

June 2012

CHILDREN'S HEALTH INSURANCE

Opportunities Exist for Improved Access to Affordable Insurance

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Why GAO Did This Study

PPACA sought to increase access to affordable health insurance, and major provisions, such as a tax credit to offset the cost of private insurance premiums, will become effective in 2014. GAO estimated the extent to which (1) uninsured children would be eligible for Medicaid, CHIP, or the premium tax credit under PPACA, and (2) children would experience a change in eligibility among Medicaid, CHIP, and the premium tax credit under PPACA because of income changes. GAO also assessed CMS steps thus far to help states enroll children and related state challenges. GAO applied proposed and final 2014 PPACA eligibility rules to nationally representative 2009 data from the U.S. Census Bureau and interviewed officials from CMS and IRS, two federal agencies responsible for implementing relevant PPACA provisions, and six states that received federal funds for enrollment efforts.

What GAO Recommends

GAO recommends that in future rule making, the Secretary of the Treasury, in consultation with the Commissioner of Internal Revenue, consider the impact of the proposed standard for determining affordability of employer-sponsored insurance on eligible family members, and whether it would be consistent with PPACA to adopt an approach that would consider the cost of insuring eligible family members, or as necessary, seek clarification from Congress regarding its intent with respect to this standard. HHS and Treasury were given a draft of this report for review, but neither provided formal comments. Treasury provided technical comments, which GAO incorporated as appropriate.

View [GAO-12-648](#). For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

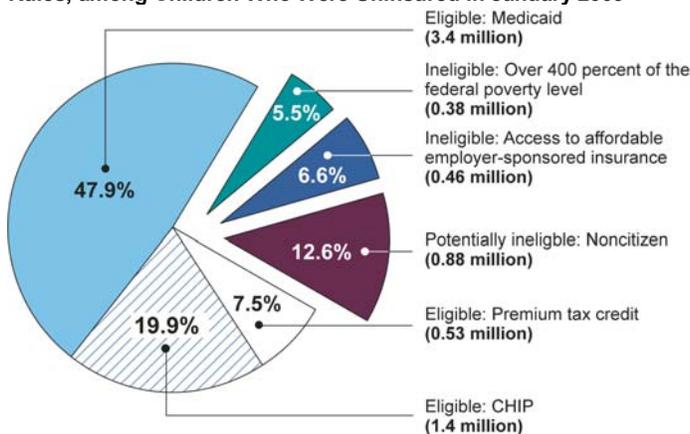
CHILDREN'S HEALTH INSURANCE

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What GAO Found

GAO estimates that under the 2010 Patient Protection and Affordable Care Act (PPACA), about three-quarters of approximately 7 million children who were uninsured in January 2009 would be eligible for Medicaid, the State Children's Health Insurance Program (CHIP), or the new premium tax credit. The remaining children had family incomes too high to be eligible, were noncitizens, or would be ineligible for the premium tax credit because they would be considered to have access to affordable employer-sponsored insurance per the Internal Revenue Service's (IRS) proposed affordability standard, in which IRS interpreted PPACA as defining affordability for an employee's eligible family members based on the cost of an employee-only plan. Some commenters raised concerns that IRS's interpretation was inconsistent with PPACA's goal of increasing access to affordable health insurance as it does not consider the higher cost of family insurance and could result in some children remaining uninsured. Under PPACA, CHIP is not funded beyond 2015, and states may opt to reduce CHIP eligibility or eliminate programs in fiscal year 2020. Without CHIP, more children could become uninsured. In May 2012, IRS finalized its rule but deferred finalizing the proposed affordability standard.

Estimated Eligibility for Medicaid, CHIP, and the Premium Tax Credit under 2014 PPACA Rules, among Children Who Were Uninsured in January 2009



Source: GAO analysis of 2009 Survey of Income and Program Participation (SIPP) data.

GAO estimates that about 14 percent of children in January 2009 who met 2014 PPACA eligibility criteria for these programs experienced a change in household income that would affect eligibility within 1 year. Changes in eligibility among children in states without policies allowing them to remain eligible for Medicaid and CHIP for a full year were estimated to be higher than in states with such policies. Frequent eligibility changes could deter enrollment if the process for changing enrollment is burdensome.

The Centers for Medicare & Medicaid Services (CMS) has provided states with financial incentives and technical guidance to improve enrollment and to implement PPACA provisions. States reported challenges to enrolling eligible children, including the need for guidance to implement certain provisions—which CMS indicated was forthcoming—and state budget constraints.

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Abbreviations

BHP	Basic Health Program
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
MAGI	modified adjusted gross income
PPACA	Patient Protection and Affordable Care Act
SIPP	Survey of Income and Program Participation
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families

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United States Government Accountability Office
Washington, DC 20548

June 22, 2012

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 State Senate

The Honorable John D. Rockefeller IV
Chairman
Committee on Commerce, Science, and Transportation
United States Senate

Approximately 7 million children in the United States had no health insurance for some or all of 2010, many of whom were in families with low incomes.¹ Medicaid and the State Children's Health Insurance Program (CHIP), federal-state programs that finance health care for certain low-income populations, play an important part in providing health insurance for low income children.² However, not all children who lack health insurance are eligible for these publicly financed programs. In addition, some uninsured children who are eligible for these programs do not enroll.

Recent federal legislation has aimed to maintain and increase Americans' access to affordable health insurance. The Patient Protection and

¹Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2010," *Current Population Reports*, P60-239 (Washington, D.C.: U.S. Government Printing Office, September 2011).

²In 2011, according to the Medicaid and CHIP Payment Access Commission's March 2012 report, nearly 44 million low-income children were enrolled in Medicaid or CHIP.

Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010,³ extended CHIP funding through 2015, prohibited states from lowering children’s existing Medicaid and CHIP eligibility through 2019,⁴ and included provisions that aim to expand adults’ and certain children’s eligibility for and enrollment in these programs.⁵ While the majority of uninsured individuals gaining eligibility for health insurance under PPACA are adults, who make up the majority of the uninsured population, children also gain new eligibility—particularly beginning in 2014, by which time major provisions of PPACA must be in place, including the following:

- American Health Benefit Exchanges (hereafter referred to as exchanges), which are marketplaces where eligible families and individuals can purchase private health insurance.
- A new refundable health insurance premium tax credit generally paid on an advance basis (hereafter referred to as the premium tax credit) to offset the cost of health insurance purchased through state exchanges by eligible low- to moderate-income families with incomes too high to qualify for Medicaid or CHIP.⁶

³Hereafter, “PPACA” will refer to PPACA as amended by the Health Care and Education Reconciliation Act of 2010. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), and Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

⁴For purposes of this report, we refer to Washington, D.C. as a state. PPACA specifically required states to maintain current Medicaid and CHIP eligibility levels, policies and procedures for children until fiscal year 2020. If CHIP funding is not available beyond fiscal year 2015, states will have to transition children enrolled in CHIP to other health insurance programs available at that time.

⁵The expansion of eligibility to adults is accompanied by an increase in the Federal Medical Assistance Percentage, the federal share of Medicaid expenditures, which is based on a statutory formula.

⁶Advance payments of the premium tax credit are made directly to the issuer of the qualified health plan in which a taxpayer enrolls. The amount of the advance payments is determined based on expected annual household income, and a taxpayer must reconcile the amount of the advance payments with the actual premium tax credit for the taxable year as computed on the taxpayer’s tax return. For purposes of this report, we refer to both advance payments of the premium tax credit and the actual premium tax credit amount as the premium tax credit.

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- Methods to determine eligibility and increase enrollment, which will generally be consistent across Medicaid, CHIP, and the new premium tax credit.

PPACA builds upon prior federal legislation, namely the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which established new Medicaid and CHIP enrollment policy options for states, and incentives, such as performance bonuses, for adopting them.⁷

States, the Department of Health and Human Services (HHS), and the Department of the Treasury all play a role in implementing this legislation.⁸ While states manage and run their individual Medicaid and CHIP programs, and may choose to run their own exchanges, HHS's Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury's Internal Revenue Service (IRS) are responsible for implementing PPACA's eligibility rules. For example, CMS is responsible for implementing changes to Medicaid eligibility under PPACA in addition to providing guidance, grant funding, and other assistance to the states; overseeing enrollment provisions of CHIPRA and PPACA; and providing performance bonuses to states that meet or exceed specified Medicaid enrollment goals. IRS is responsible for overseeing tax-related provisions of PPACA, including issuing regulations to implement certain eligibility rules for the premium tax credit. As states, CMS, and IRS work to implement the various PPACA provisions, questions remain regarding PPACA's anticipated effect on children's access to affordable health insurance. For example, uncertainty exists regarding whether some low-income children will remain ineligible for any of these types of assistance, whether changes in eligibility caused by shifting family circumstances or differences in eligibility between children and their parents could deter enrollment, and whether states will be able to fully implement key provisions of PPACA by 2014.

Because of your interest in ensuring that all children have access to affordable health insurance, you asked for information about children's access to health insurance under PPACA. This report examines the following questions:

⁷See Pub. L. No. 111-3, 123 Stat. 8 (Feb. 4, 2009).

⁸Other federal entities, such as the Department of Labor, also have roles in implementing certain provisions of PPACA.

-
1. To what extent would uninsured children be eligible for Medicaid, CHIP, or the premium tax credit under PPACA?
 2. To what extent would children experience a change in eligibility among Medicaid, CHIP, or the premium tax credit because of changes in household income during the course of a year, under PPACA?
 3. What steps has CMS taken thus far to help states enroll eligible children, and what challenges have states encountered?

