GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 10, 2011

The Honorable Harry Reid
Majority Leader
United States Senate

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor, and Pensions
United States Senate

Subject: *Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children's Health Insurance Program*

The federal Pre-Existing Condition Insurance Plan (PCIP) was created in 2010 to provide access to insurance for individuals previously unable to acquire coverage due to pre-existing conditions.[1] Eligibility is limited to those who have been uninsured for at least 6 months prior to application, thus focusing the program on those who have been locked out of the private insurance market. The Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, required the establishment of the PCIP program. The program will provide coverage through the end of 2013, at which point enrollees will be guaranteed access to plans offered in the private market. States were given the option to run their own PCIP with federal funding or allow the Department of Health and Human Services (HHS) to run the program in their state.[2] Early estimates by the Congressional Budget Office (CBO)

[1]The PCIP program is modeled after existing state-operated high risk pools (HRP), which provide access to coverage and subsidize premiums for those with pre-existing conditions to make them more affordable. HRPs existed in 35 states as of September 2011, according to the website of the National Association of State Comprehensive Health Insurance Plans, the national organization of state-operated HRPs. See http://naschip.org.

[2]Pub. L. No. 111-148, § 1101, 124 Stat. 119, 141 (2010). Twenty-seven states elected to administer a PCIP, while 23 states and the District of Columbia opted for HHS to administer their PCIP. By law, PCIP premiums must be established at a standard rate for a standard population and may vary only by age—by no more than a 4 to 1 ratio—geography, and smoking status.

suggested that the program could cover an average of 200,000 individuals per year with the $5 billion appropriated in PPACA, but that demand would likely be greater.[3]

In July 2011, we reported on various aspects of the implementation of the PCIP program, including initial enrollment and spending trends, program features, and federal oversight.[4] As part of that work we interviewed PCIP officials from states with and without existing high risk pools (HRP) about the steps taken to implement PCIP in their states.[5]

As a new federal program, there is interest both in how the PCIP program has been implemented and how its implementation compares to another publicly funded insurance program—the Children's Health Insurance Program (CHIP). CHIP was authorized in August 1997 to reduce the number of low-income uninsured children in families with incomes too high to qualify for Medicaid.[6] Like Medicaid, CHIP is funded jointly by the federal government and the states. CHIP enrollment data are provided to HHS quarterly by the states, beginning with the first quarter of fiscal year 1998. When CHIP was passed, the CBO estimated that the program would provide coverage to about 2.3 million children per year after 1999.

You asked us to compare early program implementation and enrollment across PCIP and CHIP. In this report, we examine: (1) how long it took to implement PCIP and CHIP in all states; (2) initial enrollment trends for PCIP and CHIP; and (3) any differences in implementing PCIP, and trends in enrollment, between states that had high risk pools prior to the enactment of PPACA, and those that did not.

To address these objectives, we relied primarily on our July 2011 report examining implementation of the PCIP program and a report prepared under contract with the Centers for Medicare and Medicaid Services (CMS) within HHS examining CHIP enrollment patterns.[7] To compare how long it took to implement PCIP and CHIP, we identified the date enrollment began in each state and determined the number of months until the programs were active in all 50 states and the District of Columbia.[8,9]

---

[3]CBO estimated in June 2010 that if funding were not limited to $5 billion, enrollment could reach 700,000 by the end of 2013 at a cost of up to $15 billion. See Congressional Budget Office, letter to the Honorable Michael Enzi regarding the high risk insurance pools included in PPACA (June 21, 2010).

[4]See GAO, *Pre-Existing Condition Insurance Plans: Program Features, Early Enrollment and Spending Trends, and Federal Oversight Activities*, GAO-11-662 (Washington, D.C.: July 27, 2011).

[5]We interviewed officials in eight states, including four with existing HRPs (Alaska, Connecticut, Illinois, and North Carolina) and four without (Maine, Michigan, Ohio, and Pennsylvania).

[6]Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4901(a), 111 Stat. 251, 552. The act appropriated funds in 1-year increments over a period of 10 fiscal years (1998-2007), a total of approximately $40 billion for allotment to states to carry out the CHIP program.

[7]See GAO-11-662 and "*SCHIP's Steady Enrollment Growth Continues: Final Report, May 2003,*" Mathematica Policy Research, Inc., Cambridge, Mass., a report prepared under contract with CMS. PCIP data were originally provided by CMS. CHIP data reported by Mathematica were obtained from CMS's CHIP Statistical Enrollment Data System.

