MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
50TH LEGISLATIVE SESSION

March 20, 1987

The meeting of the Business and Labor Committee was called to order by Chairman Les Kitselman on March 20, 1987 at 8:00 a.m. in room 312-F of the state capitol.

ROLL CALL: All members were present.

EXECUTIVE ACTION

ACTION ON SENATE BILL NO. 250

Rep. Thomas moved that Senate Bill No. 250 BE CONCURRED IN. The motion carried unanimously.

Rep. Spaeth will carry the bill in the House.

ACTION ON SENATE BILL NO. 341

Rep. Brandewie moved that Senate Bill No. 341 BE CONCURRED IN.

Rep. Thomas moved the amendments to Senate Bill No. 341. The motion carried unanimously.

Rep. Brandewie moved that Senate Bill No. 341 BE CONCURRED IN AS AMENDED. The motion carried unanimously.

Rep. Simon will sponsor the bill in the House.

ACTION ON SENATE BILL NO. 298

Rep. Hansen moved that Senate Bill No. 298 BE CONCURRED IN.

Rep. Hansen moved the amendments to Senate Bill No. 298. The motion carried with 8 opposed.

Rep. Cohen moved that Senate Bill No. 298 BE TABLED. The motion failed 11 to 7.

Rep. Driscoll moved that Senate Bill 298 BE CONCURRED IN AS AMENDED. The motion carried.

Rep. Bardanouve will sponsor the bill in the House.

ACTION ON SENATE BILL NO. 360

Rep. Glaser moved that Senate Bill No. 360 BE CONCURRED IN. The motion passed unanimously.

Rep. Spaeth will carry in the House.

ACTION ON HOUSE BILL NO. 853

Rep. Simon moved that House Bill No. 853 BE TABLED. The motion carried with 10 votes for and 8 votes opposed.

ACTION ON HOUSE BILL NO. 854

Rep. Driscoll moved that House Bill No. 854 DO PASS. The motion carried.

ACTION ON HOUSE BILL NO. 855

Rep. Thomas moved that House Bill No. 855 BE TABLED. The motion failed on a tie vote.

Rep. Thomas moved that House Bill No. 855 DO NOT PASS. The motion failed.

Rep. Cohen moved House Bill No. 855 DO PASS. The motion carried with 2 opposed.

ACTION ON HOUSE BILL NO. 856

Rep. Cohen moved that House Bill No. 856 DO PASS.

Rep. Cohen moved the amendments to House Bill No. 856. The motion carried unanimously.

Rep. Thomas moved that House Bill No. 856 BE TABLED. The motion carried 10 to 8.

ACTION ON HOUSE BILL NO. 869

Rep. Thomas moved that HB 869 BE TABLED. The motion carried with a vote of 11 to 7.

ACTION ON HOUSE JOINT RESOLUTION 42

Rep. Thomas moved that HJR No. 42 BE TABLED. The motion failed.

Rep. Pavlovich moved HJR 42 DO PASS. The motion carried with 5 opposed.

HOUSE JOINT RESOLUTION 46 - Requesting An Interim Study of Agricultural Lien Laws, sponsored by Rep. Ray Brandewie, House District No. 49, Bigfork. Rep. Brandewie stated the bill requests an interim study of Montana's agricultural lien laws and requires a report of the study to the 51st legislature.

PROPONENTS

Pam Langley, representing Montana Agricultural Business Association. Ms. Langley stated they would like a thorough study of the lien laws that exist in Montana.

John Cadby, representing Montana Bankers Association. Mr. Cadby stated they would like to get this problem resolved.

Ronna Alexander, representing Montana Petroleum Marketers. Ms. Alexander stated this is an area that needs to be addressed.

OPPONENTS

None.

QUESTIONS

None.

CLOSING

Rep. Brandewie made no further comments.

EXECUTIVE ACTION

ACTION ON HOUSE JOINT RESOLUTION 46

Rep. Brandewie moved HJR 46 DO PASS. The motion carried with Rep. Grinde opposed.

SENATE BILL 353 - Regulate Health Maintenance Organizations, sponsored by Senator Darryl Meyer, Senate District No. 17, Great Falls. Sen. Meyer stated this bill would regulate the formation and operation of health maintenance organizations. He said because they emphasize prevention of illness and disease, HMO's are promoted as an effective means of health care cost containment. He commented the difference between an HMO and health insurance company is that an HMO actually provides health care services through an assigned physician or provider.

PROPONENTS

Kathy Irigoin, State Auditor's Office, explained the legislation and submitted amendments (exhibit 2), which she explained. Exhibit Nos. 1 and 2.

Bill McDonald, representing an HMO group Health of Western Montana. Mr. McDonald expressed support for the legislation and the amendments presented by the Auditor's office with the exception of number six (6).

Mona Jamison, representing the Rocky Mountain Treatment Center, spoke in support of the legislation and the importance of allowing the consumer to choose what treatment center they want to utilize and pay a comparable fee.

Ann Scott, Rocky Mountain Treatment Center, Great Falls, expressed support for the legislation and the amendments that allow freedom of choice for treatment centers at a comparable fee.

Joan Rebish, representing Montana Mental Health Counselors, stated support for the bill, particularly on page 2 that specifically addresses treatment of mental illness that was added, and the amendments proposed by the State Auditor's Office.

William Evans, representing Montana Chapter of Social Workers, expressed their support for the Auditor's office to establish rules and regulations for HMO providers and the amendments.

Steve Waldron, representing the Mental Health Association, expressed support for the legislation and distributed an amendment and a Business and Health article on the hidden costs of HMOs. Exhibit Nos. 3 and 4.

Pat Callbeck Harper, representing Montana Psychological Association, presented written testimony. Exhibit No. 5.

Mike Murry, representing Chemical Dependency Association. Mr. Murry stated they support the bill and the amendments proposed by Ms. Jamison.

Dennis Duncan, representing Montana Medical Association, presented the Association's position paper on SB 353. Exhibit No. 6.

Joy McGrath, representing Montana Mental Health Association. Ms. McGrath stated they support the bill and the amendments proposed. They feel that the multi-disciplinary utilization boards are important for mental health consumers.

Chuck Butler, Vice President, Blue Cross/Blue Shield. Mr. Butler stated that Blue Cross/Blue Shield is the only organization in the state of Montana that is operating an HMO. He stated that Blue Cross/Blue Shield is in favor of passage of SB 353 which is a result of a two year study. He commented Blue Cross/Blue Shield welcomes the competition from any HMO that can meet the requirements established by this legislation. He suggested that there be some exclusions made for Blue Cross/Blue Shield, other insurers, and federally qualified HMO's that can by current statute or federal law provide HMO programs and are currently regulated. He said their proposed amendments address this. Mr.

Butler submitted proposed amendments and a promotional flier explaining their HMO program. Exhibit Nos. 7 and 8.

OPPONENTS

None.

QUESTIONS

Rep. Wallin asked Mr. Duncan to explain how the cost effectiveness of HMO programs. Mr. Duncan responded that the cost effectiveness is difficult to quantify in terms of dollars and cents. He said the HMO product that is offered is traditionally very competitive cost wise, and that the cost effectiveness of all HMO's are found in the fact that the utilization controls that are utilized in the HMO product is a means of controlling unnecessary hospitalizations, physician services or ancillary services.

Rep. Wallin asked at what point did the HMO organizations become attractive. Mr. Duncan responded that from experiences shown in the industry HMO's become attractive when it can be shown to employers, who are traditionally buying that health care product for their employees, and can have a significant number of physicians that are going to be able to offer the health care services to their employees.

Rep. Wallin asked what was the largest hospital in Montana that has HMO that would be willing to accept patients, for example, from Helena. Chuck Butler responded that HMO Montana have patients and members from Lewis and Clark County that could be treated at any hospital in the state of Montana and their services would be reimbursed.

CLOSING

Sen. Meyer stated that a lot of work had been done attempting to make this a good bill, which would give consumers financially sound HMO program in Montana.

SENATE BILL NO. 371 - Regulate Preferred Provider Arrangements, sponsored by Senator Pat Regan, Senate District No. 47, Billings. Senator Regan stated this bill allows insurers to enter into agreements with health care providers and to issue policies that include incentives for utilizing services rendered by providers with whom the insurer has an agreement, or they may limit reimbursements if they do not use that service. She said under current law there are no provisions for this kind of statute and have always used freedom of choice of practitioner. She commented this bill would not prohibit freedom of choice, but rather would award a person if the preferred provider was used. She added that industry and she agrees with the amendments proposed by the State Auditor's Office.

PROPONENTS

Kathy Irigoin, State Auditor's Office, submitted written testimony and amendments. Exhibit Nos. 9 and 10.

Steve Brown, representing Blue Cross/Blue Shield. Mr. Brown stated they support this bill and submitted proposed amendments. Exhibit No. 11.

Tom Hopgood, representing Health Insurance Association of America, also submitted amendments for clarification of the proposed legislation. Exhibit No. 12.

Steve Waldron, representing Mental Health Association. Mr. Waldron explained his amendments to the bill. Exhibit No. 13.

Bill Leary, representing Montana Hospital Association. Mr. Leary stated they support the intent of this bill as long as it remains in a permissive situation, rather than mandatory.

Pat Harper, representing Montana Psychological Association. Ms. Harper submitted written testimony. Exhibit No. 14.

Joan Rebish, Montana Mental Health Council Association, expressed support for the bill and the amendments proposed by Mr. Waldron which would give the kind of protection that the consumer needs.

Joy McGrath, representing Mental Health Association of Montana. Ms. McGrath expressed support for the bill and the amendments.

Ann Scott, representing Montana Chemical Dependency Association, expressed support for the bill and the amendments presented by Mr. Waldron.

Dennis Duncan, representing Montana Medical Association, expressed support for the bill which would provide a choice in the health care market. He asked for consideration that not all of the amendments proposed to the legislation be adopted so that the employer has a true choice and the employer and employee can choose what is best for them.

QUESTIONS

Rep. Driscoll asked Senator Regan what protection would there be for the employee that lives in a small rural community and the provider is in a larger community such as Billings. Senator Regan responded that there is a provision for emergency services if the insured cannot reasonably reach a preferred provider.

Rep. Hansen asked if this bill was permissive in what health care system was used. Senator Regan responded that this bill is not an attempt to take over the health care system, it is entirely permissive, with a lot of freedom of choice.

Chairman Kitselman asked Senator Regan to comment on the absence in this bill of the provisions for the licensure of the agents or distributors of this particular product. Senator Regan responded the insurance company will contract with health care providers that are licensed within the state. Ms. Irigoin responded that one of the distinctions between an HMO and a PPO act is that a group of physicians can form an HMO, and they want them to use licensed agents to explain the program to the people they enroll. She said this bill only permits insurance companies, health service corporations, and all of those that are already subject to the various parts of the insurance code requiring their representatives to be licensed, so it wasn't necessary to include a licensing provision in this bill.

CLOSING

Sen. Regan apologized for all the amendments, and she hoped the subcommittee could work on them.

Chairman Kitselman referred Senate Bill Nos. 353 and 371 to a subcommittee composed of Reps. Thomas, Brown, and Kitselman, with Rep. Kitselman as chairman.

HOUSE BILL NO. 884 - Payroll Tax to Fund Workers' Comp. Plan No. 3: Sale of Bonds, sponsored by Rep. Clyde Smith, House District No. 5, Kalispell. Rep. Smith stated the bill would provide a supplemental funding source for the Workers' Compensation State fund through an employer's payroll tax, provide for the sale of bonds to finance the unfunded liability of the state fund, provide that the employer's payroll tax is security for payment of the bonds, and to statutorily appropriate the payroll tax to pay principal, premium, and interest on the bonds.

Rep. Paula Darko, House District No. 2, Libby. Rep. Darko stated that her concern is that all the work that has been done will be lost if this bill does not pass. She said the fund will be defunct by fiscal year 1988. She commented that workers in the state will be taking benefit cuts, which will lower the rates for plan 3 that insures people with the workers' compensation fund. She said what is not seen is the advantage and the cost saving that plan 1 and 2 insureds will receive by these benefit cuts. She suggested the Committee weigh those cost savings against what those extra costs to employers will be. She added there are going to be lower premiums on plan 2 insureds, and those people who are insured with the private insurers will have about a 23% rate reduction in their premiums. She commented the people that

are self insured will have a substantial cost savings in the benefits paid.

Bob Robinson, Administrator, Workers' Compensation Division, spoke on the technical aspects of the legislation. He noted the amendments to the legislation which will clarify the uses of the .57% tax. He stated a sunset provision is needed in the legislation to establish a termination of the tax. Mr. Robinson explained the current situation with the unfunded liability covering the background, problems being faced, alternatives and recommendations being proposed in HB 884. Exhibit Nos. 15 and 16.

PROPONENTS

Rep. Jerry Driscoll, House District No. 92, Billings. Rep. Driscoll presented a state insurance fund financial activity projection with the assumption of SB 315 passing and HB 884 failing or all other funding mechanisms failing. Exhibit No. 17. He noted the projection shows the fund would be insolvent by December, 1988. He stated he believes the market share of the fund will drop because of the self insurance pools available, more competitive rates from the private sector if SB 315 passes because the state is now undercharging rates and cannot lower rates, and the possibility of the fund becoming insolvent. Rep. Driscoll also said the law states that if the state fund becomes insolvent, the employers are liable as well as the state fund. He said the people that are in the state fund who cannot get out of it, for whatever reason, and as the market share of the state fund shrinks and there are less amounts of employees in the state fund, the rates must go up to pay off the $16 million a year. He noted as employers opt out of the state fund, rates to the remaining employers covered by that fund will start escalating, and all government agencies, by state law, must buy from the state fund. He commented that under this scenario a rate increase of 27% would be needed to those remaining in the fund, and with no shared risk pool in the state 50% of the premium dollars would be paid by 20% of the employers. He said this, compounded by employees trying to settle out before the fund goes bankrupt, will accelerate the decline of the fund.

Gene Huntington, Governor's Office, referred to the constraints mentioned in previous testimony, i.e. the unfunded liability is inescapable and the Supreme Court decision overthrowing the legislature's attempt to adjusting benefits retroactively. He stated another constraint and the reason for the bonding is the problem of cash flow and the need to find suitable backing for the bonds. He commented that other constraints are if a less expensive type of financing available for the state is wanted and to spread that, which is municipal bonds, there needs to be a reliable source of

income to make the bond holders happy. He said if this mechanism is to be used, the premiums can't be looked at for retiring bonds. He added that if these bonds are going to be marketed for a reasonable interest rate, there is going to have to be some type of pledge of tax from the state.

Rep. Bill Glaser, House District No. 98, Billings. Rep. Glaser stated a solution needs to be found for this problem. He commented that the state fund, if SB 315 passes and SB 884 or some other solution does not, will lose about a 30% share of the market, which will render it insolvent in June, 1988. He said it is obvious that doing nothing won't solve the problem, and asked that ideas and solutions be found.

Keith Olson, Executive Director, Montana Loggers Association, Kalispell. Mr. Olson stated that payroll taxes are stifling employers in the state of Montana and no industry is more adversely affected than logging, and their payroll costs are rapidly approaching 50%, with $10,000 per year per employee are not uncommon for Montana loggers. He said it was not easy to appear as a proponent for another payroll tax. However, he stated, without money to cover the unfunded liability, the state fund will be forced to raise premium rates by approximately 30%.

Gene Fenderson, State Building Construction Trades Union. Mr. Fenderson stated they support this bill for the numerous reasons and figures that have been stated by the previous proponents. He said something needed to be done about the problem and this is the solution to do that, or eventually the fund will be insolvent, and the employers will be being much higher premiums for the same services.

