Interim Report to the Secretary

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Table of Contents

Page

Executive Summary

Prior to the receipt of the first State Planning Grant (SPG) by the Montana Department of Public Health and Human Services (DPHHS) in 2002, Montana relied on extrapolating data from national and private sources to describe its uninsured population.

The results of that grant, including the series of recommendations on how to cover more of Montana's uninsured population are contained in two documents: the **Montana Strategic Plan to Provide More Affordable Health Care Coverage (Summary of the Montana State Planning Grant Recommendations August, 2004)** and the **Final Report to the Secretary Spring, 2004.**

This Interim Report references that first **Final Report to the Secretary, the 2004 Strategic Plan**, and the very beginning stages of possible recommendations/policy guidance of the Steering Committee from this second SPG (also awarded to DPHHS) known as a continuation grant.

The purposes of this continuation grant are to:
(1) analyze the impact of current legislative initiatives that expand health coverage for the uninsured; **(2)** develop sustainable methods to gather information about health insurance for the population in total and information related to employer-based health insurance, and **(3)**create a "home" for continuing health policy development that addresses providing health care coverage to all Montanans.

In 2005, the Director of DPHHS appointed a twenty four member SPG Steering Committee to create a comprehensive plan with specific short-and long-term actions that would lead to accessibility of affordable high quality health care coverage for all Montanans by the Year 2012. Also, a multidisciplinary Project Work Team including staff from DPHHS, the Department of Labor and Industry (DOLI), and from the State Auditor's Office (SAO) also known as the Insurance Commissioner's Office was chosen to assist the grant director and contractors to: **(1)** continue to refine and create a sustainable source of data on the insurance status of Montanans, including employer-based insurance; **(2)** analyze the impact of current policies and programs influencing access to health care coverage; and **(3)** develop and recommend possible policy options for consideration by the Steering Committee.

DPHHS contracted with the University of Montana's (U of M) Bureau of Business and Economic Research (BBER) to:

(1) conduct a follow-up employer survey, using the same sample of employers surveyed (refreshing the sample as needed) during the state's first state planning grant; and,
(2) analyze survey data and prepare/present a final report.

The results of the follow-up survey and analysis will be presented on September 12, 2006 at the next meeting of the SPG Steering Committee.

DPHHS also contracted with the University of Minnesota's State Health Access Data Assistance Center (SHADAC) to:

(1) review and advise on the University of Montana's follow-up survey, Montana's Behavioral Risk Factor Surveillance System (BRFSS) Questionnaire, and on a potential DOLI employer survey;
(The follow-up employer survey memo was delivered to the University of Montana in December, 2005. The SHADAC memo advising on a future potential DOLI Employer Survey was finalized and delivered August, 2006. The SHADAC memo on the BRFSS will be finalized by the end of September, 2006.)

(2) develop an evaluation plan for the 2005 legislative health coverage initiatives (developed from the 2004 SPG recommendations) that became law;
(The evaluation plan for the Montana's 2005 legislative initiatives is currently being developed by SHADAC.)

(3) develop an Issue Brief describing Montana's and other frontier states' health care initiatives and and programs; and (**Because of its size, the SHADAC Issue Brief became a full report and was supplemented by a smaller report (on five other states with recent significant changes impacting their uninsured populations). These two reports were delivered in July, 2006.)**

(4) generally provide technical assistance to the grant director, steering committee and project team, with a formal presentation of contract products as well.

Montana continues to have one of the higher rates of uninsurance in the nation. (Please reference pages 1 and 2 in the **Executive Summary of the Montana Strategic Plan to Provide More Affordable Health Care Coverage [available at: http:www.dphhs.mt.gov/uninsured/index.shtml]** submitted in August of 2004 and the **August, 2006 US Census Bureau Report on Income, Poverty, and Health Insurance Coverage in the United States, 2005**)

The Final Report (to be submitted in February, 2007) will include findings from the 2005 BRFSS. Questions about health care access were added to the core survey to update Montana's knowledge of the extent of its uninsured problem.

In summary, as a result of this grant, Montana policy makers will also have the guidance of:

- the SHADAC BRFSS memos and appendices which not only provide BRFSS questions from other state BRFSS instruments, they also provide specific recommended individual health care related questions, employer specific questions and questions to measure health care coverage of children;
- The SHADAC report on Health Insurance Access Programs and Policies in Montana and Other Frontier States plus a supplemental report on Additional State Initiatives to Improve Health Insurance Coverage; and
- A SHADAC memo on ways of Monitoring Trends in Employer-Sponsored Health Insurance Data in Montana.

The Final Report will also include the findings and analysis of the follow-up Employer Survey conducted by the U of M (BBER).

Upon completion of grant activities, these grant products will all be available on the DPHHS website stated above.

As of August 31, 2006, the Steering Committee has begun to develop new and/or amended recommendations/policy guidance (from the 2004 Strategic Plan document from the first SPG) within the following action arenas:

- Continuing to support the current infrastructure that provides data on the uninsured;
- Expanding coverage to target populations;
- Expanding pooling;
- Promoting cost avoidance through prevention;
- Expanding the safety net;
- Expanding eligibility in public health care programs; and
- Valuing and building health care workforce.

Section 1. Summary of Findings: Uninsured Individuals and Families

This section will be completed by Dr. Joanne Oreskovich (DPHHS) in the Final Report.

Section 2. Summary of Findings: Employer-Based Coverage.

