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Report to the Chairman, Committee on Commerce, House of Representatives

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MEDICAID

Three States' Experiences in Buying Employer-Based Health Insurance

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Health, Education, and
Human Services Division

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The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives

Dear Mr. Chairman:

More and more members of low-income families now qualify for Medicaid[1] as a result of federal and state eligibility expansions in recent years. In fiscal year 1996, Medicaid expenditures totaled about $160 billion for about 37 million people who received services. Certain Medicaid beneficiaries also have access to employer-based group health insurance—for example, as an employee or through a working parent—which in some cases is more economical than Medicaid.

In 1990, in an effort to achieve Medicaid cost savings, the Congress added section 1906 to the Social Security Act, requiring states to pay premiums, deductibles, and coinsurance on behalf of Medicaid beneficiaries eligible for enrollment in employer-based group health plans when it is cost-effective to do so. The states must also pay the insurance premiums, but not deductibles and coinsurance, for non-Medicaid-eligible family members if it is cost-effective and necessary to obtain private coverage for eligible individuals.

Currently, little is known about the extent and effectiveness of the states' efforts to implement this law, which became effective January 1, 1991. Comprehensive, reliable national data are not readily available because states have been inconsistent in reporting their section 1906 expenditures to the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), the federal agency responsible for overseeing the Medicaid program. In 1992, the HHS Office of Inspector General surveyed the states and found that at that time only 18 states had purchased employer-based insurance for Medicaid-eligible individuals.[2]

You asked us to build upon the Inspector General's study and further examine states' implementation of section 1906. In discussions with your staff, we agreed to focus our work on selected states considered to be

[1]Medicaid is a joint federal-state health financing program established under title XIX of the Social Security Act to provide health care coverage for the poor, disabled, and medically needy.

[2]The HHS Office of Inspector General mailed a questionnaire to the 50 states and the District of Columbia in 1992. Two states did not respond.

successful in implementing section 1906 to determine (1) the extent to which these states are purchasing employer-based health insurance for Medicaid-eligible individuals and achieving budgetary savings, as well as the potential for greater savings; (2) the cost-effectiveness criteria these states use and the populations and services covered; (3) the outreach efforts used and barriers hindering states' implementation of section 1906; and (4) legislative proposals suggested by others to improve states' efforts.

To conduct our work, we collected and analyzed information reported for Health Insurance Premium Payment (HIPP) programs in Iowa, Pennsylvania, and Texas, which state Medicaid officials, HCFA officials, and other experts consider to be aggressive and successful programs in implementing section 1906 and achieving cost savings. We also contacted HCFA headquarters officials and three HCFA regional offices to obtain information regarding states' implementation of section 1906, and we reviewed studies and other literature discussing state section 1906 efforts. For more detailed information on our scope and methodology, see the appendix.

Results in Brief

Although Iowa, Pennsylvania, and Texas are recognized as operating aggressive HIPP programs, the number of people enrolled in their programs and their reported cost savings are relatively small. The three programs are trying to identify and enroll more Medicaid eligibles, and state officials anticipate enrollment increases in the future. Even with the expected increases, however, the programs are expected to remain small when compared with the total Medicaid populations in the three states. Texas, for example, purchased employer-based health insurance for 5,507 Medicaid eligibles enrolled in its HIPP program as of August 1996 and reported savings of $4.6 million (0.1 percent of its Medicaid expenditures) for state fiscal year 1996.[3] Texas officials said they would like their HIPP program to grow to about 10,000 enrollees, which would represent about 0.4 percent of Texas' total Medicaid population.

In assessing the cost-effectiveness of purchasing employer-based insurance for Medicaid eligibles, Iowa, Pennsylvania, and Texas use criteria designed to enroll anyone whose expected Medicaid costs exceed the total of the premiums, deductibles, expected coinsurance, and program administrative costs. The three states do not target their programs to only those populations with high-cost medical conditions,

[3]Each time we refer to a year in conjunction with state-reported data, we are referring to the states' fiscal years. Iowa's and Pennsylvania's fiscal year is July 1 through June 30, and Texas' fiscal year is September 1 through August 31.

such as acquired immunodeficiency syndrome (AIDS) patients, because program officials believe this would limit potential cost savings. For example, Iowa officials reported a HIPP program caseload composed primarily of families with children.

HIPP program outreach and enrollment efforts in the three states rely primarily on Medicaid eligibility workers to identify those potential enrollees with access to employer-based insurance. The enrollment process, including the assessment of cost-effectiveness, also relies on the cooperation of Medicaid eligibles and their employers to provide needed information, such as health plan costs and benefits. A variety of barriers, however, limit the states' effectiveness in identifying and enrolling Medicaid eligibles. For example, Medicaid eligibles do not always disclose their access to insurance coverage, and employers do not always respond to states' requests for information on health plans.

