SJR 22 Joint Subcommitte on Health Care and Health Insurance

57th Montana Legislature

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MINUTES

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Committee tapes are on file in the offices of the Legislative Services Division. **Exhibits for this meeting are available upon request. Legislative Council policy requires a charge of 15 cents a page for copies of documents.**

First Meeting of Interim
Room 137, State Capitol
August 30, 2001

SUBCOMMITTEE MEMBERS PRESENT

Rep. Joe McKenney, Chair
Rep. Bob Lawson
Rep. Michelle Lee
Rep. Bill Price
Rep. Trudi Schmidt
Sen. Jon Ellingson, Vice-Chairman
Sen. Dorothy Berry
Sen. Royal Johnson
Sen. Jerry O'Neil
Sen. Linda Nelson
Sen. Glenn Roush

SUBCOMMITTEE MEMBERS EXCUSED

Rep. Kathleen Galvin-Halcro
Rep. Gary Matthews
Rep. Bill Thomas

STAFF MEMBERS PRESENT

Gordy Higgins, Research Analyst
Lois O'Connor, Secretary

VISITORS' REGISTER AND AGENDA

Visitors' Register (ATTACHMENT #1)
Agenda (ATTACHMENT #2)

SUBCOMMITTEE ACTION

- Adopted two goals: (1) the access to affordable health care insurance for as many Montanans as possible and (2) the access to cost effective, quality health care for as many Montanans as possible
- Adopted the Subcommittee's proposed meeting schedule
- Approved that the October 29, 2001, Subcommittee meeting be devoted to a comprehensive, broad-based discussion of the options available to address the issue of providing affordable health care insurance and providing cost effective, quality health care (i.e. options from other states and options from the stakeholders)

CALL TO ORDER AND ROLL CALL

The meeting was called to order by Rep. McKenney; Chair at 9:00 a.m. Roll call was noted, Representatives Galvin-Halcro, Matthews, and B. Thomas were excused. (ATTACHMENT #3)

Rep. McKenney's opening remarks included an explanation of the meeting approach and a statement to the stakeholders that the solutions to the challenges ahead of the Subcommittee regarding health care and health insurance were going to come from the people who work in the health care industry. He requested the stakeholders' help in finding those solutions.

OVERVIEW OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) AND MEDICAID, INCLUDING THE BLUECHIP PROGRAM

Mary Dalton, Medicaid Services and CHIP Bureau Chief, Department of Public Health and Human Services (DPHHS), provided an overview of Montana's CHIP program and a county-by-county list of CHIP enrollments. (EXHIBITS #1 and #2 respectively)

Rep. Schmidt asked if other states were also purchasing private insurance coverage for their uninsured populations. Ms. Dalton said that one-half of the state chose to expand their Medicaid programs, 13 states did a combination approach whereby they used Medicaid coverage for some children and private insurance for others, and 13 other states, Montana included, chose to buy a private insurance package. A new trend that is emerging, only two states have tried it, is a Medicaid-look-alike program. Instead of making the CHIP program an entitlement through their Medicaid programs, they chose to offer the same benefit package in a look-alike project but they can limit the number of children that are served under the package.

Sen. Ellingson asked if the 30,450 children (the difference between the 82,350 children who are at 150% of the poverty level and the number of uninsured children, the children enrolled in CHIP, and the Medicaid-eligible children combined) were covered by other insurance. Ms. Dalton said yes, and the majority are covered by private insurance. Sen. Ellingson asked if he could assume that the 4,800 uninsured children in Montana were not Medicaid eligible, and of the 4,800 children, what percentage has applied for the CHIP program or are they on a waiting

list. Ms. Dalton said only 4,800 of the children that under 150% of the federal poverty level (FPL) were not Medicaid eligible and there are 1,124 children currently on the CHIP waiting list. She added that the Department receives approximately 450 to 500 children a month who apply for CHIP. As the program is getting more full, approximately 250 children were moving off every month because they turned 18 years of age, moved out of state, received another insurance product, or moved onto Medicaid because of a decrease in their family fortunes. Ms. Dalton anticipates that the waiting list will continue to grow once school begins because children need sports physicals and eye glasses, etc. Sen. Ellingson asked if the reason why there was such a large waiting list was because of insufficient funding, and if so, what would be the solution to provide the funding. Ms. Dalton said that it is a state funding issue and she would provide the Subcommittee with the information. Governor Martz also proposed $291,000 in general fund per year to expand the CHIP program to 160% of poverty.

