IDAHO

STATE PLANNING GRANT

Strategic Report

Submitted to Governor Kempthorne by the Steering Committee of the Idaho State Planning Grant

February 2002

Introduction

The Idaho State Planning Grant, administered by the Idaho Department of Commerce, is one of twenty state planning grants funded in the past two years by the Health Resources and Services Administration, U.S. Department of Health and Human Services. The charge of the Grant is to identify and describe Idaho's uninsured, to evaluate a wide array of policy options, and to develop a comprehensive plan for providing access to insurance for all Idahoans.

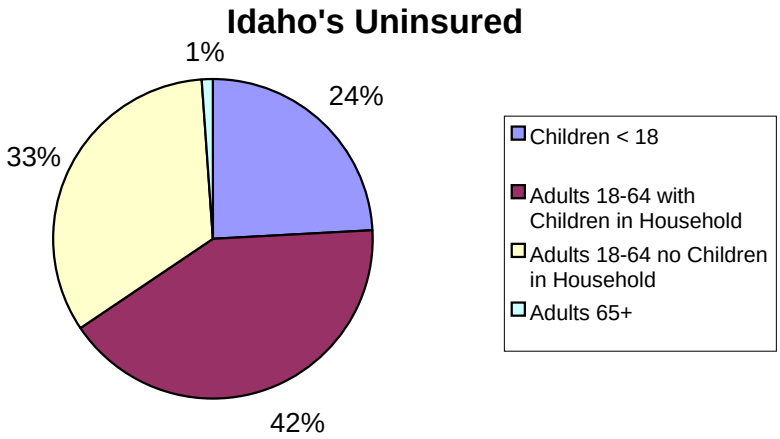
The Grant's Steering Committee—which has broad representation from the legislature, state universities, state agencies, medical institutions, private businesses, and community organizations—is responsible for overall project management and provides guidance to Grant staff and work groups. The Steering Committee is issuing this strategic plan for expanding coverage to the uninsured to Governor Kempthorne.

Four work groups complete the Grant's governance structure: the Data, Policy, Model Development, and Strategic Planning teams, each of which also has broad representation from the key stakeholders listed above. These teams have devoted many hours to studying the issue of the uninsured, developing policy options, and evaluating those options. When all work groups are combined, more than 60 Idahoans have been involved in the development of this report (a complete list of participants is provided in Appendix C).

Grant staff has traveled throughout Idaho in the past six months talking to key constituencies about the impact of Idaho's uninsured on the state's economy and the quality of life of its citizens. Staff has met with chambers of commerce, key legislative committees, the Governor's health insurance advisors, industry groups, charitable organizations, county and city elected officials, county and city associations, and various interest and advocacy groups.

Idaho's Uninsured

Data collected and analyzed with Grant funding indicate that 18% of Idahoans are uninsured (approximately 234,000 from a state population of 1.3 million). Approximately 24% of the uninsured are children under age 18, 41% are adults between ages 18 and 64 with dependent



Source: 2000 Idaho BRFSS, Official 2000 Census, and Claritas population estimates

children, 34% are adults between ages 18 and 64 with no dependents, and 1% are adults age 65 or older. Among adults between age 18 and 64 who are uninsured (who constitute 75% of the uninsured), over 70% are working and nearly 80% are members of working families.

Uninsured Idahoans (Ages 18-64) by Employment Status

Employment Status	Percent Who Are Uninsured*	Number Uninsured**	Percent Of All Uninsured*
Employed for wages	16.3%	77,030	51.3%
Self-employed	34.8%	30,180	20.1%
Unemployed	51.1%	15,920	10.6%
Homemaker	18.5%	10,960	7.3%
Student	20.1%	6,160	4.1%
Retired	13.8%	3,900	2.6%
Unable to work	21.6%	6,010	4.0%

* Results from 2000 Idaho BRFSS.

** Estimates based upon Claritas population estimates. Official 2000 Census population figures are approximately 3.8% higher; current 2001 estimates are not yet available.

These numbers are not static. Based on recent population growth rates in Idaho, there are approximately 635 new Idahoans without health insurance each month. In addition, the recent economic downturn has likely created a substantial number of newly uninsured.

The Idaho State Planning Grant has published a 22-page summary of the data on Idaho's uninsured: *Idahoans Without Health Insurance, A Data Report.* This report is also accessible through a Web site, at **www.idahouninsured.org**.

Policy Evaluation Process

The Strategic Planning Team had the specific charge of determining which of the more than twenty policy options developed by the Model Development and Data and Policy work groups are most appropriate for Idaho. The Strategic Planning Team submitted its recommendations to the Steering Committee in a report presented on January 14, 2002. The Steering Committee adopted all of the Strategic Planning Committee's recommendations for covering Idaho's uninsured.

The range of policy options considered included such approaches as changing or expanding Medicaid or CHIP, medical savings accounts and defined contributions by employers, a public-private partnership that would make it more feasible for businesses to provide insurance to low-wage employees, private market reform, and universal coverage, among others. A list of these options is provided in Appendix A.