State Medicaid officials and health policy analysts have proposed legislative changes to address some of these barriers and improve HIPP program implementation throughout the country. For example, proposals have been made to require greater employer cooperation in enrolling Medicaid eligibles and parents of Medicaid-eligible dependents. Another proposal is to require that employers and insurers allow HIPP applicants to join employers' health plans at the time Medicaid eligibility is established rather than having to wait for an open enrollment period limited to a certain time of the year.

Background

Section 1906 of the Social Security Act, enacted in the Omnibus Budget Reconciliation Act of 1990, requires that states use Medicaid funds to purchase employer-based group health insurance on behalf of Medicaid-eligible individuals if such insurance is available and it is cost-effective to do so. States must also purchase employer-based health insurance for non-Medicaid-eligible family members if this is necessary for Medicaid-eligible individuals to receive coverage and the insurance is still cost-effective.[4]

As defined by section 1906, an individual's enrollment in an employer-based plan is cost-effective if paying the premiums, deductibles, and coinsurance is likely to be lower than a state's expected cost of directly providing Medicaid-covered services. HCFA, which oversees the

[4]The states pay the premiums, deductibles, and coinsurance for Medicaid eligibles. For non-Medicaid-eligible family members, the states pay the insurance premiums but not the deductibles and coinsurance.

Medicaid program, has provided the states with guidelines for calculating cost-effectiveness, including a suggested formula for determining expected deductible and coinsurance costs. States may use an alternative method for determining cost-effectiveness after obtaining HCFA's approval.

If an employer-based health plan is determined likely to be cost-effective, individuals are required to enroll as a condition of their Medicaid eligibility. However, a child cannot be denied Medicaid eligibility or services because a parent does not enroll in an employer's plan.

Medicaid eligibles enrolled in employer-based health plans are entitled to receive full Medicaid benefits. The health plans become the primary payers for the services they cover. The states must provide coverage for those Medicaid services not included in the private plans. In addition, according to HCFA, states are required to reimburse providers for enrollee deductibles and coinsurance according to the employer-based plans' fee schedules rather than the state Medicaid fee schedules.

Federal Medicaid matching funds are available, at each state's regular matching rate,[5] for premium, deductible, and coinsurance payments made by the states for Medicaid eligibles. Federal matching funds are also available for the premium payments made by states for noneligible family members, but not for their deductibles, coinsurance, or other cost-sharing obligations.

The administration's budget proposal for fiscal year 1998 would eliminate section 1906 of the Social Security Act as part of an effort to "eliminate unnecessary administrative requirements." According to the administration, section 1906 is not necessary because states have an "inherent incentive" to move Medicaid beneficiaries into private health insurance when it is cost-effective. Moreover, current, detailed, "one-size-fits-all" federal rules hinder the states from designing programs that most effectively suit local circumstances, according to the administration.[6]

[5]The federal government pays a percentage of each state's cost of Medicaid benefits. The federal matching rate for each state is determined by the state's average per capita income and ranges from 50 to 83 percent.

[6]The administration's fiscal year 1998 budget proposal included per capita spending limits for Medicaid. The administration cited these spending limits as an increased incentive for states to purchase cost-effective private health insurance for Medicaid beneficiaries. However, the per capita spending limits were not included in the subsequent agreement between the Congress and the administration to balance the federal budget by 2002.

HIPP Programs' Enrollment, Savings, and Growth Potential

Although Iowa, Pennsylvania, and Texas have implemented HIPP programs to enroll Medicaid eligibles and achieve budgetary savings, to date only small portions of the Medicaid populations in these states are signed up. And, as expected, the Medicaid budgetary savings achieved in the three states have also been relatively small. None of the state officials we talked with expect their HIPP programs to enroll large numbers of Medicaid eligibles in the future.

Enrollment Levels and Savings Achieved

As a percentage of the total state Medicaid population, Iowa's HIPP program enrollment was the largest of the three states. In June 1996, Iowa had 2,504 Medicaid eligibles enrolled in its HIPP program, representing 0.8 percent of the approximately 333,500 Medicaid eligibles in the state. For 1996, Iowa's HIPP program reported an estimated savings of $2.4 million (0.2 percent of Medicaid expenditures). Table 1 shows HIPP program enrollment and estimated Medicaid savings reported to us by each of the three states included in our evaluation.

Table 1: HIPP Program Enrollment and Estimated Budgetary Savings in Three States, 1996

	Number of enrollees[a]	Percentage of state Medicaid population[a]	Estimated budgetary savings (in millions)	Estimated savings as a percentage of Medicaid expenditures
Iowa	2,504	0.8%	$2.4	0.2%
Pennsylvania	4,700	0.3	9.7	0.2
Texas	5,507	0.2	4.6	0.1

Note: The estimated budgetary savings were reported for each state's fiscal year 1996.

