Access and Barriers to Health Care

A Final Report of the SJR 22 Subcommittee
of the
Economic Affairs Interim Committee

Rep. Joe McKenney, Chairman, SJR 22 Subcommittee
Sen. Dale Mahlum, Chairman, Economic Affairs Interim Committee

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December 2002

SJR 22 SUBCOMMITTEE ON HEALTH CARE AND HEALTH INSURANCE

2001-2002 Interim

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WHEREAS, rising health care costs are detrimental to stable lifestyles and the well-being of families; and

WHEREAS, health care costs and health insurance rates are increasing above the rate of inflation; and

WHEREAS, rising health insurance costs have a significant impact on the overall personnel and salary budgets of governmental agencies; and

WHEREAS, uncompensated care is a burden on all taxpayers, insurance carriers, and insurance consumers; and

WHEREAS, prescription drug costs may be driven by advertising that extols the virtues of the newest expensive drug; and

WHEREAS, because of the increased cost, a large percentage of employers in Montana no longer offer insurance benefits to their employees and many employees who have insurance have dropped dependents from coverage; and

WHEREAS, all Montanans should have the opportunity to have health insurance coverage, yet 20% are not covered; and

WHEREAS, mandating coverage for certain health care services and providers adds to the cost of insurance; and

WHEREAS, the 58th Legislature will likely have numerous health care and health insurance issues to address; and

WHEREAS, a study of health care and health insurance and how the state might deal with rising costs will provide the members of the 58th Legislature with a head start in handling this complex problem.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Legislative Council be requested to designate an appropriate interim committee, pursuant to section 5-5-217, MCA, or direct sufficient staff resources to study:

(1) purchasing pools for individual and small group insurance;

(2) provider reimbursement rates and cost shifting of health care costs;

(3) access to affordable prescription drugs;

(4) strategies to decrease the number of uninsured Montanans;

(5) factors causing health insurance rates to increase above the rate of inflation;

(6) the feasibility of recreating the Health Care Advisory Council; and

(7) any other issues that the committee or the staff deem appropriate and relevant to the problem.

BE IT FURTHER RESOLVED, that the interim committee or the staff designated to conduct the study seek the participation and input of the Office of the Insurance Commissioner, health care and health insurance consumers, provider organizations, insurers, the Department of Public Health and Human Services, representatives of public employee and private sector health benefit plans, local government representatives, hospitals, and any other appropriate individuals or entities.

BE IT FURTHER RESOLVED, that if the study is assigned to staff, any findings or conclusions be presented to and reviewed by an appropriate committee designated by the Legislative Council.

BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review requirements, be concluded prior to September 15, 2002.

BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions, comments, or recommendations of the appropriate committee, be reported to the 58th Legislature.

- END -

Executive Summary

During the 2001-02 legislative interim, the SJR 22 Subcommittee on Health Care and Health Insurance examined a variety of issues affecting the cost and availability in Montana of health insurance and health care. In relatively short order, the Subcommittee decided to focus on three areas: the Children's Health Insurance Program or CHIP; the adoption or expansion of purchasing pools for prescription drugs; and a tax deduction for health insurance premiums paid. The Subcommittee also perceived a need to better coordinate legislative efforts to address issues falling within the category of "health care". The recommendations made by the Subcommittee to the full Economic Affairs Interim Committee reflected the Subcommittee's focus as indicated below.

RECOMMENDATION 1

The SJR 22 Subcommittee recommends: that the Department of Public Health and Human Services (DPHHS) explore the option of participating in a multi-state purchasing pool for prescription drugs on behalf of the citizens that DPHHS serves; that the Administration explore with the Confederated Salish and Kootenai Tribes' their legal authority under the Hellgate Treaty of 1855, the Jay Treaty, and other treaties or federal laws, whether the federal government will allow the Tribes to enter into agreements with Canadian tribes for the importation into Montana of certain prescription drugs; and that the Administration explore whether the purchasing pool for prescription drugs in which the state participates on behalf of state employees can be expanded to include a broader spectrum of Montana's citizens.

RECOMMENDATION 2

The SJR 22 Subcommittee recognizes the importance of the CHIP program in providing medical insurance for uninsured children and the value of the federal match in CHIP. At the same time, the Subcommittee recognizes the fiscal difficulties facing the state and, within the context of those difficulties, urges the Administration to place a high priority on maintaining the size of the CHIP program or expanding it if funding resources could be found, while keeping other programs in the DPHHS that have proven to be valuable to the health of the entire state.

RECOMMENDATION 3

The SJR 22 Subcommittee recommends that the state offer a tax credit to certain low-income individuals and to small businesses for a portion of health insurance premiums paid. For individuals, eligibility should be based on income and the credit amount should be based on the age of the insured. For small business, eligibility should be based on income and on the number of individuals employed by the small business and the credit amount should be based on the average age of the insured. The amount of credits that may be claimed in the aggregate in any fiscal year may not exceed $45 million. The credit should be offered on a trial basis as a pilot program and be terminated after 4 years, unless reauthorized by a future legislature.

RECOMMENDATION 4

The SJR 22 Subcommittee recommends that the 58th and subsequent Legislatures strive to direct studies of "health care" issues to the most appropriate forum which is, in the Subcommittee's opinion, is the Children Families, Health and Human Services Interim Committee or a subcommittee of the CFHHS dedicated to "health care".

The Subcommittee made these recommendations to the full Economic Affairs Interim Committee, i.e., the interim committee to which the SJR 22 study of health care and health insurance was assigned. Ultimately, the full Economic Affairs Interim Committee approved the Recommendations 1, 2, and 3 and has adopted those three of the Subcommittee's recommendations. Recommendation 4 was made to the Economic Affairs Interim Committee and, as well, to the Children, Families, Health and Human Services Interim Committee, the Legislative Finance Committee, the HJR 1 Subcommittee on Mental Health, and the Legislative Council.[1]

[1] See September 12, 2002 memorandum from SJR 22 Subcommittee chairman, Rep. Joe McKenney; on file in Montana Legislative Services Division.

Chapter 1
Introduction

Background

Senate Joint Resolution No. 22 (SJR22) requested that the Legislature study the issue of health care and health insurance costs and make recommendations to the 58th Legislature to address a variety of pressing health policy issues. Central among those concerns were the rising cost of health care and health insurance and the higher than average rate of uninsured in the state. Lawmakers, consumers, medical care providers, and the insurance industry all recognized that a problem exists and that developing quality, targeted solutions is a daunting task.

Selected Demographic Information

According to the Kaiser Commission on Medicaid and the Uninsured[2], nationwide growth in the number of uninsured individuals grew from 16.2 percent in 1989 to 18.4 percent in 1998. During the same reporting period, Medicaid enrollment grew to 10.4 percent from 7 percent. It reached a high enrollment rate of 12.5 percent in 1994-1995. In 1989, 66 percent of Americans were covered under employer-sponsored plans. That number declined slightly to 65 percent following a decade low of 60 percent in 1993.

Currently, the percentage of uninsured in Montana is 18.4 percent.[3] Table 1 details the distribution of health insurance coverage in the state by type of coverage. Private insurance, whether employer-sponsored or purchased in the individual market, accounts for the bulk of health insurance in the state.

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[2] *Kaiser Commission on Medicaid and the Uninsured*, Eileen R. Ellis, Vernon K. Smith, Ph.D., and David M. Rousseau, Washington D.C., 2001 (update).

[3] U.S. Census Bureau, Current Population Survey, March 1999, 2000, and 2001. There are various estimates of the percentage of uninsured in Montana. Differences in reporting periods or data gathering may account for slight variations. However, most annual indices place the percentage between 18.4 and 19. The term "uninsured" is used in this report and means a person who is not covered by any type of health insurance, including private pay, employer sponsored, or any other type of private pay insurance or by any form of publicly funded health insurance, such Medicare, Medicaid, or CHIP.

Table 1: Montana's Population Distribution by Insurance Status, 1997-1999

Insurance Provider	Number	Percent
Employer	466690	52
Individual	68700	8
Medicaid	88900	10
Medicare	103390	11

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured based on pooled March 2000, 1999, and 1998 Current Population Surveys.

Table 2 provides some details on the uninsured population in Montana as measured by the Federal Poverty Guidelines. This information begins to establish the importance of targeting policy ideas to reduce the uninsured population. As the Subcommittee examined information related to solutions, some recommendations to make health insurance more affordable were recognized as more effective when they are applied to distinct populations within the uninsured population. Also, some ideas may be more suited to addressing the issue of affordable coverage for those people who have access to health insurance through either an employer or in the individual market.

Table 2: Distribution of Nonelderly Uninsured in MT:1997-1999

by FPL	Number	Percent
Under 100%	66,899	39
100-199%	50,916	29
200 % or more	55,918	32
Total	173,733	100

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured based on pooled March 2000, 1999, and 1998 Current Population Surveys.

State Comparisons

Table 3 provides a glimpse into where Montana stands in relation to other states in the areas of uninsured population, median income, and state expenditures for health care in the aggregate and per capita. The information presented allows some conclusions to be drawn that relate to higher median income and lower percentages of uninsured and, with one exception, state health care expenditures and the uninsured rate.

Table 3: Comparing Uninsured Rates, Median Income, and State Health Care Expenditures of Various States, FY 1999

State	Rate of Uninsured	Median Income	Rank	Health Care Expenditures per Capita	Rank	Health Care Expenditures (in millions)	Rank
Montana	*19%*	*$25,682*	*49*	*$654*	*43*	*587*	*46*
Minnesota	9%	$38,449	5	$807	25	3879	20
Washington	13%	$38,006	6	$954	11	5401	13
New Hampshire	11%	$37,916	7	$762	34	956	41
Utah	14%	$37,691	8	$519	49	1113	39
Wisconsin	10%	$36,000	14	$766	32	4136	16
Oregon	14%	$31,681	25	$744	30	2640	27
Maine	13%	$31,289	27	$1,084	9	1377	36

Compiled from Urban Institute and Kaiser Commission on Medicaid and the Uninsured, based on pooled March 2000, 1999, and 1998 Current Population Surveys.

"State Health Care Expenditures" in Table 3, above, includes state-funded health care expenditures for Medicaid, the State Children's Health Insurance Program or CHIP,[4] state employees' health benefits, corrections, higher education, insurance and access expansion, public health-related expenditures, state facility-based services, and community-based services. Sources of state

[4] In Montana, this program is most frequently referred to as CHIP. In other venues, it is sometimes referred to as SCHIP.

expenditures include general funds, other state funds, and federal funds.

Within the health care arena, the Kaiser 50-State review generated some interesting information on the number of health care providers, hospital beds, and emergency room visits.[5] Montana has approximately 5 hospital beds per 1,000 people, the 4th highest rate in the nation. North and South Dakota rank 2 and 3, respectively.

Montana ranks 19th in nurses per 10,000 people, ties for 25th in Physician Assistants, and is 46th in the nation for total health care-related employment. The number of emergency room visits per 1,000 people is just under 300, putting the state 42nd lowest in the nation. There are many other measures that can be listed to help establish where Montana sits in relation to the rest of the nation and to develop a sense of what policymakers might consider recommending in order to address the goals of affordable health insurance and cost-effective, quality health care. In terms of whether solutions that are successful in other states, the information provided by the Kaiser Commission could help lawmakers determine, to a certain extent, whether increased public spending, the nature of a state's economy, demographic indices, or other measures have had a positive effect on increasing coverage or improving access to care. Whether Montana can duplicate the success other states have seen requires a better understanding of what the problem looks like in this state, and whether conditions here are comparable to conditions in other states.

Finally, because the term Federal Poverty Guidelines, sometimes referred to interchangeably as the Federal Poverty Level (FPL), is used here and elsewhere, some clarification is warranted. The Federal Poverty Guidelines are published annually by the U.S. Department of Health and Human Services and used to determine eligibility for a variety of federal programs. The dollar amount listed is the Federal Adjusted Gross Income (FAGI) for a family unit. Adjusted Gross Income is gross income less allowable deductions.

Table 4 describes the Federal Poverty Guidelines and income levels reflected by multiplying those guidelines by various percentages.

[5]State Health Facts Online is a searchable repository of facts related to health care and health insurance. The online site allows people to conduct searches for individual states and a 50-state comparison. The Internet address is: <http://www.statehealthfacts.kff.org>.

Table 4: Federal Poverty Level Guidelines and Percentage Multipliers

Size of Family Unit	FPL in 48 Contiguous States	@ 150% of FPL	@ 175% of FPL	@ 200% of FPL
1	$8,590	$12,885	$15,033	$17,180
2	$11,610	$17,415	$20,318	$23,220
3	$14,630	$21,945	$25,603	$29,260
4	$17,650	$26,475	$30,888	$35,300
5	$20,670	$31,005	$36,173	$41,340
6 or more persons	Add $3,020 per additional person	Add $4,530 per additional person	Add $5,497 per additional person	Add $6,040 per additional person

Source: *Federal Register,* Vol. 66. No. 33, February 2001, pp.10695-10697. Poverty Guidelines using percentage multipliers calculated by Legislative Services Division Staff

Legislative Study

The SJR 22 Subcommittee[6] on Health Care and Health Insurance (Subcommittee) was created as a result of the passage and subsequent assignment of Senate Joint Resolution 22 (SJR 22, L. 2001) to the Economic Affairs Interim Committee (EAC).