[8]The BBA established the CHIP program upon enactment, while PPACA required HHS to establish the PCIP program within 90 days of enactment. To facilitate our comparison of the implementation time frames of both programs, we measured the number of months from the date of enactment until the programs began enrolling individuals.

[9]We generally refer to the 50 states and the District of Columbia as "51 states."

To compare initial enrollment trends, we compared quarterly enrollment data for the first year of each program. Additionally, we interviewed officials from CMS to identify key factors to consider when comparing implementation and enrollment across the two programs. To compare any differences in implementing PCIP, and trends in enrollment, in states that did and did not have an existing HRP, we reviewed interviews conducted with state PCIP officials for our July 2011 report and analyzed implementation dates and enrollment data.

To assess the reliability of PCIP and CHIP implementation and enrollment data, we discussed with CMS officials the steps taken to ensure data accuracy and completeness and reviewed related documentation. We determined the data were sufficiently reliable for our purposes. We conducted this performance audit from August 2011 through October 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

We found that the PCIP program was implemented in all states within 7 months, while the CHIP program rolled out over a period of nearly 3 years.[10] In comparing the two programs, there are differences to consider that may account for the difference in implementation times, such as the different statutory requirements regarding implementation time frames, the mandatory versus voluntary nature of the two programs, the relative complexity of program requirements, the number of design decisions to be made, and different funding sources.

Enrollment in the PCIP and CHIP programs was slow to start but increased steadily over the first year, ending with more than 27,000 and 705,000 enrollees, respectively. Changes to PCIP eligibility criteria and premium rates intended to help expand enrollment were made immediately after the first year of the program.

PCIP implementation took slightly less time, on average, in states that had an existing HRP compared to those that did not—5.5 months compared to 6.1 months. Enrollment, however, was lower relative to the uninsured population in each state with an existing HRP—3.7 individuals per 10,000 uninsured, compared to 5.5 among states without an HRP.

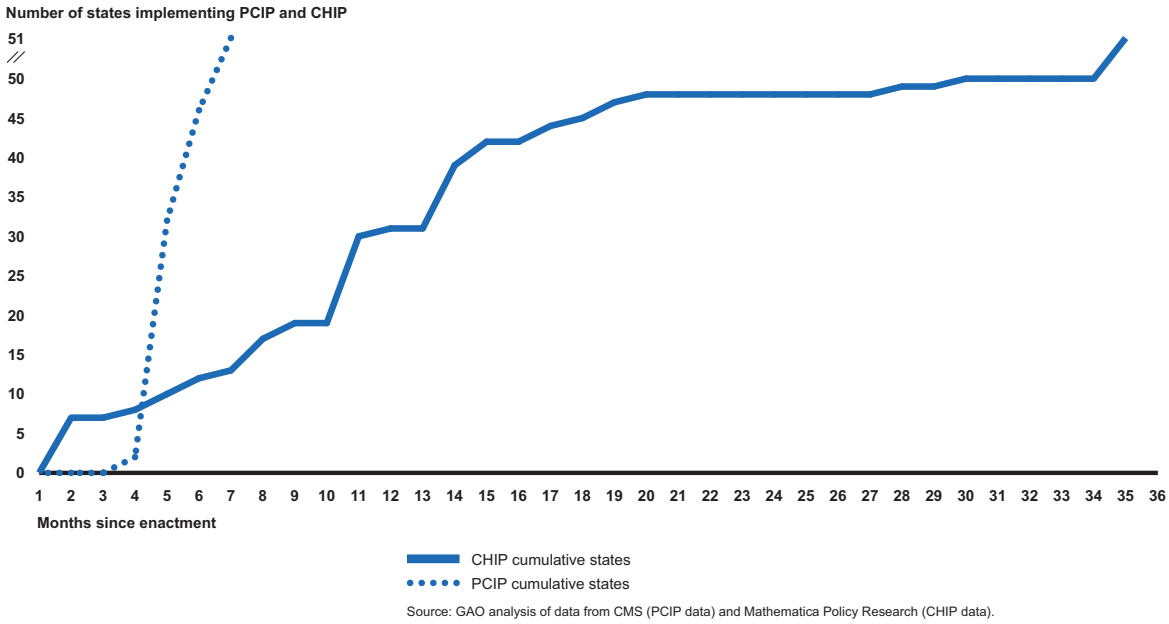
In reviewing a draft of this report, HHS provided technical comments, which we incorporated as appropriate.