Sen. Roush asked how often the Department reviewed the income levels of the CHIP parents. Ms. Dalton said that parental income levels are reviewed annually. Sen. Roush asked if Medicaid coverage was better than CHIP coverage. Ms. Dalton said that if a child is Medicaid eligible, the child must be on Medicaid and Medicaid coverage is a richer package than the CHIP package. Medicaid covers more services, there is no co-pay for children's services, and it is more flexible than CHIP. CHIP cover those children who are between 100% and 133% of poverty and 150% of poverty who are ineligible for Medicaid or if their families have resources. The resource limit for Medicaid is $3,000 which is not very much.

Ms. Dalton provided an overview of the Montana Medicaid program and a side-by-side comparison of the differences between the CHIP and Medicaid programs (EXHIBITS #3 and #4 respectively)

Chuck Butler, Blue Cross Blue Shield of Montana (BCBSMT), said that BCBSMT is the only insurer in Montana that is partnering with the state on the CHIP program. The CHIP program will be entering its fourth year and there are 9,700 children in the program. He requested further Subcommittee discussion regarding the available federal funds for CHIP to go to 200% of poverty. The 9,700 children covered under CHIP has taken the dent out of the 180,000 Montanans who are currently uninsured. He also requested that the Subcommittee consider Governor Martz' proposal to expand CHIP eligibility. He said that even at 150% of poverty, all of the uninsured children up to 150% are not being served. Mr. Butler disagreed with Ms. Dalton in the fact that he felt the CHIP program was a flexible program, and in terms of benefit design, it is a rich benefit plan. He said that children in the CHIP program have about the best health insurance benefits that anyone could afford or purchase in the state.

Sen. Ellingson asked what the cost would be for the state to go to 200% of poverty. Ms. Dalton will provide the information. Mr. Butler added that there are proposals in Congress to expand the CHIP program to include adult parents of the children enrolled in CHIP. He requested that the Subcommittee explore the expansion of CHIP to adult parents.

Sen. Johnson asked if the percentage of state matching funds was the same at 200% of poverty as it is at 150% of poverty. Ms. Dalton said that there is only enough money to expand to 200% of poverty as the state spends some of the unspent money from previous years. For example, in fiscal year (FY) 2002, the state is spending 1999 grant funds. She added that the state could cover pretty close to 200% of poverty but she was unsure whether it could get all the way. Sen. Johnson commented that if it were true that there was enough money to go to 200% of poverty, the state will have to know how much money it takes to get there. If the percentages are the same, neither one of the numbers would be sufficient.

Sen. Nelson asked why senior citizens were taking such a large share of the Medicaid funds. Ms. Dalton said that it was a combination of factors-- more senior citizens are living longer and living out their years in nursing homes while others are choosing to live at home. The fastest growing segment of the population in the U.S. today are senior citizens over 85 years of age. As a person gets to be over 85, more things need to be “tweaked” in their bodies and the newer medications are keeping people alive longer.

Rep. Lawson said that according to the statistics, the state is not serving the uninsured children under 150% of poverty. He asked why change the eligibility if the state is not currently doing the job with the targeted people. Ms. Dalton said that if the Legislature would have appropriated more money for expansion of the CHIP program, the first people to be taken off the program would be those at the 150% poverty rate. It does not make sense to cover people at a higher income level until the people are covered in the lower levels. Had the Department received the additional funding, it would have done a phase-in program to raise it on a rule basis to cover 160% to 175% of poverty. Rep. Lawson asked if it would make more sense to ask for money to take care of the people that the Department is already dealing with rather than to expand eligibility to deal with people that it cannot deal with under the existing program. Ms. Dalton said that during the 2001 Session, the waiting list for CHIP was 36. It has since increased. She said that she believed that people would get discouraged by being on a waiting list for four or five months but they continue to apply for CHIP.

Rep. Schmidt asked about the projected pharmacy costs related to the elderly. Ms. Dalton said that there are new drugs that are much more expensive and there has been significant cost increases at the manufacturer level. However, this is not the case at the retail pharmacy level.

Sen. O'Neil said that if the state extends the CHIP program to 200% of the federal poverty level, it will give insurance to everyone except the taxpayers who are paying for it. He asked what it would cost the state to extend health care coverage to all Montanans and would there be a downside to doing that. Ms. Dalton said that statistically, 40% of all Montanans are under 200% of poverty. The debate about whether health care coverage should be expanded to all Montanans, would be worthwhile listening to.

