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Washington, DC 20548

January 19, 2010

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

The Honorable Henry A. Waxman
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

Subject: *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs*

Fiscal pressures, rising health care costs, and increases in the number of uninsured may lead states to look toward public-private partnerships to help finance health insurance coverage. Through Medicaid and the State Children's Health Insurance Program (CHIP), states have had long-standing authority to operate premium assistance programs that subsidize the purchase of private health insurance.[1] Enacted in February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which reauthorized CHIP and made changes to Medicaid, provided states with additional options for operating premium assistance programs. As of November 2009, states had not implemented premium assistance programs under the new authorities provided by CHIPRA, but, as allowed by CHIPRA, states were continuing to operate their programs under preexisting authorities.

Through premium assistance programs, states use Medicaid funds, CHIP funds, or both to subsidize the cost of private health insurance—such as employer-sponsored insurance (ESI)—for eligible individuals. As such, premium assistance programs contrast with direct coverage, where states provide Medicaid or CHIP benefits to enrollees by paying doctors and other providers directly or contracting with managed care organizations. Previous reports on premium assistance programs have described the programs' potential benefits, as well as

[1]Medicaid and CHIP are joint federal-state programs that finance health insurance coverage for certain categories of low-income adults and children.

potential issues that have been raised about them.[2] One potential benefit reported is that premium assistance programs could generate cost savings for Medicaid and CHIP by leveraging private financial resources for health insurance coverage—such as employer contributions—and decreasing enrollment in direct coverage. Additional potential benefits include helping families make the transition to private health insurance, expanding coverage to family members who are not themselves eligible for coverage under Medicaid or CHIP, and supporting the private insurance market. In contrast, a reported issue with premium assistance programs is that there may be disparities in the benefits and cost-sharing protections offered to enrollees in such programs compared with those in direct coverage. Reports also note that premium assistance programs may not be cost-effective—that is, premium assistance may be more expensive than providing direct coverage through states' Medicaid and CHIP programs. Finally, reports have raised the possibility that premium assistance programs may create incentives for families to reduce their contributions toward the cost of health insurance coverage, thus shifting the costs of coverage to public funds.

CHIPRA required GAO to study cost and coverage issues related to state premium assistance programs receiving Medicaid and CHIP funds.[3] In this report, we describe states' premium assistance programs, including the (1) funding source, operating authority, and type of private health insurance coverage subsidized; (2) policies regarding eligibility and enrollment; (3) benefits, premiums, and cost sharing; (4) expenditures and cost-effectiveness policies; and (5) challenges program officials reported in implementing and operating such programs, as well as the effect that CHIPRA may have on these challenges.

To describe these programs, we administered a Web-based survey to officials from the states that had premium assistance programs funded by Medicaid, CHIP, or both. To identify which states had premium assistance programs funded by Medicaid or CHIP, we asked Medicaid and CHIP officials in each state and the District of Columbia if the state used Medicaid or CHIP funds to subsidize the purchase of private health insurance.[4] We compared the information we received from state officials with information in published reports and with information received from the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that oversees states' Medicaid and CHIP programs—about which states have authority to operate premium assistance programs. On this basis, we identified 47 premium assistance programs in 39 states.[5] Officials

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[2]See J. Alker, *Choosing Premium Assistance: What Does State Experience Tell Us?* (Washington, D.C.: Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, May 2008); D. Belnap and S. Schwartz, *Premium Assistance*, Pub. No. 2007-109 (Portland, Maine: National Academy for State Health Policy, October 2007); M. Herman, *Premium Assistance Programs: Potential Help for the Uninsured?* (Washington, D.C.: Forum for State Health Policy Leadership, National Conference of State Legislatures, 2004); C. Shirk and J. Ryan, *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?* Issue Brief no. 812 (Washington, D.C.: National Health Policy Forum, The George Washington University, July 2006); and C. Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs* (Portland, Maine: National Academy for State Health Policy, April 2003).

[3]See Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 301(c), 123 Stat. 8, 11-15, 57-63.

[4]Our review of premium assistance programs did not include Medicaid- or CHIP-funded programs in which the states only subsidize premiums for insurance packages they created, as opposed to private health insurance packages created by employers or insurance companies. At least three states—Arkansas, Massachusetts, and New Mexico—have such programs.

[5]Officials from 11 states and the District of Columbia reported not having a Medicaid- or CHIP-funded premium assistance program. An official representing 1 of those states reported having a premium assistance program in the past that was discontinued, and an official representing another state reported plans to implement a program in the future.

in 8 of the 39 states reported having 2 premium assistance programs; states with more than one program may have separate programs for different populations or one program funded by Medicaid and another funded by CHIP. From August through October 2009, we administered a survey to officials representing the 47 premium assistance programs we identified.[6] To ensure the clarity and precision of our survey questions, we pretested the survey with officials from 3 states and with a researcher who has extensively studied premium assistance programs. The survey requested information about several dimensions of a state's premium assistance program, including funding sources, operating authorities, type of private health insurance subsidized, eligibility, enrollment, covered benefits, premiums, cost sharing, expenditures, and cost-effectiveness. The survey also asked respondents about any challenges faced in implementing and operating their premium assistance programs, as well as for their views on the effect that CHIPRA may have on those challenges. Of the 47 Medicaid- or CHIP-funded premium assistance programs we identified, we received survey responses from officials representing 45 programs in 37 states, although not every official responded to every question.[7] We relied on the data as reported by the state officials who were identified as the primary contact for the premium assistance program and did not independently verify these data or ask CMS to verify them. However, we reviewed all responses for reasonableness and internal consistency, and followed up with state officials for clarification where necessary. Based on these activities, we determined these data were sufficiently reliable for the purpose of our report.

We conducted our work from June 2009 through January 2010 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. This framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

Background

Before the enactment of CHIPRA, states had the authority to operate premium assistance programs under Medicaid and CHIP. CHIPRA provides states with additional options for operating premium assistance programs.

Premium Assistance Authorities that Preceded CHIPRA

The Medicaid and CHIP statutes authorize states to obtain federal funding for the operation of state premium assistance programs. A key authority to operate a Medicaid-funded premium assistance program was provided through section 1906 of the Social Security Act (SSA),[8] which authorizes states to use Medicaid funds to purchase group health plan

[6]In states with more than one Medicaid- or CHIP-funded premium assistance program, officials were asked to complete a separate survey for each program.

[7]We did not receive completed surveys from North Carolina or West Virginia and thus were unable to include information about these two states' premium assistance programs.

[8]Section 1906 of the SSA was enacted in the Omnibus Budget Reconciliation Act of 1990 and amended in the Balanced Budget Act of 1997. See Pub. L. No. 101-508, title IV, § 4402(a)(2), 104 Stat. 1388-161, as amended by Pub. L. No. 105-33, title IV, § 4741(b), 111 Stat. 523.

coverage for eligible individuals.[9] Programs operated under section 1906 of the SSA are commonly referred to as Health Insurance Premium Payment programs. The authority to operate CHIP-funded premium assistance programs was first provided in section 2105(c)(3) of the SSA, which permits states to provide coverage to CHIP-eligible children and their families by subsidizing premiums for group health plan and nongroup coverage.[10] Table 1 compares requirements for premium assistance programs under these two authorities, both of which existed prior to the enactment of CHIPRA.

[9]Other, less frequently used authorities through which states can operate Medicaid-funded premium assistance programs are provided in sections 1902 and 1905 of the SSA. Section 1902(a)(10)(F) of the SSA allows states to use Medicaid funds to pay premiums for COBRA continuation coverage for certain low-income individuals who are not currently eligible for Medicaid but who are likely to become Medicaid eligible in the future and have high health care costs. COBRA, an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, included provisions giving employees the opportunity to remain in their employer's group coverage when they would otherwise lose coverage. Section 1905(a) of the SSA allows states to use Medicaid funds to subsidize premiums for group or nongroup health coverage. In this report, we define nongroup health coverage as coverage purchased from the individual market.

[10]States with CHIP Medicaid expansion programs can operate CHIP-funded premium assistance programs through Medicaid authorities, such as section 1906 of the SSA. States may use one of three basic options for structuring their CHIP programs: (1) a Medicaid expansion program, (2) a separate child health program, or (3) a combination program that includes both a Medicaid expansion and a separate child health program. States operating CHIP Medicaid expansion programs must follow Medicaid rules, while states operating separate child health programs follow CHIP rules. Section 2105(c)(3) of the SSA permits payment to a state for family coverage under a group health plan or health insurance coverage. Regulations at 42 C.F.R. § 457.1010 implement the provisions of the statute related to family coverage. 42 C.F.R. § 457.10 implements requirements related to premium assistance programs in connection with group health plan coverage. For this report, we consider programs operated under either authority to be premium assistance programs.

Table 1: Requirements under Two Premium Assistance Operating Authorities that Existed Prior to CHIPRA

Category	Section 1906 of the SSA	Section 2105(c)(3) of the SSA
Eligibility	Individuals eligible for Medicaid or for CHIP Medicaid expansion programs.[a]	Individuals eligible for separate child health programs.[a]
Type of coverage subsidized	Group health coverage, such as employer-sponsored insurance.	Group health coverage, such as employer-sponsored insurance, and nongroup coverage.
Enrollees' existing or prior insurance coverage	Enrollees' existing insurance coverage does not affect eligibility.	Enrollees must not have had group health coverage for at least 6 months prior to enrollment in the premium assistance program; reasonable exceptions are permitted.[b]
Mandatory enrollment	Can be mandatory at state option.[c]	Can be mandatory at state option.[d]
Benefits	States must ensure that enrollees have access to the full range of Medicaid benefits[e] either through the group health coverage or wraparound coverage.[f]	States must ensure that children receive benefits meeting requirements for CHIP benchmark coverage, benchmark-equivalent coverage,[g] or Secretary-approved coverage, either through the group health coverage or wraparound coverage.[f]
Premiums and cost sharing[h]	Same as for direct coverage in Medicaid.[i] Premiums are prohibited for individuals with incomes at or below 150 percent of the federal poverty level (FPL) and for pregnant women and certain children at higher incomes. Cost sharing is prohibited for some services and groups[j] and is otherwise limited to nominal amounts for individuals with incomes below 100 percent of the FPL but is allowed to be as much as 20 percent of service costs for individuals with higher incomes. Total premiums and cost sharing for eligible individuals in the family cannot exceed 5 percent of family income.	Same as for direct coverage in CHIP.[i] Specific limits on premiums and cost sharing exist for families with incomes at or below 150 percent of the FPL. Cost sharing is prohibited for preventive care. Total premiums and cost sharing for eligible individuals in the family cannot exceed 5 percent of family income.
Cost-effectiveness	States may enroll eligible individuals as long as the cost, including premiums and cost sharing under the group health plan and any additional administrative costs, is likely to be less than the cost of an equivalent set of Medicaid services.[k] Cost-effectiveness can be measured on an individual or aggregate basis.	States may enroll eligible individuals in health coverage as long as the cost is not greater than the cost of direct coverage.[i] Cost-effectiveness can be measured on an individual or aggregate basis.
Covering noneligibles	States may pay premiums to enroll noneligible family members in a group health plan if cost-effective and needed to obtain coverage for the Medicaid-eligible family members. Federal matching funds are not available to pay cost sharing for noneligibles.	States can purchase coverage for noneligible family members, provided the family includes at least one CHIP-eligible child. Coverage for the family must cost no more than direct coverage for the eligible children.[i]
Employer contribution	No minimum contribution specified.	States must identify a minimum contribution representative of the employer-sponsored market in their state and evaluate whether substitution of public for private coverage is occurring.