Before evaluating the policies, the Strategic Planning Team developed a list of criteria it could use to objectively judge how appropriate each approach would be for Idaho, based on team members' perceptions of the state's values and vision. These criteria follow:

- ü The policy can significantly reduce the percentage of Idahoans who are uninsured,
- ü Is politically feasible,
- ü Is affordable to the state,
- ü Is cost effective, with minimal bureaucracy in mandating benefits and regulation,
- ü Provides "real world" benefits and reimbursement that exist in private sector,
- ü Requires personal responsibility in paying for and using services,
- ü Is available to people based on their incomes,
- ü And is affordable to the consumer.

The Strategic Planning Team acknowledges that policy options such as medical savings accounts, defined contribution plans, and tax credits have merit and could be more effective than the recommended options in containing the rapidly rising costs of health care; however, changes in federal tax laws would be required in order to maximize the benefits to Idahoans. Therefore these options, while appealing, are not feasible at this time.

The Steering Committee reviewed these criteria early in the evaluation process and concurs with their appropriateness for use in selecting the best policy options for Idaho.

Recommendations to Governor Kempthorne and the U.S. Department of Health and Human Services

The following policy recommendations are described mainly at conceptual levels; Grant staff and strategic partners plan to spend much of 2002 studying and designing the final recommendations in order to make them appropriate for implementation in Idaho. Each of these policy descriptions contains basic philosophical and conceptual precepts as well as summary information on anticipated coverage, costs, potential funding sources, and actions needed in order to implement the policy. Finally, this report contains a strategic plan in the form of suggested timelines for implementing each option.

The data on Idaho's population identify three distinct populations of uninsured: children, college students, and adults. The policy options recommended in this report address these populations as distinct targets; in combination, these approaches could extend coverage to all three groups. By combining the top three policy recommendations, coverage could be extended to all of Idaho’s citizens under 200% of the federal poverty level (FPL). However, while it is desirable to extend insurance coverage to this entire population, it is also possible to implement these recommendations in phases—for example, the recommendation to cover adults could be designed to be capped within funds available or by number of potential enrollees, or the state could target a federal poverty level (such as 100% FPL) and expand to higher income groups as resources become available. The ability to establish clear caps either through available funding or number of enrollees is a very appealing feature of waivers currently available from the federal government. This provision ensures that program designs are not of an “entitlement” nature as in more traditional Medicaid programs.

The Steering Committee also recommends implementing a health insurance education initiative to support these policies. While not strictly a policy option for reducing the number of uninsured, an education initiative will assist people in making informed decisions about health insurance programs, both public and private, and may indirectly lead to a reduced rate of uninsurance in the state.

When considering the costs of these policy recommendations, it is important to keep in mind that Idaho currently spends large amounts of money on the uninsured through county indigent funds and the state catastrophic fund. Counties spent approximately 18 million on the uninsured in fiscal year 2000, and 9.8 million was spent through the catastrophic fund in that year as well. Additionally, Idaho hospitals spent $90 million in charity care and bad debt in 1999 alone, a number that increased $20 million from the previous year. Clearly, Idaho spends a substantial amount on treating the uninsured when their health conditions are most serious and treatments are most expensive. The Idaho State Planning Grant Steering Committee strongly recommends that Idaho spend health care dollars in a more rational and cost-efficient manner by expanding health insurance access so those currently uninsured can get care early, when it is least expensive and most effective.

Covering College Students

Currently, students attending state universities and colleges are generally required to have insurance, but many are able to request a refund for student insurance programs without showing proof of other coverage. Though many students feel they do not need health insurance and prefer not to purchase it—even though the premiums are quite affordable—those who do need medical care often end up on Medicaid or have their expenses paid with county indigent funds.

Recommendation: The Steering Committee recommends that students at these institutions either show proof of insurance coverage or pay as part of their tuition the cost of enrolling in the student health insurance plan. The State Board of Education could require that the state's universities and colleges implement this policy in the upcoming fiscal year. The State Board, in consultation with the institutions, could determine the number of credit hours above which students would be required to participate. The institutions might also consider creating one large insurance pool of college students and purchase one insurance product cooperatively instead of each buying separate plans.

Anticipated Coverage: It is projected that this proposal would cover 5,000 people.

Cost: No additional public funding is required.

Potential Funding Sources: No public funds are required.

Actions Needed to Implement: Mandate from State Board of Education.

Covering Children

Currently, the term “Children’s Health Insurance Program” (CHIP) refers, in Idaho, to all children insured by Title XIX Medicaid funds as well as those covered by Title XXI SCHIP funds. “SCHIP” refers to the federal Title XXI State Children’s Health Insurance Program. As of October 2001, Medicaid covered 85,465 children in Idaho and SCHIP covered 11,717 children. Eligibility for these programs depends on the federal poverty level (FPL) of the child’s family. Generally, Medicaid

funding covers children from ages 0-6 up to 133% of FPL and ages 7-18 up to 100% of FPL. SCHIP funding covers children between the Medicaid limit and 150% of FPL.

Based on a 2000 estimate and considering an enrollment of 14,000 children during 2001 (as of November 2001), there are approximately 14,000 children remaining who are eligible to be covered by Medicaid and SCHIP at the existing FPL limits. If Idaho raised CHIP eligibility to 200% FPL, an additional 9,200 children could qualify for coverage under CHIP.

