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October 2002

HEALTH INSURANCE

States' Protections and Programs Benefit Some Unemployed Individuals

GAO-03-191

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GAO Highlights

Highlights of GAO-03-191, a report to the Ranking Minority Member, Senate Committee on Finance and Senator Gordon Smith.

Why GAO Did This Study

In March 2001, the longest economic expansion in United States history ended, and the country entered a recession, signified in part by a significant increase in unemployment. Because rising unemployment can adversely affect individuals' health insurance status, GAO was asked to review the policies of six states with significant recent increases in unemployment to (1) identify protections in place that assist unemployed individuals in maintaining or obtaining health insurance coverage and (2) assess the extent to which unemployed individuals and their families can rely on Medicaid and the State Children's Health Insurance Program (SCHIP) as a source of health insurance.

What GAO Found

The six states reviewed had in place a variety of protections, established prior to the economic downturn, to assist unemployed individuals in maintaining health insurance coverage:

- State-mandated continuation coverage, which required small businesses to extend their group health coverage to former employees and their families who choose to pay for it.
- Guaranteed conversion, which required insurers to allow eligible individuals to convert their group coverage to individual health insurance policies.
- Guaranteed issue, which required insurers to offer coverage to those who did not have access to group coverage or public insurance.
- High-risk pools, state-created associations that offered comprehensive health insurance benefits to individuals with acute or chronic health conditions.

However, individuals generally bore the full cost of the premiums, which was usually higher than their premium cost under employer-sponsored plans. For individuals who relied on unemployment benefits as their principal income, premiums absorbed a significant share of the benefit.

State Protections that Facilitate Access to Health Insurance Coverage for the Unemployed in Six Selected States

State	State-mandated continuation coverage	State-mandated guaranteed conversion	State-mandated guaranteed issue	High-risk pool
Colorado	✓	✓		✓
New Jersey	✓		✓	
North Carolina	✓	✓		
Ohio	✓	✓	✓	
Oregon	✓			✓
Utah	✓	✓		✓

Source: State information, October 2002.

Unemployed workers were less likely than their children to be eligible for coverage under state Medicaid or SCHIP programs because adult eligibility thresholds were less generous than those for children. Coverage of adults was limited in four of the six states, as average unemployment benefits were at least twice the amount of income allowed for Medicaid eligibility. Colorado, Oregon, and Utah have received recent federal approval to expand Medicaid and SCHIP coverage for certain low-income adults. While New Jersey had a similar expansion of coverage in 2001, it suspended new enrollment for adults in June 2002 due to budgetary constraints.

We incorporated technical comments provided by representatives from states' insurance departments, high-risk pools, and Medicaid programs, as appropriate. We did not obtain comments from the Department of Health and Human Services because we did not assess its role in these programs.

www.gao.gov/cgi-bin/getrpt?GAO-03-191.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen (202) 512-7114.

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Abbreviations

COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPS	Current Population Survey
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
MEPS	Medical Expenditures Panel Survey
PPO	preferred provider organization
SCHIP	State Children's Health Insurance Program

GAO
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United States General Accounting Office
Washington, DC 20548

October 25, 2002

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Gordon Smith
United States Senate

In March 2001, the longest economic expansion in United States history ended, and the country entered a recession, as indicated by a significant decline in overall business activity, including employment, over several months.[1] From March 2001 to March 2002, the national unemployment rate increased from 4.3 percent to 5.7 percent—or from 6.1 to 8.1 million unemployed individuals—the highest unemployment rate in more than 6 years.[2] Since about two-thirds of nonelderly Americans obtain their health insurance coverage through an employer, individuals who become unemployed face not only a loss of income, but also potentially the loss of employer-subsidized health insurance. Although the number of people without health insurance increases as the unemployment rate increases, the rates of increase are not the same because a sizable number of workers (25 percent) do not have health insurance through their employers. Workers less likely to receive insurance include those who work in industries where employment is cyclical in nature, such as agriculture or construction; when they lose their jobs, their health insurance status is unaffected.

Federal laws provide some protections to help newly unemployed individuals maintain health insurance coverage by allowing them to

[1]See *The Business-Cycle Peak of March 2001*, National Bureau of Economic Research (Nov. 26, 2001). The National Bureau of Economic Research identifies recessions on the basis of several indicators, including employment, sales in the manufacturing and trade sectors, and industrial production.

[2]The U.S. Bureau of Labor Statistics characterizes individuals as unemployed if they are at least 16 years of age, do not have a job, have actively looked for work in the prior 4 weeks, and are currently available for work. Persons who were waiting to be recalled to a job from which they had been laid off need not have been looking for work to be classified as unemployed. Persons who have lost a job and are not looking for work are not counted as unemployed.

purchase coverage under their former employer's group health plan or to obtain coverage through the individual insurance market. Because states regulate many aspects of health insurance, they may also require additional protections for unemployed workers. Two federal-state health financing programs for certain low-income individuals—Medicaid and the State Children's Health Insurance Program (SCHIP)—may also be a source of health insurance coverage for unemployed individuals or their families.

In light of the recent rise in unemployment and its relationship to health insurance coverage, you asked us to review selected states with significant recent increases in unemployment to (1) identify what protections states have to assist unemployed individuals in maintaining or obtaining health insurance coverage and (2) assess the extent to which unemployed individuals and their families can rely on these states' Medicaid and SCHIP programs as a source of health insurance coverage.

To examine these issues, we analyzed national and state employment data from the Bureau of Labor Statistics and data on the uninsured from the 2002 Current Population Survey (CPS) Annual Demographic Supplement.[3] Also, we reviewed six states (Colorado, New Jersey, North Carolina, Ohio, Oregon and Utah) that had above-average increases in unemployment from March 2001 to March 2002. We also contacted representatives from states' insurance and labor departments and Medicaid programs and obtained statutory, regulatory and other information on state protections and programs that assist unemployed individuals in maintaining or obtaining health insurance coverage. We conducted our work from May 2002 through October 2002 in accordance with generally accepted government auditing standards.

Results in Brief

The six states we reviewed had established various protections prior to the economic downturn to assist individuals in maintaining or obtaining health insurance coverage. These protections benefit individuals who have lost their jobs in maintaining coverage under their former employer's group plan or in obtaining individual health insurance. They included: requiring small businesses to extend their group health coverage to former employees and their families if the former employees pay for it; requiring insurers to allow individuals to convert group coverage into individual

[3]Our national review included the District of Columbia, which we referred to as a state for purposes of this report.

coverage; and establishing high-risk pools that offer comprehensive health insurance benefits to individuals with acute or chronic health conditions. However, because states generally did not provide subsidies and the individual thus bore the full cost of the premium under the state protections, unemployed persons generally had to pay more for coverage than they would as participants in an employer-sponsored plan. For those relying on unemployment benefits as their principal income, the premium costs under these various protections would absorb a significant share. For example, the premiums for the high-risk pool in one state nearly equaled the entire average unemployment benefit. The six states we reviewed did not have data on the number of individuals who lost their health insurance during the current economic downturn and therefore could not quantify the number who might benefit from these protections. A few states quantified the number of persons who actually used certain protections. For example, states tracked participation in high-risk pools and found increased enrollment from March 2001 to March 2002. However, increased participation could not be attributed solely to increases in the number of unemployed because other conditions, such as insurers leaving the market in the state, may have also had an effect.

Unemployed individuals who look to states' Medicaid and SCHIP programs for health insurance coverage for themselves and their families may find their eligibility limited. Unemployed workers were less likely than their children to be eligible for coverage under Medicaid or SCHIP because adult eligibility thresholds were less generous than those for children. In four of the six states we reviewed, average unemployment benefits were at least twice the amount of income allowed for Medicaid eligibility. Two states with lower income eligibility for adults—Utah and Colorado—have received federal approval to expand Medicaid and SCHIP coverage for some adults who would otherwise be ineligible for public coverage—a potential benefit for some unemployed individuals. In addition, Oregon also recently received federal approval for program expansions. In the wake of recent fiscal pressures resulting from the economic downturn, however, New Jersey recently suspended new enrollment for adults for its Medicaid and SCHIP programs due to budgetary constraints. In addition, some states' efforts to expand coverage for uninsured adults, in part by providing adult coverage with funds intended for children, has raised significant federal fiscal and legal issues.