Source: GAO analysis of Medicaid and CHIP statutes and regulations, and interviews with CMS officials.

[a]Individuals eligible for Medicaid include certain mandatory populations, such as low-income pregnant women and children. Other populations, including those with higher incomes, can be covered at state option. CHIP was designed to provide health care coverage to children in families whose incomes, while low, are above Medicaid's eligibility requirements. States may use one of three basic options for structuring their CHIP programs: (1) a Medicaid expansion program, (2) a separate child health program, or (3) a combination program that includes both a Medicaid expansion and a separate child health program. States operating CHIP Medicaid expansion programs must follow Medicaid rules, while states operating separate child health programs follow CHIP rules.

[b]See 42 C.F.R. § 457.810 (2009). Requiring enrollees to be without coverage for at least 6 months is intended to discourage crowd-out—the substitution of public health insurance for private insurance. Separate child health programs are required to monitor the extent to which crowd-out may be occurring among enrollees in direct coverage, and programs with eligibility thresholds above 200 percent of the FPL may be required to implement policies to minimize crowd-out. For more information on state efforts to monitor crowd-out, see GAO, *State Children's Health Insurance Program: CMS Should Improve Efforts to Assess whether SCHIP Is Substituting for Private Insurance*, GAO-09-252 (Washington, D.C.: Feb. 20, 2009).

[c]Eligible children cannot be denied direct coverage if their parent fails to enroll them in the group health plan.

[d]States must offer individuals the option, at initial enrollment and at redetermination of eligibility, of enrolling in direct coverage if their group health plan does not provide certain enrollee protections specified in the CHIP regulations, including the opportunity for external review of delays or denials of health services.

[e]Medicaid requires certain mandatory benefits, such as physician and hospital services, and states can also cover optional benefits such as dental services and prescription drugs.

[f]Benefits wraparound coverage refers to states' direct coverage of any services to which premium assistance enrollees are entitled but which are not covered under their private health insurance plan.

[g]A benchmark benefits package is a package substantially equivalent to the benefits provided by the Federal Employee Health Benefits Program's Blue Cross/Blue Shield Standard Option, a health benefits plan offered by the state to its own employees, or a plan offered by the HMO with the largest commercial enrollment in the state. A benchmark equivalent package has the same actuarial value as one of the benchmark plans.

[h]Premiums are payments required for insurance coverage for a given period of time. Cost sharing is an out-of-pocket payment for part of the cost of services used by an enrollee and can include coinsurance, copayments, and deductibles.

[i]Direct coverage refers to the coverage provided to Medicaid or CHIP enrollees who are not in premium assistance. For example, in Medicaid, direct coverage includes all mandatory benefits and any optional benefits that the state has chosen to provide.

[j]Cost sharing is largely prohibited for children in mandatory coverage groups; for any preventive services for children, regardless of income; and for pregnancy-related services.

[k]Cost-effectiveness is defined in section 1906(e)(2) of the SSA and further explained in section 3910 of the State Medicaid Manual.

Under certain circumstances, a state may operate a premium assistance program that does not follow the Medicaid or CHIP statutory requirements that usually apply. To do so, states must obtain a waiver under section 1115 of the SSA. Section 1115 of the SSA allows the Secretary of HHS to waive certain statutory requirements in the case of experimental, pilot, or demonstration projects that are likely to promote program objectives.[11] According to CMS officials, section 1115 waivers have been used to permit states to provide premium assistance to populations not otherwise eligible for coverage and to subsidize the cost of nongroup health coverage. Additionally, premium assistance programs operated under section 1115 waivers may not have to comply with all of the benefits, premiums, cost sharing, and cost-effectiveness requirements outlined in table 1 above.

Additional Options for Premium Assistance Available under CHIPRA

When CHIPRA was enacted in February 2009, it created additional options for premium assistance in Medicaid and CHIP, including allowing states to subsidize ESI for Medicaid- and CHIP-eligible children and their parents if the employer's contribution is at least 40 percent of the total premium cost, enrollment in the program is voluntary, and the ESI meets certain criteria.[12] CHIPRA requires states that operate premium assistance programs under these new options to provide the full range of Medicaid or CHIP benefits through benefits wraparound coverage, where states directly cover any services to which premium assistance enrollees are entitled but which are not covered under their private health insurance. Additionally, CHIPRA specifies limits on the amount of enrollee cost sharing. Premium

[11]Through a waiver under section 1115 of the SSA, the Secretary of HHS could, for example, allow states to provide services or cover individuals not normally eligible for Medicaid and CHIP and provide federal funds for costs not otherwise eligible for payment.

[12]See Pub. L. No. 111-3, § 301, 123 Stat. at 57-63. While CHIPRA provided additional options for states to operate premium assistance programs, no state had implemented a program under these new options as of November 2009.

assistance programs that operate under the new Medicaid option created through CHIPRA do not have to meet a cost-effectiveness requirement.

CHIPRA also amended the Employee Retirement Income Security Act (ERISA) of 1974, the Internal Revenue Code of 1986, and the Public Health Service Act to make eligibility for Medicaid or CHIP a basis for enrollment in a group health plan for which the Medicaid or CHIP enrollees are otherwise eligible to enroll. As a result of this change, new Medicaid or CHIP enrollees may not be required to wait for an open enrollment period to enroll in a group health plan and participate in the state's premium assistance program because Medicaid or CHIP eligibility would be considered a qualifying event. CHIPRA also requires health plan administrators to provide information about plan benefit packages when requested by states and requires employers to provide written notice to employees about the availability of premium assistance if their state operates a program.

Results In Brief

Funding Source, Operating Authority, and Type of Insurance Coverage Subsidized

- Based on our survey results from 45 of the 47 premium assistance programs, 30 premium assistance programs were funded solely by Medicaid, 6 programs were funded solely by CHIP, and 9 programs were funded by both Medicaid and CHIP.

- According to our survey results, most premium assistance programs operated under the authority of section 1906 of the SSA (29), while 16 programs operated under section 1115 waivers, 1 program operated under section 2105(c)(3) of the SSA, and 9 programs operated under other authorities. These other authorities included section 1902(a)(10)(F) of the SSA which allows states to use Medicaid funds to pay premiums for COBRA continuation coverage for certain low-income individuals and section 1905(a) of the SSA which allows states to use Medicaid funds to subsidize private health insurance premiums. In some cases, states' premium assistance programs operated under multiple authorities.

- All but two premium assistance programs operated statewide. The two exceptions were Florida's program, which operated in five counties, and Colorado's CHP+ at Work program, which operated only in the metropolitan Denver area.

- Based on our survey results, all 45 of the premium assistance programs subsidized premiums for some type of group coverage, with 32 of the programs subsidizing premiums for multiple types of group coverage. More specifically, 43 programs subsidized coverage for ESI, 32 subsidized COBRA coverage, and 17 subsidized other group health coverage. Of the 43 premium assistance programs that subsidized ESI,

    - 8 required that employers contribute a minimum amount toward the cost of enrollees' premiums, with the required minimum contribution ranging from 25 to 50 percent;

    - 5 limited participation to employers with a certain number of employees, typically fewer than 100; and

    - 8 had data on the number of participating employers; among those 8 programs, the number of participating employers ranged from less than 30 to nearly 4,800.

- Twenty-one of the 45 premium assistance programs subsidized nongroup coverage, namely policies purchased from the individual market.

Enclosure I provides additional information on the funding source, operating authority, and type of insurance coverage subsidized for states' premium assistance programs.

Eligibility and Enrollment Policies

- Twenty-five of the 37 premium assistance programs that provided eligibility information covered only low-income individuals—which the Census Bureau defines as those with family incomes at or below 200 percent of the FPL. The remaining 12 programs covered at least some individuals with family incomes above 200 percent of the FPL, but only 2 of the 12 covered any individuals with incomes above 300 percent of the FPL.

- Most of the 37 programs that provided eligibility information covered children (32 programs), parents (29 programs), or pregnant women (27 programs).[13] Fewer covered childless adults (13 programs) or other groups (12 programs).[14]

- Thirty-three of the 45 premium assistance programs subsidized premiums for noneligible family members under certain circumstances—for example, if the noneligible family member had to be enrolled in the health plan for the eligible family member to obtain coverage.

- At least 8 programs targeted premium assistance to individuals with high health care costs, such as pregnant women, premature or low birth weight infants, or individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), diabetes, or cancer.

- According to our survey results, fewer than half of the premium assistance programs (20) mandated enrollment for any eligible individuals. Programs with mandatory enrollment required individuals to enroll in the premium assistance program if they had access to private health insurance and met the program's eligibility requirements; individuals who chose not to enroll in premium assistance would not be eligible for direct coverage from the state.[15] Of the 20 programs with mandatory enrollment, 19 required all eligible individuals to enroll, while the remaining program required only certain individuals to enroll.

- Eleven programs, 10 of which were at least partially funded by CHIP, imposed waiting periods, requiring individuals to be without group health insurance for some period of time—typically either 3 or 6 months—before they could enroll in the premium assistance program.

- All 45 programs collected documentation of individuals' enrollment in private health insurance. Most also reported collecting a description of benefits offered by that insurance plan (38 programs), as well as documentation of premiums (35 programs).

- Reported premium assistance program enrollment—generally as of June 30, 2009—ranged from fewer than 10 individuals in 5 programs to more than 10,000 individuals in 4 programs—including 1 program with more than 30,600 individuals. Over half of the programs (25) had fewer than 1,000 enrollees.

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[13]The "parents" coverage group includes legal guardians, and the "pregnant women" coverage group includes unborn children. Under CHIP, states may choose to extend eligibility to unborn children and provide prenatal care and delivery. *See* 67 *Fed. Reg.* 61956 (Oct. 2, 2002).

