2/6/07

OVERVIEW: MEDICAID PROGRAM REVIEW

INFORMATION REQUESTED DURING FEBRUARY 5-6 MEETINGS
PHPG FOLLOW-UP

Requestor	Information Requested	Response
Governor's Office		
Anna Kim	Methodology used in review of DHSS eligibility regulation crosswalk	The attorney conducting the review examined the crosswalk in its entirety and followed-up on a small number of items which appeared to merit further examination (this was the "spot review" mentioned in the report). No issues ultimately were identified, either from the comprehensive read-through or any of the follow-up activities.
Anna Kim	Definition of "uninsured" used in reporting Alaska's uninsured rate of 17.8 percent.	The structure of the CPS questionnaire elicits uninsured status for the entire preceding year. The percentage therefore is intended to represent the portion of the population that went without insurance for the entire year. (It is likely, however, that some people still respond based on their status at the time of the survey.)
House		
Representatives Joule & Meyer	Table documenting fiscal impact of report recommendations	See **Attachment 1**, which contains estimates for the recommendations included in the PowerPoint® matrix
Representative Meyer	Information on premium and other cost-sharing requirements imposed on Medicaid/SCHIP beneficiaries in other states	See attached GAO report (**Attachment 2**), Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries. The data is several years old, but still is an accurate depiction of cost sharing approaches across the 50 states.

Requestor	Information Requested	Response
Representative Crawford	Information on strategies employed in other states to increase health insurance coverage, including through employer-sponsored insurance initiatives	See attached NASHP report (**Attachment 3**), SCHIP Buy-In Programs, describing initiatives in a number of states directed at children with incomes above SCHIP eligibility limits. Also attached are summaries of four premium assistance programs mentioned in the PHPG report and operated under Medicaid waivers (**Attachments 4a – 4d**): Massachusetts Insurance Partnership; Oklahoma O-EPIC Program; Rhode Island RIte Share; and Vermont Catamount Health. Each program has a website with additional information. Oklahoma's, which is particularly well-designed, can be found at www.ok.oepic.gov. Full disclosure: PHPG assisted in the development of the Oklahoma and Vermont initiatives and the original Rhode Island waiver program onto which RIte Share was later added.

Requestor	Information Requested	Response
Representative Hawker	Information on nature of DD waitlist population	The DD waitlist is comprised of persons eligible to receive waiver services, but who generally have not had a "triggering" event sufficient to result in enrollment upon the opening of a slot. Examples of triggering events (as discussed in the February 2006 report, Ad Hoc Committee on the Developmental Disability Waitlist – Recommendations for Change) include: an individual at imminent risk of substantial harm or significant regression; an individual living in an unsafe or unhealthy circumstance; an individual whose medical or behavioral needs are creating a hazard; an individual without supports who is at risk of involvement with the Justice System; an individual at risk of institutionalization in a psychiatric hospital, nursing home or jail, who would be unable to live in the community without supports; and an individual living with a caregiver who is no longer able to continue in that capacity such as the death of a parent.
Representative Hawker	Support for claim that "Bring the Kids Home" initiative is saving money	Basis for finding was the 2005 "Bring the Kids Home Annual Report", which stated that 2004-2005 RPTC expenditures grew by the smallest amount (5.5 percent) since 1998, concurrent with the first significant shift from out-of-state to in-state placements. The primary driver for savings in the BTKH model is reduced lengths-of-stay
Senate		
Senator Davis	Language for a resolution encouraging preventive care and early intervention	See **Attachment 5**, with proposed language.

ATTACH. 1

SUMMARY OF PHPG RECOMMENDATIONS FOR ALASKA MEDICAID

Program Area	Recommendation	Action Required	Potential Dollar Impact (Annual)
CAMA Program	• Convert to federally matched model under a Section 1115a Waiver	• Federal approval • Possible statutory action (if covered populations/services change)	• Federal portion of $1.8 million budgeted • Current FMAP is 57.58%, so savings would be $1,036,440 (this amount also could be invested into the program to cover more Alaskans)
Pharmaceutical Pricing	• Differential pricing strategies, by location	• Regulatory amendments	• Dollar impact would depend on specific nature of tiered pricing policy (DHSS is researching this now) • Every one percent reduction in expenditures would save about $1 million (state and federal)
Personal Care Attendant (PCA)/HCBS Waivers	• Comprehensive pre-admission screening • Convert to waiver service • Target alternatives for individuals with Alzheimer's dementia	• Regulatory changes • Possible statutory action (if covered populations/services change) • Federal approval	• Intent of recommendation is to slow the rate of growth in long term care expenditures, including by converting PCA to a waiver service and offering less costly service settings for Alzheimer's patients • Every one percentage point reduction in the growth rate for LTC saves approximately $2.5 million (state and federal)
Nursing Facilities	• Provider tax • 6% tax allowed by Federal Law	• Statutory approval	• $2 million in new federal funds associated with Medicaid-funded days, assuming no upper payment limit restrictions on the tax (note – tax also would be assessed on Medicare/private pay days for an unknown dollar impact)
Developmentally Disabled	• Mandatory, uniform cost reporting tool • Explore federal matching funds through waiver	• Regulatory Changes • Federal approval	• $5 million in new federal funds if the entire unmatched amount is made matchable • Additional savings from cost reporting requirements (not quantifiable)
"Bring the Kids Home"	• Reinvest savings in early intervention/community based services	• Evaluate options for enhanced community based services	• BTKH Annual Report for 2005 describes reduced RPTC growth rate concurrent with implementation of the initiative (and associated reduced lengths-of-stay). Long term dollar impact not quantifiable at this stage
Tribal Health	• Designate tribal system as managed care entity Construct tribally-operated nursing facility	• Develop application for Section 1115a waiver • Develop detailed cost-benefit analysis	• $90-$100 million in new federal funds (amount in federal fiscal year 2005 would have been $93 million)
PERM and MMIS	1) Legislative monitoring	1) Routine status reporting	• Intent of recommendation is to avoid federal disallowances (recoupments) associated with incorrect payments. • Some savings may accrue as the result of reduced payment errors and improved utilization management functionality

ATTACH #2

United States General Accounting Office

GAO

Report to Congressional Requesters

March 2004

MEDICAID AND SCHIP

States' Premium and Cost Sharing Requirements for Beneficiaries

G A O

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GAO-04-491

March 2004

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Highlights

Highlights of GAO-04-491, a report to congressional requestors

MEDICAID AND SCHIP

States' Premium and Cost Sharing Requirements for Beneficiaries

Why GAO Did This Study

Over 50 million low-income adults and children receive health insurance coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). Federal law allows states to require beneficiary contributions, such as premiums and cost sharing (coinsurance, copayments, and deductibles), for at least some Medicaid and SCHIP beneficiaries. GAO was asked to (1) identify and compare states' Medicaid and SCHIP beneficiary contribution requirements for children, (2) identify states' Medicaid beneficiary contribution requirements for adults, and (3) determine the extent to which states' Medicaid and SCHIP beneficiary contribution requirements have changed since 2001.

GAO surveyed Medicaid and SCHIP program offices in the 50 states and the District of Columbia about their beneficiary contribution requirements as of August 2003, including their requirements for specific population groups and for six selected services, such as inpatient hospital, physician services, and prescription drugs. For each population group covered, states were asked to indicate the portion of the group charged beneficiary contributions by selecting "all," "most," "some," or "none." GAO also interviewed officials of the Centers for Medicare & Medicaid Services (CMS) regarding the Medicaid and SCHIP statutory requirements for beneficiary contributions.

www.gao.gov/cgi-bin/getrpt?GAO-04-491

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

GAO's survey found that children were more likely to be subject to beneficiary contributions, specifically premiums and cost sharing, in SCHIP than in Medicaid. Overall, 26 states reported charging premiums for a portion of children—"some," "most," or "all"—in SCHIP, compared to 9 states in Medicaid. Twenty-five states charged cost sharing for some portion of children in SCHIP, compared to 6 states for Medicaid. States used copayments as the primary form of cost sharing for children. Most states that reported charging cost sharing applied copayment requirements to the six health care services.

Most states reported requiring beneficiary contributions from adults enrolled in Medicaid. Twenty-five states charged premiums, generally charging portions of certain populations, such as adults with disabilities. Over 40 states charged cost sharing to most, if not all, adults, including those with disabilities, noninstitutionalized elderly persons, and parents. Copayments were the predominate form of cost sharing. States most frequently reported copayments for prescription drugs and physician services.

States with Copayments for Selected Services and Populations, as of August 1, 2003

	Number of states		
Population	Inpatient hospital	Physician services	Prescription drugs
Children			
Medicaid	4	5	4
SCHIP	12	21	22
Medicaid adults			
Pregnant women	2	2	2
Noninstitutionalized elderly	18	25	35
Adults with disabilities	19	34	36
Parents	16	22	31

Source: GAO analysis of state survey responses.

From the beginning of their 2001 state fiscal years through August 1, 2003, 34 states reported increasing and 10 states reported decreasing the amount of beneficiary contributions required in Medicaid, SCHIP, or both. For the 33 states that provided information on the amount of increases, premium increases to existing requirements ranged from $2 a month to $30 a month. Other states added new premium requirements, some of which were as much as several hundred dollars a month. In most instances, reported copayment increases were generally limited to $5 or less.

GAO asked CMS officials to provide technical comments on the statutory and regulatory information on Medicaid and SCHIP beneficiary contributions, which were incorporated as appropriate.

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Abbreviations

ADL	activity of daily living
AHRQ	Agency for Healthcare Research and Quality
CMS	Centers for Medicare & Medicaid Services
ER	emergency room
FPL	federal poverty level
IADL	instrumental activity of daily living
HHS	Department of Health and Human Services
MEPS	Medical Expenditures Panel Survey
SCHIP	State Children's Health Insurance Program

GAO
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United States General Accounting Office
Washington, DC 20548

March 31, 2004

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Sherrod Brown
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
House of Representatives

Over 50 million low-income adults and children receive health insurance coverage largely through two federal-state programs—Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid generally covers low-income families and individuals who are aged or disabled, while SCHIP provides health care coverage to children in families whose incomes, while low, are above Medicaid's eligibility requirements. Health insurance often includes beneficiary contribution requirements of some type, which require the insured individual to pay some portion of medical expenses. The most common types of beneficiary contribution requirements are premiums—a payment required for insurance coverage for a given period of time—and cost sharing—an out-of-pocket payment for part of the cost of services used by a beneficiary. Medicaid and SCHIP limit the use of beneficiary contribution requirements. The Medicaid statute limits the amount of the premiums that can be charged and prohibits states from instituting cost sharing provisions for certain categories of individuals, such as children under age 18 and pregnant women. Under SCHIP, federal law caps the amount of beneficiary contributions that can be charged for certain children and exempts preventive services for certain children from any cost sharing. States must seek authority from the federal government to waive these requirements to implement beneficiary contributions beyond Medicaid and SCHIP limits.

Opinions differ over the extent to which beneficiary contributions are appropriate and useful tools for managing health care utilization among low-income populations. Premiums are sometimes viewed as promoting personal responsibility by having the beneficiary participate in the cost of coverage. Proponents of cost sharing believe that copayments can make individuals more price-conscious consumers of health care services, which may reduce the use of unnecessary services. Others believe that cost sharing requirements may limit service use, such as physician visits, causing individuals to defer necessary treatment, resulting in more severe conditions and potentially higher expenses. Concerns have been expressed that, as states seek to increase the use of beneficiary contributions for Medicaid, SCHIP, or both programs, eligible individuals may reduce their program participation or use of services.

You asked us to (1) identify and compare states' Medicaid and SCHIP beneficiary contribution requirements for children, (2) identify states' Medicaid beneficiary contribution requirements for adults, and (3) determine the extent to which states' Medicaid and SCHIP beneficiary contribution requirements have changed since 2001.

To identify the beneficiary contribution requirements in states' Medicaid and SCHIP programs, we surveyed offices of each program in the 50 states and the District of Columbia.[1] The survey asked which beneficiary contribution requirements existed in the state as of August 1, 2003, the populations subject to each requirement, and changes made to the requirements since the beginning of the state's 2001 fiscal year.[2] For Medicaid, states were asked to report on requirements for nine population groups—children, children with special needs, pregnant women, individuals in nursing homes and institutions, noninstitutionalized elderly persons, adults with disabilities, medically needy,[3] parents, and any other populations defined by the state. We divided these categories into two

[1]Throughout this report, the term "states" refers to the 50 states and the District of Columbia.

[2]The time periods for states' fiscal years were different: most used a fiscal year that began July 1 and others used either the federal fiscal year (Oct. 1 through Sept. 30) or another time period.

[3]Medically needy individuals are generally people who fall into one of the eligibility categories that are composed of broad groups—children, individuals with disabilities, or the elderly—and who incur medical expenses such that their income, less these expenses, makes them eligible for Medicaid.

groups—children and adults.[4] For SCHIP, states were asked to report on requirements for children, children with special needs, and any other populations defined by the state. For each population group covered, such as children or individuals in nursing homes, the state was asked to indicate the portion of the group charged each of the four types of beneficiary contributions (premiums, copayments, coinsurance, and deductibles) by selecting "all," "most," "some," or "none." States were also asked to indicate if their Medicaid or SCHIP program did not cover a specific population. The survey asked states about their cost sharing requirements for six selected services (inpatient hospital, outpatient hospital, physician services, prescription drugs, nonemergency use of the emergency room (ER), and dental). In addition to their survey responses, states submitted documentation of the amounts of their beneficiary contribution requirements. We corroborated survey responses with documentation provided by states and other available data on states' Medicaid and SCHIP programs. We also contacted officials from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees states' Medicaid and SCHIP programs, regarding the Medicaid and SCHIP statutory requirements for beneficiary contributions. We performed our work from July 2003 through March 2004 in accordance with generally accepted government auditing standards.

Results in Brief

Our state survey showed that children were more likely to be subject to beneficiary contributions, specifically premiums and cost sharing, in SCHIP than in Medicaid. Overall, 26 states reported charging premiums for some portion of children—either "some," "most," or "all"—in SCHIP compared to 9 states in Medicaid. Twenty-five states charged cost sharing for some portion of children in SCHIP, while 6 states had cost sharing requirements for some portion of children in Medicaid. States used copayments as the primary form of cost sharing for children. Most states that reported charging cost sharing applied copayment requirements to the six health care services that we considered. The amount of beneficiary contributions required for children varied on the basis of factors such as

[4]The adult population group can include both children and adults. For example, a child (aged 18 or younger) may be placed in a nursing home or institution, be pregnant, or be considered medically needy. However, since the majority of the individuals in this group were likely to be over the age of 18, we categorized pregnant women, individuals in nursing homes and institutions, and medically needy population groups as adults for purposes of our report.

family income. For example, two states' Medicaid programs limited yearly premium amounts to a percentage of annual family income; SCHIP copayments for most services in one state were $2 or $5 depending on family income.

Nearly half of the states reported assessing premiums for some adults enrolled in Medicaid and the majority of the states required cost sharing for some portion of adults, primarily in the form of copayments for services. Twenty-five states charged premiums, generally limiting the charges to portions of certain population groups, such as working adults with disabilities. Over 40 states charged cost sharing to most, if not all, adults, including adults with disabilities, noninstitutionalized elderly persons, and parents. Copayments were the predominate form of cost sharing. The services for which states most frequently required copayments were physician services and prescription drugs. Copayment amounts varied depending on the service and the state. For example, across states, copayments ranged from $.50 to $25 for physician services and prescription drugs.

Thirty-four states reported increasing the amount of beneficiary contributions required in Medicaid, SCHIP, or both programs, while 10 states reported decreasing such requirements during states' fiscal years 2001 through August 1, 2003. Amounts of beneficiary contributions for children increased in 18 states—3 states in Medicaid, 12 states in SCHIP, and 3 states in both programs—and increased for adults in Medicaid in 30 states. The requirement most often increased was the copayment requirement, and the increases generally were targeted to noninstitutionalized elderly persons, adults with disabilities, and parents. Across the 33 states that provided us information on the amount of beneficiary contribution increases, premium increases to existing requirements ranged from $2 a month to $39 a month. Other states added new premium requirements, some of which were as much as several hundred dollars a month. Copayment increases were generally limited to $5 or less; in a small number of instances, increases were higher. For the 10 states that decreased beneficiary contribution requirements during the time period we reviewed, 5 states decreased requirements for some portion of children in SCHIP and 5 states decreased requirements for some portion of adults in Medicaid.

Officials in CMS provided technical comments on the statutory and regulatory information on Medicaid and SCHIP beneficiary contributions, which we incorporated as appropriate.

Background

Health insurance coverage often includes beneficiary contributions, which require an insured individual to pay some portion of medical expenses. The medical expenses charged to an individual—particularly for certain types of beneficiary contributions—can vary depending on the amount and type of services used. The two most common forms of beneficiary contribution requirements—health insurance premiums and cost sharing—differ in the method and frequency with which they are applied. Premiums are charged at regular intervals, such as monthly, and generally the same amount is charged each time. In contrast, cost sharing charges can vary depending on the amount and type of services used. There are three types of cost sharing arrangements: coinsurance, copayments, and deductibles (see table 1).

Table 1: Common Health Care Cost Sharing Arrangements

Type of cost sharing	Definition
Coinsurance	A percentage of the cost of health care services, such as physician visits and prescriptions filled.
Copayment	A fixed amount for each service paid at the time of service. Examples include payments for each physician visit and for each prescription filled.
Deductible	An amount that must be paid by the insured before the insurer will begin paying. For example, a covered individual with a $50 deductible would have to pay the first $50 of health care charges, after which the insurer would begin paying.

Source: Slee, Virgil N. et al., Slee's Health Care Terms, Third Comprehensive Edition (St. Paul, Minn.: Tringa Press, 1996).

Among low-income populations, approximately 40 percent of children and nondisabled adults had at least one nonpreventive physician visit during 2000.[5] Among these individuals, children averaged close to three nonpreventive physician visits per year, while nondisabled adults averaged fewer than five visits per year. Similarly, for individuals who filled at least one prescription, the average number of filled prescriptions ranged from approximately 4 per year for children to over 32 per year for adults with

[5]The Medical Expenditure Panel Survey (MEPS) provides national data on individuals' annual utilization of medical services. MEPS, conducted by the Agency for Healthcare Research and Quality (AHRQ), consists of four surveys, including the Household Component, which provides nationally representative data and expenditures for the U.S. civilian noninstitutionalized population.

disabilities.[6] (See app. I for more information on beneficiary service utilization.)

Medicaid and SCHIP generally limit the use of beneficiary contribution requirements. The following sections contain specific information about the programs and the federal laws pertaining to their use of beneficiary contributions.

Medicaid

Established in 1965, Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income families, children, pregnant women, and individuals who are aged or disabled. In fiscal year 2001, there were more than 46 million Medicaid enrollees, over half of whom were children, and federal and state expenditures totaled $228 billion. Medicaid eligibility is based in part on family income and assets; states set their eligibility criteria within broad federal guidelines. Eligibility criteria for each state's Medicaid program are outlined in a CMS-approved state plan.

Medicaid allows states to require certain beneficiaries to contribute to the cost of their coverage by charging premiums and requiring cost sharing.[7] The populations that can be required to make beneficiary contributions under federal law differ depending on the type of beneficiary contribution—premiums or cost sharing—and the law places limits on the amounts of the contributions states can require. Federal law generally bars states from requiring beneficiary contributions of certain populations, but exceptions do exist. Additionally, states may seek federal approval to waive certain provisions regarding beneficiary contributions.

Federal Law Governing Premiums in Medicaid

States are prohibited from requiring premiums from certain low-income individuals within certain groups, including children, pregnant women, individuals in families with dependent children, individuals with disabilities, and elderly persons, but exceptions exist.[8] Specifically, in

[6] MEPS data showed that approximately 45 percent of low-income children had a prescription filled during a year, compared to approximately 96 percent of disabled adults.

[7] Social Security Act section 1902(a)(14) (codified at 42 U.S.C. 1396a(a)(14)).

[8] Medicaid classifies certain individuals as categorically needy. Categorically needy persons are those within certain eligibility categories, including persons who are disabled, elderly, pregnant, children, beneficiaries of cash assistance programs, and whose income and resources do not exceed specified levels.

Medicaid, the law allows states to require premiums from certain populations, such as certain working individuals with disabilities and families.[9] (See table 2 for examples of these exceptions.) Additionally, states are allowed to charge premiums to medically needy individuals—generally, people who fall into one of the eligibility coverage groups indicated above, but who incur medical expenses such that their income, less these expenses, makes them eligible for Medicaid.[10] If states require premiums for medically needy individuals, the regulations specify that the premiums be assessed on a sliding scale, from $1 to $19 per person per month, on the basis of their family's total gross income.

[9]Social Security Act section 1916 (codified at 42 U.S.C. 13960).

[10]Medically needy coverage is also termed "spend-down" coverage; as of November 2002, 36 states opted to cover Medicaid beneficiaries under the medically needy or spend-down category.

Table 2: Examples of Exceptions to Prohibitions on Premiums in Medicaid, by Population Group

Population	Exception
Children	• Children under age 1 in families with incomes equal to or exceeding 150 percent of the federal poverty level (FPL)[a] may be charged premiums at states' discretion.[b] Premiums may not exceed 10 percent of family income that is above 150 percent of the FPL.[c]
Pregnant women	• Pregnant women whose incomes are equal to or exceed 150 percent of the FPL may be charged premiums at states' discretion.[b] Premiums may not exceed 10 percent of their income that is above 150 percent of the FPL.[c]
Individuals in families with dependent children	• Under "transitional Medicaid assistance," families moving from cash assistance to employment may maintain health insurance coverage under Medicaid for up to 1 year.[d] Premiums may be charged for the final 6 months of coverage for families above a certain level of income but may not exceed 3 percent of the family's average gross monthly earnings (less the average monthly costs for child care necessary to enable the caretaker relative to engage in employment).
Individuals with disabilities	• Under the Balanced Budget Act of 1997, states may cover working individuals with disabilities who have family incomes exceeding 250 percent FPL and there is no limit to the amount of premiums states can charge. • Under the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), states may require premiums of up to 7.5 percent of income from working individuals with disabilities whose annual incomes do not exceed 450 percent of the FPL.

Source: GAO analysis of federal law, as of March 2004

[a]In 2003, the FPL for an individual equated to $8,980 per year and $15,260 for a family of three in the 48 contiguous states and the District of Columbia

[b]Population group is covered under an optional categorically needy group in states that, as of December 19, 1989, had established, or passed legislation authorizing or appropriating funds for, a minimum income eligibility level for Medicaid greater than 133 percent of the FPL.

[c]If the minimum income eligibility level in the state for the optional categorically needy group exceeds 150 percent of the FPL, premiums may not exceed 10 percent of the family income that exceeds that minimum.

[d]Authorized by section 1925 of the Social Security Act (codified at 42 U.S.C. 1396r-6 (2000)).

Federal Law Governing Cost Sharing in Medicaid

Federal law prohibits states from applying cost sharing requirements for certain individuals and certain services. Specifically, cost sharing may not be charged for categorically and medically needy children under 18 years of age,[11] and pregnant women, for services related to the pregnancy or to conditions that could complicate the pregnancy. Additionally, cost sharing may not be charged for the categorically and medically needy for

- services furnished to individuals residing in a nursing home or other institution, who were required to spend most of their income for medical care;[12]
- services furnished to individuals receiving hospice care;
- emergency services; and
- family planning services and supplies.

States may require nominal copayments, coinsurance, or deductibles within federal limits from other beneficiaries or for other services (see table 3). Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts.

[11]States may require cost sharing for individuals aged 18 to 21 even if they are considered children by the state.

[12]States may not charge cost sharing on medical services furnished to a person who is an inpatient in a hospital, long term care facility, or other medical institution if, as a condition of receiving those services, the person was required to spend almost all of his or her income in order to qualify for Medicaid. See 42 CFR 447.53(b)(3) (2003).