Recommendation: The Idaho State Planning Grant recommends taking the initial step of covering children who are currently eligible for Idaho's CHIP program but not yet enrolled. The recommended next step is to expand Idaho's CHIP program to 200% of FPL. The Grant also recommends adopting several of the recommendations made by the 1998 Idaho CHIP Task Force to the Director of the Department of Health and Welfare:

- ü To manage CHIP as a stand-alone program, not an extension of Medicaid, in order to give greater flexibility to the program as well as to delink it from any perceived negative stigma attached to Medicaid.
- ü To base eligibility on a sliding scale so that people pay some portion, based on their incomes, of the premium and co-pays.
- ü To restructure reimbursement to be closer to what service providers received from private payers.
- ü To offer a benefit package similar to what is provided in private-sector insurance. Benefits would include basic inpatient, outpatient, diagnostic, pharmacy, preventive services, vision, dental, mental health/substance abuse, and therapies.
- ü To use an electronic payment transfer system, in the form of an "access card," to enable parents to purchase insurance for their children on the private market.

The original Task Force recommendations proposed that a non-Medicaid state-administered program would cover children up to 140% FPL and private commercial insurance would be used to cover children from 141-200%, through the use of vouchers. Children from 141-200% would use the vouchers based on a sliding scale system. According to the original Task Force recommendations, this would provide "a means of transitioning a family from a government insurance program to private insurance", rather than making an "all or nothing" cut-off point. Today, implementing an electronic payment transfer system, or access card, might be preferable to using vouchers. The Task Force also suggested that the Department of Health and Welfare explore the possibility of using vouchers or access cards to allow children from families with incomes from 140%-200% FPL to buy into the Idaho Medicaid program. This recommendation would guarantee that there was an available insurance product for children using the access card.

There are a number of challenges in implementing this approach. The original CHIP Task Force proposal would also have required family contributions in excess of the 5% gross income limit in federal regulations. Although waiving this 5% limit may have a negative impact on take-up rates, a waiver would permit flexibility in designing new programs. The Idaho State Planning Grant's final report to the Health Resources and Services Administration will include an appeal for permission to implement cost-sharing in excess of 5% for this and other policy options. Other challenges in this approach include meeting the federal benchmark requirements for private coverage and administrative simplicity. These aspects of a CHIP expansion would require detailed examination and planning before implementation.

Anticipated Coverage: As of December 2000, there were approximately 28,000 children eligible for the current programs but not enrolled. Between December 2000 and November 2001, approximately 14,000 children were enrolled. Without considering increases in the child population or continuing decreases in employer-sponsored coverage for dependents, a remaining 14,000 children would be still eligible but not yet enrolled. Given the historical trend that 25% of newly enrolled children have been eligible for SCHIP and 75% eligible for Medicaid, we anticipate that enrolling the remaining children in families with incomes to 150% will yield 3,500 new SCHIP enrollees and 10,500 new Medicaid enrollees.

Raising eligibility for SCHIP from 150% of FPL to 200% would cover an additional 9,200 children. Therefore, our recommended changes to the SCHIP program would cover, in total, the 11,717 children already enrolled, the 3,500 children currently eligible but not yet enrolled, and the 9,200 eligible between 150 and 200% FPL.

The following chart details the enrollment in the current program and what enrollment and new state costs would be if Medicaid and SCHIP were separated and SCHIP brought up to 200% FPL.

Current Program	FPL Covers Today	Number Covered as of 11/01	FPL Covered on Proposal	Total Number of Children	New State Dollars to Expand	Cost Sharing
Medicaid Title XIX	Ages 0-6: 0-133% Ages 7-18: 0-100%	85,465	N.A.	N.A.	N.A.	N.A.
SCHIP Title XXI	Ages 0-6: 134-150% Ages 7-18: 101-150%	11,717	N.A.	N.A.	N.A.	N.A.
Totals		97,182				
Proposed Revision	FPL Covers Today	Number Covered as of 11/01	FPL Covered on Proposal	Total Number of Children	New State Dollars to Expand	Cost Sharing
Medicaid Title XIX	Ages 0-6: 0-133% Ages 7-18: 0-100%	85,465	No change	95,965 (enrollment growth due to outreach and demand)	$4.725 million to cover enrollment growth	No
New Separate CHIP Program	N.A.	N.A.	Ages 0-6: 134-200% Ages 7-18: 101-200%	24,417 (11,717 currently enrolled; 12,700, potential enrollees)	$3.3 million new funding: $1.05 million for 3,500 currently eligible but not enrolled (at least half of this is already budgeted) and $2.76 million for the 9,200 newly eligible.	Yes, at 5% federal limit, could generate $365,000 in state funds
Totals				119,912	$8.025 million	

Cost: The original Task Force recommended using Resource-Based Relative Value Scale (RBRVS) rates for physician reimbursement. If private coverage were purchased in this model, reimbursement rates would be those used in the private sector unless insurers developed a new package. While the original Task Force used a goal of $100 per member per month (pmpm), actual CHIP costs have approximated $125 pmpm. If the program is designed as a straight Medicaid expansion, the $125 pmpm cost is a safe estimate. This is consistent with the scope of benefits, utilization, and medical inflation. Experience in other states has shown a range between $110 and $135 pmpm.

