#519

Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

Mississippi's Children's Health Insurance Program: A Policy Analysis

The Children's Health Insurance Program (CHIP) is a joint federal/state program funded primarily through a block grant from the federal government that is based on the number of children in low-income families, the number of those children who are uninsured, and the state cost factor. The federal government provides the majority of the funding for the program through an enhanced federal match rate, which was 83.4% for Federal Fiscal Year 2008.

States have the authority to design their own CHIPs. Mississippi law sets out minimum requirements for the state's CHIP and authorized a CHIP Commission to set up the structure of the program. The CHIP Commission recommended that Mississippi's Children's Health Insurance Program operate as a separate, fully insured program under the direction of the State and School Employees' Health Insurance Management Board. The Division of Medicaid also has CHIP responsibilities and the division's officials are ultimately held responsible by the federal Centers for Medicare and Medicaid Services for program administration and oversight.

Mississippi operates a separate CHIP that provides benchmark equivalent "plus" coverage, which means that Mississippi's CHIP provides all of the benefits provided by the benchmark plan (i. e., the State and School Employees' Life and Health Plan), as well as additional benefits (e. g., dental and vision coverage).

The current CHIP insurer, Blue Cross Blue Shield of Mississippi (BCBSMS), was selected through a competitive bidding process. The current agreement allows the insurer to operate similar to a third-party administrator. BCBSMS is allowed to set aside a portion of premiums paid by the state for administration and then pay claims out of the remaining amount. If the amount of claims paid out is more than the set-aside amount of the premium, BCBSMS is allowed to recover that amount.

From January 2004 through June 2008, the total cost of Mississippi's CHIP was approximately $605 million, with the federal government contributing $505 million and the state contributing approximately $100 million. The cost of CHIP varies yearly and depends largely on the premium rate structure charge by the insurer.

PEER believes that Mississippi's CHIP has opportunities for cost savings that the state has not yet achieved, including restructuring benefits, increasing cost sharing, implementing prescription drug cost containment measures, and implementing enrollment controls.

Given that no clear best practice model for a state CHIP emerged from a national survey and PEER's own survey of selected states and given that Mississippi's present contract with BCBSMS ends December 2009, PEER recommends that the state issue a request for proposals for a new service delivery structure to be effective for 2010. This structure should incorporate PEER's recommended cost savings measures and changes in contract terms.

December 10, 2008

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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December 10, 2008

Honorable Haley Barbour, Governor
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Honorable Billy McCoy, Speaker of the House
Members of the Mississippi State Legislature

On December 10, 2008, the PEER Committee authorized release of the report entitled **Mississippi's Children's Health Insurance Program: A Policy Analysis**.

Senator Sidney Albritton, Chair

This report does not recommend increased funding or additional staff.

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Mississippi's Children's Health Insurance Program: A Policy Analysis

Executive Summary

Introduction

The federal Children's Health Insurance Program (CHIP), a federal grant program, officially ended September 30, 2007, but has been extended several times through federal legislation. At present, CHIP is funded through March 2009 and Congress will either reauthorize the program or consider another funding extension. Also, Mississippi's current contractual relationship with its CHIP insurer, Blue Cross Blue Shield of Mississippi, was scheduled to end December 31, 2008. (The State and School Employees' Health Insurance Management Board [HIMB] has exercised an option to extend the agreement one year to December 31, 2009.)

In light of the above information, a legislator requested PEER to review the administrative structure of Mississippi's CHIP, determine possible changes that could be implemented to the structure, identify the implications of any change, and attempt to assign a cost basis to the components of various CHIP models.

PEER sought to answer the following questions:

- What are the legal authority and funding structure for Mississippi's CHIP?
- How does Mississippi operate its Children's Health Insurance Program and how has program enrollment trended in recent years?
- How do other states operate their Children's Health Insurance Programs?
- What are the total costs of Mississippi's CHIP and the cost components of the CHIP premium rate structure?
- How does provider access compare between Mississippi's CHIP and Medicaid?
- What actions should Mississippi take regarding its CHIP?

Conclusions

What are the legal authority and funding structure for Mississippi's Children's Health Insurance Program?

Title XXI of the Social Security Act created the Children's Health Insurance Program and its funding mechanism. States have the authority to design their own CHIPs. MISS. CODE ANN. Section 41-86-1 et seq. (1972) set out minimum requirements for the state's CHIP and authorized a CHIP Commission to structure a program consistent with minimum standards set forth in federal and state laws. Following the guidelines promulgated by state law, the CHIP Commission recommended that Mississippi's Children's Health Insurance Program operate as a separate, fully insured program under the direction of the State and School Employees' Health Insurance Management Board.

CHIP is a joint federal/state program funded primarily through a block grant from the federal government that is based on the number of children in low-income families, the number of those children who are uninsured, and the state cost factor. The federal government provides the majority of the funding for the program. The federal match rate for Federal Fiscal Year (FFY) 2008 was 83.4%.

How does Mississippi operate its Children's Health Insurance Program and how has program enrollment trended in recent years?

MISS. CODE ANN. § 41-86-9 (2) (a) (1972) gave the CHIP Commission the authority to designate either the Division of Medicaid (DOM) or the State and School Employees' Health Insurance Management Board as the administering agency for the program. In its report, the CHIP Commission directed the State and School Employees' Health Insurance Management Board (HIMB) to administer the program. The Division of Medicaid also has CHIP responsibilities and the division's officials are ultimately held responsible by the federal Centers for Medicare and Medicaid Services for program administration and oversight.

Mississippi operates a separate CHIP that provides benchmark equivalent "plus" coverage, which means that Mississippi's CHIP provides all of the benefits provided by the benchmark plan (i. e., the State and School Employees' Life and Health Plan), as well as additional benefits (e. g., dental and vision coverage).

The current CHIP insurer, Blue Cross Blue Shield of Mississippi, was selected through a competitive bidding process. The term of the contractual agreement is for four years (January 1, 2005, through December 31, 2008; the HIMB has exercised an option to extend the agreement for

one year.) The current CHIP agreement contains a one-time premium call that requires the state to reimburse the insurer for any claims costs that exceed the amount available to pay claims and the insurer to reimburse the state any excess amount when the premiums paid exceed claims incurred. This is typical of a participating insurance arrangement, which is the type of agreement that currently exists between the insurer and the state, and has the effect of removing substantial risk from the insurance product. Removing risk from the contract could remove the insurer's incentive to implement vigorously certain required components of the contract such as utilization review. Strong utilization review could have a financial impact on providers in the network.

The overall enrollment for the program has remained consistent in recent years, with the majority of CHIP enrollment consisting of enrollees from families earning less than 150% of the federal poverty level and children age six to eighteen.

How do other states operate their Children's Health Insurance Programs?

A survey by the National Academy for State Health Policy and PEER's own survey of selected states show a range of administrative and service structures but yield no best practice model or most efficient organization. Each state's program has its own strengths and weaknesses based on that state's target population and service goals.

According to the National Academy for State Health Policy's 2005 survey of states' CHIPs:

- many states are moving toward separate CHIPs;
- most separate CHIPs are housed in the state's Medicaid agency or the agency that houses Medicaid;
- most CHIPs contract with administrative service organizations;
- cost sharing for CHIPs is restricted by federal guidelines; and,
- the most common type of delivery system is through managed care companies that deliver a comprehensive set of benefits.

PEER also conducted its own survey of six selected states and found a variety of administrative and service delivery structures, program costs, and benefits/services package. Among the states surveyed, Calendar Year 2007 program expenditures per member per month ranged from $100 in Arkansas to $210 in Tennessee, but PEER cautions that states' program expenditures are not comparable for a variety of reasons. While the states surveyed are comparable with each other and Mississippi in basic

benefits provided, states varied in requirements for cost sharing, level of maximum benefits, and percentages paid for covered services.

What are the total costs of Mississippi's CHIP and the cost components of CHIP's premium rate structure?

From January 2004 through June 2008, the total cost of Mississippi's CHIP was approximately $605 million, with the federal government contributing $505 million and the state contributing approximately $100 million. The cost of CHIP varies yearly and depends largely on the premium rate structure charge by the insurer.

The premium rate for CHIP is based on the sum of six components. The six components that fluctuate and can cause premium rate changes (depending on program utilization) are trended claims, the recoupment component, administrative fees, risk pool assessments, premium taxes, and vision service premiums. Mississippi's per member per month premium for calendar year 2008 is $231.13.

The current participating agreement with Blue Cross Blue Shield of Mississippi allows the insurer to operate similar to a third-party administrator. Currently, BCBSMS is allowed to set aside a portion of premiums paid by the state for administration and then pay claims out of the remaining amount. If the amount of claims paid out is more than the set-aside amount of the premium, BCBSMS is allowed to recover that amount. Conversely, if the portion of the premium amount that is set aside to pay claims is greater than the amount of claims incurred, then BCBSMS must refund the overage to the state. Department of Finance and Administration officials have stated that this agreement limits increases in the administrative component of the premium that the insurer charges the state.

PEER believes that Mississippi's CHIP has opportunities for cost savings that the state has not yet achieved, including restructuring benefits, increasing cost sharing, implementing prescription drug cost containment measures, and implementing enrollment controls. (See pages 45 through 50 of the report for a full discussion of these cost savings opportunities.)

How does provider access compare between Mississippi's CHIP and Medicaid?

Factors affecting the provider networks for CHIP and a Medicaid population resembling CHIP include access to the nearest provider, provider caseload, and allowable reimbursements for services rendered. All of these factors are important for adequate health care access. Data analysis shows that provider access (distance from

beneficiary to nearest provider) is comparable between Mississippi's CHIP and a similar Medicaid population. However, data analysis suggests differences in the provider caseloads between the two groups, with the Medicaid group having the greater demand for services. Also, an allowable charge comparison shows that on selected services, the Medicaid allowable amount is 48% of the current CHIP allowable amount.

What actions should Mississippi take regarding its CHIP?

Given that no clear best practice model for a state CHIP emerged from a national survey and PEER's own survey of selected states and given that Mississippi's contract with BCBSMS ends December 2009 (because HIMB exercised an option to extend the contract one year), PEER recommends that the state issue a request for proposals for a new service delivery structure to be effective for 2010. This structure should incorporate PEER's recommended cost savings measures and changes in contract terms.

Policymakers should be aware of the impediments to change that could exist in implementing cost savings measures or changing to a different administrative structure. These impediments include the requirements of existing state law, review and approval of changes by the federal Centers for Medicare and Medicaid Services, whether the program will be reinstated at the federal level, and the effects of the CHIP funding formula.

Recommendations

1. Based on the comparisons between the current CHIP and a Medicaid population that resembles CHIP with respect to access to care, provider to beneficiary ratio, and allowable charges, PEER sees no reason to question the decision made by the CHIP Commission in 1998 and the current structure of the program.

   If CHIP is to remain under the control of the Health Insurance Management Board, any public policy debate should include the following:

   a. During the 2009 session, the Legislature should amend MISS. CODE ANN. Section 25-15-303 (1972) to add the Executive Director of the Division of Medicaid to the HIMB to be included as a voting member of the board concerning matters related exclusively to the CHIP, to be effective upon passage.

b. After this amendment becomes effective, the HIMB should, utilizing program data from the last ten years, develop a request for proposals for a new CHIP service delivery structure. The RFP should be issued in 2009 for contract year 2010 and beyond. The new service delivery structure should incorporate cost savings measures such as those identified in this report, including:

- restructuring benefits so that they are more in line with the State and School Employees' Life and Health Plan, a step that could require the Legislature to amend MISS. CODE ANN. §41-86-17 (1972);
- increasing cost sharing, a step that could require the Legislature to amend MISS. CODE ANN. §41-86-17 (1972);
- implementing prescription drug cost containment measures, a step that could require the Legislature to amend MISS. CODE ANN. §41-86-17 (1972);
- implementing enrollment controls; and,
- utilizing alternative administrative structures, examples of which are included in Appendix B, page 113.

The RFP should request proposals for both an insurance product as well as a self-insured product with third-party administrator(s). A bid for a self-insured product should consider all of the costs such as, but not limited to, reinsurance for claims that are abnormally high. The HIMB should choose the best and most cost efficient proposal.

c. In the event that the board chooses to issue an RFP for insurance coverage, it should make clear in its RFP that it will no longer include a one-time premium call at the end of any contract and that all future premium rates should be based solely on actuarial history and projections.

2. Prior to any decision of transferring CHIP to DOM, the division should submit the following information to the Legislature:

a. a continuation of services plan that outlines how the division intends to operate the CHIP, including such factors as the:

- type of program the division intends to operate--e. g., Medicaid expansion, separate, or combination;

- administrative service structure that will be utilized--e. g., in-house, contracting out, or a combination;

- service delivery methods that will be implemented--e. g., contractor-based, primary care, or fee for service;

- list of medical service providers; and,

- how DOM will ensure that the service structure will not suffer as a result of a program transfer.

b. the allowable rates for medical services rendered that DOM will utilize for providers to determine the effect they will have on the provider network that services the current CHIP population;

c. a survey conducted of the current CHIP providers to determine whether they intend to remain as providers in the program given the continuation plan and the allowable rates DOM will utilize; and,

d. the provider to beneficiary caseload ratio to determine whether CHIP beneficiaries who are currently in the program will encounter an appreciable loss of service as a result of a program transfer.

3. The Legislature should amend MISS. CODE ANN. Section 25-61-9 (1972) to exclude PEER and other investigative bodies from the scope of any protective order limiting public access to documents in the possession of state agencies.

   Additionally, the Legislature should adopt legislation that would clearly authorize legislative enforcement of subpoenas through the court system if a committee deems such enforcement necessary to carry out its prerogatives. The Legislature should also define in law the criminal offense of contempt of the Legislature and establish a penalty for such.

For More Information or Clarification, Contact:

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Mississippi's Children's Health Insurance Program: A Policy Analysis

Introduction

Authority

In accordance with MISS. CODE ANN. Section 5-3-51 et seq. (1972), the PEER Committee conducted a policy analysis of Mississippi's Children's Health Insurance Program (CHIP).

Problem Statement

The federal Children's Health Insurance Program, a federal grant program, officially ended September 30, 2007, but has been extended several times through federal legislation. At present, CHIP is funded through March 2009 and Congress will either reauthorize the program or consider another funding extension. Also, Mississippi's current contractual relationship with its CHIP insurer, Blue Cross Blue Shield of Mississippi, was scheduled to end December 31, 2008. (The State and School Employees' Health Insurance Management Board has exercised an option to extend the agreement one year to December 31, 2009.)

In light of the above information, a legislator requested PEER to review the administrative structure of Mississippi's CHIP, determine possible changes that could be implemented to the structure, identify the implications of any change, and attempt to assign a cost basis to the components of various CHIP models.

Scope and Purpose

In conducting this review, PEER sought to answer the following questions:

- What are the legal authority and funding structure for Mississippi's CHIP?
- How does Mississippi operate its Children's Health Insurance Program and how has program enrollment trended in recent years?

- How do other states operate their Children's Health Insurance Programs?
- What are the total costs of Mississippi's CHIP and the cost components of the CHIP premium rate structure?
- How does provider access compare between Mississippi's CHIP and Medicaid?
- What actions should Mississippi take regarding its CHIP?

PEER did not attempt to evaluate the management performance of any of the state entities involved in the administration of this program (i. e., the Division of Medicaid [DOM], the Department of Finance and Administration [DFA], or the State and School Employees' Health Insurance Management Board [HIMB]).

Method

In conducting this review, PEER:

- analyzed state and federal laws regarding the operation of the Children's Health Insurance Program;
- reviewed programmatic and/or utilization documents and records submitted by DOM, DFA, Blue Cross Blue Shield of Mississippi (the Mississippi program's insurer), and other states' children's health insurance programs; and,
- interviewed personnel with DOM, DFA, Blue Cross Blue Shield of Mississippi, the federal Centers for Medicare and Medicaid Services, and other states' children's health insurance programs.

Protective Order and Potential Fieldwork Constraints for Future Reviews

Contractors who are concerned about their competitors obtaining their companies' confidential information sometimes obtain protecting orders to protect the release of information submitted in response to request for proposals for which they were eventually awarded the contract. PEER has encountered two such protective orders within the past year that have affected staff fieldwork activities. Consequently, this affects the

Legislature's ability to carry out its responsibility of overseeing expenditures made with public funds.

The request for proposals for this review was protected from release under similar circumstances. However, this protective order was not an impediment to PEER during the fieldwork phase.

Blue Cross Blue Shield of Mississippi (BCBSMS), the CHIP insurer, sought and received a protective order in the First Judicial District of Hinds County to prohibit the company's response to the request for proposals for the state's CHIP agreement from being disclosed. The order cited MISS. CODE ANN. §25-61-9 and §79-23-1 (1972), which are the statutes addressing the release of commercial and financial information that companies submit in response to requests for proposals. The court granted this protection on the grounds that the proposal, with exhibits and the agreement and all renewals, amendments and extensions, contained confidential information. PEER makes a recommendation on page 62 of this report to protect against such orders barring legislative bodies from obtaining information needed to support the policymaking activities of state government. Also, PEER recommends clarification regarding the enforcement of legislative subpoena power.

Chapter 1: What are the legal authority and funding structure for Mississippi's Children's Health Insurance Program?

State law set minimum requirements for the state's CHIP and authorized a CHIP Commission to set the structure of a program consistent with minimum standards set forth in federal and state laws. The federal government provides the majority of the funding for CHIP.

Title XXI of the Social Security Act created the Children's Health Insurance Program and its funding mechanism and gave states the authority to design their own CHIPs. MISS. CODE ANN. Section 41-86-1 et seq. (1972) sets out minimum requirements for the state's CHIP and authorized a CHIP Commission to set the structure of a program consistent with minimum standards set forth in federal and state laws. The federal government provides the majority of the funding for CHIP. The federal government grants funds in unique funding categories throughout the federal fiscal year and allows the state to match state funds at the enhanced federal match rate, which was 83.4% in Federal Fiscal Year 2008. Generally, Mississippi has utilized all federal fund allotments available.

This chapter provides answers to the two components of the above question:

- What is the legal authority for Mississippi's CHIP?
- What is the federal funding allotment formula?
- What is the federal funding process?

The following sections address these questions.

What is the legal authority for Mississippi's CHIP?

The Federal Balanced Budget Act of 1997 created Title XXI of the Social Security Act, which established CHIP. State law, in conjunction with recommendations of the state's CHIP Commission, established Mississippi's CHIP as a separate program that is implemented by a single insurer and is administered through the Mississippi State and School Employees' Health Insurance Management Board.

Statutory Authority for Mississippi's CHIP

Title XXI of the Federal Social Security Act established CHIP. MISS. CODE ANN. Section 41-86-1 et seq. (1972) governs Mississippi's CHIP, creating a CHIP Commission that established the operational aspects of the program.

Congress established the State Children's Health Insurance Program (SCHIP) through the Balanced Budget Act of 1997 and created Title XXI of the Social Security Act. The purpose of SCHIP was to expand health insurance coverage

to children in families whose income is modest but too great to qualify for traditional Medicaid. States are given broad guidelines and flexibility (Title 42, Chapter IV, Part 457 of the *Code of Federal Regulations*) to implement and design their own CHIPs, including eligibility, benefits, and cost sharing provisions.

Congress established the State Children's Health Insurance Program to expand health insurance coverage to children in families whose income is modest but too great to qualify for traditional Medicaid.

The Mississippi CHIP Program is governed by MISS. CODE ANN. §41-86-1 et seq. (1972). This statute created the Children's Health Insurance Commission and empowered it to develop the State Child Health Plan, which determines the structure for CHIP. The plan had to meet the requirements set forth in Title XXI of the Social Security Act. Duties of the commission included designation of the agency to administer the program, coordination of health care benefits under the program with other sources of health care benefits, establishment of benefits and eligibility standards, and institution of quality assurance measures. The commission submitted its final report in July 1998 and was dissolved by law on August 1, 1998.

Recommendations of Mississippi's CHIP Commission

Following the guidelines promulgated by state law, the CHIP Commission recommended that Mississippi's Children's Health Insurance Program operate as a separate, fully insured program under the direction of the State and School Employees' Health Insurance Management Board.

The commission designated the Health Insurance Management Board (the board) to administer Mississippi's Children's Health Insurance Program. (See pages 12 through 14 for additional detail on the duties of each.) The commission directed the state to operate a fully insured separate insurance program with a single insurer, with the coverage to be benchmarked to the State and School Employees' Life and Health Plan. The program was to be operated by the State and School Employees' Health Insurance Management Board (HIMB), which oversees the State and School Employees' Health Insurance Plan. The commission members left open the possibility that the program could become self-insured if economically feasible.

The CHIP Commission believed that a separate insurance program would give better access to providers than a Medicaid expansion program would give.

State law directed the powers and duties of the commission, enrollee eligibility determination, and benefit coverages. These directives are codified in MISS. CODE ANN. §41-86-9, §41-86-15, and §41-86-17 (1972). In making the decision that the state's CHIP would be a separate insurance program (see a discussion of the types of program design on pages 14 through 16), the commission believed that a private plan could provide a level of benefits at least equal to those of Medicaid's comprehensive care services benefit package and would cap the cost at the federally allotted amount. A Medicaid expansion program would obligate the state to pay for the

amount necessary to cover the program and, as a result, could require spending above the CHIP funding amounts. Also, the commission believed that a separate insurance program would give better access to providers than a Medicaid expansion program would give. At the time, fewer physicians were accepting Medicaid because of low reimbursement rates and provider acceptance of insurance was far greater than acceptance of Medicaid. The commission referenced the facts of program design flexibility and perceived social stigmas associated with Medicaid. The federal provisions regulating a separate CHIP would allow for more flexibility than the regulations governing Medicaid and therefore provide the ability for the state to make revisions to CHIP in the future.

What is the federal funding allotment formula?

CHIP is a joint federal/state program funded primarily through a block grant from the federal government that is based on the number of children in low-income families, the number of those children who are uninsured, and the state cost factor. The federal government provides the majority of the funding for the program. The federal match rate for Federal Fiscal Year 2008 was 83.4%.

CHIP is a joint federal/state program. Enrollees pay no premiums to participate in the program.

Studies suggest that the formula used to calculate the state's allotment could be disproportionate to states such as Mississippi that have low health care average wages and that are also successful in enrolling children for the program.

The federal government provides a fixed allotment to each state every federal fiscal year (October 1 to September 30) using a formula that is based on the number of children in low-income families (children who are younger than nineteen in families that earn less than 200% of the federal poverty level), the number of such children who are uninsured, and the state cost factor. The *state cost factor* is a ratio of each state's annual wages in the health care industry to the national average wages in the health care industry.

Studies suggest that the formula used to calculate the state's allotment could be disproportionate to states such as Mississippi that have low health care average wages and that are also successful in enrolling children for the program. A May 2007 paper entitled *The State Children's Health Insurance Program*, published by the Congressional Budget Office, noted:

> *Each year, federal funding for SCHIP is allocated to states on the basis of a formula that takes into account the number of children in low income families (with income less than 200 percent of the poverty level) in each state, the number of such children who are uninsured, and wages in the health services section. An important and*

> *unintended limitation of the formula is that it reduces allotments for states that enroll more children in SCHIP.*

A January 2007 technical brief from the Center for Mississippi Health Policy entitled *How the SCHIP Funding Formula Disadvantages Mississippi* notes:

> *There are two primary factors in the SCHIP funding formula that have a negative effect on Mississippi: The state cost factor and the calculation for 'number of children'. The 'State Cost Factor' is based on annual average wages in the health services industry in each state and is meant to serve as a proxy for health care costs. This factor, however, does not equate to health care costs. There is very little correlation between this measure and overall health care costs. In addition, use of this factor serves to reduce the allotments to states with low wages, such as Mississippi, which is contrary to the interest of directing SCHIP funds to low income uninsured children.*
>
> *The 'Number of Children' is calculated as 50% of the number of low-income uninsured children and 50% of the number of low-income children. Program enrollment is not considered. Therefore, the more successful a state is in enrolling low income children into the Program, the more the state is penalized by the formula because the 'number of children' is reduced.*

In the past, Mississippi has always received sufficient amounts from the federal government to compensate for all CHIP expenditures.

