



MONTANA LEGISLATIVE BRANCH

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DATE: March 12, 2014

TO: Legislative Finance Committee

FROM: Lois Steinbeck
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RE: Healthy Montana Kids Briefing Paper

SUMMARY

The Healthy Montana Kids (HMK) program was enacted by citizen initiative November 4, 2008. The initiative:

- o Created a single health insurance program for children combining the Medicaid and the Children's Health Insurance Program (CHIP) services
- o Raised financial eligibility for children in both Medicaid and CHIP
- o Diverted 33% of the insurance premium tax to a state special revenue account to fund increased enrollment in HMK
- o Restricted the use of the HMK state special revenue to pay costs only for new enrollees (the number of additional children enrolled above the enrollment as of November 4, 2008)

Enrollment in HMK has increased substantially since passage of the initiative, from 63,632 in October 2008 to 102,861 children as of December 2013¹. Enrollment increases are due to eligibility changes enacted in the initiative and changing economic conditions related to the Great Recession as well as enrollment outreach and simplification efforts by the Department of Public Health and Human Services (DPHHS).

In FY 2014, the total cost for medical services provided through the HMK program is estimated to be \$401.9 million, with \$114.9 million required in state matching funds and the balance funded from federal Medicaid and CHIP funds. State matching funds are paid by the general fund and the following sources of state special revenue:

- o HMK – insurance tax proceeds
- o Tobacco settlement funds
- o Tobacco settlement trust interest
- o Health and Medicaid initiatives - tobacco taxes

¹ HMK Eligibility Summary, Department of Public Health and Human Services, March 2014.

HEALTHY MONTANA KIDS PROGRAM

The HMK program was enacted by citizen initiative November 4, 2008. The initiative combined the Medicaid program and Children’s Health Insurance Program (CHIP) and made the following changes:

- o Raised financial eligibility for children with household incomes up to:
 - o 250% of the federal poverty level (FPL) for CHIP (previously 175% FPL)
 - o 185% FPL for Medicaid (previously up to 133% FPL for children up to age 6 and 100% FPL for children age 6 to 18)²
- o Removed consideration of family assets in determining Medicaid eligibility for children
- o Diverted 33% of insurance premium tax to the state special revenue account, which had previously been deposited to the general fund³
- o Restricted the use of the state special revenue funds to pay the state cost to cover the number of additional enrollees in the plan that exceeds the number of children enrolled as of November 4, 2008
- o Required DPHHS to implement presumptive eligibility⁴ for children in households that appear to meet HMK eligibility criteria, with the presumptive period lasting up to two months
- o Allowed DPHHS to implement a premium assistance program for families who have access to employer sponsored insurance

STRUCTURE OF HMK SERVICES AND FUNDING

DPHHS established three major eligibility groups for HMK as show in Figure 1:

- o HMK/CHIP
- o HMK Plus Age 6 - 18 CHIP Funds
- o HMK Plus Age 0 - 18

Figure 1

The HMK CHIP group receives CHIP services and is funded from the federal CHIP grant. The HMK Plus Age 6 – 18 CHIP Funds group receives Medicaid services funded from the federal CHIP grant. The final group HMK

HMK Eligibility Group, Services, Funding, Income Levels			
HMK Group	Services	Funding	Family Income % of FPL*
HMK/CHIP	CHIP	CHIP	144% to 261%
HMK Plus Age 6 - 18 CHIP Funds	Medicaid	CHIP	110% to 143%
HMK Plus	Medicaid	Medicaid	
Children Age 0 - 6			0% to 143%
Children Age 6 - 18			0% to 109%
*Income eligibility levels were changed to comply with ACA. These changes are discussed near the end of this report.			

² The 2009 Legislature established appropriations based on providing Medicaid services to children in families with incomes up to 133% FPL.

³ The 2009 Legislature temporarily lowered the amount of insurance premium tax proceeds deposited to the HMK state special revenue account to 16.67%. Beginning in FY 2014, 33% of the insurance premium tax proceeds are deposited to the HMK account.

