MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on January 30, 1991, at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

HEARING ON HB 326

Presentation and Opening Statement by Sponsor:

REP. FRED THOMAS, House District 62, Stevensville, stated that this is a general provision concerning duties of the veterans burial supervisor. **EXHIBIT 1**

Proponents' Testimony:

Bill Stefani, Veterans Burial Supervisor, Ravalli County, stated that this bill will clarify three points: the current law does not authorize a coast guard person, who serves during war time under the navy, to receive the veteran burial compensation of

$250; the current law states that the veterans burial supervisor shall decently inter the body of any veteran who was a resident of the state. If a veteran dies, the supervisor gets the body and buries it. The bill doesn't say anything about conferring with the next of kin or any other person prior to doing something; the current law says it shall also be the duty of the clerk, upon receiving the report of the burial of the veterans, to make application to the proper United States authorities for a suitable headstone to be placed on the grave. There are many people who do not desire to have a veterans headstone put on their departed loved one's grave.

Rich Brown, Administrator, Montana Veterans Affairs, submitted written testimony. **EXHIBIT 2**

Opponents' Testimony: None

Questions From Committee Members:

REP. JOHNSON asked **REP. THOMAS** if he agreed with the amendments that **Mr. Brown** had submitted. **REP. THOMAS** said yes.

Closing by Sponsor:

REP. THOMAS stated that the concept of the bill is to change the intent of the law to require the Burial Supervisor to work with the family instead of doing this on his own.

HEARING ON HB 341

Presentation and Opening Statement by Sponsor:

REP. DOROTHY BRADLEY, House District 79, Bozeman, stated that this bill allows Physical Therapists (PTs) to apply topical medication when prescribed for certain treatments by a physician. This change is needed because it was thought that the use of topical medications was in violation of the Pharmacy and Nurses Practices Act. The PTs decided the law should be clarified by an amendment in the Physical Therapy Practices Act. The act involves use of a topical medication, which is a medication applied on top of the skin as opposed to an injection, to enhance the treatment, i.e. using electrical currents which is called iontophoresis and a second using ultrasound called phonophoresis. The language states that this medication must be prescribed by a medical practitioner and must be purchased from a pharmacy. This will involve the doctor who prescribed the medication and the dosage; the therapist who provides the treatment; and the pharmacist who sells the product. This is efficient and clearly safe for the consumer.

Proponents' Testimony:

Lorin Wright, President, Chapter of the American Physical Therapy Association, submitted written testimony. **EXHIBIT 3**

Aimee V. Hachigian, Orthopedic Surgeon, stated that PTs are trained in practical use and trained in the cause of risks and complications from drug side effects. PTs are trained to know the direct protocols and when to use and stop the application. By virtue of their education, they actually have more training than physicians do in the use and application of medications. Given the way that they change drugs today, topicort is a gel form of a topical steroid as applied with a steroid machine.

Carrie Gajdosik, Physical Therapist, submitted written testimony. **EXHIBIT 4**

REP. WILBUR SPRING, submitted written testimony from a constituent. **EXHIBIT 5**

Jerry Loendorf, Montana Medical Association stated that PTs are well educated and trained to administer topical medications in the manner indicated in the bill.

Mona Jamison, Montana Chapter of the American Physical Therapy Association, referred to the amendment on page 6, line 5 of the bill. After discussing the issue with the massage therapists (MTs), they would propose and defer to the drafter for the exact wording that would read "physiotherapy for a massage therapist to the extent they do massage". There is no intent in this language to prevent a MT from doing a massage. So to the extent that massage therapy and the practice of PT overlap the proposed language makes it clear that a MT can still do massage and not be in violation of the PT act. She submitted another amendment. **EXHIBIT 6**

Gary Luson, Physical Therapist, submitted written testimony. **EXHIBIT 7**

Paige Asten, American Massage Therapy Association, Montana Chapter, stated that the MTs opposed this bill until Ms. Jamison. added the amendments. They support the bill with the new amendments.

<u>Opponents' Testimony</u>:

Roger Tippy, Montana State Pharmaceutical Association, stated that he disagrees with the language in section 2, subsection 3, page 5. The concept is that a PT would purchase both the quantities of some of the topical medications and would administer them on commanding borders of the physician who has written an overall prescription to the pharmacy so they can make up a large quantity of the medication. This does not fit within the scope of prescribing drugs. The administrative rules of the Board of Pharmacy state what a prescription shall include. The federal government requires the states to have standards in the areas of date of issuance, name and address of patient, strength, dosage, form and quantity of the drug being prescribed for that patient, number of pills authorized if applicable, and any

directions for use by the patient are all very particularized. The bill calls for protocols to take the place of this type of information which is required to be on the prescription. They disagree with this because in section 2, subsection 3, it cuts the pharmacist out of the important aspect of their practices. Patient counseling, at the time of dispensing the drug will now be mandatory for Medicaid patients. For these reasons, it seems the bill should be amended to specify that the patient continue to pick up the medication dosage prescribed to that individual dosage and take it to the PTs office to be administered by the PT.

Questions From Committee Members:

REP. TUNBY asked what is the difference between PTs or nurses explaining the medicine. **Mr. Tippy** stated that the Board of Pharmacy's regulations contemplates that any facility where there is a pharmacist on staff and available for consultation, the nursing staff does not have to bring the pharmacist in at any time to administer.

REP. KASTEN asked if there is need for another amendment. **Ms. Jamison** stated that the PT would be willing to work with the pharmacists to see if there is something that could be done to ease their concerns. This practice has been going on for years, not only in this state but nationally. The reason is that the PTs are trained in the application of those topical medications. When this practice was raised by the Board of Pharmacy, we decided to come in with this bill. We would welcome amendments saying how we could still facilitate the treatment by having a standing order by the doctor so the PTs know that a medication was gotten legally. Being able to know that it cannot be applied until the patient comes in with the prescription would indicate how much is necessary and how it is to be applied.

REP. BOHARSKI asked what section 4 of the bill meant. **REP. BRADLEY** stated that that was cleanup language. There was some concern from the MTs that they were eliminated in that language. Their training is entirely different from PTs so the amendment was add MTs to the extent they practice their massage. **Ms. Jamison** stated that Title 37 of the Code contains all of the professional and occupational licensing statutes for all of the professions and occupations in Montana. Most of the statutes have a section called "exemptions" which in this case says that by virtue of licensing PTs the legislature is not intending to limit the other professions. It is a legislative statement that those practices overlap and where the professions overlap the Legislature is exempting MTs from the licensing of PTs under this particular act. The amendment says an MT, to the extent they do massage, need not get a license to practice physical therapy.

Closing by Sponsor:

REP. BRADLEY stated that she feels she is not only representing

the concerns of the PTs, but the consumers as well. There is a very difficult Medicaid rule that states have to abide by. There are some problems with Medicaid patients. One is a that these people are on very strict budgets and there is question as to whether they have the ability and time to make the extra trip to pick up the medication that they need. Will the public fill and pay to buy the whole quantity at the pharmacy when a smaller amount may have been used by the PTs. With regard to consulting with a pharmacist, this patient will have already consulted in detail with a physician in order to be pursuing the treatment. Finally, section 3 on protocols, lines 20 thru 22 requires that rules be adopted. They will be adopted in conjunction with the Board of Pharmacy and will concern procedure, techniques, actions, and contradictions. She would have real reluctance amending anything that deals with the standard basis.

HEARING ON HB 355

Presentation and Opening Statement by Sponsor:

REP. MARK O'KEEFE, House District 45, Helena, stated that there are problems with employees who are chemically dependent in industries. This bill is for individuals in the communities who need treatment. Chemical dependency is a disease of physiological and psychological dependence that a person has developed on a drug. This bill involves policy questions of should insurance rates be mandated now so that later there is a chance that rates will come down. The need for medical services for associated illnesses and disease such as alcoholism are so high that by allowing people who want to go for treatment now, there is a chance we can reduce the cost to industry later. **REP. O'KEEFE** submitted written testimony. **EXHIBIT 8**

Proponents' Testimony:

John Shontz, Mental Health Association, submitted written testimony. **EXHIBIT 9**

Larry Fasbender, Chemical Dependency Programs in Montana, stated that the fiscal note was originally drafted and submitted to the sponsor. They recognized that it was attributing some huge costs to mental health care for inpatient purposes. This bill does not, in any way, effective to address those costs. Once you take out the mental health costs you will notice that the mandated benefits that are being put into this particular legislation actually have a fairly insignificant cost increase. This was never our intent, as far as doubling the rates, the amount for a minor or the amount for an adult is something that can be compounded. The last section of this bill addresses the question of whether or not an insurer can deny treatment by specifying the type of treatment. The committee can come up with some different language to make it clear what that section does. Once these programs have gone through the process of being approved by the State of Montana, it is not necessary to repeat that by having

health care providers go back in and reexamine those programs to see whether is appropriate treatment.

Anne Bellwood, Director, Rocky Mountain Treatment Center, Great Falls, stated that in 1989, the largest insurer in the state, Blue Cross Blue Shield (BCBS), spent $1,655,000 on inpatient and outpatient chemical dependency. It costs 3.25 cents per day per covered individual. The cost for chemical dependency total payout for BCBS has only risen 4.25 cents per day. Considering that chemical dependency/alcoholism is the single most costly contributor to health care problems, the amount of money we are spending on chemical dependency is a disgrace. It costs this country billions of dollars every year for our chemical dependency and alcoholism problems. These problems contribute largely to prison problems, job productivity, child abuse, and incest. These are all problems caused by chemical dependency and yet the state only spends 3.25 cents per individual. If by doubling these benefits that would double the cost, it would cost an additional $10 per year per covered individual. Compare that to $9 a month for dental care; it is clear why we need these mandated benefits. She submitted written testimony. **EXHIBIT 10**

David Cunningham, Rimrock Foundation, submitted written testimony. **EXHIBIT 11**

Mona Jamison, Rocky Mountain Treatment Center, stated that the next worst thing to no insurance is inadequate insurance. Over 50% of the people incarcerated, are in prison as the result of their crimes of alcoholism and an addiction to other chemicals. The issue is when do we pay, now or later. Cover these people who need this assistance. The state will pay in the prison, jails, and later through insurance. The state must deal with liver disease and other diseases where the treatment is far more expensive then dealing with it in the beginning. As a statement of public policy, mandated benefits are law in the State of Montana today. The issue is whether or not this increase is justified. To provide adequate services, these increases are justified.

