

DEPARTMENT OF  
PUBLIC HEALTH AND HUMAN SERVICES  
HEALTH POLICY & SERVICES DIVISION



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STATE OF MONTANA

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April 10, 1998

Nancy-Ann Min DeParle, Director  
Health Care Financing Administration  
Center for Medicaid and State Operations  
7500 Security Blvd.  
Baltimore, MD 21244

Attention: Family & Children's Health Insurance Program  
Mail Stop C4-14-16

Dear Ms. DeParle:

The enactment of Title XXI presents an opportunity to improve the health status of children in Montana and across the nation. The state of Montana is looking forward to working with you to enact a program that will best serve the health needs of **our** uninsured children. We have engaged in active solicitation of public comment about how that might best be done in Montana. The State Plan we are submitting at this time reflects careful and thoughtful consideration by Montanans about how to best serve **our** children.

Questions about the Montana State Plan can be directed to **Mary** Dalton, the Children's Health Insurance Plan Coordinator at the Department of Public Health and Human Services. She can be reached by phone at (406) 444-4144, by FAX at (406) 444-1861, or by E-mail at mdalton@mt.gov.

Sincerely,

MARC RACICOT  
Governor

c: HCFA Region VIII  
1.8.4

med/chip/govcov

PHONE: (406)444-4940 FAX: (406) 444-1861

MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: MONTANA  
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

\_\_\_\_\_  
4-10-98  
(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21228 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503,

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MONTANA CHILDREN'S HEALTH INSURANCE PLAN

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**Section 1. General Description and Purpose of the State Child Health Plans** (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1.  **Obtaining coverage that meets the requirements for a State Child Health Insurance Plan** (Section 2103); **OR**
- 1.2.  **Providing expanded benefits under the State's Medicaid plan** (Title XIX); **OR**
- 1.3.  **A combination of both of the above.**

Overview

Montana is pleased to submit our Title XXI State Plan to expand children's access to health coverage. Montana's Children's Health Insurance Plan (CHIP) will use private insurance for this project. Our target population will be children ages zero through eighteen at or below 150% of the federal poverty level. Financial eligibility will be based on a family's adjusted gross income. There will be no asset or resource tests.

Benefit coverage is based upon a benchmark equivalent package. Covered benefits include inpatient and outpatient hospital services, physician services, lab and x-ray, well-child and well-baby services including age appropriate immunizations, prescription drugs, mental health and substance abuse treatment services, hearing and vision exams.

Children may obtain health insurance from either an indemnity insurance plan or a health maintenance organization (HMO). Families will be given a choice of which type of coverage they wish for their children. This choice will be dependant on the geographic availability of the insurance product in the area where they live and the insurance carriers willingness to participate.

An annual enrollment fee of \$25 per child up to a maximum of \$100 per family will be charged to families at or below 100% of poverty. Families between 101-150% of poverty will pay an annual enrollment fee of \$50 per child up to a maximum of \$200 per family. A \$3 co-pay per emergency room service will be assessed. No other cost-sharing mechanisms are used.

Montana's CHIP program is not an entitlement. The legislature will appropriate funds for CHIP each biennium. Enrollment will be limited based on this funding and any private donations available to the program.

Implementation of the CHIP program has been and will continue to be a collaborative process. The program was developed with the assistance of a broad-based advisory council and several legislative committees. Public comment was actively solicited and received on the program in

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numerous forums.

The Health Policy and Services Division of the Montana Department of Health and Human Services (DPHHS) will administer the project. This Division includes public health specialists who administer the Title V Maternal and Child Health Block grant and the Title X family planning grant, and Medicaid specialists who administer acute and primary services. All parties mentioned have been integral to the design of the CHIP program.

This State Plan represents the first of a two-phase approach to implement the Children's Health Insurance Plan. Montana's legislature will not convene until January **1999** so we will start the program with a \$210,000 intergovernmental transfer from the Commissioner of Insurance's office.

During the first phase, targeted to begin in the fall of **1998**, a small number of children will be served. Contracts will be negotiated with insurance companies. Eligibility, enrollment, and management information system infrastructures will be built, marketing and outreach campaigns will be implemented, and identification of additional revenue sources for the state match will be identified.

In January **1999**, the legislature will be asked to appropriate the general fund match to allow the state to draw down its full **CHIP** allotment. Legislation will be introduced which describes the cost-sharing mechanisms, benefit package, and children who will be targeted for service. Upon approval of the appropriation, the state will expand services to additional children. Montana will submit amendments, if necessary, to this State Plan to implement this second phase.

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Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

Data describing the target population, beyond the census figures showing that there are 20,000 targeted low-income children in the state, is not available at this time. Questions will be added to the Behavioral Risk Factor Surveillance Survey (BRFSS) to establish both baseline information and an ongoing assessment of the insurance status of Montana children.

- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

- 2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Montana currently has several efforts in place to identify and enroll children who are not presently covered by health insurance but who may be eligible to participate in Medicaid or to receive public health services. Public health core functions include the responsibility to assess health care needs **and** resources, including access to health services and insurance, and to assure access by being knowledgeable about available resources, referring appropriately and providing services if no other option exists.

Montana's services and programs intended to assure access include:

1. Public health referral systems - Womens', Infants' and Childrens' (WIC) Nutrition programs and public health home visiting services include assessment of high risk conditions such as developmental, nutritional, psycho social and income factors. Clients with access needs are referred to eligibility workers in local settings who determine whether the client is eligible to be covered by Medicaid. In the case of programs for high risk pregnant women, home visiting services and others may also do an initial screen for Medicaid eligibility authorizing clients as eligible for presumptive eligibility. WIC is funded with United States Department of

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Agriculture funding and public health home visiting with a combination of Title V and state general fund resources.

2. Federally Qualified Health Centers - Montana has twelve federally qualified health centers, including six Community Health Centers (CHCs), five urban Indian clinics and one Migrant health clinic. Each of these facilities has the resources necessary to determine presumptive Medicaid eligibility, and has applications for the Caring Program for Children if the client is not Medicaid eligible. CHCs are also mandated to provide services regardless of the ability to pay. Four of the Community Health Centers are co-located with public health departments and referrals between services are made to assure access.

Community Health Centers use standard procedures to determine appropriate pay level for each client including providing a financial screen for each new patient or family, providing information on and explanation of services family members are eligible for, assisting with completing applications and collecting required documentation, determining eligibility on-site or forwarding applications to the determining agency and communicating with family about eligibility status and assisting families when their financial situation and eligibility changes.

3. The Caring Program for Children - is a public/private partnership administered by Blue Cross/ Blue Shield of Montana, to provide preventive medical, dental, and vision services, as well as outpatient diagnostic, emergency, accident and surgical services. Children aged eighteen and under who are "not currently covered under a state or federal medical assistance program (i.e., Medicaid) or under any private health insurance program" are eligible for the program. The Caring Program is not licensed as, nor does it function as an insurance product in Montana. Clients determined eligible for Medicaid in the screening process are referred to the appropriate local agency.
4. Children's Special Health Services (CSHS) - provides coverage for a limited number of children who have special health care needs. This program provides reimbursement for health care charges if they are not covered by Medicaid or other health care insurance. The application for the CSHS program includes income determination to screen for Medicaid eligibility. The CSHS program activities are funded with Title V resources.
5. Family Planning programs - are contract services that identify clients in

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need of primary care services. They specifically target low-income clients. These clinics identify funding sources available to pay for preventive health services, including Medicaid and other insurances, and refer clients appropriately to those resources. The state funds Family Planning clinics with Title X funding, and local contributions may include Title V and other resources.

6. Rural Health Clinics (RHC) and National Health Service Corp (NHSC) providers - a loose network of primary care services throughout the state that allow clients to pay on a sliding fee scale. Twenty-three RHCs provide services on a sliding fee scale, and twelve NHSC providers located in federally designated shortage areas provide services on a sliding fee scale. RHCs may refuse service to clients, but NHSC must accept any client regardless of ability to pay.
7. Part C of the Individuals with Disabilities Education Act - provides statewide early intervention services to meet the needs of Montana's infants and toddlers with diagnosed disabilities or with developmental delays that warrant concern for the child's future development. Children deemed eligible for Part C Services in Montana who appear to be Medicaid eligible are referred to the local county office for Medicaid determination.
8. Montana's Mental Health Access Plan (MHAP) - provides mental health services through a single statewide capitated program. MHAP is not an insurance plan. MHAP contains two components. The Medicaid portion of the program operates under a 1915(b) waiver. The state only portion of the program serves people of all ages below 200% of poverty who have a serious emotional disturbance or severe mental illness. Eligibility determinations are done by the contracted managed care organization for the "state only" group. Clients who appear to be eligible for Medicaid in the screening process are referred to the appropriate county office.
9. Medicaid - provides health coverage for low-income, elderly and disabled Montanans'. Infants born to Medicaid enrolled women remain eligible for Medicaid for twelve months. Children age zero through five are covered at 133% of poverty, at age six through fourteen they are covered at 100% of poverty, at age fifteen through eighteen they are covered at 40.5% of poverty. The Department of Public Health and Human Services administers Medicaid. County public assistance offices determine eligibility for Medicaid, TANF, and food stamps.

Presumptive eligibility sites for pregnant women and outstationed

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eligibility sites for Medicaid include Federally Qualified Health Centers, Health Care Clinics, Migrant Health Clinics, Tribal Health clinics, and Indian Health Services facilities. Staff at these sites help people apply for Medicaid by providing assistance in completing the application and then forwarding the application to the county public assistance offices for eligibility determination. Outreach to inform potential recipients about Medicaid is accomplished through the resources previously noted and by distributing Medicaid information to many health care advocacy groups and providers in Montana.

**2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:**

Montana currently has no health insurance programs that involve a public-private partnership.

**23. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:**

(Section 2102)(a)(3)

Montana's outreach and enrollment efforts will be designed to maximize the number of children served under the Medicaid and CHIP programs. (We have no health insurance programs that involve a public-private partnership.) The state plans to coordinate the Children's Health Insurance Plan enrollment efforts with:

- Medicaid;
- Local public health departments;
- WIC;
- School Nutrition and Health Programs;
- Federally Qualified Health Care Centers which include Community, Urban Indian, and Migrant Health Centers;
- Case Management Providers;
- The Caring Program for Children;
- Family Planning and Planned Parenthood Centers;
- Rural Health Clinics;
- Mental Health Access Plan;
- Children with Special Health Care Needs Program;
- County Eligibility Examiners and Families Achieving Independence in Montana (FAIM) Coordinators;

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- Indian Health Services;
- Tribal Health Services;
- Early Intervention Services (**Part C**);
- Child Support Enforcement;
- Child Protective Services;
- Head Start and Early Head Start; and
- Other Programs as they are identified.

These providers will:

- Inform participants in their programs of the Children's Health Insurance Plan;
- Distribute brochures and application forms for the Children's Health Insurance Plan;

Special outreach and coordination efforts will take place between CHIP, Medicaid and the Caring Program. Medicaid applicants with children who do not qualify for Medicaid will be asked to sign a release **form** permitting the information provided for their Medicaid application to be used to determine if the child may be eligible for the Children's Health Insurance Plan.

Montana will ensure that Medicaid eligible children are enrolled in Medicaid. CHIP applicants who appear to be Medicaid eligible will receive assistance in completing a Medicaid application **as** described in Section **4**.

Because the Caring Program provides only primary and preventive health care and is not **an** insurance product, children currently on this program will be allowed to choose to stay with this program or apply for the CHIP program. Outreach informing current participants in the Caring Program of their option to enroll in CHIP will be done. See Section **5** for a description of the outreach methods to current Caring Program participants.

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**Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

**3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)**

Montana's population is approximately 880,000. Of this number, only 23,130 people receive their health care services through a Health Maintenance Organization (HMO). 2269 of these HMO participants are Medicaid recipients. This low penetration rate for managed care requires that Montana rely primarily on indemnity insurance plans for coverage for the CHIP program. We intend to contract with as many indemnity plans as are willing to meet our contracting criteria. In this way we hope to offer clients a choice in the more populated areas of the state. In the areas where an HMO is geographically available, clients will be offered this choice as well.

Contracts with indemnity insurance plans and HMOs will address the following areas: cost sharing, enrollment, marketing, benefits, premiums, provider network, utilization management, quality of care, access to care, member rights, and grievance procedures. Contract standards will be based on a review of standards from the following sources: National Association of Insurance Commissioners (**NAIC** Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and existing Medicaid managed care contracts.

Montana may vary significantly from provider standards established in other states. Montana is a frontier state characterized in the east by sparsely populated plains, and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population density, we are unable to use a single distance and/or travel time to gauge adequacy of a provider network. Instead, we decide availability of primary care practitioners and specialists in the normal service delivery area for each town or locale. This has proven successful in our Medicaid PASSPORT program (our primary care case management model) which has been in operation since 1993. This methodology is also the basis for legislation passed last year to ensure network adequacy for commercial HMOs operating in Montana. We find in a frontier state such as Montana, this case-by-case approach is more meaningful to clients who are accustomed to, and often choose to, live extended distances from services.

Essential Community Providers

Indemnity insurance plans and HMOs will be required to offer Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Title X Family Planning providers, Indian Health Service providers, Tribal Health providers, Urban Indian Centers, Migrant Health Centers and county public health departments who serve enrollees a provider network contract. The contract must offer terms and conditions at least as favorable as

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those offered to other entities providing the same or similar services. This provision is only in effect, however, if the afore-named entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the plan.

The state will offer assistance in contract negotiations between these essential providers and the insurance plans.

**3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)**

HMOs and indemnity insurance plans who contract with CHIP will perform the primary utilization management functions. Contract standards will require a participating insurer/HMO to have adequate staff and procedures to assure that services provided to enrollees are medically necessary and appropriate. At a minimum the plans must address the use of referrals, prior authorizations, and client educational services.

Plans will be encouraged to use a primary care provider (PCP) to serve **as** the child's medical home. The PCP should perform all routine non-emergency care for the child and make necessary arrangements for a child who needs referral to a specialist or hospital. A specialist could serve **as** the child's primary care provider. The state Medicaid program has extensive experience in using a PCP system and will offer technical assistance to insurance plans in this area.

Plans will include in their educational material for enrollees and providers information about additional services available to children with special health care needs. Examples of these services are the Mental Health Access Plan, the state program for Children with Special Health Care Needs, public health case management services for pregnant women and children, and Part C.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

4.1.1  Geographic area served by the Plan:

4.1.2  Age: The plan is available to children zero through eighteen years of age. Coverage for children who are eighteen years of age will continue until the date of the child's 19<sup>th</sup> birthday.

4.1.3  Income: Children from families whose adjusted gross income (as defined for federal income tax purposes) is at or below 150% of the federal poverty level are eligible. Earned (wages, tip, salary, etc.) and unearned (child support, unemployment, etc.) income will be counted when determining adjusted gross income. Any income excluded by other federal statute will not be counted.

The applicant must provide verification of income which could include wage/salary stubs, W-2 forms, income tax returns (state/federal), an employer's payroll records, or an employer's written statement of earnings.

For purposes of determining financial eligibility for CHIP, a family unit consists of:

1. The child for whom they are applying;
2. The natural/adoptive parents of the child;
3. Spouses residing together;
4. Siblings (natural, adoptive, half, or stepbrothers/sisters) from age zero through eighteen, with the following exception. If a sibling is between age nineteen through twenty-two, is attending an institute of higher learning, and is considered a dependant for income tax purposes, he or she may be counted in the family unit.

\*An emancipated minor, who applies for CHIP, will be considered his or her own family.

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- 4.1.4  **Resources (including any standards relating to spend downs and disposition of resources):**
- 4.1.5  **Residency: U.S. Citizenship and Montana residency is required for purposes of this plan. A Montana resident is anyone who declares him or her self to be living in the state. This includes migrant and other seasonal workers. The parent will be required to certify on the application that the child is a U.S. citizen or Qualified Alien and a Montana resident. Montana will follow federal guidelines in determining whether a child is a U.S. citizen or Qualified Alien who is eligible for CHIP.**
- 4.1.6  **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because of eligibility for Medicaid, not for reasons of disability status.
- 4.1.7  **Access to or coverage under other health coverage:** A child will be found ineligible when: 1) the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; 2) the child is eligible for Medicaid; 3) the child has a parent who is a state employee; or 4) the child is not a U.S. citizen or Qualified Alien as defined under federal statute.
- 4.1.8  **Duration of eligibility:** Once a child has been accepted, he or she remains eligible for one year from the date of enrollment in CHIP unless the child moves from the state, is enrolled in Medicaid, is found to have other creditable coverage, or becomes financially ineligible.
- 4.1.9  **Other standards (identify and describe):** Usually, a child will be ineligible for CHIP if they have been covered under an individual or group health plan during the three months prior to application for CHIP. If, however, a parent who is providing the primary insurance is fired, laid off, can no longer work because of a disability, or has a lapse in insurance coverage because he or she obtains new employment, the three-month waiting period for the Children's Health Insurance Plan will not apply.

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**4.2 The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(a)(B))**

- 4.2.1  **These standards do not discriminate on the basis of diagnosis.**
- 4.2.2  **Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.**
- 4.2.3  **These standards do not deny eligibility based on a child having a pre-existing medical condition.**

**4.3 Describe the methods of establishing eligibility and continuing enrollment. (Section 2102(b)(2))**

Montana will be using two separate applications for the Children's Health Insurance Plan and the Medicaid program. CHIP will only consider family income in determining eligibility. Montana Medicaid also considers a family's assets and resources. Families who have completed a Medicaid application and who have been denied may submit the Medicaid form instead of the CHIP form. It will be necessary, however, for families who are determined potentially eligible for Medicaid during a CHIP application to complete the regular Medicaid application.

Eligibility Determination

Children age zero through age eighteen in families whose income is at or below 150% of the federal poverty level will be eligible for CHIP. In the first year of implementation, the state will be making the eligibility determination at a central location. By October 1999, the state plans to contract with an enrollment broker. This enrollment broker will determine initial eligibility and ongoing eligibility (annually) for the Children's Health Insurance Plan.

In both instances, applications will be mailed from enrollment sites and/or directly from families. The following information will be collected to establish eligibility:

- family income;
- family size;
- each child's name and date of birth,
- whether the child is covered by another insurance or Medicaid and dates of coverage;
- child's citizenship, residency **status** and social security number; and
- if parent is employed by a state agency.

CHIP eligibility will be denied when: 1) the child's parent is employed by a state agency; 2) the child is covered by another creditable insurance as defined in section 2791

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of the Public Health Service Act; 3) the child is covered by Medicaid; or 4) the child is not a U.S. citizen or Qualified Alien as defined under federal statute. For all other children, the information noted above is compared with the Medicaid financial eligibility tables. If the child appears to be eligible for Medicaid, CHIP eligibility will be denied pending a denial of Medicaid eligibility. The eligibility broker will help the family complete the Medicaid application and will forward it electronically to the appropriate Public Assistance Office. If the child meets the CHIP criteria and does not appear to be eligible for Medicaid, the application form will be processed and the child will be enrolled in CHIP.

As part of the eligibility determination process, the state (and later the enrollment broker) will:

- track and determine recipient application/file status;
- process applications;
- determine eligibility;
- refer children not eligible to the Medicaid or Caring Program;
- assist the family in choosing an insurance plan;
- operate a 1-800 number that enrollees may call to receive information about CHIP coverage and eligibility issues;
- develop and operate a system to send annual re-enrollment notices to participants of CHIP;
- collect enrollment fees;
- provide training and support for application and outreach sites;
- provide a grievance process for applicants who are denied CHIP eligibility;
- facilitate a smooth transition between different Children's Health Insurance Plan providers and between CHIP and Medicaid or CHIP and private insurance; and
- provide eligibility data needed for annual reports.

#### Enrollment in Health Plans

The Children's Health Insurance Plan applications will include information on insurance plans and/or HMOs available in different geographic locations. Parents will be instructed to select a plan/HMO for their child(ren) and will be offered a toll-free telephone number of the enrollment broker to answer any questions they may have.

#### Redetermination of Eligibility

Children enrolled in the Children's Health Insurance Plan will be guaranteed eligibility for twelve months. Proof of income upon renewal must be documented as in the initial enrollment. A renewal packet will be mailed to the families 45 days before the end-of-coverage date. A reminder card to reapply to CHIP will be mailed 30 days before the end-of-coverage date. If the application is not returned by the end-of-coverage date, coverage will terminate. The child may reapply for coverage at a later date without a penalty. The child will not, however, be given preference for coverage and acceptance will be subject to whether there is available funding.

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### Enrollment Fee

An annual enrollment fee of **\$25** per child up to a maximum of \$100 per family will be charged to families at or below 100% of poverty. Families between 101-150% of poverty will be assessed an enrollment fee of \$50 per child up to a maximum of \$200 per family. The enrollment fee must be paid before the child will be enrolled in the CHIP program. A \$3 co-pay per emergency room service will be assessed. No other cost-sharing mechanism will be utilized.

## **4.4 Describe the procedures that assure:**

### **4.4.1 Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan (Section 2102(b)(3)(A))**

Because Montana's Medicaid eligibility depends upon age, income, and assets, each child in a family must be separately screened for possible Medicaid eligibility. If one child of several in a family is found to be eligible for Medicaid, the plan's information system will allow technicians to enroll **only** those children not eligible for Medicaid into the Children's Health Insurance Plan.

CHIP will not be determining Medicaid eligibility. Screening for Medicaid eligibility, however, will be done by the state or its enrollment broker. If a child appears to be eligible for Medicaid, the family will be notified by a letter saying the child cannot be insured by the Children's Health Insurance Plan because the child appears to be eligible for Medicaid. The family will be offered assistance in completing the Medicaid application and will be given a toll-free telephone number to call with further questions. The family will be notified the CHIP denial will be reconsidered if parents have applied for and been denied Medicaid within the last six months. In this instance, a copy of the Medicaid denial letter must be sent to the CHIP eligibility broker.

Families who apply for Medicaid and are denied will be informed about CHIP. With a family's permission, the Children's Health Insurance Plan will receive information collected for the Medicaid application. The Medicaid form may be used in place of the CHIP form to avoid families having to fill out two forms.

#### Other Creditable Coverage Screening

The Children's Health Insurance Program application will ask the applicant to report any health insurance coverage. If the family reports creditable coverage as defined in section **2791** of the Public Health Service Act, the child will be found ineligible. Insurance plans/ HMOs contracting with the CHIP will be required contractually to notify CHIP whenever they have reason to believe a member has

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other coverage. The CHIP program will investigate and if the child has other creditable insurance coverage, CHIP coverage will be terminated.