Irv Dillinger, Executive Secretary, Montana Building Material Dealers Association. Mr. Dillinger stated that everybody is partially responsible for the problem, and until someone has a better solution, this bill should be supported.

Robert Helding, representing Montana Motor Carriers Association. Mr. Helding stated they support the bill.

OPPONENTS

George Wood, Executive Secretary, Montana Self-Insurers Association. Mr. Wood stated this bill uses the taxing power of the state to fund the private debt of state fund insured employers, and has legal and constitutional problems. In discussing the problems of the state fund, he noted a few years ago the state fund had a surplus in excess of $60 million and paid dividends to those insured by the state fund, not to all Montana employers. Mr. Wood noted the viability of Montana operations is being considered by many employers because of Workers' Compensation costs. He concluded by stating HB 884 is unjust and unfair and

requested the bill be given a do not pass recommendation. Exhibit No. 18.

Lloyd Lockrem, Montana Contractor's Association. Mr. Lockrem stated this bill creates a state subsidized insurance plan to compete with the private sector. He stated the state is trying to attract industry into the state and this legislation says to every new employer considering locating in the state that for every $1 million of payroll brought into the state they will be charged $5,700 to support the state Workers' Comp fund. He noted some objections to the technical aspects of the bill, particularly in the definition of gross payroll as related to overtime. He suggested a state monopoly as an alternative to this legislation, and another alternative to use the current cash flow. He suggested waiting until the next legislative session, which would give an opportunity to measure two years of experience of the reform that is in SB 315; measure whether or not plan 2 insureds are coming back to the state, and give two years to determine whether or not the state plan can maintain 47% of the market, and give the Department two more years to reorganize. He added by waiting, it would give an opportunity to determine the course of action that needs to be taken for this problem.

Ray Conger, Chairman, Montana Council on Classification and Rating Committee. Mr. Conger stated that this issue should be treated as an executive issue and not legislatively, as it is an administrative problem. He said this bill is blatantly unfair by requiring employers who pay for their own insurance protection to also subsidize the insurance consumer who purchases coverage from the state. He submitted written testimony. Exhibit No. 19.

Ted Rollins, representing ASARCO Inc. Mr. Rollins expressed opposition for the following reasons: ASARCO's Montana operations, with its two units, with 600 employees, and annual payroll of $17.5 million, are marginal operations and have recently concluded wage and salary negotiations in an effort to return these operations to profitability in times of high taxes and depressed worldwide metal prices. He stated this legislation represents a tax in excess of $100,000 of additional annual taxation to them.

The Chairman stated they were out of time, but would allow time for other opponents to state their names. He said further testimony and discussion could be handled during the subcommittee meetings.

Mike McCone, Western Environmental Trade Association
Bill Molmen, American Insurance Association
Fred Johnson, Montana Homebuilders
Bob Correa, Bozeman Chamber of Commerce
Rose Skoog, Montana Health Care Association

Bill Leary, Montana Hospital Association
Don Jenkins, Golden Sunlight Mine, Whitehall
Gary Langley, Montana Mining Association
Karla Gray, Montana Power Company, Entech, Inc.
George Allen, Montana Retail Association
John Alke, Montana Dakota Utilities Company
Gene Phillips, Pacific Power and Light Company
Mons Teigen, Montana Stockgrowers, Montana Cattlewomen Org.
Lorna Frank, Montana Farm Bureau
Don Allen, Montana Wood Products Association

QUESTIONS

Rep. Simon asked Rep. Smith to explain the issue that the state fund has a current problem because of their practices in the past because their rates were artificially low which boosted their market share and drove out a lot of the plan 2 people, and forced everybody into the plan. He said the state plan be reinforced because market shares will be lost. Rep. Smith responded there are a lot of various problems with the state fund. He said several years ago there was an appropriation request by the Division for two more staff attorneys and more claims adjusters; but were turned down, and claims management has been a part of the problem. He added the Division has problems, and they have discussed them, but he has not heard any good solutions from anybody.

Rep. Simon asked Rep. Smith rather than taxing the employers of the state, if it is a state responsibility and a state problem, why not directly state that there should be a general fund appropriation. Rep. Smith responded that he did not know where they would get the money.

Rep. Thomas asked how they could justify the .07% surcharge or tax paid by the three groups paying workers' compensation in the state to essentially lower the premium for one group of premium payers in the state. Rep. Smith responded that the only justification is the fact that the state fund is assigned every poor risk and everybody that can, gets insurance someplace else.

Rep. Driscoll responded that the only justification for any tax is because the money is needed. Rep. Driscoll stated that the bill is lowered for those people that have to go to the state fund, because the state fund must take everybody.

Rep. Swysgood asked that given the scenario that the employer is going to have to pay if the fund falls, and state plan 2 is there, what is going to happen to the state fund. Mr. Robinson responded that if a lot of firms recognize this or fear that the state fund would not be able to pay and make that jump, that market share drops dramatically and that unfunded liability has to be paid on a smaller group, and

when that can't be paid, the person with the plan 1 or 2, the cost will go to that employer also.

CLOSING

Rep. Smith stated that the greatest protection that the employers in the state can have from uncontrolled workers' compensation insurance rate increases, is the survival of the three insurers systems. The state fund provides a balance that controls rapid refluctuations. He said this issue is critical, and if nothing is done in a length of time, the ability to pay benefits will depend on how rapidly state fund insurers move to plan 2 carriers.

Chairman Kitselman stated that he will refer House Bill No. 884 to a subcommittee with Senate Bill No. 315 composed of Reps. Glaser, Smith, Nisbet, Grinde, and Driscoll, with Rep. Glaser as chairman.

ADJOURNED

The meeting was adjourned at 11:30 a.m.

REP. LES KITSELMAN, Chairman

DAILY ROLL CALL

BUSINESS & LABOR COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date MARCH 20, 1987

NAME	PRESENT	ABSENT	EXCUSED
REP. LES KITSELMAN, CHAIRMAN			
REP. FRED THOMAS, VICE-CHAIRMAN			
REP. BOB BACHINI			
REP. RAY BRANDEWIE			
REP. JAN BROWN			
REP. BEN COHEN			
REP. JERRY DRISCOLL			
REP. WILLIAM GLASER			
REP. LARRY GRINDE			
REP. STELLA JEAN HANSEN			
REP. TOM JONES			
REP. LLOYD MCCORMICK			
REP. GERALD NISBET			
REP. BOB PAVLOVICH			
REP. BRUCE SIMON			
REP. CLYDE SMITH			
REP. CHARLES SWYSGOOD			
REP. NORM WALLIN			

STANDING COMMITTEE REPORT

March 20 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 250

☐ do pass ☒ be concurred in ☐ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. LES KITSELMAN Chairman

Rep. Spaeth will sponsor

THIRD BLUE
reading copy (color)

STANDING COMMITTEE REPORT

MARCH 20 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 298

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☒ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Page 2, line 19
Following: "members"
Insert: "that will provide a balance of professional expertise and public interest and accountability"

2) Page 2, line 20
Following: "representative of"
Insert: ": (a)"

3) Page 2, line 21
Following: "community"
Strike: ","
Insert: "; (b)"
Following: "business"
Strike: ","
Insert: "; (c)"
Following: "agriculture"
Strike: ","
Insert: ";"
Following: "and"
Insert: "(d)"

4) Page 2, lines 21 through 23
Following: "labor" on line 21
Strike: the remainder of line 21, line 22 in its entirety, and line 23 through "accountability"

5) Page 3, line 1
Following: line 25 on page 2
Insert: "NEW SECTION". Section 2. Advisory board. (1) There is an investment advisory board within the department of commerce.

(2) The advisory board shall provide nonfinancial advice to the board of investments created in [section 1]. The advisory board shall consider long-term goals and methods of implementing those goals from the viewpoint of affected parties rather than investment

Rep. Bardanouve will sponsor

THIRD reading copy (BLUE color)

[redacted] and report their conclusions to the board of investments. The board of investments must consider reports of the advisory board and report to the advisory board whether it approves, disapproves, or will further examine their advice.

(3) The advisory board consists of 5 members appointed by the governor. A member serves a term of 4 years and may not be reappointed. The members shall not be appointed based on financial expertise but one member shall be appointed from each of the following areas:

(a) small business;
(b) agriculture;
(c) labor;
(d) economics; and
(e) local government.

(4) The members of the advisory board shall elect a chairman from its members. The advisory board shall meet at least two but not more than four times a year. The advisory board may meet anyplace within the state. Members of the advisory board are entitled to mileage, lodging, and meals as provided in 2-18-501 for meetings.

(5) The board of investments shall provide clerical assistance to the advisory board and shall pay necessary costs of meeting rooms and member's travel costs."

Renumber: subsequent sections

6) Page 23, line 19
Strike: "Section"
Insert: "Sections"
Following: "1"
Strike: "is"
Insert: "and 2 are"

7) Page 23, line 21
Strike: "section"
Insert: "sections"
Following: "1"
Insert: "and 2"

SJR 8

STATE PUB. CO.
Helena, Mont.

Chairman.

STANDING COMMITTEE REPORT

MARCH 20 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 341

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Page 4, lines 2 and 3
Strike: "or other consideration"

2) Page 4, line 13
Following: line 12
Insert: "(2) No fee shall be solicited or accepted as an application or registration fee by any employment agency solely for the purpose of being registered as an applicant for employment."
Renumber: subsequent subsection

Rep. Simon will sponsor

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

March 20 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 250

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

Rep. Spaeth will sponsor

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

MARCH 20 19 87

Mr. Speaker: We [redacted]mmittee on BUSINESS AND LABOR

report [redacted] BILL NO. 360

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

Rep. Spaeth will sponsor

THIRD reading copy (BLUE color)

STANDING COMMITTEE REPORT

MARCH 20 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report HOUSE BILL NO. 855

☒ do pass ☐ be concurred in ☐ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. LES KITSELMAN Chairman

first reading copy (white color)

STANDING COMMITTEE REPORT

MARCH 20 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report HOUSE BILL NO. 854

☒ do pass
☐ do not pass

☐ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

FIRST WHITE
reading copy (color)

STANDING COMMITTEE REPORT

EHB

MARCH 27 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report [redacted] 66

☒ do pass
☐ do not pass

☐ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

Bussiness & labor
Committee Secretary
Elsie Sebens Armstrong
Rm 312-E

FIRST reading copy (WHITE color)

STANDING COMMITTEE REPORT

MARCH 20 19 87

Mr. Speaker: We the committee on BUSINESS AND LABOR

report [redacted] 42

☒ do pass
☐ do not pass

☐ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

FIRST reading copy (WHITE color)

EXHIBIT 1
DATE 3-20-87
HB SB 353

WRITTEN TESTIMONY OF STATE AUDITOR'S OFFICE
SENATE BILL 353
March 20, 1987

I. Reason for Senate Bill 353

The State Auditor requested Senate Bill 353 because existing law (specifically 33-22-111, MCA--Montana's freedom of choice of practitioners law) precludes health maintenance organizations (HMOs) from operating in Montana unless they are federally qualified or operated by a health service corporation like Blue Cross/Blue Shield. A health service corporation may operate a HMO in Montana because a Montana Attorney General's opinion holds that health service corporations are not insurance companies and therefore are not subject to the Montana Insurance Code (37 Op. Att'y Gen. 151 (1978)). A federally qualified HMO may operate in Montana because the Federal HMO Act (42 U.S.C. 300e (Supp. V. 1975)) preempts state laws like Montana's freedom of choice of practitioner's law (42 U.S.C. 300e-10(a)(1)(A) through (C)). Because of Montana's freedom of choice of practitioners law, no other HMO may operate in Montana. Senate Bill 353, if passed, would permit any HMO that meets its requirements to operate in Montana.

II. Senate Bill 353 Includes Necessary Consumer Protections

Senate Bill 353 includes important consumer protections. For example, Senate Bill 353 meaningfully addresses the financial solvency of an HMO. It requires a HMO to have a minimum capital of at least $200,000 (page 34, line 7). The $200,000 minimum capital required by Senate Bill 353 reflects the $200,000 that the Montana Insurance Code requires disability insurance companies to maintain (33-2-109, MCA). The $200,000 minimum capital required by Senate Bill 353 also takes into consideration that Montana should not require a HMO to have a higher minimum capital requirement than it requires disability insurance companies to maintain. In addition, Senate Bill 353 permits financial examination of an HMO (page 41, lines 11 through 17; and page 42, lines 2 through 9).

In terms of consumer protections related to matters other than financial integrity of the HMO, Senate Bill 353 specifies that each evidence of coverage must contain definitions of key terms used in the evidence of coverage (page 21, lines 13 through line 21); clear disclosure of each provision that limits benefits or access to services (page 21, line 22 through line 14, page 22); clear disclosure of limits on certain benefits (page 21, line 22 through line 14, page 22); clear

disclosure of benefits (page 22, lines 15 through 19); newborn infant coverage (page 22, lines 20 through 22; and page 24, line 10 through line 6, page 25); mandatory coverage for medical treatment of mental illness, alcoholism, and drug addiction (page 22, line 23 through line 2, page 23); conformity with state statutes (page 23, lines 3 through 8); conversion rights (page 23, lines 9 through 13); and clear disclosure of the amount of money an enrollee shall pay the HMO for basic health care services (page 24, lines 3 through 5).

Senate Bill 353 requires a HMO that denies a claim or initiates disenrollment, cancellation, or nonrenewal to notify the affected enrollee of the right to file a complaint with the HMO (page 28, lines 19 through 23). Senate Bill 353 also restricts and requires disclosure of the reasons for which and a HMO may disenroll, cancel, or refuse to renew an enrollee (page 36, line 9 through line 22, page 37).

Senate Bill 353 requires an individual, partnership, or corporation who acts as an agent selling HMO coverage to be licensed as disability insurance agent (page 39, line 4 through line 4, page 40). The states of Washington and Idaho have the same requirement.

III. Senate Bill 353 Incorporates Suggestions of the Department of Health

Senate Bill 353 incorporates suggestions of the department of health, which will regulate and review the availability, accessibility, and continuity of health care in HMOs operating in Montana because the insurance department lacks the expertise to perform those duties (page 13, lines 5 through 25; and page 41, line 18 through line 1, page 42). In addition, Senate Bill 353 includes authority for the director of health to contract with qualified persons to make recommendations concerning the determinations he is required to make (page 53, line 23 through line 4, page 54).

Senate Bill 353 gives the department of health 60 days (with an optional extension of 30 days) to certify a HMO application to the insurance commissioner (page 14, lines 1 and 16). Senate Bill 353 clarifies that the HMO Act does not exempt HMO activities from applicable certificate of need requirements (page 18, lines 17 through 20; page 41, lines 7 through 10; and page 52, lines 18 through 21).

Senate Bill 353 provides the department of health rulemaking authority (page 47, lines 6 through 7). Senate Bill 353 merely permits the director of health to attend and participate in an administrative hearing instituted by the

insurance commissioner (page 47, lines 18 through 19). Senate Bill 353 authorizes the director of health to assess fees necessary and adequate to cover the expenses of his functions, other than examinations (page 49, lines 16 through 21).

IV. Senate Bill 353 Accommodates the Small Insurance Department Staff

Senate Bill 353 requires an applicant for a HMO certificate of authority to provide information that will assist the small insurance department staff in corresponding with the applicant (page 6, lines 9 through 20). It also permits an HMO to file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract to decrease the amount of paper the part-time staff person must spend to review contracts and to accommodate the shortness of storage space in the insurance department (page 7, lines 19 through 21). Senate Bill 353 gives the insurance department 180 days after receipt of the certified application for a HMO certificate of authority from the department of health to issue or deny a certificate of authority (page 14, lines 17 through 20). Under present insurance law, the insurance department is under no time limitation to approve or deny an application for a certificate of authority.

