# MINUTES

## MONTANA HOUSE OF REPRESENTATIVES
## 54th LEGISLATURE - REGULAR SESSION

## SELECT COMMITTEE ON HEALTH CARE

**Call to Order:** By **CHAIRMAN SCOTT ORR**, on February 2, 1995, at 3:00 P.M.

### ROLL CALL

**Members Present:**
Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. John Johnson (D)
Rep. Royal C. Johnson (R)
Rep. Betty Lou Kasten (R)
Rep. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)
Rep. Carolyn M. Squires (D)

**Members Excused:** Rep. Beverly Barnhart

**Members Absent:** None

**Staff Present:** David Niss, Legislative Council
Susan Fox, Legislative Council
Vivian Reeves, Committee Secretary

**Please Note:** These are summary minutes. Testimony and discussion are paraphrased and condensed. Secretary wrongly stated the date as February 22 on the cassette tape. These minutes are from February 2, 1995.

**Committee Business Summary:**
Hearing: HB 202
Executive Action: None

### Informational Testimony:

**REP. ORR** introduced the guest speaker, **Claudia Clifford, State Auditor's Office.**

**Ms. Clifford** spoke about the Small Employer Health Insurance Reform Act which includes the Reinsurance Program. **Ms. Clifford** indicated that **Clyde Dailey, State Auditor's representative to the Montana Comprehensive Health Association Program,** administered by Blue Cross/Blue Shield, is present to answer any questions on that program.

**Ms. Clifford** stated that the Small Employer Health Insurance Reform Act requires insurance companies to provide policies to small businesses as Guaranteed Issue. No one would be denied health insurance coverage. Since insurance companies will be insuring high risk individuals, the insurance companies may purchase reinsurance. The Reinsurance Program would be a non-profit, independent program where insurance companies could purchase reinsurance. **Ms. Clifford** explained that "reinsurance is simply insurance for insurance companies." She stated that if claim costs for an individual or a group exceeds what the insurance company anticipates they can pay, then the insurance company has the option to purchase reinsurance to help cover those costs. This reinsurance is guaranteed. An insurance company does not have to buy reinsurance; some companies are set up to reinsure themselves. An insurance company may opt to buy reinsurance from a private carrier; however, a "private company could turn them down for reinsurance coverage."

**Ms. Clifford** stated that the coverage is purchased through the Reinsurance Program; the rates are set by the Board. The coverage is the same for each insurance company who purchases reinsurance. She said, "Once a company incurs $5000 worth of claims from an individual, then the reinsurance coverage begins to cover the cost." She indicated that the reinsurance coverage covers 80% of the costs while the company continues to cover 20% of the costs, up to a $100,000 limit at which point the reinsurance coverage covers 100% of the cost. "The total out-of-pocket expenses by a company that has purchased reinsurance through the program is $25,000."

**Ms. Clifford** stated that the Reinsurance Program is set up with premiums to cover the costs of any lives or groups which is technically called "ceding." If the premiums that are charged do not cover the costs of the program, then there is an assessment mechanism which assesses companies for the additional cost. "The assessment pool is very broad; it includes any company that sells major medical insurance in the state of Montana and includes all of their lines of business from individual coverage, small group coverage, and large group coverage." This creates a broad assessment base in which to spread those costs. Some exceptions to the assessment base are the State of Montana Plan, the University Plan, and any self-insured political subdivision of the state. "In fact, any ERISA (Employees Retirement Income Security Act) exempt plan or self-insured plan would automatically be an exception, or not part of the reinsurance base because the state cannot regulate an ERISA-exempt plan." ERISA is a federal exemption for the self-insured.
**Ms. Clifford** stated that all of the other private carriers and their premium base is assessable. There are approximately 900+ insurance carriers licensed to sell health insurance in Montana. About 400+ insurance carriers report to the State Auditor's Office that they have active accounts in Montana. These 400+ insurance carriers would actually be the assessment base for the Reinsurance Program. There are no public dollars involved in the

program, unlike the Montana Comprehensive Health Association (MCHA). MCHA does have an effect on the general fund. The MCHA plan does have an assessment base; however, the assessment to insurance companies through MCHA is deductible dollar for dollar against their premium tax and the premium tax goes into the general fund.

**Ms. Clifford** provided a list of the Reinsurance Board Members. The Board includes representatives from six insurance companies; five of those companies represent the largest small group carriers in Montana at the time the Board was established. **EXHIBIT 1** The Board operates on a three-year term rotation; vacancies would be filled by the top five carriers. The sixth insurance carrier is appointed by the Commissioner; the sixth insurance carrier on this particular Board is Mutual of Omaha. Mutual of Omaha has people in their organization who are involved in all of the other states' Reinsurance Programs; Mutual of Omaha "offered us a real expertise in what's happening in the other states that have Reinsurance Programs." There are approximately 18 or 19 states that have Reinsurance Programs. The other three members of the Board are a small employer from Great Falls, Montana, a provider representative with the Kalispell Regional Hospital, and a Montana citizen. The Board sets the reinsurance rates. The Board had a proposal from which a subcommittee determined the premiums for the reinsurance. This work was led by the State Auditor's Office Actuary, **Margaret Miksch,** who worked with the actuaries from the top five companies and Mutual of Omaha. This proposal was adopted at the end of October; a small modification in those rates was made in late November.

**Ms. Clifford** announced that the Reinsurance Board would be holding their annual meeting on February 7, 1995. She stated that public comments would begin at 9:00 A.M. specifically on the discussion of rates. She provided the committee with an agenda of the Reinsurance Board annual meeting. **EXHIBIT 2**

**Ms. Clifford** stated that the Reinsurance Program became effective on December 7, when policies started to be marketed as Small Group Reform. The administrating carrier is Travelers Insurance who is also the administrating carrier for 18 other states. She indicated that Connecticut was the first state with Small Group Reform and an insurance program. She stated that Travelers Insurance provides good experience for Montana and provided the least expensive bid for administrating the program. **Ms. Clifford** reported that there have been no lives ceded to the pool yet. This is partly because the companies are in an early stage of selling small group products. Companies need to carefully evaluate if they want to cede a life and spend the money to buy reinsurance for the additional people that they are insuring.

**Questions From the Committee and Responses**

**REP. BETTY LOU KASTEN** inquired why an insurance company would reinsure or decide not to insure if they had a real risk when they have to complete to the risk pool anyway.

**Ms. Clifford** responded that if the insurance company evaluates an individual and decides that they are a high risk then the company would choose to purchase reinsurance. Insurance companies wouldn't automatically be paying into the program unless there was an assessment.

**REP. KASTEN** inquired why the Montana risk pool is kept separate from the insurance pool.

**Ms. Clifford** stated that the difference between the two programs is that the Reinsurance Program focuses solely upon small groups and only a small group carrier may cede a life. The insurance company decides whether or not to take advantage of the program. The MCHA program is for those individuals who cannot get health insurance. The Reinsurance Program is for companies and the MCHA is a program for individuals.

**REP. KASTEN** inquired why a statute change wasn't made to keep the money within the pool, rather than going into the general fund, and having just the one pool.

**Ms. Clifford** responded that with the MCHA the general fund is affected in the sense the money that's assessed to companies is a "dollar-for-dollar deductible" against their premium tax that they pay into the general fund.

**REP. KASTEN** inquired what the administrative cost paid to Travelers Insurance would be.

**Ms. Clifford** responded that there is a contract with Travelers. This year, the total cost was $34,000 which included the start-up costs. By the contract, each year the cost decreases; after the third year there will be no more start-up costs, but only a cost per life which **Ms. Clifford** estimates was about $7 per life.

**REP. KASTEN** inquired how many people would be expected to be covered under the Reinsurance Program. **Ms. Clifford** indicated that last year Idaho had 70 lives.

**REP. KASTEN** inquired how long Idaho had been on the program. **Ms. Clifford** responded since April 1994.

**REP. BRUCE SIMON** inquired if an insurance company purchased "stock loss" through the risk pool for a high risk individual, then the insurance company's total risk would be the cost of the premium for the risk pool and a potential risk of up to $25,000. **Ms. Clifford** responded that was correct.

**REP. SIMON** stated that the MCHA is not really a risk pool, but rather like it's an insurance company. The MCHA provides coverage for high risk individuals at a high price per month, but there is coverage available. If the premiums that are charged do not cover the costs of the program, then an assessment is made on all of the companies for the additional cost. **Ms. Clifford** responded that was correct.

**REP. SIMON** said there is one additional layer in the small group than for the MCHA; this is allowing insurance companies to decide whether or not to buy reinsurance, thereby creating the risk pool. **Ms. Clifford** replied yes, that allows the insurance companies to manage their risk by deciding whether or not to buy reinsurance.

