MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON TAXATION

Call to Order: By DAN HARRINGTON, CHAIR, on February 22, 1991, at 9:04 a.m.

ROLL CALL

Members Present:

Dan Harrington, Chairman (D)
Bob Ream, Vice-Chairman (D)
Ben Cohen, Vice-Chair (D)
Ed Dolezal (D)
Jim Elliott (D)
Orval Ellison (R)
Mike Foster (R)
Bob Gilbert (R)
Marian Hanson (R)
David Hoffman (R)
Jim Madison (D)
Ed McCaffree (D)
Bea McCarthy (D)
Tom Nelson (R)
Mark O'Keefe (D)
Bob Raney (D)
Barry "Spook" Stang (D)
Fred Thomas (R)
Dave Wanzenried (D)

Members Absent: Russell Fagg (R)
Ted Schye (D)

Staff Present: Lee Heiman, Legislative Council
Lois O'Connor, Committee Secretary

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

HEARING ON SB 194

Presentation and Opening Statement by Sponsor:

SEN. TOWE, Senate District #46, Billings, introduced SB 194 as "the perfect bill" because it only affects people with over $2 million in property holdings, no one pays any additional taxes, yet the state receives some tax benefit. The federal government has instituted a generation-skipping tax which is separate from the federal estate tax. This has come about because people were avoiding taxes where not intended. To differentiate between the

federal estate and generation-skipping tax: the estate tax affects property to children in excess of $600,000; the generation-skipping tax affects property left to grandchildren or great-grandchildren, skipping a generation. There is a $1 million exclusion and an additional $1 million exclusion if the Gallo exemption provisions are met. The tax doesn't affect anyone until over $2 million is left to a grandchild or great-grandchild. In the past, tax could be avoided by putting property in trust for children for their lifetime after which time it transferred to the next generation.

The federal government allows up to 5% credit for any generation-skipping tax generated by the State. At this time, Montana exempts all lineal descendants and spouses from inheritance tax. This bill levies 5% tax on the generation skipped. Consequently, proceeds generated from the tax come to the state instead of going to the federal government. The taxpayer pays no more but the state receives some income. There is no good way to estimate the proceeds, as the Fiscal Note indicates.

Proponents' Testimony: None

Opponents' Testimony: None

Questions From Committee Members:

REP. MARK O'KEEFE said there was a three-year window of opportunity built in when the federal law took affect. **SEN. TOWE** said he might be referring to either of two things: the Gallo exemption, which terminates in 1990 or 1991; or when the original generation skipping tax went into effect with the Tax Reform Act of 1979, it was proposed to not take affect for five years - that provision was repealed and not implemented. Later, in the Tax Reform Act of 1986, it was reinstated. **REP. O'KEEFE** asked if there was a need for a one- or two-year window to allow tax accountants, and others, to anticipate the tax. **SEN. TOWE** said no, since all the bill does is attach to federal legislation. When federal law levies $1.00, Montana wants to get $.05. An exclusion would deflect proceeds from the state to the federal government for that period of time until it became effective.

Closing by Sponsor: None

HEARING ON HB 699

Presentation and Opening Statement by Sponsor:

REP. ORVAL ELLISON, House District #81, McLeod, said the bill repeals a nuisance tax on travertine. There is a unique history in Montana: Northwest Improvement Company, a subsidiary of Northern Pacific Railroad, started to mine and process travertine in the 1920's. The enterprise was not profitable and production terminated. Until 1988 there was no tax levied on travertine, at

which time it began to be taxed as a mineral by Department of Revenue ruling. The tax issue has never come before the Legislature. To his knowledge, there was only one operation in the state but a few other deposits which are not being mined. The existing operation is mined in one county and processed in another and is represented by **REP. ELLISON** and **REP. RANEY.** The operation is small employing 4-5 people including the owners. Several travertine products are produced including decorative rock made from chips and rubble. Each product has a different value and amount of processing work. It is difficult to break out labor and machinery costs for each product and to record how much of each is sold. There has always been contention about what to exclude from gross proceeds to arrive at net proceeds; that is the case with travertine. **REP. ELLISON** compared the tax to the store license and recommended removing it. **EXHIBIT 1**

Proponents' Testimony:

Greg Strong, Livingston Marble and Granite, said his travertine operation was small, employing three people in addition to himself. Gross revenues for 1989 and 1990 were less then $250,000 each year. According to his accountant, net proceeds would create many problems for his operation, costing more for accounting procedures that the tax itself. There was no tax levied on his operation until 1988. In that year, DOR conducted an audit pertaining to net proceeds tax and informed him a determination was to be made on the tax owed. He expected it to be reasonable - perhaps $400-$500. He was given an estimate of $75,000. DOR ruled travertine a mineral. The Forest Service classifies travertine as a common mineral similar to sand and gravel as it is non-locateable and a claim can't be filed on it. He contacted his Senator and Representative who arranged a meeting with DOR.

In that meeting it was learned the $75,000 estimate was inclusive of 1980-1987. DOR suggested that he ask the Legislature to rule to exempt building stone from the tax. This week he received a 1989 tax estimate from DOR for $18,000. Net profit for 1989 was $8,000. He will not be able to stay in business with current tax policy.

REP. RANEY said he would like to be on record as a proponent.

