MINUTES OF THE MEETING
HUMAN SERVICES AND AGING COMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

March 6, 1985

The meeting of the Human Services and Aging Committee was called to order by Chairperson Nancy Keenan on March 6, 1985 at 3:15 p.m. in Room 312-2 of the State Capitol.

ROLL CALL: All members were present with the exception of Representative Bradley who was excused by the Chair.

HOUSE BILL NO. 757: Hearing commenced on House Bill No. 757. Representative Stella Jean Hansen, District #57, sponsor of the bill stated that an act establishing a health care cost containment board allocated to the Department of Administration; providing for funding through an appropriation; and providing an effective date was needed. Mrs. Hansen also indicated that a seven member board will be set up by the Governor. Amendments were also provided by Representative Hansen.

Proponent Wade Wilkison, representing LISCA supplied a fact sheet, Exhibit 1, which contained several questions and answers in support of this legislation. Mr. Wilkison also stated that in the amended form, House Bill No. 757 provides the state of Montana a virtually cost-free way of reducing hospital health cost increases. It also provides an alternative to the continuous history in Montana of studying the crisis of health care costs. This bill gives a specific proven method of cost containment in an area where cost increases threaten the ability of Montanans as individuals or as a society, to pay these increases. This bill can keep people on fixed incomes from being unable to receive proper medical care. Norma Keil, representing the North Central Area Agency on Aging supplied Exhibits 2. Ms. Keil stated that the concensus from the many senior citizens was that continment of the cost of health care would be their number one priority because rising health care costs affect everyone, young and old alike. Over the past twenty years, national health expenditures have increased 700%. Keil also supplied a joint legislative resolution regarding House Bill 757. Tom Ryan, representing the Senior Citizens Association stated that seniors' can't cope with the rising cost of health care. William Leary, representing the Montana Hospital Association supplied Exhibit 3. Mr. Leary said that the Association represents 57 general hospitals in the State of Montana and their 28 attached nursing homes and that they are opposed to this legislation. The so-called hospital cost containment proposal as it is a pure rate control commission proposal is not valid.

Governor Schwinden, by accepting a recommendation of the State Health Coordinating Council, has appointed a Governor's Council on Health Care Cost Containment. I am sure you are all aware of this council. The avowed purpose of the council is to work together in a rational and non-pressure situation to investigate all the elements of the rising health care costs. This will include hospitals, nursing homes, physicians, third party payers, business, labor, and all other elements that go into this extremely complex, and in many respects confusing issue. That council has already had its first meeting and over the next 18 months will have several more meetings to fully explore the issues in depth. The public - providers and consumers alike - will be asked to testify before that council. It is far better to allow that council time to develop rational recommendations for Governor Schwinden's use in addressing solutions to the major problems in the Montana health care system. Mr. Leary also supplied the ranking hospital expenditures, adjusted per admission for 1983, a medicare costs per patient chart and a newspaper article entitled Montana: cheap place to be sick. Signe Sedlacek, representing the Montana Hospitals Rate Review System Board of Directors supplied Exhibit 4. Ms. Sedlecek said that the Montana Hospitals Rate Review System is a non profit, voluntary organization established in 1970 to demonstrate that Montana's hospitals could and would impose self-restrictions on themselves which would result in the lowest possible rates for their services. That hospitals would voluntarily permit an "outside" agency to examine, evaluate, and pass judgment on their rate structures appears to be proof of their sincerity. That Montana ranks 46th in the nation in charges per admission appears to demonstrate their effectiveness. Chad Smith, representing the Montana Hospital Association as their attorney said that costs in Montana hospitals are the lowest in the nation and that this legislation is not feasible. Rose Skoog, representing the Montana Health Care Association supplied Exhibit 5. Ms. Skoog said that there are problems we should be working on relating to the financing of long term care. The solutions are in the area of better medicare coverage for such services, incentives to insurance companies to offer comprehensive long term care insurance, incentives to elderly to encourage the purchase of long term care insurance, and educating people generally about the need to provide for the situation when chronic illness makes long term care services necessary. Molly Monro, representing the Montana Association of Homes for the Aging supplied Exhibit 6. Ms. Monro said that it would be impossible for this group of unprofessional people to review the operations of a facility and be able to set their rates. Representative

Ben Cohen supplied Exhibits 7 which consisted of letter of opposition and petitions in opposition to House Bill No. 757. Representative Wallin said that there was no mention of doctors costs in this bill and he stated his opposition.

There were no further proponents and opponents present. Representative Hansen was then excused by the Chair.

There being no further discussion on House Bill No. 757, the hearing was closed.

HOUSE JOINT RESOLUTION NO. 23: Hearing commenced on House Joint Resolution No. 23. Representative Hansen, District #57, sponsor of the bill said that a joint resolution of the Senate and the House of Representatives of the State of Montana congratulating the Camp Fire Organization on its 75th birthday was needed.

Proponent Jane Morgan, representing Camp Fire Organization supplied Exhibit 8 which stated that the goal of the Camp Fire is to provide opportunities for youth to realize their potential and to function effectively as caring, self-directed individuals responsible to themselves and others.

There were no further proponents and opponents present. Representative Hansen was then excused by the Chair.

There being no further discussion on House Joint Resolution No. 23, the hearing was closed.

HOUSE JOINT RESOLUTION NO. 22: Hearing commenced on House Joint Resolution No. 22. Representative Raney, District #82, sponsor of the bill stated that a joint resolution of the Senate and House of Representatives of the State of Montana requesting an interim study of alcohol regulation and youths was needed.

Proponent Mike Males of Livingston stated that the law had changed three times since 1970. Raising the drinking age to 21 will be "a mess." Punitive law has no effect on teenagers. Mr. Males also said that there were three approaches - 1) transition; 2) being able to socialize with adults and 3) merit system. See Exhibit 9.

Opponent Jim Manion, representing the Montana Automobile Association supplied Exhibit 10. Mr. Manion said that the problem of teenage drinking was "studied to death" and that AAA recognizes that education and rehabilitation are not the total answer to the DWI problem. There are no panaceas for eliminating the drunken driver. AAA also supports reasonable deterrence measures, and for the

reasons enumerated supports the minimum drinking age of 21. Jerry Loendorf, representing the Montana Medical Association also stated his opposition to this bill. Mr. Loendorf said that passage of the proposed Senate bills regarding this same subject should be accomplised first.

There were no further proponents and opponents present. Representative Raney was then excused by the Chair.

There being no further discussion on House Joint Resolution No. 22, the hearing was closed.

SENATE BILL NO. 16: Hearing commenced on Senate Bill No. 16. Mr. Jim Lehr, an attorney for the Legislative Council introduced the bill for Senator Kolstad. Lehr said that an act to generally revise and clarify laws relating to health, social services, and transportation was needed.

There were no proponents and opponents present. Senator Kolstad being represented by Mr. Lehr was then excused by the Chair.

There being no further discussion on Senate Bill No. 16, the hearing was closed.

SENATE BILL NO. 103: Hearing commenced on Senate Bill No. 103. Senator Jacobson, District #36, sponsor of the bill said that an act revising the laws relating to disability insurance by including licensed social workers in the provisions regarding freedom of choice of practitioners and coverage for mental illness, alcoholism, and drug addiction was needed. Jacobson stated that the social workers were qualified and should be allowed reimbursement from insurance coverage.

Proponent Cal Winslow, representative of district 89 stated that 40% of the health care being treated by social workers was done in the outlaying areas where mental health centers were not located. Sharon Hanson, representing the National Association of Social Workers supplied Exhibit 11 which was a fact sheet on the cost effectiveness of licensed social work services. This fact sheet contained the effect on utilization of medical services and the effects on the cost of psychotherapy plus eight questions and answers regarding the inclusion of social workers in the insurance codes of Montana. Andre Deligdisch, a social worker from Great Falls stated that some insurance companies will pay and some insurance companies will not pay for psychotherapy. Gail Kline, representing the Women's Lobbyist

Fund stated that the freedom of choice, the economics of social workers as a less expensive alternative for therapy and the quality of services which would consist of the educational requirements would aid clients in receiving more choices for excellent mental health services that will be covered by insurance. Exhibit 12 was presented by Ms. Kline.

Opponents included John Alke of the Montana Physician's Service. Mr. Alke supplied Exhibit 13. Alke supplied testimony as to the effects of social worker legislation in Utah. Bill Jensen representing Blue Cross of Montana in Great Falls supplied Exhibit 14 which consisted of an article on the hidden dangers in mandatory health care benefit laws. Also provided was the NAIX policy on evaluating mandates; a list of the Montana Board of Examiners social workers, newspaper articles and legislation from New York.

There were no further proponents and opponents present. Senator Jacobson was then excused by the Chair.

Representative Waldron questioned as to whether hospital fees are out of control. Representative Wallin questioned the educational background of social workers. Representative Gilbert asked if this was a mandatory or a by choice bill with regards to insurance coverage. Representative Darko asked how many psychotherapists and psychyistrists there were in the state. Representative Bergene asked if the freedom of choice had been offered. Representative Keenan asked Mr. Jensen of Blue Cross if the list he had provided for the committee was complete with respect to the number of social workers in Montana.

There being no further discussion on Senate Bill No. 103, the hearing was closed.

SENATE BILL NO. 19: Hearing commenced on Senate Bill No. 19. Senator Lynch, District #34, sponsor of the bill said that an act establishing and funding a child abuse prevention program, granting rulemaking authority, requiring mandatory fines for certain offenses against children was needed. Senator Lynch also supplied amendments proposed for this bill.

Proponent JoAnn Peterson, representing the Montana Educational Association and Gloria Sprague, representing the Montana Junior League stated their support. Cindy Garthwaite, representing Parents Anonymous was formerly a

child who had been abused and urged the committee to consider this bill seriously because "children should not have to wait any longer." Bill Thomas, representing the CTF Steering Committee indicated his support. Terry Alpert, a former incest victim and former child abuser told of her experiences in her rehabilitation. Jerry Loendorf, representing the Montana Hospital Association stated that a definite funding source would be available. Marty Adrion, a member of the Task Force on Abuse stated that a fee from marriage license sales would not be feasible but that a surcharge on the sale of certified copies of birth certificates. William E. Leary, representing the Montana Hospital Association indicated his support as did Bailey Mullin. Gail Kline, representing the Women's Lobbyist Fund said that our children and grandchildren deserve our support. Exhibit 15 was supplied by Ms. Kline. Tina Sunino stated that her husband had abused their child and as a consequence the child had been placed in foster care. Through counseling Ms. Sunino and her husband now attend Parents Anonymous. Judith Carlson, representing the Association of Health Departments indicated her support of this legislation. Tom Druger of the MRCCA indicated his support as did Andre Deligdisch of Great Falls. Linda Walrath, a welfare worker indicated her support of this legislation. John Madsen, representing the Montana Department of Social and Rehabilitation Services stated that the Department can only supply a minimal amount of after care.

There were no further proponents and opponents present. Representative Lynch was then excused by the Chair.

Questions from the Committee were then called for. Representative Waldron asked what type of preventive activities were available. Representative Hansen asked if the money went to SRS, how would it be funded. Representative Keenan then explained to Representative Hansen the funding from the reading of the bill. Representative Bergene questioned the use of a board of directors. Representative Simon questioned day care centers.

There being no further discussion on Senate Bill No. 19, the hearing was closed.

EXECUTIVE SESSION

ACTION ON HOUSE JOINT RESOLUTION NO. 23: Representative Gould made a motion which was seconded by Representative Darko to do pass on House Joint Resolution No. 23. A vote was taken and unanimously passed by Committee. House

Joint Resolution was voted DO PASS.

ACTION ON HOUSE JOINT RESOLUTION NO. 22: Representative Gould made a motion which was seconded by Representative Darko to do pass on House Joint Resolution No. 22. A vote was taken and all Committee members voted yes with the exception of Representative Wallin voting no. House Joint Resolution was voted DO PASS.

ACTION ON SENATE BILL NO. 16: Representative Gould made a motion which was seconded by Representative Hansen to do pass on Senate Bill No. 16. A vote was taken and unanimously passed by Committee. Senate Bill No. 16 was voted to BE CONCURRED IN.

ADJOURN: There being no further business before the Committee, the meeting was adjourned at 7:20 p.m.

Nancy Keenan

NANCY KEENAN, Chair

STANDING COMMITTEE REPORT

March 6 19 85

MR. Speaker

We, your committee on Human Services and Aging

having had under consideration Senate Bill No. 16

first reading copy (white color)

Revise laws relating to health, social services and transportation

Respectfully report as follows: That Senate Bill No. 16

DO PASS

Chairman.

STATE PUB. CO.
Helena, Mont.

COMMITTEE SECRETARY

STANDING COMMITTEE REPORT

March 6 19 85

MR. Speaker

We, your committee on Human Services and Aging

having had under consideration House Joint Resolution Bill No. 22

first reading copy (white color)

Request for interim study on alcohol regulation and youths

Respectfully report as follows: That House Joint Resolution Bill No. 22

DO PASS

Chairman.

STATE PUB. CO.
Helena, Mont.

COMMITTEE SECRETARY

STANDING COMMITTEE REPORT

March 6 19 85

MR. Speaker

We, your committee on Human Services and Aging

having had under consideration House Joint Resolution Bill No. 23

first reading copy (white color)

Campfire resolution

Respectfully report as follows: That House Joint Resolution Bill No. 23

DO PASS

Chairman.

STATE PUB. CO.
Helena, Mont.

COMMITTEE SECRETARY

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

49th LEGISLATIVE SESSION -- 1985

Date March 6, 1985

NAME	PRESENT	ABSENT	EXCUSED
NANCY KEENAN	X		
BUDD GOULD	X		
TONI BERGENE	X		
DOROTHY BRADLEY			X
JAN BROWN	X		
BUD CAMPBELL	X		
BEN COHEN	X		
MARY ELLEN CONNELLY	X		
PAULA DARKO	X		
BOB GILBERT	X		
STELLA JEAN HANSEN	X		
MARIAN HANSON	X		
MARJORIE HART	X		
HARRIET HAYNE	X		
JOHN PHILLIPS	X		
BRUCE SIMON	X		
STEVE WALDRON	X		
NORM WALLIN	X		

EXHIBIT 1
March 6, 1985

HB 757 Fact Sheet

Wade Wilkison
LISCA

Q. WHAT IS THE ORIGIN OF HB 757?

A. Specifically, the concept embodied in HB 757 was considered by the 1984 session of Legacy Legislature and was ranked fourth, or among the highest of senior citizen priorities, by Legacy Legislature. More generally, as will be discussed below, the concept and model has been implemented in other states and has a proven ability to reduce annual health care cost increases as generated by hospitals by an average of 6%.

Q. WHY DID LEGACY LEGISLATURE AND OTHER SENIOR CITIZEN ORGANIZATIONS BECOME INVOLVED IN THIS ISSUE?

A. There is a crisis in America---the crisis of increases in health care costs. As a society we have prided ourselves in developing technological changes in the health care realm that have greatly expanded our abilities to preserve the quality of life and to extend life dramatically, and to offer that technology to all our people. The monolith of the health care industry which has emerged from this intense expenditure of care, research, and application of technology has become powerful and expensive. There has been almost an exponential increase in the cost of health care, an increase that threatens 1)to deny health care to those who cannot afford it themselves, and 2)to bankrupt the private businesses and state agencies which attempt to insure their employees, and 3)to drive up to unreasonable levels our state and federal taxes to pay for those state and federal programs responsible for providing health care to those without other health insurance coverage. Because of the crisis in health care costs, some steps have already been implemented, for example DRG (diagnostic related group) prospective payment mechanisms, but DRGs represent an early and incomplete answer to the health care cost crisis. We must do more, and HB 757 offers a clear and demonstrated way to more.

Q. ARE THERE ANY CHANGES THAT SHOULD BE MADE IN HB 757 BEFORE PASSAGE FROM THIS COMMITTEE?

A. Yes. Attached to this fact sheet are significant changes in how the hospital health costs containment board should be funded and its administrative focus. First, the board should be primarily self-funded, based on a sliding-scale fee schedule paid by Montana's hospitals. Second, we have ample evidence of the success of this sort of board in other states when focused on hospital care cost containment, but the evidence becomes less clear when other health agencies are included. Therefore only the clearly documented success focus of hospital care costs containment should be included.

Q. WHAT ARE THE CURRENT ALTERNATIVES TO HB 757?

A. There are several: 1)we can continue to do nothing, and have health care costs continue to erode the meager savings of our

senior citizens and others on fixed incomes---over the past five years, annual health care costs have averaged a 16% increase, and 80% of people over the age of 65 have at least one chronic health condition requiring at least medication;

2)we can pretend to do something, which is perhaps worse, by continuing to study the problem rather than attempting to take specific steps to begin to control the problem---since we know that this approach works, why delay implementing it?

3)Ellen Hekman, on behalf of the National Conference of State Legislatures, has synthesized a 31 page comparison of what states are attempting to do in the realm of health care cost containment(State Efforts at Health Care Cost Containment, September, 1984). The many other ideas on health care cost containment included in this study merit study, but the fact that there are additional ways to contain health care cost increases in other parts of the health provision system should not be used as an excuse to delay implementing the proven specific measures in HB 757;

4)opponents will cite a voluntary hospital board already in existence in Montana as their desired alternative, but that voluntary mechanism:1)does not include all hospitals precisely because it is voluntary;2)cannot enforce ceilings on health care costs, again because it is voluntary;3)is used primarily as a platform for more effective communications among the state's hospitals rather than the cost containment concept embodied in HB 757. Opponents might further argue that the cost of this hospital rate board---$300,000 over the period 1986-1987---if paid by the hospitals will be included in the cost of health care, and this would represent an unnecessary cost increase. The contrast, however, between $300,000 and the much more extensive cost savings that could be created through the hospital costs containment board make this an easy choice.

Q. SPECIFICALLY, WHAT OTHER STATES ARE USING THE APPROACH EMBODIED IN HB 757 AND WHAT IS THE PROVEN SUCCESS FACTOR?

A. 11 States have mandatory hospital rate setting boards already in place: Connecticut*; Florida; Maine*; Maryland*; Massachusetts*;New Jersey*; New York*; Rhode Island; Washington; West Virginia; and Wisconsin. The six states with asterisks include all payors under the rate setting board, as proposed in HB 757. The all-payors-included feature prevents hospitals from shifting costs from public-pay sources to private payors, or individuals, and so actually creates a ceiling on health care costs rather than simple transfer of costs from the public sector to the individual who is not covered by large corporate or state or federal health insurance. Connecticut fully implements this all-payors-included feature in 1986 and so its current cost containment history does not include this important element.

The five comparable states---Maine, Maryland, Massachusetts, New Jersey, and New York---over a five year period (1979-1983) experienced hospital health care cost increases ranging from 7% to 13%, for an average of about 10% increase per year. In contrast, in states without a hospital health care cost board, cost increases were dramatically higher; nationally over the same period annual health care cost increases were 16%.

Q. IN SUMMARY, WHAT DOES HB 757 OFFER?

A. In the amended form we recommend, HB 757 provides the state of Montana a virtually cost-free way of reducing hospital health cost increases. HB 757 provides an alternative to the continuous history in Montana of studying the crisis of health care costs---pushing off into the indefinite future any concrete action---and instead offers you the opportunity to begin to bring this crisis under control. HB 757 gives you a specific, proven method of cost containment in an area where cost increases threaten the ability of us---as individuals or as a society---to pay for these increases. HB 757 can keep people on fixed incomes from being unable to receive proper medical care.

RELEVANT HEALTH CARE COST FACTS

OVER $1 BILLION A DAY IS BEING SPENT IN THE US ON HEALTH CARE.

OVER THE PAST 20 YEARS, NATIONAL HEALTH EXPENDITURES HAVE INCREASED 700%.

EXPENDITURES FOR HEALTH ARE PROJECTED TO DOUBLE BY 1990, WHEN WE WILL BE SPENDING $2 BILLION A DAY FOR HEALTH CARE.

HEALTH CARE PRICES HAVE BEEN RISING TWICE AS FAST AS ALL OTHER PRICES IN THE ECONOMY.

CONTRARY TO POPULAR BELIEF, GROWTH IN THE OLDER POPULATION HAS LITTLE TO DO WITH THE ESCALATION IN HEALTH COSTS.

HOSPITAL PRICES IN PARTICULAR HAVE SOARED. THESE SOARING HOSPITAL COSTS ARE THE MAIN DRIVING FORCE BEHIND THE HEALTH COST CRISIS.

THREE-QUARTERS OF MEDICARE'S MONEY IS SPENT ON HOSPITAL CARE, SO HOSPITAL COSTS ARE THE MAIN CAUSE OF MEDICARE'S PROBLEMS: BY 1990 MEDICARE'S MAIN TRUST FUND IS EXPECTED TO BE EXHAUSTED, AND BY 1996 MEDICARE WILL FACE A STAGGERING DEFICIT OF NEARLY $300 BILLION.

CHRYSLER ESTIMATES THAT HEALTH INSURANCE COSTS FOR ITS WORKERS ADDS $600 TO THE PRICE OF EACH NEW CAR IT MAKES.

HOSPITAL COST INCREASES THUSLY THREATEN THE MAINTENANCE OF BOTH PUBLIC (MEDICARE) AND PRIVATE HEALTH INSURANCE PROGRAMS.

EXHIBIT 2
March 6, 1985

TESTIMONY FOR H.B. 757

Madame Chairman, and members of the Human Services Committee. I am Norma Keil, Conrad, Legislative District #10. I was elected by Senior Citizens of the North Central Area Agency on Aging to represent them on the Third Legacy Legislature which was held in September 1984. During the campaign for that office, issue forums were conducted throughout the area. The concensus from the many senior citizens in attendance was that containment of the cost of health care would be their #1 priority because rising health care costs affect everyone, young and old alike. We all have a stake in controlling the spiralling health care costs.

1. Workers and their dependents have a stake because of the cutbacks they face in their health insurance protection.
2. Consumers have a stake because soaring costs are reflected in the rising prices of goods and services.
3. Older Americans have a stake because medicare is in deep financial trouble and because increasingly older persons are less able to afford the cost of essential medical goods and services.

During the past decade, health care costs have been skyrocketing at more than double the general inflation rate. Over the past twenty years, national health expenditures have increased 700%. If this trend is not curbed, the expenditures are expected to more than double by 1990.

The health care costs are not just threatening medicare but also jeopardizing private health insurance plans. Most businesses purchase private health insurance coverage for their workers and their dependents. The costs of private health insurance have

already resulted in cutbacks in many worker's insurance protection. On the average, American companies annually pay over $1000. for each employee for health insurance protection.

Thus, these costs mean that many businesses must demand higher prices for the goods and services they sell to consumers. Chrysler estimated that the health insurance bill for its workers is adding $600.00 to the price of every car it manufactures.

Recognizing the seriousness of the situation as it relates to Montana, a Statewide Health Coordinating Conference was held in [redacted], 1983. That conference addressed the many health care problems facing Montana. The outcome of the conference was a set of specific, practical and measurable action plans. [redacted] January 21, 1985, [redacted] Governor Schwinden announced the creation of a Health Care Cost Containment Council. Quoting from his news release, "The Council is charged with finding ways to reduce the rate of growth". Quoting further from that press release, "Montana spent a total 906.3 million dollars in 1983, a 9.7% increase over 1982".

The Governor is to be commended for his action. [redacted]

[redacted] The legislature has the opportunity to follow the recommendations from the above mentioned action plan of the Statewide Health Coordinating Council to be initiated "as soon as possible and involve the legislature, the governor and other appropriate persons". Refer to (Article 3 of Summary of Consumers Plan) page 3 of Executive Summary of S.H.C.C.

Your serious consideration [redacted] will play an important role in solving some of the problems of rising health care costs, as well as giving strength to the Governor's Council.

Thank you!

In lieu of the preceding testimony I submit the following resolution.

JOINT LEGISLATIVE RESOLUTION REGARDING HOUSE BILL 757 AN ACT TO ESTABLISH A HEALTH CARE COST CONTAINMENT BOARD

WHEREAS, Americans are incurring health costs of $1 billion a day; and

WHEREAS, Montanans spent nearly $1 billion in 1983 for health care, representing nearly a ten percent increase from 1982; and

WHEREAS, health care consumes a significant and growing portion of government expenditures; and

WHEREAS, controlling rising health care costs has been identified as a major concern of the Legacy Legislature and Montana's senior citizens; and

WHEREAS, Montanans are increasingly concerned about rising health care costs and the affordability of quality health care.

WHEREAS, there is a need to develop a partnership among health care consumers, providers and public agencies in order to contain health care costs.

NOW, THEREFORE, BE IT RESOLVED by the 49th Montana Legislature that the Governor's Health Care Cost Containment Council recommend changes in public policies to the 50th Legislature that will reduce the rate of growth in Montana health care costs.

Statewide Health Coordinating Council
1983 Governor's Conference

Health Care: The Critical Balance

EXECUTIVE SUMMARY

by
Counseling and Education Development Service, Inc.
March 1, 1984

The 1983 Governor's Conference on Health Care was designed to produce specific action plans that address the health care problems facing Montana. The Statewide Health Coordinating Council (SHCC) initiated the conference and contracted with Counseling and Education Development Service, Inc. (CEDS) to plan and organize the conference in cooperation with a SHCC subcommittee and staff.

The conference process allowed Montana citizens, including representatives from health care consumers, health care providers, private business and government, to participate. The outcome of the conference was a set of specific, practical and measurable action plans.

The Conference was held on November 2 and 3, 1983 in Helena. 74 representatives participated. The results of the Conference are summarized below.

Classification of Health Care Problems

To ensure the manageability of the Conference discussions, health care problems were categorized into three types:

1. The costs of health care;

2. The quality of health care; and

3. The accessibility of health care.

However, participants were briefed on the interrelationships of these problems. They were also given a staff-prepared list of current important health care problems in Montana and the opportunity to add to the list as they saw fit. These problems were used as stimuli to develop action plans.