**REP. SIMON** stated that the insurance companies determine their risk in determining whether or not to purchase reinsurance and be covered by the risk pool. **Ms. Clifford** stated that was correct.

**REP. DICK SIMPKINS** inquired if there was an increase in premiums when this program was initiated in 1986. **Ms. Clifford** responded that she didn't know. **Clyde Dailey, State Auditor's Office, Insurance Department,** indicated no with a shake of his head.

**REP. SIMPKINS** redirected the question to **Larry Akey** who responded, "I think not. My initial response to that would be no."

**REP. SIMPKINS** inquired if an insurance company paid a high risk premium, it may be deducted from the premium tax they are paid. **Ms. Clifford** responded, "only with the Montana Comprehensive Health Association, not the Reinsurance Program."

**REP. SIMPKINS** restated that the MCHA can deduct the amount paid on a high risk premium from the premium tax, "so, in effect, we're funding this program out of our general fund."

**Mr. Dailey** responded if the claims exceed the premiums that are bought. The assessments would be minor.

**REP. SIMPKINS** asked if they don't deduct from their premium tax until they've lost money. **Mr. Dailey** answered, "Until there's a danger of a solvency problem." If the actuaries serving on the Board in conjunction with the administrator evaluate the insurance company's financial condition and feel that there is not enough cushion, that's when they make an assessment.

**REP. SIMPKINS** stated that within the MCHA program, if an insurance company stays solvent then the tax is not reduced. However, if the insurance company does not maintain the threshold of solvency within the expected margins, it may be deducted from the premium tax the insurance company paid to the state.

**Mr. Dailey** clarified that it is assessed on the basis of how much premium the insurance company received. He stated that based on the amount of premiums the insurance company collects is what the assessment would be based on. "The basis for that is your participation in the MCHA."

**REP. SIMPKINS** inquired if the premium tax been used since the establishment of the MCHA in 1986. **Mr. Dailey** responded that there have been assessments.

**Bill Jensen, Chair of the MCHA,** indicated that the assessments that the MCHA has had have varied by year. "Since 1993 there have been no assessments. During 1994, we chose not to and in fact, we froze the rates. In 1993, there was a $200,000 assessment." He indicated that there was about three years that the association assessed about $1 million. At the present time, the pool is in good shape.

**REP. TUSS** requested clarification of the phrase "cede a life." **Ms. Clifford** responded that the term is used when a company buys reinsurance from a reinsurance carrier; "so, it's ceding a life, or ceding responsibility."

**REP. NELSON** interjected "C-E-D-E."

**Ms. Clifford** summarized that the MCHA program is where an individual can obtain health insurance. The individual does not have any dealings with the Reinsurance Program, so the cost is "transparent" to the individual. Reinsurance is an administrative cost to the insurance company and the insurance companies are responsible for spreading those costs. An individual would not see those costs directly; there would not be a surcharge on the policy stating "this is because we bought reinsurance for you."

**REP. SIMON** stated that Blue Cross/Blue Shield (BCBS) of Montana is a major carrier in Montana, is involved in the assessment process, and pays the largest assessment. He inquired how BCBS handles that assessment within the company without paying the premium tax. **Mr. Butler** responded that the BCBS assessments come out of the BCBS reserves.

**REP. SIMON** clarified that BCBS pays it directly. **Mr. Butler** responded that was correct.

**REP. SIMON** inquired about the risk pools established in other states.

*{Tape: 1; Side: 2}*

**Margaret Miksch, State Auditor's Office, Actuary,** indicated that it's her impression that there have been no more minimal assessment. She stated that the number of people involved in the program varies widely due to population and other factors. In

Kansas (population 2.7 million) has had their small group program in effect since May 1, 1993 and have "absolutely nobody in their Reinsurance Program." Connecticut (population 3.8 million) has had their small group program in effect since May 1991, and has 6,744 in their Reinsurance Program. **Ms. Miksch** estimated that Montana's Reinsurance Program would be similar to Idaho because they are neighboring states, have similar population size and probably similar population effigies. She thought they had 82 in the Reinsurance Program. She indicated that Montana's rates were based on Idaho's rating system and the rates were adjusted for what was expected for Montana. She indicated that Idaho has since lowered their rates after getting so many on their Reinsurance Program.

**Ms. Clifford** stated that programs have had to make assessments, especially in the first start-up years. She indicated that even with the number of lives that Connecticut had to have assessed, the assessments are usually very low, like 1% of their market.

**REP. LIZ SMITH** inquired of **Ms. Miksch** if she anticipates Montana's plan to carry the same membership or cede lives.

**Ms. Miksch** responded that it's hard to tell. Idaho was chosen as the model for Montana's Reinsurance Plan based on the similar populations. **Ms. Miksch** indicated that she had spoken to the company that set the rates for the Idaho plan; he had told **Ms. Miksch** that one reason Idaho has so many ceded lives is because a majority of those come from one insurance company. He would not, however, indicate which insurance company it was, or whether this insurance company was licensed to sell health insurance in Montana; thereby making it more difficult to predict what might happen in Montana.

**REP. SMITH** inquired if Idaho's plan is a 3 to 25 membership? **Ms. Miksch** indicated that she believes it is a 3 to 25.

**REP. SMITH** inquired if **Ms. Miksch** was aware of other states expanding perhaps to 100. **Ms. Miksch** stated that she doubts that it would be 100. She indicated that the top for a small group would be 50. She indicated that she did not know if other states had expanded.

**Ms. Clifford** indicated that there are currently states based from 2 to 50 on their small employer program. Some states considering purchasing pools are moving to larger numbers. "I think currently the largest number is 2 to 50."

**REP. SMITH** stated that "if we all are in this pool, then we all can share and therefore there is better coverage for less stress on the system." She inquired why that is impractical in Montana?

**REP. NELSON** inquired if it's impractical "to require insurance?"

**REP. SMITH** stated that she is asking about the pooling for assessments and the reinsurance base. She asked, "Why are we not opening that up for everybody to share. I understand that BCBS carried 50% of the insured carriers in the state of Montana. They're exempt from being part of that process. Is that not true?" **REP. NELSON** answered no.

**Ms. Clifford** stated that BCBS is responsible for assessable carriers for both the MCHA program and the Reinsurance Program. She stated that "they share in their costs."

**REP. SMITH** inquired if everyone couldn't be part of the same pool? **Ms. Clifford** responded that "the Small Group Program is for people who are employed in small groups. The Individual Program is for individuals who can't get insurance at all. She elaborated as to why individuals and groups may have been turned down for coverage. **Ms. Clifford** stated that the two are actually complementary; they cover different sectors of the population.

## HEARING ON HB 202

**Opening Statement by Sponsor:**

**REP. TOM NELSON, House District 11, Billings, Montana,** provided the committee with a handout regarding the issues of fairness and affordability. **EXHIBIT 3** He indicated an error on page 2, the last figure on the page should read $6,785 instead of $8,274.39. **REP. NELSON** announced that HB 202 had a very good hearing in House Taxation and stated that HB 202 had been re-referred to the Select Committee on Health Care because the primary topic is health care and insurance. He stated that the purpose of this committee is to develop a package of insurance and some health care reforms which probably would encompass tax questions which deal with health insurance and health insurance premiums.

**REP. NELSON** stated that HB 202 is an act allowing for individual income tax deductions for premium payments for medical care insurance. He stated that he had been in the insurance and health insurance business for 32 years; in the 1960's, a major medical policy with $10,000 lifetime benefits to a family of 4 for about $15 per month. Today, it is not uncommon to sell a policy for less than $200 to $400 per month in premium depending on the age of the insured, the family and the number of insured, and the benefits.

**REP. NELSON** stated that he considers this an issue of fairness and an issue of affordability. He indicated that most of the insurance reform issues that Congress "wrestled" with deal with availability, but not affordability. "Until we do something as a people and as a nation to slow down the inflation in the area of medical costs, we need to have some way to exacerbate the effects of high premiums which are a natural result from high costs of medical care."

**REP. NELSON** reviewed the issue on fairness, with the committee. **(See Exhibit 3, Page 1)** He indicated an inconsistency in the federal and state tax laws regarding who pays the premiums on the medical insurance: the employer, the self-employed individual, or the individual who pays all of his own premiums that are not provided in any way by his employer. **REP. NELSON'S** examples deal with both federal and state taxes to show what the net disposable income is after taxes and cost of health insurance.

**REP. NELSON** reviewed the issue on affordability, page 2, with the committee. **EXHIBIT 3, PAGE 2** He stated that the cost of health insurance premiums have doubled in four years. He said, "We need some relief for people not to be able to buy this insurance, but to be able to keep it for another year or two. Hopefully, then as a nation and as a people we can do something about this health care crisis and not just pay lip service by trying to change insurance laws. We need to slow down inflation by the providers. And we also need to be more careful purchasers and consumers of health care. Otherwise all the insurance reform we're going to do in this committee won't be worth a tinker."

