SJR 22 Joint Subcommittee on Health Care and Health Insurance

57th Montana Legislature

SENATE MEMBERS
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DOROTHY BERRY
ROYAL JOHNSON
JERRY O'NEIL
LINDA NELSON
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COMMITTEE STAFF
GORDY HIGGINS
RESEARCH ANALYST
BART CAMPBELL
STAFF ATTORNEY
LOIS O'CONNOR
SECRETARY

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.**

Third Meeting of Interim
Room 137, State Capitol
November 29, 2001

SUBCOMMITTEE MEMBERS PRESENT

Rep. Joe McKenney, Chairman
Rep. Bob Lawson
Rep. Kathleen Galvin-Halcro
Rep. Gary Matthews
Rep. Bill Price
Rep. Trudi Schmidt
Rep. Bill Thomas
Sen. Jon Ellingson, Vice Chairman
Sen. Royal Johnson
Sen. Jerry O'Neil

SUBCOMMITTEE MEMBER EXCUSED

Rep. Michelle Lee
Sen. Dorothy Berry
Sen. Linda Nelson
Sen. Glenn Roush

STAFF MEMBERS PRESENT

Gordon Higgins, Research Analyst
Bart Campbell, Staff Attorney
Eddye McClure, Staff Attorney
Lois O'Connor, Secretary

VISITORS' REGISTER AND AGENDA

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

SUBCOMMITTEE ACTION

- Approved the minutes from the October 29, 2001, meeting

CALL TO ORDER

The meeting was called to order by Rep. McKenney, Chair, at 9:35 a.m. Roll call was noted, Senators Berry, Nelson, and Roush and Representative Lee were excused. (ATTACHMENT #3)

Sen. Johnson **moved** that the minutes from the October 29, 2001, meeting be approved. Motion passed unanimously.

PRESCRIPTION DRUGS PRESENTATION

Dr. Tim Stratton, University of Montana-Missoula, School of Pharmacy, provided background information and a power point presentation on the Dynamics of the U.S. Pharmaceutical Industry (prescription drugs). (EXHIBIT #1)

Sen. O'Neil asked how much money for research and development of prescription drugs was paid by the federal government. Dr. Stratton said that there have been many discussions that the federal government was subsidizing much of the pharmaceutical industry research through research grants to universities and university researchers, but he disagreed. Pharmaceutical companies set up large clinical trials, for example, involving several thousand patients. The company will cover much of the drug costs for the trials. If patients are reimbursed for their participation, the reimbursement cost is taken from the research grant. However, most of the money is used to cover the researchers' costs. The argument that pharmaceutical companies should be picking up those costs will not produce much help.

Rep. Schmidt asked about model legislation related to the fair market drug approach currently being used in Maine and California. She said that the fair market drug approach lowers pharmaceutical prices for the state Medicaid program and uninsured individuals. States engage in voluntary negotiations with drug companies. If the pharmaceutical companies do not want to participate, they do not have to negotiate. Dr. Stratton understood that 50 pharmaceutical companies have signed on to the legislation. He said that Maine is still permitted to work with those companies even though its overall program is currently being held up in court. The key is "voluntary"; and if pharmaceutical companies will not negotiate, what kind of stick does the state have to whack them with in order to get them to negotiate. This is where legal questions arise. California can drive much of the market share as a state and it is in a better position to negotiate with pharmaceutical manufacturers because it can guarantee a large percentage of the drug volume which makes it cheaper for the manufacturer to produce the drug. The savings are passed along to consumers. It would be hard for Montana to do this because of its minimal population.

Sen. Ellingson asked what recommendations did Dr. Stratton have on how to make drugs available to Montanans without breaking the bank. Dr. Stratton said that Maine, New Hampshire,

and Vermont are exploring the use of group purchasing or a purchasing cooperative arrangement that look much like the hospital purchasing groups which use a prime vendor or wholesaler. The states negotiate prices with the manufacturers and those prices would be honored through the prime vendor. He suggested that the Subcommittee talk to hospital purchasing agents or hospital pharmacy managers. One possible downside, from a pharmacy practice standpoint in the community, is how are drugs purchased at a low cost for low-income patients separated from those people who can afford or have prescription drug coverage in some other way. Pharmacies would have to run two inventories which could be expensive. He said that a short term solution would be to join a purchasing cooperative.