Table 3: Medicaid Cost Sharing Limits

Type of cost sharing	Limit[a]
Coinsurance	Rates may not exceed 5 percent of the amount the state pays to Medicaid providers for the services for noninstitutional care or be more than 50 percent of the Medicaid payment for the first day of institutional care per admission.
Copayment	Amount is limited—from $0.50 to $3.00—for noninstitutional care and may be no more than 50 percent of the Medicaid payment for the first day of institutional care per admission.
Deductible	Amount is limited to $2.00 per family per month for each period of eligibility for noninstitutional care and to no more than 50 percent of the Medicaid payment for the first day of institutional care per admission.

Source: GAO analysis, as of October 2003, of Medicaid regulations.

[a]States may seek authority from CMS to charge up to twice the cost sharing limit for nonemergency services delivered in a hospital emergency room provided that the state can demonstrate that alternative sources of nonemergency, outpatient services are available and accessible to beneficiaries. See Social Security Act sections 1916(a)(3) and 1916(b)(3) (codified at 42 U.S.C. 1396o(a)(3) and (b)(3)).

Waivers of Premium and Cost Sharing Law in Medicaid

States must seek permission from the federal government to charge premiums or cost sharing beyond what is allowed under Medicaid. Under section 1115 of the Social Security Act, the Secretary of Health and Human Services has broad authority to approve demonstration projects that he determines are likely to promote Medicaid objectives.[13] The Secretary may waive certain provisions of the statute if the Secretary finds it necessary for the performance of the experimental, pilot, or demonstration projects. Section 1115 waivers have been used to provide coverage to individuals not normally eligible for Medicaid—or to expand coverage to those who are eligible under Medicaid but are not included in the scope of the state's plan. Beneficiary contribution requirements for individuals who become eligible for Medicaid through an 1115 waiver may be approved at the Secretary's discretion, subject to some limitations. CMS reviews states' proposed beneficiary contribution requirements for 1115 waivers as part of the waiver approval process and specifies any terms and conditions that a state must adhere to as a condition of the waiver approval.

[13]For purposes of this report, we will refer to demonstration projects approved under section 1115 as 1115 waiver programs.

According to CMS, because the provisions of Medicaid law related to limitations on beneficiary contributions[14] are applicable only to persons eligible under the state plan, specific waivers of the beneficiary contribution provisions are not always necessary. Waivers are necessary when states want to charge premiums or cost sharing amounts that are generally prohibited under federal law for individuals who are already covered under the state's plan. As of February 2004, two states—Arkansas and Vermont—have received approval to charge individuals premiums and one state—Arizona—has received approval to charge individuals both premiums and cost sharing.

For other populations, specific waivers of requirements regarding beneficiary contributions are not necessary. In particular, states are permitted to charge beneficiary contributions in excess of what would otherwise be permitted for populations who, without a waiver, would not be eligible for coverage under the state's Medicaid plan. For these populations, states are permitted to end coverage for beneficiaries who fail to pay premiums or deny services to those who fail to pay cost sharing. As of February 2004, of the 22 states with statewide 1115 waivers, 21 states covered populations in their Medicaid program for which the Medicaid statutory provisions regarding limits on beneficiary contributions are not applicable.

SCHIP

In 1997, Congress established SCHIP, which provides health care coverage to low-income, uninsured children living in families whose incomes exceed the states' eligibility limits for Medicaid. SCHIP covered over 5.8 million children during fiscal year 2003,[15] and federal and state expenditures were approximately $6.1 billion. States have three options in designing SCHIP—expand their Medicaid program, develop a separate child health program that functions independently of Medicaid, or combine these two approaches.

The approach that a state chooses affects its beneficiary contribution policies. A state that uses its SCHIP allocation to expand Medicaid must follow Medicaid rules—thus SCHIP beneficiaries are subject to the state's Medicaid policies with regard to premiums and cost sharing. For a state

[14]See section 1916 of the Social Security Act.

[15]This number represents an unduplicated count of all beneficiaries enrolled at any time in fiscal year 2003.

with a separate SCHIP program, federal law limits the premiums and cost sharing amounts it may charge. States with a separate SCHIP program are prohibited from requiring premium or cost sharing contributions together totaling more than 5 percent of family income.[16] States with separate SCHIP programs are also prohibited from charging any cost sharing on preventive services.[17] In addition, for children in families with income at or below 150 percent of the FPL, there are specific limits on the amounts of premiums and cost sharing that states may charge in a separate SCHIP program (see table 4). For these individuals, federal regulation also prohibits states from requiring more than one type of cost sharing charge on each service. Additionally, regardless of family income or a state's SCHIP design, states are prohibited from charging premiums or cost sharing to American Indians or Alaska Natives.[18]

[16] 42 CFR 457.560 (2003).

[17] Regarding preventive services, federal regulations prohibit these states from charging cost sharing for well baby and well child services, including routine physical examinations, associated laboratory tests, immunizations, and routine preventive and diagnostic dental services. See 42 CFR 457.520 (2003).

[18] 42 CFR 457.125, 457.535 (2003).

Table 4: Federal Limits on Separate SCHIP Programs' Premium and Cost Sharing for Children in Families with Income at or Below 150 Percent of the Federal Poverty Level

Type of beneficiary contribution	Limits for children in families with income at or below 100 percent of the federal poverty level (FPL)	Limits for children in families with income from 101 to 150 percent of the FPL
Premium	• May not exceed the Medicaid premium schedule for the medically needy, which operates on a sliding scale, with a maximum premium of $19 per person per month.	• Limits are the same as those for families with income at or below 100 percent of the FPL.
Coinsurance	• May not exceed 5 percent of the state payment for noninstitutional services; and • may not exceed 50 percent of the state payment for the first day of institutional care per admission.	• May not exceed 5 percent of the state payment for noninstitutional services; and • may not exceed 50 percent of the state's Medicaid fee-for-service payment for the first day of institutional care per admission.
Copayment	• From $0.50 to $3 for noninstitutional services; and • may not exceed 50 percent of the state payment for the first day of institutional care per admission.	• From $1 to $5 for noninstitutional services provided under fee-for service; • may not exceed $5 per visit for noninstitutional services provided under managed care; • may not exceed 50 percent of the state's Medicaid fee-for-service payment for the first day of institutional care per admission; • may not exceed $5 for hospital emergency services; and • may not exceed $10 for nonemergency services furnished in an emergency room.
Deductible	• May not exceed $2 per family per month per period of eligibility for noninstitutional services; and • may not exceed 50 percent of the state payment for the first day of institutional care per admission.	• May not exceed $3 per family per month per period of eligibility for noninstitutional services; and • may not exceed 50 percent of the state's Medicaid fee-for-service payment for the first day of institutional care per admission.

Source: GAO analysis of SCHIP regulations, March 2001.

Similar to Medicaid, to require premiums or cost sharing in SCHIP beyond what is permissible under federal law, states must seek waivers from the Secretary of Health and Human Services. In establishing SCHIP, Congress extended the applicability of section 1115 of the Social Security Act to SCHIP "in the same manner" as it applies to states under Medicaid.[9] According to CMS, six states with SCHIP programs that are Medicaid expansions have received section 1115 waivers to require beneficiary

[9]Social Security Act section 2107(e)(2)(A) (codified at 42 U.S.C. 1397gg(e)(2)(A)(2000)).

contributions that would be allowable in a separate SCHIP program.[20] In some cases, 1115 waiver approvals have allowed states to increase cost sharing in their premium assistance programs—programs in which the state helps individuals gain access to available employer-based insurance by using SCHIP funds to pay for part of an individual's share of the cost of coverage. Specifically, two states—Illinois and Oregon—have waivers to allow for increased cost sharing for children in such premium assistance programs.

Children Were More Likely to Be Subject to Beneficiary Contributions in SCHIP than in Medicaid

In response to our survey, states reported that children were more likely to be subject to premiums and cost sharing in SCHIP than in Medicaid. Overall, 26 states charged premiums for some portion of children—"some," "most," or "all" in SCHIP, and 9 states charged premiums, through the use of 1115 waivers, for some portion of children in Medicaid. Twenty-five states charged cost sharing for children in SCHIP compared to six states for Medicaid. Most states that reported charging cost sharing applied copayment requirements to the six services we reviewed.[21] In addition, the amounts of beneficiary contributions required for children varied on the basis of factors such as family income.

Premiums

Twenty-six states reported charging premiums for some portion of children in SCHIP, compared to 9 states for Medicaid: 5 states charged premiums for some portion of children in both Medicaid and SCHIP, 21 states charged premiums for SCHIP children only, and 4 states charged premiums for Medicaid children only. (See table 5.)

[20]The six states that received section 1115 waivers are Arkansas, Missouri, New Mexico, Ohio, Rhode Island, and Wisconsin. As of March 2001, Ohio had not implemented its waiver.

[21]Our survey asked states about their cost sharing requirements for six services: inpatient hospital, outpatient hospital, physician services, prescription drugs, nonemergency use of the ER, and dental.

Table 5: States' Use of Premiums for Children in Medicaid and SCHIP, as of August 1, 2003

Charge premiums in		Number of states	States
Medicaid?	SCHIP?		
No	No	21	Alaska, Colorado, District of Columbia, Idaho, Kentucky, Louisiana, Mississippi, Montana, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Virginia, West Virginia, and Wyoming
No	Yes	21	Alabama, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New York, Texas, Utah, and Washington
Yes	No	4	Arkansas,[a] Hawaii,[b] Minnesota,[c] and Tennessee[d]
Yes	Yes	5	Arizona, Massachusetts, Rhode Island, Vermont, and Wisconsin

Source: GAO analysis of state survey responses.

[a]Arkansas's 1115 waiver included premium charges for children who are receiving medical care at home that otherwise would be provided in an institution.

[b]Hawaii charged premiums for children in families with incomes above 200 percent of the FPL, which in 2003 equated to $20,660 per year for an individual and $35,100 for a family of three.

[c]Minnesota allowed individuals the choice of participating in its 1115 waiver program, which includes premium charges, or its traditional Medicaid program, which does not include premium charges for children.

[d]Tennessee did not have a SCHIP program.

Although federal law generally prohibits states from charging premiums for children in Medicaid, some states reported having received waivers from the Secretary of Health and Human Services granting them authority to do so. Of the nine states charging premiums for children in Medicaid, six states required premiums for children included in their 1115 waiver populations only. For example, Rhode Island charged premiums only for children with incomes between 150 and 250 percent of the FPL, all of whom became Medicaid eligible through its 1115 waiver. The remaining three states—Arizona, Arkansas, and Vermont—also had 1115 waivers but had received approval to waive provisions related to premium requirements. Thus, they were allowed to charge premiums for children.

States generally are not allowed to charge premiums for children in their SCHIP Medicaid expansion programs, as these programs follow the law governing the Medicaid program. According to CMS, six states have

received SCHIP 1115 waivers to require beneficiary contributions for children in their SCHIP Medicaid expansion programs. Three of those states—Missouri, Rhode Island and Wisconsin—used their 1115 waiver to implement premiums for some portion of their SCHIP beneficiaries. The remaining three states—Arkansas, New Mexico and Ohio—did not charge premiums for children in their SCHIP program.

Among states with premium requirements for children, SCHIP programs often reported charging premiums for a larger proportion of their children than did Medicaid programs (see app. II). Ten of the 26 states charging premiums for children in SCHIP required them for all or most of their SCHIP children. In contrast, all nine of the states with premiums for children in Medicaid required them for only some of the population.

The amount of premiums required for Medicaid and SCHIP children varied across and within states. (See app. III for the range in premiums for all states.) Some states reported varying premium amounts on the basis of beneficiaries' family income, and some states reported capping the amount of premiums a beneficiary could be subject to in a given year. (See table 6.) The following are examples of the variation in states' premium requirements.

- In Vermont, Medicaid premiums were assessed for eligible children in families with incomes above 185 percent of the FPL, and amounts varied from $25 to $35 a month depending on the family income.
- Medicaid programs in Rhode Island and Minnesota limited total yearly premium amounts to 4 percent and 7.5 percent of annual family income, respectively.
- In SCHIP, monthly premiums in Washington were $10 per child, with a cap of $360 per family per year. In New York, monthly premiums for families with incomes between 133 and 185 percent of the FPL were $9 per eligible child with a cap of $27 per family per month; families with incomes above 185 were charged $15 per eligible child with a cap of $45 per family per month.

Table 6: States' Premium Charges for Children in Medicaid and SCHIP, as of August 1, 2003

Characteristic	Number of states	
	Medicaid	SCHIP
States charging premiums for children	9	26
States varying premiums by income	9	20
States capping premium charges	4	11

Source: GAO analysis of state survey responses

Cost Sharing

In requiring cost sharing amounts, states reported relying on copayments and generally did not report using the other two main types of cost sharing requirements—coinsurance and deductibles. Twenty-five states charged copayments for some portion of children in SCHIP, while six states charged copayments for some portion of children in Medicaid. (See table 7.) With regard to coinsurance, three states charged coinsurance in Medicaid; Alaska and Missouri charged only children aged 18 or over, and Arkansas charged only children in its 1115 waiver program. Additionally, four states charged coinsurance in SCHIP (Alaska, Arkansas, Colorado, and Utah). None of the states reported using deductibles as a form of cost sharing for children.

Table 7: States' Use of Copayments for Children in Medicaid and SCHIP, as of August 1, 2003

Charge copayments in		Number	
Medicaid?	SCHIP?	of states	States
No	No	24	District of Columbia, Georgia, Hawaii, Idaho, Kansas, Louisiana, Maine, Maryland,[a] Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New York, Ohio, Oregon, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Vermont, Washington, and Wyoming
No	Yes	21	Alabama, Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kentucky, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Texas, Utah, Virginia, and West Virginia
Yes	No	2	Delaware[b] and Tennessee[c]
Yes	Yes	4	Alaska, Arkansas, Missouri, and Wisconsin

Source: GAO analysis of state survey responses.

[a]Maryland did not charge copayments to children in Medicaid. In SCHIP, the state did not charge copayments, but SCHIP beneficiaries receiving coverage through the employer-sponsored insurance program may be charged copayments by their health plan.

[b]Although Delaware did not require a copayment in SCHIP, the state did have a fee for inappropriate use of the ER. In Medicaid, Delaware's only copayment was for nonemergency transportation.

[c]Tennessee did not have a SCHIP program.

While federal law prohibits states from charging cost sharing for children in Medicaid under age 18, some states require cost sharing to the extent it is permissible under Medicaid provisions or through an 1115 waiver. For the six states that charged copayments for some portion of Medicaid children, Alaska's, Missouri's, and Wisconsin's copayment requirements applied to children age 18 or over, and Delaware reported charging copayments for nonemergency transportation, requirements that are permissible under federal law.[23] Arkansas charged copayments only to children in its state's 1115 waiver population. Tennessee, whose entire Medicaid program operates under an 1115 waiver, charged copayments to children at or above the FPL.

[23]In Medicaid, nonemergency transportation can be considered either a service or an administrative cost. Delaware treats nonemergency transportation as an administrative cost and thus was allowed to charge a copayment for this service.

With regard to cost sharing in SCHIP, six states obtained section 1115 waivers that allowed them to require beneficiary contributions from children in their SCHIP Medicaid expansion programs.[23] Four of the states—Arkansas, Missouri, New Mexico and Wisconsin—used their 1115 waiver to implement copayments for some portion of their SCHIP beneficiaries. The remaining two states—Ohio and Rhode Island—did not charge copayments for children in their SCHIP programs. Among states with copayment requirements for children, SCHIP programs were more likely to charge a larger proportion of their population compared to Medicaid (see app. IV).

Most states that reported charging cost sharing applied copayment requirements to the six health care services that we considered. (See table 8.) In addition, the amount of cost sharing that states charged for the six selected services varied by service and state. For example, in the Texas SCHIP program, copayments varied on the basis of family income, ranging from $2 to $10 per physician visit, and from $25 to $100 per inpatient hospitalization. Across states with copayments for physician services, copayment amounts ranged from $1 per visit in Missouri's Medicaid program and Wisconsin's Medicaid and SCHIP programs to as high as $25 per visit in Tennessee's Medicaid program. (See app. V.)

[23]Section 2107(e)(2)(A) of the Social Security Act extends the Secretary's authority under section 1115 to the SCHIP statute.

Table 8: States' Use of Cost Sharing for Children for Six Services, by Program and Service, as of August 1, 2003

	Number of states					
	Copayment		Coinsurance		States using cost sharing for this service	
Service	Medicaid	SCHIP	Medicaid	SCHIP	Medicaid	SCHIP
Inpatient hospital	4	12	1	2	5	13[a]
Outpatient hospital	3	17	1	2	4	18[a]
Physician services	5	21	0	0	5	21
Prescription drugs	4	22	0	1	4	22[a]
Nonemergency use of the emergency room	4	21	1	1	5	22
Dental	4	14	1	2	4[b]	15[a]

Source: GAO analysis of state survey responses.

[a]Utah SCHIP charged a copayment for children with a family income at or below 150% FPL and charged copayment or coinsurance for children in a family with a higher income level.

[b]Missouri Medicaid charged a copayment or coinsurance, depending on the dental service. Specifically, the state charged a coinsurance for dentures and charged a copayment for all other dental services.

Some states varied cost sharing amounts for children on the basis of family income. For example, in Virginia, SCHIP copayments for children in families with income from 133 percent to below 150 percent of the FPL were $2 per physician visit or per prescription and $5 for these services for children in families with higher incomes. Of the six states that charged cost sharing for children in Medicaid, only Tennessee capped cost sharing amounts for children. In SCHIP, seven states set specific caps for cost sharing amounts for a child in a given year. (See table 9.) For example, SCHIP cost sharing was capped at $650 a year in Connecticut and $750 a year in West Virginia.

Table 9: States' Use of Cost Sharing Charges for Children in Medicaid and SCHIP, as of August 1, 2003

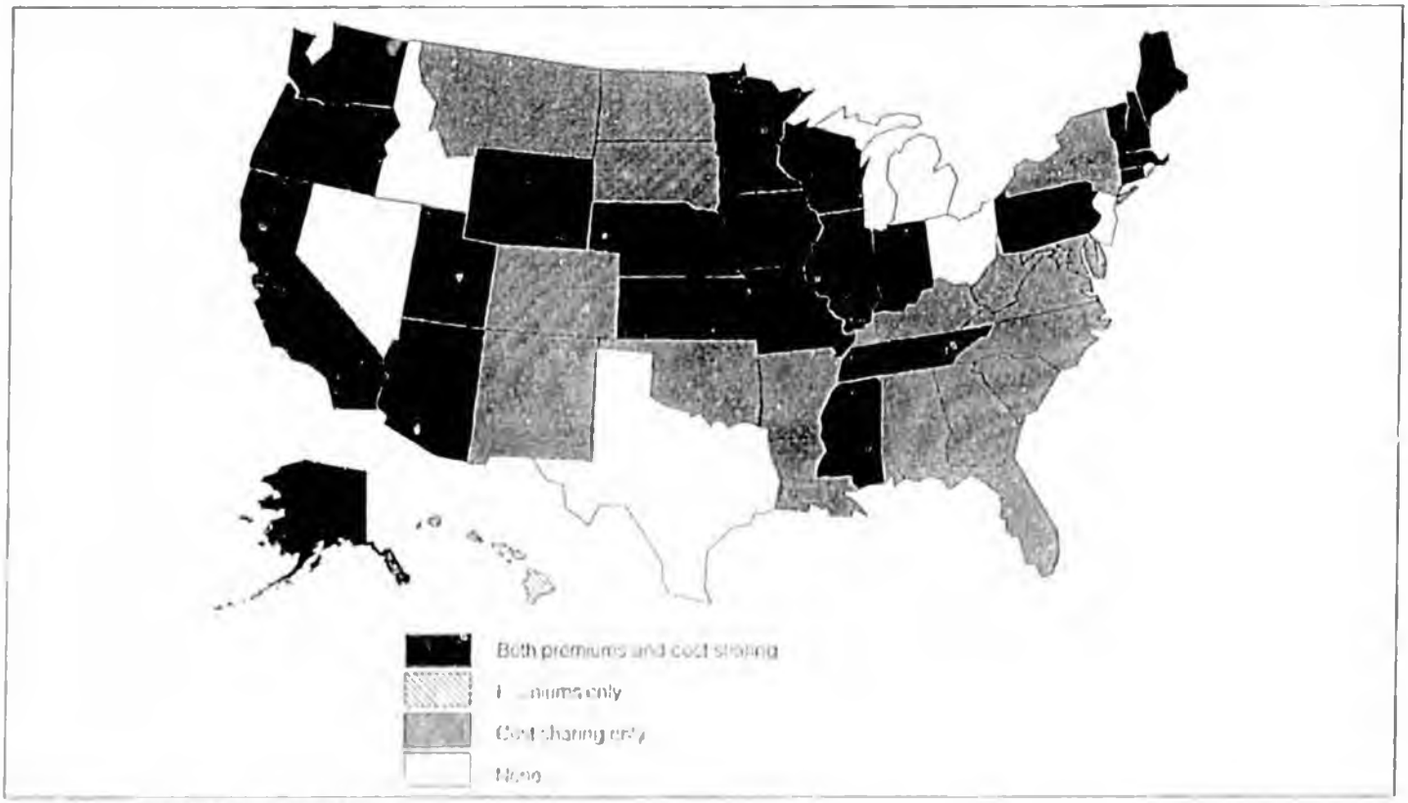
	Number of states	
Characteristics	Medicaid	SCHIP
States charging cost sharing for children	6	25
States varying cost sharing by income	1	14
States capping cost sharing charges	1	7

Source: GAO analysis of state survey responses.

For Adults in Medicaid, Nearly Half the States Assessed Premiums and a Majority Required Cost Sharing

Nearly half the states (25) reported assessing premiums for some adults enrolled in Medicaid, and a majority of the states (43) reported requiring cost sharing for some portion of adults, primarily in the form of copayments. Overall, 45 states required some portion of adults to share in the cost of their care by charging premiums, cost sharing, or both. (See fig. 1.) The states that required premiums generally did so on a limited basis, targeting portions of particular population groups, such as certain adults with disabilities. In contrast, the states with cost sharing requirements for adults in Medicaid charged several population groups and a larger portion of each group.

Figure 1: States' Use of Premiums and Cost Sharing for Adults in Medicaid, as of August 1, 2003



Source: GAO analysis of state survey responses.

Premiums

Twenty-five states reported assessing premiums for some portion of their adult Medicaid populations. States mainly charged premiums to adults with disabilities (23 states)[21] and parents (9 states), but a few states charged premiums to other adults, such as pregnant women (4 states) and noninstitutionalized elderly individuals (2 states). (See table 10.) (App. VI contains details on the portion of the populations charged premiums in each state.)

Table 10: States' Use of Premiums for Adults in Medicaid, by Population Group, as of August 1, 2003

	Number of states charging all, most, or some of this population		
Population[a]	**All**	**Most**	**Some**
Pregnant women	0	0	4
Individuals in nursing homes and institutions	0	0	0
Noninstitutionalized elderly	0	0	2
Adults with disabilities	0	0	23
Medically needy	0	0	0
Parents	0	1	8

Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of a specific population group was charged premiums by selecting "all," "most," "some," or "none."

[a]Five states reported charging premiums to other adult populations, such as childless adults.