Sen. Ellingson asked if Medicaid-eligible people were not receiving services because they cannot find a provider who will accept them because of low Medicaid reimbursement rates. Ms. Dalton said yes, adding that the Department is paying 55 cents on the dollar for physician care through Medicaid but it does not have the access problem in that area. However, it does have a huge access problem in the dental area. The Legislature just appropriated an increase in Medicaid dental which she hopes will be helpful. Currently, most dental care is private pay and there is a large supply and demand problem.

PERSPECTIVE OF THE OFFICE OF THE STATE AUDITOR AND INSURANCE COMMISSIONER

John Morrison, Insurance Commissioner, State Auditor's Office, stated the following:

- To many people in Montana cannot afford health insurance, to many people are uninsured, to many small businesses are unable to provide insurance to their employees even though they want to, and to many people are financially crippled by the crushing cost of insurance.
- The most significant issue in the debate is the concept of cost shifting.
- Health insurance is not like any other insurance. There is a legal framework in society that means when people have critical medical needs, they will be taken care of. The question is who is going to pay for it. The question is not insurance; the question is a health care financing system.
- Studies conclude that the people who do not have health insurance, do not receive timely health care and tend to not seek care until they are critical and in need of the most expensive settings. These people incur costs that they cannot pay for and those costs get shifted on to those who do pay which raises the cost of everyone else's insurance premiums.
- The very poor receive rich benefits under Medicaid and Montana has a good insurance system for people who are covered under employer-based insurance. People in the income category between Medicaid and those accessing traditional coverage that represent the largest number of uninsured.
- The ideal health care system should serve two goals: (1) the system should be as efficient and cost effective as possible as long as it is consistent with providing first-class

care and (2) each individual should pay as much of his or her fair share of health care costs as possible. If people can pay $100, they should not be paying $0 because when they pay $0 and incur the expensive care, the whole amount get transferred on to everyone else while the person receiving the care has not contributed anything to the cost of their own health care.

- Health care coverage needs to be expanded without expanding health care bureaucracy by using the power of policymaking to create incentives that move people and employers toward health care coverage.
- Twenty percent (165,000) of Montana citizens are uninsured and 40% of Montana's businesses offer employee insurance, but 60% do not. The 40% ranks Montana last in the U.S. Businesses in Montana with less than 10 employees, 26% provide coverage and those with greater than 50 employees, more than 90% provide coverage on a national basis. Eighty percent of the uninsured in Montana are from households where at least one person is working full time. Montana statistics from 1998 show that $67 million in hospital costs were unpaid by the people who received the service and shifted to those who do pay.
- **Solutions:** Insurance Commission Morrison provided the report State and Local Initiatives to Enhance Health Coverage for the Working Uninsured that included a list of solutions that he requested the Subcommittee to consider in its deliberations along with the added requests to consider guidance from other states' systems for solutions to Montana health care problems, to encourage Montana's Congressional Delegation to allow Montana's allocation from the federal government to come without too many strings attached, and to consider a tobacco tax to provide a tax credit for individuals and small businesses that would shift the cost of health care on to the people who incur it. (EXHIBIT # 5)
- Insurance Commissioner Morrison has planned to begin roundtable discussions on health insurance reform around the state and the State Auditor's Office intends to present a package of legislation to the 2003 Session. He will keep the Subcommittee informed of the discussions.

Rep. Lawson asked if the cost of insurance fraud was adding to the problem, and if so, could anything be done to plug the gap. Insurance Commissioner Morrison said that the legal department of the State Auditor's Office is constantly investigating and prosecuting criminal insurance fraud on the health arena as well as the life, property, and casualty side. The State Auditor's Office has the authority to pursue criminal prosecution. However, it is more of a law enforcement question and he has not thought about policy issues to address insurance fraud. Rep. Lawson asked how much insurance fraud has cost the state. Insurance Commissioner Morrison was unsure about the estimated amount of insurance fraud in the medical arena but he would provide the information to the Subcommittee.

Rep. Schmidt asked about the schedule for the proposed roundtable discussions. Insurance Commissioner Morrison will provide the dates to the Subcommittee.

