AK LEGISLATURE FINANCE COMMITTEES FILES 2007-2008 3122

Credit Program: Small Business Economic Development Loans

- **Objective:** To provide private sector employment by financing the star-up and expansion of business that will create significant long-term employment.
- **To qualify:** Must have fewer than 500 employees, net worth under $6 million and average net income after taxes of less than $2 million for preceding two years.
- **Maximum loan amount:** $300,000
- **Maximum term:** 20 years for fixed asset loans

This program is administered by the Division of Investments, DCCED.

Development Finance Program

- **Objective**: To finance infrastructure necessary to support Alaskan economic development projects.
- **Method:** AIDEA owns the project and is repaid through user fees, leases and other revenue sources.

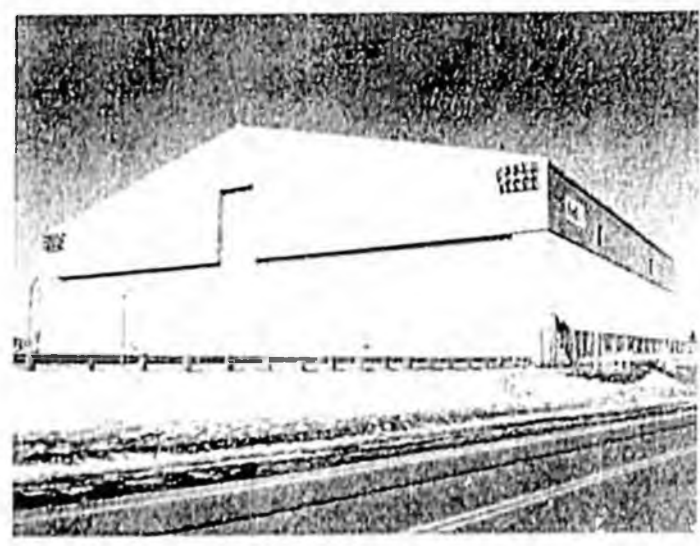
Development Finance Program

To qualify: The project must be endorsed by the local government and 3AAC 99.530 requires that:

- the project and its development under AS44.88 will be economically advantageous to the state and to the general public welfare and will contribute to the economic growth of the state;
- the project applicant is financially responsible; and
- the project is economically and financially feasible and able to produce revenue adequate to repay the bonds or loans with which it is financed.

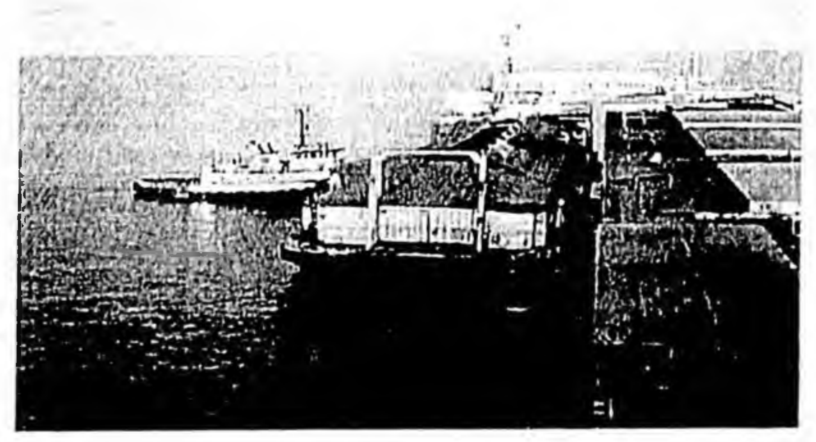
Development projects

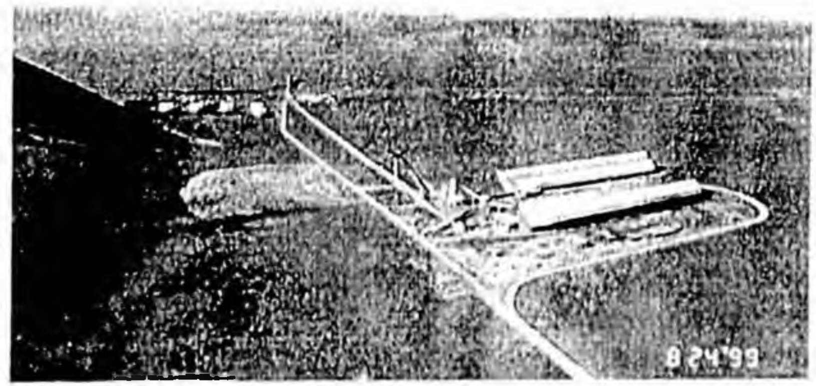
- DeLong Mt. Transportation System
- FedEx Maintenance Hanger
- Snettisham Hydroelectric
- Ketchikan Shipyard
- Skagway Ore Terminal
- Healy Clean Coal Project