Because the scope of SJR 22 was so broad, the EAC chose to request the participation of legislator members from the Legislative Finance Committee (LFC) and the Children, Families, Health and Human Services Interim Committee (CFHHS). Thus, the 14-member Subcommittee set out to examine the main topics identified in SJR 22:

- purchasing pools for individual and small group insurance;
- provider reimbursement rates and cost shifting of health care costs;
- access to affordable prescription drugs;
- strategies to decrease the number of uninsured Montanans;
- factors causing health insurance rates to increase above the rate of inflation;
- the feasibility of recreating the Health Care Advisory Council;

[6] Gordon Higgins was initially the lead staffer for the Subcommittee and the EAC. Due to his departure in June 2002, this report is an amalgamation of his work and that of his successor as lead staffer, Dave Bohyer.

and

- any other issues that the committee or the staff deem appropriate and relevant to the problem.

The Subcommittee met formally eight times and various working groups met informally, e.g., in conference calls, on a few other occasions. The subjects examined by the Subcommittee were recapitulated by the Subcommittee's chairman, Rep. Joe McKenney, at the final meeting of the full EAC. As stated by Rep. McKenney, the Subcommittee looked at:

> ... tax policy changes, medical savings accounts, the subsidized buy-in to the state employee purchasing pool, the full-cost buy-in to the public health insurance, the CHIP employer buy-in, the expansion of CHIP to cover parents, single-payer systems; purchasing pools for health insurance, the MCHA and its needs, hospital rate review regulations, certificate of need, prescription drug costs, assistance for senior citizens and purchasing pools, the West Virginia multi-state purchasing pool, the reestablishment of the former Health Care Authority, the need for a health care inventory and ombudsman. and a defined contribution plan for health benefits.

Narrowing the Focus

It was relatively clear to the Subcommittee during the early stages of the study that not all of the subjects could be examined fully. Eventually, the Subcommittee narrowed its focus to a multi-state purchasing pool for prescription drugs, the Children's Health Insurance Program or CHIP, and a tax credit proposal to mitigate the cost of health insurance purchased by certain individuals and small business.

The remainder of this report is a fuller exploration of the subjects covered by the Subcommittee. The recommendations made by the Subcommittee--examining the creation of or expansion of prescription drug purchasing pools, retention and expansion of CHIP, and tax credits for individuals and small businesses--underpin the commentary in chapters 2, 3, and 4, respectively. Chapter 5 summarizes the Subcommittee activities in regard to ongoing legislative study of health care issues. Chapter 6 provides some background information on a number of the other topics examined over the Subcommittee's 13-month life span. Chapter 7 outlines several topics that are left to future committees to study. The appendices include supporting information, including drafts of legislation recommended by the Subcommittee and requested, ultimately, by the full Economic Affairs Interim Committee.

Chapter 2
Purchasing Pools and Prescription Drugs

The concept of pooling interests for purchasing commodities in bulk dates back some time and is not limited to either the public sector or private sector. The theory goes that purchasing 10,000 items at one time is less costly to the seller of the items than, say, 1,000 sales of ten items each.[7] The savings resulting from the bulk purchase are passed on to the purchaser.

To illustrate the concept, the State of Montana has had for many years a "central stores" program that purchases a variety of office supplies in bulk. The central store then resells the items to state agencies at a price that is only marginally marked up from the wholesale cost of the items. The low mark-up means that an individual agency is able to purchase the items from the central store at a considerable discount to the going rate that the agency would otherwise pay at a retail supplier. Thus, the bulk purchasing power of central stores benefits the state agencies directly and, indirectly, the states' taxpayers.

The Subcommittee explored the pooling concept in two related but very different areas of health insurance: (1) by pooling covered employees through a consortium of employers; and (2) by examining the prescription drug purchasing pooling concept, as implemented in West Virginia and several other states.

An attempt to pool the employees of several employers

The Subcommittee was briefed by Joyce Brown, Benefits Bureau Chief, Department of Administration, on Montana's attempts at pooling employees .[8] Recent history shows that several large employers and trade associations formed the Montana Association of Health Care Purchasers (MAHCP) in 1993. The MAHCP is a non-profit organization devoted to information sharing and cooperative efforts to control health care costs and improve the quality of health

[7] The theory is generally applicable to anything that is "commoditized", which nowadays includes health care and prescription drugs.

[8] The history of the MAHCP, provided here in a slightly edited form, has been taken from a presentation given by Joyce Brown, Benefits Chief, for the State of Montana. The presentation, "Purchasing Pools in Montana: A Presentation to the SJR 22 Subcommittee on Health Care and Health Insurance". was delivered by Ms. Brown to the Subcommittee in October 2001, and a written form of the presentation is on file in the Legislative Services Division, State Capitol, Helena.

care services. The group was comprised of both private and public sector employers including the State of Montana, the Montana University System, Montana Power, First Interstate Banc System, The Auto Dealers Association, and the Montana Logging Association.

The MAHCP recognized that controlling health care costs for small employers and expanding insurance coverage was critical to stemming cost shifting and increased costs to large employers. Consequently, it participated in crafting the voluntary purchasing pool legislation passed in 1995 (designed to primarily benefit small employers) and undertook formation of the state's first purchasing pool for both large and small employers.

The MAHCP later created a subsidiary purchasing cooperative, called Community Health Options (CHO), in 1997 and offered its first health plan, Yellowstone Community Health Plan, to its members in 1998. The goal was to first establish the pool for large employers who had sufficient numbers of employees to attract participating health plans and, once established, to bring in small employers. For whatever reason, CHO was never able to bring in small employers and has proven problematic for large employers.

The features and objectives of the CHO are essentially what might be predicted, as shown below.[9]

CHO Features -- Typical of purchasing pools:

- A standard benefit package.
- Competition between health plans based on their efficiency and resulting price (premium) to provide the standard benefits package. The competition might also be measured on the plans' quality of service, provider networks, and customer service.
- A choice of participating health plans by each individual employee.
- Central administration of choice offerings, enrollment, and billing by the purchasing pool to minimize the burden on small employers of multiple-plans.

CHO objectives:

- Increased health plan value for both large and small employers – expansion of insurance coverage.
- Individual choice by employees rather than employers.
- Increased usage (and increased development in Montana) of more efficient health plan models -- HMOs and other managed

[9] Ibid.

care plans. While a single HMO with a limited panel of providers may not be acceptable to a small employer and his or her employees, competing HMOs with different panels of providers may be acceptable because employees can pick the HMO that offers the employee's preferred providers.

Establishing an effective health insurance purchasing pool among employers would require a major restructuring of the health insurance market. To be successful, a purchasing pool must induce more than one health plan to compete based on their efficiency and quality of care– how well they coordinate and manage care, their provider contracts, and administrative and customer service systems. Effective competition cannot result from only minor differences in the benefits package offered, the insurers' ability to attract good risks and limit adverse ones, or their control of and inducements to agent networks. Thus, effective competition might be achieved by:

- standardizing the benefit package so it is the same for all participating health plans;
- standardizing the rating structure so the base rates each participating plan offers are adjusted uniformly (on the same basis) to reflect the health risks of each employee group to whom the plans are offered.[10]
- standardizing the sales or agent force so that the purchasing pool has its own agents to market the entire purchasing pool product rather than a single plan, effectively allowing a choice of multiple health plans.

Outcome of the CHO effort

The CHO was unsuccessful in inducing the minimum number off broad-based health plans to participate, i.e., at least two, despite offering the carrot of a large, formerly self-insured employee base. The Yellowstone Community Plan participated in 1998, 1999 and 2000 until it merged with Blue Cross and Blue Shield. The then newly formed New West Health Plan participated in 1999 and again in 2000 but lost money in 2000 and declined to participate in 2001. Big

[10] Ibid. According to Brown, "A purchasing pool cannot be community rated, i.e., it cannot offer the same rate to all participating employer groups, when it operates in an insurance market without community or modified community rating requirements. If a purchasing pool could do that, then healthy, low-risk groups could find lower prices in the open market and would not join, leaving only higher-risk groups in the purchasing pool. Under this, essentially noncompetitive market the best a purchasing pool might hope for would be to use some of the savings accruing from the low-cost group to narrow the spread between rates offered to high-risk groups and low-risk groups."

Sky Health Plan participated in 2000 and 2001 but was available in the Butte area only.

For reasons unknown, Blue Cross and Blue Shield has consistently declined to participate in a purchasing pool involving small employer groups. As the state's largest health insurer, Blue Cross and Blue Shield has expressed fundamental problems with purchasing pool features that CHO and its consultants have considered critical to successfully including small employers in a purchasing pool, more specifically: a standardized rating structure and purchasing pool agents to market the product. Blue Cross and Blue Shield has also expressed doubts that savings can offset the administration costs of a purchasing pool. Doubts about a purchasing pool involving small employers have also been expressed by the New West Health Plan.

Without the commitment and participation of these two plans, Blue Cross Blue Shield of Montana and New West, a purchasing pool cannot achieve its primary objective of offering broad-based competing plans to its members. Because CHO and its consultants have put a lot of time and resources into attempting to negotiate the details of a standardized rating structure with Montana Health Plans (and have offered additional protections such a rear-end premium adjustment for plans that picked up more than their share of risk), it appears that at least Blue Cross and Blue Shield finds unacceptable the central and essential features of a purchasing pool.[11]

<u>In the matter of prescription drugs</u>

The West Virginia Rx Purchasing Pool

The program, as simply described as possible, is a contract between the West Virginia Public Employees Insurance Agency (WV) and Express Scripts, Inc. (ESI) in which ESI provides "prescription benefit management" (PBM) services to WV for certain fees, reimbursements, and rebates.[12] Under the agreement, WV is required to use ESI as the exclusive provider of prescription drug

[11] Ibid. Note that this discussion of MAHCP has been adapted from "Purchasing Pools in Montana: A Presentation to the SJR 22 Subcommittee on Health Care and Health Insurance", Joyce Brown, Benefits Chief, Montana Department of Administration, October 2001. In the paper, Ms. Brown also discusses the state's recent experience with "whole plan" insurance and self-insured plans, both of which are beyond the scope of the pooling subject covered in this chapter.

[12] *Express Scripts, Inc. Managed Prescription Drug Program Agreement*, in *Minutes*, SJR 22 Subcommittee, Sept. 13, 2002; on file in Montana Legislative Services Division.

benefits, including pharmacy network management, claims processing, mail service pharmacy, formulary development, and rebate management during the term of the contract. Pharmacy reimbursement rates, administrative fees, and rebates are conditioned on ESI's exclusive status under the contract. Additionally, ESI may negotiate modifications to the reimbursement rates, administrative fees, or rebates if WV elects to use on-site clinics or pharmacies to dispense prescription drugs to covered members and the use of the clinics or pharmacies materially reduces: (1) rebates generated by WV under the contract; (2) covered drug claims submitted on-line; or (3) formulary compliance.

Notably, the WV program is available to and covers *only* employees or retirees of West Virginia higher education, K-12 public education, teachers' service personal, state employees, and some local government entities. Thus, persons *not* covered under the WV plan include:

- uninsured West Virginians;
- senior citizens who are not retired state employees;
- low-income children whose parents are not covered by the WV plan;
- the host of other West Virginia individuals and businesses (small and large) who are not state employees.

The director of the WV program, Mr. Tom Susman, told the Subcommittee that West Virginia has realized considerable savings under the program.[13] He said that the program is "market driven" and it allows the states participating in the purchasing pool to receive price discounts that would otherwise be unavailable. Mr. Susman said that West Virginia has estimated savings of $6 million per year on total pharmacy benefit costs of $134 million. The contract is general-pricing-based on prior utilization, volume, and the type of system that the state has (which type can vary by state within the pool). According to Mr. Susman, 99% of West Virginia's claims go through local independent or regional community pharmacies and 1% go through mail. In West Virginia, community and independent pharmacies are treated the same with regard to dispensing fees, and West Virginia has been looking at a (somewhat higher) dispensing fee for rural pharmacies to help them get extra money. Mr. Susman said that the pharmacy distribution is left up to each state and that West Virginia tries to get the money from the PBMs rather than from the local pharmacies, thus helping to protect the viability of local pharmacies.

[13] Mr. Susman's comments are contained in the *Minutes* of the SJR 22 Subcommittee, August 30, 2002. At the meeting, the Subcommittee and others participated in a conference call with Mr. Susman on the West Virginia Public Employees Insurance Agency prescription drug purchasing pool program.

In Montana's case, state employees, excluding public university system employees, have prescription drug benefits through the health insurance benefit that is part of state employee compensation. The Supreme Court and District Court judges and employees are generally under the State insurance plan. County employees have their own policies. The Montana University System (MUS) has its own plan that covers the employees of all units of the MUS. Each elementary, high school, and combined elementary-high school district has its own plan. Any of these other plans can differ a great deal from the State plan, but each public employer entity belongs to the Montana Association of Health Insurance Plans. Consequently, guidelines that are similar to one another are typically used when a contract for health insurance is drafted by any of the public entities. The various entities also use each other's employee benefits specialists as information or distribution sources whenever a global issue is raised or pending.[14]

Because West Virginia, like Montana, is largely a rural state whose citizens persevere with generally low incomes and that has a relatively high percentage of residents who live without health insurance coverage, the Subcommittee saw an opportunity to explore further the possible expansion of the "contract" under which pharmacy benefits are purchased for Montana state employees. For these reasons and others:

Recommendation 1

The SJR 22 Subcommittee recommends: that the Department of Public Health and Human Services (DPHHS) explore the option of participating in a multi-state purchasing pool for prescription drugs on behalf of the citizens that DPHHS serves; that the Administration explore with the Confederated Salish and Kootenai Tribes' their legal authority under the Hellgate Treaty of 1855, the Jay Treaty, and other treaties or federal laws, whether the federal government will allow the Tribes to enter into agreements with Canadian tribes for the importation into Montana of certain prescription drugs; and that the Administration explore whether the purchasing pool for prescription drugs in which the state participates on behalf of state employees can be expanded to include a broader spectrum of Montana's citizens.

