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Facing the Gordian Knots of Health Care Reform
Coverage, Costs, and Responsibility

A Primer on Health Care Issues in Montana and Report on the HJR 48 Study

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Introduction

Health insurance reforms, and the broader arena of health care reforms, are daunting subjects. There's no vacuum that would allow an independent examination of any particular issue. Instead, the interplay needed to address reforms involves federal and state laws, powerful insurance and health care industries, and personal and government responsibilities. When the Economic Affairs Interim Committee (the Committee) took up the work plan for House Joint Resolution No. 48, sponsored by Rep. Gary MacLaren, there were 12 study areas facing them. (See Appendix I). At early meetings, the Committee decided to pursue information on 10 of the study areas, omitting as not specifically related to health insurance reform and coverage the discussions of access issues, particularly related to rural areas (study area XI), and workforce planning and medical education funding (study area XII). This report reviews the 10 study areas, incorporating presentations made to the Committee, along with background information about what currently exists regarding health care coverage in Montana and proposals that have been under study or are being implemented in other states.

The dual purpose of this report is to review the work of the Committee on health insurance reform and provide legislators interested in health care with needed information as they seek to understand the health care provider and health insurance industries, health care reform proposals, and options for improving insurance coverage or health care access and addressing health care costs in general.

The report is divided into the following sections:

- Executive Summary
- Section 1: an overview of health insurance and health care problems and other states' efforts to increase health insurance coverage and address rising health care costs.
- Section 2: a review of Montana's health insurance coverage and health status statistics.
- Section 3: examination of issues considered by the Economic Affairs Interim Committee and discussions related to HJR 48.
- Section 4: reports on health care cost and access issues studied by the Children, Families, Health, and Human Services Interim Committee under Senate Joint Resolution No.15.
- Section 5: other issues not addressed by panels but requested in the HJR 48 and by the Committee.
- Section 6: issues related to health care reform not addressed above.

Executive Summary

Health care is a multi-faceted industry regulated either by the federal government or the states. As concerns mount about the ever-increasing share that health care takes in America's gross national product so do calls for health care and health insurance reform. A few states, often called the workshops of innovation, have taken steps toward either universal coverage or efforts to control costs. Far more have considered legislation but not passed major reforms. Because the national government is a central player in many aspects of health care, no state can initiate reforms that completely address how all the health care industry interacts with all health insurance companies and employers buying health insurance. Even public assistance decisions intertwine federal and state policies. States, however, are seeking improvements, sometimes incrementally and sometimes broadly. The frequently cited analogy of a pushing on a balloon is appropriate for many efforts at reforming health care: no matter where one pushes on a balloon, the result is a bulge somewhere else and no change to the balloon's original universe.

Over the 2007-2008 interim the Economic Affairs Interim Committee and a subcommittee of the full committee heard from various players in the health care universe. The background information reinforced the complexities of health care reform. Concurrent private sector efforts by the Montana Health Care Forum (a volunteer group comprised of health care industry representatives, consumers, and insurers) plus organizers of a statewide ballot initiative to expand children's insurance coverage under the Healthy Montana Kids initiative created cross-currents that made navigation through health care reform difficult from an interim committee perspective. As a result, the Economic Affairs Interim Committee chose to make available a primer on health care issues in Montana, providing information for legislators and others interested in pursuing health care reforms. This report is that primer as well as a summary of work done by the HJR 48 subcommittee and the entire Economic Affairs Interim Committee.

Subcommittee members appointed at the first meeting, June 5, 2007, included:
Rep. Scott Mendenhall, chair
Rep. Michele Reinhart
Sen. Don Steinbeisser
Rep. Bill Thomas

The subcommittee heard panel discussions on insurance and coverage at a November 7, 2007, meeting in Miles City and presentations about reforms being enacted or considered in other states at a February 6, 2008, meeting in Helena. The full Economic Affairs Committee heard about mandates and possible reform considerations from individuals and the Montana Health Care Forum coverage work group at a meeting in Missoula on May 8, 2008. A teleconference call on June 17, 2008, of the full committee focused on a discussion of mandates. In all, subcommittee and committee time spent on HJR 48 amounted to about 12 hours, excluding the time spent in discussing the work plan and the work of individual legislators on the issue.

SECTION 1 – Health Care Issues and Reforms in the States

The Problem:

At a Montana Health Care Forum in October 2007 one of the speakers indicated that America's health care expenditures as a share of gross national product is climbing at an unsustainable rate. Andrew Rettenmaier of the Private Enterprise Research Center at Texas A&M University projected that National Health Expenditures as a percentage of Gross Domestic Product (GDP) would rise continuously from nearly 17% of GDP in 2007 to roughly 37% in 40 years and just under 45% of GDP in 70 years.[1] That is unlikely to happen without a correction in the trajectory. But the reasons for the increasing costs -- and the opportunities to address those increases -- are many.

The following frequently cited complications arise in dealing with health care reforms:

- In America an impressive array of health care services is available, not just to people who can afford them but to everyone who can get in the door of a hospital. Federal law requires hospitals with an emergency room to stabilize a patient before transferring them to a health care facility that can treat them. In some people's thinking, this means that emergency room care is free, just because care is provided. But availability is one thing. Paying for it is another. Further complicating inappropriate use of emergency rooms is that people who avoid obtaining preventive care through a primary care doctor may end up in emergency rooms, using some of the most expensive care available. Furthermore, those who fail to use preventive care may find in the emergency room that their conditions are more complicated than they would have been at an earlier stage.
- Too many people lack health insurance coverage, which – if they become sick and are unable to pay for their health care results in the cost of that care being shifted onto those who do have health insurance. That, in turn, leads to higher premiums, which may drive some people out of paying for health insurance and going without.
- Too many people are underinsured. The underinsured may find that their copayments or deductibles are too great in worst-case scenarios and, as a result, they end up mired in medical debt, or potentially bankrupt.
- Too many people misuse insurance. Instead of insuring against risk as they do with homeowners or car insurance, some people may feel the need to extract services for all their health insurance premiums. In this sense, some people feel health insurance is more of a prepaid system and less a way to offset risks. The more people use insurance, the more pricing of premiums reflect that use rather than being based solely on an actuarial estimate of risk.
- There is a disconnect for those with health insurance between those paying for the insurance (often employers), those paying for the care (profit and nonprofit insurers), those receiving the care (individuals), those providing the care (profit and nonprofit health care providers and profit and nonprofit health care facilities). This disconnect interferes with creating incentives because the target may not be the ultimate actor. The mix of players also creates an unequal base on which to establish tax and payment policies.
- The mix of science and hope for miracles does not blend well in a society that has an equal opportunity mentality but a diverse payment system. So, because research and

access to care have minimized the number of deaths brought about either by a range of acute diseases or critical emergencies, the expectation persists in the American psyche that one more operation, one more drug, one more procedure of some sort will work, which means that many people will continue to seek care whether they can afford it or not, because it is unfair that just because they cannot afford it does not mean they should not receive it. This situation is complicated by public payment arrangements like Medicaid and Medicare, which pays for disabled or elderly but not the able-bodied who work possibly for a company that does not provide good, or any, health insurance.

- Inequity between group insurance and individual insurance results generally in more advantages for group insurance. Group insurance can have tax benefits for employers and employees plus lower group premiums, while the worker who buys insurance individually may not have the same advantages.
- Although people refer to a health care system, the uneven legs of the triangle of health care (payors, providers, and users) means that shifts benefiting one leg of the triangle impacts another leg. Efforts to control Medicare or Medicaid outlays may lead to cutting of payments to providers, who then refuse to treat Medicare or Medicaid patients. That may save public money but result in fewer covered lives and more people who may seek uncompensated care, which in turn can drive up the premium costs of those who have insurance.
- State laws regulate only certain insurance aspects, with federal law regulating other aspects. This makes uniform approaches difficult and limits interstate insurance plans for multiple employers.
- The effort to expand coverage is inextricably linked to controlling costs, which increase as a result of inflation and expansion of competition among health care providers. Competition in turn has the potential to increase utilization, including use of prescription drugs.

Some Offsets to the Problems

Health care reform efforts in various states have tackled different aspects of the problems mentioned above.

