MINUTES

MONTANA SENATE
58th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN JERRY O'NEIL,** on January 17, 2003 at 3 P.M., in Room 317-A Capitol.

ROLL CALL

Members Present:
Sen. Jerry O'Neil, Chairman (R)
Sen. Duane Grimes, Vice Chairman (R)
Sen. John C. Bohlinger (R)
Sen. John Esp (R)
Sen. Dan Harrington (D)
Sen. Emily Stonington (D)

Members Excused: Sen. Bob DePratu (R)
Sen. Brent R. Cromley (D)
Sen. Trudi Schmidt (D)

Members Absent: None.

Staff Present: Dave Bohyer, Legislative Branch
Andrea Gustafson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing(s) & Date(s) Posted: SB 111, 12/20/2002; SB 148, 12/30/2002
Executive Action:

HEARING ON SB 111

Sponsor: SEN. LINDA NELSON, SD 49, Medicine Lake

Proponents: Claudia Clifford, State Auditor
Mickey Matule, Butte
Aidan Myhre, Montana Comprehensive Health Association, (MCHA)

Chuck Notbohm, American Association of Retired Persons, (AARP)

Opponents: None.

Opening Statement by Sponsor:

SEN. LINDA NELSON, SD 49, Medicine Lake, handed in written testimony **EXHIBIT(phs10a01).**

Proponents' Testimony:

Claudia Clifford, State Auditor's Office, handed out a fact sheet showing a schedule of premiums for the Montana Comprehensive Health Association's Traditional Plan **EXHIBIT(phs10a02).** MCHA is a high risk pool of people who are having a hard time getting coverage. She comes with SB 111, which would address the issue of people who have very expensive individual insurance, who may have access to the MCHA program. The bill sets up criteria saying, if a person is paying 150% more for insurance than a healthy person is paying for similar insurance, he could get onto the high risk pool. The insurance premiums cannot be one dollar more than MCHA to be accepted in the program. Examples of consumers who contacted the state auditor's office were given, found on the bottom of exhibit 1. In exhibit 2, **Ms. Clifford** explained the first column was the age, the second column was the MCHA premium, and the last column was the minimum being paid to the individual insurance, to qualify for MCHA. It is still expensive insurance, but does give a little bit of a price break. The program is funded through the consumers premiums and through assessments on insurers.

Mickey Matule, Self, said her daughter was diagnosed with cancer. The premiums went from $480 to $1702 a month. She said her family only made approximately $3000 a month. She said her family would benefit if her daughter could be accepted into the MCHA program.

Aidan Myhre, MCHA, said MCHA had two separate plans. The traditional plan is for people who cannot get insurance on the private market, such as those with pre-existing conditions. The other plan is the portability plan designed for people who leave a group covered plan. **Ms. Myhre** said MCHA was governed by a board of directors, one consumer member, and six representatives from insurance carriers that do business in Montana. The insurance carriers range from Blue Cross Blue Shield to Mutual of Omaha bringing their expertise to the board and work with the Insurance Commissioner as well. Together they define policies and promote a good healthy plan. The board members' companies

subsidize the plan by 2.5 million dollars a year. The board has worked hard with the Insurance Commissioner on this issue and does not have any objections to SB 111.

Chuck Notbohm, AARP, handed in written testimony in support of SB 111 **EXHIBIT(phs10a03).**

Opponents' Testimony: None.

Informational Testimony: None.

Questions from Committee Members and Responses:

SEN. CROMLEY asked **Ms. Myhre** for some background information of the persons applying for MCHA. **Ms. Myhre** said there are two separate groups. The first one is the Traditional Plan that includes those, who may have had insurance, dropped it, and have a health problem that has prevented them from obtaining it in the individual market. Or, they may never have had insurance. They are individuals that have a pre-existing condition, who if they were to go look for it on the market, would not find anyone who would insure them. The second plan is the Portability Plan. It is designed for those who do have insurance, who are leaving it and have a place to go. An example would be someone who sells his business and is too young to go onto Medicare. Another reason is that a person left a group health insurance plan.