- 4.4.2 That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan (Section **2102(b)(3)(B)**)

The CHIP Program will screen applicants for Medicaid eligibility. If income suggests probable eligibility for Medicaid, the eligibility broker will help the family in completing the Medicaid application and will forward the application to the appropriate County Public Assistance Office. (If the family agrees to do so.) Children who appear to be Medicaid eligible will only be enrolled in the Children's Health Insurance Program after they have received a denial letter from Medicaid.

- 4.4.3 That the insurance provided under the state child health plan does not substitute for coverage under group health plans (Section **2102(b)(3)(C)**)

Usually, a child will be ineligible for CHIP if they have been covered under a creditable individual or group health plan during the three months prior to application for CHIP. If, however, a parent who is providing the primary insurance is fired, laid off, can no longer work because of a disability, or has a lapse in insurance coverage because he or she obtains new employment, the three-month waiting period for the Children's Health Insurance Plan will not apply.

- 4.4.4 The provision of child health assistance to targeted low income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement act, 25 **U.S.C. 1603(c)**) (Section **2102(b)(3)(D)**)

The Children's Health Insurance Plan will work directly with tribes, urban Indians, the Indian Health Service, Tribal Health Services, and Urban Indian Centers to inform Native Americans living across Montana about the CHIP program. Tribal chairpersons and other influential Native Americans have been contacted to begin this process. Insurance plans will be required to offer a contract to Urban Indian Centers, Indian Health and Tribal Service providers who meet certification qualifications. See Sections 3.1 and 9.9 for further information.

- 4.4.5 Coordination with other public and private programs providing creditable coverage for low income children (Section **2102(b)(3)(E)**)

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Steps will be taken to ensure that coordination with private insurance coverage takes place as outlined in Section 4.4.3. CHIP will be coordinated with state Maternal Child Health and mental health programs to ensure that children with needs beyond what CHIP covers will be referred for service to these existing programs (examples include the program for Children with Special Health Care Needs, the Mental Health Access Program, visiting nurses, etc.). Montana currently has no health insurance programs that are a public-private partnership and provide creditable insurance coverage.

The state will continue to work for streamlined enrollment procedures and collaborative outreach efforts to further the plan's goal to coordinate with other public and private programs.

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**Section 5. Outreach and Coordination (Section 2102(c))**

**Describe the procedures used by the state to accomplish:**

**5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))**

Montana has utilized a broad based outreach team in developing the state plan. Members of this outreach team represent schools, day care centers, managed care organizations, public and private health care providers, children's advocacy groups, Native Americans, and other stakeholders. This team will continue to meet as CHIP is implemented and will recommend to Montana DPHHS the most effective outreach plan, materials design, and marketing strategy to ensure eligible families are notified that CHIP is available and how they can apply.

Assumptions about the target population for CHIP are based on the experience of the Montana Medicaid Program, the Caring Program for Children, and social services and health care agencies and providers. For an audience consisting of families with a variety of financial needs, the plan must appeal to both those who have regular interaction with human service agencies, and to the working poor who have traditionally avoided government programs. Outreach efforts for the Child Health Insurance Plan, therefore, will emphasize that this is a low-cost private health insurance plan that is a collaborative effort between families and both the state and federal governments to assure children receive health care.

Outreach and Coordination Methods - Phase I

The first phase of this program scheduled to begin in the fall of **1998** will serve a limited number of children. Outreach for this small number of participants will be targeted in the following manner. Children currently enrolled in the Caring Program for Children (which covers primary, preventive medical, dental, and vision services, **as well as** outpatient diagnostic, emergency, and surgical services) will be sent applications for the new, full coverage CHIP program. Indian Health Services (IHS) maintains a data base of IHS service users who are not on Medicaid or other insurance. This data base will be used to target uninsured Native American children. Families who receive subsidized child care through DPHHS, those who have left the TANF program, Children with Special Health Care Needs, and children participating in the Mental Health Access Plan will be targeted **as well**. These families will receive enrollment information and applications to enroll in CHIP through direct mailings.

Outreach and Coordination Methods-Phase II

After the legislature meets and appropriates additional funding for CHIP, the program will be marketed statewide as a full benefit health plan, following four primary strategies:  
1) direct appeal to eligible families through press releases, public service announcements,

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and video; 2) outreach through school districts; 3) outreach through collaboration with local agencies, grass root organizations, and providers; 4) outreach collaboration with statewide maternal child health organizations. Each of these strategies is further detailed below.

**Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, and Video**

Radio and television public service announcements will be aired about CHIP. A toll free number to call for more information will be featured in the public service announcements, printed materials, and press releases. Frequent news releases will be sent to the press about the increased insurance coverage available to children. Radio stations, TV and cable stations, Montana daily and weekly newspapers, and specialty publications and newsletters for professional associations in children's health care, parenting, day care, and education will receive the press releases.

Outreach methods other than written materials will be employed whenever possible. All outreach materials will prominently feature the 1-800 telephone number. Callers to the toll-free number will hear a recorded message about the plan, speak to a customer service representative, or leave their name and address to receive an application.

**Outreach through School Districts**

CHIP will collaborate with the Office of Public Instruction to conduct back-to school enrollment campaigns in school districts statewide. Enrollment information and applications will be mailed to schools who express interest in helping to conduct CHIP outreach. These applications will be sent home to each family.

This method of outreach has been the most successful means employed by the Florida Healthy Kids project and Montana's Caring Program for Children. It involves relatively low costs and we believe that through our CHIP program we can replicate the success of these two programs.

**Outreach through Collaboration with Local Agencies, Grass Root Organizations and Providers**

Outreach and training sessions on CHIP eligibility will be conducted for the staff of county public health departments, county social services, WIC coordinators, county public assistance offices, family resource centers, churches, the program for Children with Special Health Care Needs, community-centered boards of grass root organizations, Child Care Resource and Referral agencies, tribal health and social services staff, Head Start, and Child Find. These programs have all been active in providing Medicaid outreach in the past.

Outreach for CHIP and Medicaid will continue to be conducted through the DPHHS home visiting and case management program. Home visitors will give pregnant women and parents CHIP and Medicaid program information and answer questions.

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**CHIP** will also build upon Montana Medicaid Program's relationships with primary care providers and Medicaid recipients. Newsletters are sent to providers monthly and recipients three times a year to update them on developments in the Medicaid program. Articles about CHIP will be included in these mailings.

The CHIP Program will work with Native American leaders, both urban and reservation, to develop specific outreach activities for this population. Similarly, we will work with the Montana Migrant Council to develop specific outreach activities for migrant workers statewide.

Outreach through Collaboration with Maternal Child Health Organizations

Montana DPHHS contracts with the Montana Coalition for Healthy Mothers, Healthy Babies (HMHB) to provide a comprehensive outreach, information and referral, and a public relations campaign called Montana's Child. Information about CHIP will be featured in this program. In addition, HMHB operates the Maternal Child Health toll-free hotline through a contract with DPHHS. This hotline will be used to dispense information about CHIP.

The Montana Council for Maternal Child Health is doing a series of community forums where family health care issues will be discussed. They have pledged to prominently feature the CHIP program in these forums.

**5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(e)(2))**

The Children's Health Insurance Plan's outreach efforts described above will be coordinated **as** often as possible with Medicaid and other children's health coverage or direct services. This coordination will be facilitated by the fact that CHIP, Title X, Title V, and Medicaid reside in the Health Policy and Services Division of DPHHS and top management staff for **the** programs meet at least weekly.

Coordination efforts have been described in Sections 2.3, 4.3 - **4.4.5**, and 5.1

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

- 6.1.1.  Benchmark coverage; (Section 2103(a)(1))
- 6.1.1.1.  FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)
- 6.1.1.2.  State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3.  HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) \_\_\_\_\_
- 6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4).
- The Actuarial report and supporting documentation are found in Appendix A. Background detail for the proposed insurance rate of \$91.40 per member per month is found in Appendix B.
- 6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefit's package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."
- 6.1.4.  Secretary-Approved Coverage. (Section 2103(a)(4)) \_\_\_\_\_

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**6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to  
the amount, duration and scope of services covered, as well as any exclusions or  
limitations) (Section 2110(a))**

The following statements apply to all services listed as covered in this section (6.2):

1. There are no pre-existing condition limitations.
2. Experimental procedures, custodial care, personal comfort/hygiene/convenience items which are not primarily medical in nature, whirlpools, organ and tissue transplants, TMJ treatment, treatment for obesity, acupuncture, biofeedback, chiropractic services, elective abortions, in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis, cosmetic surgery, radial keratotomy, private duty nursing, treatment for which another coverage such as workers compensation is responsible, routine foot care, services for members confined in criminal justice institutions, and any treatment not medically necessary are not a covered benefit. These exclusions are in addition to any exclusions noted in the individual coverage descriptions.
3. A \$1 million lifetime maximum benefit coverage per insured person applies.

**6.2.1.  . Inpatient services (Section 2110(a)(1)):** Semi-private room; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging services; physical, speech, occupational, heat, and inhalation therapy; operating, recovery, birthing and delivery rooms; routine and intensive nursery care for newborns; and other medically necessary services and supplies for treatment of injury or illness are covered.

Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for caesarean section is guaranteed.

Services for mental and chemical dependency disorders are outlined in sections 6.2.10 and 6.2.18.

Organ and tissue transplants are not covered.

**6.2.2.  . Outpatient services (Section 2110(a)(2)):** All services described in 6.2.1 which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization services) or ambulatory surgical center; chemotherapy; emergency room services for surgery, accident or medical emergency; and other services for diagnostic

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or outpatient treatment of a medical condition, accident, or illness are covered.

Services for mental and chemical dependency disorders are outlined in sections 6.2.11 and 6.2.19

A \$3 co-pay per emergency room service is applied.

- 6.2.3.  **Physician services** (Section 2110(a)(3)): Office, clinic, home, outpatient surgical center and hospital treatment for a medical condition, accident, or illness by a physician or mid-level practitioner are covered.

Well child, well baby, and immunization services as recommended by the American Academy of Pediatrics are covered.

Routine physicals for sports, employment, or as required by a governmental authority are covered.

Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered providing that surgical and/or hospital benefits are also covered. Hypnosis, local anesthesia (unless it is included as part of a global procedure charge), and consultations prior to surgery are not covered.

- 6.2.4.  **Surgical services** (Section 2110(a)(4)): Covered as described in 6.2.1, 6.2.2, and 6.2.3. In addition, professional services rendered by a physician, surgeon, or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

Organ and tissue transplants are not covered.

- 6.2.5.  **Clinic services (including health center services) and other ambulatory health care services.** (Section 2110(a)(5)): Covered as described for other services described in this section(6.2).

- 6.2.6.  **Prescription drugs** (Section 2110(a)(6)): Coverage includes drugs prescribed by a practitioner acting within the scope of his practice. Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, birth control drugs/supplies, and drugs needed after an organ or tissue transplant are covered.

Plans may use the Medicaid formulary.

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Diabetic supplies including insulin, test tape, syringes, needles, and lancets are covered as a prescription drug.

Food supplements and vitamins (with the exception of prenatal vitamins), whether or not requiring a written prescription, are not covered.

6.2.7.  **Over-the-counter medications** (Section 2110(a)(7))

6.2.8.  **Laboratory and radiological services** (Section 2110(a)(8)): Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness, or medical condition that are not described elsewhere in this section(6.2).

X-ray, radium, or radioactive isotope therapy are covered.

6.2.9.  **Prenatal care and prepregnancy family services and supplies** (Section 2110(a)(9)): Prenatal care covered as described for other medical conditions in this section(6.2). Prepregnancy family planning services and supplies covered.

Medical or surgical treatment to reverse surgically induced infertility; fertility enhancing procedures beyond diagnosis; and sex change operations excluded.

6.2.10.  **Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services** (Section 2110(a)(10)): Inpatient mental health services are a comprehensive benefit that will be coordinated between insurance plans who contract with CHIP and Montana's Mental Health Access Plan (MHAP). For insured persons who do not meet the state established criteria for being seriously emotionally disturbed, the insurance plan will cover up to twenty-one days of combined mental health/chemical dependency benefits per benefit year. Partial hospitalization services may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days. A partial hospitalization program that is operated by a hospital must comply with the standards for a partial hospitalization program that are published by the American association for partial hospitalization.

CHIP enrollees who have mental health needs beyond this amount of coverage, or who have been diagnosed as seriously emotionally disturbed, will be eligible for MHAP services. MHAP is a comprehensive program

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that provides mental health care to Montanans' who are seriously emotionally disturbed. MHAP is required to meet a child's mental health needs and has no coverage limits beyond medical necessity.

- 6.2.11.**  Outpatient mental health services, other than services described in **6.2.19**, but including services furnished in a state-operated mental hospital and including community-based services (**Section 2110(a)(11)**): Outpatient mental health services are a comprehensive benefit which will be coordinated between the insurance plans which contract with CHIP and Montana's Mental Health Access Plan (MHAP). MHAP will provide services for CHIP enrollees who meet the state's established criteria for being seriously emotionally disturbed and for other children who have continuing mental health needs beyond those covered by the insurance plan. MHAP is a comprehensive program that provides mental health care to Montanans' who are seriously emotionally disturbed. MHAP is required to meet a child's mental health needs and has no coverage limits beyond medical necessity.

Professional outpatient services up to a maximum of twenty visits/year will be paid through the insurance plan. Partial hospitalization services are paid as described in section 6.2.10.

- 6.2.12.**  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (**Section 2110(a)(12)**)
- 6.2.13.**  Disposable medical supplies (**Section 2110(a)(13)**)
- 6.2.14.**  Home and community-based health care services (See instructions) (**Section 2110(a)(14)**)
- 6.2.15.**  Nursing care services (See instructions) (**Section 2110(a)(15)**)
- 6.2.16.**  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (**Section 2110(a)(16)**):
- 6.2.17.**  Dental services' (**Section 2110(a)(17)**)
- 6.2.18.**  Inpatient substance abuse treatment services and residential substance abuse treatment services (**Section 2110(a)(18)**): Coverage is limited to twenty-one days of combined mental health /chemical

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dependency benefits per benefit year. A maximum of \$4000 in a 24-month period, \$8000 per member per lifetime also applies.

- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19)): Professional services are covered up to a maximum of \$1000 per member per benefit year.
- 6.2.20.  Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24)):  
Vision Services and Medical Eye Care - Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his/her license are covered. Vision exams are also covered. Corrective lenses are not covered.  
  
Audiological Services - Hearing exams, including newborn hearing screens in a hospital or outpatient setting, are covered. Coverage includes assessment and diagnosis. Hearing aides are not a covered benefit.
- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26))
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

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6.3. Waivers - Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1.  Cost Effective Alternatives. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1 .1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(I))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through . contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))

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6.3.2.  Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage **only** of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

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Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan and continue on to Section 8.

**7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A))**

Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1.  Quality standards
- 7.1.2.  Performance measurement
- 7.1.3.  Information strategies
- 7.1.4.  Quality improvement strategies

Only 23,130 of the states insured population are served through a Health Maintenance Organization (HMO). No Montana HMOs are accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditations of Healthcare Organizations (JCAHO) or any other national accreditation body. This low penetration rate for managed care, our sparse population, and lack of national accreditation for our HMOs necessitate that Montana choose quality and appropriateness standards applicable to both **HMO** and indemnity insurance plans. Medicaid and CHIP management staff are also interested in assuring continuity and comparability between the measures we use in the two programs. Medicaid currently uses HEDIS measures for both its Primary Care Case Management Program (PASSPORT) and its HMO program. For these reasons, CHIP will use HEDIS performance measurements to evaluate effectiveness of care for CHIP enrollees.

The contracts with the insurance plans will require them to collect and report HEDIS data. The following is a list of required measures:

HEDIS 3.0

- Childhood immunization status
- Adolescent immunization status
- Children's access to primary care providers
- Well-child visits in the first fifteen months of life
- Well-child visits in the third, fourth, fifth, and sixth year of life
- Adolescent well care visits

CHIP will also monitor consumer and provider complaints to the Commissioner of Insurance.

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The CHIP will use these performance measures--HEDIS and complaint data--to evaluate a health plan's performance annually and to provide information to assist enrollees in choosing a plan. While HEDIS measures will be an important component of the CHIP quality program, the data will not be available until after a full year of plan operation. Until then, the program will rely on reported complaints to monitor quality of care.

Consumer education tools will be developed to ensure CHIP enrollees have adequate information to negotiate plan enrollment. A plan member handbook will be developed by the plans and reviewed and approved by state CHIP staff, to assure that benefit, provider network, and grievance procedures are communicated effectively. Other consumer education materials will be developed as part of CHIP's quality assurance program and will be based on the results of performance measures.

The state has had active participation from the advisory council throughout the development of the CHIP program. We will continue to use an advisory council to facilitate communication about what is working well and where improvements can be made in the CHIP program.

**7.2 Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))**

Access Assurance for Care Delivered through Insurers and the CHIP Provider Network

Access to services will be measured by evaluating and monitoring the adequacy of provider networks and by analyzing the results of complaint data and performance measures. Provider network analysis will look at the number and types of physicians and non physician providers of health care for children, their locations, and their hours. For HMOs, the primary data source for this evaluation will be the HMOs Network Access Plan. The Department of Public Health and Human Services (DPHHS) is responsible for monitoring HMO network adequacy under state law. **An** HMO's access plan details its provider network including numbers, types, locations, referrals, and accommodation of members with special needs, e.g., physically accessible facilities. Indemnity insurance providers will be required to produce a similar access plan for CHIP. DPHHS staff will evaluate this network as described in Section 3.1. CHIP staff will also annually evaluate access-related performance measures such as access-related complaints and access to primary care physicians (HEDIS).

Emergency Services Access

Contracts with insurance plans will specify that insurance plans may not require prior authorization for emergency medical conditions. **An** emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average

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knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the child (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Access to emergency services will be monitored by analysis of complaint data.

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Section 8. Cost Sharing and Payment (Section 2103(e))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

**8.1.** Is cost-sharing imposed on any of the children covered under the plan?

- 8.1.1.**  **YES**  
**8.1.2.**  **NO**, skip to question **8.5.**

**8.2.** Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

- 8.2.1.** Premiums: \_\_\_\_\_  
**8.2.2.** Deductibles: \_\_\_\_\_  
**8.2.3.** Coinsurance: \_\_\_\_\_

**8.2.4.** Other: **An** annual enrollment fee of \$25 per child up to a maximum of \$100 per family will be charged to families at or below 100% of the federal poverty level. Families between 101-150% of poverty will pay an annual enrollment fee of \$50 per child up to a maximum of \$200 per family. This fee corresponds with the 12-month eligibility period for the CHIP program. This annual enrollment fee was chosen after careful study of experience in other states who have assessed monthly or quarterly premiums in their children's health insurance programs and after looking at Montana's demographics. Currently in Montana, 44.3% of the AFDC or AFDC related families have one child, 26.6% have two children, and **15.8%** have three children. Because of the relatively small family size in Montana, we believe that the annual enrollment fee is affordable and will be easier for families to comply with than a monthly premium. It is also much more cost efficient to administer since tracking and renewal of certification does not have to be done **as** frequently. This cost efficiency will allow us to serve more children.

A \$3 co-pay per emergency room service will also be assessed. No other cost-sharing mechanism will be used.

**8.3.** Describe how the public will be notified of this cost-sharing and any differences based on income: **A** description of the annual enrollment fee will be contained in the application, the outreach material and educational material distributed about CHIP.

**8.4.** The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

- 8.4.1.**  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

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- 8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
- 8.4.3.  No child in a family with income less than **150%** of the Federal Poverty Level will incur cost-sharing that is not permitted under **1916(b)(1)**.
- 8.4.4.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
- 8.4.5.  No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
  
- 8.4.6.  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A))
- 8.4.7.  Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1,1997. (Section 2105(d)(1))
- 8.4.8.  No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- 8.4.9.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))
  
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed **5** percent of such family's annual income for the year involved (Section 2103(e)(3)(B)): This section is not applicable since Montana will not serve families above 150% of the federal poverty level. ~~Our~~ enrollment fee falls under the cost-sharing guidelines for the Medicaid program as required by section 2103(e)(3)(A).
  
- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
  - 8.6.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

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- 8.6.2.  The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:**
- 

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**Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)**

**9.1 Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:**

Montana's strategic objectives are to:

1. Improve the health status of children covered by the CHIP program with a focus on preventive and early primary treatment.
2. Increase the proportion of children who are insured and reduce the financial barriers to affordable health care coverage.
3. Prevent "crowd out" of employer coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
5. Increase the enrollment of currently eligible, but not participating, children in the Medicaid program.

**9.2 Specify one or more performance goals for each strategic objective identified:**

Because Montana has not previously had a children's health insurance program and funding constraints will limit ~~our~~ first year efforts, all performance goals noted below are targets for State Fiscal Year 2001 unless otherwise noted.

1. Improve health status of children covered by the CHIP program with a focus on preventive and early primary treatment.  
Performance goals:
  - Ninety percent (90%) of children under ~~two~~ years of age receive the basic immunization series.
  - Ninety percent (90%) of thirteen year olds receive required immunizations.
  - Sixty percent (60%) of children under fifteen months receive recommended number of well child visits.
  - Sixty percent (60%) of three, four, five and six-year-old children receive at least one well-child visit during the year.
  - Fifty percent (50%) of children twelve through seventeen receive at least one well-care visit during the year.
  
2. Decrease the proportion of children in Montana who are uninsured and reduce the financial barriers to affordable health care coverage.  
Performance goal:
  - Decrease the proportion of children  $\leq$  150% of federal poverty who are uninsured.

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3. Prevent “crowd out” of employer coverage.  
Performance Goal:
  - Maintain the proportion of children  $\leq$  150% of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy.
  
4. Co-ordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.  
Performance Goals:
  - Enroll a minimum of 50% of children currently receiving benefits through the Caring Program for Children into the Child Health Insurance Program by December 1, 1999.
  - Ensure that 50% of children referred from CHIP to Medicaid enroll in Medicaid.
  - Co-ordinate with the Title V Children With Special Health Care Needs and the Mental Health Access programs to ensure that children who need care beyond what is offered under CHIP are referred to these programs.
  - Enroll 10% of the children served by the Children With Special Health Care Needs program in CHIP.
  - Enroll 90% of children in the Mental Health Access Plan who are also eligible for CHIP into the CHIP program.
  