Sen. Ellingson said that hospital purchasing groups negotiate their own prices with the drug manufacturers. When drugs are dispensed directly out of the hospitals, the costs are controlled by their purchasing. He asked if drug companies were making a profit by selling to hospitals. Dr. Stratton said that this is where states get into the issue of cost shifting--if a state is getting a deal on one side, is somebody else picking up the tab. From a manufacturer's stand point, it would be better to make some revenue rather than no revenue which happens if they get locked out of a contract for a year. Presumably, drug manufacturers are making some money or they would not be bidding on the contract. Sen. Ellingson said that if Montana created a state-wide purchasing group that negotiated for the state or in coordination with other states, would there be a particular reason why Montana would have to offer the drugs only to low-income individuals. Could the drugs be offered to all Montanans? Dr. Stratton said that years ago, hospitals in Oregon were involved in purchasing groups and it ran out-patient pharmacies through the hospitals. It was selling medications based on the much-lower prices that it was paying than what community pharmacies could even buy the drug for. As a result, community pharmacies sued the drug companies for the arrangement. Hospitals were allowed to continue to purchase drugs at the contract price, but they had to restrict the use to hospital patients only. If the hospitals were running an out-patient operation as well, they had to have a separate stock and they had to buy the inventory at the going market rate. Dr. Stratton said that this was his only hesitation with opening it up to all Montanans. There may be some legal issues involved.

Jim Smith, Montana Pharmacy Association, said that although multi-state purchasing pools have some appeal, he felt that Montana could find itself in trouble and run into practical challenges in terms of mixing with other states in order to meet the critical mass that aggregate buying power requires. He suggested that the Subcommittee review a limited, state-based prescription drug benefit plan. (EXHIBIT #2)

MAINERX, AND THE LATEST COURT RULING

Bart Campbell, Staff Attorney, Legislative Services Division, stated the following:

- The MaineRX program was enacted because residents who were not Medicaid eligible but near the poverty level could not afford the necessary prescription drugs.
- The Maine Legislature based the concern on the fact that volume buying of prescription drugs by Medicaid administrator, insurance companies, or HMOs resulted in substantially lower prices for those entities than an individual purchaser would pay for the same drug.
- The MaineRX program is open to all state residents of Maine and it allows enrollees to purchase drugs from participating Maine pharmacists at a discounted price.
- The discount offered by the pharmacies is reimbursed to the pharmacies by the state from a dedicated fund created by collecting rebate payments from participating drug manufacturers.

- The obligation of the drug manufacturer to pay the rebate is triggered by the retail sale of the drug to an enrollee for a participating pharmacy.
- The program directs the head of Maine's Department of Health Services to negotiate a rebate agreement with drug manufacturers which are to be similar in form to the rebate agreements required of manufacturers participating in the Maine Medicaid out-patient drug program.
- The Director is directed to consider the rebate amount calculated under the federal Medicaid rebate program when negotiating with manufacturers and is directed to use the best efforts to obtain an initial rebate in the same amount.
- Rebate payments on paid on a quarterly basis based upon the retail sales for that quarter.
- The incentives for manufacturers to participate in the rebate program are: (1) the names of non-participating manufacturers are released to the state health care providers and are made public, and (2) drugs of non-participating manufacturers are required to be subjected to the prior authorization requirements that exist under the state Medicaid program--a drug cannot be dispensed to a patient without prior approval from the state Medicaid administrator.
- The Pharmaceutical Research and Manufactures of America (PhRMA) sued Maine in federal District Court arguing that the Act was unconstitutional, that it violated the Commerce Clause, and that it was preempted by the federal Medicaid law under the Supremacy Clause--any state law in conflict with the federal law is void and that the U.S. Constitution in all federal law is the supreme law of the land.
- PhRMA sought a preliminary injunction to prevent Maine from implementing the Act.
- The District Court issued the preliminary injunction and found that the law violated the Commerce Clause because it regulated revenues that out-of-state pharmacy manufacturers received when selling to out-of-state distributers.
- The Court also stated that the law was preempted by the Supremacy Clause because it conflicted with the Medicaid program, specifically the prior authorization requirement under Medicaid was in conflict with Medicaid law.
- Maine appealed the ruling to the federal Circuit Court of Appeals.
- The Appellate Court was in direct opposition to the lower Court and vacated the lower Court's judgment.
- The Appellate Court found that between the Act and Medicaid statute with respect to prior authorization procedures, were consistent with procedures explicitly permitted by Medicaid, and therefore, there was no conflict with federal law and there was no preemption under the Supremacy Clause.
- In addition, the Appellate Court said that PhRMA had not established that the administrative burden imposed by obtaining prior authorization would likely harm Medicaid recipients. Because of the injunction, the Act had not been implemented and there was no way to tell whether the administrative burden would have had an adverse effect on recipients. The Court was not dismissing PhRMA's case with prejudice.
- The Court also said that there was no violation of the Commerce Clause. The law did not regulate the conduct occurring outside of the state but that it only regulated in-state activity.
- Local benefits of the law which was access to prescription drugs for low-income people appear to outweigh any incidental burden on inter-state commerce.
- The Appellate Court concluded that since PhRMA was not likely to succeed on the merits of its constitutional challenge to the law, it was not entitled to a preliminary injunction.