DeLong Mt. Transportation System

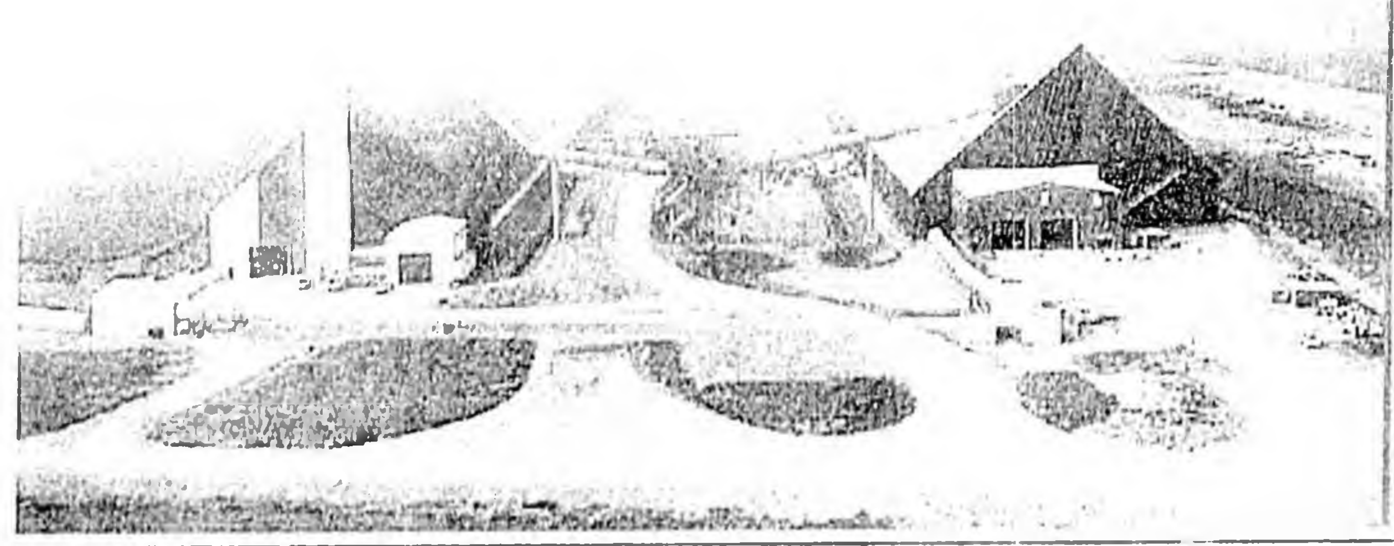
- AIDEA's investment in the Delong Mountain Transportation System (DMTS) made Red Dog mine a reality and created a tax base that led to the formation of the Northwest Arctic Borough.





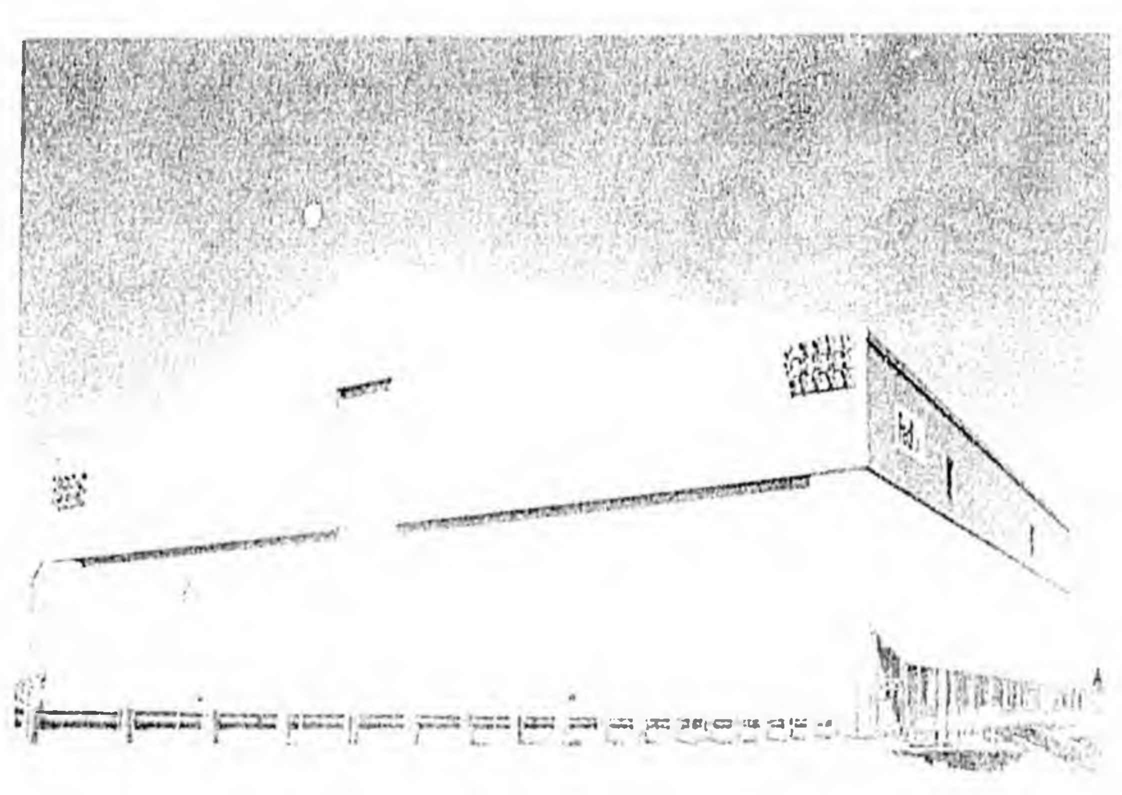
DMTS and Red Dog Mine provide jobs

- Over 500 jobs, with over 57% of jobs held by NANA shareholders.
- These jobs represent over 30% of the private sector jobs in the NANA region.



