State of Montana Benefit Plan

Department of Administration
Health Care & Benefits Division
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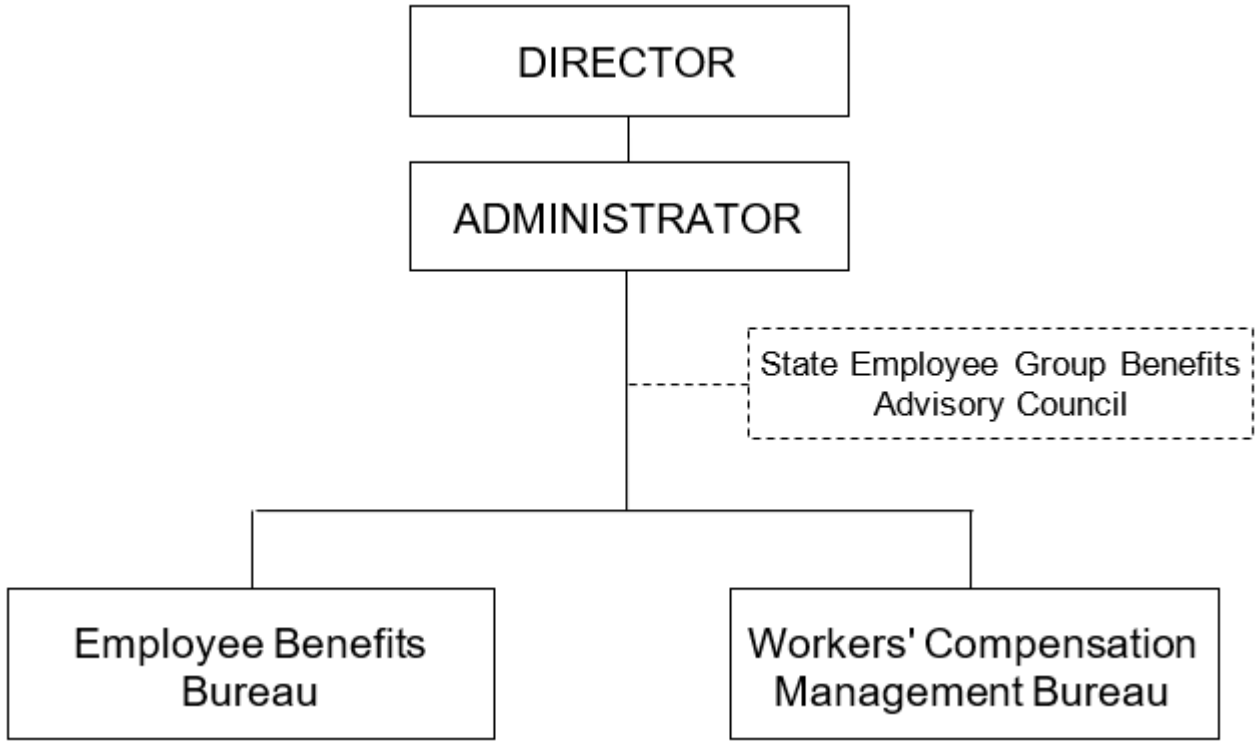
DIVISION STRUCTURE

HCBD manages the State of Montana Benefit Plan (State Plan) which provides health plan benefits to State of Montana employees, retirees, legislators, survivors, and their covered dependents.

HCBD's Workers' Compensation Bureau (WCMB) performs workers' compensation policy management and oversight via its workplace safety and return to work programs.



Total FTE: HCBD: 18.7, WCMB: 3.17

Total HB 2 FTE: 0

BACKGROUND

State Employee Group Benefit Advisory Council (SEGBAC)

- Established in 1979 pursuant to §2-15-122, MCA and §2-15-1016, MCA
- Body of state employees and retirees who provide advice on health plan matters
- Department of Administration recommends council members and Governor approves
- Employees, labor organizations, and retirees must be adequately represented
- Meets quarterly

BACKGROUND

State of Montana Benefit Plan (State Plan)