- However, there has been some action subsequent to ruling by the Court.
- PhRMA asked for rehearing by the Appellate Court. The motion was denied.
- PhRMA also appealed to the Supreme Court and, in the interim, got the Appellate Court to reinstate the injunction. Maine could not implement the program.
- The U.S. Supreme Court ordered the Solicitor General to submit a brief on how the Solicitor General feel the government should proceed on the issue.
- The opinion will be ready and distributed on December 7, 2001.
- In late December, legal representative of PhRMA met with the Solicitor General to argue its side of the case. On other side, the Northwest Legislative Association adopted a resolution urging the Solicitor General to find that the Maine Act should be upheld on the basis of states' rights.
- The possible scenarios are as follows: (1) the Supreme Court is ultimate decider of issue and could affirm Maine's law and agree with appellate court. Many states, including Montana, are looking at the program and may adopt it if upheld; (2) the Supreme Court could find the law in complete violation of the Constitution, that the lower Court was correct, that the law violates the Commerce Clause, that it is in conflict with Medicaid law, and is therefore, in violation of the Supremacy Clause; or (3) that the law is partially flawed, that the Maine law does not violate Commerce Clause, that it does not effect inter-state commerce but that in fact, it only regulates in-state sales and is, therefore, okay. At the same time, it may find that the Maine law does conflict with Medicaid law. If this is the decision of the Court, legislators may want to decide whether the law could be "tweaked" to fix the problem.
- Mr. Campbell will continue to monitor the situation for Subcommittee.

Rep. Schmidt asked about Maine's Medicaid waiver program. Mr. Campbell said that Maine followed a program from Vermont and Vermont was also subject to a lawsuit. He was unsure what the program was or what it did. He would gather the information on the program and where the litigation sits for the Subcommittee. Rep. Schmidt said that according to information that she received at a conference she attended, Maine' program was based on Vermont's program and Vermont had just lost its program.

Sen. Ellingson asked if the Appellate Court was unanimous in its decision. Mr. Campbell was unsure. Sen. Ellingson asked if the Supreme Court had been petitioned for a writ of certiorari. Mr. Campbell said that certiorari has not necessarily been granted, the appeal has been timely made, and an opinion has been order to be prepared by the Supreme Court. One of steps that the Court could still take is denying the certiorari without making comment which upholds the Appellate Court's decision without the Supreme Court actually taking a stand.

MONTANA COMPREHENSIVE HEALTH ASSOCIATION (MCHA) (HIGH-RISK INSURANCE POOL)

Chuck Butler, Blue Cross Blue Shield of Montana (MCBCM), provided a power point presentation and packet of information on Montana's Comprehensive Health Association's (MCHA) high-risk insurance pool and a copy of the booklet Health Care At-A-Glance: A Statistical Profile of Montana's Health Care Environment. (EXHIBITS #3 and #4)

Claudia Clifford, Office of Insurance Commissioner, said that Montana's Congressional delegation has put in requests to help start the MCHA program for low-income individuals. The Insurance Commissioner's Offices receives many calls from individuals who could qualify for

high-risk coverage but cannot afford the rates. The appropriations process should end mid-December and it will not be as much as MCHA had originally requested. MCHA will need to streamline the program to qualify for federal funding and other sources. Senate Bill No. 441 directs the Commissioner of Insurance to provide legislative options on how to refinance or restructure the financing system for the program. The Board of the program brought before the Legislature legislation to broaden the assessment base to help pay for the program, particularly targeted at some of the self-funded groups and stop-loss carriers that provide backup insurance to self-funded groups. The legislation did not pass and an agreed upon compromise bill will be introduced in the 2003 Legislature.

Rep. Price asked about the difference between the traditional and the portability plans and what were their losses. Mr. Butler said that under the traditional plan, for every $1 taken paid in premium, a $1.40 paid out in claims. Under the portability plan, for every $1 of premium taken in, a $1.70 is paid out. He will provide a breakdown of the actual losses to the Subcommittee. He said that the losses cannot be made up in volume. The portability plan is growing substantially, between 25 to 40 members per month. The traditional plan is growing at a rate of 5 members a month. The more people that are enrolled, the greater the losses.

