Facing the Gordian Knots of Health Care Reform

Coverage, Costs, and Responsibility

A Primer on Health Care Issues in Montana

and Report on the HJR 48 Study

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INTRODUCTION

When viewing health care as an elementary school-style picture of myriad colored strings, focusing on any one string or issue leaves an incomplete picture. Instead, understanding the role of federal and state laws, powerful insurance and health care industries, and personal and governmental responsibilities both individually and as they fit within the whole is critical to addressing healthcare reforms. When the Economic Affairs Interim Committee (the Committee) took up the work plan for House Joint Resolution No. 48, sponsored by Rep. Gary MacLaren, there were 12 study areas facing them. (See Appendix I). At early meetings, the Committee decided to pursue information on 10 of these study areas. Omitted as not specifically related to health coverage were study area XI regarding access issues, which was part of a study under Senate Joint Resolution No. 15, and study area XII, regarding workforce planning and medical education funding. This report reviews the 10 study areas, incorporating presentations made to the Committee, along with background information about what currently exists regarding health care coverage in Montana and proposals that have been under study or are being implemented in other states.

UNDERSTANDING THE ROLE OF FEDERAL AND STATE LAWS, POWERFUL INSURANCE AND HEALTH CARE INDUSTRIES, AND PERSONAL AND GOVERNMENTAL RESPONSIBILITIES BOTH INDIVIDUALLY AND AS THEY FIT WITHIN THE WHOLE IS CRITICAL TO ADDRESSING HEALTHCARE REFORMS.

The dual purposes of this report are to review the work of the Committee on health care coverage, including its proposed legislation for a Health Policy Council, Senate Bill No. 44, and to provide legislators interested in health care with needed information as they seek to understand the health care provider and health insurance industries, health care reform proposals, and options for improving insurance coverage and addressing health care costs in general.

The report is divided into the following sections:

- ☐ Executive Summary
- ☐ Section 1: an overview of health insurance and health care problems and other states' efforts to increase health insurance coverage and to address rising health care costs.
- ☐ Section 2: a review of Montana's health status statistics and health insurance coverage.
- ☐ Section 3: an examination of issues considered by the Economic Affairs Interim Committee and discussions related to HJR 48.
- ☐ Section 4: reports on health care cost and access issues studied by the Children, Families, Health, and Human Services Interim Committee under Senate Joint Resolution No.15.
- ☐ Section 5: other issues not addressed by panels but requested in the HJR 48 and by the Committee.
- ☐ Section 6: issues related to health care reform not addressed above.
- ☐ Conclusion

EXECUTIVE SUMMARY

The multi-faceted health care industry is regulated either federally or by the individual states. As concerns have mounted over the ever-increasing share that health care consumes of America's gross national product so too have calls increased for health care and health insurance reforms. A few states have taken steps towards either universal coverage or efforts to control costs, underscoring a state's role as a workshop of innovation. Far more states have considered legislation but ultimately not passed major reforms. Because the federal government is a central player in many aspects of health care, no state can initiate reforms that completely address interaction among all health care players: consumers, health insurance companies, employers buying health insurance, and health care providers. Public assistance decisions intertwine federal and state policies. States are seeking improvements, whether incrementally or broadly. The frequently cited analogy of squeezing on a balloon is appropriate for the many efforts at reforming health care: no matter where one presses a balloon, the bulge moves elsewhere, with the balloon's original universe unchanged.

BECAUSE THE FEDERAL GOVERNMENT IS A CENTRAL PLAYER IN MANY ASPECTS OF HEALTH CARE, NO STATE CAN INITIATE REFORMS THAT COMPLETELY ADDRESS INTERACTION AMONG ALL HEALTH CARE PLAYERS: CONSUMERS, HEALTH INSURANCE COMPANIES, EMPLOYERS BUYING HEALTH INSURANCE, AND HEALTH CARE PROVIDERS.

Over the 2007-2008 interim the Economic Affairs Interim Committee and a subcommittee of the full committee heard from various players in the health care universe. The background information reinforced the complexities of health care reform. Concurrent private sector reform efforts by the Montana Health Care Forum (a group comprised of health care industry representatives, consumers, and insurers) and a statewide ballot initiative to expand children's insurance coverage under the Healthy Montana Kids Initiative created cross-currents that made navigation through health care reform difficult from an interim committee perspective. As a result, the Economic Affairs Interim

Committee chose to make available a primer on health care issues in Montana, providing information for legislators and others interested in pursuing health care reforms. This report is that primer as well as a summary of work done by the HJR 48 subcommittee and the entire Economic Affairs Interim Committee.

Subcommittee members appointed at the first meeting, June 5, 2007, included:

Rep. Scott Mendenhall, chair	Sen. Don Steinbeisser
Rep. Michele Reinhart	Rep. Bill Thomas

In all, subcommittee and committee time spent on HJR 48 amounted to about 12 hours, excluding the time spent in discussing the work plan (see Appendix I) and the work of individual legislators or staff.

Subcommittee activities included:

November 7, 2007 Panel discussions on insurance and coverage. Meeting in Miles City.

February 6, 2008 Presentations about reforms being enacted or considered in other states. The subcommittee discussed preferred options for further study, which included a bill draft that would allow insurers to offer an individual policy with limited mandates. Meeting in Helena.

Full Committee activities included:

May 8, 2008 Review of mandates and possible reform considerations. The Montana Health Care Forum coverage work group presented its list of activities. Meeting in Missoula.

June 17, 2008 Discussion of mandates. Teleconference call on June 17, 2008.

September 12, 2008 Moved forward a bill draft request, LC 420 (which became Senate Bill 44), for a Health Policy Council, which the Montana Health Care Forum coverage work group had proposed. This final Committee meeting was in Helena.

SECTION 1: Health Care Issues and Reforms in the States — an overview of health insurance and health care problems and other states' efforts to increase health insurance coverage and address rising health care costs

The Problem

Some say the problem is access to health care. Others say the problem is the ever-rising costs of health care, which result in fewer and fewer people being able to afford either the cost of health insurance or the direct cost of care unless they are on some sort of public assistance. Public assistance, in turn, means the rising health care costs are borne by the public. One example of the rising costs of health care is reflected in a report that health insurance premiums increased 91% cumulatively between 2000 and 2007 compared with a 24% increase in wages, according to researchers at the Commonwealth Fund.[1]

At the inaugural meeting of the Montana Health Care Forum[2] in October 2007 one speaker indicated that overall health care expenditures as a share of gross domestic product (GDP) are climbing at an unsustainable rate. Andrew Rettenmaier of the Private Enterprise Research Center at Texas A&M University projected that national health expenditures would rise from nearly 17% of GDP in 2007 to roughly 37% in 40 years and just under 45% of GDP in 70 years.[3] To prevent that from happening, a correction in health care cost's trajectory is critical. The reasons for the increasing costs — and the opportunities to address those increases — are many. This report looks at components of

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[1] Cathy Schoen, et al., "How Many are Underinsured? Trends Among U.S. Adults, 2003 And 2007", *Health Affairs*, July/August 2008, vol. 27(4), p. 298.

[2] The Montana Health Care Forum, sponsored by health insurers, banks, Carroll College, and other private sector and some public sector entities, was first held in October 2007. A second forum was held in November 2008, building on the work done by interested parties over a year of almost monthly meetings on health care issues. For more information, see http://www.montanahealthcareforum.com/.

[3] Andrew Rettenmaier, "Medicare's Past, Present, and Future", slide 15. Presented at the Montana Health Care Forum, Oct. 29, 2007. Based on "The Diagnosis and Treatment of Medicare", AEI Press. http://www.montanahealthcareforum.com/assest_global/files/presentations/3%20Andrew%20Rettenmaier.pdf.

health care costs and coverage more than at health care access, which was studied under the Senate Joint Resolution (SJR) 15 study of the health care delivery system and will be referenced when appropriate.

The following complications, frequently cited in health care literature, arise in dealing with health care reforms:

- ***Care available — but payment is another matter***

In America an impressive array of health care services is available, not just to people who can afford them but to anyone who can get in the door of a hospital. Federal law[4] requires hospitals with an emergency room to stabilize a patient before transferring them to a health care facility that can more appropriately treat them. In some people's thinking, this means that emergency room care is free, just because care may have to be provided. But availability is one thing. Paying for it is another. Further complicating inappropriate use of emergency rooms is that those who avoid obtaining preventive care through a primary care doctor may end up in emergency rooms, using some of the most expensive care available. Those who ignore preventive care may find in the emergency room that their conditions are more complicated than if they had received care earlier.

THIS REPORT LOOKS AT COMPONENTS OF HEALTH CARE COSTS AND COVERAGE MORE THAN AT HEALTH CARE ACCESS, WHICH WAS STUDIED UNDER THE SJR 15 STUDY OF THE HEALTH CARE DELIVERY SYSTEM.

- ***Lack of health insurance coverage***

Too many people lack health insurance coverage, which – if they become sick and are unable to pay for their care — results in the cost being shifted onto those who do have

[4] Known as EMTALA, the Emergency Medical Treatment and Advanced Labor Act passed by Congress in 1986 requires hospitals that offer emergency services to examine a person brought to an emergency room for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to stabilize a person with an emergency medical condition or, if unable to stabilize the person within its capability or if the patient requests, initiate an appropriate transfer.

health insurance. That, in turn, leads to higher premiums, which may drive the cost out of reach for employers or individuals, who may end up going without.

- ***Too many people are underinsured***

In worst case scenarios, the underinsured may find that their copayments or deductibles are too great. As a result, they end up mired in medical debt or even potentially bankrupt. Providers may be left writing off costs or waiting lengthy periods to be paid.

- ***Insurance vs. prepaid health care***

Instead of insuring against risk as happens with homeowner or car insurance, some people may feel the need to extract services for all of their health insurance premiums. In this sense, some people feel health insurance is more of a prepaid system and less a way to offset risks. The more that people use insurance, the more the pricing of premiums reflect that use rather than being based solely on an actuarial estimate of risk. Some insurers, however, have a mission to offer prepaid health care. A health service corporation, a type of nonprofit insurer represented in Montana by Blue Cross Blue Shield of Montana and New West Health Services, is defined in 33-30-101(1), MCA, as a: "nonprofit corporation organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care, and other health care and services, or reimbursement therefor, may be furnished to a member or beneficiary".

- ***A disconnect involving perverse incentives for payors, providers, and users***

One of the arguments among proponents who want to remove employment from its current ties to health insurance is the disconnect between employers paying for insurance premiums while the employee has the opportunity to overuse the benefit without paying close attention to costs. A corollary is that insurers may be most familiar with the costs, because they pay anywhere from 50% to 80% of the bills, or so the argument goes. If the individual receiving care pays for the premium and for the care, the individual might exercise more restraint in seeking care and be more aware of the costs among different health care providers. In other words, the competitive model is skewed in health care. This disconnect interferes with the use of incentives because the target of the incentive may not be the ultimate actor. The mix of players also complicates the use of tax and

payment policies to achieve certain goals. The argument for employers handling health care group purchases is that an employer has more bargaining power than an individual. Additionally, without a guarantee of coverage, an individual with health problems may never get coverage or may pay a very high price for coverage on the individual market. The policy choice may seek to balance coverage and wise use incentives in deciding health care approaches.

- ***Health care as science, miracle, and business***

The mix of science and hope for miracles does not blend well in a society that has an equal opportunity mentality but a diverse payment system. After research and access to care minimized the number of deaths brought about by acute diseases or critical emergencies, expectations began to arise in the American psyche that one more operation, one more drug, one more procedure of some sort would provide a cure, even for chronic diseases that may result in lifelong treatment. Given the hope of science and expectations for miracles, many people may seek care whether they can afford it or not, reasoning that just because they cannot afford it does not mean they should not receive it. But health care, as practiced in America, is a business. Health care providers may extend charity but physicians as gatekeepers of sorts may also recommend alternate treatment if a person is unable to pay for the more expensive care. The inequities in this situation are complicated by public payments through Medicaid to low-income people and Medicare for the disabled or the elderly.

- ***Group vs. individual issues***

Group insurance, provided to a group of people with a common interest and either paid for in whole or in part by an employer or a union or association, allows tax benefits for employers and employees plus lower premiums for those with higher health risks and fewer restraints on coverage (generally). A person who buys insurance individually may not have the same cost advantages, depending on their age and their health and their willingness to assume risk. A buyer of individual insurance also may face exclusion of preexisting conditions for the term of a policy and not just the short term exclusion required by some group insurance policies. Conversely, some group insurance offers more benefits than any one individual may need. All group policies have more mandates than individual insurance does. In terms of access to coverage, however, there is inequity

between group insurance, which allows risk sharing by a group of people, and individual insurance, which is more specifically underwritten and priced for the risks presented by that individual.

- ***Health care cost shifts among payors***

Although people refer to a health care system, the uneven legs of the triangle of health care (insurers, providers, and users) means that shifts benefiting one leg of the triangle impact another leg. Efforts to control outlays by the tax-funded Medicare or Medicaid systems may lead to reduced payments to providers, who then refuse to treat Medicare or Medicaid patients. That may save public money but result in fewer covered lives and more people who may seek uncompensated care, which in turn can boost premium costs for those with insurance.

- ***Mix of federal and state regulation***

State laws regulate only certain aspects of health insurance, with federal law regulating other aspects. Hands-off territory for the states are self-funded employer plans governed federally under the Employee Retirement Income Security Act (ERISA), which regulates the workings of employer self-funded pension and health benefit plans other than those that are collectively bargained, government, or church benefit plans. However, states generally regulate insurers. Not everyone likes this setup, and various members of Congress have sought legislation to allow certain groups to provide an insurance policy to members across state lines. Many state insurance commissioners have fought the interstate insurance proposal out of a concern that a policy provided across state lines would have the fewest consumer protections and be a lowest-cost denominator type of policy. The counterpoint from groups representing businesses is that such a policy might be cheaper and allow more people to be insured.

- ***Coverage vs. costs and competitive failings***

The effort to expand coverage is inextricably linked to controlling costs, which increase in part because of inflation. Some analysts also contend that expansion of competition among health care providers increases costs because providers have certain fixed costs and compete for a limited supply of health care workers; that prevents them generally from lowering costs so they instead try to compete by providing more services.

Competition among health care providers in turn has the potential to increase utilization, including use of prescription drugs, laboratory services, and imaging services.

Some Offsets to the Problems

Various states have tackled health care reform by focusing on different aspects of the problems mentioned above.

- For the problem of misuse of emergency rooms, some states have established uncompensated care pools that reimburse hospitals for patients unable to pay for emergency care. Some states expect that the tax-free status of nonprofit hospitals is a *quid pro quo* for the charity care that hospitals provide in their emergency rooms and elsewhere. The use of federally designated and funded community health centers or other publicly funded health clinics also help encourage preventive care, which has the potential to offset the misuse of emergency rooms for preventive care.

- As part of its broad health insurance reforms, Massachusetts changed its uncompensated care pool to a safety net fund. Critics say that compensation went from full-cost payment to 60% to 70% reimbursement.[5] Advocates say Massachusetts hospitals recorded uncompensated care costs of $98 million in the first quarter of 2008, compared with $166 million in the first quarter of fiscal 2007.[6]

- Massachusetts made headlines with its enactment of an individual mandate that requires people to buy health insurance, combined with increased public subsidies to help people who cannot afford premiums to obtain health insurance coverage. An August 2008 press release from the Commonwealth Health Insurance Connector said U.S. Census Bureau figures indicate less than 8% of the Massachusetts population lacked insurance in 2006 and 2007, compared with an

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[5] Linda Gorman, "Colorado Health Care Reform: Reincarnating Failed Policies", opinion citing a study by the Cambridge Health Alliance, Independence Institute, March 25, 2008. http://www.i2i.org/main/article.php?article_id=1453.

[6] *New York Times* editorial, "The Massachusetts Way", August 30, 2008. http://www.nytimes.com/2008/08/30/opinion/30sat1.html?_r=1&scp=1&sq=Massachusetts%20Health&st=cse&oref=slogin.

uninsured rate of 10.3% in 2004 and 2005. Roughly 43% of the newly insured bought insurance without the government subsidy and the remainder received government help.[7] The penalty that Massachusetts imposes on the individual is loss of the individual's tax deduction if the tax return includes no proof of health insurance. The reforms reportedly decreased the number of people who sought free care from hospitals by 37%, and state payments for treating those people from an uninsured care fund fell by 41% to $98 million from $166 million.[8] However, the reforms did not address health care costs, and problems reported with the Massachusetts system are that premiums still are costly for families now required to buy insurance. Massachusetts, unlike Montana, also has guaranteed coverage, which means that the individual buying a policy is guaranteed coverage regardless of health problems.

- Hawaii, in contrast to Massachusetts, has a mandate for employers to provide health care for their employees. Although ERISA excludes most large employers and the Prepaid Health Care Act specifically excludes federal, state, city, and certain other employers, the law requires standard benefits for employees who work 20 or hours more a week and earn a certain percentage of the Hawaii minimum wage a month. The law, enacted in 1974, has been the subject of both opponents and proponents for mandated care.[9]

- Indiana sought to expand the use of health savings accounts, which are tax-free accounts that must be used for health care. The accounts can be tapped for other purposes at the end of the year but only if taxes are paid on the amount that is

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[7] *Boston Business Journal,* (an online *journal),* "Feds say Massachusetts has fewest uninsured residents", August 26, 2008. http://www.bizjournals.com/boston/stories/2008/08/25/daily23.html.

[8] Glenn Johnson, "Big Jump in Health Coverage Lowers Mass. Uninsured Costs", online *Insurance Journal*, August 21, 2008. http://www.insurancejournal.com/news/east/2008/08/21/92953.htm.

[9] For more on the Hawaii law, see: Hawaii Revised Statutes §393-1 et seq. and http://hawaii.gov/labor/dcd/aboutphc.shtml.

used for nonhealth expenses. Otherwise, unlike flexible spending accounts offered by some employers, the health savings accounts roll over for use in the next year.

- Vermont initiated its Catamount Health Care Plan that included a range of transparency measures intended to prompt patients and consumers to have a greater role in their health care and a greater understanding of health care costs. The overall Catamount Health Care Plan expanded coverage for the uninsured through subsidies for private insurance for those under 300% of the federal poverty level and incentives for employers to provide insurance. (See Appendix II.) One aspect encouraged consumer-directed health care, which was estimated to save $550 million over 10 years in health care costs if information about pricing, common outcome measures, best practices, and payment methodologies became available to consumers.[10]

- States that have sought to combat the disconnect between users of health care and payors who are not the users have required health care providers to provide itemized bills to patients who request itemization. Pricing transparency also helps to give upfront information on costs so that consumers can decide where or by whom an elective procedure should be done.

- For the problem of differing tax benefits and premium costs between group and individual health insurance, some states are providing incentives or mandates for businesses to use Section 125 plans allowed by the Internal Revenue Service Code. These plans allow an employer to deduct health insurance premiums (and certain expenses for dependent care) on a pre-tax basis, which both reduces an employee's tax liability and the employer's liability for payroll taxes for Social Security and Medicare. Minnesota enacted legislation that provides incentives to

[10] Christina Kent, "Vermont Approves 'Catmount Health,' Chronic Care Initiative", State News, *State Health Notes*, May 15, 2006. http://www.ncsl.org/programs/health/shn/2006/sn467.htm.

employers of 10 or more employees for implementing a Section 125 plan. The Minnesota legislation was to take effect in 2009.[11]

- Colorado implemented some recommendations from a Blue Ribbon Task Force on Health Care Reform aimed at balancing the unequal legs of the health care triangle. One change allows physicians to review and challenge insurance companies' credentialing systems, which, for example, determine whether a physician can participate in a preferred provider organization. Another requires standardized insurance health plan cards.[12]

- Some health care analysts are promoting less use of employer-paid health insurance as a way of promoting more personal recognition of costs and utilization.