Chapter 3
The State Children's Health Insurance Program or CHIP

In Montana, the CHIP program provides health insurance to approximately 9,300 children who are ineligible for other publicly funded

[14]Conversation with Amber Ireland, Benefits Bureau, State Personnel Division, Department of Administration, November 13, 2002.

health care and whose parents have not purchased health insurance for other, typically economic, reasons.

The *Legislative Fiscal Report 2003*[15] describes CHIP as follows:

> The Children's Health Insurance Program (CHIP) program [is] an insurance program for children in families with incomes less than 150 percent of the federal poverty level ($26,475 for a family of 4 in 2001). The state contracts with private insurance carriers to provide and pay for services. Families with incomes above 100 percent of the federal poverty level pay an annual co-payment of $215.
>
> CHIP is funded from a fixed federal grant. States have three years from the time it is received to spend the grant allotment. Federal funds require a state match based on a percentage of the match rate for Medicaid benefits. The Montana match requirement for federal CHIP funding is 19.09 percent in fiscal 2002, and 19.24 percent in fiscal 2003. Administrative costs are limited to 10 percent of the grant amount.[16]

In slightly different language, the DPHHS describes CHIP as follows[17]:

In very general terms, there are no preexisting condition limitations and the following services are covered under CHIP:

- physician and advance practice registered nurses;
- inpatient and outpatient hospital services;
- routine sports or employment physicals;
- general anesthesia services;
- surgical services;
- clinic and ambulatory health care services;
- prescription drugs;
- laboratory and radiological services;
- inpatient, outpatient, and residential mental health services or substance abuse treatment services; and
- dental services, vision exams, eyeglasses, and hearing exams.
- Due to limitations[18] in state general funds, CHIP is essentially "capped" at approximately 9,300 children, who are enrolled on a first-come, first-served basis. A sizeable waiting list of eligible children is retained by the DPHHS and, as CHIP-insured children become ineligible and are removed from CHIP coverage, the children on the waiting list are enrolled.

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[15] *Legislative Fiscal Report for the 2003 Biennium* , Legislative Fiscal Division, June 2001.

[16] Ibid., p. B-84.

[17] Information provided by Mary Noel, Department of Public Health and Human Services, November 13, 2002.

[18] The *Legislative Fiscal Report for the 2003 Biennium* (p. B-11) reported, "In fiscal 2000, Montana reverted $5.5 million of unspent CHIP grant. Congress reallocated reverted grant amounts first to states that had fully expended their grants and second to states that had not. Montana was reallocated $4.4 million of the reverted amount, which must be expended by September 30, 2002. The amount of estimated reversion from the 1999 grant amount is $1.6 million and the estimated reallocation is $1.3 million."

As a federal-state program, each state must "pony up" for a portion of the cost of the program. Montana's match amount in recent years has been approximately a 20%/80% ratio, i.e., $1 of state general fund that is matched by $4 of federal funds.

The Subcommittee learned that eligibility criteria can be made less restrictive if the state requests and receives federal approval for a program waiver, or if the state bears 100% of the cost of expanding the eligibility criteria. With that option available, the Subcommittee considered whether it would be advisable to expand CHIP to possibly include:

- simply increasing the state general fund appropriation for CHIP to capture the entire available federal match, thus increasing the number of children at which the program would be "capped";
- children living in a household with income of more than 150% of the federal poverty level;
- the parents of children who are currently eligible under the CHIP eligibility criteria;
- "senior citizens" who are not Medicare or Medicaid eligible and who, but for their age, would otherwise meet the eligibility criteria for CHIP enrollment;
- employees of certain small businesses; and
- other individuals or distinct groups that are generally uninsured in Montana and who could be discretely identified by various, predetermined criteria (as yet undefined).

In the end, the Subcommittee noted both the condition of the state fisc and the range of policy and fiscal questions to which answers must be provided before the Legislature should act. For those and other reasons:

Recommendation 2

The SJR 22 Subcommittee recognizes the importance of the CHIP program in providing medical insurance for uninsured children and the value of the federal match in CHIP. At the same time, the Subcommittee recognizes the fiscal difficulties facing the state and, within the context of those difficulties, urges the Administration to place a high priority on maintaining the size of the CHIP program or expanding it if funding resources could be found, while keeping other programs in the DPHHS that have proven to be valuable to the health of the entire state.

Chapter 4
Tax Credits for Health Insurance Premiums Paid

Perhaps foremost among the options considered by the Subcommittee was the potential benefit from tax credits for health insurance premiums paid. As stated in a scoping report to the Subcommittee, "Tax Credits and Purchasing Pools: Implications for Affordable Health Insurance"[19]

> One of the Subcommittee's... goals is to develop strategies to increase the number of people who have access to affordable health insurance coverage. One way to achieve that goal is to uncover whether changes to tax policy, either alone or in conjunction with other policy ideas, would lower the percentage of the uninsured.

And so it was that the Subcommittee set off on its journey to explore the myriad complexities of the interfaces among demographics, economics, health insurance, and state tax policy. The narrative that follows, which was borrowed quite liberally from "Tax Credits and Purchasing Pools", was the Subcommittee's introduction to some of the issues.

Tax-Based Programs to Increase Health Insurance Coverage

Whether it is the deductibility of health insurance premiums or refundable tax credits, the tax systems at the state and federal levels are important sources of subsidy for health insurance coverage. Tax deductibility is likely to help those in higher income brackets who pay higher tax rates, whereas refundable credits would extend some benefit to those that may not have any tax liability and have either opted not to take up employer-sponsored coverage or have no access to employer-sponsored coverage. Focusing on only refundable tax credits begins to illustrate a few key points that health policy experts suggest lawmakers consider. First, if a refundable tax credit is established for individual taxpayers, some analysts advise that the credit be designed to complement existing coverage sources, such as allowing eligible employees to use the credit to fund

[19] From "Tax Credits and Purchasing Pools: Implications for Affordable Health Insurance" by Gordy Higgins, Legislative Services Division, June 2002, p. 1.

their portion of the premium for an employer-sponsored plan.[20] Another option that has been proposed is to allow people with tax credits to buy into public programs, or combine public subsidies with tax credits to make coverage in the individual market more affordable.[21] If neither of these options prove workable, the recipients of tax credits must access the individual market to find coverage. In the individual market, insurer's usually rate the risks of the individual and base rates on a person's age, health status, and previous illnesses. Analysts from the Center for Studying Health System Change state that without significant reforms in the individual market, namely underwriting restrictions, the success of tax credits for purchasing health insurance may be disappointing.[22]

Recently, the move has been to determine whether individual solutions that have exhibited limited success can be combined to provide a more comprehensive answer to the issue of high uninsured rates. One area that seems to be gaining momentum is merging tax credits with health insurance purchasing pools. The concept behind purchasing pools is that they may offer similar advantages currently being realized by large group plans or large employer plans. Purchasing pools have the effect of providing additional choices for consumers, pooling risks, achieving greater bargaining power in the market, and promoting potential cost-savings as a result of economies of scale.[23] The rationale behind this marriage of ideas is that by mimicking large employers, which a purchasing pool is designed to do, individuals seeking health insurance would be brought together on the basis of income, not health status. In effect, pool participants would realize the benefits of group rating mechanisms rather than individual risk rating (underwriting).

There are a number of design issues associated with developing effective purchasing pools combined with refundable tax credits. These issues include determining who is eligible for the tax credit and enrollment into the pool; what the standard benefit package would be; how the pools would interact with existing state insurance regulations (such as mandated benefit requirements); whether all small employers must purchase coverage through the pool; and whether to

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[20] *Stand-Alone Health Insurance Tax Credits Aren't Enough*, Center for Studying Health System Change, Issue Brief No. 41, July 2001.

[21] Ibid.

[22] Ibid.

[23] Alain Enthoven, "Health Plan Purchasing Cooperatives: Helping the Market to Work for Consumers Who
Are Not Sponsored by Large Employers," Discussion Draft, January 7, 2000.

require that anyone receiving a tax credit be required to join a pool.[24]

As the SJR 22 Subcommittee deliberated the various approaches designed to expand insurance coverage or make coverage more affordable to those who have it, the members worked to understand what opportunities might exist in Montana and how restructuring those opportunities might best meet adopted goals and objectives.

Existing Montana tax policy in re health insurance

The Department of Revenue (Department or DOR), each biennium, releases a report[25] that describes the provisions of and forecasts the impact of each tax credit, deduction, exemption, etc. As part of the *Report*, the Department estimates revenue losses associated with the use of a variety of tax deductions, credits, and exclusions. This loss of revenue, or tax expenditure, represented a reasonable approach for the Subcommittee to recognize existing state tax policies as they relate to health insurance, to health care and the estimated use of it in terms of numbers or percentage of Montanans, and to overall cost.

For the Subcommittee's purposes, a tax expenditure was recognized as a provision of the tax code that provides for special exclusions, exemptions, deductions, deferrals, or preferential tax rates that result in forgone revenue.[26] Generally, the purpose of a tax expenditure is to provide financial assistance to a certain group of taxpayers, or provide an economic incentive that encourages specific taxpayer behavior. In most cases, financial assistance or behavioral incentives could be accomplished through direct government spending programs to those targeted groups.[27] In their

Report, the DOR authors provide some guidelines for policymakers

[24] Health Care Financing & Organization, Findings Brief, Vol. 4, Issue 1, June 2000, and *Stand-Alone Health Insurance Tax Credits Aren't Enough*, Center for Studying Health System Change, Issue Brief No. 41, July 2001.

[25] *Biennial Report of the Montana Department of Revenue: July 1, 1998 to June 30, 2000* by the Montana Department of Revenue, Tax Policy and Research, Sam W. Mitchell Bldg., Helena, MT. Publication of the *Report* is statutorily required under 15-1-205, MCA. Note: Each *Biennial Report* covers the fiscal biennium during which the *Report* is compiled and published.

[26] Montana Department of Revenue, *Biennial Report, July 1, 1998 to June 30, 2000*, p 103.

[27] Ibid., p. 103.

when using tax expenditures as a way to assist in developing new policy directions. In effect, tax expenditure estimates should be viewed as a measure of the amount of relief, assistance, or subsidy currently being provided through the tax code, and not necessarily as the amount of revenue that would be realized by repealing expenditure provisions currently in law.[28] What follows is a description of four different tax expenditure provisions in state law that may affect decisions related to health care and health insurance.

Individual Income Tax Exemptions and Exclusions

The Montana Medical Savings Account (15-61-202, MCA)

The medical savings account offers resident taxpayers an opportunity to save money for medical expenses by contributing money to an account administered by either an account administrator or the resident taxpayer. The taxpayer may contribute any amount to the account, but only the first $3,000 annually may be used to reduce taxable income. Money left in the account, or withdrawn for eligible medical expenses, is not subject to taxation in Montana, but is subject to taxation at the federal level. Eligible medical expenses are defined by the IRS Code Section 213 (d) and include items such as health insurance premiums, prescription drugs, medical, dental, and nursing care, eyeglasses, crutches, hearing aids, and certain travel and lodging expenses associated with receiving medical care. Long-term care insurance for the account holder or the account holder's dependents is also an eligible expense that would not be subject to taxation if withdrawn.

Medical Insurance Premium Expense Deduction (15-30-121 (1), MCA)

Montana law allows taxpayers to deduct allowable health insurance premiums. The premiums must be paid by the taxpayer with after-tax dollars. The purpose of this deduction is to provide assistance to taxpayers paying out-of-pocket insurance premiums.

Medical and Dental Expenses (15-30-121 (1), MCA)

Expenditures for specified medical expenses are deductible to

[28] Ibid., p. 105

the extent that they exceed 7.5% of the taxpayer's adjusted gross income. This deduction targets both taxpayers who have unusually large and unplanned medical costs and taxpayers who may not have health insurance.

Disability Insurance Tax Credit (15-30-129, MCA and 15-31-132, MCA)

Employers with 20 or fewer employees may obtain a non-refundable tax credit of up to $3,000 annually ($25 per month for 10 employees) for expenditures on employee health insurance premiums.[29] The credit may not exceed 50% of the premium cost of each employee and may not be claimed for a period of more than three years. An employer may not be granted the credit within 10 years of the last consecutive credit claimed. This credit may be applied against individual income taxes or corporation license (income) taxes. The Department estimates that this tax credit results in an annual tax expenditure of less than $25,000.

Table 5 provides an estimate, by income group, of the numbers of taxpayers who were estimated to be eligible to claim individual income tax deductions and exclusions for tax (calendar) year 2001.

[29] The term "disability insurance" as defined in 33-1-207, MCA, includes health insurance within its meaning.

Table 5: Income Tax Expenditures by Decile Group, Specific Deductions, Forecast Tax Year 2001[30]

Decile Group	Income Bracket	Medical Savings Accounts		Medical Insurance Premiums		Medical Deductions	
		No.	Percent	No.	Percent	No.	Percent
1	$0 - 5,900	1	0.00%	56	0.02%	65	0.02%
2	$5,901 - 7,250	4	0.02%	759	0.18%	680	0.26%
3	$7,251 - 13,680	13	0.14%	3314	1.16%	2555	1.48%
4	$13,681 - 17,600	44	0.79%	5083	2.57%	3456	2.95%
5	$17,601 - 21,140	93	1.66%	7358	5.29%	4744	5.48%
6	$21,141 - 32,500	150	3.86%	9982	8.72%	6268	9.60%
7	$32,501 - 37,200	205	5.93%	10691	11.78%	6457	12.71%
8	$37,201 - 52,260	287	11.22%	12684	16.46%	7330	17.85%
9	$52,261 - 70,940	410	19.98%	14139	21.52%	7679	20.88%
10	$70,941 - +	734	56.41%	16110	32.30%	5865	28.77%

Compiled from the *Biennial Report* of the Department of Revenue, July 1, 1998 to June 30, 2000.

