MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN SCOTT ORR**, on January 5, 1995, at 3:05 P.M.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. John Johnson (D)
Rep. Royal C. Johnson (R)
Rep. Betty Lou Kasten (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)
Rep. Carolyn M. Squires (D)

Members Excused: N/A

Members Absent: Rep. Tom Nelson

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.

CHAIRMAN ORR welcomed members of the House Select Committee on Health Care and announced that **VICE CHAIR CARLEY TUSS** and he will review the minutes before signing.

CHAIRMAN ORR announced that proxies should have Select Health Care Committee and the date written on them. **REP. TUSS** will handle the proxies for the minority party and **REP. Dick SIMPKINS** will handle the proxies for the majority party.

CHAIRMAN ORR announced that committee members with soft voices should sit closer to the microphone for better reception on the cassette tape. Where the committee members sit at the next meeting will be the assigned seating.

CHAIRMAN ORR took a collection of $2.00 from each committee member for the coffee fund.

The purpose of the meeting is to hear the guest speaker **Dr. Larry Bartlett.**

Sam Hubbard, Executive Director Health Care Authority, announced that folders have been put together for committee members which includes a copy of the memorandum relating to the Montana Health Care Authority's budget proposal for the next biennium, a Summary of Recommendations for the Market-Based Sequential Health Care Reform Plan, a list of board members and ex-officio members and the staff with their office and home phone numbers, and the reports entitled: "Designing a Health Purchasing Pool for Montana," and "An Assessment of Montana's Certificate of Need Program," both reports required by SB 285. (EXHIBIT 1, January 3, 1995)

The guest speaker is **Dr. Larry Bartlett, Health Care Authority Consultant.** Dr. Bartlett is the founder and Director of Health Systems Research which is a Washington, D.C.-based firm consulted as a resource for the Health Care Authority for the Universal Access planning. Dr. Bartlett is a health care expert in finance and delivery systems and has worked for the National Governor's Association. Health Systems Research has considerable experience with states with significant rural populations.

Dr. Larry Bartlett said he would like to discuss why there is a focus on health care reform, the problems, and the future, and to give a better understanding of the work Health Systems Research did in the last 12 months.

Pollsters worked to define the problems within the health care system as an access problem, a quality problem, or a cost problem. The pollsters' findings reflected a cost problem.

The data collected and analyzed for Montana showed clearly that health care costs were rising more rapidly than other aspects of the economy. Between 1980 to 1990 there was a little less than 10 per cent increase in inflation within Montana; by contrast, during that same ten year period, health care expenditures increased 143 per cent. That 143 per cent is a problem because it is higher than the growth in the economy. The per capita health care spending in Montana is less than the national average and much less than a lot of the states in the United States. Montana's rate of growth during that 10 year period is about the same as the national level. At the end of 1993, close to 14 per cent of gross national product is going to health care.

Most Montanans receive their health care coverage through their place of work and it is tied to some aspect of the economy. Of the public health care premiums or health care payments paid by the workers in Montana, if we have 143 per cent increase during that 10 year period the average wages and salaries in Montana grew by about 52 per cent according to Montana's Department of Labor. Health care expenditures in Montana grew almost three

times as much as the wage and salary base which is usually the basis for those payments. This meant that employer benefit payments provided to workers in Montana grew at three times the rate of the base for the salaries, and that it was an increasingly bigger portion of the cost of labor within Montana. In fact, a lot of the increases in health care costs were probably responsible for only a 52 per cent growth in wages and salaries because of the crowding out of the cost of that benefit on take home pay to individuals. Health care costs to workers, non-workers, their families, and to the government has been an increasing burden over the last decade due to the effect that it had on salaries and the out-of-pocket expenses. The Medicaid budget has been growing rapidly.

On the national level for 1993, health care costs dropped from about 10 per cent to about 7.8 per cent. However, there are two things that should be kept in mind:

1. Health care costs are related to the increase of overall inflation. For 1993, inflation has been low. The about 7.8 per cent is still about three percentage points above the overall level of inflation and above what the gross domestic product has been.

2. Some interesting research on the ebb and flow of policy making at the national level and the changes in health care spending shows throughout a good period of time, that whenever there has been significant discussion of major health care reform and policy changes to the health care system, you will see increases in health care spending drop. After those proposals have gone by the wayside, a major increase in health care spending can be anticipated.

Dr. Bartlett does not expect to see a breakthrough in major changes in the trends in health care nationally or in the state of Montana. He does not feel that we can expect them to suddenly bring health care costs in line with the economy of the state of Montana and the ability of the people in the state of Montana to pay for health care. It is **Dr. Bartlett's** opinion that the health care cost problem will be with us in the future.

The second problem found was that the state of Montana, and just about every state in the union, have a fairly significant portion of its population that is uninsured. They are not covered by private coverage, Medicare, or Medicaid. The estimates show that about 100,000 people within the state of Montana at any point in time are lacking health care coverage. The per cent of Montana's population that is uninsured is a little below the national average. The Census Bureau showed a 15 per cent increase uninsured from 1993 to 1994 in Montana; not too dissimilar from the increases that were seen at the national level. However, the data shows that one reason the number of uninsured in the state of Montana is not significantly greater is because Montana has experienced significant increase in enrollment within the Medicaid program. This has been driven in part by some of the requirements established at the Federal level stating that

certain individuals have to be covered. Many of the uninsured are young; many are low-income workers; about 85 per cent of the uninsured in the state of Montana are non-elderly adults with full or part-time jobs, or dependents of those workers. This group does not have employer-based coverage. This is a concern because they do not get the care that they need, they don't benefit from preventive care and when they do get sick they go to emergency rooms with much more frequency than those who are insured. The cost of covering the uninsured, particularly if they are low-income, is cost-shifting greatly, and passed on through higher charges levied upon individuals that do have coverage by providers. This enables them to remain financially stable. The trends that are being seen in the state of Montana and nationally is that the number of uninsured is probably going to rise.