[a]The program enrollment data were provided as of a specific month, which differed for each state: Iowa as of June 1996, Pennsylvania as of January 1997, and Texas as of August 1996.

Some Program Growth Expected

Because Iowa, Pennsylvania, and Texas are trying to identify and enroll more people in their HIPP programs, state officials expect enrollment levels to increase. The anticipated increases and potential budgetary savings, however, would remain modest.

Iowa officials expect their HIPP program enrollment to rise because the Iowa Department of Human Services' request for an increase in its 1998 appropriation for additional staff was approved by the state legislature. The officials said the appropriation increase, effective July 1, 1997, will allow the size of the department's HIPP unit to grow from 7 to 14 staff, and

2 computer specialists will be added to enhance the unit's automation capabilities. The officials predicted HIPP program enrollment will increase by as much as 30 percent, as the additional staff will likely process more HIPP applications and help eliminate the backlog that has existed. With a 30 percent increase, program enrollment would constitute 1 percent of Iowa's total Medicaid population.

Pennsylvania's HIPP program, which started in 1995, has grown steadily. Pennsylvania officials said they are not sure when enrollment will level off but believed the program has considerable room for growth. Texas officials said they would like to reach an enrollment level of about 10,000. This goal would almost double the August 1996 enrollment, representing less than 0.4 percent of Texas' total Medicaid population.

Iowa and Texas officials, as well as a HCFA official, noted that some states may be unlikely to start or expand HIPP programs as they focus their Medicaid programs on managed care. Such states may believe it is cheaper and administratively easier to include Medicaid eligibles in contracted managed care plans rather than operate a separate HIPP program at the same time. One official noted that when the cost of employer-based insurance is compared with that of paying a Medicaid managed care plan, it does not appear as cost-effective as it does when it is compared with Medicaid fee-for-service program costs. Other officials said some states have simply ignored employer-based insurance because of their increased attention and emphasis on Medicaid managed care.

Contrary to what some other state officials may believe about the practicality of HIPP programs coexisting with managed care, Iowa and Texas HIPP officials expect their HIPP programs to remain viable and cost-effective as managed care expands in those states. The officials said that buying employer-based insurance in their HIPP programs can be less costly than paying monthly payments to Medicaid managed care plans in Iowa and Texas. According to the officials, this is primarily because employer-based insurance plans sometimes can provide coverage for any size family for the same premium, while state payments to Medicaid managed care plans are made for each family member covered. They also noted that because employers typically contribute to the cost of the insurance premiums for HIPP enrollees, the state does not have to pay the entire amount.

A Texas official said another reason the Texas HIPP program will remain viable as Medicaid managed care expands is that the state plans to place

all new Medicaid eligibles who have access to employer-based insurance in the Medicaid fee-for-service program, at least initially. Starting in the spring of 1998, such potential HIPP enrollees will not be allowed to join a Medicaid managed care plan unless their employer-based health insurance is determined not to be cost-effective. Texas' intent is to prevent enrollment in Medicaid managed care plans, and thus the accompanying monthly payments to such plans, when the state can achieve greater cost savings by enrolling Medicaid eligibles in the HIPP program.

Cost-Effectiveness Criteria, Services Provided, and Populations Covered

Iowa, Pennsylvania, and Texas include any Medicaid eligibles in their HIPP programs who have access to employer-based health insurance and whose expected Medicaid costs exceed the costs associated with purchasing the insurance. The programs do not focus on only those with high-cost medical conditions because program officials believe this would limit potential cost savings. Each of the three states provide their HIPP enrollees with coverage for all Medicaid services not included in the employer-based insurance plans.

States Use Own Cost-Effectiveness Criteria

The three HIPP programs essentially consider an insurance plan to be cost-effective if the expected Medicaid costs[7] of a Medicaid eligible exceed HIPP insurance costs, including premiums, deductibles, any expected coinsurance, and HIPP program administrative costs. The programs use their own criteria for assessing cost-effectiveness, rather than following HCFA's suggested guidelines. A major difference is that the programs base estimates of coinsurance costs on their Medicaid fee schedules. This produces lower estimates of coinsurance payments and results in more insurance plans determined to be cost-effective and more people enrolled.

