

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID PAYMENTS OF PREMIUMS  
FOR EMPLOYER GROUP HEALTH  
INSURANCE**



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# EXECUTIVE SUMMARY

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## PURPOSE

To determine the extent State Medicaid agencies pay employer group health plan insurance premiums for Medicaid-eligible individuals.

## BACKGROUND

Expenditures for Medicaid benefits have grown dramatically in recent years. From Calendar Year 1989 through 1991, Federal and State spending rose 49 percent, increasing from \$59 billion to \$88 billion.

The rate of growth in Medicaid expenditures is a major concern to both Federal and State governments. Both are seeking ways to curb spending. One method is to pay private health insurance premiums for Medicaid-eligible individuals. Under this method, private insurance becomes the primary payer for medical services and Medicaid becomes the secondary payer.

### *Purchasing Employer Group Health Plan Insurance for Medicaid Recipients*

Effective January 1, 1991, Section 1906 of the Social Security Act mandated State Medicaid agencies, when cost effective, to pay premiums for employer group health plan (EGHP) insurance for Medicaid-eligible individuals. Individuals must enroll in the EGHP as a condition of Medicaid eligibility when a State determines it is cost effective for them to do so. Section 1906 also requires that States use EGHP fee schedules rather than Medicaid fee schedules when paying deductibles and coinsurance.

We surveyed the 50 States and District of Columbia to determine State practices for paying EGHP premiums. We completed our data collection April 30, 1993.

## FINDINGS

### *Most States have not purchased EGHP insurance for Medicaid-eligible individuals*

- Eighteen States had paid EGHP premiums for Medicaid-eligible individuals.
- Only 1 of the 18 States that paid EGHP premiums also used the EGHP fee schedule to pay deductibles and coinsurance.
- One State had begun a pilot program, but had not yet purchased insurance.
- Thirty States had not implemented Section 1906 at all, and two States did not respond to our survey.

***Substantial savings result from purchasing EGHP insurance for Medicaid-eligible individuals***

Seven of the 18 States that purchased EGHP insurance had conducted cost/benefit analyses. Officials from five of the seven reported a savings of about \$2.7 million resulting from private insurance companies having paid for medical care that otherwise would have been paid by Medicaid. Of the remaining two States, one reported saving \$24 for every \$1 spent, and the other saved about \$12 for every \$1 spent.

We estimated that \$32,000,000 in Federal and State Medicaid funds could be saved annually if all States purchased EGHP insurance for Medicaid-eligible individuals when cost effective to do so. We based our estimate on cost/benefit figures provided by four of the seven States that had conducted cost/benefit analyses. Data from the other three States were not complete enough to use in our calculations. We calculated a weighted average savings per person per year for the four States and determined the four States' ratio of savings to Medicaid recipients. We then used that ratio to compute potential savings.

***Compliance with current legislation could reduce potential savings resulting from EGHP insurance***

Seventeen of the 18 States that purchased EGHP insurance for Medicaid-eligible individuals did not use the EGHP fee schedule to pay deductibles and coinsurance. Instead, they used their established Medicaid fee schedules. They did so because (1) the EGHP fee schedule is higher (more costly to Medicaid) than State Medicaid fee schedules, and (2) using the EGHP fee schedule would require unnecessarily high administrative expense.

**RECOMMENDATIONS**

We have two recommendations that could increase cost savings from EGHP.

1. **The Health Care Financing Administration (HCFA) should continue to strongly support States implementing Section 1906 of the Social Security Act. HCFA can do so by transferring technology from States that have developed systems and procedures for 1906 programs to States without such systems and procedures.**
2. **HCFA should propose legislation that allows States to pay EGHP deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules.**

## AGENCY COMMENTS

The Assistant Secretary for Management and Budget (ASMB) and the HCFA Administrator commented on our draft report.

ASMB remarked that HCFA's Office of the Actuary estimated \$230 million in Medicaid savings in 1994 if States purchased EGHP insurance for eligible individuals when cost effective. The methodologies used for HCFA's estimated savings and our estimate differ, and both have limitations. Our estimate is based on actual experiences of four States. It is possible that those States are different in some important ways from the rest of the nation. HCFA's estimate is based on census data and certain assumptions about the extent to which Medicaid recipients have access to EGHP insurance that is cost effective for States to purchase. Therefore, HCFA's estimate represents theoretical savings.