The third problem seen in Montana is that Montana has a very "frail" delivery system. Many of the people in Montana do not have adequate access to health care. This is probably one of the main reasons why Montana's per capita health care costs are lower than national rates. Montana has some fairly significant shortages in provider capacity, particularly in primary care. Half of the state of Montana, and half of the counties are designated as medically underserved areas. A fairly significant number of Montana's rural hospitals are in a level of financial stress caused, in part, by Medicare problems in terms of Medicare payment shortfalls; also, because of the configuration of Montana's delivery system in terms of efficiency.

Another major problem is the fact that a lot about what is going on within a very major segment of Montana's economy is not known. We, as the people of Montana, don't have a lot of knowledge about what is being spent, what we're getting for our dollars, what the efficiency or effectiveness of our delivery system is.

Dr. Bartlett asserted that market-based changes taking place probably will not be enough to deal with the health care problems. Firstly, the health care market place is not like an efficient economic market in the sense that there are many areas of the state where competition just does not exist. Secondly, the people who make decisions within the market need good information in order for markets to work efficiently and do all of the beneficial things that they can do. They need good information about prices, outcomes and effectiveness in one approach versus another, and those things just don't exist. **Dr. Bartlett** feels that there is a lot of potential for markets to play a very important role and address some of these problems to some degree. Also, reflected in some of the provisions made by the Authority of Health Care is that there may be a role for the public sector to play in dealing with some of these deficiencies and making the health care market perform better.

REP. LIZ SMITH wanted to know how the data had been collected for the state of Montana.

Dr. Bartlett said that they had used every source available nationally and statewide. Estimates were taken from the Census data for the state of Montana and combined multiple years to retrieve information that was statistically solid. The Department of Labor was used to retrieve information about the composition and characteristics of Montana's business force and the employment of the state of Montana, so that they could determine what the impact of different financing approaches would be. They had very good cooperation from some of the major carriers within Montana, such as Blue Cross Blue Shield. They pulled data from the Insurance Commissioner's Office in terms of other private sector plans. They pulled information from Medicare at the Federal level, and Medicaid. There has been survey work done through the regional board that has been quite valuable. They put together a broad cross-cut of health care spending within the state of Montana.

However, there are some major holes in the data in certain areas. They were unable to get good information on self-funded or self-insured larger businesses that provide health care coverage to their workers in Montana. This is, likely, a very significant piece of health care spending in Montana, but there is no way of pulling that information.

REP. SMITH wanted to know how to collect additional and accurate data, and what resources could be utilized.

Dr. Bartlett responded that it depends on what information you are looking for. Claims payments would be a good starting point, or collecting resources through the Resource Management Plan. One of the big questions is how much we spend on health care within the state of Montana. Claims payments can give you information on price levels on services. A sensible starting point would be to gather information between a provider and an individual, or a provider and an insurer, or a provider and an employer. Additional follow up activities could be pursued, such as looking at different levels in surgical rates, hysterectomy rates, tonsillectomy rates, across communities that look exactly the same, after adjusting for age, sex, and other variables. Information needs to be gathered to gain knowledge, and then to learn to use that information. We don't know a lot about what works, what doesn't work, what level is right or wrong, etc.

REP. RICHARD SIMPKINS noted an example of a medical bill processed through CHAMPUS. CHAMPUS only allowed one-half of $9000 on the hospital bill. If Montana's per capita health care spending is about average, the disparity difference indicates that the government is not picking up their fair share of the same rate.

Dr. Bartlett agreed that **REP. SIMPKINS** was correct, and made two very good points. Remember that even if your health care spending is average, you still have an increase problem. A 10 per cent average is a lot more average increase than everything else.

Greater and greater cost shifting has been taking place nationally in terms of who pays the bills. The third party payer is trying to control their own costs, so they pay less. This cost shifts over to you.

There is a difference between containing the costs by cost shifting to someone else to pick up, or truly containing costs by doing something to lower the overall cost of the procedure.

REP. SIMPKINS noted that private insurance carriers eliminated scheduled benefits to maintain costs, and yet the federal government is still maintaining that schedule. **REP. SIMPKINS** also noted that the private carrier is "getting a bad rap" when the "government is still maintaining that schedule and just failing to adjust it" and using that as their allowable amount.

Dr. Bartlett agrees that there is no question that the federal government, particularly through the Medicare program in recent years, leans towards "taking care of itself," as does CHAMPUS, and the state and federal the Medicaid program. "Insurance carriers have certainly always gotten the rap in terms of why is my premium going up. There is probably some blame to go around if insurance carriers don't push for cost containment."

REP. SIMPKINS said that "it is time that we admit that the practices of the federal government has caused our personal insurance rates to go up."

REP. SIMPKINS asked if they checked insurance coverages such as Medicaid, Medicare, and individual insurance policies to see if they "have not really increased the deductible portion of the front end deductible in the same relationship as to the annual inflation rates." **REP. SIMPKINS** wanted to know "if we had kept up that deductible along with the inflation factor, we wouldn't see such a great growth in insurance premiums."

Dr. Bartlett replied that "there is not a lot of deductions or co-payments and the like in Medicaid," for example, partly because of the nature of the population it served. The low income population doesn't have a lot of money. Some cost sharing provisions have been put in place "on the hospital side" and in a couple of other areas. "Research shows that there are very effective co-payments in reducing utilization and , therefore, reducing costs. Particularly, the lower income you are, the faster you are going to get that effect." The research also shows that of the "types of services that are no longer utilized, when that utilization drops down, what is lost is both ineffective services as well as effective services. There is no distinction or differentiation in terms of how that utilization decrease is achieved."

Dr. Bartlett said that "one of the major losses, in terms of deductibles, co-insurance, or any type of cost sharing on preventive services, particularly for kids, will have a very

positive effect in reducing utilization for those services," and **Dr. Bartlett** suggests "a very negative effect on the positive aspect of that benefit on approving status of those kids." Preventive care is cost effective. **Dr. Bartlett** said that if one of your policy objectives is to get people access to preventive care, deductibles in that area can be self-defeating. "You will probably find that the cost sharing on the private sector side has probably gone up faster than that rate of growth." There are two types of cost sharing and both have gone up; they are the "terms of the per cent of the premium that you pay, and what you pay out-of-pocket once you have the coverage, deductibles and co-insurance." Data shows that "cost sharing has been the answer rather than cutting benefits or doing other things, they just raise the deductible."