For a review of health care reforms in other states, see Appendix II, which is based on one of the handouts provided to the Committee.

[11] Laws of Minnesota for 2008, Chapter 366, Article 17, p. 198, Sec. 4. http://www.health.state.mn.us/healthreform/legislation/hf3149.pdf.

[12] Doug Trapp, "Colorado adopts doctor rating standards, health system reforms", amednews.com, July 7, 2008, http://www.ama-assn.org/amednews/2008/07/07/gvsb0707.htm.

SECTION 2: Montana's Health Insurance Status and Coverage — a review of the insured, uninsured, underinsured, other statewide health status statistics, and options for coverage in Montana

Status Report

The good news for the majority of Montanans is that their health status is generally good compared with the rest of the country. For example, a 2007 report on Healthy Americans by the nonprofit, nonpartisan Trust for America's Health indicated that Montana ranked among the lowest in the nation for cases of tuberculosis (46th), AIDS in those 13 and older (48th), Alzheimer's (44th), and new cases of cancer (44th). Infant mortality, however, was 24th (in 2005) and asthma rates for adults was 28th (using a 2005-2007 average).[13]

Coverage

While health status is generally good, coverage by health insurance is not so good. Montana has one of the nation's highest rates of the uninsured, ranging between 16% and 20%. The rate of children without insurance was 11% in 2006 and 12.6% in 2007 or ninth highest in the nation.[14] But for children whose parents' income was below 124% of the federal poverty level, the ratio was 19%. (The state requires parents' income to be at or below 100% of the federal poverty level for children between the ages of 5 and 19 to obtain Medicaid.)

MONTANA HAS ONE OF THE NATION'S HIGHEST RATES OF THE UNINSURED, RANGING BETWEEN 16% AND 20%.

Other relevant factors for health reform include other demographics, for example, the number of Montana residents served by the Indian Health Service, and Montana's

[13] Trust for America's Health, The State of Your Health: Montana. Key Health Facts. http://healthyamericans.org/states/?stateid=MT

[14] *Ibid.* for 2007 data. For 2006 data, Kids Count Data Center, Montana Profile for children 17 and younger. This ratio was 15% in 2004. http://www.kidscount.org/datacenter/profile_results.jsp?r=28&d=1&c=11&p=5&x=137&y=3

regulatory climate, which differs from the regulatory climate in places where mandated coverage was put into effect, such as Massachusetts.

- ***Who is covered in general***

At any particular time, 80% to 84% of Montana citizens have some form of health care insurance. The 2008 U.S. Census Bureau report indicated that the number of uninsured in Montana in 2006-2007 had decreased to 16.4% from 16.9% in 2004-2005. That is a higher percentage than the national average of 15.5% (15.1% in 2004-2005). Texas (24.8%), New Mexico (22.7%), and Florida (20.7%) had the most uninsured people in 2006-2007. Neighboring states (see Table 1) all had lower rates of uninsured than does Montana.[15]

Table 1: 2006-07 uninsured rates in nearby states

Montana	16.4%
Idaho	14.6%
Wyoming	14.1%
North Dakota	11.1%
South Dakota	11.0%
U.S. Average, 2006-07	15.5%

Source: U.S. Census, 2008

- ***How coverage is obtained***

Most of those with health insurance in Montana receive it as an employment benefit. When employers first began offering health insurance and the cost of health care was much lower than it is today, the benefit was intended to attract workers not necessarily by offering a higher salary but by offering better benefits at a reasonable cost. The significant number of insured in Montana is primarily a result of most employees working for large employers, often public-sector employers (which in 2006 employed 81,254 people in

[15] U.S. Census Bureau, Current Population Reports, P60-235, "Income, Poverty, and Health Insurance Coverage in the United States, 2007", U.S. Government Printing Office, Washington, D.C. 2008, p. 25.

federal, state, or local government work). The Montana Department of Labor and Industry indicates that 92% of those employers with more than 100 employees offer health insurance.[16]

Table 2: Type of health benefit plans vis-a-vis employer

Type of Coverage*	Type of Employer
Self-funded benefits (including ERISA** plans)	Tends to be larger employers. Includes governments, unions, church plans and MEWAs that don't buy insurance policies or groups under the Davis-Bacon Act that do not buy insurance.
Group fully insured plans	Might be any size employer of 2 or more people or association plan that uses insurer for benefits. Includes Insure Montana plans.
Multiple-employer welfare arrangements (MEWAs)	Associations of groups like loggers, contractors, or professional employer organizations. May either be self-funded (not insurance) or through an insurer.
Individual insurance	Sole proprietors or employees or their dependents not covered by an employer plan.

*More information on these types of insurance is available in Section 3. **ERISA stands for Employment Retirement Income Security Act, a federal law governing employer-sponsored health and pension insurance.

Bigger employers typically have self-funded group plans. Those firms that operate across state lines may use a self-funded plan to provide coverage under the same administration at all its units. These businesses are not subject to state insurance laws, unless they choose instead to buy an insurance policy through health service corporations or insurers operating in this state. An example of those who may be self-funded, other than government, are the following employers in the list of Montana's 20 largest nongovernmental, nonagricultural employers with more than 500 employees (most with more than 1,000 employees): 8 hospitals, 3 banks, 3 grocery or retail-related, and 2 mining or energy-related firms. The rest are generally service-related. These businesses tend to be in the larger cities. In 19 of Montana's smaller counties, the one or two largest employers have no more than 250 employees.

[16] Fourteen of Montana's top employers listed more than 1,000 employees in 2007. In 2006 Montana's top 100 employers included only firms with more than 250 employees. For more information on Montana employers, see http://www.ourfactsyourfuture.org/cgi/databrowsing/?PAGEID=4&SUBID=153.

A key point about self-funded health coverage is that state law does not apply to employers who operate under the requirements of the Employment Retirement Income Security Act (ERISA). This means that the impact of state laws on health care is limited, primarily affecting the small group or individual markets.

A KEY POINT ABOUT SELF-FUNDED HEALTH COVERAGE IS THAT STATE LAW DOES NOT APPLY TO EMPLOYERS WHO OPERATE UNDER THE REQUIREMENTS OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT (ERISA).

The small group market includes most businesses in the state because most businesses have fewer than 10 employees. These are eligible for subsidies or tax credits under the Insure Montana program. Employers with between 2 and 50 employees also can access insurance under the Small Employer Health Insurance Availability Act, Title 33, Chapter 22, part 18, which includes some rating protections. Few voluntary insurance pools have formed, an issue that will be addressed later.

Among the most likely pool of uncovered workers are the large number of self-employed people in Montana, such as independent contractors and small owner-controlled businesses, including those that file income taxes as S Corporations. A 2005-2006 study of independent contractors by the Department of Labor and Industry indicated that in 2002 independent contractors comprised 7.5% of Montana's average annual employment, higher than other states studied. Florida at 2.4% was next closest. South Dakota with a similar average annual employment number had just 0.6% of its work force with independent contractor exemptions.[17]

At the May 2008 Committee meeting Riley Johnson, the Montana representative for the National Federation of Independent Businesses, told the Committee that more than 3,000 business owners in Montana do not carry insurance on their employees. More than 1,300 of these business owners are eligible for individual insurance. He voiced a concern that

[17] Maggie Connor, *Independent Contractors in Montana,* presentation at the Department of Labor and Industry to the Senate Bill 270 Study Committee, Oct. 22, 2003. http://erd.dli.mt.gov/sb270/iccommittee.ppt#393,9,Slide 9.

AMONG THE MOST LIKELY POOL OF UNCOVERED WORKERS ARE THE LARGE NUMBER OF SELF-EMPLOYED PEOPLE IN MONTANA, SUCH AS INDEPENDENT CONTRACTORS AND SMALL OWNER-CONTROLLED BUSINESSES.

businesses that do not offer health insurance but do provide workers' compensation may face higher workers' compensation premiums if workers inappropriately substitute that form of insurance for health insurance.[18]

University of Montana Health Economist Steve Seninger reported in his 2006 study for Montana Kids Count that the likely uninsured in Montana are those who are self-employed, working in wholesale, retail, agriculture, construction, part-time, or in firms with fewer than 10 employees. He noted that 75% of Montana firms have fewer than 10 employees.[19] Conversely, 43.6% of Montana's work force in 2006 worked for employers with more than 100 employees. More than half of the state's workers, 55.8%, drew paychecks from firms with 50 or more employees. And more narrowly, 21.2% worked for employers with 500 or more employees. Larger firms typically offer health insurance for full-time employees but part-time or temporary workers do not always receive that offer nor do all full-time employees sign up for health insurance from their employer (either because they receive coverage elsewhere or do not want to pay their part of the premium).

Another demographic factor is the number of people in Montana who have multiple jobs. Although someone with multiple jobs may get insurance through one of the jobs, there also is the likelihood that a multiple job holder does not obtain insurance through any employer. If insurance is not obtained through an employer, the worker may turn to the

[18] In 2007 a Rhode Island legislator sought to address what is apparently a similar concern by proposing legislation for a policy that combined health and workers' compensation policies. These policies typically are not offered by the same companies, which raises a whole new workability issue.

[19] Steve Seninger, "Healthcare Spending & Access for Montana Kids and Families", Montana Kids Count, The University of Montana-Missoula Bureau of Business and Economic Research, Feb. 1, 2006. Slide titled "Employment & Health Insurance".

individual market, which means there is no opportunity to spread risk or obtain insurance with pre-tax dollars.

Table 3: Picture of the uninsured in Montana

Has high school degree	92%
White	86%
Employed	77%
Adult older than age 25	67%
Self-employed or working with firms of fewer than 10 workers	60%
Income of 2 times the federal poverty level	45%

Source: Steve Seninger, *Montana Kids Count,* 2006

For those without insurance, Seninger noted these characteristics:

- Adults between the ages of 19 and 25 were more than twice as likely to be uninsured as the general population. (The information was compiled prior to 2006. In 2007 the legislature enacted SB419, which required state-regulated insurers to offer parents a choice of extending coverage under the parent's policy for unmarried children up to the age of 25, to be paid by the parent.)
- American Indians were more than 2 times as likely to be uninsured as non-Indians in this state.[20]
- Montanans with incomes lower than the federal poverty level were 2 times more likely to be uninsured than the statewide average.[21]
- The overall picture of the uninsured in Montana reflected 86% white, 67% adults older than age 25, 92% with a high school degree or higher, 77% employed, 60% self-employed or working for firms of fewer than 10 employees, and 45% with incomes 2 times the federal poverty level.[22]

[20] The Indian Health Service — IHS — is not an insurer but provides direct services to an eligible Indian enrolled in a federally recognized tribe at reservation-based clinics or hospitals. If an Indian has insurance or Medicaid, that third-party may be billed for the services. If IHS cannot provide specialty or emergency services, a patient may be referred elsewhere and IHS covers the contracted costs if funds are available and necessary requirements are met. However, IHS may not always have funds available to provide the contracted services.

[21] Seninger*, op. cit.,* Slide titled "Who have the Highest UI Rates?"

[22] Seninger, *op. cit.,* Slide titled "Who are Montana's Uninsured?"

Who Is Underinsured?

Census studies indicate who is not insured, but the number of underinsured is less explored, even though the plight of the underinsured has impacts similar to that of the uninsured if each ultimately is unable to pay for health care. An estimate provided to a U.S. Senate Health, Education, Labor, and Pensions Committee meeting in February 2009 by The Commonwealth Fund is that 25 million adults under the age of 65 were underinsured in 2007. At that meeting, a person who is underinsured was described as someone with insurance "whose family medical expenditures total 10% or more of their income or whose health plan includes deductibles greater than 5% of income".[23] The Commonwealth Fund further estimated that more than half of the underinsured went without treatment compared to two-thirds of the uninsured going without treatment.

The Montana Department of Public Health and Human Services (DPHHS) used its 2005 Behavioral Risk Factor Surveillance System survey to find out who is underinsured. The survey found 6.5% of Montana's adult population to be underinsured, or insured but not visiting a doctor because of cost.[24] DPHHS sought a private-sector grant to more specifically determine the number of the underinsured children in Montana but did not obtain funding.

One way of viewing the underinsured is to look at uncompensated care in hospitals. Table 4, taken from a January 2008 study for the Attorney General's office of charity care at Montana's larger hospitals by Lawrence L. White, a research assistant professor in the School of Public and Community Health Services at the University of Montana, shows the

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[23] Melissa Attias, Congressional Quarterly Staff, "Senate HELP Committee Probes Problem of Underinsurance" Feb. 25, 2009. Quoted in The Commonwealth Fund Newsletter of March 2, 2009: http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Mar/ Washington-Health-Policy-Week-in-Review-March-2-2009.aspx. Adults whose income is less than 200% of the federal poverty level, are considered underinsured if their medical expenses amount to at least 5% of their income, according to a study of the underinsured by Cathy Schoen and others for the Commonwealth Fund, reported in *Health Affairs*, *op. cit*.

[24] Montana Department of Public Health and Human Services, "Final Report to the Secretary: Montana Continuation Health Resources and Services Administration State Planning Grant", March 2007.

ratios of charity care and bad debts in relation to hospital operating expenses.[25] For the purposes of these assessments, charity care did not include the money lost by hospitals for being reimbursed for Medicaid cases at less than cost. In terms of bad debt, which means a patient did not apply for charity care or was not considered eligible and did not pay some or all of a hospital bill, 7 of the 11 hospitals contacted for the study had higher bad debt percentages to operating costs than charity care to operating costs. A December 2008

Table 4: Bad debt as an indicator of underinsurance vs. charity care, a representation for the uninsured, at select Montana hospitals

Hospital	Bad Debt/ Operating Expenses	Charity Care/ Operating Expenses	Combined ratio in 2007
Northern Montana Hospital	4.09%	0.75%	4.98%
Bozeman Deaconess Health Services	3.88%	1.37%	7.12%
Kalispell Regional Medical Center	3.46%	1.61%	5.28%
St. Peter's Community Hospital	2.92%	1.57%	5.09%
Holy Rosary Healthcare	2.89%	2.07%	5.86%
St. Patrick Hospital & HealthCare Sciences	2.82%	2.86%	4.65%
St. James Healthcare	2.78%	2.90%	6.24%
St. Vincent Healthcare	2.69%	1.57%	5.31%
Billings Clinic	2.34%	3.42%	5.59%
Community Medical Center	1.97%	0.88%	3.83%
Benefis Healthcare	1.38%	1.51%	4.14%

Shaded areas indicate that these hospitals had a greater percentage of operating expenses in charity care than in bad debt in first report.

Source: Lawrence L. White, Jr., *Montana's Hospitals,* January 2008. Combined ratio from December 2008 report.

[25] Lawrence L. White, Jr., "Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana Consumers, A Report Prepared for Montana Attorney General Mike McGrath", January 2008, p. 7 (p. 10 of the on-line version). http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport.pdf.

study reworked this analysis and combined charity care and bad debts into uncompensated care as compared to operating expenses. In comparison to the value of the tax exemptions provided to these nonprofit hospitals, the report concluded that all of the 11 evaluated hospitals "provided between two and three times (214% - 322%) the community benefit as they gained in tax exemptions in 2007".[26]

Further analysis in the January 2008 study indicated that hospitals that sought to recover the bad debts through collections routinely received a 17.5% return, compared to a 25% return on nonmedical accounts. That study noted that between 2004-2006 there were 17,719 medical cases involved in bankruptcy and cited a 2005 national report noting that medical problems "contribute to about half of all bankruptcies in the nation". Efforts to recover hospital bill payments from a bankruptcy case yielded just a 1.01% return, which prompted the author to recommend that Montana's hospitals reevaluate their debt collection efforts related to bankruptcies and refocus efforts on signing people up for charity care.[27] The December 2008 study noted that the average amounts sent to collections and tallied in bankruptcy proceedings were similar to the earlier study amounts. More information on both studies is found under Section 4 on the SJR 15 study.

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[26] Lawrence L. White, Jr., "Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana Consumers, Second Annual Report", December 2008, p. 6 (p. 8 of online version). http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport200812.pdf.

[27] *Ibid*., p. 11.

SECTION 3: HJR 48-Related Issues

This section addresses the following issues related to the HJR 48 study resolution, either presented to the Committee or subcommittee or provided as background information:

- ☐ Review of Montana insurance issues: Types of coverage and the regulatory climate
- ☐ Aspects of the Massachusetts reforms and other state reforms, including the Insurance Connector and Section 125 plans
- ☐ Cost shifting and impacts on premiums
- ☐ Differences among insurers and third-party administrators
- ☐ Public interaction with insurance incentives, mandates, and tax options, including: Insure Montana, small business health insurance pools, mandate discussions, and medical and health savings accounts
- ☐ Use of health care trusts by the Montana Contractors Association and others
- ☐ Montana Comprehensive Health Association
- ☐ Montana's Public Health Insurance Coverage
- ☐ Expansion of the Children's Health Insurance Program
- ☐ Mandates
- ☐ Activities of the Montana Health Care Forum

Montana Coverage Issues

As in other states, the picture of how Montanans receive health benefits in the private-sector market includes: self-funded plans, multiple employer welfare arrangements (MEWAs), fully insured health plans provided by either nonprofit or for-profit companies, individual plans, and Medicare Advantage or Medicare supplemental plans. See Table 5 for samples of plans.

Table 5: Examples of coverage in Montana by various types of plans

Type of plan	Sample entity providing health benefits	Covered lives	Point in time
Self-insured not part of ERISA	State of Montana	32,429	7/2008
	Montana University System Employee Plan	17,980	12/2008
	Montana Association of Counties Health Care Trust	2,290	3/2009
	Montana Municipal Insurance Authority Employee Benefits Program	3,578	4/2009
	Montana Unified School Trust	19,400	4/2009
Self-insured, ERISA-covered	First Interstate Banc Corp.	3,032	12/2008
	Northwestern Energy	4,753	12/2008
	Stillwater Mining Co.	4,181	3/2009
	Washington Companies. (25% of covered lives are outside Montana.)	~6,100	4/2009
Church plans	Diocese of Helena	258	4/2009
	Sisters of Charity of Leavenworth Health System (for St. Vincent Healthcare in Billings, Holy Rosary Healthcare in Miles City, and St. James Hospital in Butte)	7,363	4/2009
Self-funded, ERISA-covered Multiple Employer Welfare Arrangement	Montana Medical Association Health Care Plan and Trust	345	4/2009
	Associated Employers Group Benefit Plan & Trust Has 410 different types of employers. (grandfathered in)	~13,500	4/2009
Fully insured, ERISA-covered Multiple Employer Welfare Arrangement	State Bankers Association Group Benefits Trust	~2,700	4/2009
	State Bar of Montana Group Benefits Trust	~1,700	4/2009
	Montana Food Distributors Association Group Benefits Plan	~580	4/2009
Union or Taft-Hartley plans, not through insurer	Pipe Trades Trust of the Northern Rocky Mountain Area (includes Montana, North Dakota, South Dakota, small part of Minnesota)	~3,300	12/2008
	Laborers' Health and Welfare Trust of Montana	~1,900	12/2008
Davis-Bacon Act-eligible employer	The Montana Contractors Association Trust. 80 major contractors are members. (The trust also is a MEWA as a bona fide association defined under ERISA.)	~8,000	12/2008
Fully insured plan*	Montana University System Student Plan, covering 6 campuses and using Blue Cross Blue Shield for services not provided at student clinics	9,210	12/2008

*Fully insured plans include those in Insure Montana, the Children's Health Insurance Program, and any coverage directly with an insurer. These plans are fully subject to state insurance laws under Title 33.

