MINUTES OF THE MEETING OF THE HUMAN SERVICES COMMITTEE
March 9, 1983

The meeting of the Human Services Committee held on March 9, 1983, 12:30 p.m. in Room 224A of the Capitol Building was called to order by Chairman Marjorie Hart. All members were present except Rep. Winslow, who was absent.

SENATE BILL 193

SEN. CONOVER, sponsor. This bill would change the standard of medication for mentally ill patients from those advocated by the U. S. Food and Drug Administration to those "consistent with current medical practice".

PROPONENTS:

JERRY LOENDORF, Montana Medical Association, said that the bill is "housekeeping" in nature. It deals with administration of medication to patients in mental health facilities. Currently, it provides the use of medication to these patients shall not exceed standards set by the Food and Drug Administration. The U. S. Food and Drug Administration generally tells you when a drug is safe to be placed on the market. It does not tell you how much and how often you give medication to a patient for a specific disease or injury. Really, there is no standard now and this bill provides a standard, in effect, where there is none. And that standard is probably current medical practice, which is followed anyway (EXHIBIT 1).

OPPONENTS:

REP. McBRIDE, District 85. I stand before you as a concerned person who began to look into the area of rights of patients in mental institutions and as presenting some information for individuals from the Board of Visitors. This bill does do a little bit more than you would be led to believe. The FDA standards do establish guidelines for the safe and effective use and distribution of medicines. Those standards also have requirements and go through some sort of testing in order to be put on the market to begin with. In addition, regulations for the labeling of drugs which require the statement of drug's purpose, its effect, the dosage, the method for dispensing the drug, the frequency and the duration. Based on my conversations with the people who do look to see if there is excessive medication, without some sort of a standard, such as the FDA standard, what is being proposed under this bill would be no standard at all and you would have no method for determining whether it was excessive. Current medical practices could

vary and make it very difficult to determine what is the standard. There is a certain amount of peer review that goes on as to degrees of medication. That review may or may not work. From the standpoint of one professional challenging another, I think it may not always work. In my conversations with some folks from the institutions and the Board of Visitors, in many cases one psychiatrist looking at another doctor's prescription will not change that as there is a certain degree of professionalism that goes on there. I hope that the Committee will look very carefully at this because what you may be doing is setting no standard at all. And, certainly, if there is a right to be free from unnecessary medication, there must be some standard from which to judge that.

SEN. CONOVER closed saying what Rep. McBride is concerned with--right now, the federal government does not exceed the standard of what they are doing now. You might say, it is just kind of a rubber stamp. That is one reason they asked for the change in the wording of that. Dr. Norman says this is just a formality with the federal government and this would just clarify the language.

QUESTIONS:

REP. KEYSER: Aren't the physicians now responsible for any medication they give to these patients by existing law? And also, no medication shall be administered unless there is a written prescription?
JERRY LOENDORF: Prescription drugs need to have a written prescription by physician.

REP. FARRIS: Did you say the FDA is just a rubber stamp?
SEN. CONOVER: They have to go through that formality. They just approve it. He said the doctors themselves in the institutions, if they are using these drugs by prescription and they are going by the federal law and they do not exceed them, they do not have to get a permit from the federal government.

REP. FABREGA: It says "Use of medication shall not exceed the standards that are presently advocated by the Food and Drug Administration." What is the dosage they advocate? Based on the manufacturer's recommended dosage--is that what Food and Drug Administration recommends?

JERRY LOENDORF: The Food and Drug Administration performs a function different from the prescribing physician. When any individual is prescribed that medication by a doctor, he may, and probably will, be told to take different dosages. The Food and Drug Administration doesn't attempt to say what should be given to any individual.

REP. FABREGA: But if anything, the Food and Drug Administration would say we approve this drug based on the schedule as recommended by the manufacturer, or do they even go that far?

JERRY LOENDORF: To my knowledge, the Food and Drug Administration doesn't recommend dosages. They might have a "Not to Exceed" a certain amount.

REP. FABREGA: The recommendation on "not exceeding a certain amount" is that generally provided to Food and Drug Administration by drug manufacturer. Does the manufacturer conduct the testing or does the Food and Drug Administration conduct its own testing.

JERRY LOENDORF: I have always assumed the Food and Drug Administration does independent testing.

REP. JONES: It is the normal procedure, is it not, for a doctor to prescribe medicines consistent with medical standards of the Food and Drug Administration.

JERRY LOENDORF: I don't think the Food and Drug Administration recommends dosages other than maximum standards you would not exceed for any patient.

REP. JONES: The Food and Drug Administration decides whether drug is safe to use. Don't you think it would be very unusual to exceed the limit a patient should have.

JERRY LOENDORF: He would only be prescribing drugs approved by the Food and Drug Administration.

REP. SWIFT: The Food and Drug Administration only approves for safety and use.

JERRY LOENDORF: Yes.

REP. HANSEN: Who sets the current medical practice standards? Do you have a set rule?

JERRY LOENDORF: It is the same as when you go to a doctor. He recommends that decision on a case by case basis.

REP. DOZIER: If this bill passes, what changes are the doctors going to have in medication prescriptions?

JERRY LOENDORF: None.

REP. SOLBERG: It seems to me that you are trying to get out from under the Food and Drug Administration. Why not leave that in and "consistent with current medical practices." Would that be a conflict:
JERRY LOENDORF: I don't think so.
REP. SOLBERG: They set the standards all over the United States.
JERRY LOENDORF: You might say "Drugs Approved by Food and Drug Administration and Administered by Current Medical Practice."

REP. FABREGA: Does the Food and Drug Administration publish standards of use at this time.
REP. McBRIDE: The information I have is there are regulations for the labeling of drugs which includes or requires a statement of drug purpose, dosage, the method for dispensing, frequency and duration. There is one other important point. You can have a Food and Drug Administration drug but have it prescribed for a purpose for which the Food and Drug Administration has not approved. The people who having worked at Warm Springs have, at least one case, denied one request by a physician to use a drug that was, in fact, not approved for the purpose for which the doctor wanted it. The section of law you are amending is the patient's right to be free from unnecessary medication. It is not the doctor's ability to prescribe or not to prescribe.
REP. FABREGA: There are no standards of use that are prescribed by the Food and Drug Administration.
JERRY LOENDORF: That is correct. In a prescription drug, the physician prescribes the dosage. In the case where you buy a nonprescription drug, there is going to be a statement of dosage on the container. A physician is not bound by that statement on a nonprescription drug. He could prescribe that in a larger amount.

REP. CONNELLY: This is to take care of the problem in a nursing home or Warm Springs. The staff may be giving the drugs to keep a patient under control. You are protecting the patient. You are allowing the nursing home to give what dosage they want.

REP. SWIFT: Is it federal law that any nonprescribed drug has to have that information on the bottle?
JERRY LOENDORF: I haven't read it by I am sure REP. McBRIDE is correct.
REP. FABREGA: The physician-patient relationship is what should rule. The patient is not a patient of the Food and Drug Administration but of the physician.

REP. FARRIS: REP. CONNELLY said the purpose of the bill was to regulate staff of nursing homes and other places where patients are not in an immediate view of their doctor when they are taking medication and to see if the bill was written from that point of view. I just wondered if you agreed with that?
REP. McBRIDE: I don't think so. I think the other part of it is--who, in fact, is protecting the rights of the patients when they are in an institution. Who is going to be looking to see if there is excessive medication. The patient is not going to be the one to raise that issue. If there are no standards for those groups to look at who deem whether or not the medication is excessive, there is no one to protect the patient's rights other than the physician. I think it is important to realize unless there are those people looking to protect the rights or people in institutions, the doctor has to be the one prescribing. I am not too sure there are many nurses prescribing drugs. I think REP. CONNELLY hit on the purpose of this statute to begin with and that was to protect the patients from unnecessary medication that was just to control them. It is important to realize that it is the staff's job to protect the rights of the patients and they will have no standards by which to judge whether the medication is excessive or not.

REP. FARRIS: One of the things we have heard--that valium is one of the most abused drugs today. We don't seem to see very good regulation among medical professionals who do prescribe various kinds of medications. If there is no rule or limit set by the Food and Drug Administration or whomever, who sees to it that things happen consistent with medical practice.
SEN. CONOVER: The point was, we don't think there is any rule now. The Food and Drug Administration isn't telling you how much valium to give Joe Jones. That is done by the physician.

REP. FARRIS: How would anyone know if the doctor over-prescribed if we didn't have the standards established?
JERRY LOENDORF: Peer review. The Board of Medical Examiners reviews every complaint they receive and contrary to popular belief, they take plenty of licenses.

REP. FABREGA: Consistent with current medical practices, how are those standards determined?
JERRY LOENDORF: I don't know that I can find the answer.
REP. FABREGA: Your position is then that the patients are better off as patients of Food and Drug Administration than the physician.
REP. McBRIDE: I am not sure I can say that there is not some better standard than the U. S. Food and Drug Administration standards. There needs to be some sort of standards because otherwise people looking at protecting the patient's right has no way to judge that.
REP. FABREGA: Are all of these resolved by suits or malpractice?
REP. McBRIDE: While the comparison may be made to anyone who is given a prescription drug, the clientele in the mental institution may not have the advantage of anyone of us who has a prescription drug. We can go to another doctor but people in an institution don't have that advantage.
REP. FABREGA: Are you suggesting that when a patient is in an institution, the patient relationship doesn't exist as well.
REP. McBRIDE: I think it is different because the person has been admitted voluntarily to the institution.
REP. FABREGA: Is this bill intended to affect only those that are institutionalized?
JERRY LOENDORF: That section of the law deals only with people in mental health facilities.