The Subcommittee was intrigued with the possibility that a tax credit or credits could be designed to make the affordability of health insurance sufficiently attractive that a portion of Montana's uninsured population would buy or at least could afford coverage. By using tax credits and, perhaps, designing a purchasing pool concept to work in concert with the credits, the Subcommittee attempted to reach a targeted section of the uninsured and underinsured.

The Subcommittee's First Decision

The Subcommittee initially had such a surfeit of options before it that Chairman McKenney appointed a "Tax Credit Working Group" (hereafter, "Group") to focus exclusively on the potential of a Montana

[30] Each Decile Group includes one-tenth of all households filing income tax returns. The first decile group includes households with the very lowest incomes, while the tenth decile group includes those households having the highest incomes. The decile groups are based on actual 1999 incomes, but the tax expenditures are those projected to calendar year 2001.

tax credit.[31] The Group met initially in scoping sessions to gain better understanding of numerous variables to be considered in crafting a tax credit for Montana. The objectives considered, and in large part adopted, by the Group are summarized below.

Objectives for Health Insurance Tax Credits
Identified by the SJR 22 Working Group on Tax Credits

- Tax credits should be targeted to both individuals and small businesses.
- The credit should be structured to assist the insured and the uninsured.
- Tax credits to small businesses should not be limited to those businesses who have not or are not offering coverage to their employees.
- All business entities should be eligible for a tax credit, including non-profit entities.
- The credit should forge a balance between cost and effectiveness.
- The credit must be large enough or be attractive enough for the eligible population to take advantage of the credit.
- From a small business perspective, the tax credit proposal must be simple enough to warrant its use.

Once the objectives were established, the Group identified a number of questions that members and others believed would need to be answered as the actual credits took shape.

Questions, Questions, Questions...

- Who is eligible for a tax credit (including decisions related to income eligibility, size of small businesses, history of offering or having health insurance, etc)?
- What is the average cost of a basic and traditional insurance plan for individuals and small groups?
- Should the credit be a set dollar amount or a percentage of average premiums?
- Should the credit be refundable, advanceable, or both?

[31] Sen. Jon Ellingson was appointed chairman of the Group, with Rep. Bob Lawson and Rep. Bill Price as the legislator members. Other persons attending the Group's meetings included: Keith Colbo, New West Health Care and Pfizer Pharmaceutical; Aidan Myhre and Webb Brown, MT Chamber of Commerce; Tanya Ask and Chuck Butler, Blue Cross/Blue Shield of MT; David Kendall, Progressive Policy Institute (Missoula); Jean Branscum, Office of the Governor; Claudia Clifford, Office of the Insurance Commissioner; Mary Whittinghill, Montana Taxpayers' Association; Mary Allen, MT Insurance Agents and Financial Advisors; and Riley Johnson, National Federation of Independent Business - MT.

- Should the credit be indexed to allow for growth over time?
- How should the credit be structured to ensure it is used for the purchase of health insurance?
- Should a standard, basic health benefit package be created to increase the chances of purchasing insurance with the credit?
- Should deductibility be maintained, reduced by the credit, or eliminated as a condition for receiving the credit?
- What is the effect on the state general fund?
- How should the credit be financed?
- What percentage of an annual premium should the credit cover?
- How will the differences between the individual and small group market affect the credit design?
- If a tax credit is authorized, how should existing deductibility of premium costs be addressed?
- Would individuals and small businesses rather deduct their costs associated with providing health insurance or receive a tax credit?
- How well known and how widely used is the deductibility provision in Montana tax law?
- How would a tax credit work with public health insurance programs?
- Should the credit allowed to be used to "buy-in" to CHIP?
- How does the uninsured population change over time?

Clearly, the questions outnumbered the answers available at the Group's initial meetings. As work progressed, however, a number of the answers became available, while a number of the questions faded in relative importance.

By the Group's July 26, 2002 meeting, some clarity was beginning to appear and, by the August 30 meeting, the main criteria had been established. The following discussion describes some of the consideration given by the Group to the numerous subissues.[32]

[32] The Group's also received for the August 30, 2002, meeting, "Issue Paper: Tax Credit for Health Insurance Premiums" prepared by the Group's staffer, Dave Bohyer. The paper is included herein at Appendix A.

Features of the Individual and Small Business Tax Credits

General eligibility criteria

- ☞ The tax credits should be available to "low-income" individuals and to Montana "small" businesses.
- ☞ The tax credits should be both refundable and advanceable. As a result, a person or small business claiming a credit that exceeds actual tax liability would receive a refund. Further, the tax credit could actually be claimed before the taxpayer's tax liability is finally determined, in which cases the "advanced credit" would be sent directly to the insurer.
- ☞ An individual should not benefit from both the credit available to individuals and the credit available to small employers.
- ☞ An individual who claims a credit under the federal Trade Act of 2002[33] would not be eligible for the state credit.
- ☞ The tax credits would be proposed as a "pilot program", having a limited, relatively short, life span. Under the program, interested or employers persons would apply to the DOR for the credits. The total amount of the credits available in any fiscal year would be capped at $45 million.[34]

Eligibility criteria for the individual credit

- ☞ The credit would be available initially only to individuals with family income under 175% of the federal poverty level (FPL). The DOR would be required to incrementally increase the income threshold to 200% FPL if the "take-up rate" is sufficiently low.[35]
- ☞ An individual would not be eligible for the individual credit if the individual's employer claimed the small business tax credit on that person. However, an individual could claim the individual tax credit for buying coverage for a spouse or dependent.

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[33] H.R. 3009 was enacted as the Trade Act of 2002, covering trade adjustment assistance (TAA), trade promotion authority (fast-track procedures), Andean trade preferences, and other trade provisions. The Act may be cited as Public Law No. 107-210.

[34] The Group reviewed several series of spreadsheets that attempted to estimate the application of the credits as originally conceived. A copy of the spreadsheets is available at the Legislative Services Division.

[35] A table of Federal Poverty Level (Guidelines) incomes and family size is provided as Table 4 in Chapter 1. The "take-up rate" is the percentage of uninsured who use the credit.

- An individual, regardless of income level, would be eligible for the credit if the individual is covered under the Montana Comprehensive Health Association (MCHA) high risk coverage under 33-22-1521, MCA, and pays the MCHA premium.

Eligibility for the small employer credit

- The credit is available and limited to "small employers", initially, those with 4 or fewer employees. The DOR would be required to incrementally increase the threshold up to employers employing 9 or fewer employees if the "take-up rate" is sufficiently low.
- The employer's contribution would have to be equal to or greater than twice the amount of the tax credit claimed, which would provide the employer with a maximum credit of 50% of premiums paid.
- The tax credit would not be available to a small business whose annual net income is over $ 750,000.

The form of the credits

- The credits would be "flat amounts" (rather than a percentage of premiums) for each eligible individual for whom coverage is paid.
- The amount of the credit would be based on the age of the insured. For the individual credit, the covered individual's age would be the measure. For the small employer credit, the average age of the group covered would be the measure. (See Table 6.)
- The credit would be increased by $40 per month for an eligible, covered spouse or dependent.
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Table 6: Proposed Distribution and Amount of Tax Credits

Age	Individual Credit		Small Business
	Market	MCHA	
Under age 19	$ 75	$ 75	$ 40
Age 19 – 45	$ 125	$ 130	$ 100
Over age 45	$ 200	$ 200	$ 125

With eligibility criteria established, the form and amount of the

credits set, and the credit alternative designated as a 4-year pilot project that was capped at a cost of $45 million annually, the Group concluded its work by making the conceptual credits a recommendation to the full Subcommittee. In turn, the Subcommittee on August 30, 2002, adopted the recommendation and forwarded it to the full Economic Affairs Interim Committee, which also endorsed the concept on September 12, 2002 by formally requesting that a bill establishing the credits be drafted "by request" of the EAC. (See Appendix B for a copy of the draft bill as recommended by the EAC.)[36]

Recommendation 3

The SJR 22 Subcommittee recommends that the state offer a tax credit to certain low-income individuals and to small businesses for a portion of health insurance premiums paid. For individuals, eligibility should be based on income and the credit amount should be based on the age of the insured. For small business, eligibility should be based on income and on the number of individuals employed by the small business and the credit amount should be based on the average age of the insured. The amount of credits that may be claimed in the aggregate in any fiscal year may not exceed $45 million. The credit should be offered on a trial basis as a pilot program and be terminated after 4 years, unless reauthorized by a future legislature.

[36] As provided in Appendix B, the bill draft is marked "LC6020, which was the working reference given to the draft before it was formally endorsed and requested by the Economic Affairs Interim Committee. Once requested by the EAC, the draft became LC 0494.

Chapter 5
Legislative Study of Health Care Issues

Senate Joint Resolution No. 22 (2001) asked specifically for the committee to study "the feasibility of recreating the Health Care Advisory Council". This chapter provides a brief history of the Health Care Advisory Council (Council) and the duties that were assigned to it by the Legislature.[37] Because the Subcommittee was asked to consider reestablishing the Council, it is apparent that it didn't exist during the 2001 legislative session. However, several references to the Council remain in statute and the Code Commissioner bill being prepared for the 58th Legislature will propose to repeal these references.

Chronology and legislative activity

Montana began to study its health care system in 1993[38] when the Legislature created the Montana Health Care Authority (HCA) and charged it with developing a comprehensive statewide health care reform strategy to provide all Montanans with improved access to high quality, affordable health care.[39] The HCA had prepared a statewide universal healthcare access plan based on a single payer system and a regulated, multiple payer system plan. Those plans were submitted to the Governor and the Legislature along with a third alternative--a market-based, sequential health care reform package.[40] The HCA was repealed and the Council, designed to replace the HCA, was created by House Bill No. 511 (1995). [41] As established, the Council consisted of four legislative members, five members selected by the Governor, each representing a health care

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[37] The bulk of the information in this Chapter 5 was originally prepared for the Subcommittee by Gordy Higgins as "The Montana Health Care Advisory Council: History, Duties, and Accomplishments" and was given to the Subcommittee in advance of the October 2001 meeting. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

[38] "Health care" per se had been studied previously at various times prior to 1993, but looking back more than 10 years was thought to offer minimal benefit in this case.

[39] *A Big Sky Opportunity to Expand Health Insurance Coverage*, Montana State Planning Grant Application, April 2002.

[40] *Ibid.*

[41] Chapter 378, Laws of Montana, 1995.

planning region, and one additional member representing the Executive Branch, also appointed by the Governor. The Council was required to be established by May 1, 1995 and terminated on June 30, 1997.

The members of the Council and the members of the HCA were required to hold one meeting before June 30, 1995. On or before June 30, 1995, the HCA was required to transfer the documents and materials that it had compiled previously to the Council.

The Council was required to monitor and evaluate implementation of recent health care reform initiatives, including: (1) small group insurance reform; (2) the development of medicaid managed care; (3) tort reform; (4) changes to the antitrust statutes; (5) voluntary purchasing pools; and (6) the efficiency of the certificate of need process.

The Council was required to provide reports on the progress of these reforms to the general public and the Legislature. The Council was also to continue studying potential solutions to the health care crisis and study methods of cost reduction in health care services and health care delivery systems. The Council was required to report its findings to the Governor and the Legislature by October 1, 1996.

House Bill No. 531, also enacted in 1995,[42] required the Council to appoint a task force of consumers, employers, health insurers, hospitals, health care providers, and legislators to design a consumer report card intended to enhance consumer responsibility in the use of health care services. The Council was required to submit to the Legislature by October 1, 1996, the task force's proposal containing the information needed to prepare the consumer report card.

House Bill No. 531 (1995) had also required the Council to develop standards for uniform data to be provided by health insurers, hospitals, and health care providers and to take into account the feasibility and cost-effectiveness of the standards.[43]

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[42] Chapter 349, Laws of Montana, 1995.

[43]The Legislative Audit Division recently released a financial compliance audit for the Department of Public Health and Human Services (Audit Report No 01-11, December 2001). Among the many recommendations was one urging the Department to comply with the requirement contained in 50-4-502, MCA, to develop a health care database. The Legislative Auditor concluded that the agency has not designed or developed a database that includes data on health care resources and the cost and quality of health care services. The audit report acknowledged that the Department had requested but was not granted funding for the development of the database during the 1997, 1999, and 2001 Legislative sessions. The audit report went on to suggest that the agency should assess the need for the law and seek legislative change if it is warranted. However, until any changes were made, the agency should comply with the requirements. The agency partially concurred with the recommendation and suggested that they may seek legislation to repeal the requirement for a health care database.

Not unexpectedly, the Council was re-authorized and in 1999 they chose to prioritize their efforts towards the rising number of uninsured Montanans.[44] Members of the Council, the DPHHS, and health care policy specialists from the State Coverage Initiatives (SCI) Program prepared a White Paper titled “Strategies for Improving Access to Health Care Coverage”.

Because the 57th Legislature did not re-authorize the Council during the 2001 Session, the Council terminated on July 1, 2001.