REP. SIMPKINS noted that "most people are concerned about their personal private insurance." Many people do not understand the principles of Medicaid. Medicaid has a zero deductible. We have a system that had available preventive Medicare at zero cost and it was not utilized.

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REP. SIMPKINS wanted to know if when using the census data for person's uninsured, does the data reflect individuals "laid off the job for periods of time and are already lumped into that number but should be taken out" to reflect a true picture of the problem.

Dr. Bartlett responded that the data reflects a "point in time estimate." This data was taken in March. The estimate includes a mix of folks who may be temporarily uninsured because they're changing jobs, and people uninsured for the entire year. "On any given day there are roughly 100,000 persons uninsured."

REP. SIMPKINS asked for clarification that out of 100,000, approximately 50 per cent are a problem.

Dr. Bartlett responded that he would not say that. It is a risk factor. For the period of time that an individual is uninsured, they are vulnerable. If they should happen to be diagnosed with a catastrophic illness that would preclude them from ever getting coverage. Remember, however, that there are far more people who are under-insured and at risk of catastrophic loss if they become sick, then there are uninsured people.

Dr. Bartlett reported that Montana has a lot of people as compared to the nation as a whole, who have "fairly bare bones coverage, have high deductibles." In terms of the risk factor, there are a lot of people, including a lot of Montanans who are under-insured who are at risk of financial problems.

REP. SIMPKINS noted the "immortality complex" of many young adults who would rather buy other things instead of insurance.

Dr. Bartlett responded that the highest age group of uninsured are young adults, ages 18 to 24. The reasons they are uninsured is because they lose their parent's health care coverage, they're starting out on the work force with low paying jobs with few benefits. This age group is healthier, but a study done in the state of Florida showed that "over 50 per cent of all the uncompensated hospital care passed on to private payers were due to pregnancies and accidents." The 18 to 24-year-old age group is most likely to experience pregnancies and accidents. This group is probably at the highest risk to generate uncompensated care that the private payer will end up paying for.

REP. BRUCE SIMON asked for confirmation that the data for the number of uninsured was done in March.

Dr. Bartlett responded that the interview is usually done in March. It is part of the national current population survey.

Rep. Simon noted that in the state of Montana, March may be a "point in time when there would likely be a lower level of employment for a lot of people in highway construction, building construction, agriculture, tourism," where people may be employed, but not in March. If your statistics look at the employment rate, of March, they may have artificially changed the true picture on an annual basis.

Dr. Bartlett agrees that the issue is potentially a factor, and that it can be worked with. **Dr. Bartlett** "does not recall a significant increase in the disproportionate picture" of Montana's uninsured being full-time, part-year workers. Likely, those people in tourism, construction, agriculture, and the like are probably moving into jobs, however, they may not be receiving health benefits through those jobs.

Dr. Bartlett noted that when they were looking at Alaska, they found that the uninsured in Alaska were relatively wealthy, and they were disproportionately full-time, part-year. What they found was that there were a lot of people involved in fishing, mining and tourism during several months of the year. These people made "a lot of money, but did not get health care through their place of work," and had a tough time getting it on their own.

REP. SIMON said that health care today is a different product than it was 20 years ago. **REP. SIMON** wanted to know how do we make the comparisons come out to be reasonable when discussing health care increases.

Dr. Bartlett responded that some of the underlying causes for the health care cost increases are aging in population, increase in population, price changes in terms that health care commodities

have been basically running at twice the price levels for Consumer Price Index (CPI). There is, also, residual for technology changes and utilization changes.

There is a debate about whether technology is really the driving force behind this whole thing. Data on medical effectiveness research on a number of different studies showed that when a group of experts look at procedures that had been done, and evaluated to see if they were medically indicated, or really have some value added, about 38 per cent were considered inappropriate.

"Yes. The products are different, I'm not saying that we're not getting more for our money on an inflation adjusted basis." There are indications that "cost expenditures are going quite high, faster than the underlying trend." **Dr. Bartlett** said that a lot of the expenditures are for things that don't have proven cost effectiveness. "What we're looking to move to are systems where someone, whether it be the provider, the system, the managed care entity, or someone is trying to make those informed decisions and try to make sure that what we are purchasing is, in fact, for improving health outcomes."

REP. SIMON said the measurement of health outcomes can be a difficult problem. **REP. SIMON** had studied recently the treatment of heart disease in the U.S. and Canada. The U.S. does considerably more bypass surgeries and angioplasties than Canadians do on a percentage basis, and yet the outcomes measured, based on mortality, were almost the same. However, if measured a year later on the quality of life factor, "the Canadians were way up the scale on symptomatic, whereas the Americans had returned to a normal life." **REP. SIMON** wanted to know how to measure this.

Dr. Bartlett responded that medical effectiveness research is some of the most complicated, costly work. There are multiple outcomes. "What we have done in effectiveness research, historically, is look at 30-day, post-discharge mortality. Most of the medical effectiveness research that we've done has been on surgical interventions and the measures post, 30-day mortality." There are indications that there "are a lot of stuff going on out there that is not medically indicated." Not necessarily that people are "gouging people or trying to make a buck", but it is just that there is a lot of variation.

REP. SIMON wanted to know how far back **Dr. Bartlett's** study went concerning CPI and health care cost increases. "The spike in that particular graph occurs, interestingly enough, at the same time as we had government intervention into the health care system in the form of Medicare, and it has gotten worse with Medicaid." **REP. SIMON** focused on statistics that the government is probably a bigger problem than the insurance companies, or the hospitals, or the doctors.