CHAIRMAN HART closed the hearing on SENATE BILL 193.

SENATE BILL 107

SEN. BLAYLOCK, sponsor. This bill would require disability insurance policies and contracts to provide basic levels of benefits for the treatment and care of mental illness, alcoholism, and drug addiction. Currently, such coverage must be made available by insurer, but is not required in group policies. The bill would apply to policies and contracts delivered or issued after December 31, 1983.

He stated that this bill will help solve some of the problems in Montana. It tries to put the sickness of alcoholism and drug addiction under group insurance policies. It becomes mandatory that these two diseases be covered by group health insurance.

PROPONENTS:

JOANNE SALINA, representing the State Council of Community Mental Health Boards, Inc., said that although outpatient services provided by a mental health center are less costly than hospital care, insurance companies usually do not pay for them, or will pay only at a greatly reduced level because of limitations in their policies. This forces many patients to seek more costly and sometimes unnecessary hospitalization because their insurance will pay (EXHIBIT 2).

HAROLD GERKE, State Council of Community Mental Health Boards, Inc., stated this is an excellent piece of legislation--one that is long overdue in this state. He also said that JOHN NESBIT, County Commissioner, Shelby, wanted to go on record as supporting this bill.

STEVE SHUMATE, Director, Alcohol Programs of Montana, stated that the vast majority of insurance carriers right now already provide some form of coverage for alcoholism and drug addiction treatment services. This bill addresses a sizeable minority of carriers who do not. Those carriers who have provided this coverage to their clients do so and are able to remain competitive in the insurance line. This bill provides a base line for alcoholism treatment services and, especially, those services that are least expensive--non-hospital patient care. Insurance carriers are paying for the cost of alcohol and drug addiction at the present time. The problem with that is they are paying for the complications in the deteriorating and progressed aspects of the disease. We are presenting a bill that will address alcoholics behavior, drug addictive behavior in a far earlier stage, and perhaps in many cases prevent expensive complications of these diseases (EXHIBIT 3).

JOY McGRATH, representing the Mental Health Association of Montana, strongly supported and actively endorsed SENATE BILL 106, the equal insurance bill (EXHIBIT 4).

ANN SCOTT, member of a private group attempting to start an alcohol treatment center in Great Falls, said that one of the things this bill does--it allows a freestanding alcohol treatment center to be treated the same way as a hospital for alcohol treatment purposes. This doesn't mean they are treated the same for the detox program or any program that involves actual hospitalization for medical coverage. It just means that in the rehabilitative process of alcohol treatment, that a freestanding facility that is licensed by the state will be treated the same way as a hospital. I want to address a question that is going to be brought up by the opponents and that is what you are going to do here is increase cost to the policy holders. Please consider what happens when an individual can't pay for their alcohol treatment program. If the expenses can't be collected, it is just added on to everybody else's treatment or the treatment center realizes that they can't pay so they go to Galen. Who picks up the cost at Galen? The state. We all pick it up. We had better realize that the costs are already out there. They are just in some other form. She urged support of this bill.

RON JELMSTAD, Hill-top Recovery, Havre, said the hearing was necessary because the health insurance industry in Montana has chosen to ignore the recognition by the world health organization and by the people of the state of Montana that state that alcoholism is an illness. In their refusing to recognize systematically when it suits them exclude coverage for what has become the major health problem in our society. One of the ways the insurance industry avoids paying for chemical dependency treatment has been to adopt the policy that says they will pay for alcoholism or drug addiction as long as it is provided in a general hospital setting. Under this kind of approach here in Montana, two of the most noted chemical dependency treatment programs would be unable to collect third party payments. Both are specialized addictions hospitals. They are not housed or associated with a general hospital setting. The evidence is overwhelming that treatment of chemical dependency is a highly specialized field and that specialization has been developed over a number of years. This policy must be recognized for the benefit of the citizens of our state.

ROGER TIPPY, Attorney, representing the Montana Beer and Wine Wholesalers Association, said the alcohol beverage industry, whose taxes support a major portion of regional nonprofit alcoholism treatment programs, believes these programs need a broader revenue base on which to operate. This means more efforts to collect fees from clients and reimbursement from third party insurers (EXHIBIT 5).

KAY FLINN, chemical dependency counselor in private practice, supported this legislation. She had two major concerns: (1) language of the bill--segments of the bill that deals with approval of chemical dependency centers, and (2) licensure for treatment of chemical dependency problems (EXHIBIT 6).

DAVID CUNNINGHAM, Rimrock Foundation, Billings, said this bill has been implemented in most states throughout the midwest and the Rocky Mountain region. We believe that it is to our benefit to allow for application the intent of definitions of eligible providers so that Montanans who buy coverage can be assured of benefits for alcoholism treatment (EXHIBIT 7).

ED SHEPHERD, St. Patrick's Hospital, Missoula, said if we do not take action on SENATE BILL 107, we are saying it is all right to have diabetes because third party carriers will back it up but it is not alright to have the disease of alcohol.

JACK HASTY, Administrator, Sunrise Ranch and Alcohol Treatment Center, Helena, urged support and passage of SENATE BILL 107.

KEN ANDERSON, Flathead Valley Chemical Dependency Center, Kalispell, said that a portion of this bill allows for out-patient treatment. A certain small percentage of people who are chemically dependent are appropriate for outpatient treatment. What we have done--we have chosen to send these people to a more expensive treatment center because some of their insurances did cover it.

REPRESENTATIVE TED SCHYE, REPRESENTATIVE JIM JENSEN, and REPRESENTATIVE DENNIS IVERSON, were in support of this legislation.

BRUCE McCRACKEN urged passage of this bill.

Jo Caste, Director of Boyd Andrews Center, Helena, asked to be listed as a proponent of SENATE BILL 107.

OPPONENTS:

JACK NOBLE, Deputy Commissioner for Management and Fiscal Affairs, stated he has no opposition to the mental health aspects of this bill. We do object to the unlimited treatment of alcohol and drugs. Our current plan does cover alcoholism and drug treatment. We recognize that alcoholism is an illness. What we object to in this bill is the lack of limitations. Our current plan has a 24-month limitation, the maximum an employee can draw and then we have a lifetime limit an employee can use. His organization believes it is unnecessary and unwise to mandate insurance coverage for mental illness, alcoholism, and drug addiction under the same benefit umbrella. Mental illness has been taken care of fairly well in most contracts. They would prefer that the bill allow for a 50% coinsurance rates on an inpatient basis and outpatient basis--not the same rate as for other physical illness. They preferred a do not pass as they are against mandated coverage (EXHIBIT 8).

ALLEN KANE, representing Blue Shield and Blue Cross, said they are not opposed as an industry to the treatment of alcoholism. Their job is to provide payment for the kind of benefits their groups want. Many of their groups have reached the limit for what they can handle. The availability of insurance coverage is one of the things which has led to a proliferation of providers and an increase in utilization. Their people have to back up that cost. If benefits like this are mandated where they have no choice then those people are going to have to start to cut their benefits in other areas. He said he couldn't support this legislation.

TOM HARRISON, representing Blue Cross, addressed his remarks to the Senate Amendment, page 2, line 5, which put "free-standing inpatient facility" in the bill. What it has done is take a $1,000 outpatient benefit and superimpose on it another 30-day inpatient benefit. For anyone to say that we are talking pennies to put a brand new inpatient with hospital costs at $250 to $400 per day benefit in a bill and mandate it--whether a person does or does not drink, whether they are young or old, or whatever--is incredible.

The Director of Personnel appeared at the Senate hearing and quoted a figure of $80 per year per person. Between Blue Cross and Blue Shield, we insure 250,000 people in Montana times $80 is $20 million. That should be viewed as a $20 million tax. You can see the free standing placement on page 2 was not the way the bill was introduced. We have no trouble with the other provisions of the bill.

TOM SCHNEIDER, Director of the Montana Public Employees Association and also a member of the State Insurance Advisory Committee, stated they would never oppose better coverage for illness and health treatment in the state of Montana. For a brief rundown--five years ago, most of our groups had programs which had no deductible and full-paid health coverage. The state group at that time was paying a premium for a family of about $90 a month. In five years we have gone to a $100 deductible, 80% coinsurance and our family premium today is $155 per month. His major problem with the bill--in 27 different health groups, none of the people speaking in favor of the bill ever approached one of the employees and askedthem to look into this type of coverage for their health group. They went to bid on all of their major programs and have bid the programs with every conceivable type of coverage that people have ever asked for to see what the cost was. If this had been given to them, they would know today what the insurance companies felt the cost of this type of coverage was. None of the employees have ever come to them and asked for this type of coverage. Our health programs are in trouble and we have some major concerns about legislating, mandating, and coverages that we feel are less than other coverages. He had a problem with one area--the outpatient benefit, page 5, line 20. The sponsor stated that this bill requires a 50% payment but this bill does not really do that. This bill says at least 50% but if you have a coinsurance of 80%, 70% or 75%, that is what it is really going to pay. What I see happening with our groups--when we go in next time and the employees don't have the money to pay higher premiums, the employer isn't going to pay any more and we start looking at cutting, immediately we are going to drop coinsurance to 50% because this bill says you have to have the figure which is greater. This bill, in some ways, is to the detriment of the people by providing language which is going to reduce other coverages.