PUBLIC COMMENT: HEALTH INSURANCE CONSUMERS, CARRIERS, AND COSTS

Steve Turkiewicz, Executive Vice President, MT Auto Dealers Association (MADA), stated the following:

- MADA was formed in 1913 and represented franchised new care dealers throughout the state.
- In 1947, it created the MADA Insurance Trust which currently covers 3,800 Montanans.
- Since 1989, the MADA has seen its paid claims go from $2 million to over $5.3 million in the year 2000.
- In 1998, its paid claims were $4.3 million and its insurance premiums were $150 for an employee and $354 for a family.
- In 2000, the MADA's paid claims jump to $5.3 million resulting in an increase in premiums to $205 for an employee and $485 for a family.
- MADA identifies large claims as $10,000, and in the year 2000, the total cost was $2.7 million for 94 Montanans.
- He requested that before the Subcommittee thinks about reforming health insurance, it should review health care and how it is delivered in Montana.
- In addition to having to increase its premiums, AMDA had to change its copay--from an 80-20 co-pay to a 70-30 co-pay and its deductible increase from $500 to $1,000 for an individual. Family maximum liability has increased from $2,000 to $4,000.
- This money is going to health care providers--doctors, pharmacies, hospitals, and therapists.
- There has been dramatical new drugs available that are costly but very effective, new diagnostics, new technologies, new facilities, and better provider training are contributing to the rising cost of health care.
- There is also a major change in philosophy. When people buy auto or business property and casualty insurance, they hope to never use it. But how many people go through the year and review their health care costs and realize that they have met their deductible?
- The Association believes that the state needs a firm handle on what the charges and costs are for delivered health care services and how they compare to the regional areas.
- Montana must use that information to develop a public policy of what Montanans expect from its health care system, what it should look like, and what it should cost.

Riley Johnson, National Federation of Independent Businesses (NFIB), agreed with Mr. Turkiewicz regarding the development of a public policy for the delivery of health care (i.e., cost differentials, service differentials, and what can Montanans expect from a health care system that serves 900,000 people).

Tanya Ask, Blue Cross Blue Shield of MT (BCBSMT), provided an overview of BCBSMT Health Care Issues and information regarding identified health care issues and exhibits. (EXHIBITS #6 and #7 respectively)

Doug Lowney, MT Association of Insurance and Financial Advisors (MTAIFA), stated the following:

- The Subcommittee can get a sense of what people are thinking in their local communities by contacting the Association's membership.
- He suggested using CHIP funds in the same way as using Medicaid funds to pay private insurance premiums. Most health insurances have individual and family deductibles. The more people covered in a family under a private health insurance, the sooner the family gets to the family deductible resulting in the insurance company paying a larger amount of the claim. If the dollars that the state is paying to CHIP were going to the families individual health insurance, indirectly, it is allows the family to have health insurance that is more efficient for that family.
- He requested that the Subcommittee encourage Montana's Congressional Delegation to expand the flexibility of the state and expand the federal tax incentives, particularly in the area of medical savings accounts (MSA).
- He requested that the Subcommittee review the health care system as a whole, purchasing pools, cost shifting, and that it request a cost analysis of future legislation and past mandates to provide those paying insurance premiums with options or choices as to the coverage they want.
- Montana is only 1% of the national market and it should not want to chase out insurers because currently there are less insurers available for consumers.

Jerry Driscoll, MT AFL-CIO, stated the following:

- There is a growing sector of Montana's population between the ages of 55 and 65 that want to or who are retired but are not yet eligible for Medicare who need major medical or catastrophe insurance.
- He requested that the Subcommittee consider a policy for retirees who are not yet eligible for Medicare and the policy should be offered without any mandates connected to it.

Tom Bilodeau, Research Director, MEA-MFT, provided information on Montana teacher salaries and insurance costs for Montana schools during the 1990s. (EXHIBIT #8) He stated the following:

- Montana schools employ approximately 20,000 people. About 16,000 of the 20,000 are insured through their employer.
- The insurance is divided equally among self-insured groups in the larger districts, the Montana Unified School Trust, and BCBSMT.
- Over the past 17 years, he has watched the cost of insurance premiums for MEA-MFT members more than triple. The employer has also increased the employers contribution to insurance costs but have not matched anything close to the additional cost of total premium.
- As a consequence, 8% of school district budgets are consumed by employer-paid health care premium payments. Next year, full-family health insurance premiums will cost over $600 a month on average and will require employees to pay in excess of $250 a month on average out of pocket toward premiums alone.
- In the same 1990 time period, both deductibles and co-pays increased and coupled with the state's pay structure, ranking Montana 47th in the nation and 25% behind the entry-level teacher pay, and deduct from that out-of-pocket health care cost ($3,000 to $4,000 a year), it makes Montana very uncompetitive in attracting and retaining a quality educational workforce.