**REP. NELSON** stated that the next speaker will review an amendment for HB 202.

**Bob Turner, Department of Revenue, Income and Miscellaneous Tax Division,** indicated that on page 3, line 13, that there are two parts to HB 202. Firstly, there is an insurance deduction of 100% allowed for tax payers. Secondly, insurance premiums are deducted if they are included in your federal gross income. He stated that this second part "is already contained in our present law as it stands under 15-30-1112H." **Mr. Turner** stated that he'd be glad to work with the legislators on this.

**Mr. Turner** that he spoke to the Taxation Committee earlier about amendment 2. He stated that as amendment 2 stands it allows a deduction on insurance premiums, under 15-31-21, Subsection 1, which exceed 7.5% adjusted gross income. **Mr. Turner** stated that this would be in addition to what needs to be amended "to say to the extent that it's not taken in Sub Section 1, so they don't get a double deduction."

**Proponents' Testimony**:

**Riley Johnson, representing the National Federation of Independent Business (NFIB),** and due to a prior commitment he also speaks on behalf of **Jim Tutwiler, Montana Chamber of Commerce.** Both organizations support HB 202. He agreed with **REP. NELSON** on the issues of fairness and affordability. **Mr. Johnson** commented on and agreed with the figures and stated, "this is a very good representation of what's happening to the small employer and as you can see we get hit the hardest." **(see Exhibit 3)** He said tax laws should be fair and that it is not being fair to the self-employed as we have it today.

**Robert White, Bozeman Chamber of Commerce, and licensed insurance agent in Montana,** stated that both the city of Bozeman and the Chamber of Commerce strongly support and urge the passage of HB 202.

**Brad Griffin, representing the Montana Retail Association,** strongly supports HB 202. He stated that the 7.5% threshold is difficult to reach.

**Larry Akey, Montana Association of Life Underwriters,** stated that all 700 members support HB 202 because it is a good tax policy and because it is a good health care policy. He stated that there are problems both of availability and affordability of health insurance in Montana today. This is an issue of affordability. He stated that the more people are insured, the better the system will work for all.

**Susan Good, representing Heal Montana,** supported HB 202 and congratulated **REP. NELSON** on a "dynamite presentation." She stated that HB 202 is not only good tax policy, but good health care policy as well.

**Sam Hubbard, representing the Montana Health Care Authority (MHCA),** indicated that the MHCA included in the Market-based Sequential Plan a recommendation that would agree with HB 202. The MHCA urged passage of HB 202.

*{Tape: 2; Side: 1}*

**Tanya Ask, representing Blue Cross/Blue Shield of Montana (BCBS),** indicated the **BCBS** has worked for several years with the **Montana Hospital Association, Medical Association, Large and Small Employers and Retired Individuals** on health care reform. "One of the concepts that we also thought...needed to be adopted by this legislature was the individual tax deductibility of insurance premiums." She supported HB 202.

**Bob Frazier** personally supports HB 202. He stated that he is not here to represent the Campuses of the University of Montana. He stated that in 1992, he served on Governor Stan Stephen's Health Care for Montanans Committee and stated that at that time uniform application of tax deductions from health insurance premiums was recommended. The recommendation was to promote tax equity, and to encourage the purchase of insurance, which reduces bad debt cost shifting, tax laws need to be amended. **EXHIBIT 4, PAGE 17** This has not changed, and has probably been exacerbated.

**Mary Allen, testified on behalf of the Montana Medical Benefits Plan (MMBP), Montana Area Agency on Aging Association** in support of HB 202. She stated that at a time when increasing medical expenses are a concern to everyone, a taxable deduction on the first dollar of medical expense is desirable as health insurance premiums can be a heavy financial burden on all. Any deduction "in tax personal disposable income...is an economic benefit for

all, and especially the elderly citizens who are often on a fixed or a declining income."

**Edmund Caplis, Executive Director of the Montana Senior Citizens Association (MSCA),** supported HB 202 as a step toward making health insurance affordable.

Opponents' Testimony:

None

Questions From Committee Members and Responses:

**REP. KASTEN** stated that on Assumption 11 of the FN for HB 202 by the Department of Revenue which states "No additional households will individually purchase health insurance as a result of this legislation," and yet Assumption 9 shows that the group percentage is less in households between 20,000 and 30,000. She said, "don't you think that maybe those are the people who will take advantage of this?" They probably will fall in that 28% group, if they are a single person, "which gives them maybe total 30%, which means that a third of their premium would be paid." She inquired if Assumption 11 is a true assumption.

**REP. NELSON** responded that it is probably "truer than we'd like to believe." He stated that he didn't think people would buy health insurance because the premium was deductible.

**REP. KASTEN** stated, "you've never been a rancher."

**REP. NELSON** said no, but indicated that he'd been self-employed for 37 years and felt that there was some similarity.

**REP. KASTEN** indicated that it might be an incentive with the ranch community because affordability has been the key.

**REP. NELSON** stated that may be correct on Assumption 11. He indicated that his concern is large increases in the annual premiums, and maybe this would allow somebody to be able to keep their policy maybe a year or two longer that may be right at the edge of having to drop it because of affordability.

Closing by Sponsor:

**REP. NELSON** closed by commenting that "we have seen fit to make some premiums deductible." He stated that when it comes to premiums paid by our senior citizens for long-term health care insurance HB 202 completes the circle of premiums that needed to be tended to.

**REP. ORR** said that this closed the hearing on HB 202 and reminded the Committee that HB 405 is scheduled for hearing on Tuesday 7, 1995. He invited those interested to stay for the Insurance Reform Subcommittee after adjournment.

**ADJOURNMENT**

**Adjournment:** 4:08 P.M.

**SCOTT ORR**, Chairman

VIVIAN REEVES, Secretary

SO/vr

# HOUSE OF REPRESENTATIVES

## Select Committee on Health Care

ROLL CALL DATE Feb. 2, 1995

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| Rep. Scott Orr, Chairman | ✓ | | |
| Rep. Carley Tuss, Vice Chairman | ✓ | | |
| Rep. Beverly Barnhart | | | ✓ |
| Rep. John Johnson | ✓ | | |
| Rep. Royal Johnson | ✓ | | |
| Rep. Betty Lou Kasten | ✓ | | |
| Rep. Tom Nelson | ✓ | | |
| Rep. Bruce Simon | ✓ | | |
| Rep. Dick Simpkins | ✓ | | |
| Rep. Liz Smith | ✓ | | |
| Rep. Carolyn Squires | ✓ | | |

EXHIBIT 1
DATE Feb. 2, 1995
HB

# STATE AUDITOR
STATE OF MONTANA

*Mark O'Keefe*
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

## MONTANA SMALL GROUP REINSURANCE BOARD

Merle Pederson
Martha Crist
Principal Mutual Life
Insurance Company
Des Moines, IA 50392-0220
(800)-325-2532 x 82186
Fax (515)248-8469

Ray Havig
Western Mutual Insurance
Company
P.O. Box 20099
Billings, MT 59102
(406)252-3999
Fax (406)252-3058

Patrick Carmody
Rebecca Smart
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175
(402)978-5620 Pat
(402)351-8160 Rebecca
Fax (402)978-2465

Hank Frantz
John Alden Life Insurance
P.O. Box 659002
Sacramento, CA 95865-9002
1610 Arden Way, Suite 175
Sacremento, CA 95815
(916)565-5810
Fax (916)565-5899

Garth Trusler
Bill Jensen
Blue Cross Blue Shield of
Montana
P.O. Box 4309
Helena, MT 59604
(406)444-8570
Fax (406)442-6946

Carl Halcro
Carl's EXXON
2300 10 Avenue South
Great Falls, MT 59405
(406)452-2262

Sherry Abel
Kalispell Regional Hospital
310 Sunnyview Lane
Kalispell, MT 59901
(406)752-1724
Fax (406)756-2703

Christian MacKay
4630 Victoria
Helena, MT 59601
(406)449-4171 home
(406)4421441 work
Fax (406)442-1324

Merle Colpron
Continental Life & Accident
Company
Colpron and Associates
2399 S. Orchard St. Suite 208A
P.O. Box 44375
Boise, ID 83711
(208)388-0129
FAX (208)388-0312

EXHIBIT 2
DATE Feb. 2, 1995
HB

# STATE AUDITOR
STATE OF MONTANA

*Mark O'Keefe*
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

MONTANA SMALL EMPLOYER HEALTH REINSURANCE BOARD

Annual Meeting of February 7, 1995

Room 209, Cogswell Building
Helena, Montana

Board of Directors
Sherry Abel
Patrick Carmody &
Rebecca Smart
Mutual of Omaha
Hank Frantz
John Alden Life
Carl Halcro
Merle Pederson
& Martha Crist
Principal Mutual Life
Ray Havig
Western Mutual Insurance Company
Merlyn D. Colpron
Continental Life & Accident Company
Christian MacKay
Garth Trusler
William Jensen
MT Blue Cross/Blue Shield

A G E N D A

8:30 a.m. Convene
Activities of Reinsurance Pools Nationally - Karl Ideman
Report on small business market and status of small business carriers - Claudia Clifford

9:00 a.m. Legislative report
Discussion of premium rates and public comment

10:30 a.m. - 3:00 p.m. Required annual meeting agenda items
(Break at noon for lunch)

1. Review this Plan of Operation and submit proposed amendments, if any, to the Commissioner for approval.

2. Review reports of the Administering Carrier, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters.

3. Review reports of the committees established by the Board.

4. Determine whether any technical corrections or amendments to the Act shall be recommended to the Commissioner.

5. Review and give consideration to the performance of the Program in support of the goals of the Act.

6. Review the rates for reinsurance coverages, benefit plan design and communication programs.

7. Review the net premiums, the Program administration expenses and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

8. Determine if an assessment is necessary for the proper administration of the Program.

9. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the Program.

