State of Mississippi

From the Office of the State Auditor
Phil Bryant

A Limited Analysis of the State Children's Health Insurance Program (SCHIP)

Performance Audit

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Office of the State Auditor
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A Limited Review of the Children's Health Insurance Program

Executive Summary

This limited review of the State Children's Health Insurance Program (SCHIP) provides a historical overview of the program, eligibility requirements, enrollment and renewal procedures, program funding sources, as well as recommendations on reducing program costs without compromising the basic healthcare of its participants. This analysis not only compares the SCHIP program to that of the State and School Employees Health Plan and the private market within Mississippi, but also makes comparisons with SCHIP programs in other states.

The State is currently facing an estimated deficit of more than $152 million for the SCHIP program through the next three fiscal years (refer to the chart below) –lowered from $186 million after receiving $35.5 million in redistributed funds from other states on January 19,2005. This additional $35.5 million dollars assisted the state in alleviating the $19.4 million deficit for FY2005 and lowered the estimated deficit for FY06 by another $14.6 million to $68.2 million. However, this still leaves the state with a projected deficit of $152,762,163 over the next three years. This deficit is caused by an increase in premium costs and decreases in federal funding and redistributions from other states. The Governor's Office is one of many entities continually working with the federal delegation as well as the administration (CMS) to assist Mississippi with financial relief. This only increases the sense of urgency for Mississippi to begin formulating a financial plan for the SCHIP program.

These issues present a real opportunity for Mississippi's Medicaid program to identify ways to streamline processes, structure, and benefits; assess contracts to reduce costs; find creative ways to raise funds; and evaluate current funding to determine how tax dollars can be utilized more efficiently and effectively. This Performance Audit review of the SCHIP program administered by the Division of Medicaid examines specific options to allow for better management and planning of Medicaid funds under the state plan and specifically include (but are not limited to): reducing benefits, capping/reducing enrollment, and finding better ways to redistribute funds.

SCHIP Deficit Projections as of February 2005

	Total Costs of Approved SCHIP Plan	Federally Funded Share	State Funded Share	Additional Amount Needed to Fund Projected Enrollment
FY2005	$143,026,577	$134,220,699	$23,413,451	$0
FY2006	$157,329,235	$63,358,200	$25,754,796	$68,216,239
FY2007	$173,062,158	$60,185,959	$28,330,275	$84,545,924
			Three Year Total:	**$152,762,163**

Source: The Division of Medicaid

As a result of the funding constraints faced by the State, it is recommended that the Division of Medicaid (DOM) begin identifying ways to contain costs for the State Children's Health Insurance Program. Policy makers may wish to consider cost reduction actions implemented by other states, as well as cost containment recommendations issued by the National Academy for State Health Policy, or increasing State matching revenue through additional taxes. The survival of this program may depend upon Mississippi's ability to learn from the lessons and experiences of other states. While considerable time and effort will be involved to achieve financial stability for the SCHIP program in Mississippi, the program is vital to insuring that the children of this state obtain basic healthcare needs. As one DOM representative stated, *"SCHIP is a major step forward for Mississippi to improve the long-term overall health status of Mississippians."*

Four major findings and recommendations have been issued by the Office of the State Auditor. These findings relate directly to the funding shortfalls of the program and offer ways to begin cost containment actions. It is recommended that these findings receive immediate attention and action. Other findings and recommendations can be found in Appendix 1 at the end of this document to enable decision makers to address the problems and implement workable solutions.

Finding	*Recommendation*
The State of Mississippi has provided qualified children with the best possible all-inclusive healthcare coverage available at little or no cost. However, the costs to the State must be examined and options to reduce costs should be considered. The benefits under the SCHIP plan can be reduced to meet the basic benchmark coverage to lower program costs, without compromising the basic healthcare of its participants.	The Office of the Governor should direct the Division of Medicaid to prepare a cost analysis of SCHIP premiums if coverage were reduced to benchmark levels to determine potential cost savings.
The Division of Medicaid has not been given any directive to look into finding more state match funds through other sources such as United Way, foundation grants, or other sources allowed under federal law. Furthermore, there is no plan in place for future funding should federal allotments begin to dissipate; there has been no directive to formulate a plan to set aside funds for unforeseen circumstances that would effect the program's operation. Mississippi cannot sustain the current number of enrollees in the SCHIP program without relying on redistribution of funds from other states. If the funding dependency continues, the State would have to cap enrollment and decrease the federal poverty level rate to reduce the current number of eligible participants or substantially increase taxes to keep the program in its current format.	It is crucial that Mississippi's dependence on redisbursements from other States for funding the SCHIP program stop and a plan be created to fund this program for both the short-term and long-term.
A report issued by the Department of Finance and Administration's (DFA) actuary, published in August 2003, found that there is a potential cost savings to SCHIP when comparing the "allowed charges" and the "submitted charges" for services supplied by medical providers under the plan. There are ten (10) suppliers who are not providing adequate discounts for services rendered to SCHIP participants (see page 31 for details).	HIMB needs to push BCBS to negotiate improved "*allowed charges*" for these services with the provider for the next contract period which begins January 1, 2005. This will assist in the decrease of overall claims costs for these services which can reduce overall premiums.
Mississippi was the first state to be approved for Employer-Sponsored Health Insurance buy-in for children qualified under SCHIP, but due to the stringent laws and regulations regarding this feature at the program's inception, it was never implemented. As the program has matured the laws and regulations have become more lenient in governing this feature of the program. The DOM has not pushed this feature, but there appears to be increasing interest for the State to provide this service. Many states (14 to date) are adopting an Employer-Sponsored Health Insurance Program (for children and families), and 10 others have requested approval of this feature, to reduce SCHIP program costs and cover more people by taking advantage of employer contributions toward the cost of coverage. This program offers the following cost effective benefits: ➢ States save money by sharing a portion of the premium costs with the employer; ➢ Allows families the benefit of one insurance plan;	Because the benefits of a premium assistance program are great, as seen from other states, and because the laws and regulations surrounding the program have changed dramatically since the program's inception, the Office of the Governor should issue a recommendation to the Division of Medicaid to re-visit the possibility of implementing this program as a way to assist in funding the SCHIP program.

The information below offers fast facts of the Mississippi Children's Health Insurance Program:

- ✓ The Mississippi SCHIP program began in January 2000.
- ✓ Targets families at or below 200% of the Federal Poverty Level (FPL); which means a family of four can qualify with an annual income up to $37,704.
- ✓ Insures children up to age 19.
- ✓ Benefits include medical, dental, vision, prescription drug coverage, and residential mental health services.
- ✓ Enrollment has risen from 508 to over 66,011 children.
- ✓ Only 5% (3,000) of enrollees are children of State and School Employees.
- ✓ The average age of a SCHIP participant is 10 years old.
- ✓ There are no co-pays and no annual deductibles for participants below 150% of the FPL, or for children who are of American Indian/Alaskan Native descent with family incomes at any income level.
- ✓ Families with incomes above 150% of the FPL are responsible for a minimal co-payment of $5 for a Doctor visit and $15 for an Emergency Room visit. There are annual out-of-pocket maximums of $800 for families at 151% to 175% of FPL and $950 for families at 176% to 200% of FPL.
- ✓ Premiums have increased from $363 thousand to over $10 million in the past 4 years (due to the increase in enrollment).
- ✓ Current premium costs per child per month are $154.
- ✓ The annual cost per participant in FY2002 was $1,478 which is 25% higher in comparison of other states in our study for that same year.
- ✓ The program is federally funded at 83.6% with a state match of 16.4%.
- ✓ At this time and due to current program costs, Mississippi's SCHIP program is facing a $152 million deficit over the next three years.

Report Summary

Mississippi's SCHIP program is facing a $152.7 million deficit over the next 3 years.

"The only viable way that Mississippi will be able to continue providing health insurance coverage to eligible children is with adequate federal funding, and changes to the funding formulas for allotments and redistributions are critical to this outcome." - DFA

SCHIP is targeted to children of families at or below 200% of the FPL. That means a family of four earning a gross income of $37,704 or less can qualify for the program.

In September 2004, the Mississippi Division of Medicaid announced the need for an additional $273 million raising their total state need to $692 million for Medicaid to operate next year. Of this amount, $80 million would be allocated for the State Children's Health Insurance Program (SCHIP). Furthermore, the program is facing a $152.7 million deficit, and needs to find ways to contain costs and cover this current funding crisis. This has prompted several questions regarding the services of SCHIP and Medicaid and is the focus of this limited review.

This review raises questions about how Medicaid management can work to streamline processes, program structure and benefits, assess contracts to reduce costs, find creative ways to raise funding, and evaluate current funding to determine how tax dollars can be utilized more efficiently and effectively. In this review of the SCHIP program administered by the Division of Medicaid, the Office of the State Auditor has been looking into specific options to allow for better management and planning of Medicaid funds under the state plan. These options include but are not limited to: reducing benefits, capping/reducing enrollment, increasing state matching revenue through additional taxes, and finding better ways to redistribute funds.

States provide health care coverage to low-income uninsured children largely through two federal-state programs, Medicaid and the State Children's Health Insurance Program (SCHIP). The Children's Health Insurance Program was designed to assist the lower-middle working class families with health insurance for their children and is generally targeted to families with incomes at or below 200% of the Federal Poverty Level (FPL); each state may set its own income eligibility limits, within certain guidelines, providing families with higher poverty levels an opportunity to afford health insurance. According to a study conducted by the Centers for Medicaid and Medicare (CMS)*, Mississippi has increased its coverage of uninsured children by approximately 45%.

There are four options States can use when determining the type of program they want to offer.

1. **Benchmark coverage** – *the standard Blue Cross Blue Shield preferred provider option offered under the Federal Employees Health Benefits program, a health plan offered and generally available to state employees in the state, or the health coverage that is offered by an HMO with the largest commercial enrollment in the state.*
2. **Benchmark-equivalent coverage** - *a package of benefits that is certified in an actuarial memorandum as having the same or greater actuarial value as one of the benchmark benefit packages. Benchmark-equivalent coverage must include each of the four basic benefits - inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray, and well-baby/well-child care including age-appropriate immunizations. They must also include at least 75% of the actuarial value of the coverage provided under the benchmark for benefits grouped in "categories of additional services" – prescription drugs, mental health, vision and hearing services.*
3. **Existing state-based coverage** – *option to expand the current Medicaid program to the states of New York, Florida, and Pennsylvania who already had an existing program to insure children of those states.*

* Centers for Medicaid and Medicare Services. Trends in the Rate of Uninsured, Low-Income Children Under Age 19 as a Percent of Total Children, By State.

Enrollment has increased from 508 children to 66.011

The average age of SCHIP participant is 10 years.

"The overall increased enrollment is the primary reason costs are on the rise."

State match funds are contributed from the State's Tobacco Fund money.

4. **Secretary approved coverage** – *coverage that in the determination of the Secretary, provides appropriate coverage for the population of targeted low-income children covered under the program. This may include Medicaid equivalent coverage, comprehensive coverage offered by the State under a Medicaid demonstration project approved by the Secretary under §1115 of the act, coverage that includes benchmark health benefits coverage, or coverage that the State demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan through use of a benefit-by-benefit comparison of the coverage demonstrating that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.*

Mississippi has Secretary approved coverage. Benefits under SCHIP include all the same benefits under the State and School Employees' High Option Health Insurance Plan including inpatient, outpatient, surgical services, clinic services, prescription drugs (with some exclusions), residential mental health services, medically necessary durable medical equipment, home and community-based health care services, and nursing care services.

Also included under SCHIP are vision, including eye exams and eyeglasses, dental benefits including preventive dental care and routine fillings were covered, as well as restoration and repair but no orthodontia, and there are no exclusions for pre-existing conditions. All of which are not included under the State and School Employees' High Option Plan.

An eligible child is defined as a low-income child who meets the following criteria: (Eligibility may not be denied on the basis of health status or medical history.)

- *Is younger than 19 years of age;*
- *Has a household income at or below 200% of the Federal Poverty Level*
- *Is a Mississippi resident with intent to stay;*
- *Does not have creditable health coverage at the time of application;*
- *Is not eligible for Medicaid;*
- *Is not an inmate of a public institution or a patient in an institution for mental diseases.*

The enrollment growth in the Mississippi SCHIP program has risen from 508 children in January 2000 to 66,011 children as of October 1, 2004. Of the number of children currently enrolled 3,000 are state employees' children. The overall increased enrollment is the primary reason costs are on the rise. Mississippi needs to evaluate possibilities of lowering eligibility requirements and/or capping enrollment as a cost containment measure, without compromising the States fiscal relief which provides the Federal Match Funds for the State. The State's legislative leadership may also look at increasing program revenue by raising taxes.

There are no co-pays and no annual deductibles for participants below 150% of the FPL, or for children who are of American Indian/Alaskan Native descent with family incomes at any level. Other eligible families with incomes above 150% of the FPL are responsible for a minimal co-payment of $5 for Outpatient Health Care Professional Visit and $15 for an Emergency Room visit. There are annual out-of-pocket maximums of $800 for families at 151% to 175% of FPL and $950 for families at 176% to 200% of FPL.

Mississippi's per child cost in SCHIP for FY2002 was 25% higher than the average of the other states in our comparison.

"Benefits under SCHIP can be reduced to the benchmark equivalent without compromising basic healthcare needs."

There is no long-term or short-term plan for funding the SCHIP program in Mississippi.

Mississippi can not sustain the current number of enrollees in SCHIP without the dependency on the redistribution of funds from other states.

The program is primarily funded through the federal government at 83.6%, with a required state match of 16.4%. State Match funds are contributed from the State's Tobacco Fund money. Title XXI provides for an "enhanced Federal Matching Assistance Percentage (FMAP)" for child health care under Title XXI. Allotments are determined in accordance with the statutory formula that is based on two factors (1. number of children potentially eligible for SCHIP, and 2. the State cost factor) that are multiplied to yield a final allotment product for each State. Mississippi's allotment for FY2004 is $36.8 million.

Mississippi's allotments began to decrease in the fiscal year 2002. The state has also received redistributions of unspent allotments from other states totaling $74,189,023 and there is another redistribution scheduled for February 2005. To date the state has spent the carryover of allotments from years past as well as the unspent allotments received from the redistributions. By law the state has three years to spend each year's SCHIP funds. The state will begin using the FY2004 allotments that should last through March 2005. Once these funds are spent the allotments for FY 2005 will be used.

The average cost per SCHIP enrollee has risen significantly since the programs start in 2000. The cost per enrollee has increased 39% since the fiscal year 1999, and has climbed 120% since its lowest point in fiscal year 2000. In fiscal year 2003 the cost per enrollee amounted to $1,648. Mississippi's per child cost for SCHIP for FY2002 was 25% higher than the average ($1,178) of the other states in our comparison.

The benefits under SCHIP can be reduced to meet the basic benchmark coverage to lower program costs, without compromising basic healthcare needs. As a result, the Office of the Governor should direct the Division of Medicaid to prepare a cost analysis of SCHIP premiums if coverage was reduced to benchmark levels to determine any potential cost-savings.

The Mississippi Division of Medicaid has indicated that it has been given no formal directive to look into finding more state match funds through other sources such as the United Way, or other sources allowed under federal law. Furthermore, there is no financial plan set in place for future funding should federal allotments begin to dissipate, and there has been no directive to formulate a plan to set aside funds for unforeseen circumstances that would affect the programs operation. There is no long-term or short-term plan for funding the SCHIP program in Mississippi.

Mississippi cannot sustain the current number of enrollees in the SCHIP program without the dependency of the redistribution of funds from other states. In fact, comparing the deficit to the average past redistributions the program cannot be sustained even with the additional redistributions the Division of Medicaid expects. Other states are being more judicious about their funds, and are quoted as saying they will no longer let their allotments expire and be redistributed.

It is crucial that Mississippi's dependency on reimbursements for funding of the SCHIP program stop and a plan be created to fund this program for both the short-term and long-term. If the funding dependency continues in its current path the state would have to cap enrollment and lower the Federal Poverty Level rate to cut current eligible participants.

National SCHIP Fast Facts:

* *10 States have set eligibility below 200% of the FPL.*
* *28 States have set SCHIP eligibility at 200% of the FPL.*
* *13 States have set SCHIP eligibility level above 200% of the FPL.*
* *Of the 35 States with separate SCHIP programs (16 States with only a separate SCHIP Program and 19 States with combination programs)*
* *24 States require a monthly premium or an annual premium/ enrollment fee.*

It is the recommendation of the Office of the State Auditor that the Governor's Office should direct the Division of Medicaid to have a short-term and a long-term plan to deal with loss regardless of any potential of redistributed funds.

Due to the funding problems the State is facing with regard to its Medicaid programs it is crucial that the Division of Medicaid begin finding ways to contain costs for the State Children's Health Insurance Program. There are many actions that other states are taking to reduce costs to their programs and Mississippi would be wise to heed the same advise. One measure many States are taking is to implement a premium assistance program. This program is a way for states to reduce the costs under their Medicaid and SCHIP plans by helping families purchase health insurance through their employers. The state's costs are reduced as employers pay a portion of health insurance premiums for employees and their dependants. Mississippi was the first State to be approved for this program, but has never implemented it.

Because the benefits of a premium assistance program are so great (e.g., cost effective-saves the state money by employers paying a portion of the premium costs, allows family's the benefit of one insurance plan for all members, encourages use of private insurance), as seen from other states, and because the laws and regulations surrounding the program have changed dramatically since the programs inception, it is the recommendation of the Office of the State Auditor that the Office of the Governor should issue a recommendation to the Division of Medicaid to re-visit the possibility of implementing this program to provide additional funding.

Furthermore, it is possible to use outside sources for funding the SCHIP program. The state is currently using the tobacco funds as a funding means, which is also used by many other states. However, this single source of funding is no longer sufficient to handle the rising costs of SCHIP premiums. It is recommended that the state look at possible local and county funding, foundation grants, and private donations (such as United Way, diabetes foundation, sponsorship) as means for raising additional funding for SCHIP.

The National Academy for State Health Policy researched the Medicaid and SCHIP programs in the 50 States and has provided recommendations on how States can reduce overall costs to their programs; furthermore, they offer both the pros and cons of implementing any of the cost containment actions. Included in this document are some of the recommendations made in the review that may be beneficial for Mississippi to follow to ensure its participants continue to receive health care coverage.

It is no secret that the SCHIP benefits package is top-notch and simply can not be matched. The state of Mississippi has provided qualified children with the best possible all-inclusive healthcare coverage available at little or no cost to its participants. However, the costs to the State must be examined and options to reduce costs should be considered without compromising the basic healthcare of SCHIP participants.

