MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 10, 1993, at 6:30 p.m.

ROLL CALL

Members Present:
Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: Sen. Hager

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Laura Turman, Committee Secretary

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

Committee Business Summary:
Hearing: SB 285, Questions from the Committee
Executive Action: None.

HEARING ON SB 285

Chairman Eck said this would not be a formal hearing, but the Committee would have the opportunity to ask questions there wasn't time for during the earlier hearing on SB 285.

Questions From Committee Members and Responses:

Sen. Rye said he would like some opinions as to how the health care crisis came about, and why the proponents from the medical community all stressed cost containment. Sen. Rye said the AMA (American Medical Association) previously fought involvement of the federal government, and "socialized medicine." Dr. McMahon, Montana Medical Association, said doctors are not getting richer. His income from Medicare, per case, has dropped 25% under the relative value system which the Association has asked be

incorporated into SB 285 as an amendment. Dr. McMahon said the remuneration procedure has changed, and some procedures have an extremely high remuneration. Now these procedures placed in the high reimbursement level don't occur. Under any reorganization system, there's not a provider who will not see a per procedure decrease in reimbursement.

Sen. Rye said he was implying that there is more self-interest on the part of medical providers in SB 285 than in SB 267. Sen. Rye said this is not a bad thing. Sen. Rye said he would not believe that the medical establishment was acting "purely out of altruism." Dr. McMahon said under a single-payor system that's immediately enacted, the United States has no experience other than the Medicare system, veterans system, and the public health system. Problems which may occur under a single-payor system are that those who are most in need now, the poverty stricken, those who can't afford insurance, will be most affected unless it is defined what will be paid for under this system. Dr. McMahon said there must be concentration on "what we know works," and there must be a system that does not pay for what does not work.

Sen. Rye asked Clyde Dailey to respond to his original question. Mr. Dailey said there are too many reasons to list "what went wrong," but significant factors include new, expensive technology, and a shift in emphasis from general practitioners to specialists. This has increased the cost, but has improved the care. There is a much more fractured system than before. Mr. Dailey said that "you couldn't run a business the way our health care system is being run today."

Chairman Eck said the Committee needs to focus on the facts more than the philosophy of health care reform.

Sen. Christiaens asked Dr. McMahon about elective surgeries being placed on a waiting list in a system such as Canada's. Dr. McMahon said it depends upon how the Health Care Authority establishes the Montana system. In Canada, there is generally a prioritization system of urgent, emergent and electorate. The vast majority of surgeries fall under the electorate category. Dr. McMahon said there are thirteen different Canadian systems and these systems are probably good and cheap, but they are not fast. The American system is good and fast, but not cheap.

Sen. Christiaens asked Dr. McMahon if he foresaw all physicians accepting Medicaid payments as this evolves. Dr. McMahon said he didn't see how physicians could stay in business accepting only Medicaid payments. Physicians' expenses exceed the costs of the Medicaid payments, and that's why their amendment suggests there be recognized an adjustment of insurance companies and patients' payments.

Sen. Christiaens asked Dr. McMahon about costs varying by provider. Dr. McMahon said he was referring to the adjustments in payment by Blue Cross, for example, and Medicaid. A patient

with multiple providers, for example, might pay different bills for different one-hour sessions. Dr. McMahon said there must be something in the system to recognize differences in provider's educational background, and expense differences.

Chairman Eck asked Maureen Testoni from Sen. Max Baucus's office to respond to questions regarding waivers, specifically Maryland establishing waivers that may apply to everyone. Ms. Testoni said that Maryland has a waiver for Medicare and Medicaid which means that they can do what they want with those funds. Maryland has established an "all-payor reimbursement system" for hospitals which means that all payers pay the hospital according to a set fee schedule. Ms. Testoni said this is the language in SB 285.

Chairman Eck asked Ms. Testoni if the state set the fees, and Medicaid and Medicare agree to pay them. Ms. Testoni said that was true, the state sets the fees, but they do it in negotiations with the hospital. Maryland was able to get the waivers because their legislation is "tightly written", and because both Medicare and Medicaid know this is a way to keep hospital expenses from increasing as quickly as they are in other states. Ms. Testoni said regarding an ERISA waiver, Maryland negotiated with the self-insured businesses. Federal law states that a state cannot require businesses to follow a state fee schedule, but because Maryland has such a good system in place, the self-insured business agreed to go along with the rates. Therefore, an ERISA waiver was not needed.