10. Review and evaluate the contracts and services with the administrating carrier and staff. With support of 5 directors of the board, the contract will be renewed.

3:00 p.m. Business survey of health insurance coverage

3:15 p.m. Review terms of office for board members

3:45. p.m. Approve minutes from previous meetings

4:00 p.m. Adjourn

EXHIBIT 3
DATE Feb. 2, 1995
HB 202

Issue: FAIRNESS

By Rep. Tom Nelson

Example: Taxation of premiums paid by corporate or government employer, vs. xa versus taxation of premiums for a self-employed person or an employee who pays all of his own medical insurance premiums. Assume $24,000 gross income in each case.

I. Gov't or private employee:

| | | | |
|---|---|---|---|
| A. | Adj. Gross Income | | $24,000.00 |
| | FICA paid by employer | | $1,800.00 |
| | Medical premiums paid by employer | | $3,600.00 |
| | Total compensation | | $29,400.00 |
| B. | Adj. Gross Income | | $24,000.00 |
| | Federal withholding | | $3,000.00 |
| | State withholding | | $960.00 |
| | FICA | | $1,800.00 |
| | Net (or disposable) income | | $18,240.00 |

II. Self-Employed:

| | | |
|---|---|---|
| Adj. Gross Income | | $24,000.00 |
| Self-employment tax | $3,408.00 | |
| Federal withholding | $2,800.00 | |
| State withholding | $800.00 | |
| | | $7,008.00 |
| Net income | | $16,992.00 |
| less insurance premiums | | $3,600.00 |
| disposable income | | $13,392.00 |

III. Employee who pays own premiums:

| | | |
|---|---|---|
| Gross Income | | $24,000.00 |
| FICA | $1,800.00 | |
| Federal withholding | $3,000.00 | |
| State withholding | $960.00 | |
| | | $5,760.00 |
| Net income | | $18,240.00 |
| less insurance premiums | | $3,600.00 |
| disposable income | | $14,640.00 |

Issue: AFFORDABILITY

by Rep. Tom Nelson

Individual Major Medical Policy
$1000 deductible
80/20% to $5,000

Monthly Premiums: $358.39

| | Tom | Bernie |
|---|---|---|
| Yearly Medical expenses | $2,960.00 | $897.00 |
| Co-insurance factor | 80.00 % | 80.00 % |
| | $2,368.00 | $717.60 |
| less deductible | $1,000.00 | $1,000.00 |
| Insurance payment | $1,368.00 | $0.00 |

Recap:

| | | |
|---|---|---|
| Tom's medical expenses | | $2,960.00 |
| Bernie's medical expenses | | $897.00 |
| | | $3,857.00 |
| less insurance recovery | | $1,368.00 |
| Out-of-Pocket | | $2,489.00 |
| Monthly premiums | $358.00 | |
| x 12 months | 12 | |
| annual premium costs | | $4,296.00 |
| total out-of-pocket cost | | $6,785.00 |
| Gross income required | | $8,274.39 |
| less FIT @ 15% | $1,241.16 | |
| less SIT @ 3% | $248.23 | |
| | | $1,489.39 |
| net income | | ~~$8,274.39~~ $6,785 |

EXHIBIT 4
DATE Feb. 2, 1995
HB 202

# PHASE II: STEPS TO IMPLEMENTATION

## Governor Stan Stephens

*October 7, 1992*

*Part A and Part B*

## HEALTH CARE FOR MONTANANS

# *INTRODUCTION*

The first phase of the Governor's Health Care for Montanans Project culminated in numerous legislative successes in the 1991 session. The Governor made a commitment to build upon those successes. This proposal is a result of that commitment.

Nearly one hundred committee members presented a package of recommendations to the Governor on September 15, 1992. That report was the result of the largest effort ever undertaken in the State of Montana in the area of health care planning. To the many people who put in the many hours, a great deal of gratitude is expressed. This was truly a citizen built proposal.

This proposal represents the second phase of the Governor's commitment to providing quality health care to all Montanans. This proposal does not solve all of Montana's health care problems. It does present achievable proposals; ones that will make a difference in many people's lives. It continues the Governor's realistic approach to health care reform. Incremental changes will lead to the eventual resolution of our health care problems, whereas the debate over major solutions such as single payer systems remains just that: a debate awaiting Congressional action authorizing state initiatives. The goal of these proposals is to help people gain and keep health coverage now, while others continue planning.

Increasing access to health care costs money. Money for state programs is a scarce resource in Montana at this time. Because of limited funds, this proposal has been divided into a Part A and Part B. Part A requires no new funds. Part B contains proposals requiring additional funds. A tentative proposal for funds would be leveling a 1.1 percent tax on hospitals with all funds going to a Health Care Trust Fund for expanded health access. This tax would not apply to Montana's rural hospitals. The proposal also contains an increase in Medicaid rates paid to hospitals. This proposal is offered for discussion to ascertain the viability of establishing a trust and leveling a provider tax. If, after the Governor's Health Care Conference and meetings with affected groups, the provider fee has no support, it will not be offered in the Governor's budget and the recommendations costing money will not be pursued by the Stephens' administration this biennium.

The Governor is pleased to present the State of Montana the next phase for health care reform.

(All committee recommendations are contained in the Project's May 12, 1992 Draft Recommendations document and the Steering Committee's decisions are contained in the September 15, 1992 Report to the Governor.)

## Phase II: Steps to Implementation

### Part A:
### No funding required

Step 1 - Undertake health insurance reform. - Legislation requested by Rep. Tom Nelson

Step 2 - Address physician liability. - Legislation requested by Rep. Steve Benedict

Step 3 - Encourage priority for professional training programs.

Step 4 - Develop infrastructure for a telemedicine demonstration project with financing available from Big Sky Dividend.

Step 5 - Implement recommendations for prevention and wellness.

### Part B:
### Requires funding

Step 1 - Establish a Montana Health Care Commission with block grants for health planning regions and an electronic claims processing system. - Legislation requested by Sen. Dennis Nathe and Sen. Dorothy Eck

Step 2 - Provide health insurance for all of Montana's poor children. - Legislation requested by Rep. John Cobb and Sen. Dorothy Eck

Step 3 - Provide uniform application of tax deductions for health insurance premiums. - Legislation requested by Rep. Tom Nelson

Step 4 - Establish a family practice residency program.

Step 5 - Redesign Medicaid's hospital reimbursement system to ensure reasonable and adequate payment.

Step 6 - Establish a health care fund to support health care initiatives. - Legislation requested by Rep. John Cobb

Step 7 - Implement a tax on larger hospitals to help finance a health care trust fund. - Legislation requested by Rep. John Cobb

## GOVERNOR STAN STEPHENS'

# Phase II: Steps to Implementation

EXHIBIT 4
DATE 2-2-95
HB 202

### Part A:
### No funding required

**Step 1 -** *Undertake health insurance reform. - Legislation requested by Rep. Tom Nelson*

**Step 2 -** *Address physician liability. - Legislation requested by Rep. Steve Benedict*

**Step 3 -** *Encourage priority for professional training programs.*

**Step 4 -** *Develop infrastructure for a telemedicine demonstration project with financing available from Big Sky Dividend.*

**Step 5 -** *Implement recommendations for prevention and wellness.*

## *PART A STEP 1: HEALTH INSURANCE REFORM*

**BACKGROUND**: A majority of Montanans are employed by small employers. In recent years many factors have combined to make buying and keeping health insurance a difficult situation. One seriously ill employee can now cause a group to lose its coverage and not be able to purchase coverage elsewhere. Employers often do not know from year-to-year whether they will still be insured.

