

April 2013

PATIENT
PROTECTION AND
AFFORDABLE CARE
ACT

Enrollment and
Spending in the Early
Retiree Reinsurance
and Pre-existing
Condition Insurance
Plan Programs



G A O

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Why GAO Did This Study

In March 2010, the Patient Protection and Affordable Care Act (PPACA) appropriated \$5 billion each to establish and carry out two temporary programs—ERRP and PCIP. ERRP reimburses sponsors of employment-based health plans to help cover the cost of providing health benefits to early retirees—individuals age 55 and older not eligible for Medicare. The PCIP program is a high-risk pool that provides access to health insurance for individuals unable to acquire affordable coverage due to a preexisting condition. Both programs are operated by CCIO within CMS (an agency within the Department of Health and Human Services) and are intended to operate through 2013, after which PPACA will provide new insurance coverage options.

GAO was asked to provide updated information on ERRP and PCIP spending. This report describes the current status of ERRP and PCIP enrollment and spending as well as projected PCIP spending and how CCIO is ensuring that program funding is sufficient through 2013. GAO obtained the most recent data available on ERRP and PCIP enrollment and spending and on overpayments recovered from ERRP plan sponsors during the claims adjudication process. GAO also obtained other supporting documentation where available. GAO interviewed CMS officials about ERRP and PCIP enrollment and spending as well as their predictions of future PCIP spending and steps they are taking to ensure the sufficiency of PCIP funding.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Enrollment and Spending in the Early Retiree Reinsurance and Pre-existing Condition Insurance Plan Programs

What GAO Found

The Center for Consumer Information and Insurance Oversight (CCIO) discontinued enrollment in the Early Retiree Reinsurance Program (ERRP) in early 2011 and stopped most program reimbursements the following year to keep spending within the \$5 billion ERRP appropriation. Specifically, anticipating exhaustion of funds, CCIO stopped ERRP enrollment in May 2011. According to CCIO officials, CCIO suspended making reimbursements to plan sponsors in September 2012, as reimbursements had reached the \$4.7 billion cap established for paying claims under the original appropriation, and the remainder was reserved for administrative expenses. When the cap was reached, significant demand for the program remained with 5,699 ERRP reimbursement requests left outstanding that accounted for about \$2.5 billion in unpaid claims. CCIO officials told GAO that they planned to pay some of the outstanding reimbursement requests by redistributing any overpayments recovered from plan sponsors—when, for example a plan receives a rebate that lowers the total cost of a prior claim—as well as money recovered from program audits. As of January 2013, officials told GAO that CCIO had recovered a total of \$54 million and redistributed \$20.7 million of this amount.

Enrollment and spending for the Pre-existing Condition Insurance Plan (PCIP) program have grown substantially. Cumulative PCIP enrollment had reached 103,160 by the end of December 2012, more than doubling from a year earlier. By the end of January 2013, total PCIP spending reached about \$2.6 billion, representing over half of the \$5 billion PCIP appropriation compared to a year earlier when only about 16 percent of the total appropriation had been spent. PCIP spending has varied on a monthly basis, but overall, monthly spending also has increased over the life of the program. Most recently, monthly spending reached its highest point since the program's inception, increasing about 35 percent from December 2012 to January 2013.

According to CMS, PCIP spending is likely to approach the \$5 billion appropriation by the end of 2013, and CCIO is taking steps intended to ensure it does not exceed this amount. In June 2012, Office of the Actuary (OACT) within the Centers for Medicare & Medicaid Services (CMS) released a projection that the entire \$5 billion in PCIP funding would be used “through 2013.” Similarly, CCIO officials told GAO they anticipate total PCIP spending to closely approach \$5 billion, and that they are taking program management steps—many of which are not yet reflected in spending data—to ensure appropriated funding lasts through 2013. For example, in the second half of 2012, CCIO was able to obtain lower provider reimbursement rates for the PCIP program. Also, in January 2013, CCIO instituted benefit changes that shifted more costs onto PCIP enrollees, including by increasing enrollee coinsurance from 20 percent to 30 percent in many states. Due to growing concerns about the rate of PCIP spending, in February 2013, CCIO suspended PCIP enrollment to ensure the appropriated funding would be sufficient to cover claims for current enrollees through the end of the program. Officials told GAO that if spending trends begin to indicate that funding will not be used as quickly as they are projecting, they could reinstate PCIP enrollment to use remaining funds.

Contents

Letter		1
	Background	5
	CCIIO Discontinued ERRP Enrollment in Early 2011 and Stopped Most Reimbursements the Following Year to Keep Spending within the \$5 Billion Appropriation	9
	PCIP Enrollment and Spending Have Grown Substantially	10
	PCIP Spending Is Likely to Approach the \$5 Billion Appropriation in 2013, and CCIIO Is Taking Steps Intended to Ensure Spending Does Not Exceed This Amount	15
	Agency Comments	16
Appendix I	GAO Contact and Staff Acknowledgments	18
Related GAO Products		19
Figures		
	Figure 1: Cumulative Pre-existing Condition Insurance Plan (PCIP) Enrollment, July 2010 through December 2012	12
	Figure 2: Cumulative Pre-existing Condition Insurance Plan (PCIP) Spending, December 2010 to January 2013	13
	Figure 3: Monthly Pre-existing Condition Insurance Plan (PCIP) Spending, January 2011 to January 2013	14

Abbreviations

CCIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
ERRP	Early Retiree Reinsurance Program
GEHA	Government Employees Health Association, Inc.
HHS	Department of Health and Human Services
OACT	Office of the Actuary
PCIP	Pre-existing Condition Insurance Plan
PPACA	Patient Protection and Affordable Care Act

