COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 4585-05
Bill No.: HCS for HB's 2413, 2355, 2394 & 2398
Subject: Health Care; Insurance-Medical; Insurance Department
Type: Original
Date: April 17, 2008

Bill Summary: This legislation establishes the Insure Missouri Program to provide health insurance coverage to eligible low-income working adults.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
General Revenue	(Unknown but Greater than $49,017,646)	(Unknown but Greater than $52,675,915)	(Unknown but Greater than $55,885,849)
Total Estimated Net Effect on General Revenue Fund	**(Unknown but Greater than $49,017,646)**	**(Unknown but Greater than $52,675,915)**	**(Unknown but Greater than $55,885,849)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 25 pages.

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
Insurance Dedicated Fund	$5,450	$0	$0
County Foreign Insurance Fund	($3,093,976)	($3,093,976)	($6,187,953)
Missouri Health Insurance Pool	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Federal Reimbursement Allowance Fund	($9,205,265)	($57,195,697)	($99,921,029)
Total Estimated Net Effect on Other State Funds	**Unknown to (Unknown but Greater than $12,293,791)**	**Unknown to (Unknown but Greater than $60,289,673)**	**Unknown to (Unknown but Greater than $106,108,982)**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
Federal	Unknown	Unknown	Unknown
Total Estimated Net Effect on All Federal Funds	**Unknown**	**Unknown**	**Unknown**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
General Revenue	1.08 FTE	1.08 FTE	1.08 FTE
Federal	.92 FTE	.92 FTE	.92 FTE
Total Estimated Net Effect on FTE	**2 FTE**	**2 FTE**	**2 FTE**

☐ Estimated Total Net Effect on All funds expected to exceed $100,000 savings or (cost).

☒ Estimated Net Effect on General Revenue Fund expected to exceed $100,000 (cost).

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
Local Government	**($6,187,952)**	**($6,187,952)**	**($12,375,906)**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Missouri Senate**, **Office of the State Courts Administrator**, **Missouri Health Facilities Review Committee**, **Office of Prosecution Services** and the **Department of Revenue** each assume the proposal would have no fiscal impact on their respective agencies.

Officials from the **Office of the Attorney General (AGO)** states that it represents the Certificate of Need Review Committee. The AGO assumes that because of this proposal's changes in the Committee's information gathering powers, the AGO may have increased responsibilities (Section 197.330.3). AGO assumes that any potential costs arising from this proposal can be absorbed with existing resources.

Officials from the **Office of the Secretary of State (SOS)** state many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The SOS is provided with core funding to handle a certain amount of normal activity resulting from each year's legislative session. The fiscal impact for this fiscal note to the SOS for Administrative Rules is less than $2,500. The SOS recognizes that this is a small amount and does not expect that additional funding would be required to meet these costs. However, the SOS also recognizes that many such bills may be passed by the General Assembly in a given year and that collectively the costs may be in excess of what the office can sustain with the core budget. Therefore, the SOS reserves the right to request funding for the cost of supporting administrative rules requirements should the need arise based on a review of the finally approved bills signed by the governor.

Oversight assumes the SOS could absorb the costs of printing and distributing regulations related to this proposal. If multiple bills pass which require the printing and distribution of regulations at substantial costs, the SOS could request funding through the appropriation process. Any decisions to raise fees to defray costs would likely be made in subsequent fiscal years.

Officials from the **Department of Mental Health** states the proposal would provide health insurance coverage for certain uninsured persons. It is not known how many individuals would be affected or what services they might receive through the medical assistance program, therefore the projected savings are unknown.

Officials from the **Department of Health and Senior Services (DHSS)** states the following:
Division of Senior and Disability Services (DSDS):
Section 376.991.(17)- Specifies that one of the services covered will be personal care. DHSS assumes the Department of Social Services (DSS) will calculate the fiscal impact associated with

ASSUMPTION (continued)

determining eligibility under the "Insure Missouri" program, the cost of services for the eligible recipients, and the cost of any administrative hearings regarding denial of eligibility.

DSDS assumes the "Insure Missouri" program administration will be similar to that of the MO HealthNet program. Based on this assumption, DSDS has determined that it would be the agency designated to assess and authorize requests for personal care services under the new program. Services would be provided for individuals with incomes up to 225 percent of Federal Poverty Level (FPL).

Estimates provided by DSS on March 14, 2008, indicate the "Insure Missouri" program will cover approximately 213,692 individuals after the complete phase-in. Based on utilization of MO HealthNet for eligibility categories which exclude the disabled and those over age 65, DSDS assumes that approximately .17 percent of the eligible individuals would utilize personal care services equaling 363 individuals (213,692 X .0017 = 363.28). Per Section 208.1315 of the proposed legislation, DSDS assumes these individuals will be added in phases.

As of June 30, 2007, caseloads for the DSDS' Social Service Workers averaged approximately 156 per FTE ((41,504 In-Home + 10,068 Consumer-Directed)/329.60). Pursuant to Section 660.021, RSMo, the Caseload Standards Advisory Committee recommended that caseloads should be no more than 80 per worker. DSDS would request additional staff in an effort to reduce average caseloads to at least 100 per Social Service Worker. These standards are the basis for FTE estimates.

