COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5477-01
Bill No.: HB 2398
Subject: Health Care; Medicaid, Social Services Department; Insurance-Medical
Type: Original
Date: April 2, 2008

Bill Summary: This legislation establishes the Insure Missouri Plan to provide insurance coverage to 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 $48,821,831)	(Unknown but Greater than $51,536,738)	(Unknown but Greater than $51,657,865)
Total Estimated Net Effect on General Revenue Fund	**(Unknown but Greater than $48,821,831)**	**(Unknown but Greater than $51,536,738)**	**(Unknown but Greater than $51,657,865)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 26 pages.

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
State School Moneys Fund*	$0	$0	$0
Insurance Dedicated Fund	$5,450	$0	$0
Federal Reimbursement Allowance Fund	($30,984,784)	($85,651,667)	($114,754,946)
Total Estimated Net Effect on Other State Funds	**($30,979,334)**	**($85,651,667)**	**($114,754,946)**

*Unknown savings and losses would net to $0.

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	3.08 FTE	3.08 FTE	3.08 FTE
Federal	.92 FTE	.92 FTE	.92 FTE
Total Estimated Net Effect on FTE	**4 FTE**	**4 FTE**	**4 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	**Unknown**	**Unknown to (Unknown)**	**Unknown to (Unknown)**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Missouri House of Representatives**, **Office of the Missouri Governor**, **Missouri Senate** and the **Office of the State Courts Administrator** each assume the proposal would have no fiscal impact on their respective agencies.

Officials from the **Office of the Attorney General (AGO)** states that the AGO 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 **Missouri Health Facilities Review Committee (MHFRC)** assume the proposal could result in a change from the way Certificate of Need (CON) meetings are now conducted to more of a judicial process where applicants would be placed under oath when testifying before the MHFRC. It would also change the structure of the MHFRC and eliminate ex parte contact.

ASSUMPTION (continued)

Under the new judicial process, the length of CON meetings could increase substantially resulting in the need to conduct meetings more frequently, perhaps on a monthly basis. This would result in additional travel expenses. A new clerical position would be needed to make travel arrangements, process expense vouchers, and prepare meeting materials.

Finding meeting space for additional meetings could be problematic so there would be an added cost to rent meeting rooms. Currently the MHFRC conducts its meetings in the Capitol building at no cost. Under the new process, a new attorney would be required on staff to process subpoenas, place witnesses under oath, and assure legal procedure compliance. There would be additional costs for a court reporter, because under the judicial process, it would be necessary to have a transcript made of each meeting.

MHFRC expects that there would be more public hearings held in local communities to provide an opportunity for residents to comment on a project. This would also result in additional travel expenses for Committee members and staff.

MHFRC does not anticipate a change to the number of applications which would be filed or the amount of applications fees going in to General Revenue.

The MHFRC fiscal impact includes: One new Office Support Assistant (clerical) $20,748, One staff attorney $45,000, travel (attorney) $5,000, four additional CON meetings/year $6,400 and meeting rooms $750.

Officials from the **Department of Elementary and Secondary Education (DESE)** assume there is no state cost to the foundation formula associated with this proposal. Should the new crimes and amendments to current law result in additional fines or penalties, DESE cannot know how much additional money might be collected by local governments or the Department of Revenue to distribute to schools. To the extent fine revenues exceed 2004-2005 collections, any increase in this money distributed to schools increases the deduction in the foundation formula the following year. Therefore, the affected districts will see an equal decrease in the amount of funding received through the formula the following year; unless the affected districts are hold-harmless, in which case the districts will not see a decrease in the amount of funding received through the formula (any increase in fine money distributed to the hold-harmless districts will simply be additional money). An increase in the deduction (all other factors remaining constant) reduces the cost to the state of funding the formula.

ASSUMPTION (continued)

Oversight notes that local school districts would see an increase in fine revenue as a result of this proposal. As stated by DESE, this fine revenue would be a deduction the next year for some of the school districts. Oversight assumes an unknown amount of revenue would be realized each year by school districts and a corresponding decrease in school funding from the state the following year. Oversight assumes the fine revenue will fluctuate from year to year, therefore, the net fiscal impact to local school districts from FY 2009 on could be Unknown to (Unknown).

Officials from the **Department of Mental Health** states the proposal would provide a medical assistance program 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 Insurance, Financial Institutions & Professional Registration (DIFP)** estimates 109 insurers would be required to submit amendments to their policies to comply with the legislation. Policy amendments must be submitted to the DIFP for review along with a $50 filing fee. One-time additional revenues to the Insurance Dedicated Fund are estimated to be up to $5,450 (109 insurers X $50).

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.