⁴ Health care providers, primarily hospitals, can review persons’ financial data and determine that household income falls within HMK eligibility limits making a child eligible for HMK for up to two months. Eligibility continues beyond that point only if the family applies and the child is determined eligible through the health insurance exchange/marketplace or directly through DPHHS.

Plus receives Medicaid services paid from Medicaid funds. DPHHS structured the groups to maximize the use of federal CHIP grant funds since the state match for the CHIP grant is about 10% lower than the state match for the Medicaid program (for FY 2014 - CHIP state match is 23.63% and the state Medicaid match for services costs is 33.75%). The groups are differentiated by income level.

DPHHS contracts with Health Care Service Corporation for third party administration of all CHIP services except dental, vision, outpatient services provided by certain health care centers, pharmacy, and some mental health services, which are administered by DPHHS. The third party administrator contracts with providers, establishes fee schedules, and processes claims. DPHHS pays the claims costs and is at full risk for all costs.

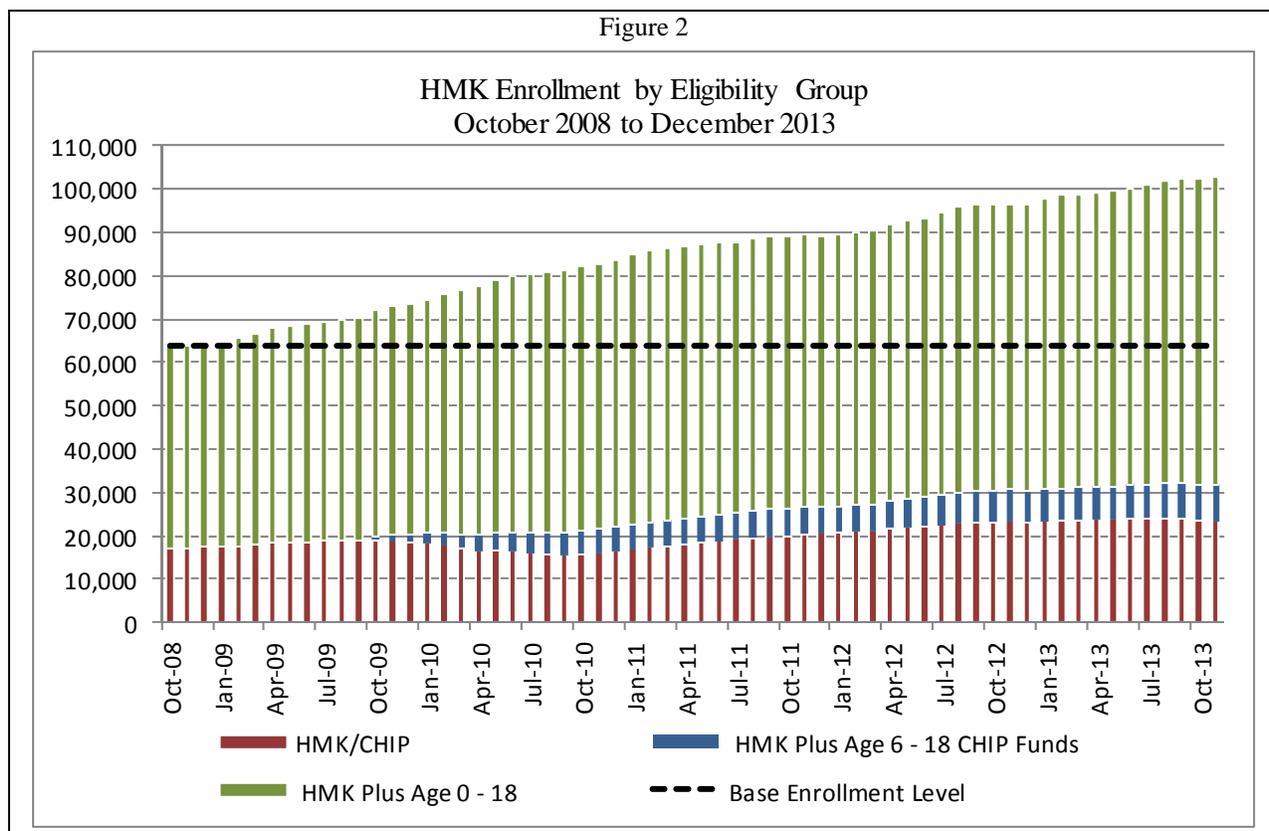
HMK Medicaid services are administered by DPHHS as part of its overall Medicaid program. DPHHS enrolls providers, establishes fee schedules, and pays claims.