<u>Opponents' Testimony</u>:

Tom Schneider, Montana Public Employees Association (MPEA), stated that self insured groups are currently not covered by state law. Self insured groups do not have mandated benefits, but after the passage of this type of benefit last session, we were put through an intense lobbying effort. MPEA was told it had to do it because the Legislature passed it for everybody else--how could the state employees not have the same thing everybody else had. If you pass this bill, MPEA will have provided mandated benefits like those who are covered by law. That will double our cost again. Mandated benefits are wonderful, except they don't leave the people who have to design health insurance programs any latitude. Other benefits are denied in order to provide the mandated benefits. If the

mandated benefits are raised, then they have to increase the premiums, to do away with another benefit, or increase the deductibles. The state health insurance program has run out of money. It needs $58 per person per month for the next biennium. Anything less than that, will be taken out of coverage for the people covered by that program. If you combine not giving us that money with mandating additional cost for benefits, we are going to have to give up some very important things.

Joyce Brown, Department of Administration, submitted written testimony. **EXHIBIT 12**

Steve Brown, Blue Cross & Blue Shield (BCBS), stated that on page 2, line 22, the bill is a separate limit for minors. Can those limits be combined. There is a limit of $8,000 for minors and an additional $10,000 for adults. If that is not intended, some language is needed to make it clear. If stacking is intended, it will increase the overall cost of this bill to employers and those who supply health insurance to themselves. There is some concern with the medical language on page 4, lines 1 through 4. There is also a question about language in existing law which states that deductibles and prepayments apply. When you get to subsection 3, page 4, it states that the limits previously enacted service was described by health care professionals. The other question is whether the limits of this bill apply to prepayments and deductibles. There is question about subsection 2, it is in fact an automatic escalator for the limits proposed in this bill. The CPI units for medical services is usually higher than the regular CPI annuals. The CPI factor that is being built in is going to be a substantial yearly increase in the limits in this bill. This approach has been proposed in many other areas to the legislature in previous years. Increases in funding or increases in this type of limitation to the bill should be subject to an automatic escalator. Written testimony was submitted. **EXHIBITS 13 & 14**

Dr. John Schanlan, Blue Cross & Blue Shield, stated that chemical dependency is a problem. Chemical dependency treatment is appropriate for many individuals, whether it is with high costs for inpatient residential setting or on an outpatient basis. They are not arguing whether chemical dependency needs to be treated, but rather where it needs to be treated and the intensity and the cost that should go with it. Eating disorders, gambling and co-dependency are other addictions. An addiction to food is a contradiction in terms. We all are dependent on food because people have to eat.

Mick DiFronzo, Insurance Agent, DiFronzo & Co. Inc., stated that each year when he goes to renew a group's insurance policy, he is not welcome because in the last several years, there have been tremendous increases. This isn't a situation of needs or wants, it is can we afford it. Even the situation to ask for more now and save more later will not work. Employers have had it with rate increases. Family rates average $350 a month and the only

choice is to cut back benefits. Most groups have been from the private sector. We have been carrying the burden even for the self insured plans that don't come under the mandated plans. The only course that we can take is into a group to eliminate group benefits. They eliminate disability, dental, and vision and we increase deductibles. We are looking at more increases. This is the worst time in Montana to do it. The issue is not whether the bill is bad; it is a matter of can it be afforded.

Riley Johnson, NFIB, stated that he represents 6,000 small independent businesses in Montana. In 1987, there was a survey taken of their membership, 67% of members had in some way participated in health insurance. In 1989, the same survey indicated it was down to 62%. The overall reason was cost.

Terry Smith, Local 320 Aluminum Workers, stated that he represents 395 workers at the aluminum plant who have a group insurance plan. Their group cannot afford these changes. In the last four years, more insurance contractors had to cut benefits on a plan or raise the premium.

David Hartman, Montana Education Association, stated that in too many instances, members are not covered by a group insurance plan, in fact, they are not covered by any insurance plan. Their retirements do control health care costs and premiums that are paid to insure employees for group health insurance purposes.

Gregory Van Horsen, Health Insurance Association America (HIAA), stated that there are enough people in Montana without insurance. HIAA strongly objects to the first three sections of this bill. These sections will drastically increase health insurance and will take some people out of the insurance market.

Larry Craft, President, Aluminum Workers Council, stated that the aluminum workers in the Twin Falls Aluminum Company are opposed to this bill.

Teresa Redden, Montana Federation of Teachers (MFT) and Montana Federation of State Employees (MFSE), stated opposition.

David Emonson, Montana University System (MUS), stated opposition.

James Tutwiler, Montana Chamber of Commerce (MCC), stated opposition.

Keith Olson, Montana Logging Association, stated opposition.

Jack Whitaker, Cascade County Commissioner, submitted written testimony. **EXHIBIT 15**

Questions From Committee Members:

REP. JOHNSON asked why this bill does not deal with mental

illness. **Ms. Jamison** stated that it deals with mental illness only outpatients. There is no inpatient mental illness.

REP. JOHNSON asked if the state group health insurance plan will be required to comply with the provisions of the bill. Is there no one in the state health plan that needs this type of help? **REP. O'KEEFE** stated that there are people under the state plan who need this type of help. However, the State of Montana does not come under the amendments because the amended law doesn't apply to the self insured.

REP. JOHNSON asked if we are going to amend the law to mandate the benefits. **REP. O'KEEFE** stated that the Department of Administration agrees with that also.

REP. JOHNSON asked about the insignificant cost increase for this type of thing. **Mr. Fasbender** stated that when you look at the numbers and the amount that is paid out for the treatment of alcohol and chemical addiction and compare all of the other costs that are there it is insignificant. Increasing benefits will cost less than half a percent increase for those people who are insured.

REP. JOHNSON asked what percentage and numbers are referred to. **Mr. Brown** stated that the numbers that BCBS had 1989 chemical dependency is $1.655 million, however the benefits for mental health were $6.16 million, which is about $7.8 million total. The reason we put them together is because we run into questions about chemical dependency and alcoholism. The cost of the benefits mandated by the bill works out to about $4.30 per month per person.

Closing by Sponsor:

REP. O'KEEFE stated that inpatient treatment for mental illness is not covered in this bill. The total cost for inpatient and outpatient treatment is $725,353. The total cost is a combination of outpatient ($25,524) and the alcoholism and drug abuse inpatient ($6,892) which is a total of $32,416, not $725,353. The big difference is the mental illness inpatient. That is a large sum of money and a whole other issue. It is going to cost insureds money, but in the long run they are going to save money. In 1979, approximately 19% of insurers in the country covered post primary treatment. In 1989, 31% of all insurers cover post primary. By the year 1999, it is expected that 47% of insurance companies on their own cover post primary.

HEARING ON HB 299

Presentation and Opening Statement by Sponsor:

REP. SHEILA RICE, House District 36, Great Falls, stated that this bill deals with permanency planning for foster children. Those of us who don't work in foster care and have never been a

foster care child don't really understand what the foster care system is and what it does. Foster care is a temporary solution. These children deserve a much more permanent solution. The children in foster care don't have a home, nor are they available for adoption. Section 1, page 1, deals with the length of time a child is in foster care and disposition. Subsection 1, section 1 proposes that a child that has been out of the home for a year or longer pursuant to court order and is substantially neglected or whose parents willfully refused to remedy the circumstance that caused that child to be in foster care, is an abandoned child. If the child has been abandoned by their parents after a year in foster care, the court has remedy. Section 2, deals with the parents who are making it more difficult to make a decision. The parent has somehow been unable to remedy the circumstance that has caused the child to stay in foster care. It is likely that parent will never be capable of exercising proper child care. The bill requires the court to order the termination of the parent/child relationship if it finds the parent has failed to successfully complete treatment plans in the time period specified. The court has the option of ordering other permanent legal custody.

Proponents' Testimony:

Helen Costello, Great Falls, stated that she worked as a foster care parent and adoption worker. She also submitted written testimony. **EXHIBIT 16**

Jeanne Scott, Adoptive Mothers & FACET, stated that she has adopted six children through the foster care system. She told her story of how hard and expensive it is to adopt children without having insurance.

Judy Garrity, Montana Child Alliance, submitted written testimony. **EXHIBIT 17**

Penny Howard, Adoptive Mothers, stated that if you cannot make the commitment to your birth children then the ideal thing is permanent foster placement. My husband and I have permanently committed to thirty adopted children, most of them physically and mentally handicapped. Children who live in institutions, have no one to advocate for them. Sometimes they have someone's old used wheelchair. Sometimes they don't get situated so they can sit better in wheelchairs. Sometimes they don't get surgery that would prolong their life because no one sees the quality of life. When children die they have no one to cry for them.

Clint Howard, Adopted Child, read a poem about his brother who died in August of 1989. His brother was in an institution and died there because the institution said no one would want to adopt a child that was handicapped.

Trish Tochett, Adoptive Parent, stated the hardest thing for the children is rejection and insecurity. These boys are in a good

home, but foster care is temporary. They have a 4 1/2 year old boy who has severe mood swings and constantly attempts suicide. They took him to a doctor and he is now taking medicine that controls his mood swings. He is no longer paranoid.

Warren Weagan, Prospective Adoptive Parent, stated that he and his wife are trying to adopt children. The most important thing that needs to be co-shared is good and fast placement for the kids. They need to utilize the biological factor of where they come from. Any family that is desperate would make the children feel special no matter where they came from. The faster a child is placed, the less chance of abuse there would be. The bonding will start sooner. The state is very good at paying medical bills. Many times foster care families do not have time to take the children to doctors for routine things.

Judith Carlson, Montana Chapter, National Association of Social Workers (NASW), stated that she is proud to associate herself with the proponents of this bill.

Kathy McGowan, Montana Residential Child Care Association (MRCCA), stated that permanency planning is very important. Permancy planning needs to be funded properly to carry out the philosophy of permanency planning.

Opponents' Testimony: None

Questions From Committee Members:

REP. CROMLEY asked what does permanent placement mean. **Ms. Costello** stated that adoption is a type of permanent placement, but there are other types too. The first permanent placement is giving the child a minimum level of care to get the child home. The next thing would be to try to get the child to relatives. The foster parents will allow the child to stay where he is comfortable because he has already formed an attachment. This gives foster parents an opportunity to adopt the children that have already been in their care for two or three years. Nation wide 50% of the children adopted, are adopted by their foster parents.

REP. RUSSELL asked if a child is put into permanency foster planning, then into a foster home and the parents were unable to follow through on the department's recommendations on how to get their children back; and it was delayed for a number of years, would that child still be able to go back into his biological family. **Mr. Walsh** stated that it depends upon the legal status of the children at that point. If the parents weren't interested in keeping their child, then at that point the parents no longer have a legal right. The state is the parent until such time as the child is adopted or someone else seeks custody of the child.

REP. HANSEN asked if there is a limit on how long a child can stay in a foster home. **Mr. Walsh** answered no.