Phase I - Upon implementation on July 1, 2008, DSS estimates 42,222 individuals would become eligible. Applying the .17 percent rate for personal care, DSDS estimates 72 individuals would begin accessing these services (42,222 X .0017 = 71.77). Keeping with the previous request to reduce caseloads to 100 per worker, DSDS will require one Social Service Worker II FTE to provide case management for those that are newly eligible as a result of this legislation (72 clients/100 = .72).

Phase II - The second phase, which begins July 1, 2009, DSS estimates an additional 45,154 individuals would be added to the program. Applying the .17 percent rate, DSDS estimates an additional 77 individuals would access personal care services (45,154 X .0017 = 76.76). Based on the caseload standard of 100 per worker, DSDS will require one additional Social Service Worker II FTE (77 clients /100 = .77).

ASSUMPTION (continued)

Phase III - Upon implementation of the third phase on January 1, 2011, DSS estimates an additional 26,724 adults would gain eligibility under the program. Applying the .17 percent personal care utilization rate, an additional 45 individuals would access this care (26,724 X .0017 = 45.43). Based on the standard caseload of 100 per FTE, DSDS assumes these individuals could be absorbed into current caseloads; no additional FTE would be needed for this phase.

Phase IV - This phase, which begins January 1, 2012, would add 23,221 adults. At the .17 percent utilization rate, 39 additional individuals would be accessing personal care services (23,221 X .0017 = 39.48). Based on the standard caseload of 100 per FTE, DSDS assumes these individuals could be absorbed into current caseloads, so no additional FTE would be needed for this phase.

Phase V - Upon implementation of Phase V on January 1, 2013, the addition of 47,353 additional adults at the .17 percent personal care utilization rate would result in an additional 81 clients accessing these services (47,353 X .0017 = 80.5). These additional clients would result in the need for one Social Service Worker II FTE (81 clients/100 = .81).

Phase VI - On January 1, 2014, 16,514 adults will be added to the program. Based on the .17 percent rate, another 28 clients will access personal care services (16,514 X .0017 = 28.07). DSDS assumes these individuals could be absorbed into current caseloads, so no additional FTE would be needed for this phase.

Social Service Worker II duties include the responsibility for investigation of hotlines; eligibility determination and authorization of state-funded in-home services, and care plan management.

Currently, the ratio of Home and Community Area Supervisors (HCSAS) is one supervisor for every ten Social Service Worker (SSW) FTE. This legislation will require two SSW II FTE during the first three years of the proposed legislation, DSDS will not request any additional supervisors or clerical staff and will absorb those duties with existing staff.

Since the program is not an entitlement, the estimated cost of full implementation of this proposal will be zero to $31,474 in year one; zero to $69,600 in year two; and zero to $67,875 in year three in General Revenue. DSDS assumes there will be Federal reimbursement to offset the Federal costs of zero to $31,483 in year one; zero to $70,835 in year two; and zero to $69,710 in year three. The blended Federal participation rate of 54 percent General Revenue and 46 percent Federal was applied to this cost estimate for Personal Services and Expense and Equipment.

ASSUMPTION (continued)

Division of Community and Public Health (DCPH):
Section 376.991 - DHSS, DCPH, HIV/AIDS program may also result in General Revenue cost savings. Currently, the program costs $15,600 per adult per year, and includes medications, primary care and case management costs. There are 533 HIV positive clients between the ages of 19 and 65 years old. Approximately 25 percent of program costs consist of General Revenue and 75 percent come from other sources, including federal and rebate funding. If all 533 adults received services through the Insure Missouri Plan, DHSS assumes there would be a program savings of approximately $2,078,700 in General Revenue. There would be a $6,236,100 reduction in Federal funds, including grant and rebate funds which would have offset costs in the same amount, for a net affect on the Federal funds of zero dollars. DHSS would prefer to retain the anticipated General Revenue savings of $2,078,700 to use to match the federal dollars, which would allow DHSS to serve a portion of the 6,700 people in the State of Missouri who are currently not in DHSS, DCPH, HIV case management. DHSS would wish to retain the GR funding so we can be more aggressive in serving these 6,700. DHSS included the savings generated on the fiscal estimate worksheet.

As a result of working adults age 19 to 65 (whose income level is up to 225 percent of poverty) obtaining insurance coverage through MO HealthNet, DCPH assumes this legislation would result in a cost savings to the Adult Genetics Program, which includes the metabolic formula program. The adult programs (cystic fibrosis, hemophilia, and sickle cell disease) are for any Missouri resident age 21 and older who is at 185 percent of poverty or below. Metabolic formula coverage is for any Missouri resident regardless of age; for adult coverage, the maximum poverty level is 185 percent. For the first eight months in FY 2008, the program has served 30 adults at a cost of $30,477 for cystic fibrosis, hemophilia, and sickle cell disease; and 29 adults at a cost of $93,250 for metabolic formula. There are three adults with hemophilia and one with metabolic formula coverage who are age 65 or over and would not qualify under this legislation. Payments on these three adults over the age 65 with hemophilia total $4,431 and metabolic payments total $6,568. Since adults will not be covered Insure Missouri Program they are subtracted from the estimated cost savings of the program. For the eight month period through February 2008 savings are estimated at $112,728 ($30,477 + $93,250 - $4,431- $6,568 = $112,728). It is assumed that all being served could qualify based on conditions specified in the bill. If all adults currently being served were to obtain insurance through MO HealthNet, there would be an estimated $169,092 ($112,728 cost of program for eight month period/8 months X 12 months) savings in General Revenue for a full twelve-month period. If no adults served by the program obtain coverage through MO HealthNet, there would be no savings realized in this program.

