsured parents through the use of section 1115 waiver authority.[11] The agency questioned waiver proposals to cover parents during the first year of SCHIP implementation, expressing concern that waivers should not circumvent the SCHIP goal of insuring low-income children. The agency indicated to states that the waivers' purpose was to test innovative approaches, not to waive statutory provisions that the states found objectionable. In July 2000, however, the agency announced to states that it would consider waivers to use unspent SCHIP funds to cover parents, but it was silent on the application of the cost-effectiveness test.

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[9]HHS approved Colorado's HIFA demonstration waiver without a premium assistance provision because of the difficulty of designing a cost-effective premium assistance program for pregnant women only. The agency required Colorado to include a premium assistance program as a second phase of the state's waiver.

[10]For premium assistance programs, HHS's guidelines for HIFA waivers indicate that states are not required to meet a specific cost-effectiveness test but that states should monitor their waivers to ensure that aggregate costs for those enrolled are not "significantly higher" than they would be under a direct coverage program. For direct-coverage programs, HIFA guidelines are silent on the application of a cost-effectiveness test.

[11]See U.S. General Accounting Office, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999).

Four Other HIFA Waiver Proposals Reviewed by HHS

In addition to the five HIFA waivers approved from July 2002 through December 2003, HHS reviewed four other states' HIFA proposals involving the use of SCHIP funds. These proposals targeted coverage to various populations, such as childless adults, parents and guardians of SCHIP- and Medicaid-eligible children, and pregnant women. Of these four, one proposal was denied, two were pending as of December 2003, and one was withdrawn by the state. (See enclosure I for a summary of HIFA waiver proposals.)

In March 2003, HHS denied Delaware's HIFA application. The state proposed using SCHIP funds to cover childless adults and pregnant women and, in the future, uninsured parents of Medicaid or SCHIP children. The proposal sought to move some current Medicaid beneficiaries into SCHIP, thereby reducing their benefits and increasing their share of costs. Had the proposal been approved, the shift of existing coverage from Medicaid to SCHIP would also have enabled the state to cap enrollment for those beneficiaries previously covered by Medicaid and to claim SCHIP's higher federal matching rate.[12] HHS denied the waiver because, contrary to HIFA requirements, Delaware's proposal did not expand coverage or plan to coordinate with the private health insurance market.

As of December 2003, HHS was reviewing HIFA applications from two states. A January 2003 proposal from Arkansas would use SCHIP funds, an employer tax, and enrollee cost sharing to provide a basic benefit package to cover as many as 55,000 uninsured adults working for small employers. The state proposes to coordinate with private insurers to help pay the costs of health insurance premiums for the adults covered by the waiver. Michigan submitted a HIFA application in March 2002, withdrew the submission 4 months later, and resubmitted a new application in April 2003. The state's proposal, currently under review, would use SCHIP funds to cover childless adults with incomes at or below 35 percent of FPL. Participants would pay unspecified cost sharing, which the state expects to be about 3.2 percent of monthly countable income. The benefit package would include hospital and physician services, laboratory tests and X-rays, prescription drugs, and mental health and substance abuse services.

HHS also reviewed a HIFA application submitted in August 2002 by Washington, which proposed using SCHIP funds to cover parents of Medicaid children and also childless adults with incomes at or below 200 percent of FPL. After making changes that put its proposal outside of HHS's HIFA guidelines, the state withdrew its application and, in July 2003, submitted a non-HIFA waiver application to require premiums for some Medicaid families.

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[12] Arizona's HIFA demonstration waiver permitted the state to use SCHIP funds to cover a population that was already covered under the state's Medicaid plan. Because the federal matching rate is higher for SCHIP than for Medicaid (77 percent in Arizona in fiscal year 2003 for SCHIP and 67 percent for Medicaid), moving a population from existing Medicaid coverage into SCHIP shifts costs to the federal government.

Concluding Observations

The legal and policy concerns that we raised in our July 2002 report remain: HHS continues to approve waivers allowing states to use SCHIP to fund health insurance coverage for childless adults, despite SCHIP's statutory objective of expanding coverage to low-income children. We believe that these approvals are inconsistent with SCHIP's goals because they allow SCHIP funds to be diverted from the needs of low-income children. In the absence of congressional clarification of whether SCHIP funds may be used to cover parents and guardians of Medicaid- or SCHIP-eligible children without regard to cost-effectiveness, we also question HHS's approval of additional waiver proposals for such coverage.