REP. HANSEN asked what the recommendation from the court is to the foster parent about adoption. **Mr. Walsh** stated that the intent is to reunify the child with the parents. If that doesn't work, the child remains in foster care then the foster parents may consider adoption.

REP. LEE asked if this plan is in the Governor's budget. **Mr. Walsh** stated that it is outside of the budget, however the mandate that came from the last Legislature requested a report in terms of services needed by the agency.

REP. CROMLEY asked if every child is being placed in foster homes on a temporary basis for the adoption. **Mr. Walsh** stated that they are being placed, but the issue is that they are not being placed appropriately.

REP. J. RICE asked if the court terminates the parents rights and makes placements. **Ann Gilkey** stated that the problem isn't the court. The problem is more with the workers who are overwhelmed with services not being given to the children who are in foster care and going before the court and saying treatment has failed at this time.

REP. J. RICE asked if funding the appropriation, to provide the DFS staff to get these cases prepared and into court, would that solve the problem. **Ms. Gilkey** stated that it certainly would help. The timeframe would give the judge one more factor to determine whether or not the parents would be able to handle it. **Ms. Scott** stated that this is a major problem. Children are given low priority in the court system.

Closing by Sponsor:

REP. S. RICE read a letter from a foster care family. **EXHIBIT 18**

HEARING ON HB 260

Presentation and Opening Statement by Sponsor:

REP. BEVERLY BARNHART, House District 80, Bozeman, stated that this bill is to stop discrimination. This bill simply treats adopted parents and adopted children in the same way birth parents and birth children are treated. Should adoptive parents be treated differently from birth parents regarding insurance.

Proponents' Testimony:

Harriet Tamminga, Montana Interagency Adoption Council, stated that she is an adoptive parent who experienced discrimination. They support this bill because it guarantees people insurance for adopted children. Adoption is a lengthy process. It takes a lot of thought and a lot of effort when you have talked about having the insurance coverage start at the time of placement, which is the time the child enters the home, and the hearts of the

adoptive parents. It should be assured by law that insurance companies will cover adoptive children at the time of placement. She submitted written testimony. **EXHIBIT 19 & 20**

Gary Luson, Adoptive Parent, submitted written testimony. **EXHIBIT 21**

Alice Pendleton, Adoptive Parent, stated that in 1983 they adopted a daughter. The insurance company said she would be automatically covered. When their daughter was placed they attempted to add her to their policy. She was denied for her medical condition. They retained an attorney and sued. She had two surgeries in which they paid for themselves. They were given a partial payment and then the insurance company dropped her completely. Adoption is another way to build a family. All of the energy and time spent and the commitment qualifies us to be real parents. Being a parent of three biological children and an adopted child gives them the feeling as a parent just the same. Adopted children should be treated the same as biological children regarding insurance coverage.

Ann Gilkey, Department of Family Services, submitted written testimony. **EXHIBIT 22**

Opponents' Testimony:

Tanya Ask, Blue Cross & Blue Shield, stated that BCBS is in favor of providing coverage for adoptive children and do at the present time. BCBS covers the child from the time it is placed in the home. She submitted amendments. **EXHIBIT 23**

Larry Akey, Montana Association of Life Underwriters (MALU), stated that the members of MALU are not members of insurance companies, they are small business owners. MALU was reluctant to testify in opposition of this bill. There is a special place in heaven for families who adopt children with special needs, but the contrary complaints that we have heard today need to be recognized. Insurance companies do not take claims, insurance consumers do. We create a special treatment for adopted children with this bill because we prevent insurance companies from excluding preexisting conditions. The amendment proposed by BCBS will, in fact, do what the proponents say they want to do with this bill, treat adoptive children the same way the biological children are treated. As introduced, this bill does not do that. The bill creates another mandated health benefit. We have over 20 types of mandated coverage in the statutes now and this would only add another one.

Gregory Van Horsen, Health Insurers Association of America (HIAA), stated that this bill creates another mandate. They endorse the amendments proposed by BCBS. HIAA does not object to adopted children being treated equally biological children.

Questions From Committee Members:

REP. TUNBY asked what the amendments would do. **Ms. Ask** stated that the amendment to the definition of "placement for adoption" would make it more practical because it refers back to the legal definition of placement, so they know exactly when they are going to be required to do to insure that child. Once there is placement, according to that definition, the natural parental rights have been given up and the child is placed in a status for adoption. It is much clearer who is responsible for that child.

REP. BECKER asked if the amendments would require that the adopted child be covered by insurance if placed in less than 30 days after birth. **Ms. Ask** said that is correct. If the child is over 30 days of age, if there was a preexisting condition, then that child would be subject to the preexisting waiting period for that condition. That child would then have coverage just as any other child in the family would and that is exactly what happens now.

REP. KASTEN asked how this differs between a family that is adopting a child with a preexisting condition and a family that may not have had coverage, but needs coverage after a child has had an accident. **REP. BARNHART** stated that her intent is that if a person has insurance and adopts a child, that child should be covered under their insurance.

Closing by Sponsor:

REP. BARNHART stated that she hopes there is a special place in Montana for those parents who want to carry their adoptive child on their insurance.

REP. RUSSELL appointed a subcommittee for HB 93 with all of the amendments. **REP. S. RICE**, Chair and **REPS. SQUIRES, BECKER, J. RICE,** and **LEE.**

ADJOURNMENT

Adjournment: 7:00 p.m.

ANGELA RUSSELL, Chair

Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 1-30-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN	✓		
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		

CS05HUMSER.MAN

EXHIBIT 1
DATE 1-30-91
HB 326

Amendments to House Bill No. 326
First Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
February 1, 1991

1. Page 2, lines 8 and 9.
Strike: "executor, administrator"
Insert: "personal representative"

2. Page 2, line 18.
Strike: "executor, administrator"
Insert: "personal representative"

3. Page 4, line 14.
Strike: "record"
Insert: "book required to be kept by the clerk of the board of county commissioners by 10-2-504"

EXHIBIT 2
DATE 1-30-91
HB 326

VETERANS AFFAIRS DIVISION
DEPARTMENT OF MILITARY AFFAIRS

STAN STEPHENS, GOVERNOR

STATE OF MONTANA

HOUSE BILL 326

MY NAME IS RICH BROWN AND I AM THE ADMINISTRATOR FOR THE MONTANA VETERANS AFFAIRS DIVISION. I AM APPEARING TODAY IN SUPPORT OF H.B. 326.

SECTION 1, PART (2) SIMPLY CLARIFIES THE DEFINITION OF "VETERAN" TO INCLUDE CERTAIN ELIGIBLE MEMBERS OF THE UNITED STATES COAST GUARD. THIS DEFINITION IS MORE RESTRICTIVE THAN FEDERAL LAW WHICH SIMPLY DEFINES THE U.S. COAST GUARD AS PART OF THE "ARMED FORCES". YOU MAY WISH THEREFORE TO PUT A PERIOD AFTER COAST GUARD ON LINE 17 AND STRIKE THE REMAINDER OF LINE 17, 18, AND 19 WHICH IS UNDERLINED.

SECTION 2 PART (2) DEFINES FURTHER THE DUTIES AND RESPONSIBILITIES OF THE BURIAL SUPERVISOR. IT SHOULD BE NOTED THAT I HAVE NOT YET FOUND A PAID VETERANS BURIAL SUPERVISOR, ALL OF THESE INDIVIDUALS, INCLUDING MOST OF THE MONTANA VETERANS AFFAIRS DIVISION SERVICE OFFICERS, DO THIS ON A VOLUNTEER BASES. I ALSO BELIEVE ALL BURIAL SUPERVISORS NOW DO THEIR VERY BEST TO ENSURE COMPLIANCE WITH WISHES OF THE VETERANS AND HIS/HER HEIRS. I DO NOT SEE THIS AS A PROBLEM UNLESS A LEGAL DISPUTE COULD CREATE NEW LIABILITY FOR THE BURIAL SUPERVISOR.

SECTION 10 MOVES THE RESPONSIBILITY OF THE HEADSTONE OR MARKER FROM THE COUNTY CLERK TO THE BURIAL SUPERVISOR. AGAIN, I DO NOT SEE A PROBLEM WITH THIS SECTION. FOR ALMOST ALL CASES

WITHIN MONTANA, THE FUNERAL DIRECTORS HAVE PREPARED THE MARKER APPLICATION, THE BURIAL SUPERVISOR'S RESPONSIBILITY IS MOSTLY FOLLOW-UP TO ENSURE THE JOB IS COMPLETED AND MARKER PLACED.

SECTION 3, CLARIFIES RECORDS AND RECORDS KEEPING.

I BELIEVE H.B. 326 IS NECESSARY TO DEFINE THE DUTIES OF A VETERANS BURIAL SUPERVISOR. THE DEPARTMENT OF VETERANS AFFAIRS (V.A.) ESTIMATES OVER 30,000 MONTANA VETERANS WILL DIE BETWEEN 1984 AND 2004. ACCURATE RECORDS MUST BE KEPT AND THE DUTIES AND RESPONSIBILITIES CLEARLY DEFINED.

EXHIBIT
DATE 3-26
HB 1-30-91

Department of Veterans Affairs

fiche top page only

APPLICATION FOR STANDARD GOVERNMENT MONUMENT FOR INSTALLATION IN A PRIVATE, STATE OR U.S. CEMETERY

RESPONDENT BURDEN - Public reporting burden for this collection of information is estimated to average one-fourth hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (723), 810 Vermont Avenue, NW, Washington, DC 20420; and to the Office of Management and Budget, Paperwork Reduction Project (2900-0222), Washington, DC 20503.

BENEFIT PROVIDED

a. MONUMENT - Furnish upon application for the **unmarked grave** of any deceased veteran. Applicant must certify the grave is **unmarked** and a Government monument is preferred to a privately purchased monument. This restriction does not apply to a family monument which identifies more than one gravesite. Applicant may be anyone having knowledge of the deceased.

b. MEMORIAL MONUMENT - Furnished upon application by a relative recognized as the next of kin for installation in a private, State veterans' or national cemetery to commemorate any veteran whose remains have not been recovered or identified, were buried at sea, donated to science, or cremated and the remains scattered. Check box in block 2 and explain in block 27.

c. BRONZE NICHE MARKER - See illustration for standard bronze niche marker if entombment is in a columbarium or mausoleum, and if desired so indicate in block 27.

WHO IS ELIGIBLE - Any deceased veteran discharged under conditions other than dishonorable. To expedite processing, attach a copy of the deceased veteran's discharge certificate or a copy of other official document(s) pertaining to military service, if available. **Do not send original documents.** Persons whose only active duty service is training while in the National Guard or Reserves are not eligible unless there are special circumstances, e.g., death while on, or as a result of training. Service after September 7, 1980, must be for a minimum of 24 months or be completed under special circumstances, e.g., death on active duty. Service prior to World War I requires detailed documentation, e.g., muster rolls, extracts from State files, military or State organization where served, pension or land warrant, etc.