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SCHIP Historical Overview

States provide health care coverage to low-income uninsured children largely through two federal-state programs, Medicaid and the State Children's Health Insurance Program (SCHIP). SCHIP was signed into law in 1997 (Title XXI of the Social Security Act). The law appropriated $40 billion over ten years to help states expand health insurance to children whose families earn too much for traditional Medicaid, yet not enough to afford private health insurance. SCHIP is generally targeted to families with incomes at or below 200% of the Federal Poverty Level (FPL); each state may set its own income eligibility limits, within certain guidelines. Using the flexibility built into the statute, states' income eligibility for SCHIP are as high as 350% (New Jersey) of the FPL as of October 2004.

The Children's Health Insurance Program was designed to assist the lower-middle working class families with health insurance for their children. The U.S. Department of Health and Human Services defines the poverty guidelines for the 48 contiguous states and the District of Columbia at 100% or $18,850 per year for a family of four.[1] SCHIP covers children between 101%-350% of the FPL, providing families with higher poverty levels an opportunity to afford health insurance.

In implementing SCHIP states had two options: 1) They could choose to expand their Medicaid programs, thus providing SCHIP eligible children the same benefits and services that the state Medicaid program provides; or 2) They could construct a separate child health insurance plan offering a minimum benefit package. In Mississippi the Children's Health Insurance Program is governed by §41-86-1 et seq. of the Mississippi Code.

Mississippi is one of the thirty-five states that chose to provide a separate health insurance plan. In determining SCHIP coverage there are four options states could choose from:

- ***Benchmark Coverage***
- ***Benchmark Equivalent Coverage***
- ***Existing State-Based Coverage***
- ***Secretary Approved Coverage***[2]

Mississippi has a Secretary approved coverage that was introduced and approved in two separate phases. The benefits covered are inpatient, outpatient, surgical services, clinic services, clinic services, prescription drugs (with some exclusions), mental health services, medically necessary durable medical equipment, home and community-based health care services, and nursing care services. Certain surgeries and inpatient hospitalizations require a precertification from the health plan. Medically necessary laboratory and radiological services are covered but some diagnostic tests require a precertification. The mental health component of the benefit package includes up to 30 days/year for inpatient psychiatric treatment, 60 days/year for partial hospitalizations, and 52 outpatient visits per year.

In 2001, a vision network was added to the program and in 2002, dental benefits were expanded. Although initially only preventive dental care and routine fillings were covered, dental services currently include restoration and repair but no orthodontia.[3]

In September 2004, the Mississippi Division of Medicaid announced the need for an additional $273 million totaling $692 million[4] for Medicaid to operate next year. Of this amount, $80 million would be allocated for the SCHIP program. This has prompted several questions regarding the services of SCHIP and Medicaid and is the focus of this limited review.

[1] Federal Register/Vol. 69, No. 30/Part V/Department of Health and Human Services/Annual Update of the HHS Poverty Guidelines; Notice/Friday, February 13, 2004.
[2] Each state developing a child health care plan separate from its Medicaid program are required to get approval from HHS Secretary Donna E. Shalala before commencing or changing the program.
[3] Information received from DOM, DHS, and Shenkman, Elizabeth P., Wegener, Donna H., Quality of Care in the State Children's Health Insurance Program in Mississippi: *Institute for Child Health Policy*. April 2003.
[4] $692 million was quoted in the Clarion Ledger – Has not been confirmed by DOM.

Program Organizational Structure

The SCHIP program in Mississippi is administered jointly by the Division of Medicaid, the Department of Human Services, the Health Insurance Management Board, the Department of Finance and Administration, and the health care insurer Blue Cross Blue Shield of Mississippi. Their current roles and responsibilities are outlined below:

The Division of Medicaid

- Receives all state and federal funds for the Program.
- Responsible for all correspondence with Centers for Medicare and Medicaid Services (CMS).
- Implements outreach activities.
- Contracts with the Department of Human Services for eligibility determination for the Program *(This has changed since 01/01/2005)*
- Contracts with the Health Insurance Management Board to administer the separate insurance program.
- Pays monthly premiums to the Health Plan.

The Department of Human Services

Note: As of January 1, 2005, the following tasks are performed by the Division of Medicaid and DHS is no longer involved in this program.

- Determines eligibility for the Program.
- Provides all enrollment information electronically to the Health Plan.
- Responsible for investigating inquiries from the Health Plan related to Program enrollment/eligibility.
- Provides enrollment reports to the Division of Medicaid.

The Health Insurance Management Board (HIMB)

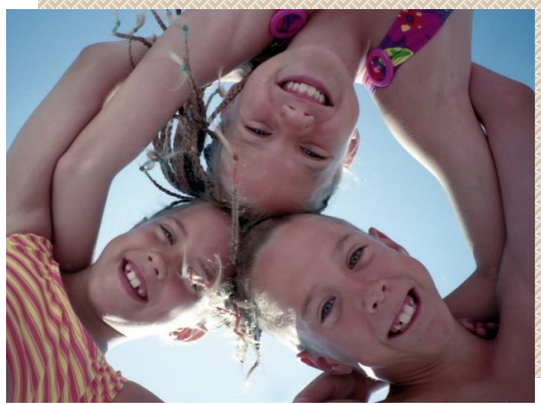
- Adopts the Rules and Regulations for the Program.
- Defines Plan benefits.
- Contracts with the Health Plan.
- Evaluates performance of the Health Plan.

The Department of Finance & Administration/Office of Insurance

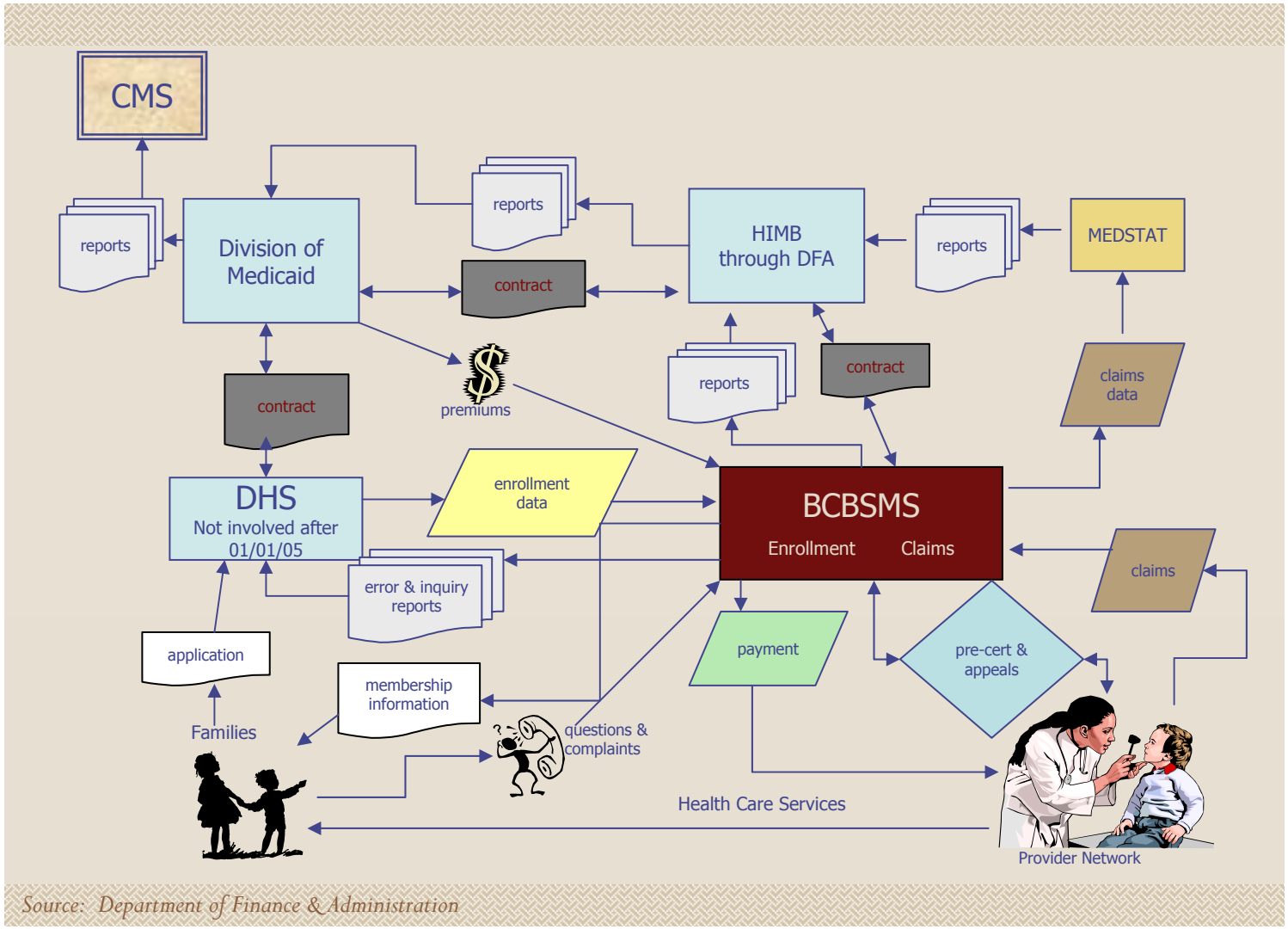
- Responsible for day to day operations; staff for the HIMB.
- Serves as liaison between agencies and the Health Plan.
- Monitors and evaluates access to services and quality of services.
- Reviews all written materials sent to enrollees for content/clarity.
- Subcontracts for actuarial, consulting, auditing, and other administrative services as needed.
- Provides reports to the Division of Medicaid.

The Health Care Insurer (BCBSMS)

- Provides health insurance coverage.
- Accepts enrollment information from DHS.
- Conducts pre-certifications/prior-authorizations and appeals.
- Provides Customer/Provider Service to address questions on benefits, coverage date(s), etc.
- Contracts with and credentials providers.
- Transfers claims data to data management vendor.
- Conducts basic reporting.



The process flow chart for SCHIP administration is illustrated below.



Source: Department of Finance & Administration

Eligibility Requirements

In Mississippi, families with age eligible children (0-19), who have incomes that are at higher levels than Medicaid eligible families, may be eligible for SCHIP up to 200% of the Federal Poverty Level (FPL), if the gross annual income does not exceed the income levels in the chart below. (The Department of Health and Human Services determines the poverty guidelines each year based on the last year's increase in prices as measured by the Consumer Price Index. This chart outlines the poverty guidelines for the year 2004 for the 48 contiguous states and for the District of Columbia.)

Federal Poverty Level Annual Incomes by Family Size for 2004

Family Size	200% FPL*	100% FPL**
1	$18,624	$9,312
2	$24,984	$12,490
3	$31,344	$15,670
4	$37,704	$18,850
5	$44,064	$22,030
6	$50,424	$25,210
7	$56,784	$28,390
8	$63,144	$31,570

*For family units with more than 8 members, add $6,360 for each additional member.
** For family units with more than 8 members, add $3,180 for each additional member.

Eligibility Criteria

An eligible child is defined as a low-income child who meets the following criteria:

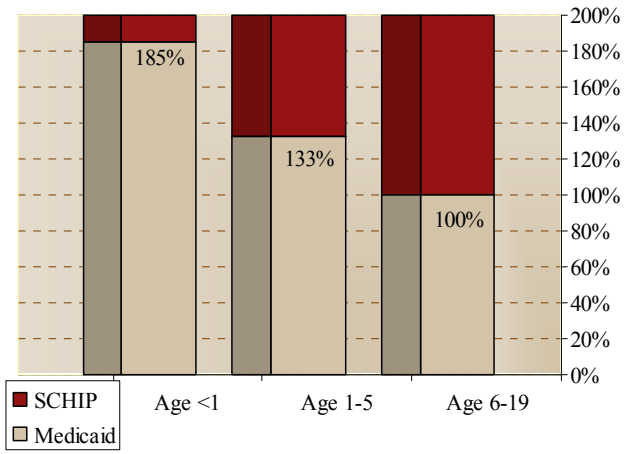
- *Is younger than 19 years of age;*
- *Has a household income below 200% of the Federal Poverty Level*
- *Is a Mississippi resident with intent to stay;*
- *Does not have creditable health coverage at the time of application;*
- *Is not eligible for Medicaid;*
- *Is not an inmate of a public institution or a patient in an institution for mental diseases.*

Furthermore, Department of Medicaid rules and regulations for the SCHIP program state eligibility may not be denied on the basis of health status or medical history, and a newborn child for whom an application for SCHIP is made within 31 days of birth will not be subject to review of creditable coverage.

Are You Qualified for Medicaid or SCHIP?

There are two thresholds of qualifying factors for determining whether a child is eligible for Medicaid versus SCHIP, 1) A child's age, and 2) their family's Federal Poverty Level (FPL) rate. The chart below illustrates the thresholds of eligibility to determine health care coverage of a qualified child.

Threshold for Eligibility of SCHIP and Medicaid by FPL and Age



Finding - *There are instances when a family with multiple children can have one child covered under Medicaid and one child covered under SCHIP because of the child's age. In this situation parents may have to use separate doctors for their children because not all providers accept both Medicaid and SCHIP. The Division of Medicaid has received complaints from participants about having to use separate providers for their children.*

Recommendation - *To provide better customer service, supply a list of providers who cover both Medicaid and SCHIP plans to families with children enrolled under both programs.*

Fraud & Abuse Prevention

The selected county DHS offices are audited by the Mississippi DOM bureau of Compliance and Financial Review. This audit includes review of the clients' records at the county office as well as clients' interviews. The required documents provided by the applicant are included in the clients' case record. Social security numbers must be provided or applied for, if under age one, for all applicants. The social security number will be used to verify information such as income and insurance coverage.

Eligibility Change within an Enrollment Period

If a participant wants to cancel their coverage because they no longer require the services of the program, the participant is required to submit in writing to the Division of Medicaid their intent to cancel their policy. According the DOM this does not occur very often.

Cases are only routinely reviewed for eligibility on an annual basis. The health insurer (BCBSMS) notifies DHS if they detect address changes, other insurance coverage, or any other information that may affect the enrollee's eligibility.

Finding - *There are limited safeguards in place to routinely check eligibility status of participants within the twelve month enrollment period.*

Recommendation - *Begin routinely checking eligibility status on all participants on a semi-annual basis and they should require proof of income, check for third party insurance, and any other information that could change the eligibility status of a participant.*

Update - *Since the draft of this report has been issued, the Division of Medicaid now requires face-to-face interviews along with proof of income, household status, and check for third party insurance in order to make a determination for eligibility. This is done on an annual basis.*

Application Process

There is a shared application for Medicaid and SCHIP, *The Mississippi Health Benefits* application. The application can be downloaded from the DOM website www.mfcf.org/coveringkids.html, and is available by mail and at many locations that serve children's needs like local health departments, Human Services Offices, community health centers, rural health clinics, Head Start centers, public schools, and some hospitals and private clinics.

In the past, the Department of Human Services (DHS) made the eligibility determinations for SCHIP. As of January 2005, DOM will make eligibility determinations based on a face-to-face interview, and the applicant must provide proof of at least one month's income along with proof of age and social security numbers for all applicants applying. Once approved, eligibility is continuous for one year with a predetermination of eligibility at that time.

Applicants are first screened for Medicaid eligibility. Children found eligible for Medicaid are to be enrolled in Medicaid.[5] If the income limits exceeds Medicaid, then the application is screened for SCHIP. Children approved for SCHIP will receive an identification card from Blue Cross Blue Shield, along with an informative packet outlining the providers, benefits, and services. (SCHIP is never retroactive except in instances of newborns.

Renewal Notices

Up to three renewal notices are sent out to the member household prior to the end of the twelve month eligibility period. The first notice is mailed on the 15th of the month prior to the last month of the certification period. If the form is not returned, a second notice is sent ten days later, and if the renewal form is still not returned, then the third and final notice is sent five days later. If the renewal is not returned participant is dropped from the program.

Previously, applicants simply checked a box stating whether or not their eligibility information has changed (income, address, age, etc.), update with any necessary changes, sign, and mail the form back to the Division of Medicaid. Once returned, applications were reviewed for qualification of benefits for another year and their benefits automatically rollover for the next cycle year.

Since the draft of this report has been issued, the Division of Medicaid now requires a face-to-face interview to determine eligibility on an annual basis.

Enroll/Cancel/Re-enrolling

Finding - *For enrollees who enroll in the SCHIP program, cancel service, and re-enroll again, there is no fast efficient way of admitting them back into the program. Participants have to fill out the application for enrollment each time they need to re-enter the program. This adds to the administrative demands and as a result increases administrative costs.*

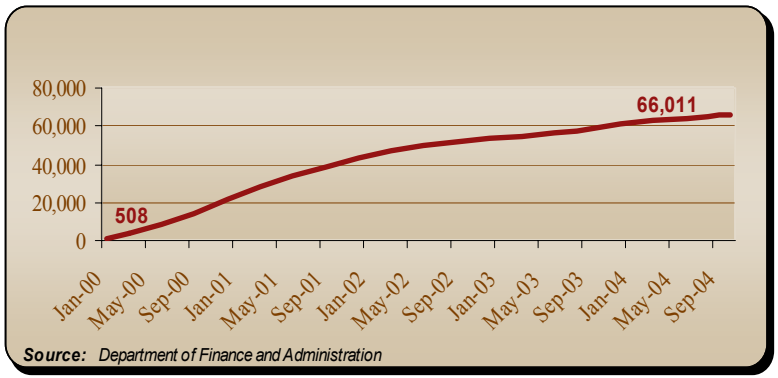
Recommendation - *To provide better customer service and keep administrative costs to a minimum, provide a more streamlined and efficient process for re-enrolling applicants within a year of canceling their service. Also, keep an electronic history of the participants information to assist in determining eligibility. This will also provide additional safeguards on fraudulent and/or duplicative enrollment of applicants.*

[5] The Catalog of Federal Domestic Assistance, 93.767 State Children's Insurance Program

Enrollment Trends

The chart below illustrates the enrollment growth trend in the Mississippi SCHIP program since its commencement in January 2000 through October 1, 2004. The total number of enrolled children has gone from 508 to 66,011.

SCHIP Enrollment January 2000 through October 1, 2004



Of the 66,011 enrolled in the program 3,000 are state employees' children. The chart below illustrates the percentage of state employee children enrolled in SCHIP.

Percentage of State Employee Children Enrolled Under SCHIP as of August 2004

Source: *Division of Medicaid*

Mississippi and North Carolina are the only two states that are authorized by the federal government to offer SCHIP to children of state and school employees, that authorization comes because the State and School Employees' Health Plan requires the employee to pay the full premium for family coverage.

Enrollment and Cost

The overall increased enrollment is the primary reason costs are on the rise. Mississippi needs to evaluate possibilities of lowering eligibility requirements and/or capping enrollment. However, this is something of a double–edged sword because the SCHIP statute and the fiscal relief measure which provides the Federal Match Funds for the State contain maintenance of effort requirements that can result in the loss of federal financial participation.[6]

[6] Shirk, Cindy, *Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP.* (Portland, ME: National Academy for State Health Policy), February 2004.