Generally, states are not permitted to require certain individuals to pay premiums, including elderly persons, individuals with disabilities, and pregnant women. However, certain exceptions exist, for example:

- Four states (Hawaii, Minnesota, Rhode Island, and Vermont) reported charging premiums to pregnant women through their states' 1115 waiver

[21]In many cases, these states only charged working individuals with disabilities. In 2003, the following states provided Medicaid coverage to working individuals with disabilities: Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, South Carolina, Utah, Vermont, Washington, Wisconsin, and Wyoming. See U.S. General Accounting Office, *Medicaid and Ticket to Work: States' Early Efforts to Cover Working Individuals with Disabilities*, GAO-03-587 (Washington, D.C.: June 13, 2003) and Jennifer Hess and Karen Tritz, *Ticket to Work and Work Incentives Improvement Act of 1999: Implementation Status* (Washington, D.C.: Congressional Research Service, June 3, 2003).

programs. Vermont had a waiver of the specific Medicaid provision regarding premium requirements, while the other three states charged pregnant women in their 1115 waiver programs. Hawaii, Rhode Island, and Vermont charged premiums only to pregnant women with incomes exceeding 185 percent of the FPL. In the fourth state, Minnesota, pregnant women with incomes at or below 275 percent of the FPL could choose whether to enroll in the state's regular Medicaid program or the state's 1115 waiver program. Only those enrolled in the 1115 waiver program were charged premiums, and failure to pay the required premiums did not result in the women's disenrollment from the program.

- As allowed under federal law, states may charge premiums in Medicaid to certain individuals with disabilities, primarily those who are employed. For example, Connecticut reported charging premiums to working individuals with disabilities with incomes above 200 percent of the FPL. These individuals were required to pay a monthly premium equivalent to 10 percent of their income that exceeded 200 percent of the FPL, minus the amount the individuals or their spouses paid for any other health insurance.

Premium amounts and requirements varied significantly across the 25 states. For example, in Massachusetts, monthly premiums ranged from $15 for families with incomes at the poverty level to over $928 for families with incomes over 1,000 percent of the FPL. Maine charged premiums equal to 3 percent of families' net incomes for eligible parents with incomes above 150 percent of the FPL. (See app. VII for the income thresholds and ranges in amounts for premiums charged to adults in each state.) Twelve states capped the amount of premiums that beneficiaries could be subject to in a given year. For example, premiums for working individuals with disabilities in Mississippi were capped at 5 percent of annual income, and in Maine, premiums for some adults were capped at 3 percent of annual income. (See table 11.)

Table 11: States' Premium Charges for Adults in Medicaid, as of August 1, 2003

Characteristic	Number of states
States charging premiums	25
States varying premiums by income	25
States capping premium charges	12*

Source: GAO analysis of state survey responses.

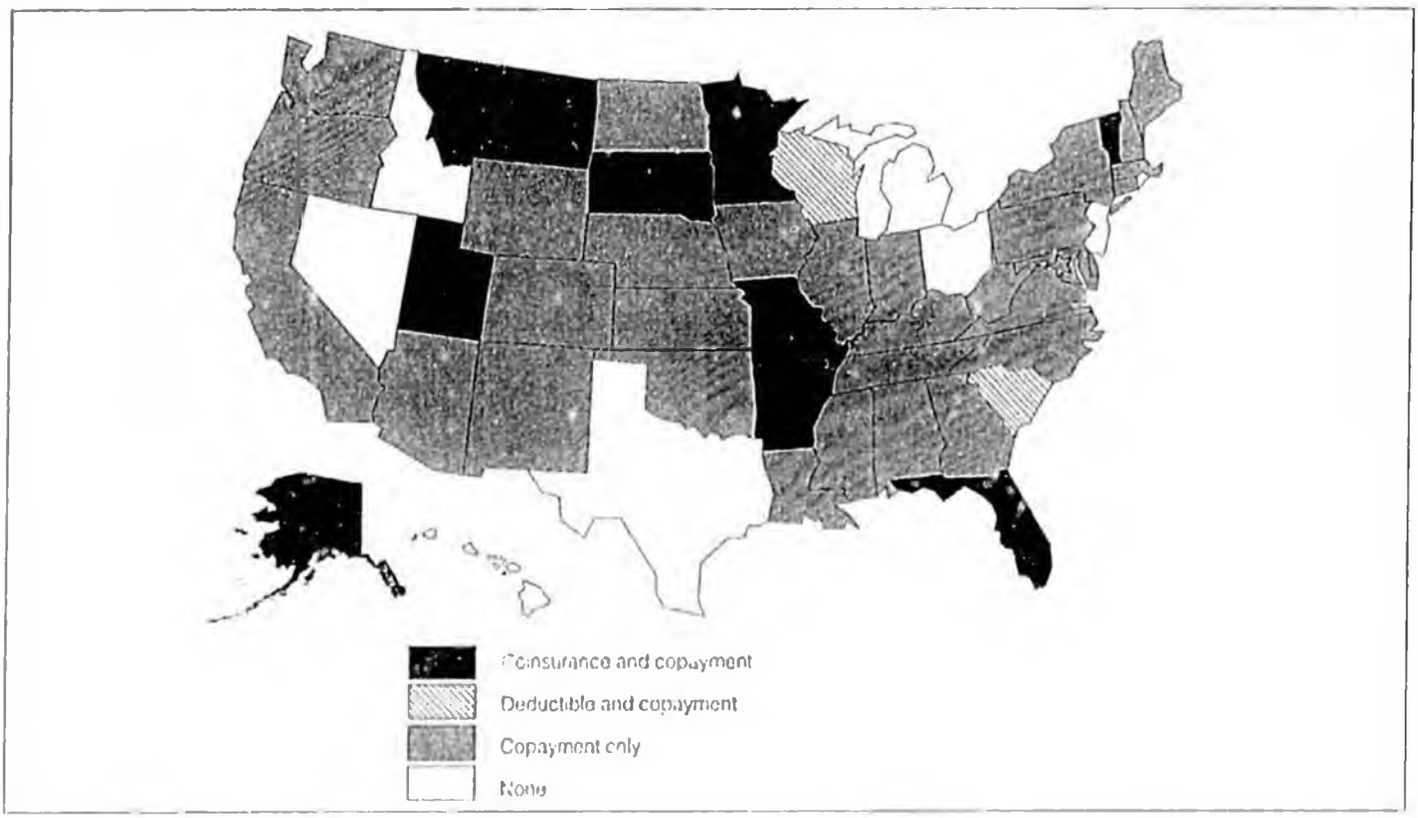
*Three of these states reported that premium charges were capped for some beneficiaries.

Cost Sharing

Forty-three states reported requiring adult populations to share in the cost of their care by charging copayments, coinsurance, or deductibles. (See fig. 2.) All 43 states charged copayments for selected services to some portion of adults. Nine of these states also charged coinsurance to some portion of adults.[25] Two of the 43 states—South Carolina and Wisconsin—required a deductible for elderly individuals who received pharmacy—but no other—benefits from the states' Medicaid program. For example, all participants in South Carolina's Medicaid pharmacy program were required to pay a $500 deductible for prescription drugs.

[25]The nine states are Alaska, Arkansas, Florida, Minnesota, Missouri, Montana, South Dakota, Utah, and Vermont.

Figure 2: States' Use of Cost Sharing for Adults in Medicaid, as of August 1, 2003



Source: GAO analysis of state survey responses.

Copayments were the predominate form of cost sharing for adults, with states most frequently reporting copayments for adults with disabilities, noninstitutionalized elderly persons, and parents. (See table 12 and app. VIII.) Three states required copayments for pregnant women (Delaware, Virginia, and Wisconsin) for services unrelated to the pregnancy.[28] While states generally are prohibited from charging cost sharing, including copayments, for medical services for individuals residing in institutions, Delaware considers nonemergency transportation to be an administrative cost and thus was allowed to charge a $1 copayment.

[28]Delaware charged a copayment for nonemergency transportation and Wisconsin charged a copayment for dental services. Virginia charged a copayment for inpatient hospital services, outpatient hospital services, physician services, and prescription drugs when the services were unrelated to the pregnancy.

Table 12: States' Use of Copayments for Adults in Medicaid, as of August 1, 2003

	Number of states and portion of population charged		
Population[a]	All	Most	Some
Pregnant women[b]	1	0	2
Individuals in nursing homes and institutions[c]	1	0	0
Noninstitutionalized elderly persons	21	8	11
Adults with disabilities	21	9	11
Medically needy	14	7	8
Parents	16	11	9

Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of the population were charged copayments by selecting "all," "most," "some," or "none." They were also asked to designate if a population was not covered by their state's Medicaid program.

[a]Ten states reported charging copayments to other adult populations, such as childless adults.

[b]Three states required copayments for services unrelated to the pregnancy.

[c]One state charged individuals in institutions for nonemergency transportation.

The services for which states most frequently reported charging copayments were physician services and prescription drugs. (See table 13.) Copayment amounts varied depending on the service and the state. Across states, copayments ranged from $.50 to $25 for physician services and prescription drugs. Across the services, most states that required copayments for inpatient hospital services charged higher copayment amounts for this service compared to the other five services. For example, Montana's copayment requirement for inpatient hospital services was $100 per stay, whereas its copayment requirements for the five remaining services we reviewed were $1 to $5. (See app. IX for details on the cost sharing amounts, including copayments, for adults, by state.)

Table 13: States' Use of Copayments for Adults for Six Services, by Population Group, as of August 1, 2003

	Number of states charging copayment					
Population[a]	Inpatient hospital	Outpatient hospital	Physician services	Prescription drugs	Nonemergency use of the ER	Dental
Pregnant women	2	2	2	2	0	1
Noninstitutionalized elderly persons	18	21	25	35	16	13
Adults with disabilities	19	22	26	36	16	14
Medically needy	11	13	16	25	8	9
Parents	16	19	22	31	12	14

Source: GAO analysis of state survey responses.

[a]No states required copayments for individuals in nursing homes and institutions for any of the six services; thus, this population is excluded from the table.

In five states, the amount of cost sharing charged varied by income for some portion of adults. For example, copayment amounts for physician services in Utah varied from $3 or $5 per visit depending on income. Six states reported placing a cap on the amount of cost sharing an individual could be subject to in a given year. For example, in Pennsylvania cost sharing expenses were capped at $90 per beneficiary every 6 months, and in New Mexico cost sharing amounts for working individuals with disabilities were capped at 3 to 5 percent a year depending on income.

Thirty-Four States Increased and Ten States Decreased the Amount of Beneficiary Contributions

From the beginning of their 2001 state fiscal years through August 1, 2003, 34 states reported increasing and 10 states reported decreasing the amount of beneficiary contributions they required in Medicaid, SCHIP, or both.[9] We considered states to have increased beneficiary contribution requirements if they either raised the amount of existing contributions or instituted new contribution requirements for certain populations or services. For children, 18 states increased the amount of beneficiary contributions required in Medicaid, SCHIP, or both. For adults in Medicaid, 30 states increased the amount of beneficiary contributions. For the states that provided us information on the amount of beneficiary

[9]The time periods for states' fiscal years were different: most used a fiscal year that began July 1 and others used either the federal fiscal year (Oct. 1 through Sept. 30) or another time period.

contribution increases,[28] premium increases to existing requirements ranged from $2 a month to $39 a month. Other states added new premium requirements, some of which were as much as several hundred dollars a month. In contrast, states primarily increased copayment requirements by $5 or less. For a small number of states, however, copayment increases were more significant. New Hampshire SCHIP, for example, increased copayments for ER visits from $25 to $50 per visit. While no states reported decreasing their beneficiary contribution requirements for children in Medicaid, five states decreased these requirements (premiums, cost sharing, or both) for some portion of children in SCHIP, and five other states decreased cost sharing requirements for some portion of adults in Medicaid.

Eighteen States Increased and Five States Decreased Beneficiary Contributions for Children

From the beginning of their 2001 state fiscal years through August 1, 2003, 18 states reported increasing the amount of beneficiary contributions required for children in Medicaid, SCHIP, or both. Beneficiary contribution requirements were increased solely in Medicaid by 3 states, solely in SCHIP by 12 states, and in both Medicaid and SCHIP by 3 states. During the same period, 5 states decreased the amount of beneficiary contributions required for children, with all decreases occurring in states' SCHIP programs.

Premiums

Of the 9 states charging premiums for children in Medicaid, 5 reported increases in premiums. Eleven of the 26 states charging premiums for children in SCHIP also reported increased premium amounts. (See table 14.) Some states increased existing premiums, while other states added new premiums, as shown in the following examples.

- Vermont increased its existing Medicaid monthly premiums by $5 or $9 per household depending on income;[29] it increased its SCHIP monthly premiums by $20 per household.[30]

[28]Thirty-three of the 34 states that increased beneficiary contributions in Medicaid, SCHIP or both provided us with information on the amount of increases.

[29]In some states, such as Vermont, premiums are charged for a household—individuals living together in the same house.

[30]In Vermont, monthly premiums for Medicaid increased from $20 to $25 for children in households with income from 185 percent through 225 percent of the FPL and from $24 to $35 for children in households with higher income. In SCHIP, monthly premiums increased by $20—from $50 to $70.

- Premiums for newly covered populations of children were added in Arizona's Medicaid program and Maryland's SCHIP program.[31]

Table 14: Changes in States' Premiums for Children in Medicaid and SCHIP, State Fiscal Year 2001 through August 1, 2003

	Number of states	
Premium changes	Medicaid[a]	SCHIP
States that increased	5 (Arizona, Arkansas, Massachusetts, Rhode Island, and Vermont)	11 (Florida, Georgia, Kansas, Massachusetts, Maryland, Missouri, New Jersey, New Hampshire, Rhode Island, Utah, and Vermont)
States that decreased	0	2 (Kansas and Utah)
States with no changes	3 (Hawaii, Minnesota, and Wisconsin)	15 (Alabama, Arizona, California, Connecticut, Delaware, Iowa, Illinois, Indiana, Maine, Michigan, Nevada, New York, Texas, Washington, and Wisconsin)

Source: GAO analysis of state survey responses.

[a]One of the states charging premiums for some portion of children in Medicaid, Tennessee, did not report whether changes were made to the state's premium requirements.

While no states decreased their premiums for children in Medicaid, two states—Kansas and Utah—decreased SCHIP premium amounts. For example, in February 2003, Kansas increased its monthly premium amounts by $20 or $30, depending on family income, and then decreased them by $10 or $15 dollars a few months later.

Cost Sharing

Delaware was the only state of the 6 states charging copayments for children in Medicaid that reported increasing copayment amounts, compared to 6 of the 25 states charging copayments for children in SCHIP that reported increasing copayment amounts. (See table 15.) Delaware added a copayment in Medicaid for nonemergency transportation services

[31]Since state fiscal year 2001, Arizona has implemented a program under the Ticket to Work Act that provides Medicaid coverage to certain working individuals with disabilities, including some children aged 18. Maryland implemented a separate SCHIP program in July 2001, which raised the state's SCHIP income eligibility level from 200 percent to 300 percent of the FPL. Both states' new programs included a premium requirement.

in 2002. As described in the following, of the six states that reported increasing SCHIP copayment requirements, two increased existing copayments, and four both increased existing copayments and added new copayment requirements.

- Missouri and New Hampshire increased existing copayments. For example, New Hampshire increased copayments for nonemergency use of the ER from $25 per visit to $50 per visit and increased copayments for physician visits from $5 to $10.
- Kentucky, Texas, Utah, and West Virginia made multiple changes to their copayment requirements. For example, Utah added a copayment for dental services for children in families with incomes at or below 150 percent of the FPL and increased copayment amounts for children in families with incomes above 150 percent of the FPL.

Table 15: Changes in States' Copayments for Children in Medicaid and SCHIP, State Fiscal Year 2001 through August 1, 2003

Copayment changes	Medicaid*	SCHIP
States that increased	1 (Delaware)	6 (Kentucky, Missouri, New Hampshire, Texas, Utah, and West Virginia)
States that decreased	0	4 (Colorado, Texas, Utah, and Virginia)
States with no changes	4 (Alaska, Arkansas, Missouri, Wisconsin)	17 (Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Florida, Illinois, Indiana, Iowa, Mississippi, Montana, New Jersey, New Mexico, North Carolina, North Dakota, Wisconsin)

Source: GAO analysis of state survey responses.

*One of the states charging copayments for some portion of children in Medicaid, Tennessee, did not report whether changes were made to the state's copayment requirements.

While no states reported decreasing copayment amounts for children in Medicaid, four states did so for SCHIP. Colorado decreased the SCHIP copayment for nonemergency use of the ER from $5 to $3, and Virginia decreased copayments for vision exams from $25 to either $2 or $5, depending on family income. In addition to decreasing copayment amounts, the remaining two states, Texas and Utah, also increased copayments during the same period. Texas' changes to copayments varied by service and family income. For example, the state decreased the copayment for generic prescription drugs by $1 or $2 for certain SCHIP beneficiaries, while increasing the copayment for brand name prescription drugs by between $3 and $10 for these and other beneficiaries. Copayment

increases for other services in Texas ranged from $3 to $50. Utah decreased SCHIP copayment amounts for children in families with incomes at or below 150 percent of the FPL by $2 for physician services, inpatient and outpatient hospital services, and ER services. The state also increased copayments by $5 for physician and ER services, and $1 for certain prescription drugs for children in families with incomes above 150 percent of the FPL.

While none of the states changed coinsurance requirements for children in Medicaid,[32] one of the four states (Alaska, Arkansas, Colorado, and Utah) that charged coinsurance in SCHIP (Colorado) increased its coinsurance requirements.

Thirty States Increased and Five States Decreased Beneficiary Contributions for Adults

Thirty states reported increasing the amount of beneficiary contributions charged to some portion of adults in Medicaid. Most of these states (24) increased copayment amounts; fewer states increased premiums (12) and coinsurance amounts (2). Five states decreased beneficiary contribution requirements, specifically with respect to cost sharing.

Premiums

From the beginning of their 2001 state fiscal years through August 1, 2003, 12 states reported increasing premiums for some portion of adults in Medicaid. Half of these states increased the amount of existing premium requirements.[33] For example, Rhode Island increased monthly premiums from approximately 3 percent of a family's income to approximately 4 percent,[34] and Vermont increased premiums for certain working individuals with disabilities by $25 to $36 a month, depending on the individual's income and whether he or she had other insurance. The other half of these states added new premium requirements.[35] For example, in January 2003, Arizona began covering working individuals with

[32]The three states that charged coinsurance to children in Medicaid were Alaska, Arkansas, and Missouri.

[33]The six states were Massachusetts, Mississippi, New Hampshire, Oregon, Rhode Island, and Vermont.

[34]In Rhode Island, monthly premiums for certain parents with incomes from 150 percent through 185 percent of the FPL increased from $13 to $61. Monthly premiums for pregnant women increased from $53 to $77 for those with incomes from 185 percent through 200 percent of the FPL, and from $53 to $92 for those with incomes at or above 200 percent of the FPL.

[35]The six states were Arizona, Illinois, Kansas, Minnesota, Missouri, and Washington.

disabilities, requiring the new beneficiaries to pay monthly premiums of $15 or $25, depending on their income. In 2002, Washington added a premium for certain families covered under transitional Medicaid assistance.[36] While a few states increased premiums for pregnant women, adults with disabilities, and parents, no states increased premiums for noninstitutionalized elderly beneficiaries. (See table 16.) No states decreased premium amounts for adults during this period.

Table 16: States' Changes to Premiums for Adults in Medicaid, State Fiscal Year 2001 through August 1, 2003

	Number of states		
Population	Increased premiums	Decreased premiums	No change
Pregnant women	2	0	2
Individuals in nursing homes and institutions	0	0	0
Noninstitutionalized elderly	0	0	2
Adults with disabilities	10	0	13
Medically needy	0	0	0
Parents	3	0	6

Source: GAO analysis of state survey responses.

Cost Sharing

With regard to cost sharing, 25 states reported increasing requirements for some portion of Medicaid adults. Twenty-two of these states increased only copayment requirements, one state increased only coinsurance requirements, and two states increased a combination of cost sharing requirements.[37] States' cost sharing increases were generally targeted to noninstitutionalized elderly persons, adults with disabilities, parents and medically needy individuals. (See table 17.) Some states increased the amount of existing cost sharing requirements, while other states added cost sharing requirements for new services, as shown in the following examples:

[36] The premium was equal to 1 percent of income after deducting certain child care expenses.

[37] For the two states increasing charges in more than one cost sharing category, one state (Utah) increased both copayment and coinsurance requirements, while the other state (South Carolina) increased both copayment and deductible requirements.

- Both Nebraska and South Carolina increased prescription drug copayments by $1, and Utah increased copayments for drugs by $2.
- In North Dakota, copayments for inpatient hospitalization increased from $50 to $75 per stay, and copayments for nonemergency visits to the ER increased from $3 to $6 per visit.
- Washington implemented a $3 copayment for nonemergency visits to the ER in July 2002, while Oklahoma added $1 to $3 copayments for certain services, such as outpatient hospital services.

Table 17: States' Changes to Cost Sharing for Adults in Medicaid, State Fiscal Year 2001 through August 1, 2003

	Number of states					
	Copayment			Coinsurance		
Population	Increased	Decreased	No change	Increased	Decreased	No change
Pregnant women	2	0	1	0	0	1
Individuals in nursing homes and institutions	1	0	0	0	0	0
Noninstitutionalized elderly persons	24	4	15	2	1	4
Adults with disabilities	24	4	16	2	1	4
Medically needy	17	4	11	2	1	2
Parents	21	3	14	2	1	4

Source: GAO analysis of state survey responses.

During this same time period, five states reported decreasing copayment or coinsurance requirements for portions of their adult population. Specifically, Illinois, Indiana, Maryland, and Montana decreased copayment amounts for some portion of adults. For example, both Illinois and Maryland eliminated their $1 copayments for generic prescription drugs.[34] Only Arkansas decreased coinsurance requirements for adults. In November 2001, the state decreased the coinsurance amount for inpatient hospitalization for most adults by 12 percent, from 22 percent of the cost of the first day of hospitalization to 10 percent.[35]

[34]Maryland eliminated its generic prescription drug copayment in November 2002, and Illinois made its change in July 2003. Both states still required some portion of adults to pay copayments for brand name prescriptions.

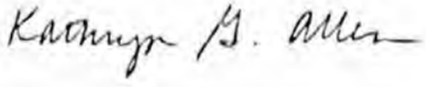
[35]In Arkansas, the cost sharing requirements for working individuals with disabilities were different from those of other Medicaid adults. The state did not change cost sharing requirements for working individuals with disabilities during the period under review.

Agency Comments

We asked CMS officials to verify the technical accuracy of the statutory and regulatory information on Medicaid and SCHIP beneficiary contributions presented in the background section of this report. These officials provided technical comments, which we have incorporated as appropriate. Because we did not evaluate CMS's management of the Medicaid and SCHIP programs, we did not ask CMS to comment on other sections of this report.

As agreed with your offices, we plan no further distribution of this report until 30 days from its date of issue, unless you publicly announce its contents. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please call me on (202) 512-7118 or Carolyn Yocom on (202) 512-4931 if you have questions about this report. Major contributors to this report are listed in appendix X.



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Service Utilization Rates for Low-Income Individuals

The medical expenses charged to an individual—particularly for cost sharing provisions—can vary depending on the amount and type of services used. The Medical Expenditure Panel Survey (MEPS) provides data on individuals' annual utilization of medical services. MEPS, conducted by the Agency for Healthcare Research and Quality (AHRQ), consists of four surveys, including the Household Component, which provides nationally representative data and expenditures for the U.S. civilian noninstitutionalized population. The MEPS Household Component is a survey of individuals regarding their demographic characteristics, health insurance coverage, and health care use. At the time of our analysis, the 2000 version of the MEPS household component was the most recent version with all of the necessary data available.