This will be completed by Dr. Steve Seninger (University of Montana BBER)in the Final Report

Section 3. Summary of Findings: Health Care Marketplace

3.1 **How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?**

3.2 This issue was not addressed by the first grant or the current SPG continuation.

3.3 **What is the variation in benefits among non-group, small group, large group and self-insured plans?**

This issue was not addressed by the first grant or the current SPG continuation.

3.4 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

This issue was not addressed by the first grant or the current SPG continuation.

3.5 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

I have met with DPHHS Medicaid and CHIP staff, who will develop the statistics to be able to respond to this question in the Final Report. I also have scheduled a meeting with the Administrator of the State Benefits Plan to be able to respond to the part of this question concerning the impact of the state employee benefit plans with current figures, again in the Final Report.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

This issue was not addressed by the first grant nor has it been addressed by the current SPG continuation grant to date.

3.6 How would universal coverage affect the financial status of health plans and providers?

This issue was not addressed by the first grant nor has it been addressed by the current SPG continuation grant.

3.7 How did the planning process take safety net providers into account?

While the first SPG actually had a Safety Net Work Group to guide the recommendation development by the first Steering Committee, this Steering Committee includes a representative from the Primary Care Association which represents safety net providers. The extent of Montana's safety net was presented to the Steering Committee during the orientation of this continuation grant Steering Committee.

Among the action arenas for consideration of new recommendations (on the September 12 agenda for the Steering Committee) is the expansion of Community Health Centers (CHC), a significant part of the safety net. Policy guidance will be forthcoming and state legislation may be introduced to appropriate $2M in 2008 and $2M in 2009 to create two new non-federally-funded Community Health Centers. Further, another $450,000 is proposed to be appropriated for medical, mental health, and/or dental service expansions to existing Federally Qualified Community Health Centers with an additional $450,000 proposed appropriation to provide grants to existing Federally Qualified Community Health Centers.

3.8 How would utilization change with universal coverage?

This issue was not addressed by the first SPG grant or this continuation grant to date.

3.9 Did you consider the experience of other States with regard to:

Yes.

One of the SHADAC products under their current contract is a report of health insurance access programs and policies in other frontier states. They also issued a supplemental report of initiatives to improve health insurance coverage in five additional states. These reports were issued in July, 2006, prior to the beginning of the discussion by the SPG Steering Committee on either new or amended (from the first SPG) recommendations to be a resource to committee members in their discussions.

Further, numerous national articles were shared among the grant Project Team and Steering Committee members as they appeared in the national and local media.

Staff of Montana's SPG have engaged in email communication with SPG representatives from other states and have found the networking at the national SPG meetings to be beneficial. We look forward to the upcoming national SPG meeting in November.

Expansions of public coverage; Public/private partnerships; Incentives for employers to offer coverage; Regulation of the marketplace:

DPHHS contracted with SHADAC to prepare a report that identified and summarized public, employer-based and individual market health insurance coverage expansion initiatives that have been implemented in the four frontier states of Montana, Idaho, South Dakota and Utah.

Using the most current data available in those states, SHADAC reviewed programs and policies implemented by the four states to improve both access to and expand health insurance coverage within the states. The report reviewed three categories of initiatives the four states have implemented including Medicaid/SCHIP programs small employer initiatives and group/non-group insurance initiatives.

The final report summarized the program highlights that stand out in each of the four states.

This report did also address the Insure Montana Program, an effort underway to make health insurance more affordable for small businesses and their employees. Under this program, small businesses (2-9 employees) not currently offering insurance coverage to their workers, are eligible for subsidies that are available for both employers and employees as well as their dependents. Premium assistance is applied to the employee's share of the premium and premium incentives are applied to the employer's share.

Finally, this SHADAC report did summarily address regulation in the Idaho marketplace, while acknowledging the need for regulation review.

Section 4. Options for Expanding Coverage

The purpose of this section is to provide specific details about the policy options selected by Montana. The answers to this Section will focus on updated information (progress) on the recommendations from Montana's first State Planning Grant and include brief references to areas of interest for possible future recommendations (see end paragraph of bullet points in Executive Summary) resulting from the proceedings of the Steering Committee of this continuation grant.

4.1-4.13 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

Montana's first state planning grant process yielded policy recommendations summarized on pages 21-35 of the **Final Report to the Secretary Spring, 2004** and on pages 5-24 of the **Montana Strategic Plan to Provide More Affordable Health Care Coverage, August, 2004**. The status of those recommendations from the first SPG, which have all (except for the HIFA Waiver and the discount drug program) been only first implemented in 2006, is summarized below. The status report includes the pages on which the first state planning grant recommendations appear in the 2004 Strategic Plan and also, the names and phone numbers of individuals to contact with specific questions about the referenced program. The HIFA Waiver application, submitted in July, 2006 is available at http://www.dphhs.mt.gov.