What is the federal funding process?

Federal funds are provided to the state throughout the year in funding categories such as allotments, redistributed funds, and shortfall amounts. Generally, states have three years to spend federal funds from the date of receipt. Mississippi has utilized most of the federal funding allotted for CHIP. However in 2001 and 2002, when enrollment was building but still much lower than current enrollment, the state returned approximately $23 million to the redistribution pool. Also, in 2007, approximately $13 million, which was specifically earmarked to cover program funding shortages, was not utilized. Mississippi returned this amount to the federal government in July 2008.

To encourage states' participation in the program, the federal government matches the state funds spent at an enhanced federal match rate (which is greater than the match rate for regular Medicaid). Currently, the federal government matches state funds for CHIP at a rate of 83.4%, meaning that for every $100 spent on CHIP, the federal government provides $83.40 and the state provides $16.60. The following is a brief discussion on the federal funding process, DOM's policy with respect to federal funds, and the agency's utilization of those funds.

For every $100 spent on CHIP, the federal government provides $83.40 and the state provides $16.60.

Federal funding is made available to the state throughout the year in various funding categories. Such categories include: allotments, unused previous years' allotments, retained amounts, redistributed amounts, and shortfall amounts. In most instances, federal funds must be used within three years from the time that they are received. A description of each category follows.

- *Allotments* are those funds allocated to states based on the formula referred to on page 6. Also, CMS allows the state to roll over unused previous years' allotments. These are amounts that are not used within the year in which they were originally allotted and are carried over to the next federal fiscal year.

- *Retained amounts* are portions of an allotment that the state did not spend within the three-year period and that CMS did not add to the redistribution pool. This category was only used for Federal Fiscal Year (FFY) 1998 and FFY 1999 allotments. CMS made a special allowance for those years by allowing states that did not expend all of their funds to keep a portion of those funds while the remaining amount was redistributed to other states that exhausted all of their funds.

- *Redistributed amounts* are allotments that other states did not use within the allotted three-year

window and those funds are returned to the federal government and distributed to other states that are running CHIP program deficits. However, redistributed amounts may also contain shortfall amounts allocated by Congress because of projected program deficits.

- *Shortfall amounts* are those funds specifically allocated by Congress to cover projected program deficits. According to PEER's analysis of Mississippi CHIP CMS documents, CMS began using the shortfall classification in Federal Fiscal Year 2006. DOM provides estimates to CMS concerning the amount of funding needed to fund CHIP fully. From this amount, CMS subtracts the current funding amount (allotments and redistributions) that state has on hand. The remaining is the amount needed to fund the shortfall. The state is not guaranteed to receive the entire amount to fund the shortfall, as it is contingent on funds being available at the federal level.

According to DOM officials, states must inform CMS officials of the order in which the funds are to be used. Unlike most categories that must be used within three years of receipt, DOM officials stated that redistributed amounts must be used within a year from the time that they are received. It is DOM's policy to utilize the funds in the order in which they will expire. However, CMS has the final say regarding the order in which funds can be spent.

The average monthly enrollment for Mississippi's CHIP for Calendar Year 2008 (through August) has been approximately 64,000.

In general, Mississippi has spent most of the federal funds allotted. In its analysis of reported spending of federal dollars, PEER found that of federal dollars from FFYs 2000 and 2001, the state returned approximately $23.5 million to the redistribution pool. However, during these years, CHIP enrollment was considerably lower than it is today. For calendar year 2000, the average monthly enrollment was approximately 9,800 and for calendar year 2001 the average monthly enrollment was approximately 34,000. The average monthly enrollment for Calendar Year 2008 (through August) has been approximately 64,000. (See page 25 for a discussion on Mississippi CHIP enrollment trends.)

Also, in FFY 2007 the federal government awarded $23.5 million to the state and earmarked that money as "Shortfall." The state spent approximately $10.5 million, which left about $13 million marked as unused. CMS did not allow DOM to carry over the unused $13 million because it was designated to be used to cover any deficits after allotment and redistributed funding were exhausted. This did not adversely affect Mississippi CHIP in FFY 2008,

as the federal government granted the state $71.6 million designated as shortfall for FFY 2008.

Exhibit 1, below, shows combined federal funding categories and expenditure amounts for Federal Fiscal Years 2000 through 2008.

Exhibit 1: Summary of Federal Funds for Mississippi's Children's Health Insurance Program, Federal Fiscal Years 2000 through 2008

	A	B	C	D	E	F
Federal Fiscal Year	Previous Federal Fiscal Year Carryover (Type of Funds)	New Federal Funds (Type of Funds)	Expenses	Returned to Redistribution Pool ($)	Federal Shortfall Amounts (*)	Federal Funds Carried Over (see Note)
2000	$103,677,589 @	$58,036,226 (@)	$21,086,359	$9,505,452	NA	$131,122,004
2001	131,122,004	55,987,988 (@#)	48,998,466	13,988,752	NA	124,122,774
2002	124,122,774	37,917,154 (@#)	69,735,044	$0	NA	92,304,884
2003	92,304,884	78,536,430 (@$)	88,704,790	$0	NA	82,136,524
2004	82,136,524	70,222,817 (@$)	101,857,303	$0	NA	50,502,038
2005	50,502,038	78,238,639 (@$)	112,462,868	$0	NA	16,277,809
2006	16,277,809	123,498,191 (@*)	103,343,670	$0	$0	36,432,330
2007	36,432,330	84,027,670 (@*)	107,462,912	$0	$12,997,088	$0
2008	$0	133,440,000 (@$*)	104,826,782	$0	Not yet determined	Not yet determined

Federal funds received in a given year may contain the types of funds as designated by the following symbol(s):

[@] Allotments for current federal fiscal year.

[#] Retained allotments are funds that did not transfer to the redistribution pool, even though the funds were not spent in the three-year required time frame and CHIP was allowed to keep them.

[$] Redistributed funds may contain first-time redistributed funds and redistributed funds carried over from previous federal fiscal years.

[*] Shortfall funds are funds dedicated for that fiscal year only to cover any deficits that might occur after allotments have been exhausted.

Note: Table formula for calculating end of the federal fiscal year carryover: Columns A + B – (C + D + E) = F

SOURCE: PEER analysis of federal reports (CMS Form 21C).

Chapter 2: How does Mississippi operate its Children's Health Insurance Program and how has program enrollment trended in recent years?

Mississippi's CHIP administration is divided between two state entities. Mississippi operates a separate CHIP that provides benchmark equivalent "plus" coverage, which means that Mississippi's CHIP provides all of the benefits provided by the benchmark plan (i. e., the State and School Employees' Life and Health Plan), as well as additional benefits (e. g., dental and vision coverage). The state's agreement with Blue Cross Blue Shield of Mississippi contains a one-time premium call provision that eliminates all financial risk being assumed by the insurer. This, in essence, makes the Mississippi CHIP a self-insured program. The overall enrollment for the program has remained consistent in recent years, with the majority of CHIP enrollment consisting of enrollees from families earning less than 150% of the federal poverty level and children age six to eighteen.

To answer this question, PEER sought the answers to several related, more specific questions:

- What entities are responsible for administering Mississippi's CHIP?
- What options do states have for designing their benefit programs and what option has Mississippi chosen?
- What are the terms of Mississippi's agreement with its CHIP insurer?
- What are the eligibility requirements for Mississippi's CHIP?
- What are the federal minimum benefit requirements for a state CHIP and what benefits does Mississippi's CHIP provide?
- What were the enrollment trends for the Mississippi CHIP for the last four and a half years?

The following sections address these questions.

What entities are responsible for administering Mississippi's CHIP?

Responsibility for administration of Mississippi's CHIP is divided between the Division of Medicaid and the State and School Employees' Health Insurance Management Board, with administrative support provided by the Department of Finance and Administration.

The Centers for Medicare and Medicaid Services (CMS) administers CHIP at the federal level. Among other duties, CMS is responsible for approving the state plan for each state and territory that implements CHIP. As noted on page 5, the state plan is the mechanism that begins federal financial participation. It describes the purpose, nature, and scope of the state's CHIP and gives assurance that the program is administered in conformity with federal laws and regulations. Without CMS approval and federal financial participation, Mississippi could not operate the program.

The federal Centers for Medicare and Medicaid Services is responsible for approving the state plan for each state and territory that implements CHIP.

MISS. CODE ANN. § 41-86-9 (2) (a) (1972) gave the CHIP Commission the authority to designate either the Division of Medicaid or the State and School Employees' Health Insurance Management Board as the administering agency for the program. In its report, the CHIP Commission directed the State and School Employees' Health Insurance Management Board (HIMB) to administer the program. Acting in accordance with MISS. CODE ANN. § 41-86-11 (1972), the HIMB, acting administratively through DFA, entered into an interagency agreement with DOM and roles and responsibilities for administering the program were set as described in Exhibit 2, page 13. As the program's insurer, BCBSMS also has program duties as described in the exhibit.

The federal government requires that states not cover children under both Medicaid and CHIP programs.

No federal regulations govern which state agency may administer CHIP. A 2005 survey conducted by the National Academy for State Health Policy (NASHP) found that in most states, the Medicaid program or department that administers Medicaid is responsible for administering CHIP. Of thirty-six programs that reported operating a separate program, twenty-eight of the thirty-six (or 78%) of those programs were operated either by the Medicaid agency or the department that includes the Medicaid agency. All states with a Medicaid expansion CHIP program had that program operated by the Medicaid agency or the department that includes Medicaid. (See page 14 for a definition of Medicaid expansion program.) The NASHP survey attributed the number of states with Medicaid agency administration of CHIP to two factors. First, Medicaid agencies were performing most of the functions that a separate program would need when CHIP began. Second, Medicaid programs must coordinate eligibility because many states use CHIP as gap coverage for Medicaid. The federal government requires that states

Exhibit 2: Responsibilities for Mississippi's Children's Health Insurance Program

State and School Employees' Health Insurance Management Board (HIMB)[1] (Acts Administratively through DFA)
HIMB Policy/Decision Making Functions
Adopts rules and regulations for CHIP
Defines the plan benefits
Contracts with the insurer
Evaluates the performance of the insurer
DFA Administrative Functions
Responsible for day-to-day operations
Serves as liaison between agencies and the insurer
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
Division of Medicaid (DOM)
Receives and is accountable for all state and federal funds
Responsible for all correspondence with Centers for Medicare and Medicaid Services[2]
Implements outreach activities
Enters into contract with HIMB
Pays monthly premiums to insurer
Determines who is eligible for CHIP benefits
Submits enrollment information to insurer
Investigates inquiries from the insurer related to enrollment
Provides enrollment reports
Approves CHIP requests for proposals prepared by HIMB

Health Plan Insurer (Currently Blue Cross Blue Shield of Mississippi)
Provides health insurance coverage
Accepts enrollment information from DOM
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 on CHIP to HIMB
Provides membership information on the plan

SOURCE: PEER's analysis of the federal CHIP Rules and Regulations (effective January 1, 2005) and the Interagency Agreement Between DOM and HIMB (signed December 2000).

[1]HIMB awarded the current agreement to BCBSMS effective January 1, 2005, after a competitive RFP process was conducted. BCBSMS was one of two companies to submit a proposal. The other company was disqualified because it did not meet the minimum vendor requirements.

[2]The Centers for Medicare and Medicaid Services is the federal entity that approves the state's CHIP and allows the state to receive federal program matching funds, currently at a rate of 83.4% to 16.6% state matching funds.

not cover children under both Medicaid and CHIP programs and housing CHIP with the Medicaid department would facilitate coordination.

PEER does not question the CHIP Commission's judgment in allowing the HIMB to operate CHIP. The commission believed that the logical agency to run a state-designed insurance program would be the HIMB because the board implements the benchmark program for CHIP. However, according to the CHIP state plan for Mississippi, DOM officials are listed as being ultimately responsible for program administration and financial oversight.

What options do states have for designing their benefit programs and what option has Mississippi chosen?

In designing their CHIPs, states may either expand Medicaid, design a CHIP entirely separate from Medicaid, or combine the Medicaid and separate program options. Mississippi operates a separate CHIP that provides benchmark equivalent plus coverage, which means that Mississippi's CHIP provides all of the benefits provided by the benchmark plan (i. e., the State and School Employees' Life and Health Plan), as well as additional benefits (e. g., dental and vision coverage).

A state has three options when designing its CHIP:

- use SCHIP funds to expand Medicaid eligibility to children who previously did not qualify for the program;
- design a CHIP entirely separate from Medicaid; or,
- combine the Medicaid and separate program options.

A brief discussion of each option follows.

Medicaid Expansion Program

States that choose the Medicaid expansion option must offer the full range of mandatory Medicaid benefits, as well as optional services specified in their Medicaid state plans.

States that choose this option must offer the full range of mandatory Medicaid benefits, as well as optional services specified in their individual Medicaid state plans. A Medicaid expansion program is not a capped block grant program, like separate CHIPs; rather, it is an entitlement program. This means that if the federal allotment for CHIP in a particular state were depleted, the children enrolled in CHIP would transfer to the Medicaid program and still have insurance coverage, with the federal

government providing the regular Medicaid match instead of the enhanced CHIP match.

Separate Program

Separate CHIP programs are capped block grants. Once federal allotments are depleted, the children enrolled in CHIP lose health insurance coverage.

A separate CHIP is not an extension of Medicaid. In general, in designing these programs, states must follow guidelines regarding health benefits coverage that are set forth in the *Code of Federal Regulations*. Separate programs are capped block grants. Once the federal allotments are depleted, the children enrolled in CHIP would lose their health insurance coverage. However, this has never happened to Mississippi's CHIP.

States that choose this option must then choose from three additional options: benchmark coverage, benchmark equivalent coverage, or secretary-approved coverage (i. e., any plan that the Secretary of the U. S. Department of Health and Human Services deems adequate and will provide appropriate coverage to targeted uninsured children). These are described below.

Benchmark Coverage

A *benchmark* package includes one of the following three plans: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program; (2) the health coverage that is offered and generally available to state employees; or, (3) the health coverage that is offered by a health maintenance organization with the largest commercial (non-Medicaid) enrollment in the state.

Benchmark Equivalent Coverage

Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. A state that elects to provide benchmark-equivalent coverage must cover each of the benefits in what is termed the basic benefits category. Basic benefits required by the *Code of Federal Regulations* (42CFR457.410 and 42CFR457.430) in a benchmark equivalent plan are:

- inpatient and outpatient hospital services;
- physicians' surgical and medical services;
- lab and x-ray services;
- well-baby and well-child care;

- age-appropriate immunizations; and,
- emergency services.

Secretary-Approved Coverage

Secretary-approved coverage, as stated above, is coverage that the Secretary of the U. S. Department of Health and Human Services deems appropriate for the targeted low-income population. Generally, this type of coverage must be the same as that provided to children under the Medicaid plan, comprehensive coverage offered under a demonstration project, or equivalent to one of the benchmark packages listed above.

Combination Program

A combination CHIP is one in which a state implements both a Medicaid expansion program and a separate CHIP.

A combination CHIP is one in which a state implements both a Medicaid expansion program and a separate children's health insurance program. For example, a state may cover most children under the children's health insurance program. However, because of maintenance of effort level, the Medicaid children must be matched at the Medicaid match rate and not at the enhanced match rate. The separate part of the combination program that serves the CHIP enrollees (who are not eligible to receive Medicaid) may operate exactly like the Medicaid part of the combination program but is not required to do so. However, for coordination between the two parts and for ease of administration, combination programs tend to provide the same benefits to both groups of enrollees.

What are the terms of Mississippi's agreement with its CHIP insurer?

The current CHIP insurer, Blue Cross Blue Shield of Mississippi, was selected through a competitive bidding process. The term of the contractual agreement was for four years (January 1, 2005, through December 31, 2008) and the HIMB has exercised an option to extend the agreement for one year (to December 31, 2009). The current agreement contains a one-time premium call that reimburses the insurer for any claims cost overages and thus makes the program function as a self-insured program. Removing risk from the contract also removes the incentive to implement vigorous utilization review. Strong utilization review could have a financial impact on providers in the network.

Selection of Current Insurer

Mississippi's current CHIP insurer is Blue Cross Blue Shield of Mississippi. The insurer was chosen after a request for proposals was advertised and two companies submitted proposals.

As noted on page 5, the commission's recommendations gave the HIMB the authority to operate a fully insured program with a single insurer. Blue Cross Blue Shield of Mississippi (BCBSMS) was the state's CHIP insurer from January 1, 2000, to December 31, 2004. DFA's Office of Insurance, on behalf of the HIMB, competitively bid the second agreement for CHIP by issuing a request for proposals (RFP) in February 2004. BCBSMS, as well as one other company, submitted proposals in response to the RFP; however, the other company failed to meet the minimum vendor requirements.

Blue Cross Blue Shield of Mississippi has served as the state's CHIP insurer since January 1, 2000.

BCBSMS was retained to be the state's CHIP insurer for the period of January 1, 2005, to December 31, 2008. The State and School Employees' Health Insurance Management Board has exercised an option to extend the agreement one year to December 31, 2009. (DFA is not required to seek approval through the Personal Service Contract Review Board for insurance products. However, the agency has in the past followed the Personal Service Contract Review Board's rules for advertising and soliciting proposals.)

One-Time Premium Call

The current agreement with Blue Cross Blue Shield of Mississippi contains a one-time premium call provision that essentially requires CHIP to pay all of the claims for the program. This provision causes the current program to function much like a self-insured plan in that a substantial amount of risk has been removed from the insurer.

The current agreement between HIMB and BCBSMS contains a one-time premium call provision. The presence

of the one-time premium call provision results in minimal financial risk being transferred to the insurance company. Risk assumption is a fundamental component of the concept of insurance. Generally, in an insurance agreement, two parties agree to a policy that states the coverage available to the insured for an agreed-upon premium that is paid to the insurer. In such cases, the insured contracts away all financial risk to the insurer in exchange for the premium. In the matter under review, the insured has agreed to pay additional fees at the close of the agreement to make the insurer whole in the event that claims have exceeded those anticipated.

However, under the current agreement, BCBSMS pays claims from its own funds as well as for administrative procedures such as claims processing, adjudication, and appeals. This results in a minimal transfer of risk from the state to the insurer because of the potential loss of interest that could be accruing if those funds were not spent on CHIP and invested in another manner. While this is not typical of a self-insurance plan, this agreement functions similar to such because the insurer will eventually be reimbursed for all claims at the end of the agreement.

Provider Network and Utilization Management

BCBSMS is responsible for ensuring that a sufficient provider network is available for members as well as implementing a utilization management program. The one-time premium call removes financial responsibility on the part of BCBSMS. Removing risk from the contract also removes the incentive to implement vigorous utilization review. Strong utilization review could have a financial impact on providers in the network.

BCBSMS may not be motivated to operate a vigorous utilization management program that would ensure timely and cost-effective treatment.

Under the current agreement, BCBSMS is responsible for providing an adequate provider network that will ensure services to enrollees for the program as well as develop utilization management and cost avoidance initiatives that positively impact health outcomes and result in savings for the program. Without the transfer of financial risk to the insurance company and because of the need to keep a healthy provider network, BCBSMS may not be motivated to operate a vigorous utilization management program that would ensure timely and cost-effective treatment.

What are the eligibility requirements for Mississippi's CHIP?

Among other criteria, eligibility for CHIP is determined by age and family income.

In accordance with state and federal laws, the HIMB has set the following eligibility requirements for Mississippi's CHIP:

- family income must not exceed 200% of the federal poverty level[1] (FPL);
- must be a Mississippi resident;
- must not be eligible for Medicaid; and,
- must not be an inmate of a public institution or a patient in an institution for mental illnesses.

These eligibility requirements have been submitted to and approved by CMS. Eligibility is further determined by age and income levels (also referred to as *maintenance of effort* levels), shown below:

Ages of Children Eligible for Coverage	Annual Family Income
Birth to 12 months	185% to 200% FPL
Ages 1 – 5	133% to 200% FPL
Ages 6 – 18	100% to 200% FPL

A child is eligible for Medicaid up to the lower income limits for each age category. These levels prevent placement of Medicaid-eligible children in the CHIP program in order to receive the enhanced federal match rate for CHIP.

[1] The *federal poverty level* (also known as *federal poverty guideline)* is updated periodically in the *Federal Register* by the U. S. Department of Health and Human Services under the authority of 42 U.S.C. 9902 (2). For 2008, the federal poverty guideline for a family of 1 is $10,400 and a family of 2 is $14,000. Each additional individual raises the level by $3,600.

What are the federal minimum benefit requirements for a CHIP program and what benefits does Mississippi's CHIP program provide?

For a separate CHIP, the benefit coverage for the program must meet the minimum requirements of its benchmark. The program must include well baby and well child coverage, age-appropriate immunizations, and emergency services. Mississippi's CHIP provides benchmark equivalent plus coverage because it provides coverage in addition to that of its benchmark.

Minimum Federal Requirements for CHIP

CHIP coverage must meet the minimum requirements of its benchmark, which must include well baby and well child coverage, age-appropriate immunizations, and emergency services.

Federal regulations regarding minimum CHIP requirements are written to prevent a state from implementing a "mandate-light" CHIP benefit package.

Regardless of the benefits provided in the benchmark program, federal regulations require that well baby and well child care services, age-appropriate immunizations, and emergency services must be provided. The federal regulations are written to prevent a state from implementing a "mandate-light" CHIP benefit package.

Well baby and well child benefits are to be defined by each state and approved by CMS. For immunizations, federal law requires the states implementing separate programs to utilize the recommended guidelines according to the Advisory Committee on Immunization Practices. The federal definition of emergency services does not differ substantially from that of Mississippi's benchmark plan (see following section).

Mississippi's CHIP: Benchmark Equivalent Coverage Plus Additional Benefits

Mississippi's CHIP provides benefit coverage in addition to the State and School Employees' Life and Health Plan, which is the benchmark for the state's CHIP. CHIP essentially provides 100% coverage for medical, dental, and vision services.

In addition to benefits provided by the benchmark plan, Mississippi's CHIP provides vision and hearing screening, eyeglasses and hearing aids, preventive dental care, and routine dental fillings.

CMS has characterized Mississippi's CHIP as "benchmark equivalent plus" coverage because the plan covers more benefits than the plan that it is benchmarked against. State law requires that CHIP provide early and periodic screening and diagnosis services equal to those provided under Medicaid and that the benefits and services offered under the State and School Employees' Life and Health Plan be used as a benchmark for CHIP services. However, state law further expands coverage beyond what is in the State and School Employees' Life and Health Plan to

include vision and hearing screening, eyeglasses and hearing aids, preventive dental care, and routine dental fillings. Exhibit 3, page 22, compares the benefits offered under CHIP and the benefits offered under the State and School Employees' Life and Health Plan.