V. Explanation of Amendments

Having considered amendments proposed by various parties interested in Senate Bill 353, the State Auditor's Office offers 14 amendments, including amendments suggested by representatives of mental health providers and Blue Cross/Blue Shield.

Amendment 1 removes language from the statement of intent that no longer is necessary since the Senate amended section 12 so that the commissioner will not adopt HMO investment guidelines by rule. It also removes the suggestion that the commissioner look to regulations adopted by the state of Minnesota in implementing the bill.

Amendment 2 clarifies that the commissioner must approve or disapprove, within 30 days, an exercise of certain powers by a HMO.

Amendment 3 removes undefined language ("unjust, unfair, inequitable, misleading, or deceptive") from the bill.

Amendments 4 and 5 correct the reference to the insurance laws relating to coverage of mental illness, alcoholism, and drug addiction.

Amendment 6 provides that a HMO may not limit an enrollee to a HMO provider for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction.

Amendment 7 clarifies that the commissioner must approve or disapprove a form within 60 days after it is filed.

Amendment 8 clarifies that the commissioner require a HMO to submit only "relevant" information in determining whether to approve or disapprove a form filing.

Amendments 9 and 14 clarify that if House Bill 741 does not pass, an individual, partnership, or corporation enrolling people into a HMO operated by a health service corporation must be licensed as a disability insurance agent.

Amendment 10 removes language from the bill that would have allowed the commissioner to examine the affairs of providers with whom an HMO has contracts, agreements, or other arrangements.

Amendment 11 corrects language in the bill consistent with amendments made in the senate.

Amendments 12 and 13 add an annual fee of $300 for a HMO to continue its certificate of authority.

VI. Conclusion

The Senate Public Health Committee and subcommittee considering Senate Bill 353 devoted considerable time in coming up with the legislation before you today. The bill embodies compromises reached through discussion between all who are affected by it--industry, providers, potential HMO consumers, the Department of Health, and the Insurance Department. A lot of work went into making this a good bill--a bill that all parties can support and that all agree is in the best interests of Montanans. If Senate Bill 353 passes, Montana consumers can expect to find financially sound HMOs that treat them fairly.

EXHIBIT 2
DATE 3-20-87
HB SB 353

PROPOSED AMENDMENTS OF STATE AUDITOR'S OFFICE
SENATE BILL 353
March 20, 1987

1. Statement of intent, page 2, lines 9 through 14.
Strike: lines 9 through 15 in their entirety

2. Page 18, line 3.
Following: "may"
Insert: "within 30 days"

3. Page 20, lines 18 through 19.
Strike: "unjust, unfair, inequitable, misleading, or deceptive; that encourages misrepresentation; or that is"

4. Page 23, line 1.
Following: "limits"
Insert: "and coverage"

5. Page 23, line 2.
Strike: "33-22-703"
Insert: "Title 33, chapter 22, part 7"

6. Page 23.
Following: line 2
Insert: "A health maintenance organization may not limit an enrollee to a health maintenance organization provider for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction"

7. Page 26, lines 3 through 4.
Strike: "a reasonable period"
Insert: "60 days"

8. Page 26, line 15.
Following: "any"
Insert: "relevant"

*9. Page 39, line 8.
Following: "4"
Insert: "[or chapter 30]"

*NOTE: See amendment 14 for coordination instruction.

10. Page 41, lines 13 through 15.
Strike: "and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements"

11. Page 47, lines 21 through 22.
Strike: "quality"
Insert: "availability, accessibility, and continuity"

12. Page 49, line 9.
Strike: "."
Insert: "; and"

13. Page 49.
Following: line 9
Insert: "(d) for annual continuation of certificate of authority, $300.

14. Page 62.
Following: line 13
Insert: "Section 33. Coordination instruction. If House Bill 741 is not passed and approved, the bracketed language in subsection (1)(a) of section 15 of this act is void."

EXHIBIT 3
DATE 3.20.87
SB 353

SB 353 AMENDMENTS
HEALTH MAINTENANCE ORGANIZATION (HMO)

Page 39, line 3,
insert: (8) A health maintenance organization may not knowingly offer direct incentive payments or direct disincentive payment reductions to a physician as an inducement to limit referrals to specialty health care providers.

v3:sb353hmo.amd

EXHIBIT 4
DATE 3-20-87
SB 353

The Hidden Costs of HMOs

BY GWYNNE R. WINSBERG

Without employer specific data, few companies can tell what, if any, savings HMOs produce.

COST MANAGEMENT REPORT

The demand by employers for data, which can be used to make rational judgments in the design and offering of health care benefits, has escalated rapidly in the last three years. Insurance carriers and third party administrators, whose previous concern was paying claims in a timely fashion, kept only the data necessary for the calculation of next year's premiums. Now they increasingly are meeting the new market need for sophisticated data on their clients' use of the health care system.

Employer specific health care utilization data that currently are being generated by a few insurance carriers are not available, however, from the typical health maintenance organization (HMO). Therefore, in the majority of cases, an HMO cannot tell a given employer whether or not employees are utilizing HMO services in a cost-effective manner. The employee usually is satisfied if the out-of-pocket cost for an HMO is no more or only a few dollars more than the traditional indemnity coverage offered by an employer, and the employer is satisfied if the premium is lower or the same as for the traditional plan.

No Savings for Employers

The ratio of HMO premiums to indemnity premiums varies radically across the country and depends less on an employer's utilization experience than on efficiency of HMO management and the need to compete for market share. Thus, while the savings credited to the reported radical reduction in hospital days by HMOs should be more than sufficient to offset theoretical increased utilization of ambulatory services, employers have no means of knowing the magnitude of these savings. Moreover, the employer cannot determine if savings are being used up through excessive ambulatory visits, unusually high costs per patient hospital day, poor HMO management or high returns to investors or physician providers.

Several studies undertaken by the U.S. Department of Health and Human Services during the late 1970s showed considerable evidence that organized systems of health care, such as the community health center, decreased the cost of medical care to the government even for the urban and rural poor populations represented. The costs for these populations, located in Kentucky, Michigan, Minnesota, and California, were significantly reduced by giving the community access to primary care physicians as an alternative to the hospital emergency room. As a result, hospital days per 1,000 average length of stay and hospital admissions radically decreased along with inappropriate visits to the emergency room.

The HMO has also demonstrated by using primary care physicians as gatekeepers that hospitalization days per 1,000 and visits to the emergency room can be reduced drastically. What this should mean to the employer, who pays the insurance bill, is a significant savings in benefit costs. This is only rarely the case.

Some HMOs, in spite of good management and excellent medical outcomes, fail to pass on savings to their subscribers. If the employer is satisfied with an HMO premium $5 or $6 below that of the alternative plans, then no incentive to lower the premium exists. Many well-managed HMOs have become price followers, but the corporate buyer does not have the tools to determine this yet.

Nevertheless, the HMO is an increasingly attractive health care delivery option to employers of all sizes. In those areas of the country where HMO premiums are lower than that of less comprehensive indemnity plans, such as in California and Michigan, the employer at first appears to realize considerable cost savings. And, of course, the larger the employer, the greater the apparent cost savings over the indemnity premium. There is also speculation among corporations that HMOs reduce em-

Gwynne R. Winsberg is president of GRW Associates, Inc. in Chicago.

ployee absences because they focus on prevention and health promotion. At present, however, there is no clear-cut research to validate this assumption.

To determine the nature of the HMO risk, it is necessary to know the characteristics of the enrollees of the individual employer. Data must be kept on all workers as to age, sex, marital status, number of dependents, generally and number under six years of age, job classification and prior health status. In addition, the employer must be able to determine how HMO enrollees differ in these characteristics from other employees enrolled in an indemnity plan or other health care options.

If a study of HMOs could show that they tended to reduce absenteeism among enrollees, then an additional cost savings to the employer could be realized. Short-term absences, unlike the long-term absences covered by disability insurance, require a significant outlay of funds for replacement of the worker, frequently doubling the amount paid for the days of sick leave. These costs should be added to the premiums paid for the health care benefit in order to understand the cost of that benefit. Unfortunately, any savings in workdays, or even in the amount of hospitalization, also can be attributed to better health status of the employees choosing the benefit.

Who Uses HMOs?

General Motors was chosen as the subject for a 1983 study funded by The John A. Hartford Foundation on the effect of employee health plan selection on absenteeism. The study population consisted of over 30,000 blue-collar workers at four separate plant sites of the GM system in Flint, Detroit and Saginaw, Mich., and Rochester, N.Y. Data were obtained from the employer that, in addition to hours of excused absence, included choice of benefit plan, worker age, seniority, marital status, sex, number of dependents, occupational code and several measures of hours worked and hours scheduled.

People who worked less than 1,000 hours in the year were eliminated on the basis that they were not regular full-time employees. The final sample included 5,024 HMO enrollees and 23,618 enrollees in a high option, Blue Cross-Blue Shield plan. No retirees were included in this study.

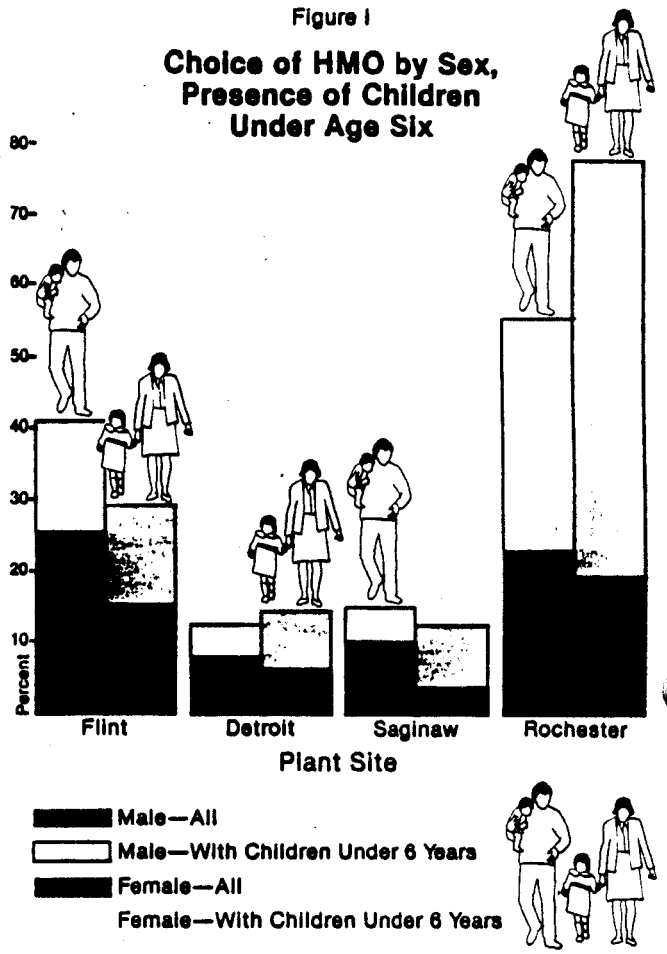
The worksites offered a range of activities from auto assembly to light manufacturing and were chosen on the basis of several criteria: Each had to offer an HMO; the HMO had to have been in existence for more than three years; and it had to have been offered to GM employees for at least two years. The HMOs selected had the highest penetration rates (8.2 percent to 24.5 percent) for GM hourly employees. Both independent practice association (IPA) and group-staff models, as well as private nonprofit and Blue Cross-Blue Shield subsidiary HMOs were represented.

The study was based on data for the 1983 work year. Thus, GM workers tended to be older than expected — an average 40 years of age in all plants — due to the extensive layoffs in the auto industry at that time. Seniority and age were correlated closely. However, workers in Rochester had slightly lower seniority than in the other three sites.

Employees were classified into production workers, nonproduction workers and skilled workers. The HMOs studied encompassed three group-staff models, two of which were subsidiaries of Blue Cross, one in Rochester and the other in Michigan. The fourth HMO was a privately owned, nonprofit IPA.

Figure I

Choice of HMO by Sex, Presence of Children Under Age Six



Source: G.R. Winsberg and J. Vidmar, "Absenteeism and Health Care," (Final Report, The John A. Hartford Foundation: New York City, March 1985).

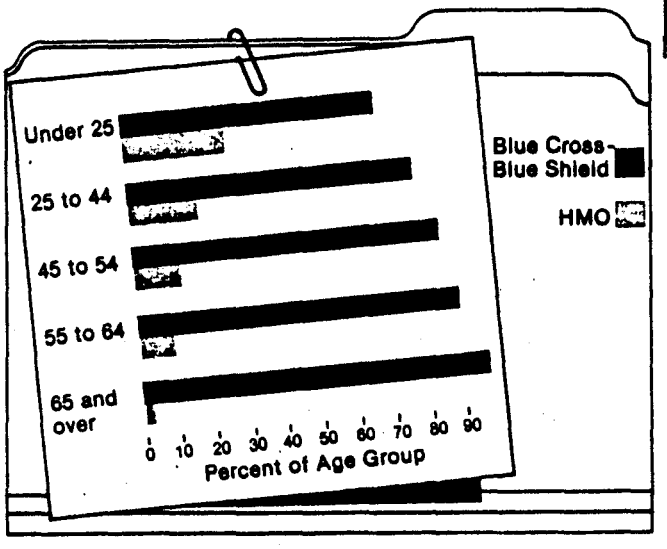
In this study, those GM employees choosing the HMO option tended to be younger than the average age of 40, had more dependents, were more likely to be married and living with a spouse, and to be in a skilled worker category. They also were more likely to be male. In all but a few cases, comparisons between Blue Cross and HMO enrollees were statistically significant regarding those choosing each of the plan options at each of the four sites across the six characteristics presumed to affect health behavior and utilization: age; seniority; number of dependents; marital status; sex and occupational level.

The presence of children under age six, those most likely to have need for the preventive care offered by the HMO, appeared to have a strong influence on worker choice for the HMO option. This effect was particularly strong at Rochester, where males were more than twice as likely to choose an HMO if they had children under age six and women were nearly four times as likely to

do so (see Figure I). Having young children, of course, highly correlates with the age of the worker. A very strong effect of age on choice of health plan was found across all of the plant locations. Sixty-two percent of HMO enrollees were under age 40 compared to 45 percent of Blue Cross beneficiaries. The likelihood of choosing the HMO option decreased markedly with increasing age of the worker, with the greatest likelihood occurring in the age group under 25, where nearly 30 percent of workers chose the HMO option. More than one out of five workers in the 25 to 44 age group chose the HMO, but this percentage dropped off rapidly to about 12 percent in the 45 to 54 age group and to 10 percent in the group between 55 and 65 years of age (see Figure II).

Figure II

Choice of Health Plan by GM Worker Age All Plants



Source: G.R. Winsberg and J. Vidmar, "Absenteeism and Health Care," (Final Report, The John A. Hartford Foundation: New York City, March 1985).

The relationship between choice of health benefit plan and worker skill is striking. At three of the four plants, Flint, Saginaw and Rochester, there was a very strong and statistically significant likelihood of the skilled workers choosing HMOs at a higher rate than workers in the other two categories. Only in Saginaw was the relationship somewhat weaker, although it was in the expected direction.

Over half of the workers in all four plant locations had four or fewer days of absence for all causes. In the year studied, almost 28 percent of the workers had negligible absences or none at all. Conventional wisdom suggests that absences associated with illness and disability would increase with age. However, in this group, high levels of absence decreased with increasing age. Unfortunately, worker absence in order to seek health care for himself, herself or dependents was not distinguishable from absence for reasons such as jury or military duty.

