HJR 20 SUBCOMMITTEE REPORT TO CFHHS INTERIM COMMITTEE
Meeting September 12, 2017
Prepared by Rep. Kathy Kelker, HJR 20 Subcommittee Presiding Officer

PURPOSE, TOPICS AND GOALS

Using HJR 20 as a guide, the subcommittee reached consensus on the following purpose statement for its work:

Purpose: To study ways the state of Montana can ensure that health care consumers receive transparent information about price and options for comparable health care services.

Over the five meetings scheduled for the subcommittee, the members agreed by consensus to pursue information about seven topics.

Topics:

- Costs for practitioner, payers, government, and consumers
- Reimbursement to practitioners from payers
- Prices for health care (e.g., actual cost, negotiated cost, price and quality of service, and outcomes)
- Interests of consumers (premiums, deductibles, co-pays, out-of-pocket) and purchasers (e.g, private and public insurance, employers)
- Most effective methods for providing transparent pricing information
- Effective initiatives in other states
- Role of the State of Montana in ensuring transparent pricing information

The discussion on goals led to a conversation about how wide the subcommittee's study should be. Should it be narrowly construed as a study of electronic bulletin boards displaying health care prices? Or should the goals go broader to include "bending the curve" in increasing health care costs? After much discussion, there was consensus that HJR 20 did not contemplate the broad scope of studying ways to slow down the increases in health care costs to consumers and payers.

Sen. Buttrey then raised a more specific question: Should the subcommittee involve the Governor so that he provides some assurance that the work of the subcommittee will not result in the Governor vetoing legislation on transparency in health care pricing?

Sen. Buttrey had a pricing transparency bill (SB362) in the 2017 Session that was vetoed by the Governor. SB362 focused on requiring health care providers to make pricing information available using transparency tools (electronic bulletin boards). The Governor vetoed the bill because this type of transparency tool "would require health plans to develop new technology and pass the costs on to patients…." The Governor noted that peer-reviewed and scientific studies had determined that online pricing tools are not used by consumers, and when they are, they actually drive up costs.

A review of the study bill itself reveals that HJR20 is not limited to recommending online pricing tools. The bill says the subcommittee is to study "…methods for encouraging consumers to

make informed decisions about health care costs." This mandate leaves the range of options open to a variety of potential methods.

Based on the purpose and topics already adopted, the subcommittee chose five goals to guide its study.

Goals:

1. Understand provider costs and reimbursement sources
2. Identify factors that set health care prices
3. Determine what consumers want and need to know about health care costs and pricing
4. Identify effective methods and processes for educating consumers about health care costs and pricing
5. Determine what the role of the State of Montana should be in ensuring health care pricing transparency

STANDARD OPERATING PROCEDURES

The subcommittee has an unusual make-up for a legislative committee because it includes only four legislators and 11 individuals with background in health care economics and consumer issues. The subcommittee must adhere to policies that govern interim committees, but can be somewhat more informal in its discussions. To govern the interactions of the subcommittee, the following standard operating procedures were adopted by consensus:

- For most matters, make decisions by consensus
- Focus on the stated purpose and expected outcomes of the meetings
- Respect the agenda, noting that some items require formal votes
- Listen actively to others
- Avoid side conversations during meetings
- Limit the length of comments
- Avoid interrupting others
- Support consensus decisions once the group has made them

In compliance with interim committee rules, the subcommittee members will do the following:

- When subcommittee members are not going to attend a meeting, they must notify Ms. Sue O'Connell.
- Members who are absent may submit proxy votes prior to a subcommittee meeting.
- The subcommittee will not appoint alternates for subcommittee members who must be absent. However, if members must be absent, they can send a member from their organization to attend the meeting and interact with the subcommittee.

TOPIC TERMINOLOGY

For every meeting of the subcommittee, members will receive a list of terms that pertain to the topic. These terms are particular to the health care field, so they may be unfamiliar to some members. The idea is for all members to have the same understanding of what the topic terms mean. For the September 12th meeting the terms referred to different types of health care providers and practices (e.g., critical access hospital, tertiary hospital, solo practitioner) and definitions of cost, price, health care spending and reimbursement for health care.