HCFA agreed with our recommendation that they should continue to strongly support States' implementation of Section 1906. However, they deferred comment on our recommendation that HCFA should propose a legislative change, noting that the requirements of Section 1906 of the Social Security Act may change under the proposed health reform plans Congress is presently considering. We believe HCFA should closely watch legislative activity, and at the appropriate opportunity, propose the necessary legislative change if it is not superseded by the broader legislative reform. Revising legislation would likely be an incentive for States to implement an EGHP program.

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# INTRODUCTION

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## PURPOSE

To determine the extent State Medicaid agencies pay employer group health plan insurance premiums for Medicaid-eligible individuals.

## BACKGROUND

### *Medicaid Program*

The Medicaid program, authorized by Title XIX of the Social Security Act, provides health care coverage for specified individuals who have low incomes and few assets. States administer the Medicaid program under Federal laws and guidelines. Generally, States pay health care providers who treat and provide care to Medicaid-eligible individuals. States set their own fee schedule, or payment rate, for medical services provided to Medicaid-eligible individuals. Health care providers who accept Medicaid-eligible patients agree to treat them for the rate established by a State.

The Federal government pays a percentage of Medicaid benefits, based on a State's per capita income. Generally, poorer States receive a larger Federal contribution than affluent States. In Fiscal Year 1993, the Federal share ranged from 50 percent to 79 percent. Within the Department of Health and Human Services, the Health Care Financing Administration (HCFA) has Federal responsibility for Medicaid.

### *Concern Over Medicaid Costs*

Expenditures for Medicaid benefits have grown dramatically in recent years. From Calendar Year 1988 through 1991, Federal and State spending rose 49 percent, increasing from \$59 billion to \$88 billion.<sup>1</sup>

The rate of growth in Medicaid expenditures is a major concern to both Federal and State governments. Both are seeking ways to curb spending. One method is to pay private health insurance premiums for Medicaid-eligible individuals. Under this method, private insurance becomes the primary payer for medical services and Medicaid becomes the secondary payer.

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<sup>1</sup>Health Care Financing Administration, *HCFA 1992 Statistics*, September 1992

### *Purchasing Private Insurance for Medicaid Recipients*

Two sections of the Social Security Act allow States to use Medicaid funds to pay private insurance premiums for **Medicaid-eligible** individuals.

For several years, Section 1905(a) of the Social Security Act has allowed States to use Medicaid funds to pay a Medicaid recipient's private insurance premiums. States may choose this option when a Medicaid-eligible individual is expected to have high medical costs. When States choose this option, private insurance pays for the majority of medical care, and Medicaid pays the amount that exceeds the third party's liability up to the Medicaid rate. States use their established Medicaid fee schedule to determine the amount they will pay toward the difference.

The Omnibus Budget Reconciliation Act of 1990 established Section 1906 of the Social Security Act. Effective January 1, 1991, Section 1906 required State Medicaid agencies, when cost effective, to pay premiums, deductibles and coinsurance for employer group health plan (EGHP) insurance for Medicaid-eligible individuals. Individuals must enroll in an EGHP as a condition of Medicaid eligibility when a State determines it is cost effective for them to do so. When a non-Medicaid-eligible family member must be enrolled in an EGHP in order for the Medicaid-eligible member to receive coverage, the State must pay the premiums (not deductibles and coinsurance) for the non-eligible member. Section 1906 also required that States use an EGHP fee schedule rather than their established Medicaid fee schedule when paying deductibles and coinsurance.

States still have the option of following the payment guidelines of Section 1905(a) and pay premiums for insurance other than EGHP--for example, Medicare supplements and cancer policies. States may pay EGHP premiums and use the Section 1905(a) payment guidelines if they have determined it is not cost effective to use Section 1906 guidelines.

### *Purchasing Private Insurance For Non-Medicaid Recipients*

A third part of the Social Security Act, Section 1902, allowed States to use Medicaid funds to pay EGHP premiums for **non-Medicaid-eligible** individuals.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required employers to provide individuals an opportunity to continue their group health insurance when they leave employment or reduce hours of employment. Under Section 1902, States can pay EGHP insurance premiums--but not deductibles and coinsurance--for certain low income individuals<sup>2</sup> when they consider it cost effective. States may use this option to purchase EGHP insurance for individuals who (1) have

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<sup>2</sup>Individuals who are not eligible for Medicaid, but have incomes below the poverty level and assets less than twice the maximum allowed for Supplemental Security Income (SSI) eligibility.

health problems that are expensive to treat, and (2) are likely to become Medicaid-eligible in the future.