HOW TO APPLY - Mail the original of the completed application (VA Form 40-1330) to:

Monument Service (42)
Department of Veterans Affairs
810 Vermont Avenue, NW.
Washington, DC 20420

The copy is for your records. No Government monument may be furnished unless a fully completed application form has been received (38 U.S.C. 906).

SIGNATURES REQUIRED - The applicant, next of kin or other responsible person, signs in block 15, obtains the signature of consignee in block 22 and cemetery official in block 24. If there is no official on duty at the cemetery write "NONE" in block 24. State Veterans' Cemeteries are not required to complete blocks: 15, 16, 22 and 23.

ASSISTANCE NEEDED - If assistance is needed to complete this application, contact the nearest VA Regional Office, national cemetery, or a local veterans' organization. No fee should be paid in connection with the preparation of this application. Use block 27 for any clarification or information you wish to provide.

INSTALLATION - All costs to install the monument must be paid from private funds.

TRANSPORTATION - The monument is shipped without charge to the consignee, designated in block 19 of the application. The consignee must have a full street address; **delivery cannot be made to a Post Office Box.** An address showing Rural Delivery must show a telephone number in block 20 to obtain delivery.

DUPLICATION OF BENEFITS PROHIBITED - The applicant has the option of requesting a monetary allowance instead of a Government monument. **An application may be filed for only one benefit.** Application for the monetary allowance must be submitted on VA Form 21-8834, Application for Reimbursement of Headstone or Marker Expenses, which may be obtained from, and submitted to the nearest VA Regional Office.

CAUTION - After completing the application, please check carefully to be sure you have accurately furnished all required information, thereby avoiding delays in marking the gravesite. Mistakes cannot be corrected after a monument has been ordered. Monuments furnished remain the property of the United States Government and cannot be used for any purpose other than to honor the memory of the decedent for whom the monument is issued.

DETACH AND RETAIN THIS GENERAL INFORMATION SHEET AND THE COPY OF THE APPLICATION

EXHIBIT 2
DATE 1-30-91
HB 326

10-2-504. DUTY OF CLERK. It shall be the duty of the clerk of the board of county commissioners, upon receiving the report and statement of expenses, to transcribe in a book to be kept for that purpose all the facts contained in such report concerning such serviceman or servicewoman. It shall also be the duty of the clerk, upon receiving the report of the burial of such deceased person, to make application to the proper authorities under the government of the United States for a suitable headstone as provided by act of congress and to cause the same to be placed at the head of the grave of such serviceman or servicewoman, the expense of which shall not exceed the sum of $30 for cartage of and properly setting up each stone. The expense thus incurred shall be audited and paid as provided in 10-2-502 for the burial expenses.
History: En. Sec. 4, Ch. 39, L. 1903; re-en Sec. 2068, Rev. C. 1907; re-en. Sec. 4539, R.C.M. 1921; re-en. Sec. 4539, R.C.M. 1935; amd. Sec. 1, Ch. 146, L. 1963; amd. Sec. 4, Ch. 310, L. 1967; R.C.M. 1947, 71-123; amd. Sec. 1, Ch. 442, L. 1979.

10-2-505. NO COMPENSATION FOR BURIAL SUPERVISOR. The person appointed as provided in 10-2-501 shall not receive any compensation for any duties he may perform in compliance with this part.
History: En. Sec. 5, Ch. 39, L. 1903; re-en. Sec. 2069, Rev. C. 1907; re-en. Sec. 4540, R.C.M. 1921; re-en. Sec. 4540, R.C.M. 1935; R.C.M. 1947, 71-124.

10-2-506. NOT TO APPLY TO NONRESIDENTS. This part shall not apply to servicemen and servicewomen who, at the time of their death, shall not have a legal residence within this state.
History: En. Sec. 6, Ch. 39, L. 1903; re-en. Sec. 2070, Rev. C. 1907; re-en. Sec. 4541, R.C.M. 1921; amd. Sec. 1, Ch. 125, L. 1931; re-en. Sec. 4541, R.C.M. 1935; amd. Sec. 5, Ch. 310, L. 1967; R.C.M. 1947, 71-125.

EXHIBIT 3
DATE 1-30-91
HB 341

MONTANA CHAPTER
OF THE
AMERICAN PHYSICAL THERAPY ASSOCIATION

January 30, 1991

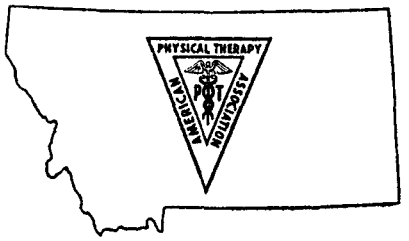
House Human Services and Aging Committee RE: HB 341

Dear Chairman Russell and Members of the Committee,

I am Lorin R. Wright,P.T. President of the Montana Chapter of the American Physical Therapy Association. Historically physical therapists have used topical medications in conjunction with physical therapy procedures nearly since the beginning of the profession. I have been in practice nearly twenty years and received training in the use of topical medications in procedures such as phonophoresis (which is the use of ultrasound to apply medications into the body) and iontophoresis (which is the use of electricity to apply medications into the body). The ability and educational preparation for physical therapists to use topical medications has never been questioned however the Board of Pharmacy pointed out to the Board of Physical Therapy that physical therapists may be violating both the Pharmacy and Nursing Acts when we use these treatment techniques.

We are not asking to prescribe medications. A prescription must accompany treatment and the medications are always linked to the treatment technique. At the present time we would have to have a medical doctor write one prescription for the medication then another for the treatment technique. Then the patient would have to have the prescription for medication filled and remember to bring it to their physical therapist. The physical therapist would then have to hire or find a nurse (a profession which is in short supply and has more critical things to do) to apply the medication to the patients body so that the treatment ordered by the physician can be legally rendered. The patient would have to transport the medication each session. I am sure you can see how impractical this is. The patient would in many cases have to purchase more medication than was actually used or return to his M.D. for another prescription to complete the prescribed length of treatment. If it were available at the Physical Therapists office the charge would be only for the quantity of medication used and the patient would not have excess medication sitting in his medicine chest. Physical therapy is the profession trained and authorized to use the agents needed in phonophoresis and iontophoresis. To continue as we must now do is a needless inconvenience and cost to the patient and frustrating to the professionals involved.

Record keeping requirements. labeling, and protocols are all spelled out in the bill. The remainder of the bill is housekeeping for our board.



MONTANA CHAPTER
OF THE
AMERICAN PHYSICAL THERAPY ASSOCIATION

must reach many more people in the House to be effective. We must be unified and energetic in our responses. We may have opposition from the Pharmacy Association. Our bill will be heard in the House on Wednesday 1-30-91.

My thanks to all of you especially our tenacious legislative chairman Gary Lusin. If you have questions or concerns please contact me or Gary. We will try to keep you informed and will activate the phone tree again soon.

Sincerely,

Lorin Wright.PT
President

Two commonly used methods by physical therapists for introducing topically applied medication through the skin are phonophoresis and iontophoresis. Phonophoresis is used to introduce topically applied medication through the skin by the use of ultrasound. Ultrasound are soundwaves of a very high frequency. Physical therapists ordinarily use ultrasound for heating the tissues, but is also used to propel medication through the skin in a painfree manner. Iontophoresis is the introduction of topically applied medication by use of a very low dose direct electrical current. Physical therapists use a variety of electrical currents (without medication) for a range of problems, such as, pain control and muscle strengthening. Iontophoresis is only one of many applications of electrical current.

Student education on phonophoresis and iontophoresis includes lecture, lab, and supervised clinical experience. The lecture covers the physical and mechanical background of the machine, current, and ultrasound; theoretical basis for the procedure; medications that could be used; indications for use of the modality; contraindications (or when it should not be used); and application technique. In the lab students practice the application with the appropriate machine on their peers. In the clinic the students perform the procedure on a patient under the direction of a licensed physical therapist.

The purposes and contraindications of various medications are reviewed in class. Students are advised to have a physician's referral and that the patient should bring the prescribed medication.

Physical therapy students are also trained in sterile technique. These skills are necessary for applying sterile bandaging, which may or may not include medication.

EXHIBIT 5
DATE 1-30-91
HB 341

PRICE RITE DRUG CENTERS

33 WEST MAIN BELGRADE, MONTANA 59714 (406) 388-4111
910 NO. 7th AVE. BOZEMAN, MONTANA 59715 (406) 587-0608

January 29,1991

Mr. Wilbur Spring
House Human Services and Aging Comm.
Helena,Montana

Dear Wilbur,

I have reviewed House bill 341 regarding Physical therapists administering medications prescribed by a physician, and I cannot see any violation of the pharmacy act, no more than nurses in the hospital or doctors offices administering medications, or Physicians Assistants as they have in some rural areas.

I therefore endorce House Bill 341 and encourage your help in passing it. If you have any questions from me please do not hesitate to call me at the Bozeman store or at my home 587-4375. Thank you for your help.

Yours Truly.

Ed.Harrington RG.Ph.Montana

EXHIBIT 6
DATE 1-30-91
HB 341

MONA JAMISON
ATTORNEY AT LAW

POWER BLOCK BUILDING, SUITE 4F
POST OFFICE BOX 1698
HELENA, MONTANA 59624

PHONE: (406) 442-5581
FAX: (406) 449-3668

AMENDMENT TO HB 341

Submitted by
Mona Jamison

On Behalf of the Montana Chapter
of the American Physical Therapy Association

1. Pages 6 and 7, line 7 on page 6 through line 1 on page 7:

Delete Section 5 in its entirety.

EXHIBIT 1
DATE 1-30-91
HB 341

BOZEMAN
PHYSICAL THERAPY CENTER
Suite 703G • Medical Arts Center
300 North Willson
Bozeman, Montana 59715
(406) 587-4501

TOPICAL MEDICATIONS: PRACTICAL USES BY PHYSICAL THERAPISTS

Physical therapists are frequently referred patients, by physicians, with any one or two of a variety of musculoskeletal conditions. A physician will oftentimes prescribe physical therapy treatment for that patient's condition which involves either phonophoresis, iontophoresis, or certain treatments which involve open wounds or burns that require the application of topical medications through the course of treatment.

The most common use is in phonophoresis which typically involves a 10% hydrocortisone mixture which is applied to the skin overlying specific injury site and which is driven into the injured tissue by ultrasound. Physicians will oftentimes elect this type of treatment instead of local injection to the area.

