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Medicaid State Children's  
Health Insurance Program  
(Title XXI)

**Draft Recommended Alternatives  
Report**

State of Nebraska

**MERCER**



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## Executive Summary

### Project Overview

The State of Nebraska Department of Health and Human Services (DHHS) contracted with Mercer Government Human Services Consulting (Mercer) to assist in developing a Recommended Alternatives Report as required by State Statute. Similar to other states, the expenditures for the Medicaid (Title XIX) and the State Children’s Health Insurance Program (Title XXI) programs in Nebraska continue to increase. In an effort to ensure long-term savings and program stability for the Title XXI program, the legislature recognized the necessity for change. Section 68-949(2)(a) of the Nebraska Revised Statutes requires DHHS to “...develop recommendations relating to the provision of health care and related services for Medicaid-eligible children under the state children's health insurance program as allowed under Title XIX and Title XXI of the federal Social Security Act. Such study and recommendations shall include, but not be limited to, the organization and administration of such program, the establishment of premiums, copayments, and deductibles under such program, and the establishment of limits on the amount, scope, and duration of services offered to recipients under such program.” This report outlines the recommended alternatives for review and consideration.

### Title XXI Background

Under Federal regulations, as authorized by Title XXI of the Social Security Act, states are allowed the flexibility to select one of three program types for their State Children’s Health Insurance Program:

- Medicaid Expansion Program (MCHIP)
- Separate State Children’s Health Insurance Program (SCHIP)
- Combination Program, which includes both a MCHIP and SCHIP

Since the implementation of Title XXI of the Social Security Act and the State’s Title XXI program, changes have occurred in Federal regulation that allow states additional flexibility in designing and managing their Title XIX and Title XXI programs. The recommended alternative

options presented in this report reflect options available to the State at this time. At the time of production of this report, Congress had passed Title XXI reauthorization and final approval sits with the President. These options could be impacted by the final outcome of reauthorization or other Federal changes that may occur during implementation of any recommended alternative options, if chosen.

Nebraska's child health program, under Title XXI, is a Medicaid expansion program, or MCHIP. In developing a MCHIP, Nebraska was able to use the same delivery system, benefit plan, provider network, payment levels and Medicaid Management Information System (MMIS) as the Nebraska Title XIX program. The MCHIP expansion also meant that all Medicaid-eligible children in a family received the same benefits. Administration of the program is further eased by the use of consistent eligibility determinations such as no asset test and the same treatment of income between the Title XIX and Title XXI Programs. These consistencies between the programs result in reduced administration and per child costs when compared to SCHIP programs.

Nebraska's MCHIP program provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 185 percent of the Federal Poverty Level (FPL). For reference, 185 percent of FPL is equal to an adjusted monthly income of \$38,203 for a family of four. Specifically, the State's MCHIP covers:

- Under age 1 between 150 and 185 percent of the FPL
- Ages 1 to 5 between 133 and 185 percent of the FPL
- Ages 6 to 18 between 100 and 185 percent of the FPL

Nebraska's MCHIP provides full coverage including all the benefits of the Medicaid (Title XIX) program. Nebraska's MCHIP does not currently include premiums or cost sharing, as federal rules prohibited cost sharing for children in MCHIP until the recent passage of the Deficit Reduction Act (DRA) of 2005.

The MCHIP also allows the State to utilize the same delivery system as the Title XIX Program. The programs utilize two models, a Primary Care Case Management (PCCM) network and a HMO, in a designated geographic area including Douglas, Sarpy and Lancaster counties. These models provide the basic benefit plan of medical/surgical services. Dental services and pharmacy services are carved out and are reimbursed to providers on a fee-for-service (FFS) basis by Nebraska.

The Nebraska managed care program also provides managed care for mental health and substance abuse (MH/SA) services. Effective January 2002, Nebraska changed the management of the MH/SA component from a capitated/risk model to a non-risk model. The new MH/SA program structure operates as a Specialty Physician Case Management (SPCM) system under 42 CFR 431.55(c)(1)(ii) and a 1915(b)(1) and 1915(b)(4) waiver.

## Recommended Alternatives

If the State chooses to make changes to the Title XIX and/or Title XXI programs, the following three recommended alternative options are presented for consideration by the Legislative Health and Human Services (HHS) Committee and the Medicaid Reform Council and are provided for public comment:

- Option A: Medicaid Expansion (MCHIP) Combined with Health Insurance Premium Payment (HIPP) Program
- Option B: Medicaid Expansion (MCHIP) with Modified Benefit Plans and Combined with Health Insurance Premium Payment (HIPP) Program
- Option C: Separate Child Health Insurance Plan (SCHIP)

These options were developed based on review of Nebraska's existing Title XXI program, the various Title XXI authorities and programs implemented by other states. Each of these options has its own benefits and limitations. An overview of each option is provided below, with additional detail included in the Recommended Alternatives section.

### ***Option A: Medicaid Expansion (MCHIP) Combined with Health Insurance Premium Payment (HIPP) Program***

Under this recommended option, Nebraska would continue to maintain its current MCHIP and would implement a Health Insurance Premium Payment (HIPP) program for MCHIP children. Currently, states may not enroll children with health insurance otherwise eligible for Title XXI into Title XXI programs. They may, however, enroll Title XXI children with other health insurance coverage into their Medicaid programs and receive Medicaid (Title XIX) matching funds, which is a lower matching rate than Title XXI. This match rate would apply to premiums and medical service costs paid by the State.

Nebraska currently manages a HIPP program for Title XIX eligibles with other health insurance. In this program, the State pays the health coverage premium for the eligible if determined cost effective plus any wrap-around services from the Title XIX benefits beyond the other health insurance benefits. In order to implement this option for Title XXI, the State would be required to amend its Title XXI State Plan to enroll children otherwise eligible for Title XXI with other health insurance coverage into the Title XIX Medicaid program. Other states that have implemented this type of program include Iowa, South Carolina and Wisconsin.

This option would allow the State to avoid paying the total costs for medical services for children where employer-sponsored insurance is dropped or not selected to obtain the Medicaid benefits through the State's current MCHIP. Instead, the State would pay the monthly insurance premiums for Title XXI children whose parents have access to employer-sponsored insurance and receive the Federal matching funds at the Title XIX rate for the premium costs as well as the medical costs for wrap-around services. This will allow the State to gain more budget predictability and long-term program sustainability. The State benefits by receiving federal matching funds for payments of premiums for qualifying children and also cost-avoids full payment of the medical services provided, as the health insurance becomes the primary payer

on medical claims covered by the enrolled child's plan. This option reduces overall costs to the State per child. Premiums would only be paid for children who qualify based on a formula for determining cost effectiveness. As a result, it is likely the State will cover more children under the Title XIX and Title XXI Programs while expending the same general funds.

We estimate this option, if aggressively pursued, could cover up to 6,000 additional children, with perhaps half of those children coming from the existing MCHIP rolls. We further estimate a cost savings of up to \$190,000 or 1% of budgeted state fiscal year (SFY) 2009 total State expenditures. This cost estimate includes the offsetting impact of additional administration needs of \$250,000 annually.

### ***Option B: Medicaid Expansion (MCHIP) with Modified Benefit Plans and Combined with Health Insurance Premium Payment (HIPP) Program***

Under this option, the State would utilize the DRA to implement a MCHIP that would provide the flexibility to design benefit plans that more closely align with individual needs and to allow for member cost sharing. Because this option is based on the Medicaid program, the current Title XIX delivery system, provider network, and fee schedule can be utilized. This option provides substantially similar authority as allowed under a SCHIP or under MCHIP programs with an 1115 demonstration waiver as previously approved in other states, but requires less reporting and monitoring. In addition to implementing a program that modifies the benefit plan and implements cost sharing, we also recommend implementing the HIPP program outlined in Option A for children with health insurance otherwise eligible for Title XXI.

The DRA allows the State to offer a reduced, "basic" benefit plan to higher income children in Medicaid and under the State's MCHIP. Under Option B, it is assumed these benefit plans will be available for MCHIP eligibles only. In addition to the "basic" benefit plan, MCHIP will also offer a "plus" plan that may add benefits considered as optional (i.e., dental) and an "enhanced" plan that would be for high-risk children and could include MH/SA benefits. These benefit plans would be offered with a requirement of higher premium payments. When this option is combined with enrolling individuals with other health insurance coverage, it essentially allows parents to retain private insurance for their children and receive additional benefits, such as dental or mental health, through the State Medicaid program in exchange for payments of the premium established for the MCHIP benefit plan selected.

Under this option, the State will generate savings from offering various benefit plans, which more closely align with private-coverage options, implementing cost sharing and paying premiums for children with other health insurance coverage when cost effective. This option would not only address the goals of cost savings and long-term fiscal and program sustainability, but it would also promote personal responsibility.

Since this option is a Medicaid expansion (MCHIP) option, the State will be required to provide wrap-around early and periodic screening, diagnostic and treatment (EPSDT) benefits for children enrolled in private health insurance. Furthermore, as an MCHIP, the State cannot cap enrollment into the program based upon fiscal limitations. If the Title XXI allotment is expended,

the Centers for Medicare and Medicaid Services (CMS) will continue to match costs, although at the reduced Title XIX match rate.

There are a variety of ways that a benefit plan under this alternative can be constructed. Modeling a “basic” benefit plan that mirrors the benefits covered under the State Employee Health Benefit Plan, we estimate this option could cover 291,500 children. This is a decrease of one-half percent over the projected MCHIP enrollment for SFY 2009. We further estimate a cost savings of \$2.2 million or 15 percent of budgeted SFY 2009 total MCHIP State expenditures. This cost estimate includes the offsetting impact of the State’s share of additional administration needs of \$1 million for the first year. These estimates are based on moderate levels of premiums and no copayments. Decreased enrollment and increased savings can be expected when cost sharing is increased to maximum levels as permitted by CMS.

### ***Option C: Separate Child Health Insurance Plan (SCHIP)***

Under this recommended option, the State would convert the current MCHIP into a SCHIP that allows the maximum flexibility to implement cost sharing and to design benefit plans that more closely mirror the commercial health care market. For example, the State could establish a benefit plan equal to the State Employee Health Benefit Plan. This type of program allows states to offer SCHIP program enrollees commercially-oriented products without Title XIX requirements such as EPSDT or compliance with managed care regulations.

The SCHIP is a separate program from the Title XIX Medicaid program, and states generally use private insurers to provide the medical coverage. As a result, states may pay higher reimbursement levels to providers because commercial payment rates are typically higher than Medicaid reimbursement. However, an offsetting factor to higher reimbursement is commercial-level benefits with cost sharing. This option would address the goal of long-term fiscal and program sustainability while promoting personal responsibility. In addition, financial risk is shifted to private insurers by the State paying the insurers a set monthly amount per enrollee regardless of the actual costs paid by the insurer for the medical services provided. Unlike Options A and B, once the Title XXI allotment is expended, there is no further Federal match available. Due to this constraint, states are allowed to establish enrollment caps and waiting lists.

We estimate this option will cover 281,000 children. This is a decrease of 4 percent over the current MCHIP enrollment as fewer children are expected to participate in a program with monthly premium payments. We further estimate a cost increase of \$3.2 million or 22 percent of budgeted SFY 2009 total MCHIP State expenditures. This cost estimate includes the impact of additional administration needs of \$1 million. These estimates are based on moderate levels of premiums and no copayments. Decreased enrollment and potentially, additional savings can be expected when cost sharing is increased to maximum levels of 5 percent of family income as permitted by CMS.

## Next Steps

Legislative Bill (LB) 1248 of the 2006 Nebraska Legislative session required the DHHS to develop recommended alternatives for the provision of health care and related services, for Medicaid-eligible children Under Title XXI that allow for long-term savings and program

sustainability. Mercer conducted this draft Recommended Alternatives Report as the second step in assisting DHHS in complying with legislative requirements.

Once the recommended alternative options have been reviewed by the Legislative HHS Committee and the Medicaid Reform Council, Mercer will prepare a final report of recommended alternatives, which will include the recommended alternative options Nebraska may select for the Title XIX and/or Title XXI programs. The final recommendations will consider any changes necessary as a result of public comment and will be provided, for the Governor, the Legislative HHS Committee and the Medicaid Reform Council, no later than December 1, 2007.



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## Background

### Nebraska Title XXI Background

Similar to other states, the expenditures for the Medicaid (Title XIX) and Title XXI programs in Nebraska continue to increase. Nebraska anticipates that in absence of additional funding from the Federal government, with the reauthorization of funding for Title XXI set to expire on September 30, 2007, it will experience a shortfall in its MCHIP by April of 2008.

At the time the report was being written, Congress had agreed upon the reauthorization of the national program and future funding with a Presidential veto being threatened, but resolution is anticipated this year. In 2007, Congress passed a supplemental budget for Title XXI as many states had exceeded their annual Federal allocation and would have faced a financial shortfall. As it stands, Congress must reauthorize, and the President must sign the reauthorization of Title XXI by October 1, 2007, in order for program funding to continue.

Nebraska's child health program, under Title XXI, is a Medicaid expansion program, or a MCHIP. Nebraska's MCHIP provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 185 percent of the Federal Poverty Level (FPL). An adjusted monthly income for a family of four at 185 percent of FPL is \$38,203. Children enrolled in MCHIP are eligible for all the benefits of the Title XIX program including EPSDT. EPSDT are benefits which focus on prevention, immunization and early diagnosis and treatment of health problems for children. Because of Federal prohibitions at the time of MCHIP implementation, the State does not currently allow children with other health insurance to enroll in the MCHIP. Finally, Nebraska's MCHIP does not currently include premiums or cost sharing as it is tied to the benefit structure of the Title XIX Program. Appendix A provides additional details on Nebraska's MCHIP as well as other health care programs in Nebraska.

The average number of eligible children in MCHIP on a monthly basis in SFY 2006 was 23,700. During Federal fiscal years (FFY) 2004 through 2006, costs and eligibility have remained fairly stable, with total expenditures (Federal and State general funds) of \$49,549,579 for MCHIP in FFY 2006. The administration portion of the FFY 2006 expenditures is \$2,814,032 for both the

Federal and State portions. Refer to Appendix B for additional details on Nebraska's Title XXI expenditures.

## Program Authorities

Under Federal regulations, states are allowed the flexibility to select one of three program types for their Title XXI program:

- Medicaid Expansion Program (MCHIP)
- Separate State Children's Health Insurance Program (SCHIP)
- Combination Program, which includes both a MCHIP and SCHIP

In addition to the above program types, each state has statutory authority to implement various program designs. To accommodate these programs, states may amend their state plans and/or may also modify one of the above program design authorities for Title XXI programs through:

- 1115 demonstrations waivers
- Health Insurance Premium Payment (HIP) and premium assistance programs
- New options made available under the Deficit Reduction Act (DRA)

Details related to each authority and possible program designs were provided in the Options and Feasibility Report, and have been included in Appendix C of this report.

## Project Approach

Mercer initially provided DHHS with a comprehensive review of all available options under Title XXI in a Feasibility and Options Report. Mercer considered three key components in that report.

- Nebraska's current Title XXI, Title XIX and other programs
- Title XXI program types and authority options
- Title XXI program types and designs utilized in other states

After conducting a comprehensive review of Nebraska's current Title XXI program and gaining an understanding of the program types and authorities utilized in other states, DHHS and Mercer held an onsite meeting to confirm understanding of Nebraska's current Title XIX and Title XXI programs, gathered additional information on the administrative oversight and discussed the vision and challenges DHHS faced with this program. During this meeting, Nebraska selected a number of states for Mercer to include in this report.

After the first onsite meeting, research continued on programs implemented in other states and the feasibility of each option for Nebraska. In total, 15 different state programs were reviewed. Mercer also collected data summaries from DHHS to gain an understanding of underlying trends and program costs by category of service. Finally, Mercer communicated with DHHS to gather additional information to support the analysis in the initial report. A summary of the options and comparisons of the benefits and limitations of each option considered in the Feasibility and Options report can be found in Appendix D. Descriptions of the programs from the 15 states reviewed can be found in Appendix E.

After completing the Options and Feasibility Report, Mercer conducted a second onsite meeting to discuss the possible options with DHHS. During this meeting, Nebraska selected the recommended alternative options to be included in this draft Recommended Alternatives Report. After the second onsite meeting, Mercer more fully developed the benefits and limitations of each option including more emphasis on implementation issues and costs that could be experienced by Nebraska under each model. For further information on the cost modeling methodology, refer to Appendix F.

This draft Recommended Alternatives Report identifies three alternative options for Nebraska to consider under Title XIX and XXI of the Social Security Act, including new options allowed under the DRA of 2005. The report includes an evaluation of the recommended alternative options as they have been implemented by other states. In this report, the benefits and limitations of each option are outlined as they relate to specific principles identified in the Medicaid Reform Plan Report and with regards to implementation.





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## Recommended Alternatives

In support of the Medicaid Reform Initiatives, Mercer reviewed the State's current MCHIP, researched Title XXI authorities and analyzed the experience of other states to assist DHHS in developing options to ensure long-term savings and program sustainability. The three recommended alternative options presented in this section also address the following reform principles identified in Nebraska's Medicaid Reform Plan Report.

- **Appropriate Health Care:** Assist Nebraska residents in accessing appropriate health care services when needed.
- **Appropriate Utilization:** Encourage and enable Nebraska residents to live healthy lives and avoid the utilization of more intensive and more costly health care services.
- **Personal Responsibility and Accountability:** Encourage personal independence, freedom of choice, greater personal and private sector responsibility, accountability for the provision and prudent utilization of health care services.
- **Fiscal Sustainability:** Ensure long-term fiscal sustainability

In reviewing the Options and Feasibility Report, Mercer discussed with DHHS that the overall financial impact of each program option is often difficult to distinguish as program expenditures are driven by benefits covered, reimbursement methodologies and administrative costs. Any single factor such as cost sharing may or may not impact the overall per person cost of a Title XXI program. Other factors such as benefit design, whether or not the providers are paid based on a discounted Title XIX fee schedule and the extent to which a state is able to leverage private insurance appears to impact the overall fiscal sustainability of Title XXI programs.

In examining 2005 data from states implementing various models of Title XXI, the most influential factors for overall financial impact appear to be a states ability to utilize private insurance through Health Insurance Premium Payment (HIPP) and premium assistance, the ability to utilize the discounted Title XIX fee schedule and the ability to modify benefits to more efficiently meet the needs of Title XXI children. For comparisons of state Title XXI expenditures, refer to Appendix H.

As a result of these conclusions, DHHS requested the following three recommended alternative options be outlined in this report:

- Option A – Medicaid Expansion (MCHIP) Combined with Health Insurance Premium Payment (HIPP) Program
- Option B – Medicaid Expansion (MCHIP) with Modified Benefit Plans and Combined with Health Insurance Premium Payment (HIPP) Program
- Option C – Separate Child Health Insurance Plan (SCHIP)

Each of these three options has benefits and limitations when compared to each other and to the current Nebraska MCHIP. The following table provides a side-by-side comparison of the three options to the current Nebraska MCHIP.

**Table 1: Recommended Alternative Options Comparison**

	MCHIP (Current Nebraska Model)	Option A – MCHIP Combined with HIPP Program	Option B – MCHIP with Modified Benefit Plans and Combined with HIPP Program	Option C – SCHIP
<b>Uses Medicaid Delivery System</b>	Yes	Yes	Yes	Not Typically
<b>Uses Medicaid Fee Schedule</b>	Yes	Yes	Yes	Not Typically
<b>Allows Flexibility of Benefits</b>	No	No	Yes – EPSDT Still Mandated	Yes
<b>Allows Cost Sharing</b>	No	No	Yes	Yes
<b>Federal Funding After Allotment Exhausted</b>	Yes – Title XIX	Yes – Title XIX	Yes – Title XIX	No
<b>Entitlement</b>	Yes	Yes	Yes	No
<b>Allows Title XXI Children with Insurance Under Medicaid</b>	No	Yes	Yes	No
<b>Matches HIPP Payments by State at Title XXI Rate</b>	Not Applicable	No – Title XIX	No – Title XIX	Not Applicable
<b>Medicaid Look-Alike</b>	Yes	Yes	Yes	Not Typically
<b>Maintains Administrative Simplicity</b>	Yes	Yes, but additional administration for coordination	More Complicated	More Complicated

	MCHIP (Current Nebraska Model)	Option A – MCHIP Combined with HIPP Program	Option B – MCHIP with Modified Benefit Plans and Combined with HIPP Program	Option C – SCHIP
<b>Option can be Approved by CMS within Specified Time Period</b>	Yes	Yes	Yes – however, prior discussions with CMS necessary, which may lengthen development/approval process	Yes
<b>Allows Enrollment Cap</b>	No	No	No	Yes
<b>Mirrors Commercial Market</b>	No	No	Possible – For Benefits	Yes
<b>Provider Education Needs are Same/Similar to Medicaid</b>	Yes	Yes	No – Differing benefits, Medicaid could potentially change as well	No
<b>Main Objectives</b>	Administrative Simplicity Medicaid Look-Alike	Administrative Simplicity Medicaid Look-Alike Discourages Crowd- Out	Medicaid Look-Alike Lowest Cost Cutting Edge Flexible Benefits and Cost Sharing Discourages Crowd- Out	Bridge to Private Insurance Flexible Benefits and Cost Sharing

In general, the MCHIP programs (Nebraska and Options A and B) have a delivery system that remains the same as the rest of the Title XIX Medicaid program. In addition, if the Title XXI allotment is exhausted, the Federal government begins matching MCHIP expenditures at the Title XIX Medicaid rate. Finally, MCHIPs typically utilize the Title XIX provider network and FFS fee schedules. These discounted fee schedules often result in lower per person expenditures than SCHIP (Option C), which often utilize commercial health plans and higher commercial fee schedules. Since the current MCHIP uses the same benefits as Title XXI, cost sharing and premiums are not permitted in absence of an 1115 demonstration or a reform plan under the DRA (Option B). Also, Options B and C allow for flexibility of benefits, while Nebraska’s current MCHIP and Option A would mirror the current State Medicaid, Title XIX, benefit plan.

The table above outlines the main objectives states typically consider when implementing available program options. All options address the objectives of cost savings and program sustainability to some extent. Options A and B continue to provide an entitlement to services (all eligibles who meet eligibility requirements receive benefits and Federal funding match continues after Title XXI Federal allotments are expended). Option C is not an entitlement program and allows the State to implement enrollment caps and waiting lists to balance program costs and Federal Title XXI allotment. Also, Option C is typically used as a program to bridge the gap between public and private health care coverage by being more commercially-oriented in

benefits and reimbursement. This is an option many states are using to expand coverage to their uninsured populations, which are at higher income levels than the levels defined by their Title XIX and Title XXI programs.

As the State considers the options presented below, consideration must be made for the Federally-mandated cost sharing limitations based on family income levels and the authority used to administer each option. Table 2 below demonstrates the applicable limitations and the cost sharing modeled under each option.

**Table 2: Recommended Alternative Options Cost Sharing Regulations**

Option	Authority	Rule		Model <sup>1</sup>	
		100%-150% FPL	Over 150% FPL	100%-150% FPL	Over 150% FPL
Option A: Medicaid Expansion (MCHIP) Combined with Health Insurance Premium Payment (HIPP) Program	Medicaid regulations <sup>2</sup>	No cost sharing or premiums allowed	No cost sharing or premiums allowed	No copayments or premiums Savings are derived from coordination of other health insurance coverage	No copayments or premiums Savings are derived from coordination of other health insurance coverage
Option B: Medicaid Expansion (MCHIP) with Modified Benefit Plans and Combined with Health Insurance Premium Payment (HIPP) Program	The Deficit Reduction Act <sup>3</sup>	No premiums allowed Copayments up to 10% of medical costs (costs based on Title XIX FFS reimbursement) Copayments prohibited on well-child care and for Native Americans. All cost sharing in aggregate must be less than 5% of family income.	Unlimited premiums Copayments up to 20% of medical costs (costs based on Title XIX FFS reimbursement) Copayments prohibited on well-child care and for Native Americans. All cost sharing in aggregate must be less than 5% of family income.	Model B.1: No premiums; no copayments	Model B.1: \$10 per member per month (PMPM) premiums; no copayments
				Model B.2: No premiums; copayments within limits	Model B.2: \$25 PMPM premium with significant coinsurance and copayments within limits
Option C: Separate Child Health Insurance Plan (SCHIP)	SCHIP regulations <sup>4</sup>	Premiums \$15 or below permitted Copayment limits apply per 42 CRF 457.555 Copayments prohibited on well-child care and for Native	Unlimited premiums and copayments Copayments prohibited on well-child care and for Native Americans. All cost sharing in aggregate must be less than 5% of family income.	Model C.1: \$5 PMPM premiums; no copayments No copayments on well-child care. All cost sharing less than 5% of family income. Unable to modify for Native Americans.	Model C.1: \$12 PMPM premiums; no copayments No copayments on well-child care. All cost sharing less than 5% of family income. Unable to modify for Native Americans.

<sup>1</sup> See Appendix G

<sup>2</sup> See 42 CFR 447.50 through 42 CFR 447.60

<sup>3</sup> See Dear State Medicaid Letter #06-015 June 16, 2006

<sup>4</sup> See 42 CFR 457.515 through 42 CFR 457.570

**Table 2: Recommended Alternative Options Cost Sharing Regulations**

Option	Authority	Rule		Model <sup>1</sup>	
		100%-150% FPL	Over 150% FPL	100%-150% FPL	Over 150% FPL
		Americans. All cost sharing in aggregate must be less than 5% of family income.		Model C.2: \$12 PMPM premiums; copayments within limits  No copayments on well-child care. All cost sharing less than 5% of family income. Unable to modify for Native Americans.	Model C.2: \$25 PMPM premiums; with significant coinsurance and copayments within limits  No copayments on well-child care. All cost sharing less than 5% of family income. Unable to modify for Native Americans.

For each option identified, this section will include:

- A **description** of the recommended alternative option and the main objectives for each
- Differences in program **authority** and regulatory issues related to the State Plan and/or SPAs, as well as potential advantages and disadvantages
- **Benefits and limitations** of each option including specific policy issues to be considered
- Specific **other state experience** and how the option would be applicable to Nebraska's MCHIP including the feasibility of implementing the option in Nebraska
- The **impact on enrollment and expenditures** including savings and additional administrative expenses
- The **implementation considerations and timing** of the recommended alternative including consideration of the existing and anticipated MMIS in 2011

## Option A – Medicaid Expansion (MCHIP) Combined with Health Insurance Premium Payment (HIPP) Program

### ***Description***

Under this recommended option, the State would continue to maintain its current MCHIP and would implement a HIPP program for MCHIP children. Implementing this option would achieve the following:

- Continue the entitlement to Medicaid services for eligible children
- Build on the current infrastructure of Medicaid and the Title XIX HIPP, adding minimal administrative complexity
- Allow children to maintain their current health insurance coverage and receive the additional Medicaid benefits
- Discourage families from dropping other health insurance coverage (private or employer-sponsored health plans) to become eligible for MCHIP – commonly referred to as crowd-out
- Gain budget predictability and long-term program sustainability by shifting risk to private health insurers as a result of paying premiums rather than all medical expenses

Under a current MCHIP, states may not enroll children otherwise eligible for Title XXI with health insurance and receive Federal matching funds under Title XXI. States can provide medical assistance to low-income children meeting the income guidelines regardless of the child's insurance status through Title XIX. The State does have an existing HIPP program for Title XIX eligibles. This option would extend the HIPP program to enroll qualified Title XXI children with other health insurance coverage into the Medicaid program based on cost effectiveness and receive Medicaid (Title XIX) matching funds.

This HIPP option includes two components:

- HIPP – The State pays the child's premium for the other source of health care coverage if determined to be cost effective. The State also pays for the Medicaid wrap-around services.

- TPL – The family pays the child’s premium for the other sources of health care coverage as defined by Third Party Liability (TPL) regulations (not limited to group health insurance as in HIPP). The State is responsible for paying the Medicaid wrap-around services.

Under both components, the premiums and wrap-around services are matched at the Title XIX rate.

### ***Authority***

Under Section 1906 of the Social Security Act, states may enroll Title XIX beneficiaries (including Title XXI MCHIP participants) into a group health plan, otherwise known as a HIPP program, and receive Medicaid matching funds. Section 1906 requires that the Title XIX program provide wrap-around benefits and cost sharing to ensure that children enrolled in group coverage continue to receive the full Title XIX benefit plan at no additional cost.<sup>5</sup> HIPP programs use Medicaid funds to purchase employer coverage for eligible persons when such coverage is available and cost effective and to pay for wrap-around services. All states were required to develop HIPP programs by 1991, but the programs have since become optional. Since Nebraska already has the authority and currently operates a HIPP, it may be relatively simple to include this option under MCHIP and utilize existing health insurance coverages. Based on the current authorities employed by Nebraska and the experience of other states, Nebraska would be required to amend its Title XXI State Plan to implement this recommendation. This is consistent with what was required for South Carolina.

### ***Benefits and Limitations***

The following table outlines the benefits and limitations of Option A: Medicaid Expansion (MCHIP) Combined with Health Insurance Premium Payment (HIPP) Program

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<sup>5</sup>"Charting Separate Child Health Insurance Program Separate Child Health Insurance Program III", p. 17

**Table 3: Option A Benefits and Limitations**

Benefits of Option A	Limitations of Option A
<ul style="list-style-type: none"> <li>▪ <b>Appropriate Health Care:</b> Allows variation of amount, duration and scope to provide through Medicaid only those services not covered by group health coverage for eligibles with other health insurance coverage.</li> <li>▪ <b>Appropriate Utilization:</b> Allows variation of amount, duration and scope in modifying the benefit plan to emphasize preventive services, such as EPSDT services for eligibles with other health insurance coverage.</li> <li>▪ <b>Fiscal Sustainability:</b> Promotes fiscal sustainability because private insurance is only purchased when the insurance is considered cost effective. The State becomes the secondary payer on services provided to qualified children, reimbursing claims at the Medicaid fee schedule rate after payment by the health plan.</li> <li>▪ <b>State Approval:</b> Requires an amendment to the Title XXI State Plan to reflect the intent to implement a HIPP program for the MCHIP.</li> <li>▪ <b>Administration:</b> Limits administrative change as it builds upon Nebraska’s current HIPP, in which MCHIP children with other health insurance coverage are enrolled in Title XIX.</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Flexibility:</b> Must follow the Title XIX benefit plan and does not allow for flexibility in member cost sharing or benefit design.</li> <li>▪ <b>Personal Responsibility and Accountability:</b> Without flexibility in member cost sharing and benefit design there is a lack of personal responsibility and accountability.</li> <li>▪ <b>Protracted Review:</b> May be a protracted review if CMS also requires an amendment of the Title XIX State Plan.</li> <li>▪ <b>Matching Rate:</b> The State does not access the Title XXI match rate. The Federal match rate if the child is found MCHIP eligible under Medicaid HIPP criteria and enrolled is the Title XIX rate for the premium as well as for medical services. However, the State is currently paying for all services for children dropping other health insurance coverage for MCHIP services at the Title XXI match rate.</li> </ul>

Again, since a HIPP program is already established under Title XIX, this recommended alternative option will be the least complicated option to implement.

***Other State Experience***

The state of Wisconsin has been able to expand reliance on private insurance through its HIPP program in Medicaid and its Section 1115 premium assistance program. Under this program design, Wisconsin determines whether it is cost effective to purchase family coverage through its HIPP program using Title XIX dollars or through the Title XXI cost effectiveness test in the 1115 waiver. Wisconsin originally received enhanced match for the entire family with incomes below 100 percent of the FPL if the Title XXI cost effectiveness criteria was met, or for the children if the Title XXI cost effectiveness criteria was not met. With the approval of the MCHIP Section 1115 demonstration, Wisconsin receives enhanced Federal Medical Assistance Participation (FMAP) for all eligible family members above 100 percent of the FPL. Similarly, South Carolina has modified its Title XXI state plan to include children with other health insurance coverage in its Medicaid program. Both Wisconsin and South Carolina receive the lower Medicaid match for participants meeting Medicaid HIPP and insurance coverage requirements. Wisconsin receives the higher Title XXI match for participants meeting SCHIP premium assistance requirements under its 1115 demonstration waiver.

Iowa operates the oldest and one of the largest HIPP programs. This example of a HIPP program is included because although the program targets those eligible for Medicaid (versus

uninsured workers), a significant portion of HIPP beneficiaries are non-Medicaid-eligible family members (about 35 percent in Iowa). The HIPP program will pay for the minimum coverage option that allows the Medicaid-eligible person/persons to be covered. For example, if the employer offers single, single plus dependents, and family coverage and the Medicaid-eligible individual is a child, HIPP will pay for the employee and the dependents (including the Medicaid-eligible child), but not the spouse.

One of the drawbacks of the HIPP option is low enrollment in these programs. In Wisconsin, only 109 family applications out of almost 50,000 employer information forms were determined eligible for HIPP. Of the 109 families, only 32 families actually enrolled in the premium assistance program. While there is not one reason cited as being responsible for the low proportion of eligibles in HIPP, the layering of many requirements had a powerful impact on reducing enrollment.<sup>6</sup> Another reason for this relatively modest enrollment is that many families in public coverage, perhaps more than might be suggested by national data, do not have access to employer coverage.<sup>7</sup>

### ***Impact on Enrollment and Expenditures***

In this option, Mercer modeled the impact on enrollment and program expenditures with the implementation of a HIPP program in conjunction with the State's current MCHIP program. Results may vary based on Nebraska's aggressive pursuit of enrolling individuals with other health insurance available (e.g., HIPP and TPL). Based on our modeling, as many as 6,000 children could enroll in this type of program. Many of these children may not have previously been eligible to enroll due to existing private coverage.