[10]We use “implemented” to indicate that the state was actively enrolling individuals in a program, or, in the case of one state’s PCIP plan, had operationalized the program but had not yet enrolled any applicants.

PCIP Was Implemented within 7 months, while CHIP Rolled Out More Slowly

Within months the PCIP program was implemented in all states. The first PCIP plans (in New Hampshire and South Dakota) began enrolling individuals in July 2010, 4 months after PPACA was enacted. Plans were established in most states by August, and in all 51 states by October 2010, just 7 months after passage. CHIP was implemented more slowly. By the first CHIP quarterly enrollment report ending December 1997—4 months after enactment of the Balanced Budget Act of 1997—8 states had begun enrollment. By the end of fiscal year 1998, 31 states had implemented their programs. An additional 17 states began enrolling during fiscal year 1999, and all states had implemented their programs by the end of fiscal year 2000, nearly 3 years after enactment. See figure 1, and for more details see enclosure I.

Figure 1: Number of States Implementing PCIP and CHIP by Months Since Enactment



Note: For the PCIP program, enrollment in state-run programs began with 2 states in July 2010 (4 months after enactment), 9 states in August, 12 states in September, and 4 states in October 2010. Among states that opted for HHS to run the program, 21 began in August 2010, 2 in September, and 1 in October 2010.

In comparing the pace of implementation between PCIP and CHIP, there are certain key differences to consider. First, PCIP was a mandatory program statutorily required to be implemented within a specified time frame,[11] while the implementation of CHIP was conditioned on the voluntary participation of states[12] and without a specified time frame. Second, the programs varied in terms of their relative complexity. The steps taken to implement the PCIP program were relatively straightforward—for example, PCIP plans were required to determine the eligibility of applicants, provide certain minimum benefits, and calculate premiums based on the standard market rate. In the process of establishing CHIP, states faced similar and

[11]Specifically, PPACA required HHS to establish the PCIP program within 90 days of enactment.

[12]BBA conditioned state participation in the CHIP program on submission of a state child health plan meeting applicable requirements, subject to HHS approval.

some additional design decisions—for example, whether to implement CHIP by expanding their Medicaid programs, creating a stand-alone CHIP program, or both; eligibility; scope of benefits; and cost-sharing, among others.[13] Third, the two programs are funded differently. PCIP plans are funded through the $5 billion appropriation and premiums collected from enrollees, whereas states were required to fund a significant share of CHIP spending, adding weight to the effect of their timing and design choices. Further, for states that opted to let HHS administer the PCIP in their state, the use of a single national carrier may have provided efficiencies resulting in earlier implementation. CHIP, in contrast, was separately administered by each state.

Enrollment in Both Programs Was Slow to Start, but Increased during First Year

The initial enrollment levels for both PCIP and CHIP were significantly below CBO projections. During its first quarter, PCIP saw a modest enrollment of less than 3,000 individuals. Enrollment had increased to more than 11,000 by the second quarter and to more than 27,000 by the end of the first year.[14] CHIP, a much larger-scale program, ended its first quarter with more than 47,000 enrollees. Enrollment more than doubled by the second quarter and rose to more than 705,000 across 31 states by the end of the first year.[15] See table 1 for a quarterly breakdown of total enrollment and number of states with active programs and enclosure II for year-end enrollment by state.

[13]For more details on states' initial approach to CHIP implementation, see GAO, *Children's Health Insurance Program: State Implementation Approaches are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999). See also GAO, *Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization*, GAO-07-558T (Washington, D.C.: Mar. 1, 2007).

[14]PCIP enrollment as of August 31, 2011, the most recent data available at the time of this report, was 33,958.

[15]CHIP continued to grow steadily for more than a decade, eventually exceeding CBO's projection of about 2.3 million enrollees per year during its third year of operation. By the final quarter of fiscal year 2000, all 51 states had implemented CHIP with a total enrollment of nearly 2.7 million. By fiscal year 2010, CMS reported CHIP enrollment had reached nearly 7.7 million.