- For the problem of misuse of emergency rooms, some states have established uncompensated care pools that reimburse hospitals for patients unable to pay for emergency care. Some states, like Montana, expect that the tax-free status of nonprofit hospitals is a quid pro quo for the charity care that hospitals provide in their emergency rooms and elsewhere. The use of federally designated community health centers or publicly funded health clinics help encourage preventive care, which has the potential to offset the misuse of emergency rooms for preventive care.
- As part of its broad health insurance reforms, Massachusetts changed its uncompensated care pool to a safety net fund. Critics say that compensation went from full-cost payment to 60 to 70% reimbursement.[2] Advocates say Massachusetts hospitals recorded uncompensated care costs of $98 million in the first quarter of 2008, compared with $166 million in the first quarter of fiscal 2007.[3]
- Massachusetts made headlines with its enactment of an individual mandate to have health insurance and increased public subsidies to help people who cannot afford premiums to obtain health insurance coverage. As quoted in the online *Boston Business*

Journal, an August 2008 press release from the Commonwealth Health Insurance Connector said U.S. Census Bureau figures indicate under 8% of the Massachusetts population lacked insurance in 2006 and 2007, compared with an uninsured rate of 10.3% in 2004 and 2005. Roughly 43% of the newly insured bought insurance without the government subsidy and the remainder received government help.[4] The penalty that Massachusetts imposes on the individual is loss of the individual's tax deduction if the tax return includes no proof of health insurance.

- Indiana sought to expand the use of health savings accounts, which are tax-free accounts that must be used for health care. The accounts can be tapped for other purposes at the end of the year but only if taxes are paid on the amount that is tapped for nonhealth expenses. Otherwise, unlike flexible spending accounts offered by some employers, the health savings accounts roll over for use in the next year. Health savings accounts (HSAs) are both a boon and a bane. They can be used to pay for the copayments and deductibles of a high-risk insurance policy (but not premiums). Or they can be used as savings accounts. A spokesman for MHA, an Association of Montana Health Care Providers, said informally that Montana hospitals are finding that patients are not using their health savings accounts to pay hospital bills, although no specific investigation has been done. If the HSAs are not tapped, people may delay access to preventive care, which increases the potential for problems from delayed care.
- Vermont initiated its Catamount Health Care Plan that included a range of transparency measures intended to prompt patients and consumers to have a greater role in their health care and a greater understanding of health care costs. The overall Catamount Health Care Plan expanded coverage for the uninsured, but one portion tackled consumer-directed health care. An estimated savings of $550 million over 10 years would result if information about pricing, common outcome measures, best practices, and payment methodologies became available to consumers.[5]
- States that have sought to combat the disconnect between payors and users of health care have required health care providers to provide itemized bills to patients who request itemization. Pricing transparency also helps to give upfront information on costs so that consumers can decide where or by whom an elective procedure should be done.
- For the problem of differing tax benefits and premiums costs between group and individual health insurance, some states are providing incentives or mandates for businesses to use the Internal Revenue Service Section 125 plans. Minnesota enacted Section 125 plan legislation that provides incentives to employers of 10 or more employees and that takes effect in 2009.[6]
- Colorado implemented some recommendations from a Blue Ribbon Task Force on Health Care Reform aimed at balancing the unequal legs of the health care triangle. One allows physicians to review and challenge insurance companies' credentialing systems. Another requires standardized insurance health plan cards.[7]
- Some health care analysts are promoting less use of employer-paid health insurance as a way of promoting more personal recognition of costs and utilization. By putting the mandate to buy insurance on the individual, Massachusetts contributed to this philosophy but also arranged for an entity (the Connector) that reviewed policies for reasonable rates, made information available to all purchasers, and served as an entity that offered pre-tax purchasing advantages for the insurance.

For a review of health care reforms in other states, see Appendix II, which is based on one of the handouts provided to the Committee.

SECTION 2 -- Montana's Health Insurance Coverage and Status

The good news for the majority of Montanans is that their health status is generally good compared with the rest of the country. For example, a report on Healthy Americans by the nonprofit, nonpartisan Trust for America's Health indicated that Montana ranked among the lowest in the nation for cases of tuberculosis (48), AIDS in those 13 and older (48), Alzheimer's (45), and new cases of cancer (44). Smoking rates for high school students, however, were right at 25%, with adults at 35%.[8i]

While health status is generally good, coverage by health insurance is not so good. Montana has one of the nation's highest rates of uninsured, roughly 20%. Montana also has a regulatory climate that differs from the regulatory climates of places where mandated coverage was put into effect, such as Massachusetts.

Who is covered?

As of any particular time, 80% to 84% of Montana citizens have some form of health care insurance. The most recent U.S. Census Bureau report indicated that the number of uninsured in Montana in 2006-2007 had decreased to 16.4% from 16.9% in 2004-2005. That is a higher percentage than the national average of 15.5% (15.1% in 2004-2005). Texas (24.8%), New Mexico (22.7%), and Florida (20.7%) had the most uninsured people in 2006-2007. Neighboring states Wyoming (14.1%), South Dakota (11%), North Dakota (11.1%), and Idaho 14.6% all had lower rates of uninsured than Montana.[ii]

The majority of Montana employees work for large businesses, which typically have self-funded group plans or contracts with one of two nonprofit health service corporations. The large number of small businesses in the state, those with fewer than 10 employees, are eligible for Insure Montana subsidies or tax credits. Employers with between 2 and 50 employees can access insurance under the Small Employer Health Insurance Availability Act, Title 33, Chapter 22, part 18, which includes some rating protections.

Among the most likely pool of uncovered workers are the large number of self-employed people in Montana, including independent contractors, and small owner-controlled businesses, including those that file income taxes as S Corporations. A 2005-2006 study of independent contractors by the Department of Labor and Industry indicated that in 2002 the independent contractors comprised 7.5% of Montana's average annual employment, higher than other states studied. Florida at 2.4% was next closest. South Dakota with a similar average annual employment number had just 0.6% of its work force with independent contractor exemptions. At the May 2008 Economic Affairs Committee meeting Riley Johnson told the committee that over 3,000 business owners in Montana do not carry insurance on their employees. More than 1,300 of these business owners are eligible for individual insurance. And he noted a concern that businesses that do not offer health insurance but do provide workers' compensation insurance may face higher workers' compensation premiums if workers inappropriately substitute that form of insurance for health insurance.

University of Montana Health Economist Steve Seninger reported in his 2006 study for Montana Kids Count that the likely uninsured in Montana are those who are self-employed, working in wholesale, retail, agriculture, construction, part-time, or in firms with fewer than 10 employees.

He noted that 75% of Montana firms have fewer than 10 employees.[iii] Conversely, 43.6% of Montana's work force in 2006 worked for employers with more than 100 employees. More than half of the state's workers, 55.8%, drew paychecks from firms with 50 or more employees. And more narrowly, 21.2% worked for employers with 500 or more employees. The Montana Department of Labor and Industry indicates that 92% of those employers with more than 100 employees offer health insurance.

For those without insurance, Seninger noted these characteristics:

- Adults between the ages of 19 and 25 were more than twice as likely to be uninsured as the general population (the information was compiled prior to 2006. In 2007 the legislature enacted SB419, which required state-regulated insurers to extend coverage under a parent's policy for unmarried children up to the age of 25.
- Indians in Montana were more than 2 times as likely to be uninsured as non-Indians in Montana.
- Montanans with incomes lower than the federal poverty level were 2 times more likely to be uninsured as the statewide rate.[iv]
- The overall picture of the uninsured in Montana reflected 86% white, 67% adults older than age 25, 92% with a high school degree or higher, 77% employed, 60% self-employed or working for firms of fewer than 10 employees, and 45% with incomes 2 times the federal poverty level.[v]

Who is underinsured? (To be filled in later)

What do current tax and insurance laws offer for those who are insured?
For the purposes of this draft, see analysis provided by Dan Dodds of the Montana Department of Revenue, Appendix III.

Montana's Public Health Care Programs and Coverage (to be filled in later)
Who is covered under Medicaid and CHIP?
Youth
Disabled
Pregnant Women
Elderly

- Rules for Trusts, etc.

Uneven Access to Care for Indians on Reservations (to be filled in later)
Indian Health Service facilities and funding shortfalls

Urban clinics

Flathead Reservation differences

Section 3: HJR 48-related Issues Considered by the Economic Affairs Interim Committee

- Review of Montana Insurance Issues: Types of Insurance and Regulatory Climate
- Insurance Connector as represented by Massachusetts Plan
- Cost Shifting and Impacts on Premiums
- Differences among Insurers and Third-party Administrators
- Insure Montana
- Use of Health Care Trusts by the Montana Contractors Association and others
- Montana Comprehensive Health Association
- Montana's Public Health Insurance Coverage
- Other States' Activities in Health Insurance Reform
- Section 125 Plan Overview
- Expansion of Children's Health Insurance Program
- Mandates

Montana Insurance issues

As in other states, Montana's insurance picture includes: self-funded plans, multiple employer welfare arrangements (MEWAs), fully insured health plans either provided by nonprofit or for-profit companies, and Medicare supplemental plans. Self-funded plans and some MEWAs operate under federal regulation of the Employee Retirement Income Security Act (ERISA), which generally preempts state regulation.