5. Increase the enrollment of currently eligible, but not participating, children in the Medicaid program.  
Performance goals:
  - Ensure that 50% of children referred from CHIP to Medicaid enroll in Medicaid.

**9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state’s performance, taking into account suggested performance indicators as specified below or other indicators the state develops: .**

Objective One: Improve health status of children covered by the CHIP program with a focus on preventive and early primary treatment.

Insurance plans and HMOs will be required to collect and report HEDIS data. The Department of Public Health and Human Services will use this data to measure the success of the plans in reaching the performance goals regarding immunization and well-child care.

Objective Two: Decrease the proportion of children in Montana who are uninsured and reduce the financial barriers to affordable health care.

Performance goals under this objective will be measured based on the decrease in the

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proportion of children in families with incomes  $\leq$  150% of the federal poverty level who are uninsured compared with the proportion that were uninsured before the effective date of this state plan. Two different measures will be used to determine the number of uninsured children. First, baseline numbers of uninsured children will be calculated from a three-year average of the 1995, 1996, and 1997 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year. Second, questions will be added to the Behavioral Risk Factor Surveillance System (BRFSS) to establish both baseline information and an ongoing assessment of the insurance status of Montana youth. This data will be used to supplement the census data.

Clients who leave the CHIP program before their twelve months of eligibility have expired and those who fail to re-enroll will be surveyed to learn why they are no longer using CHIP. Responses will be tracked and used to evaluate the extent that CHIP has reduced financial barriers to affordable health care coverage.

Objective Three: Prevent “crowd out” of employer coverage.

Performance goals under this objective will be measured based on the proportion of children  $\leq$  150% of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy. The proportion of children covered under an employer-based plan will be evaluated, and analysis will be conducted to test for evidence of “crowding out.” The baseline for comparison will be obtained from a 3-year average of the 1995, 1996, and 1997 March supplement to the Current Population Survey. Questions will also be added to the Behavioral Risk Factor Surveillance System (BRFSS) to establish both baseline information and an ongoing assessment of the insurance status for Montana youth. This latter data will be used to supplement the census data.

In addition, the eligibility determination process will include questions relating to past employer-based insurance coverage. This will allow the state to track the number of children who have access to employment-based coverage and to ensure that children enrolling in the CHIP are uninsured and are not dropping their employment-based coverage to enroll in CHIP.

Objective Four: To coordinate and consolidate with other health care programs providing services to children to create a seamless system for low-income children in need of health care.

Performance goals under this objective will be based on the enrollment of children previously receiving care through the Caring Program for Children, the Mental Health Access System, and Medicaid. Clients who enroll in CHIP will be tracked in an eligibility determination module that will interface with the Medicaid Management Information System allowing for coordination with Medicaid. The CHIP eligibility

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system will also conduct Medicaid screening and will allow the state to track the number of children who were referred to Medicaid through the eligibility determination process. CHIP will query Medicaid enrollment data to learn how many children referred from CHIP to Medicaid have enrolled. CHIP will also query the Mental Health Access Plan to find whether children are enrolled in both programs. Data from the enrollment form will be used to determine the number of children previously covered by the Caring Program.

Objective Five: Increase the enrollment of currently eligible, but not participating, children in the Medicaid program.

Clients who enroll in CHIP will be tracked in an eligibility determination module that will interface with the Medicaid Management Information System allowing for coordination with Medicaid. The CHIP eligibility system will also conduct Medicaid screening and will allow the state to track the number of children who were referred to Medicaid through the eligibility determination process. CHIP will query Medicaid enrollment data to determine how many children referred **from** CHIP to Medicaid have enrolled.

Check the applicable suggested performance measurements listed below that the state plans to use:

- 9.3.3  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2  The reduction in the percentage of uninsured children.
- 9.3.3  The increase in the percentage of children with a usual source of care.
- 9.3.4  The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5  **HEDIS** Measurement Set relevant to children and adolescents younger than **19**.
- 9.3.6  Other child appropriate measurement set. List or describe the set used.
- 9.3.7  If not utilizing the entire **HEDIS** Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1  Immunizations

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- 9.3.7.2  Well child care
- 9.3.7.3  Adolescent well visits
- 9.3.7.4  Satisfaction with care
- 9.3.7.5  Mental health
- 9.3.7.6  Dental care
- 9.3.7.7  Other, please list: Children's access to primary care providers.
- 9.3.7.8  Performance measures for special targeted population

- 94  The state assures it will collect all data, maintain records and furnish reports to the Secretary (clarify the Secretary) at the times and in the standardized format that the Secretary requires.
- 95  The state assures it will comply with the annual assessment and evaluation required under Section 10.1 and **10.2**. (See Section 10) Briefly describe the state's plan for these annual assessments and reports.

The Montana Department of Public Health and Human Services will do the ~~annual~~ assessments and evaluations required in Section 2108(a). The **Annual** Report will include an assessment of the operation of the Children's Health Insurance Plan, its progress toward meeting its strategic objectives, and performance goals. The baseline number of uninsured children will be calculated from an average of the 1995, 1996, and 1997 March supplements to the Current Population Survey produced by the Bureau of the Census. Questions will **also** be added to the Behavioral **Risk** Factor Surveillance System (BRFSS) to establish both baseline information and an ongoing assessment of the insurance status for Montana youth. This data will be used to supplement the census data.

By March 21, 2000, the state will submit an evaluation that includes the following elements as specified in Section 2108(b).

- A. **An** assessment of the effectiveness of the CHIP in increasing the number of children with creditable health coverage. One of the plan's strategic objectives is to decrease the proportion of low-income children in Montana who are uninsured. The effectiveness of the plan in meeting this

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goal will be evaluated by examining the proportion of children in families with incomes  $\leq 150\%$  of the federal poverty level who are uninsured and the percentage of children who are income and asset eligible for Medicaid, who are enrolled in Medicaid. In addition, an estimate of the change in the proportion of children with incomes  $\leq 150\%$  who are covered under **an** employment-based plan will be done to evaluate the extent that coverage provided under the plan does not substitute for coverage that would have been provided through an employer.

B. A description and analysis of the effectiveness of the elements of this plan that will include, but is not limited to:

1. Demographics - The assessment will evaluate the characteristics of children covered under the CHIP including age, family income, ethnicity, and coverage by other health insurance prior to enrolling in CHIP.
2. Quality - As described in section 7.1, quality will be measured through the use of HEDIS and complaint data.
3. Subsidies and Cost-sharing - Another strategic objective is to provide access to appropriate medical care to children in low-income families by reducing the financial barriers to affordable health care coverage. Therefore, the state will report the amount of subsidies paid out of state and federal funds, the amount of cost-sharing paid in by enrollees, and the percentage of children who do not enroll for financial reasons. This measure will also allow plan administration to determine families' compliance with cost sharing structures.
4. Service area - The analysis will include a description of the service area of CHIP and will address the ability of the state to acquire contracts to provide statewide coverage.
5. Time limits - CHIP enrollees will be guaranteed twelve months of eligibility unless they move **from** the state, are enrolled in Medicaid, are found to have other creditable insurance, or become financially ineligible. The evaluation will analyze how many children receive coverage for the full twelve months. If children receive coverage for less than twelve months or fail to re-enroll, the reason why coverage was discontinued will be examined.
6. Benefits Covered and other Methods Used to Provide Health Assistance - The analysis will include a description of the benefits covered and any other methods that the state uses to provide health assistance.
7. Sources of Non-Federal Funding - The assessment will describe and detail sources of state and private funding used to cover the costs of CHIP.

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- C. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- D. A review and assessment of State activities to coordinate the CHIP with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services. A strategic objective of the plan is to coordinate and consolidate health care programs providing services to children. This assessment will evaluate the ability of the CHIP to coordinate with Medicaid, the Caring Program for Children, the Mental Health Access Plan, and the program for Children With Special Health Care Needs.
- E. An analysis of changes and trends in the state that effect the provision of accessible, affordable, quality health insurance and health care to children. Trends that will be examined include changes in health care cost indexes, changes in state demographics and income, changes in the level of unemployment, the level of HMO penetration across the state, and any new state legislation enacted subsequent to this plan that will affect children's health care.

- 9.6.  The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))
- 9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))
  - 9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)
  - 9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)
  - 9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)
  - 9.8.4.  Section 1115 (relating to waiver authority)
  - 9.8.5.  Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

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- 9.8.6. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. ☒ Section 1128A (relating to civil monetary penalties)
- 9.8.9. ☒ Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.H Section 1132 (relating to periods within which claims must be filed)

**9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))**

Public involvement and support are essential if we are to make CHIP a successful program in Montana. To ensure that we obtain support, the state has held numerous discussions and meetings with key stakeholders in Montana. The primary means we used are outlined below:

CHIP Advisory Committee

DPHHS hosted a preliminary meeting on 7/31/97 to discuss a planning strategy for the CHIP program with children's advocacy groups, the Governor's budget staff, Title X, Medicaid, and health insurers. DPHHS then formed a broad-based Children's Health Insurance Advisory Committee to develop the plan for implementing the block grant. The Advisory Committee includes representatives from the Governor's office, DPHHS (Title X, Title V, Medicaid, Part C, TANF), State Insurance Commissioners Office, Office of Public Instruction, members of the State Legislature, children's advocacy groups, families, schools, clergy, business, insurance, health care providers, Native Americans and others. The Advisory Council met four times (on 9/22/97, 10/20/97, 1/27/98, and 3/31/98). These meetings have been open to the public. They were advertised in the newspapers and on the Department bulletin board and have been well attended (eighty to 130 people in attendance at each meeting). The last two meetings used the state's interactive video technology. This enabled people from eight different communities to participate.

Basic design of the CHIP program including using Medicaid, private insurance or a combination for coverage; insurance benefit design; and cost-sharing options were discussed thoroughly. All parties' comments and suggestions were given serious consideration in developing the state plan. The "draft" state plan itself was the topic of the 3/31/98 meeting.

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This advisory committee will be reconstituted once CHIP is implemented to help perform oversight of the implementation phase. Public input will continue to be actively solicited.

### Public Forums

In late November and early December of **1997**, public forums were held in Miles City, Billings, Great Falls, Missoula, Kalispell, and Bozeman to gather public opinion about the design of the CHIP program. Invitations were sent to more than **1020** people/organizations (including Head Starts, tribal chairs, county public assistance directors, legislators, county commissioners, Human Resource Development Councils, family preservation groups, the DPHHS Native American Advisory Council, Medicaid Primary Care Providers, provider and consumer associations, Montana Health Care Coalition, Montana Health Care Advisory Council and low income advocacy groups).

The forums were held in the evening to ensure maximum participation. More than 120 people attended the forums. Fifty of those attending signed in as citizens, taxpayers, or members of a low income advocacy coalition. An overview of the program was given and people were specifically asked their thought on coverage (Medicaid, private insurance, or a combination), components of the benefit package, and cost-sharing.

### Native Americans

Presentations on the proposed components of the CHIP package were made to Native Americans in three different forums. These include the Region VIII HCFA Tribal Consultation meeting **11/6/97**, the Montana-Wyoming Area Indian Health Board meeting on **11/24/97**, and the DPHHS Native American Advisory Council meeting **12/9/97**. Again, an overview of the program was given and people were specifically asked their thought on coverage (Medicaid, private insurance, or a combination), components of the benefit package, and cost-sharing. Each audience was asked about their ideas for outreach to Native American populations as well.

### Legislative Input

Montana's Legislature does not reconvene until January **1999** so a presentation to the full body will not be possible until then. The Department has made presentations at ten interim committee meetings on the CHIP program between October **1997** and March **1998**. These include the Legislative Finance Committee, the Oversight Committee on Children and Families, and the Committee on Indian Affairs. In addition, all legislators received three newsletters containing CHIP program development updates and an invitation to attend the public forums. Four key legislators serve on the CHIP Advisory Council.

### Meetings With Interested Parties

CHIP staff have given more than forty presentations to other interested parties. Some of the groups we have talked to include: Montana Hospital Association, Montana Health Coalition, Health Advisory Council, statewide Public Health Association conference, Family Planning State Council, Montana Council for Maternal and Child Health,

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Montana Children's Alliance, Children's Committee of the Mental Health Association, Head Start, statewide meeting of Public Health and School Nurses, Governor's Council on Children and Families, and the Montana Association of Counties Human Services Committee. At the request of several of these organizations, a CHIP update/presentation is done at each meeting.

**9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))**

**ADMINISTRATIVE COST (INCLUDING MARKETING AND OUTREACH)**

<b>CHILD HEALTH INSURANCE PLAN</b>			
<b>ADMINISTRATIVE BUDGET SFY 99-01</b>			
	<b>FY99</b>	<b>FY00</b>	<b>FY01</b>
<b>I. PERSONNEL</b>			
DATA ANALYSIS AND SYSTEMS	\$0	\$37,148	\$37,148
PROGRAM ADMINISTRATION	<u>\$37,148</u>	<u>\$96,705</u>	<u>\$96,705</u>
SUBTOTAL	<u>\$37,148</u>	<u>\$133,853</u>	<u>\$133,853</u>
<b>II. OTHER DIRECT COSTS</b>			
GENERAL OPERATIONS	<u>\$8,000</u>	<u>\$27,000</u>	<u>\$27,000</u>
SUBTOTAL	<u>\$8,000</u>	<u>\$27,000</u>	<u>\$27,000</u>
<b>III. INDIRECT COSTS</b>	80,000	\$173,762	\$185,962
<b>IV. EQUIPMENT AND COMPUTER SYSTEMS</b>			
SERVER	\$12,000	\$0	\$0
OFFICE EQUIPMENT	\$1,200	\$3,600	\$3,600
MMIS MODIFICATIONS	\$0	\$250,000	\$150,000
PERSONAL COMPUTERS	<u>\$2,400</u>	<u>\$7,200</u>	<u>\$0</u>
SUBTOTAL	<u>\$15,600</u>	<u>\$260,800</u>	<u>\$153,600</u>
<b>V. CONTRACT AGREEMENTS</b>			
ELIGIBILITY, PREMIUM ENROLLMENT	\$50,000	\$500,000	\$560,000
EVALUATION & AUDIT	\$8,000	\$48,000	\$8,000
MARKETING CONSULTANTS	<u>\$22,000</u>	<u>\$92,000</u>	<u>\$107,000</u>
SUBTOTAL	<u>\$80,000</u>	<u>\$640,000</u>	<u>\$735,000</u>
<b>TOTAL</b>	<b>\$160,748</b>	<b>\$1,235,415</b>	<b>\$1,235,415</b>

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## **I. Personnel**

Four positions will be required to administer the CHIP program: a program manager, a nurse to perform quality assurance, a combination data analyst/systems administrator, and a clerical position.

The program manager will manage the day to day activities of the program. Primary duties include program development and assessment, contract management, fiscal management including capping enrollment to stay within the legislative appropriation.

The quality assurance nurse will conduct network adequacy review of the insurance plans/HMOs and monitor the performance measurements specified in this state plan. Because Montana will use both HMO and indemnity insurance plans, we anticipate that the QA nurse will need to work closely with the insurance plans to assure that necessary encounter data is collected and reported correctly. This position, along with the data analyst will be responsible for completing the analysis of how the CHIP program is functioning and making an annual report to HCFA. The position will also assist in preparing the evaluation which must be submitted by March 2000.

The data analyst/systems administrator will provide data analysis and support for program management. The position will be responsible for management of the CHIP portion of the MMIS contract. Other primary duties include serving as the CHIP liaison with the decision support and eligibility systems. Because Montana will utilize both HMO and indemnity insurance plans, we anticipate that the data analyst will need to work closely with the insurance plans to assure that necessary encounter data is collected and reported correctly. Along with the QA nurse, the data analyst position will be key in gathering information to complete both the annual reports that are required and the evaluation report of the program which must be submitted to HCFA in March 2000.

The clerical position will perform support functions for the program.

## **II. Direct Costs**

General Operations: Operating costs include equipment maintenance and repair, travel, office supplies, postage, printing, telephone maintenance, and toll charges.

## **III. Indirect Costs**

Charges for indirect costs are estimated based on past experience with the Department's approved indirect cost allocation system. Indirect costs include personnel, space, computer

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linking, maintenance, fiscal and other related charges that will be associated with the CHIP program but which cannot be directly charged to the program.

#### IV. Equipment and Computer Systems

Server: A server will be purchased to support the development of remote eligibility determination.

Office Equipment: Equipment such as desks, chairs, file cabinets, etc. for new CHIP program staff.

Modifications to the Medicaid Management Information System (MMIS), Eligibility System (TEAMS), and Decision Support Systems: The Medicaid MMIS will be expanded so that in FY 1999, it can make premium payments and account for encounter data. Links will be established with the TEAMS system to prevent duplication and ensure appropriate enrollment of individuals into either CHIP or Medicaid. A data warehouse will be established for CHIP data so that it can be accessed through the existing Medicaid Decision Support System.

Personal Computers: CHIP staff will each need a personal computer at a cost of approximately \$9,600.

#### V. Contractual Agreements

Eligibility Determination, Premium Processing & Enrollment in an Insurance Plan: In FY 1999 during the first phase of this program, the state (or its contractor) will determine eligibility, process enrollment fees, and enroll children in insurance plans.

After the legislature meets and appropriates additional funding for the CHIP program, we will contract with an enrollment broker to determine eligibility, process enrollment fees, and enroll children in insurance plans. One of the duties of this entity will be to assist clients in selecting an insurance plan which best meets their individual child's needs. The enrollment broker will **also** assist families who appear to be eligible for Medicaid to apply for Medicaid. (We assume that some people applying for CHIP will be eligible for Medicaid and will need to be referred to that program. Only the costs associated with eligibility determination and enrollment of the CHIP population are shown. Costs associated with Medicaid eligibility will be borne by the Medicaid program). The enrollment broker will be required to develop and operate a system that sends re-enrollment notices to current participants of CHIP annually. The broker will provide training and support for application and outreach sites, provide a grievance procedure for applicants who are denied, operate a 1-800 number that enrollees may call to receive information about CHIP coverage and eligibility issues, and provide eligibility data needed for annual reports.

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Evaluation and Audit: The Department will contract out part of the March 2000 evaluation of the CHIP program. We estimate the cost at \$40,000. We will also add questions about children's insurance status to the Behavioral Risk Factor Surveillance System (BRFSS) to establish a baseline for and monitor on an ongoing basis the number of uninsured children in the state. The annual cost of obtaining data through BRFSS is \$8000. We are assuming that any audits of the CHIP program will be performed by the Legislative Auditor's Office as part of their single audit responsibilities for the Department.

Marketing Consultants: Consultants will design a logo and images that will be associated with CHIP, develop and print brochures and applications, and perform outreach activities as described in section 5 of this plan.

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**CHILD HEALTH INSURANCE PLAN  
BENEFIT BUDGET SFY 1998 - 2001**

	Average Monthly Enrollment	Monthly Capita Cost	Total Cost
SFY 1999			
Infants	38	\$88.73	\$40,575
1-5 Year Olds	200	\$88.73	\$212,798
6-12 Year Olds	285	\$88.73	\$302,995
13-18 Year Olds	434	\$88.73	\$462,662
Total	957		\$1,019,030
SFY 2000			
Infants	363	\$88.73	\$386,659
1-5 Year Olds	1,904	\$88.73	\$2,027,869
6-12 Year Olds	2,712	\$88.73	\$2,887,401
13-18 Year Olds	4,141	\$88.73	\$4,408,955
Sub Total Health Insurance	9,120		\$9,710,884
Mental Health Access Plan	151		\$1,438,906
Total			\$11,149,790
SFY 2001			
Infants	363	\$88.73	\$386,659
1-5 Year Olds	1,904	\$88.73	\$2,027,869
6-12 Year Olds	2,712	\$88.73	\$2,887,401
13-18 Year Olds	4,141	\$88.73	\$4,408,955
Sub Total Health Insurance	9,120		\$9,710,884
Mental Health Access Plan	151		\$1,438,906
Total			\$11,149,790

Background detail for the proposed insurance rate of **\$91.40** per member per month is found in Appendix B. Monthly capita costs shown are net of the **\$2.67** monthly average enrollment fee (**\$91.40-\$2.67=\$88.73**). The **\$2.67** reflects the monthly weighted average of the annual enrollment fee of **\$25/child** which families at or below 100% of poverty will be assessed (estimated to be **72%** of enrollees) and **\$50/child** which families between 101-150% of poverty will be assessed. We estimate that we will collect **\$292,205** from the enrollment fees annually. This budget reflects expenditures after this amount has been removed. The **\$292,205** was not matched with federal funds.

The payment to the contractor for the Mental Health Access Plan (MHAP) reflects the cost for mental health services for children dually eligible for CHIP and MHAP. This cost estimate reflects our experience to date with children under 150% of poverty.

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## CHILD HEALTH INSURANCE PLAN NON-FEDERAL FUNDING SFY99-01

	SFY98-99	SFYSS00	SFY00-01
CHIP General Fund Appropriation	\$60,126	\$2,552,591	\$2,552,591
Special Revenue Funds from the Insurance Commissioner's Office	\$210,022		
<b>TOTAL STATE AND PRIVATE FUNDING AVAILABLE</b>	<b>\$270,140</b>	<b>\$2,552,591</b>	<b>\$2,552,591</b>

The special revenue from the Insurance Commissioner's Office derives from an intergovernmental transfer of funds received by the Commissioner in a settlement with an insurance company.