The federal minimum requirements for CHIP are those of the benchmark plan (refer to benchmark options on page 15) and, if not included in the benchmark program, well-baby and well-child services, age-appropriate immunizations, and emergency services. The State and School Employees' Life and Health Plan, CHIP's benchmark, provides the mandatory coverage required by federal CHIP guidelines. As shown in Lines 9, 16, 49, and 50, Exhibit 3, page 22, the State and School Employees' Life and Health Plan provides well-child physician office visits and well-newborn nursery care. These services fulfill recommendations for preventive pediatric health care made by the American Academy of Pediatrics. The State and School Employees' Life and Health Plan's benefits cover newborn hospital confinement and normal care by a hospital or physician at 100%, well child-care physician office visits and certain diagnostic tests at 100%, and immunizations, based on Advisory Committee on Immunization Practices standards, at 80%. Emergency services are provided in benefits of the state health plan.

According to an actuarial study contracted by DFA, for CY 2006 and CY 2007, CHIP claims allowed per child were 22% higher than claims allowed per child in the State and School Employees' Life and Health Plan.

An actuarial study produced for DFA by its contracted actuary compared the costs of Mississippi's CHIP to its benchmark plan--the State and School Employees' Life and Health Plan--and examined claims cost per child from CY 2006 and CY 2007 (incurred through December 2007 and paid through March 2008). The study found that, excluding dental and vision claims (since they are not a part of the State and School Employees' Life and Health Plan) and prior to out-of-pocket costs, the claim amount allowed per child in CHIP was $144 per child and claim amount allowed per child under the State and School Employees' Life and Health Plan was $118 per child. CHIP claims allowed per child were 22% higher than claims allowed per child in the State and School Employees' Life and Health Plan. As discussed earlier, CHIP pays all claims associated with the program. Since the medical claims allowed by CHIP that were incurred through December 2007 and paid through March 2008 were 22% higher than the medical claims allowed by the State and School Employees' Life and Health Plan (CHIP's benchmark plan), it is reasonable to assume that cost savings are available.

Exhibit 3: Comparison of Benefits Between Mississippi's CHIP and the State and School Employees' Life and Health Plan (Note 1)

	Insurance Information	Mississippi Children's Health Insurance Program (All services must be rendered by network providers) (Note 2)		State and School Employees' Life and Health Plan (In-Area Participant Coverage) (Note 3)	
Item	**Benefit Information**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
1	Benefit Period	Calendar Year	Calendar Year	Calendar Year	Calendar Year
2	Lifetime Maximum Benefits	None	None	$1,000,000	$1,000,000
3	Annual Medical Deductible Amounts	$0 (Most Services)	$0 (Most Services)	Individual - $500 Family - $1,000 (Most Services)	Individual - $1,000 Family - $2,000 (Most Services)
4	Individual Medical Co-Insurance Maximum Costs Per Year	$0 - < 151% FPL $800 - 151% to 175% FPL $950 - 176% to 200% FPL FPL - Federal Poverty Level (Note 6)	$0 - < 151% FPL $800 - 151% to 175% FPL $950 - 176% to 200% FPL FPL - Federal Poverty Level (Note 6)	$2,000	$3,000
	Covered Services				
5	Ambulance	100%	100%	80%	75%
6	Ambulatory Surgical Facility Services	100%	No Coverage in Health Plan	80%	60%
7	Anesthesia	100%		80%	75%
8	Cardiac Rehabilitation (Outpatient)	100% (Pre-Approved)	100% (Pre-Approved)	80% (Pre-Approved)	60% (Pre-Approved)
9	Childhood Routine Immunization Administration (Health Department Provides Shot Vaccine for CHIPS Patients)	100% **(Mandatory CHIP Benefit Per Federal Regulations)**		80%	
10	Chiropractic Services	100% ($1,500 Limit Per Year)		80% ($1,500 Limit Per Year)	60%
11	Dental Services (Limited)	100% ($1,500 Per Year)			
12	Diabetes Self Management Training/Education and Medical Nutrition Therapy	100% ($250 Limit Per Year) (Pre-Approved)		80% (Covered Through Doctor's Services)	
13	Diagnostic Facility	100%		80%	60%
14	Diagnostic Services	100%		80%	60%
15	Durable Medical Equipment	100% (Pre-Approved)		80% (Pre-Approved)	60% (Pre-Approved)
16	Emergency Room Visits for Medical Emergencies	100% (After $15 Co-Pay if >150% FPL) **(Mandatory CHIP Benefit Per Federal Regulations)**	100% (Note 4)	80% ($50 Co-Pay Per Visit After First One)	60% ($50 Co-Pay Per Visit After First One)
17	Family Planning Services	100%			
18	Female Health Services (Routine Ob/Gyn Services)	100%		80%	60%
19	Hearing Services (Limited to Services)	100% (One Annual Visit)	100% (One Annual Visit)		
20	Home Infusion Therapy*	100%		80%	60%
21	Hospice Care	100% ($15,000 Per Member Lifetime) (Pre-Approved)	100% ($15,000 Per Member Lifetime) (Pre-Approved)	80% (Six Month Maximum) (Pre-Approved)	60% (Six Month Maximum) (Pre-Approved)
22	Hospital In/Out Patient (Room & Board, Dietary, General Nursing, and Other Services)	100%		80%	60%
23	Maternity - Attending Physician	100%		100%	90%
24	Maternity Hospital - Other Services	100%		80%	60%
25	Maternity/Prenatal	100% (Under 19 Year Old Girls)		80%	60%
26	Medical Supplies	100% (Inpatient - 30 Day Limit)		80%	75%

Exhibit 3: Comparison of Benefits Between Mississippi's CHIP and the State and School Employees' Life and Health Plan (Note 1)

	Insurance Information	Mississippi Children's Health Insurance Program (All services must be rendered by network providers) (Note 2)		State and School Employees' Life and Health Plan (In-Area Participant Coverage) (Note 3)	
Item	**Benefit Information**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
27	Mental Health - Residential) (Inpatient)	100% (30 Days Per Year) (Pre-Approved)		80% (30 Day Limit) (Pre-Approved)	75% (30 Day Limit) (Pre-Approved)
28	Mental Health - Residential (Outpatient Hospital and Professional Visits)	100% (52 Visits Per Year) ($5 Co-Pay for (Professional Office Visit)		50% (52 Visits Per Year) (Pre-Approved)	50% (52 Visits Per Year) (Pre-Approved)
29	Mental Health - Residential (Intensive Day Treatment/Partial Hospital Program	100% (60 Days Per Year) (Pre-Approved)		80% (60 Day Limit) (Pre-Approved)	75% (60 Day Limit) (Pre-Approved)
30	Nurse Practitioner/Home Health Nursing Services	100%		80%	60%
31	Occupational Therapy	100% (Pre-Approved)	100% (Pre-Approved)	80%	60%
32	Organ Transplant Benefits	100% (Pre-Approved)		80% (Pre-Approved)	60% (Pre-Approved)
33	Orthotic/Prosthetic Procedures and Devises	100% (Pre-Approved)	100% (Pre-Approved)	80%	75%
34	Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug Infusion)	100%		80%	60%
35	Outpatient Health Care Professional Visits Except Well Child Care and Routine Well Baby Services Other Office Services	100% (After $5 Co-Pay if >150% FPL) 100%		80%	60%
36	Outpatient Prescription Drugs ** The Drug Benefits for the State and School Employees Are in A Separate Drug Plan. This Plan Does Not Provide Benefits on A Network Basis.*	100% (Generic and Brand Names)		30-Day Supply Price Generic Drug $13 Preferred Brand $33 Other/Non-Preferred Brand with No Generic) $33 ($50 Annual Deductible)	
37	Physical Therapy	100% (Pre-Approved)	100% (Pre-Approved)	80%	60%
38	Podiatry Services	100%		80%	75%
39	Private Duty Nursing (Includes Home Health)	100% ($10,000 Limit Per Year) (Pre-Approved)	100% ($10,000 Limit Per Year) (Pre-Approved)	80% ($10,000 Limit Per Year) (Pre-Approved)	60% ($10,000 Limit Per Year)
40	Skilled Nursing Facility	100% (60 Day Limit Per Year)	100% (60 Day Limit Per Year)	80% (Pre-Approved)	60% (Pre-Approved)
41	Skilled Nursing Services	100% (60 Day Limit Per Year)	100% (60 Day Limit Per Year)	80%	60%
42	Specified Routine Tests	100%		100%	
43	Speech Therapy	100% (Pre-Approved)	100% (Pre-Approved)	80%	60%
44	Substance Abuse (Inpatient Care*)	100% ($8,000 Per Year) ($16,000 Lifetime) ($1,000 More - Alcohol Abuse)		80% ($8,000 Per Year) ($16,000 Lifetime) (Pre-Approved)	75% ($8,000 Per Year) ($16,000 Lifetime) (Pre-Approved)
45	Substance Abuse (Outpatient Care)	100% ($8,000 Per Year) ($16,000 Lifetime) ($1,000 More - Alcohol Abuse)		50% ($8,000 Per Year) ($16,000 Lifetime)	50% ($8,000 Per Year) ($16,000 Lifetime)
46	Substance Abuse (Intensified Outpatient Program)	100% ($8,000 Per Year) ($16,000 Lifetime) ($1,000 More - Alcohol Abuse)	100% ($8,000 Per Year) ($16,000 Lifetime) ($1,000 More - Alcohol Abuse)	50% ($8,000 Per Year) ($16,000 Lifetime)	50% ($8,000 Per Year) ($16,000 Lifetime)

Exhibit 3: Comparison of Benefits Between Mississippi's CHIP and the State and School Employees' Life and Health Plan (Note 1)

	Insurance Information	Mississippi Children's Health Insurance Program (All services must be rendered by network providers) (Note 2)		State and School Employees' Life and Health Plan (In-Area Participant Coverage) (Note 3)	
Item	**Benefit Information**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
47	Temporomandibular/ Craniomandibular Joint Disorder (TMJ) (Surgery Diagnostic Services)	100% ($5,000 Lifetime) (Pre-Approved)		80% ($5,000 Lifetime)	75% ($5,000 Lifetime)
48	Vision Services (Routine)	100% (One Visit)			
49	Well-Child Physician Office Visits/Immunizations	100% **(Mandatory CHIP Benefit Per Federal Regulations)**		100%	
50	Well-Newborn Nursery Care/Immunizations	100% **(Mandatory CHIP Benefit Per Federal Regulations)**		100%	
51	Wellness/Preventive Services (18 and Over Participants) (Under 18 Dependents)			100% ($1,000 Yearly with Completed Annual Health Risk Assessment)	
52	X-Rays/Laboratory Services	100%		80%	60%

Note 1: PEER compared Mississippi's Children's Health Insurance Program to the in-area benefits in the State & School Employees Life and Health Plan, Select Coverage. Of the two options for state employees, this health plan is the most costly to the state and represents the most conservative analysis of differences in benefits between the two insurance programs.

Note 2: The Department of Finance and Administration (DFA) describes the Children's Health Insurance Program as a fully insured health benefit program that uses the State & School Employee's Select Health Plan as its benchmark for its services to eligible children. The State and School Employees Health Insurance Management Board is the decisionmaking body that determines the policies/plan benefits and performs contract administration/oversight for the participant insurance contract. DFA performs day-to-day program administration for this board, while the Division of Medicaid in the Office of the Governor performs federal grant administration, eligibility determination, and program promotion responsibilities.

Note 3: The State of Mississippi uses a self-insured health benefit program for state employees with two coverage methods: Basic and Select. Both methods provide the same coverage benefits with different annual individual/family deductibles and individual maximum co-insurance costs to all employees. Individuals hired on or after January 1, 2006, must pay a portion of the monthly insurance cost if they choose the Basic Coverage option. The state provides the Select Coverage option at state cost to all individuals who were employees as of December 31, 2005.

Note 4: The Mississippi Children's Health Insurance Program benefits for emergency room services will be provided only in cases of a medical emergency. When a program participant uses emergency room services for a medical emergency, 100% coverage will be provided. If a member uses emergency room services of a non-network provider for a non-emergency situation, no benefits will be provided to the member.

Note 5: This PEER comparison shows that the MCHIP coverage is significantly more generous than the State and School Employees' Select Coverage Health Plan against which the MCHIP is benchmarked. Specifically, MCHIP provides:

A. 100 percent state-paid coverage for 38 of 42 eligible In-Network medical services. For these medical services, the state and school employee plan pays 80% (35 services) and 50% (3 services). The state pays 100% in both health coverage plans for four medical services: Maternity- Attending Physician, Specified Routine Tests, Well-Child Physician Office Visits, and Well-Newborn Nursery Care.

B. Provides four medical services to participants that are not provided to state and school employees: Dental, Family Planning, Hearing, and Vision.

C. Co-pay requirements for two covered medical services: Mental Health Outpatient Hospital/Professional Visits and Outpatient Professional Office Visits and no deductible or co-pay for pharmacy. The state and school employee plan has a co-pay requirement for all covered medical and pharmacy services.

Note 6: The guidelines for the Federal Poverty Levels are updated periodically in the *Federal Register* by the U. S. Department of Health and Human Services under authority of 42 U.S.C. 9902 (2). For 2008, the federal poverty guideline for a family of 1 is $10,400 and a family of 2 is $14,000, adding $3,600 for each additional person.

SOURCES: DFA/Blue Cross Blue Shield CHIP Contract, State and School Employees' Life and Health Plan, and State Auditor Performance Audit Report #91, Dated March 22, 2005.

The actuarial study found that CHIP members have, in essence, 100% coverage for medical, drugs, dental and vision benefits, whereas members of the State and School Employees' Life and Health Plan have approximately 71% to 72% percent medical and prescription drug coverage.

(See page 45 for a discussion of restructuring benefits as a cost savings measure.) It is not uncommon for states to cover benefits that are in addition to the benefits as required by federal regulations. A 2005 survey conducted by the National Academy for State Health Policy (NASHP) show that the coverage in most separate CHIPs is comprehensive and includes dental, mental health, and home health services. However, significantly fewer separate programs reported to provide private duty nursing services (21 out of 36, or 58%), a service that Mississippi's CHIP covers at 100%.

The actuarial study referenced above took into account that CHIP benefits provide for dental and vision coverage, whereas the State and School Employees' Life and Health Plan does not. Also, as required by federal regulations and state law (MISS. CODE ANN. Section 41-86-17 [1972]), CHIP enrollees realize minimal out-of-pocket expenses in the forms of premiums, co-payments, deductibles, and coinsurance. The study found that CHIP members have, in essence, 100% coverage for medical, drugs, dental and vision benefits, whereas members of the State and School Employees' Life and Health Plan, the benchmark package after which CHIP is patterned, have approximately 71% to 72% percent medical and prescription drug coverage.

What were the enrollment trends for the Mississippi CHIP for the last four and a half years?

The overall enrollment in Mississippi CHIP remained relatively consistent during calendar years 2004 through 2007 and through August 2008 (i. e., for fifty-six months). During this period, the majority of the enrollees (61%) were from families earning less than or equal to 150% of the federal poverty level, which could have implications on the amount of cost sharing that can be imposed on enrollees. The overwhelming majority (82%) of enrollees were ages six to eighteen.

PEER examined the enrollment for the Mississippi CHIP program from January 2004 to August 2008 (fifty-six months) to determine the average monthly enrollment levels and enrollment variations from month to month. In order to accomplish this, PEER analyzed monthly enrollment "point-in-time report" totals and calculated yearly averages based on those "point-in-time" figures and then rounded to the nearest whole number. The figures represented in exhibits in this section of Chapter 2 are only intended to portray enrollment in the CHIP with respect to age and federal poverty level and are approximate due to rounding.

PEER found that the average enrollment during this period remained relatively consistent, with an average high in 2005 of 67,221 enrollees and an average low in 2007 of 60,824 enrollees. Exhibit 4, below, shows the overall monthly average total enrolled in the CHIP program.

Exhibit 4: Calendar Years 2004 through 2008 Averages of Monthly CHIP Enrollment Totals

[1]Overall Monthly CHIP Averages by Year	
Year	Average Monthly Enrollment
2004	64,544
2005	67,221
2006	61,019
2007	60,824
2008*	64,253

*2008 is an average of eight months (January through August).

NOTE: The Center for Mississippi Health Policy estimates that approximately 38,000 Mississippi children who are currently uninsured would qualify for Mississippi CHIP based on their age and poverty level. PEER does not take a position on the accuracy of this estimate.

SOURCE: PEER analysis of BCBSMS monthly enrollment reports submitted with invoices to DOM and HIMB.

Since eligibility for CHIP is determined by age and income levels (see discussion on page 19), further examination by age, income, and federal poverty levels is warranted to obtain an accurate picture of the characteristics of the children utilizing the program. Again, PEER reviewed "monthly point-in-time enrollment reports" that aggregate the monthly enrollment totals by poverty level and calculated averages based on these totals. Exhibits 5 through 7, pages 27 through 29, display this information in varying forms. This examination of enrollment gives policymakers an important decisionmaking tool for making any changes in Mississippi's CHIP with respect to benefits or cost sharing.

Over the last four and a half years, 61% of Mississippi's CHIP enrollees were children living in families earning less than 150% of the federal poverty level.

Generally, the number of children making up the different federal poverty level groups remained fairly consistent annually over the 4½-year period. As evidenced by Exhibit 5, page 27, the largest federal poverty level group is the children living in families earning less than 150% of the federal poverty level. In the 4½-year period, approximately 61% of the children on the program were from families in this income bracket. Twenty-two percent resided with families who earned between 151% and 175% of the federal

poverty level and 17% resided with families who earned between 176% and 200% of the federal poverty level.

During the last four and a half years, approximately 39% of CHIP enrollees resided with families earning between 151% and 200% of the federal poverty level. According to federal regulations, more aggressive cost sharing measures may be applied to this income group.

PEER aggregated numbers of children residing with families earning between 151% and 200% of the federal poverty level because according to federal regulations, more aggressive cost sharing measures may be applied to this income group. Approximately 39% resided in families earning between 151% and 200% of the federal poverty level. Refer to page 48 of the report to see a discussion on this income group and the amount of cost sharing that may be applied to this group to shift some of the cost of CHIP to the enrollee.

Exhibit 5: Average Enrollment for Mississippi's Children Health Insurance Program by Year and Federal Poverty Level (FPL) for Calendar Years 2004 through 2008 (through August 2008)

Year	Enrollees in Families Earning Less than or Equal to 150% FPL	Enrollees in Families Earning between 151% and 175% FPL	Enrollees in Families Earning between 176% and 200% FPL	Total Overall	[1]Enrollees in Families Earning between 151% and 200% FPL
2004	41,717 (65%)	13,921 (21%)	8,906 (14%)	64,544 (100%)	22,827 (35%)
2005	42,136 (63%)	13,957 (21%)	11,128 (16%)	67,221 (100%)	25,085 (37%)
2006	36,380 (60%)	13,451 (22%)	11,188 (18%)	61,019 (100%)	24,639 (40%)
2007	35,936 (59%)	14,508 (24%)	10,380 (17%)	60,824 (100%)	24,888 (41%)
2008[2]	37,811 (59%)	15,445 (24%)	10,997 (17%)	64,253 (100%)	26,442 (41%)
Totals	193,980 (61%)	71,282 (22%)	52,599 (17%)	317,861 (100%)	123,881 (39%)

[1]According to current federal regulations, more aggressive cost sharing limits may be applied to this income group.

[2]2008 is an average of eight months (January to August 2008).

Note: Percentages are approximate due to rounding.

SOURCE: PEER analysis of BCBSMS monthly enrollment reports.

Because enrollment in the four poverty level groupings did not change significantly from year to year, PEER examined enrollment by age and federal poverty level for all 4½ years combined. (See Exhibit 6, page 28.) This analysis illustrates the age population of the children enrolled in the program and into what federal poverty level categories

they fall. Children who fall in the ages six through eighteen category compose the majority of every federal poverty level category examined.

Exhibit 6: Average Enrollment for Mississippi Children's Health Insurance Program by Age and Federal Poverty Level (FPL) for Calendar Years 2004 through June 2008

Age	Less than or Equal to 150% FPL	151% to 175% FPL	176% to 200% FPL	151% to 200% FPL
Under 1	172 (.7%)	105 (.2%)	332 (.6%)	437 (.4%)
Ages 1 to 5	23,341 (12%)	19,077 (26.8%)	13,627 (26%)	32,704 (26.4%)
Ages 6 to 18	170,467 (87.3%)	52,099 (73%)	38,640 (73.4%)	90,739 (73.2%)
Totals	193,980 (100%)	71,281 (100%)	52,599 (100%)	123,881 (100%)

SOURCE: PEER analysis of BCBSMS monthly enrollment reports.

The majority of the enrollees (82%) utilizing CHIP services are between the ages of six and eighteen.

Next, PEER examined the overall total aggregated by year and age regardless of the federal income level categories. (See Exhibit 7, page 29.) The majority of the enrollees (82%) utilizing CHIP services are categorized as being between the ages of six and eighteen. This is understandable when taking into account two factors. First, this age grouping is broader in range than the other two age groupings and secondly, the federal poverty limit imposed on families that have children in the six- to eight-year-old category is much broader than the federal poverty limit for the other two CHIP age groups. (Refer to page 19 for a more in-depth discussion on income and federal poverty limits and how those factors relate to CHIP.) Exhibit 7, page 29, lists annual averages by year and age grouping.

Exhibit 7: Total CHIP Enrollment Averages by Year and Age (Regardless of Federal Poverty Level [FPL])

Year	*Under 1 (All FPL)	xxAges 1 to 5 (All FPL)	xxAges 6 to 18 (All FPL)	Total Average Enrollment
2004	251 (.4%)	12,984 (20.1%)	51,309 (79.5%)	64,544 (100%)
2005	174 (.3%)	12,839 (19.1%)	54,208 (80.6%)	67,221 (100%)
2006	70 (.1%)	10,204 (16.7%)	50,745 (83.2%)	61,019 (100%)
2007	70 (.1%)	9,741 (16.0%)	51,013 (83.9%)	60,824 (100%)
2008	45 (.1%)	10,277 (16.0%)	53,931 (83.9%)	64,253 (100%)
Total by Age	610 (.2%)	56,045 (17.6%)	261,206 (82.2%)	317,861 (100%)

*Percentages for the under 1 (All FPL) age category are not materially significant (less than one percent) and therefore not calculated.

xxPercentages in these age categories have been rounded to the nearest whole percentage.

SOURCE: PEER analysis of BCBSMS monthly enrollment reports.

Chapter 3: How do other states operate their Children's Health Insurance Programs?

A survey by the National Academy for State Health Policy and PEER's own survey of selected states show a range of administrative and service structures but yield no best practice model or most efficient organization. Each state's program has its own strengths and weaknesses based on that state's target population and service goals.

Results of the 2005 Survey by National Academy for State Health Policy

According to the National Academy for State Health Policy's 2005 survey of states' CHIPs:

- ***many states are moving toward separate CHIPs;***
- ***most separate CHIPs are housed in the state's Medicaid agency or the agency that houses Medicaid;***
- ***most CHIPs (both Medicaid expansion and separate programs) contract with administrative service organizations;***
- ***cost sharing for CHIPs is restricted by federal guidelines; and,***
- ***the most common type of delivery system (both separate and Medicaid expansion programs) is through managed care companies that deliver a comprehensive set of benefits.***

In September 2006, the National Academy for State Health Policy (NASHP) published a report entitled, *Charting S-CHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs.* The information reported by NASHP is based on a survey of CHIP programs sent to all states and the District of Columbia. The survey identifies strategies and policies that states use to implement their CHIPs. The following subsections summarize the results of NASHP's survey.