The cost-effectiveness criteria that the three states use do not restrict or target HIPP program enrollment to only those Medicaid eligibles expected to incur high medical costs. The Iowa program requires a minimum projected savings of only $5 per month per household. The Pennsylvania and Texas programs do not require any minimum monthly savings for a plan to be considered cost-effective. Officials from the three programs said that Medicaid savings are increased by enrolling more than just high-cost Medicaid eligibles. A Pennsylvania official noted, however, that the state's program gives priority to enrolling those with "special conditions" (for example, pregnant women, AIDS patients, people needing an organ

[7]The three programs estimate each HIPP applicant's likely Medicaid costs on the basis of the applicant's past medical bills and/or the Medicaid costs of beneficiaries with similar demographic characteristics and medical conditions.

transplant), and this has resulted in increased Medicaid cost savings as reflected in the program's estimated $9.7 million savings for 1996.

The Iowa program considers an employer-based health plan that provides comprehensive medical coverage[8] to automatically be determined cost-effective when the plan provides coverage to a Medicaid-eligible pregnant woman; the employee's share of the premium cost is $50 or less per month for a one-person Medicaid-eligible household; or the employee's share of the premium cost is $100 or less per month for households of two or more Medicaid eligibles. An Iowa HIPP official explained that the $50 and $100 criteria were established for an automatic determination of cost-effectiveness because the program wanted to reduce the administrative work load involved in processing its backlog of HIPP applications. The official said the actual cost-effectiveness of plans with these premium amounts has been analyzed and such plans are virtually always cost-effective, primarily because the plans provide comprehensive medical coverage. On the very few occasions when such plans were found not to be cost-effective, the Medicaid eligibles were enrolled anyway because of the program's established criteria.

The three programs have devised cost-effectiveness assessment formulas that result in lower estimates of HIPP enrollees' coinsurance costs than if HCFA's suggested guidelines were used. HCFA's cost-effectiveness guidelines take into account the requirement that HIPP programs pay coinsurance and deductible costs for covered services according to the employer-based plans' fee schedules. However, the three HIPP programs pay coinsurance based on their Medicaid fee schedules, which are generally lower and may allow the programs to avoid paying coinsurance.[9] If the HIPP programs used HCFA's guidelines, their cost-effectiveness assessments would overstate the expected coinsurance payments, and fewer insurance plans would be determined to be cost-effective. Iowa, for example, does not factor in any coinsurance costs in its cost-effectiveness analysis because its actual coinsurance obligation for HIPP enrollees is negligible, according to an Iowa HIPP program official.

[8]The Iowa HIPP program does not have a strict definition of comprehensive medical coverage. However, program officials said they generally consider such coverage to be for services such as inpatient hospital care, outpatient hospital care, physician services, laboratory services, and X rays.

[9]For example, if a provider billed an employer-based insurance plan $100 for a covered medical service, and the plan allowed $100 for the service and paid 80 percent of the cost, or $80, the HIPP program would be responsible for paying $20 in coinsurance if it used the employer-based plan's fee schedule. However, if the HIPP program used the Medicaid fee schedule and that schedule allowed $80 for the service, the program would not pay the $20 coinsurance.

All Medicaid Services Are Covered

In assessing the cost-effectiveness of employer-based health insurance plans, the three HIPP programs consider which services the plans cover. HIPP program enrollees are entitled to all of the states' Medicaid benefits, including those not included in the employer-based insurance plans. The Texas program, for example, will not enroll a HIPP applicant unless the insurance plan covers certain Medicaid services, including inpatient hospital care, physician services, and prescription drugs.

The state Medicaid programs provide "wrap-around" coverage for services that the insurance plans do not cover by paying claims submitted by providers. Iowa and Pennsylvania HIPP officials, for example, said every HIPP enrollee has a Medicaid card he or she must present to providers to receive medical services. The cards indicate if a Medicaid eligible has coverage by a private insurance plan and which services are covered. In reading the cards, the providers can tell whom to bill, either a private plan or the Medicaid program. In Pennsylvania, the HIPP enrollee must also present a private insurance plan card.

As the three states receive provider claims for HIPP enrollees, they pay deductibles and coinsurance costs as appropriate. The Iowa and Pennsylvania HIPP officials noted that their Medicaid payment systems will reject any provider claims that should have been submitted to a private insurance plan.

More Than High-Cost Populations Enrolled

The HIPP program officials in the three states we reviewed reported having relatively few enrollees with high-cost medical conditions. The Texas HIPP program, for example, reported that in 1996 only 11 percent of HIPP enrollees were blind or disabled, and 10 percent were pregnant women or newborns. Texas HIPP officials said they consider people in these groups to be high cost. In contrast, 69 percent of the HIPP enrollees in Texas were children, a group that typically incurs low medical costs, according to the Texas officials.

Pennsylvania program officials told us that as of January 1997, about 22 percent of the HIPP enrollees were considered to have "special conditions." These included pregnant women, AIDS patients, and the severely disabled. The officials said they could not provide a more detailed breakdown, and their program does not maintain data on the enrollees by other characteristics.