Types of Insurance Coverage (this will be added to later)

- **Self-funded plans** – Montana's major employers, those with more than 500 employees, typically self-fund their insurance and either use third-party administrators or handle the insurance administration themselves. Fifteen of Montana's top 20 employers have more than 1,000 employees.[vi] Examples of self-funded plans in Montana include:
  - The State of Montana

- **Multiple Employer Welfare Arrangements (MEWA)** – A MEWA can be regulated by the state or can avoid state regulation. Those not regulated by the state avoid state requirements for minimum reserves, among other issues, according to a U.S. Department of Labor publication.[vii] Examples of MEWAs in Montana include:
  - The Montana Contractors Association Trust
  - The Montana Unified Schools Trust

- **Fully insured health plans** – Two non-profit health service corporations, Blue Cross Blue Shield of Montana and New West Health Partnership, had more than 53% of Montana's direct written premium business in 2006.

  The remaining top 15 insurers write between 6% and 0.6% of policies. Many of these insurers handle supplemental Medicare policies.

  Included in the fully insured health plans are those that participate in Insure Montana. (see below)

Regulatory Climate

- **Guaranteed Issue** – Only group coverage offered by fully insured health plans are "guaranteed issue" in Montana, which means that regardless of preexisting conditions a person will be able to obtain coverage. The plans may be able to delay coverage for a limited time (12 months, for example, under 33-22-110, MCA, or 18 months for a late enrollee under 33-22-514, MCA). Guaranteed issue is considered necessary if a mandate for coverage is to be enacted because requiring buyers to obtain insurance does not work if the insurers can decide not to cover unhealthy buyers. While group policies have a guarantee of issuance, insurers can decide against insuring a high-risk person under an individual plan.

  Federal law requires a state either to guarantee issue or to have a high-risk pool to cover individuals unable to buy insurance elsewhere. This means that policy makers either must support some form of sustainability for the Montana Comprehensive Health Association, which is Montana's high-risk pool (see below), or establish guaranteed issue.

- **Regulatory Review** – Montana's Insurance Commissioner approves health insurance forms but does not have prior approval authority, a term that means a state regulator must review proposed health insurance rate increases to determine if increases are reasonable and necessary. A Families USA briefing paper on prior approval authority indicates that 33 states have some form of prior approval authority for health insurance. The briefing paper notes:

  > Insurance companies complain that the prior approval process is burdensome, but evidence from states that enforce these regulations clearly demonstrates that they are good for health care consumers and that they do not cause the negative consequences that insurance companies cite.[viii]

  The one provision in Montana for rate regulation is under the small employer health insurance availability act, Title 33, chapter 18. Insurance policies offered under this part have limits on rate variations between classes of jobs of 20% and within a class of 25% as compared to the index rate.

  Under 33-22-1706, MCA, the "terms or conditions of an insurance policy or subscriber contract, except those already approved by the commissioner, are subjects to the prior approval of the commissioner."

Commonwealth Insurance Connector as represented by Massachusetts Plan

Massachusetts adopted its Commonwealth Health Insurance Connector Authority (the Connector) in 2007 as a quasi-public, independent entity that reviews premiums for affordability and offers one-stop shopping for individuals obtaining insurance with their own funds or with a combination of employer funds and their own funds. The Connector also serves as an entity through which insurance purchasers can take advantage of Section 125 in the Internal Revenue Code, which describes cafeteria plans and opportunities for purchasing health insurance with pre-tax dollars.

An original expectation of the Connector was that it would be able to combine the employer contributions from someone who had more than one job. However, the lack of consistent income from someone with more than one part-time job complicated the pooling of funds necessary to assure payment for annual health insurance premiums. The Connector found that employees working on average fewer than 64 hours per month (for example, 8 days at 8 hours) would not be eligible for using the Connector as a Section 125 pre-tax payer for health insurance premiums. Also ineligible for Section 125 advantages were service employees who earned on average less than $400 in monthly payroll wages.[ix]

Cost Shifting and Impacts on Premiums (this will be added to later)
Insurers base premiums on a combination of expected payouts, administrative costs, maintenance of reserves.

Differences among Insurers and Third-Party Administrators
Insurers in Montana may be third-party administrators but not all third-party administrators are insurers. Insurers include those entities that pay premium taxes and health service corporations, which do not pay premium taxes. Although health service corporations like Blue-Cross, Blue Shield of Montana dn New West Health Partnership do not pay premium taxes, they do pay an assessment for the Montana Comprehensive Health Association, Montana's high-risk pool. Third-party administrators pay neither premium taxes (because they are not insurers) or the MCHA assessment.

Top 5 Insurers by Market Share in Montana in 2006 by Direct Premiums Written, Etc.

Insurer	Direct Premiums Written	Premium Taxes Paid	Assessments for MCHA	Covered lives served by TPAs

Blue Cross Blue Shield of Montana	***2006:*** $479,873,108 ***2007:*** $509,971,909	-- --	***2006:*** $3,663,085 ***2007:*** Not available yet	46,500 lives
New West Health Services	***2006:*** $69,803,995 ***2007:*** $72,844,040	--	***2006:*** $597,613 ***2007:*** Not available yet	
Assurant Group (combination of Time Insurance Co. (T), formerly Fortis, John Alden Life Insurance Co.(J), and Union Security Co. (U))	***2006:*** $64,588,863 ***2007:*** $64,221,340	Total 2006: $1,874,460 Of which: T = $931,567 J = $785,853 U = $157,040 Total 2007: $1,848,431 Of which: T = $918,630 J = $793,765 U = $136,036	***2006:*** $634,359 ***2007:*** Not available yet	
United Healthcare Insurance	***2006:*** $36,960,696 ***2007:*** $37,406.856	2006: $743,983 2007: $692,310	***2006:*** $336,682 ***2007:*** Not available yet	
Sterling Life Insurance Co.	***2006:*** $30,117,654 ***2007:*** $48,549,014	2006: $315,909 2007: $275,007	***2006:*** $114,518 ***2007:*** Not available yet	

Information from the Montana State Auditor's Office and Blue Cross Blue Shield for TPA information

The top three Third-Party Administrators (TPAs) in Montana pay no premium tax for the TPA service (although Allegiance Benefit Plan Management, Inc.'s sister company pays the premium tax as an insurer). Nor do the TPAs pay an assessment for the Montana Comprehensive Health Association. These TPAs typically handle policy administration for self-funded businesses, trusts, and MEWAs in groups that have 50 employees or more. In 2006, Allegiance Benefit Plan Management, Inc. covered 101,500 lives in 45 self-funded benefit plan groups. Employee Benefit Management Services (EBMS) had 47,680 lives in 72 self-funded benefit plan groups. Blue Cross Blue Shield of Montana handled policies for 46,500 lives in TPA plans.

Insure Montana

A presentation on Insure Montana at the November meeting of the HJR 48 subcommittee provided details on the number of firms participating in the program, which was established in 2005 to provide incentives to small employers (those with at least 2 employees and up to 9, depending on funding) to offer health insurance. The incentives were in the form of tax credits or premium assistance payments.

More Later

Use of Health Care Trusts by the Montana Contractors Association and others
To Be Filled In Later

Montana Comprehensive Health Association
To Be Filled In Later

Montana's Public Health Insurance Coverage
To Be Filled In Later

Other States' Activities in Health Insurance Reform
To Be Filled In Later (See Appendix II)

Section 125 Plan Overview
To Be Filled In Later

Expansion of Children's Health Insurance Program
To Be Filled In Later

Mandates
The Committee discussed whether one of the ways to expand coverage would be to enable insurers to offer individual policies that had few of the mandates required currently by state law. Federal mandates obviously would be retained.

Mandates that are federally required include: newborn coverage if a policy offers maternity benefits, post-mastectomy care and reconstruction, and minimum stay after childbirth. Montana mandates that affect individual policies are: provider-related expansions, mammograms, severe mental illness, PKU-Metabolic disorders (newborn screening), well-child care and immunizations, continuation of coverage for disabled dependents, disclosure of cancer screening coverage, and coverage of dependents to age 25. Possibly covered under individual policies, depending on how statutes are read, are: chemical dependency, mental health parity, convalescent care, and a pre-existing condition look back period, which is questionable regarding whether it is considered a mandate or not.

Also under the mandate mantle are provisions that incorporate court decisions or Attorney General opinions, which have the force of law until decided by a court. These generally have resulted in policies covering maternity care (based on nondiscrimination by sex) and contraception, which similarly comes under human rights/civil rights nondiscrimination rulings.

A calculation by Blue Cross Blue Shield of Montana in 2006 indicated that all mandates required in Montana, both federal and state, added up to about $22 a month per person per premium. The $22 figure did not distinguish between group and individual policies. Individual policy costs for mandates presumably would not be as high because they do not have the full complement of state-required mandates.