SEN. ESP referred to page one of the bill where it defines eligibility and asked what **Ms. Myhre's** understanding of it was in laymen's terms. **Ms. Myhre** said it was an individual who is currently insured and has a very high premium. The eligibility standard for MCHA right now is for the individual who had coverage and left it. Then they have an opportunity to come into the MCHA plan. This is applied to those with pre-existing conditions or they are on an old plan and have such high premiums that go up to levels much higher than the normal standard. In other words, they are paying 150% above what the average is.

SEN. ESP asked what coverage consisting solely of accepted benefits means. **Christina Goe,** an attorney with the Auditor's Office, said it meant they have a policy that is major medical. It may be a cancer or accidental policy. There is a list of approximately ten of those who would not qualify as a person who has other insurance. They would not be excluded because they had for example, an accidental policy or a cancer policy.

SEN. ESP asked if this outlined further statute of this program beyond the one talked about. **Ms. Goe** said no, it was a clarification.

SEN. HARRINGTON referred to exhibit two, asking if they were the premiums that would go in effect if the bill were to be passed. **Ms. Clifford** said yes, the premiums would stay relative to the cost on the market.

SEN. O'NEIL asked for clarification on how the program is funded. **Ms. Clifford** said there is no general funding. Premiums generally pay for 60% of the policy. The insurance assessments pay 40%. It varies depending on what MCHA is charging and what the market is.

SEN. O'NEIL wanted to know what the average cost is for a premium. **Ms. Clifford** said that answering it was difficult. MCHA does not collect information on what individuals are paying for insurance. In the insurance department, they only have information about the financial condition of carriers.

SEN. O'NEIL asked if passing SB 111 was going to add a price to the insurance policy to the non-comprehensive health care policy. **Ms. Clifford** said no, the program is self funded and bases its rates in comparison to the market. Information is collected from the five top carriers in the market to set what they are charging for a similar product. Then they rate it up because an unhealthy person would pay more than a healthy person. The program would not affect the rate a person would pay out in the commercial market.

SEN. O'NEIL asked if it were assessed upon insurance companies in Montana. **Ms. Clifford** said yes, that assessment cost is tacked onto the consumers of the business. The assessments are capped. She did not think the bill would affect the assessments. She said it would help a few people. It will not help hundreds of people, but for the cases of those who end with the high cost, they will benefit.

SEN. O'NEIL asked how much the assessment cap was. **Ms. Clifford** said it was 1% of the carriers' income for the year.

SEN. ESP asked if the 2.5 million the highest the insurance companies could go with the caps in place. **Ms. Clifford** said right now 1% of carriers premiums are providing approximately five million dollars a year to the program from all the various carriers to the state.

{Tape: 1; Side: A}

SEN. O'NEIL wanted to know if the program is costing them another 2.5 million above what the people who are receiving this insurance are paying. **Ms. Clifford** said that was correct. She

explained, by paying this money and these carriers do not have to insure them. What it does is pool all these higher risk people together, so the carriers are contributing to help provide insurance for them. As a trade off, they get to help underwrite the market.

Closing by Sponsor:

SEN. LINDA NELSON, SD 49, Medicine Lake, said this was a good compromise bill. She applauded the board of the insurance commissioner's for going along with this to help people out. She said this bill would not break the bank. Neither will it bring in hoards of people, but it will stop some people from going bankrupt.

HEARING ON SB 148

Sponsor: SEN. CAROLYN SQUIRES, SD 34, Missoula

Proponents: Angela Huschka, State Auditor's Office
Chris Blackmore, Bozeman
Chuck Notbohm, AARP
Raymond Berg, MT Nurses Association

Opponents: Tanya Ask, Blue Cross Blue Shield
Denise Pizzini, New West Health Services
Greg Van Horssen, State Farm Insurance Company
John Metropolis, Farmer's Insurance, National Association of Independent Insurers

Opening Statement by Sponsor:

SEN. CAROLYN SQUIRES, SD 34, Missoula, gave written testimony **EXHIBIT(phs10a04).**

Proponents' Testimony:

Angela Huschka, State Auditor's Office, passed out three letters from consumers who voiced their support for SB 148 and shared their personal experience with the insurance industry**EXHIBIT(phs10a05).**
She stated that UCR, Usual and Customary Rate, is still new. Insurance companies, with the help of specialists in the market, compile data from medical providers, hospitals, clinics, radiologists, based up on procedural technology codes, called CPT codes. These codes are universally used throughout the health industry. These costs are put in a database, which is used to

decide the UCR. Consumers are billed for additional charges based on the UCR, over and beyond their deductible and copay. The costs may not be geographically specific to their area, where the services are being provided. Part one of this bill address existing law. The change being made in part one is to make the information more visible to the consumer at the time of application. Currently, what the insurance companies is being asked to provide is not changing. What they are being asked, is to provide it at the time of application on coverage statements. This is so the consumer will know up front there may be additional charges. This is especially for those buying a product in a network provider situation, and need to go outside the network. Part three of SB 148 requires insurers to use the UCR consistently and to use one UCR for each product. Part four of SB 148 requires the insurer to provide the Auditor's Office with calculations and payments of UCR. This is so staff in the Auditor's Office can help consumers. **Ms. Huschka** said her office understood that information may be considered proprietary, and are not asking for the insurer to reveal that information to the consumer, but to her office, to help consumers that contact them. She affirmed that her office would treat that information as confidential to the extent the Montana constitution allows. Part five further defines UCR in relation to other similar terms being used in the marketplace. In summary, she said this bill required insurers to inform consumers about UCR.

Chris Blackmore, Self, handed in written testimony **EXHIBIT(phs10a06).**

Chuck Nothbohm, AARP, handed in written testimony **EXHIBIT(phs10a07).**

Raymond Berg, MT Nurses Association, said the MT Nurses Association rose in support of SB 148. He said the cumbersome process of interpreting the language of insurance polices can often lead to unpleasant, unknown outcome, especially when explaining charges. The new language in SB 148 helps the individual know what they are purchasing at what price. It will insure honesty. Furthermore, a standard to be consistently applied to set charges, will insure fairness. SB 148 asks the insurer to provide information requested by the commissioner that would insure justice. In short, the MT Nurses Association say SB 148 helps patients, aids making insurance policies consumer friendly, and clarifies cost of coverage.

Opponents' Testimony:

Tanya Ask, BCBSMT, first pointed out if this bill were to be applied to Medicare/Medicaid they would be prohibited from paying

the way they are currently paying because they use more than one UCR in their credit reimbursements. **Ms. Ask** said it is a serious consideration. She went through the bill section by section pointing out the problems. The first concern was on page 1 line 21 where it states ". . . and conspicuously display any document summarizing coverage . . .". She then handed out a summary of benefits for two different plans BCBS submit to individuals for marketing, Value Blue **EXHIBIT(phs10a08)** and Security Plan **EXHIBIT(phs10a09)**. These are summaries given when an individual first gets the information on an insurance plan. On both of them, half way down the front, there is already the disclosure that the bill is referring to. She said BCBSMT agreed that disclosures be supplied for reimbursement differences between network and non-network. She also agreed that it should be told if a consumer were to have additional out of pocket costs for going to a non-network provider. She said this too, is also shown in their summary of benefits in the two plans passed out. **Ms. Ask** then handed out their definition from BCBS's current contracts **EXHIBIT(phs10a10)**. BCBS does not use language such as UCR, Usual, Customary, Reasonable, nor do they use the other things that are currently included in the general definitions. She explained BCBS uses several different reimbursement methodologies to pay claims. This is in part because claims, as they are submitted, come in different ways. Hospitals do not bill the same way physicians bill. Nor do hospitals pay the same way a pharmacy claim will come in. There are many claim submissions by providers and there are many commonly accepted uniform coding methodologies that also lead to the possibility of different reimbursements, different allowables. Medical professionals can bill two different ways. Reference was made to Current Procedural Terminology, CPT. Not all claims come in with a CPT code because those codes come in only from physicians or other medical professionals. CPT's do not come in from hospital services. In addition, coding will also come in using HCPCS, Healthcare Common Procedure Coding System.