Types of Coverage

- ***Self-funded plans***

An employer who has adequate funding or consistent cash flow to cover health care costs for its employees may choose to self-fund that coverage. If they expect to have sufficient funds, they may cover all health care costs, or they may seek to limit that risk by purchasing reinsurance. (Reinsurance is secondary coverage that a self-insurer may purchase to pay for costs once a claim exceeds a certain dollar amount or when total costs for the employer exceed a set dollar amount in a year. Self-insurers may develop their own benefit plans or they may use insurance carriers' existing benefit plans, but the acceptance of risk is by the entity that self-insures. The self-insurer determines benefits levels and the maximum lifetime amount of coverage. Self-insurers generally use certain services that insurance companies or entities known as third-party administrators offer, such as negotiated discounts with health care providers, computer claims processing capabilities, and care management services. In certain cases, the self-insurer might administer plans entirely in-house. This approach allows the self-insurer to keep money in the bank rather than paying into an insurer's risk reserves and increases the incentive to promote wellness programs among employees. Those who self-fund also may avoid state regulation because of ERISA-provided preemptions.[28] (See Section 2 for other details on self-funded coverage.)

Among those using self-funded plans are many governmental entities and certain single employers, some MEWAs, some union plans, church plans, and some businesses covered by the Davis-Bacon Act, a federal law requiring contractors engaged in public works projects to pay a region's prevailing wage (and fringe benefits like health

[28] Some courts have cited ERISA in overturning efforts to apply state law to entities with self-funded health insurance, including Maryland's bid to require large employers to provide health insurance to all employees or pay into a fund to defray the state's Medicaid costs. Maryland legislators overrode a gubernatorial veto in January 2006 to enact the Maryland Fair Share Health Care Fund Act. On July 19, 2006, Judge J. Frederick Motz of the U.S. District Court for the District of Maryland ruled that ERISA preempted the Maryland law (Retail Industry Leaders Association v. Fielder, et al. Civ. No. JFM-6-316).

insurance). Unlike some of the ERISA-covered entities, state or municipal government or university system insurance[29] may be required to meet some state regulations, either by specific mention under the regulations of Title 33, the insurance code, or requirements under Title 2, chapter 18, which generally address employee plans provided by the state, local governments, school districts, or the Montana university system.

MONTANA'S MAJOR EMPLOYERS, THOSE WITH MORE THAN 500 EMPLOYEES, TYPICALLY SELF-FUND THEIR HEALTH CARE COVERAGE AND EITHER USE THIRD-PARTY ADMINISTRATORS OR HANDLE THE ADMINISTRATION THEMSELVES.

Montana's major employers, those with more than 500 employees, typically self-fund their health care coverage and either use third-party administrators or handle the administration themselves. Fifteen of Montana's top 20 employers have more than 1,000 employees.[30] However, eligibility for insurance may vary and not include part-time or temporary workers and may require employee contributions to premiums that not all employers may choose (or be able) to pay.

- ***Multiple Employer Welfare Arrangements (MEWA)***

A MEWA may buy insurance coverage, using a fully insured plan, or handle coverage without using an insurer, which means the MEWA is not then regulated by the state. Those not regulated by the state avoid state requirements for minimum reserves, among other issues, according to a U.S. Department of Labor publication.[31]

- ***Fully insured health plans***

Two non-profit health service corporations, Blue Cross Blue Shield of Montana and New West Health Partnership, had more than 53% of Montana's direct written premium

[29] State and local governments and the Montana University System operate under Title 2, chapter 28, part 2, provisions for group health insurance. Title 33 covers other insurers.

[30] http://www.ourfactsyourfuture.org/?PAGEID=67&SUBID=154#SC.

[31] U.S. Department of Labor, Employee Benefits Security Administration, "Multiple Employer Welfare Arrangements under the Employment Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation", September 2004.

business in 2006. The remaining top 15 insurers write between 6% and 0.6% of policies. Many of these insurers handle supplemental Medicare policies. (See Table 6 on p. 36.) Included in the fully insured health plans are those that participate in Insure Montana. (See below.)

■ ***Medicare***

This overview of the federal Medicare program, available to those 65 and older, is intended in part to explain the private insurance related to Medicare and the deductibles/copayments that vary depending on the type of Medicare being used (Part A, B, C, or D)[32] and certain other factors. The two types of private insurance are Medicare Advantage (Medicare Part C) and supplemental Medicare plans.

Part A Medicare:

- insures for hospitalization or skilled nursing facilities and some home health care;
- available without premiums for those eligible for Medicare because they have worked sufficient quarters and reached age 65 or been rated eligible for a disability;[33]
- has deductible/copayments that vary depending on length of stay. For the first 60 days of hospitalization Medicare pays all but $1,068 of the hospital stay for "reasonable and necessary care". After that, Medicare requires copayments above a certain daily amount based on length of stay. For a skilled nursing facility, the daily cost is $133.50 for days 21 through 100 of each benefit period, which lasts until a person has been out of the hospital or skilled nursing facility for 60 consecutive days.

[32] Medicare Part C is a program through private insurance also called Medicare Advantage that combines Part A and Part B coverage under one policy. Some also include Part D, the prescription drug plan coverage.

[33] Possible disabilities include someone under age 65 who is receiving dialysis for kidney failure or someone who has amyotrophic lateral sclerosis (Lou Gehrig's Disease).

Part B Medicare:

- provides a person who is age 65 or older or disabled with insurance for eligible physician services, outpatient hospital services, and certain home services and medical equipment charges;
- requires a monthly premium. The 2009 premium for Part B is $96.40 a month but may be higher for people with an individual income of $85,000 or more or $170,000 or more for a married couple.[34]
- requires deductibles/copayments. After a $135 deductible, those with Medicare Part B have a 20% copay of the Medicare-approved amounts.

Part C Medicare:

- also called Medicare Advantage;
- a private-sector approach that allows a combination of hospitalization and outpatient insurance coverage (substitutes for Medicare Parts A and B);
- premiums, deductibles, and copayments vary as do the benefit terms.

■ ***Medicare Supplemental Plans***

To help with copayments, those who use Medicare Parts A and B may choose a Medicare supplemental plan. The insurers that offer these plans must register with the Montana State Auditor's Office, which has developed a Consumer's Guide to Medicare Supplement Insurance.[35] The guide explains, among other topics: the differences among the 14 standard benefit plans that an insurer may offer; the option of Medicare Advantage (Medicare Part C); prescription drug coverage under Medicare Part D; and enrollment periods. Another document on the State Auditor's website compares premiums for various Medicare Supplement Plans.[36]

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[34] Information on Medicare is available from the government website: http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=2100.

[35] The guide is available at: http://sao.mt.gov/seniors/medsupguide.pdf.

[36] Comparison information for Medicare Supplement Plans is available at: http://sao.mt.gov/consumers/Guide%20-%20Medicare%20Supplement%20Insurance2.pdf.

Regulatory Climate

Some of the states that have instituted health care reforms have statutes in place on which the reforms hinge. Each have pluses and minuses. For example, a law requiring an individual to buy insurance (as is done in Massachusetts) would be easily frustrated by an insurer refusing to sell a policy if no state law required an insurance company to issue a health insurance policy regardless of the underlying health condition of the purchaser. Some other policies, such as those that limit the amount that an insurer can expend on administration, may require review to determine compliance. A third type of regulation, used elsewhere, is community rating, which often is used to spread risk among a larger group of people so that insurance policies are not beyond affordability for those who are very sick, although the corollary is that insurance policies may cost more for the healthy. Finally, some states have considered preventing health insurers from rescinding individual policies if the policyholder becomes seriously ill. The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires renewability for group insurance except for nonpayment of premium and other limited reasons. Montana further guarantees renewability in the individual insurance market, with some limited exceptions.

- ***Guaranteed Issue***

SOME OF THE STATES THAT HAVE INSTITUTED HEALTH CARE REFORMS HAVE STATUTES IN PLACE ON WHICH THE REFORMS HINGE. EACH HAVE PLUSES AND MINUSES.

This term, which means that a health insurer cannot deny coverage to an otherwise eligible person because of underlying health problems, usually applies just to individual insurance policies (and does not refer to the requirement for guaranteed coverage by a high-risk pool, such as the Montana Comprehensive Health Association). Among states with guaranteed issue in the individual market are: Idaho, Maine, Massachusetts, New Jersey, New York, and Vermont. Essentially, large group coverage offered by fully insured health plans is “guaranteed issue” because, while a group plan might have an initial period during which preexisting conditions are excluded, the plan covers an enrolled person regardless of underlying health problems. Under 33-22-110, MCA, an insurer may exclude preexisting conditions for 12 months and under 33-22-514, MCA, for 18 months for a late enrollee. In Montana the small employer group market for groups of 2 to 50 employees requires guaranteed issue under Title 33, chapter 22, part 18.

Guaranteed issue is considered necessary if a mandate for coverage is to be enacted, because requiring buyers to obtain insurance does not work if the insurers can decide not to cover unhealthy buyers. Conversely, insurance companies claim that guaranteed issue results in healthy people not buying insurance until they feel they need it, which means that the risk associated with insurance is not spread over a large group of people but instead is concentrated on those most in need of insurance. The result is higher premiums or insurers pulling out of the market.[37]

Federal law requires a state either to guarantee issue or to have a high-risk pool to cover individuals unable to buy insurance elsewhere. Montana has chosen the option of a high-risk pool, which is handled by the Montana Comprehensive Health Association.

- ***Regulatory Review***

Montana's Insurance Commissioner approves health insurance forms but does not have prior approval authority for rates, a term that means a state regulator must review proposed health insurance rate increases to determine if increases are reasonable and necessary. A Families USA briefing paper on prior approval authority indicates that 33 states have some form of prior approval authority for health insurance. The briefing paper notes:

> Insurance companies complain that the prior approval process is burdensome, but evidence from states that enforce these regulations clearly demonstrates that they are good for health care consumers and that they do not cause the negative consequences that insurance companies cite.[38]

The one provision in Montana for rate regulation is under the small employer health insurance availability act, Title 33, chapter 18. Insurance policies offered under this part have limits on rate variations between classes of jobs of 20% and within a class of 25% as compared to the index rate.

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[37] Leigh Wachenheim and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Markets", prepared by Milliman, Inc., for America's Health Insurance Plans, July 10, 2007.

[38] Families USA, "The Facts about Prior Approval of Health Insurance Premium Rates", Health Policy Memo, June 2008, p. 1. http://www.familiesusa.org/assets/pdfs/prior-approval.pdf.

Under 33-22-1706, MCA, which allows a provider agreement, insurance policy, or subscriber contract to contain components designed to control the cost and improve the quality of health care, the “terms or conditions of an insurance policy or subscriber contract, except those already approved by the commissioner, are subject to the prior approval of the commissioner.” The State Auditor's actuary reviews payment reimbursement and incentive differentials under this section.

- ***Community Rating***

Community rating is a way of limiting premium rates in the individual insurance market by preventing insurers from using age, gender, or geographic location in calculating premiums. (Montana already limits both group and individual insurance from discriminating based on gender, under 49-2-309, MCA, in the Montana Human Rights Act.)

States with community rating or modified community rating are: Maine (limits for age, occupation or industry, geographic area, smoking status, and family size), Massachusetts (limits based on family composition, age — within a 2:1 rating band — and geographic regions — within a 1.5:1 ratio), New Jersey (pure community rating - same rates regardless of age with differences allowed for family size or types of benefits in plan), New York (variations for family type, geographic region, and benefit plan design), and Vermont (rates may vary based on family size and benefit level for nonprofits and health maintenance organizations and within a 20% rating band for commercial insurers).[39]

Community rating typically means that healthier people pay higher premiums than they otherwise might as insurers spread risk over the entire population pool because they are unable to underwrite to avoid insuring specific populations that might have health concerns. As in guaranteed issue, insurers may leave a market that is not cost-effective from their perspective. Community rating would resolve situations in which workers in certain industries (for example, crop dusters) may be unable to obtain individual insurance policies based on their occupation.

[39] Wachenheim and Leida, *op. cit.* Not in the report but also requiring adjusted community rating is Washington state.

- ***Postclaim Underwriting or Recission***

Under 33-18-215, MCA, Montana prohibits postclaim underwriting as an unfair trade practice except in cases of material misrepresentation or fraudulent misstatement on an application. As applied to health insurance policies, postclaim underwriting or recission has meant that people who have obtained health insurance may be denied use of that insurance within 2 years (in Montana) if the insurer discovers a misstatement in a person's health history or sometimes even if the insurer fails to investigate a statement made in the application prior to issuing the insurance. In 2005, Senate Bill 209 sought to require that insurers do their due diligence before issuing a policy and not afterward. The bill did not become law.

Massachusetts Reforms and Other States' Activities in Health Insurance Reform

Elements of the Massachusetts health care reforms were presented at two meetings of the subcommittee. In Miles City HJR 48 sponsor Rep. Gary MacLaren reviewed aspects of the Massachusetts Commonwealth Connector (the Connector), and staff presented handouts on reforms in other states (see Appendix II). In Helena two presenters discussed specific aspects of the Massachusetts reforms. Ed Haislmaier of the Heritage Foundation included descriptions of the Massachusetts reforms, particularly the Commonwealth Connector which he helped to draft, when he provided an overview of activities in various states at the February subcommittee meeting. Rick Szczebak, an attorney with the Connector, discussed how the Connector allows participating Massachusetts employers and employees to obtain Section 125 pretax benefits. (Section 125 refers to that section of the Internal Revenue Service Code that describes cafeteria plans and opportunities for purchasing health insurance with pre-tax dollars.)

The Connector, established in 2007 as a quasi-public, independent entity, works as a health insurance exchange in that it sets standards for affordable insurance[40] and serves

[40] The Connector has a 2009 insurance affordability schedule for those not eligible for employer-provided insurance. An individual earning up to $21,672 a year would pay $39 a month in premiums. An individual making up to $54,600 a year would pay $342 a month in premiums. For incomes above that amount, individual insurance is considered affordable. For a family (of at least one parent and one child) the affordability schedule indicates a monthly insurance premium in 2009 of $232 for a family with income between $45,781 and $54,936. Those families earning more than $114,401 are considered able to buy insurance. The Connector website is: http://www.mahealthconnector.org/portal/site/connector/ .

as a one-stop shopping coordinator where employers and employees can put pretax dollars to obtain health insurance. One expectation of the Connector initially was to allow insurance portability for people who bought their insurance through the Connector, perhaps with the help of contributions from an employer, so that the employee buying the insurance retained the insurance if the employee changed jobs rather than having to rely on an employer for health insurance. Haislmaier noted that the Utah legislature was considering private-sector efforts through banks to set up an insurance exchange and that Mississippi was considering a model based on the Massachusetts Connector. He noted that the Heritage Foundation had a model law that he worked to develop aimed partly at disassociating employers from health insurance.

An original expectation of the Connector was that it would be able to combine the employer contributions from someone who had more than one job. However, the lack of consistent income from someone with more than one part-time job complicated the pooling of funds necessary to assure payment for annual health insurance premiums. The Connector found that employees working on average fewer than 64 hours per month (for example, 8 days at 8 hours) would not be eligible to use the Connector as a Section 125 pre-tax entity for health insurance premiums. Also ineligible for Section 125 advantages were service employees who earned on average less than $400 in monthly payroll wages.[41] IRS requirements also prohibit a sole proprietor from using Section 125 tax advantages.

For employees who work on average more than 64 hours a month, the Connector serves as an entity through which insurance purchasers can take advantage of Section 125 pre-tax benefits. In addition to describing requirements of Section 125 plans at the February subcommittee meeting, Szczebak noted that Massachusetts requires Section 125 plans for companies that have 11 or more employees, but he added that 11 is an arbitrary

[41] Jon Kingsdale, Executive Director of the Commonwealth Health Insurance Connector Authority, "Massachusetts' Section 125 Requirement: Implementation and Lessons Learned", presentation at Section 125 Plans: Policy and Implementation Issues seminar, July 18, 2008, Denver, Colorado.

figure. Both a Powerpoint and a guidebook on Section 125 plans were part of the presentation. They are on the Committee's website: http://leg.mt.gov/css/Committees/Interim/2007_2008/econ_affairs/default.asp.

Cost Shifting and Impacts on Premiums

Insurers base premiums on a combination of expected payouts, administrative costs, and maintenance of reserves for potential but unforeseen payouts. When an insurer prices a premium, they look at usage data from not only their own insured pools but also from providers. As explained by one insurance company representative, cost-shifting happens this way (roughly): a hospital has a mix of payors. Known payments are government-set Medicare and Medicaid reimbursement rates. These may or may not fully cover the expected costs of care. If costs go up (say the hospital has hired a new physician or added a new imaging machine), the charges to Medicaid and Medicare cannot be more than they were previously, even if the hospital's expenses are greater. So these costs must be averaged among other payors. It isn't just Medicare and Medicaid that have fixed rates. Some insurers negotiate to pay only a certain percentage of costs (under a preferred provider option). If expenses have increased in the meantime, the insurers may not be paying all of the increase, only a percentage. The one payor facing full costs is the patient without insurance who may have no clue that there may be options for discounts.

INSURERS BASE PREMIUMS ON A COMBINATION OF EXPECTED PAYOUTS, ADMINISTRATIVE COSTS, AND MAINTENANCE OF RESERVES FOR POTENTIAL BUT UNFORESEEN PAYOUTS.

Mark Burzynski of Blue Cross Blue Shield of Montana provided the subcommittee with information about cost-shifting and impacts on premiums at a meeting in November in Miles City. He also distributed a study done for Premera Blue Cross of Washington state in which actuarial consulting firm Milliman, Inc. estimated that physicians and hospitals in that state charged higher commercial insurance rates "to offset payment shortfalls from Medicaid and Medicare" amounting to $620 million overall for physicians and $738 million for hospitals in 2004. The cost-shifting amounted to about $902 for each family in 2004, Mr. Burzynski said. The analysis also found that "Medicare and Medicaid cost-shifting, not employees' medical care, accounted for 29.9 percent of the increase in employee hospital costs paid by Washington employers in

2004".[42] A study for Montana Attorney General Mike McGrath in 2008 also found that many of the hospitals estimated that the shortfall in Medicaid and Medicare payments amounted to the equivalent of charity care, which commercial insurer charges also offset.

Differences Among Insurers and Third-Party Administrators

Insurers in Montana may be third-party administrators but not all third-party administrators are insurers. Insurers include those entities that pay premium taxes and health service corporations, which do not pay premium taxes. Although health service corporations like Blue Cross Blue Shield of Montana and New West Health Partnership do not pay premium taxes, they do pay an assessment for the Montana Comprehensive Health Association, Montana's high-risk pool. See Table 6 to compare premium taxes paid by insurers and assessments paid for the Montana Comprehensive Health Association.