- Purchasing pools has been an objective of MEA-MFT for a decade. Legislation introduced by Sen. John Harp in 1997 would have established a mandatory statewide K-12 health care risk pool, and MEA-MFT remains committed to it.

Laura Marshall, Human Resource Manager, City of Billings, said that the city of Billings is self-insured, it insures 2,300 employees and dependents, it came very close to going bankrupt, and there is a sense of urgency. Between the employees and employer, the city of Billings has substantially increased their contributions. Its claims expense is $4 million. She hears the cry and the cry is from uninsured people and the lack medical care and Medicaid reimbursement.

Aidan Myhre, MT Chamber of Commerce, stated the following:

- When SJR 22 was enacted, the Chamber sought input from its members. What the Chamber heard was that the issue of health care was going to be energy issue of the 2003 Session.
- Businesses want to offer health insurance because they find that it is the primary benefit that they can offer to attract and retain qualified employees.
- The Chamber promotes creative ideas, purchasing pools, and a health services inventory (i.e., what is available in terms of insurance companies, medical provider, hospitals, what does Montana have in order to create a model for Montana by reviewing what other states are doing in the area of cost containment.)

Jerry Loendorf, MT Medical Association, provided written comments. (EXHIBIT #9)

Bill McDonald, Executive Director, MT Association of Health Care Purchasers provided a list of the percentage of people without health insurance coverage throughout the year by state. (EXHIBIT #10) He stated the following:

- The Association just negotiated a pharmacy benefit on behalf of its large employers, such as the Montana Power Company, the state universities, and First Interstate Bank.
- By forming the purchasing cooperative, the entities are receiving a benefit that is only offered to groups of 100,000 employees or more.
- Montana is a small state, and he requested that the Subcommittee look beyond individual businesses and asked what it could it do as an entire state.
- The Association has also negotiated, on a direct contract arrangement, with hospitals; and through its indemnity plans with large employers, has been able to negotiate some significant discounts with hospitals. The Association will research how it can include smaller employers in the effort.

Alec Hansen, MT League of Cities and Towns, said that there are 129 cities and towns in Montana with approximately 10,000 employees. In trying to provide health insurance to these employees, there have been significant increases in insurance premiums in recent years. He offered the League's help to the Committee to find solutions.

QUESTIONS FROM THE SUBCOMMITTEE

Sen. Ellingson asked how the state could get a handle on the cost of medical services and drug programs which is the driving force behind the cost of insurance. Ms. Ask said that although there are innovative things currently happening in the area of drug programs, there are working against those ideas, such as direct consumer advertizing. There are many fantastic new drugs currently available but the cost of those drugs is also fantastic. The state needs to take a look at whether everyone need a wonder drug or only certain people with certain indications. Another idea for exploration is purchasing cooperatives for pharmaceuticals that can be established on a multi-state basis as well as individual purchasing. Ms. Ask added that the problem of over all medical costs is a societal issue and each person's individual's expectation of what they are truly willing to pay for as a state. She said that Montana is paying the same costs that people in Wyoming are paying, but people in Wyoming are earning $5,000 per household per year more than Montana households. Sen. Ellingson asked if this would lead to the conclusion that Montana needs state regulation that would prohibit certain areas of the state from having certain types of technologies. Ms. Ask said that this type of legislation has been tried in Montana before through certificate of need. It did not work very well which is why an inventory of medical services would make sense. Montana needs the answers to the medical services inventory questions because currently it does not. If more information was available and more Montanan's know about them as well as the costs of those services, purchasers would probably have different answers to the question of "Do I want to buy this?".

Sen. O'Neil asked if Montana encouraged the development of a public policy, would it mean that Sen. Johnson was wrong when he carried legislation that limited certificate of need and how would independent businesses be encouraged to provide health care. Riley Johnson said that his concept is not to dictate what public policy should be. He is only asking that the Legislature begin the process of developing and acting on the idea of a public policy on health care in Montana. He said that in 1974 and 1975, he sat on a board that tried to implement legislation that developed a certificate of need idea in the state. It failed miserably. Tax incentives would encourage his associates to provide health care.

Sen. Roush commented that a number of stakeholders in the health care industry should establish a coalition to find some solutions to the problems and bring them back to the Subcommittee for consideration.