## SCOPE

This report focuses on the extent that State Medicaid agencies (1) purchase EGHP insurance for Medicaid-eligible individuals when cost effective to do so, and (2) pay deductibles and coinsurance at the EGHP rate. We surveyed all 50 States and the District of Columbia to identify any private insurance States purchased with Medicaid funds in State Fiscal Year (FY) 1992. This report reflects what States told us they were doing as of April 30, 1993. We did not conduct a compliance review.

## METHODOLOGY

We mailed a standardized questionnaire to all 51 jurisdictions<sup>3</sup> on July 15, 1992. A total of 49 States returned completed questionnaires by December 1992. As needed, we conducted telephone interviews with State Medicaid staffs to obtain clarification and elaboration on responses to the mailed questionnaire. Florida and Ohio did not respond to the survey.

To review State program operations, we visited two State agencies that reported they had implemented Section 1906. One State, Iowa, implemented the program in July 1991. The other State, New York, implemented a program making it mandatory to pay insurance premiums in 1982--nine years prior to the enactment of Section 1906.

We interviewed staffs from HCFA and the American Public Welfare Association (APWA) to get their opinion on State implementation of Section 1906. APWA is an advocacy group representing State welfare and Medicaid agencies.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

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<sup>3</sup>For convenience in summarizing survey results, we counted the District of Columbia as a 51st State.

# FINDINGS

## MOST STATES HAVE NOT PURCHASED EGHP INSURANCE FOR MEDICAID-ELIGIBLE INDIVIDUALS

Section 1906 of the Social Security Act required State Medicaid agencies, when cost effective, to pay (1) EGHP premiums, and (2) deductibles and coinsurance using EGHP fee schedules.

- Eighteen States paid EGHP insurance premiums for Medicaid-eligible individuals. One other State had implemented a pilot EGHP program, but had not paid any premiums (see Table 1). Appendix A shows a profile of each of the 19 States.
- Only 1 of the 18 States that paid EGHP insurance premiums also used the EGHP fee schedule to pay deductibles and coinsurance. The other 17 States used their Medicaid fee schedules when paying coinsurance and deductibles. Officials from 2 of the 17 States told us that they will pay deductibles and coinsurance at the EGHP rate if a provider requests it. However, at the time of our study no providers had done so.
- Thirty States had not implemented Section 1906 at all, and two States did not respond to our survey.

**TABLE 1  
STATES PAYING EGHP INSURANCE PREMIUMS**

<i>STATE</i>	<i>MEDICAID RECIPIENTS<sup>1</sup></i>	<i>STATE</i>	<i>MEDICAID RECIPIENTS<sup>1</sup></i>	<i>STATE</i>	<i>MEDICAID RECIPIENTS<sup>1</sup></i>
<i>Alabama</i>	<i>2</i>	<i>Montana<sup>3</sup></i>	<i>202</i>	<i>Oregon<sup>3</sup></i>	<i>1257</i>
<i>Colorado</i>	<i>50</i>	<i>Nebraska</i>	<i>40</i>	<i>S. Carolina<sup>3</sup></i>	<i>43</i>
<i>Connecticut</i>	<i>29</i>	<i>Nevada</i>	<i>5</i>	<i>S. Dakota</i>	<i>1</i>
<i>Idaho<sup>2</sup></i>	<i>115</i>	<i>N. Hampshire<sup>3</sup></i>	<i>33</i>	<i>Tennessee</i>	<i>5</i>
<i>Iowa<sup>3</sup></i>	<i>1417</i>	<i>New Jersey<sup>3</sup></i>	<i>77</i>	<i>Vermont<sup>3</sup></i>	<i>20</i>
<i>Minnesota</i>	<i>3000</i>	<i>New York<sup>3</sup></i>	<i>20,000</i>	<i>Washington<sup>3</sup></i>	<i>199</i>

<sup>1</sup>Approximate number of Medicaid individuals covered under Section 1906. Virginia has an EGHP pilot program underway. We excluded Virginia from the table because the State had not yet begun paying premiums at the time this report was written.

<sup>2</sup>State that routinely pays deductibles and coinsurance using EGHP fee schedules.

<sup>3</sup>States that also pay insurance premiums under Section 1905(a). Data from New Jersey, New York, and South Carolina did not distinguish number of individuals covered by Sections 1905(a) and 1906.