Representatives from these states' insurance departments, high-risk pools, and Medicaid programs provided technical comments on a draft of this report, which we incorporated as appropriate. We did not obtain comments from the Department of Health and Human Services (HHS)

because we did not assess HHS's role or performance with respect to protections or programs that may benefit unemployed individuals.

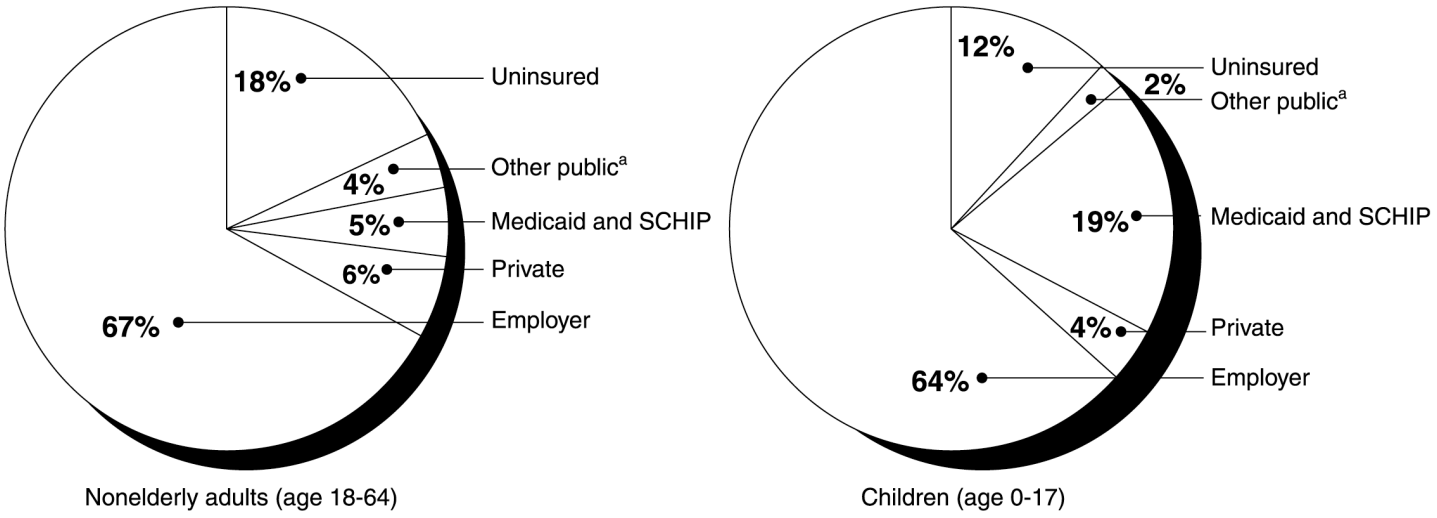
Background

Employer-sponsored coverage is the predominant source of health insurance in the United States. In 2001, 67 percent of all nonelderly adults (over 118 million) and 64 percent of all children (46 million) obtained health insurance through an employer (see fig. 1). Nearly all large firms and almost half of smaller firms offer health insurance coverage for their employees.[4] Federal tax laws provide incentives for employers to pay some or all of the premiums because their contributions are tax deductible as a business expense; the employer-paid portion of the premiums is also not considered taxable income for employees. Although the share of the premiums paid by employers varies with the size of the firm and the type of health plan, firms pay an average of more than 80 percent of the premiums for single coverage and more than 75 percent for family coverage.[5] Also, for many individuals, the premiums for employment-based insurance are lower than those in the private market for comparable individual coverage.

[4]According to the 2000 Medical Expenditures Panel Survey (MEPS), 59 percent of all firms offer health insurance coverage, with 97 percent of firms with more than 50 employees and 47 percent of firms with fewer than 50 employees offering coverage.

[5]According to the 2000 MEPS data, firms with fewer than 50 employees paid an average of 85 percent of the premiums for single coverage and 72 percent for family coverage. Larger firms (with 50 or more employees), paid an average of 82 percent of the premiums for single coverage and 77 percent for family coverage.

Figure 1: Source of Health Insurance Coverage of Nonelderly Adults and Children, 2001



Note: Due to rounding, percentages may not add to 100 percent.

[a]Includes Medicare and military health insurance coverage.

Source: GAO Analysis of the 2002 Current Population Survey Annual Demographic Supplement.

Medicaid and SCHIP

Low-income individuals without access to employer-based insurance coverage may qualify for Medicaid or SCHIP. These public insurance financing programs covered over 40 million low-income people at a cost of about $232 billion in federal and state expenditures in 2001.

Established in 1965, Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income individuals. Medicaid eligibility is based in part on family income and assets. States set their own eligibility criteria within broad federal guidelines. For example, states vary in the kind and amount of income they exclude from consideration when determining eligibility. Similarly, while some states set a ceiling on the value of assets—such as cars, savings accounts, or retirement income—that individuals may have available to them in order to be deemed eligible for Medicaid, other states have no asset test for eligibility. To the extent that asset tests are present in a state's Medicaid program, individuals would need to "spend down" or dispose of their assets to become eligible for Medicaid.

More than half of the individuals enrolled in Medicaid are children. Federal law requires states to provide Medicaid coverage to children age 5 and under if their family income is at or below 133 percent of the federal poverty level and to children age 6 to 19 in families with incomes at or below the federal poverty.[6] Most states have received federal approval to set income eligibility thresholds that expand their Medicaid programs beyond the minimum federal statutory levels for children.

Medicaid eligibility for nondisabled adults is more limited. Federal law requires states to provide Medicaid coverage to pregnant women up to 133 percent of the federal poverty level, and mandatory eligibility for parents is linked to the Medicaid family coverage category established in the 1996 federal welfare reform law.[7] At a minimum, federal law requires states to offer Medicaid coverage to parents in families that meet the income and other eligibility rules that the state had in place on July 16, 1996, for determining eligibility for welfare assistance. Nationwide, considerable variation in Medicaid eligibility thresholds for parents exists. For example, Alabama covers parents whose family income is up to 13 percent of the federal poverty level. At the other end of the spectrum, Minnesota covers parents with family incomes up to 275 percent of the federal poverty level. The Medicaid statute does not generally provide for mandatory or optional coverage of nondisabled childless adults. However, some states have

[6]For 2002, the federal poverty level is $8,860 a year for a single individual and $15,020 for a family of three. Medicaid eligibility is mandatory for all children born after September 30, 1983, whose family incomes are less than or equal to the federal poverty level. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VII), (l)(1)(D) and (l)(2)(C) (2000).

[7]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

received federal approval to expand their Medicaid programs to include coverage for some of them.[8]

In 1997, the Congress created SCHIP to provide health coverage to children living in families whose incomes exceed the eligibility limits for Medicaid. While SCHIP is generally targeted to children in families with incomes at or below 200 percent of the federal poverty level, each state may set its own income eligibility limits, within certain guidelines.[9] As of January 2002, states' upper income eligibility threshold for SCHIP ranged from 133 to 350 percent of the federal poverty level. Unlike Medicaid, which entitles all those eligible to coverage, SCHIP has a statutory funding limit of $40 billion over 10 years (fiscal years 1998 through 2007). Under SCHIP, states can cover the entire family—including parents or custodians of eligible children—if it is cost-effective to do so, meaning that the expense of covering both adults and children in a family does not exceed the cost of covering just the children. Similar to Medicaid, states can obtain federal approval of SCHIP expansions through a section 1115 waiver.