Conference Process

Conference staff divided participants into four discussion groups, each with a mixture of persons from the consumer, provider, business and government communities. Each group's task was to develop prioritized actions it could take to address health care problems in Montana.

GROUP 1: What "Business" can do;

GROUP 2: What "Consumers" can do;

GROUP 3: What "Health Care Providers" can do;

GROUP 4: What "Government" can do.

Groups "brainstormed" action ideas, prioritized them and then

developed action plans for the top priority ideas. Actions included the following specific information:

1. What, exactly, the action is.

2. Who will take the action (a lead group was to be named).

3. When the action should begin.

Summary of Recommended Action Plans

Though the conference participants addressed costs, quality and access to care, the clear overriding concern was the escalating cost of health care. All groups saw that health care costs have a major impact on the quality and accessibility of health care for Montanans. The necessity of preserving quality and accessibility while controlling health care costs was usually the context in which quality and accessibility were discussed.

High priority action plans tended to fall into six major areas:

1. Prevention/education (Eight Action Plans)

2. Planning and legislation (Seven Action Plans)

3. Alternative health care delivery systems (Seven Action Plans)

4. Transportation in rural areas (Three Action Plans)

5. Public funding of health care (Three Action Plans)

6. Health care utilization controls (Two Action Plans)

These thirty action plans are summarized into twenty action plans, due to duplications within groups. Duplications between groups were maintained.

Summary of Business' Action Plans

1. A Statewide coalition of business, government, unions, the University system, and special interest consumer groups should be formed. It should facilitate the control of health care costs through employee wellness programs, incentives, health care cost education, hazard controls and utilization controls. This action plan is to be implemented within 1984, but no lead organization was designated.

2. The Insurance Commission, in a new and expanded role, should promote implementation of alternative health insurance structures, such as self-insurance, cost-sharing and incentives for wellness. This would be enabled by legislative changes and should occur over the next one and one-half years. The Insurance Commission should take the lead, and the public, especially labor leaders, should participate.

3. The Departments of Transportation and Commerce, involving appropriate State and local agencies and businesses, should initiate a plan for health care-related transportation in Montana. This should occur in FY 1984.

4. Business should increase involvement in the "Certificate of Need" (CON) review process. There should be a more thorough study and disclosure of the total financial impact of a CON request on health care costs in all segments of a community. The Montana Department of Health and Environmental Sciences (MDHES), the lead agency, should take action during 1984.

Summary of Consumers' Action Plans

1. The SHCC should promote the establishment of "HMO-type" health plans in Montana in 1984-85. Cost-sharing, incentives, and cooperatives for health care should be considered. Educating consumers, including Medicare and Medicaid populations, in home care and health is another issue that should be addressed in this effort.

2. A task force of consumers and providers should promote a more aggressive and cost-efficient health "case management" system. Special consideration should be given to home health care and outpatient services. The Montana Public Health Association and representatives from the insurance industry should initiate action in this area in 1984.

3. Participation by consumers in the Health Systems Agency process should be strengthened through policy changes and public education. This should give consumers more power in CON decisions. The State Board of Health's role in the CON process should also be critically examined. The SHCC should initiate action as soon as possible and involve the legislature, governor and other appropriate persons. (See #4 in Business' Action Plans.)

4. The SHCC and University System should stimulate the development of 1) more consumer health education programs

for the public and required programs for schoolchildren; and 2) a "minor" program in health education in the Montana University System to train Montana teachers in health education. This action should occur in 1984-85.

Summary of Health Care Providers' Action Plans

1. The SHCC should initiate action in 1984 to increase the use of medical peer review by health care purchasers.

2. The Montana Emergency Medical Services Association, Councils on Aging, and ambulance services should immediately initiate an effort to improve the availability and use of health care-related transportation in Montana. Consideration of telephone access through a centralized directory system (e.g. 911) was recommended as a part of this action. (See #3 in Business' Action Plans.)

3. The SHCC should establish an appropriate task force in 1984 to simplify the application and eligibility process for government health programs.

4. An education program for health care providers should be established in 1984 regarding issues in health care costs, such as Diagnosis Related Groups (DRG's) and cost-shifting. Though no lead organization was designated, individual health care providers, State government and the legislature were mentioned as appropriate participants in this action.

5. Beginning in 1984, action should be taken, through new legislation, to provide health insurance for the unemployed. No lead organization was designated.

6. A task force should be established immediately to explore different health care delivery alternatives. (See #2 in (Business' Action Plans). The Department of Social and Rehabilitative Services (SRS) was suggested as the lead agency, but a host of other agencies, organizations and professional societies were recommended as participants in the action.

7. A public information program on DRG's and an evaluation of their effects should be developed by an appropriate agency, to be suggested by the SHCC in 1984.

8. The Governor should appoint a committee in 1984 to facilitate the development of discussions on the ethical issues of new health technology, its costs and uses.

Summary of Government's Action Plans

1. SRS should take action in 1984 to have the legislature fully fund the Medicaid program.

2. The MDHES should take the lead to increase funding for cost-effective, cost-beneficial prevention/education programs for health. This action should begin in 1984 and be complete by September, 1984.

3. A greater portion of current State taxes on alcohol and tobacco should be used to fund health care programs. The Governor should initiate action immediately and prepare draft legislation by July 1, 1984.

4. The Governor should appoint a State government council to facilitate the control of State government employees' health care costs. This action should begin in January, 1984.

5. The MDHES and SRS should immediately initiate studies on the cost-effectiveness of different long-term health care alternatives. They should be completed by September, 1984 and be updated annually.

6. The HSA should play an active role in better distributing "compatible" physicians to rural areas. The HSA should develop draft legislation by September, 1984.

7. The SHCC should investigate the role of the State Board of Health in the CON process and structure communication between HSA, MDHES and the Board. This should be accomplished by September, 1984.

8. The State should build employee incentives for healthy lifestyles into its health care program and consider wellness and employee assistance programs. The State Department of Administration should initiate this, but no deadline was indicated.

EXHIBIT 3

March 6, 1985

HOUSE BILL 757 - AN ACT ESTABLISHING A HEALTH CARE COST CONTAINMENT BOARD

Testimony by: William E. Leary, President, Montana Hospital Association

The Montana Hospital Association, which represents 57 general hospitals in the state of Montana and their 28 attached nursing homes, is opposed to House Bill 757 - the so-called hospital cost containment proposal - as it is a pure rate control commission proposal.

All the general acute care hospitals in Montana are managed by a local hospital board, either elected by the people in a hospital district, appointed by county commissioners in the case of county hospitals, or appointed by existing boards for the nonprofit community hospitals. Across the Big Sky State we have over 550 hospital trustees who serve on a voluntary, nonpaid basis and develop the policy to guide hospital administration in the 55 Montana communities where we have hospitals ranging from the smallest of 6 beds to the largest at 282 beds.

I assure you that these individuals, your neighbors and community leaders, function as a toughminded rate setting board and as trustees, are acutely aware of their responsibility to provide, in concert with other health care institutions, the best possible health care service at the lowest cost. Since they serve without pay or remuneration of any kind, from a personal standpoint they have nothing to gain by setting rates and charges above the minimal level required to maintain appropriate services.

In addition to the control exerted by local trustees over rates and charges, a majority of Montana's hospitals belong to the Montana Hospitals Rate Review System, a voluntary organization, originally established by the Montana Hospital Association but which has been independent of the Montana Hospital Association since 1969. This move was taken to assure the public that an independent, although voluntary, organization does have a significant role in helping to contain the increases of hospital costs.

Certainly Montana's senior citizens and the members of the American Association of Retired Persons want to contain health care costs - as do all of us who work in the industry. We - the responsible hospital executives, physicians, nurses, trustees - are continually working towards health care cost containment. Later this spring I will be reporting to the Governor's Council on Health Care Cost Containment in detail on the efforts Montana hospitals have been making in this area.

However, I call your attention to the fact that House Bill 757 will regulate only hospitals and nursing homes, the two components of the health care system for which there is already a fixed and regulated reimbursement for services to the elderly - hospitals under the Medicare DRG system and nursing homes under the Medicaid negotiated reimbursement system.

All hospitals take Medicare assignment and accept in full, payment of a fixed fee regardless of the cost or charges incurred by the patient. Yes, we still have Medicare discounts, which is the amount of money that is charged off of revenue, but that too is holding the line. For example, in 1983 the deductions from revenue for Medicare discounts was some $31,564,605, a 43.3 percent increase of 1983 over 1982. In 1984 we still have $31,859,446 as Medicare discounts but the percentage of increase ot 1984 over 1983 is significantly lower, demonstrating the impact of DRGs. Yes, the Medicare recipient still has to pay $400 deductible and the co-insurance factors starting on the 61st day as dictated by federal law. But, the significance of the decrease in percentage of increase of Medicare discounts is that the nationally imposed prospective payment system is working and if it is allowed to continue without tinkering, Montana hospitals should continue to receive adequate reimbursement to assure the elderly that they will receive quality care at a reasonable cost.

The nationwide trend of decreasing admissions to hospitals has put the hospital industry in a depressed situation. In 1984 Montana hospitals experienced about 119,077 admissions, nearly a 6 percent decrease from 1983. The declining admissions as well as an average length of stay of 5.19 days has put some of our Montana hospitals in a precarious financial position. They are coping, however, by implementing more effective group purchasing programs, freezes on hiring, as well as lay-off of personnel, generally through attrition, and a general limit on salary increases to all personnel from the top administration to housekeepers and food servers - belt tightening in its truest form.

A necessary preliminary to any discussion of increased regulation of the hospital industry in Montana is an examination of the present status of that industry and whether there is a need for such additional regulation.

Let's look at the facts. At the present time in the United States there are 11 states which have established governmental mandatory hospital rate control commissions. In all instances, Montana hospitals compare favorably with hospitals in those states where rate control bureaucracies are in place.

Let's look at hospital expenses, admissions and patient days in Montana and the rate control states. Attachment I to this paper shows hospital expenditures on a per admission basis in 1983 in the 50 states plus the District of Columbia. The 11 rate commission states are outlined in brackets and Montana is starred. Note that Montana at $2,389 per admission ranks 45th in the country, which was far lower than any of the rate commission states. Attachment II shows the average length of stay in each of the 50 states plus the District of Columbia. You will note that generally the states in the Northeast, New York, Massachusetts, Pennsylvania, New Jersey, Rhode Island, all exceed 8 days as an average length of stay, while the states in the West, and in particular the Rocky Mountain area, are generally below 6 days. In this category, Montana ranks 47th in the nation with 5.4 days average length of stay. It might interest you to know that the 1984 data for Montana hospitals shows our average length of stay dropping to 5.19 days and our total admissions dropping another 6 percent to 119,077. If any person says that Montana hospitals are not efficient and productive, I would challenge them just on these "turnover" statistics.

Chart III shows the hospital expenditures on a per capita basis for 1983 compared to the per capita for 1982. You will note that the 1982 per capita for Montana was $329 and for 1983 had increased to $374. In terms of ranking, the 1983 per capita hospital expenditures ranks 40 out of 51 in the nation. An interesting sidelight which I discovered in researching for this paper, was that in 1982, Montana's per capita personal income (based on 805,000 population) was $9,544 and it had increased in 1983 to $9,943 (based on 817,000 population). The federal Department of Economic Analysis ranks the 1983 Montana per capita personal income as 37th out of 51. Compare that to the per capita hospital expenditure ranking of 40 out of 51.

I also draw your attention to Attachment IV which illustrates how Montana hospitals rank in Medicare costs per patient. Last December I requested the American Hospital Association to compare Medicare costs per discharge in 1981 and 1985 for Montana and rate regulated states. For this comparison, the AHA selected the four current Medicare waiver states (Maryland, Massachusetts, New Jersey and New York), three states with rate review for all payers except Medicare (Connecticut, Rhode Island and Washington) and three states that passed legislation in 1983 implementing an all payer rate control system (Maine, West Virginia and Wisconsin). 1981 Medicare cost report data was used to calculate average cost per discharge for each state and then "rolled forward" to 1985 levels by using

actual and projected rates of increase in hospital costs. The results of this comparison are shown in Attachment IV and, as you can see, it shows Montana has the lowest cost per discharge compared to all of the other states, both in 1981 and 1985.

I now call your attention to the attached newspaper clipping which appeared in the Independent Record, March 3, 1985, as further verification that Montana hospital costs per day are less than in any other state except South Dakota. This was developed by the U.S. Statistical Abstract of the United States.

I have presented all this information to demonstrate to you that the Montana hospital economy is one of the most efficient and productive health care systems in the United States. The infusion of another governmental bureaucratic commission will do nothing more than to increase hospital costs as I would predict that Montana hospitals, large and small, would of necessity have to come before the seven person commission to justify their budgets and allow a commission to establish their rates. The hospitals would have to be well armed with CPAs, health care economists, and attorneys, for it would be their only time to come before a public service commission. All of the costs of hiring these experts would have to go into the hospital budget and not one dollar of this would be utilized to provide patient care to the persons utilizing our health care system.

If such a commission is established, its principle mission, and perhaps sole mission, will be to cut costs. That will eventually force Montana hospitals to reduce the quality or quantity, or access to health care, or perhaps all three. One of the AARP slogans is to "Cut the costs, not the care".

Creation of such a commission would add yet another facet to the growing, often resented, government bureaucracy. It would be simple for such a commission to order cuts in the fees charged by Montana hospitals, but therein lies the danger. They may no longer be the kind of hospitals people would want to go to.

The national hospital industry inflation rate for the last 8 months of 1984 was 4.8 percent, just slightly above the overall inflation rate for the nation.

Chronic illness, not episodic illness, is emerging as America's major health care concern as the nation's elderly population continues to increase. No rate commission, regardless of how well it is financed or staffed, will solve this problem.

Members of the Committee, I remind you that the Washington State Hospital Rate Commission operates in a state which controls 124 hospitals which would be compared to 60 Montana hospitals under this current proposal. The 1981-1983 biennial appropriation for the Washington State Hospital Rate Commission was

$1,379,450; 1983-1985 that figure is estimated to be $2,277,361; and the proposal for 1985-1987 is $2,923,650. If you approve establishment of this commission and the $300,000 appropriation, I predict that it's only the beginning, the tip of the iceberg, for in subsequent sessions this same committee, or more likely the Committee on Appropriations, will be faced with finding more money to finance a bureaucratic commission which will continue to issue regulations to control an industry which is already proven to be one of the most cost effective and efficient in our state.

Governor Schwinden, by accepting a recommendation of the State Health Coordinating Council, has appointed a Governor's Council on Health Care Cost Containment. I am sure you are all aware of this council. The avowed purpose of the council is to work together in a rational and nonpressure situation to investigate all the elements of the rising health care costs. This will include hospitals, nursing homes, physicians, third party payers, business, labor, and all other elements that go into this extremely complex, and in many respects confusing, issue. That council has already had its first meeting and over the next 18 months will have several more meetings to fully explore the issues in depth. The public - providers and consumers alike - will be asked to testify before that council. Today you have just heard about one-half of the hospitals' testimony. It is far better to allow that council time to develop rational recommendations for Governor Schwinden's use in addressing solutions to the major problems in the Montana health care system.

I would encourage your solid Do Not Pass vote on House Bill 757.

RANKING HOSPITAL (1983) EXPENDITURES, ADJUSTED PER ADMISSION
(HIGHEST TO LOWEST)
SOURCE: AMERICAN HOSPITAL ASSOCIATION HOSPITAL STATISTICS (1984 EDITION)

1.	DISTRICT OF COLUMBIA	5061
2.	MASSACHUSETTS	4472
3.	CALIFORNIA	4253
4.	ALASKA	4023
5.	NEVADA	3927
6.	NEW YORK	3916
7.	MICHIGAN	3758
8.	CONNECTICUT	3690
9.	ILLINOIS	3663
10.	RHODE ISLAND	3661
11.	ARIZONA	3646
12.	PENNSYLVANIA	3639
13.	MARYLAND	3415
14.	DELAWARE	3379
15.	OHIO	3361
16.	HAWAII	3349
17.	MISSOURI	3246
18.	COLORADO	3204
19.	FLORIDA	3139
20.	MAINE	3078
21.	MINNESOTA	3031
22.	WISCONSIN	3000
23.	OREGON	2938
24.	INDIANA	2933
25.	NEW MEXICO	2898
26.	KANSAS	2897
	UNITED STATES AVERAGE	$3203
27.	NEW JERSEY	2889
28.	VIRGINIA	2856
29.	WASHINGTON	2848
30.	NEW HAMPSHIRE	2799
31.	IOWA	2763
32.	UTAH	2748
33.	LOUISIANA	2732
34.	VERMONT	2672
35.	NEBRASKA	2621
36.	OKLAHOMA	2614
37.	TEXAS	2589
38.	NORTH DAKOTA	2509
39.	ALABAMA	2499
40.	WEST VIRGINIA	2453
41.	NORTH CAROLINA	2448
42.	GEORGIA	2418
43.	TENNESSEE	2408
44.	SOUTH CAROLINA	2400
45.	*MONTANA	2389
46.	WYOMING	2295
47.	KENTUCKY	2291
48.	IDAHO	2290
49.	SOUTH DAKOTA	2237
50.	ARKANSAS	2108
51.	MISSISSIPPI	1939

TRENDS IN AVERAGE LENGTH OF STAY - 1983
Source: American Hospital Association - Hospital Statistics 1984

		Average Length of Stay
1.	New York	9.18
2.	Dist. of Columbia	8.74
3.	Massachusetts	8.52
4.	Rhode Island	8.10
5.	Pennsylvania	8.02
6.	New Jersey	8.00
7.	Maryland	7.90
8.	Delaware	7.80
9.	Connecticut	7.71
10.	Ohio	7.65
11.	Michigan	7.60
12.	Illinois	7.52
13.	Missouri	7.49
14.	Indiana	7.44
15.	Florida	7.36
16.	Virginia	7.26
17.	North Carolina	7.19
	U.S. Average	7.14
18.	Kansas	7.13
19.	Minnesota	7.01
20.	Iowa	6.85
21.	Vermont	6.80
22.	Wisconsin	6.78
23.	Tennessee	6.78
24.	South Carolina	6.71
25.	Maine	6.70
26.	Kentucky	6.69
27.	West Virginia	6.66
28.	Nebraska	6.62
29.	Alabama	6.61
30.	Arizona	6.61
31.	Mississippi	6.51
32.	Texas	6.47
33.	North Dakota	6.46
34.	Oklahoma	6.36
35.	New Hampshire	6.35
36.	Arkansas	6.25
37.	South Dakota	6.21
38.	Georgia	6.17
39.	California	6.17
40.	Hawaii	6.17
41.	Colorado	6.13
42.	Louisiana	6.12
43.	Nevada	6.03
44.	Oregon	5.59
45.	Washington	5.53
46.	New Mexico	5.43
* 47.	MONTANA	5.42
48.	Utah	5.33
49.	Alaska	5.24
50.	Idaho	5.19
51.	Wyoming	4.80

TRENDS IN HOSPITAL EXPENDITURES PER CAPITA - COMPARISON 1983 WITH 1982
Source: Population-Census & Economic Information Center

	Per Capita-1983		Per Capita-1982	
Dist. of Columbia		$1,331		$1,198
California		523		497
Massachusetts		679		623
Nevada		534		504
New York		580		537
Alaska		369		340
Illinois		595		562
Michigan		572		516
Rhode Island		491		452
Maryland		456		414
Connecticut		486		443
Pennsylvania		604		531
Arizona		450		407
Ohio		564		507
Missouri		588		543
Hawaii		334		312
Florida		521		464
U.S. Average		494		452
Delaware		447		393
Minnesota		471		433
Colorado		432		396
Wisconsin		465		428
New Jersey		435		394
Kansas		478		461
Maine		460		423
Oregon		404		365
Indiana		478		419
Virginia		395		365
Nebraska		488		464
Oklahoma		410		404
Washington		374		332
New Mexico		350		327
Louisiana		476		424
Vermont		371		354
North Dakota		509		467
Iowa		468		430
New Hampshire		378		342
Utah		333		311
Texas		415		415
Alabama		475		415
Tennessee		502		451
West Virginia		500		455
North Carolina		353		326
Georgia		409		367
South Dakota		390		367
South Carolina		315		294
MONTANA	(9,943)*	374	(9,544)*	329
Idaho		295		275
Kentucky		399		354
Arkansas		391		349
Wyoming		315		284
Mississippi		355		326

* Montana per capita personal income for the year specified

Table 1. Estimates of the Resident Population of States, 1981 to 1983, and Components of Change Since 1980

(Numbers in thousands. Includes Armed Forces residing in each State)

Region, division, and State	Estimate			April 1, 1980 (census)	Change, 1980-83		Components of change			
	July 1, 1983 (provisional)	July 1, 1982	July 1, 1981		Number	Percent	Births	Deaths	Net migration	
									Number	Percent
United States	233,981	231,786	229,518	226,546	7,435	3.3	11,850	6,463	2,048	0.9
Northeast	49,519	49,305	49,258	49,135	383	0.8	2,162	1,524	-255	-0.5
New England	12,489	12,432	12,417	12,348	141	1.1	534	365	-28	-0.2
Middle Atlantic	37,029	36,873	36,841	36,787	243	0.7	1,628	1,159	-226	-0.6
Midwest[1]	58,953	58,925	58,991	58,866	88	0.1	3,047	1,695	-1,265	-2.1
East North Central	41,531	41,582	41,700	41,682	-151	-0.4	2,121	1,180	-1,092	-2.6
West North Central	17,422	17,343	17,291	17,183	239	1.4	926	514	-173	-1.0
South	79,539	78,405	77,003	75,372	4,167	5.5	4,062	2,168	2,272	3.0
South Atlantic	38,805	38,303	37,784	36,959	1,846	5.0	1,804	1,089	1,132	3.1
East South Central	14,946	14,858	14,780	14,666	280	1.9	756	432	-44	-0.3
West South Central	25,788	25,244	24,438	23,747	2,041	8.6	1,503	647	1,184	5.0
West	45,970	45,150	44,267	43,172	2,797	6.5	2,578	1,076	1,295	3.0
Mountain	12,331	12,068	11,746	11,373	958	8.4	755	266	469	4.1
Pacific	33,639	33,082	32,521	31,800	1,839	5.8	1,824	811	826	2.6
New England:										
Maine	1,146	1,136	1,133	1,125	21	1.9	54	34	1	0.1
New Hampshire	959	948	937	921	38	4.1	45	25	18	2.0
Vermont	525	520	516	511	14	2.7	26	15	3	0.5
Massachusetts	5,767	5,750	5,757	5,737	29	0.5	242	175	-38	-0.7
Rhode Island	955	953	952	947	8	0.9	40	30	-2	-0.2
Connecticut	3,138	3,126	3,123	3,108	30	1.0	127	86	-11	-0.3
Middle Atlantic:										
New York	17,667	17,567	17,556	17,558	109	0.6	789	544	-136	-0.8
New Jersey	7,468	7,427	7,407	7,365	103	1.4	316	222	8	0.1
Pennsylvania	11,895	11,879	11,878	11,864	31	0.3	522	393	-98	-0.8
East North Central:										
Ohio	10,746	10,772	10,799	10,798	-52	-0.5	541	314	-278	-2.6
Indiana	5,479	5,482	5,489	5,490	-11	-0.2	277	154	-134	-2.4
Illinois	11,486	11,466	11,467	11,427	60	0.5	603	332	-212	-1.9
Michigan	9,069	9,116	9,210	9,262	-193	-2.1	457	248	-403	-4.4
Wisconsin	4,751	4,745	4,735	4,706	45	1.0	242	133	-64	-1.4
West North Central:										
Minnesota	4,144	4,133	4,112	4,076	68	1.7	223	109	-46	-1.1
Iowa	2,905	2,906	2,917	2,914	-9	-0.3	148	88	-70	-2.4
Missouri	4,970	4,942	4,939	4,917	54	1.1	251	159	-38	-0.8
North Dakota	680	672	661	653	28	4.3	40	18	5	0.8
South Dakota	700	694	692	691	9	1.3	42	21	-12	-1.7
Nebraska	1,597	1,589	1,583	1,570	27	1.7	88	48	-13	-0.8
Kansas	2,425	2,408	2,387	2,364	62	2.6	133	71	-	-
South Atlantic:										
Delaware	606	600	596	594	12	1.9	28	15	-2	-0.3
Maryland	4,304	4,270	4,258	4,217	87	2.1	202	112	-3	-0.1
District of Columbia	623	626	632	638	-15	-2.4	30	22	-24	-3.7
Virginia	5,550	5,485	5,436	5,347	203	3.8	260	138	81	1.5
West Virginia	1,965	1,961	1,960	1,950	15	0.8	91	62	-13	-0.7
North Carolina	6,082	6,019	5,958	5,882	200	3.4	276	160	83	1.4
South Carolina	3,264	3,227	3,186	3,122	142	4.5	167	83	58	1.8
Georgia	5,732	5,648	5,573	5,463	269	4.9	295	145	120	2.2
Florida	10,680	10,466	10,183	9,746	933	9.6	455	353	831	8.5
East South Central:										
Kentucky	3,714	3,692	3,675	3,661	54	1.5	187	109	-24	-0.7
Tennessee	4,685	4,656	4,630	4,591	94	2.1	218	131	8	0.2
Alabama	3,959	3,941	3,927	3,894	65	1.7	200	115	-19	-0.5
Mississippi	2,587	2,569	2,548	2,521	67	2.6	151	76	-8	-0.3
West South Central:										
Arkansas	2,328	2,307	2,300	2,286	42	1.8	117	74	-2	-0.1
Louisiana	4,438	4,383	4,300	4,206	232	5.5	271	117	78	1.9
Oklahoma	3,298	3,226	3,102	3,025	273	9.0	181	95	186	6.2
Texas	15,724	15,329	14,736	14,229	1,494	10.5	934	361	922	6.5
Mountain:										
Montana	817	805	796	787	30	3.8	47	22	5	0.6
Idaho	989	977	964	944	45	4.8	64	23	4	0.4
Wyoming	514	509	493	470	45	9.5	35	10	20	4.4
Colorado	3,139	3,071	2,983	2,890	249	8.6	172	64	141	4.9
New Mexico	1,399	1,367	1,334	1,303	96	7.4	88	29	38	2.9
Arizona	2,963	2,892	2,807	2,718	245	9.0	168	71	147	5.4
Utah	1,619	1,571	1,524	1,461	158	10.8	135	27	50	3.4
Nevada	891	876	844	800	91	11.3	46	20	65	8.1
Pacific:										
Washington	4,300	4,276	4,235	4,132	168	4.1	225	105	49	1.2
Oregon	2,662	2,668	2,669	2,633	29	1.1	137	71	-37	-1.4
California	25,174	24,697	24,220	23,668	1,506	6.4	1,369	612	750	3.2
Alaska	479	444	416	402	77	19.2	33	6	50	12.4
Hawaii	1,023	997	981	965	59	6.1	60	16	15	1.6

[1]Formerly the North Central Region.