Officials from the **Department of Health and Senior Services (DHSS)** states the following:

Division of Regulations and Licensure (DRL):
Section 376.1460 - Requires the DHSS to promulgate rules regarding the use of "switch communications" by health benefit plans. DHSS, DRL currently has no involvement with regulation of health benefit plans and no expertise regarding "switch communications". If regulation of switch communications by health benefit plans were to be undertaken by the DRL, the fiscal impact to do so is unknown, greater than $100,000 at this time.

Division of Senior and Disability Services (DSDS):
Sections 208.1306.1 to .3 - Defines the services covered by the "Insure Missouri" program. The program will cover specified medically necessary services in the manner and extent determined by the MO HealthNet division.

ASSUMPTION (continued)

Section 208.1306.2 (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 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 208.1303 - 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.

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 - Information Technology Services Division (DSS-ITSD)** assumes the following fiscal impact to the Division:

Legacy Costs: Contractors: 7896 hours X $75 per hours	=	$592,200
FAMIS Costs: Contractors: 1360 hours X $89 per hours	=	$121,040
Total	=	$713,240

ASSUMPTION (continued)

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 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).

ASSUMPTION (continued)

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

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).

ASSUMPTION (continued)

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.

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.

ASSUMPTION (continued)

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:

Section 197.310 to 197.330 Missouri Health Facilities Review Committee:
The changes will not result in a fiscal impact to MO HealthNet Division.

Section 208.955 MO HealthNet Oversight Committee:
The number of members of the committee is increased from 18 to 22 and the composition is defined. Based on historical cost of expenses reimbursed to committee members the annual cost per member is $175. Since it is a minimal amount, MHD will absorb the cost. Therefore, there is no fiscal impact.

Subsection 208.955.2(12) is new adding to the committee's functions the approval of health insurance plans for the Insure Missouri plan established under Sections 376.1300 and 376.1345, RSMo. There will be no fiscal impact to this provision.

Section 208.1303.5 MO HealthNet to Establish Quality Review and Section 208.1345 Section 1115 Demonstration Waiver:
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.

ASSUMPTION (continued)

Section 376.1460 Drug Switch Communication:
Section 1 defines "switch communication" as a communication that recommends a patient's medication be switched to a different medication than originally prescribed. It does not require switch communications to be sent by health benefit plans, it just requires DHSS to promulgate regulations governing those switch communications that are made. The definition also states that the "switch communication" is a recommendation, not that the "switch" has been made.

The remainder of section 2, as well as section 3 discusses the requirements for the switch communication.

MO HealthNet fee for service is not included as a health benefit plan or health carrier under chapter 376, but MHN Managed Care plans are included.

The communication requirements in subsection 2 and 3 would likely result in a cost to the plan, which could in turn result in a cost to the MHN Managed Care because plans may pass that cost along to the state when they re-bid their contracts.

The cost to the MHD would be unknown, but greater than $100,000.

Total cost for this legislation excluding Insure Missouri (Section 208.1300 to 208.1345) is:
FY09 Unknown > $600,000 ($286,819 GR); FY10 $600,000 ($286,819 GR); FY11 $600,000 ($286,819 GR).

Section 208.1303 - 208.1345 Insure Missouri:

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 - 41,378; Custodial Parents from 85% to 100% of FPL - 12,032; Childless Adults Under 85% of FPL - 24,960; Childless Adults from 85% to 100% of FPL - 7,258; Adults from 100% to 125% of FPL - 26,190; Adults from 125% to 150% of FPL - 22,757; Adults from 150% to 200% of FPL - 46,405; Adults from 200% to 225% of FPL - 16,183; Uninsurable Adults up to 225% (High Risk Pool) - 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 childless adults. To determine the number of childless adults below 100% of the FPL, the Census Bureau estimate of

ASSUMPTION (continued)

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 childless 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. 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. Total Insure Missouri participants including the 4,024 uninsurable adults are 201,187.

Calculation of Costs - 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. Claim amounts were reduced to reflect the provision of preventive care to the participant. The proposal allows for the first $500 of preventive care to be provided at no cost to the participant. MHD 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 $500 and the $253 represented a good estimate of preventive care.

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 $546 was multiplied by each participant's group.
- This means the formula is: 41,378 custodial parents below 85% x 11.71% x $546 = $2,645,569 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. The total per member per year costs for the high risk pool participants is $9,739, or $812 per month.