ELMER HOSKINS, Lobbyist for Montana Association of Life Underwriters, said they opposed this bill because it would increase overall health care costs. There were also some questions about the licensing as opposed to the state licensing provisions.

LES LOBLE, attorney, representing American Council of Life Insurance, shared a remark from the Maryland Legislature. "It appears from the data in the Blue Cross and Blue Shield report that the mandated coverage as passed by the Legislature in the last decade may have increased the cost of health care and health insurance by the policy holder without necessarily improving the quality of where a health service is added as a benefit paid by insurance, the incidence of an unncessary utilization of that service may increase. The Committee questions the ability of the average policyholder to afford these mandated coverages when one considers there is doubt as to whether his health has been improved."

CHAD SMITH, Montana Hospital Association, appeared in opposition to SENATE BILL 107. He stated among all the businesses and industries in Montana, the one that would be most affected on a business basis by the passage of this bill would be the hospital industry. We are opposed to the bill because we feel it is basically unfair. We do not believe legislation should be introduced which is mandated. If this is a problem of society, then it should be met as a society obligation. There should be appropriations by society as a whole to take care of this problem. It should not be placed on the back of an individual who is insuring himself for another purpose altogether. This does not address the matter of financing the alcohol treatment for one of the groups for which you have the greatest problem and that is the medicaid area. We have tried to get SRS and those that handle medicaid payment to include the type of treatment (30 day) for the medicaid patient and their response is that it is too expensive. There is absolutely no way that government can handle that. If government can't handle it, why should the burden be placed on the back of the private insured who doesn't want that coverage in the first place. He asked that SENATE BILL 107 not be concurred in.

QUESTIONS:

REP. DOZIER: Alcoholism is a problem of the person who has it and not the insurance company. If he doesn't have diabetes, he should have that portion of his insurance policy deleted.
MR. HARRISON: If you wanted to buy a policy that excluded diabetes, the policy is issued.

REP. DOZIER: There were some points made as to employee abuse in the studies you referred to. Does that ever come up?
JOY McGRATH: In the studies that I have been able to look at, they didn't mention employee abuse but they are a small portion of the people who are covered for mental health and rarely use that insurance.

REP. MENAHAN: Why is mental health and alcoholism in a bill together.
SEN. BLAYLOCK: I didn't draft the bill so I can't be specific in answering that.
JOY McGRATH: During the last Legislature, the two were lumped together.

REP. SEIFERT: We have a large group policy with the employees at home and every year that is negotiated whether they want dental insurance, eye insurance, etc. Under this bill, it would be mandated they would have to subscribe to this type of insurance. Wouldn't it be better if it were optional?
SEN. BLAYLOCK: If you do not make alcoholism and drug dependency mandatory, it will never happen.

REP. DRISCOLL: Would the insurance pay for involuntary commitment?
DAVID BRIGGS: If someone is committed to a private program by a judge, it would be applicable. If they are committed to a state program, it would not apply.

REP. SWIFT: Discussion was made to amending the bill to insert the freestanding. What was the reason?
SEN. BLAYLOCK: Because we have the two freestanding inpatient facilities in Montana. They wanted it to be covered under this so they would also be available for third party payments.
REP. SWIFT: Doesn't that increase costs enormously.
SEN. BLAYLOCK: Insurance companies keep saying how much this is going to cost. I would like to have this Committee ask the insurance companies to substantiate costs.
REP. SWIFT: Doesn't this say there is no cutoff date.
SEN. BLAYLOCK: Yes.
REP. SWIFT: He could be there any number of times as inpatient.
SEN. BLAYLOCK: Yes. As an outpatient, he would be limited to once.

REP. FABREGA: Presently, there is 30-day inpatient coverage.
SEN. BLAYLOCK: The current coverage in the bill is the way the law currently stands on the books. It would require that the company offer thirty days in the hospital acute-type care. For alcoholism treatment centers, it has a $1,000 per year limit. It has to be available to people buying this coverage. The large bulk coverage is purchased by large groups.
REP. FABREGA: Does your whole group participate or does a committee select coverage.
MR. NOBLE: It is a committee comprised of three individuals from each campus who are either elected or appointed.

REP. MENAHAN: A couple of hears ago, we were going to have an increase in our policy. We had a wave of letters from senior citizens protesting the increase. How would this affect them?
MR. NOBLE: This would not apply to them.
REP. MENAHAN: If you are a senior citizen, you would not get this benefit?
MR. NOBLE: Not the way the bill is drafted.

REP. BRAND: What is the basic purpose for having insurance if it isn't for something like this?
INSURANCE REPRESENTATIVE: It would be nice to have coverage for as broad a spectrum as you could. I think the position we find ourselves in now, the federal government is saying you can't have any more coverage and they are starting to squeeze it down so it is almost impossible to get. At the same time at the state level, we see an effort to mandate certain types of coverage. Peoples' benefits will have to be cut some where.

REP. BRAND: If that coverage is not covered in a group plan, the individual will have to provide their own?
INSURANCE REPRESENTATIVE: The only way we can control health care costs, we have to force people to share economically in the cost of their health care.

REP. BRAND: You think we ought to have socialized medicine?
INSURANCE REPRESENTATIVE: No, sir, we do not.

SEN. BLAYLOCK closed saying what we have heard here today are some differences in philosophy. His philosophy is that government can help those who cannot help themselves. I doubt that Mr. Schneider or the university group will ever get a majority that says we want to have alcoholism or drug addiction under a group plan. If we don't do this, the alcoholics will go to Galen and we take care of them as taxpayers. If they

can't get in under the insurance, they say they have a liver that is giving them problems; they go into the hospital. You really can't beat it. He urged support of this legislation. Additional testimony is attached (EXHIBIT 9).

SENATE BILL 70

SEN. ECK, sponsor. This legislation builds on the bill that was passed during the last session--the nurse practice act. One of the things that that bill did was to recognize nurse specialists and to provide that these specialists be qualified and licensed under regulations. During the last year, that has happened. They have promulgated regulations that assures that these persons are well qualified and well trained and meet the requirements. This Act provides that these nurse specialists can be entitled to third party payments as well as a number of other professionals. This bill recognizes those specialists and enables them to practice independently and to do their own billing. I think it is an important way of recognizing a group who do provide some very good professional service.

PROPONENTS:

SHIRLEY THENNIS, representing the Montana Nurses Association, spoke in support of SENATE BILL 70. She said one of the major changes adopted in the revision to the Nurse Practice Act was the recognition and definition of specialty areas of nursing. The revised Act also gave the Board of Nursing authority to adopt rules to define the educational requirements and other qualifications applicable to specialty areas of nursing. The rules require that the use of the title of Nurse Practitioner, Nurse Midwife, or Nurse Anesthetist has to be approved by the board and that such approval is only granted after the individual has obtained additional education beyond that required for licensure as a Registered Nurse who has also successfully passed a national certification examination which is recognized by the Board of Nursing. Now that the nursing specialists have been recognized in the law and rules and regulations are in place to assure the consumer that before a person can use a nursing specialist title that person has met additional educational requirements, the Montana Nurses' Association believes that SENATE BILL 70 is needed to help give the nurse specialist some economic assistance so that the specialist can practice within the scope of his/her license, education, and skills (EXHIBIT 10).

ELIZABETH VEIGN, registered nurse and a certified family nurse practitioner, presented testimony on behalf of the 43 members of the Montana Nurse Practitioners, a special interest group of the Montana Nurses' Association, in support of SENATE BILL 70. She stated that this bill would mandate that health insurers provide reimbursement for services of nursing specialists (nurse practitioners, nurse midwives, nurse anesthetists) if the consumer chooses the nursing specialists as their health care provider. It would give the consumer freedom of choice in choosing their primary health care provider and it would be a cost-saving measure for the health care system (EXHIBIT 11). She also read into the record testimony from COLLETTE NEWMAN (EXHIBIT 12).

TOM RYAN, Montana Senior Citizens and Montana Peoples' Association, also supported this legislation.

STACY FLAHERTY, Women's Lobbyist Fund, stated under current law, a nurse specialist is not allowed to function at his or her skill and education level. SENATE BILL 70 corrects this injustice to the profession by allowing nurse specialists the ability to circumvent third party billing (EXHIBIT 13).

BOB WALTMIRE, LISCA, supported SENATE BILL 70.

WADE WILKISON, Director of LISCA, said he would also like to provide support for this bill.

SEN. ECK closed saying there is good rationale for this bill. It is good for the nurses and it is good for the state in an effort to maintain health care.

CHAIRMAN HART closed the hearing on SENATE BILL 70.

EXECUTIVE ACTION

SENATE BILL 70

REP. MENAHAN moved SENATE BILL 70 BE CONCURRED IN.