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GAO

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

April 30, 2013

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

Dear Senator Hatch:

In March 2010, the Patient Protection and Affordable Care Act (PPACA) appropriated \$5 billion each to establish and carry out two temporary programs, the Early Retiree Reinsurance Program (ERRP) and the Pre-existing Condition Insurance Plan (PCIP) program.¹ The programs are intended to provide access to health insurance coverage for early retirees—individuals age 55 and older who are not eligible for Medicare—and individuals with preexisting medical conditions, respectively.² Both populations historically have faced challenges obtaining health insurance in the individual market due, among other things, to being charged higher premiums than younger or healthier individuals on the basis of age or health status, or to being denied coverage altogether.³ In addition, while some early retirees may have access to health insurance through their employer, the number of large employers offering retiree coverage has

¹Pub. L. No. 111-148, §§ 1102(e) and 1101(g), 124 Stat. 143, 145 (2010). The funds are available without fiscal year limitation.

²Medicare is the federal health insurance program for persons aged 65 or over, individuals under the age of 65 with certain disabilities, and individuals with end-stage renal disease.

³Individuals without employment-based group coverage may buy coverage in the private individual market directly from insurers. In addition to early retirees, these include the self-employed; those whose employers do not offer health insurance coverage; individuals not in the labor force; and individuals who lose their jobs and are either ineligible for or have exhausted the right to continue their employer-based coverage for 18 months.

We previously reported that 19 percent of applicants in the individual market were denied enrollment and a quarter of insurers had denial rates of 40 percent or higher, using data collected by the Department of Health and Human Services (HHS) for the first quarter of 2010. See GAO, *Private Health Insurance: Data on Application and Coverage Denials*, [GAO-11-268](#) (Washington, D.C.: Mar. 16, 2011).

been declining.⁴ ERRP and the PCIP program are intended to operate through December 31, 2013, after which new coverage options will become available through PPACA's health insurance Exchanges.⁵

ERRP provides reimbursement to participating employment-based health plans that is intended to cover a portion of the cost of providing health benefits to early retirees in order to help employers continue to offer these benefits and provide financial relief to plan participants.⁶ Under the program, sponsors of health plans—which can include commercial organizations, government entities, nonprofit organizations, religious organizations, and unions—may use ERRP reimbursements to reduce their costs for providing health benefits, plan participants' health benefit costs, or any combination of these costs.⁷ The PCIP program is a high-risk pool that provides access to health insurance at standard market

⁴The number of large employers offering health insurance coverage to retirees was 66 percent in 1988, 34 percent in 2000, and 25 percent in 2012. See Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2012 Annual Survey* (Menlo Park, Calif. and Chicago, Ill.: September 2012). Large employers were defined as firms with 200 or more employees.

⁵Starting in 2014, PPACA establishes new options for individuals to obtain health insurance coverage through state-based health insurance marketplaces called "Exchanges." The law also will prohibit insurers in the individual market from denying coverage to individuals with preexisting conditions or charging them more in premiums, and limit how much insurers can vary what they charge for premiums based on age. See Pub. L. No. 111-148, Title I, Subtitles C and D, 124 Stat. 154 et seq., as amended by §§ 10103 and 10104, 124 Stat. 892, et seq.

⁶Under ERRP, health benefits provided to spouses, surviving spouses, and dependents of early retirees are also eligible for reimbursement, even if these individuals are under the age of 55 or are eligible for Medicare. Throughout this report, we use the term early retirees to refer to early retirees and their spouses, surviving spouses, and dependents. In addition to early retirees, eligible plans can also cover active employees and their spouses and dependents as well as retirees who are eligible for Medicare.

⁷Typically, employment-based health plans are not a discrete entity to which payments can be directly made. Therefore, in implementing the program, the Department of Health and Human Services (HHS) has interpreted this provision to require reimbursement to a sponsor, which it has defined to mean: a "plan sponsor" as defined in § 3(16)(B) of the Employee Retirement Income Security Act of 1974, except that in the case of a plan maintained jointly by one employer and an employee organization and for which the employer is the primary source of financing, the term means the employer. Early Retiree Reinsurance Program, 75 Fed. Reg. 24450, 24451, 24467 (May 5, 2010) (definition of "sponsor" codified at 45 C.F.R. § 149.2).

rates for individuals unable to acquire affordable coverage due to a preexisting condition.⁸

In order to carry out responsibilities under various provisions of PPACA, including ERRP and the PCIP program, the Department of Health and Human Services (HHS) created the Center for Consumer Information and Insurance Oversight (CCIIO) in April 2010.⁹ CCIIO began ERRP enrollment in June 2010 and PCIP enrollment shortly after in July 2010. We reported in September 2011 on various aspects of ERRP, including CCIIO's process for implementing the program, initial program expenditures and the types of plan sponsors enrolled, and how plan sponsors intended to use ERRP reimbursements.¹⁰ Also in 2011, we reported on various aspects of the PCIP program, including initial enrollment and spending trends, program features, and CCIIO's oversight.¹¹

Because ERRP and the PCIP program were each appropriated a fixed amount of money, questions have been raised about the rate of spending and how long the funding would last. For example, while enrollment in the PCIP program has been lower than initially projected, per member per

⁸The PCIP program was modeled after existing state-operated high-risk pools, which, as of February 2012, operated in 35 states and similarly provide access to coverage for individuals with preexisting conditions; however, the PCIP program differs from state-operated high-risk pools in certain ways. For example, while the PCIP program requires that individuals be without health insurance coverage for 6 months to be eligible, state-operated high-risk pools generally do not have such a requirement. Once enrolled, however, many state operated pools impose waiting periods of 6 to 12 months for coverage of the preexisting condition, while the PCIP program does not impose waiting periods.