The results of the GM analysis showed a statistically significant difference in absence hours for HMO enrollees, which on the average, was about 10.5 hours fewer per year than for indemnity plan participants. However, the effect of plan choice on absenteeism was considerably less than that of sex differences. Males had considerably lower annual absences than females, accounting for nearly a five-day difference in the regression analysis. Location also was a strong factor, with the Flint site experiencing considerably higher absence rates than either Rochester or Detroit. The higher absence rate at Flint may be attributed to a significantly higher proportion of single males employed at the GM plant. HMO membership among GM employees, however, appeared to be associated with an average day to a day and a half reduction in worker absenteeism annually when compared to Blue Cross enrollees.

Impact on the Work Force

Given the demographic differences between the two types of enrollees in the GM study, the data strongly suggest that these HMOs are enrolling employees who are better health risks. Absenteeism and other indicators of health status, such as the younger age of the HMO enrollees, would indicate an expected lower level of illness and utilization of costly hospital based services. High worker skill level, which can be seen as a proxy for educational level and occupational status, is also positively associated with HMO membership. In general, utilization data suggest that the presence of the more skilled or more educated workers in the HMO would also tend to lower the overall demand for services.

The higher average number of dependents associated with the HMO enrollees indicates a higher overall use of services. However, the population under age six tends to use the less expensive, well child or preventive services, including immunizations and checkups. It is precisely in this area that HMOs are generally found to offer superior services.

If, as this and other studies suggest, healthier individuals tend to choose the HMO, then some of the favorable utilization and cost experience that the literature has documented may be an effect of the initial differences between the enrollees in the different types of plans, rather than entirely the result of the organizational incentives of the health benefit plan itself.

Since 1983, GM employees at the company's urging have begun to select the HMO option more frequently. GM currently offers a preferred provider organization (PPO) as well. It is even more important now to GM to develop the tools necessary to understand how the new programs affect the overall health care risk. While the data analyzed in this study provide some interesting and provocative insights into factors influencing the choice of health benefit plan among their hourly blue collar workers, many questions remain unanswered.

To explore more fully the factors influencing choice of health plan, as well as the effects of HMOs on worker absence, existing data collection needs to be improved to provide information in three general areas: the health status and prior health care utilization of the worker; family structure, including health benefit coverage through

a spouse's employment, the work status of the spouse and the health status of the spouse or other family members; and better measures of worker absence.

Without data from either the HMO or traditional indemnity plan regarding the utilization behavior of enrolled employees, it is impossible for a business, large or small, to determine the cost-effectiveness of any plan selection, unless it compiles its own data. Findings of the GM study suggest, for example, that employers might conduct periodic surveys of health status and health care utilization of workers and their families in order to monitor adverse risk effects of alternative health plan choices. To assure the validity of responses and to protect the confidentiality of worker responses in sensitive areas, it is desirable to have such surveys conducted by outside researchers.

Employers also should review their internal data files for purposes of improving the manner in which data on worker absences are collected and monitored. At a minimum, reasons for absences related to illness or seeking health care should be coded differently from other causes in the data files.

Two of the four HMOs in the GM study kept employer specific data on both inpatient and outpatient utilization, and all of the HMOs kept provider utilization profiles for the purposes of internal management. In two of the HMOs, ambulatory visits per enrollee averaged 2.5 per year, which was considerably below the reported national average of 4 to 4.5 visits per enrollee per year in all systems of care.

There was no evidence that any of the HMOs limited access through excessive waiting periods for appointments. In all cases, urgent problems were seen the same day or next day. Requests for nonurgent appointments were honored within two weeks at the most. Patients rarely were kept waiting for more than 30 minutes after their appointment time. The low rate of ambulatory visits, along with the consistently reported reductions in hospitalization days per 1,000 enrollees, should result in lower premium dollars spent by the employer (see table). However, in each case, the HMO premium was only a few dollars less than the indemnity plan premium.

Elsewhere in the HMO community, data collection is less prevalent. For instance, at a March 1985 meeting in Chicago of the Midwest Business Group on Health, two Illinois based HMO officials stated that no data on utilization of office visits were kept. They argued that employer specific utilization was irrelevant to the HMOs because the HMOs community rate and do not base their premiums on the individual company's experience.

Small Employers Disproportionally Affected

The selection of the HMO option by the youngest and presumably healthiest employees is particularly devastating to smaller employers. Many employers of 100 to 2,000 workers, when an HMO option is offered, find that their indemnity premiums skyrocket as older, chronically ill employees with an established physician relationship tend to remain on the indemnity plan.

Many smaller corporations that self-insure are using pooled statistics from their third party administrators to analyze retrospectively employee utilization of health benefits. While smaller employers have a difficult time managing the health care risk due to insufficient data and lack of staff for analysis, both large and small employers have similar problems with regard to HMO enrollment and operation. Most HMO marketing efforts are directed toward an employer's younger and healthier employees and, consequently, are more likely to enroll such members, leaving a disproportionate number of the older and sicker individuals in an employer's indemnity plan.

HMO Characteristics by Site
1983

Site	HMO Type	Membership	Penetration Rate (percent)	HMO Hospital Days/1,000	Blue Cross Hospital Days/1,000
Private-nonprofit ownership					
Flint	IPA	70,000	24.5%	450	800 to 1,000
Detroit	Group-staff	130,000	8.2	500	800 to 1,000
Blue Cross-Blue Shield					
Saginaw	Group-staff	28,800	9.7	400	800 to 1,000
Rochester	Group-staff	35,500	22.8	324	500

Source: G.R. Wineberg and J. Vidmar, "Absenteeism and Health Care," (Final Report, The John A. Hartford Foundation: New York City, March 1985).

In larger companies, as well, this has been a problem. For example, this type of adverse selection occurred against the indemnity plan offered by J.C. Penney & Co. to its employees. The company has been a strong supporter of HMOs since the late 1970s. However, this past spring, one of the 145 HMOs offered to Penney employees unilaterally terminated medical coverage for 1,400 Atlanta area employees because it believed that a rate change requiring larger out-of-pocket employee contributions for HMO coverage would result in the loss of the younger, healthier members from its enrollment population, leaving behind those members who most needed medical care.

Good benefit design that allows an employer to fully reward sound case management by individual employees' personal physicians in the long run may be more advantageous to the employer than endorsing an HMO option. For example, adequate incentives to use the full panoply of home care options in order to shorten or eliminate hospital stays should be included along with recognition that employee education must keep apace of the rapidly occurring changes in the health care system.

Through the formation of business coalition user groups, consisting of employers using the same insurer or third party administrator who work together to extract and analyze claims information on employees' use of health services, some of the secrets of health care are being yielded (BUSINESS AND HEALTH, March 1985, p. 12-16). These secrets, however, are being unraveled only to those employers large enough to hire the cast of medical counselors, statisticians and analysts necessary to translate these data into action plans. Many smaller companies do not have the internal resources to manage the health care benefit risk effectively and will have to consider seriously how to meet this challenge. ■

EXHIBIT 5
DATE 3-20-87
HB SB 353

Montana Psychological Association

Testimony on SB 353
March 20, 1987

The Montana Psychological Association represents 200 professional psychologists in the state of Montana in private and public sector mental health care. Out of its concern for cost-effective, innovative mental health care and for protected freedom of choice for Montana health care consumers, the MPA supports Senate Bill 353 with the addition of strengthening amendments.

The rising expenditures for health care in the U.S. to over $465 billion have led to unprecedented steps to control health care costs through new cost-efficient ways of doing business with health care providers. Health Maintenance Organizations pose not only innovative opportunities but also significant challenges to you as you develop an HMO statute for the state of Montana.

In some other states certain practices of HMO's restrict the delivery of mental health care only to selected physicians, denying psychologists the opportunity to be fully participating members and also limiting the consumer's choice in mental health care.

In addition some HMO's limit the opportunity for health care professional other than physicians to participate on governing boards and policymaking bodies handling the administration of these organizations.

Profit incentives that are given directly to individual "gatekeepers" in HMO's also run the risk of dictating lower levels of good patient care. Consumers are often unaware of the profit incentives and cost containment mandates under which "gatekeeper" physicians operate.

The MPA, therefore supports SB 353 with the addition of strengthening anti-discrimination amendments on incentive plans, freedom of choice provisions when patients are referred-out. We offer the following two amendments of our own:

1. "Interdisciplinary boards and panels" - HMO's in this state shall have governing boards or similar utilization panels that are multidisciplinary, and may include providers or other individuals, or both." (Rewording of Section 6 (1) [p. 18, line 21+]

   (The inclusion of multidisciplinary professionals would make it possible for mental health care providers in addition to physicians to participate in the administration of HMO's)

2. Addition of words "coverage and" after words "accordance with the..." in Sect 8, (3) (f) [p. 23, line 1+].

(This clarifies that the coverage for mental illness, drug and alcohol treatments is included, not just the "limits" as listed in 33-22-703.)

The MPA stands in opposition to any amendments that would require all employers in the state of Montana with 25 or more employees to offer an HMO plan if they already offer a group insurance plan. We feel this is a serious financial burden to place on employers of this sector across our state.

We recognize that this is a significant piece of legislation and it is important that a strong bill be developed for our state and our health care consumers. We will work with the Committee and its subcommittee to perfect and pass a strong Montana HMO statute.

Thank you for your consideration of our concerns and the amendments we offer.

Dr. Ann Pincus, practicing
psychologist in Helena

Pat Callbeck Harper
lobbyist for MPA

EXHIBIT 6
DATE 3-20-87
HB SB 353

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Suite 12 • Helena, Montana 59601

POSITION PAPER ON
SENATE BILL #353

The Montana Medical Association supports Senate Bill #353 as amended. Despite the fact SB #353 may contain certain provisions which the Medical Association would have an interest in seeing amended, SB #353 represents a recognition by the legislature that HMOs as alternative delivery systems need to be dealt with in a different regulatory manner than the traditional third party payment systems offered by insurers or health service corporations.

The history of health maintenance organizations have shown that it is important that legislators recognize the distinction between the traditional health insurance products offered by the insurers and health service corporations and HMOs as alternative delivery systems. While HMO and PPO products are often offered by insurers and health service corporations, this area has also opened up to joint ventures such as combinations between hospitals and clinics and/or state or local medical associations. These groups do not provide the traditional means of prepayment of medical expenses but would be eligible if properly structured and financed to receive a certificate of authority and operate HMOs. Numerous hospital corporations such as Humana have started HMOs in a number of states and state medical societies including Georgia and South Dakota have started statewide IPA HMOs. In addition, there are numerous physician groups across

the country that are not federally qualified HMOs but have started HMOs which have a localized service area.

Senate Bill #353 is legislation with far-reaching consumer ramifications. Without the statutory enabling legislation of Senate Bill #353, the field of those who would be eligible to start HMOs would be restricted. It is the opinion of the Montana Medical Association that absent HMO legislation similar to Senate Bill #353, the only parties that would be in a position to start HMOs in the State of Montana would be insurers and health service corporations who do business in the State of Montana or who qualify to do business in Montana and who would meet statutory requirements for doing business in the State of Montana. Meeting the requirements to do business as an insurer or health service corporation in the State of Montana are considerably different than the requirements found in this HMO legislation. Senate Bill #353 allows parties in addition to insurers and health service corporations to present to the Division of Insurance an application for a Certificate of Authority to operate HMOs. The applications must set out information such as projections as to enrollment, market projections, and administrative costs which will allow the Division of Insurance to make some decisions concerning the reserve requirement necessary to start such an HMO and to impose other reasonable requirements to insure the continued viability of HMOs. The continued solvency of HMOs are critical to the consumers of Montana who choose alternative delivery systems such as HMOs over traditional insurers.

It is not the intent of this position paper to indicate that any HMO products presently being offered in this state are not financially viable; however, it is the position of the Montana Medical Association that it is important to the consuming public that there is preserved the method by which other parties may enter the HMO market and that any alternative delivery system which they become associated with remain a financially viable product. This statute allows other parties the ability to enter the HMO market and provides for the continued monitoring of the operation of HMOs by the filing of a number of annual reports which will provide the Division of Insurance with a means to track the continued growth of the HMO. In addition, the means will be provided to insure HMOs are properly funded and meeting the needs of the consumer who has chosen that product.

Absent specific HMO enabling legislation the field of players in the HMO market in this state would be limited and it would be the position of the Montana Medical Association that limiting the participants in this field is not in the best interests of either the State of Montana nor the consuming public. Therefore, the Montana Medical Association would urge that Senate Bill #353 as presented to the Committee be adopted with the inclusion of any necessary amendment the Committee feels is necessary and that over the period of the next two years that the participants in the alternative delivery systems, together with the Division of Insurance, work towards agreement on statutory language which will meet the concerns of all involved.

Thank you.

EXHIBIT 2
DATE 3-20-91
HB SB353

PROPOSED AMENDMENTS TO SENATE BILL 353

Senate Bill 353, Third Reading Copy, is hereby amended as follows:

1. Page: Statement of Intent, page 2
   Following: Line 11
   Strike: Lines 12 through 14

2. Page: 10
   Line: Following line 15
   Strike: Lines 16 through 20
   Insert: "name the person and describe:"

3. Page: 12
   Line: Following line 25
   Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner."

4. Page: 18
   Line: 3
   Following: "may"
   Insert: ", after notice and hearing,"

5. Page: 18
   Line: 4
   Following: "power"
   Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

6. Page: 18
   Line: Following line 9
   Strike: Lines 10, 11 and "commissioner." on line 12

7. Page: 20
   Line: 18
   Following: "that is"
   Strike: "unjust, unfair, inequitable,"

8. Page: 20
Line: 19
Following: "deceptive;"
Strike: "that encourages misrepresentation;"

9. Page: 26
Line: 3
Following: "within"
Strike: "a reasonable period"
Insert: "60 days"

10. Page: 26
Line: 6
Following: "form"
Strike: "or use a schedule of charges"

11. Page: 26
Line: 7
Following: "form"
Strike: "or the health maintenance organization files the schedule of charges"

12. Page: 26
Line: 15
Following: "any"
Insert: "relevant"

13. Page: 29
Line: 4
Strike: Lines 4 and 5 and renumber all subsequent subsections.

14. Page: 29
Line: 22
Following: "subsection (1)(d)"
Strike: "(iii)
Insert: "(ii)"

15. Page: 29
Line: 24
Following: "regulations."
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation under title 33, chapter 30,"

16. Page: 39
Line: 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 313"

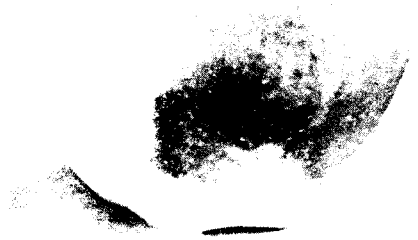
17. Page: 41
Line: 17
Following: "every"
Strike: "3"
Insert: "4"

18. Page: 41
Line: 25
Following: "every"
Strike: "3"
Insert: "4"

19. Page: 43
Line: 25
Following: "[section 3],"
Insert: "and provided that such operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner,"

EXHIBIT 8
DATE 3-20-87
HB SB 353

Take A Big Bite Out Of Your Health Care Costs.



HMO Option I

HMO
Montana

Helena Office
P.O. Box 5804
560 N. East Custer Ave.
Helena, MT 59604
(406) 444-8250

Missoula Office
P.O. Box 8050
2505 Russell
Missoula, MT 59808
(406) 721-3004

Sponsored by
Blue Cross and Blue Shield of Montana

HMO
Montana

EXHIBIT 9
DATE 3-20-87
SB 371

WRITTEN TESTIMONY OF STATE AUDITOR'S OFFICE
SENATE BILL 371
March 20, 1987

I. Purpose/Background

Under existing law, only a health service corporation may enter into a preferred provider agreement. To date, the Montana Insurance Department has taken the position that the freedom of choice of practitioners law, which applies only to insurance companies (33-22-111, MCA), prevents them from entering into preferred provider agreements. If pressed, however, the Insurance Department may not prevail in its position, and preferred provider agreements may be formed without oversight.