## CHILD HEALTH INSURANCE PLAN SUMMARY BUDGET SFY99-01

	TOTAL	STATE ONLY EXPENDITURES	MATCHABLE EXPENDITURES	STATE MATCH	FEDERAL MATCH
<b>SFY98-99 JULY 1, 1998 - JUNE 30, 1999</b>					
ADMINISTRATIVE COSTS	\$160,748	<del>\$44,081</del>	\$116,667	\$24,045	<b>\$92,622</b>
BENEFIT COSTS	\$1,019,030	\$0	<b>\$1,019,030</b>	\$210,022	<b>\$809,008</b>
<b>TOTAL</b>	<b>\$1,179,778</b>	<b>\$44,081</b>	<b>\$1,135,697</b>	<b>523,407</b>	<b>\$901,630</b>
<b>SFY 99-00 JULY 1, 1999 - JUNE 30, 2000</b>					
ADMINISTRATIVE COSTS	<b>\$1,235,415</b>	\$0	\$1,235,415	\$254,619	<b>\$980,796</b>
NET MATCHABLE BENEFIT COSTS	<b>\$11,149,790</b>	\$0	\$11,149,790	\$2,297,972	<b>\$8,851,818</b>
GROSS PROGRAM COSTS					
ENROLLEE PREMIUM COST SHARING					
<b>TOTAL</b>	<b>\$12,385,204</b>	<b>\$0</b>	<b>\$12,385,204</b>	<b>\$2,552,591</b>	<b>\$9,832,614</b>
<b>SFY 00-01 JULY 1, 2000 - JUNE 30, 2001</b>					
ADMINISTRATIVE COSTS	\$1,235,415	<b>\$0</b>	\$1,235,415	525,4619	<b>\$980,796</b>
NET MATCHABLE BENEFIT COSTS	<b>\$11,149,790</b>	<b>\$0</b>	\$11,149,790	<b>\$2,297,972</b>	<b>\$8,851,818</b>
GROSS PROGRAM COSTS					
ENROLLEE PREMIUM COST SHARING					
<b>TOTAL</b>	<b>\$12,385,205</b>	<b>\$0</b>	<b>\$12,385,205</b>	<b>\$2,552,591</b>	<b>\$9,832,614</b>

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1.  The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2.  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

10.2.  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

10.2.1.  An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1.  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2.  The quality of health coverage provided including the types of benefits provided;

10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4.  The service area of the state plan;

10.2.2.5.  The time limits for coverage of a child under the state plan;

10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7.  The sources of non-Federal funding used in the state plan.

10.2.3.  An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

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- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5.  An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7.  Recommendations for improving the program under this Title.
- 10.2.8.  Any other matters the state and the Secretary consider appropriate.
- 10.3.  The state assures it will comply with future reporting requirements as they are developed.
- 10.4.  The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Proposed Effective Date: April 10 1998

# **APPENDIX A:**

# **ACTUARY REPORT**

**Proposed Effective Date: April 10, 1998**

STATE AUDITOR  
STATE OF MONTANA

*Mark O'Keefe*  
STATE AUDITOR



COMMISSIONER OF INSURANCE  
COMMISSIONER OF SECURITIES

ACTUARIAL MEMORANDUM

Actuarial Opinion Regarding the Actuarial Value of the Montana Children's Health Insurance Program

I, Margaret A. Miksch, am an Associate of the Society of Actuaries and a member of the American Academy of Actuaries, and I meet the Academy's qualification standards for actuarial opinions related to health insurance premium rates, rating methodologies, and cost analyses. I am employed as a life and health actuary at the Montana Insurance Department. At the request of the Montana Department of Public Health and Human Services (DPHHS) I have determined the actuarial value of coverage of the benchmark benefit package and of coverage of the Montana Children's Health Insurance Program (CHIP). I have concluded that the CHIP meets the requirements of Title XXI of the Social Security Act with respect to its actuarial value. In the following memorandum, I will outline the methods used in my determination.

The actuarial value of the benchmark plan is based on the utilization and price factors from the Tillinghast-Towers Perrin 1998 Medical Manual and from the Tillinghast 1998 Medical and Dental HealthMAPS Health Rating Software which accompanied the manual, as well as on some price factors from the Montana section of the Tillinghast-Towers Perrin 1998 State Mandated Benefits Manual. The CHIP plan is valued as a HMO plan, based on utilization assumptions and price factors from the two above-referenced manuals and from the Tillinghast HealthMAPS 1998 PMPM program which also accompanied the manual. Attached are Exhibits I through XVII which detail the calculation of the actuarial values of the benchmark plan and of the CHIP plan.

The health insurance plan chosen as the benchmark plan is the Basic Plan offered to employees of the State of Montana. Accompanying this memorandum, and labeled Attachment 1, is a copy of a summary description of the employee health plan options, titled "Employee Medical Plans." The middle column of the "General Benefit Description" section and the left column of the "Specific Benefit Description" section provide the details of the benefits provided by the Basic Plan. The plan offers different levels of benefits based on whether the insured utilizes in-network or out-of-network providers, and also offers different outpatient mental health and chemical dependency benefits depending on whether or not the insured was referred by an Employee Assistance Program (EAP) counselor. (For the purpose of valuing the benchmark plan for a standardized population that is representative of privately insured children, the EAP counselor will be referred to in this memorandum as a counselor from a mental health managed care company specified by the plan). Four different HealthMAPS programs were run to obtain pricing assumptions for: (1) exclusively in-network utilization & the counselor referral for outpatient mental health and chemical dependency; (2) exclusively in-network utilization without the counselor referral for outpatient mental health and chemical dependency; (3) exclusively out-of-network utilization with the counselor referral for outpatient mental health and chemical dependency; and (4) exclusively out-of-network utilization without the counselor referral for outpatient mental health and chemical dependency.

The Tillinghast Medical Manual assigns the entire state of Montana to Medical Area B: this is the medical area chosen in attached Exhibits I and II, the HealthMAPS "In-Network Monthly Costs" output exhibits,

which differ only in the mental health and chemical dependency costs referred to in (1) and (2) in the above paragraph. Exhibits III and IV show the out-of-network monthly costs for Medical Area A, and differ only in the mental health and chemical dependency costs described in (3) and (4) above. Area A was chosen to approximate the 10% reduction in allowable charges covered by the State Basic Plan for services of out-of-network providers, as provided by Section K of the Medical Plan Benefits section of the Employee Benefits Plan booklet. A copy of Section K is included as Attachment 2.

The HealthMAPS program was run to obtain cost assumptions rather than the final actuarial value. Only the costs shown in the "children" column are meaningful. The table below explains, line by line, the rationale behind the input values. The program calculates the results in the columns and, in a few cases, the dollar amount in the input column.

BENCHMARK PLAN

HEALTHMAPS GUIDE

<u>Description</u>	<u>Input</u>	<u>Explanation</u>
1. Base Cost:	No entry	The program automatically inputs the base cost which the Medical Manual assigns to the deductible amount, assuming <b>80%</b> coinsurance <b>after</b> satisfaction of the deductible.
<u>Deductible:</u>		
2. Calendar Year Deductible:	\$750	The benchmark plan's annual deductible
3. Deductible Accumulation Period	12 (months)	The benchmark plan's specification
4. Eliminate Carry-Forward	Yes	The benchmark plan's specification
5. Deductibles Per Family	4.00	The plan provides for a \$1,500 family deductible, roughly equivalent to the individual deductible being satisfied by two insureds. The HealthMAPS program makes adjustments only to the children rate, since the children rates assume that most of the deductible will apply to the parents' coverage. Since this is child-only coverage, setting the stoploss maximum per family at 4 is equivalent to satisfaction of the individual deductible by two children.
6. Hospital Deductible per Admission	\$0	No per-admission deductible
7. Waive Deductible for Surgery	No entry	No deductible waiver for surgery
<u>Policy Specification:</u>		
8. In-Full Surgical Units	0.00	Cost-sharing applies immediately to surgical costs
9. In-Full Hospital Amount	\$0	Cost-sharing applies immediately to hospital costs
10. ICU Maximum	Unlimited	No specified ICU maximum

<u>Description</u>	<u>Input</u>	<u>Explanation</u>
<u>Covered Level:</u>		
11. <del>Room</del> and <del>Board</del>	Use area defaults	HealthMAPS's area default approximates the actual average room and board costs in Montana
12. surgical	Use area defaults	HealthMAPS's area default approximates the actual average surgical costs in Montana
13. Adjusted <del>Base</del> Cost	No entry	Sum of the costs and cost adjustments produced by the input entries
13a PPO Discount <del>Value</del>	0	The in-network <del>and</del> out-of-network values will be calculated by using Area B <del>costs</del> for the former and Area A <del>costs</del> for the latter
<u>Coinsurance - General:</u>		
14. <del>First</del> Coinsurance Percentage	75%	The benchmark plan's coinsurance percentage after the deductible
15. on first <del>\$X</del> after deductible	\$5,000	The benchmark plan's coinsurance stoploss limit
16. Second Coinsurance Percentage	100%	The plan pays 100% after the deductible <del>and</del> coinsurance requirements have been met
17. on next <del>\$Y</del> incurred	\$0	A \$0 entry in the <del>dialog box</del> indicates that the Second <del>Coinsurance</del> Percentage applies up to the lifetime <del>maximum</del>
18. Third Coinsurance Percentage	0%	Not applicable to the benchmark plan
19. <del>Stop-Loss</del> Max <del>per</del> Family	3	The plan provides for a \$10,000 family stoploss, roughly equivalent to the individual coinsurance limit being satisfied by two insureds. The HealthMAPS program makes <del>adjustments</del> only to the children rate, since the children rates assume that <del>most</del> of the <del>coinsurance</del> will apply to the <del>parents'</del> coverage. Since <del>this</del> is child-only coverage, setting the stoploss maximum <del>per</del> family at 3 is equivalent to satisfaction of the individual deductible by one child. 3 is the maximum number allowed by the HealthMAPS program.
20. Lifetime <del>Maximum</del> (omit 000's)	\$1,000	The benchmark plan's lifetime <del>maximum</del> is \$1,000,000

<u>Description</u>	<u>Input</u>	<u>Explanation</u>
<u>Mental Health and Substance Abuse:</u>		
21. Outpatient - Coinsurance	00% or 50%	The benchmark plan pays <b>75%</b> of outpatient mental health and substance abuse charges, after satisfaction of the plan deductible, if the insured is referred by a counselor from a mental health managed care company specified by the plan; and 50% otherwise. The HealthMAPS program <b>only</b> allows for one of <b>two</b> options: 00% and 50%.
22. Outpatient - <b>Max.</b> Covered Charge	<b>\$3,000</b> or <b>\$2,000</b>	The coinsurance applies <b>to</b> a maximum of <b>30</b> visits per member with the <b>referral</b> described above, and to a maximum of 20 visits otherwise. <b>HealthMAPS</b> provides, for entry of a dollar maximum, not a maximum number of <b>days</b> ; the <b>\$3,000</b> and <b>\$2000</b> amounts are based on an estimate of a <b>\$100 per</b> day average charge. (These provisions were effective January <b>1, 1998</b> , and replace the benefit description in Attachment 1. The current benefit provisions are described in Attachment 3).
23. Outpatient - <b>Annual</b> Maximum	<b>\$0.00</b>	The benchmark plan's benefits <b>are</b> limited in terms of days of coverage, not by a dollar maximum
24. Include Outpatient Substance Abuse	Yes	The same benefits are provided for substance abuse <b>as</b> for mental health
25. Outpatient Adjustment Factor	<b>0.9375</b> or <b>1.00</b>	<b>75%/80%=0.9375</b> is the factor to convert the 80% coinsurance option in HealthMAPS to the <b>75%</b> coinsurance provided by the plan with the required counselor referral. Since the <b>50%</b> coinsurance provided in the absence of <b>this</b> referral is a HealthMAPS option, <b>the</b> adjustment factor for <b>this</b> non-managed care counselor referral coverage is 1.00.
26. Inpatient - <b>Max.</b> Days	<b>30</b>	The durational limit defined by the benchmark plan for inpatient mental health and chemical dependency
27. Inpatient - Adjustment Factor	<b>1.00</b> or <b>0.79</b>	1.00 is the adjustment factor for in-network coverage; <b>0.79</b> is the factor for out-of-network coverage. HealthMAPS calculates the inpatient mental health and substance abuse <b>cost as</b> 3% of Be base cost on line 1. The adjustment factors were calculated as the change in <b>cost</b> due to the different cost-sharing assumptions in the benchmark plan's provisions. <b>See</b> Exhibits VII and VIII.

<u>Description</u>	<u>Input</u>	<u>Explanation</u>
<u>Extended Care Facility:</u>		
28. ECF Daily Benefit	50% of R&B	The benchmark plan covers skilled nursing facility stays of up to 70 <b>days</b> . The Tillinghast Medical Manual's monthly cost calculation for "skilled nursing facilities" matches the HealthMAPS cost for "extended care facilities."
29. ECF <b>Maximum</b> Number of Days	70	The durational limit defined by the benchmark <b>plan</b>
<u>Policy Specifications:</u>		
30. Waiver of <b>Coinsurance</b> : CP Surgical	None	The benchmark plan provides for no such waiver
31. Supplemental Accident <b>Maximum</b>	<b>\$0</b>	The benchmark <b>plan</b> provides no such benefit
32. Eliminate Prescription Drugs	Yes	The prescription drug coverage is calculated separately <b>by</b> the HealthMAPS Prescription Drug Card Costs program, <b>as</b> shown in Exhibits V and VI. The benefits vary depending on whether the prescription <b>drugs</b> are purchased by <b>mail</b> through a <b>prearranged</b> agreement with a specified pharmacy or <b>are</b> purchased directly from the pharmacy.
<u>Copayments:</u>		
33. Primary <b>Office</b> Visit Copay	\$15	The benchmark plans copay requirement for allowable office visit charges
34. Specialist <b>Office</b> Visit Copay	<b>\$15</b>	The benchmark plans copay requirement for allowable office visit charges
35. <b>Max. Number</b> of Copays per <b>Year</b>	<b>100</b>	The benchmark plan provides no limit. <b>An entry</b> of 100 <b>results</b> in a "no limit" adjustment.
36. <b>Emergency Room</b> Copay	<b>\$0</b>	The benchmark plan provides for no such copay.
37. Outpatient Surgical Center Copay	<b>\$0</b>	The benchmark plan provides for no such copay.
<u>Misc. In-Network Adjustment:</u>		
38. None	<b>\$0.00</b>	Though the benchmark plan provides coverages not specifically accounted for in the HealthMAPS program, <b>they</b> are not adjusted for here because the CHIP coverage <b>does</b> not include <b>them</b> ; therefore they are not needed for comparison <b>purposes</b> .

<b>Description</b>	<b>Input</b>	<b>Explanation</b>
<u>Well Care Benefit:</u>		
39. <b>Nursery</b> Benefits-Maternity on <i>Kids</i>	<b>\$656</b> or <b>\$600</b>	In-network and out-of-network values, reflecting the average in-hospital newborn costs for medical areas B and A respectively (obtained by multiplying the 1998 Medical Manual's assumption of an Area E average <b>cost</b> of \$800 by 0.82 and <b>0.75</b> ).
Adjustment Factor	1.00	The HealthMAPS cost reflects the effects of the deductible and <b>coinsurance</b> inherent in the plan. <b>Since</b> the benchmark plan waives the deductible and <b>coinsurance</b> for newborn coverage, <b>this cost</b> will be <b>derived</b> from another <b>source</b> . The adjustment is irrelevant.
41. Well Care <b>Benefits</b> Adult	<b>No</b>	Irrelevant; only the children <b>costs</b> are relevant.
42. Adjustment Factor	<b>No entry</b>	Irrelevant; only the children factors are relevant.
43. Well <b>Care</b> Benefits <b>Children</b> - Physical Exam <b>Only</b>	No ancillary limit	<b>None is</b> provided in the benchmark plan
44. Total Expense Limit	\$146	The plan pays up to <b>\$250</b> of well care benefit in the <b>first</b> year, and up to \$125 in each of the following <b>5</b> years. $\$250 / 6 + \$125 \times 5 / 6 = \$146$ .
45. Benefits Terminate at Age	<b>6</b>	The benchmark plan provides well child preventive care through age <b>5</b> .
46. <b>Manual Cost</b> (before adjustment)	<b>No entry</b>	<b>Sum of</b> the adjusted base <b>cost</b> from line 13 and the <b>costs</b> and cost adjustments produced by the input entries following line 13.

<u>Description</u>	<u>Input</u>	<u>Explanation</u>
<u>Factor Adjustments:</u>		
47. Experience Factor	0.526	The factor of 0.526 is a conversion of children rates to child rates (1/1.9). Tillinghast's children claim costs assume 1.9 children per family. <b>An</b> experience adjustment is not applicable, since the benchmark plan's value will be compared to a startup plan.
48. Underwriting Factor	1.03	<b>This</b> input reflects <b>an</b> increase in overall value because of benefits covered by the benchmark plan that are not included in Tillinghast's assumptions. <b>This</b> is actually <b>an</b> adjustment factor, not <b>an</b> underwriting factor.
49. Trend Factor	September 1998	HealthMAPS calculated <b>1.014</b> as the trend from July 1, 1998, which is the <b>start</b> date of the 12-month period over which the HealthMAPS claim costs are effective, to September 1, 1998, when the <b>CHIP</b> program is estimated to take effect.
50. Age Gender Factor	Age 19	<b>This</b> entry results in a HealthMAPS adjustment to convert to Tillinghast's general assumption of coverage of students to age 23 and other children to age 19 to the <b>CHIP</b> provision of coverage to age 19 for all children.
51. Child "Coverage From"	From birth	The benchmark plan's provision
52. Pre-Admission Certification Factor	Yes	The benchmark plan's provision
53. <b>SIC</b> Factor	<b>No</b>	The benchmark plan has no <b>SIC</b> variations in premium
54. Final <b>Total Manual Costs</b>	<b>No entry</b>	Product of the manual cost before adjustments from line 46 and the adjustment factors from lines 47 through 53.

The prescription **drug** coverage is covered **through** a drug card program in the benchmark plan, and offers **two different** copay bases. **Attachment 4**, which is a copy of the **description** of the prescription drug benefit effective January 1, 1998 is attached. **As** described in **Attachment 4**, if the prescription **drugs** are purchased directly **from** the pharmacy, the **copays** consist of a **\$50** deductible, **70%** coinsurance for brand name drugs, and **90%** coinsurance for generic equivalents. **The** HealthMAPS calculation of the cost of **this** coverage is shown in Exhibit **V**. The plan also offers an option of mail order through a specified pharmacy. The copays are **\$30 per** order for brand name **drugs** and **\$10 per** order for generic **drugs**, 100% coverage after the copay. The HealthMAPS **cost** calculation for **this** coverage is shown in Exhibit **VI**. HealthMAPS calculates the base cost directly **from** the input information; the only adjustment is for trend. All entries in the input column were manually input except for the **retail cost**, which is entered by HealthMAPS as the Tillinghast default value.

Exhibits **VII** and **VIII**, referred to in the line 27 explanation column, demonstrates the calculation of the IP Adjustment Factor to apply to the cost automatically calculated by the HealthMAPS program. First each

exhibit shows the calculation of mental health and chemical dependency expected annual costs, and the resulting expected amount covered by the benchmark plan, using a methodology demonstrated in the "State Mandated Benefits" of the Tillinghast-TowersPerrin 1998 Medical Manual. All of the assumptions come from the Tillinghast demonstration, but the average daily cost for both mental and substance abuse is 82% of the Tillinghast assumption to reflect an Area B cost for in-network service, and 75% of the Tillinghast assumption to reflect an Area A cost for out-of-network service. 80% of the expected annual cost is also shown to reflect the Tillinghast HealthMAPS program's calculation of the inpatient mental health and substance abuse cost for 30-day coverage as 3% of the base cost of a \$750 deductible, 80% coinsurance plan with no stoploss beyond the lifetime maximum. The ratio of the benchmark plan result and the Tillinghast-based result is shown as the lightly-outlined percentage for both mental health and substance abuse coverage in each exhibit.

The calculation of HealthMAPS line 27 IP-Adjustment Factor is shown in the bottom half in each exhibit. In each case, the HealthMAPS claim cost is split into mental health and substance abuse costs. The Medical Manual assumes that the inpatient substance abuse cost is 30% of the inpatient mental health cost. Therefore the mental health portion of the HealthMAPS cost is estimated to be 1/1.3 times the total cost, and the substance abuse cost is estimated as 0.3/1.3 times the total cost. Each portion is then multiplied by the corresponding ratio calculated in the top half of the exhibit, and the two adjusted costs are added. In the case of the in-network cost, there is almost no difference, so a factor of 1.00 is the IP-Adjustment Factor input into the HealthMAPS program. In the out-of-network case, there is a significant difference, and the input factor is 0.79.

Exhibit IX shows the final calculation of benchmark plan actuarial value. Separate calculations are shown for in-network and out-of-network costs. The actuarial value is calculated in the third section, in which the assumed split between in-network and out-of-network utilization is 75%/25%. The children claim costs are equal to 1.9x the child claim cost; the conversion to child cost is made for each benefit. The final column in the blended costs section discounts the child claim cost values by 4.8% for coverage of all children only through age 18 (the Tillinghast costs are based on the assumption that student coverage is through age 22).

The claim cost by benefit is derived as follows:

- (1) The base cost on the first line is the sum of the Adjusted Base Cost (line 13) and the coinsurance adjustment shown on the Third Coinsurance Percentage line (line 18) of Exhibits I and III respectively.
- (2) The percentages shown in connection with many of the benefits are taken directly from the distribution of comprehensive plan benefits on page 11-2 of the 1998 Medical Manual's section titled "Comprehensive Major Medical Claim Costs." Each corresponding claim cost, with one exception, is simply the percentage times the base cost. The one exception is the cost of office visits; the same calculation is used, then the adjustment cost from line 35 of HealthMAPS is added to the product. (The value in the HealthMAPS program is not the total value of the cost of office visits, but a load for replacing the deductible with a small copay).
- (3) The inpatient mental health and chemical dependency claim cost is the HealthMAPS claim cost, shown on the bottom half of Exhibits VII and VIII as the starting value of the IP-Adjustment Factor calculation, less the deduction indicated on line 27 which results from the IP-Adjustment Factor entry, plus a 20% load to cover partial hospitalization as a covered benefit of inpatient services.
- (4) The cost of the extended care facility benefit is the HealthMAPS claim cost from line 29.
- (5) The outpatient mental health and chemical dependency claim cost is a weighted average of the cost of such service upon referral by a counselor from a mental health managed care company specified by

the plan and the cost without such a referral. The weighting is **75%** for the cost with the referral and **25%** for the cost without the referral. In addition, the costs were adjusted for Area B and Area A costs by multiplying the blended cost by **0.82** and **0.75** respectively. (HealthMAPS made **no** such adjustment).

- (6) The cost of newborn coverage is the HealthMAPS claim cost from line **40** of Exhibit XII (which is the HealthMAPS output page for the CHIP actuarial valuation, which will be discussed later). That value is used rather than the ones from the benchmark plan output pages because the HealthMAPS program applies the deductible and coinsurance to the cost; under the benchmark plan provisions, the deductible and coinsurance provisions are waived for newborn coverage. Since the CHIP plan has no general cost-sharing (**as** will be discussed later), the value shown in Exhibit XII actually reflect the appropriate value for the benchmark plan.

It should be noted that, even though the coverage is labeled “Nursery Benefits” in the HealthMAPS program, the **1998** Medical Manual defines the same benefit **as** “Newborn Children” and includes coverage for **illness** immediately from the birth of a child, which is consistent with the benchmark plan’s provisions.