If it is possible to implement a program in which electronic transfer payments are used and Idaho receives Federal approval for cost-sharing beyond the 5% limit, Idaho could reduce its costs and cap its responsibility within an established budget. At present, it is too early to estimate costs for this approach. Therefore, subsequent cost estimates are based on the $125 pmpm anticipated for a straight Medicaid expansion.

The 2001 Idaho Legislature appropriated sufficient state funds to cover 13,350 children for an entire fiscal year in CHIP. With enrollment currently at 11,717, there is funding allocated but unspent for 1,633 children. Enrolling the additional 1,867 children who make up the balance of the 3,500 eligible but not yet enrolled children would cost Idaho an additional $560,100, which is based on the federal government's CHIP match rate of 20% state and 80% federal dollars.

Expanding CHIP to 200% of FPL would require funding for an additional 9,200 children—the state's portion of which would be $2,760,000.

As mentioned above, efforts to enroll already-eligible children could add another 10,500 to Medicaid, which could cost $4.725 million in state funds. (The state's Medicaid cost is higher than its CHIP cost because the federal match is 70%-30% instead of the 80%-20% match rate for CHIP.)

This assumes that all eligible children will enroll and that the estimates of eligible children are reasonably accurate. Actual take-up rates are difficult to estimate. Historical take-up estimates for CHIP have always been lower than actual take-up. While there would not be 100% take-up, even a take-up rate of 80% could easily be offset by increases in eligible children due to population growth and the current recession. If one assumes that the new CHIP would be advertised, then near-maximum participation (95%) must be assumed for budgeting purposes. Total state cost per year with cost-sharing and at this take-up rate would be $7.22 million.

Scope of benefits, utilization, reimbursement levels, administration, and cost-sharing all impact the total program cost. Some of these program aspects could decrease cost and some could increase it when compared to the present CHIP Medicaid expansion program. The use of an electronic transfer access card may reduce state administrative costs. State-operated claims payment costs would also be reduced. Cost-sharing may impact take-up rates and utilization. A different scope of benefits would also reduce costs. Provider reimbursement paid at current private insurance rates would increase costs, as would the need for private carriers to generate an operating margin. Private insurance products would have to be made available that would meet the design elements of this group as well as the federal SCHIP requirements for benchmark coverage.

Potential Funding Sources: For the state's share of the subsidy, financing could come from several sources, such as Idaho hospitals (Disproportionate Share or Upper Payment Limit dollars), the Millennium Fund (state tobacco settlement money), county indigent funds, a premium tax, or a possible tobacco tax.

Actions Needed to Implement: Details of the plan would have to be designed. The original Task Force recommendations would have to be reviewed and the new plan would have to be developed and integrated with existing programs. Federal cost-sharing limits could require some changes from the original Task Force recommendations.

The Idaho Legislature would need to expand CHIP by appropriating funding. The Department of Health and Welfare may need to request waivers dependent upon program design, which would require that the Idaho Legislature first approve the pursuit of that waiver. The federal government would need to approve the waiver, which would then ensure long-term federal funding.

Covering Adults

The 2000 Behavioral Risk Factor Surveillance System estimated that there are 100,000 adults in Idaho with incomes up to 200% FPL who are uninsured. The Steering Committee recommends exploration of two different approaches to covering these adults: a private-public partnership based on a model currently being pursued in New Mexico and expanding the CHIP program to adults.

The two approaches described below are similar in several respects. Both include an element of cost-sharing and therefore a requirement for personal responsibility on the part of the individual. For both options, expanding CHIP to 200% FPL to cover children is necessary if federal excess CHIP dollars are to be used and if coverage for adults is expanded to 200% FPL. In addition, both options allow a typical "commercial-type" benefit package to be extended to enrollees. However, only the New Mexico public-private partnership allows for three-way sharing of the premium costs—spreading costs between employees, employers, and a combined state and federal subsidy. The cost of a CHIP expansion would be shared only by the individual and by Medicaid; the program would not capture employer dollars.

Recommendation:

A Public-Private Partnership/The New Mexico Model

Small business is the primary employer in Idaho, employing 63% of the state's total work force; 97% of businesses in Idaho are small businesses. Small businesses fuel our economy. Unfortunately, securing health coverage has emerged as a major problem for increasing numbers of these businesses. The challenge is particularly acute for very small businesses with low-wage workers. These businesses are several times more likely to have difficulties offering affordable coverage to their employees and employees less likely to be able to afford coverage even if it's offered. This puts these businesses at a disadvantage in the marketplace.

In March of 2000, the Boise Metro Chamber of Commerce established a Steering Committee comprising small business owners and employees, physicians and hospitals, state and local government, and other community voices. The mission of the Committee has been to develop a practical, business-based plan of action to address the problem of uninsurance. In the course of examining the problem, it became apparent that it extends beyond Ada County and is in fact of greater concern for the states' rural areas.