Senate Bill 371 provides a regulatory framework for preferred provider agreements. The Insurance Department has amendments that Senator Regan, the sponsor of Senate Bill 371, has reviewed. They add definitions for terms used in the bill and modify language to conform with defined terms.

II. Explanation of amendments

Amendment 1 changes the title to the act to the "Preferred Provider Agreements Act".

Amendment 2 provides a purpose section.

Amendments 3 through 5 add definitions to terms used, but not defined, in Senate Bill 371 to decrease chances of litigation on the meaning of provisions contained in it.

Amendment 6 inserts a defined term--"health care insurer".

Amendments 7 and 8 insert clarifying language using defined terms.

Amendment 9 adds to the list of situations that may be addressed in preferred provider agreements.

Amendments 11 and 12 change the numbering within the "Incentives in Health Benefit Plans" section.

Amendments 13 and 15 add that a policy or health benefit plan must contain a provision that clearly identifies the differentials in benefit levels for health care services of a preferred provider and benefit levels for health care services of a nonpreferred provider.

Amendments 10, 14, 16, and 17 change the term "arrangements" to "agreements" because "agreements" is the term used in the rest of Senate Bill 371.

Amendment 18 adds an applicability section that requires PPOs already operating in the state to notify the commissioner of their existence and comply with Senate Bill 371.

Amendment 19 adds a coordination instruction providing that if Senate Bill 353 does not pass, the reference to it in the definition of "health care insurer" is void.

EXHIBIT 10
DATE 3-25-87
HB 371

PROPOSED AMENDMENTS BY STATE AUDITOR'S OFFICE
SENATE BILL 371

1. Page 1, line 13.
Strike: ""Health Care Reimbursement Reform"
Insert: "Preferred Provider Agreements"

2. Page 1.
Following: line 15
Insert: "Section 2. Purpose. The purpose of [this act] is to allow health care insurers providing group disability insurance benefits to negotiate and contract with licensed health care providers either to provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider or to enter into agreements whereby the participating providers accept negotiated fees as payment in full for health care services that the health care insurer is obligated to pay for or provide under the health benefit plan."
Renumber: subsequent sections

3. Page 2.
Following: line 4
Insert: "(4) Health care insurer" means an insurer that provides disability insurance as defined in 33-1-207, a health service corporation as defined in 33-3--101, a health maintenance organization [as defined in section 1 of Senate Bill No. 353], a fraternal benefit society as defined in 33-7-102, or any other entity regulated by the insurance department that provides group health coverage."
Renumber: subsequent subsections

4. Page 2, lines 14 through 17.
Strike: subsections (5) in its entirety
Insert: "(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.
"(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider."
Renumber: subsequent subsections

5. Page 2.
Following: line 20
Insert: "(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is paying for or providing health care coverage."

6. Page 2, line 23.
Strike: "an"
Insert: "a health care"

7. Page 2, line 25.
Strike: "the insurer's"

8. Page 3, line 1.
Following: "insureds"
Insert: "or subscribers on whose behalf the health care insurer is providing health care coverage"
Following: "including"
Insert: "preferred provider"
Following: "to"
Insert: "(i)"

9. Page 3, line 2.
Following: ";"
Strike: "and"
Insert: "(ii) the amount and manner of payment to the provider;

"(iii) the review and control of utilization of health care services, if those agreements do not result in imposition of costs on insureds or subscribers by reason of postutilization denial of payment for services over which those insureds or subscribers have no control; and"

10. Page 3, line 12.
Strike: "ARRANGEMENT"
Insert: "agreement"

11. Page 3, line 18.
Strike: "(1)"

12. Page 3, line 22.
Strike: "(2)"

13. Page 3, line 23.
Following: "LEAST"
Insert: "the following: (1)"

14. Page 3, line 25.
Strike: "ARRANGEMENT"
Insert: "agreement"

15. Page 4, line 3.
Strike: "."
Insert: "; and

"(2) a provision that clearly identifies the differentials in benefit levels for health care services of a preferred provider and benefit levels for health care services of nonpreferred providers."

16. Page 4, line 12.
Strike: "ARRANGEMENTS"
Insert: "agreements"

17. Page 4, line 13.
Strike: "ARRANGEMENTS"
Insert: "agreements"

18. Page 5.
Following: line 2.
Insert: "Section 7. Applicability--filing with commissioner. Within 60 days of [the effective date of this act], a person or organization performing the functions enumerated in [this act] shall notify the commissioner of its existence and continue to operate subject to applicable laws."
Renumber: subsequent sections

19. Page 5.
Following: line 6
Insert: "Section 9. Coordination instruction. If Senate Bill No. 353, including the definition of "health maintenance organization" is not passed and approved, the bracketed language in subsection (4) of section 3 of this act is void."
Renumber: subsequent sections

EXHIBIT 11
DATE 3-30-87
HB SB 371

PROPOSED AMENDMENTS TO SENATE BILL 371

Senate Bill 371, Third Reading Copy, is hereby amended as follows:

1. Page: 3
   Line: 12
   Following: "A"
   Strike: "PREFERRED PROVIDER ARRANGEMENT"
   Insert: "health insurance policy or subscriber contract"

2. Page: 4
   Line: 14
   Strike: All of the language on line 14 through line 16

3. Page: 4
   Line: 20
   Following: "CONDITIONS OF"
   Strike: "A PROVIDER ARRANGEMENT,"
   Insert: "AN"

4. Page: 4
   Line: 21
   Following: "POLICY"
   Strike: ","

5. Page: 4
   Beginning on Line 24:
   Following: "rules"
   Strike: "prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under"
   Insert: "concerning"

NOTE: If the rulemaking amendment is adopted, a necessary change will have to be made in the statement of intent.

EXHIBIT 12
DATE 3-20-97
HB SB 371

SB 371
AMENDMENTS

1. Page 3, line 13.
Following: "DENY"
Insert: "or restrict"

2. Page 4, line 4.
Strike: Section 5 in its entirety.
Renumber: remaining sections accordingly.

---

1. Page 4, line 11.
Strike: subsection (A), in its entirety.
Renumber: all subsections accordingly.

2. Page 4, line 20.
Following: "OF"
Strike: "A PROVIDER ARRANGEMENT"
Insert: "an"

---

1. Page 4, line 11.
Strike: subsection (A) in its entirety.
Insert: "(A) a provision setting a payment differential for reimbursement of a non-preferred provider as compared to a preferred provider. In the event such insurance policy of subscriber contract contains such a payment differential provision, the payment differential may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed."

2. Page 4, line 20.
Following: "OF"
Strike: "A PROVIDER ARRANGEMENT"
Insert: "an"

EXHIBIT 13
DATE 2-20-07
HB SB 371

SB 371 AMENDMENTS

Page 2, line 7, after license,
strike: or
insert: ,

Page 2, line 7, after authorization,
insert: , or providing services covered within title 33, chapter 22, part 7

Page 2, line 19, after licensed,
strike: or
insert: ,

Page 2, line 19, after authorized,
insert: , or providing services covered within title 33, chapter 22, part 7

v3:sb371amd.87

3. Section 4 (2) [p. 3, line 14] - the addition of a definition of "MEDICALLY NECESSARY COVERED EXPENSES" would strengthen this statute.

The MPA recognizes that this is very important legislation and it is fully aware that PPO's are an emerging alternative to more traditional forms of health care delivery and reimbursement.

We do not yet know what the long term impact of PPO's will be on consumer access to quality health care or on the health care professions themselves.

We therefore support SB 371 and promise to work hard with the Committee and its subcommittees to make Montana's PPO law a strong and fair one with special protections for the health care consumer of Montana.

Thank you very much for your favorable consideration of SB 371, with the inclusion of strengthening anti-discrimination amendments.

Dr. Ann Larson, practicing psychologist in Helena

Pat Caldwell Harper, lobbyist for Montana Psychological Assn.

EXHIBIT 14
DATE 3-20-87
SB 371

Montana Psychological Association
Testimony on SB 371, March 20, 1987

The Montana Psychological Association represents 200 professional psychologists in the state of Montana in private and public sector treatment of mental illness. Out of its concern for cost-effective, innovative mental health care and freedom of choice for Montana health care consumers, the MPA supports Senate Bill 371.

Expenditures for health care in the U.S. totaled $465 billion in 1985. Experts preditct that the health care market will continue to evolve into a system based on fiscal considerations and competition, evidenced by the fact that employers and major purchasers are taking unprecedented steps to control health care costs through new cost-efficient ways of doing business with health care providers.

HMO's and PPO's (Preferred Provider Organizations) provide both important opportunities for cost-effective mental and physical health care as well as significant challenges to professional providers and consumers. In some states, certain practices of HMO's and PPO's restrict the delivery of some forms of mental health care to only physicians.

Because we feel that the Montana mental health care consumer is entitled to the optimum freedom of choice within the restrictions of the PPO agreements, we support the inclusion of strengthening "anti-discrimination" provisions into SB 371.

We offer two such provisions as amendments that have been enacted in other states in response to the practice of some PPO's:

1. "Willing Provider" provision - Section 4, new (4)

"No licensed provider, physician or hospital who agrees to the terms and conditions of the preferred provider agreement shall be denied the right to become a preferred provider to offer health services within the limits of their license."

2. Prohibit PPO's from requiring hospital privileges in order for a provider to be eligible - Sect. 4, new

"A Preferred Provider agreement issued or delivered in this state may not require hospital staff privileges as criteria for designation as a "preferred provider" in a Preferred Provider Organization."

(In other states this requirement has been used to exclude professional health care providers who are not physicians - those who carry hospital staff privileges - and therefore limit the choice of health care consumers to only physicians.)

EXHIBIT 15
DATE 3-2-87
SB 884

Amendments to House Bill 884
Introduced bill (white copy)

1. Title, line 11.
Following: "BONDS"
Insert: "AND THE UNFUNDED LIABILITY OF THE STATE FUND"
Following: "BONDS;"
Insert: "AMENDING SECTION 17-7-502, MCA"

2. Page 3, line 21.
Following: "the"
Insert: "employer's"
Following: "payroll"
Strike: "tax is intended to"
Insert: "shall"

3. Page 3, line 23.
Following: "[section 5]"
Insert: "and benefits for injuries that occurred prior to June 30, 1987"

4. Page 3, line 24.
Following: "the"
Insert: "employer's"
Following: "payroll"
Strike: "tax is intended to"
Insert: "must"

5. Page 5, line 3.
Following: "account"
Strike "and are"
Insert: ". An amount of the tax proceeds equal to .5% of each employer's payroll is"

6. Page 5, line 5.
Following: "[section 5]"
Insert: "and benefits for injuries that occurred prior to June 30, 1987"
Following: "."
Insert: "An amount equal to .07% of each employer's payroll is statutorily appropriated, as provided in 17-7-502, to the state fund."

7. Page 5, line 9.
Following: "(1)"
Insert: "and statutorily appropriated for payment on bonds"

8. Page 5.
Following: line 21
Strike: subsection (4) in its entirety

9. Page 9.
Following: line 18.

Insert: "Section 17-7-502, MCA, is amended to read:

17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;
(b) 2-17-105;
(c) 2-18-812;
(d) 10-3-203;
(e) 10-3-312;
(f) 10-3-314;
(g) 10-4-301;
(h) 13-37-304;
(i) 15-31-702;
(j) 15-36-112;
(k) 15-70-101;
(l) 16-1-404;
(m) 16-1-410;
(n) 16-1-411;
(o) 17-3-212;
(p) 17-5-404;
(q) 17-5-424;
(r) 17-5-804;
(s) 19-8-504;
(t) 19-9-702;
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305;
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;
(ee) 20-8-111;
(ff) 23-5-612;
(gg) 37-51-501;
(hh) 53-24-206;
(ii) 75-1-1101;
(jj) 75-7-305;

(kk) 80-2-103;
(ll) 80-2-228;
(mm) 90-3-301;
(nn) 90-3-302;
(oo) 90-15-103; ~~and~~
(pp) Sec. 13, HB 861, L. 1985 and
(qq) [section 4].

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments.

Renumber: subsequent subsections.

BG/BG2/hb884 amd.txt

EXHIBIT 16
DATE 3-20-87
SB 224

House Bill 884 Information

BACKGROUND

Late in 1986, actuarial estimates of the unfunded liability in the State Fund jumped from $29 million to over $81 million. Shortly after, the Supreme Court ruling in the Buckman case found that the legislature could not retroactively reduce benefits. The Buckman decision not only removed legislative options to deal with the unfunded liability, but increased that liability by $20-30 million.

THE PROBLEM

The state fund must pay a potential $140 million in benefits for which the fund holds less than $40 million in reserves. Any resolution of this problem is complicated by the following:

- Most of the unfunded liability (75%) will need to be paid out in the next three years. Without a significant rate increase or other revenue, the State Fund will run out of cash in fiscal year 1989 or 1990.

- Efforts to pay the unfunded liability by increasing rates for state fund insurers could be counterproductive. An estimated 30% rate increase would be needed to retire the unfunded liability over 6-7 years. Any rate increase would chase customers from the state fund to private insurers. The reforms within SB 315 will allow private insurers to be very competitive with the State Fund. These insurers will be able to reduce costs while the State Fund can, at best, hope to avoid a rate increase. Even without a rate increase, the State Fund could lose customers and a large part of the revenue base from which the unfunded liability must be paid.

ALTERNATIVES

If the state of Montana is to continue to require employers to have workers' compensation insurance and the State Fund is required to pay its liabilities, one of the following alternatives must be pursued:

- Pay the unfunded liability with general tax dollars.

- Create a State Fund monopoly so the unfunded liability can be paid from a broader premium base and rates can be increased without losing customers to private and self insurance plans.

- Maintain the three plan system by imposing a tax on all three plans to pay the unfunded liability.

RECOMMENDATION

HB 884 would maintain the three plan system by imposing a .05% tax on payroll subject to workers' compensation coverage. By pledging the payroll tax to retire bonds and pay unfunded benefits, the time the state has to pay the unfunded liability would be extended. The reasons for recommending this alternative and HB 884 are as follows:

- The use of tax-exempt bonds will allow the unfunded liability to be amortized over a longer period at the lowest interest rates. In order to obtain bond financing at a reasonable interest rate a specific tax needs to be pledged to pay the bonds. It is unlikely that bonds could be sold if they were backed only by anticipated premium payments.

- The tax would apply to all three plans. Therefore, private and self insurance plans would receive no additional advantage in the market from efforts to pay the unfunded liability. Under Senate Bill 315, these insurers may receive cost reductions of 22%.

- The State Fund serves as the insurer of last resort. In recent years, as the costs of benefits increased rapidly, private carriers withdrew from the marke, leaving the State Fund to insure small and high-risk employers. If coverage is mandatory for all employers, it is reasonable that all insurers who benefit from having an insurer of last resort should share in the costs.

- All employers benefit from preserving the basic industries that have high-risk employment. These industries usually must insure with the State Fund because private insurance is either unobtainable or unaffordable. Many employers in basic industry cannot survive another major rate increase.