PCIP premiums are set at 100 percent of the standard rate for a standard population in each state or market, and can vary on the basis of age by no more than a 4 to 1 ratio.

⁹CCIIO was initially known as the Office of Consumer Information and Insurance Oversight. Its name was changed to CCIIO in January 2011 when it was transferred to the Centers for Medicare & Medicaid Services (CMS) within HHS.

¹⁰See GAO, *Private Health Insurance: Implementation of the Early Retiree Reinsurance Program*, [GAO-11-875R](#) (Washington, D.C.: Sept. 30, 2011).

¹¹See 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) and *Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children's Health Insurance Program*, [GAO-12-62R](#) (Washington, D.C.: Nov. 10, 2011).

month claim costs have been higher than expected, leading some to question whether spending could exhaust its \$5 billion appropriation as enrollment continues to grow.¹² You asked us to provide updated information on spending for ERRP and the PCIP program. In this report, we describe

1. the current status of ERRP enrollment and spending,
2. the current status of PCIP enrollment and spending, and
3. projected PCIP spending and how CCIIO is ensuring that program funding is sufficient through 2013.

To describe the current status of ERRP enrollment and spending, we obtained cumulative enrollment and spending data from CCIIO through October 2012 or the most recent data available at the time of our analysis.¹³ We also obtained information as of January 2013 on funds recovered from ERRP plan sponsors from overpayments identified through the claims adjudication process. We interviewed CCIIO officials about ERRP enrollment and spending and obtained supporting documentation where available, such as answers to frequently asked questions on ERRP's website. We also interviewed knowledgeable agency officials about their efforts to ensure the quality of the enrollment and spending data and checked for anomalies. We determined these data were sufficiently reliable for our purposes.

To describe the current status of PCIP enrollment and spending, we obtained monthly enrollment data through December 2012 and spending data through January 2013 from CCIIO, the most recent data available at the time of our analysis. We interviewed CCIIO officials about PCIP enrollment and spending and obtained supporting documentation where available, such as PCIP policies and procedures. We also interviewed knowledgeable agency officials about their efforts to ensure the quality of

¹²For example, the Office of the Actuary within CMS initially projected that PCIP enrollment would be 375,000 by the end of 2010, but the actual number was 9,042. At the same time, in February 2012, CCIIO reported that, on average, the PCIP program experienced claims costs 2.5 times higher than anticipated. See CCIIO, *Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program* (Washington, D.C: Feb. 23, 2012).

¹³In addition, we accessed earlier information on ERRP enrollment and spending from our 2011 report on ERRP, [GAO-11-875R](#), and CCIIO's website.

the enrollment and spending data and checked for anomalies. We determined these data were sufficiently reliable for our purposes.

To describe projected PCIP spending and how CCIIO is ensuring that program funding is sufficient through 2013, we interviewed CCIIO officials about their estimates of future PCIP spending as well as steps they are taking to ensure program funding is sufficient through 2013. In addition, we discussed estimates of PCIP spending through 2013 with officials from the Office of the Actuary (OACT) within the Centers for Medicare & Medicaid Services (CMS). We obtained supporting documentation where possible, such as documents containing PCIP benefit changes.

We conducted this performance audit from December 2012 to March 2013 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.

Background

ERRP

In implementing ERRP, CCIIO is responsible for, among other things, determining which plan sponsors are eligible to participate in the program and providing reimbursements to the participating sponsors. Eligibility for participation is determined by a plan sponsor meeting a number of requirements, including being able to document claims, implement programs and procedures that have the potential to generate cost savings for plan participants with chronic and high-cost conditions, and having policies and procedures in place to detect and reduce fraud, waste, and abuse. When requesting reimbursement, sponsors must provide documentation of the cost of medical claims,¹⁴ which can include costs

¹⁴Health costs that are eligible for ERRP reimbursement under PPACA include those covered by medical, surgical, hospital, prescription drug, and other health benefits as determined by the Secretary of Health and Human Services. See Pub. L. No. 111-148, § 1102(a)(2)(A), 124 Stat. 143. In general, CCIIO applies the Medicare benefit standard to determine whether a given item or service is a health benefit and thus eligible for ERRP reimbursement.

paid by early retirees in the form of deductibles, copayments, or coinsurance. For eligible claims paid by a plan on behalf of each early retiree, CCIIO will reimburse 80 percent of the amount that exceeded \$15,000 (the cost threshold) but was not greater than \$90,000 (the cost limit) in a given year.¹⁵ ERRP reimbursement requests are paid in the order in which they are received, and CCIIO may stop taking ERRP applications or, if an application is approved, deny all or part of a reimbursement request, based on the availability of funding.¹⁶

Plan sponsors are not required to use ERRP reimbursements by the end of the plan year in which they are provided, but are expected to use reimbursements as soon as possible and no later than December 31, 2014.¹⁷ Under PPACA, plan sponsors can use the reimbursements to reduce their own premium contributions or other health benefit costs; reduce plan participants' premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs; or reduce any combination of these costs.¹⁸ However, sponsors are not permitted to use the funds received as general revenue, and thus must maintain the same level of contribution toward the plan as they did prior to applying to enroll in ERRP. CCIIO may conduct audits of plan sponsors to verify their compliance with this and other program requirements.