- Self-funded plan created in 1979

- Authorized in Title 2, Chapter 18, Parts 7 & 8, MCA
  - Officer and employee eligibility for the plan: §2-18-702, MCA
  - Continued coverage for employees affected by reduction in force: §2-18-1205, MCA
  - Employer contributions (State Share): §2-18-703, MCA
  - Retiree participation: §2-18-704, MCA

- Legislator participation in Title 5, Chapter 2, Part 303, MCA
  - Continued coverage authorized for term-limited legislators: §2-18-820, MCA

BACKGROUND

Self-funded State Plan

The self-funded State Plan is funded by the State of Montana via the employer contribution (State Share), bi-weekly employee contributions, and monthly retiree contributions. The State Plan:

- Provides coverage in accordance with state and federal law
- Sets the monthly rates and out-of-pocket costs for benefits
- Carries the liability for all 28,000+ members of the State Plan - employees, legislators, retirees, and their dependents
  - Provides for self-funded medical, prescription, vision, and dental benefits
  - Provides plan members with access to near-site employer health clinics
  - Provides for fully insured life and long-term disability insurance

BACKGROUND

Self-funded State Plan

The self-funded State Plan contracts with outside companies to process claims, administer State Plan benefits, and expertise and cost savings contracts. Vendors include:

- BlueCross BlueShield of Montana (BCBSMT) – Medical Benefits and fully insured life and long-term disability coverage
- VSP Vision Care – Vison Benefits
- Delta Dental – Dental Benefits
- Navitus Health Solutions – Prescription Benefits
- ASIFlex – Flexible Spending Accounts (FSAs)
- Premise Health – manages Montana Health Centers
- ComPsych – Employee Assistance Program (EAP)
- Cedar Gate – Data Warehouse

BACKGROUND

Self-funded State Plan

Past –

- BlueCross BlueShield of Montana (BCBSMT) – TPA from 2003-2012
- Cigna – TPA from 2013-2015
- Allegiance Benefit Plan Management – TPA from 2016-2022 (Reference Based Pricing Program effective July 1, 2016)
- BlueCross BlueShield of Montana (BCBSMT) – TPA 2023-2024

Present –

- BlueCross BlueShield of Montana (BCBSMT) – TPA Effective January 1, 2025
  - Contract requirements for reimbursement targets that are a reference of Medicare
  - Contract performance guarantees for meeting reference of Medicare reimbursement

