

**Health Care Utilization and Costs of Full-Pay and Subsidized Enrollees
in the Florida KidCare Program**

**Prepared for the
Florida Healthy Kids Corporation**

Prepared by

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I. INTRODUCTION

Florida KidCare is the state's health insurance program for uninsured children under age 19. The Title XXI State Children's Health Insurance Program (SCHIP) components of Florida KidCare provide health insurance to low-income uninsured children who are not eligible for Medicaid. The MediKids program serves children ages 1-4 years old, and the Florida Healthy Kids Program serves children ages 5-18 years. Children who meet the program eligibility requirements with family income between 101-200% of the federal poverty level (FPL) are eligible for subsidized premiums. Families whose annual income is less than or equal to 150% of the FPL pay monthly premiums of \$15 per family per month (PFPM). Families whose annual income is 151-200% of the FPL pay \$20 PFPM. Since the program's inception, the Florida Healthy Kids Program has permitted families whose income exceeds the Program's subsidy level to buy into the program at the full monthly premium cost for each enrolled child. The MediKids program began offering a similar buy-in option on July 1, 2006. The current premium amount for the Florida Healthy Kids buy-in program is \$128 per child per month for medical and dental coverage, or \$116 per child per month for families who opt out of the dental coverage. The premium amount for the MediKids buy-in program is \$159 per child per month for medical and dental coverage. From July 1, 1998 through July 1, 2008, enrollment of these "full-pay" children was limited to 10% of total program enrollment.

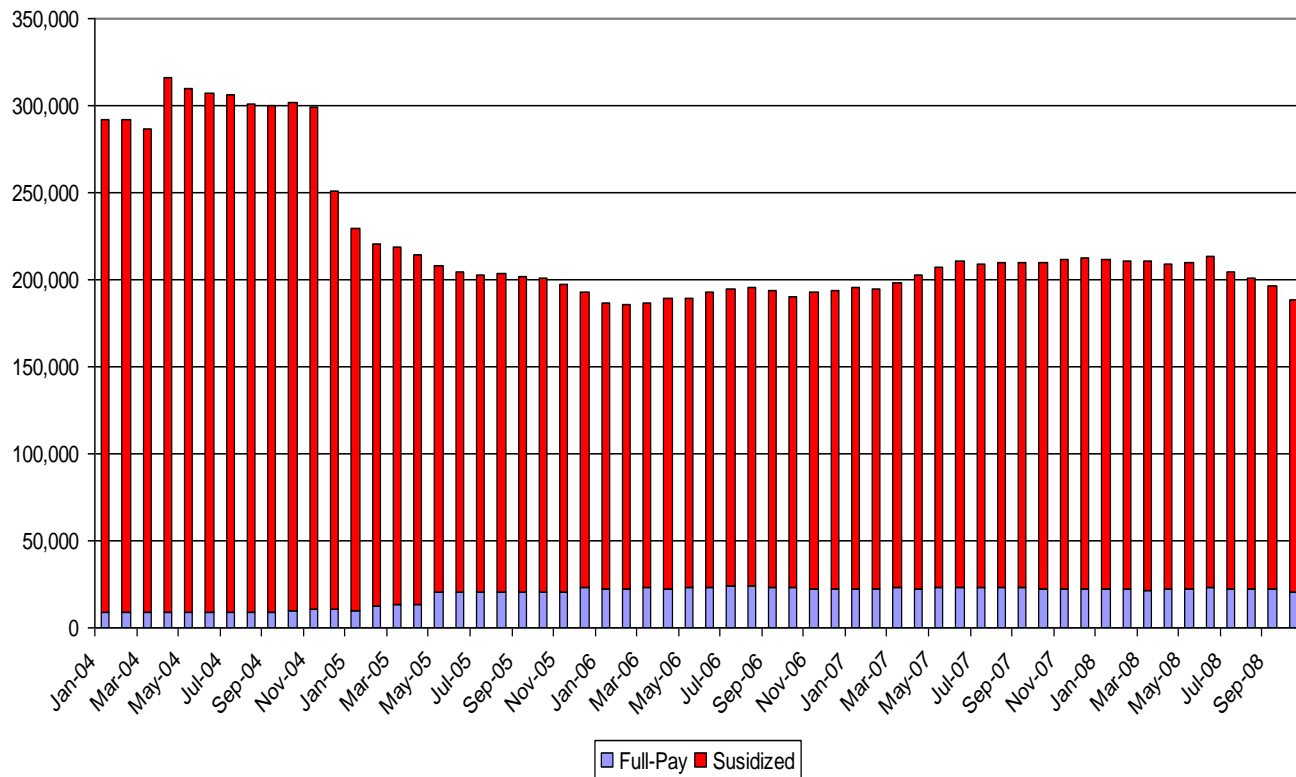
During the 2008 Florida Legislative Session, the 10% enrollment limit was removed effective July 1, 2008. The legislation charged the Florida Healthy Kids Corporation with providing a study to the Legislature and the Governor that (1) compares the utilization and costs of the full-pay enrolled population and the subsidized enrolled population, (2) evaluates the premium impact to the subsidized portion of the program of including the full-pay program, and (3) makes recommendations on how to mitigate possible impacts to the subsidized population. The Florida Healthy Kids Corporation contracted with the Institute for Child Health Policy to conduct this evaluation. This report covers only the Florida Healthy Kids Program because data for the MediKids program were not available for analysis. This report will be appended to include MediKids enrollees when the data are available.

II. BACKGROUND

Florida is one of only eight states with a longstanding buy-in program (Kenney et al. 2008; Virginia DMAS 2006). A growing number of states have recently approved or are considering developing buy-in programs to expand children's health insurance coverage (Heberlein et al. 2008). From July 1, 1998 through July 1, 2008, Florida limited enrollment of the buy-in population to 10% of total program enrollment. Among the eight states with longstanding buy-in programs, Florida was the only one that limited enrollment; however, two states restricted participation in their buy-in programs to former SCHIP enrollees. Although the Florida KidCare buy-in program consists primarily of children whose family income exceeds 200% of the FPL, there are some lower-income families who have been permitted to participate for other reasons. These include children who are dependents of state employees, children whose families voluntarily cancelled employer coverage in the past six months, and children who have access to employer coverage that costs less than 5% of income. The enrollment limit of 10% only applied to families whose income exceeded 200% of the FPL and not to families permitted to participate in the buy-in program for these other reasons. The Florida Healthy Kids Corporation never needed to operationalize the enrollment cap. On July 1, 2008, the cap was legislatively removed. Figure 1 shows enrollment in the Florida Healthy Kids program for full-pay and subsidized enrollees from July 2004 through October 2008. Since January 2006, there has been some fluctuation in the subsidized enrollment, but enrollment in the full-pay component of the program has been very stable. Preliminary enrollment data for the period July 2008 through October 2008 after the cap was removed do not indicate an increase in the number of full-pay enrollees.¹

One of the primary concerns with implementing a buy-in program is the potential for adverse selection. Any voluntary health insurance program has the potential to experience adverse selection when the premium amount reflects the average cost of coverage for a group of people. Adverse selection occurs when sicker individuals (i.e., those whose expected health care costs are greater than average) disproportionately obtain coverage compared to healthier individuals (Cutler and Zeckhauser 2000). The greater the cost of obtaining coverage, the more likely it is that adverse selection will occur because fewer healthy individuals elect to obtain coverage thereby increasing the average risk and cost of the covered group. The cost of obtaining coverage is not limited to premiums, it also includes the enrollment costs incurred by families – i.e., the time and effort required to fill out required paperwork and gather necessary information (Kenney et al. 2008). The premiums in SCHIP buy-in programs are typically significantly higher than the subsidized premiums. As a result, adverse selection is likely to be a greater concern for buy-in programs than for subsidized programs. That is, those families who do not expect to use many health care services have less incentive to incur the premium and enrollment processing costs required to enroll their children in the buy-in program.