Rep. Matthews said that the Legislature needs to review spreading the assessment costs around but that there will be a fight from the state plan, the Universities, and the MEWAs. He asked for detail on the assessments. Mr. Butler said that currently, MCHA assessments are based on the insured business of health insurance companies for their business and their premium income in the state. Larger employers in Montana are self-insured and self-fund their own health benefits plans and they are not assessed. This is a very contentious issue. The MCHA would like, as part of the SB 441 study, to figure out how to address the issues and concerns of the University System, the state of Montana, and the larger employers, to figure out how to spread the risk so that the assessment would not have to be 1%. It will have to come out of somebody's pocket but, the fact of the matter is, that everyone who is part of a self-insured group has access to MCHA's plan. The MCHA believes that since the program was created by the state and federal governments, taxpayers have some responsibility to their fellow citizens.

Sen. Johnson asked if the proposal was to put low-income individuals into MCHA's plan or is it to put them in their own plan. Ms. Clifford said that low-income individuals would be put into their own plan. They would receive the same benefits as the traditional coverage but MCHA must keep track of the individuals as separate set of book of business. The legislation requires that the MCHA find funding to fully pay for their costs. Low-income individuals would be paying some premium on sliding scale basis, but the rest of their cost would have to be for by the funding that is found. Sen. Johnson asked if MCHA's plans require a means test. Mr. Butler, no, not on either existing plan. There is and will be if the MCHA receives the funding from Congress. Sen. Johnson asked how Montana residency was measured. Mr. Butler said that a resident of the state must live in the state for an X period of time but they do not have to live in Montana year around.

Rep. Schmidt asked if that if a part of the interest from the tobacco settlement trust fund was designated for health care purposes. Ms. Clifford said that $2 million was received from the initial tobacco funds for purposes of health care but that there was no current statute that directs the interest other than the tobacco trust itself states that the interest must be used for health care purposes.

CURRENT FISCAL CONDITIONS OF THE MEDICAID PROGRAM

John Chappius, Deputy Director, Department of Public Health and Human Services, provided an overview of the current fiscal condition of the state's Medicaid program and the entire department. (EXHIBIT #5)

Sen. Johnson about what approach the Department was going to take to remedy the shortfall. Mr. Chappius said that the Department will begin by looking within the programs themselves to find ways to remedy the situation; and where money is available, the Department may be able to transfer funds between the Divisions.

Sen. O'Neil if it was a normal procedure for the Department's budget to be in the red in the first year of the biennium and made up in the second year of the biennium. Mr. Chappius said no, but that the Department did not anticipate the substantial increase in caseload. In addition, the problem with Medicaid is that once it is started, problems continue to exist in the second year of the biennium because it is very difficult for the second year to pay off the first year.

Rep. Price asked about the potential deficit in the Child Support Enforcement Division. Mr. Chappius said that the federal government had an incentive grant and the primary rules in place that showed that Montana would receive a much larger grant. Several factors changed. In order for states to participate in the incentive grants, they must pass audits. Montana had very good program in terms of numbers of errors within the program. When amount of money that the Division takes in versus the entire nation as the denominator of those states that could participate was the percentage of the incentive. Larger states have joined into the denominator resulting in Montana's set amount of incentive grant funds being reduced.

Sen. Johnson said that the deficit in the Director's Office was due to an accounting change. If an accounting change is made, it should have been budgeted for somewhere else in the budget. He asked where. Mr. Chappius said that it was budgeted for in the various other Divisions of the Department and the money must be transferred to the Director's Office to cover the deficit. Sen. Johnson asked if the liability was a potential or a real liability that exists. Mr. Chappius that the liability is currently potential. There will be some liability but the exact amount will not be known for at least two years. Sen. Johnson suggested a further update at the February meeting because he felt that the Subcommittee could not make decisions without the correct numbers.

Rep. McKenney asked about the increase in caseloads. Mr. Chappius said that some of the ways that eligibility, particularly for the Disabilities Services Division, is determined for Social Security have been changed. It is getting people on the rolls faster and more people are recognized as being disabled under the Social Security rules.