As part of the subcommittee discussion in Miles City, Susan Witte of Allegiance Health, and Frank Cote of Blue Cross Blue Shield compared perspectives about the benefits of self-funded plans and the costs shifted to others. More details are available under the information related to self-funded plans and the Montana Comprehensive Health Association (see below).

[42] Premera Blue Cross, "Quantifying the Impact of Medicare and Medicaid Payment Levels to Washington Hospitals and Physicians", Executive Summary, May 2006, pp. 1 and 2. Presented by Will Fox and John Pickering for Milliman, Inc.

Table 6: Top insurers by market share* in Montana plus MCHA assessments, TPA covered lives

Insurer	Direct Premiums Written, 2008	Market share %, 2008	Premium Taxes Paid**	Maximum Possible MCHA Assessments**, 2008	Covered lives served as TPA
Blue Cross Blue Shield of Montana	$517,915,809	43.26%	—	$3,825,169	48,420 lives in 2008
Humana Insurance Co.	$111,211,846	9.29%	$7,653	$2,780	
New West Health Services	$82,002,602	6.85%	—	$649,602	16,164 lives in 2008
Assurant Group (combination of Time Insurance Co. (formerly Fortis), John Alden Life Insurance Co., and Union Security Co.)	$61,746,928	5.15%	$1,698,040	$606,519	
United Healthcare Insurance	$59,685,437	4.99%	$266,672	$96,514	
Sterling Life Insurance Co.	$39,401,084	3.29%	$743,945	$268,624	
Allegiance Life & Health Insurance Co., Inc.	$26,705,239	2.21%	$734,394	$267,052	101,500 (in 2008 through allied unit***)

*Market share means the entire health insurance market, which includes major medical policies as well as specific illness and other policies.
**Humana Insurance Co., Sterling Life Insurance Co., and other insurers that offer Medicare Advantage insurance do not pay premium or other taxes on that portion of their business, because of certain exemptions for Medicare Advantage policies under federal law.
***The allied unit is Allegiance Benefit Plan Management, Inc., handling claims for approximately 45 self-funded groups.
Sources: The Montana State Auditor's Office, Blue Cross Blue Shield of Montana, New West, Allegiance Life and Health Insurance Co., Inc., and the Montana Association of Health Care Purchasers.

The top three third-party administrators (TPAs) in Montana pay no premium tax because they are not insurers, although Allegiance Benefit Plan Management, Inc.'s sister company pays the premium tax as an insurer. Nor do the TPAs pay an assessment for the Montana Comprehensive Health Association, although those insurers like Blue Cross Blue Shield of Montana and New West Health Services pay assessments but not as TPAs. As administrators, TPAs typically handle the administration of claims and benefits for self-funded businesses, trusts, and certain MEWAs, none of which pay the MCHA assessment because they are not subject to state laws. In 2008, Allegiance Benefit Plan Management, Inc. covered 101,500 lives in 45 self-funded benefit plan groups. Employee Benefit Management Services (EBMS) covered 47,680 lives in 72 self-funded benefit plan groups. Blue Cross Blue Shield of Montana handled policies for 46,500 lives in TPA plans. New West Health Services provided TPA services for 16,164 lives for three self-funded benefit groups.

What Private Insurance Incentives and Tax Options Currently Exist in Montana?

- ☐ ***Insure Montana***
- ☐ ***Small Business Health Insurance Pools***
- ☐ ***Past "Mandate Light" provisions***
- ☐ ***Medical (and Health) Savings Accounts***

■ ***Insure Montana***

This program, created under 2005 legislation, provides assistance to employers of between 2 and 9 employees as well as to employees of those employers. Available incentives, with conditions, are for tax credits, premium assistance, or premium incentives. If any employee earns more than $75,000 a year (excluding the employer, owner, or partners), the business is ineligible for the program. Slight changes were proposed in 2009 through SB 135, requested by the State Auditor's Office.

The goal has been to help small businesses that have never offered health insurance and other small businesses that may offer insurance on a cost-sharing basis but at rates often too high for all employees to participate. Current funding, which is from a portion of taxes on certain tobacco products as applied to the Health and Medicaid Initiatives Special Revenue Account, is insufficient to meet demand, based on a waiting list for both types of

programs — about 600 businesses waiting for premium assistance/incentives and 65 businesses waiting for tax credits.[43] Expanded funding was included in HB 258 in the 2009 session to help cover businesses on both waiting lists.

To qualify for the first-come, first-served purchasing pool option, a small employer may not have offered group health insurance in the past 24 months. An employer receives an incentive payment for providing partial payment on a group health policy, and the employee receives assistance on premium payments, depending on income and family size.

Insurance under the purchasing pool is made available through one of two Blue Cross Blue Shield plans, which pool customers in the Insure Montana purchasing pool, or through qualified association plans, which are vetted by the insurance commissioner. The State Auditor's Office lists the following Associated Health Plans as eligible to participate in Insure Montana:

- Employers Association of Western Montana
- Montana Chamber of Commerce
- Montana Dental Association
- Montana Logging Association
- Montana Nonprofit Association
- Montana Retailers Association
- State Bar of Montana
- Western Association of Employers
- Western Petroleum.

The Insure Montana website[44] provides samples showing various costs and incentives for a hypothetical employee-only plan, an employee and spouse plan, or a family plan for an employee, spouse, and two children. Actual incentives and assistance may vary, depending on the number of participants and the amount of money available annually for

[43] Undated information from the Montana State Auditor's Office distributed to the 2009 Legislature.

[44] The Insure Montana website is: http://sao.mt.gov/InsureMontana/purchasingpool.asp.

the program. The plans do not free employers or employees from all costs but do reduce costs. In each case, the employer would be paying one-half of the employee only plan, hypothetically $173. The employer premium incentive would be $73, leaving the employer with a $100 cost. The employee premium assistance would vary, ranging from $102.20 for the employee-only insurance to $490.40 for an employee, spouse and two children. The plans have deductibles ranging from $750 (under the Premier Healthlink plan) for an employee-only plan with a 75-25 copay to $3,000 for a family (under the Standard Healthlink plan) with a 60-40 copay.

Table 7: Insure Montana participation and costs as of January 5, 2009

	Purchasing Pool Option	***Tax Credit Option***
Number of Businesses Participating	672	700
Number of Covered Employees	1,862	2,436
Number of Covered Lives (includes employees, spouses, dependents)	3,632	4,098
Average Annual Cost for Business	$2,451.36	$5,455.52
Average Annual Costs for Employee*	$1,526.16	not applicable
Number of Businesses on Waiting List	~600	~65
Actual FY2008 Budget Costs	$5,618,763	$4,028,570

*For the tax credit option, an employer may cover all or part of the costs. The cost for employee is not calculated for this option.

To qualify for a refundable income tax credit, an employer must offer group health insurance for its employees through a fully funded insurance carrier. Additional assistance is available if the employer also pays insurance premiums for an employee's spouse or dependents.

A presentation on Insure Montana at the November 2007 meeting of the HJR 48 subcommittee provided details on the number of participants. Updated information is in Table 7. The Insure Montana statutes are in Title 33, chapter 22, part 20.

- ***Small Business Health Insurance Pools***

Montana has offered small businesses the opportunity to pool risk since 1993. The Montana Chamber of Commerce, mentioned earlier as a qualified association plan, is one of the businesses that has gathered other businesses into a purchasing pool under the small business health insurance act, codified under Title 33, chapter 22, part 15.

While the potential exists for small businesses to pool their risk, which is intended to help lower the underwriting risks for group insurance, not many small businesses have taken advantage of the purchasing pool option, whether through lack of organization or lack of interest from insurers to provide group insurance to these groups of purchasing pools.

- ***Medical Savings Accounts***

Since 1995 Montana has provided an exclusion from income taxes for medical savings accounts (MSAs) for amounts up to $3,000 contributed in one year for an individual account. The accumulated savings and interest in the account remain untaxed unless money is withdrawn from the account for a use other than eligible medical expenses. See Title 15, chapter 61, part 2.

The MSA, phased out elsewhere, still exists in Montana law and was a precursor of a health savings account, which is exempt from taxes under the Internal Revenue Code when used for eligible medical expenses. Both health savings accounts and Montana's medical savings accounts use similar definitions of eligible medical expenses, which can be used for copayments and deductibles required for health insurance policies. Premiums are not generally eligible unless used for long-term care insurance, a continuation of coverage under COBRA,[45] health insurance while receiving unemployment compensation,

[45] Named for the Consolidated Omnibus Budget and Reconciliation Act of 1985, COBRA generally is shorthand for a requirement in federal law for employers with 20 or more employees that offer health insurance to allow continued participation under the group policy when the employee leaves the job. The employee leaving the job may have to pay the premiums plus an administrative fee.

or the costs of Medicare for those 65 and older, other than premiums for supplemental Medicare policies.[46]

The major differences between the Montana MSA and the federal HSA are:

- A HSA is tied to a high-deductible health insurance plan. The MSA does not have that requirement.
- The HSA offset affects federal income taxes and, consequently, state income taxes.
- The MSA offset applies only to Montana income taxes.

The expected benefit of MSAs (and HSAs) is to allow people to save money in an account that can be used tax-free on medical expenses, thus allowing people to buy insurance with a higher deductible (and thus a lower premium). The thought is that MSAs and HSAs help remove the middle man of insurance at the preventive care level in particular so that people actually will pay for optional health care out of their own account and, thus, use health care more wisely. Not everyone feels the MSAs and HSAs work as intended. A spokesman for MHA, an Association of Montana Health Care Providers, said informally that Montana hospitals are finding that patients are not using their health savings accounts to pay hospital bills, although no specific investigation has been done.

Concerns about MSAs (and HSAs) include:

- A potential to delay preventive care rather than pay for prevention out of the medical or health savings account. This suggests the potential for higher-cost medical problems from delayed care.
- A MSA or HSA is intended to build up over time to be able to address the out-of-pocket costs of medical care. For people faced with an unexpected illness, accident, or turn of events, the medical or health savings accounts may not contain sufficient savings to cover health care costs until a major medical insurance policy kicks in. A MSA or HSA of $10,000 may seem adequate for healthy 25-year-old newlyweds who opt for a major medical policy with a $10,000 deductible and a

[46] Internal Revenue Service Publication 969 (2008), "Health Savings Accounts and Other Tax-Favored Health Plans". http://www.irs.gov/publications/p969/ar02.html#en_US_publink100038782.

20% copayment for incurred bills. But, unless the couple has saved that $10,000 the amount they are required to pay for an emergency may seem as out of reach as the total medical costs.

- Money saved in a MSA may be tapped at the end of the calendar year under the penalty of paying ordinary income tax on the amount plus a 10% penalty. Because an account holder can tap the account, there is also the potential to not have enough money in savings for catastrophic costs.

The MSA or HSA remains an option for forward-thinking people to address the link between those paying for services and medical costs. The MSA is exempt under state policy but not federal income tax policy. The HSA is tax exempt under both federal and state laws.

- ***Other Tax Benefits***[47]

- Self-employment premium deductions. Both federal and state law allow self-employed taxpayers to deduct health insurance premiums as a business expense. According to the Department of Revenue (DOR), self-employed taxpayers can take the above-the-line adjustment to gross income for premiums even if they take a standard deduction. In contrast, most medical expenses that offset income are included under itemized deductions (see below). DOR data indicate that of the 246,696 households that itemized deductions in 2006, less than 9% or 20,940 households claimed as a self-employed business expense a deduction for health insurance. This amount topped $95.7 million.
- Medical expenses that surpass 7.5% of a taxpayer's adjusted gross income may be deducted on the federal income tax return, including medical premiums. A taxpayer claiming this deduction must itemize. Of the households that itemized deductions in Montana in 2006 about 39% claimed health insurance premiums as a deduction (which does not include those who may have been able to make a claim but took a standard deduction nor does it indicate how much of the 7.5% in

[47] Information for this section was supplied by Dan Dodds of the Montana Department of Revenue. See Appendix III.

excess of adjusted gross income went for health insurance premiums and how much for medical expenses.).

- Medical savings account or health savings account deductions were claimed in 2006 by 13,720 households.
- Employer-sponsored health insurance. Under 15-31-132, MCA, an employer with 20 or fewer workers may receive a tax credit for paying at least 50% of the health insurance premium. The tax credit is available at $25 a month if the employer pays 100% of the employee's premium and less than that if the employer pays less than 100%. The tax credit can be used only for a maximum of 10 employees, for 36 months, and only once in every 10-year period. In 2006, there were 641 individuals who claimed $559,023 in credits and 138 corporations claiming $134,711 under this statute. Under the Insure Montana program, employers participating in the tax credit program also can receive a tax credit as specified in 33-22-2006 through 33-22-2008, MCA. In 2006 there were 591 individuals claiming a total of $1,832,523 in tax credits and 147 corporations claiming $773,560 in credits.

Use of Health Care Trusts by the Montana Contractors Association, MACO and Others

At the November subcommittee meeting, Martell Hilderbrand of the Montana Health Trust Insurance Plan for the Montana Contractors Association and Owen Voigt of the Montana Association of Counties (MACO) Health Care Trust shared information about how health care trusts work. The health care trusts in Montana tend to be self-funded by employers with basic similarities. A trust operates as a separate entity and determines the benefits, premiums, and whether reinsurance is needed from an outside entity and whether the need for reinsurance is triggered by an individual surpassing a certain dollar amount of covered obligations or the entire trust surpassing a certain dollar amount of covered obligations.

Mr. Hilderbrand noted that the contractors' trust covers 75 employers with 2,700 employees and 3,800 dependents of employees. The trust offers insurance "portability" to an employee who may work for one period for one contractor who participates in the trust and another period for another contractor participant. Given the seasonal work of many

contractors, the trust also offers a way for employees to build up coverage for times when they may not be working.

Mr. Voigt described how the MACO Trust provides counties, special districts, some cities and towns, and retirees of those public groups with health insurance by providing separate plans financed in a variety of ways, including special taxes and county general taxes. In this sense, the trust is similar to an insurance exchange or the Massachusetts "Connector", which provides options to employees on types of insurance coverage vetted by a nonemployer familiar with insurance.

Montana Comprehensive Health Association

Established by legislation in 1985 and codified in Title 33, chapter 22, part 15, the Montana Comprehensive Health Association (MCHA) is an insurer of last resort for those who have been turned down for insurance by at least two insurers or those whose insurance has been terminated because a company laid off workers or terminated its insurance policy. Those in the latter group access MCHA insurance under "portability" provisions as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which says, in part, that a state must have either guaranteed issue or a portability plan. Montana does not have guaranteed issue but applies the portability terms to MCHA. For those without sufficient financial resources who are considered "uninsurable" in the first "traditional" group, MCHA offers a premium assistance plan, currently for those at 150% of the federal poverty level.

Table 8: MCHA data as reported in the Annual Report for year ending June 2008

	Premium Assistance	Traditional	Portability Plan
Length of time enrolled	41 months	32 months	26 months
Enrollment	255 — 8% of total	1,364 — 45% of total	1,397 — 47% of total
Total revenue by plan (& percent)	$1,953,207 (8%)	$11,213,006 (45%)	$11,762,194 (47%)
Claims paid hospitals (inpatient & outpatient) (& percent of total)	$2,077,744 63%	$5,763,051 55%	$5,731,886 49%
Claims paid physicians (& percent of total)	$614,220 19%	$2,377,348 22%	$2,271,243 20%
Most claimed major diagnostic unit and amount paid out	spine, bone marrow $865,646	musculoskeletal $1,241,591	musculoskeletal $1,349,062

THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION (MCHA) IS AN INSURER OF LAST RESORT FOR THOSE WHO HAVE BEEN TURNED DOWN FOR INSURANCE BY AT LEAST TWO INSURERS OR THOSE WHOSE INSURANCE HAS BEEN TERMINATED BECAUSE A COMPANY LAID OFF WORKERS OR TERMINATED ITS INSURANCE POLICY.

Tanya Ask of New West Health Partnership described MCHA for the subcommittee at its November meeting. She is one of the representatives of Montana's major insurers who has had a seat on the MCHA board. Other information on MCHA is available at the organization's website, including specific information on premium rates for enrollees. For example, premium rates for enrollees are related to age, ranging from a low of $88 a month paid for a child under the age of 18 under a traditional plan with a $10,000 deductible to a high of $1,335 a month for someone 64 and older under a traditional plan with a $1,000 deductible.[48]

Blue Cross Blue Shield of Montana has been awarded the contract to provide insurance to MCHA since operations began in 1987. Contracts are for a 3-year period.

[48] For more information on MCHA see: http://www.mthealth.org

Among issues of concern related to MCHA are:

- self-funded plans do not contribute to the assessment for MCHA;
- premiums tend to be high especially for those who are no longer teenagers, which may result in short-term use of MCHA until a person can no longer afford premiums; and
- the insurer of last resort has a limitation on preexisting conditions.

The premiums paid by MCHA enrollees are insufficient to cover costs and are supplemented by assessments on insurance carriers operating in Montana. Self-funded health plans and MEWAs do not contribute to the MCHA — a bone of contention among some insurers because self-funded plans and MEWAs can be written in a way that limits lifetime benefits so that once a person with serious medical problems reaches the lifetime limit that person is dropped from the self-funded plan's coverage. The result is a type of self-funded plan "dumping". The issue was part of discussions during both the November 2007 and the February 2008 meetings as subcommittee members heard that some third-party administrators urge groups with as few as 50 members to self-fund. The third-party administrators, as separate noninsurance entities, also do not contribute to MCHA, yet they benefit by administering many of the self-funded plans. From the self-funded group's perspective, pooling provides group members with a benefit that helps with occasional unexpected illnesses and keeps premiums reasonable by tying the benefits to low lifetime limits that move a person with chronic or unexpected, costly medical usage off of self-funded insurance.

Testimony offered in favor of House Bill 250 in the 2009 session by the State Auditor's Office noted that the lack of contributions by self-funded health plans "has placed an economic strain on the MCHA".[49] MCHA advocates sought a general fund appropriation in House Bill 250 to help assure solvency and keep premiums in a range that enrollees could afford but neither the appropriation nor the bill succeeded. The bill, which was tabled in the Senate, also would have increased to 200% of the federal poverty level the

[49] Testimony in favor of House Bill 250, presented on behalf of Montana State Auditor Monica Lindeen at the House Business and Labor Committee, January 30, 2009.

eligibility for premium assistance and allowed up to $2 million in lifetime benefits rather than the $500,000 currently allowed.

Data from MCHA indicate that the average age for a member of MCHA is 48.5 years and that an average enrollment period is 32 months on the traditional plan. Officials with MCHA indicate that, while some enrollees are on MCHA plans for years, several people are on MCHA only briefly. No surveys have been done to indicate whether the reason for the brief enrollment is an inability to pay premiums, obtaining a job with health insurance coverage, surpassing the lifetime benefits limit, or some other reason.