Medicaid services are more comprehensive than CHIP services particularly for children with a disability. However, CHIP services are more comparable to Medicaid services since the last legislature approved funding to expand some services for CHIP. Provider reimbursements for CHIP are higher than Medicaid reimbursement rates.

HMK ENROLLMENT

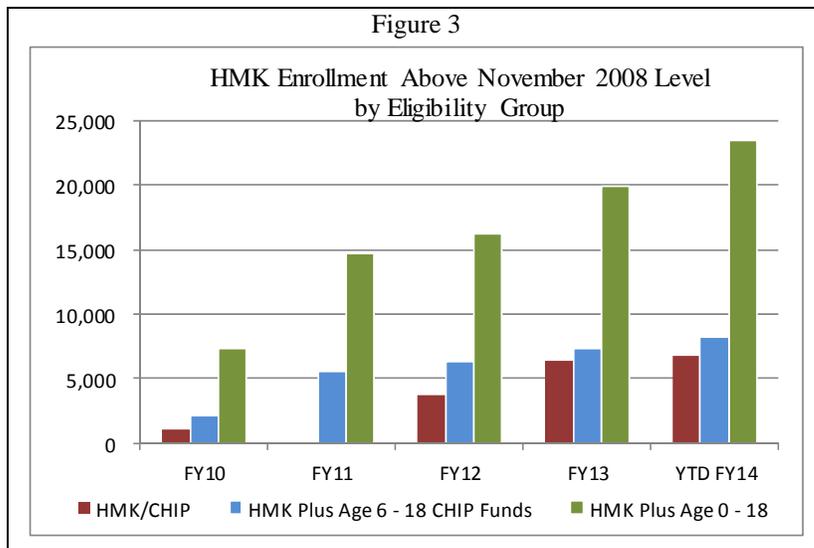
Enrollment in HMK has increased from 63,632 in October 2008 to 102,861 children as of December 2013 or about 62%. Figure 2 on the following page shows enrollment in HMK by eligibility group compared to the total enrollment level when the initiative was passed.

Figure 2



Most of the enrollment growth has occurred in the HMK Plus Age 0 – 18 group or those generally in the lowest income households. Figure 3 shows the year to date FY 2014 enrollment by group compared to enrollment levels as of October 2008. Enrollment in the HMK Plus Age 0 – 18 group is about 23,000 children higher than the October 2008 enrollment, while enrollment in the HMK/CHIP component is about 7,000 greater over the same time period. Some of the enrollment growth in the HMK Plus groups was due to children moving from HMK/CHIP to Medicaid services. Children in families with incomes below 133% FPL that had resources in excess of \$3,000 were eligible for CHIP but not Medicaid prior to the enactment of the HMK program. When family assets were no longer considered for Medicaid eligibility those children moved from HMK/CHIP to the HMK Plus groups. DPHHS staff estimate that 12,000 to 14,000 children moved from HMK/CHIP to HMK