Limitations of an advisory council

Section 2-15-122, MCA, governs the creation of advisory councils by Executive Branch agencies. Each advisory council is required to be allocated to an agency for administrative purposes as provided in 2-15-212, MCA. The term "advisory capacity" is defined as the "furnishing of advice, gathering information, making recommendations, and performing other activities that may be necessary to comply with federal funding requirements and does not mean administering a program or function or setting policy".[45] Interpreting the role of an "advisory council" to act beyond simply furnishing advice or making recommendations runs counter to the statutory limitations imposed by 2-15-122, MCA.

The SJR 22 Subcommittee did not make a recommendation regarding reestablishing a Health Care Advisory Council. However, that option is open to the 58th Legislature.

Legislative study regarding "health care"

The study requested in SJR 22 was accompanied by a related study contained in House Joint Resolution No. 1 (2001). The HJR 1 study, not unlike SJR 22, was to be a continuation of activities that had begun in previous years. The purpose of HJR 1, as stated in the "whereas" clauses, is indicative of the complexity of "health care" issues and the overlapping authorization or mandates among different groups, legislative and otherwise:

> WHEREAS, the ultimate public policy goal of the integration of mental health services within the various divisions of the Department of Public Health and Human

[44] *Ibid.*

[45] The definition of "advisory capacity" is contained with section 2-15-102, MCA.

Services, between state agencies, and in cooperation with local governments will require integration of study between multiple legislative interim committees in fulfillment of their respective statutory responsibilities; and

WHEREAS, the Department of Public Health and Human Services has a Mental Health Oversight Advisory Council that provides input to the Department in the development and management of any public mental health system and is required to provide to the Legislative Finance Committee and other appropriate interim committees copies of meeting summaries and recommendations made to the Department by the Advisory Council and the Department is required to report its response to those recommendations; and

WHEREAS, the Children, Families, Health, and Human Services Interim Committee and the Legislative Finance Committee are both involved in various aspects of monitoring the Department of Public Health and Human Services, including the Addictive and Mental Disorders Division; and

WHEREAS, many of the issues that have been raised involve the corrections and criminal justice systems that are under the purview of the Law, Justice, and Indian Affairs Interim Committee and affect agencies monitored by the Legislative Finance Committee; and

WHEREAS, mental health issues arise in the context of veterans' health care needs encountered by the State Administration, Public Retirement Systems, and Veterans' Affairs Interim Committee and interact with various aspects monitored by the Legislative Finance Committee; and

WHEREAS, the issues revolving around mental illness touch many areas of government, and many resources must be brought to bear to understand the issues, to work towards resolution, and to provide strong public policy direction for the further integration and delivery of public mental health care services.

It became apparent to the Subcommittee that in addition to the SJR 22 study, the HJR 1 study and a number of other examinations of subtopics under the "health" umbrella were being conducted by a variety of legislative, executive, and hybrid groups. This situation caused or resulted in legislators and legislative and executive branch staff either serving on, assisting, or reporting to the panoply of working groups, advisory councils, subcommittees,

committees, etc. The overlap and, to some extent, duplication of effort was precisely one situation that the adoption of SB 11 (1999)[46] and SB 10 (2001)[47] had intended to eliminate or at least mitigate. As a result, the Subcommittee proposed:

Recommendation 4

The SJR 22 Subcommittee recommends that the 58th and subsequent Legislatures strive to direct studies of "health care" issues to the most appropriate forum which is, in the Subcommittee's opinion, is the Children Families, Health and Human Services Interim Committee or a subcommittee of the CFHHS dedicated to "health care".

[46] Chapter 19, Laws of Montana, 1999.

[47] Chapter 210, Laws of Montana, 2001.

Chapter 6
*Sidebars: Health-Related Topics Before the Subco*mmittee

In addition to purchasing pools, the CHIP program, and tax credits for health insurance premiums, the Subcommittee encountered a number of other issues. This chapter is largely a recapitulation of information provided to or developed by the Subcommittee.

Part 1: Health Insurance and Health Care Cost Drivers[48]

Under SJR 22, the Subcommittee was charged with addressing the rising cost of health care and health insurance. Within that broad mandate was a request to determine why health care costs and health insurance rates are rising at a rate higher than the overall inflation rate. Presumably, if the Subcommittee could conclude why this was occurring, they might also be able to recommend policies to keep the health care related costs from increasing or increasing at such a rapid pace. Some cost drivers are more apparent than others, but each of the drivers identified deserves at least some attention in the discussion.

The Consumer Price Index

The Consumer Price Index (CPI), produced by the U.S. Bureau of Labor Statistics, is a general measure of the change in consumer prices over time in a market basket of goods and services. The CPI and the market basket of goods is based on prices of food, clothing, shelter, fuels, transportation, charges for medical services and drugs, and other goods and services that people buy for day-to-day living. Once gathered, the CPI measures price changes from a designated reference date, in this case 1982-1984, and the "base" for the index is set at 100. Percentage increases or decreases are shown as a relationship to the base of 100. For example, an increase of 10% is shown in the CPI as 110.

[48] "Health Insurance and Health Care Cost Drivers" was originally prepared for the Subcommittee by Gordy Higgins in August 2001. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally written is available at the Legislative Services Division.

Measuring for medical care in the CPI

Medical care is one of the major item groups within the CPI and consists of medical care commodities and medical care services. The group of "medical care services" is organized into two expenditure categories, professional medical services and hospital and related services. Medical care commodities, comprised of prescription drugs and non-prescription medical equipment and supplies, is the other major component of medical care.[49]

The following three tables compare the percentage change in prices between all items and medical care and all items and individual categories of medical care. Percentage changes were chosen for the tables rather than the indices to better address the statements made in SJR 22.

Table 7: 2001 CPI Percentage increases by month for All Items and Medical Care

Category	March	April	May	June	July	August	Sept.	12 mo. ending Sept.
All items	0.1	0.3	0.4	0.2	0	0.1	0.4	2.6
Medical Care	0.4	0.4	0.3	0.4	0.1	0.5	0.3	4.5

Compiled from U.S. Bureau of Labor Statistics, September 2001 Consumer Price Index.

When extracting the different components of medical care, the September 2001 CPI report showed that charges for hospital and related services had increased 6.2% over the previous year. Medical care commodities, which includes prescription drugs and medical supplies, rose 0.2% between August 2001 and September 2001 to increase to 4.3% from the previous year.

[49]Publications and news releases prepared by the U.S. Bureau of Labor Statistics provide detailed information related to the Consumer Price Index and can be found online at the following address: <http://www.bls.gov/cpi>.

Table 8: Percentage changes from September 2001 for Medical Care compared to All Items

Category	September 2001	August 2001
All Items	2.6	0.5
Medical Care	4.5	0.2
Medical Care Commodities	4.3	0.2
Medical Care Services	4.6	0.2
Professional Services	3.6	0.1
Hospital and Related Services	6.2	0.4

Compiled from U.S. Bureau of Labor Statistics, September 2001 Consumer Price Index.

From a brief, but historical perspective, medical care percentage increases since 1994 began to slow from previous years during the mid-1990's to a low of 2.8% in 1997. Starting in 1998, however, they reaccelerated and have since increased fairly steadily.

Table 9: Historical Percentage change in CPI for all items and medical care, 1994-2001

	1994	1995	1996	1997	1998	1999	2000	2001
All items	2.7	2.5	3.3	1.7	1.6	2.7	3.4	2.8
Medical Care	4.9	3.9	3	2.8	3.4	3.7	4.2	4.8

Compiled from U.S. Bureau of Labor Statistics, September 2001 Consumer Price Index.

What drives health care and health insurance costs?

The acceleration in health insurance premiums and health care costs can be attributed to a number of factors. While the following list is not exhaustive, it begins to provide policymakers with a sense of

the complexity of the problem.[50] Additionally, some cost factors can be viewed as having a traditional or historic effect on costs, and some can be seen as relatively new contributors or taking on a more prominent role in underlying cost trends.[51] Also, these factors represent a national perspective and Montana's health care system may be influenced in different ways. The most commonly recognized factors include:

- general price inflation;
- new, expensive medical technology, and the demand from consumers that technology be used for diagnostic and treatment purposes;
- pharmaceutical costs related to research and marketing, and utilization of newer and potentially more effective drugs;
- demographic changes witnessed by an aging population;
- heightened pressure from consumers demanding choice in the health care and health insurance marketplace;
- cost-shifting from government payers to private payers; and
- new insurance underwriting cycles.

Clearly, an aging population, both nationally and in Montana, along with advancements in pharmaceuticals and in medical technology could be considered to be relatively recent contributors to the overall cost of health care and health insurance. It is difficult to imagine a set of policies that state lawmakers could develop that would preclude medical researchers from developing the latest advancements in diagnostic equipment or life-saving or quality-of-life enhancing drugs. And no public policy can keep people from growing older. Consumers have witnessed and have come to expect constant, substantial improvements in health care. However, someone must pay the bill for such advancement and apparently no one want to pick up the tab.

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[50]A review of the literature on health care costs indicates that certain variables contributing to costs include poor quality of care or inappropriate care, fraud and abuse of payment and reimbursement systems, an oversupply of facilities, federal and state regulatory requirements and mandated coverage, etc. However, in each case, there is little agreement as to whether one component is more influential than another, or whether the specific cost factor should be included at all when determining costs. For the purposes of this report, the sources that cite similar cost drivers or agree on those cost factors that drive the bulk of the overall health care costs were used.

[51]*Deja Vu All Over Again: The Soaring Cost of Private Health Insurance and Its Impact on Consumers and Employers*, Joel E. Miller, National Coalition on Health Care, May 2000; *Inflation That's Bad For Your Health*, Rakesh Shankar, April 2001, <www.dismal.com>; *Job-Based Health Insurance in 2001:Inflation Hits Double Digits, Managed Care Retreats*, Jon Gabel, et al, Health Affairs, Vol 20, No. 5; and *Tracking Health Care Costs*, Center for Studying Health System Change, Data Bulletin No. 21- Revised, September 2001.

Recent trends in health care costs

According to a Milliman USA Health Cost Index report and an analysis of the study released by the Center for Studying Health System Change, hospital inpatient and outpatient spending per capita increased in 2000 by 2.8% and 11.2% respectively.[52] The growth rate in per capita spending on prescription drugs dropped slightly during the same period, from 18.4% to 14.5%. Spending for all services rose 7.2%. In data collected through March of 2001(covering a 12-month period) the percentage change for each component, with the exception of physician spending, increased from the previous year. Table 10 shows the annual per capita spending trends.

Table 10: Annual Percentage Change per Capita in Health Care Spending, by Component 1998-2001

Year	Inpatient	Outpatient	Physician	Rx	All Services
1998	-0.6	7.9	4.8	14.1	5.3
1999	1.6	8.9	5.7	18.4	7.1
2000	2.8	11.2	4.8	14.5	7.2
2001	3.5[a]	12.5[a]	4.8[a]	15.2[a]	7.7[a]

Compiled from *Tracking Health Care Costs,* Data Bulletin No. 21 - Revised, September 2001.

[a] Data through March 2001, change from corresponding months in 2000.

Finally, the study reports an increase in payroll costs and that pressures from understaffing in hospitals, particularly among nursing staff, contributed to higher hourly wage growth during the first five months of 2001.[53]

In February 2001, the Center for Studying Health System Change released a report detailing their initial findings from a series of community site visits to assess changes and trends in health care markets.[54] Researchers concluded that several developments have occurred over the last few years, including:

[52] *Tracking Health Care Costs*, Center for Studying Health System Change, Data Bulletin No. 21-Revised, September 2001.

[53] Ibid.

[54] *Back to the Future? New Cost and Access Challenges Emerge*; Center for Studying Health System Change, Issue Brief No. 35, February 2001.

- managed care has been losing its power to control costs;
- hospital consolidation increases leverage against health plans;
- increased tension between providers and hospitals; and
- employers have largely absorbed premium increases in health insurance.

Focusing, for the time being, on health insurance price increases, employees with employer-sponsored health insurance plans were largely insulated by the increase in premiums due to their employers' willingness to absorb costs in a tight labor market. As the nation's economy slows, unemployment levels rise, and employers look critically at the bottom line, more of the effects of the cost increases could be borne by employees.

In all likelihood, the information presented here will affirm what policy makers and others intuitively realize. Health care costs and health insurance costs have increased over time, and in some cases significantly over the previous few years. The focus here has been on cost-driving factors that have been present historically in the health care system and on the entry of new cost factors. While there is evidence that cost containment efforts implemented in the past were at least somewhat successful in slowing the increases, it is difficult to determine whether redesigning those policies would have a similar effect today and on into the future. Furthermore, legislators and others may also recognize that certain factors contributing to health care and health insurance costs are beyond legislative control -- at least if free market principles are allowed to work. Nevertheless, lawmakers and others may be able to draw some conclusions from the information presented and proceed to uncover why certain components of the health care system cost what they do. Where they are successful, they may also be able to identify, design, and recommend policies that slow or limit the increases.

Part 2: Pooling Through Employer Buy-in Programs[55]

Over the past several years, some states have worked to allow public funds to be used to subsidize private health insurance coverage, essentially "buying in" to private, employer-sponsored

[55] The information in this "Part 2" was originally prepared for the Subcommittee by Gordy Higgins in 2001 as a staff report, "Employer Buy-In Programs", and was given to the Subcommittee in advance of the October 2001 meeting. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

coverage. In large part, these efforts have been designed to target low-income workers (and especially their children) who have access to employer-sponsored coverage, but opt not to enroll due to high contribution rates. There are four states that have engaged in buy-in programs of this type: Oregon (which does not use federal dollars for its program, but runs a state-funds-only plan); Massachusetts; Wisconsin; and Mississippi. Of the three states receiving federal matching funds, strict federal rules apply, including:[56]

- benchmark equivalency tests, requiring that employer-sponsored plans offer benefits at least equal to one of three federally designated benchmark plans;
- a cost-effectiveness test to assure that a subsidy is no greater than the payment the state would make if the child was enrolled in a separate CHIP plan;
- a crowd-out prevention provision, prohibiting subsidization of any child who was privately insured during the previous 6 months; and
- a minimum employer contribution of 60 percent of the premium.