To examine the extent to which uninsured children would be eligible for Medicaid, CHIP, or the premium tax credit under PPACA, we analyzed 2009 data from the Survey of Income and Program Participation (SIPP)—a nationally representative survey conducted by the U.S. Census Bureau. The SIPP follows households over a multiple-year period and collects relevant information for each individual on a monthly basis, such as type of health insurance (if any), amount and types of income, age, citizenship status, and state of residence. To determine the reliability of SIPP data, we reviewed related documentation and conducted electronic testing for missing data, outliers, and apparent errors, and determined that the SIPP data were sufficiently reliable for our purposes. For purposes of this analysis, we used final or proposed 2014 eligibility rules in place as of April 2012. To estimate the percentage of uninsured children that would be eligible for Medicaid, CHIP, or the premium tax credit, we applied final CMS and proposed IRS 2014 PPACA eligibility rules to SIPP data representing the United States population of noninstitutionalized children ages 0 through 18 in January 2009.⁹ Specifically, we calculated household income expressed as a percentage of the federal poverty level (FPL),¹⁰ based on IRS and CMS rules for counting household income and family size for Medicaid, CHIP, and the premium tax credit. We compared these calculations to federally specified FPL eligibility levels for the premium tax credit and Medicaid and to state-specific Medicaid and CHIP FPL eligibility levels, accounting for variation in eligibility levels for

⁹As discussed later in this report, IRS's proposed rule was finalized in May 2012, after we had completed our analysis; however, the eligibility standards we used were consistent with the final rule.

¹⁰We use FPL to refer to federal poverty guidelines issued by HHS each year in the *Federal Register*. These guidelines provide poverty income thresholds that vary by family size and for certain states and are updated using the consumer price index.

children of specific ages. We also considered other eligibility criteria, such as citizenship status, in our analyses. The estimates are based on 2009 data and do not project forward to 2014; rather, they illustrate what uninsured children's eligibility for health insurance assistance would be had 2014 PPACA eligibility rules as issued by CMS and IRS to date been in place in 2009. (See app. I for more information on our analysis of SIPP data and limitations of the analysis.) We also interviewed IRS officials and reviewed comments submitted by state agencies and certain other organizations in response to IRS's 2011 proposed rule implementing the premium tax credit.¹¹

To estimate how many changes in eligibility within 1 year would have occurred among children eligible for Medicaid, CHIP, or the premium tax credit because of changes in household income if the proposed IRS and final CMS 2014 PPACA eligibility rules had been in place in 2009, we also relied on the SIPP analysis. In developing our estimates, we considered whether states had policies—known as continuous eligibility—that allowed children to remain eligible for Medicaid and CHIP for a full year, regardless of changes in household income. We also analyzed the extent to which the frequency of eligibility changes differed among children living in states with such policies versus children in states without such policies.

To identify the steps that CMS has taken to help states enroll eligible children, and the challenges that states have encountered, we reviewed CMS data on grants and bonuses awarded to states, reviewed CMS guidance implementing relevant provisions of CHIPRA and PPACA, and interviewed CMS officials about plans for future guidance. To identify the challenges that states have encountered, we spoke to Medicaid, CHIP, and exchange officials from six states, which we selected from among those states that had received a CHIPRA performance bonus reflecting state progress in increasing enrollment of uninsured children in Medicaid, or a PPACA grant reflecting state progress in implementing an exchange.¹² We also reviewed all comments submitted by state agencies and national associations of state officials in response to CMS's 2011

¹¹Health Insurance Premium Tax Credit, 76 Fed. Reg. 50931 (Aug. 17, 2011).

¹²At the time we selected the 6 states, CHIPRA performance bonuses were awarded to 16 states, and PPACA exchange implementation grants were awarded to 17 states. The 6 states are California, Illinois, Indiana, Maryland, Oregon, and Washington.

proposed rules implementing PPACA eligibility and enrollment provisions.¹³

We conducted this performance audit from June 2011 through June 2012 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

The federal government has historically established minimum eligibility requirements for Medicaid and CHIP and provided states with considerable flexibility in expanding eligibility to individuals in households with higher incomes. PPACA made numerous changes to existing federal Medicaid and CHIP eligibility requirements and specified eligibility criteria for new types of assistance, such as the premium tax credit. PPACA also provided for a continued focus on certain CHIPRA initiatives; specified additional policies to facilitate eligible children's enrollment in Medicaid, CHIP, and the premium tax credit; and included provisions to facilitate children's access to private health insurance. Federal and state implementation of PPACA enrollment and eligibility provisions is under way.

Current Eligibility Requirements and Enrollment Policies for Medicaid and CHIP

Eligibility for Medicaid and CHIP is limited to U.S. citizens and certain legally residing immigrants and is generally based on household income in relation to the FPL. For Medicaid, the federal government requires that states cover children with household incomes at or below specific eligibility levels, which range from 100 through 133 percent of FPL depending on the age of the child. States have flexibility to increase eligibility levels beyond the federally required levels for children of specific ages. For example, several states have Medicaid eligibility levels of 185 percent of FPL for infants, and a more limited number of states also have eligibility levels higher than the federal requirement for children older than age 1. Because Medicaid eligibility levels vary by children's

¹³Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51148 (Aug. 17, 2011) and Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers 76 Fed. Reg. 51202 (Aug. 17, 2011).

age, some members of a given family may qualify for Medicaid, while others do not. With CHIP programs, states cover children whose household incomes are too high for Medicaid eligibility; most states' CHIP eligibility levels are between 200 and 300 percent of FPL.¹⁴ States use different methods for counting household income; for example, some states disregard portions of certain types of income, such as earned income, and states have varying standards regarding which household members to include when determining family size.

State enrollment policies, which encompass state efforts to identify, enroll, and retain eligible individuals in publicly financed health programs, are also important to children's access to Medicaid and CHIP. States have authority to coordinate Medicaid and CHIP enrollment with other human services programs; this coordination can occur through a variety of mechanisms. For example, some states have joint applications for Medicaid, CHIP, and other human service programs, such as the Supplemental Nutrition Assistance Program (SNAP),¹⁵ while other states have implemented "express lane" eligibility, a relatively new tool authorized by CHIPRA, whereby they use eligibility information such as household income data from a separate human service program, such as SNAP, or other public agency to determine eligibility for Medicaid or CHIP. In addition to coordination with other human service programs, states may adopt other optional policies to facilitate Medicaid and CHIP enrollment and retention, such as 12-month continuous eligibility policies for children, under which children who are determined to be eligible for Medicaid or CHIP generally remain eligible for 12 months, despite any fluctuations in household income within this time frame. CHIPRA authorized an incentive to encourage states to adopt such policies by providing performance bonuses beginning in fiscal year 2009 through 2013 to states that both employed at least five policies to facilitate enrollment and achieved specific goals with respect to the enrollment of eligible children in Medicaid. Beginning in fiscal year 2009, CHIPRA also provided outreach grants for efforts to identify and help enroll Medicaid- and CHIP-eligible children.

¹⁴States have the choice of three design approaches for their CHIP programs: (1) a CHIP-funded Medicaid expansion, (2) a separate CHIP program, or (3) a combination program, which has both a Medicaid expansion program and a separate CHIP program.

¹⁵SNAP was formerly known as the Food Stamp Program.

Eligibility Requirements for Medicaid, CHIP, and the Premium Tax Credit under PPACA

With regard to changes to children's eligibility for Medicaid and CHIP and eligibility specifications for the new premium tax credit, which are to be fully effective in 2014, PPACA included the following provisions.

- PPACA expanded Medicaid eligibility to children and adults under age 65 with household incomes at or below 133 percent of FPL.¹⁶ As a result, minimum eligibility levels for Medicaid will generally be the same for all family members.¹⁷ Some children with household incomes higher than 133 percent of FPL will continue to be eligible for Medicaid in states that have established higher eligibility levels for children. These states are not allowed to lower their Medicaid eligibility levels for children until fiscal year 2020.
- PPACA required a uniform method of counting household income, based on a household's modified adjusted gross income (MAGI) to determine eligibility for Medicaid, CHIP, and the premium tax credit. As a result, household income for Medicaid and CHIP, as well as for the premium tax credit, will be determined consistently in all states.¹⁸
- PPACA defined eligibility criteria for the new premium tax credit, which will apply in all states. Similar to Medicaid and CHIP, eligibility for the premium tax credit will be limited to U.S. citizens and legally residing immigrants. Eligibility will also be limited to individuals with household incomes between 100 and 400 percent of FPL. In addition, to be eligible for the premium tax credit, an individual cannot have access to public insurance such as Medicaid or CHIP or to affordable

¹⁶Medicaid eligibility will remain limited to U.S. citizens and certain legally residing immigrants. In addition, income equivalent to 5 percent of FPL will be disregarded when determining Medicaid eligibility. Therefore, the effective federally required income eligibility level will be 138 percent of FPL.

¹⁷We previously reported that children are more likely to be insured if their parents are insured. See GAO, *Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families*, [GAO-11-264](#) (Washington, D.C.: Feb. 4, 2011).

¹⁸Some Medicaid eligibility categories, such as the blind or disabled, will not be subject to the MAGI income counting method; eligibility for these populations will continue to be determined based on existing criteria.

employer-sponsored health insurance that provides a minimum value.^{19,20}

A child's eligibility for Medicaid, CHIP, and the premium tax credit can change over time under PPACA as his or her household income fluctuates. For example, a child who begins the year eligible for the premium tax credit may become eligible for Medicaid or CHIP if household income declines during the year. Conversely, depending on the state, a child who begins the year eligible for Medicaid or CHIP may lose eligibility for these programs if household income increases.

Enrollment Policies for Medicaid, CHIP, and the Premium Tax Credit under PPACA

PPACA also contained provisions to facilitate eligible children's enrollment in Medicaid, CHIP, and private health insurance subsidized by premium tax credits. For example, PPACA extended funding for CHIPRA outreach and enrollment grants through fiscal year 2015, prohibited states from requiring in-person interviews for enrollment beginning in 2014, provided for income to be verified through a federally managed hub of data electronically accessible to states, and specified a coordinated enrollment process, whereby with one federally defined uniform application, states will assess families for eligibility for Medicaid, CHIP, or the premium tax credit. PPACA also made funding available to states to plan and implement exchanges, which will provide eligible individuals and families—including those eligible for premium tax credits—the ability to compare, select, and enroll in participating private health insurance plans with standardized benefit and cost-sharing packages. Under PPACA, exchanges must be established in every state by January 1, 2014, either by the state itself or by the Secretary of HHS.

PPACA's Private Health Insurance Market Provisions

Although not the focus of this report, PPACA also contained provisions to facilitate children's access to private health insurance, apart from the provision of the premium tax credit. For example, as of September 2010, PPACA prohibited health plans and issuers from limiting or denying

¹⁹Effective January 1, 2014, PPACA also provides for cost-sharing subsidies for individuals and families with household incomes up through 250 percent of FPL to reduce out-of-pocket costs for deductibles, co-payments, and other costs.