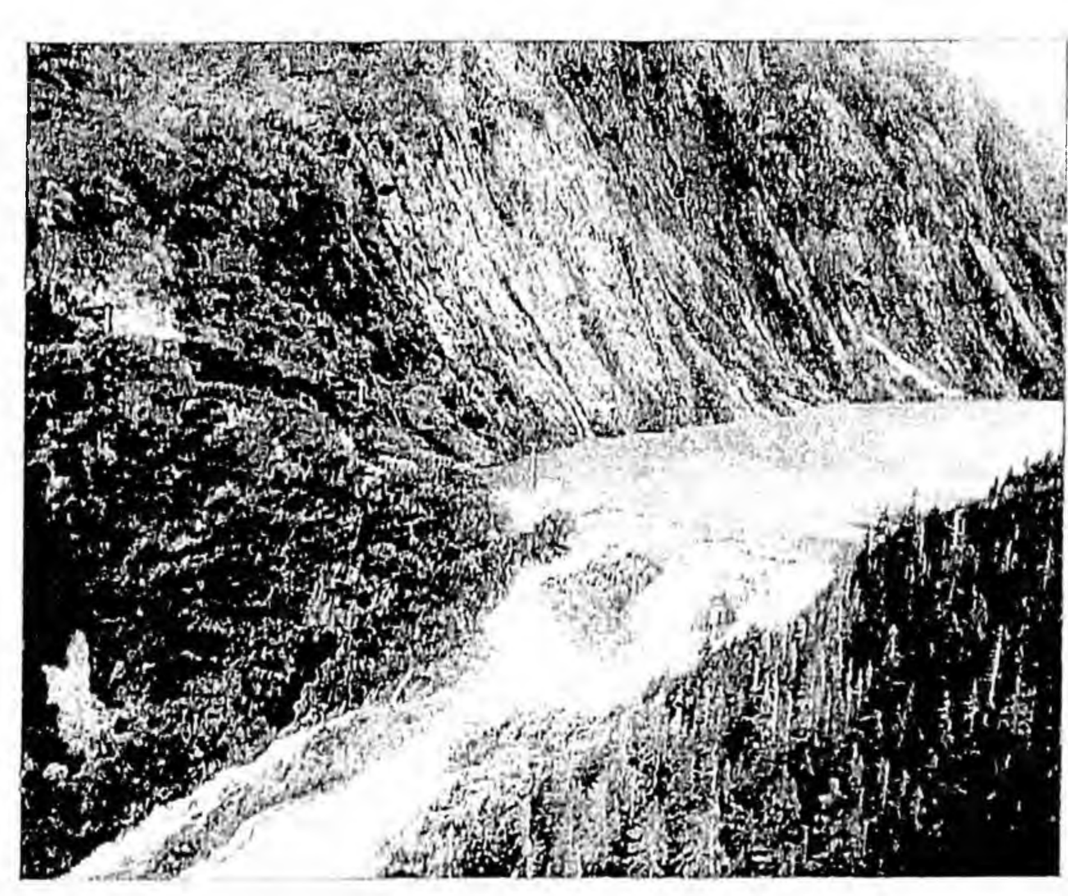
FedEx maintenance facility

- Created 20 permanent, highly-skilled jobs
- Brought a pilot base to Alaska
- Infuses income into Southcentral year-round
- Strengthens Alaska's role as an international air crossroads



Snettisham hydroelectric project

- A 78,210 kw hydroelectric project located 28 air miles southeast of Juneau.
- Snettisham provides approximately 80% of the Juneau-Douglas area electrical energy.
- AEL&P purchases all project power under a long-term power sales agreement.