Chairman Eck said they have heard that waivers granted to one state will be granted to other states, and asked Ms. Testoni to what extent that would apply. Ms. Testoni said President Clinton has made it clear that he is committed to making it easier for states to get waivers. However, states will still have requirements that must be met in order to get those waivers, for example, that this is a serious cost-control program.

Sen. Klampe asked Clyde Dailey what provisions in his plan (SB 267) there are for the over-utilization of services. Mr. Dailey said they struggled with "first dollar coverage." Within the Health Care Authority there must be designed the ability for providers to recognize patients who are attempting to over-utilize the system.

Sen. Klampe asked Mr. Dailey if there were no plan so far. Mr. Dailey said the existing plan is to let the Authority look at copayments or premiums as a deterrent for over-utilization. People must contribute something, or there will be a chance of over-utilization.

Sen. Klampe asked Mr. Dailey what procedures would not be covered under his plan, or would every procedure attempt to be covered. Mr. Dailey said cosmetic surgery was specifically eliminated where it wasn't absolutely vital to the patient. The Authority will have the flexibility to leave it to the providers to

designate what they feel are "elective procedures." That's where it must begin.

Sen. Klampe asked Mr. Dailey if there would be "rationing" under his system. Mr. Dailey said there is "rationing by the pocket book" right now.

Sen. Klampe asked Mr. Dailey what Canada had done about the two problems he brought up. Mr. Dailey said patients in Canada wait.

Sen. Towe asked Sen. Franklin about Section 14 in SB 285 regarding the transfer of vital statistics to the Health Commission which was amended out of the bill. Sen. Franklin said the burden of vital statistics was not needed, and did not add anything to the bill providing that there is some coordinating language allowing accessibility to vital statistics as needed.

Sen. Towe asked Sen. Franklin what was the intent of Section 13, what was being accomplished regarding small employer group health insurance. Sen. Franklin said the guiding principles of continuity of coverage, community rating, portability, open enrollment so as not to limit those with preexisting conditions.

Sen. Towe said he had concerns regarding the database in Section 12, Paragraph 7, "the duties of the Authority under this section may not be construed to allow the Authority to use the database to manage a corporate health care facility in a manner that usurps the appropriate powers of the board of directors of the facility." Sen. Franklin said there were concerns about the autonomy of agencies. For example, would the data collection component of SB 285 dictate policy to agencies in terms of how that agency was run.

Sen. Towe asked Sen. Franklin if the reverse were likely to be true, that because of this statement and the prohibition of using the data to interfere with the management of the hospital that somehow the data will be used to limit the action of the Authority. Sen. Franklin said that was not the intent, and she did not read that into that section of the bill.

Chairman Eck asked Rick Hardin to speak about the task force on data. There is a section in Sen. Nathe's bill which was drafted by the task force. Mr. Hardin asked the project director to discuss it.

Mike McInerney, Montana Cooperative Center for Health Statistics, said the Center arose out of a grant application made by the state to the Robert Wood Johnson Foundation's Information for State Policy Center. The state of Montana was awarded a planning grant of $150,000, and the stipulation of the Robert Wood Johnson Foundation was that the planning grant formulate a policy generation unit for health care which is data based. The Center, a group of health data specialists, was appointed by Governor Stephens. The result of the project will be that in May, they

will submit a grant to the Robert Wood Johnson Foundation for implementation funding, up to $350,000 for each of four years. Sen. Nathe's bill takes up their concerns in the direction of the work the Center has done.

Chairman Eck asked Mr. McInerney how his proposals fit into the sections dealing with data collections sections of these two bills (SB 267 and SB 285). Chairman Eck asked Mr. McInerney if the Center's language could be amended into these bills. Mr. McInerney said SB 267 and SB 285 take a narrower view of data collection than the Center. There are many aspects to data collection, including volumes of data being collected in various public health programs. In order to make the most utility of all the data, all pieces should be tied together into one program that can assist health policy. Sen. Nathe's bill does combine most data aspects with health utilization and health cost into one central program. Mr. McInerney said there is tremendous overlap, 50% or more.

Chairman Eck asked Mr. McInerney if he was working on policy determination. Mr. McInerney said they were working on a system whereby policy determination can be taken. They are trying to put together a data system which will answer policy questions.

Chairman Eck asked Mr. McInerney if it would be helpful to the Health Care Authority. Mr. McInerney said it would be.