Characteristics of Uninsured Individuals

While more than 85 percent of Americans obtain health insurance coverage from the private insurance market or public programs, 40.9 million nonelderly Americans (16.5 percent) had no health insurance in 2001. Approximately 75 percent of the uninsured nonelderly adults had jobs. Individuals working part time, for small firms, or in certain industries, such as agriculture or construction, were more likely to be uninsured (see table 1). Young adults, minorities, and low-income persons

[8]Under section 1115 of the Social Security Act, the Secretary of Health and Human Services can waive many of the statutory requirements in the case of experimental, pilot, or demonstration projects that are likely to promote Medicaid's objectives. See 42 U.S.C. § 1315 (2000). Use of this authority allows states to provide services or cover individuals not normally eligible for Medicaid and SCHIP and to receive federal funds under these programs for services and populations not otherwise eligible. To receive approval for waivers, states must show that expansions of coverage should not result in the federal government spending more money in the state than would have been spent in the absence of the waiver. We have reported that section 1115 waivers approved for several states were not budget neutral. See *Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs*, GAO/HEHS-96-44 (Washington, D.C.: Nov. 8, 1995) and *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817 (Washington, D.C.: July 12, 2002).

[9]SCHIP allows a state to expand eligibility up to 50 percentage points above its Medicaid income eligibility standard in 1997. As with the Medicaid program, SCHIP allows states to set their own income and asset eligibility criteria. 42 U.S.C. § 1397jj(b)(1)(B)(ii) (2000).

were also more likely to be uninsured.[10] The percentage of uninsured is generally higher in the South and West and lower in the Midwest and Northeast (see fig. 2). Texas had the highest uninsured rate of nonelderly Americans (25.9 percent) of any state in 2001, while Iowa had the lowest (8.7 percent).

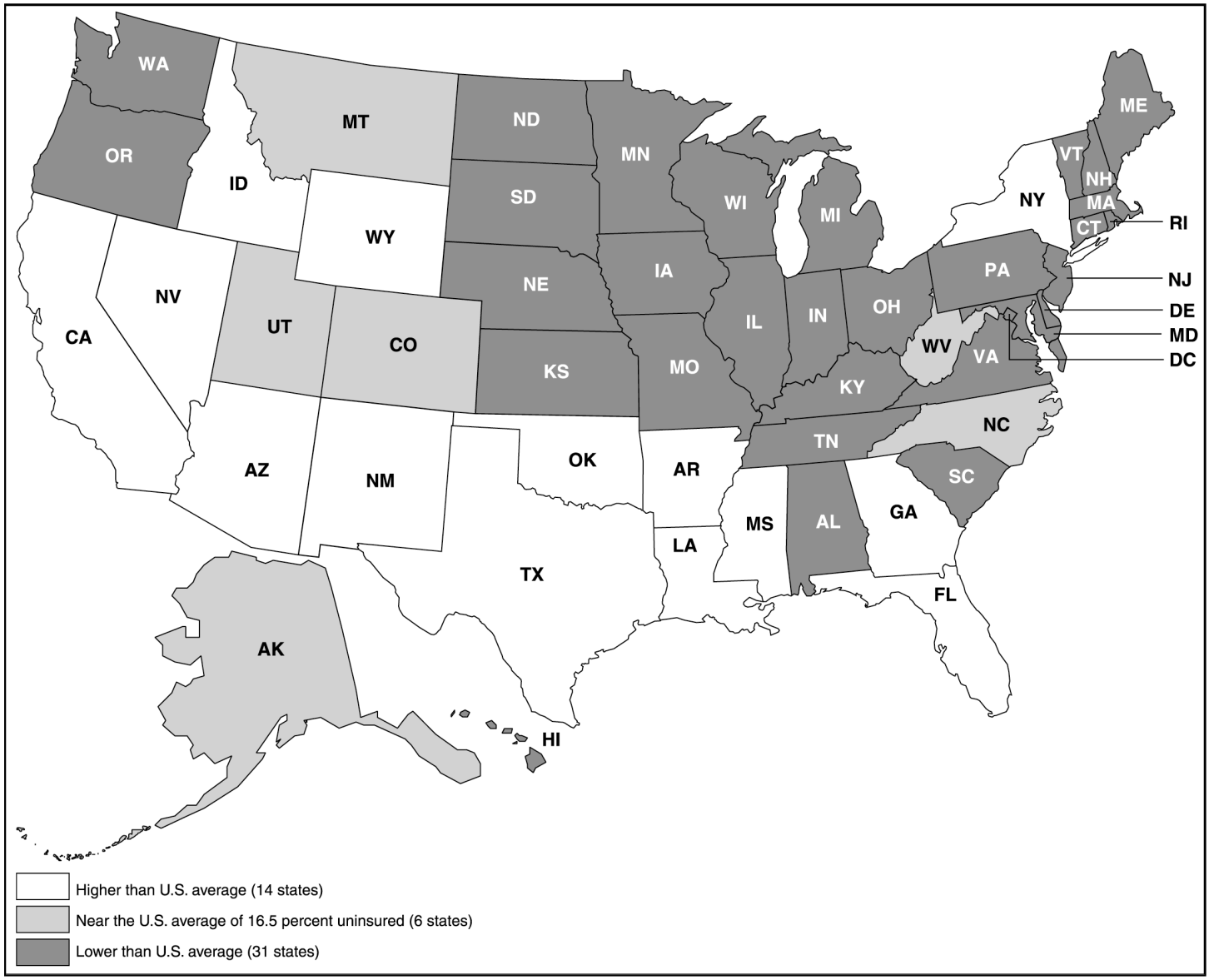
Table 1: Insurance Status of Nonelderly Adults, by Employment Level, Firm Size, and Industry, 2001

Employment characteristic	Percentage uninsured
By employment level	
Part-time	24.0
Full-time	13.8
By firm size	
Fewer than 10 employees	30.3
10 to 24 employees	25.7
25 to 99 employees	18.9
100 or more employees	10.9
By industry	
Agriculture, forestry and fishing	38.2
Construction	31.9
Trade	23.9
Services	15.0
Mining	12.9
Transportation and public utilities	12.7
Manufacturing	11.8
Finance, insurance and real estate	9.2
Government	4.3

Source: GAO analysis of the 2002 Current Population Survey Annual Demographic Supplement.

[10]See U.S. General Accounting Office, *Health Insurance: Characteristics and Trends in the Uninsured Population*, GAO-01-507T (Washington, D.C.: Mar. 13, 2001).

Figure 2: States' Shares of Nonelderly Residents Who Are Uninsured Compared to U.S. Average, March 2002



Source: GAO Analysis of the 2002 Current Population Survey Annual Demographic Supplement.

Changes in Employment

From March 2001 to March 2002, the national unemployment rate increased 1.4 percentage points, from 4.3 percent to 5.7 percent, with nine states experiencing above-average increases. The largest percentage point increases occurred in Colorado (2.6), Oregon (2.5), and Utah (2.0) (see table 2).

Table 2: Changes in Unemployment by State, March 2001 to March 2002

Change (percentage points)	State
2.6	Colorado
2.5	Oregon
2.0	Utah
1.9`	Ohio
1.8	Arizona, New Jersey
1.7	California, North Carolina
1.6	New York
1.5	Maryland, New Mexico, Tennessee, Texas
1.4	**United States**, Virginia
1.3	Florida, Mississippi, Wisconsin
1.2	Massachusetts, Michigan
1.1	Nevada, Pennsylvania
1.0	Alabama, New Hampshire, Indiana
0.9	Georgia, Illinois, South Carolina, Washington, West Virginia
0.8	Idaho, Minnesota
0.7	Connecticut, Missouri
0.6	Maine, Nebraska, Oklahoma, Vermont
0.4	Hawaii, North Dakota
0.3	Arkansas, District of Columbia, Iowa, Kentucky
0.2	Kansas, South Dakota, Wyoming
0.1	Delaware
0.0	Alaska, Montana
-0.2	Louisiana
-0.5	Rhode Island

Source: U.S. Bureau of Labor Statistics data.

Across the six states we reviewed—Colorado, New Jersey, North Carolina, Ohio, Oregon and Utah—the greatest unemployment increases were generally seen in manufacturing, construction, and transportation and public utilities (see table 3).