SB 315 PASSES HB 884 FAILS
MARKET SHARE DROPS TO 44% IN FY 88
OTHER ASSUMPTIONS THE SAME AS
AUDIT COMMITTEE MEMO

EXHIBIT 17
DATE 3-20-87
HB 884

STATE INSURANCE FUND FINANCIAL ACTIVITY PROJECTION

Assumptions:
after fy 87

1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
$49,292,000	$50,861,305	$54,800,000	$60,374,942	$60,973,254	$61,5[illegible],481	$62,204,366	$62,826,410	$63,454,274	$64,[illegible],211	$64,730,113	$65,377,414	$66,031,188
$7,401,282	$7,964,872	$4,315,697	$1,400,000	$770,000	$242,000	$0	$0	$0	$0	$0	$0	$0
$426,000	$313,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
$57,119,282	$59,139,177	$63,115,607	$61,774,942	$61,748,894	$61,[illegible],481	$62,204,366	$62,826,410	$63,454,274	$64,065,221	$64,730,113	$65,377,414	$66,0[illegible],188
			$61,944,000	$42,456,000	$21,404,000	$14,964,000	$6,874,000	$4,272,000	$4,176,000	$2,610,000	$2,088,000	$1,044,000
$38,034,472	$43,866,927	$53,091,639	$5,365,045	$15,717,892	$24,449,822	$32,150,627	$35,021,840	$36,923,920	$38,026,763	$38,791,391	$39,366,320	$39,946,[illegible]
$14,085,173	$20,472,171	$28,587,805	$3,211,947	$8,463,491	$12,152,285	$17,[illegible],076	$15,[illegible]	$19,862,[illegible]	$20,482,425	$20,857,966	$21,197,249	$21,509,195
$5,021,998	$6,672,158	$6,800,000	$7,000,000	$7,200,000	$7,500,000	$7,900,000	$8,100,000	$8,300,000	$8,500,000	$8,700,000	$8,900,000	$9,100,000
$100,144	$248,948	$0	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000	$200,000
$57,241,787	$71,260,204	$88,479,444	$76,320,992	$74,037,373	$70,719,112	$72,526,532	$71,[illegible],062	$7[illegible],175,020	$71,197,[illegible]	$71,189,965	$71,751,569	$71,795,902
		INCURRED:	$57,356,198	$57,929,760	$58,503,027	$59,094,148	$59,685,089	$60,281,940	$60,884,760	$61,493,607	$62,108,543	$62,729,[illegible]
		Loss Ratio:	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95
$57,737,038	$47,951,191	$28,587,354	$12,041,308	($247,371)	($9,133,002)	($19,455,129)	($27,774,730)	($34,498,147)	($41,802,140)	($48,256,012)	($54,640,172)	($60,408,970)
		$174,000,000	$160,235,206	$151,527,593	$147,017,538	$141,685,183	$136,524,211	$137,128,121	$135,[illegible],566	$134,519,284	$133,376,256	$134,205,901
		($145,412,646)	($148,193,899)	($151,774,964)	($156,150,540)	($161,140,221)	($166,299,001)	($171,626,26[illegible])	($17[illegible],121,800)	($182,785,30[illegible])	($188,016,430)	($194,614,870)
[illegible],945,656,824	$3,956,237,969	$3,995,800,349	$4,035,758,322	$4,076,115,900	$4,116,877,095	$4,158,045,866	$4,199,626,325	$4,241,622,588	$4,284,038,814	$4,326,879,202	$4,37[illegible],147,994	$4,41[illegible]
[illegible],756,337,982	$1,888,932,494	$1,907,994,567	$1,775,733,675	$1,793,491,012	$1,811,425,922	$1,829,540,181	$1,847,835,583	$1,866,313,939	$1,884,977,078	$1,903,826,845	$1,922,865,117	$1,942,093,769
44.51%	47.75%	47.75%	44.00%	44.00%	44.00%	44.00%	44.00%	44.00%	44.00%	44.00%	44.00%	44.00%
$2.81	$2.69	$3.40	$3.40	$3.40	$3.40	$3.40	$3.40	$3.40	$3.40	$3.40	$3.40	$3.40

Dec 87 Jan

Dec 88

MONTANA SELF-INSURERS ASSOCIATION

EXHIBIT 18
DATE 3-20-87
HB 884

GEORGE WOOD, Executive Secretary

MARCH 17, 1987

FOR THE RECORD, MY NAME IS GEORGE WOOD, EXECUTIVE SECRETARY OF THE MONTANA SELF-INSURERS ASSOCIATION. I ARISE TO VOICE OUR STRONG OPPOSITION TO HOUSE BILL 884.

THIS IS A BAD BILL, BUT AN INTERESTING BILL. IT HAS MYSTERY-MORAL AND LEGAL PROBLEMS, AND THE BOTTOM LINE IS THE NEED TO JUDGE THE BILL ON THE SIMPLE ISSUE OF FAIRNESS WHILE WEIGHING ITS OTHER PROBLEMS.

IN ORDER TO CONSIDER THIS BILL, WE MUST REVIEW CERTAIN PROVISIONS IN THE WORKERS' COMPENSATION ACT.

THE STATE FUND ACTS AS A STATE OPERATED ASSESSABLE MUTUAL INSURANCE COMPANY. THE INTENT OF PLAN 3 (STATE FUND) IS TO ALLOW AN EMPLOYER TO INSURE WITH A STATE OPERATED WORKERS' COMPENSATION INSURANCE SYSTEM. (39-71-2301)

THE STATUTES GIVE EXPLICIT DIRECTIONS ON HOW THE STATE FUND SHALL BE OPERATED. THE DIVISION IS GIVEN FULL POWER AND AUTHORITY TO DETERMINE PREMIUM RATES AND CLASSIFICATIONS. THE STATE FUND SHALL BE NEITHER MORE OR LESS THAN SELF SUPPORTING. SEPARATE ACCOUNTS SHALL BE KEPT OF THE AMOUNTS COLLECTED AND EXPENDED IN EACH CLASS FOR ACTUARIALLY DETERMINING RATES. THE

P.O. Box 2899 • Missoula, Montana 59806 • Phone (406) 543-7195

DIVISION SHALL DETERMINE THE HAZARDS OF THE DIFFERENT CLASSES OF OCCUPATIONS, AND FIX THE PREMIUM AT THE LOWEST RATE CONSISTENT WITH MAINTENANCE OF AN ACTUARIALLY SOUND INDUSTRIAL INSURANCE FUND, AND CREATION OF ACTUARIALLY SOUND SURPLUS AND RESERVES. THE STATE FUND SHALL USE AN EXPERIENCED RATING SYSTEM THAT SHALL REWARD EMPLOYERS WITH A BETTER THAN AVERAGE SAFETY RECORD AND PENALIZE EMPLOYERS WITH A WORSE THAN AVERAGE SAFETY RECORD. (39-71-2304)

THE MONEY IN THE INDUSTRIAL INSURANCE FUND SHALL BE HELD IN TRUST FOR THE PURPOSE FOR WHICH THE MONEY WAS COLLECTED, THAT IS, PAYMENT OF BENEFITS TO INJURED WORKERS. (39-71-2322) ANY SURPLUS CAN BE REFUNDED TO EMPLOYERS WHO HAVE PAID PREMIUMS IN TO THE INDUSTRIAL INSURANCE TRUST FUND, GIVING CONSIDERATION TO THE PRIOR PAID PREMIUMS AND ACCIDENT EXPERIENCE OF EACH INDIVIDUAL EMPLOYER DURING THE DIVIDEND YEAR. (39-71-2323)

THE STATUTES CERTAINLY HAVE GIVEN EXPLICIT INSTRUCTIONS ON HOW THE STATE FUND SHOULD HAVE BEEN OPERATED.

OF PARTICULAR INTEREST IN CONSIDERATION OF HOUSE BILL 884 IS SECTION 39-71-2326 AND I QUOTE: **"DISBURSEMENTS OUT OF INDUSTRIAL INSURANCE EXPENDABLE TRUST FUND - EMPLOYER TO PAY WARRANT IF FUNDS INSUFFICIENT.** DISBURSEMENTS OUT OF THE INDUSTRIAL INSURANCE EXPENDABLE TRUST FUND SHALL BE MADE BY THE DIVISION. IF AT ANY TIME THERE IS NOT SUFFICIENT MONEY IN THE FUND WITH

WHICH TO PAY ANY WARRANTS DRAWN THEREON, THE EMPLOYER ON ACCOUNT OF WHOSE WORKERS THE WARRANT WAS DRAWN SHALL PAY THE SAME, AND UPON HIS NEXT CONTRIBUTION TO THE FUND, HE SHALL BE CREDITED WITH THE AMOUNT SO PAID, WITH INTEREST THEREON AT THE RATE OF 6% PER ANNUM FROM THE DATE OF SUCH PAYMENT TO THE DATE UPON WHICH THE NEXT ASSESSMENT BECOMES PAYABLE; AND IF THE AMOUNT OF THE CREDIT EXCEEDS THE AMOUNT OF SUCH ASSESSMENT, HE SHALL HAVE A WARRANT UPON SUCH FUND FOR THE EXCESS; AND IF THE WARRANT IS NOT PAID FOR WANT OF FUNDS, IT SHALL BE CREDITED TO THE EMPLOYER AND BE APPLIED UPON SUCCEEDING ASSESSMENTS." THIS STATUTE WAS OBVIOUSLY ENACTED TO GUARANTEE TO THE INJURED WORKER HIS BENEFITS UNDER THE ACT. THE FINAL RESPONSIBILITY IS WITH HIS EMPLOYER. THIS STATUTE IS CLEAR AND CERTAINLY NOT SUBJECT TO INTERPRETATION. THE INABILITY OF THE FUND TO PAY CLAIMS IS NOT AN OBLIGATION OF THE STATE OF MONTANA, BUT OF THE EMPLOYER INSURED BY THE STATE FUND. NO WHERE DOES THE STATUTE PROVIDE THAT ANY EMPLOYER NOT INSURED WITH THE STATE FUND HAS ANY OBLIGATIONS TO PROVIDE FUNDS TO PAY CLAIMS INCURRED BY EMPLOYERS INSURED BY THE STATE FUND. HOUSE BILL 884 TRANSFERS THE COST FROM STATE FUND INSURED EMPLOYERS TO ALL EMPLOYERS IN MONTANA. <u>THE BILL USES THE TAXING POWER OF THE STATE TO FUND THE PRIVATE DEBT OF STATE FUND INSURED EMPLOYERS</u>.

<u>THE BILL HAS LEGAL AND CONSTITUTIONAL PROBLEMS</u>.

SOME WILL SAY THAT THE STATE OF MONTANA HAS A MORAL OBLIGATION TO EMPLOYERS INSURED UNDER PLAN 3 FOR NOT MAINTAINING AN ACCEPTABLE LEVEL OF FUNDS IN THE INDUSTRIAL INSURANCE EXPENDABLE TRUST FUND SUFFICIENT TO PAY ALL CLAIMS AND, THEREFORE, CREATING A LIABILITY FOR EMPLOYERS. A LIABILITY THEY FELT THEY HAD DISCHARGED WHEN THEY PAID THEIR PREMIUMS TO THE STATE FUND.

LET ME BRIEFLY DISCUSS THE PROBLEMS OF THE STATE FUND. IF MY MEMORY SERVES ME CORRECTLY, A FEW SHORT YEARS AGO THE STATE FUND HAD A SURPLUS IN EXCESS OF 60 MILLION DOLLARS. THE FUND PAID DIVIDENDS, NOT TO ALL MONTANA EMPLOYERS, BUT ONLY TO THOSE INSURED BY THE STATE FUND. WE NOW ARE TOLD THAT THE UNFUNDED LIABILITY OF THE STATE FUND IS APPROXIMATELY $140 MILLION. THIS IS A TURN AROUND OF $200 MILLION. THIS CREATES A MYSTERY:

1. HOW COULD THIS OCCUR IF THE STATUTE HAD BEEN COMPLIED WITH?

2. WHICH CODE CLASSIFICATIONS HAVE CREATED THE UNFUNDED LIABILITY?

3. WHY WERE PREMIUM RATES NOT ADJUSTED AS REQUIRED BY LAW?

THE LAW REQUIRES THE STATE FUND TO BE NO MORE OR NO LESS THAN SELF SUPPORTING.

I WOULD CERTAINLY AGREE THAT COURT DECISIONS INTERPRETING THE LAW IN A LIBERAL MANNER CREATED LIABILITIES THAT WERE UNEXPECTED. OUR HOPE IS THAT SENATE BILL 315 WILL CREATE THE REFORM NECESSARY TO PROVIDE A COST REDUCTION IN WORKERS' COMPENSATION CLAIMS. SELF-INSURED EMPLOYERS HAD THE SAME PROBLEM AS THE STATE FUND, WHICH WAS CAUSED BY THE LIBERAL INTERPRETATIONS. OUR SOLUTION HAD TO BE TO INCREASE THE RATES CHARGED THE INDIVIDUAL OPERATING DEPARTMENTS OF OUR COMPANIES TO COVER THE INCREASED LIABILITY. THIS DECREASED THE AVAILABLE MONEY FOR WAGES, EQUIPMENT, OR PLANT EXPANSION. JOBS THAT MAY WELL HAVE BEEN CREATED WERE LOST. THE VIABILITY OF MONTANA OPERATIONS IS STILL BEING CONSIDERED BY MANY MONTANA EMPLOYERS BECAUSE OF WORKERS' COMPENSATION COSTS.

WHAT DOES HOUSE BILL 884 SAY TO SELF-INSURED EMPLOYERS IN MONTANA? FIRST, CONSIDER OUR PAYROLL IS APPROXIMATELY $415 MILLION, MAKING OUR ANNUAL ASSESSMENT IN EXCESS OF ~~$230 MILLION.~~ $2,300,000.00 A NUMBER OF INDIVIDUAL SELF-INSURERS HAVE ANNUAL PAYROLLS IN THE $40 MILLION TO $50 MILLION RANGE. THIS MEANS AN ANNUAL ASSESSMENT IN AMOUNTS BETWEEN $225,000 AND $285,000, TO PAY WORKERS' COMPENSATION CLAIMS INCURRED BY OTHER EMPLOYERS, SOME OF WHOM ARE BUSINESS COMPETITORS.

WHAT ELSE DOES HOUSE BILL 884 SAY TO SELF-INSURED EMPLOYERS? THE BUSINESS CLIMATE IN MONTANA, AS PROVIDED IN THIS BILL, PENALIZES HIGHER WAGES AND INCREASED EMPLOYMENT IN AN AMOUNT SUFFICIENT TO DISCOURAGE LOCATION OR EXPANSION. THIS BILL WILL ALSO INCREASE THE TAXES TO ALL TAX PAYERS, INCLUDING SELF-INSURED EMPLOYERS, BECAUSE OF THE INCREASED COSTS TO SCHOOL DISTRICTS, CITIES, COUNTIES AND STATE GOVERNMENT.

SOME SPECIFIC COMMENTS ON THE FINDINGS AND PURPOSE OF HOUSE BILL 884.

"THE STATE, IN THE EXERCISE OF ITS POLICE POWER, HAS DETERMINED THAT IT IS GREATLY AND IMMEDIATELY NECESSARY TO THE PUBLIC WELFARE TO MAKE WORKERS' COMPENSATION INSURANCE AVAILABLE TO ALL EMPLOYERS THROUGH THE STATE FUND AS THE INSURER OF LAST RESORT". IT IS TRUE THAT THE STATE FUND MUST INSURE ALL EMPLOYERS WHO APPLY FOR COVERAGE. THEY DO NOT NEED TO SUBSIDIZE THE SO CALLED "BAD RISKS". IN FACT, THE STATUTES REQUIRE THE STATE FUND TO ADVANCE THE RATE. OF INTEREST IS, THAT AT NO TIME, DURING THE MEETINGS OF THE ADVISORY COUNCIL OR IN SENATE BILL 315 DID THE STATE FUND ASK TO BE RELIEVED OF ITS RESPONSIBILITY TO INSURE ALL APPLICANTS. THERE HAS BEEN NO REQUEST FOR AN ASSIGNED RISK POOL. WHY?