Each of the states administering these programs has identified several public policy objectives, including:[57]

- maximizing coverage of uninsured children and encouraging private contributions toward health insurance coverage;
- reaching children whose parents have access to employer sponsored coverage but are hesitant to enroll;
- encouraging parental self-sufficiency through employment as states implement welfare reform;
- gaining experience in developing programs that enhance public-private partnerships without further extending already stretched public programs; and
- keeping families together under a single health plan to increase the likelihood that children receive the needed care.

In November of 2000, the State of Maryland was approved by

[56]*Employer Buy-In Programs, How Four States Subsidize Employer-Sponsored Insurance,* State Coverage Initiatives, March 2001.

[57]*Ibid.*

the CMS[58] to expand its CHIP income-eligibility from 200 to 300 percent of the Federal Poverty Level (FPL). The move allowed Maryland to extend health coverage to an additional 19,600 previously uninsured children. The challenge was to design a program that provided a premium-assistance program that used the existing employer-sponsored insurance plans.

Of the other three states mentioned here, Mississippi had not implemented its program as of October 2001, and Wisconsin, as of June 2000, had only seven publicly subsidized children in employer-sponsored insurance plans. Oregon, the only state operating its program outside of federal guidelines, has perhaps been the most successful. In May of 2000, Oregon covered nearly 4,500 children through a public-private partnership.[59]

These types of buy-in programs could be made available in Montana as well, most likely through the waiver process. The sticking point, again, is the likely need for additional state-source financing, i.e., state general fund.

Part 3: Pooling Through Full Cost Buy-ins[60]

Full Cost Buy-In(FCBI) programs are distinguished from Employer Buy-In (EBI) programs in that FCBI programs allow the uninsured an opportunity to pay the full premium associated with a state-run insurance program, like CHIP.[61] An FCBI expands eligibility to public programs typically by ignoring income thresholds. Five states -- Connecticut, Florida, Minnesota, New York, and Washington -- have developed FCBI programs that are targeted primarily toward increasing coverage for children. Minnesota and

[58] The Centers for Medicare and Medicaid Services or CMS is a reconstitution of the former Health Care Financing Authority which was referred to by the acronym HCFA.

[59] *Ibid.*

[60] The information in this "Part 3" was originally prepared for the Subcommittee by Gordy Higgins in 2001 as a staff report, "Fully Cost Buy-Ins" and was given to the Subcommittee in advance of the October 2001 meeting. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

[61] *Full Cost Buy-Ins: An Overview of State Experiences*, State Coverage Initiatives, Issue Brief, August 2001.

Washington had expanded their programs to include adults, but have since closed those programs and returned to a child-only FCBI.[62]

Like EBI programs, FCBI programs are designed to target low-income workers and their families. In the case of the states mentioned, the targeted population includes workers without access to employer-sponsored health insurance who cannot afford coverage in the individual market or those workers who opt not to enroll in employer-sponsored plans due to their inability to meet the premium cost. The main objective behind these programs is not to constrain insurance prices, but to offer an opportunity for affordable access to insurance.[63]

There are a number of issues associated with an FCBI program that require a state to design a program that does not create incentives that may result in problems in the future. Three of the more important issues include:

- competition with the private insurance market offerings;
- potential for attracting a disproportionately unhealthy population; and
- potential for blending state high-risk pools with FCBI's.

Under the first design issue, a state-offered program like an FCBI begins to compete with the private market's insurance offerings as eligibility to public programs increases. In effect, if low-income workers decide to enroll in a state-sponsored program like an FCBI, it may have a detrimental impact on private insurance.

The second issue reflects the need for a state to design a program that avoids an influx of unhealthy people that could raise premium levels. Some ways to address this include pre-existing condition exclusions and waiting periods.

Finally, a third issue relates to the potential for an FCBI to inadvertently become another state high risk pool. Ensuring that an FCBI does not become the de facto high risk pool is important for an FCBI program's success and viability. States can avoid this blending by prohibiting migration from one program to the other or providing specific programmatic requirements that act as a disincentive to switch from one program to the other. Limiting benefits and avoiding capping premiums for FCBI programs have been successful in some states.[64]

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[62] *Ibid.*

[63] *Ibid.*

[64] *Ibid.*

The FCBI approach targets one component within the uninsured population: low-income workers without access to employer-sponsored plans and with income levels above eligibility thresholds for enrollment into public programs. The principle goal behind FCBI's is access to insurance, not necessarily affordability, and policymakers need to be cognizant of designing a program that, to the extent possible, holds harmless the private insurance market.[65]

Evidence from states that have adopted FCBI's suggests that with the right blend of goals and objectives, coupled with design features that reduce the chances of crowd-out and adverse selection, an FCBI program may be an option to expand coverage without using public funds.

Part 4: Proposals for Prescription Drug Benefit Plan Pooling in Other States[66]

During 2001, the National Conference of State Legislatures reported that more than 180 bills addressing prescription drugs were being considered in 37 states. The bills proposed to address prescription drug access, costs, and pricing in a variety of ways, but each state was seeking ways to deal with the increasing cost of pharmaceuticals.

At the time the Subcommittee was examining "purchasing pools", the National Conference of State Legislatures and the National Governor's Association both suggested in issue briefs and other published articles that Montana was negotiating with Idaho, Oregon, Washington, and Alaska to form a purchasing pool. However, representatives of the Montana Departments of Public Health and Human Services and Administration reported that they had not been working with other states to form a multi-state pool. Furthermore, the Subcommittee was informed that the Montana Medicaid program does not purchase prescription drugs, but rather provides to Medicaid recipients prescription drug coverage like any other health plan with a drug benefit. Therefore, joining other states in a pool may

[65] *Ibid.*

[66] The information in this "Part 4" was originally prepared for the Subcommittee by Gordy Higgins in 2001 as a staff report, "Prescription Drug Benefit Plan Proposals", and was given to the Subcommittee in advance of the October 2001 meeting. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

not be an effective option for the Montana Medicaid program.[67]

On a related matter, Montana's state employee health plan contracts with a pharmacy benefits manager to negotiate with drug manufacturers to secure the best price for delivering the plan's pharmacy benefit. There is speculation, however, that the state employee health plan could benefit from joining or forming a purchasing arrangement with other states.

The chart below describes different legislative options that were under consideration by other states during the Subcommittee's study.

Types of Legislation	States	Description
Elderly or Disabled on Medicare eligible for discount prices based on Medicaid Rx Rates	Alaska, California, Colorado, Connecticut, Georgia, New Mexico. Other states are also looking at the option of expanding pools through cooperative arrangements	Eligibility covers persons age sixty-five years or older; with no other prescription drug benefit; includes an enrollment fee not to exceed $60.00 per year to cover the cost of administering the program.
Medicaid Waiver to provide discounts to eligible population (based on the VT and ME plan)	Colorado, New Mexico, Washington, Vermont	Would require a state Medicaid waiver application to create "an expanded coverage group composed of any Medicare-covered individual with no Medicare supplement policy or retiree health benefit plan that covers drugs, and other individuals with household incomes up to 300 percent of the federal poverty level.

Types of Legislation	States	Description

[67] Joining other states might could be an effective option under certain conditions, such as if changes are made to require that the state purchase and warehouse drugs for either the Medicaid program or for the state employee insurance plan's pharmacy benefits.

State or multi-state bulk purchasing for better price discounts for an eligible population.	Alabama, Idaho, Iowa, Maryland, New Mexico, South Dakota, Washington	Either resolutions encouraging states to cooperate with neighboring states, or in the case of Alabama, legislation directing the state to aggregate state agency Rx needs, join a pool, or both.

Multi-State arrangements in 2001

The Northeast Legislative Association on Prescription Drug Pricing was created in 1999 and includes legislative leaders from New England, New York, and Pennsylvania. During the SJR 22 study, the Association was reviewing legislative options that would help seniors gain access to prescription drugs at reasonable prices. The options being studied included the creation of an interstate compact and the creation of a prescription drug purchasing pool that would leverage the size of the combined population of seniors within the participating states to negotiate reduced drug prices for seniors.

The Tri-State Prescription Drug Purchasing Pool, formed by Maine, New Hampshire, and Vermont had selected a pharmacy benefit manager to negotiate for better pricing deals from drug manufacturers. The pool includes approximately 330,000 people covered under Medicaid programs in the states. The goal is to expand the eligible population to small businesses and local government self-funded groups. Most importantly, the pool seeks to provide cheaper drugs for the uninsured population.

In Idaho, House Concurrent Resolution No. 26 urged the Governor and the Department of Public Health and Welfare to "pursue the opportunity to develop a compact with our sister states to facilitate purchases of prescription drugs" and report back to the Legislature regarding any efforts among the "sister" states.

Washington State Senate Memorial 8001 specifically mentioned that the states of Alaska, Oregon, Idaho, and Montana should consider "cooperative strategies" including model legislation, joint pricing and purchasing agreements, programs to provide to eligible people access to drug company purchasing assistance programs, and programs to encourage and ensure that drugs are prescribed in the most effective manner.

Seniors eligible for Medicaid price discounts

New Mexico approved a law that would provide a prescription drug benefit to seniors by using an existing "retiree health care authority" responsible for providing group health insurance under the Retiree Health Care Act. The "authority" is also responsible for administering the senior prescription drug program in conjunction with the consolidated purchasing process in place in New Mexico.

In order to be eligible for the program, a person: must be a resident of the state; must be 65 years of age or older; and may not have any other prescription drug benefit. Once qualified and enrolled, a person pays an enrollment fee of $60 to cover the costs of administering the program. When purchasing drugs, the cost to the eligible senior is the contracted discount price secured by the Authority, plus the dispensing fee.

The Authority, which includes a pool of retirees and schools districts, has had success in consolidating the purchasing power of a number of groups and that has resulted in significant discounts for prescription costs. The rates, discounts, and in some cases rebates, were possible because of the plan design and the formulary negotiated with a pharmacy benefit manager (PBM) and a network of pharmacies.

Medicaid waivers

Under this approach, states are applying to Centers for Medicare and Medicaid Services (CMS)[68] for a Medicaid waiver to expand the eligible population of residents that would qualify for a prescription drug benefit program. There are different variations of this proposal being considered in a number of states. Maine and Vermont were the first to try this approach and both received waivers from CMS. However, in both cases pharmaceutical manufacturers challenged the programs by alleging that the CMS waivers violated Medicaid law. A federal district court agreed with PhRMA's objection to the Vermont waiver, but recently upheld the Maine waiver.

In the case of Maine, program eligibility is set at a maximum of 300% of FPL, and participants in the demonstration project would pay the price that is equivalent to that which Medicaid pays, including the dispensing fee, less the program subsidy, which is based on the average rebate received by the state. Eligible seniors are also required to pay an annual enrollment fee. Like other waivers to expand Medicaid, a state must establish that the project will be

[68] The Centers for Medicare and Medicaid Services or CMS is a reconstitution of the former Health Care Financing Authority which was referred to by the acronym HCFA.

budget neutral, meaning that the overall cost of expanding the program may not be more than the cost of the program without the waiver.

Colorado, Maryland, New Mexico, New York, and numerous other states are reviewing this approach to determine whether a waiver to provide prescription drug benefits to seniors is feasible. Most of these states have introduced legislation that requires the agency responsible for administering the Medicaid program to review the requirements necessary and apply to CMS for waiver approval.

The Subcommittee has recommended that the appropriate executive branch agencies investigate these and other options to address the issues associated with the rising cost and diminishing affordability of prescription drugs. (See Chapter 2 of this report for a fuller explanation of the Subcommittee's recommendation.)

Medicaid and Montana[69]

The administrative savings on processing claims under the West Virginia plan comes primarily from the addition of new members to the WV plan. The more members and groups participating in the plan, the cheaper it costs to process claims. While this works under the WV purchasing pool, there would not be a savings for Montana Medicaid because Montana doesn't pay by the claim for processing pharmacy claims or other health care claims. Instead, Montana Medicaid pays a flat rate contract with ACS Healthcare to process all claims. If Montana were to join the WV purchasing pool, it is likely that new administrative costs for processing claims would be incurred by DPHHS. That said, DPHHS likely could offset some of the cost by negotiating a contract amendment with ACS Healthcare to reduce the flat rate contract, but it is doubtful this would save the state money on processing claims.

[69] The narrative under this subheading is adapted from information provided in a November 18, 2002, memo to Dave Bohyer, the SJR 22 Subcommittee's staffer, by Maggie Bullock, Administrator, Health Policy and Services Division, Montana Department of Public Health and Human Services, re "Drug Purchasing Pools".