Dr. Bartlett responded that there are no Montana figures that go back, but that **REP. SIMON** is entirely correct, and that Medicare and Medicaid were passed at about the same time in the late 1960's, and what the graph shows is a steepening curve in health care expenditures. There is a new infusion of dollars that probably meant more people using more services, probably people increasing prices because there was a demand, as well as the promotion of an industry to "develop new techniques because there is funding out there." **Dr. Bartlett** thinks that all of these things came into play. Looking at that number and what is an acceptable rate of growth, "we don't really don't have an idea what is okay. How much of that big increase was to provide access to medically necessary services to low income people or to elderly people that did not have access to it before." There was a "steeper incline, and it was for good stuff."

Dr. Bartlett said that "in 1965, we hadn't the foggiest idea about effectiveness research or value for money, or whatever it might be." **Dr. Bartlett** told us that there was an even steeper increase in the 1950's when private insurance came on board. It was in the 1940's when there was a move towards antibiotics during WWII where there was the biggest incline because "it was a market that almost didn't exist, 60 years ago."

REP. SIMON wanted to know if there was any way to separate an inflationary increase and the utilization components from the statistics, and how much is an increase due to the utilization components and how much is an actual component created by increases in prices.

Dr. Bartlett replied that he doesn't have that information on Montana because it doesn't exist. **Dr. Bartlett** asked if the price increases are a problem or not a problem. **Dr. Bartlett** said that "is it a problem, or people perceive it as a problem because it is a rate of growth that is significantly exceeding our ability to pay for it." **Dr. Bartlett** reiterated that there is some "unsettling information to indicate that we may not be getting value for our dollar." Some purchases may not be a proven effectiveness or don't really improve health status, or we may be delivering services in an ineffective fashion. The rate of growth is a concern.

Dr. Bartlett stated that all the underlying problems still exist within the health care system.

Dr. Bartlett said to keep in mind that the focus on the two Alternative Universal Access Plans really were driven by the legislature. **Dr. Bartlett** stated that SB 285 was fairly specific "about what the authority had to look at, what had to be modeled out, costed out and the like." **Dr. Bartlett** commented that the Single Payer Plan in SB 285, for example, "is not the typical Canadian approach and really does have a market component in there, to the degree that the authority members decided that they really did want to have plan choice, really did want to spur some

competition across plans even if one entity through a tax basis was really paying for it."

Dr. Bartlett said a key issue in the Regulated Multiple Payer approach is responsibility when dealing with Universal Coverage, if it is not government through a tax-based system. Whether the responsibility issue lay on the employer or the individual is a tough question. He states that it tends to lie with the individual because employer mandates might be generated."

Dr. Bartlett stated "that if neither of those things are politically viable" at this point in time, not to consider it a wasted effort. **Dr. Bartlett** characterizes SB 285 in the state of Montana and the authority as doing is looking at the "big picture." **Dr. Bartlett** said, "I will tell you to a state, just about every state that we have dealt with in terms of taking those little half-steps at some point in time throws up their hands and said, 'this is making no sense to me because I don't have a game plan." However, taking the little half-steps and looking at the big picture are complimentary. Look at a major number of the recommendations in the Third Plan Recommendations received from the authority. You will, also, find them in the Regulated Multiple Payer Approach as being part of a process of making steps in the right direction for addressing problems that exist in the system, and, it "also, bit off the very tough objective of providing Universal Coverage for everyone." **Dr. Bartlett** reiterated that he does not consider it a wasted effort. **Dr. Bartlett** stated that "there was a ton of data" pulled from various sources and compiled to give the legislatures a better sense of the health care environment within the state of Montana. **Dr. Bartlett** noted that there was a lot of very good discussion among the authority members on some of the really tough issues, such as, "if you had to achieve Universal Coverage, are we talking about an employer mandate, or are we talking about an individual with requirements, or is there any way around that." There was more public involvement in that process than **Dr. Bartlett** had seen in any other state in the union.

Dr. Bartlett stated that "you don't want to have to keep on relying on someone like me" to put together data and say "this is what we think the health care within the state of Montana looks like. You want to know. You want to have a sense. You want to think about how you want to use that information, and you're never going to get there unless you take that step and start thinking about the data system."

If underlying inflation goes up, then health care inflation is going to go up. Then people become fear driven. When the costs were going up, and there was pressure on the employers, a lot of people were afraid that their employer was going to drop coverage or that their health care benefits weren't going to be there for them when they needed it. **Dr. Bartlett** said "we have low inflation now, but as soon as it kicks back in, I think you're going to have that fear element come back in."

In the Small Market Reform, at least for a segment of the market place, is designed to address individuals who are in between coverage and the portability issue, and of being "lopped off coverage," in terms of "if you became ill, then you were rated through the roof and you couldn't get coverage, or your employer was dropped.

REP. BEVERLY BARNHART stated that most people get health insurance from the business community. However, it is a wide mix of different coverages, and some people may have to pay the whole thing even though it comes from their workplace.

Dr. Bartlett responded that Coopers & Lybrand describes the types of coverage which is in the market place. (See Exhibit 1) In general, a profile of the coverage which exists within Montana shows a lot more individual coverage than exists at the national level "in terms of whether you get group coverage, usually through your place of employment, or whether you buy private coverage on your own." This is due to the agricultural nature of the state of Montana and a number of other factors where there is not a link to the work place. The coverage in Montana leans toward high cost sharing, when compared to deductibles and the like.

REP. BARNHART wanted to know if the 85 per cent that are working full-time, but are uninsured, were offered insurance premiums.

Dr. Bartlett responded that very few people who are offered health care coverage at their place of employment refuse it on the individual basis. However, a trend seen clearly across the country is that about one quarter of all uninsured children have at least one parent who has employment-based coverage. Nationally, you will find a fairly significant disparity in terms of what business premium sharing arrangements are. They will usually pick up about 80 per cent of the premium for individual coverage for the worker. Nationally, small businesses pick up close to 100 per cent of the coverage. "On the family coverage side of things, they usually pick up about 50 per cent." That can be between two and three times the individual policy. They think the reason why a lot of children are uninsured, even though their parents have individual coverage, is because the parents cannot afford the very significant premium contribution required to cover the family.

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REP. CAROLYN SQUIRES stated that problems still haven't been resolved. Some good has been done for Montanans, but we still have a faction of society that still has the same problem.