- (7) The well child care claim cost is derived from the HealthMAPS cost on line 2. Since HealthMAPS does not adjust the cost of **this** benefit by medical area, the costs shown in Exhibit IX reflect the HealthMAPS cost multiplied by **0.82** and **0.75** respectively.
- (8) The prescription drug card cost is the average of the prescription drug card costs calculated **as** illustrated in Exhibits V and VI. It is assumed that half the benefits will be used through the mail order program and half from purchases directly from the pharmacy. No area adjustment is **made**, since the plan pays up to the plan allowance for prescriptions for non-network pharmacies **as well as** for network pharmacies.
- (9) The cost of vision services is derived **from** the cost of vision care in the State Mandated Benefits section of the **1998** Medical Manual. Since the cost of vision hardware is not included in the benchmark plan’s benefit, but is included in the Tillinghast rate, the cost is reduced by **75%**. In addition, the cost is adjusted for Areas B and A by multiplying the result by **0.82** and **0.75** respectively. That result is then divided by **4** to account for the fact that the **1998** Medical Manual’s cost includes the cost of lenses and frames. The benchmark plan’s vision coverage only covers routine eye exams, which is estimated to be only **25%** of the Medical Manual Cost. Finally, this result is multiplied by **75%** to account for a **\$10** copay required by the benchmark plan (**this** copay is estimated to be **25%** of the cost).
- (10) As stated, hearing services are not covered under the benchmark plan.

The starting point of the calculation of the actuarial value **of** the Montana Children’s Health Insurance Program plan is the Tillinghast HealthMAPS **1998** PMPM program. All the areas in the PMPM **Lotus** spreadsheet are protected from direct changes by a confidential password. The factors within the outlines are unprotected so that adjustment factors can be entered **so** that the resulting utilization rates and costs per unit of service are appropriate for the particular population to be covered under the plan.

Exhibit X shows the **1998** PMPM spreadsheet which calculates the cost of the majority of benefits covered by the CHIP plan. The calculation of the costs of the remaining benefits are shown in exhibits following **this** one, which will **be** discussed one by one. Below is a description of the types of adjustments in the outlined columns of Exhibit X which modify the Tillinghast assumptions to calculate the per member per month costs for the CHIP plan.

Column (B): The utilization adjustment factors in column (B) of Exhibit X adjust the utilization and cost per service from blended employee/spouse/children rates to appropriate child rates. Section III of the 1998 Medical Manual, titled “Per Member Per Month (PMPM) Costs,” states that the PMPM claim cost level is “consistent with the utilization and cost per service inherent in this manual,” and further states that “the benefits are the same as those whose utilization and costs are detailed on the more traditional basis in Section V.” Thus basing the utilization adjustment factor on the ratio of the child claim cost to the blended employee/spouse/children claim cost for Medical Area B from Section V (“Distribution of Expenses and Continuance Tables”) is deemed to be actuarially consistent with the HealthMAPS assumptions used to calculate the actuarial value of the benchmark plan.

The assumption in the 1998 PMPM spreadsheet is that the underlying population has the following characteristics: 48% of the members are employees, 22% are spouses, and 30% are children. Also, the costs are based on Medical Area E. Exhibit XI shows the Medical Area B employee, spouse and child annual claim costs from Section V. The blended claim costs in the fourth claim cost column uses the same 48%/22%/30% distribution assumed in the assumed in the 1998 PMPM model. Finally, the last column shows the ratio, as a percent, of each benefit’s child cost to its blended cost. The utilization adjustment factors in Exhibit X are the percents shown in Exhibit XI. The factors were entered in Column (B) to four decimal places, though Exhibit X only shows the decimal rounded to two places. (The program will not allow a format adjustment to show the four-place decimal; however, the calculation uses the exact decimal entered).

The entries of “Manual” in this column and in Columns (E) and (I) indicate that the benefit is included in the CHIP plan, but the PMPM has been calculated separately because of characteristics of the benefit that do not necessarily reflect the value of the benefit in the PMPM spreadsheet. Entries of N/A in these columns indicate that the benefit is not included in the CHIP plan.

Column (E) The discount adjustment factor in Column (E) is actually a combination of two adjustments: (a) a factor of 0.82 to convert the Area E costs per unit of service to Area B equivalents, and (b) a factor of 0.952 to convert the Tillinghast assumption of student coverage through age 22, which is inherent in the costs, to coverage of all children only through age 18. The factor of 0.78 shown in the column is actually  $0.82 \times 0.952 = 0.78064$ .

Column (G) The copay per unit of service is \$0 in all cases except emergency room service. This copay per use is \$3.00 for a true emergency and \$6.00 for non-emergency use of the emergency room. The assumption is that half the utilization will be for emergency use and half for non-emergency use.

Column (J) The adjustment factor for the benefits for which utilization and claim cost assumptions were provided is simply 1.00, since all the necessary adjustments have already been made. For five different benefits the only assumption provided is the Area E cost per member per year. The final adjustment factor for each of these benefits is simply the product of the three adjustment factors (the child-to-blended expense ratio applicable to the benefit, the Area B conversion factor, and the age 18 limitation factor) indicated in the Column (B) and Column (E) descriptions.

Exhibit XII is the output page for the HealthMAPS program that was run to obtain some costs not included in the PMPM spreadsheet results. The explanation of the input would correspond to the explanation in the “Benchmark Plan HealthMAPS Guide” (adjusted for the characteristics of the CHIP plan). All entries in the

input column reflect the characteristics of the CHIP plan except **those** for the mental abuse and substance abuse section (lines 21 through 27). The CHIP plan's mental health and chemical dependency benefits correspond to Montana's mandated minimum coverage, which makes the features different enough from the options given by the HealthMAPS program that the input and the results in that section should be disregarded.

Only two CHIP plan monthly costs are taken from the HealthMAPS program. For this reason, the assumptions underlying the HealthMAPS calculation of only these two benefits will be discussed.

- (1) The cost of newborn children coverage is derived **from** line **40** of Exhibit XII. As was explained previously, even though the HealthMAPS program calls the coverage "nursery benefits", the cost reflects that of full coverage of newborn children for the first 31 days after birth. The input value of \$656 in line 39 is used by HealthMAPS to calculate the cost. **\$656**, calculated as 82% of the Area E cost of newborn coverage used in the calculation of the newborn children cost in the State Mandated Benefits section of 1998 Medical Manual, is the estimated Area B newborn children cost.
- (2) The well care benefit for children covers children of all ages under the CHIP plan, and covers both physical and gynecological exams. There is no specific expense limit; the input value of \$500 on line 44 **is** interpreted by HealthMAPS **as** "no limit."

Exhibit XIII is the output of the HealthMAPS prescription drug card costs program. The CHIP plan covers 100% of the cost of prescription **drugs**, and also provides 100% coverage of birth control. HealthMAPS calculates the base cost directly from the input information; the only adjustment is for trend. All entries in the input column were manually input except for the retail cost, which is entered by HealthMAPS **as** the Tillinghast default value.

Exhibit XIV shows the calculation of inpatient and outpatient mental health costs and of inpatient and outpatient chemical dependency costs. The calculation of the inpatient mental health and chemical dependency costs uses the same methodology **as** the one used in calculating expected annual amount covered by the plan for the benchmark plan. The calculation of the monthly cost per child is then accomplished by multiplying **this** expected annual amount by the frequency assumption used in the 1998 Medical Manual's demonstration. This result is increased by 20% to cover partial hospitalization, **as** recommended in the Medical Manual's explanation.

The results of the calculation of the outpatient mental health and chemical dependency child costs are also shown on Exhibit XIV. The base **costs** of both coverages **as** defined by the **CHIP** plan (which provides the benefits on the same basis **as** the **minimum** required by Montana's insurance code) are provided in the 1998 State Mandated Benefits Manual: \$4.15 for outpatient mental health and \$0.78 for outpatient chemical dependency. Since these costs assume 80% coinsurance, the final cost was calculated as the base cost / 0.8, to reflect the conversion from 80% coinsurance to 100% coinsurance.

Exhibit XV shows the final calculation of the actuarial value of the CHIP plan. The benefits whose **costs** were not included in the 1998 PMPM spreadsheet are listed; the source of the base cost of each, with the exception of three separate benefits - immunizations, vision, and audiology - has already been explained. The source of the base cost of each of these is the State Mandated Benefits section of the 1998 Medical Manual. Following is a brief explanation of the derivation of each of the base cost for each of the three.

- (1) The immunizations monthly cost from the manual is \$3.50 for children, which is converted to a per child basis by dividing by 1.9 to obtain **\$1.84**.

- (2) The vision cost from the manual is \$3.33 per child, which is assumed to cover routine eye exam, refractions, lenses and frames. Since the CHIP plan does not cover optical hardware, the cost is divided by 4 to estimate the monthly cost of routine eye exams.
- (3) The audiology-related coverage in the manual is labeled "treatment for loss or impairment of speech or hearing," and is described as "coverage of some extended benefits for an impairment which is chronic and not acute and might involve practitioners not generally covered or hearing aids or speech therapists to correct impediments not due to injury or sickness." The manual's monthly cost for children is \$3.30, which is converted to a \$1.16 per child rate after dividing by 1.9. This rate is divided by 4 to remove the cost of coverage speech-related benefits and hearing aid (neither of which are covered by the CHIP plan).

The costs of these three benefits are the Area E cost. The Area B conversion factor column in Exhibit XV contain the factor of 0.82 for these three, and 1.00 for all others (since they were already converted in their calculations shown in previously-described exhibits). The conversion factor for coverage of all children through age 18 (to age 19) is applied to all the base costs. The adjusted cost is the product of the base cost, the area conversion factor, and the age conversion factor.

The sum of these individual benefits and the grand total of the other plan benefits from the 1998 PMPM spreadsheet is shown as the overall grand total actuarial value of the CHIP plan.

Exhibit XVI lists the benefit categories used in the 1998 Medical Manual's traditional plan distribution of expenses as well as the additional categories priced separately. The actuarial values by benefit category for the benchmark plan and the CHIP plan are listed side by side. The values for the benchmark plan are taken directly from the right-hand column of Exhibit IX - the Benchmark Plan Actuarial Value Illustration. The values for the CHIP plan are taken from Exhibit X - the Per Member Per Month Cost Distribution Model, and from Exhibit XV - the Calculation of the Actuarial Value for the Montana Children's Health Insurance Program. Following is an explanation of the division of the CHIP plan's costs into the traditional plan categories used to illustrate the benchmark plan's distribution.

- Inpatient Hospital: The total cost from the Inpatient Hospital category on Exhibit X, less the Surgical cost
- Inpatient Professional: The sum of the following costs from the physician section of Exhibit X: Surgical Inpatient, Normal Delivery, C-Section, Maternity Other, Anesthesia, and Professional Inpatient
- Inpatient Mental Health and Chemical Dependency: The sum of the costs of these two coverages from Exhibit XV
- Inpatient Surgical: The Surgical cost in the Inpatient Hospital category of Exhibit X
- Extended Care Facility: Not covered by the CHIP plan
- Outpatient Hospital: The total cost from the Outpatient Hospital category on Exhibit X, less the Surgical cost
- Outpatient Professional: The sum of the following costs from the physician section of Exhibit X: Surgical Outpatient, Surgical Office, and Professional Outpatient
- Outpatient Mental Health and Chemical Dependency: The sum of the costs of these two coverages from Exhibit XV
- Outpatient Surgical: The Surgical Cost in the Outpatient Hospital category of Exhibit X

Diagnostic X-Ray and Lab: The sum of the X-Ray and Lab costs in the Physician category of Exhibit X

Office Visits: The Office Visit cost in the Physician category of Exhibit X

Newborn Coverage: The Newborn Children cost from Exhibit XV

Well Child Care: The sum of the Well Child Care cost and the Immunizations cost in Exhibit XV

Prescription Drugs: The Prescription Drugs cost from Exhibit XV

Vision Services: The Vision cost from Exhibit XV

Hearing Services: The Audiology cost from Exhibit XV

The final exhibit, Exhibit XVII, shows the values of the services defined in Title XXI of the Social Security Act for the benchmark plan and the CHIP plan, and shows the ratio of the CHIP to the benchmark plan. The ratio column clearly shows that each of the CHIP categories has a higher value than the value of the corresponding category for the benchmark plan. This is largely due to the full dollar coverage of benefits under the CHIP plan (except for a small emergency room copay) versus the \$750 deductible, 75% coinsurance on the next \$5,000 before 100% coverage becomes effective under the benchmark plan.

The actuarial values of the basic services and the additional services are taken from the costs listed in Exhibit XVI. Following is an explanation the costs included in each service category's value.

<u>Basic Services</u>	<u>Costs Used to Calculate the Services' Actuarial Value</u>
Inpatient and Outpatient Hospital Services	The sum of the Inpatient Hospital and Outpatient Hospital costs
Physicians' Surgical and Medical Services	The sum of the Inpatient Professional, Inpatient Surgical, Outpatient Professional, Outpatient Surgical, and Office Visits costs
Laboratory and X-Ray Services	The Diagnostic X-Ray and Lab cost
Well-Baby and Well-Child Care	The sum of the Newborn Coverage and Well Child Care costs
<u>Additional Services</u>	<u>Costs Used to Calculate the Services' Actuarial Value</u>
Coverage of Prescription Drugs	The Prescription Drugs cost
Mental Health Services	The sum of the Inpatient Mental Health and Chemical Dependency and the Outpatient Mental Health and Chemical Dependency costs
Vision Services	The Vision Services cost
Hearing Services	The Hearing Services cost

The total value of the benchmark plan in Exhibit XVII is \$2.50 less than the benchmark plan's total cost in Exhibit XVI because of the exclusion of the costs of extended care facility coverage and of the "other miscellaneous" category in the actuarial value calculation.

This completes the explanation of the calculation and comparison of the actuarial values of the Montana Children's Health Insurance Program's proposed plan and of the State Basic Plan chosen as the benchmark benefit coverage required by Title XXI. I certify that, to the best of my knowledge and judgment and relying on the accuracy and validity of the assumptions in the Tillinghast-Towers Perrin 1998 Medical Manual, in

the accompanying software, and in 1998 State Mandated Benefits Manual, the aggregate actuarial value of the **CHIP** plan is greater than the actuarial value of the benchmark benefit package; that the actuarial value of each of the **CHIP** plan's basic services and of each of its additional **services**, as defined in Title XXI, is greater than the actuarial value of the **corresponding service** under the benchmark plan; and that the Montana Children's Health Insurance **Program** health plan **meets** the requirements of Title XXI with respect to its actuarial value in relation to the actuarial value of the benchmark benefit package.

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Margaret A. Miksch, ASA, MAAA  
Life and ~~Health~~ Actuary  
Montana Insurance Department

4/8/98  
Date

# EMPLOYEE MEDICAL PLANS'

•Benefits in Effect September 1, 1994•

	TRADITIONAL & MEDICARE COORDINATED	BASIC	HMO
<b>General Benefit Description</b>	Maximum Plan member responsibility for allowable* expenses per:		
	Individual	Family	Individual
	Family	Individual	Family
<b>ANNUAL DEDUCTIBLE:</b> First allowable* medical expenses each benefit year paid entirely by Plan member(s)	\$200	\$600	\$750
			\$1,500
			\$0
			\$100
			\$300
			Annual referral deductible on outpatient non-PCP** professional services to which member is referred by the PCP
<b>COPAY:</b> Portion of allowable* medical expenses paid by Plan member(s) after the deductible	25% of next \$3,000	25% of next \$6,000	25% of next \$5,000
	See Specific Benefits for Exceptions	See Specific Benefits for Exceptions	25% of next \$10,000
			\$15 per office visit
			See Specific Benefits for Exceptions
<b>OUT-OF-POCKET MAXIMUM:</b> Maximum allowable* expenses Plan member(s) pay(s) each benefit year before Plan pays 100% of remaining allowable* expenses.	\$950	\$2,100	\$2,000
	See Specific Benefits for Exceptions	See Specific Benefits for Exceptions	\$4,000
			\$750
			+\$100
			\$1,500
			+\$300
			Annual referral deductible on referred outpatient professional services by non-PCP
			See Specific Benefits for Exceptions
<b>SPECIFIC BENEFIT DESCRIPTION</b>			
Office/Clinic Visit	Outpatient services by a physician or surgeon for treatment of an injury or illness. Subject to annual deductible and general copay.		Outpatient services rendered by a physician or surgeon for treatment of an injury or illness. Member pays \$15 copay on allowable office visit charges. Allowable charges for any ancillary services are subject to annual deductible and general copay.
			Professional services performed by or approved/referred by PCP. PCP referred visits to another physician are subject to annual referral deductible. Visits without PCP referral are not covered. Member pays a \$10 copay per PCP office visit and, after the referral deductible, a \$10 copay on allowable charges per referred non-PCP office visit.
	TRADITIONAL MEDICARE COORDINATED & BASIC PLANS		HMO PLAN
Hospital Inpatient Medical/Surgical	Inpatient services during hospital days certified as medically necessary. Subject to annual deductible and general copay.		Inpatient services during hospital days certified as medically necessary. \$300 copay per member per hospital admission.
Hospital/Surgi-Center Outpatient Medical/Surgical	Outpatient services of hospital/center and professional services of physicians, surgeons, and anesthesiologists or anesthesiologists for medically necessary surgery and medical care. Subject to annual deductible and general copay.		Outpatient services of hospital/center and professional services of physicians, surgeons and anesthesiologists or anesthesiologists when referred by PCP. No copay on facility charge; Plan pays 100% of allowable charges. \$10 copay on professional charges per office visit. Non-PCP professional services are subject to annual referral deductible.
Diagnostic Xray, Lab, Chemotherapy, and Radiation	Subject to annual deductible and general copay.		No copay; Plan pays 100% of allowable charges for services ordered by PCP or other provider to whom member has been referred by PCP. Subject to annual referral deductible if provided by other than PCP.
Emergency Room	Services for surgery, accident or medical emergency only. Subject to annual deductible and general copay.		Services for authorized emergency use only. \$50 copay per visit, unless member admitted for inpatient hospital care.
Preventive Services	DEDUCTIBLE COPAY EXCEPTION Well child care, including immunizations, from moment of birth paid at 100% of allowable charges up to first-year maximum of \$250 and subsequent year maximum of \$125 per year through age five. Schedule of adult preventive tests, PAP smears, mammograms, and proctoscopic exams. Not subject to annual deductible. General copay applies - \$15 Basic copay waived.		When performed by the PCP, physical exams (at PCP's discretion), gynecological exams, hearing exams and well child care, including immunizations. Subject to \$10 copay per office visit.
Ambulance Services	For medical emergency to nearest qualified hospital within 500 miles. Subject to annual deductible and general copay.		For medical emergency to nearest appropriate facility. No copay; Plan pays 100% of allowable charges.
Durable Medical Equip/Supplies and Prostheses	Preauthorization required for replacement/repair. Allowable charges paid for foot orthotics limited to \$100 per foot in any 12-month period. Subject to annual deductible and general copay.		Paid at 80% of allowable charges when ordered by PCP or other provider to whom member has been referred by PCP. Rentals not to exceed purchase price. Preauthorization required if cost over \$300. No coverage for foot orthotics. Member pays other 20% which does not apply to out-of-pocket maximum.