Ketchikan Shipyard

Owner

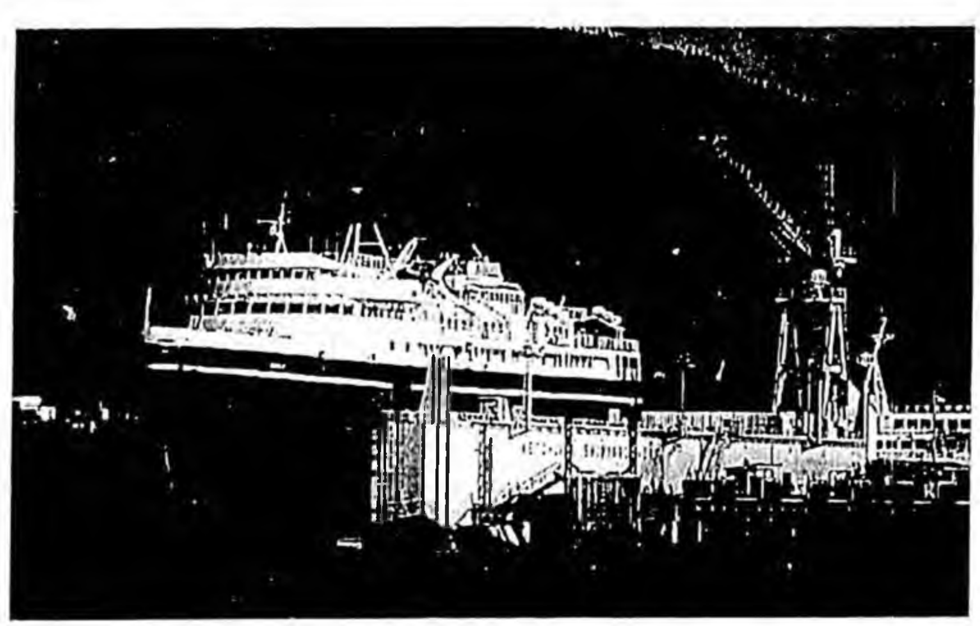
- AIDEA

Local partners

- Ketchikan Gateway Borough
- City of Ketchikan
- Ketchikan Public Utilities

Operator

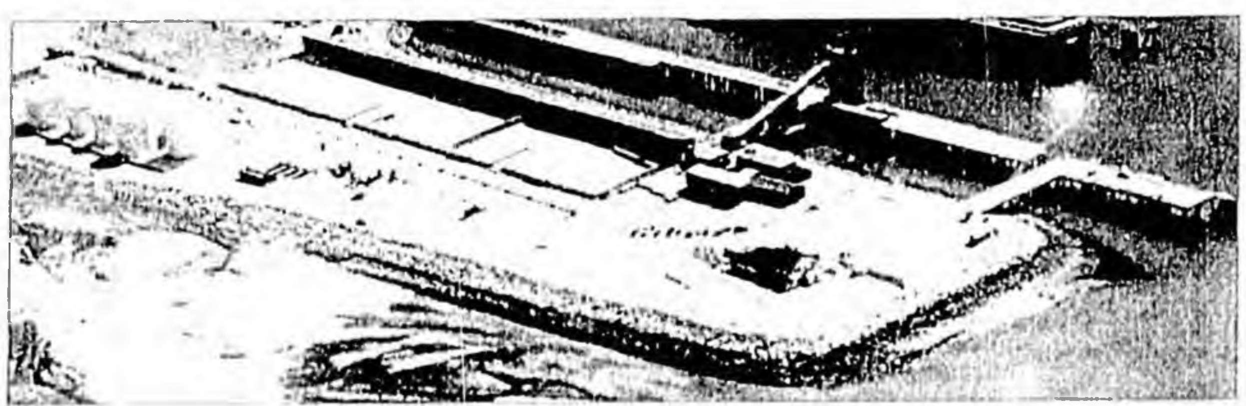
- Alaska Ship and Drydock



Skagway Ore Terminal

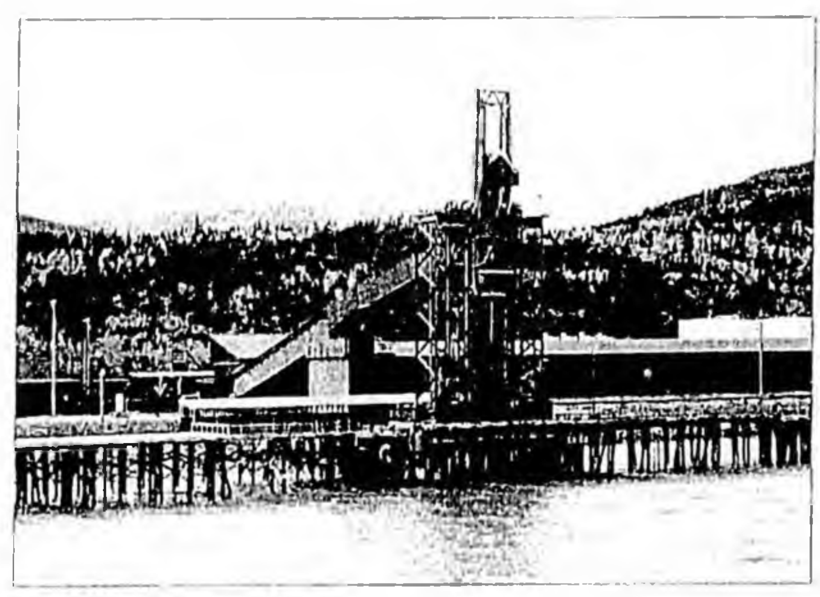
- Idle since 1998.

- On January 19, 2007 AIDEA signed a seven year user agreement with Sherwood Copper of Vancouver, B.C., to trans-ship copper-gold production from a mine located at Minto, Y.T.



Skagway Ore Terminal

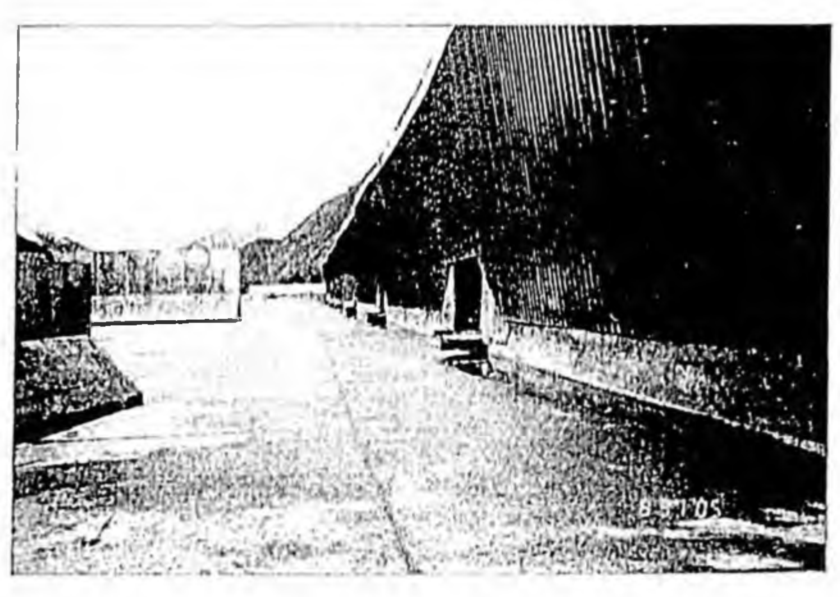
- The *estimated* cost of this project is $7.6 million.
- AIDEA will receive an estimated annual user fee of approximately $1.75 million.
- Option to extend for an additional ten years if agreed upon by both parties.



All AIDEA out-of-pocket costs will be paid by the user.