HEALTH CARE PRESENTATIONS FROM HOSPITALS AND PROVIDERS

Bob Olsen, MT Hospital Association, provided an overview of information that included what entities regulate hospitals, the nation's health care dollars (where they come from and how they

are spent), Montana's health care dollars (where they come from and how they are spent), information on hospital expenses by category, and discounts from gross revenue in Medicare and Medicaid. (EXHIBIT #11) He stated the following:

- In 1985, discussions were held on how to get a handle on the rising cost of health care. The standard answer was to cut people and jobs; to cut services (if people are not covered for hospital services, dental, or eye glass care, the state would not have to reimburse people for the cost of those services); or to cut rates or the amount that is paid.
- Cutting rates was Montana's policy in 1985 and continues to be the policy. Montana compensates providers who are willing to work for less and less while providing the same care, and it has left providers with the task of finding solutions to the problems.
- If services that were insured become uninsured, the burden is cost shifted to compensate someone for providing the service away from insurance plans on to someone else.
- For example, in the late 1980s when the state engaged in workers' compensation reform, it passed legislation that stated that insurance companies that are delivering coverage for workers' compensation did not have to pay anymore from year to year for health care than they paid in 1987. This took the cost of treating injured workers off of the back of workers' compensation and put it on the backs of the business community with private insurance.
- Montana's infrastructure is not just dealing with Montana's, it is dealing with tourism as well because people are mobile. If people cannot receives services in Montana, they relocate to where the services are. Merely holding Montanans in check will not contain costs but it will export them.
- The Subcommittee must keep in mind that what ever it does to enhance private insurance or whatever it does to toggle the system, everyone else gets the same deal and everyone else is effected.
- More than one-half of the expenses incurred by hospitals are payroll costs.
- Montana needs a political mind change in order to control health care costs. Montana's mind set is that it will not apply for federal dollars because it will not put up the state dollars to match the federal funds. It must also address the replenishment of its health care labor pool. If Montana cannot hire competent staff, it must hire temporary staff at a much greater cost. In addition, Montana's university system does not produce the numbers of people that hospitals need to employ and the health care work force has not had a rate increase in five years.
- Bad debt and charity care have cost Montana over $85 million. There is a difference between giving someone charity and having to write something off to bad debt. Charity is used in situations where it is known that a person cannot pay and the decision is made to offer them care without compensation. Bad debt is used for people who can pay but choose not to do so. However, it has been found that bad debt and charity care are one and the same.

Tom Ebzery, St. Vincent Healthcare, Holy Rosary Healthcare, and St. James Healthcare, Billings, provided written comments. (EXHIBIT #12)

Jani McCall, City of Billings and Deaconess Billings Clinic (DBC), stated the following:

- DBC is the largest nongovernmental employer in Yellowstone County and the largest health care provider in the state.
- Fifty three percent of the patients at DBC are Medicaid and Medicare qualified.
- In 2000, DBC had $11.7 million of unreimbursed care for Medicaid and Medicare.
- In 2000, DBC provided $3.5 million in charity care and $3.2 million of subsidized health care services (i.e., psychiatric services and mental health services for children and adults).
- DBC and the City of Billings is involved in a joint partnership to negotiate directly for contracts for services.

Dr. Joseph Canabe, Cardiologist and Internist, Western Montana Clinic, Missoula, echoed Insurance Commissioner's John Morrison's plea for tax fairness in the arena of health insurance. The reality is that most of the individuals who cannot afford health insurance in Montana are in marketplace where they, even if they could buy health insurance, are disenfranchised from the benefits of tax incentives that he receives from the large purchaser markets. He added that advanced technology and the demographic reality that Montanans are getting older are driving the cost of health care, both of which cannot be stopped. Montana is missing opportunities by not seeing activities that are already in place in the state and by not taking advantage of those opportunities. He encouraged the Subcommittee to contact the constituents in their communities and other entities who are doing yeoman work in cost containment.

PRESCRIPTION DRUGS

Jeff Buska, Acute Services Section, DPHHS, provided an overview of Montana's Medicaid Pharmacy Program. (EXHIBIT #13) He suggested that the Subcommittee make some time on its agenda to hear from Dr. Stratton from the University of Montana-Missoula who is an expert on the pharmaceutical industry and teaches pharmacy economics.