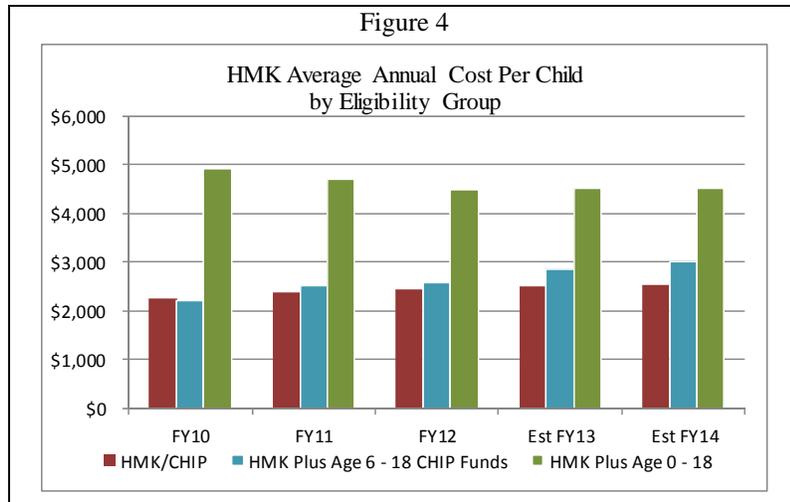
Figure 3



Plus groups throughout FY 2010 and FY 2011. This migration resulted in an annual enrollment for the HMK/CHIP group in FY 2011 that was slightly lower than the enrollment in CHIP when the HMK initiative was passed.

AVERAGE PER CHILD COST FOR HMK

Figure 4 shows the annual average per child cost for HMK by type of eligibility. Data for FY 2010 through FY 2012 are based on actual costs. FY 2013 and FY 2014 costs are estimated based on data that supported the DPHHS 2015 biennium budget request, the most recent DPHHS calculations of the average cost for various Medicaid eligibility groups, and the estimated



increase in per child costs in the fiscal note for the citizen initiative to expand Medicaid (0.3% annually).

The HMK Plus Age 0 – 18 is the highest average cost group, while the HMK/CHIP group has the lowest. HMK/CHIP has the lowest average cost due to a less robust service package compared to the Medicaid program and because children with disabilities and higher medical costs are most likely eligible for Medicaid.

The average per child cost for HMK Plus Age 0 – 18 has declined slightly since FY 2010. Neither DPHHS nor LFD staff has analyzed why costs have declined, but one factor appears to be increasing enrollment in the number of nondisabled children compared to the number of disabled children. A higher number of children with potentially fewer chronic medical conditions would lower the average cost across the group.

TOTAL COST AND STATE SHARE OF COSTS FOR HMK

Figure 5 shows the total cost for HMK from FY 2010 through FY 2014. FY 2010 through FY 2012 are actual costs and the remaining two years are estimated costs. As with the estimated average cost per child, FY 2013⁵ and FY 2014 costs are estimated based on the most recent data available from DPHHS.

Total costs for HMK have risen from \$311.5 million in FY 2010 to an estimated \$401.9 million in FY 2014. The state share has grown from \$89.4 million to an estimated \$114.5 million over the same time period.

⁵ Medicaid claims payment for FY 2013 will be final by June 30, 2014.

Figure 5

Total Cost and State Share by HMK Eligibility Group - Actual and Projected					
HMK Eligibility Group	<-----Actual*----->			<----Projected**---->	
	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Total Cost					
HMK/CHIP	\$40,391,390	\$40,147,561	\$50,658,541	\$58,186,802	\$59,590,145
HMK Plus Age 6 - 18 CHIP Fund	4,538,423	13,888,256	16,271,432	20,677,837	24,558,822
HMK Plus Age 0 - 18	<u>270,067,829</u>	<u>294,434,794</u>	<u>288,585,719</u>	<u>301,209,458</u>	<u>317,766,317</u>
Total Cost HMK	314,997,643	348,470,611	355,515,692	380,074,097	401,915,285
State Share of Cost					
HMK/CHIP	10,905,675	10,839,841	13,677,806	15,710,437	16,089,339
HMK Plus Age 6 - 18 CHIP Fund	1,225,374	3,749,829	4,393,287	5,583,016	6,630,882
HMK Plus Age 0 - 18	<u>78,319,671</u>	<u>85,386,090</u>	<u>83,689,858</u>	<u>87,350,743</u>	<u>92,152,232</u>
Total State Share	<u>\$90,450,720</u>	<u>\$99,975,761</u>	<u>\$101,760,951</u>	<u>\$108,644,195</u>	<u>\$114,872,453</u>

* Actual costs are based on enrollment and cost per enrollee provided by DPHHS in February 2014 for FY 2010 - FY 2014 for the HMK Plus groups. Actual costs for HMK/CHIP were provided by DPHHS in November 2012 and December 2010 as part of the executive budget request.