Distribution of Costs between Insured and State/Federal Governments - Participants above 85% of FPL are required to contribute to a health care account. We are assuming custodial parents below 85% of FPL are covered by a state plan and would be an entitlement. Contributions by participants covered by a state plan are limited to nominal copays. We are also assuming since childless adults below 85% of FPL are not required to contribute to a health care account they would pay nominal co-pays too. For both of these groups, copays of $25 per year were assumed. All other adults are required contribute to a Health Care Account based on the individuals annual income range. The maximum contribution is $1,000 per year. If the participant's required

ASSUMPTION (continued)

contribution is less than the $1,000 maximum, the state and federal governments will make up the difference. The contribution by the participant is based on the lowest percentage of poverty for each group.

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 $500) 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.

Total Cost - 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%-185% of 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 the 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 $210,229,145 in FY09, $357,977,479 in FY10 and $436,634,988 in FY11.

Officials from the **Office of Prosecution Services (OPS)** have not responded to Oversight's request for fiscal information.

FISCAL IMPACT - State Government	FY 2009 (10 Mo.)	FY 2010	FY 2011
GENERAL REVENUE FUND			
Savings - Department of Elementary and Secondary Education*			
Reduced appropriations to the State School Moneys Fund (from deduction of fine revenue from previous year)	$0	Unknown	Unknown
Savings - Department of Mental Health*			
Program Savings	Unknown	Unknown	Unknown
Savings - Department of Health and Senior Services**			
HIV/AIDS Program Savings	$2,078,700	$2,078,700	$2,078,700
Costs - Missouri Health Facilities Review Committee*			
Personal Services	($56,434)	($69,752)	($71,845)
Fringe Benefits	($24,955)	($30,844)	($31,770)
Equipment and Expense	($11,753)	($14,192)	($14,618)
Total Costs - MHFRC	($93,142)	($114,788)	($118,233)
FTE Change - MHFRC	2 FTE	2 FTE	2 FTE
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)
Program Costs	(Unknown but Greater than $100,000)	(Unknown but Greater than $100,000)	(Unknown but Greater than $100,000)
Total Costs - DHSS	(Unknown but Greater than $131,474)	(Unknown but Greater than $169,600)	(Unknown but Greater than $167,875)
FTE Change - DHSS	1.08 FTE	1.08 FTE	1.08 FTE

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
Costs - Department of Social Services*			
Program Costs - ITSD	($684,190)	$0	$0
Program Costs - FSD	($957,680)	($4,335,131)	($4,452,813)
Program Costs - MHD	(Unknown but Greater than $286,819)	(Unknown but Greater than $286,819)	(Unknown but Greater than $286,819)
Program Costs - MHD Insure Missouri	($46,800,000)	($46,800,000)	($46,800,000)
Total Costs - DSS	(Unknown but Greater than $48,728,689)	(Unknown but Greater than $51,421,950)	(Unknown but Greater than $51,539,632)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**(Unknown but Greater than $48,821,831)**	**(Unknown but Greater than $51,536,738)**	**(Unknown but Greater than $51,657,865)**
Estimated Net FTE Change for General Revenue Fund	3.08 FTE	3.08 FTE	3.08 FTE

*Oversight assumes costs will exceed savings.
**Oversight assumes DHSS savings and costs would net to $0.

FEDERAL REIMBURSEMENT ALLOWANCE FUND			
Costs - Department of Social Services			
Program Costs - MHD Insure Missouri	($30,984,784)	($85,651,667)	($114,754,946)
ESTIMATED NET EFFECT ON FEDERAL REIMBURSEMENT ALLOWANCE FUND	**($30,984,784)**	**($85,651,667)**	**($114,754,946)**

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
STATE SCHOOL MONEYS FUND			
Savings - Department of Elementary and Secondary Education			
Reduced distributions to local school districts	$0	Unknown	Unknown
Losses - Department of Elementary and Secondary Education			
Reduced appropriations from General Revenue Fund	$0	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON STATE SCHOOL MONEYS FUND	**$0**	**$0**	**$0**
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**

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 $133,582,991	Unknown but Greater than $229,514,898	Unknown but Greater than $279,186,810
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 - ITSD	($29,050)	$0	$0
Program Costs - FSD	($796,390)	($3,675,896)	($3,793,578)
Program Costs - MHD	(Unknown but Greater than $313,190)	(Unknown but Greater than $313,190)	(Unknown but Greater than $313,190)
Program Costs - MHD Insure Missouri	($132,444,361)	($225,525,812)	($275,080,042)
Total Costs - DSS	(Unknown but Greater than $133,582,991)	(Unknown but Greater than $229,514,898)	(Unknown but Greater than $279,186,810)

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			
Revenues - School Districts			
Income from fines	Unknown	Unknown	Unknown
Losses - School Districts			
Reduced distributions from State School Moneys Fund	$0	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON POLITICAL SUBDIVISIONS	**Unknown**	**Unknown to (Unknown)**	**Unknown to (Unknown)**

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 health care services and establishes the Insure Missouri Plan in the MO HealthNet Division within the Department of Social Services.