IV.

MEDICARE COSTS PER PATIENT

STATE	AVERAGE COST PER DISCHARGE 1981	AVERAGE COST PER DISCHARGE 1985
MONTANA	1521	2280
** WASHINGTON	1690	2429
*** WEST VA.	1670	2443
*** MAINE	1896	2807
*** WISCONSIN	1963	2889
* NEW JERSEY	2091	2955
* NEW YORK	2151	3049
** RHODE ISLAND	2090	3057
** CONNECTICUT	2156	3154
* MARYLAND	2107	3199
* MASSACHUSETTS	2334	3426

* All payer systems
** Most payers regulated (not including Medicare)
*** Passed legislation in 1983 allowing establishment of all payer system

Source: American Hospital Association - December 1984
Special request of Montana Hospital Association

Montana: Cheap place to be sick

WASHINGTON (AP) — If you're sick and have to stay in a hospital, Montana is a good place to be. Hospital stays cost less here than in any other state, except South Dakota, government statistics show.

On the other hand, don't get sick on your next trip to Alaska, a state where hospital beds are relatively scarce. At $508 per day in 1982, Alaska recorded the most expensive hospitals in the country, according to figures published in the new 1985 edition of the Statistical Abstract of the United States.

Montana, by comparison, ranked 49 with an average cost of $226 a day.

North Dakota and South Dakota, which have the most available beds per resident, are also among the least costly places for a hospital stay, according to the figures.

South Dakota was the least expensive place to spend time in a hospital with an average cost of only $217 per day. And by comparison it ranked second in available beds, at 818 per 100,000 residents of the state.

Rounding out the five most expensive states to stay in a hospital were California at $507 per day; Nevada, $494; Arizona, $410, and Oregon, $382.

Availability of beds in those states was: California, 452 per 100,000 residents, 42nd; Nevada, 407, 47th; Arizona, 419, 44th, and Oregon, 446, 43rd.

Besides the Dakotas and Montana, at the other end of the cost scale were Mississippi, $227 and South Carolina, $251. Montana ranked 16th in availability with 651 beds per 100,000 residents; Mississippi was 12th with 680 and South Carolina was No. 36 with 531 beds.

Independent Record March 3, 1985

EXHIBIT 4
March 6, 1985

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, FOR THE RECORD MY NAME IS SIGNE SEDLACEK. I AM A CONSUMER REPRESENTATIVE TO THE MONTANA HOSPITALS RATE REVIEW SYSTEM BOARD OF DIRECTORS AND AM ITS CHAIRMAN. I AM HERE TO SPEAK IN OPPOSITION TO HOUSE BILL 757.

THE MONTANA HOSPITALS RATE REVIEW SYSTEM IS A NON PROFIT, VOLUNTARY ORGANIZATION ESTABLISHED IN 1970 TO DEMONSTRATE THAT MONTANA'S HOSPITALS COULD AND WOULD IMPOSE SELF-RESTRICTIONS ON THEMSELVES WHICH WOULD RESULT IN THE LOWEST POSSIBLE RATES FOR THEIR SERVICES. THAT HOSPITALS WOULD VOLUNTARILY PERMIT AN "OUTSIDE" AGENCY TO EXAMINE, EVALUATE, AND PASS JUDGEMENT ON THEIR RATE STRUCTURES APPEARS TO BE PROOF OF THEIR SINCERITY. THAT MONTANA RANKS 46TH IN THE NATION IN CHARGES PER ADMISSION APPEARS TO DEMONSTRATE THEIR EFFECTIVENESS. THE SYSTEM'S BOARD OF DIRECTORS HAS TEN MEMBERS WITH A SPECIFIC ALLOCATION TO EACH OF THE SEATS. THREE OF THE MEMBERS ARE CONSUMER REPRESENTATIVES, THREE ARE HOSPITAL REPRESENTATIVES, THREE REPRESENT INSURORS (1 FEDERAL-STATE AGENCIES, 1 MEDICARE FISCAL INTERMEDIARY, AND 1 PRIVATE INSUROR), AND ONE DOCTOR REPRESENTING PHYSICIANS.

MEMBER HOSPITALS MUST SUBMIT, PRIOR TO A RATE INCREASE, COMPLETE FINANCIAL AND STATISTICAL INFORMATION TO SUBSTANTIATE THEIR REQUEST. THE DATA IS EVALUATED BY THE STAFF AND BOARD, THE HOSPITAL APPEARS AT A HEARING, AND A DETERMINATION AS TO THE EQUITY OF THE REQUESTED RATES IS MADE. IF THE FACILITY HAS NOT JUSTIFIED THE REQUESTED RATE STRUCTURE IT IS EITHER REJECTED OR MODIFIED. BY THE WRITTEN AGREEMENT BETWEEN THE FACILITY AND THE SYSTEM, THE HOSPITAL IS BOUND BY THE DECISION OF THE BOARD. AN APPEALS PROCESS THROUGH THE COURTS EXISTS, BUT HAS YET TO BE

UTILIZED BY ANY HOSPITAL.

SINCE RATE CONTROL HAS BEEN OUR BUSINESS FOR THE PAST FOURTEEN YEARS WE BELIEVE WE ARE WELL QUALIFIED TO EXAMINE AND COMMENT ON THE BILL NOW BEFORE YOU.

ON THE SURFACE EACH OF THE SECTIONS AND SUBSECTIONS WOULD APPEAR TO BE REASONABLE FROM THE STANDPOINT OF CONTROL OF CHARGES MADE BY HOSPITALS AND LONG-TERM CARE FACILITIES. HOWEVER, ON CLOSER EXAMINATION SOME QUESTIONS AND INCONSISTENCIES ARISE.

THE PURPOSES OF THE BOARD ARE TO LIMIT THE RATE OF INCREASE (IN CHARGES) AND TO PROTECT THE QUALITY AND ACCESSIBILITY OF CARE TO THE PEOPLE OF MONTANA TO HOSPITAL AND LONG-TERM CARE. THIS PRESUPPOSES THE BOARD, WHO BY DEFINITION HAVE NO FIRSTHAND KNOWLEDGE IN HOSPITAL AND LONG-TERM CARE FACILITY OPERATION, ARE ABLE TO DEFINE AND ESTABLISH LEVELS OF QUALITY CARE. IT IS TO ACCOMPLISH THIS BY ASSURING THE FISCAL VIABILITY OF AN EFFICIENT AND EFFECTIVE HEALTH CARE SYSTEM IN THE STATE. THIS IT DOES BY LIMITING THE RATE OF INCREASE (IN RATES). A PORTION OF THAT LIMITATION IS TO BE ACCOMPLISHED THROUGH THE CREATION OF A FORMULA WHICH UTILIZES PRICE CHANGE AND WAGE CHANGE MEASURES PUBLISHED BY THE BUREAU OF LABOR STATISTICS. THIS CAUSES RETROSPECTIVE MEASURES TO BE USED IN CREATING PROSPECTIVE PAYMENTS. THE BUREAU OF LABOR STATISTICS DATA IS BASED ON A UNIVERSE WHICH IS VERY DISSIMILAR FROM THE SITUATION IN WHICH THE MAJORITY OF MONTANA FACILITIES FIND THEMSELVES. ONLY TWO OF MONTANA'S CITIES ARE EVEN INCLUDED IN THEIR DATA.

THE PLANNED APPROPRIATION OF $300,000 FOR TWO YEARS OF BOARD

OPERATION WILL FALL SIGNIFICANTLY SHORT OF TOTAL NEED. FOR COMPARATIVE PURPOSES THE COST OF ONE YEAR'S SYSTEM OPERATIONS IS $100,000. THIS COMPENSATES A STAFF OF TWO PERSONS, PURCHASES SUPPLIES AND EQUIPMENT, PAYS RENT, AND REIMBURSES TRAVEL EXPENSE. THE BOARD DOES NOT RECEIVE COMPENSATION FOR THEIR SERVICES. THE SYSTEM DOES NOT REVIEW NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES. IT SEEMS UNLIKELY THE STATE WILL BE ABLE TO REVIEW A SUBSTANTIALLY LARGER NUMBER OF FACILITIES, PAY ITS BOARD, PAY THE WAGE COSTS OF A COMPETENT STAFF OF SUFFICIENT SIZE, AND PERFORM THE MANY ADJUNCT OPERATIONS CAUSED BY STATE REGULATIONS FOR THE AMOUNT TO BE APPROPRIATED.

THE GOVERNOR HAS APPOINTED A HEALTH CARE COST CONTAINMENT COUNCIL TO EXAMINE THE MANY FACETS OF THE HEALTH CARE SYSTEM IN MONTANA. WE HAVE OFFERED THE COUNCIL OUR ASSISTANCE IN ANY WAY THAT WE ARE ABLE. WE SUGGEST THIS COUNCIL BE PERMITTED TO PERFORM ITS FUNCTIONS PRIOR TO ANY PREMATURE LEGISLATIVE ACTION.

THANK YOU FOR THIS OPPORTUNITY TO APPEAR. SHOULD ANY OF THE MEMBERS HAVE QUESTIONS, I WILL BE HAPPY TO RESPOND.

EXHIBIT 5
March 6, 1985

mhca
MONTANA HEALTH CARE ASSOCIATION

34 So. Last Chance Mall, No. 1
Helena, Montana 59601
Telephone: 406-443-2876

STATEMENT OF THE MONTANA HEALTH CARE ASSOCIATION

on

HOUSE BILL 757

RELATING TO THE ESTABLISHMENT OF A HEALTH CARE COST CONTAINMENT BOARD

before the

HOUSE HUMAN SERVICES AND AGING COMMITTEE

March 6, 1985

For the record, I am Rose M. Skoog, of Helena, Executive Director of the Montana Health Care Association, an organization representing approximately two thirds of the long term care facilities in the state of Montana--including both non-profit and for profit facilities.

We oppose House Bill 757 as being both unnecessary and inappropriate in dealing with issues related to the cost of long term care in Montana.

Total expenditures for long term care in Montana increase based on two factors:

(1) increased utilization of services; and
(2) increased cost per service.

The demand for long term care services is increasing in Montana, as in most places, due to the graying of our population. While the over 65 age group is growing more rapidly than the under 65 age groups, the over 80 and over 85 age groups--where nursing home utilization is very high--is growing at an even faster pace than the over 65 group as a whole. Controlling increases in total long term care costs which are due to increased utilization depends on the availability of a continuum of long term care services for the increased numbers of people needing them. All we can really hope to do is insure that those who need long term care services receive them in the most appropriate and cost-effective setting.

House Bill 757 simply does not address this aspect of increased costs, yet over the long run, cost increases due to substantially increased numbers of people needing services will become a far more significant factor in the cost of long term care than increases in the per unit cost of this care.

Increased cost per service is, in fact, an area that House Bill 757 attempts to address. However, this bill is totally unnecessary since increases in the per service cost of nursing home care in Montana are already contained within acceptable bounds.

The average cost per day for a day of nursing home care in Montana over the past several years has increased at a rate less than the rate of inflation being experienced by nursing homes. The following compares actual or projected inflation for the period 1983 through 1987 to actual rates of increase in nursing home cost per service.

Year	Actual/Projected Inflation	Actual Increase in Nursing Home Rates
1983	6.3%	6.1%
1984	4.8%	5.9%
1985	4.9%	3.2%
1986	5.5%	3.75%
1987	5.9%	3.75%

Clearly, nursing homes in this state already know the meaning of the words "cost containment". In fact, further efforts at cost containment in our nursing homes could yield only one result: a decrease in the quality of the service we provide. We do not feel that anyone--including the proponents of House Bill 757--want to see that happen.

Nursing home care is perhaps the most cost-effective health care service available in Montana today. The average cost of a day of care is about $43.00. Included in that rate is 24-hour nursing care, social services, rehabilitation services, meals and snacks, personal assistance with activities of daily living, laundry services, and social and spiritual programs. A simple cost comparison that might help put nursing home costs in perspective is:

Cost comparison (Helena):

St. Peter's Hospital.....$198.50/day
Home Health Nurse Visit (up to 1 hr.)..$ 40.00
Colonial Inn.....$ 39.00/day
Western Care Nursing Home.....$ 38.25/day
Helena Nursing Home.....$ 42.87/day
Cooney Nursing Home.....$ 49.54/day

The cost of a day of nursing home care is economical. However, those requiring it need it 24 hours a day, 7 days a week, 365 days a year--for 2, 5, or maybe 10 years. The cumulative affect of paying for this care over a long period of time puts it beyond the resources of most people--even people who think they have provided adequately for their old age.

Clearly, there are problems we should be working on relating to the financing of long term care. However, the solutions are in the area of better Medicare coverage for such services, incentives to insurance companies to offer comprehensive long term care insurance, incentives to elderly to encourage the purchase of long term care insurance, and educating people generally about the need to provide for the situation when chronic illness makes long term care services necessary. Other states are in fact studying these problems and possible solutions,

However, House Bill 757 does nothing to address the real problems associated with the cost of long term care.

We urge a "do not pass" recommendation on this bill.

Thank you for the opportunity to testify. I would be pleased to answer any questions you may have at the appropriate time.

EXHIBIT 6
March 6, 1985

MONTANA
ASSOCIATION OF HOMES FOR THE AGING

715 NORTH FEE
P.O. BOX 5774
HELENA, MT 59604

(406) 443-1185

March 6, 1985

TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE

RE: HB 757

BY: Molly Munro, Executive Secretary

The Montana Association of Homes for the Aging opposes HB 757 on the grounds that a governing board of seven members, who, not having any understanding of the workings and dealings of a long-term care facility, could not make the decision that a facility was run correctly under all regulations and standards, and, more importantly, run efficiently.

It would be impossible for this group of unprofessional people to review the operations of a facility and be able to set their rates. Because of different demographics, wages of staff, demands of residents, and building requirements, not all facilities can be judged the same.

The provisions of the bill also infringe on free business enterprise.

The costs of this board, $300,000 would be a further drain on the state's monies. It is an exhorbitant amount to pay for an unnecessary board.

EXHIBIT 7
March 6, 1985

80 signatures

NORTH VALLEY HOSPITAL

We, the undersigned, oppose House Bill #757 which would establish a "qusai-judicial board" to regulate the rates for hospital charges. The bill is a duplication of the Montana Hospitals Rate Review System, a private, voluntary, non-profit corporation established to provide a system to review proposed and existing rates and charges for patient services by member hospitals, while making sure the hospital remains economically sound and able to provide the best, most up-to-date hospital care possible.

Montana ranks 46th in America in terms of health care costs, and last year Montana hospital charges increased less than 5%. North Valley Hospital held their increase down to only 3.9%, and reduced charges on several surgical procedures with no increase in any surgery charge. We're already doing our utmost to contain health care costs.

House Bill #757 would create additional bureaucracy and cost to patients. It would take flexibility away from hospitals and might even endanger the financial viability of Montana hospitals and their ability to offer needed care.

NAME	POSITION	TOWN
Teresa Lovell	Physical Therapy	C.F.
Lisa Morris	Patient	Kal.
Sharon K. Hilton	Physical Therapy	W.F.
Lisa Port	Nurse Aid	W.F
Mary Banks	Nurse Aid	Kal.
Betty [illegible]	Housekeeper	W Kalispell
Jane D. Handley	DRG coordinator	W.F.
Rita Labella	RN	WF
Anita Bennett	LPN	WF
Laurie Barnes	admission Clerk	WF

NORTH VALLEY HOSPITAL

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NAME	POSITION	TOWN
Larry Pancrelli	Admin. Ass	Whitefish
Jerry Hauser	Maint. Supr.	Whitefish
Nancy Byrne, R.P.T.	Phys. Therapy - Supervisor	Whitefish
C.E. Wright, CNOR	O.R. Supv.	Whitefish
Maura Fields RN	Director of Professional Services	Whitefish
Ron & Kemp	Dir of Support Sv.	Columbia Falls
Sonja VanSkyke	admissions Clerk	Columbia Falls
Dale Jump	Administrator	Columbia Falls
Stephen Pohl	RN	Whitefish
[illegible]	RN	[illegible]
[illegible]	RN	[illegible]
[illegible]	Admissions	[illegible]
[illegible]	RN OR	[illegible]
[illegible]	RN	[illegible]
[illegible]	[illegible]	Columbia Falls
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Joleen Brown	C.R.T.	Columbia Falls
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	(RN)	[illegible]

north valley HOSPITAL

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NAME	POSITION	TOWN
Louise A. Bowie	Dietic	Whitefish
Darlene De Ree	Hskpg + Laundry Supv	[illegible]
Esther Conger	Hskpg	[illegible]
James J. Alderson	Dir of Fiscal Services	W/FISH
John H. Goldschm[illegible]	Resp. Therapist	W/F[illegible]
[illegible]	[illegible]	[illegible]
[illegible] McG[illegible]	Pharmacist	WF
Jacquie J. Lindt	super. Med. Rec.	Whitefish
Linda B. Small	MT	[illegible]
Delores Holtsley	RN	Whitefish
J. Weller	LPN	"
Jerrold E. Johnson MD	Staff Physician	Whitefish
Ethel J. Boisdert	admin. Clerk	Whitefish
Tom Nikora	LAB SUPERVISOR	WHITEFISH
Lois Newberg	Activities Dir	Whitefish
Jacqueline B. Graham	Activities Dept	Whitefish
Nancy Henman	auxiliary Member	Columbia Falls
Kathy Swanson	Auxiliary Member	Whitefish
Chris Kirchhoffer	C.N. Aide	Whitefish
[illegible]	nursing Supervisor	W/fish
Donna Allen	LPN	Kalispell

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NAME	POSITION	TOWN
Carol Ost	ECF Bus. Off.	Whitefish
Mary Louise Bosshardt	Director of Education	Whitefish
Shelley Radosevich	Purchasing Supervisor	Kalispell
Bill Burnett	Physical Therapist	Columbia Falls
Karen Viddaleyne	Purchasing Assistant	Whitefish
Linda M. Hall		Whitefish
Richard N. Field	Maint.	Whitefish
Jan Ackerstrom	Dietitian	Kalispell
Suzanne Homestead	Business Office	Whitefish
Nona Bardauskas	Business Office	Whitefish
Beth Albrecht	Business Office	Whitefish
Patti Reed	Business Office	Whitefish
Joanne Barner	Dietary Supervisor	Whitefish
Penny Faust	Dietary	Whitefish
Regina Lake	Dietary	Whitefish
Gloria Gerbens	Medical Rec.	Columbia Falls
Tom Allen	ECF V.P.	Whitefish
Robert M. Allen	ASD	Whitefish

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NAME	POSITION	TOWN
Jake Barta	Med/X-Ray Tech	Whitefish
[illegible]	Rela	"
Marilyn Rastrud	LPN	Whitefish
[illegible]	RN, B.S., RN, CAS	Whitefish
Virginia Chaplin	RN	Whitefish

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NAME	POSITION	TOWN
Jennie Swanson	R.N.	Whitefish
Peta Kaplan	N.A.	Whitefish
Judith Cottrell	N.A.	Whitefish
Frances Lloyd	N.A.	Whitefish
Barb Rodmer	RN	Wfish

NORTH VALLEY HOSPITAL

February 27, 1985

Benjamin R. "Ben" Cohen
House of Representatives
Capitol Station
Montana State Capitol Building
Helena, MT 59620

Dear Ben:

I ask that you, as a member of the Human Services and Aging Council, firmly oppose House Bill #757 which establishes a "quasi-judicial board" to regulate the rates for hospital charges.

The bill is an unnecessary duplication of the Governor's task force on controlling medical costs, which is known as the State Health Care Cost Containment Council. The Council is an outgrowth from the Governor's 1983 Conference on Health Care. The goal of the Council is to discover ways of containing costs "with a minimum of regulation, while striving to maintain a high standard of quality," according to Governor Schwinden. Twenty-two Montanans have been appointed to this Council. Let's not tie their hands with a legislative bill.

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Please oppose House Bill #757. Thank you.

Sincerely,

Don McMillan, Chairman
Board of Directors

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

NORTH VALLEY HOSPITAL

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L. J. Casazza, M.D.
Board of Directors

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Sincerely,

Glen Kartheiser

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Board of Directors

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

north valley HOSPITAL

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R. W. Covill, M.D.
Board of Directors

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Sincerely,

Joyce Hoffmann
Board of Directors

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

north valley HOSPITAL

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Sincerely,

Ron Loveall

Ron Loveall
Board of Directors

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

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Sincerely,

Larry Wilson

Larry Wilson, Past Chairman
Board of Directors

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

north valley HOSPITAL

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Sincerely,

Jessie Harring

Jessie Harring, President
North Valley Hospital Auxiliary

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

Alaska leading nation in hospitalization cost

WASHINGTON (AP) — A hospital stay costs more in Alaska, a state where hospital beds are relatively scarce, government statistics show.

North Dakota and South Dakota, which have the most available beds per resident, are among the least costly places for a hospital stay, according to figures published in the new 1985 edition of the Statistical Abstract of the United States.

Among the information compiled in the massive annual volume issued last week were the comparative availability of hospital beds — and average cost per patient per day — for each state.

At $508 per day in 1982, Alaska recorded the most expensive hospitals, according to the Abstract. That state ranked 48th in availability of hospital beds, with 387 per 100,000 residents. Alaska in general has a higher cost of living than any other state, government reports have shown.

South Dakota was the least expensive place to spend time in a hospital with an average cost of $217 per day. And by comparison it ranked second in available beds, at 818 per 100,000 residents of the state.

North Dakota was No. 1 in available hospital facilities at 899 beds per 100,000 state residents, and its cost was 47th in the nation, $244-a-day.

Rounding out the five most expensive states to stay in a hospital were California at $507 per day; Nevada, $494; Arizona, $410, and Oregon, $382.

Availability of beds in those states was: California, 452 per 100,000 residents, 42nd; Nevada, 407, 47th; Arizona, 419, 44th, and Oregon, 446, 43rd.

Besides the Dakotas, at the other end of the cost scale were Montana, $226; Mississippi, $227 and South Carolina, $251. Montana ranked 16th in availability with 651 beds per 100,000 residents; Mississippi was 12th with 680 and South Carolina was No. 36 with 531 beds.

The statistics were among many contained in the new, 105th edition of the Abstrast, subtitled the National Data Book and Guide to Sources.

HOSPITAL BEDS

WASHINGTON (AP) — Here, from the new Abstract, is a state-by-state rundown of the number of hospital beds available per 100,000 residents, and rank, and the average cost per day, and rank.

State	Beds	(Rank)	Cost	(Rank)
Pacific				
Washington	367	(49)	$376	(6)
Oregon	446	(43)	$382	(5)
California	452	(42)	$507	(2)
Alaska	387	(48)	$508	(1)
Hawaii	412	(46)	$307	(23)
Mountain				
Montana	651	(16)	$226	(49)
Idaho	414	(45)	$266	(38)
Wyoming	537	(35)	$303	(25)
Colorado	493	(40)	$336	(13)
New Mexico	462	(41)	$317	(21)
Arizona	419	(44)	$410	(4)
Utah	336	(50)	$376	(6)
Nevada	407	(47)	$494	(3)
East South Central				
Kentucky	509	(38)	$261	(39)
Tennessee	682	(11)	$275	(36)
Alabama	657	(15)	$276	(35)
Mississippi	680	(12)	$227	(48)
West South Central				
Arkansas	591	(21)	$253	(45)
Louisiana	593	(20)	$337	(12)
Oklahoma	549	(33)	$333	(15)
Texas	552	(32)	$307	(23)
New England				
Maine	580	(27)	$296	(27)
New Hampshire	495	(39)	$288	(29)
Vermont	559	(31)	$256	(44)
Massachusetts	721	(5)	$370	(8)
Rhode Island	622	(17)	$332	(16)
Connecticut	581	(26)	$354	(11)
Middle Atlantic				
New York	717	(6)	$312	(22)
New Jersey	570	(29)	$260	(34)
Pennsylvania	698	(9)	$320	(20)
East North Central				
Ohio	582	(24)	$325	(19)
Indiana	582	(25)	$287	(30)
Illinois	621	(18)	$369	(9)
Michigan	530	(37)	$357	(10)
Wisconsin	610	(19)	$283	(32)
West North Central				
Minnesota	710	(7)	$257	(43)
Iowa	705	(8)	$260	(40)
Missouri	693	(10)	$328	(18)
North Dakota	899	(1)	$244	(47)
South Dakota	818	(2)	$217	(50)
Nebraska	745	(4)	$260	(40)
Kansas	789	(3)	$292	(28)
South Atlantic				
Delaware	663	(13)	$302	(26)
Maryland	583	(23)	$329	(17)
Virginia	575	(28)	$282	(33)
West Virginia	658	(14)	$271	(37)
North Carolina	541	(34)	$258	(42)
South Carolina	531	(36)	$251	(46)
Georgia	585	(22)	$284	(31)
Florida	570	(30)	$335	(14)

NORTH VALLEY HOSPITAL

February 27, 1985

Benjamin R. "Ben" Cohen
House of Representatives
Capitol Station
Montana State Capitol Building
Helena, MT 59620

Dear Ben:

I ask that you, as a member of the Human Services and Aging Council, firmly oppose House Bill #757 which establishes a "quasi-judicial board" to regulate the rates for hospital charges.