FUNDING

State of Montana Benefit Plan

Contributions

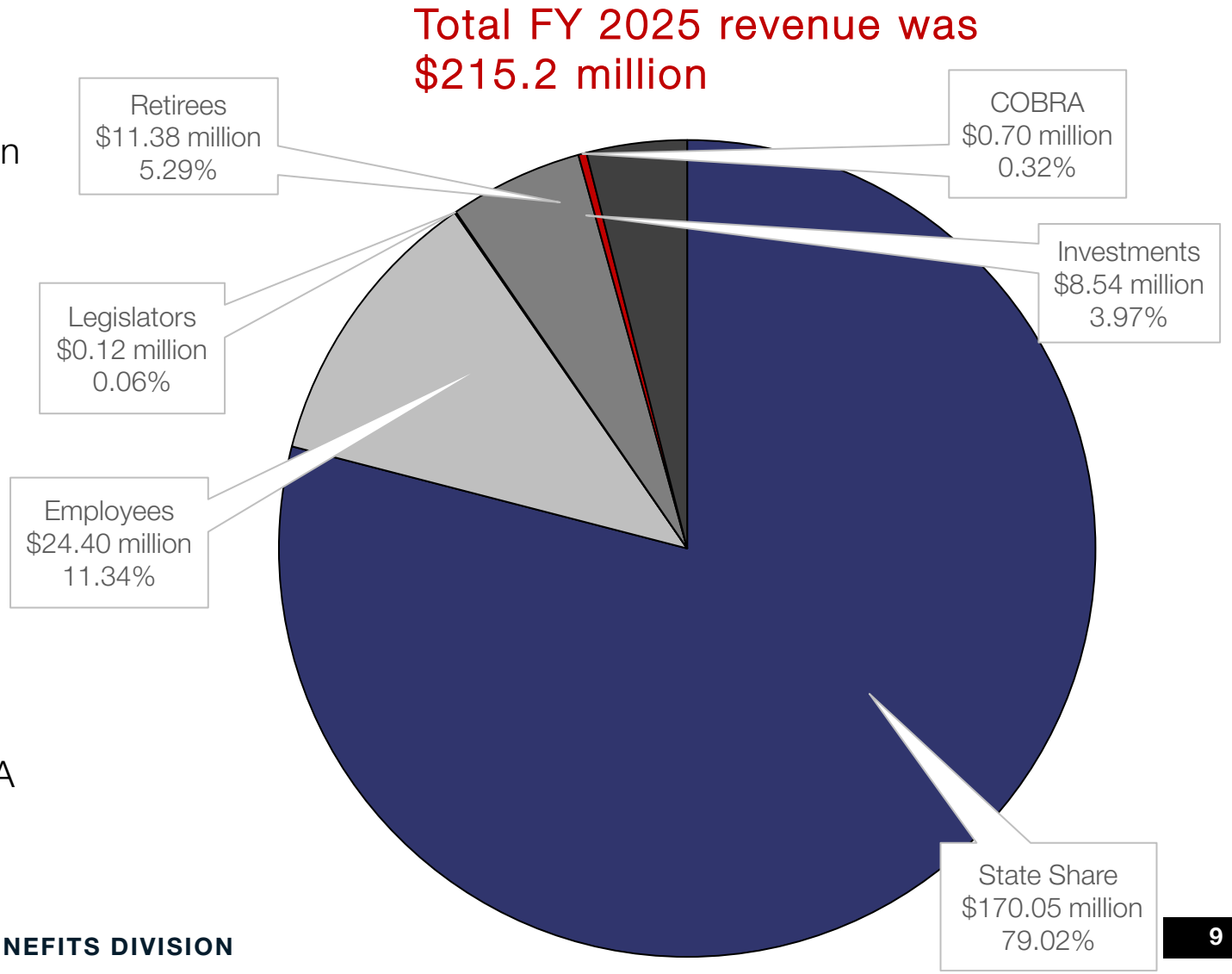
- Legislature defines “rates and fees” for state employee programs as State Share contribution toward employee group benefits
  - State Share is $1,080 per month per filled benefits eligible position, §2-18-703, MCA
  - Bargained with unions each budget cycle and included in legislative pay plan
- Employees and retiree contributions are reviewed annually and adjusted when necessary to meet requirements of §2-18-812(1), MCA
  - Requires the department to maintain state employee group benefits plans on an actuarially sound basis

FUNDING

State of Montana is a health plan fiduciary and is responsible for management of the group health plan and ensuring it operates in the best interests of plan participants and beneficiaries.

Legislature defines “rates” for the State Plan, often referred to as State Share or the employer contribution.