Our modeling also suggests that despite the lower Federal match rate for enrollees in this type of program, the State may achieve savings because program costs for individuals with other insurance coverage are generally lower than expenditures for the traditional MCHIP enrollees. We estimate total expenditures for the Medicaid and MCHIP programs combined could decrease by approximately \$1.4 million annually. We estimate the State's share of the MCHIP expenditures could decrease by \$190,000, which is about 1% of projected program MCHIP expenditures in SFY 2009. While the number of individuals enrolled does increase in this model, individual costs are not as significant as the current enrolled population.

While the modeling identifies a significant enrollment growth and an ability to lower program expenditures, it should be noted that these results are based on an assumption of aggressive outreach and promotion of the HIPP program. If the program is not pursued aggressively, or if employers are unwilling to participate in the program, there may be no budgetary savings achieved.

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<sup>6</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 21.

<sup>18</sup> Data from the 1999 National Survey of American Families showed that 63 percent of low-income, non-elderly adults were covered by ESI in Wisconsin compared to a national average of 51 percent. "Snapshot of State Experience Implementing Premium Assistance Programs", p.22.

## ***Implementation Considerations and Timing***

To implement this option, the State will be required to amend its Title XXI State Plan. The State should be able to work with the South Carolina state plan amendment (SPA) to prepare its own Title XXI SPA for CMS consideration. Since much of the infrastructure for this option is already in place, it is anticipated this recommendation will take 60 to 90 days to implement. If CMS requires more than the Title XXI SPA, the review could utilize 3 full 90-day review periods: CMS initial review, State response and CMS final review. Option A would be operated under the current configuration of the Title XIX and XXI programs probably does not require additional statutory authority. However, Nebraska's own legal counsel will need to make final determination of the ability of the State to modify its Title XXI and/or Title XIX State Plans under existing statutory authority. If changes are necessary, the process to change statutory authority will likely add 6 months to the implementation timing.

It is anticipated that three additional full-time employees (FTEs) will be needed to help in the day-to-day management of the expanded HIPP program. It is further assumed the State will make system enhancements for automating the management process of the current HIPP program. In addition, this option is compatible with the current MMIS as well as the new MMIS planned for implementation in 2011. The State may need to make slight modifications to the MMIS edits to allow for an insurance coverage indicator for the MCHIP population similar to the Medicaid population.

## Option B – Medicaid Expansion (MCHIP) with Modified Benefit Plans and Combined with Health Insurance Premium Payment (HIPP) Program

### ***Description***

Under this option, the State would continue to maintain its MCHIP although multiple benefit plans would be established that would include a commercial-like “basic” benefit plan and plans that include additional benefits such as dental and mental health. This option would also include the same HIPP program for children with other health insurance coverage who are otherwise eligible for Title XXI as outlined in Option A. Implementing this option would allow the State to:

- Continue an entitlement to needed services for eligible children
- Build on the current infrastructure of Medicaid and the Title XIX HIPP programs
- Establish benefit plans that more closely align with individual needs
- Introduce premiums and copayments or other cost sharing within the limitations of Federal statutes (see Table 2 earlier in this section)
- Promote personal responsibility and accountability for when and how services are received based on the benefit plan and the applicable cost sharing
- Allow children to maintain their current health insurance coverage and receive additional benefits
- Encourage families to maintain their current health insurance coverage rather than dropping coverage so children become MCHIP eligible to receive needed benefits such as dental or mental health

With this option, the State would offer a reduced, “basic” benefit plan to higher income children in Medicaid and under the MCHIP. The benefits would be similar to a commercial benefit plan, such as the State Employee Health Benefit Plan. With the passage of the DRA, states are allowed to require enrollment in alternative benefit plans equal to SCHIP benchmark or benchmark-equivalent plans for certain higher-income, healthy children under a MCHIP. Use of benchmark or benchmark-equivalent benefit coverage is at the discretion of a state, and may be used in conjunction with employer-sponsored health plans as a coverage option for individuals in the Medicaid program who have access to private health insurance. For more details on benchmark plans under SCHIP, refer to Option C in this section.

A “plus” benefit plan would also be offered to cover additional benefits that could be considered more optional in nature, such as dental. A third “enhanced” plan would also be offered to provide a more extensive plan for high-needs children (i.e., could be identical to the “plus” plan but adds mental health services). Each plan would sequentially require higher premiums for enrollment.

The State would be required to establish premiums to comply with DRA regulation and may be established at a nominal level or at the maximum allowed based on combined cost sharing limits. The premium could be set equal to the value of benefits each child is expected to receive for services considered to be more optional in nature (e.g., dental) under the “plus” plan and could be nominally increased for high-needs children in the “enhanced” plan. Conversely, the State could determine that only children meeting certain high-risk criteria via an independent screening process would be placed in the “enhanced” benefit plan, and not charge those high-risk children a premium. Because premiums are not permitted for children with incomes from 100 to 150 percent of the FPL under this authority, this option allows the State to determine that only children meeting certain high-risk criteria via an independent screening process would be placed in the “enhanced” benefit plan and would not be charged a premium. The screening process could be extended to the children over 150 percent of the FPL at the State’s discretion.

The new DRA provisions specific to cost sharing allow states the ability to charge premiums for certain Medicaid enrollees (including MCHIP children) with family incomes above 100 percent of the FPL. In addition, states may implement cost sharing up to 20 percent of the cost of the medical service (based on the Title XIX fee schedule) for families with incomes over 150 percent of the FPL. Copayment limits are set at 10 percent of the cost of the service for enrollees (including MCHIP children) for some individuals with incomes between 100 and 150 percent of the FPL. The requirements allow states to vary the amount of premiums and cost sharing imposed by geographic area and type of service, as well as across and within eligibility categories.

### ***Authority***

With the passage of the DRA, states now have new authority options available to gain flexibility in administering their Title XIX state plan. While these authorities are specific to the Title XIX state plan, they may also be targeted to specific groups based on income and eligibility category. Since a MCHIP must operate under rules applicable to the Title XIX program and offer coverage consistent with the Title XIX state plan, a state could utilize the DRA SPA option to target programmatic changes to the MCHIP population. Under the DRA, the following three options regarding program design merit additional consideration: (1) creation of benchmark

plans, (2) implementation of cost-sharing provisions and (3) implementation of Health Opportunity Accounts (HOAs). A Health Opportunity Account Demonstration SPA offers beneficiaries the option of enrolling in a high deductible health plan.

The DRA allows states to replace the standard Title XIX benefit plan through a new state plan option with benchmark coverage for certain healthy children and adults (this includes all children in a MCHIP). In addition to modifying the benefit plan, the DRA changed Federal provisions regarding cost-sharing requirements. Since MCHIPs were required to follow Title XIX cost-sharing requirements, the DRA offered another option for states to consider. Finally, the DRA permits the Secretary to authorize 10 demonstrations to implement HOAs.

For certain healthy children and adults eligible for Title XIX through a state plan prior to February 8, 2006, a state may require enrollment in alternative benefit plans equal to SCHIP benchmark or benchmark-equivalent plans. In addition, children under age 19 who are covered under a state plan under Section 1902(a)(10)(A) of the Social Security Act must receive wrap-around benefits to the benchmark plan, consisting of EPSDT services defined in Section 1905(r). Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefit plan, these individuals receive the full EPSDT benefit.

Several Medicaid categories of individuals may not be required to enroll in an alternative benefit plan including:

- Poverty-level pregnant women
- Blind and disabled under Supplemental Security Income (SSI)
- Medicare beneficiaries
- Individuals on hospice or spend-down
- Foster care or children with special health care needs
- Individuals eligible for Aid to Families with Dependent Children (ADC)

While states are permitted to offer exempt individuals an alternative benefit plan, a state may not require those exempt individuals to enroll. In any case where a state offers an individual the option to enroll in an alternative benefit plan, a state must inform the individual that enrollment is voluntary and the individual may opt out of such alternative benefit plan at any time. A state must inform the individual of the benefits available under the alternative benefit plan and provide a comparison of how the benefits differ from those available under the original state plan. A state must document in the eligibility file that the individual was informed and voluntarily chose to enroll in the alternative benefit plan.

### ***Benefits and Limitations***

The following table outlines the benefits and limitations of Option B: Medicaid Expansion (MCHIP) with Modified Benefit Plans and Combined with Health Insurance Premium Payment (HIPP) Program.

**Table 4: Option B Benefits and Limitations**

Benefits of Option B	Limitations of Option B
<ul style="list-style-type: none"> <li>▪ <b>Flexibility:</b> Allows flexibility in administering the MCHIP by developing different benefit plans.</li> <li>▪ <b>Cost Sharing:</b> Allows the assessment of premiums and copayments.</li> <li>▪ <b>Appropriate Health Care:</b> Allows variation of amount, duration and scope in modifying the benefit plans to align coverage with individual needs.</li> <li>▪ <b>Appropriate Utilization:</b> Allows variation of amount, duration and scope in modifying the benefit plans to emphasize preventive services.</li> <li>▪ <b>Personal Responsibility and Accountability:</b> Allows the individual to have choice of health care coverage, and thus, promotes responsibility.</li> <li>▪ <b>Fiscal Sustainability:</b> Promotes fiscal sustainability due to the more limited benefit plans offered and because private insurance is only purchased when the insurance is considered cost effective.</li> <li>▪ <b>State Approval:</b> Requires an amendment to the Title XXI state plan to modify benefit plans and reflect the intent to implement a HIPP program for the MCHIP.</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Administration:</b> Increases administrative complexity to offer and adjudicate differing benefit plans. Also, more administration required to initially enroll children in a benefit plan and evaluate potential needs that would warrant a change in benefit plan. Finally, takes considerable time to develop and implement due to significant changes required to the current MMIS.</li> <li>▪ <b>Matching Rate:</b> May result in lower Federal match rate if the child is found eligible under Title XXI HIPP criteria and enrolled in Title XIX.</li> </ul>

The DRA provides states with several options to implement provisions similar to a SCHIP. Most notable is the flexibility around benefit designs a state may adopt that mirror the benchmark plans under a SCHIP. Therefore, it provides substantially similar authority to a SCHIP, and it provides a state with new options regarding cost-sharing requirements.

### ***Other State Experience***

The new SPA options available under the DRA would allow Nebraska the ability to modify benefits and implement premiums and copayments on higher income children without an 1115 demonstration waiver. Historical research indicates that increasing public premiums reduces the insurance coverage of children. In addition, requiring or increasing copayments, especially on well-child visits, reduces access to preventive care.<sup>8</sup> Through its MCHIP program, Missouri has

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<sup>8</sup> The HIE project was started in 1971 and funded by the Department of Health, Education, and Welfare (now the Department of Health and Human Services). It was a 15-year, multimillion-dollar effort that to this day remains the largest health policy study in U.S. history. The study's conclusions encouraged the restructuring of private insurance and helped increase the stature of managed care. A summary of the major findings of the RAND Health Insurance Experiment can be found in the publication at: Robert H. Brook, Emmett B. Keeler, Kathleen N. Lohr, Joseph P. Newhouse, John E. Ware, William H. Rogers, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Patricia Camp, Caren Kamberg, Arleen Leibowitz, Joan Keesey, David Reboussin, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate—

2006"; [http://www.rand.org/pubs/research\\_briefs/RB9174/](http://www.rand.org/pubs/research_briefs/RB9174/)

found the same to be true; that as premiums increase, enrollment decreases.<sup>9</sup> More recent studies continue to support these older findings. One study in particular found that raising public premiums reduces enrollment in public programs because some children maintain private coverage and others become uninsured. The latest results continue to indicate that public premiums have larger effects when applied to lower-income families<sup>10</sup>.

Another advantage of the DRA option is the ability to require and/or allow more beneficiary responsibility. Examples of recently approved DRA SPAs that emphasized personal responsibility are as follows:

- Idaho's Title XIX reform contained several components, one of them being a new preventive health assistance benefit similar to Kentucky's Get Healthy Benefit. This benefit is designed to encourage tobacco cessation, weight management and current well-child checks and immunizations. MCHIP enrollees can also participate in a Wellness Preventive Health Assistance, which is a mechanism to assist participants with their premium payment obligation. Each participant can earn premium discounts by following preventive protocols.
- West Virginia's Title XIX program used the DRA to require a partnership agreement between the beneficiary and the State in which individuals who agreed to certain goals would be able to obtain additional optional benefits. Upon enrollment, individuals will choose, or be assigned to a medical home and will be counseled in order to obtain and receive appropriate health services. Individuals electing to sign a membership agreement, which focuses on appropriate health and wellness programs and beneficiary, provider and state rights and responsibilities, rewards participation by providing enhanced benefits targeted to the specific health needs of the individual.
- South Carolina's recently approved DRA SPA allows the use of benchmark plans. In addition, CMS approved South Carolina's request to implement a HOA demonstration. Title XIX beneficiaries, including children eligible under the MCHIP, now have the option to voluntarily enroll in a high deductible health plan with a savings account. South Carolina will deposit up to \$1,000 per eligible child in the HOA.

Many of the new state initiatives have fairly complex program designs and participation rules. Often the complexity is a result of efforts to target limited resources to specific segments of the uninsured population. In addition, programs become more complex with requirements meant to ensure new public programs do not encourage either employers to cease offering coverage or individuals to drop existing coverage. These participation rules often lead to additional steps in the enrollment process, which can create operational barriers for the target population. Income requirements are a fairly standard condition of eligibility. Eligibility is also often limited to

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<sup>9</sup> Enrollment at the highest income levels decreased in the Missouri Separate Child Health Insurance Program Separate Child Health Insurance Program by 10.9 percent after premium increases. Alicia Smith and Associates, LLC, "Evaluation of the Missouri Medicaid 1115 Demonstration Waiver", (August 19, 2004).

<sup>10</sup> Fredric Blavin, Genevieve M. Kenney, Jack Hadley, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003" Inquiry, Volume 43, Number 4 (Winter 2006/2007):, p.345-361. This study uses 2000 to 2004 Current Population Survey data to examine the effects of public premiums on the insurance coverage of children whose family incomes are between 100 percent and 300 percent of the Federal poverty level.

individuals who have been uninsured for a specific period of time and who work for an employer of a certain size that does not currently offer coverage. Many states also require employers to participate by beginning to offer employer coverage where it was previously not available. With so many factors in play, the underlying complexity of the program design can undermine implementation, despite the best efforts to reach out to the eligible population.

Due to the program complexity, states have identified the need to commit additional administrative resources to implement the programs. States have placed specific emphasis on informing individuals of their choice and responsibilities and some have contracted with enrollment brokers. Additionally, these programs often require a significant amount of information systems programming to reflect different benefit plans, and cost-sharing requirements and as such many states contract with managed care plans.

### ***Impact on Enrollment and Expenditures***

The enrollment and expenditures impact of Option B could vary considerably, depending on benefit design and cost sharing elements such as premiums and copayments. To illustrate the types of results Nebraska could achieve under this option, Mercer modeled two different scenarios. Both scenarios use the State Employee Health Benefit Plan as a benchmark for the covered services of the “basic” plan. This plan is a comprehensive set of medical benefits, but does not include dental services, non-emergent transportation, enhanced mental health benefits and a few other services provided through the current MCHIP program. Benefit descriptions for Options B.1 and B.2 are provided in Appendix G.

Options B.1 and B.2 vary only in the premium and copayment levels applied. Option B.1 uses moderate premiums and no point-of-service cost sharing (copayments or coinsurance). Option B.2 uses higher premiums and more aggressive point-of-service cost sharing as allowed under the DRA.

Based on other states’ experience with implementing premiums and copayments in their MCHIP and SCHIP programs, it is expected Nebraska’s MCHIP enrollment would drop with these options. The magnitude and duration of the enrollment decrease would be affected by a variety of factors, including the size of the premiums and copayments, whether there is an enrollment “lock-out period” after premium non-payment, and the method of billing and collecting premiums. For the purposes of this modeling, Mercer used mid-range results as reported for other states to model expected enrollment reductions. Nebraska’s actual experience could vary depending on its selected program parameters. We estimate that SFY 2009 enrollment could drop by 0.5 percent for Option B.1 (moderate premiums and no copayments) and 4.0 percent for Option B.2 (higher premiums and copayments).

Both of the modeled options illustrate large potential budgetary savings for the State for SFY 2009. Option B.1 produces savings of approximately \$2.2 million (15 percent) of State MCHIP expenditures, while B.2 illustrates savings of approximately \$5.1 million (35 percent) of State MCHIP expenditures. These figures are net results after consideration of the State’s share of additional administrative costs of \$1 million. These large savings estimates are driven by three major factors: fewer benefits covered, a portion of the benefit costs borne by the enrollees in the form of premiums and copayments, and fewer enrollees participating. Of these three factors, the level of covered benefits is critical, producing most of the savings projected for Option B.1. If the State should decide to pursue a DRA-based alternative benefit plan, the achievable savings would be very sensitive to the set of covered benefits selected.

The second of these factors, the level of enrollee cost sharing, is also quite influential and can result in savings of 15 to 20 percent if the full flexibility allowed under the DRA is utilized. However, some of the savings associated with point-of-service copayments is associated with lower service utilization. Under DRA rules, providers are allowed to refuse clients at the point-of-service if the copayment is not paid. Research has shown that copayment requirements can cause low-income populations to delay seeking needed care. Implementation of full cost sharing may produce results that are not desirable for reasons other than cost savings maximization.

Finally, the enrollment decreases associated with implementing a premium is another driver of savings. State expenditures are lower, in part, due to fewer children receiving coverage. This element is not a large factor in the savings projected for Option B.1, as premiums are moderate and enrollment loss is mostly offset by projected HIPP-related Medicaid enrollment increases. However, the 4 percent enrollment decrease illustrated for Option B.2 is a material contributor to the overall savings estimate.

These impact estimates further assume the MCHIP individuals are all receiving the “basic” benefit plan. In reality, individuals will be distributed between the “basic”, “plus” and “enhanced” plans. The determination of the additional benefits to be added in each plan and the associated premiums for each of the plans will be instrumental in driving an overall cost savings estimate for this option. For example, if dental was the only additional benefit added to the “basic” plan, typical costs for dental may run between \$10 and \$20 PMPM. However, when dental is the only benefit difference and the family is required to pay a sizeable premium for this plan, the heavy utilizers of the service will select this plan and the actual PMPMs will be significantly higher than the \$10 to \$20 range. Based on the DRA cost-sharing limitations, the State may not be able to establish a premium that would fully offset costs. This would result in a reduction in the estimated savings. That reduction will be directly impacted by the distribution of children between plans and the differential between the premiums and the expected costs for the additional benefits.

### ***Implementation Considerations and Timing***

The implementation of Option B would require extensive program design and SPAs to the Title XIX and Title XXI State Plan in addition to SPAs to include children now eligible for Title XXI with other health care coverage in the Medicaid State Plan. The current State staff may need to be temporarily augmented with a contracted consultant (if internal resources are not available) to assist with program design and writing the DRA SPA. South Carolina's Title XXI State Plan could serve as an example for State staff to make this modification for HIPP.

Permanent staff to pursue HIPP and assist with provider training on the different benefit models, premiums and cost sharing, as well as any additional provider requirements, would be necessary. Additionally, resources would be required on a statewide basis to assist with enrollee education, the identification of high-needs children, benefits choice counseling and any community/media information needs. The identification of children with high risks in the 100 to 150 percent of FPL range who would be placed in the enhanced benefit plans would occur through this latter set of resources because the current Nebraska model of community health nursing/enrollment broker already includes a high-risk screening process, which could be modified to address this need.

The administrative cost estimates include 3 additional FTEs to pursue HIPP and TPL, two additional provider training staff members and a moderate consultant contract amount for writing the SPA and assisting with program design (assumes the State will implement the program without outside assistance). In addition, administrative cost estimates reflect a statewide budget equal to the PMPM amount for the current community health nursing/enrollment broker function for the managed care program in Douglas, Sarpy and Lancaster counties, in addition to the current administration already required for Medicaid and MCHIP.

This option also requires extensive reprogramming of Nebraska's MMIS to accommodate different benefit plans that would be reimbursed through FFS, or additional contract oversight if implemented through private health plans. It is further assumed the State will make system enhancements for automating the management process of the current HIPP program. For these reasons, Mercer has assumed this model will not be implemented until after the new MMIS is designed so the reprogramming could be included in the system redesign. If this option were implemented earlier, additional information system resources would be required.

Extensive preparation and work would be necessary to implement this option. It is anticipated that implementation would take 3 to 4 years planning and implementing this option. Moving forward with this option may track well with the planned timing of the new MMIS. The approval of the DRA SPAs could take up to three full 90-day periods. In addition, Option B would be operated under an expansion of the Medicaid program as called for under LB 1063. However, it significantly changes the benefit offerings to the MCHIP population and requires a SPA. This option will require additional enabling legislation to modify the benefit plan for the MCHIP population as outlined here. The process to change statutory authority will likely add 6 to 9 months to the implementation timing.

## Option C – Separate Child Health Insurance Plan (SCHIP)

### **Description**

Under this recommended option, the State would convert its current MCHIP into a separate, stand alone SCHIP. This option provides the maximum flexibility to the State for administering its Title XXI program. There are several advantages to implementing a SCHIP:

- A SCHIP is not an entitlement and is able to establish separate eligibility rules. In addition, a SCHIP may limit its own annual contribution, create waiting lists or stopping enrollment once the program funds have been exhausted.
- Although SCHIPs must comply with statutory benefit standards, the benefits are more flexible (e.g., do not require EPSDT coverage) and can mirror commercial benefit designs.
- SCHIPs may impose limited cost sharing through premiums, copayments or enrollment fees for children in families with incomes above 150 percent of the FPL up to 5 percent of family income, annually. In addition to the 5 percent cost-sharing limit, cost sharing is not permitted for well-baby and well-child services, Native American and Alaska Natives, and is limited to the nominal Medicaid limits for families with income between 101 and 150 percent of the FPL.

For a SCHIP, the State must establish a benefit design based on one of the following benchmark plans:

- **Benchmark Plan:** A benefit plan consistent with the Federal Employees Health Benefits Program (FEHBP) BlueCross BlueShield Standard Option (coverage generally available to Federal employees), coverage generally available to state employees, or coverage under a state's health maintenance organization (HMO) with the largest insured commercial, non-Medicaid enrollment.
- **Benchmark-Equivalent Plan:** A benefit plan including basic coverage for inpatient and outpatient hospital, surgical and medical physician, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations. The health benefits coverage must have an aggregate value that is at least actuarially equivalent to the coverage under one of the benchmark plans.
- **Secretary-Approved Plan:** A benefit plan consisting of coverage determined appropriate for targeted low-income children. Secretary-Approved coverage can include, but is not limited to, coverage provided under the Medicaid state plan; coverage provided under a Medicaid 1115 demonstration waiver; benchmark coverage plus additional coverage; existing comprehensive state-based coverage; or coverage substantially equivalent to, or greater than, coverage under a benchmark plan.

This type of program allows states to offer SCHIP enrollees commercially-oriented products without Title XIX requirements such as EPSDT or compliance with the Title XIX managed care regulations. Many states implement this program by mirroring the State Employee Health Benefit Plan, which allows for some economies in scale by pooling enrollment and using current administrative processes such as contracting and competitive bidding between plans.

### ***Authority***

A SCHIP is a program for which a state receives a Federal funding allotment under an approved plan that meets the requirements of Title XXI. A SCHIP does not create an entitlement for individuals meeting eligibility requirements, and thus, waiting lists, enrollment caps, open enrollment periods or other limitations are available to assist the State to balance financing the program with available Federal funds. To implement this recommendation, the State would need to apply for a SCHIP SPA. A SCHIP also allows the State to provide commercial-like benefit coverage and implement premiums and copayments.

### ***Benefits and Limitations***

The following table outlines the benefits and limitations of Option C: Separate Child Health Insurance Plan (SCHIP).

**Table 5: Option C Benefits and Limitations**

Benefits of Option C	Limitations of Option C
<ul style="list-style-type: none"> <li>▪ <b>Flexibility:</b> Allows a state to obtain additional flexibility in administering a Title XXI program by choosing a benefit plan that is not equal to the Medicaid state plan.</li> <li>▪ <b>Cost Sharing:</b> Authority allows the assessment of premiums, enrollment fees and copayments.</li> <li>▪ <b>Appropriate Health Care:</b> Allows for variation of amount, duration and scope of benefits based on a benchmark, benchmark equivalent, or Secretary-approved plan design.</li> <li>▪ <b>Appropriate Utilization:</b> Allows for variation of amount, duration and scope of benefits as long as benefits are at least actuarially equivalent to the benchmark plan.</li> <li>▪ <b>Personal Responsibility and Accountability:</b> Authority allows coverage to resemble private insurance.</li> <li>▪ <b>Fiscal Sustainability:</b> Allows a state to introduce premiums, cost sharing and commercial benefits. However, programs typically pay providers at commercial rates.</li> <li>▪ <b>Review:</b> There is a timeframe in which CMS must review and approve or disapprove a request for a SCHIP SPA. In addition, there is less oversight over contracts in SCHIP. A waiver is not required to operate a managed care program.</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Delivery System:</b> States typically contract with a commercial plan to provide coverage, which provides limited ability to build upon the current Medicaid delivery system without major modifications in the Title XIX or Title XXI system.</li> <li>▪ <b>Coordination with Private Insurers:</b> Due to the crowd-out requirements, it is difficult to coordinate with employer-sponsored insurance or other third-party insurers without a waiver.</li> <li>▪ <b>Administration:</b> Many states must hire additional staff to manage the programs and also need to contract for certain administration services.</li> </ul>

Compared to MCHIPs, SCHIPs are more flexible around benefit design, cost sharing and enrollment limits and also more comparable to private insurance, while MCHIPs must adhere to the same rules as Title XIX programs.<sup>11</sup>

Nebraska may want to consider the creation of an SCHIP benchmark plan if it chooses to implement a more commercially-oriented benefit plan based on one of the statutorily allowed plans. Many states implement this program by mirroring the State Employee Health Benefit Plan, which allows for some economies of scale by pooling enrollment and using current administrative processes such as contracting.

***Other State Experience***

Kansas has implemented a SCHIP utilizing the state employee health benefit plan as a benchmark plan. Kansas contracts with acute care managed care organizations (MCOs), as well as separate mental health and dental MCOs. To address the concern about coordination between Title XIX and SCHIP, Kansas chose to blend the Title XIX program into the SCHIP benchmark program. Because Kansas' benefit plan is predetermined and equal to the Kansas

<sup>11</sup>David Bergman, "Perspectives on Reauthorization Separate Child Health Insurance Program Separate Child Health Insurance Program Directors Weigh In," National Academy for State Health Policy, (June 2005).

Health Employee Benefit Plan, the Kansas SCHIP request for proposal process outlines the services to be provided and requires interested insurers to bid competitively based on rates. If Nebraska followed a similar process to Kansas, the State would be offered competitive pricing and potential savings through a SCHIP benchmark plan.

### ***Impact on Enrollment and Expenditures***

Similar to Option B, the enrollment and expenditure impact associated with this option can be quite varied depending on how the program is designed. To assist policymakers with understanding the range of possible results, Mercer modeled two scenarios for Option C. These two scenarios mirror the Option B scenarios, such that Option C.1 represents moderate premiums and no point-of-service cost sharing, while Option C.2 represents higher premiums and more aggressive point-of-service cost sharing as allowed under the Title XXI regulations. Both scenarios are based on the benefits covered under the State Employee Health Benefit Plan and represent service delivery provided by a private health plan that pays providers at commercial reimbursement levels. See Appendix G for the benefit designs and premiums modeled for these scenarios. These impact estimates reflect private health plan participation across the State. To the extent this cannot be achieved, the estimates would require revision. Appendix I includes information on the health insurers currently doing business in Nebraska.

Enrollment effects under an SCHIP design are similar to those illustrated for the MCHIP design with premiums and copayments (Option B), but as SCHIP allows premium application to the enrollees below 150 percent of the FPL, the effect is magnified. For example, the moderate premiums modeled in Option C.1 could produce an enrollment decrease of 4 percent as compared to SFY 2009 projections for the current MCHIP program. The higher premiums used for Option C.2 could result in 9 percent fewer children covered under the program.

However, despite the lower projected enrollment levels and the premium revenue available to offset expenditures, the scenarios in Option C do not appear to provide major budgetary savings opportunities for the State. Cost reductions associated with lower enrollment, premium revenue and point-of-service cost sharing are offset by the considerably higher provider reimbursement levels and administration loads in the commercial health insurance environment. Option C.1, which has no copayments and moderate premiums, is projected to increase the State share of MCHIP expenditures by almost 23 percent (\$3.3 million for SFY 2009). Under Option C.2, the State share of program expenditures could be reduced by \$175,000 (-1.2 percent). As noted earlier, this savings is achieved by covering 9% fewer children at more aggressive premium and copayment levels. Additional State administrative costs could be approximately \$600,000 annually.

### ***Implementation Considerations and Timing***

The implementation of Option C would require a Title XXI SPA to modify the existing MCHIP program into an SCHIP program. The Kansas SPA could serve as an example for State staff to make this modification. Based on the following implementation process, it is anticipated this option will take 24 to 36 months to implement.

- Writing of SPA estimated at 3 to 6 months
- CMS approval process allows for 3 full 90-day review periods
- Competitively bid procurement process including writing contracts and procuring for health insurers estimated at 9 to 12 months

Option C is operated under a SCHIP. Because LB 1063 mandated implementation of a Medicaid expansion MCHIP program, legislation is necessary to implement this option. The process to change statutory authority will likely add 6 to 9 months to the implementation timing. Resources on a statewide basis would be required to assist with enrollee education and any community/media information needs. However, the information associated with this program could be limited if only one plan is available statewide and because SCHIP does not require beneficiary choice. Much of the new administration associated with this program would be performed by the contracted health plans although Nebraska SCHIP staff would need to oversee the new plan option. The administration cost estimates include a statewide budget equal to 25 percent of the per member per month amount for the current community health nursing/enrollment broker function for the managed care program in Douglas, Sarpy and Lancaster counties in addition to the current administration already required for Medicaid and MCHIP. Administration costs also reflect the costs for an additional FTE to support the program and an amount for an actuarial contract.

Under this option, most system administration would be provided by the health plans. The State would need to be able to provide capitation payments to the health plans and collect their encounter data. The State currently has the capabilities from the administration of the managed care program to conduct these activities. It is expected the current MMIS and the planned MMIS for 2011 will be able to accommodate this option with minimal system changes.



## Appendix A

# Nebraska's Medicaid Programs

## MCHIP Program Summary

Implemented in two phases, Nebraska's MCHIP program provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 185 percent of the FPL. Phase I of the MCHIP, implemented May 1, 1998, expanded Title XIX eligibility for children age 15 through 18, to 100 percent of the FPL. Phase II, implemented September 1, 1998, was a Title XXI expansion of the Medicaid program, raising income eligibility for uninsured children, from birth through age 18, to 185 percent of the FPL. In expanding through a MCHIP, Nebraska was able to use the same delivery system, benefit plan, provider network, payment levels and MMIS as the Nebraska Title XIX Program.

With the implementation of MCHIP, Nebraska adopted the name MCHIP and began an aggressive outreach plan to enroll uninsured children into the MCHIP program. The re-naming of Title XIX for children under age 19 to MCHIP was an intentional effort by the DHHS to remove the stigma of the Title XIX program being associated with welfare programs, and may also have had a positive impact on the number of families applying.

Under Title XXI, CMS encouraged states to implement changes to reduce barriers to enrollment for children in state medical programs including presumptive eligibility for children, reducing documentation requirements, eliminating asset requirements and allowing 12-month continuous eligibility. Nebraska adopted these changes for both the MCHIP and Title XIX programs for children with the implementation of the MCHIP program. Nebraska's Legislature reduced 12-month continuous eligibility for children to 6-month continuous eligibility upon initial eligibility, with month-to-month eligibility after the initial 6-month period, in a special Legislative session. Presumptive eligibility for children was then eliminated in the following Legislative session.

To streamline the process, the Nebraska application for MCHIP and Title XIX was reduced from an 11-page form to a 1-page form, front and back. The application was revised to include brochure information and was created in color as a marketing tool for the program.

For MCHIP eligibility, a child must be a resident of Nebraska, under 19 years of age, not covered by health insurance (including Title XIX) and a US national, citizen, legal alien or permanent resident. In addition, the child must meet certain household annual income standards, which vary by age.

Nebraska's Title XIX Medicaid program covers:

- Children under age 1 up to 150 percent of the FPL
- Children ages 1 to 5 up to 133 percent of the FPL
- Children ages 6 to 18 years of age up to 100 percent of the FPL

Nebraska's Title XXI covers children with income over the Medicaid limits up to 185 percent of the FPL. Table 6 provides a summary of income standards for 2007 by family size and percentage of the FPL. There is no resource test for children in the Nebraska MCHIP program.<sup>12</sup> Income eligibility is compared to the family's countable income.

**Table 6: 2007 Poverty Level Guidelines  
(all states except Alaska and Hawaii, including DC)**

Family Size	Percent of Poverty		
	133%	150%	185%
1	\$13,579	\$15,315	\$18,889
2	\$18,208	\$20,535	\$25,327
3	\$22,836	\$25,755	\$31,765
4	\$27,465	\$30,975	\$38,203
5	\$32,093	\$36,195	\$44,641
6	\$36,721	\$41,415	\$51,079
7	\$41,350	\$46,635	\$57,517
8*	\$45,978	\$51,855	\$63,955

\*For family units of more than 8 members, add \$3,480 for each additional member.