The insurance model developed by the Chamber (HealthLink of Idaho) split the cost of a basic benefit package premium between the employer, the employee, and combined federal and state funding. Several of the states awarded HRSA grants are developing models that encourage employer

contributions to employees' health insurance premiums. The primary reasons for interest in these approaches are: 1) employer-provided insurance is the primary approach used to provide insurance in this county, 2) the recognition that many of the uninsured are part of working families (again, that includes 80% of the adult uninsured in Idaho, 70% of whom are actually working and 10% of whom are homemakers in working families), 3) research indicating that many employers believe that it is appropriate to provide such a benefit, and 4) employers' general willingness to contribute to or match the employee share of the premium cost if it were affordable.

Both HealthLink of Idaho and a similar model currently being pursued in New Mexico are designed to encourage employer participation in a public-private partnership. Although the HealthLink model has weaknesses in the areas of long-term funding, affordability and salability, it may still be possible to pilot a public-private partnership that addresses these weaknesses and whose target market would be employees of small businesses.

New Mexico's public-private partnership, on the other hand, addresses the weaknesses of the small business model. It is possible to design the New Mexico model to be within a capped level of appropriation or number of individuals served. Thus, the New Mexico model affords broad flexibility for Idaho to design a non-entitlement public-private partnership program for adults that requires private participation at some level from every participant (either from the employer, individual, or both, depending on income level and employment status). Extensive work would have to be undertaken to make this model appropriate for implementation in Idaho. The following details are generally based on the New Mexico model and provide a framework for how the program could be implemented in Idaho.

Anticipated Coverage: The target population for this coverage would be adults ages 19 through 64 who are not currently eligible for Medicaid and who have household incomes up to 200% FPL. The maximum eligible population for this option is 100,000 low-income adults, though it is expected that take-up would be less than 100%. Because Medicaid now allows caps in terms of both numbers of individual covered and in terms of dollars, it would be possible to limit actual enrollment to the available funding.

Benefit Design: The benefit package design in New Mexico is similar to a basic "commercial-type" package and includes inpatient and outpatient hospital, physician visits, emergency room, lab and x-rays, physical therapy, speech therapy, occupational therapy, behavioral health and substance abuse, and pharmacy. There would be some limit to the number of physician visits covered in a year. There would also probably be requirements for expenditure restrictions on prescription drugs ($1000 maximum in a year and use of formularies), and the establishment of co-pays and deductibles. Specifics in these areas are currently being developed in New Mexico and will need to be developed separately in Idaho in order to meet Idaho needs. The model would operate through the existing commercial insurance structure.

Cost: The program is designed to use Medicaid funds to pay premiums to insurance carriers. Premiums would vary by age and sex. Employees would pay premiums based on their family incomes, with premium differential based on income brackets. Income brackets and premiums will need to be developed. However for purposes of this discussion, income levels could be 0 to 100% of FPL, 101 to 150% of FPL, and 151 to 200% FPL. Co-pays would also be based upon these three FPL categories. Unemployed individuals would have the same sliding scale as the employed but they would also have to pay the employer portion.

Beginning actuarial studies in Idaho, conducted by Milliman USA, show that an initial estimate of the premium costs for our state is $205 pmpm. Assumptions made in reaching this number include:

1) The co-pays, deductibles, annual maximum and most other costs used in the New Mexico plan design, which would have to be re-examined for Idaho, 2) a reduction through a reimbursement factor of 0.92 to reflect lower reimbursement levels than assumed for the small business model, 3) an adverse selection factor of 1.50, 4) a 5% reduction for a pre-existing condition clause which would not provide coverage for the first 12 months for conditions which occur within six months prior to enrollment, 5) a reduction factor for a limit of $1,000 on prescription drugs, and 6) a reduction factor for a moderate amount of underwriting.

A. Unadjusted New Mexico model cost	$173.68
B. Reimbursement factor	0.92
C. Adverse selection factor	1.50
D. Pre-existing condition clause factor	0.95
E. $1,000 annual Rx limit	0.966
F. Moderate underwriting factor	0.93
G. Adjusted model cost (AxBxCxDxExF)	$205

If Idaho were to increase its CHIP eligibility limit to 200% FPL, it would use most of the available federal matching funds for those children. Thus, the regular state Medicaid match rate of 30% state to 70% federal would be used to fund adults under this approach. Based on an estimated take-up rate of 39% (a weighted average of take-up estimates of 20% for 0-100% FPL, 50% for 101-150% FPL and 60% for 151-200% FPL) and employee shares of $10, $35 and $50 pmpm, the average employee share would be $35. An average cost breakdown of $205 pmpm might be as follows: $50 per employer, $35 per employee, a state subsidy of $36 and a federal subsidy of $84. At a cost to the state of $36 pmpm, coverage could be expanded to 39% of the eligible population (or 39,000 Idahoans) at an initial cost of $16.76 million per year to the state. State cost per enrollee per year would be $432. State costs would be lower yet if it were possible to use some of the CHIP funds at the 80-20 match rate for the subsidy.

If the entire eligible population of 100,000 people enrolled in the program using the same sliding scale for employee costs, the average employee share would be $27 pmpm, the state's share would be $38.4 pmpm, and the total maximum cost to the state per year would be $46.08 million. In order to reach an average employee share of $35 pmpm if 100% of the eligible population enrolled, costs on the sliding scale would have to be $25, $40 and $50. Total state costs per year if 100% of the eligible population enrolled would be $43.2 million. However, initial research shows that this sliding scale may be too high to be salable.