Many self-employed individuals and others face very similar problems in the individual policy market.

Highly skilled and motivated workers are not advancing because of the fear of losing insurance when they change employers. This loss could result because they are uninsurable or are subject to pre-existing condition exclusions.

**RECOMMENDATION**: Enact comprehensive insurance reform. This reform would be based on the National Association of Insurance Commissioners "Small Employer Health Insurance Availability Model Act" for small employers. The act will apply to insurance provided to employers of between 3 and 25. The community rating, portability and guaranteed renewability provisions are also extended to the marketing of individual policies. Major provisions include:

Guaranteed Issue: All small employer groups would have the right to obtain basic benefits level private health insurance regardless of the health risk presented by such a group.

Guaranteed Renewability: A carrier cannot cancel coverage of a group or individual at renewal time because of the status of the health of an individual or an individual within a group.

Portability: Once an insured person satisfies the pre-existing conditions restrictions of a health benefits plan, such a person will not have to meet new pre-existing conditions restrictions for similar benefits when changing jobs or switching carriers.

Community Rating: Appropriate limits will be imposed on premium rate variations for group and individual policies.

Basic Benefit Plan: Create a Health Benefit Plan Committee to develop a basic benefits plan which all carriers participating in the small employer market must make available to all small employer applicants.

Reinsurance Mechanism: Since carriers are required to accept and keep groups, some carriers will receive a disproportionate share of higher risk groups and individuals. To spread this risk evenly and fairly a reinsurance pool will be established. The State and the insurance industry are currently negotiating how to pay for the reinsurance pool without relying on State general funds. An attempt will be made to avoid relying entirely on the small employer group market to fund the pool.

The recommendation to adopt these provisions carries a warning that effective medical cost control measures must be enacted at the same time. There will be premium rate increases to generally healthier groups or individuals. The increases are estimated to be between 5 - 10%. Savings from cost controls would help offset these increases. Insurance purchasers need to be educated that along with the increases comes the security of knowing that they will not be canceled or have large premium increases when they or a member of the group becomes seriously ill.

**LEGISLATIVE INITIATIVE**: Yes

**COST**: No general fund cost.

## *PART A STEP 2: ADDRESSING PHYSICIAN LIABILITY*

**BACKGROUND**: Affordable health care is one of the most important issues for the people of the United States. In particular, health care at a reasonable cost and access to medical services in rural communities are important issues for residents of the state of Montana. The costs associated with lawsuits involving medical malpractice and the accompanying increase in medical malpractice insurance have caused medical costs to escalate and have resulted in physicians limiting their practice or moving out of rural areas. In many instances physicians are leaving the state of Montana in order to maintain a more profitable medical practice. There are 35 counties considered by the federal government to be medically under-served, including 26 counties which have three or less physicians and 9 counties without any physician services. Since 1985, 41.9% of urban and rural physicians have given up the practice of obstetrics, 22 counties are without obstetrical services and 14 hospitals no longer provide obstetrical care.

**RECOMMENDATION**: Below are legislative proposals in two areas:

Part A: Tort Reform

In order to correct the above problems, legislation will be introduced to change current law in seven areas. The legislation shall include a statement of intent and a requirement that follow-up measurements be conducted to determine impact of legislation.

1. $250,000 cap on non-economic damages (excluding physical impairment and disfigurement).

2. Reverse sliding-fee scale limits on contingency fees for attorneys.

3. Heightened evidentiary standards in cases where the physician delivering the baby has not provided prenatal care.

4. Heightened evidentiary standards for regular emergency room personnel and hospitals; expansion of "good samaritan" law to physicians in an emergency who are not usually emergency room personnel.

5. Shorten the statute of limitations for medical malpractice actions by adults and minors.

6. Mandated periodic payment of future damages.

7. Specify certain expert witness qualifications.

Part B: Liability Carrier Reporting

Improve the reporting process for liability carriers and the process for disseminating the information gathered. Currently it is difficult to determine how much the carriers are paying out in settlements, costs, awards, etc. Long term information will be critical to the health care planning process.

**LEGISLATIVE INITIATIVE**: Yes

**COST**: None

## *PART A STEP 3: ENCOURAGE PRIORITY FOR PROFESSIONAL TRAINING PROGRAMS*

**BACKGROUND**: Health care services continue to contribute substantially to the state's economic viability. As a growth industry in Montana, it experienced greater gains than any other business service category in the past decade. During the same period, agriculture and mining declined while manufacturing reported no appreciable gains in spite of short term peaks.

Health care services expand the total delivery of goods and services. Previous studies have estimated that each physician generates 16 jobs. Hospitals are frequently among Montana communities' largest employers; generating jobs, retail sales, and an expanded tax base.

In summary, health care services contribute substantially to the state's total delivery of goods and services. Investment in Montana's health care delivery system through expanded education programs is a sound investment in the state's economic future.

**RECOMMENDATION**: Encourage the Board of Regents and the legislature to consider health care professional training programs as a top priority in the program planning and budgeting process. Also, encourage the Board of Regents to consider the following:

1. Rural Montana will rely more and more on mid-level practitioners, such as nurse practitioners and physician assistants, as primary care physicians become increasingly scarce. No programs are currently offered in Montana to train these critically needed practitioners.

2. Development of an articulated nursing education program would ensure more efficient use of limited academic resources in all nursing programs.

3. Consider expanded programs for mental health/substance abuse professional and social work services to address the increased demands for these services.

4. An expanded role of the Commissioner of Higher Education, as frequently referenced in the 1990 publication, "Montana Crossroads: Montana Higher Education in the Nineties," will be essential in developing a coordinated, well integrated education system that can truly meet identified needs.

**LEGISLATIVE INITIATIVE**: None.

**COST**: None

## *PART A STEP 4: DEVELOPMENT OF INFRASTRUCTURE FOR TELE-MEDICINE DEMONSTRATION PROJECT*

**BACKGROUND**: Access to health care services in rural areas is severely limited by a shortage of primary care providers. Rural residents must, therefore, travel great distances and incur unreasonable delays and additional expense to gain needed medical and mental health services. One method of bringing medical services to rural areas is through the use of telecommunications.

**RECOMMENDATION**: Include fiber optic construction costs as eligible for funding as an infrastructure in the Big Sky Dividend. There are several technologies available to establish two-way video links. The one method of linking that allows the best on demand access is fiber optic lines.

Because of Montana's rural nature, the benefits to medicine, education, and many others would be immeasurable with video linking. To make video link-ups a reality in the immediate future will require an acceleration in the installation of fiber optic lines between communities.

It is recommended that the State of Montana assist in building necessary links. Approximately $3 million in new funds are needed to install lines from hospitals and post-secondary institutions to existing or planned fiber optic capacity.

An appropriate source of this money would be the Big Sky Dividend which is designed to improve Montana's infrastructure in order to promote economic development. If quality health care is not available in a community it is less likely an enterprise will locate in that area.

Once the technology is in place, two way video communication will allow quality health care to be offered in rural areas. Health care will help keep that area economically viable.

**LEGISLATIVE INITIATIVE**: Yes

**COST**: No general fund cost.

## *PART A STEP 5: RECOMMENDATIONS FOR PREVENTION AND WELLNESS PROGRAMS*

**BACKGROUND**: The single best method of saving health care dollars is the prevention of illness. Of all cost containment measures it is also the most difficult and elusive. It involves encouraging people to change their habits and lifestyles. While we will never see all citizens adopt the optimum lifestyle in regards to good health, we must never stop trying to reach that goal.

**RECOMMENDATION**: Examples of efforts to promote prevention and wellness include:

1. The Department of Health and Environmental Services should develop a plan to ensure that all children are immunized.

2. Implement a statewide toll-free hot line to provide health information and referral.

3. Explore the use of "health banks". Health banks replace the common deductibles and co-insurance payments with a monetary account owned by the patient. The patient pays for initial services with the account which can only be used for medical care. The balance of an account belongs to the patient.

4. Develop the use of "Health Fairs" to promote wellness. One example, initiated by the Governor's Office on Aging, is a health promotion project entitled "Heart of the Community".

5. Encourage health care providers to be open outside regular work hours. This expansion would help to better meet the needs of working families.

6. Encourage well-child screening of Medicaid eligible children by requesting a waiver from the federal government to reduce welfare benefits for persons who do not get well child care for their children.

7. Promote nutritional services. Many of the chronic diseases of our society are caused by lifelong poor nutritional practices.