[14]The "other" coverage groups most commonly reported were certain unemployed individuals, aged or disabled individuals, or individuals receiving Supplemental Security Income benefits.

[15]Certain exceptions may apply. For example, states that operate their premium assistance programs under the authority of section 1906 of the SSA cannot deny direct coverage to eligible children if their parent fails to enroll them in a group health plan.

Enclosure II provides additional information about eligibility and enrollment policies for states' premium assistance programs.

Benefits, Premiums, and Cost Sharing

- Officials from almost three-quarters of the state premium assistance programs (33) reported that the program has minimum requirements that private health insurance benefit packages must meet in order to qualify for a state subsidy. The most commonly reported requirements were requiring coverage of certain services specified by the state (20 programs)—such as inpatient and outpatient hospital and physician services—and meeting state health insurance regulations (16 programs). Twelve programs did not have any requirements for the private health insurance benefit package.

- Thirty-three premium assistance programs provided complete benefits wraparound coverage to some or all eligible individuals, meaning the state supplemented private insurance benefits up to the level individuals would receive under direct coverage.[16] Of the remaining 12 programs, 3 programs provided partial benefits wraparound coverage to some or all eligible individuals[17] and 9 programs provided no benefits wraparound coverage.[18]

- Officials from 34 premium assistance programs reported that they did not monitor access to care or utilization of services for individuals enrolled in the premium assistance program. Of the remaining 11 programs, 7 programs monitored utilization of services, 3 programs monitored both utilization of services and access to care, and 1 program did not report whether it conducted either type of monitoring. Programs' monitoring efforts typically involved examining enrollees' private insurance claims, often in the process of determining whether their enrollment in premium assistance was cost-effective for the state.

- According to our survey results, at least 26 programs paid 100 percent of the enrollee's share of the premium. Officials from a few other programs indicated that the program may pay 100 percent of the enrollee's share of the premium under certain circumstances. Other programs varied in the extent to which they subsidized premiums. For example, some programs paid a specified dollar amount and some paid a percentage that was less than 100 percent of the enrollee's share of the premium. Officials from 2 programs did not provide information on the way in which the program subsidizes enrollees' premiums.

[16]Two programs also provided at least some benefits wraparound coverage to noneligible family members.

[17]In programs that provide partial benefits wraparound coverage, the state supplements private health insurance benefits, but not to the level an individual would receive under direct coverage. For example, states may supplement only certain benefits, such as dental care, mental health care, or immunizations.

[18]The authority under which a premium assistance program operates determines whether or not the program has to provide benefits wraparound coverage. For example, programs operating under section 1115 waivers may not have to provide benefits wraparound coverage. Of the nine programs that provided no benefits wraparound coverage, two had a mandatory enrollment policy for eligible individuals. Additionally, three of the nine programs that provided no benefits wraparound coverage subsidized premiums for nongroup coverage.

- Officials from most programs (34) reported that the programs paid some or all cost sharing for at least some eligible individuals; cost sharing refers to out-of-pocket costs other than premiums, such as copayments.[19] The remaining 11 programs did not pay cost sharing for any eligible individuals.[20]

- At least 5 programs limited the amount of out-of-pocket costs, such as premiums and cost sharing, which an individual enrolled in the premium assistance program would have to pay in a year.

Enclosure III provides additional information about benefits, premiums, and cost sharing in states' premium assistance programs.

Expenditures and Cost-Effectiveness Policies

- Among the 42 premium assistance programs that provided expenditure data, annual expenditures for premium assistance totaled at least $222 million.[21] Actual expenditures, however, were higher, because 32 of the 42 programs did not provide data for all program activities. For example, 19 of the 42 programs did not report the amount of expenditures for program administration.[22] Furthermore, 3 premium assistance programs did not provide any data on program expenditures.

- Thirty-eight programs required premium assistance to be cost-effective, meaning that the cost for Medicaid or CHIP to provide premium assistance is likely less than the cost to provide direct coverage. Of those 38 programs, 32 assessed cost-effectiveness on an individual or family level, while the remaining 6 assessed cost-effectiveness on an aggregate (or programwide) level. To calculate cost-effectiveness, 18 of the 38 programs reported using the method outlined in the State Medicaid Manual—referred to as the Secretary's method—and 20 used another method.[23]

[19]Of the 34 programs that reported paying at least some cost sharing, 21 reported paying all cost sharing for all eligible individuals covered through premium assistance, 12 reported paying some cost sharing for all eligible individuals, and 1 reported paying all cost sharing for some eligible individuals and no cost sharing for the other eligible individuals. Additionally, 1 program reported paying some cost sharing for noneligible family members.

[20]Of those 11 programs that did not pay cost sharing for any groups covered by premium assistance, 2 programs were mandatory programs, in that individuals eligible for premium assistance were required to enroll.

[21]Data were generally for the 12-month period from July 1, 2008, through June 30, 2009, and included both the state and federal share.

[22]Additionally, 24 of the 36 programs that provided benefits wraparound coverage did not report the amount of expenditures in this category. Twenty-six of the 34 programs that paid at least some cost sharing did not report the amount of expenditures in this category.

[23]Section 3910 of the State Medicaid Manual indicates that an individual's enrollment in premium assistance is cost-effective if the amount paid for premiums, coinsurance, deductibles, other cost sharing, as well as administrative costs, is likely to be less than the Medicaid expenditures for an equivalent set of services. To determine whether premium assistance is cost-effective, section 3910 offers a calculation states can use. This calculation—referred to as the Secretary's method—involves a seven-step process that takes into account information on the group health plan, average Medicaid costs, Medicaid cost for services included in the group health plan, the group health plan cost for included services, an adjustment for coinsurance and deductible amounts, and additional administrative costs for processing the group health plan information. States that use another method for determining cost-effectiveness must have their methodology approved by CMS.

- Officials from 18 programs reported having conducted an analysis to assess whether any cost savings were realized as a result of their state's premium assistance program. Twelve programs submitted documentation that showed cost savings relative to direct coverage, but we could not calculate average savings due to differences in the types of documentation provided.

Enclosure IV provides additional information about expenditures for and cost-effectiveness policies in states' premium assistance programs.

Challenges Officials Reported to Program Implementation and Operation, and the Effect of CHIPRA

- Program officials who responded to our survey identified several challenges to premium assistance program implementation and operation. The two most frequently identified challenges were a limited number of individuals with access to private health insurance (18 programs), and difficulty identifying individuals with access to private health insurance (17 programs).

- Officials from 13 programs reported that the provisions in CHIPRA would have an effect on the challenges they identified to premium assistance program implementation or operation. For example, officials from 9 of the 13 programs specifically noted that the CHIPRA provision making eligibility for premium assistance a qualifying event for enrollment in a group health plan would have an effect on the challenges; officials from some of the programs noted that this provision will make it easier to enroll individuals in the premium assistance program.

- Officials from 11 programs reported that they were planning or considering premium assistance program changes due to CHIPRA. For example, officials from 5 of these programs reported that as a result of CHIPRA the state may expand its existing program—by including new populations, such as CHIP-eligible individuals, or expanding benefits, such as adding benefits wraparound coverage for dental services.

Enclosure V provides additional information about challenges states reported in implementing and operating their premium assistance programs.

Agency Comments

We provided a draft of this report to HHS for comment, which in turn provided us with written comments from CMS (see encl. VI). Overall, CMS commended GAO's data collection efforts and noted that the data will provide a useful baseline to inform Congress and other stakeholders about Medicaid- and CHIP-funded premium assistance programs. CMS noted that while it did due diligence to verify the accuracy of the information we presented in the report, the agency was unable to verify all of the data reported by the state officials who responded to our Web-based survey. As we explained in the description of our methodology, this report presents information provided to us by the state officials identified as primary contacts for each premium assistance program; we did not ask CMS to verify states' responses. Finally, in its comments, CMS summarized some of the findings from our draft report, including information on state premium assistance program operating authorities and the extent to which programs provided benefits wraparound coverage. We have updated these data in our final report based upon further clarification we received from state officials. CMS also provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Administrator of CMS and other interested parties. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in enclosure VII.

Carolyn L. Yocom
Acting Director, Health Care

Enclosures – 7

Enclosure I

States' Premium Assistance Programs' Funding Source, Operating Authority, and Type of Insurance Coverage Subsidized

Table 2: Program Name, Implementation Year, and Source of Federal Funds, by State Premium Assistance Program, 2009

State	Program name	Implementation year	Federal funding source	
			Medicaid	CHIP
Alabama	Health Insurance Premium Program	1993	●	
Alaska	Health Insurance Premium Payments	2006	●	●
Arizona	Employer Sponsored Insurance Program	2008		●
California	Health Insurance Premium Payment	1989	●	
Colorado-1	CHP+ at Work	2007		●
Colorado-2	Health Insurance Buy-In	1992	●	
Florida	Medicaid Reform Opt Out Program	2006	●	
Georgia	Medicaid Health Insurance Premium Payment Program	1994	●	
Idaho-1	Children's Access Card	2004		●
Idaho-2	Access to Health Insurance	2005		●
Illinois	Health Insurance Premium Payment Program	1994	●	
Iowa	Health Insurance Premium Payment Program	1991	●	
Kansas	Health Insurance Premium Payment System	1991	●	
Kentucky	Health Insurance Premium Payment Program	1994	●	
Louisiana	Health Insurance Premium Assistance Program	1991	●	●
Maine	Private Health Insurance Premium	1992	●	
Massachusetts-1	MassHealth Premium Assistance	1997	●	●
Massachusetts-2	Medical Security Program	1997	●	
Minnesota	Cost-effective health insurance reviews for Medical Assistance	1990	●	
Missouri	Health Insurance Premium Payment Program	1992	●	
Montana	Health Insurance Premium Payment	1992	●	
Nebraska	Health Insurance Premium Payment Program	1994	●	
Nevada-1	Check Up Plus	2006		●
Nevada-2	Health Insurance Premium Program	1992	●	
New Hampshire	Health Insurance Premium Payment Program	1991	●	
New Jersey-1	Payment of Premiums Program	1993	●	
New Jersey-2	Premium Support Program	2001	●	●
New York	Employer Sponsored Health Insurance Initiative	2008	●	
North Dakota	Cost Effective Employer-Based Group Health Plans	1993	●	●
Oklahoma	Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC)	2006	●	