The Iowa HIPP program also did not have data available on the population characteristics of its caseload. An Iowa official said the program was mostly composed of families with children.

Barriers to HIPP Program Outreach and Enrollment

HIPP program outreach and enrollment efforts in the three states face a variety of barriers. The programs are not able to identify all potential enrollees who have access to employer-based health insurance. When potential enrollees are identified, the programs often face additional barriers in attempting to collect needed information from employers and the potential enrollees themselves.

Processes to Identify Potential Enrollees Are Limited

The three HIPP programs rely primarily on Medicaid eligibility workers in the field to identify potential HIPP enrollees. The eligibility workers communicate with potential enrollees when they first apply for Medicaid eligibility, when their eligibility is periodically redetermined, and if they later report new employment. In two of the states we contacted, HIPP program officials said Medicaid eligibility workers are sometimes not sufficiently knowledgeable about the states' HIPP programs.

Medicaid eligibility workers in Pennsylvania and Texas refer identified potential HIPP enrollees (for example, those who indicate they are employed and have access to health insurance through their employer) to their state's HIPP program, which then contacts the employers and requests information about health plan premium costs and benefits. In Iowa, the eligibility workers send a form directly to employers requesting information about earnings and health plan benefits and costs, collect the completed forms, and forward copies to the HIPP program when employers indicate health insurance is available. The HIPP programs need information about each insurance plan's premium costs and benefits package to determine the cost-effectiveness of purchasing insurance.

Texas officials said there is a high turnover of eligibility workers in their state. Consequently, many of them do not understand the HIPP program and cannot adequately explain it to Medicaid eligibles. The officials consider this a major barrier to program enrollment.

Pennsylvania HIPP officials also told us that eligibility workers need to be more knowledgeable about the program so the workers can better identify potential enrollees and explain the program to them. The officials believe training eligibility workers about the HIPP program will increase Medicaid

eligibles' awareness of it and result in greater enrollment. In April 1997, the eligibility workers in Pennsylvania started automatically referring potential enrollees to the HIPP program when they reapply for Medicaid eligibility and report new employment, in addition to making referrals at their initial application for Medicaid benefits. Program officials had discovered that the eligibility workers were missing these opportunities to identify potential enrollees. Two weeks after the eligibility workers started referring potential HIPP program enrollees upon their reapplication and reporting of employment, the number of referrals jumped from 470 in a week to over 1,300.

In Iowa and Texas, potential HIPP enrollees may also be identified as a result of computerized data matches of state employment information and Medicaid eligibility information, which can help identify employed Medicaid eligibles.[10] However, according to HIPP officials, the employment information is not always current. Frequently, identified Medicaid eligibles are no longer working, have changed jobs, or no longer have access to insurance. Iowa officials said this information has not been productive and has not resulted in many enrollments. In Texas, only about 7 percent of the active HIPP caseload in August 1996 had been identified through the use of the computerized state employment data.

Some Potential HIPP Enrollees Do Not Disclose Insurance or Provide Needed Information

Some potential HIPP enrollees do not disclose their access to employer-based health insurance even when they know about the HIPP program. In addition, potential enrollees who have been identified often do not respond to the states' requests for information. For example, an individual may fail to provide the program with a requested insurance card or paycheck stub showing a deduction for health insurance premiums. Texas HIPP program officials cited "client non-responsiveness" as the biggest barrier limiting the number of enrollees in their program. Iowa officials also noted problems with potential enrollees not providing information.

According to the Texas officials, there are many reasons people do not comply with requests for information and enroll in the HIPP program, and convincing people to participate can be very difficult. Sometimes Medicaid eligibles are afraid to disclose the necessary health plan information because of an unfounded fear of losing their Medicaid benefits if they have

[10]The Iowa data matches use computerized information from the Iowa Department of Employment Services, which receives wage information from employers for all employees. The Texas HIPP program obtains information from the Texas Work Force Commission database, which contains information on all workers for whom an employer pays unemployment insurance.

access to, or are already covered by, private insurance. Iowa officials said apathy may be the primary reason Medicaid eligibles fail to provide information regarding their health insurance. A 1996 report on Medicaid and employer-financed health insurance coverage by the Institute for Health Policy Solutions noted that Medicaid eligibles may not be eager to disclose their insurance because to do so results in extra work for themselves (that is, obtaining information on their employer's health plan), reveals their potential Medicaid status to their employer, and generates an administrative burden for their employer.[11]

Employers Do Not Always Cooperate

Another barrier to enrollment is that some employers do not respond to the states' requests for information on health plan costs and benefits. This information is needed to assess the cost-effectiveness of purchasing an employer's insurance.