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Transportation	Reasonable expenses for one-way travel to out-of-state facility for treatment if not available in Montana.	Reasonable expenses for one-way travel to out-of-state facility for treatment if not available in Montana.
Chemical Dependency	<p>INPATIENT - Up to 30 days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary. Limited to a maximum of \$4,000 in a 24-month period, \$8,000 per member per lifetime. Subject to annual deductible and general copay.</p> <p>OUTPATIENT - Professional services paid at 75% of allowable charges (after deductible) up to a maximum of \$2,250 per member per benefit year when referred by an EAP counselor; paid at 50% of allowable charges (after deductible) up to a maximum of \$1,500 when not referred by an EAP counselor. Member pays other 25%/50% which does not apply to out-of-pocket maximum.</p>	<p>INPATIENT - Up to 30 days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary when authorized by the PCP. Limited to a maximum of \$4,000 in a 24-month period, \$8,000 per member per lifetime. After the \$300 inpatient copay, Plan pays 100% of allowable charges up to the maximum benefit.</p> <p>OUTPATIENT - Professional services paid at 75% of allowable charges up to a maximum of \$2,250 per member per benefit year when referred by PCP. Member pays 25% which does not apply to out-of-pocket maximum. No benefits when not referred. Referred non-PCP professional services are subject to annual referral deductible.</p>
Mental Health Care	<p>INPATIENT - Up to 30-days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary. After annual deductible, the Plan pays 80% of allowable charges of a Preferred Provider Network facility until member reaches annual out-of-pocket maximum, then 100%. Plan pays 60% of allowable charges of an out-of-network facility until member reaches annual out-of-pocket maximum, then 80%.</p> <p>OUTPATIENT - Professional services paid at 75% of allowable charges (after deductible) up to a maximum of \$2,250 per member per benefit year when referred by an EAP counselor; paid at 50% of allowable charges (after deductible) up to a maximum of \$1,500 when not referred by an EAP Counselor. Member pays other 25%/50% which does not apply to out-of-pocket maximum. Partial hospitalization days may be exchanged for inpatient days at a rate of one (1) inpatient day for two partial days up to a maximum of 15 inpatient days.</p>	<p>INPATIENT - Up to 30 days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary when authorized by the PCP. After the \$300 hospital copay, Plan pays 100% of allowable charges of a Preferred Provider Network facility and 60% of allowable charges of out-of-network facility until member reaches annual out-of-pocket maximum, then 80%.</p> <p>OUTPATIENT - Professional services paid at 75% of allowable charges up to a maximum of \$2,250 per member per benefit year when referred by a PCP. Member pays 25% which does not apply to out-of-pocket maximum. No benefits when not referred. Referred non-PCP professional services are subject to the annual referral deductible. Partial hospitalization days may be exchanged for inpatient days at a rate of one (1) inpatient day for two partial days up to a maximum of 15 inpatient days.</p>
Physical, Occupational & Speech Therapy	<p>INPATIENT - Up to 60 days of rehabilitation services per benefit year during hospital days certified as medically necessary. Subject to annual deductible and general copay.</p> <p>OUTPATIENT - Limited to \$2,000 per benefit year, for all outpatient rehabilitative services. Subject to annual deductible and general copay.</p>	<p>INPATIENT - Up to 60 days of rehabilitation services per benefit year during hospital days certified as medically necessary. Subject to \$300 hospital copay.</p> <p>OUTPATIENT - Services to which member is referred by PCP. Benefits limited to \$2,000 per benefit year for all outpatient rehabilitative services. Subject to \$10 copay per office visit and annual referral deductible on referred non-PCP professional services.</p>
Maternity	Obstetrical care including delivery, prenatal, postpartum. Subject to annual deductible and general copay.	Obstetrical care including delivery, prenatal, postpartum. \$150 copay per delivery for physician services. \$300 copay for hospital stay.
Newborn Care	DEDUCTIBLE/COPAY EXCEPTION Plan pays 100% of allowable charges for physician/lab services for newborn care during post-natal hospitalization. Not subject to annual deductible. General copay applies to other services.	Routine newborn care not subject to separate hospital copay unless infant admitted for non-routine treatment.
Hospice	Hospice care up to plan limits when ordered by patient's attending physician. Subject to annual deductible and general copay.	Hospice care up to plan limits when ordered by PCP. No copay; Plan pays 100% of allowable charges. Subject to annual referral deductible on non-PCP professional services.
Skilled Nursing	Up to 70 days during a convalescent period during any one benefit year. Subject to annual deductible and general copay.	Up to 70 days during a convalescent period during any one benefit year when ordered by PCP. No copay; Plan pays 100% of allowable charges. Subject to annual referral deductible on non-PCP professional services.
Chiropractic	Includes therapeutic, palliative and rehabilitative care. Up to a maximum 25 visits per benefit year and \$30 per visit. Subject to annual deductible and general copay.	Includes therapeutic, palliative and rehabilitative care. Up to a maximum of 25 visits per benefit year and \$30 per visit when referred by PCP. Subject to \$10 office visit copay and annual referral deductible on referred non-PCP professional services.
Acupuncture	Limited to treatment of injury or illness. Up to a maximum of 25 visits per benefit year and \$30 per visit. Subject to annual deductible and general copay.	No coverage.
Home Health Care	Up to 70 days of service during any one benefit year. Home health aide services in excess of four hours in any one day shall be considered an additional day. Subject to annual deductible and general copay.	Up to 70 days during one benefit year, when ordered by PCP. Home health aide services in excess of four hours in any one day shall be considered as an additional day. No copay; Plan pays 100% of allowable charges. Subject to annual referral deductible on referred non-PCP professional services.
Organ Transplant	Lifetime maximum allowances for the following human-to-human organ transplant: Liver; Heart; Lung; Heart/Lung; Bone Marrow; Pancreas. Contact the Employee Benefits Bureau for specific allowance per transplant. Allowable charges for Cornea and kidney transplants are also covered. All transplants must be certified as medically necessary. Subject to annual deductible and general copay.	Lifetime maximum allowances for the following human-to-human organ transplant: Liver; Heart; Lung; Heart/Lung; Bone Marrow; Pancreas. Contact the Employee Benefits Bureau for specific allowance per transplant. Allowable charges for Cornea and kidney transplants are also covered. All transplants must be certified as medically necessary and ordered by PCP. Subject to \$300 hospital copay and annual referral deductible on non-PCP professional services.
<p>* ALLOWABLE CHARGES - Under all three Plans, only charges within Plan allowances are covered. Charges by physicians and other health care providers which exceed allowances are not paid by the Plans or credited toward deductible or out-of-pocket maximum. Plan members are responsible for paying unallowed charges by non-member providers. PCPs and other BC/BS member providers accept Plan allowances.</p>		<p>**PCP (Personal Care Physician) - The HMO participating physician you select to be your Personal Care Physician. Your PCP will manage your health care and refer you to an appropriate specialist when medically indicated. Professional services of a non-PCP are only covered when referred by the PCP.</p>

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## CHAPTER 3

### MEDICAL PLAN BENEFITS

#### K. THE PORTION OF COVERED MEDICAL EXPENSES WHICH ARE PAID BY THE PLAN

##### K-1 Allowable Charges

Allowable charges are charges which are:

1. covered medical expenses (as defined in Sections L and M of this Chapter); and;
2. within Usual, Customary, and Reasonable limits (UCR) (see definition in Chapter 9).

Allowable charges appear in the "approved for payment" column of the explanation of benefits (EOB) form. Only these charges will be:

1. credited toward your deductible;
2. credited toward any co-payment you must make; and/or;
3. paid by the Plan as described in the following provisions (K-2 and K-3).

*Disallowed charges are not paid by the Plan or credited toward your deductible or co-payment. (See the EOB illustration in Appendix A.)*

When covered medical expenses (as defined in Sections L and M), are not allowed because they exceed Usual, Customary, and Reasonable limitations (UCR), it is generally due to one of the following reasons:

1. the provider's charges are out of line - higher than 90 percent of the charges for the service by all similar providers in the state in which the service was received; or
2. the claims administrator (Blue Cross and Blue Shield) has not received correct information on the service provided (the procedure code on the claim could be incorrect or there could be complications not reflected on the claim).

Most Montana Physicians have agreed to accept Blue Cross and Blue Shield or State Plan UCR allowances and not require you to pay charges which exceed allowances. You will receive lists of these member physicians periodically and you may ask your physician directly if he or she is a member physician. The allowance for non-member Montana Physicians is 10 percent below the allowance for member physicians.

For non-emergency procedures you plan to receive from a non-member physician, you can determine in advance what charges will be allowed by obtaining a predetermination (see provision G-3).

benefits as specified in the State Employee Group Benefit Plan or the family member is not covered under State Health Insurance, you are solely responsible for the costs associated with the outside assistance.

**When** referral to additional counseling is made and the referred counseling is for a State Health Insurance plan member and for a covered service as specified in the State Employee Group Benefit Plan, payment for the additional counseling is made as follows:

**a) Outpatient Services under the Traditional and Basic Plans:**

After the annual deductible is met, payment will be **75%** of allowable charges up to a maximum of **30** visits per member per benefit year with a referral from an EAP counselor. You will be responsible for the **25%** copay, any amounts above allowable charges (if you use a non-member provider), and for any amounts above the **30** visit benefit year maximum.

Without a referral from an EAP counselor, counseling services will continue to be paid at 50% of allowable charges (after deductible) up to a maximum of **20** visits per member per benefit year.

**b) Outpatient Services under an HMO:**

When your EAP counselor recommends additional counseling or treatment, the counselor will consult, with your written approval, with your **HMO** Personal Care Physician regarding a referral. **When** referral to recommended care is made by your Personal Care Physician, payment will be **75%** of allowable

charges up to a maximum of 30 visits per **member** per benefit year just as it is under the Traditional and Basic Plans with an EAP counselor's referral.

Under an HMO, **all** specialty care requires a referral from your Personal Care Physician. If you **do** not have your Personal Care Physician's referral, you will be solely responsible for all incurred costs.

**c) Inpatient Services:**

Payment for medically necessary *chemical dependency* and *mental health care* will be paid as defined in the State Employee Group Benefit Plan. When inpatient care is recommended, your EAP counselor, with your approval, will work with Managed Care Montana to certify medical necessity and, if you are covered by an **HMO**, with your Personal Care Physician to obtain a referral.

**PHONE NUMBERS BY LOCATION**

Billings	(406) 254-6263
Bozeman	(406) 587-8238
Butte	(406) 782-0471
Great Falls	(406) 727-4358
Helena	(406) 443-1127
Kalispell	(406) 752-6443
Miles City	(406) 232-3040
Missoula	(406) 327-7000
<i>All Other</i> Locations	(800) 999-1077

**For 24-hour, seven days per week crisis counseling, call  
800-833-3031**

### Covered State Employees, Retirees and Dependents

The State of Montana has contracted with Express Scripts and Buttrely Food and Drug to provide you the convenience and cost savings of a Prescription Drug card and Mail Order Plan. This plan allows you to meet your prescription needs by:

1. obtaining up to a 30-day supply or 100 pills, whichever is greater, of all covered prescriptions from a local pharmacy in the Express Scripts Network.
2. obtaining up to a 90-day supply of covered long term prescriptions through a mail order service provided by Buttrely Food and Drug.

### Advantages of Using Your New Card and Mail Order Options

- You pay only your portion of the costs when you obtain your prescriptions
- No paperwork
- No claim forms to file
- Lower prescription drug costs for you and your health plan
- The added peace of mind of sophisticated computer edits to identify possible problems . . . dangerous drug interactions, dangerous dosage amounts, etc.
- the added convenience and cost savings of mail-order for long term prescriptions.

### Other Plan Features

Licensed pharmacists are available around the clock to consult with members about their medicines. Express Scripts' Help Desk staff answers network pharmacist's questions to ensure you get timely service at their pharmacy.

Your new Prescription Drug Plan has been designed to offer plan members the combination of:

- Quality
- Cost Savings
- Convenience
- Service

Please familiarize yourself with the specific terms and conditions of your prescription drug coverage. You will receive the maximum coverage of Rx costs that you are entitled to under the terms of your plan when you fill your prescriptions at participating pharmacies and the mail order service.

## How Your Plan Works

### When you mail order:

1. Consider mail order for maintenance medications. These are medications taken on a regular basis over months or years to treat long-lasting or chronic conditions. Unlike medications needed unexpectedly and immediately, they can be put on a mail order schedule.
2. Have your doctor write a prescription for up to a 90-day supply, where appropriate, plus refills. Since maintenance prescriptions typically don't change, it is usually more convenient and less costly to get a 90-day supply at a time. You save money both on low mail order rates and from paying one co-payment rather than several.
3. Complete the Patient Profile/Order Form and enclose your original prescription along with:
  - a co-payment of \$10 for a generic prescription
  - a co-payment of \$30 for a brand name
  - mail service prescriptions are not subject to deductible
 If you are unsure of whether your prescription is brand name or generic, you may call Buttrely's toll free number below or send \$30. If your prescription is generic, you will receive a \$20 credit which you may use for your next prescription. You may send a check, money order or you may charge the amount to your VISA, Discover or MasterCard.
4. Refill orders by simply calling the toll-free number. The prescription label will indicate the number of times you may have a prescription refilled. If you charge your co-payment of \$10 for Generic drugs or \$30 for Brand name drugs to your credit card you needn't mail anything for a refill.
5. A pharmacist will check for any potential problems with drugs you are currently using, potential allergic reactions and other, clinical and administrative problems with the aid of the Express Scripts computer network.
6. Upon verification that both the patient and drug requested are covered, the pharmacist will send the prescription. Allow 7 to 10 working days for delivery. Prescriptions are delivered directly to your home, postage-paid along with ordering instructions and forms for refills and/or new prescriptions.

For Mail Order Customer Service and Refill Orders Call Toll-Free 1-800-790-0869



### When you go to a Network Pharmacy:

1. Present the Express Scripts PERx ID Card to any participating pharmacy along with your prescription.
2. The pharmacist keys in your member ID number and prescription information to the Express Scripts on-line system.
3. The pharmacist will check for any potential problems with drugs you are currently using, potential allergic reactions and other clinical and administrative problems with the aid of the Express Scripts computer network.
4. Upon verification that both the patient and the drug requested are covered by the plan, the pharmacist will instruct you as to your deductible and co-payment obligation. You pay the pharmacist your obligation and receive your prescription.
5. Your obligation:
  - Co-pay: 10% for generic drugs  
30% for brand name drugs
  - Deductible: The first \$50 of charges per member (a maximum of \$150 per family) in the benefit year.

For Network Customer Service or General Information on Medications Call Toll-Free 1-800-206-4005

### When you go to a Pharmacy Out-Of-Network (cash & carry):

If for some reason you are unable to use a participating network pharmacy and need to purchase a prescription outside the network, you may do so and be reimbursed. Simply pay for your prescription, obtain a receipt from the pharmacy showing the name of the drug, dosage, strength and price and date of service. Then obtain a claim form from the Employee Benefits Bureau and send it to the address shown on the form. Your claim will be processed and you will be reimbursed according to your Plan Benefit subject to deductible and co-payment. Reimbursement will not exceed the amount that would have been paid if the prescription were purchased at an Express Scripts Network Pharmacy.

After the member has paid \$300 out-of-pocket per individual/a maximum of \$600 per family in deductible and co-pay in a benefit year, the plan will pay 100% the year's remaining allowable prescription charges

Company Name: Montana Insurance Dept  
 Plan Name: State Basic Plan  
 Sub Name: In-Network, EAP Counselor

Effective Date: September 1998  
 Rates Guaranteed: 12 months  
 Medical Area: B  
 SIC: No Adjustment

Pre-admission Certification: Yes  
 Deductible Plan Type: All Expenses  
 PPO Participation: 100%

	Input	Employee	Spouse	Children	Comp. Dep	Retiree
1. Base Cost:		\$119.21	\$140.14	\$81.23	\$180.33	\$262.95
<b>Deductible:</b>						
2. Calendar Year Deductible (combined)	\$750					
3. Deductible Accumulation Period	12	20	0.00	0.00	0.00	0.00
4. Eliminate Carry-Forward	Yes	(4.8)	(4.80)	(2.93)	(6.25)	(8.58)
5. Deductibles Per Family	4.00			(6.50)	(4.87)	
6. Hospital Deductible Per Admission	\$0	0.0	0.00	0.00	0.00	0.00
7. Waive Deductible for Surgery						
<b>Policy Specifications:</b>						
8. In-full Surgical Units	0.00	0.00	0.00	0.00	0.00	0.00
9. In-full Hospital Amount	\$0	0.00	0.00	0.00	0.00	0.00
10. ICU Maximum	Unlimited	1.31	1.31	0.67	1.74	4.80
<b>Covered Level:</b>						
11. Room and Board	\$545	0.00	0.00	0.00	0.00	0.00
12. Surgical	\$106	0.00	0.00	0.00	0.00	0.00
13. Adjusted Base Cost:		\$115.74	\$136.65	\$72.67	\$170.95	\$256.17
13a. PPO Discount Value (at 80%)		0.00	0.00	0.00	0.00	0.00
<b>Coinsurance - General:</b>						
14. First Coinsurance Percentage	75%					
15. on first \$x incurred after ded	\$5,000					
16. Second Coinsurance Percentage	100%					
17. on next \$Y incurred	to					
18. Third Coinsurance Percentage	0%	11.35	12.10	3.90	13.61	34.23
19. Stop-loss Max Per Family	3.00			0.00	0.00	
20. Lifetime Maximum (omit 000's)	\$1,000	0.00	0.00	0.00	0.00	0.00
<b>Mental Health and Substance Abuse:</b>						
21. OP - Coinsurance	80%					
22. OP - Max Covered Charge	\$3,000					
23. OP - Annual Maximum	\$0					
24. Include OP Substance Abuse	Yes					
25. OP - Adjustment factor	0.94	12.36	12.36	11.65	16.62	25.56
26. IP - Max Days	30					
27. IP - Adjustment Factor	1.00	0.00	0.00	0.00	0.00	0.00
<b>Extended Care Facility:</b>						
28. ECF Daily Benefit	\$273			0.00		
29. ECF Maximum Number of Days	70	1.64	1.91	0.66 (6.75)	2.73	0.81
<b>Policy Specifications:</b>						
30. Waiver Of Coinsurance For OP Surgical	None	and	0.00		0.00	0.00
31. Supplemental Accident Maximum	to	and	0.00		0.00	0.00
32. Eliminate Rx Drugs	Yes	(9.91)	(11.65)	5.67	(14.99)	(21.89)
<b>Co-payments:</b>						
33. Primary Office Visit Co-pay	\$15			0.00		
34. Specialist Office Visit Co-pay	\$15			0.00		
35. Max Number of Co-pays Per Year	100	1.50	1.8	0.00	5.22	(0.68)
36. Emergency Room Co-pay	to	0.00	0.00	0.00	0.00	0.00
37. Outpatient Surgical Center Co-pay	\$0	0.00	0.00	0.00	0.00	0.00
<b>Misc. In-Network Adj.:</b>						
38. Adjustment for Additional Benefits in the State Plan		and	0.00	0.00	0.00	0.00
<b>Well Care Benefit:</b>						
39. Nursery Benefits - Maternity On Children	\$656					
40. Adjustment Factor	1.00	0.66	2.64	1.15	2.50	
41. Well Care Benefits, Adult - No	NA					
42. Total Expense Limit	NA	0.00	0.00		0.00	0.00
43. Well Care Benefits, Children - Phy Exam Only	No Anc Lmt					
44. Total Expense Limit	\$146					
45. Benefits Terminate Upon Attainment of Age	6			3.20		
46. Manual Cost: (before factor adjustments)		\$133.36	\$155.76	\$92.64	\$196.64	\$306.23
<b>Factor Adjustments:</b>						
47. Experience Factor	0.526					
48. Underwriting Factor	1.030					
49. Trend Factor	1.0140					
50. Age Gender Factor	Yes	1.000	1.000	0.952	0.964	1.000
51. Child "Coverage From" (additive)	From Birth		0.000		0.000	
52. Pre-Admission Certification Factor - Yes	1.000					
53. SIC Factor - No	1.000					
54. Final Total Manual Costs		\$73.32	\$96.62	\$48.69	\$127.66	\$168.23

**Tillinghast-lowers Perrln Medical Manual Costs—1998**  
**In-Network Monthly Costs**

Company Name	Montana Insurance Dep't	Effective Date:	September 1998	Pre-admission Certification:	Yes
Plan Name	State Basic Plan	Rates Guaranteed:	12 months	Deductible Plan Type:	All Expenses
Sub Name	In-Network, no EAP Counsel	Medical Area:	B	PPO Participation:	100%
		SIC:	No Adjustment		

	Inuit	Employee	Spouse	Children	Comp. Dep	Retiree
<b>1 Base Cost:</b>		\$119.23	\$140.14	\$81.23	\$180.33	\$262.95
<b>Deductible:</b>						
2. Calendar Year Deductible (combined)	\$750					
3. Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4. Eliminate Carry-Forward	Yes	(4.80)	(4.80)	(2.93)	(8.25)	(8.56)
5. Deductibles Per Family	4.00			(8.50)	(4.87)	
6. Hospital Deductible Per Admission	\$0	0.00	0.00	0.00	0.00	0.00
7. Waive Deductible for Surgery						
<b>Policy Specifications:</b>						
8. In-full Surgical Units	0.00	0.00	0.00	0.00		0.00
9. In-full Hospital Amount	\$0	0.00	0.00	0.00		0.00
10. ICU Maximum	Unlimited	1.31	1.31	0.87		4.80
<b>Covered Level:</b>						
11. Room and Board	\$545	0.00	0.00	0.00		0.00
12. Surgical	\$108	0.00	0.00	0.00		0.00
<b>13. Adjusted Base Cost:</b>		\$115.74	\$138.86	\$72.87	\$170.95	\$258.17
13a. PPO Discount Value (at 80%)		0.00	0.00	0.00	0.00	0.00
<b>Coinsurance - General:</b>						
14. First Coinsurance Percentage	75%					
15. on first \$x incurred after ded	\$5,000					
16. Second Coinsurance Percentage	100%					
17. on next \$y incurred	\$0					
18. Third Coinsurance Percentage	0%	11.35	1216	3.90	13.81	34.23
19. Stop-loss Max Per Family	3.00			0.00	0.00	
20. Lifetime Maximum (omit 000's)	\$1,000	0.00	0.00	0.00	0.00	0.00
<b>Mental Health and Substance Abuse:</b>						
21. OP - Coinsurance	50%					
22. OP - Max Covered Charge	\$2,000					
23. OP - Annual Maximum	\$0					
24. Include OP Substance Abuse	Yes					
25. OP - Adjustment factor	1.00	7.85	7.85	6.45	11.34	16.44
26. IP - Max Days	30					
27. IP - Adjustment Factor	1.00	0.00	0.00	0.00	0.00	am
<b>Extended Care Facility:</b>						
28. ECF Daily Benefit	\$273					
29. ECF Maximum Number of Days	70	1.64	1.91	1.36	273	9.81
<b>Policy Specifications:</b>						
30. Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	0.00
31. Supplemental Accident Maximum	\$0	0.00	0.00	0.00	0.00	0.00
32. Eliminate Rx Drugs	Yes	(9.81)	(11.65)	(8.75)	(14.99)	(21.86)
<b>Co-payments:</b>						
33. Primary Office Visit Co-pay	\$15					
34. Specialist Office Visit Co-pay	\$15					
35. Max Number of Co-pays Per Year	100	1.50	1.89	5.87	5.22	1.69
36. Emergency Room Co-pay	\$0	0.00	0.00	0.00	0.00	0.00
37. Outpatient Surgical Center Co-pay	\$0	0.00	0.00	0.00	0.00	0.00
<b>Misc. In-Network Adj.:</b>						
38. Adjustment for Additional Benefits in the State Basic Plan		0.00	0.00	0.00	0.00	am
<b>Well Care Benefit:</b>						
39. Nursery Benefits - Maternity On Children	\$656					
40. Adjustment Factor	1.00	0.89	264	1.15	250	
41. Well Care Benefits, Adult - No	NA					
42. Total Expense Limit	NA	0.00	0.00		0.00	0.00
43. Well Care Benefits, Children - Phy Exam Only	No Anc Lmt					
44. Total Expense Limit	\$148					
45. Benefits Terminate Upon Attainment of Age	8			3.20		
<b>46 Manual Cost: (before factor adjustments)</b>		\$128.87	\$151.25	\$87.65	\$191.38	\$297.11
<b>Factor Adjustments:</b>						
47. Experience Factor	0.528					
48. Underwriting Factor	1.030					
49. Trend Factor	1.0140					
50. Age Gender Factor	Ye.	1.000	1.000	0.952	0.984	1.000
51. Child "Coverage From" (additive)	From Birth		0.000		0.000	
52. Pre-Admission Certification Factor - Yes.	1.000					
53. SIC Factor - No	1.000					
<b>54. Final Total Manual Costs</b>		<b>\$70.84</b>	<b>\$83.14</b>	<b>\$45.87</b>	<b>\$163.81</b>	<b>\$163.32</b>