State	Program name	Implementation year	Federal funding source	
			Medicaid	CHIP
Oregon-1	Family Health Insurance Assistance Program (FHIAP)	2002	●	●
Oregon-2	Health Insurance Premium Payment/Private Health Insurance Premium Payment	1992	●	
Pennsylvania	Health Insurance Premium Payment Program	1994	●	
Rhode Island	RIte Share	2001	●	●
South Carolina	Health Insurance Premium Payment	1994	●	
South Dakota	Private Health Insurance Premium Payment	2000	●	
Texas	Health Insurance Premium Payment Program	1994	●	
Utah-1	Premium Partnership for Health Insurance	2003	●	●
Utah-2	Medicaid Operations Buyout Program	1990	●	
Vermont	Catamount Health & Employer-sponsored premium assistance	2007	●	
Virginia-1	Family Access to Medical Insurance Security (FAMIS) Select	2005		●
Virginia-2	Health Insurance Premium Payment	1993	●	
Washington	Premium Payment Program	1988	●	
Wisconsin	BadgerCare Health Insurance Premium Program	2001	●	●
Wyoming	Health Insurance Premium Payment Program	1993	●	
Total			**39**	**15**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Federal funding source used.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, the State Children's Health Insurance Program (CHIP), or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

Table 3: Operating Authority, by State Premium Assistance Program, 2009

State[a]	Section 1906 of the SSA[b]	Section 1115 waiver	Section 2105(c)(3) of the SSA[c]	Other
Alabama	●			
Alaska	●			
Arizona		●		
California	●			
Colorado-1		●		
Colorado-2	●			●[d]
Florida		●		
Georgia	●			
Idaho-1		●		
Idaho-2		●		
Illinois	●			
Iowa	●			●[e]
Kansas	●			
Kentucky	●			
Louisiana	●			
Maine	●			
Massachusetts-1	●	●	●	
Massachusetts-2		●		
Minnesota	●			●[e]
Missouri	●			
Montana	●			
Nebraska	●			
Nevada-1		●		
Nevada-2	●			
New Hampshire	●			
New Jersey-1	●			●[e]
New Jersey-2		●		
New York		●		
North Dakota	●			●[d,e]
Oklahoma		●		
Oregon-1		●		
Oregon-2	●			
Pennsylvania	●			
Rhode Island	●			
South Carolina	●			●[d]
South Dakota				●[f]
Texas	●			
Utah-1		●		
Utah-2	●			●[e]
Vermont		●		

State[a]	Section 1906 of the SSA[b]	Section 1115 waiver	Section 2105(c)(3) of the SSA[c]	Other
Virginia-1		●		
Virginia-2	●			
Washington	●			●[d,e]
Wisconsin		●		
Wyoming	●			
Total	**29**	**16**	**1**	**9**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Operating authority used.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]SSA is an abbreviation for the Social Security Act.

[c]Section 2105(c)(3) of the SSA permits payment to a state for family coverage under a group health plan or health insurance coverage. Regulations at 42 C.F.R. § 457.1010 implement the provisions of the statute related to family coverage. 42 C.F.R. § 457.10 implements requirements related to premium assistance programs in connection with group health plan coverage. For this report, we consider programs operated under either authority to be premium assistance programs.

[d]These programs also operated under the authority of section 1902(a)(10)(F) of the SSA, which allows states to use Medicaid funds to pay premiums for COBRA continuation coverage. COBRA, an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, allows employees the opportunity to remain in their employer's group coverage when they would otherwise lose coverage.

[e]Officials representing this program also reported that the program operated under the authority of section 1905(a) of the SSA, which allows states to use Medicaid funds for the cost of insurance premiums for certain Medicaid-eligible individuals.

[f]According to state officials, this program operated under the authority of section 1903(a)(7) of the SSA, which allows for federal funding for the proper and efficient administration of states' Medicaid programs.

Table 4: Type of Private Health Insurance Coverage Subsidized, by State Premium Assistance Program, 2009

State[a]	Group health insurance coverage			Nongroup coverage
	Employer-sponsored	COBRA[b]	Other group coverage	
Alabama	●	●	●	
Alaska	●		●	
Arizona	●			
California	●	●		●
Colorado-1	●			
Colorado-2	●	●	●	●
Florida	●	●		
Georgia	●	●	●	●
Idaho-1	●			●
Idaho-2	●			
Illinois	●	●	●	●
Iowa	●	●		●
Kansas	●	●		
Kentucky	●			
Louisiana	●	●		
Maine	●	●		●
Massachusetts-1	●	●		
Massachusetts-2		●		●
Minnesota	●	●	●	●
Missouri	●	●	●	●
Montana	●	●	●	●
Nebraska	●	●	●	●
Nevada-1	●			
Nevada-2			●	
New Hampshire	●	●	●	●
New Jersey-1	●	●		●
New Jersey-2	●			
New York	●	●		
North Dakota	●	●	●	●
Oklahoma	●			
Oregon-1	●	●	●	●
Oregon-2	●	●		
Pennsylvania	●	●		
Rhode Island	●	●	●	
South Carolina	●	●		●
South Dakota	●	●		●
Texas	●	●		
Utah-1	●			
Utah-2	●	●	●	●

State[a]	Group health insurance coverage			Nongroup coverage
	Employer-sponsored	COBRA[b]	Other group coverage	
Vermont[c]	●	●		
Virginia-1	●	●	●	●
Virginia-2	●	●		
Washington	●	●	●	●
Wisconsin	●			
Wyoming	●			
Total	**43**	**32**	**17**	**21**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Type of insurance coverage subsidized.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]COBRA, an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985, allows employees the opportunity to remain in their employer's group coverage when they would otherwise lose coverage.

[c]Officials representing this program indicated that the program also subsidized premiums for "Catamount Health," a state-sponsored program in the nongroup market.

Table 5: State Premium Assistance Programs with Employer Contribution or Size Requirements, 2009

State[a]	Minimum employer contribution	Limits on participation based on employer size
Arizona	30 percent	No requirement
Colorado-1	50 percent	No requirement
Idaho-2	50 percent[b]	2 to 50 employees
Massachusetts-1	50 percent[c]	No requirement
Nevada-1	50 percent[b]	2 to 50 employees
New Jersey-2	50 percent	2 or more employees
Oklahoma	25 percent[b]	Less than 100 employees
South Dakota	No requirement	[d]
Utah-1	50 percent[b]	No requirement

Source: GAO Web-based survey administered to states' premium assistance programs.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]The survey response indicated that the minimum employer contribution applied to the premium for the employee, while other responses did not make this distinction.

[c]The employer contribution requirement pertained only to certain groups covered by Massachusetts' premium assistance program, specifically children and childless adults.

[d]Officials from this program indicated that the program had a requirement on employer size, but did not indicate the limit on the size of employers.

Table 6: State Premium Assistance Programs with Data on the Number of Employers Participating, June 30, 2009

State[a]	Employer size			Total employers
	Fewer than 50 employees	50 to 199 employees	200 or more employees	
Colorado-1	—	—	1	1
Florida	1	—	—	—
Idaho-2	121	NA	NA	121
Nevada-1	27	NA	NA	27
Oklahoma	4,529	223	NA	4,752
Texas	[b]	[b]	[b]	3,500[c]
Washington	[b]	[b]	[b]	782[d]
Wisconsin	[b]	[b]	[b]	172[e]

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

— = Response not provided.

NA = Not applicable; the program does not allow participation by employers of this size.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]Officials with these programs reported that data by employer size were not available.

[c]Program officials reported the total number of employers as of August 24, 2009.

[d]Program officials reported the total number of employers as of June 26, 2009.

[e]Program officials reported the total number of employers as of June 30, 2008.

States' Premium Assistance Programs' Policies Regarding Eligibility and Enrollment

Table 7: Income Eligibility Standards as a Percentage of the Federal Poverty Level (FPL) and State Subsidy of Premiums for Noneligible Family Members, by State Premium Assistance Program, June 30, 2009

	Children							
State[a]	Under age 1 year	Ages 1 through 5 years	Ages 6 through 18 years	Pregnant women/ unborn children[b]	Parents/ legal guardians	Childless adults	Other individuals[c]	Subsidize premiums for noneligible family members[d]
Alabama	0-133	0-133	0-100	0-133	0-11			Yes
Alaska	150-185	150-185	150-185	150-185	150-185	150-185	100-250	Yes
Arizona	140-200	133-200	100-200					Yes
California	—	—	—	—	—	—	—	No
Colorado-1	134-205	134-205	100-205	134-205				Yes
Colorado-2	0-133	0-133	0-100	0-133	0-60			Yes
Florida	—	—	—	—	—	—	—	Yes
Georgia	—	—	—	—	—	—	—	Yes
Idaho-1	133-185	133-185	100-185					No
Idaho-2				133-185	25-185	0-185		No
Illinois	0-200	0-133	0-133	0-200	0-133		0-100	Yes
Iowa	0-200	0-133	0-133	0-200	0-133	0-133	0-250	Yes
Kansas	100-150	100-149	100-132					Yes
Kentucky	—	—	—	—	—	—	—	Yes
Louisiana	0-250	0-250	0-250	0-200	0-250			Yes
Maine	0-185	0-150	0-150	0-200	0-200	0-100		Yes
Massachusetts-1	0-300	0-300	0-300	0-200	0-133	0-200		No
Massachusetts-2							0-400	Yes
Minnesota	0-275	0-150	0-150	0-275	0-100		0-100	Yes
Missouri	0-299	0-299	0-299	0-185	—		0-85	Yes
Montana	0-133	0-133	0-100	0-150	0-40		0-58	Yes
Nebraska	—	—	—	—	—	—	—	No
Nevada-1	133-200	133-200	100-200		100-200		100-200	No
Nevada-2	0-133	0-133	0-100	0-185	0-130		133-185	Yes
New Hampshire	0-185	0-185	0-185	133-185				Yes
New Jersey-1	—	—	—	—	—	—	—	Yes
New Jersey-2	0-350	0-350	0-350		0-200			No
New York					0-150	0-100	0-150	Yes
North Dakota	0-133	0-133	0-100	0-133	0-83		0-225	Yes
Oklahoma				0-200	0-200	0-200		No
Oregon-1	0-185	0-185	0-185	0-185	0-185	0-185		No
Oregon-2	0-185	0-133	0-100	0-185	0-41			Yes
Pennsylvania	—	—	—	—	—	—	—	Yes
Rhode Island	0-250	0-250	0-250	0-250	0-185			Yes

State[a]	Children			Pregnant women/ unborn children[b]	Parents/ legal guardians	Childless adults	Other individuals[c]	Subsidize premiums for noneligible family members[d]
	Under age 1 year	Ages 1 through 5 years	Ages 6 through 18 years					
South Carolina	—	—	—	—	—	—	—	Yes
South Dakota	0-140	0-140	0-140	0-133	0-52			No
Texas	0-185	0-133	0-100	0-185	0-13			Yes
Utah-1	133-200	133-200	0-200		0-150	0-150		No
Utah-2	0-133	0-133	0-100	0-133	0-42	0-150	0-185	Yes
Vermont					0-200	0-200		No
Virginia-1	134-200	134-200	134-200					Yes
Virginia-2	0-133	0-133	0-133	0-133	0-30			Yes
Washington	0-200	0-200	0-200	0-185	0-79	0-100		Yes
Wisconsin	0-250	0-250	0-250	0-300	0-200	0-200		Yes
Wyoming	0-133	0-133	0-100	0-133	0-36			Yes

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

— = Response not provided.