Table 1: First-year Quarterly Enrollment for PCIP & CHIP

	First quarter	Second quarter	Third quarter	Fourth quarter
PCIP				
Total enrollment[a]	2,777	11,377	18,351	27,416
Time period	July – Sept. 2010	Oct. – Dec. 2010	Jan. - March 2011	April - June 2011
Number of states[b]	46	51	51	51
CHIP				
Total enrollment[a]	47,082	106,617	408,160	705,004
Time period	Oct. – Dec. 1997	Jan. - March 1998	April - June 1998	July – Sept. 1998
Number of states[b]	8	12	18	31

Source: GAO analysis of data from CMS (PCIP data) and Mathematica Policy Research (CHIP data).

[a]Enrollment totals for PCIP represent the number of individuals enrolled in the final month of each quarter. Enrollment totals for CHIP represent the number of children ever enrolled in CHIP during the quarter, including those who may have disenrolled before the end of the quarter.

[b]Number of states represents those states that were actively accepting enrollment applications.

In comparing enrollment growth between the two programs, there are certain key differences to consider. To avoid covering applicants who had access to other sources of coverage, the PCIP statute required that eligible applicants be uninsured for at least 6 months—the most common factor explaining lower than expected enrollment cited by the state PCIP officials we interviewed for our prior PCIP report. Such uninsured periods prior to eligibility were less of an issue with CHIP. While CHIP was similarly intended for children without access to other sources of coverage, the statute did not prescribe any particular method to exclude them, and only some states did so during the first year of implementation by requiring applicants to go without insurance coverage for a specified period. Additionally, state PCIP officials told us they considered the cost of premiums—more than $400 per month on average for a 50-year-old person—to be a barrier to enrollment. In contrast, many states did not charge any CHIP premiums, and among those states that did, premiums were significantly lower compared to PCIP.

Enrollment data for the PCIP program do not reflect recent changes made by HHS to increase enrollment, including relaxing eligibility standards, lowering premiums, and increasing its outreach efforts.[16] Specifically, HHS decided to allow, beginning July 2011, a letter from a provider attesting to an individual's pre-existing condition as acceptable documentation for enrollment in the federal PCIP.[17] Also beginning in July, HHS reduced premiums in 18 federally run PCIP states, ranging from 2 percent in 1 state to 40 percent in 6 states. The department increased its outreach efforts in 2011 to include PCIP marketing at more than 100 events and conferences, made arrangements with major insurance carriers to include information about the PCIP program in denial letters, and established referral fees for agents and brokers who successfully enroll individuals in a PCIP plan.

[16]See "HHS to Reduce Premiums, Make it Easier for Americans with Pre-Existing Conditions to Get Health Insurance," HHS news release (May 31, 2011), accessed June 1, 2011, www.hhs.gov/news/press/2011pres/05/20110531b.html.

[17]HHS had previously only accepted a denial letter from an insurance carrier or an offer of insurance but with a rider excluding coverage for the pre-existing condition as evidence of an applicant's pre-existing condition.

States That Had Existing HRPs Implemented PCIPs Somewhat Faster than Those That Did Not, but Their Enrollment Was Lower

Among the 27 states that administered their own PCIP, enrollment generally began somewhat sooner in states that had an existing HRP. The difference in implementation time was small, however—an average of 5.5 months after enactment for states with an existing HRP compared to 6.1 months for those states without.[18] States with existing HRPs may have benefited from their familiarity with a similar risk pool program. The states we interviewed in preparing our prior report that had an existing HRP—Alaska, Connecticut, Illinois, and North Carolina—all cited examples of building upon those programs when implementing PCIP. For example, in Alaska, the same nonprofit organization that administers its HRP was also selected by the state to run its PCIP, making use of the same provider network, pharmacy benefits manager, and disease management organization. Connecticut chose the same third-party administrator to handle enrollment and premium collection that runs its existing HRP and its health insurance program for uninsured adults. Although Illinois runs its PCIP separately from its existing HRP, the state Department of Insurance entered into an interdepartmental agreement with the board that oversees its HRP to use some of its expertise in advising the PCIP. Further, North Carolina, which had launched its HRP only 16 months before HHS solicited states' interest in administering their own PCIP, similarly decided to run its own program, governed by the same board that oversees its HRP.

While states with existing HRPs generally implemented PCIP somewhat sooner, their enrollment tended to be lower than PCIP enrollment in states that did not have an existing HRP. As we reported in July 2011, compared to the size of the uninsured population in each state, PCIP enrollment among states with an existing HRP was about 3.7 individuals per 10,000 uninsured, compared to 5.5 among states without an HRP. As we noted then, the availability of state-supported health insurance programs, such as existing HRPs, may have resulted in lower than expected PCIP enrollment in some states. See enclosure III for states' status regarding an existing HRP and whether their PCIP was state or federally run.