To determine service utilization for low-income populations, we included individuals with incomes below 200 percent of the FPL.[1] For this cohort, we analyzed data for the following five population groups: (1) children (defined as individuals under age 18), (2) pregnant women aged 18 and over, (3) elderly persons—individuals aged 65 and over, (4) adults aged 18 to 64 with disabilities,[2] and (5) nondisabled adults aged 18 to 64. For each of these population groups, we calculated the proportion of the population that used the following five services—(1) inpatient hospital, (2) outpatient hospital, (3) physician, (4) prescription drug, and (5) dental—at least once during the year (see table 18).[3] For example, approximately 38 percent of children had a nonpreventive physician visit during the year, and almost 79 percent of adults with disabilities visited the physician for nonpreventive care.

[1]In 2000, the FPL for an individual equated to $8,350 per year and $14,150 for a family of three in the 48 contiguous states and the District of Columbia.

[2]MEPS defines individuals with disabilities as individuals who identified needing assistance with at least one activity of daily living (ADL) or instrumental activity of daily living (IADL). MEPS identifies ADLs as basic physical activities such as bathing, dressing, or getting around the house and IADLs as cognitive or social functions such as using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping. MEPS offers a relatively expansive definition of disability in that it does not distinguish the number of ADLs or IADLs with which an individual may require assistance.

[3]For physician services, we did not include services provided by non-physician practitioners. We excluded orthodontia from our analysis of dental services, and nonemergency use of the emergency room because there was no MEPS category for these services.

Table 18: Percentage of the Population Below 200 Percent of the FPL Who Used Selected Services during 2000

Services	Children	Pregnant women	Noninstitutionalized elderly	Adults with disabilities	Nondisabled adults
Inpatient hospital (discharges)	3.9	50.5	19.3	26.8	6.4
Outpatient hospital (visits)	4.8	29.5	27.2	28.1	9.2
Office-based physician visits					
Nonpreventive	38.1	60.5	68.7	78.7	39.7
Nonemergency	56.0	89.7	87.3	86.8	51.2
Prescription drugs (prescriptions filled)	44.8	83.2	89.4	96.0	54.2
Dental (visits)					
Nonpreventive	4.6	11.9	14.2	13.1	9.2
Nonemergency	25.9	25.0	27.3	28.4	23.1

Source: GAO analysis of AHRQ's MEPS household component, 2000.

Note: For each service, the data represent the percentage of the population below 200 percent of the FPL who used that particular service at least once during the year.

For the individuals in each population group who used a service, we calculated their average utilization rates for each of the selected services. The utilization rates for each service, displayed in table 19, represent the average use among individuals who used that particular service at least once during the year. Additionally, since federal law generally does not allow states to charge Medicaid cost sharing for emergency services, we calculated the utilization rates for nonemergency physician and dental visits by excluding visits classified in MEPS as emergencies. Similarly, since SCHIP generally does not allow states with separate SCHIP programs to require cost sharing for preventive medical or dental visits, we excluded certain types of visits we considered as preventive, such as well-child exams and dental visits for teeth cleaning.

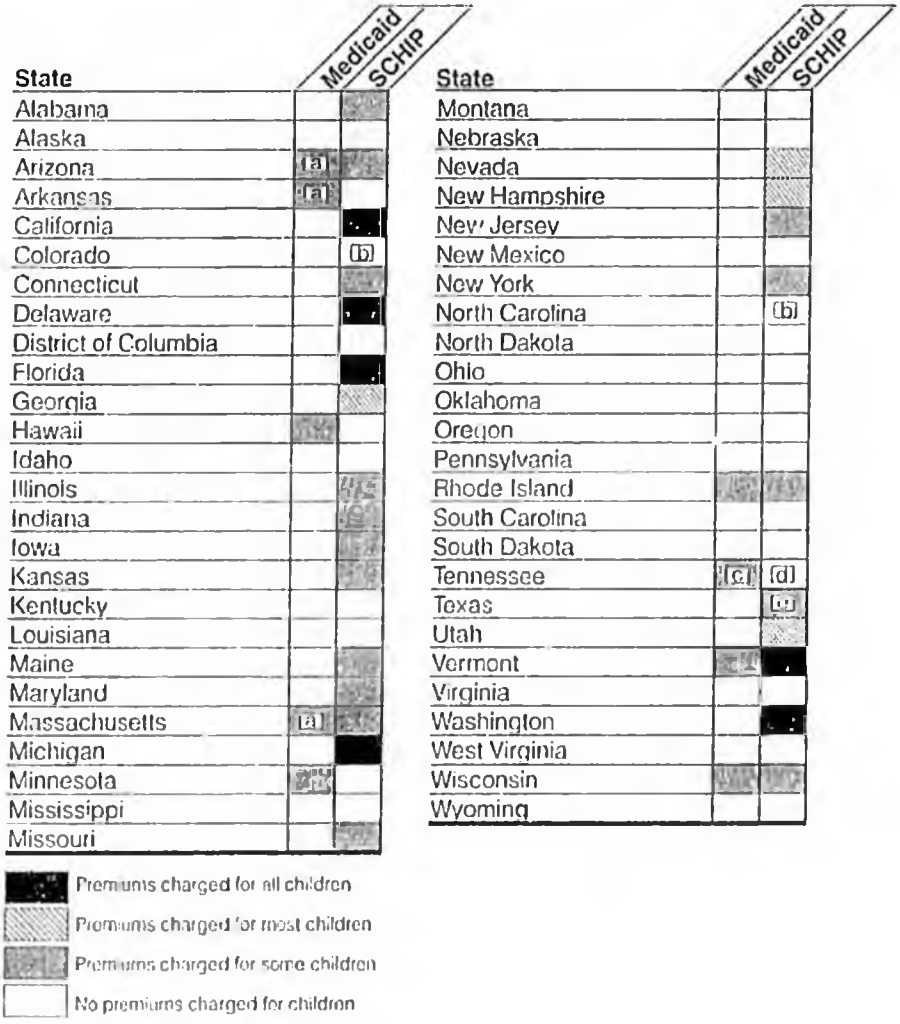
Table 19: Average Utilization Rates for Individuals Below 200 Percent of the FPL Who Used Selected Services during 2000, by Population

Service	Children	Pregnant women	Noninstitutionalized elderly	Adults with disabilities	Nondisabled adults
Inpatient hospital (discharges)	1.18	1.17	1.43	1.86	1.26
Outpatient hospital (visits)	1.99	3.21	5.73	7.79	3.51
Office-based physician visits					
Nonpreventive	2.94	6.58	5.39	8.42	4.55
Nonemergency	3.17	8.91	7.11	9.37	4.63
Prescription drugs (prescriptions filled)	4.22	15.68	25.71	32.69	11.85
Dental (visits)					
Nonpreventive	1.58	2.31	2.26	2.62	2.73
Nonemergency	1.60	2.43	2.61	2.58	2.28

Source: GAO's analysis of AHRQ's MEPS household component, 2000.

Note: For each service, the data represent the average utilization of individuals who used that particular service at least once during the year. For example, among the children who had at least one outpatient hospital visit during the year, the average was 1.99 visits during the year.

Appendix II: Premium Requirements for Children in Medicaid and SCHIP, by State, as of August 1, 2003



Source: GAO analysis of state survey responses.

Note: In our survey, states were asked to indicate what portion of the population was charged premiums by selecting "all," "most," "some," or "none."

[a] State only charged premiums to some portion of children with special needs.

[b] State did not charge premiums, but had an enrollment fee.

[c] Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged premiums for some children in families with incomes at or above the FPL.

[d] Tennessee did not have a SCHIP program.

[e] Texas also had an enrollment fee.

Appendix III: Premium Amounts for Children in Medicaid and SCHIP, by State, as of August 1, 2003

State	Lowest percentage of the FPL at which state charged premiums[a]	Range of premium amounts[b]	Unit charged[c]
Medicaid			
Arizona	100	$15 or $25	Individual
Arkansas	Varied[d]	$21 to $458[e]	Family
Hawaii	>200	$60	Individual
Massachusetts	>150	$12 per child with $36 family maximum; or $15 to over $928; or 60% to 85% of full premium[f]	Individual and family
Minnesota	[g]	$4 to $300 per individual; $8 to $900 per family[h]	Individual or family
Rhode Island	150	$61 to $92	Family
Tennessee	100	$20 to $550 for an individual; $40 to $1,375 for a family[i]	Individual or family
Vermont	185	$25 or $35	Household
Wisconsin	>150	$30 to over $360[j]	Individual
SCHIP			
Alabama	>150	$50 annual premium per child with a $150 family maximum	Individual and family
Arizona	>150	$10 per child; $15 for more than 1 child	Family
California	>100[k]	$4 or $9	Individual
Connecticut	>235	$30 per child, with a $50 per family maximum	Individual and family
Delaware	101	$10 or $25	Family
Florida	≤200	$20	Family
Georgia	>100	$10 to $20	Household
Illinois	150	$15 to $30	Individual
Indiana	>150	$11 to $25	Family
Iowa	>150	$10 per child with a $20 family maximum	Individual and family
Kansas	151	$10 or $15	Family
Maine	>150	$5 to $20 for 1 child; $10 to $40 for more than 1 child	Individual or household
Maryland	>185	$37 to $50	Family
Massachusetts	>150	$12 per child with a $36 family maximum; or $15 to $35; or 60% of full premium	Individual or family
Michigan	>150	$5	Family
Missouri	226	$59 to $225[l]	Family
Nevada	100	$10 to $50	Household
New Hampshire	185	$25 to $100	Individual

State	Lowest percentage of the FPL at which state charged premiums[a]	Range of premium amounts[b]	Unit charged[c]
New Jersey	200	$16.50 to $110	Family
New York	133	$9 or $15 per individual; $27 or $45 per family	Individual or family
Rhode Island	150	$61 to $92	Family
Texas	151	$15 to $18	Family
Utah	≤150	$13 to $25 per quarter	Family
Vermont	>225	$70	Household
Washington	>200[m]	$10 per individual with $30 family maximum	Individual or family
Wisconsin	≥150	$30 to $360[l]	Family

Source: GAO analysis of state survey responses and documentation provided by states.

[a]In 2003, the FPL for an individual equated to $8,980 per year and $15,260 for a family of three in the 48 contiguous states and the District of Columbia.

[b]Premiums were paid on a monthly basis unless otherwise noted.

[c]In Medicaid and SCHIP, states determine premium charges for an individual, family unit, or household (individuals living in the same house).

[d]Arkansas charged premiums to children in a family of any size with an income above $25,000. The estimated equivalent percentage of FPL at which the state began charging children could have ranged from 120 percent for a family of five to 300 percent based on a family size of 1.

[e]In Arkansas, the highest premium amount, $458 per month, would be charged to a child from a family whose income exceeded $200,000 per year.

[f]In Massachusetts, premiums of $928 or more per month would be charged to a child from a family whose income exceeded 1,000 percent of the FPL, which equated to approximately $153,000 per year for a family of three. Other individuals with other health insurance coverage can be charged a percentage of premiums in order to obtain supplemental coverage.

[g]In Minnesota, families could choose to enroll their children in either the state's regular Medicaid program or its 1115 waiver program – both of which covered children from families with incomes up to 275 percent of the FPL. Children in families that chose to enroll in the 1115 waiver program were charged premiums regardless of their family income. Thus, families with incomes less than 1 percent of the FPL could choose to pay premiums.

[h]In Minnesota, the highest premium amount, $900 per family per month, would be charged to a family whose income was at least 275 percent of the FPL, which equates to approximately $42,000 per year for a family of three.

[i]In Tennessee, the highest premium amount, $1,375 per month, would be charged to a family of three whose income was at least 600 percent of the FPL, which equated to approximately $91,600 per year.

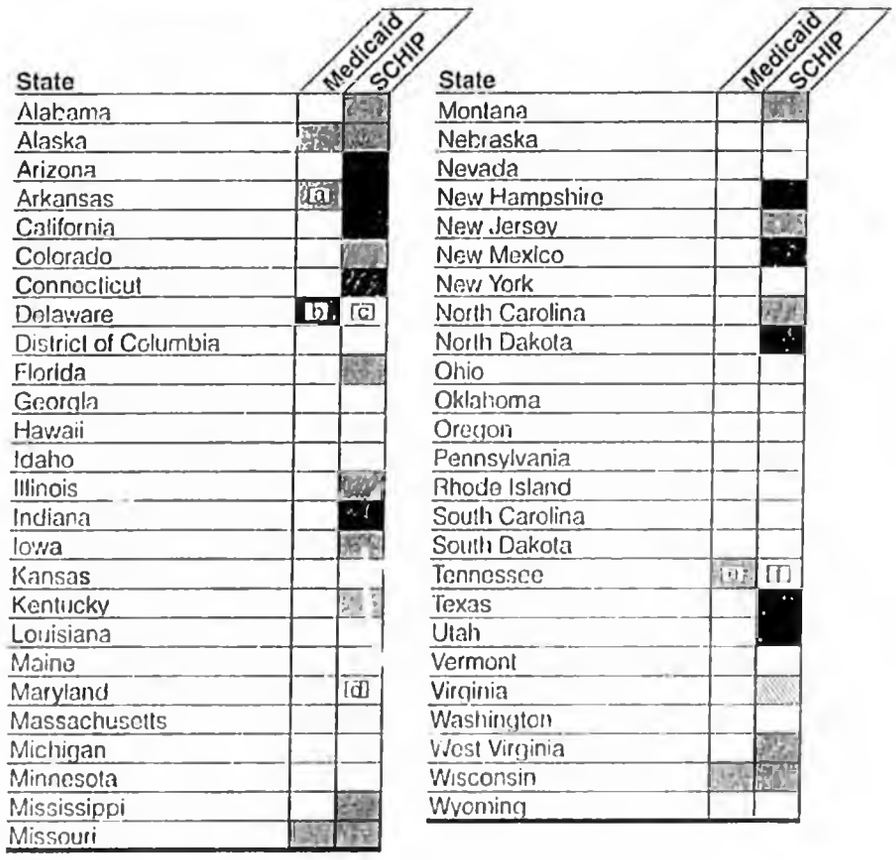
[j]In Wisconsin, monthly premiums of $360 and above would be charged to a child from a family whose annual income was at least $144,000.

[k]The percentage represents an estimated equivalent for the monthly income figures that California provided based on one family member in 2003.

[l]In Missouri, the highest premium amount, $225 per month, would be charged to a family of six or more whose income exceeds $61,700 per year.

[m]The percentage represents an estimated equivalent for the monthly income figures that Washington provided based on one family member in 2003.

Appendix IV: Copayment Requirements for Children in Medicaid and SCHIP, by State, as of August 1, 2003



Source: GAO analysis of state survey responses

Note: In our survey, states were asked to indicate what portion of the population was charged copayments by selecting "all," "most," "some," or "none."

[a]Arkansas charged copayments to all children in its 1115 waiver program, but did not charge copayments to other children.

[b]Delaware's only copayment, which the state charged to all populations in its Medicaid program, was for nonemergency transportation services.

[c]Although Delaware did not charge copayments to children in SCHIP, the state did charge a fee for inappropriate use of the emergency room.

[c]Maryland's SCHIP program did not charge copayments, but SCHIP beneficiaries receiving coverage through Maryland's employer-sponsored insurance program may be charged copayments by their health plan.

[d]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged copayments for some children in families with incomes at or above the FPL.

[e]Tennessee did not have a SCHIP program.

Appendix V: Cost Sharing Amounts for Children in Medicaid and SCHIP, by State, as of August 1, 2003

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of emergency room[a]	Dental services[a]
Medicaid						
Alaska	$50 per day (maximum of $200 per discharge)	5% of allowable charges	$3	$2	5% of allowable charges	NA
Arkansas	20% of the cost of the first day	$10	$10	$5	$10	$10
Delaware[c]	NA	NA	NA	NA	NA	NA
Missouri	$10	$2	$1	[d]	$1 or $2	5% for dentures; $0.50 to $3 for other services
Tennessee	$100 or $200	NA	$5 to $25	$5 or $10	$25 or $50	$15 or $25
Wisconsin	$3	$3	$1 to $3	$0.50 or $1	$3	$0.50 to $3
SCHIP						
Alabama	$5	$5	$5	$1 or $3	$5	$5
Arizona	NA	NA	NA	NA	$5	NA
Alaska	$50 per day (maximum of $200 per discharge)	5% of allowable charges	$3	$2	5% of allowable charges	NA
Arkansas	20% of the cost of the first day	$10	$10	$5	$10	$10
California	NA	$5	$5	$5	$5[e]	$5 per service
Colorado	NA	$2 or $5	$2 or $5	$1 to $5	$3 or $15	coinsurance not to exceed $5 per non-routine service
Connecticut	NA	$5	$5	$3 to $6	$25	$5
Florida	NA	$3	$3	$3	$10	NA
Illinois	$2 or $5	$2 or $5	$2 or $5	$2 to $5	$25	$2 or $5
Indiana	NA	NA	NA	$3 or $10	NA	NA
Iowa	NA	NA	NA	NA	$25	NA
Kentucky	NA	NA	$2	$1	NA	$2
Mississippi	$5	$5	$5	NA	$15	$5
Missouri	NA	$5 or $10	$5 or $10	$9	$5 or $10	$5 or $10
Montana	$25	$5	$3	$3 or $5	$5	NA
New Hampshire	NA	NA	$10	$5 or $10	$50	NA
New Jersey	NA	$5	$5 or $10	$1 to $10	$1 to $10	NA
New Mexico	$25	$5	$5	$2	$15	$5

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of emergency room[a]	Dental services[a]
North Carolina	NA	$5	$5	$6	$20	$5
North Dakota	$50	NA	NA	$2	$5	NA
Texas	$100	NA	$10	$3 to $20	$3 to $50	NA
Utah	$3 or 10% of allowable charges[i]	$3 or 10% of allowable charges[i]	$3 or $15[i]	$1 to $5 or 50% of allowable charges[i]	$3 or $35[i]	$3 or 20% of allowable charges[i]
Virginia	$15 or $25	$2 or $5	$2 or $5	$2 or $5	$10 or $25	$5
West Virginia	$25	$25 per procedure	$15	$5 to $15	$35	NA
Wisconsin	$3	$3	$1 to $3	$0.50 to $1	$3	$0.50 to $3

Source: GAO analysis of state survey responses and documentation provided by states.

NA = Not applicable. The state did not charge cost sharing for this service.

Note: This appendix reflects cost sharing amounts charged by states for the portion of the Medicaid and SCHIP populations subject to cost sharing charges. The amount of cost sharing and the services subject to cost sharing may vary within a state by population. See Appendix IV for details on the portion of children subject to copayment requirements in Medicaid and SCHIP.

[a]Cost sharing amount is on a per visit or per admission basis unless otherwise noted.

[b]Cost sharing amount is on a per prescription basis unless otherwise noted.

[c]Delaware charged a $1 copayment for nonemergency transportation.

[d]Missouri did not have a copayment for prescription drugs in Medicaid, but some children were charged a dispensing fee for prescriptions.

[e]California charged a $5 copayment for emergency services, which is waived if the beneficiary is hospitalized. However, the state did not cover nonemergency services provided in the emergency room.

[f]Utah SCHIP charged a copayment for children with a family income at or below 150 percent FPL and charged copayment or coinsurance for children in a family with a higher income level.

Appendix VI: Premiums for Adult Populations in Medicaid, by State, as of August 1, 2003

State	Pregnant women	Adults in nursing homes or institutions	Noninstitutionalized elderly	Adults with disabilities[a]	Medically needy	Parents
Alaska					[b]	[b]
Arizona						
California						
Connecticut				[c]		
Hawaii[d]						
Illinois				[c]		
Indiana						
Iowa						
Kansas						
Maine[e]						
Massachusetts						
Minnesota						
Mississippi					[b]	
Missouri					[b]	
Nebraska						
New Hampshire						
Oregon[d]					[b]	
Pennsylvania						
Rhode Island						
Tennessee[f]	[g]	[g]	[g]	[g]	[g]	[g]
Utah[h]						
Vermont[i]						
Washington				[c]		
Wisconsin						
Wyoming				[c]	[b]	

Premiums charged for all adults

Premiums charged for most adults

Premiums charged for some adults

No premiums charged for adults

Source: GAO analysis of state survey responses.

Notes: In our survey, states were asked to indicate what portion of the population was charged premiums by selecting "all," "most," "some," or "none." They were also asked to designate if Medicaid did not cover a population in their state.

The following states did not charge premiums to any adults in Medicaid: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Michigan, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Virginia, and West Virginia.

[a]This population includes working adults with disabilities. States may require premiums from certain working adults with disabilities who received Medicaid coverage under the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999.

[b]Population not covered in the state's Medicaid program.

[c]State charged premiums to all working individuals with disabilities, but did not charge premiums to other adults with disabilities.

[d]State charged premiums to some portion of childless adults.

[e]Maine charged premiums to individuals in the state's HIV/AIDS waiver program.

[f]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged premiums to some adults enrolled in the state's 1115 waiver program who had incomes at or above the poverty level.

[g]Not applicable: Tennessee did not report information based on these population groups.

[h]Utah charged an enrollment fee to all adults enrolled in the state's primary care waiver program.

[i]Vermont charged premiums to some adults enrolled in the state's 1115 waiver program.

Appendix VII: Premium Amounts for Adults in Medicaid, by State, as of August 1, 2003

State	Lowest percentage of the FPL at which state charged premiums[a]	Range of premium amounts[a]	Unit charged
Alaska	100	Formula based on family income	Individual
Arizona	100	$15 or $25	Individual
California	[b]	$20 to $250 for an individual; $30 to $375 for a couple	Individual or couple
Connecticut	>200	10% of monthly income exceeding 200% of the FPL	Individual and spouse
Hawaii	[b]	$30, $60, or amount varied[c]	Individual
Illinois	>250	$6 to $100	Individual
Indiana	150	$48 to $187 for an individual; $65 to $254 for a couple	Individual or couple
Iowa	>150	$20 to $201	Individual
Kansas	100	$55 to $152 for an individual; $74 to $205 for a couple	Individual or couple
Maine	150[d]	$10 to $40; 3% of family income[e]	Individual or family
Massachusetts	>100[d]	$15 to over $928; 60 to 85% of full premium[f]	Individual or family
Minnesota	[b]	$4 to $900[g]	Individual, family, or household
Mississippi	150	$55 to $91 for an individual; $75 to $122 for a couple	Individual or couple
Missouri	>150	Formula based on income	Individual
Nebraska	100[d]	$31 to $183 for an individual; $41 to $247 for a couple; $22 to $139 for a household	Individual, couple, or household
New Hampshire	150	$80 to $220	Individual
Oregon	[b]	$6 to $20	Individual
Pennsylvania	[b]	5% of income	Individual
Rhode Island	150[d]	$61 to $92	Family
Tennessee	100	$20 to $550 for an individual; $40 to $1,375 for a family	Individual or family
Utah	100	15% of income	Individual
Vermont	> 50[d]	$10 semi-annually to $75 per month	Individual or household
Washington	11[d]	Formula based on income	Individual or household
Wisconsin	>150	$25 to $100[h]; $30 to $300	Individual or family
Wyoming	100	Formula based on income	Individual

Source: GAO analysis of state survey responses and documentation provided by states.

Notes: The following states did not charge premiums to any adults in Medicaid: Alabama, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Michigan, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Virginia, and West Virginia.

This appendix reflects the range in premiums states charged across their entire adult population.

[a]In 2003, the FPL for an individual equated to $8,980 per year and $15,260 for a family of three in the 48 contiguous states and the District of Columbia.

[b]Unless otherwise noted, premiums were paid on a monthly basis. Additionally, states have discretion in defining income for purposes of eligibility determination.

[c]The lowest income level at which an adult could be charged premiums in this state's Medicaid program equated to less than one percent of the FPL. However, for certain populations, there were higher income thresholds at which the state began charging premiums.

[d]In Hawaii, the premium amount for certain individuals varied based on the individual's age, gender, geographic location and health plan.

[e]Represents the lowest income level at which an adult could be charged premiums in this state's Medicaid program. However, for certain populations there were higher income thresholds at which the state began charging premiums.