PCIP

To be eligible for PCIP, individuals must have a preexisting condition and have been without creditable coverage for at least 6 months prior to

¹⁵Pub. L. No. 111-148, § 1102(c), 124 Stat. 144. Eligible claims must be calculated excluding any negotiated price concessions. The \$15,000 cost threshold and \$90,000 cost limit are to be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers. For plan years that started on or after October 1, 2011, the annual cost threshold was adjusted to \$16,000 and the annual cost limit to \$93,000.

¹⁶75 Fed. Reg. 24450, 24466 (May 5, 2010) (codified at 45 C.F.R. § 149.45(a)).

¹⁷While ERRP is scheduled to operate through December 31, 2013, CCIIO will allow sponsors until December 31, 2014 to use their reimbursements.

¹⁸Although plan sponsors can only receive reimbursement for health benefit costs paid on behalf of early retirees, plan sponsors who use the reimbursements to reduce plan participants' costs must reduce costs for all participants, including retirees who are eligible for Medicare, active employees, and their spouses and dependents.

application.¹⁹ This requirement effectively prevents enrollment by those who were already insured, thus limiting the program to individuals who likely have been unable to access insurance because of their preexisting condition.²⁰ PCIP programs must not impose waiting periods for coverage based on the enrollee's preexisting condition, and plan benefits must cover at least 65 percent of the total cost of coverage until enrollees hit a statutory out-of-pocket spending limit, at which point PCIP covers 100 percent of the cost. PPACA requires that HHS develop procedures to transition PCIP enrollees from the program to the Exchanges when they begin in 2014 and that such procedures ensure these enrollees do not experience a lapse in coverage.²¹ At the same time, if HHS estimates that, for any fiscal year, PCIP funding will be insufficient to cover the payment of claims, PPACA authorizes it to make such adjustments as are necessary to eliminate this deficit and to stop PCIP enrollment.²²

To begin implementing the PCIP program, CCIIO determined a state-by-state allocation of the total \$5 billion PCIP appropriation. The initial allocations were based on a formula similar to that used for the Children's Health Insurance Program, using factors that reflected each state's population, number of uninsured individuals under age 65, and a geographic variation in the cost of care.²³ In addition, states were given the option to operate their own PCIP with federal funding, or to allow HHS

¹⁹Pub. L. No. 111-148, § 1101(d), 124 Stat.142. Creditable coverage is defined for this purpose as coverage for an individual under: a group health plan, health insurance, Medicare Part A or B, Medicaid, the military health care system, the Indian Health Service, a state health benefits high-risk pool, the Federal Employees Health Benefits Program, the Peace Corps health benefit plan, or a public health plan as defined in regulations. See Public Health Service Act, § 2701(c)(1).

²⁰To be eligible for PCIP, individuals must also be citizens, nationals, or lawfully present in the United States, as well as residents of the state in which they enroll in the PCIP program.

²¹Pub. L. No. 111-148 §1101(g)(3)(B), 124 Stat.143.

²²Pub. L. No. 111-148 §1101(g)(2),(4), 124 Stat.143.

²³The Children's Health Insurance Program is a joint state and federal program for uninsured children in families whose incomes are too high for Medicaid, but too low to afford private coverage.

Initial PCIP allocations ranged from \$8 million for North Dakota, Vermont, and Wyoming to \$761 million for California. CCIIO reserves the right to reallocate unused funds to states in future years from initial allocations and make adjustments as necessary to eliminate any potential deficit due to projected expenses exceeding a state's allocation.

to operate the PCIP in their state. Twenty-seven states elected to operate a PCIP for their residents, while 23 states and the District of Columbia opted to allow HHS to operate their PCIPs. For the 27 states that chose to operate their own PCIPs, HHS directly contracted with states or their designated nonprofit entities. The contracts established that HHS would reimburse states or their designated entities for claims and administrative costs incurred in excess of the premiums they collected. To implement the federally run PCIP for the 24 states that opted not to operate their own PCIP, HHS coordinated with other federal agencies and selected the Government Employees Health Association, Inc. (GEHA) to help operate the program. GEHA was awarded a cost-plus-award fee contract, which established that HHS would reimburse GEHA for claims and administrative costs in addition to granting fixed and performance-based award fees.²⁴ For both the federally and state-run PCIPs, HHS established a limit on administrative costs of no more than 10 percent of total spending over the lifetime of the program.

²⁴The fixed award fee was set at 5 percent of annual projected administrative costs. The incentive award fee was based on performance measures such as claims processing timeliness and accuracy, care management, and cost containment. See 48 C.F.R. § 16.405-2 (2010) (Federal Acquisition Regulation §16.405-2) (definition of cost-plus-award-fee contracts).

CCIIO Discontinued ERRP Enrollment in Early 2011 and Stopped Most Reimbursements the Following Year to Keep Spending within the \$5 Billion Appropriation

CCIIO stopped accepting applications for ERRP enrollment in May 2011, anticipating the \$5 billion appropriation would be exhausted. As we previously reported, at that time the total number of approved plan sponsors was more than 6,000—most of which enrolled within the first 6 months of the program—and CCIIO had already spent \$2.4 billion reimbursing plan sponsors for claims incurred.²⁵ Officials told us that in September 2012, CCIIO suspended making reimbursements to plan sponsors, with reimbursements having exceeded the \$4.7 billion cap established for paying claims under the original appropriation nearly a year earlier.²⁶ In anticipation of exceeding the cap, CCIIO had issued guidance on December 13, 2011, stating that it would not accept reimbursement requests for ERRP claims incurred after December 31, 2011.²⁷ However, the program continued to accept requests for claims incurred on or before this date and officials explained that a number of factors led to it taking until September 2012 for all \$4.7 billion to be spent, including that reimbursements must go through a clearance process to make sure funds are paid appropriately. When the \$4.7 billion was reached, significant demand for the program remained with 5,699 ERRP reimbursement requests left outstanding that accounted for about \$2.5 billion in unreimbursed claims.²⁸

²⁵ See [GAO-11-875R](#) for more information on initial ERRP enrollment and expenditures.