A PECULIAR STATEMENT: "THE BURDEN OF THIS UNFUNDED LIABILITY SHOULD NOT BE BORN SOLELY BY THOSE EMPLOYERS WHO HAVE INSURED WITH THE STATE FUND, BECAUSE THE AVAILABILITY OF INSURANCE TO ALL EMPLOYERS THROUGH THE STATE FUND HAS BENEFITED ALL EMPLOYERS WHO HAVE WORKERS' COMPENSATION COVERAGE." HOW?

AGAIN I QUOTE: "THE PURPOSE OF [THIS ACT] IS TO PROVIDE A SUPPLEMENTAL SOURCE OF FINANCING FOR THE UNFUNDED LIABILITY AND TO PROVIDE A GENERAL RATE REDUCTION FOR EMPLOYERS INSURED UNDER THE STATE FUND." WHAT KIND OF A LAW IS IT THAT CAN REQUIRE US TO PAY PART OF SOME OTHER EMPLOYER'S INSURANCE PREMIUM?

FROM THE BILL - "IN MAKING THIS INSURANCE AVAILABLE, THE STATE FUND HAS INCURRED THE UNFUNDED LIABILITY." THIS IS TRUE. THE IMPLICATION IS THAT IT IS BECAUSE THE STATE FUND IS THE INSURER IN THE WORDS OF THE BILL, "OF LAST RESORT". THIS IS UNTRUE.

I CALL YOUR ATTENTION TO SECTION 10 WHICH REPEALS 39-71-2326. THIS CERTAINLY INDICATES THAT THE AUTHORS OF THE BILL ARE AWARE OF WHO IS LIABLE FOR THE UNFUNDED LIABILITY. YOU SHOULD ALSO NOTE THAT THE REPEAL WOULD REMOVE FROM THE INJURED WORKER, HIS RIGHTS TO COLLECT BENEFITS FROM HIS EMPLOYER.

THE PROBLEMS OF THE UNFUNDED LIABILITY CLEARLY POINT OUT THAT THE FUNDS OF AN INSURANCE COMPANY COLLECTED TO PAY WORKERS' COMPENSATION BENEFITS, SHOULD NOT BE DIVERTED TO IMPLEMENT SOCIAL OR POLITICAL PHILOSOPHY.

ARE THERE ALTERNATIVES TO THE FUNDING PROVIDED IN HOUSE BILL 884? YES! EACH OF THEM WILL BE AS UNPALATABLE TO THE FUNDER AS THIS BILL IS TO US.

1. INCREASED PREMIUM RATES TO STATE FUND INSURED EMPLOYERS SUFFICIENT TO ALLOW PAYMENT OF UNFUNDED LIABILITY ON A CASH FLOW BASIS. THE UNFUNDED LIABILITY EVIDENTLY REPRESENTS PREMIUM RATE SUBSIDIES IN THE PAST.

2. A TAX ON WAGES - THE UNFUNDED LIABILITY WOULD THEN BE COLLECTED FROM THOSE WHO WOULD RECEIVE THE BENEFITS.

3. AN ASSUMPTION BY THE STATE OF WHAT MAY BE THEIR MORAL RESPONSIBILITY BY APPROPRIATING SUFFICIENT FUNDS TO OVERCOME THE REPORTED STATE FUND "CASH FLOW CRUNCH", AND MAINTENANCE OF PREMIUM RATES SUFFICIENT TO PAY LIABILITIES AS THEY BECOME DUE FROM CASH FLOW.

THE BOTTOM LINE IS TO BE JUST AND FAIR. HOUSE BILL 884 IS UNJUST AND UNFAIR AND WE RESPECTFULLY REQUEST THE BILL BE REPORTED

"DO NOT PASS".

THANK YOU.

GEORGE WOOD

EXECUTIVE SECRETARY

GW/CS

EXHIBIT 14
DATE 3-20-87
HB 884

House Bill No. 884 introduced in the Montana Legislature by Rep. Clyde Smith, R-Kalispell and others, is intended to solve the $100 million deficit at the State Workers' Compensation Insurance Fund.

This payroll tax would require that all employers in Montana pay to the State Insurance Fund 57¢ for each $100 in wages they pay to their employees over, atleast, the next seven (7) years. Of this 57¢, 50¢ will be used to retire the unfunded liability and 7¢ will be used to provide a general rate reduction to State Fund insureds.

Not only will the employers who purchase coverage from the State be required to pay this 57¢/$100 tax, but ALL other employers who purchase their insurance from a private insurance company or employers who insure themselves will be required to pay this 57¢/$100 tax.

This type of "add-on" tax proposal is blatantly unfair. It requires employers, who pay for their own insurance protection, to also subsidize the insurance consumer who purchases workers' compensation insurance from the State of Montana.

The State workers' compensation fund currently provides insurance coverage to only 47% of the payroll earned in Montana. The other 53% of payroll is insured with private insurance companies or in self insurance programs. This proposal will require that the employers who have no insurance with the State, employers who have not contributed to the problems at the State, employers who will receive no benefit from the State to pay the largest burden of the deficit created.

This proposal will provide an additional $23 million each year for the next seven years, atleast, to the State Fund to spend as they see fit. One should question whether this makes sense when looking into their past history. In 1979 when the State Fund had a net operating loss of $1.2 million, they paid a dividend to policyholders

that totalled $6.6 million. This created an overall loss for that year of atleast $7.8 million. In 1980, their net operating loss for that year was $4.2 million and they paid a $3.8 million dividend, resulting in a net overall loss of $8.0 million. In 1981 and 1982, they also paid dividends in years they had net operating losses.

This proposal will not require the State Insurance Fund to conduct their operations in a self sufficient manner. The State Fund is a state operated insurance company, a special trust of the State of Montana created in 1915. It was created in a manner to allow the State to provide insurance protection to employers who didn't want to self insure themselves for insurance purposes and employers who did not want to purchase insurance from a private insurance company. When the State Fund was created, Section 39-71-2326 R.C.M. addressed the solution to a financial shortfall, a shortfall that may occur in the near future. This section of the Montana laws require that the employers' who purchase insurance from the State Fund be responsible if the State Fund is unable to pay the outstanding bills. HB 884 will repeal this section of the law.

This proposal will allow the State Fund to continue to charge a rate for insurance that is less than adequate to meet the current obligations. This proposal will require that parties not insured by the State Fund contribute to the State Fund in the future. This proposal may well eliminate most private insurance companies and self-insured programs in Montana. It will create a State Fund monopoly in the workers' compensation insurance field.

Also of significant importance, this 57¢ per $100 of payroll tax will mean a tremendous increase to the employers, who in the past, have shown the most concern for the safety of their workers. It will severely penalize the low risk concern at the expense of the high risk concern. The following is a sample breakdown of the increases in premium that certain groups of employers' should expect to receive if this bill passes:

	State Fund Rate	With/57¢	Percentage Increase
School Teachers	.33	.90	172.7%
Clerical Office workers	.39	.96	146.2%
Retail Store Workers	1.19	1.76	47.9%
Clothing Store Workers	.98	1.55	58.2%
Accountants	.84	1.41	67.9%
Newspapers	1.93	2.50	29.5%
Hospital Nurses	1.97	2.54	28.9%
Loggers	34.39	34.96	1.5%
Sawmill workers	28.18	28.75	2.0%
Restaurants or Bars	3.86	4.43	14.8%

A flat payroll tax is a tremendous advantage to risks that have a high frequency of injury and a high severity type of injury. For instance, the rate of school teachers is $.33 per $100 of payroll while the logging rate is $34.39 per $100; or the logging rate is 104 times greater than the teachers rate. The teachers don't suffer as many injuries, nor are they as severe. Now to make the teachers pay the same 57¢ as the loggers to retire this deficit and provide for a general rate reduction is incorrect, since the rate charged is always in direct proportion to the risk assumed.

Where will the local school districts be able to come up with the monies required to pay off this additional burden on their already tight budget? Where will the cities and counties of this State find the additional monies needed? The only alternative is to increase the property taxes that all Montanan's must pay. This additional burden will be a problem for the private business that is fighting to survive in Montana. This will be a hinderance to new business that wants to come into Montana since they will know that they too will be required to pay off a debt that they were not a party too.

It certainly is a problem when the State operated insurance company is $100 million in the red, but they should be required to solve their own financial problems by increasing the rate charged to their insureds, proportionately, based on accident exposure. That is what an insurance company is supposed to do and they are supposed to be an insurance company.

3-26-87
HB 884

TESTIMONY IN OPPOSITION TO HB 884

by

William E. Leary, Special Consultant
Montana Hospital Association

Representing the 55 licensed MHA member hospitals.

Many of the hospital have gone the self-insured route while the county-owned and district hospitals have no choice - as governmental units, they have been told they must be under the state fund.

Conservatively, adoption of HB 884 would cost Montana hospitals

1987	-	$865,000
1988	-	$882,000
1989	-	$900,000

Montana hospitals have already given in 1987 - $5.7 million in Medicaid discounts and we will have our reimbursement frozen for two years.

SB 315 has the potential to mandate that the division set hospital rates and then freeze those rates for two years - thus the hospital industry, which only had a 3.7 percent gain from operations and which already has collectively low costs and low charges, will be further penalized.

Hospitals have spent considerable money and time to establish effective safety and educational programs to keep our industrial accidents to a minimum. Now to ask this front line health care industry which must legally and morally treat the injured worker, to pay this new employers' tax is adding insult to injury.

I suggest tnat if HB 884 is given any serious consideration that it be changed to an "employee" tax wherein all employees would have 57¢ per $100 deducted from their salaries each pay period to be remitted to the state by the employer, much as we all do for state withholding taxes.

It would have to be clear that since this "employee" tax is state policy, it cannot and would not be an issue in negotiations in any collective bargaining contracts.

It might just be the vehicle whereby the "employee" tax would provide the incentive needed to encourage all "employees" to be very conscious of safety on the job.

VISITORS' REGISTER

BUSINESS AND LABOR COMMITTEE

BILL NO. HJR 46 DATE MARCH 20, 1987

SPONSOR REP. RAY BRANDEWIE

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Ronna Alexander	Mont. Petroleum Marketers	X	
Pam Langley	Montana Agri Business Assn.	X	
JOHN CADBY	MT BANKERS ASSN	X	
Joe Thaler	MT IND. BANKERS ASSN	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

BUSINESS AND LABOR COMMITTEE

BILL NO. SENATE BILL NO. 353 DATE MARCH 20, 1987

SPONSOR SENATOR DARRYL MEYER

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
[illegible]	[illegible]	✓	
Pat Callbeck Harper	MT Psychological Assoc	✓	
Judith H Carlson	Mt Ch - NASW		
Bill McDonald	Group Health Plan Mont	✓	
Steve Waldron	Mental Health Centers	X	
Dennis Duncan	Montana Medical Assoc.	✓	
JAMES W. BORCHARDT	STATE AUDITOR	✓	
MT Optometric Assoc	Mt Optometric Assoc	✓	
Jay McGrath	Mental Health Assoc	X	
William Evans	Montana NASW	X	
Mike Murray	Chemical Dependency Programs of MT.	X	
Steve Brown	Blue Cross-Blue Sh.	✓	
Ted J. Doney	Mt. Mental Health Counselors Assn	✓	
Joan Kelich	Mt. Mental Health Couns.	✓	
Myrna Jamison	LMTC	✓	
Ann Scott	RMTC	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

VISITORS' REGISTER

BUSINESS AND LABOR COMMITTEE

BILL NO. SENATE BILL NO. 371 DATE MARCH 20, 1987

SPONSOR SENATOR PAT REGAN

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Jerome Loveridge	Mt. Retired Am	✓	
Pat Callbeck Harper	MT Psychological Assoc	✓	
Steve Waldron	Mental Health Centers	X	
Tom Hopgood	Health Ins. Assoc of Amer	X	
Bill LEARY	MT. Hosp. Assn	X	
Roland Pratt	MT Hospital Assoc	X	
Jay McGrath	Mental Health Assoc	X	
Ted J Dorey	MT Mental Health Counselors Assn.	✓	
Joan Kelleth	MT Mental Health Counc	✓	
Don Scott	Rocky Mtn Treatment Center	✓	
Mike Murray	Chemical Dependency Programs of MT	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

BUSINESS AND LABOR COMMITTEE

BILL NO. HOUSE BILL NO. 884 DATE MARCH 20, 1987

SPONSOR REP. CLYDE SMITH

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
BOB HELDING	Mt. Motor Carriers Assoc	✓	
Dan Glenny	Orion Group Inc		X
Brookes Morin	City of Helena		X
Ray Conger	Montana C&R Comm.		X
Bill McIlvers	American Insurance Assn.		X
Ron Jenkins	Golden Sunlight Mines		X
A.C. Bunning	self		X
Lorna Frank	Mt. Farm Bureau		X
Roger McGlenn	Independent Ins. Agents Assoc. of MT		X
Mous Teigen	Mt Stockgrowers Assn		X
Mike Lavin	WETA		X
Ted Rollins	ASARCO INC.		X
Jerry Wood	Mt. Self Insurers Assn		X
Gordon Morris	MAE		X
Bruce D MacKenzie	~~D.A. Davidson & Co~~ DADCO Incorporated		X
Brian Gallagher	Montana Building Industries Assn	X	
Joe Ricci	Montana Loggers	X	
Bill Leary	MT Hosp. Assoc		X
Karla Stay	MPC/Entech		X

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

BUSINESS AND LABOR COMMITTEE

BILL NO. HOUSE BILL NO. 884 DATE MARCH 20, 1987

SPONSOR REP. CLYDE SMITH

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Riley Johnson	Mont. Home Builders, NFIB		X
Keith Olson	MT. Logging Assn	✓	
Rose Skoog	MT. Health Care Assn		X
George Allen	MT. Retail Assn		X
Bob Correa	Boz. Chamber Comm		X
[illegible]	Mont. Cont. Assoc		X
[illegible] Scott	EMTC		X
Carol Mosher	Montana Cattle Women		X
GENE PHILLIPS	PP&L		X
Jon Alke	Mt. Wood Products Assn		X
[illegible]	Montana Mining Assn		✓
JAMES T. MULAR	BRAC (AIRLINE DIVISION)	✓	
[illegible]	Mt Bldg Trades	✓	
Gene [illegible]	MDU Resources		✓
John Alke	MDU		X

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

MEETING MINUTES
WORKERS COMPENSATION SUBCOMMITTEE
MARCH 25, 1987

The meeting of the Workers' Compensation Subcommittee was called to order at 9:08 a.m. on March 25, 1987 in room 202a of the state capitol building by Chairman Bill Glaser.

All committee members were present.

SENATE BILL 315

EXECUTIVE ACTION

(7a:250) Betsy Griffing, staff attorney, Legislative Council, covered the proposed amendments list (exhibit 1) and described some of the major points. These points included the retroactive changes for mediation, proposed amendments numbers 58, 59, and 60, and clarification language in proposed amendment 18. Ms Griffing also addressed proposed amendments 35, 39, 6 and 11. She noted the rest of the proposed amendments were clerical and technical changes.

(7a:530) Ms Griffing then presented the history behind proposed amendment number 22. She stated the original bill stated 30 days, and in processing this was dropped and 10 days inserted. The proposed amendment would reinstate 30 days, as originally intended in the legislation.

In response to a question from Chairman Glaser, Ms Griffing stated the department was concerned about having sufficient time for mailing. Chairman Glaser expressed his concern that the division make every effort they can to make sure these people are taken care of as quickly as possible so that a situation isn't created where individuals think an attorney is needed to get prompt service from the division. He stated the division should recognize that the 30 day factor is the outside time limit, not the target number of days.

Ms Griffing stated that 20 days would be the minimum amount of time needed for processing.

(7a:632) Rep Driscoll stated the proposed amendment, number 11, was meaningless. He said "new hires" or "recently hired employees" should be inserted.