Agency Comments

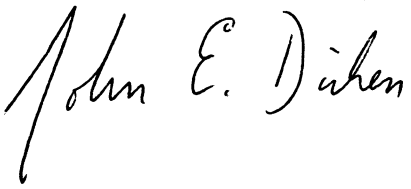
HHS provided written comments on a draft of this report (see enc. IV). In its comments, HHS reiterated the general purpose of the PCIP and CHIP programs. HHS also provided technical comments, which we incorporated as appropriate.

– – – – –

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of this report to the Secretary of HHS and interested congressional committees. The report will also be available at no charge on GAO's Web site at http://www.gao.gov.

[18]Of the 27 states that administered their own PCIPs, 20 had an existing HRP.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are Randy DiRosa, Assistant Director; George Bogart; Drew Long; and Perry Parsons.



John E. Dicken
Director, Health Care

Enclosures – 4

Enclosure I

Implementation Schedules for PCIP and CHIP

The following tables show for both the Pre-Existing Condition Insurance Plan (PCIP) program and the Children's Health Insurance Program (CHIP), the month each state's programs began enrolling individuals, the number of months after enactment of the law creating the program until enrollment began, and the cumulative number of states with active programs.

Table 2: PCIP Implementation

Month PCIP enrollment began	Months since enactment[a]	Number of active states	States
July 2010	4	2	New Hampshire, South Dakota
August 2010	5	32	Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oregon, South Carolina, Tennessee, Texas, Virginia, Wisconsin, Wyoming
September 2010	6	46	Alaska, Arkansas, Colorado, Connecticut, Illinois, Iowa, Maryland, Ohio, Oklahoma, Rhode Island, Utah, Vermont, Washington, West Virginia
October 2010	7	51	California, District of Columbia, Michigan, New York, Pennsylvania

Source: GAO analysis of data from CMS.

[a]Legislation requiring the establishment of the PCIP program was enacted in March 2010.

Table 3: CHIP Implementation

Month CHIP enrollment began	Months since enactment[a]	Number of active states	States
October 1997	2	7	Connecticut, Idaho, Indiana,[b] Massachusetts, Rhode Island, South Carolina,[b] Tennessee
December 1997	4	8	Oklahoma
January 1998	5	10	Illinois, Ohio
February 1998	6	12	Alabama, New Jersey
March 1998	7	13	California
April 1998	8	17	Colorado, Florida, Michigan, New York
May 1998	9	19	New Hampshire, Pennsylvania
July 1998	11	30	Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Nebraska, Oregon, South Dakota, Texas, West Virginia
August 1998	12	31	Utah
October 1998	14	39	Arkansas, District of Columbia, Minnesota,[c] Nevada, North Carolina, North Dakota, Vermont, Virginia
November 1998	15	42	Arizona, Georgia, Louisiana
January 1999	17	44	Kansas, Montana
February 1999	18	45	Delaware
March 1999	19	47	Alaska, New Mexico
April 1999	20	48	Wisconsin
December 1999	28	49	Wyoming
February 2000	30	50	Washington
July 2000	35	51	Hawaii

Source: GAO analysis of data from Mathematica Policy Research.

[a]Legislation establishing CHIP was enacted in August 1997.

[b]The source for states' CHIP implementation date (Mathematica) indicates a start date earlier than October 1997 for Indiana and South Carolina, but according to CMS officials this may have referred to the date those states began taking applications, as CHIP funding was not available to states until October 1997.

[c]The start date provided by Mathematica for Minnesota was September 30, 1998; however, enrollment was not reported until the following quarter.

Enclosure II

First-Year Enrollment in PCIP and CHIP, by State

State	PCIP enrollment	CHIP enrollment
Alabama	118	8,106
Alaska	38	-
Arizona	639	-
Arkansas	254	-
California	2,659	18,291
Colorado	807	10,377
Connecticut	57	5,952
Delaware	73	-
District of Columbia	30	-
Florida	1,201	51,664
Georgia	822	-
Hawaii	45	-
Idaho	79	4,339
Illinois	1,491	22,899
Indiana	273	20,551
Iowa	161	4,798
Kansas	216	-
Kentucky	140	5,779
Louisiana	166	-
Maine	18	3,204
Maryland	430	27,880
Massachusetts	1	17,448
Michigan	339	5,224
Minnesota	66	-
Mississippi	105	5,477
Missouri	433	10,809
Montana	236	-
Nebraska	79	2,115
Nevada	222	-
New Hampshire	183	71
New Jersey	670	16,614
New Mexico	498	-
New York	1,638	259,999
North Carolina	1,671	-
North Dakota	13	-
Ohio	1,398	40,804
Oklahoma	380	14,748
Oregon	919	6,488
Pennsylvania	3,617	57,481
Rhode Island	125	1,636