Dr. Bartlett responded that the legislators did a good thing in preventing some people from being priced completely out of the

market. People that really need the coverage who are dropped "when they move from plan to plan can't get back in because of preexisting conditions and the like." Probably the biggest misconception that exists is that the group market reforms are a cost containment mechanism. Intrinsically they are not. They are an access issue.

Dr. Bartlett said that by moving from plan to plan, each year there is a one-year exclusionary period for preexisting conditions which will reduce the rate. The next year the rate goes up because those preexisting condition problems are covered. There are a lot of people who just change plans. This is to try to prevent that, which means that this will probably bring people who are costly onto the system. It is not cost containment. "The reason that some people are uninsured may be personal choice, but at the heart of the whole thing in terms of the employer decision, and to some degree the family decision, it's a cost issue." **Dr. Bartlett** says that you can't necessarily evaluate the effectiveness of different interventions. "I always say figure out what it's supposed to do in the first place and then evaluate it on the basis of that." Small group reform is not cost containment. "Some of the things that are in there in terms of the hope of establishing the purchasing pools to pull the small businesses together give them some clout and some negotiating ability through the pool with insurers who in turn will have to put the squeeze on purchase on the providers. That has potential cost containment aspects." But, unless you bring costs under control, and not necessarily in a heavy, regulatory way, there is a movement towards managed care in the state of Montana. You can mandate it. The Universal Coverage Approaches mandate it or say it's a state responsibility. That's an attempt to put someone in charge and make some decisions, as to whether a procedure is going to give the benefits or have the value associated with it. There are a lot of issues in terms of whether there is inappropriate restrictions on access and how do we maintain quality. It is in many instances one of the few ways designed to reduce cost which in turn can make coverage more affordable and more accessible.

REP. SQUIRES announced that she had attended a conference in Scottsdale regarding HMO's, accessibility and portability. She stated that many people do not have access to coverage.

Dr. Bartlett said that he asked the Authority members if it is possible to have Universal Coverage without some type of requirement. The answer is no.

REP. SQUIRES wanted to know what would be the comfort zone for actual coverage.

Dr. Bartlett responded that we are currently at about 15 per cent now, or 85 per cent comfort level. Costs continue to go up higher than our ability to pay for it. To get to 95 per cent comfort zone something policy-wise has to be done to make sure

that you move from 85 to 95, as opposed to slipping from 85 down to 80.

REP. SIMON stated that Volunteer Purchasing Pools sound like a good thing because with a lot of people in the pool, you have more clout to negotiate with. But, it seems like, what we have done within the insurance companies is what we have essentially done on an overall scale with health care. The two big groups, Medicare and Medicaid, cost-shifted out of the private insured. Now we have private insured with big groups that have negotiated a better deal and they cost-shifted over to the individual. If all of the individuals are put into a group, there is no place to cost shift to. **REP. SIMON** noted that they'd have more negotiating power, but wanted to know how it would affect the overall total dollars, and have we really changed anything.

Dr. Bartlett responded that is entirely correct, "but let's carry it through a little bit." If you group the people together to negotiate for lower rates there are a couple of things that need to occur, and there are success stories about this in other jurisdictions. To negotiate for lower rates as a group you have to have at least a handful of insurance plans that will cover the group. The insurer will be worried that others are taking their business from them, so they will work harder to get their prices down. The insurer can perhaps cost-shift to someplace else, but if people negotiate as a group they are running out of places to cost-shift to. The expectation of this market-based approach is that the insurer does two things. The insurer introduces some organization and management in order to provide these people good health care for this amount of money, and the insurer will have to eliminate useless and inappropriate things.

Dr. Bartlett said another approach an insurer may take to cover a group is to offer a 20 per cent discount which puts pressure all the way down the line to the provider community to reduce prices. Reducing prices isn't going to mean reduced cost, if utilization goes up. There have to be things in effect so that insurers will be worried about losing business, and that means that there has to be another place for business to go, which is an issue in the state of Montana. But, if they all shadow price, that isn't going to do much good either. For market forces to work, they have to be strong forces that say, "if you can't get your price down, I'm going with this guy." There has to be some ability to make a difference so that they try to get their costs down. Research shows that there is a tremendous amount of potential there.

Dr. Bartlett commented on adverse selection. "The bigger the group, the less the adverse selection."

REP. SIMPKINS stated, "I understand that when dealing with senior citizens, the highest cost period is 10 days prior to death. "Secondly, we have insurance as primary Medicaid paying for high

risk problems." We will be faced with the question of rationing health care.

Dr. Bartlett responded that it is a probability issue that we don't have enough knowledge in medicine to know who will make it and who will die.

REP. SIMPKINS brought up the issue that we're spending billions of dollars on medical research to extend the 10 days prior to death to 12 days. We are extending the high cost period. "It's a terrible dilemma to resolve, and I don't think you have a solution to Universal Care without making those decisions."

Dr. Bartlett replied that "some of what we're buying is keeping people alive from 10 days to 12 days. Others are keeping people alive for 20 years."

Dr. Bartlett replied that a lot of these issues become political issues.

REP. CARLEY TUSS announced that the institution she works for deals with the clinical financial information system where it is merged and compare their own experience with hundreds of other hospitals called benchmarking. It is cost effective and people get very good care. **REP. Tuss** wanted to know if that was the type of information which is missing for people driving public policy in Montana.

Dr. Bartlett answered what is missing is benchmarking plus effectiveness research which links inpatient and outpatient data, and looks at matched sets of people with different starting points and who received different intervention and what happened to them." You could use information gathered from claims-payments to link with outcome data, or post-hospital mortality, and that type of information. **Dr. Bartlett** suggested building an expenditure data base based upon claims or to gather information on resources such as how many hospitals there are, the occupancy rate, how many different types of providers there are, how much technology there is and how is it being utilized, etc. Another suggestion would be to take population based data to look at incidence rates of surgical procedures.

REP. TUSS wanted to know if creating and using the data base described would strengthen Montana's fragile health care delivery system.