[f]In Massachusetts, premiums of $928 or more per month would be charged to a child from a family whose income exceeded 1,000 percent of the FPL, which equated to approximately $153,000 per year for a family of three. Other individuals with other health insurance coverage can be charged a percentage of premiums in order to obtain supplemental coverage.

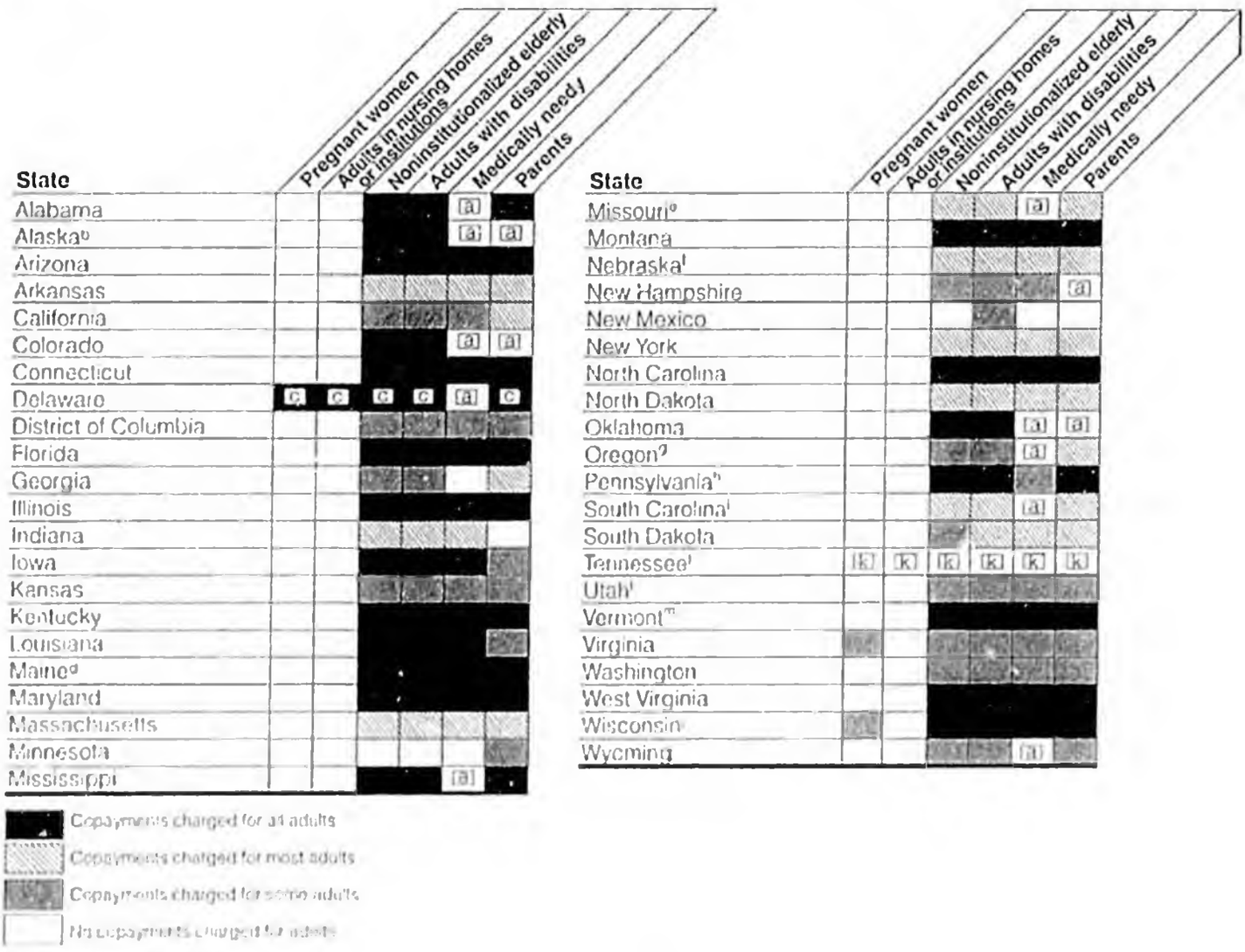
[g]In Minnesota, the highest premium amount, $900 per family per month, would be charged to a family whose income was at least 275 percent of the FPL, which equated to approximately $42,000 per year for a family of three.

[h]Pennsylvania charged premiums only for working individuals with disabilities whose incomes were below 250 percent of the FPL.

[i]The highest premium amount, $1,375 per month, would be charged to a family whose income was at least 600 percent of the FPL, which equated to approximately $91,600 per year.

[j]The highest premium amounts were for certain working individuals with disabilities. The premium amount charged was approximately three percent of the individual's earned income and all of the individual's unearned income after disregarding certain living and medical expenses.

Appendix VIII: Copayment Requirements for Adults in Medicaid, by State, as of August 1, 2003



Source: GAO analysis of state survey responses.

Notes: In our survey, states were asked to indicate what portion of the population was charged cost sharing by selecting "all," "most," "some," or "none." They were also asked to designate if a population was not covered by their states' Medicaid program.

The following states did not charge copayments to any adults in Medicaid: Hawaii, Idaho, Michigan, Nevada, New Jersey, Ohio, Rhode Island, and Texas.

[f]Population not covered in the state's Medicaid program.

[b]Alaska also charged copayments to all individuals qualifying for transitional Medicaid assistance.

[d]Delaware's only copayment, which the state charged to all populations in its Medicaid program, was for nonemergency transportation services.

[e]Maine also charged copayments to all individuals enrolled in its HIV/AIDs waiver program and all individuals in its comprehensive 1115 waiver program.

[f]In addition, individuals participating in the Missouri's 1115 waiver program, which extends 12 months of additional coverage to working parents or caretakers, were also charged copayments. As of January 2004, this program had approximately 2,400 beneficiaries.

[g]Nebraska also charged copayments to most individuals in its refugee resettlement program.

[h]Oregon also charged copayments to most childless adults.

[i]Pennsylvania also charged copayments to most adults in its general assistance program.

[j]State also charged copayments to all individuals in its state's Medicaid pharmacy program.

[k]Tennessee, which operates its entire Medicaid program under an 1115 waiver, charged copayments to some adults enrolled in the state's 1115 waiver program who had incomes at or above the poverty level.

[l]Not applicable: Tennessee did not report information based on these population groups.

[m]Utah also charged copayments to all individuals enrolled in its primary care waiver program.

[n]Vermont also charged copayments to all individuals enrolled in its 1115 waiver program.

Appendix IX: Cost Snaring Amounts for Adults in Medicaid, by State, as of August 1, 2003

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of the emergency room[a]	Dental services[a]
Alabama	$50	$3	$1	$0.50 to $3	$3	NA
Alaska	$50 per day ($200 maximum per discharge)	5% of allowable charges	$3	$2	5% of allowable charges	NA
Arizona	NA	NA	$1	NA	$5	NA
Arkansas	10% to 25% of per diem amount	$10	$10	$0.50 to $15	$10	$10
California	NA	$1	$1	$1	$5	NA
Colorado	$15	$3	$2	$0.75 or $3	$3	NA
Connecticut	NA	NA	NA	$1	NA	NA
Delaware[c]	NA	NA	NA	NA	NA	NA
District of Columbia	NA	NA	NA	$1	NA	NA
Florida	$3	$3	$2 per day per provider	NA	NA	5% of charges
Georgia	$12.50	$3	$2	$0.50	$3	NA
Illinois	$2 or $3 per day[f]	NA	$2	$1 to $3	NA	NA
Indiana	NA	NA	NA	$0.50 to $3	$1 to $2	NA
Iowa	NA	N/	$3	$0.50 to $3	NA	$3
Kansas	$48	$3	$2	$3	NA	$3
Kentucky	NA	NA	$2	$1	NA	$2
Louisiana	NA	NA	NA	$0.50 to $3	NA	NA
Maine	$0.50 to $3[e]	$0.50 to $3[e]	$0.50 to $3[e]	$2.50 to $10	NA	NA
Maryland	NA	NA	NA	$2 to $7.50	NA	NA
Massachusetts	NA	NA	NA	$2	NA	NA
Minnesota	NA	NA	NA	$3	NA	50% of payment rate
Mississippi	$10 per day (maximum of one-half of first day per diem)	$3	$3	$1 or $3	$3	$3
Missouri	$10	$2 or $10[f]	$1[g] or $10[f]	$0.50 to $2 or $5[f]	$1 or $2	$0.50 to $3 or 5% of charges or $10[f]
Montana	$100	$5	$4	$1 to $5	$5	$3

State	Inpatient hospital[a]	Outpatient hospital[a]	Physician services[a]	Prescription drugs[b]	Nonemergency use of the emergency room[a]	Dental services[a]
Nebraska	NA	$3	$2	$2 per person	NA	$3 per service
New Hampshire	NA	NA	NA	$0.50 or $1	NA	NA
New Mexico	$25	$5	$5	$2	$15	$5
New York	$25 per visit with an overnight stay	$3	NA	$0.50 or $2	$3	NA
North Carolina	NA	$3	$3	$1 or $3	NA	$3 per service
North Dakota	$50	$1 or $2	$2	$3 (brand name only)	$3	$2
Oklahoma	$3 per day	$3 per day	$1 per service	$1 or $2	NA	NA
Oregon	$250	$3 to $20	$3 to $5	$2 to $15	$50	$10 to $100
Pennsylvania	$3 per day; maximum of $21 per admission	$0.50 to $3	$0.50 to $3	$1	$1 to $6	$0.50 to $3
South Carolina	NA	NA	NA	$3 to $21[b]	NA	NA
South Dakota	NA	5% of payment; maximum of $50	$2	$2	5% of payment; maximum of $50	$1
Tennessee	$100 or $200	NA	$5 to $25	$5 or $10	$25 or $50	$15 or $25
Utah	$220	$2 or $3	$3 or $5	$2 to $5 or 25% of cost	$6 or $30	10% of allowable Medicaid payment
Vermont	$50 or $75	$3 or $25 per day	$7	$1 to $10 or 50% to 60%	$60	$3
Virginia	$100	$3	$1	$1	NA	NA
Washington	NA	NA	NA	NA	$3	NA
West Virginia	NA	NA	NA	$0.50 to $3	NA	NA
Wisconsin	$3 per day; maximum of $75	$3	$1 to $3	$.50 to $15[c]	$3	$.50 to $3
Wyoming	NA	$6	$2	$2 to $25	$6	NA

Source: GAO analysis of state survey responses and documentation provided by states.

NA = Not applicable. The state did not charge cost sharing for this service.

Notes: The following states did not charge cost sharing to any adults in Medicaid: Hawaii, Idaho, Michigan, Nevada, New Jersey, Ohio, Rhode Island, and Texas.

Appendix IX: Cost Sharing Amounts for Adults in Medicaid, by State, as of August 1, 2003

This appendix reflects cost sharing amounts charged by states for the services and portions of the Medicaid adult populations subject to cost sharing charges. The amount of cost sharing and the services subject to cost sharing may vary within a state by population. See Appendix VIII for details on the adult populations subject to copayment requirements in Medicaid.

[a]Cost sharing amount is on a per visit or per admission basis unless otherwise noted.

[b]Cost sharing amount is on a per prescription basis unless otherwise noted.

[c]Delaware's only cost sharing was a $1 copayment for nonemergency transportation.

[d]Illinois did not require cost sharing for all procedures within this service.

[e]Maine had a $3 daily limit and a $30 monthly limit for these services.

[f]Copayment is for individuals participating in the Missouri's 1115 waiver program, which extends 12 months of additional coverage to working parents or caretakers. As of January 2004, this program had approximately 2,400 beneficiaries.

[g]Missouri's copayment for physician services is only for services rendered in a hospital outpatient clinic or emergency room.

[h]South Carolina had a $500 deductible for elderly individuals enrolled in the state's pharmacy waiver.

[i]Wisconsin also had a deductible—either $500 or $850, depending on income levels—for elderly individuals enrolled in the state's pharmacy waiver program.

Appendix X: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn Yocom, (202) 512-4931

Acknowledgments

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ATTACH #3

NATIONAL ACADEMY *for* STATE HEALTH POLICY

May 2006

SCHIP Buy-in Programs

Prepared by: Cynthia Pernice and
David Bergman

The State Children's Health Insurance Program (SCHIP) was created in 1997 to cover uninsured children from families with incomes of 200% or less of the Federal Poverty Level (FPL). In 2005, 49 states and the District of Columbia were operating a SCHIP program. These programs have had their intended effect of reducing the number of uninsured children. Some states, however, have observed that children leaving the SCHIP program due to loss of financial eligibility become uninsured because their families either do not have access to employer coverage or cannot afford private coverage.

By 2005 seven states had developed programs to fill in this coverage gap by augmenting their SCHIP programs with "buy-in" programs. In a buy-in program families with incomes in excess of SCHIP program eligibility limits are allowed to purchase insurance coverage for their children through the state's SCHIP program.[1] Families pay for a significant portion (or all) of the cost the state incurs for the coverage. The seven states operating buy-in programs are Connecticut, Florida, Maine, North Carolina, New Hampshire, New York, and Pennsylvania. Four of these states – Florida, New Hampshire, New York, and Pennsylvania – had implemented a buy-in program prior to the passage of SCHIP. In September 2005, these seven states reported covering a total of 837,290 children in their SCHIP programs, and 44,416 in their buy in programs (Table 1). These states further report that their buy-in programs cost them little to operate and are needed to fill a coverage gap for children.

Table 1: Enrollment in SCHIP and SCHIP buy-in programs

State	Point in time SCHIP enrollment (as of September 2005)	Point in Time Buy-in Enrollment (as of September 2005)
Connecticut	14,963	708
Florida	202,133	20,401
Maine	14,300	100
North Carolina	130,291	2,655
New Hampshire	7,114	1,409
New York	340,000	12,262
Pennsylvania	128,589	7,881

Source: NASHP staff research

State SCHIP program staff have expressed interest in learning more about these seven states' experience in operating buy-in programs so that they might make a more informed decision about whether or not to pursue establishing buy-in programs of their own.

To meet this need, National Academy for State Health Policy (NASHP) staff examined key elements of the seven state buy-in programs in operation in 2005. The information used to prepare this brief was collected from state websites and telephone interviews with the state staff who administer buy-in programs. Representatives from each of the seven states also reviewed a draft of this brief. The remainder of this brief summarizes essential aspects of buy-in programs in the areas of administration, eligibility, and premiums and benefits.

Program Administration

All seven states use the same administrative structure for their buy-in programs as they do for their SCHIP programs. States that contract with a vendor to administer their SCHIP program use the same vendor—and often the same contract—to provide the same functions for their buy-in programs. Similarly, state staff that perform administrative functions for the SCHIP programs perform those same functions for the buy-in programs.

Six of the seven states with buy-in programs pass on the full cost of administering the program to the families participating in the program. They do this by charging participating families a premium that covers both the amount the state pays for the health care coverage and the cost to administer the program. However, in New Hampshire, the New Hampshire Healthy Kids Corporation (NHHK), the administrative vendor that manages the SCHIP program, operates the buy-in program outside of its contract with the state. NHHK has negotiated agreements with insurers to donate their administrative cost so the only administrative cost added to the family premium is for NHHK administrative costs.

About SCHIP

The Balanced Budget Act of 1997 included the authorization of Title XXI of the Social Security Act, otherwise known as the State Children's Health Insurance Program (SCHIP). In creating SCHIP, Congress sought to assist state efforts to initiate and expand the provision of health benefits coverage to uninsured, low-income children.

States can provide SCHIP coverage to low-income children by using one of three options:

- Create a separate child health program (S-SCHIP),
- Expand eligibility for benefits under the state's Medicaid plan (M-SCHIP), or
- Implement both types of programs (combination).

All SCHIP programs are designed and administered by states within federal SCHIP rules. States have more flexibility in the design of S-SCHIP programs than M-SCHIP programs because S-SCHIP programs are bound by federal SCHIP rules while M-SCHIP programs are bound by both SCHIP and Medicaid rules.

ELIGIBILITY

The states that offer buy-in programs have established income eligibility policies (Table 2) that indicate the program's purpose of filling in a coverage gap for children from families with incomes too high to qualify for SCHIP.

In six of the seven states the minimum income eligibility limit for the buy-in program is explicitly set at the point at which income eligibility for the SCHIP program ends. North Carolina, New Hampshire, and Pennsylvania have also established upper income limits for their buy-in programs. New Hampshire specifies that in order to qualify for the buy-in program a child must be a legal alien and not eligible for SCHIP. This means that legal alien children who have not been in the United States for 5 years (the minimum for SCHIP eligibility) are eligible for the buy-in program.

Maine and North Carolina make a direct link between qualifying for eligibility in the buy-in program and losing eligibility for the SCHIP program due to increased income. In these states the only children who qualify for the buy-in program are those leaving the SCHIP program (in effect there can be no break in coverage between "graduating" from the SCHIP program and entering the buy-in program). In addition, in North Carolina only children who have been enrolled in SCHIP for a least one year are eligible for the buy-in.

Table 2: Overview of eligibility policies in the seven state buy-in programs

State	Lower Income Limit (FPL)	Upper Income Limit (FPL)	Upper Age Limit (years)	Maximum Time a Child May Remain in the Program (months)	How Often Eligibility is Redetermined	Other limits
Connecticut	300%	None	Through 18	None	Annually	None
Florida	200%	None	Through 18	None	Annually	Enrollment capped at 10% of total SCHIP enrollment[2]
Maine	200%	None	Through 18	18	Never	May only join when leaving the SCHIP program
North Carolina	200%	235%	Through 18	12	Never	May only join when leaving the SCHIP program
New Hampshire	300%	400%	Through 18, except until 21 if in high school	None	Never	None
New York	208% net 250% gross	None	Through 18	None	Never	None
Pennsylvania	200%	235%	Through 18	None	Annually	None

Source: NASHP staff research

Six of the seven states have established an upper age limit for the buy-in program that is the same as the SCHIP program age limit (though age 18). New Hampshire requires most children to leave the program after their 19th birthday but allows those who are high school students to remain until age 21.

Five of the seven states with buy-in programs have a mechanism in place that positions their buy-in programs as a bridge to other coverage—not as a long-term source of coverage.

- Maine and North Carolina have a maximum limit (18 months and 12 months, respectively) on the length of time a child may remain in the buy-in program.
- Connecticut, Florida, and Pennsylvania require program participants to submit information annually to determine their eligibility.

In all seven states with buy-in programs, a family that participates may request an eligibility assessment at any time to determine if they are eligible for SCHIP or Medicaid.

Premiums and Benefits

Monthly premiums range from a low of $97 per child in one region of New York[3] to $220 per child for a plan in Connecticut (Table 3). In six of the buy-in programs (all but Pennsylvania), participating families pay the full cost of the premium. In Pennsylvania, the premium cost is shared by the state and participating families—each pays half of the full premium cost of $132 per child per month.

Table 3: Overview of premiums and benefits in the seven buy-in programs

State	Premium (per child per month)	Uses same contract for buy-in and SCHIP program	Offers Same Benefit Package to Buy-in and SCHIP program Participants
Connecticut	$168-$220 depending on the plan	Yes	Yes
Florida	$110 ($98 without dental coverage)	Yes	Yes, except families may elect not to take dental for a reduced premium
Maine	$102	Yes	Yes
North Carolina	$196.74	Yes	Yes
New Hampshire	$130	No	No, package excludes prenatal, labor, and delivery services
New York	$97-$152 (depending on the plan)	Yes	Yes
Pennsylvania	$132 (State-wide average of 7 different contractors. The family pays half of the total.)	Yes	Yes

Source: NASHP staff research

Six of the seven states (all except New Hampshire) offer the same benefits to children enrolled in the buy-in program as they do to those enrolled in the SCHIP program—and these six states have also included buy-in participants in the contracts they have with health plans for their SCHIP programs. New Hampshire offers a reduced benefit package and has separate contracts with health plans for the buy-in participants.

Conclusion

Buy-in programs for children no longer eligible for SCHIP, such as those described here, cost states little to operate. The states with buy-in programs view them as filling a coverage gap for children of working families who don't have access to or cannot afford employer-based or private coverage. While enrollment it these programs is small, they do offer a vehicle for coverage for a population of children that would not otherwise be covered.

Notes

[1] Federal SCHIP funding is not used to pay for any part of the cost of covering these families.

[2] Florida reports that the buy-in program has historical enrollment levels of approximately 5% of the SCHIP enrollment. However, over the last 18 months, buy-in enrollment as a percentage of SCHIP enrollment has steadily increased. In October 2005 buy-in enrollment reached a peak of 10.1%.

[3] In New York, Health Plans create regions in which they offer different plans. An individual region could have multiple plans competing for enrollees. Nonetheless, the premiums within the state range from $97 PM/PM to $152 PM/PM.

About NASHP

The National Academy for State Health Policy is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states. We are a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice.

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4A

Help Paying for Health Insurance

The Insurance Partnership
From the Commonwealth of Massachusetts

THE COST OF HEALTH CARE IS ON THE RISE. That's why the Commonwealth of Massachusetts has created a program to help you and your employees pay for health insurance. The Insurance Partnership is not a health plan. Instead, the Insurance Partnership makes health insurance more affordable for qualified business owners (including self-employed) and their uninsured employees.

Important Advantages for Your Business:

- decreases the cost of health insurance coverage for the employer
- makes it more affordable for employees to pay for health insurance
- improves a company's business reputation
- helps attract and retain valued employees - and improves morale
- delivers payments up-front, to help with cash flow
- makes health insurance more accessible to all employees

How Does the Insurance Partnership Help Pay?

For each enrolled employee, the Insurance Partnership pays the business a fixed monthly sum determined by the tier of coverage the employee elects. Additionally, the business will receive a Premium Assistance payment(s) made on behalf of its' enrolled employees; your company is responsible for reducing enrolled employee's payroll deductions to reflect our Premium Assistance payment(s). Our monthly statement provides a breakdown of all payments made.

How Much Can Your Business Save?

For each eligible employee enrolled, the business will receive up to $1,000 a year in Insurance Partnership payments based on the employee(s) tier of coverage (the business must have an enrolled eligible employee to receive a payment).

Tier of Coverage	Monthly Payment to Employer	=	Annual Savings of:
Individual	$33.33		$ 400 per enrolled
Couple	$66.66		$ 800 "
One adult, one child	$66.66		$ 800 "
Family	$83.33		$1,000 "

Does Your Business Qualify?

To join the Insurance Partnership, a business must:

- employ 50 or fewer full-time employees (or be self-employed)
- offer (or plan to offer) comprehensive health insurance to its employees
- contribute (or be willing to contribute) at least 50% of the cost of the insurance purchased by the employee
- Have at least one uninsured employee

How Will Your Employees Benefit?

A currently uninsured employee's cost for health insurance can be significantly reduced to as little as $12 to $160 per month – we pay the balance (up to $150 each for an employee and spouse, and up to $210 for each child under the age of 19). Employees cannot be currently enrolled in the company health plan to apply, as this program is for uninsured employees.

Do Your Employees Qualify?

To qualify for the Insurance Partnership Program, an employee must:

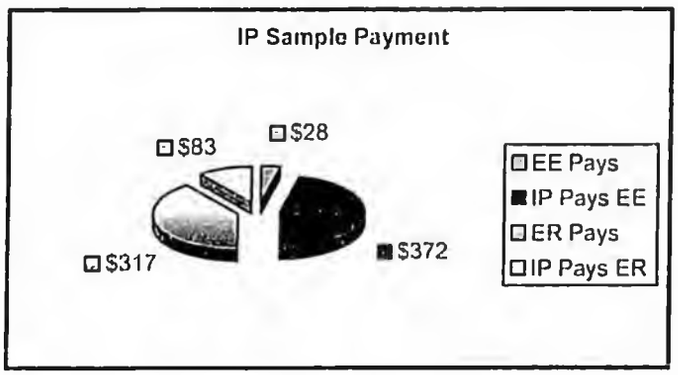
- be between the ages of 19 and 64 (inclusive)
- be a resident of Massachusetts
- not have been offered health insurance through his employer during the past six months, and not have been eligible for coverage through his spouse's employer during the past six months
- have a family income that does not exceed the Employee Income Standards to the right

Employee Income Ceilings*:

Family Size	Maximum Family Income*
1	$29,412
2	$39,600
3	$49,800
4	$60,012
5	$70,200

*Each additional dependent please add $10,200. Effective October 1, 2006 through March 31, 2007.