Blank = Population not covered.

Notes: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, the State Children's Health Insurance Program (CHIP), or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

The FPL is updated annually to reflect changes in the cost of living and varies according to family size.

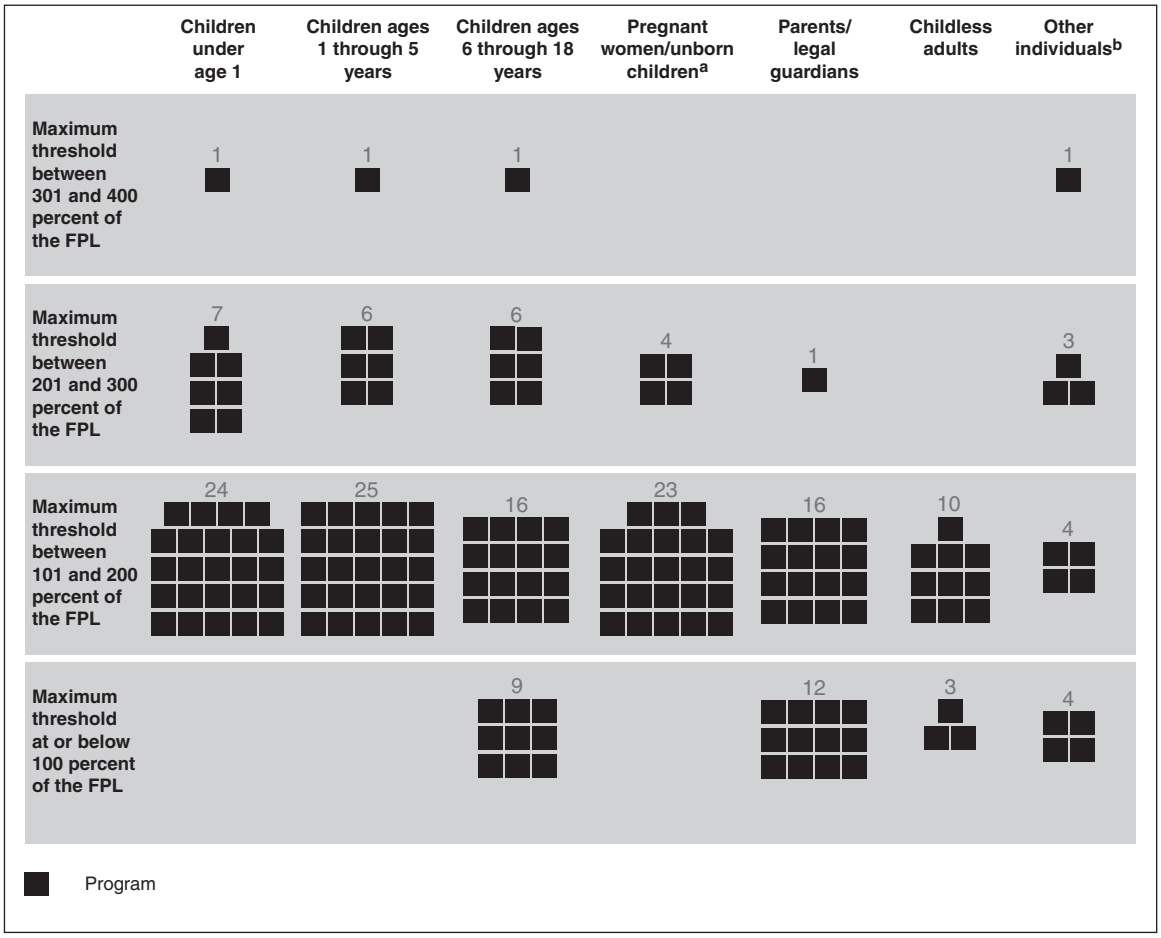
[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]Under CHIP, states may choose to extend eligibility to unborn children and provide prenatal care and delivery. *See* 67 *Fed. Reg.* 61956 (Oct. 2, 2002).

[c]Individuals commonly included in this group were certain unemployed individuals, aged or disabled individuals, or individuals receiving Supplemental Security Income benefits.

[d]Programs may subsidize premiums (provide incidental coverage) for noneligible family members under certain circumstances—for example, if the noneligible family member must be enrolled in the health plan for the eligible family member to obtain coverage.

Figure 1: Number of State Premium Assistance Programs that Set Maximum Family Income Eligibility Thresholds within Selected Ranges, Expressed as Percentages of the FPL, by Coverage Group, June 30, 2009



Source: GAO Web-based survey administered to states' premium assistance programs.

Notes: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey. Officials from 8 premium assistance programs did not provide information on income eligibility thresholds.

The FPL is updated annually to reflect changes in the cost of living and varies according to family size.

[a]Under CHIP, states may choose to extend eligibility to unborn children and provide prenatal care and delivery. *See* 67 *Fed. Reg.* 61956 (Oct. 2, 2002).

[b]Individuals commonly included in this group were certain unemployed individuals, aged or disabled individuals, or individuals receiving Supplemental Security Income benefits.

Table 8: Enrollment Policies, by State Premium Assistance Program, 2009

State[a]	Mandatory enrollment[b]			Months individuals are required to be without group health insurance before enrollment in premium assistance is permitted[c]
	Yes, for all individuals	Yes, for some individuals	No, enrollment is voluntary for all individuals	
Alabama			●	[d]
Alaska			●	[d]
Arizona			●	3
California			●	[d]
Colorado-1			●	[d]
Colorado-2			●	[d]
Florida			●	[d]
Georgia			●	[d]
Idaho-1			●	6
Idaho-2			●	6
Illinois			●	[d]
Iowa	●			[d]
Kansas	●			[d]
Kentucky	●			[d]
Louisiana	●			[d]
Maine			●	[d]
Massachusetts-1	●			6[e]
Massachusetts-2	●			[d]
Minnesota	●			[d]
Missouri	●			[d]
Montana	●			[d]
Nebraska			●	[d]
Nevada-1	●			6
Nevada-2	●			[d]
New Hampshire			●	[d]
New Jersey-1	●			[d]
New Jersey-2		●[f]		3
New York			●	[d]
North Dakota	●			[d]
Oklahoma			●	[d]
Oregon-1			●	6
Oregon-2	●			[d]
Pennsylvania	●			[d]
Rhode Island	●			[d]
South Carolina			●	[d]
South Dakota			●	[d]
Texas			●	[d]

State[a]	Mandatory enrollment[b]			Months individuals are required to be without group health insurance before enrollment in premium assistance is permitted[c]
	Yes, for all individuals	Yes, for some individuals	No, enrollment is voluntary for all individuals	
Utah-1			●	3
Utah-2			●	[d]
Vermont	●			12
Virginia-1			●	4
Virginia-2			●	[d]
Washington			●	[d]
Wisconsin	●			3[g]
Wyoming	●			—
Total	**19**	**1**	**25**	

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Enrollment policy used.

— = Response not provided.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]Enrollment was considered to be mandatory if individuals who met the program's eligibility requirements—which may have included having access to cost-effective private health insurance—were required to enroll in the premium assistance program in order to get Medicaid or CHIP benefits. Although a premium assistance program may have mandatory enrollment for all eligible individuals, under section 1906 of the Social Security Act (SSA), eligible children cannot be denied direct coverage if their parent fails to enroll them in a group health plan.

[c]Programs may permit reasonable exceptions.

[d]This program does not require individuals to be uninsured for any period of time before enrolling in premium assistance.

[e]Officials from this program reported that only children receiving premium assistance through CHIP were required to be uninsured for the 6 months prior to enrollment in premium assistance.

[f]Officials from this program reported that the program did not have mandatory enrollment for individuals with incomes less than 134 percent of the FPL.

[g]Officials from this program reported that childless adults were required to be uninsured for the 12 months prior to enrollment in premium assistance.

Table 9: Number of Individuals and Families Covered, by State Premium Assistance Program, June 30, 2009

State[a]	Number of Medicaid- or CHIP-eligible individuals[b]	Number of noneligible family members[b]	Total number of individuals[b]	Number of families[c]
Alabama	6	0	6	0
Alaska	16	29	71[d]	14
Arizona	3	—	3	1
California	1,033	[e]	[f]	[e]
Colorado-1	103	61	164	42
Colorado-2	432	[e]	432	403
Florida	21	[e]	[f]	13
Georgia	937	[e]	[f]	882
Idaho-1	133	0	133	0
Idaho-2	347	0	347	[e]
Illinois	145	[e]	[f]	67
Iowa	3,019	4,319	8,086[d]	1,949
Kansas	[e]	[e]	[e]	[e]
Kentucky	6	—	[f]	6
Louisiana	2,621	831	3,452	743
Maine	869	172	1,041	314
Massachusetts-1	30,653	0	30,653	18,397
Massachusetts-2	3,500	2,034	5,534	3,500
Minnesota	20,276	—	20,276	6,569
Missouri	1,549	1,297	2,846	781
Montana	747	[e]	747	267
Nebraska	320	750	1,070	285
Nevada-1	4	0	4	4
Nevada-2	48	110	158	[e]
New Hampshire	127	98	229[d]	94
New Jersey-1	73	58	131	64
New Jersey-2	300	0	300	95
New York	1,380	—	[f]	255
North Dakota	54	24	78	[e]
Oklahoma	14,217	[e]	14,217	[e]
Oregon-1	6,692	0	6,692	3,506
Oregon-2	658	205	863	[e]
Pennsylvania	26,693	[e]	[f]	12,462
Rhode Island	8,493	[e]	8,493	[e]
South Carolina	215	40	255	211
South Dakota	70	[e]	[f]	[e]
Texas	7,822	849	8,671	1,351
Utah-1	728	0	728	331
Utah-2	200	5	205	200

State[a]	Number of Medicaid- or CHIP-eligible individuals[b]	Number of noneligible family members[b]	Total number of individuals[b]	Number of families[c]
Vermont	6,989	0	6,989	0
Virginia-1	449	342	791	147
Virginia-2	2,199	[e]	[f]	1,489
Washington	[e]	[e]	6,041	3,393
Wisconsin	1,110	[e]	[f]	304
Wyoming	8	—	8	5

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

— = Response not provided.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]The data on the number of individuals enrolled in states' premium assistance programs were generally as of June 30, 2009. However, the following programs provided data as of a different date: Arizona – April 1, 2009; Georgia – July 31, 2009; Maine – August 19, 2009; Minnesota – January 1, 2009; Nevada-2 – August 14, 2009; New Hampshire – July 17, 2009; Texas – August 24, 2009; Utah-1 – August 1, 2009; Washington – June 26, 2009; and Wisconsin – June 30, 2008.