The bill is an unnecessary duplication of the Governor's task force on controlling medical costs, which is known as the State Health Care Cost Containment Council. The Council is an outgrowth from the Governor's 1983 Conference on Health Care. The goal of the Council is to discover ways of containing costs "with a minimum of regulation, while striving to maintain a high standard of quality," according to Governor Schwinden. Twenty-two Montanans have been appointed to this Council. Let's not tie their hands with a legislative bill.

Montana ranks 46th in America in terms of health care costs, and last year Montana hospital charges increased less than 5%. North Valley Hospital Board of Directors held their increase to only 3.9%, and in addition reduced its charges on several surgical procedures and no increase in any surgery charge. We're already doing our utmost to contain health care costs.

Please oppose House Bill #757. Thank you.

Sincerely,

Sally Torcasetti

WHITEFISH, MONTANA 59937 TELEPHONE (406) 862-2501

EXHIBIT 8
March 6, 1985

PONDEROSA COUNCIL OF CAMP FIRE

2700 Clark Street • Missoula, Montana 59801 • (406) 542-2129

A United Way Agency

Re: HJR

March 6,1985

March 17 marks the 75th Anniversary of Camp Fire nationwide. For 74 of those years Camp Fire has been active in Montana. Formerly called Camp Fire Girls, the program opened to boys in 1975 and the Girls was dropped from the name.

Seven Camp Fire Councils serve Montana: Gold Country Council(Helena area), Headwaters Council(Bozeman area), Otanka Council(Butte area), Ponderosa Council (Western Montana), Big Sky Council(Billings area), North Central Montana Council (headquartered in Great Falls), and the Camp Fire Council of Glendive. Many adult volunteers serve as leaders to hundreds of youth in clubs. Their goal is to provide" opportunities for youth to realize their potential and to function effectively as caring, self-directed individuals responsible to themselves and others".

The Camp Fire motto is "Give Service". Camp Fire youth and adults contribute energy and talent to community activities such as making valentines for the vetrans, gathering food and clothing for the needy, preparing a lot for a community garden, cleaning up parks, etc.

Camp Fire "Response Programs" reach out to all the youth in the community with programs such as "I Can Do It", a self-reliance program for latch-key kids; "Caution Without Fear", a safety on the street program for all young kids; "I'm Safe and Sure", a citizenship and safety program for Kindergarten and First Graders; "Child Care Course" for beginning baby-sitters; "Good Touch/ Bad Touch", a sexual abuse prevention program.

The entire Camp Fire structure is based on the American democratic process. Through participation at all levels adult volunteers and youth members learn to function as responsible members of society. Youth members are encouraged to participate as Board of Director members and delegates to conferences. Each council is an individual unit comprised of voting members who in turn elect delegates to regional and national meetings where policy is set in much the same way as we do in the state Legislature or national Congress.

Camping is still a popular activity in Camp Fire. All seven Montana councils run at least one Day Camp. Some councils have several Day Camps in different communities. Five of the councils operate Resident Camps lasting from one to three weeks. Most Camp Fire camps are open to anyone regardless of whether or not they are club members.

With the club programs, camps and Response Programs some of the Camp Fire councils in Montana have reached the lives of as many as 6,000 kids in their territory in 1984. Aside from their own programs, Camp Fire personnel contribute time and energy to community task groups, youth advocacy, and assessing youth needs in their community.

..... "To provide, through a program of informal education, opportunities for youth to realize their potential and to function effectively as

Public Law 98-363
98th Congress

An Act

To amend the Surface Transportation Assistance Act of 1982 to require States to use at least 8 per centum of their highway safety apportionments for developing and implementing comprehensive programs concerning the use of child restraint systems in motor vehicles, and for other purposes.

July 17, 1984
[H.R. 4616]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 203(a)(1) of the Surface Transportation Assistance Act of 1982 is amended to read as follows:

96 Stat. 2138.

"SEC. 203. (a)(1) There is hereby authorized to be appropriated for carrying out section 402 of title 23, United States Code (relating to highway safety programs), by the National Highway Traffic Safety Administration, out of the Highway Trust Fund (other than the Mass Transit Account), $126,500,000 for the fiscal year ending September 30, 1985, and $132,000,000 for the fiscal year ending September 30, 1986.".

Appropriation authorization.

(b) Section 203(a) of such Act is amended by adding at the end thereof the following new paragraph:

State and local governments.

"(4)(A) Each State shall expend each fiscal year not less than 8 per centum of the amount apportioned to it for such fiscal year of the sums authorized by paragraph (1) of this subsection, for developing and implementing comprehensive programs approved by the Secretary of Transportation concerning the use of child restraint systems in motor vehicles. Upon request of the Governor of any State, the Secretary may reduce the amount required to be expended by the State for any fiscal year under the preceding sentence if the State demonstrates to the satisfaction of the Secretary that the percentage of children under the age of four traveling in motor vehicles in the State who are properly restrained by a child restraint system is greater than 75 per centum.

"(B) No project for developing and implementing a comprehensive program concerning the use of child restraint systems in motor vehicles may be approved by the Secretary of Transportation in the fiscal years ending September 30, 1985, and September 30, 1986, unless the State applying for approval of such project enters into such agreements with the Secretary as the Secretary may require to ensure that such State will maintain its aggregate expenditures from all non-Federal sources for such programs at or above the average level of such expenditures in its two fiscal years preceding the date of enactment of this paragraph.

"(C) Subparagraphs (A) and (B) of this paragraph shall not apply to sums authorized to be appropriated for any fiscal year beginning after September 30, 1987.".

SEC. 2. Section 203(b) of the Surface Transportation Assistance Act of 1982 is amended to read as follows:

96 Stat. 2138.

"(b) Notwithstanding any other provision of law, the total of all obligations for highway safety programs carried out by the National Highway Traffic Safety Administration under section 402 of title 23, United States Code, shall not exceed $126,500,000 for the fiscal year

EXHIBIT 9
March 6, 1985

ending September 30, 1985, and $132,000,000 for the fiscal year ending September 30, 1986, and the total of all obligations for highway safety programs carried out by the Federal Highway Administration under section 402 of title 23, United States Code, shall not exceed $10,000,000 per fiscal year for each of the fiscal years ending September 30, 1985, and September 30, 1986.".

SEC. 3. (a) The sixth sentence of section 402(c) of title 23, United States Code, is amended by striking out the period at the end thereof and inserting in lieu thereof the following: ", except that the apportionments to the Virgin Islands, Guam, and American Samoa shall not be less than one-quarter of 1 per centum of the total apportionment.".

(b) Section 401 of title 23, United States Code, is amended by striking out ", except that all expenditures for carrying out this chapter in the Virgin Islands, Guam, and American Samoa shall be paid out of money in the Treasury not otherwise appropriated." and inserting in lieu thereof a period.

23 USC 401 note.

(c) The amendments made by subsections (a) and (b) shall only apply to fiscal years beginning after the date of enactment of this Act.

Drugs and drug abuse.

SEC. 4. (a) Section 408(a) of title 23, United States Code, is amended by inserting "or a controlled substance" immediately after "alcohol".

(b) Section 408(c)(1) of title 23, United States Code, is amended by inserting "and controlled substance" immediately after "alcohol".

(c) Section 408(f) of title 23, United States Code, is amended—

(1) by striking the period at the end of paragraph (7) and inserting in lieu thereof "; and"; and

(2) by adding at the end thereof the following:

"(8) for the creation and operation of rehabilitation and treatment programs for those arrested and convicted of driving while under the influence of a controlled substance or for the establishment of research programs to develop effective means of detecting use of controlled substances by drivers.".

Grants.

SEC. 5. Section 402 of title 23, United States Code, is amended by adding at the end thereof the following:

23 USC 402.

"(k)(1) Subject to the provisions of this subsection, the Secretary shall make a grant to any State which includes, as part of its highway safety program under section 402 of this title, the use of a comprehensive computerized safety recordkeeping system designed to correlate data regarding traffic accidents, drivers, motor vehicles, and roadways. Any such grant may only be used by such State to establish and maintain a comprehensive computerized traffic safety recordkeeping system or to obtain and operate components to support highway safety priority programs identified by the Secretary under this section. Notwithstanding any other provision of law, if a report, list, schedule, or survey is prepared by or for a State or political subdivision thereof under this subsection, such report, list, schedule, or survey shall not be admitted as evidence or used in any suit or action for damages arising out of any matter mentioned in such report, list, schedule, or survey.

"(2) No State may receive a grant under this subsection in more than two fiscal years.

"(3) The amount of the grant to any State under this subsection for the first fiscal year such State is eligible for a grant under this subsection shall equal 10 per centum of the amount apportioned to such State for fiscal year 1985 under this section. The amount of a grant to any State under this subsection for the second fiscal year such State is eligible for a grant under this subsection shall equal 10 per centum of the amount apportioned to such State for fiscal year 1986 under this section.

"(4) A State is eligible for a grant under this subsection if—

"(A) it certifies to the Secretary that it has in operation a computerized traffic safety recordkeeping system and identifies proposed means of upgrading the system acceptable to the Secretary; or

"(B) it provides to the Secretary a plan acceptable to the Secretary for establishing and maintaining a computerized traffic safety recordkeeping system.

"(5) The Secretary, after making the deduction authorized by the second sentence of subsection (c) of this section for fiscal years 1985 and 1986, shall set aside 10 per centum of the remaining funds authorized to be appropriated to carry out this section for the purpose of making grants under this subsection. Funds set aside under this subsection shall remain available for the fiscal year authorized and for the succeeding fiscal year and any amounts remaining unexpended at the end of such period shall be apportioned in accordance with the provisions of subsection (c) of this section.".

SEC. 6. (a) Chapter 1 of title 23, United States Code, is amended by adding at the end thereof the following new section:

"§ 158. National minimum drinking age

23 USC 158.

"(a)(1) The Secretary shall withhold 5 per centum of the amount required to be apportioned to any State under each of sections 104(b)(1), 104(b)(2), 104(b)(5), and 104(b)(6) of this title on the first day of the fiscal year succeeding the fiscal year beginning after September 30, 1985, in which the purchase or public possession in such State of any alcoholic beverage by a person who is less than twenty-one years of age is lawful.

Alcohol and alcoholic beverages.

23 USC 104.

"(2) The Secretary shall withhold 10 per centum of the amount required to be apportioned to any State under each of sections 104(b)(1), 104(b)(2), 104(b)(5), and 104(b)(6) of this title on the first day of the fiscal year succeeding the second fiscal year beginning after September 30, 1985, in which the purchase or public possession in such State of any alcoholic beverage by a person who is less than twenty-one years of age is lawful.

"(b) The Secretary shall promptly apportion to a State any funds which have been withheld from apportionment under subsection (a) of this section in fiscal year if in any succeeding fiscal year such State makes unlawful the purchase or public possession of any alcoholic beverage by a person who is less than twenty-one years of age.

"(c) As used in this section, the term 'alcoholic beverage' means—

"(1) beer as defined in section 5052(a) of the Internal Revenue Code of 1954,

26 USC 5052.

"(2) wine of not less than one-half of 1 per centum of alcohol by volume, or

"(3) distilled spirits as defined in section 5002(a)(8) of such Code.".

26 USC 5002.

(b) The table of sections of chapter 1 of such title is amended by adding at the end thereof the following new item:

"158. National minimum drinking age.".

EXHIBIT 10
March 6, 1985

WHY THE LEGAL DRINKING AGE SHOULD BE 21

The American Automobile Association presents this information on alcohol-related traffic accidents in the hope that the compelling data detailed in the brochure will help convince state legislatures to raise the legal drinking age to 21.

Twenty-five thousand Americans die each year in alcohol-related traffic accidents. Five thousand victims are teenagers; over eight thousand victims are between the ages of 16 and 24, although the latter group comprises only 18 percent of the general population.

The severity of this problem was highlighted in a recent Surgeon General's report which noted that life expectancy in this country has increased for every age group with the exception of the 15- to 24-year-olds. Unfortunately, inexperience in driving and in coping with the effects of alcoholic beverages too often combine to bring about tragic consequences.

During the past seven years the legal drinking age has been raised in 21 states. Nineteen states, comprising 44 percent of the population, now have 21 as their legal minimum drinking age for all alcoholic beverages, with twenty-five states specifying 21 as the legal drinking age for distilled spirits. While effectiveness evaluations have not been made in every state, where studies have been made the findings strongly suggest that raising the legal drinking age has been an effective deterrent to alcohol-related traffic accidents.

- Michigan raised its drinking age to 21 in 1978. Involvement in alcohol-related traffic accidents of 18- to 20-year-old drivers decreased by 31 percent in 1979.

- Illinois raised its drinking age to 21 in January 1980. During 1980 it experienced an 8.8 percent reduction in single-vehicle nighttime accidents involving male drivers under 21.

- Maine's action in raising its drinking age to 20 was followed by a 17 percent drop in non-injury, alcohol-related crashes.

- A study by the Insurance Institute for Highway Safety found a 28 percent reduction in alcohol-related accidents in eight of nine states where drinking age had been raised.

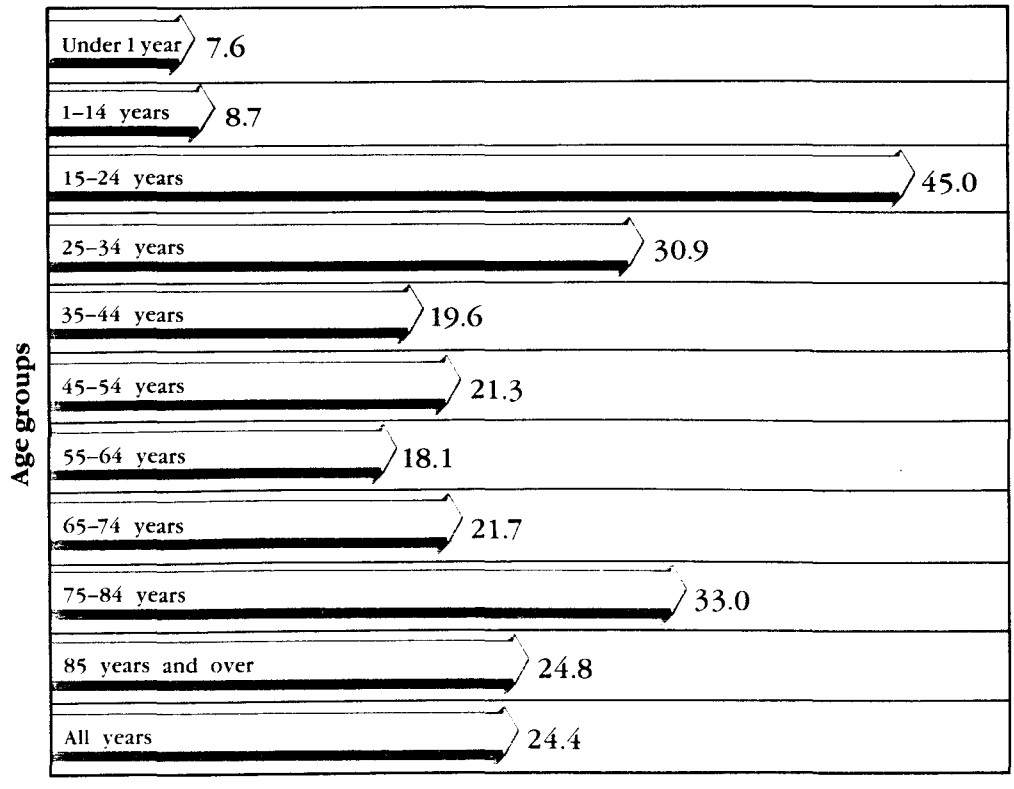
Historically, young people are involved in a disproportionate number of alcohol-related accidents. For instance, in Florida in 1981, 19- and 20-year-olds killed more people in such accidents than any other age group. That year, 170 people were killed by drunk drivers under the age of 21, which was 25.5 percent of all alcohol-related deaths in Florida, even though drivers under 21 make up only 10 percent of all Florida licensed drivers and drive only nine percent of the vehicle miles driven. Unfortunately, the Florida experience is typical of states with minimum drinking ages less than twenty-one.

DID YOU KNOW THAT:

- In 1981, approximately 25,000 died from alcohol-related highway accidents. That amounts to seventy lives a day, one every 23 minutes.
- In 1981, 4,884 persons died in alcohol-related highway accidents in which the driver was under 21. This represents 23.6 percent of all alcohol-related fatalities.
- Drivers under 21 represent about 10 percent of the licensed drivers, and drive about 9 percent of the vehicle miles driven.
- 5,000 teenagers are killed and 130,000 are injured yearly in drunken driving accidents.
- The results of a January 1983 Gallup Poll indicate that 77 percent of the population favor a uniform drinking age of 21. Even the affected age group (those 18- to 20-years-old) favored 21 in 58 percent of individuals polled.

Source: National Transportation Safety Board

According to a 10 percent national sample of deaths collected by the National Center for Health Statistics in 1980, death rates from motor vehicle accidents distributed by 10-year age groups are as follows:



BACKGROUND INFORMATION

The American Automobile Association has long been concerned and involved with the problem of drinking and driving. AAA Foundation for Traffic Safety began research in 1964 for the *DWI Phoenix* project, a rehabilitative program which was implemented in 1970 to deter convicted survivors from repeating alcohol-related offenses and to encourage them to seek help if their problems with alcohol were pervasive. While conducting the research for the DWI program, investigators noted that habitual offenders had begun to drink during their teenage years. This led to an exploration of the role of beverage alcohol in the lives of young people.

During this investigation, it was discovered that not only were most teenagers drinking, but alcohol consumption was more than incidental for a sizable percentage of them. As the *DWI Countermeasures Course for High School* was being field-tested in 1974, it became apparent that the program for driver education classes might come too late. Drinking patterns were beginning to form as early as 7th and 8th grades. This startling information raised the question as to the magnitude of the problem of alcohol among youth and indicated the need for additional research. In view of this, AAA developed the *AL-CO-HOL* education program for junior high schools.

Convincing evidence was found that the elementary school years are a formative period for future attitudes and decisions concerning alcohol use. AAA concluded that the earlier alcohol and traffic safety education begins, the more effective it is likely to be in later years in combating drunk driving and other symptoms of alcohol misuse and abuse. Consequently, *Starting Early: An Alcohol Awareness Program for Elementary School (K-6)* was developed, field-tested and evaluated in 1982.

All of the AAA alcohol programs available were developed at Teachers College, Columbia University, under the direction of Dr. James L. Malfetti, through funding provided by the AAA Foundation for Traffic Safety. All materials were extensively field-tested with thousands of students from grade levels K-12, and adults representing urban, suburban and rural communities throughout the country, so that the AAA alcohol programs would have nationwide applicability.

AAA of course recognizes that education and rehabilitation are not the total answer to the DWI problem. There are no panaceas for eliminating the drunken driver. AAA also supports reasonable deterrence measures, and for the reasons enumerated in this brochure, supports a minimum drinking age of 21.

Government Affairs Department
Falls Church, Virginia 22047

EXHIBIT 11
March 6, 1985

QUESTIONS AND ANSWERS REGARDING THE INCLUSION OF SOCIAL WORKERS IN THE INSURANCE CODES OF MONTANA

1. WHAT DOES THE INCLUSION OF SOCIAL WORKERS BILL PROPOSE?

The bill provides that if a person has health insurance which includes coverage for mental health services, the insured could choose to receive those services from a licensed social worker. These services would be covered by insurance.

2. WHY IS THIS BILL NEEDED?

Recognition of social workers in the State Insurance Codes will provide consumers with the knowledge that licensed social workers are qualified providers of mental health services. It will also activate consistency of coverage and provide guidelines for insurance companies.

3. DOES THIS BILL MANDATE MENTAL HEALTH COVERAGE BY INSURANCE COMPANIES?

No. What it does is provide increased choice of qualified mental health providers to Montanans. Studies show that models of treatment used by qualified social workers are cost effective. It would decrease the burden of service on the existing subsidized state system. It would reduce existing waiting lists within the mental health system by allowing referral to private licensed social workers.

4. WHAT ARE THE ADVANTAGES OF THIS BILL TO CITIZENS OF MONTANA?

Many Montanans live in areas giving them limited access to mental health practitioners. There are more licensed social workers throughout the State of Montana who are available for providing mental health services. This will offer freedom to select the licensed practitioner of their choice.

5. DO LICENSED SOCIAL WORKERS IN OTHERS STATES GET REIMBURSEMENTS FROM INSURANCE COMPANIES FOR MENTAL HEALTH SERVICES?

Yes. Ten other states now have this legislation: California 1977; Louisianna 1977; Maryland 1977; New York 1978; Utah 1978; Virginia 1979; Oregon 1981; Massachusetts 1982; Oklahoma 1982; and Kansas 1982.

6. WHAT REQUIREMENTS MUST A SOCIAL WORKER MEET TO BE LICENSED IN MONTANA?

Licensed social workers must have a minimum of a master degree in social work, 3,000 hours of practice in psychotherapy and pass a review by the Board of Social Work Examiners as well as a written test.

7. WHAT SAFEGUARDS INSURE QUALITY SERVICES BY LICENSED SOCIAL WORKERS?

The State Board of Social Work Examiners has the power to investigate reported unethical behavior of social workers. If it is proven that a social worker has acted in an unprofessional manner toward a client, his/her license can be revoked.

The Montana Chapter of the National Association of Social Workers through its Committee on Inquiry also has the power to investigate claims made against social workers.

Nationally, a peer review board has been established by the National Association of Social Workers to aid insurance companies in screening various claims. Its purpose is to have an independent body look at various mental health treatment modalities and decide whether appropriate treatment and reimbursement is being provided.

8. WILL THIS BILL INCREASE INSURANCE RATES?

No. This bill asks for social workers to be included in the range of licensed mental health practitioners. It does not mandate or increase insurance benefits.

The CHAMPS study showed a savings of $250,000 during their one year evaluation period during which they allowed clinical social workers to provide mental health services to the military personnel. These results were so positive that the military authorized the continuation of certified or licensed social workers as CHAMPUS providers.

FACT SHEET

COST EFFECTIVENESS OF LICENCED SOCIAL WORK SERVICES

A. Effect on Utilization of Medical Services

1. The meta-analysis of 475 controlled psychotherapy studies included a review of 11 studies to determine the use of psychotherapy on the utilization of general medical services. Results of those studies indicate that the average reduction of utilization of other medical services following psychotherapy was 14%.[1]

2. 25 studies were reviewed to determine whether treatment for alcoholism, drug abuse, or mental illness would reduce subsequent general medical care use. Twelve studies found reductions of 5% to 8.5% in medical care utilization by study groups subsequent to a mental health intervention. The 12 studies also showed reduction of 26% - 69% in utilization of medical care by study groups after treatment for alcohol abuse. Thirteen of the 45 studies used some form of comparison groups and 6 of the 13 were health studies. By comparing the six study groups with their control groups, they found the relative reductions of medical utilization were: 68%, 8%, 26%, 36%, 21%, and 66.5%.[2]

3. Studies at Kaiser-Permanente in San Francisco revealed that high medical users significantly reduced their utilization of medical services following psychotherapy, and that the costs of psychotherapy were offset by the savings in general medical costs.[3]

4. Comparable outcomes are reported in terms of improved attendance, productivity and reduced medical claims when employers offer employee assistance programs that utilize social workers as therapists.[4]

B. Effects on the Cost of Psychotherapy

1. "The Defense Department's CHAMPUS Program for dependents of military personnel estimates that it saved over $253,000 between December 1980 and March 1982 through its experimental reimbursement of clinical social workers.

The estimate is based on a comparison of the fees charged by social workers and psychiatrists in 32 states where 8 CHAMPUS insurance carriers have been reimbursing clinical social workers independent of physician supervision or referral. A report on the fee comparison appeared in the October 1982 NEWS.

CHAMPUS'S savings estimate is contained in an interim report on claims activity from October 1981 through March 1982."[5]

BIBLIOGRAPHY

1. Mumford, Emily; Herbert J. Schlesinger, and Gene V. Glass. "Effects of Psychological Intervention on Recovery from Surgery and Heart Attacks." American Journal of Public Health, Volume 72, No. 2, February, 1982. P. 141 ff.

2. Jones, op. cit. See also "The Implications of Cost Effective Analysis of Medical Technology: The Efficacy and Cost of Psychotherapy." Washington, D.C.: Congress of the United States, Office of Technology Assessment, 1980.

3. Cummings, Nicholas A. and W.T. Follette. "Brief Psychotherapy and Medical Utilization: An eight Year Follow-up." In H. Dorken, ed., The Professional Psychologist Today: New Developments in Law, Health Insurance and Health Practice. San Francisco: Jossey-Bass, 1975.

4. Schmidt, Sylvia A. Licensed Clinical Social Workers as Providers of Mental and Nervous Disorders Services. National Association of Social Workers, California Chapter, 1976.