The motion was voted and PASSED UNANIMOUSLY.

The meeting adjourned at 2:30 p.m.

Marjorie Hart
CHAIRMAN MARJORIE HART

Geri Brant
Secretary

Ex 1

SB 193

WITNESS STATEMENT

Name Jeleane T. Leendertz Committee On HHS

Address Helena, Mt. Date 3-9-83

Representing Mt. Pediatrician Support ✓

Bill No. S 193 Oppose

Amend

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

1.

2.

3.

4.

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

FORM CS-34
1-83

SB 193

Senate Bill 193 is concerned with the administration of medication to patients in mental health facilities.

The law currently provides, "The use of medication shall not exceed standards of use that are advocated by the United States Food and Drug Administration." The amendment proposed by this bill changes the law to read, "The use of medication shall not exceed standards of use that are consistent with current medical practice."

This change is necessary because the United States Food and Drug Administration makes determinations such as when a drug is safe to be placed on the market. The U. S. Food and Drug Administration does not tell us how much and how often a certain drug should be given to a specific patient afflicted with a certain disease or injury. This decision must be made by a physician on a case by case basis.

The effect of this bill is to provide a standard where now, for all practical purposes, none exists.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 193 DATE 3-9-83

SPONSOR SENATOR CONOVER

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
[illegible]	Helena, Mt	Mt. Med. Assn	✓	
Kathleen McBride		State Rep #85		✓

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

TESTIMONY IN SUPPORT OF SB-107

BY THE STATE COUNCIL OF COMMUNITY MENTAL HEALTH BOARDS, INC.

Historically, Montanans have had inadequate insurance coverage for mental illness. While insurance coverage for physical illness has kept pace with developments in medical care, this is not the case for mental health care. Insurance companies have imposed many limitations on mental health treatment, including higher deductibles, higher co-payments and fewer services which are covered.

Physicians often refer patients to mental health centers as an alternative to costly hospitalization. Although outpatient services provided by a mental health center are less costly than hospital care, insurance companies usually do not pay for them, or will pay only at a greatly reduced level because of limitations in their policies. This forces many patients to seek more costly and sometimes unnecessary hospitalization because their insurance will pay.

Some insurance plans have provided equitable coverage for mental illness. In many cases, the result has been a reduction in medical usage and costs. The reason for this is that between 35 to 50% of the patients who go to a physician have symptoms due wholly or in part to emotional factors. We have spent a great deal of time gathering data on the effects of this type of coverage. The information available has been limited and not always comprehensive. However, the data we have gathered indicates that when outpatient psychiatric care is paid for by insurance, inpatient psychiatric care and general medical usage are reduced and in some cases overall costs are also reduced. For example, the University of Washington Health Service found a 41% reduction in the use of outpatient medical services by individuals receiving mental health care.

Two researchers, Jones and Vischi, reviewed 13 insurance plans and found decreased medical usage in 12 of the 13 when mental health care was insured. Reductions in usage ranged from 5% to 85% with an average reduction of 20%. The Kaiser Permanente study found a 62% reduction in outpatient medical visits and a 68% reduction in hospital days by the fifth year after psychotherapy was covered.

Insurance coverage for outpatient mental health care has benefits for employers. When Kennecott Copper instituted an Employee Assistance Program it resulted in a six to one benefit to cost ratio. For example, Kennecott Copper experienced a 52% reduction in absenteeism. In addition, when Equitable Life Assurance initiated an employee emotional health program they increased productivity by $3.00 for every $1.00 spent on the program.

Ten states have guaranteed insurance benefits for mental illness. We contacted those states through the Montana Insurance Commissioner's office to request information about the effects on premiums and health care costs. They reported a lack of good evidence on how general health costs have been affected. Some states did give us specific information on premiums. The increase in premiums was generally modest and ranged from 17 cents in Minnesota to about 50 cents in Maryland, per person per month.

In some states which have passed similar legislation, insurance payments to mental health centers increased dramatically. In New Hampshire, insurance payments to mental health centers increased 100% from 1977 to 1980.

This legislation should, in the future, decrease mental health centers' dependence on State tax dollars, stabilize health costs and ensure the availability of quality mental health care for all Montanans.

Ex 3
SB107

TESTIMONY FOR SB 107

REQUIRING HEALTH INSURANCE COVERAGE FOR

ALCOHOL & DRUG ABUSE TREATMENT

It's strange...if someone in your family has heart disease or diabetes, you can count on your health insurance to cover treatment costs. Your insurance will pay for any treatment needed to reduce the impact of the disease, and it will probably pay for a variety of other services needed to help you and your loved-ones regain a reasonably normal life.

But if your family is troubled by alcoholism or drug abuse, you can't count on your insurance to help - at least in Montana. It may pay for a limited stay in the hospital, if you have reached the point that you must have acute medical care. But your policy probably won't pay for any follow-up outpatient treatment and most won't pay a nickel for an alcoholism counselor to help on the difficult road back from alcoholism to a normal life. Why?

Certainly not because alcoholism and drug abuse aren't significant health problems. In fact, substance abuse is the third worst severe health problem in the country. Nearly 100,000 Montana citizens struggle with alcohol and drug problems. Alcohol and drugs are involved in domestic violence, child abuse and divorce. They destroy families, undermine job performance, maim people on our highways and, according to the American Hospital Association, are at least a part of the problem in a third of all general admissions to hospitals. Put a dollar estimate on the size of Montana's alcohol and drug problem and the figure approaches $200,000,000 - each year - in lost work production, health and welfare costs, property damage, accidents and medical expenses. And that doesn't begin to count the human costs of broken homes, ruined careers and personal anguish.

Is it because substance abuse is a "self-inflicted" condition?

If so, it is hard to understand why most health insurance covers pregnancies or suicide attempts. For many people both of these conditions would be classed as "acts of free will" and therefore would be self-caused. Lung cancer is caused primarily by cigarette smoking; many traffic injuries by a decision or habit of not "buckling up." Why should alcoholism or drug abuse be singled out for exclusion on that basis when so many other health problems are covered?

Is it the cost of the coverage?

Not really. Fourteen other states require insurance companies to cover substance abuse treatment costs, and they have been able to do so quite economically. California's pilot program provided alcoholism coverage at a little over $2.00 annually per policy and other programs are providing coverage at between $2.00 and $8.00 annually. The Kemper Insurance Company expanded coverage in 1973 for alcoholism at no cost to policy holders. So did Employers of Wausau.

Why is it then?

Montana is playing "catch-up" when the question of requiring coverage for alcoholism and drug abuse is raised. Practical out-patient and residential treatment are available and at much less cost than hospitalization. There is no need any longer to put up with the costly and frustrating "revolving door" in which an alcoholic

or drug abuser goes through detoxification again and again with no follow-up treatment because his insurance only covers actual hospital care.

The trouble is that Montana is behind. We are behind Ohio, Illinois, Wisconsin, Minnesota and other states. We think you will agree that it's high time Montana required your health insurance policy to cover alcoholism and substance abuse as well as it does other diseases.

Submitted by: Alcoholism Programs of Montana
219 North Rodney
Helena, Montana 59601
443-2343

Ex 4
SB107

Mental Health Association of Montana

A Division of the national Mental Health Association
State Headquarters
201 South Last Chance Gulch
Helena, Montana 59601
(406) 442-4276

March 9, 1983

Testimony before House Human Services Committee
In Support of SB 107

I am Joy McGrath of Helena representing the Mental Health Association of Montana, which is a non-governmental, non-profit organization advocating better mental health for all Montanans. We strongly support and actively endorse SB 107, the equal insurance bill.

Our State has always shown a commitment to the care of the mentally ill citizens. This bill ensures that many citizens of Montana needing mental health, alcohol, or drug treatment services will have such services available more within their means. Enactment of SB 107 should save tax dollars and ensure the availability of quality mental health, alcohol and drug treatment for all Montanans.

On behalf of the State Association and its more than 1400 members, I ask for your careful consideration of this bill and urge a DO PASS recommendation on SB 107.

Ex 5
SB

WITNESS STATEMENT

Name ROGER TIPPY Committee On Human Services

Address P.O. Box 124 Date March 9, 1983

Representing Montana Beer & Wine Wholesalers Assn. Support X

Bill No. SB 107 Oppose

Amend

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

1. Alcohol beverage industry, whose taxes support a major portion of regional non-profit alcoholism treatment programs, believes these programs need a broader revenue base on which to operate. This means more efforts to
2. collect fees from clients and reimbursement from third party insurers.

3.

4.

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

FORM CS-34
1-83

Ex 6
SB107

WITNESS STATEMENT

Name Kay Flinn, CDC
Committee On Human Services
Address 555 Fuller
Date 3-9-83
Representing Self, Counseling Consortium
Support ✓
Bill No. SB 107
Oppose
Amend ✓

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

1. Concern with moratrium on approval for additional alcohol / drug treatment programs. [Carroll South, director DoE 1981]

2. Concern with lack of approval process by State authority for private treatment providers.

3. Concern with exclusion of social workers from coverage.

4. Lack of licensure availibility for M.H. centers through the State authority.

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

FORM CS-34
1-83

Ex 7
SB10

ALCOHOL AND DRUG ABUSE TREATMENT BENEFIT PROJECT UPDATE

JULY, 1981

The Blue Cross Association (BCA), in cooperation with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has been engaged since 1976 in a series of projects to develop and market comprehensive alcoholism and drug abuse treatment benefits. In June, 1979, the Association and NIDA began a project to demonstrate drug abuse benefits at two selected Blue Cross and Blue Shield Plans - Blue Cross of Greater Philadelphia and Blue Cross and Blue Shield of Alabama.