ASSUMPTION (continued)

Division of Regulations and Licensure (DRL):
Section 191.1001.3 - Requires DHSS to include a link on its web site to any organization that provides quality of care data if the organization requests that we include a link. It also requires the DHSS by January 1, 2009 to either provide through its web site, or through a link, the Medicare fee schedule for all providers, and for each hospital, the Medicare diagnosis-related-group payment for each code.

Per ITSD, there would be no fiscal impact to publish links on the DHSS website or to post fee schedules on the website via PDF files.

Section 191.1008.3(1) - Requires DRL to investigate complaints of alleged violations of this section by any person or entity other than a health carrier. If the complaint were against an individual, DRL would have no authority. These complaints would need to be handled by the Board of Healing Arts or the Board of Nursing. Complaints against an entity could also include types of health care settings that are not currently under the regulatory charge of DHSS such as physician's offices, clinics, etc. The violations referred to in this section do not seem to be clinical or regulatory in nature. Instead, they appear to be concerned more with data disclosure.

The DHSS, DRL is not able to determine how many complaints would be received that would require investigation, therefore we are unable to determine the fiscal impact of this section. DHSS are assumes the fiscal impact to be unknown.

Officials from the **Department of Insurance, Financial Institutions & Professional Registration** estimates approximately 109 insurers would be required to submit amendments to their policies to comply with legislation. Policy amendments must be submitted to the Department for review along with a $50 filing fee. One-time additional revenues to the Insurance Dedicated Fund are estimated to be $5,450.

Additional staff and expenses are not being requested with this single proposal, but if multiple proposals pass during the legislative session that require policy form reviews, the DIFP will need to request additional staff to handle the increase in workload.

DIFP assumes existing appropriation will cover the creation of the website link as described in 191.1001. However, should additional appropriation be necessary the Department will request it, in conjunction with OA-ITSD, through the regular budget process.

ASSUMPTION (continued)

DIFP assumes that the appeals process outlined in 191.1010 will be contracted. The Department currently contracts out a similar review/appeal process that is used on an as needed basis and is billed based on an hourly rate. If the cost of contracting exceeds what existing appropriation can absorb, additional authority will be requested.

DIFP states in tax year 2006, $1,339,809,506 in premium was written by health insurers in the state. Two percent of that amount, $26,796,190 was collected in premium tax. These health insurers also wrote insurance in other lines of business. The total amount of tax credits taken by these health insurers in tax year 2006 was $54,174,527. Taking a proportion of the health insurance premium to total premium written by these insurers, $14,420,286 was deducted from the total premium collected. The net premium tax collected from health insurers in 2006 was $12,375,904. Premium tax is split 50/50 between General Revenue and the County Foreign Insurance Fund, which is later distributed to schools. The legislation proposes diverting 50% of the total premium collected from health insurers to the Missouri Health Insurance Pool in 2009 and 2010. 100% of the amount would be diverted in 2011.

Currently all health insurers in the state are assessed for any operational shortfall in the Missouri Health Insurance Pool. The health insurers are then allowed to take a credit against premium tax for this assessment. This credit would cease to exist if the legislation is passed. The assessment in tax year 2006 was $5,846,937.

The total cost to the Missouri Health Insurance Pool under the stop-loss provisions of the proposal are currently unknown.

Officials from the **Department of Elementary and Secondary Education (DESE)** states during FY 2007, the county foreign insurance fund received $97,168,230 which was distributed to the local school districts throughout the state. DESE assumes, in accordance with section 148.380, the general revenue fund also received $97,168,230. Therefore, DESE assumes the state received a total of $194,336,460 as a result of insurance premium taxes.

This proposal would take 50% of these premium taxes for FY 2009 and 2010 and distribute them to the health insurance pool. For FY 2011 and every year thereafter, 100% of the premium taxes collected would be distributed to the health insurance pool.

Oversight assumes the $97,168,230 included in the DESE response was all income deposited into the County Foreign Insurance Fund and not limited to the health related income. Therefore, Oversight assumes the fiscal impact to the local school districts is $6,187,952 in FY09 & FY10 and $12,375,906 in FY11.

ASSUMPTION (continued)

Officials from the **Department of Social Services - Division of Legal Services (DSS-DLS)** assumes since the Department will be making determinations as to income and other eligibility factors under Medicaid waivers, these persons will be given a right to a hearing if they do not agree with the decision.