²⁰PPACA also provides states with the option to create a new public health insurance program, called the Basic Health Program, for children and adults whose household incomes are low—less than or equal to 200 percent of FPL—but too high to qualify for Medicaid or CHIP.

coverage for children under age 19 because of preexisting health conditions. (See table 1.)

Table 1: Selected PPACA Provisions for Health Plans and Issuers in the Private Health Insurance Market

Provision	Description
Annual limit	Generally prohibits health plans and issuers from imposing annual limits on the dollar value of certain covered health benefits, effective January 2014; restricted annual limits on the value of those benefits are allowed until that time ^{a,b}
Appeals process	Requires an internal appeals process for determinations and claims, and an external review process that meets certain standards, effective September 2010 ^{a,c}
Dependent coverage	Requires health plans and issuers offering dependent coverage to continue to make such coverage available to unmarried children until they reach age 26, effective September 2010 ^{a,d}
Lifetime limit	Prohibits lifetime limits on dollar value of certain covered health benefits for any individual, effective September 2010 ^e
Patient protections	Establishes patient protections, such as coverage of emergency services without prior authorization, effective September 2010 ^{a,f}
Preexisting condition	Prohibits health plans and issuers from imposing any preexisting condition exclusions for children under age 19, effective September 2010; this prohibition will be extended to adults effective January 2014 ^{a,g}
Preventive services	Requires coverage of preventive health services, effective September 2010; for example, for children these services include behavioral assessments, obesity counseling, and immunizations ^{a,h}
Rescissions of coverage	Prohibits health plans and issuers from rescinding coverage, except in the case of fraud or intentional misrepresentation of material fact, effective September 2010 ⁱ

Source: PPACA and Health Care and Education Reconciliation Act.

^aNot applicable to certain health plans that were in effect as of March 23, 2010.

^bPPACA, § 10101(a), 124 Stat. at 883, adding § 2711(a)(2) of the Public Health Service Act.

^cPPACA, § 10101(g), 124 Stat. at 887, adding § 2719 of the Public Health Service Act.

^dPPACA, § 1001, 124 Stat. at 132, adding § 2714 of the Public Health Service Act.

^ePPACA, § 10101(a), 124 Stat. at 883, adding § 2711(a)(1) of the Public Health Service Act.

^fPPACA, § 10101(h), 124 Stat. at 888, adding § 2719A of the Public Health Service Act.

^gPPACA, §§ 1201, 10103(e)(2), 124 Stat. at 154, 895, adding § 2704 of the Public Health Service Act.

^hPPACA, § 1001, 124 Stat. at 131, adding § 2713 of the Public Health Service Act; Health Care and Education Reconciliation Act, § 2301(b), 124 Stat. at 1082, amending § 2713 of the Public Health Service Act.

ⁱPPACA, § 1001, 124 Stat. at 131, adding § 2712 of the Public Health Service Act.

Implementation of PPACA Eligibility and Enrollment Provisions

Implementing PPACA's changes to Medicaid and CHIP eligibility determination and enrollment policies and preparing for implementation of the premium tax credit and other provisions of PPACA will require significant state and federal efforts. In August 2011, CMS and IRS

separately issued three proposed rules to implement key PPACA provisions related to eligibility and enrollment for Medicaid, CHIP, and the premium tax credit; the CMS rules were finalized in March 2012.²¹ According to CMS, more detailed guidance, such as the specific information to be collected in the uniform application or the nature of the data available from the federal hub, will be distributed at a later date. The IRS proposed rule specified how to calculate household MAGI for determining premium tax credit eligibility, and the CMS rules adopted these methods for determining Medicaid and CHIP eligibility, with certain exceptions.²² IRS finalized its proposed rule in May 2012 with minimal change to these methods.²³ The IRS proposed rule also described the standard for determining whether an individual has access to affordable employer-sponsored insurance for purposes of determining eligibility for the premium tax credit. Under the proposed affordability standard, employer-sponsored insurance is considered affordable if the cost of a self-only plan—meaning a plan that only covers the employee—does not exceed 9.5 percent of household income. Under the proposed standard, if one family member has access to affordable self-only employer-sponsored insurance, all other family members who are eligible to enroll in the employee’s plan are also considered to have access to affordable insurance and are therefore ineligible for the premium tax credit. In this manner, the proposed rule applied the same standard to all family members eligible for the employee’s plan, even if the cost of enrolling the family as a whole exceeds the 9.5 percent threshold. In the preamble to its proposed rule, IRS stated that the PPACA statute specifies using the self-only insurance affordability standard for employees as well as for spouses and dependents of an employee, citing a report issued by the Joint Committee on Taxation that similarly interpreted the law. Some who commented on the proposed rule suggested that it would be more

²¹See Medicaid Program; Eligibility Changes Under the Affordable Care Act, 77 Fed. Reg. 17144 (Mar. 23, 2012) and Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 (Mar. 27, 2012).

²²For example, how certain types of income, such as lump sum payments and educational grants, are treated in calculating MAGI differ when determining Medicaid and CHIP eligibility versus eligibility for the premium tax credit.

²³The definition of MAGI was, however, revised to include Social Security benefits, as required by the Three Percent Withholding Repeal and Job Creation Act, Pub. L. No. 112-56, § 401, 125 Stat. 711, 734 (Nov. 21, 2011). See Health Insurance Premium Tax Credit, 77 Fed. Reg. 30377 (May 23, 2012).

consistent with congressional intent to interpret the statute to require the use of the cost to an employee of insuring all eligible family members in determining access to affordable employer-sponsored insurance.²⁴ In its final premium tax credit rule, IRS confirmed that the proposed self-only insurance affordability standard would apply to employees, but it deferred a decision on the affordability standard for other eligible family members, such as children, to future rule making. Therefore, because this report focuses on children, the relevant affordability standard remains a proposed standard, and is referred to as such for the remainder of the report.

An Estimated Three-Quarters of Uninsured Children Would Be Eligible for Medicaid, CHIP, or the Premium Tax Credit under PPACA, but the Proposed Affordability Standard May Result in Some Children Remaining Uninsured

Over three-quarters of uninsured children in January 2009 would be eligible for Medicaid, CHIP, or the premium tax credit under 2014 PPACA eligibility rules, according to our estimates.²⁵ Applying final CMS and proposed IRS rules for 2014 program eligibility to 2009 SIPP data, we estimate that on the basis of household income and other eligibility criteria, such as citizenship, nearly 68 percent of the approximately 7 million children who were uninsured in January 2009 would be eligible for Medicaid or CHIP—about 48 percent for Medicaid and about 20 percent for CHIP.²⁶ In addition, 7.5 percent of the uninsured children would be eligible for the premium tax credit. Nearly 13 percent of the uninsured children were noncitizens for whom we did not estimate eligibility because of limitations in the data.²⁷ We estimate that the final approximately 12 percent of uninsured children would be ineligible for

²⁴GAO did not conduct an independent analysis of the scope of IRS's authority with regard to this issue.

²⁵Researchers estimated that in 2008, 65 percent of uninsured children were eligible for Medicaid or CHIP but not enrolled. Genevieve M. Kenney, Victoria Lynch, Allison Cook, and Samantha Phong, "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs*, vol. 29, no. 10 (2010): 1920-1929.

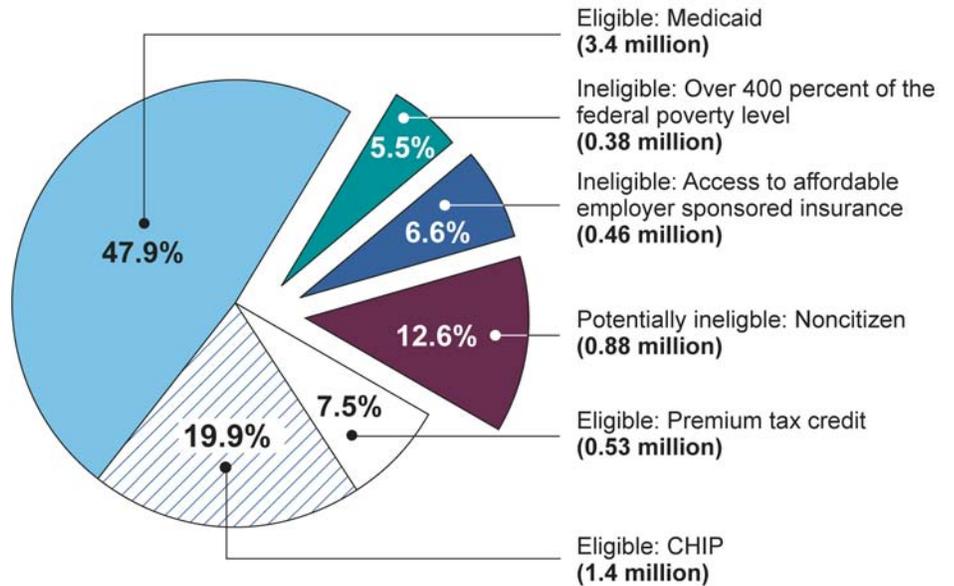
²⁶The 20 percent includes children who would be eligible for either a CHIP-funded Medicaid expansion or a separate CHIP program.

²⁷SIPP data generally do not provide information about the documentation status of children who are noncitizens. We treated noncitizen children as eligible legally residing immigrants if they or their parents participated in public assistance programs such as SNAP, which require documentation of legal residence, and treated other noncitizen children as potentially ineligible noncitizens. SIPP data do include information on whether certain noncitizens who were aged 15 and older were permanent U.S. residents; we did not incorporate this information into our analysis.

Medicaid, CHIP, or the premium tax credit. Specifically, 5.5 percent would be ineligible because they were in families with a household income that was too high—at greater than 400 percent of FPL. The remaining 6.6 percent would be ineligible because, though their families were considered low-income in that they met the household income requirements for the premium tax credit, they were considered to have access to affordable employer-sponsored insurance based on IRS's proposed affordability standard. In particular, these children had at least one parent with employer-sponsored insurance that had an estimated cost below 9.5 percent of household income for a self-only plan.²⁸ (See fig. 1.) These children would not be automatically eligible for the premium tax credit if the affordability standard were instead based on a family plan; their eligibility would depend on the cost of the family plan to which they had access. See appendix I for more information about our estimates.