**Tillinghast-Towers Perrin Medical Manual Costs—1998**  
**Out-of-Network Monthly Costs**

Company Name: <u>Montana Insurance Dep't</u>		Effective Date: <u>September 1998</u>		Pre-admission Certification: <u>Yes</u>			
Plan Name: <u>State Basic Plan</u>		Rates Guaranteed: <u>Input</u>		Deductible Plan Type: <u>All Expenses</u>			
Sub Name: <u>Out-of-Network, EAP Course</u>		Medical Area: <u>SIC:</u>		PPO Participation: <u>0%</u>			
		<u>Input</u>	<u>Employer</u>				
			\$107.7				
	\$750						
1	Base Cost:	12	0.02	<u>Spouse</u>	<u>Children</u>	<u>Comp. Ben</u>	<u>Retiree</u>
	Deductible:	Yes	\$104.87	\$126.68	\$72.34	\$162.30	\$239.85
2	Calendar Year Deductible (combined)	\$0	0.0				
3	Deductible Accumulation Period		0	0.00	0.00	0.00	0.00
4	Eliminate Carry-Forward		0	(4.80)	(2.93)	(6.25)	(8.58)
5	Deductibles Per Family	4.00				(4.34)	
6	Hospital Deductible Per Admission		0	0.00		0.00	0.00
7	W e Deductible for Surgery						
<b>Policy Specifications:</b>							
8	In-full Surgical Units	0.00	0.00	0.00	0.00	0.00	0.00
9	In-full Hospital Amount	\$0	0.00	0.00	0.00	0.00	0.00
10	ICU Maximum	Unlim	1.21	1.21	0.80	1.61	4.43
<b>Covered Level:</b>							
11	Room and Board	\$503	0.00	0.00	0.00	0.00	0.00
12	Surgical	\$87	0.00				
13	Adjusted Base Cost:		\$104.18	\$123.09	\$64.42	\$153.32	\$235.70
<b>Coinsurance - General:</b>							
14	First Coinsurance Percentage	75%					
15	on first \$x Incum'd after deductible	\$5,000					
16	Second Coinsurance Percentage	100%					
17	on next \$Y Incum'd	\$0					
18	Third Coinsurance Percentage	0%	9.47	10.09	3.49	11.45	28.78
19	Stop-loss Max Per Family	3.00			0.00	0.00	
20	Lifetime Maximum (omit 000's)	\$1,000	0.00	0.00	0.00	0.00	0.00
<b>Mental Health and Substance Abuse:</b>							
21	OP - Coinsurance	80%					
22	OP - Max Covered Charge	\$3,000					
23	OP - Annual Maximum	\$0					
24	Include OP Substance Abuse	Yes					
25	OP Adjustment Factor	0.94	1240	124d	11.68	18.87	25.63
26	IP - Max Days	30					
27	IP - Adjustment Factor	0.79	(1.09)	(1.28)	(0.48)	(1.40)	(2.42)
<b>Extended Care Facility:</b>							
28	ECF Daily Benefit	\$252					
29	ECF Maximum Number of Days	70	1.51	1.76	1.28	252	9.05
<b>Policy Specifications:</b>							
30	Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	0.00
31	Supplemental Accident Maximum	\$0	0.00	0.00	0.00	0.00	0.00
32	Eliminate Rx Drugs	Yes	(9.23)	(10.85)		(13.90)	(20.55)
<b>Co-payments:</b>							
33	Primary Office Visit Co-pay	\$15					
34	Specialist Office Visit Co-pay	\$15					
35	Max Number of Co-pays Per Year	100	1.19	1.34	4.90	4.40	(1.26)
36	Emergency Room Co-pay	\$0	0.00	0.00	0.00	0.00	0.00
37	Outpatient Surgical Center Co-pay	\$0	0.00	0.00	0.00	0.00	0.00
<b>Misc. Out-of-Network Adj.:</b>							
38	Adjustment for Additional Benefits in the State Plan		0.00	0.00	0.00	0.00	0.00
<b>Well Care Benefit:</b>							
39	Nursery Benefits - Maternity On Children	\$800					
40	Adjustment Factor	NA	0.00	23d	1.00	222	
41	Well Care Benefits, Adult - No	No Anc Lmt		0.00		0.00	0.00
42	Total Expense Limit	\$146					
43	Well Care Benefits, Children - Phy Exam Only	6					
44	Total Expense Limit						
45	Benefits Terminate Upon Attainment of Age		\$119.02		3.20		
46	Manual Cost: (before factor adjustments)		\$119.02	\$138.88	\$83.29	\$177.48	\$274.92
<b>Factor Adjustments:</b>							
47	Experience Factor	0.526					
48	Underwriting Factor	1.030					
49	Trend Factor	1.0140					
50	Age Gender Factor	Yes	1.000	1.000	0.952	0.984	1.000
51	Child "Coverage From" (additive)	From Birth		0.000		0.000	
52	Pre-Admission Certification Factor - Yes	1.000					
53	SIC Factor - No	1.000					
54	Final Total Manual Costs		\$68.43	\$76.34	\$43.59	\$96.00	\$161.12

Exhibit III

**Tillinghast-Towers Perrin Medical Manual Costs-1998**  
**Out-of-Network Monthly Costs**

Company Name: Montana Insurance Dep't      Effective Date: September 1998      Pre-admission Certification: Yes  
 Plan Name: State Basic Plan      Rates Guaranteed: 12 months      Deductible Plan Type: All Expenses  
 Sub Name: Out-of-Network, no EAP Cou      Medical Area: A      PPO Participation: 0%  
 SIC: No Adjustment

	Input	Employee	Spouse	Children	Comp. Dep	Retiree
1	<b>Base Cost:</b>	\$107.77	\$126.68	\$72.34	\$162.30	\$239.85
	<b>Deductible:</b>					
2	Calendar Year Deductible (combined)	.750				
3	Deductible Accumulation Period					
4	Eliminate Carry-Forward					
5	Deductibles Per Family	12	0.00	0.00	0.00	0.00
6	Hospital Deductible Per Admission	4800	(0.00)	(4.00)	(0.00)	(0.00)
7	Waive Deductible for Surgery		0.00	0.00	(4.34)	(0.00)
	<b>Policy Specifications:</b>					
8	In-full Surgical Units	0.00	0.00	0.00	0.00	0.00
9	In-full Hospital Amount	90	0.00	0.00	0.00	0.00
10	ICU Maximum	Unlimited	1.21	1.21	0.80	4.43
	<b>Covered Level:</b>					
11	Room and Board	\$503	0.00	0.00	0.00	0.00
12	Surgical	\$97	0.00	0.00	0.00	0.00
13	<b>Adjusted Base Cost:</b>	\$104.18	\$123.09	\$84.42	\$153.32	\$235.70
	<b>Coinsurance - General:</b>					
14	First Coinsurance Percentage	75%				
15	on first \$x Incurred after deductible	\$5,000				
16	Second Coinsurance Percentage	100%				
17	on next \$Y Incurred	\$0				
18	Third Coinsurance Percentage	0%	9.47	10.09	3.49	11.45
19	Stop-loss M u Per Family	3.00		0.00	0.00	28.78
20	Lifetime Mulmum (omit Oars)	\$1,000	0.00	0.00	0.00	0.00
	<b>Mental Health and Substance Abuse:</b>					
21	OP - Coinsurance	50%				
22	OP - Max Covered Charge	\$2,000				
23	OP - Annual Maximum	\$0				
24	Include OP Substance Abuse	Yes				
25	OP - Adjustment Factor	1.00	7.85	7.85	6.45	11.34
26	IP - Max Days	30				
27	IP - Adjustment Factor	0.78	(1.00)	(1.28)	(0.46)	(1.40)
	<b>Extended Care Facility:</b>					
28	ECF Daily Benefit	\$252				
29	ECF Maximum Number of Days	70	1.51	1.76	1.26	252
	<b>Policy Specifications:</b>					
30	Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00
31	Supplemental Accident Maximum	\$0	0.00	0.00	0.00	0.00
32	Eliminate Rx Drugs	Yes	(9.23)	(10.85)	(6.20)	(13.90)
	<b>Co-payments:</b>					
33	Primary Office Visit Co-pay	\$15				
34	Specialist Office Visit Co-pay	\$15				
35	Max Number of Co-pays Per Year	100	1.19	1.34	4.90	4.40
36	Emergency Room Co-pay	\$0	0.00	0.00	0.00	0.00
37	Outpatient Surgical Center Co-pay	\$0	0.00	0.00	0.00	0.00
	<b>Misc. Out-of-Network Adj.:</b>					
38	Misc. Adjustment		0.00	0.00	0.00	0.00
	<b>Well Care Benefit:</b>					
39	Nursery Benefits - Maternity On Children	\$900				
40	Adjustment Factor	1.00	0.60	234	1.00	2.22
41	Wall Cue Benefits, Adult - No	NA				
42	Total Expense Limit	NA	0.00	0.00	0.00	0.00
43	Well Care Benefits, Children - Pny Exam Only	No Anc Lmt				
44	Total Expense Limit	\$148				
45	Benefits Terminate Upon Attainment of Age	6		3.20		
46	Manual Cost: (before factor adjustments)	\$114.48	\$134.34	\$78.08	\$189.95	\$285.74
	<b>Factor Adjustments:</b>					
47	Experience Factor	0.526				
48	Underwriting Factor	1.030				
49	Trend Factor	1.0140				
50	Age Gender Factor	Yes	1.000	1.000	0.952	0.984
51	Child "Coverage from" (additive)	From Birth		0.000	0.000	1.000
52	Pre-Admission Certification Factor - Yes	1.000				
53	SIC Factor - No	1.000				
54	<b>Final Total Manual Costa</b>	\$62.93	\$73.84	\$48.86	\$91.92	\$148.87

**Tillinghast-Towers Perrin Prescription Drug Card Manual Costs—1998  
Prescription Drug Card Costs**

Company Name: Montana Insurance Dep't Effective Date: September 1998 Pre-admission Certification: Yes  
 Plan Name: State Basic Plan Rates Guaranteed: 12 months Deductible Plan Type: All Expenses  
 Sub Name: In-Network, no EAP Couns Medical Area: B  
 SIC: No Adjustment

	Input	Employee	Spouse	Children	Comp. Dep	Retiree
<b>Base Cost:</b>		\$14.68	\$16.15	\$11.11	\$21.92	\$47.5
Include Birth Control as a covered expense?	No					
<b>Average Prescription Cost</b>		0.00	0.00	0.00	0.00	0.0
Percent of Retail	NA					
Other	NA					
Retail	\$33.55					
<b>Benefit Design</b>						
Co-pay per prescription						
Brand	NA					
Generic	NA					
Annual Deductible	\$50.00					
<b>Coinsurance Percentage:</b>						
Brand Name	70.00%					
Generic	90.00%					
Age Gender Factor Adjustment		0.00	0.00	0.00	0.00	0.0
Trend Factor using 1.4% Monthly Trend		0.41	0.45	0.31	0.61	1.3
Apply Major Medical Offset	No	0.00	0.00	0.00	0.00	0.0
<b>Net Monthly Manual Cost:</b>		15.09	16.60	11.42	22.53	48.9
<b>Administrative Costs</b>						
Per Prescription	\$0.00	0.00	0.00	0.00	0.00	0.0
As a Percent Claims	0.00%	0.00	0.00	0.00	0.00	0.0
Additional Retention	0.00%	0.00	0.00	0.00	0.00	0.0
<b>Final Gross Rx Drug Card Costs</b>		\$16.08	\$16.60	\$11.42	\$22.53	\$48.91

Appendix A-25

**Tillinghast-Towers Perrin Prescription Drug Card Manual Costs—1998  
Prescription Drug Card Costs**

Company Name: Montana Insurance Dept Effective Date: September 1998 Pre-admission Certification: Yes  
 Plan Name: State Basic Plan Rates Guaranteed: 12 months Deductible Plan Type: All Expenses  
 Sub Name: In-Network, EAP Counselo Medical Area: B  
 SIC: No Adjustment

Input	Employee	Spouse	Children	Comp. Dep	Retiras
<b>Base Cost:</b>	\$7.51	\$8.21	\$6.26	\$11.59	\$22.30
Include Birth Control as a covered expense?	No				
<b>Average Prescription Cost</b>	0.00	0.00	0.00	0.00	0.00
Percent of Retail	NA				
Other	NA				
Retail	\$33.55				
<b>Benefit Design</b>					
Co-pay per prescription					
Brand	\$30.00				
Generic	\$10.00				
Annual Deductible	NA				
<b>Coinsurance Percentage:</b>					
Brand Name	100.00%				
Generic	100.00%				
Age Gender Factor Adjustment	0.00	0.00	0.00	0.00	0.00
Trend Factor using 1.4% Monthly Trend	0.21	0.23	0.18	0.32	0.62
Apply Major Medical Offset	No	0.00	0.00	0.00	0.00
<b>Net Monthly Manual Cost:</b>	<b>7.72</b>	<b>8.49</b>	<b>6.44</b>	<b>11.91</b>	<b>22.92</b>
<b>Administrative Costs</b>					
Per Prescription	\$0.00	0.00	0.00	0.00	0.00
As a Percent Claims	0.00%	0.00	0.00	0.00	0.00
Additional Retention	0.00%	0.00	0.00	0.00	0.00
<b>Final Gross Rx Drug Card Costs</b>	<b>\$7.72</b>	<b>\$8.49</b>	<b>\$6.44</b>	<b>\$11.91</b>	<b>\$22.92</b>

**CALCULATION OF THE BENCHMARK PIANIP-ADJUSTMENT FACTOR (UNE 27 OF THE HEALTHMAPS OUTPUT) FOR AREA B**

In-patient In-Network Mental Health Average Cost Calculation - Benchmark Plan

Recalculation of Tillinghast's example, assuming 80% of first \$6250 and 100% for remaining days (30-day maximum)

In-Patient Days				Using 80% coinsurance forever (ala Tillinghast)	
Range	Average	Avg. Cost	Relative Frequency	30 Days	
Avg. Daily Cost: \$848.70					
Under 10	5	\$4,244	0.32	\$4,244	
10-30	15	\$12,731	0.4	\$12,731	
30-60	45	\$38,192	0.14	\$25,461	
Over 60	70	\$59,409	0.14		
Expected annual cost				\$13,579	

Am't covered by plan \$12,329 \$10,863 **113.49%**

Ratio: Benchmark to Tillinghast

In-patient In-Network Substance Abuse Average Cost Calculation - Benchmark Plan

Recalculation of Tillinghast's example, assuming 75% of first \$5,000 and 100% for remaining days (30-day maximum), \$4,000 2-year maximum

Using 80% coinsurance forever (ala Tillinghast)

In-Patient Days				Using 80% coinsurance forever (ala Tillinghast)	
Range	Average	Avg. Cost	Relative Frequency	30 Days	30 Days
Avg. Daily Cost: \$254.61					
Under 10	5	\$1,273	0.32	\$1,273	\$1,273
10-30	15	\$3,819	0.4	\$3,819	\$3,819
30-60	45	\$11,457	0.14	\$4,000	\$11,457
Over 60	70	\$17,823	0.14		
Expected annual cost				\$3,055	\$5,143

Expected am't covered by plan \$2,291 \$4,114 **55.69%** ratio to HealthMAPS cost due to the 75% coinsurance to \$5,000 and due to the \$4,000 limit

Exhibit VII

Appendix A-27

Calculation of HealthMAPS Line 27 IP Adjustment Factor

HealthMAPS Claim Cost	Separated into Mental Health & Substance Abuse	Adjusted by the Benchmark to Tillinghast Ratio	Ratio of the Adjusted Total Claim Cost to the HealthMAPS claim cost
\$2.44	\$1.88	\$2.13	100.15%
	\$0.56	\$0.31	
		\$2.44	

**CALCULATION OF THE BENCHMARK PLAN IP-ADJUSTMENT FACTOR (LINE 27 OF THE HEALTHMAPS OUTPUT) FOR AREA A**

**In-patient Out-of-Network Mental Health Average Cost Calculation - Benchmark Plan**

Recalculation of Tillinghast's example, assuming 60% of first \$3125 and 80% for remaining days (to max. O-O-P) (30-day maximum)

<b>In-Patient Days</b>				
Avg. Daily Cost: \$776.25				
Range	Average	Avg. Cost	Relative Frequency	30 Days
Under 10	5	\$3,881	0.32	\$3,881
10-30	15	\$11,644	0.4	\$11,644
30-60	45	\$34,831	0.14	\$23,288
Over 60	70	\$54,338	0.14	
Expected annual cost				512,420
Ratio: Benchmark to Tillinghast				
Am't covered by plan				\$9,311 <b>85.71%</b>

**In-patient Out-of-Network Substance Abuse Average Cost Calculation - Benchmark Plan**

Recalculation of Tillinghast's example, assuming 75% of first \$5,000 and 100% for remaining days (30-day maximum), \$4,000 2-year maximum

Using 80% coinsurance forever

<b>In-Patient Days</b>					
Avg. Daily Cost: \$232.88					
Range	Average	Avg. Cost	Relative Frequency	30 Days	30 Days
Under 10	5	\$1,164	0.32	51,164	\$1,164
10-30	15	\$3,493	0.4	\$3,493	\$3,493
30-60	45	\$10,479	0.14	\$4,000	\$10,479
Over 60	70	\$16,301	0.14		
Expected annual cost				\$2,890	\$4,704
61.43% ratio to the due to the HealthMAPS cost due to the \$4,000 limit					
Expected am't covered by plan				\$2,167	\$3,763
57.59% ratio to HealthMAPS cost due to the 75% coinsurance to \$5,000 and due to the \$4,000 limit					

Exhibit VIII

**Calculation of HealthMAPS Line 27 IP Adjustment Factor**

HealthMAPS Claim Cost	Separated into Mental Health & Substance Abuse	Adjusted by the Benchmark to Tillinghast Ratio	Ratio of Adjusted Total Claim Cost to
\$2.17	\$1.67	\$1.43	
	\$0.50	\$0.29	
		\$1.72	<b>79.22%</b>

Appendix C-28

**BENCHMARK PLAN ACTUARIAL VALUE ILLUSTRATION**

	State Basic Plan <u>In-Network Costs</u>			State Basic Plan <u>Out-of-Network Costs</u>			State Basic Plan <u>Blended Costs: In-/Out-of-Network</u>			
	Percent of Base <u>Cost</u>	Children Claim <i>costs</i>	Child Claim <i>costs</i>	Percent of Base <u>Cost</u>	Children Claim <u>Costs</u>	Child Claim <i>costs</i>	Percent of Base <u>Cost</u>	Children Claim <i>costs</i>	Child Claim <i>costs</i>	Adjusted for Age <u>Limit of 18</u>
Base Cost (based on a \$750 deductible and 75% coinsurance on next \$5000, 100% thereafter)		\$76.57	\$40.30		\$67.91	\$35.74		\$74.41	\$39.16	\$37.28
Inpatient Hospital	19.5%	\$14.93	\$7.86	19.5%	\$13.24	\$6.97	16.9%	\$14.51	\$7.64	\$7.27
inpatient Professional	3.0%	\$2.30	\$1.21	3.0%	\$2.04	<b>\$1.07</b>	2.6%	\$2.23	\$1.17	\$1.12
Inpatient Mental Health and Chemical Dependency		\$2.93	<b>\$1.54</b>		\$2.05	<b>\$1.08</b>		\$2.71	\$1.43	<b>\$1.36</b>
Inpatient Surgical	4.4%	\$3.37	<b>\$1.77</b>	4.4%	\$2.99	<b>\$1.57</b>	4.4%	\$3.27	\$1.72	\$1.64
Extended Care Facility		<b>\$1.36</b>	\$0.72		\$1.26	\$0.66		\$1.34	\$0.70	\$0.67
Outpatient Hospital	21.3%	\$16.31	\$8.58	21.3%	\$14.46	<b>\$7.61</b>	21.3%	\$15.85	\$8.34	<b>\$7.94</b>
Outpatient Professional	2.1%	\$1.61	\$0.85	2.1%	\$1.43	\$0.75	2.1%	\$1.56	\$0.82	\$0.78
Outpatient Mental Health and Chemical Dependency		\$8.49	\$4.47		\$7.76	\$4.09		\$8.31	\$4.37	\$4.16
Outpatient Surgical	7.4%	\$5.67	\$2.98	7.4%	\$5.03	\$2.64	7.4%	\$5.51	\$2.90	\$2.76
Diagnostic X-Ray & Lab	10.0%	<b>\$7.66</b>	\$4.03	10.0%	\$6.79	<b>\$3.57</b>	10.0%	\$7.44	\$3.92	\$3.73
Office Visits	18.9%	\$20.14	\$10.60	18.9%	\$17.73	\$9.33	18.9%	<b>\$19.54</b>	\$10.28	\$9.79
<b>Newborn</b> Coverage		\$1.47	<b>\$0.77</b>		\$1.34	\$0.71		\$1.44	\$0.76	\$0.72
Well Child Care		\$2.62	\$1.38		\$2.40	\$1.26		\$2.57	\$1.35	\$1.29
Prescription Drugs		<b>\$8.93</b>	\$4.70		\$8.93	\$4.70		\$8.93	\$4.70	\$4.47
Vision Services		\$0.97	\$0.51		\$0.85	\$0.45		\$0.94	\$0.50	\$0.47
Hearing Services Not Covered		\$0.00	\$0.00		\$0.00	\$0.00		\$0.00	\$0.00	\$0.00
Other Miscellaneous	4.9%	<b>\$3.75</b>	<b>\$1.97</b>	4.9%	<b>\$3.33</b>	<b>\$1.75</b>	4.9%	<b>\$3.65</b>	<b>\$1.92</b>	<b>\$1.83</b>
		\$102.50	\$53.95		\$91.63	<b>\$48.23</b>		\$99.79	\$52.52	<b>\$50.00</b>