[c]The data on the number of families enrolled in states' premium assistance programs were generally as of June 30, 2009. However, the following programs provided data as of a different date: Alaska – July 31, 2009; Arizona – April 1, 2009; Georgia – July 31, 2009; Minnesota – January 1, 2009; New Hampshire – July 17, 2009; Texas – August 24, 2009; Utah-1 – August 1, 2009; Virginia-1 – July 1, 2009; Washington – June 26, 2009; and Wisconsin – June 30, 2008.

[d]We have reported the data as they were reported to us in states' survey responses even though the data on the number of individuals and noneligible family members enrolled in these states' premium assistance programs did not equal the data provided on the total number of individuals enrolled in the programs.

[e]According to program officials, data on enrollment were not available for the specified category.

[f]These programs provided data on the number of eligible individuals enrolled in premium assistance, but either indicated that data were not available on the total number of individuals enrolled in premium assistance programs or did not provide data on the total number of individuals enrolled in premium assistance programs.

States' Premium Assistance Programs' Benefits, Premiums, and Cost Sharing

Table 10: Minimum Requirements Programs Have for Private Health Insurance Benefit Packages to Qualify for a State Subsidy, by State Premium Assistance Program, 2009

State[a]	No requirement	Must cover certain services[b]	Must meet state insurance regulations	Must meet other requirements
Alabama				●[c]
Alaska			●	
Arizona		●		
California				●[d]
Colorado-1		●		
Colorado-2		●		
Florida			●	
Georgia		●		
Idaho-1		●	●	
Idaho-2		●	●	
Illinois	●			
Iowa		●		
Kansas		●		
Kentucky	●			
Louisiana		●		
Maine			●	
Massachusetts-1		●	●	●[e]
Massachusetts-2			●	
Minnesota	●			
Missouri	●			
Montana	●			
Nebraska			●	
Nevada-1			●	
Nevada-2		●		
New Hampshire			●	
New Jersey-1				●[f]
New Jersey-2				●[e]
New York		●		
North Dakota	●			
Oklahoma		●	●	●
Oregon-1		●	●	●[g]
Oregon-2			●	
Pennsylvania	●			
Rhode Island			●	●[h]
South Carolina	●			
South Dakota	●			
Texas		●		●[i]
Utah-1		●		●[i]

State[a]	No requirement	Must cover certain services[b]	Must meet state insurance regulations	Must meet other requirements
Utah-2		●		●[h]
Vermont		●	●	●[j]
Virginia-1	●			
Virginia-2		●		
Washington	●			
Wisconsin		●	●	
Wyoming	●			
Total	**12**	**20**	**16**	**12**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Requirement.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, the State Children's Health Insurance Program (CHIP), or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]See table 11 for a list of services required.

[c]In order to qualify for a state subsidy, the private insurance benefit package was required to cover the services needed to treat the premium assistance program applicant's high-cost condition.

[d]In order to qualify for a state subsidy, the private insurance benefit package was required to cover the premium assistance program applicant's high-cost medical condition and be a comprehensive health coverage policy.

[e]In order to qualify for a state subsidy, the private insurance benefit package was required to meet one of the CHIP benchmarks for benefit packages.

[f]At a minimum, the plan was required to cover the services most utilized by a client.

[g]In order to qualify for a state subsidy, the private insurance benefit package was required to be actuarially equivalent to federally mandated Medicaid benefits.

[h]In order to qualify for a state subsidy, the private insurance benefit package was required to be actuarially equivalent to the benefit package eligible individuals would receive under direct coverage.

[i]In order to qualify for a state subsidy, the private insurance benefit package was required to offer a lifetime maximum benefit at or above a certain amount.

[j]In order to qualify for a state subsidy, the private insurance benefit package must have a deductible of $500 or less.

Table 11: Services Programs Require Private Health Insurance Benefit Packages to Cover in Order to Qualify for a State Subsidy, by State Premium Assistance Program, 2009

State[a]	Inpatient hospital	Physician services	Outpatient hospital	Pharmacy or prescription drugs	Mental health	Well-baby and well-child care	Immunizations	Other services
Arizona	●	●	●	●	●	●	●	
Colorado-1	●	●				●	●	
Colorado-2	●	●	●	●				●
Georgia	●	●	●	●	●			
Idaho-1	●	●	●					
Idaho-2	●	●	●	●	●	●		●
Iowa	●	●	●					
Kansas	●	●	●	●				
Louisiana	●	●	●	●				
Massachusetts-1	●	●	●	●	●	●	●	
Nevada-2	●	●	●	●	●	●	●	●
New York	●	●	●		●	●	●	●
Oklahoma	●	●	●	●	●			●
Oregon-1	●	●	●	●	●	●	●	●
Texas	●	●	●	●				●
Utah-1	●	●		●		●	●	
Utah-2	●	●	●	●	●	●	●	
Vermont	●	●	●	●	●			●
Virginia-2	●	●	●	●			●	
Wisconsin	●	●	●					
Total	**20**	**20**	**18**	**15**	**10**	**9**	**9**	**8**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Service required.

Notes: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

Table includes only state premium assistance programs which reported a requirement that the private health insurance benefit package cover certain services specified by the program to qualify for the state subsidy (see table 10). States may cover directly any services to which eligible individuals are entitled that are not covered by the private health insurance plan; see table 12 for more information.

[a]Some states operated two premium assistance programs. For program names, see table 2.

Table 12: Level of Benefits Wraparound Provided to Eligible Individuals, by State Premium Assistance Program, 2009

State[a]	Complete benefits wraparound provided[b]	Partial benefits wraparound provided[c]
Alabama	●	○
Alaska	●	○
Arizona	○	○
California	●	○
Colorado-1	○	○
Colorado-2	●	○
Florida	○	○
Georgia	●	○
Idaho-1	○	●
Idaho-2	○	○
Illinois	●	○
Iowa	●	○
Kansas	●	○
Kentucky	●	○
Louisiana	●	○
Maine[d]	●	○
Massachusetts-1	◉	○
Massachusetts-2	○	○
Minnesota	●	○
Missouri	●	○
Montana	●	○
Nebraska	●	○
Nevada-1	○	○
Nevada-2	●	○
New Hampshire	●	○
New Jersey-1	●	○
New Jersey-2	●	○
New York	●	○
North Dakota[d]	●	○
Oklahoma	○	○
Oregon-1	○	○
Oregon-2	●	○
Pennsylvania	●	○
Rhode Island	●	○
South Carolina	●	○
South Dakota	○	○
Texas	●	○
Utah-1	○	◉
Utah-2	●	○
Vermont[e]	◉	◉

State[a]	Complete benefits wraparound provided[b]	Partial benefits wraparound provided[c]
Virginia-1	○	●
Virginia-2	●	○
Washington	●	○
Wisconsin	●	○
Wyoming	●	○

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = All individuals.

⦿ = Some individuals.

○ = No individuals.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]States that offer complete benefits wraparound coverage supplement private insurance benefits up to the level an individual would receive under direct coverage.

[c]States that offer partial benefits wraparound coverage supplement private insurance benefits, but not to the level an individual would receive under direct coverage. For example, states may supplement only certain benefits, such as dental care, mental health care, or immunizations.

[d]State also provided benefits wraparound coverage to noneligible family members.

[e]Individuals eligible for the state's Vermont Health Access Program and receiving subsidized employer-sponsored insurance (ESI) through the premium assistance program received complete benefits wraparound coverage. Individuals receiving subsidized ESI but not eligible for the Vermont Health Access Program receive benefits wraparound coverage for prevention and maintenance of specified chronic conditions.

Table 13: Monitoring of Enrollees' Access to Care and Utilization of Services, by State Premium Assistance Program, 2009

State[a]	State monitors access to care	State monitors utilization of services
Alabama		
Alaska		
Arizona		
California		
Colorado-1		
Colorado-2		
Florida	—	—
Georgia		●
Idaho-1		
Idaho-2		
Illinois		●
Iowa		
Kansas	●	●
Kentucky		
Louisiana		
Maine		●
Massachusetts-1		
Massachusetts-2		
Minnesota		
Missouri		
Montana		
Nebraska		
Nevada-1		
Nevada-2		
New Hampshire		●
New Jersey-1		
New Jersey-2		
New York		
North Dakota		
Oklahoma		
Oregon-1		
Oregon-2		
Pennsylvania		
Rhode Island	●	●
South Carolina		●
South Dakota		
Texas	●	●
Utah-1		
Utah-2		●
Vermont		

State[a]	State monitors access to care	State monitors utilization of services
Virginia-1		
Virginia-2		
Washington		
Wisconsin		●
Wyoming		
Total	**3**	**10**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = State monitors.