Jim Smith, MT Pharmacy Association, stated the following:

- There are 120 independently owned pharmacies and approximately 100 chain drug stores, not including those located in hospitals or other specialty facilities, in Montana; and it has pharmacies in 48 of the 56 counties in addition to pharmacies in every medium and small size town.
- They exist because of the pharmacists' dedication to their communities and because of Medicaid. Medicaid has put an emphasis on access and Medicaid reimbursements are the small pharmacies best source of income.
- The average cost of a prescription nationwide is approximately $40 of which 78% represents the cost of acquiring the drug while 20% represents the pharmacists' overhead, leaving a 2% profit margin.

- The Association believes that if the pharmacy outlay is “squeezed down”, there will be a correlating increase in physician, hospitalization, and emergency room visits within the Medicaid program and private market place.
- He suggested that the Subcommittee also consider the cost of noncompliance (i.e., people who receive the drugs but do not take them, those who receive the drugs and do not finish their courses of therapy, or those who are receiving too many prescriptions from too many physicians).
- The solution is for Montana’s pharmacists to be a more meaningful member of the health care team and to be able to interact more completely with physicians, nurses, and patients.
- Other solutions would be for Montana to allow its pharmacies to practice value-added pharmacy and to expand Medicaid in order to cover more senior citizens on the federal level.

Sen. Roush asked if Montana pharmacies were carrying an abundant supply of generic drugs or upper-grade drugs. Mr. Buska said yes, adding that many of the pharmacies carry generic drugs and often substitute for the more expensive drugs and it is mandatory under the Medicaid program that pharmacies do that.

Rep. Lee asked if 48 of the 56 counties in Montana had pharmacies, where were the people in the remaining counties going for pharmaceuticals. Mr. Buska was unsure but added that the Medicaid population is very mobile and will travel to seek health care services and some pharmacists will mail prescriptions.

Sen. Johnson asked the Department’s Drug Rebate Program. Mr. Buska said that the Drug Rebate Program is a program whereby the Department bills manufacturers for drugs that the Department has paid for its Medicaid recipients. The Department takes all of its paid-claims history on a quarterly basis and bills the Center for Medicaid Services (CMS) (formerly HCFA). CMS calculates the unit rebate amount. The Department aggregates all the claims paid for a particular drug and it sends a bill to the manufacturer. The manufacturer then rebates the state back for the drugs that Montana paid for under the Medicaid program. The Department then uses the Medicaid rebate as an abatement to the Medicaid program expenditures. In addition, the Department must reimburse the federal government for the Medicaid match but it keeps the general fund portion of the rebate amount.

Sen. Nelson asked about purchasing prescriptions on-line from foreign companies. Mr. Smith said that Internet pharmacy is a growing segment of the pharmaceutical marketplace. There are some concerns about this being done but he does not foresee the trend discontinuing. He also does not hold out hope for the reimportation legislation that has been introduced in Congress. Sen. Nelson asked why people were getting more reasonably priced drugs in Canada and Mexico, for example. Mr. Smith said that drugs are not manufactured in Canada

and there are socio-economic considerations of the country to which the drugs are being sent. He suggested again that the Subcommittee hear from Dr. Stratton about the pharmaceutical industry. Sen. Nelson requested that the Subcommittee followup on the cost of pharmaceuticals.

Rep. Schmidt asked for more elaboration on across-the-border drug purchases. Ms. Smith said that the Congressional reimportation legislation was not a productive path for the nation to go down. The concern is the safety and integrity of the drug supply and counterfeit drugs being manufactured in other countries finding their way into the U.S. In addition, the price of drugs is not the same universally or internationally. Prices are based on a number of factors. Mr. Buska added that a number of European countries, Canada, and Mexico have price controls that are set by the government.

Sen. Berry commented that she attended the PNWER Conference in British Columbia. Testimony was heard from a practicing physician from Canada who spoke about the people coming across the border to buy drugs. He said that the picture is not as good as it looks for everyone. Some drugs can be bought at a cheaper price in Canada but many of them cannot.

Sen. Ellingson asked for an update on Maine's legislation establishing cooperative buying groups, whether it was found to be constitutional, and whether it could be an option for Montana. Mr. Buska said that Maine entered into a buying cooperative with a few other states. It was challenged by the pharmaceutical industry because it was being used more for a senior program rather than for purchasing drugs for a Medicaid program. Part of the package included that the manufacturers would give the best prices on the purchase of drugs as well as rebates. If the manufacturers did not sign rebate agreements with the co-op, they could put all of their drugs under the Medicaid program with prior authorization. He understood that the Court's held that the states could implement a cooperative buying group and put the drugs, under prior authorization, under the Medicaid program if the pharmaceutical industry and the manufacturers refused to sign rebate agreements.