Demographic Characteristics

The next table displays the demographic characteristics of the children who were enrolled in the SCHIP program during the period January 2001 through December 2001. The male population equated for just over half (51%) of the enrollees. Two-thirds of the program enrollees (65%) live in families with household incomes less than 150% of the Federal Poverty Level. An additional 22% live in households where the income is between 151%-175%. Therefore, almost nine out of ten children (87%) in the enrollee population live in families where the reported incomes are less than 175% of the FPL.[7]

The average age of enrollees is 10.24 years of age, with the highest percentage (58%) being children between the ages of 6 and 14 years. About eight out of every ten (79%) enrolled children used the health care system; while 21% of the enrollees did not have a health care visit during their enrollment in 2001. This percentage varied by geographic region with some regions having as little as 3% of the enrollees who had not used health care services to a high of 26% in the Jackson region and 11% in the Coast region. [7]

Selected Demographic Characteristics of MS SCHIP Children January 2001 through December 2001

Characteristic	Enrollees (N-48,004)	
Child Gender	Number	Percentage
Male	24,481	51%
Female	23,523	49%
Household Income by FPL		
FPL up to 150%	31,336	65%
FPL 151% - 175%	10,633	22%
FPL 176% - 200%	6,035	13%

Characteristic	Enrollees	
Age Distribution	Number	Percentage
<1 year	174	<1%
1 to 5 years	8,911	18%
6 to 14 years	28,733	58%
15 to 19 years	11,454	23%
Mean Age	10.24 years of age	
Number of Months Enrolled in 2001		
3 months	9,867	21%
6 months	8,449	18%
9 months	10,791	22%
All 12 months	19,002	39%
Continuously Enrolled since 1/2000	1,111	2%
User of Health Care Services		
Yes	38,918	79%
No	10,284	21%
If a user of Health Care, identified as a Special Health Care Needs (CSHCN)		
Yes	5,392	11%
No	42,712	89%

Source: Quality of Care: Mississippi SCHIP. Final Report: April 2003

Using the claims and encounter data and a diagnostic list developed at the Institute for Child Health Policy to identify children with special health care needs, approximately 11% of those children who used health care services were identified as having special health needs (CSHCN). Approximately 4% of the children had a diagnosis of attention deficit hyperactivity disorder (ADHD) and another 5% had a diagnosis of asthma. In addition, there were 162 children (.5%) with a diagnosis of diabetes.[9]

[7] Shenkman, Elizabeth P., Wegener, Donna H., Quality of Care in the State Children's Health Insurance Program in Mississippi: *Institute for Child Health Policy*. April 2003.

Benefits under SCHIP include all the same benefits under the State and School Employees' High Option Health Insurance Plan as well as vision and hearing screenings, eyeglasses, hearing aids, immunizations, preventive dental care, routine dental fillings, restorative dental services, and residential mental health services. There are no exclusions for pre-existing conditions.

The benefits covered are inpatient, outpatient, surgical services, clinic services, prescription drugs (with some exclusions), mental health services, medically necessary durable medical equipment, home and community-based health care services, and nursing care services. Certain surgeries and inpatient hospitalizations require a precertification from the health plan. Medically necessary laboratory and radiological services are covered but some diagnostic tests require a precertification. The mental health component of the benefit package includes up to 30 days/year for inpatient psychiatric treatment, 60 days/year for partial hospitalizations, and 52 outpatient visits per year. Also included are vision, including eye exams and eyeglasses, dental benefits including preventive dental care and routine fillings were covered, as well as restoration and repair but no orthodontia.

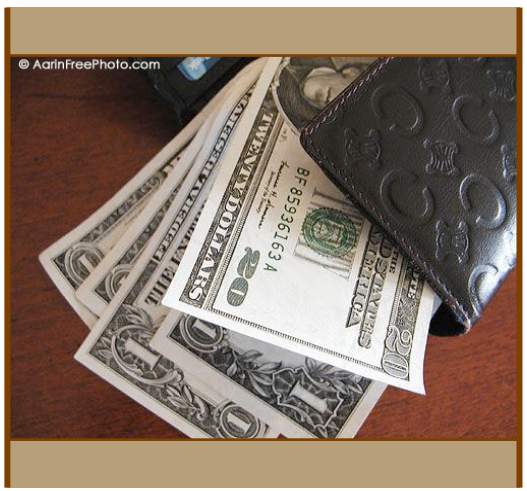
Covered Services

- Ambulance
- Anesthesia
- Ambulatory Surgical Facility
- Cardiac Rehabilitation
  - Outpatient
- Childhood Routine Immunization
- Chiropractic Services
- Dental
  - Preventive
  - Restoration
- Diabetes Self Management Training
- Durable Medical Equipment
- Emergency Room Visits
- Family Planning Services
- Female Health Services
- Free-Standing Diagnostic Facility
- Home Health Nursing Services
- Home Infusion Therapy
- Hospice
- Hospitalization
- Laboratory
- Maternity Attending Physician
- Maternity Hospital
- Medical Supplies
- Mental Health
  - Inpatient
  - Outpatient
  - Day Treatment
  - Partial Hospitalization
- Nurse Practitioner
- Occupational Therapy
- Optometric Services
- Organ Transplants
- Other Therapy Services
  - Radiation
  - Chemotherapy
  - Dialysis
  - Drug Infusion
- Physical Therapy
- Podiatry Services
- Prescription Drugs
- Private Duty Nursing Services
- Prosthetic and Orthotic Services
- Routine Hearing
- Skilled Nursing Services
- Speech Therapy
- Specified Routine Tests
- Substance Abuse
  - Inpatient
  - Outpatient
  - Intensified Outpatient Program
- Temporomandibular Joint
  - Disorder (TMJ)
- Vision Care
- Well-Child Care
- Well-Newborn Nursery Care
- Well-Child Physician Office Visits
- X-Rays

Cost Sharing Features

There are no premiums charged to eligible families and no cost-sharing requirements (deductibles, co-payments, etc.) for preventive services, including immunizations, well child care, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations and eyeglasses, and hearing aids. Illustrated below are the annual deductibles for SCHIP participants based on the family Federal Poverty Level.

There are no co-pays and no annual out-of-pocket maximums for participants below 150% of the FPL, or for children who are of American Indian/Alaskan Native descent with family incomes less than 200% FPL. Other eligible families with incomes above 150% of the FPL are responsible for a minimal co-payment of $5 for Outpatient Health Care Professional Visit and $15 for an Emergency Room visit. There are annual out-of-pocket maximums of $800 for families at 151% to 175% of FPL and $950 for families at 176% to 200% of FPL. Furthermore, once the family's co-payment amounts total to the out-of-pocket maximum, the family will no longer be required to pay co-payments for the remainder of the benefit period.



Annual out-of-pocket Maximums by FPL

	Federal Poverty Level Rate		
	<150%	151%-175%	176%-200%
Lifetime Maximum Benefits	No Limit	No Limit	No Limit
Family Calendar Year Maximum	-0-	$800	$950
Individual Calendar Year Maximum	-0-	$800	$950

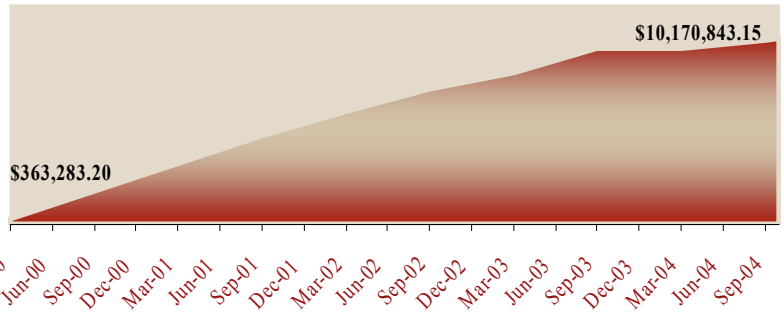
Co-payments per Visit by FPL

	Federal Poverty Level Rate	
	<150%	151%-200%
Outpatient Physician		
In-Network	-0-	$5
Out-of-Network	Not Covered	Not Covered
Emergency Room		
In-Network	-0-	$15
Out-of-Network	-0-	$15

Quarterly Trends in Premium Costs

Premiums paid for SCHIP from January 2000 through October 1, 2004 total $360,024,642.92. The chart below illustrates the elevated costs in premium charges as enrollment continues to grow under the SCHIP Program. DOM projects enrollment to only increase by 10% over the next year.[8]

Premium Trends from March 2000 through October 2004



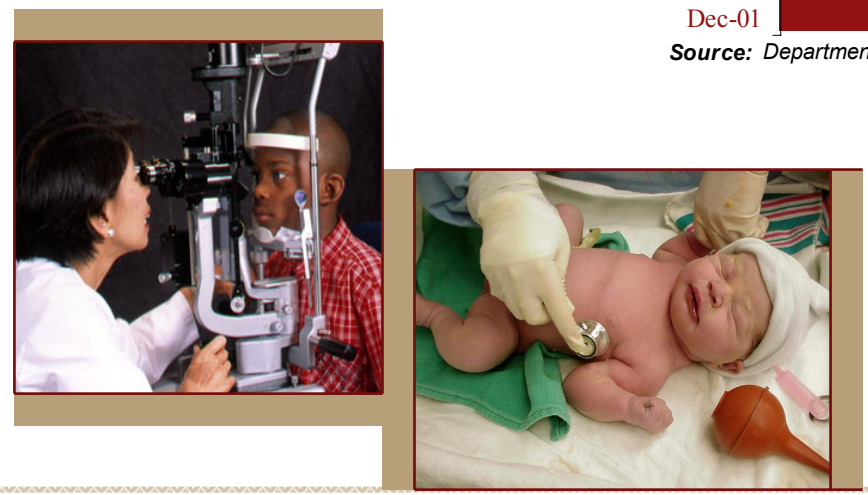
Source: *Department of Finance and Administration*

The SCHIP premium is projected based on incurred medical claims and the resulting claim liability as well as adjustments for prior periods. The premium decrease in 2003 was the result of these factors. This is the third time premiums have decreased upon premium renewal. The fluctuations in premiums at renewal have moderated as enrollment in the program has grown.[9]

The next illustration displays the change in the premium year over year per participant. (The table starts with December 2001 because there were three slightly different premiums each period before that date based on the number of children in the program.)

Individual Premium Rates per Month from December 2001 through October 2004

Source: *Department of Finance and Administration*



[8] The 10% increase in enrollment was an estimated figure provided by the Department of Medicaid
[9] Department of Finance and Administration. Personal Interview. 01 Sep. 2004.

RFP & Contract Bid

DFA Insurance, on behalf of the Health Insurance Management Board and with the approval of the Division of Medicaid, issued the Request for Proposal (RFP) for the provision of insurance services for SCHIP. Blue Cross Blue Shield's (BCBS) proposal was selected as the lowest and best through the competitive bid process. This four year contract became effective January 1, 2000 and has the option to run another year, making the contract expire December 31, 2004. On June 22, 2004 the Health Insurance Management Board, through another competitive bid process, selected BCBS of Mississippi for contract negotiations for the next four years beginning January 1, 2005.

The decisions regarding insurance coverage for children in SCHIP are determined at various levels and all state contract requirements are outlined in the RFP. The following are determining factors when determining SCHIP contractual coverage:[12]

- *Federal law and regulations governing SCHIP contain certain requirements regarding coverage, such as which benchmarks are acceptable and how much benefits can vary from the benchmark selected.*
- *The State Plan amendment submitted by the Division of Medicaid and approved by CMS contains an outline of benefits.*
- *State law governing SCHIP contains requirements related to benefits (e.g. §41-86-17) and authorized the Children's Health Insurance Program Commission to establish benefits for the initial program (§41-86-9).*
- *Within the limits outlined in federal law and regulations, the approved State Plan Amendment, and State law, the Health Insurance Management Board, acting administratively through the Department of Finance and Administration, can make decisions regarding benefits and other provisions contained in the insurance policy/contract.*
- *Because the children enrolled in SCHIP are insured through a fully insured arrangement, the insurance company providing coverage makes certain decisions such as determination of medical necessity or prior authorization requirements.*

[10] Department of Finance and Administration. "Questions Regarding SCHIP". Email to the department. 18 Oct. 2004.

Contract Elements Worth Noting

The state is exempt from standard contract rules with BCBS. However, the terms and conditions are adhered to as a courtesy. The contract includes a 90 day out clause, and the contract terms can be changed and modified at anytime during the four year agreement. If funding for the program becomes an issue there is a clause allowing the state to withdraw from the contract with no penalty.

> *"This agreement is subject to annual legislative funding. Failure to appropriate funds necessary to operate the Plan shall constitute grounds for the termination of this agreement. However, in the event of a reduction in legislative funding, the parties will promptly confer to determine the feasibility of Agreement modifications or other measures to permit the continued operation, or if necessary, termination of this Agreement without damage or penalty."* [11]

The contractual rates are not tied to the number of children enrolled in the program, but is based on the actual claims paid within a period. Therefore, adding participants to the program will not reduce premium costs, but will most likely increase them through greater utilization of services and escalating the overall cost in claims. Premiums are adjusted every six months to recover any gain or loss by either the state or BCBS. Blue Cross Blue Shield, through the bid process, generates a profit from the administrative costs for handling claims and providing customer service to the program participants and state agencies.

When changes to the benefits program are made DFA, DOM, and the Health Insurance Management Board are all involved in making changes/modifications in benefits, but may also involve the Legislature, the insurer, providers, advocates, the consultants, and other interested parties as appropriate.[12]

Premium Payment Process

DOM pays the premiums on each eligible child enrolled in the program. The program is a fully insured plan versus a self-insured plan like the State and School Employees Health Insurance Plan. For the fully insured plan, the insurer (BCBS) collects premiums which have been set in the anticipation the premiums will be adequate to cover costs. The risk is with the insurer. If the costs aren't covered a true-up will occur in the premium renewal and reconciliation process and rates will increase, or vise versa.

Every six months an actuary for BCBS reviews the claims data and prepares an analysis to set a premium for SCHIP. Once this is prepared, the report goes to DFA Insurance where an actuary for DFA Insurance reviews the premium. DFA Insurance then prepares a letter to DOM informing them of the change in premium.[13]

Verification of Claims Costs

DFA Insurance personnel receive reports from BCBS related to SCHIP. The reports contain information such as enrollment and utilization by category of service. The reports are reviewed for obvious errors and further reviewed for "red flags" such as large jumps in a category of service. DFA insurance also compares the claims data for SCHIP to the claims information for the children on the State Employees Health Insurance Plan to determine if the claims amounts' seem reasonable.[14]

Complaints & Grievances

Complaints from providers or participants in SCHIP initially go through BCBS. Those that do not get resolved there usually go to the DOM SCHIP personnel. Some of the calls are then referred to DFA Insurance.

[11] Contract between Blue Cross Blue Shield of Mississippi and the Mississippi Health Insurance Management Board for the Children's Health Insurance Program. December 1, 1999.
[12] Department of Finance and Administration. "Questions Regarding SCHIP". Email to the department. 19 Oct. 2004.
[13] Department of Finance and Administration. Personal Interview. 01 Sep. 2004.
[14] Department of Finance and Administration. Personal Interview. 01 Sep. 2004.

Federal Allotments

The program is primarily funded through the federal government at 83.6%, with a required state match of 16.4%. Title XXI provides for an "enhanced Federal Matching Assistance Percentage (FMAP)" for child health care under Title XXI. Allotments are determined in accordance with the statutory formula that is based on two factors. These factors are multiplied to yield a final allotment product for each State.

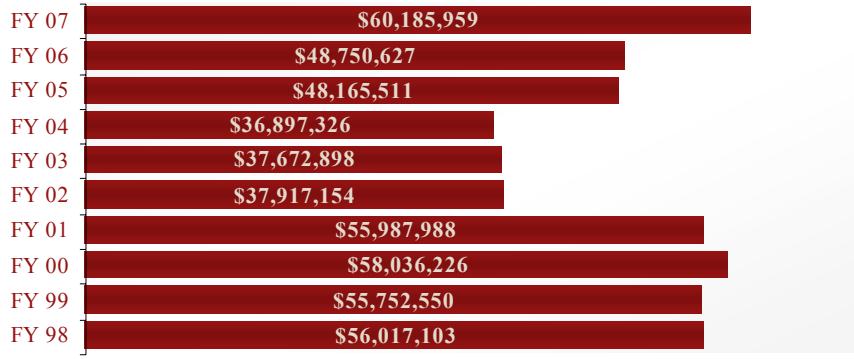
1. *Number of children (those potentially eligible for SCHIP) - based on 50% of the low-income uninsured children in the state and 50% of the number of low-income children in the state.*

2. *The State cost factor – is a geographic cost factor that is based on annual wages in the health care industry for each state.*

Mississippi's allotments began to decrease in the fiscal year 2002 (FY 2002). The state also received redistributions of unspent allotments from other states totaling $74,189,023 and we just received another redistribution totaling $35,539,271 on January 19, 2005. Since receiving this new allotment the state was able to cover its FY05 deficit of $19,495,225 and to carryover $14,607,573 to FY06. By law the state has three years to spend each year's SCHIP funds. The state will begin using the FY 2004 allotments that should last through March 2005. Once these funds are spent the allotments for FY 2005 will be used.[15]

The next chart defines the federal allotment schedule for Mississippi since SCHIP's commencement in 1998 through fiscal year 2007. The total amount of the State's federal allotments for this ten year period totals $495,383,342.[16]

Mississippi's Federal Allotment Schedule
Fiscal Year 1998 through Fiscal Year 2007



Source: Office of the Governor

Sources of State Match Funding

In reviewing the Health Care Trust Expenditures for the SCHIP program, there is no way to determine the exact sources of State match funding for the program. All funds are taken from a general fund used for all Medicaid funding. It is understood that some of the State match funding is provided through the States Tobacco Fund money, but there are other contributing sources as well. Therefore, it is difficult to determine all of the exact funding sources in this limited review.

The Agency Audit Division within OSA did determine, after reviewing the SCHIP expenditures, that SCHIP did have sufficient expenditures, which were eligible to be paid for with tobacco funds, to make the transfer necessary to cover the costs for the program (transfer made on January 13, 2004 in the amount of $15.5 million).

[15] Division of Medicaid. "SCHIP Questions". 15 October 2004.
[16] Office of the Governor: "SCHIP Dip" and 10- year Revenue and Cost Projection Survey. October 2004.

"The only viable way that Mississippi will be able to continue providing health insurance coverage to eligible children is with adequate federal funding, and changes to the funding formulas for allotments and redistributions are critical to this outcome."