**Figure 1: Full-Pay and Subsidized Enrollment in the Florida Healthy Kids Program
July 2004 – October 2008**



III. DATA SOURCES AND MEASURES

A. Data Sources

The following data sources were used:

1. Enrollment files provided by the Florida Healthy Kids Corporation. The enrollment files contain information about the children's age, gender, family income, monthly premium amounts, and enrollment status. These files were used to (1) identify the children's monthly enrollment and subsidy status and (2) obtain information about the children's sociodemographic characteristics.
2. The enrollment files were matched to health care claims and encounter data submitted by all of the health plans participating in the Florida Healthy Kids Program. The person-level claims and encounter data include inpatient, outpatient, and pharmacy files. These files contain Physician's Current Procedural Terminology (CPT) codes, International Classification of Diseases, 9th Revision (ICD 9-CM) codes, and National Drug Codes. The claims and encounter data were used to classify the children's health status and identify their health care utilization.

B. Sample

We analyzed enrollment, health care utilization, and costs for 293,994 unique children ages 5-18 enrolled in the Florida Healthy Kids Program for at least one month during calendar year 2007 who could be matched to the claims and encounter data.² These children collectively represented 2,456,096 months of coverage. The full-pay premium amount was \$120 from January – September and \$128 from October – December for medical and dental coverage. The corresponding amounts for families who opted out of the dental coverage were \$108 and \$116, respectively. Approximately, 85% of those in the full-pay group had the combined medical and dental coverage. The analytic dataset was constructed such that there were 12 records for each child (one for each month of the year), and analyses were conducted at the child-month level.

C. Measures

Subsidy Status. An enrollment month was classified as “subsidized” if the monthly premium amount was \$20 or less. An enrollment month was classified as “full-pay” if the monthly premium amount was greater than \$20. The full-pay category includes all children who participated in the buy-in option, including those below 200% who qualified for the buy-in option due to the other reasons described previously.

Children's Health Status. The health care claims and encounter data were used to characterize the children's health status using the Clinical Risk Groups (CRGs). The CRGs uses ICD-9-CM diagnosis codes from all health care encounters, except those associated with providers known to frequently report unreliable codes (e.g., non-clinician providers and ancillary testing providers), to assign individuals to a hierarchically defined core health status group (Neff et al. 2001). The CRGs has been tested and validated for identifying children with special health care needs (Bethell 2002; Neff et al. 2001). Children more than 12 months old must be enrolled for at least six months to be classified. This time frame allows for a sufficient claims history for classification.

The CRGs has nine health status categories that were reduced to the following five groups using instructions from the developers: (1) healthy (including non-users of health care services), (2) significant acute conditions (e.g., meningitis and traumatic brain injury), (3) minor chronic conditions (e.g., attention deficit disorder), (4) moderate chronic conditions (e.g., diabetes and depression), and (5) major chronic

conditions (e.g., cystic fibrosis, cancer, and schizophrenia). Children not meeting the minimum enrollment criteria of six months for CRG classification are labeled “unclassified.” Unclassified children include new enrollees and children who cycle in and out of the program.

Demographic Characteristics. The children’s age and gender were obtained from the enrollment files.

Utilization. Within each subsidy category (full-pay and subsidized), utilization was assessed at the child-month level and averages were calculated for the entire sample. Utilization measures were calculated for the following categories of service:

- outpatient encounters,
- inpatient stays,
- emergency room visits,
- prescription drugs,
- chemical dependency services,
- mental health services,
- therapy services,
- ancillary services (laboratory, radiology, and pathology), and
- durable medical equipment.

Where possible, utilization measures were calculated using the specifications provided in the National Commission on Quality Assurance (NCQA) HEDIS Technical Specifications manual.

Costs. Within each subsidy category (full-pay and subsidized), total costs were assessed at the child-month level. Per member per month (PMPM) averages were calculated for the entire sample. During the time period examined, the health plans were not required to report their payment information to the ICHP on all of their encounter data. For those plans that reported payments, the reporting was not sufficiently complete to allow for an assessment of the final disposition of the amounts paid by the health plans. In addition, health plans have different reimbursement policies which could confound the analysis of the costs of serving full-pay enrollees. Therefore, to calculate the PMPM costs, CPT, NDC, and other procedure codes (such as the Healthcare Common Procedure Coding System – HCPCS – codes) were linked to the state Medicaid fee schedule. The fee schedule applies a uniform price across the health plans for each medical service and, therefore, captures the relative resource intensity of medical services provided. Because the purpose of these cost calculations is to examine the relative differences between the two subsidy groups, we normalized the PMPM costs to a value of \$1 PMPM for subsidized enrollees. The actual dollar amounts or exact costs are not as critical as the relationships observed between the two groups.

Analytic Methods. Tests of statistical significance were used to determine whether there were significant differences between enrollees in the full-pay and subsidized premium categories. Chi-square tests were used to compare the sociodemographic characteristics and health status of the two groups. Because utilization and cost data are skewed, nonparametric Wilcoxon-Mann-Whitney tests were used to compare these measures. Utilization and cost comparisons were analyzed for the sample overall and within each health status category. Differences between the two subsidy categories were considered statistically significant for p -values $\leq .05$.

IV. RESULTS

A. Sociodemographic Characteristics and Health Status

A total of 2,456,096 enrollment months were analyzed for the 293,994 children in our sample. On average, children were enrolled 8.4 months during the year. Table 1 shows the distribution of the sociodemographic characteristics and health status of enrollees by subsidy category. Overall, 52% of enrollees were ages 12 or older and 51% were male. Full-pay enrollees were more likely to be older than subsidized enrollees ($\chi^2=3,000$; $p<.0001$). Approximately 57% of full-pay enrollees were 12 years of age or older compared to 51% of subsidized enrollees. Full-pay enrollees also were somewhat more likely to be male, but the difference was less than two percentage points.

Overall, 70% of enrollees were classified as healthy, 7% had significant acute conditions, 6% had minor chronic conditions, 7% had moderate chronic conditions, 1% had major chronic conditions, and 9% had insufficient enrollment during the observation period to be classified. A smaller percentage of full-pay enrollees were unclassified (6.6%) compared to those with subsidized premiums (9.5%), which suggests that full-pay enrollees on average are more likely to have longer enrollment spells or fewer disruptions in coverage. Full-pay enrollees were less likely to be classified as healthy (65%) compared to enrollees with subsidized premiums (71%) and more likely to have significant acute or chronic conditions ($\chi^2=16,000$; $p<.0001$). For example, 10% of full-pay enrollees had moderate chronic conditions compared to 6% of those with subsidized premiums.