FIRST STATE PLANNING GRANT RECOMMENDATION UPDATES

RECOMMENDATION I No significant Fiscal Impact to the State of Montana	
Coverage Options	**Updates**
A. Explore benefits of purchasing pools **Pps. 5 and 8 of Strategic Plan** **Erin McGowan (SAO) 444-4613** **(Insurance Commissioner's Office)**	• **HB 104 Revise laws for Insurance Purchasing Pools (2003 signed into law)** lowered number of eligible individuals necessary to form purchasing pool from 1000 to 51. • Chamber Choices and Montana Nonprofit Association formed as a result of this law, growing in membership; also, growing their membership pools is: Montana Logging Association, Montana Retailers Association and State Bar of Montana Association. • **Insure Montana Program (as a result of Health Care Affordability Act aka, HB 667 signed into law 2005)** allows tax credits, premium payments, and purchasing pools to help small business owners). > 1369 additional Montanans have insurance coverage through the purchasing pool as of July 1. Nearly 3000 more Montanans will be insured once fully operational, and with the passage of the HIFA Waiver, up to 1200 additional Montanans could be served. The tax credit side of the program is benefiting 611 businesses and 3219 total Montanans.
B. University system develops consistent internal policies and procedures requiring proof of existing insurance coverage or the purchase of health insurance from University system. **Pps. 5 and 9 of Strategic Plan** **Paul Bogumill 406-444-0329** **Commissioner of Higher Education**	• Large campuses do have consistent internal policies; community colleges differ depending on funding. • Robin Hood Plan for employees meeting financial eligibility; e.g. difference between premium coverage for single versus parent with children is waived.

C. Education of public about benefits of health insurance coverage by promoting health literacy (including how to buy the best health insurance product to meet individual or family needs) and value of maintaining good health.
 	
Pps. 5 and 10 of Strategic Plan
 	
Jane Smilie 406-444-4141
(DPHHS)
	• Some Public Health public education efforts:
	  • Diabetes education
	  • Smoking cessation campaigns
	  • Pregnancy prevention efforts
	  • Worklife Wellness
	  • Collaboration with 32 Public Health Advisory Councils
	  • Partnerships with organizations interacting with uninsured, working poor and underinsured, including Hospital Association, Safety Net providers, Senior Citizen Association, other state agencies, community health fairs, health screenings.
	  • Other efforts ongoing in other organizations
	  • Counties and tribes are major partners
	General education on benefits and importance of insurance and what product to buy to fit needs.

RECOMMENDATION II Requires New State Legislation and/or New State Dollars	
Cover Options	**Updates**
A. Recognize and support Safety Net as a vital component of the health care delivery system **Pps. 5 and 11 of 2004 Strategic Plan** **Mary Beth Frideres 406-442-2750** **Primary Care Association**	• 11 Community Health Centers; 1 Migrant and Seasonal Farm Worker Program; 1 Healthcare for the Homeless Program (1 in 14 people) • 41 certified Rural health Clinics • 50 Nat'l Health Service Corps Providers • 3 J-1 Visa physicians • 4 urban Indian clinics • 15 Family Planning Clinics • 2 volunteer Physician clinics • Some federal funds being cut • Safety Net extremely fragile because of increasing demands
B. Sustain and expand health insurance in private markets **Pps. 5 and 13 of 2004 Strategic Plan** **Erin McGowan (SAO) 406-444-4613** **Tanya Ask 406-444-8297** **Blue Cross/Blue Shield of Montana**	**Insure Montana (HB 667) see above in Recommendation IA.** Minimum qualification: • Businesses with between 2-9 employees, where no employee makes > $75,000 (excluding owner); Refundable tax credits available to small businesses in danger of dropping current health insurance plans because of rising premiums. **Blue Care** (from Blue Cross/Blue Shield with more than 300 Montanans covered)

RECOMMENDATION III Requires Legislation and/or a State Funding Mechanism	
Coverage Options	**Updated**
A. Enroll children currently eligible for Medicaid and CHIP **Pps. 5/6 and 16 of 2004 Strategic Plan** **Linda Snedigar (DPHHS/Medicaid Eligibility) 406-444-6676** **Jackie Forba (DPHHS/CHIP) 406-444-5288**	• **HB 552 Change Asset Test for Medicaid Children (2005 signed into law)** raises resource limit from $3000 to $15,000 for the two largest children's Medicaid programs, covering children (0-6 at 133%FPL and 6-18 at 100%FPL). • New CHIP applications and renewal applications with children determined by CHIP staff to be potentially eligible for Medicaid will continue to be referred to the Offices of Public Assistance. • The change in the Medicaid resource limit may result in 3000 more CHIP slots in SFY 2007. • June, 2006 saw an increase of 2,256 children in CHIP from the June, 2005 figure of 10,995 children. June, 2006 enrollment was 13,165 children.

B. Expand CHIP 1. Graduated increments up to 200% FPL 2. Increase cost sharing for children between 151%-200% FPL **Pps. 6 and 17 of 2004 Strategic Plan** **Jackie Forba 406-444-5288**	• Attempt (**unsuccessful**) to increase financial eligibility (SB 156) during 2005 Legislature; financial eligibility still at 150% FPL. Also, increased cost sharing for between 151%-200%FPL **did not occur** because FPL remained at 150%.