Type of Benefit Coverages in States' CHIPs

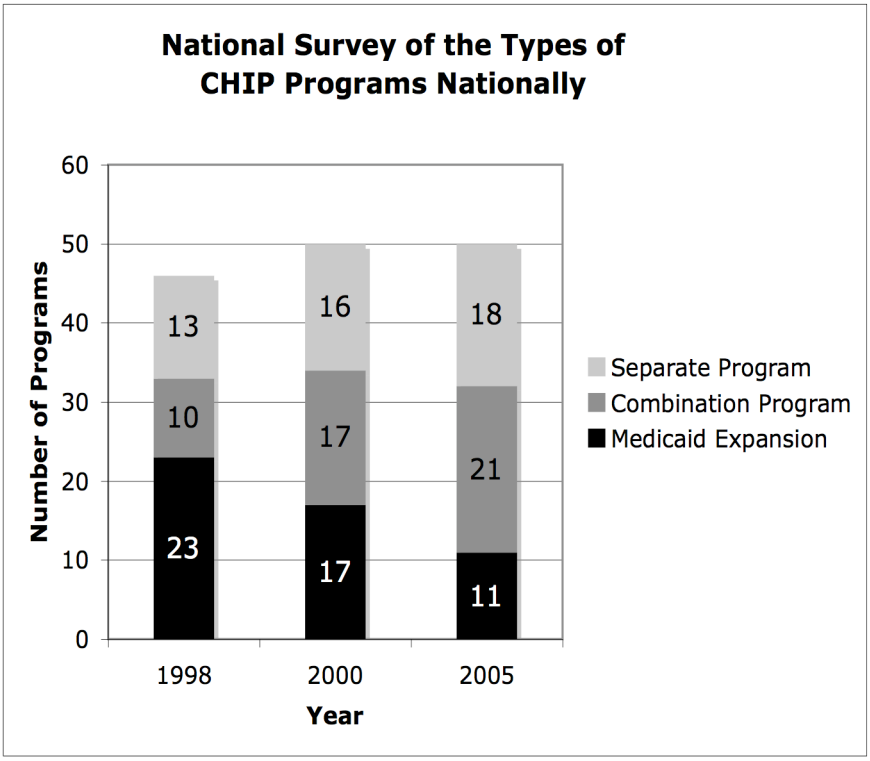
In the beginning of CHIP, states utilized the quick start-up benefit of expanding their Medicaid programs. However, as time passed, more states wanted to take advantage of the flexibility provided by the separate CHIP design.

According to the NASHP survey, many states implemented Medicaid expansion programs in the early days of CHIP for the purpose of a quick start-up. However, as time progressed, states began shifting to a separate or combination program that offers more flexibility in benefit design and operation. States have built programs that

utilize flexibility of a separate CHIP to create programs with innovative features that work within their environments. Exhibit 8, below, illustrates the shift away from Medicaid expansion programs that has been taking place since 1998.

Mississippi operated a Medicaid expansion program from July 1998 through December 2000. On January 1, 2000, Mississippi's separate program took effect.

Exhibit 8: Results of the NASHP National Survey Regarding Types of CHIP Programs



N = 46 for 1998 because 24 states were operating a CHIP and 22 states had submitted a state plan to operate a CHIP.

N= 50 for 2000 and 2005 and represented data from 49 states and the District of Columbia. In 2005, Tennessee was not operating a CHIP, but as NASHP was publishing its report, the state legislature was considering establishing a program.

SOURCE: *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*, Published by the National Academy for State Health Policy, funded by the David and Lucile Packard Foundation, 2006.

Agency Homes for States' CHIPs

For ease of administration and coordination of benefits, most separate programs were housed in the Medicaid agency or the agency that houses Medicaid.

In 2005, all of the Medicaid expansion CHIPs were operated by the agency that houses Medicaid. Likewise, 28 of the 36 separate programs reporting (78%) operated their CHIPs in the Medicaid agency or the agency that houses Medicaid. The survey document cited two possible reasons for this fact. Medicaid agencies could assume many of the tasks that CHIP would have to perform since the agency was already performing those tasks and eligibility between the two programs could be coordinated more efficiently.

As noted previously, the State and School Employees' Health Insurance Management Board (HIMB) is the administrative agency for CHIP. However, HIMB and DOM share responsibilities (see page 12).

Contracted Administrative Services for States' CHIPs

Most CHIP programs, both Medicaid expansion and separate programs, contract with administrative service organizations to conduct services needed to carry out CHIP.

Aside from providing insurance coverage, BCBSMS conducts pre-certifications/prior authorizations and appeals, contracts with credential providers, provides customer service, and provides membership information on the health plan.

Most states' CHIPs hire administrative service organizations to handle functions such as actuarial studies, claims processing, outreach, and quality assurance. Separate programs are more likely than Medicaid expansion programs to contract out administrative functions. Medicaid expansion programs reported using administrative service organizations to handle provider education, claims processing, member services, and outreach. Separate programs reported contracting services such as customer service, participant surveys, premium/cost-sharing collection, and claims processing.

Mississippi contracts most of the administrative services needed for CHIP. Aside from providing the insurance coverage, BCBSMS conducts pre-certifications/prior authorizations and appeals, contracts with credential providers, provides customer service, and provides membership information on the health plan. HIMB contracts for consulting services such as conducting the request for proposals process for potential insurers, actuarial services, and database management services.

Cost Sharing/Premiums of States' CHIPs

Federal guidelines prohibit cost sharing for well child and well baby services provided through CHIP. In Mississippi, state law further defines cost sharing restrictions for the program. Therefore, cost sharing is limited for Mississippi's CHIP enrollees.

Medicaid expansion programs are generally more restricted in the cost sharing provisions that they can apply than are separate programs. According to federal regulations, cost sharing cannot be implemented for well-child and well-baby services; families with lower incomes cannot be charged more that families with higher incomes; cumulative cost sharing cannot exceed five percent of the aggregate family income; and American Indians and Alaskan Natives are exempt from all cost sharing.

Mississippi's CHIP requires very little in the form of cost sharing.

In 2005, twelve separate CHIPs reported requiring an enrollment fee/premium, six reported requiring co-pays, and fifteen reported requiring both enrollment fee/premiums and copays. In the same year, three Medicaid expansion program CHIPs reported requiring enrollment fees/premiums, four reported requiring co-pays, and one reported requiring both enrollment fees/premiums and co-pays.

Mississippi's CHIP requires very little in the form of cost sharing. The state does not impose any premiums on enrollees or require any deductibles to be met. However, co-payments are required for enrollees in families with income at or above 151% of the federal poverty level. In addition, MISS. CODE ANN. § 41-86-17 (1972) prohibits cost sharing for vision and hearing screening, eyeglasses and hearing aids, preventive dental care, and routine dental fillings.

Service Delivery Methods of States' CHIPs

Federal guidelines provide states with a variety of options in terms of the type of service delivery method a state may choose to implement CHIP services. The NASHP survey categorized these systems as contractor based, primary care case management based, and fee-for-service delivery based system.

NASHP's survey showed that the prevalent type of delivery system for both separate and Medicaid expansion programs was through managed care companies that deliver a comprehensive set of benefits.

Federal CHIP regulations provide states with a wide variety of options in designing the delivery system methods to provide services. States have taken advantage of this discretion and have implemented services that program officials believe are tailored to their clients.

The survey report categorized delivery systems into three major types: contractor based, primary care case management (PCCM) based, and fee-for-service delivery based systems. NASHP's survey showed that the prevalent type of delivery system for both separate and Medicaid

expansion programs was through managed care companies that deliver a comprehensive set of benefits.

Mississippi utilizes a contractor-based delivery system.

Mississippi utilizes a contractor-based delivery system through Blue Cross Blue Shield of Mississippi, which contracts with providers of services.

A brief description of each of the three types of delivery systems follows.

Contractor Based Delivery System

In a contractor based delivery system, the CHIP does not use its own set of providers to deliver services, but instead contracts with one or more contractors to provide services. Types of contractor-based providers are managed care companies such as health maintenance organizations or managed care organizations that deliver a comprehensive set of benefits; managed care companies that deliver a limited set of benefits; and companies such as Blue Cross Blue Shield. Blue Cross Blue Shield uses its network of providers that is available to individuals with other insurance plans.

Primary Care Case Management Based Delivery System

In a primary care case management based delivery system, the responsibility for an enrollee's health care is assigned to a specific primary care provider, usually on a fee-for-service basis. The state signs agreements with health care providers (rather than with insurers, third-party administrators, or fiscal agents) that manage enrollees' health care services and act as a gatekeeper, making referrals as needed. These providers agree to provide direct care or refer the enrollee to another provider for specialized services. The provider may receive a fee for providing direct care and a small fee per enrollee for acting as health care gatekeeper.

Fee-for-Service Based Delivery System

In a fee-for-service based delivery system, the state delivers services to enrollees through providers that the state contracts with directly. The state is responsible for managing and paying for services provided to enrollees.

Results of PEER's Survey of Selected States' CHIPs

PEER surveyed six other states and found a variety of administrative and service delivery structures, program costs, and benefits/services package. Among the states surveyed, Calendar Year 2007 program expenditures per member per month ranged from $100 in Arkansas to $210 in Tennessee, but PEER cautions that states' program expenditures are not comparable for a variety of reasons. While all seven states are comparable in basic benefits provided, states varied in requirements for cost sharing, level of maximum benefits, and percentages paid for covered services.

Survey Method

To compare Mississippi's CHIP to other state models, PEER surveyed six other states and asked them to report on their state's basic program components (e. g., type of program, benefit structure, contracted functions, service delivery method, number of enrollees, cost per member per month, and benefit levels). Appendix A on page 63 of this report is the compilation of responses to PEER's survey.

The six states in PEER's survey have wide discretion as to how to implement their CHIPs and officials have taken advantage of that flexibility in order to reach targeted low-income children.

PEER surveyed Alabama, Arkansas, Georgia, Louisiana, and Tennessee because four of them are contiguous to Mississippi and all of them are southern states. PEER chose Montana to survey because it operated a fully insured program through Blue Cross Blue Shield of Montana until October 2006, when the state changed to a third-party administrator contract and reported that it realized significant savings.

The results of PEER's survey of selected states' CHIPs confirmed what the NASHP nationwide CHIP survey reported. States have wide discretion as to how to implement their CHIP and officials have taken advantage of that flexibility in order to reach targeted low-income children.

Administrative and Service Delivery Structures

Among the states surveyed by PEER, three operated a separate program similar to Mississippi's CHIP, while three others operated a combination program. Administrative responsibilities and service delivery structures varied among the states surveyed.

Of the six programs surveyed, three operated a separate program and three operated a combination program. Of the three separate programs, benchmark or benchmark equivalent were cited as the type of benefits provided. Within the combination programs, the type of health care benefits provided depended on the eligibility of the children and the type of program they would qualify for

(i.e., Medicaid or CHIP). For instance, in Louisiana the children whose families earn up to 200% of the federal poverty level are placed on the Medicaid expansion program that uses Medicaid benefits, but children whose families earn between 200% and 250% of the federal poverty level are placed on a separate plan that is benchmarked to the state employees' health plan. Arkansas provides secretary-approved benefits, similar to the benefits available to its state employees' plan, that are available for CHIP-eligible and Medicaid-eligible children as well. In Arkansas, Medicaid-eligible recipients are allowed to be on CHIP.

Of the six programs PEER surveyed, three operated a separate program and three operated a combination program.

The six programs reported utilizing different administrative service organizations to perform various functions for the program. A variety of fiscal agents and third-party administrators were used for functions. Claims processing, customer service, enrollee outreach, provider network services, and eligibility are all functions that states reported they contracted out.

Likewise, the six programs reported different methods of service delivery. Self insured, primary care case providers, fee-for-service delivery and managed care arrangements were all cited as means of providing health care benefits.

Provider networks were varied among the states. Among the provider networks cited were: Blue Cross Blue Shield, Medicaid, state employee's health plan, separate managed care plan providers, and an established commercial network.

Program Costs

Among the states PEER surveyed, CY 2007 program expenditures per member per month ranged from $100 in Arkansas to $210 in Tennessee. The requirements for CHIP cost sharing are fairly uniform among the states, but PEER cautions that states' program expenditures are not comparable for a variety of reasons.

PEER calculated Mississippi's average CHIP expenditures per member per month for calendar years 2004, 2005, 2006, 2007, and through June 2008 as shown in Exhibit 9, page 37. PEER calculated these figures by adding quarterly net expenditures and dividing those sums by average enrollment data.

PEER surveyed selected states regarding their per member per month costs for Calendar Year 2007. These costs ranged from $100 per member per month in Arkansas to $210 per month in Tennessee.

Exhibit 9: Program Expenditures Per Member Per Month for Mississippi's CHIP

Calendar Year	PEER-Calculated Program Expenditures Per Member Per Month	Percentage Increase from previous Year
2004	$158	Not applicable
2005	172	9%
2006	160	(7%)
2007	177	11%
2008[1]	253	43%

[1]Data reported for 2008 reflects CHIP costs and enrollment through June 2008.

SOURCE: PEER obtained cost of the CHIP program from federal reports and obtained monthly enrollment numbers from monthly enrollment figures produced by DOM.

Although the program expenditures per member per month give a snapshot of what each of these states' programs actually cost for calendar year 2007 based on self-reported information, these amounts are not directly comparable for the following reasons:

- *The cost components for the program expenditures per member per month amount are not comparable.* For example, some of the states surveyed included all administrative costs, some included vendor administration costs but not staff administration costs, and some did not respond regarding whether they included administrative expenditures.

- As evidenced in Appendix A, page 63, *benefit percentages varied greatly from state to state.* For example, Mississippi's CHIP covers ambulance expenses at 100% for network providers, while Montana excludes ambulance services altogether and Alabama, Louisiana, and Arkansas require a nominal co-pay for such services.

- *PEER calculated Mississippi's per member per month amount from actual program documents submitted by DOM to CMS and enrollment data produced by DOM.* However the information from the other states was obtained through a purposive survey of self-reported information not audited by PEER.

- *Factors such as provider reimbursement rates, number of providers, and access to providers vary among states.*

For the reasons above, as well as other possible reasons, cost studies generally have not been a part of the evaluation approach for states' CHIPs. The staff of the National Conference of State Legislatures (NCSL) staff confirmed this to PEER.

Cost studies generally have not been a part of the evaluation approach for states' CHIPs.

The requirements for CHIP cost sharing are fairly uniform among the states. Georgia is the only state charging a monthly premium, but does not implement any other cost sharing components. On services for which the states were allowed to charge copayments, the amount ranged from $3 to $15. The only state implementing a deductible was Louisiana and that is for mental health/substance abuse benefits. Three of the programs reported implementing an out-of-pocket maximum based on 5% of family income amounts set by the individual states.

Benefits/Services Packages

States surveyed by PEER provided similar CHIP benefits and services, such as medical, dental, and vision coverage. However, services in some states had varying levels of cost-sharing requirements while other services were available only to children whose families fall within certain income levels.

Most states did not impose a lifetime maximum payout on the amount of dollars expended on services for an enrollee. Montana capped the payout at $1 million and Louisiana capped the LaCHIP Affordable at $5 million.

Generally, states provided benefit packages that were fairly uniform across the board. As per federal regulations, a state either has to provide the Medicaid benefit package or select a benchmark that provides well-baby and well child care services, age-appropriate immunizations and emergency services, inpatient and outpatient hospital services, physicians' surgical and medical services, and laboratory and x-ray services.

Some states exclude medical services that Mississippi's CHIP provides at 100% coverage (minus any cost sharing that might apply).

However, some states exclude medical services that Mississippi's CHIP provides at 100% coverage (minus any cost sharing that might apply). Montana does not provide coverage for services such as ambulance, chiropractic, hospice and prosthetic/orthotic procedures and devices. Louisiana's LaCHIP Affordable (for children whose families have incomes between 200% and 250% FPL) does not provide coverage for attending physician maternity (pre-natal and delivery), maternity hospital services, private duty nursing, or skilled nursing services. Georgia does not cover private duty nursing services. Arkansas excludes hospice care, occupational therapy, physical therapy, private duty nursing, prosthetic/orthotic procedures and devices, and routine hearing services.

States reported limitations on other services. Montana places a $350 benefit year maximum on routine dental

services (but children may get orthodontics because of severe craniofacial anomalies) and Louisiana's LaCHIP Affordable plan does not provide any dental or vision care benefits.

Chapter 4: What are the total costs of Mississippi's CHIP and the cost components of CHIP's premium rate structure?

From January 2004 through June 2008, the total cost of Mississippi's CHIP was approximately $605 million, with the federal government contributing $505 million and the state contributing approximately $100 million. The cost of CHIP varies yearly and depends largely on the premium rate structure charge by the insurer. Mississippi's current premium rate has six components. The three components that fluctuate and can cause premium rate changes are the trended claims, recoupment component, and administrative fees. The recoupment component allows the vendor to mitigate some of the claims loss or gain on an annual basis. PEER believes that the CHIP administrative structure presents opportunities for cost savings that the state has not yet achieved.

This chapter contains a discussion of the major cost components of Mississippi's CHIP, including the premium rate structure, the major cost categories, and per member per month cost.

Total Cost of Mississippi CHIP

The total cost of Mississippi's CHIP was approximately $605 million from January 2004 through June 2008, averaging approximately $134 million per year. Of the total amount, the federal government contributed approximately $505 million and the state contributed approximately $100 million. However, the total cost of CHIP varies from year to year and is largely dependent on the per enrollee premium charged by the insurer, BCBSMS.

As stated on page 6, CHIP is a joint federal/state program funded primarily through a block grant from the federal government. PEER examined documents submitted quarterly to CMS to estimate the total cost of the program in terms of federal and state funds. PEER examined quarterly documents for calendar years 2004 through 2007 and for the first two quarters of 2008, for a total of fifty-four months.

The *total computable amount* is a term used in federal reports that is the sum of:

- the premiums paid to BCBSMS;
- inoculation charges paid to the Department of Health for the administration of immunizations;
- administration charges paid to DFA by DOM for the agency's expenditures for Mississippi's CHIP; and,

- cost of outreach and eligibility determination.

In total, the federal government contributed approximately $505 million (84%) to the program while the state contributed approximately $100 (16%) million, for a total computable amount of $605 million (i. e., approximately $134 million per year over the 4½-year period). Exhibit 10, below, shows the federal share and the state share of the total computable amount spent on this program as reported by DOM to CMS.

Exhibit 10: Mississippi's CHIP Total Computable Expenditures by Federal and State Share

Calendar Year	Federal Share of Total Computable Expenditures	State Share of Total Computable Expenditures	Total Computable Expenditures
2004	$103,018,907	$19,681,079	$122,699,986
2005	116,251,285	22,535,656	138,786,941
2006	97,364,699	19,687,993	117,052,692
2007	107,300,107	21,694,043	128,994,150
2008[1]	80,947,395	16,111,833	97,059,228
Total	$504,882,393	$99,710,604	$604,592,997
Percentage of Total	84%	16%	100%

[1]CY 2008 contains information from the first and second quarters only (January through June).

SOURCE: Reports submitted by DOM to the federal government concerning CHIP.

Exhibit 10, above, illustrates how expenditures on CHIP fluctuate. This depends largely on the number of enrollees in the program and the premium rate charge per enrollee. (See discussion on page 42 for an explanation of the premium rate structure.)

PEER calculated a per enrollee per year cost by dividing the total computable expenditure amount by the total number of enrollees for a year as reported by the insurer. Exhibit 11, page 42, illustrates the per enrollee per year of the total computable expenditure amount, the federal government's share of the total computable cost per enrollee per year, and the state's share of the total computable expenditure amount per enrollee per year.

Exhibit 11: Federal, State, and Total Computable Expenditures per Enrollee per Year

Calendar Year	Federal Share of Total Computable Expenditures per Enrollee per Year	State Share of Total Computable Expenditures per Enrollee per Year	Total Computable Expenditures per Enrollee per Year	Percentage Increase/(Decrease) from Previous Calendar Year
2004	$133	$25	$158	NA
2005	144	28	172	9%
2006	133	27	160	(7%)
2007	147	30	177	11%
[1]2008	211	42	253	43%
Average	$154	$30	$184	NA

[1]Calendar Year 2008 contains information from the first and second quarters only (January through June).

SOURCE: PEER analysis of BCBSMS monthly enrollment reports and CMS Form 21 summary sheets.

An increase or decrease in the enrollee premium per month is largely affected by the changes in three components of the per enrollee per month premium charged by the insurer: recoupment component, trended/incurred claims component, and administrative fee.

The total computable amount and the total computable per enrollee expenditure increases and decreases are a reflection of the per enrollee per month premium charged by the insurer. An increase or decrease in the enrollee premium per month is largely affected by the changes in three components of the per enrollee per month premium charged by the insurer: recoupment component, trended/incurred claims component, and administrative fee. (See the following section for a discussion of these components.)

For example, the average total computable expenditure per enrollee increased from $177 in 2007 to $253 in 2008, which was a 43% increase. This increase was due in large part because the per member per month premium increased from $183.43 in 2007 to $231.13 in 2008. The premium rate structure is discussed in more detail in the next section.

Premium Rate Structure

The premium rate for CHIP is based on the sum of six components. The three components that fluctuate and can cause premium rate changes (depending on program utilization) are trended claims, the recoupment component, and administrative fees. Mississippi's per member per month premium for calendar year 2008 is $231.13.

For Mississippi's current CHIP agreement, the premium rate is arrived at by the insurer by using a trended claims estimate, which is an estimate based on historical claims information, enrollment, and projections, vision service contract rate premium, risk pool fee, recoupment component, administrative fee, and premium tax.

With review by HIMB, Blue Cross sets the per member per month premium rate for each calendar year.

The CHIP RFP set a premium rate of approximately $156 per member per month for January 1, 2005, to June 30, 2005, which was the initial rate period for the second agreement. According to the agreement, the insurer was allowed to increase the premium in July 2005. From January 2006 until December 31, 2008 (the end of the term of the agreement with Blue Cross), the premiums were guaranteed for twelve months and were subject to adjustment on the agreement anniversary date. With review by HIMB, Blue Cross sets the per member per month premium rate for each calendar year. Exhibit 12, below, lists the monthly per member per month premiums broken down by components for Mississippi's CHIP program since January 2005.

Exhibit 12: CHIP Premium Components from 2005 to 2008

	Jan. to June 2005	July to Dec. 2005	2006	2007	2008
Trended/Incurred Claims	$138.49	$148.88	$151.15	$158.84	$192.42
Recoupment		16.58	(11.63)	3.93	16.86
Administration Fee	9.65	11.05	11.73	12.66	13.17
Vision Service Provider	4.75	3.75	3.75	3.75	3.71
Risk Pool	1.00	1.50	1.50	1.50	1.50
Premium Tax	2.38	2.77	2.38	2.75	3.47
Pharmacy Rebate	(.50)				
Nurse Hotline	.40				
Total Premium	$156.17	$184.53	$158.88	$183.43	$231.13

SOURCE: Blue Cross Blue Shield documents provided by Department of Finance and Administration.

The trended/incurred claims, recoupment, and administrative expenditures are the components that make the premium fluctuate. As noted previously, the trended claims amount is developed through an examination of previous claims and enrollment from the past year(s) and an attempt to project that information forward. The recoupment component allows the vendor to mitigate some of the claims loss or gain on an annual basis. Regarding administrative expenditures, the state's agreement with Blue Cross Blue Shield of Mississippi allows the company to be paid for administrative services rendered by the insurer. However, the value of these services is limited by the agreement between the state and the insurer.