Unless Congress and HHS take action in response to the matters for congressional consideration and recommendations to the Secretary that we presented in our July 2002 report—namely that (1) Congress consider amending title XXI of the Social Security Act to specify that SCHIP funds are not available to provide health insurance coverage for childless adults; (2) Congress consider establishing, for parents or guardians of SCHIP-eligible children, which statutory objectives should take precedence, those of title XXI to provide family coverage only if it is cost-effective or those of section 1115, which allow the cost-effectiveness test to be waived; and (3) the Secretary of HHS amend approval of all section 1115 waivers to prevent future use of SCHIP funds for childless adults and deny any pending or future state applications to spend SCHIP funds for such coverage—it appears likely that HHS will continue to allow states to use SCHIP funds for childless adults and, in the case of low-income parents or guardians, without regard to the cost-effectiveness of such coverage.

Agency Comments and Our Evaluation

We provided a draft of this report for comment to HHS. In its response, the department stated that it continues to believe that its actions to increase coverage through waivers are appropriate to help low-income Americans who do not have health insurance, and that it maintains its position in response to our July 2002 report. The department stated that the approved demonstrations are required to prioritize use of SCHIP funds for children over other uses and that these demonstrations are anticipated to reduce the number of uninsured children. The department also expects that these waivers will increase health insurance to adults who potentially could become parents or caretaker relatives in the future and will strengthen the health status of the low-income community in general. HHS's comments are reprinted in enclosure II.

We believe that in allowing states to use unspent SCHIP funds for their own adult populations, HHS is reducing the unspent SCHIP funds available for future redistribution to states that have exhausted their allotments for covering uninsured low-income children. HHS has not adequately explained how the objectives of the SCHIP statute are promoted by insuring childless adults.

HHS also provided technical comments that we incorporated where appropriate.

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As arranged with your offices, unless you release its contents earlier, we plan no further distribution of this report until 30 days after its date. At that time, we will send copies to the Secretary of HHS, the Acting Administrator of CMS, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions, please contact me at (202) 512-7118 or Katherine Iritani at (206) 287-4820. Other major contributors to this report include Ellen W. Chu, Jennifer DeYoung, Suzanne Rubins, and Ellen M. Smith.

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Enclosures - 2

Summary of HIFA Waivers Reviewed by HHS, July 2002–December 2003

From July 2002 through December 2003, the Department of Health and Human Services (HHS) reviewed nine Health Insurance Flexibility and Accountability Initiative (HIFA) waiver proposals that would use State Children's Health Insurance Program (SCHIP) funds to cover individuals other than children, approved five of them, and denied one. As of December 2003, two applications were under review, and one had been withdrawn by the state. Table 2 provides additional details on these HIFA waiver proposals.

Table 2: Approved, Denied, Pending, and Withdrawn HIFA Waivers

State and waiver status	Description
Approved	
New Mexico Submitted April 3, 2002 Approved August 23, 2002 Not implemented as of December 2003 because of state budget constraints	**Projected enrollment:** 40,000 individuals. **Projected expenditures:** Total $246.8 million in SCHIP funds over 5 years; federal share $193.3 million, state share $53.5 million. **Highlights:** Uses SCHIP funds to expand coverage, through subsidized private insurance, to 40,000 uninsured adults ages 19 through 64 with incomes at or below 200 percent of the federal poverty level (FPL), including 29,000 parents of Medicaid and SCHIP children and 11,000 single or childless adults. **Benefits:** Premium assistance for a state-established reduced commercial benefit package, to be delivered under contracts with managed care organizations. Beneficiaries to pay premiums and sliding-scale co-payments; employers to contribute monthly premiums of $75 per enrollee. **Employer-sponsored insurance component:** The entire waiver is to be implemented as a premium assistance program to enable eligible beneficiaries to obtain private insurance coverage through their employers.