### *The Extent of EGHP Insurance Coverage Varied Among States*

As shown by Table 1, the number of individuals for whom States paid EGHP varied widely among States.

Many factors can contribute to the variation in purchasing EGHP insurance among States. For example, State financial condition and commitment to the EGHP program could partly account for the differences among States. While we did not compare one State to another in terms of providing EGHP coverage, we observed three factors that partly accounted for extent of EGHP coverage provided in a given State.

- Date of Implementation - At the time of our survey, most States had operated their 1906 programs less than two years. To start programs, States usually pay premiums for only a few individuals. As problems are identified and solved, States begin purchasing insurance for more individuals. Thus, States with older programs usually had more individuals included.
- Degree of Automation - States that have computer technology to perform functions such as determining cost effectiveness have larger EGHP caseloads than States that perform such functions manually.
- Degree of Targeting Cases - Some States target EGHP premium payments only for individuals they know will have high medical expenses, such as pregnant women. Other States determine cost effectiveness of purchasing EGHP for all individuals who are entitled to EGHP coverage.

### *Reasons for Not Purchasing EGHP Insurance*

Officials in 18 of the 30 States<sup>4</sup> (60 percent) that had not purchased EGHP insurance and paid deductibles and coinsurance as required by Section 1906 said they did not do so because of the high administrative costs and lack of resources.

To illustrate, to purchase EGHP insurance and pay deductibles and coinsurance, a State must first determine that it is cost effective to do so for each potentially eligible person. Several State officials expressed particular concern over this requirement. They said they did not have resources to obtain automated systems for determining cost effectiveness. Further, doing so manually is very labor intensive. At the time of our inspection, only six of the 30 States said they had needed automation technology to determine cost effectiveness of purchasing EGHP.

To determine cost effectiveness of purchasing EGHP, a State must compare the cost and potential benefits of purchasing EGHP to the average Medicaid cost for a person who had characteristics (e.g., age, gender, class of assistance) similar to an individual

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<sup>4</sup>Excludes two States that did not respond to our survey.

who would be entitled to EGHP. These calculations sometimes include examining the medical needs of specific individuals which may require reviewing their medical records and previous insurance claims. This analysis indicates the potential of a State Medicaid program to save money by purchasing EGHP insurance for a specific individual.

State officials also cited several other cost and resource needs that have partly prevented their implementation of an EGHP program. They noted that additional staff and system resources would be needed to

- pay premiums to insurance companies,
- pay premiums to individuals when premiums are withheld from wages,
- pay premiums for non-Medicaid-eligible individuals in order to enroll Medicaid-eligible family members,
- update Medicaid recipient files, and
- redetermine cost effectiveness of EGHP when premium and fee schedules change.

HCFA is aware that States are experiencing such problems implementing EGHP programs. To assist States in implementation, HCFA, in conjunction with APWA, conducted a workshop on Section 1906 at the 1991 National Medicaid Management Information System (MMIS) / Third Party Liability (TPL) Conference. The 1993 National Conference included three workshops in which five States that have implemented EGHP programs shared their experiences. In 1992, HCFA regional offices conducted conferences for the States in their respective regions. Section 1906 was an agenda topic at each regional conference. In addition, HCFA's "TPL Trends" newsletter highlighted Iowa's and Idaho's EGHP programs in the September 1992 issue. HCFA continues to provide technical assistance to States on an ongoing basis and is monitoring State performance through System Performance Reviews and Management Reviews.

## **SUBSTANTIAL SAVINGS RESULT FROM PURCHASING EGHP INSURANCE FOR MEDICAID-ELIGIBLE INDIVIDUALS**

Officials from the 18 States that had purchased EGHP insurance for Medicaid-eligible individuals said they had realized substantial savings. The savings resulted because private insurance companies now pay for medical care that otherwise would have been paid by Medicaid. Generally, the difference between what Medicaid would have paid for medical care and what it did pay in EGHP insurance premiums is considered a savings to the Medicaid program.

### ***Reported Savings by States with EGHP Programs***

Seven of the 18 States that purchased EGHP insurance for Medicaid-eligible individuals had conducted cost/benefit analyses of their programs. Officials from five of the seven States reported about \$2.7 million in savings during Fiscal Year 1992. The remaining two States had not computed total savings, but they reported substantial cost benefits from purchasing EGHP insurance for Medicaid-eligible individuals. One reported saving \$24 for every \$1 spent, and the other about \$12 for every \$1 spent.

