

Presented by Tanya Blk
Blue Cross + Blue Shield
SENATE TAXATION
EXHIBIT NO. 84
DATE 4-4-05
HB 667
State Planning Grant

Section I - No Significant Fiscal Impact to the State of Montana

I. A. Recommendation:

Encourage Associations and groups to explore the benefit of purchasing pools, given the legislative changes made in the 2003 Legislative session.

I.A
II.B

Target Population:

Groups of 51 or more eligible individuals

Support/Rationale:

Private sector recommendation

The 2003 Legislative Session, in House Bill 104, lowered the number of eligible individuals needed to form a purchasing pool from 1000 to 51. This recommendation offers new coverage or makes continuing coverage affordable.

The 2003 Montana Household and Employer Survey identified that 77% of Montana's uninsured are employed. The survey found that sixty percent of the State's uninsured are either self-employed or work for a small business with ten or fewer employees.

Recently two Associations announced the availability of an insurance plan. The Montana Nonprofit Association (MNA), after over a year of study and analysis, partnered with New West Health Services, to offer lower cost health care insurance through an Association plan. This plan includes coverage for single employee nonprofit groups. Montana Chamber Choices (MCC) is available to small employers with 2 to 50 employees who are members of a local chamber or the State Chamber. MCC, in association with Blue Cross Blue Shield of Montana offers three standard health insurance options.

Administrative Issues:

Staff resources from within Association(s) associated with research of potential plans, projections of take-up rates; benefit design and other related start-up.

Cost:

No state funding involved

Funding Sources:

Employer and employee

Implementation:

- *Encourage current associations to poll their members to identify the number of uninsured and facilitate opportunities to train members about available options.
- * Encourage the Chamber of Commerce and MNA to track the take-up rate with their respective association plans.
- *Outreach and employer education to other Associations by the State Auditor, Chamber of Commerce, National Federation of Independent Business (NFIB), the Montana Society of Association Executives.

I. B. Recommendations:

1. Recommend the Commissioner of Higher Education, Board of Regents and the University/Community College system develop consistent internal policies and procedures to require proof of existing insurance coverage (parents or employers) or require student to purchase health insurance offered through the University System.

Target Population:

Uninsured, at minimum between the ages of 18-26. The requirements may provide an avenue for insurance coverage for those full-time students over the age of 26. 18% of undergraduates at the University of Montana are age 25 or older.

The University of Montana and Montana State University had a total enrollment of approximately 25,000 students, with over 19,000 students considered full-time. Almost 82% of the students attend school on a full time basis.

Assumption:

One half of the full-time students are covered by their parents' policies (9500); one-quarter purchase insurance or is covered through University Plan, employer or spouse (4750). This recommendation could potentially reduce the uninsured by more than 4750 individuals.

Target Number of Uninsured this proposal will address:

Potentially more than 4,750 post-secondary students.

Support/Rationale:

Public and public-private sector recommendation)

The Montana Household survey findings identified a 39% uninsured (32,000 individuals) for people between the ages of 19-25. The uninsured rate for those between the ages of 26-49 is 24% (75,000 adults) Montana State University (Bozeman and Billings campus) and the University of Montana (Missoula) campus have existing internal policies and procedures to require proof of insurance for students carrying twelve or more credits.

The premium cost for students to purchase the University policy is approximately \$400 per semester.

Administrative Issues:

Consistency in implementation and enforcement

Cost:

No state cost.

Recommendation:

*Commissioner of Higher Education and the Board of Regents implementation of a statewide policy.

I. C. Recommendation:

Educate the public in the benefits of health insurance coverage by promoting health literacy and the value of maintaining one's health.

1. Improve health promotion with consumers and employers (i.e. wise pharmacy)
2. Promote preventive health curricula with the education system (Consumer Education, General life skills, Driver's education etc.)

Target Population:

All Montanans

Support/Rationale:

Public /private recommendation

The Montana Household Survey and the Employer Survey identified increased health care costs and health insurance affordability as critical issues for Montanans. Health literacy is defined by Healthy People 2010 as "the degree to which people can obtain, process and understand basic health information and services they need in order to make health decisions." Health literacy is about the entire process of exchanging healthcare information. The National Academy on an Aging Society reports that "over 90 million adults with low health literacy skills have limited ability to read and understand the instructions contained on prescriptions or medicine bottles, appointment slips, informed consent documents, insurance forms, and health education materials...the estimated additional health care expenditures due to low health literacy skills are about \$73 billion in 1998 health care dollars." When we better understand health information and the benefits of healthier life styles, we help tackle the cost issues.