PRE-MEETING READING
Josh Poulette, a fiscal analyst with the Legislative Fiscal Division, reviewed with the subcommittee a chapter from Paul Feldstein's book on the economics of health care. This chapter covered the history of increases in medical expenditures through the period that included passage of Medicare and Medicaid and the ACA and the responses to rising costs for consumers. Dr. Feldstein characterized this period from the 1960s to the present as one of "sovereignty of consumers" because patients who had insurance either privately or through government-funded plans did not have to be concerned about the full cost of their care. During this period, consumers demanded choice of physicians, more amenities in hospitals (private rooms and bathrooms), and access to the latest technology and newest medications. The drivers of increasing costs included technology and drugs, larger number of elders living longer, and expanded access to health care.

PANEL DISCUSSION: COSTS FOR HEALTH CARE PRACTICES

PANEL MEMBERS	ORGANIZATION	LOCATION
Rob Brandt, CEO	Mountainview Medical Center Critical Access Hospital	White Sulphur Springs
JJ Carmody Director of Reimbursement and Healthy Policy	Billings Clinic Major Hospital	Billings
Kurt Lindemann, DDS	Small Private Practice	Kalispell
Roy Strong, CEO	Ortho Montana Private Clinic	Billings

SUMMARY OF PANEL RESPONSES

QUESTIONS	JJ Carmody	Rob Brandt	Kurt Lindemann	Roy Strong
For Profit			**For Profit**	**For Profit Personal Service Corporation**
What is your profit margin?			Profits are hard to predict. As the owner, KL pays staff salaries and expenses and then pays himself a salary.	Profits are hard to predict. Profits are received by the physician owners as their salaries after expenses are paid.
Nonprofit	**Nonprofit**	**Nonprofit**		
What is your budget margin?	BC maintains a 4%-5% margin in order to satisfy Standard & Poor's A-rating requirements.	Budget margin is small 2%-3% because of high expenses and relatively low volume.		
What role do donations play in your budget?	BC has a Foundation. Donations are used for new projects like the internal medicine residency and capital campaigns (e.g., Cancer Center).	Mountainview has a Foundation. Local donors help purchase new equipment (CT scanner).		
QUESTIONS	**JJ Carmody**	**Rob Brandt**	**Kurt Lindemann**	**Roy Strong**

DISTRIBUTION OF EXPENSES				
	Salaries & Benefits Physicians **18%** Salaries & Benefits Staff **39%** Supplies **12%** Drugs **8%** Purchased Services **6%** Other **6%** Depreciation **4%** Operating Margin **4%** Repairs & Maintenance **3%** Insurance **1%**		Salaries & Benefits Staff **32%** Dentist/Owner Compensation **25%** Supplies/Equipment **21%** Facility **10%** Miscellaneous variable **6%** Miscellaneous fixed **3%** Office supplies **3%**	Ortho Montana utilizes Relative Value Units (RVU) to develop a fee structure. Utilizing internal (expenses) and external data (RVU and frequency), a conversion factor is developed. This conversion factor is then multiplied against the RVU to develop the fee schedule/cost. Factors that are considered include practice expenses, payer mix, total compensation, and malpractice costs. Market dynamics are also considered.
EXPENSES THAT HAVE INCREASED	--Salaries for physicians and staff --Drugs --Equipment --More acute patients since Medicaid expansion --Inadequate reimbursement from government --Compliance to government requirements	--Salaries for physicians and staff --Drugs --Equipment --IT Technology (electronic medical records)	--Personnel costs: competitive wages, vacations, holidays, sick time, retirement and insurance --Surgical equipment and supplies—patient demands for technology, digital imaging lasers, one-appointment crowns --Decreased or stagnant reimbursement --Increasing costs of government regulations—HIPAA, translations services, medical device tax	Costs have not increased materially.
WAYS TO REDUCE COSTS	BC implemented a lean six sigma performance program that focuses on eliminating waste and increasing efficiency. Since 2009 BC has recognized $66.4 million in cost savings.	Encouraging local usage of the hospital by having a variety of services	Prevention --serving in a free clinic --applying sealants for children in low-income schools --lobbied for preventive codes for adults with Medicaid --ABCD program to inform dentists how to use preventive techniques with infants and toddlers	--In-office procedures --Bundling services --Moving inpatient surgery to outpatient facility --Reducing high-cost imaging --Reducing cost of implants