** Projected costs are based on enrollment and cost per enrollee provided by DPHHS on November 29, 2012 in response to LFD questions about the executive budget request for the 2015 biennium for HMK/CHIP and HMK Plus Age 6-18 CHIP Funded. The remaining projections use year to date enrollment with the lowest annual increase applied to FY 2014 to FY 2015 and 0.3% annual increase in per child costs based on the assumptions in the fiscal note for the citizen initiative to expand Medicaid.

The state share of HMK costs is paid from the general fund and various state special revenue sources including:

- o HMK – insurance tax proceeds
- o Tobacco settlement funds
- o Tobacco settlement trust interest
- o Health and Medicaid initiatives – tobacco taxes

State statute allocates:

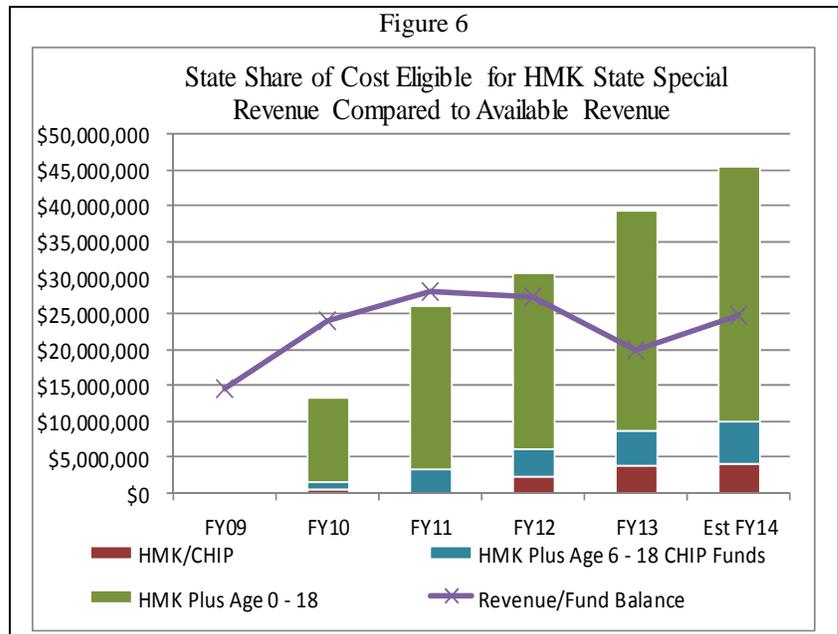
- o All HMK state special revenue to pay for the cost of children enrolled above the level of enrollment on November 4, 2008 and associated administrative costs
- o A portion of tobacco settlement funds to pay for HMK state match

The remaining sources of state special revenue are appropriated by the legislature among HMK, other Medicaid services, and other DPHHS programs. Most of the HMK appropriations from other state special revenue sources support provider rate increases for Medicaid services and in some instances eligibility and service expansion for various Medicaid groups.

ADEQUACY OF HMK STATE SPECIAL REVENUE TO FUND STATE SHARE OF COST

The funds allocated to the HMK state special revenue account are not adequate to pay the state share of costs for all of children enrolled in HMK that are in excess of the number enrolled as of November 2008. Figure 6 shows the cost of the state match associated with the increased enrollment by HMK eligibility group through FY 2014 compared to the revenue available to cover the state match. Figure 6 includes only medical services costs and no administrative costs associated with managing enrollment growth in HMK.

The flow of insurance tax proceeds into the HMK account began in FY 2009. However, there were no expenditures from the account that year, leaving about \$15.0 million in revenue to carry forward into FY 2010. The amount of revenue allocated to the HMK account was reduced from 33% to 16.67% from FY 2010 through FY 2013. The revenue flow over that time period was about \$10.0 million annually. Beginning in FY 2014, the temporary reduction expired and 33% of insurance premium taxes will be deposited to the account.