It is assumed that a benefits hearing officer can handle 900 hearings per year. Therefore, it is assumed that by full implantation in FY14, a fiscal impact of 1 hearing officer at that time, but no fiscal impact by FY11.

Oversight assumes the DSS-DLS could absorb one hearing officer FTE.

Officials from the **Department of Social Services - Family Services Division (DSS-FSD)** states the following:

Based on information gathered from 2006 Census Bureau, and if funds were appropriated to cover this at 100%, FSD has determined there would be 201,188 new participants for this program. These participants would be phased in over a period of six years, as outlined below.

The FSD fiscal note is based on determining the income eligibility only. The cost to manage the health care accounts, determining the amount of the cost share for each person, and determining at which point benefits will become available after the cost share is met will be funded through MO HealthNet Division's fiscal note and budget.

To manage the new caseload, FSD will use a variety of methods, such as a call center or other automated services. To project a cost to implement these methods FSD is using the cost of staff to mange the caseload. However, the funding will be used to implement new methods to manage the increase in caseload.

PHASE I:
The first phase, to be implemented 7/1/08, would provide health care for 42,222 custodial parents. These are custodial parents already known to FSD as their children are currently receiving MO HealthNet benefits. FSD would not see an increase in caseload size due to these participants.

FSD estimates FAMIS cost of 3000 hours @ blended rate of $89/hour to coordinate with the Missouri Health cabinet to engage in any activities that will implement improved collaboration of agencies in order to create, manage, and promote coordinated policies, programs and

ASSUMPTION (continued)

service-delivery systems that support improved health outcomes. Total FAMIS cost estimated $267,000 (3000 hours x $89/hour). This cost would be incurred as a one-time cost for the first phase.

PHASE II:
The second phase, to be implemented 7/1/09, would provide health care for 32,876 non-custodial parents under 100% FPL. The 12,278 custodial parents are already known to FSD as their children are currently receiving MHN benefits. FSD would not see an increase in caseload size due to these participants.

Based on 32,876 additional cases, and a 243 caseload standard, FSD would need 135 new Eligibility Specialists (32,876/243 = 135).

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 14 new Eligibility Supervisors (135/10 = 13.5, rounded up to 14).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Clerical Staff, we would need an additional 25 clerical staff, with 19 OSA and 6 SOSA. (135+ 14 = 149 ÷ 6 = 24.83, rounded up to 25. 25 x 75% = 19 OSA; 25 - 19 = 6 SOSA.

Total new FTE for 2nd phase: 135 + 14 + 25 = 174

PHASE III:
The third phase, to be implemented 1/1/2011, would provide health care to 26,724 adults. FSD anticipates that 50% of these would be custodial parents and known to FSD. 26,724 x 50% = 13,362. There would be 13,362 new cases.

Based on 13,362 additional cases, and 243 caseload standard, FSD would need 55 new Eligibility Specialists (13,362 /243 = 54.98, rounded up to 55).

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 6 new Eligibility Supervisors (55/10 = 5.5, rounded up to 6).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Professional Staff, we would need an additional 16 professional support staff, with 12 OSA and 4 SOSA. (55 + 6 = 61 ÷ 6 = 10.16 rounded down to 10. 10 x 75% = 7 OSA; 10-7 = 3 SOSA.

Total new FTE for 3rd phase: 55 + 6 + 10 = 71

ASSUMPTION (continued)

PHASE IV:
The fourth phase, to be implemented 1/1/2012, would provide health care to 23,221 adults. FSD anticipates 50% of these would be custodial parents and known to FSD. 23,221x 50% = 11,610.5. There would be 16,611 new cases.

Based on 11,611 additional cases, and 243 caseload standard, FSD would need 48 new Eligibility Specialists (11,611/243 = 48).

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 7 new Eligibility Supervisors (48/10 = 4.8, rounded up to 5).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Professional Staff, we would need an additional 14 professional support staff, with 11 OSA and 3 SOSA. (48 + 5 = 53 ÷ 6 = 8.833 Rounded to 9 9 x 75% = 7 OSA; 9-7 = 2 SOSA.

Total new FTE for 4th phase: 48 + 5 + 9 = 68

PHASE V:
The fifth phase, to be implemented 1/1/2013, would provide health care to 47,353 adults. FSD anticipates 50% of these would be custodial parents and already known to FSD. 47,353 x 50% = 23,677. There would be 23,677 new cases.

Based on 23,677additional cases, and 243 caseload standard, FSD would need 97 new Eligibility Specialists.

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 10 new Eligibility Supervisors (97/10 = 9.7).

On a ratio of 6-1 Eligibility Specialist/Supervisor to Professional Staff, we would need an additional 18 professional support staff, with 14 OSA and 4 SOSA. (97 + 10 ÷ 6 = 17.8. Rounded up to 18 x 75% = 14 OSA; 18-14 = 4 SOSA.

Total new FTE for the 5th phase: 97 + 10 + 18 = 125

PHASE VI:
The sixth phase, to be implemented 1/1/2014, would provide health care to 16,514 adults. FSD anticipates 50% of these would be custodial parents and known to FSD. 16,514 x 50% = 8,257. There would be 8,257new cases.