Table 1: Sociodemographic Characteristics and Health Status by Premium Subsidy Status						
January 1, 2007 to December 31, 2007						
	Total Enrollment Months		Premium Subsidy Status			
			Subsidized Premium		Full-pay	
	N	Column %	N	Column %	N	Column %
Total	2,456,096	100.00%	2,183,422	100.00%	272,674	100.00%
Age						
5-11 years	1,185,248	48.26%	1,067,073	48.87%	118,175	43.34%
12-18 years	1,270,848	51.74%	1,116,349	51.13%	154,499	56.66%
Gender						
Female	1,213,863	49.42%	1,082,899	49.60%	130,964	48.03%
Male	1,242,233	50.58%	1,100,523	50.40%	141,710	51.97%
Health Status Category						
Healthy	1,723,421	70.17%	1,546,564	70.83%	176,857	64.86%
Significant Acute	166,338	6.77%	145,197	6.65%	21,141	7.75%
Minor Chronic	154,886	6.31%	130,936	6.00%	23,950	8.78%
Moderate Chronic	163,431	6.65%	136,306	6.24%	27,125	9.95%
Major Chronic	22,752	0.93%	17,178	0.79%	5,574	2.04%
Unclassified	225,268	9.17%	207,241	9.49%	18,027	6.61%

B. Utilization by Service Category

Outpatient Encounters. Table 2 provides the utilization per 1,000 member months for outpatient encounters, which was calculated using the following formula:

$$(\text{total visits}/\text{total member months}) \times 1,000.$$

Three categories of outpatient encounters were examined:

- (1) Total outpatient encounters during the month were identified by using the CPT codes specified in the NCQA HEDIS Technical Specifications manual to identify outpatient encounters. Following the HEDIS approach, mental health and chemical dependency services were excluded and are reported as separate service categories.
- (2) Office or other outpatient visits are a subcategory of total outpatient encounters and reflect evaluation and management services provided in an outpatient setting. CPT E&M codes 99201-99205 and 99211-99215 were used to identify these encounters.
- (3) Outpatient consultations are another subcategory of total outpatient encounters and capture specialty referrals in an outpatient setting. These encounters were identified using CPT E&M codes 99241-99245. Outpatient consultations may be indicative of a greater need for health care services overall and for specialty services in particular.

Overall, full-pay enrollees averaged 445 outpatient encounters per 1,000 member months compared to 340 encounters for those with subsidized premiums, and this difference was statistically significant. The ratio of full-pay outpatient encounters to subsidized outpatient encounters was 1.31, indicating a 31% higher utilization rate among full-pay enrollees overall. Utilization also was higher among full-pay enrollees within each health status category, and these differences were statistically significant. However, the utilization ratio between the two subsidy groups is smaller among enrollees who have significant acute or chronic conditions compared to healthy and unclassified enrollees. Similar results were obtained for outpatient office visits: full-pay enrollees have a significantly greater number of outpatient office visits compared to subsidized enrollees overall and for every health status category except minor chronic; the utilization is 30% higher overall; and there are smaller but still significant differences in utilization among children with significant acute and chronic conditions (except minor chronic). A somewhat different result is obtained for outpatient consultations. Overall, full-pay enrollees averaged 11 outpatient consultations per 1,000 member months compared to 8 consultations per 1,000 member months for subsidized enrollees, and this difference was statistically significant. Within health status categories, children classified as healthy and those with insufficient enrollment to be classified (unclassifieds) had statistically significant differences. However, among children with significant acute and chronic conditions, the differences in utilization between the two subsidy groups were not statistically significant except for the moderate chronic category. This suggests that access to consultations may be perceived to be more critical for children with identified special health care needs.

**Table 2: Outpatient Encounters by Premium Subsidy Status and Child Health Status
January 1, 2007 – December 31, 2007**

	Outpatient Encounters per 1,000 Member Months		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,183,422 member months)	Full-pay (272,674 member months)		
Total Outpatient Encounters				
Total*	340.39	444.76	1.31	<0.0001
By Health Status				
Healthy*	225.55	266.54	1.18	<0.0001
Significant Acute*	735.89	782.70	1.06	<0.0001
Minor Chronic*	656.05	694.28	1.06	0.0009
Moderate Chronic*	817.67	890.69	1.09	<0.0001
Major Chronic*	1,586.22	1,721.03	1.08	0.0067
Unclassified*	303.72	399.79	1.32	<0.0001
Outpatient Office Visits				
Total*	123.21	160.21	1.30	<0.0001
By Health Status				
Healthy*	84.83	102.54	1.21	<0.0001
Significant Acute*	257.11	272.13	1.06	0.0001
Minor Chronic	238.12	245.18	1.03	0.1151
Moderate Chronic*	283.88	309.79	1.09	<0.0001
Major Chronic*	484.05	518.48	1.07	0.0174
Unclassified*	107.64	146.00	1.36	<0.0001
Outpatient Consultations				
Total*	8.17	11.25	1.38	<0.0001
By Health Status				
Healthy*	4.13	5.16	1.25	<0.0001
Significant Acute	21.96	23.04	1.05	0.3892
Minor Chronic	22.97	23.34	1.02	0.9771
Moderate Chronic*	22.31	24.18	1.08	0.0448
Major Chronic	46.22	46.47	1.01	0.7419
Unclassified*	6.88	10.76	1.57	<0.0001

*Statistically significant at the $p \leq .05$ level.

Inpatient Stays. Table 3 shows the utilization per 1,000 member months for (1) inpatient discharges and (2) inpatient days. Inpatient discharges were calculated as: (total discharges/ total member months)*1,000. Inpatient days were calculated as: (total days/total member months)*1,000. Inpatient stays with a mental health and chemical dependency principal diagnosis were excluded and reported as a separate service category.

Overall, full-pay enrollees averaged nine inpatient discharges per 1,000 member months compared to six discharges for those with subsidized premiums, and this difference was statistically significant.³ Full-pay enrollees averaged a greater number of days compared to subsidized enrollees. However, with the exception of children with moderate chronic conditions and unclassified enrollees, there were no statistically significant differences in utilization between the two subsidy categories within each health status category. Another way to examine inpatient utilization is to compare the average length of stay, which is the total number of days divided by the total number of discharges. Table 4 summarizes the average length of stay for the two subsidy status categories. The full-pay enrollees have a 14% longer average length of stay than subsidized enrollees, and the difference between the two groups was the greatest for children with minor chronic and major chronic conditions.

Table 3: Inpatient Discharges and Days by Premium Subsidy Status and Child Health Status January 1, 2007 – December 31, 2007				
	Discharges and Days per 1,000 Member Months		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,183,422 member months)	Full-pay (272,674 member months)		
Inpatient Discharges				
Total*	5.77	8.64	1.50	<0.0001
By Health Status				
Healthy	2.15	2.35	1.09	0.0526
Significant Acute	14.31	15.09	1.05	0.3351
Minor Chronic	16.34	14.78	0.90	0.0944
Moderate Chronic*	20.15	22.60	1.12	0.0440
Major Chronic	78.35	88.98	1.14	0.0923
Unclassified*	4.67	8.88	1.90	<0.0001
Inpatient Days				
Total*	10.93	18.72	1.71	<0.0001
By Health Status				
Healthy	3.22	4.15	1.29	0.0526
Significant Acute	24.80	25.07	1.01	0.3392
Minor Chronic	30.14	30.52	1.01	0.0965
Moderate Chronic*	43.81	49.33	1.13	0.0455
Major Chronic	208.64	261.93	1.26	0.0859
Unclassified*	8.54	17.36	2.03	<0.0001

*Statistically significant at the $p \leq .05$ level.