Speaking for small health care practices, the dentist on the panel asked that the subcommittee consider these recommendations:

- Do not impose new requirements that exceed the capacity of small providers to meet;
- Minimize the increased costs of health care due to increased costs for small practice regulatory compliance;
- Avoid compliance penalties and certainly those that fall disproportionately on small practices;

- Include requirements that promote patient understanding of the full picture of health care based not only on costs, but also balanced with quality measures that are uniquely suited to small practices available through current systems, meaningful to patients, and fair to small practice providers.

SUBCOMMITTEE TAKE-AWAYS

Member of the subcommittee made the following list of ideas that they gleaned from the panel that will be useful in meeting the study's goals:

- To be wise consumers, patients need to receive full information about health outcomes as well as costs of care, including premiums, deductibles, prior approval, co-pays, in network and out-of-network costs and out-of-pocket costs. Merely knowing the price of a procedure does not give consumers the full picture of what they will be paying and what insurance will pay.
- Health care is a labor-intensive service. Health care organizations, large, medium and small, have to pay competitive wages in order to attract and retain skilled workers. For rural facilities with lower volumes of patients, the personnel costs become a larger portion of their budget.
- Preventive health care is a cost-reduction strategy that prevents costly services like emergency rooms from being used by health and dental patients.
- Access to health care is important, especially for those in rural areas. How much is access valued and how much are we willing to pay for access in both rural and urban settings?
- Government programs pay what they call "reasonable costs," but providers find that government reimbursement, especially for Medicaid, is well below the actual cost to the provider.
- Pharmacy costs, especially for new medications, can be extremely high; providers and payers struggle with how to manage drugs to keep overall costs under control.
- New technology and medical devices are expensive. For example, the critical access hospital representative on the panel said he budgets $400,000 per year for IT in order to be able to have electronic medical records.
- In the Dental Association, the members are considering creating a cooperative purchasing entity to buy supplies in bulk at less cost. The critical access hospital CEO says he buys in larger quantities and shares with health care partners in the community.
- Critical access hospitals (and other rural health care providers) are very vulnerable financially if local people go elsewhere for their health care. Local providers are able to provide all kinds of routine health care and procedures, but sometimes patients travel to larger communities unnecessarily.
- In eastern Montana, critical access hospitals have to provide local people with a wide array of services because otherwise patients would have to miss work and travel long distances for routine care. Employers who pay for insurance would rather have people seen locally so that employers are not burdened with additional costs for travel and absent workers.
- Some health care practitioners in Montana are moving away from the fee-for-service model for reimbursement and experimenting with value-based payment. Smaller practices are largely fee-for-service, but larger ones are using models that demonstrate value by providing positive health outcomes while reducing costs to the patient and the third-party payer.

- The panel members all expressed a desire to look at new ways to curb costs. Health care practitioners are experimenting with different clinical care models that may reduce costs to consumers. For example, shorter stays in the hospital or doing more procedures as outpatient services is saving dollars for consumers.
- All the panel members were enthusiastic about providing consumers with transparent information. The dentist on the panel described how his patients receive a treatment plan that shows all the costs that the patient will pay. The patient signs the agreement before the treatment so that there are no surprises when it comes time to pay. This is an ideal situation from the consumer's viewpoint.

PREVIEW OF NEXT MEETING

The next meeting of the subcommittee on November 16 will include two panels, one on health care reimbursement and pricing and another on cost savings models. Materials for this meeting will include:

- AJPH Health Policy Goals (a study showing where there is common ground between Republicans and Democrats)
- Articles on government and private payer reimbursement
- An article comparing U.S. prices for common procedures to prices in other advanced countries
- Report from the Governor's Council on Health Care Innovation and Reform
- An article on health care pricing in Singapore, the country in the world that has the best health outcomes for its general population
- Two Topic Terminology Lists

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