MCHIP eligible children are currently not subject to cost sharing in the form of copayments, premiums, deductibles or coinsurance. Children in MCHIP are eligible for all the benefits of the Title XIX program, including EPSDT.

The average number of eligible children in MCHIP on a monthly basis in SFY 2006 was 23,700. The average monthly enrollment of MCHIP eligible children in Nebraska's managed care program was 8,815 in SFY 2006. Table 7 presents Nebraska's average monthly MCHIP eligibility in FFY 2006.

<sup>12</sup> Nebraska MCHIP SPA, p. 22.

**Table 7: MCHIP Monthly Eligibility for FFY 2006**

Month	Count	Month	Count
October 2005	23,740	April 2006	23,527
November 2005	23,936	May 2006	23,411
December 2005	24,097	June 2006	23,194
January 2006	24,155	July 2006	23,099
February 2006	24,106	August 2006	23,145
March 2006	23,922	September 2006	23,499

From FFY 2002-2004, Nebraska's MCHIP program experienced large increases in eligibility and program costs. These increases resulted from a change in income treatment. As a result, 24,000 older children with higher income levels lost Title XIX eligibility and many of those children became eligible for MCHIP. From FFY 2004-2006, costs and eligibility have remained fairly stable, with total expenditures (Federal and State general funds) of \$49,549,579 for MCHIP in FFY 2006. The administrative portion of the FFY 2006 estimate is \$2,814,032 for both the Federal and State portions. While trends from FFY 2004-2005 continued to be high, the trend from FFY 2005-2006 has been flat. The categories with the largest trends include outpatient hospital, dental, therapies (occupational and speech) and laboratory and radiology. The majority of the program expenditures are generated in the 6 to 18 age group. The less than 1 and the 1 to 5 age groups combined account for about 25 percent of total cost, and the overall trend has been negative for these two age groups.

Appendix B includes exhibits summarizing MCHIP expenditures based on medical expenditures from Nebraska's Title XXI CMS 64 Report and administrative expenditures as outlined in the Nebraska Title XXI Annual Report for FFYs 2002 through 2006.

## Nebraska Medicaid Reform

Medicaid expenditures in Nebraska have mirrored the experience of other states. Nebraska's expenditures for Title XIX and MCHIP have increased by 41.9 percent in the last five years. Medicaid and MCHIP consumed 17.2 percent of the Nebraska General Fund appropriations in SFY 2004-2005. In 2005, the State Legislature recognized the necessity for change and mandated Medicaid Reform through LB 709. In 2006, LB 1248 incorporated the reform suggestions into law.

The Medicaid program in Nebraska developed a set of Reform Initiatives, detailed in a final report submitted to the Legislature December 1, 2005. The purpose of Medicaid Reform is long-term savings to Nebraska and fiscal sustainability of all programs, including MCHIP. The bill also required the DHHS to develop recommended alternatives regarding the provision of health care and related services for Medicaid-eligible children under MCHIP, as allowed under Title XIX and Title XXI of the Social Security Act. The study and recommended alternatives shall include, but not be limited to, the organization and administration of Title XXI; the establishment of premiums, copayments, and deductibles; and the establishment of limits on the amount, scope and duration of services offered to program recipients.

## Covered Services

Nebraska's MCHIP provides health care coverage for qualified children age 18 years and younger. The program provides well care for children to help prevent disease, find and treat problems early and maintain good health and development. Regular check-ups include:

- Baby check-ups and immunizations
- Yearly check-ups for school age children, including school and sports physicals
- Immunizations for school age children
- Dental check-ups and dental sealants
- Vision and hearing tests

MCHIP also provides medical care for injuries and illnesses. Treatment includes:

- Doctor's visits
- Medications
- Hospital care
- Lab tests and x-rays
- Dental treatment
- Eyeglasses
- Specialty services for children with disabilities or chronic health conditions
- Mental health and substance abuse assessment and treatment services
- Counseling

Currently there are no cost-sharing requirements for MCHIP enrolled children. If Nebraska chooses to implement cost sharing, including assessment of premiums, Nebraska already has a mechanism for collecting premiums. Nebraska has two eligibility groups for which premiums are collected; individuals receiving Transitional Medicaid Assistance (TMA) with household incomes above 100 percent of the FPL, and Medical Insurance for the Working Disabled. For both groups, the family is billed at the beginning of the month. Premiums must be received by the 21st of the following month. A family is permitted to pay the premiums two to three months in advance.

Currently, all claims for the MCHIP children not enrolled in the capitated HMO are paid through Nebraska's MMIS. A new MMIS is planned for implementation by Nebraska in 2011.

## Summary of Managed Care Program

Nebraska's managed care program was implemented on July 1, 1995. The program utilizes two models, a PCCM network and a HMO, in a designated geographic area. The geographic area includes Douglas, Sarpy and Lancaster counties. These models provide the basic benefit plan of medical/surgical services. Dental services and pharmacy services are carved-out and are reimbursed to providers on a FFS basis by Nebraska.

Enrollment in Nebraska's managed care program is mandatory for specified clients. In both models, the client chooses a primary care physician (PCP) and a managed care plan in the enrollment process. Nebraska contracts with one PCCM network administered by BCBS of Nebraska and one MCO, United Health Care of the Midlands (now an AmeriChoice product), known as ShareAdvantage. The community health nursing contractor/enrollment broker, Access Medicaid, provides enrollment and related activities through an interagency agreement with the Lincoln/Lancaster County Health Department. Of the total SFY 2006 MCHIP enrolled children, on average 8,815 children in Douglas, Sarpy and Lancaster were enrolled in one of the medical/surgical Medicaid managed care plans in a month.

The Nebraska managed care program also provides managed care for mental health and substance abuse (MH/SA) services. Effective January 2002, Nebraska changed the management of the MH/SA component from a capitated/risk model to a non-risk model. The new MH/SA program structure operates under a contract with Nebraska Magellan Behavioral Health (MBH) as a SPCM system under 42 CFR 431.55(c)(1)(ii) and a 1915(b)(1) and 1915(b)(4) waiver. Changes to the programmatic and operational structure were minimal, with the exception of claims payment that became the responsibility of the DHHS. Participation in the MH/SA SPCM is mandatory for specific clients in the medical/surgical program as well as clients with private insurance. Of the total SFY 2006 MCHIP enrolled children, on average 23,700 children were enrolled monthly in the MH/SA managed care plans.

## Nebraska's Medicaid Third Party Liability and HIPP Programs

### ***Third Party Liability (TPL)***

All TPL available to a Title XIX Medicaid member must be utilized for all or part of their medical costs before Medicaid becomes a payer for services. TPL are any individual, entity, or program that is, or may be, contractually or legally liable to pay all or part of the cost of any medical services furnished to a member. Children with TPL of health insurance or group health plan coverage are Federally prohibited from enrolling in the MCHIP. TPL include, but are not limited to:

- Private health and casualty insurance including medical payment provisions of automobile and commercial insurance policies
- Employment-related group health insurance including group health plans defined under section 607(1) of ERISA
- Medicare
- Medical support from non-custodial parents (court or administrative ordered) or other liable third parties who are not insurance carriers
- Excess income/share of cost
- Workers' compensation
- Other Federal programs (unless excluded by statute, such as Indian Health Services programs and Migrant Health programs, Title V and Maternal Child Health Program)
- Any other party contractually or legally liable to pay medical expenses

Through TPL, the private insurer pays first with the member being responsible for payment of premiums. Medicaid is the payer of last resort unless there is a specific Federal statutory provision that permits Medicaid payment prior to the TPL. Medicaid payment is the lower of the provider's usual and customary charge or the Nebraska Medical Assistance Program (NMAP) allowable less all third party payment. When a claim is submitted to NMAP with a payment from TPL, the provider is considered paid in full when payment from the third parties and/or Medicaid equals or exceeds the NMAP allowable amount. The provider may only bill the member for a Medicaid non-covered service, or Medicaid copayments, where applicable, or if the member has received payment from the TPL source.

### ***Health Insurance Premium Payment (HIPP)***

The Nebraska Medical Assistance Program (NMAP) covers payment for health insurance premiums for individuals who are otherwise eligible for Title XIX when determined to be cost effective. The State does not have a similar provision to cover health insurance premiums for individuals who are otherwise eligible for Title XXI. At the time the State implemented its HIPP, Federal regulation did not allow for the similar treatment of Title XXI individuals with other health care coverage as allowed today.

Cost effectiveness is a determination made by the DHHS that the amount NMAP would pay for premiums, coinsurance, deductibles and other cost-sharing obligations under a health plan, plus an amount for administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services for a client in the same Medicaid eligibility category. Payments under the HIPP program are matched by the Federal government at the regular Title XIX Medicaid match rate. Medicaid pays only up to the amount allowed under the NMAP for services provided to qualified clients. The provider is not permitted to bill the client for the difference between the Medicaid payment and the billed amount.



## Nebraska Title XXI Expenditures

Total Costs

Cost of Approved SCHIP	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006
<b>Medical Service Costs from CMS 64</b>	<b>\$ 16,028,217</b>	<b>\$ 34,045,772</b>	<b>\$ 47,903,003</b>	<b>\$ 46,497,218</b>	<b>\$ 46,735,547</b>
<b>Administration Costs (Title XXI Annual Report)</b>	<b>\$ -</b>				
Personnel	\$ 433,890	\$ 367,710	\$ 267,089	\$ 1,732,838	\$ 1,856,527
General Administration	\$ -	\$ -	\$ -	\$ -	\$ -
Contractors/Brokers (e.g., enrollment contractors)	\$ -	\$ -	\$ -	\$ -	\$ -
Claims Processing	\$ 120,934	\$ 468,290	\$ 835,572	\$ 906,908	\$ 881,199
Outreach/Marketing costs	\$ -	\$ -	\$ -	\$ -	\$ -
Other General administrative overhead	\$ 40,164	\$ 35,779	\$ 57,705	\$ 48,294	\$ 76,306
Health Services Initiatives	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total Administration Costs</b>	<b>\$ 594,988</b>	<b>\$ 871,779</b>	<b>\$ 1,160,366</b>	<b>\$ 2,688,040</b>	<b>\$ 2,814,032</b>
<b>Total Costs of Approved CHIP Plan</b>	<b>\$ 16,623,205</b>	<b>\$ 34,917,551</b>	<b>\$ 49,063,369</b>	<b>\$ 49,185,258</b>	<b>\$ 49,549,579</b>

CMS 64	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFY 2006
Premiums					
Up To 150% - Gross Premiums Paid	\$ -	\$ -	\$ -	\$ -	\$ -
Up To 150% - Cost Sharing Offset	\$ -	\$ -	\$ -	\$ -	\$ -
Over 150% - Gross Premiums Paid	\$ -	\$ -	\$ -	\$ -	\$ -
Over 150% - Cost Sharing Offset	\$ -	\$ -	\$ -	\$ -	\$ -
Medical Services					
Inpatient Hospital Services - Reg. Payments	\$ 2,077,917	\$ 5,297,900	\$ 7,023,234	\$ 5,510,246	\$ 5,615,976
Inpatient Hospital Services - DSH	\$ -	\$ -	\$ -	\$ -	\$ -
Inpatient Mental Health - Reg. Payment	\$ 511,165	\$ 1,360,720	\$ 1,883,042	\$ 2,106,457	\$ 2,196,988
Inpatient Mental Health - DSH	\$ -	\$ -	\$ -	\$ -	\$ -
Nursing Care Services	\$ 35,514	\$ 15,703	\$ 12,506	\$ 35,611	\$ 13,274
Physician/Surgical	\$ 2,139,282	\$ 4,463,120	\$ 5,953,726	\$ 5,913,603	\$ 5,805,151
Outpatient Hospital Services	\$ 1,696,801	\$ 3,222,935	\$ 4,017,742	\$ 4,555,743	\$ 4,939,921
Outpatient Mental Health	\$ -	\$ -	\$ -	\$ -	\$ -
Prescribed Drugs	\$ 2,982,033	\$ 6,796,323	\$ 10,997,228	\$ 9,841,986	\$ 9,889,713
Drug Rebate - National	\$ -	\$ -	\$ (874,298)	\$ (2,659,748)	\$ (2,958,611)
Drug Rebate - State	\$ -	\$ -	\$ -	\$ -	\$ -
Dental Services	\$ 1,921,638	\$ 3,482,238	\$ 3,784,626	\$ 4,515,099	\$ 4,786,587
Vision Services	\$ -	\$ -	\$ -	\$ -	\$ -
Other Practitioners	\$ 663,299	\$ 1,220,324	\$ 1,445,590	\$ 1,518,389	\$ 1,507,154
Clinic Services	\$ 1,236,559	\$ 3,270,842	\$ 6,941,786	\$ 7,164,261	\$ 6,514,989
Therapy Services	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory/Radiological Services	\$ 314,528	\$ 597,347	\$ 706,557	\$ 791,271	\$ 824,810
Medical Equipment	\$ 198,248	\$ 357,319	\$ 578,676	\$ 718,335	\$ 780,755
Family Planning	\$ 16,269	\$ -	\$ -	\$ -	\$ -
Abortions	\$ -	\$ -	\$ -	\$ -	\$ -
Screening Services	\$ 313,511	\$ 705,453	\$ 854,969	\$ 1,052,972	\$ 1,047,231
Home Health	\$ 12,690	\$ 69,524	\$ 277,885	\$ 102,655	\$ 43,970
Medicare Payments	\$ -	\$ -	\$ -	\$ -	\$ -
Home And Community	\$ -	\$ 1,750	\$ -	\$ -	\$ -
Hospice	\$ -	\$ -	\$ -	\$ -	\$ -
Medical Transport	\$ -	\$ -	\$ -	\$ 7,848	\$ 9,163
Case Management	\$ 1,155,563	\$ 1,281,047	\$ 2,577,733	\$ 3,249,918	\$ 3,470,437
Other Services	\$ 753,200	\$ 1,903,227	\$ 1,722,001	\$ 2,072,572	\$ 2,248,039
<b>Total</b>	<b>\$ 16,028,217</b>	<b>\$ 34,045,772</b>	<b>\$ 47,903,003</b>	<b>\$ 46,497,218</b>	<b>\$ 46,735,547</b>





## Appendix C

### Program Design Options

In the Balanced Budget Act of 1997, Congress authorized \$24 billion dollars over a ten-year period in creating the State Children's Health Insurance Program under Title XXI of the Social Security Act. The goal of this program was to assist states in expanding health insurance coverage to over 5 million of the nation's uninsured children. States were given the opportunity to provide health coverage to children in families with incomes higher than those of the Medicaid, or Title XIX, program.

CMS has regulatory authority over Title XXI programs. States are allowed to implement Title XXI as a Medicaid expansion program (MCHIP); a separate, stand-alone program (SCHIP); or as a combination of both program types. Title XXI is jointly financed by the Federal and state governments and is administered by the states. Within broad Federal guidelines each state determines the design of its program, eligibility groups, benefit plans, payment levels for coverage and administrative and operational procedures. Title XXI provides a capped amount of funds to states on a matching basis through FFY 2007. Federal payments to states under Title XXI are based on state expenditures under approved plans effective on or after October 1, 1997. The Federal funds are referred to as "enhanced match", since the Federal match rate is higher in Title XXI than the match rate in Title XIX. Nebraska implemented its Medicaid expansion MCHIP program on September 1, 1998.

In addition to separate funding rules for medical coverage, Title XXI provides specific guidance and limitations regarding allowable administrative costs. Allowable costs include marketing, outreach, staff salaries, printing, data collection, program planning, quality assurance activities, eligibility determination, assessment of the state plan and coordination with other public and/or private entities. Similar to the cap on funding for medical services, in a Title XXI program there is also a 10 percent administrative cap.

While Title XXI is a distinct program from Title XIX, there are required coordination activities regarding eligibility determination. Each child meeting the eligibility criteria for Title XXI must be evaluated for eligibility in the Title XIX children's medical programs before Title XXI eligibility can be granted. Children must be enrolled through the applicable eligibility process defined in each program if the eligibility criteria are met. Therefore, children applying for Title XXI may be found

eligible for Title XIX and would then be enrolled in Title XIX. This requirement is commonly referred to as "screen and enroll". Depending on the program type, Medicaid expansion, stand-alone or combination, the eligibility and enrollment process may vary.

On August 17, 2007, CMS published a "Dear State Health Official" letter targeted to states which extend eligibility under the Title XXI to children in families with effective family income levels above 250 percent of the FPL. States that expand eligibility above an effective level of 250 percent of the FPL must expand the following crowd-out strategies:

- Imposing waiting periods between dropping private coverage and enrollment
- Imposing cost sharing in approximation to the cost of private coverage
- Monitoring health insurance status at the time of application
- Verifying family insurance status through insurance databases
- Preventing employers from changing dependent coverage policies that would favor a shift to public coverage

In addition, the following components must be implemented as part of those strategies:

- The cost sharing requirement under the State Plan compared to the cost sharing required by competing private plans must not be more favorable to the public plan by more than one percent of the family income, unless the public plan's cost sharing is set at the five percent family maximum
- The state must establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage
- Monitoring and verification must include information regarding coverage provided by a non-custodial parent

In addition, CMS will require the state to make the following assurances:

- The state has enrolled at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for either Title XXI or Title XIX (including a description of the steps the state takes to enroll these eligible children)
- The number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period
- The state is current with all reporting requirements in Title XXI and Title XIX and reports data on a monthly basis relating to the crowd-out requirements

Over the last several years, expenditures related to Title XIX and Title XXI have increased considerably and represent a significant portion of most state budgets. As a result, many states have initiated activities to reform Title XIX and/or Title XXI in an effort to ensure fiscal sustainability. In 2007, Congress passed a supplemental budget for Title XXI as many states had exceeded their expenditure cap and would have faced a financial shortfall.

## Title XXI Program Types and Authority Options

States are allowed the flexibility to design their Title XXI program under Federal regulations that fit into one of the following program types:

- Medicaid Expansion Program (MCHIP)
- Separate State Children's Health Insurance Program (SCHIP)
- Combination Program, which includes both MCHIP and SCHIP

In implementing one of the above program types, a state must request statutory authority from CMS. Such authority includes a Title XXI SPA with the option to add an 1115 demonstration waiver, HIPPP/premium assistance program, or options made available under the DRA SPA, as they apply to a Medicaid expansion program. The statutory authority allows states to vary the program design specific to their needs. The following discusses each of the program types identified above in more detail. In addition, Table 10 is included at the end of this appendix which makes comparisons between the program type and authority options available at the time this report was written.

### ***Medicaid Expansion Child Health Insurance Program (MCHIP)***

A Medicaid expansion, or MCHIP, builds on the existing Title XIX program by expanding eligibility to targeted low-income children. Subparts D, E and I of 42 CFR Part 457 (i.e., Title XXI Regulations) do not apply to MCHIP because Title XIX rules govern benefits, cost sharing, program integrity and other provisions included in those subparts. States that elect to implement a MCHIP must submit an approvable Title XXI SPA and amend any portions of the Title XIX state plan necessary (e.g., amending Title XIX eligibility sections for presumptive eligibility determinations of MCHIP children). A MCHIP program creates a Title XIX entitlement for individuals meeting eligibility criteria. As a result, if Title XXI Federal funds are exhausted the program will then revert to Title XIX Federal funding. No waiting lists or other limitations are permitted in a MCHIP.

### ***Separate Child Health Insurance Program (SCHIP)***

SCHIP is a program under which a state receives Federal funding from its Title XXI allotment under an approved plan that provides child health assistance through coverage meeting the requirements of Section 2103 of the Social Security Act. States that elect to implement SCHIP must comply with all the requirements in 42 CFR Part 457, Title XXI Regulations. A SCHIP program does not create an entitlement for individuals meeting eligibility requirements. To the extent a state cannot finance the program due to lack of Federal funding, a state may establish a waiting list or other limitations. This has been an issue for states when the enrollment is greater than anticipated and the financing allotment from the Federal government is exhausted.

SCHIP and MCHIP programs are each defined by different rules and regulations. Generally, SCHIP programs have some flexibility around benefit design, cost sharing and enrollment limits, while MCHIP programs must adhere to the same rules and regulations as a state's Medicaid

program under Title XIX.<sup>13</sup> Under Federal law, a SCHIP program uses one of the following benefit plan options:

- Benchmark Plan
- Benchmark-Equivalent Plan
- Existing Comprehensive State Coverage
- Secretary-Approved Plan

The benchmark plan consists of the FEHBP BCBS standard option (coverage generally available to Federal employees), coverage generally available to state employees, or coverage under a state's HMO with the largest insured commercial, non-Medicaid enrollment. This plan is defined in 42 CFR 457.420.

The benchmark-equivalent plan consists of basic coverage for inpatient and outpatient hospital, surgical and medical physician, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations. A state description must include the amount, duration and scope of each service, as well as any exclusions or limitations. The health benefits coverage must have an aggregate value that is at least actuarially equivalent to the coverage under one of the benchmark plans. An actuarial report certifying that the benefits meet these benchmarks is required, as defined in 42 CFR 457.430.

The existing comprehensive state coverage plan consists of coverage equivalent to state-funded child health programs in Florida, New York or Pennsylvania, as defined in 42 CFR 457.440. These three programs existed prior to the creation of Title XXI and were grandfathered in as allowable plan designs for the states operating the program. These programs may only exist in the states identified and, as such, this report does not address this option.

Finally, the Secretary-Approved plan consists of coverage determined appropriate for targeted low-income children. This is defined in 42 CFR 457.450. Secretary-Approved coverage can include, but is not limited to:

- Coverage provided under the Medicaid state plan
- Coverage provided under a Medicaid 1115 demonstration waiver
- Benchmark coverage plus additional coverage
- Existing comprehensive state-based coverage
- Coverage substantially equivalent to, or greater than, coverage under a benchmark health benefits plan

### ***Combination Program***

A combination program is a program under which a state provides child health assistance through both a MCHIP and SCHIP. States that elect to obtain health benefit coverage through both programs must meet the requirements of each program.

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<sup>13</sup> David Bergman, "Perspectives on Reauthorization SCHIP Directors Weigh In", National Academy for State Health Policy (June 2005).

Table 8 provides a summary of the program types implemented by each state as of 2007. As noted below, 11 states operate a MCHIP, 19 states operate a SCHIP and 20 states operate a combination program.

**Table 8: Summary of Title XXI Program Types**

Type of Program	States
Medicaid Expansion (MCHIP)	Alaska, District of Columbia, Hawaii, Louisiana, Missouri, Nebraska, New Mexico, Ohio, Oklahoma, South Carolina and Wisconsin
Separate Child Health Insurance Program (SCHIP)	Alabama, Arizona, Colorado, Connecticut, Georgia, Kansas, Mississippi, Montana, Nevada, New York, North Carolina, Oregon, Pennsylvania, Texas, Utah, Vermont, Washington, West Virginia and Wyoming
Combination – Separate Child Health Program and Medicaid Expansion (SCHIP and MCHIP)	Arkansas, California, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Maine, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, North Dakota, Rhode Island, South Dakota and Virginia

Source: GAO, NASHP and state websites

Table 9 provides an overview of the number of states implementing each program type since 1998. In 1998, 23 states operated MCHIP programs. Those programs could be implemented quickly and would secure Federal funding. By 2007, 12 of the 23 MCHIP states changed their program type to an SCHIP or a combination program.

**Table 9: Implementation of Title XXI Program Types**

Program Type	1998		2000		2007	
	Number	Percentage	Number	Percentage	Number	Percentage
MCHIP	23	50%	17	34%	11	22%
SCHIP	13	28%	16	32%	19	38%
Combination	10	22%	17	34%	20	40%
<b>Total Number of States (Including DC) with Title XXI Programs</b>	<b>46</b>		<b>50</b>		<b>50</b>	

Source: NASHP and state websites

Appendix D provides a number of state experiences with the various program designs.

### Additional Statutory Authority to Modify Title XXI Programs

Once a state has selected the program type, a state may request additional flexibility to implement a program under various statutory authorities based on programmatic goals. The following discusses the additional statutory authority available under an 1115 demonstration waiver, the DRA and a HIPP program.

## ***1115 Demonstration Waiver***

Section 1115 of the Social Security Act permits the Secretary to waive certain provisions of the Title XIX and Title XXI statutes, in order to modify statutory provisions or to provide Federal matching payments for state costs that would not otherwise be matched. These programs are often referred to as waivers because the Secretary may allow a state to implement a demonstration that “waives” certain statutory requirements in Title XIX or Title XXI. Unlike SPAs, 1115 demonstration waivers allow flexibility from statutory and regulatory requirements to test new and innovative ideas, cover the uninsured and reduce the rate of uninsurance. In addition, under an 1115 demonstration waiver, as under a 1915(b) Waiver, states may enhance access, quality and coordination of care, and provide enrollees a medical home.

CMS will only approve 1115 demonstration waivers that are budget neutral to the Federal government (i.e., With Waiver expenditures are less than or equal to Without Waiver expenditures). Without Waiver Demonstration projections are projections of spending for all services and eligibility groups included in the current Title XIX program (i.e., should only include program components that are already included in the state plan). With Waiver Demonstration projections are projections of enrollment and costs for current and new eligibles and services included in the demonstration. Under a Health Insurance Flexibility and Accountability (HIFA) 1115 demonstration waiver for SCHIP enrollees, expenditures are capped at the Federal financial allotment.

In return for flexibility gained through the 1115 demonstration waiver, a state commits to a policy experiment that can be evaluated within allowed Federal funds. While the Secretary has broad authority to waive Federal requirements, there are limitations. Provisions the Secretary is not allowed to waive under an 1115 demonstration waiver include:

- Services to pregnant women, and children under age 19
- Drug rebate provisions
- Federal Medical Assistance Participation (FMAP) rate
- Title XXI allotments

### ***Health Insurance Flexibility and Accountability (HIFA) 1115 Demonstration Waivers***

In August 2001, the HHS created a new preprint for an 1115 waiver called HIFA to facilitate approval of waivers under Section 1115 authority. HIFA was expressly designed to, among other things, “Give states the programmatic flexibility required to support approaches that increase private health insurance coverage options.”<sup>14</sup> An important element of HIFA is to coordinate Title XXI and Title XIX programs with private and employer-sponsored insurance. HIFA provides greater flexibility for states with respect to cost effectiveness, benefits, and cost sharing in these programs. For example, HIFA permits states to allow beneficiaries to select direct state coverage or employer-sponsored insurance coverage. Also, under a HIFA demonstration in the case of optional Title XXI and Title XIX eligibles, states may allow families

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<sup>14</sup> Neva Kaye, Cynthia Pernice, Ann Cullen, "Charting SCHIP III: An Analysis of the Third Comprehensive Study of State Children's Health Insurance Programs", National Academy of State Health Policy, (September 2006), p. 18.

to enroll in their employer plans and are no longer required to offer wrap-around benefits and cost-sharing protections for these individuals. States also are not required to meet a specific cost effectiveness test for premium assistance programs, such as those required under HIPP. States are typically required to monitor the costs in the premium assistance program to ensure they are not substantially higher than the costs in direct coverage programs.

### ***Deficit Reduction Act (DRA) Provisions***

The DRA allows states to replace the standard Title XIX benefit plan through a new state plan option with benchmark coverage for certain healthy children and adults. In addition to modifying the benefit plan, the DRA changed Federal provisions regarding cost-sharing requirements. Since MCHIP must follow Title XIX cost-sharing requirements, the DRA offered another option for states to consider. Finally, DRA permits the Secretary to authorize 10 demonstrations to implement Health Opportunity Accounts (HOAs). The demonstration program provides annual coverage for medical expenses for items and services which would otherwise be provided, after an annual deductible has been met and contributions into a HOA account as defined under section 1938 of the Social Security Act.

### ***DRA Summary of Benchmark Coverage***

For certain healthy children and adults eligible for Title XIX through a state plan prior to February 8, 2006, a state may require enrollment in alternative benefit plans equal to SCHIP benchmark or benchmark-equivalent plans. In addition, children under age 19 who are covered under a state plan under Section 1902(a)(10)(A) of the Social Security Act must receive wrap-around benefits to the benchmark plan, consisting of EPSDT services defined in Section 1905(r). Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefit plan, these individuals receive the full EPSDT benefit.

Several Medicaid categories of individuals may not be required to enroll in an alternative benefit plan including poverty-level pregnant women, blind and disabled under SSI, Medicare beneficiaries, individuals on hospice or spend-down, foster care or children with special health care needs, and individuals eligible for ADC.

While states are permitted to offer exempt individuals an alternative benefit plan, a state may not require individuals to enroll. In any case where a state offers an individual the option to enroll in an alternative benefit plan, a state must inform the individual that enrollment is voluntary and the individual may opt out of such alternative benefit plan at any time. A state must inform the individual of the benefits available under the alternative benefit plan and provide a comparison of how the benefits differ from those available under the original state plan. A state must document in the eligibility file that the individual was informed and voluntarily chose to enroll in the alternative benefit plan.

### ***Health Insurance Premium Payment (HIPP) and Employer Sponsored Insurance***

There are a variety of means for a state to purchase employer-sponsored insurance for eligible persons when such coverage is available and cost effective or to utilize privately purchased insurance that is liable for medical costs including:

- Health Insurance Premium Payment (HIPP) under Section 1906 of the Social Security Act (Title XIX funds and matching rate)
- TPL under the Medicaid program (Title XIX funds and matching rate)
- Premium assistance programs in SCHIP under the Title XXI state plan, following rules outlined in the Title XXI regulations (Title XXI funds and matching rate)
- Premium assistance program in MCHIP or SCHIP under 1115 demonstration authority. Under 1115 authority the Secretary may waive many of the requirements that premium assistance programs must otherwise meet under HIPP or the Title XXI regulations. For example, states may receive approval under an 1115 authority to implement a premium assistance program that does not offer wrap-around benefits or cost sharing. (The funds and matching rate are negotiated between the state and Federal government. Typically Title XXI funds and matching rate are negotiated).

Under Medicaid through Section 1906 of the Social Security Act, states may enroll Title XIX beneficiaries (including children who would otherwise be Title XXI MCHIP program participants) into a group health plan, otherwise known as a HIPP program. Section 1906 requires that the Title XIX program provide wrap-around benefits and cost sharing to ensure that children enrolled in group coverage continue to receive the full Title XIX benefit plan at no additional cost.<sup>15</sup> These programs use Medicaid funds to purchase employer coverage for eligible persons when such coverage is available and cost effective. All states were required to develop HIPP programs by 1991, but the programs have since become optional.

States may also enroll Title XIX beneficiaries with TPL (including children who would otherwise be Title XXI MCHIP program participants except for their current health insurance coverage even if it is unaffordable or incomplete) in the Medicaid program. The Title XIX program, using Medicaid funding, provides wrap-around benefits and cost sharing to ensure that children with TPL continue to receive the full Title XIX benefit plan at no additional cost.

Title XXI permits states choosing the SCHIP program option to provide child health assistance through premium payments for private health care insurance coverage. The Title XXI regulations define premium assistance programs as a component of a SCHIP, under which a state pays for part, or all, of the SCHIP enrollees' share of premiums for coverage under a group health plan. Enrollees in SCHIP premium assistance programs must receive one of the benchmark or Secretary-Approved benefit plans permitted under SCHIP rules. If the employer's plan does not meet one of these benefit plans, the SCHIP program must provide wrap-around benefits. Also, if the cost-sharing requirements of the employer's plan exceed those allowed under SCHIP in Title XXI, separate programs must offer wrap-around cost sharing. Only children who are uninsured and have not had group coverage for six months can participate.<sup>16</sup>

As indicated above, under 1115 authority the Secretary may waive many of the requirements that premium assistance programs, operating under Section 1906 or under Section 2103(e) of

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<sup>15</sup>"Charting SCHIP III", p. 17

<sup>16</sup> Claudia Williams, "A Snapshot of State Experience Implementing Premium Assistance Programs", The National Academy for State Health Policy, (April, 2003), p.5

Title XXI, must otherwise meet. For example, states may receive approval under a Section 1115 waiver to implement a premium assistance program that does not offer wrap-around benefits or cost sharing. Most states that operate a premium assistance program under a Section 1115 waiver obtained approval for their innovations under the Federal HIFA initiative.

Premium assistance programs under Title XIX and Title XXI must meet specified statutory provisions regarding, cost effectiveness, coverage, benefits, cost sharing, employer-contributions and mandatory enrollment. The Secretary may waive these provisions under a HIFA, using 1115 authority. Table 3 summarizes some of the requirements for HIPP, SCHIP and HIFA premium assistance program characteristics. Since each of these requirements can significantly affect the success of the program, the key issues have been highlighted.

In 2005, nine states reported operating a premium assistance program for MCHIP and/or SCHIP program participants. The states and authority include<sup>17</sup>:

- Louisiana, Rhode Island and Wisconsin under 1906 authority
- Massachusetts, New Jersey and Wisconsin under 1115 non-HIFA waivers
- Idaho, Oregon, Illinois and Virginia under 1115 HIFA waivers

Most of the nine states require children with access to qualified employer-sponsored coverage to join premium assistance programs. However, some states have used Section 1115 waiver authority to establish a premium assistance program that is voluntary for children. This is typical when a state has created a premium assistance program that does not offer supplemental benefits and/or cost sharing, which wrap-around the private coverage to bring that coverage up to the levels provided in the basic SCHIP program.