Mr. Smith said that the Association opposed similar legislation in the 2001 Session because it felt that it imposed price controls on its member pharmacies. If the state is talking about a program that will cover all senior citizens, pharmacies did not have the option to not enter into the agreement. Sen. Ellingson requested that staff provide an update on Maine's legislation for Subcommittee consideration.

Sen. O'Neil asked if a pharmaceutical company sold drugs in Montana and sent them to the prescriber at a 20% savings, for example, would it be an incentive for Medicaid recipients to purchase their drugs in the same way. Mr. Buska said that if the pharmaceutical companies are able to provide drugs at a lesser cost and they charged the Medicaid program less, and if the charges were less than the AWP of 10%, the Department would be paying the company its bill charges. The Medicaid program would also reap the benefit of the business practice of purchasing the drugs at a discount and pass it on to the consumers.

MISCELLANEOUS

Gordy Higgins, Research Analyst, Legislative Services Division, said that Sen. Grimes amended the SJR 22 study to include the feasibility of recreating the Health Care Advisory Council to provide information and documentation for agencies that have the responsibility to regulate areas of health care and health insurance. Maggie Bullock, Health Policy and Services Administrator would like the opportunity to talk about other ideas she has using existing advisory boards, commissions, and committees that are currently working with the Department. He suggested leaving the question of recreating the Health Care Advisory Council for a later discussion in the interim once the Subcommittee decides its priorities. Sen. Grimes has also expressed interest in participating in that aspect of the study.

Sen. Johnson suggested that stakeholders and staff contact Sen. Grimes to ask that he put in writing his thought process and what prompted him to make the recommendation rather than the Subcommittee trying to figure out what he wanted.

SUBCOMMITTEE ISSUES AND DISCUSSION

Mr. Higgins provided an overview of the draft SJR 22 study plan. (EXHIBIT #14)

Subcommittee members thoroughly discussed their priorities and options and made the following motions:

- Sen. O'Neil **moved** that the Subcommittee's priority study topics be the access to affordable prescription drugs, the development of strategies to decrease the number of uninsured Montanans, and to assess the factors causing health insurance rates to increase above the rate of inflation.
- Rep. Lee made a **substitute motion** that the Subcommittee's priority study topics be the access to affordable prescription drugs and the development of strategies to decrease the number of uninsured Montanans.
- Following a statement by Rep. Lawson that he was uncomfortable prioritizing the study topics when he felt that the Subcommittee was directed pursuant to the SJR22 study resolution to study all of the core policy issues listed in the resolution and that he was unsure where the Subcommittee was going by prioritizing the study issues, Rep. Lee and Sen. O'Neil withdrew their previous motions.

- Along with the core policy issues listed in SJR 22, the Subcommittee agreed to the following:
  - that staff summarize what other states with similar demographics to Montana have done to address health care problems and what they have done creatively with their allotted TANF funds and intergovernmental transfers;
  - to consider the possibility of establishing a health care policy for Montana; and
  - to review the "bells and whistles" connected to medical savings accounts.
- Rep. Schmidt stated that the Subcommittee must first figure out what its goals were before it prioritized its study topics. She **moved** that the Subcommittee adopt two goals: (1) the access to affordable health care insurance for as many Montanans as possible and (2) the access to cost effective, quality health care for as many Montanans as possible.
- Sen. O'Neil made a **substitute motion** that the Subcommittee focus on tax incentives for health care at its October 29, 2001, meeting.
- Following a statement by Rep. McKenney that the Subcommittee could decide its focus options for the next meeting after a vote was taken on Rep. Schmidt's motion, Sen. O'Neil withdrew his motion. Rep. Schmidt's motion passed unanimously.
- Sen. Ellingson **moved** the adoption of the Subcommittee's proposed meeting schedule. Motion passed unanimously.
- Sen. Ellingson **moved** that the October 29, 2001, meeting be devoted to a comprehensive, broad-based discussion of the options available to address the issue of providing affordable health care insurance and providing cost effective, quality health care (i.e. options from other states and options from the stakeholders). Motion passed on a 10 to 1 vote with Rep. Lawson voting no.

There being no further business, the meeting adjourned at 4:00 p.m.

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