²⁸Our analysis used 2011 data on costs of employer-sponsored insurance and did not estimate or otherwise consider how the affordability standard or other PPACA provisions could affect employers' contributions to employees' premiums in the future.

Figure 1: Estimated Eligibility for Medicaid, CHIP, and the Premium Tax Credit under 2014 PPACA Eligibility Rules among Children Who Were Uninsured in 2009



Source: GAO analysis of 2009 SIPP data.

Notes: Percentages and estimated numbers of children reflect proposed IRS and final CMS 2014 PPACA eligibility rules applied to uninsured children in January 2009. The CHIP category includes children eligible for CHIP-funded Medicaid expansion and separate CHIP programs.

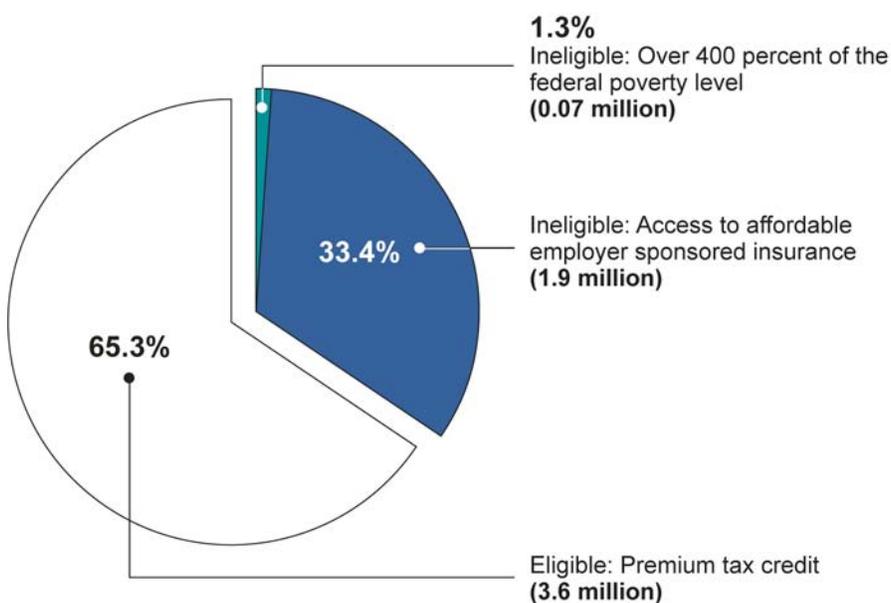
The proposed affordability standard could potentially affect significantly more children than the approximately 460,000 uninsured children we estimated above under certain scenarios. Many children eligible for CHIP have a parent with employer-sponsored insurance.²⁹ Under PPACA, CHIP is not funded beyond 2015, and, even if federal funding is extended, states may opt to reduce eligibility levels for CHIP or eliminate CHIP programs altogether beginning in fiscal year 2020.³⁰ Without CHIP-funded Medicaid expansion or separate CHIP programs, we estimate that

²⁹We limited our estimates of the effect of the affordability standard to uninsured and CHIP-eligible children and did not consider the effect of the standard on additional populations, such as children with private health insurance.

³⁰The CHIP maintenance of eligibility provision expires in fiscal year 2020, at which time states may opt to eliminate CHIP programs or limit CHIP eligibility. The Congressional Budget Office has projected that about half of states will eliminate CHIP programs at that time.

an additional 1.9 million children who would otherwise be eligible for CHIP would be considered to have access to affordable insurance under this proposed standard and would be ineligible for the premium tax credit.³¹ (See fig. 2.)

Figure 2: Estimated Eligibility for the Premium Tax Credit among Children Estimated to Be Eligible for CHIP under 2014 PPACA Eligibility Rules, Who Were Uninsured or Enrolled in Medicaid or CHIP in 2009



Source: GAO analysis of 2009 SIPP data.

Notes: Percentages and estimated numbers of children reflect proposed IRS and final CMS 2014 PPACA eligibility rules, applied to uninsured or publicly insured children in January 2009. The CHIP category includes children eligible for CHIP-funded Medicaid expansion and separate CHIP programs.

In commenting on IRS’s proposed rule on eligibility for the premium tax credit, some states and other organizations noted that IRS’s proposed interpretation of access to affordable employer-sponsored insurance—defining affordability on the basis of the cost of a self-only plan, and not on the cost of a family plan—could result in some children remaining uninsured. They explained that although a self-only plan for the employee

³¹This estimate included both children who were uninsured and children who were participating in CHIP or Medicaid in 2009.

may cost less than the 9.5 percent threshold, a family plan that would also insure the employee's eligible family members could exceed it. As a result, some employees would not be able to afford the higher premiums to insure their family members, who therefore could remain uninsured. We did not estimate the cost associated with defining the affordability standard based on the cost of a family plan. The cost of such a change would depend on multiple factors, many of which remain uncertain, such as the availability of CHIP funding beyond 2015, the extent to which eligible families avail themselves of the premium tax credit, employer decisions, and the extent to which additional enrollees could affect the aggregate cost of premiums. The Congressional Budget Office has commented on the high degree of uncertainty inherent in projecting the future actions of employees and employers under PPACA as well as other factors that may affect federal costs, such as the number of individuals and families who will have household income in specific eligibility ranges in future years.

We did not examine how many of the children estimated to be ineligible for the premium tax credit because of access to affordable employer-sponsored insurance would become eligible if the affordability standard were instead based on the cost of a family plan; the cost of family plans available to employees who chose not to purchase them was not available in the data we analyzed. However, separate data on the cost of family plans among employees who purchased a family plan suggest that some of these uninsured children, particularly those in families facing higher-than-average premium contributions, could become eligible for the premium tax credit if the affordability standard were based on the cost of a family plan. For example, in a 2011 survey, the Kaiser Family Foundation and Health Research & Education Trust found that on average, employees contributed \$4,129 annually for a family plan, or 28 percent of the total cost to the employer of an annual family premium, which averaged \$15,073.³² For a family of four with household income equivalent to 250 percent of the FPL, \$4,129 represents about 7 percent of household income. However, the percentage of the annual premium paid by employees ranged widely around this average, and 15 percent of employees with family plans paid more than 50 percent of the annual premium. For a family of four with household income equivalent to

³²Kaiser Family Foundation and Health Research & Education Trust, *Employer Health Benefits 2011 Annual Survey* (Menlo Park, Calif., and Chicago, Ill.: September 2011).

250 percent of the FPL, paying 51 percent of the average annual premium (or \$7,687) would represent just over 13 percent of household income, exceeding the 9.5 percent threshold. Whether families ultimately choose to purchase insurance for children will depend on many factors, including individual decisions regarding what they can afford for health insurance.

An Estimated 14 Percent of Children Eligible for Medicaid, CHIP, or the Premium Tax Credit under PPACA Would Experience a Change in Eligibility within 1 Year

Applying final CMS and proposed IRS 2014 PPACA eligibility rules to children in 2009, we estimate that nationally, 9 percent of children eligible for Medicaid, CHIP, or the premium tax credit experienced a change in household income within 6 months that would affect their eligibility for a specific form of assistance, and 14 percent of these children experienced at least one such change within 1 year.³³ (See table 2.) In addition, some children experienced multiple income changes within these time periods that would affect their eligibility for assistance more frequently. We estimate that, nationally, 2 percent of eligible children experienced changes in household income that would affect eligibility two or more times within 6 months, and 6 percent experienced two or more such changes within 1 year.

³³This analysis considered state-specific continuous eligibility policies in place as of March 2012. We did not count Medicaid- and CHIP- eligible children who lived in states with applicable continuous eligibility policies as experiencing changes in program eligibility, regardless of any change in household income. According to CMS data, as of March 2012 there were 23 states with continuous eligibility policies for Medicaid and CHIP. We estimate that 52 percent of eligible children in our analysis lived in these states. There were 18 states without continuous eligibility policies for Medicaid or CHIP; we estimate that 22 percent of eligible children in our analysis lived in these states. An additional 10 states have adopted continuous eligibility for CHIP but not Medicaid. Although children who become eligible for Medicaid or CHIP mid-year do not necessarily lose eligibility for the premium tax credit, we considered such children as having experienced a change in eligibility because they would gain eligibility for potentially lower-cost insurance through Medicaid or CHIP.

Table 2: Estimated Percentage of Eligible Children Who Would Experience a Change in Eligibility under PPACA Because of Household Income Fluctuations

Type of eligibility change	6 months	1 year
Between Medicaid and CHIP	2	4
Between Medicaid and the premium tax credit	3	4
Between CHIP and the premium tax credit	1	2
Between Medicaid or CHIP and ineligibility for any assistance	3	4
Total	9	14

Source: GAO analysis of 2009 SIPP data.

Notes: Percentages reflect estimated eligibility changes among children, had states' 2012 continuous eligibility policies and proposed IRS and final CMS 2014 PPACA eligibility rules been in place in 2009. We defined eligibility for the premium tax credit as lasting for 1 year; however, we considered children who were eligible for the premium tax credit at the beginning of the year, but who were in families that experienced a midyear decrease in income that would make them eligible for Medicaid or CHIP, as having experienced a change in eligibility because they would gain eligibility for potentially lower cost insurance. The CHIP category includes children eligible for CHIP-funded Medicaid expansion and for separate CHIP programs; however, we did not consider a change in eligibility between Medicaid and CHIP-funded Medicaid expansions to be a change in program eligibility. We did not count Medicaid- and CHIP-eligible children who lived in states with applicable continuous eligibility policies as experiencing changes in program eligibility, regardless of any change in household income.

The effect of continuous eligibility policies for Medicaid and CHIP on the frequency of eligibility changes becomes apparent when we consider children in states with versus states without such policies separately. Eligibility changes are higher than the national average in states without continuous eligibility policies in either their Medicaid or CHIP programs, and lower than the national average in states with them. In states with continuous eligibility policies for Medicaid and CHIP, eligibility changes under PPACA would be limited to children who begin the year eligible for the premium tax credit but experience a decrease in household income that would result in eligibility for Medicaid or CHIP instead. Therefore, the percentage of children experiencing changes in eligibility, and at risk of experiencing disruptions in coverage, is lower than the national average among children in the 23 states that have adopted continuous eligibility in both their Medicaid and CHIP programs and greater than the national average among children in the 18 states that do not have continuous eligibility in either program. Specifically, we estimate that about 3 percent of eligible children in states with continuous eligibility for Medicaid and CHIP experienced a change in household income that would affect eligibility under PPACA within 1 year. In contrast, we estimate that about 19 percent of eligible children in states without continuous eligibility experienced a change in household income that would affect program

eligibility under PPACA at least once within 6 months, and about 30 percent experienced such a change within 1 year. (See table 3.)

