# MINUTES

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

## SELECT COMMITTEE ON HEALTH CARE

**Call to Order:** By **CHAIRMAN SCOTT ORR**, on January 26, 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. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)

**Members Excused:** None

**Members Absent:** Rep. Carolyn M. Squires (D)

**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.

**Committee Business Summary:**
Hearing: Informational Meeting on HMOs and the Yellowstone Community Health Plan
Executive Action: None

*{Tape: 1; Side: A; Approx. Counter: 000; Comments: This meeting was recorded on two 90-minute tapes.}*

### INFORMATIONAL MEETING ON HMOs

**Tom Ebzery, Attorney, Yellowstone Community Health Plan (YCHP), Billings,** named two other people that were present to discuss HMOs--**Mark Burzynski**, chief executive officer of the Plan, and **Kay Wagner**, chief operating officer of the Plan. **Mr. Ebzery** said they would provide an overview and history of HMOs and explain how their plan differs from others and what their accomplishments have been.

**Mark Burzynski** said he had two objectives: to explain the foundational concepts of an HMO and how the state might use the HMO tools to change the future of health care in Montana. He shared the philosophic background on which the Yellowstone Community Health Plan was started three years ago. He quoted: "When health care organizations are able to redirect their considerable resources, both technological and financial, toward the root causes of a community's health problems, these organizations will have realized their responsibilities as public trusts. ... Building networks, developing new relations, reducing duplicative services, and introducing economic efficiencies are but the means to an end, the end is the enhanced health status of a community." He submitted written testimony. **EXHIBIT 1**

*{Tape: 1; Side: A; Approx. Counter: 725; Comments: n/a.}*

**Kay Wagner** said she was involved more in the operational aspect of the Yellowstone Community Health Plan and has spent much time on small employer legislation. They are very interested in competing in the 3-25 market and have sometimes felt like a "square peg trying to fit in a round hole." They've researched the mandated cost containment measures and continue to work with the insurance commissioner's office. As an HMO, they offer first dollar coverage. She provided an example of a family of three with a child and the number of visits to a doctor that could be expected, and the expected costs and coverage provided by an HMO.

She described the kinds of services provided by an HMO as compared to the "indemnity world." The HMO doctor is willing to answer questions on the phone and to help organize their care because they are getting paid every month whether they have an appointment or not. In the indemnity world, the physician is only paid when the patient shows up, as opposed to when they sign up. She asked the committee if her diagram was understandable.

**Questions From Committee Members and Responses**:

**REP. BETTY LOU KASTEN** asked how much the premium would be for a 40-year-old male, for instance. **Ms. Wagner** said it was hard to provide figures because they don't have an individual product and it would depend on the age and gender of the group. **REP. KASTEN** asked what an average premium per month would be, in the area of $300 or $400 per month? **Ms. Wagner** said no, it would be more like $160 for a single employee. She explained that they have struggled at the Yellowstone Community Health Plan to keep premiums low. For a premium of $285, for instance, a co-payment is not required for out-patient treatment, and the HMO would bear the entire amount.
*{Tape: 1; Side: A; Approx. Counter: 1012; Comments: n/a.}*

**REP. LIZ SMITH** asked when the deductible would be charged. **Ms. Wagner** replied it was by the service and she provided some examples and said it depended on the plan that was selected.

**REP. NELSON** asked about out-patient prescriptions. **Ms. Wagner** said they have a prescription rider, and depending upon the plan, they would pay $5 or $10 for prescriptions.

**REP. BRUCE SIMON** asked about the unisex law that would prevent them from setting rates based on gender. **Mr. Burzynski** explained they determine the community rating by class, and use age, sex and industry for criteria. It was hard to answer the premium question because it differs from community to community.

**CHAIRMAN SCOTT ORR** clarified this issue and said in a peer community rating the rates are not based on health, but can be based on gender and age. **Mr. Burzynski** said they are not underwriting, but do adjust for sex, age and industry. A peer community rating is a flat average across the entire community.

**REP. SIMON** told **Mr. Burzynski** it was exciting to see the second HMO get started in the state, but legislatively it happened a long time ago. He wondered what advice he would give the committee, as they are looking to make adjustments in existing laws, that would facilitate the creation of these kinds of plans throughout the state.

**Mr. Burzynski** said all the work they have done under the HMO law has been done through the insurance commissioner's office, so he couldn't say that anything statutorily has gotten in their way. His concerns have to do with how they credential providers. Not every physician or provider is going to be on track with their vision of where community health care should be. He provided an example of the lack of care management that can happen when, for instance, a mental health provider may continue to see a patient beyond a reasonable time. One of the things they have to do is to find providers who are willing to help them manage the community resources. They need to familiarize the community with the concept and trust it.