Skagway Ore Terminal

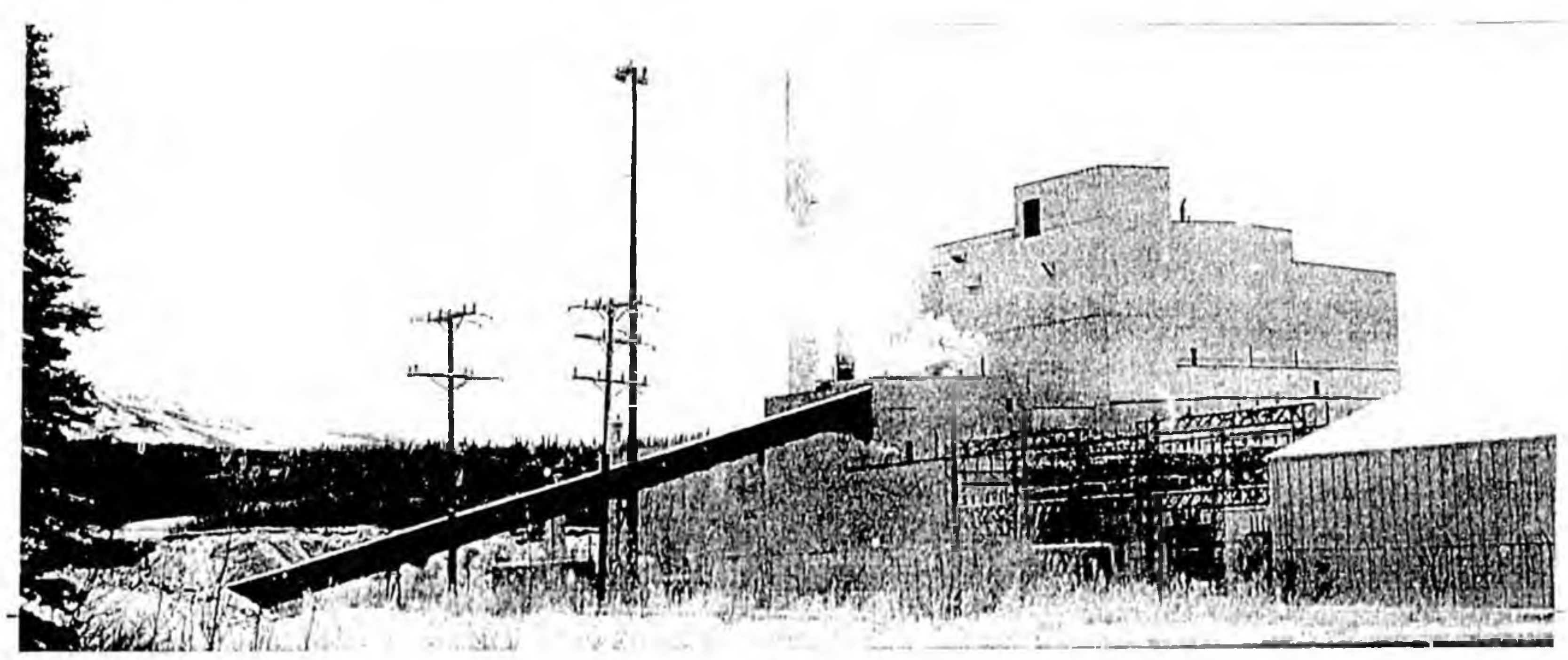
Local benefits



- Five full-time equivalent year-round jobs
- Local contractor to perform upgrade work
- Diversifies local economy
- Improves seasonal economic development

Healy Clean Coal Project

- In November 2006, AIDEA signed agreements with Homer Electric Association (HEA) to re-start and operate the plant. HEA will also purchase power from the plant.
- AIDEA continues litigation/mediation with Golden Valley Electric over access issue to AIDEA's facility.



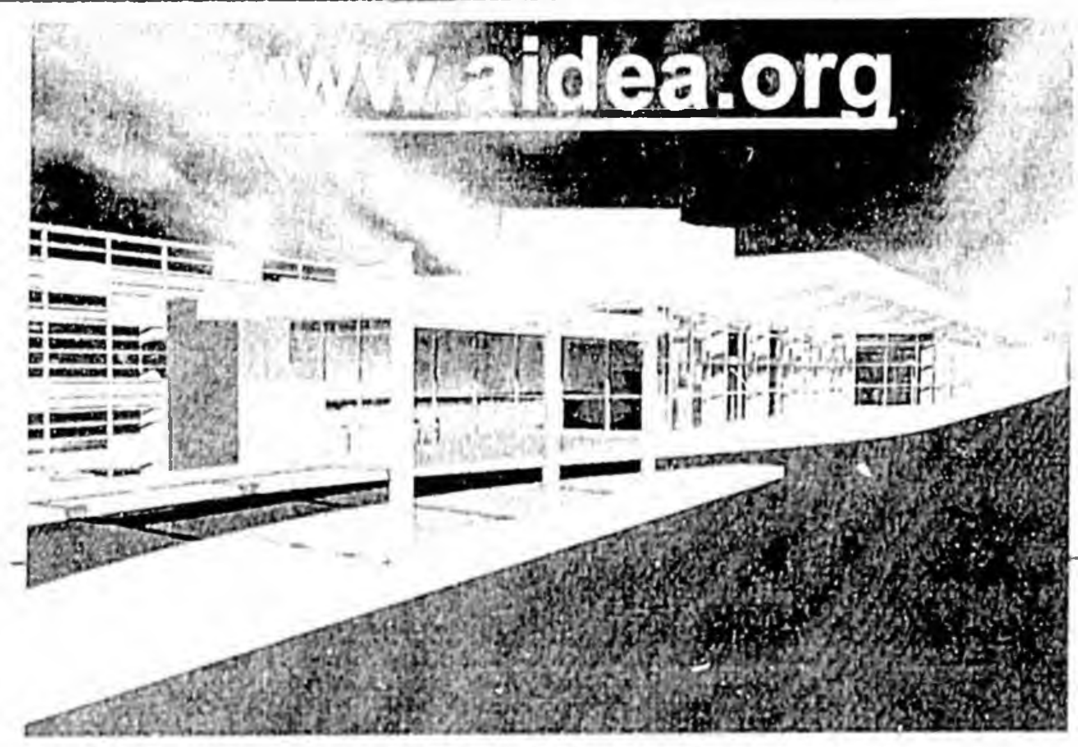
AIDEA and the ALASKA ENERGY AUTHORITY

- By statute, AIDEA oversees and staffs the Alaska Energy Authority (AEA) whose mission is providing safe, reliable and efficient energy for Alaska.

AIDEA and the ALASKA ENERGY AUTHORITY

- AEA builds rural energy projects
- AEA owns state energy assets – Bradley Lake Hydro Project, Alaska Intertie, Larsen Bay Hydro
- AEA manages the Power Cost Equalization program
- AEA provides training and assistance to rural utilities
- AEA pursues alternative energy programs
- AEA responds to electrical power emergencies

AIDEA is Alaska's financing agency!



Alaska Industrial Development and Export Authority

813 West Northern Lights Blvd.

Anchorage, AK 99503

907-269-3000

1/31/07 OVERVIEW: DEPT. OF LABOR

HFIN
FILE

Alaska Department of Labor and Workforce Development

FY 08 Operating Budget
Presentation to the House Finance Committee
Click Bishop, Commissioner
January 31, 2007

Jobs for Alaskans

"We must promise to stay focused on our mission: to build trust; **to create opportunities so that Alaskans have a chance to work**; to fund essential services without unsustainable spending; **to help improve the success of our students**; and make our homes and communities places of safety, prosperity and peace."