Promoting health literacy provides formal and informal avenues of targeting all ages of the uninsured across Montana. Surgeon General Richard Carmona, at the 2003 Governor's Health Care Summit in Billings stated, "Health Literacy can save lives, save money and improve the health care and well-being of millions of Americans."

Administrative Issues:

Coordination of efforts, especially given the rural nature of our state is critical. Encourage collaborative partnerships in sharing of information and the message.

Cost:

Unknown

Funding Sources:

Explore grant applications, such as Robert Wood Johnson Foundation, federal grants, etc.

Implementation:

Includes, but is not limited to:

- *DPHHS, as the primary coordinator, in collaboration with state agencies (Commerce, Labor, Insurance Commissioner, OPI, University System,) and the private sector, to promote health wellness.
- *Explore existing technology avenues in Montana to enhance opportunities to deliver the message of health literacy (telecommunications, web sites, Public Service Announcements etc.)
- *Promote role of Advisory Council on Work Life Wellness.
- *Office of Public Instruction to encourage the development of curriculums in primary and secondary education settings (health classes, life skill classes)
- *Montana Hospital Association, Community Health Fairs and Health Screenings
- *Continued collaboration with the 32 Public Health Advisory Councils
- *Media literacy with Montana Broadcasters, Montana Newspaper Association, School of Journalism
- *Partner with organizations that interact with the uninsured, working poor and under-insured.
- *Explore the 211 concept (telephone access, statewide and/or regionally to health care information)
- *Collaboration with Montana Safety Net providers
- *AARP/Montana Senior Citizen Association outreach
- *Head Start and early childhood program outreach to families and young children

Section 2 - Requires New State Legislation and/or New State Dollars

II. A. Recommendation:

Recognize and support the Safety Net (Community Health Centers, FQHC, Urban Indian Clinics etc.) as a vital component of the health care delivery system. Support recommendations to enhance the Safety Net's ability to operate throughout the state.

Target Population:

Uninsured, under-insured and low-income residents. Currently fourteen rural communities are interested in pursuing grants to be designated as a Community Health Center. (Kalispell, Plains, Miles City, Lewistown, Baker, Ekalaka, Fort Benton, White Sulphur Springs, Cut Bank, Shelby, Hamilton, Townsend, Sheridan and Conrad).

Support/Rationale:

Public/private sector recommendation

Within the development of the five year strategic plan, it is not feasible to achieve a 100% uninsured rate in Montana, therefore the on-going development of primary and preventive health care access is critical. The uninsured, under-insured and low-income of Montana are served by a significant number of safety net health care providers across the State. Safety Net services are part of the fabric of providing health care to all Montanans, especially given our frontier designation.

The U.S. Public Health Act provides federal funds to three major programs in Montana:

- Community Health Centers
- Migrant Health Centers
- Homeless Programs.

Montana is currently served by eleven Community Health Centers in fifteen different communities across Montana. The Montana Migrant Program, headquartered out of Billings, also provides seasonal services in nine sites across the state. The Homeless program, based out of Billings provides satellite services in three communities. In addition, since 1998, through the Rural Hospital Flexibility Program, 35 Montana communities have received designation as Critical Access Hospitals. With the cost-based reimbursement (Medicaid and Medicare), many rural communities were able to maintain health care access for under-insured, uninsured and low-income Montanans.

Based on 2002 data, approximately 75% of the people who used Community Health Center services, had incomes below 100% of the federal poverty level. In addition, approximately 15 of those served were privately insured; just over 20% had Medicaid and/or Medicare coverage. The Community Health Centers provide primary and preventive care to the uninsured across the state. Supporting the development of additional Community Health Centers will provide additional health care access as well as bolster economic development opportunities for our smaller communities. The Montana Primary Care Association has identified more than \$8 million dollars in direct federal grant dollars coming to local Montana communities as a result of the existing grants. Ongoing services are supported by a variety of funding sources including, but not limited to: patient fees, donations, Medicaid and Medicare payments, contracts, private insurance etc. A minimum of \$300,000 yearly is provided to these communities through these grant funds.