Table 4: Inpatient Average Length of Stay by Premium Subsidy Status and Child Health Status January 1, 2007 – December 31, 2007			
	Average Length of Stay		
	Subsidized Premium	Full-pay	Ratio of Full-pay to Subsidized
Average Length of Stay			
Overall	1.89	2.17	1.14
By Health Status			
Healthy	1.50	1.77	1.18
Significant Acute	1.73	1.66	0.96
Minor Chronic	1.84	2.06	1.12
Moderate Chronic	2.17	2.18	1.00
Major Chronic	2.66	2.94	1.11
Unclassified*	1.83	1.96	1.07

Emergency Room Visits. Table 5 shows the utilization per 1,000 member months for emergency room visits that did not result in an inpatient admission. ER visits with a mental health and chemical dependency principal diagnosis were excluded and are reported separately. ER visits were 16% higher overall among full-pay enrollees with statistically significant differences within health status categories only for healthy enrollees and those with moderate chronic conditions.

Table 5: ER Visits by Premium Subsidy Status and Child Health Status January 1, 2007 – December 31, 2007				
	Visits per 1,000 Member Months		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,183,422 member months)	Full-pay (272,674 member months)		
ER Visits – No Inpatient Admission				
Total*	39.37	45.85	1.16	<0.0001
By Health Status				
Healthy*	26.85	30.11	1.12	0.0120
Significant Acute	91.69	89.02	0.97	0.2279
Minor Chronic	72.79	73.74	1.01	0.0870
Moderate Chronic*	82.39	75.80	0.92	0.0002
Major Chronic	150.83	139.22	0.92	0.4916
Unclassified	37.46	38.66	1.03	0.3144

*Statistically significant at the $p \leq .05$ level.

Prescription Drug Utilization. Table 6 shows prescription drug utilization measured in two ways: (1) the number of prescriptions per 1,000 member months and (2) the number of prescriptions per member per year. Prescription drug utilization was 59% higher among full-pay enrollees compared to subsidized enrollees. Moreover, prescription drug utilization was significantly higher among full-pay enrollees within each health status category, with the greatest difference among children whose health status could not be classified due to insufficient enrollment length. The smallest differences between the two subsidy categories were among enrollees with significant acute and minor chronic conditions.

Table 6: Prescription Drug Utilization by Premium Subsidy Status and Child Health Status January 1, 2007 – December 31, 2007						
	Prescriptions per 1,000 Member Months		Prescriptions Per Member Per Year (PMPY)		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,191,072 member months)	Full-pay (273,652 member months)	Subsidized Premium	Full-pay		
Prescriptions						
Total*	266.88	424.69	3.20	5.10	1.59	<0.0001
By Health Status						
Healthy*	169.37	231.42	2.03	2.78	1.37	<0.0001
Significant Acute*	411.30	475.19	4.94	5.70	1.16	<0.0001
Minor Chronic*	629.66	748.98	7.56	8.99	1.19	<0.0001
Moderate Chronic*	802.71	1114.18	9.63	13.37	1.39	<0.0001
Major Chronic*	1288.45	1801.22	15.46	21.61	1.40	<0.0001
Unclassified*	227.03	367.62	2.72	4.41	1.62	<0.0001

*Statistically significant at the $p \leq .05$ level.

Mental Health and Chemical Dependency Services. Table 7 shows mental health and chemical dependency services per 1,000 member months. These services were identified using the ICD-9 principal diagnosis codes for mental health and chemical dependency services, respectively, identified in the HEDIS Technical Specifications manual. These services are grouped in the following categories: (1) outpatient encounters, which include ER visits that do not result in an inpatient admission, (2) inpatient discharges, (3) inpatient days, and (4) other encounters with the appropriate principal diagnosis codes. The HEDIS technical specifications for outpatient services require that some of the procedure codes be combined with place of service or provider type; however, the claims and encounter data provided by the health plans did not include place of service and provider type. Rather than omitting all of the services represented by these combination codes, the “other” category was used to capture medical services with a mental health or chemical dependency principal diagnosis code that did not otherwise meet the HEDIS technical specifications. Outpatient encounters were 84% higher for mental health services and 53% higher for chemical dependency services among full-pay enrollees. Inpatient discharges, inpatient days, and other encounters also were higher among full-pay enrollees.

Table 7: Mental Health and Chemical Dependency Services by Premium Subsidy Status January 1, 2007 – December 31, 2007				
	Services per 1,000 Member Months		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,183,422 member months)	Full-pay (272,674 member months)		
Mental Health				
Outpatient Encounters*	26.14	48.00	1.84	<0.0001
Inpatient Discharges*	0.44	0.71	1.61	<0.0001
Inpatient Days*	1.80	3.94	2.19	<0.0001
Other Encounters*	11.02	18.71	1.70	<0.0001
Chemical Dependency				
Outpatient Encounters*	0.58	0.89	1.53	0.0002
Inpatient Discharges*	0.09	0.17	1.78	0.0073
Inpatient Days*	0.57	0.96	1.70	0.0073
Other Encounters	0.26	0.30	1.16	0.5201

*Statistically significant at the $p \leq .05$ level.

Therapy, Ancillary Services, and Equipment. Table 8 shows the utilization rates for (1) therapy services, (2) radiology, laboratory, and pathology procedures, and (3) durable medical equipment. Therapy services included physical therapy, occupational therapy, speech therapy, and respiratory therapy. Because many therapy procedures are measured in time intervals (e.g., 15 or 30 minutes) that result in multiple units per procedure code, utilization was measured in units of service by summing the number of units for all of the relevant procedure codes. Radiology, laboratory, and pathology were measured by summing the number of procedures. Durable medical equipment utilization was identified using HCPCS codes and was measured in units of service by summing the number of units for each code. Utilization is presented per 1,000 member months. Full-pay enrollees had a higher rate of utilization in all three categories, ranging from 29% higher for ancillary services to almost four times higher for durable medical equipment. However, only 360 children, or less than 1% of enrolled children, had claims for durable medical equipment.

Table 8: Therapeutic and Ancillary Procedures and Durable Medical Equipment January 1, 2007 – December 31, 2007				
	Services per 1,000 Member Months		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,183,422 member months)	Full-pay (272,674 member months)		
Therapy Procedures*	7.81	14.80	1.90	<0.0001
Radiology, Laboratory and Pathology Procedures*	75.51	97.16	1.29	<0.0001
Durable Medical Equipment*	0.57	2.26	3.93	0.0072

*Statistically significant at the $p \leq .05$ level.

C. Costs

Per member per month (PMPM) health care costs were examined to provide a comprehensive measure of the relative resource utilization between full-pay and subsidized enrollees. PMPM costs are equal to total costs divided by total member months. As noted previously, to calculate the PMPM costs, CPT, HCPCS, and NDC codes were linked to the state Medicaid fee schedule. The purpose of these cost calculations is to examine the relative differences between the two subsidy groups, and the fee schedule allows us to measure the relative intensity of utilization and relative risk of full-pay enrollees. For this evaluation, the actual dollar amounts or exact costs are not as critical as the relationships observed between the two groups. Therefore, the calculated costs were normalized to a value of \$1.00 PMPM for the subsidized population. Table 9 shows the normalized PMPM health care costs for the two subsidy groups overall and within each health status category. These costs do not represent actual program costs; rather, they reflect the relative PMPM costs by subsidy status and child health status. Overall, full-pay enrollees have PMPM costs that are 55% greater on average compared to subsidized enrollees. Within each health status category, the differences in costs were greatest for those with insufficient enrollment length to be classified and healthy enrollees.