Sen. Towe asked Jim Ahrens about if a preferred provider were the subject in SB 285, Section 8, Pages 12 and 13. Mr. Ahrens said that language could reference managed care or an HMO as well. It could be a variety of things.

Sen. Towe asked Sen. Franklin if that were her understanding. Sen. Franklin said it was.

Sen. Towe said Page 8, Line 13, references things which the Health Care Authority may modify, for example, to take into account population increases or decreases and "cost beyond the control of the health care providers." Sen. Towe asked Sen. Franklin to what that referred. Sen. Franklin said there were concerns about events over which hospitals or physicians have no control, and they felt there should be some language in SB 285 to address this.

Dr. Chet Strickler said that two years ago the federal government put a $50.00 per bottle surcharge onto a certain vaccine. This was something that happened suddenly and was beyond the physician's control.

Dr. Jack McMahon said that drugs involved with treating cancer may cost as much as $10,000.00 to $15,000.00 per shot, and this is totally out of the control of the health care provider.

Sen. Towe said that somewhere along the line there is a provider

responsible for the cost increases. Dr. McMahon said liability providers, for example, are not currently under the definition of a provider. Physicians have a duty to inform the public of effectiveness of chemotherapy, but some patients will insist on very expensive but ineffective treatments. These high costs are out of the physician's control.

Sen. Towe said that Page 8, Part B of SB 285 states that a system "may" include prioritization of services. Sen. Towe asked if this were intended to sound like the Oregon Plan of prioritization. Sen. Franklin said the "may" was very meaningful. Physicians were concerned that they would have no options, and prioritization was a way that they would have some guidelines. The "may" includes other guidelines such as clinical protocol guidelines as well. This is one way to limit demand and physicians wanted the option to pursue that.

Sen. Towe asked Sen. Franklin if prioritization might include an Oregon Plan approach. Sen. Franklin said prioritization might include clinical protocol, or preventive care. At least there are options to develop.

Sen. Christiaens asked Jim Ahrens to address the anti-trust issue. Jim Ahrens said they are concerned with violations of the Sherman Anti-trust Act, for example, in discussing budget proposals. Mr. Ahrens said it is extremely crucial that hospitals work together under state supervision so they are not accused of dominating the market, which they do not want to do.

Sen. Christiaens asked about "gate-keeper" options, and if this were an effective way to manage this. Dr. McMahon said a gate-keeper system means that every patient is assigned to a primary care physician. Before a patient could be referred to a specialist, it must go through the primary care physician.

Sen. Christiaens asked Dr. McMahon if it had any merit in determining if something needing immediate attention. Dr. McMahon said that depends upon who the gate-keeper is and what the case is. The Stephens program study showed that 35% of Medicaid population in Helena considered the emergency room their primary care source. A gate keeper system would go a long way to keep down Medicaid costs. He would recommend that the gate keeper system be expand to all Medicaid patients.

Clyde Dailey said that there are a variety of mid-level practitioners who should not be overlooked who could act very effectively in this fashion, for example, nurse practitioners or physician assistants. This is important especially for rural areas where it is difficult to attract physicians.

Dr. Chet Strickler said he is a gate-keeper as a pediatrician and it works well. Medicaid has a just begun gate-keeper system called Passport to Health, and significant savings in health care costs are anticipated.

Sen. Christiaens said he has worked with this, and it might be something which could be put into SB 285 because it has a lot of merit and can save a lot of money.

Dr. Strickler said a Medicaid "medical home" is attempting to be established to serve children so they have a place to come for primary care. There is significant savings in health care costs as well as improved health care.

Sen. Rye asked if SB 285 would provide incentives for physicians to move elsewhere or to come to Montana. Dr. McMahon said that every time a physician reads SB 285, they think "we've all become socialists." There is an ongoing program to educate the physicians of Montana about why they support SB 285. Dr. McMahon said the fact is that changes are going to happen nation-wide. There is an underinsured need to be addressed, as well as the wasteful spending in health care which must stop. Hospitals and doctors cannot be told what procedures to do and not to do, but they must be told what procedures will be paid for, or not paid for under this program.

Sen. Rye asked Dr. McMahon how he felt about SB 267 in this regard. Dr. McMahon said business cannot continue in its current manner, regardless which bill is addressed.

Chairman Eck asked Frank Cote to address the insurance issue.