C. Maintain/Increase MCHA high-risk pool availability of coverage through: 1. Ensuring enrollment for those currently eligible a. maintain or increase low-income eligible b. explore increasing FPL from 150% to 200% c. continue participation in TAA **Pps. 6 and 19 of 2004 Strategic Plan** **MEDICAID WAIVER** **Duane Preshinger (DPHHS) 406-444-4145** **MCHA** **Tanya Ask (Blue Cross/Blue Shield) 406-444-8297** **TAA** **Deb Buxbaum (DOLI) 406-444-3351**	**Under new HIFA Waiver application**, Medicaid will fund a portion of the existing state-funded MCHA Premium Assistance Program for people whose incomes are equal to or less than 150%. 260 MCHA clients are estimated to benefit from this. **State still participates in Trade Adjustment Assistance Act Program (TAA);** victims of layoffs draw unemployment and after registering with IRS, are eligible for health care tax credit (40/60) for health care. Approximately 80 more high-risk Montanans will have premium assistance if Montana receives part of the national TAA appropriation.
D. Explore prescription benefits for adults 62-64 **Pps. 6 and 21 of Strategic Plan** **Jo Thompson (DPHHS) 406-444-9197**	**SB 324 Prescription Drug Assistance and Discount Drug Program (2005 signed into law)** **Rx Discount Program-in development-**prescription discount program for all Montanans up to 250% FPL who lack or who have exceeded their drug benefit coverage. **Late 2006/early 2007 implementation.** **Big Sky Rx-**payment of monthly Medicare prescription drug premiums up to $33.11 (3135 enrolled to date). **MT PharmAssist** Program-**in development-**provision of free consultation. **Late 2006/early 2007 implementation.** **Prescription Drug Education-in development-**creation of educational resources, including a website to inform consumers and practitioners on clinically effective and cost-conscious drugs. **Late 2006/early 2007 implementation.**

RECOMMENDATION IV Public Health Redesign Recommendations	
Coverage Options	**Updates**
A. Address current eligibles under existing programs but not enrolled in Medicaid or CHIP. B. Expand CHIP to cover children @ 200 FPL-**Not done** C. Maintain health care access for low income Montanans by addressing Medicaid reimbursement and streamlining where possible. **Pps. 6 and 21 of 2004 Strategic Plan** **Jackie Forba 406-444-5288** **Linda Snedigar 406-444-6676**	**Barriers to CHIP removed:** • July, 2005 survey of families not re-applying for CHIP. • Discontinued 16 page universal application; implemented 4 page CHIP application. • Development of web-based interactive application to apply on-line (must still sign and mail application to CHIP). • Implementation of electronic report to CHIP of children denied or losing Medicaid so CHIP follow-up can occur. • Decreased time of uninsurance prior to CHIP enrollment from 3 months to 1 month. **CHIP outreach efforts:** • Ongoing statewide media campaign in 2006. • Update and training (including brochure insert and poster for Tribal health and Indian Health Services (IHS) staff on 7 reservations, spring and summer of 2006. • Update and training for community partners (CHIP Champions) in Billings and Missoula in spring, 2006. Partnerships with approximately 300 health care associations, health care providers, schools, and community organizations to increase enrollment through distribution of CHIP materials. • Direct mail campaign to potential CHIP families. **Medicaid outreach and streamlining:** • Developed a Medicaid-only application. • Conducted targeted reviews to insure Native American income and resources appropriately considered in determining eligibility. • Continue presumptive eligibility and federal benefits training to raise awareness and facilitate Medicaid applications. Participated in Grandparents Raising Grandchildren conferences to promote awareness of Medicaid programs for children.

D. Waiver considerations 1. insure parents/guardians (especially at or below 100% FPL) of publicly insured children a. Provide a premium assistance program or basic medical plan. b. Explore a modified, self-directed concept, e.g., a debit card. 2. Expand Medicaid to cover parents/guardians between 101%FPL and 150%FPL a. Provide a premium assistance program or basic medical plan. b. Explore a modified, self-directed concept, e.g., a debit card.	**HIFA Waiver application (submitted July, 2006)** to cover up to 600 working parents < or = to 200% FPL, no longer eligible for Medicaid, but whose children continue to be enrolled in Medicaid can choose: • Assistance (up to $166/month) with cost of monthly premium of employer based insurance; • Payment of monthly premium (up to $166/month) for private individual insurance policies; or • Medicaid individual health care benefits averaging up to $2000 per person per year. In addition, the Waiver proposal identified another 1200 potential eligibles under the provisions of **Insure Montana**.
3. Explore options to provide coverage to Mental Health Service Plan recipients and/or low income working adults. a. Provide a premium assistance program or basic medical plan. b. Explore a modified, self-directed concept, e.g., a debit card. **Pps. 7 and 23 of 2004 Strategic Plan** **Duane Preshinger 406-444-2584**	**Persons with severe disabling mental illness** who are = to or < than 150% FPL and who have no health insurance, will receive mental health services and a drug benefit as well as a choice of one of three options: a. Assistance (up to $166/month) with cost of monthly premium of employer based insurance; b.Payment of the monthly premium for private individual insurance policies (up to $166/month); c.Medicaid individual health care benefits averaging up to $2000 per person per year.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

SHADAC is developing an evaluation plan (due the end of September, 2006) for all the 2005 program initiatives that have been implemented or are in the development stages for implementation. They are developing this in conjunction with state staff most involved in the implementation of the initiatives. We will provide an answer to this question in the Final Report.

4.15 How (and how often) will the program be evaluated?

See answer to 4.14 above.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

Am in the process of scheduling meetings with staff (most involved in shepherding coverage options through the most recent legislative session in 2005) to retrospectively determine the major political and policy considerations that worked in favor or against the option. The Final Report will contain a response to this question.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed, and administrative actions such as waivers), and the remaining challenges.

See above chart includes the passage of legislation during Montana's most recent legislative session (or earlier sessions) in 2005 that was required to move forward the initiatives from the first SPG.

The following four tables are of program features of those 2005 legislative initiatives and are excerpted (with updates) from the **July 2006 Final Report entitled Health Insurance Access programs and Policies in Montana and Other Frontier States by the State Health Access Data Assistance Center (SHADAC)** prepared for DPHHS during this continuation grant. In table 4 below current eligibility figures on MCHA were obtained from Montana Blue Cross/Blue Shield.