Exhibit IX

Appendix A-29

**Per Member Per Month Cost Distribution Model**  
1998 Medical Rate Manual

Type of Service	Annual Frequency per 1000 Members (A)	Utilization Adjustment Factor (B)**	Adjusted Utilization (A)*(B)=(C)	Cost per Unit of Service (D)	Discount Adjustment Factor (E)**	Adjusted Cost per Unit of Service (D)*(E)=(F)	Copy per Unit of Service (G)**	After Copy Cost per Unit (F)-(G)=(H)	Cost Per Member Per Year (C)*(H)=(I)	Final Adjustment Factor (J)**	Final PMPM (I)*(J)/12
<b>Inpatient Hospital</b>											
Medical	85 days	0.43	36.2	1,813.00	0.78	1,415.30	0.00	1,415.30	51.25	1.00	4.27
Surgical	80 "	0.48	38.7	2,175.60	0.78	1,696.36	0.00	1,696.36	65.76	1.00	5.48
ICU/CCU	52 "	0.43	22.2	4,532.50	0.78	3,536.25	0.00	3,536.25	76.38	1.00	6.53
Normal Delivery	22 "	0.07	1.5	2,175.60	0.78	1,696.36	CM	1,696.36	2.59	1.00	0.22
C-Section	12 "	0.07	0.8	2,175.60	0.78	1,696.36	CM	1,696.36	1.41	1.00	0.12
Other Maternity	2 "	0.07	0.1	2,175.60	0.78	1,696.36	0.00	1,696.36	0.24	1.00	0.02
Mental	59 "	Manual	0.0	1,118.00	Manual	0.00		0.00	0.00	Manual	0.00
<b>Total</b>	<b>312</b>		<b>99.6</b>	<b>2,568.08</b>		<b>2,004.74</b>		<b>2,004.74</b>	<b>199.62</b>		<b>16.63</b>
<b>Outpatient Hospital</b>											
Emergency Room	168 cases	0.62	104.8	270.00	0.78	210.77	4.50	206.27	21.61	1.00	1.80
Outpatient Surgery	76 cases	0.58	43.9	2,188.00	0.78	1,708.04	0.00	1,708.04	74.81	1.00	6.24
Radiology	210 cases	0.62	131.0	636.00	0.78	496.49	0.00	496.49	65.03	1.00	5.42
Pathology	158 cases	0.62	98.5	159.00	0.78	124.12	0.00	124.12	12.23	1.00	1.02
Other								108.00		0.49	4.30
<b>Total</b>								<b>279.79</b>			<b>18.78</b>
<b>Physician</b>											
Surgical Inpatient	49 procs	0.48	23.7	2,408.00	0.78	1,879.78	CM	1,879.78	44.58	1.00	3.72
Surgical Outpatient	103 procs	0.58	59.4	1,290.00	0.78	1,007.03	CM	1,007.03	59.86	1.00	4.98
Surgical Office	309 procs	0.58	178.3	147.00	0.78	114.75	0.00	114.75	20.48	1.00	1.71
Normal Delivery	11 cases	0.07	0.8	2,808.00	0.78	2,192.04	CM	2,192.04	1.67	1.00	0.14
C-Section	3 cases	0.07	0.2	4,914.00	0.78	3,836.06	CM	3,836.06	0.80	1.00	0.07
Maternity Other									13.00	0.05	0.06
Anesthesia									23.98	0.42	0.84
Professional Inpatient									78.53	0.37	2.39
Professional Outpatient									30.19	0.54	1.35
X-ray	612 procs	0.80	368.9	225.00	0.78	175.64	CM	175.64	64.79	1.00	5.40
Lab	2,091 procs	0.80	1,260.2	45.00	0.78	35.13	0.00	35.13	44.27	1.00	3.69
Office Visits	4,437 visits	0.74	3,280.7	80.00	0.78	62.45	0.00	62.45	204.88	1.00	17.07
<b>Total</b>								<b>587.01</b>			<b>41.42</b>
Prescription Drugs	6,456 scripts	Manual	0.0	33.50	Manual	0.00	0.00	0.00	0.00	Manual	0.00
<b>Miscellaneous</b>											
Ambulance	20 trips	N/A	0.0	416.00	N/A	0.00	N/A	0.00	0.00	N/A	0.00
DME	31 items	N/A	0.0	312.00	N/A	0.00	N/A	0.00	0.00	N/A	0.00
Substance Abuse	29 days	Manual	0.0	836.50	Manual	CM	CM	0.00	0.00	Manual	0.00
Other									96.12	Manual	0.00
<b>Total</b>								<b>96.12</b>			<b>0.00</b>
<b>Grand Total</b>								<b>1,162.54</b>			<b>76.84</b>

\*\* Columns B, E, G and J can be used to adjust the basic values to reflect user specified utilization, discounts, copays and other factors.

Exhibit X

Appendix A-30

**Analysis of Cost Comparisons by Medical Procedure**  
 Purpose: to convert the Tillinghast PMPM Blended Costs to Child Costs

Medical Area B	<u>Annual Expenses</u>			Blended	Child Expense as a Percent of the Blended Expense
	<u>Employee</u>	<u>Spouse</u>	<u>Child</u>		
Hospital Inpatient - Normal Mat	\$55.34	\$175.63	\$4.61	\$66.58	6.92%
Hospital Inpatient - All Other	\$596.50	\$652.11	\$209.91	\$492.76	42.60%
Hospital Inpatient - Total	\$651.84	\$827.74	\$214.52	\$559.34	38.35%
Hospital Outpatient	\$424.31	\$463.87	\$234.55	\$376.09	62.37%
Surgical Inpatient - Normal Mat	\$38.47	\$122.09	\$3.21	\$46.29	6.93%
Surgical Inpatient - All Other	\$107.10	\$117.08	\$43.69	\$90.27	48.40%
Surgical Inpatient - Total	\$145.57	\$238.17	<b>\$46.90</b>	<b>\$136.56</b>	<b>34.34%</b>
Surgical Outpatient	\$155.84	\$170.37	\$78.37	\$135.80	57.71%
Professional Inpatient	\$82.04	\$89.69	\$32.19	\$68.77	46.81%
Professional Outpatient	\$35.57	\$38.89	\$22.25	\$32.30	68.88%
<b>DX&amp;L - Normal Maternity</b>	\$2.58	\$8.19	\$0.22	\$3.11	7.08%
<b>DX&amp;L - All Other</b>	<b>\$195.89</b>	<b>\$214.15</b>	<b>\$105.86</b>	<b>\$172.90</b>	<b>61.23%</b>
<b>DX&amp;L - Total</b>	<b>\$198.47</b>	<b>\$222.34</b>	<b>\$106.08</b>	<b>\$176.00</b>	<b>60.27%</b>
Office visits	\$293.10	\$320.43	\$200.66	\$271.38	73.94%
Prescription Drug	\$204.65	\$223.73	\$96.06	\$176.27	<b>54.50%</b>
Miscellaneous	\$110.89	\$121.23	<b>\$46.00</b>	\$93.70	49.09%
Maternity Total	\$96.39	\$305.91	\$8.04	\$115.98	6.93%
Non-Maternity Total	<b>\$2,205.89</b>	<b>\$2,411.55</b>	<b>\$1,069.54</b>	<b>\$1,910.23</b>	55.99%
<b>All Expenses Total</b>	<b>\$2,302.28</b>	<b>\$2,717.46</b>	<b>\$1,077.58</b>	<b>\$2,026.21</b>	53.18%

Exhibit XI

Appendix A-1

**Tillinghast-Towers Perrin Medical Manual Costs-1008  
in-Network Monthly Costs**

Company Name: Montana Insurance Dept      Effective Date: September 1996      Pre-admission Certification: Yes  
 Plan Name: Children's Health Insurance      Rates Guaranteed: 12 months      Deductible Plan Type: All Expenses  
 Sub Name: Actual Value Calculation      Medical Area: B      PPO Participation: 100%  
 SIC: No Adjustment

	Adult	Children	Spouse	Childen	Childen	Childen
<b>1. Base Cost:</b>						
<b>Deductible:</b>						
2. Calendar Year Deductible (combined)	\$0	\$0	\$0	\$0	\$0	\$0
3. Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4. Eliminate Carry-Forward	Yes	0.00	0.00	0.00	0.00	0.00
5. Deductibles Per Family	3.00	0.00	0.00	0.00	0.00	0.00
6. Hospital Deductible Per Admission	\$0	0.00	0.00	0.00	0.00	0.00
7. Waive Deductible for Surgery						0.00
<b>Policy Specifications:</b>						
8. In-full Hospital Units	0.00	0.00	0.00	0.00	0.00	0.00
9. In-full Hospital Amount	\$0	0.00	0.00	0.00	0.00	0.00
10. ICU Maximum	3 Times R&B	0.00	0.00	0.00	0.00	0.00
<b>Covered Level:</b>						
11. Room and Board	\$645	0.00	0.00	0.00	0.00	0.00
12. Surgical	\$108	0.00	0.00	0.00	0.00	0.00
<b>13. Adjusted Base Cost:</b>						
13a. PPO Discount Value (at 90%)		\$153.55	\$181.19	\$138.55	\$253.64	\$306.02
<b>Coinsurance - General:</b>						
14. First Coinsurance Percentage	100%	0.00	0.00	0.00	0.00	0.00
15. on first \$x incurred after ded	\$0					
16. Second Coinsurance Percentage	100%					
17. on next \$Y incurred	\$0					
18. Third Coinsurance Percentage	0%	65.28	77.01	58.03	107.80	130.08
19. Stop-loss Max Per Family	3.00					
20. Lifetime Maximum (omit 000's)	\$1,000	0.00	0.00	0.00	0.00	0.00
<b>Mental Health and Substance Abuse:</b>						
21. OP - Coinsurance	80%					
22. OP - Max Covered Charge	\$2,000					
23. OP - Annual Maximum	\$0					
24. Include OP Substance Abuse	Yes					
25. OP - Adjustment factor	1.00	13.19	13.19	12.43	20.08	27.28
26. IP - Max Days	30					
27. IP - Adjustment Factor	1.00	0.00	0.00	0.00	0.00	(Loo
<b>Extended Care Facility:</b>						
28. ECF Daily Benefit	\$0					
29. ECF Maximum Number of Days	0	0.00	0.00	0.00	0.00	0.00
<b>Policy Specifications:</b>						
30. Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	0.00
31. Supplemental Accident Maximum	\$0	0.00	0.00	0.00	0.00	0.00
32. Eliminate Rx Drugs	Yes	(25.16)	(28.66)	(22.38)	(41.57)	(50.15)
<b>Co-payments:</b>						
33. Primary Office Visit Co-pay	\$0					
34. Specialist Office Visit Co-pay	\$0					
35. Max Number of Co-pays Per Year	0	4.30	4.84	5.02	7.87	am
36. Emergency Room Co-pay	\$5	0.32	0.38	0.48	0.84	0.27
37. Outpatient Surgical Center Co-pay	\$0	0.00	0.00	0.00	0.00	aw
<b>Misc. In-Network Adj.:</b>						
38. Misc. Description and Adjustment		0.00	0.00	0.00	0.00	0.00
<b>Well Care Benefit:</b>						
39. Nursery Benefits - Maternity On Children	\$658					
40. Adjustment Factor	1.00	0.66	2.56	1.47	2.43	
41. Well Care Benefits, Adult - No	NA					
42. Total Expense Limit	NA					
43. Well Care Benefits, Children - Phy and Gyn Exams	No Ans Limit	0.00	0.00		0.00	0.00
44. Total Expense Limit	\$500					
45. Benefits Terminate Upon Attainment of Age	No Limit			10.19		
<b>46. Manual Cost: (before factor adjustments)</b>		\$212.11	\$248.45	\$201.79	\$350.68	\$422.24
<b>Factor Adjustments:</b>						
47. Experience Factor	0.528					
48. Underwriting Factor	1.000					
49. Trend Factor	1.0120					
50. Age Gender Factor	Yes	1.00	1.000	0.962	0.964	1.000
51. Child "Coverage From" (additive)	From Birth		0.000		0.000	
52. Pre-Admission Certification Factor - Yes	1.000					
53. SIC Factor - No	1.000					
<b>54. Final Total Manual Costs</b>		\$112.97	\$132.88	\$182.32	\$183.79	\$224.98



**Children's Health Insurance Program**

**Inpatient Mental Health**

Calculation using Montana's minimum requirements from 33-22-703, MCA.

**\$848.70** = the Montana average cost per day

<b><u>Inpatient Days</u></b>	Avg. No.	Relative	Avg. Cost
<b>Range</b>	<b>of Days</b>	<b>Frequency</b>	<b>21 days max.</b>
Under 10	5	0.32	\$5,175
10-21	13	0.24	\$13,455
21-30	23	0.16	\$21,735
30-60	45	0.14	
Over 60	70	0.14	
			\$14,449
Am't covered by plan			\$14,449
Annual frequency			0.00135
Annual cost per child			\$19.51
Monthly cost per child			\$1.63
Increased 20% for partial hospitalization coverage			\$1.95

**Outpatient Mental Health**

See page 177, 1998 Tillinghast State Mandated Benefits Manual

Maximum 20 annual visits, \$100 charge per visit, no copay **\$4.15**

Montana monthly cost per child \$5.19 for outpatient mental health

**Inpatient Chemical Dependency**

Calculation using Montana's minimum requirements from 33-22-703, MCA.

**\$254.61** = the Montana average cost per day

<b><u>Inpatient Days</u></b>	Avg. No.	Relative	Avg. Cost
<b>Range</b>	<b>of Days</b>	<b>Frequency</b>	<b>\$4,000 max.</b>
Under 10	5	0.32	\$1,235
10-21	13	0.24	\$3,211
21-30	23	0.16	\$4,000
30-60	45	0.14	
Over 60	70	0.14	
			\$2,926
<b>Area B</b>			
Expected am't covered by plan			\$2,926
Biennial frequency			0.0027
Biennial cost per child			\$7.90
Monthly cost per child			\$0.33
Increased 20% for partial hospitalization coverage			\$0.39

**Outpatient Chemical Dependency**

See page 177, 1998 Tillinghast State Mandated Benefits Manual

Maximum yearly benefit of **\$1,000** **\$0.78**

Montana monthly cost per child \$0.98 for outpatient chemical dependency

CALCULATION OF THE ACTUARIAL VALUE FOR THE MONTANA CHILDREN'S HEALTH INSURANCE PROGRAM  
Including Cost Calculation for the Benefits not Included in the HealthMAPS PMPM Program's Assumptions

	Base cost	Area B Conversion Factor	Coverage to Age 19 Conversion Factor	Adjusted <u>Cost</u>
Newborn Children	\$0.77	1.00	0.952	\$0.73
Inpatient Mental Health	\$1.95	1.00	0.952	\$1.86
inpatient Chemical Dependency	\$0.39	1.00	0.952	\$0.37
Immunizations	\$1.84	0.82	0.952	\$1.44
Well Child Care	\$5.36	1.00	<b>0.952</b>	\$5.10
Prescription Drugs	\$10.31	1.00	0.952	\$9.82
Outpatient Mental Health	\$5.19	1.00	0.952	\$4.94
Outpatient Chemical Dependency	\$0.98	1.00	<b>0.952</b>	<b>\$0.93</b>
Vision	\$0.83	0.82	<b>0.952</b>	\$0.65
Audiology	\$0.04	0.82	<b>0.952</b>	<b>\$0.03</b>
			<b>Total</b>	\$25.87
			Grand Total from the 1998 PMPM Spreadsheet	<b><u>\$76.84</u></b>
			Total Actuarial Value	<b><u>\$102.71</u></b>

Exhibit XV

Appendix A-35

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**Monthly cost comparisons by category based on the  
1998 Medical Manual's traditional plan distribution of expenses**

	<u>Benchmark</u>	<u>CHIP</u>
Inpatient Hospital	\$7.27	\$11.15
Inpatient Professional	\$1.12	\$7.22
Inpatient Mental Health and Chemical Dependency	\$1.36	\$2.23
Inpatient Surgical	\$1.64	\$5.48
Extended Care Facility	\$0.67	\$0.00
Outpatient Hospital	\$7.94	\$12.54
Outpatient Professional	\$0.78	\$8.05
Outpatient Mental Health and Chemical Dependency	\$4.16	\$5.87
Outpatient Surgical	\$2.76	\$6.24
Diagnostic X-Ray & Lab	\$3.73	\$9.09
Office Visits	\$9.79	\$17.07
Newborn Coverage	\$0.72	\$0.73
Well Child Care	\$1.29	\$6.54
Prescription Drugs	\$4.47	\$9.82
Vision Services	\$0.47	\$0.65
Hearing Services	\$0.00	\$0.03
Other Miscellaneous	<u>\$1.83</u>	<u>\$0.00</u>
<b>TOTAL</b>	<b>\$50.00</b>	<b>\$102.71</b>

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Appendix A-36

Exhibit XVI

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**Comparison of the Actuarial Values  
of the Benchmark Plan and CHIP Plan**

	<b><u>Benchmark Plan</u></b>	<b><u>CHIP Plan</u></b>	<b><u>Ratio: CHIP to Benchmark</u></b>
<b><u>BASIC SERVICES</u></b>			
Inpatient and Outpatient Hospital Services	\$15.21	\$23.69	1.56
Physicians' Surgical and Medical Services	\$16.09	\$44.06	2.74
Laboratory and X-Ray Services	\$3.73	\$9.09	2.44
Well-Baby and Well-Child Care (including age-appropriate immunizations)	\$2.01	\$7.27	3.62
<b><u>ADDITIONAL SERVICES</u></b>			
Coverage of Prescription Drugs	\$4.47	\$9.82	2.20
Mental Health Services	\$5.52	\$8.10	1.47
Vision Services	\$0.47	\$0.65	1.38
Hearing Services	\$0.00	\$0.03	ERR
<b>Total</b>	<b>\$47.56</b>	<b>\$102.71</b>	<b>2.16</b>

Exhibit I, XVII

Appendix A-37

**APPENDIX B:**

**SUPPORTING  
DOCUMENTATION FOR  
INSURANCE RATE**

Proposed Effective Date: April 10, 1998

**CALCULATION OF THE PREMIUM RATE FOR THE MONTANA CHILDREN'S HEALTH INSURANCE PROGRAM**  
 Including Detailed Pricing of the Benefits not Included in the HealthMAPS PMPM Pricing Program's Assumptions

	<b>Base Cost</b>	Network Discount Factor	Area B Conversion Factor	Coverage to Age 19 Conversion Factor	Risk, Trend & Expense Adjustment	Other Adjustments	Risk Reduction Factor	Adjusted Cost
Nursery Charges for Newborns	\$0.77	0.970	1.00	0.952	1.0638	20%	100.0%	\$0.15
Inpatient Mental Health	\$2.22	1.000	1.00	0.952	1.0638	60%	07.5%	\$1.18
Inpatient Chemical Dependency	\$0.45	1.000	1.00	0.952	1.0638	60%	07.5%	\$0.24
Immunizations	\$1.84	0.850	0.82	0.952	1.0638	100%	100.0%	\$1.30
Well Child Care	\$5.36	0.850	1.00	0.952	1.0638	100%	100.0%	\$4.61
Prescription Drugs	\$10.31	1.000	1.00	0.952	1.0761	100%	100.0%	\$10.56
Outpatient Mental Health	\$5.71	0.960	1.00	0.952	1.0638	70%	90.0%	\$3.50
Outpatient Chemical Dependency	\$1.08	0.960	1.00	0.952	1.0638	70%	90.0%	\$0.66
Vision	\$0.83	1.000	0.82	0.952	1.0638	100%	100.0%	\$0.69
Audiology	\$0.04	1.000	0.82	0.952	1.0638	100%	100.0%	\$0.03
							Total	\$22.93
							<b>Grand Total from the PMPM Pricing Program</b>	<b>\$68.47</b>
							<b>Overall Grand Total</b>	<b>\$91.40</b>

Appendix B-1

**Per Member Per Month Cost Distribution Model**  
1996 Medical Rate Manual

Type of Service	Annual Frequency per 1000 Members (A)	Utilization Adjustment Factor (B)**	Adjusted Utilization (A)*(B)=(C)	Cost per Unit of Service (D)	Discount Adjustment Factor (E)**	Adjusted Cost per Unit of Service (D)*(E)=(F)	Copay per Unit of Service (G)**	After Copay Cost per Unit (F)-(G)=(H)	Cost Per Member Per Year (C)*(H)=(I)	Final Adjustment Factor (J)**	Final PMPM (I)*(J)=12
<b>Inpatient Hospital</b>											
Medical			38.2	1,813.00	0.76	1,372.84	0.00	1,372.84	49.71	1.03	428
Surgical	80	0.48	38.7	2,175.60	0.76	1,647.41	0.00	1,647.41	63.79	1.03	5.49
ICU/CCU	52	0.43	222	4,532.50	0.76	3,432.10	0.00	3,432.10	76.03	1.03	6.54
Normal Delivery	22	0.01	0.3	2,175.60	0.76	1,647.41	0.00	1,647.41	0.50	1.03	0.04
C-Section	12	0.01	0.2	2,175.60	0.76	1,647.41	0.00	1,647.41	0.27	1.03	0.02
Other Maternity	2	0.01	0.0	2,175.60	0.76	1,647.41	0.00	1,647.41	0.05	1.03	0.00
Mental	58	Manual	0.0	1,118.00	Manual	0.00	0.00	0.00	0.00	Manual	0.00
<b>Total</b>	<b>312</b>		<b>97.8</b>	<b>2,576.09</b>		<b>1,950.67</b>		<b>1,950.67</b>	<b>190.35</b>		<b>16.38</b>
<b>Outpatient Hospital</b>											
Emergency Room			104.8	270.00					20.79	1.03	1.79
Outpatient Surgery			43.8	2,188.00					72.67	1.03	6.25
Radiology			131.0	636.00					63.08	1.03	5.43
Pathology			98.5	159.00					11.86	1.03	1.02
Other									108.00	0.47	4.18
<b>Total</b>									<b>274.40</b>		<b>18.68</b>
<b>Physician</b>											
Surgical Inpatient			23.7	2,408.00					37.89	1.03	3.26
Surgical Outpatient			S A	1,290.00					50.88	1.03	4.38
Surgical Office			178.3	147.00					17.39	1.03	1.50
Normal Delivery			0.2	2,808.00					0.28	1.03	0.02
C-Section			0.0	4,914.00					0.14	1.03	0.01
Maternity Other									13.00	OB1	0.01
Anesthesia									20.44	0.37	0.63
Professional Inpatient									80.28	0.32	2.15
Professional Outpatient									31.96	0.47	1.26
X-ray	612 procs	0.60	368.9	225.00					55.07	1.03	4.74
Lab	2,091 procs	0.60	1,260.2	45.00					37.63	1.03	3.24
Office Visits	4,437 visits	0.60	2,673.8	80.00					141.93	1.03	12.22
<b>Total</b>									<b>486.92</b>		<b>33.41</b>
<b>Prescription Drugs</b>											
	6,456 scripts	Manual	3.0	33.50					0.00	Manual	0.00
<b>Miscellaneous</b>											
Ambulance	20 trips	N/A	0.0	416.00	N/A	0.00			0.00	N/A	0.00
DME	31	N/A	0.0	312.00	N/A	0.00			0.00	N/A	0.00
Substance Abuse	29 days	Manual	0.0	838.50	Manual	0.00			0.00	Manual	0.00
Other									98.12	Manual	0.00
<b>Total</b>									<b>98.12</b>		<b>0.00</b>
<b>Grand Total</b>									<b>1,047.79</b>		<b>68.47</b>

\*\* Columns B, E, G and J can be used to adjust the basic values to reflect user specified utilization, discounts, copays and other factors.