*{Tape: 1; Side: B; Approx. Counter: 000; Comments: n/a.}*

**REP. SIMON** said it appeared their cost containment strategy centered on capitated care. He asked if their strategy also included a "gatekeeper," a primary physician, and how does that person link up with specialists and how would this fit with cost containment.

**Mr. Burzynski** said their major cost containment strategy is the actual coordination of care. Rather than the word "gatekeeper," they prefer to use the term "gateway." He said they ask themselves if they have created a system that creates a gateway to the appropriate care. Education is important to make sure people understand how HMOs work. In answer to the question about referrals to specialists, they must be made through the person's selected primary care physician.

**REP. SIMON** asked how much the consumer would benefit financially while they are making choices to access available health care at the appropriate level. **Mr. Burzynski** said they are educating people on what their benefit offers. Since their HMO is new, they have situations where people have self-referred to specialists, had x-rays done in the wrong place, and have inappropriately used the ER. She said they are counseling these participants with the plan to discuss how to best use their benefits. The first time they'll pay, the next time they want them to use it appropriately.

People have been conditioned by indemnity plans not to take advantage of health care services, so when someone is reluctant to call their primary care physician under an HMO, he said they encourage people to call their doctor, because that doctor is still getting paid to take care of them whether they call or not.

*{Tape: 1; Side: B; Approx. Counter: 175; Comments: n/a.}*

**REP. NELSON** asked what the status of the YCHP was at the present time. **Ms. Wagner** said they are still waiting to be approved for the 3-25 marketplace. They don't have a problem with guaranteed issue, because they feel it's their mission to get people some kind of coverage with the guaranteed issue.

**REP. NELSON** asked if it is possible for individuals to sign up with an HMO and **Mr. Burzynski** said not at this time, they are only concentrating on employee groups. They are managing this HMO with very low overhead costs, and are trying to create momentum on the employer side so premiums are kept low.

**REP. SIMON** referred to the small employer group legislation and said it was not proposed with an HMO in mind. He asked for guidance as legislators to make the HMO fit better in the vision for small employer group insurance. **Ms. Wagner** said they were involved as the rules were being made and hope to take advantage of the opportunities. **REP. SIMON** asked about **REP. NELSON'S** bill that would revise the small group insurance laws. He wondered what **Ms. Wagner's** thoughts were on these revisions. She said she welcomed that opportunity.

**REP. BEVERLY BARNHART** asked what would happen if she wanted her primary care physician to be a nurse practitioner. **Mr. Burzynski** said that the plan allows for a nurse practitioner to be the primary care provider, but must be supervised by a physician, so there would be a combination team automatically in place.

*{Tape: 1; Side: B; Approx. Counter: 342; Comments: n/a.}*

**REP. CARLEY TUSS** asked if they charge a small fee every time a person seeks health care. **Mr. Burzynski** said every time someone interacts with the system, there is a co-payment, which is their attempt to create consumerism, so the participant must decide what their choices are based on the cost. **REP. TUSS** asked if the

payment is made up-front before they see their provider. **Mr. Burzynski** agreed that was the expectation and would allow the person to know what they're going to pay.

**REP. TUSS** presented a scenario, based on a true story, where a gentleman arrived in the emergency room, has a primary care physician, the ER calls the primary care physician who says he doesn't want him seen in the ER, but wanted him to come to his office. The gentleman drives to the doctor's office and is asked for his $10 co-payment, which he doesn't have on him at the time. The doctor says when he has the money, he will be seen, whereupon he returns to the emergency room and is admitted with a 104° fever and acute hepatitis. She asked how the YCHP would handle this kind of situation from an administrative standpoint.

**Mr. Burzynski** said there can be some restrictions on enrollee agreements in handling complaints. He didn't think the ER should have released such a sick person. A practitioner who insisted on a payment would be dropped from the network. They are monitoring how physicians are doing under the HMO. He gave another example of a physician who had no intention of following the rules they outlined for clinical decision-making, so they dropped him from the program.

*{Tape: 1; Side: B; Approx. Counter: 558; Comments: n/a.}*

**Mr. Burzynski** discussed his role as a hospital administrator and the relationships between doctors and insurance companies, and others involved in the industry.