— = Response not provided.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

Table 14: Description of Monthly Premium Subsidy Provided, by State Premium Assistance Program, 2009

State[a]	Premium subsidy
Alabama	100 percent of enrollee's share of premium
Alaska	100 percent of enrollee's share of premium
Arizona	Up to $100 per eligible child
California	100 percent of enrollee's share of premium
Colorado-1	Up to $100 per eligible enrollee
Colorado-2	Portion of premium that covers eligible enrollee (amount policyholder would save if eligible enrollee were not covered)
Florida	Pays up to amount state would pay if individual were in a Medicaid Reform Plan which varies between individuals[b]
Georgia	100 percent of policyholder's share of premium
Idaho-1	Up to $100 per enrollee with $300 family cap
Idaho-2	Up to $100 per member
Illinois	100 percent of enrollee's share of premium
Iowa	—
Kansas	100 percent of enrollee's and policyholder's share of premium
Kentucky	100 percent of enrollee's share of premium
Louisiana	100 percent of enrollee's share of premium, up to $200
Maine	100 percent of enrollee's share of premium
Massachusetts-1	Portion of enrollee's premium
Massachusetts-2	80 percent of enrollee's share of premium, up to $450 per individual or $1,110 per family
Minnesota	100 percent of enrollee's share of premium
Missouri	100 percent of policyholder's share of premium
Montana	100 percent of enrollee's share of the premium
Nebraska	100 percent of enrollee's share of premium
Nevada-1	50 percent of employee's coverage cost, up to $100 per enrollee
Nevada-2	100 percent of enrollee's share of premium
New Hampshire	100 percent of enrollee's share of premium
New Jersey-1	100 percent of enrollee's share of premium
New Jersey-2	100 percent of employee's share of premium
New York	100 percent of employee's share of premium
North Dakota	• 100 percent of individual/family's share of premium • If an individual has to spend down assets to qualify for Medicaid, then the premium subsidy is reduced by that amount
Oklahoma	• At least 60 percent of the cost of covering the employee and 85 percent of the cost of covering the spouse • Employee's premium contributions are limited to 3 percent of gross income
Oregon-1	50 to 95 percent of eligible family member's premium
Oregon-2	100 percent of enrollee's share of premium
Pennsylvania	—
Rhode Island	100 percent of enrollee's share of premium

State[a]	Premium subsidy
South Carolina	• 100 percent of enrollee's share of premium • If necessary to cover enrollee, program will pay the policyholder's share of premium
South Dakota	100 percent of enrollee's share of premium
Texas	100 percent of policyholder's share of premium
Utah-1	• Up to $150 for covered adults • $120 for children whose insurance covers dental services and $100 for children whose insurance does not cover dental services
Utah-2	Up to 100 percent of enrollee's share of premium[c]
Vermont	Percentage of enrollee's share of premium based on enrollee's income
Virginia-1	Up to $100 per month towards enrollee's share of premium
Virginia-2	The lesser of the cost-effective rate for each Medicaid-eligible individual or the employee's share of premium[d]
Washington	100 percent of enrollee's share of premium
Wisconsin	100 percent of enrollee's share of premium
Wyoming	100 percent of enrollee's share of premium

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

— = Response not provided.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]A Medicaid Reform Plan is a managed care health plan—chosen by Medicaid-eligible individuals—which provides them with health coverage.

[c]Officials from this premium assistance program indicated that, depending on the cost-effectiveness calculation, the state's premium subsidy may be negotiated with the enrollee to be an amount less than 100 percent of the enrollee's share of the premium.

[d]Officials from this premium assistance program indicated that the cost-effective rate was based on several factors including age, gender, and region of the state where the eligible individual lived.

Table 15: Extent to Which the State Paid for Cost Sharing Expenses (Excluding Premiums), by Coverage Group and State Premium Assistance Program, 2009

	Coverage groups				
State[a]	Children	Pregnant women/ unborn children	Parents	Childless adults	Other individuals
Alabama[b]	⊙	⊙	⊙	NA	⊙[c]
Alaska	●	●	●	●	●
Arizona	○	○	○	○	○
California[d]	⊙	⊙	⊙	⊙	⊙
Colorado-1	○	○	NA	NA	NA
Colorado-2	●	●	●	●	●
Florida	○	○	○	○	—
Georgia	●	●	●	●	—
Idaho-1	○	NA	NA	NA	NA
Idaho-2	NA	○	○	○	NA
Illinois[b]	⊙	⊙	⊙	○	⊙
Iowa	●	●	●	●	—
Kansas	●	●	●	●	●
Kentucky	●	●	●	●	—
Louisiana	●	●	●	NA	NA
Maine	●	●	●	●	○
Massachusetts-1	●	●	●	○	○
Massachusetts-2	NA	NA	NA	NA	○
Minnesota	●	●	●	NA	●[e]
Missouri[f]	⊙	⊙	⊙	—	⊙[g]
Montana	●	●	●	●	—
Nebraska	⊙	⊙	⊙	⊙	NA
Nevada-1	○	NA	○	NA	○
Nevada-2	●	●	●	●	—
New Hampshire[b]	⊙	⊙	NA	NA	⊙[h]
New Jersey-1[f]	⊙	NA	⊙	⊙	—
New Jersey-2	●	NA	●	NA	—
New York	NA	●	●	●	—
North Dakota	●	●	●	NA	●[i]
Oklahoma[j]	NA	⊙	⊙	⊙	—
Oregon-1	○	○	○	○	NA
Oregon-2[f]	⊙	⊙	⊙	NA	—
Pennsylvania	●	●	●	●	●
Rhode Island	●	●	●	NA	—
South Carolina	⊙	⊙	⊙	⊙	—
South Dakota	○	○	○	○	○
Texas	●	●	●	NA	NA
Utah-1	○	NA	○	○	NA

State[a]	Coverage groups				
	Children	Pregnant women/ unborn children	Parents	Childless adults	Other individuals
Utah-2	⦿	⦿	⦿	⦿	—
Vermont	NA	NA	⦿[k]	⦿[k]	—
Virginia-1	○	NA	NA	NA	NA
Virginia-2	●	●	●	NA	NA
Washington	●	●	●	●	—
Wisconsin	●	●	●	●	NA
Wyoming	●	●	●	NA	NA

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = State pays all cost sharing for the coverage group.

⦿ = State pays some cost sharing for the coverage group.

○ = State pays no cost sharing for the coverage group.

NA = Not applicable; the coverage group is not eligible for the premium assistance program.

— = Response not provided.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]Officials representing these programs indicated that the state paid cost sharing up to the Medicaid allowed payment for a particular service if the enrollee received that service from a Medicaid participating provider. The officials noted that if the enrollee sees a provider that does not participate in Medicaid, the state did not pay cost sharing.

[c]Officials representing this program indicated that the state paid some cost sharing for individuals eligible for the Supplemental Security Income program.

[d]Officials representing this program indicated that the state paid cost sharing up to the Medicaid allowed payment for a particular service if the enrollee received that service from a Medicaid participating provider. The officials noted that if the enrollee sees a provider that does not participate in Medicaid, the state did not pay cost sharing. Additionally, if the enrollee were required to spend down income to qualify for Medicaid, then the state did not pay for cost sharing until the enrollee contributed his or her spend-down amount.

[e]Officials representing this program indicated that the state paid cost sharing for elderly and disabled individuals.

[f]Officials representing these programs indicated that the state paid cost sharing for Medicaid covered services only.

[g]Officials representing this program indicated that the state paid some cost sharing for individuals who are aged, blind, or permanently disabled.

[h]Officials representing this program indicated that the state paid cost sharing for individuals who are blind, disabled, or in foster care.

[i]Officials representing this program indicated that the state paid some cost sharing for individuals who are aged or disabled.

[j]Officials representing this program indicated that the state paid up to $900 for cost sharing if the household's out-of-pocket expenses had exceeded 5 percent of their gross income.

[k]Officials representing this program indicated that the state paid all cost sharing for parents with incomes below 185 percent of the federal poverty level (FPL) and childless adults with incomes below 150 percent of the FPL.

States' Premium Assistance Programs' Expenditures and Cost-Effectiveness Policies

Table 16: Program Expenditures, by Type of Expenditure and State Premium Assistance Program, July 1, 2008, through June 30, 2009

State[a]	Premium subsidies	Benefits wraparound	Cost sharing	Administration	Total
Alabama	$17,051	$31,176	$0	$0	$48,227[b]
Alaska	34,498	—	—	—	34,498[b]
Arizona	900	NA	NA	0	900[b]
California	5,845,615	[c]	[c]	590,606	6,436,221[b]
Colorado-1	63,018	NA	NA	—	63,018[b]
Colorado-2	935,864	[c]	7,246	[c]	943,110[b]
Florida	10,023	NA	NA	23,400	33,423
Georgia	2,915,713	—	—	—	2,915,713[b]
Idaho-1	130,258	0	NA	18,795	149,053[b]
Idaho-2	305,151	NA	NA	41,348	346,499
Illinois	391,744	[c]	0	[c]	391,744[b]
Iowa	6,498,885	[c]	[c]	1,140,909	7,639,794[b]
Kansas	[c]	[c]	[c]	[c]	736,763[b]
Kentucky	1,073	[c]	[c]	[c]	1,073[b]
Louisiana	2,037,783	5,553,673	0	382,875	7,974,331
Maine	885,834	[c]	[c]	410,000	1,295,834[b]
Massachusetts-1	49,000,000	[c]	[c]	[c]	49,000,000[b]
Massachusetts-2	19,792,990	NA	NA	737,046	20,530,036
Minnesota	14,712,740	[c]	—	[c]	14,712,740[b]
Missouri	3,495,089	[c]	30,179	[c]	3,525,268[b]
Montana	990,551	[c]	[c]	44,935	1,035,486[b]
Nebraska	1,035,560	0	[c]	62,501	1,098,061[b]
Nevada-1	3,574	NA	NA	39,388	42,962
Nevada-2	173,940	407,931	—	—	591,219[b,d]
New Hampshire	911,581	0	0	82,686	994,267[b]
New Jersey-1	584,943	[c]	16,638	[c]	601,581[b]
New Jersey-2	206,980	[c]	32,408	[c]	239,388[b]
New York	[c]	[c]	[c]	[c]	[c]
North Dakota	140,590	[c]	[c]	[c]	140,590[b]
Oklahoma	[c]	NA	[c]	[c]	[c]
Oregon-1	20,792,412	NA	NA	3,824,058	24,616,470
Oregon-2	724,360	[c]	[c]	[c]	724,360[b]
Pennsylvania	—	—	—	—	—
Rhode Island	8,174,977	1,793,526	—	[c]	9,968,503[b]
South Carolina	493,659	[c]	[c]	119,042	612,701[b]
South Dakota	268,568	NA	NA	50,000	318,568
Texas	17,478,158	4,330,790	[c]	917,042	22,725,990[b]

State[a]	Premium subsidies	Benefits wraparound	Cost sharing	Administration	Total
Utah-1	609,042	19,200	NA	64,235	823,155[e]
Utah-2	—	[c]	[c]	[c]	520,000[b]
Vermont	23,697,720	454,787	—	1,278,217	25,430,724
Virginia-1	448,288	1,034	NA	83,617	532,939
Virginia-2	4,968,135	[c]	[c]	342,367	5,365,702[b,f]
Washington	6,738,384	—	—	1,040,267	7,778,651[b]
Wisconsin	915,495	764,977	[c]	[c]	1,680,472[b]
Wyoming	50,758	—	—	—	50,758[b]
Total	**196,481,904**	**13,357,094**	**86,471**	**11,293,334**	**222,670,792[g]**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

NA = Not applicable; the premium assistance program did not pay for this item.

— = Response not provided.

Notes: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, the State Children's Health Insurance Program (CHIP), or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

Amounts shown are combined federal and state expenditures.