5. "CHAMPUS Study Finds Social Work Services Effective in Cutting Costs." NASW NEWS, January, 1983, p. 2 (final report available from OCHAMPUS or NASW)

6. Cited in Schmidt, op. cit. Similar data are reported in the "Annual Survey of Fees" of Psychotherapy Finances.

7. Correspondence of Walter Chan, Senior Actuarial Analyst, to John B. Milnes, MSW, June 3, 1980.

EXHIBIT 12
March 6, 1985

WOMEN'S LOBBYIST FUND

Box 1099
Helena, MT 59624
449-7917

March 6, 1985

Testimony of the Women's Lobbyist Fund (WLF) by Gail Kline, before the Human Services and Aging Committee

Madam Chairwoman and members of the Human Services and Aging:

The Women's Lobbyist Fund supports SB 103, and I, Gail Kline, am speaking in favor of this bill. I have already testified before this committee on a similar bill of Rep. Bergene's HB 571, requiring mandatory licensing and regulation of professional counselors. The WLF supports SB 103 for the same three major reasons.

Freedom of Choice: By adding social workers, a largely female profession, to our Montana Code's existing list of those services covered under disability insurance, we give clients another choice.

Economics: A social worker offers a less expensive alternative. For example, in Billings, the going rate for a psychiatrist is about $100 per hour, a psychologist is $70 to $85 per hour and a social worker is $30 to $50 per hour, with $68 as "tops". In states where social workers and counselors have been included in insurance coverage, insurance rates have not gone up.

Quality Service: Under our state law, social workers are required to hold a doctorate or master's degree in social work, have 3,000 hours of practice in psychotherapy within the past five years and pass an examination.

SB 103 will aid clients in receiving more choices for excellent mental health services that will be covered by insurance.

The WLF urges you to pass SB 103.

Thank you

EXHIBIT 13
March 6, 1985

THE EFFECTS OF SOCIAL WORKER LEGISLATION IN UTAH

by Joan VanDeventer and Brad Kuhnhausen

Actuarial Services
Blue Cross and Blue Shield of Utah

March, 1983

THE EFFECTS OF SOCIAL WORKER LEGISLATION IN UTAH

On March 20, 1977 Governor Matheson signed into law Senate Bill 343 which for the first time regulated the practice of Social Workers in Utah. The Social Worker Act was one of several laws passed by the Utah legislature during that session which effected the delivery of health care. Its sister legislation included the regulation of pharmacologists, chiropractors and dentists.

These health care regulations were designed to recognize the legitimacy of non-physician treatment of certain mental and physical ailments. In the case of social workers, the state would establish criteria for certification of practitioners who had earned at least a master's degree. Once certified, the MSW or DSW would be allowed to perform the types of individual, family, or group therapy previously authorized for psychologists (PhD) and psychiatrists (MD). Of course, the use of prescriptive drugs, surgery or other "medical" techniques in the treatment of mental illness were reserved exclusively for physicians.

The Social Worker Act was premised upon two issues; fairness and cost containment. The fairness issue was borne from the apparent inconsistency in state regulations which sanctioned non-physician treatment of mental illness by psychologists but not social workers. Social Workers claimed that this was an unfair restraint of trade, because the health insurance industry would not reimburse the services of unrecognized providers. Additionally, social workers argued that they would be able to provide quality mental health services more inexpensively than psychiatrists or psychologists, thereby reducing the total cost to the public.

The remainder of this paper will explore these issues. In particular, emphasis will be placed on empirical evidence of the effects of this legislation on the mental health care market. First, we will examine changes in the aggregate supply of mental health care providers in Utah. Finally we will analyze the trends in cost and utilization as experienced by a particular, typical, population group.

PROVIDER POPULATION

Table One - Total Licensed Providers

	1978	1980	1982
Social Workers (MSW/DSW)	372	446	572
Psychologists (PhD)	231	213	279
Psychiatrists (MD)	96	109	115 (est)

As demonstrated by Table One, the total number of mental health professionals has risen dramatically. When one considers that this number has increased from about 300 total providers prior to state sanctioning in 1977, to over 950 today, it becomes clear that this act had more than marginal effect on the marketplace.

This marked increase should not surprise anyone, since the Act requires the attainment of only a masters degree. This means that an individual may provide mental health services after two years of graduate studies in social work. Obviously that takes less commitment and time than obtaining the required doctorate in psychology, yet Utah allows social workers the same clinical privileges as psychologists. In fact, out of those social workers registered with Blue Shield, less than four percent (4%) have doctorates.

Table Two shows the net population change experienced by several different classes of health care providers in the last two years (1980 - 1982). Providers of mental health services seem to be increasing more rapidly than most.

Table Two - Change in Registered Providers (1980 - 1982)

	Total Change	Percentage Change
Licensed Practical Nurses	(391)	(10%)
Physical Therapists	34	11%
Medical Doctors	531	16%
Psychologists	66	31%
Social Workers	126	28%

MARKET EFFECTS

The demand for mental health services is not quantifiable. Unlike broken legs, there are no fixed number of neuroses to treat in a given year. Moreover, the task of diagnosing a particular mental illness is exceeded in difficulty only by the task of determining the "best" treatment program. There are no x-rays or lab tests which can help document the types of conditions which social workers treat. Similarly, it is a subjective process which determines which patient has "recovered sufficiently" to discontinue treatment.

In light of this, and because health insurance benefits tend to be extremely limited for mental health care in an out-patient setting, accurate and pertinent data concerning utilization and costs are difficult to compile. Using aggregate data requires a parallel analysis of the changing composition of benefit packages chosen by subscribers. Unlike first dollar coverages such as hospital admission data, mental health data are contaminated with a hodgepodge of benefits ranging from no coverage at all to 50%/50% co-payments with various dollar maximums.

In order to mitigate these problems, we conducted a case study. This study examines a large, relatively fixed population whose benefit package covered out-patient mental health services generously and consistently for a number of years. By examining cost and utilization patterns of this group we hope to shed some light on the aggregate effects of Utah's social worker legislation.

CASE STUDY

(All utilization and cost data contained in this report are measured on an incurred rather than paid basis.)

Population: Government workers located in one of the SMSA's in Utah. The group averaged 3,257 contracts and 9,474 members throughout the study.

Benefits: (1978 - 1981) 80% of charge up to $25.00 charge per visit (maximum reimbursement is $20.00). Limited to 50 visits per year.

(1982) 80% of charge up to $60.00 (maximum is $48.00). Limited to 50 visits per year.

Graph One shows the impact of the legislation on the incidence of mental health treatments. The data indicates that social workers have not taken any significant amount of business from either psychiatrists or psychologists but rather have drawn on a pool of patients which previously did not receive care covered by mental health insurance benefits.

Note the leveling off of the trend in 1981 followed by the sharp increase in visits in 1982. This can be explained in large part by the fact that the particular population was able to anticipate a benefit increase which went into effect January 1, 1982. Since mental health services are in many cases voluntary and the impending benefit increase was well publicized, it can be assumed that some people deferred their treatment to save money in co-payments.

Table Three

Average annual (compounded) increase in visits per 1,000

	Psychologists	Psychiatrists	Social Workers
1978 - 1981	31%	14%	77%
1978 - 1982	41%	13%	90%

Table Three describes the same data contained in Graph One, but in terms of annualized percentage increases. Total mental health visits,

aggregating all three provider types, increased by a compounded rate of 29 percent from 1978 to 1981 and 37 percent from 1978 to 1982.

While these dramatic increases in utilization seem shocking, one would assume they might be explained by a decline in the market price of mental health services resulting from the rapid increase in provider population. This seems especially plausible given the fact that social workers can enter the market with considerably less investment than their established competition (i.e. with a masters degree rather than a doctorate or medical degree).

The evidence, however, does not support this supposition. Measured as a function of exposure (see Graph Two) the increase in the monthly cost of mental health services outpaced even the utilization figures.

Table Four shows the average annual rate of increase in the per month costs of provider mental health services. Also shown is the corresponding increase in all medical expenses for the same population. The cost of mental health services is accelerating much more rapidly than total health care expenses.

Table Four

Average annual (compounded) increase in cost per contract month.

	1978 - 1981	1978 - 1982
Psychologists	33%	63%
Psychiatrists	18%	39%
Social Workers	77%	108%
All Mental Health	33%	59%
Total Health Care	20%	28%

Of course the average cost per contract is a measure that is constrained by the maximum payment schedule. Regardless of the provider's billed charge, be it $25.00 or $85.00, the maximum payment would be $20.00 through 1981. Thus, additional insight into the societal costs of the Social Worker Act can be gained by examining the billed charges of mental health care providers.

Graph Three shows the relationship between the cost of the average service provided by the three major providers of mental health services. Over the time period, social workers billed an average of 97% of the typical psychologists charge and 87% of the typical charge by psychiatrists.

For each of the three providers, individual psychotherapy constitutes the majority of rendered services. From 1980 through 1982 these individual treatments, ranging from 45 to 60 minutes each, accounted for 83%

of psychologist's business, 63% of psychiatrist's business, and 92% of social worker's case load.

Graph Four shows the unit charge for individual psychotherapy sessions. It indicates that social workers are certainly no "bargain" when it comes to routine services. In fact, the trends would lead one to anticipate that social worker services will become more costly than those of psychologists some time in 1983, just six years after the legislation became law.

DISCUSSION

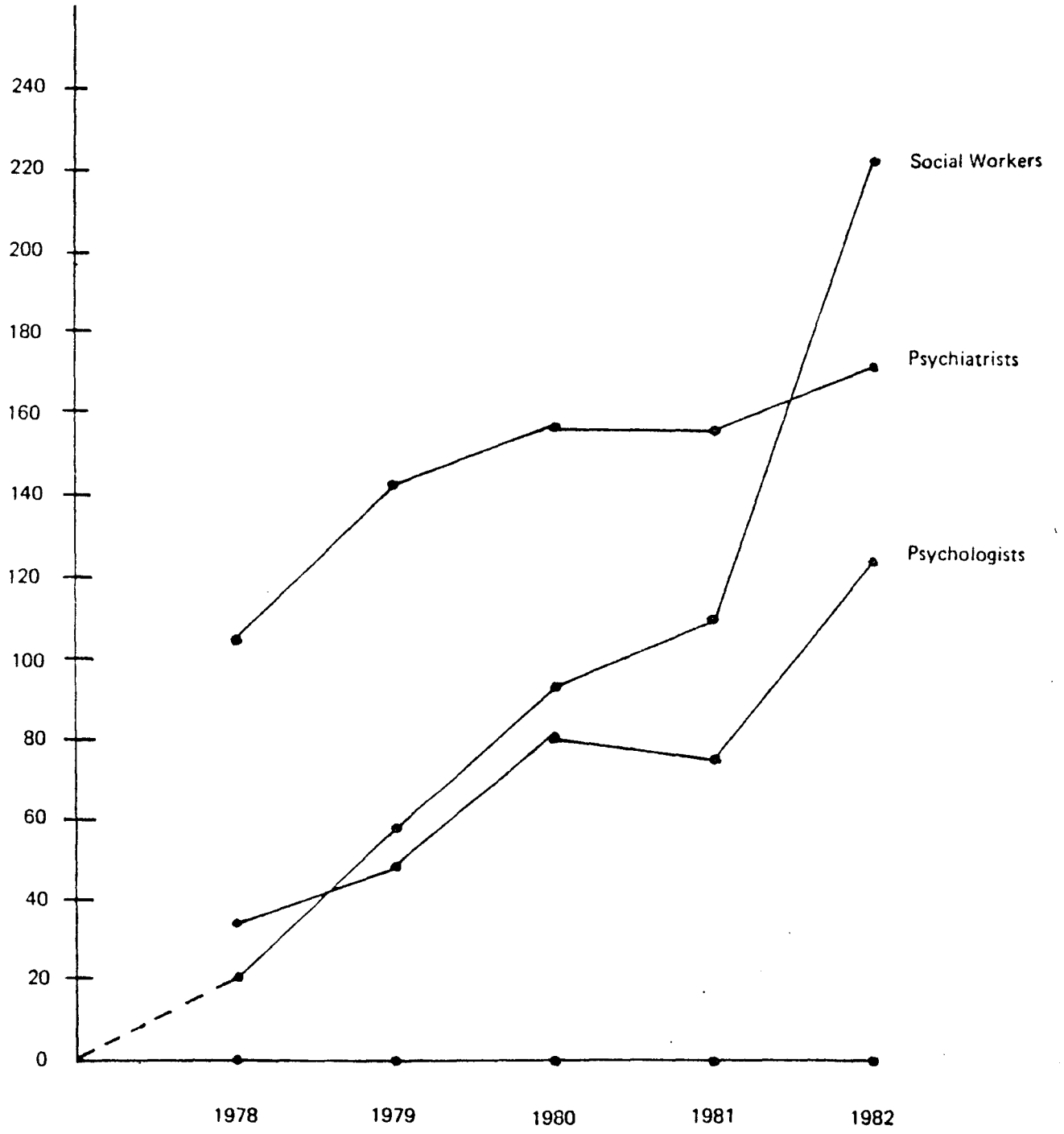
The evidence indicates that the state sanctioning of social workers is not a cost containment measure. Despite the lessing of the barriers to entry in the Utah mental health care market, there is no evidence that the forces of competition have reduced either the marginal or total cost to the insured consumer. On the contrary, the preponderance of data indicates that the effects of the legislation have been exactly opposite of that which the economics of competitive markets would predict. Specifically, both the price and quantity of those services are escalating in the face of rapid increases in supply.

There is another issue which this paper has avoided, but which does require comment. That issue is of course, quality. The qualify of care issue goes beyond the scope of this paper. However, some insight can be gained through the indirect measure of price elasticity. Price elasticity refers to the effects of price changes on consumption. Without attempting to quantify this measure, it can be noted that consumers are still flocking to social workers, despite their relative high cost given their lower educational standards. It seems that consumers cannot justify a wide disparity in fees between psychologists and social workers (who have identical clinical privileges), but are willing to pay a premium to be treated by a medical doctor specializing is psychiatry.

In conclusion, it seems clear that the market for mental health services is governed by forces other than perfect competition. What appears to be a logical policy - the sanctioning of lower overhead competition into the market - backfired in terms of the expected cost containment effects. Instead of increased supplier competition for a fixed demand by consumers, an entire new source of patients appeared in the market. Instead of resulting in lower costs, both marginal and total costs accelerated as a consequence of the social worker legislation.

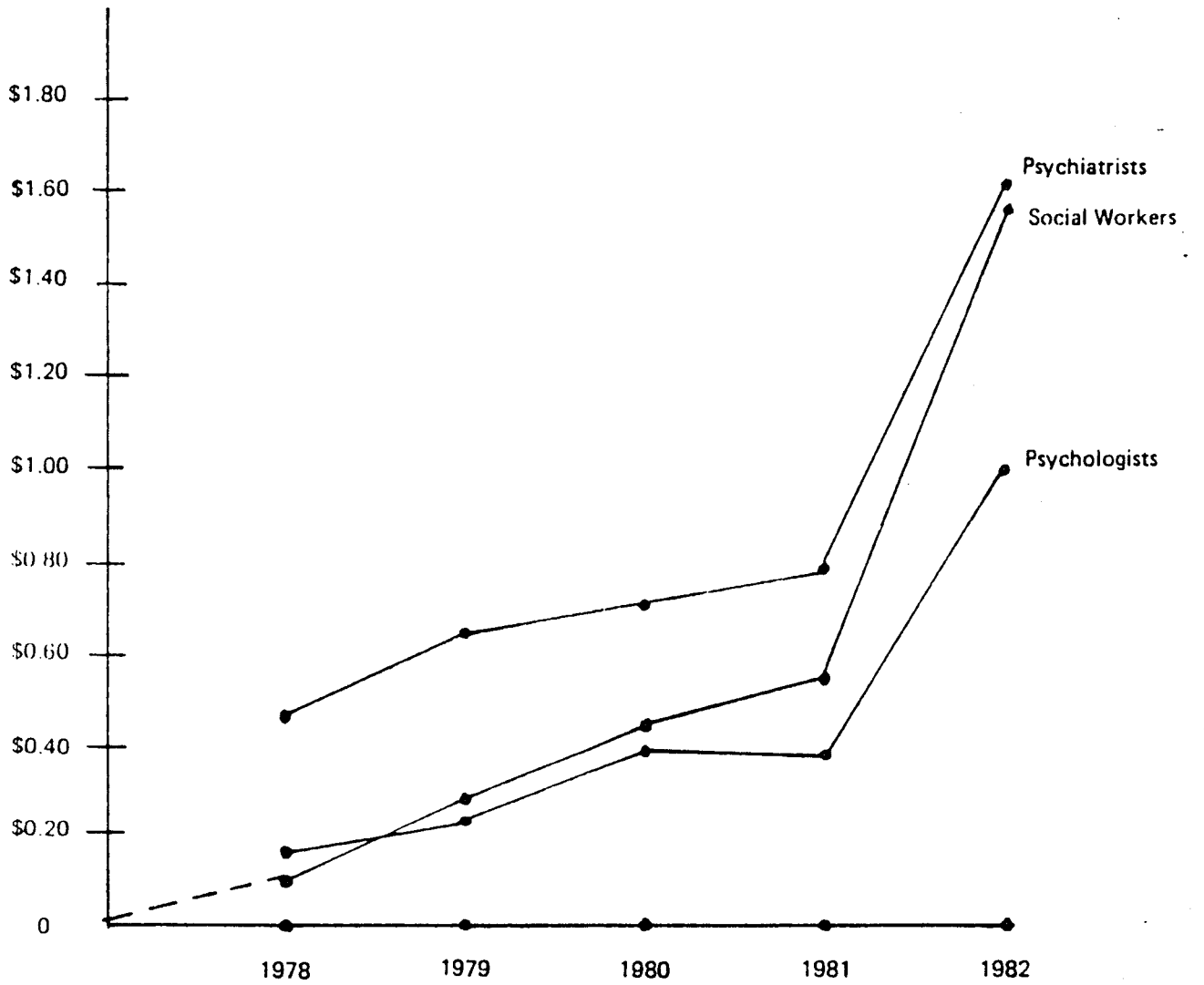
Graph 1

VISITS PER 1000 MEMBERS PER YEAR



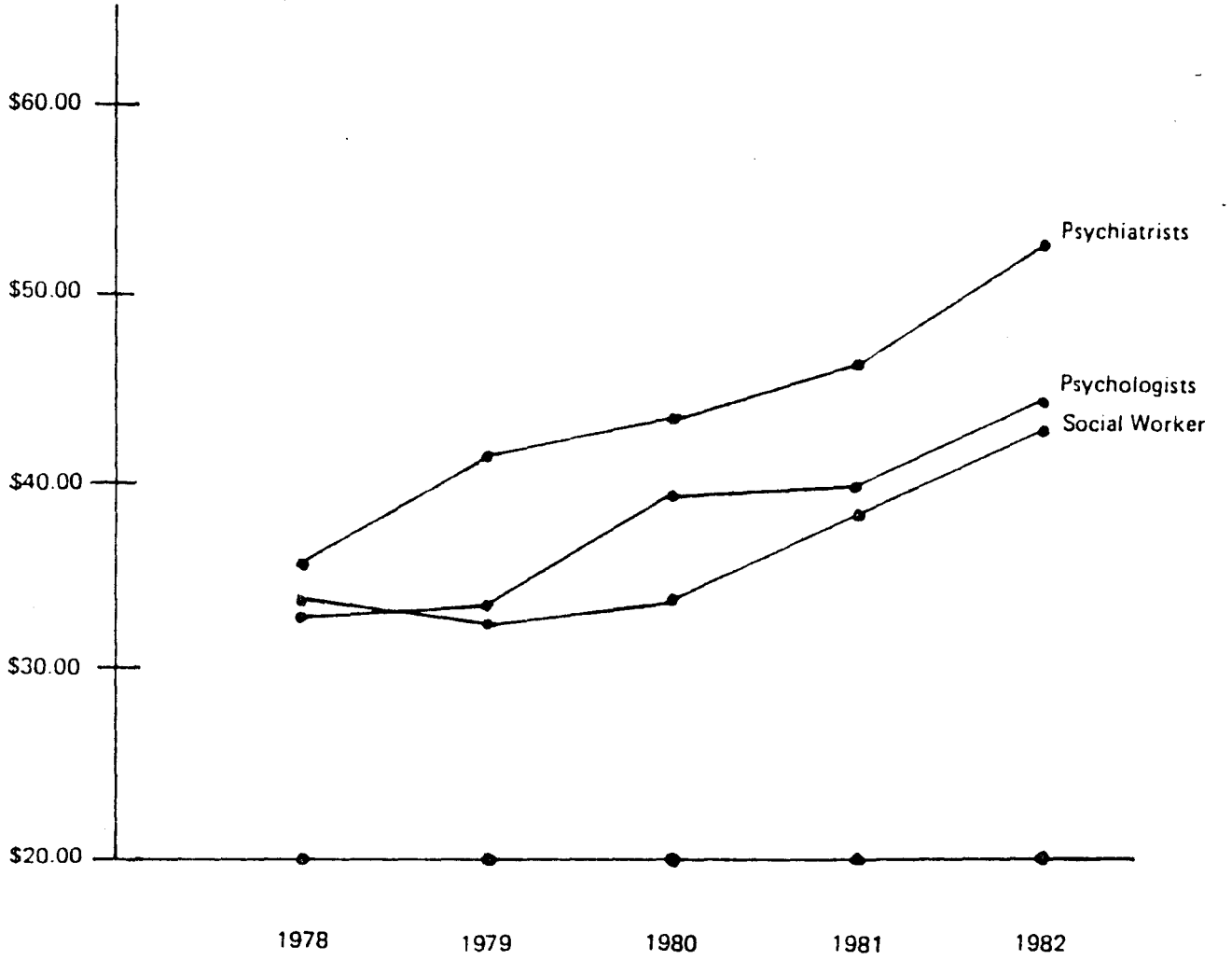
Graph 2

COST PER CONTRACT PER MONTH



Graph 3

AVERAGE CHARGE PER VISIT



Graph 4

CHARGE PER MINUTE OF INDIVIDUAL PSYCHOTHERAPY

(BASED ON A FIFTY MINUTE HOUR)

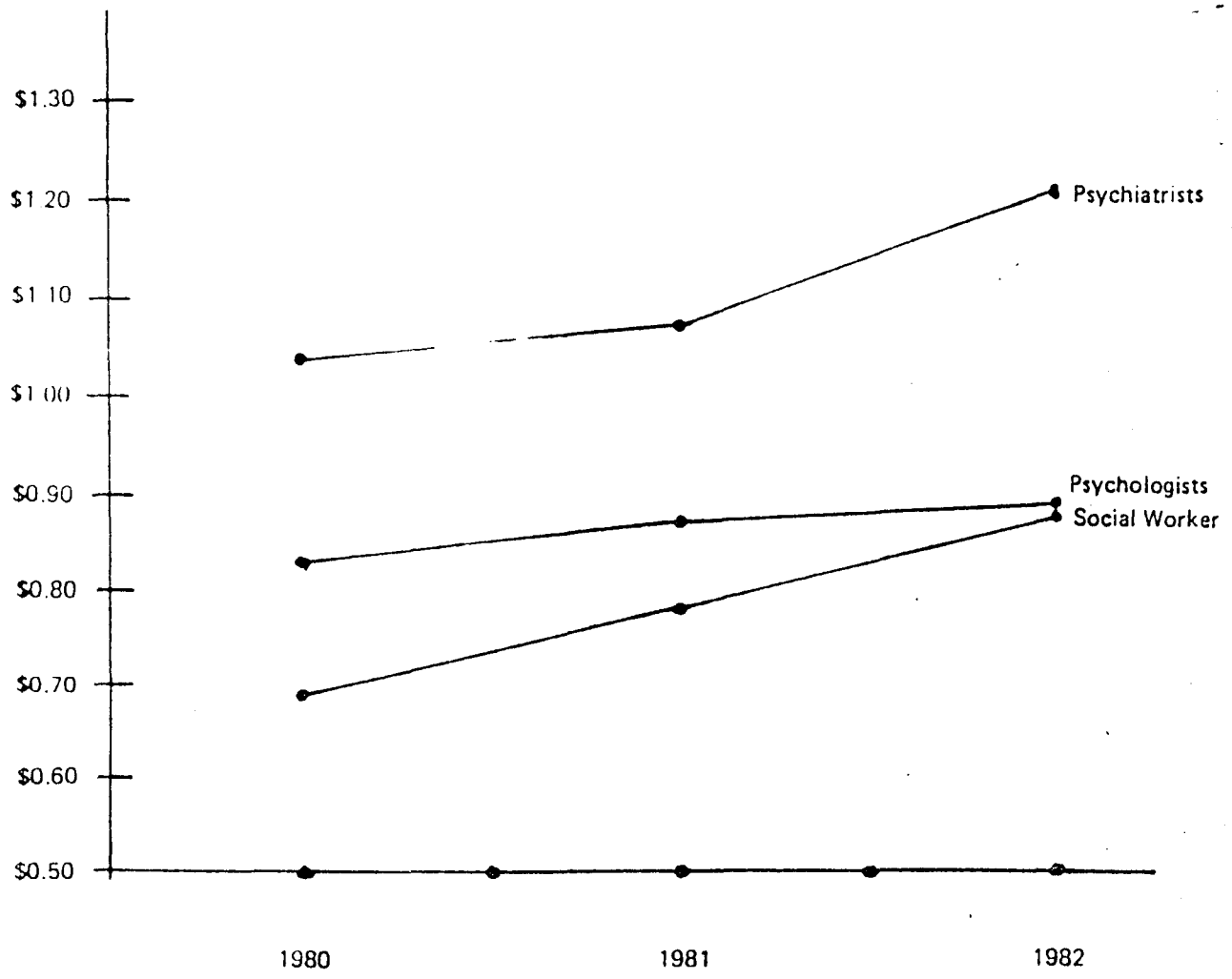
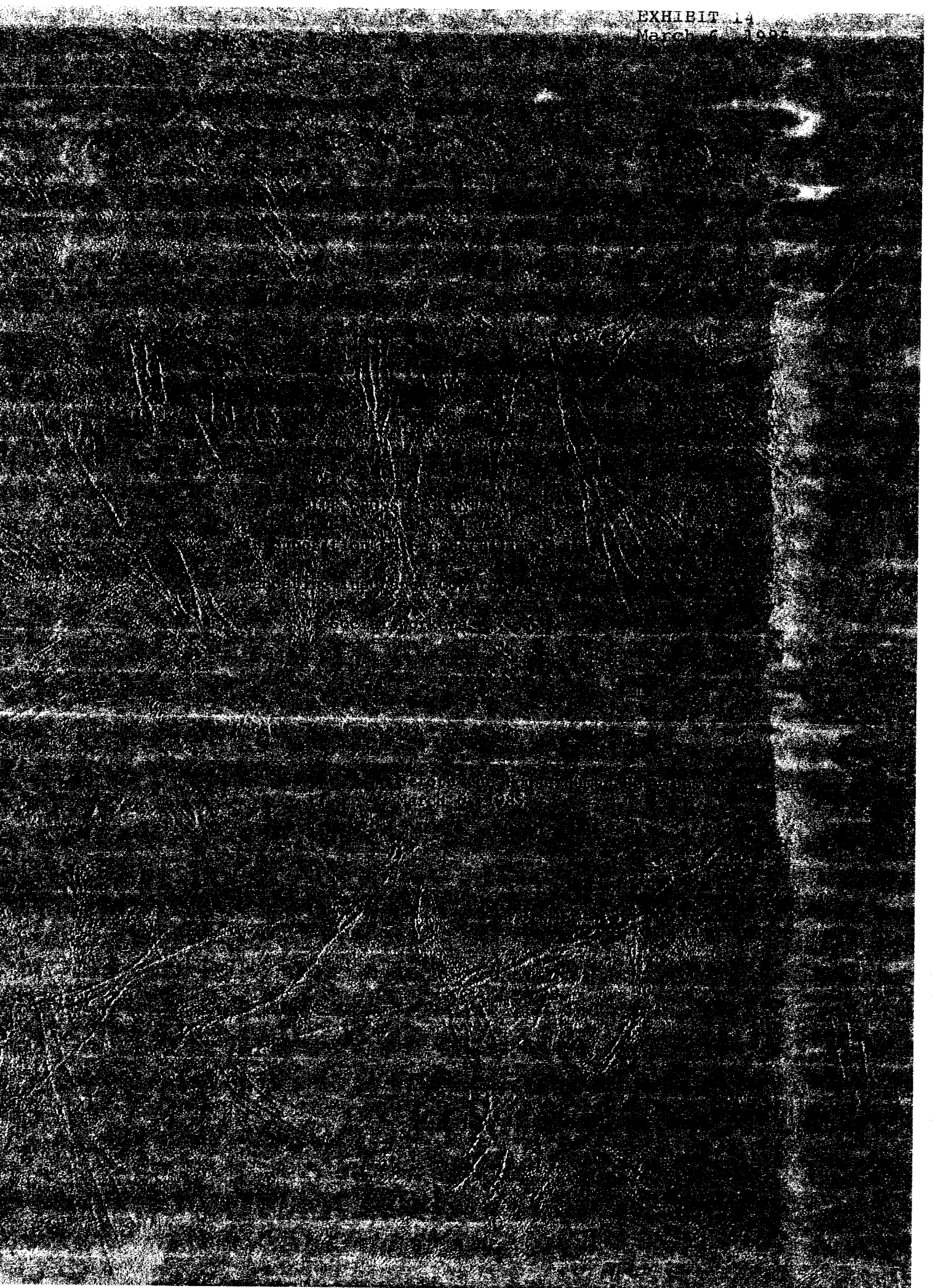