As expenditures from the HMK account increased, the revenue from the FY 2009 carry forward was gradually expended, thereby lowering the total funds available beginning in FY 2012 to pay the full share of costs eligible for HMK state match. Despite the increase in revenue in FY 2014, the HMK account is estimated to cover about 54% of the total share of eligible costs for enrollment increases. General fund pays the remaining share of state matching costs not covered by the HMK account and other state special revenue funds.

IMPACT OF THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act (ACA) affects HMK in several ways:

- o It requires eligibility to be based on modified adjusted gross income (MAGI) for certain Medicaid groups
- o It imposes sanctions (loss of federal Medicaid matching funds) if a state lowers or reduces children's eligibility for CHIP or Medicaid compared to standards in place as of March 23, 2010⁶

⁶This eligibility maintenance of effort for children is in place until September 30, 2019.

- o It provides for a 23% increase in the federal CHIP match rate, but limits the federal share to no more than 100% of total cost beginning October 1, 2015
- o It extends the CHIP program through September 30, 2019, but does not extend funding for CHIP beyond September 30, 2015

MAGI and Sanctions

Effective January 1, 2014, ACA required states to base eligibility on MAGI for certain groups including children eligible for CHIP and Medicaid. For most families, MAGI is a household's modified adjusted gross income as calculated on its federal income tax return. ACA also imposes hefty sanctions on a state that implements eligibility standards, methodologies, or procedures that are more restrictive than those in place as of March 23, 2010, with the exception of waiting lists for enrolling children in CHIP.

Prior to January 1, 2014, financial eligibility for HMK included disregards and exclusions for some types of income to determine final countable family income. Eligibility was based on the level of household income after the disregards and exclusions were applied. Therefore, children in households with incomes above the income eligibility listed in statute could be eligible for CHIP depending on the total amount of applicable disregards and exclusions. This anomaly did not exist for Medicaid services since HMK funding covered children in households with incomes up to 133% FPL while statute allows Medicaid eligibility up to 185% FPL.

To implement MAGI rules, DPHHS determined what HMK income eligibility would be using a MAGI standard by incorporating the effect of income disregards and exclusions used prior to January 1. The translation of the "old" eligibility determination method to the new MAGI method clarified the effective income eligibility by accounting for income disregards and exclusions. For instance, CHIP eligibility under the old system was 250% FPL after consideration of disregards and exclusions compared to 261% FPL under MAGI rules.

Increase in Federal CHIP Match Rate

The ACA extends the CHIP program through September 30, 2019 and raises the federal CHIP match rate by 23% beginning October 1, 2015. That change brings the federal share of funding for CHIP to nearly 100% for Montana during the 2017 biennium, which would free up an estimated \$46.1 million in HMK and other state special revenue currently used as CHIP match.⁷ The freed up state special revenue could be used to offset general fund costs in Medicaid and would more than offset the gap between increased HMK enrollment costs and the HMK state special revenue account shown in Figure 6.

Federal Funds not Appropriated

Although ACA enacts the increase in the federal CHIP match rate, Congress has not appropriated funds to continue the CHIP program past September 30, 2015, the day before the increased match rate takes effect.

⁷This estimate is based on information included in the fiscal note prepared by DPHHS for the citizen initiative to expand Medicaid – I-170. It includes both administrative costs as well as total services costs for CHIP.

Funding and Reauthorization of CHIP

The funding for and reauthorization of CHIP will be influenced by several factors, including the availability of premium subsidies and copay assistance for low income families who purchase health insurance through the federal health insurance exchange/marketplace and minimum Medicaid eligibility levels. Premium assistance is available for families with incomes above 100% FPL but below 400% FPL. Copay assistance is available to families with incomes from 100% to 250% FPL. Both premium and copay assistance are based on a sliding fee scale with lower income households receiving greater subsidies.

State Medicaid programs must cover children in households with incomes up to 138% FPL based on federal regulations. Therefore, there will be assistance to low income children through Medicaid and health insurance exchanges/marketplaces that may overlap CHIP eligibility limits in some states.

The decision to reauthorize and fund CHIP will also likely be influenced by the comparison of the CHIP program and health insurance purchased on the marketplace regarding:

- o The types of services offered
- o The total out of pocket cost for a family
- o Adequacy of provider networks