Ms. Ask passed around both a CPT book and HCPCS book, both about 2-3 inches thick, for the committee members to see. She acknowledged that finding common terminology is difficult. Medicaid and Medicare use Resource Based Relative Value, RBRV, which is recognized by the insurance department and an acceptable method for paying an insurance claim. RBRV is not built by subsection B's old definition. It was built by a group of professionals HCFA contracted with. HCFA being the predecessor of CMS, which currently administers the Medicare/Medicaid programs for the federal government. CMS decided to have a universal reimbursement for Medicare programs for all Medicare beneficiaries around the United States. That kind of reimbursement came only from physician services and only for the physician services included in the CPT code book. If the

physician service or another professional service is included in this book, they have a different payment methodology. It is not predicated by a "database." **Ms. Ask** went on to say there has been a series of studies done by the Harvard School of Public Health that helped develop this reimbursement methodology. She acknowledged it may have a few kinks in it, but it is one that is used nationally. The reason she pointed this out was it creates a problem when looking at section 3, page 2 of the bill. This states an insurer may only use one type of UCR for a particular insurance product. She pointed out BCBS uses the same reimbursement methodology for all physicians, despite a product they sell. It is not the same methodology used for prescription drugs or for hospitals. If Medicare/Medicaid were to be subject to this code, they would be in violation, because they use two or more methodologies for their programs. Medicare and Medicaid pay hospitals according to a DRG. They pay physicians according to the RBRV scheme that was mentioned earlier. They may have other reimbursements for other types of medical services. This bill would require BCBS to move off National standards. The reimbursement methods put in place and BCBS network of providers have saved consumers millions and millions of dollars. By moving this bill, it would require insurance agencies to do away with what is accepted by and developed by the federal government, for reimbursing physicians, hospitals, and prescription drugs. Those are just three of the services that are vastly different in their reimbursement. SB 148 would add to the cost of the insurance. It will have a tremendous impact on how claims are paid and what companies can do. **Ms. Ask** also said, providing a summary of every detail at the time of application, before an individual has accepted the policy is problematic. She did not think this bill will make the consumer more insured. She urged the committee not to pass SB 148.

Denise Pizzini, New West Health Services, MT Benefits and Health Connections, confirmed everything Tanya Ask stated in her testimony.

Greg Van Horssen, State Farm Insurance, said State Farm had MedPay coverage provisions in their auto policy. This bill would cover their auto policies, their auto insurers, and claims in Montana. Mr. Van Horssen expressed concern for the potential increases in cost for their product if SB 148 were to pass.

This bill would require changes in State Farm's auto policy in the state of Montana. He said any time that happens, it requires expenditures, which are passed along in increased premiums. **Mr. Van Horssen's** concern was any increase in auto insurance would result in more uninsured motorists. He asked to consider tabling

this bill based on the concerns of the health insurers and State Farm's concerns.

John Metroplis, Farmer's Insurance, National Association of Individual Insurers, said his clients were concerned about this bill for the same reasons **Mr. Van Horssen** described. He said in the end it may make some insurance difficult to get, driving costs up.

Jacqueline Lenmark, American Insurance Association, opposed SB 148 for the same reasons as **Mr. Van Horssen.** She said AIA rose against the bill for another reason. She said this bill represented a very large step away from national uniformity. Every time a step is taken away from nation uniformity, costs increase. We have plain English requirements in Montana Code already in place. Those statutes are contained in Title 33, Chapter 15. They are specific to health insurance policies and require any policy filed with the department meet certain level of understandability for the consumer.

Lori Ferrin, Payne Financial Group, had concerns with section two where it says information needed to be provided at the time of application. She works with businesses who have many employees and wondered if she would be required to sit with every individual when selling group insurance, before it is submitted. She wondered what the time line would be for insurance agents to go through before insurance could be issued. **Ms. Ferrin's** other concern was from a consumer standpoint, regarding cost. She said consumers needed to take responsibility and be part of the equation, by asking pointed questions what costs are going to be, not let the insurance company be solely responsible in getting the information to the consumer.