Rep Smith expressed his concern about having to fire an employee in order to rehire an injured worker. Rep Driscoll

stated that this was the intent, if the injured worker was able to return to work, a preference for that injured worker. He said that was the intent of the original study commission language. Rep Smith stated this was not his understanding of this issue, but that the injured worker would return to work if there was a vacant position available.

Bob Robinson, administrator of the Workers' Compensation Division (WCD), stated he recalled the WCAC discussion on this issue on whether the injured worker would bump people or have a preference over other new hires, and that the language was not precise; and that the new hire language was exactly what was in the advisory council recommendations; but he said it was his recollection and the understanding of the division and the department that it meant a preference over other new applicants, not a layoff of someone on the job in order to accommodate a former injured worker. Rep Smith concurred with this interpretation.

In response to a question from Rep Smith, Norm Grosfield, _____, stated his opinion was that the legislation's intent was that an injured worker, returning to work, would be able to "bump" an individual already hired. He stated he didn't believe that an individual could be given preference over someone already hired.

(7b:065) Ms Griffing then clarified the intent of proposed amendments 52, 53 and 54.

(7b:120) In response to an inquiry from Rep Smith, Norm Grosfield and Bob Robinson both agreed with the amendment, and that this language provided better clarification.

(7b:134) Ms Griffing stated proposed amendments numbers 60 and 61 came out of the legislative council over a concern for the intent for retroactive legislation and the need to express it in the legislation. Mr Robinson clarified that the retroactive provision applies only to accidents and the resolution of disputes and that it did not affect benefits by reducing or expanding them.

(7b:266) Rep Driscoll noted that the mediation process is mandated in the legislation for workers who have been injured prior to the passage of this bill; that the worker does not have an option.

(7b:309) Mr Grosfield commented on proposed amendment number 46, and stated he felt it expands and allows the insurer much greater discretion on deciding termination of benefits if the insurer believes that the claimant is not abiding by rehab. The insurer could unilaterally, on its

own, make that determination as opposed to the current system where it is the provider that decides that issue.

Ms Griffing presented a brief description of this part of the legislation and noted the inconsistencies of "rehabilitation services" on page 69 line 23, and "rehabilitation provider" on page 70 line 1. She noted the council was concerned with consistency between these two lines.

Mr Robinson referred to page 57 line 9 defining rehabilitation provider and line 14 defining rehabilitation services. He stated non cooperation with a rehabilitation provider means you are not cooperating with some insurance companies counselor. He said the intent was that the individual was not cooperating with the Rehabilitation program, i.e. an individual in school not going to classes. He said there should be some impetus in the legislation to force that individual to participate and progress with the program and service as defined on page 57 line 6. He stated this was an oversight and should have been picked up earlier. He said it was intended that the individual cooperate and progress with the services that were being provided. He stated if they do not progress and cooperate with the provider, that happens way before they have the rehabilitation panel.

Mr Grosfield stated it was his understanding that the greatest problem as raised by rehab people was that the injured workers would not cooperate with the person making the decision, the professional in the field that is making the decisions. That is why , he said, he thought this dealt with non cooperation of providers as opposed to a very general genetic term regarding services. He said that that didn't mean that if someone isn't following what the provider says, the provider can't go and say they are not cooperating and following the directions they were given. He added by leaving provider in the legislation there is still sufficient protection to the insurer or the division and yet it doesn't give the insurance carrier unbridled authority to decide on its own whether a person is cooperating or not.

Mr Robinson stated the bottom line was that the committee needed to determine who was the provider. By the definition the provider is the rehab counselor employed by the insurer and what Mr Grosfield said was correct, it aught to be someone who is making the determination that the claimant is not cooperating or progressing, who is not the provider. The provider is out of the picture by the time the claimant is progressing, it is the service person who is dealing with the claimant at this point. If the claimant does not cooperate with the provider, SRS or the panel, there are no teeth.

Driscoll: It's his money, it comes off his 500 weeks.

Robinson: You can't get it off.

Driscoll: Its coming off his 500 weeks.

Robinson: So he stays on temporary total benefits for 500 weeks.

Driscoll: That is the intent - help the injured worker - give him 500 weeks -

Robinson: If he is progressing

(7b:450) Rep Driscoll stated the intent of the bill was to give the injured worker 500 weeks benefits and charge it off to his rehabilitation. He said now permanent partial benefits come off his 500 weeks, where it didn't under the old law, it was in addition to his permanent partial. Now the individual is taking his rehabilitation under his 500 weeks. Bob Robinson stated the program would be administered so that only half of the rehabilitation would be taken off the individual's 500 weeks.

Proposed Amendment Number 46

Rep Driscoll made a motion to change line 23 page 69, deleting "services" and inserting "provider".

A voice vote was taken and the motion PASSED unanimously.

Proposed Amendments Numbers 1, 3-10, 12-21, 23-45, 47-58

(7b:655) Rep Grinde made a motion to accept proposed amendments numbers 1, 3-10, 12-21, 23-58.

A voice vote was taken and the motion PASSED unanimously.

Proposed Amendments Numbers 2, 59, 60, and 61

Rep Driscoll made a motion to amend appropriate language in the bill stating that a worker "may use" the mediation process in retroactive cases.

A roll call vote was taken and the motion FAILED, with Rep Driscoll and Rep Nisbet voting yes, Rep Glaser, Rep Grinde, and Rep Smith voting no.

The committee noted that the following votes should be recorded for accepting proposed amendments numbers 2, 59, 60, and 61: Rep Driscoll and Rep Nisbet voting no, Rep Glaser, Rep Grinde, and Rep Smith voting yes.

Proposed Amendment Number 11

(8a:023) Rep Driscoll made a motion to not accept proposed amendment number 11.

(8a:074) Rep Nisbet made a substitute motion to amend page 34 by striking on line 14 "new hires", insert "other applicants"; line 15 strike (:); line 16 strike "(a)", line 17 strike (;) and, insert (.); strike lines 18 and 19 in their entirety; line 11 strike if, insert when; on line 15 after "vacant" strike within such 2 year period.

(8a:251) Ms Griffing read the amendment as proposed in Rep Nisbet's substitute motion: (2) When an injured worker is capable of returning to work within two (2) years from the date of injury and has received a medical release to return to work, the worker must be given a preference over other applicants for a comparable position that becomes vacant if the position is consistent with the worker's physical condition and vocational abilities.

A voice vote was taken and the motion PASSED unanimously.

Proposed Amendment Number 22

Rep Smith made a motion to to accept proposed amendment number 22, page 39, line 23, striking "10" and inserting "30".

A voice vote was taken and the motion PASSED, with Rep Driscoll voting no.

(8a:387) Rep Smith made a motion to reject three (3) proposed amendments submitted by Chiropractors, Hospital Association and from Plan Two (2).

There was general consensus and agreement to accept the motion.

Rep Driscoll made a motion to amend page 46 line 17, strike "500 weeks", insert "life".

A roll call vote was taken and the motion FAILED, with Rep Glaser, Rep Grinde, and Rep Smith voting no, Rep Driscoll and Rep Nisbet voting yes.

Rep Driscoll made a motion to amend page 55, strike lines 4 through 10; line 3 insert after advance: but may not charge interest.

A roll call vote was taken and the motion FAILED, with Rep Driscoll and Rep Nisbet voting yes, Rep Glaser, Rep Grinde, and Rep Smith voting no.

(8a:535) Rep Driscoll made a motion to amend HB 884 in its entirety into SB 315.

A voice vote was taken and the motion FAILED, with Rep Driscoll and Rep Nisbet voting yes, Rep Glaser, Rep Grinde, and Rep Smith voting no.

The meeting was adjourned at 10:52 a.m. (8a:604)

_____

Bill Glaser, Chairman

bg/gmc/3.25 DRAFT

DAILY ROLL CALL

WORKERS COMPENSATION SUBCOMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date March 25, 1987

NAME	PRESENT	ABSENT	EXCUSED
Rep William Glaser	X		
Rep Jerry Driscoll	X		
Rep Larry Grinde	X		
Rep Jerry Nisbet	X		
Rep Clyde Smith	X		

ROLL CALL VOTE

WORKERS COMPENSATION SUBCOMMITTEE

DATE March 25, 1987 AGENCY SB 315 NUMBER 1

NAME	AYE	NAY
Rep William Glaser		xxx
Rep Jerry Driscoll	xxx	
Rep Larry Grinde		xxx
Rep Jerry Nisbet	xxx	
Rep Clyde Smith		xxx
TALLY	2	3

Secretary Chairman

Motion: Proposed Amendments Numbers 2, 59, 60 and 61

Rep Driscoll made a motion to amend appropriate language in the bill stating that a worker "may use" the mediation process in retroactive cases.

Form CS-31A
Rev. 1985

ROLL CALL VOTE

WORKERS COMPENSATION SUBCOMMITTEE

DATE March 25, 1987 AGENCY SB 315 NUMBER 2

NAME	AYE	NAY
Rep William Glaser		xxx
Rep Jerry Driscoll	xxx	
Rep Larry Grinde		xxx
Rep Jerry Nisbet	xxx	
Rep Clyde Smith		xxx
TALLY	2	3

Secretary Chairman

Motion: Rep Driscoll made a motion to amend page 46, line 17, strike "500 weeks", insert "life".

Form CS-31A
Rev. 1985

ROLL CALL VOTE

WORKERS COMPENSATION SUBCOMMITTEE

DATE March 25, 1987 AGENCY SB 315 NUMBER 3

NAME	AYE	NAY
Rep William Glaser		xxx
Rep Jerry Driscoll	xxx	
Rep Larry Grinde		xxx
Rep Jerry Nisbet	xxx	
Rep Clyde Smith		xxx

TALLY 2 3

Secretary Chairman

Motion: Rep Driscoll made a motion to amend page 55, strike lines 4 through 10; line 3 insert after "advance": "but may not charge interest".

Form CS-31A
Rev. 1985

EXHIBIT 1
DATE 3-25-87
HB

Amendments to Senate Bill 315
Third reading copy (blue)
House Labor Subcommittee

1. Title, line 17.
Following: "39-71-122,"
Insert: "39-71-309,"

2. Title, line 20.
Following: "MCA;"
Insert: "MAKING CERTAIN PROVISIONS RETROACTIVE;"

3. Page 11, line 25.
Strike: "or"
Insert: ","
Following: "lodging"
Insert: ", rent, or housing"

4. Page 12, line 1.
Strike: ","
Insert: "and is"
Following: "on"
Strike: "the"
Insert: "its"
Strike: "of the" on line 1 through "housing" on line 2

5. Page 14, line 20.
Strike: "-- criminal penalty"

6. Page 15, line 7.
Following: "72"
Insert: ",other than the disputes described in subsection (2),"

7. Page 16, lines 7 and 8.
Strike: "A" on line 7 through "A" on line 8
Insert: "Upon motion of a party, the"

8. Page 16, line 9.
Strike: "the"
Insert: "either"

9. Page 16, line 13.
Strike: "(6)"
Insert: "(d)

10. Page 32, line 3.
Strike: "39-71-61"
Insert: "39-71-611"

11. Page 32, line 14.
Strike: " new hires"
Insert: "other applicants"

Exhibit 3/25/87

12. Page 32, line 18.
Following: "equally"
Insert: "as"

13. Page 33, line 4.
Strike: "injuries producing"

14. Page 35.
Following: line 16
Insert: "on"

15. Page 35, line 17.
Following: "more"
Strike: "that"
Insert: "than"

16. Page 36, line 4.
Strike: "injuries causing"
Insert: "permanent"

17. Page 36, line 5.
Following: "disability"
Insert: "-- impairment awards and wage supplements"

18. Page 36.
Following: line 15
Insert: "The benefits available for permanent partial disability are impairment awards and wage supplements."

19. Page 38, line 20.
Strike: "subsections"
Insert: "subsection"
Strike: "and (2)"

20. Page 39, line 14.
Following: "request of"
Strike: "he"
Insert: "the"

21. Page 39, line 15.
Following: "direct"
Strike: "a"
Insert: "the"

22. Page 39, line 23.
Strike: "10"
Insert: "30"

23. Page 40, line 25.
Strike: "a workers'"
Insert: "the"

24. Page 41, line 1.
Following: "subsection"

Strike: "(3)(b)(ii) or (3)(b)(iii)"
Insert: "(3)(b)(i) or (3)(b)(ii)"

25. Page 41, line 4.
Following: "subsection"
Strike: "(3)(b)(iii)"
Insert: "(3)(b)(ii)"

26. Page 41, line 14.
Following: "services"
Insert: "-- fee schedules and hospital rates"

27. Page 42, line 20.
Following: "January"
Insert: "1,"

28. Page 43, line 2.
Following: "January"
Insert: "1,"

29. Page 44, line 7.
Following: "total"
Insert: "disability"

30. Page 45, line 20.
Strike: "39-71-116"

31. Page 46, line 4.
Following: "and"
Strike: "39-71-116"

32. Page 46, line 8.
Following: "wage"
Insert: "at the time of injury"

33. Page 46, line 22.
Following: "through"
Strike: "39-71-116"

34. Page 49, line 2.
Strike: "and"
Insert: ","

35. Page 49, line 3.
Following: "payments"
Insert: ", and lump-sum advance payments"

36. Page 52, line 16.
Following: "agree"
Insert: "to a settlement"

37. Page 53, line 16.
Strike: "worker's"
Insert: "workers'"

38. Page 53, line 19.
Strike: "RELEASES"
Insert: "RELEASE"

39. Page 54, lines 11, 15, and 16.
Following: "lump-sum" (the second "lump-sum" on line 11)
Insert: "advance"

40. Page 54, line 25.
Strike: "accident"
Insert: "injury"

41. Page 55, line 2.
Strike: "accident"
Insert: "injury"

42. Page 66, line 3.
Strike: "services"
Insert: "appeals"

43. Page 67, line 15.
Strike: "nd"
Insert: "and"

44. Page 68, line 13.
Following: "a"
Insert: "total of"
Following: "$4,000"
Strike: "total"

45. Page 69, line 11.
Strike: "and"
Insert: "but"

46. Page 70, line 1.
Strike: "provider"
Insert: "services"

47. Page 70.
Following: line 24
Insert: "rehabilitation"
Strike: "under this part"

48. Page 72, line 8.
Following: "security"
Insert: ", in addition to the security described in subsection (1)"

49. Page 72, line 13.
Following: "security"
Insert: "provided for in subsection (2)"

50. Page 80, line 24.
Strike: "-- limitation"

EXHIBIT 1
3-25-87

51. Page 82, line 2.
Following: "or"
Insert: "by"

52. Page 83, line 16.
Strike: "as defined in"
Insert: ", damage, or death as set forth in"

53. Page 83, line 17.
Strike: "but which"
Insert: "and"

54. Page 83, line 18.
Strike: "is"

55. Page 84, line 5.
Strike: "(SiO SB2"
Insert: "(SiO)"

56. Page 86, line 9.
Strike: "and"
Insert: "or"

57. Page 91, line 19.
Following: "39-71-122,"
Insert: "39-71-309,"

58. Page 92.
Following: line 7.
Insert: "(2) Sections 8, and 52 through 57 are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to sections 8, and 52 through 57."

Renumber: subsequent subsections

59. Page 93, lines 9 and 11.
Strike: "The" on line 9 through "disputes" on line 11
Insert: "Sections 8, and 52 through 57"
Following: "apply"
Insert: "retroactively, within the meaning of 1-2-109,"

60. Page 63, line 12.
Following: "occurrence."
Insert: "With respect to rehabilitation disputes, sections 8, and 52 through 57 apply retroactively, within the meaning of 1-2-109, unless the division had jurisdiction over the dispute under the law in effect at the time of injury."

61. Page 63, lines 13 though 20.
Strike: subsection (2) in its entirety

Renumber: subsequent subsection