F I S C A L I M P A C T R E P O R T

SPONSOR Gardner **ORIGINAL DATE** 02/18/09 **LAST UPDATED** **HB** 587

SHORT TITLE Premium Assistance Maximization Act **SB**

ANALYST Earnest

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY09	**FY10**		
	$.01 Indeterminate but significant	Recurring	General Funds and Federal Matching Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY09	FY10	FY11	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total	$200.2	$506.6	$206.6	$913.2	Recurring	General Fund and Federal Matching Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Department of Finance and Administration (DFA)
Public Regulation Commission (PRC)

SUMMARY

Synopsis of Bill

The bill enacts the Premium Assistance Maximization Act to require the Human Services Department (HSD) to determine which health plans offered in the state meet the criteria of being a "benchmark benefit package" or "benchmark equivalent benefit package." The bill requires

HSD to amend the state Medicaid plan to adopt each package permitted under Medicaid or the State Children's Health Insurance Program (SCHIP) of the Social Security Act. Once the plans have been adopted and certified as "qualified health benefit plans" as defined by federal law, the bill directs the Secretary of HSD to require all persons eligible for a full Medicaid benefit to enroll in a plan.

The secretary of HSD, in consultation with the Superintendent of Insurance, is to determine whether a health benefit plan provides "appropriate coverage" so as to be considered a "qualified health benefit plan," as defined by federal law.

FISCAL IMPLICATIONS

The fiscal implications of the legislation are difficult to determine. The bill proposes a significant change to the state's Medicaid program by implementing new "benchmark" plans recently allowed by the federal government, as well as costs sharing and incentive programs. Some cost factors are described below.

Depending on the adopted "benchmark benefit package" the bill could result in lower costs for the Medicaid program, particularly if the benefit package is more limited than the current plan. The Human Services Department (HSD) pays premiums now on behalf of most Medicaid eligibles under the SALUD! and Coordination of Long Term Services (CoLTS) programs.

For plans that do not offer early and periodic screening, diagnostic and treatment (EPSDT) services, the secretary must ensure access for eligible children under 19 by paying premiums that reimburse benefit plans or licensed health professionals to provide these services. The cost for these services would be "over and above regular premium payments for EPSDT services not covered by benefit plans." EPSDT services are still required to be offered by federal law and regulation.

The bill would require HSD to pay benefit plans for cost sharing incurred that is in excess of the maximum allowable amount. HSD does not currently pay for cost sharing in excess of the maximum allowable amount.

The legislation requires the establishment of an incentive program that reduces cost sharing obligations for persons who participate. HSD would have additional costs with respect to cost sharing reduction, but may recognize longer term savings in the form of lower health care costs for services.

HSD estimates the need for 3 FTE to administer the program, and finds that there would be costs for IT systems changes. Annual costs for 3 FTE at range 65 are calculated to be $68.5 thousand per year.

SIGNIFICANT ISSUES

HSD notes that the Center for Medicare and Medicaid Services (CMS) has not issued final regulations for benchmark benefit packages.

The federal Deficit Reduction Act of 2005, which authorize these new plans, exempted a number of populations from benchmark benefit packages. These exemptions apply to pregnant women, blind or disabled individuals, dual eligibles, inpatient, the medically frail, children eligible through Children, Youth and Families Department programs, and breast and cervical cancer clients.

Benchmark benefit packages apply to able bodied populations and would not include disabled individuals. Benchmark benefit packages may not include service currently offered benefit packages, such as such as dental, vision, and transportation. As a result, HSD indicates access to services and health outcomes will be impacted.

Benchmark-equivalent coverage is defined as a benefit that has an aggregate actuarial value at least equivalent to one of the above benchmark plans. The statute sets forth a standard to determine the actuarial value. For mental health services and prescription drugs (as well as vision and hearing services), the benchmark-equivalent coverage need be at least 75% of the actuarial value of the benchmark plan.

Services covered under any of these plans need only include:

1) inpatient and outpatient hospital services;
2) physicians' surgical and medical services;
3) laboratory and x-ray services;
4) well-baby and well-child care, including age-appropriate immunizations; and
5) other appropriate preventive services, as designated by the Secretary of HSD

States have the option to provide additional benefits as "wraparound" coverage to any of the beneficiaries who are moved into benchmark plans, as they are required to do so for EPSDT services.

According to DFA:

> as of December 2007, eight states had approved state plan amendments that implement this section of the DRA. Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia and Wisconsin have approved benchmark plans for some (or all) groups of Medicaid beneficiaries. Texas and Missouri have announced plans to create reforms to their Medicaid program which may include benchmark plans.
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> Of these states, Idaho, Kentucky and West Virginia have made substantial changes to their Medicaid programs. In addition, South Carolina has created significant change for a pilot population in one county. Four of the states used the benchmark-plan option to improve coverage for specific populations: Kansas, Virginia, Washington and Wisconsin. In these states there is no reduction in basic Medicaid.
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> Mental health coverage in the benchmark plans of the three states with comprehensive changes is limited, emphasizing basic inpatient and outpatient services with limits for most populations, although those with disabilities generally have broader coverage.

ADMINISTRATIVE IMPLICATIONS

HSD noted the following implications:

> HSD would be required to draft a state plan amendment that allows for benchmark benefit packages. HSD would be responsible for consulting with the insurance division to determine which plans meet the criteria of being a benchmark plan. HSD would have to ensure EPSDT services are provided to children under 19. HSD would need to set up an incentive program that would improve health outcomes and lower health care costs. The costs in establishing and administering a premium assistance program are significant.

PRC reports that the bill requires that the Secretary certify self-funded health benefit plans, to see whether they qualify as a "benchmark benefit plan" or a "benchmark equivalent benefit plan," but since these plans are not subject to state regulation, it is not clear how the secretary will have the authority to examine the plans to determine whether they qualify, and to monitor the plans for future compliance once the plan is certified, again, absent voluntary participation in these processes by the self-insured or FEHBP plans.

BE/svb