Table 3: Percentage Change in Employment for Selected Industries for Six States, March 2001 to March 2002

Industry	Colorado	New Jersey	North Carolina	Ohio	Oregon	Utah
Construction	-5.2	2.2	-3.6	-3.2	-10.1	-8.2
Finance, insurance and real estate	-1.0	2.6	-0.8	0.0	1.0	0.7
Government	3.9	2.0	1.4	1.4	0.8	1.4
Manufacturing	-8.8	-6.3	-6.4	-4.1	-7.5	-6.8
Mining	8.9	0.0	2.6	-3.1	-11.1	-5.0
Services	-3.3	0.3	0.7	0.0	-0.9	1.4
Trade	-1.3	0.0	-0.6	-1.1	-1.3	-1.5
Transportation and public utilities	-7.0	-3.7	-1.4	-2.2	-3.5	-3.3

Source: U. S. Bureau of Labor Statistics data.

Unemployed individuals may be eligible for financial assistance through the Unemployment Insurance Program, a federal-state partnership designed to partially replace the lost earnings of individuals who become unemployed through no fault of their own.[11] While program requirements vary by state, individuals eligible for unemployment insurance generally (1) have worked for a specified period in a job covered by the program, (2) left the job involuntarily, and (3) are available, able to work, and actively seeking employment. Most states provide a maximum of 26 weeks of benefits, although benefits in some states have been extended for an additional 13 weeks in times of high unemployment.[12] Benefits are generally based on a percentage of an individual's earnings over the prior year, up to a maximum amount. The national average weekly unemployment benefit was $254 in the first quarter of 2002, with benefits lasting an average of nearly 15 weeks. In the six states we reviewed, the weekly unemployment benefit ranged from $253.80 in Ohio to $327.15 in New Jersey (see table 4).

[11]Established in 1935 by the Social Security Act, the Unemployment Insurance Program is funded through federal and state taxes levied on employers.

[12]On March 9, 2002, the President signed the Temporary Extended Unemployment Compensation Act of 2002, which provides eligible individuals with up to 13 weeks of federally financed extended unemployment benefits. Pub. L. No. 107-147, Tit. II. 116 Stat. 21, 26.

Table 4: Unemployment Benefits in Six States, First Quarter 2002

State	Average weekly benefit amount (in dollars)	Average duration (in weeks)
Colorado	311.62	13.0
New Jersey	327.15	17.2
North Carolina	256.24	11.4
Ohio	253.80	14.4
Oregon	261.99	15.3
Utah	275.28	12.7
United States	254.00	14.7

Source: U.S. Department of Labor.

Federal Protections

Although many aspects of health insurance, including premiums, are regulated at the state level,[13] two federal laws— the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)[14] and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[15]—established requirements designed to help certain individuals maintain health coverage after loss of employment.

COBRA provided that firms with 20 or more employees offer former employees and their dependents the opportunity to continue their group coverage for at least 18 months.[16] To qualify for COBRA benefits, former employees must have been covered by the employer's plan the day before they stopped working at the firm. Former employees are eligible only for the health plan coverage that they received while employed. COBRA coverage is not available if the former employer discontinues health benefits to all employees, as in a company closure.

[13]While all states have enacted laws that require insurers to provide certain health care benefits, certain types of health insurance plans are exempt from these requirements. The Employee Retirement Income Security Act of 1974 generally preempts states from regulating employers that assume the risk for, or "self-fund," their employees' health benefits.

[14]Pub. L. No. 99-272, 100 Stat. 83, 222 (1986).

[15]Pub. L. No. 104-191, 110 Stat. 1937, 1939.

[16]Under certain circumstances unrelated to job loss, such as the case of a covered employee's death, spouses and dependent children are able to continue group coverage under COBRA for up to 36 months.

While employers must allow COBRA-eligible former employees to continue receiving coverage under the employer's group health plan, the employer does not have to pay for it. The former employee can be required to pay the full cost of the group health premium plus 2 percent, which is designed to cover the employer's administrative cost of keeping the former employee in the plan.[17] Based on data from a 2002 survey of employers, the average cost of COBRA coverage is approximately $260 a month for an individual and $676 a month for a family.[18] Based on a survey of a national sample of 1,001 nonelderly adults, a recent study estimated that because of the cost of COBRA continuation coverage, "only 23 percent of employed, insured adults would be very likely to participate in the COBRA program if they lost their jobs."[19]

Unlike COBRA, which provided the opportunity for individuals losing their jobs to continue their private group health insurance, HIPAA provisions guarantee certain individuals losing group coverage the right to purchase coverage in the individual market.[20] HIPAA provides guaranteed access to health coverage for individuals who, among other criteria, had at least 18 months of coverage without a break of more than 63 days and with the most recent coverage being under a group health plan. HIPAA stipulates that states must either require health insurers to make certain of their policies available to qualifying individuals or use an "alternative

[17]The Trade Act of 2002, Pub. L. No. 107-210, enacted on August 6, 2002, gives eligible individuals an immediate 65 percent refundable tax credit for certain health insurance coverage, including COBRA coverage. The credit, which takes effect in November 2002, is for workers who lose their job as a result of trade agreements and for retirees age 55 to 64 who lack health care benefits and whose former employer's pension plan was taken over by the Pension Benefit Guaranty Corporation. The Congressional Budget Office estimated that this legislation would increase the number of workers eligible for coverage by about 50 percent, to nearly 200,000 annually; the refundable portion of this credit is estimated to cost the federal government $1.6 billion over fiscal years 2003 through 2012.

[18]Costs were calculated based on 102 percent of average monthly premiums for employer-sponsored health plans. See The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* (Menlo Park, Calif.: 2002).

[19]Jennifer N. Edwards, Michelle M. Doty and Cathy Shoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey* (New York, N.Y.: August 2002).

[20]HIPAA also provides protections for individuals changing jobs and obtaining other coverage by setting group market limitations on preexisting conditions, exclusion periods, previous coverage credit requirements, and prohibitions on exclusions based on health status.

mechanism" to offer them coverage. An example of an alternative mechanism is a state-sponsored high-risk pool, which offers comprehensive insurance coverage to individuals with preexisting health conditions who are otherwise unable to obtain coverage in the individual market or who may be able to obtain coverage only at a prohibitive cost. (Appendix I describes how the six states that we reviewed guarantee access to coverage under HIPAA.) As with COBRA, individuals bear the full cost of individual coverage received under HIPAA. Since HIPAA provides for coverage in the individual insurance market, in which premiums are generally based on the characteristics of the individual applicant, this coverage is likely to be more costly for many applicants for a similar level of coverage than premiums for groups, where risk is spread over all members of the group. The differences will be smaller in some states that have imposed restrictions on how much insurers can vary premiums based on an individual's characteristics.

Various State Protections Offer Assistance, but Unemployed Individuals Generally Bear the Full Premium Cost

The six states we reviewed had instituted various protections that might assist individuals who have lost their jobs in maintaining or obtaining health insurance. Unemployed individuals, however, generally bore the full cost of the premium. States did not have data on the number of individuals who lost their health insurance during the economic decline and thus, who could benefit from these protections, but did have data on the number of individuals using some of the protections.

States' Protections Generally Allow Unemployed Individuals to Purchase Insurance at Full Cost

The six states we reviewed had in place a variety of protections, which were established prior to the economic downturn. Unemployed individuals, however, were generally responsible for bearing the full costs of purchasing health insurance. Key protections to assist unemployed individuals in maintaining health insurance coverage included:

- State-mandated continuation coverage, through which states require small businesses to extend their group health coverage to former employees and their families if the former employees pay for it;
- Guaranteed conversion, through which states require insurers to give eligible individuals the ability to convert their group coverage to an individual health insurance policy;

- Guaranteed issue, through which states require insurers to offer coverage to individuals who do not have access to group coverage or public insurance; and
- High-risk pools, in which states create associations that offer comprehensive health insurance benefits to individuals with acute or chronic health conditions.

Table 5 indicates the extent to which the six states we reviewed had adopted such protections.

Table 5: State Protections That Facilitate Access to Health Insurance Coverage for the Unemployed in Six Selected States

State	State-mandated continuation coverage	State-mandated guaranteed conversion	State-mandated guaranteed issue	High-risk pool
Colorado	✓	✓		✓
New Jersey	✓		✓	
North Carolina	✓	✓		
Ohio	✓	✓	✓	
Oregon	✓	[a]		✓
Utah	✓	✓	[b]	✓
Total	**6**	**4**	**2**	**3**

[a]Oregon requires insurers to offer either a low-cost or prevailing benefit plan to eligible individuals leaving that insurers' group coverage. To be eligible, individuals must, among other criteria, be state residents, have at least 6 months of prior group coverage, and not be eligible for Medicare or Medicaid.