Health care services to Native Americans are provided through Indian Health Services, Urban Indian Clinics, tribal facilities and other safety net providers. Funding for health care services to those Native Americans who are Medicaid eligible and receive services directly from Indian Health Services or tribal facilities are paid with 100% federal funds. As identified in the 2004 Public Health Redesign report, "... 100% federal reimbursement is only available for those services allowable under the state's approved Medicaid State Plan."

Administrative Issues:

Technical support is necessary to support the small, rural communities in completing the federal grant applications.

Costs:

Provide state funding options to assist small rural communities in their grant applications for various federal programs which will help improve health care access and promote local economic development such as:

1. \$50,000 yearly appropriation to provide five communities with start-up funds to initiate and complete the grant process or
2. Provide an appropriation to create a 50-50-state/community match to help communities with resources to help with the grant processes.

Funding Sources:

Tobacco Initiative dollars, Community Block Grant dollars, and/or state funding.

Recommendations:

*Primary Care Bureau of DPHHS identification of the health care professional shortage areas and related program placement of health care professionals in programs like the National Health Service Corp.

*Montana Primary Care Association to provide technical assistance to the rural communities in their CHC grant applications.

*Montana Hospital Association (MHA) - An Association of Montana health care providers to continue to provide technical assistance to rural communities and their designation as Critical Access Hospitals.

II. B. Private Market Recommendation

Increase the affordability of health care insurance and expand health insurance options in the private market by providing tax incentives to low-income individuals and small employers.

1. Pursue tax credits options for low-income individuals with family incomes less than 175% FPL and employers with fewer than 5 employees who do not have any employees earning more than \$150,000 per year. Continue to pursue tax credit incentives at 50% employer level and for individuals at 175% Federal Poverty Level (as introduced in 2003 Legislative Session: HB 204 and HB 216) Explore capping available tax credits at maximum of \$10 M per year.

Target Population:

Small Business and low income individuals

First Step - Small Businesses

Recommendation:

A public/private recommendation could cover up to 6,000 uninsured individuals this proposal.

1. Year 2 & 3: Target employers with fewer than 5. Depending on the take-up rate, provide flexibility to increase credits for employers with 9 or less employees.
2. Year 3 & 4: Target employers with 9 or less employees.

Support/Rationale:

Tax relief proposals fill the coverage gap that exists between poor children and parents who are eligible for Medicaid and the Children's Health Insurance Plan (CHIP), as well as those who do not have access to or who cannot afford to purchase employer-sponsored insurance. The 2003 Montana Employer Survey, conducted by the University of Montana, identified that 56% of uninsured Montanans work for small businesses with ten or fewer employees. 48% of employers not currently offering health insurance coverage would do so with a tax credit of 50% or more. Further, close to sixty per cent of small businesses with ten or fewer employees do not offer health insurance. Eighty one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance.

Administrative Issues:

Refundable tax credits utilize existing administrative systems and require less coordination and verification of coverage with employers. The Fiscal Notes for HB 204 and HB 216 identified at minimum increased workloads for the Department of Revenue and the State Auditor's Offices. (Credit payments, eligibility and outreach). The SHADAC Issue Brief #2 identifies additional advantages and disadvantages.

Cost:

The Fiscal Notes for HB 204 and HB 216 identified anticipated costs.

With the tax credit model, the State bears one-half of the cost. A Pilot Program identified in HB 204, based on a sample take-up projection of 12,700 individual credit and small group credit projected costs at \$19 M for each year of the biennium.

HB 216 identified 38,997 income tax returns with combined incomes of less than 175% FPL. The fiscal note calculated the tax rate for eligibles that used the medical insurance deduction to be 3.65%. The net reduction in calendar revenue in FY 2004 was \$20M and \$41M in FY 2005.

Both legislative proposals would also require additional FTE within state government.

Funding Sources:

One of the intended uses of the revenue generated by a proposed tobacco tax increase is specifically targeted to new tax credits or to fund new program to assist small businesses with the costs of providing health insurance benefits to employees. Critical to the future of this proposal is the issue of sustainability for small businesses.

Implementation:

*Legislation would be required.

*Montana Department of Labor is encouraged to add questions to their survey of employers regarding health insurance, in order to track progress we have made in reducing the number of uninsured.

II. B. Private Market Recommendation

Expand health insurance options in the private market.

2. Explore the feasibility of reducing cost drivers such as mandated benefits, utilization and administrative complexity. Creative approaches should include consideration of basic benefit designs, care management programs, benefit limits and caps, cost sharing by consumers, and streamline of applications and paperwork related to healthcare coverage.