For implementation of a two-year pilot period, enrollment might be capitated at 5,000 adults with incomes at or below 100% FPL. The cost breakdown of $205 pmpm would then be as follows: $10 for the employee share, $50 for the employer share, and a subsidy of $145 pmpm. In order to implement this pilot with some restrictions on enrollment and without a Medicaid waiver, the state or other non-Medicaid sources would need to pay the total cost of the $8.7 million subsidy for the two-year period.

Potential Funding Sources: Because eligibility for participation in this program is based on individuals' incomes rather than business size or average hourly wage, it is much more likely to meet the requirements for a federal match. The state funding piece could come from a combination of

several sources, such as Idaho hospitals (Disproportionate Share or Upper Payment Limit dollars), the Millennium Fund (state tobacco settlement money), county indigent funds, a premium tax, or a possible tobacco tax.

Actions Needed to Implement: This plan would have to be re-designed for Idaho before implementation in our state, which would include examining such details as benefits, demographics of the target population, costs, administration, and the provider network, among others. The state would need to pursue a federal Medicaid waiver, which would require that the Idaho Legislature first approve the pursuit of that waiver. The state would also have to agree to fund the state's portion of the Medicaid subsidy. The federal government would need to approve the waiver, which would then ensure long-term federal funding of the subsidy.

Expanding CHIP to Parents

This option would expand CHIP so that it covers parents of children who are eligible for CHIP. This option would not cover all uninsured adults under 200%, only parents of CHIP children. The following features have been suggested:

- ü Modify the scope of benefits to more closely resemble benefits offered through commercial insurers. This could be equivalent to the package being considered for the public-private partnership/New Mexico model.
- ü Implement cost sharing for families based on a sliding scale. If families are treated as a group, the 5% cost-sharing maximum in the children's program does not apply, allowing more flexibility in creating a cost-sharing package for low income families to purchase with some public subsidy.
- ü Utilize innovative strategies including the potential for a beneficiary to buy into employer-sponsored plans.
- ü Consider the use of an electronic payment transfer system in the form of an access card to enable adults to purchase insurance on the private market.

Anticipated Coverage: This option has the potential to insure up to 64,000 parents of CHIP and Medicaid children. The estimate assumes eligible parents and children up to 200% FPL.

Benefit Design: Benefits are assumed to be similar to New Mexico's model, but would have to be reviewed before implementation of the program: the model assumes a basic "commercial-type" package including inpatient and outpatient hospital, physician visits, emergency room, lab and x-rays, physical therapy, speech therapy, occupational therapy, behavioral health and substance abuse, and pharmacy. There would be some limit to the number of physician visits covered in a year. There would also probably be requirements for expenditure restrictions on prescription drugs ($1000 maximum in a year and use of formularies), and the establishment of co-pays and deductibles. Specifics in these areas will need to be developed.

Cost: If a benefit package and other variables similar to the public-private partnership model were used, the estimated cost would also be $205 pmpm. However, the adverse selection factor used in cost estimates for the public-private partnership is assumed to be too high for this policy option, as parents of CHIP children are likely to be younger on average. Therefore, with a factor of 1.25 instead of 1.5, the estimated premium cost would be $170 pmpm.

Individuals would pay premiums based on their family incomes, with categories of up to 100% of FPL, 101 to 150% of FPL, and 151 to 200% FPL. Co-pays would also be based upon these three FPL categories. As a separate program design for adults, the cost-sharing rules of Medicaid and SCHIP would not apply. The state could set cost-sharing at a level deemed reasonable. Unlike the public-private partnership, no employer dollars could be captured with this program. This program could also be capped based either on appropriated levels or number of enrollees. Thus, while figures for the total program assuming full enrollment are given here, committee discussions focused on the possibility of incrementally growing into full enrollment over a period of years.

If Idaho were to increase its CHIP eligibility limit to 200% FPL, it would use most of the available federal funds for those children. Thus, the regular state Medicaid match of 30% state to 70% federal dollars would be used to fund this approach. Assuming that all 64,000 parents enrolled, the total cost would be $130.56 million per year. If parents contributed 5% cost-sharing, that would reduce the cost to $124 million. The state share of the total program cost per year would be $37.2 million. State cost per enrollee per year would be $581.25.

The actual enrollment in this program would probably be less than 100% and caps could be considered to control costs. Traditional Medicaid programs in Idaho have had take-up rates of around 67%. Since this program includes cost-sharing, take-up rates would probably be lower. Also, parents would, if required, probably spend limited cost-sharing dollars on their children. Therefore, we could estimate a take-up rate of 50%, which could take two to three years to reach. At that level, the annual cost in state funds would be $18.6 million.

It may also be possible to implement this program incrementally, starting with CHIP parents with incomes of up to100% FPL—a population estimated in 2000 to be 31,440—or with parents with incomes up to 150% FPL.

Potential Funding Sources: The state funding piece could come from a combination of several sources, such as Idaho hospitals (Disproportionate Share or Upper Payment Limit dollars), the Millennium Fund (state tobacco settlement money), county indigent funds, a premium tax, or a possible tobacco tax.