**LEGISLATIVE INITIATIVE**: No

**COST**: None

# Summary of Fiscal Impact for Governor Stephens' Health Care for Montanans Proposal – A

| | Description | FY 94 General Fund Cost | FY 94 Total Cost | FY 95 General Fund Cost | FY 95 Total Cost | FY 96 General Fund Cost | FY 96 Total Cost |
|---|---|---|---|---|---|---|---|
| 1. | Undertake Health Insurance Reform | $0 | $0 | $0 | $0 | $0 | $0 |
| 2. | Addressing Physician Liability | $0 | $0 | $0 | $0 | $0 | $0 |
| 3. | Professional Training Programs | $0 | $0 | $0 | $0 | $0 | $0 |
| 4. | Development of Telemedicine | $0 | $0 | $0 | $0 | $0 | $0 |
| 5. | Prevention and Wellness | $0 | $0 | $0 | $0 | $0 | $0 |
| | Total Costs of Health Care Proposals | $0 | $0 | $0 | $0 | $0 | $0 |

EXHIBIT 4
DATE 2-2-95
HB 202

## Phase II: Steps to Implementation

### Part B:
### Requires funding

**Step 1 -** *Establish a Montana Health Care Commission with block grants for health planning regions and an electronic claims processing system. - Legislation requested by Sen. Dennis Nathe and Sen. Dorothy Eck*

**Step 2 -** *Provide health insurance for all of Montana's poor children. - Legislation requested by Rep. John Cobb and Sen. Dorothy Eck*

**Step 3 -** *Provide uniform application of tax deductions for health insurance premiums. - Legislation requested by Rep. Tom Nelson*

**Step 4 -** *Establish a family practice residency program.*

**Step 5 -** *Redesign Medicaid's hospital reimbursement system to ensure reasonable and adequate payment.*

**Step 6 -** *Establish a health care fund to support health care initiatives. - Legislation requested by Rep. John Cobb*

**Step 7 -** *Implement a tax on larger hospitals to help finance a health care trust fund. - Legislation requested by Rep. John Cobb*

## *PART B STEP 1: MONTANA HEALTH CARE COMMISSION (MHCC)*

**BACKGROUND**: Health care is one of the most significant factors in all peoples lives. It has a major impact on us not only in terms of our well-being but economically as well. Every aspect of health care affects each one of us daily, either directly or indirectly. Because of this we must approach delivery and payment of health care in a focused manner.

Until recently, the direction of health care has been driven by numerous players responding individually to opportunities or demands presented. Since the costs are now so much more than they used to be, we can no longer afford to continue this method of responding to needs. It is time this state, particularly in the absence of federal leadership, comes together and plans most aspects of health care under one umbrella. The creation of a health planning commission would allow the state to consolidate many different health related functions and thereby eliminate duplicative structure.

**RECOMMENDATION**: That the state utilize current structure and create a Montana Health Care Commission and allocate the necessary resources for the commission to properly function. Specifics of the commission's mission, objectives, functions and organization are described as follows:

Mission: To advise, provide guidance, and establish priorities on Health Care Issues.

Objectives: The primary objectives of the Montana Health Care Commission are: Responsibility for statewide and local health planning; Exploring universal access to health care for all state residents; Development of a health care database in conjunction with approved state agencies, including data on provider rates; Coordination of health care resources; Exploring health insurance reform strategies; Defining a minimum health insurance benefits package; and the promotion of public heath education and prevention activities.

Specific Functions/Activities: Specific functions/activities for MHCC are: Continue research and planning of health care issues including: universal coverage, uniform benefits, standardized reimbursement of all provider types, cost containment measures, portability of coverage regardless of job status, and applicable fiscal analysis. Develop a plan for 1995 Legislature; Make recommendations to the legislature; Facilitating statewide and local health care planning and implementation processes; Coordinate implementation of a statewide electronic claims processing system; Facilitating development and use of cost effective technology, such as telecommunications; Assisting with planning the most efficient use of public health care dollars in such areas as Medicaid and workers' compensation; Establishment of a public resource center for health insurance information

and to develop proposals for a Montana Health Care Trust, small employer buying cooperatives, and a basic health insurance package; Oversight of the Montana Center for Health Statistics; Apply for grants for demonstration projects; Develop a Health Information Help Line; Develop a pilot for single point of access for long term care; Study and make recommendations to the legislature on appropriate legislation on medical ethics issues such as quality of life and right to die issues; Study the effectiveness of the Montana Comprehensive Health Association, the high risk reinsurance plan for individuals.

Organization: The MHCC would consist of 23 members, all appointed by the Governor except four legislative appointments. One of those members would be a full-time executive director located in the Department of Health and Environmental Sciences. There would also be an appointed secretary. The commission positions would be exempt serving at the pleasure of the Governor. The budget would include funds for commission travel, operating expenses and contractual monies for projects such as electronic claims processing implementation.

Health Planning Regions: The Commission would also organize health planning regions as follows:

Planning regions are in existence now but have been relatively inactive. Part of the function of the MHCC would be to reactivate the five planning regions, establish activities/ functions, organization, etc. Examples of regional activities would be the establishment of small business health insurance cooperatives, promotion of public health education and prevention activities, exploring needs for health facilities and services. It is also envisioned that block grants would be made available to each region in order to fund such needs as: single point of access for long term care, recruitment of health care professionals including subsidizing malpractice insurance premiums, unique rural health care needs and other innovative programs of value to a region. The block grants would be $200,000 per year per region.

**LEGISLATIVE INITIATIVE: YES**

| **COST:** | FY 94 | FY 95 | FY 96 |
|---|---|---|---|
| GENERAL FUND | $122,238 | $1,072,238 | $1,072,238 |
| TOTAL COST | $344,475 | $1,144,475 | $1,144,475 |

## *PART B STEP 2: MONTANA CHILD HEALTH INSURANCE PLAN*

**BACKGROUND**: Currently 142,000 Montanans are uninsured. Over 50,000 of the uninsured, or more than one out of three are children. The Low Income Energy Assistance Program (LIEAP) health care survey showed that well over half the households surveyed are without health insurance and have overdue medical bills. Many are working adults who cannot afford adequate health care for their children because their income exceeds Montana requirements. The Medicaid Program currently covers pregnant women and children through age 6 at 133% of the federal poverty level (FPL) and children through age 9 at 100% of the FPL. Children age 10 through age 19 are covered at only 52% of the FPL. Federal regulations allow states to expand pregnant women and infants up to 185% of the FPL and expand eligibility for older children to 100% of the FPL. Expanding eligibility for pregnant women and children would reduce the number of uninsured and provide them access to appropriate health care. It would also allow the state to obtain federal funding at the rate of 72 cents for every state dollar. The expansion will reduce the amount of uncompensated care provided by hospitals and other medical providers that currently contributes to a cost shift to private payers.

**RECOMMENDATION**:

1. To expand Medicaid eligibility for pregnant women and infants to 150% of the Federal Poverty Level. This would allow Medicaid to cover an additional 483 pregnant women and infants and increase the number of Medicaid covered births in the state from 27% to 34%. It would allow more women access to prenatal care during their pregnancy which will reduce the overall costs associated with low birth weight babies and infant deaths.

2. To expand Medicaid eligibility for children up to 100% of the Federal Poverty Level. By SFY 95 we would have covered children at this level through age 11. This expansion will allow those children age 12 to age 18 to be covered up to 100% of the FPL. This expansion will allow Medicaid to cover an additional 7844 children in 1995. It will provide them access to all services covered under the current Medicaid program. Emphasis will be placed on providing regular well child care under the Kids Count Program to identify and treat conditions at the earliest possible stage.

   A summary description of the major program elements follow.

Eligibility Criteria:

- Family income and resources do not exceed program guidelines.

- Age 1 up to age 18 or pregnant
- Montana resident
- Families must enroll in group health insurance if available. Medicaid will pay the premiums if determined by SRS to be cost effective.
- Families must choose one primary care provider who will provide primary care and refer for specialty care.

* The Medicaid Program is going to research the possibility of applying for federal waivers to allow eligibility for severely handicapped children regardless of parental income.

Covered Services: Children and pregnant women will receive all services currently covered under the Montana Medicaid Program.

Reimbursement: Reimbursement will be the same as Medicaid which approximates 85% of charges for obstetrical care and 80% of charges for pediatric care. Providers must enroll in the Montana Medicaid Program to be reimbursed under this program.

Enrollment Process: Families will apply for the program at the county offices or at other qualified provider sites.

Families must pay a monthly enrollment fee of $10 per child up to a maximum of $360 per family per year.

**LEGISLATIVE INITIATIVE**: Yes

**COST**: FY95 General Fund Cost is $2,712,482
FY96 General Fund Cost is $2,893,711

Bob Frazier exhibits

EXHIBIT 4
DATE Feb. 2, 1995
HB 202



## PART B STEP 3: PROVIDE FOR UNIFORM APPLICATION OF TAX DEDUCTIONS FOR HEALTH INSURANCE PREMIUMS

**BACKGROUND**: Individuals who are privately insured receive health insurance through several financing methods. They either receive all or some of their insurance through their employer, or they buy it themselves as self-employed individuals, or they purchase individual policies. How their insurance is obtained and who pays the premiums determines who receives what tax credits or deductions and how much. Our current system does not treat all insurance premium payers equally.