**REP. ROYAL JOHNSON** told **Ms. Wagner** they will be breaking into three subcommittees, one of which is insurance reform. He asked if she said her HMO would like to be included in the 3-25 small employer category. He asked if they could operate the HMO as they wish the way the law is currently written. **Ms. Wagner** said they could, but the premium they have to provide is currently unaffordable. **Mr. Burzynski** said it is possible that while they will market the product, it will be too expensive for most people to afford.

**REP. JOHNSON** then asked **Ms. Wagner** what her plans were to reduce the premium, and what they would remove from the policy so it could be more affordable. **Ms. Wagner** said one of the things would be to have a co-payment on out-patient procedures. Other small things would reduce the cost because they don't fit with the current design. Some services need limits and some little "tweaking" could be done that would bring the costs down.

**REP. JOHNSON** asked if they have looked closely enough at the program to be able to put a number with that. **Ms. Wagner** said they assign value on incidents per thousand. **REP. JOHNSON** asked if that kind of information could be provided to **REP. NELSON** and she said they would create a "tweak list" with a cost attached to it.

**REP. LIZ SMITH** asked with regard to comparing HMOs to indemnities, what happens after the enrollee has exhausted their 2.2 visits per year. **Ms. Wagner** said there is an average number of visits that an average 40-year-old woman is going to have and that's where that number came from, but she said the co-payment stays the same no matter how many visits they make per year, and there is no limit on the number of visits.

**REP. LIZ SMITH** asked about the high cost of the HMO package. **Ms. Wagner** said they attended hearings for HB 285 and submitted comments that were sometimes accepted and sometimes not.

**REP. LIZ SMITH** asked **Mr. Burzynski** about the HMO concept and asked about capitations within HMO systems. He replied that they have not connected with the other HMOs, but have consulted with them on putting together their premiums. He said there is concern about where they are located in the state and other providers who are protective of their patients, and have approached this cautiously. Their goal at this time is to create a functional system and to develop a "formulary," which is the condensing of the 15,000 drugs available to a list of 500. Getting 135 doctors to agree on those 500 drugs has been difficult, but they have started the effort.

**REP. LIZ SMITH** asked if they provide services in the HMO and there are some high risks provided, then as time goes on, if they're not using the entire community base, is there potential to not have a profit to reinvest in the HMO. **Mr. Burzynski** said in reference to risk management, the more members they have, the better off they'll be. He said there's a market in Yellowstone County of about 55,000 - 59,000 people who would be eligible for a commercial insurance policy. They don't need that many, but want a few committed providers who are willing to do something different on behalf of people. He addressed the question about whether or not people need an annual physical exam. He elaborated on how they've tried to decide appropriate procedures.

**REP. LIZ SMITH** asked how to provide HMO services in small hospitals in rural Montana. **Mr. Burzynski** said he believed there might be a greater opportunity for HMO development in rural areas than in urban areas, because of the kinds of practitioners in rural areas. He said Billings has many specialists, for instance, but rural areas don't have access to such specialists. He expected rural doctors to be more amenable to an HMO than specialists because they don't have as many patients. They believe that patients appropriately served in rural Montana should stay there, and not have to come to urban areas to get health care.

**REP. BARNHART** asked if a phone call to her physician would cost her $10 or $15. He responded no. She then asked about restrictions on going to the nurse practitioner and **Mr. Burzynski** said they don't always know if that person is their primary care

provider, but the nurse practitioner would be trained to get to the right resource.

**REP. SIMON** asked when they sell the plan to a company of 55 employees, do they underwrite that group. **Mr. Burzynski** said no. **REP. SIMON** asked if they take them all. **Mr. Burzynski** said yes. **REP. SIMON** asked if it was basically a volunteer plan and he responded yes. **Mr. Burzynski** clarified that if an employer offered coverage but they don't pay for much of it, they are trying to encourage collaboration between the employee and the employer so there's an equal cost sharing.

**REP. SIMON** referred to HB 285 and the tweaking that was previously discussed. He said under this bill they would have a standard plan and a basic plan. The standard plan would be benefit-rich and a basic plan would be anything else that has fewer benefits. If they offered co-payments, he wondered if they are providing fewer benefits in a basic plan. **Mr. Ebzery** replied that he attended the hearings on HB 285 where they developed a standard plan and then stated that a basic plan must be less, but just follows the standard. **REP. SIMON** asked if the tweaking needed to be done to the standard plan or the basic plan or other state-mandated benefits.

*{Tape: 2; Side: A; Approx. Counter: 000; Comments: n/a.}*

**REP. SIMON** continued asking his question about state-mandated benefit levels in state law or mandated benefits created by the committee when they developed the standard plan.