Table 3: Estimated Percentage of Eligible Children Who Would Experience a Change in Eligibility under PPACA Because of Household Income Fluctuations in States without Continuous Eligibility for Either Medicaid or CHIP

Type of eligibility change	6 months	1 year
Between Medicaid and CHIP	5	9
Between Medicaid and the premium tax credit	3	5
Between CHIP and the premium tax credit	3	4
From Medicaid or CHIP to ineligible for any assistance	8	12
Total	19	30

Source: GAO analysis of 2009 SIPP data.

Notes: Percentages reflect estimated eligibility changes among children living in states without continuous eligibility for either Medicaid or CHIP, had states' 2012 continuous eligibility policies and proposed IRS and final CMS 2014 PPACA eligibility rules been in place in 2009. We defined eligibility for the premium tax credit as lasting for 1 year; however, we considered children who were eligible for the premium tax credit at the beginning of the year, but who were in families that experienced a midyear decrease in income that would make them eligible for Medicaid or CHIP, as having experienced a change in eligibility because they would gain eligibility for potentially lower-cost insurance. The CHIP category includes children eligible for CHIP-funded Medicaid expansion and separate CHIP programs; however, we did not consider a change in eligibility between Medicaid and CHIP-funded Medicaid expansions to be a change in program eligibility. According to CMS data, as of March 2012 there were 18 states without continuous eligibility policies for either Medicaid or CHIP.

Changes in eligibility caused by income fluctuations could deter children's enrollment in relevant programs if the process for changing enrollment is burdensome for the families and could further complicate other eligibility complexities, such as variation in eligibility within households. Eligibility for specific types of assistance can vary within households because low- to moderate-income adults with household incomes greater than 133 percent of FPL will typically be ineligible for any assistance or will be eligible for the premium tax credit rather than Medicaid or CHIP, while children in some of these households—particularly in states with higher income eligibility levels for Medicaid and CHIP—will be eligible instead for Medicaid or CHIP. We estimate that based on 2009 data, 21 percent of children eligible for Medicaid, CHIP, or the premium tax credit under PPACA would have different eligibility from their parents as of the beginning of the year. However, because of income fluctuations that occurred over the course of the year, we estimate that an additional 9 percent of eligible children would encounter this situation.

CMS Has Provided States with Tools to Increase Enrollment, and States Express a Need for Further Guidance and Note Budget Constraints

CMS has provided states with incentives and guidance to implement current initiatives to improve enrollment policies and has made progress assisting states in implementing PPACA requirements aimed at further simplifying Medicaid and CHIP enrollment. State officials reported ongoing challenges with regard to enrolling eligible children, including the need for timely guidance to implement PPACA provisions, concerns about enrolling family members who are not eligible for the same program, and state budget constraints.

CMS Has Provided States with Financial and Technical Assistance to Facilitate the Enrollment and Retention of Eligible Children in Medicaid and CHIP

Through an array of financial incentives and technical assistance, CMS has worked with states to enroll and retain eligible children in Medicaid and CHIP and to set up state exchanges under PPACA. Many of these efforts were initiated with funds appropriated under CHIPRA and continue under PPACA. For example, CHIPRA appropriated \$100 million for fiscal years 2009 through 2013 in outreach grants and related efforts to improve the enrollment and retention of underserved populations in Medicaid and CHIP, and by the end of fiscal year 2011, CMS had awarded \$80 million in such grants.³⁴ CMS awarded the first round of outreach grants in fiscal year 2009 to 69 applicants in 43 states, which included state agencies and community-based and other nonprofit groups, and the second round in fiscal year 2011 to 39 applicants in 23 states.³⁵ In our interviews with officials from selected states, officials noted that the outreach grants had helped the agencies reach eligible children. For example, Oregon Medicaid officials said that the CHIPRA outreach grant their agency received was crucial to reaching the state's Hispanic population. The grant sought to support outreach by safety net providers, public health departments, and school-based health centers.

Since fiscal year 2009, CMS has also awarded performance bonuses annually to states that implemented at least five of the eight enrollment initiatives outlined in CHIPRA and met specific enrollment goals, which

³⁴PPACA amended the CHIPRA provision, appropriating an additional \$40 million in grant funding and extending the availability of funding through fiscal year 2015.

³⁵Individual grants in the first round ranged from approximately \$70,000 to nearly \$1 million, and grants in the second round ranged from \$200,000 to \$2.5 million. Individual grantees were eligible to apply for grants in both rounds of funding.

are based on the state's current Medicaid enrollment and population growth.³⁶ (See table 4.) The number of states receiving these bonuses has more than doubled over the 3 years that bonuses have been awarded, increasing from 10 states in fiscal year 2009 to over 23 states in fiscal year 2011.³⁷ In 2011, the amount of the performance bonuses ranged from approximately \$1.3 million for Idaho to over \$28 million for Maryland. (See app. II for a summary of the states that received these performance bonuses and the amounts of the awards.) In addition, among the 23 states that received a performance bonus in 2011, 16 received an enhanced bonus for exceeding their enrollment target by more than 10 percent.³⁸ CMS plans to provide these performance bonuses annually through fiscal year 2013.

Table 4: CHIPRA Initiatives to Improve Children's Enrollment in Medicaid and CHIP

CHIPRA enrollment initiative	Description of initiative
Elimination of in-person interview	No longer require an in-person interview to enroll in Medicaid or CHIP
Liberalization of asset requirements	Do not impose an asset test, or allow administrative verification of assets
Same application and renewal forms	Use same or interchangeable application and renewal forms for Medicaid and CHIP
12-month continuous eligibility	Assure coverage of a child for 12 months, regardless of changes in circumstances, with some exceptions
Automatic/administrative renewal	Make renewal determinations automatically, based on information the state has available, provide a prepopulated renewal form to families, or both
Presumptive eligibility	Enroll children who appear to be eligible for Medicaid and CHIP pending a full determination of eligibility
Express lane eligibility	Enroll children in Medicaid or CHIP based on information available through other public programs
Premium assistance	Provide premium assistance for private coverage through a state's Medicaid or CHIP program

Source: CMS.

³⁶CHIPRA authorizes performance bonuses to be awarded annually, from 2009 through 2013.

³⁷CMS awarded over \$37 million in performance bonuses to 10 states in fiscal year 2009, over \$167 million to 16 states in fiscal year 2010, and nearly \$300 million to 23 states in fiscal year 2011.

³⁸The performance bonus a state received was based on a formula that considers the percentage that enrollment increased and the current per capita cost of covering each child in the state. The enhanced bonus is based on a similar formula for rewarding increased enrollment but does so at a higher level per percentage point increase in children's enrollment.

CMS has also provided states with financial assistance to facilitate their implementation of PPACA provisions aimed at simplifying enrollment. For example, recognizing that states will need to upgrade their information technology systems to comply with PPACA, CMS has provided states with the opportunity to claim an enhanced Federal Medical Assistance Percentage (FMAP) through fiscal year 2015 for the costs associated with certain Medicaid systems improvements, such as updates to their claims processing and enrollment systems, and beyond 2015, for costs associated with administering new systems. Specifically, instead of the 50 percent FMAP historically available for most Medicaid administrative expenses, qualified states can obtain a 90 percent FMAP for the costs of implementing new information systems and a 75 percent FMAP for the costs of administering these new systems.³⁹ California officials said they plan to use the enhanced FMAP to better integrate their Medicaid eligibility systems with their SNAP and Temporary Assistance for Needy Families (TANF) eligibility systems and are interested in eventually using their Medicaid system to determine the eligibility of enrollees for other state programs.⁴⁰ In addition to the enhanced FMAP for information systems improvements, CMS has awarded exchange planning grants and exchange establishment grants under PPACA to assist states in planning and developing exchanges. In September 2010, CMS awarded exchange planning grants totaling nearly \$50 million to 50 states,⁴¹ and from May 2011 through February 2012, CMS awarded exchange establishment

³⁹To be eligible for the enhanced FMAP, states must submit explicit plans for upgrading their information systems to CMS for approval. Medicaid Program; Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, 75 Fed. Reg. 21950 (Apr. 19, 2011). As of April 27, 2012, CMS had approved plans from 36 states, and an additional 8 states had submitted plans for approval.

⁴⁰TANF is a government program that provides cash assistance and other services to eligible low-income families.

⁴¹Exchange planning grants were designed to provide resources for states to conduct research and planning and determine how exchanges will be operated and governed. States were able to apply for an exchange planning grant of up to \$1 million, and most states were awarded the full amount. Louisiana returned the exchange planning grant money that it had received. If states choose not to set up their own exchanges, the federal government is required to do so.

grants totaling over \$600 million to 34 states.⁴² (See app. II for more information on the initiatives and funding available to states to facilitate enrollment and implementation of PPACA.) CMS plans to award exchange establishment grants on a quarterly basis through 2014.

In addition to financial assistance, CMS has provided states with technical assistance to facilitate their efforts to enroll and retain eligible children. For example, CMS has hosted conference calls and meetings to provide support to outreach grantees. CMS officials told us that a conference of outreach grantees served as a venue for identifying best practices and getting state input on additional ways that CMS can assist states with enrollment. CMS has also helped states implement the enrollment initiatives outlined in CHIPRA. For example, Oregon officials worked directly with CMS when developing a renewal form for Medicaid and CHIP to make sure their approach met the administrative renewal requirements for the CHIPRA performance bonus. CMS has also provided technical assistance to states on a number of PPACA provisions. For example, CMS has issued letters to state Medicaid directors, including one on the new eligibility groups for Medicaid (e.g., covering children up through 133 percent of FPL) and published frequently asked questions related to essential health benefits and maintenance of effort requirements. CMS officials also told us that the agency has contracted with groups of states to develop guidance on key issues, such as eligibility, enrollment, and information technology, that will be disseminated to all states. CMS officials said that the agency has offered states additional opportunities for technical assistance through calls, webinars, user groups, working group meetings, larger conference meetings, and establishment reviews, a process under which CMS directly assists and monitors a state's effort to meet the requirements to build an exchange. Most recently, CMS's final exchange rule, which allows states to hire private entities to help enroll eligible individuals into qualified health plans participating in their exchanges, could further facilitate state enrollment efforts.