Premium Components

The current agreement with Blue Cross Blue Shield allows the insurer to operate as a third-party administrator. Currently, BCBSMS is allowed to set aside a portion of premiums paid by the state for administration and then pay claims out of the remaining amount. If the amount of claims paid out is more than the set-aside amount of the premium, BCBSMS is allowed to recover that amount. DFA officials stated that this agreement allows the agency to control increases in the administrative component of the premium the insurer charges the state.

Under the current agreement, BCBSMS is paid a per member per month premium in advance for insurance coverage to be provided. BCBSMS sets aside a negotiated portion of the total premium to cover administrative fees and nursing advice hotline fees. The amount remaining is the amount that BCBSMS uses to pay all claims associated with CHIP.

Claims associated with CHIP include medical and dental costs, premium tax paid to the state as required by agreement, vision plan premiums, and risk pool assessments. Occasionally CHIP receives credits, such as pharmacy rebates, and those are credited to the claims. The gain or loss for a specific year is computed by subtracting the total claims from the total available for claims. This is a gain or loss for CHIP as a program. Gains will be credited to the next premium rate in the form of a reduced premium and losses are recouped by the company.

The recoupment component (previously referenced on page 43) for calendar year 2008 was calculated by dividing $12,598,883 (total claims loss from calendar years 2005, 2006, 2007 [as of September 30, 2007]) by the total number of enrollees estimated for calendar year 2008 (746,400 [62,200 members per month for 12 months]). The recoupment component built into the 2008 premiums is $16.86 per member per month.

As the current agreement is structured, CHIP pays all of the insurance claims and an administrative amount to BCBSMS.

Exhibit 13, page 45, represents for calendar years 2005 through 2007 the total amount of premiums paid to BCBSMS (column B); administrative fees, incurred claims and other expenditures (columns C, D, and E, respectively), and net gain/loss amounts resulting after claims and other expenditure amounts were subtracted (column F).

As the current agreement is structured, CHIP pays all of the insurance claims and an administrative amount to BCBSMS. As previously discussed, this is a participating insurance agreement between the HIMB and the insurer which functions similar to self-insurance, whereby a third-party administrator is paid a fee for administrative services and all claims costs are paid by the plan.

DFA officials state that for the past two agreement periods, there was not enough historical data for CHIP for

a company to provide a reasonable and competitive bid on a conventional[2] premium for CHIP. In fact, they found it difficult to get companies to bid. One company bid on the first agreement and two companies bid on the second agreement, but one of those companies was disqualified because it did not meet minimum vendor qualifications. DFA officials were concerned that there might be dramatic increases in premiums or the state would pay too much for insurance coverage if the insurer bid a premium that was too low or too high for the first premium period.

Exhibit 13: Selected Components of the Premium Renewal Calculation, Calendar Years 2005-2007

A	B	C	D	E	F
Calendar Year	Total Premiums Paid to BCBSMS	Administrative Fees	[b]Incurred Claims	[c]Other Expenditures	[d]Net Gain/Loss after Administrative Fees, Claims, and Other Expenditures Subtracted
2005	$137,107,885	$8,913,494	$113,179,102	$5,604,689	$9,410,600
2006	116,342,263	8,589,468	116,769,877	4,785,357	(13,802,439)
[a]2007	133,679,198	9,226,292	127,612,493	5,029,604	(8,189,191)
Total	$387,129,346	$26,729,254	$357,561,472	$15,419,650	($12,581,030)

SOURCE: Blue Cross Blue Shield of Mississippi Premium Renewal Calculation worksheet.

[a]CY 2007 data is actual data for January to September. Due to a lag in claims processing, data for October, November, and December is projected.

[b]Incurred claims include claims for medical and dental, including mental health.

[c]Other expenditures include premium taxes, payments to the vision service provider, payments into the state's risk pool, and any additions for rebates.

[d]Gain/loss was calculated by subtracting incurred claims, premium tax, vision service provider premium, and risk pool fee from the amount available for claims and adding any incurred rebates.

Opportunities to Reduce Costs

PEER believes that Mississippi's CHIP has opportunities for cost savings that the state has not yet achieved, including restructuring benefits, increasing cost sharing, implementing prescription drug cost containment measures, and implementing enrollment controls.

Restructuring Benefits

Mississippi's CHIP provides benefits in addition to those of its benchmark, the State and School Employees' Life and Health Plan. Scaling back

[2] A conventional premium does not have a one-time premium call. The revenue generated from the premium pays for all claims and administrative expenses borne by the insurer, whereby all risk is transferred to the insurer.

benefits would reduce claims costs and, in turn, lower the cost of the program.

Mississippi's CHIP is categorized as a benchmark plus benefit package because it provides more benefits than the plan to which it is benchmarked (see Exhibit 3, page 22, which is a comparison of benefits between CHIP and the State and School Employees' Life and Health Plan). Because the state has chosen to benchmark its CHIP plan to the State and School Employees' Life and Health Plan, it must provide services at least equivalent to those offered by that plan. From a cost perspective, the benefits provided in CHIP could be scaled back to be more in line with its benchmark plan. The State and School Employees' Life and Health Plan does not provide dental or vision benefits. DFA's actuarial study reports that dental and vision claims (prior to cost sharing) contributed an average of $32 claims cost per child in additional costs to CHIP in calendar years 2006 and 2007.

The State and School Employees' Life and Health Plan does not provide dental or vision benefits. DFA's actuarial study reports that dental and vision claims (prior to cost sharing) contributed an average of $32 claims cost per child in additional costs to CHIP in calendar years 2006 and 2007.

Restructuring CHIP in this manner would most likely make it more comparable to benefit packages that workers receive through their employers and could encourage families to join their employers' health plans rather than CHIP. Restructuring of benefits could easily be reversible at a later date. However, savings from this option might not meet expectations and there could be opposition from participants or advocacy groups if benefit restructuring is proposed.

MISS. CODE ANN. § 41-86-17 (1972) requires that benefits in addition to the benchmark be provided to CHIP enrollees and it restricts the cost sharing that may be implemented for these benefits. Should the state choose to restructure benefits or increase cost sharing, the law would need to be amended concerning these requirements.

Increasing Cost Sharing

Federal regulations limit the amount of cost sharing possible for CHIP. However, Mississippi may not be utilizing the total amount of cost sharing allowed under federal law.

Currently, for Mississippi's CHIP, no cost sharing provisions apply to families whose incomes are below 150% of the federal poverty limit and there are modest limits on families whose incomes are greater than 150% of the federal poverty limit.

Federal regulations limit the amount of cost sharing that may be imposed on families in CHIP. In separate CHIP programs, federal regulations allow cost sharing for certain populations and services. Cost sharing cannot be charged for preventive services[3]. For children whose family income is below 150% of the federal poverty level, premium amounts cannot exceed the limits established under the state's Medicaid program and cost sharing is limited to amounts of $1 to $5 for services. For families whose income is above 150% of the federal poverty level, cost sharing may be imposed in any amount, provided that cost sharing for higher income children is not less than cost sharing for lower income children. However, for all income levels, total amount of cost sharing that a family is required to pay (i. e., premiums, deductibles, copayments, and any other charges) cannot exceed 5% of the family's annual income.

Mississippi's CHIP does not require the maximum amount of cost sharing allowed by federal law. No cost sharing provisions apply to families whose incomes are below 150% of the federal poverty limit and there are modest limits on families whose incomes are greater than 150% of the federal poverty limit, even though the state could impose cost sharing amounts of up to 5% of annual income. Exhibit 14, page 48, shows cost sharing requirements for Mississippi's CHIP enrollees.

In Mississippi, CHIP benefits for enrollees whose family's income is less than 150% of the federal poverty level are limitless when using a network provider because there are no copayments, deductibles, premiums, cost sharing, or lifetime maximums.

There are no out-of-pocket expenses for enrollees on CHIP whose family's income is less than 150% of the federal poverty level. This means that program benefits for this group are limitless when using a network provider because there are no copayments, deductibles, premiums, cost sharing, or lifetime maximums. However, as discussed earlier, the amounts the state can charge for this income group are limited. For enrollees whose families earn 151% to 175% of the federal poverty level, there is an $800 out-of-pocket maximum. This means that after the family has paid $800 in cost sharing for services for all members who are in the program, the remaining claims are paid at 100% with no additional cost sharing. For enrollees whose families earn between 176% to 200% of the federal poverty

[3] CMS defines *preventive services* to include the following: all healthy newborn inpatient physician visits, including routine screening (inpatient and outpatient); routine physical examinations; laboratory tests; immunizations and related office visits; and routine preventive and diagnostic dental services.

Exhibit 14: Cost Sharing Requirements of Mississippi's CHIP

	Less than 150% FPL	151% - 175% FPL	176% - 200% FPL
Premiums	None at any income level		
Deductibles	None at any income level		
Copayments			
Doctor Visit	None	$5.00	$5.00
Emergency Room Visit	None	$15.00	$15.00
Out-of-Pocket Maximum	Enrollees pay no out-of-pocket expenses	$800	$950

SOURCE: Mississippi's State Plan Document for CHIP

level, there is a $950 out-of-pocket maximum. This means that after the family has paid $950 in cost sharing for services for all members who are on the program, the remaining claims are covered at 100% with no additional cost sharing.

Based on the CY 2007 federal poverty levels, PEER estimates that the cost-sharing range, based on the 5% maximum of family income allowed by federal law, for a family of four whose income is between 151% and 175% of the federal poverty level, is between approximately $1,550 and $1,800. For a family of four whose income falls between 176% and 200% of the CY 2007 federal poverty levels, the cost-sharing range is between approximately $1,817 and $2,065. Cost sharing could promote equity because many low-income workers who are in the same or just slightly higher income brackets as CHIP families pay into their employers' health insurance plan, while families participating in CHIP receive better coverage for little cost. When enrollees pay into CHIP, state costs are reduced, which frees more funds to be used to cover additional children. Cost sharing is common in private market plans but very limited in Medicaid.

If considering cost sharing, the state should first conduct a cost benefit study. Some states have found that cost sharing mechanisms such as premiums and fees are easier and more cost efficient to collect.

However, if cost sharing is implemented, fewer people may sign up for CHIP or utilize the services because of increased costs and limited family incomes. Cost sharing can be costly and administratively burdensome to providers. Also, states must consider their own administrative costs when considering whether to implement cost sharing mechanisms. If considering cost sharing, the state should first conduct a cost benefit study. Some states have found that cost sharing mechanisms such as premiums and fees are easier and more cost efficient to collect.

As noted previously, MISS. CODE ANN. § 41-86-17 (1972) requires that benefits in addition to the benchmark be provided to CHIP enrollees and it restricts the cost sharing that may be implemented for these benefits. Should the state choose to restructure benefits or increase cost

sharing, the law would need to be amended concerning these requirements.

Implementing Prescription Drug Cost Containment Measures

CHIP pays 100% of costs for in-network generic or brand name medically necessary drugs. The program could take measures to limit costs of the prescription drug benefit, such as implementing a preferred drug list and mandating the use of generic drugs when available.

Mississippi's CHIP pays 100% of the drug costs in-network for generic and brand name drugs. Prescription drugs must be medically necessary and approved for general use by the U. S. Food and Drug Administration.

On average, children utilize prescription drugs far less than adults and the impact of cost containment measures on the majority of CHIP enrollees could be minimal, resulting in limited savings to the state.

CHIP administrators could take several steps to contain prescription drug costs. The state could mandate a preferred drug list such as that used for the State and School Employees' Life and Health Plan. Drugs would be selected based on clinical effectiveness and cost and the state could negotiate the lowest possible price. Also, the state could mandate the use of generic drugs when available and/or limit the number of prescriptions the enrollee is allowed to receive in a given time frame. The program could mandate different levels of co-payments based on a preferred drug list and whether the drug is generic. With the State and School Employees' Life and Health Plan, a $50 deductible must be met for each individual on the plan plus co-payments as follows: $13 for generic drugs, $33 for preferred brand name drug, and $55 for other/non-preferred drugs with no generic equivalent.

On average, children utilize prescription drugs far less than adults and the impact of cost containment measures on the majority of CHIP enrollees could be minimal, resulting in limited savings to the state.

Implementing Enrollment Controls

CHIP could implement an enrollment control process, which would most likely reduce program expenditures per member per month.

PEER believes that the fairest enrollment control process would be need-based, whereby the program would cover those most in need first, but only up to the level that the state could afford.

One of the driving factors of cost in CHIP is enrollment. According to program officials, not only do total program costs increase as program enrollment increases, but the per member per month program expenditures remain the same or in some cases, increase.

At present, Mississippi's CHIP ultimately pays for all of the claims that are made on the policy as a result of the one-time premium call. CHIP's benefit structure is heavily structured toward preventive care and wellness and all

benefits are provided at little or no cost to the enrollee's family.

State law gives the Division of Medicaid the authority to limit CHIP enrollment when necessary to ensure that the cost of the program does not exceed federal and state funding allotments.

State law gives the Division of Medicaid the authority to limit CHIP enrollment when necessary to ensure that the cost of the program does not exceed federal and state funding allotments. PEER believes that the fairest enrollment control process would be need-based, whereby the program would cover those most in need first, but only up to the level that the state could afford. The process for determining need would need to be developed based on analysis of program data.

Chapter 5: How does provider access compare between Mississippi's CHIP and Medicaid?

Factors affecting the provider networks for CHIP and a Medicaid population resembling CHIP include access to the nearest provider, provider caseload, and allowable reimbursements for services rendered. All of these factors are important for adequate health care access. Data analysis shows that provider access (distance from beneficiary to nearest provider) is comparable between Medicaid and CHIP. However, data analysis suggests differences in the provider caseloads between the two groups, with the Medicaid group having the greater demand for services. Also, an allowable charge comparison shows that on selected services, the Medicaid allowable amount is 48% of the current CHIP allowable amount.

States have a choice of operating a separate stand-alone CHIP, expanding their Medicaid program to include the CHIP-eligible participants, or operating a combination of both programs. If the state chooses to continue to operate a separate CHIP, the state may use the Medicaid provider network. However, if the state chooses to operate a Medicaid expanded program, the state must utilize the existing Medicaid provider network.

In this chapter, PEER examines aspects of both provider networks, a crucial component of access to health care, for both Mississippi's CHIP and Medicaid. This should give policymakers an idea of the advantages or disadvantages of a separate CHIP versus a Medicaid-expanded CHIP.

Provider Access

According to beneficiary and primary care provider information from the Division of Medicaid and BCBSMS, access to the nearest provider is similar for both a Medicaid population similar to CHIP and the current CHIP population.

PEER obtained provider and beneficiary information for the current CHIP population and a Medicaid population that resembles CHIP that details access data with respect to primary care physicians for a time frame beginning January 1, 2007, and ending June 30, 2008. BCBSMS and DOM both provided PEER with data sets that contained the following information: provider name and address, number of distinct beneficiaries each provider is serving, number of distinct beneficiaries residing in a zip code, and the number of distinct beneficiaries residing in a county. (*Distinct beneficiaries* means that these beneficiaries are only counted once, regardless of the number of claims that can be attributable to them.) Because of Health Insurance Portability and Accountability Act (HIPAA) requirements, PEER was unable to obtain the addresses of beneficiaries. This restriction limited the analysis because PEER could

not provide the most precision possible with respect to beneficiary access to providers in terms of mileage.

Using the information above, PEER used statistical geoaccess computer software to calculate in concentric rings the distances beneficiaries are from active providers.[4] The data sets referenced above contained an address for the provider and a zip code for the beneficiary. For each provider, a point location was generated using the address as the criteria, and for each beneficiary the point location was generated to the geographic center (i. e., centroid) of the zip code, as PEER was unable to obtain beneficiary addresses. (See previous paragraph.) The distance from the beneficiary centroid to the nearest provider was calculated using point-to-point (straight line) measures and not following transportation routes. After the distances were calculated, the software categorized the distances into natural mileage breaks from the beneficiary to the provider. PEER then manually adjusted the distances to the nearest whole distance for both datasets.

PEER's analysis of all beneficiaries, regardless of their status as urban or rural, shows that access to providers was similar for both the current CHIP population and a Medicaid population that resembles CHIP.

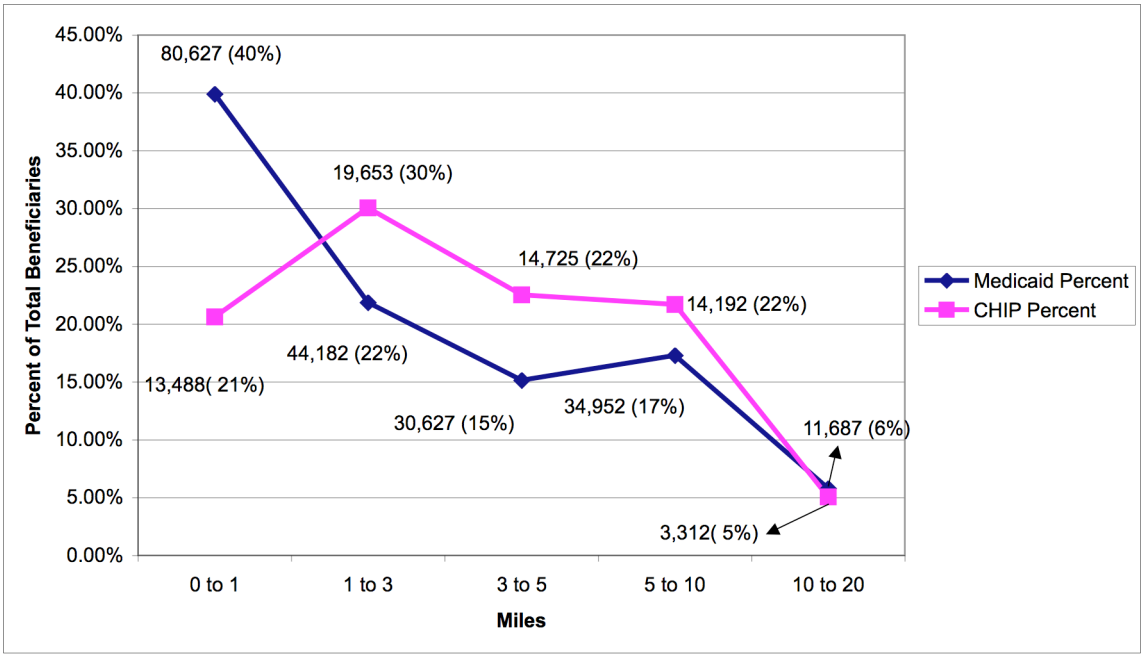
PEER analyzed the distance from beneficiary to provider in three different ways. First, PEER calculated the distance from provider to beneficiary without any regard as to whether the beneficiary resided in a rural or metropolitan area. PEER then examined the percentages of beneficiaries in the dataset living within a metropolitan area and the beneficiaries living outside a metropolitan area.

An analysis of all beneficiaries, regardless of their status as urban or rural, shows that access to providers in both datasets was similar. Exhibit 15, page 53, is a graphical comparison of percentage of all beneficiaries by distance to the nearest provider. For ease of comparison, PEER also provides a summary combining the five mileage categories into two mileage categories.

PEER then considered whether the beneficiary resided in a metropolitan statistical area (MSA). An MSA is a core area, containing more than 50,000 or more in population, together with adjacent communities having a high degree of social and economic integration with that core. PEER categorized beneficiaries living outside an MSA as rural and beneficiaries living within an MSA as urban.

[4] PEER defines an active provider as a provider that had at least one claim from January 1, 2007, through June 30, 2008.

Exhibit 15: Comparison of Percentage of Mississippi's CHIP and Similar Medicaid Beneficiaries by Distance to Provider (January 1, 2007, through June 30, 2008)



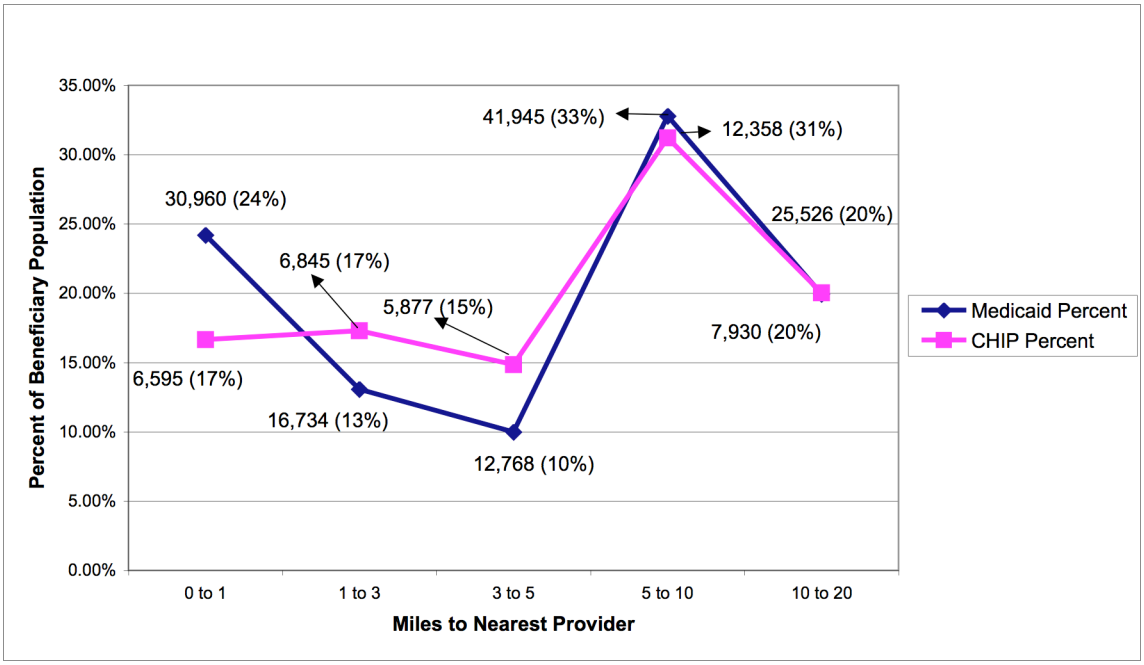
Summary Comparison of Beneficiary by Distance to Provider:

Mileage Category (number of miles)	Medicaid Percentage	CHIP Percentage
0 to 5	77%	73%
5 to 20	23%	27%

SOURCE: PEER analysis of provider and beneficiary access care information submitted by the Division of Medicaid and BCBSMS.

When examining only rural beneficiaries, access to the nearest provider for Medicaid beneficiaries and CHIP beneficiaries is comparable (see Exhibit 16, page 54). For both Medicaid and CHIP, the percent of beneficiaries living between zero and five miles of the nearest provider decreases when examining the rural subset as opposed to examining all beneficiaries. As expected, the percentage of rural beneficiaries living within five to twenty miles of the nearest providers increases for both datasets, as compared to looking at all beneficiaries because it is expected a rural beneficiary lives farther from a city center where health care is usually located. For ease of comparison, PEER also provides a summary combining the five mileage categories into two mileage categories.