House Bill 341 will greatly simplify the process whereby this type of physical therapy treatment can be provided. The law will allow a physician to refer a patient to physical therapy with a prescribed treatment of phonophoresis (or other topical medication treatments as necessary) and the patient may then go to a physical therapist and have that treatment provided. Without the law the physician will have to write a prescription to the patient who will then have to go to a pharmacy to pick up the topical medication and then go to the physical therapist to have it administered with the appropriate instrument. If the patient does not get the prescribed topical medication filled and then goes to the physical therapist for treatment then appropriate physician ordered treatment will not be able to be carried out.

I believe the language in the bill makes it very clear as to what procedure will be taken by physical therapists in the use of these topical medications and clearly will make it very convenient for patients to receive appropriate physical therapy care when it has been prescribed by a physician. The physician will determine the medication and dosage, the physical therapists will purchase the topical medications through local pharmacies, appropriate record keeping systems will be established to assure compliance with topical medication shelf life, and patients will be assured that treatment will be able to be administered in a timely and effective manner.

Gary Lusin, MS, ATC, PT

Gary Lusin, P.T.
Mary Jo Lusin, P.T.

EXHIBIT 8
DATE 1-30-91
HB 355

MEDICAL SERVICES INCREASES SINCE 1979

YEAR	CPI% INC.	4000	1000
1979	1.098	$4,392	$1,098
1980	1.113	$4,888	$1,222
1981	1.107	$5,411	$1,353
1982	1.118	$6,050	$1,512
1983	1.087	$6,576	$1,644
1984	1.06	$6,971	$1,743
1985	1.061	$7,396	$1,849
1986	1.077	$7,966	$1,991
1987	1.066	$8,491	$2,123
1988	1.065	$9,043	$2,261
1989	1.077	$9,739	$2,435
1990			

Ex. 8
1-30-91
HB 355

HB-355

"A BILL FOR AN ACT ENTITLED: AN ACT INCREASING THE MINIMUM MANDATORY INSURANCE COVERAGE PROVIDED UNDER GROUP HEALTH PLANS WITH REGARD TO MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION; PROVIDING SEPARATE MINIMUM AMOUNTS FOR ADULTS AND MINORS; PROVIDING FOR ADJUSTMENT OF MINIMUM AMOUNTS EVERY THREE YEARS BASED ON THE CONSUMER PRICE INDEX; REQUIRING AN INSURER TO PAY FOR ALL TYPES OF TREATMENT AND OTHER BENEFITS PROVIDED OR PRESCRIBED BY A HEALTH CARE PROFESSIONAL; AMENDING SECTION 33-22-703, MCA; AND PROVIDING AN EFFECTIVE DATE."

Section 1.

Some re-numbering and clean-up of language is done on page 1 and page 2 through line 19.

Page 2, line 20 is the first substantive change and changes the current charge of $4000 for <u>inpatient</u> treatment to $8000 for an adult and creates an additional category for minors in the amount of $10,000. Both of these amounts are for treatment for any 24 month period.

Page 2, line 22 sets the lifetime inpatient benefits for adults at $16,000 and for minors at $20,000. This basically allows for a person to be treated twice in their life.

Page 3, line 16 changes the current charge of $1000 for <u>outpatient</u> treatment to $2000 for an adult and creates an additional category for minors in the amount of $4000.

Page 4, line 1 establishes the amount of outpatient benefits that can be paid in any 24-month period at $8000 for an adult and at $10,000 for a minor.

Page 4, line 3 establishes the lifetime benefits for outpatient treatment at $16,000 for an adult and $20,000 for a minor.

Page 4, line 5 through **line 14** indexes all of the mandated benefit amounts to the medical component of the consumer price index and once every three years adjusts them to reflect whatever change has occurred during that time.

Page 4, line 15 through **line 19** makes it clear that the benefits established under this section cannot be reduced if the care is being provided under a program approved by the Department of Institutions [redacted].

Section 2. Provides an effective date.

EXHIBIT 4
DATE 1-30-91
HB 355

Mental Health Association of Montana

A Division of the National Mental Health Association

State Headquarters • 555 Fuller Avenue • Helena, Montana 59601
(406) 442-4276 • Toll-Free 1-800-823-MHAM

Working for Montana's Mental Health

MEMORANDUM

TESTIMONY CONCERNING H.B. 355
JANUARY 30, 1991
HUMAN SERVICES AND AGING COMMITTEE
HOUSE OF REPRESENTATIVES

Chairwoman Russell and Members of the Committee:

My name is John Shontz. I represent the Mental Health Association of Montana.

The Mental Health Association of Montana supports the increased minimum insurance benefits that House Bill 355 would mandate for outpatient mental health services. This mandate will foster the process of deinstitutionalization and treatment of mentally ill persons at the community level. As in many branches of medicine today, advances in the treatment of mental illnesses require less and less inpatient hospitalization and institutionalization.

The Mental Health Association of Montana is deeply concerned with the fiscal note attached to this bill. The fiscal note appears to be erroneous in its assumption that the legislation will cause a dramatic increase in the cost of mental health care delivered through and paid for by the University System's insurance program and, by implication, non-government policies should this bill become law.

The fiscal note seems to assume that the minimum coverage requirements for mental health coverage will increase along with those requirements for chemical dependency treatment. This is false. Neither the current law nor the bill place any monetary restrictions on mental health services covered by insurance policies. Mental health illness is treated the same as any other medical illness; coverage is not capped and therefore no increase in costs will occur should,this bill become law. We encourage a new fiscal note be developed for this bill that properly reflects the financial impact of the bill on the delivery of mental health services.

We are further troubled by the definitions used in the fiscal note - Mental Disorders verses Mental and Behavioral Problems. We ask the committee to request the fiscal note describe exactly what is meant by these definitions; they are quite confusing to us.

Thank you.

From left: John, Allen, Tim and Bill Arlint of Glacier Wholesalers, Kalispell.

The check

"We had Blue Cross and Blue Shield of Montana for more than 20 years. Loved it. But when rates started climbing, we cut our coverage, cut our cost and went with a different company. Well, the cheaper deal meant lots of paperwork for us. We'd do it—and they'd send it back and make us do it all over again. And they covered only certain items—we never seemed to get beyond their deductible.

"We don't want our employees worrying about unpaid medical bills. That's another reason we came back."

John Arlint, secretary and treasurer, Glacier Wholesalers

Real people. Real claims. Could your employees write the check?

Condition	Total Charge*
Broken pelvis and leg	$20,140
Car accident	60,743
Heart surgery	32,099
Pneumonia	23,249
Premature baby	40,556

*Actual charges submitted to Blue Cross and Blue Shield of Montana during 1989.

Call us. We offer coverage options to fit your needs.

10
1-30-91
355

1-800-388-6950

EXHIBIT 11
DATE 1-30-91
HB 355

RIMROCK FOUNDATION®

Leading Quality Addiction Treatment in the Northern Rockies

TESTIMONY IN SUPPORT OF HOUSEBILL 355

BY DAVID W. CUNNINGHAM, CEO

I am here, today, to address this need in behalf of the many many patients who seek care for their addiction problem. It has no doubt been said that this bill, to increase the minimum limits for insurance coverage, seems self-serving on the part of healthcare providers. In fact, however, the need to increase coverage limits is in the interest of patients today in Montana who find themselves paying health insurance premiums and significant cash balances for needed addiction treatment services. Increasingly, this is resulting in the creation of barriers to treatment for those in need.

It is hardly news to you that Montana's economy is down. But it might be new information to realize that these insurance limits have not been revised for ten years. The charges for Chemical Dependency treatment in Montana are well below the national average, and providers have been responsible in maintaining reasonable costs. If, however, you operate a business, you know that in the course of ten years, your costs have risen significantly and there is probably not one among you who has not increased the price of your product or services to customers within the past ten years. Treatment providers have controlled increases to around 5% in this ten year period. Unlike acute medical services, addiction treatment charges have not soared out of control and will not do so if insurance limits are increased.

Our country is waging a war on drugs, so our leaders exclaim, yet despite the billions of dollars expended on this war, none are designated for treatment. Thus, it falls to the private sector and the patient to fund treatment efforts. While this may or may not be appropriate, it is a fact. If we really want to win this war, treatment must be part of the equation and Montanan's must continue to have access to affordable treatment.

That is what this bill is about and for whom it is about--patients who need professional treatment services to overcome their addiction. It is working! Montana can be proud of its treatment system and proud of the economy with which that system is provided our citizens.

None of us, however, not the patient and not the treatment provider, can be expected to maintain quality, affordable services for the next ten years without some increase in the reimbursement system. Keep in mind that, for example, Chemical Dependency and mental health benefits payouts by Blue Cross/Blue Shield of Montana, our largest insurance company, comprise only 7% of their total medical services payouts--7%.

It seems reasonable to assume then, that fears of huge insurance premium increases are unfounded.

EXHIBIT 12
DATE 1-30-91
HB 355

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

STAN STEPHENS, GOVERNOR

ROOM 130, MITCHELL BUILDING

STATE OF MONTANA

(406) 444-3871

HELENA, MONTANA 59620

Testimony in Opposition to HB355
Before the House Human Services Committee
by the Department of Administration
January 30, 1991

Madam Chairman, Members of the Committee, I am Joyce Brown, Chief of the State Employee Benefits Bureau, with the State Personnel Division, Department of Administration.

I am reluctantly opposing HB-355 because it will have an impact on the State Employee Insurance Plan. Although, we are exempt from the insurance codes, health insurance mandates affect us in two ways:

1. The State plan has always attempted to voluntarily comply with such mandates since they represent legislative guidance on health plan minimums.

2. They create tremendous pressure from providers who unknowingly or, perhaps in some cases, knowingly advise patients that costs of mandated benefits will be reimbursed.

For any employer health plan, this has to be the most inopportune time to date to be expanding mandated benefits.

The State, like many employers is not able to pay for benefits it has provided in the past. The question the State Plan, and other employer plans face is not what benefits to add. THE QUESTION IS WHAT BENEFITS WE MUST CUT OR FORCE EMPLOYEES TO PAY FOR.

EXAMPLES:

1. Last year the State Plan was forced to increase the annual deductible and co-payment employees are responsible for so that employees' potential out-of-pocket costs rose from $650 to $800 per year per individual; and from $1,450 maximum pr family to $1,775 per family. Supplemental accident benefits were eliminated. ORGAN TRANSPLANT BENEFITS WERE CAPPED AT $100,000. **This forces employees who need organ transplants costing twice that to choose between foregoing a potentially life-giving treatment and mortgaging their families economic future to pay for it.**

2. Far more drastic changes are in store for next year. Current funding proposals will leave the Employee Benefit Plan over $9,000,000 short for the biennium. The Employee Benefits Advisory Council will be struggling with such options as:

a. Increasing Revenue: ie increasing employees' out-of-pocket costs for dependent premiums by $66.00 per month on average over the biennium. This would increase employees' costs to cover their families from $53.00 per month to $119.00. This would more than wipe out some employees projected pay increase, jeopardizing the ability of low-income employees to keep up with hikes in utility and food costs.

b. Decrease Benefits: ie increase the risks employees must assume by increasing the annual deductible to $300 per month - **AND** increasing co-payment maximums so an employee can pay up to $5,000 per year and a family up to $10,000.