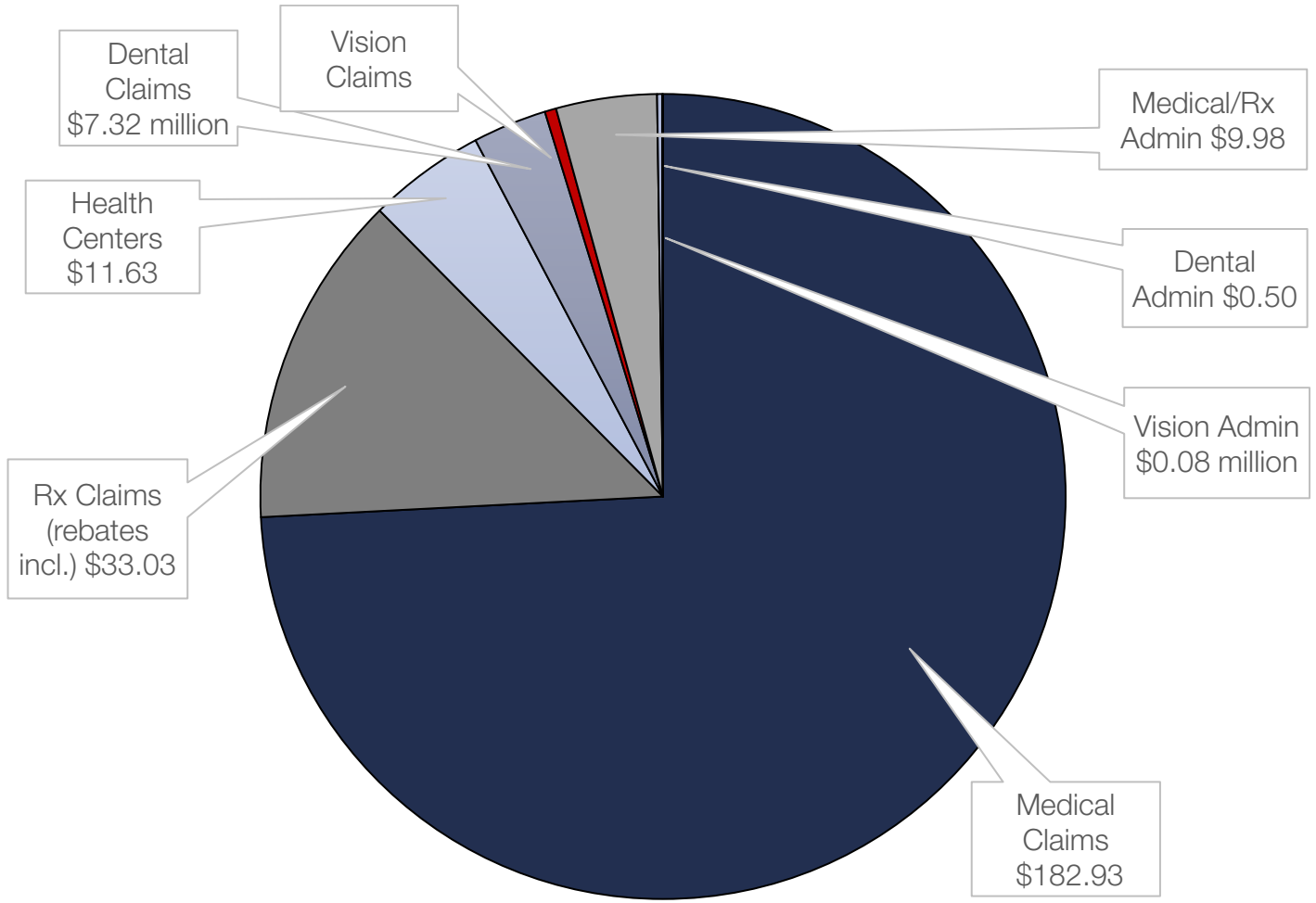
- State Share is $1,080 per month per filled benefits eligible position, §2-18-703(2)(a), MCA
- Requires the department to maintain state employee group benefit plan on an actuarily sound basis, §2-18-812(1), MCA