Table 9: Normalized Costs by Premium Subsidy Status and Child Health Status January 1, 2007 – December 31, 2007				
	Normalized PMPM Costs⁺		Ratio of Full-pay to Subsidized	p-value
	Subsidized Premium (2,183,422 member months)	Full-pay (272,674 member months)		
Normalized PMPM Costs				
Total*	1.00	1.55	1.55	<0.0001
By Health Status				
Healthy*	0.50	0.66	1.31	<0.0001
Significant Acute*	1.88	2.01	1.07	<0.0001
Minor Chronic*	2.47	2.51	1.02	<0.0001
Moderate Chronic*	3.27	3.93	1.20	<0.0001
Major Chronic*	10.59	12.59	1.19	<0.0001
Unclassified*	0.87	1.58	1.82	<0.0001

*Statistically significant at the $p \leq .05$ level.

⁺ PMPM costs were normalized to a value of \$1.00 PMPM for the subsidized group. Therefore, the costs reported in Table 9 do not represent actual program costs; rather, they reflect the relative PMPM costs by subsidy status and child health status.

C. Summary of Relative Utilization and Costs

Utilization rates were consistently higher for full-pay enrollees across all service categories. The most comprehensive measure of the relative resource utilization of full-pay enrollees compared to subsidized enrollees is the relative PMPM cost, which was 1.55 during our study period. Therefore, full-pay enrollees' resource utilization was 55% higher than that for subsidized enrollees on average. The consistent finding of higher utilization rates in every service category and higher PMPM costs among full-pay enrollees suggests that adverse selection is present. However, the presence of higher utilization within health status categories for less urgent categories of service (e.g., outpatient office visits and prescription drugs) but not for more urgent categories of service (e.g., inpatient hospital stays) suggests

that factors other than illness severity, such as income, may be contributing to the higher observed utilization among full-pay enrollees.

It also is interesting that enrollees classified as healthy and those with insufficient enrollment length to be classified were more likely to have the highest full-pay to subsidized ratio than children with significant acute or chronic conditions. There are several possibilities that may explain this finding. Children with significant acute or a chronic conditions have an identified health care need, and parents who have children with identified health care needs are more likely to enroll their children and keep them enrolled. Many of the medical services required by these children are essential to manage their health conditions, and parents may be less likely to forgo these critical services. As a result, there may be many types of services for which there are not significant differences in utilization between full-pay and subsidized enrollees with identified health problems. Children in the healthy and unclassified enrollment categories are more diverse. Healthy children include nonusers of health services, children who are healthy, and children have an underlying chronic condition but were seen only for routine needs during the classification period. Unclassified children include new enrollees as well as children who cycle in and out of the program; by definition, their health status is unknown. For both unclassified and healthy enrollees, the observed differences likely reflect a combination of differences in illness severity and higher income to afford the copayments. Families not eligible for subsidized premiums are more likely to purchase coverage at the higher premium rate if they expect to use health care services. Unclassified children in particular had a significantly higher full-pay to subsidized ratio compared to children who had sufficient enrollment length for classification. One explanation for this is that there may be a greater tendency in the full-pay program for families to enroll their children when they have specific health care needs. The full-pay program would be more likely to experience this type of adverse selection than the subsidized program because of the higher premium rate.

V. PREMIUM IMPACTS

Average utilization and costs are greater among full-pay enrollees compared to subsidized enrollees. The impact of full-pay enrollees on overall program costs depends on two main factors: (1) how much higher resource utilization is among full-pay enrollees and (2) the percentage of total enrollment accounted for by full-pay enrollees. Table 10 combines these two factors to evaluate the impact of increased resource use among full-pay enrollees on overall program costs.

Full-pay Costs as a Percentage of Subsidized Costs	Full-Pay Enrollment as a Percentage of Total Enrollment								
	7%	8%	9%	10%	11%	12%	13%	14%	15%
100%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
110%	0.70%	0.80%	0.90%	1.00%	1.10%	1.20%	1.30%	1.40%	1.50%
120%	1.40%	1.60%	1.80%	2.00%	2.20%	2.40%	2.60%	2.80%	3.00%
130%	2.10%	2.40%	2.70%	3.00%	3.30%	3.60%	3.90%	4.20%	4.50%
140%	2.80%	3.20%	3.60%	4.00%	4.40%	4.80%	5.20%	5.60%	6.00%
150%	3.50%	4.00%	4.50%	5.00%	5.50%	6.00%	6.50%	7.00%	7.50%
160%	4.20%	4.80%	5.40%	6.00%	6.60%	7.20%	7.80%	8.40%	9.00%
170%	4.90%	5.60%	6.30%	7.00%	7.70%	8.40%	9.10%	9.80%	10.50%
180%	5.60%	6.40%	7.20%	8.00%	8.80%	9.60%	10.40%	11.20%	12.00%
190%	6.30%	7.20%	8.10%	9.00%	9.90%	10.80%	11.70%	12.60%	13.50%
200%	7.00%	8.00%	9.00%	10.00%	11.00%	12.00%	13.00%	14.00%	15.00%

A numerical example is helpful to illustrate the impact. Suppose that the PMPM cost is equal to \$50 when the enrollment pool is composed only of subsidized enrollees, and suppose there are 100,000 enrollees. The total cost is $\$50 \times 100,000 = \$5,000,000$. Suppose instead that 10% of the enrollment pool, or 10,000 enrollees, is composed of full-pay enrollees and that the full-pay PMPM cost is \$75, or 50% higher than the subsidized PMPM cost. The total cost is now

$$90,000 \times \$50 + 10,000 \times \$75 = \$5,250,000,$$

and the PMPM cost averaged across all enrollees is $\$5,250,000 / 100,000 = \52.50 . The PMPM cost has increased by \$2.50 per enrollee, or by 5%. This is the value in the table that corresponds to a 10% enrollment rate and a 150% ratio of full-pay enrollee costs to subsidized enrollee costs. If the full-pay population as a percentage of total enrollment increased from 10% to 15% and the ratio of full-pay costs to subsidized costs remained at 150%, then the PMPM cost would increase by 2.5 percentage points from 5% to 7.5%.

VI. APPROACHES TO MITIGATE THE PREMIUM IMPACT OF THE FULL-PAY PROGRAM

The impact of full-pay enrollees on program costs is influenced by policies that affect: (1) the share of full-pay enrollees relative to total enrollment and (2) health care utilization among full-pay enrollees.

A. Premium Adjustments

One strategy to decrease the number of full-pay enrollees relative to subsidized enrollees is to increase the premiums for full-pay enrollees. However, uniformly increasing the premiums to all full-pay enrollees risks exacerbating adverse selection problems. The families most likely to drop coverage if premiums increase are those who do not expect to use as many health care services because their children are healthy. If healthy children disproportionately drop coverage, the adverse selection problem is exacerbated because the remaining pool of children in the buy-in program will be sicker and more expensive on average. The impact of increased premiums will be greatest among lower-income full-pay enrollees – i.e., those who are closer to 200% of the FPL. To illustrate the impact of higher premiums on household expenses, Table 11 shows the premium costs for families who participate in the full-pay program at the current premium rate of \$128.00 relative to family income expressed as a percentage of the FPL. Families with income equal to 210% of the FPL pay 4.4%, 7.0%, 8.9%, and 10.6% to cover one, two, three, and four children, respectively. Even at 300% of the FPL, families pay 4.9% of income to cover two children and more than 5% of income to cover three or more children. The children’s total health care costs are greater than the amounts shown, because these costs only represent the premium payments and do not reflect other costs such as copayments. Consequently, further increasing the premium rates will make it more difficult for families to afford coverage through the buy-in program.