SCHIP Administrator

Historical Budget Analysis

The total costs of the approved SCHIP plan for the same ten year period shows a total of $733,718,693 in Federal funds and $143,840,054 for the state match. This shows an overall estimated expense of $877,558,747 for SCHIP or an average of $87,755,874.70 per year in overall expenses.[17]

Total Costs of Approved SCHIP Plan Fiscal Year 1998 through 2007

Fiscal Year	Federal Share	State Share
1998	-0-	-0-
1999	$8,092,064	$1,570,102
2000	$21,086,359	$4,088,377
2001	$48,998,466	$9,493,197
2002	$69,735,044	$14,020,714
2003	$88,690,910	$17,360,639
2004	$101,196,402	$19,808,503
2005	$119,613,126	$23,413,451
2006	$131,574,439	$25,754,796
2007	$144,731,883	$28,330,275

Source: Office of the Governor

Sources of Non-Federal Funding

The Centers for Medicaid and Medicare assist in identifying ways for states to come up with non-federal funding for their SCHIP programs. States are able to use such resources as local and county funding, foundation grants, and private donations such as United Way, the Diabetes Foundation, and other sponsorship as means for raising funding for SCHIP. The only restrictions on financing state match funds are that the states cannot use any federal funds, provider taxes, or cost sharing with enrollees.

[17] Source: Office of the Governor: "SCHIP Dip" and 10- year Revenue and Cost Projection Survey.

Rockefeller-Smith Bill S.2671

On July 1, 2004, the federal government dropped the federal match rate for Medicaid spending, putting many states in an even worse economic position. Because many states are currently faced with financial hardships in financing their Medicaid and SCHIP programs the Rockefeller-Smith State Relief Act of 2004 (S.2671) was introduced on July 15, 2004 but was never passed. This bill would have provided states with an additional 15 months of fiscal relief to allow for recovery in budget deficits, and would have provided the state of Mississippi with an additional $100 million dollars for its Medicaid programs.

Mississippi is facing in excess of $152 million dollar deficit over the next three fiscal years to fund its SCHIP program. The Governor's Office is still pushing for this or a similar bill to be passed on Capitol Hill for financial relief. The chart below outlines the approved costs, federal allotments, and state match to determine the funding shortfalls for FY2006 and FY2007.[18]

SCHIP Deficit Projections as of October 2004

	Total Costs of Approved SCHIP Plan	Federally Funded Share	State Funded Share	Additional Amount Needed to Fund Projected Enrollment
FY2005	$143,026,577	$134,220,699	$23,413,451	$0
FY2006	$157,329,235	$63,358,200	$25,754,796	$68,216,239
FY2007	$173,062,158	$60,185,959	$28,330,275	$84,545,924
			Three Year Total:	**$152,762,163**

Source: The Division of Medicaid

Finding - The Division of Medicaid has not been given any directive to look into finding more state match funds through other sources such as United Way, foundation grants, or other sources allowed under federal law. Furthermore, there is no plan in place for future funding should federal allotments begin to dissipate; there has been no directive to formulate a plan to set aside funds for unforeseen circumstances that would effect the program's operation. Mississippi cannot sustain the current number of enrollees in the SCHIP program without relying on redistribution of funds from other states. If the funding dependency continues, the State would have to cap enrollment and decrease the federal poverty level rate to reduce the current number of eligible participants or raise additional revenue through tax increases.

Mississippi cannot sustain the current number of enrollees in the SCHIP program without the dependency of the redistribution of funds from other states and federal fiscal relief. In fact, comparing the deficit to the average past redistributions the program cannot be sustained even with the additional redistributions the Division of Medicaid expects. Other states are being more judicious about their funds, and are quoted as saying they will no longer let their allotments expire and be redistributed.

Recommendation - It is crucial that Mississippi's dependence on redisbursements from other States for funding the SCHIP program stop and a plan be created to fund this program for both the short-term and long-term. If the funding dependency continues in its current path the state would have to cap enrollment and lower the Federal Poverty Level rate to cut current eligible participants or increase revenue through significant tax increases.

The Governor's Office should direct the Division of Medicaid to have a short-term and a long-term plan to deal with loss regardless of any potential of redistributed funds.

[18] Source: The Division of Medicaid: "SCHIP Dip" and 10- year Revenue and Cost Projection Survey.

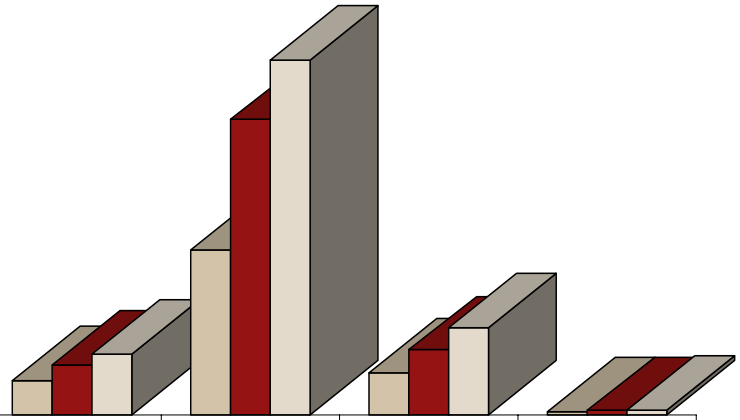
Paid Claims History

Since overall costs to the SCHIP program is determined by the usage of services a history of paid claims information was obtained to determine what services are being utilized the most. Understanding the claims history allows the Office of the State Auditor to make recommendations for cost saving measures. Below are the total claims paid for all provided services per fiscal year.

Fiscal Year	Paid Claims
2002	$55,600,963
2003	$78,844,198
2004	$99,147,642

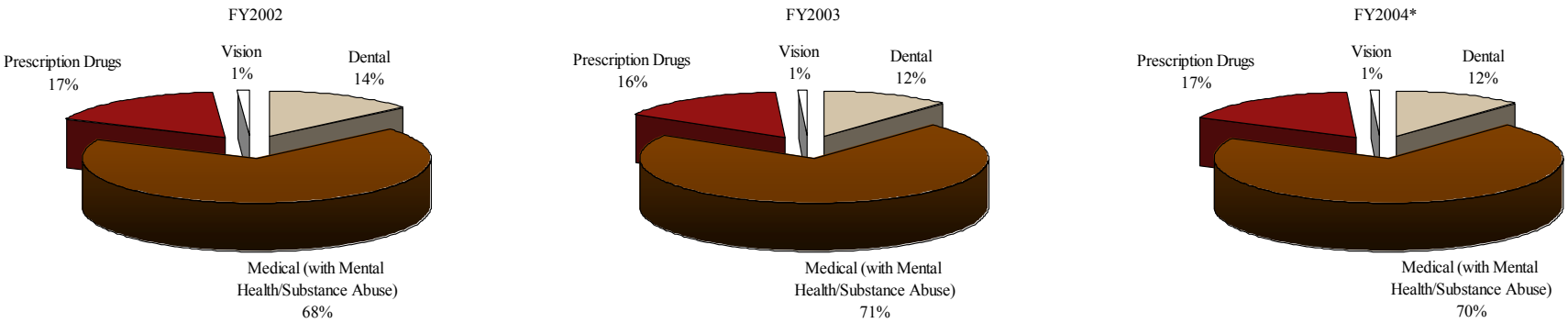
The paid claims from FY2002 to FY2004 has risen by 73%. The next chart illustrates the amounts by claim type for the same fiscal years. The amounts for Medical, Mental Health, and Substance Abuse have been combined for all three fiscal periods because these amounts were not recorded separately for FY2002.

Total Paid Claims Cost by Service for FY2002 through FY2004



	Dental	Medical (with Mental Health/Substance Abuse)	Prescription Drugs	Vision
Paid FY2002	$7,658,545.00	$37,754,537.00	$9,543,164.81	$644,716.00
Paid FY2003	$11,377,691.00	$67,466,507.17	$14,661,274.47	$755,586.76
Paid FY2004 *	$13,779,774.30	$81,273,468.80	$19,687,008.66	$944,399.21

Total Percentage of Paid Claims by Service

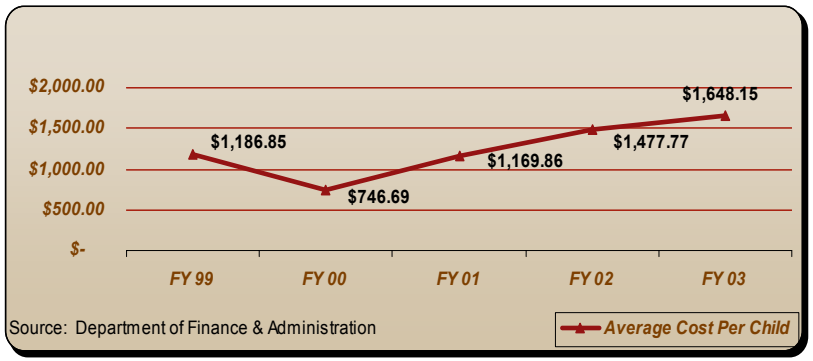


*FY2004 data is approximately 96% complete.
Source: Department of Finance & Administration

Annual Cost per Mississippi Participant

The average cost per SCHIP enrollee has risen significantly since the programs start in 2000. The cost per enrollee has risen 39% since the fiscal year 1999, and has risen 120% since its lowest point in fiscal year 2000.[19] In fiscal year 2003 the cost per enrollee amounted to $1,648. The chart below displays the growth in participant cost year over year.

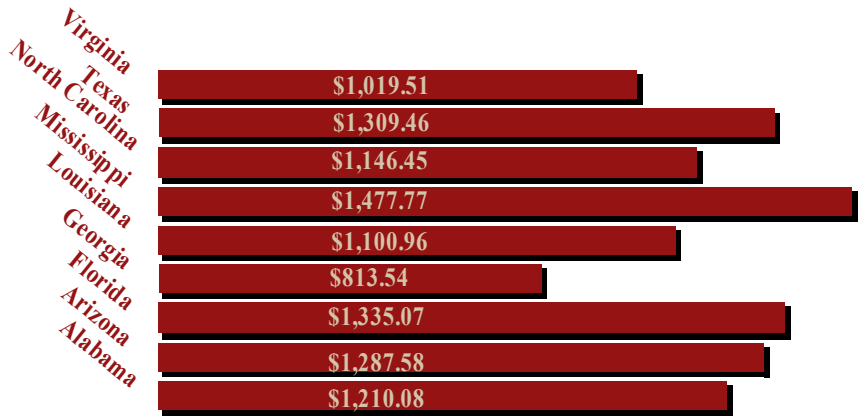
SCHIP per Participant Cost FY1999 through FY2003



Annual Cost Comparison with Other States

Looking at other states of similar size it was determined that as of the FY2002, Mississippi's per child cost for SCHIP was 25% higher than the average ($1,178) of the other states in our comparison. The table below illustrates the costs per child by state for the FY 2002.[20]

State Comparison of SCHIP per Participant Cost FY2002



Source: Centers for Medicare and Medicaid

States Program Variables Impacting Costs

It must be known that each state program is unique, offering different variables to the SCHIP program. The competitive health insurance markets in each state play a major factor in overall medical costs. Mississippi's health insurance coverage is more expensive than in other states because of high rates of diabetes, obesity (highest in the nation), ADHD, and overall "poor" health of Mississippians.

[19] Cost per enrollee was figured using the total costs of approved SCHIP plan divided by the number of enrollees at the end of each fiscal year.
[20] Centers for Medicaid and Medicare: Total SCHIP Costs for FY 02 divided by the total number of enrollees by state as of the end 4th Qtr FY 02.

Reducing Claims Costs

Under the current insurer contract structure the only way to reduce premium costs per enrollee would be to reduce the benefits coverage in areas that are being utilized. Regardless of the type of health benefits coverage provided by a state, coverage must be provided for well-baby and well-child care, age-appropriate immunizations, and emergency services. If the State were to change to benchmark equivalent coverage, certain rules would apply:

- The coverage must be actuarially equivalent to coverage under one of the benchmark packages described in the regulations.
- The coverage must include inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services' and may include other services.
- If the benchmark package includes prescription drugs, mental health, vision or hearing services then the value of the coverage for each of these services in the package offered by the State must equal at least 75% of the value of these services under the benchmark.

In summary, the State could reduce benefits under SCHIP as long as the benefit package met the minimum requirements under the regulations and was approved by CMS.

Finding - *The State of Mississippi has provided qualified children with the best possible all-inclusive healthcare coverage available at little or no cost. However, the costs to the State must be examined and options to reduce costs should be considered. The benefits under the SCHIP plan can be reduced to meet benchmark coverage to lower program costs, without compromising the basic healthcare of its participants.*

Recommendation - *The Office of the Governor should direct the Division of Medicaid to prepare a cost analysis of SCHIP premiums if coverage were reduced to benchmark levels to determine potential cost savings.*

State and School Employee's Health Insurance Plan

SCHIP has been somewhat controversial from its inception. The idea of free or nearly free health care for some children while other parents must pay for health care for their children, even though both families' incomes are similar, doesn't seem quite fair to some of SCHIP's detractors. As a DOM representative stated, *"one can be a dollar in or out of the program."*

One particular group where this possible disparity becomes evident is State employees. SCHIP is based on the State and School Employee's High Option Insurance Plan but SCHIP has many extra benefits that the State and School Employee's Insurance Plan does not have, including Dental, Vision, and Residential Mental Health Services. State employees making over 200% of the FPL have the "double-whammy" of having to not only pay relatively high premiums to insure their children but also receiving poorer insurance to SCHIP.

There are two coverage options for state employees under the State and School Employee's Health Insurance Plan for children; a Basic Plan, and a High Option Coverage Plan.[21] There is an additional premium for the High Option Coverage each month. This high option provides coverage for well-newborn nursery care and well-child physician office visits at 100%, which is also covered by SCHIP with no additional premium. Most other services are paid on an 80/20 percent cost-sharing split.

It should be noted that state employees don't pay for their own insurance, but they do pay 100% for child coverage. As such, the following chart shows the amount an active State employee pays out-of-pocket for insurance for their child on a monthly basis. (The "1 Child + High Option" is the plan being compared with SCHIP.)

State and School Employee Health Insurance Out-of-Pocket Premiums for Children

Number of Children	Monthly Rate	Annual Deductible (In-Network)	Annual Out-of-Pocket Maximum
1 Child	$105	$450	$2000
Children	$210	$450	$2000
1 Child + High Option[22]	$125	$450	$2000
Children + High Option	$230	$450	$2000

[21] Benefit option used as the Benchmark for the state Children's Health Insurance Program.

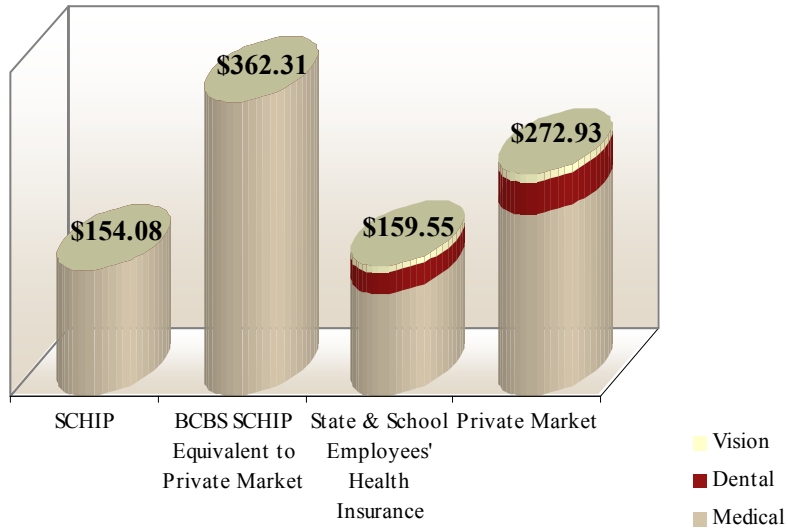
Private Market Insurance Costs for Children

The Performance Audit Division, as part of this analysis, obtained a comparative premium price quote from BCBS of Mississippi for an insurance plan identical to that of SCHIP. Blue Cross Blue Shield of Mississippi's actuarial staff has determined that if such a benefit would be offered in the individual private market the average cost per contract would be $362.31 per individual per month. In addition, the $362.31 price is for a healthy individual and rates for less healthy individuals could be substantially more.

Through other research with insurance companies' nationally, it was determined that there is no comparable health plan available that is equal in benefits and cost-sharing as that of SCHIP. Mississippi insurers only offer two health care plans to the private market. One is the *Blue Care* product managed by BCBS, and the other is offered by Golden Rule (a subsidiary to United Health Care). On average, most health insurance plans offer an 80/20 percent split for in-network benefits with varying degrees of annual deductibles. In order to do an equal comparison, rates for dental and vision should be added to the health plan rates. However, these health plans still do not measure up to the cost-sharing benefits when compared with SCHIP.

Several vendors were contacted to provide rates on dental and vision plans in order to compare the "complete" package of health care as provided under the SCHIP program. The following chart shows the monthly premium rate comparisons between SCHIP, Blue Cross Blue Shield of MS Private Market "SCHIP" equivalent, State and School Employees' Health Plan[22], and a "comparable" plan on the private market for children up to age 19.[23] It should be noted that 100% (no state subsidy) of the cost is borne by the private individual who is not eligible for SCHIP.

Health Insurance Premium Rate Comparison for Children



[22] Because rates for Dental and Vision under the State and School Employees' Health Plan vary by department and agency, OSA took the average costs for similar plans from DFA, MHS, and OSA to determine an average cost.
[23] In order to provide an average market cost of health plan premium rates in the private market, OSA took the average of the two available health plans (*Blue Care* BCBS & Golden Rule), plus the amounts quoted for dental and vision to determine an overall SCHIP "equivalent" plan. (Health coverage does not provide 100%, but on average an 80/20 percent split.)

Response to *Analysis of CHIP Experience Report*

A report was issued by the Department of Finance and Administration's consulting actuary on August 20, 2003 to document some of the analysis of the MEDSTAT system data and to report on certain key findings. In this report the actuary looked at data from CY2001 and FY2002 for both the SCHIP and State and School Employee health plans to compare claims cost per member age 0-18.

The report shows that there is a potential cost savings to SCHIP when comparing the *"Allowed Charges"*[24] and the *"Submitted Charges"*[25] for the services under the plan. There are ten (10) suppliers that are receiving 100% or close to 100% of the total amount they are billing to the insurance provider. Because the usages of many of these services are relatively high they affect the overall premium expenses per child for the state.

The next chart shows that the State is only achieving a savings of $7,443 per year for services provided by these suppliers. The FY2002 total for all services for *Submitted Charges* was $16,445,609 and the *Allowed Charges* were $12,725,777 showing a grand total savings of $3,719,832.