## Cost Sharing

### ***Title XIX Requirements Prior to DRA for MCHIP***

Section 1902(a)(14) of the Social Security Act permits states to require certain recipients to share some of the costs of Title XIX by imposing payments such as enrollment fees, premiums, deductibles, coinsurance, copayments or similar cost-sharing charges as provided in Section 1916. However, those same provisions prohibited states from imposing deductibles, coinsurance, copayments or similar charges upon children, including MCHIP eligibles. Services furnished to individuals under 18 years of age (or individuals from age 18 to 21, at a state's discretion) were excluded from cost sharing under the state plan. Enrollment fees, premiums or similar charges could also not be charged to categorically needy individuals for any services available under Title XIX. MCHIP eligibles are categorically needy children above the income limits in Title XIX and, as such, rules governing Title XIX cost sharing also apply to MCHIP eligibles.

### ***Cost Sharing under DRA Provisions***

The new provisions in the DRA for cost sharing allow states the ability to charge premiums for certain enrollees (including MCHIP children) with family incomes above 100 percent of the FPL.

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<sup>17</sup> "Charting SCHIP III", p. 18

In addition, states may implement cost sharing up to 20 percent of the cost of the medical service for families with income over 150 percent of the FPL. Copayment limits are set at 10 percent of the cost of the service for enrollees (including MCHIP children) for some individuals with incomes between 100 percent and 150 percent of the FPL. The requirements allow states to vary the amount of premiums and cost sharing imposed by geographic area, type of service, as well as across and within eligibility categories. States are prohibited from imposing premiums and cost sharing on certain groups, including mandatory children and pregnant women. Certain services are also exempt from cost sharing, including preventive services for children, pregnancy-related services and emergency services.

The DRA assists states in ensuring payment of premiums and copayments are enforceable by allowing providers the ability to deny services if cost-sharing requirements are not met, and allowing states to make prepayment of the premium a condition of Medicaid eligibility for non-exempt individuals with incomes above 150 percent of the FPL. Finally, the DRA provides additional options for states to impose cost sharing on non-preferred prescription drugs and inappropriate emergency room use. No groups of beneficiaries are exempt from the cost sharing for non-preferred prescription drugs. Permitted copayments and cost sharing are outlined in 42 CFR 447.50.

### ***Authority to Waive Cost-Sharing Requirements***

As indicated above, states may request an 1115 waiver to permit the imposition of an enrollment fee, premium or similar charge for optional Title XIX eligibles, including MCHIP children. The Secretary may waive requirements regarding cost sharing to impose a deductible, cost sharing, or similar charge when the Secretary finds, after public notice and opportunity for comment, the application met several conditions. However, the Secretary's authority to waive cost-sharing provisions for deductibles, copayments and co-insurance is limited. While there are limits regarding deductibles, copayments and co-insurance, such limitations do not apply to waiver authority to permit the imposition of enrollment fees or premiums. As such, several states have used the 1115 waiver to impose enrollment fees and premiums on MCHIP children.

Under Title XXI SCHIP programs, cost sharing, including premiums, is limited to a cap of 5 percent of family income. This cap is applied to only cost-sharing amounts that can be attributed directly to the child (e.g., copayments for the child's physician visits or prescription drugs) and must be counted against the cap of up to 5 percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as child cost sharing for the purposes of the up to 5 percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap. A state must describe the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to 5 percent of the family's income.

**Table 10: Title XXI Authority Options Comparison**

	MCHIP	MCHIP with HIPP/TPL	MCHIP with 1115	MCHIP with DRA	SCHIP Benchmark	SCHIP Benchmark Equivalent	SCHIP Secretary Approved	SCHIP Benchmark Equivalent with 1115
<b>Uses Medicaid Delivery System</b>	Yes	Yes	Yes	Yes	Not Typical	Not Typical	Not Typical	Not Typical
<b>Uses Medicaid Fee Schedule</b>	Yes	Yes	Yes	Yes	Not Typical	Not Typical	Not Typical	Not Typical
<b>Allows Flexibility of Benefits</b>	No	No	Yes	Yes (except EPSDT)	Yes	Yes	Yes	Yes
<b>Allows Cost Sharing</b>	No	No	Yes	Yes	Yes	Yes	Yes	Yes
<b>Federal Funding After Allotment Exhausted</b>	Yes – Title XIX	Yes – Title XIX	Yes – Title XIX	Yes – Title XIX	No	No	No	No
<b>Entitlement</b>	Yes	Yes	Yes	Yes	No	No	No	No
<b>Allows Title XXI Children with Insurance Into Medicaid</b>	No	Yes	Yes	Yes	No	No	No	No
<b>Matches HIPP Payments by State at Title XXI Rate</b>	Not Applicable	No – Title XIX	Yes	No – Title XIX	No	No	No	No
<b>Medicaid Look-Alike</b>	Yes	Yes	Yes	Yes	No	No	Possible	No
<b>Maintains Administrative Simplicity</b>	Yes	Yes, but additional administration for coordination	No – additional evaluations, reporting and	No – information programming; systems – could pose	No	No	No	No – additional evaluations, reporting and monitoring

**Table 10: Title XXI Authority Options Comparison**

	MCHIP	MCHIP with HIPP/TPL	MCHIP with 1115	MCHIP with DRA	SCHIP Benchmark	SCHIP Benchmark Equivalent	SCHIP Secretary Approved	SCHIP Benchmark Equivalent with 1115
			monitoring	risk to insurance company if contracted out				
<b>Approved by CMS within a Specified Time Period</b>	Yes	Yes	No – prolonged approval typical	Yes – may require additional discussions that prolong approval time	Yes	Yes	No – if public process	No – prolonged approval typical
<b>Allows Enrollment Cap</b>	No	No	No	No	Yes	Yes	Yes	Yes
<b>Mirrors Commercial Market</b>	No	No	No	Similar	Yes	Yes	Yes	Yes
<b>Provider Education Needs Same/Similar to Medicaid</b>	Yes	Yes	No- Differing benefits; Medicaid could potentially change	No- Differing benefits; Medicaid could potentially change	No	No	No	No
<b>Main Objectives</b>	Administrative Simplicity Medicaid Look-Alike	Administrative Simplicity Medicaid Look-Alike	Maximum Flexibility Cutting Edge	Lowest Cost Cutting Edge	Lowest Cost	Budget Stability	Lowest Cost Most Flexible Benefits without 1115	Lowest Cost Cutting Edge Budget Stability

Appendix D

## State Experience with Program Designs

The following outlines several Title XXI program design options available at the time of this report for Nebraska to consider as part of their Medicaid Reform Initiative. While all current available program types and authorities were presented in Appendix C of this report, this appendix focuses on program designs implemented in other states. Fifteen states were selected for this analysis. The states selected are either similar in demographics to Nebraska, have MCHIP programs, or have implemented their Title XXI programs using flexibility available through an 1115 demonstration waiver or the DRA. While Section 3 of this report identifies the recommended alternatives, this appendix provides practical information regarding potential plan designs and case studies that summarize the impact of program implementation in each state. It also presents benefits and limitations that DHHS considered when finalizing recommended alternatives. Below is a summary of the states reviewed:

### Medicaid Expansion Programs (MCHIP)

- Missouri – 1115 Demonstration Waiver
- Wisconsin – HIPP and Premium Assistance
- South Carolina – DRA

### Separate Child Health Programs (SCHIP)

- Kansas – Benchmark Plan
- Utah – Benchmark-Equivalent Plan
- Colorado – Benchmark-Equivalent Plan with Premium Assistance
- Wyoming – Secretary-Approved Plan

### Combination Program

- Arkansas – 1115 Demonstration Waiver and Secretary-Approved Benefit Plan
- Iowa – MCHIP and Benchmark-Equivalent Plan
- Idaho – DRA and Secretary-Approved Benefit Plan

- Illinois – 1115 Demonstration, Premium Assistance (MCHIP) and Benchmark-Equivalent Program
- Indiana – MCHIP and Benchmark-Equivalent Plan
- Kentucky – DRA and Benchmark-Equivalent Plan
- North Dakota – MCHIP and Benchmark-Equivalent Plan
- West Virginia – DRA and Benchmark-Equivalent Plan

In order to ensure sustainability of the Title XXI program, Nebraska must first determine whether a MCHIP program design or a SCHIP program is more suitable to meet their needs. This appendix is divided into two subsections. The first examines the benefits and limitations of various MCHIP programs and the second examines the benefits and limitations of SCHIP programs. Each subsection will outline options other states have adopted within their Title XXI program, including the impact of each option for each state.

For each option identified, this section will identify:

- How the option would be applicable to Nebraska's MCHIP
- The feasibility of implementing the option in Nebraska
- Differences in program authority and regulatory issues related to the state plan and/or SPAs, as well as potential advantages and disadvantages
- The feasibility of revising current management policies
- Specific policy issues to be considered (e.g., limitations on expenditure authority; implications on organizational structure; establishment of premiums, copayments and deductibles; waiting periods; and limitations on amount, duration and scope)

Specific consideration was given to the reform principles identified in Nebraska's Medicaid Reform Plan Report.

- **Appropriate Health Care:** Assist Nebraska residents in accessing appropriate health care services when needed.
- **Appropriate Utilization:** Encourage and enable Nebraska residents to live healthy lives and avoid the utilization of more intensive and more costly health care services.
- **Personal Responsibility and Accountability:** Encourage personal independence, freedom of choice, greater personal and private sector responsibility, accountability for the provision and prudent utilization of health care services.
- **Fiscal Sustainability:** Ensure long-term fiscal sustainability.

## Medicaid Expansion Program

As Nebraska found when first implementing their MCHIP program, there are many benefits to simply expanding eligibility under this program type. First, the delivery system remains the same as the existing Title XIX program. While additional eligibility, program outreach and reporting resources are necessary to accommodate MCHIP, no additional delivery system oversight is necessary. In Nebraska, the mental health, managed care, acute care and long-term care Title

XIX program staff were able to incorporate an additional population group (namely MCHIP) into its program with minimal increases to existing workloads.

Second, Federal funding is maintained if a state exhausts its Title XXI allotment. In a MCHIP program, if the Title XXI allotment is exhausted, the Federal government begins matching Title XXI expenditures at the lower Title XIX rate. Under a SCHIP program, a state must fund shortages with state general funds, establishing waiting lists or capping enrollment. MCHIP is especially advantageous in a state where a strong child advocacy lobby exists, and it is politically difficult in lean budget years to restrict child health care through waiting lists or capping enrollment. It is also advantageous in states where weak child advocacy lobbies exist and there is political difficulty in funding shortages through additional state funding. Third, under a MCHIP, states typically utilize the Title XIX provider network and established FFS fee schedules. These fee schedules are often discounted and result in lower per person expenditures than in SCHIP programs, which often utilize commercial health plans with higher commercial fee schedules. In the states examined, Missouri, Illinois and North Dakota are three examples of states utilizing potentially lower Medicaid fee schedules for their MCHIP populations. In contrast, Iowa's *hawk-i* program and Wyoming's SCHIP program utilized commercial networks with commercial rates.

Despite the advantages of a straightforward MCHIP, states have often complained about the lack of flexibility to design a more streamlined benefit plan, require cost sharing (especially of higher-income children) and coordinate with private insurance. Several states have been able to implement these flexibilities and still take advantage of a streamlined delivery system and the availability of Federal funding once the MCHIP allotment is exhausted through the use of demonstration waivers, HIPP authority and options available under the DRA.

### ***1115 Demonstration Waiver Authority to Operate a MCHIP Program***

Under MCHIP, a state must follow the requirements of their Title XIX program with respect to eligibility, coverage and cost sharing. Therefore, many of the inherent flexibilities attributable to a SCHIP program do not apply. In order to obtain such flexibility under a MCHIP, states have sought an 1115 demonstration waiver. Missouri operates their MCHIP program under an 1115 demonstration waiver, which provides authority to modify the Title XIX benefits offered to MCHIP enrollees and impose premiums. Until recently, Missouri imposed copayments on MCHIP children. This enabled Missouri to continue utilizing the Title XIX delivery system while creating a benefit plan more closely resembling the State Employee Health Plan in both benefit design and cost sharing.

Missouri's legislature supported this initiative because the benefit plan resembled private insurance and required higher income families to assist in funding their child's health insurance. Although the administration of the program has been simplified through the use of the Title XIX delivery system, there are other administrative tasks required to manage the waiver. See Appendix E for more information on Missouri and other MCHIP states.

Historically, research indicated that increasing public premiums reduces the insurance coverage of children. In addition, requiring or increasing copayments, especially on well-child visits,

reduces access to preventive care.<sup>18</sup> Through this program, Missouri has found the same to be true; that as premiums increase, enrollment decreases.<sup>19</sup> More recent studies continue to support these older findings. One study in particular found that raising public premiums reduces enrollment in public programs because some children maintain private coverage and others become uninsured. The latest results continue to indicate that public premiums have larger effects when applied to lower-income families<sup>20</sup>.

Should Nebraska choose to establish premiums, a closer examination of Missouri's reliance on the State Employee Health Plan premiums may be beneficial. Each July, Missouri updates the premium amount charged to MCHIP enrollees to equal the amount charged by the Missouri Consolidated Health Care Plan. Missouri has established an affordable insurance standard equal to 9 percent of the median income level for a family of 3, which varies by income level. In addition, Missouri applies the MCHIP cost-sharing limits and caps total cost sharing for MCHIP children at 5 percent of the family's income.

Additionally, Nebraska may want to duplicate some of Missouri's policies which have reduced the burden on providers. Similar to Title XIX, MCHIP providers are required to collect copayments from the enrollees at the time of service. Historically, the provider was still required to serve the enrollee, regardless of whether or not the enrollee paid the copayment. Missouri disenrolled children for a pattern of failure to pay the copayments. In the past year, Missouri has modified the cost-sharing design by eliminating copayments and restructuring premiums. The premiums are based solely on a sliding-scale for children with an income level of 151 through 300 percent of the FPL. As a result, individual providers are not penalized for an enrollee's failure to pay copayments.

Nebraska could apply for similar waivers under an 1115 demonstration and modify the benefit plan to more closely mirror the State Employee Health Plan. Additional state administration funds would be required to develop the demonstration application, to support demonstration evaluations and to increase staffing to monitor and report on the demonstration. Nebraska may also want to consider looking at Missouri's experience with copayments and working with

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<sup>18</sup> The HIE project was started in 1971 and funded by the Department of Health, Education, and Welfare (now the Department of Health and Human Services). It was a 15-year, multimillion-dollar effort that to this day remains the largest health policy study in U.S. history. The study's conclusions encouraged the restructuring of private insurance and helped increase the stature of managed care. A summary of the major findings of the RAND Health Insurance Experiment can be found in the publication at: Robert H. Brook, Emmett B. Keeler, Kathleen N. Lohr, Joseph P. Newhouse, John E. Ware, William H. Rogers, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Patricia Camp, Caren Kamberg, Arleen Leibowitz, Joan Keeseey, David Reboussin, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate—2006", [http://www.rand.org/pubs/research\\_briefs/RB9174/](http://www.rand.org/pubs/research_briefs/RB9174/)

<sup>19</sup> Enrollment at the highest income levels decreased in the Missouri SCHIP program by 10.9 percent after premium increases. Alicia Smith and Associates, LLC, "Evaluation of the Missouri Medicaid 1115 Demonstration Waiver", (August 19, 2004).

<sup>20</sup> Fredric Blavin, Genevieve M. Kenney, Jack Hadley, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003" Inquiry, Volume 43, Number 4 (Winter 2006/2007):, p.345-361. This study uses 2000 to 2004 Current Population Survey data to examine the effects of public premiums on the insurance coverage of children whose family incomes are between 100 percent and 300 percent of the Federal poverty level.

providers to determine if copayments are the most effective manner of requiring higher income families to contribute to the costs of their health care.

### ***1115 HIFA Demonstration Waiver Authority***

A HIFA 1115 demonstration waiver would allow Nebraska the ability to maintain the MCHIP program and gain the flexibility to modify the benefit plan and add premiums and copayments for its MCHIP population. Under a HIFA demonstration, CMS requires states to coordinate with employer-sponsored insurance. Illinois uses its HIFA waiver to offer SCHIP beneficiaries a choice of delivery system. In Illinois, eligibles are offered a premium assistance program (KidCare Rebate) and a more traditional MCHIP program (KidCare Assist). This choice allows Illinois to benefit from employer-sponsored insurance and commercially-oriented health insurance for lower-income children. However, as noted below, the complexity of design has been carefully streamlined and hidden from the consumer.

Nationwide, enrollment in premium assistance programs has generally been low. A recent study found that, with one exception, enrollment constituted less than 1 percent of the relevant eligibility groups in Titles XIX and XXI.<sup>21</sup> The simplicity of the program design is a major factor in determining the participation rate among eligible enrollees. When faced with too many choices, eligible individuals may be overwhelmed with information and choose not to enroll. For example, many argue the Medicare Part D prescription program has been too complex, and as a result participation has suffered.

In contrast, the Illinois All Kids program has been noted as an exception to the current tendency to design a program that is viewed as overly complex by potential enrollees. In its waiver, Illinois has five SCHIP benefit plans with differing enrollment, benefits and cost sharing. In addition, Illinois All Kids has a buy-in program for all children in the state, allowing any uninsured child regardless of income to obtain coverage from the program. The program is marketed as providing insurance to all children in Illinois regardless of income, but with parental contribution according to income. As a result of strategic marketing of the program, and through streamlined applications and points of contact for enrollment, the public has viewed the program as a streamlined insurance option and responded with high numbers of children being enrolled in the program.

By creating a program that is open to all uninsured children regardless of income, the State has been able to clarify the outreach message to families and increase enrollment rates. The participation rules are very broad. The only requirement is that the child is uninsured for 12 months, and the state uses the sliding scale premium to target public subsidies to families with incomes below specific thresholds. The biggest advantage of this simplicity is that enrollment in the program is very high – over 130,000 children in Illinois participated in just the MCHIP-funded portion of the program in 2006. One thing for Nebraska to consider with this program design is being able to duplicate the simplicity of the enrollment messaging while maintaining high enrollment and satisfaction with the program.

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<sup>21</sup> Alker, J. "Premium Assistance: A Look at Recent State Activity", Washington, DC: Kaiser Commission on Medicaid and the Uninsured, (November 2003).

### *Benefits of an 1115 Waiver*

- **Flexibility:** Allows additional flexibility in administering MCHIP and coordinating with employer-sponsored insurance.
- **Premiums and Copayments:** Allows the assessment of premiums, enrollment fees and copayments in excess of statutory limits established in Title XIX and Title XXI, for MCHIP.
- **Appropriate Health Care:** Allows implementation of a benchmark benefit plan in which the amount, duration and scope may be modified to align coverage with appropriate health care needs.
- **Appropriate Utilization:** Allows the benefit plan to emphasize preventive services by modifying the amount, duration and scope of services.
- **Personal Responsibility and Accountability:** Allows variation in amount, duration and scope to ensure that coverage resembles private insurance.
- **Delivery System:** Allows a state to build upon the current Title XIX delivery system.
- **Fiscal Sustainability:** Allows the use of the discounted Title XIX fee schedules while introducing premiums, cost sharing and modified benefits.

### *Limitations of an 1115 Waiver*

- **State Approval:** Some state laws require legislative authority to seek or implement an 1115 waiver, which may delay the reform process.
- **Protracted Review:** There is no required timeframe in which CMS must review and approve or disapprove a request for an 1115 waiver. Therefore, negotiation may be protracted.
- **Innovation:** Waiver approval typically requires an innovative or research component.
- **Administration:** Many states must hire additional staff to manage programs operated under the waiver due to CMS waiver monitoring requirements.

### *Summary*

The 1115 waiver is an option that will provide maximum flexibility in administering the program, and states have often used the authority to reform both Title XIX and MCHIP. Nebraska may want to examine their reform objectives and determine whether or not the objectives can be accomplished through another authority that is easier to obtain and requires less reporting and monitoring, such as a SPA.

### ***Medicaid Expansion with Health Insurance Premium Payment (HIPP) or Premium Assistance Program***

Because children with insurance may not be enrolled a Title XXI program, states must exercise other options for children who have access to cost-effective insurance through their parents or guardians or for children who have limited or partial health insurance. Nebraska could:

- Purchase health insurance available to the child and is cost-effective through the parent's employer through the HIPP program under Section 1906 of the Social Security Act. Section 1906 requires that the Title XIX program provide wrap-around benefits and cost sharing to ensure that children enrolled in group coverage continue to receive the full Title XIX benefit

plan at no additional cost.<sup>22</sup> These programs use Medicaid funds to purchase employer coverage for eligible persons when such coverage is available and cost effective. All states were required to develop HIPP programs by 1991, but the programs have since become optional. (Title XIX funds and matching rate)

- Enroll Title XIX children with TPL in the Medicaid program. The Title XIX program, using Medicaid funding, provides wrap-around benefits and cost sharing to ensure that children with TPL continue to receive the full Title XIX benefit plan at no additional cost.
- Make premium assistance program in Medicaid Expansion Program under 1115 demonstration authority. Under 1115 authority the Secretary may waive many of the requirements that premium assistance programs must otherwise meet under HIPP or the Separate Child Health Insurance Program regulations. For example, states may receive approval under a Section 1115 waiver to implement a premium assistance program that does not offer wrap-around benefits or cost sharing. (The funds and matching rate are negotiated between the State and Federal government. Typically Title XXI funds and matching rate are negotiated).

The state of Wisconsin has been able to expand reliance on private insurance through its HIPP program and its Section 1115 premium assistance program. Under this program design, Wisconsin determines whether it is cost effective to purchase family coverage through its HIPP program using Title XIX dollars or through the Title XXI cost effectiveness test in the 1115 waiver. Wisconsin originally received enhanced match for the entire family with incomes below 100 percent of the FPL if the Title XXI cost effectiveness criterion was met, or for the children if the Title XXI cost effectiveness criterion was not met. With the approval of the MCHIP Section 1115 demonstration, Wisconsin receives enhanced FMAP for all eligible family members above 100 percent of the FPL.

A HIPP program must meet the requirements of HIPP under Section 1906 of the Social Security Act. Since Nebraska already has the authority to operate a HIPP, it may be relatively simple to include this as new option under MCHIP and take advantage of existing TPL. In addition, obtaining an 1115 authority to generate MCHIP funding for families under the Title XXI cost effectiveness criterion may enhance family coverage, save the state money by utilizing private dollars and bridge the gap to private insurance.

One of the drawbacks of the HIPP and premium assistance options is low enrollment in these programs. States with narrow income bands, public coverage for children but not adults, restrictions on the types of employers or coverage that is eligible and implementation of the program only in one segment of the publicly covered population (e.g., in Title XXI, but not Title XIX) have had more modest enrollment or no enrollment growth in their premium assistance and HIPP programs.<sup>23</sup> In Wisconsin, only 109 family applications out of almost 50,000 employer information forms were determined eligible for HIPP. Of the 109 families, only 32 families actually enrolled in the premium assistance program. While there is not one reason cited as being responsible for the low proportion of eligibles in HIPP, the layering of many requirements

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<sup>22</sup>"Charting SCHIP III", p. 17

<sup>23</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 21.

had a powerful impact on reducing enrollment.<sup>24</sup> In an effort to increase enrollment levels, Wisconsin has recently reduced the minimum employer contribution to 40 percent (from 60 percent) and made self-insured employer coverage eligible.

Another reason for this relatively modest enrollment is that many families in public coverage, perhaps more than might be suggested by national data, do not have access to employer coverage. Wisconsin, for instance, was somewhat surprised to learn how few of its applicants had access to employer-sponsored insurance family coverage, even though the state has higher employer-sponsored insurance coverage rates for low-income families than many other states.<sup>25</sup>

### *Benefits of Implementing a Health Insurance Premium Program (HIPP)*

- **Flexibility:** Allows flexibility in administering the MCHIP program.
- **Appropriate Health Care:** Allows variation of amount, duration and scope in modifying the benefit plan to align coverage with appropriate health care.
- **Appropriate Utilization:** Allows variation of amount, duration and scope in modifying the benefit plan to emphasize preventive services.
- **Personal Responsibility and Accountability:** Allows the individual to have choice of health care coverage, and thus, promotes responsibility.
- **Fiscal Sustainability:** Promotes fiscal sustainability because private insurance is only purchased when the insurance is considered cost effective.
- **State Approval:** Requires an amendment to the Title XXI state plan only to reflect the intent to implement a HIPP program for the MCHIP.
- **Administration:** Limits administrative change as it builds upon Nebraska's current HIPP and TPL programs, in which MCHIP children otherwise eligible for MCHIP are enrolled in Title XIX with TPL.

### *Limitations*

- **Protracted Review:** May be a protracted review if a state seeks to implement a premium assistance program under 1115 waiver authority.
- **Matching Rate:** May result in lower Federal match rate if the child is found eligible under Medicaid HIPP criteria and enrolled in Title XIX.

### *Summary*

Nebraska may want to consider implementing a HIPP program similar to Wisconsin or Iowa's program. To the extent Nebraska chooses to maintain a MCHIP program under Title XXI, consideration for implementing this would allow Nebraska to pay premiums for children whose parents have access to employer-sponsored insurance.

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<sup>24</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 21.

<sup>18</sup> Data from the 1999 National Survey of American Families showed that 63 percent of low-income, non-elderly adults were covered by ESI in Wisconsin compared to a national average of 51 percent. "Snapshot of State Experience Implementing Premium Assistance Programs", p.22.

## ***Medicaid Expansion with DRA Options***

With the passage of the DRA in 2005, states have new authority options available to gain flexibility in administering their Title XIX State Plan. While these authorities are specific to the Title XIX State Plan, they may also be targeted to specific groups based on income and eligibility category. Since a MCHIP program must operate under rules applicable to the Title XIX program and offer coverage consistent with the Title XIX state plan, a state could utilize the DRA SPA option to target programmatic changes to the MCHIP population. Under the DRA, the following three options regarding program design merit additional consideration: (1) creation of benchmark plans, (2) implementation of cost-sharing provisions and (3) implementation of HOAs.

The new SPA options available under the DRA would allow Nebraska the ability to modify benefits and implement premiums and copayments on higher income children without an 1115 demonstration waiver. Unlike 1115 demonstration waivers, this option does not require extensive monitoring and additional evaluation of contracts. However, obtaining approval would likely require additional resources. This option also requires extensive re-programming of the Nebraska's MMIS to accommodate different benefit plans that would be reimbursed through FFS, or additional contract oversight if implemented through private health plans.

Another advantage of the DRA option is the ability to require and/or allow more beneficiary responsibility. Examples of recently approved DRA SPAs that emphasized personal responsibility are as follows:

- Idaho's Title XIX reform contained several components, one of them being a new preventive health assistance benefit similar to Kentucky's Get Healthy Benefit. This benefit is designed to encourage tobacco cessation, weight management and current well-child checks and immunizations. MCHIP enrollees can also participate in a Wellness Preventive Health Assistance, which is a mechanism to assist participants with their premium payment obligation. Each participant can earn premium discounts by following preventive protocols.
- West Virginia's Title XIX program used the DRA to require a partnership agreement between the beneficiary and the State in which individuals who agreed to certain goals would be able to obtain additional optional benefits. Upon enrollment, individuals will choose, or be assigned to a medical home and will be counseled in order to obtain and receive appropriate health services. Individuals electing to sign a membership agreement, which focuses on appropriate health and wellness programs and beneficiary, provider and state rights and responsibilities, rewards participation by providing enhanced benefits targeted to the specific health needs of the individual.
- South Carolina's recently approved DRA SPA allows the use of benchmark plans. In addition, CMS approved South Carolina's request to implement a HOA demonstration. Title XIX beneficiaries, including children eligible under the MCHIP, now have the option to voluntarily enroll in a high deductible health plan with a savings account. South Carolina will deposit up to \$1,000 per eligible child in the HOA. Initial implementation is limited to 1,000 beneficiaries, including adults and children, who are Richland County residents. In the initial phase, South Carolina will operate this program on a FFS basis. South Carolina anticipates contracting with an insurer after the initial phase.

Many of the new state initiatives have fairly complex program designs and participation rules. Often the complexity is a result of efforts to target limited resources to specific segments of the uninsured population. In addition, programs become more complex with requirements meant to ensure new public programs do not encourage either employers to cease offering coverage or individuals to drop existing coverage. These participation rules often lead to additional steps in the enrollment process, which can create operational barriers for the target population. Income requirements are a fairly standard condition of eligibility. Eligibility is often also limited to individuals who have been uninsured for a specific period of time and who work for an employer of a certain size that does not currently offer coverage. Many states also require employers to participate by beginning to offer employer coverage where it was previously not available. With so many factors in play, the underlying complexity of the program design can undermine implementation, despite the best efforts to reach out to the eligible population.

Due to the program complexity, states have identified the need to commit additional administrative resources to implement the programs. States have placed specific emphasis on informing individuals of their choice and responsibilities and some have contracted with enrollment brokers. Additionally, these programs often require a significant amount of information systems programming to reflect different benefit plans, and cost-sharing requirements and as such many states contract with managed care plans.

### *Benefits of DRA Options to Modify Benefits and Cost Sharing to Medicaid Expansion*

- **Flexibility:** Allows a state to obtain additional flexibility in administering their MCHIP program by imposing cost sharing and implementing benchmark plans similar to the plans available under SCHIP.
- **Appropriate Health Care:** By allowing implementation of benchmark plans, Nebraska could vary the amount, duration and scope of services covered for MCHIP and modify the benefit plan to align coverage with appropriate health care.
- **Appropriate Utilization:** The use of benchmark benefit plans allows variation of amount, duration and scope compared to Medicaid benefits, for select enrollees. In addition, many states have eliminated cost-sharing provisions for preventive services in order to encourage utilization.
- **Personal Responsibility and Accountability:** Allows the individual to have another choice of health care coverage and thus promotes responsibility.
- **Fiscal Sustainability:** Promotes fiscal sustainability as a state may implement benchmark benefit plans and cost sharing. In addition, HOAs promote choice.
- **Approval:** As a state plan option to implement a benchmark benefit plan or modified cost sharing, CMS is required to approve or disapprove the program within two 90-day review periods, plus an additional 90 days in which a state may respond to a request for additional information.
- **Delivery System:** This option allows a state to build upon the current Title XIX delivery system

## *Limitations of DRA Options to Modify Benefits and Cost Sharing to Medicaid Expansion*

- **Limited Flexibility:** Cost sharing is limited to individuals with higher income limits and, as such, does not apply uniformly to all enrollees.
- **Administration:** Many of these program initiatives require a significant amount of administration and often require additional staff to manage contractors including enrollment brokers.
- **Enrollment:** As a MCHIP, a state could not limit enrollment if it choose to or fiscally could not sustain the program.
- **System Changes:** Extensive system changes are needed to reflect differences in benefit plans or a contract or must manage different benefit plans.
- **Approval:** While HOAs are a new demonstration option under DRA, there is no standard approval time in which CMS must consider a request.

### *Summary*

The DRA provides states with several options to implement provisions similar to a SCHIP program. Most notable is that the benchmark benefit plans a state may adopt mirror the benchmark plans under a SCHIP program. Therefore, it provides substantially similar authority to a SCHIP program. In addition, it provides a state with new options regarding cost-sharing requirements.

In determining whether this option provides sufficient authority to achieve Nebraska's goals, the State may want to consider some of the limitations identified above and whether the administrative authority would be less than creating a SCHIP.

## Separate Child Health Insurance Programs (SCHIP)

Compared to MCHIP programs, SCHIP programs are considered more flexible and more comparable to private insurance. There are several advantages to implementing a SCHIP program instead of a MCHIP program.

First, SCHIP programs may establish separate eligibility rules and establish enrollment caps. In addition, a SCHIP program may limit its own annual contribution, create waiting lists or stop enrollment once the funds budgeted for SCHIP are exhausted. A MCHIP must follow Title XIX eligibility rules regarding income, residency, and disability status, and thus generally cannot limit enrollment.<sup>26</sup> By establishing a SCHIP program there is clear indication that coverage under the program is not an entitlement and provides a state with the opportunity to close off enrollment in tight budget times. While a difficult decision, it provides a state with readily available authority to adjust the program during budget downturns without seeking additional authority from CMS or changing benefits to the entire Title XIX population.

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<sup>26</sup> General Accounting Office (GAO), "States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization", (March 1, 2007), p. 6.

Second, SCHIP programs must use benchmark benefit standards that use specified private or public insurance plans as the basis for coverage. However, Title XIX and; therefore, a MCHIP, must provide coverage of all benefits available to the Title XIX population, including certain services for children. In particular, EPSDT requires states to cover treatments or stabilize conditions diagnosed during routine screenings, regardless of whether the benefit would otherwise be covered under a state's Medicaid program.<sup>27</sup> A SCHIP program does not require coverage of all benefits available under Title XIX.

Third, SCHIP programs may impose limited cost sharing (through premiums, copayments, or enrollment fees) for children in families with incomes above 150 percent of the FPL up to 5 percent of family income annually. Since the Title XIX program did not previously allow cost sharing for children, a MCHIP program under Title XXI would have followed this cost-sharing prohibition.<sup>28</sup>

These advantages of a SCHIP program often outweigh the relative disadvantages. Despite additional administrative requirements, states have utilized the flexibility to design more streamlined benefit plans; to require cost sharing, especially of higher income children, and to coordinate with private insurance. In addition, several states have been able to implement additional flexibilities using demonstration waivers. See Table 7 for a comparison of SCHIP program options to a straightforward MCHIP such as the Nebraska program.

### ***Separate Child Health Insurance Program (SCHIP) – Benchmark Benefit Plan***

Under the SCHIP program benchmark benefit plan, a state may establish a benefit plan equal to the FEHBP BCBS standard option, coverage generally available to state employees or coverage under a state's HMO with the largest insured commercial non-Medicaid enrollment. This type of program allows states to offer SCHIP enrollees commercially oriented products without Title XIX requirements such as EPSDT or compliance with the Title XIX managed care regulations.