MISSOURI HEALTH FACILITIES REVIEW COMMITTEE:
Currently, the Missouri Health Facilities Review Committee for the Certificate of Need Program is composed of two members of the Senate, two members of the House of Representatives, and five members appointed by the Governor. The legislation changes the membership of the committee.

All members will be appointed by the Governor with the advice and consent of the Senate and serve a four-year term. No more than five members can be from the same political party.

For all hearings held by the committee:

This legislation requires all testimony and other evidence taken during the hearings to be under oath and subject to the penalty of perjury.

This legislation specifies that the committee can, upon a majority vote of the committee, subpoena witnesses and require the attendance of witnesses, the giving of testimony, and the production of records.

This legislation prohibits all ex parte communications between members of the committee and any interested party or witness regarding the subject matter of the hearing at any time prior to, during, or after the hearing.

This legislation requires any party opposing the issuance of a certificate of need to show by clear and convincing evidence that the need does not exist or that the new facility will cause a substantial and continuing loss of medical services within the affected region or community.

This legislation specifies that all committee hearings will be governed by rules adopted by the committee but not be bound by the technical rules of evidence.

This legislation authorizes the committee, upon a majority vote, to assess the costs of court reporting transcription or the issuance of subpoenas to one or both of the involved parties.

FISCAL DESCRIPTION (continued)

MO HEALTHNET OVERSIGHT COMMITTEE:
The legislation increases from 18 to 22 the number of members on the MO HealthNet Oversight Committee by adding two representatives of rural health clinics, one licensed podiatrist, and one licensed nurse.

The oversight committee is required to approve health insurance plans for the Insure Missouri Plan.

INSURE MISSOURI PLAN:
This legislation requires the Department of Insurance, Financial Institutions, and Professional Registration and the MO HealthNet Division within the Department of Social to oversee the marketing practices of the plan.

This legislation requires the Division to promote the plan, provide information to eligible individuals, ensure that enrollment is distributed throughout the state, and establish standards for consumer protection.

This legislation requires the plan to provide participants with a health care home.

This legislation specifies covered, medically necessary services.

This legislation requires the plan to provide, at no cost to a participant, $500 of qualifying preventative care services per year. The plan must consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services. Any additional preventative care services covered under the plan will be subject to the deductible and payment requirements of the plan.

This legislation specifies that at least 85% of the moneys appropriated by the General Assembly for the plan must be used to pay for health care services.

This legislation specifies that the plan 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 plan participants is dependent on the moneys appropriated by the General Assembly, and eligibility for the plan can be phased in incrementally based on appropriations.

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

FISCAL DESCRIPTION (continued)

This legislation establishes a health care account for an individual with an income over 85% of the federal poverty level into which payments for his or her participation can be made by the participant, an employer, the state, or any philanthropic or charitable contributor. The account will be used to pay the individual's deductible under the plan.

This legislation specifies that an individual's participation in the plan 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 as determined by the Department.

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.

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 plan period but must file a renewal application to remain in the plan.

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

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

This legislation specifies that a participant who is medically uninsurable will receive health insurance coverage through the Missouri Health Insurance Pool.

This legislation requires the Division to apply to the United States Department of Health and Human Services for a waiver to develop and implement the plan and to submit the proposed

FISCAL DESCRIPTION (continued)

waiver application to the Joint Committee on MO HealthNet for its review and recommendations prior to submitting the application for the waiver.

STANDARDIZED INSURANCE APPLICATIONS:
The Director of the Department of Insurance, Financial Institutions, and Professional Registration must establish by rule uniform insurance application forms to be used by all insurers.

RECOMMENDATIONS FOR SWITCHING MEDICATIONS:
The Department of Health and Senior Services is required to establish rules governing switch communications from health benefit plans and specifies that the term "switch communication" is a communication that recommends a patient's medication be switched to a different medication than originally prescribed by the primary health care professional.

All switch communications must clearly disclose any financial interest that the health care insurer, pharmacy benefits manager, prescriber, or their agent has in the patient's decision to switch medications. Any person who issues or delivers or causes to be issued or delivered a switch communication that has not been approved, provides a misrepresentation or false statement in a switch communication, or commits any other material violation of the provisions of the bill will be subject to a fine of up to $25,000.

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 Social Services
Office of the Missouri Governor
Missouri Health Facilities Review Committee

SOURCES OF INFORMATION (continued)

Missouri House of Representatives
Missouri Senate
Office of the Secretary of State

Not Responding: Office of Prosecution Services

Mickey Wilson

Mickey Wilson, CPA
Director
April 2, 2008