The Institute for Health Policy Solutions report points out that there are varying degrees of financial disincentives for employers to participate in a Medicaid HIPP program. For example, an employer with mostly minimum-wage employees may offer health insurance but have few participating employees because many of them cannot afford the insurance. If Medicaid is available to pay the employees' costs, the employer will have a larger number of employees for whom it must pay the employer's share of costs. Employers with fewer minimum-wage employees are less affected. Small employers in certain states may also face the possibility that their insurance premiums will increase if HIPP enrollees added to the health plans are considered to be high risk (for example, because of health status, where they live, or demographic category such as age or gender). For self-insured employers, adding HIPP enrollees to plans means there is a greater potential for having to pay more claims. The Institute's report noted that an additional disincentive to employer cooperation is the administrative burden of providing the state with copies of benefit plans and premium costs.

Iowa HIPP program officials told us it is difficult for them to get information from employers, particularly self-insured employers covered under the Employee Retirement Income Security Act of 1974 (ERISA). The majority of employers contacted in Iowa failed to respond when first asked to submit a copy of their health benefits plan or policy. In contrast, Pennsylvania and Texas officials said that employers in their states

[11]Institute for Health Policy Solutions, Improving Health Care Coverage for Low-Income Children and Pregnant Women: Optimizing Medicaid and Employer-Financed Coverage Relations (Washington, D.C.: Institute for Health Policy Solutions, Nov. 21, 1996).

generally respond to HIPP program requests for health plan coverage and contribution information. The officials in Iowa and Texas also noted, however, that the states have no legal authority to require that employers provide the needed health plan information.

Health Plan Enrollment Periods Are a Barrier to HIPP Enrollment

HIPP officials in the three states also cited limited health plan enrollment periods as a barrier to enrolling Medicaid eligibles in HIPP programs. Many employers allow employees to enroll in their health plans only at the start of employment; during an annual open enrollment period; or at the time of certain events, such as a marriage, divorce, or birth of a child. These enrollment periods often do not coincide with application for Medicaid eligibility or eligibility redetermination. As a result, many months can elapse between the time someone applies for Medicaid and the next opportunity to enroll in an employer's health plan.

Iowa officials said health plan enrollment periods are sometimes an impediment to enrolling Medicaid eligibles in the HIPP program. The officials said that if the establishment of an individual's Medicaid eligibility was considered to be one of the events permitting enrollment in employer health plans, their HIPP program could enroll more people. Pennsylvania officials said they need to obtain the employer's cooperation to enroll a Medicaid eligible in an employer-based plan outside of an open enrollment period, and employers have allowed such enrollments roughly 50 percent of the time the situation has come up. While open enrollment periods are not considered a significant problem for the Pennsylvania HIPP program, the officials believe there would be more enrollments if establishing Medicaid eligibility was considered to be an event that permits employees to enroll in employer health plans. Texas officials believe that such a change would significantly increase enrollment in their program.

Legislative Remedies Proposed to Improve HIPP Program Implementation

States and others have proposed legislative changes to address some of the HIPP program implementation barriers. These proposals seek to increase program enrollment and Medicaid cost savings.

Require Greater Cooperation From Potential Enrollees and Employers

An Iowa Department of Human Services official suggested that the Congress require greater cooperation from employers, including employers with self-insured plans under ERISA, to prevent noncooperating parents from failing to enroll Medicaid-eligible dependents in available

employer health plans. Another Iowa HIPP official suggested that such legislation could require employers to (1) provide the state with information about the health benefits they offer their employees and (2) enroll Medicaid-eligible employees, or parents of Medicaid-eligible dependents, in available health insurance plans when requested to do so by the state, even without the employees' cooperation.

The Institute for Health Policy Solutions' report contains another proposal to require greater employer cooperation. According to the Institute, under ERISA, it is not clear that self-insured employers have any obligation to furnish health plan benefit and cost information to employees who are not enrolled in an employer-based plan, except during open enrollment periods. The states are not authorized to obtain this information on their own. Without plan benefit and cost information, state Medicaid agencies cannot determine if it is cost-effective to purchase employer-based insurance coverage in a HIPP program. The Institute's report suggests it be clarified[12] that under ERISA, eligible employees have the right to obtain information about health plan benefit coverage and premium amounts, even if they are not participating in the plan. The Institute concluded that federal action could clear the way for states to obtain this information. Without federal action, state efforts to require greater employer cooperation would not significantly affect self-insured plans.

Allow Enrollment in Employer Health Plans at Any Time

Another proposal is that employers and insurers be required to treat the establishment of Medicaid eligibility as an event permitting enrollment in employers' health plans. This would eliminate the problem of established health plan enrollment periods not coinciding with Medicaid eligibility determinations.