Example Breakdown: *Assuming example to right, an $800 monthly premium and 50% employer contribution, savings are:*



An Insurance Partnership Example:

The ABC Company has an eligible employee* (EE) with the family tier of coverage and one child. With the Insurance Partnership (IP), the employee will pay only $28 per month towards health insurance. The employer (ER) receives a separate payment of $83.33 each month for covering this family.

**This example assumes the family has an annual income of $49,000.*

To Apply for The Insurance Partnership:

I. **Complete the applications.** You will need to fill out both the **Employer Application**, and your eligible employees will have to fill out **Medical Benefit Request forms (MBRs)**. If you don't have these applications, please call us or download the applications from our web site.

II. Gather the necessary paperwork: **Businesses with employees** will need to provide a copy of your **WR-1** listing employees, a copy of your **health insurance bill**, or a quote for health insurance if you don't currently offer health insurance. **Your employees** will need to provide along with their completed MBR, 1) copies of their 2 most recent **paystubs**, 2) appropriate proof of identification and/or citizenship – please call for details, and 3) the Insurance Partnership Affidavit.

Self-employed will need to submit copies of last year's **tax returns including Schedule C** (if you are a new business – please call us), a copy of your **health insurance quote**, both the **Employer Application and MBR**, appropriate proof of identification and/or citizenship – please call for details, and the Insurance Partnership Affidavit.

III. Call customer service at the number below to make sure that your applications are complete.

IV. Mail your completed applications to:

The Insurance Partnership
354B Turnpike Street, Suite 204
Canton, MA 02021-2746

Or call us at **1-800-399-8285**
or 781-830-8282

4B

Getting Started

1. Make sure the employer meets the eligibility requirements. (see inside)
2. Contact an insurance agent. (For a list of trained agents, knowledgeable in O-EPIC, visit www.insureoklahoma.org)
3. Complete an O-EPIC business application. (www.insureoklahoma.org)
4. Upon approval, the employer will receive application information for its employees.
5. Employees must then apply and be approved.
6. Employer must send the monthly health plan invoice to O-EPIC.
7. O-EPIC will pay the premium subsidy to the employer monthly.

An example of how the O-EPIC program could work...

This example assumes:

Employee has a family of four: Husband, wife, and two children*

Annual household income: $34,000

Monthly premiums are: $300 for individual and $600 for individual and spouse

Employer Premium Share Amount: $ 75

Employee Premium Share Amount: $ 85

O-EPIC Subsidy Amount: $ 440

O-EPIC will calculate the following:

Payer	Individual	Spouse	Total
Employer	$75	0	$75
Employee	$42.50	$42.50	$85
O-EPIC	$182.50	$257.50	$440
Totals	$300	$300	$600

The employer share is 25 percent of the employee premium rate of $300, or $75.

The employee share is 15 percent of $600, or $90. Since the $90 exceeds 3 percent of the employee family income, the employee share is capped at the 3 percent figure, or $85.

The O-EPIC subsidy equals the remaining balance of $440.

*Children are not eligible for O-EPIC, but may be covered under ***SoonerCare***. Please visit http://www.okhca.org/client/client.asp or contact your local county OKDHS office to find out.

This publication was printed and issued by the Oklahoma Health Care Authority as authorized by 65 O.S. 1991, sec. 3-110, and was funded by tobacco tax revenues deposited into the Health Employee and Economy Improvement Act Revolving fund at a cost of $790.00 for 10,000 copies. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

O-EPIC

Oklahoma Employer/employee Partnership for Insurance Coverage

Citizens, small businesses, the insurance industry, and state government working together to insure Oklahomans.

Health Care Premium Assistance for Employees of Small Businesses

Health Care Premium Assistance for Employees of Small Businesses

The O-EPIC Employer Sponsored Insurance (ESI) program will pay part of the health plan premiums for eligible employees working for qualified Oklahoma small businesses (with 50 or fewer employees). Participation in this program is voluntary.

Oklahoma Small Employer

To be eligible, a business must:

- Have 50 or fewer employees.
- Be located in Oklahoma.
- Offer an O-EPIC qualified health plan.*
- Contribute at least 25 percent of premiums for eligible employees.
- Complete an O-EPIC application packet.

*For a list of qualified O-EPIC plans, please go to http://www.insureoklahoma.org and click on health plans.

An O-EPIC Individual Plan will be offered to people who cannot access Employer Sponsored Insurance through an employer. Enrollment begins January 9, 2007.

For an **employer enrollment packet** or a list of qualified health plans, please contact your local health insurance agent or visit our Web site at http://www.insureoklahoma.org

Oklahoma Employees and their Spouses

To be eligible, an employee must:

- Be between the ages of 19 and 64.
- Agree to participate in the employer's qualified health plan.
- Be an Oklahoma resident and meet citizenship guidelines.
- Have a gross annual household income at or below the annual guidelines.
- Contribute at most 15 percent of monthly premium costs *(not to exceed 3 percent of gross annual household income).*
- Contribute 15 percent of premium costs for spouses eligible for coverage.

The state pays 60 percent of employees' premium costs and 85 percent of premium costs for spouses.

For more detailed program information, please visit http://www.insureoklahoma.org

Employees may apply for O-EPIC after the small business has been approved. For more information, please visit http://www.insureoklahoma.org

2006 Gross Annual Household Income Guidelines

Family Size	Maximum Income
1	$18,130
2	$24,420
3	$30,710
4	$37,000
5	$43,290
6	$49,580
7	$55,870
8	$62,160
9	$68,450
10	$74,740

For families larger than 10 add $6,290 to the maximum income for each additional member.

Toll-Free: 1-888-365-3742

Fax: 1-405-949-9563

Web site: www.insureoklahoma.org

oklahoma health care authority

Oklahoma Health Care Authority
4545 N. Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105

4C

How does Rite Share benefit employers?

Because participation in Rite Share allows your employees to enroll in your company's health insurance at little or no cost to them, you will...

- Attract and retain qualified employees by giving them access to affordable health insurance
- Decrease absenteeism and increase productivity
- Increase participation rates in your health plan, which may help your company maintain qualification for group insurance coverage
- Improve employee satisfaction and health

What do employers need to do to participate in Rite Share?

It's easy to participate in Rite Share and there is no cost to your company. Simply:

- Agree to accept upfront payments from Rite Share for all or part of your employee's share of higher monthly premium
- Help your employee enroll in your company's health insurance plan
- Complete a short application, including information on your company's health insurance plan. This information will allow DHS to determine whether your existing plan meets the benefit levels required for participation in Rite Share. The most common commercial health plans in Rhode Island meet these requirements.

For more information or to schedule a presentation about Rite Share, call the Employer Contact Unit at

(401) 462-0311

or e-mail us at

RiteShare@gw.dhs.state.ri.us

RITE SHARE

Rhode Island Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920
www.dhs.state.ri.us

Non-Discrimination Notice

The Rhode Island Department of Human Services (DHS) does not discriminate against any person on the basis of race, color, national origin, disability, political beliefs, sexual orientation, age, religion, or sex in admission to, participation in, or receipt of the services and benefits of any of its programs and activities. For more information about this policy, call the Community Relations Unit at (401) 462-2181 or TTY hearing impaired (401) 462-0740.

Interpreter Services Notice

DHS will arrange for an interpreter or bilingual staff member to help you read English and sign papers. Before or after a visit or appointment, call DHS. If you have problems getting an interpreter or bilingual services at the Department of Human Services, please call the Limited English Proficiency Coordinator at (401) 462-2181 or TTY hearing impaired (401) 462-0740.

RITE SHARE

Health Insurance Premium Assistance Program

Good for employees, good for business.

Christine C. Ferguson
Director

Lincoln Almond
Governor

Are your employees having difficulty paying their share of your company's health insurance?

RITE SHARE can help!

What is RIte Share?

RIte Share is a public/private partnership that helps low and middle income employees participate in your company's health insurance plan. RIte Share will pay all or part of an employee's share of your company's family health insurance premium. This makes your offer of health insurance more affordable for your employees and their families.

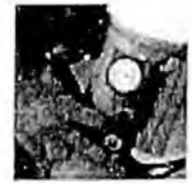
Eligible employees are able to enroll their entire family in your company's existing health insurance plan. RIte Share will pay all or part of an employee's co-payments or premiums.

Who can qualify for RIte Share?

RIte Share is designed for low and middle income working families with children under the age of 19.

Employees apply directly to the RI Department of Human Services (DHS) to determine if they qualify for RIte Share. If your employee qualifies for RIte Share, DHS works with you and your employee to ensure that he or she is enrolled in your company's health plan.

Frequently Asked Questions by Employers about RIte Share



Q: ***Will participating in RIte Share cost my company anything?***

A: There is no cost to participate in RIte Share.

Q: ***Is it difficult to participate in RIte Share?***

A: No, it's easy! As an employer, you complete a short application, and submit a Summary of Benefits for the health plan(s) you offer. You also agree to accept pre-payments from RIte Share for all or part of your employee's contribution to your monthly health insurance premium.

Q: ***Do I have to change the health insurance plan I offer?***

A: No. Most of the health insurance plans that are sold in Rhode Island meet RIte Share benefit level requirements.

Q: ***Why is RIte Share good for my employees?***

A: RIte Share is great for your employees because:

- Employees who qualify for RIte Share get all of the benefits covered by your health insurance plan. They may also receive additional benefits offered and paid for directly by the Rhode Island Medical Assistance Program.
- If previously uninsured, your employees will have less absenteeism and greater productivity.
- RIte Share helps your employees cover their entire family together under one plan.

Q: ***Do I have to offer different benefits to my employees enrolled in RIte Share?***

A: No. As an employer, you continue to offer the same benefits to all of your employees. When employees are found eligible for RIte Share, they are also eligible for a separate Medical Assistance insurance card, which provides additional services not always covered by commercial health insurance.

Q: ***Will this mail bookkeeping more complex and time consuming?***

A: RIte Share is designed to be easy to administer. As an employer, you may have to stop or reduce your eligible employee's payroll deduction for health insurance, inform RIte Share if there are any changes in the employee's status (e.g., employment or access to benefits), and provide information on your health insurance rates to RIte Share on an annual basis.

Q: ***What if I decide to participate and have additional questions about RIte Share?***

A: The RI Department of Human Services has created a special unit, the Employer Contact Unit, a one-stop shop for all of your questions or concerns about the RIte Share program. The staff is dedicated to making participation in RIte Share simple and problem-free.

We care what you think. If you have comments or questions about RIte Share, please call the Employer Contact Unit at (401) 462-0311.

4D

On May 9, 2006, the Vermont General Assembly passed the Health Care Affordability for Vermonters Act. Governor Jim Douglas signed the bill into law on May 25.

The new law will have a significant impact on access to health insurance by Vermonters and on how health care is delivered to Vermonters with chronic diseases.

The bill has three key elements. They are summarized in this brochure. For more details, go to:

www.leg.state.vt.us/HealthCare/2006LegAction.htm

BlueCross BlueShield of Vermont

June 13, 2006

BlueCross BlueShield of Vermont

The Health Care Affordability for Vermonters Act

I. Providing affordable coverage for the uninsured.
II. Changing the way that health care is delivered to Vermonters with chronic diseases.
III. A new tax on employers of $365 per year for each employee not offered insurance or who is offered insurance, chooses not to enroll, and is uninsured.

About 60,000 Vermonters, 10% of the state's population, do not have health insurance. The new law contains two provisions designed to make a comprehensive health insurance policy available and affordable to the uninsured. Both provisions contain a premium subsidy program for Vermonters with incomes less than 300% of poverty (about $60,000 for a family of four).

1. Catamount Health – This is a new insurance product that will be offered by Blue Cross/Blue Shield of Vermont to Vermonters who have been uninsured for 12 months, do not qualify for a government health insurance program or have lost private coverage during the past 12 months for certain specific reasons, such as loss of employment, divorce, or death of a spouse. For in-network services, the new insurance plan will contain a $500 deductible for families, 20% co-insurance, $10 office co-pay, prescription drug coverage with co-pays and an out-of-pocket maximum for a family of $1600.

2. A subsidy for employer sponsored insurance premiums – This government subsidy will make employer sponsored insurance more affordable for workers whose employers offer insurance but who cannot afford to pay the employee share of the premiums. The employer sponsored insurance will have to offer benefits substantially similar to those offered under Catamount Health.

Both Catamount Health and the subsidy program for employer sponsored insurance are scheduled to become available October 1, 2007.

A disease is chronic if it is expected to last a year or more and requires ongoing medical management. Common examples are diabetes, high blood pressure, mental illness and cancer.

About 75% of all health care spending today is for people with chronic diseases.

Our health care system was designed long ago to deal with so-called acute episodes, such as a broken leg. By identifying Vermonters with chronic disease and managing their care on an ongoing basis according to medical best practices, people with chronic disease will live healthier lives and the rate of growth in health care costs may be restrained.

This part of the new law sets a goal of January 1, 2009, for participation by all health care professionals, hospitals, insurers, third-party administrators and Vermonters with chronic diseases in a chronic care management plan to be developed by the Vermont Health Commissioner.

Effective April 1, 2007, with the first quarterly payment due on July 30, 2007, a new tax, called a "premium contribution assessment," will be imposed on employers whose employees do not have health insurance. The assessment is $91.25 per quarter, which is $365 per year, or one dollar per day. This new tax will help to pay for the premium subsidies described earlier in this brochure and will be paid on three kinds of employees:

- All employees of employers who do not offer insurance to anyone.
- Employees of employers who offer insurance to some employees, but who are not eligible themselves.
- Employees who are eligible for their employer plans, but who choose not to enroll and are uninsured.

The tax will be collected quarterly on Full Time Equivalents (FTEs). A FTE is a hypothetical employee who works 40 hours per week for 13 weeks. This methodology allows the tax to be collected for part time employees and employees who work less than the entire quarter.

Small employers are somewhat protected from the new tax by the exemption of eight FTEs in the first two years, six in the third year and four in the fourth year and thereafter.

ATTACH #5

Resolution on Importance of Preventive Care & Early Intervention Services

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS, a growing body of research links early childhood access to preventive health and developmental services with later cognitive, social, emotional, and physical health and development; and

WHEREAS, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the child health component of Medicaid, is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services, including preventive health and early intervention services; and

WHEREAS, the Kaiser Commission on Health recently found that, "while the EPSDT benefit is important to all children, it has been especially beneficial for the 1.3 million children with disabilities enrolled in Medicaid. For these children, Medicaid, through EPSDT, provides more comprehensive coverage than the typical private insurance plan and increases access to needed services that improve the quality of daily life"; and

WHEREAS, Article 7, Section 4 of the Alaska Constitution states that the Legislature shall provide for the promotion and protection of public health; and

WHEREAS, the Legislature has designated the Department of Health and Social Services (DHSS) as the responsible state agency for promoting the health of all Alaskans; and

WHEREAS, the Division of Public Health within DHSS defines as one of its core missions assuring access to early preventive services and quality health care; and

WHEREAS, the Division of Health Care Services within DHSS is responsible for operation of major components of the Alaska Medicaid program, including the state's EPSDT program; and

WHEREAS, in federal fiscal year 2005 Alaska's EPSDT screening rate for Medicaid beneficiaries was reported as 69 percent, with 49,000 out of an expected 69,000 screens performed;

BE IT RESOLVED by the Alaska State Legislature that DHSS, through its Divisions of Public Health and Health Care Services, shall develop strategies and initiatives to promote preventive care and early intervention services and increase the state's EPSDT screening rate; and be it

FURTHER RESOLVED that DHSS shall report periodically to the Legislature on its adopted strategies and initiatives and its progress toward achieving a 100 percent screening rate.

Handout - 2/6/07

Alaska
Medicaid Program Review

PRESENTAT)N OF FINDINGS

The Pacific Health Policy Group
February 2007

MEDICAID REVIEW
Introduction

Pacific Health Policy Group

- PHPG is a health care consulting firm, founded in 1994
- Offices in California and Illinois
- Our focus is Medicaid/SCHIP and other government-funded health care programs
- Have provided assistance to 20+ states
- We also have worked with counties, providers, foundations and private health insurers

MEDICAID REVIEW
Introduction

Project objectives:

- Evaluate the Alaska Medicaid program relative to other states ("50-state analysis")
- Ensure that program operations reflect current statutes, rules and policies ("regulatory review")
- Assess current program operations and identify best practices from other states ("operational review")
- Assist the legislature with the evaluation of short and long term program reform initiatives – identify strategies that enable the program to operate with the flexibility necessary to best serve Alaskans, recognizing budgetary realties
- Identify oversight priorities for the legislature

MEDICAID REVIEW
Introduction

Potential reforms defined in RFP:

- Developing public/private partnerships between Medicaid and employers – adopting market-based reforms
- Introducing managed care, to the extent feasible
- Enacting cost sharing – premiums/co-pays, perhaps tied to benefits
- Containing costs through program caps
- Increasing federal financial participation by obtaining matching dollars for services funded with state dollars only
- Strengthening the tribal health system

MEDICAID REVIEW
Introduction

Work Steps:

- Interviewed provider representatives and beneficiary stakeholders
- Consulted with DHSS and other state agency staff
- Reviewed recently-issued reports examining Medicaid's long term growth; long term care system; and behavioral health system
- Compared Alaska enrollment and expenditure data to comparable data for the other fifty states
- Evaluated best practices and innovative approaches in other states for applicability to Alaska
- *Note: DHSS has not had the opportunity to review figures/assumptions*

MEDICAID REVIEW
Introduction

Topics to be Covered Today

1. Summary findings from 50-state review
   - Demographics and Medicaid eligibility
   - Covered services & aggregate expenditures
2. Current operations & trends, by service type
   - Acute care
   - Long term care – elderly/physically disabled & MR/DD
   - Behavioral health
   - Tribal health (all services)
   - Administration
3. Recommendations for reform and oversight

MEDICAID REVIEW
Introduction

"Executive Summary":

- Alaska is expensive, on a per beneficiary basis
- However, the state falls into the middle range in most areas, in terms of the populations and services covered
- The aging of the state's population is going to place significant pressures on the delivery system and Medicaid's budget
- There are a number of reforms within the existing Medicaid structure that can be taken to improve services and better control costs
- There also are structural reforms that the state should consider to ensure the program's long term sustainability

50-STATE SUMMARY
Demographics & Medicaid Eligibility

Overview

- Medicaid eligibility is segmented into mandatory and optional populations
- Mandatory groups have a "categorical" linkage to eligibility – e.g., children, pregnant women, disabled
- Optional groups typically are persons who meet mandatory/categorical criteria but whose income is too high
- Every state covers some optional groups, although the extent of the coverage varies widely
- Some states also cover "medically needy" persons through Medicaid – similar to Alaska's Chronic & Acute Medical Assistance (CAMA) eligibles

50-STATE SUMMARY
Federally Defined Coverage Groups

Mandatory Group	Optional Group
1) Children under age 6 in households with income below 133 percent of FPL ($21,945 for a family of two in Alaska)	1) Children under age 6 in households at or above 133 percent of FPL
2) Children ages 6 and older in households with income below 100 percent of FPL ($16,500 for a family of two)	2) Children ages 6 and older in households at or above 100 percent of FPL
3) Parents at or below a state's AFDC cutoffs from July 1996, when welfare reform was enacted (75 percent of FPL for non-working parents, 81 percent for working parents)	3) Low-income parents above the state's AFDC cutoff
4) Pregnant women at or below 133 percent of FPL	4) Pregnant women above 133 percent of FPL
5) Aged, blind and disabled SSI beneficiaries with income below 75 percent of FPL ($9,188 for a household of one)	5) Aged, blind and disabled beneficiaries between 75 and 100 percent of FPL
6) Working disabled persons at or below SSI limits	6) Working disabled above SSI limits
7) Medicare eligibles above SSI limits qualifying for limited benefits (QMB, SLMB and QI groups)	7) Nursing home residents above SSI limits but below 300 percent of SSI
	8) Individuals at risk of needing nursing facility or ICF/MR placement but served through an HCBS waiver
	9) Women with breast or cervical cancer
	10) Medically needy individuals

50-STATE SUMMARY
Alaska Optional Coverage Groups (sfy'05)

Group	Enrollment		Expenditures		
	Enrollees	Percent of Total Enrollment	Expenditures	Percent of Total Expenditures	Expenditures per Enrollee
Children (non-disabled)					
Title XXI Kids/Title XIX Kids (Denali Kid Care)	20,703	15.8%	$43,773,909	4.3%	$2,114
Kids in Custody – Foster care	2,067	1.6%	$22,833,156	2.2%	$10,888
Pregnant Women					
Pregnancy/Post Partum – Pregnant women [illegible] income is between 133 and [illegible]% of FPL	976	0.8%	$1,619,098	0.2%	$1,665
Aged, Blind & Disabled					
Optional Adult Public Assistance – Persons above SSI cash income limit up to 100% of FPL (many TC)	8,564	6.5%	$129,583,235	12.7%	15,188
LTC Non-Cash – Persons above SSI cash income limit residing in nursing facility or enrolled in HCBS waiver	1,782	1.4%	$95,369,535	9.3%	$53,518
Disabled Children					
TEFRA Children – Disabled children at home not receiving SSI and enrolled under federal TEFRA option	423	0.3%	$4,643,213	0.5%	$11,491
Subsidized Adoption – Children with special needs	288	0.2%	$2,075,375	0.2%	$7,206
BCC Women					
Women eligible due to diagnosis of breast or cervical cancer	171	0.1%	$1,912,435	0.2%	$11,321
Working Disabled					
Working disabled persons with incomes in excess of 100% of FPL	421	0.3%	$3,336,161	0.3%	$8,329
Subtotal – All Optional	35,405	27.0%	$305,966,135	29.9%	$8,642
All Mandatory	95,731	73.0%	$718,951,865	70.1%	$7,510
Grand Total – Medicaid	**131,136**	**100.0%**	**$1,024,918,000**	**100.0%**	**$7,815**

50-STATE SUMMARY
Coverage of Optional Populations

Alaska is middle-range in coverage of major optional categories, such as children and pregnant women

	Under One Year	Ages 1 – 5	Ages 6 – 18	Pregnant Women
US Requirement	133%	133%	100%	133%
Highest State	300%	300%	300%	275%
Lowest State	133%	133%	100%	133%
Alaska	175%	175%	175%	175%
Alaska Rank	*36th*	*19th*	*17th*	*36th*

Source: State Health Facts

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50-STATE SUMMARY
Coverage of Optional Populations

Overall, Alaska's optional groups account for a smaller than average portion of enrollment and spending

Enrollment (2005)

Expenditures (2005)

Sources: CMS and DHSS MSI Medicaid Budget Unit

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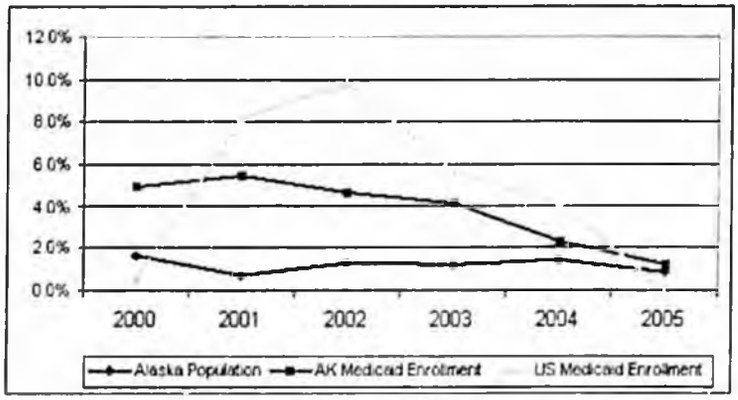
50-STATE SUMMARY
Enrollment Growth