**Mr. Ebzery** said that would be a good way to do it, but they wouldn't be successful. He cited an attempt by the legislature to have mandated benefits and said it was very difficult. It would more appropriate for the committee to provide direction as done by HB 285 (which was not fully implemented). He said if they could get away from restrictions on what the standard plan must look like, and they could develop a basic "bare bones" plan, which would not require the mandated benefits, the plan would be affordable and accessible.

**REP. SIMON** clarified if heard him say the focus should be more on the basic plan or a combination of both. **Mr. Ebzery** said they would like to be able to offer a basic plan, 3-25, with minimum benefits so more people could participate and they could sell them. If it's a standard plan that is too expensive, they shouldn't waste their time or limited resources on that.

The meeting was adjourned at 4:45 p.m.

*{Tape: 2; Side: A; Approx. Counter: 75; Comments: n/a.}*

A discussion among the committee members on how the three subcommittees will operate continued until 5:20 p.m.

**ADJOURNMENT**

**Adjournment:** 5:20 P.M.

SCOTT ORR, Chairman

for VIVIAN REEVES, Secretary

SO/vr

# HOUSE OF REPRESENTATIVES

## Select Committee on Health Care

ROLL CALL DATE Jan. 26, 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 Jan. 26, 1995
HB HMO

# COMMENTS FOR HOUSE SELECT COMMITTEE ON HEALTH

1. This afternoon I have 2 objectives:

   1. Help you understand a few of the foundational concepts of a HMO; and,

   2. To discuss how we as a state might use some of these basic tools to shape the future of health care in Montana.

2. YCHP is a health maintenance organization. To best understand what that means it might be helpful to identify a few key characteristics of HMOs:

   * **Shift the risk** of the cost of care.

     Currently risk is **shared by employer and/or individual and the payer.**

     In a prepaid HMO arrangement, where essentially all care is paid for in advance, risk shifts. Instead of being shared by the employer and payer, it is now shared **between the payer and providers,** such as hospitals and physicians.

   * Risk is shifted to providers through compensation arrangements based on capitation. **Capitation works as follows:** A physician is paid a set amount for providing care to a group of people. If the cost of care exceeds the physician's set payment, the physician

absorbs costs the employer would have traditionally been forced to pay. If the set payment to the physician exceeds the care delivered, the physician is rewarded for coordinating care and/or improving the health status of his patients.

* **Primary care coordination of care** is another hallmark of HMOs. As a member of a HMO, I have a primary care physician that is responsible for coordinating my care and ultimately, improving my health. **This is throwback to the days of the family physician.** The one physician that knew everything about you and your family. The idea is the same.

**Our current system is extremely costly because we don't coordinate care.** I'd like to share several examples with you:

- It is not uncommon for a person to be taking several drugs at the same time, all prescribed by different physicians. Some of which clearly compromise the effectiveness of one of the other drugs and may be detrimental to the patient.

- A new enrollee of YCHP has been seeing a psychiatrist and four counselors at the same time.

- A new enrollee of YCHP saw two different orthopedic surgeons and a chiropractor in a 2 week period of time.

- People are routinely using the emergency room for primary care.

EXHIBIT 1
DATE 1-26-95
HB HMO

**Coordination is not designed to deprive people of care. Coordination is the cornerstone to having the right care delivered at the right time in the right place by the right provider at the right price.**

* HMOs use a **copayment rather than a deductible and/or coinsurance.** This small copayment is required every time someone uses services. The theory behind a copayment is that the enrollee has to make a **cost benefit decision** to enter the system. For example, is it worth $75 to go to the ER, $15 to see my primary care physician or $2 to see a nurse practitioner. Yet these amounts clearly **will not be a barrier to care** as are deductibles of $1,000 or $1,500. What's also nice about copayments is that the enrollee knows exactly what it will cost. If you're going to see your primary care physician, take your $15 along.

3. What features make the YCHP a unique HMO and this is not a sales pitch, but it indicates what the possibilities are for Montana, especially in the rural areas. We believe that **what we've done in Billings, can be done in the smallest community** of Montana, even those communities, which may be served by a physician extender. All is takes is some **hard work, willingness to change and a recognition that the community comes first**. It was a pretty simple process: We simply had hospital and physician representatives sit around a table and listen to employers. Then we asked the employers to listen to the providers. It created some good chemistry.

**As for the unique features of YCHP:**

* **It is not-for-profit.** Any surplus generated by the plan

**can only be reinvested in our community** in 3 ways:

- Reduction of premiums
- Investment in wellness and prevention programs
- Provision of indigent care.