The Committee considered whether allowing a "mandate light" policy would increase the affordability of health insurance, recognizing that some insurance may be better than no insurance at all. The risk of removing mandates includes the potential of removing screening processes that detect illness or disease before treatment becomes extremely costly or removing essential services for certain populations.

The Committee received two reports on mandates and requested a bill draft for discussion purposes. Public comment included many opponents to a mandate light individual policy at meetings in May and June plus some proponents who encouraged the Committee to consider allowing a mandate light policy as one way of increasing coverage. Staff reports on the subjects included:

- A briefing paper titled Mandates and Insurance in Montana.[x]
- A bill draft for discussion purposes, LC7777, for minimum mandate individual policies.
- A memo on mandate light research with comments from Montana insurers.[xi]

Summaries of proponents and opponents testimony is available in Committee minutes from May and June 2008.

Section 4: Health care cost and access issues studied by the Children, Families, Health, and Human Services Interim Committee under Senate Joint Resolution No.15

- Pricing Transparency
- Charity Care
- Electronic Health Records
- Billing Efficiencies
- Hospice and End-of-Life Care
- School Nurses and Early Childhood Access to Care
- Community Health Centers
- Economic and Insurer Credentialing
- Specialty Hospitals and Conflict of Interest Issues
- Availability of Services and other information from a Montana Health Care Facilities survey

Pricing Transparency

Pricing transparency is short-hand for several terms tied to ways to improve consumer awareness of health care costs and quality. Several states have adopted legislation to enhance the ability of consumers to compare costs and quality. The Children, Families, Health, and Human Services Interim Committee (CFHHS Committee) studied various issues related to pricing transparency during the 2007-2008 interim.

Typical options for transparency include information on:

- costs for inpatient and outpatient procedures at area hospitals;
- mortality, error rates, and other quality issues for the procedures; and
- cost calculators provided by insurance companies to help an insured person determine out-of-pocket costs for a procedure.

A work group associated with the informal Montana Health Care Forum, which originated in October 2007, kept pressure on the transparency issue. That work group included representatives of hospitals, doctors, insurers, the CFHHS chair, and health care organizations. In July the board of directors of MHA, an Association of Health Care Providers, agreed to independently pay for participation in the Price Point system, which gathers from health care facilities such data as costs for procedures and facility room charges. Hospital associations in roughly 10 states have opted to use the Price Point system. MHA demonstrated the future website capabilities at an Aug. 21 CFHHS Committee meeting. That website is: http://www.mtinformedpatient.org.

Some states prefer maintaining more control over the transparency issues. States like Pennsylvania have spent millions of dollars providing analysis on both pricing and quality among hospitals in that state. Arizona contracts with Rand Corp. to handle analysis for its health care providers' pricing and quality comparisons. For more specific information, see the final report for the CFHHS SJR 15 study and related appendices.

Charity Care

Montana's not-for-profit hospitals receive a tax exemption under both federal and state laws. That tax exemption generally is associated with the idea that hospitals provide a community benefit, which includes charity care, education, and research, among other items recognized by the Internal Revenue Service in its Form 990H. In exchange for the community benefit, the community does not tax the hospital for health care-related revenues.

During the 2007-2008 interim as part of its SJR 15 study of health care facilities and access, the CFHHS Committee reviewed tax policies related to hospitals as well as a charity care report conducted for the first time by the Montana Attorney General's Office. Several other states' attorneys general also conducted similar studies our of a concern that the community benefits provided were not comparable to the value of the income tax deduction.

Findings from the Montana Attorney General's report indicated that charity care varies at the state's 11 major hospitals. After the report came out in January 2008, disagreements arose over the definition of charity care and whether the base revenue analysis was appropriate. The community benefits analyzed in the report included lost income from charges/costs written off (for those determined in advance as unable to pay) and the difference between what Medicaid patients actually cost versus what Medicaid paid. The report's author, Larry White, a professor at the University of Montana and former chief executive officer of St. Patrick Hospital in Missoula, recommended that the hospitals improve their efforts to determine whether a patient is eligible for charity care in advance and avoid the cost of trying to collect after the fact.

Of interest, the report pointed out that some hospitals in Montana have a much higher percentage of Medicaid patients than other hospitals do. Also of note is that total charity and Medicaid costs exceeded the value of the tax exemption for 8 of the 11 hospitals. See the Attorney General report and addendum posted on the CFHHS Committee website.

Electronic Health Records

Throughout the 2007-2008 interim a nonprofit organization, Health Share Montana, reported to the CFHHS Committee on its proposal to develop a health information exchange for Montana to be used for disease and preventive care management. Specifically, the volunteer group representing 55 organizations[xii] has been working to implement an electronic continuity of care record that would allow health care providers to share information about a patient's medical history in a secure (privacy-protected) environment. Improved efficiency and higher quality care plus lower costs from improved chronic disease outcomes and fewer repeated tests were among the benefits that proponents said electronic health records could provide.

Health Share Montana asked the CFHHS Committee for legislative support for a demonstration project that would serve up to 100 providers. The group requested that the governor include $1.5 million for the demonstration project in his 2010-2011 budget and also has requested that Montana's Congressional delegation include an appropriation for at least half of that amount (which would lower the state's investment to $750,000). The CFHHS Committee sent a letter to Governor Schweitzer supporting the budget request[xiii] and voted at its August 2008 meeting to sponsor a committee bill supporting funding for the demonstration project (LC339).

As one example of potential cost savings from better chronic disease management, information presented by Health Share Montana indicated that savings of $2,000 per patient per year could be expected from "avoided complications" just by using a continuity of care record to track and monitor the estimated 60,000 diabetics in Montana, of which 32,400 are estimated to have less than ideally controlled illnesses. The overall cost savings for improved diabetes management, the group estimated, could be up to $65 million a year once disease management systems are fully deployed.[xiv]

Although internet firms Google and Yahoo both offer the opportunity for users to establish personal health records, personal health records are not accessible if a person is in an emergency room and unresponsive. They also are not necessarily helpful if information is not current or comprehensive. Nor do they offer any disease management capabilities. The Health Share Montana proposal is for a system that allows health care providers and hospitals to use their current software but link to a server that would be accessible to other participants.

As stated on the Transparency Work Group page of the Montana Health Care Forum, a continuity of care record would make available clinical information to a provider or a health care facility extending care to a patient. The patient also may have access to the information. http://healthinfo.montana.edu/healthit.html Health Share Montana anticipates that the continuity of care record and electronic health records would become self-sustaining by 2011 (either through payments by providers or sale of aggregated data).

The pilot project would take place at 5-10 sites and include a mix representing a hospital, hospital emergency department, clinic, long-term care facility, primary care provider savvy enough to handle health information technologies, and a provider who has no health information technology access. Health Share Montana estimates that invitations to participate would be extended across the state and appropriate participants selected from respondents.

Billings Efficiencies

One goal of consumer-directed health care, a focus of the SJR 15 study by the CFHHS Committee, is to provide sufficient information for a consumer to make decisions regarding health care. One aspect of this is being able to understand hospital and provider bills. A presentation by legislative staff attorney Eddye McClure at a January CFHHS meeting highlighted the problems that consumers have in deciphering billing, particularly when many of the consumers are dealing with illnesses that make them less than combat-ready for doing battle with accounting departments. McClure showed one small stack of bills provided by the Virginia Mason Clinic, which incorporated both facility and provider charges in one bill where procedures and charges lined up. She contrasted that with several file folders of bills from a Montana hospital, each with a different accounting clerk, which featured only hospital bills. Her provider bills came separately. Although part of the difficulty arises from different types of hospital systems (one with employed doctors and the other with doctors outside the hospital's employ), the confusion is exacerbated by difficulties in obtaining itemized statements and lack of standardized billing.

Various states (for example, Illinois, Texas, and Vermont) have targeted standardized billing by

health care providers as one way of encouraging consumer awareness of health care costs and creating cost-efficiencies through standardization. A Montana statute, 50-4-505, MCA, allows but does not require the commissioner of insurance to adopt "by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims...". The statute covers only health insurers but ironically is in Title 50 under health care policy and not in Title 33, which governs most of the insurance commissioner's actions.