In Novemember, 1980, with support from NIAAA, the project was expanded to include alcoholism treatment. The additional funding will also support the examination of state licensure in lieu of JCAH accreditation as a provider standard, additional data collection activities, and the addition of a third demonstration site. The participation of NIAAA significantly strengthens the project's capability to improve the understanding of alcoholism and drug abuse benefits and to support its expansion among Plans.

The purpose of the demonstration is to refine administrative and marketing materials; to obtain data on the cost and utilization of alcoholism and drug abuse benefits; and to examine standards for treatment providers participating with the Plans. Based on the results of the demonstration project, the Association anticipates a recommendation to expand the benefit to other Plans.

The first year of the project entailed primarily administrative activity: the demonstration sites were selected; the benefit design was modified to meet local Plan needs; Plan administrative systems were modified to accomodate the new benefit; marketing and utilization plans were drafted; and an evaluation methodology was developed to provide for a case study analysis of each demonstration site. This work was described in a previous update (September, 1980).

This update reports the expansion of the project, marketing of the benefit, and utilization promotion activities conducted during the past year.

This project is being conducted under Contract No. 271-79-1405 with the National Institute on Drug Abuse; Alcohol, Drug Abuse, and Mental Health Administration; Department of Health and Human Services.

Albany Selected as Third Site

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has contracted with the Blue Cross Association (BCA) via the National Institute on Drug Abuse (NIDA), to fund an expansion of the drug abuse treatment benefit project to include alcoholism coverage. The contract modification supports the addition of a third demonstration site Plan, the collection of alcoholism data and alternative provider standards.

Blue Cross of Northeastern New York, Inc. (BCNNY), in Albany was selected as the third demonstration site. BCNNY serves the Northeast quadrant of New York State. The position of Project Coordinator is filled by Jim Gaw, Director of Marketing Support Services. Mr. Gaw previously served as a member of the project's advisory committee (DABSAC). Pat Jarvis, a Plan employee with three years of Blue Cross experience, was named the Project Specialist. Ms. Jarvis has experience in the areas of claims administration and quality assurance.

The benefit being marketed by the Albany Plan covers up to 120 days of rehabilitation in a residential program, up to 30 days of which may be used for hospital inpatient care. Up to 120 days may be used for outpatient visits, 15 of which can be used for family therapy. The benefit covers two 365 days periods. The premium will be approximately $.82 for an individual and $1.65 for a family per month.

The Plan has identified target accounts for the marketing effort, including the Plan itself, groups currently enrolled under the Plan's alcoholism rider, groups participating in EAP activities, and selected industries with historical interest in the control of employee alcoholism and drug abuse problems. This potential segment of the Plan's market amounts to approximately 47,000 contracts, or 19% of the Plan's experience rated groups.

A strategy has also been developed to reach enrollment and utilization objectives. The strategy includes using broadcast advertising, press releases, presentations, brochures, and transmitting other information on the new benefits to key decision makers at all eligible accounts. The strategy includes a special training program for sales representatives. Marketing began in June, 1981.

At BCNNY, special attention will be focused on examining provider qualification issues. For the period of the demonstration project, the Plan will not require JCAH accreditation for alcoholism and drug abuse treatment providers, but will rely on state licensure and Plan standards.

Benefits Being Offered

The benefits being offered by the three Plans are summarized below.

Blue Cross of Northeastern New York, Inc.

- 2 benefit periods. (Benefit period means a period of 12 consecutive months that begins the first day a member receives treatment after the effective date of coverage.)
- Inpatient coverage up to 30 days.
- Residential/outpatient coverage up to 120 days.
- No dollar maximum.

Blue Cross and Blue Shield of Alabama

- o 2 benefit periods with a maximum dollar limit of $5,000 per benefit period.
- o Inpatient coverage up to 30 days.
- o Residental/outpatient coverage up to 120 days.
- o 4 to 1 tradeoff between inpatient and residential/ outpatient.
- o $1,000 lifetime reserve for outpatient care.

Blue Cross of Greater Philadelphia

- o 2 benefit periods with 135 units (days/visits) of coverage per benefit period.
- o Inpatient coverage up to 30 days (60 units).
- o Residential/outpatient coverage up to 135 days/visits. (1 unit = 1 day/visit).
- o No dollar maximum.

Expanded Advisory Committee Meets

With the expansion of the project, the Drug Abuse Benefit Study Advisory Committee (DABSAC) became the Alcohol and Drug Abuse Treatment Benefit Study Advisory Committee (ADABSAC), and several new members were added. A meeting of the ADABSAC was held on May 14 and 15 in Washington, D.C. During the two day meeting, project staff from each of the demonstration site Plans presented status reports and the Advisory Committee discussed issues related to the major topics of marketing, provider relations and utilization promotion. Three issues received particular attention by the Committee members: marketing alcoholism and drug abuse benefits, the requirement of JCAH accreditation as a provider standard, and plans for year three of the project.

To enhance the marketing effort, special training sessions for marketing representatives have been held. The Plans have also taken other steps to promote sales of the benefit. For example, the Philadelphia Plan will distribute the initial rate for the benefit (60¢/individual and $1.70/family per month) over 2 years. Thus, an account will be charged monthly, only 30¢/individual and 85¢/family each year. Thereafter the account will be charged based on claims experience.

A second level of benefits with a reduced rate was also developed based on requests from several potential purchasers of the benefit. The scaled down benefit covers approximately half as much treatment as the full benefit. The rate for the modified benefit program is 40¢/individual and $1.15 per family, to be charged at 20¢ and 58¢, respectively, for the first two years. The rates set for the Alabama Plan are 35¢ per individual and $1.00 per family.

It was agreed that there is a need to study the use of JCAH accreditation and state licensure as provider criteria further. BCA is collecting information and reviewing this issue on a continuous basis. A recommendation will be made in BCA's final report.

During the discussion of plans for the third year of the project, project staff noted that marketing and promoting utilization will continue to be the Plans' primary activities.

The Association will collect cost and utilization data (see below), and will develop a plan for national implementation of alcoholism and drug abuse benefits. This plan will discuss the ways in which the conclusions and recommendations of the project can have maximum impact. Also during the next year the demonstration site Plans will prepare case studies describing their experience with alcohol and drug abuse treatment benefits.

Plan for Data Collection

The availability of accurate cost and utilization data is essential to the continued growth of alcoholism and drug abuse treatment benefits. To supplement the demonstration site Plans efforts, the Blue Cross Association has prepared a comprehensive plan for utilization data. During the coming months project staff will be contacting many Blue Cross and Blue Shield Plans, major industries and EAPs, and organizations in the treatment field to collect information on treatment norms, utilization patterns, and treatment costs. At the end of the project this data will be combined with data collected by the demonstration site Plans as a basis for the project's conclusions and recommendations. If you have data on the cost and utilization of alcoholism and drug abuse benefits we would appreciate your experience. Please contact Dave Strachan, Project Director, at the address given on page 6.

BCGP Sponsors Seminar: Alcoholism and Drug Abuse in the Workplace

Blue Cross of Greater Philadelphia (BCGP) held a marketing seminar on April 1, entitled Alcoholism and Drug Abuse in the Workplace. The seminar was attended by approximately 30 representatives from 23 accounts, as well as Plan marketing personnel.

Project Coordinator, Leonard Davis, served as moderator. The seminar began with a word of welcome by Jack McMeekin, BCGP Senior Vice President, and ended with a presentation by Ted Franchetti, Senior Director of Marketing. The agenda included presentations by several guest speakers from the treatment field and industry. Their presentations addressed the diseases and their treatment, and various aspects of alcoholism and drug abuse at the worksite. A panel discussion of all speakers was held to answer questions from the audience.

BCBSA's Utilization Promotion Activities

The Blue Cross and Blue Shield of Alabama (BCBSA) has begun developing an in-house employee assistance program (EAP) for its own employees. Larry Nolen, the Project Specialist, has been working with the Personnel Director on drafting a policy statement and referral procedures. In June, the Plan's executive staff approved the use of a Plan consultant to develop the training curriculum, train supervisors, and coordinate the EAP. The Plan's internal publications will be used extensively to promote the EAP to employees.

On February 19, Mr. Nolen made a presentation about the new benefit at the North Alabama Conference held in Huntsville. The Conference, entitled "The Employee Assistance Program - Cost Effective Answer", was sponsored by Alabama's ALMACA chapter, the Health Service Committee of the Decatur Chamber of Commerce and Retreat Hospital. A luncheon address was made by the Honorable Wilbur Mills. Participants included treatment providers from the area, representatives of business and labor from many parts of the State, and BCBSA marketing representatives responsible for accounts in the Huntsville area.