Target Population:

Unknown at this time.

Recommendation:

This private sector recommendation would require additional study and analysis. The 2002 Colorado Health Care Cost Study may provide comparative information. If the hypothesis is correct and alternatives can be identified, this recommendation may benefit small businesses that do not offer health insurance.

Support/Rationale:

As identified in the Montana Household and Employer Survey, eighty one percent of Montana firms not offering health insurance cite high premiums as the major reason why they do not offer insurance. Further, close to sixty per cent of small businesses with ten or fewer employees do not offer health insurance.

Administrative Issues:

Some of the current cost drivers are based on federal laws.

Cost:

Unknown

Funding Sources:

Pursue additional HRSA grant funds or request state funding via an interim legislative study.

Implementation:

*A Legislative Interim Study and/or other resources would be needed for a study/analysis of cost drivers.

II. B. Private Market Recommendation:

Develop Legislative proposals that create more health insurance options to serve the private sector uninsured.

3. Pursue development of legislative proposals that encourage group sponsored health care plans like the currently available individual only plans such as Blue Care or the New West Bridge Plan.

Target Population:

A private sector recommendation that would help address the uninsured in a number of categories: Young adults, especially those who are turning 19 and are no longer eligible for Medicaid or CHIP, Adults in the 19-26 year old category not enrolled in post-secondary schools and adults working for small businesses who do not offer health insurance.

Support/Rationale:

With one in every five Montanan currently uninsured, there is value in the Legislature exploring other options in order to provide health care services for the uninsured.

Employers are very interested in an affordable option to traditional health insurance plans. While a limited benefit plan is not considered optimal, it offers a considerable improvement over the absence of health care coverage for thousands of individuals. Such a plan also provides a broader base for cost sharing across a group that is not currently participating.

The safety net that exists now to cover the uninsured places the cost on the shoulders of individuals obtaining care and providers. Under a limited plan design, cost may be modified by insurers who have the capability to direct care, offer care management and who may negotiate reimbursement on behalf of their covered members.

Currently there are only two programs in Montana which specifically address the uninsured:

- Blue Care, a product offered by Blue Cross Blue Shield, offers a low premium benefit for uninsured individuals and families. The basic benefit package includes primary care, emergency room, pharmacy and hospitalization. Maximum benefits are capped.
- The 2003 Legislative Session, in HB 384, provided avenues for a demonstration project to provide limited health care services to uninsured Montanans. The current demonstration project, sponsored by New West Health Plan, provides insurance to uninsured Montanans under the age of 65 and not on Medicare, who have been uninsured for the previous six months and live within a 30-mile radius of Billings or Helena. The provisions within HB 384 allow the demonstration project to exclude some of the services that are a mandated requirement of health insurance plans. The New West Health Plan includes access to primary and specialist care in the office setting, basic lab and x-ray, generic prescription medication, mental health and other outpatient therapies. It does not provide services for emergency room and inpatient hospitalization.

While enrollment is currently quite low, only 50% of the enrollees have utilized services in the first quarter. This demonstrates a cost sharing opportunity of such a plan.

Administrative Issues:

Flexibility in Legislation, as evidenced by HB 384.

Cost:

No state cost.

Implementation:

*Legislation would be required for this private sector recommendation.

*The State Auditor's office will review and study the annual reports submitted by New West Health Plan regarding the Bridge Program, the pilot project created by the 2003 Legislative session.

*Legislation (HB 384) enabling plans such as New West's Bridge Plan sunsets in 2009.

Section 3 - Requires Legislation and/or State Funding Recommendations

III. Requires Legislation and/or State Funding Recommendation:

A. Enroll those currently eligible:

1. for Medicaid
2. for the Children's Health Insurance Plan (CHIP) at or below 150% Federal Poverty Level.

Target Population:

Uninsured, eligible children for Medicaid and those children currently eligible for CHIP below 150% FPL. DPHHS has estimated that 7,000 children could be covered by Medicaid and 15,000 additional children by CHIP.

Support/Rationale:

Public-private sector recommendation

Covering the most needy has been a consistent theme identified by the various committees of the State Planning Grant. The Montana Household Survey findings identified approximately 22,000 children in Montana are uninsured and living in households with annual gross incomes below 150% FPL. The current CHIP eligibility income limit is at or below 150% FPL.