State/Federal Actions Needed to Implement: Details of this plan would need to be closely examined before implementation, including the scope of benefits, costs, administration, and the provider network, among others. The state would need to pursue a federal Medicaid waiver, which would require that the Idaho Legislature first approve the pursuit of that waiver. The state would also have to agree to fund the state's portion of the Medicaid subsidy. The federal government would need to approve the waiver, which would then ensure long-term federal funding of the subsidy.

Conclusion: Cost Comparison and Implementation Timelines

Strategy	Policy Option	Potential (New) Enrollees	State Cost per Enrollee per Year	New State Cost per Year, Maximum	Estimated Take-Up Rate	Estimated New State Cost per Year
#1. Covering College Students	Mandate coverage for college students	5,000	N.A.	$0	100%	$0
#2. Covering Children	Bring CHIP to 200%	21,000	$371.42	$8.025 million	95% with 5% cost-sharing	$7.22 million
#3. Covering Adults	Public/Private Partnership	100,000	$432 if 39% take-up; $460.8 if 100% take-up	$46.08 million	39% (39,000 adults)	$16.76 million
#3A.	Pilot of above option	5,000	$1,740 (not split bet. state and fed. gov.)	$8.7 million **for two years**	100% of pilot population	$8.7 million **for two years**
#4. Covering Adults	Expand CHIP to Parents	64,000	$581.25	$37.2 million	50% (32,000 adults)	$18.6 million
#4A	Incremental implementation to CHIP Parents up to 100% FPL	31,440	$581.25	$18.27 million	50% (15,720 adults)	$9.14 million

It is important to note that these are fully annualized costs. With any new program, enrollment would grow over a two- to five-year period. Thus the initial annual costs would be much lower than when the program is at "full" capacity.

Strategy 1: Covering College Students **Mandate coverage for college students**							
Tasks	**Project Partners**	**FY02 Projected Milestones**		**FY03 Projected Milestones**			
		Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Work with State Board of Ed. and schools already implementing this policy to achieve consensus on details	State Board of Education	Mandate coverage		Roll out programs		Resurvey universities to evaluate impact	
		FY04 Projected Milestones				**FY05 Projected Milestones**	
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**

Strategy 2: Covering Children **Implement CHIP Task Force recommendations and bring CHIP to 200%**							
Tasks	**Project Partners**	**FY02 Projected Milestones**		**FY03 Projected Milestones**			
		Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Reconvene Task Force to re-examine recommendations	State Legislature, Dept. of Health and Welfare	Reconvene Task Force to address program details	Research implementation details	Develop detailed implementation plan	Secure legislative funding and approval		Implement program
		FY04 Projected Milestones				**FY05 Projected Milestones**	
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
		Monitor implementation					

Strategy 3: Covering Adults **Implement a public-private partnership model**							
Tasks	**Project Partners**	**FY02 Projected Milestones**		**FY03 Projected Milestones**			
		Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Convene a committee to determine details of program, get buy-in from key stake-holders, write a Medicaid waiver, submit a bill to state legislature, submit waiver	Chambers of Commerce, State Legislature, Dept. of Health and Welfare		Convene a committee to determine details of program	Conduct research to complete waiver application	Secure legislative funding and plan approval	Write and submit waiver	
		FY04 Projected Milestones				**FY05 Projected Milestones**	
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
					Implement program		

Strategy 3A: Covering Adults **Pilot the public-private partnership model**							
Tasks	**Project Partners**	**FY02 Projected Milestones**		**FY03 Projected Milestones**			
		Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Convene a committee to determine details of program, get buy-in from key stake-holders, secure funding	Chambers of Commerce, Dept. of Health and Welfare		Convene a committee to determine details of program	Conduct ongoing research into funding options			
		FY04 Projected Milestones				**FY05 Projected Milestones**	
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
		Implement pilot program	Conduct ongoing outreach and enrollment		Monitor program		

Strategy 4: Covering Adults **Expand CHIP to parents**							
Tasks	**Project Partners**	**FY02 Projected Milestones**		**FY03 Projected Milestones**			
		Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Define scope of benefits and benchmark plan; secure waiver to utilize Medicaid match	State Legislature, Dept. of Health and Welfare					Re-convene Task Force to address details	Research implemen-tation details
		FY04 Projected Milestones				**FY05 Projected Milestones**	
		Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
		Conduct research to complete waiver application; secure legislative funding and plan approval	Write waiver	Submit waiver	Implement program		

Appendix A

Policy Options Evaluated by the Idaho State Planning Grant

Employer Tax Credit: Providing a tax credit to firms who employ low-wage workers as an incentive for the firm to provide health insurance for those workers.

Individual Tax Credits: Giving either state or federal income tax credit for individuals or families to enable them to purchase health insurance.

CHIP / Medicaid Expansion through a County Option: Requesting waivers from the federal Center for Medicaid Services to allow counties to extend coverage for children up to 200% of the FPL, their parents, and childless adults if any county chose to do so and identified the funding for this expanded coverage

Remove the Cap on CHIP Enrollment: The 2001 Idaho Legislature placed a cap on available state funds for the Title XXI Children's Health Insurance Program. This policy option suggested ways to eliminate the cap.