Dr. Bartlett said he thinks it could in a couple of ways. In other states people in a small community want their failing hospital to be rescued, but in many instances when they get do get sick they "scoot right on by their hospital" and go to a larger institution.

Comparing data on utilization and the types of activity, and facilitating community discussions on what they need and what

might be a better mix of resources to meet their health care needs, could be used to build a better delivery system and build a stronger delivery system to better serve the needs of the population.

REP. TUSS announced that on Tuesday, January 10, 1995, at 3:00 P.M., the guest speakers will be Dr. Paul Gorsuch from HEAL Montana/Project '94, and Mr. Ed Grogan from Montana Medical Benefit Plan.

ADJOURNMENT

Adjournment: 5:20 P.M.

SCOTT ORR, Chairman

Vivian Reeves, Secretary

SO/vr

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL DATE Jan. 5, 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	✓		

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EXHIBIT 1
DATE Jan. 5, 1995
HB

Carolyn

This is some prep for Health Care Select

October 26, 1994

Mr. Sam Hubbard, Executive Director
Montana Health Care Authority
28 North Last Chance Gulch
P.O. Box 200901
Helena, Montana 59620-0901

Dear Sam:

RE: Project 94 Medi*Choice Cost Estimates

As you requested, we have developed 1996 price estimates for the HEAL Montana-Project 94 Medi*Choice Proposal (Volume 94, Issue 3-May 1994). Because of the complexity of the proposal and its lack of specific cost-sharing features and other important provisions, please note that the estimates in this letter reflect one example of the major element of the Project 94 Medi*Choice proposal, the use of a Medical Savings Account (MSA) with one high deductible plan. This analysis does not reflect the costs of other proposal provisions such as state premium subsidies, preventive care incentive payments, high-risk pool subsidies, or other significant but unspecified features.

Cost Estimates

Based on our interpretation that Medi*Choice would use either a $500 or a $1000 deductible plan design, our pricing worksheets for a Montana Medicaid and a commercial population are attached. We have updated our initial analysis presented at the June 1994 HCA meeting as follows:

- Estimates for the Montana Medicaid population were revised to reflect data on the actual number of Medicaid program eligibles (which was originally based on available data on the number of recipients, adjusted by data from the Oregon Medicaid program).

- They were also revised to reflect the full Medicaid population, not just the AFDC aid category.

- Commercial population estimates were updated to reflect premium pricing performed for the project. To incorporate costs for residents of Montana, we started with actual costs of the state employees' plan in order to include normal utilization by well-covered individuals.

- We then obtained reduction factors from Montana Blue Cross Blue Shield to adjust usage to a high deductible level and to calculate the cost of funding the MSAs for all individuals.

As we discussed, we have not been able to locate any information that would allow us to model any changes in the effects of the proposed plan beyond the first year. As indicated in the provisions of the proposal, we have assumed that premiums and contributions to MSAs will continue with the same pattern of utilization and cost in subsequent years.

On average, our analysis shows that the P94 proposal would increase per capita Medicaid costs by 34% assuming a $500 deductible/$500 MSA, and by 44% assuming a $1000 deductible/$1000 MSA. These increases are primarily due to bringing Medicaid payments to commercial levels and to the funding of MSAs for individuals with total claims below the deductible amount. The proposal may "break even" at a low deductible/MSA level of approximately $100; that level, however, would appear to be too low to effectively change individual utilization. These estimates are shown in Exhibit I.

For the commercial population, per capita costs would increase by approximately 8% assuming a $500 deductible/MSA, and by approximately 32% assuming a $1000 deductible/MSA. These increases are due to the funding of MSAs for individuals with total claims below the deductible amount. Please note that these estimates reflect average utilization, assuming the entire covered population enrolls in a Project 94-type of plan. Savings cited by many MSA proponents are derived from corporate "cafeteria" plans which provide MSA-like programs and individual choice of high or low deductible options, thus confounding any analysis of similar cost-savings. See Exhibit 2 for estimates.

Taken in total, we estimate that the P94 approach would increase the average monthly per capita cost of the Multiple Payer Reform Scenario with the Minimum Benefits Plan by approximately 14% for the $500 deductible/MSA option and by approximately 35% for the $1000 deductible/MSA option. In 1996, estimated costs would be as follows:

Project 94-Medi*Choice Proposal
Estimated 1996 Premium and MSA Costs

	$500 Deductible/MSA	**$1000 Deductible/MSA**
Monthly Per Capita Costs	$119	$141
Total Annual Costs	$966,000,000	$1,142,000,000

Observations

We would also like to offer the following observations on the HEAL Montana proposal:

EXHIBIT 1
DATE 1-5-95

State Costs

The plan includes many new State costs that we have not quantified, including:

- uncertain costs of subsidizing Medicaid health care credits and MSAs because cost sharing requirements are not specified;
- unknown tax/state revenue losses from establishing tax-exempt MSAs;
- unknown cost of subsidizing BASIC premiums of working poor individuals up to certain percentage of their income;
- unknown cost of incentive payments for preventive services for the Medicaid population; and
- unknown costs of subsidizing a state high-risk pool, particularly with eligibility cut-off set at 150% of average premium.

State Medicaid Costs

- In addition to the new cost of funding MSAs, the proposal assumes (p.7 of the Project 94 proposal) that Medicaid payments will be brought to commercial levels. According to Medicaid program data, the Montana Medicaid program currently reimburses providers participating in the program at an average of 68% of the amount they charge. (Our estimates assume a cost increase of 25% to bring current reimbursement to private sector payment rates.)
- The amount of the State health care credit would also have to be considered carefully because, in fact, Medicaid eligibles have different utilization patterns than age-matched non-Medicaid groups and individuals (p.8), particularly assuming that all Medicaid eligibility categories will be included in the program (p.8 references only the AFDC population). Based on overall current Medicaid utilization patterns, many/most Medicaid eligibles would be placed in the high risk pool based on premiums higher than 150% of the state average.
- Also, note that the $3300 figure on p.7 is per "recipient" of medical services, not per person eligible for the program. A state health care credit to purchase an insurance policy and set up an MSA would have to be provided for every person eligible. It is unclear how these changes be accomplished within the current Medicaid budget.
- Another unknown factor may be the inducement for residents of other states to move to Montana to receive payments for the MSA, especially if they are healthy. Our estimates only assume costs for current Montana residents.