Kansas has implemented such a benchmark plan in a SCHIP program utilizing the state employee health benefit plan. Kansas contracts with acute care MCOs, as well as separate mental health and dental MCOs.

To address the concern about coordination between Title XIX and SCHIP, Kansas chose to blend the Title XIX program into the SCHIP benchmark program. In 2001, the Title XIX managed care program was blended with the SCHIP into the HealthWave program to help ensure a seamless product. HealthWave enables families with children who are eligible for SCHIP and Title XIX to have the same health plan and health provider for all family members. The HealthWave program also serves Medicaid-eligible adults and children in the Temporary Assistance to Families (TANF) and Poverty Level Eligible (PLE) programs.

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<sup>27</sup> While coverage of EPSDT is difficult to measure, Federal studies have generally found state efforts to be inadequate. See GAO, "Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services", (July 13, 2001).

<sup>28</sup> As of March 31, 2006, states may impose cost sharing for children whom the state has chosen to cover under Medicaid. 42 U.S.C. § 1396o-1. If a state imposes cost sharing for Medicaid, a Medicaid expansion program for SCHIP-eligible children would follow this rule.

The state of Kansas (Kansas) has strived to create a single health care delivery system that appears seamless to the member through the integration of Title XIX and Title XXI. Through the development of a delivery system of care that more closely resembles commercial health insurance, Kansas has attempted to uncouple healthcare from other welfare programs and reduce the stigma currently associated with Medicaid. In addition, Kansas encourages innovations which enhance the blending of Title XIX and Title XXI into a single program that mirrors commercial health plans.

Kansas also uses a combined simplified, Title XIX and Title XXI SCHIP application/enrollment form and the central clearinghouse, where eligibility is determined for either Title XIX or SCHIP coverage based on income and age level. The benefit of this program design is that Kansas built upon the popularity of its separate standalone program by adding the Title XIX population to its commercially-based program. Although the Title XXI contractors were required to adopt certain Title XIX requirements, the program benefited by pooling the entire population thus increasing the buying power of the program. Another benefit of the streamlined program is the co-location of Title XIX and Title XXI staff facilitates the screen and enroll process.

Finally, because Kansas' benefit plan is predetermined and equal to the Kansas Health Employee Benefit plan, the Kansas HealthWave RFP process outlines the services to be provided and requires interested insurers to bid competitively based on rates. Following a similar process to Kansas, Nebraska would be offered competitive pricing and potential savings under a benchmark SCHIP program.

### *Benefits of a SCHIP Program – Benchmark Benefit Plan*

- **Flexibility:** Allows a state to obtain additional flexibility in administering a SCHIP program by choosing a benefit plan that is not equal to the Medicaid state plan.
- **Premiums and Copayments:** Authority allows the assessment of premiums, enrollment fees and copayments.
- **Persons Responsibility and Accountability:** Authority allows coverage to resemble private insurance.
- **Fiscal Sustainability:** Allows a state to introduce premiums, cost sharing and commercial benefits. However, programs typically pay providers at commercial rates. The standard benefit plan accommodates competitive bidding based on price.
- **Review:** There is a timeframe in which CMS must review and approve or disapprove a request for a SCHIP SPA. In addition, there is less oversight over contracts in SCHIP. A waiver is not required to operate a managed care program.

### *Limitations*

- **Appropriate Health Care:** Does not allow variation of amount, duration and scope from one of the benchmark plans. A state may not modify the benefit plan to align coverage with appropriate health care of children.
- **Appropriate Utilization:** Does not allow variation of amount, duration and scope, a state may not modify the benefit plan to emphasize preventive services.

- **Delivery System:** Under a benchmark plan, states typically contract with a commercial plan to provide coverage which provides limited ability to build upon the current Medicaid delivery system without major modifications in the Title XIX or Title XXI system.
- **Coordination with Private Insurers:** Due to the crowd out requirements, it is difficult to coordinate with employer-sponsored insurance or other third-party insurers without a waiver.
- **Administration:** Many states must hire additional staff to manage the programs and also contract for certain administration services.

## Summary

Nebraska may want to consider the creation of an SCHIP benchmark plan if it chooses to implement a more commercially oriented benefit plan based on one of the statutorily allowed plans. Many states implement this program by mirroring the State Employee Health Plan, which allows for some economies of scale by pooling enrollment and using current administrative processes such as contracting.

### **Separate Child Health Insurance Program (SCHIP) Benchmark-Equivalent Benefit Plan**

As under the benchmark plan, a state may establish an alternative benefit plan under the SCHIP program benchmark-equivalent benefit plan. This benefit plan must include the amount, scope and duration of each service; as well as any exclusions or limitations for basic coverage for inpatient and outpatient hospital, physicians' surgical and medical, laboratory and x-ray, and well-baby and well-child care, including age-appropriate immunizations. It must be actuarially equivalent to the value of the benchmark coverage. This type of program also allows states to offer SCHIP enrollees commercially-oriented products without Medicaid requirements, such as EPSDT, or compliance with the Medicaid managed care regulations. In addition, it allows states to modify the benefit structure to address population needs such as child preventive care. Of the states reviewed in the case study, most states that operate a SCHIP provide benefits through a benchmark-equivalent plan based on the state health employee program.

One of the primary differences between the implementation of the Kansas benchmark plan and the Iowa benchmark-equivalent plan is the contracting process. Rather than requiring competitive price bidding as Kansas does, Iowa has a benchmark-equivalent plan set equal to the Iowa Health Employee Benefit Plan. This allows insurers in Iowa to bid different benefit plans based upon contract rates that are actuarially equivalent to the state employee health benefit plan. This policy results in each of the Iowa *hawk-i* insurer benefit plans to differ from one another. Each time a health plan changes or a health plan benefit plan changes, Iowa must amend its state plan to reflect the changes in the equivalent benefit plan. This time-consuming process might require some additional administrative resources from Nebraska staff and contracted actuaries.

Depending upon its priorities, Nebraska could take advantage of the differences between the Kansas and Iowa SCHIP plan designs. For example, Nebraska would be offered budget stability and flexible benefits under a benchmark-equivalent SCHIP program such as the Iowa proposal where plans bid a benefit plan that is actuarially equivalent to the chosen benchmark plan.

Another contrast to Kansas is that Iowa separates its *hawk-i* program from its Medicaid program and MCHIP expansion. *Hawk-i* provides health care coverage, via contracts with commercial health care plans including indemnity plans, whereas the Title XIX population and MCHIP program provide health insurance through separate Title XIX contracts including a State-administered PCCM program. The advantage of this design is that Iowa's *hawk-i* program is a popular program not publicly perceived to be an entitlement. However, program administration costs are duplicated because managers monitor the *hawk-i* commercial plans separately from the Title XIX program.

All applications are screened for Title XIX eligibility and the presence of health insurance coverage by a contracted third party. The *hawk-i* application is also used as an application for Title XIX benefits. Historically, a number of state eligibility workers have been co-located at the third-party administrator to facilitate this coordination.

Iowa and Colorado have the authority within their state plans to maintain a waiting list if necessary. This is an advantage in tight budget times. This may be necessary since under a SCHIP program because a state is subject to the annual allocation provided. If the allocation is exceeded, a state may be eligible for redistribution of funds from other states. However, in recent years the availability of redistribution funds has been very limited. In May 2007, Congress passed a supplemental appropriation to cover shortfalls in states as the redistribution of funds was insufficient to address their needs.

Similar to Iowa and Wyoming's programs, North Dakota's Title XXI program demonstrates the feasibility of creating a SCHIP program as a method to create a separate benefit plan similar to commercial coverage, including cost sharing requirements, by contracting with an indemnity insurer to cover the services on a FFS basis due to the lack of availability of managed care within the state. The feasibility of this option for Nebraska will be dependent upon the availability of insurers and whether or not such option is cost effective when compared to the current MCHIP program.

North Dakota's addition of cost sharing requires that North Dakota develop a process to ensure cost sharing does not exceed 5 percent of family income. The State appears to have implemented a practical method to monitor this requirement. Like many other states, North Dakota employs the "shoe box" approach in determining whether or not the cost-sharing limit has been met. The family tracks out-of-pocket costs. Once the family submits evidence that they have reached the 5 percent cap, the State notifies providers that no more cost sharing may be charged to the family.

### *Benchmark-Equivalent Benefits*

- **Flexibility:** Allows a state to obtain additional flexibility in administering its SCHIP.
- **Appropriate Health Care:** Allows variation of amount, duration and scope from one of the benchmark plans. A state may modify the benefit plan to align coverage with appropriate health care of children.
- **Appropriate Utilization:** Allows variation of amount, duration and scope. A state may modify the benefit plan to emphasize preventive services.

- **Premiums and Copayments:** Authority allows the assessment of premiums, enrollment fees and copayments.
- **Personal Responsibility and Accountability:** Authority allows variation in amount, duration and scope so that coverage resembles private insurance.
- **Fiscal Sustainability:** Allows a state to introduce premiums, cost sharing and commercial benefits. However, programs typically pay providers at commercial rates.
- **Review:** There is a timeframe in which CMS must review and approve or disapprove a request for a SCHIP SPA. In addition, there is less oversight over contracts in a SCHIP program. A waiver is not required to operate a managed care program.

### *Limitations*

- **Delivery System:** Does not allow a state to build upon the current Title XIX delivery system without major modifications in the Title XIX or Title XXI system.
- **Coordination with Private Insurers:** Does not allow a state to coordinate with employer-sponsored insurance or other TPL.
- **Administration:** Many states must hire additional staff to manage the programs operated under the SCHIP program because the delivery system is often separate from Title XIX.

### *Summary*

Nebraska may want to implement a benchmark-equivalent plan if it chooses to implement a more commercially oriented benefit plan and be able to select the benefits to be included in the coverage. Under this option, Nebraska would have more flexibility in structuring benefits. Nebraska would also be able to benefit financially from budget stability if the State set the actuarial budget standard and allowed plans to bid benefit plans meeting the needs of the children to be covered, as well as the budget standard.

### ***SCHIP Program Benchmark-Equivalent with Premium Assistance***

In the same way a state may use an 1115 demonstration to modify a MCHIP program, a state is able to obtain flexibility from the requirements of the SCHIP program under an 1115 demonstration. Although more flexible than a MCHIP program, under an SCHIP program, a state must still follow the requirements of the Title XXI program with respect to eligibility, coverage and cost sharing. In order to obtain additional flexibility under a SCHIP, states have sought an 1115 waiver. These waivers have been used to implement premium assistance programs utilizing SCHIP funds, such as the program implemented in Colorado or the approval pending in Wyoming.

Unlike Nebraska, Colorado operates their Title XXI program as a SCHIP program under an authority of a HIFA waiver. The SCHIP program provides a state with the ability to create a benchmark-equivalent benefit plan and to assess cost sharing to enrollees. The 1115 HIFA waiver allows Colorado the ability to implement a premium assistance program to children enrolled in the State's SCHIP program. This would not otherwise be possible as Federal law prohibits enrollment of children with other health insurance coverage in a SCHIP program. In addition, operating a premium assistance program can provide for administrative simplification because a state is not required to provide benefits not covered by the health insurance plan.

As indicated with several other SCHIP programs which have been reviewed, the creation of a SCHIP program provides sufficient authority to develop a benefit plan separate from Title XIX and require cost sharing for certain enrollees. If Nebraska wanted to consider implementing a premium assistance program similar to Colorado, it would need authority under an 1115 waiver. Under an 1115 demonstration, such as Colorado's HIFA waiver or the pending Wyoming HIFA waiver, a premium assistance program would be easier to administer because states are not subject to the same cost effectiveness tests as under the HIPP program or to the same requirements for wraparound services, thus simplifying the administration. Colorado's program highlights the need to obtain an 1115 waiver to implement a premium assistance program for a SCHIP program.

### *Benefits*

- **Flexibility:** Allows a state to obtain additional flexibility in administering its SCHIP program and to coordinate with Employer Sponsored Insurance.
- **Appropriate Health Care:** By allowing variation of amount, duration and scope, a state may modify the benefit plan to align coverage with appropriate health care.
- **Appropriate Utilization:** By allowing variation of amount, duration and scope, a state may modify the benefit plan to emphasize preventive services.
- **Personal Responsibility and Accountability:** Allows the individual to have another choice of health care coverage and thus promotes responsibility in addition the coverage resembles private insurance.
- **Fiscal Sustainability:** Promotes fiscal sustainability because private insurance is only purchased when the insurance is considered cost effective.

### *Limitations*

- **Protracted Review:** If a state seeks to implement a premium assistance program under an 1115 waiver authority, there may be a protracted review. There is no required timeframe in which CMS must review and approve or disapprove a request for an 1115 research and demonstration waiver.
- **Matching Rate:** If the child is found eligible under Medicaid HIPP criteria, a state typically enrolls the child in the Medicaid program and obtains the lower match rate.
- **State Approval:** Some states have state laws that require legislative authority in order to seek or implement an 1115 waiver that may delay the reform process.
- **Innovation:** To obtain approval, the waiver typically requires an innovative or research component.
- **Administration:** Many states must hire additional staff to manage the programs operated under the waiver as well manage reporting to CMS due to waiver monitoring requirements.

### *Summary*

Nebraska may want to consider implementing a premium assistance program similar to Colorado's program if it chooses to establish a SCHIP under Title XXI. This would allow the State to pay premiums for children whose parents have access to employer-sponsored

insurance. Nebraska should consider their reform objectives and determine if the objective can be accomplished using a different authority that is easier to obtain and requires less reporting and monitoring such as SPA or a Title XIX program.

### ***SCHIP Program Secretary-Approved Benefit Plan***

Under a Secretary-Approved benefit plan, a state has the most flexibility to establish benefit plans. This type of program also allows states to offer SCHIP enrollees commercially-oriented products without Title XIX requirements, such as EPSDT or compliance with the Medicaid managed care regulations. In addition, it allows states to modify the benefit structure to address population needs such as child preventive care. The benefit plan established must meet one of five criteria: (1) coverage equal to the Medicaid state plan, (2) comprehensive coverage under a Medicaid 1115 waiver demonstration, (3) coverage equal to benchmark coverage plus additional coverage, (4) coverage equal to existing comprehensive state-based coverage and (5) coverage equal to or greater than coverage under a benchmark plan.

Similar to the benchmark benefit plan, the Secretary-Approved benefit plan offers a standard benefit plan typically approved by CMS in advance of procurement. Nebraska could implement this design in order to gain a competitive pricing advantage with a standard plan benefit that varies from the three benchmark plans allowed by CMS (e.g., FEHBP, State Employees Benefit Plan, and HMO with the largest insured commercial non-Medicaid enrollment). If Nebraska wishes to have competitive bidding based on pricing, but does not believe that the three standard benefit plans meet the needs of SCHIP children, then the State may wish to implement a Secretary-Approved benefit plan.

Wyoming's program demonstrates the feasibility of creating a SCHIP program as a method to create a separate benefit plan similar to commercial coverage, including cost-sharing requirements, as a method to control cost and utilization. It is also notable that the SCHIP program is in a state with little managed care and no PCCM program. Wyoming was able to implement some utilization management activities by contracting with an indemnity insurer to cover the services on a FFS basis.

A SCHIP Secretary-Approved benefit plan offers the most flexibility to a state. Rather than being strictly bound to a particular Federal, state or commercial benefit plan, as under the benchmark option; or a particular actuarial budget, as in the benchmark-equivalent option; Nebraska would be allowed more flexibility to select benefits for the SCHIP population as long as CMS approval could be gained.

The downside of this additional flexibility would be if Nebraska was unable to decide upon a particular set of benefits to be offered to SCHIP children. If the public debate on the content of the benefit plan was extended, Nebraska may find itself unable to obtain approval on the plan from CMS or to have a timely competitive procurement. Nebraska may want to limit the discourse on the content of that benefit plan in order to have timely submission of State Plan submissions and procurement processes.

Another advantage of the Secretary-Approved SCHIP option is that, like the benchmark option, Nebraska could select a set of benefits in advance and allow plans to competitively bid the

pre-selected benefits on the basis of price. Nebraska would be offered competitive pricing and potential savings under a Secretary-Approved SCHIP program.

### *Benefits*

- **Flexibility:** Allows a state to obtain additional flexibility in administering its SCHIP program.
- **Appropriate Health Care:** Allows variation of amount, duration and scope from one of the benchmark plans. A state may modify the benefit plan to align coverage with appropriate health care of children.
- **Appropriate Utilization:** Allows variation of amount, duration and scope. A state may modify the benefit plan to emphasize preventive services.
- **Premiums and Copayments:** Authority allows the assessment of premiums, enrollment fees and copayments.
- **Personal Responsibility and Accountability:** Authority allows variation in amount, duration and scope so that coverage resembles private insurance.
- **Fiscal Sustainability:** Allows a state to introduce premiums, cost sharing and commercial benefits. However, programs typically pay providers at commercial rates.
- **Review:** There is a timeframe in which CMS must review and approve or disapprove a request for a SCHIP SPA. In addition, there is less oversight over contracts in a SCHIP. A waiver is not required to operate a managed care program.

### *Limitations*

- **Delivery System:** This option does not allow a state to build upon the current Title XIX delivery system without major modifications in the Title XIX or Title XXI system.
- **Coordination with Private Insurers:** Does not allow a state to coordinate with employer-sponsored insurance or other TPL.
- **Administration:** Many states must hire additional staff to manage the programs operated under the SCHIP program because the delivery system is often separate from Title XIX.
- **Determination of Benefit Plan:** A public process may create opportunities for endless debate over the content of the benefit plan.

### *Summary*

Nebraska may want to implement a Secretary-Approved plan if it chooses to implement a more commercially-oriented benefit plan and wants to be able to select the benefits to be included in the coverage. However, Nebraska may want to limit the discourse on the content of that benefit plan in order to have timely submission of State Plan submissions and procurement processes. Finally, Nebraska would be able to benefit financially from competitive bidding if it set a standard benefit plan in advance of any procurement.

## Overall Financial Impact

The overall financial impact of each program option is often difficult to distinguish as program expenditures are driven by benefits covered, reimbursement methodologies and administrative

cost. While the program components vary significantly, it can be helpful to look at program costs in comparison to other states. When comparing MCHIP program expenditures, the contrasts are very stark. As detailed in Table 11, Nebraska and Kentucky spent the least on a per person basis in annual administrative expenses, at \$22 and \$25 respectively, and more per person in benefit costs when compared to other peer MCHIP states in 2005, excluding North Dakota (for additional detail see Appendix H 2). *Note: Kentucky's DRA reforms were not implemented until July, 2006.*<sup>29</sup> Generally, states with basic MCHIP programs (Iowa, Nebraska and North Dakota, with the exception of Indiana) had the highest per person annual costs.

**Table 11: Comparison of 2005 Annual Per Member (PM) Benefit and Administration costs and Percentage of Net Costs collected in Premiums Compared to Nebraska<sup>30</sup>**

	CHIP	Admin**	% Net Cost Collected in Premiums
Nebraska	\$1,040	\$22	
Idaho	\$896	\$95	
Illinois	\$437	\$52	
Indiana	\$790	\$43	
Iowa	\$1,038	\$52	1.32%
Kentucky	\$1,538	\$25	0.50%
Missouri	\$1,026	\$30	1.79%
North Dakota	\$2,778	\$115	
South Carolina	\$844	\$57	
Wisconsin	\$511	\$47	12.22%

\*\*Administration costs are calculated inclusive of both MCHIP and SCHIP costs for combination states. Wisconsin administration PM includes adults in 1115 in the denominator.

The two states with the lowest benefit cost are Wisconsin and Illinois, which both took full advantage of private health insurance through HIPP and premium assistance programs. In addition, Illinois is noted for having low Medicaid reimbursement under their FFS when compared to the commercial market. However, both states had higher administrative costs per person than Nebraska, Missouri and Kentucky, which relied more on their Medicaid program infrastructure. (Wisconsin also relied extensively on premiums, which offset net benefit costs by 12.22 percent.)

A MCHIP state like Nebraska has favorable per member benefit and administrative costs compared to most SCHIP states, as shown by Table 12. One reason for this is that while MCHIP programs generally offer more expansive benefits and less cost sharing than SCHIP programs,

<sup>29</sup> Like Kentucky, Idaho and South Carolina's Medicaid expansion programs were not implemented prior to this data collection and therefore represent more traditional programs.

<sup>30</sup> Source: 2005 CMS 64.21 and CMS-21 data accessed on August 28, 2007 at [http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02\\_CMS64.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage) and 2005 Enrollment data accessed on August 28, 2007 at <http://www.cms.hhs.gov/NationalSCHIPPpolicy/SCHIPER/list.asp#TopOfPage>

MCHIP programs pay providers using the Medicaid fee schedules, which are typically less than commercial rates. Administration may also be less in MCHIP states utilizing the Medicaid delivery systems than in SCHIP, where states often contract for eligibility reviews and delivery system oversight. Table 12 provides a comparison of per member benefit and administrative costs for SCHIP states evaluated in the case studies.

**Table 12: Comparison of 2005 Per Member SCHIP Benefit and Administration Costs<sup>31</sup>**

	CHIP	SCHIP*	Adult*	Admin**	% Net Cost Collected in Premiums***
Nebraska	\$1,040				
Colorado		\$877	\$877	\$97	
Idaho		\$632	\$632	\$95	
Illinois		\$1,239	\$1,239	\$52	-0.72%
Indiana		\$648		\$43	-9.10%
Iowa		\$1,170		\$52	-3.05%
Kansas		\$1,146		\$108	-2.82%
Kentucky		\$1,110		\$25	-9.40%
North Dakota		\$1,226		\$115	
Utah		\$764		\$47	-1.94%
West Virginia		\$969		\$78	-0.96%
Wyoming		\$1,261		\$67	

\*PMPMs calculated use child and adult enrollment; Adult costs are not separated out to calculate own PMPM

\*\*Administration costs are calculated inclusive of both MCHIP and SCHIP costs for combination states.

\*\*\*Colorado, Idaho, North Dakota, and Wyoming did not report premiums or collections on the CMS.21 in 2005.

Of the eleven SCHIP states evaluated in the case study, five states, Colorado, Idaho, Indiana, Utah and West Virginia, have significantly lower per member annual costs than Nebraska. Colorado, similar to Wisconsin and Illinois, has a premium assistance program and leverages TPL. Idaho has lower costs in its SCHIP than in its MCHIP program, even prior to its DRA Medicaid reforms. Indiana also has lower costs in SCHIP than in MCHIP. Part of this lower cost may be due to extensive reliance on member cost sharing. Although Utah has pushed the envelope in terms of requesting cost sharing, Utah's reported costs do not demonstrate extensive reliance on premiums, as premiums comprise less than 2 percent of total costs. West Virginia's reported costs prior to implementation of DRA were \$969 per member, compared to Nebraska's per member cost of \$1,040.

The implementation of cost sharing alone does not appear to result in fiscal sustainability, as it is possible to have greater cost sharing and still have per member costs that are not substantially less than programs with less reliance on cost sharing. Both Indiana and Kentucky rely

<sup>31</sup> Source: 2005 CMS 64.21 and CMS-21 data accessed on August 28, 2007 at [http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02\\_CMS64.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage) and 2005 Enrollment data accessed on August 28, 2007 at <http://www.cms.hhs.gov/NationalSCHIPPpolicy/SCHIPER/list.asp#TopOfPage>

extensively on premiums, which account for over 9 percent of revenue in their SCHIP programs. However, Kentucky has one of the highest per member costs at \$1,110 per member for its SCHIP program. Furthermore, Kansas, Iowa, North Dakota, Illinois, Wyoming and Arkansas SCHIP programs all permit premiums and/or cost sharing and have higher per person costs than the existing Nebraska MCHIP program, which does not have premiums or cost sharing. This may be partially attributable to higher reimbursement rates paid under SCHIP.

### **Summary**

A single factor such as cost sharing, may not affect the overall per person cost of a SCHIP program. Other factors such as benefit design, whether or not the providers are paid based on a discounted Medicaid fee schedule, and the extent to which a state is able to leverage private insurance appears to impact the overall fiscal sustainability of the SCHIP programs. Examining 2005 data, the most influential factors for overall financial impact appear to be a state's ability to leverage private insurance through HIPP and premium assistance, the ability to utilize the Medicaid discounted fee schedule, and the ability to modify benefits in a cost effective manner.



Appendix E

## Summaries of Various State Programs

### Arkansas

#### ***Program Authority/Design***

The state of Arkansas (Arkansas) was approved to implement a Medicaid expansion program under Title XXI on October 1, 1998. The program is administered by the Division of Medical Services, the single state agency responsible for administering the Medicaid program and covered children at or below 100 percent of the FPL. Prior to the submission of the SPA for SCHIP, CMS had approved Arkansas' request for an 1115 waiver, called ARKids B, to cover uninsured children through age 18 with family incomes up to 200 percent of the FPL that did not qualify for Medicaid. CMS allowed Arkansas to claim the enhanced match for children enrolled in ARKids B.

On December 4, 1998, Arkansas submitted an amendment to create a SCHIP program. The goal of creating the SCHIP program was so that Arkansas could transfer enrollees in ARKids B. While approved, CMS would not permit the transfer due to the cost-sharing requirements. As such, Arkansas did not transfer enrollment. Then, on April 2, 2004, Arkansas added coverage for unborn children with family incomes up to 200 percent of the FPL under the SCHIP program.

Arkansas operates a delivery system that is seamless to the enrollees. The Medicaid PCCM program, ConnectCare, is the delivery system used to provide service to all enrollees, including both ARKids B enrolled under the 1115 demonstration and the unborn eligible expansion children. Children in the SCHIP expansion receive the same benefit plan provided to the ARKids B enrollees under the demonstration.

CMS approved Arkansas' request for a HIFA 1115 waiver on March 3, 2006, with an implementation date of October 1, 2006, entitled Arkansas Safety Net Benefit Program. Under the waiver Arkansas intended to transition all enrollees participating in the ConnectCare program to the demonstration and expand coverage to up to 50,000 uninsured individuals who have a family income of up to 200 percent of the FPL over a 5 year period. Expenditures for

parents and caretaker relatives will be provided with the enhanced match, and childless adults will be covered under Title XIX at the regular match rate.

### **Cost Sharing**

Children in the SCHIP expansion and the ARKids B are subject to the same cost-sharing requirements as follows:

- \$5 per prescription
- \$10 per office visit, excluding preventive visits
- 20% of the Medicaid allowed amount for durable medical equipment
- 20% of the Medicaid per diem for the first inpatient day

There are no premiums or separate enrollment fees, and copayments do not apply to unborn children.

### **Program Size**

At the end of the first Federal fiscal quarter in FFY 2006, there were a total of 1,265 children enrolled in the SCHIP program. Arkansas did not report enrollment figures in the Medicaid expansion group.<sup>32</sup> However, their 1115 demonstration application in 2005 reported that enrollment was approximately 70,000. In the FFY 2006 Title XXI Annual Report, Arkansas projected FFY 2007 expenditures would be \$60,709,988 with administrative costs of \$6,548,256. The Title XXI allotment for FFY 2007 is \$34,154,500, and the enhanced Federal matching rate for FFY 2007 expenditures is 81 percent.

## Colorado

### **Program Authority/Design**

The state of Colorado (Colorado) was approved to implement a SCHIP program under Title XXI on April 22, 1998. The program was named Child Health Plan + (CHP+) and built upon an existing state-only program that provided basic medical services to children. The Department of Health Care Policy and Financing is responsible for administering the program and subcontracts for provider network administration, enrollment, outreach and customer service. Initially, Colorado covered children under the age of 17 at or below 185 percent of the FPL. In 2005, it raised the upper eligibility limit for children covered under the state plan from 185 percent to 200 percent of the FPL.

Since its inception, Colorado has submitted six amendments to their state plan as follows:

- On January 19, 1999, Colorado submitted its first amendment to extend coverage to children under the age of 18 at or below 185 percent of the FPL. CMS granted a retroactive approval date back to the implementation of the program.

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<sup>32</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

- On December 20, 2000, Colorado submitted its second amendment to eliminate premiums and implement an annual enrollment fee for families with incomes between 151 percent and 185 percent of the FPL.
- Then on December 27, 2000, Colorado submitted its third amendment to change its application process and delivery system.
- On June 28, 2002, Colorado submitted its fourth amendment which indicated compliance with the new Title XXI regulations and added a dental benefit.
- On December 10, 2003, Colorado submitted its fifth amendment to eliminate an enrollment freeze as state funds became available.
- Finally on September 27, 2005, Colorado submitted its sixth amendment request to raise the income criteria to 200 percent of the FPL.

As a SCHIP program, Colorado uses a benchmark-equivalent benefit plan. The benefit plan includes inpatient services, outpatient services, physician services, surgical services, dental services, vision services, prescription drugs, lab and radiology services, prenatal care and family planning services, inpatient and outpatient mental health services, outpatient substance abuse treatment services, durable medical equipment, home and community-based health care, case management services, physical and occupational therapy, hospice care, medical transportation, organ transplant and skilled nursing facility care.

Colorado contracts with managed care plans, where available, to provide services to SCHIP enrollees. Under State law (House Bill 97-1304), Colorado may only contract with a managed care plan that is also willing to contract for Medicaid. This is done in an effort to reduce potential disruption in service when the child loses eligibility under one program and transfers to another program. In areas of Colorado where there is no contracted managed care plan, the FFS network developed by the original Child Health Plan which was originally contracted with the University of Colorado Health Sciences Center is used. In 1999, Colorado contracted with an entity to manage all aspects of the network. The network provides services to both Title XIX and Title XXI enrollees while the child is in the FFS system. Under Title XXI, this is typically limited to the period from eligibility to enrollment in a plan.

Colorado uses a single application for both Medicaid and CHP+. The Department of Health Care Policy and Financing is responsible for eligibility reviews and screens for Medicaid eligibility prior to assessing eligibility for Title XXI. Children with creditable coverage who are eligible for Medicaid are ineligible for the program. In addition, to prevent crowd-out, Colorado imposes a 3-month waiting period if the child was covered by an employer plan within the prior 3 months and the employer paid 50 percent or more of their premium. A child determined eligible for CHP+ receives 12 months of continuous coverage until the child turns 19, moves from the state, becomes eligible for Medicaid or obtains private health insurance coverage.

In addition to the state plan authority for Title XXI, Colorado was approved for an 1115 HIFA waiver on September 27, 2002, which was renewed on February 27, 2006, through September 20, 2009. The waiver originally extended coverage to pregnant women with incomes up to 185 percent of the FPL. As part of the renewal of the HIFA waiver, Colorado implemented a premium assistance program for families who choose to voluntarily enroll their children in employer-

sponsored insurance coverage and expanded coverage to pregnant women up to 200 percent of the FPL.

### ***Cost Sharing***

In December 2000, Colorado submitted a SPA to eliminate premiums and implement an annual enrollment fee for families with incomes between 151 percent and 185 percent of the FPL. The annual enrollment fee for one child is \$25 and \$35 for two or more children. In addition to the annual fee, all enrollees are required to pay copayments for select services. The copayments are staggered based on income and waived for select preventive services. Specific copayment requirements are as follows:

For a family with an income at or below 150 percent of the FPL, the following copayments apply:

- \$2 per office visit
- \$2 per outpatient mental health or substance abuse visit
- \$1 per prescription
- \$2 per physical, speech or occupational therapy visit
- \$2 per vision visit
- \$3 per emergency visit and urgent/after-hours visit

For a family with an income above 150 percent of the FPL, but below 185 percent of the FPL, the following copayments apply:

- \$5 per office visit
- \$5 per outpatient mental health or substance abuse visit
- \$3 per generic prescription
- \$5 per physical, speech or occupational therapy visit
- \$5 per vision visit
- \$15 per emergency visit and urgent/after-hours visit

Copayments do not apply to select preventive services such as newborn screens, inpatient visits, routine examinations, laboratory tests and immunizations. As required under Title XXI, total cost sharing cannot exceed 5 percent of the family's annual income. Like many other states, Colorado employs the "shoe box" approach to determine whether or not the cost-sharing limit has been met. Once the family submits evidence that they have reached the 5 percent cap, Colorado issues a "copayment exempt" sticker that can be placed on their member card.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were 44,900 children enrolled in CHP+. The Title XXI allotment for FFY 2007 is \$71,544,798, and the enhanced Federal matching rate for expenditures is 65 percent. Projected administrative expenses were \$4.5 million of which \$635,829 represented personnel costs, \$1 million represented outreach

expenses, \$961,552 represented expenditures for an enrollment broker and \$1.8 million represented systems changes.

## Idaho

### ***Program Authority/Design***

The State of Idaho (Idaho) was approved to implement a Title XXI state plan to expand Medicaid coverage to optional targeted low-income children on June 15, 1998. The program is administered by the Medicaid Agency. The program initially covered children who are under age 19 with a family income at or below 160 percent of the FPL. The program was later modified to add a SCHIP program with a Secretary-Approved benefit plan for children up to 185 percent of the FPL. In the amendment related to Idaho's new DRA SPA, premiums and copayments are now charged to higher income enrollees enrolled in the Basic Benchmark Benefit Plan but not to special needs children enrolled in the Enhanced Benchmark Benefit Plan.

Since the original implementation of the program, Idaho has submitted eight Title XXI SPAs.