The other savings under the WV purchasing pool come from a limited formulary, rebates, etc. The same savings are unavailable under the federal Medicaid program because it operates under the federal requirements of OBRA[70] 1990 and 1993 that define the current scope and form of the Medicaid prescription drug program. The OBRA legislation defines the drug rebate program, specifies drug coverage, requires drug utilization review, and encourages electronic claims processing. Montana has implemented all of these requirements for its Medicaid program and the purchasing pool, if applied to Montana Medicaid, would have to adhere to the same requirements. A purchasing pool cannot implement a limited formulary and pick and choose which drugs to cover or not for Medicaid like they do for other private plans. This is where the WV purchasing pool generates most of the savings it claims.[71]

It is possible that a purchasing pool could generate additional drug rebates for the state of Montana. However, DPHHS representatives are skeptical that savings of 4.5% would result from the entire Medicaid pharmacy program by participating in the WV purchasing pool. The DPHHS has implemented reimbursement cuts and other administrative program changes that have generated savings in the Medicaid pharmacy program. For example, in state FY 2003 DPHHS changed the reimbursement for drugs from average whole price (AWP) minus 10% to AWP minus 15%. This is estimated to save the program approximately $4 million in total funds for state FY 2003.

The Montana Medicaid program does not purchase drugs directly from wholesalers or manufacturers for recipients who are covered under the program. Instead, the Medicaid program reimburses the pharmacy for the cost of the drug product and a dispensing fee for the pharmacist's services. Therefore, it is typically the local pharmacy that purchases the drugs from wholesalers or manufacturers for their clients.

The premise behind drug purchasing pools (or cooperatives) is to combine multiple agencies or states to form a single entity to better control prescription drug costs through greater economies of scale. A pool of this type uses its increased number of covered individuals to negotiate better prescription pricing through the use of increased discounts on administrative fees for processing claims, increased

[70] OBRA stands for "Omnibus Budget Reconciliation Act".

[71] The estimated savings claimed under the West Virginia plan were reported by Tom Susman, WV Program Director, in a conference call with the SJR 22 Subcommittee in July 2002.

manufacturer rebates, and additional manufacturer supplemental rebates through the establishment of a preferred drug list. Research reveals two basic prescription drug purchasing pool models exist, the bulk drug-purchasing model and the Pharmacy Benefit Management (PBM) model.

The State, DPHHS, and other purchasing pool options[72]

The current bulk drug-purchasing model available in Montana is through the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP). MMCAP is a group of state agencies and nonfederal governmental units that are eligible to obtain pharmaceuticals and allied supplies and services using contracts established with pharmaceutical manufacturers and other vendors. MMCAP is administered by the Minnesota Department of Administration, Materials Management Division. Funding is provided through administrative fees collected from contracted manufacturers and is used solely to support this program. There is no membership fee to participate in MMCAP. This program has been in existence since 1985 and has grown to over 2,939 participating facilities in 40 states. The annual pharmaceutical sales volume is $600 million. MMCAP has moved into national account status with all of the major and generic pharmaceutical manufacturers.[73]

As a member of MMCAP, Montana can utilize its services at state facilities but has contracted with McKesson Medication Management LLC to deliver pharmaceuticals and pharmacy services to the Department of Corrections, Montana State Hospital, Montana Developmental Center, and the Montana Chemical Dependency Center. Although the State of Montana has a contract with MMCAP for providing pharmaceuticals, the state has approved McKesson's use of its own drug contracts as long as it can prove it provides them at less cost to the State than is provided through MMCAP purchases.

In the Pharmacy Benefit Management (PBM) model, multiple states combine their eligible populations under one umbrella to cover all plans. The plan design can be similar across all programs. Current PBM models in operation include the New England Tri-State Purchasing Coalition, consisting of Maine, New Hampshire, and

[72] The narrative under this subheading is also adapted from information provided in the November 18, 2002, memo to Dave Bohyer from Maggie Bullock. (See footnote ***).

[73] The statements here are from the November 18 memo from Maggie Bullock, but originated from the website, *MMCAP Home Page*., Minnesota Multi-state Contracting Alliance for Pharmacy. 13 Nov. 2002 . <http://www.mmd.admin.state.mn.us/mmcap.htm>

Vermont, and the Southern States Coalition Pharmacy Working Group consisting of Alabama, Arkansas, Georgia, Louisiana, Maryland, Mississippi, Missouri, New Mexico, North Carolina, Tennessee, Washington, West Virginia, and Wyoming. The Southern States Coalition Pharmacy Working Group issued an RFP under the West Virginia Public Employees Insurance Agency. None of the states included in the RFP had included their Medicaid plans in the proposal.[74]

Georgia follows the PBM model and includes their Medicaid program. Their contract is broken into two sides: the government side (Medicaid / CHIP) and the commercial side (state employees and higher education). The "commercial side" could have chosen from many standard formulary options, but ended up creating a hybrid.

The "government side" kept the formulary as mandated by federal CMA/HCFA[75] regulations because a Medicaid program does not have the option to *not* cover certain drugs, it can only restrict and limit their use. This PBM model has resulted in high administrative costs to Georgia. However, the plan's annual growth in prescription costs has decreased from 24% to 17%.

Cost containment strategies for the pooled PBM model include "negotiation of price and rebates, greater efficiency and lower administrative cost per member in pharmacy claim processing, reduced claims processing for ineligibles, cost avoidance for clients with third party payers, prospective drug utilization review, prevention of fraudulent or duplicate claims, and positive relations with providers."[76] Other strategies include disease management, provider education programs, the use of formularies and preferred drug lists common to participating states, and mail order pharmacies.

Cost variations under the models

[74] The statements here are from the November 18 memo from Maggie Bullock, but originated from the website, *WV PEIA RFP Home Page*, State of West Virginia Public Employee Agency Request for Proposal for Pharmacy Benefit Management Services. 14 Nov. 2002 <http://www.hlthmgt.com/WVRXIS/RFP.doc>

[75] The Centers for Medicare and Medicaid Services or CMS is a reconstitution of the former Health Care Financing Authority which was referred to by the acronym HCFA.

[76] The statements here are from the November 18 memo from Maggie Bullock, but originated from the website, *National Governors' Association Home Page*, NGA Center for Best Practices Issue Brief: "Pharmaceutical Purchasing Pools". 8 Nov. 2002 <http://www.nga.org/cda/files/102401PHARMPOOLS.pdf>

Standard practice in the PBM model is each state or entity contracting individually with the selected PBM under the cooperative's umbrella. Costs will vary from state to state depending on the services desired by each entity. PBM's typically make their money on a per claim basis and by reimbursing providers at a negotiated lower rate than that set by the state. Most PBMs also profit from retaining a percentage of the manufacturer rebate.

Montana Medicaid currently pays a flat fee for claims processing to its fiscal agent ACS (formerly Consultec) State Healthcare at a cost of approximately $3.6M annually. This cost includes all services related to claims processing for all provider types, and includes provider relations, manual production, and database maintenance. Many of the cost-saving methods used by the pooled PBM model are currently in place under Montana Medicaid's prescription drug program. These include the following:

- prior authorization of certain medications;
- drug utilization review which reviews the prospective and retrospective use of drugs;
- reimbursement by federal upper limit which sets a maximum reimbursement based on the current market price;
- over-the-counter drug coverage when prescribed by a physician is a cost effective alternative to higher priced federal legend drugs;
- manufacturer rebates that result from a federal agreement signed with drug manufacturers. In order for a drug to be covered under Montana Medicaid, a rebate agreement must be signed by the manufacturer and CMS; and
- mandatory generic substitution that requires pharmacies to dispense the generic form of a drug.

With the rural nature of Montana and the large number of independent pharmacies, the DPHHS believes that the use of a pooled PBM model could be damaging to pharmacies throughout Montana. The use of mail order pharmacies would reduce the amount of business to Montana's rural pharmacies. These reductions could result in pharmacy closures or further limit access to prescription drugs by all Montanans, not just Medicaid recipients. The potential reduction in pharmacy reimbursement and dispensing fees could also adversely affect Montana's pharmacies.

The DPHHS has recognized the advantage of increasing the economies of scale, using bargaining power to buy for a large volume of members. This is why the State of Montana entered into an agreement with MMCAP and ACS State Healthcare for providing

pharmaceuticals to state facilities that purchase medication.

In contrast, Montana Medicaid does not purchase medication. Instead, the Montana Prescription Drug Program reimburses pharmacies for dispensing pharmaceuticals to eligible recipients served by the Department through either the Medicaid program or the Mental Health Services Plan (MHSP). Reimbursement rates for pharmacy benefits are outlined in the Administrative Rules of Montana. Effective July 1, 2002, the Medicaid program cut reimbursement rates to pharmacy providers from Average Wholesale Price (AWP) minus 10% to AWP minus 15%. This reduction is consistent with the finding of the Office of the Inspector General report regarding the price at which pharmacies are able to purchase drugs from their wholesaler. Assuredly, the DPHHS will continue to seek more efficient and cost effective ways to bring a drug benefit to its clients.

Part 5: The Concept of "Basic" Health Insurance[77]

In 1991, the Montana Legislature approved the creation of a basic health benefit package by adopting House Bill No. 693.[78] The legislation authorized the creation of a limited benefit disability insurance policy that was exempt from certain mandates, established to whom the policies could be issued, and outlined the minimum benefits the limited plan must provide. The bill also provided a tax credit to businesses (which remains in Title 15) for providing health insurance benefits, and exempted the premiums paid from the premium tax.

The plan was exempt from the following requirements and mandates:

- freedom of choice of providers (33-22-111, MCA);
- coverage for services provided by physician assistants (33-22-114, MCA);
- coverage of PKU treatment (33-22-131, MCA, now inborn

[77] The information in this "Part 5" was originally prepared for the Subcommittee by Gordy Higgins in 2001 as a staff report, ""Basic" Health Insurance: An Option for Consideration" and was given to the Subcommittee in advance of the October 2001 meeting. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

[78] Chapter 606, Laws of Montana, 1991.

errors of metabolism);
- coverage of newborns under individual policies and group coverage (33-22-301, MCA and 33-22-504, MCA);
- continuation of coverage for disabled children reaching certain age limits under individual and group coverage (33-22-304, MCA and 33-22-506, MCA);
- preexisting conditions (33-22-509, MCA);
- availability of coverage for home health care (33-22-1002, MCA); and
- dentists performing services for which a physician would be paid (33-22-1011, MCA).

Eligible purchasers of the limited plan included:

- small employers (less than 20 employees) who had been in operation in the state for at least one year and had not offered health benefits for a period of one year;
- disabled or injured persons;
- unemployed persons;
- self-employed persons; and
- a parent, or the state, when required to provide health benefits for children on a court or administrative order.

The minimum benefits that were required to be provided included, but were not limited to:

- maternity care consisting of prenatal and obstetrical care;
- newborn care consisting of hospital nursery and pediatric care for at least 31 days;
- well-child care consisting of immunizations and checkups for children under two years old;
- services for the care and treatment of mental illness and alcoholism and substance abuse with a minimum annual benefit of $1,000; and
- hospital care under terms and conditions established by the policy.

After a scant 6 years in existence, the statutory, basic health benefit package option was repealed in 1997.[79]

A bare bones approach

[79] Sec. 44, Chapter 531, Laws of Montana, 1997.

A brief review of literature revealed that basic health package recommendations have been proposed as one way of reducing costs and making some level of health insurance more accessible to those who cannot afford traditional benefit plans. The Delaware Health Care Commission has suggested a basic, minimum benefit package as one method of making health insurance more affordable to low-income individuals.[80]

Two concepts were proposed that tried to address a variety of problems. The first was the "Bare Bones" catastrophic plan that represents "...what insurance is supposed to be: a means for spreading the risk of expensive, unpredictable losses among a population group".[81] The plan as proposed would be free of mandated benefits.

The Commission believed that no state financing would be necessary because consumers would purchase the less expensive plan without need of state assistance. While the Commission believed that the plan would be more affordable than standard or comprehensive insurance products, there was concern over the lack of coverage for preventive or primary care. Also, the Commission felt that consumers may want more comprehensive coverage and the plan would not be widely used.

A limited benefit approach

An alternative approach called for the creation of a benefit plan that covered only primary care, preventive services, and prescription drugs. If an insured with this plan were to need hospitalization or other acute-care services, the plan would not provide coverage and related expenses may become uncompensated care for providers.[82] One of the potential problems associated with a primary care basic plan is that it runs counter to what many see as a primary purpose of insurance--to protect against personal financial devastation--and this plan, the second of Delaware's proposed plans, would not protect consumers from serious financial burdens if hospitalization or acute-care services were necessary.

In the Winter 1997 issue of *Spectrum*, a Council of State

[80]The report, along with other state research efforts can be accessed at the following Internet address: <http://www.statecoverage.net/statereports/>.

[81]*Options for Expanding Coverage to the Uninsured in Delaware*, Delaware Health Care Commission, p. 25, (date unknown), <http://www.statecoverage.net/statereports/de2.pdf>.

[82]*Ibid.,* p. 26.

Governments publication, it was reported that over 30 states had implemented "bare-bones" policies intended to provide some minimal level of insurance coverage.[83] Staff did not conduct a more current survey to determine how many states still had or had authorized "bare bones" policies more recently than 1997. However, with Montana having repealed its bare bones statute after the *Spectrum* article was written, there would be at least one state fewer than otherwise would have been the case.

Part 6: Waivers for Medicaid and Chip[84]

Section 1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid or the state Childrens' Health Insurance Program (CHIP) for the purpose of conducting pilot, experimental, or demonstration projects that are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid or CHIP programs, including: eligibility requirements; the scope of services available; the freedom to choose a provider; a provider's choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program. Demonstration waivers are granted for research purposes, to test a program improvement, or to investigate an issue of interest to CMS. Projects for which a waiver is sought usually must include a formal research or experimental methodology and provide for an independent evaluation. Most projects run for a limited time, no more than 5 years, and are usually not renewable.