Although designed to cover the "uninsurable", the MCHA traditional plan has a preexisting condition limitation, which means that coverage is not available for the preexisting condition for 12 months for those not eligible for premium assistance and for four months for those who are eligible for premium assistance. MCHA specifies that this limitation includes pregnancy but does not apply to newborn children or children newly adopted because mandates require coverage at least initially in these cases. A person with a preexisting condition not able to obtain other insurance and thus on MCHA's doorstep still has to cover that illness or condition for a period without insurance until coverage kicks in. However, if the enrollee has had prior creditable coverage (meeting certain requirements), the preexisting condition limitation is waived. Enrollees admitted under the portability plan provisions also have no limitation on preexisting conditions.

Montana's Public Health Care Programs and Coverage

This section will review overall information on the public health care programs and coverage, including information provided to the subcommittee at its November and February meetings. Montana's main public health assistance programs are Medicaid and the State Children's Health Insurance Program (CHIP), both of which depend on federal and state funding.

- ***Children's Health Insurance Program***

The subcommittee heard from John Morrison, then State Auditor and one of the proponents for the Healthy Montana Kids Initiative, an initiative that took shape over the same interim period as the subcommittee studied health care issues. Morrison spoke on

the initiative in November as plans were taking shape and again in February as part of a discussion about the Children's Health Insurance Program, which was the program mainly affected by the Healthy Montana Kids Initiative, I-155.[50] The statutory references for CHIP are Title 53, chapter 4, part 10.

MONTANA'S MAIN PUBLIC HEALTH ASSISTANCE PROGRAMS ARE MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), BOTH OF WHICH DEPEND ON FEDERAL AND STATE FUNDING.

Prior to voter approval of the Healthy Montana Kids Initiative in November 2008, the Children's Health Insurance Program covered children whose family's income was under 175% of the federal poverty level, raised to that level by the 2007 Legislature from 150%. Other eligibility provisions included a requirement that the child be a Montana resident, not be eligible for Medicaid, not have other creditable health insurance, not be 19 years old or older, or not be eligible for insurance through a parent employed by the state or the Montana University System. The Medicaid eligibility provision was one of the problems that the Healthy Montana Kids Initiative sought to address because the parents of children eligible for CHIP might be sporadically eligible for Medicaid. Other factors related to CHIP and Medicaid include:

- The federal share under CHIP is larger (approximately 77%) than for Medicaid (approximately 67%, depending on the state's economy), which may be seen as a benefit by those who do not mind the federal government paying more of the costs and a detriment from the perspective of those concerned about federal payments and reliance on them.
- CHIP, provided in a fully insured plan, is a limited benefit, which means that if money starts to run out, services can be cut or eligibility limited. Conversely, Medicaid is considered an entitlement. Although a state statute, 53-6-101, MCA, allows limits on Medicaid services if funding is insufficient, federal law requires early and periodic screening and diagnosis, plus treatment for those services allowed by federal law for children eligible for Medicaid, which means the federal

[50] For the text of the initiative see: http://sos.mt.gov/Elections/archives/2000s/2008/I/I-155.asp.

government would require those services regardless of a fiscally imposed state limit.

The Healthy Montana Kids Initiative sought to smooth the transition between CHIP and Medicaid as well as provide premium assistance to children whose parents needed extra help to put the children on their employer-sponsored plan.

The benefits of CHIP both before and after the Healthy Montana Kids Initiative included:

- no premiums paid by families. (State funding was through the tobacco tax originally and after the Healthy Montana Kids Initiative through a percentage of insurance premiums put into a state special revenue account. The premiums previously had flowed into the general fund.)
- small copayments for those above 100% of the federal poverty level and not enrolled tribal members. The copayments are between $3 and $5 per visit but no more than $215 a year for a family. No copayments are required for well-child checkups, shots, dental visits, or eyeglasses.
- coverage for office visits, including well-child checkups and sports or job physicals, shots, emergency care, hospital care, prescription drugs, lab and x-ray services, hearing and vision exams, mental health services, substance abuse services, and dental visits.

After the Healthy Montana Kids Initiative received voter approval in November, Medicaid eligibility based on the family's combined income could be established at 185% of the federal poverty level for children and 250% of the federal poverty level for CHIP, although the 2009 Legislature was weighing adjustment of the CHIP percentage out of concern over funding.[51]

[51] In addition to changing the income eligibility levels to 250% of federal poverty levels for CHIP and 185% of federal poverty levels for Medicaid, the Healthy Montana Kids Initiative as approved by voters removed assets tests for children's coverage, provided that a percentage of insurance premiums be diverted from the general fund to a state special revenue account, and specified that the state special revenue funds be used to pay for enrollment levels in CHIP and Medicaid above those in effect on Nov. 4, 2008. The initiative also stated that DPHHS could set lower eligibility levels based on available funding.

Table 9: Montana Medicaid enrollment, expenditures

	Enrollment - %	Expenditure -%
Those 65 years and older	7,583 - 9%	$158,522,107 - 22%
Blind and disabled	19,359 — 23%	$323,444,945 - 46%
Other adults, including pregnant women	11,937 — 14%	$71,424,882 - 10%
Other children, including infants	45,281 - 54%	$152,288,912 - 22%

From the Montana Medicaid Program Annual Report for State Fiscal Year 2007/2008

As reported at the February subcommittee meeting, CHIP served 15,798 children as of January 1, 2008. Roughly 30,000 more children were expected to be covered after implementation of the Healthy Montana Kids Initiative, although the numbers depend on funding. At 200% of the federal poverty level, approximately 15,000 additional children would be eligible.

- ***Medicaid***

At a subcommittee meeting in Helena in February, John Chappuis and other officers of the Department of Public Health and Human Services reviewed Medicaid in addition to the Children's Health Insurance Program. As one of the state's larger budget items,[52] Medicaid generates interest at both the fiscal and the social service levels. Constraints of the one affect the other. Medicaid similarly has ripple effects on the total Montana economy, in part through its reimbursement provisions for health care providers. If efforts at cost control lead to decreases in reimbursement of health care providers, fewer providers may be willing to serve the Medicaid population, which could mean more cost-shifting for hospitals and facilities that do accept Medicaid but are not fully reimbursed for

[52] A 2008 brochure prepared by the Legislative Fiscal Division on Medicaid states that funding for Medicaid services amounted to nearly 21% of all funds appropriated in House Bill 2 for the 2009 biennium.

Table 10: Medicaid categories and eligibility

Category	Eligibility factors
Children up to age 5*	Family income at or below 133% of federal poverty level (FPL)**
Children ages 6 up to 19 years old*	100% of FPL
Nonworking parents	37% of FPL
Working parents	64% of FPL
Pregnant women	150% of FPL
Medically needy individuals	73% of FPL
Medically needy couples	54% of FPL
Poor elderly or disabled people (for those over 65 there are ways to help pay for Medicare through Medicaid)	Depending on income and if receiving SSI (Supplemental Security Income)
Women between the ages of 50 and 64 may be eligible for the Montana Breast and Cervical Cancer Program, which provides Medicaid benefits.	200% of FPL or less and no comprehensive health insurance coverage that covers the treatment or Medicare. Also must have been screened through the program and diagnosed with breast or cervical cancer or a precancerous condition.

*Eligibility terms prior to passage of the Healthy Montana Kids Initiative. After passage, eligibility is generally 185% of FPL.
**The federal poverty level depends on the size of the family as well as income levels.

costs (see discussion on cost-shifting above). In the 2007 session, legislators authorized a 6% rate increase for physicians and psychiatrists. The increase starts in 2010. The fund established for this is in 53-6-1201, MCA. Through a hospital bed-tax and a nursing home utilization fee the state seeks to help fund its Medicaid inpatient facility costs, Chappuis told the subcommittee.

Department handouts at the meeting showed that people eligible for Medicaid had decreased from a high in March 2006 of 82,952 to 77,438 as of January 2008, which included 30,981 adults and 46,457 children. As of March 2009, the total enrollee count was up again, to 80,381. Enrollment fluctuates with the economy, Chappuis told the subcommittee, which means that as the economy worsens the Medicaid caseload increases.

■ ***Medicaid waivers and state plan options***

As a federal-state program, Medicaid has myriad regulations. Under a state plan associated with Medicaid under the provisions of Title 53, chapter 2, part 2, the state lays out eligibility and service options. The state plan and any amendments must be submitted to U.S. Department of Health and Human Services for review and approval.[53] If the state wants to go beyond what the standard federal regulations allow, waivers are possible under Section 1115 of the Social Security Act, called the Health Insurance Flexibility and Accountability Demonstration Waiver, which is used in various states to experiment with different options for publicly funded health care for eligible populations. Approval of Section 1115 waivers by the U.S. Department of Health and Human Services has declined over the years. (Montana references Section 1115 waivers under 53-2-215, MCA.)

The state has used another possible waiver, the Section 1915 waiver, for community-based services for persons with developmental disabilities, for adults with a severe and disabling mental illness, and for home and community-based services for those 65 and older and those with a physical disability. Use of waivers in Montana is limited.

At the February subcommittee meeting Chappuis stressed that waivers must be cost neutral to the federal government. He gave an example of efforts to maintain elderly people in their own homes and keep them out of nursing homes or state institutions that must balance out in terms of costs not spent on institutional care.

■ ***Who is covered under Medicaid?***

As in most states, Montana's eligibility requirements for Medicaid include legal residency, with noncitizens allowed to obtain benefits if they have the proper immigration documents. Income is the key eligibility for most categories, as indicated by Table 10. Adults who are not aged, blind, or disabled may not have assets exceeding $3,000, generally excluding a home and a motor vehicle.

[53] Contingency clauses on certain CHIP-related statutes also depend on approval by the U.S. Department of Health and Human Services of changes made in state law.

DPHHS, as administrator of the state's Medicaid program, also provides 100% federal pass-through funding for Medicaid services provided by IHS facilities or IHS-recognized counterparts. The state has contracts with the Indian Health Service in Browning, Crow Agency, Harlem, Hays, Heart Butte, Lame Deer, Lodge Grass, Poplar, Pryor, St. Ignatius, and Wolf Point. All these provide outpatient services. Browning, Crow Agency, and Harlem also provide inpatient services. The Rocky Boy Reservation has a separate contract for services and the Chippewa Cree Tribe has an agreement with the state to handle Medicaid eligibility determinations for three family-related programs on the reservation. For more on access to health care on reservations, see Section 6.

Mandates

The Committee discussed whether one of the ways to expand health insurance coverage would be to enable insurers to offer individual policies that had few of the mandates required currently by state law. Federal mandates obviously would be retained. Mandates that are federally required include: newborn coverage if a policy offers maternity benefits, post-mastectomy care and reconstruction, and minimum stay after childbirth.

Montana mandates that affect individual policies are:

- provider-related (requiring coverage by chiropractors, physical therapists, and others) ;
- mammograms;
- severe mental illness;
- PKU-Metabolic disorders (newborn screening);
- well-child care and immunizations;
- continuation of coverage for disabled dependents;
- disclosure of cancer screening coverage; and
- coverage of dependents to age 25.

Possibly covered under individual policies, depending on how statutes are read, are: chemical dependency, mental health parity, convalescent care, and a pre-existing condition look-back period, which may or may not be considered a mandate.

Also under the mandate mantle are provisions that incorporate court decisions or opinions of the Montana Attorney General. The latter, which have the force of law until decided by a court, generally have resulted in policies covering maternity care (based on nondiscrimination by sex) and contraception, which similarly comes under human rights/civil rights nondiscrimination rulings. An example of a court decision that insurers might choose to follow rather than face a lawsuit is the Snetsinger decision by the Montana Supreme Court, which held that if a group insurer (such as the Montana University System) extends benefits to an unmarried man and woman who cohabitate and sign an affidavit that they are a couple, then based on the equal protection under the laws principle the insurer also should allow benefits to a same-sex couple.[54] Some insurers say they leave the question up to the entity buying the policy, but generally the insurers do not operate contrary to the court decision.

A calculation by Blue Cross Blue Shield of Montana in 2006 indicated that all mandates required in Montana, both federal and state, added up to about $22 a month per person per premium. The $22 figure did not distinguish between group and individual policies. Individual policy costs for mandates presumably would not be as high because they do not have the full complement of state-required mandates. Nor did the estimate indicate whether certain mandates save money downstream by preventing worse illnesses (as through immunizations).

A CALCULATION BY BLUE CROSS BLUE SHIELD OF MONTANA IN 2006 INDICATED THAT ALL MANDATES REQUIRED IN MONTANA, BOTH FEDERAL AND STATE, ADDED UP TO ABOUT $22 A MONTH PER PERSON PER PREMIUM.

The Committee considered whether allowing a "mandate light" policy would increase the affordability of health insurance, recognizing that some insurance may be better than no insurance at all. The following issues were discussed:

- the rationale of charging everyone for benefits that some might not use at all;

[54] Snetsinger v. the Montana University System, 104 P.3d 445 (2004) can be found at: http://fnweb1.isd.doa.state.mt.us/idmws/docContent.dll?Library=CISDOCSVR01^doaisd510&ID=003719696.

- the costs of mandates for insurance companies to provide certain services or include coverage by certain providers, which insurers say increases paperwork and administrative costs even when less costly providers are included along with more costly providers;
- the benefit of requiring upfront, preventive coverage to avoid downstream costs; and
- the projected increased cost of overall insurance, which may result in fewer people being able to afford basic insurance.

Public comment included many opponents to a "mandate light" individual policy at meetings in May and June and proponents who encouraged the Committee to consider a mandate "light" policy as one way of increasing coverage. Summaries of proponents and opponents testimony is available in Committee minutes from May and June 2008. The Committee received two staff reports on mandates and requested a bill draft for discussion purposes. The reports and bill draft, available on the Committee website,[55] included:

- A briefing paper titled Mandates and Insurance in Montana.
- A bill draft for discussion purposes, LC7777, for minimum mandate individual policies.
- A memo on mandate "light" research with comments from Montana insurers.

This review of mandates is not the first by the Montana legislature. A 1992 interim study reviewed health insurance mandates as did an earlier Health Care Cost Containment Advisory Council established by Governor Ted Schwinden in January 1985. That council recommended an interim study of the effects of existing mandated benefits on health insurance costs and the effects on health insurance costs of mandating new benefits or

[55] To see the report, go to: http://leg.mt.gov/content/committees/interim/2007_2008/econ_affairs/meeting_documents/mandates_w_coverdraft.pdf. To see the memo, go to: http://leg.mt.gov/content/Committees/Interim/2007_2008/econ_affairs/meeting_documents/mandate_memo.pdf. The proposed bill draft is available at: http://leg.mt.gov/content/committees/interim/2007_2008/econ_affairs/meeting_documents/LC7777_revised.pdf.

eliminating existing ones.[56] The 1991-92 interim committee study of mandates recommended that a commission be established to review mandated health insurance benefits. One option studied was a Montana Health Care Cost Commission that would review proposed mandates or mandates being eliminated or amended for social impacts, financial impacts, medical efficacy, and the effects of balancing each of the impacts.[57] The study committee's proposed legislation was not enacted.

In 2003 the legislature provided for a demonstration project aimed primarily at minimizing mandates for a prevention-oriented plan that did not include hospitalization. New West reported in mid-2008 that the company had sold fewer than 100 of the policies over the roughly 5 years that the option was in place. The demonstration project statute, 33-22-262, MCA, is set to expire in June 2009.

[56] Montana Legislative Council, "Review of Mandated Health Insurance Benefits", October 1992, p. 11.

[57] *Ibid.*, pp. 13-14.

SECTION 4: Reports on Health Cost and Access Issues Studied by the Children, Families, Health, and Human Services Interim Committee under Senate Joint Resolution No.15

This section provides a brief overview of the issues studied by the Children, Families, Health, and Human Services Interim Committee under Senate Joint Resolution No.15 as they related to the HJR 48 study of health care. Although the Economic Affairs Interim Committee had created a subcommittee with the plan of working with a subcommittee of the Children, Families, Health, and Human Services to jointly study HJR 48 and SJR 15, the Children, Families, Health, and Human Services Committee chose to retain the full oversight of SJR 15 itself. The following issues were part of the SJR 15 study:

- ☐ Pricing Transparency
- ☐ Charity Care
- ☐ Electronic Health Records
- ☐ Billing Efficiencies
- ☐ Hospice and End-of-Life Care
- ☐ School Nurses and Early Childhood Access to Care
- ☐ Community Health Centers
- ☐ Economic and Insurer Credentialing
- ☐ Specialty Hospitals and Conflict of Interest Issues
- ☐ Availability of Services and other information from a Montana Health Care Facilities survey

Pricing Transparency

Pricing transparency is short-hand for several terms aimed at improving consumer awareness of health care costs and quality. Several states have adopted legislation to enhance the ability of consumers to compare costs and quality. The Children, Families, Health, and Human Services Interim Committee (CFHHS Committee) studied various issues related to pricing transparency during the 2007-2008 interim.

Typical options for transparency include information on:

- costs for procedures at area hospitals (inpatient and outpatient) and ambulatory care centers (outpatient);
- mortality, error rates, and other quality issues related to the procedures; and
- cost calculators provided by insurance companies to help an insured person determine out-of-pocket costs for a procedure.

PRICING TRANSPARENCY IS SHORT-HAND FOR SEVERAL TERMS AIMED AT IMPROVING CONSUMER AWARENESS OF HEALTH CARE COSTS AND QUALITY.

A work group associated with the informal Montana Health Care Forum kept attention focused on the transparency issue. That work group included representatives of hospitals, doctors, insurers, the CFHHS chair, and health care organizations. In July the board of directors of MHA, an Association of Health Care Providers, agreed to independently pay for participation in the Price Point system, which is used in more than 10 states to gather from health care facilities such data as costs for procedures and facility room charges. In many of these states the area hospital association collaborates with the Price Point system. MHA initiated its informational website — http://www.mtinformedpatient.org — in January 2009.

Some states prefer maintaining more control over transparency issues. States like Pennsylvania have spent millions of dollars providing analysis on both pricing and quality among hospitals in that state. Arizona contracts with the Rand Corp. to handle analysis for its health care providers' pricing and quality comparisons. For more specific information, see the final report for the CFHHS SJR 15 study and related appendices.

Charity Care

Montana's not-for-profit hospitals receive a tax exemption under both federal and state laws. That tax exemption generally is associated with the idea that hospitals provide a community benefit, which includes charity care, education, and research, among other items recognized by the Internal Revenue Service in its Form 990H. In exchange for the community benefit, the community does not tax the hospital for health care-related revenues.

During the 2007-2008 interim as part of its SJR 15 study of health care facilities and access, the CFHHS Committee reviewed tax policies related to hospitals as well as a charity care report conducted for the first time by the Montana Attorney General's Office under its charge to monitor nonprofit corporations and under the auspices of its Office of Consumer Protection. Several other states' attorneys general also conducted similar studies out of a concern that the community benefits provided were not comparable to the value of the income tax deduction. A second report expanding on the charity care topics was released in December 2008.