Retaining and attracting families to the program who are close to the 200% FPL cut off also is beneficial from a risk pooling perspective because of potential spillover effects into the subsidized population. Similar to the positive spillover effects of SCHIP enrollment efforts on Medicaid enrollment, SCHIP buy-in programs may have positive spillover effects on enrollment in the subsidized program (Kenney et al. 2008). To diminish the negative consequences of a uniform premium increase, proposals to adjust full-pay premiums may want to consider using a graduated premium schedule as family income increases, keeping in mind that even families at 300% of the FPL with 2 or more children already pay almost 5% or more of their income to cover their children. A graduated premium that reduces the financial burden among lower-income full-pay enrollees (i.e., those closer to 200% of the FPL) can help to decrease adverse selection among the buy-in population by making it more affordable for and attractive to families with healthier children. Implementing a graduated premium structure, however, has the disadvantage of greater program complexity and increased administrative costs.

Family Income as a Percentage of the Federal Poverty Level	Number of Children			
	1	2	3	4
210%	4.40%	7.00%	8.90%	10.60%
220%	4.20%	6.60%	8.50%	10.10%
230%	4.00%	6.40%	8.10%	9.60%
240%	3.80%	6.10%	7.80%	9.20%
250%	3.70%	5.80%	7.40%	8.90%
260%	3.50%	5.60%	7.20%	8.50%
270%	3.40%	5.40%	6.90%	8.20%
280%	3.30%	5.20%	6.70%	7.90%
290%	3.20%	5.00%	6.40%	7.60%
300%	3.10%	4.90%	6.20%	7.40%

*Family income was determined using the U.S. Census Bureau’s 2007 Poverty Thresholds for a household with two adults plus the number of children indicated in each column.

B. Increasing Copayments

Outpatient services with copayments, such as office visits and prescription drugs, had higher utilization among full-pay enrollees compared to subsidized enrollees even within each health status category. The higher utilization within health status categories may be attributable to differences in illness severity within each health status category – for example, greater illness severity among moderate chronic enrollees in the full-pay group compared to moderate chronic enrollees in the subsidized premium group. But this may also reflect other factors that affect utilization, such as income. Families in the full-pay category have greater income than those with subsidized premiums and, therefore, may more easily afford the \$5 copayments for office visits and prescriptions and generally have greater means (e.g., better access to transportation) to access health services.

Increasing the copayments for higher income families would likely reduce utilization among full-pay enrollees as well as lowering the share of costs paid for by the health plans. Studies of the impact of copayments on utilization in public insurance programs have found copayments to be associated with decreased utilization, including physician visits, visits to outpatient hospital clinics, hospital admissions, and prescription drugs (Artiga and O'Malley 2005). Although increased cost sharing can reduce program expenditures, such increases may have unintended negative consequences for access to health coverage and services. Increasing copayments may discourage families from getting necessary care for their children and result in adverse health outcomes. In addition, as noted previously, many families in the buy-in program already spend a significant portion of their income on the premium payments to obtain coverage. Increasing copayments further increases the share of families' household income required to provide medical care for their children, especially for families who have children with chronic conditions. Proposals to increase copayments for full-pay enrollees may want to consider using graduated copayments as family income increases combined with an out-of-pocket maximum in order to limit the financial risk faced by families. However, implementing a graduated copayment structure may increase program complexity and administrative costs.

C. Limiting the Scope of the Benefits Package

The program costs of serving full-pay enrollees also are influenced by the benefit package offered. Full-pay enrollees currently receive the same benefit package as subsidized enrollees (Appendix A). Offering less comprehensive coverage would decrease full-pay program costs through two main effects. First, enrollees' medical costs would be directly affected by the decreased service utilization that results from covering fewer services. Second, less comprehensive benefits packages are less attractive for chronically or seriously ill individuals and may attract more healthy individuals if they are accompanied by lower premium rates. As a result, a less comprehensive benefit package could potentially result in a relatively healthier case mix. However, a reduced benefits package also would likely increase the financial risk of families, especially those whose children have chronic conditions.

D. Implementing Waiting and Lockout Periods

Currently, applicants to the full-pay program are not required to be uninsured for a period of time prior to enrolling. Once they are in the program, they must wait 60 days to re-enroll if they were cancelled due to premium nonpayment. Implementing a policy that children must be uninsured for some period of time prior to obtaining coverage may discourage families from dropping private coverage to participate in the buy-in program. However, requiring that children be uninsured for a period of time could decrease access to care and result in adverse health consequences. Extending the waiting period for re-enrollment would serve as a greater deterrent for families to enroll and disenroll their children based on their health care needs (Kenney et al. 2008).

E. Case Management of High-Cost Enrollees

Well-designed case management programs may produce net cost savings by decreasing hospitalizations and emergency room visits. The FHKC could build off of health plans' existing disease management programs and develop a program-wide case management approach that prospectively identifies enrollees' at risk for high health care costs, analyzes the characteristics that contribute to higher risk, and design interventions targeted toward those enrollees. To be effective, such programs must be carefully designed and monitored for their impacts both on the quality of care provided and on program costs.

F. Limiting Enrollment in the Full-Pay Program

Reinstating an enrollment cap would decrease enrollment in the buy-in portion of the program. This, however, will counteract the goal of expanding children's health coverage. In addition, the experience in Florida and in other states has indicated that take-up of coverage among SCHIP buy-in programs tends to be relatively low. As discussed previously, Florida's enrollment cap of 10% was never operationalized. An analysis of other states with buy-in programs found take-up rates of eligible uninsured children ranged from 7.9% - 11.0% (Kenney et al. 2008).

G. Increasing Enrollment in the Subsidized Program

Full-pay enrollment as a percentage of total enrollment is affected not only by the number of full-pay enrollees, but also by the number of subsidized enrollees. As shown in Figure 1, full-pay enrollment has been very stable during the past two years, whereas subsidized enrollment has experienced greater fluctuation. Increasing enrollment in the subsidized program more rapidly than in the full-pay program will reduce the proportion of full-pay enrollees and decrease the average PMPM cost. Table 12 illustrates the impact of fluctuations in subsidized enrollment on the *percentage* of full-pay enrollees when the *number* of full-pay enrollees is stable. For example, when there are 20,000 full-pay enrollees, the percentage of full-pay enrollees relative total program enrollment is equal to 11.76% when there are 150,000 subsidized enrollees. That percentage decreases to 9.09%, 7.41%, and 6.25% when subsidized enrollment increases to 200,000, 250,000, and 300,000, respectively. Therefore, it is important to continue efforts to retain existing enrollees and enroll uninsured children who are eligible for subsidized premiums. The buy-in program itself can contribute to this effort because it allows coverage to be more widely marketed to all children rather than select children, thereby resulting in greater program awareness and reaching more families.

Full-Pay Enrollment	Subsidized Enrollment			
	150,000	200,000	250,000	300,000
10,000	6.25%	4.76%	3.85%	3.23%
15,000	9.09%	6.98%	5.66%	4.76%
20,000	11.76%	9.09%	7.41%	6.25%
25,000	14.29%	11.11%	9.09%	7.69%

The percentage of full-pay enrollees was calculated as: $(\text{full-pay enrollment})/(\text{full-pay} + \text{subsidized enrollment})$.

VII. SUMMARY

A greater proportion of children in the full-pay premium category had significant acute and chronic health conditions compared to children with subsidized premiums. Average utilization across all service categories examined was greater among full-pay enrollees. The most comprehensive measure of the relative resource utilization of full-pay enrollees compared to subsidized enrollees is the relative per member per month cost between the two subsidy groups, which was 1.55 during the time period we examined. Therefore, full-pay enrollees' resource utilization was 55% higher than subsidized enrollees on average. These findings suggest that adverse selection exists among the pool of full-pay enrollees. However, we also found that some types of medical services had greater utilization even within each health status category. These included outpatient office visits and prescription drugs. Differences within a health status category may be attributable to differences in illness severity within that category, but these differences also may reflect other factors that affect utilization, such as income. Therefore, policy changes designed to reduce the relative resource utilization of full-pay enrollees should take into account such factors.