To promote utilization, Larry Nolen has had discussions about the EAP concept with several accounts which have purchased alcoholism and drug abuse coverage. Arrangement for more detailed presentations are being made via the marketing representative. On March 24, Mr. Nolen made a formal presentation to a Board of Education which purchased the benefit. The Personnel Director of the Board indicated a strong interest in setting up an EAP by the beginning of the new school year in September. The Plan's Project Specialist will continue to provide support and technical assistance.

Other Activities

In addition to the on-going project activities, the Plans have participated in seminars and other activities which serve to support the project.

In Philadelphia, Len Davis (Project Coordinator) addressed the industrial Social Services Council about the benefit. The group is composed of social workers that generally work as EAP coordinators in industry. Rebecca Aggrey (Project Specialist) was interviewed by a local affiliate of ABC-TV for a tape shown on an evening news telecast. She also spoke to a reporter for an article which appeared in the Philadelphia Inquirer. In the interviews, Ms. Aggrey discussed the benefit, alcohol and drug abuse treatment and employee assistance programming.

In Alabama, Larry Nolen attended the 5th Annual Business and Industry Seminar entitled "A Cost Effective Approach to Health Management". It was sponsored by Brookwood Lodge in coordination with Brookwood Medical Center in Birmingham. The group attending the seminar was composed mainly of representatives from business and industry. William Mandy, President of BCBSA spoke about the role of third party payors in health management. The "Brookwood Lodge Quarterly Newsletter for Business and Industry" also contained a full page article on the new BCBSA benefit, following an interview with Mr. Nolen. The newsletter is distributed throughout the southeastern United States.

After a BCBSA press release in early January, Mr. Nolen was interviewed about the benefit for evening news telecasts shown in Birmingham and Huntsville. He also provided information to a reporter from the Birmingham Post-Herald, who wrote an article for the business section on alcoholism in the workplace and the value of employee assistance programs.

In Albany, Jim Gaw (Project Coordinator) became a member of the Board of Directors of Schoharie Family and Community Services, parent organization of Schoharie Substance Abuse Services. Mr. Gaw and Pat Jarvis attended the fourth Annual New York State Substance Abuse Conference,

March 27-27, 1981. The Plan and the Blue Cross Association jointly presented a workshop for participants.

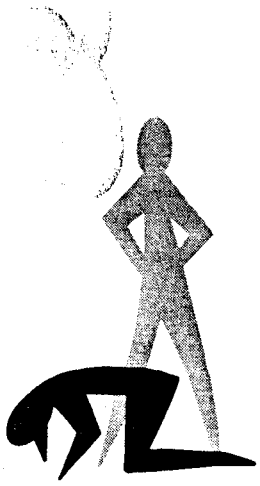
Blue Cross of Northwestern New York has also been invited to serve on an alcoholism panel at a forum of the Lake George-Lake Champlain sub-area council of the local Health Systems Agency. In addition, the Albany Plan will also provide assistance to New York State agencies on confidentiality issues and on proposed state standards for programs.

Project Contact

If you have suggestions or comments about the project, or would like additional information about the Alcohol and Drug Abuse Treatment Benefit Project, contact Project Director, Dave Strachan. Please call 312/440-5824, or write to him at:

Blue Cross and Blue Shield Associations
Program Development - 11th Floor
676 N. St. Clair
Chicago, IL 60611

Ex 7
SB107



Rimrock Foundation®

P.O. Box 30374 Billings, Montana 59107 (406) 248-3175

March 8, 1983

TESTIMONY BEFORE: HOUSE HUMAN SERVICES COMMITTEE

By

David W. Cunningham, M.H.A.
Executive Director

SB107
HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

The bill you are considering today has been implemented in most states throughout the Mid-West, Rocky Mountain and West Coast.

Far-sighted Montana Legislators implemented it four years ago. We are this session, seeking to clarify the intent and the definitions of eligible providers so that Montanans who buy alcohol and drug dependence coverage can be assured of benefits when they seek treatment at licensed centers close to their home community. Several carriers have used the vague definitions in the old law to disallow benefits to consumers unless they seek their treatment in an acute care hospital setting. There are only three hospitals in Montana providing alcohol/drug treatment programs -- all other treatment programs are private free-standing centers.

The National Blue Cross Association has been engaged since 1976 in a series of projects to expand alcoholism and drug abuse treatment benefits. Their national research on cost and utilization data indicate the premium range for coverage is 30¢/individual and 85¢/family each year. The highest rate for family coverage is ~~$100~~ $1.00 in Alabama. This national

data by the Blues suggests to us that insurance coverage is a reasonable means by which Montana's #1 health problem can be financed long-term to ensure that the need for public funds for treatment can remain at stable levels. Thus, consumers who use the services pay for them.

Alcohol and Drug Abuse Treatment Benefit Project Update, Blue Cross/NIAAA/NIDA, July, 1981

still has additional opportunity for treatment. They can return to the hospital or treatment center for $1,200 of additional coverage until they hit a maximum of $2,400. That's it! If they can't get their problem under control after expending $2,400 of our group insurance money, we feel they should do it on their own. S. B. 107 has no such limits. An alcoholic can beat the plan to death every year without ever having to assume the responsibility for his or her own actions. We strongly disagree with this concept! I might add that the persons providing the treatment also have an inexhaustible source of income -- continual treatment and continual insurance reimbursement. This bill is designed to encourage abuse.

6) We believe that it is unnecessary and unwise to mandate insurance coverage for mental illness, alcoholism, and drug addiction under the same benefit umbrella. While all of the above ailments or conditions are unfortuante, we feel that drug addiction is not a creeping illness such as alcoholism, but is self-inflicted. Often times in direct violation of our laws. Our committee does not favor providing continual and unlimited treatment to some cocaine sniffer with our employee's insurance premiums. There must be limits.

7) Mental illness has been taken care of fairly well in most contracts. We would prefer that the bill allow for a 50% coinsurance rates on an inpatient basis and outpatient basis -- not the same rate as for Other physical illness.

Our preference is a do not pass as we are against mandated coverage.

As a minimum, we would ask that the bill exclude mental health and drug addiction coverage and deal only with alcoholism. It should be amended to allow for 24 month limits and lifetime limitations on the coverage on both an inpatient basis and an outpatient basis. We feel that these types of limits are imperative if we are ever to slow the staggering growth in health care costs.

JHN/llt

SENATE BILL NO. 107

INTRODUCED BY BLAYLOCK, SCHYE, MCBRIDE, BACHINI, PECK, HARPER, IVERSON, HAZELBAKER, FULLER, J. JACOBSON, OCHSNER, LYNCH, LANE

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE FOR BASIC LEVELS OF BENEFITS UNDER DISABILITY INSURANCE POLICIES AND CONTRACTS FOR THE CARE AND TREATMENT OF MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION; AMENDING SECTIONS 33-22-701 THROUGH 33-22-704, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-701, MCA, is amended to read:

"33-22-701. Purpose Scope of part -- purpose. The purpose of this part is to encourage consumers to avail themselves of basic levels of benefits under health insurance policies and contracts provisions of this part apply to all GROUP policies of accident and health insurance and GROUP subscriber contracts offered to Montana by insurers and health service corporations for the care and treatment of mental illness, alcoholism, and drug addiction. and it is the purpose of this part to preserve the rights of the consumer to select have such coverage according to his medical and economic needs."

Section 2. Section 33-22-702, MCA, is amended to read:

"33-22-702. Definitions. For purposes of this part, the following definitions apply:

(1) "Inpatient hospital benefits" means benefits payable for charges made by a hospital OR FREESTANDING INPATIENT FACILITY, as defined in the policy or contract, for the necessary care and treatment of mental illness, alcoholism, or drug addiction furnished to a covered person while confined as a hospital AN inpatient and, with respect to major medical policies or contracts, also includes those benefits payable for charges made by a physician, as defined in the policy or contract, for the necessary care and treatment of mental illness, alcoholism, or drug addiction furnished to a covered person while confined as a hospital inpatient.

(2) "Outpatient benefits" means benefits payable for:

(a) reasonable charges made by a hospital for the necessary care and treatment of mental illness, alcoholism, or drug addiction furnished to a covered person while not confined as a hospital inpatient;

(b) reasonable charges for services rendered or prescribed by a physician for the necessary care and treatment for mental illness, alcoholism, or drug addiction furnished to a covered person while not confined as a hospital inpatient; and

(c) reasonable charges made by a mental health,

alcoholism, or drug addiction treatment center for the necessary care and treatment of a covered person provided in the treatment center, INCLUDING CHARGES BY A LICENSED SOCIAL WORKER AFFILIATED WITH THE TREATMENT CENTER; and

(d) reasonable charges for services rendered by a licensed psychiatrist OR psychologist or social worker.

(3) "Alcoholism treatment center" and "drug addiction treatment center" mean a treatment facility which provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and monitored by a physician PHYSICIAN OR chemical dependence DEPENDENCY counselor certified by the state, and which facility is also:

(a) affiliated with a hospital under a contractual agreement with an established system for patient referral; or

(b) licensed, certified, or approved as an alcoholism or drug addiction treatment center by the ALCOHOL AUTHORITY OF THE state.

(4) "Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a licensed physician, psychiatric social worker, and psychologist, and which

facility is also:

(a) licensed as a mental health treatment center by the state;

(b) funded or eligible for funding under federal or state law; or

(c) affiliated with a hospital under a contractual agreement with an established system for patient referral.