Insurance premiums paid by businesses are fully deductible either as credits or expense deductions. Self-employed individuals receive a 25% credit. Insurance premiums paid by individuals are not deductible unless their total medical expenses exceed 7.5% of their income. Fortunately most people do not reach 7.5%. Unfortunately, and unfairly, they also receive no tax advantage.

Some individuals do receive full exemption from taxes on their premiums if they are insured by a plan that allows premiums to be paid with pre-tax dollars. They, however, lose some flexibility in choosing this option.

While there is debate as to the effects of allowing 100% deductibility of premiums, it is only fair to give equal credit to all persons paying insurance premiums, regardless of how the payments are made.

**RECOMMENDATION**: To promote tax equity and to encourage the purchase of insurance, which reduces bad debt cost shifting, tax laws need to be amended. The amendment should allow 100% full deductibility to any individual who pays insurance premiums. The three groups of individuals affected by this change are self-employed persons, those who purchase private individual policies, and those where the employee's share of employer provided insurance is paid with taxable income.

While we cannot change federal tax law we can change state law. Perhaps these changes will not result in significant increases in the number of insured individuals, but they will at least provide fairness in taxation.

**LEGISLATIVE INITIATIVE**: Yes

**COST**: Loss of income tax revenue to general fund is estimated at a low of $500,000 and possibly up to $1,200,000 per year.

EXHIBIT 4
DATE 2-2-95
HB 202



## *PART B STEP 4: FAMILY PRACTICE RESIDENCY PROGRAM*

**BACKGROUND**: The State of Montana is experiencing a growing shortage of physicians. There were approximately 1,250 practicing physicians in 1991. This is a physician to population ratio of 1:640. There are 35 counties listed in the September 1991 Federal Registry as Health Professional Shortage Areas. A number of these 35 have no physician. This continuing loss of physicians along with an increasing difficulty to recruit them to our rural and frontier counties is presenting a major problem for rural hospitals. This problem also severely limits the ability to provide health care access to local citizens.

Montana is one of two states (Alaska being the second) without a Family Practice Residency Program. Data indicate that approximately 70% of physicians choose an initial practice within the area, or state, where their residency was taken. This situation is compounded with the state's lack of a medical school. Montanans who want a medical education must go out of state to receive such an education.

**RECOMMENDATION**: Encourage the private sector to establish a Family Practice Residency Program within the state. This process has been started and is described below, and the ongoing efforts are endorsed assuming the November 19, 1992 study meeting also endorses the effort. This would be a public/private partnership and if the private effort agrees to continue, the state will do its part.

> "On June 1, 1992, a feasibility study was begun in order to decide whether or not a Residency in Family Practice could be started in Montana in July of 1995.
>
> The model that this particular feasibility study is looking at would require a family practice center to be built most likely in Billings. At this family practice center the main program of the residency, which would include four residents per year for a three year residency, would be housed. Those residents would be primarily trained in Billings and also some of the surrounding areas. The study is also examining a separate rural training track.
>
> It is hoped that a decision can be made at the next Steering Committee meeting on 11/19/92 as to whether this program can be implemented. If it can be implemented, the first residents would not be started until 1995 because of the lengthy process of developing accreditation and affiliation."

**LEGISLATIVE INITIATIVE**: Yes

**COST**: $200,000 general fund per year for residency program.

## *PART B STEP 5: INPATIENT HOSPITAL SERVICES RATE INCREASE AND SYSTEM UPDATE*

**BACKGROUND**: Federal law requires that state Medicaid programs reimburse hospitals with rates that are reasonable and adequate to meet the costs that must be incurred by an efficiently and economically operated hospital to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

A study of hospital reimbursement completed for the Medicaid Services Division in September 1992 indicates that an increase in the rate of payment for inpatient hospitals services is required, in order to comply with the Boren amendment. The requested increase will bring hospital payments to a level that will comply with federal regulations. The study also indicated that the Montana Medicaid Information System (MMIS) for hospital payments will need to be updated in order to more effectively control the rise of costs and distribution of payments in the hospital program. While hospitals received only minimal increases in the **base** rate in 1990 and 1991, a rapidly increasing number of cases were being paid through the policies intended only for exceptions. This has caused a rapid increase in the cost of inpatient services to the Medicaid program, without the control that can be achieved through regular updates to the MMIS reimbursement system. Inpatient hospital services is one of the most significant parts of the Montana Medicaid Program; 1993 reimbursement is projected to approach $67,000,000. According to the study, failure to update the MMIS system will likely result in a higher rate of increase of hospital costs to the Medicaid program, due to the ever increasing number of cases that qualify as exceptions under the current system.

Hospitals have received no increase in the base payment rate since FY 1991. A scheduled increase for fiscal year 1993 was canceled in the 1992 special legislative session.

**RECOMMENDATIONS**:

1. Increase the payment level to inpatient hospitals to adequately reimburse hospitals according to the requirements of the Boren Amendment.
2. Update the MMIS operating system to ensure the maintenance of control over hospital levels of payment.

**LEGISLATIVE INITIATIVE**: Yes

| **COST**: | SFY 1994 | SFY 1995 |
|---|---|---|
| GENERAL FUNDS | $1,932,064 | $2,788,349 |
| FEDERAL FUNDS | $4,188,738 | $5,789,530 |
| TOTAL FUNDS | $6,120,802 | $8,577,879 |

**ASSUMPTIONS**:

The federal funding participation will be approximately 71.12% in 1994 and 1995.

The federal funding participation for MMIS updates will be 75% in 1994 and 1995.

State Medical is all General Fund.

1994 projected expenditures, with no volume increase, and before the requested rate increase will be $66,979,267.

1994 rate increase of 8.24% will result in a total increase for Medicaid of $5,515,940 ; and a total increase for State Medical of $204,862.

1995 rate increase of 3.8% will result in a total increase for Medicaid of $8,270,757 ; and a total increase for State Medical of $307,122.

Update of the MMIS system will cost $400,000 in SFY 1994.

That these increases in the hospital rates and accompanying controls on the reimbursement system will result in payment of approximately 92% of the cost of the hospitals associated with treating Medicaid patients.

| **FUNDING NOTES**: | 1994 | 1995 |
|---|---|---|
| PRIMARY CARE | $5,515,940 | $8,270,757 |
| MMIS | 400,000 | 0 |
| STATE MEDICAL | 204,862 | 307,122 |
| TOTAL | $6,120,802 | $8,577,879 |

## *PART B STEP 6: ESTABLISH A HEALTH CARE TRUST FUND.*

**BACKGROUND**: Health care planning and reform requires long range vision and goals. This process can only succeed if adequate funding is assured from year to year. Expanded coverage for children up to 100% of poverty and the Montana Health Care Commission are two examples of critical programs which need a solid funding base in order to properly perform their functions and achieve their goals.

All expenditures associated with the recommendations of Phase II of Health Care for Montanans are to be financed with their own funding source. The general fund is not asked for an appropriation. To assure the revenue sources for Phase II are appropriated to the original purposes, it is necessary those funds be protected.

**RECOMMENDATION**: Establish a Montana Health Care Trust Fund to receive all designated revenues. Funds could then be appropriated by the legislature only for certain health care purposes. Less resistance is expected from payers of designated revenue sources if the money is guaranteed to go to health care spending. The trust fund would be administered by the Montana Health Care Commission. Much of the funds could be used for matching for federal Medicaid dollars. This will greatly enhance the total resources of the trust fund.