Governor Sarah Palin
State of the State, January 17, 2007

Our Mission

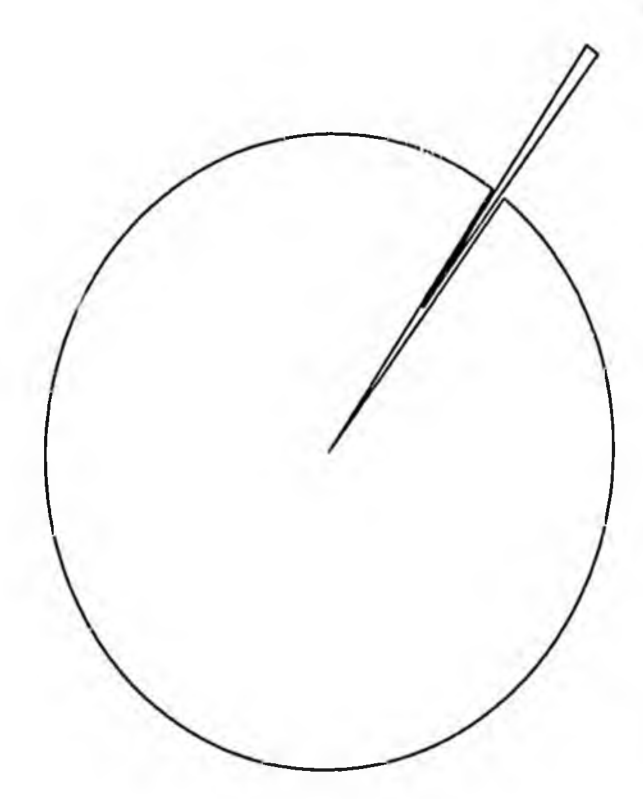
- Provide safe and legal working conditions and advance opportunities for employment.
  - Employment assistance.
  - Worker training and education.
  - Assuring fair compensation for work performed.
  - Assuring a safe workplace.
  - Injured worker and unemployment compensation.
  - Assisting people with disabilities to obtain and maintain employment.

Key Program Accomplishments—FY 06

- Approximately 40,000 Alaskans found jobs through the Alaska job center network, including the web-based labor exchange system.
- 4,248 individuals received employment and/or training services for jobs through federally funded job training programs operated by the department.
- 96% of participants trained through department grant programs entered employment.
- 524 Vocational Rehabilitation Division consumers were employed.
- 2% reduction in the rate of lost workday accidental injuries and illnesses—2.24 per 100 employees.
- Issued 1,846 General Education Development Diplomas.

FY 08 Budget is $176.9 million…

Department of Labor
$31,544.9 (0.88%)