While more than 6,000 plan sponsors were approved for ERRP enrollment, by the end of October 2012, payments had been made to 2,858 unique plan sponsors, which officials said was in part because not all sponsors who were approved ended up submitting a reimbursement request.

²⁶ Officials told us that at the start of ERRP, CCIIO allocated \$4.7 billion to cover payments to plan sponsors for reimbursement requests and the remaining \$300 million to cover administrative expenses, such as staff salaries, overhead, and contracts for information technology and other support services. CCIIO officials told us that they expected \$300 million to be sufficient to cover administrative expenses through the end of the program, noting that such expenses would continue through fiscal year 2015. Through the end of fiscal year 2012, CCIIO had paid \$61.2 million for administrative expenses.

²⁷ See Early Retiree Reinsurance Program, Notice, 76 Fed. Reg. 77537 (Dec. 13, 2011).

²⁸ According to CCIIO officials, one reason for the large number of outstanding reimbursement requests was that as funding for ERRP ran low and CCIIO put out notice that it would no longer be accepting claims incurred after December 31, 2011, sponsors rushed to submit claims so that they could get paid. Officials also noted that some of the outstanding requests are corrections to previously submitted claims. By January 2013, 75 reimbursement requests had been made in addition to those outstanding when the \$4.7 billion cap was reached in September 2012, 12 of which were new and 63 of which revised previous claims.

CCIIO is recovering portions of the \$4.7 billion from plan sponsors that were overpaid and using those funds to pay outstanding reimbursement requests in the order in which they were received. Overpayments are identified through the claims adjudication process and can happen when, for example, a plan receives a rebate from a provider that lowers the total cost of a claim after the claim was initially submitted to ERRP. In addition, because early reimbursement requests were based on summary claims data, CCIIO required plan sponsors to submit a more detailed accounting of the actual costs of these requests by April 27, 2012.²⁹ Officials told us that if an overpayment was identified for a reimbursement request, or if sponsors failed to meet the April deadline, costs associated with that request were to be recovered by CCIIO. As of January 2013, CCIIO had identified \$60.2 million in overpayments and recovered \$54 million of this amount. CCIIO was pursuing collection of the remaining \$6.2 million and estimated that as much as an additional \$15 million in overpayments may be identified and collected in fiscal year 2013.

In addition to recovering overpayments, officials told us that any money recovered from program audits would also be used to pay outstanding reimbursement requests. CCIIO hired a contractor with a goal of conducting audits of 30 ERRP plan sponsors that officials said account for 30 percent of program reimbursements. As of January 2013, CCIIO had initiated 17 audits, but had not yet received any audit reports from the contractor. Consequently, officials told us that they were not yet able to estimate how much recovered ERRP funds would be identified through this process.

PCIP Enrollment and Spending Have Grown Substantially

PCIP enrollment has grown substantially. By the end of December 2012, cumulative enrollment had reached 103,160, up more than 50,000 from a year earlier when enrollment was 48,862. (See fig. 1.) Enrollment in state-run PCIPs represents a larger percentage of total enrollment compared to the federally run PCIP; however, the federally run PCIP has accounted for an increasing percentage of the total over time. When we last reported on

²⁹CCIIO officials said that in submitting reimbursement requests based on summary claims data, plan sponsors were required to aggregate eligible claims for early retirees and provide a Summary Cost Report that calculated the ERRP reimbursement amount. Subsequently, CCIIO required plan sponsors to also submit detailed data for each claim in these reimbursement requests in order to substantiate the reimbursement amount plan sponsors were paid.