Hospice and End-of-Life Care

The CFHHS Committee requested information on hospice services in Montana as part of the committee's focus on consumer-directed health care. A main concern voiced by one of the CFHHS Committee members was that the greatest health expenditures in a person's life typically come in the last 6 months of life. The hospice philosophy is to avoid extraordinary health care measures to extend a person's life in favor of palliative care and better qualify of life. The CFHHS Committee also received updates on the number of people who have signed up with the Montana Attorney General's Office since creation of the end-of-life registry (6,800) along with 475 health care providers. The end-of-life registry was created under HB 742 in the 2005 legislative session.
http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15hospicemarch2008.pdf

School Nurses and Early Childhood Access to Care

School nursing is unevenly available in Montana, with only certain school districts dedicating resources to having a school nurse available. Services provided by school nurses include the expected help with medical emergencies but also assistance in connecting families with health care if the families do not have health insurance. School nurses also monitor children for early signs of mental ill health, in an attempt to catch problems before they become serious. The President of the Montana Association of School Nurses, Sue Buswell, and a representative of the National Association of School Nurses, Kathy Boutilier, asked the CFHHS Committee March 18, 2007, to consider recommending to the legislature that school nursing be a greater priority in Montana school districts.

Community Health Centers

Federally qualified health centers offer a wide range of primary health care services on a sliding scale based on ability to pay. In Montana there are 12 federally funded Community Health Centers plus a Migrant Health Program, and a Health Care for the Homeless Program. Satellite clinics provide services in an additional 12 communities. A report put together by Lil Anderson of the Yellowstone City-County Health Department for the CFHHS Committee said that 1 in 12 Montanans receive care from a Community Health Care Center.[xv]

The requirement to serve regardless of ability to pay results in Montana Community Health Care Centers serving a patient population of which 56% are uninsured, 19% have private insurance, 14% are on Medicaid, 9% on Medicare, and 2% are on the Children's Health Insurance Program (CHIP), according to Anderson's information. The Deering Clinic in Yellowstone County, as one example, had 17,930 patients in 2006, of which 77% participated

in the sliding fee scale. The clinic charges a $10 minimum fee for a medical visit or service and $20 for a dental visit.

Health care providers who work at the clinics qualify for coverage under a federal tort protection act, which means that these providers do not have to carry malpractice insurance. For the community of Libby, that provision has allowed two doctors to remain in practice delivering babies when the cost of malpractice insurance threatened to drive them out of practice.

In the 2007 session the legislature provided $1.3 million for the biennium that could be used either to create and support a community health center or expand services or infrastructure at existing community health centers. An advisory group established by HB 406 requested proposals from communities for a state-funded community health center model that included primary care services. The goal was to ultimately move the state-funded community health center to a federally qualified and funded community health center. The community of Kalispell received the grant out of the three communities that applied. (Hamilton and Lewistown also bid).

Economic and Insurer Credentialing

One of the main focuses of the SJR 15 study was to review the conditions in an economic credentialing statute enacted in 2007, which prevented hospitals from denying credentials to a physician who had an economic interest in another health care facility. A termination date for that statute was intended to give the statute time to work but also give interested parties time to refine the statute. If agreements on the statute could not be reached, then 50-5-117, MCA, was to expire on June 30, 2009. Over the 2007-2008 interim, a subcommittee of the CFHHS Committee heard testimony from interested persons and worked to obtain consensus on revisions to the economic credentialing statute. (See SJR 15 final report for more on this study.) As part of the review of credentialing, the CFHHS Committee also heard from insurers about their credentialing process and considered issues related to the hospital-physician relationship like on-call requirements. Questions raised during these discussions, as related to health care costs and efficiencies, included whether insurer credentialing: results in increased costs and inefficiencies as insurers duplicate some of the activities required for health care provider licensing; provides a better way of predicting quality care by further examining physician records in ways that licensing boards do not; or serves as an alternative to hospital credentialing for assuring such issues as on-call requirements.

Insurers credential to boost the quality of physicians and other health care providers in their networks, according to insurer presenters at a June 11, 2008, CFHHS Committee meeting. Although 33-22-1705, MCA, prohibits health care insurers from requiring hospital staff privileges of a health care provider as a condition for being in a preferred provider network, the insurers say they must be able to show that physicians can provide continuity of care either through their own privileges at a hospital or an agreement with someone who does have privileges at a hospital, such as a hospital-employed hospitalist.

Specialty Hospitals and Conflicts of Interest

Another of the main focuses of the SJR 15 study was how to deal with specialty hospitals in Montana if a moratorium on specialty hospital licensing expires, as statute currently provides, on June 30, 2009. The subcommittee studying economic credentialing also considered comments from proponents and opponents of a specialty hospital moratorium. Among the comments were concerns, as related to both economic credentialing and specialty hospitals, about conflicts of interest among health care providers who own for-profit health care facilities. One result of a conflict of interest is that health care providers who have an economic interest in a facility may encourage greater utilization for profit purposes than is necessary for medical purposes. Comments at the subcommittee meetings prompted the subcommittee to recommend to the full CFHHS Committee legislation that would require all health care providers to disclose whether they had an economic interest or an employment interest related to a referral. Separately, the subcommittee recommended, and the full CFHHS Committee requested, legislation to ban certain forms of kickbacks among health care providers, expanding to all health care providers, regardless of payor, the essence of federal laws that prohibit kickbacks to any health care provider receiving Medicare, Medicaid, or certain other federal funds.

As related to specialty hospitals, proponents of a moratorium or a ban contended that ultimately health care costs increase when specialty hospitals begin competing for patients with nonprofit community hospitals. The reason is that the owners of the specialty hospitals, usually physicians, have incentives to encourage more surgeries or procedures at the for-profit hospitals. Opponents of the moratorium (those who favor specialty hospitals) contended that specialty hospitals could decrease an individual's cost of care because specialization would increase efficiency and potentially quality care associated with performing the same procedure frequently, improving with repetition.

Because Congress continues to consider taking action to limit future specialty hospitals, the CFHHS Committee did not suggest revising legislation or extending (or making permanent) a moratorium related to specialty hospitals. The 2009 session also has the option of addressing specialty hospitals from any of these approaches.

Availability of Health Care Services

Montanans who live in rural communities and who need sophisticated health care services know that those services are in limited supply. Even Montanans living in the state's major cities may know that certain hospitals have more experience than other hospitals with certain operations. For example, anyone having a baby in Missoula is likely to head to Community Medical Center but if they have cardiac concerns they are likely to go to St. Patrick Healthcare Center in the same community. As hospitals look at their bottom line, however, more hospitals are moving toward offering elective procedures that are profitable, which may mean increased competition within a community as well as with communities within 200 miles.

A survey of Montana's health care facilities, specified as one of the study targets in SJR 15, showed that many Montanans travel out of their community to have babies in a hospital with a birthing center and that specialized services are limited to major hospitals. Even without a

major mental health care study funded by the 2007 legislature, it is clear that mental health care is extremely limited in Montana. (See SJR 15 health care survey and related appendices.)

Section 5: Other Issues Not Addressed by Panels but Requested in HJR 48 or by the Committee

- The Montana Health Care Forum
- Health Care Council
- Medical Education
- Medical Work Force Planning

The Montana Health Care Forum
This gathering of private and public stakeholders interested in health care reforms began with an October 29 and 30, 2007, forum reviewing access to health care, charity care, Medicare, state innovations, quality, and efficiency.[xvi] After the initial meeting, which had sponsors ranging from health care insurers to banks, informal meetings continued almost monthly in Helena with work groups and full group sessions.

More later

Health Care Council
The coverage work group of the Montana Health Care Forum reviewed various proposals for expanding coverage. One of the work group's suggestions was for legislation creating a Health Care Council with a focus on developing health care policy for legislative consideration.

More later

Medical Education
More later

Medical Work Force Planning
More later

Section 6: Other Issues Related to Health Care Reform

Malpractice Insurance

In the 2003-2004 interim, the Legislative Council studied medical malpractice issues. For the report on that study see:
http://leg.mt.gov/content/Committees/Administration/Legislative%20Council/2003-4/Subcommittees/default.asp

Legislation enacted in 2005 included creation of a process designed to make sure that malpractice insurance is available if malpractice insurers threaten to pull out of the Montana market.

More later

Privacy

The Health Information Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d, et seq., governs many aspects of health care, including patient privacy. Montana's Uniform Health Care Information Act, Title 50, chapter 16, part 5, includes a provision in the legislative findings 50-16-502, MCA, that extends privacy concerns to persons other than health care providers and to health care providers not covered by HIPAA.

More later

The Law and Justice Interim Committee's Review of "Detainee" Uncompensated Care

More later

North Dakota's Collaborative Model

More later

Appendix I : HJR 48 Work Plan

(✔ indicates the committee had panel discussions or briefing papers on this topic specifically and these will be discussed as part of the examination of issues. Items listed as (will be included in final report) will be incorporated into the "other issues" section.):

I. Study creation of a system of universal, portable, affordable health insurance coverage that involves private health insurance issuers and incorporates existing public programs.

A) Briefing paper on other states' health insurance reforms involving expanded coverage, including options for expanded public programs. ✔
- Incorporate overview of differences between those states and Montana's existing, relevant laws to clarify what changes would be needed.