Claims Savings for FY2002

Service Supplier	Submitted Charges	Allowed Charges	Variance
Nurse Practitioner	$1,224,324	$1,224,261	$63
Therapy (Physical)	$290,727	$290,722	$5
Psychologist	$401,437	$401,313	$124
Therapists (Supportive)	$514,692	$514,692	$0
Dentist MD & DDS (NEC)	$79,085	$71,834	$7,251
Podiatry	$146,833	$146,833	$0
Anesthesiology	$121,913	$121,913	$0
Mental Health Facilities	$17,833	$17,833	$0
Optometrist	$38,440	$38,440	$0
Midwife	$11,265	$11,265	$0
Totals:	**$2,846,549**	**$2,839,106**	**$7,443**

Finding - *Certain suppliers under the SCHIP contract are not providing adequate discounts for services rendered to SCHIP participants.*

Recommendation – *HIMB needs to push BCBS to negotiate improved "allowed charges" for these services with the provider for the next contract period which begins January 1, 2005. This will assist in the decrease of overall claims costs for these services which can reduce overall premiums.*

[24] Allowed Charges are charges agreed to by the supplier and the insurance provider for a particular service.
[25] Submitted Charges are the charges submitted to the insurance provider for a particular service, regardless of the agreed amount.

Overview of Other State Programs

The current year has brought the hardest financial hardship that states have faced in the history of the Medicaid program. Medicaid cost containment measures have been implemented by every state and the District of Columbia in 2003 and additional steps are planned in 2005. Gannett News Services performed a recent investigation and found that 22 states have implemented eligibility and other restrictions in their SCHIP programs during the last year and a half, with more cuts possible for 2005. States are projecting additional Medicaid budget deficits in the neighborhood of over $70 billion in 2004 for all populations. SCHIP is a smaller program than Medicaid, yet its reach and influence has been broad. Currently 37 states operate at least a portion of SCHIP through the separate program option.[26]

As of October 2004 each state has varying levels of eligibility for children qualified under the Children's Health Care Insurance Program ranging from 100% through 300% of the Federal Poverty Level. Every state also has a unique cost-sharing structure that ranges from $0-$113 for monthly premiums, and $0-$25 for visit copays. Appendices 4 displays the eligibility levels and cost-sharing for Medicaid and SCHIP for each state as of August 2004.

Fast Facts[27]

* *10 States have set SCHIP eligibility below 200% of the FPL.*
* *28 States have set SCHIP eligibility at 200% of the FPL.*
* *13 States have set SCHIP eligibility level above 200% of the FPL.*
* *Of the 35 States with Separate SCHIP Programs (16 States with only a separate SCHIP Program and 19 States with combination programs)*
* *24 States require a monthly premium or an annual premium/enrollment fee.*

The next several pages provide a few sample cases from other states whose SCHIP plans similar to that of the state of Mississippi. We reviewed Arkansas, Georgia, Texas, and Virginia to determine success and failures in the programs eligibility requirements, cost-sharing requirements, program benefits, cost-cutting measures, and overall management of the program. Comparing these elements will assist in determining the overall success and pitfalls of the SCHIP program in Mississippi.

[26] Shirk, Cindy, *Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP.* (Portland, ME: National Academy for State Health Policy), February 2004.
[27] National Academy for State Health Policy. "Fast Facts". October 2004 <http://www.nashp.org/_catdisp_page.cfm?LID=2A78988C-5310-11D6-BCF000A0CC558925>.

Arkansas - ARKids 1st Program

ARKids 1st is the SCHIP funded program designed by the state of Arkansas. This program enrolls eligible children up to age 19 with family incomes less than 200% of the FPL. The overall program is very similar to that of Mississippi's, providing basic health care, as well as vision and dental insurance. There are similar co-pays for services ranging from $5 per prescription drug, and $10 for each outpatient, emergency room, ambulance, eye care, or dental visit. There is no monthly premium charged to the participant.

The Arkansas Division of Legislative Audit performed a review of their ARKids program in April 2002. In this audit they evaluated the following:

- The success Arkansas DHS has had in enrolling previously uninsured children in the program;
- The success of program's efforts in monitoring eligibility;
- The effectiveness of the program's efforts in ensuring access to medical services;
- The State's compliance with Medicaid authority necessary to continue the program; and
- A Comparison and contrast of the Arkansas program to similar programs in other states.

They concluded that the Arkansas DHS *"has done an excellent job in providing health insurance to the uninsured children in the state whose total household income is less than 200% of the FPL… However, the following areas of weakness were noted:*

Elimination of Co-pays

Finding *– "Required co-pays are perhaps the largest disadvantage to the program. Co-pays for medical services range from $5-$10. Hospital stays require a 20% co-pay for charges incurred during the first day.*

Recommendation *- Consider eliminating or restructuring this part of the program."*[28]

[28] State of Arkansas. Arkansas Division of Legislative Audit, Performance Audit. ARKids 1st Department of Human Services. Arkansas: 11 Apr. 2002.

Georgia - PeachCare Program

Georgia's PeachCare currently insures around 199,000 children up to the age of 18 years old. The *Atlanta Journal-Constitution* reported that the PeachCare program could face a $63 million deficit by June 2004 if it does not receive any additional funds or cap enrollment. The state's share of the deficit is $18 million. The Georgia General Assembly appropriated $214.2 million for PeachCare in 2004, but the program will cost $277.2 million to operate by June 2004.[29]

Eligibility and Cost Sharing

Eligible families have children under the age of 18 years old with household incomes less than 235% of the FPL. PeachCare for Kids pays for preventive services and acute medical care, as well as vision and dental. There is no cost for children under age 5 years. Starting at age 6, premiums are $10 per child/max $20 per household per month. Households below 150% of FPL pay $15 and households between 151%-235% of FPL pay $20 per month. There are no co-pays or deductibles. However, children must be uninsured for three months before applying (there are exceptions for children who have involuntary lost coverage).[30]

Plan Benefits

PeachCare provides qualified applicants with services such as hospital care, prescription drugs, emergency services, hospitalization, mental health care, vision, dental, and regular health check-ups and immunizations.

Rhode Island – RIteShare & RIteCare

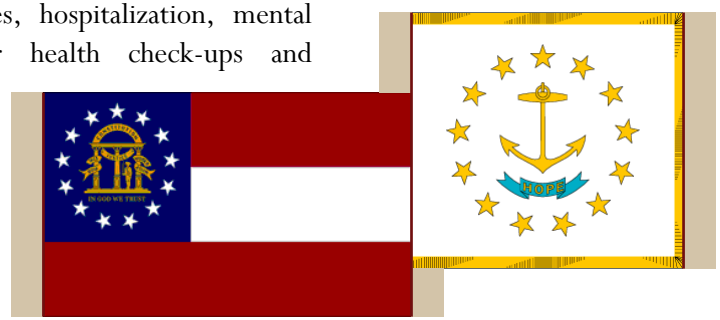
There are two inter-linked programs in Rhode Island that assist low-middle class families obtain health insurance coverage; these are known as "RIteCare" and "RIteShare". Rhode Island exercised their option to expand upon an existing program using their SCHIP funds from the federal government.

RIteCare

RIteCare is a managed care program that provides eligible uninsured children up to age 19, as well as pregnant women, and parents with comprehensive health insurance coverage up to 250% of the Federal Poverty Level (FPL). Families receive their health care through one of three participating health plans: Neighborhood Health Plan of Rhode Island, United HealthCare of New England and Blue SCHIP of Blue Cross Blue Shield.

RIteShare

RIteShare is a premium assistance program that helps families get health insurance coverage through their employer (or spouse's employer). If a family qualifies, RIteShare will pay for all or part of the employee's share of the health insurance premium. RIteShare also pays for co-payments in the employer's health insurance plan.[31]



[29] Daily Health Report. Coverage & Access: Georgia's CHIP Program Faces $63M Deficit, Enrollment Could be Capped. 08 Aug. 2003. Oct. 2004. <http://www.kaisernetwork.org/daily_report/rep_index.dfm?DR_ID=19277>.

[30] Children's Defense Fund: Leave no Child Left Behind. Georgia PeachCare for Kids. Oct. 2004. < http://www.childrensdefense.org/childhealth/chip/signthemup/states/georgia.asp>.

[31] Rhode Island DHS. RIteCare: Rhode Island's Medicaid Managed Care Program & RIteShare: Health Insurance Premium Assistance Program. 13 Oct. 2004. <http://www.dhs.state.ri.us/dhs/famchild/shcare.htm>.

Rhode Island – RIteShare & RIteCare

Eligibility

- Families with children – with annual family income up to 185% of the Federal Poverty Level.
- Children (up to age 19) – with annual family income up to 200% of the Federal Poverty Level.
- Pregnant Women – with annual family income up to 250% of the Federal Poverty Level.[32]

Cost Sharing for RIteCare & RIteShare

- Families with incomes up to 150% of the FPL receive RIteCare or RIteShare at no cost.
- Families with incomes between 150% and 250% of the FPL pay a monthly premium (for either RIteCare or RIteShare of $61, $77, or $92 per month, depending on their income.

Plan Benefits

This list includes both in-plan benefits (through a health plan) and out-of-plan benefits (through Medicaid fee-for-service, also called Medical Assistance).

- Doctor's office visits
- Immunizations
- Prescriptions
- Lab tests
- Prenatal Care
- Mental Health Services
- Drug or Alcohol treatment
- Referral to specialists
- Hospital care
- Emergency care
- Skilled nursing care
- Family Planning services
- Nutrition services
- Interpreter services
- Childbirth Education programs
- Parenting classes
- Smoking cessation programs
- Transportation services
- Dental care

Texas – TexCare Program

The Texas version of SCHIP has several similarities to Mississippi's SCHIP benefit program. With 355,528 children enrolled in the program as of September 2004, it is one of the largest programs in the country. TexCare provides qualified applicants up to 200% of the FPL with services such as hospital care, surgery, x-rays, physical/speech/occupational therapies, prescription drugs, emergency services, transplants, and regular health check-ups and immunizations. A few notable differences are 1) applicants pay a monthly premium, based on their FPL rate, ranging from $0-$25 per month per family; 2) cost-sharing is involved at all levels of qualified applicants up to the federal allowed maximum as seen in the table below.[33]

Texas Cost Sharing Levels by FPL

	Federal Poverty Level Rate			
Benefit Coverage	*100% or Below*	*101%-150%*	*151%-185%*	*186%-200%*
Monthly Premium per Family	-0-	$15	$20	$25
Office Visit	$3	$5	$7	$10
Emergency Room Visit	$3	$5	$25	$50
Generic Drug	-0-	-0-	$5	$5
Brand Drug	$3	$5	$20	$20
Co-pay Cap (based on family income)	1.25%	1.25%	2.50%	2.50%
Facility Co-pay, Inpatient (Per Admission)	$10	$25	$50	$100

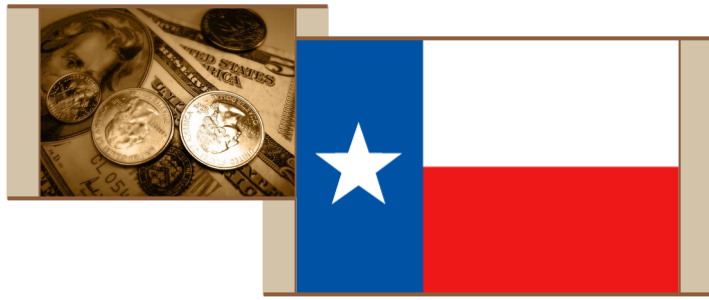
Source:http://www.texcarepartnership.com/CHIP-CHIP-Montly-Premiums-Frame.htm

[32] Rhode Island DHS. RIteCare: Rhode Island's Medicaid Managed Care Program & RIteShare: Health Insurance Premium Assistance Program. 13 Oct. 2004. <http://www.dhs.state.ri.us/dhs/famchild/shcare.htm>.
[33] Texas Health and Human Services Commission. CHIP Monthly Premiums Table. 13 Oct. 2004. <http://www.texcarepartnership.com/CHIP-CHIP-Montly-Premiums-Frame.htm>.

Texas – TexCare Program

Recently, the Texas Health and Human Services Commission (HHSC) have made the following changes to its program in an initiative to cut costs:[34]

- *Beginning October 1, 2003, families enrolling in SCHIP for the first time, or re-enrolling because of a time lapse in coverage, will have a three-month waiting period before benefits can be used.*
- *Beginning November 1, 2004, HHSC will temporarily suspend collection of monthly premiums for all SCHIP-enrolled families.*
- *For new SCHIP enrollees, HHSC will continue to require families to pay their initial premium to enroll their children. This directive was issued on August 11, 2004 to further delay implementation of the disenrollment deadline for families who have missed three or more monthly premium payments and to explore the development of alternative premiums or incentives to ensure qualified families have access to SCHIP benefits.*
- *As of September 11, 2003, the 78th Legislature, Regular Session, made the following changes to the SCHIP policy:*
  - ✓ *Change term of coverage from 12 months to 6 months.*
  - ✓ *Eliminates deductions to income so that eligibility is based on gross income.*
  - ✓ *Restricts eligibility for families at or above 150% of FPL to those with assets within allowable levels.*
  - ✓ *Directs that a Preferred Drug List (PDL) be implemented, with prior authorization required for prescribed drugs on the PDL.*



- *Prescription drugs were given the following limitations:*
  - ✓ *Brand-name drugs will be limited to a 34-day supply and a maximum of four prescriptions per month, if determined to be cost-effective.*
  - ✓ *No limits will be placed on number of generic prescriptions.*
- *Limits the benefit package to coverage of* ***basic health care services.*** *The following health care benefits were discontinued –*
  - ✓ *Most behavioral health services (benefits will include one outpatient diagnostic visit per enrollment period, 6 medication management visits per enrollment period, consultation in an inpatient or emergency setting after stabilization of an emergency condition).*
  - ✓ *Dental Services*
  - ✓ *Hospice Care Services*
  - ✓ *Skilled Nursing Facilities*
  - ✓ *Tobacco Cessation programs*
  - ✓ *Vision Benefit, including eyeglasses and exams*
  - ✓ *Chiropractic Services*

[34] Texas Health and Human Services Commission. CHIP Policy Changes 78th Legislature, Regular Session 2003. 13 Oct. 2004. <http://www.hhsc.state.tx.us/news/post78/CHIP_Policy_Changes.html>.

Virginia – FAMIS Program

Virginia developed a new healthcare plan under Title XI for their SCHIP program. FAMIS (Family Access to Medical Insurance Security Plan) is provided to children up to age 19 with a family household income up to 200% of the Federal Poverty Level. All benefits offered are similar to Mississippi's SCHIP plan **except** for the following:[35]

- *Prescription Drugs ordered by a Physician must be filled using a GENERIC drug. If you choose the brand when a generic is available, you are responsible for the co-payment **plus 100%** of the difference between the allowable charge of the generic drug and the brand drug.*
- *Vision Care covers routine eye examinations every **24 months**.*

Co-pays are charges to all participants and amounts are based on their Federal Poverty Levels. The following co-pays apply:

Benefit Coverage	Co-Pay Status 1	Co-Pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
ER (non-emergency visit)	$10 per visit	$25 per visit
Yearly Co-Payment Limit (per family)	$180	$350

Source: http://www.FAMIS.org

FAMIS also provides Employer-Sponsored Health Insurance for family health insurance coverage assistance. Known as ESHI, this program—if offered by the applicants' employer—assists families in paying for the monthly premium costs for that health insurance. FAMIS will also cover the cost of most co-payments and deductibles charged by the employer's health plan for the children of the family enrolled.

[35] State of Virginia. Family Access to Medical Insurance Security Plan (FAMIS): Member Handbook. 15 Oct. 2004. <http://www.FAMIS.org>.

Employer-Sponsored Health Insurance

Employer-Sponsored Health Insurance also known as Premium Assistance is an authorized Medicaid program under Section 1906 and approved by CMS through an amendment to the state Medicaid plan. This program is a way for states to reduce the costs under their Medicaid and SCHIP plans by helping families purchase health insurance through their employers. The state's costs are reduced as employers pay a portion of health insurance premiums for employees and their dependants. Mississippi was the first State to be approved for this program, but has never implemented it.

Health and Human Services "strongly encourages" the use of SCHIP funds to purchase either individual or employer-sponsored coverage for eligible people.[36]

Waiver 1115 Approach

The HIFA Section 1115 demonstration initiative encourages states to use premium assistance programs as an integral part of program expansions. HIFA guidance states that aggregate costs of coverage provided through premium assistance must not be "significantly higher" than in the public program. The guidance does not define what is meant by significantly higher costs. States that have pursued HIFA have taken a variety of approaches to assuring cost effectiveness.[37]

States Offering Premium Assistance Programs as of October 2004

States Offering Premium Assistance Programs	Program Authority
California	Section 1906
Georgia	Section 1906
Illinois	HIFA Section 1115
Iowa	Section 1906
Massachusetts	Section 1906 & 1115
Missouri	Section 1906
New Jersey	Section 1115 w/HIFA amendment
Oregon	HIFA section 1115
Pennsylvania	Section 1906
Rhode Island	Section 1906
Texas	Section 1906
Utah	Section 1115
Virginia	Section 1906 Title XXI
Wisconsin	Section 1906 & 1115

Source: http://www.patoolbox.org/_docdisp_page.cfm?LID=A27DFE16-1F0F-4329-942794A17CF0547B

[36] Mississippi Health Advocacy Program – Jackson. Bush Policy Regarding Section 1115 Waiver. 23 Nov 2004. <Source: http://www.mhap.org/regarding_waivers.html>

[37] Premium Assistance Toolbox for States. Assisting States to develop premium assistance programs. 26 Oct. 2004. <Source: http://www.patoolbox.org/_docdisp_page.cfm?LID=A27DFE16-1F0F-4329-942794A17CF0547B>.

State Practices & Findings in Implementing Premium Assistance Programs

Defined Subsidy – Illinois provides a subsidy of up to $75 per eligible family member. The maximum subsidy is set by state law at a level that ensures that the average payment does not exceed the average payment for their public program. Utah's section 1115 (non-HIFA) demonstration uses a similar approach.

Work Closely with Stakeholders – Iowa and Massachusetts both report issues with employers that did not want sicker employees to join their health plans because it increases their costs. The states' preferred approach to this problem is to explain to employers the benefits of providing health insurance, such as more satisfied employees and fewer absences from work. In some cases it is necessary to tell employers they do not have a choice; enrollment cannot be denied based on health status (pre-existing conditions).