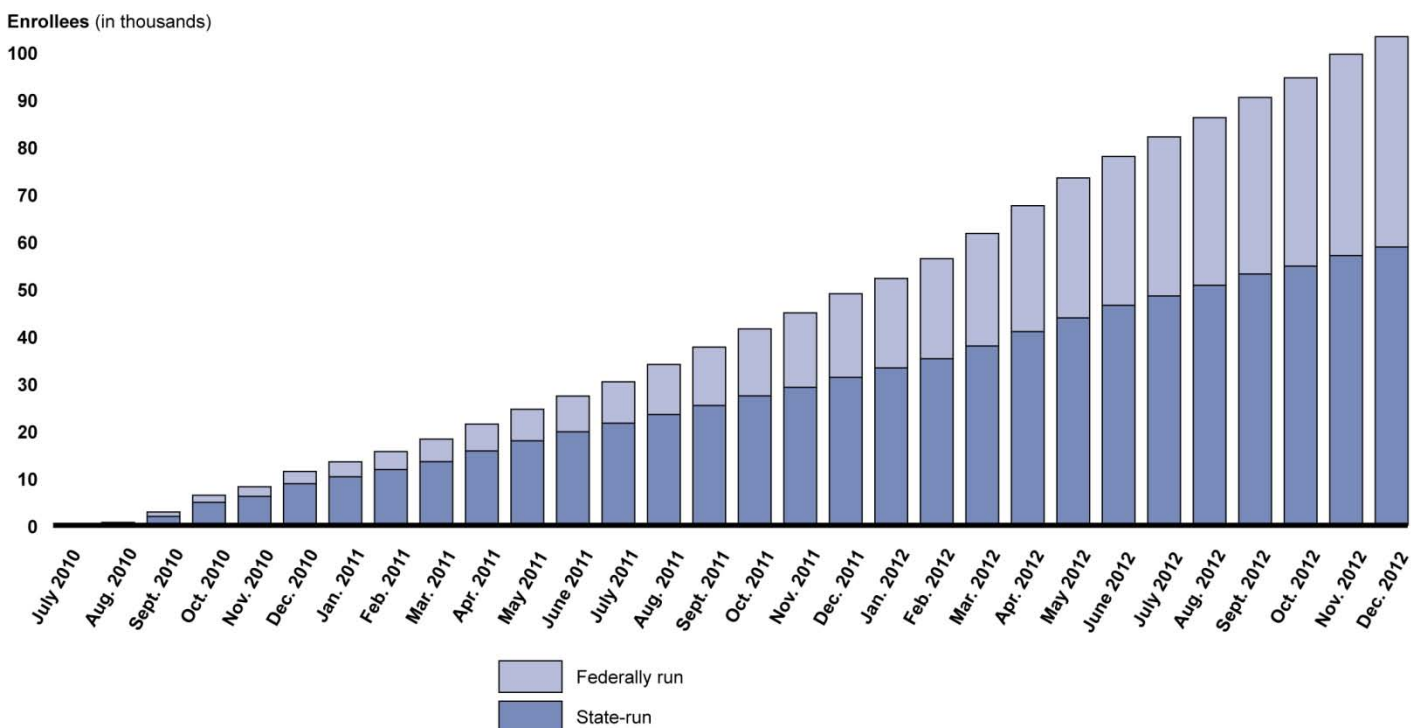
the PCIP program, as of April 2011, enrollment in the federally run PCIP represented about 26 percent of total enrollment; by the end of December 2012, it represented about 43 percent.³⁰ CCIIO officials told us that their decision to accept, starting in July 2011, a letter from a health care provider as proof of a preexisting condition in the federally run PCIP likely contributed to this shift—although CCIIO later reversed this decision in May 2012.³¹ Similar to prior months, PCIP enrollment continued to vary widely across states, ranging from 1 in Vermont to 15,101 in California.³²

³⁰For information on enrollment trends in our previous report see [GAO-11-662](#).

³¹CCIIO officials explained that they initially allowed such documentation in an effort to increase enrollment in the federally run PCIP, as it was significantly lagging behind state-run PCIPs, many of which allowed such documentation. However, enrollment grew so quickly in the federally run program that CCIIO decided to reverse its decision in an attempt to temper enrollment growth. According to CCIIO guidance, children under age 19 or residents of Massachusetts or Vermont were excluded from the reversal.

³²Because Vermont already implemented many of the broader market reforms that will take effect through PPACA in 2014, commercial plans in the state already offer guaranteed coverage to individuals with preexisting conditions at premiums comparable to PCIP.

Figure 1: Cumulative Pre-existing Condition Insurance Plan (PCIP) Enrollment, July 2010 through December 2012



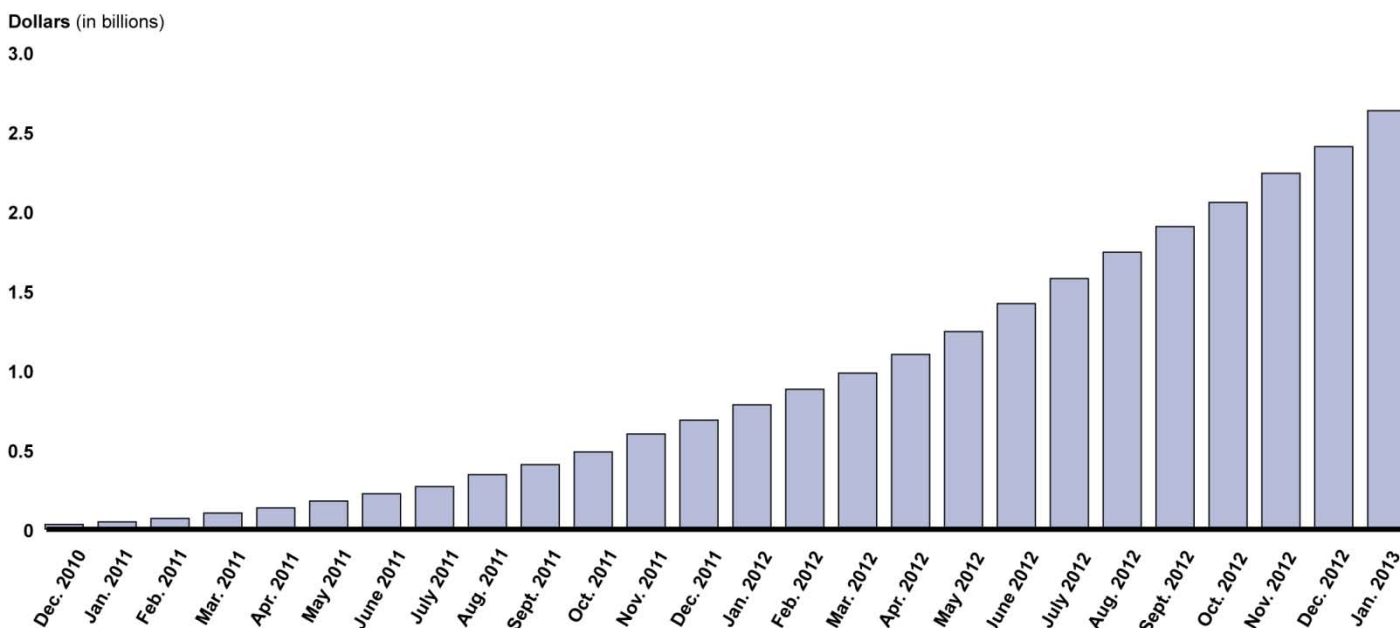
Source: GAO analysis of CCIO data.