The Institute for Health Policy Solutions proposed amending ERISA to make the establishment of Medicaid eligibility a "qualifying event" for enrolling in an employer's insurance plan outside the open enrollment period, which normally occurs once a year. In a similar proposal, an Iowa official suggested that a provision be added to section 1906 allowing states to enroll Medicaid recipients in an insurance plan at any time. The Texas HIPP program officials we met with said there are no laws establishing which events permit enrollment in employer-based health insurance plans. Instead, these events are agreed upon by employers and their health plans.

[12]According to the report, this clarification may not require a legislative change but may be able to be accomplished by revising ERISA regulations.

Federal or state law could be enacted to permit enrollment in a health plan whenever an individual becomes qualified for Medicaid (if the individual is otherwise qualified to enroll in the employer-based plan). In the case of self-insured plans under ERISA, federal legislation would be needed to require that employer-based plans comply with this requirement. To obtain cooperation from those employers who do not self-insure and depend on health insurance policies regulated by the states, states could—under their own legislative or regulatory authority—require that insurers consider Medicaid eligibility a qualifying event for enrollment in an employer's health insurance plan outside the open enrollment period.

States May Have Authority to Use Medicaid Fee Schedules

In its May 1994 report,[13] the Inspector General recommended that HCFA propose legislation allowing the states to pay employer-based health insurance plan deductibles and coinsurance using Medicaid fee schedules instead of the individual plans' fee schedules as currently required.[14] In making this recommendation, the Inspector General relied on HCFA's interpretation of section 1906 requirements that states must use employer-based health plan fee schedules. Our analysis of section 1906, however, suggests that another reasonable interpretation is that states already have the authority to use their Medicaid fee schedules when paying deductibles and copayments.

In its 1994 report, the Inspector General said that 17 of the 18 states reporting the purchase of employer-based insurance for Medicaid eligibles reimbursed providers according to their state Medicaid fee schedules. They did so because using the individual plans' fee schedules is more costly to Medicaid and requires increased administrative expenses.

All three state HIPP programs included in our review use Medicaid fee schedules for reimbursing providers. HIPP officials we contacted commented on the difficulty that would be involved in trying to use employer-based health plans' fee schedules. According to the officials, there are many health plans and each has its own fee schedule, resulting in a wide variety of cost-sharing arrangements. Some officials called the requirement to use the employer-based plans' fee schedules "unworkable," "administratively impossible," and "the largest stumbling block for states

[13]HHS, Office of Inspector General, Medicaid Payments of Premiums for Employer Group Health Insurance, OEI-04-91-01050 (Washington, D.C.: HHS, May 1994).

[14]In commenting on the Inspector General's draft report, HCFA deferred comment on this recommendation and noted that the requirements of section 1906 could change under proposed major health reform plans the Congress was then considering. More recently, the administration's budget proposal for fiscal year 1998 would eliminate section 1906 altogether.

trying to implement these [section 1906] provisions." The Institute for Health Policy Solutions report also noted that the current cost-sharing requirement can be cumbersome and costly to administer.

According to HCFA, section 1906 requires states to reimburse providers for enrollee deductibles and coinsurance according to the employer-based plans' fee schedules, rather than state Medicaid fee schedules. However, it is not clear to us that this is the only reasonable conclusion to be reached under section 1906, and it is one that may undermine states' efforts to achieve Medicaid cost-savings.

In establishing the requirement for states to enroll Medicaid beneficiaries in employer-based plans and pay deductibles and coinsurance, section 1906 refers to another provision of Medicaid law that establishes requirements for Medicaid payments when a beneficiary is already enrolled in an employer-based (or other) health plan. That law allows states to use their Medicaid fee schedules when paying deductibles and coinsurance after a private insurance plan has paid for Medicaid-covered services.[15] In addition, language related to section 1906 in the 1990 congressional Conference Report suggests to us that the use of Medicaid fee schedules is authorized. Specifically, the report states that the House bill "[r]equires a provider treating beneficiaries enrolled under a plan to accept the greater of the plan's reimbursement rate or the Medicaid rate as payment in full, and prohibits a provider from charging the beneficiary or Medicaid an amount that would result in aggregate payment greater than the Medicaid rate."[16] The language in the final version was slightly different than that in the House bill, but we interpret the quoted description as being equally applicable to the final language. It appears to us that existing law may provide adequate statutory authority for the states to continue to use their Medicaid fee schedules without the need for congressional action.

Concluding Observations

Iowa, Pennsylvania, and Texas HIPP programs to enroll Medicaid eligibles and achieve Medicaid cost savings have encountered barriers that have limited their size. Although enrollment in these programs is expected to

[15]Under section 1902(a)(25) of the Social Security Act, private insurance coverage for Medicaid recipients is treated as a third-party liability. According to this law, when employer-based health insurance plans are liable to pay for care or services covered by Medicaid, the employer-based plans provide the primary coverage, and states then pay deductibles and coinsurance using their Medicaid fee schedules.