[b]Utah does not have a guaranteed issue law, but residents who do not meet the medical criteria for the state's high-risk pool are guaranteed access to a policy from the private insurance company that had declined them coverage.

Source: State information, October 2002.

Of the six states we reviewed, only Oregon assisted lower income unemployed individuals in paying for the cost of premium coverage. Previously funded solely with state resources, the program was unable to expand enrollment for nearly 3 years and had a significant waiting list due

to budget constraints. However, in October 2002, Oregon received approval to expand this program using federal funds.[21]

State-Mandated Continuation Coverage

Each of the six states that we reviewed had a health care coverage continuation law, which applied to employers with fewer than 20 employees and thus were not subject to COBRA requirements. While the states required that employers make health insurance coverage available to eligible individuals, the employers were not required to pay for this coverage. In New Jersey, North Carolina and Utah, eligible individuals can be required to pay up to 102 percent of the cost of the premium charged under their former employer's plan (the full cost of the group health premium plus a 2 percent fee to cover the employer's administrative costs) (see table 6). In the other three states, individuals may be required to pay up to the full cost of the premium, but no administrative fee may be added. Like COBRA, the state health care coverage continuation laws did not apply to companies that terminate coverage, such as when going out of business. Nationally, premiums for state continuation coverage averaged approximately $260 a month for an individual and $676 a month for a family in 2001, which equals 24 to 61 percent of the average unemployment benefit.[22]

[21]Begun in 1998 as a state-funded program, Oregon's premium assistance program paid from 70 to 95 percent of the health insurance premiums for individuals with incomes below 170 percent of the federal poverty level. The program had over 3,300 enrollees and a waiting list of more than 29,000 as of June 2002. With the newly approved federal waiver, the program will pay from 50 to 95 percent of health insurance premiums for individuals with incomes up to 185 percent of the federal poverty level. Expanded eligibility for premium assistance is scheduled to begin on November 1, 2002. The state expects enrollment in the program to increase by approximately 25,000 people, with enrollment to be limited based on the availability of state funding.

[22]Costs were calculated based on 102 percent of average monthly premiums for employer-sponsored health plans. Actual costs of state continuation coverage may be higher or lower depending on the characteristics of the firm or health insurance policy. See The Kaiser Family Foundation and Health Research and Educational Trust, *Employers Health Benefits: 2002 Annual Survey* (Menlo Park, Calif.: 2002).

Table 6: State Continuation Coverage Requirements and Benefits

State	Maximum premium (expressed as a percentage of group rate)	Prior continuous coverage requirement (in months)	Maximum required length of coverage (in months)
Colorado	100	6	18
New Jersey	102	[a]	12
North Carolina	102	3	18
Ohio	100	3	6
Oregon	100	3	6
Utah	102	6	6

[a]Individuals must have been covered by employer-sponsored insurance on their last day of employment.

Source: State continuation coverage laws, as of October 2002.

Eligibility for, and the length of required coverage under, states' continuation coverage laws were often more limited than under COBRA. While under COBRA individuals must only be insured the day before they stop working, five of the six states that we reviewed had more stringent requirements. They required individuals to have been continuously insured for the 3 to 6 months immediately prior to the separation from their job. New Jersey, Ohio, Oregon, and Utah required employers to offer a year or less of continuation coverage, compared to 18 months under COBRA and in Colorado and North Carolina.

State-Mandated Guaranteed Conversion

Once individuals exhaust their COBRA or state health care continuation coverage, they may become eligible to convert to an individual policy. Although the HIPAA provisions require states to ensure that eligible individuals can move from group to individual health insurance coverage, state guaranteed conversion is specific to an insurer. Four of the six states we reviewed (Colorado, North Carolina, Ohio, and Utah) required insurers to provide individual policies to eligible individuals previously covered under a group policy sold by their company. To be eligible for guaranteed conversion, individuals had to have been continuously insured by the group health plan, or its predecessor, for 3 to 12 months (depending on the state) prior to their application for conversion—requirements that are less stringent than the 18 months of prior continuous coverage under HIPAA.[23]

[23]HIPAA does allow individuals to have a break in coverage of 63 days or less and still remain eligible.

State laws on guaranteed conversion contained no maximum length of required coverage; as with other individual health insurance policies, beneficiaries could renew the policies as long as they agreed to continue paying the premiums and did not commit fraud. Individuals were responsible for the conversion plan premiums, which could generally be based on the demographic and health characteristics of the individual. Thus, individual coverage under conversion policies—for which individuals pay the full premium—was generally more expensive than group coverage especially for higher-risk individuals.

State-Mandated Guaranteed Issue

Of the six states we reviewed, New Jersey and Ohio had "guaranteed issue," which required insurers to offer coverage to all individuals in the state who were not eligible for group coverage or public insurance programs, if they were willing to pay for it. According to Ohio statute, insurers in that state could charge an individual up to 2.5 times the rate charged to another individual with a similar policy.[24] In New Jersey, insurers were required to charge each applicant the same price for five standard plans, but monthly premiums varied by insurer.[25] For a policy issued by a health maintenance organization (HMO) in New Jersey, with a $30 copayment per visit to the doctor, monthly premiums for single coverage ranged from $324 to more than $394, depending on the insurer, while premiums for the other standard health plans were more expensive.[26] (A comparison of the five standard plans is in table 7.) In the four states we reviewed that did not have guaranteed issue laws, insurance companies could choose not to offer coverage to individual applicants and have few or no restrictions on what they could charge individuals based on their health status, age, or other factors.

[24]For individuals eligible for HIPAA, Ohio statute limits the rate to twice the midpoint rate charged any other individual with a policy with similar copayments and deductibles. For individuals not eligible for HIPAA, Ohio statute limits the rate to 2.5 times the highest rate charged to any other individual with a policy with similar copayments and deductibles.

[25]Although New Jersey did not regulate premium rates, insurers were required to pay at least 75 cents in benefits for every dollar received in premiums or refund a portion of the premiums.

[26]The four remaining standard plans can either be indemnity plans or preferred provider organizations (PPO). The indemnity plans allow individuals to choose any physician or hospital for care, while the PPOs pay for a greater portion of care received from a selected panel of doctors and hospitals typically reimbursed on a fee-for-service basis.

Table 7: Selected Characteristics of the Standard Guaranteed Issue Plans Covering Hospital and Medical Services in New Jersey, September 2002

		Indemnity/PPO				
Type of plan[a]		**Plan A[b]**	**Plan B**	**Plan C**	**Plan D**	**HMO**
Individuals' share of provider covered charges		50%	40%[c]	30%	20%	Copayment per visit[d]
Individuals' maximum out of pocket cost (above their deductible)		$5,000[e]	$3,000[e]	$2,500[e]	$2,000[e]	[f]
Range in monthly premiums for single coverage across carrier[g]						
Deductible						
	$500	Not offered	Not offered	Not offered	$1,200 - $8,127	[h]
	$1,000	$434 - $2,150	$480 - $2,457	$381 - $3,071	$423 - $4,914	[h]
	$2,500	$348 - $1,843	$409 - $2,150	$309 - $2,457	Not offered	[h]
	$5,000	$237 - $416	Not offered	Not offered	Not offered	[h]
	$10,000	$153 - $311	Not offered	Not offered	Not offered	[h]
Copayment						
	$10	[h]	[h]	[h]	[h]	$487 - $727
	$15	[h]	[h]	[h]	[h]	$462 - $512
	$20	[h]	[h]	[h]	[h]	$379 - $463
	$30	[h]	[h]	[h]	[h]	$324 - $394

Note: Plans A through D, and the HMO plan, represent standard insurance packages defined by the state, which were available from multiple insurers.