There have been challenges in implementing the various initiatives (none of which began before January 1, 2006). See in above tables that some of these initiatives are still in development (Discount Drug Program, Pharmacy Assist Program, Prescription Drug Education Program) and the Waiver awaits approval.

a. For example, the **Waiver application submission** was delayed because the instate approval process was delayed while DPHHS tried to assure that all parties who needed to, were educated about the Waiver concepts and what their implementation would mean. Much time was allowed for input and response.
b. **Raising the asset level for Medicaid children** (**HB 552**) faced challenges of necessary systems changes to track this change; time needed for policy changes; staff training and then the transition from CHIP to Medicaid faced by newly eligible families.
c. The **Insure Montana Program (HB 667)** faced very short timelines for program implementation; longer than anticipated time needed by businesses to complete and return coverage applications for the Purchasing Pool; the complication of the creation of the new information sharing (with the Departments of Administration and Revenue) database; and maintaining low rates and good coverage in a volatile health insurance market.
d. Providing information to and encouraging families who believe their children aren't eligible for **CHIP,** to apply for CHIP continues to be a major challenge for CHIP. A further program challenge for CHIP is providing information to Native American families who may not realize their children can receive health care services at HIS and tribal health facilities while still being covered by CHIP. Montana is closely monitoring federal CHIP proposed reauthorization levels in FFY 2007, wanting to assure the provision of an annual allocation which will allow this state to continue to cover, at a minimum, the currently enrolled children.
e. The reluctance of some major drug manufacturers to join the state in a partnership for drug rebates (because they already provide other forms of drug assistance and are hesitant to duplicate efforts) is a challenge facing the **Drug Discount Program (SB 324). The Big Sky Rx Program (a part of SB 324)** is having a difficult time reaching Montanans enrolled in a Medicare Part D Program. There is speculation that because Part D has been complicated and this population has rarely been eligible for past State or Federal assistance (because they've been over on assets and/or income), they don't think they're eligible for Big Sky Rx and don't apply.

Table 1: SCHIP Program in Montana

Program/Initiative	Eligibility	Enrollment	Benefits
Separate CHIP Program Initiated in 1998 ("MT's Children Health Insurance Plan") State Plan amended in 1999, 2002; new amendment submitted in 2005 Expanded funding and enrollment in 2005 (increased state funding through a tobacco tax)	Family income limit initially set and has remained at ≤150% FPL for children < 19 years One-month period of uninsurance required (some exceptions apply)	No enrollment cap effective July 2005 13,165 children enrolled as of 06/2006	Benefits: Benchmarked on state employee health plan; includes • Inpatient/outpatient hospital • ER • Physician • Surgical • Lab and x-ray • Well-child/well-baby visits and immunizations • Prescription drugs • Mental health and substance abuse treatment • Hearing and vision exams • Dental ($350 maximum payment per benefit year) Cost Sharing: • No co-pays for families with incomes ≤100% FPL • Co-pays ($3-$25) for >100% FPL; annual family co-pay max is $215 per benefit year • No annual enrollment fee • No co-pays for well-baby/child care, immunizations and dental services Continuous Eligibility: Eligibility is determined every 12 months. An enrollee remains eligible unless child moves from state, moves in state and CHIP is unable to locate family, is eligible for Medicaid, is eligible for state employee benefit plan, found to have other creditable health insurance, turns 19 in age, or becomes an inmate of public institution.

Table 2: Medicaid/SCHIP Waivers in Montana

Program/Initiative	Eligibility	Enrollment	Benefits
HIFA Demonstration Waiver Medicaid Redesign State legislation enabling waiver in 2005 Waiver application and CMS approval pending	Uninsured Mental Health Services Plan (MHSP) participants ≤150% FPL Uninsured children ≤150% FPL Seriously emotionally disturbed (SED) youth ages 18-20, ≤150% FPL Working parents ≤200% FPL with Medicaid-eligible children	Estimated: • 1,500 MHSP clients • 1,500 children • 300 former SED youth • 600 working parents	Benefits: For MHSP and working parents (up to $2,000 in total value): • Premium assistance for employer-sponsored or private market insurance or Medicaid individual health care benefits For uninsured children and SED youth: • SCHIP-equivalent package Cost Sharing: • For MHSP: Yes, refer to **Montana's Waiver application** at**: http://www.dphhs.mt.gov** • For SED youth: same as SCHIP program • For uninsured working adults: Yes, refer to **Montana's Waiver application** at: **http://www.dphhs.mt.gov** ▪ Co-pay the responsibility of recipient depending on chosen insurance health plan. If beneficiary chooses a Medicaid Health Care benefit, the following State Plan co-pays apply: • $1-$5 co-pays • $100 coinsurance on hospital stays • $25 monthly prescription max • No enrollment fee • No cost sharing for tribal members receiving services at Indian Health Service
Section 1115 Waiver Montana Basic Medicaid for Able-Bodied Adults Initiated in 2004 Amended in 2004	Parents and caretakers of dependent children who are aged 21-64 years and neither pregnant nor disabled	17,137 eligible as of 1/2004	Benefits: Limited Medicaid benefits similar to typical employer insurance coverage. Stricter limits or exclusions pertain to: dental, vision, hearing, personal services and durable medical equipment. Cost Sharing: equivalent to State Plan amounts. • $1-$5 co-pays • $100 coinsurance on hospital stays • $25 monthly prescription max • No enrollment fee • No cost sharing for tribal members receiving services at Indian Health Service