Keep it Simple – New Jersey and New Mexico both report that employers were concerned that they would be inundated with paperwork and did not want to be involved in money issues (e.g., receiving the state subsidies). Although the design of premium assistance in these two states is very different, they have addressed the issue by minimizing the amount of information that employers must provide and providing premium subsidies to enrollees rather than employers.

Monitoring - Oregon compares the overall weighted average subsidy cost (which is reported on a per member per month basis) to the pre member per month cost of their public program. Monitoring is done on a quarterly basis.

Automation Impacts Program Enrollment - Pennsylvania initially lacked an automated system to process enrollments into the program, thus limiting the number of enrollments being completed.

Source: http://www.patoolbox.org/_docdisp_page.cfm?LID=A27DFE16-1F0F4329-942794A17CF0547B>.

Finding - *Mississippi was the first state to be approved for Employer-Sponsored Health Insurance buy-in for children qualified under SCHIP, but due to the stringent laws and regulations regarding this feature at the programs inception, it was never implemented. There were also numerous questions surrounding the issue of how premiums would be paid to the employer or the family.*

As the program has matured the laws and regulations have become more lenient in governing this feature of the program. The agency has not pushed this feature, but there have been many requests by others to provide this service. Many states (14 to date) are adopting an Employer-Sponsored Health Insurance Program (for children and families), and 10 others have requested approval of this feature, to reduce SCHIP program costs and cover more people by taking advantage of employer contributions toward the cost of coverage.

Recommendation – *Because the benefits of a premium assistance program are great (e.g., cost effective-saves the state money by employers paying a portion of the premium costs, allows families the benefit of one insurance plan for all members, encourages use of private insurance), as seen from other states, and because the laws and regulations surrounding the program have changed dramatically since the programs inception, the Office of the Governor should issue a recommendation to the Division of Medicaid to re-visit the possibility of implementing this program under Title XXI for the SCHIP and Medicaid programs.*

Review of "Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP"

The National Academy for State Health Policy researched the Medicaid and SCHIP programs in the 50 States and has provided recommendations on how States can reduce overall costs to their programs; furthermore they offer both the pros and cons of implementing any of the cost containment actions. Below are some of the recommendations made in the review that may be beneficial for Mississippi to follow to ensure its participants continue to receive health care coverage.

Because each State's SCHIP program is unique in its design determining which cost containment strategy to adopt will depend on factors such as current enrollment patterns, benefit structures, cost sharing features, delivery systems, and administrative structure.[38]

" Choices Recommendation: Limiting Enrollment

By reducing the number of children in these programs states have been able to contain costs. As mentioned earlier, enrollment is one of the key reasons costs for SCHIP have increased.

Methods to reduce eligibility

- *Cap or freeze enrollment.*
- *Open enrollment periods.*

Pros:

- *Avoids reducing eligibility levels.*
- *Easily reversible.*

Cons:

- *Equity – some children within the same income levels will go without health care.*
- *Plans and providers don't like on/off programs.*
- *Can jeopardize federal fiscal relief .*

[38] Shirk, Cindy, *Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP.* (Portland, ME: National Academy for State Health Policy), February 2004.

Recommendation: Eligibility Restrictions

Expanded eligibility for children in SCHIP (and Medicaid) is one of the key reasons for cost growth in children's services. Children's eligibility for public health programs has grown dramatically since SCHIP was enacted in 1997. SCHIP enrollment has climbed steadily since its implementation, serving 5.3 million children in 2002 nationwide. SCHIP permits states to expand coverage up to 200% of the FPL, or 50 percentage points above the Medicaid eligibility levels that were in effect on April 15, 1997 (whichever is higher).[39]

Methods to reduce eligibility

- Reduce income levels or eliminate eligibility groups.
- Institute asset tests.
- Eliminate income disregards.
- Change how medical bills are counted for determining spend down eligibility.

Pros:

- *Addresses a key driver of recent cost increases for children: Eligibility expansions in recent years, coupled with decreased family income resulting from the economic downturn, have greatly increased enrollment in Medicaid and SCHIP.*
- *Savings to program are almost immediate.*
- *Focuses program on lowest income groups who are most in need of services .*

Cons:

- *Possibility of losing some or all of the State's access its federal SCHIP allotment.*
- *Requires legislation and may be difficult to reinstate at a later date.*
- *Strong opposition and legal challenges.*

"Choices" Recommendation: Restructuring Benefits

Many other states have looked at restructuring their benefit packages in order to contain costs. Seven states have made changes to their Medicaid and SCHIP programs that would impact children.

Methods to restructure benefits

- Change to a different benchmark plan or actuarial equivalent in the separate SCHIP program, keeping in mind the required benchmark required services.

Pros:

- *More in line with commercial market.*
- *Easily reversible at a later date.*

Cons:

- *Strong opposition.*
- *Special needs children may be disproportionately affected.*
- *Savings may not meet expectations.*

[39] Shirk, Cindy, *Tough Choices: A Policy Maker's Guide to Cost Containment Actions Affecting Children in Medicaid and SCHIP.* (Portland, ME: National Academy for State Health Policy), February 2004.

Recommendation: Increased Cost Sharing

Increased cost sharing for enrollees is a common method that states are using to contain their program costs, with 32 states reporting new or higher co-payments for one or more services during the 2002-2004 period. Cost sharing can take the form of enrollment fees that are paid upon joining the program and premiums that are paid on a monthly basis, as well as co-payments, deductibles, and coinsurance that are paid at the point of service.

Methods to restructure benefits

- SCHIP programs can charge "nominal" cost sharing for children in families with incomes at or below 150% of the FPL. Nominal cost sharing is defined as $5 or less for co-payments and $19 or less per month (depending on family income) for premiums. Above 150% of the FPL, there are no specific dollar limits on co-payments and premiums but total out-of-pocket costs cannot exceed 5% of a family's income for any eligible SCHIP participant. Studies have shown that the impact of cost sharing has reduced utilization, thereby reducing overall healthcare costs per participant.

Pros:

- *Reduced state costs*
- *Cost sharing makes SCHIP different from a "welfare program"*
- *Equity*

Cons:

- *Cost to providers*
- *Administration*

"Choices" Recommendation: Increasing premiums and enrollment fees

- ***Premiums*** are charged on a monthly basis.
- ***Enrollment fees*** are similar to premiums but, rather being charged monthly, are charged to cover a longer period of time (every 6 months to a year). Currently five states use enrollment fees for SCHIP.

Pros:

- *Targeting the program*
- *Shared responsibility*
- *No need to track cost sharing paid at point of service*
- *May offset some administrative costs*

Cons:

- *If premiums or enrollment fees are too high it may prove to be a barrier to participation*
- *Administration Increase – however, DOM is not currently utilizing all of its allowed administrative costs for this program.*

Recommendation: Increasing co-payments/deductibles

- *Co-payments* are a form of cost sharing in which enrollees pay a small fee each time a service is rendered.
- A *deductible* is a specified amount of expense that an enrollee must incur before an insurer will assume any liability for all or part of the remaining cost of covered services.

Pros:

- *Utilization changes – policy makers believe that co-payments affect utilization in a positive way. By having to pay each time they visit a doctor they may be more careful and judicious about when they choose to go.*
- *Cost Savings*
- *Fewer administrative costs for states*

Cons:

- *Affects provider revenue*
- *Administration*

"Choices" Recommendation: Premium Assistance

As mentioned before this is a service that provides assistance to families to purchase health insurance through their employers. State costs are reduced as employers pay a portion of health insurance premiums for employees and their dependants.

Pros:

- *Cost effective*
- *Encourages use of private coverage*
- *Family members in the same health plan – this is a major benefit to qualified Mississippians.*

Cons:

- *Administration - again Mississippi still has available funds for adding needed administration.*

Recommendation: Prescription drug cost containment

Prescription drug costs grew at an average rate of about 18.1% a yearly between 1997 and 2000 and accounted for nearly 20% of the increase in Medicaid spending during that time. In 2003, 46 states implemented cost containment actions related to prescription drugs, and 44 states plan to take new or additional action for FY04.

Methods to contain costs

- Prior Authorization
- Preferred Drug Lists (PDL)- Established by a committee that includes physicians and pharmacists and include all drugs from manufacturers that have a rebate agreement with the federal government.
- Mandated use of generics
- Reduce payments for drugs- For acquisition costs states pay a percentage of the average wholesale price (AWP) of the drug. To reduce costs states can lower the percentage of AWP that is paid. States have also reduced dispensing fees to pharmacies.
- Supplemental rebates from manufactures
- Limit the number of prescriptions

Pros:

- *Address key driver of rapidly escalating costs for adults*
- *Minimal enrollee impact if designed well*
- *Clinical efficacy drives prescribing habits*
- *Drug companies are better able to absorb cuts than many others*

Cons:

- *Administration*
- *Legal challenges*
- *Limited immediate savings*

"Choices" Recommendation: Program management

Changes in program management offer states the potential for cost savings.

Methods to contain program management costs

- Increase fraud and abuse activities
- Increase third party liability recoveries
- Billing errors
- Data collection and evaluation

Pros:

- *Enrollees are not impacted*
- *Program is more efficient*
- *GAO/Congressional concerns – Actions in this area can help to address the issues found in the January GAO report.*

Con:

- *Requires increased administrative and personnel costs – Mississippi has funds available to handle this change/increase.*

Cost Containment Actions Already Taken by the State

The Division of Medicaid and the Department of Finance & Administration have taken the following cost containment measures recommended by The National Academy for State Health Policy.

- Application/Enrollment Process Changes
  - *Require face-to-face interviews*
  - *Require documentation of income*
  - *Reduce outreach*

It has to be said that the SCHIP benefits package is top-notch and simply can not be matched. The state of Mississippi has provided qualified children with the best possible all-inclusive healthcare coverage available at little or no cost to its participants. However, the costs to the State must be examined and options to reduce costs should be considered without compromising the basic healthcare of SCHIP participants.

Rising Health Care Costs

From spring 2003 to spring 2004, premiums increased 11.2% (compared with 13.9% last year). Since 2001, premiums have increased 59%, employee contributions have grown by 57% for single coverage and 49% for family coverage, and the percentage of workers covered by their own employer's health plan has fallen from 65% in 2001 to 61% in 2004. The worst of the current round of premium inflation appears to be over, but employers plan to increase employee cost sharing next year.[40]

The costs that the State pays for health insurance coverage under the State and School Employee's Health Insurance Plan and SCHIP are directly related to enrollment and the price and utilization of health care by enrollees. Cost management therefore needs to include controlling eligibility and enrollment, as well as the price and use of health care services.

DFA's Thoughts on Saving Money

Clearly, restricting eligibility and enrollment will save money. In a group plan, policies and procedures should minimize adverse selection. Reducing benefits will save money, but this is really a matter of shifting costs to the enrollee. The same can be said for limiting price; what the Plan doesn't pay is generally charged to the enrollee as the State has no control over what the provider charges. Because federal regulations will not permit families of SCHIP enrollees to be charged more than the minimal co-pays, price control is much more difficult under this plan.

Some control over price has been achieved through provider networks and prospective payment systems, but an increasing number of providers are balking at these restrictions.

Utilization of health care can be controlled through programs such as prior authorization, pre-certification, and case management. These programs, however, increase administrative costs and member dissatisfaction and so must be used judiciously. It is also important to monitor claims for possible fraud and abuse, as well as potential third party liability.

Because most costs are associated with a small number of enrollees, it is essential to manage high cost claims. Case management, disease management, and similar health management programs are designed to address this area. Vendor management will minimize administrative costs. The competitive bid process serves to ensure that the company with the lowest and best proposal is selected to serve the plan.

There is a close relationship among cost, access, and quality, and these must be balanced. Mississippi, in its State Plan, could reduce prescription drug costs, for example, by restricting the pharmacy network to selected chain pharmacies, but this would create access problems for participants and financial hardship on many discount suppliers by implementing a restricted formulary. As a result, many participants would not be able to receive the prescription drugs their doctors had prescribed. If prices are limited too stringently, providers will refuse to participate in the provider network, thereby causing access problems for Plan members. Some cost saving measures should be avoided because they could result in higher costs in the long term if Plan members do not receive preventive or primary care when they need it.

[40] "Health Benefits In 2004: Four Years Of Double-Digit Premium Increases Take Their Toll On Coverage". Health Affairs Vol 23, Issue 5, 200-209. Copyright © 2004 by Project HOPE DOI: 10.1377/hlthaff.23.5.200

Health insurance costs reflect the cost of health care. Until the factors driving health care costs are addressed, most health insurance cost control efforts will primarily involve shifting costs. If providers raise their charges by twenty percent, for example, the Plan can refuse to pay the increase, thereby causing more providers to exit the Network. Or, the State can pass the increase along to the Plan participant in the form of higher premiums, deductibles and co-insurance, or share the increase with Plan participants. For the most part, the State and School Employees' Health Insurance Plan has been sharing the cost increases among the State, employees and retirees, and providers.

At this point the financial incentives in the health care financing system are misaligned; the market forces serve more to drive costs higher rather than to contain costs. Health insurance tends to insulate the consumer from the impact of direct costs, and consumers do not associate their insurance costs with their usage of health care services. In addition, the system provides little incentive to improve quality or reduce errors.

Appendix 1 – Purpose, Scope & Methodology

Purpose

The Performance Audit Division (the Division) was requested to perform a limited examination of the SCHIP program. The purpose of this review is to provide information and to make recommendations for better management techniques that can reduce costs and increase the efficiency of the State Children's Health Insurance Program (SCHIP). The report provides the Governor, the Division of Medicaid and other interested parties information for use in future decisions on Mississippi's Children's Health Insurance Program (SCHIP).

Scope

The focus on this report is on the State Children's Health Insurance Plan, State and School Employee Health Insurance Plan, and Private Health Insurance in Mississippi, as well as the SCHIP information in other states, as it relates to benefits, spending, enrollment, cost-containment, and other policy-making during a time of significant, on-going state budget stress. Recommendations will be provided based on research findings and successful strategies used by other states; furthermore, hypothetical changes will be disclosed.

Methodology

In conducting the review, the Performance Audit Division performed the following procedures:

- Interviewed representatives of DFA Insurance, Division of Medicaid, and the Office of the Governor;
- Reviewed applicable parts of the Mississippi Code and the federal guidelines on SCHIP;
- Reviewed websites of Mississippi Agencies, other state agencies, and national/federal agencies for information on SCHIP;
- Reviewed financial information on Mississippi and other states SCHIP programs;
- Obtained and reviewed comparative cost and rate information for child Health Care in Mississippi;
- Reviewed reports issued by various parties regarding the SCHIP programs nationally, as well as, in Mississippi;
- Conducted other web research as necessary.

Appendix 2 – Findings & Recommendations

1) **Finding** - There are instances when a family with multiple children can have one child covered under Medicaid and one child covered under SCHIP because of the child's age. In this situation parents may have to use separate doctors for their children because not all providers accept both Medicaid and SCHIP. The Division of Medicaid has received complaints from participants about having to use separate providers for their children.

Recommendation - To provide better customer service DoM should supply a list of providers who cover both Medicaid and SCHIP plans to families with children enrolled under both programs.

2) **Finding** - There are limited safeguards in place to routinely check eligibility status of participants within the twelve month enrollment period.

Recommendation - Begin routinely checking eligibility status on all participants on a semi-annual or more frequent basis. Require proof of income, check for third party insurance, and any other information that could change the eligibility status of a participant at each of these checks.

3) **Finding** - For enrollees who enroll in the SCHIP program, cancel service, and re-enroll again, there is no fast or efficient way of admitting them back into the program. Participants have to fill out the enrollment application each time they need to re-enter the program. This adds to the administrative demands and as a result increases administrative costs.

Recommendation - To provide better customer service and keep administrative costs to a minimum, provide a more streamlined and efficient process for re-enrolling applicants within a year of canceling their service. Also, keep an electronic history of the participants information to assist in determining eligibility. This will also provide additional safeguards on fraudulent and/or duplicative enrollment of applicants.

4) **Finding** - The Mississippi Division of Medicaid has indicated that it has been given no formal directive to look into finding more state match funds through other sources such as the United Way, or other sources allowed under federal law. Furthermore, there is no financial plan set in place for future funding should federal allotments begin to dissipate, and there has been no directive to formulate a plan to set aside funds for unforeseen circumstances that would affect the programs operation.

Mississippi can not sustain the current number of enrollees in the SCHIP program without the dependency of the redistribution of funds from other states. In fact, comparing the deficit to the average past redistributions the program can not be sustained even with the additional redistributions the Division of Medicaid expects. Other states are being more judicious about their funds, and are quoted as saying they will no longer let their allotments expire and be redistributed.

It is crucial that Mississippi's dependency on reimbursements for funding of the SCHIP program stop and a plan be created to fund this program for both the short-term and long-term. If the funding dependency continues in its current path the state would have to cap enrollment and lower the Federal Poverty Level rate to cut current eligible participants.

Recommendation - The Governor's Office should direct the Division of Medicaid to have a short-term and a long-term plan to deal with loss regardless of any potential of redistributed funds.

5) **Finding** - The State of Mississippi has provided qualified children with the best possible all-inclusive healthcare coverage available at little or no cost. However, the costs to the State must be examined and options to reduce costs should be considered. The benefits under the SCHIP plan can be reduced to meet the basic benchmark coverage to lower program costs, without compromising the basic healthcare of its participants.

Recommendation - The Office of the Governor should direct the Division of Medicaid to prepare a cost analysis of SCHIP premiums if coverage were reduced to benchmark levels to determine potential cost savings.

6) **Finding** - Certain suppliers under the SCHIP contract are not providing adequate discounts for services rendered to SCHIP participants.

Recommendation - HIMB needs to push BCBS to negotiate improved "allowed charges" for these services with the provider for the next contract period which begins January 1, 2005. This will assist in the decrease of overall claims costs for these services which can reduce overall premiums.

7) **Finding** - Mississippi was the first state to be approved for Employer-Sponsored Health Insurance buy-in for children qualified under SCHIP, but due to the stringent laws and regulations regarding this feature at the programs inception, it was never implemented. There were also numerous questions surrounding the issue of who premiums would be paid to, the employer or the family.

As the program has matured the laws and regulations have become more lenient in governing this feature of the program. The agency has not pushed this feature, but there have been many requests by others to provide this service. Many states (14 to date) are adopting an Employer-Sponsored Health Insurance Program (for children and families), and 10 others have requested approval of this feature, to reduce SCHIP program costs and cover more people by taking advantage of employer contributions toward the cost of coverage.

Recommendation – Because the benefits of a premium assistance program are so great (e.g., cost effective-saves the state money by employers paying a portion of the premium costs, allows family's the benefit of one insurance plan for all members, encourages use of private insurance), as seen from other states, and because the laws and regulations surrounding the program have changed dramatically since the program's inception, the Office of the Governor should issue a recommendation to the Division of Medicaid to re-visit the possibility of implementing this program under Title XXI for the SCHIP and Medicaid programs.