Exhibit 16: Comparison of DOM and CHIP Percentage of Rural Beneficiaries by Distance to Provider (January 1, 2007, through June 30, 2008)



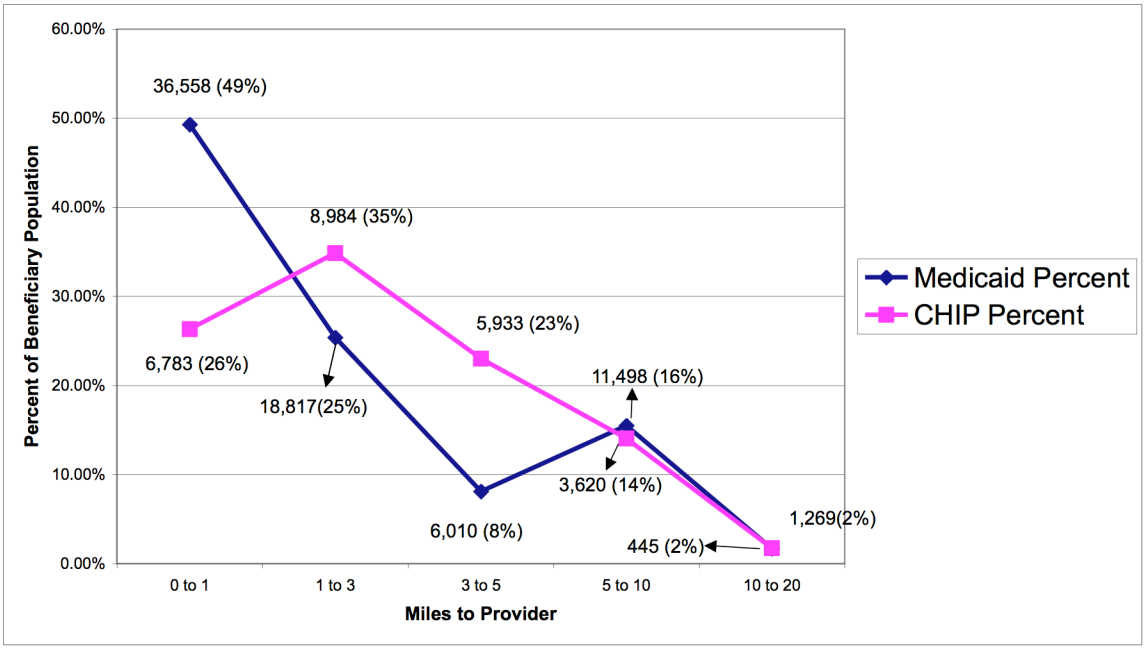
Summary Comparison of DOM and CHIP Percentage of Rural Beneficiaries by Distance to Provider:

Mileage Category (number of miles)	Medicaid Percentage	CHIP Percentage
0 to 5	47%	49%
5 to 20	53%	51%

SOURCE: PEER analysis of provider and beneficiary access care information submitted by the Division of Medicaid and BCBSMS.

When examining urban beneficiaries, the access to health care to the nearest provider is comparable between the two datasets (see Exhibit 17, page 55). As expected, the percentages of beneficiaries living between zero and five miles of a provider increases for both Medicaid and CHIP beneficiaries as compared to looking at all beneficiaries combined. Likewise, the percentage of urban beneficiaries living within five to twenty miles of the nearest providers decreases for both datasets because health care is usually located within a city center. For ease of comparison, PEER also provides a summary combining the five mileage categories into two mileage categories.

Exhibit 17: Comparison of DOM and CHIP Percentage of Urban Beneficiaries by Distance to Provider (January 1, 2007, through June 30, 2008)



Summary Comparison of DOM and CHIP Urban Beneficiaries by Distance to Provider:

Mileage Category (number of miles)	Medicaid Percentage	CHIP Percentage
0 to 5	82%	84%
5 to 20	18%	16%

SOURCE: PEER analysis of provider and beneficiary access care information submitted by the Division of Medicaid and BCBSMS.

Provider to Beneficiary Caseload

An overall examination of the DOM's beneficiary caseload and the CHIP's caseload yielded significant differences between the two in provider to beneficiary caseloads that shows a greater service demand for providers in the Medicaid dataset than providers in the CHIP dataset. Overall, there is one provider for every 110 beneficiaries in Medicaid and one provider for every 34 beneficiaries in CHIP.

PEER views a provider's caseload (i. e., the number of beneficiaries a provider sees) as an indicator of timely access to appropriate care. As noted above, PEER asked both DOM and BCBSMS to submit information on

providers[5] and the number of distinct beneficiaries those providers saw from January 1, 2007, through June 30, 2008.

PEER aggregated the beneficiaries and providers into a rural category (not in an MSA) and an urban category (within an MSA) (see Exhibit 18, page 56). Overall, the datasets yielded differences in provider caseload between the Medicaid and CHIP populations, with the Medicaid providers carrying a heavier burden than the CHIP providers.

The overall Medicaid ratio to is one provider for every 110 beneficiaries, contrasting to the CHIP overall ratio, which is one provider for every thirty-four beneficiaries. Categorizing the providers and beneficiaries for the Medicaid into rural and urban groups did not make a significant difference, with the rural providers having a slight increase in burden of four beneficiaries over the urban providers. However, categorizing the CHIP providers and beneficiaries by rural and urban did have a significant difference, with the rural providers having an increase in burden of sixteen beneficiaries over the urban providers.

This information does not take into account a provider's additional caseload resulting from other non-Medicaid or CHIP patients. The actual caseload for each provider will vary.

Exhibit 18: Comparison of the Beneficiary Burden on Medicaid Providers to the Beneficiary Burden of CHIP Providers

	Medicaid Beneficiary	Medicaid Providers	Ratio: Medicaid Beneficiary to Provider	CHIP Beneficiary	CHIP Provider	Ratio: CHIP Beneficiary to Provider
Rural	127,933	1,140	112 to 1	39,605	940	42 to 1
Urban	74,142	682	108 to 1	25,765	969	26 to 1
Overall	202,075	1,822	110 to 1	65,370	1,909	34 to 1

SOURCE: PEER analysis of provider and beneficiary access care information submitted by the Division of Medicaid and BCBSMS.

[5] PEER defined an active provider as a provider that had at least one claim from January 1, 2007, through June 30, 2008.

Allowable Reimbursements for Providers

In comparing a purposive sample of the allowable amounts for the most frequently used current procedural terminology (CPT) codes for CHIP to the Medicaid-reimbursable amounts for those same CPT codes, PEER concluded that on average, the Medicaid reimbursable amounts are approximately 48% of CHIP reimbursable amounts.

Health care system reimbursement amounts for physician services are vital to ensuring the adequacy of a provider network. Providers must make a profit in order to stay in business and continue providing health care.

PEER requested a purposive sample of the most frequently used current procedural terminology (CPT) codes and their allowable reimbursement amounts for CHIP for January 1, 2007, through December 31, 2007. CPT codes are commonly used physician codes used for reporting medical services and procedures. PEER then requested the Medicaid allowable reimbursement amounts for the same CPT codes in order to compare the allowable reimbursement amounts and determine whether a significant difference exists.

PEER's purposive sample produced a list of thirty-one distinct CPT codes and the allowable amounts per code. The thirty-one distinct codes are 63% of the total physician claims for occurrences for CHIP for calendar year 2007. PEER calculated a percentage difference between the Medicaid-allowed reimbursement amount and the CHIP-allowed reimbursement amount for twenty-nine of these codes. PEER did not calculate a percentage difference on two codes because Medicaid did not allow a reimbursable amount for one code and the other code had too many unknown variables to make a reasonable estimate.

PEER estimates that the added costs to provide medical services using the CHIP reimbursement codes over the Medicaid reimbursement codes to be approximately $6.4 million for calendar year 2007.

On average, Medicaid's reimbursements for the twenty-nine CPT codes examined were approximately forty-eight percent of the CHIP allowable reimbursements. Of sampled codes, in terms of dollars reimbursed, Medicaid rates were closest to CHIP rates for an emergency room visit, reimbursing $83.40 per occurrence versus a $109 CHIP reimbursement per occurrence. The Medicaid rate was 76.5% of the CHIP amount for emergency room reimbursement. The Medicaid reimbursement rate was the farthest from CHIP reimbursement rates for a radiologic examination, reimbursing $9.76 per occurrence versus a $65 CHIP reimbursement per occurrence. For radiologic examination, the Medicaid reimbursement is 15% of the CHIP amount. PEER estimates that the added costs to provide medical services using the CHIP reimbursement codes over the Medicaid reimbursement codes to be approximately $6.4 million for calendar year 2007.

Chapter 6: What actions should Mississippi take regarding its CHIP?

Given that no clear best practice model for a state CHIP emerged from a national survey and PEER's own survey of selected states and given that Mississippi's present contract with BCBSMS will end December 2009 (due to HIMB exercising an option to extend one year), PEER recommends that the state issue an RFP for a new service delivery structure to be effective for 2010. This structure should incorporate PEER's recommended cost savings measures and changes in contract terms.

Implications for Change

The state must move quickly to determine what form its Children's Health Insurance Program will take after the current agreement ends on December 31, 2009.

As noted previously, Mississippi's contractual relationship with Blue Cross Blue Shield was scheduled to end December 31, 2008, and the HIMB exercised an option to extend the agreement one year to December 31, 2009. The state must move quickly to determine what form its Children's Health Insurance Program will take after the agreement ends.

The NASHP and PEER surveys of other states' CHIPs yielded no clear best practice model or most efficient organization (see page 30). PEER believes that Mississippi's CHIP presents opportunities for cost savings that the state has not yet achieved.

The Legislature should also be aware that impediments to change may exist for some of the cost savings measures discussed on pages 45 through 50.

Possible Impediments to Change

Policymakers should be aware of the impediments to change that could exist in implementing cost savings measures or changing to a different administrative structure. These impediments include the requirements of existing state law, review and approval of changes by the federal Centers for Medicare and Medicaid Services, whether the program will be reinstated at the federal level, and the effects of the CHIP funding formula.

Requirements of State Law

As noted previously, MISS. CODE ANN. § 41-86-1 et seq. (1972) empowered the CHIP Commission to set up the structure of the program. The law also requires that benefits in addition to the benchmark be provided to CHIP enrollees and it restricts the cost sharing that may be implemented for these benefits. If changes were made in these areas, state law would first have to be amended.

Review and Approval of Changes by CMS

Any state plan amendment would need to be submitted to CMS and would take at least ninety days to obtain approval.

Changes in the state plan for CHIP must be approved by the federal Centers for Medicare and Medicaid Services. The state would need to submit a state plan amendment, which would take at least ninety days to obtain approval. In any program design change, policymakers must take into account CMS regulations, such as those regarding advertising the intent to change the program, benefit arrangements, and cost sharing.

Option for Reinstatement of the Federal CHIP Program

Federal lawmakers could change the SCHIP program from the way it currently operates.

The federal SCHIP program officially ended September 30, 2007, but has been funded through March 2009. At that time, Congress will either have to reauthorize the program or consider additional funding extensions. Policymakers should keep this in mind when considering long-range decisions, as federal lawmakers could change the program from the way it currently operates.

Effects of the Funding Formula

An unintended consequence of the current federal funding formula for CHIP is that it reduces the allotment for states that have lower health care wages and enroll more children (see page 6). If the funding formula is not addressed during the reauthorization of CHIP, state policymakers should consider the negative impact that enrolling more children might have on the allotment. In the past, Mississippi has always received a sufficient amount from the federal government to make up for any difference between the allotment and the amount needed to fund the program.

Recommendations

1. Based on the comparisons between the current CHIP and a Medicaid population that resembles CHIP with respect to access to care, provider to beneficiary ratio, and allowable charges, PEER sees no reason to question the decision made by the CHIP Commission in 1998 and the current structure of the program.

   If CHIP is to remain under the control of the Health Insurance Management Board, any public policy debate should include the following:

   a. During the 2009 session, the Legislature should amend MISS. CODE ANN. Section 25-15-303 (1972) to add the Executive Director of the Division of Medicaid to the HIMB to be included as a voting member of the board concerning matters related exclusively to the CHIP, to be effective upon passage.

   b. After this amendment becomes effective, the HIMB should, utilizing program data from the last ten years, develop a request for proposals for a new CHIP service delivery structure. The RFP should be issued in 2009 for contract year 2010 and beyond. The new service delivery structure should incorporate cost savings measures such as those identified in this report, including:

      - restructuring benefits so that they are more in line with the State and School Employees' Life and Health Plan, a step that could require the Legislature to amend MISS. CODE ANN. §41-86-17 (1972);

      - increasing cost sharing, a step that could require the Legislature to amend MISS. CODE ANN. §41-86-17 (1972);

      - implementing prescription drug cost containment measures, a step that could require the Legislature to amend MISS. CODE ANN. §41-86-17 (1972);

      - implementing enrollment controls; and,

      - utilizing alternative administrative structures, examples of which are included in Appendix B, page 113.

      The RFP should request proposals for both an insurance product as well as a self-insured

product with third-party administrator(s). A bid for a self-insured product should consider all of the costs such as but not limited to reinsurance for claims that are abnormally high. The HIMB should choose the best and most cost efficient proposal.

c. In the event that the board chooses to issue an RFP for insurance coverage, it should make clear in its RFP that it will no longer include a one-time premium call at the end of any contract and that all future premium rates should be based solely on actuarial history and projections.

2. Prior to any decision of transferring CHIP to DOM, the division should submit the following information to the Legislature:

   a. a continuation of services plan that outlines how the division intends to operate the CHIP, including such factors as the:

      - type of program the division intends to operate--e. g., Medicaid expansion, separate, or combination;

      - administrative service structure that will be utilized--e. g., in-house, contracting out, or a combination;

      - service delivery methods that will be implemented--e. g., contractor-based, primary care, or fee-for-service;

      - list of medical service providers; and,

      - how DOM will ensure that the service structure will not suffer as a result of a program transfer.

   b. the allowable rates for medical services rendered that DOM will utilize for providers to determine the effect they will have on the provider network that services the current CHIP population;

   c. a survey conducted of the current CHIP providers to determine whether they intend to remain as providers in the program given the continuation plan and the allowable rates DOM will utilize; and,

   d. the provider to beneficiary caseload ratio to determine whether CHIP beneficiaries who are

currently in the program will encounter an appreciable loss of service as a result of a program transfer.

3. The Legislature should amend MISS. CODE ANN. Section 25-61-9 (1972) to exclude PEER and other investigative bodies from the scope of any protective order limiting public access to documents in the possession of state agencies.

   Additionally, the Legislature should adopt legislation that would clearly authorize legislative enforcement of subpoenas through the court system if a committee deems such enforcement necessary to carry out its prerogatives. The Legislature should also define in law the criminal offense of contempt of the Legislature and establish a penalty for such.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
General Description of the Program	The Alabama Children's Health Insurance Program, called ALL Kids, is a self funded, stand-alone, private insurance model program. Benefits are delivered through Blue Cross Blue Shield of Alabama (BCBSAL), which maintains a sufficient number and type of providers in accessible locations for the population to be served. The providers are reimbursed based on the insurer's allowable charges. Providers not participating in this network are considered to be out of network providers and no benefits are provided for their services except for emergencies and as otherwise approved by ALL Kids.
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Separate
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	Benchmark coverage
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	BCBSAL - ASO
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	Self insured, claims are paid by BCBS fee for service base on the preferred provider fees schedule
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007 - 66,603; June 2007 - 67,715; September 2007 - 69,076; December 2007 - 70,082
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	$153.08, includes all insurance vendor administrative costs but not CHIP staff administrative costs
Provider Network (Use Medicaid Providers Only?)	BCBSAL
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	BCBS preferred provider (PPO) fee schedule

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
Age and Income Limits	0 - 5 years old, 133 - 200 % FPL, 6-18 years old, 100 - 200 % FPL
Benefit Period	12 months
Coordination of Benefits	If enrollees obtain other insurance during the 12 months of CHIP enrollment, CHIP always pays secondary. Enrollee will not be renewed at end of 12-month period due to having other insurance.
Copay/Co-insurance Amounts	No copays for preventive services. Specific copay amounts listed under applicable service.
Premiums	Premiums range from $50 to $100 per child per year for the first three children.
Deductible	none
Lifetime Maximum	none
Out of Pocket Amounts	$500.00
Pre-Existing Limitations	none
Ambulance	$5 or $10 copay

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
Ambulatory Surgical Facility	$3 or $5 copay
Chiropractor	$3 or $5 copay
Dental Care (no orthodontics)	$3 or $5 copay, for non-preventive visit
Durable Medical Equipment (DME)	no copay
Emergency Room Service	For emergencies, $5 or $15 copay, for non emergencies, $10 or $20 copay
Federally Qualified Health Center	In network, copays the same

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
Female Health Service	N/A
Free-Standing Diagnostic Facility	$3 or $5 copay
Home Health	No copay, 60 day limit
Home Infusion Therapy	Covered if medically necessary and approved by BCBSAL.
Hospice	Covered if medically necessary and approved by BCBSAL.
Hospital Services	Although PEER did not request this information in the survey, federal law requires that hospital services be included
Immunizations	Covered based on American Academy of Pediatrics recommendations
Lab and X-ray	$3 or $5 copay
Maternity - Attending Physician (Pre-natal and delivery)	No copay

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
Maternity - Hospital Services	$5 or $10 copay
Medical Supplies	No copay
Mental and Behavioral Health	20 outpatient visits, 20 intensive outpatient treatment days, 30 inpatient days
Nurse Midwife	If in the BCBS network
Occupational Therapy	No copay
Organ Transplants	Covered per BCBS review process
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	Covered per BCBS review process
Outpatient Hospital	$5 or $10 copay
Physical Therapy	No copay

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
Physician Services	$3 or $5 copay, for sick care (no copay for preventive)
Podiatry	$3 or $5 copay
Prescription Drugs	Generic $1 or $2, Preferred brand $3 or $5, Non-preferred brand $5 or $10
Preventive Health Screening	No copay
Private Duty Nursing Services	Covered per BCBS review process
Prosthetic/Orthotic Procedures and Devices	Covered per BCBS review process
Routine Hearing	No copay
Rural Health Clinic	In network, copays the same
Skilled Nursing Services	No copay

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Alabama "All Kids"
Speech Therapy	No copay
Vision Care	One exam and one pair of classes covered per year
Sources:	Alabama Department of Public Health

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
General Description of the Program	All benefit payments are based on the provider being properly enrolled with the Arkansas Medicaid Division of the Arkansas Department of Human Services and the beneficiary being properly enrolled with a Primary Care Provider (PCP) and receiving proper referrals for specialty services. Any services provided outside of program benefit coverage or limits, or services provided by a non-participating Medicaid provider or without PCP referral would not be covered by Medicaid.
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Combination (ARKids B is a 1115 Demonstration and the Separate program covers pregnant women and unborn children)
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	Secretary-Approved Coverage
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	Claims processed by EDS, all other services performed in-house
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	Same as Medicaid, primary care case management program called ConnectCare
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007: 77,811; June 2007: 77,461; Sept. 2007: 78,210, Dec. 2007: 79,925. These numbers represent the number of children who were ever enrolled during each of these respective months, as Arkansas could not provide PEER with point-in-time data.
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	$100 per member per month, but does not include administration costs.
Provider Network (Use Medicaid Providers Only?)	Medicaid Network
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	Medicaid rates

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
Age and Income Limits	Birth to age 19, up to 200% FPL (gross income)
Benefit Period	Enrollees are covered for a year from certification; however, benefits and cost sharing run on the state fiscal year (July 1 - June 30)
Coordination of Benefits	None
Copay/Co-insurance Amounts	$10 Office and $10 Emergency Room - Other copay and co-insurance amounts are different for some categories of covered services. See each specialty coverage listing for applicable benefit restrictions and beneficiary responsibility amounts.
Premiums	No premiums, but a small copayment may apply
Deductible	None
Lifetime Maximum	No lifetime maximum amount
Out of Pocket Amounts	5% of the family's annual gross income (example: $40,000 x 5% = $2,000) per state fiscal year
Pre-Existing Limitations	None
Ambulance	Medical necessity; $10/trip

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
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Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
Ambulatory Surgical Facility	Medical necessity; PCP referral; $10/visit
Chiropractor	Medical necessity; PCP referral; $10/visit
Dental Care (no orthodontics)	Routine Dental Care; $10/visit
Durable Medical Equipment (DME)	$500/Fiscal Year; PCP referral and prescription; 20% copay per DME item
Emergency Room Service	Medical necessity; $10/visit
Federally Qualified Health Center	Medical necessity; $10/visit

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
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Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
Female Health Service	Covered as medical/physician visits PCP or referral $10/visit
Free-Standing Diagnostic Facility	All physician services are covered through treatment by PCP or referral to specialist by the PCP - when the provider is properly enrolled with Arkansas Medicaid. Physician services in a free-standing group diagnostic practice would be covered with the PCP's referral under physician's benefits with $10/visit copay considered as payable in the physician's office as the place of service.
Home Health	Medical necessity; PCP referral - 10 visits/FY; $10/visit
Home Infusion Therapy	Covered under prescription drug benefit with nursing covered as home health services, limited to 10 visits per state fiscal year.
Hospice	EXCLUDED
Hospital Services	Although PEER did not request this information in the survey, federal law requires hospital services to be included.
Immunizations	All per protocol; PCP and Arkansas Department of Health (ADH) administered
Lab and X-ray	Medical necessity; PCP referral; $10/visit
Maternity - Attending Physician (Pre-natal and delivery)	Pre-natal care can be provided to a pregnant teen in ARKids B with a co-payment of $10 for each office visit. However, the pregnant teen remains in ARKids B until after the birth.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
Maternity - Hospital Services	Covered as inpatient hospital stay with 20% of hospitals providing Medicaid daily rate copay for first day of stay.
Medical Supplies	Medical necessity; PCP prescriptions - limited to $125/month with extension based on medical necessity
Mental and Behavioral Health	Outpatient only - $2,500 limit; PCP referral; $10/visit
Nurse Midwife	Medical necessity; $10/visit
Occupational Therapy	EXCLUDED
Organ Transplants	Covered as medical/physician/hospital/surgeon/prescription drug visits/benefits per program coverage with applicable copays for visits/services. Does require prior authorization.
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	Dialysis is not covered, as it is excluded under End Stage Renal Disease Services. The other therapies listed would be covered under the separate programs of physician, prescription drug and lab and x-ray services with applicable copays per visit.
Outpatient Hospital	Medical necessity; PCP referral; $10/visit
Physical Therapy	EXCLUDED

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
Physician Services	Medical necessity; PCP referral to specialist; $10/visit
Podiatry	Medical necessity; PCP referral; $10/visit
Prescription Drugs	Medical necessity; $5/script; must use generic when available
Preventive Health Screening	All per protocol; primary care provider and Arkansas Department of Health administered
Private Duty Nursing Services	EXCLUDED
Prosthetic/Orthotic Procedures and Devices	EXCLUDED
Routine Hearing	EXCLUDED
Rural Health Clinic	Medical necessity; $10/visit
Skilled Nursing Services	Covered under home health benefit $10/visit, with a limit of 10 visits per state fiscal year

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Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Arkansas - ARKids B, Self-Insured Medicaid Expansion Program
Speech Therapy	Medical necessity; PCP referral; $10/visit
Vision Care	1 eye exam and 1 pair eyeglasses/year; routine exams and diagnostic; $10/visit
Sources:	Arkansas Department of Human Services

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
General Description of the Program	Georgia's PeachCare for Kids is a stand-alone SCHIP program that is operated as a Medicaid "look-alike"
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Separate
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	Benchmark coverage plus added benefits to bring it in line with Medicaid services with the exception of non-emergency transportation and targeted case management services.
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	Policy Studies, Inc., third-party administrator responsible for enrollment, eligibility, member services. Claims processed through Medicaid Management Information System; current Medicaid fiscal agent ACS. Contract with Department of Family and Children's Services for outreach and enrollment assistance for family Medicaid, SCHIP.
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	Full-risk managed care arrangements with 3 health plans (WellCare, Amerigroup, and Centene) - contract is joint with Medicaid. Fee-for-service coverage for members prior to managed care enrollment.
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007=284,841; June 2007=276,551; Sept. 2007=275,039; December 2007=254,820 (note: enrollment was closed from 3/11/07 - 7/12/07 due to federal funds shortfall and eligibility changed from self declaration to full verification 7/1/07).
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	Approximately $118. This includes administrative costs.
Provider Network (Use Medicaid Providers Only?)	Each health plan responsible for network development. Share fee-for-service network with Medicaid. They have three third-party providers.
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	Health plan rates negotiated for SCHIP based on utilization data.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
Age and Income Limits	Infants, 185% to 235%; 1-5, 133% to 235%; 6-18 100% to 235%
Benefit Period	No continuous eligibility
Coordination of Benefits	Cannot have third-party liability under separate SCHIP
Copay/Co-insurance Amounts	Just premiums below
Premiums	FPL Cap / One Child / Family 100% - 150% $10.00 $15.00 151% - 160% $20.00 $40.00 161% - 170% $22.00 $44.00 171% - 180% $24.00 $48.00 181% - 190% $26.00 $52.00 191% - 200% $28.00 $56.00 201% - 210% $29.00 $58.00 211% - 220% $31.00 $62.00 221% - 230% $33.00 $66.00 231% - 235% $35.00 $70.00 No cost sharing for ages 5 and under
Deductible	None
Lifetime Maximum	None
Out of Pocket Amounts	Just premiums above
Pre-Existing Limitations	None
Ambulance	Emergency ambulance services are covered for an enrollee whose life and/or health is in danger.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
Ambulatory Surgical Facility	Outpatient services covered in full. Prior approval needed for some services.
Chiropractor	None
Dental Care (no orthodontics)	Dental and oral surgical services are covered as follows: 2 visits (initial or periodic) for dental exams/screens and 2 emergency exams during office hours and two emergency exams after office hours per calendar year are allowed; 2 cleanings per calendar year; 1 restorative (filling) procedure per tooth per restoration; the maximum number of surfaces covered is four; sealants for first and second permanent molars only; orthodontic services with prior approval. Orthodontics does count towards calendar year maximum.
Durable Medical Equipment (DME)	Durable medical equipment and supplies prescribed by a physician are covered. Prior approval required for custom molded shoes and repairs to certain prosthetic devices. Hearing aids are allowed every three years without prior approval. Medical necessity for hearing aids must be approved by Children's Medical Services. Prior approval is based upon the completion of hearing evaluation by the prescribing physician or licensed practitioner. Medical equipment purchases and one-way mileage for delivery in excess of $200 require prior approval.
Emergency Room Service	Covered
Federally Qualified Health Center	Covered

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Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
Female Health Service	Covered services include initial and annual examinations, follow-up, brief and comprehensive visits, pregnancy testing, birth control supplies, and infertility assessment.
Free-Standing Diagnostic Facility	Covered
Home Health	Home health services, ordered by a physician and provided in the enrollee's home, including part-time nursing services, physical, speech and occupational therapy, and home health aide services are covered for 75 visits per calendar year. Home health services exceeding 75 visits per calendar year may be covered when requested by a physician and determined to be medically necessary.
Home Infusion Therapy	If on approved drug list
Hospice	Covered under a plan of care when provided by an enrolled hospice provider
Hospital Services	Although PEER did not request this information in the survey, federal law requires that hospital services be included.
Immunizations	Covered
Lab and X-ray	Radiology services are covered in a hospital setting or in a physician's office only. Note: laboratory and radiological services are covered as two separate services.
Maternity - Attending Physician (Pre-natal and delivery)	These services are covered in full. This includes Childbirth Education Services, a series of 8 classes regarding the birth experience and tools to prepare for a healthier pregnancy, birth and postpartum period.