- On October 13, 1998, Idaho submitted an amendment to its approved Title XXI plan to lower the income eligibility standards from incomes through 160 percent of the FPL to incomes through 150 percent of the FPL, retroactive to July 1, 1998. This change was mandated by the Idaho Legislature, and Idaho discussed this change in its original Title XXI plan proposal.
- On March 21, 2000, Idaho submitted an amendment to its Title XXI plan to implement program design changes to increase coordination of efforts across agencies, simplify the application, and improve media and outreach approaches.
- Idaho's third amendment updated the Title XXI state plan to comply with Federal regulations.
- On February 25, 2004, Idaho submitted an amendment to create a SCHIP program (CHIP B), to expand coverage to children with family incomes over 150 percent through 185 percent of the FPL.
- On August 30, 2004, Idaho submitted its fifth Title XXI SPA, and subsequently revised it on December 1, 2004, to request Secretary approval for a new benefit plan for Idaho's SCHIP program, CHIP B. The amendment specifically:
  - Removed the 20-day limit on coverage of outpatient mental health services
  - Limited coverage of inpatient mental health services to 30 days per year
  - Eliminated coverage for dental services, except for emergency dental
  - Eliminated coverage for durable medical equipment
  - Limited coverage of therapy services (i.e., physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders) to only those services provided by a hospital
- On June 9, 2005, the sixth amendment was submitted to remove the enrollment cap on the CHIP B and changes the consequences for delinquent CHIP B premium payments from a family losing eligibility for one year, with the debt forgiven, to a family losing eligibility until the debt is paid in full.

- On April 28, 2006, the seventh amendment was submitted to implement a school-based health service initiative for low-income children as allowed under the 10 percent administrative cap of SCHIP. Grants will be made to school districts to assist with the salary expenses of registered nurses working in schools. Services provided will include health counseling and education, health screenings, prevention services, health coordination, referral to care outside of school and application assistance leading to enrollment in Title XIX and Title XXI health coverage programs.
- In April 2006, Idaho submitted a Section 1115 waiver to CMS.<sup>33</sup> In response to a recommendation from CMS, Idaho tabled waiver activities and made changes using the SPA process under DRA authority.
- On May 5, 2006, Idaho submitted its eighth amendment. This amendment changes the lower income eligibility level for the SCHIP program for children from birth through 18 years from 150 percent of the FPL to above 133 percent of the FPL, yielding a revised income eligibility standard of above 133 percent of the FPL through 185 percent of the FPL. This amendment also limits enrollment in the State's Title XXI Medicaid expansion program to children ages 6 through 18 years with family income above 100 percent of the FPL through 133 percent of the FPL. The amendment removes the resource limits related to program eligibility and imposes premiums for children with family income above 133 percent of the FPL. Enrollees in the Basic Benchmark Benefit Plan with higher family incomes are subject to premiums. Enrollees in the Enhanced Benchmark Benefit Plan are not subject to premiums. This amendment also changes the current benefit plan to a Secretary-Approved plan, entitled the Basic Benchmark Benefit Plan or an Enhanced Benchmark Benefit Plan, for children with special health care needs.

Idaho utilizes its current Medicaid delivery system to provide services to Title XXI enrollees. The delivery system is a PCCM model. Idaho uses a single application for Title XIX and SCHIP, and children are first evaluated for Title XIX. A child who is eligible for Title XIX is ineligible for SCHIP and enrolled in the Title XIX program.

Idaho requires a 6-month period of uninsurance for Title XXI. The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance will be made if the applicant lost private insurance through no fault of their own (i.e., employer driven) or due to hardship. In addition, substitution of coverage under MCHIP is monitored by tracking the number of eligibility denials due to having creditable insurance.

In 2006, CMS approved several parts of Idaho's reform proposal through a DRA SPA and the eighth Title XXI SPA noted above. Additional components of Idaho's reform are pending additional interpretation of the DRA. Idaho is enrolling the Title XIX and Title XXI populations into three major benefit plans using the Secretary-Approved benchmark-benefit option in the DRA:

- **Medicaid Basic Plan:** For low-income children and working-age adults, the Basic Plan covers most primary and acute care services with a few limitations. The Basic Plan does not

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<sup>33</sup> State Coverage Initiatives, a national program of Robert Wood Johnson Foundation administered by Academy Health, "State of the States 2007", (January 2007), at [www.statecoverage.net](http://www.statecoverage.net).

include services not needed by participants with average health needs, such as case management, hospice, or institutional or home and community-based LTC services.

- **Medicaid Enhanced Plan:** For individuals with disabilities or special health needs, the Enhanced Plan covers all the services that were covered under Idaho Medicaid prior to the reform.
- **Medicare-Medicaid Coordinated Plan:** This plan serves elders or those otherwise dually eligible for Title XIX and Medicare who are enrolled in certain Medicare Advantage managed care plans. This plan integrates Title XIX and Medicare benefits to improve access to care. Idaho will pay a capitated rate per enrollee to Medicare Advantage plans for integrated services, Medicare-excluded drugs, and “wrap-around” benefits. The new coordinated plan will be implemented in mid-2007.

SCHIP enrollees will receive one of two benefit plans based on health care needs. Most children will be covered under the Basic Benchmark Benefit Plan. Children with special health needs will be enrolled in the Enhanced Benchmark Benefit Plan. The benefit plan includes well-baby and well-child services, immunizations, emergency services, inpatient and outpatient care, prescription drugs, diagnostic services, vision services and inpatient and outpatient mental health services.

Beginning in July 2006, Title XIX and Title XXI enrollees were placed into the Basic Plan or the Enhanced Plan at their annual re-enrollment. New enrollees will also be placed into one of the new plans. Idaho has three triggers that place an enrollee in the Enhanced Plan or that move an individual from the Basic to the Enhanced Plan:

- Physician diagnosis of special health needs
- Utilization of mental health services up to the limits in the Basic Plan
- Receiving other forms of assistance from the Idaho Department of Health and Welfare or other public assistance, such as Social Security Disability

All enrollees in the Basic and Enhanced Plans receive services through a PCCM program known as Healthy Connections. Idaho’s Medicaid reform includes multiple components in addition to its new benefit plans, including a new “preventive health assistance” benefit similar to Kentucky’s Get Healthy Benefit. This benefit is designed to encourage tobacco cessation, weight management, and current well-child checks and immunizations. Idaho has also implemented a self-directed service model for individuals with disabilities, a pay-for-performance pilot program, new purchasing strategies such as “best price” for supplies and outsourced dental services, a new Healthy Schools program that provides preventive services to all students in school districts with a high percentage of low-income students, and other reforms authorized through a recent SPA.

## ***Cost Sharing***

Premiums are imposed for children with family income above 133 percent of the FPL. Enrollees in the Basic Benchmark Benefit Plan with family incomes above 133 percent of the FPL to 150 percent FPL will be subject to a premium in the amount of \$10 per member per month for medical services and are not subject to a dental premium. Enrollees in the Basic Benchmark

Benefit Plan with family incomes of 150 percent of the FPL through 185 percent of the FPL will be subject to a premium in the amount of \$10 per member per month for medical services and an additional \$5 per member per month for dental services. Enrollees in the Enhanced Benchmark Benefit Plan are not subject to premiums.

SCHIP enrollees can participate in a Wellness Preventive Health Assistance, which is a mechanism to assist participants with their premium payment obligation. Each participant can earn a premium discount by following preventive protocols. Enrollees will be subject to a nominal copayment of \$3 for participants who seek care at a hospital emergency department for a condition that is not an emergency condition and a nominal copayment of \$3 for participants who access emergency transportation for a condition that is not an emergency medical condition.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 11,404 children enrolled in the SCHIP program and 2,375 enrolled in Idaho's MCHIP.<sup>34</sup> In FFY 2006, Idaho reported that 24,727 children were enrolled in its Title XXI program. In the FFY 2006 Title XXI Annual Report, Idaho projected that benefit costs for FFY 2007 would be \$12,337,108 including \$302,091 collected in cost sharing and total administrative costs of \$1,328,548. The Title XXI allotment for FFY 2007 is \$24,316,412, and the enhanced federal matching rate for expenditures is 79.25 percent for FFY 2007.

## Illinois

### ***Program Authority/Design***

On April 1, 1998, the State of Illinois (Illinois) was approved to operate a Title XXI plan to provide extended benefits under Illinois' Medicaid Title XIX program. The program expanded eligibility to children between the ages of 0 and 19 with family incomes above the March 31, 1997, Title XIX eligibility standard and below 133 percent of the FPL. On November 10, 1998, Illinois submitted an amendment to its approved Title XXI plan to create a SCHIP program, KidCare, which expanded coverage to children under 19 years of age with family incomes between 133 percent and 185 percent of the FPL.

Since the original implementation and amendment approval, Illinois has submitted 8 additional amendments and CMS has approved 5 of those amendments. Two amendments were withdrawn. In addition, Illinois has an approved HIFA demonstration with several amendments applicable to the children in KidCare.

- Illinois' second amendment updated the Title XXI state plan to comply with the Federal regulations and eliminated the 3-month waiting period for KidCare Share and Premium applicants.

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<sup>34</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

- On October 13, 2002, Illinois received approval of its third amendment to operate a HIFA waiver, which is the authority for the KidCare Assist and KidCare Rebate programs. Illinois uses its HIFA waiver to offer SCHIP beneficiaries choice of delivery system. In Illinois, children are able to choose between a premium assistance program (KidCare Rebate) and a more traditional MCHIP expansion program (KidCare Assist). This choice allows Illinois to leverage employer-based and commercially-oriented health insurance for lower income children.
- On March 31, 2003, Illinois submitted its fourth amendment to add coverage for unborn children with family incomes at or below 200 percent of the FPL and not eligible for Title XIX. Coverage is under a SCHIP program and will begin at confirmation of pregnancy and continue for 12 months. Benefits will include prenatal care and associated health services for children.
- On June 3, 2003, Illinois submitted its fifth amendment to expand coverage for children enrolled in KidCare Premium by raising the upper income eligibility limit from 185 percent of the FPL to 200 percent of the FPL.
- Illinois submitted its sixth amendment to expand coverage for children with family incomes from 185 percent to 200 percent of the FPL in the KidCare Rebate premium assistance program effective January 16, 2004. In 2004, Illinois also implemented presumptive eligibility for children and a health services initiative to cover the costs for children who appear eligible for KidCare during the period after an application has been submitted but prior to the determination of presumptive eligibility.
- Illinois submitted its seventh amendment on June 29, 2005 to implement a dental varnish program. Illinois withdrew this amendment on February 15, 2007.
- Illinois submitted its eighth amendment on September 1, 2005 to rescind unborn coverage. Illinois withdrew this amendment on February 15, 2007.

Today, KidCare includes five plans including one Title XIX plan, two MCHIP plans and two SCHIP programs under Title XXI. Each plan has varying eligibility and financial responsibility requirements based on the FPL:

- **KidCare Moms and Babies:** Pregnant women and their babies up to age 1 with family incomes at or below 200 percent of the FPL receive benefits with no cost-sharing requirements. This plan is under the Illinois' Title XIX program.
- **KidCare Share:** This plan provides benefits for children with family income between 133 percent and 150 percent of the FPL, who are not covered by KidCare Moms and Babies. The benefit plan is provided through benchmark-equivalent coverage. The coverage is equivalent to the State Employee Health Plan. Families with children enrolled in KidCare Share pay small copayments for services. (SCHIP program)
- **KidCare Premium:** KidCare Premium provides benefits for children with family income above 150 percent and up to 185 percent of the FPL, who are not covered by KidCare Moms and Babies. Like KidCare Share, benefits are provided based on a benchmark-equivalent plan (State Employee Health Plan). Families with children enrolled in KidCare Premium pay modest premiums to the state in addition to small copayments. (SCHIP program)
- **KidCare Rebate:** This plan is available to those with family income above 133 percent up to 185 percent of the FPL whose children are insured. KidCare Rebate reimburses part of the

cost for private health insurance for children under Title XIX under a HIFA 1115 demonstration. (MCHIP with premium assistance HIFA)

- **KidCare Assist:** Children with family income at or below 133 percent of the FPL enroll and receive services through the state's Medicaid Program under Title XIX under a HIFA 1115 demonstration (MCHIP with HIFA).

The Illinois Department of Public Aid administers the program. Children receive health care services through fee for service and prepaid providers included in the current Medicaid Program.

Individuals enrolling in the program are generally given a choice of receiving direct state coverage or receiving premium assistance to purchase coverage from his/her parent's employer if available.

Illinois uses a joint application for all KidCare programs to coordinate between Title XIX and Title XXI. The simplified applications are screened for Title XIX eligibility and the presence of health insurance coverage. If the applicant is not Title XIX eligible, KidCare Share or KidCare Premium eligibility is determined. If the child has health insurance, coverage under KidCare Rebate is determined. Applications are reviewed by local offices and a central processing unit.

The KidCare Rebate Plan serves as a significant "anti-crowd out" strategy. Illinois will monitor the effect of KidCare on private insurers and modify the program if it appears that, because of availability of KidCare Share and KidCare Premium, persons or employers are inappropriately dropping privately funded coverage.

### ***Cost Sharing***

Premiums are not imposed for unborn children or families at or below 150 percent of the FPL. For families between 150 and 185 percent of the FPL (KidCare Premium) with one child, premiums are \$15 per month, with two children \$25 per month, and \$30 per month for three or more children.

A family with an income above 133 percent and below 150 percent of the FPL (KidCare Share) is also required to pay a \$2 copayment for medical visits, prescription drugs and non-emergency use of the emergency room. A family with an income above 150 through 185 percent of the FPL (KidCare Premium) is required to pay a \$5 copayment for medical visits, a \$3 copayment for generic prescriptions and \$5 copayment for brand-name prescriptions and a \$25 copayment for non-emergency use of the emergency room. There is a \$100 annual copayment maximum for all families. Unborn children are exempt from copayments.

Illinois has adopted the "shoe-box" approach to reimburse families who exceed the copayment limit. Under this process, the individual is responsible for keeping track of copayments and submitting documentation to Illinois when the limit is reached. Once Illinois obtains and verifies the information, it updates the medical card to reflect that they have reached the limit. Designations are made in the data systems to reflect the maximum has been met.

## ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 68,684 children enrolled in the Illinois SCHIP program and 68,449 enrolled in its MCHIP program. In FFY 2005, Illinois reported that 316,781 children were enrolled in its SCHIP program.

In the FFY 2006 Title XXI Annual Report, Illinois projected benefit costs for FFY 2007 would be \$257,400,000 including \$9,900,000 in cost sharing and a total administrative enrollment cost of \$14,300,000. The Title XXI allotment for FFY 2007 is \$209,767,107, and the enhanced Federal matching rate for expenditures is 65 percent.

## Indiana

### ***Program Authority/Design***

On April 1, 1998, the State of Indiana (Indiana) was approved to operate a MCHIP expansion program. The program operates under the same name as Indiana's 1915(b) waiver, Hoosier Healthwise. The original program, called Phase I, expanded eligibility to children between the ages of 0 and 19 with family incomes above the March 31, 1997, Title XIX standard and below 133 percent of the FPL. Phase II was submitted on September 22, 1999, to expand health insurance coverage through a SCHIP program. The Phase II amendment provided coverage to children less than 19 years of age in families with annual incomes greater than 150 percent of the FPL and not more than 200 percent of the FPL.

Since the original implementation of the program, Indiana has submitted three additional amendments as follows:

- Indiana submitted its second amendment on September 9, 2002, to update its Title XXI State Plan to indicate compliance with the final Title XXI regulations. This amendment also revised the re-determination process so that children remain eligible as long as they meet income and other eligibility requirements. Eligibility is re-determined at 12 months if Title XXI is the only program the child is enrolled in, or every 3 to 6 months if the child is enrolled in Title XXI plus other State programs.
- Indiana submitted its third amendment on August 24, 2004, to fund clinical messaging software and data repository development for their proposed Information Exchange (IHIE) health services initiative. This amendment was withdrawn on May 30, 2006.
- Indiana submitted its fourth amendment on October 4, 2005, to increase monthly premiums for families with incomes above 150 to 200 percent of the FPL. This doubled the premium previously paid by families.

Title XXI is administered by the Office of Medicaid Planning and Policy, Indiana Family and Social Services Administration through the Title XIX managed care delivery system. Indiana currently has an approved 1915(b) waiver comprised of a PCCM system and a risk-based managed care system. Primary medical providers provide preventive and primary medical care, and furnish authorizations and referrals for most specialty services. Phase I and Phase II children are integrated into these managed care networks, thereby assuring they have a medical home.

Children eligible for Phase I receive the full Title XIX benefit plan. Children eligible for Phase II receive benchmark-equivalent coverage. The Phase II benefit plan is at least actuarially equivalent to the children's health insurance coverage provided by the standard BCBS preferred provider option (PPO) service benefit plan offered under the FEHBP.

The Division of Family and Children Central Office employs a simplified shortened Hoosier Healthwise application form, including Hoosier Healthwise on a joint application that allows families to apply for Hoosier Healthwise at the same time that they apply for other programs.

Because Phase I limits family income to 150 percent of the FPL, the possibility of crowd out is reduced as many of the lower income families do not have the option of employer-based health insurance. Poverty level children with other insurance are covered by Indiana under the regular Title XIX matching rate, thereby reducing the incentive for families to drop coverage. Phase II minimizes crowd out by requiring that applicants be uninsured for 3 months before they are allowed to enroll in Phase II. Those who lose coverage involuntarily are exempted from this requirement. In addition, Phase I and Phase II parents must attest to the lack of current coverage and indicate when the child last had coverage at the time of application or recertification. Denial reasons are tracked, resulting in: (1) a count of applicants who were denied because they voluntarily dropped coverage but did not wait the required 3 months before applying, (2) a count of applicants who were denied because they currently carry private insurance and (3) a count of currently enrolled children who are denied because they gained private coverage rendering them ineligible for Title XXI.

### Cost Sharing

Families of Phase I children are not subject to cost sharing. Families of Phase II children are subject to cost sharing in the form of sliding-scale premiums and copayments for certain services. To ensure that cost sharing does not exceed 5 percent of the family's yearly income, families will use the "shoe-box" approach. Refer to Tables 13 and 14 below for cost-sharing schedules. American Indian children are not subject to cost sharing.

**Table 13: Indiana Premiums**

Income (as a Percentage of the FPL)	Monthly: One Child	Monthly: Two or More Children
Above 150% to 175%	\$22	\$33
Above 175% to 200%	\$33	\$50

**Table 14: Indiana Copayments**

Service	Copayment
Prescription Drugs – Generic, Compound and Sole-Source	\$3
Prescription Drugs Brand Name	\$10
Emergency Ambulance Transportation	\$10

## **Program Size**

At the end of the first Federal fiscal quarter in 2006, there were a total of 19,989 children enrolled in the separate children's health insurance program.<sup>35</sup> Indiana reported that 133,696 children were enrolled in Hoosier Healthwise in FFY 2006. In the FFY 2006 Title XXI Annual Report, Indiana projected expenditures for 2007 would be \$125,440,676 including cost-sharing collections of \$2,935,578 and a total administrative cost of \$ 5,069,483. The Title XXI allotment for FFY 2007 is \$93,469,355, and the enhanced Federal match rate for expenditures is 73.83 percent.

## Iowa

### **Plan Authority/Design**

On June 1, 1998, the State of Iowa (Iowa) submitted a Title XXI State Plan to provide health insurance coverage to uninsured children through an expansion of the Title XIX program. The program provides Title XIX coverage to children ages 6 through 18 in families with income up to 133 percent of the FPL. Iowa also has a SCHIP program. On February 25, 1999, Iowa submitted an amendment, effective January 1, 1999, to its approved Title XXI SPA. This amendment, entitled the *hawk-i* program, is the non-Title XXI component of Iowa's SCHIP program. *Hawk-i* provides health care coverage, via contracts with commercial health care plans, to children whose family income does not exceed 185 percent of the FPL.

Iowa has submitted, and CMS has approved, 10 amendments to the Title XXI SPA since the initial design of the program was finalized.

- The second and third amendments modified earned income and added an additional managed health care plan to the *hawk-i* program. They also removed cost sharing for American Indian/Alaska Native children, and also allowed a deduction for depreciation of capital assets when considering self-employment income.
- The fourth amendment expanded coverage to children under the Title XIX program for infants up to 1 year of age in families with income at or below 200 percent of the FPL. In addition, it expanded coverage under the *hawk-i* program to children up to age 19 in families with income at or below 200 percent of the FPL.
- The fifth amendment removed a health plan from participating under *hawk-i*.
- The sixth amendment updated the Title XXI state plan for compliance with Federal regulations.
- On August 13, 2003, Iowa submitted its seventh amendment to eliminate the 6-month waiting period for uninsured children who have been insured through an employer sponsored health plan in the 6 months prior to application for *hawk-i* and to indicate the expansion of Iowa Health Solutions coverage under Iowa's *hawk-i* program to two additional counties. This amendment also updates the effective date in the State Plan to specify when

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<sup>35</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

Iowa began allowing depreciation of capital assets as a deduction to self-employment income.

- On June 20, 2005, Iowa submitted its eighth amendment to revise the process for children who no longer qualify for Title XIX to be referred to the *hawk-i* program, allow dental plans to participate in the *hawk-i* program, remove Iowa Health Solutions as a participating health plan in the *hawk-i* program, allow individuals to apply for the *hawk-i* program through the Internet and revise the strategic objectives and performance goals.
- On March 31, 2006, Iowa submitted its ninth amendment to change the health care provider in 20 counties from Classic Blue (Wellmark Blue Cross Blue Shield of Iowa) to the John Deere Health Plan.
- On January 16, 2006, the State submitted its tenth amendment to make the following changes: (1) added a new managed care plan, Wellmark Health Plan of Iowa (WHPI) effective July 24, 2006. WHPI also expanded into 26 counties effective September 1, 2006, (it now covers a total of 69 counties in Iowa); (2) AmeriChoice and Delta Dental Health Plan of Iowa expanded into four counties (Carroll, Des Moines, Fayette, and Wayne) effective September 15, 2006; and, (3) changed the name of UnitedHealthcare of the River Valley to AmeriChoice, effective July 1, 2006. With this amendment approval, *hawk-i* members now have a choice of managed care plans in 43 counties in Iowa. Also, 27 counties are covered by a single managed care plan and the remaining 29 counties are covered by an indemnity plan.

For the *hawk-i* program, Iowa contracts with commercial insurers. Both indemnity and managed care plans may participate. For the MCHIP program, Iowa contracts with an MCO and administers a PCCM program. Beneficiaries may choose the delivery system under which they access care depending upon the availability in each county. MCHIP beneficiaries receive their mental health services under a Prepaid Inpatient Mental Health Plan contract with Magellan.

The *hawk-i* program provides a benchmark plan that is equivalent to the Iowa state employees benefit plan. *Hawk-i* enrollees receive dental benefits through Delta Dental of Iowa.

The Department of Human Services (DHS) has contracted with a third-party administrator to provide the following services for *hawk-i*:

- Distribute applications
- Determine eligibility
- Screen for Medicaid eligibility and coordinate with Title XIX eligibility workers
- Calculate, bill, and collect cost sharing
- Assist the family in selecting a health plan and enrolling the child in the selected plan
- Gather encounter data from the health plans
- Provide DHS with demographic, statistical and encounter data for Federal reporting

All applications are screened for Title XIX eligibility and the presence of health insurance coverage. The *hawk-i* application is also used as an application for Title XIX benefits. If it appears that the child is eligible for Title XIX, the *hawk-i* application will be forwarded to the

Eligibility Worker for obtaining the social security number, any necessary child support information, and an eligibility review. If the applicant is not Title XIX eligible, *hawk-i* eligibility is determined. If the child has health insurance coverage and is not Title XIX-eligible, coverage under *hawk-i* is denied. Iowa monitors for substitution by asking insurance history questions on the application form, which is then tracked by Iowa's third-party administrator.

When an application is screened for Title XIX eligibility, and it is determined that the child does not qualify or will no longer qualify for Title XIX due to excess income, a referral is made to *hawk-i*. The referral can be accomplished either electronically or using a paper form. In either format, the referral includes the name of the child (or children), the Title XIX application date (for children denied Title XIX) or the Title XIX end date (for children cancelled from Title XIX), and the reason for the referral. The electronic referral also includes the income amounts used to determine Title XIX ineligibility. A copy of the Title XIX notice of decision denying or canceling Title XIX accompanies the paper referral. This notice contains a calculation showing how Title XIX ineligibility due to excess income was determined.

Iowa was one of the first states to implement the provisions of Section 1906, which mandated states to purchase employer-related health insurance coverage for Title XIX-eligible persons when it was determined cost effective to do so. Iowa implemented the HIPP program on July 1, 1991. Although Section 1906 has now become optional, Iowa continues to maintain a strong HIPP program. Although this program is primarily designed to reduce Title XIX expenditures by providing a TPL for Title XIX eligible persons, often times it is cost effective to purchase family coverage which results in providing coverage for the non-Title XIX eligible household members as well. By initiating coverage while on Title XIX, families have coverage in place when they leave the Title XIX rolls.

### ***Cost Sharing***

*Hawk-i* premiums are \$10 per child per month, with a maximum of \$20 per family for families whose countable income is equal to or greater than 150 percent of the FPL. Families whose countable income is equal to or greater than 150 percent of the FPL shall be assessed a \$25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 20,635 children enrolled in the *hawk-i* program (SCHIP program and 11,851 enrolled in the MCHIP program).<sup>36</sup> In the FFY 2006 Title XXI Annual Report, Iowa projected benefit cost for FFY 2007 would be \$73,081,949 including \$1,258,468 collected in cost sharing and a total administrative cost of \$4,241,370. The Title XXI allotment for FFY 2007 is \$36,229,776, and the enhanced match rate for expenditures is 74.53 percent.

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<sup>36</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

## Kansas

### ***Program Authority/Design***

On September 1, 1998, the State of Kansas (Kansas) received approval for their initial Title XXI State Plan, HealthWave, a SCHIP program designed to expand coverage to low-income children in families with incomes up to 200 percent of the FPL, who are not eligible for Title XIX.

Since the original implementation of the program, Kansas has amended their Title XXI program seven times.

- The first amendment on March 30, 1999, allowed an infant born to a mother, who is under age 19 and enrolled in HealthWave, to retroactively enroll in HealthWave starting with the month of birth as a means of ensuring continuity of care for the newborn. However, the infant must be screened for Title XIX eligibility and enrolled in Title XIX, if appropriate, no later than 90 days from the date the Agency was notified of the infant's birth. The mother of the infant will already be screened for Title XIX eligibility as a pregnant woman, with a family size that includes the unborn child. This amendment also specifies that the clearinghouse contractor is responsible for enrollment of HealthWave eligibles into participating health plans.
- On March 21, 2001, Kansas' second amendment eliminated the requirement that a child be uninsured for a 6-month period prior to application to its SCHIP insurance program, HealthWave.
- The third, fourth and fifth amendments updated the SCHIP program for new Federal regulations and modified premiums from \$30 to \$20 per month per family where family income is between 151 percent and 175 percent of the FPL, and decreased premiums from \$45 to \$30 per month per family where family income is between 176 percent and 200 percent of the FPL.
- Kansas' sixth amendment transferred administration of the Title XIX program to the Kansas Health Care Authority, the new single state agency.
- On March 31, 2006, Kansas submitted its seventh amendment to add presumptive eligibility for children ages 0 through 18 who appear to be eligible for Title XXI until a final eligibility determination is made. It also streamlines the administrative processing of dental claims for the Kansas Medical Assistance Program (KMAP) by having one entity responsible for claims payment of both Title XIX and Title XXI dental claims. In addition, the amendment removes the \$1,500 stop loss (annual dental limit) for MCOs.

Title XIX managed care and Title XXI are combined into a program, called HealthWave designed to provide one seamless managed care option for families. Title XXI is provided only in a capitated managed care model. Kansas contracts with entities that include insurance companies, health maintenance organizations, nonprofit dental service corporations, or nonprofit hospital and medical insurance corporations.

The State Employee Benefit Plan is used as the benchmark plan along with enhanced dental benefits and anti-hemophiliac drug benefits. Although technically reported as a benchmark plan based on the state employee's benefits, Kansas relies heavily on the amount duration and

scope of benefits in the Title XIX FFS program. In instances needing additional clarification, Kansas relies upon coverage under the State Employee Benefit Plan for final definition.

Title XXI beneficiaries do not have any services provided to Title XIX beneficiaries outside of the waiver (except for Anti-Hemophilic Drugs) such as:

- Long Term Care Services
- Alcohol and Drug Abuse Services with the exception of Acute Medical Detoxification
- Abortions
- Services provided by Community Developmental Disability Organizations
- Inpatient hospital services for transplants not otherwise stipulated in this agreement
- School-based Services, Early Intervention Services ordered through an Individual Education Plan or Independent Family Services Plan Local Education Agencies, Head Start Facilities, Part C of the Individuals With Disabilities Education Act
- Laboratory services performed by the Kansas Department of Health and Environment
- Services provided under a Home and Community Based Services (HCBS) waiver

Kansas uses a combined simplified Title XIX and Title XXI application/enrollment form and the central clearinghouse, eligibility is determined for either Title XIX or Title XXI coverage based on income and age level. HealthWave provides a one-page application allowing families with children the opportunity to apply and see which program they may qualify for; HealthWave 21 or HealthWave 19 (Title XIX). The HealthWave Clearinghouse provides a toll-free Customer service center to answer questions and provide assistance with the application. Household income verification is needed to complete the application and renewal process. All applications are screened for HealthWave 19 (Title XIX) first.

Eligibility is continuous for 12 months and re-established annually. Presumptive eligibility is provided for children who appear to be eligible for the state's Title XXI program. Individuals found to be presumptively eligible for Title XXI at the time of application will receive a Secretary-Approved benefit plan until a final eligibility determination is made. Children with other insurance may not enroll in HealthWave because it is a SCHIP. Kansas monitors for substitution of coverage by tracking the number of applicants who are denied SCHIP eligibility because they were found to have other health insurance coverage.

### ***Cost Sharing***

Families with incomes from 151 percent through 175 percent of the FPL pay \$20 per month per family in premiums. Families with incomes from 176 percent through 200 percent of the FPL pay \$30 per month per family. There are no copayments in the HealthWave program.

## **Program Size**

At the end of the first Federal fiscal quarter in 2006, there were a total of 36,206 children enrolled in the SCHIP program.<sup>37</sup> In the FFY 2006 Title XXI Annual Report, Kansas projected the net benefit cost for FFY 2007 would be \$61,288,394 including \$1,694,101 in cost sharing and total administrative costs of \$5,814,281. The Title XXI allotment for FFY 2007 is \$36,541,720, and the enhanced match rate for expenditures is 72.18 percent.

## Kentucky

### **Program Authority/Design**

The State of Kentucky (Kentucky) was approved to implement a Medicaid expansion under Title XXI, called Kentucky MCHIP (KMCHIP) on November 25, 1998. Kentucky's initial MCHIP expansion provided coverage for children ages 14 through 19 in families up to 100 percent of the FPL. Coverage was further expanded to children ages 1 to 19 in families up to 150 percent of the FPL. Children 0 to 19 years of age in families up to 200 percent of the FPL who are not otherwise eligible for Title XIX are enrolled in a SCHIP program (KMCHIP). KMCHIP is a benchmark plus plan that is based on the state employee's health benefits plan with additional services that bring the plan almost to the level of the Title XIX plan. The Kentucky Department for Title XIX Services holds operational responsibility for both the MCHIP and SCHIP programs.

Since the original implementation of the program, Kentucky has submitted eight amendments.

- Kentucky implemented its first amendment on July 1, 1999, expanding eligibility for its MCHIP expansion to 150 percent of the FPL for children from birth to age 19.
- On June 19, 2000, Kentucky submitted its second amendment to change the service delivery mechanism by substituting the existing Title XIX infrastructure, and to create a SCHIP program for children with family income between 150 percent and 200 percent of the FPL. Eligibility and health care services are provided through the existing Title XIX service delivery system. Cost sharing was eliminated.
- On August 28, 2001, Kentucky submitted a third amendment to its Title XXI State Plan to change the enrollment and re-certification process in both the MCHIP and SCHIP programs. Beginning June 1, 2001, the Department for Medicaid Services (DMS) resumed requiring written verification of income and proof of child-care expenses with the KMCHIP/Medicaid initial mail-in application. DMS also resumed face-to-face interviews and verification of income and expenses for recipients at the time of their KMCHIP re-certification. The amendment also updated the description of the state's service delivery model.
- On June 27, 2002, Kentucky submitted a fourth amendment that updates and amends the Title XXI State Plan to indicate the state's compliance with the final SCHIP regulations and to change the initial application and renewal processes.
- On September 24, 2002, Kentucky submitted a fifth amendment to charge 18-year olds a \$1 copayment for pharmacy prescriptions.

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<sup>37</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>.

- On July 25, 2003, Kentucky submitted its sixth amendment to charge 18-year olds \$2 copayments for office visits to dentists (except for preventive dental visits), optometrists, opticians, audiologists, hearing aid dealers, chiropractors and podiatrists.
- On October 29, 2003, Kentucky submitted its seventh amendment to impose premiums of \$20 per family per month for families with incomes from 151 percent through 200 percent of the FPL. In addition, the amendment revises the KMCHIP performance goals to increase consistency with available performance data, to make the goals more achievable given current performance in meeting the initial goals, and to bring one performance goal in line with the state's Healthy Kentuckian initiative.
- On April 27, 2006, Kentucky submitted its eighth amendment to change the benefits, cost-sharing requirements, and care delivery system for children with family income above 150 percent of the FPL up to 200 percent of the FPL. Kentucky removed coverage for inpatient and outpatient substance abuse services. Delivery of services for all children will be through a Title XIX managed care capitated system, except for those children living in Louisville and the surrounding counties who will remain enrolled in a Health Care Partnership, known as the Passport Health Care Plan.