Bob Olson, Montana Hospital Association, said that the Department is going to begin a process that the Subcommittee should pay attention to. There are a substantial new number of people who non-titled under Montana statutes and federal regulations for medical care. The state has not appropriated enough money to pay for the services that they are currently using. If these people are deleted from the system and if eligibility standards are changed, they come back to the Legislature as uninsured people who continue to have medical care delivered but who no longer have a payer. If the Department cuts the amounts that they pay hospitals, doctors, and pharmacists, etc., the costs are not eliminated just the revenues for those services. Providers

must then figure out who will pay those costs. Governor Martz also has an incredible number of requests for dollars that could be put into human services. However, by not putting those dollars in, Montana will not only lose the $4.5 million in general fund but will lose the federal funds also, which makes the tab approximately $10 million. He said that collectively hospitals in Montana have lost $32 million in patient care in the year 2000 and had to first, find out how to make up those dollars in order to cover their cost which came from non-operating activities and investment income. Mr. Olson provided a copy of Health Care At-A-Glance: A Statistical Profile of Montana's Health Care Environment. (EXHIBIT #6)

Sen. Ellingson said that St. Patricks Hospital has had a surplus over the last 10 years even though people do not pay for what they are billed. Mr. Olson said that hospitals located in larger communities have been far more able to profits because they have less exposure to public programs and more options to balance their losses. What the Association sees coming is that the state, the federal government, the private payers, and citizens want to pay less. To the degree that they can, they will. However, they are moving the other way on costs. Smaller rural hospitals are making it on depreciation.

Rep. Matthews asked how may hospitals were making money in Montana and are they located exclusively in the larger cities. Mr. Olson said that 12 communities that have hospitals of considerable size and fiscal strength. Communities having hospitals with 50 beds and less have ever-changing fortunes of war. The smaller the facility the more dependent they are on Medicare and Medicaid as a source of funding. On the bottom end of the spectrum, critical access hospitals get paid their costs from Medicare and Medicaid and are better able to cover their costs but they have no pay source to create a profit. Mr. Olson added that hospitals have not been raising charges; they have been managing their charges. As health care spending increases, it is not the same thing as health care charges increasing.

Rep. Schmidt asked where Mr. Olson felt the funds to cover the Department's cost overruns should come from. Mr. Olson said that if states entitles people, states should pay for the entitlement that is granted. This does not translate well into tax policy in Montana. He said that the Coal Tax Trust Fund is always a center of controversy because there is $440 million in a fund that is working for the state. If Montana were to maximize its Medicaid budget, it could spend $400 million every year. However, Montana must have the wherewithal to raise the state's share which is where the problem lies. The Association, along with the Department and Governor, are looking at possible ways to get additional general fund and additional state match. It becomes a very political issue.

Rep. Price asked Mr. Olson to address how hospitals are forming purchasing groups. Mr. Olson said that hospitals, because they have a closed or restricted formulary within the hospitals, they are not faced with the problem of a wide-open formulary. Hospitals are buying drugs packaged in large quantities and it is easier for to contract and to drive discounts and prices. Many hospitals, through purchasing arrangements, have been able to cut deals and drive the costs of pharmaceuticals down far below what community pharmacies can. However, it cannot be translated into saving for the consumer because it violates the Robinson-Patman Act (hospitals cannot distribute drugs or prescriptions into the community).

PROVIDER REIMBURSEMENT RATES

Medicaid

Maggie Bullock, Administrator, Health Policy Division, said that dentists received a 19.8% rate increase; ambulance drivers, a 30% increase because their wages are so low; physicians, a 1.5% increase; and hospitals received a minimal rate increase.

Workers' Compensation

Jerry Keck, Employment Relations Division, Department of Labor and Industry, said that the Department is charged with establishing provider reimbursement rates in hospital and non-hospital medical fees. Provider reimbursement rates are grounded. The general principle of the provider rates in workers' compensation was put in place in the late 1980s--the rate of increase and reimbursement for both hospital and non-hospital charges should not be any greater than the increase in the state's average weekly wage. In 1997, the MHA brought forth a concern that inflation had occurred so rapidly in the hospital arena that the Legislature agreed to a 1-time adjustment to the hospital reimbursement discount factor so that no hospital would receive less that 69% of their usual and customary charge. In 1993, the DPHHS established a fee schedule that kept revenue neutral the amount of payment in workers' compensation paid to all non-hospital providers. Every year since that time, the Legislature has increased the reimbursement, conversion-factor rates for all non-hospital providers by the average rate of the increase of the state's average weekly wage. In addition, under workers' compensation, prescription drugs must be billed as generic prescription drugs, if available. Providers are reimbursed at the average wholesale price plus a dispensing fee of no more than $5.50. All non-durable medical goods and supplies are reimbursed at a rate that would not have a profit margin of greater than 30%. They are reimbursed at 30% of the cost including freight up to a maximum of $30 per item.