EXHIBIT 14
March 6, 1985



TESTIMONY OF BLUE CROSS OF MONTANA

IN OPPOSITION TO

SENATE BILL 103 - SOCIAL WORKERS BILL

Blue Cross of Montana opposes Senate Bill 103. Section 2 of that bill adds a mandated benefit for charges by social workers for outpatient benefits for Mental Illness, Alcoholism and Drug Addiction. This committee will remember that Blue Cross of Montana has been here before to testify where special interests have sought to add their professions to the list of providers of health care who are entitled to insurance policies or health membership contracts.

Before I address the social workers bill specifically, I want to briefly touch on the whole issue of mandated benefits and the so called freedom of choice laws. Blue Cross of Montana is concerned about the rising number of these bills offered in each legislative session, and so should you be as members of

the legislature because the effect of the bills may be the opposite of what you intend. We are not alone in these concerns, however. Attached to my testimony as Exhibit I is an article reporting on speeches to the Conference of Insurance Legislators (COIL) this fall. I invite your reading of that article, particularly the first four paragraphs.

In addition to COIL, the National Association of Insurance Commissioners (NAIC) is becoming alarmed at legislatively-adopted mandates. I have attached as Exhibit II to my testimony an advisory committee report to the NAIC. At page 5, the 5 recommendations for evaluating proposed and existing mandated benefits legislation point out problems that many people are thinking of.

I want to talk about several of the five recommendations as

they apply to the bill before you, using some of the questions found on pages 6 through 10 of the NAIC committee report.

1. Does the mandated coverage meet a clear, unmet need by the citizens of the State?

I believe all persons within the State have access to one of the other outpatient providers currently mandated by law. Exhibit III shows, for example, that we have in Montana 47 facilities providing outpatient alcohol and drug addiction benefits; one for nearly every county. In addition, scattered throughout the State are regional mental health centers available for our citizens.

Exhibit IV is a list of who is currently licensed as social workers in the State. By my count, that list adds

a potential 139 new providers to an already adequately staffed field. Those licensees live primarily in the metropolitan areas of the State, the same areas already being served. Many of those licensed social workers, of course, are currently employed for institutions which now provide outpatient Mental Illness, Alcoholism and Drug Addiction care.

Does the State Department of Health recommend this addition? If so, Blue Cross of Montana is not aware of it. Will the proposed benefit contribute to the quality of care? If so, Blue Cross of Montana is not aware it.

Does this legislation meet a medical need or a broader social need? It is submitted that the medical needs of our citizens are being adequately served. This

legislation fits a social need. As a social need, we question whether it fits into the role of insurance. There is only so much money to go to the payment of insurance benefits and, when you mandate a social need as eligible for insurance benefits, the insurance company's options may be to start cutting where available. The available area now is the area of medical needs rather than social.

Who advocates this legislation? Providers or consumers? We suggest it is the providers who advocate the bill. How is the service being paid for now? The law already allows physician psychiatrists to prescribe services which include those of social workers where medically necessary.

2. What is the cost impact of the legislation? Blue Cross of Montana does not know. We do know that the budget

director, in the fiscal note for House Bill 821 which would make alcoholism treatment and psychiatric services a mandated benefit under Medicaid, said of that legislation, "Expansion of Medicaid benefits into this area may have the effect on increasing Medicaid utilization substantially. Such an increase is impossible to predict."

We also know that the services to be performed don't just overlap services currently being provided. The result is more providers and more costs, not less.

When insurance payments are guaranteed, a result is a phenomenon called "fee creep". Because insurance companies are required to pay, fees tend to go up to the point where they frequently approach that of medical doctors.

You have heard reference to a report on the Champus experimental study on reimbursement of independent clinical social workers. I have attached a copy of that report as Exhibit V of my testimony because Blue Cross of Montana believes it is important you have the facts contained in that report. Several things are significant.

Over one-half of the claims submitted were billed for amounts higher than allowed by the fiscal intermediaries (insurers).

Even though over $457 thousand was supposedly saved nationwide, the social workers in Hawaii charged $94 an hour, which was $6 an hour more than that allowed to psychiatrists. An impact of that one state's claims significantly offset savings realized in all the other

states.

Claims for Montana were the 14th largest in the nation, out of 40 states with claims submitted.

Table 5 of the report compares prevailing fees of psychiatrists and social workers. It shows in Montana, while psychiatrists charged $60 per hour, social workers charged $50, an extremely high charge for persons without medical credentials.

3. What effect does the mandated legislation have on the State's ability to regulate insurers? It may be just the opposite of what you intend.

The COIL article I enclose says, "The increase in mandated benefits is causing an increase in self-funded plans which escape state regulation". The more you mandate benefits, the less able insurers and health service corporations are to compete with self-insured plans which do not have to have reserves and are not subject to state regulation or scrutiny. You could be buying into wholly inadequate protection for the employees of self-insured plans.

Finally, who pays for mandated benefits? It is not the insurer or the health service corporation. It is the hard-pressed employer who buys over two-thirds of the contracts of Blue Cross of Montana in this State; the business which is already being pressed on all sides. Do you really want to add another requirement to those very small businesses who are telling us, "Enough Blue Cross; I

cannot afford anymore dues; contain medical costs; don't increase them".

Look at the editorial from Delaware that I have attached as Exhibit VI. Delaware's governor vetoed its social worker mandated benefit legislation after that article appeared. Look at the veto message of Governor Hugh Cary of New York attached as Exhibit VII. Governor Cary had the same concerns.

During 1983 and 1984, over 500 bills to mandate coverage were introduced into state legislatures across the nation, an average of 12 per state. In the last 6 years, over 350 laws have been enacted dealing with mandated coverages. Our citizens, our subscribers, cannot afford to pay for many more of these gifts from you. I urge you to stop. I urge you to give a do not pass report for Senate Bill 103.

Attachments

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C.O.I.L. WARNED ON HIDDEN DANGERS IN MANDATORY HEALTH CARE BENEFITS LAWS

No matter how innocuous they seem when they are passed, laws mandating certain health care benefits often counteract cost-containment efforts -- even when they are presented as cost-effective. In addition, the increase in mandated benefits is causing an increase in self-funded plans which escape state regulation. More such laws are being passed in the states every day, but their effect on cost-containment and regulation is seldom perceived at the time of passage.

The hidden costs of legislatively mandated benefits were revealed at the annual meeting of the CONFERENCE OF INSURANCE LEGISLATORS in Little Rock, Ark., by a state legislative employee and by two members of BLUE CROSS/BLUE SHIELD ASSOCIATIONS. Each of the speakers warned COIL members not to pass mandated benefits laws without severe scrutiny of their ultimate cost to the overall group.

JOHN B. WELSH JR. of the OFFICE OF PROGRAM RESEARCH of the WASHINGTON STATE HOUSE OF REPRESENTATIVES, said most of the mandated coverage proposals are being pushed by provider groups to increase their clientele and to assure a steady flow of fees.

"The third-party reimbursement system has been identified as the biggest culprit of the health care cost spiral," he said. "The patient is insulated from the true costs and the provider is given an economic incentive to maximize services regardless of cost benefits. This is the equivalent of a patient being offered an a la carte menu with the provider acting as his waiter and encouraging his appetite while the bill is being paid by someone else."

LINDA LANAM of BLUE CROSS/BLUE SHIELD of Washington, D.C., pointed to another reason to hold the reins on mandated benefits. She said that an increasing percentage of the health care marketplace is moving out of insurance and into the self-funded marketplace -- which means that the impact of mandated benefits lies only on the insured segment. She warned that this movement into self-funded plans also takes away state legislators' and regulators' control for that portion of the benefits marketplace by taking it out of the state insurance regulatory system mechanism completely.

Dr. JAMES M. YOUNG, vice president of BLUE CROSS/BLUE SHIELD OF MASSACHUSETTS demonstrated how mandated benefits for psychological and psychiatric care in his state increased dramatically the use of such services and thereby the overall cost of health care in the state.

Mr. Welsh pointed out some of the reasons for the increase in mandated coverage proposals are the expanding definition of what health care is with health care becoming increasingly technological and new treatments and services appearing yearly; anti-physician sentiment, especially by non-mainstream providers; the expansion of the types of practitioners in the market; changing values and expectations of society; and incomplete coverages.

The proposals, he said, fall into certain categories -- those that provide coverage for a very limited number of people; broad-base coverages, such as alcoholism treatment, those that attempt to use the insurance delivery system to address to social problem such as mandates to bring more people into the coverage program who would otherwise not be in it; and those that bring in a new provider service, where a health care profession tries to use the insurance mechanism as a marketing stimulus.

Mr. Welsh advised legislators to review mandate proposals to be sure they

(Continued on Page 216)

HIDDEN DANGERS IN MANDATORY HEALTH CARE BENEFITS LAWS (Cont'd from Page 215)

are truly in the public interest. Analysis, he said, should be as objective as possible, especially in the legislative forum "where too often politics is the art of the possible."

Ms. Lanam explained how state regulation is affected by mandated health benefits laws. She said that ERISA creates a preemption from state regulation of employee benefit welfare plans. State insurance laws affect only that portion of employee benefits that are fully insured, she said, and the self-funded portion is growing. She also noted that "no state insurance laws and almost no federal laws apply to the self-funded benefits."

She said it may be necessary to consider allowing ERISA to pre-empt state regulation on the issue of benefit design (but not solvency regulation, market conduct or unfair trade practices enforcement) in order to enable the insured community to compete in the self-insured marketplace and to bring that portion of the marketplace under appropriate state regulation.

She asked the legislators to look at the issue of mandated benefits not just as individual pieces of legislation, and not just as provider-driven issues or public issues, but to decide whether they are the appropriate role for the state legislature and state regulator.

Ms. Lanam also agreed with Mr. Welsh that mandated benefit proposals are increasingly provider-driven. "They are affected not by public or consumer interest but all too often by the desire of providers to assure their payment through inclusion in the insurance coverage process," she said. In addition, she said, many arguments on behalf of these proposals are "encased in the currently popular health care cost-containment rhetoric." State legislators, she advised, must look at the best interest of citizens and not just special interest groups.

According to Dr. Young, Massachusetts was confronted with the detrimental effects of mandatory benefits when the state decided to deinstitutionalize mental patients and at the same time, passed mandated benefits legislation to facilitate it. "Some of the results of this legislation were not foreseen," Dr. Young said.

The mandate for mental health care was passed in December 1973 and applied to all contracts issued in the state after January 1976. The annual dollar amount required was $500 over a 12-month period for each individual insured. He pointed out that in MASSACHUSETTS the law requires Blue Cross and Blue Shield to be a non-profit insurance company that can insure only for health insurance and no one is denied such insurance. He said some 3.5 million of the state's 6 million residents are covered by Blue Cross-Blue Shield.

Dr. Young showed how the use of psychological services in Massachusetts has grown since the mandate, with the implication that in many cases it is overused and unnecessary and has raised the cost of health care for the entire group.

He said that since mental illness needs the participation of the patient and the therapist in order for the patient to show progress, "there is a significant advantage if there is a participation in a co-insurance plan, as well.

He advised the legislators to not mandate coverages but instead to mandate their offering. "This is a time of free choice. Don't bend to the individual special interest groups. Resist them. Do what is best for the overall group. We will be far better off if you do." (National Underwriter, 11-30-84)

B. TURNING THINGS AROUND

5. The NAIC Policy on Evaluating Mandates

I INTRODUCTION

The health care financing world has changed considerably since Congress established the Medicare and Medicaid programs in 1965. Three major factors contributing to the change are the prevalence of two-worker households, the proliferation of health benefit plans with comprehensive health care coverage, and the continuing escalation of health care costs.

For economic reasons, the focus of concern among public policy makers, employers and insurers has shifted from removing financial barriers to care to containing the costs of care. Indeed, much of the competition in the health services and health benefits markets now revolves around the ability to contain costs. The steady growth of HMOs, the recent exploration of preferred provider arrangements, the increased popularity of cost sharing, and the proliferation of ambulatory surgery, utilization review and other programs testify to employer, insurer, and provider commitment to try new approaches to cost control. Health benefit plans which are not subject to state regulation of their benefit design are free to implement new approaches to cost control, while existing state laws often stand in the way of health carriers adopting the same initiatives.

Several recent polls indicate a majority of consumers medical cost containment through health benefit design, and there

there is evidence of a strong demand on the part of employers for plan changes implementing cost containment mechanisms. Insurers' failure to meet that demand can result in more employers electing self-insurance.

As state governments evaluate policy options, it is important that the rapidly changing nature of health care delivery and financing be recognized. Otherwise, we risk adopting policies conceived when competition was not a significant factor in health care cost containment and perhaps in the process, inhibiting the effectiveness of competition as a restraint on health care costs.

Health care cost containment measures should be addressed to factors that will result in the greatest overall savings. For example, we know that hospitals account for more than 40% of the national health care expenditures. Those expenses are, therefore, a logical target for cost control initiatives. However, any such initiatives should be designed so that they do not consume, through cost of administration, much of the cost savings to be effected.

This report discusses cost sharing and nonduplication of benefit payments as health care cost containment mechanisms. We also focus on criteria to assess and evaluate new and existing mandated benefit legislation.

II SUMMARY OF RECOMMENDATIONS

A. The NAIC should adopt as part of its health care cost containment policy the following criteria for evaluating proposed and existing mandated benefit legislation:

1. The legislation fills a clear, current need.
2. The short term and long term costs to consumers and to total health care expenditures are measured.
3. Overutilization which may result from passage of the legislation can be minimized.
4. The mandated benefit does not create an unfair market disadvantage to insurers motivating group policyholders to self-insure.
5. Whenever possible, the need should be filled by mandating availability of the coverage, rather than inclusion in all plans.

B. The NAIC should urge state insurance commissioners to employ the criteria in reviewing proposed and existing mandated health benefit plan legislation and regulations; and the NAIC through its liaison with CCIL and NCSL should recommend that those organizations adopt the criteria for use in evaluating such legislation.

C. Cost sharing through particular deductibles, copayments, or coinsurance should not be a mandatory part of health insurance policies. Market forces should be relied upon to introduce specific forms of cost sharing.

D. Where duplication of benefits from any source exists, benefits paid should not exceed 100% of covered expenses.

E. Consideration should be given to development of a system under which aggregate benefit payments can be limited to less than 100% of covered expenses.

F. Implementing steps, including consideration of statutory and regulatory changes necessary to accomplish D above, should be defined.

G. A study and report should be made on the feasibility of a health claims index for the purpose of facilitating nonduplication of benefits payments, and to aid in discovery of fraud before payment is made.

III MANDATED HEALTH BENEFIT PLAN LEGISLATION

For purposes of this report we refer to laws affecting mandated benefits, cost sharing and nonduplication of benefits payments as mandated health benefit plan legislation. Mandated benefits legislation requires offering or extending coverage for particular diseases, for types of treatment and allied health professions, or for a specified level of coverage. Mandated cost sharing legislation would require state regulated health care financing to impose on the insured specified deductibles, coinsurance or copayments. Mandated nonduplication of benefits legislation would attempt to reduce duplication of benefits payments by requiring, for example, COB provisions in all health insurance policies.

Most people have their primary health insurance through employee benefits. Therefore, the ERISA preemption issue is of prime importance in any discussion of mandated health benefit plan legislation. 1/ If such laws are preempted by ERISA, their application and supposed protections will be limited primarily to those covered under non-employment plans. If, on the other hand, ERISA is determined not to preempt such laws, the combined effect of mandated health benefit plan legislation may be to accelerate the trend to self-insurance, leaving more and more people unprotected by insurance regulation and defeating the purpose of the legislation.

Mandated health benefit plan legislation may have other undesirable effects. Mandating certain features in employer-employee group policies interferes, perhaps impermissibly, with the collective bargaining process. 2/ Mandated health benefit plan legislation may add to the cost of insurance coverage, thereby adding to affordability problems for many. Such legislation often frustrates health care cost containment and deprives consumers of deciding which coverages are most appropriate and affordable to them. Too, the added costs of administration resulting from the need to prepare and file multiple policy forms conforming to diverse requirements of the various states add to the economic arguments for applying careful analyses before proposing and enacting mandated health benefit plan legislation.

A. MANDATED BENEFITS LEGISLATION

In the past twenty years, there has been a dramatic increase in legislation introduced to mandate the kinds of institutions insurers, hospital and medical service plans, and other third parties must pay for patient care, the types of treatment and specific diseases which must be covered, the health care personnel who are to be paid for their services, and the level of coverage to be provided. For purposes of this report, we view mandated benefit legislation as falling into three general categories: (1) laws mandating payment for the service of specific providers, either institutions or individuals; (2) laws mandating coverage of specific illnesses or treatment methods; and (3) laws mandating specific coverage levels.

The advisory committee has not attempted to study the effects on costs of particular benefit or provider mandates. 3/ It is felt that time constraints preclude a meaningful cost analysis. For a thorough discussion, however, of the cost impact of mandated benefit legislation, see Larson, Mandated Health Insurance Coverage -- A Study of Review Mechanisms, Report to the Bureau of Insurance, State of Virginia 1979 ("Larson Report" herein).

The Larson Report suggests that the long-term effects of state-mandated benefits are sometimes harmful, rather than helpful, to the groups they are designed to protect. It proposes that they receive close scrutiny prior to enactment

and suggests the application of uniform evaluation criteria to each mandated benefit proposal. The report views adoption of the criteria as "an absolutely critical component" of the legislative process.

We concur and recommend the NAIC adopt as part of its medical cost containment policy the following for evaluating proposed and existing mandated benefit legislation. Three of the criteria are suggested in the Larson Report, along with questions illustrating what must be analyzed in order to perform a thorough evaluation. We add two criteria suggested by our analysis of the current health care financing marketplace.

1. Unmet Need - Whether it be a mandated coverage or payment of new practitioners' services, the rationale usually is that a segment of the population does not have necessary access to medical care or suffers an unnecessary financial hardship in the purchase of such services. Some of the issues to be considered in determining whether there is a clear unmet need include the following:

   a. Current geographical distribution of pertinent providers/health care personnel.

   b. What are other alternatives to meeting the identified need?

   c. What are the findings, if any, of the State Health Planning Agency and the appropriate Health Systems Agencies?

d. How will the proposed benefit contribute to the quality of patient care and the health status of the populace?

e. Is this a medical or a broader social need and does it fit in with the role of health insurance?

f. Is proposed mandated benefit legislation advocated by providers or consumers? What are consumer attitudes regarding the need for this legislation?

g. How is the service being paid for now?

h. What evidence and/or experience in other states is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?

2. Cost Impact - This must be analyzed in terms of additional premium expense to consumers and the impact on total health care expenditures.

a. What is the projected utilization of the service to be covered by the mandated benefit over the next five years?

b. What are the anticipated fees/rates for the next five years and how do they compare with alternative providers?

c. What is the estimated increase in insurance premiums for the proposed benefit over the next five years?

d. What is the probable magnitude of the impact on the total health care expenditures?

3. Control Overutilization and Costs/Fees - Given the already alarming inflation in cost of medical care, changes in coverage or payment of new practitioners must be accompanied by measures to minimize unnecessary utilization and excessive growth of costs. This chiefly pertains to payment of new practitioners.

   a. How will non-physicians be reimbursed: fee-for-service, costs, or other; and which one minimizes costs?

   b. Will the appropriate professional organization maintain a "registry" with standards to assure a high degree of clinical proficiency?

   c. Is the quality of services proposed to be offered by non-physician practitioners an acceptable substitute for, or better than, that delivered by a physician?

4. Mandated benefit legislation should be applicable to all payors, including self-insureds.

To this end the ERISA preemption issue must be resolved. The extent to which the proposed mandated benefit will motivate group policyholders to self-insure to avoid the costs of the benefit should be identified.

5. Can the problem be solved by mandating availability of the coverage, rather than mandating inclusion of the coverage in all plans? 4/

In conclusion, we recommend that the NAIC urge states to analyze and evaluate existing and proposed mandated benefit legislation using the criteria suggested in this report, and other criteria evolving from the evaluation process. Should the legislature determine that the proposed mandated benefit meets the first four criteria, then rather than mandate its inclusion in all policies, it should consider mandating its availability. This will be less disruptive in the health care financing marketplace.

B. MANDATED COST SHARING

Cost sharing attempts to directly place the responsibility for cost consciousness on the consumer. It takes several forms:

a. Deductibles, wherein the individual assumes the responsibility for costs up to a stated dollar amount.

b. Coinsurance, wherein the individual assumes responsibility for a specific percentage of the cost for services.

c. Copayment, wherein the individual assumes responsibility for a specific amount, but not the total cost, for specific services.

Cost sharing as a health care cost containment mechanism is offered on the theory that cost sharing will motivate consumers to make informed health care decisions, thereby deterring unnecessary or inappropriate utilization.

The response to that theory is that regardless of cost sharing, most consumers do not make the health care decisions after they have sought care, particularly for the most costly health care, and they also lack sufficient knowledge and information to make those decisions. If that is so, cost sharing would not have the desired effect of reducing the unnecessary use of medical services. It would only shift health care costs to consumers. It would also place a disproportionate burden on low income people who would have to pay a higher percentage of their income on health care costs.

Other arguments in opposition are that cost sharing also interferes with the concept of preventive health care and employee health awareness while not preventing hospitalization costs, where utilization and expense factors are the highest. If a deductible or copayment is large enough to reduce health care expenditures, it may also be large enough to discourage seeking preventive and primary care and may be socially unacceptable. If small enough to be socially acceptable, it may not be large

enough to discourage incurring unnecessary medical expenses, serving only to reduce the premium and having little or no impact on the costs of health care.

There is evidence that cost sharing requirements, if large enough, will reduce utilization. One approach is to redesign or modify health benefit plans providing first dollar coverage to bring employees into the payment system, as did U.S. Steel when it established a deductible payment similar to Medicare and experienced an 18% decrease in hospital admissions. There appears to be a trend to cost sharing in group plans.5/

But statistics on the decrease in utilization, or the increase in market demand for cost sharing should not be used as a rationale for mandating changes in existing benefit plans. Although the interim results of the Rand Study 6/ indicate that full coverage leads to more people using services and to more services per user, it is important to note that the study indicates that medical expenditures after admission to the hospital did not differ significantly between plans studied. In addition, data are insufficient to determine whether higher use by persons with free care is unnecessary care, or whether lower use by those with income related catastrophe coverage reflects failure to obtain necessary care.