Findings from both the January 2008 and December 2008 reports indicated that charity care varies at the state's 11 major hospitals. After the report came out in January 2008, disagreements arose over the definition of charity care and whether the base revenue analysis was appropriate. Two community benefits analyzed in the report were: lost income from charity care, or the charges/costs written off for those determined in advance as unable to pay, and the difference between what Medicaid patients actually cost versus what Medicaid paid. The report's author, Larry White, a professor at the University of Montana and former chief executive officer of St. Patrick Hospital in Missoula, recommended that hospitals improve their efforts to determine whether a patient is eligible for charity care in advance and thus avoid the cost of trying to collect after the fact.[58] The followup report in December 2008 added community health improvement services and subsidized health services along with a category termed "all other". The second report calculated community benefits in comparison to both operating and total income. One hospital, Northern Montana Hospital in Havre, showed negative operating income and a total cost in community benefits of nearly $3.9 million, more than half of which was from subsidized health services.[59]

Of interest, the report pointed out that some hospitals in Montana have a much higher percentage of Medicaid patients than other hospitals do. In the first report, charity and Medicaid costs exceeded the value of the tax exemption for 8 of the 11 hospitals. The

[58] White, *op. cit.*, January 2008, p. 7 (p. 10 of on-linen version).

[59] White, *op. cit.*, December 2008, pp. 6-7. (pp. 8-9 of online version).

second report listed all hospitals as providing a greater proportion of community benefits than they gained in tax exemptions.

Electronic Health Records

Throughout the 2007-2008 interim a nonprofit organization, HealthShare Montana, reported to the CFHHS Committee on its proposal to develop a health information exchange for Montana to be used for disease and preventive care management. Specifically, the volunteer group representing 55 organizations[60] has been working to implement an electronic continuity of care record that would allow health care providers to share information about a patient's medical history in a secure (privacy-protected) environment. Improved efficiency and higher quality care plus lower costs from improved chronic disease outcomes and fewer repeated tests were among the benefits that proponents said electronic health records could provide.

HealthShare Montana asked the CFHHS Committee for legislative support for a demonstration project that would serve up to 100 providers. The group requested that the governor include $1.5 million for the demonstration project in his 2010-2011 budget and also has requested that Montana's Congressional delegation include an appropriation for at least half of that amount (which would lower the state's investment to $750,000). The CFHHS Committee sent a letter to Governor Schweitzer supporting the budget request[61] and voted at its August 2008 meeting to sponsor a committee bill supporting funding for the demonstration project (LC339), which became House Bill 86 and died in committee.

As one example of potential cost savings from better chronic disease management, information presented by HealthShare Montana indicated that savings of $2,000 per patient per year could be expected from "avoided complications" just by using a continuity of care record to track and monitor the estimated 60,000 diabetics in Montana, of which

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[60] HealthShare Montana has a 21-member board that includes representatives from state government, health insurance payers, consumer groups, physicians, and health care facilities. See www.healthsharemontana.org or http://healthinfo.montana.edu/healthit.html) for more information.

[61] The CFHHS letter to Governor Schweitzer regarding budget inclusion of a continuity of care demonstration project is at: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sjr15schweitzer-hitltr.pdf.

32,400 are estimated to have less than ideally controlled illnesses. The overall cost savings for improved diabetes management, the group estimated, could be up to $65 million a year once disease management systems are fully deployed. [62]

Although internet firms Google and Yahoo both offer the opportunity for users to establish personal health records, personal health records are not accessible if a person is in an emergency room and unresponsive. They also are not necessarily helpful if information is not current or comprehensive. Nor do they offer any disease management capabilities. The HealthShare Montana proposal is for a system that allows health care providers and hospitals to use their current software but link to a server that would be accessible to other participants.

As stated on the Transparency Work Group page of the Montana Health Care Forum, a continuity of care record would make available clinical information to a provider or a health care facility extending care to a patient. The patient also may have access to the information. (http://healthinfo.montana.edu/healthit.html) HealthShare Montana anticipates that the continuity of care record and electronic health records would become self-sustaining by 2011 (either through payments by providers or sale of aggregated data).

The pilot project would take place at 5-10 sites and include a mix representing a hospital, hospital emergency department, clinic, long-term care facility, primary care provider savvy enough to handle health information technologies, and a provider who has no health information technology access. HealthShare Montana estimates that invitations to participate would be extended across the state and appropriate participants selected from respondents.

Billing Efficiencies

One goal of consumer-directed health care, a focus of the SJR 15 study by the CFHHS Committee, is to provide sufficient information for a consumer to make decisions regarding health care. One aspect of this is being able to understand hospital and

[62] HealthShare Montana, An Overview, August 2008. PowerPoint presentation, slide titled "Preventable Complications of Diabetes."

provider bills. A presentation by legislative staff attorney Eddye McClure at a January CFHHS meeting highlighted the problems that consumers have in deciphering billing, particularly when many of the consumers are dealing with illnesses that make them less than combat-ready for doing battle with accounting departments. McClure showed one small stack of bills provided by the Virginia Mason Clinic, which incorporated both facility and provider charges in one bill where procedures and charges lined up. She contrasted that with several file folders of bills from a Montana hospital, each with a different accounting clerk, which featured only hospital bills. Her provider bills came separately. Although part of the difficulty arises from different types of hospital systems (one with employed doctors and the other with doctors outside the hospital's employ), the confusion is exacerbated by difficulties in obtaining itemized statements and a lack of standardized billing.

VARIOUS STATES HAVE TARGETED STANDARDIZED BILLING BY HEALTH CARE PROVIDERS AS ONE WAY OF ENCOURAGING CONSUMER AWARENESS OF HEALTH CARE COSTS AND CREATING COST-EFFICIENCIES THROUGH STANDARDIZATION.

Various states (for example, Illinois, Texas, and Vermont) have targeted standardized billing by health care providers as one way of encouraging consumer awareness of health care costs and creating cost-efficiencies through standardization. A Montana statute, 50-4-505, MCA, allows but does not require the commissioner of insurance to adopt "by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims...". The statute covers only health insurers and typically would be in Title 33, which governs most of the insurance commissioner's actions. However, the statute is in Title 50, chapter 4, in the realm of health policy.

Hospice and End-of-Life Care

The CFHHS Committee requested information on hospice services in Montana as part of the committee’s focus on consumer-directed health care. A main concern voiced by one of the CFHHS Committee members was that the greatest health expenditures in a person’s life typically come in the last 6 months of life. The hospice philosophy is to avoid extraordinary health care measures to extend a person’s life in favor of palliative care and

better qualify of life. The CFHHS Committee also received updates[63] on the number of people who have signed up with the Montana Attorney General's Office since creation of the end-of-life registry (6,800) along with 475 health care providers. The end-of-life registry was created by HB 742 in the 2005 legislative session.

School Nurses and Early Childhood Access to Care

School nursing is unevenly available in Montana, with only certain school districts dedicating resources to having a school nurse available. Services provided by school nurses include the expected help with medical emergencies but also assistance in connecting families with health care if the families do not have health insurance. School nurses also monitor children for early signs of mental illness, in an attempt to catch problems before they become serious. The President of the Montana Association of School Nurses, Sue Buswell, and a representative of the National Association of School Nurses, Kathy Boutilier, asked the CFHHS Committee March 18, 2007, to consider recommending to the legislature that school nursing be a greater priority in Montana school districts.

Community Health Centers

Federally qualified health centers offer a wide range of primary health care services on a sliding scale based on ability to pay. In Montana there are 12 federally funded Community Health Centers plus a Migrant Health Program, and a Health Care for the Homeless Program. Satellite clinics provide services in an additional 12 communities. A report prepared for the CFHHS Committee by Lil Anderson of the Yellowstone City-County Health Department said that 1 in 12 Montanans receive care from a Community Health Care Center. [64]

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[63] For more information on hospice programs and the end-of-life registry see the SJR 15 final report and the CFHHS Committee website: http://leg.mt.gov/content/committees/ interim/2007_2008/ child_fam/assigned_studies/sj15hospicemarch2008.pdf.

[64] Lil Anderson prepared a Powerpoint presentation, "Delivering Health Care through Community Health Centers", presented to the Children, Families, Health, and Human Services Committee, Jan. 25, 2008. http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/ sj15commhealthcntrsjan2008.pdf.

The requirement to serve regardless of ability to pay results in Montana Community Health Care Centers serving a patient population of which 56% are uninsured, 19% have private insurance, 14% are on Medicaid, 9% on Medicare, and 2% are on the Children's Health Insurance Program (CHIP), according to Anderson's information. The Deering Clinic in Yellowstone County, as one example, had 17,930 patients in 2006, of which 77% participated in the sliding fee scale. The clinic charges a $10 minimum fee for a medical visit or service and $20 for a dental visit.

Health care providers who work at the clinics qualify for coverage under a federal tort protection act, which means that these providers do not have to carry malpractice insurance. For the community of Libby, that provision has allowed two doctors to remain in practice delivering babies when the cost of malpractice insurance threatened to drive them out of practice.

In the 2007 session the legislature provided $1.3 million for the biennium that could be used either to create and support a community health center or expand services or infrastructure at existing community health centers. An advisory group established by HB 406 requested proposals from communities for a state-funded community health center model that included primary care services. The goal was to ultimately move the state-funded community health center to a federally qualified and funded community health center. The community of Kalispell received the grant out of the three communities that applied. (Hamilton and Lewistown also bid).

IN THE 2007 SESSION THE LEGISLATURE PROVIDED $1.3 MILLION FOR THE BIENNIUM THAT COULD BE USED EITHER TO CREATE AND SUPPORT A COMMUNITY HEALTH CENTER OR EXPAND SERVICES OR INFRASTRUCTURE AT EXISTING COMMUNITY HEALTH CENTERS.

Economic and Insurer Credentialing

One of the main focuses of the SJR 15 study was to review the conditions in an economic credentialing statute enacted in 2007, which prevented hospitals from denying credentials to a physician who had an economic interest in another health care facility. A termination date for that statute was intended to give the statute time to work but also give interested parties time to refine the statute. If agreements on the statute could not be reached, then

50-5-117, MCA, was to expire on June 30, 2009. Over the 2007-2008 interim, a subcommittee of the CFHHS Committee heard testimony from interested persons and worked to obtain consensus on revisions to the economic credentialing statute. (See SJR 15 final report for more on this study.) As part of the review of credentialing, the CFHHS Committee also heard from insurers about their credentialing process and considered issues related to the hospital-physician relationship like on-call requirements. Questions raised during these discussions, as related to health care costs and efficiencies, included whether insurer credentialing: results in increased costs and inefficiencies as insurers duplicate some of the activities required for health care provider licensing; provides a better way of predicting quality care by further examining physician records in ways that licensing boards do not; or serves as an alternative to hospital credentialing for assuring such issues as on-call requirements.

Insurers credential to boost the quality of physicians and other health care providers in their networks, according to insurer presenters at a June 11, 2008, CFHHS Committee meeting. Although 33-22-1705, MCA, prohibits health care insurers from requiring hospital staff privileges of a health care provider as a condition for being in a preferred provider network, the insurers say they must be able to show that physicians can provide continuity of care either through their own privileges at a hospital or an agreement with someone who does have privileges at a hospital, such as a hospital-employed hospitalist.

Specialty Hospitals and Conflicts of Interest

Another of the main focuses of the SJR 15 study was how to deal with specialty hospitals in Montana if a moratorium on specialty hospital licensing expires, as statute currently provides, on June 30, 2009. The subcommittee studying economic credentialing also considered comments from proponents and opponents of a specialty hospital moratorium. Among the comments were concerns, as related to both economic credentialing and specialty hospitals, about conflicts of interest among health care providers who own for-profit health care facilities. One result of a conflict of interest is that health care providers who have an economic interest in a facility may encourage greater utilization for profit purposes than is necessary for medical purposes. Comments at the subcommittee meetings prompted the subcommittee to recommend to the full CFHHS Committee legislation that would require all health care providers to disclose whether they had an

economic interest or an employment interest related to a referral. Separately, the subcommittee recommended, and the full CFHHS Committee requested, legislation to ban certain forms of kickbacks among health care providers, expanding to all health care providers, regardless of payor, the essence of federal laws that prohibit kickbacks to any health care provider receiving Medicare, Medicaid, or certain other federal funds.

As related to specialty hospitals, proponents of a moratorium or a ban contended that ultimately health care costs increase when specialty hospitals begin competing for patients with nonprofit community hospitals. The reason is that the owners of the specialty hospitals, usually physicians, have incentives to encourage more surgeries or procedures at the for-profit hospitals. Opponents of the moratorium (those who favor specialty hospitals) contended that specialty hospitals could decrease an individual's cost of care because specialization would increase efficiency and potentially quality care associated with performing the same procedure frequently, improving with repetition.

Because Congress continues to consider taking action to limit future specialty hospitals, the CFHHS Committee did not suggest revising legislation or extending (or making permanent) a moratorium related to specialty hospitals. The 2009 session also had the option of addressing specialty hospitals from any of these approaches.

Availability of Health Care Services

Montanans who live in rural communities and who need sophisticated health care services know that those services are in limited supply. Even Montanans living in the state's major cities may know that certain hospitals have more experience than other hospitals with certain operations. For example, anyone having a baby in Missoula is likely to head to Community Medical Center but if they have cardiac concerns they are likely to go to St. Patrick Healthcare Center in the same community. As hospitals look at their bottom line, however, more hospitals are moving toward offering elective procedures that are profitable, which may mean increased competition within a community as well as with communities within 200 miles.

A survey of Montana's health care facilities, specified as one of the study targets in SJR 15, showed that many Montanans travel out of their community to have babies in a

hospital with a birthing center and that specialized services are limited to major hospitals. Even without a major mental health care study funded by the 2007 legislature, it is clear that mental health care is extremely limited in Montana. (See SJR 15 health care survey and related appendices.)

SECTION 5: Other Issues Not Addressed by Panels or White Papers but Requested in HJR 48 or by the Committee

- ☐ The Montana Healthcare Forum
- ☐ Health Policy Council
- ☐ Medical Education
- ☐ Medical Work Force Planning
- ☐ Certificate of Need Review

The Montana Healthcare Forum

This gathering of private and public stakeholders interested in health care reforms began with an October 29 and 30, 2007, forum reviewing access to health care, charity care, Medicare, state innovations, quality, and efficiency.[65] After the initial meeting, which had sponsors ranging from health care insurers to banks, Carroll College, and the State Auditor's Office, informal meetings continued almost monthly in Helena with work groups and full group sessions. The second forum on November 20-21, 2008, continued to take an international, national, and local look at the topics that the first forum had raised.

The Forum work groups addressed the following topics: consumer engagement, coverage, delivery systems, transparency, and value. Among recommendations made by the various work groups were the following that became legislation in the 2009 session or were otherwise implemented:

- putting health care prices and consumer information online, which MHA - An Association of Montana Health Care Providers did in January 2009. That website is: http://www.mtinformedpatient.org/.
- supporting a prescription drug monitoring program, which became House Bill No. 267. The bill was tabled in the House.

[65] See the agenda at: http://www.montanahealthcareforum.com/agenda.htm

- creating a health policy council. Work group members provided a framework[66] for the council, which underwent change as Senate Bill No. 44 evolved (see below).
- expanding funding for Insure Montana and the Montana Comprehensive Health Association (MCHA) and fully funding the Healthy Montana Kids Plan. The bill expanding funding for MCHA, HB 250, was tabled in the Senate. Insure Montana and the Healthy Montana Kids Plan were on track to receive some expanded funding.
- expanding access to primary care, including expansion of funding for community health centers (House Bill No. 280); and
- encouraging wellness efforts at work places across the state.[67]

Health Policy Council

Senate Bill 44, proposed as a committee bill by the Economic Affairs Interim Committee at its September 12, 2008, meeting, originated as something of a compromise in the coverage work group of the Montana Healthcare Forum. One of that work group's suggestions was for legislation creating a Health Policy Council, which according to some work group members was intended in part to continue the work of the Montana Healthcare Forum and its work groups, while others said it was intended to bring legislative policymakers together with stakeholders in a routine effort to address health care concerns.

The Health Policy Council was to be composed of legislators whose sole focus was health policy. Although the original concept was to incorporate the work groups into the policy council, a concern about the costs and requirements of public records, public notice of meetings, and the staffing of work groups resulted in a decision by the appointed sponsor, Sen. Ken Hansen, to focus the council on legislators who would seek recommendations from work groups and act as a policy sounding board for work group recommendations. SB 44 died in the Senate Public Health, Welfare, and Safety Committee.

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[66] See: http://leg.mt.gov/content/Committees/Interim/2007_2008/econ_affairs/meeting_documents/healthcareforum_health_policy_council.pdf.

[67] For the Health Forum work group recommendations see the progress report 2008: http://www.montanahealthcareforum.com/assest_global/files/11Feb09/progress%20report%202-3-2009%20final.pdf.

Discussion at some of the meetings of the Montana Healthcare Forum included the following concerns about formalizing the approach to health care policy through another legislative study:

- Some people noted the success over a year's worth of meetings of the voluntary nature of the work groups, which featured both interested persons volunteering their time and people whose work revolved around the subject matter and who presumably counted the meetings as part of their work day. They questioned whether there was a need to change the approach.
- Some voiced concerns about the effectiveness of a council assigned to study health care, when similar studies had made little progress in the past.
- Proponents said the nexus between work groups comprised of people knowledgeable about health care and legislators who may or may not have a broad background in health care is the only way to move policies forward in a broad-based, educated way.

Among past studies were the following:

- 1993-94 - A comprehensive Montana Health Care Authority involved full-time staff and a budget of about $1 million. The chair and vice chair were legislators, Dorothy Bradley and Sonny Lockrem Jr., respectively. Regional health boards helped to outline Montana-specific concerns, including access. Presentations addressed different types of health care approaches, ranging from a mandate on the individual to obtain coverage (much like the Massachusetts system) to a single payor system allied with a universal coverage approach. Included in legislation presented to the 1995 Legislature was a statute (50-4-104, MCA) setting out a state health care policy that urged a role for individuals in their use of a health care system and the use of market-based approaches to contain the growth in health care spending while improving access and quality.[68]

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[68] **50-4-104. State health care policy.** (1) It is the policy of the state of Montana to continue to investigate and develop strategies that result in all residents having access to quality health services at costs that are affordable.

(2) It is further the policy of the state of Montana that:

(a) Montana's health care system should ensure that care is delivered in the most effective and efficient manner possible;

(b) health promotion, preventative health services, and public health services should play a central role in the system;

- 2001-2002 — Senate Joint Resolution (SJR) No. 22 requested a study of health care and the increasing cost of health insurance, including provider reimbursement rates and cost shifting, access to affordable prescription drugs, strategies to decrease the number of uninsured Montanans, purchasing pools for individual and small group insurance, and the feasibility of recreating the Health Care Advisory Council. The study also included a review of whether returning to certificate of need requirements would help to reduce health care costs by regulating the number of facilities or high-cost imaging machines.[69] The analysis of states with certificate of need compared with those without certificate of need was not conclusive regarding the benefits of certificate of need legislation.

Special interest studies have included a medical malpractice study in 2003-2004 and a mental health study completed by a contractor in 2008. Studies by advisory councils convened by various governors or the Department of Public Health and Human Services also have addressed health care, access to health care providers, and related subjects. Various other states have approached health care reforms through health care commissions, some of them blue-ribbon commissions and others ongoing commissions.

(c) the patient-provider relationship should be a fundamental component of Montana's health care system;

(d) individuals should be encouraged to play a significant role in determining their health and appropriate use of the health care system;

(e) accurate and timely health care information should play a significant role in determining the individual's health and appropriate use of the health care system;

(f) whenever possible, market-based approaches should be relied on to contain the growth in health care spending while attempting to achieve expanded access, cost containment, and improved quality; and

(g) the process of health care reform in Montana should be carried out gradually and sequentially to ensure that any undesirable impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

(3) The legislature recognizes the need to increase the emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only those services to the consumer that are reasonable and necessary.

