

Montana State Legislature

Exhibit Number: 11

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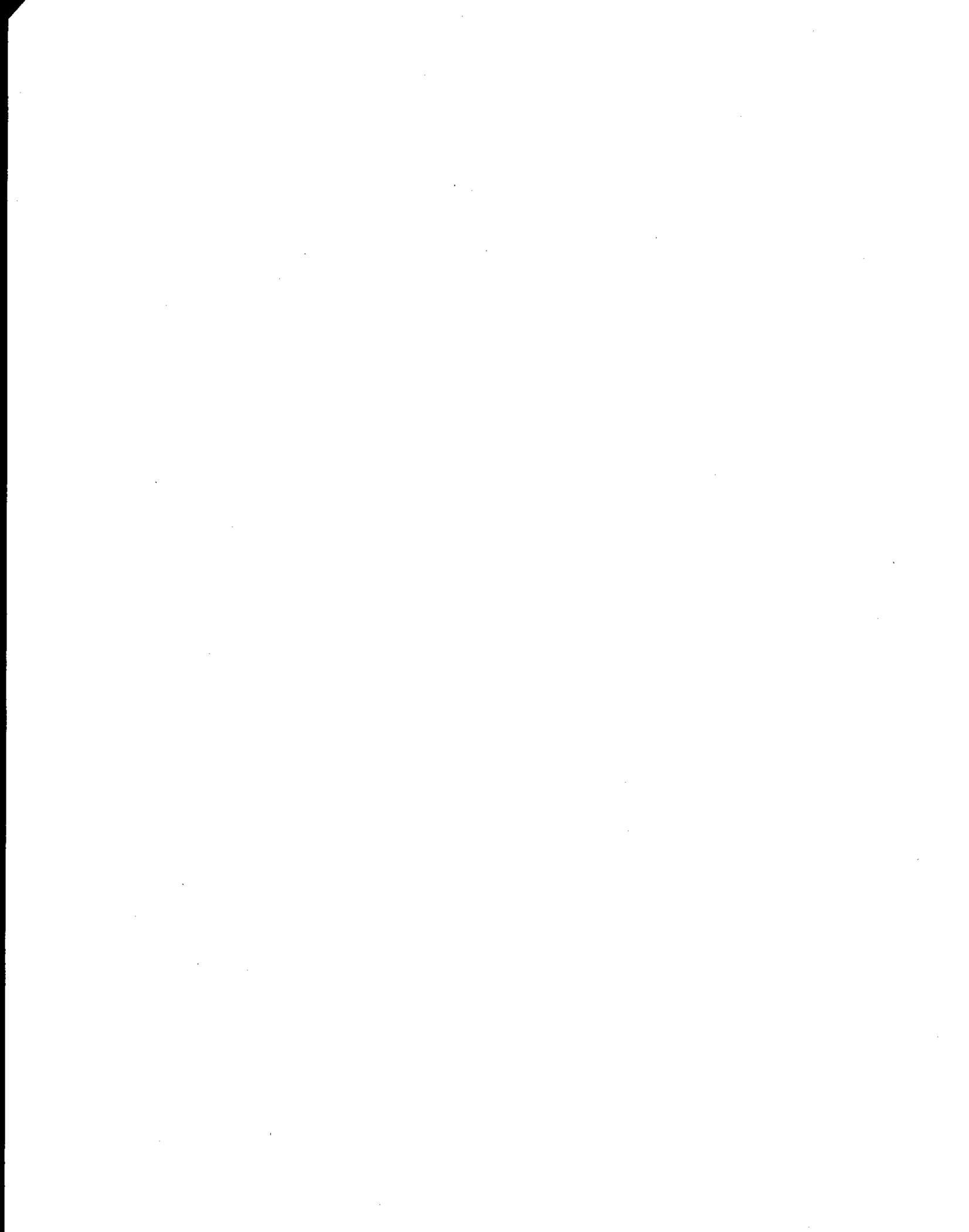


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**REPORT ON CHANGING MONTANA CHIP
FROM AN INDEMNITY PLAN
TO A SELF INSURED PLAN**

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**Montana Department of
Public Health and Human Services**

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Montana's Children's Health Insurance Plan (CHIP) purchases indemnity insurance for children enrolled in CHIP from Blue Cross Blue Shield of Montana (BCBSMT), paying a premium each month for each child. Now, six years since the program began, the Department of Public Health and Human Services (DPHHS) will determine if the current arrangement is the most cost effective and efficient to provide health care coverage for Montana children. This report looks at CHIP's current operation and explores options for consideration of policy makers and the public.

Section 1. Background

Congress added the States' Children's Health Insurance Program (SCHIP) as Title XXI of the Social Security Act by the Balanced Budget Act of 1997 to provide health care coverage to uninsured children. The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) the government agency that also administers Medicare and Medicaid, was designated as the responsible federal agency for SCHIP. DPHHS has an SCHIP State Plan approved by CMS to operate SCHIP in Montana.