Other States had not completed cost/benefit analyses, but they provided anecdotal examples indicating substantial savings. One State Medicaid official, for example, was in process of completing a cost/benefit analyses. This official had already identified one individual for whom the State paid EGHP insurance and saved \$97,000. This savings alone almost equaled the State's total investment in EGHP insurance.

### ***Potential Savings Resulting from a Nationwide EGHP Program***

We estimated that \$32 million in Federal and State Medicaid funds could be saved annually if all States purchased EGHP insurance for Medicaid-eligible individuals when cost effective to do so. (The 90 percent confidence interval for our nationwide estimate of savings is \$15,736,000 to \$48,816,000.) We based our estimate on the cost/benefit figures provided by four of the seven States that had completed cost/benefit analyses. We did not include the cost/benefit studies of the other three States in our analyses because they did not have adequate information. Specifically, they did not have the number of months that they had purchased EGHP per individual. Thus, we could not use their EGHP experience in our savings calculation.

Our estimate of \$32 million is a much lower estimate than the estimate prepared by the HCFA Office of the Actuary. HCFA estimated that \$230 million savings would result in 1994 from purchasing EGHP insurance. The methodologies used for HCFA's estimated savings and our estimate differ, and both have limitations. Our estimate is based on actual experiences in four States. It is possible that those States are different in some important ways from the rest of the nation. HCFA's estimate is based on census data and certain assumptions about the extent to which Medicaid recipients have access to EGHP insurance that is cost effective for States to purchase.

Appendix B contains (1) our methodology and assumptions for estimating the savings that would result from a nationwide EGHP program, and (2) a short description of the methods HCFA used to determine savings.

## COMPLIANCE WITH CURRENT LEGISLATION COULD REDUCE POTENTIAL SAVINGS RESULTING FROM EGHP INSURANCE

Currently, Section 1906 of the Social Security Act requires that when cost effective, States purchase EGHP insurance for Medicaid-eligible individuals and use an EGHP fee schedule to pay deductibles and coinsurance. However, 17 of the 18 States that purchased EGHP insurance for Medicaid-eligible individuals in their States did not use the EGHP fee schedule as required to pay deductibles and coinsurance. Instead, they used their established Medicaid fee schedules. They did so because (1) the EGHP fee schedule is higher (more costly to Medicaid) than State Medicaid fee schedules, and (2) using the EGHP fee schedule would require unnecessarily high administrative expense.

The following hypothetical example shows the difference in Medicaid cost sharing obligations using an EGHP fee schedule and a Medicaid fee schedule. Further, it shows that using the required EGHP fee schedule could reduce potential savings resulting from purchasing EGHP insurance for Medicaid-eligible individuals.

*A medical service costs \$100. The EGHP allows \$100 for the service and pays 80 percent (\$80). The State's Medicaid fee schedule allows \$90 for the service.*

*Using the EGHP's fee schedule, Medicaid's payment for the coinsurance would be \$20.*

*\$100 Allowed by EGHP fee schedule  
- 80 Paid by Insurance  
\$ 20 Medicaid's Payment for Coinsurance*

*Using the Medicaid fee schedule, Medicaid's payment for the coinsurance would be \$10.*

*\$90 Allowed by Medicaid's fee schedule  
- 80 Paid by Insurance  
\$10 Medicaid's Payment for Coinsurance*

Although this hypothetical example illustrates a Medicaid savings of \$10, State officials reported much greater differences usually exist between the Medicaid and EGHP fee schedules. Frequently when using the Medicaid fee schedule, Medicaid does not have any cost sharing obligation. This situation results because the amount paid by the EGHP insurance is sometimes more than the amount allowed by a State Medicaid fee schedule.

State officials told us the administrative costs of using an EGHP fee schedule to pay claims for deductibles and coinsurance is prohibitive because those claims must be paid manually. States said they cannot simply add EGHP fee schedules to their automated systems. State systems are designed for the State Medicaid fee schedule. Those systems will not accommodate EGHP fee schedules which vary by plan. There is no single EGHP fee schedule at which to program State systems. It is possible for each EGHP policy to have a different fee schedule. Therefore, a State like Minnesota may need a different automated program for each policy held by the 3000 recipients enrolled in EGHPs. If the State did not have an automated system to process EGHP claims for deductibles and coinsurance, staff would have to process EGHP claims manually.