[69] For information on the SJR 22 study, see the final report "Access and Barriers to Health Care": http://leg.mt.gov/content/publications/committees/interim/2001_2002/econ_affairs/Access.pdf.

Medical Education

In the 2005 Legislature Sen. Corey Stapleton of Billings sponsored SB 273, authorizing the creation at Montana State University-Billings of a Montana School of Rural Medicine. The bill, which missed transmittal, would have established a planning council to begin gathering data, evaluating existing training programs, and possibly start collecting private funds. The hearing before the Senate Finance and Claims Committee included discussions of the WWAMI program, which trains medical students from Washington, Wyoming, Alaska, Montana, and Idaho — thus the acronym — at the University of Washington and satellite schools. Sen. Stapleton noted a $3 million cost of Montana's participation in WWAMI, which he said might be better spent in Montana than in sending students out of state, particularly because the percentage of students trained under WWAMI and returning to Montana after medical school is just 42%.[70]

Another legislative study proposal, initiated under House Joint Resolution No. 22 in the 2007 session, sought to examine programs that might expand the number of dentists practicing in Montana. A September 2007 background report to the Joint Subcomittee on Postsecondary Education Policy and Budget (PEPB) noted that the Montana state budget funds 12 Montana dental students each year at a cost of $247,200 (FY 2008 costs) for dental school either in the WWAMI program or in the Minnesota dental program. The briefing paper also reviewed a previous study under House Bill 522, requested by the 2005 Legislature, which resulted in House Bill 395 in the 2007 session. HB 395 requested $2.4 million in the 2009 biennium to expand the number of dental students in a combined Montana State University-Bozeman and WWAMI program. The bill failed, but generated the HJR 22 study for different options to increase the number of dentists practicing in this state. The proposal in HB 96, introduced in the 2009 session, was to provide a state special revenue account that the Board of Regents could use to pay the educational debts of dentists who were practicing in underserved areas of Montana or underserved populations. The bill was tabled in the House.

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[70] Senate Finance and Claims Committee minutes, March 3, 2005. See: http://data.opi.mt.gov/legbills/2005/minutesPDF/Senate/050303FCS_Sm1.pdf. The state's participation in WWAMI allows Montana students to attend the University of Washington School of Medicine at a reduced tuition rate.

Medical Work Force Planning

Montana's medical services are concentrated in its major population centers, leaving large areas of the state with limited medical coverage. A 2007 block grant application for Maternal and Child Health Services, sought by the Department of Public Health and Human Services, noted in its rationale for federal assistance that:

- 9 of Montana's 56 counties have no private medical services;
- 60% of primary care physicians are located in the seven most populated counties: Cascade, Gallatin, Flathead, Lewis and Clark, Missoula, Silver Bow, and Yellowstone;
- in 2002 there were 2.0 physicians for every 1,000 people, compared to the national average of 2.3 physicians for every 1,000 people; and
- Montana needs nearly 1,000 more health care workers to reach the national average.[71]

MONTANA'S MEDICAL SERVICES ARE CONCENTRATED IN ITS MAJOR POPULATION CENTERS, LEAVING LARGE AREAS OF THE STATE WITH LIMITED MEDICAL COVERAGE.

Emergency medical service providers, often volunteers, fill a gap in services. Sustainability for these providers was part of a study conducted by the Children, Families, Health, and Human Services Interim Committee in 2007-2008 under Senate Joint Resolution No. 5.[72]

In 2002 the Governor's Blue Ribbon Task Force on Health Care Workforce Shortages reported its findings, which in turn were further analyzed by a Primary Care Liaison

[71] Montana Department of Public Health and Human Services, "Maternal and Child Health Services Title V Block Grant State Narrative for Montana", Application for 2008, Annual Report for 2006, October 4, 2007, pp. 10-12. http://www.dphhs.mt.gov/PHSD/family-health/MT-Narratives_000.pdf.

[72] For more information on the SJR 5 study, see: http://leg.mt.gov/css/Committees/Interim/2007_2008/child_fam/assigned_studies/sjr5.asp.

Group[73] that outlined four recommendations to further the work of the blue ribbon task force. These included:

- development and implementation of a comprehensive health care workforce communication plan that links the health care industry, state agencies (including both the legislative and executive branches), public school systems, institutions of higher education, and the public;
- development of a comprehensive health care workforce data collection and analysis system that can be used for various types of planning, application for a federal designation as a health care shortage area, and recruitment and retention incentive programs;
- development of a comprehensive statewide system for health education program planning, that includes new delivery models and health care provider educational "pathways"; and
- development of a Montana Center for Rural Health Research and Policy that would target improvements in quality, safety, efficiency, and effectiveness of health care, among other issues, including reductions of unnecessary expenditures related to health care.[74]

Certificate of Need Review

As part of the SJR 22 study conducted in the 2001-2002 interim, staff provided a white paper on the impacts of certificate of need in various states. The goal of a certificate of need is to demonstrate that new, costly equipment or additional services or facilities are needed and will not increase the costs of health care unnecessarily by promoting overuse in order to justify the expenditure for them. Under 50-5-301, MCA, Montana requires a certificate of need for the following health care facilities: nonfederal home health agencies,

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[73] The Montana Primary Care Liaison Group, formed in the late 1980s, includes in its members, officials with the Department of Public Health and Human Services, the Montana Hospital Association (MHA - an Association of Montana Healthcare Providers), Montana State University, the Montana Primary Care Association, the Montana Rural Institute at the University of Montana, and the Montana Physician Assistant Program at Rocky Mountain College.

[74] Montana Primary Care Liaison Group, "Montana's Health Care Workforce: Review and Analysis of the Governor's Blue Ribbon Task Force on Health Care Workforce Shortages and Recommendations of the Montana Primary Care Liaison Group", January 31, 2006. See: http://healthinfo.montana.edu/ PCLGFINALPAPER1-31-06.rtf.

long-term care facilities, or inpatient chemical dependency facilities. Legislation in 1989 excluded hospitals from facilities required to obtain certificates of need.[75] The issue was raised but not explored during the discussion on specialty hospitals under the SJR 15 study.

[75] For more details on certificate of need impacts, see the final report of the SJR 22 study,"Access and Barriers to Health Care":http:/.leg.mt.gov/content/publications/committees /interim/2001_2002/ econ_affairs/Access.pdf.

SECTION 6: Other Issues Related to Health Care Coverage Not Addressed Above

This section addresses the following topics related to health care coverage:

- ☐ Access to care for Indians on reservations and elsewhere
- ☐ Malpractice insurance
- ☐ Privacy
- ☐ Mental health issues

Uneven Access to Care for Indians on Reservations

The good news regarding health care for Indians living on federally recognized reservations in Montana is that, except for the Confederated Salish and Kootenai Tribes on the Flathead Reservation, the Indian Health Service provides facilities, staffing, and some funding. The bad news is that funding shortfalls routinely leave a good portion of the year uncovered for specialized services, so that IHS pays for only the most serious "life or limb" injuries during that time (although routine care may be available). More bad news is that the remote location of many of Montana's reservations may require air-lifting of accident or emergency patients to a larger medical center. This may also deplete the money available for contracted services. The ramifications for health and for coverage for Indians is critical. But all Montanans feel the effects of inadequate coverage in the form of higher costs for uncompensated care if those unable to receive assistance at the Indian Health Service seek emergency room coverage and are unable to pay for services.

- ■ ***Urban Indian clinics***

For Indians not living on reservations, four urban clinics serve Indians and operate as federally qualified health care centers. These are: the Indian Health Board in Billings, the Helena Indian Alliance, the Native American Center of Great Falls, and the North American Indian Alliance of Butte.

■ ***Flathead Reservation differences***

The Confederated Salish and Kootenai Tribes (CSKT) operate three clinics on the Flathead Reservation independently of the Indian Health Service, which determined that existing medical care on the reservation, including hospitals in Ronan and Polson among other health care providers, offered sufficient services to preclude federally provided services for the tribes. CSKT services include ambulatory care and referrals to specialists for services not provided in the clinics. CSKT has a contract with IHS for funding of certain services outside of the tribal clinics, while tribal funding covers the clinics. The clinics treat all Indians who are eligible at an IHS facility. CSKT also provides pharmacy services for eligible beneficiaries either in St. Ignatius or in Polson regardless of whether the prescribing providers are off or on the reservation. For beneficiaries enrolled in the tribe and for descendants of enrolled tribal members, CSKT also covers service costs charged by a designated primary provider off the reservation or by urban Indian clinics if a CSKT clinic or contracted provider makes a referral.

Malpractice Insurance

In the 2003-2004 interim, the Legislative Council studied medical malpractice issues. Among the recommendations of the SJR 32 subcommittee[76] were:

- to establish a Health Care Liability and Injured Patients Compensation Act, which would create a type of reinsurance program to partially indemnify a person or entity involved in a civil action for medical negligence, or alternatively establish a joint underwriting association to assure health care providers of medical malpractice insurance if the insurance commissioner determines a dearth of medical malpractice insurance for certain providers in the voluntary market. (This latter approach was enacted in HB 331.)
- to adopt tort reforms for medical malpractice claims for several aspects of case law in Montana, including situations that would decouple the hospital and physician in cases of medical malpractice in which the physician is not an employee of the hospital; and

[76] For the report on medical malpractice, see: http://leg.mt.gov/content/Committees/Administration/Legislative%20Council/2003-4/Subcommittees/default.asp.

- to allow health care providers to convey words of condolence without those words being used against them as indications of fault.[77]

Privacy

The Health Information Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d, et seq., governs many aspects of health care, including patient privacy. Montana's Uniform Health Care Information Act, Title 50, chapter 16, part 5, includes a provision in the legislative findings in 50-16-502, MCA, that extends privacy concerns to persons other than health care providers and to health care providers not covered by HIPAA. Insurers have their own privacy requirements under Title 33, chapter 19.

PRIVACY CONCERNS HAVE PLAYED A ROLE IN THE DEVELOPMENT OF THE ELECTRONIC RECORDS PROPOSAL FROM HEALTHSHARE MONTANA AND IN PROPOSALS TO MONITOR PRESCRIPTION DRUGS.

Privacy concerns have played a role in the development of the electronic records proposal from HealthShare Montana and in proposals to monitor prescription drugs. The HealthShare Montana discussions have involved a work group tasked with determining ways to assure security with electronic health records.[78] The work group's statement of principles said the goal for HealthShare Montana was to a provide "a higher standard for privacy and security protection than under either federal law (known as HIPAA) or Montana state law".[79] The standards further state that HealthShare Montana will establish a complaint mechanism and will exclude from participation any entity that fails to maintain privacy practices.

[77] "Describing the Ailment, Prescribing the Cure: Final Report of the SJR 32 Subcommittee on Medical Liability Insurance", September 2004. See: http://leg.mt.gov/content/Committees/Administration/Legislative%20Council/2003-4/Subcommittees/Staff%20Reports/final_3.pdf.

[78] For more information on HealthShare Montana, see: http://healthsharemontana.org/.

[79] HealthShare Montana, Privacy and Security Principles, 10.2.08 draft with "protected HI".

Mental Health Issues

■ ***Study by the Children, Families, Health, and Human Services Committee***

Mental health is a major issue in a rural state where services are concentrated in Great Falls, Billings, and points west with eastern Montana having no physicians licensed to practice psychiatry and just seven psychologists in May 2008, according to a mental health study by DMA Health Strategies.[80] In the southwest region, there were 31 psychiatrists listed and 24 in the western region. Adding in Great Falls and Billings psychiatrists, the total for the state numbered 83, as listed with the state's Health Care Licensing Bureau.

The findings of the DMA Health Strategies study, reported to the Children, Families, Health, and Human Services Committee in October 2008, included recommendations to:

- restructure the mental health system, including coordination of how the Addictive and Mental Disorders Division and the Children's Mental Health Bureau are administered;
- continue to pursue expansion of services to adults with serious and disabling mental illness and certain other groups, as sought under a Health Insurance Flexibility and Accountability (HIFA) waiver, as well as expansion of funding for crisis response and stabilization;
- improve use of the Montana State Hospital at Warm Springs and use of community services;
- improve recruitment and payment for psychiatrists;
- enhance coordination with Indian Health Services for tribal populations;
- enhance interdepartmental coordination, including between the Department of Public Health and Human Services and the Department of Corrections for prison populations; and
- improve a collaborative advisory process with all involved in planning and access to both adult and child mental health systems.

[80] DMA Health Strategies, "Report to the State of Montana: Legislative Mental Health Study", October 2008, Appendix F, listing physicians with a specialty of psychiatry licensed by the Montana Department of Labor and Industry as of May 5, 2008.

The Children, Families, Health, and Human Services Committee requested bill drafts to implement some of the recommendations. For more information see that Committee's final report: "Time for a Check-Up: Monitoring Health Care Services in Montana".[81]

- ***Study by the Law and Justice Committee***

In the 2007-2008 interim, the Law and Justice Committee also tackled mental health issues, including studies on mental health in adult and juvenile corrections under HJR 26 and precommitment psychiatric evaluations in HJR 50. The committee also heard requests from hospitals to address the cost of potentially uncompensated care if a "detainee" is injured seriously enough to be hospitalized but not arrested because once arrested the costs of hospitalization are the responsibility of the arresting agency. The Law and Justice Committee recommended four bills that evolved from the studies:

- HB 130, which established a grant program for county crisis intervention and jail diversion programs;
- HB 60, for a pilot project on suicide prevention in jails (this missed a transmittal deadline);
- HB 131, requiring the Department of Public Health and Human Services to contract for up to three secure psychiatric treatment beds in each of the state's four mental health regions; and
- HB 132, relating to involuntary commitment hearings, short-term inpatient treatment, and contracting of short-term inpatient treatment beds.

For background information on the Law and Justice Committee's work and more information, see the committee report, "Diverting the Mentally Ill from the Justice System and Providing Involuntary Commitment Alternatives".[82]

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[81] http://leg.mt.gov/content/Publications/committees/interim/2007_2008/2008timeforcheckup.pdf.

[82] http://leg.mt.gov/content/Publications/committees/interim/2007_2008/2009lawandjustice.pdf.

SECTION 7: Conclusion

Charged with studying health care coverage, the Economic Affairs Interim Committee had a huge task. The many threads of health care reform first had to be analyzed as part of an overall picture of health care coverage that involves costs and delivery of services. Those topics were also part of the SJR 15 study, assigned to the Children, Families, Health, and Human Services Committee regarding the impacts of certain health care services on health care delivery. The breadth and depth of the subject of health care coverage, combined with the Committee's interest in addressing three other studies,[83] resulted in limited time being available to study all aspects of health care coverage. That was one of the reasons that the Committee endorsed as its sole committee bill SB 44, the legislative creation of a health policy committee. A health policy committee was seen as involving stakeholders and legislators in determining the direction that a future legislature might head to improve health care costs and health care coverage. Recognizing that previous legislatures also had sought to study health care with few major changes resulting, the Committee acknowledged that a new policy group may not be in the right place at the right time. But at the urging of interested stakeholders, the Committee agreed to move the idea for a council forward. The Committee also recommended providing a "primer" on health care issues, which is what this document is intended to be, and a reference source for Montana health-related issues and other materials related to health care subjects.

THE BOTTOM LINE IS THAT THE GORDIAN KNOT OF HEALTH CARE ISSUES INVOLVES MANY INTERSECTING STRINGS, INCLUDING TIES REGARDING AFFORDABILITY AND COVERAGE, STATE AND FEDERAL REGULATION, EMPLOYERS AND EMPLOYEES, AND INSURERS AND HEALTH CARE PROVIDERS.

The bottom line is that the Gordian knot of health care issues involves many intersecting strings, including ties regarding affordability and coverage, state and federal regulation,

[83] The Economic Affairs Interim Committee also was assigned HJR 39, a study of academic research and commercialization, HJR 28, a study of business infrastructure and economic development, and SJR 13, a study of value-added agriculture.

employers and employees, and insurers and health care providers. Cutting through one thread of the knotty health care problem does not necessarily resolve the problems of the uninsured, the underinsured, access to care, costs, and related concerns. For that reason, the Committee chose to provide information on the issues to help those addressing future reforms.

APPENDIX I: HJR 48 Work Plan

(✔ indicates the committee had panel discussions or briefing papers on this topic specifically as part of the examination of issues. Items listed as (will be included in final report) are incorporated into the "other issues" section.):

I. Study creation of a system of universal, portable, affordable health insurance coverage that involves private health insurance issuers and incorporates existing public programs.

A) Briefing paper on other states' health insurance reforms involving expanded coverage, including options for expanded public programs. ✔
- Incorporate overview of differences between those states and Montana's existing, relevant laws to clarify what changes would be needed.

B) Presentations by representatives of selected states or people knowledgeable about the reforms in those states. ✔
C) Panel discussions by insurers, State Auditor's Office, and representatives of existing programs in Montana, like the Montana Contractors Association plan, which has some portability features. ✔

D) Panel discussions of:
- Insurance pricing as that affects affordability.
- Transparency, involving representatives of hospitals, physicians, insurers, the Attorney General's office. (will be included in final report)
- Certificate of need or public service commission-type approaches to review of allowing new health care competitors or services. (Will be included in final report.)

E) Review options for expanding public programs, with commentary by DPHHS.

II. Ways to improve the quality, affordability, and delivery of health care.

A) Panel discussion on how to regulate/achieve improvements in quality. (will be included in final report)

B) Incorporate Study Area (I) for affordability.
- Expand to include formal study of health care costs in Montana. (will be included in less formal way in final report)

C) Panel discussion on options to expand health care delivery systems in a way that improves access to care (e.g. Community Health Centers) (will be included in final report)

D) Briefing paper on quality, affordability, and delivery issues (some of which are in SJR 15) (will be included in final report)

E) Updates on SJR 15 study of health care delivery systems. ✔

III. Use of a health insurance exchange and implementation issues

A) Presentation and panel discussion involving people involved with the Massachusetts Plan, the Montana Contractors Association Trust regarding its portability factor, State Auditor's Office, and insurer representatives ✔

B) Briefing paper

IV. Examine similar reforms enacted in other states, including the cost of the reforms to the states and to consumers, any improvements in affordability or availability, and barriers to enactment, along with solutions to those barriers.

A) Choose 4 to 6 states with different approaches (e.g. Massachusetts, Maine, Vermont, Indiana, Hawaii, and New York) and calculate cost of reforms for states and consumers, etc., for each. Prepare as a briefing paper. ✔

B) Include presentations by representatives in each state either in person or by teleconference. Incorporate with study area (3).

V. Study advantages and disadvantages of mandating private universal coverage.

A) Incorporate with Study Areas (1), (3) and (4) as they pertain to Massachusetts (individual coverage) and Hawaii (employer mandate) (will be included in final report)

B) Presentations by representatives of each (in person or by teleconference)

C) Briefing paper

VI. Address whether and, if so, how to incorporate existing state-related insurance programs (e.g. Insure Montana and MCHA) into reforms.

A) Panel discussion involving State Auditor's Office and insurer representatives.✔
B) Panel discussion of briefing paper detailing state law changes that would be necessary, based on different scenarios of change.
C) Briefing paper

VII. Address whether to include public employee health benefit programs in a reform proposal.

A) Panel discussion by State Auditor's Office, state, county, municipal, university system, and school health benefits officials regarding impacts of any proposed changes.✔
B) Briefing paper detailing state law changes that would be necessary.