The department of Administration and the State Employee Group Benefits Advisory Council would like to make these tough choices in cooperation with our members free of legislative mandates. Far from improving employee benefits, mandates limit the ability of health plans to involve their members in the tough choices that are rightfully theirs.

Finally, I would like to note that all non-acute care is even more subject to expansion than acute care. The amount of care needed typically expands to meet the capacity of providers in an area to provide it and of insurance plans to pay for it. Treatment of drug and alcohol problems are no different in this regard than physical therapy and other non-acute treatment. For this reason we think language limiting the ability of insurance plans to review the medical necessity of treatment through case management (part 3) is a dangerous precedent.

We believe this bill will at least double plan costs for drug and alcohol treatment. That would increase State plan costs from $600,000 to $1,200,000 assuming we continue to pay out patient services at 50%. That extra $600,000 is desperately needed to cover current medical benefits.

EXHIBIT 12
DATE 1-30-91
HB 355

THE CHANGING FACE OF HEALTH INSURANCE

NO HEALTH INSURANCE

141,600 Montanans (approximately 20% of the population) under the age of 65 have no health insurance ("Final Report on Health Care for Montanans; 1990).

35% of these (49,430) uninsured are children under 18 years of age (Id.)

From FY '81 to FY '91, the number of people served under the Medicaid program increased 40%, the average cost per case increased 70%, and total Medicaid expenditures increased 139%.

DEDUCTIBLES

Five years ago, more than 50% of all Blue Cross - Blue Shield members had coverage under paid-in-full plans. By late 1990, no individuals and only 6.6% of group members were on paid-in-full plans.

COPAYMENT

In 1990, 80% of all individual members had coinsurance plans in which they pay at least 30% of most hospital and physician charges.

MONTANANS SERVED BY BLUE CROSS AND BLUE SHIELD

1. Traditional Blue Cross and Blue Shield insurance covers approximately 159,000.

2. Blue Cross and Blue Shield provides administrative functions only (e.g., state employee plan) 45,000

Mandatory mental illness and alcohol treatment under Section 33-22-703, MCA, applies to insurers and health service corporations regulated by Title 33, MCA.

Mandatory mental illness and alcohol treatment under Section 33-22-703, MCA, does not apply to self insured or ERISA exempted groups such as IBM, Washington Corporation, Montana Power; many hospitals such as St. James, St. Peter's; many Governmental agencies such as State of Montana, Missoula County. (33-1-102, MCA.)

The people most impacted by an increase in mandatory mental illness and alcohol treatment benefits are those least able to pay and most likely to drop health insurance coverage for their employees - - small employers with less than 25 employees.

Blue Cross - Blue Shield groups by numbers of members:

9 or fewer	10-25	26-100	over 100
69	17%	11%	3%

Montana is a small business state. The Montana Department of Labor classifies businesses by number of employees as follows:

1-19 employees	20-99 employees	100 or more
21,000 plus	1,953	328

The Small Business Administration reports that 3 of every 4 uninsured workers are employed by small businesses ("Consumer Affairs," November, 1990).

	1990	1987
Medical Component CPI	9.6%	6.6%
CPI	6.1%	3.6%
Wage Index Montana 1989	1.9%	2.0%
Mental Illness		
	*	
Inpatient		
Admits/1000	3.8%	3.1%
Days/1000	55.3%	32.9%
Charges/Case	8620	4302
Charge/Day	$589.00	$406.00
Outpatient		
Visits/1000	249.4	162.0
Charge/Case	$122.00	$113.00
Chemical Dependency		
	*	
Inpatient		
Admits/1000	2.9%	3.0%
Days/1000	53.9%	61.0%
Charge/Care	$5613	$4767
Charge/Day	$297.00	$234.00
Outpatient		
Visits/1000	13.6	9.2
Charge/Case	$215.00	$278.00
	1990	1989
Cost of Mandated Benefits (Family of four)	$238.56	$197.76

* Based on first six months of 1990.

"If costs continue rising at the current rate, medical benefits would rise to $22,000 per employee by the year." (Wall Street Journal, January 29, 1991)

2000

EXHIBIT 14
DATE 1-30-91
HB 355

Some other Legislation to be considered by the 1991 Legislature which may increase the cost of health insurance.

Bill	Subject
HB 260	Require insurance to cover adopted child from placement and preexisting condition.
HB 355	Increase mandatory health insurance for drug and alcohol addiction.
HB 405	Extend physician liens to payments due from health service corporation.
Bill Draft Request No.	
1672	Revise PPO agreements to make available to all.
338	Mandatory well baby insurance coverage.
727	Non-discrimination insurance for Down's syndrome.
771	Fund health insurance for low income children.
808	Insurance funding for long-term health care.
920	Revise PPO agreements.
921	Regulate Utilization review.
1320	Compulsive gambler review.
1354	Mandatory coverage for mammograms.
1399	Reimbursement for mental health services.
1436	Regulation of managed health care.
1539	Alcohol pricing to cover treatment costs.
1740	Continue funding for genetics program.

TA/smp
R291M

DATE 1-30-91
HB 355

HB 355

Cascade County

State of Montana

TELEPHONE: (406) 761-6700

Great Falls, Montana 59401

January 28, 1991

Representative Patrick G. Galvin
Montana State Capitol
Capitol Station
Helena, MT 59620

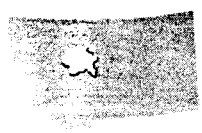
Dear Representative Galvin:

Health care costs have a great impact on the cost of our benefit plan for 525 employees and retirees of Cascade County and their families. You already have heard of several pieces of legislation which would increase that cost to the County and to our employees who only saw an average of 2.9 percent increase in wages last year. Much of that increase was absorbed by increases in their retirement system and an increase in dependent insurance benefits.

We have taken an aggressive approach to better managing our health insurance package, and as a result we saw virtually no change in the employee portion of the program last year. (The dependent cost portion did increase.) We implemented a Health Maintenance Organization program as an option for employees and added a pre-hospital admission and review plan. We cannot afford to see the gains made by Cascade County wiped out by costly legislation, the cost of which will be borne by County employees, their families and the taxpayers of this community.

The first issue concerning us is the attempt to thwart the effectiveness of utilization review activities. These reviews by an insurance company or third party review organization, examine inpatient hospital stays to determine whether they are necessary and whether they are being provided in the appropriate setting. These programs save us money. It is also better for our employees to know upfront if services could be provided in another setting rather than getting a bill which would later be cut back.

One attempt to deny this type of review is already before you - HB 355. This bill not only denies upfront review, but would deny any kind of claim review after the hospitalization in specific types of cases. This would make Cascade County an open checkbook for those types of cases.



Ex. 15
1-30-91
HB 355

Our second area of concern is mandated benefit additions or increases. Any time a new benefit is added or an existing benefit, such as chemical dependency or psychiatric care is increased, the cost of our employee benefit plan increases. An excellent example is HB 355 which increases the amount we must pay for necessary chemical dependency treatment, primarily inpatient treatment. The services may be good services but please let the employer decide what level of benefits he or she can afford to pay for.

Thirdly, certain providers are attempting to gut the PPO statute passed in 1987. This is the innovative type of proposal we would like to be able to work toward in Cascade County and it is one that the school district has used in the past. This statute was part of then Governor Schwinden's health care cost containment advisory council's attempt to get a handle on health care cost containment. It should be noted the Federal Trade Commission has examined this type of activity and said that competition actually increases as a result of these types of arrangements. PPO or Preferred Provider Organization introduces the element of price competition into health care resulting in the ability to negotiate price with health care providers. We are very interested in pursuing this, and urge you not to change existing legislation, hampering our ability to get a better price for our employees and the taxpayers of Cascade County.

These issues are of great concern to us, and we urge your careful consideration in evaluating the costs you are going to pass back to the employees and the taxpayers of Cascade County with these various areas of legislation.

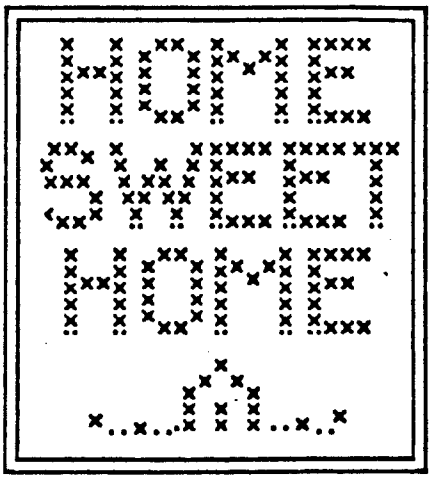
Richard Gasvoda
Chairman
Cascade County Commissioners

Jack Whitaker
Cascade County Commissioner

Harry Mitchell
Cascade County Commissioner

RG:wpe/MARKET-376

EXHIBIT 16
DATE 1-30-91
HB 299



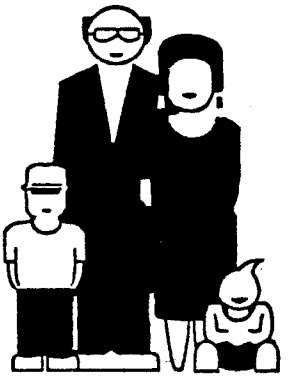
Services called Permanent Planning, Legal Assistance, and Adoption make sure children do not grow up in temporary foster care.

These services help kids feel wanted and secure by finding them a permanent family to call their own.

Look first to parents as the child's best resource for a permanent family.

When parents can't give the child a safe home, relatives or foster parents with close ties to the child are considered.

Sometimes a new family must be found to meet the child's needs.



Permanency services are:

✔Safe homes for kids

✔Visits, keeping kids and parents in close contact

✔Pinpointing what is keeping the family apart

✔Agreeing on what needs to be done for the kids to go home and how long it will take

✔Finding help for parents and kids

✔Straight talk about how things are going

✔Moving kids to a permanent home

When adoption is the plan:

•Deciding adoption is best for the child and it really can happen

•Freeing kids for adoption by getting parents' consent or court termination of parents' rights

• Preparing families, then:

•Finding the family that best meets the child's needs

•Saving memories and family history for the child

•Helping kids say good-by to the past.