Private Payers

Tanya Ask, BCBSMT, provided an overview of BCBSMT's provider reimbursement rates from private payers (EXHIBIT #7), a copy of the BCBSM's Provider Network Listing (EXHIBIT #8), and several copies of BCBSMT's newsletter for health care providers. (EXHIBITS #9 through #12 respectively)

Sen. Ellingson asked if BCBSMT's negotiated provider rates. Ms. Ask said that BCBSMT negotiates provider rates within its Managed Care Book of Business. Currently, this amounts to approximately 9% of the overall BCBSMT business. On the traditional business, which is the majority of what it does, it has some hospitals that have agreed to negotiate joint arrangements on behalf of BCBSMT's beneficiaries. On the professional side, BCBSMT has set an allowance or fee schedule. In order to set allowance on the medical side, it uses the resource base relative value system (RBRVS) which is a good methodology to use for reimbursing. BCBSMT sets a schedule so that professionals know that for specific medical service, they will be reimbursed a specific amount. Sen. Ellingson asked if the medical providers with which BCBSMT has contracts with agreed to provide services at a discount. If a person is uninsured, the person would be paying the full amount. Ms. Ask said that the providers agree to accept the allowance or their bill charge if the bill charge is less that the allowance. If a person does not have health insurance, medical professionals will frequently negotiate with them and accept something less than their bill charges for providing a service. In addition, there are time when the bill is written off completely.

Sen. Ellingson asked about the relationship between Medicaid and workers compensation reimbursement rates and the cost of medical insurance and health care for Montanans who do

not have medical insurance. Ms. Ask said that there are fixed costs built into medical facilities or a provider offices that need to be covered. The reimbursement rate for providing medical care may be lower than the actual cost to the facility or professional. If it is lower, hospitals and professionals must still pay those fixed costs which are shifted onto the rest of the paying population.

Mr. Olson MHA, said that the Medicaid program last calibrated its rates paid to hospitals for inpatient care to produce payments that were equal to 88% of their costs several years ago. The Legislature has not updated those payment rates to keep pace with inflation. The Association believes that hospitals receives approximately 82% of the costs to deliver medical care for Medicaid recipients. According to a survey from the federal MedPack Committee--the group that advises the federal government on Medicare policy--private paying patients in Montana are paying 125% of the true cost of care to compensate for the federal and state programs that pay less than the cost of care, which is the cost shift.

Rep. Schmidt asked if the BCBSMT special programs had the same reimbursement rates. Ms. Ask said no, that the CHIP and the Caring Program for Children receive a 10% or 15% discount from bill charges for care received from hospitals. FEP and Champus are federal program that have more negotiated rates based on discounts. Because they are federal program, there are certain criteria in order to participate that all carriers must comply with. Bluecare is designed to cover uninsured adults who are at or below 150% of poverty. The idea behind the program is to pay hospitals their cost for providing health care so that the costs are not shifted to the rest of the population.

Rep. Thomas asked for information on the total reimbursement rate increase received by dentists, ambulance drivers, physicians, and hospitals and information on the overhead costs compared to the reimbursement rates of each category. Ms. Bullock said that she would provide the figure to the Subcommittee, if possible.

Sen. Ellingson asked if neighboring state had different rates of Medicaid reimbursement than Montana, how did it impact them if they had higher reimbursement rates, and did it helped lower hospital costs. Mr. Olson said that Montana ranks well with other state Medicaid programs. State Medicaid programs nationwide have trouble covering costs. Because every state sets its own Medicaid policies and prices, there is a wide variety of rates.

STATUS OF CERTIFICATE OF NEED

Roy Kemp, Administrator, Quality Assurance Division, DPHHS, provided an overview of the certificate of need (CON) program and its goals and objectives. (EXHIBIT #13)

Rep. Schmidt asked about changes made in the 2001 Session to the certificate of need program. Mr. Kemp said that changes were made to the requirement that an ambulatory surgery center seek a CON review. If a county had a population of less than 20,000, a CON review was needed. If in a county had a population over 20,000, it was not needed. He said that the purpose of a CON program was to contain costs and to not duplicate services.

Rep. Lawson suggested an inventory of medical services be conducted in Montana (i.e. doctors, specialists, nurses, therapists, the services available, the charges and costs of those services, the need and reason to leave a local area or the state for services, the utilization and duplication

of services, and the costs of services. He felt that it would be helpful for the Subcommittee in its decisionmaking process.

Sen. O'Neil about the costs between the 38 states that use CONs compared to the remaining states that do not use CONs. Mr. Kemp will provide the information to the Subcommittee. He said that the 38 states may have a variety of different approaches to CONs. They may regulate one entity or them may regulate all entity or they may regulate them by a dollar threshold.