B) Presentations by representatives of selected states or people knowledgeable about the reforms in those states. ✔
C) Panel discussions by insurers, State Auditor's Office, and representatives of existing programs in Montana, like the Montana Contractors Association plan, which has some portability features. ✔

D) Panel discussions of:
- Insurance pricing as that affects affordability.
- Transparency, involving representatives of hospitals, physicians, insurers, the Attorney General's office. (will be included in final report)
- Certificate of need or public service commission-type approaches to review of allowing new health care competitors or services. (will be included in final report)

E) Review options for expanding public programs, with commentary by DPHHS.

II. Ways to improve the quality, affordability, and delivery of health care.
A) Panel discussion on how to regulate/achieve improvements in quality. (will be included in final report)

B) Incorporate Study Area (1) for affordability.
- Expand to include formal study of health care costs in Montana. (will be included in less formal way in final report)

C) Panel discussion on options to expand health care delivery systems in a way that improves access to care (e.g. Community Health Centers) (will be included in final report)

D) Briefing paper on quality, affordability, and delivery issues (some of which are in SJR 15) (will be included in final report)

E) Updates on SJR 15 study of health care delivery systems. ✔

III. Use of a health insurance exchange and implementation issues
A) Presentation and panel discussion involving people involved with Massachusetts Plan, the Montana Contractors Association Trust regarding its portability factor, State Auditor's Office, and insurer representatives ✔

B) Briefing paper

IV. Examine similar reforms enacted in other states, including the cost of the reforms to the states and to consumers, any improvements in affordability or availability, and barriers to enactment, along with solutions to those barriers.

A) Choose 4 to 6 states with different approaches (e.g. Massachusetts, Maine, Vermont, Indiana, Hawaii, and New York) and calculate cost of reforms for states and consumers, etc., for each. Prepare as a briefing paper. ✔

B) Include presentations by representatives in each state either in person or by teleconference. Incorporate with study area (3).

V. Study advantages and disadvantages of mandating private universal coverage.
A) Incorporate with Study Areas (1), (3) and (4) as they pertain to Massachusetts (individual coverage) and Hawaii (employer mandate) (will be included in final report)

B) Presentations by representatives of each (in person or by teleconference)

C) Briefing paper

VI. Address whether and, if so, how to incorporate existing state-related insurance programs (e.g. Insure Montana and MCHA) into reforms.
A) Panel discussion involving State Auditor's Office and insurer representatives.✔
B) Panel discussion of briefing paper detailing state law changes that would be necessary, based on different scenarios of change.
C) Briefing paper

VII. Address whether to include public employee health benefit programs in a reform proposal.
A) Panel discussion by State Auditor's Office, state, county, municipal, university system, and schools health benefits officials regarding impacts of any proposed changes.✔
B) Briefing paper detailing state law changes that would be necessary.

VIII. Address whether to maximize the use of federal funds and ensure broader coverage through existing publicly funded health care programs, including Medicaid and the

Children's Health Insurance Program, and, if so, what types of changes might be needed.

A) Incorporate this with Study Area (1).
B) Obtain financial estimates of the cost of expanding existing publicly funded health care programs. (will be included in final report)
C) Review various federal waivers to determine how federal money can be maximized.✔
D) Review what types of changes are necessary in existing law for expansion. Presentation by DPHHS.
E) Briefing paper on the A through D.

IX. Examine how health care providers handle uncompensated care and provide an estimate of the uncompensated costs.

A) Staff contact major health care providers to determine how they handle uncompensated care and obtain estimate of their costs. (will be included in final report)
B) Request information from Attorney General on the Department of Justice study of hospitals' uncompensated
care.✔
C) List other states' options for dealing with uncompensated care (e.g. creating an uncompensated care pool by taxing providers who do not handle uncompensated care)
D) Panel discussion by providers on menu of state options
E) Briefing paper

X. Examine opportunities for coordination with the federal government and tribes regarding health care services and programs.

A) Panel discussion on interconnections between Indian Health Service, Medicaid, private providers on or near reservations. Include discussion of uncompensated care, contract services, community health centers.
B) Compile a literature review regarding options that might be employed to treat health care problems before they become critical, particularly on or near reservations or involving urban Indians. (will be included in final report)
C) Briefing paper on the subjects in A and B.

The following study areas were not specifically addressed by the Economic Affairs Committee:

XI. Examine other issues related to access to health care, including access in rural areas.

XII. Examine opportunities for coordinating workforce planning and medical education funding.

Appendix II: Selected Other States' Health Insurance Reforms

A briefing paper provided in February 2008 to the HJR 48 subcommittee reviewed activities in other states related to health care reforms. Titled, "Other States' Health Financing Reforms: Are there approaches that Montana wants to adopt?", the briefing paper reviewed Montana's own history of health care reform efforts along with both enacted and proposed legislation in other states. The following table includes information on enacted legislation from that report with additional information from other states that have enacted laws since that time. Much of the information is from the National Conference of State Legislatures. See: http://leg.mt.gov/content/committees/interim/2007_2008/econ_affairs/sub_com/staff_reports/2_6other_states.pdf

Health Insurance Reforms in Other States

Connecticut		
Plan name or Key Feature	Purpose and Specifics	Begun
Charter Oak Health Plan: Expand access to affordable health care coverage	• Subsidies to those earning under 300% of federal poverty level • Copay of 10% of hospital bills • Annual coverage limit of $100,000 • Premium prices between $75 and $259 a month. • SIgn-up not required.	2008
Colorado		
Plan name or Key Feature	Purpose and Specifics	Begun
Expand coverage	• Medicaid eligibility level increased to 113% of federal poverty level for youth aged 6 to 19 years as of July 1, 2009. Increases to 225% from 205% the poverty guidelines for Colorado's Children's Basic Health Plan.	Signed into law 6/3/2008
Florida		
Plan name or Key Feature	Purpose and Specifics	Begun

Mandates limited	• Bare-bones policies to be made available to Florida residents aged 19 to 64 who are ineligible for public assistance. The purchasers could not be rejected based on age or health status. Still required would be provisions for preventive services, office visits, screenings, surgery, prescription drugs, durable medical equipment, diabetes supplies, and autism. Not included were more than 40 other mandates required of standard policies. Insurers are allowed to limit days of hospitalization or put dollar caps on certain services. The per month premium charge is anticipated to be $150 or less.	Signed into law 5/21/2008
Indiana		
Plan name or Key Feature	Purpose and Specifics	Begun
Check Up Plan Uses Health Savings Accounts in combination with high-deductible health plans http://www.in.gov/legislative/bills/2007/HCCP/CC167802.001.html	• POWER Accounts – combination of HSA-like accounts combined with high-deductible back-up commercial plans. The POWER Account is $1,100, funded by uninsured in Indiana paying between 2% and 5% of their incomes on a means-tested scale. The state contributes the remainder needed to get to $1,100 and $500 worth of preventive care as well as the premiums for the back-up plans. After each year at least $500 must stay in account and participant may withdraw amounts above the $500. (NCSL summary). Back-up plans must include mental health, home health services including case management, substance abuse services, dental, and vision. Providers must be paid at Medicare rates. • Expand income limit to 200% of FPL for pregnant women enrolled in Medicaid. • Continuous eligibility for Medicaid and CHIP until age 3. • Certain small employers allowed to join together to buy group health insurance. • Qualifying employers allowed tax credit for 1st 2 years that the employer makes coverage available to employees (the lesser of $2,500 or $50 for each employee enrolled in the health plan)	signed into law 4/30/07
Iowa		
Plan name or Key Feature	Purpose and Specifics	Begun

Expand coverage	• Goal is to cover every uninsured child by 2011, expanding the Children's Health Insurance program eligibility up to 300% of the federal poverty level from 200%. Children between 200% and 300% may face higher cost-sharing requirements on a sliding scale. • An advisory council is directed to develop a plan by December 2008 for access to affordable, private coverage for children ineligible for public assistance but uninsured and under age 19. • Two task forces were directed to recommend affordable coverage options for uninsured adults by December 2008. • Private insurance coverage required to extend up to age 25 coverage for a child on the parent's plan, unless the child marries or moves out of state. • Private insurers barred from excluding or limiting coverage if a consumer moves from a group plan to an individual plan. • Offers taxpayers opportunity on income tax return to designate if child is uninsured. If income is in range for public assistance, the state will notify the taxpayer of program eligibility.	Signed into law May 2008
Maine		
Plan name or Key Feature	Purpose and Specifics	Begun