There are two main factors that affect the impact of the full-pay group on overall program costs: (1) the relative utilization of the full-pay group and (2) the proportion of enrollment accounted for by the full-pay group. To decrease the impact of the full-pay group on overall program costs, at least one of these two factors must be addressed. Preliminary enrollment data for the months immediately following the removal of the full-pay enrollment cap indicate that there was not an increase in full-pay enrollment during that time period. It will be important to continue to monitor the enrollment trends. Should full-pay enrollment as a share of total enrollment become a concern, there are a number of policy options available. Increasing premiums or copayments can reduce the share of costs paid by health plans, slow down the rate of enrollment growth, and decrease utilization. However, proposals to adjust premiums or copayments need to be designed carefully because higher premiums and copayments risk exacerbating adverse selection problems and decreasing access to health care services. Offering a more limited benefits package would directly reduce the program costs of full-pay enrollees and could result in a healthier case mix, but it also would increase the financial risk of families whose children have chronic conditions or a serious illness. Requiring a period of uninsurance prior to enrolling and increasing waiting periods for re-enrollment may limit adverse selection, but such policies could also reduce access to care and result in adverse health consequences. Carefully designed case management programs with targeted interventions for high-cost/high-risk enrollees offer the potential for both improving the quality of care and producing net cost savings. Other policies directly target the share of full-pay enrollees as a percentage of total enrollment. Both limitations on full-pay enrollment and efforts to increase enrollment and retention in the subsidized program will help to maintain or decrease the proportion of full-pay enrollees relative to total program enrollment, thereby decreasing the impact that full-pay enrollees have on the average per member per month costs.

Appendix A: Florida Healthy Kids Program Benefits

BENEFIT	LIMITATIONS	CO-PAYMENTS
<p>A. <u>Inpatient Services</u> All covered services provided for the medical care and treatment of an Enrollee who is admitted as an inpatient to a hospital licensed under part I of Chapter 395. Covered services include: physician's services; room and board; general nursing care; patient meals; use of operating room and related facilities; use of intensive care unit and services; radiological, laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; special duty nursing; radiation and chemotherapy; respiratory therapy; administration of whole blood plasma; physical, speech and occupational therapy; medically necessary services of other health professionals.</p>	<p>All admissions must be authorized by INSURER. The length of the patient stay shall be determined based on the medical condition of the Enrollee in relation to the necessary and appropriate level of care. Room and board may be limited to semi-private accommodations, unless a private room is considered medically necessary or semi-private accommodations are not available. Private duty nursing limited to circumstances where such care is medically necessary. Admissions for rehabilitation and physical therapy are limited to fifteen (15) days per contract year. Shall not include experimental or investigational procedures defined as a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria, as determined by INSURER: 1. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II or III clinical trials; or, 2. Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular patient is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives; or, 3. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.</p>	<p>NONE</p>

BENEFIT	LIMITATIONS	CO-PAYMENTS
<p>B. <u>Emergency Services</u> Covered Services include visits to an emergency room or other licensed facility if needed immediately due to an injury or illness and delay means risk of permanent damage to the Enrollee's health.</p>	<p>Must use an INSURER designated facility or provider for emergency care unless the time to reach such facilities or providers would mean the risk of permanent damage to Enrollee's health.</p> <p>INSURER must also comply with the provisions of s. 641.513, Florida Statutes.</p>	<p>Ten dollars (\$10.00) per visit waived if admitted or authorized by primary care physician</p>
<p>C. <u>Maternity Services and Newborn Care</u> Covered services include maternity and newborn care, prenatal and postnatal care, initial inpatient care of adolescent participants, including nursery charges and initial pediatric or neonatal examination.</p>	<p>Infant is covered for up to three (3) days following birth or until the infant is transferred to another medical facility, whichever occurs first.</p> <p>Coverage may be limited to the fee for vaginal deliveries.</p>	<p>NONE</p>
<p>D. <u>Organ Transplantation Services</u> Covered services include pretransplant, transplant, post discharge services and treatment of complications after transplantation.</p>	<p>Coverage is available for transplants and medically related services if deemed necessary and appropriate within the guidelines set by the Organ Transplant Advisory Council or the Bone Marrow Transplant Advisory Council.</p>	<p>NONE</p>
<p>E. <u>Outpatient Services</u> Preventive, diagnostic, therapeutic, palliative care, and other services provided to an Enrollee in the outpatient portion of a health facility licensed under Chapter 395.</p> <p>Covered services include well-child care, including those services recommended in the Guidelines for Health Supervision of Children and Youth as developed by Academy of Pediatrics; immunizations and injections as recommended by the Advisory Committee on Immunization Practices; health education counseling and clinical services; family planning services, vision screening; hearing screening; clinical</p>	<p>Services must be provided directly by INSURER or through pre-approved referrals.</p> <p>Routine hearing screening must be provided by primary care physician.</p> <p>Family planning limited to one annual visit and one supply visit each ninety (90) days.</p> <p>Chiropractic services shall be provided in the same manner as in the Florida Medicaid program.</p> <p>Podiatric services are limited to one (1) visit per day totaling two (2) visits per month for specific foot disorders. Dental services must be provided by an oral surgeon for medically necessary reconstructive dental surgery due to injury.</p> <p>Immunizations are to be provided by the primary care physician.</p> <p>Treatment for temporomandibular joint (TMJ) disease is specifically excluded.</p> <p>Shall not include experimental or investigational</p>	<p>None Co-Payment for well child care, preventive care or for routine vision and hearing screenings.</p> <p>Five dollars (\$5.00) per office visit</p>

BENEFIT	LIMITATIONS	CO-PAYMENTS
<p>radiological, laboratory and other outpatient diagnostic tests; ambulatory surgical procedures; splints and casts; consultation with and treatment by referral physicians; radiation and chemotherapy; chiropractic services; and podiatric services.</p>	<p>procedures defined as a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria, as determined by INSURER:</p> <ol style="list-style-type: none"> 1. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular Enrollee is the subject of ongoing phase I, II or III clinical trials; or, 2. Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the circumstances of a particular Enrollee is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives; or, 3. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services. 	
<p><u>F. Behavioral Health Services</u> Covered services include inpatient and outpatient care for psychological or psychiatric evaluation, diagnosis and treatment by a licensed mental health professional.</p>	<p>All services must be provided directly by INSURER or upon approved referral.</p> <p>Inpatient services are limited to not more than thirty (30) inpatient days per contract year for psychiatric admissions, or residential services in lieu of inpatient psychiatric admissions; however, a minimum of ten (10) of the thirty (30) days shall be available only for inpatient psychiatric services when authorized by INSURER physician.</p> <p>Outpatient services are limited to a maximum of forty (40) outpatient visits per contract year.</p>	<p>INPATIENT: NONE</p> <p>OUTPATIENT: Five dollars (\$5.00) per visit.</p>
<p><u>G. Substance Abuse Services</u> Includes coverage for inpatient and outpatient care for drug and alcohol abuse including counseling and placement assistance. Outpatient services include evaluation, diagnosis and treatment by a licensed practitioner.</p>	<p>All services must be provided directly by INSURER or upon approved referral.</p> <p>Inpatient services are limited to not more than seven (7) inpatient days per contract year for medical detoxification only and thirty (30) days residential services.</p> <p>Outpatient visits are limited to a maximum of forty (40) visits per contract year.</p>	<p>INPATIENT: NONE</p> <p>OUTPATIENT: Five dollars (\$5.00) per visit.</p>