Administrative Issues:

The program is currently operational. Additional staff will be needed to address workload associated with increased enrollment.

Cost:

Assuming an 85% utilization, the cost to the State to cover those currently eligible for Medicaid would be \$3.5 M and \$4 M for CHIP. An annual cost to the State to insure a child under Medicaid is \$590.35. Annual cost to the State to insure a child under CHIP is \$311.60.

Funding Sources:

State and Federal dollars
Donations to CHIP program

Implementation:

*Legislative Recommendation:

-Request DPPHS address funding needs through HB 2 in order to assure general fund appropriations for the state share for Medicaid and CHIP.

*DPHHS:

- Funds for DPHHS staff and associated costs to develop and maintain outreach efforts to educate parents about the program.
- Document and track barriers for those who do not apply for programs for which they are eligible.
- Continue collaboration with Tribal Health and DPHHS to enroll Native Americans in Medicaid and/or CHIP if eligible.

III. Requires Legislation and/or State Funding Recommendation:

B. Provide coverage for uninsured children up to 200% Federal Poverty Level.

1. Expand CHIP to cover children at 200% Federal Poverty Level.

Expand CHIP in graduated increments:

- a. 165% FPL
- b. 185% FPL
- c. 200%FPL

2. Institute increased cost sharing for children between 151% - 200% FPL.

Target Population:

Uninsured, eligible children below 200% FPL.

Target number of uninsured individuals this proposal will address: 13,900, identified in the 2003 Montana Household Survey. If graduated increments are implemented in order to decrease the number of uninsured children, we would see the following number of children potentially served:

- Up to 165% FPL would include an additional 2,700 children
- Up to 185% FPL would include an additional 4,700 children
- Up to and including 200% FPL would include an additional 6,500 children
- A total target population of 13,900 children would be served.

In proposing an incremental approach to serving more children, it is the goal of the State Planning Grant to attain a 3% uninsured rate among Montana children.

Support/Rationale:

Public-private sector recommendation

The Montana Household Survey findings identified approximately 13,900 children in Montana who are uninsured and living in households with annual gross incomes between 151% and 200% FPL. The current CHIP income limit is 150% FPL.

Administrative Issues:

The program is currently operational. Additional staff will be needed to address workload associated with increased enrollment.

CHIP coverage cannot be expanded to children within this income range until all the children living at or below 150% FPL are covered.

Cost:

CHIP contracts with an insurance plan for medical benefits. Total cost per year per child for medical benefits, dental services, eyeglasses, and state administration is \$1,639.99, of which the state share is \$311.60

Assuming an 85% take-up rate, 11,815 children between 151% and 200% FPL would be covered. The total annual cost would be \$19,360,082, of which the state share is \$3,808,128.

Recommendations:

		(State Share)
Year 2	Serve 2,295 up to 165%	Cost: \$715,122
Year 3	Serve 6,290 up to 185%	Cost: \$1,959,964
Year 4	Serve 9,265 up to 200%	Cost: \$2,886,974
Year 5	Serve 11,815 up to 200%	Cost: \$3,681,532

Increased cost sharing: Cost sharing for this group can be increased up to a 5% of annual gross household income.

Increased cost sharing would mitigate the premium for the medical benefit and the costs listed above would be slightly lower. Maximum annual cost sharing for each income group:

165% FPL	\$702 (\$58 per month)
185% FPL	\$772 (\$64 per month)
200% FPL	\$865 (\$72 per month)

Funding Sources:

State and Federal dollars
Donations to CHIP program

Implementation:

***Legislative Recommendation:**

- Request DPPHS address funding needs through HB 2 in order to assure general fund appropriations for the state share for CHIP.
- Request a change in statute to increase CHIP income level from a maximum of 150% FPL to 200% FPL.

***DPHHS:**

- Implement administrative changes in order to serve uninsured children at determined Federal Poverty Level.
- Implement cost sharing, if approved. Note there is no cost sharing at 100% FPL. The cost sharing is limited to 5% of the gross family income. Co-payments currently exist for the children between 101-150% Federal Poverty Level.