ASSUMPTION (continued)

Based on 8,257additional cases, and 243 caseload standard, FSD would need 34 new Eligibility Specialists.

On 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 3 new Eligibility Supervisors (34/10 = 3.4, rounded down to 3).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Professional Staff, we would need an additional 10 professional support staff, with 8 OSA and 2 SOSA. (34+ 3 ÷ 6 = 6.16 rounded down to 6. 10 x 75% = 5 OSA; 6-5 = 1 SOSA.

Total new FTE for the 6th phase: 34 + 3 + 6 = 43

Total Cost:
The total cost by phase by fiscal year if implemented with staff or staff equipment is $267,000 for FY09, $9,664,892 for FY10 and $10,841,707 for FY11.

However, the Division believes that with the implementation of a call center at $6,078,049 annually with a one-time start-up cost in FY 09 of $1,487,069 and investing 20% of the staffing cost into technology, the Division can absorb these cases with existing staff. Therefore the Division is projecting the following fiscal: $1,754,069 for FY09, $8,011,027 for FY10 and $8,246,390 in FY11.

Officials from the **Department of Social Services -MO HealthNet Division (DSS-MHD)** states the following:

The MHD will incur costs to establish a quality review process to establish consumer protection standards, to receive participant grievances and appeals, and to create reports regarding performance and consumer experience and cost. MHD will also incur costs to apply for the Section 1115 demonstration waiver with the requirements set forth in the proposal. MHD estimates that these requirements will cost about $500,000 annually.

CON (Section 197.310):
This section is revised to change the makeup of the Missouri Health Facilities Review and the function of the committee is modified. This legislation does not change what health care facilities or services would be approved or disapproved; therefore the MO HealthNet assumes no impact.

ASSUMPTION (continued)

Transparency in Pricing and Quality Information:
This legislation will have a fiscal impact to the MO HealthNet Division. MHD will have costs for a contractor to collect, compile, evaluate and compare the quality of care data. The costs for a contractor are unknown, but greater than $250,000.

Insure Missouri program (Section 148.380, Section 376.962 through 376.991 and Sections 1 through 8):
Number of Participants - This legislation provides health care coverage for adults up to 225% of the federal poverty level (FPL). Custodial Parents Under 85% of FPL - 40,550; Non-Custodial Adults Under 85% of FPL - 24,461; Adults from 86% to 125% of FPL - 44,571; Adults from 125% to 150% of FPL - 22,302; Adults from 150% to 200% of FPL - 45,477; Adults from 200% to 225% of FPL - 15,860; Uninsurable Adults up to 225% (High Risk Pool) - 4,024; Transitional Coverage - 4,024

Custodial parents below 100% of the FPL were determined from the number of parents who had earned income with children covered by MO HealthNet for Kids. The remaining participants are based on 2006 Census Bureau estimates of the number of uninsured in Missouri that were working. Approximately 53% of the uninsured are estimated to be non-custodial adults. To determine the number of non-custodial adults below 100% of the FPL, the Census Bureau estimate of working uninsured below 100% of the FPL was multiplied by 53%. The proportional relationship of custodial parents below 100% of FPL was used to allocate non-custodial adults below 85% of FPL and between 85% and 100% of FPL. The other categories of adults are based on actual Census Bureau estimates for each of the percent of poverty ranges. Custodial and non-custodial adults between 86% and 100% are included with the 100% to 125% group. All categories of participants have been reduced by 2% to reflect the number of participants it is assumed would not qualify for Insure Missouri because they are uninsurable. These individuals would be covered by the High Risk Pool. There are 201,187 Insure Missouri including 4,024 high risk pool participants.

The bill provides for transitional benefits for participants in the program once their income is above 225% of FPL. This benefit is afforded to those participants without a break in services at the same premium rates established for Insure Missouri. All costs of premiums are the responsibility of participants in the transitional program. Costs were included to recognize a transitional benefit for participants up to 225% of FPL as participants are phased-in until 2014. For example the fiscal note estimates that on January 1, 2011 coverage will include adults up to 125% of FPL. However, if income increased to 130% of FPL before the next phase-in the potential exists that coverage would be suspended until the Insure Missouri phase-in schedule

ASSUMPTION (continued)

reached 150% of FPL on January 1, 2012. It was assumed that 2% of current participants would be in transition after 12 months on Insure Missouri. Of this amount 70% were assumed to be below 225% of FPL and costs are included in the fiscal note. The remaining 30% would be above 225% of FPL and no costs are included.

No costs have been included in this fiscal note for the uninsurable above 225% of FPL, for individual stop-loss coverage (section 376.981) or the two year small employer pilot project (section 376.983).

Costs are based on a distribution of claims by size of claim. Average claim amounts for each distribution group were multiplied by the percentage distribution and the number of estimated participants. Additional costs for pregnancy-related services are recognized for pregnant women between 185% and 225% of FPL. Pregnant women below 185% of FPL are covered by MO HealthNet. Claim amounts were reduced to reflect the provision of preventive care to the participant. The proposal allows for $300 of preventive care and two physician visits per year to be provided at no cost to the participant. We used the average claim amount of $253 from the claim grouping "less than $500". It was assumed due to the low cost, these claims represented preventive care. It was further assumed that on average, not all participants would use the full $300 and the $253 represented a good estimate of preventive care. Claims below $500 would not include a second physician visit. For participants with claims above $500 an additional $100 in preventative care was included to recognize the additional physician visit, bringing the cost to $353.