Appendix 3 – Benefits Comparison Chart

	CHIP (All services must be rendered by network providers**)		State & School Employee's Basic Health Plan (In-Area Participants Only)		Private Individual Quote*** (BCBS Blue Care Plan)	
Benefit Coverage	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Health Care Professional Visit	100% ($5 co-pay if >150% of FPL)	Not Covered	80%	60%	$15 co-pay / 100%	Not Covered
Emergency Room Visit	100% ($15 co-pay if >150% of FPL)	Not Covered[1]	80%	60%	80%	50% (will pay 80% if accident or emergency)
Hospital In/Out Patient* (room & board, dietary and general nursing services)	100%	Not Covered	80%	60%	80%	50%
Ambulance	100%	Not Covered[1]	80%	75%	N/A	N/A
Anesthesia	100%	Not Covered	80%	75%	N/A	N/A
Ambulatory Surgical Facility	100%	Not Covered	80%	60%	80%	50%
Cardiac Rehabilitation (outpatient)	100% (Prior approval required)	100% (Prior approval required)	80% (Prior approval required)	60% (Prior approval required)	N/A	N/A
X-Rays, Laboratory	100%	100%	80%	60%	80%	50%
Maternity Attending Physician	100%	Not Covered	100%	90%	Not Covered (optional add-on)	Not Covered (optional add-on)
Maternity Hospital*; Other Services	100%	Not Covered	80%	60%	Not Covered (optional add-on)	Not Covered (optional add-on)
Well-Child Physician Office Visits	100%	Not Covered	100%	Not Covered	100% (after co-pay-PCP $15; Specialist $25)	Not Covered
Well-Newborn Nursery Care	100%	Not Covered	100% (High Option Plan)	Not Covered	80%	50%
Specified Routine Tests	100%	Not Covered	100%	Not Covered	N/A	N/A
Childhood Routine Immunization	100%	Not Covered	80% (High Option Plan)	Not Covered	100%	Not Covered
Other Services						
Family Planning Services	100%	Not Covered	N/A	N/A	N/A	N/A
Female Health Services	100%	Not Covered	80%	60%	100%	Not Covered
Free-Standing Diagnostic Facility	100%	Not Covered	80%	60%	N/A	N/A
Chiropractic Services	100% ($1500 Limit per benefit period)	Not Covered	80% ($1500 Limit per benefit period)	60%	N/A	N/A
Diabetes Self Management Training	100% ($250 limit per benefit period)	Not Covered	Covered through doctor services	Not Covered	N/A	N/A
Durable Medical Equipment	100%	Not Covered	80%	60%	N/A	N/A
Home Infusion Therapy*	100%	Not Covered	80%	60%	N/A	N/A
Hospice	100% ($15,000 lifetime maximum per member)	100% ($15,000 lifetime maximum per member)	Covered through case management	N/A	N/A	N/A

Medical Supplies	100% (inpatient 30 day limit)	Not Covered	80%	75%	N/A	N/A
Mental Health	*Residential*					
Inpatient*	100%	Not Covered	80% (30 day limit)	75%	80% (30 visit limit)	50% (30 visit limit)
Outpatient	100% (52 visit limit)	Not Covered	50% (52 visit limit)	50%	80% (52 visit limit)	50% (52 visit limit)
Day Treatment/Partial Hospitalization	100% (60 day limit)	Not Covered	80% (60 day limit)	75%	50%	50%
Nurse Practitioner/Home Health Nursing Services*	100%	Not Covered	80%	60%	N/A	N/A
Occupational Therapy	100% (Prior approval required)	100% (Prior approval required)	80%	75%	N/A	N/A
Optometric Services (routine vision)	100% (1 annual visit handled by VSP)	Not Covered	Not Covered	Not Covered	N/A	N/A
Organ Transplants	100% (Prior approval required)	Not Covered	80% (Prior approval required)	60% (Prior approval required)	N/A	N/A
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug Infusion)	100%	Not Covered	80%	60%	N/A	N/A
Physical Therapy	100% (Prior approval required)	100% (Prior approval required)	80%	60%	N/A	N/A
Podiatry Services	100%	Not Covered	80%	75%	N/A	N/A
Private Duty Nursing Services	100% ($10,000 limit per benefit period)	100% ($10,000 limit per benefit period)	80%	60%	N/A	N/A
Prosthetic/Orthotic Procedures and Devises	100% (Prior approval required)	100% (Prior approval required)	80%	60%	N/A	N/A
Routine Hearing	100% (1 annual visit)	100% (1 annual visit)	Not Covered	Not Covered	N/A	N/A
Skilled Nursing Services	100% (limited to 60 days per benefit period)	100% (limited to 60 days per benefit period)	Not Covered	Not Covered	N/A	N/A
Speech Therapy	100% (Prior approval required)	100% (Prior approval required)	80%	75%	N/A	N/A
Substance Abuse						
Inpatient*	100% ($8,000 annual max & $16,000 lifetime	Not covered	80% ($8,000 annual max & $16,000 lifetime max)	75% ($8,000 annual max & $16,000 lifetime max)	$25 co-pay / 80% ($1,500 annual max)	$25 co-pay / 50% ($1,500 annual max)
Outpatient	100% ($8,000 annual max & $16,000 lifetime max)	Not Covered	50% ($8,000 annual max & $16,000 lifetime max)	50%	$25 co-pay / 80% ($1,500 annual max)	$25 co-pay / 50% ($1,500 annual max)
Intensified Outpatient Program	100% ($8,000 annual max & $16,000 lifetime	100% ($8,000 annual max & $16,000 lifetime	50%	50%	$25 co-pay / 80% ($1,500 annual max)	$25 co-pay / 50% ($1,500 annual max)
Temporomandibular Joint Disorder (TMJ)	100% ($5,000 lifetime max)	Not Covered	80% (lifetime maximum $5,000)	75% (lifetime maximum $5,000)	$ 15 co-pay / 80% ($5,000 lifetime max)	$ 15 co-pay / 50% ($5,000 lifetime max)

' CHIP: Benefits for emergency room services will be provide in cases of a medical emergency. When emergency room services of a non-network provider are used by a member for a medical emergency, the network level of benefits will be provided.

Source: SCHIP- http://www.bcbsms.com/InvokePage.do?menu=Your%20Benefits

Source: State & School Employees Health Plan "Know Your Benefits" Plan Document. April 2003.

Source: Blue Cross Blue Shield of MS "Blue Care" Plan http://www.bcbsms.com/InvokePage.do?menu=Individual

Appendix 4 – SCHIP Benefits Coverage Detail

Benefit Coverage	Terms & Conditions / Limitations & Exclusions
In-Patient Services	Inpatient services must be pre-certified as medically necessary and include the following: 1) Hospital room and board (including dietary and general nursing services). 2) Use of operating or treatment rooms. 3) Anesthetics and their administration. 4) Intravenous injections and solutions. 5) Physical therapy. 6) Radiation therapy. 7) Oxygen and its administration. 8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms. 9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs. 10) Dressings and Supplies, sterile trays, casts, and orthopedic splints. 11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies. 12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations. 13) Intensive, Coronary, and Burn Care Unit services. 14) Occupational therapy. 15) Speech therapy.
Medical Services/Clinical Services	1) In-hospital medical care. 2) Medical care in the Practitioner's office, enrolled child's home, or elsewhere. 3) Surgery 4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the program. Injury to teeth as a result of chewing or biting is nto considred an Accidental Injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten days of the accidental injury. 5) Administration of anesthesia. 6) Diagnostic services, such as clinical labroatory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests. 7) Radiation therapy. 8) Consultations. 9) Psychiatric and psychological service for nervous and mental conditions. 10) Physicians assisting insurgery, where appropriate. 11) Emergency care or surgical services rendered in a Practitioner's office including but not limited to surgical and Medical Supplies, dressings, casts, anesthetic, tetanus serum and x-rays. 12) Well child assessments, vision screening, hearing screening, and laboratroy tests according to the American Academy of Pediatrics' recommendations for preventive pediatric health care. Vision and hearing screening are to be included as part of the periodic well child assessments. 13) Routine Immunizations (according to ACIP guidelines) - Vaccine will be purchased and distributed throught the State Department of Health. The Health Plan will reimburse providers for the administration of the vaccine.
Surgical Services	Certain surgeries may be pre-certified as medically necessary. Benefits are provided for the following covered medical expenses furnished to the Enrolled Child by an Ambulatory Surgical Facility: 1) Services consisting of routine pre-operative labortory procedures directly related to the surgical procedure. 2) Pre-operative preparation. 3) Use of facility (operating rooms, recovery rooms, and all surgical equipment). 4) Anesthesia, durgs and surgical supplies.
Prescription Drugs	**The following drugs and medical supplies are covered:** 1) Legend drugs (federal law requires tehse drugs be dispensed by prescription only). 2) Compounded medication of which at least one ingredient is a legend drug. 3) Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape). 4) Disposable insulin needles/syringes. 5) Growth hormones. 6) Insulin. 7) Lancets. 8) Legend contraceptives. 9) Retin-A. 10) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets). 11) Vitamin and mineral supplements, when prescribed as replacement therapy. **The following drugs are EXCLUDED:** 1) Anabolic steroids (e.g., Winstrol, Durabolin). 2) Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder. 3) Anti-wrinkle agents (e.g., Renova). 4) Charges for the administration or injection of any drug. 5) Dietary supplements. 6) Infertility medications (e.g. Clomid, Metrodin, Pergonal, Profasi). 7) Minerals (e.g., Phoslo, Potaba). 8) Medications for the treatment of alopecia, e.g. Minoxidil (Rogaine). 9) Non-legend drugs other than those listed as covered. 10) Pigmenting/depigmenting agents. 11) Drugs used for cosmetic purposes. 12) Smoking deterent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorrette, Nicoderm, etc.). 13) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes. 14) Any medication proven effective in general medical practice. 15) Investigative drugs and drugs used other than for the FDA approved diagnosis. 16) Drugs that do not require a written prescription. 17) Prexcription drugs if an equivalent product is available over the counter. 18) Refills in excess of the number specified by the Practitioner or any refills dispensed more than one year after teh date of the Practitioner's original prescription. 19) Over the counter medication is excluded.
Laboratory & Radiological Services	Medically Necessary laboratory and radiological services are covered, but certain diagnostic tests must be pre-certified, as determined by the Board or the Health Plan.
Prenatal care and pre-pregnancy family planning services and Supplies	Infertility services are excluded.

Benefit Coverage	Terms & Conditions / Limitations & Exclusions
Mental Health	**Inpatient mental health services, other than services described under substance abuse services, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services.** 1) Benefits for covered medical expense are paid for medically necessary inpatient psychiatric treatment of an enrolled child for a period of up to 30 days annually. 2) Benefits for covered medical expenses are provided for Partial Hospitalization for a period of up to 60 days annually. 3) Certification of medical necessity by the Utilization Managment Program is required for admissions to a hospital. 4) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse. **Outpatient Mental Health Services, other than services described under substanse abuse services:** 1) Benefits for covered medical expenses for treatment of nervous and mental conditions on an outpatient basis are limited to 52 visits annually. 2) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.
Disposable Medical Supplies	Supplies provided which are Medically Necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an Enrolled Child to effectively carry out a Practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the Enrolled Child's home.
Home and Community-based Health Care Services	1) Services and supplies required for the administration of Home Infusion Therapy regimen must be (a) Medically Necessary for the treatment of the disease; (b) ordered by a Practitioner; (c) as determined by the Utilization Management Program capable of safe administration in the home; (d) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the Utilization Management Program; (e) ordinarily in lieu of inpatient hospital therapy; and (f) more cost effective than inpatient therapy. 2) Benefits for home health nursing services must be approved by the Utilization Management Program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually. (Refer to Nursing care services in following section.)
Nursing Care Services	1) Benefits are provided for Covered Expenses when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered. Nurse practitioner services are covered as Medical Services. 2) Benefits for nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) are covered only when ordered and supervised by a Practitioner and when the services rendered require the technical skills of a RN or LPN. 3) Benefits for private duty nursing services are provided for an illness or injury that the Utilization Management Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. 4) Benefits are provided for nursing services in the home for illness or injury that the Utilization Management Program determines to require the skills of a RN or LPN. Benefits for nursing services provided in an Enrolled Child's home must be approved by the Utilization Management Program in lieu of hospitalization. (5) Benefits for nursing services are limited to $10,000 annually. This limit does not apply to nurse practitioner services. (6) No nursing benefits are provided for the following: (a) Services of a nurse who ordinarily lives in the Enrolled Child's home or is a member of the Enrolled Child's family; (b) Services of an aide, orderly or sitter; or (c) Nursing services provided in a Personal Care Facility. 7) Benefits are provided for confinement in a skilled nursing facility for up to 60 days per benefit period, subject to utilization management requirements.
Abortion	Elective abortions are covered only when documented to be medically necessary in order to preserve the life or physical health of the mother.
Dental Services	1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). The following Covered Dental Services are limited to $1500 each calendar year: (a) Bitewing X-Rays-as needed, but no more frequently than once every six months; (b) Complete Mouth X-Ray and Panoramic X-Ray- as needed, but no more frequently than once every twenty (24) months; (c) Prophylaxis- one every six (6) months; must be separated by six full months; (d) Fluoride Treatment – limited to one each six (6) month period; (e) Space maintainers – limited to permanent teeth through age 15; (f) Sealants – covered up to age 14, every 36 months. 2) Benefits are provided for restorative, endodontic, periodontic and surgical dental services as indicated below and are limited to $1500 each calendar year: (a) Amalgam, Silicate, Sedative, and Composite Resin Fillings including the replacement of an existing restoration; (b) Stainless steel crowns to posterior and anterior teeth; (c) Porcelain crowns to anterior teeth only; (d) Simple extraction; (e) Extraction of an impacted tooth; (f) Pulpotomy, pulpectomy and root canal; (g) Gingivectomy, gingivoplasty and gingival curettage.

Benefit Coverage	Terms & Conditions / Limitations & Exclusions
Other Dental Services (The Calendar Year Maximum does not apply to these services.)	1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Enrolled Child is covered under the Plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury. 2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Enrolled Child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. 3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. 4) Benefits are provided for diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome
Substance Abuse Treatment Services	1) **Inpatient substance abuse treatment services and residential substance abuse treatment services**: Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse. (b) Benefits for covered medical expenses are provided for Medically Necessary inpatient stabilization and residential substance abuse treatment. (c) Certification of Medical Necessity by the Health Plan's Utilization Management Program is required for admissions to a hospital or residential treatment center. (d) Benefits for inpatient and outpatient care shall not exceed $8,000 during a Benefit Period and shall not exceed a Lifetime Maximum of $16,000 except that a maximum of $1,000 per Benefit Period will be provided Inpatient and Outpatient alcohol abuse once the Enrolled Child's $16,000 Lifetime Maximum is exhausted. (e) Benefits for substance abuse do not include services for treatment of nervous and mental conditions. **2) Outpatient substance abuse treatment services:** (a) Benefits are provided for covered medical expenses for Medically Necessary Intensified Outpatient Programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility. (b) Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient. (c) Benefits for inpatient and outpatient care shall not exceed $8,000 during a Benefit Period and shall not exceed a Lifetime Maximum of $16,000 except that a maximum of $1,000 per Benefit Period will be provided Inpatient and Outpatient alcohol abuse once the Enrolled Child's $16,000 Lifetime Maximum is exhausted. (d) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.
Case Management Services	Medical Case Management may be performed by the Utilization Management Program of the Health Plan for those Enrolled Children who have a catastrophic or chronic condition. Through medical case management, the Utilization Management Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and Supplies which are not otherwise covered. The decision to provide extended or alternative benefits is made on a case-by-case basis to Enrolled Children who meet the Utilization Management Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the Utilization Management Program.
Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders	1) Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the Enrolled Child's Practitioner and provided by a licensed physical therapist. 2) Benefits are provided for Medically Necessary occupational therapy services prescribed by the Enrolled Child's Practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist. 3) Benefits are provided for Medically Necessary speech therapy services prescribed by the Enrolled Child's Practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders. 4) Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.
Durable Medical Equipment	1) Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, at the Healths Plan's discretion, the purchase price of such equipment may be allowed. 2) To be DME, an item must be a) made to withstand repeated use; b) primarily used to serve a medical purpose; c) generally not useful to a person in the absence of illness, injury or disease; and d) appropriate for use in the enrolled child's home. 3) Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from acidental injury, illness, or congenital abnormalities are covered serices. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following: a) a surgical boot which is part of an upright brace; b) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes; and c) a custom fabricated shoe in the case of significant foot deformity. 4) Eyeglasses are limited to one per year. 5) Hearing aids are limited to one per ear, as indicated, every three years.
Hospice Care	Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of $15,000.
Anesthesia	Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

Benefit Coverage	Terms & Conditions / Limitations & Exclusions
Transplants	1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies: (a) the Enrolled Child obtains prior approval from the Utilization Management Program; and (b) the condition is life-threatening; and (c) such transplant for that condition is the subject of an ongoing phase III clinical trial; and (d) such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and (e) the Enrolled Child is a suitable candidate for the transplant under the medical protocols used by the Utilization Management Program. 2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure. 3) Benefits are provided for transportation costs of recipient and one other individual to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of one individual at the site of transplant surgery. Reasonable and necessary expenses for transportatio meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to $10,000. 4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient, the following applies: (a) The following expenses are covered: □ A search for matching tissue, bone marrow or organ; □ Donor's transportation; □ Charges for removal, withdrawal and preservation; □ Donor's hospitalization. (b) When only the recipient is an Enrolled Child, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the Enrolled Child's contract. (c) When both the recipient and the donor are Enrolled Children, the donor is entitled to
Manipulative Therapy	Manipulative therapy is a covered medical expense, but benefits are limited to $1,500 per benefit period.
Optometric Services	Benefits are provided for Medically Necessary services and Supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for an annual routine eye examination, if indicated by the results of a vision screening, and the fitting of eyeglasses.
Medical transportation	Professional ambulance services to the nearest hospital which is equipped to handle the Enrolled Child's condition in connection with covered hospital inpatient care, or when related to and within 72 hours after accidental bodily injury or medical emergency whether or not inpatient care is required, are covered expenses.