Table 3: Small Employer Initiatives in Montana

Program/Initiative	Eligibility	Enrollment	Benefits
Small Business Health Care Affordability Act Initiated in 2006	Small businesses (2-9 full-time employees) that currently do not offer insurance Employees of small businesses (2-9 full-time employees) that currently do not offer insurance Small businesses (2-9 full-time employees) that currently offer insurance	6,200 employees estimated to be eligible First-come, first-served basis All slots currently filled	Benefits: For businesses not offering insurance: • The Small Business Health Insurance Pool is created • Monthly premium incentive (applied to employer) and monthly premium assistance (applied to employee): incentive will average $75 per employee per month; assistance will be 20%-90% of premium For businesses offering insurance: • Refundable tax credits in the amount of $100 per employee per month

Note: HIFA Waiver includes the utilization of federal match dollars for those who would be Medicaid eligible up to 200% in an effort to cover more people targeted to workers with children.

Table 4: Group and Non-Group Insurance Initiatives

Program/Initiative	Eligibility	Enrollment	Benefits
Montana Comprehensive Health Association (MCHA) "High risk pool equivalent" Known as traditional plan 1987	Residents rejected for disability/ health insurance by at least two insurers in the last six months or have premiums >150% higher than the average rate for MCHA	1,630 enrollees as of 6/05 1419 enrollees as of 6/06	Benefits: • In-patient/out-patient hospital • X-ray • Prescription drug coverage • Preventive care • Disease management added in 1999 No vision care or dental benefits. Coverage not included for pre-existing conditions during first 12 months of enrollment. Lifetime max of $1,000,000. Cost Sharing: • Premium capped at 200% of standard risk rate • $1,000 annual deductible • 80/20 coinsurance • $5,000 annual maximum deductible/co-pay expense
MCHA Premium Assistance	MCHA-qualified	197 enrollees as of 6/05	Benefits:

Pilot Project Initiated in 2002 **N.B.** In its **Waiver application**, Montana proposes to utilize benefits of HIFA Waiver to assist in stabilizing of **MCHA**.	individuals with family incomes ≤150% FPL	226 enrollees as of 6/06	Similar to MCHA plan benefits and services <u>Cost Sharing:</u> Similar to MCHA plan; in addition, a premium subsidy of 45%
MCHA Individual Limited-Benefits Plan Known as Portability Plan Initiated in 1997 as a result of HIPAA	Individuals who have been uninsured for > 90 days	1713 enrollees as of 6/05 1578 enrollees as of 6/06	<u>Benefits:</u> • Unlimited office-based care • Lab and X-ray services • Generic prescription medicines • Some mental health • Outpatient therapies • Coverage for newborns (limited) • ER (limited) • Severe mental illness (limited) Inpatient services not covered. Carriers required to disclose limited/uncovered services. No restrictions for pre-existing conditions. <u>Cost Sharing:</u> Co-pays and deductibles based on household income; no deductible for pre-existing conditions.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

The only initiative not followed up was raising the CHIP FPL from 150% to 200%. Available state dollars was the challenge in trying to increase the CHIP FPL.

4.19 How will your State address the eligible but not enrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

See right hand column entitled "Barriers to CHIP removed" and "CHIP outreach efforts" under **Recommendation IV, Public Health Redesign Recommendations** on page 11 of this interim report.

For the Medicaid Program, see right hand column under **Recommendation IV, Public Health Redesign Recommendations** for **Medicaid Outreach and Streamlining** also on page 11 of this report.

Section 5. Consensus Building Strategy

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

During the composition of this grant application to HRSA, key State agencies were identified (the Departments of Public Health and Human Services, Labor and the State Auditor's Office) and involved by the team of individuals who drafted the grant application.

Subsequent to the awarding of this continuation grant, the Director of Montana's Department of Public Health and Human Services appointed a twenty four member SPG Steering Committee to create a comprehensive plan with specific short-and long-term actions that would lead to accessibility of affordable high quality health care coverage for all Montanans by the Year 2012. Committee members included public and private sector leaders representing business and industry, the Governor's Office, the legislature, the private non-profit sector, the health care delivery industry, the health insurance sector, minority populations, state agencies, and health care consumers.

Also, a multidisciplinary Project Work Team including staff from the Departments of Public Health and Human Services, Labor and Industry and from the State Auditor's Office (the Insurance Commissioner) was chosen to assist the grant director and contractors to: **(1)** continue to refine and create a sustainable source of data on the insurance status of Montanans, including employer-based insurance; **(2)** analyze the impact of current policies and programs influencing access to health care coverage; and **(3)** develop and recommend possible policy options for consideration by the Steering Committee.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Public input was and will continue to be solicited at each Steering Committee Meeting. The schedule of these meetings is always posted on Montana's DPHHS electronic calendar. Committee members who are familiar with or members of groups interested in the work of this grant, are encouraged to forward all electronic communication (including documents/products of the grant) regarding this grant to those groups not currently on the list of "interested others" who regularly receive all information either emailed or snail mailed to the Steering Committee members.

All products of this grant were offered to the Steering Committee and Project Team members as drafts for input from them and the constituency they presented. The University of Montana's Bureau of Business and Economic Research conducted a follow-up survey of the same employers (with an additional sample of new employers to refresh the sample) surveyed three years earlier to update information on health insurance from the employers' perspective. Questions were added to the state's 2005 BRFSS to update information regarding health care access from the individual Montanan's point of view.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

All formal communication efforts with the local (state and city/county) media continue to be coordinated by the DPHHS Public Information Officer through the Governor's Office.