An example of the calculation using the $500 to $1,000 claim group follows:

- People in this group had 11.71% of all claims.
- The average claim for this group was $799.
- When reduced by the cost of preventive care, the remaining cost of $446 was multiplied by each participant's group.
- This means the formula is: 40,550 custodial parents below 85% of FPL x 11.71% x $446 = $2,117,789 in cost to be shared between the insured and the state/federal governments. The total per member per year cost is $3,896, or $325 per month for non-pregnant women categories. The total per member per year cost for the high risk pool participants is $9,739 or $812 per month.

Distribution of Costs between Insured and State/Federal Governments-All adults are required to contribute to an Insure Missouri Account based on the individual's annual income range. If the participant's required contribution is less than the amount required to cover deductibles or co-pays, the state and federal governments will make up the difference. The contribution by the

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participant is based on the lowest percentage of poverty for each group. See the table below for participant contribution amounts. (The contribution by the adults below 100% of FPL is based on 50% of FPL).

Calculations were based on a family size of 2. An adult in the 100% to 125% of FPL group would be expected to pay on average $274 per year. The cost of health services (after providing preventive care up to $300 and two physician visits) are paid for by the participant up to the $274 in this example. Costs above that amount would be paid by the state and federal governments.

The total cost for the insured and the state/federal governments is presented in the table below. Costs are shown cumulatively based on the implementation dates including 6.15% inflation per year. The inflation is based on the Center for Medicare and Medicaid National Health Expenditure Index. The following take-up rates were used: 1) custodial parents below 85%-100% take-up, 2) custodial parents between 85% and 100%-100% take-up, 3) childless adults below 85%-85% take-up, 4) childless adults between 85% and 100%-85% take-up, and 5) all other categories-65% take-up.

The cost to the insured has been reduced by the amount of SCHIP premium collections. The bill allows the insured to reduce the contribution to the Health Care Account by payments made to MO HealthNet, SCHIP and Medicare. This will require an offset for the SCHIP premiums to be paid by the state. No payments were considered for MO HealthNet or Medicare. The cost of the insured has also been adjusted to recognize the federal 5% of income cost sharing limit. When determining the annual contribution to the health care account three scenarios were considered: 1) the household has one adult, 2) the household has two adults and one adult is uninsured, and 3) the household has two adults and both are uninsured. For the first two categories the 5% limit is not applicable. However, for households with two uninsured adults, two separate contributions to the health care account would, in some cases, exceed the federal 5% limit. The cost estimate assumes 32.1% of the working uninsured with a health care account are in a household of one. For households with two adults, 39.6% had one uninsured adult. In 28.3% of the households, both adults were uninsured. The distribution of two-adult households is based on a 1996 Census Bureau medical expenditure panel survey (MEPS).

The fiscal impact is $151,365,582 in FY09, $281,069,452 in FY10 and $396,543,322 in FY11.

In response to a similar proposal from this year (HB 2398), officials from the **Office of the Missouri Governor** and the **Missouri House of Representatives** each assume the proposal would have no fiscal impact on their respective agencies.

FISCAL IMPACT - State Government	FY 2009 (10 Mo.)	FY 2010	FY 2011
GENERAL REVENUE FUND			
Savings - Department of Mental Health			
Program Savings	Unknown	Unknown	Unknown
Savings - Department of Health and Senior Services			
HIV/AIDS Program Savings	$2,219,609	$2,247,792	$2,247,792
Costs - Department of Health and Senior Services			
Personal Services	($14,517)	($35,886)	($36,962)
Fringe Benefits	($6,570)	($16,242)	($16,729)
Equipment and Expense	($10,387)	($17,472)	($14,184)
Section 191.1008.3(1)	(Unknown)	(Unknown)	(Unknown)
Total Costs - DHSS	(Unknown but Greater than $31,474)	(Unknown but Greater than $69,600)	(Unknown but Greater than $67,875)
FTE Change - DHSS	1.08 FTE	1.08 FTE	1.08 FTE
Costs - Department of Insurance, Financial Institutions & Professional Registration			
Decrease in Tax Collections	($3,093,976)	($3,093,976)	($6,187,953)
Costs - Department of Social Services			
Program Costs - FSD	($957,680)	($4,335,131)	($4,452,813)
Program Costs - MHD	(Unknown but Greater than $250,000)	(Unknown but Greater than $250,000)	(Unknown but Greater than $250,000)
Program Costs - MHD Contractor	(Unknown but Greater than $104,125)	(Unknown but Greater than $375,000)	(Unknown but Greater than $375,000)
Program Costs - MHD Insure Missouri	($46,800,000)	($46,800,000)	($46,800,000)
Total Costs - DSS	(Unknown but Greater than $48,111,805)	(Unknown but Greater than $51,760,131)	(Unknown but Greater than $51,877,813)