[a]New Jersey's standard guaranteed issue included three different types of health plans: (1) indemnity plans, which allowed individuals to choose any physician or hospital for care, (2) PPOs, which paid for a greater portion of care received from a selected panel of doctors and hospitals typically reimbursed on a fee-for-service basis, and (3) HMOs, which were prospectively paid a fixed monthly fee per patient to provide or arrange for most health services and, in turn, pay providers either retrospectively for each service delivered on a fee-for-service basis or through prospective capitation payment arrangements.

[b]The state refers to this plan as Plan A/50.

[c]Beneficiaries must pay an additional $200 per day hospital charge for each of the first 5 days of hospitalization, up to a maximum of $2,000 per person each year.

[d]HMOs offered copayment options of $10, $15, $20 and $30 for physician and outpatient services. Other copayments applied to inpatient hospitalizations, emergency room visits, and maternity care. Also, prescription drugs could be covered subject to either a 50 percent coinsurance or a $15 copayment, at the option of the carrier.

[e]Under the PPO options, insurers paid 100 percent of charges after total covered charges, paid by either the individual or the insurer, reaches $10,000.

[f]Plan did not have a maximum out-of-pocket cost.

[g]All individuals, regardless of age or health status, paid the same premium.

[h]Plan did not have this type of deductible or copayment for policyholders.

Source: State information.

High-Risk Pools

Three of the states we reviewed (Colorado, Oregon, and Utah) have established high-risk pools that served individuals with acute and chronic conditions.[27] The high-risk pools in these three states began operation in the early 1990s and also served individuals eligible for coverage under HIPAA (see table 8). High-risk pools are subsidized. Because enrollees often have major health problems, medical claims costs are high and would exceed unsubsidized premiums collected from their enrollees. Oregon's risk pool was subsidized by a fee assessed on insurers based on the number of people they cover. Utah subsidized the operation of its high-risk pool with state funds. Colorado used a combination of these approaches.

High-risk pool premiums are higher than standard premiums for individual insurance paid by healthy applicants although not necessarily higher than a high-risk individual would be charged in the individual market if coverage were available. State high-risk pool laws generally capped premiums at 125 to 200 percent of comparable standard commercial coverage rates. Premiums varied based on factors such as age, geographic location, type of health plan, and deductible. One state, Colorado, provided a 20 percent premium discount to certain low-income individuals. Across the three states we reviewed that had high-risk pools, undiscounted premiums for nonelderly adults ranged from less than 10 percent to close to 100 percent of the average unemployment benefit in the state.

[27]Nationally, 30 states have high-risk pools. See Communicating for Agriculture & the Self-Employed, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis.* (Fergus Falls, Minn.: 2002).

Table 8: Selected Characteristics of High-Risk Pools in Three States, June 2002

State (year began operation)	Medical eligibility requirements	Number enrolled[a]	Premium limits	Factors used to determine premiums for an individual	Range of individual monthly premiums
Colorado (1991)	State residents for at least 6 months who • were denied coverage because of a medical condition; • were accepted for coverage, but with a premium higher than that under the high-risk pool; • were accepted for coverage, but with a pre-existing condition exclusion of greater than 6 months; OR • have one of 30 acute or chronic medical conditions but were not necessarily denied coverage.	3,886	150 percent of the standard individual rate	• Age • Gender • Smoking status • County • Deductible amount ($300 to $5,000)	$75 - $1,283[b]
Oregon (1990)	Individuals who were denied individual health insurance coverage within the last 6 months because of their health condition.	8,762	125 percent of the prevailing market rate for an individual policy	• Age • Geographic location • Type of health plan[c]	$118 - $661
Utah (1991)	State residents for at least 12 months or dependent children 25 years of age or younger of such individuals, who • meet the high-risk pool's health underwriting criteria established under Utah statute,[d] • apply for coverage not more than 63 days after being denied coverage by a private individual insurer, AND • pay the established premium. OR Individuals who terminated similar coverage from another state's high-risk pool within the previous 63 days because they were no longer a resident of that state and who pay premiums for the entire coverage period in Utah.[e]	2,061	Generally set at 150 percent of the prevailing premium level for the five largest small employer insurers in the state offering comparable coverage	• Age • Deductible amount ($500 to $2,500)	$152 - $471

[a]Enrollment figures represent the total enrollment in the high-risk pool and thus include individuals who qualify either because of medical reasons or through HIPAA.

[b]Reflects the premiums for individuals between the ages of 20 and 64. Premiums are lower for children and higher for individuals over age 65. Individuals with household incomes of $32,500 or less, and with liquid assets of $50,000 or less, can qualify for a 20 percent premium discount.

[c]Premiums in Oregon vary by health plan. Enrollees have a choice of four health plans: a traditional indemnity plan, a PPO, HMO, or low cost/limited benefit plan.

[d]Under the state's criteria, points were assigned to various medical conditions based on the expected medical claims or complications for that condition. Individuals with conditions that have points totaling above a specified level were eligible for the high-risk pool.

[e]Under certain circumstances, individuals would be ineligible for the high-risk pool. For example, individuals eligible for other public programs that provide medical care were not eligible for the high-risk pool.

Source: GAO analysis of state information.

States Lack Data on Current Numbers of Uninsured; Knowledge of Beneficiaries' Use of State Protections Varies

Although Ohio, Oregon, and Utah collected data on the number of uninsured residents, none of the states that we reviewed had data sufficiently current to determine how many of their residents had lost health insurance during the recent economic decline. States' knowledge of any changes in the numbers of individuals benefiting from the different states' protections varied by option and the state, with data most often available for the three states' high-risk pools. None of the states we reviewed tracked how many of its residents obtained health coverage through state-mandated continuation coverage. Of the four states that required insurers to offer conversion plans, only Utah tracked the number of policies issued but it did not have data current enough to determine whether usage increased during the current economic decline. New Jersey tracked the number of individuals receiving individual health coverage through its five standard plans. Enrollment in these standard plans declined in the past year, which a state representative attributed to the rising cost of coverage.[28]

Each of the three states we reviewed that had high-risk pools tracked enrollment in their pools. From March 2001 to March 2002, enrollment in high-risk pools increased by 47 percent in Colorado, almost 23 percent in Oregon, and 37 percent in Utah. But it is not clear how much of the increased participation came from the ranks of the unemployed. For example, a Colorado official said a large portion of the increased enrollment in the state's high-risk pool was likely due to insurers leaving the individual and small group health insurance market in the state. Therefore, it is difficult to determine how much of the increase included those dropped from individual or nonemployer-based group coverage and how much included the newly unemployed.

[28]The number of individuals covered by standard plans in New Jersey declined by almost 14,000, from 97,790 individuals in the first quarter of 2001 to 83,896 people in the first quarter of 2002.

Eligibility for Medicaid and SCHIP Programs Is Limited for Unemployed Adults Despite Expansions in Some States

Given the cost of maintaining coverage under their former employers' health insurance plan or obtaining alternative coverage, unemployed individuals may look to states' Medicaid and SCHIP programs for coverage for themselves and their families. Unemployed adults, however, are less likely to qualify for these programs than their children due, in part, to less generous eligibility levels set for adults than for children. Colorado, Oregon, and Utah have recently received federal approval for waivers to expand eligibility for adults in Medicaid and SCHIP, which may increase coverage for unemployed individuals. In the wake of recent fiscal pressures resulting from the economic downturn, however, New Jersey has suspended its Medicaid and SCHIP coverage expansion for new applicants. Efforts by some states to expand Medicaid and SCHIP coverage for uninsured adults have raised significant federal fiscal and legal issues, at times providing adult coverage with funds intended for children.

Unemployed Adults Are Less Likely Than Children to Qualify for Medicaid and SCHIP Coverage

As unemployed adults seek health insurance, they will likely find it more difficult to secure coverage under Medicaid or SCHIP for themselves than for their children. Under Medicaid, the majority of states had set eligibility levels for nondisabled adults that were less generous than those for children.

In the six states we reviewed, Medicaid's maximum income eligibility levels for non-disabled adults were lower than the levels for children.[29] In Colorado, New Jersey, North Carolina, and Utah, the maximum income levels for coverage for these adults were under 50 percent of the federal poverty level.[30] In contrast, Medicaid and SCHIP coverage for children ranged from those in families with incomes up to 170 percent of the

[29]However, on October 15, 2002, Oregon received federal approval to expand Medicaid and SCHIP eligibility for children and adults in families with incomes up to 185 percent of the federal poverty level. Increased eligibility levels for most adults will be phased in over time while eligibility for children and pregnant women is scheduled to be increased to 185 percent of the federal poverty level on February 1, 2003.