Frank Cote, Chief Deputy to the Insurance Commissioner for the State of Montana, provided written testimony. (Exhibit #1)

ADJOURNMENT

Adjournment: Chairman Eck said the only Executive Action that would be taken on Friday, February 12, would be to decide which bill, SB 267 or SB 285, to work with and amend. Chairman Eck adjourned the meeting.

Dorothy Eck

SENATOR DOROTHY ECK, Chair

Laura Turman

LAURA TURMAN, Secretary

DE/LT

ROLL CALL

6:30

SENATE COMMITTEE Public Health DATE 2-10-93

NAME	PRESENT	ABSENT	EXCUSED
Eck	✓		
Franklin	✓		
Klampe	✓		
Hager			✓
Towe	✓		
Mesaros	✓		
Rye	✓		
Christiaens	✓		

FC8

Attach to each day's minutes

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-10-93
BILL NO. SB 285

Madam Chair, members of the committee, for the ~~record my name~~ is Frank Cote. I am the Chief Deputy Insurance Commissioner for the State of Montana.

Our office looked at model legislation from many states. After thorough review and adaptation to Montana's laws and unique situations, we would like to offer the following amendments, which I would like to walk you through. We have created Small Employer Health Care Reform, which I will discuss in a minute.

On page 5 of Senator Franklin's bill, we have added the Commissioner of Insurance to the Montana Health Care Authority as an ex-officio member. This will allow us to have an easier flow of information between our department and the Health Care Authority. Also on page 5 we have added Health Service Corporations in order to include the Blues. On page 18, we have removed Section 13 and have replaced it with Small Employer Health Insurance Reform. New Section 14 states the purpose of the reform.

Generally, the purpose is to promote availability of health insurance coverage to small employers regardless of health status or claims experience, and to the overall fairness and efficiency of the small employer health insurance market.

Section 15, page 1 of the amendments deals with definitions. Of note here, on page 7 of the amendments is the definition of small employer. The definition lists a small employer as one employing at least three people and no more than 25.

Section 16 on page 8 is the applicability and scope of the Act. Section 17 establishes the classes of business.

Section 18 on page 9 deals with the restrictions relating to premium rates. Of importance here is under Section 1, Subsection (a) which says: "The index rate of one class of business may not exceed another class by 20%." And also, Subsection (b)(i) which says: "Premium rates charged in a rating period may not exceed the index rate by 25%." It's also important to note here that if the managed healthcare authority reaches its cost containment goals by 1999, this percentage will drop to 20%.

Section 19 on page 15 deals with renewability of coverage. Important to note there is that a health benefit plan subject to the provisions of Sections 13 through 27 is renewable with respect to all eligible employees or their dependents. With some exceptions including non payment of premiums or fraud or misrepresentation of the small employer. Also, at least 180 days prior to non-renewal of any plan, the carrier must provide notice of that effect to the small employer.

Section 20 on page 17 deals with the availability of coverage. Each carrier shall offer at least two benefit health plans: one plan a basic plan; and one plan a standard plan. Benefit plans

may not exclude benefits because of a preexisting condition for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage.

Section 21 on page 21 deals with the reinsurance program. There is a non-profit entity known as the Montana Small Employer Health Reinsurance Program. The program operates subject to the supervision and control of the board. the board consists of 9 members appointed by the Commissioner plus the Commissioner or a designated representative who shall be an ex-official member of the Board. It is the Board's duty, within 180 days of appointment, to submit a plan of operation to the commissioner for equitable administration of the program. Commissioner, after notice and hearing, may approve the plan. If the Board fails to submit a program within 180 days, the commissioner shall after notice and hearing adopt a temporary plan of operation. This plan must establish the procedures of operation.

Section 22, page 29 is the Health Benefit Plan Committee. This gives the Commissioner the authority to appoint a Health Benefit Plan Committee. It is this committee's responsibility to recommend benefit levels of coverages by small employers carriers. Benefit plans must include the cost effective measures such as utilization review of health care services.

Section 23 on page 31 deals with periodic market evaluation of Sections 13 through 27. In general, the board in consultation with the committee must report to the commissioner the effectiveness of the Small Employer Health Care Reform.

Section 24 waves certain state laws but does not include waver of mandated benefits. Section 25 discusses administrative procedures in the adoption of rules. Section 26 is the standards to ensure fair marketing.

Section 27 on page 34 deals with the restoration of terminated coverage.

Madam Chair and members of the committee these amendments take a significant step towards health care reform, and we feel we can effectively implement to the benefits of Montana insurance consumers.