Total Medicaid enrollment until 2005 exceeded state population growth, but trailed the national rate



Sources: US Census Bureau, CPS Data and DHCS Fiscal Year 2007 Budget Overview

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50-STATE SUMMARY
Medicaid & Uninsured Populations

Medicaid covers a large percentage of Alaskans, but the percentage without insurance is also relatively high

Percent with Medicaid		
Rank	State	Percent
1	District of Columbia	21.9%
2	Mississippi	21.1%
3	Vermont	19.9%
4	Alaska	19.7%
5	Maine	19.6%
6	New York	18.4%
7	Rhode Island	17.2%
8	New Mexico	17.0%
9	Tennessee	16.4%
10	Arizona	16.1%
(tie)	Alabama	16.1%

Percent Uninsured		
Rank	State	Percent
1	Texas	24.2%
2	Florida	20.7%
3	New Mexico	20.4%
4	Arizona	20.2%
5	California	19.4%
6	Georgia	18.9%
7	Louisiana	18.8%
8	Oklahoma	18.5%
9	West Virginia	17.9%
10	Alaska	17.8%
(tie)	Arkansas	17.8%

Source: US Census Bureau, CPS Data (2005)

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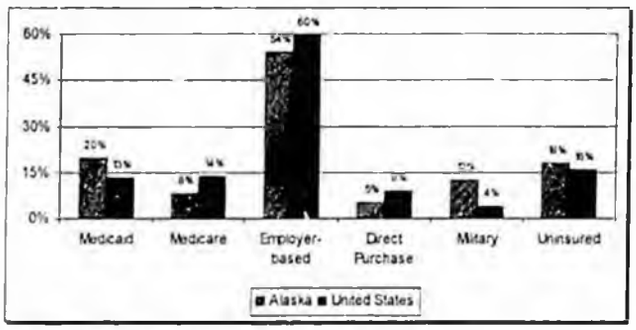
50-STATE SUMMARY
Distribution by Payor Mix

Relatively fewer Alaskans have employer-sponsored coverage, not surprising given the prevalence of small employers in the state



Sources: US Census Bureau, CPS Data (2005)

50-STATE SUMMARY
Medically Needy & CAMA

Overview

- Medically Needy programs serve persons whose incomes exceed categorical limits, but who incur medical expenses sufficient to qualify on that basis
- Alaska is one of 16 states without a Medically Needy program
- The state's CAMA program is similar to a Medically Needy program, but is funded with state doliars only ($2.2 million in 2004)
- Some states have added CAMA-like populations to Medicaid through waivers, thereby capping the state's financial liability, while drawing down additional federal matching dollars

50-STATE SUMMARY
Medically Needy & CAMA

Overview

- Example: Mississippi added a program in 2005 through a Section 1115a waiver covering most of the same groups as CAMA (cancer, diabetes etc.)
- Mississippi projected the program would be "budget neutral" by forestalling onset of disabling conditions requiring long term care
- Converting the CAMA program would likely not require legislation, unless the eligibility standards for the program were altered

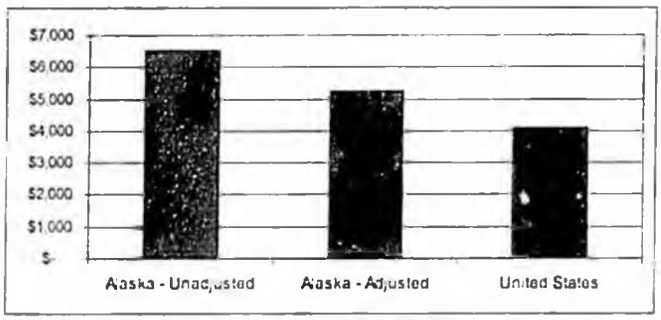
50-STATE SUMMARY
Covered Services

Overview

- Medicaid-covered services are also segmented into mandatory and optional groups (children are entitled to a wider range of mandatory services than adults)
- Alaska is comparable to most other states in terms of the optional services offered
- Alaska spends more per beneficiary than other states and costs grew rapidly in the first part of the decade
- DHSS has taken a number of steps to contain costs, consistent with actions in other states
- Demographic trends are going to impose serious cost pressures in the next decade

50-STATE SUMMARY
Expenditures per Beneficiary

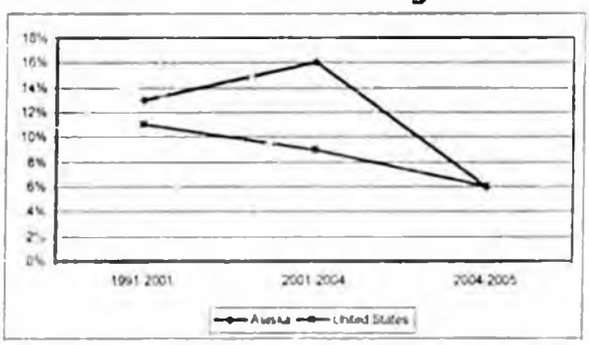
Alaska spent more than the national average per beneficiary in 2003, even after adjusting for cost-of-living



Source: State Health Facts. Adjustment made by applying ratio of FPL dollar income in the 48 contiguous states to Alaska's FPL and multiplying the unadjusted value by this ratio.

50-STATE SUMMARY
Expenditure Growth

Alaska's Medicaid expenditures grew faster than the average annual rate early in the decade, but have since fallen back to the middle-range



Source: State Health Facts. Drivers are for medical claims costs + Rx expenditures. Administrative costs are not included.

50-STATE SUMMARY
Expenditures by Beneficiary Type

Alaska ranked in the top 5 in every category (unadjusted dollars)

	Children	Adults	Elderly	Blind & Disabled	Total
United States	$1,467	$1,672	$10,799	$12,265	$4,072
Highest State	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Lowest State	$912	$813	$5,054	$5,623	$2,520
Alaska	$3,506	$4,443	$17,921	$23,402	$8,512
Alaska Rank	3rd	1st	5th	2nd	3rd

Source: State Health Facts

[illegible]

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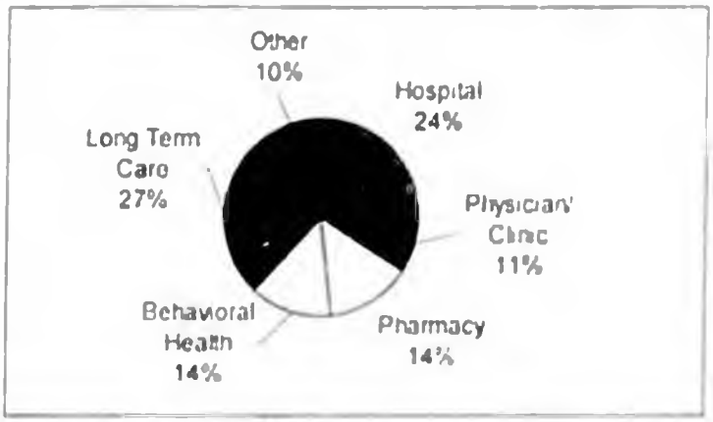
ALASKA MEDICAID
Where Are the Dollars Spent?

Most spending falls into five major service categories



Source: [illegible]

[illegible]

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ALASKA MEDICAID
Acute Care

Hospital Services

- In 2003, Alaska spent $1,200 per beneficiary for inpatient services, fourth highest in the country
- Alaska spent $168 per beneficiary for outpatient services, second highest in the country
- The higher costs occurred despite lower than average utilization

ALASKA MEDICAID
Acute Care

Physician/Clinic

- Alaska's physician payment rates are the highest in the country, partly because of the prevalence of tribal and cost-based providers
- Physicians perceive the fee schedule to be essential for supporting their practices – the reverse of what normally occurs
- The state faces a worsening physician supply shortage -- one that could be exacerbated by cutting fees
- Telemedicine is a promising concept for stretching provider capacity. The state implemented payment regulations in 2002, but utilization remains low

ALASKA MEDICAID
Acute Care

Pharmacy

- In 2003, prescription drug expenditures per beneficiary (before rebates) were $788, 13th highest in the country
- The state has taken a number of cost containment actions, including joining a purchasing pool and introducing a preferred drug list
- Alaska pays among the highest rates for drugs and dispensing fees – which to some extent supports critical access pharmacies
- The state should consider differential pricing strategies, targeting urban chains for discounts. This likely could be enacted through regulation, without the need for a statutory change

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ALASKA MEDICAID
Long Term Care

Nursing Facilities/HCBS

- LTC accounted for one-quarter of Medicaid expenditures in 2005, but is projected to grow significantly as the state's elderly population grows in size (from 55,000 seniors in 2005 to 80,000 in 2015)
- Under current trend lines, Medicaid LTC spending is projected to increase from $273 million in 2005 to $877 in 2015
- Nursing home rates are highest in the country, but utilization is the lowest, partly due to a lack of beds
- Pioneer Homes, which are licensed as Assisted Living Facilities, are becoming de facto Alzheimer's providers, though in a relatively costly setting

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ALASKA MEDICAID
Long Term Care

Nursing Facilities/HCBS

- The state has two HCBS waiver programs for elderly and physically disabled persons (OA and OPD), but neither are designed to serve persons with Alzheimer's/dementia.
- The waivers also offer limited in-home support services, encouraging many to seek Personal Care Attendant (PCA) services outside the waiver
- In 2005, PCA costs reached $80 million, while the two waivers amounted to only $42 million
- The state has introduced prior authorization rules for PCA, but a comprehensive pre-admission screen encompassing all community services (with PCA converted to a waiver service) would allow the state operate a more holistic system

ALASKA MEDICAID
Long Term Care

Nursing Facilities/HCBS Recommendations

- Institute up-front, comprehensive pre-admission screening and care planning
- Convert PCA to a waiver service
- Add waiver services targeted to Alzheimer's/Dementia as less costly alternatives to Pioneer Homes (e.g., AFC) and/or establish case-mix adjusted payments for Pioneer Homes
- Also consider a provider tax on Nursing Facilities as a revenue source (also recommended by PCG in its report). Federal law permits up to a six percent tax
- The tax would require legislative action. The other recommendations would require federal approval

ALASKA MEDICAID
Long Term Care

Developmentally Disabled

- Alaska serves all DD beneficiaries through waivers, outside of institutional settings – one of only a handful of states to do so (making it a leader)
- In 2004, expenditures per waiver beneficiary were sixth highest in the country ($63,000 versus $37,000 average)
- DHSS should develop and introduce a mandatory, uniform cost reporting tool for providers (and audit requirements)
- Rates should be updated through application of a reasonable annual inflator and rebased periodically (e.g., every four or five years)
- This likely could be implemented at the regulatory level through changes to the principles of reimbursement

ALASKA MEDICAID
Long Term Care

Developmentally Disabled

- About 12 percent of the state's DD spending is through state-funded grants ($18 million in 2005) – average for the fifty states, but below states that have achieved close to 100 percent federally-matched programs
- Unmatched DD dollars are being spent, in part, on persons on the DD waiver waiting list and persons deemed not eligible under current screening criteria – the reverse of the elderly/physically disabled program
- The state could create a second waiver, with distinct eligibility criteria. Enrollment could be capped at the numbers served today with state dollars – and the dollars matched
- The new waiver would require federal approval and possibly legislative action, if the waivers are authorized in statute

ALASKA MEDICAID
Behavioral Health

Overview

- Over 80 percent of behavioral health dollars in 2005 went toward treating children, with 90 percent of all spending split between Residential Psychiatric Treatment Centers (RPTCs) and general mental health
- The state spends very little on early intervention activities, to prevent or treat behavioral health conditions at an initial stage
- CMHC rates have been flat for over a decade – with most additional funding going to serve persons in crisis
- The "Bring the Kids Home" initiative is an important effort, though it will bring Alaska only to the stage many states reached years ago and will leave Alaska dependent on inpatient care
- Savings achieved through Bring the Kids Home should be at least partly invested in early intervention/community-based services, in line with trends in other states

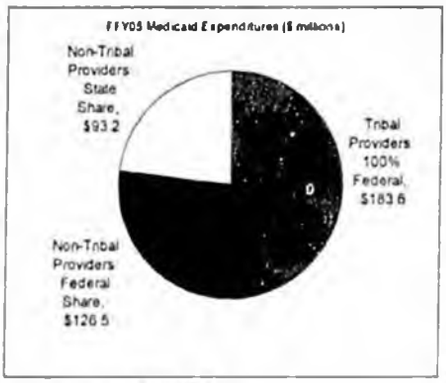
ALASKA MEDICAID
Tribal Health

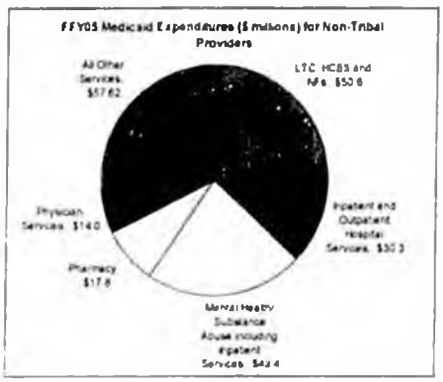
Overview

- American Indian/Alaska Natives (AI/AN) represent 40 percent of the state's Medicaid population; tribal health is a $740 million delivery system
- The tribal system faces significant fiscal challenges, as IHS funding has been increasing at 1 – 2 percent per year
- The health status of Alaska Natives is significantly worse than that of the general population on many key measures, such as tuberculosis and diabetes
- The AI/AN population is younger than average, but its elderly segment is growing significantly and will require a tribal LTC provider infrastructure that does not exist today
- The state may have an opportunity to dramatically alter the fiscal landscape – and provider system – for AI/AN beneficiaries

ALASKA MEDICAID
Tribal Health

AI/AN Current Medicaid Funding





Source: DHSS Tribal Funding Office

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ALASKA MEDICAID
Tribal Health

Tribal Health Recommendation

- Alaska spends about $19 million per year on nursing facility costs for AI/AN beneficiaries residing in non-tribal facilities ($8 million state dollars)
- The state should consider investing in development of tribal long term care capacity, to allow beneficiaries to be served closer to family/friends, while garnering 100 percent federal matching dollars. For example:

	State	Federal	Total
Nursing Facility Expenditures - Non-Tribal Provider			
Cost per nursing facility day	$172	$230	$402
Total annual Medicaid expenditures to serve 50 clients	$3,068,860	$4,093,940	$7,162,800
Ten year Medicaid expenditures (3% annual growth)	$44,858,959	$60,861,947	$105,751,906
Investment in Tribal Provider Infrastructure			
State investment	$8,000,000		
Equal to estimated construction cost of 50 bed facility	—	$7,500,000	$7,500,000
Ten year Medicaid expenditures (annual = 50 clients)	—	$105,751,906	$105,751,906
Total Expenditures	$8,000,000	$105,751,906	$105,751,906
Potential State Savings Over Ten Years - Single Facility	$36,858,959		

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ALASKA MEDICAID
Tribal Health

Tribal Health Recommendation

- Medicaid expenditures within the tribal health system receive 100 percent federal funding; services provided to AI/AN beneficiaries by non-tribal providers are matched at the regular rate
- Under a Section 1115a waiver, the state, in collaboration with tribal providers, could designate the tribal system as a managed care entity

  The entity would be funded for all care – including services furnished by non-tribal providers. However, the "capitation payment" would be submitted for 100 percent federal match
- The new entity would have flexibility to invest savings into areas of greatest need for AI/AN beneficiaries
- This initiative would require federal approval, which is not assured

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ALASKA MEDICAID
Administration

Overview

- DHSS was reorganized into four major divisions in 2003 – the department overall falls into the "super agency" structure adopted by many states to consolidate public health/behavioral health/ Medicaid
- In 2003 (pre-reorganization), Medicaid's administrative costs were $504 per beneficiary (or $403, adjusting for cost-of-living), versus a national average of $224
- Administrative costs represented 6.8 percent of total expenditures, closer to the national average of five percent
- Administrative spending also grew more slowly in Alaska from 1997 to 2004 than it did nationally

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ALASKA MEDICAID
Administration

Program Integrity/Provider Payments

- The federal government is phasing-in a new audit structure for states, known as the Payment Error Rate Measurement (PERM) process; Alaska's first audit is scheduled for 2008
- States that have error rates significantly above the national rate face disallowances and may be ordered to refund federal monies
- DHSS has established a Program Integrity and Analysis function and has re-codified service regulations, as a means of bringing better clarity and oversight to the payment process; the Department also has conducted test audits to prepare for PERM
- However, the PERM audit will overlap with implementation of a new MMIS – on a schedule which appears to be very ambitious
- The legislature should monitor both processes closely because of their fiscal implications for the program

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ALASKA MEDICAID
Administration

Regulations

- The updating of Medicaid regulations, beginning with HCBS waiver rules, was essential and is already yielding results
- The Department's recently-issued draft regulations for covered services comply with federal law and regulations, with only a few areas for potential follow-up by DHSS identified
- Of the 481 regulations reviewed, only 8 potential inconsistencies were detected, representing 1.66% of the total
- It appears that Alaska performed a very thorough review of applicable federal authorities when it sought to repeal existing state regulations and propose revised rules

ALASKA MEDICAID
Broad-Based Reform

Planning for Reform

- The federal government in recent years has shown a willingness to grant states greater flexibility in running their Medicaid programs, if presented as part of a comprehensive reform model
- Vermont, Massachusetts and, to a lesser extent, Florida have undertaken major reforms under the aegis of 1115a waivers
- Under such waivers, states agree to operate their programs at no greater cost than would have occurred without reform. In return, the federal government agrees to "waive" traditional rules governing how the program operates and who can be served
- Denali KidCare operates under an 1115a waiver

ALASKA MEDICAID
Broad-Based Reform

Reform Objectives

- Ensure the best use of public resources to meet Alaskans' health care needs
- Ensure the program is culturally appropriate and recognizes Alaska's unique demography
- Ensure the program is fiscally sustainable for the long term
- Encourage preventive care and early intervention
- Promote access to quality care
- Ensure the state has the necessary tools to quickly respond to client needs, changes in the delivery system and fiscal constraints

ALASKA MEDICAID
Broad-Based Reform

Reform Steps

- Define Medicaid's top programmatic needs over the next decade
- Project likely spending authority over same period
- Draft waiver proposal seeking flexibility to restructure program
- Identify specific reforms to be undertaken
  - CAMA program
  - Tribal health
  - DD waiver
  - Long Term Care

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MEDICAID REVIEW
Summary

Program Area	Recommendation	Action Required
CAMA Program	• Convert to federally-matched model under a Section 1115a waiver	• Federal approval • Possible statutory action (if covered populations/services change)
Pharmaceutical Pricing	• Differential pricing strategies, by location	• Regulatory amendments
Personal Care Attendant (PCA)	• Comprehensive pre-admissions screening	• Regulatory changes • Possible statutory action (if covered populations/services change)

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MEDICAID REVIEW
Summary

Area		
Personal Care Attendant (PCA)	➢ Convert to waiver service ➢ Target alternatives for individuals with Alzheimer's/dementia	➢ Federal Approval
Nursing Facilities	➢ Provider Tax ➢ 6% tax allowed by Federal Law	➢ Statutory approval
Developmentally Disabled	➢ Mandatory, uniform cost reporting tool ➢ Fixed rate increases	➢ Regulatory changes

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MEDICAID REVIEW
Summary

Area	Recommendation	Action Required
"Bring the Kids Home"	➢ Reinvest savings in early intervention/community based services	➢ Evaluate options for enhanced community based services
Tribal Health	➢ Designate tribal system as managed care entity ➢ Construct tribally-operated nursing facility	➢ Develop application for Section 1115a waiver ➢ Develop detailed cost-benefit analysis
PERM and MMIS	➢ Legislative monitoring	➢ Routine status reporting

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Handout 3/6/07

The LEWIN GROUP

and

ECONorthwest

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

Prepared for:

Alaska Department of Health and Social Services

Prepared by:

The Lewin Group and ECONorthwest

February 15, 2006

Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025

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February 15, 2006

This report is available on the Internet at:

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Executive Summary

In April 2005 the Alaska Department of Health and Social Services (ADHSS) contracted with the Lewin Group and ECONorthwest to develop a long-term forecasting model of Medicaid spending for the State of Alaska. This document describes the steps undertaken in the development of the forecasting model and provides details on the projected growth in enrollment, utilization, and spending on Alaska's Medicaid program through 2025.

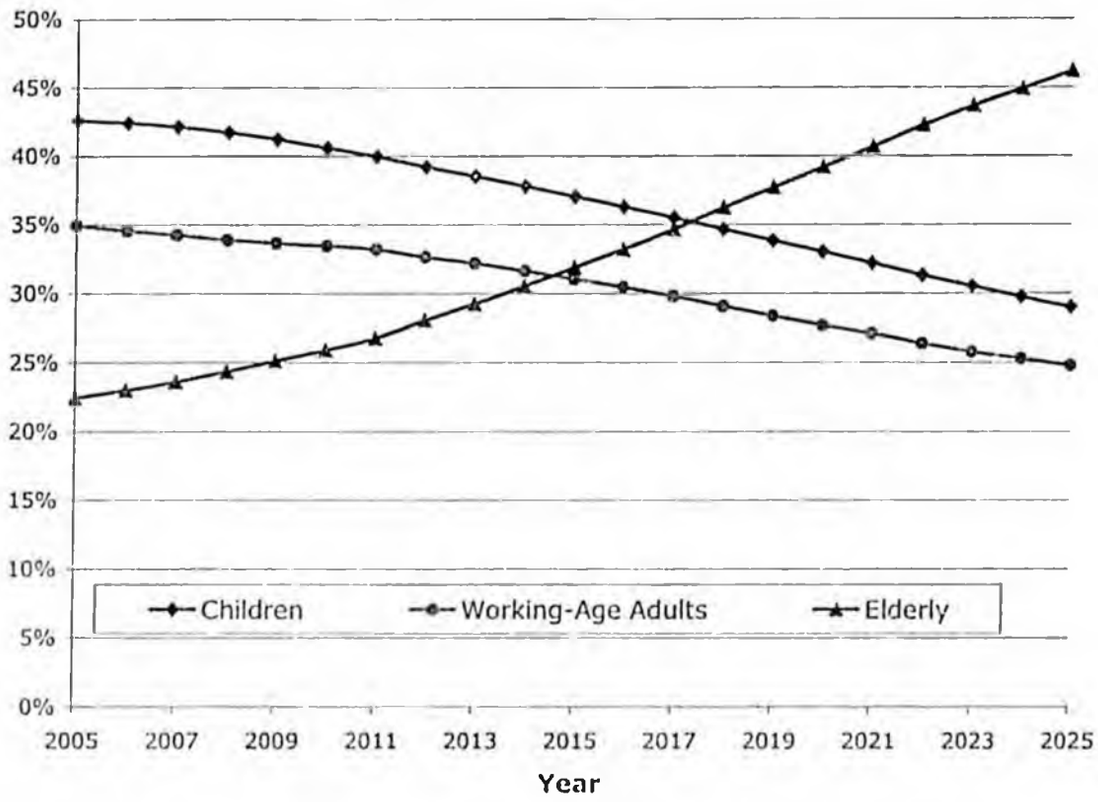
This report is intended to inform ADHSS executives and the Alaska State Legislature of the substantial projected growth in total spending on Alaska's Medicaid program and the projected growth in state matching fund spending on the Medicaid program. The projections of total and state matching fund spending presented in this report assume that the mix of Medicaid services remains constant and that eligibility criteria do not change in the future. These assumptions were necessary to show how Medicaid spending in Alaska would grow under the program's status quo. The statistical models developed for this analysis will be provided to ADHSS staff providing them the ability to update the Medicaid forecast as more timely data become available.