- Even if all Medicaid eligibles are assigned to the BASIC policy (p.7), there will still be necessary services that remain outside the benefits package. Will the State remain responsible for these expenses, or will providers have to absorb the costs?

- Private insurance plans have a higher percentage of administrative costs (12-15%) than Medicaid (approximately 3%). We have increased the administrative costs by 10% for Medicaid eligibles to reflect the mid-point of this range. Administering MSA accounts would increase this cost.

MSA Administration

- Systems would have to be developed to verify withdrawals from MSAs for medical purposes (premium payments or direct payments for medical services). Withdrawals for non-medical purposes are allowed only if the account contains adequate funds to cover "anticipated medical needs and a long-term care savings plan"(p.4(A)) . It will be difficult to determine "adequacy", and fiduciary institutions which currently administer IRAs are not prepared to do so. Funds may be withdrawn if the MSA balance exceeds twice the annual deductible (p.4(B)), or for tax-free withdrawal, if MSA funds are sufficient to pay long-term care and premiums for an actuarially determined life expectancy (p.4 (D)). Because average long-term care costs are difficult to estimate and vary greatly by age and future plan premium increases are unknown, these provisions would be difficult to link to accounting controls on MSAs.

- These rules would be further complicated for the Medicaid population. In addition to the private account requirements, the system would have to be able to:
  - reference the yet-to-be-determined "portion" of savings to be paid to the State and to the recipient and pay distributions to each (p.35)
  - track full compliance with preventive services requirements before payment is made for withdrawals for non-medical purposes (p.10(B)), and
  - follow individuals after leaving the Medicaid program until they are eligible for rollover of funds to a private account (p.11).

High Risk Pool

- It would be a significant actuarial effort to estimate the subsidy that would be necessary to fund the proposed high-risk pool as described in the Project 94 proposal.

- If Medicaid eligibles with high risk conditions (p.12) and the working poor whose BASIC policy premium exceeds 150% of the state average (p.20) are required to purchase coverage through the pool, more than 1-4% of the population may be placed in the pool for subsidies.

EXHIBIT 1
DATE 1-5-95

- It is unclear how Medicaid recipients would be determined to have a "high risk" condition (p.12). It is likely that the entire Aid to Disabled population would qualify.

- Requiring government and self-insured employers to pay into the State Guaranteed fund as proposed (p.21) is currently prohibited by ERISA and would require a change in Federal law.

Insurance Reform Provisions

- If all insurers are required to offer the BASIC benefits plan (p.12, p.13) with limitations on rate increases, which will primarily protect individuals/groups with higher than average costs, costs for individuals or groups with lower than average costs are likely to increase more than they otherwise would have. These lower than average utilization groups or individuals are more likely to drop their coverage under a voluntary system, leaving a higher-risk and higher-cost pool than was present on implementation of the provisions. This effect is similar to that of community rating where purchase of a policy is not mandatory.

- Estimates of the proposal's cost must be adjusted for the effects of partial insurance reform provisions, such as use of premium increase limits, guaranteed issue or other common incremental reform provisions which increase access to insurance coverage.

Other

- The RAND study results cited on p.6 are outdated and overstate the cost-saving effects of consumer cost-sharing because hospital admissions are now almost completely pre-certified. An accurate calculation of the likely cost of services under this proposal needs to consider Montana-specific practice patterns.

- Two of the medical savings/incentive plans cited for their cost savings (p.8), Dominion Resources and Quaker Oats, are offered in the context of flexible benefits programs. Because employees are offered many choices as to how to structure their benefits, high users choose low deductible plans. The savings are, therefore, due to more than only the plans medical savings account provisions. None of the three savings/incentive programs cited is structured like the MSA system proposed.

- The proposal requires that insurance policies be structured so that the balance of the health care credit after payment of the premium would be sufficient to pay any deductible (p.9(D)). Based on our estimates, it does not appear possible to adequately fund a sizable MSA (e.g., $500 or more) with savings generated by a reduced insurance premium and reduced utilization.

- It is unclear throughout the document whether program minimum deductibles will be set on an individual or a family basis. It seems that if the $500 minimum deductible is assessed on an per-individual basis, and that families (e.g., table, p.20) would have to have a deductible based on the number of covered individuals. Higher health care credits would be necessary to fund these higher deductibles in MSAs.

- The Montana Comprehensive Health Plan would be unable to rate any pre-existing condition upon request to estimate insurance costs (p.22). Actuarial rating of pre-existing conditions would be very, very difficult and not reliable for determining the amount of a credit. Also, nearly all individuals rated may require services for the condition.

- Refunding premiums if claims paid are less than the premium amount (p.36) would require all premiums to be grossed-up. This provision appears to be counter to the concept of insurance risk-sharing for high cost illnesses. Under any insurance arrangement, there are always a percentage of people who use no services in a year. The premiums for these people are used to fund the costs for people who require high levels of health care services. Because the referenced section (Sub-section 1, Paragraph G) does not exit, we will assume that this inconsistency is no longer intended to be part of the proposal.

- Some cost shifting is likely to remain in the system, as benefit packages will be leaner and more services will not covered by insurance. Those requiring services when their MSAs are depleted who are without access to cash (Medicaid recipients in particular) will still receive services. Hospitals and other providers will shift these uncompensated care costs onto other payors.

* * *

We hope these estimates of our interpretation of the Project 94 Medi*Choice plan and our comments will meet your immediate needs. If the State considers moving forward with this approach, more extensive analyses will be necessary when cost-sharing provisions are specified in adequate detail.

If you have any questions, please call me at 415/957-3132 or Sandi Hunt at 415/957-3330.