The service delivery system is the same as Title XIX. Title XIX and KMCHIP beneficiaries are served through Title XIX MCOs in all of Kentucky except the Louisville Region where beneficiaries are served by a Health Care Partnership, a MCO authorized through a Section 1115 Title XIX waiver. The local Department for Community Based Services offices determine eligibility for Title XIX, and KMCHIP's enrollment process is blended with Title XIX.

Applicants cannot be enrolled in KMCHIP if they have had health insurance within the past 6 months, unless they met an exception as defined by the state. Exceptions include loss of employment due to factors other than voluntary termination, death of a parent, divorce when the child's coverage was provided by a non-parental adult, and change to employment that does not offer dependent coverage.

In May 2006, Kentucky received SPA approval from CMS to move forward on plans to redesign its Title XIX program using DRA flexibility. The new plan, KyHealth Choices, offers four different benefit plans tailored to specific populations, increases cost sharing, and expands access to community-based long-term care (LTC). The new targeted benefit plans replace the Title XIX benefit plan with Secretary-Approved coverage. The four plans are:

- **Global Choices:** Global Choices is designed for pregnant women, working parents up to 68 percent FPL, foster children, medically fragile children, SSI-related groups, and women with breast and cervical cancer. Global Choices covers basic medical services with new benefit limits and increased cost sharing. LTC services are excluded.
- **Family Choices:** Family Choices is designed for most children, including children enrolled in Kentucky's SCHIP program. Family Choices offers the same benefit plan as Global Choices except there is no prescription drug limit and a higher vision care maximum benefit.
- **Optimum Choices:** For individuals with developmental disabilities and mental retardation in need of LTC services, Optimum Choices covers all the benefits in Global Choices as well as three levels of LTC services.

- **Comprehensive Choices:** For the elderly and individuals with disabilities in need of nursing facility level care, Comprehensive Choices offers all the benefits of Global Choices plus two levels of LTC, including services offered through Kentucky's current HCBS waivers.

Under the DRA option, KyHealth Choices also includes an employer-sponsored insurance option for adults only. Enrollees can choose to receive a subsidy for private plans that meet the state employee plan benchmark and certain "economy and efficiency" criteria, but there is no wrap-around coverage. Enrollees can move back to a Title XIX plan at any time. The program also includes Get Healthy Benefits, allowing individual members with specific diseases to access additional benefits, such as vision, dental, smoking cessation and nutrition visits, if they participate in a disease management program for one year. Enrollees have six months to use their new benefits. Benefits are lost after disenrollment from Title XIX.

### ***Cost Sharing***

Kentucky implemented new cost-sharing requirements in June 2006. There are no copayments for preventive services, and pregnant women and mandatory children are exempt from cost sharing. KyHealth Choices includes new benefit limits; however, services beyond the benefit limits may be approved through a prior authorization process. Kentucky is limited in assessing nominal cost sharing on individuals with incomes below 100 percent FPL. Kentucky is the only DRA SPA that elected the benchmark option. In doing so, they also submitted amendments to add copayments for services and redefined some services. Then in developing the benchmark plans, they waived some of the copayments for select benchmark plans.

Premiums are set at \$20 per family per month for families with income from 151 percent through 200 percent of the FPL. All enrollees pay \$1 for a preferred generic prescription, \$2 for a preferred brand prescription, or \$3 for a non-preferred drug prescription, \$2 for office visit and testing for allergy services, and 5 percent of the cost of service for non-emergency use of emergency room. Total annual out-of-pocket expenses for medical costs and for pharmacy costs are capped at \$225 each, for a total of \$450.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 16,590 children enrolled in Kentucky's MCHIP expansion and 35,038 enrolled in SCHIP.<sup>38</sup> Kentucky reported that 64,861 children were enrolled in Title XXI in FFY 2006. In the FFY 2006 Title XXI Annual Report, Kentucky projected net benefit costs for FFY 2007 to be \$98,601,384 including \$4,800,472 in cost-sharing collections and a total administrative cost of \$1,533,500. The Title XXI allotment is \$70,114,712 and the enhanced match rate is 78.71 percent for FFY 2007.

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<sup>38</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

## Missouri

### ***Program Authority/Design***

The State of Missouri (Missouri) was approved to implement a MCHIP program under Title XXI on April 28, 1998 as part of the Missouri Care Plus (MC+) program. At the same time the state plan was approved, Missouri received 1115 demonstration approval to waive certain aspects of the approved state plan. The waiver allowed Missouri to cover children up to age 19 with incomes up to 300 percent of the FPL. Missouri receives the enhanced match rate under Title XXI for this population. Eligible children receive all Title XIX benefits, except non-emergent medical transportation (NEMT). The demonstration was also approved to cover some limited adults.

In response to Missouri's cost-cutting initiatives and legislative action, Missouri later implemented eligibility changes to the MC+ demonstration. Missouri eliminated eligibility for most adults except for postpartum uninsured women who lose their Title XIX eligibility 60 days after the birth of their child (extending eligibility for women's health services for 1 year) and optional targeted low-income children (up to 300 percent of the FPL). The demonstration combines Title XIX and Title XXI funding streams. The MCHIP children are funded through Title XXI. All other demonstration populations and services are covered through Title XIX through diverted Disproportionate Share Hospital (DSH) funds.

All eligible populations receive services through managed care where the Section 1915(b) MC+ waiver has been implemented, with the exception of certain individuals not required to enroll in managed care under the Section 1915(b) MC+ waiver. In the regions of Missouri in which managed care has not been implemented, services are provided through the fee for service system.

Program applications are typically submitted through a mail-in process. Eligibility is primarily determined in service centers with telephone help lines. Applications may also be submitted in local offices. Children who have had private coverage within the last 6 months have a 6-month waiting period for Title XIX coverage.

Since the original implementation of the program, CMS has approved eight amendments of the Missouri 1115 waiver. Not all of the amendments addressed the children in Title XXI or remain in effect today.

- The first amendment on January 11, 1999 allows Missouri to impose cost sharing on children and disenroll beneficiaries who show a pattern (four or more instances) of failing to pay the copayment requirements. Providers may not deny services based upon a lack of payment of a copayment, but must keep a record of such instances and report them. Missouri will evaluate the effects of not providing non-emergency medical transportation and on the effects of imposing cost sharing on children, including the disenrollment provisions.
- The third, fourth and fifth modifications increased monthly premiums and cost sharing for children. The increases were mandated by the legislature in accordance with changes to the Missouri Consolidated Health Care Plan. A clarification of this approval was provided on January 23, 2001, to allow Missouri to increase the pharmacy copayment from \$5 to \$9 for

this same group. A modification was approved on May 30, 2001, to allow Missouri to increase monthly premiums from \$80 to between \$83 and \$218 for children in families with incomes between 226 percent and 300 percent FPL. The exact amount of the premium is determined by a sliding scale methodology outlined by the state in its letter requesting the amendment. The increase affected approximately 3,500 children.

- On September 30, 2004, CMS approved the seventh amendment to the MC+ Section 1115 demonstration to exempt children with special health care needs from Missouri's 6-month period of uninsurance and from the 30-day waiting period. Missouri also submitted a Title XXI SPA on July 1, 2004, to update the state plan to reflect these changes made in Missouri's MC+ Demonstration.
- CMS approved the eighth amendment to MC+ on September 15, 2006 to allow Missouri to change its Section 1115 MCHIP program from a cost sharing copayment and premium structure to solely a sliding-scale premium structure based on income level for children 151 percent through 300 percent of the FPL. Copayment requirements were eliminated. The amendment also eliminated Missouri's authority to provide any additional transitional medical assistance (TMA) beyond the 12-month statutory requirement, eliminated the 30-day waiting period for all children in the demonstration from the date of application (before health care coverage can begin), eliminated the 6-month waiting period penalty before re-enrollment after non-payment of an ongoing premium for children with family incomes between 151 percent and 225 percent of the FPL, and changed Missouri's presumptive eligibility criteria for children to be consistent with the changes in the premium structure.

### ***Cost Sharing***

Eligible children were originally subject to cost sharing, including both premiums and cost sharing at higher income levels. As noted above, the premium structure follows a sliding-scale based on income level for children 151 percent through 300 percent of the FPL. Copayment requirements were eliminated. Children can be disenrolled for failure to pay the premium. Prior to disenrollment, Missouri will determine whether any extenuating hardship circumstances were present. Beneficiaries who are disenrolled may reapply after six months.

Because these children are part of MCHIP under Title XXI, all MCHIP cost-sharing requirements must be met. No family will pay more than the 5 percent of their income for cost sharing. Each family's cost-sharing limit is calculated at the time of eligibility determination. Families are asked to track their cost-sharing expenses and notify the state when they reach their limit. Cost-sharing requirements will be suspended for the remainder of the 12-month eligibility period for families who reach their individual limit.

Missouri's legislation provides that children with family incomes over 150 percent of the FPL shall pay premiums. Total cost sharing shall not exceed 5 percent of the family's income. The following is how the state has implemented the 5 percent cost-sharing cap:

**Table 15: Missouri Cost Sharing**

Percentage of FPL	Premium as Percentage of Family Income
Above 150% to 185%	1%
Above 185% to 225%	3%
Above 225% to 300	5%

Effective July 1, 2006, monthly premiums range from \$11 to \$282 based on family size. Premiums are collected for individuals with an income between 150 percent and 300 percent of the FPL. Premiums change annually in July. The affordable insurance standard changed effective July 1, 2006, to 9 percent of the median income level for a family of three. The affordability standard is set at 133 percent of the average premium of the Missouri Consolidated Health Care Plan. The affordability guidelines as of July 1, 2006, are:

- Above 150% up to 185% of FPL = \$209/month
- Above 185% up to 225% of FPL = \$255/month
- Above 225% up to 300% of FPL = \$375/month

Before July 1, 2006, there was only one affordability standard for all individuals with income above 150 percent of the FPL, and it was \$342/month.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 69,476 children enrolled in the MCHIP program.<sup>39</sup> In the FFY 2006 Title XXI Annual Report, Missouri projected the net benefit cost for FFY 2007 would be \$114,897,649 including \$9,009,598 collected in cost sharing and a total administrative cost of \$2,891,232. The Title XXI allotment for FFY 2007 is \$43,424,901, and the enhanced match rate for expenditures is 73 percent.

## North Dakota

### ***Program Authority/Design***

The state of North Dakota (North Dakota) was approved to implement a Title XIX program under Title XXI on October 1, 1998. North Dakota named the program Healthy Steps Program. The Department of Human Services is responsible for administering both the Title XIX and Title XXI program. The program initially covered children who are under the age of 19 with a family income at or below 100 of the FPL.

Since the original implementation of the program, North Dakota has submitted four amendments to its Title XXI state plan.

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<sup>39</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

- The first amendment submitted on July 12, 1999, established a Title XXI program to cover children from age 3 with family incomes between 133 percent to 140 percent of the FPL and children age 6 through 18 with family incomes between 100 to 140 percent of the FPL.
- Then on November 28, 2001, North Dakota submitted its second amendment to expand eligibility by eliminating the Medicaid assets test.
- On July 1, 2002, North Dakota submitted its third amendment to indicate compliance with the final Title XXI regulations.
- Then on October 28, 2005, North Dakota submitted its fourth amendment to redefine certain eligibility standards.

Since North Dakota operates a combination program under Title XXI with children enrolled in MCHIP and children enrolled in a SCHIP program, there are multiple delivery systems depending on the program the child is enrolled in and where the child resides. North Dakota has limited managed care and most children enrolled in MCHIP receive the Title XIX benefit plan and obtain their services from a statewide PCCM program, except for children in Grand Forks County who have a choice between a PCCM and an HMO. For children enrolled in the SCHIP program, the child receives a benefit plan that is actuarially equivalent to the state employee's health insurance and is enhanced by the addition of preventive and vision services. North Dakota contracts with Noridian Mutual insurance company, a licensed indemnity carrier, to cover services to children enrolled in the SCHIP plan. North Dakota pays the carrier a monthly premium adjusted every two years.

North Dakota uses a single application for both Title XIX and Healthy Steps. The Department of Health is responsible for the eligibility reviews and screens for Title XIX eligibility prior to assessing eligibility for Title XXI. A child determined eligible for Healthy Steps will receive 12 months of continuous coverage until the child turns 19, loses state residency, no longer resides with the family or their family acquires credible health insurance coverage, at which time coverage will terminate in the month of the change.

### ***Cost Sharing***

For children enrolled in the MCHIP program, the program does not assess any cost sharing to children. For children enrolled in the SCHIP program, there are the following copayments:

- \$50 for the first day of an inpatient hospital or a psychiatric or substance abuse inpatient facility stay
- \$5 per visit to a hospital emergency room
- \$2 for each allowable prescription

There are no separate premiums or enrollment fees. Aggregate cost sharing cannot exceed 5 percent of the family's income. Families must keep track of cost sharing and inform North Dakota when they reach the 5 percent limit. Once verified, North Dakota will notify the insurer and the insurer will send the family a new membership card noting that they are not subject to cost sharing for the remainder of the year.

## **Program Size**

At the end of the first Federal fiscal quarter in 2006, there were a total of 3,259 children enrolled in Title XXI of which 2,021 were enrolled in the SCHIP program and 1,238 were enrolled in the MCHIP program<sup>40</sup>. Based on information submitted in its FFY 2006 Title XXI Annual Report, North Dakota projected FFY 2007 expenditures for the program to be \$8.6 million for insurer services and \$6.2 million for managed care services for a total of \$14.8 million dollars. Administrative expenses were projected to be \$342,000 for personnel expenses. No administrative expenses for contractors were reported. The Title XXI allotment for FFY 2007 is \$7,737,529, and the enhanced match rate for expenditures is 75.30 percent.

## South Carolina

### **Program Authority/Design**

The State of South Carolina (South Carolina) was approved to implement a Medicaid expansion program under Title XXI on October 1, 1997. South Carolina branded the program, Partners for Healthy Children. The South Carolina Department of Health and Human Services (SC-DHHS), the single State agency for Title XIX, is also responsible for administering MCHIP. South Carolina covers children under the age of 19 at or below 150 of the FPL.

South Carolina uses a single application for both Title XIX and Title XXI. SC-DHHS contracts with the Department of Social Services to determine Title XIX and Title XXI eligibility. A child determined eligible for Partners for Healthy Children will receive 12 months of continuous eligibility. South Carolina's state plan for Title XXI notes that they place a child with other insurance coverage, who would not otherwise be eligible for MCHIP, in the Title XIX program so that they can coordinate coverage. This is done in an effort to deter families from dropping coverage in order to qualify for Title XXI.<sup>41</sup>

In 2005, South Carolina initiated efforts to reform their Title XIX program and provide more budget predictability by developing a defined contribution model. To implement their reform program, South Carolina is implementing a program called Healthy Choice Connections to encourage more individuals to enroll in a managed care or PCCM program. In addition, South Carolina anticipates submitting an amendment to create a combination program in which children with incomes between 151 and 200 percent of the FPL will be enrolled in an SCHIP plan.

On March 14, 2007, South Carolina was the first state in the nation to be approved to operate a HOA demonstration. In addition, CMS also approved a benchmark benefit program under the DRA. South Carolina will provide individuals with the opportunity to enroll in other health care

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<sup>40</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

<sup>41</sup> Centers for Medicare and Medicaid Services, "SC Current State Plan," available at <http://www.cms.hhs.gov/LowCostHealthInsFamChild/>

systems statewide. One of the new options will be the choice to enroll in a HOA. Title XIX beneficiaries now have the option to voluntarily enroll in a high deductible health plan with a savings account. South Carolina will deposit up to \$1,000 per eligible child in the HOA. South Carolina is still evaluating whether or not children in the MCHIP program will be provided the option to enroll in an HOA. Initial implementation is limited to 1,000 beneficiaries, including adults and children, who are Richland County residents. In the initial phase, South Carolina will operate this program on a FFS basis but anticipates contracting with an insurer.

### **Cost Sharing**

As a MCHIP program, Healthy Partners uses the Title XIX delivery system which requires children to enroll in South Carolina's PCCM program or an HMO where available. Because the original Title XXI program, Partners for Healthy Children, operates as a MCHIP, the program does not assess any cost sharing to children. However, with the rollout of the new DRA option program, Healthy Choices, it is expected that additional managed care options will be available.

### **Program Size**

At the end of the first Federal fiscal quarter in 2006, there were 43,726 children enrolled in Partners for Healthy Children. Based on information submitted in its FFY 2006 Title XXI Annual Report, South Carolina projected FFY 2007 expenditures for the program to be \$5.1 million for insurer services and \$56.8 million for FFS payments for a total of \$61.9 million dollars in health care expenditures. Projected administrative expenses in FFY 2007 were expected to be \$5.98 million for personnel expenses. No administrative expenses for contractors were reported. The Title XXI allotment for FFY 2007 is \$70,651,421, and the enhanced match rate for expenditures is 78.68 percent.

While South Carolina has been recognized for their creative outreach strategies which successfully resulted in high enrollment levels, their FFY 2006 Title XXI Annual Report to CMS noted a 14 percent decline in enrollment from FFY 2005.<sup>42</sup> South Carolina noted that there was also a similar decline in Title XIX enrollment and believed the decline was attributable to the new citizenship verification requirements under the DRA.

## Utah

### **Program Authority/Design**

On July 10, 1998, CMS approved the State of Utah's (Utah) Title XXI program. The Utah Department of Health administers the Utah SCHIP. Utah contracts with two MCOs to provide medical care for children enrolled in SCHIP. These MCOs have extensive provider networks throughout Utah. The program initially covered children under age 19 with family income at or below 200 percent of the FPL.

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<sup>42</sup> State of South Carolina, Improving Food Stamps, Medicaid and SCHIP Participation: Strategies and Challenges, by Mathematica Policy Research, Inc, February 18, 2002.

Since the original implementation of the program, Utah has submitted 4 amendments and CMS has approved three of those amendments.

- On November 29, 1999, CMS disapproved a SPA to add cost sharing for families with incomes below 100 percent of the FPL. Utah requested approval to apply the same cost-sharing schedule for families with incomes below 100 percent of the FPL that was previously approved for families with incomes from 100 percent to 150 percent of the FPL.
- Utah's second amendment submitted on March 1, 2002, allowed the establishment of an enrollment cap of 24,000 enrollees; required premiums and increased copayments for enrollees above 100 percent of the FPL; disregarded the child's income when determining family income; and modified the dental, vision and hearing services within the benefit plan.
- Utah's third amendment complied with the final Title XXI regulations. The amendment also restored dental benefits to the pre-January 2002 level, and revised Utah's enrollment cap by raising the limit from 24,000 enrollees on average to 28,000 enrollees on average.
- Utah's fourth amendment submitted on June 1, 2005, raised the enrollment cap from 28,000 to 40,000 enrollees and added an exception to the 90-day, crowd-out period. Additionally, clarifications were made to explain the renewal process, to clarify the disenrollment process for failure to pay quarterly premiums, and to describe the process to notify families of their cost sharing maximum and the procedures a family must follow once their maximum has been reached.

Health services in the urban areas (Davis, Salt Lake, Utah and Weber counties) and in the rural areas (all other counties) are delivered by MCOs. Utah's SCHIP offers benchmark-equivalent coverage. The state's plan includes an actuarial analysis comparing the offered benefit plan to the benefit plan provided to Utah State employees.

The application process requests information about health insurance coverage for the children in the household. Every Title XXI application is screened through the Title XIX eligibility determination process to determine if the child qualifies for Title XIX. The application is screened first for Title XIX eligibility prior to determining eligibility for SCHIP. A child is found ineligible for SCHIP if the child has been voluntarily terminated from health insurance coverage within the 3 months prior to the application date for coverage under SCHIP. Exceptions to the 90-day ineligibility period are:

- Voluntary termination of COBRA coverage
- Voluntary termination of coverage by a non-custodial parent
- Involuntary termination from a group health plan
- Voluntary termination of the State Health Insurance Pool
- Voluntary termination of health insurance coverage purchased after the previous SCHIP open enrollment period ended, but before the beginning of the current open enrollment period and who met SCHIP eligibility requirements at time of purchase

### ***Cost Sharing***

Effective January 1, 2002, premiums and copayments are as follows:

**Table 16: Utah Cost Sharing**

Benefit	Family Income 101-150% FPL Premium Payment & Copayment	Family Income 151-200% FPL Premium Payment & Copayment
Premium Payment	\$13 per family per quarter	\$25 per family per quarter
Hospital Inpatient, Outpatient Care	\$3	10% of allowed amount
Emergency Room Visit	\$3	\$35
Outpatient Office Visits	\$3	\$15
Formulary Prescription Drugs	\$1	\$5
Non-Formulary Prescription Drugs	\$3	50% cost per prescription
Lab services Under \$50.00	\$1	\$5
Lab services Over \$50.00	\$2	10% of allowed cost
X-ray Under \$100.00	\$1	\$5
X-ray Over \$100.00	\$3	10% of allowed cost
Dental	\$3 for all covered services except cleanings, exams, X-rays, fluoride, and sealants	20% of allowed amount for all covered services except cleanings, exams, X-rays, fluoride, and sealants
Mental Health Inpatient Patient Care	\$3	10% of allowed amount for first 10 days; 50% of allowed amount for next 20 days
Mental Health Outpatient Patient Care	\$3	50% of allowed amount

### **Program Size**

At the end of the first Federal fiscal quarter in 2006, there were a total of 35,430 children enrolled in the SCHIP.<sup>43</sup> Utah reported that 51,967 children were enrolled in its program during FFY 2006. In the FFY 2006 Title XXI Annual Report, Utah projected the net benefit cost for FFY 2007 would be \$45,877,800 including \$876,500 collected in cost sharing and a total administrative cost of \$4,083,700. The Title XXI allotment for FFY 2007 is \$40,485,868, and the enhanced match rate is 79.10 percent.

## West Virginia

### **Program Authority/Design**

On September 15, 1998, the State of West Virginia (West Virginia) was approved to provide Title XXI under a MCHIP called, West Virginia MCHIP. Its SCHIP state plan expanded Title XIX eligibility for children between the ages of 1 and 5 in families with incomes up to 150 percent of the FPL. On December 21, 1998, West Virginia submitted a SPA which created a SCHIP

<sup>43</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

program covering children between the ages of 6 and 18 in families with incomes equal to or less than 150 percent of the FPL.

The Title XXI program is administered by the West Virginia Children's Health Insurance Agency, which is located within the State Department of Administration. The Public Employees Insurance Agency is the third-party administrator managing the benefit plan. With the implementation of West Virginia's second amendment on October 1, 2000, all children enrolled in Title XXI are served through fee for service.

Since implementation and amendment approvals, West Virginia has submitted five additional amendments:

- On June 30, 2000, West Virginia submitted its second amendment to incorporate children from their MCHIP program into the SCHIP program effectively eliminating their MCHIP.
- On July 19, 2000, West Virginia submitted its third amendment to expand eligibility in its SCHIP program to children under age 19 with income between 150 percent and 200 percent of the FPL and to impose cost sharing on this population. American Indian/Alaska Native (AI/AN) enrollees were exempt from cost-sharing requirements.
- West Virginia submitted its fourth amendment on July 1, 2002. This amendment updates and amends the Title XXI State Plan to indicate West Virginia's compliance with the final regulations. The amendment also adds cost sharing on pharmaceuticals for enrollees at or below 150 percent of the FPL and changes it for enrollees above 150 percent of the FPL, adds an annual \$200,000 limit on benefits, and incorporates a \$1,000,000 lifetime limit on benefits.
- West Virginia submitted its fifth amendment on February 10, 2006. This amendment eliminates coverage of drugs excluded from the State's Preferred Drug List. There are three exceptions to this policy: documentation from a physician demonstrating medical necessity; mental health pharmaceuticals in certain therapeutic drug classes; and, over-the-counter pharmaceuticals in certain therapeutic drug classes. Prior provisions imposing copayments for these drugs were removed.
- West Virginia submitted its sixth amendment on September 22, 2006. This amendment increases the eligibility level from 200 percent to 220 percent of the FPL. Children in this income level will also have eligibility, benefit and cost-sharing requirements that are different from individuals at or below 200 percent of the FPL. The following applies:
  - **Waiting Period:** Families at or below 200 percent of the FPL will continue to be subject to a 6-month waiting period, while families above 200 percent of the FPL will have a 12-month waiting period.
  - **Benefits:** Families at or below 200 percent of the FPL will continue to have comprehensive dental and vision services. Families above 200 percent of the FPL will receive preventive dental services with an annual limit of \$150, and will not receive vision services.
  - **Pharmacy Copayments:** There are no copayments for generic drugs. For formulary brand drugs, families at or below 150 percent of the FPL will continue to pay \$5 and families above 150 percent to 200 percent of the FPL will continue to pay \$10. Families above 200 percent of the FPL will be required to pay a \$15 copayment for formulary brand drugs.

- **Premiums:** Families at or below 200 percent of the FPL continue to not have a premium. Families above 200 percent of the FPL will be required to pay premiums based on a two-tier system. Families with one child will pay a monthly premium of \$35 and families with two children or more will pay \$71 per month.
- **Other Copayments:** The entire State Plan population will be charged a copayment amount when a child obtains non-preventive care from a provider other than the one designated to serve as the child's medical home. The copayment amount will vary by FPL, as follows: \$5 for individuals at or below 150 percent of the FPL, \$15 for individuals 150 percent to 200 percent of the FPL, and \$20 for individuals above 200 percent of the FPL. Total cost-sharing amounts will continue to adhere to the Title XXI cost sharing limit of 5 percent of family income.

Eligibility determinations are conducted for both Title XIX and Title XXI by the same Agency. Applications are first screened for Title XIX eligibility. During this process, the Title XIX system is queried to ascertain current Title XIX coverage. Only if the child is ineligible for Title XIX services and is not covered by other health insurance will they be allowed to enroll into Title XXI.

The benefit plan is a benchmark-equivalent plan to state employee coverage. Services provided include: inpatient; outpatient; physician; surgical; clinic and other ambulatory care; prescription drugs; laboratory and radiological; prenatal care and pre-pregnancy family services and supplies; inpatient and outpatient mental health; durable medical equipment and medically-related or remedial devices; disposable medical supplies (therapeutic); home and community-based care; nursing care; abortion only to save the mother's life or pregnancy is a result of rape/incest; dental; inpatient, residential, and outpatient substance abuse treatment; case-management services; care coordination; physical and occupational therapy, and services for speech, hearing, and language disorders; hospice care; eye exams for prescriptive lenses; and medically necessary transportation. Families at or below 200 percent of the FPL will continue to have comprehensive dental and vision services. Families above 200 percent of the FPL will receive preventive dental services with an annual limit of \$150, and will not receive vision services. There is a \$200,000 annual limit on benefits and a \$1,000,000 lifetime limit on benefits.

Children below 200 percent of the FPL must be uninsured for a period of 6 months prior to application. Children above 200 percent of the FPL must be uninsured for a period of 12 months prior to application. Exceptions are made if the employer terminates coverage; a job is involuntarily terminated and the family loses benefits; private insurance is not cost effective which is defined as the employee's contribution for family coverage exceeding 10 percent of family gross annual income; loss of coverage for child is due to a change in employment; or loss of coverage was outside the control of an employee.

West Virginia monitors substitution through its application process. Applications are denied if the child has private health insurance. Applicants must specify whether the applicant child had private group coverage in the previous 6 months. Data on applications that are denied eligibility due to coverage in the prior 6 months is collected and analyzed for trends over time.

In May 2006, West Virginia received CMS approval to move forward on plans to redesign its Medicaid program. Taking advantage of the flexibility outlined in the DRA, West Virginia utilized

the SPA process. This SPA implements Section 6044 of the DRA to provide Secretary-Approved benchmark benefit plans for Medicaid eligibles, except those exempted under Section 1937 of the Social Security Act. *Note: West Virginia's DRA SPA did not include SCHIP children. This summary is noted here because of the unique design features of the Medicaid DRA program, which may be of interest to Nebraska.*

The SPA includes these key features:

- This population is primarily the healthy adults and children.
- The benchmark benefits are comparable to the minimum required Medicaid benefit plan and they include EPSDT services for children.
- In accordance with Section 1937 of the Social Security Act, the individuals will be mandated into the basic benefit plan.

A four-year, phased-in implementation began in July 2006. Approximately 50 percent of West Virginia's Title XIX beneficiaries will be able to participate in the program once it is completely phased in. It is estimated that approximately 160,000 beneficiaries will be affected at the completion of the phase in.

These Title XIX beneficiaries are generally healthy adults and healthy children on Title XIX. These include individuals receiving assistance through TANF or are TANF-related individuals. Disabled and elderly individuals **are not** included in this reform plan at this time.

The planned delivery system for the program is managed care, or a managed care and FFS hybrid. Services will be delivered in the medical home, which will consist of clinics as well as provider offices. The delivery system will be determined as the program is phased in, and may vary for each of the geographic areas.

The West Virginia reform streamlines eligibility and moves healthy children and parents into one of two plans:

- **Basic Plan:** The basic benefit plans provide all mandatory Title XIX services, as well as age appropriate optional services such as limited vision, dental and hearing for children, and family planning for adults. Children continue to receive services under the EPSDT benefit. Enrollees can access additional benefits covered by the Enhanced Plan by signing a member agreement.
- **Enhanced Plan:** For individuals who have signed a member agreement, the enhanced benefit plans also provide all mandatory Title XIX services, with the addition many optional age appropriate services that focus on wellness. Examples of these services include cardiac rehabilitation, tobacco cessation programs and chiropractic services for adults, nutritional education, chemical dependency and mental health services for children. The Enhanced Plan is comparable to West Virginia's previous Title XIX benefits plan.

The cornerstone of West Virginia's plan is the member agreement and the Healthy Rewards pilot program. This innovative reform program creates the opportunity for beneficiaries to obtain optional benefits using the partnership agreement between the beneficiary, the medical home and West Virginia. Unique to this program are the following features:

- Upon enrollment, individuals will choose or be assigned to a medical home and will be counseled about obtaining and receiving appropriate health services.
- Individuals electing to sign a membership agreement, which focuses on appropriate health and wellness programs, receive access to enhanced benefits targeted to the specific health needs of the individual.

Enrollees who sign a member agreement, a “personal responsibility contract,” are enrolled in the Enhanced Plan and receive a fixed amount of credits per quarter in a Healthy Rewards account. The credits can be used to cover medical and pharmaceutical copayments and bonus credits are added for meeting health goals. Individuals who do not meet their responsibilities are moved to the more limited Basic Plan.

To continue receiving enhanced services, the member must:

- Receive screenings as directed by the health care provider
- Adhere to health improvement programs as directed by their health care provider
- Attend scheduled appointments
- Take medication as directed by their health care provider

Members will have to adhere to their member agreement and will have appeal rights prior to being moved from the Enhanced Benefit Plan to the Basic Benefit Plan for non-compliance.

Other than at the programs’ inception, beneficiaries are offered additional chances to “sign up” for healthy behaviors through the member agreement. At the time of re-determination, each beneficiary will have the option to commit to the member agreement, thereby gaining or regaining access to the enhanced benefit plan.

### **Cost Sharing**

Enrollees at or below 150 percent of the FPL are subject to the following copayment schedule: \$5 for formulary brand drugs; and \$5 for non-preventive care from a provider other than the one designated to serve as the child’s medical home.

Enrollees above 150 percent to 200 percent of the FPL are subject to the following copayment schedule: \$10 for formulary brand drugs; \$15 for non-preventive care from a provider other than the one designated to serve as the child’s medical home; \$25 for inpatient admission and outpatient procedures; and \$35 for emergency room services that are waived if the individual is admitted.

Enrollees above 200 percent of the FPL are subject to the following copayment schedule: \$20 for non-preventive care from a provider other than the one designated to serve as the child’s medical home. Families above 200 percent of the FPL will be required to pay a \$15 copayment for formulary brand drugs.

In addition, enrollees above 200 percent of the FPL are subject to the following monthly premiums: \$35 for one child; or \$71 for two or more children. Families at or below 200 percent of

the FPL do not have to pay a premium. There is no cost sharing for preventive care, dental and vision services. The AI/AN population are exempt from cost sharing.

In families with one child, the copayment maximum for prescriptions is \$100 and the medical maximum is \$150. In families with two children, the copayment maximum for prescriptions is \$200 and the medical maximum is \$300. In families with three or more children, the copayment maximum for prescriptions is \$300 and the medical maximum is \$450.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 24,587 children enrolled in the SCHIP program. West Virginia reported that there were 28,307 children enrolled in SCHIP in FFY 2006.<sup>44</sup> In the FFY 2006 Title XXI Annual Report, West Virginia projected that the net benefit costs in FFY 2007 would be \$42,616,345 including \$1,027,523 in cost sharing and \$3,155,201 in administrative costs. The Title XXI allotment for FFY 2007 was \$18,550,788, and the enhanced match rate was 81 percent.

## Wisconsin

### ***Program Authority/Design***

The State of Wisconsin (Wisconsin) initially received approval to use funding for its Title XXI program to expand Title XIX coverage on May 29, 1998. The BadgerCare 1115 demonstration, which is inclusive of Title XXI and the Title XIX eligibility expansion for adults, is administered by the Wisconsin Department of Health and Family Services. The program initially covered children ages 15 through 18 who are in families with incomes at or below 100 percent of the FPL. Under both an amendment to their Title XXI and the Department's Section 1115 demonstration authority for a Title XIX expansion, a second MCHIP was implemented to include all remaining children not currently covered by Title XIX and their parents with net family income up to 200 percent of the FPL.

The Title XIX state plan currently covers all children from 0 through age 5 years in families with incomes at or below 185 percent of the FPL, and children who are 6 through 18 years in families with incomes at or below 100 percent of the FPL.

