MONTANA LEGISLATIVE BRANCH

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Director
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DATE: September 13, 2012

TO: Legislative Finance Committee

FROM: Lois Steinbeck, Senior Fiscal Analyst

RE: Update – SJ 26 Healthy Montana Kids Monitoring

The Legislative Finance Committee (LFC) decided to review Medicaid and Healthy Montana Kids (HMK) enrollment at each meeting as part of recommendations included in Senate Joint Resolution 26 (SJ 26).

RECENT ENROLLMENT TRENDS

Several graphs attached to this memo show the most recent enrollment in Medicaid and HMK. Medicaid enrollment has risen from levels reported at the June LFC meeting, increasing to its most recent peak of 107,018 in June from 105,040 in March 2012. The most recent enrollment is about 2,000 persons higher than reported at the last LFC meeting. Enrollment in HMK continues to rise, totaling 93,174 in June compared to the total last reported to the LFC at 90,300 children. A number of HMK enrollees – about 71,000 - are also counted in the Medicaid enrollment.

Medicaid

Family Medicaid (low-income parents and children) stands at 17,921, lower than its high point of about 20,700 persons in February 2011 and lower than the 18,092 reported at the June LFC meeting. There has been an increase of about 100 enrollees over 65, rising from 6,913 at the beginning of FY 2012 to 7,026 persons in June, but slightly below the peak of 7,046 in April. The number of Medicaid enrollees in the category aged and disabled in an institutional setting reached a high of 3,421 in March 2011 and stands at 3,321 in June 2012, which is about 700 persons lower that reported at the last LFC meeting. The number of disabled individuals enrolled in Medicaid continues to grow and stands at 19,569 the highest level over the most recent 24 months reported.

Healthy Montana Kids

The following table shows the 2011 session estimate for the annual HMK enrollment by group compared to average enrollment for FY 2012[1]. Overall actual enrollment was about 8% lower than the session estimate.

[1] The reporting format for HMK enrollment has changed slightly from the March 2012 report. The presumptive category of eligibility is shown separately in the March report, but allocated among the three major enrollment categories in this report. This change more accurately reflects the likelihood that a child presumed to be eligible for 60 days will be determined to be eligible for HMK and remain in the program longer than the initial 60 day period.

About 70% of HMK enrollment is children in families with the lowest incomes (below 100% of the federal poverty level - FPL), while about 23% is in higher income families (between 134% to 250% FPL). The remaining enrollment is children in families with incomes between 101% and 133% FPL.

FY 2012 Average Annual Enrollment in Healthy Montana Kids Compared to 2011 Session Estimate

Session Enrollment Estimate/ FY 2012 Average/ Difference	HMK Plus*	HMK* Plus Expansion	HMK** CHIP	Total
Session Estimate	67,147	10,612	20,618	98,377
Annual Average	63,215	6,152	20,687	90,117
Over (Under) Session Estimate	(3,932)	(4,460)	69	(8,260)
% Over or Under (-) Session Est.	-5.9%	-42.0%	0.3%	-8.4%

*HMK Plus - children in families with incomes below 100% of the federal poverty level

*HMK Plus Expansion - children in families with incomes from 101% - 133% of the federal poverty level

**HMK CHIP - children in families with incomes from 134% - 250% of the federal poverty level

Actual enrollment for the CHIP component of HMK is the closest to session estimates; the difference is less than 1%. However, the two Medicaid components were lower than session estimates by 6% (children in families with incomes below 100% of the federal poverty level) and 42% (children in families with incomes from 101% of the federal poverty level to 133%).

General Fund Reversion Higher due to Lower HMK Enrollment

The FY 2012 general fund reversion for DPHHS of $12.2 million was about $3.0 million higher due to lower HMK enrollment. HMK is funded from the federal CHIP grant and Medicaid entitlement funds, both of which require a state match. The state match is funded from general fund and several state special revenue sources. The most significant source of state special revenue is a portion (16.5%) of insurance premium tax revenues, which were diverted from the general fund to the state special revenue fund supporting HMK by the citizen initiative that established HMK.

Because FY 2012 HMK enrollment was about 8% below the estimate used to establish the appropriation, actual expenditures were lower than the appropriation. There was $3.6 million in unexpended insurance premium tax state special revenue authority remaining in the HMK state special revenue account. In accordance with 17-7-108(1), MCA[2], DPHHS used $3.0 million of the insurance tax premium state special revenue to offset the general fund match for Medicaid services provided to children in families with incomes below 100% of the federal poverty level, thereby raising the general fund reversion by a like amount.

[2] 17-2-108. Expenditure of nongeneral fund money first. (1) Except for the exemptions applicable to the Montana historical society in 22-3-114(5), the Montana state library in 22-1-226(5), the Montana school for the deaf and blind in 20-8-107(5), and the department of public health and human services in 53-1-612, an office or entity of the executive, legislative, or judicial branch of state government shall apply expenditures against appropriated nongeneral fund money whenever possible before using general fund appropriations.