**LEGISLATIVE INITIATIVE**: Yes

**COST**: No general fund cost.

# How Federal Medicaid Matching Works

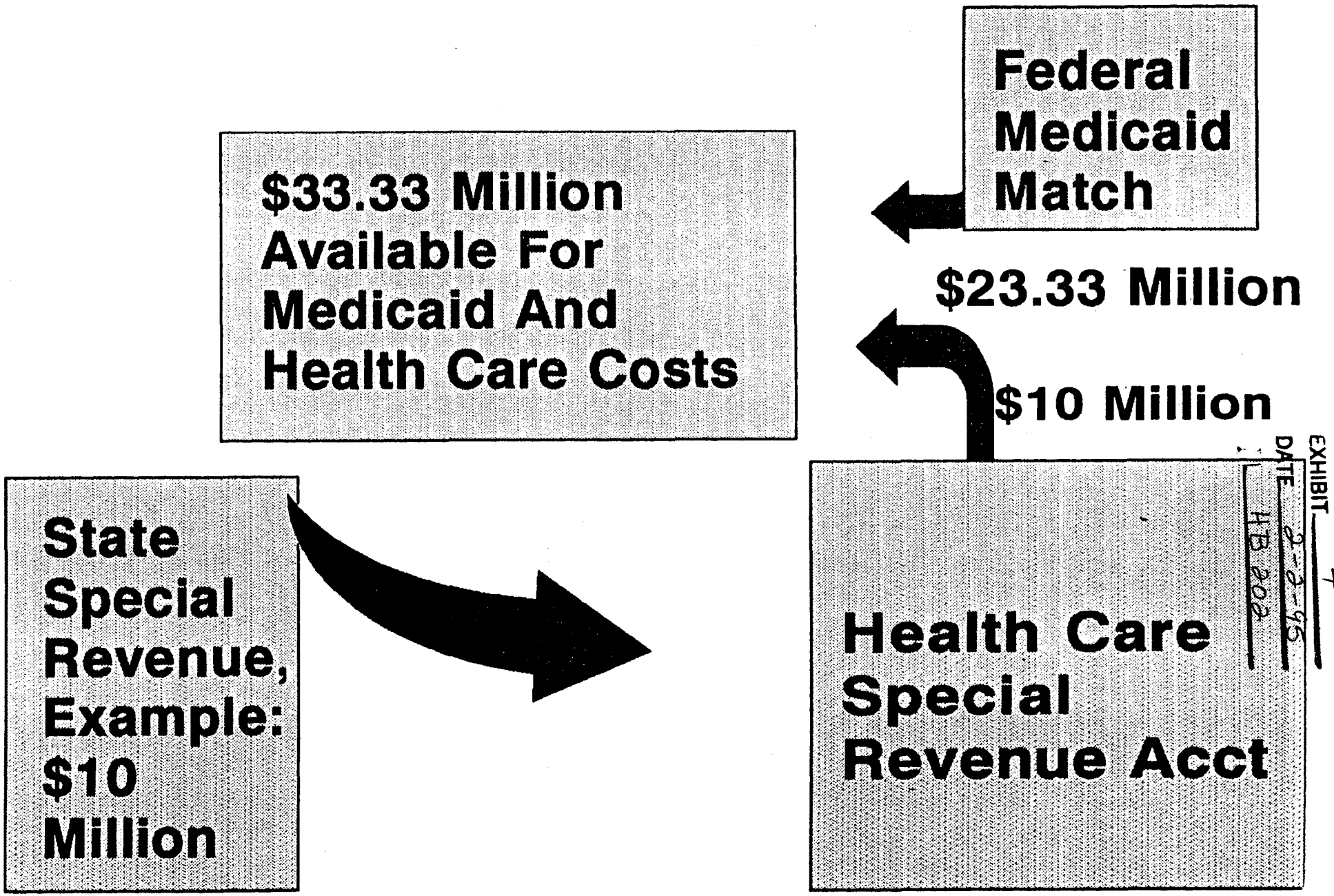


EXHIBIT 4
DATE 2-2-95
HB 202

## *PART B STEP 7: HOSPITAL REVENUE TAX PROPOSAL*

**BACKGROUND**: A 1.1 percent tax on hospital revenues is proposed to fund Health Care For Montanans - Phase II. All funds generated by this proposal would be placed in the Health Care Trust. These funds can only be used to improve access to health care.

Hospital revenue taxes, ranging from 1 to 19 percent, are utilized in 17 states according to a state survey conducted by the American Public Welfare Association in August 1991. These taxes have been used to fund expansions to state Medicaid programs, raise provider rates, and in the case of Minnesota, to cover Minnesota's uninsured by taxing all health care providers.

In Montana, the definition of tax revenue will not include cash discounts, bad debt, uncompensated or charity care or contractual allowances. It will also exclude revenue generated from licensed nursing facilities that are operated by a hospital. A federal waiver to exempt 5 medical assistance facilities and 20 rural hospitals from the tax will be applied for. Rural hospitals are those facilities located in counties with less than 2500 residents as designated by the Department of Agriculture. These facilities are being exempted because they are in such sparsely populated sites that they have difficulty sustaining a hospital at present and a significant access problem for acute care services will exist if the existing facilities do not continue to be operational.

**RECOMMENDATIONS**:

1. Implement a provider tax on larger hospitals at 1.1% which will be matched by Medicaid federal funds.

**LEGISLATIVE INITIATIVE**: Yes

**COST**:

| | SFY 1994 | SFY 1995 |
|---|---|---|
| GENERAL FUNDS | $3,859,063 | $ 8,374,168 |
| FEDERAL FUNDS | $6,078,584 | $13,461,671 |
| TOTAL FUNDS | $9,937,647 | $21,835,839 |

# Summary of Fiscal Impact for Governor Stephens' Health Care for Montanans Proposal – B

| | Description | FY 94 General Fund Cost | FY 94 Total Cost | FY 95 General Fund Cost | FY 95 Total Cost | FY 96 General Fund Cost | FY 96 Total Cost |
|---|---|---|---|---|---|---|---|
| 1A. | Montana Health Care Commission | $72,238 | $144,475 | $72,238 | $144,475 | $72,238 | $144,475 |
| 1B. | Block Grants To Regions ($200,000 to each Region | $0 | $0 | $1,000,000 | $1,000,000 | $1,000,000 | $1,000,000 |
| 1C. | Single Billing System | $50,000 | $200,000 | $0 | $0 | $0 | $0 |
| 2. | Insurance For Low Income Children | $133,933 | $317,867 | $2,712,482 | $8,559,822 | $2,893,711 | $9,017,455 |
| 3. | Uniform Application of Tax Deductions | $850,000 | $850,000 | $850,000 | $850,000 | $850,000 | $850,000 |
| 4. | Family Practice Residency Program | $200,000 | $200,000 | $200,000 | $200,000 | $200,000 | $200,000 |
| 5. | Redesign Hospital Reimbursement System | $1,932,064 | $6,120,802 | $2,788,349 | $8,577,879 | $2,788,349 | $8,577,879 |
| | Total Costs of Health Care Proposals | $3,238,235 | $7,833,144 | $7,623,069 | $19,332,176 | $7,804,298 | $19,789,809 |
| 7. | Implement Provider Tax on larger hospitals at 1.1% | ($3,859,063) | ($9,937,647) | ($8,374,168) | ($21,835,839) | ($9,086,000) | ($24,062,149) |
| 6. | Health Care Trust Fund ** | $620,829 | $2,104,503 | $751,099 | $2,503,663 | $1,281,702 | $4,272,340 |

** Assumes that the health care trust fund monies can be matched with federal funds.

## HEALTH CARE FOR MONTANANS
### Steering Committee

*Julia E. Robinson, Chair*
*Director*
*Department of Social & Rehabilitation Services*

*Representative Fred Thomas*
*Stevensville, MT*

*Senator Dorothy Eck*
*Bozeman, MT*

*Van Kirke Nelson, M.D.*
*Ob-Gyn Associates, P.C.*

*Hank Hudson, Deputy Director*
*Department of Social & Rehabilitation Services*

*Carl Visser, Executive Director*
*District 7, HRDC*

*Barbara Bartell*
*Business and Professional Women's Association*

*Tom Cherry*
*Montana Hospital Research*
*and Education Foundation*

*Ex-Officio Members:*
*Bob Frazier*
*U of M President's Office*

*Nancy Ellery*
*Department of SRS*

*SRS Staff:*
*Rick Harden*
*Terry Frisch*
*Sylvia Kinsey*

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 202

DATE 2-2-95 SPONSOR(S) Nelson

**PLEASE PRINT PLEASE PRINT PLEASE PRINT**

| NAME AND ADDRESS | REPRESENTING | BILL | OPPOSE | SUPPORT |
|---|---|---|---|---|
| Brad Griffin | MT Retail Assoc. | 202 | | X |
| Riley Johnson | NFIB | 202 | | X |
| Jim Tutwiler | MT Chamber | HB 202 | | ✓ |
| Robert White | Bozeman Chamber | HB 202 | | ✓ |
| Ed Caplis | MSCA | HB 202 | | ✓ |
| Susan Good | Nat Montana | HB 202 | | ✓ |
| Bob Fraser | | HB 202 | | ✓ |
| John Flink | MHA | | | ✓ |
| Mary Allen | MMBP MHAAAA Assoc. | HB 202 | | ✓ |
| LARRY AKEY | MT ASSOC OF LIFE UNDERWRITERS | HB 202 | | ✓ |
| | | | | |
| | | | | |
| | | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 202

DATE 2-2-95 SPONSOR(S) Nelson

**PLEASE PRINT PLEASE PRINT PLEASE PRINT**

| NAME AND ADDRESS | REPRESENTING | BILL | OPPOSE | SUPPORT |
|---|---|---|---|---|
| Sam Hubbard | Health Care Authority | HB202 | | X |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.