Section 1931 of the Social Security Act was established as part of the 1996 welfare reform law. Historically, the majority of Medicaid beneficiaries became categorically eligible for the program as a result of their enrollment in Aid to Families with Dependent Children (AFDC).[85] Welfare reform delinked Medicaid and cash assistance and created a new eligibility category which is based on state AFDC

[83] *Spectrum*, "Small Group Group Insurance Reform: How are State Programs Measuring Up?", Winter, 1977, pp. 22-25.

[84] The information in this "PART 6" was originally prepared for the Subcommittee by Gordy Higgins in 2001, and given to the Subcommittee in advance of the October 2001 meeting. As presented here, the original narrative has been marginally edited, primarily to provide currency. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

[85] Under the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the Aid to Families with Dependent Children (AFDC) program was significantly changed and renamed Temporary Assistance for Needy Families or TANF.

eligibility standards in effect on July 16, 1996. Section 1931 requires states to cover at least those families with incomes below the 1996 AFDC income limits, regardless of whether they receive cash assistance. In addition, under Section 1931, states have greater flexibility to extend eligibility to more low-income families using any of these three mechanisms: (1) income disregards; (2) asset disregards; or (3) increasing income and asset limits by as much as the increase in inflation since July 1996.

The Health Insurance Premium Payment program is a Medicaid program that pays for the cost of health insurance premiums, coinsurances, and deductibles. The program pays for health insurance for Medicaid-eligible persons with access to employer-based insurance whenever it is proven cost-effective to do so.

An example of this type of waiver, in New York, is estimated to expand coverage under New York's Family Health Plus to an estimated 352,000 uninsured parents whose income ranges up to 150 percent of the federal poverty level. The waiver initially covered childless adults at or below the poverty level and uninsured parents at 120 percent of the federal poverty level. Uninsured parents at 133 percent of the federal poverty level became eligible on October 1, 2001, and uninsured parents at 150 percent of the federal poverty level became eligible on Oct. 1, 2002.

Another example, Minnesota's waiver, will allow the state to receive an enhanced federal matching rate for uninsured parents and relative caretakers of Medicaid and Chip eligible children with family incomes between 100 and 200 percent of the federal poverty level. Effective July 2002, the state will eliminate premiums for CHIP children in families with incomes up to 185 percent of FPL. Parents will pay premiums and copayments on a sliding fee scale. For parents between 100 and 200 percent of FPL, out of pocket costs will begin at 2.3 percent of income. In addition to the states that have received federal CMA approval for CHIP waivers that allow them to cover the parents of children who are eligible for the CHIP program, Arizona, Illinois, and Louisiana have enacted legislation to direct their states to apply for such waivers.

Part 7: Certificate of Need Requirements[86]

[86] The information in this "PART 7" was originally prepared for the Subcommittee by Pat Murdo as "Certificate of Need Comparison among States" and given to the Subcommittee for the August 30, 2002 meeting. As presented here, the original

The Subcommittee perceived that "Certificate of Need" authority in Montana could be a cost-driver affecting the costs of health care and health insurance. In an effort to gain understanding about Certificate of Need authority (CON), the Subcommittee was presented with comparative information for states that have CON and states that no longer require CON.

Goals of certificate of need authority

There are two, at least, schools of thought regarding CON. One school contends that requiring a CON for certain facilities or equipment will reduce the overall cost of health care because fewer CON facilities will be built or less CON equipment will be purchased. With fewer facilities built or equipment purchased, the aggregate costs to the users of the facilities or services will be lower than without CON authority.

Another school contents that requiring a CON for facilities or equipment will increase overall costs for health care because CON-authorized facilities or equipment will command a virtual monopoly within its region. Having a monopoly, the CON-authorized facilities or equipment will be either overused or overpriced, due simply to a lack of free market competition.

Certificate of Need authority has been used in various states to:

- control the growth of medical costs by regulating services' growth; or
- control increases in urban medical facilities that may threaten the survival of medical facilities serving rural, underserved areas (by siphoning off patients to bigger centers).

In Montana, the purported goals for CON were to:[87]

- avoid unnecessary duplication of services;
- encourage development of affordable services; and
- provide a forum for public input.

Possible effects of CON

A number of effects are perceived in CON states. One effect is that a state can determine winners and losers in applications for new facilities or expansion. Some existing nursing homes, for example,

narrative has been marginally edited. A copy of the paper as originally provided to the Subcommittee is available at the Legislative Services Division.

[87] Policy Studies Inc., A Comprehensive Study of the Montana Certificate of Need Program, Draft 12/1999, p. 46

may want Certificate of Need retained because they would rather not compete with newer or more convenient facilities.

Another effect is that the CON application and review process takes time and money. Estimates range from up to 6 months and anywhere from $5,000 to $15,000 of the applicant's funds for an approved application. A rejected application, if appealed, can cost much more.

A more difficult effect to assess with certainty is whether CON authority controls medical costs. Nowadays it is particularly difficult to determine in most cases, because CON authority is no longer required as a general rule. Hospitals are no longer regulated under CON and approximately 60 percent of Montana's hospital costs are driven by the larger hospitals, according to state health policy analysts.

Finally, the quality of care may or may not be affected.

Relevant questions for consideration of Certificate of Need authority

Any number of questions may be asked when policy makers and others consider the advisability of CON authority. Several of the more obvious questions are listed below.

- Is the state adoption of Certificate of Need regulation due to interest in holding down medical costs, especially costs paid by Medicaid? If so, is Certificate of Need authority, through legislation, the best option?

- What role, if any, does the state have in maintaining survival of medical facilities in rural, underserved areas?

- Does the state have any reason to erect barriers to competition?
- Does competition encourage lower or higher health care costs?
- As a "gatekeeper," does the state have an obligation to citizens to see that an applicant's entry into the market is appropriate? Certificate of Need authority can assess economic viability of a nursing home, for example. Are there other mechanisms that the state should consider to see if an applicant is financially capable of carrying out the project? (The assumption is that a business person will not invest in a project that is not financially feasible. Does the state have any responsibility or reason for review of financial information?)
- If the state were to decide that CON preview of certain health care facilities or equipment is important, should the review/comment period be done by a local government, by a group with a regional perspective, or some other entity, such as a state Health Care Advisory Panel?

- What obligation, if any, does the state have to facilities that came into existence under a Certificate of Need review?

Concerns related to CON authority

Historically, a variety of concerns have been raised or recognized with respect to CON authority. A few of the more commonly mentioned concerns are listed below.

- Certificate of Need authority does not provide an even playing field for types of health care facilities. For example, nursing homes must apply for a CON, but personal care/assisted living facilities and hospitals do not. Yet, critical access hospitals can have "swing beds" that can be used as nursing home beds. Personal care/assisted living facilities also can have a limited number of nursing care beds. Hospitals can charge full cost for the swing beds in a Critical Access Hospital, but Medicaid reimbursement is not allowed after a certain number of days. Technically the beds are not to be used long-term. However, waivers are allowed. This means that a nursing home could be at a cost disadvantage because Medicaid reimbursement typically is less than non-Medicaid hospital room charges. Similarly, the hospitalized patient may be capable of participating in activities and could do so at a nursing home but not in a hospital that doesn't provide the services.

- Market forces do not necessarily mean that competition lowers health care costs because the provision of more services may drive providers' costs higher. A hospital, for example, may be in competition with another hospital on one type of service, but the cost of overall service may increase due to cost-shifting.

- Certificate of need provisions are "gatekeeper" regulation, aimed only at controlling entry to a market and not with regulating quality or cost control after the fact.

- Gatekeeper regulation works to protect existing facilities that may be older, and more established, from competition with newer or otherwise better facilities of the same type.

- A mixed system of payers affects the question of whether CON regulation: (a) can control growth in health-care costs; or (b) increases the state's health-care costs, primarily through Medicaid. Example of (a): There is a question of whether more than one ambulatory surgical center, for example, increases labor and equipment costs in an area to a degree that requires either more patients to be treated (possibly from outside the area), higher charges per patient, or cost-shifting in a less competitive area. By limiting the number of ambulatory surgery centers, the state may ultimately hold down

the overall cost of service. If a mechanism were available to cipher out direct costs, thus preventing cost-shifting for Medicaid patients, then the state's major concern would be with potentially rising premiums for all non-Medicaid payers, who would be paying the cost-shifted amounts.

Example of (b): Assisted living/personal care centers do not have a CON obligation. They also do not take Medicaid patients, except in certain circumstances that allow waivers. Nursing homes have CON requirements and Montana nursing homes receive roughly 60 percent of their income, on average, from Medicaid. A patient trying to decide on the type of facility that will be used may base that decision not solely on the level of care needed but on which facility the patient can afford or which facility is available. Private-pay patients may choose, if they are generally healthy, to go to an assisted care facility. A Medicaid patient, even if generally healthy, may have no choice on where to go. The interest for the state is that private-pay patients also can help to offset the prices at nursing homes, both from higher occupancy values and possible cost-shifting. Changing CON regulations to include assisted living/personal care facilities or to exclude nursing homes would not affect such decisions or payments. Under these conditions, holding down costs does not apply under CON. If the state wanted to hold down Medicaid payments, another tactic would be necessary.

Comparison of cost factors between states with and without CON

Montana has some areas where Certificate of Need applies and others where it doesn't.

Generally, the best data for comparison of CON versus non-CON states relates to nursing home care. Montana has CON requirements for nursing homes. So do Alaska, Nebraska, Nevada, Oregon, Washington, and Missouri. States examined without CON regulation were: Arizona, California, Colorado, Idaho, Kansas, North Dakota, Pennsylvania, Texas, Utah, and Wyoming.

Results of checking the following data were inconclusive as to whether CON authority had an affect on quantity of homes or cost:

- Occupancy rates in nursing homes.
- Charges per day in nursing homes (January 1999 figures).
- Per day Medicaid reimbursement (1999).
- Number of MRI units.

Among the findings: Occupancy rates and charges per day in a nursing home do not differ much from a regulated to a non-regulated area. A correlation is evident between Alaska's high cost per day in a nursing home ($413) and the higher salaries that Alaska pays to LPNs than are paid elsewhere (17 percent more than the average

LPN is paid nationally).

Another observation: Those states that regulate MRIs (or other highly technical equipment) do not appear to have fewer MRIs than states that do not regulate them. Therefore, it is presumed that the difference in saturation is most likely population-driven.

Table 11 shows selected states that continue to have CON regulation and the areas that they regulate. Nationwide, 37 states continue to have some form of CON authority. Montana ranks as one of the 14 states with the fewest number of areas regulated.[88] Maine, Connecticut, Georgia, Alaska, West Virginia, Vermont, Missouri and South Carolina have the most regulation.[89]

Table 12 provides a comparison of selected issues for states with and without CON authority. As Table 12 indicates, CON authority apparently does not affect occupancy rates (Texas and Nevada both have low occupancy rates in nursing homes), charges per day (Alaska is a high of $413 while Montana, North Dakota and Wyoming all have low charges of $100). States without CON have both the highest and the lowest nursing home operations' daily cost and Medicaid daily reimbursement rate. And, finally, pay rates for licensed practical nurses apparently have little or no correlation with CON authority, since both Montana and North Dakota pay LPNs below the national average while Alaska and California pay above. See Tables 13 and 14 for a broader review of states and issues.

[88] See American Health Planning Association's *National Directory of Health Planning, Policy and Regulatory Agencies*, 13th ed., January 2002.

[89] Ibid.

Table 11: Items covered by Certificate of Need authority by selected states

State	Hospital Growth	Nursing Home Growth	New Equipment	Swing Beds	Ambulatory Surgery Cntrs	Home Health	Mental Health, Chemical (ICF/MR) Rehab Facilities
Montana	No	Yes	No	Yes	Yes (counties of < 20,000 population)	Yes	Yes (moratorium imposed)
Alaska	Yes, if > $1 million	Yes	Yes	Yes	Yes	Only hospital based	No, but review specialty hospital dealing with substance abuse.
Missouri	As of 12/31/01 no hospital reviews	Yes	Yes, if > $400,000 for nursing homes, $1 million for hospitals	No	As of 12/31/01 no ambulatory surgery centers reviewed	No	Yes, but not substance abuse facilities after 12/31/01
Nebraska	No	Yes, any LTC app. >10 beds or 10% > capacity.	No	No	No	No	No
Nevada exempts Las Vegas & Reno	Yes	Yes	No	No	Yes	No	Yes
Oregon	No	Yes	No	Yes	No	No	No
Washington	Yes	Yes	No	Yes	Yes	Yes	No

Table 12: Comparison of selected states with and without Certificate of Need on selected issues

Item	MT	States with CON		States without CON	
		High	*Low*	*High*	*Low*
Occupancy Rates	*79%*	91.4% (ND)	68.2% (TX)	83.8% (AK)	65.1 % (NV)
Charges/day	*$100*	$413 (AK)	$100 (MT)	$156 (CA)	$100 (WY-ND)
Medicaid daily reimbursement rate, 1999	*$93*	$107 (WA)	$93 (MT)	$125 (PA)	$78 (TX)
Nursing home operations' daily cost (average)	*$103*	$119 (WA)	$101 (MO)	$135 (PA)	$82 (TX)
Percent LPN pay above/below average in 2000	*-17%*	17% (AK)	-17% (MT)	16% (CA)	-12% (ND)

*Montana changed its reimbursement schedule in 2001 to reflect acuity of Medicaid patients. Also, more recent payments include Intergovernmental Transfers, which help to meet the federally required match. Montana's current rate for Medicaid is approximately $73 federal dollars for $27 state dollars. The same rate is used for nursing home care as for hospitalization or physician visits.