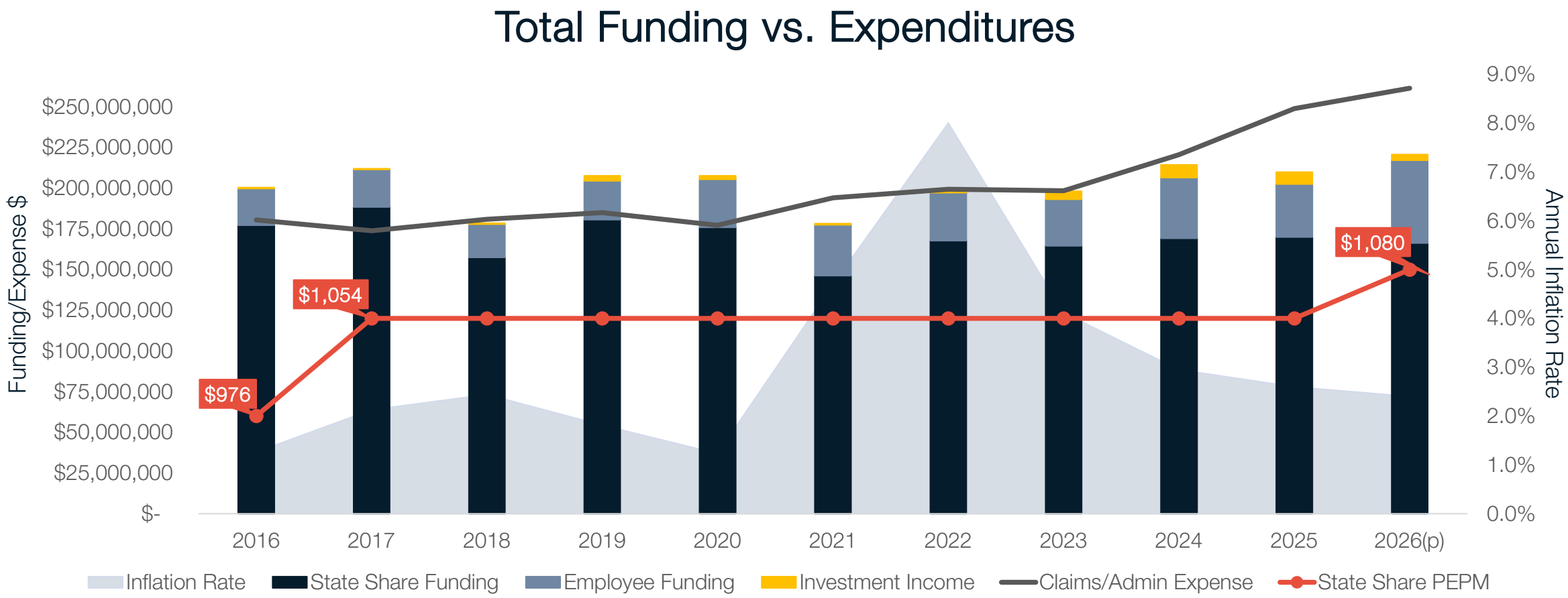
EXPENSE

State of Montana Benefit Plan

Total FY 2025 expenditures for benefits was $246.6 million



STATE PLAN FINANCIAL STATUS / UTILIZATION



*** Funding bars **include** the State Share holiday reductions of $26M in 2018 and $28M in 2021. Does not include the OTO infusion of $30M in 2023.***

Claims/Admin Expense line reflects expense trending since the 2016 and 2017 State Share increases, implementation of RBP in 2016, as well as the dip in 2020 due to COVID shut down and then ongoing continuous increases.

STATE PLAN FINANCIAL STATUS / UTILIZATION

What is happening in the market to drive the higher costs and utilization?

Negative Impacts to Cost

- Consequences of ongoing deferred care
- Episodic care versus continuous care
- Prescriptions not being filled/taken due to affordability
- State and federal regulations
- Out-of-state ownership and influence
- Growing demand for mental health and substance use disorder treatment
- Gene therapies being introduced to market
- Cancer being seen in younger adults
- Increased utilization of GLP-1s
- Provider shortages – especially in primary care
- Population is aging and requiring more care
- Increased options and treatment for cancer care – 33% of cancers can be treated using a pharmaceuticals
- Medical inflation and higher care prices
- Loss of Affordable Care Act subsidies
- Fraudulent eligibility

Positive Impacts to Cost

- More utilization of telehealth / virtual care
- Biosimilars replacing high-cost specialty brand drugs
- State and federal regulations

REFERNCE BASED PRICING (RBP)

Standardization and Predictability

- Using Medicare rates as a reference provides a consistent, transparent framework for other payers.

Cost-Reflective Benchmark

- Medicare rates are calculated using resource-based formulas that account for labor, non-labor costs, and geographic adjustments. They reflect the average cost of providing care for Medicare patients, making them a reliable indicator of what it costs to deliver services.

Regulatory and Legal Compliance

- Medicare is the largest single purchaser of hospital services. Medicare rates as a reference ensures compliance with federal statutes and regulations.

State and Private Payer Alignment

- State health purchasers and private insurers use Medicare rates as a reference point for their own programs. California, Oregon, and Washington have varying degrees of state regulation that require a Medicare reference point for payment.
- National Academy for State Health Policy (NASHP) – Montana is the only State on record for implementing their own, non-statutorily required RBP program. Montana RBP rates are significantly lower than rates set by statute in CA, OR, WA.

Financial Viability and Sustainability

- Basing reimbursements on Medicare rates, hospitals can avoid overpayment for services and ensure that their revenue covers expenses.