State and waiver status	Description
Illinois[a] Submitted February 15, 2002 Approved September 13, 2002 Implementation started October 1, 2002	**Projected enrollment:** Approximately 300,000 individuals. **Projected expenditures:** Total $1.1 billion over 5 years, including $889.1 million SCHIP funds (federal share $577.9 million, state share $311.2 million) plus $209.0 million in Medicaid funds (federal and state shares each $104.5 million). **Highlights:** Uses SCHIP, Medicaid, and state general revenues to expand coverage to approximately 300,000 individuals over 5 years, including as many as 268,000 parents of Medicaid and SCHIP children with incomes up to a maximum of 185 percent of FPL, as many as 1,000 adults who are low income and uninsurable because of their medical conditions with incomes up to 185 percent of FPL (including those without children), and as many as 43,000 children from a state-funded premium assistance program with family incomes up to 185 percent of FPL. As implemented, in October 2002, the waiver covered parents with incomes up to 49 percent of FPL and other groups with incomes up to 185 percent of FPL, including SCHIP children, children from a state-funded premium assistance program, and low-income uninsurable adults. HHS has reviewed several proposed changes to Illinois' waiver and approved, effective July 2003, expanding coverage for parents to those with incomes from 49 to 90 percent of FPL. **Benefits:** Depend on whether waiver enrollees choose direct state coverage or premium assistance to purchase coverage through an employer. State benefits for parents are nearly the same as children's Medicaid or SCHIP coverage; cost sharing varies by income. State provides defined benefits for individuals who are uninsurable because of their medical conditions, with variable premiums and cost-sharing requirements. **Employer-sponsored insurance component:** Illinois already had a premium assistance program in place for low-income people including children, and the waiver continues that option.

State and waiver status	Description
Colorado Submitted May 8, 2002 Approved September 27, 2002 Implementation started October 9, 2002 Closed to new enrollees in May 2003; suspended as of November 1, 2003	**Projected enrollment:** 13,000 pregnant women. **Projected expenditures:** Total $64.0 million in SCHIP funds over 4 years; federal share $41.6 million, state share $22.4 million. **Highlights:** Uses SCHIP and state tobacco settlement funds to expand coverage to 13,000 pregnant women with incomes from 134 through 185 percent of FPL who are not otherwise eligible for Medicaid or SCHIP in Colorado. **Benefits:** Waiver extends comprehensive SCHIP benefits, excluding dental coverage; services are to be delivered through a SCHIP network of managed care providers. **Employer-sponsored insurance component:** HHS did not require this component in Colorado's waiver because the agency agreed with state officials that a population comprising only pregnant women is not appropriate for a premium assistance program. HHS is considering this waiver as phase I while awaiting submission of a separate, phase II HIFA waiver with an employer-sponsored insurance component and including parents. **Suspension:** Colorado suspended enrollment in the prenatal program in May 2003. Services continued for waiver participants until November 1, 2003, which coincided with the date that the state closed enrollment in its SCHIP program because of budget constraints. According to the waiver's terms and conditions, Colorado could not close enrollment in SCHIP while the waiver demonstration program was in effect.