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July 2008

Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
Maternity - Hospital Services	Covered, but few pregnant women on SCHIP. Most are income-eligible for pregnancy Medicaid coverage.
Medical Supplies	Covered - see DME
Mental and Behavioral Health	Inpatient mental health services covered only for short-term acute care in general acute care hospitals up to 30 days per admission. Services furnished in state-operated mental hospital not covered. Services furnished in Institution for Mental Disease not covered. Residential or other 24-hour therapeutically planned structural services covered only through DHR MATCH Program. Psychotherapy limited to 10 hours per calendar month. Outpatient mental health services covered through Community Mental Health Centers.
Nurse Midwife	Covered
Occupational Therapy	Physical, occupational and speech pathology therapy covered as follows: 1 hour/day up to 10 hours/calendar month for physical therapy; 1 hour/day up to 10 hours/calendar month for occupational therapy; 1 session/day up to 10 sessions/month for individual speech therapy. With prior approval these limits may be exceeded.
Organ Transplants	Covered - medical necessity
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	Covered
Outpatient Hospital	Outpatient services include outpatient surgery, clinic services, and emergency room care. Outpatient services are covered in full. Prior approval is needed for some services.
Physical Therapy	Physical, occupational and speech pathology therapy are covered as follows: 1 hour per day up to 10 hours per calendar month for occupational therapy; 1 session per day up to 10 sessions per month for speech therapy. With prior approval these limits may be exceeded.

Appendix A: CHIP
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Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
Physician Services	Physician services include services provided by a participating physician for the diagnosis and treatment of an illness or an injury. Physician services are covered in full. Prior approval is needed for some services.
Podiatry	Services included: diagnosis, medical, surgical, mechanical, manipulative, electrical treatment of ailments of foot or leg authorized in GA statute governing podiatric services.
Prescription Drugs	Prescribed drugs (from participating rebate manufacturers) and supplies approved by Division of Medical Assistance and dispensed by enrolled pharmacist covered in full. Some drugs require prior approval or have therapy limitations. Prescriptions or refills are limited to six/month per enrollee. Procedures in place allow a member to receive medically necessary prescriptions in excess of six per month
Preventive Health Screening	Covered
Private Duty Nursing Services	Not covered
Prosthetic/Orthotic Procedures and Devices	Covered, prior approval
Routine Hearing	Covered
Rural Health Clinic	Covered
Skilled Nursing Services	See home health benefit

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
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Description of Program/Service	Georgia - PeachCare for Kids, Separate SCHIP
Speech Therapy	Physical, occupational, and speech pathology therapy are covered as follows: 1 hour/day up to 10 hours per calendar month for physical therapy; 1 hour/day up to 10 hours per calendar month for occupational therapy; 1 session/day for up to 10 sessions per month for individual speech therapy. With prior approval these limits may be exceeded.
Vision Care	Services including eyeglasses, refractions, dispensing fees, and other refractive services covered. Medically necessary diagnostic services also covered. Limitations: 1 refractive exam, optical device, fitting, and dispensing fee within a calendar year; additionally, such services require prior approval Prior approval is also required for other services including but not limited to: contact lenses, trifocal lenses, oversized frames, hi-index and polycarbonate lenses.
Sources:	Georgia Department of Community Health

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
General Description of the Program	The LaCHIP Program (expansion) offers a statewide network of contracted health care providers that are enrolled with the Louisiana Department of Health and Hospitals (DHH). Recipients are linked to a Primary Care Provider and receive referrals for specialty services. Out-of-network benefits are not provided unless a provider chooses to enroll as a DHH provider. The LaCHIP Affordable Plan (separate) offers health coverage through the state employees' health plan for enrollees with income between 200%-250% of the Federal Poverty Income guidelines. Participants responsible for cost sharing and have access to the state employees' health plan network of providers.
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Combination. The LaCHIP program is an expansion, and the LaCHIP Affordable Plan is a separate program.
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	The LaCHIP Affordable program benefits are benchmark coverage, tied to the state employees' health plan.
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	LaCHIP claims processing is handled by UNISYS, the fiscal intermediary. The LaCHIP Affordable Plan claims processing is administered by the State Employees' Health Plan.
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	LaCHIP- Primary Care Case Management and Fee-for-Service. LaCHIP Affordable Plan - Fee-for-Service administered by a third party.
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007=102,931; June 2007=107,261; September 2007=111,019; December 2007=113,995
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	LaCHIP estimated per member per month (PMPM) cost: $123. LaCHIP Affordable anticipated PMPM cost $182, offset by $50 premium cost sharing for a net PMPM cost of $132.
Provider Network (Use Medicaid Providers Only?)	LaCHIP - Medicaid providers only. LaCHIP Affordable Plan- Network of providers used by the State Employees' Health Plan.
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	LaCHIP - Medicaid rates. LaCHIP Affordable- Rates paid by the State Employees' Health Plan.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
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Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
Age and Income Limits	Medicaid - income up to 100% Federal Poverty Income Guidelines (FPIG) and 133% for children under 6 years of age. LaCHIP -Children up to age 19. Income up to 200% FPIG with deductions. LaCHIP Affordable Plan - Children up to age 19 with income between 200% and 250% FPIG.
Benefit Period	12 months from certification
Coordination of Benefits	None
Copay/Co-insurance Amounts	LaCHIP - none. LaCHIP Affordable copay = 10% of contracted rate, Prescription 50% of drug costs at point of purchase up to a maximum copayment of $50 per 30-day prescription dispensed. Emergency room has a $150 copay but this is waived if the enrollee is admitted.
Premiums	LaCHIP - No premiums LaCHIP Affordable - $50 per month per family.
Deductible	LaCHIP - none. LaCHIP Affordable- none except for $200 mental health and substance abuse benefits.
Lifetime Maximum	LaCHIP -No lifetime maximum amount. LaCHIP Affordable - $5 million.
Out of Pocket Amounts	LaCHIP - none. LaCHIP Affordable out of pocket maximum is 5% of annual income for the plan year.
Pre-Existing Limitations	None
Ambulance	LaCHIP-Emergency ambulance services maybe reimbursed if circumstances exist that make the use of any conveyance other than an ambulance medically inadvisable for transport of the patient. LaCHIP Affordable - provided -10% copayment.

Appendix A: CHIP
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Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
Ambulatory Surgical Facility	LaCHIP - Covered (No restrictions other than medical necessity) LaCHIP Affordable - covered
Chiropractor	LaCHIP -Spinal manipulations covered for recipients 0-20 years of age. LaCHIP Affordable - Covered
Dental Care (no orthodontics)	LaCHIP -Provided for recipients 0-21 years of age. Bi-annual screening consisting of an examination, radiographs as appropriate, prophylaxis, topical fluoride application and oral hygiene instruction. No calendar year maximum. Orthodontics only for accident or severe anomalies. LaCHIP Affordable - Excluded
Durable Medical Equipment (DME)	LaCHIP- Medical equipment and appliances such as wheelchairs, leg braces, ostomy supplies, etc. LaCHIP Affordable - Member pays 10% of contracted rate.
Emergency Room Service	LaCHIP -Inpatient and outpatient hospital services, including emergency room services, covered. LaCHIP Affordable - $150 copay and 10% of contracted rate for emergency room treatment (waived if admitted).
Federally Qualified Health Center	LaCHIP-Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. Immunizations are covered for recipients under age 21. LaCHIP Affordable- covered when billed by the appropriate provider type.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
Female Health Service	LaCHIP- Covered LaCHIP Affordable - Member pays 10% of contracted rate.
Free-Standing Diagnostic Facility	LaCHIP - Excluded (not an approved Medicaid provider type) LaCHIP - LaCHIP Affordable - covered
Home Health	LaCHIP - Intermittent/part-time nursing services, including skilled nurse visits, aide visits, physical therapy services, occupational therapy, speech/language therapy. LaCHIP Affordable - case management required and member pays 30% of negotiated rate.
Home Infusion Therapy	LaCHIP - Covered (normal fee schedule restrictions apply) LaCHIP Affordable- Covered (Home Health nursing is covered via case management and the infusion drugs would be covered with State Employees' Health Plan primary or secondary)
Hospice	LaCHIP -Covered. LaCHIP Affordable - Case management required and member pays 20% of negotiated rate.
Hospital Services	LaCHIP - Covered LaCHIP Affordable - Covered
Immunizations	LaCHIP - Immunizations are covered for recipients under age 21. LaCHIP Affordable - Covered at 100% for network providers.
Lab and X-ray	LaCHIP -Most diagnostic testing and radiological services ordered by the attending or consulting physician. LaCHIP Affordable - Member pays 10% of contracted rate.
Maternity - Attending Physician (Pre-natal and delivery)	LaCHIP - Office visits. Other pre- and post-natal care and delivery. Lab and radiology services- All covered for female recipients of child-bearing age. LaCHIP Affordable - Excluded

Appendix A: CHIP
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Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
Maternity - Hospital Services	LaCHIP - Delivery covered for female recipients of child-bearing age. LaCHIP Affordable - Excluded.
Medical Supplies	LaCHIP- must be prescribed by a doctor and is subject to prior authorization. LaCHIP Affordable - covered.
Mental and Behavioral Health	LaCHIP -Clinic services, including evaluations and assessments, treatment, and counseling services. Medication management and injections are also covered. LaCHIP Affordable- Inpatient and outpatient covered; $200 deductible.
Nurse Midwife	LaCHIP - Covered LaCHIP Affordable - Covered.
Occupational Therapy	LaCHIP - Covered. LaCHIP Affordable Plan- Member pays 10% of contracted rate.
Organ Transplants	LaCHIP- Covered but must have prior authorization. LaCHIP Affordable - covered
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	LaCHIP -Chemotherapy administration and treatment drugs, as prescribed by physician. LaCHIP Affordable - Chemotherapy and radiation therapy covered (enrollee pays 10% of contracted rate).
Outpatient Hospital	LaCHIP -Diagnostic and therapeutic outpatient services, including outpatient surgery and rehabilitation services. LaCHIP Affordable- outpatient procedure certification is required.
Physical Therapy	LaCHIP - Covered. LaCHIP Affordable- Member pays 10% of contracted rate.

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July 2008

Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
Physician Services	LaCHIP -Professional medical services, including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialist, physician assistant, audiologist. LaCHIP Affordable - member pays 10% of contracted rate.
Podiatry	LaCHIP -Office visits. Certain radiology and lab procedures and other diagnostic procedures. LaCHIP Affordable - covered under physician services
Prescription Drugs	LaCHIP - No copayments- covers prescription drugs. Prior authorization is required if the medication is not on the preferred drug list. LaCHIP Affordable Prescription-50% of drug costs at point of purchase up to a maximum copayment of $50 per 30-day prescription dispensed.
Preventive Health Screening	LaCHIP - covered. LaCHIP Affordable -covered.
Private Duty Nursing Services	LaCHIP- Covered LaCHIP Affordable - Excluded
Prosthetic/Orthotic Procedures and Devices	LaCHIP - covered. LaCHIP Affordable - custom orthotics must be specially made and not available at retail stores.
Routine Hearing	LaCHIP - Covered LaCHIP Affordable- Excluded (Routine hearing exams are not a covered benefit but hearing exams are covered when filed with a treating diagnosis)
Rural Health Clinic	LaCHIP- Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists. LaCHIP Affordable - Covered.
Skilled Nursing Services	LaCHIP - Covered LaCHIP Affordable - Excluded.

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Description of Program/Service	Louisiana "LaCHIP" and "LaCHIP Affordable Plan"
Speech Therapy	LaCHIP - Covered. La CHIP Affordable - Member pays 10% of contracted rate
Vision Care	La CHIP - vision screenings and treatment of eye conditions, including examinations for vision correction, refraction error. La CHIP Affordable - Not Covered
Sources:	Louisiana Department of Health and Hospitals

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
General Description of the Program	The Mississippi Children's Health Insurance Program (CHIP) offers a statewide network of health care providers in Mississippi. The insurer, Blue Cross Blue Shield of Mississippi, maintains a sufficient number and type of providers in accessible locations for the population to be served. The providers are reimbursed based on the insurer's allowable charges. Providers not participating in this network are considered to be out-of-network providers and no benefits are provided for their services except for emergencies and as otherwise approved by the insurer.
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Separate
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	Benchmark equivalent plus
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	Fully insured product through Blue Cross Blue Shield of Mississippi. BCBS is paid a per member per month rate; however, there is a recoupment rate if BCBS pays out more in claims than is brought in in premiums. Likewise, if the state pays BCBS more in premiums than is paid out in claims, then the state is reimbursed the overpayment.
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	N/A, fully insured product through BCBS
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007 = 59,970; June 2007 = 60,460; September 2007 = 60,320; December 2007 = 60,195
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	$183.43 per enrollee; yes, this includes administration
Provider Network (Use Medicaid Providers Only?)	Blue Cross Blue Shield's Key Provider Network that is available to anyone on a private insurance plan though BCBS. About 82% of the physicians practicing in the state are in the network and 55% of the practicing dentists in the state provide services.
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	No, negotiated rates with providers and hospitals

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Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
Age and Income Limits	Infants, 185% to 200%; age 1-5, from 133% to 200%; age 6-18, 100% to 200%
Benefit Period	Calendar Year
Coordination of Benefits	None
Copay/Co-insurance Amounts	100% - 150% Federal Poverty Level (FPL): $0 Copay; 151% - 175% FPL: $5 Office Visit and $15 Emergency Room; 176% - 200% FPL: $5 Office Visit and $15 Emergency Room
Premiums	No premiums
Deductible	None
Lifetime Maximum	No lifetime maximum amount
Out of Pocket Amounts	100% - 150% FPL: $0; 151% - 175% FPL: $800 maximum amount/calendar year; 176% - 200% FPL: $950 maximum amount/calendar year
Pre-Existing Limitations	None
Ambulance	In-network - 100%; Out-of-network - 100%.

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Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
Ambulatory Surgical Facility	In-network - 100%; Out-of-network - not covered
Chiropractor	In-network - 100%, $1500 limit/calendar year; Out-of-network - not covered
Dental Care (no orthodontics)	In-network - 100%, covered services, $1500/calendar year maximum; Out-of-network - not covered
Durable Medical Equipment (DME)	In-network - 100%, prior approval required; Out-of-network - not covered
Emergency Room Service	In-network: 100%. No copay is required for individuals within 100% - 150% of FPL; a copay of $15/emergency room visit is required for individuals within 151% - 200% of FPL. Out-of-network: 100%. Benefits for emergency room services provided in cases of a medical emergency. When emergency room services of a non-network provider are used for a medical emergency, the network level of benefits will be provided. If a member uses emergency room services of a non-network provider for a non-emergency situation, no benefits will be provided. Small copays apply.
Federally Qualified Health Center	In-network - 100%; Out-of-network - not covered

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Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
Female Health Service	In-network - 100%; Out-of-network - not covered
Free-Standing Diagnostic Facility	In-network - 100%; Out-of-network - not covered
Home Health	100% in-network of the following types of services in the home: Skilled Nursing Services, Physical/Occupational Therapy, Private Duty Nursing. Requires pre-certification. Maximum per member per benefit period applies. No benefit for out-of-network providers.
Home Infusion Therapy	In-network - 100%, prior approval required; Out-of-network - not covered
Hospice	In-network: 100%, prior approval required; $15,000 per member lifetime. Out-of-network: 100%, prior approval required; $15,000 per member lifetime.
Hospital Services	In-network-100%. Out-of-network-not covered.
Immunizations	In Network:100%, Administration of the Advisory Committee on Immunization Practices-recommended routine childhood immunizations; providers must agree to participate in immunization registry. Non-routine immunizations (influenza or tetanus boosters) provided after an injury; Out-of-network:not covered
Lab and X-ray	In-network - 100%; Out-of-network - not covered
Maternity - Attending Physician (Pre-natal and delivery)	In-network - 100%; Out-of-network - not covered

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Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
Maternity - Hospital Services	In-network - 100%; Out-of-network - not covered
Medical Supplies	In-network - 100%; Out-of-network - not covered
Mental and Behavioral Health	In-network - 100% - inpatient, 30 day limit/calendar year; prior approval required. In-network - 100% - outpatient, 52 visit limit/calendar year; out of network - not covered
Nurse Midwife	In-network - 100%; Out-of-network - not covered
Occupational Therapy	In-network - 100%; prior approval required Out-of-network - 100% prior approval required
Organ Transplants	In-network - 100%, prior approval required; Out-of-network - not covered
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	In-network - 100%; Out-of-network - not covered
Outpatient Hospital	In-network - 100%; Out-of-network - not covered
Physical Therapy	In-network - 100%; prior approval required Out-of-network - 100%; prior approval required

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Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
Physician Services	In-network - 100%; Out-of-network - not covered
Podiatry	In-network - 100%; Out-of-network - not covered
Prescription Drugs	In-network - 100%; Out-of-network - not covered
Preventive Health Screening	Well-Baby/Child - In-network - 100%, Based on age/sex parameters; out-of-network - not covered
Private Duty Nursing Services	In-network - 100%; prior approval required Out-of-network - 100%; $10,000 limit/calendar year, prior approval required
Prosthetic/Orthotic Procedures and Devices	In-network - 100%; prior approval required Out-of-network - 100%; prior approval required
Routine Hearing	In-network - 100%; 1 visit/calendar year Out-of-network - 100%; 1 visit/calendar year
Rural Health Clinic	In-network - 100%; Out-of-network - not covered
Skilled Nursing Services	In-network - 100%; limited to 60 days/calendar year Out-of-network - 100%; limited to 60 days/calendar year

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Description of Program/Service	Mississippi - Separate, Fully-Insured Single Insurer Program
Speech Therapy	In-network - 100%; prior approval required Out-of-network - 100%; prior approval required
Vision Care	In Network - 100%; 1 eye exam and 1 pair of eyeglasses/ calendar year. Out-of-network - not covered
Sources:	Mississippi Department of Finance and Administration

Appendix A: CHIP
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Description of Program/Service	Montana Children's Health Insurance Plan
General Description of the Program	The Montana Children's Health Insurance Plan (CHIP) is a self-administered insurance program. The majority of claims are processed with a third-party administrator, Blue Cross Blue Shield of Montana (BCBSMT). Dental and eyeglasses claims are reimbursed according to a CHIP fee schedule. Extended Mental Benefit claims are reimbursed at the MT Medicaid rate. Claims processed through BCBSMT are reimbursed 80% of the approved provider reimbursement rate. Claims processed through the MT Medicaid system are reimbursed at the approved Medicaid rates or a set fee that has been set by CHIP.
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Separate
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	Benchmark - State Employee Health Plan
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	BCBSMT is third-party administrator for claims. BCBSMT provides claims processing, customer service, customer outreach, case management, reporting, and provider network services.
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	Medical services are paid through third-party contract with BCBSMT. Eyeglasses, dental, Extended Mental benefits are provided on a fee-for-service basis. See above for scope of services.
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007 = 13,291; June 2007 = 13,289; September 2007 = 14,860; December 2007 = 15,700
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	$146 per member per month (this cost includes BCBSMT and state government staff administration)
Provider Network (Use Medicaid Providers Only?)	BCBSMT provider for medical services. CHIP provider network for dental and Extended Mental.
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	80% BCBSMT negotiated provider rates for medical services. CHIP fee schedule for dental and Medicaid rate for Extended Mental.