III. C. Recommendation:

Maintain or increase the Montana Comprehensive Health Association (MCHA) high-risk pool availability of coverage, recognizing MCHA is charged with serving as the access mechanism for Montanans with high-risk medical conditions through:

1. Ensuring enrollment for all those currently eligible
2. Maintaining or increase the low-income premium assistance state subsidy established by the 2003 Legislature.
3. Exploring the possibility of expanding the current premium assistance program for eligible individuals from 150% Federal Poverty Level to 200% Federal Poverty Level.
4. Continuing participation in the Trade Adjustment Assistance Act (TAA) and consider support for Trade Adjustment Assistance expansion.
 - a. If an individual is TAA qualified, one can receive tax credits and participate in the portability pool.
 - b. Additional TAA support is available through a federal grant for the entire MCHA, not just those who are eligible for TAA credit. MCHA, a current TAA grant recipient should apply for future grants as they become available.

Target Population:

MCHA offers subsidized policies of individual insurance to eligible Montana residents who are considered uninsurable due to medical conditions or have lost coverage subject to the Health Insurance Portability and Accountability Act (HIPAA) and are eligible for HIPAA Portability coverage. Currently MCHA serves the following:

- The traditional plan covers over 1400 people
- The Portability plan covers over 1680 individuals.
- The MCHA premium assistance program serves more than 180 individuals. The MCHA premium assistance program provides an additional premium subsidy for persons with qualifying conditions and a family income at or below 150% FPL. The 2003 Legislature also qualified the MCHA Portability Plan as a coverage option for persons certified as eligible for the Trade Adjustment Act assistance (TAA), (see page 20).

It is difficult to predict the take-up if the program was expand to 200% FPL. It is also likely some individuals currently covered through MCHA would move to the additional premium assistance program if the income criteria was raised to 200% FPL.

Target number of uninsured individuals this proposal will address: 3,500 – 4,000 individuals

Support/Rationale:

Public-private sector recommendation

Created by the 1985 Legislature, MCHA, Montana's high-risk pool provides access to health care coverage to Montanans, who are otherwise considered uninsurable due to existing medical conditions. If coverage were not offered to these individuals, providers may be faced with charity and uncompensated health care services. Individuals served by this program have been rejected for health insurance coverage or been offered a policy with a rider excluding a primary health condition. The 1997 Montana Legislature created a new MCHA plan to comply with the Health Insurance Portability and Accountability Act. This act requires that the individual who loses employer group coverage have guaranteed access to individual coverage with credit for preexisting medical conditions.

Administrative Issues:

The MCHA Board directs the program and the plan administered by Blue Cross and Blue Shield of Montana.

Cost and Funding Sources

Current legislative appropriation of \$1,150,000 for the biennium helps with the funding of the low-income Premium Assistance program; together with federal HRSA grant funds.

Traditional and Portability coverage is currently funded through premiums paid by the program participants (roughly 60% of program costs) and assessments against all insured health premiums in Montana picking up the balance. MCHA was also awarded a federal Trade Adjustment Assistance Act (TAA) grant of \$638,228 to help offset health care expenses in calendar year 2004.

As identified in the Montana Household Survey uninsured individuals can afford to pay low monthly premiums. When faced with pre-existing medical conditions and or having lost coverage, the premium cost is a major factor for most. The State Planning Grant recommends the MCHA Board consider a benefit redesign for low-income individuals at different levels of the Federal Poverty Level (FPL).

Aggregate cost of an additional 3000 individuals would be in excess of twenty million dollars for individuals not receiving the additional premium assistance. In that current premiums cover about 60% of costs that leaves about \$8million to be covered elsewhere, a small portion of which would be assessment dollars. Since assessments are capped, additional funds would be needed.

Implementation

*Legislature: 17-6-606 MCA: Continue subsidy of MCHA and the premium assistance, established by the 2003 Session. (The statute is referenced rather than HB 2 since it is a statutory allocation and as of July 1, 2005 some of the other allocations terminate. These dollars may need to be identified with the Governor's Executive Planning Process.)

*MCHA Board/State Auditor: Continue to pursue federal funding sources where applicable

- Ensure sustainability of current MCHA program.
- Continue to explore expansion of the MCHA assessment base to provide MCHA sustainability into the future.
- MCHA continue current outreach including requesting all insurance agents provide MCHA to those who do not qualify for other plans, public service announcements, Health Fairs etc.
- Identify a means to document current barriers regarding affordability of coverage.
- Continue to review and monitor the health status responses to the Behavioral Risk Factor Surveillance Survey (BRFSS) conducted annually by the Department of Public Health and Human Services (DPHHS) [these statistics may help identify approximate numbers of persons with health risk factors and/or pre-existing conditions.]
- Continue Annual Report to Legislature and State Auditor's Office regarding enrollment and access issues and to insure funding sources.