Title XXI applicants must have net family incomes at or below 185 percent of the FPL to enter the program but can remain in the program until their net family incomes exceed 200 percent of the FPL. Children living with a caretaker relative are also covered if Title XIX does not otherwise cover them under the State Plan, but the caretaker relative for these children will not be covered under this expansion.

Applicants are not eligible for BadgerCare if they are currently covered by health insurance, have had insurance in the 3 months prior to the month of application, or have had access to a group health insurance plan in which their employer paid at least 80 percent of the monthly

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<sup>44</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

premium in the past 18 months. A few states have tracked the share of applicants who fail to qualify for eligibility. In Wisconsin, 5 percent of all applicants (some of whom may not have had access to eligible employer coverage) were disqualified because they were insured at the time of application.<sup>45</sup>

Wisconsin uses a Title XIX managed care delivery system for its BadgerCare program, excluding HIPP and premium assistance. The Title XIX benefit plan is offered. Unborn children receive the pregnancy and pregnancy-related benefits offered under the Title XXI State Plan.

Since the original implementation and amendment of the program, Wisconsin has obtained approval for three additional amendments. The second amendment reduced the minimum amount of the employer contribution for participation in Wisconsin's premium assistance program from 60 percent to 40 percent and made self-insured employer coverage eligible. The third amendment updated its state plan to indicate compliance with the final Title XXI regulations. Wisconsin submitted its fourth amendment on May 8, 2006, which creates a Title XXI program to provide coverage for uninsured unborn children, who are ineligible for Title XIX, with family income up to and including 185 percent of the FPL.

Wisconsin's premium assistance program covers employer-sponsored insurance when the employer's contribution is between 40 percent and 80 percent. The program only includes families who are in BadgerCare, which covers families up to 185 percent of the FPL, who are not eligible for Medicaid, and no family member has been covered by employer-sponsored insurance in the past 6 months.<sup>46</sup>

Through its fiscal agent, EDS, Wisconsin sends all employers who are identified by applicants an information request form that includes questions about health plans offered, the cost of the plans and the employee share of the premium. If the employer does not respond to this request, EDS follows up by phone. If the employer has not responded within 56 days, eligible family members are enrolled in the regular BadgerCare program. Approximately 20 percent to 30 percent of the information request forms sent out to employers are never completed and returned.<sup>47</sup>

After verification of access to employer-sponsored insurance coverage has been made, Wisconsin makes a determination if it is cost effective to purchase family coverage either through its own HIPP program using Title XIX dollars or through the Title XXI cost effectiveness test. A regular Title XIX buy-in program exists for covering families when employer-sponsored insurance coverage did not meet the Title XXI cost effectiveness test.

Wisconsin has analyzed the proportion of employer plans that do not meet the cost effectiveness test. Of the 127 (out of 48,967) applicants meeting all other program requirements,

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<sup>45</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 20.

<sup>46</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 7.

<sup>47</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 11.

coverage was not cost effective for 18.<sup>48</sup> In addition, almost 50,000 employer information forms (corresponding to an equal number of applicants) were returned to Wisconsin, but from these only 109 families were determined eligible and 32 families actually enrolled in the premium assistance program.

As of July 31, 2007, there are 750 individuals (310 cases) enrolled in the BadgerCare/premium assistance program. Since 2004, Wisconsin has improved its process and doubled enrollment by obtaining a legal right to enroll individuals when the case is found cost effective, and not having to wait until the employer's open enrollment period to enroll the individual in the employer-sponsored insurance. They are hoping to implement BadgerCare Plus in January 2008, which will increase the number of individuals eligible for the program. One policy change that will be effective with BadgerCare Plus is that there will not be a requirement that employers pay a minimum of between 40 to 80 percent of the premiums. However, the new eligibles have a lower income level and are less likely to be working. Or, if they are working, they are less likely to be employed by a business that offers health insurance, so the effect of the new policy is not expected to result in large numbers of new enrollees in the HIPPP/premium assistance program.

Families enrolled in employer-sponsored insurance will receive Medicaid wrap-around for services not included in the employer's insurance plan. While program managers acknowledge that setting up wrap-around benefit systems can be complex and administering them a bit cumbersome, they also point out that many states have the infrastructure and experience to make it work. Wisconsin uses the Title XIX FFS system to pay wrap-around benefit claims, which works relatively smoothly.<sup>49</sup>

Another issue is how to make wrap-around benefits accessible and easy to use for participants. Most states give participants a Title XIX or Title XXI insurance card that participants use to cover wrap-around benefits and cost sharing above the Title XXI or Title XIX limits. Wisconsin employs this strategy and also asks participants to seek care from providers who participate in Title XIX, facilitating the payment process.<sup>50</sup>

## ***Cost Sharing***

Families with incomes above 150 percent of the FPL pay a premium that is 5 percent of family income. Premiums are collected through several methods as follows: (1) direct payment by check or money order (2) wage withholding or (3) electronic funds transfer. Failure to pay premiums will result in the disenrollment of the family from BadgerCare. The family is not eligible to re-enroll for another 6 months except for reasons of good cause (i.e., an administrative error in recording the non-payment of premiums or a change in the family composition).

States overwhelmingly prefer paying premium subsidies directly and prospectively to families. This reduces the burden on employers and preserves enrollee confidentiality. One exception is

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<sup>48</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 14.

<sup>49</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 14.

<sup>50</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 15.

Wisconsin, which make payments to the employer or insurance company in the rare cases where the employer prefers one of these options. Usually the first premium payment is sent to a participant once Wisconsin receives confirmation they are enrolled in employer-sponsored insurance. To monitor continued enrollment, Wisconsin requires applicants to submit monthly pay stubs.<sup>51</sup>

There are no copayments or deductibles for BadgerCare services provided under managed care.

Participants in Wisconsin can use their Title XIX FFS cards (provided by Wisconsin to pay wrap-around benefits and cost sharing) to pay employer copayments so long as they use a Title XIX provider. Providers bill Title XIX as the secondary payer responsible for these amounts. As is common for secondary coverage generally, Wisconsin providers can only bill Title XIX once the initial payment is received from the employer's plan.<sup>52</sup>

### **Program Size**

At the end of the first Federal fiscal quarter in 2006, there were a total of 29,875 enrolled in Wisconsin's MCHIP.<sup>53</sup> The state reported that 56,627 children were enrolled in the program during FFY 2006. The enrollment for adults, funded under Title XXI, in the 1115 demonstration, Badger Care, was 109,568 in FFY 2006. The most recent BadgerCare enrollment statistics can be found at: <http://www.dhfs.state.wi.us/badgercare/html/enrollmentstats.htm>

In the FFY 2006 Title XXI Annual Report, Wisconsin projected a net benefit cost of \$125,372,023 including \$7,448,182 in cost-sharing collections and a total administrative cost of \$8,832,800. The Title XXI allotment for FFY 2007 is \$69,563,162, and the enhanced match rate for expenditures is 70.23 percent. The parents were covered at the enhanced FMAP using the Department's Section 1115 demonstration authority for a Title XIX expansion. The children were covered under the Title XXI enhanced FMAP. However, Wisconsin also received the enhanced FMAP for both the parents and the children if cost effectiveness for family coverage through employer-sponsored insurance was demonstrated under Title XXI criteria.

## Wyoming

### **Program Authority/Design**

The State of Wyoming (Wyoming) was approved to implement a SCHIP program under Title XXI, called Wyoming Kid Care, on April 1, 1999. The Department of Health, the single state agency responsible for administering the Title XIX program, works with the Kid Care coalition to

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<sup>51</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 16.

<sup>52</sup> "Snapshot of State Experience Implementing Premium Assistance Programs", p. 17.

<sup>53</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>

administer the SCHIP program. The program initially covered children who are under the age of 19 with a family income at or below 133 of the FPL.

Since the original implementation of the program, Wyoming has submitted five amendments.

- The first amendment submitted on March 16, 2001, established a Kid Care C which sought to provide coverage to children with incomes between 134 to 150 percent of the FPL through a health insurance premium program. While approved by CMS, Wyoming did not implement KidCare C.
- Then on June 20, 2002, Wyoming submitted its second amendment to indicate compliance with the final Title XXI regulations.
- On April 1, 2003, Wyoming its third amendment to extend coverage to children with family incomes between 134 to 185 percent of the FPL and replaced the Title XIX look-a-like benefit plan with a Secretary-Approved benefit plan with cost sharing.
- On April 5, 2005, Wyoming submitted its fourth amendment which extended eligibility to 200 percent of the FPL and added dental services and increased the maximums for dental services and therapy services.
- Then on April 16, 2007, Wyoming submitted its fifth amendment to increase inpatient mental health benefits and add additional vision and dental services.

While Wyoming operates a SCHIP program under Title XXI, children in Title XIX and Kid Care receive services on a FFS basis due to the absence of managed care plans or a PCCM program. For children enrolled in the SCHIP program, Wyoming contracts with an insurer who is responsible for covering a benefit plan that is actuarially equivalent to the state employee's health insurance.

Wyoming uses a single application for both Title XIX and Title XXI. The Department of Health is responsible for the eligibility reviews and screens for Title XIX eligibility prior to assessing eligibility for Title XXI. A child determined eligible for Kid Care will received 12 months of continuous coverage until the child turns 19 or moves out of the state, at which time coverage will automatically terminate.

On November 6, 2006, Wyoming submitted a request for an 1115 HIFA waiver to request coverage for the MCHIP 4 Parents Program in which Wyoming is seeking to provide health insurance coverage to 3,720 parents and caretakers with incomes below 200 percent of the FPL. The program has two options, MCHIP employer-sponsored insurance and MCHIP Parents. The request is still pending CMS review.

### ***Cost Sharing***

Under Kid Care, enrollees are responsible for the following copayments:

- \$5 per visit for physician office visits, hospital emergency room visits and outpatient hospital visits
- \$3 per generic prescription and \$5 per brand-name prescription

There are no separate premiums or enrollment fees.

### ***Program Size***

At the end of the first Federal fiscal quarter in 2006, there were a total of 5,424 children enrolled in SCHIP.<sup>54</sup> In the FFY 2006 Title XXI Annual Report, Wyoming projected net benefit costs for 2007 would be \$10,374,142. The projected per member per month premium for FFY 2007 was \$157.65 with total administrative costs of \$856,300 of which \$273,000 was to be paid to a contractor for enrollment broker services. The Title XXI allotment is \$6,942,463, and the enhanced match rate for expenditures is 67.04 percent for FFY 2007.

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<sup>54</sup> Centers for Medicare and Medicaid Services, "SCHIP Enrollment Reports," (May 15, 2007), available at: <http://cms.hhs.gov/SCHIP/enrollment/>



Appendix F

## Cost Modeling Methodology

In order to quantify the potential change in expenditures associated with the three evaluated options, Mercer conducted a series of modeling exercises using Nebraska MCHIP historical claims data, Nebraska MCHIP SFY 2009 budget projections, other states' historical claims and enrollment experience and other commercial and national benchmarks as appropriate. The modeling performed and estimates produced for this analysis are high-level budget estimates specifically for Nebraska and are not appropriate for other purposes. To develop these estimates, we have relied on data and other information provided by the State. We have not audited that information, but did review it for reasonableness. If that data and information is inaccurate or incomplete, our results may require revision.

To identify the potential savings associated with Option A, which would incorporate a HIPP/TPL program into the current MCHIP program, Mercer developed expected HIPP/TPL costs using a variety of sources. We used the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS) for information about average premium and employee contribution levels in Nebraska. We used actuarial cost models based on Nebraska MCHIP claims experience to value services that would be provided as "wrap-around" benefits to employer sponsored coverage under this option, including the value of coordination of benefits expenses. On the advice of State staff, experience from the existing Medicaid HIPP program does not provide a useful guide, as it covers primarily disabled adults.

To identify the potential changes in expenditures for Options B and C, which involve changes to benefit design and cost sharing, Mercer used actuarial cost models based on Nebraska MCHIP claims experience and service utilization patterns. We used commercial benchmarks and other reference information as appropriate to estimate the cost of providing services at commercial payment levels rather than the Medicaid payment levels that are used in the current program. Where premiums were included in an option, Mercer estimated the potential adverse selection impact on expenses using our proprietary participation/selection models.

Estimates of enrollees eligible for the HIPP/TPL program and enrollees that might drop coverage due to the application of premiums were based on published studies that report other states' experience with similar programs and premium imposition.

Finally, additional administrative expenses for each option were estimated by developing estimates of additional staff and vendor requirements and collecting costs associated with those services. These additional expenses were based on Nebraska's wage information and the administration costs of operating the current Title XIX and Title XXI programs. Information from other state programs implementing similar programs was also reviewed.



## Cost Modeling Scenarios

### Scenario B.1 – Medicaid Expansion with Modified Benefit Plans Combined with HIPP; Basic Plan with No Point-of-Service Cost Sharing

	100%-150% FPL	150%-185% FPL
Average Monthly Premium	None	\$10.00
Calendar Year Deductible	None	
Maximum Out-Of-Pocket Each Calendar Year, Combined with Premium	5% of household income	
Inpatient Services, Skilled Care, Physical Rehab and Long Term Acute Care	No co-pay	No co-pay
Outpatient Hospital, Outpatient Services, Outpatient Surgical Centers	No co-pay	No co-pay
Diagnostic Lab and X-Ray (regardless the facility)	No co-pay	No co-pay
<b>Physician Office Visit and Physician Services</b>		
▪ Office Visits/ Consultations/Specialist	No co-pay	No co-pay
▪ Maternity and Family Planning Services	No co-pay	No co-pay
▪ Allergy Testing/Shots	No co-pay	No co-pay
▪ Surgery	No co-pay	No co-pay
▪ Radiology and Lab (office)	No co-pay	No co-pay
▪ Chemotherapy	No co-pay	No co-pay
▪ All Other Physician Services	No co-pay	No co-pay
<b>Preventive/Routine Services</b>		
▪ Well Baby and Well Child Visits	No co-pay	No co-pay
▪ Routine Immunizations for Children Through Six Years of Age	No co-pay	No co-pay
▪ Other Preventive/Routine Services	No co-pay	No co-pay
<b>Emergency Care Services</b>		
▪ Ambulance	No co-pay	No co-pay
▪ Urgi-Center (minor medical clinic) Services	No co-pay	No co-pay
▪ Hospital Emergency Room Services – Co-pay Waived for Emergency or if Admitted as Inpatient for the Same Diagnosis Within 24 Hours	No co-pay	No co-pay
Durable Medical Equipment, Home Health, Organ Transplant	No co-pay	No co-pay
Prescription Drugs	No co-pay	No co-pay
Hospice	No co-pay	No co-pay
TMJ Treatment (\$5,000 benefit maximum)	No co-pay	No co-pay
<b>Outpatient Rehabilitation Services (maximum of 60 combined sessions per calendar year)</b>		
▪ Occupational, Physical and Speech Therapy, Chiropractic and Osteopathic Physiotherapy, Spinal Manipulations/Adjustments	No co-pay	No co-pay
Inpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)	No co-pay	No co-pay
<b>Outpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)</b>		
▪ Therapy Visits	No co-pay	No co-pay
▪ Misc. Charges (i.e., lab)	No co-pay	No co-pay

### Scenario B.2 – Medicaid Expansion with Modified Benefit Plans Combined with HIPP; Basic Plan with Allowed Point-of-Service Cost Sharing

	100%-150% FPL	150%-185% FPL
Average Monthly Premium	None	\$25.00
Calendar Year Deductible	None	
Maximum Out-Of-Pocket Each Calendar Year, Combined with Premium	5% of household income	
Inpatient Services, Skilled Care, Physical Rehab and Long Term Acute Care	10% co-insurance	15% co-insurance
Outpatient Hospital, Outpatient Services, Outpatient Surgical Centers	10% co-insurance	15% co-insurance
Diagnostic Lab and X-Ray (regardless the facility)	10% co-insurance	15% co-insurance
<b>Physician Office Visit and Physician Services</b>		
▪ Office Visits/ Consultations/Specialist	\$5 co-pay	\$10 co-pay
▪ Maternity and Family Planning Services	No co-pay	No co-pay
▪ Allergy Testing/Shots	10% co-insurance	15% co-insurance
▪ Surgery	10% co-insurance	15% co-insurance
▪ Radiology and Lab (office)	10% co-insurance	15% co-insurance
▪ Chemotherapy	10% co-insurance	15% co-insurance
▪ All Other Physician Services	10% co-insurance	15% co-insurance
<b>Preventive/Routine Services</b>		
▪ Well Baby and Well Child Visits	No co-pay	No co-pay
▪ Routine Immunizations for Children Through Six Years of Age	No co-pay	No co-pay
▪ Other Preventive/Routine Services	No co-pay	No co-pay
<b>Emergency Care Services</b>		
▪ Ambulance	No co-pay	No co-pay
▪ Urgi-Center (minor medical clinic) Services	10% co-insurance	15% co-insurance
▪ Hospital Emergency Room Services – Co-pay Waived for Emergency or if Admitted as Inpatient for the Same Diagnosis Within 24 Hours	\$25 co-pay if non-emergent	\$50 co-pay if non-emergent
Durable Medical Equipment, Home Health, Organ Transplant	10% co-insurance	15% co-insurance
Prescription Drugs	\$5 per script	\$10 per script
Hospice	No co-pay	No co-pay
TMJ Treatment (\$5,000 benefit maximum)	10% co-insurance	15% co-insurance
<b>Outpatient Rehabilitation Services (maximum of 60 combined sessions per calendar year)</b>		
▪ Occupational, Physical and Speech Therapy, Chiropractic and Osteopathic Physiotherapy, Spinal Manipulations/Adjustments	10% co-insurance	15% co-insurance
Inpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)	10% co-insurance	15% co-insurance
<b>Outpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)</b>		
▪ Therapy Visits	\$5 co-pay	\$10 co-pay
▪ Misc. Charges (i.e., lab)	10% co-insurance	15% co-insurance

### Scenario C.1 – Separate Child Health Insurance Program (SCHIP); No Point-of-Service Cost Sharing

	100%-150% FPL	150%-185% FPL
Average Monthly Premium	\$5.00	\$12.00
Calendar Year Deductible	None	
Maximum Out-Of-Pocket Each Calendar Year, Combined with Premium	5% of household income	
Inpatient Services, Skilled Care, Physical Rehab and Long Term Acute Care	No co-pay	No co-pay
Outpatient Hospital, Outpatient Services, Outpatient Surgical Centers	No co-pay	No co-pay
Diagnostic Lab and X-Ray (regardless the facility)	No co-pay	No co-pay
<b>Physician Office Visit and Physician Services</b>		
▪ Office Visits/ Consultations/Specialist	No co-pay	No co-pay
▪ Maternity and Family Planning Services	No co-pay	No co-pay
▪ Allergy Testing/Shots	No co-pay	No co-pay
▪ Surgery	No co-pay	No co-pay
▪ Radiology and Lab (office)	No co-pay	No co-pay
▪ Chemotherapy	No co-pay	No co-pay
▪ All Other Physician Services	No co-pay	No co-pay
<b>Preventive/Routine Services</b>		
▪ Well Baby and Well Child Visits	No co-pay	No co-pay
▪ Routine Immunizations for Children Through Six Years of Age	No co-pay	No co-pay
▪ Other Preventive/Routine Services	No co-pay	No co-pay
<b>Emergency Care Services</b>		
▪ Ambulance	No co-pay	No co-pay
▪ Urgi-Center (minor medical clinic) Services	No co-pay	No co-pay
▪ Hospital Emergency Room Services – Co-pay Waived for Emergency or if Admitted as Inpatient for the Same Diagnosis Within 24 Hours	No co-pay	No co-pay
Durable Medical Equipment, Home Health, Organ Transplant	No co-pay	No co-pay
Prescription Drugs	No co-pay	No co-pay
Hospice	No co-pay	No co-pay
TMJ Treatment (\$5,000 benefit maximum)	No co-pay	No co-pay
<b>Outpatient Rehabilitation Services (maximum of 60 combined sessions per calendar year)</b>		
▪ Occupational, Physical and Speech Therapy, Chiropractic and Osteopathic Physiotherapy, Spinal Manipulations/Adjustments	No co-pay	No co-pay
Inpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)	No co-pay	No co-pay
<b>Outpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)</b>		
▪ Therapy Visits	No co-pay	No co-pay
▪ Misc. Charges (i.e., lab)	No co-pay	No co-pay

Point-of-service cost sharing is prohibited for Native Americans and Alaskan Natives.

### Scenario C.2 – Separate Child Health Insurance Program (SCHIP); Allowed Point-of-Service Cost Sharing

	100%-150% FPL	150%-185% FPL
Average Monthly Premium	\$12.00	\$25.00
Calendar Year Deductible	None	
Maximum Out-Of-Pocket Each Calendar Year, Combined with Premium	5% of household income	
Inpatient Services, Skilled Care, Physical Rehab and Long Term Acute Care	15% coinsurance, up to \$500 per admit for inpatient	15% co-insurance
Outpatient Hospital, Outpatient Services, Outpatient Surgical Centers	\$5 co-pay	15% co-insurance
Diagnostic Lab and X-Ray (regardless the facility)	\$5 co-pay	15% co-insurance
<b>Physician Office Visit and Physician Services</b>		
▪ Office Visits/ Consultations/Specialist	\$3 co-pay	\$10 co-pay
▪ Maternity and Family Planning Services	No co-pay	No co-pay
▪ Allergy Testing/Shots	\$3 co-pay	\$10 co-pay
▪ Surgery	\$3 co-pay	\$10 co-pay
▪ Radiology and Lab (office)	\$3 co-pay	\$10 co-pay
▪ Chemotherapy	\$3 co-pay	\$10 co-pay
▪ All Other Physician Services	\$3 co-pay	\$10 co-pay
<b>Preventive/Routine Services</b>		
▪ Well Baby and Well Child Visits	No co-pay	No co-pay
▪ Routine Immunizations for Children Through Six Years of Age	No co-pay	No co-pay
▪ Other Preventive/Routine Services	No co-pay	No co-pay
<b>Emergency Care Services</b>		
▪ Ambulance	No co-pay	No co-pay
▪ Urgi-Center (minor medical clinic) Services	\$5 co-pay	\$15 co-pay
▪ Hospital Emergency Room Services – Co-pay Waived for Emergency or if Admitted as Inpatient for the Same Diagnosis Within 24 Hours	\$10 co-pay if non-emergent	\$50 co-pay if non-emergent
Durable Medical Equipment, Home Health, Organ Transplant	\$5 co-pay	15% co-insurance
Prescription Drugs	\$5 per script	\$10 per script
Hospice	\$5 co-pay	No co-pay
TMJ Treatment (\$5,000 benefit maximum)	\$5 co-pay	15% co-insurance
<b>Outpatient Rehabilitation Services (maximum of 60 combined sessions per calendar year)</b>		
▪ Occupational, Physical and Speech Therapy, Chiropractic and Osteopathic Physiotherapy, Spinal Manipulations/Adjustments	\$3 co-pay	15% co-insurance
Inpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)	\$3 co-pay	15% co-insurance
<b>Outpatient Mental Illness and Substance Abuse Treatment – Benefits Subject to a 60-Day Maximum per Calendar Year (benefits for serious mental illness are not subject to this maximum)</b>		
▪ Therapy Visits	\$3 co-pay	\$10 co-pay
▪ Misc. Charges (i.e., lab)	\$3 co-pay	15% co-insurance

Point-of-service cost sharing is prohibited for Native Americans and Alaskan Natives.





## State Program Costs and Enrollment

		MCHIP	SCHIP*	Adult*	Total	Admin	Premiums Collected and % of Total	Premiums Collected and % of Total
Arkansas**	Enrollment	\$ 70,000	\$ 1,214		\$ 71,214			
	Dollars	\$ 63,137,114	\$ 5,863,907		\$ 69,001,021	\$ 7,666,780		
	Annual PM	\$ 902	\$ 4,830		\$ 969	\$ 108		
Colorado	Enrollment		\$ 59,530	\$ 1,575	\$ 61,105			
	Dollars		\$ 53,601,502		\$ 53,601,502	\$ 5,898,003		\$ (141,750)
	Annual PM		\$ 877	\$ 877	\$ 877	\$ 97		-0.26%
Idaho	Enrollment	\$ 18,639	\$ 3,200	\$ 135	\$ 21,974			
	Dollars	\$ 16,700,064	\$ 2,107,139		\$ 18,807,203	\$ 2,089,689		
	Annual PM	\$ 896	\$ 632	\$ 632	\$ 856	\$ 95		
Illinois	Enrollment	\$ 120,582	\$ 160,850	\$ 175,994	\$ 457,426			
	Dollars	\$ 52,747,363	\$ 417,480,954		\$ 470,228,317	\$ 23,849,290		\$ (3,018,548)
	Annual PM	\$ 437	\$ 1,239	\$ 1,239	\$ 1,028	\$ 52		-0.72%
Indiana	Enrollment	\$ 93,666	\$ 35,878		\$ 129,544			
	Dollars	\$ 73,979,126	\$ 23,253,264		\$ 97,232,390	\$ 5,612,507		\$ (2,115,034)
	Annual PM	\$ 790	\$ 648		\$ 751	\$ 43		-9.10%
Iowa	Enrollment	\$ 16,453	\$ 30,109		\$ 46,562			
	Dollars	\$ 17,071,268	\$ 35,216,987		\$ 52,288,255	\$ 2,427,739	\$ (226,190)	\$ (1,074,765)
	Annual PM	\$ 1,038	\$ 1,170		\$ 1,123	\$ 52	-1.32%	-3.05%
Kansas	Enrollment		\$ 47,323		\$ 47,323			
	Dollars		\$ 54,212,004		\$ 54,212,004	\$ 5,119,743		\$ (1,529,119)
	Annual PM		\$ 1,146		\$ 1,146	\$ 108		-2.82%
Kentucky	Enrollment	\$ 41,180	\$ 22,548		\$ 63,728			
	Dollars	\$ 63,321,377	\$ 25,032,653		\$ 88,354,030	\$ 1,589,747	\$ (313,546)	\$ (2,353,488)
	Annual PM	\$ 1,538	\$ 1,110		\$ 1,386	\$ 25	-0.50%	-9.40%
Missouri	Enrollment	\$ 115,355			\$ 115,355			
	Dollars	\$ 118,305,367			\$ 118,305,367	\$ 3,504,111	\$ (2,120,372)	
	Annual PM	\$ 1,026			\$ 1,026	\$ 30	-1.79%	
Nebraska	Enrollment	\$ 44,706			\$ 44,706			
	Dollars	\$ 46,497,218			\$ 46,497,218	\$ 964,276		
	Annual PM	\$ 1,040			\$ 1,040	\$ 22		
North Dakota	Enrollment	\$ 1,936	\$ 3,789		\$ 5,725			
	Dollars	\$ 5,379,032	\$ 4,644,998		\$ 10,024,030	\$ 657,890		
	Annual PM	\$ 2,778	\$ 1,226		\$ 1,751	\$ 115		
South Carolina	Enrollment	\$ 80,646			\$ 80,646			
	Dollars	\$ 68,047,065			\$ 68,047,065	\$ 4,596,131		
	Annual PM	\$ 844			\$ 844	\$ 57		
Utah	Enrollment		\$ 43,931		\$ 43,931			
	Dollars		\$ 33,563,755		\$ 33,563,755	\$ 2,074,939		\$ (652,420)
	Annual PM		\$ 764		\$ 764	\$ 47		-1.94%
West Virginia	Enrollment		\$ 38,614		\$ 38,614			
	Dollars		\$ 37,406,927		\$ 37,406,927	\$ 3,014,225		\$ (358,656)
	Annual PM		\$ 969		\$ 969	\$ 78		-0.96%
Wisconsin***	Enrollment	\$ 57,165		\$ 108,808	\$ 165,973			
	Dollars	\$ 29,235,237		\$ 84,778,279	\$ 114,013,516	\$ 7,807,293	\$ (3,571,554)	\$ (8,981,090)
	Annual PM	\$ 511		\$ 779	\$ 687	\$ 47	-12.22%	-10.59%
Wyoming	Enrollment		\$ 6,120		\$ 6,120			
	Dollars		\$ 7,719,679		\$ 7,719,679	\$ 411,640		
	Annual PM		\$ 1,261		\$ 1,261	\$ 67		

\*PMPMs calculated use child and adult enrollment; Adult costs not separated out to calculate own PMPM, with the exception of Wisconsin

\*\*Arkansas Medicaid Expansion program is under an 1115. The 2005 renewal application stated that enrollment was approximately 70,000.

\*\*\*Wisconsin adults are in a separate SCHIP program and costs are reported under the CMS.21.

Source: 2005 CMS 64.21 and CMS-21 data accessed on August 28, 2007 at [http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02\\_CMS64.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidBudgetExpendSystem/02_CMS64.asp#TopOfPage) and 2005 Enrollment data accessed on August 28, 2007 at <http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/list.asp#TopOfPage>



Appendix I

## Nebraska Private Insurers

### Licensed Medical Insurers and HMOs

The availability of private insurers willing to serve the Title XXI population Statewide will impact the options available to Nebraska. For example, many states rely upon private insurers in separate Child Health Insurance Programs (SCHIP). If there are not insurers interested in participating in the Title XXI population, then a MCHIP will continue to be more feasible for Nebraska.

The following is a list of all health insurance companies in Nebraska.<sup>55</sup>

- BlueCross and BlueShield of Nebraska
- Coventry Health Care of Nebraska, Inc.
- Exclusive Healthcare, Inc.
- United Healthcare of Midlands, Inc.
- United Dental Care of Nebraska, Inc.
- Delta Dental Plan of Nebraska #1, Inc.
- Avera Health Plans, Inc. (also licensed as an HMO)
- Corporate Health Insurance Company
- Coventry Health and Life Insurance Company
- First Pyramid Life Insurance Company of America
- Health Care Service Corporation, A Mutual Legal Reserve Company
- Humana Health Plan, Inc. (also licensed as an HMO)

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<sup>55</sup> The Nebraska Department of Insurance website accessed on September 20, 2007 at <http://www.doi.ne.gov/appointments/search/fullSummary.cgi?subType=domHealth>

- Imerica Life and Health Insurance Company
- Mamsi Life and Health Insurance Company
- Medco Containment Life Insurance Company
- Medical Savings Insurance Company
- OneNation Insurance Company
- QCC Insurance Company
- Renaissance Life & Health Insurance Company
- Sterling Life Insurance Company
- United Concordia Insurance Company
- Vision Service Plan Insurance Company
- Wellington Life Insurance Company

### HMOs Licensed in Nebraska

The following are HMOs that are licensed in Nebraska and their enrollment numbers as of the dates shown with their service areas as of October 26, 2006<sup>56</sup>.

**Table 14: Domestic HMOs**

HMO	Enrollment	Service Areas
<p><b>Coventry Health Care of Nebraska, Inc.</b> – 63115</p> <p>13305 Birch Street, Suite 100 Omaha, NE 68154</p> <p>Formerly Principal Health Care</p>	42,296 (March 22, 2003)	In Nebraska, including counties: Adams, Antelope, Arthur, Blaine, Boone, Boyd, Brown, Burt, Buffalo, Butler, Cass, Cedar, Chase, Cherry, Clay, Colfax, Cuming, Custer, Dakota, Dawson, Dixon, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greely, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Keya Paha, Kearney, Keith, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Sherman, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler and York. (83 counties)
<p><b>Exclusive Healthcare, Inc.</b> – 22945</p> <p>Mutual of Omaha Plaza Omaha, NE 68175</p>	5,433 (March 2005)	Iowa, Kansas, Missouri, Nebraska, Nevada and Texas

<sup>56</sup> The Nebraska Department of Insurance website accessed on September 20, 2007 at <http://www.doi.ne.gov/brochures>

HMO	Enrollment	Service Areas
<p><b>United HealthCare of the Midlands, Inc.</b> – 76483</p> <p>2717 No. 118th Circle Omaha, NE 68164-6792</p>	<p>49,511 (December 2004)*</p>	<p>In Nebraska, including counties: Douglas, Sarpy, Lancaster, Gage, Madison, Pierce, Polk, Butler, Jefferson, Knox, Cass, Saunders, Otoe, Johnson, Burt, Nance, Nemaha, Richardson, Colfax, Dixon, Washington, Seward, Dodge, Saline, Buffalo, Pawnee, Thayer, Fillmore, Nuckolls and Dakota. (30 counties)</p> <p>In Iowa, including counties Pottawattamie, Cass, Woodbury, Mills, Monona, Fremont, Shelby and Harrison.</p>

\*Includes clients enrolled in Medicaid managed care at this time.

In addition, the Nebraska State Employee Health Plan contracts with two companies to provide health insurance across the state: Mutual of Omaha and BCBS of Nebraska. Mutual of Omaha offers two plans to State employees residing in three zip codes (680, 681 and 685) only. The plans are an HMO and Point of Service (POS) delivery model. BCBS offers four plans to Nebraska State employees. Two BCBS of Nebraska plans, a PPO and a High Deductible PPO, are offered statewide. Two additional BCBS plans, BlueChoice and BlueSelect, are only for employees residing outside the Mutual of Omaha zip codes. State employees are also offered supplemental dental and vision plans in addition to the Mutual of Omaha and BCBS of Nebraska plans.

Furthermore, the following companies cover a significant service area in the State of Nebraska with Medicare Advantage health plans:

- Advantra Freedom/Coventry Health Care, Inc.
- BCBS of Nebraska
- Humana Insurance Company
- SecureHorizons MedicareDirect
- Sterling Life Insurance Company
- Unicare Life & Health Insurance Company

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