Montana CHIP

The 1999 Montana Legislature created Montana's Children's Health Insurance Plan (CHIP) and appropriated funds to insure about 9,500 children. Under federal law, a state can operate SCHIP as a Medicaid expansion, a separate health coverage plan, or a combination of the two. The Montana Legislature chose to create a separate plan in Montana. Under a separate plan, state costs are controlled by the amount of state funds appropriated. Once the maximum enrollment is reached for the amount of money available, a waiting list or enrollment freeze can be implemented. A Medicaid expansion is an entitlement and all eligible children must be covered, making control of costs more difficult. The Montana Legislature chose to remove the element of risk, designed CHIP to be an insurance plan if insurers were interested, and designated the DPHHS to administer CHIP. Montana CHIP is actuarially benchmarked on the state employee health plan.

Any health insurance plan in Montana can contract with DPHHS to provide health insurance coverage for children enrolled in CHIP. One insurance plan, BCBSMT, has a contract with DPHHS, and receives a premium payment from DPHHS each month for each child enrolled with CHIP. Depending on annual income, some families pay a copayment when services are received.

(See Copayments, Appendix 1.)

The DPHHS contract with BCBSMT provides for a fully insured health benefit. BCBSMT assumes the risk and pays claims for covered services for children insured with CHIP. DPHHS administers dental benefits and eyeglasses benefits separately and

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pays providers directly for those services, through the Department's Fiscal Agent, Affiliated Computer Services, Inc. (ACS).

Like other health coverage plans, CHIP has experienced rising costs due to increased health care costs and the development of new health care technology and prescription drugs. Table 1 shows CHIP medical claims expenditures for five years.

Table 1 Medical claims information—Montana CHIP

	CY 1999	FFY 2000	FFY 2001	FFY 2002	FFY 2003
Average monthly enrollment	940	4,098	9,414	9,400	9,547
Total amount claims paid	\$599,758	\$3,577,585	\$8,940,183	\$9,229,194	\$10,337,223
Total number claims processed				59,227	59,535
Average number claims per enrollee				6.3	6.2
Average amount spent per enrollee	\$638	\$873	\$950	\$982	\$1,083

Source: Montana Children's Health Insurance Plan. 2004 claims data was not available for inclusion in this report.

Funding

Montana CHIP is funded with a combination of state and federal funds. State funds were appropriated from Montana's tobacco settlement for the 2003-2004 biennium. In SFY 2004, the federal match was 81.01%. CHIP's SFY 2004 expenditures were \$16,824,455. Benefits include monthly premiums paid to BCBSMT and payments to providers for dental and eyeglasses services. DPHHS performs the following administrative functions, which are approximately six percent of total program costs:

- Systems development
- Dental and eyeglasses programs, including provider relations
- Eligibility determination
- Enrollment
- Outreach
- Plan relations
- Advocacy
- Enrollee and family education, and family support
- Quality assurance
- Complaint resolution, administrative review, and fair hearings
- Web site development and maintenance
- Compliance with federal and state rules and regulations
- Federal and state reporting

SCHIP in other states

A state has the option to operate SCHIP as a Medicaid expansion, a separate stand-alone health coverage plan, or a combination of the two.

Medicaid expansion only	12 states
Separate plan only	18 states
Combination	21 states

Table 2 lists states with separate SCHIP plans, types of delivery systems, federal poverty levels, and program expenditures for year ended September 30, 2002.

Table 2 Separate SCHIP States.

State	Benefit delivery system	FPL	FFY 2002 expenditures (in millions)	
			State	Federal
Alabama	Self-insured, TPA is BCBSAL	200%	14.3	54.9
Arizona	Purchases through various health plans	200%	41.1	126.8
Colorado	Purchases through MCOs and HMOs	185%	16.8	31.1
Connecticut	Managed care contracts—competitive bidding	300%	8.7	16.1
Georgia	Medicaid child health assistance delivery system	235%	42.6	105.9
Kansas	Purchases through HMOs and limited indemnity	200%	13.9	35.9
Mississippi	Purchases indemnity from BCBSMS	200%	14.0	69.7
Montana	Purchases indemnity from BCBSMT	150%	2.8	12.1
Nevada	Purchases 72% from MCOs, self-insured FFS 28%	200%	11.0	20.4
North Carolina	FFS through Teachers and State Employee Plan Administration, some MC	200%	31.8	86.0
Oregon	Oregon Health Plan, prepaid health plans and PCCMs	185%	6.5	16.3
Pennsylvania	Purchases through MCO 95%, self-insured FFS 5%	200%	48.4	104.0
Texas	Purchases through managed care—HMO/EPO	200%	207.1	742.8
Utah	Purchases through MCOs	200%	6.9	25.9
Vermont	Self-insured FFS—PCCM	300%	.89	2.6
Washington	Purchased from MCOs	250%	4.3	8.0
West Virginia	Self-insured: FFS, TPA is Public Employee Insurance Agency	200%	5.6	26.9
Wyoming	Purchases indemnity from BCBSWY	185%	1.1	3.2

Source: State data collected by Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, July 2004. Benefit delivery system data collected by CMS.

As Table 2 shows, most separate SCHIP states purchase coverage for enrolled children, although the delivery systems may be very different. Additional information on programs in Alabama, Georgia, Idaho (a combination state), North Carolina, Vermont, and West Virginia is presented in more detail in Appendix 2. These programs are examples of the various types of arrangements states developed to provide health care to children through SCHIP.