Rep. Matthews asked if the Department denied Silver Bow County's home health agencies CON. Mr. Kemp said that the CON was granted but a competing entity did not want the competition.

Rep. Price asked why state facilities, such as the nursing home in Lewistown, are not included. Mr. Kemp said that state facilities are exempt from CONs and he was unsure about the admission practices of a private facility versus a state facility. He will research the issue and provide the information to the Subcommittee.

DISCUSSION ON CREATING HEALTH CARE OMBUDSMAN

Rep. Lawson said that an ombudsman is a government official who investigates citizens complaints. He was interested in the idea of a clearing house for information related to health care and an advocate for consumer interests. He said that there were many health programs that were unknown and he was convinced that many people did not know where to go to acquire health insurance, for example . He requested that the Subcommittee consider a central source to provide this information because he felt it would be useful in achieving the goals of the Subcommittee.

Claudia Clifford, Office of the Commissioner of Insurance, said that the Commissioner's Insurance Department has 40 employees, 8 of which are devoted to handle consumer complaints. Of the 35,000 calls received in a year, 40% are related to health insurance. The Office is able to take care of claim disputes and it often asks consumers if they have exhausted other means by appealing to companies. In terms of complaints that deal with decisions made by insurance companies, particularly managed care companies, on whether or not to pay for a procedure, there is a peer review system through DPHHS set up to appeal medical determinations. She said that there is a great need for more health insurance and health care information and she supported the intent of Rep. Lawson's idea.

Bob Olson MHA, said a medical resource inventory project was undertaken several years ago by the Montana Health Care Authority. The Authority has since been disbanded and he was unsure if anyone remained in the DPHHS who knew whether the document still exists. The Authority was replaced by the Health Care Advisory Council. One of the last projects put forward by the Council was to create a health information network. The proposal was considered in 1997 Legislature. Although it was tabled in the House Human Services Committee, the materials may be available, and both documents could be resources for the Subcommittee to review.
Bonnie Adee, Mental Health Ombudsman, said that there is clearly a role for investigation of complaints and making recommendations about public policy and decisions. However, she was unsure whether Rep. Lawson's idea was the model necessary to meet the needs. She said that the Insurance Commissioner's Office and the Offices of Public Assistance available in each

county under DPHHS are good resources for information regarding public services including Medicaid.

Mary Noel, Health Policy and Services Division, DPHHS, said that the Division has a function that provides many of the ideas suggested by Rep. Lawson. It focus is on on low-income families but the same concept could apply to other areas or the function could expand. The Division is very knowledgeable about individual community programs that are available.

Rep. Schmidt asked about the proposal introduced by the Montana Health Care Authority. Ms. Clifford said that the Health Care Authority was proposing a much more comprehensive data base of information not necessarily a consumer resource entity. Rep. Schmidt asked if Rep. Lawson wanted a PSC for health care. Rep. Lawson said that he would not exclude the idea.

MENTAL HEALTH ANNUAL REPORT

Bonnie Adee, Mental Health Ombudsman, provided an overview of the newspaper version of the Mental Health Ombudsman Report. (EXHIBIT #14) She suggested that the Subcommittee receive the document handed out at the HJR1 Subcommittee meeting. In summary, Ms. Adee stated that at some point, the state will have to deal with the results of not getting the proper mental health treatments. She said that the results of not receiving proper mental health treatment are cost shifts, loss of school days and productivity, and people using the back door approach, such as the criminal justice system and being charged with medical neglect, which in the end become more costly.

Rep. Lawson asked about the volume of mental health inquiries and the resources available to Ms. Adee had to call upon. Ms. Adee said that the Office has a data base that tracks all contacts annually. Last year, there were 433 contacts which represent everything from a single phone call to a complex investigation that resulted in an investigative report. The Office also tracks outcomes to the point of which her Office finishes the case. Her Office refers to any person who has responsibility or authority to assist a person with mental health needs. These include the Insurance Commissioner, many in the DPHHS, the federal system, and other advocates, such as the Board of Visitors and the Montana Advocacy Program.

Rep. Galvin-Halcro asked if the mental health information provided by the Mental Health Ombudsman's Office include information on programs related to attention deficit disorder (ADD) and attention deficit and hyperactivy disorder (ADHD). Ms. Adee said that eligibility for the non-Medicaid portion is diagnosis driven. A youth under Medicaid who has a medical necessity or need will receive services. However, in a state funded, non-Medicaid youth with ADHD would not be covered unless it is a secondary diagnosis to a primary mental health diagnosis.