Dirigo Plan - Expands insurance options for businesses of 2 to 50 employees, the self-employed, and eligible individuals without access to employer-sponsored insurance.	• Created Dirigo Health Agency to administer a DirigoChoice insurance option for small (2 to 50 employee) businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance. • Sliding scale premium subsidy for those eligible who earn up to 300% of FPL plus limits on out-of-pocket costs and deductibles. Funding from a combination of employer (60% of employee only cost) and individual contributions, the general fund, Medicaid, and inputs from hospitals related to bad debt and charity care. • Dirigo Health Agency also established Maine Quality Forum, which obtains quality data, including nursing care quality. http://www.dirigohealth.com/2006%20Fact%20Book%20Final%20020607.pdf • Required determination of savings offsets (from having more insureds so that uncompensated care decreased). Dirigo Board to file with the Superintendent of Insurance a report on aggregate measurable cost savings, which determined ratio assessed on paid claims. In 2005, for example, the assessment was 2.408% for health insurance carriers on annual paid claims, for third-party administrators on annual paid claims for residents, and on employee benefit excess insurance carriers. The ratio was lowered to 1.85% in 2006. Offset cannot exceed 4% of paid claims. • Coordinated payments for Maine's Medicaid program from various sources to increase federal to state funding input. • Hospital profit limit of 3%. 2005 report indicated that "many hospitals did not feel profit constraints at the hospital entity level due to the voluntary profit limit of 3% in the Dirigo Act." Of 8 hospitals that earned operating profits below baseline levels, 4 were at or below 3% and 4 were between 3.6 and 4%. http://www.maine.gov/pfr/insurance/dirigo/pdf/Health_Witness_Designation.pdf	enacted June 2003
Massachusetts, part 1		
Plan name or Key Feature(s)	Purpose and Specifics	Begun
Health Payment Reform Commission	• Attempts to restructure payment system with incentives for efficient and effective care by providing consumer information, establishing cost containment and quality goals, and requiring providers and insurers to report on progress toward the goals. • Standardizes billing and coding to be developed and in place by 2012. Computerized entry for tests expected to save $170 million a year. (State Health Notes, Vo. 29, Issue 522, 9/2/08) • Mandated statewide adoption of electronic health records. • Public explanation by providers and insurers of increases.	Signed into law August 2008

Massachusetts, part 2		
Individual mandate to have insurance Expand coverage	• Individual mandate enforced initially by disallowing personal income tax exemption if no documented insurance. Later penalty can be up to half the monthly cost of lowest-cost plan within a region for each month without coverage. Connector Board to determine if lowest-cost plan affordable. If not penalty not applied. • Creation of a Commonwealth Connector, a quasi-public entity designed to: --reduce health insurance administrative costs for small businesses; --review, approve affordable policies through the Connector; --serve as a Section 125 entity, allowing individuals to buy insurance with pre-tax dollars; --allows employees to keep same insurance if they change jobs --Connector requires nonsubsidized policies to cover all statutory mandated benefits. --Deductibles and cost-sharing of Connector-offered policies must be approved by Connector and Massachusetts Commissioner of Insurance (Health Affairs article 9/14/06) • Subsidized health insurance available through connector for those eligible under 100% FPL • Employers with 11 or more workers who do not make "fair and reasonable" contribution to employees' health insurance required to contribute up to $295 a year for each uncovered full-time worker. Health Affairs article of 9/2006 says, "This amount is the estimated private sector share of the average per worker cost of free care provided to workers whose employers do not provide health insurance."(p. 425) • All employers required to establish Section 125 cafeteria plans but not required to contribute to premiums. • Establishes "free rider surcharge" on employers with 11 or more full-time employees who do not offer insurers or set up Section 125 plans and who have uninsured employees that use more than $50,000 worth of care covered by the Uncompensated Care Pool. • Children's eligibility increased to 300% of FPL from 200% for children's health insurance • Health Disparities Council established. • Provides rate increases for hospitals, but requires them to meet improved quality or pay for performance standards. • Quality and Cost Council established. Duties include providing cost information on web for consumers. • Funded $5 million for computerized physician order entry systems in hospitals. • Built on existing uncompensated care pool, which is financed by federal, state, hospital, and third-party payers. • Expected to cost $1.3 billion in FY 2007 up to $1.4 billion in FY 2009, which includes $125 million each year in general fund money, $160 million in third-party payer assessments and $160 million in hospital assessments and less than $100 million from "Fair Share" and "Free Rider" assessments combined.	passed in April 2006, portions to be imple-mented over time

Minnesota		
Plan name or Key Feature	Purpose and Specifics	Begun
Expand coverage and Control costs	• Increases eligibility for MinnesotaCare for childless adults up to 250% of the federal poverty level and reduces sliding scale premiums. • Requires employers with 11 or more full-time employees who provide health insurance to set up a Section 125 Plan. • Promotes the use of health care homes. • Seeks to increase transparency and quality through an incentive-based payment system. • Provides for an interoperable electronic health records system.	Signed into law 5/29/08
New Jersey		
Plan name or Key Feature	Purpose and Specifics	Begun
Expand coverage	• Expand eligibility for the state's Children's Health Insurance Program (FamilyCare) to include higher income adults, moving eligibility from 133% of the federal poverty level to 200%. • Mandate insurance coverage for children. As a way of determining coverage, the law requires parents to state on income tax returns whether dependents have insurance. Those without insurance will be sent applications either for Medicaid or FamilyCare. An earlier law allows families with income above 350% of poverty to use their own funds to pay for FamilyCare for their children. • Prohibits hospitals from claiming charity care for emergency services extended to uninsured children. The hospitals will be told to bill either Medicaid or FamilyCare. • Adjusts the state's community rating in the individual health insurance market to allow actual or expected claims or age to set premiums provided that the highest priced plan is no more than 3.5 times the cost of the lowest-cost plan. Retains ban on use of gender, health status, occupation, or geographic location when insurers underwrite individual policies. • Increases the minimum percentage of profits that insurers must spend on claims (instead of administration) to 80% from 75%.	Signed into law July 7, 2008
Oregon		
Plan name or Key Feature	Purpose and Specifics	Begun
Healthy Oregon Act	• Provides a timeline for reform and creates the Oregon Health Fund Board to propose reforms to the 2009 Oregon Legislature.	Signed into law 6/28/07

Vermont		
Plan name or Key Feature	Purpose and Specifics	Begun
Catamount Health and Health Care Affordability Acts Designed to increase coverage and address affordability through cost transparency http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM	• Increased coverage through private-sector insurance subsidies on a sliding scale for people under 300% FPL who have not had insurance for 12 months or who lost insurance for various specified reasons. If employed in a firm that offers insurance, employee subsidy to pay for that insurance. Subsidy funding from co-pays, tobacco taxes, Medicaid, and employer assessments. • An employer who does not provide health insurance assistance or who provides insurance but an employee elects not to be insured is assessed $91.25 for each full-time equivalent employee per quarter (in excess of a specified number of employees). Enrollment dependent on availability of subsidy funds. Children not required to be covered by employer insurance program. Benefits to be similar to those of major plans covering most people in small group and association markets. • Established Catamount Health plan targeting $250 deductible for individual in network and $500 for a family, with a 20% co-pay. Catamount Health coverage to be guaranteed and community rated, but preexisting conditions that existed up to 12 months before coverage may be excluded for 12 months (some exceptions). • Provided for free immunizations to the extent allowed by the appropriation (state as a 2nd payer). • Affordability issues addressed through cost transparency including multi-payer data collection and consumer price and quality information, uniform hospital uncompensated care policies, health information technology uses, common claims administration. Insurance commissioner required to develop standard uncompensated care policy, including criteria for payment forgiveness, sliding scale payment amounts, and amount of service calculations. Also may collect data on types of patients using uncompensated care. Set uniform credentialing policy. (section 9408a) • Established advisory committee for development system of chronic care management and chronic disease prevention, including best practices and protocols. • Revised Medicaid provider rates upward to decrease cost-shifting to private-pay insurers or individuals. • Created nongroup market security trust to lower costs and increase access to health care coverage in the individual or nongroup market. Mechanism for shifting 5% of a carrier's claims costs to the trust, with insurance commissioner balancing amount paid to actual expenses. • Approximately $5 million appropriated for subsidies and program startup costs.	enacted in 2006

Appendix III. Montana Tax-Related Issues Affecting Health Insurance

From Dan Dodds, Montana Department of Revenue email, 8/21/2008

There are three types of information on state tax returns that relate to taxpayers' medical insurance:

--deductions taxpayers claim for medical insurance expenses;

-- deductions taxpayers claim for deposits to medical savings accounts, and

-- credits employers claim for providing health insurance to employees.

Similar information is collected on federal returns, but the IRS does not publish state totals for the relevant lines. The rest of this e-mail explains the information from state returns, and the attached spreadsheet gives a summary of the numbers (table inserted below rather than the spread sheet).