RBP MODERNIZED APPROACH

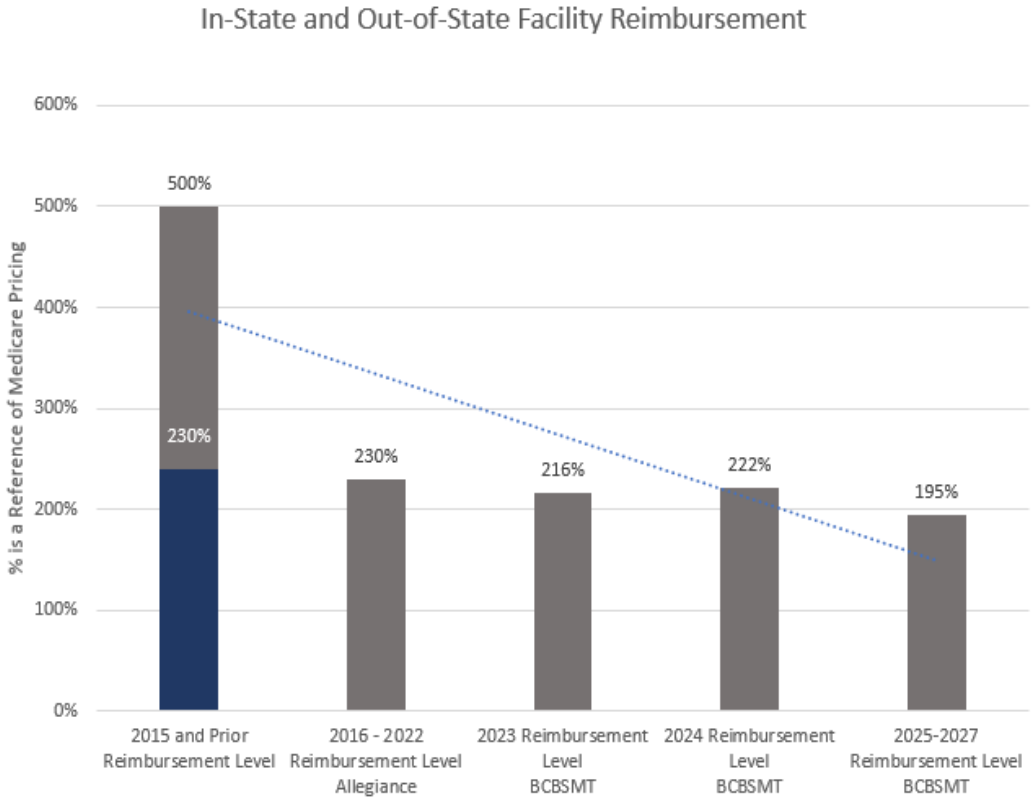
Modernized Approach to Referenced Based Pricing (RBP) – Specific reimbursement rates are required by contract.