## RECOMMENDATIONS

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States are struggling to develop ways to curb the escalating costs of Medicaid benefits. Section 1906 programs have produced savings for those States that have implemented them; however, 17 of those 18 States are paying deductibles and coinsurance using Medicaid fee schedules. If States had to bear the administrative costs of using EGHP fee schedules, the savings would be reduced. The costs of staying abreast of changes in EGHP fee schedules and paying deductibles and coinsurance manually are prohibitive.

Further, using EGHP fee schedules could create inequitable treatment among Medicaid recipients. Higher payments would be made for those recipients for whom States pay premiums than for other Medicaid recipients. Physicians are likely to prefer treating Medicaid recipients for whom States are paying EGHP premiums to get the higher payment. This could limit the choice of providers available to other Medicaid recipients.

As more States implement and expand 1906 programs, greater Medicaid savings will be realized. We have two recommendations which will help accomplish this objective.

1. HCFA should continue to strongly support States implementing Section 1906 of the Social Security Act. They can do so by transferring technology from States that have developed systems and procedures for 1906 programs to States without such systems and procedures.
2. HCFA should propose legislation that allows States to pay EGHP deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules.

## AGENCY COMMENTS

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The Assistant Secretary for Management and Budget (ASMB) and the HCFA Administrator commented on our draft report. Appendix C shows the full text of their comments.

ASMB remarked that HCFA's Office of Actuary estimated much larger Medicaid savings than we did if States purchased EGHP insurance for eligible individuals when cost effective. We compared HCFA's methodology for estimating savings to the methodology we used. Both methods had limitations. We revised our draft report to show both HCFA's and our estimates and include a comparison of the two methodologies. (See page 7 and appendix B.)

HCFA agreed with our recommendation that they should continue to strongly support States' implementation of Section 1906. However, they deferred comment on our recommendation that HCFA should propose a legislative change, citing that the requirements of Section 1906 of the Social Security Act may change under the proposed health reform plans Congress is presently considering. We believe HCFA should closely watch legislative activity, and at the appropriate opportunity, propose the necessary legislative change if it is not superseded by the broader legislative reform. Revising legislation would likely be an incentive for States to implement an EGHP program.

In response to HCFA's technical comments, we made appropriate revisions to the report.

# APPENDIX A

## PROFILE OF STATES PAYING PREMIUMS FOR EGHP As of April 30, 1993

STATE (Approx. No. In 1906 Program)	LENGTH OF TIME WITH PROGRAM	DETERMINING COST EFFECTIVENESS:			COST BENEFIT STUDY
		HOW?	BY WHOM?	FOR?	
Alabama (2)	2 Years	Manually	State Office	Recipients	Yes
Colorado (50)	2 Years	Computer & Manually	State Office	Recipients	Yes
Connecticut (29)	3 Years	Manually	State Office	Applicants & Recipients	No
Idaho (115)	2 Years	Computer & Manually	State Office	Applicants & Recipients	No
Iowa (1417)	3 Years	Computer & Manually	State Office	Recipients	Planned
Minnesota (3000)	3 Years	Manually	Local & State Offices	Applicants & Recipients	Yes
Montana (202)	2 Years	Manually	State Office	Applicants & Recipients	Yes
Nebraska (40)	2 Years	Computer & Manually	State Office	Applicants & Recipients	No
Nevada (5)	2 Years	Manually	State Office	Recipients	No
New Hampshire (33)	1 Year	Manually	Local & State Offices	Recipients	Yes
New Jersey (77)	2 Years	Manually	State Office	Applicants & Recipients	Yes
New York (20,000)	3 Years*	Computer & Manually	Local Offices	Applicants & Recipients	No
Oregon (1257)	2 Years	Manually	Local & State Offices	Recipients	No
South Carolina (43)	2 Years	Manually	State Office	Applicants & Recipients	Yes
South Dakota (1)	2 Years	Manually	State Office	Recipients	No
Tennessee (5)	2 Years	Manually	State Office	Recipients	No
Vermont (20)	Over 2 Yrs.	Manually	State Office	Recipients	No
Virginia	Piloting Program in Two Counties - All Procedures Not Yet Developed				
Washington (199)	Over 3 Yrs.	Computer & Manually	State Office	Applicants & Recipients	No

\*New York has had a State program making it mandatory to pay EGHP premiums since 1982.