[30]While income eligibility levels for adults in New Jersey is currently under 50 percent of the federal poverty level, adults already enrolled in Medicaid may have higher incomes due to increased eligibility levels established by the state in the past.

federal poverty level to those in families with incomes up to 350 percent of the federal poverty level (in Oregon and New Jersey, respectively).[31]

In four of six states, adults eligible for unemployment benefits might not have qualified for Medicaid because the average of their unemployment benefits would have been at least twice as much income as allowed for Medicaid eligibility. In the remaining two states—Ohio and Oregon—adults that received the average unemployment benefit would have met the income eligibility requirements for Medicaid in those states (see table 9).

Table 9: Receipt of Unemployment Benefits Often Made Parents Ineligible for Medicaid

State	Average monthly unemployment benefit (in dollars)	Monthly Medicaid income eligibility level for parents[a] (in dollars)	Income within Medicaid eligibility levels
Colorado	1,350	421	No
New Jersey	1,418	443	No
North Carolina	1,110	544	No
Ohio	1,100	1,252	Yes[b]
Oregon	1,135	1,252[c]	Yes[b]
Utah	1,193	583[d]	No

[a]Medicaid income eligibility levels for parents are based on a family of three.

[b]To qualify for Medicaid, an individual would also need to meet asset test and other eligibility requirements.

[c]On October 15, 2002, Oregon received federal approval to expand Medicaid and SCHIP coverage for adults, including parents, up to 185 percent of the federal poverty level, or $2,316 per month for a family of three. The state plans to implement this expansion in increments beginning November 1, 2002.

[d]In Utah, some adults with incomes above this eligibility level may qualify for Medicaid under another eligibility category that limits benefits to primary and preventive care.

Sources: State and U.S. Bureau of Labor Statistics data, 2002.

In Colorado, North Carolina, Oregon, and Utah, Medicaid coverage for unemployed adults was more restricted than it was for children because adults' accumulated assets could have made them ineligible for coverage

[31]Upon implementation of Oregon's expansion, which is expected to begin on February 1, 2003, Medicaid and SCHIP coverage for children will increase from 170 percent of the federal poverty level to 185 percent of the federal poverty level.

even after their unemployment benefits run out. The amount of assets allowed and the types of assets included for eligibility purposes varied by state (see table 10). For purposes of determining whether individuals reached or exceeded their asset limit, North Carolina included the cash value of life insurance, checking and savings accounts, and other investments, but excluded the value of an applicant's primary residence and vehicle. Utah required that families with children over age 6 have assets below $3,000 (with allowances for an additional $25 in assets for each additional family member) but excluded the value of one home and of one vehicle, up to $15,200.

Table 10: Asset Exclusions for Parents under Medicaid in Six States

State	Asset limit	Treatment of home	Treatment of vehicle
Colorado	$2,000	Excluded	Value of one vehicle excluded
New Jersey	None	N/A	N/A
North Carolina	$3,000	Excluded	Value of one vehicle excluded per adult age 18 or older
Ohio	None	N/A	N/A
Oregon	$2,000	Excluded	Value of vehicles excluded
Utah	$2,000 -$3,000	Home occupied or being purchased by the applicant is excluded	Value of one vehicle excluded (up to $15,200); OR $1,500 of the value of any vehicle

Source: State information, October 2002.

In contrast, most states nationwide have eliminated family asset tests in determining Medicaid and SCHIP eligibility for children. As of January 2002, 44 states had eliminated family asset tests for all children in families with incomes at or below the poverty level and two other states dropped it for certain categories of children. Among the six states we reviewed, four states did not have asset tests for children in Medicaid, while five states did not have asset tests for children in SCHIP (see table 11).

Table 11: Medicaid and SCHIP Family Income Eligibility Limits and Asset Tests for Children's Eligibility in Six States, 2002

State	Upper income eligibility (as percentage of federal poverty level)[a]	Family asset test applies to children's eligibility for:	
		Medicaid	SCHIP
Colorado	185	Yes	No
New Jersey	350	No	No
North Carolina	200	No	No
Ohio	200	No	No
Oregon	170[b]	No	Yes
Utah	200	Yes[c]	No

[a]Medicaid eligibility can vary by the child's age. For example, Colorado covers infants and children up to age 5 in families with incomes up to 133 percent of the federal poverty level and children age 6 to 19 in families with incomes up to 100 percent of the federal poverty level. SCHIP eligibility would begin above these levels and end for children in families earning up to 185 percent of the federal poverty level.

[b]Oregon received federal approval to expand Medicaid and SCHIP coverage for children up to 185 percent of the federal poverty level, which it plans to implement on February 1, 2003.

[c]State counts family assets for eligible children age 6 and older.

Source: State information.

Among unemployed adults, childless adults often had more difficulty qualifying for Medicaid than parents. The Medicaid programs in Colorado, North Carolina, and Ohio did not cover any nondisabled childless adults. In New Jersey, childless adults faced a lower Medicaid income eligibility level than parents did. Oregon and Utah covered a small number of childless adults, all of whom earned less than 150 percent of the federal poverty level (see table 12).

Table 12: Eligibility Levels for Childless Adults and Parents Applying for Medicaid, 2002

	Income level below which coverage is granted (expressed as percentage of federal poverty level)[a]	
State	**Childless adults**	**Parents**
Colorado	No coverage	34
New Jersey	19	35[b]
North Carolina	No coverage	43
Ohio	No coverage	100
Oregon	100[c]	100[c]
Utah	[b]	47[b]

[a]Income eligibility levels for childless adults are based on the individual, while the levels for parents are based on a family of three.

[b]Income eligibility does not reflect state's coverage expansions under federally-approved waivers because eligibility was either no longer available to new applicants (New Jersey) or provided a more limited benefit with additional cost sharing (Utah).

[c]Oregon received federal approval to expand Medicaid and SCHIP coverage for adults up to 185 percent of the federal poverty level. The state plans to implement this expansion in increments beginning November 1, 2002.

Source: State information.

States' Expansions Can Offer Coverage for Unemployed Individuals, but Some Raise Fiscal and Legal Issues

Some states have received approval from the federal government to expand Medicaid and SCHIP coverage for parents and childless adults, including recently unemployed individuals. Of the states we reviewed, Utah recently received a section 1115 waiver to expand Medicaid coverage to certain parents and childless adults for a benefit package limited to primary care and preventive services. Utah's waiver is estimated to cover an additional 16,000 parents with family incomes under 150 percent of the federal poverty level and 9,000 childless adults with incomes under 150 percent of the federal poverty level. The expansion, implemented on July 1, 2002, is funded by enrollment fees and cost sharing by participants and savings from increased cost sharing and new limits on some optional services, such as mental health services, vision screening and physical therapy, for certain groups of currently eligible adults. On September 27, 2002, Colorado received approval to cover pregnant women with family income between 134 and 185 percent of the federal poverty level using SCHIP funds. Oregon also received approval on October 15, 2002, for a section 1115 waiver to expand insurance coverage for adults and children up to 185 percent of the federal poverty level using Medicaid and SCHIP funds. Oregon expects to cover an additional 60,000 individuals, but plans to phase in implementation of this expansion. On November 1, 2002, the

state plans to expand its premium assistance program by paying between 50 and 95 percent of premiums for eligible individuals with incomes up to 185 percent of the federal poverty level, using both Medicaid and SCHIP funds.[32] On February 1, 2003, Oregon plans to expand Medicaid and SCHIP eligibility to pregnant women and children with incomes up to 185 percent of the federal poverty level, and to other eligible individuals, including parents and childless adults, with incomes up to 110 percent of the federal poverty level. Further eligibility expansions may occur each quarter depending upon the availability of state funding.