State and waiver status	Description
Oregon Submitted May 31, 2002 Approved October 15, 2002 Implementation started November 1, 2002, for premium assistance component; February 1, 2003, for coverage expansion to pregnant women and children with incomes to 185 percent of FPL	**Projected enrollment:** As originally approved, approximately 581,000 people, including about 535,000 currently eligible individuals plus 46,000 expansion individuals. **Projected expenditures:** Total $13.3 billion over 5 years for combined HIFA and statewide Medicaid waivers, including $379 million in SCHIP funds (federal share $272 million, state share $107 million) and $12.9 billion in Medicaid funds (federal share $9 billion, state share $3.9 billion). **Highlights**: Approved to use SCHIP and Medicaid funds to expand coverage to approximately 46,000 additional individuals over 5 years, including pregnant women and children, with incomes from 170 through 185 percent of FPL and other individuals in a state-funded premium assistance program with incomes up to 185 percent of FPL (includes children, parents, and childless adults). The HIFA waiver restructures the existing statewide waiver, known as the Oregon Health Plan. Since approval of the original HIFA waiver, HHS has approved revisions that reduce certain benefits. The state informed HHS in May 2003 that a planned expansion in the Oregon Health Plan for parents and childless adults with incomes above 100 percent of FPL would not occur because of state budget constraints. In September 2003, Oregon requested additional amendments to the Oregon Health Plan to implement state legislation. These amendments, which were under review by HHS as of December 2003, include some proposed service reductions, the addition of a prescription drug-only benefit for some new low-income seniors and disabled individuals, expanded coverage under SCHIP from 185 to 200 percent of FPL, and expanded coverage under the premium assistance program for individuals with incomes from 185 to 200 percent of FPL. **Benefits:** The Oregon Health Plan expands coverage to pregnant women and children with incomes from 170 to 185 percent of FPL and covers parents and other adults with incomes from 100 to 185 percent of FPL only if they choose to enroll in the premium assistance program. The Oregon Health Plan also reduces benefits (eliminating dental, durable medical equipment, mental health, and chemical dependency services) and caps enrollment for some previously eligible parents and adults, and it expands cost-sharing requirements, such as co-payments. **Employer-sponsored insurance component:** Oregon expanded its existing state-funded premium assistance program and offers it as an option to previously eligible and new beneficiaries.

State and waiver status	Description
New Jersey Submitted July 15, 2002 Approved January 31, 2003 Implementation started March 1, 2003	**Projected enrollment:** 12,000 parents and caretaker relatives. **Projected expenditures:** Total $1 billion over 5 years, including $134 million in SCHIP funds (federal share $87.1 million, state share $46.9 million) and $866.8 million in Medicaid funds (federal share $433.4 million, state share $433.4 million). **Highlights:** Uses SCHIP funds to expand coverage to as many as 12,000 uninsured parents and caretaker relatives of Medicaid- and SCHIP-eligible children with family incomes at or below 200 percent of FPL.[b] This expansion group comprises individuals whose applications for the New Jersey FamilyCare program, under an existing SCHIP waiver, were pending when enrollment for that program was frozen in June 2002. **Benefits:** The state will reduce benefits for all parents and adults in its existing SCHIP waiver to health maintenance organization-equivalent coverage, and it will use the savings to fund the expansion group of parents and caretaker relatives. Premiums and co-payments, capped at 5 percent of adjusted family income per year (in keeping with federal SCHIP rules), are required for families with incomes above 150 percent of FPL. **Employer-sponsored insurance component:** The state's existing SCHIP waiver includes a premium assistance program implemented in July 2001. The HIFA waiver requires beneficiaries who have access to employer-sponsored private insurance to enroll in this premium assistance program.
Denied	
Delaware Submitted May 16, 2002 Denied March 19, 2003	**Projected enrollment:** 7,075 individuals. **Projected expenditures:** Total $68.9 million in SCHIP funds over 5 years; federal share $44.8 million, state share $24.1 million. **Highlights:** Proposed using SCHIP funds and other sources to cover about 7,000 low-income uninsured adults, including those in transitional medical assistance (temporary coverage for individuals who have lost full Medicaid eligibility), pregnant women with incomes from 133 through 200 percent of FPL, uninsured adults with incomes at or below 100 percent of FPL, and other eligible adults with incomes from 65 through 75 percent of FPL. Also proposed future expansion, with sufficient funding, to cover uninsured parents of Medicaid and SCHIP children. **Benefits:** Proposed moving some current Medicaid beneficiaries into SCHIP, reducing their benefits, increasing cost sharing (including sliding-scale premiums), and capping enrollment.