- **Insurance Premium Deductions**

There are three places where taxpayers can deduct medical insurance premiums. Both federal and state law allow all taxpayers who itemize deductions to take a deduction for medical expenses, including medical insurance premiums, that are more than 7.5% of their adjusted gross income. In addition, Montana law allows taxpayers an itemized deduction for all medical insurance premiums. On state tax returns, these deductions are on two adjacent lines. One records the federal deduction for medical costs over 7.5% of adjusted gross income, and the other records the additional state deduction.

Both federal and state law allow self-employed taxpayers to deduct medical insurance premiums as a business expense. The difference between this and the itemized deduction available to all taxpayers is that this deduction is part of the calculation of the taxpayer's adjusted gross income while the itemized deduction is subtracted from adjusted gross income in calculating the taxpayer's taxable income. Self-employed taxpayers can take this above-the-line deduction even if they take the standard deduction.

Some taxpayers take both the self-employed business expense deduction and the itemized deduction. This would be legitimate if a taxpayer had one policy paid for through their business and additional coverage, perhaps for other household members, not paid for through the business.

For 2006, there were 224,696 out of 416,691 households who itemized deductions rather than taking the standard deduction. (This is counting married couples who filed separate returns on the same form as one household.) Of these, 87,321 took the itemized deduction for medical insurance premiums. The total amount of medical insurance premium deductions was $304,942,061. This understates the number of taxpayers purchasing health insurance and the total amount of premiums for two reasons: It does not count households who paid for insurance but took the standard deduction. It also does not include the portion of any medical insurance premiums that were more than 7.5% of the taxpayer's adjusted gross income. This amount is included in the federal deduction for medical costs, but there is no way to divide that deduction between insurance premiums and direct payments.

There were 20,940 households who took the business expense deduction for medical insurance for the self-employed. The total amount of deductions was $95,735,690. Taxpayers can claim this above-the-line deduction whether they itemize or take the standard deduction. This means that this should be a relatively good measure of the number of households where one or more members is self-employed and provides health insurance for themselves through their business. Both the number of households and the amount of premiums may be understated to a small extent because a self-employed person may not deduct more insurance premiums as a business expense than the amount of income they earn from self-employment. For example, a self-employed person whose business did not make a profit in 2006 would not be able take this deduction. However, any premiums not deducted as a business expense can be taken as an itemized deduction.

There were 4,612 households that took both the business expense deduction and the itemized deduction. They took business expense deductions of $15,860,380 and itemized deductions of $12,843,297. (These amounts are included in the totals in the preceding paragraphs.)

Medical Savings Account Deductions.

Deposits to certain types of medical savings accounts are exempt from federal and/or state income tax. Deposits to these accounts are deducted from total income in calculating adjusted gross income. (Like the business expense deduction, they are above-the-line deductions.) There are two types of account defined in federal law and one in Montana law. The federal accounts are the Archer Medical Savings Account and the Health Savings Account. The Archer account was a pilot program that is being phased-out and replaced by the Health Savings Account. Deposits to these accounts are exempt from both federal and state taxes. There is also a state Medical Savings Account that is exempt from state but not federal taxes.

These accounts are only available to taxpayers whose only health insurance is a high-deductible plan with a deductible of at least $1,100 for an individual or $2,200 for a family.

For 2006, 13,720 households claimed a deduction for deposits to one or more of these types of accounts. (399 claimed a deduction for deposits to more than one.) The total amount of deductions was $25,641,174. Of these households, 5,717 also took either an itemized deduction or business expense deduction for health insurance premiums.

Credits for Employers Providing Insurance to Employees

There are two tax credits employers may claim for providing health insurance to employees. The credit for providing insurance to uninsured Montanans provides an incentive for employers to begin offering health insurance to their employees. An employer may take the credit for three years but then may not take it again for ten years. For 2006, there were 641 individuals who took $559,023 in credits and 138 corporations who took $134,711 in credits.

The Insure Montana program allows employers to choose between taking a tax credit and receiving direct incentive payments. For 2006, there were 591 individuals who claimed $1,832,523 in credits and 147 corporations who took $773,560 in credits. This program is administered by the State Auditor's Office. Jill Sark of the SAO has information on the number of employers taking direct incentive payments and the number of employees, spouses, and dependents covered by the program.

Insurance Deductions in Montana Income Tax Records

	Households		Corporations	
• Insurance Premium Deductions	Number	Dollars	Number	Dollars
• Self-Employed Business Expense	20,940	$95,735,690	--	--
• Itemized Deduction	87,321	$304,942,061		
• Either or Both	103,649	$400,677,751		
Archer MSA, Federal HSA, or State MSA	13,720	$25,641,174		
Credits for Employers Providing Health Insurance				
• Insurance for Uninsured Montanans	641	$559,023	138	$134,711
• Insure Montana	591	$1,832,523	147	$773,560

ENDNOTES (problem with numbering will be fixed)

1. Andrew Rettenmaier, "Medicare's Past, Present, and Future", slide 15. Presented at the Montana Health Care Forum, October 29, 2007. Based on "The Diagnosis and Treatment of Medicare", AEI Press. http://www.montanahealthcareforum.com/assest_global/files/presentations/3%20Andrew%20Rettenmaier.pdf

2. Linda Gorman, "Colorado Health Care Reform: Reincarnating Failed Policies", opinion, Independence Institute, March 25, 2008. http://www.i2i.org/main/article.php?article_id=1453

3. *New York Times* editorial, "The Massachusetts Way", August 30, 2008. http://www.nytimes.com/2008/08/30/opinion/30sat1.html?_r=1&scp=1&sq=Massachusetts%20Health&st=cse&oref=slogin.

4. *Boston Business Journal,* "Feds say Massachusetts has fewest uninsured residents", August 26, 2008. http://www.bizjournals.com/boston/stories/2008/08/25/daily23.html.

5. Christina Kent, "Vermont Approves 'Catmount Health,' Chronic Care Initiative", State News, *State Health Notes*, May 15, 2006. http://www.ncsl.org/programs/health/shn/2006/sn467.htm.

6. Laws of Minnesota for 2008, Chapter 366, Article 17, p. 198, Sec. 4. http://www.health.state.mn.us/healthreform/legislation/hf3149.pdf.

7. Doug Trapp, "Colorado adopts doctor rating standards, health system reforms", amednews.com, July 7, 2008, http://www.ama-assn.org/amednews/2008/07/07/gvsb0707.htm

8. Trust for America's Health, The State of Your Health: Montana. Key Health Facts. http://healthyamericans.org/state/index.php?StateID+MT

ii. U.S. Census Bureau, Current Population Reports, P60-235, "Income, Poverty, and Health Insurance Coverage in the United States, 2007", U.S. Government Printing Office, Washington, D.C. 2008, p. 25.

iii. Steve Seninger, "Healthcare Spending & Access for Montana Kids and families", Montana Kids Count, The University of Montana-Missoula Bureau of Business and Economic Research, February 1, 2006. Slide titled "Employment & Health Insurance">

iv. Ibid. Slide titled "Who have the HIghest UI Rates?"

v. Ibid. Slide titled "Who are Montana's Uninsured?"

vi.http://www.ourfactsyourfuture.org/?PAGEID=67&SUBID=154#SC

vii.U.S. Department of Labor

viii. Families USA, "The Facts about Prior Approval of Health Insurance Premium Rates", Health Polilcy Memo, June 2008, p. 1. http://www.familiesusa.org/assets/pdfs/prior-approval.pdf.

ix. Jon Kingsdale, Executive Director of the Commonwealth Health Insurance Connector Authority, "Massachusetts' Section 125 Requirement: Implementation and Lessons Learned", presentation at Section 125 Plans: Policy and Implementation Issues seminar, July 18, 2008, Denver, Colorado.

x. To see the report, go to: http://leg.mt.gov/content/committees/interim/2007_2008/econ_affairs/meeting_documents/mandates_w_coverdraft.pdf

xi. To see the memo, go to: http://leg.mt.gov/content/Committees/Interim/2007_2008/econ_affairs/meeting_documents/mandate_memo.pdf

xii. Health Share Montana has a 21-member board that includes representatives from state government, health insurance payers, consumer groups, physicians, and health care facilities. See www.healthsharemontana.org or http://healthinfo.montana.edu/healthit.html) for more information.

xiii. The CFHHS letter to Governor Schweitzer regarding budget inclusion of a continuity of care demonstration project is at: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sjr15schweitzer-hitltr.pdf

xiv. Health Share Montana, An Overview, August 2008. PowerPoint presentation, slide titled "Preventable Complications of Diabetes."

xv. Lil Anderson-prepared powerpoint presentation, "Delivering Health Care through Community Health Centers", presented to the Children, Families, Health, and Human Services Committee, January 25, 2008. http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15commhealthcntrsjan2008.pdf

xvi. See the agenda at: http://www.montanahealthcareforum.com/agenda.htm