Sincerely,

John M. Bertko, F.S.A.
Partner

Attachments

EXHIBIT 1
DATE 1-5-95

Montana Health Care Authority
Project 94-HEAL Montana Estimates
Medicaid Eligibles

EXHIBIT I

Medical Savings Account Effects, $1000 Deductible

New Medicaid Per Capita Cost	$2,778
Premium Credit Needed (for total claims amounts exceeding the $1000 deductible)	
- Based on Oregon Medicaid data, claims of more than $1000 equalled 86.0% of total claims dollars	x .86
	$2,389
Utilization Reduction Savings	
- Assume 1/3 reduction (RAND study) in utilization for claims in discretionary area (claims between $1000-$1500)	
- From Oregon data, claims between $1000-$1500 accounted for approximately 9.3% of total claims dollars	
1/3 x 9.3% x $2778 =	($86)
	$2,303
Cost of Funding Individual MSAs (at $1000 per MSA)	
- From Oregon data, 75.4% of Medicaid eligibles have total claims of less than $1000	
$1000 x 75.4% =	$754
	$3,057
Percent Increase over Original Medicaid Per Capita Cost	144%

Montana Health Care Authority
Project 94-HEAL Montana Estimates
Medicaid Eligibles

EXHIBIT I

Medicaid Per Capita Costs

Estimated Montana Medicaid Per Capita Costs	
- FY 92 Total Montana Medicaid Medical Payments (Extend Care SNF, ICF-MR, and 80% of Resident Psych, Home Health, and Personal Care deleted)	$157,417,568
- Estimated FY 92 Average Monthly Medicaid Eligibles (Total FY92 Montana eligibles, adjusted based on Oregon Medicaid data on average length of program eligibily to reach average monthly eligibles)	74,016
- Estimated Per Capita Cost per Medicaid Eligible	$2,127
Change to Private Health Plans	
- Higher private sector payment rates (add an estimated 25%)	x 1.25
- Administrative costs increase 10% (from 3% to 13%)	x 1.10
	$2,924
Savings from Eliminating Cost Shifting	
- 5% savings (10% savings from contract reductions, 50% recovered)	x .95
	$2,778
Benefit Changes	
- Unknown cost savings from eliminating mandated benefits	0
- Prevention costs fully covered (full pass through)	0
- Cash payments for use of preventive services	0
New Medicaid Per Capita Cost	$2,778
Percent Increase over Original Medicaid Per Capita Cost	131%

EXHIBIT 1
DATE 1-5-95

Montana Health Care Authority
Project 94-HEAL Montana Estimates
Medicaid Eligibles

EXHIBIT I

Medical Savings Account Effects, $500 Deductible

New Medicaid Per Capita Cost	$2,778
Premium Credit Needed (for total claims amounts exceeding the $500 deductible)	
- Based on Oregon Medicaid data, claims of more than $500 equalled 93.5% of total claims dollars	x .935
	$2,598
Utilization Reduction Savings	
- Assume 1/3 reduction (RAND study) in utilization for claims in discretionary area (claims between $500-$1000)	
- From Oregon data, claims between $500-$1000 accounted for 7.5% of total claims dollars	
1/3 x 7.5% x $2778 =	($69)
	$2,528
Cost of Funding Individual MSAs (at $500 per MSA)	
- From Oregon data, 62.9% of Medicaid eligibles have total claims of less than $500	
$500 x 62.9% =	$315
	$2,843
Percent Increase over Original Medicaid Per Capita Cost	134%

Montana Health Care Authority
Project 94-HEAL Montana Estimates
Commercial Population

EXHIBIT II

Commercial Per Capita Claims Costs

Estimated Montana Commercial Per Capita Claims Costs	$1,520
Administrative Costs--assume no changes	0
Savings from Eliminating Cost Shifting	
- 5% savings (10% savings from contract reductions, 50% recovered)	x .95
	$1,444
Benefit Changes	
- Unknown savings from eliminating mandated benefits	0
- Prevention costs fully covered (full pass through)	0
New Commercial Per Capita Claims Cost	$1,444
Percent Increase/Decrease from Original Commercial Per Capita Claims Cost	-5%

EXHIBIT 1
DATE 1-5-95

Montana Health Care Authority
Project 94-HEAL Montana Estimates
Commercial Population

EXHIBIT II

Medical Savings Account Effects, $500 Deductible

New Commercial Per Capita Claims Cost	$1,444
Premium Credit Needed (for total claims amounts exceeding the $500 deductible)	
- Based on 1993 Montana Blue Cross Blue Shield claims data, claims of more than $500 equalled 96.0% of total claims dollars	x .96
	$1,386
Utilization Reduction Savings	
- Assume 1/3 reduction (RAND study) in utilization for claims in discretionary area (claims between $500-$1000)	
- From Montana Blue Cross Blue Shield data, claims between $500-$1000 accounted for 4.8% of total claims dollars	
1/3 x 4.8% x $1444 =	($23)
	$1,363
Cost of Funding Individual MSAs (at $500 per MSA)	
- From Montana Blue Cross Blue Shield data, 57.0% of individuals have total claims of less than $500	
$500 x 57.0% =	$285
	$1,648
Percent Increase over Original Commercial Per Capita Claims Cost	108%

Montana Health Care Authority
Project 94-HEAL Montana Estimates
Commercial Population

EXHIBIT II

Medical Savings Account Effects, $1000 Deductible

New Commercial Per Capita Claims Cost	$1,444
Premium Credit Needed (for total claims amounts exceeding the $1000 deductible)	
- Based on 1993 Montana Blue Cross Blue Shield claims data, claims of more than $1000 equalled 91.2% of total claims dollars	0.912
	$1,317
Utilization Reduction Savings	
- Assume 1/3 reduction (RAND study) in utilization for claims in discretionary area (claims between $1000-$1500)	
- From Montana Blue Cross Blue Shield data, claims between $1000-$1500 accounted for approximately 3.0% of total claims dollars	
1/3 x 3.0% x $1444 =	($14)
	$1,303
Cost of Funding Individual MSAs (at $1000 per MSA)	
- From Montana Blue Cross Blue Shield data, 70.3% of individuals have total claims of less than $1000	
$1000 x 70.3% =	$703
	$2,006
Percent Increase over Original Commercial Per Capita Claims Cost	132%