State of Alaska
GF Operating
Budget
$3,601,749.6

Non-General Funds

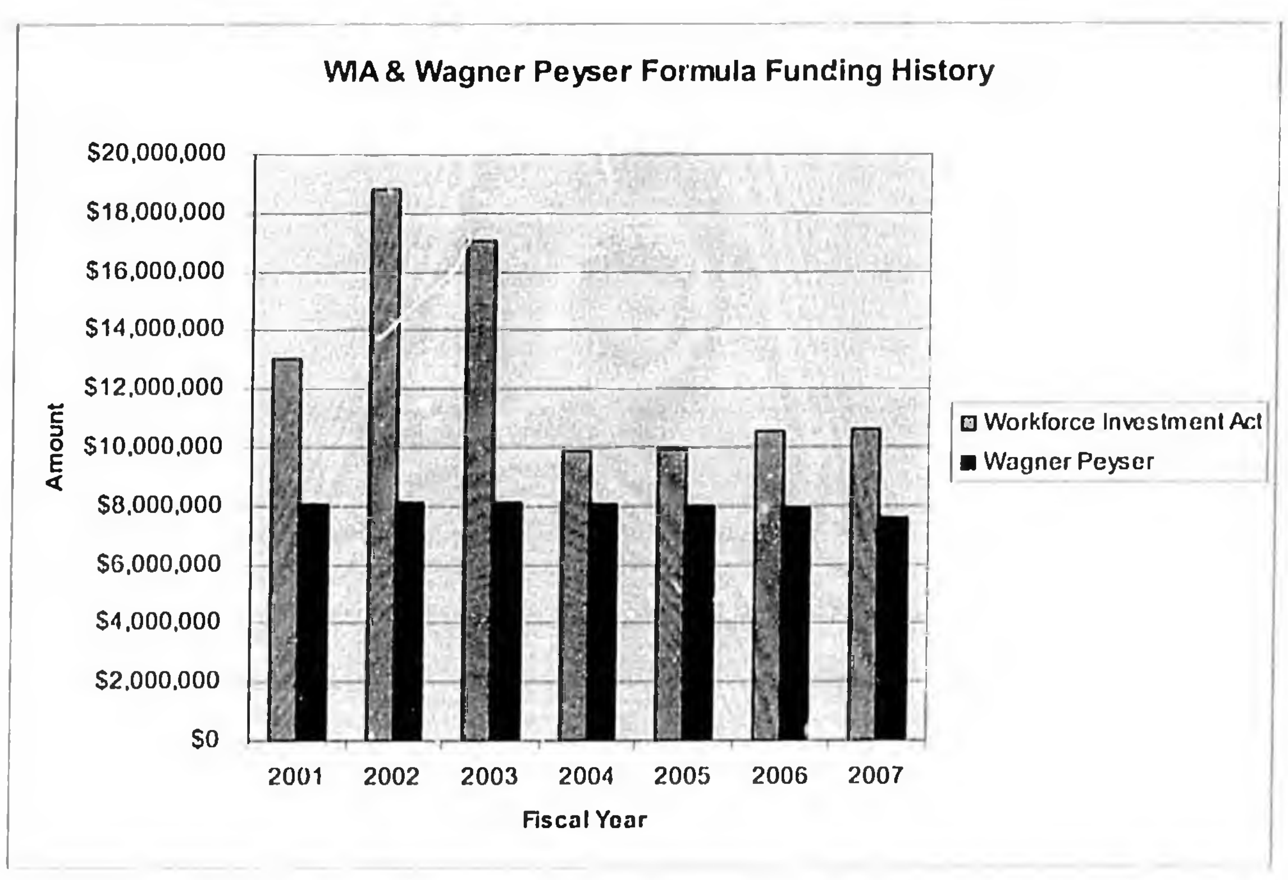
Federal: $93,256.2

Other: $52,090.9

Challenges

- Up to 48,000 new jobs will be created in Alaska by 2014, bringing the total to 349,000.
- Replace baby boomers exiting the workforce.
- Between 20,500 and 25,600 Alaskans are officially unemployed in any month (based on UI claims).
- A preliminary estimate for construction of the gas pipeline is that 8,600 skilled workers will be needed.
- The number and percentage of nonresidents working in Alaska in 2005 increased due to strong growth in the construction, accommodations and food services, and mining (oil and gas) industries. The nonresident hire rate rose from 18.4% in 2004 to 19.1% in 2005. The number of resident wage and salary workers grew by 2,317, while 3,899 nonresident workers were added in 2005.
  - **There is a shortage of skilled Alaska workers.**

Key Workforce Development Federal Funding for Job Centers, Job Referral and Job Training has declined, while costs increased....



Retirement cost increases are the main cost driver in FY 08. For example, the Employment Security Division is requesting $3.58 million GF to cover the PERS increase. Historically, this division has been funded with federal dollars and non GF state dollars.

Department-wide, Federal Funding has been at best flat and in some cases declining…

- For example, the Employment Security Division reduced federal authorization in the FY 08 budget by $5.3 million and eliminated 53 full-time positions.
- Along with cost efficiency measures throughout the department, we are requesting general fund increments in federally funded programs to cover PERS cost increases to provide essential employment services.

Preparing Alaska's Youth for the workforce....

- Approximately 12,000 Alaskans turn 18 each year.
- Only 62% of Alaskan high school graduates remain in Alaska for training or employment each year.
- Only 28% of Alaskans age 18 to 24 attend any type of education after high school. Lowest % of any state.
- 2000 U.S. Census estimates that over 57,000 Alaskans age 18 and older do not have a high school diploma.
- Less than 60% of Alaska's 9th graders graduate high school after 4 years. Many drop out altogether. Only 7 states perform worse.

We need to do better at keeping Alaska youth in school, engaged and prepared for Alaska jobs...

Improving the success of Alaska's students...

- "Alaska Youth First" was initiated in FY 06 under a federal grant to prepare workers for jobs in the energy industry.
- Formula funded federal youth grants limited to "high risk" targeted populations and funding has been declining.
- Youth First continued in FY 07 with a combination of one-time federal funding, partnering with the Denali Commission, $850.0 GF in the operating budget, and $1 million in the capital budget.
- Focus: career awareness, youth employability, pre-vocational training, teacher-industry externships, student internships, and summer youth academies.
- FY 08: $4.3 million GF to continue and expand Youth First to include the construction training academy at the King Career Center, career counselors in the schools, youth training/career awareness grants to school districts and non-profit educational organizations.
- Successes: Youth Employability Skills certificate program in Kenai; Job and Career Clubs in Fairbanks; Tanana Chiefs placed 25 youth with ASRC to learn pipeline repair skills; King Career Center construction academy will train 200 youth and 200 adults this fiscal year.

Vocational-Technical Training Programs

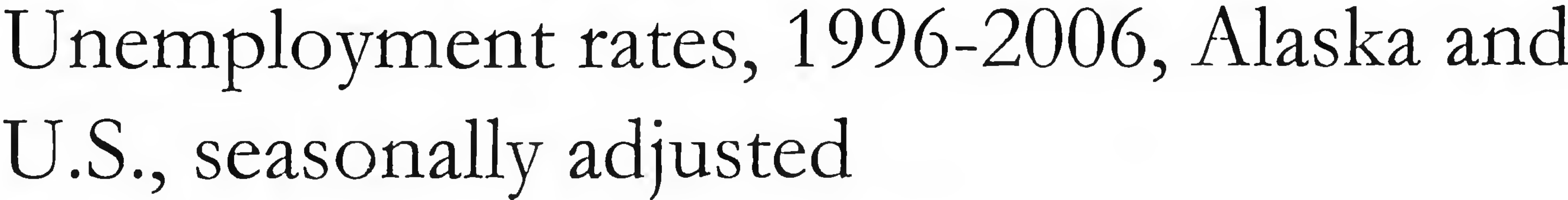
- Alaska Vocational Technical Center
  - Provides adult vocational technical education and training to Alaskans
    - 16 certificate programs in Alaska's high priority industries including health care, construction, transportation, hospitality, and information technology. 1,382 completers in FY 06.
    - 81% completion rate for long term programs (6 weeks to one year). 385 enrolled in FY 06.
    - 93% placement of long term program graduates in training related jobs

Vocational Training Programs

- **State Training and Employment**
  - 20% of workers' unemployment insurance contributions are directed by statute to the STEP account. Approximate annual revenue: $5.5 million.
  - In FY 06, 1,853 Alaskans received training and support services
  - Most recent data—95% of STEP participants were employed within 12 months following program exit.
  - In FY 05, exiting STEP participants earned more than $73 million in Alaska wages in the year following exit, a 22.6% increase over pre-training earnings.
  - STEP exiters saw a 23% reduction in total unemployment benefits paid the 12 months following exit compared to the 12 months prior to entry into the program.
  - **Program will expire on June 30, 2008 unless extended by the Alaska legislature.**

Gas Pipeline Workforce Preparation

- Construction workforce strategic plan was approved by the Alaska Workforce Investment Board in April 2006.
- Gas Pipeline workforce estimates range from 4,300 to more than 8,600.
- Competitive grants from federal and STEP funds for job training.
- Memoranda of Understanding between the department, trainers and employers to ensure training program graduates get jobs.
- Six years of Fairbanks Joint Pipeliner Training.
- Funding for a Fairbanks Training Facility focusing on pipeline related jobs.
  - $1.5 million in FY 05 for equipment.
  - $3.0 million in FY 06 toward facility construction.
  - Total facility cost: $6-$9 million.
- Alaska Hire Commitment by Developers of Gas Pipeline.