BENEFIT	LIMITATIONS	CO-PAYMENTS
H. <u>Therapy Services</u> Covered services include physical, occupational, respiratory and speech therapies for short-term rehabilitation where significant improvement in the Enrollee's condition will result.	All treatments must be performed directly or as authorized by INSURER. Limited to up to twenty-four (24) treatment sessions within a sixty (60) day period per episode or injury, with the sixty (60) day period beginning with the first (1 st) treatment.	Five dollars (\$5.00) per visit.
I. <u>Home Health Services</u> Includes prescribed home visits by both registered and licensed practical nurses to provide skilled nursing services on a part-time intermittent basis.	Coverage is limited to skilled nursing services only. Meals, housekeeping and personal comfort items are excluded. Services must be provided directly by INSURER. Private duty nursing is limited to circumstances where such care is medically appropriate.	Five dollars (\$5.00) per visit.
J. <u>Hospice Services</u> Covered services include reasonable and necessary services for palliation or management of an Enrollee's terminal illness.	Once a family elects to receive hospice care for an Enrollee, other services that treat the terminal condition will not be covered. Services required for conditions totally unrelated to the terminal condition are covered to the extent that such services are otherwise covered under this contract.	Five dollars (\$5.00) per visit.
K. <u>Nursing Facility Services</u> Covered services include regular nursing services, rehabilitation services, drugs and biologicals, medical supplies, and the use of appliances and equipment furnished by the facility.	All admissions must be authorized by INSURER and provided by an INSURER affiliated facility. Participant must require and receive skilled services on a daily basis as ordered by an INSURER physician. The length of the Enrollee's stay shall be determined by the medical condition of the Enrollee in relation to the necessary and appropriate level of care, but maybe no more than one hundred (100) days per contract year. Room and board is limited to semi-private accommodations unless a private room is considered medically necessary or semi-private accommodations are not available. Specialized treatment centers and independent kidney disease treatment centers are excluded. Private duty nurses, television, and custodial care are excluded. Admissions for rehabilitation and physical therapy are limited to fifteen (15) days per contract year.	NONE

BENEFIT	LIMITATIONS	CO-PAYMENTS
<p>L. <u>Durable Medical Equipment and Prosthetic Devices</u> Equipment and devices that are medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary by Enrollee's INSURER physician.</p>	<p>Equipment and devices must be provided by authorized INSURER supplier.</p> <p>Covered prosthetic devices include artificial eyes, limbs, braces and other artificial aids.</p> <p>Low vision and telescopic lenses are not included.</p> <p>Hearing aids are covered only when medically indicated to assist in the treatment of a medical condition.</p>	<p>NONE</p>
<p>M. <u>Refractions</u> Examination by a INSURER optometrist to determine the need for and to prescribe corrective lenses as medically indicated.</p>	<p>Enrollee must have failed vision screening by primary care physician.</p> <p>Corrective lenses and frames are limited to one (1) pair every two (2) years unless head size or prescription changes.</p> <p>Coverage is limited to Medicaid frames with plastic or SYL non-tinted lenses.</p>	<p>Five dollars (\$5.00) per visit.</p> <p>Ten dollars (\$10.00) for corrective lenses.</p>
<p>M. <u>Pharmacy</u> Prescribed drugs for the treatment of illness or injury or injury.</p>	<p>Prescribed drugs covered under this Agreement shall include all prescribed drugs covered under the Florida Medicaid program. INSURER is responsible for the coverage any drugs prescribed by Enrollee's dental provider under Healthy Kids.</p> <p>INSURER may implement cost utilization controls or a pharmacy benefit management program if FHKC so authorizes.</p> <p>Brand name products are covered if a generic substitution is not available or where the prescribing physician indicates that a brand name is medically necessary.</p> <p>All medications must be dispensed through INSURER or an INSURER designated pharmacy.</p> <p>All prescriptions must be written by the Enrollee's primary care physician, INSURER approved specialist or consultant physician or Enrollee's dental provider.</p>	<p>Five Dollars (\$5.00) per prescription</p>
<p>N. <u>Transportation Services</u> Emergency transportation as determined to be medically necessary in response to an emergency situation.</p>	<p>Must be in response to an emergency situation.</p>	<p>Ten dollars (\$10.00) per service</p>

REFERENCES

- Artiga S. and M. O'Malley. 2005. "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences." Kaiser Commission on Medicaid and the Uninsured. Accessed December 22, 2008. Available at: <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261>.
- Bethell, C. and D. Read. 2002. "Approaches to Identifying Children and Adults with Special Health Care Needs: A Resource Manual for State Medicaid Agencies and Managed Care Organizations." Oregon Health and Science University: The Child and Adolescent Health Measurement Initiative. Accessed December 1, 2008. Available at: http://cshcndata.org/documents/CMS%20Manual_revised_apr_06_compressed.pdf.
- Cutler DM and RJ Zeckhauser. 2000. "The Anatomy of Health Insurance." In: *Handbook of Health Economics* [Vol1A], edited by AJ Culyer and JP Newhouse, pp. 563-643. Amsterdam: Elsevier.
- Economic Research Service, United States Department of Agriculture. 2000. "Rural-Urban Commuting Area Codes." Available at: <http://www.ers.usda.gov/Data/RuralUrbanCommuntingAreaCodes/>.
- Heberlein, M., C. Mann, J. Guyer, and D. Horner. 2008. "States Moving Forward: Children's Health Coverage in 2007–2008." Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute.
- Kenney G., L. Blumberg, and J. Pelletier. 2008. "State Buy-In Programs: Prospects and Challenges." Health Policy Center, Urban Institute. Accessed December 1, 2008. Available at: http://www.urban.org/health_policy/url.cfm?ID=411795.
- Neff, J.M., V. Sharp, J. Muldoon, J. Graham, J. Popalisky, and J. Gay. 2001. "Identifying and Classifying Children with Chronic Conditions Using Administrative Data with the Clinical Risk Group Classification System." *Journal of Ambulatory Pediatrics* 2(1):72-79.
- Virginia Department of Medical Assistance Services. 2006. "SCHIP Buy-In Programs: An Assessment of Buy-In Programs Operating in Other States and the Feasibility of Developing a Program for Virginia." Accessed December 1, 2008. Available at: http://www.urban.org/health_policy/url.cfm?ID=411795.

ENDNOTES

¹ The enrollment data for May-October 2008 were obtained from AHCA reports. The enrollment numbers are reconciled periodically by the state, and the numbers reported are current as of December 15, 2008.

² Because there is a lag time between the date of service and the date that claims are paid, there were insufficient claims and encounter data to analyze costs and utilization for 2008 at the time this report was prepared. This report will be appended to include more recent data as they become available. However, we would not expect to observe significant changes with the inclusion of these additional data because full-pay enrollment has remained stable.

³ The inpatient discharge rates reported may be lower than the actual experience because one of the health plans incorrectly reported certain outpatient services, such as outpatient ER visits, as inpatient admissions. We corrected this error for the cases that we could positively identify as outpatient ER visits, but we are continuing to review the inpatient utilization data with the health plan. If additional corrections are required, this report will be amended accordingly.