*Department of Labor:

- Develop and maintain outreach to potentially eligible persons
- Continue to pursue federal funding sources (i.e. TAA)

III. D. Recommendation:

Explore a prescription benefit for those adults: Between the ages of 62-64, up to and including 200% Federal Poverty Level and who have applied for disability and have the two-year waiting period.

Target Population:

Underinsured and Uninsured adults

Total number of Montanans between the ages of 62-64 is 22,684 (2000 Census Data). The assumption is that no more than half are at or below 200%FPL (11,342).

Support/Rationale:

Public-private sector recommendation

The cost of prescription drugs is a significant cost driver. Nationwide prescription costs have been increasing as much as twenty to thirty percent per year. Moreover, prescription services may delay or obviate the need for inpatient services and thereby prevent more expensive care.

Administrative Issues:

Legislative proposals were introduced in the 2003 Session. The eligibility requirements, as identified in SB 474 were complicated. The program would not go into effect until January 2005. Eligibility system enhancements would be required if this program was administered by DPHHS. SB 473, dependent upon approval of federal waivers, expanded the Medicaid prescription drug program. The fiscal note identified the average cost of a prescription at \$49.67 in FY 2005.

Costs:

The fiscal note of SB 474 identified that the required amount of state funding was undefined. The fiscal note of SB 473 identified state special revenue (generated from an application fee), state and federal dollars in order to establish and maintain the program.

Funding Sources:

Based on past legislative history funds would include state general funds; state special revenue, federal funds and prescription rebate fees. In addition, one of the intended uses of the revenue generated by a proposed tobacco tax increase is specifically targeted to fund a state prescription drug program.

Implementation:

*In the interim, until the program is funded, provide outreach regarding Patient Assistance programs offered by pharmaceutical companies and/prescription discount programs/cards. Use the Information and Assistance program within the ten Area Agencies on Aging.

*Explore the use of preferred drug lists as a way to control the high cost of drugs.

*Review, as identified by the Safety Net work group, the evidence based research (i.e. Oregon)

*As identified in the Health Literacy section, provide education and consultation on the wise use of prescriptions. (i.e. PharmAssist program)

*Review Rx programs offered in the District of Columbia, Idaho, Alaska, Indiana, Vermont, Minnesota, Maine and Hawaii.

*Request FDA approval for importation of drugs from Canada.

IV. A. General Recommendation to Public Health Redesign Committee

1. Address those currently eligible under existing programs that are not enrolled in Medicaid or CHIP (See Recommendation III A.)
 - a. Document and track barriers for those who do not apply for programs for which they are eligible.
 - b. Continue collaboration with existing groups to enroll Native Americans in Medicaid and/or CHIP, if eligible.
2. Expand CHIP to cover children at 200% Federal Poverty Level
 - a. Expand CHIP in graduated increments (165%FPL, 185% FPL, 200% FPL). See Recommendation-III.B.
 - b. Expand CHIP to cover children at 200% FPL.
 - c. Institute increased cost sharing for children between 151% FPL and 200% FPL. See Recommendation III. B.
3. Administrative Issues: Maintain health care access for low-income Montanans by addressing Medicaid reimbursement and streamlining, where possible, administrative requirements.

Target Population:

1. Uninsured, eligible children below 150% FPL for Medicaid and those currently eligible for CHIP below 150% FPL is estimated to be 22,000 children.
2. There are approximately 13,900 uninsured children, between 150% FPL and 200% FPL identified in the 2003 Montana Household survey. If graduated increments are implemented in order to decrease the number of uninsured children, we would see the following numbers of children potentially served:
 - Up to 165 % FPL would include an additional 2,700 children
 - Up to 185% FPL would include an additional 4,700 children
 - Up to and including 200% FPL would include an additional 6,500 children
 - A total target population of 13, 900 children would be served.

Support/Rationale:

Public-private sector recommendation
Covering the most needy has been a consistent theme identified by the committees of the State Planning Grant.

Administrative Issues:

The program is currently operational. Additional staff may be needed to address increased volume associated with application process etc.