UPDATE ON INSURANCE COMMISSIONER'S HEALTH INSURANCE ROUNDTABLE DISCUSSIONS

Claudia Clifford, Office of the Insurance Commissioner, provided a copy of the questionnaire used for by the Office of the Insurance Commissioner's statewide roundtable discussions on health care and health insurance. (EXHIBIT # 15) She said that 5 of 8 meetings have been held statewide. Concerns, possible solution, and possible funding sources brought forward from those meetings are as follows:

- **Concerns:**

- the affordability of health care coverage and the high cost of medical services and health insurance;
- consumers are not involved enough in the cost and utilization of health care, primarily focused on the lack of information;
- cost shifting–providers focus on cost shifting from the Medicaid reimbursement rates to the cost shifting of uninsured.
- the overuse of emergency services and lack of access to affordable primary care;
- small employers and individual coverages is too expensive;
- public employee groups, particularly smaller schools, are struggling to find affordable coverage;
- not enough insurance companies in Montana;
- the health care systems was to complicated, particularly the Medicaid system;
- too many mandated insurance benefits; and
- the lack of providers and the expense of infrastructure.

- **Possible Solutions Offered:**
  - a universal or socialized system of health care;
  - repeal of all government involvement with the health care system;
  - maximize federal funds to expand programs such as CHIP and Medicaid;
  - prioritize services that public programs pay for;
  - access to larger purchasing arrangements for prescription drugs and coverage;
  - more consumer information on costs and helping consumers manage expensive diseases;
  - tax credits;
  - a low-cost basic health plan which would be available to all citizens ;
  - community-based preventive and primary care programs;
  - a state goal or policy for coverage for everyone;
  - mandatory catastrophic coverage for everyone; and
  - state assurance that insurers cover very large losses.

  - **Possible Funding sources:**
  - more grants and federal funds;
  - using more of the tobacco settlement funds;
  - tobacco taxes;
  - income tax surcharge; and
  - the use of lottery funds.

Rep. Schmidt asked if medical savings accounts were discussed. Ms. Clifford said the flex-account mechanism is a pre-tax dollar, use-it-or-lose-it type of account. A medical savings account (MSA) is not use-it-or-lose it system. It is an ongoing savings account administered through a bank or savings institution and more difficult for insurance agents to set people up with because of the technicalities of the system. Rep. Schmidt if unspent flex-account funds could be over into CHIP. **Joyce Brown, Administrator, State Employee Benefit Plan, Department of Administration**, said that the unspent funs reverts back to a reserve fund and is used to pay claims. It is also used to offset losses.

Rep. Lawson asked about the number of people who do not use their entire flex account. Ms. Brown said there are a few people who do not use their entire accounts. However, the usually find ways to spend it.

FEDERAL INITIATIVES AFFECTING STATE AND SUBCOMMITTEE ACTIVITIES

Gordy Higgins, Research Analyst, Legislative Services Division, discussed the status of the congressional economic stimulus proposals affecting health care and health insurance. (EXHIBIT #16) More information will be provided at the February Subcommittee meeting.

PUBLIC COMMENT

Clyde Dailey, Associate State Director, AARP of Montana, said that there are135,000 AARP members in Montana. AARP has been holding nationwide focus groups on health care and prescription drugs issues. One clear message of the focus group was that AARP members expect the leaders of the country to move forward on certain domestic issues even though they understand that there is less money available. AARP membership begins at age 50. The age 50 to 65 year olds are very often those who do not have a safety net. If they cannot get insurance, if they lose their jobs, or if they are unable to be covered under the portability plans, AARP and the Commissioner of Insurance receive the calls. Mr. Dailey offered AARP of Montana as a Subcommittee resource.

INSTRUCTIONS TO STAFF AND ADJOURNMENT

The Subcommittee's next meeting will be held on February 14, 2002; and Rep. McKenney requested that members give serious thought to the direction in which it wants to go.

Agenda items will include the following:

- a budget report from Chuck Swysgood, Director, Office of Budget and Program Planning and any other agency regarding available funds that could be used as accessibility to health care and increasing costs;
- an update from Insurance Commissioner Morrison;
- a laundry list of possibilities, including purchasing pools, a mental health ombudsman, tax credits, prescription drug plans, the cost of mandated benefits, market incentives, expansion of existing programs, and federal funding; and
- information on the previous activities of the former Montana Health Care Advisory Council and the present Health Care Authority.

Some discussion was given to the possibility of a 2-day meeting in February, but the Subcommittee decided that a 2-day meeting was unnecessary in February but that one could be needed at a subsequent meeting if it becomes apparent.

There being no further business, the meeting adjourned at 4:15 p.m.

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