• On-going supportive services;

Children's Services helps :

✔Parents get legal custody again

✔Consents to adoption of children in permanent custody

✔Recommends a guardian, when adoption is not a possibility

An important part of creating a permanent family is to make sure the child has legal ties to the new family.

1991 CHILDREN'S AGENDA ISSUE:

DATE 1-30-91
HB 299

ASSURING PERMANENT HOMES FOR CHILDREN: A PRIORITY FOR CHILDREN TEMPORARILY IN FOSTER CARE IN MONTANA

A change in Montana law is needed -- to require permanent homes for children:

The Montana Children's Agenda supports the position that Montana law needs to require that children in out-of-home placements be provided a permanent stable home in the shortest possible time by the Department of Family Services. This will require additions to the Montana laws that specify requirements and safeguards for children who are removed from their homes as temporary protection from abuse or neglect and are temporarily placed in foster care.

Additional staff resources are needed to assure the amended law is implemented:

To effectively implement the amended law requiring such permanent homes for children, the Department of Family Services should be provided funding for five Permanency Homes Services Managers (one for each of DFS' five regions), whose job will be to assure that children in out-of-home placements are provided a permanent stable home in the shortest possible time. These Permanent Home Services Managers may be either employees of the Department of Family Service or contracted services providers.

Rationale for the needed changes:

A high priority emphasis on assuring that Montana children have permanent, stable homes -- preferably their own natural family's home -- is necessary because the human and financial costs of the exploding population of children in foster care in Montana for long periods are unacceptable.

The number of children in DFS out-of-home placements has been increasing by an average of 5.1% annually during the FY84-FY90 period. In FY84, the unduplicated number of children in out-of-home placements was 2,302 and the number in FY90 was 3,125.

National research has shown that permanency planning must begin very early after a child has been removed from his/her home in order to avert long-term, multiple, traumatic, and costly out-of-home placements. Additional staff are needed to assure that such permanency planning occurs for every child DFS places temporarily in an out-of-home placement.

DFS statistics concerning the approximately 1400 children who were in foster care/out-of-home placements in Montana every month this last year show the urgent need for increased requirements and emphasis for finding permanent homes for children as soon as possible. Approximately 300 of these children are in the permanent custody of the department -- i.e., they are legally the department's children. DFS needs to assure permanent family homes, life-long family ties, not temporary or even long-term foster care homes, for these children. Not doing so is inconsistent with a commitment to the idea that Montana children, as all children, have a right to and a need for a permanent, stable home.

The job of the five additional staff working as Permanent Home Services Managers:

The main, urgent focus of the five Permanent Home Services Managers would be on returning children in out-of-home placements to their family homes. If returning to their own family home is not possible, achieving another permanent family situation -- such as adoption or guardianship or other life-long legal ties to one, permanent family -- in the shortest time possible will be the focus of their efforts.

The Permanent Home Services Managers will conduct case reviews of all children in foster care over three months -- in order to (1) determine what needs to be done in each case to assure a permanent stable home for each child and (2) assist DFS social workers to effectively utilize/find the resources to implement positive and realistic permanency plan options for these children.

Additional key functions of the Permanent Home Services Managers will be to (1) find adoptive homes for children who have been in care for longer periods of time, (2) provide expert case consultation with DFS social workers and family resource specialists, (3) conduct training for DFS workers, supervisors, family resource specialists, teachers, judges, probation officers, guardian ad litems and foster parents on the key features of permanency planning and (4) do education of the general public about the need for permanent stable homes for children.

Benefits for Montana's children:

The avoidance of the trauma and long-term adverse effects of out-of-home placements is the essential and primary benefit of success with this project for assuring permanent homes for children.

Another a clear benefit will be the large savings that will be made when lengthy out-of home placements are replaced by adoptions, family reunifications and life-long legal ties to permanent families. The average length of stay in foster care in Montana is 1.5 years. The minimum cost of family foster care is $300 per month. If 24 children were in family foster care for one year, the cost would be $129,600. Assuming that this project could remove 144 children from family foster care -- whose placements would last an average of 1.5 years at $300/month -- the money saved over three years by not spending it on foster care would be $777,600. Costs savings for the more costly residential treatment placements would be even higher. The department identified a need for five additional staff assigned specifically to adoptive services to move 50 children in the permanent custody of DFS into permanent homes.

When the permanent homes found are adoptive homes, years of foster care payments are saved and the best alternative to natural families (i.e., adoptive families) is achieved. And encouraging the use of adoption subsidies, to assist families who otherwise would not be able to take on the responsibilities of adoption, would also amount to cost savings since such adoption subsidies are always less than foster care payments.

Endorsements for this Permanent Homes for Children proposal:

This project of assuring permanent homes for children is endorsed by the Montana Interagency Adoption Council, whose members are Catholic Social Services, Lutheran Social Services, LDS, Shodair, MICAH, Inc., DFS, Florence Crittendon Home, Montana Post Adoption Center. The proposal is also supported by the Montana State Foster/Adoptive Parents Association.

Cost estimate:

Costs for basic salary only: $203,200 in basic salaries for the FY92-FY93 biennium
-- FTE or Contracted Personnel salary at grade 14
-- $20,320/year x 5 = $101,600 per year

Total costs (salary, operating costs, training): $371,200 for the biennium
-- $37,120 per position x 5 = $185,600 per year

12/3/90

30 January 1991

EXHIBIT 10
DATE 1-30-91
HB 299

Dear Members of the 1991 Legislature

We are writing in support of House Bill 299 introduced by Representative Sheila Rice which would both expand and streamline services to Montana children often "caught" in the limbo of temporary placements which often span many years of time.

We were united with four siblings under a foster/adopt plan in September, 1986 and finalized our adoption in October, 1987. The siblings ranged in age in 1986 from 2 years of age to 7 years and included a girl with cerebral palsy. During the span of each child's life, by that point, they had been exposed to multiple temporary placements and often separated from each other. By the time the

Until parents had relinquished custody, multiple adoptive homes were not considered which would mean permanent placement, but permanent separation from and by both of the children.

Because of quick and skilled creativity of adoption staff interventions these siblings "happened" to be placed together with George and Sam as capable, willing and nurturing adoptive parents. We enjoy an open adoption, cultivating positive relationships with a large extended biological family and several foster families.

Quick, decisive planning and processing can/will greatly diminish the children's wait for permanency.

Mary Hunter for Helena

3146 4th Ave N
Great Falls, MT 59401

EXHIBIT 19
DATE 1-30-91
HB 260

NCFA UPDATES to May/June 1988 OURS Reprint on "State Laws on Insurance Coverage For Adopted Children"

Florida - For infants, coverage begins from the date of birth, providing there is a written agreement to adopt the child.

Georgia - In 1988, Georgia passed a new law requiring that insurance policies cover adopted children just like newborns. This coverage must include congenital defects.

Louisiana - A 1988 law requires that insurance coverage for adopted children begin at date of placement.

Minnesota - Minnesota law requires that adopted children be treated just like biological children for health insurance purposes. Thus, pre-existing conditions may not be used as criteria by health insurers to deny coverage to newly adopted children, and coverage must begin at date of placement.

New Mexico - A 1988 law required that insurance policies cover adopted children from the date of placement and that coverage must include pre-existing conditions.

South Dakota - A 1988 law specifically required that health insurers must make claim payments during the bonding period.

EXHIBIT 20
DATE 1-30-91
HB 260

Rep. Wesley J. Skoglund
District 61B
Hennepin County

Minnesota House of Representatives

COMMITTEES: CHAIR, INSURANCE; ENVIRONMENT AND NATURAL RESOURCES; TAXES; CAPITOL AREA ARCHITECTURAL AND PLANNING BOARD; LEGISLATIVE AUDIT COMMISSION; MULTI-STATE TAX COMPACT ADVISORY COMMITTEE

January 25, 1991

Harriet Tamminga
Executive Director
Montana InterCountry Adoption
109 South 8th Ave.
Bozeman, MT 59715

Dear Ms. Tamminga:

Thank you for your phone call. I am pleased to hear that Montana is considering legislation to guarantee equal insurance treatment for adopted children. In 1983 I authored a bill in Minnesota requiring our insurance companies and HMOs to cover adopted and biological children equally.

As you can expect, the insurance companies and some HMOs warned of dire consequences for the financial well-being of their organizations if we passed the bill. Nonetheless, we enacted it and none of their predictions came true.

As the Chair of the Insurance Committee of the Minnesota House of Representatives, and as one who also works in employee benefits in private industry and serves on the Legislative Health Care Cost Containment Task Force, I can say that the cost of covering adopted children is no greater than that of covering biological children. Actually, since maternity benefits do not have to be paid for adoptive mothers and health insurance benefits do not have to be paid for newborns before they are adopted, it could be argued that adoptive families cost less to insure than their counterparts who have biological offspring.

Since the bill passed there have been minor amendments to clarify it, but the insurance companies and HMOs have made no attempt to repeal it.

Thank you again for your phone call. I hope I've been helpful in explaining the bill.

Very truly yours,

Wes Skoglund

Wes Skoglund
State Representative

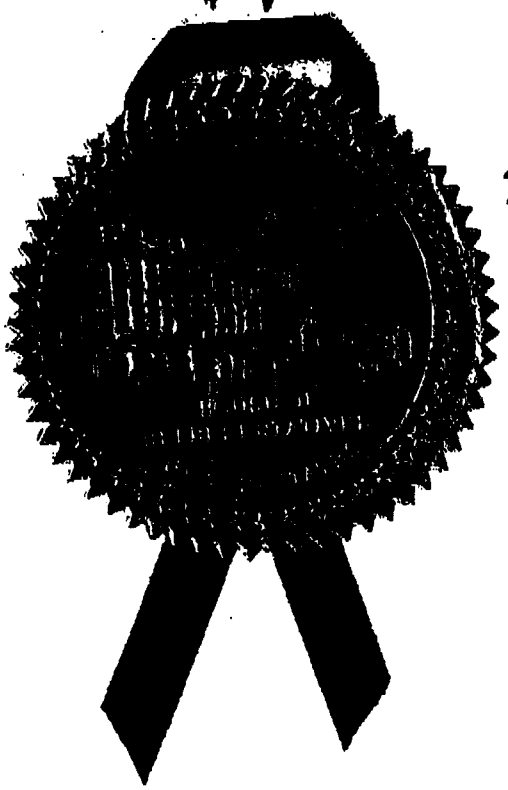
(2) an appropriate official of the National Association of Insurance Commissioners.

Attest:

Walter J. Stewart

Secretary of the Senate.

Attest:



Donnald K. Anderson

Clerk of the House of Representatives.