Enclosure II

State	PCIP enrollment	CHIP enrollment
South Carolina	504	40,768
South Dakota	105	1,047
Tennessee	419	12,445
Texas	2,020	25,176
Utah	395	2,653
Vermont	0	-
Virginia	424	-
Washington	446	-
West Virginia	30	161
Wisconsin	676	-
Wyoming	87	-
Total	**27,416**	**705,004**

Source: GAO analysis of data from CMS (PCIP data) and Mathematica Policy Research (CHIP data).

Note: Enrollment totals for PCIP represent the number of individuals enrolled in June 2011, the final month of the first year of program coverage. Enrollment totals for CHIP represent the number of children ever enrolled during the final quarter of fiscal year 1998 (July - September 1998), including those who disenrolled before the end of the quarter. A dash indicates that the program had not yet been implemented.

States' Status Regarding an Existing HRP and whether PCIP Was State- or Federally Run, 2010-2011

State	Did state have an existing HRP?	Was PCIP state or federally run?
Alabama	Yes	Federal
Alaska	Yes	State
Arizona	No	Federal
Arkansas	Yes	State
California	Yes	State
Colorado	Yes	State
Connecticut	Yes	State
Delaware	No	Federal
District of Columbia	No	Federal
Florida	Yes	Federal
Georgia	No	Federal
Hawaii	No	Federal
Idaho	Yes	Federal
Illinois	Yes	State
Indiana	Yes	Federal
Iowa	Yes	State
Kansas	Yes	State
Kentucky	Yes	Federal
Louisiana	Yes	Federal
Maine	No	State
Maryland	Yes	State
Massachusetts	No	Federal
Michigan	No	State
Minnesota	Yes	Federal
Mississippi	Yes	Federal
Missouri	Yes	State
Montana	Yes	State
Nebraska	Yes	Federal
Nevada	No	Federal
New Hampshire	Yes	State
New Jersey	No	State
New Mexico	Yes	State
New York	No	State
North Carolina	Yes	State
North Dakota	Yes	Federal
Ohio	No	State
Oklahoma	Yes	State

Enclosure III

State	Did state have an existing HRP?	Was PCIP state or federally run?
Oregon	Yes	State
Pennsylvania	No	State
Rhode Island	No	State
South Carolina	Yes	Federal
South Dakota	Yes	State
Tennessee	Yes	Federal
Texas	Yes	Federal
Utah	Yes	State
Vermont	No	Federal
Virginia	No	Federal
Washington	Yes	State
West Virginia	Yes	Federal
Wisconsin	Yes	State
Wyoming	Yes	Federal

Source: GAO.

Note: States' status regarding an existing HRP was the same at the end of our review (September 2011) as it was when the PCIP program began (July 2010).

Enclosure IV

Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

John Dicken, Director
Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

OCT 28 2011

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft correspondence entitled, "Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children's Health Insurance Program" (GAO-12-62R).

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

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRE-EXISTING CONDITION INSURANCE PLAN: COMPARISON OF IMPLEMENTATION AND EARLY ENROLLMENT WITH THE CHILDREN'S HEALTH INSURANCE PROGRAM" (GAO-12-62R)

The Department appreciates the opportunity to review and comment on this draft report.

The Pre-Existing Condition Insurance Plan (PCIP), created by the Affordable Care Act, helps uninsured people with a pre-existing condition get high quality care at market prices and serves as a bridge to 2014, when insurers will no longer be allowed to deny coverage to people because of any pre-existing condition. The Children's Health Insurance Program (CHIP), enacted in 1997, reduces the number of low-income uninsured children in families with incomes too high to qualify for Medicaid. Since children began receiving insurance through CHIP in 1997, the program has helped states expand health care coverage to millions of the nation's uninsured children. CHIP was reauthorized on February 4, 2009, when President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This report compares early program implementation and enrollment across PCIP and CHIP and illustrates how these two important programs have expanded access to health insurance to individuals with pre-existing conditions and to uninsured children.

(290971)

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548