{Tape: 2; Side: A}

Informational Testimony: None.

Questions from Committee Members and Responses:

SEN. CROMLEY wanted to know if the auto insurance was paid with the medical bills, and is it looked at as usual and customary rate. **Mr. Van Horssen** said the auto insurers generally paid medical expense, however, the SB 148 covers MedPay, which is included in the policy. He said even though auto insurers have a different standard, it will affect their product and documents.

SEN. CROMLEY asked **Mr. Van Horssen** what additional information would he have to supply and where would that requirement come from in the bill. **Mr. Van Horssen** said the people in his company said it would require potential changes to summary documents and conspicuous language as referred to in the bill.

SEN. CROMLEY pointed out disclosure was required only if the payments are going to be based on UCR costs. The insurance moneys paid by an auto insurer are not based upon the UCR costs, are they. **Mr. Van Horssen** said with the information he received in response to this bill from his company, the UCR terms are used to describe the coverage in their policies. They are terms that exist in the MedPay policies.

SEN. CROMLEY said if it were possible, he would like to see the language about which he was talking. **Mr. Van Horssen** said he would be glad to find and itemize those concerns.

SEN. CROMLEY asked **Ms. Huschka** if the concern were with just PPO situations or was this bill designed to address more universal insurance coverage. **Ms. Huschka** said most of the complaints came from consumers who do not have a PPO type of arrangement or have to go outside the network.

SEN. BOHLINGER asked what **Ms. Huschka's** assessment was of the opponents claim the bill would increase insurance costs. **Ms. Huschka** said the bill was an information bill and consumers need to know there are additional costs. It is not the intent to raise insurance costs. The Auditor's Office was required to address the concerns of the uninsured in Montana. If the insurance industry feels the language in part three, requiring a carrier to only use a particular standard per product would raise costs, she would be happy to visit with them about that. She said she would be interested in hearing from the carriers about the costs involved. She said BCBS did a good job of getting the information out to consumers, but not all carriers do that.

SEN. BOHLINGER wondered if standardizing UCR statewide was possible. **Mr. Berg** said it would be like eating an elephant, one bite at a time. He did not have an answer to that other than to say it does effect the ability of rural providers to stay in business in rural Montana.

SEN. STONINGTON saw two key problems. One was the lack of customers' knowledge of the network vs. the non-network provider system. The second problem was insurance carriers underpaying what is usual, customary, and reasonable charges. Her question was can the insurance commissioner's through statutes bring a 'bad actor' in line. **Ms. Huscka** said there are insurers in the market that perform poorly. Some action can be taken toward the company showing a general business practice. The insurance commissioner's office needs to see many complaints regarding the same company to do something about how they are paying policies. What has been found in dealing with a particular company, was that they were not using UCR that was in line with their geographical area. It was this that the commissioner's office was trying to get at.

SEN. STONINGTON asked how a universal standard would be applied to uniform a non-uniform network in carriers disclosures. **Ms. Huschka** said there may be two problems in SB 148. One, getting information to consumers. Two, how products are priced. She said there may need to be further discussion with the insurance industry on the one standard and was willing to talk about it. Getting the information to the consumer was the highest priority in this bill.

SEN. STONINGTON asked how the insurance commissioner's office would respond to the Medicaid policy that **Ms. Ask** referred to. **Ms. Huschka** said there was no intention of changing the federal law as with this bill. She would like to study the Medicare/Medicaid issue further.

SEN. GRIMES had similar concerns as **SEN. STONINGTON.** He referred to page 2,line eleven, it states the commissioner would get any information. At what point does the information become proprietary? He said he asked this because he believes it takes a great deal of information to find out if an insurer is a "bad actor" or not. **Ms. Huschka** said the information was often proprietary and are sympathetic and willing to keep it confidential in their files, to the extent the constitution allows them to. Any confidential information, used in helping

the consumer with relief to their issue, will not go to the public.

{Tape: 2; Side: B}

SEN. GRIMES talked about the detail the bill requires and asked **Ms. Ask** to speak to that. **Ms. Ask** said the information the department has requested of her company in the past has been provided to them and have worked with them in providing that information. She said anything proprietary had not been disclosed. The basic method used is a nationally recognized method and is available in the public domain. When anything gets into proprietary information, it is not shown. When the department has requested information, BCBS has complied.

