September 9, 2000

Michael Boyd
Director, Policy and Planning Division
Office of the Governor
20th Floor Walter Sillers Building
Jackson, MS 39202

Dear Mr. Boyd:

This letter is in response to your inquiry regarding the potential for converting Phase II of the Children's Health Insurance Program from a fully-insured plan to a self-insured plan. Since Phase II of the Program is a separate insurance program, as opposed to a Medicaid expansion, it is referred to by the federal government as SCHIP, and I will use this acronym in this letter to refer to Phase II.

Your first question dealt with the need to change any state law, so I will review the legislative authority for such a conversion. The state law governing SCHIP (§ 41-86-1 et seq.) authorized the Children's Health Insurance Program Commission to determine the structure of the program. The Final Report of the Children's Health Insurance Program Commission established the structure of SCHIP as "a fully insured single insurer state program with a contract awarded to the vendor who submits the best and most cost-effective bid with an option for employer subsidized coverage....An option to become self-insured if economically feasible in future years may be considered by the Insurance Management Board."

Section 41-86-11 of the law governing SCHIP provides that "the administering agency shall execute a contract or contracts to provide the health care coverage and services under the program, after first receiving bids." This section of the law is patterned after the law governing the State and School Employees' Life and Health Insurance Plan. It does not restrict the Board to a fully-insured contract as it may also apply to services required to administer a self-insured plan. Accordingly, I feel that no change is needed in state law to convert to a self-insured plan.

The rationale used by the Commission for establishing the structure of the "fully insured single insurer state program" was two-fold. The first reason centered on the need to implement a separate insurance program as quickly as possible. It is certainly much faster to purchase a single insurance product than to bid out every function of a self-insured plan and build it from the ground up. The second reason was that under a fully-insured plan, all payments to the insurer, including for the costs of administering the plan, are considered direct costs. Under a self-insured arrangement, all payments to vendors for administrative services would count against the state's ten percent cap on administrative costs. It was well understood by everyone involved that a considerable amount of administrative funds would be needed for start-up and outreach at the initiation of the Program.

The general discussion at the time was that once a demographic profile, claims history, and reserve fund could be established for the SCHIP population, the Board would consider converting to a self-insured plan. It may be possible to avoid the application of the administrative costs to the ten percent cap by structuring the Program so that the Division of Medicaid pays a "premium" to the Board for insuring children eligible for SCHIP. This type of structure is used in other states such as North Carolina.

Conversion to a self-insured plan would need to be planned and budgeted carefully. The Board in essence would be moving from a purchaser of an insurance policy to the administrator of an insurance company. Because the Board already administers the State and School Employees' Health Insurance Plan, it may be possible to "piggy-back" onto some of the State Health Plan's contracts, as the Board did with the contract for actuarial services. Amending current contracts to include SCHIP would speed up the conversion only by eliminating the competitive bid process; the implementation time would not be shortened. We would still be essentially building a separate insurance plan with independent eligibility requirements, benefits, and funding.

DFA, as the administrative arm of the Board, would need to hire staff to perform certain administrative functions now conducted by Blue Cross Blue Shield as the insurer. These functions include, but are not limited to, accounting, customer service and appeals, communications, benefit and claims analysis, and coordination of vendors. Some of these positions are already in the budget, and some would need to be requested through the budget process.

The advantages of converting SCHIP to a self-insured plan include a reduction in costs and an increase in control over routine decisions. The disadvantages include the disruption of services caused by a change in vendors and providers, a possible shift of accounting of funds from direct expenditures to administrative costs, the State's becoming the focal point for complaints (and lawsuits) as opposed to the insurance company, possible confusion about the SCHIP children being thought of as covered by the State Health Plan, and a perception that the population is no longer receiving "private insurance" but a "state program."

I hope this adequately outlines the major issues involved in converting SCHIP to a self-insured plan. Should you need clarification or additional information, please call me at 359-6708.

Sincerely,

Therese Hanna
State Insurance Administrator

cc: Gary Anderson