The National Center for Health Services Research, a division of the Department of Health and Human Services, performed a

study and reached the conclusion that deductibles and coinsurance as they relate to the Reagan Administration's tax cap proposal would reduce coverage for health expenses, such as dental and vision care, rather than reducing inpatient medical expenses. 7/

The Advisory Committee recommends against mandating cost sharing through deductibles, copayments or coinsurance for health insurance policies. Our primary reasons for this recommendation are:

1. This issue is a critical collective bargaining issue;
2. Such a mandate may motivate group policyholders to self-insure to avoid the mandate;
3. We lack reliable data on the effectiveness of cost sharing as a health care cost containment initiative;
4. Cost sharing can inhibit seeking necessary primary and preventive health care; and
5. The health care financing market has been and is responding to demands for cost sharing.

C. MANDATED NONDUPLICATION OF BENEFITS

The extent of duplication of payments by group health plans, individual health plans, and casualty insurance is difficult to isolate for a statistical demonstration because there is no methodology in existence which would feasibly allow quantification. Those studies which have been done indicate clearly

that there is considerable duplication and that in the larger claims particularly, the claimants are reimbursed at substantially more than 100% of their expenses. 8/

According to a survey done in the summer of 1983 by the NAIC, however, some regulators take the position that having paid a premium for a benefit, the insured should receive that benefit even if it results in payment exceeding 100% of covered expenses. It should be recognized that this position may encourage overutilization of health care. To the extent this factor contributes to escalating health care costs, it should be neutralized. We do not have statistics to measure the degree of overinsurance, nor a definition of overinsurance. We only state that it is not in the public interest to allow patients to make a profit on health care financing.

We recommend the task force consider the policy that where duplication of benefits from any source exists, benefits paid should not exceed 100% of covered expenses. Consideration should also be given to development of a system under which aggregate benefit payments can be limited to less than 100% of covered expenses.

Either policy will require removal of inhibitions prohibiting coordination of benefits among all payors. Such inhibitions exist according to the state survey submitted at the September meeting by the NAIC COB Task Force. The Advisory

Committee stands ready to help define those steps, including consideration of statutory and regulatory changes, necessary to implement either policy.

The Advisory Committee further recommends the NAIC authorize a study of a mechanism which has the potential to promptly discover and identify claims for duplication of benefit payments for a given accident or illness. That mechanism is a health insurance claims index, or loss register. All health insurance claims exceeding a threshold amount would be reported to that index with a request for information concerning any pending health care payment claims from other insurers. The reporting would not include the amount of payment requested or made, but only the fact that a claim was made. If a second insurer reported to the index, both would receive notification that a claim for expenses arising out of an accident occurring on the same day, or treatment or hospitalization covering the same period, was pending with another insurer. The insurers would then communicate with one another for information necessary to coordinate the coverages.

For a small fee each would uncover potential duplication of benefits payments and increase the accuracy of COB greatly. Another incentive is the discovery of insurance speculation and fraud before claim payment is made.

A threshold for reporting claims should be set at a level to reduce the number of claims reported, and at the same time to lo-

cate most of the duplication of benefits. While it is true that on a computerized system it is possible to report all health insurance claims in the United States, the purpose for reporting should be kept in mind. Banks report every banking transaction that is made every day, and credit it to a named account. That is essential to the operation of their business. However, the reason for reporting health insurance claims to a single source is to discover duplication of benefits. There should be a threshold which is cost-effective and it should change as the medical price indices fluctuate. 9/ We recommend the amount of the threshold be determined by the index managers.

The use of a health insurance claims index could have an additional beneficial effect. If a subscription to the index were conditioned upon acceptance of the NAIC Coordination of Benefit provisions, it would accomplish two salutory aims. The first would be to speed up claims handling by establishing a universal order of health care expense benefit determination among the payors subscribing to the index. The second would be the powerful incentive for acceptance of COB guidelines by those third-party payors which are outside the reach of state regulation. This is more than conjecture. At present, hundreds of self-insured employers subscribe to the AIA third-party liability index. They do so on a voluntary basis, for the purpose of reducing their health care expense payments.

The degree of usefulness for such an index, and the degree of incentive it would provide to establish a uniform order

of medical expense benefit determination would depend primarily upon its cost-effectiveness. We recommend a feasibility study be undertaken to determine the following:

a. Are there data organizations with the capacity to establish a health insurance claims index?
b. What threshold for reporting should initially be employed?
c. What types of health insurance claims should be excluded?
d. Should the reporting be national or regional?
e. Should the reporting be mandated by law, or voluntary?
f. What would be the costs and anticipated savings?
g. How can it be used to discover insurance fraud?

Lastly, the Advisory Committee offers its continued assistance to the Task Force in exploring the feasibility of a health claims index.

Footnotes

1/ §514(a) of the Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws that "relate to" employee benefit plans [29 U.S.C. 1144(a)]. The "savings clause," §514(b) exempts from preemption state laws regulating insurance, banking, or securities [29 U.S.C. 1144(b)(2)(A)]. The "deemer clause" provides that employee benefit plans and trusts established under such plans shall not be deemed to be an insurance company or engaged in the business of insurance for purposes of any state law purporting to regulate insurance companies or insurance contracts [29 U.S.C. 1144(b)(2)(B)].

Since its passage in 1974, §514 has generated much litigation seeking clarification of the inter-relationship of the provisions. In May 1981, the U.S. Supreme Court affirmed an appeals court decision that §514 preempted a New Jersey statute prohibiting the offset of private pension benefits by state workers' compensation payments Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 519, 68 L. Ed. 2d. 402, 101 S. Ct. 1895 (1981). The court made it clear that the phrase "relate to any employee benefit plan" in §514(a) is to be interpreted broadly. In June, 1983, the Supreme Court decided Shaw v. Delta Airlines, Inc., 77 L. Ed.2d 490, 51 U.S.L.W. 4968, 103 S.Ct. 2890 (1983), broadening the extent to which ERISA preempts state laws "related to" employee benefits, reaffirming the preeminence of federal interests over state interests, and reiterating its position that Congress had negated the decision in General Electric Company v. Gilbert, 429 U.S. 125, 50 L. Ed. 2d 343, 97 S. Ct. 401 (1976). The Supreme Court has not, however, definitively determined whether ERISA preempts the application of mandated benefits legislation to employee benefit plans which provide benefits through a contract with an insurer subject to regulation by a state insurance department.

Following Alessi, lower courts have applied the broadened scope of §514 to various employee benefit plan situations with varying results. State laws requiring health insurance policies to cover certain services or provide specific benefits have been held preempted by ERISA in General Split Corp. v. Mitchell, 523 F.Supp. 427 (E.D. Wis. 1981) and, most recently, in Michigan United Food and Commercial Workers Union v. Baerwaldt, No. 82-73821 (E.D. Mich. 1983).

In General Split, the court determined that ERISA preempted application, to self-funded plans with stop-loss coverage, of state laws mandating a conversion privilege and establishing a health insurance risk pool. The Michigan United case involved a state law requiring that group policies include certain coverage for substance abuse treatment.

But, in Ins. Com'r. of State v. Metropolitan Life Ins. , 296 Md. 334, 463 A.2d 793 (Md. 1983), a state law mandating certain coverage in health insurance policies, including coverage for psychotherapy services, was held to be a law regulating insurance, and not preempted by ERISA. Similarly, in McLaughlin v. Connecticut General Life Ins. Co., 565 F.Supp. 434 (N.D. Cal. 1983), state rules for construing the implied covenant of good faith and fair dealing were deemed to be laws regulating insurance, and not preempted by ERISA.

2/ See, for example, Michigan United Food and Commercial Workers Union v. Baerwaldt, supra, in which the court stated that a Michigan law requiring that a group insurance policy which provides a specified level of benefits for substance abuse treatment "disturbs a mandatory subject of collective bargaining; namely, the provision of health benefits. Because of its effect, it must be preempted."

3/ There are a number of studies on the issue of second surgical opinions. One of them (Paul M. Gertman, M.D., Debra A. Stackpole, R.N., et al, "Second Opinions For Elective Surgery", The New England Journal of Medicine 302:21 1169) was conducted in Massachusetts following legislation on second surgical opinions. It is significant that coverage was still afforded if the second opinion recommended against surgery. The first law on the subject developed in New York would have denied payment if the second opinion was negative, and that law was declared unconstitutional. Medical Soc. of N.Y. v. Toia, 560 F.2d 535 (N.Y. 1977).

Seventy-seven percent of the covered patients participated in the second opinion program. Of 1,591 participating patients who had received a recommendation for one of the eight specified types of surgeries, 123 received a recommendation against any type of surgery in the second or third opinion sought. A

benefit-to-cost analysis was performed for one of the 8 procedures. The benefit-to-cost assessment showed $61,994 in benefits saved at a cost of $27,354 in procedures attributable to second and third surgical opinions for that procedure. Even in this careful study of costs and benefits, the "costs" studied did not include patients' out-of-pocket costs, costs for diagnostic procedures performed by second and third opinion consultants, the cost of the Department of Public Welfare's staff time devoted to administration of the program, and any cost of subsequent medical treatment for patients who did not undergo surgery because of the program. Nor did the benefits include a measure of a reduction in the number of surgeries proposed due to the existence of the second surgical opinion program. The authors cite one study (McCarthy E.G. and Finkel M.L., "Second Opinion Elective Surgery Programs: Outcome Status Over Time," Med Care, 16 (1978): 984-94 showing that 18.2% of patients confirmed for surgery would have no operation, and 37.4% of those not confirmed by a second opinion would have surgery. If true in the Massachusetts Medicaid study, this would have greatly reduced the savings, if it did not eliminate the savings altogether.

While some studies show second surgical opinions can reduce costs, this study indicates they don't reliably reduce costs in all cases. It should be left to the contracting parties to evaluate the potential savings in their case, and to tailor the program to achieve those savings.

Concerning coverage for outpatient services on the same basis as inpatient services, there are studies indicating that most testing, and perhaps 20% to 40% of surgical procedures, can be done safely on an outpatient rather than inpatient basis. Those and other studies measure the savings that can be attained on any given procedure. (Magerlein, David B.; "New Systems Can Mean Real Savings," Health Finance Management, (May 1980) 32(5):18). The important factor missing from the studies is the increased utilization of those procedures if they are covered by insurance on an outpatient basis in the same manner as inpatient services. Unless there are adequate controls to prevent over-utilization of outpatient testing and surgery, or to reduce inpatient utilization, anticipated savings might not materialize. At this point in development, we are unaware of any available controls over outpatient utilization which could be legislatively mandated.

4/ Mandated availability is consistent with a report commissioned by the Federal Trade Commission discussing alternative services to those furnished by a physician or hospital. The authors recommend that "where legislative and regulatory interventions are involved, they should be directed at removing

obstacles to market entry and fair competition for non-traditional providers as opposed to guaranteeing their inclusion in private insurance." Lazarus, Levine, and Lewin for the Federal Trade Commission, Competition Among Health Practitioners: the Influence of the Medical Profession on the Health Manpower Market; Vol. 1: p. V-11 (February 1981).

5/ In several 1983 surveys of employers, about one-third of those responding have recently acted to increase cost sharing, and substantially more are considering such actions. William Mercer, Survey Employee Benefit Plan Review 5 (April 1983): 324-1. Overall 33% of 1420 respondents reported instituting or raising cost sharing. However, of those companies employing more than 25,000 employees, 49% reported taking such action.

National Association of Employers for Health Care Alternatives (NAEHCA), Survey Employee Benefit Plan Review 5 (July 1983): 324.-9. NAEHCA surveyed 308 of the largest U.S. employers. There were 165 responses. About half of these had redesigned their benefits plans recently. Of these, 53% increased deductibles and 25% increased coinsurance. Hewitt Associates Survey Employee Benefit Plan Review 5 (September 1983): 324.-11.

In July of this year, Hewitt conducted a telephone survey of 22 major industrial corporations on changes that had recently been made or were about to be made to increase the cost-effectiveness of medical benefit plans. Nine companies had recently made changes and twelve companies were considering making changes. Four of the nine had changed the deductibles and three of the twelve were considering raising deductibles.

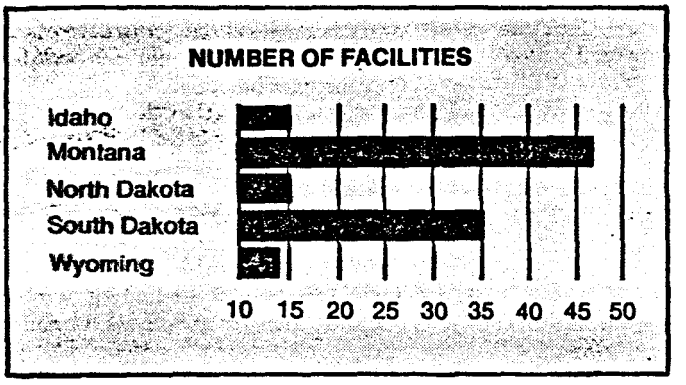
6/ J. P. Newhouse, et al. "Some Interim Results From a Controlled Trial of Cost Sharing in Health Insurance," The New England Journal of Medicine 351(25) (December 1981): 1501.

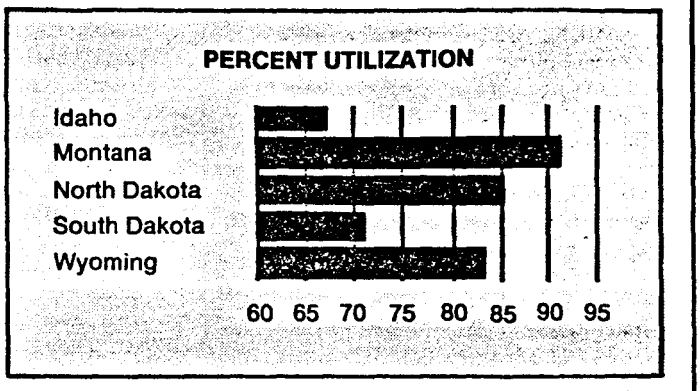
7/ National Center for Health Services Research, a division of the Department of Health and Human Services. Variations in Health Insurance Coverage: Benefits vs. Premiums. The survey classified data on employer provided health insurance for 58.3 million employees according to the extent of coverage and annual premiums. The data indicated that the most generous employer paid health insurance plans provide coverage for smaller, health expenses and reduce the employees front end, out-of-pocket liabilities. The least affected area was their protection against very large, clearly catastrophic expenses. Seventy-two percent of those covered by the health insurance were not required to pay any deductible or copayment for semi-private hospital rooms while 6% were required to pay only a deductible. Physician benefits were less comprehensive, with 60% of the employees having benefits with both a deductible and a coinsurance rate of 20% or more. Only 8% had complete out-patient physician coverage with no deductible or copayment.

8/ Report of the Duplication of Benefits Task Force, by C. Robert Wieselthier, Chairman (HIAA January 1983) Sec. 3, Extent of Duplication, quotes from three claims surveys showing 44% excess reimbursement in multiple coverage claims in 1959-1963, and 45% excess reimbursement in multiple coverage claims in 1980. The Task Force estimated that 4% of private health insurance benefits represent duplication of auto insurance medical benefits only. Using 1980 dollars, this 4% represents some 2.8 billion dollars in duplicated benefits. Although they developed no dollar estimates, the Task Force found "there also appears to be a significant level of duplication as a result of multiple individual policies, or a combination of individual and group health insurance."

9/ Concerning the level of the threshold, a survey in 1980 by Prudential Insurance Company indicated that most duplication of benefits involved group health insurance and was concentrated in claims with benefits in excess of $2,000. An AIRAC closed claims survey indicated that in accident claims, for claims under $1,000, only 20% of the claimants actually used a collateral source; but for claims over $5,000, 53% actually used a collateral source. -All-industry Research Advisory Committee, Automobile Injuries and Their Compensation in the United States, Vol. 1, p. 124-5 (March 1979).

HOW DRY WE ARE





State	Number of Facilities	Total Capacity	Inpatient	Outpatient	Percent Utilization
Idaho	15	1,433	218	1,215	67.1
Montana	47	1,826	300	1,526	91.1
North Dakota	15	1,702	354	1,348	85.0
South Dakota	35	2,368	468	1,900	71.3
Wyoming	14	927	254	673	83.1

Source: Alcohol, Drug Abuse, and Mental Health Administration

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ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

Honorable Jamie L. Whitten
Chairman, House Appropriation Committee
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Forwarded for your information and review is our final report on the CHAMPUS Experimental Study on Reimbursement of Independent Certified Clinical Social Workers. This report, which covers the period April 1, 1982 through September 30, 1982, also contains cumulative data as reported in prior interim reports that have been submitted since the start of the study (ie., December 15, 1980).

The FY 81 Defense Appropriation Act authorized the Department to reimburse certified clinical social workers who provide CHAMPUS covered services independent of physician supervision on an experimental basis. The FY 82 Defense Appropriation Act authorized an extension of the study through September 30, 1982 for the purpose of assuring sufficient claims data are acquired and compiled for formulating valid conclusions and recommendations. As provided under the Continuing Resolution of the Department of Defense Appropriation Act for FY 1983, this Office has authorized the fiscal intermediaries to continue accepting claims from clinical social workers pending amendment of the CHAMPUS Regulation.

The following significant aspects are reflected in this report:

(1) During the reporting period from April 1, 1982 through September 30, 1982, 330 clinical social workers served 1577 CHAMPUS patients for which 2,780 claims were submitted for services rendered. As indicated by the cumulative periodic data, there has been a continuing increase in utilization since the study commenced.

(2) During the course of this study, approximately 85% of the services provided were for "one hour" individual psychotherapy services, while approximately 52% of the claims

processed during this reporting period were billed higher than the amount allowed by the fiscal intermediaries. In most instances, the reduced allowances are attributable to billing in excess of prevailing charges.

(3) A noticeably high incidence of claims continues to prevail in the areas of San Antonio, Texas and Pearl City, Kailua and Honolulu, Hawaii. (The respective fiscal intermediaries have been instructed to place the involved high volume and/or high cost providers on "100% review" to preclude utilization abuse).

(4) This study suggests that the Government has experienced a cost avoidance of over $457,000 since the study commenced as a result of lower prevailing fee profiles of clinical social workers from that of physician psychiatrists fees in all states except for Hawaii which, in combination with the high volume of claims, has significantly offset savings realized in the other states.

On the basis of this study and as authorized under the Continuing Resolution of the FY 83 Department of Defense Appropriation Act, the CHAMPUS Regulation is in process of being amended to include Clinical Social Workers as authorized and recognized CHAMPUS providers independent of physician referral and/or supervision.

A similar report is being sent to the Honorable Mark O. Hatfield, Chairman of the Senate Appropriations Committee.

Sincerely,

John F. Beary, III, M.D.
Acting Assistant Secretary

Enclosure

FINAL REPORT ON THE EXPERIMENTAL STUDY ON REIMBURSEMENT OF CLINICAL SOCIAL WORKERS April 1 through September 30, 1982

A. Background. The FY 81 Department of Defense Appropriation Act directed the Assistant Secretary of Defense for Health Affairs (ASDHA) to conduct an experimental study for the acceptance and payment of claims for CHAMPUS covered mental health services provided by clinical social workers independent of physician referral or supervision.

B. Study Period. The study, originally authorized from December 15, 1980 to September 30, 1981, was extended through September 30, 1982. This extension was authorized by the FY 82 Department of Defense Appropriation Act for the purpose of assuring that sufficient claims data are acquired and compiled for formulating valid study conclusions and recommendations. As subsequently authorized under the Continuing Resolution of the Department of Defense FY 83 Appropriation Act, this Office has authorized the fiscal intermediaries to continue acceptance and processing of claims from certified clinical social workers pending Congressional authorization and subsequent amendment of the CHAMPUS Regulation authorizing and recognizing clinical social workers as authorized and recognized providers.

C. Allowable Charges. As set forth in the study criteria, payment for services of clinical social workers were based on allowable charges. A charge was considered allowable if it did not exceed th nonspecialty area prevailing charge for the same service performed by a similarly qualified professional. Accordingly, the "amount billed" vs the "amount allowed" as reported by the fiscal intermediaries was applied in evaluating the claims data. Prevailing fee profiles of clinical social workers that have been developed and established during the course of this study are reflected in Table 5 of this report.

D. Claims Activity. Table 1 indicates the number of claims received and processed by fiscal intermediary. The data indicates the following for this reporting period:

(1) All eight fiscal intermediaries currently under

contract to OCHAMPUS have received and processed clinical social worker claims representing 32 of the 50 states.

(2) A total of 2,780 claims, representing 330 providers and 1577 beneficiaries were received and processed.

(3) Of the 2,780 claims received, 1455 (or 52.3%) contained billed charges that exceeded allowances (ie., disallowed services and/or fees). It is noted that this is a decrease from the previously reported 67% in the 3rd Interim Report. In most instances, the reduced allowances are attributable to billing in excess of prevailing charges.

E. Volume and Trends.

(1) Table 2 reflects that a total of 2,780 claims were received and processed during the reporting period (April 1, 1982 through September 30, 1982) This was a 56% increase in the number of claims compared to the 1,777 claims received and processed in the previous six-month reporting period. Since the start of the study (December 15, 1980), a total of 6,200 claims have been received and processed by the fiscal intermediaries.

(2) Table 3, which reflects the number of claims received and processed by state, indicates that Hawaii continues to rank first in the number of claims with Texas as second. Of the 6,200 claims received and processed during the study period, Hawaii with 2,151 claims and Texas with 1,959 claims account for 66.3% of the total claims.

F. Type and Volume of Services. Table 4, which reflects the type and volume of services both by state and fiscal inter- mediary, indicates that 85% of the billed services are for individual psychotherapy sessions of 45 to 50 minutes. Since this category of services provides the most consistent data for computing and determining comparative costs, it is applied in evaluating the cost effectivess of this study.

G. Fee Profiles. Table 5 reflects the area prevailing fee profiles (by state) of clinical social workers as compared to psychiatrists based on processed claims since the start of this study. Under OCHAMPUS reimbursement principles and policies, these fees are reimbursed at the 80th percentile. Fees allowed ranged from a low of $40 in the states of Nebraska and Ohio to a high of $94 in Hawaii, the latter of which exceeds the physician/psychiatrist fee profile of $88.00. (This matter has been referred to our Office of Program Integrity for investigation).

H. Cost Effectiveness. In applying the difference in fee profiles between clinical social workers and physicians for the various states as reflected in Table 5 to the number of "one-hour" sessions as reflected in Table 6, an estimated cost avoidance of over $457,000 is suggested during the period of this study. It is noted however that due to the prevailing fee profile of clinical social workers in the state of Hawaii exceeding that of psychiatrists, combined with the high volume of claims in that state, maximum potential savings have not been realized. This paradoxical situation likewise results in an overall loss of savings that were generated in other states.

I. Utilization Aspects. As reflected in Table 3, no claims have been received by our fiscal intermediaries from ten states (ie., Arizona, Connecticut, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Mexico, Vermont and West Virginia). It is conversely noted that the following states have the highest incidence of claims (ie., ten highest): Hawaii, 2151 claims; Texas, 1951 claims; Maryland, 317 claims; Colorado, 266 claims; New York, 199 claims; Washington, 145 claims; Arkansas, 138 claims; Georgia, 127 claims; Virginia, 91 claims; and California with 70 claims. This data introduces questions as to why some states have excess utilization while in other states there is no utilization of clinical social workers. This office is accordingly considering the feasibility of contracting with an independent non-biased health research firm to determine and/or validate if this situation is due to the following probable factors:

(1) Aggressive clinical social worker organizations in the states where utilization is high.

(2) High incidence of beneficiaries in states where there is a high density of military installations.

(3) Obstructions enountered by clinical social worker organizations in those states where there is no utilization, (ie., legal obstacles due to state laws, licensing and other restrictions imposed by special interest groups, professional health associations, etc.).

Table 1

CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(Period: 1 April 1982 through 30 September 1982)

	NO. OF CLAIMS			REPRESENTATIVE DATA		
SCAL INTERMEDIARY	RECEIVED AND PROCESSED	BILLED WITHIN PREVAILING ALLOWANCE	BILLED IN EXCESS OF PREVAILING ALLOWANCE*	NO. OF STATES	NO. OF PROVIDERS	NO OF BENEFICIARIES
LIFORNIA, BS of	39	30	9	3	28	39
WAII MEDICAL SERVICE	1044	471	573	1	16	259
TUAL OF OMAHA	277	229	48	3	37	272
ODE ISLAND	108	80	28	3	45	58
JTH CAROLINA, BC-BS of	84	82	2	2	20	28
NNESSEE, BC-BS of	40	32	8	1	7	13
SHINGTON-ALASKA, BC of	103	99	4	7	55	91
SCONSIN PHYSICIAN SERVICE	1085	302	783	12	122	817
TOTALS	2780	1325	1455	32	330	1577

ncludes rejected claims, disallowed services, prevailing fee reductions., etc.

TABLE 2

CLINICAL SOCIAL WORKER CLAIMS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARY
(From start of experimental study (15 Dec 80) through 30 September 1982)

Fiscal Intermediary	No. Claims 1st Report 12/15/80-4/30/81	No. Claims 2nd Report 5/1/81-9/30/81	No. Claims 3d Report 10/1/81-3/31/82	No. Claims 4th Report 4/1/82-9/30/82	Tot to Dat
CALIFORNIA, BS of	7	25	26	39	
HAWAII MEDICAL SERVICE	118	398	591	1044	21
MUTUAL OF OMAHA	---	27	135	277	4
PENNSYLVANIA, BS of	25	165	---	---	1
RHODE ISLAND, BC of	41	5	105	108	2
SOUTH CAROLINA, BC-BS of	---	---	79*	84	1
TENNESSEE, BC-BS of	15	7	15	40	
VIRGINIA, BC-BS of Southwest	98	(no report)	---	--	
WASHINGTON-ALASKA, BC of	15	132	37	103	2
WISCONSIN PHYSICIAN SERVICE	44	521	789	1085	24
TOTALS	363	1280	1777	2780	62
% Increase	---	352%	39%	56%	

Note: Includes previous fiscal intermediaries, BS of Pennsylvania and BC BS of Southwest Virginia.