VIII. Address whether to maximize the use of federal funds and ensure broader coverage through existing publicly funded health care programs, including Medicaid and the Children's Health Insurance Program, and, if so, what types of changes might be needed.

A) Incorporate this with Study Area (1).
B) Obtain financial estimates of the cost of expanding existing publicly funded health care programs. (Will be included in final report.)
C) Review various federal waivers to determine how federal money can be maximized.✔
D) Review what types of changes are necessary in existing law for expansion. Presentation by DPHHS.
E) Briefing paper on A through D.

IX. Examine how health care providers handle uncompensated care and provide an estimate of the uncompensated costs.

A) Staff contact major health care providers to determine how they handle uncompensated care and obtain estimate of their costs. (Will be included in final report.)
B) Request information from Attorney General on the Department of Justice study of hospitals' uncompensated care.✔
C) List other states' options for dealing with uncompensated care (e.g. creating an uncompensated care pool by taxing providers who do not handle uncompensated care)
D) Panel discussion by providers on menu of state options
E) Briefing paper

X. Examine opportunities for coordination with the federal government and tribes regarding health care services and programs.

A) Panel discussion on interconnections between Indian Health Service, Medicaid, private providers on or near reservations. Include discussion of uncompensated care, contract services, community health centers.
B) Compile a literature review regarding options that might be employed to treat health care problems before they become critical, particularly on or near reservations or involving urban Indians. (Will be included in final report.)
C) Briefing paper on the subjects in A and B.

The following study areas were not specifically addressed by the Economic Affairs Committee:

XI. Examine other issues related to access to health care, including access in rural areas.

XII. Examine opportunities for coordinating workforce planning and medical education funding.

Appendix II: Selected Other States' Health Insurance Reforms

A briefing paper provided in February 2008 to the HJR 48 subcommittee reviewed activities in other states related to health care reforms. Titled, "Other States' Health Financing Reforms: Are there approaches that Montana wants to adopt?", the briefing paper reviewed Montana's own history of health care reform efforts along with both enacted and proposed legislation in other states. The following table includes information on enacted legislation from that report with additional information from other states that have enacted laws since that time. Much of the information is from the National Conference of State Legislatures. See: http://leg.mt.gov/content/committees/interim/2007_2008/econ_affairs/sub_com/staff_reports/2_6other_states.pdf.

Health Insurance Reforms in Other States

Connecticut		
Plan name or Key Feature	Purpose and Specifics	Begun
Charter Oak Health Plan: Expand access to affordable health care coverage	• Subsidies to those earning under 300% of federal poverty level • Copay of 10% of hospital bills • Annual coverage limit of $100,000 • Premium prices between $75 and $259 a month. • SIgn-up not required.	2008
Colorado		
Plan name or key feature	Purpose and Specifics	Begun
Expand coverage	• Medicaid eligibility level increased to 113% of federal poverty level for youth aged 6 to 19 years as of July 1, 2009. Increases to 225% from 205% the poverty guidelines for Colorado's Children's Basic Health Plan.	Signed into law 6/3/2008
Florida		
Plan name or key feature	Purpose and Specifics	Begun
Mandates limited	• Bare-bones policies to be made available to Florida residents aged 19 to 64 who are ineligible for public assistance. The purchasers could not be rejected based on age or health status. Still required would be provisions for preventive services, office visits, screenings, surgery, prescription drugs, durable medical equipment, diabetes supplies, and autism. Not included were more than 40 other mandates required of standard policies. Insurers are allowed to limit days of hospitalization or put dollar caps on certain services. The per month premium charge is anticipated to be $150 or less.	Signed into law 5/21/2008

Indiana		
Plan name or Key Feature	Purpose and Specifics	Begun
Check Up Plan uses Health Savings Accounts in combination with high-deductible health plans http://www.in.gov/legislative/bills/2007/HCCP/CC167802.001.html	• POWER Accounts – combination of HSA-like accounts combined with high-deductible back-up commercial plans. The POWER Account is $1,100, funded by uninsured in Indiana paying between 2% and 5% of their incomes on a means-tested scale. The state contributes the remainder needed to get to $1,100 and $500 worth of preventive care as well as the premiums for the back-up plans. After each year at least $500 must stay in account and participant may withdraw amounts above the $500. (NCSL summary). Back-up plans must include mental health, home health services including case management, substance abuse services, dental, and vision. Providers must be paid at Medicare rates. • Expand income limit to 200% of FPL for pregnant women enrolled in Medicaid. • Continuous eligibility for Medicaid and CHIP until age 3. • Certain small employers allowed to join together to buy group health insurance. • Qualifying employers allowed tax credit for 1st 2 years that the employer makes coverage available to employees (the lesser of $2,500 or $50 for each employee enrolled in the health plan)	signed into law 4/30/07
Iowa		
Plan name or key feature	Purpose and Specifics	Begun
Expand coverage	• Goal is to cover every uninsured child by 2011, expanding the Children's Health Insurance program eligibility up to 300% of the federal poverty level from 200%. Children between 200% and 300% may face higher cost-sharing requirements on a sliding scale. • An advisory council is directed to develop a plan by December 2008 for access to affordable, private coverage for children ineligible for public assistance but uninsured and under age 19. • Two task forces were directed to recommend affordable coverage options for uninsured adults by December 2008. • Private insurance coverage required to extend up to age 25 coverage for a child on the parent's plan, unless the child marries or moves out of state. • Private insurers barred from excluding or limiting coverage if a consumer moves from a group plan to an individual plan. • Offers taxpayers opportunity on income tax return to designate if child is uninsured. If income is in range for public assistance, the state will notify the taxpayer of program eligibility.	Signed into law May 2008

Maine		
Plan name or key feature	Purpose and Specifics	Begun
Dirigo Plan - Expands insurance options for businesses of 2 to 50 employees, the self-employed, and eligible individuals without access to employer-sponsored insurance.	• Created Dirigo Health Agency to administer a DirigoChoice insurance option for small (2 to 50 employee) businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance. • Sliding scale premium subsidy for those eligible who earn up to 300% of FPL plus limits on out-of-pocket costs and deductibles. Funding from a combination of employer (60% of employee only cost) and individual contributions, the general fund, Medicaid, and inputs from hospitals related to bad debt and charity care. • Dirigo Health Agency also established Maine Quality Forum, which obtains quality data, including nursing care quality. http://www.dirigohealth.com/2006%20Fact%20Book%20Final%20020607.pdf. • Required determination of savings offsets (from having more insureds so that uncompensated care decreased). Dirigo Board to file with the Superintendent of Insurance a report on aggregate measurable cost savings, which determined ratio assessed on paid claims. In 2005, for example, the assessment was 2.408% for health insurance carriers on annual paid claims, for third-party administrators on annual paid claims for residents, and on employee benefit excess insurance carriers. The ratio was lowered to 1.85% in 2006. Offset cannot exceed 4% of paid claims. • Coordinated payments for Maine's Medicaid program from various sources to increase federal to state funding input. • Hospital profit limit of 3%. 2005 report indicated that "many hospitals did not feel profit constraints at the hospital entity level due to the voluntary profit limit of 3% in the Dirigo Act." Of 8 hospitals that earned operating profits below baseline levels, 4 were at or below 3% and 4 were between 3.6 and 4%. http://www.maine.gov/pfr/insurance/dirigo/pdf/Health_Witness_Designation.pdf.	enacted June 2003

Massachusetts, part 1		
Plan name or key feature(s)	Purpose and Specifics	Begun
Health Payment Reform Commission	• Attempts to restructure payment system with incentives for efficient and effective care by providing consumer information, establishing cost containment and quality goals, and requiring providers and insurers to report on progress toward the goals. • Standardizes billing and coding to be developed and in place by 2012. Computerized entry for tests expected to save $170 million a year. (State Health Notes, Vo. 29, Issue 522, 9/2/08) • Mandated statewide adoption of electronic health records. • Public explanation by providers and insurers of increases.	Signed into law August 2008

Massachusetts, part 2		
Individual mandate to have insurance Expand coverage	• Individual mandate enforced initially by disallowing personal income tax exemption if no documented insurance. Later penalty can be up to half the monthly cost of lowest-cost plan within a region for each month without coverage. Connector Board to determine if lowest-cost plan affordable. If not, penalty not applied. • Creation of a Commonwealth Connector, a quasi-public entity designed to: — reduce health insurance administrative costs for small businesses; —review, approve affordable policies through the Connector; —serve as a Section 125 entity, allowing individuals to buy insurance with pre-tax dollars; —allow employees to keep same insurance if they change jobs —Connector requires nonsubsidized policies to cover all statutory mandated benefits. —Deductibles and cost-sharing of Connector-offered policies must be approved by Connector and Massachusetts Commissioner of Insurance (*Health Affairs* article 9/14/06) • Subsidized health insurance available through Connector for those eligible under 100% FPL • Employers with 11 or more workers who do not make "fair and reasonable" contribution to employees' health insurance required to contribute up to $295 a year for each uncovered full-time worker. *Health Affairs* article of 9/2006 says, "This amount is the estimated private sector share of the average per worker cost of free care provided to workers whose employers do not provide health insurance."(p. 425) • All employers required to establish Section 125 cafeteria plans but not required to contribute to premiums. • Establishes "free rider surcharge" on employers with 11 or more full-time employees who do not offer insurers or set up Section 125 plans and who have uninsured employees that use more than $50,000 worth of care covered by the Uncompensated Care Pool. • Children's eligibility increased to 300% of FPL from 200% for children's health insurance Health Disparities Council established. • Provides rate increases for hospitals, but requires them to meet improved quality or pay for performance standards. • Quality and Cost Council established. Duties include providing cost information on web for consumers. • Funded $5 million for computerized physician order entry systems in hospitals. Built on existing uncompensated care pool, which is financed by federal, state, hospital, and third-party payers. • Expected to cost $1.3 billion in FY 2007 up to $1.4 billion in FY 2009, which includes $125 million each year in general fund money, $160 million in third-party payer assessments and $160 million in hospital assessments and less than $100 million from "Fair Share" and "Free Rider" assessments combined.	Passed in April 2006, portions to be imple-mented over time

Minnesota		
Plan name or key feature	Purpose and Specifics	Begun
Expand coverage and Control costs	• Increases eligibility for MinnesotaCare for childless adults up to 250% of the federal poverty level and reduces sliding scale premiums. • Requires employers with 11 or more full-time employees who provide health insurance to set up a Section 125 Plan. • Promotes the use of health care homes. • Seeks to increase transparency and quality through an incentive-based payment system. • Provides for an interoperable electronic health records system.	Signed into law May 29, 2008
New Jersey		
Plan name or key feature	Purpose and Specifics	Begun
Expand coverage	• Expand eligibility for the state's Children's Health Insurance Program (FamilyCare) to include higher income adults, moving eligibility from 133% of the federal poverty level to 200%. • Mandate insurance coverage for children. As a way of determining coverage, the law requires parents to state on income tax returns whether dependents have insurance. Those without insurance will be sent applications either for Medicaid or FamilyCare. An earlier law allows families with income above 350% of poverty to use their own funds to pay for FamilyCare for their children. • Prohibits hospitals from claiming charity care for emergency services extended to uninsured children. The hospitals will be told to bill either Medicaid or FamilyCare. • Adjusts the state's community rating in the individual health insurance market to allow actual or expected claims or age to set premiums provided that the highest priced plan is no more than 3.5 times the cost of the lowest-cost plan. Retains ban on use of gender, health status, occupation, or geographic location when insurers underwrite individual policies. • Increases the minimum percentage of profits that insurers must spend on claims (instead of administration) to 80% from 75%.	Signed into law July 7, 2008
Oregon		
Plan name or key feature	Purpose and Specifics	Begun
Healthy Oregon Act	• Provides a timeline for reform and creates the Oregon Health Fund Board to propose reforms to the 2009 Oregon Legislature.	Signed into law June 28, 2007

Vermont		
Plan name or key feature	Purpose and Specifics	Begun
Catamount Health and Health Care Affordability Acts Designed to increase coverage and address affordability through cost transparency http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM	• Increased coverage through private-sector insurance subsidies on a sliding scale for people under 300% FPL who have not had insurance for 12 months or who lost insurance for various specified reasons. If employed in a firm that offers insurance, employee subsidy to pay for that insurance. Subsidy funding from co-pays, tobacco taxes, Medicaid, and employer assessments. • An employer who does not provide health insurance assistance or who provides insurance but an employee elects not to be insured is assessed $91.25 for each full-time equivalent employee per quarter (in excess of a specified number of employees). Enrollment dependent on availability of subsidy funds. Children not required to be covered by employer insurance program. Benefits to be similar to those of major plans covering most people in small group and association markets. • Established Catamount Health plan targeting $250 deductible for individual in network and $500 for a family, with a 20% co-pay. Catamount Health coverage to be guaranteed and community rated, but preexisting conditions that existed up to 12 months before coverage may be excluded for 12 months (some exceptions). • Provided for free immunizations to the extent allowed by the appropriation (state as a 2nd payer). • Affordability issues addressed through cost transparency including multi-payer data collection and consumer price and quality information, uniform hospital uncompensated care policies, health information technology uses, common claims administration. Insurance commissioner required to develop standard uncompensated care policy, including criteria for payment forgiveness, sliding scale payment amounts, and amount of service calculations. Also may collect data on types of patients using uncompensated care. Set uniform credentialing policy. (Section 9408a) • Established advisory committee for development system of chronic care management and chronic disease prevention, including best practices and protocols. Revised Medicaid provider rates upward to decrease cost-shifting to private-pay insurers or individuals. • Created nongroup market security trust to lower costs and increase access to health care coverage in the individual or nongroup market. Mechanism for shifting 5% of a carrier's claims costs to the trust, with insurance commissioner balancing amount paid to actual expenses. • Approximately $5 million appropriated for subsidies and program startup costs.	Enacted in 2006

APPENDIX III. Montana Tax-Related Issues Affecting Health Insurance

From Dan Dodds, Montana Department of Revenue e-mail, 8/21/2008

There are three types of information on state tax returns that relate to taxpayers' medical insurance:

— deductions taxpayers claim for medical insurance expenses;

— deductions taxpayers claim for deposits to medical savings accounts, and

— credits employers claim for providing health insurance to employees.

Similar information is collected on federal returns, but the IRS does not publish state totals for the relevant lines. The rest of this e-mail explains the information from state returns, and the attached spreadsheet gives a summary of the numbers (table inserted below rather than with the spread sheet).

- **Insurance Premium Deductions**

There are three places where taxpayers can deduct medical insurance premiums. Both federal and state law allow all taxpayers who itemize deductions to take a deduction for medical expenses, including medical insurance premiums, that are more than 7.5% of their adjusted gross income. In addition, Montana law allows taxpayers an itemized deduction for all medical insurance premiums. On state tax returns, these deductions are on two adjacent lines. One records the federal deduction for medical costs over 7.5% of adjusted gross income, and the other records the additional state deduction.

Both federal and state law allow self-employed taxpayers to deduct medical insurance premiums as a business expense. The difference between this and the itemized deduction available to all taxpayers is that this deduction is part of the calculation of the taxpayer's adjusted gross income while the itemized deduction is subtracted from adjusted gross income in calculating the taxpayer's taxable income. Self-employed taxpayers can take this above-the-line deduction even if they take the standard deduction.

Some taxpayers take both the self-employed business expense deduction and the itemized deduction. This would be legitimate if a taxpayer had one policy paid for through their business and additional coverage, perhaps for other household members, not paid for through the business.

For 2006, there were 224,696 out of 416,691 households who itemized deductions rather than taking the standard deduction. (This is counting married couples who filed separate returns on the same form as one household.) Of these, 87,321 took the itemized deduction for medical insurance premiums. The total amount of medical insurance premium deductions was $304,942,061. This understates the number of taxpayers purchasing health insurance and the total amount of premiums for two reasons: It does not count households who paid for insurance but took the standard deduction. It also does not include the portion of any medical insurance premiums that were more than 7.5% of the taxpayer's adjusted gross income. This amount is included in the federal deduction for medical costs, but there is no way to divide that deduction between insurance premiums and direct payments.

There were 20,940 households who took the business expense deduction for medical insurance for the self-employed. The total amount of deductions was $95,735,690. Taxpayers can claim this above-the-line deduction whether they itemize or take the standard deduction. This means that this should be a relatively good measure of the number of households where one or more members is self-employed and provides health insurance for themselves through their business. Both the number of households and the amount of premiums may be understated to a small extent because a self-employed person may not deduct more insurance premiums as a business expense than the amount of income they earn from self-employment. For example, a self-employed person whose business did not make a profit in 2006 would not be able take this deduction. However, any premiums not deducted as a business expense can be taken as an itemized deduction.

There were 4,612 households that took both the business expense deduction and the itemized deduction. They took business expense deductions of $15,860,380 and itemized deductions of $12,843,297. (These amounts are included in the totals in the preceding paragraphs.)

Medical Savings Account Deductions.

Deposits to certain types of medical savings accounts are exempt from federal and/or state income tax. Deposits to these accounts are deducted from total income in calculating adjusted gross income. (Like the business expense deduction, they are above-the-line deductions.) There are two types of accounts defined in federal law and one in Montana law. The federal accounts are the Archer Medical Savings Account and the Health Savings Account. The Archer account was a pilot program that is being phased-out and replaced by the Health Savings Account. Deposits to these accounts are exempt from both federal and state taxes. There is also a state Medical Savings Account that is exempt from state but not federal taxes.

These accounts are only available to taxpayers whose only health insurance is a high-deductible plan with a deductible of at least $1,100 for an individual or $2,200 for a family.

For 2006, 13,720 households claimed a deduction for deposits to one or more of these types of accounts. (399 claimed a deduction for deposits to more than one.) The total amount of deductions was $25,641,174. Of these households, 5,717 also took either an itemized deduction or business expense deduction for health insurance premiums.

Credits for Employers Providing Insurance to Employees

There are two tax credits employers may claim for providing health insurance to employees. The credit for providing insurance to uninsured Montanans provides an incentive for employers to begin offering health insurance to their employees. An employer may take the credit for three years but then may not take it again for ten years. For 2006, there were 641 individuals who took $559,023 in credits and 138 corporations who took $134,711 in credits.

The Insure Montana program allows employers to choose between taking a tax credit and receiving direct incentive payments. For 2006, there were 591 individuals who claimed $1,832,523 in credits and 147 corporations who took $773,560 in credits. This program is administered by the State Auditor's Office. Jill Sark of the SAO has information on the number of employers taking direct incentive payments and the number of employees, spouses, and dependents covered by the program.

Insurance Deductions in Montana Income Tax Records

	Households		Corporations	
• Insurance Premium Deductions	Number	Dollars	Number	Dollars
• Self-Employed Business Expense	20,940	$95,735,690	—	—
• Itemized Deduction	87,321	$304,942,061		
• Either or Both	103,649	$400,677,751		
Archer MSA, Federal HSA, or State MSA	13,720	$25,641,174		
Credits for Employers Providing Health Insurance				
• Insurance for Uninsured Montanans	641	$559,023	138	$134,711
• Insure Montana	591	$1,832,523	147	$773,560