By the end of January 2013, cumulative PCIP spending reached about \$2.6 billion, representing over half of the \$5 billion appropriated for the program.³³ This represents a substantial increase from a year earlier when about \$782 million had been spent, representing about 16 percent of the total appropriation. (See fig. 2.) Similar to the trend in enrollment, the federally run PCIP has accounted for an increasing percentage of total program spending. The percentage of PCIP spending used for

³³Spending data do not include administrative costs for HHS staff salaries and benefits, compliance and oversight, general information technology, and outreach; however, officials estimated that these costs were approximately \$12 million for fiscal years 2011 and 2012. Spending data are net of any premium revenue collected from enrollees.

administrative costs has declined over time and by the end of December 2012 it had fallen to about 7 percent.³⁴

Figure 2: Cumulative Pre-existing Condition Insurance Plan (PCIP) Spending, December 2010 to January 2013



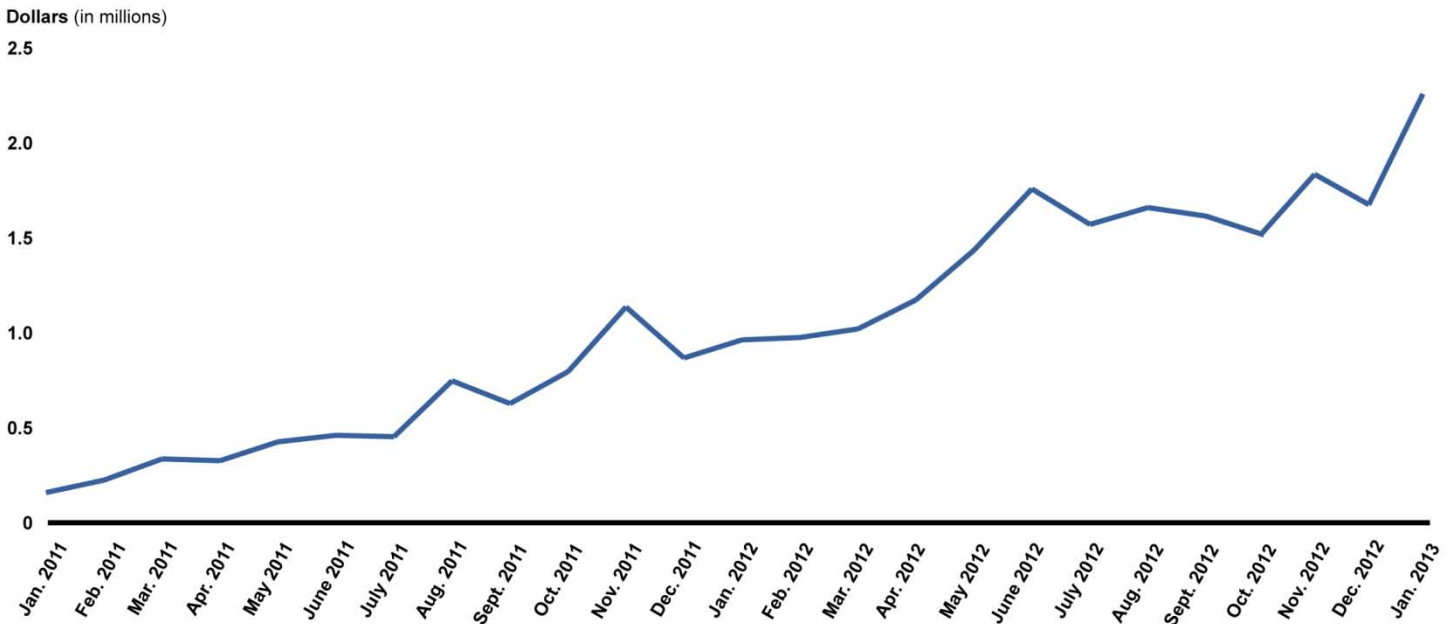
Source: GAO analysis of CCIIO data.

Notes: Data for monthly cumulative PCIP spending are not available prior to December 2010. Spending data do not include administrative costs for HHS staff salaries and benefits, compliance and oversight, general information technology, and outreach; however, officials estimated that these costs were approximately \$12 million for fiscal years 2011 and 2012. Spending data are net of any premium revenue collected from enrollees.

PCIP spending has varied on a monthly basis, but overall, monthly spending also has increased over the life of the program. Most recently, monthly spending reached its highest point since the program’s inception, increasing about 35 percent from the end of December 2012 to the end of January 2013. (See fig. 3.)

³⁴Data through December 2012 were the most recent available on PCIP administrative costs. At this time, the PCIP program had spent about \$177 million of the \$5 billion appropriation on administrative costs.

Figure 3: Monthly Pre-existing Condition Insurance Plan (PCIP) Spending, January 2011 to January 2013



Source: GAO analysis of CCIIO data.

Notes: Data for monthly PCIP spending are not available prior to January 2011.