Unemployment rates, 1996-2006, Alaska and U.S., seasonally adjusted

— Alaska
— U.S.

9 8 7 6 5 4 3 2 1 0

1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006

Source: Alaska Department of Labor & Workforce Development, Research and Analysis Section, and U.S. Bureau of Labor Statistics

Thank you for your time…

- Click Bishop, Commissioner 465-2700
- Guy Bell, Administrative Services 465-2702

2/6/07 OVERVIEW: MEDICAID PROGRAM REVIEW

HFIN FILE

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

GAO-04-491

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	10	24	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 $39 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

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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, Vergil 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. 1396o).

[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 premium 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 non-institutional 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 2004.

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.[13] According to CMS, six states with SCHIP programs that are Medicaid expansions have received section 1115 waivers to require beneficiary

[13]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 2004, 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	
Medicaid?	SCHIP?	of states	States
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.[22] 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.

[22]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

Service	Number of states					
	Copayment		Coinsurance		States using cost sharing for this 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

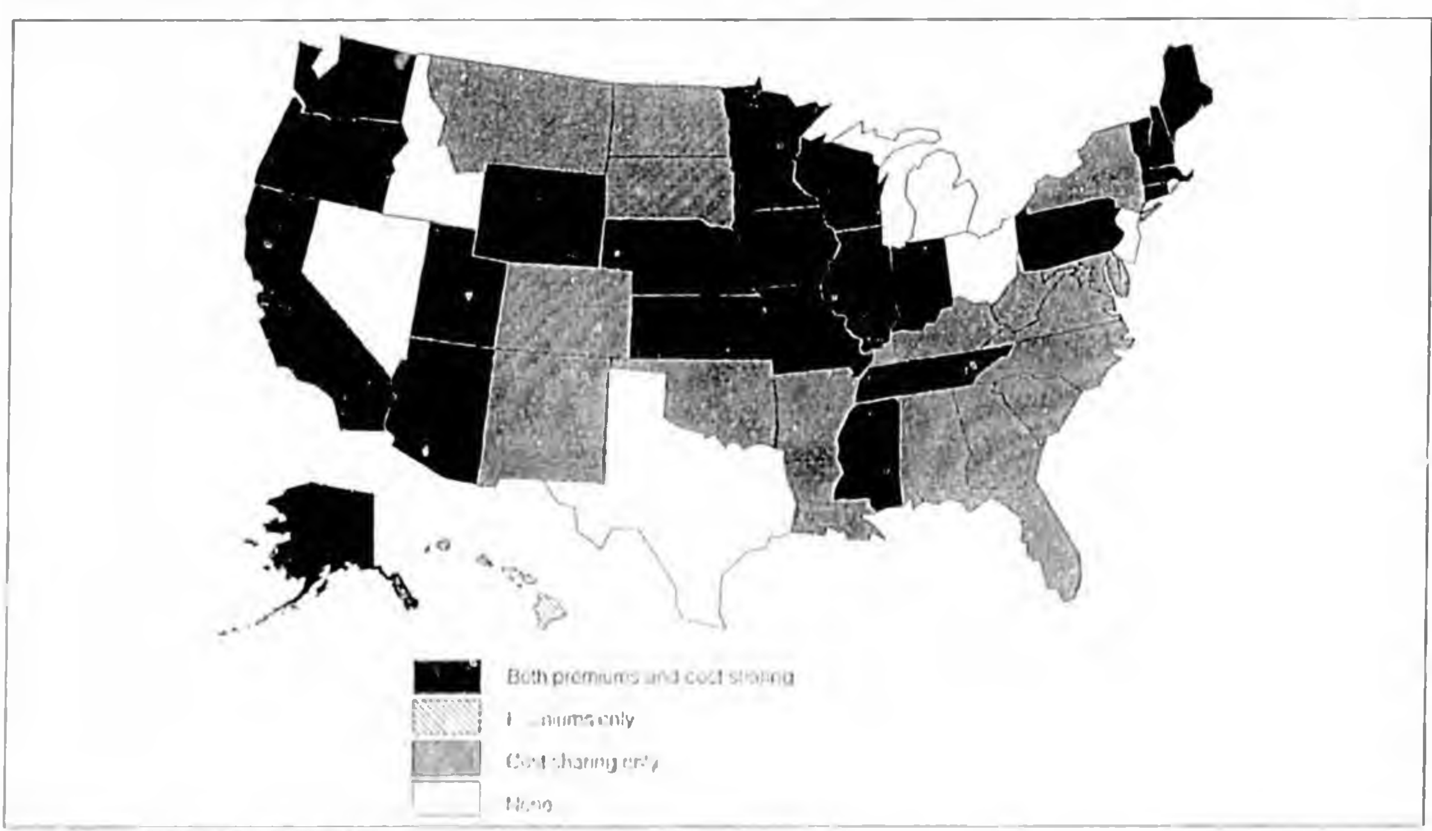
Characteristics	Number of states	
	Medicaid	SCHIP
States charging cost sharing for children	6	25
States varying cost sharing by income	1	14
States capping cost sharing charges	1	7

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



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

Population[a]	Number of states charging all, most, or some of this population		
	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[a]

Source: GAO analysis of state survey responses.

[a]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

Population[a]	Number of states and portion of population charged		
	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.[21] 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

[21]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.