# APPENDIX B

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## PROJECTED SAVINGS IF ALL STATES PURCHASE AVAILABLE EMPLOYER GROUP HEALTH PLAN INSURANCE FOR MEDICAID-ELIGIBLE INDIVIDUALS

### OIG Methodology

#### *Introduction*

We estimated that \$32,276,000 in Federal and State Medicaid funds could be saved annually if all States purchased employer group health plan (EGHP) insurance for Medicaid-eligible individuals when cost effective to do so. This figure includes the amount States with 1906 programs are currently saving. We based our estimate on a weighted average savings of \$22,168 per person per year in four States.

#### *Methods and Results*

Using documentation furnished by Alabama, Colorado, New Jersey, and South Carolina, we estimated a dollar savings attributable to EGHP enrollment on a per person per year basis. Many Medicaid recipients are enrolled for periods of less than one year. Thus, we converted the data to a standard rate per person year for comparison purposes. The following table presents the data we used.

STATE	MEDICAID RECIPIENTS	MONTHS COVERAGE	ESTIMATED SAVINGS	PER PERSON PER YEAR
Colorado	50	145	\$104,612	\$8,643
New Jersey	66	467	\$1,300,000	\$33,405
S. Carolina	43	237	\$395,751	\$20,038
Alabama	2	34	\$100,000	\$35,294

The unweighted average of the savings per person per year is \$24,345 (90 percent confidence interval -- \$14,083 to \$34,606). Using the number of recipients per State, the weighted average savings per person per year is \$22,168 (90 percent confidence interval -- \$18,222 to \$26,114). We feel a weighted average, especially since it is more conservative, is more appropriate than a simple average due to the wide distribution of the number of recipients in the four States. (The two Alabama recipients represent only one percent of the weighted data.)

Each of the States included in our analysis showed positive savings under their respective EGHP programs. However, the data furnished by the States showed

significant variation, indicating that only certain segments of their respective Medicaid populations had potential for EGHP enrollment.

The Health Care Financing Administration's Medicaid Bureau furnished data on the number of full year and part year recipients and benefit payments for FY 1992. We converted that data to person years of experience nationally and for the four States we used as a basis for our analyses. We assumed that the savings the four States reported to us represented all of the savings they achieved for one full fiscal year. We further assumed that the same level of savings could be achieved nationwide as were achieved in the average of the four States if all States had an EGHP program.

The total benefit payments for FY 1992 were \$91.48 billion for 27,754,493 person years of Medicaid experience. The four States included in our analyses represented \$5.82 billion in payments and 1,634,097 person years experience. Using ratio estimates of the savings per person years experience, we calculated that \$32,276,000 (90 percent confidence interval -- \$15,736,000 to \$48,816,000) might be saved by the Medicaid program should a similar EGHP program be instituted nationwide.

### *Conclusion*

Because of the variability in the number of Medicaid recipients in the four States, the precision estimate of our national savings projection is about 50 percent. Potentially the four States represent a biased subset of the Medicaid population. However, we believe our analyses provide a reliable estimate of potential savings in Medicaid through the EGHP program.

### HCFA Methodology

HCFA's estimate of \$230 million is based on census data and certain assumptions about the extent to which Medicaid recipients have access to EGHP insurance that is cost effective for States to purchase. Therefore, HCFA's estimate represents theoretical savings.

At our request, HCFA's Office of Actuary provided the following description of the methodology for estimating Medicaid savings.

Data from the Current Population Survey (CPS) and National Medical Expenditure Survey (NMES) were used to estimate the fraction of Medicaid recipients having access to employer-sponsored insurance (ESI) but not currently enrolled in it: about 3 percent for children and one-half percent for adults (including the disabled). We [HCFA]

assumed that about 75 percent of these individuals would be subject to the group health enrollment requirements.

Other major assumptions include the following. We [HCFA] assumed that ESI premium rates are based on utilization which is 80-90 percent of that of Medicaid enrollees for adults and children and 30-40 percent for the disabled, and that employers pay about 60-80 percent of these premiums on average. Employee cost sharing was estimated at 20 percent, and the ratio of Medicaid to employer plan recognized charges was assumed to be about two-thirds.

Clearly, there is a large difference between the OIG and HCFA savings estimates. We acknowledge the difficulties inherent in any estimating process for this program. In any event, substantial savings can be achieved through stronger implementation by the States of the EGHP provisions.