Appendix 5 – State Listing of Medicaid and SCHIP Eligibility and Cost Sharing Levels as of August 2004

State	Program Eligibility by Child's Age and Federal Poverty Level			Cost sharing (not including copays)
	Medicaid (Title XIX)	Medicaid-expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)	Premiums and enrollment fees for children in SCHIP programs
Alabama	0-5 up to 133% 6-18 up to 100%	No program	0-5 from 133% to 200% 6-18 from 100% to 200%	151%-200% $100 annual premium per child w/$300 max (copays range from $1-$15) 100%-150% $50 annual premium per chld w/$150 max (copays range from $1-$6)
Alaska	0-5 up to 133% 6-18 up to 100%	0-5 from 133% to 185% 6-18 from 100% to 185%	No program	No premium or enrollment fee
Arizona[a]	Infants up to 140% 1-5 up to 133% 6-18 up to 100%	No program	Infants from 140% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	175%-200% $25 PMPM w/$35 max 150%-175% $15 PMPM w/$25 max 100%-150% $10 PMPM w/$15 max
Arkansas	0-18 up to 200%	No program	unborn children in families with incomes at or below 200% who are not eligible for Medicaid primarily because of their immigration status	No premium or enrollment fee
California	Infants up to 200% 1-5 up to 133% 6-18 up to 100%	One month bridge from Medicaid to SCHIP children 1-18 ineligible for Medicaid due to excess property & income <250%	Infants from 200% to 250% 1-5 from 133% to 250% 6-18 from 100% to 250% AIM program[b]: 0-1 from 200% to 250% for infants born to moms enrolled in AIM prior to 7/1/04 0-2 from 200%-300% for infants born to moms enrolled on or after 7/1/04	150%-250% $9 PMPM w/$27max 100%-150% $7 PMPM w/$14max 150%-250% $6 PMPM w/$18max (discounted plan) 100%-150% $4 PMPM w/$8max (discounted plan)
Colorado	0-5 up to 133% 6-18 up to 100%	No program	0-5 from 133% to 185%[c] 6-18 from 100% to 185%	151%-185% $25 annual enrollmetn fee w/$35max
Connecticut	0-18 up to 185%	No program	0-18 from 185% to 300%	235%-300% $30 PMPM w/$50max 185%-235% No Premium
Delaware	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 186% to 200%	1-5 from 133% to 200% 6-18 from 101% to 200%	167%-200% $25 PFPM 134%-166% $15 PFPM 101%-133% $10 PFPM
District of Columbia	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	No program	No premium or enrollment fee
Florida	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 185% to 200%	1-5 from 133% to 200% 6-18 from 101% to 200%	151%-200% $20 PMPM 100%-150% $15 PMPM
Georgia	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	No program	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	Premiums are only charged on children 6 and older 100%-150% $10 PMPM w/$15 max 151%-160% $20 PMPM w/$40 max 161%-170% $22 PMPM w/$44 max 171%-180% $24 PMPM w/$48 max 181%-190% $26 PMPM w/$52 max 191%-200% $28 PMPM w/$56 max 201%-210% $29 PMPM w/$58 max 211%-220% $31 PMPM w/$62 max 221%-230% $33 PMPM w/$66 max 231%-235% $35 PMPM w/$70 max
Hawaii	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	No program	No premium or enrollment fee

State	Program Eligibility by Child's Age and Federal Poverty Level			Cost sharing (not including copays)
	Medicaid (Title XIX)	Medicaid-expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)	Premiums and enrollment fees for children in SCHIP programs
Idaho	0-5 up to 133% 6-18 up to 100%	0-5 from 133% to 150% 6-18 from 100% to 150%	0-18 from 150% to 185%	150%-185% $15 PMPM
Illinois[d]	Prenatal up to 200% Infants up to 185% 1-5 up to 133% 6-18 up to 100%	6-18 from 100%-133%	0-18 from 133% to 200% unborn children at or below 200% not eligible for Medicaid	150%-200% $15 PMPM $25 for 2, $30 for 3 or more
Indiana	Infants up to 150% 1-5 up to 133% 6-18 up to 100%	1-5 from 133% to 150% 6-18 from 100% to 150%	0-18 from 150% to 200%	175%-200% $16.50 PMPM w/$24.75 max 150%-175% $11 PMPM w/$16.50 max
Iowa	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 185% to 200% 6-18 from 100% to 133%	0-18[e] from 133% to 200%	150%-200% $10 PMPM w/$20 max
Kansas	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	No program	Infants from 150% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	176%-200% $30 PFPM 150%-175% $20 PFPM
Kentucky	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	1-5 from 133% to 150% 6-18 from 100% to 150%	Infants from 185% to 200% 1-18 from 150% to 200%	150%-200% $20 PMPM
Louisiana	0-5 up to 133% 6-18 up to 100%	0-5 from 133% to 200% 6-18 from 100% to 200%	No program	No premium or enrollment fee
Maine	Infants up to 185% 1-5 up to 133% 6-18 up to 125%	1-5 from 133% to 150% 6-18 from 125% to 150%	Infants from 185% to 200% 1-18 from 150% to 200%	185%-200% $20 PMPM w/$40 max (2 or more children) 170%-185% $15 PMPM w/$30 max 160%-170% $10 PMPM w/$20 max 150%-160% $5 PMPM w/$10 max <150% No Premiums
Maryland	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	1-5 from 133% to 200% 6-18 from 100% to 200%	0-18 from 200% to 300%	250%-300% $52 PFPM 200%-250% $41 PFPM
Massachusetts	Infants up to 185% 1-5 up to 133% and from 133%-155% fi insured at the time of application 6-18 up to 114% and from 114% to 150% if insured at the time of application 14-18 up to 86% and from 86% to 150% if insured at the time of application	Infants from 185% to 200% 1-5 from 133% to 150% if uninsured at thetime of application 6-13 from 114% to 150% if uninsured at the time of application 14-17 from 86% to 150% if unisured at the time of application 18 up to 150%	1-5 from 150% to 200% 6-13 from 150% to 200% 14-17 from 150% to 200% 18 from 150% to 200% unborn children up to 225%	Children under age 6 under 150% FPL - no premiums children under age 1 - no premiums 151%-200% $12 PMPM w/$36 max 133%-150% $12 PMPM w/$15 max
Michigan	Infants up to 185% 1-15 up to 133% 16-18 up to 100%	16-18 up to 150%	Infants from 185% to 200% 1-18 from 150% to 200% unborn chldren up to 185%	150%-200% $5 PFPM
Minnesota[f]	0-2 up to 275% 2-18 up to 150% 19&20 up to 100% and medically needy MinnesotaCare §1115 waiver; 0-21 up to 275%	0-2 from 275% to 280%	Current SCHIP §1115 waiver: parents & caretakers with income between 100% and 200% FPL enrolled in MinnesotaCare. Unborn children of mothers ineligible for Medicaid with income up to 275%	No cost sharing for infants under SCHIP Medicaid expansion and no cost sharing for newborn under separate SCHIP

State	Program Eligibility by Child's Age and Federal Poverty Level			Cost sharing (not including copays)
	Medicaid (Title XIX)	Medicaid-expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)	Premiums and enrollment fees for children in SCHIP programs
Mississippi	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	No program	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	No premium or enrollment fee
Missouri	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 185% to 300% 1-5 from 133% to 300% 6-18 from 100% to 300%	No program	185%-225% Copay ($5 office visit) 225%-300% Copay ($9 Rx, $10 office visit) Premium (variable $62 min $252 max adjusted annualy)
Montana	0-5 up to 133% 6-18 up to 100%	No program	0-5 from 133% to 200% 6-18 from 100% to 200% If not Medicaid eligible: 0-18 0% to 200%	No premium or enrollment fee
Nebraska	Infants up to 150% 1-5 up to 133% 6-18 up to 100%	Infants from 150% to 185% 1-5 from 133% to 185% 6-18 from 100% to 185%	No program	No premium or enrollment fee
Nevada	0-5 up to 133% 6-17 up to 100%	No program	0-5 from 133% to 200% 6-17 from 100% to 200% 18 up to 200%	176%-200% $70 PFPQ 151%-175% $35 PFPQ 133%-150% $15 PFPQ
New Hampshire	0-19 up to 185%	Infants 185% to 300%	1-19 from 185 % to 300%	250%-300% $45 PMPM w/$135 max 185%-250% $25 PMPM w/$100 max
New Jersey	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	6-18 from 100% to 133%	Infants from 185% to 350% 1-18 from 133% to 350%	301%-350% $113.50 PFPM 251%-300% $68 PFPM 201%-250% $34 PFPM 151%-200% $17 PFPM
New Mexico	0-18 up to 185%	0-18 from 185% to 235%	No program	Copays only
New York	Infants up to 200% 1-5 up to 133% 6-18 up to 100%	6-18 from 100% to 133%	Infants 200% to 208% 1-18 from 133% to 208%	186%-208% $15 PMPM 134%-185% $9 PMPM 100%-133% None
North Carolina	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	No program	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	150%-200% $50 annaual enrollment fee per child w/$100 max
North Dakota	0-5 up to 133% 6-18 up to 100%	Eliminated Medicaid assets test. Children who were previously not eligible for medicaid due to assets are now eligible for the SCHIP Medicaid expansion.	0-5 from 133% to 140% 6-18 from 100% to 140%	No premium or enrollment fee
Ohio[g]	0-18 up to 150%	0-5 from 133% to 200% 6-18 from 100% to 200%	No program	No premium or enrollment fee
Oklahoma	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	Infants from 150% to 185% 1-5 from 133% to 185% 6-18 from 100% to 185%	No program	No premium or enrollment fee
Oregon	0-5 up to 133% 6-18 up to 100%	No program	0-5 from 133% to 185% 6-18 from 100% to 185%	No premium or enrollment fee
Pennsylvania	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	No program	Infants from 185% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	No premium or enrollment fee
Rhode Island[h]	0-7 up to 250% 8-18 up to 100%	8-18 from 100% to 250%	Unborn children up to 250%	Rhode Island enrollees earning over 150% of FPL pay a montly premium which varies by income: 200% to 250% $92 PFPM 185% to 200% $77 PFPM 150% to 185% $61 PFPM

State	Program Eligibility by Child's Age and Federal Poverty Level			Cost sharing (not including copays)
	Medicaid (Title XIX)	Medicaid-expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)	Premiums and enrollment fees for children in SCHIP programs
South Carolina	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	1-5 from 133% to 185% 6-18 from 100% to 185%	No program	No premium or enrollment fee
South Dakota	0-5 up to 133% 6-18 up to 100%	0-5 from 133% to 140% 6-18 from 100% to 140%	0-18 from 140% to 200%	No premium or enrollment fee
Tennessee	0-18 up to 200%	No program	No program	No premium or enrollment fee
Texas	Infants up to 185% 1-5 up to 133% 6-18 up to 100%	No program	0-18 up to 200%	186%-200% $55 PFPM 151%-185% $20 PFPM 101%-150% $15 PFPM
Utah	0-5 up to 133% 6-18 up to 100%	No program	0-18 up to 200%[l]	151%-200% $25 PFPQ 101%-150% $13 PFPQ <100% No Premiums
Vermont	0-18 up to 225% and the underinsured up to 300%	No program	0-18 from 225% to 300%	225%-300% $70 PFPM
Virginia	0-5 up to 133% 6-18 up to 100%	6-18 from 100% to 133%	0-5 from 133% to 200% 6-18 from 133% to 200%	Copays only for children in Separate program
Washington	0-18 up to 200%	No program	0-18 from 200% to 250% Unborn chldren up to 185%	200%-250% $15 PMPM w/$45 max
West Virginia	Infants up to 150% 1-5 up to 133% 6-18 up to 100%	No program	Infants up to 150% to 200% 1-5 from 133% to 200% 6-18 from 100% to 200%	No premium or enrollment fee
Wisconsin	0-5 up to 185% 6-18 up to 100%	6-18 from 100% to 185% (once enrolled, those eligible may remain until 200%)	No program	150%-200% 3% of household income (This will increase to 5% on 1/1/04)
Wyoming	0-5 up to 133% 6-18 up to 100%	No program	0-5 from 134% to 185% 6-18 from 100% to 185%	$200 PFPY

Source: National Academy for State Health Policy. "*Income eligibility levels for children in Medicaid and SCHIP and Cost Sharing, as of August 2004.*" October 2004. <http://www.nashp.org/Files/Elig_and_Cost_Sharing_2004.pdf>.

[a] *Arizona has a HIFA waiver using unspent SCHIP funds covering childless adults up to 100% and parents up to 200%. Cost sharing for HIFA parents is 100% to 150% - $15 PMPM; 150% to 175% - $20 PMPM; 175% to 200% - $25 PMPM.*

[b] *The Access for Infants and Mothers Program (AIM) provides low cost health insurance coverage to uninsured, low-income pregnant women and their infants. California's SCHIP program finances coverage for children ages 0 - 2 years (but claiming Title XXI for 0-1) whose mothers are enrolled in AIM who have income between 200% and 250% of the Federal Poverty Level.*

[c] *Colorado - In separate SCHIP Program, child may be at 100% of FPL but hae too manyu assets to be eligible for Mediciad*

[d] *Illinois throguh a HIFA waiver is using SCHIP funds are covering parents and adults fro about 38% to 133% FPL.*

[e] *Although Medicaid usually covers infants, there are certain circumstances where an infant is covered on the separate program. Ths is primarily due to Medicaid not allowing depreciation of capital assets as a deduction to self-employment income whereas the SCHIP program does.*

[f] *MN has a SCHIP §1115 waiver covering parents & caretakers with income between 100% and 200 % FPL: Premiums on a sliding fee scale; co-pays: $3 prescriptions; $25 eyeglasses; 10% of hospital paid charges with $1000/$3000 max/year for individual/family; 50% of non-preventive dental services for those with income ≤175% FPL.*

[g] *Ohio implemented a wrap around program with its SCHIP implementation in January 1998. SCHIP covers uninsured kids, and Medicaid picks up ther otherwise insured kids.*

[h] *Through an 1115 waiver, Rhode Island also covers pregnant women 185%-250% FPL under a Medicaid expansion SCHIP, and parents of children under 18 up to 185% FPL under a separate SCHIP.*

[i] *Since Utah SCHIP does not have an asset test, the separate SCHIP program covers those children whose families fail the asset test.*

Appendix 6– Agency Response Letters to the Report

STATE OF MISSISSIPPI
HALEY BARBOUR, GOVERNOR

DEPARTMENT OF FINANCE AND ADMINISTRATION

J. K. STRINGER, JR.
EXECUTIVE DIRECTOR

February 25, 2005

The Honorable Phil Bryant
State Auditor
801 Woolfolk Building
501 North West Street
Jackson, MS 39201

Dear Mr. Bryant:

Thank you for the opportunity to review the final version of the draft report *A Limited Analysis of the State Children's Health Insurance Program (SCHIP).* The report provides a comprehensive review of the history and current status of this Program.

I have contacted your staff regarding a few minor wording issues, but I take no exceptions to the major findings and recommendations of the report. I agree with the overall premise of the report that this program has provided comprehensive health care coverage to eligible children and has been successful in reducing the number of uninsured children in Mississippi, but that cost containment efforts should be considered where they would not compromise the basic health of the children. I would add the caveat, however, that the administrative cost of some of the strategies should be weighed closely against any savings that may accrue. Although Mississippi has not reached its cap on administrative costs, those dollars not spent on administration can be used to provide health care coverage for eligible children.

The Office of Insurance staff is pleased to administer the insurance component of this Program on behalf of the Health Insurance Management Board and stands ready and willing to assist the Division of Medicaid in making further improvements to this Program.

Sincerely,

Therese Hanna

Therese Hanna
State Insurance Administrator

cc: Col. J. K. Stringer, Jr.
Ms. Rita Wray

HALEY BARBOUR
GOVERNOR

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR

February 25, 2005

The Honorable Phil Bryant
State Auditor
801 Woolfolk Building
501 North West Street
Jackson, MS 39201

Dear Mr. Bryant:

Thank you for the opportunity to review and respond to the final version of the draft report, *A Limited Analysis of the State Children's Health Insurance Program (SCHIP)*. My office has discussed the report with Dr. Warren Jones, Executive Director of the Division of Medicaid, and Mrs. Therese Hanna, State Insurance Administrator of the Department of Finance and Administration.

I support the comments and recommendations submitted by Dr. Jones and Mrs. Hanna concerning the report. Their expertise and knowledge of SCHIP is vital to an appropriate analysis of the program. Additionally, I know my staff has visited with your office about several issues needing further review. Specifically, I worked with our federal delegation and the Bush Administration to find a solution to the funding challenges facing SCHIP for the remainder of this fiscal year as well as working towards a more equitable funding formula for our state.

As a result of these discussions, Mississippi was fortunate to receive the needed federal deficit funding on January 19th, 2005, through the redistribution process as well as additional funds to carry over into the next fiscal year. The report as currently drafted does not reflect this new funding. Although I still believe the program cannot continue to operate as it is currently with an unstable and unbalanced federal funding mechanism, I think it is important to acknowledge the Administration's recent help.

The report contains some language that speaks to introduced federal legislation concerning SCHIP as well as some findings and recommendations regarding outside funding sources that I do not agree with entirely; however, I do agree with the report's assessment of the current SCHIP program being a comprehensive benefit package that provides good health care coverage for eligible children as well as helping in reducing the number of uninsured children. And I also agree with the report's sentiments concerning the need for cost containment efforts.

I look forward to working with you on this important program for our children. Please let me know if my office can be of further assistance to you or your staff. Thank you for your service to Mississippi and its citizens.

Sincerely,

Haley Barbour
Governor

HB/ns

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

WARREN A. JONES, M.D., FAAFP
EXECUTIVE DIRECTOR

March 3, 2005

The Honorable Phil Bryant
State Auditor
801 Woolfolk Building
501 North West Street
Jackson, Mississippi 39201

Dear Mr. Bryant:

I appreciate the opportunity to review and provide input in the draft report, A Limited Analysis of the State Children's Health Insurance Program (SCHIP), submitted to the Division of Medicaid Office of the Governor on February 14, 2005.

The Division of Medicaid, Office of the Governor has no objections to the findings listed in the report except as indicated below.

- The recommendation to implement employer sponsored insurance, or conduct quarterly reviews will result in a need for additional staff and funds, resulting in an increase in administrative cost and overall program cost.
- Another recommendation suggests that DOM require proof of income, check for other insurance, as well as other information changes (page 14). This is currently a part of the standard eligibility determination and re-determination process of the program.
- It is understood that this report was started during the summer of 2004. Consequently, there are several references to "The transition in 2005" or the structure prior to the transition (page 11). Therefore, it is suggested that the report reflects the January 2005 structure of the MS Health Benefit Program and its requirements for eligibility determination.
- Page 13 of the report states that infants who apply for CHIP within 31 days of birth are not subject to other credible insurance coverage this is contrary to the Mississippi Health Benefits Program Procedural Policy Manual.

March 3, 2005

Again, thank you and your staff for your receptiveness of our earlier comments as we have communicated to fine-tune the report if you need additional information, please contact Maria Morris at (601) 359-4294.

Sincerely,

Warren A. Jones, M.D.
Executive Director