Cost:

1. The cost to cover those currently eligible for Medicaid would be \$3.5M and \$4M for CHIP.
2. Assuming an 85% take-up rate, 11,815 children between 151% FPL and 200% FPL would be covered. The total annual cost would be \$19,360,082, of which the state share is \$3,808,128.

Funding Sources:

State and Federal dollars
Donations to CHIP program

Implementation Recommendations:

Legislative Recommendation:

Request DPPHS address funding needs through HB 2 in order to assure general fund appropriations for the state share for CHIP.

Request a change in statute to increase CHIP income level from a maximum of 150% FPL to 200% FPL.

Recommend DPHHS continue to pursue waiver options. The waiver could carve out dollars through refinancing to specifically address outreach efforts, which would result in increased enrollment in Medicaid and/or CHIP.

IV. B. Waiver Consideration for consideration by the Public Health Redesign Committee

1. Insure parents/guardians of publicly insured children with the following considerations:
 - a. At minimum, insure parents/guardians at or below 100% FPL have access to health insurance coverage.
 - b. Consider premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
 - c. Explore a modified, self-directed concept, (similar to the Home and Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for their own health care. Consider a plan, using a debit card that is front-loaded, with consumer knowledge of the balance. Expand Medicaid to cover parents/guardians between 101 - 150% FPL.
2. Expand Medicaid to cover parents/guardians between 101% FPL and 150% FPL.
 - a. Provide a premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
 - b. Explore a modified, self-directed concept, (similar to the Home and Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for their own health care. Consider a plan, using a debit card that is front-loaded, with consumer knowledge of the balance. Expand Medicaid to cover parents/guardians between 101 - 150% FPL.
3. Explore options to provide coverage to Mental Health Service Plan recipients and/or low income working adults.
 - a. Consider premium assistance program or a basic medical plan, which may have limits, exclusions and/or capped coverage for certain services.
 - b. Explore a modified, self-directed concept, (similar to the Home and Community Based Waiver), which provides the consumer with capped basic benefits, where the consumer shares an increasing responsibility for their own health care. Consider a plan, using a debit card that is front-loaded, with consumer knowledge of the balance. Expand Medicaid to cover parents/guardians between 101 - 150% FPL.

Target Population

- The SPG Coverage Options Committee recommends that parents at 150% FPL of publicly insured children, at minimum, covered.
- Based on the March 2004 enrollment of 10, 770 children in CHIP, there are 5, 385 families with children covered by the CHIP program. Statistics maintained by the Montana CHIP program indicates 6,998 parents are uninsured or 76% are uninsured. Health insurance statistics regarding parents of Medicaid children are not available.
- 76% of the parents of CHIP children are between the ages of 26-49. The Montana Household survey identifies an uninsured rate of 38% for those between the ages of 19 and 26 and 24% uninsured rate for those between the ages of 26-49. Providing health care to parents would help reduce the uninsured rate in Montana.
- The Mental Health Services Plan serves over 4,000 individuals annually. At a minimum, at least 90% of these individuals do not have health insurance.
- The waiver proposal would need to include a determination of the populations to include in the waiver, the implementation date and the coverage benefits offered.

Support/Rationale

Public-private sector recommendation

Based on the 2003 Montana Household Survey, statistics indicated that although 70% of the parents are employed, only 7% have employer-sponsored health insurance. The policy implication deducted from this

information would indicate that no single approach would be effective in providing coverage for parents. Insuring parents, however, has been determined to be a positive strategy because the absence of health insurance can have serious consequences for the entire family. National studies and analysis, as identified in the Montana Issue Brief, reinforces that increasing access to health insurance would keep working parents healthy, plus assure their children would access on-going health care and preventive services as needed.

The development of the self-directed concept improves access, reduces bureaucratic complexities and promotes health literacy.

Cost

DPHHS identified cost projections in the document following this recommendation. The modeling options presented by DPHHS include comparable health insurance products.

Administrative Issues

Baseline information has been identified by the State Planning Grant has been beneficial. DPHHS will need to determine if they move forward through the HIFA waiver option (and determine if there is a full benefit or a limited benefit offered to parents).

Funding Sources

State and Federal dollars
Through a HIFA waiver if pursued and granted

Implementation

Recommend DPHHS continue to pursue waiver options. Through the waiver, a benefit design will need to be identified. Moreover, given the five year term of the waiver, provisions could be made to provide an employer premium assistance program at some point during the life of the waiver.

Legislative approval and an associated appropriation will be necessary in order to pursue the waiver option.