* The plan's board of directors **is dominated by community representatives** and enrollees. 5 of the Board's 15 slots **must be held by enrollees**; people actually participating in the plan. There are **3 other community representatives**, who are not required to be enrollees. **It's the community's plan**, so they should have the opportunity to **establish premium** parameters, monitor **how well providers** are performing, what the **quality level** of the plan is, **how much providers** are getting paid, what are the **consequences of prevention and wellness** programs, etc.

  The unique **"turn of the tables"** here, is that physicians and hospitals have **acknowledged that they must be accountable to the community**. If one were to stop and take a look around the medical corridor in Billings, one might pause to reflect whether employers have served the medical corridor better than the medical corridor has served the community's employers.

* The **YCHP's ultimate goal** is not to provide its enrollees with a good health plan and high quality providers. Ultimately, **managed care tools such as HMOs must be designed to create and sustain healthier communities.** There's a big difference between **"health care" and "medical care."**

EXHIBIT 1
DATE 1-26-95
HMO

Currently, we deliver acute medical care and **there's nothing "systematic" about it.** To do this, YCHP is committed to 2 strategies:

1. **YCHP can not be used to steer patients to certain providers.** It can not be a **competitive vehicle**. Therefore, YCHP has invited Deaconess Medical Center and the Billings Clinic to not only contract with YCHP, but, to buy half of YCHP. The thinking is that people have a very special **relationship with their physician and their hospital.** That represents quality to them. Why in God's name should we disturb that relationship. This way each enrollee of YCHP can decide if their **practitioner is delivering quality**. If they are waiting forever for the phone to be answered, or in the waiting room, or in the little room you go into after waiting in the waiting room, then let them change. All physicians and hospitals **are getting paid the same thing, so why shouldn't you let the consumer make consumer decisions.** The focus is on the community, not what's best for providers.

2. Our current health care system tends to **"lock people out,"** who need the care the most and "lock in individuals who don't need care." YCHP's premium structure is built to "lock people in" who need care and start proactively managing their care, so their access to our current system is not dependent on their development of an acute medical condition. We are of the philosophical persuasion in which that is perceived as just not right.

* **YCHP does not reward its providers through withholds for withholding care. There's just too much incentive** there not to act appropriately for the benefit of an enrollee. YCHP's approach would be to focus on review of utilization data, to develop educational programs for the physicians that might be referring inappropriately. Ultimately, they may be dropped from the network if they just can't seem to catch on.

4. One thing that was true about all **reform initiatives is that the focus was on financial issues. We were focusing on managing financing, not managing care.** In truly managing care, we have the opportunity to focus on the clinical side of the equation where we can make a difference for people, in a cost effective manner.

   If we **can't create a health system** as our community level what makes us think we can do it at the state and/or national level. If we can't create a **health care budget** at the local level, why do we think we can do it at the national and/or state level. If **we don't focus on health status** at the local level, how will we ever improve the health status of our communities. **Employers can afford healthy employees, not crowded emergency rooms or physician waiting rooms. There are alternatives that are responsive to the unique needs of a state as geographically diverse as Montana. We believe YCHP is one such alternative fashioned after a HMO.**

EXHIBIT 2
DATE Jan. 26, 1995
HB HMOs

# HMO/INDEMNITY COMPARISON

## PHYSICIAN OFFICE VISIT BENEFITS

| | 40 YEAR OLD MALE | 40 YEAR OLD FEMALE | CHILD AGE 2 thru 4 |
|---|---|---|---|
| Average Number of PCP Office Visits per Year | 2.2 | 3.4 | 2.2 |
| Average Charge per Visit | $48 | $50 | $37 |
| **HMO PLAN – $10 OFFICE VISIT COPAYMENT** | | | |
| Enrollee Copayment Per Visit | $10 | $10 | $10 |
| HMO Responsibility Per Visit | $38 | $40 | $27 |
| **INDEMNITY PLAN – $250 DEDUCTIBLE/80% COINSURANCE** | | | |
| Insured's Payment Before Deductible | $48 | $50 | $37 |
| Insurance Plan's Payment Before Deductible | $0 | $0 | $0 |
| Number of Visits Needed to Meet Deductible | 5.2 | 5.0 | 6.8 |

The HMO Enrollee has a benefit that is payable for <u>every</u> office visit. The Indemnity Plan subscriber would have to go to the Primary Care Physician 5 to 7 times before any benefits would be paid.