DPHHS developed and continues to update the web page devoted to the state planning grant efforts.

Some Steering Committee representatives were involved (in their local communities) in Robert Wood Johnson Covering the Uninsured Week in May, 2006. The DPHHS Director submitted a Letter to the Editor regarding the progress by Montana in trying to cover more of the state's uninsured with health care. Similar letters were also prepared for select association newsletters when solicited.

The Grant Director was interviewed as part of a public television presentation on the problems of the uninsured in Montana.

The Grant Director met with members of the public and private sector (including an insurance brokerage specializing in advising private non-profit sector on best products for their members, the Director of the state's Health Care Benefits Division that oversees the state health insurance plan, and the Benefits Coordinator for the state's university health insurance plans, and who are not represented on the grant Steering Committee)directly involved in increasing the number of Montanans who become insured to inform them of the work of the grant to date and request their assistance in the proceedings of the Steering Committee when necessary.

National and local news articles were electronically shared among Steering Committee members and staff as a means of helping local communities and the Steering Committee members become more informed participants in the solution to the problem of the uninsured.

Steering Committee members have agreed to electronically share notes and products of their proceedings with both the organizations they individually represent and with other like organizations not represented on the Steering Committee.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

Please refer to the answer to this question on pages 37 and 38 of the Final Report to the Secretary, Spring, 2004. While much of that answer is still applicable, much more policy progress has been made since the publication of that report two years ago.

Montana's 2005 Legislature did in fact take most of the recommendations from the first SPG and incorporate them into legislation that did become law with the aid of an increased tobacco tax, a pending Waiver application that will use formerly unmatched state dollars to match federal Medicaid dollars, pharmaceutical manufacturer rebates, and other revenue initiatives.

The current policy and political environments appear to be very amenable to further ways to cover more Montanan's with health insurance. The Steering Committee has been informed of attempts that will be made during the 2007 Legislature to introduce bills with the primary intention of covering more Montanans with health care. There is a demonstrated overall political consensus of trying to cover more Montanans with health care.

Section 6. Lessons Learned and Recommendations to States

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating design?

Please refer to the answer to this question on page 39 of the Final Report to the Secretary, Spring, 2004. It is still applicable. Overall the qualitative and quantitative data collection activities from the first grant: (1) described the characteristics of the Montana's uninsured, contributing to a deeper understanding of how health insurance coverage varies among different population groups in Montana; (2) identified existing barriers preventing the uninsured from getting coverage; and (3) demonstrated how uninsured citizens' access to the health system is affected.

Adding to what Montana learned from the data collected during the first SPG (a baseline for Montana health care data) are the results from the 2005 BRFSS (with added questions on health care access…see the answers to Section 1 questions in this report) and the pending results of the follow-up Employer Survey again being conducted by the University of Montana which will be addressed when the questions in Section 2 are answered in the Final Report.

The first set of tables in Section 4 of this Interim Report, is reflective of an earlier similar document used by the SPG current Steering Committee to discuss potential new policy guidance/recommendations for consideration by Montana's decision makers that will get the state to new solutions for the health care coverage problems of its citizens.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Please refer to the answer to this question on page 39 of the Final Report to the Secretary, Spring, 2004. It is still applicable. Also, please refer to answer in question 6.1 of this report.

However, one of the main purposes of this continuation grant is to institutionalize the data gathering activities to continue to guide future health care coverage policy in Montana. To that end, the SHADAC products (the memos to DPHHS relative to how to best expand the existing BRFSS to continue to monitor health care coverage challenges and suggestions regarding the future use of an employer survey) and the University of Montana follow-up Employer Survey will be particularly useful to state policy makers.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

Data collection activities are being completed as originally proposed.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

As described on p. 39 of the original report, using a state based experienced vendor (the University of Montana's Bureau of Business and Economic Research [for the follow-up employer survey] as well as a known out-of-state based experienced vendor, OCRI [for the Behavioral Health Risk Factor Surveillance Survey] and the experienced state public health staff (who provide analysis for the BRFSS) only enhances the successful response rates for both of these surveys.

Again (during this continuation grant) relying on the resources of SHADAC to provide guidance and specific recommendations to those who will decide which questions will best provide the data necessary to continually evolve a solution has been and will continue to be extremely helpful.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the state have plans to conduct research?

Continuing health care access data collection either through the BRFSS and Montana's Department of Labor, potential Employee Benefits' Survey on a regular basis (or some other potential household or employer surveys) will be a necessity if Montana continues to evolve its health care access policy. We will be better able to answer this question upon concluding the proceedings (regarding recommendations to be made) of the Steering Committee, in late November, 2006.

The potential for a more global or universal health care coverage approach in Montana may still have to be addressed.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

Initially the very important lesson of being open to suggestions especially for organizational change that surface is a lesson learned. During this initial 12 months of this grant, the state has already chosen a "home" within DPHHS for the continuation of the state planning grant-like activities. Coordination among the three state departments responsible for the submission of this grant application has continued to improve.