⁴²There are two levels of exchange establishment grants. Level one grants are awarded to states in the earlier stages of exchange development, and award amounts have ranged from about \$1.6 million to nearly \$58 million. States receiving a level one grant can apply for a second year of funding, if necessary. To be eligible for a level two grant, states must meet a series of specific criteria, including legal authority to establish and operate an exchange, a budget and plan for financial stability by 2015, and a plan to prevent fraud, waste, and abuse. As of March 2012, Rhode Island was the only state that had received a level two grant.

Challenges Reported by States Include Ongoing Need for Guidance and Budget Constraints

States identified incomplete federal guidance as a challenge to their efforts to prepare to enroll eligible children under PPACA in our interviews and in comments on CMS's proposed eligibility rules. During the course of our review, in March 2012, CMS finalized its Medicaid and exchange eligibility rules, which responded to some areas of state concern. For example, in comments on the proposed Medicaid eligibility rule, several states requested that CMS's final rule allow them to continue to use joint applications for Medicaid and other human services programs, such as SNAP and TANF, a coordinated enrollment approach that 39 states currently use.⁴³ The final Medicaid eligibility rule clarified that states may continue to use such joint applications as long as a simplified application specifically for health programs is also in place. However, states' need for ongoing guidance remains. For example, in addition to the need for finalized rules, states frequently noted, during our interviews and in written comments on the proposed rules, that supplementary guidance in key areas such as the federal data hub, the conversion to MAGI for eligibility determinations, and the elements of the uniform application was needed in order for them to make the necessary changes to their business processes and information systems. For example, several states commented that they need additional guidance on what will be available in the federal data hub and how to coordinate data from the federal data hub with their current systems. States also expressed the need for additional guidance on other aspects of PPACA, such as the Basic Health Program (BHP). CMS officials told us that the agency is in the process of developing additional guidance and that the agency's highest priority is to provide states with guidance related to their eligibility and enrollment systems. For example, officials cited guidance on the federal data hub as a high priority.

States are also seeking additional guidance from CMS on how to minimize the potential for negative consequences when family members are eligible for different types of assistance. For example, in their

⁴³We have previously reported that differences in eligibility determination requirements among human services programs led to duplication of efforts, and we have an outstanding recommendation that HHS and the Food and Nutrition Service work together to (1) encourage state officials to explore better aligning participant reporting requirements, particularly for TANF and Medicaid, and (2) disseminate information and guidance to states on the opportunities available for better aligning requirements among Medicaid, SNAP, and TANF. See GAO, *Food Stamp Program: Farm Bill Options Ease Administrative Burden, but Opportunities Exist to Streamline Participant Reporting Rules among Programs*, [GAO-04-916](#) (Washington, D.C.: Sept 16, 2004).

comments on the proposed Medicaid eligibility rule, California officials requested guidance on how to handle complex situations in which family members are eligible for different types of assistance, including options for reducing the confusion and burden such families may face when enrolling in multiple plans. Further, Illinois officials requested permission to enroll children and their parents in the same type of insurance, whether Medicaid, a BHP, or a plan through the exchange. They suggested that greater harm could result from differences in insurance within families than any higher costs or reduced benefits that may result from enrolling families in the same plan. CMS officials said they would clarify policy options available to states to allow certain families to have the same type of insurance coverage. For example, to allow CHIP-eligible children and their parents to share the same insurance, CMS officials said that states could use CHIP funds to allow CHIP-eligible children to purchase the same private insurance plan as their parents through the exchange, though they had not yet provided guidance to states in this area as of April 2012. Recognizing the potential difficulties such families could face, Tennessee sought guidance from CMS in September 2011 on whether PPACA would allow the state to implement a “bridge plan,” where managed care organizations would provide a single insurance card that could be used by the entire family. This approach would be available to eligible families while at least one dependent was enrolled in Medicaid or CHIP and for a defined period afterward. However, Tennessee officials told us that as of February 2012, CMS had not indicated whether such an approach would be acceptable or how it could be implemented in a manner consistent with the law.

State officials also reported that ongoing budget constraints have affected their ability to enroll eligible children. A recent survey by the National Association of State Budget Officers found that states continue to face budgetary pressures as a result of the lack of a strong national economic recovery.⁴⁴ Under these circumstances, states continue to examine all their state programs, including Medicaid, to identify additional opportunities for cost savings. Medicaid officials in the six states in our review also acknowledged that budget constraints have affected their outreach and enrollment efforts. For example, California and Illinois officials reported reducing funding to community groups that have

⁴⁴National Association of State Budget Officers, *Fiscal Survey of States, Fall 2011* (Washington D.C.: 2011).

historically assisted families in applying for Medicaid. In addition, officials in four of the six states we interviewed added that budget constraints have also affected their funding of enrollment initiatives, such as express lane eligibility, that can increase children's enrollment in these programs. For example, Washington officials said the state was considering implementing express lane eligibility in 2011 for Medicaid. However, when estimating the cost of this initiative, the state determined that the anticipated increases in enrollment would be too expensive—despite the possibility that these costs could be offset by CHIPRA performance bonus payments—and decided not to pursue the initiative further at the time. Uncertainty about the availability of additional federal funds for future outreach and enrollment efforts creates additional challenges for states. For example, CHIPRA performance bonuses and CHIPRA outreach grants, as extended by PPACA, will no longer be provided after 2013 and 2015, respectively, and officials from a number of states raised concerns that PPACA did not authorize additional funds for outreach or enrollment.

Conclusions

A key goal of PPACA was to increase Americans' access to affordable health insurance. PPACA expanded eligibility for existing federal health programs and private health insurance, offered a new premium tax credit to offset the cost of private health insurance for some low- to moderate-income families whose incomes are too high to qualify for Medicaid or CHIP, and provided means for streamlining enrollment. Although our estimates are based on 2009 data, they illustrate the potential impact of PPACA, when fully implemented in 2014, on children's access to affordable health insurance, and highlight the importance of many of the policies introduced in CHIPRA and continued in PPACA. For example, our estimates suggest that about 68 percent of children who were uninsured in 2009 would be eligible for Medicaid or CHIP under PPACA, underscoring the continued importance of outreach and simplified enrollment policies to ensure that eligible children are enrolled in the appropriate program. Similarly, significantly higher estimates of changes in eligibility within a year among children in states without continuous eligibility policies compared to states with such policies underscore the importance of a continued emphasis on such policies to minimize changes in eligibility.

In addition, a small but significant number of uninsured children from low- to moderate-income families whose incomes are too high to qualify for Medicaid or CHIP would be ineligible for the premium tax credit under IRS's proposed definition of access to affordable employer-sponsored insurance, which is based on the cost of a self-only plan available to the

employee. Yet the cost of insuring other eligible family members could be higher and potentially unaffordable for some families. One implication of this proposal is that some families in which one member has an offer of self-only, employer-sponsored health insurance could be less likely to obtain family insurance than if no employer insurance were offered, because of their ineligibility for the premium tax credit. We recognize that in finalizing the affordability standard for an employee's eligible family members, IRS must weigh many complex factors, such as costs to the federal government and effects on employers and families, some of which are difficult to predict, as well as the scope of its authority. However, under the proposed standard, an offer of affordable employer-sponsored health insurance to one family member could impede other family members' access to affordable insurance—an outcome which would not further the broader goals of PPACA.

Recommendation for Executive Action

In the Department of the Treasury's future rule making, we recommend that the Secretary of the Treasury, in consultation with the Commissioner of Internal Revenue, consider the impact of the proposed standard for determining affordability of employer-sponsored insurance on children and other family members who are eligible to enroll, and whether it would be consistent with the goals of PPACA to adopt an alternative approach that would consider the cost of insuring eligible family members, or as necessary, seek clarification from Congress regarding its intent with respect to this standard.

Agency Comments

We provided a draft of this report for comment to HHS and the Department of the Treasury. Neither HHS nor the Department of the Treasury provided general comments on the report or its recommendation. Department of the Treasury officials provided technical comments, which we incorporated as appropriate.

As agreed with your offices, 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 relevant congressional committees, the Secretary of Health and Human Services, the Secretary of the Treasury, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or iritanik@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 III.

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive, flowing style.

Katherine M. Iritani
Director, Health Care

Appendix I: Scope and Methodology of the Survey of Income and Program Participation Analysis

Our first two objectives were to assess the extent to which uninsured children would be eligible for Medicaid, the State Children's Health Insurance Program (CHIP), or the premium tax credit available under the Patient Protection and Affordable Care Act (PPACA) and the extent to which they would experience a change in eligibility among these forms of assistance because of changes in household income during a year. We identified the Survey of Income and Program Participation (SIPP), a nationally representative, longitudinal survey conducted by the U.S. Census Bureau, as a useful data set for our purposes because it provides detailed monthly information over a multiyear period about specific types of income, family relationships, and health insurance status of individuals and households representing the civilian, noninstitutionalized population of the United States. We analyzed data from the most recently available SIPP, which began in 2008, and surveyed the occupants of approximately 42,000 households.