(5) "Mental illness" means neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder."

Section 3. Section 33-22-703, MCA, is amended to read:

"33-22-703. Availability of coverage. Coverage for mental illness, alcoholism, and drug addiction. Insurers and health service corporations transacting group or individual health insurance or group or individual health plans in this state must make available shall provide, under hospital and medical expenses incurred insurance GROUP policies and under hospital and medical service plan GROUP contracts, the level of benefits specified in this section for the necessary care and treatment of mental illness, alcoholism, and drug addiction subject to the right of the applicant for a group or individual policy or contract to reject the coverage or to select any alternative level of benefits above the minimum level of benefits described in subsections (2)(a) and (2)(b) as may be offered by the insurer or service plan corporation:

(1) Under ~~under~~ basic hospital INPATIENT expense policies or contracts, inpatient hospital benefits consisting of durational limits, dollar limits, deductibles, and ⟨coinsurance factors that are not less favorable than for physical illness generally,⟩ except that benefits may be limited to not less than 30 calendar days per year as defined in the policy or contract.

(2) Under ~~under~~ major medical policies or contracts, inpatient hospital benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors ⟨that are not less favorable than for physical illness generally,⟩ except that:

(a) ⟨inpatient hospital benefits may be limited to no less than 30 calendar days per year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 calendar days per year, the durational limits, dollar limits,⟩ deductibles, ⟨and coinsurance factors applicable thereto need not be the same as applicable to physical illness generally.⟩

(b) for outpatient benefits, the coinsurance factor may not exceed ~~50%~~ ~~20%~~ ~~50%~~ or the coinsurance factor ⟨applicable for physical illness⟩ generally, ⟨whichever is greater,⟩ and the maximum benefit for mental illness, alcoholism, and drug addiction in the aggregate during any applicable benefit period may be limited to not less than

~~$1,000 $1,500 $1,000~~

(c) maximum lifetime benefits may shall, for mental illness, alcoholism, and drug addiction in the aggregate, be no less than ⟨those applicable to physical illness generally, an amount equal to the lesser of $10,000 or 25% of the lifetime policy limit.⟩ (DOES IS UNLIMITED)

Section 4. Section 33-22-704, MCA, is amended to read:

"33-22-704. Applicability. (1) Except as provided in subsection ~~subsections~~ (2) ~~and (3)~~, this part applies to policies or contracts delivered or issued for delivery in this state more than 120 days after July 1, 1979, but does not apply to blanket, short term travel, accident only, limited or specified disease, individual conversion policies or contracts, or to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans.

(2) With respect to mental illness, this part applies to policies or contracts delivered or issued for delivery in this state after January 29, 1982.

~~(3) [This act] applies to policies or contracts delivered or issued for delivery in this state after December 31, 1984 1983, but does not apply to blanket, short-term travel, accident only, limited or specified disease, or policies or contracts designed for issuance to~~

persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans."

-End-

EX 9
SB 107

WITNESS STATEMENT

Name Glen L Drake Committee On Human Services

Address Helena Date 3/9

Representing Health Ins Ass'n of America Support

Bill No. SB-107 Oppose ✓

Amend

AFTER TESTIFYING, PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

1. (1) Bill makes mandatory alcohol & drug treatment
2. It takes away the right of choice
3. that now exists.
4. (2) It will add to the cost of all group insurance policys without consideration of the consumer.

(3) at the Senate hearing testimony was given by the department of administration that the cost to state employees would increase from $60.00 to $80.00 per year, all other consumers will be affected equally.

Itemize the main argument or points of your testimony. This will assist the committee secretary with her minutes.

FORM CS-34
1-83

TESTIMONY OF GLEN L. DRAKE
in behalf of
The Health Insurance Association of America

SENATE BILL 107

The Association opposes SB 107. SB 107 mandates that all group policies include coverage for treatment of mental illness, alcohol, and drug addiction.

The Association believes that mandated coverages are not in the best interest of the consumer or the public in general.

If this bill is passed and becomes law, costs of basic health group insurance is going to go up. A Department of Administration representative testified at the Senate hearing that the bill would increase the state plan from $60 to $80 per year.

At the Senate hearing, testimony was given to the effect that employee groups that contribute to premium cost could not afford more added costs. Thus, it is expected some group policies will be dropped if this bill is adopted and becomes law.

The bill deletes the requirement now in the law that this coverage be "offered" in all cases--be it group or individual policies. Thus, no longer will insurance companies be required to offer this coverage in individual policies.

The law, as it is, is the way it should be. Insurance companies should be required to offer the coverage but the public should be allowed to pick and choose.

The consuming public should be allowed to choose the type of policy and coverage that the particular group or person desires.

This bill is an infringement of the rights of every working or non-working person in the state.

St. Patrick Hospital

March 8, 1983

House Human Services Committee Members
Capitol Station
Helena, Montana 59601

Dear Committee Members:

A bill, SB 107, to provide insurance benefits for the care and treatment of mental illness, alcoholism, and drug addiction has been proposed. I strongly urge you to recommend passage of this bill.

In January, St. Patrick Hospital opened its inpatient Alcohol Treatment Center. We are acutely aware of the need for care and treatment of the chemically dependent patient. Statistics demonstrating the severity of this dibilitating illness are not new. The Monthly Vital Statistics Report for September 1981 from the National Center for Health Statistics indicates that alcoholism ranks third among causes of illness and disability in the United States. Statistics indicating alcohol-related deaths, automobile accidents and child abuse are overwhelming.

Alcoholism is recognized as an illness, but we are guilty of not treating the alcoholic with the care and concern we traditionally bestow upon patients with other illnesses. To not require the same kind of insurance benefits as those required for other patients in unconscionable. This bill, SB 107, provides you with an opportunity to demonstrate that which we all too frequently only say we believe--alcoholism is an illness.

Although I support the bill as a whole, I must take issue with one phrase which I believe should be deleted. An ammendment on page 3, line 3 of the bill reads, "including charges by a licensed social worker affiliated with the treatment center". At the St. Patrick Hospital Alcohol Treatment Center we have many professionals who contribute to the care of our patients. Our staff includes not only social workers, but nurses, psychologists, therapists and counselors. One category of health care professional should not be singled out in this bill. Additionally, Montana currently does not have a system for licensing social workers. A bill is proposed for establishing a licensing system--a bill I strongly oppose.

Although my comments have been relative to alcohol treatment, the treatment of mental illness requires the same consideration. Again, I urge you to recommend approval of this bill deleting the phrase pertaining to social workers. Should you have any questions regarding SB 107, please feel free to call me.

Sincerely,

Lawrence L. White, Jr.
Administrator

LLW/lj

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 107 DATE 3-9-83

SPONSOR SENATOR BLAYLOCK

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
LES LOBLE	HELENA	Am. Council of Life Ins.		✓
JACK NOOLE	HELENA	UNIVERSITY SYSTEM EMPLOYEES		✓
Ed Shepherd	Missoula	St Patrick Hospital	✓	
Kay FLINN, COX	Helena	Self, Counseling Consortium	✓	
STEVE SHUMATE	MISSOULA	Alcohol Programs of MT.	✓	
RON HELMSTAD	HAVRE	Hi-Hop Recovery	✓	
KEN ANDERSON	KALISPELL	CHEM/DEP Program	✓	
Hugh Kroetsch	Havre	Hi-Hop Recovery	✓	
Thomas Schneider	Helena	MPCA		✓
Jeanne Hall Sahlin	Great Falls	State Council CMHCs	✓	
Dick Hirsch	Great Falls	✓ ✓ ✓ ✓	✓	
Harold G. Hoke	Bldr.	— — — ✓	✓	
Elmer Sanders	Helena	MALJ		✓
Joey McGrath	Helena	Mental Health Assn. MT	✓	
Dave Brown	Helena	Community Mental Health	✓	
Hugh Tiggs	Helena	Beer & Wine Wholesalers	✓	
Tom Hanna	Helena	Blue Cross	Amend	
Ann Scott	Simms	Rocky MT A.I.	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

Ex 10
SB70

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

TESTIMONY ON SENATE BILL 70:

Madame Chairman, Comm. Members, my name is Shirley Thennis, representing the Montana Nurses' Association. I would like to speak in support of Senate Bill 70.

Prior to and during the 47th Legislature, the Montana Nurses' Association worked with members of the Legislature, the Board of Nursing, and other health care providers to amend the Nurse Practice Act in a manner which would safeguard the consumer and address the current needs and status of the profession of nursing. One of the major changes adopted in the revision to the Nurse Practice Act was the recognition and definition of specialty areas of nursing. The revised Act also gave the Board of Nursing authority to adopt rules to define the educational requirements and other qualifications applicable to specialty areas of nursing. For the past two years, the Board of Nursing has worked on these rules; and they are now in place. The rules require that the use of the title of Nurse Practitioner, Nurse Midwife, or Nurse Anesthetist has to be approved by the board and that such approval is only granted after the individual has obtained additional education beyond that required for licensure as a Registered Nurse who has also successfully passed a national certification examination which is recognized by the Board of Nursing.