Privatize CHIP / Medicaid for Children (HIFA Waiver): This waiver allows greater flexibility in establishing benefits and cost-sharing.

Expand CHIP / Medicaid Coverage for Children and Parents to 200% of FPL: This would access SCHIP federal matching funds to extend coverage to children from low-income families who earn too much to qualify for Medicaid and are without health insurance. It would use an income disregard to expand benefits to their parents.

Idaho CHIP Task Force Recommendations: In 1998, the Idaoh Children's Health Insurance Program Task Force issued a report to the Director of the Department of Health and Welfare recommending, among other things, that Idaho's CHIP program be run as a stand-alone program and have greater flexibility in designing a benefit package, establishing cost-sharing, and using a voucher system.

Medical Savings Accounts Combined with High Deductible Plans: MSAs are personal funds established by individuals or their employers to pay current out-of-pocket medical costs and to accumulate funds for future expenses. The accounts would be used in conjunction with a high-deductible health plan.

The Oregon Health Plan: Evaluating whether or not the Oregon model of extending Medicaid eligibility to all the state's residents below 100% of the federal poverty guidelines would work for Idaho.

Medicaid Primary Care Safety Net Expansion: Expanding Medicaid eligibility for adults with incomes below 100% FPL and restrict the scope of benefits to primary and preventive care services.

Primary and Preventive Care Grant Program: Giving grants to comprehensive primary care entities throughout the state to expand services and increase the numbers of low-income uninsured Idahoans that have access to primary health care.

Universal Coverage with One Risk Pool: Establishing an Idaho Trust Fund that would insure all residents of Idaho under a single plan.

Small Business Model (*HealthLink* of Idaho): Creating a public-private partnership to make insurance available to small businesses with low-wage workers.

Appendix B

Federal Poverty Levels

Family Size	100% FLP	133% FPL	150% FPL	200% FPL
One	$8,590	$11,425	$12,885	$17,180
Two	$11,610	$15,441	$17,415	$23,220
Three	$14,630	$19,458	$21,945	$29,260
Four	$17,650	$23,475	$26,475	$35,300

Appendix C

Idaho State Planning Grant Participation List

Steering Committee

Rep. Max Black, Idaho State Legislature
Dr. Richard Bowen, President, Idaho State University
Sandra Bruce, CEO, Saint Alphonsus Regional Medical Center (co-chair)
Jay Engstrom, Administrator, Division of Economic Development, Department of Commerce
Ray Flachbart, CEO, Blue Cross of Idaho
Susan Gibson, VP, Mission Services, Saint Alphonsus Regional Medical Center
Dr. James Girvan, Dean-Elect, College of Health Sciences, Boise State University
Jim Hawkins, Highway 21 Ventures
Marie Hoff, Executive Director, Catholic Charities of Idaho
Pam Hunt, Executive Director, Idaho State Planning Grant
Sen. Grant Ipsen, Idaho State Legislature
Pete Johnston, Council Community Hospital
Joan Krosch, Health Insurance Specialist, Department of Insurance
David Lehman, Policy Advisor, Office of the Governor
Gary Mahn, Director, Department of Commerce (co-chair)
Joyce McRoberts, Deputy Director, Department of Health and Welfare
Joe Morris, CEO, Kootenai Medical Center
Don Peña, Executive Director, Idaho Commission on Hispanic Affairs
Dr. Julia Robinson, Private Consultant
Dan Smith, MD, Idaho Family Physicians Association
Kirk Sullivan, President and CEO, Veritas Advisors, LLP
Kate Vanden Broek, Acting Director, Idaho State Planning Grant
Nancy Vannorsdel, President, Boise Metro Chamber of Commerce
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Other Work Group Members

Tom Bassler, General Council, Blue Cross of Idaho
Sen. Dean Cameron, Idaho State Legislature
Jonathon Cree, MD, Family Practice Residency
Ann Dewitt, small business owner
Mike Gwartney, Chairman of the Board, Regence Blue Shield
Blake Hall, State Catastrophic Fund

Leslie Halverson, small business owner
Joe Marshall, retired Chairman, Idaho Power
Steve Millard, President, Idaho Hospital Association
Rep. Bruce Newcomb, Speaker of the House, Idaho State Legislature
Bill Roden, lobbyist
Marilyn Shuler, community advocate
James Aydelotte, Dept. of Health and Welfare
Chris Johnson, Idaho Hospital Association
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Alan Porter, Dept. of Commerce
Linda Powell, Mountain States Group
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Randy Page, University of Idaho
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Stephen Weeg, SCW Consulting Services
Ted Argyle, Ada County Prosecuting Attorney's Office
Joan Asson, Director, Mini-Cassia Chamber of Commerce
Tom Bergdoll, Director, Small Business Administration
Joe Brunson, Director, Division of Medicaid
Gordon Crow, formerly of the Coeur d'Alene Chamber of Commerce
Carl Hanson, CEO, Minidoka Hospital
Chuck Pomeroy, CFO, St Lukes Regional Medical Center
John Summerton, Northwestern Group Marketing Services
Mikel Ward, VP, Marketing, Boise Metro Chamber of Commerce