SEN. GRIMES asked if it were a concern if the department could get any information necessary. **Ms. Ask** said she did not see much difference in the request now as in the past.

SEN. GRIMES asked if BCBS got inquiries about the difference in costs. **Ms. Ask** said any service in one hospital. or with one physician to another, the charge for that service is going to vary. With either a UCR or as what BCBS does with an allowable, such as a physician's service, they have the same reimbursement for a comparable service. Payment to two different doctors will be the same if they are participating providers with BCBS. If they are nonparticipating providers, the payment will be less to both of those physicians, but payment will be the same.

SEN. GRIMES asked **Ms. Ask** about consumers calling several different hospitals and getting conflicting information. **Ms. Ask** said they have had consumers having trouble with getting correct information because, if the physician or hospital has not seen the patient, they quoted a base price, but charges may vary depending on the individual's needs.

SEN. ESP wanted to know how BCBS determines usual, customary, and reasonable rates. **Ms. Ask** said when BCBS receives a general question about how they reimburse, they try to give them as much information as possible. If he calls and wants to know how much a procedure will cost, they answer by first qualifying the statement by letting them know it is an average price, and that it varies based on the individual's needs. Whether it is network or non-network is another factor that must be figured in as well. In summary, if a customer calls asking a specific question, BCBS answers it.

SEN. O'NEIL wanted to know if this bill would put out a menu out in doctors' offices to see what they would pay for services. **SEN. SQUIRES** said she did not believe it would deviate that much geographically. She said there is no real process. There will not be a laundry list, but it does standardize for the Auditor's Office.

SEN. O'NEIL asked again if there would be a menu in a doctor's office or would it be in the Auditor's Office. **SEN. SQUIRES** said the Auditor's Office would have the UCR base.

SEN. O'NEIL asked if the UCR would be the same in Helena as it is in Billings? **Ms. Huschka** said this bill did not require any menu be provided by the insurance carrier, or the state auditor have a listing, nor every insurance company pay the same amount for example, a hip replacement. All this bill is intended to do is to have one type of standard for a particular service or product and that standard be applied to that insurance company.

SEN. O'NEIL asked if this bill is intended to help him if he goes to the hospital in Polson to either charge or what the insurance will pay? **Ms. Huschka** said the bill did not go that far. This bill is intended to inform consumers there may be additional charges above their deductible and their co-pay. Furthermore, it is to make them aware and to ask their insurer if they have the opportunity before they have a procedure done, what additional charges be incurred.

SEN. O'NEIL clarified that the bill would make the insurance company put a statement in showing this? **Ms. Huschka** said yes.

SEN. O'NEIL stated that if all this bill requires is the insurance company to put a notice in the insurance policy, stating there may be additional charges, why would

BCBS be against it. **Ms. Ask** said that is not all that SB 148 is requiring. She said that it did far more than that. There is already a requirement for disclosure, which is why she handed out the two different summaries, to show it is already being done. What the bill required in a summary is not only to issue notification, but also provide information on how reimbursement is calculated. The bill would require a definition of how reimbursement is calculated such as the one she passed out earlier. Then that definition would not be sufficient according to this bill.

SEN. O'NEIL asked if the bill were to be amended to only require notification, would insurance carriers be happy with that. **Ms. Ask** said yes.

SEN. O'NEIL asked if **Ms. Ask** would be willing to help in crafting such an amendment. **Ms. Ask** said yes, if the intent is to require only the notification. If the department found it acceptable to having it stated clearly on every policy and summary document that there may be a difference, then she would be willing to help in doing that.

Closing by Sponsor:

SEN. CAROLYN SQUIRES, SD 34, Missoula, closed on SB 148.

ADJOURNMENT

Adjournment: 5:10 P.M.

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SEN. JERRY O'NEIL, Chairman

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ANDREA GUSTAFSON, Secretary

JO/AG

EXHIBIT(phs10aad)