TABLE 3

CLINICAL SOCIAL WORKER CLAIMS BY STATE
AS RECEIVED AND PROCESSED BY FISCAL INTERMEDIARIES
(From start of study (15 Dec 80) through 31 March 1982)

CODE*		STATE	No. Claims 1st Report 12/14/80-4/30/81	No. Claims 2d Report 5/1/81-9/30/81	No. Claims 3d Report 10/1/81-3/31/82	No.Claims 4th Report 4/1/82-9/30/82	Tota to Date
C	1	Alabama	---	3	---	-	
H	2	Alaska	---	13	2	8	2
A	3	Arizona	---	---	---	---	---
I	4	Arkansas	8	24	58	48	13
A	5	California	7	24	24	35	9
C	6	Colorado	---	8	77	181	26
A	7	Connecticut	---	---	---	---	---
DS	8	Delaware	---	1	---	---	1
GS	9	District of Columbia	17	---	---	---	17
A	10	Florida	----	---	2	4	6
C	11	Georgia	---	8	44	75	127
B	12	Hawaii	118	398	591	1044	2151
H	13	Idaho	---	7	4	5	16
I	14	Illinois	7	11	31	33	82
I	15	Indiana	---	3	3	12	18
I	16	Iowa	---	2	---	1	3
I	17	Kansas	3	12	9	11	35
I	18	Kentucky	2	9	7	9	27
I	19	Louisiana	---	43	23	23	89
A	20	Maine	---	1	---		1
DS	21	Maryland	25	162	65	65	317
A	22	Massachusetts	---	---	---	----	---
A	23	Michigan	---	---	---	---	---
I	24	Minnesota	3	---	1	2	6
I	25	Mississippi	---	---	---	---	---

TABLE 3 (continued)

CODE*		STATE	No. Claims 1st Report 12-15/80-4/30/81	No. Claims 2nd Report 5/1/82-9/30/81	No. Claims 3rd Report 10/1/81-3/31/82	No. Claims 4th Report 4/1/30-9/30/82	Tota Date
I	26	Missouri	11	12	10	8	41
H	27	Montana	1	22	9	18	50
C	28	Nebraska	---	---	---	---	---
A	29	Nevada	---	---	---	---	---
A	30	New Hampshire	---	---	---	---	---
E	31	New Jersey	17	---	9	17	43
A	32	New Mexico	---	---	---	---	---
E	33	New York	24	5	89	81	199
GS	34	North Carolina	4	---	2	---	6
I	35	North Dakota	1	4	---	---	5
C	36	Ohio	---	6	14	21	41
I	37	Oklahoma	5	10	6	7	28
H	38	Oregon	---	9	5	10	24
DS	39	Pennsylvania	---	2	---	---	2
E	40	Rhode Island	---	---	7	10	17
GS	41	South Carolina	17	---	---	---	17
I	42	South Dakota	---	---	1	3	4
F	43	Tennessee	15	7	15	40	77
I	44	Texas	---	393	638	928	1959
H	45	Utah	3	11	1	3	18
A	46	Vermont	---	---	---	---	---
GS	47	Virginia	60	---	12	19	91
H	48	Washington	12	64	16	53	145
C	49	West Virginia	---	---	---	---	---
I	50	Wisconsin	3	---	---	---	3
H	51	Wyoming	---	6	2	6	14
		TOTALS	363	1280	1777	2780	6200

*FI Codes:

A California, BS of
B Hawaii Medical Service
C Mutual of Omaha
D Pennsylvania, BS of
E Rhode Island, BC of
F Tennessee
G Virginia
H Washington-Alaska, BC of
I Wisconsin Physician Service
S South Carolina, BC-BS of

TABLE 4

TYPE AND VOLUME OF PSYCHOTHERAPY SERVICES

FISCAL INTERMEDIARY AND STATE	"A" INDIVIDUAL 60 MINUTE	"B" INDIVIDUAL 30 MINUTE	"C" GROUP THERAPY	"D" FAMILY THERAPY	"E" PSYCHOLOGI TESTING
CALIFORNIA, BS of					
California (South)	717	3	6	64	---
California (North)	123	2	---	6	---
Florida	28	---	---	27	---
RHODE ISLAND, BC of					
New Jersey	181	5	---	---	---
New York	645	228	---	---	---
Rhode Island.	56	---	---	---	---
SOUTH CAROLINA, BC-BS of					
Maryland	1047	2	---	---	---
North Carolina	8	---	---	---	---
Virginia	226	---	---	---	---
TENNESSEE BC-BS of					
Tennessee	288	29	15	---	---
WASHINGTON-ALASKA, BC of					
Alaska	56	---	---	---	---
Idaho	32	2	---	---	---
Montana	96	2	---	---	---
Oregon	78	---	---	3	---
Utah	11	1	---	---	---
Washington	364	17	---	8	---
Wyoming	36	1	---	---	---

TABLE 4 (continued)

FISCAL INTERMEDIARY AND STATE	"A" INDIVIDUAL 60 MINUTE	"B" INDIVIDUAL 30 MINUTE	"C" GROUP THERAPY	"D" FAMILY THERAPY	"E" PSYCHOLOG TESTING
HAWAII MEDICAL SERVICE					
Hawaii	3335	29	205	17	---
MUTUAL OF OMAHA					
Colorado	2049	329	39	420	---
Georgia	561	22	71	153	---
Nebraska	20	---	---	6	---
Ohio	389	---	10	42	---
WISCONSIN PHYSICIAN SERVICE					
Arkansas	355	8	45	4	1
Illinois	368	27	18	4	---
Indiana	102	---	---	3	---
Kansas	95	6	---	---	---
Kentucky	60	6	---	27	---
Louisiana	183	1	---	63	14
Minnesota	16	---	6	---	---
Missouri	82	9	19	4	---
Oklahoma	70	---	---	---	---
South Dakota	16	---	---	---	---
Texas	6624	77	788	275	75
TOTALS	18317	806	1222	1126	90
% of Total	(85.3%)	(03.8%)	(05.7%)	(05.2%)	(0.4%)

TABLE 5

COMPARATIVE PREVAILING FEE PROFILES
for
PSYCHOTHERAPY SESSIONS OF 45 TO 50 MINUTES
(See Notes at end of table)

State	Physician (Psychiatrist)	Clinical Social Worker
	MUTUAL OF OMAHA	
Alabama	$70	$60/70
Colorado	75	50
Georgia	75	50
Mississippi	70/75	*
Nebraska	70	40
Ohio	65/70	40
West Virginia	60/65	*
	BLUE SHIELD OF CALIFORNIA	
California (North)	75/80	50/54
California (South)	85	75
Maine	70/75	45
Massachusetts	65/70	*
Connecticut	65/70	*
New Hampshire	60/65	*
Vermont	60	*
Michigan	65	*
Florida	75/96	50/60
Arizona	75	*
Nevada	85/100	*
New Mexico	68	*

TABLE 5 (continued)

State	Physician (Psychiatrist)	Clinical Social Worker
BLUE CROSS OF SOUTH CAROLINA		
Maryland	$65	$50
Delaware	78	62
District of Columbia	65	60/45
North Carolina	70	50/40
Pennsylvania	60/70	40/45
Virginia	75	50/55
South Carolina	60	60
WISCONSIN PHYSICIAN SERVICE		
Illinois	$65/70	$45/50
Iowa	60/70	45
Kentucky	60/64	45
Louisiana	75	45/50
Minnesota	70/80	50/55
Missouri	60/65	50/55
North Dakota	80/85	42/56
Oklahoma	60/70	45/50
Kansas	65/70	50/55
Wisconsin	72/76	44/50
South Dakota	60/70	40/44
Indiana	65/75	50
Texas	75/90	60/65
Arkansas	70/75	52/55

TABLE 5 (continued)

State	Physician (Psychiatrist)	Clinical Social Worker
	BLUE-CROSS-BLUE SHIELD OF TENNESSEE	
Tennessee	65	50
	BLUE CROSS OF RHODE ISLAND	
Rhode Island	75	50
New York	75	55
New Jersey	75	55
	HAWAII MEDICAL SERVICE ASSOCIATION	
Hawaii	88	80/94
	BLUE CROSS OF WASHINGTON-ALASKA	
Alaska	80/85	75
Idaho	60	50/55
Montana	60	50
Oregon	65/75	45/50
Utah	60/65	50
Washington	55/60	40/45
Wyoming	45/50	45

Note:

(1) Asterisk (*) indicates no prevailing fee established since no clinical social worker claims were received or processed.

(2) Amounts preceeding the diagonal are profile fees established as of April 1, 1982

TABLE 6

CLINICAL SOCIAL WORKER SERVICES
(INDIVIDUAL ONE HOUR VISITS/SESSIONS)

FI		STATE	NUMBER OF VISITS 1st Report	2nd Report	3rd Report	4th Report	TOTAL VISITS	COST* AVOIDANCE PER FEE	TOTAL COST AVOIDANC
C	1	Alabama	---	28	---	28	28	$ 10/0	$ 28
H	2	Alaska	---	98	10	46	154	5/10	1,0(
A	3	Arizona	---	---	---	---	---	---	--
	4	Arkansas	17	173	76	279	545	18/20	10,36
	5	California (North)	10	41	25	98	174	25	4,35
	5	California (South)	40	196	312	405	953	10	9,53
	6	Colorado	---	31	577	1472	2080	25/30	59,36
	7	Connecticut	---	---	---	---	---	---	--
S	8	Delaware	---	6	---	---	6	16	9
S	9	District of Columbia	129	---	---	129	129	5	64
	10	Florida	---	---	32	28	60	25	1,50
	11	Georgia	---	22	222	339	583	25	14,57
	12	Hawaii	321	1089	1396	1939	4745	8/(6)	10,81
	13	Idaho	---	28	10	22	60	10/5	49(
	14	Illinois	7	112	142	226	487	20	9,74(
	15	Indiana	---	5	21	81	107	15/25	2,41
	16	Iowa	---	14	---		14	15	210
	17	Kansas	3	82	39	56	180	15	2,700
	18	Kentucky	2	35	21	39	97	15/19	1,611
	19	Louisiana	---	426	69	114	609	30/25	17,700
	20	Maine	---	9	---	---	9	25	225
	21	Maryland	163	1,038	549	498	2248	15	33,720
	22	Massachusetts	---	---	---	---	---	---	---
	23	Michigan	---	---	---	---	---	---	---
	24	Minnesota	3	---	4	12	19	20/25	440
	25	Mississippi	---	---	---	---	---	---	---
	26	Missouri	10	87	41	41	179	10	1790

The difference between the prevailing physician fee and the allowed social worker fee. Figures
ceding the diagnol are based on fee profiles est is as of 1 April 1982: figures fol
gonal are based on fee profiles established as of

TABLE 6 (continued)

FI		STATE	NUMBER OF VISITS 1st Report	2nd Report	3rd Report	4th Report	TOTAL VISITS	COST AVOIDANCE PER FEE	TOTAL COST AVOIDANC
H	27	Montana	17	75	22	74	188	10	1,88
C	28	Nebraska	---	---	---	20	20	---/30	60
A	29	Nevada	---	---	---	---	---	---	--
A	30	New Hampshire	---	---	---	---	---	---	--
E	31	New Jersey	85	---	68	113	266	20	5,32
A	32	New Mexico	---	---	---	---	---	---	--
E	33	New York	137	27	264	381	809	20	16,18
GS	34	North Carolina	20	---	9	28	29	20	58
I	35	North Dakota	1	36	---	---	37	38	1,40
C	36	Ohio	---	29	216	173	418	25/29	11,14
I	37	Oklahoma	5	26	38	32	101	15/20	1,67
H	38	Oregon	---	36	22	56	114	20/25	2,56
DS	39	Pennsylvania	---	21	---	---	21	20	42
E	40	Rhode Island	---	---	11	45	56	25	1,40
GS	41	South Carolina	58	---	---		58	0	--
I	42	South Dakota	---	---	1	15	16	20/26	41
F	43	Tennessee	43	13	63	225	344	15	5,16
I	44	Texas	---	3839	2667	3974	10461	15/25	196,51
H	45	Utah	19	34	4	7	64	19/15	67
A	46	Vermont	---	---	---	---	---	---	--
GS	47	Virginia	308	---	71	155	534	25/20	12,57
H	48	Washington	280	345	79	285	989	15	14,83
C	49	West Virginia	---	---	---	---	---	---	--
I	50	Wisconsin	3	---	---	---	3	28	8
H	51	Wyoming	---	18	17	19	54	0/5	9

TOTAL COST AVOIDANCE..... $457,07

Key, FI Codes:

A California, BS of
B Hawaii Medical Service
C Mutual of Omaha
D Pennsylvania, BS of
E Rhode Island, BC of
F Tennessee, BC-BS of
G Virginia, BC of Southwest
H Washington, Alaska, BC of
I Wisconsin Physician Service
S South Carolina, BC-BS of

Opinion

Would just clutter lawbooks

CLINICAL SOCIAL workers are sometimes the most suitable professionals for patients suffering from mental health problems. The trouble is that, suitable or not, their services are often not covered by health insurance. Should they be?

The 32 state representatives who voted for H.B. 143 last week believe they should. The bill they sent on to the Senate says health insurance policies that provide coverage for mental health services "*shall* extend to services provided by (licensed) clinical social workers."

The word "shall" is unfortunate. Nothing in Delaware law excludes licensed clinical social workers from reimbursement by health insurance. Indeed, a fact sheet prepared by supporters of H.B. 143 points out that some private insurance companies offer that coverage. Others easily could.

But a decision about scope of coverage should rest with the person or group buying the insurance and not state lawmakers. Periodic efforts are made to *mandate* chiropractic coverage as part of health insurance. These have not yet succeeded, but that does not mean policies cannot reimburse chiropractors.

For instance, one of three types of contracts Blue Cross and Blue Shield of Delaware offers state employees includes chiropractic. There is no reason an option for clinical social workers could not be added, just as coverage for birthing center delivery and hospice care are becoming available in some plans.

Since the state's 80 licensed clinical workers can, and do, receive some insurance reimbursements now, why should their inclusion in mental health coverage be required? Proponents of mandatory inclusion say it would be cost effective, because fees of these professionals are below those of psychiatrists. They also contend inclusion would end discrimination against a group of licensed mental health professionals.

With current concern over health care costs, it stands to reason that insurance carriers will start to include clinical social workers as mental health care providers without anyone in Dover so ordering. Since no law forbids reimbursement for clinical social worker services, it's hard to see how a discrimination case can be made.

There's no need to clutter state lawbooks. H.B. 143's aim can be achieved by market forces.

STATE OF NEW YORK
EXECUTIVE CHAMBER
HUGH L. CAREY, GOVERNOR

Stephen J. Morello, Press Secretary
518-474-8418
212-977-2716

FOR RELEASE:
IMMEDIATE, WEDNESDAY
JULY 28, 1982

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

July 27, 1982

I am returning herewith, without my approval, the following bill:

Assembly Bill Number 4538-A, entitled:
(Senate Reprint Number 21,035)
"AN ACT to amend the insurance law, in relation to coverage of diagnosis and treatment of mental, nervous or emotional disorders and ailments by certified and registered social workers under group accident, health and accident and health insurance contracts"

#271

N O T A P P R O V E D

The bill would amend the Insurance Law to require that all contracts of group accident and health insurance which cover services rendered by psychiatrists and psychologists for mental, nervous and emotional disorders must also provide coverage for services performed by psychiatric social workers who are certified pursuant to Article 154 of the Education Law and have six years of appropriate experience.

At present, the Insurance Law requires that those insurance companies which offer coverage for mental health services rendered by psychiatrists and psychologists must also include optional coverage of similar services performed by qualified social workers. In the absence of a compelling need for mandating inclusion of coverage for a specific health care service, the scope of health insurance coverage should be a matter for the individual purchaser.

Mandated health benefits are in fact mandates on employers, not insurance companies. To the extent that the mandated benefits are costly, they directly increase the costs of doing business in the State. While the evidence relating to the cost impact of this bill is inconclusive, experience would suggest that the expansion of insurance coverage to over 3,000 new providers would increase utilization of benefits and ultimately the costs of the insurance.

The imposition of mandated insurance benefits may also be a significant factor in an employer's decision to self-insure employee health benefits. Under the federal Employees Retirement Income Security Act, qualified self-funded plans are not subject to State regulation on the scope of benefits. Studies of business and industry trends toward self-insurance and the implications thereof are currently being conducted by the Council on Health Care Financing and by a joint task force of the State Health Advisory Council, the Insurance Department and the New York Business Group on Health. To make major additions to mandated benefits without the benefit of the results of the study would be inadvisable.

(more)

Disapproval of the bill is recommended by the Insurance Department, the Office of Mental Health, the Department of Social Services, the Department of Health, the State Health Planning Commission, the Office of Development Planning, the State Education Department, the Business Council of New York State, Inc., the New York Conference of Mayors and Municipal Officials, the Health Insurance Association of America, the New York State Conference of Blue Cross and Blue Shield Plans, the Medical Society of the State of New York and the Life Insurance Council of New York, Inc.

The bill is disapproved.

(Signed) HUGH L. CAREY

EXHIBIT 15
March 6, 1985

WOMEN'S LOBBYIST FUND

Box 1099
Helena, MT 59624
449-7917

March 6,
~~January 16,~~ 1985

TESTIMONY IN SUPPORT OF SB 19

Madame Chairwoman
~~Mr. Chairman~~ and other members of this Committee:

The Women's Lobbyist Fund (WLF) supports Senate Bill No. 19 and I, Gail Kline, will be speaking in favor of this bill. ← see below

We often use the saying, "An ounce of prevention is worth a pound of cure." In child abuse this is especially true for our children and grandchildren.

Researchers from the University of New Hampshire, Rhode Island and Delaware conducted a study of family violence into the lives of 2,143 families. A conclusion of the study is that "Adults who were frequently abused by their parents as teenagers have a spouse-beating rate four times greater than that of other adults." Adults who tend to abuse their spouses tend to be abusive parents and the cycle repeats.

We have learned much recently about the cycle of violence. The extent of this learned behavior appears in a journal called "Child Abuse and Neglect", published in 1983, which states that 38% of women reported at least one sexually assaulted experience before the age of 18. These women usually do not become abusers of others, but of themselves through drugs, alcohol or prostitution.

This priority issue, the child abuse prevention program, can help children control and understand themselves so that when they become adults their chance of being abusers or being abused will be lessened. This program, through education and counselling, among other support systems, will reduce fear and depression that so often keep people where they are.

~~This bill, based on other state laws,~~ provides its own funding ~~mechanism that is reliable and on-going~~ and seems ~~to be adequate to meet the needs of the program~~.

Our children and grandchildren deserve our support. Give them a place to go for help. The WLF urges you to pass Senate Bill No. 19.

A. I hesitated to testify on this bill because of our concern with the funding source. One of our priorities, shelters for battered women and children, is funded in part by marriage license fees. How long can we fund programs from this source?
Just a few minutes ago, it was pointed out to me that in the process — social programs are being pitted against each other. This is not right.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES AND AGING COMMITTEE

BILL SB 19 DATE 3/6/85

SPONSOR Senator Lynch

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOS
William Leary	Helena	Montana Hosp. Assn	✓	
Linda Galbraith	Missoula	Self	✓	
[illegible]	[illegible]	Montana State Council of [illegible]	✓	
[illegible]	Helena	[illegible]	✓	
Tom Dreyer	Helena	MRCCA	✓	
B. Molineux	"	Psychologists	✓	
Judy Carlson	"	Local Health	✓	
Tom Ryan	"	MSCA	✓	
Maria Sprague	Butte	Montanit St Council of Suicide League	✓	
Susan Mathers	"	"	✓	
Sharon Peterson	Bozeman	MEA	✓	
[illegible]	Missoula	Children's Trust Advis.	✓	
[illegible]	Missoula		✓	
Bill Thomas	"	CTF Steering Cmte.		
Cindy Southwick	Missoula	Parents Anonymous of Montana CTF Steering Cmte	✓	
Dori Alpert	Hamilton	Parents Anonymous of Ravalli County CTF Steering Cmte	✓	
Jim Commins	Hamilton	Parents Anonymous Ravalli County	✓	
[illegible]	Helena	MT Nurses Assoc	✓	
[illegible]	Helena	MT Medical Assn	✓	

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

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES AND AGING COMMITTEE

BILL SB 103 DATE 3/6/85

SPONSOR

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
Elmer Hausken	Helena	[illegible]		✓
Sharon Hanton	Bozeman	National Ass. of Soc. Workers	✓	
Andrée Deligdisch	Gr. Falls	Soc. Wkrs.	✓	
Carol [illegible]	Helena	Soz. Worker NASW	✓	
JACK ELLERY	HELENA	SRS		
[illegible] Larson	"	SRS		
Tony Drovzer	Helena	MACCA	✓	
Bill Jason	Great Falls	Blue Cross/[illegible]		✓
JUDY CARLSON	HELENA	SOCIAL WORKERS	✓	
Gail Kline	Great Falls	Women's Lobbyist Fund	✓	
Kelly Chandler	Missoula	Women's Lobbyist Fund	✓	
[illegible]	Helena	[illegible]		✓
[illegible]	Missoula		✓	

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

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

VISITOR'S REGISTER

HOUSE HUMAN SERVICES AND AGING COMMITTEE

BILL HJR 22 DATE 3/6/85

SPONSOR

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OPPOSE
Jim Munson	Helena	AAA		X
[illegible]	"	[illegible]		X
Steve Browning	Helena	Anheuser Busch Companies	X	
MIKE MALES	LIVINGSTON	SELF	X	

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

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES AND AGING COMMITTEE

BILL HJR 23 DATE 3/6/85

SPONSOR

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Jane Hammar	Clancy, MT	Comp Fire Councils	X	
[illegible]	[illegible]	[illegible]	X	

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

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

WITNESS STATEMENT

NAME Thomas F Keil BILL NO. 757

ADDRESS 101 S 3rd, Conrad MT. DATE 3-6-85

WHOM DO YOU REPRESENT? Legacy Legislature

SUPPORT _____ OPPOSE _____ AMEND 2

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

VISITOR'S REGISTER

HOUSE HUMAN SERVICES AND AGING COMMITTEE

BILL HB 757 DATE 3/6/85

SPONSOR

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
William LEARY	1330 9th Helena	Montana Hospital Assn		X
Lois St Leland	Havre, Montana	MHRRS		X
[illegible]	3023 11th Ave Helena	MHRRS		X
WADE WILSON	HELENA	LISCA	✓	
Molly Munro	Helena	MONTANA		X
[illegible]	Conrad	[illegible]	✓	
[illegible]	Helena	MHSCA	Concerned	
[illegible]	Kelly	Mt. Federation		✓
[illegible]	Missoula	Mont Trial Lawyers	✓	
Roland Pratt	Helena	Mt Optometric Assoc		✓
Diane Bisby	Helena		✓	
Rose Skoog	Helena	Montana Health Care Assn		✓
Charles Briggs	Helena	Governors Office		
Chas Smith	Helena	Mont Hospital Assn		X
Don Allen	Helena	MT. Hospital Assn		X

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

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITOR'S REGISTER

HOUSE HUMAN SERVICES AND AGING COMMITTEE

BILL SB 16 DATE 3/6/85

SPONSOR

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP POS
~~Joyce M. Andrew~~	~~Havre, Montana~~	~~MHRTS~~		X
Jim Lear	Helena	Code Commissioner	X	

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

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

WITNESS STATEMENT

NAME Theresa S. Rea BILL NO. S.B. 19

ADDRESS P.O. Box 661 Bonner, Mt. 59823 DATE 3/6/85

WHOM DO YOU REPRESENT? Child Trust Association

SUPPORT ✓ OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

I have worked with troubled children and youth over a period of years. It has become profoundly apparent to me that the children in our midst are indeed our responsibility. We must all accept the responsibility as "world parents" to foster the growth, education and development of all children. As the children grow, so grow the families, the communities and our nation. Our children of today will be our leaders, our builders, or our statistics of tomorrow. Our greatest investment or insurance for a prosperous future is to invest in our children.

In view of this statement, I wish to urge you to give your support to S.B. 19 with ammendments presented by Bill Thomas in testimony.

CS-34

WITNESS STATEMENT

NAME Jennifer Harvey BILL NO. SB19

ADDRESS 1127 McDonald DATE

WHOM DO YOU REPRESENT? Children's Trust Association

SUPPORT ✓ OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

S.R.S. is currently bound by time and staffing to respond only to CRISIS. This bill is aimed at prevention, and providing assistance and training to families with a potential toward the crisis of abuse. Young teenage single mothers are prime candidates to become abusive parents as they try to cope with the frustration of raising a child alone. Programs geared toward prevention have been developed across the nation which provide parenting classes, stress seminars and an on-going support group have a high success rate. The program at Sentinel High School is an example of one of these successful programs. I urge you to support SB 19 with the proposed ammendments - and take the first step towards breaking the cycle of destruction of the family.

CS-34

WITNESS STATEMENT

NAME Gloria SPRAGUE BILL NO. SB 19

ADDRESS 3303 EASTLAKE DATE

WHOM DO YOU REPRESENT? MONTANA STATE Council of Junior LEAGUES

SUPPORT ✓ OPPOSE AMEND —

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

I am representing the Leagues in the cities of Great Falls, Billings and Butte. Our total membership is over seven hundred women. We have a long history of child advacy progroms.

We strongly support this bill in order that it will be effective in bringing child abuse prevention progroms to all communities in the state. As legislatures you are aware how much money is being spent for interventions. We sincerely believe the monies spent on prevention progroms will save dollars as well as human suffering.

Trust fund bills presently exist in sixteen states and are pending in eleven,