KEY FINDINGS

The Alaska Medicaid program will fundamentally change over the next 20 years from a program that centers on children to one that is dominated by seniors (age 65 and older). This is a result of changes in Alaska's demographic profile, which will include many more seniors. On a per-recipient basis, spending on Medicaid services for seniors is substantially higher than spending for children. As this portion of the population grows rapidly over the next 20 years, Medicaid spending will also grow rapidly. In calendar year 2005, approximately 42% of spending on Medicaid claims was devoted to children and 22% was devoted to seniors. By 2025, we expect that approximately 45% of Medicaid spending will be devoted to seniors and approximately 30% will be devoted to children. As Figure 1 shows, we expect spending on Medicaid claims for the elderly to surpass spending on the working-age population by 2015 and to surpass spending on children by 2018.

Figure 1: Spending on Elderly will Surpass Spending on Other Age Groups by 2018

Forecasted Proportion of Total Spending on Medicaid Claims by Age Group, 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Spending projections are on an incurred service basis.

Among the key findings of this report are the following:

- More important than any of the other factors in our projection of the Alaska population, the 65 and older population is projected to grow rapidly, almost tripling from 43,000 to 124,000 between 2005 and 2025.

- Alaska's Medicaid program has been a program dominated by spending on services for children but it will change to one much more focused on the elderly. This change will affect the mix of benefits that Medicaid provides and, more importantly, the cost. Average per-recipient costs of Medicaid services are much higher for the elderly than for children.

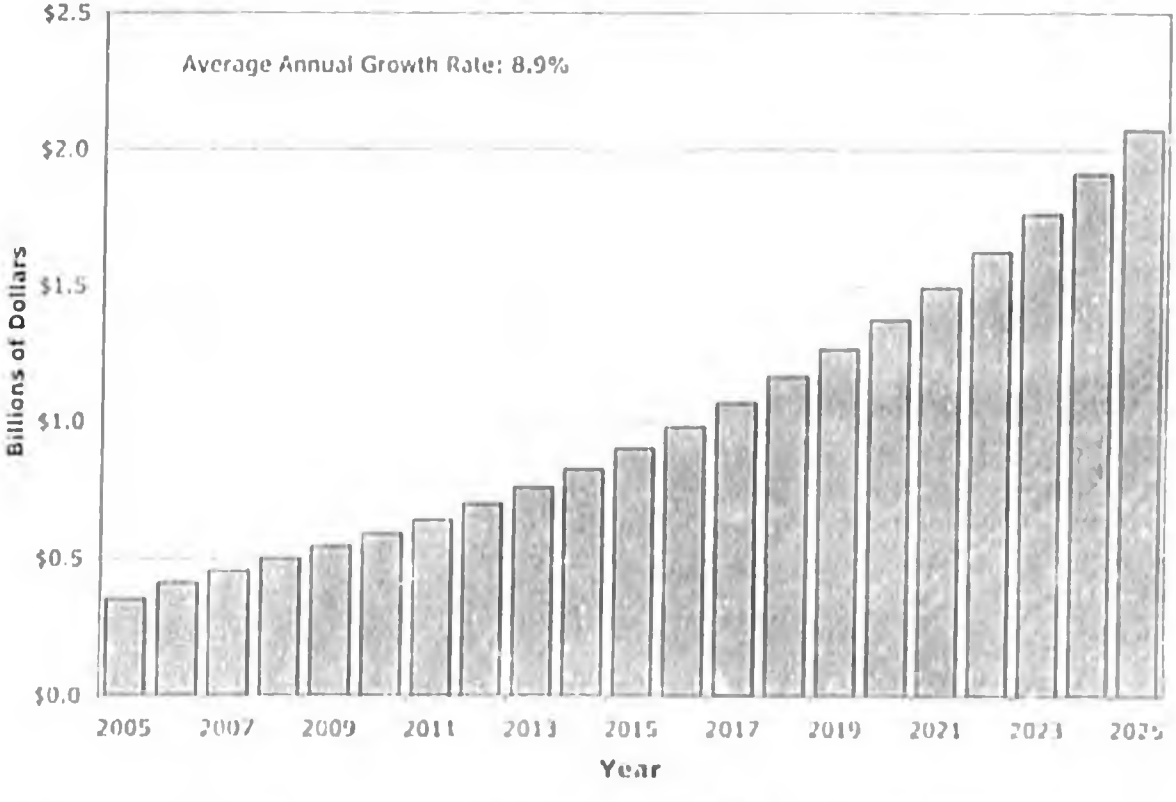
- Projected to grow a little faster than the state's population, we expect Medicaid enrollment—on a full time equivalent basis—to reach 131,000 by 2025 (compared to 95,000 in 2004).

- Total spending on Medicaid claims will increase from approximately $975 million in CY 2005 to approximately $4.7 billion in CY 2025.

- An increasing share of the Medicaid burden will be shifted away from the federal government to the state. State matching funds for Medicaid claims are projected to increase at a faster rate than the total Medicaid program—8.9% versus 7.6% for total funds (see Figure 2).

Figure 2: State Matching Fund Spending on Medicaid to Grow 8.9% Annually

Total Forecasted State Matching Funds for Medicaid Claims (in Millions of Dollars), 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data
Note: Spending projections are on an incurred service basis. Not adjusted for inflation.

Table 1 and Table 2 show projected utilization and spending for the five fastest growing Medicaid service categories. With the exception of Vision Services, these categories are also expected to be among the most expensive Medicaid services provided in 2025. In fact, As Table 2 shows, over half of state matching funds will be spent on just two service categories—Personal Care and HCB Waiver. These are two of the most important Medicaid service categories for Alaska's seniors.

Table 1: Forecast of the 5 Fastest Growing Service Categories by Utilization, 2005-2025

Medicaid Service	Calendar Year					Average Annual % Change (2005-2025)	Rank by Avg. Annual % Change
	2005	2010	2015	2020	2025		
Personal Care	5,029	8,626	14,587	23,617	35,311	9.7%	1
HCB Waiver	4,167	7,004	11,428	17,686	25,263	9.0%	2
Residential Psych./BRS	1,227	1,898	2,766	3,889	5,319	7.3%	3
Therapy/Rehabilitation	9,949	15,240	22,242	31,135	41,529	7.1%	4
Vision	24,288	35,006	47,669	61,614	75,190	5.7%	5
Unduplicated Count of Medicaid Recipients	113,953	130,047	141,184	148,117	150,743	1.4%	NA
Unduplicated Count of Medicaid Enrollees	132,344	151,036	163,971	172,022	175,073	1.4%	NA

Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: In this analysis we define service utilization as the annual unduplicated count of persons who used a particular Medicaid service during the fiscal year

Table 2: Forecast of the 5 Fastest Growing Service Categories by State Matching Funds (In Millions of Dollars), 2005-2025

Medicaid Service	Calendar Year					Avg. Annual % Change (2005-2025)	Rank by Avg. Annual % Change
	2005	2010	2015	2020	2025		
Personal Care	$48.7	$105.0	$200.6	$367.3	$629.1	12.8%	1
HCB Waiver	$40.0	$100.6	$181.8	$316.1	$520.4	11.8%	2
Residential Psych/BRS	$27.1	$52.9	$88.0	$141.1	$221.5	10.5%	3
Therapy/Rehabilitation	$11.5	$21.7	$35.4	$56.3	$85.9	10.0%	4
Vision	$0.4	$0.8	$1.2	$1.7	$2.4	8.6%	5
All Medicaid Services	$350	$591	$902	$1,377	$2,070	8.9%	NA

Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data
Note: Dollars are not adjusted for inflation

- State matching fund spending on claims provided by the Alaska Medicaid program will grow fr n approximately $350 million in calendar year 2005 to just over $2 billion in calendar year 2025.

- The main factors responsible for growth in spending on Medicaid services are population growth, aging of the population, increasing utilization of Medicaid services by enrollees, and growth in the prices of medical services.

- Growth in total (federal and state funds) spending on claims will slow from the pace of the last decade. On an average annual basis, total spending on Medicaid claims is projected to increase by 7.8%. Comparatively, between 1998 and 2004, spending on Medicaid claims increased by 16.6%.

- In calendar year 2005, state-matching fund spending on Medicaid claims was approximately $500 per Alaskan citizen. We project this will grow to approximately $2,600 by 2025—an 8.0% average annual growth rate. Comparatively, per-capita personal income in Alaska is projected to grow by less than 3.0% per year over this same period.

- By 2025, more than half of state matching fund spending on Medicaid claims is expected to be for Personal Care and HCB Waiver. In CY 2005 these two service categories account for less than 30% of the state's spending on Medicaid claims.

- Medicaid enrollment will grow at almost twice the annual rate of Alaska's population (1.4% vs. 0.86%).

- For the elderly, Medicaid enrollment is also projected to grow at a greater annual rate than the population (6.3% vs. 5.3%).

- Medicaid utilization will grow by approximately 4.3% per year between 2005 and 2010, but this rate of growth will decline to approximately 2.1% between 2020 and 2025.

- We project relatively slow growth in the enrollment rates of eligibility categories specific to children (e.g. Title XIX Kids), but high rates of growth in eligibility

categories geared more heavily toward the elderly (e.g. Long Term Care Non-Cash).

- The elderly population in Alaska will almost triple between 2005 and 2025 from 43,000 to 124,000; while the child population will remain relatively stable growing only from 205,000 to 245,000 in 20 years.

- The Native population will increase on average by 1.71% per year, while the Non-Native population is expected to increase by only 0.67%. The difference between the two growth rates is expected to result in the Native proportion of the population increasing from approximately 17% in 2005 to approximately 21% by 2025.

- Currently, Natives are almost three times as likely to be enrolled in Medicaid as are non-Natives.

- The enrollment of males into the Medicaid program is projected to grow slightly faster than females. Still, due to greater life expectancies, higher rates of poverty, and pregnancy and related needs, we expect the proportion of females in the Medicaid program to remain higher than males.

- The Anchorage/Mat-Su region, with almost half of all Medicaid enrollees in 2005, is expected to increase its Medicaid population by 2.0% per year—the fastest growth of any of the regions.

Introduction—Alaska Medicaid Spending Projection

In this study, we develop long-term forecasts of Medicaid program spending from 2005 through 2025. We project spending for 20 categories of services provided under the Alaska Medicaid program. Although results are presented at state level for all residents, analysis is conducted on a regional basis for demographic subgroups of the population.

In addition to this report, the models constructed for and used in the analysis will be installed on Alaska Department of Health and Social Services (ADHSS) computers. This will provide ADHSS staff the ability to update the forecast as more timely data become available. The models were developed in the Statistical Package for the Social Sciences (SPSS) at the request of agency staff. The SPSS modeling syntax serves as documentation of the analysis, allowing ADHSS staff to operate and, if necessary, modify the models. Indeed, the primary contributions of this project are the development of a methodology and set of statistical models that will allow ADHSS staff to prepare long-term forecasts of Medicaid spending into the future. Neither the demographic profile of Alaska's population, nor the administrative aspects of the Medicaid program are static. It is important, therefore, that ADHSS staff has the ability to inform Medicaid administrators and policy makers about fiscal issues related to the Medicaid program. ADHSS now has a tool that they can use to project the impact of proposed changes to the Medicaid program.

This report presents the findings from our analysis of long-term Medicaid spending in Alaska. It is based on the most currently available data and represents a benchmark for future forecasts, but does not reflect changes in Alaska's Medicaid program made since the last year of historical data (fiscal year 2004). We recognize that changes to the Medicaid program ADHSS has implemented since FY 2004 already have had—and will continue to have—an impact on enrollment, utilization, and spending.[1] With the new long-term forecasting model in hand, these changes will be reflected in ADHSS' future updates of the forecast. Revised projections will have the same validity as the benchmarking projection because they will be based on the same model.

[1] Examples of changes made to the Medicaid program since FY 2004 include numerous changes implemented to contain costs, the Bring the Kids Home initiative to return children in out-of-state residential psychiatric treatment centers to Alaska, changes to the Personal Care Attendant program, and the launch of Medicare's prescription drug benefits.

SUMMARY OF METHODOLOGY

The main factors responsible for growth in spending on Medicaid services are population growth, aging of the population, increasing utilization of Medicaid services by enrollees, and growth in the prices of medical services. Our methodology, therefore, entailed detailed analysis of each of these factors in order to formulate a series of statistical models to project total spending on Medicaid services. The statistical models of Medicaid enrollment, and service utilization and spending were developed using historical enrollment-level data provided by ADHSS. Population forecasts for five regions of Alaska were based on historical Census population estimates and statewide population forecasts developed by the Alaska Department of Labor and Workforce Development.

The forecast of total spending on Medicaid services depends on the following key demographic, economic, and program-related factors:

- Growth in Alaska's resident population and changes in demographic composition
- Changes in the Medicaid enrollment rate
- Changes in the utilization of Medicaid services by Medicaid enrollees
- Personal health services specific price inflation

The creation of the long-term Medicaid forecasting model for Alaska required the development of five separate modeling tasks. These include:

- **Task 1: Project population of Alaska by regional-demographic grouping:** The first step in determining the demand for Medicaid services in future years is to understand the size of the Medicaid eligible population, its demographic characteristics, and its regional distribution. We do this by projecting Alaska's population through 2025 by the following four characteristics:
    - Region (5)
    - Age Cohort (11)
    - Gender (2)
    - Native/non-Native (2)

This results in 220 subpopulations (5 * 11 * 2 * 2 = 220) that we project for each year from 2005 to 2025. The purpose of projecting Alaska's population at such detail is that eligibility for and consumption of Medicaid services differs greatly by age and gender; the federal match rate varies between Medicaid service categories and by Native/non-Native status; there may be regional differences in the eligibility and participation rates for Medicaid, as well as in the costs of service.

Task 2: Project Medicaid enrollment rate for each of the 220 subpopulations: Using Medicaid enrollment data provided by the Alaska Medicaid program for fiscal years 1997-2004, we estimated regression equations of Medicaid enrollment rates for children (0-19 years of age), working-age adults (20-64 years of age), and the elderly (65+ years of age). These equations included a range of demographic variables designed to measure differences in enrollment for these groups, including age, gender, Native/non-Native status, and region of residence.[2] Coefficient estimates from the regression equations were used to project the proportion of each of the 220 subpopulations enrolled in Medicaid through 2025. Medicaid enrollment is then allocated across the 11 eligibility classes based on historic trends. Medicaid eligibility classifications were determined by ADHSS staff.

Task 3: Project utilization by Medicaid service class for each of the 220 subpopulations: Using historic Medicaid data on utilization of Medicaid services for each of the 20 service classes, we project Medicaid utilization for each of the 20 service classes within each of the 11 eligibility groups and the 220 subpopulations. Service utilization is modeled using logistic regression, a statistical modeling technique used for estimating the probability of an event occurring. For our purposes, the event is the utilization of a particular service within a given year.

Task 4: Forecast the average and total cost per year of Medicaid services by subpopulation: Using linear regression analysis, average spending per recipient of each Medicaid service category was regressed on demographic and other explanatory

[2] In addition, we examined statewide economic data, including total personal income, per capita personal income, and employment. The statewide data provided no explanatory power in the enrollment rate models and was, therefore, dropped from the models. Regional economic data were not examined because we know of no available long-term forecasts of such data. Statewide economic data from the University of Alaska's Institute for Social and Economic Research (ISER) were also considered in the regression models. The economic data, however, did not provide additional explanatory power and were, therefore, dropped from the models.

variables.[3] One regression model was developed and estimated for each of the 20 service categories. The results obtained from the 20 models were used to project total *real* spending *per Medicaid recipient* through 2025. Using national-level forecasts of medical inflation, we then project total annual *nominal* spending per recipient through 2025.

Task 5: Forecast total state matching fund spending on Alaska's Medicaid program: The State's obligation to cover the cost of an individual's Medicaid costs differs according to the individual's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/non-Native status. Based on cost share information from ADHSS and our projections of total Medicaid spending by service category, we forecast total state matching fund spending through 2025 by the State of Alaska.

Task 6: Forecast the cost of other payments and offsetting recoveries: This final component of Medicaid spending is not directly tied to individual claims and, therefore, cannot be forecasted by the same methods described above. Rather, for projections of Offsetting Recoveries, future credits are assumed to grow at approximately the same rate as in the past. For the forecasts of Medicare Part A & Part B Premiums, the historical relationship between spending on this program and growth in the elderly population (65 and older) was statistically measured and used as a basis for projecting future spending by ADHSS on Medicare Part A & Part B Premiums. Finally, for the Supplemental Hospital Payments program, the relationship between spending on this program and spending on the Inpatient and Outpatient Hospital services categories was statistically measured and used as a basis for projecting future spending on the Supplemental Hospital Payments program.

MODEL ASSUMPTIONS AND LIMITATIONS

The Lewin Group and ECONorthwest realize that the value of economic analysis depends on the quality of the data and assumptions employed. We have worked carefully to ensure the quality of our work and the accuracy of our data. Throughout this report we identify our sources of information and the assumptions used in the analysis. We have undertaken considerable effort to validate the forecast and to confirm the reasonableness of the data and assumptions on which the forecast is based.

[3] Note: Annual Medicaid spending for each of the historical years of data is inflation adjusted into 2004 dollars.

Nonetheless, we acknowledge that any forecast of the future is uncertain. The fact that we view the forecasts in this report as reasonable does not guarantee that actual enrollment in, utilization of, and spending on the Alaska Medicaid program will equal the projections in this report. ADHSS administrators and the Alaska's elected representatives must recognize the inherent uncertainty that surrounds forecasts in considering the long-term Medicaid spending projections. The primary benefit of this report to Medicaid administrators and Alaska's policy makers is information on the direction and approximate magnitude of changes in the Medicaid program.

There are many assumptions underlying the forecast, which the Lewin Group and ECONorthwest have deemed to be reasonable. ADHSS established a steering committee of program and financial managers experienced in Medicaid policy to provide guidance throughout the process of developing the forecast models. The steering committee provided valuable feedback on the suitability of our assumptions and the reasonableness of our results. Throughout the analysis, we relied upon the best available information, including historic Medicaid claim data, the State of Alaska's official population forecast, and nationally recognized information on trends in medical prices. In addition, in no instances do we impose any speculation on future Medicaid policies or procedures. Rather, we develop the long-term forecast as if the policies and practices of today will be the status quo throughout the forecast period. Assumptions of particular importance, include, but are not limited to, the following:

- The mix of currently available Medicaid services is assumed to be constant throughout the forecast period. The State of Alaska currently provides Medicaid services not mandated by the federal government. We assume the State will continue to provide these services throughout the forecast period.

- Medicaid eligibility requirements will not change throughout the length of the forecast period.

- With respect to gender and age cohort, Alaska's population will grow at approximately the rate forecasted by the Alaska Department of Labor and Workforce Development in their February 2005 report. Relative population growth by region of the state and by Native/non-Native status will be similar to that experienced between 1990 and 2000.

- The growth rate in the prices of Alaska's Medicaid services will be the same as the projected growth rate in the prices of personal health care services, embodied

in the Center for Medicare and Medicaid services' national personal health care deflator.

- Neither the historical data nor the spending forecast will directly correspond to the ADHSS accounting or budget systems. Additionally, the claims data is based on date of service while the accounting and budget systems are based on dates of payment. There are three reasons for this:

  1. The data used in the forecast of total spending are based on date of service and not on date of payment;

  2. The payment amounts include only claim payments processed through the Medicaid Management Information System (MMIS) and do not included any payments or accounting adjustments not made through MMIS (i.e., the data do not directly correspond to accounting records);

  3. The historical data are based on the State's fiscal year, but the forecasts are on a calendar year basis. This was done to remain aligned with the population forecast.

- Claim data for Fiscal Year 2005 are used as a benchmark for the long-term forecast. These data were not, however, used in the development of the forecast. The reason for this is that the statistical models used in this analysis were developed in Q2 and Q3 2005, and the earliest the FY 2005 claim data became available was a month or more into Q3 2005. Further, because this analysis is on an incurred basis and many claims are not paid for several months or more after the service is incurred, there is currently and will continue to be for several months much missing cost data in the FY 2005 claim data.

- Data for years 1997, 1999, 2001, and 2003 are not shown in historical tables of utilization and spending because of limited space. Average annual growth rates are slightly lower when considering the period 1997-2004.

- Forecast data are only shown for 2005, 2010, 2015, 2020, and 2025. The model, however, forecasts each year from 2005 through 2025.

- The enrollment and claims data provided by ADHSS were from their Juneau Claims and Enrollment (JUCE) database. JUCE contains Medicaid enrollment records and claim-level data on paid claims, adjustments, and voids. JUCE does not include denied claims, claims pending adjudication, payments not processed through MMIS, or administrative costs. For the long-term forecasting model, ADHSS summarized enrollment and paid claims data into one record for each individual enrolled in the Medicaid program for each complete fiscal year available (1997-2004) using the following 10 criteria.

1. Claim date is based on the date the service was provided (incurred), not the date the claim was paid.

2. Only complete fiscal years are included in the data file. Data for fiscal year 2005 are excluded because there is a lag between providing the service and paying the claim. Many of the claims incurred during fiscal year 2005 will not be paid until fiscal year 2006.

3. There is one record per individual for each fiscal year he/she is enrolled in Alaska's Medicaid program, regardless of whether he/she is enrolled for one month during the fiscal year or for the entire fiscal year.

4. Data were grouped so that classifications are consistent with those typically used by ADHSS in budgeting analyses and financial reporting. The list of variables include ID, year, region, gender, race (Native/non-Native), age, months in program, eligibility classification, and service classification.

5. To protect the privacy of clients, no personally identifying information (i.e., name, birth date, social security number) was included in the data file. The Medicaid client identification numbers were recoded by ADHSS to create the ID variable and cannot in any way be used to identify individuals.

6. The race variable is one of two values: Native or non-Native. The Native category includes anyone identified as Alaska Native or American Indian. Race is a self-identified optional field on the enrollment application. Natives who left this item blank would be counted as non-Native.

7. The Months-in-Program variable is the number of months during the fiscal year in which the individual was enrolled in Medicaid. Eligibility is determined on a monthly basis. If a person is eligible for one day in the month, they are eligible for the whole month.

8. When summarizing enrollment data, if multiple values were encountered in the region, gender, race, or age variables, one of the values was chosen randomly by assigning an integer between 1 and 12 (inclusive). The integer represented the month of the fiscal year in which to determine the individual's value for the entire fiscal year.

9. The 11 eligibility classifications are based on groupings of eligibility subtype codes (See Appendix A). If a client's situation changes over time, he/she is reassigned to the eligibility code that best fits. Consequently, there is a great deal of movement between classifications and it is common

for individuals to have more than one eligibility code during the year. If multiple eligibility codes were encountered during a fiscal year, the last value was chosen.

10. Claim data were aggregated into 20 service classifications based on ADHSS categories of service (See Table 9). The net amount of claims paid, including debits, credits, and voids, was summarized for each individual enrolled for each fiscal year. Not all enrollees had claims in all service classifications. In fact, some enrollees did not have any claims at all for a fiscal year.

Alaska State Legislature
HOUSE FINANCE COMMITTEE
AGENDA
1:30 p.m.

1:36

February 6, 2007 - Tuesday

Joint meeting with the House Ways and Means Committee and the House Health and Social Services Committee
Medicaid Program Review-Presented by the Pacific Health Policy Group
Teleconference <Listen Only>

Presenters
Andy Cohen, The Pacific Health Policy Group
Scott Wittman, The Pacific Health Policy Group