Now that the nursing specialists have been recognized in the law and rules and regulations are in place to assure the consumer that before a person can use a nursing specalist title that person has met additional educational requirements,

the Montana Nurses' Association believes that Senate Bill 70 is needed to help give the nurse specialist some economic assistance so that the specialist can practice within the scope of his/her license, education, and skills. This bill would provide a method of tapping our valuable nursing resources, provide consumers with a choice, and provide economic assistance to nurse specialists.

The Nurse Practitioner can answer a definite need in a rural state like Montana in helping to provide another option for safe health care. Clients of nurse-midwives may have shorter hospital stays or no hospitalization at all, which eliminates a great expense. Studies in Georgia and California have demonstrated a decrease in the rate of neonatal mortality and low birth weights following the introduction of nurse-midwifery services. Because of some current concerns in Montana with home births, it is important to utilize nurses educated in the field of nurse-midwifery.

The MNA respectfully requests that the Committee give a "Do Pass" recommendation to Senate Bill 70. Without the benefits of third-party payments, nurse specialists are discouraged from utilizing their education and skills to provide another source of health care for the consumer.

/jo

Ex 11
SB70

TESTIMONY SUPPORTING DIRECT REIMBURSEMENT
FOR NURSING SPECIALISTS (SB-70)

My name is Elizabeth Veign and I reside at 708 15th Street South in Great Falls. I am a Registered Nurse and a Certified Family Nurse Practitioner. I am currently self-employed as a nurse practitioner consultant. I am presenting testimony on behalf of the 43 members of the Montana Nurse Practitioners, a special interest group of the Montana Nurses' Association. I am speaking in support of SB-70.

WHAT THIS BILL WILL DO:

1. Mandate that health insurers provide reimbursement for services of nursing specialists (nurse practitioners, nurse midwives, nurse anesthetists) if the consumer chooses the nursing specialists as their health care provider.

2. Give the consumer freedom of choice in choosing their primary health care provider; this is significantly diminished in the present health care system because insurance companies do not currently reimburse nurses.

3. Be a cost-saving measure for the health care system. Many studies have found that nurse practitioners can actually decrease certain health care costs because they provide preventive health care such as teaching patients about how to maintain their health. Later in my testimony I will cite some specific studies that have demonstrated significant health care savings.

WHY THIS LEGISLATION IS NEEDED:

1. To allow consumers access to the health provider of their choice. Access to nurse practitioners is especially important in a rural state like Montana where nurse practitioners have demonstrated their ability to provide high quality care in areas where physicians have not been available on a regular basis.

2. To eliminate economic barriers to nurse practitioner practice. Although the federal government has passed legislation that enables nurse practitioners to be directly reimbursed (the Rural Health Clinics Act and CHAMPUS), only a limited number of nurse practitioners in Montana are eligible for reimbursement under these programs. In many practice settings in Montana the nurse practitioner provides care for the client (patient) and the physician

2. In 21 studies comparing care provided by nurse practitioners with care provided by physicians, there were essentially no differences between the two types of health providers in relation to outcome of illness and care provided.

3. When a nurse practitioner was added to a small industrial company's health service, the company estimated its savings on industrials, medicals, taxi transportation, and lost work time to be a mean savings of $3,621 per month.

4. Nurse practitioners caring for patients with chronic illnesses have demonstrated dramatic improvements in reducing blood pressure in hypertensive patients; in reducing blood sugar levels of diabetic patients; and a 50% reduction in hospitalization. These findings have a significant impact on REDUCING HEALTH CARE COSTS.

5. The nurse practitioner/physician team was found to be 50% less costly in delivering health care for homebound patients when compared with physicians only.

WHAT IS HAPPENING IN OTHER STATES?

The following states have passed state health insurance legislation enabling third party payment for services of nurse specialists:

Alaska
California
Florida
Maryland
Mississippi
New Mexico
New York
Oregon
Pennsylvania
Utah
Washington (for all registered nurses)

INSTITUTE OF MEDICINE 1982 REPORT

The IOM has just completed a two year study of the need for federal aid to nursing education and ways to improve retention and distribution of nurses. Study concludes: "There is a need for the services of Nurse Practitioners, especially in medically underserved areas and in programs caring for the elderly. Medicare, Medicaid and other public and private payment systems should pay for the services of these practitioners in organized settings of care such as long term facilities, freestanding health centers and clinics, and health maintenance organizations, and in joint physician-nurse practi

Ex 12
SB 70

TESTIMONY SUPPORTING DIRECT REIMBURSEMENT FOR NURSING SPECIALISTS (SB-70)

Mr. Chairman and members of the Committee. My name is Collette Newman, I reside on a ranch North of Vaughn. I am the mother of 3 preschool children. I am here to speak in support of Senate Bill 70.

I have made frequent visits to Well Baby Clinics for the Well Child care of my 3 children. I have seen Beth, a FNP, at these clinics, and I was highly impressed by her thorough examinations and by her concern for my children and my family's general health. I was also pleased that I was able to receive such high quality health care for such a reasonable cost.

I feel that I would like the Nurse-Practitioners services covered by my health insurance, because I am pleased with this type of health care and would like to continue to have this type of health care as an option.

Thank you!

Ex 13

SB 70

WOMEN'S LOBBYIST FUND

Box 1099
Helena, MT 59624
449-7917

TESTIMONY OF THE WOMEN'S LOBBYIST FUND ON MARCH 9, 1983, BEFORE THE HOUSE HUMAN SERVICES COMMITTEE REGARDING SENATE BILL 70

The Women's Lobbyist Fund, representing a broad coalition of women's groups in Montana, supports the passage of SB 70 to include nurse specialists in the list of free choices for treating illness or injury covered by disability insurance or worker's compensation.

Under current law, a nurse specialist is not allowed to function at his or her skill and education level. SB 70 corrects this injustice to the profession by allowing nurse specialists the ability to circumvent third party billing.

SB 70 also helps the health care consumer by expanding the options of available health care choices.

The Women's Lobbyist Fund urges the committee to pass SB 70.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 70 DATE 3-9-83

SPONSOR SENATOR ECK

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Elizabeth Vergn	Great Falls	MT Nurse Practitioners	X	
Shirley Thomas	Helena	MNA	X	
JACK CASEY	HELENA	Sunrise Ranch	X	
Stacy Flaherty	Helena	Women's Lobbyist Fund	✓	
Tom Ryan	Helena	Montana Tavern Assoc	✓	
Judy T. Olson	Helena	Mt. Nurses Assoc.	—	
Melody Brown	Helena	MT Nurses' Assoc	✓	
Edgar Robbins	Helena	MT Nurses' Assoc	X	
Robert Wyatt	Colmbia Falls	MSCA	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33
1-83

STANDING COMMITTEE REPORT

March 8 19 83

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 70

third reading copy (blue color)

A BILL FOR AN ACT ENTITLED: "AN ACT INCLUDING NURSE SPECIALISTS IN THE LIST OF FREE CHOICES FOR TREATING ILLNESS OR INJURY COVERED BY DISABILITY INSURANCE OR WORKERS' COMPENSATION; AMENDING SECTION 33-22-111, MCA."

Respectfully report as follows: That SENATE Bill No. 70

BE CONCURRED IN

~~DO PASS~~

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

STANDING COMMITTEE REPORT

March 14, 19 83

SENATE BILL 107
Page 1 of 2

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 107

third reading copy (blue)
Color

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE FOR BASIC LEVELS OF BENEFITS UNDER DISABILITY INSURANCE POLICIES AND CONTRACTS FOR THE CARE AND TREATMENT OF MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION; AMENDING SECTIONS 33-22-701 THROUGH 33-22-704, MCA."

Respectfully report as follows: That SENATE Bill No. 107

BE AMENDED AS FOLLOWS:

1. Page 3, lines 3 and 4.
Strike: "INCLUDING CHARGES BY A LICENSED SOCIAL WORKER AFFILIATED WITH THE TREATMENT CENTER"

2. Page 4, line 23.
Following: "subsections"
Insert: "(1)(b),"

3. Page 4, line 24.
Following: line 23
Strike: "and"
Insert: ","
Following: "(2)(b)"
Insert: ", and (2)(d)"

[redacted]

DEBATE

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

4. Page 5, line 5.
Following: "that"
Insert: ":
(a)"

5. Page 5, line 8.
Following: line 7
Insert: "(b) the aggregate maximum benefit for alcoholism and drug addiction of inpatient expenses under basic inpatient policies and contracts plus inpatient and outpatient expenses under major medical policies and contracts may be limited to no less than:
(i) $4,000 in any 24 month period; and
(ii) $8,000 in lifetime benefits."

6. Page 6, line 3.
Strike: ", alcoholism, and drug addiction"

7. Page 6, line 6.
Strike: "."
Insert: ";"

8. Page 6, line 7.
Following: line 6
Insert: "(d) the aggregate maximum benefit for alcoholism and drug addiction of inpatient expenses under basic inpatient policies and contracts plus inpatient and outpatient expenses under major medical policies and contracts may be limited to no less than:
(i) $4,000 in any 24 month period; and
(ii) $8,000 in lifetime benefits."

AND AS AMENDED
BE CONCURRED IN

MARJORIE MART Chairman.

STATE PUB. CO.
Helena, Mont.