Our analysis of SIPP data is subject to limitations. The analysis uses 2009 data to illustrate the extent to which uninsured children would be eligible for Medicaid, CHIP, or the premium credit program had proposed and final 2014 PPACA eligibility rules been in effect at that time. To the extent that patterns in household income, insurance status, or other eligibility criteria differ in 2014, eligibility in 2014 will also differ. In addition, the estimates are based on a sample of the population and may differ from estimates that would be obtained if the full population had been surveyed using the same methods, and the estimates are based on self-reported information that may contain errors because of factors such as differing interpretation of survey questions, inability or unwillingness of survey participants to provide correct information, or data processing errors. The Census Bureau reported that quality control and edit procedures were used to reduce such errors.¹ Studies of SIPP income data have shown that the SIPP captures less income compared to other

¹For example, survey participants are encouraged to use financial records to aid their responses. In addition, to improve the accuracy of responses on monthly earnings, interviewers remind survey participants that certain months of the year contain 5 paydays for workers paid on a weekly basis, and 3 paydays for workers paid on a biweekly basis.

surveys, particularly for higher-income survey participants.² While our analysis focuses on lower-income survey participants, to the extent that the SIPP data underrepresent income in this population as well, our estimates would indicate that more children meet income requirements for Medicaid or CHIP versus the premium tax credit, and for the premium tax credit versus being ineligible for any type of assistance, than other surveys might suggest. Our analysis variables approximate but do not always fully capture key PPACA eligibility criteria, such as household income or citizenship status, as described further below. To determine the reliability of SIPP data, we reviewed related documentation and conducted electronic testing for missing data, outliers, and apparent errors. For example, we tested whether persons who reported being uninsured in January 2009 had reported having health insurance in the prior and following month. We also compared our results to estimates based on data from another Census Bureau survey, the American Community Survey, and to other studies that addressed related research questions. We determined that the SIPP data were sufficiently reliable for the purposes of our engagement.

Analysis Variables

A child's eligibility for Medicaid, CHIP, or the premium tax credit under PPACA is based in part on having household income below specified limits relative to the federal poverty level (FPL). The Centers for Medicare & Medicaid Services (CMS) and the Internal Revenue Service (IRS) have specified methods for determining a child's household income under PPACA in final and proposed eligibility rules, and differences exist in how household income is determined for Medicaid and CHIP versus the premium tax credit. A child's eligibility for these programs is also based on citizenship or legal residence, and, for the premium tax credit, on whether the child is considered to have access to other affordable insurance. From the available SIPP data, we developed variables for our analysis based on these eligibility rules.

²For example, one study estimated that, overall, SIPP captured 89.1 percent of calendar year 2002 income compared to the Census Bureau and the Bureau of Labor Statistics' Current Population Survey. However, for persons in the lowest three income quintiles, SIPP captured 105.6 percent, 97.0 percent, and 92.5 percent of income, respectively. See John L. Czajka and Gabrielle Denmead, "Income Data for Policy Analysis: A Comparative Assessment of 8 Surveys, Final Report" (Washington, D.C.: Mathematica Policy Research, Inc, Dec. 23, 2008) 131.

Household composition. We created two household composition variables for children on the basis of final CMS and proposed IRS rules for determining household composition for the premium tax credit and for Medicaid or CHIP. The premium tax credit household composition variable defined households as composed of a taxpayer and spouse, if applicable, and tax dependents. Tax dependents were defined as follows:

- Children under age 19 (or ages 19 through 23 who were full-time students) whose taxable income (together with a spouse's income, if applicable) was not more than half of household income.
- Other family members, who (together with a spouse, if applicable), earned less than the IRS threshold and whose total income was not more than half of household income.

Taxpayers were those who did not meet the above definition of a tax dependent. This definition of a tax dependent excluded those with significant income, but did not capture tax rules about the amount of financial support a taxpayer must provide for children or other dependents in order to claim them as tax dependents.

For example, most children under age 19 were defined as tax dependents. Households of tax-dependent children included the child, the child's taxpayer parents or guardians, and any other tax dependents of the taxpayers, such as the child's siblings. When children lived with two unmarried parents, the parent with the higher income was designated as the taxpayer parent. This household composition variable did not account for children who may be claimed as tax dependents by a noncustodial parent or for spouses who choose to file taxes separately.

The Medicaid household composition variable was the same as the premium tax credit household composition variable, with certain exceptions. When a tax-dependent child did not live with a taxpayer parent or lived with two parents who were not married to one another, or had household income below tax filing thresholds, the child's household for purposes of determining Medicaid and CHIP eligibility was composed of the child, the child's parents, siblings under age 19 (or ages 19 and 20 who were full-time students), and any children of the child. In addition, pregnant women were counted as two household members when determining Medicaid and CHIP eligibility. Pregnancy status is not directly available from the SIPP data; we estimated that women were pregnant in a given month if they had a new infant during one of the following 8 months.

Household income. We constructed four household income variables for children based on rules for counting income for Medicaid and CHIP and for the premium tax credit under PPACA. Tax dependent's income was not included in any household income variable if it was less than the amount that would necessitate filing a tax return.

- To approximate modified adjusted gross income (MAGI) household income under PPACA, a child's premium tax credit household income was defined as the sum of all income, less means-tested assistance income; child support or foster care payments; veterans and workers compensation or sickness or accident insurance payments; or gifts from relatives or friends—self-reported by individuals included in the premium tax credit household composition variable defined above, during calendar year 2009.³
- A child's baseline Medicaid household income was the sum of the same income types in the Medicaid household composition variable defined above, during specific months of 2009.⁴
- A child's adjusted Medicaid household income was equal to the baseline Medicaid household income variable, less income deductions applied in specific states in their Medicaid eligibility determination processes, including deductions of certain amounts of earned income and child care expenses.
- A child's adjusted CHIP household income was equal to the baseline Medicaid household income variable, less income deductions applied in specific states in their CHIP eligibility determination processes, including deductions of certain amounts of earned income and child care expenses.

³Our analysis was limited to children participating in SIPP throughout 2009. However, children who participated throughout 2009 could have had family members who left the survey or the child's household during the year. For family members with fewer than 12 months of 2009 income data, we divided the total income by the number of months of income data, and then multiplied the result by 12 to estimate full 2009 income. We did this in order to approximate how calendar year household income would have been projected for 2009, given a child's household composition as of January 2009.

⁴Our Medicaid household income variables did not capture the special treatment of lump sum or scholarship income for Medicaid eligibility determinations.

FPL. We constructed four percentages of FPL variables based on the four household income variables and two household composition variables defined above.

- A child's baseline Medicaid percentage of FPL was the Medicaid household income variable divided by the 2009 poverty threshold applicable to the child's state and family size contained in the Medicaid household composition variable.
- A child's adjusted Medicaid percentage of FPL was the adjusted Medicaid household income variable divided by the 2009 poverty threshold applicable to the child's state and family size contained in the Medicaid household composition variable.
- A child's adjusted CHIP percentage of FPL was the adjusted CHIP household income variable divided by the 2009 poverty threshold applicable to the child's state and family size contained in the Medicaid household composition variable.
- A child's premium tax credit percentage of FPL was the premium tax credit household income variable divided by the 2009 poverty threshold applicable to the child's state and household size contained in the premium tax credit household composition variable.

Insurance status. Employer-sponsored insurance was defined as insurance obtained through an individual's or a family member's employer, former employer, union, or the military. Individuals were not categorized as having employer-sponsored insurance if they also had Medicaid or CHIP coverage. We used a procedure that the Census Bureau has adopted for the American Community Survey to address under-reporting of Medicaid coverage. Specifically, respondents were recategorized as having Medicaid if they were one of the following:

- a child under age 19 and the unmarried child of a parent with public assistance or Medicaid,
- a citizen parent with public assistance,
- a citizen parent married to a citizen with public assistance or Medicaid,
- a foster child, or

- a Supplemental Security Income⁵ recipient who met one of the following conditions: (1) did not have children or (2) had children but was not working.

Individuals were defined as uninsured if they were not categorized as having employer-sponsored or other private insurance, Medicaid, CHIP, or other public insurance.

Access to affordable employer-sponsored insurance. Children who had a taxpayer parent as part of their household composition who had employer-sponsored insurance, and children who were taxpayers and had employer-sponsored insurance, were defined as having met the proposed standard for access to affordable employer-sponsored insurance if the average annual employee contribution for a self-only plan, \$921, was less than or equal to 9.5 percent of premium tax credit household income. This definition of access to affordable employer-sponsored insurance did not take into account the requirement that employer-sponsored insurance must provide a minimum value in order to be considered affordable, and it assumed that children were eligible to enroll in a parent's employer-sponsored insurance.

Citizenship or legal residence. Citizenship status is available in SIPP data, but the legal status of noncitizens is not directly available from SIPP data.⁶ We defined noncitizens as legally residing if they or a parent reported receiving public insurance, such as Medicaid, or other public assistance, which requires documentation of citizenship or legal residence. The remaining noncitizens were defined as potentially ineligible noncitizens.

Methodology

Based on the variables defined above, we categorized children as eligible or ineligible for Medicaid, CHIP, and the premium tax credit under proposed and final 2014 PPACA eligibility rules.

⁵The Social Security Administration's Supplemental Security Income program provides cash benefits to eligible low-income disabled individuals, including children, as well as certain others.

⁶SIPP data include information on whether certain non-citizens ages 15 and over were permanent U.S. residents; we did not incorporate this information into our analysis.

- We defined children as eligible for Medicaid under PPACA if they were citizens or legally residing noncitizens whose baseline Medicaid percentage of FPL was less than or equal to 138 percent, or who had an adjusted Medicaid percentage of FPL that was less than or equal to the 2012 state-specific income eligibility level for their age group.⁷ Foster children and Supplemental Security Income recipients were also defined as Medicaid eligible.
- We defined children as eligible for CHIP under PPACA if they were citizens or legally residing noncitizens not estimated to be eligible for Medicaid, with an adjusted CHIP percentage of FPL that was less than or equal to the applicable 2012 CHIP state-specific income eligibility level. CHIP included both CHIP-funded Medicaid expansion programs and separate CHIP programs. Children with employer-sponsored or other private insurance were defined as ineligible for separate CHIP programs.
- We defined children as eligible for the premium tax credit under PPACA if they were citizens or legally residing non-citizens not estimated to be eligible for Medicaid or CHIP, with premium tax credit percentage of FPL between 100 and 400 percent and without access to affordable employer-sponsored insurance.

Our analyses considered three groups of children: uninsured children ages 0 through 18, CHIP-eligible children ages 0 through 18 who were uninsured or publicly insured, and all children ages 0 through 18 eligible for Medicaid, CHIP, or the premium tax credit. We limited our analysis to children who participated in the SIPP for all of calendar year 2009.

- Among uninsured children, we used January 2009 SIPP data to estimate the percentage who would be eligible for Medicaid, CHIP, and the premium tax credit based on the above definitions of 2014 PPACA eligibility rules, as well as the percentage who would be ineligible.