A state that has used a waiver to expand Medicaid and SCHIP coverage may be prompted by shortfalls in its budget to limit these expansions. Of the states we reviewed, in January 2001, New Jersey expanded Medicaid and SCHIP coverage for parents earning up to 200 percent of the federal poverty level. In June 2002, however, New Jersey suspended new enrollment of adults in this program, increased the premiums and reduced the benefits for those already covered under the expansion.[33] New Jersey's program had exceeded the state's 3-year enrollment projection in 9 months.

Section 1115 waivers to expand insurance coverage under Medicaid and SCHIP can extend coverage to adults who would not otherwise qualify and who would have difficulty obtaining coverage elsewhere. However, we reported earlier that some waivers are inconsistent with the goals of the Medicaid and SCHIP programs and may compromise their fiscal integrity.[34] For example, in approving Utah's expansion, we concluded that HHS did

[32]Prior to the approved waiver, the Oregon premium assistance program used state-only funding that paid from 70 to 95 percent of the health insurance premiums for approximately 3,700 individuals with incomes below 170 percent of the federal poverty level. Due to budget constraints, however, new enrollment in the state-only premium assistance program was limited for 3 years, and had a waiting list of more than 29,000 people. Under the waiver, the state is limiting enrollment due to the availability of state funding and estimates that an additional 25,000 people will be covered.

[33]A recent study indicates that many states plan to decrease Medicaid spending in various ways, including limits on enrollment and retrenchment from program expansions. See Victoria Wachino, Kaiser Commission on Medicaid and the Uninsured, *State Budgets Under Stress: How are States Planning to Reduce The Growth in Medicaid Costs? Preliminary Results based on the Kaiser Commission on Medicaid and the Uninsured 50-State Survey* (Washington, D.C.: July 30, 2002).

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

not adequately ensure that the waiver would be budget neutral as required for approval. We estimated that Utah's waiver, if fully implemented, could cost the state and federal governments $59 million more than without the waiver. We found that the state's projection of what it would have spent without the waiver inappropriately included the estimated cost of services for a new group of people who were not being covered under the state's existing Medicaid program. Although we did not review Colorado and Oregon's waiver applications in our earlier report, we raised a broader legal issue about states' use of SCHIP funds to cover adults without children, which Oregon's recently approved expansion will do. In our earlier report, we found that HHS had approved an Arizona waiver proposal that would, among other things, use unspent SCHIP funding to cover adults without children, despite SCHIP's statutory objective to expand health care coverage to low-income children. In our view, HHS's approval of the waiver to cover childless adults is not consistent with this objective, and is not authorized. Consequently, we recommended that the Secretary of Health and Human Services not approve any more waivers that would use SCHIP funds for childless adults.[35] In addition, we suggested that the Congress amend the Social Security Act to specify that SCHIP funds are not available to provide health insurance for childless adults.

Concluding Observations

Health insurance for the majority of Americans who rely on employer-based coverage could be threatened upon job loss. Federal and state laws provide some protections that are aimed at helping individuals maintain or obtain health insurance coverage in such circumstances. The protections offered, however, are not without limitations as individuals may find that bearing the full cost of the premiums—with no employer or state subsidies—may be beyond their financial means. While those who cannot afford health insurance may look to Medicaid or SCHIP for assistance, coverage for adults is hampered by limited income eligibility and other requirements, such as asset tests, that are likely to reduce the number of adults that can qualify for coverage. Some states have made recent efforts to use the flexibility available to them under Medicaid and SCHIP to expand their programs to help cover increased numbers of uninsured adults. Tighter budgets, however, are beginning to constrain some states'

[35]HHS does not concur with our position that the spending of SCHIP funds is not authorized for childless adults. Subsequent to our recommendation, the Secretary approved New Mexico's and Oregon's waiver requests, on August 23, 2002, and October 15, 2002, respectively. Both states intend to use SCHIP funds to cover childless adults.

ability to sustain insurance coverage expansions initiated during stronger economic times. Thus, despite program expansions, coverage under Medicaid and SCHIP may not be available to unemployed adults, while other state coverage options may be too costly for these individuals.

State Comments

We provided a draft of this report for technical review to representatives of insurance departments, high-risk pools, and Medicaid programs in the six states we reviewed. Each of the states provided technical comments, which we incorporated as appropriate.

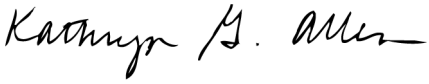
In addition, in its comments, Utah disagreed with our statement—based on findings in an earlier report—that HHS did not adequately ensure that the state's section 1115 waiver met the budget neutrality test. The state contends that its waiver is budget neutral and is consistent with long-standing HHS budget neutrality practices. Since 1995, we have expressed concern that HHS's methods for assessing budget neutrality allow the inclusion of certain costs that inappropriately inflate cost estimates and result in the federal government being at risk to spend more than it would have had the waivers not been approved.[36] We believe that continued use of these methods is inconsistent with the long-standing requirement for section 1115 waivers to be budget neutral and inappropriately places the federal government at risk of increased cost for the Medicaid and SCHIP programs.

We did not obtain comments from HHS on this report because we did not evaluate HHS' role or performance with respect to protections or programs that may benefit unemployed individuals.

As agreed with your offices, unless you publicly announce its contents earlier, we will plan no further distribution of this report until 30 days after its date. At that time we will send copies to other interested congressional committees and other parties. We also will 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.

[36]For a more detailed discussion of this issue, see GAO-02-817, pages 19-20, 34-35.

If you or members of your staff have any questions regarding this report, please contact me on (202) 512-7114 or Carolyn Yocom on (202) 512-4931. Other major contributors to this report include JoAnn Martinez-Shriver, Michael Rose, and Michelle Rosenberg.



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Appendix I: HIPAA Group-to-Individual Portability in Six States

HIPAA provides guaranteed access to coverage—"portability" from group to individual coverage—to eligible individuals who, among other criteria, had at least 18 months of coverage without a break of more than 63 days. Recognizing that many states had already passed reforms that could be modified to meet or exceed these requirements, HIPAA gave states the flexibility to implement this provision by using either the federal fallback or an alternative mechanism.

Under the federal fallback approach, insurers must offer eligible individuals guaranteed access to coverage in one of three ways. HIPAA specified that a carrier must offer eligible individuals (1) all of its individual market plans, (2) only its two most popular plans, or (3) two representative plans—a lower-level and a higher-level coverage option—that are subject to a risk spreading or financial subsidization mechanism.[1] According to a 2002 report, 11 states opted for the federal fallback approach.[2]

Under an alternative mechanism, states may design their own approach to guarantee coverage to eligible individuals as long as certain minimum requirements are met. Essentially, the approach chosen must ensure that eligible individuals have guaranteed access to coverage with a choice of at least two different coverage options. For example, one possible alternative mechanism is a state high-risk pool.

As shown in table 13 only one of the six states we reviewed relied on the federal fallback approach to ensure group-to-individual portability. The remaining states either relied on their high-risk pool, another alternative mechanism, or both.

[1]See U.S. General Accounting Office, *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators*, GAO/HEHS-98-67 (Washington, D.C.: Feb. 25, 1998).

[2]See Communicating for Agriculture & the Self-Employed, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*. (Fergus Falls, Minn.: 2002).

Table 13: Approaches to Group-to-Individual Portability in Six States

State	Federal fallback approach	State alternative mechanism approach	
		High-risk pool	Other
Colorado		X	
New Jersey			X[a]
North Carolina	X		
Ohio			X[b]
Oregon		X	X[c]
Utah		X	X[d]

[a]New Jersey provided group-to-individual portability through its individual market guaranteed issue law.

[b]Ohio used a combination of its guaranteed issue law and guaranteed conversion to provide group-to-individual portability.

[c]Oregon provided group-to-individual portability by requiring insurers to offer eligible individuals, who were previously covered by their group health plan, a choice between a low-cost and a prevailing benefit plan. Although similar to the federal fallback approach, the state characterized this as an alternative mechanism.

[d]Utah used its high-risk pool to provide group-to-individual portability for individuals eligible for HIPAA who were deemed uninsurable. HIPAA-eligible individuals who did not meet the high-risk pool's health underwriting criteria were guaranteed coverage in the private individual market.

Source: State information, October 2002.

Related GAO Products

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