# APPENDIX C

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## AGENCY COMMENTS

- ▶ Assistant Secretary for Management and Budget
  
- ▶ Administrator, Health Care Financing Administration



Washington, D.C. 20201

OCT 4 1993

TO : Bryan B. Mitchell  
Principal Deputy Inspector General

FROM : Kenneth S. Apfel *K. Apfel*  
Assistant Secretary for Management and Budget

SUBJECT : DRAFT Report: "Medicaid Payments of Premiums for Employer Group Health Insurance," OEI-04-91-01050

We reviewed the indicated draft report and find the information very enlightening. However, we wish to comment on the methodology used in estimating the potential Medicaid savings.

Using data supplied by four States, the report calculates average weighted annual per person savings (\$22,168) resulting from States purchasing Employer Group Health Plan (EGHP) insurance for eligible individuals when cost effective. A ratio of the sample data to national statistics is used to estimate nationwide savings of \$32 million by instituting EGHP programs.

The HCFA Office of the Actuary (OACT) estimates \$230 million total Medicaid savings in FY 1994 resulting from States providing EGHP insurance to eligible individuals when cost effective. This estimate was included in a proposed rule sent through Departmental clearance at the beginning of the month.

OACT used Current Population Survey data to determine the fraction of Medicaid recipients having access to employer-sponsored insurance but not currently enrolled. This population was multiplied by a standard cost which had been adjusted for private insurance rates, utilization, and cost sharing.

We believe that the OACT estimate yields a more accurate representation of the potential savings from providing EGHP insurance. The OACT estimate takes into account the size of the eligible population and offsetting cost factors which are the same principles used to develop the statute. In contrast, the OIG estimate is based solely on existing programs and has a high probability of sampling error.

Hence, we recommend that the methodology for estimating potential Medicaid savings be revised to incorporate the principles used by OACT.

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GENERAL  
 OFFICE OF INSPECTOR  
 GENERAL



**Memorandum**

Date **MAR 8 1994**  
From Bruce C. Vladeck *[Signature]*  
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Medicaid Payments of Premiums for Employer Group Health Insurance" (OEI-04-91-01050)

To June Gibbs Brown  
Inspector General

We reviewed the subject draft report which examines the extent to which State Medicaid agencies pay employer group health plan insurance premiums for Medicaid eligible individuals.

We agree with OIG's first recommendation, that the Health Care Financing Administration (HCFA) continue to strongly support States implementing section 1906 of the Social Security Act (the Act). Since this is the current law, we will continue to give priority to the States' implementation of section 1906 of the Act. We will also continue to encourage and assist those States which have not yet implemented this provision. However, the requirements under section 1906 of the Act may change under the proposed Health Security Act. Therefore, we are deferring comment on the second recommendation, that HCFA propose legislation that allows States to pay employer group health plan (EGHP) deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules, pending these changes. Several technical comments are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us if you wish to discuss our response.

Attachment

IG	_____
SAIG	_____
PDIG	_____
DIG-AS	_____
DIG-EI	_____
DIG-OI	_____
AIG-MP	_____
OGC/IG	_____
EXSEC	_____
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**Comments of the Health Care Financing Administration (HCFA)**  
**on the Office of Inspector General's (OIG) Draft Report:**  
**"Medicaid Payments of Premiums for Employer Group Health Insurance"**  
**(OEI-04-91-01050)**

**Technical Comments**

**Page 8** - The report indicates that because State systems are only designed for the Medicaid fee schedule, a State could, theoretically, have a different fee schedule for each recipient who has employer group health plan (EGHP) insurance. Therefore, the report contends that a State would need a different automated program for each recipient. We agree the State will need to design a separate system to accommodate the EGHP fee schedule. However, it is not clear from the analysis that the State will need a different program for each fee schedule.

**Page 9** - The report suggests that "using EGHP fee schedules creates inequitable treatment among Medicaid recipients [since] higher payments would be made for those recipients for whom States pay premiums than for other Medicaid recipients." We do not believe that OIG has provided data to support the implication that Medicaid recipients who use the same Medicaid provider necessarily would receive different treatment because one has EGHP insurance and the other does not. If there is any disparity, it seems more likely it would be among different providers since, admittedly, the EGHP provider receives full payment based on the EGHP fee schedule rather than the lower Medicaid fee schedule.

We would suggest that if both of these assertions remain in the report, OIG include data in support of them. If this information is unavailable, we recommend that these comments be omitted from the report.