⁷PPACA required states to maintain their existing Medicaid and CHIP income eligibility levels until fiscal year 2020. Prior to determining a child's household income level, many states currently disregard certain amounts of specific types of income. In its Medicaid rule, CMS specified that states will need to convert their existing effective income eligibility levels to a MAGI-equivalent level that adjusts for any existing practices of disregarding specific types of income. The methodology for doing this conversion has not been finalized. To approximate this standard, we created adjusted household income variables that incorporated applicable state income deductions into children's household income.

- Among uninsured or publicly insured children estimated to be eligible for CHIP, we used January 2009 SIPP data to estimate the percentage who would be eligible for the premium tax credit based on the above definitions of 2014 PPACA eligibility rules, as well as the percentage who would be ineligible, if CHIP were not available.
- Among all children estimated to be eligible for Medicaid, CHIP, or the premium tax credit in January 2009, we used calendar year 2009 SIPP data to estimate the percentage who would have experienced one or two changes in eligibility for specific types of assistance, including becoming ineligible for any type of assistance, under 2014 PPACA eligibility rules within 6 months and a year. We incorporated state-specific continuous eligibility policies; for children living in states that according to CMS had a continuous eligibility policy in place as of 2012, we did not count them as changing eligibility for the relevant program even if their income eligibility changed.
- Among all children estimated to be eligible for Medicaid, CHIP, or the premium tax credit in January 2009, we used calendar year SIPP data to estimate the percentage who would be eligible for Medicaid and CHIP under 2014 PPACA eligibility rules with a Medicaid percentage of FPL higher than 138 percent in January 2009 and during 2009 as a whole, in order to examine the percentage of children who could be eligible for different program than their parents.

For all estimated percentages, we used the SIPP 2009 calendar year sampling weight and calculated a lower and upper bound at the 95 percent confidence level using replicate weights that took into account the complex survey design.

Appendix II: Federal Initiatives and Funding Available to States to Facilitate Enrollment of Eligible Children and Implement PPACA

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and PPACA included a number of initiatives and provisions under which states may obtain federal funding to assist in enrolling eligible children, and most states have taken advantage of at least one of these. For example, CHIPRA provided incentives to states to undertake eight enrollment initiatives. Beginning in fiscal year 2009, CMS awarded performance bonuses to states that implemented at least five of the eight enrollment initiatives and also achieved specific enrollment goals.¹ (See fig. 3.) PPACA authorized the provision of planning grants and establishment grants to assist states with the implementation of the American Health Benefit Exchanges (referred to as exchanges)—marketplaces where eligible families and individuals can purchase private health insurance.² Recognizing that states will need to upgrade their Medicaid information technology systems to comply with PPACA, CMS has provided states with the opportunity to claim an enhanced Federal Medical Assistance Percentage (FMAP)—the federal share of Medicaid expenditures—through fiscal year 2015 for the costs associated with certain systems improvements, such as updates to their claims processing and enrollment systems. Specifically, instead of the 50 percent FMAP that has historically been available for most Medicaid administrative expenses, qualified states can obtain a 90 percent FMAP for the costs of implementing new information systems and a 75 percent FMAP for the costs of administering these new systems.³

¹The specific enrollment goal a state needed to meet was based, generally, on the state's current Medicaid enrollment and population growth.

²States were able to apply for an exchange planning grant of up to \$1 million, and most states applied for, and were awarded, the full amount. Louisiana returned the exchange planning grant money it had received. Alaska did not apply for an exchange planning grant. There are two levels of exchange establishment grants. Level one grants are awarded to states in the earlier stages of exchange development. States receiving a level one grant can apply for a second year of funding, if necessary. To be eligible for a level two grant, states must meet a series of specific criteria, including legal authority to establish and operate an exchange, a budget and plan for financial stability by 2015, and a plan to prevent fraud, waste, and abuse. As of March 2012, Rhode Island was the only state that had received a level two grant.

³To be eligible for the enhanced FMAP, states must submit explicit plans for upgrading their information systems to CMS for approval. As of April 27, 2012, CMS had approved plans from 36 states, and an additional 8 states had submitted plans for approval.

**Appendix II: Federal Initiatives and Funding
Available to States to Facilitate Enrollment of
Eligible Children and Implement PPACA**

Figure 3: Summary of States' Implementation of Initiatives and Receipt of Federal Funding to Facilitate Enrollment of Children and Implement PPACA

State	CHIPRA enrollment initiatives ^a								CHIPRA performance bonuses ^a			PPACA grants ^b		Enhanced FMAP ^c
	Continuous eligibility	Elimination of interview	Express lane	Premium assistance	Presumptive eligibility	Reduced asset requirements	Same form	Simplified renewal	Amount of performance bonus in 2009 (dollars in millions)	Amount of performance bonus in 2010 (dollars in millions)	Amount of performance bonus in 2011 (dollars in millions)	Exchange planning grant (grants were for approximately \$1 million) ^d	Exchange establishment grant (dollars in millions)	Status of Enhanced FMAP ^c
Alabama	●	●	●			●	●	●	1.5	5.7	19.8	●	8.6	Approved
Alaska	●	●				●	●	●	0.7	4.9	5.7			Submitted
Arizona		●				●	●					●	29.9	Approved
Arkansas		●				●	●	●				●	7.7	Submitted
California	●	●			●	●	●	●				●	39.4	Submitted
Colorado	●	●		●	●	●	●	●		18.2	26.1	●	18.0	Approved
Connecticut		●			●	●	●	●			5.2	●	6.7	
Delaware	●	●				●	●					●	3.4	Approved
D.C.		●				●	●					●	8.2	Approved
Florida	●	●				●	●	●				●		Submitted
Georgia		●	●	●		●	●	●			5.0	●		Approved
Hawaii		●				●	●	●				●	14.4	Approved
Idaho	●	●				●	●	●		0.9	1.3	●	20.4	Approved
Illinois	●	●			●	●	●	●	9.5	15.3	15.1	●	5.1	Approved
Indiana		●				●	●	●				●	6.9	Approved
Iowa	●	●	●		●	●	●	●		7.7	9.6	●	7.8	Approved
Kansas	●	●			●	●	●	●	1.2	5.5	5.9	●		Approved
Kentucky		●				●	●	●				●	65.6	Approved
Louisiana	●	●	●			●	●	●	1.5	3.7	1.9	● ^e		Approved
Maine	●	●				●	●	●				●	5.9	
Maryland		●	●			●	●	●		11.4	28.3	●	27.2	Approved
Massachusetts		●			●	●	●	●				●	11.6	Approved
Michigan	●	●			●	●	●	●	4.7	8.4	5.9	●	9.8	
Minnesota		●				●	●	●				●	30.3	Approved
Mississippi	●	●				●	●	●				●	20.1	
Missouri		●			●	●	●					●	20.9	Approved
Montana	●	●			●	●	●				6.5	●		Approved
Nebraska		●				●	●					●	5.5	
Nevada	●	●				●	●					●	19.3	Approved
New Hampshire		●			●	●	●					●		Approved
New Jersey		●	●		●	●	●	●	3.1	8.8	16.8	●	7.7	Approved
New Mexico	●	●			●	●	●	●	5.4	9.0	5.0	●	34.3	Approved
New York	●	●			●	●	●	●				●	59.2	Approved
North Carolina	●	●		●		●	●	●			21.1	●	12.4	Approved
North Dakota	●	●				●	●	●			3.2	●		Approved
Ohio	●	●			●	●	●	●		13.1	21.0	●		Approved
Oklahoma		●	●			●	●	●				●		Approved
Oregon	●	●	●			●	●	●	1.6	10.6	22.5	●	9.0	Approved
Pennsylvania	●	●	●			●	●					●	33.8	Submitted
Rhode Island		●				●	●					●	63.8 ^f	Approved
South Carolina	●	●	● ^g			●	●				2.4	●		Approved
South Dakota	●	●				●	●					●		Approved

**Appendix II: Federal Initiatives and Funding
Available to States to Facilitate Enrollment of
Eligible Children and Implement PPACA**

State	CHIPRA enrollment initiatives ^a								CHIPRA performance bonuses ^a			PPACA grants ^b	Enhanced FMAP ^c	
	Continuous eligibility	Elimination of interview	Express lane	Premium assistance	Presumptive eligibility	Reduced asset requirements	Same form	Simplified renewal	Amount of performance bonus in 2009 (dollars in millions)	Amount of performance bonus in 2010 (dollars in millions)	Amount of performance bonus in 2011 (dollars in millions)	Exchange planning grant (grants were for approximately \$1 million) ^d	Exchange establishment grant (dollars in millions)	Status of Enhanced FMAP ^c
Tennessee	●	●				●		●				●	3.8	Submitted
Texas	●	●						●				●		Approved
Utah	●	●				●	●	●				●		
Vermont	●	●				●	●	●				●	18.1	Submitted
Virginia	●	●		●		●	●	●			26.7	●		Submitted
Washington	●	●		●		●	●	●	7.9	20.6	17.0	●	22.9	Approved
West Virginia	●	●				●	●	●				●	9.7	
Wisconsin	●	●		●	●	●	●	●		23.4	24.5	●		Approved
Wyoming	●	●				●	●					●		Approved
Total	31	50	9	7	16	50	48	27	\$37.1^h	\$167.2^h	\$296.5^h	50	\$667.3^h	36 Approved 8 Submitted

- Medicaid only
- CHIP only
- Both Medicaid and CHIP

Source: CMS data.

Note: In this figure, ● stands for “yes.”

^aThis information covers initiatives as of January 1, 2012.

^bThis information covers grants as of February 22, 2012.

^cAs of April 27, 2012. CMS has provided states with the opportunity to claim an enhanced FMAP for the costs associated with certain systems improvements, such as updates to their claims processing and enrollment systems.

^dStates were able to apply for up to \$1 million in funding and most states received close to \$1 million, while Wyoming received \$800,000. Alaska did not apply for an exchange planning grant.

^eLouisiana returned the exchange planning grant money that it had received.

^fRhode Island has received both a level one grant, for \$5,240,668, and a level two grant, for \$58,515,871.

^gSouth Carolina uses express lane eligibility for Medicaid and CHIP renewal.

^hNumbers may not sum to totals because of rounding.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Susan T. Anthony, Assistant Director; Susan Barnidge; Emily Beller; Sandra George; Eagan Kemp; and Roseanne Price made key contributions to this report.

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