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Description of Program/Service	Montana Children's Health Insurance Plan
Age and Income Limits	Age 0 through 18 and income 175% of Federal Poverty Level
Benefit Period	October 1 through September 30
Coordination of Benefits	Yes, in rare cases (e. g., auto accident personal injury)
Copay/Co-insurance Amounts	$25 inpatient hospital and mental health inpatient stay; $5 outpatient hospital and emergency room visit; $3 office visit and mental health counseling; $0 laboratory (in doctor's office) and well child/baby and immunizations; $3 pharmacy generic drugs; $5 pharmacy name brand drugs; $6 mail order (3 month supply) generic drugs; $10 name brand mail order drugs
Premiums	No premiums, but copays when applicable.
Deductible	None
Lifetime Maximum	$1 million
Out of Pocket Amounts	$215 maximum copayments
Pre-Existing Limitations	None
Ambulance	Excluded

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Description of Program/Service	Montana Children's Health Insurance Plan
Ambulatory Surgical Facility	Yes
Chiropractor	Excluded
Dental Care (no orthodontics)	Yes, no copayment. There is a $350 benefit year maximum. Dental providers can request additional payment if orthodontia is needed to correct problems such as severe craniofacial anomalies.
Durable Medical Equipment (DME)	Yes, if provided by approved CHIP network provider. DME providers are not CHIP providers.
Emergency Room Service	Yes - $5 copay
Federally Qualified Health Center	Yes

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Description of Program/Service	Montana Children's Health Insurance Plan
Female Health Service	Yes
Free-Standing Diagnostic Facility	Yes, if licensed or certified by Medicare. In-network 80% of approved rate of reimbursement and not covered if out-of-network.
Home Health	N/A
Home Infusion Therapy	Yes
Hospice	Excluded
Hospital Services	Although PEER did not request this information in the survey, federal law requires hospital services to be included.
Immunizations	Yes - no copay
Lab and X-ray	Yes
Maternity - Attending Physician (Pre-natal and delivery)	Yes

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Description of Program/Service	Montana Children's Health Insurance Plan
Maternity - Hospital Services	Yes
Medical Supplies	Yes, in limited instances
Mental and Behavioral Health	Yes
Nurse Midwife	Yes, if CHIP provider
Occupational Therapy	Yes - with prior approval
Organ Transplants	Excluded
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	Yes
Outpatient Hospital	Yes
Physical Therapy	Yes - with prior approval

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Description of Program/Service	Montana Children's Health Insurance Plan
Physician Services	Yes - $3 copay
Podiatry	Yes
Prescription Drugs	Yes - copay $3 generic drugs;$5 brand name drugs; mail order (3 month supply) $6 generic drugs; $10 brand name drugs
Preventive Health Screening	Yes
Private Duty Nursing Services	N/A
Prosthetic/Orthotic Procedures and Devices	Excluded
Routine Hearing	Yes
Rural Health Clinic	Yes
Skilled Nursing Services	N/A

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Description of Program/Service	Montana Children's Health Insurance Plan
Speech Therapy	Yes, with prior approval
Vision Care	Yes
Sources:	Montana Department of Public Health and Human Services.

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Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
General Description of the Program	The Tennessee State Children's Health Insurance Program (SCHIP) offers comprehensive benefits statewide through Blue Cross Blue Shield of Tennessee health care providers. Providers are reimbursed based on the negotiated allowable charges with the Plan Administrator.
Basic Program Components	
Type of Program (Medicaid Expansion, Separate, or Combination	Combination (These answers are in reference to the separate SCHIP component of the program.)
Types of Health Benefit Coverage (Benchmark Coverage, Benchmark Equivalent, or Secretary Approved)	Benchmark equivalent
Administrative Service Organization (ASO)/Third Party Administrator/Fiscal Agent Contractor for providing services such as: Claims processing, customer relations, outreach, grievances, etc. Provide name of contractor(s) and the services provided	Fully insured product through Blue Cross Blue Shield of Tennessee BCBST is paid a per member per month rate; however, there is a recoupment rate if BCBST pays out more in claims than is brought in in premiums. Likewise, if the state pays BCBST more in premiums than is paid out in claims, then the state receives a calculated reimbursement based on the overpayment.
Delivery System of Providing Services such as: being fully self-insured, contractor-based, primary care case management (PCCM), fee-for-service, combination of the above, or other. If contracted, list the name of the contractor(s) and the scope of services	N/A
Number of Enrollees in the program (point in time data) for March 2007, June 2007, September 2007, December 2007	March 2007 - 0 enrollees (CoverKids began March 13, 2007) June 2007 - 1,091 enrollees Sept 2007 - 4,272 enrollees Dec. 2007 -14,561 enrollees
Cost Per Member Per Month for Calendar Year 2007 (yes or no, does this cost include administration)	$210
Provider Network (Use Medicaid Providers Only?)	The provider network is a large, statewide established commercial network that meets all geo-access requirements for this SCHIP program.
Reimbursement Rates (Basis for provider reimbursement rates, e.g. Medicaid rates, Medicare, privately negotiated)	No response given.

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Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
Age and Income Limits	Newborn to 1 year of age, 186 - 250% FPL Age 1 year to 6 years- 134-250% FPL Age 6 years through age 18 years, 101-250% FPL
Benefit Period	12 months of coverage from date of enrollment
Coordination of Benefits	None
Copay/Co-insurance Amounts	Up to 150% FPL - $5 copay Between 150-250% FPL - $15 copay No co-insurance
Premiums	If total household income is below 250% FPL, no monthly premiums. If total household income is 250% of FPL or above, the premium is $224.43.
Deductible	At or below 150% FPL - None. Between 150-250% FPL - None.
Lifetime Maximum	No lifetime maximum amount
Out of Pocket Amounts	At or below 150% FPL - 5% of family income. Between 150-250% FPL - 5% of family income.
Pre-Existing Limitations	At or below 150% FPL - none. Between 150-250% FPL - none.
Ambulance	At or below 150% FPL - No copay; 100% of reasonable charges when deemed medically necessary by claims administrator. Between 150-250% FPL - No copay; 100% of reasonable charges when deemed medically necessary by claims administrator.

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Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
Ambulatory Surgical Facility	At or below 150% FPL - $5 copay per visit Between 150-250% FPL - $20 copay per visit
Chiropractor	At or below 150% FPL - $5 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur. Between 150-250% FPL - $15 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur.
Dental Care (no orthodontics)	At or below 150% FPL - $5 copay; No copay for routine preventive oral exam, x-rays, cleaning and fluoride application. Between 150-250% FPL - $15 copay; No copay for routine preventive oral exam, x-rays, cleaning and fluoride application.
Durable Medical Equipment (DME)	At or below 150% FPL - No copay Between 150-250% FPL - No copay
Emergency Room Service	At or below 150% FPL - $5 copay per use in case of an emergency (waived if admitted); $10 copay per use for non-emergency. Between 150-250% FPL - $50 copay per use (waived if admitted).
Federally Qualified Health Center	In-network - 100%; Out-of-network emergency visits are covered benefits

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Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
Female Health Service	In-network - 100%; Out-of-network emergency visits are covered benefits
Free-Standing Diagnostic Facility	In-network - 100%; Out-of-network emergency visits are covered benefits
Home Health	At or below 150% FPL - $5 copay Between 150%-250% FPL - $15 copay Limited to 125 visits per year. Authorization required.
Home Infusion Therapy	Included with home health
Hospice	At or below 150% FPL - No copay Between 150%-250% FPL - No copay
Hospital Services	At or below 150% FPL - $5 per admission (waived if readmitted within 48 hours for same episode). Between 150%-250% FPL - $100 per admission (waived if readmitted within 48 hours for same episode).
Immunizations	At or below 150% FPL - No copays for services rendered under American Academy of Pediatrics guidelines. Between 150%-250% FPL - No copays for services rendered under American Academy of Pediatrics guidelines.
Lab and X-ray	At or below 150% FPL - No copay; 100% benefit. Between 150%-250% FPL - No copay; 100% benefit.
Maternity - Attending Physician (Pre-natal and delivery)	At or below 150% FPL - $5 copay obstetrician or specialist, first visit only. Between 150%-250% FPL - $15 copay obstetrician, first visit only; $20 copay specialist.

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July 2008

Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
Maternity - Hospital Services	At or below 150% FPL - $5 hospital admission. Between 150%-250% FPL - $100 hospital admission.
Medical Supplies	At or below 150% FPL - $5 copay per 31-day supply. Between 150%-250% FPL - $5 copay per 31-day supply.
Mental and Behavioral Health	< or = 150% FPL $5 copay/session; limit 52 sessions mental health/substance abuse combined. Mental Health Inpatient (preauthorization required) $5 copay/admission, limit 30 days/year. Substance Abuse Inpatient (preauthorization required) $5 copay/admission, limit 2 5-day detox stays/lifetime, plus one 28 day stay/lifetime. Mental Health/Substance Abuse Outpatient (preauthorization required) $5 copay/session, limit 52 sessions mental health/substance abuse combined. 150%-250% FPL $20 copay/session, limit 52 sessions mental health/substance abuse combined. Mental Health Inpatient (preauthorization required) $100 copay/admission, limit 30 days/year. Mental Health/Substance Abuse Outpatient (preauthorization required) $20 copay/session, limit 52 sessions mental health/substance abuse combined. Substance Abuse Inpatient (preauthorization required) $100 copay/admission, limit 2 5-day detox stays/lifetime, one 28-day stay/lifetime.
Nurse Midwife	At or below 150% FPL - $5 copay PCP or specialist. Between 150%-250% FPL - $15 copay PCP; $20 copay specialist.
Occupational Therapy	At or below 150% FPL - $5 copay per visit, limited to 52 visits per year per type of therapy. Between 150%-250% FPL - $15 copay per visit; limited to 52 visits per year per type of therapy.
Organ Transplants	Covered as medical/physician/hospital/surgeon/prescription drug visits/benefits per program coverage with applicable copays for visits/services. Does require prior authorization.
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	Therapies are covered under the separate programs of physician, outpatient, prescription drug and lab and x-ray services with applicable copays per visit.
Outpatient Hospital	At or below 150% FPL - $5 copay per visit Between 150%-250% FPL - $20 copay per visit
Physical Therapy	At or below 150% FPL - $5 copay per visit; limited to 52 visits per year type of therapy. Between 150%-250% FPL - $15 copay per visit; limited to 52 visits per year per type of therapy.

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
Physician Services	At or below 150% FPL - $5 copay PCP or specialist. Between 150%-250% FPL - $15 copay PCP; $20 copay specialist.
Podiatry	At or below 150% FPL - $5 copay PCP or specialist. Between 150%-250% FPL - $15 copay PCP; $20 copay specialist.
Prescription Drugs	At or below 150% FPL - $1 generic; $3 preferred brand; $5 non-preferred brand. Between 150%-250% FPL - $5 generic; $20 preferred brand; $40 non-preferred.
Preventive Health Screening	At or below 150% FPL - No copay Between 150%-250% FPL - No copay
Private Duty Nursing Services	EXCLUDED
Prosthetic/Orthotic Procedures and Devices	At or below 150% FPL - No copay Between 150%-250% FPL - No copay
Routine Hearing	At or below 150% FPL - No copays for services rendered under American Academy of Pediatrics guidelines. Between 150%-250% FPL - No copays for services rendered under American Academy of Pediatrics guidelines.
Rural Health Clinic	No response provided.
Skilled Nursing Services	In-network providers At or below 150% FPL - $5 copay PCP or specialist. Between 150%-250% FPL - $15 copay PCP; $20 copay specialist. Out-of-network providers - not covered

Appendix A: CHIP
Comparative Benefit Analysis, Selected States,
July 2008

Description of Program/Service	Tennessee "CoverKids"- Fully-insured program
Speech Therapy	At or below 150% FPL - No copay Between 150%-250% FPL - No copay Limited to 100 days per year following approved hospitalization
Vision Care	At or below 150% FPL - $5 copay per visit,; limited to 52 visits per year per type of therapy. Between 150%-250% FPL - $15 copay per visit; limited to 52 visits per year per type of therapy.
Sources:	Tennessee Department of Finance and Administration Cover Kids Program

Appendix B: Alternative CHIP Administrative Structures for Consideration

Now that Mississippi has had a CHIP program for ten years, enough data should be available to issue an RFP that incorporates the cost saving measures discussed on pages 45 through 50, tailored to a fully-insured (indemnity) plan or a self-insured plan. A Medicaid expansion program is also an option.

In addition to cost saving measures, the request for proposals should address service issues. Vendors should illustrate how their provider network will be sufficient so that the enrollees will have access to primary care providers and no degradation of services will occur based on the state's requirements. Vendors should also address how their benefit structure fulfills the minimum federal requirements.

Fully Insured Program

A fully insured program pays an insurer a premium to provide health insurance coverage to enrollees. The insurer assumes the risks and utilizes a contractor based service delivery system.

This type of CHIP has predictable costs because the state pays a monthly premium to provide health benefits coverage for each enrolled child. The state can cap enrollment to limit it to a certain number of children and can design a flexible benefit package to target certain eligibility levels. The insurance company assumes the claims risk. Provider rates tend to be market-driven. Most costs that are paid to the insurer are not subject to the 10% administrative cap that the federal government places on matching CHIP administrative expenses. Also, in a fully insured program the state pays into the risk pool and pay a premium tax that goes to the general fund, which is approximately $83 federal to $16 state.

However, the benefits may not be as comprehensive as those of Medicaid. The state tends to be at the mercy of the insurance company when negotiating premium increases. Rates, risk factors, and administrative overhead are determined to an extent by the insurance provider.

The intent by the CHIP Commission was for Mississippi to operate a fully insured program. However, as discussed on page 44, because of the structure of the current agreement with Blue Cross Blue Shield, Mississippi's CHIP operates as a self-insured program.

Self-Insured Program or Self-Insured with a Third-Party Administrator

In a self-insured program, the state would contract for services, usually through a third-party administrator or fiscal intermediary. All administrative cost such as claims processing and customer services would count against a 10% administrative cap imposed by the federal government.

In a self-Insured CHIP, the state provides or contracts for services and the state assumes all of the risks. Most of the administration costs, such as claims processing, outreach, and customer service, of a self-insured CHIP, either performed in-house or contracted out, are subject to a federally mandated 10% cap that is based on total benefit expenditures. In a self insured program the state provides or contacts through a fiscal intermediary for services. In third party administrator arrangement, the state may contract with a company(ies) to provide a whole range of service such as: claims processing, customer service, out reach, and case management. A third party administrator could provide medical expertise for claims utilization and processing. The state could utilize a competitive bidding process for different administrative services so that companies could provide expertise in the services the companies perform the best at the most competitive price. For example, Company A may be better and less expensive than Company B at structuring provider networks, but Company B may be better and less expensive at claims utilization services. The state could contract administering the provider network to Company A and contract claims utilization with Company B and save money while at the same time separating two functions of insurance that at times might have conflicting interests.

Medicaid Expansion Program

A Medicaid expansion program operates administratively like the state's Medicaid program. The program utilizes the same providers, provider rates, and service delivery structures.

A state providing its CHIP through a Medicaid expansion program is required to provided the same benefit package, using the same providers, at the same provider rates. The federal 10% administrative cap does not apply. In a Medicaid expansion program, CHIP program funds are utilized first. If that amount is exhausted, children then are covered under traditional Medicaid, but at the lower federal match. The state can take advantage of efficiencies of administration, since the state would already have the mechanisms in place to operate the Medicaid program, such an enrollment processing, program management, claims processing, and quality assurance.

However, this is an entitlement program that may come with a perceived social stigma. Also, the state cannot control costs as easily and the state must offer all medically necessary services.

The state can cover more children if administrative and benefit related costs are controlled. Like fully insured plans, the state can limit enrollment through caps and the state has flexibility to target certain eligibility levels.

However, in a self-administered plan, the state assumes liability for costs, which can be alleviated by introducing a lifetime maximum or purchasing stop-loss coverage. Also, the state would need to have a reserve fund on hand because federal match funds are not available until after the money is spent. The state must develop a provider network.

STATE OF MISSISSIPPI
HALEY BARBOUR, GOVERNOR

DEPARTMENT OF FINANCE AND ADMINISTRATION
KEVIN J. UPCHURCH
EXECUTIVE DIRECTOR

December 1, 2008

Honorable Sidney Albritton, Chairman
Joint Committee on Performance Evaluation and Expenditure Review
501 North West Street
Woolfolk Building, Suite 301-A
Jackson, Mississippi 39201

Dear Chairman Albritton:

We have reviewed the draft **Mississippi's Children's Health Insurance Program: A Policy Analysis** prepared by the Joint Committee on Performance Evaluation and Expenditure Review (PEER) and offer the following response from the Department of Finance and Administration.

The Department of Finance and Administration is appreciative of this PEER review of the Children's Health Insurance Program (CHIP) and the opportunity to review and respond to this report. We acknowledge PEER's recommendations relative to any public policy debate concerning CHIP, should the current structure of the program remain in place. The Department of Finance and Administration will carefully review the recommendations of PEER and continue our efforts to provide effective and efficient management of the health insurance component of the Children's Health Insurance program.

Again, thank you for the opportunity to review and respond to this draft report.

Sincerely,

Kevin J. Upchurch

Kevin J. Upchurch

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STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

VIA HAND DELIVERY

December 1, 2008

Max K. Arinder, Ph.D.
Executive Director
Joint Committee on Performance Evaluation and Expenditure Review
PEER Committee
501 North West Street, Suite 301-A
Jackson, Mississippi 39201

Re: *Mississippi's Children's Health Insurance Program: A Policy Analysis*

Dear Dr. Arinder:

The following represents the agency's official response to the above referenced PEER review.

In your May 30th letter attached herewith, describing the PEER Committee's policy analysis for the State Children's Health Insurance Program ("SCHIP"), you mention that the review will " . . . concentrate on assessing the primary alternatives for the management and administration of the program and will include, to the degree possible, a cost/benefit analysis to determine the relative efficiency and potential effectiveness of those options." From reviewing the draft analysis, it does not appear as though the report reflects PEER's initial intent as described in your letter. For example, I do not find any cost benefit analysis to determine the relative efficiency and potential effectiveness of other options to manage and/or administer the program.

The first recommendation states that " . . . .PEER sees no reason to question the decision made by the CHIP Commission in 1998 and the current structure of the program." Without objecting to or criticizing the Commission's decision, DOM respectfully submits that arguably the Health Insurance Management Board ("HIMB") and Department of Finance and Administration ("DFA") have no authority to administer SCHIP. The authority of an agency or Board is limited to that given to it by the legislature. The Board's authority and DFA's authority to administer SCHIP arose from a Commission, not the Legislature. Arguably, the authority to administer the program is questionable as such authority may not have been properly vested by the Legislature. The Mississippi

Code is silent as to the administering agency for SCHIP. Neither the Division of Medicaid ("DOM") nor HIMB/DFA has been expressly granted the authority to administer the program by the Legislature. In our opinion, the Commission should have recommended authority, not authorized it. DOM is not familiar with any agency who gained authority and power to operate a program as large and important as this one without express Legislative authority. DOM recommends that the Legislature address this fundamental issue and codify the duties and responsibilities for the agency charged with administering the program - whether it be DOM or HIMB/DFA in order to resolve this issue. It is our understanding that the HIMB recently voted to recommend that DOM be the administering agency for SCHIP.

Also, PEER's report fails to acknowledge another basic flaw in the administration of the SCHIP program. Both the Commission report and the Interagency Agreement between DFA and DOM call for the design of a fully insured program. Both the PEER Report and DOM's own analysis of the program contend that the program is operated more akin to a third party administrator or a self-insured program. In our opinion, there is no risk of loss to Blue Cross Blue Shield of Mississippi ("BCBSMS"), the risk of loss is completely on the State. Although DOM recognizes that the Department of Insurance has opined that the policy is an insurance policy, DOM believes that the original intent of the Commission and the Interagency Agreement between DOM and DFA/HIMB has not been fully honored because the program is not fully insured.

Regardless of whether the amendment to include DOM's Executive Director as a voting member of the HIMB for SCHIP purposes passes the Legislature, the HIMB must issue a Request for Proposals ("RFP") for a new SCHIP service delivery structure in calendar year 2009, in order to secure a vendor by 2010. The agency agrees with PEER's recommendations concerning the content of the RFP. DOM also submits that the premium charges accountable for taxes and fees should reflect the actual tax and fee paid. The report fails to specifically address this inefficiency in the program, that is, that the taxes and fees being paid for by DOM do not reflect the actual taxes and fees paid by BCBSMS. Under its current contract with HIMB/DFA, BCBSMS is allowed to increase its charges for these items in an amount that exceeds the actual amount paid. The difference is profit to BCBSMS. The audit performed by Clifton Gunderson on behalf of DOM identifies this issue. A copy of that audit has been provided to you.

Also, the report fails to address the inefficiencies in having two agencies administer the program. Basically, HIMB/DFA serves as a middle man between DOM and BCBSMS. Not only does DOM pay HIMB/DFA for services, DFA has contracted with MedStat to perform administrative services and DOM is essentially paying DFA to pay MedStat. There is too much waste in the administration of this program. The report fails to perform any cost benefit analysis of this inefficiency.

DOM is at a loss to understand PEER's recommendations concerning the laundry list of items that DOM should present to the Legislature before transferring authority to DOM from DFA. PEER seems to be concerned about the impact that switching the program administration from HIMB to DOM would create. References are made to the provider

network and to rates of payment. DOM contends that this is a red herring. PEER found that the provider network is comparable to that of the regular Medicaid program. It would seem to stand to reason that if a provider is willing to accept Medicaid payment, the same provider would be willing to accept a payment under SCHIP even if it is less than the full commercial rate that the provider is currently receiving.

DOM believes that there exists an opportunity to increase the number of children insured under the program if the cost of the program can be decreased. For example, if Medicaid is paying at a rate 52% below the SCHIP rate, one could put approximately 65,000 more kids on SCHIP by reducing payment to the Medicaid rate. Even if one reimburses providers at an average rate between Medicaid and the current SCHIP rate, one could add 33,000 more children to the SCHIP rolls.

DOM has not questioned the provider network or provider satisfaction with the program, the question is whether or not we could add more children to the rolls if we can find a way to reduce the cost of the program. Not by reducing services or benefits, but by reducing payments. No doubt, providers will be more satisfied receiving the higher payment. Any survey would be greatly biased towards receiving the higher payment.

All other concerns the agency has regarding SCHIP have been previously referenced in the analysis performed by Clifton Gunderson. A copy of this analysis was provided to you with our correspondence dated November 17, 2008.

Thank you for your review of this important program. It is my hope and expectation that as a result of your review and the review conducted by DOM we can make improvements to the program. The last time I read the federal regulations relating to SCHIP, I was convinced this program was paid for by taxpayers for the benefit of poor children rather than for the benefit of providers.

If I may be of further assistance to you, please feel free to contact me.

Sincerely,

Robert L. Robinson
Executive Director

Attachment

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

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May 30, 2008

Dr. Robert L. Robinson, Executive Director
Mississippi Division of Medicaid
550 High Street
Sillers Building, 10th Floor

HAND DELIVERED

Dear Dr. Robinson:

At its May 13th and 14th meeting, the PEER Committee approved a policy analysis of options for administering the Mississippi Children's Health Insurance Program (MCHIP). The analysis will concentrate on assessing the primary alternatives for the management and administration of the program and will include, to the degree possible, a cost/benefit analysis to determine the relative efficiency and potential effectiveness of those options.

PEER staff understands that currently this program is jointly administered through the Division of Medicaid (DOM) and the Department of Finance and Administration (DFA). Because of DOM's responsibilities for eligibility determination, enrollment, reporting, and outreach for the program, PEER staff needs to meet with key staff at DOM to get as much detail as possible concerning management and operational concepts used to implement the program. The Committee also asks for access to any program management or cost analyses performed by DOM personnel concerning any proposed plans your department may have considered for reorganizing, transferring, and/or consolidating the administration of MCHIP that might affect a cost/benefit analysis. If no such analysis has been performed, any thoughts or other relevant information that you and/or your staff might have for such an analysis would be greatly appreciated as well.

Either, Chad Allen or Larry Whiting, Evaluation Division Manager, will contact you to coordinate a time to meet with you and/or key personnel concerning MCHIP.

If you wish to discuss this matter with me prior to responding, please call me at 601-359-1226.

Sincerely,

Max K. Arinder, Ph.D.
Executive Director

PEER Committee Staff

Max Arinder, Executive Director
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