Section 2. Self Insurance

A self insured plan is one in which the state assumes the financial risk for providing health care benefits to CHIP enrollees. In practical terms, the state pays each claim “out of pocket” as claims are presented, instead of paying a fixed premium to an insurance carrier for a fully insured plan. Typically, the state sets up a special fund to earmark money to pay incurred claims. The state funds the risk directly from state general fund or

state special revenue, matched with federal funds. By self insuring, the state becomes obligated to pay for benefits covered under the plan.

Becoming self insured may require that CHIP explore relationships with one or more third party administrators (TPA). A third party administrator typically adjudicates and pays claims, prepares claim reports, establishes a provider network, provides case management, and other requirements (see Table 3). Additional responsibilities of the TPA might include preparing and distributing to enrollees the summary benefit descriptions, ID cards, provider directories, and other enrollee materials.

Supporters cite several advantages of a self insured plan for CHIP:

- Funds are used to provide health care for children, rather than to fund another administrative layer.
- The state can customize the plan to meet the specific health care needs of children, versus a “one size fits all” insurance policy. The state would have complete flexibility to determine the appropriate plan design.
- The state can control health plan reserves, enabling maximization of interest income—income that would be otherwise generated by an insurance carrier through the investment of premium dollars. Interest on reserves would remain under the state’s control.
- CHIP would not have to pre-pay for coverage.
- A self insured plan is not subject to state health insurance regulations or benefit mandates.
- CHIP would not be subject to state health insurance premium taxes, which are generally 2-3 percent of the premium’s dollar value. Premium tax is applied only to the stop loss premium (see Appendix 3), which is significantly less than a fully insured plan.
- The state is free to contract with providers or provider networks best suited to meet the health care needs of children.
- The state can realize risk management effectiveness through stop loss insurance and choose the amount of risk to retain and the amount to be covered by stop loss coverage.
- CHIP can leverage state purchasing power to obtain the best pricing.

Opponents believe administering CHIP as a self insured plan has these disadvantages:

- CHIP will need a reserve to smooth out fluctuations, but the reserve will be vulnerable to raiding for budget deficits in other areas.
- The state is fully at risk.
- CHIP will need additional FTE and equipment.
- A self insured plan has implications for providers, whose rates must be sufficient for adequate access.
- Paradox: The state can avoid the burden of complying with state mandates.

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- The state may see self-insurance as a hindrance to efforts to bring health care reforms to Montana. Montana assesses a fee on health plans to subsidize the Montana Comprehensive Health Association. CHIP currently pays more than \$150,000 in fees annually to subsidize MCHA.
 - Insurance companies may view a self-insured CHIP plan as uneven competition.
 - An unintended effect may be increased costs to insurers, which they may pass on to large fully insured groups. (See Prevalence of Employer Self-Insured Health Benefits: National and State Variation, Christina H. Park, *Medical Care Research and Review*, Vol. 57, No. 3 Sept 2000 340-360.)

Similar self insured entities:

Montana Medicaid: Montana Medicaid covers approximately 83,000 individuals each month. Medicaid eligibility is performed in every county using approximately 400 DPHHS employees, who also perform eligibility for other public assistance programs. Most functions related to Medicaid services, such as claims processing, provider relations and provider manuals, third party liability, decision support systems, and maintenance of MMIS, are performed by ACS. DPHHS also uses private contractors for prior authorization and administration of Passport to Health, utilization review, Nurse First, and Team Care. About 25 FTE manage Medicaid Services at the state level.

Montana University System (MUS): MUS covers about 8,000 employees and their dependents, for a total of 15,000 covered lives. Claims total about \$30 million annually (average \$2,000 per covered person). BCBSMT has had the contract to administer the MUS plan since the mid 1990s. Beginning July 1, 2005, Allegiance will be the TPA. New West and BCBSMT will continue to provide HMO plans for MUS employees. MUS has less than three months for IBNR claims and another 2-3 months as a claims fluctuation reserve. MUS will soon partner with State Employee Group Benefits for case management and utilization review services.

State Employee Group Benefits (SEGB): SEGB has been self-insured since 1984 and currently contracts with three third party administrators, BCBSMT, Allegiance, and New West, and provides four different plans. Utilization review is being brought in-house and will no longer be performed by a contractor. SEGB costs out and sets rates for each plan using DXCG risk scores. SEGB is funded through HB 13, the State Employee Pay Plan. Two thirds of the funding comes from the employee pay plan and is collected through the state payroll system. Those funds go into a proprietary account.

SEGB's current FTE level is 10. SEGB contracts with Mellon Consultants for actuarial services, and runs a parallel projection model against Mellon's projections on a quarterly basis. Pharmacy is carved out by SEGB, who contracts directly with Eckerd (now known as PharmaCare/EHS) for a substantial savings. The state's reserve as outlined in statute is the amount required to cover the unrevealed claim liability. SEGB is now building a reserve of 2 months above what is needed for the "float," to provide more stability to the financial management of the plan.