Please refer to (the answer to this question on page 40 of the 2004 Final Report, which still holds some importance as Montana continues to design ways to better serve its residents with health care). We will be better able to answer this question upon concluding the proceedings (regarding the recommendations to be made) of the Steering Committee, in late November, 2006.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Once again, the key lesson is involving the private sector (including insurance providers and the business community) in the effort to develop health policy that includes more Montana residents among the insured. They are involved not only through the State Planning Grant governing mechanism, but also as members of other state advisory groups connected to the State Auditor's Office and the Departments of Public Health and Human Services and the Department of Labor, the three state entities committed to collaborating effective health policy development.

Also, private insurance companies (through the development of new health plans) have tried to be responsive to this potential market of the uninsured. See status report chart of recommendations in Section 4.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

The two key recommendations (also noted on page 40 of the 2004 Final Report) are:

1. Involve the private and public sector in health policy development;
2. Because this is an issue that affects all Montanans, the process of obtaining input from many entities can be very time consuming, but is very necessary; and
3. Continue to solicit input from the public as health policy is drafted.

6.9 How did your State's political and economic environment change during the course of your grant?

As a result of the first State Planning Grant and this continuation grant legislators have been included in the discussion of the status of health care in Montana, thus raising their awareness and their investment in the health and well being of Montanans. The SPG data has brought credibility to the data the department uses to respond to fiscal notes and further analysis for state legislation. We believe that the SPG process

and information are what helped move health care coverage bills through the last session of Montana's Legislature in 2005 and will continue to do so. Those are included in the first set of tables in Section 4 of this interim report.

The final report will reflect more policy direction/recommendations to provide more health care access to more Montanans.

6.10 How did your project goals change during the grant period?

The project goals have not changed during this grant period.

6.11 What will be the next steps of this effort once the grant comes to a close?

The grant will end February, 2007. At that time Montana's 2007 Legislature will be in session and we are anticipating legislative initiatives furthering the goals of this continuation grant will be in place.

Administratively the next steps will be:

- Collecting the grant documents and housing them in one central location for future reference;
- Assuring placement of grant documents on DPHHS website;
- Printing and distribution of 2007 Final Report for distribution and placement on DPHHS website;
- Officially designating the DPHHS Office of Planning, Coordination and Analysis as the "home" of health policy development;
- Formalizing of agreement among three state agencies (DPHHS, DOLI, and State Auditor's Office);
- Continued regular administration of BRFSS and the DOLI Employee Benefits' Survey;
- Convening of Steering Committee as advisory body to three agencies (listed above) in development of health policy;
- Continuing collection of household and employer data relating to health care and coverage needs;
- Continuing evaluation of 2005 legislative initiated programs to provide health care coverage to more Montanans; and
- Continued development of executive and legislative initiatives to provide adequate health care coverage to more Montanans long term.

Section 7. Recommendations to the Federal Government

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

See Tables explaining SCHIP and Waiver features in Section 4. We do know that a federal waiver would be required if the legislature and Governor approved DPHHS to cover parents of children enrolled in CHIP. However, this question will be more fully addressed in the Final Report after recommendations have been developed.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

Section 8. Overall Assessments of SPG Program Activity

8.1 What is the likely impact of program activities in the near future? What were the major impediments and facilitators for improved outcomes? Include specifics about changes in budgetary environment, changes in political leadership, etc.

8.2 What is the state's current view of most feasible expansion options? What direction was deemed most feasible and why?

8.3 What do you foresee to be the sustainability of programs implemented as a result of the SPG program, or the likelihood that programs currently under consideration will be implemented?

8.4 Did your SPG program activity create an impetus to change your state's Medicaid program via a waiver, changes in eligibility or cost-sharing?

Yes, please refer to the tables in Section 4 of this report.

8.5 Please describe the realities of state decision-making regarding insurance expansion in terms of things that facilitate and inhibit policy changes.

8.6 Concretely, what was the value of funding the data collection analysis? How were the results used to shape political thinking and build consensus on ways to cover the uninsured? What is the value of data being re-collected and at what frequency?

8.7 In terms of the data collection activities pursued through the SPG grant, are there certain ones you would do differently based on experience?

8.8 How have stakeholder groups evolved over time? In hindsight, what are the central components to putting and keeping together a successful steering committee?

8.9 What activities will be discontinued as a result of the SPG grant coming to a close?

This has not yet been determined. One of the best products of this continuation grant is the close collaboration among the three state agencies directly involved with the issues surrounding the expansion of health care coverage to all Montanans and their collaboration with the private sector.

8.10 Highlight specific lessons about potential policy options that could be used by HHS and states to shape future activities.

8.11 Please comment on how helpful the site visit, availability to talk/email with AcademyHealth staff and general technical assistance of AcademyHealth was to your project.

8.12 Please comment on how helpful the HRSA SPG grantee meetings were to your project?

8.13 Please comment on how helpful the technical assistance from SHADAC was to your project?

8.14 Please comment on how helpful the Arkansas Multi-State Integrated Database System was to your project, (if applicable).

8.15 Please comment on how useful the Agency for Healthcare Research and Quality's technical assistance and survey work (e.g. MEPS-IC) was to your project.

8.16 Please comment on the long-term effect (if any) of your state's SPG program on future efforts to improve coverage via:

a. Data collection – e.g. surveys, focus groups, etc.
b. Data analysis – e.g. modeling, actuarial analysis
c. Political understanding/education
d. Approaches and structure for collaboration.

Appendix III: SPG Summary of Policy Options

Updates of the policy options generated from Montana's first SPG are provided in first set of Section 4 tables on pages 8-12 of this report. We have only begun the discussion of policy options that will result from this continuation grant. Those will be included in Appendix III of the Final Report due in February, 2007.