[16]H.R. Conf. Rep. No. 101-964, at 833 (Oct. 27, 1990).

increase, the likely increases will remain modest when compared with the total Medicaid populations and expenditures in these states.

Moreover, some state and HCFA officials believe the spread of Medicaid managed care may dissuade some states from starting new HIPP programs or expanding existing ones. Such states may decide it is less costly or administratively easier to include Medicaid eligibles in managed care plans rather than operate a separate HIPP program. In contrast, Iowa and Texas officials said they expect their HIPP programs to remain cost-effective and viable as managed care expands in their states.

The states' implementation of federal welfare reform legislation may also have an impact on HIPP programs. Over time, increased numbers of formerly unemployed welfare recipients may leave the welfare rolls and be hired into jobs, including people who are currently enrolled in Medicaid programs or parents of children who are covered by Medicaid. Many of these newly employed people may gain access to employer-based health insurance and become eligible for enrollment in a state HIPP program. This could increase the potential for states to establish or expand HIPP programs and realize associated Medicaid cost savings. However, the extent to which states will do so is uncertain given the existing barriers to such a program and the increasing role of managed care in state Medicaid programs.

Because of these uncertainties and the administration's proposal that section 1906 requirements be eliminated, it is not clear that legislative changes by the Congress to improve HIPP program implementation are warranted at this time. States could, however, decide to take action on their own to remove some of the barriers that HIPP programs face in their efforts to identify and enroll Medicaid eligibles. Such actions could include establishing laws or regulations similar to the federal legislative changes that have been proposed. For example, states may be able to use legislation or regulation, whichever is most appropriate, to obtain greater employer cooperation in providing health plan information to the state and in helping to enroll employees who are parents of Medicaid-eligible children. Without federal action to address ERISA preemption, however, any such state initiatives would have no significant impact on self-insured plans.

Agency Comments and Our Evaluation

We provided a draft of this report to the HCFA Administrator; HIPP program officials in Iowa and Texas; and an official of Pennsylvania's Department

of Public Welfare, Office of Administration. We discussed the draft with officials of the Office of Beneficiary Services within HCFA's Medicaid Bureau and officials from the three states. With one exception, these officials generally agreed with our findings.

While the HCFA officials agreed that it would be beneficial for states to have the authority to pay deductibles and coinsurance using their Medicaid fee schedules, they did not agree with our conclusion that section 1906 may be interpreted to provide such authority and believed that legislative action would be required to permit this. We continue to believe, however, that section 1906 can be interpreted to authorize states to pay deductibles and coinsurance using their Medicaid fee schedules, based on the reference in section 1906(a)(3) to section 1902(a)(25), which—in a related context—permits states to pay deductibles and coinsurance using their Medicaid fee schedules. The legislative history also supports this view. At HCFA's request, we agreed to provide additional information regarding our legal interpretation, and the officials indicated a willingness to reexamine their position at a later date.

HCFA and state officials also provided technical comments that we incorporated as appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies of this report to the Secretary of HHS; the Administrator, HCFA; and other interested parties. We will make copies available to others on request.

If you or your staff have any questions, please call me or Kathryn Allen, Acting Associate Director, at (202) 512-7114. Other major contributors to this report were Ron Viereck, Howard Cott, and Craig Winslow.

Sincerely yours,

William J. Scanlon
Director, Health Financing
and Systems Issues

Scope and Methodology

We focused our work on the HIPP programs implemented in three states: Iowa, Pennsylvania, and Texas. We selected these programs because our preliminary work showed that they are considered by state Medicaid officials, HCFA officials, and other experts as aggressive and successful programs achieving cost savings. Our findings from these three HIPP programs cannot be generalized to other states' HIPP programs.

We conducted structured interviews to obtain information from HIPP program officials in the three states. In addition, we collected and analyzed documentation on HIPP program operations from the time enrollment started in each state (Iowa, 1992; Pennsylvania, 1995; and Texas, 1995). All of the information we obtained was reported to us by the program officials, and we did not verify its accuracy.

We contacted HCFA headquarters in Baltimore, Maryland, to obtain information regarding HCFA's section 1906 requirements for states, total section 1906 expenditures reported to HCFA by all states, and other information on how the states generally are implementing section 1906. We also contacted HCFA regional offices in Dallas, Texas; Kansas City, Missouri; and Philadelphia, Pennsylvania, to obtain Medicaid state plan amendments filed with HCFA by the three states for implementation of their HIPP programs. In addition, we reviewed relevant studies discussing states' section 1906 efforts.

We conducted our review between November 1996 and June 1997 in accordance with generally accepted government auditing standards.

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