State and waiver status	Description
Pending	
Arkansas Submitted January 23, 2003	**Projected enrollment:** 55,000 individuals. **Projected expenditures:** Total $147.3 million in SCHIP funds over 5 years; federal share $120.7 million, state share $26.5 million (numbers do not add because of rounding). **Highlights:** Would use an employer tax, SCHIP funds, and beneficiary cost sharing to expand coverage to uninsured adults working for small employers by providing premium assistance for a basic benefit package. To be implemented in two phases: (1) a pilot program capped at 15,000 individuals and (2) coverage for an additional 40,000 uninsured adults with incomes up to 200 percent of FPL.
Michigan Submitted April l4, 2003	**Projected enrollment:** 62,000 childless adults. **Projected expenditures:** Total $858.6 million in SCHIP funds over 5 years; federal share $593.3 million, state share $265.3 million. **Highlights:** Proposes using unspent SCHIP allocation to expand coverage to 62,000 childless adults with incomes at or below 35 percent of FPL. **Benefits:** Include inpatient and outpatient hospital, physician medical and surgical, laboratory and X-ray, pharmacy, and mental health and substance abuse services. State estimates that cost sharing represents approximately 3.2 percent of family monthly adjusted income.
Withdrawn	
Washington Submitted August 13, 2002 Withdrawn May 2003	**Projected enrollment:** 20,000 individuals. **Projected expenditures:** Total $401 million in SCHIP funds over 5 years; federal share $260 million, state share $141 million. **Highlights:** Proposed using SCHIP funds to expand coverage to 20,000 individuals with incomes at or below 200 percent of FPL, including parents of children in Medicaid and childless adults. Expansion also to be supported by increased cost sharing, benefit reductions, and a possible Medicaid enrollment freeze for previously eligible groups, including children.

Source: Centers for Medicare & Medicaid Services (CMS).

Note: Information in this table is based on waiver documentation, including initial applications, terms and conditions, and operational protocols, and on clarifications and updates provided by CMS officials.

[a]Illinois also asked to expand coverage in three programs—the Illinois Comprehensive Health Insurance Program (ICHIP, a program for uninsurable low-income individuals), Hemophilia, and KidCare Rebate (for parents of children in Medicaid or SCHIP)—to include those with incomes from 185 to 200 percent of FPL. HHS informed the state that the department could not approve this waiver amendment because it would cover childless adults before parents. The state has asked HHS to reconsider its decision on KidCare Rebate, since that program currently includes only children, and this request for reconsideration was under review as of December 18, 2003.

[b]HHS's approval letter and press release for this waiver say that eligibility extends to individuals with incomes at or below 133 percent of FPL, but HHS representatives confirmed to us that eligibility extends to individuals with incomes at or below 200 percent of FPL.

Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 5 [illegible]

Ms. Kathryn G. Allen
Director, Health Care – Medicaid
and Private Health Insurance Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Enclosed are the Department's comments on your draft report entitled, "SCHIP: HHS Continues to Approve Waivers That Are Inconsistent With Program Goals." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Dara Corrigan
Acting Principal Deputy Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services on the General Accounting Office's Draft Report, "SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals" (GAO-04-166R)

The Department of Health and Human Services (Department) appreciates the opportunity to comment on the General Accounting Office's (GAO) draft report. The Department continues to believe that our actions to increase coverage through waivers are appropriate to help low-income Americans who do not have health insurance. The legal and policy bases for our positions are fully set forth in our response to the previous GAO report, "Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns" (GAO-02-817 issued July 2002), and it would appear unnecessary to reiterate those points in detail.

While GAO does not offer recommendations to the Department in this correspondence, we want to emphasize that the coverage of uninsured low-income children remains the priority of the State Children's Health Insurance Program (SCHIP). We are pleased that over 5.3 million children were insured through SCHIP in FY 2002 and that SCHIP has contributed to the reduction in the number of uninsured children since the inception of the program in 1997.

To assure that SCHIP funds are used for children first, States that have received Title XXI, section 1115, demonstrations continue to be required, through Special Terms and Conditions, to prioritize spending Title XXI funds for children. States are not permitted to limit or cap children's enrollment and must ensure the availability of funding for children over funding for adult expansion populations.

As we noted in our response to the previous report, we anticipate that these demonstrations will reduce the number of uninsured children. The approved demonstrations are expected to increase health insurance to adults who could become parents or caretaker relatives in the future, some of whom may be former Medicaid recipients. Furthermore, extending coverage to these adults strengthens the health status and awareness of the low-income community in general, supports the development of "medical homes" to encourage preventive care, and widens the health delivery network available to the low-income community.

Increasing access to health insurance remains one of our highest priorities. We will continue to work with States in order to provide opportunities for them to design programs that best meet the needs of their citizens. We appreciate the GAO's observations and look forward to continuing the dialogue with Congress on these important matters.

(290319)

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