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**(Unknown but Greater than $49,017,646)**	**(Unknown but Greater than $52,675,915)**	**(Unknown but Greater than $55,885,849)**
Estimated Net FTE Change for General Revenue Fund	1.08 FTE	1.08 FTE	1.08 FTE
INSURANCE DEDICATED FUND			
Income - Department of Insurance, Financial Institutions & Professional Registration			
Filing Fee	$5,450	$0	$0
ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND	**$5,450**	**$0**	**$0**
FEDERAL REIMBURSEMENT ALLOWANCE FUND			
Costs - Department of Social Services			
Program Costs - MHD Insure Missouri	($9,205,265)	($57,195,697)	($99,921,029)
ESTIMATED NET EFFECT ON FEDERAL REIMBURSEMENT ALLOWANCE FUND	**($9,205,265)**	**($57,195,697)**	**($99,921,029)**

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
COUNTY FOREIGN INSURANCE FUND			
Costs - Department of Insurance, Financial Institutions & Professional Registration			
Decrease in Tax Collections	($3,093,976)	($3,093,976)	($6,187,953)
ESTIMATED NET EFFECT ON COUNTY FOREIGN INSURANCE FUND	**($3,093,976)**	**($3,093,976)**	**($6,187,953)**
MISSOURI HEALTH INSURANCE POOL			
Incomes - Department of Insurance, Financial Institutions & Professional Registration			
Tax Collections	Unknown	Unknown	Unknown
Costs - Department of Insurance, Financial Institutions & Professional Registration			
Program Costs	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON MISSOURI HEALTH INSURANCE POOL	**Unknown to (Unknown)**	**Unknown to (Unknown)**	**Unknown to (Unknown)**

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
FEDERAL FUNDS			
Savings - Department of Mental Health			
Program Savings	Unknown	Unknown	Unknown
Savings - Department of Health and Senior Services			
Federal Assistance	$6,267,582	$6,306,934	$6,305,810
Savings - Department of Social Services			
Federal Assistance	Unknown but Greater than $96,510,832	Unknown but Greater than $181,374,651	Unknown but Greater than $254,240,871
Costs - Department of Health and Senior Services			
Personal Services	($12,366)	($30,569)	($31,486)
Fringe Benefits	($5,597)	($13,836)	($14,251)
Equipment and Expense	($8,849)	($14,884)	($12,081)
Other Costs	($4,670)	($11,545)	($11,892)
Program Costs	($6,236,100)	($6,236,100)	($6,236,100)
Total Costs - DHSS	($6,267,582)	($6,306,934)	($6,305,810)
FTE Change - DHSS	.92 FTE	.92 FTE	.92 FTE
Costs - Department of Social Services			
Program Costs - FSD	($796,390)	($3,675,896)	($3,793,578)
Program Costs - MHD	(Unknown but Greater than $250,000)	(Unknown but Greater than $250,000)	(Unknown but Greater than $250,000)
Program Costs - MHD Contractor	(Unknown but Greater than $104,125)	(Unknown but Greater than $375,000)	(Unknown but Greater than $375,000)
Program Costs - MHD Insure Missouri	($95,360,317)	($177,073,755)	($249,822,293)
Total Costs - DSS	(Unknown but Greater than $96,510,832)	(Unknown but Greater than $181,374,651)	(Unknown but Greater than $254,240,871)

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**Unknown**	**Unknown**	**Unknown**
Estimated Net FTE Change for General Revenue Fund	.92 FTE	.92 FTE	.92 FTE

FISCAL IMPACT - Local Government	FY 2009 (10 Mo.)	FY 2010	FY 2011
POLITICAL SUBDIVISIONS			
Losses - School Districts			
Loss of Insurance Premium Taxes	($6,187,952)	($6,187,952)	($12,375,906)
ESTIMATED NET EFFECT ON POLITICAL SUBDIVISIONS	**($6,187,952)**	**($6,187,952)**	**($12,375,906)**

FISCAL IMPACT - Small Business

Physicians that operate as small businesses could be economically impacted.

Small businesses that currently provide insurance for their employees may opt to discontinue that provision with the availability of Insure Missouri. Also, small businesses who are health care providers may see a decrease in the number of delinquent accounts and an increase in the amount of reimbursement received, as more Missourians are able to obtain coverage through the program.

FISCAL DESCRIPTION

The proposed legislation changes the laws regarding the Missouri Health Insurance Pool and establishes the Insure Missouri Program to provide health insurance to certain low-income adults.

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FISCAL DESCRIPTION (continued)

MISSOURI HEALTH INSURANCE POOL:
This legislation increases the lifetime benefit cap for an individual covered under the Missouri Health Insurance Pool (MHIP) from $1 million to $2 million.

This legislation reduces the pre-existing condition waiting period from 12 months to six months.