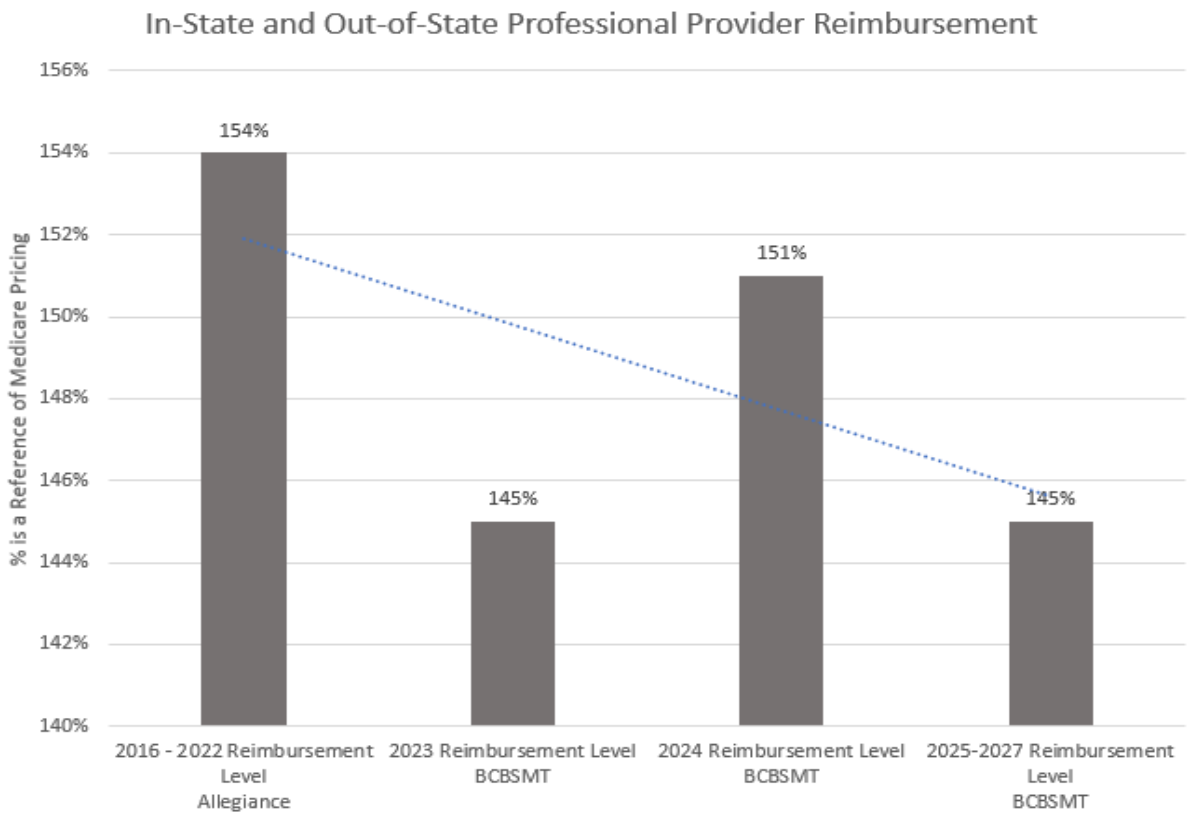
- New Model: Reduced Pricing Targets + Performance Guarantees Based on TPA Outcomes
  - In-State and Out-of-State facility claims not to exceed 195% of Medicare
  - In-State and Out-of-State professional provider claims not to exceed 145% of Medicare
  - 1-2% performance penalty applied to total medical plan spend if pricing guarantees are not met

New contract effective January 1, 2025, initial contract period 2025-2027.

- Contract Performance Guarantees – Fees for failure to meet Multiple of Medicare Guarantees
- Increased reporting on performance to the State for transparency and accountability
- Milliman study conducted annually to validate performance

RBP MODERNIZED APPROACH





As a result of the Medical Plan TPA Request for Proposal (RFP) completed in 2024, starting in 2025 the State was able to further reduce facility reimbursement levels which will result in additional cost savings. The contract requires:

- In-State and Out-of-State facility claims not to exceed 195% of Medicare
- In-State and Out-of-State professional provider claims not to exceed 145% of Medicare

OTHER OPPORTUNITIES

Cost saving strategies being evaluated for implementation:

- Ongoing facility and provider negotiations – steerage when/where necessary
- Pilot micro steerage contracts for specific services within Montana (programs with St. Peter's and Billings Clinic)
- Review of out-of-sate steerage opportunities (enhanced Centers of Excellence Program)
- Enhanced value proposition for providers to use lowest cost facility options – in-office vs. ambulatory surgery center vs. hospital
- Reimbursement negotiations with ambulatory surgery centers
- Travel benefit
- Increased focus on primary care and preventive screening
- Site of care solutions for medically administered pharmaceuticals that can be infused in the home setting versus higher cost facility settings
    - Example – Prolia - $8,380 allowed under medical plan compared to $1,850 under prescription plan
- RxPostCheck – specialized reviews of medically distributed pharmaceuticals for reimbursement and quantity errors
    - 21% of high-cost medically administered pharmaceuticals have a therapeutic equivalent substitution – average savings per case $25,936
    - 50% of medically distributed pharmaceuticals are expected to contain billing errors – average savings per case $14,077
- App based care navigation solution to assist in member education and steerage to cost effective quality providers and facilities
    - Redirecting colonoscopy & GI procedures – potentially $1.7 million in annual savings
    - Redirecting CT imaging – potentially $631,000 in annual savings

Questions