Spending data do not include administrative costs for HHS staff salaries and benefits, compliance and oversight, general information technology, and outreach; however, officials estimated that these costs were approximately \$12 million for fiscal years 2011 and 2012. Spending data are net of any premium revenue collected from enrollees.

PCIP spending also varied across states, with some states spending more than they were originally allocated and some states spending less. For example, CCIIO officials said that as of January 2013, three states—New Hampshire, South Dakota, and Utah—have spent more money than they were originally allocated because of higher than expected enrollment or per member costs. Additionally, CCIIO has obligated to five states—Alaska, Colorado, Montana, Oregon, and New Mexico—more funding in 2012 than was in their original allocation, but these states have yet to spend the additional funds. Officials also said that other states have had lower than expected expenditures—for example, North Carolina was originally allocated \$145 million, but, through December 2012, had only spent about \$26 million due primarily to lower than expected enrollment. Thus, officials said that CCIIO reallocated money originally intended for these states to the states that were exceeding their expenditure projections.

PCIP Spending Is Likely to Approach the \$5 Billion Appropriation in 2013, and CCIIO Is Taking Steps Intended to Ensure Spending Does Not Exceed This Amount

According to CMS, PCIP spending is likely to approach the \$5 billion appropriation in 2013. In June 2012, CMS's OACT released a projection of PCIP spending, and reported the entire \$5 billion in funding would be used "through 2013." When asked for more specifics, OACT officials told us that this projection was not intended to produce a point-in-time estimate for when the program would run out of money, but rather represents their expectation that the entire \$5 billion appropriation would be needed to pay for care provided through 2013. Officials also said that their projection was informed by historical enrollment, cost, and utilization data, as well as discussions with CCIIO staff about program experience. Officials noted that the historical data they used were through February 2012—the most recent program data available at that time.

CCIIO officials similarly told us that they anticipate total PCIP spending will be close to \$5 billion, and that they are taking program management steps—many of which are not yet reflected in the spending data—intended to ensure that the appropriated funding lasts until the end of 2013. For example, on behalf of the federally run PCIP, GEHA contracted in August 2012 with United Healthcare to access lower provider reimbursement rates than those the federally run program had previously. While the extent of this rate reduction varies by state, officials said that there has been about a 20 percent reduction on average. To further reduce rates, GEHA also worked with United Healthcare to approach approximately the top 100 hospitals in terms of PCIP utilization to attempt to renegotiate federally run PCIP hospital facility fees to the same rate as Medicare. According to officials, about one quarter of the hospitals approached agreed to the renegotiation. Officials told us that some states have similarly approached hospitals to lower reimbursement rates, negotiated other discounts with providers, or implemented other cost control strategies, such as disease management programs.

More recently, CCIIO instituted benefit changes for the federally run PCIP that shifted more costs onto enrollees starting in January 2013. For example, it increased enrollees' out of pocket maximum for in-network services from \$4,000 to \$6,250 and for out-of-network services from \$7,000 to \$10,000.³⁵ It also increased enrollee coinsurance from 20 percent to 30 percent. As another step, CCIIO officials said that

³⁵In-network services are those offered through a provider that has contracted with the PCIP program for reimbursement at a negotiated rate, while out-of-network services are those offered through a provider that does not have such a contract.

whereas they had previously had annual contracts with states under the PCIP program, in 2013, they moved to quarterly contracts that will allow them to allocate funding based on each state's near-term expenditures and thus prevent over-obligation of funds. Finally, due to growing concerns about the rate of PCIP spending, in February 2013, CCIO suspended PCIP enrollment to ensure the appropriated funding would be sufficient to cover claims for current enrollees through the end of the program.³⁶ In addition, CCIO requested that state-run PCIPs institute the same benefit changes that were instituted in the federally run program in January 2013 by April 1, 2013, or the earliest possible date thereafter for all of their enrollees. Officials told us that if spending trends begin to indicate that funding will not be used as quickly as they are projecting, they could reinstate PCIP enrollment to use remaining funds.³⁷

Agency Comments

We provided a draft of this report to HHS for comment. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

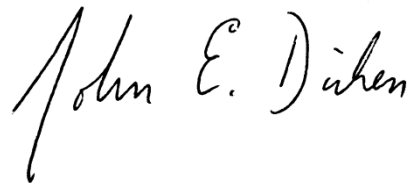
³⁶The enrollment suspension began on February 16, 2013, for the federally run PCIP and was required to begin on March 2, 2013, for state-run PCIPs; however, state-run PCIPs were allowed to discontinue enrollment prior to March 2, 2013, should they decide to do so.

The suspension will not apply to current enrollees who move to a different state and would like to reenroll in PCIP within 6 months.

³⁷According to CCIO officials, while they are not maintaining a wait list, they are keeping any applications they receive on file in the event that PCIP enrollment is reinstated.

If you or your staff 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 who made key contributions to this report are listed in appendix I.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large initial 'J' and a long, sweeping underline.

John E. Dicken
Director, Health Care

Appendix I: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Randy DiRosa, Assistant Director; George Bogart; Laura Brogan; Richard Krashevski; Yesook Merrill; Laurie Pachter; and Rachel Svoboda made key contributions to this report.

Related GAO Products

Pre-Existing Condition Insurance Plan: Comparison of Implementation and Early Enrollment with the Children's Health Insurance Program. [GAO-12-62R](#). Washington, D.C.: November 10, 2011.

Private Health Insurance: Implementation of the Early Retiree Reinsurance Program. [GAO-11-875R](#). Washington, D.C.: September 30, 2011.

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.

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