This legislation requires the pool to offer stop-loss coverage for any insurer in the private individual health insurance market to cover claim liability for an insured person who becomes uninsurable or an uninsurable dependent and to establish a two-year pilot program that offers small group stop-loss coverage to stabilize small group premiums when risks associated with specific individuals under a small group policy would result in increased premiums for the entire group. The MHIP board is required to submit a report to the General Assembly by January 1, 2011, regarding the pilot program and any recommendations to expand the program statewide. This legislation allows the MHIP board to establish a premium subsidy program for low-income individuals.

This legislation requires the pool, beginning July 1, 2008, to offer at least one plan that meets the criteria of the federal Centers for Medicare and Medicaid for uninsurable individuals eligible under the Insure Missouri Program.

This legislation establishes premium rates for health insurance coverage through the pool. For individuals with incomes of less than 300% of the federal poverty level, the premium will be equal to the standard risk rate. For individuals with incomes of 300% or more of the federal poverty level, the premium will be a sliding scale rate based on his or her income of between 100% and 125% of the standard risk rate.

This legislation specifies that any licensed insurance agent or broker who sells a health insurance policy offered under the pool to an eligible individual will receive a commission for the sale equal to 1% of the premium.

This legislation eliminates insurer assessments under the pool and distributes premium taxes currently collected from insurers offering health-related insurance products to the pool beginning January 1, 2009.

INSURE MISSOURI PROGRAM:
This legislation establishes the Insure Missouri Program within the Department of Social Services to provide health care coverage to low-income working Missourians.

FISCAL DESCRIPTION (continued)

This legislation requires the Department to apply to the United States Department of Health and Human Services for a waiver and/or a Medicaid state plan amendment to develop and implement the program and to submit the proposed application to the Joint Committee on MO HealthNet for its review and recommendations.

This legislation specifies that the program is not an entitlement program for noncustodial parents, custodial parents, or other participants with incomes over 85% of the federal poverty level. The maximum enrollment of program participants is dependent on the moneys appropriated by the General Assembly, and eligibility for the program can be phased in incrementally based on appropriations.

This legislation requires the Department to establish certain specified standards for consumer protection.

This legislation requires the program to pay 100% of the premium costs for participants, except for transitional program participants.

This legislation specifies eligibility requirements for program participants and requires them to be subject to approval by the United States Department of Health and Human Services.

This legislation specifies covered, medically necessary services and that the program can include incentives designed to promote and encourage healthy lifestyles.

This legislation establishes a health care account for each eligible individual into which payments for his or her participation can be made by the individual, an employer, the state, or any philanthropic or charitable contributor. The account will be used to pay the individual's deductible under the program.

This legislation specifies that an individual's participation in the program does not begin until the participant makes an initial payment of at least one-twelfth of the annual required payment.

This legislation specifies that a participant's annual required payment is the lesser of $1,000 less any payments under the Mo HealthNet Program, the Children's Health Insurance Program, and the federal Medicare Program or a certain percentage of his or her household income.

This legislation requires the state to contribute the difference to the participant's account if his or her annual required payment is less than $1,000.

FISCAL DESCRIPTION (continued)

This legislation specifies that a participant can be terminated from participation in the plan if his or her required payment is not made within 60 days after the required date. Written notice must be given before a participant can be terminated from the plan.

This legislation specifies that approved participants are eligible for a 12-month period but must file a renewal application to remain in the program.

This legislation specifies that an eligible individual who participates in the program without a break in service and has an income exceeding 225% of the federal poverty level at the time of renewal will be eligible for transitional participation in the program. Transitional participants will be eligible for coverage under the premium rates established for the program, but will be responsible for payment of the entire premium.

This legislation requires any moneys remaining in the health care account to be used to reduce the participant's payments for the subsequent program period if the individual renews his or her participation.
The Division must refund any amount remaining in the health care account less any healthy lifestyles incentive moneys to a participant who is no longer eligible, has not renewed participation, is terminated from the program, or is a transitional participant.

This legislation specifies how health insurance coverage will be obtained for approved program participants.

This legislation prohibits the deductible for any qualified plan under the program from exceeding $2,500.

This legislation specifies that any licensed insurance agent or broker who sells a health insurance policy offered under the Missouri Health Insurance Pool (MHIP) to an individual eligible for the program will receive a commission equal to 1% of the premium.

This legislation requires the Department, in consultation and coordination with the Department of Insurance, Financial Institutions, and Professional Registration and the board of directors for the MHIP, to ensure that eligible participants are able to obtain health insurance coverage through licensed insurance agents and brokers.

Certain provisions regarding the MHIP become effective January 1, 2009.

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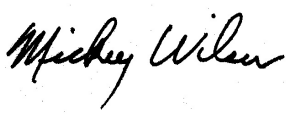
FISCAL DESCRIPTION (continued)

The legislation contains an emergency clause.

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Office of the Attorney General
Office of the State Courts Administrator
Department of Elementary and Secondary Education
Department of Insurance, Financial Institutions & Professional Registration
Department of Mental Health
Department of Health and Senior Services
Department of Revenue
Department of Social Services
Office of the Missouri Governor
Missouri Health Facilities Review Committee
Missouri House of Representatives
Missouri Senate
Office of the Secretary of State
Office of Prosecution Services



Mickey Wilson, CPA
Director
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