Data on program expenditures were generally for the period of July 1, 2008, through June 30, 2009. However, the following programs provided data for a different period: Idaho-1 and Idaho-2 – October 1, 2007, through September 30, 2008; Rhode Island and Wisconsin – July 1, 2007, through June 30, 2008; Texas – September 1, 2008, through August 31, 2009; Virginia-2 – 2007 for data on program administration and other expenditures, including Medicaid Management Information System enhancements.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]This figure is the total of all reported expenditures. However, actual total expenditures for the program are likely higher because the program did not provide data for all applicable types of expenditures.

[c]Program officials reported that data were not available.

[d]This figure includes $9,349 in other reported expenditures.

[e]This figure includes $130,678 in other reported expenditures.

[f]This figure includes $55,200 in other reported expenditures.

[g]This figure includes $195,227 in other reported expenditures, as well as $736,763 in total expenditures reported for the Kansas program and $520,000 in total expenditures reported for the Utah-2 program. Additionally, this figure is the total of all reported expenditures. However, actual total expenditures for the programs are likely higher because some programs did not provide data for all applicable types of expenditures.

Table 17: Cost-Effectiveness Requirements and Methods Used, by State Premium Assistance Program, 2009

State[a]	Cost-effectiveness requirement	Level at which cost-effectiveness is assessed		Method used to calculate cost-effectiveness	
		Individual/family	Aggregate	Secretary's method[b]	Other method[c]
Alabama	●	●			●
Alaska	●	●		●	
Arizona	●	●			●
California	●	●			●
Colorado-1		NA	NA	NA	NA
Colorado-2	●	●			●
Florida		NA	NA	NA	NA
Georgia	●	●			●
Idaho-1	●		●		●
Idaho-2	●		●		●
Illinois	●	●			●
Iowa	●	●		●	
Kansas	●	●		●	
Kentucky	●	●		●	
Louisiana	●	●		●	
Maine	●	●		●	
Massachusetts-1	●	●		●	
Massachusetts-2		NA	NA	NA	NA
Minnesota	●	●			●
Missouri	●	●		●	
Montana	●	●		●	
Nebraska	●	●			●
Nevada-1		NA	NA	NA	NA
Nevada-2	●	●		●	
New Hampshire	●	●			●
New Jersey-1	●	●		●	
New Jersey-2	●	●			●
New York	●		●		●
North Dakota	●	●		●	
Oklahoma		NA	NA	NA	NA
Oregon-1		NA	NA	NA	NA
Oregon-2	●	●			●
Pennsylvania	●	●		●	
Rhode Island	●		●	●	
South Carolina	●	●			●
South Dakota	●	●			●
Texas	●	●		●	
Utah-1		NA	NA	NA	NA
Utah-2	●		●		●

State[a]	Cost-effectiveness requirement	Level at which cost-effectiveness is assessed		Method used to calculate cost-effectiveness	
		Individual/family	Aggregate	Secretary's method[b]	Other method[c]
Vermont	●	●			●
Virginia-1	●		●	●	
Virginia-2	●	●			●
Washington	●	●		●	
Wisconsin	●	●			●
Wyoming	●	●		●	
Total	**38**	**32**	**6**	**18**	**20**

Source: GAO Web-based survey administered to states' premium assistance programs.

Legend:

● = Requirement or method used.

NA = Not applicable; the program does not have a cost-effectiveness requirement.

Note: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, CHIP, or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

[a]Some states operated two premium assistance programs. For program names, see table 2.

[b]Section 3910 of the State Medicaid Manual indicates that an individual's enrollment in premium assistance is cost-effective if the amount paid for premiums, coinsurance, deductibles, other cost sharing, as well as administrative costs, is likely to be less than the Medicaid expenditures for an equivalent set of services. To determine whether premium assistance is cost-effective, section 3910 of the State Medicaid Manual offers a calculation states can use. This calculation—referred to as the Secretary's method—involves a seven-step process that takes into account information on the group health plan, average Medicaid costs, Medicaid cost for services included in the group health plan, the group health plan cost for included services, an adjustment for coinsurance and deductible amounts, and additional administrative costs for processing the group health plan information.

[c]Respondents who indicated "other method" used a method designed by the state and approved by the Centers for Medicare & Medicaid Services.

Enclosure V

Challenges to States' Premium Assistance Programs' Implementation and Operation

Table 18: Challenges to Premium Assistance Program Implementation or Operation, 2009

Factor	Number of programs where officials indicated that factor posed a challenge
Limited number of individuals with access to private health insurance	18
Difficulty identifying individuals with access to private health insurance	17
Difficulty enrolling individuals due to limits in the enrollment periods for the private health insurance	16
Difficulty getting necessary information from health plans or employers	16
Limited participation due to voluntary enrollment	16
Difficulty meeting cost-effectiveness standards	13
Program administrative costs too high	6
Available private health plans often do not meet the minimum benefit requirements	4
Challenges providing benefits wraparound coverage	3
State fiscal challenges and other budget constraints	3

Source: GAO Web-based survey administered to states' premium assistance programs.

Notes: Data were obtained from surveys administered from August through October 2009 to officials in 39 states representing 47 premium assistance programs funded by Medicaid, the State Children's Health Insurance Program (CHIP), or both. We received responses from officials representing 45 programs in 37 states; officials from 2 states with premium assistance programs, North Carolina and West Virginia, did not respond to the survey.

Responses from program officials (representing 45 premium assistance programs) were included in this table if they indicated that the factor posed either a great or moderate challenge to program implementation or operation.

Enclosure VI

Agency Comment Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 18 2009

Carolyn Yocom
Acting Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Yocom:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs (GAO-10-258R).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Andrea Palm
Acting Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 17 2009

TO: Andrea Palm
Acting Assistant Secretary for Legislation
Office of the Secretary

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: "Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs" (GAO-10-258R)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the subject GAO Draft Report. The Children's Health Insurance Program Reauthorization Act (CHIPRA) required the GAO to study cost and coverage issues related to State premium assistance programs receiving Medicaid and Children's Health Insurance Program (CHIP) funds. In this draft report, the GAO describes States' premium assistance programs, including the--(1) funding source, operating authority, and type of private health insurance coverage subsidized; (2) policies regarding eligibility and enrollment; (3) benefits, premiums, and cost sharing; (4) expenditures and cost effectiveness policies; and (5) challenges program officials reported in implementing and operating such programs, as well as the effect that CHIPRA may have on these challenges.

From August through October 2009, the GAO administered a web-based survey to officials from the States that had premium assistance programs funded by Medicaid, CHIP, or both. The GAO identified 47 premium assistance programs in 39 States. The survey addressed all of the dimensions identified above. Of the 47 Medicaid or CHIP funded premium assistance programs identified, GAO received survey responses from officials representing 45 programs in 37 States, although not every official in the 37 States responded to each question. The GAO did not include any recommendations for CMS in this report.

Key findings from the report include, but are not limited to--

- Thirty premium assistance programs were funded solely by Medicaid, six programs were funded solely by CHIP, and nine programs were funded by both Medicaid and CHIP;
- Most premium assistance programs operated under the authority of section 1906 of the Social Security Act (the Act) (29), while 16 programs operated under section 1115 waivers, 1 program operated under section 2105(c)(3) of the Act, and 10 programs operated under other authorities;
- Reported premium assistance program enrollment ranged from fewer than 10 individuals in five programs to more than 10,000 individuals in four programs – including one

program with more than 36,600 individuals. Over half of the programs (25) had fewer than 1,000 enrollees;

- Forty-three programs subsidized coverage for employer-sponsored insurance (ESI), 32 subsidized for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, and 17 subsidized other group health coverage;
- Twenty-one of the 45 premium assistance programs subsidized non-group coverage, namely policies purchased from the individual market;
- Fewer than half of the premium assistance programs (20) mandated enrollment for any eligible individuals. Of those, 19 required all eligible individuals to enroll, while the remaining program required only certain individuals to enroll;
- Thirty premium assistance programs provided complete benefits wraparound to some or all eligible individuals. Of the remaining 15 programs, four programs provided partial benefits wraparound, 10 programs provided no benefits wraparound coverage, and one program did not indicate whether or not benefits wraparound coverage was provided;
- Thirty-eight programs required premium assistance to be cost-effective, meaning that the cost for Medicaid or CHIP to provide premium assistance is likely less than the cost to provide direct coverage. Of the 38, 32 assessed cost-effectiveness on an individual or family level, while the remaining six assessed cost-effectiveness on an aggregate level. To calculate the cost-effectiveness, 18 of the 38 programs reported using the method outlined in the State Medicaid Manual and 20 used another method;
- Officials from 34 premium assistance programs reported that they did not monitor access to care or utilization of services for individuals enrolled in the premium assistance program. Of the remaining 11 programs seven programs monitored utilization of services, three programs monitored both utilization of services and access to care, and one program did not report whether it conducted either type of monitoring;
- The two most common challenges identified by program officials who responded to the survey were a limited number of individuals with access to private health insurance (18 programs) and difficulty identifying individuals with access to private insurance (17 programs); and
- Officials from nine of 13 programs specifically noted that the CHIPRA provision making eligibility in premium assistance a qualifying event would make it easier to enroll individuals in the premium assistance program;

CMS Response

We commend the GAO for its data collection efforts in examining the various dimensions of how Medicaid and CHIP premium assistance programs operate under title XIX and title XXI of the Act, and believe these data will prove useful in serving as a baseline to inform Congress and others stakeholders in this subject area.

We appreciate the fact that the report identifies that the GAO utilized a web-based survey administered to States' premium assistance program officials as the primary source of State-specific premium assistance information however, we request that the GAO clarify in the beginning of the report that while CMS did due diligence to verify the accuracy of the information in the report, when possible, we were not able to verify all of the data. We want to

make clear that CMS is unable to verify the majority of the State-reported information for a variety of reasons, including the lack of specificity of whether the data relate to the title XIX or title XXI component, the inclusion of information (e.g., break out by type of employer sponsored coverage) in the report that is not currently collected at the Federal level, and the lack of CMS access to the detailed source information. GAO has also indicated previously that it does not expect CMS to verify the State-reported data.

We have provided some technical comments that we hope will be helpful in refining your draft. CMS appreciates the opportunity to comment on this draft report and we look forward to working with the GAO on this and other issues.

Enclosure VII

GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Acknowledgments

In addition to the contact named above, Michelle Rosenberg, Assistant Director; Christie Enders; Nancy Fasciano; Martha R. W. Kelly; Drew Long; Kevin Milne; Dan Ries; Lillian Shields; Malissa G. Winograd; and Suzanne Worth made key contributions to this report.

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