EXHIBIT 21
DATE 1-30-91
HB 260

S. Con. Res. 95 Agreed to July 26, 198

One Hundredth Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Monday, the twenty-fifth day of January, one thousand nine hundred and eighty-eight

Concurrent Resolution

Whereas at least 86,000 children in the United States are legally free for adoption and are living in foster care waiting for a permanent home;

Whereas many of the children are physically, mentally, and emotionally disabled;

Whereas some insurers deny health insurance to a disabled adopted child on the basis that the disability of the child is a preexisting condition;

Whereas the actions of the insurers impose a significant barrier to the adoption of children with disabilities because few prospective adoptive parents can afford to take the risk of adopting a child who will not be covered by health insurance;

Whereas under State law adoption severs the legal ties between the adopted child and the adopted child's birth parents, and creates a legal relationship with the adoptive parents;

Whereas in every State, State law has established that an adopted child has the same legal status as a biological child;

Whereas many insurers cover a biological child with the same disability born to the adoptive parents;

Whereas by denying health insurance coverage to disabled adopted children, insurers are discriminating against adopted children and establishing a policy contrary to State law; and

Whereas the barriers to adoption that deny children a permanent home and prevent couples and single individuals from establishing families should be eliminated: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that Congress—

(1) opposes discrimination in health insurance against adopted children;

(2) urges insurers to treat all adopted children identically to newly born biological children;

(3) urges State legislatures to encourage health insurers to cover adopted children of the insured, subscriber, or enrollee on the same basis as other dependents, with such coverage to be effective from the date of placement for purpose of adoption.

SEC. 2. The Secretary of the Senate shall transmit a copy of this concurrent resolution to—

(1) an appropriate official of the legislature of each State, and

EXHIBIT 22
DATE 1-30-91
HB 260

DEPARTMENT OF FAMILY SERVICES

STAN STEPHENS, GOVERNOR

(406) 444-5900

STATE OF MONTANA

P.O. BOX 8005
HELENA, MONTANA 59604

TESTIMONY IN SUPPORT OF HB 260
AN ACT REQUIRING INSURERS TO PROVIDE COVERAGE FOR ADOPTED CHILDREN

Submitted by Ann Gilkey, Legal Counsel
Department of Family Services

The Department of Family Services supports HB 260. The agency believes that this legislation will help encourage Montanans to consider adopting "special needs" children who otherwise may have difficulty being placed in permanent homes. Assurance of insurance coverage of their adopted child will alleviate adoptive parents' concerns of depleting their own resources or having to rely on the State's Medicaid system for payment of their child's medical expenses. The department urges your support of HB 260.

EXHIBIT 23
DATE 1-30-91
HB 260

January 30, 1991

HB-260

Blue Cross and Blue Shield of Montana-Steve Brown

Suggested amendments to HB-260

Title-page 1 line 8. After "of" strike "an" and insert "a newborn"

Section 1, page two, line 2. Following "Coverage" insert "for newborn infants as is provided in sections 33-22-301 and 33-22-504"

Section 1, page 2, line 5. Following "means", strike the remainder of line 5 and all of line 6 and insert "'placement for adoption' as is defined in section 40-8-103(10)."

Section 2, page two, line 18. Following "Coverage" insert "for newborn infants as is provided in section 33-30-1001"

Section 2, page two, line 21. Following "means", strike the remainder of line 21 and all of line 22. Insert "'placement for adoption' as is defined in section 40-8-103(10)."

Section 3, page three, line 7. Following "Coverage" insert "for newborn infants as is provided in section 33-31-102(1)(e)"

Section 3, page three, line 10. Following "means", strike the remainder of line 10 and all of line 11 and insert "'placement for adoption' as is defined in section 40-8-103(10)."

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 326

DATE 1-30-91 SPONSOR(S) Rep. Fred Thomas

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Rich Brown	MT Veterans Affairs	✓	
Terry Hurst	SRS		
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	AMTA	[illegible]	
[illegible]	Local 30 Asbestos Workers		X
M.N. Stephens	Ravalli County	X	
Jim Edwards - Helena			

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

1 of 2

Human Services & Aging COMMITTEE BILL NO. HB 341

DATE 1-30-91 SPONSOR(S) Rep. Dorothy Bradley

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Paige Aston 78 Cemetery Hill Rd Cardwell, MT 59721	American Massage Therapy Association, Montana Chapter	X	X
Aimee V. Hachigian, M.D. 1220 Central Great Falls, MT 59401	Self (Interested Physician) supporting Physical Therapists	✓	
Carrie Gaydosik 233 E Central Missoula, MT 59801	Physical Therapist	✓	
Hervey Perez 78 Cemetery Hill Rd Cardwell MT 59721	American Massage Therapy Assoc Montana Chapter	✓	✓
Gary Fuson	PT	✓	
Lorin Wright	PT	✓	
Mona Jamison	PT	✓	
~~SRS~~ Terry Krantz	SRS		
Joyce Dugan	PT	✓	
Hillman Spring Rep	PT / Legislature	✓	
266 Colonial Dr. Kirk Hanson Helena MT 59601	PT	✓	
Linda Farrell 564 3rd St. Helena ~~Linda Lee 539 3rd Helena 59601~~	~~Massage Therapist~~	✓	~~✓~~
Mona Jamison	Amer. Ch. Mt. Physical Therapy Assn.	✓	
Karen Wiegand	adopting parents	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 341

DATE 1-30-91 SPONSOR(S) Rep. Dorothy Bradley

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Roger Tippy	Mont State Pharmaceutical Assn		✓
MARY SCHWIND	AMTA	✓	✓
Jean T Swenson	Mt. Red Cross	✓	
Hank Schramm	AMTA	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

1 of 3

Human Services & Aging COMMITTEE BILL NO. HB 355

DATE 1-30-91 SPONSOR(S) Rep. Mark O'Keefe

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
J. Shontz	Mental Health Assoc.	?	
Pat Melby	Rimrock	✓	
[illegible]	Rimrock Foundation	✓	
[illegible]	Blue Cross		
James W. Gichton M.D.	Blue Cross Blue Shield of Mt.		✓
Bill Houston	Independent Ins Agency		✓
Mick DiFrancesco	DiFrancesco & Co Inc.		✓
Terry L. Smith	Local 330 Aluminum Workers		✓
Larry Craft	Aluminum Workers		X
Terry Krantz	SRS		
John Fitzpatrick	Pioneers Golf Corp.		X
Gregory Van Horssen	HIAA		X
Earl Tabberg	Blue Cross/Blue Shield		X
Clyde Bizzell	Blue Cross/Blue Shield		X

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

2 of 3

Human Services & Aging COMMITTEE

BILL NO. HB355 SPONSOR Rep. Mark O'Keefe DATE 1-30-91

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY.

WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU WANT TO SUBMIT WRITTEN TESTIMONY.

PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	SUPPORT	OPPOSE
Teresa Reardon	MFT/MFSE	355		X
George Lehnen	RMTC	355	X	~~X~~
Mary Lehnen	"	355	X	
Jim Edwards	BCBS			X
Gordon Morris	MACO	355		
LARRY AKEY	MASONIC OF LIFE UNDERWRITERS			X
Tom Schneider	MPEA			X
Larry Tabenske	COPM		X	
Ronald Hartman	MEA	HB 355		X
Myrna Jamison	Everly Wth-Treatment Center	HB 355	X	
Riley Johnson	NFIB	355		X
Joyce Brown	Dept of Administration			X
Bobbie G. Ford	AFSCME			X
DAVE EVENSON	U System			✓
Steve Brown	Blue Cross-Blue Shield			✓
Ann Ballward	RMTC	355	✓	

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

3 of 3

Human Services & Aging COMMITTEE BILL NO. HB 355

DATE 1-30-91 SPONSOR(S) Rep. Mark O'Keefe

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Mark O'Keefe	HD 45	X	
Tom Nelson	HD 95		X
Diane Sands	MT. Women's Lobby	X	
KEITH OLSON	MT. LOGGING ASSN		✓
JAMES TUTWILER	MT CHAMBER		✓
Mary McCue	MT Mental Health Counselors ass'n	X	
DR. Quinton Hebb	MMHCA	✓	
CHUCK BUTLER	BCBSMT		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

1 of 2

Human Services & Aging COMMITTEE BILL NO. HB 299

DATE 1-30-91 SPONSOR(S) Rep. Sheila Rice

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
BETTY BAY	DFS	YES	
Harriet Tamminga	MT. Interagency Adoption Council	yes	
K. McGowan	mt. Res. Child Care	yes	
[illegible]	Adoptive Mothers: F.A.C.E.T.	yes	
[illegible]	adoptive parents	yes	
D. Mark Riley	LDS SS	✓	
George Lehnek	Adoptive Mother Father	yes	
MARY LEHNECK	" "	yes	
Tomi Lehnek	Adopted Child	yes	
MIKE LEHNECK	" "	yes	
NIKKI LEHNECK	" "	yes	
JOEY LEHNECK	" "	yes	
Kari Worthey	Cattleton Home	yes	
Julia Garrity	MCA	yes	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

2 of 2

Human Services & Aging COMMITTEE BILL NO. HB 299

DATE 1-30-91 SPONSOR(S) Rep. Sheila Rice

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Rebecca Jones	Montana Children's Home Shodair	✓	
Paulette Kelleam	Self	amend	
Judith Carlson	MT Chpte, NASW	X	
Nona, O'Neil	Bozeman, Mt.	yes	
Sharon Speck	MT Post Adoption Center Helena	yes	
Ann Gilkey	Dept. Family Services	X	
Helen Costello		yes	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

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HUMAN SERVICES COMMITTEE BILL NO. HB 260

DATE 1/30/91 SPONSOR(S) Rep. Beverly Barnhart

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Ken Bjerke	Lutheran Social Service	YES	
Linda Stagenstein	Lutheran Social Services	yes	
~~Dennis Hall~~	Children of Mt	yes	
Alice Pendleton	adoptive parent	yes	
Harriet Tammenga	MT Interagency Adoption Council	yes	
BETTY BAY	DFS	YES	
Tanya Ask	Blue Cross & Blue Shield		✓
Terry Krantz	SRS	yes	
D. Mark Ricks	LDS Soc Ser	✓	
Gregory Van Horssen	HIAA		✓
Sharon Speck	MT Post Adoption Center	✓	
Rebecca Jones	Rhodair (Mont Children Home	✓	
Paulette Kohman	Self	✓	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS		—

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HOUSE OF REPRESENTATIVES
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Human Services & Aging COMMITTEE BILL NO. HB 260

DATE 1-30-91 SPONSOR(S) Rep. Beverly Barnhart

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Riley Johnson	NFIB		X
Ann Gilkey	Dept. Family Services	X	
Diane Sands	MT Women's Lobby	X	
Gary Logan	Adoptive parent	X	
Helen Costello	Mt. Post Adoption Center	X	

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