Opponents' Testimony: None

Questions From Committee Members:

REP. O'KEEFE asked DOR to explain the discrepancy between the estimated $10,000 in the fiscal note and the $85,000 tax levied. **Jeff Miller, DOR,** said he did not know. **REP. ELLISON** said the larger figure represented back taxes. Taxes for the current year are expected to be $18,000 based on DOR calculations. **REP. O'KEEFE** then asked DOR to explain the discrepancy between the estimated $10,000 and the $18,000 estimated tax. DOR is using

$60,109 multiplied by the mill levy in Gardner, which is over 320 mills to arrive at the $18,000 tax estimate. **EXHIBIT 2**

REP. BARRY STANG asked if building stone included flagstone. **Mr. Strong** said yes. He said his plant has produced a 1 x 1-1/2" thick plank for about two years. Transportation is a marketing problem. He gave an example: 800 ton of stone went to Las Vegas billed $65/ton FOB quarry for the material. The freight cost averaged about $45/ton, or 66%. Primary Montana markets are west and south, not east, where the same transportation problem exists. One of the reasons his plant began producing 1/2" material was to reduce the per square foot freight cost. The product is still in development and the plant lacks much in terms of equipment and expertise. It is a beginning and is congruent with Governor Schwinden's value-added product.

REP. TOM NELSON asked if the tax had been forgiven for 1987. **Mr. Strong** said the tax was forgiven from 1980 through 1987. He referred to a letter from Don Hoffman, Natural Resource Division, dated 4/26/89, to that effect. It had been learned that the $75,000 estimated back taxes had actually been levied in 1988. The letter said the rule process would be reopened regarding insertion of travertine as a taxable mineral and that he would be notified of the hearing. He was not notified and feels he has no obligation to file returns for 1988 and 1989. **EXHIBIT 3**

REP. RANEY asked the nature of DOR's response. **Mr. Strong** said DOR checked with their legal people and felt everything was done legally.

Closing by Sponsor:

REP. ELLISON said the bill would take care of a nuisance tax which would cost more to collect than it is worth.

HEARING ON HB 738

An act to authorize a county, city, or town to levy an additional 2 mills for the support of ambulance services if authorized by the electorate; providing that the additional mills authorized by the electorate are not subject to the property tax limitations of title 15, chapter 10, part 4; and amending sections 7-34-102 and 15-10-412 MCA.

Presentation and Opening Statement by Sponsor:

REP. JIM ELLIOTT, House District #51, said his constituency asked him to sponsor this bill to enable the Board of County Commissioners to raise a levy for ambulances. It originates from an incident in the town of Plains which had a private ambulance service. Its license was taken by the state leaving the area without ambulance service. The citizens formed a new ambulance district since the local hospital, the only private hospital in Montana, said it would not take emergency patients without

ambulance service. The citizens are now in the process of purchasing an ambulance. Ambulance service in Montana is currently supported by a one mill municipal or county-wide levy, and fundraisers. Plains doesn't have many resources, no industry, or large companies; only small businesses. Thirty eight percent of the population is over 60 years of age. His constituency asked for a bill giving county commissioners authority to levy up to three mills and enabling city and town councils to do the same within their taxing jurisdiction. He felt it would be politically advantageous to allow county commissioners to put an increase of up to two mills on the ballot to be voted on by people who would benefit from the ambulance service in the district.

Proponents' Testimony:

Gordon Morris, Montana Association of Counties (MACO), rose in support of the local option ambulance levy bill.

Opponents' Testimony: None

Questions From Committee Members:

REP. GILBERT said the bill seemed a violation of I-105. **REP. ELLIOTT** said it depended on one's interpretation as to whether people are allowed to tax themselves. This bill allows a vote of the electorate. He does not see it as a violation of I-105. **Mr. Morris** said his rationale for not pointing to the I-105 section follows the Attorney General's opinion, shortly after passage of I-105, which stated clearly that new taxing authority approved by the voters was specifically exempt from provisions of I-105. Therefore, this bill is not in violation of I-105. **REP. HARRINGTON** said it was his floor amendment to I-105 that gave the people the right to vote.

Closing by Sponsor: **REP. ELLIOTT** did not close.

HEARING ON HB 693

Presentation and Opening Statement by Sponsor:

REP. FRED THOMAS, House District #62, introduced the bill as part of the Governor's health care program and distributed, Health Care for Montanans. There are approximately 141,000 uninsured Montanans. The uninsured population includes primarily three groups: small business, self-employed and low-income working people. Without insurance, people don't take timely preventative action. Delay into the health care system exacerbates the health problem and multiplies the cost. An article from the Missoulian discusses the mortality rate in the insured vs. the uninsured general population.

Cost shift aspects of the problem have been examined: All medical bills are paid by someone. Uncompensated hospital care

is estimated to be $27,000,000 and is paid by the insuring public. Examples of uncompensated care where access to preventative care might have had significant impact were given as average costs: Newborn with extreme immaturity - 93,000; pre-term infant with chronic prenatal problems - $157,800; heart diseases - $93,000-$100,000. There is a multiplying effect when the uninsured lack access to the health care system and costs are shifted to the public.

The question becomes how to help the uninsured become insured. Research shows health insurance premiums to be very high and many times unaffordable. The main factor keeping costs high are insurance mandates built into state laws. Mandates require specific coverage and are good social statements. They apply, however, to only 25% of the insuring public because any self-insurance plan - such as state and federal employees and Medicare - is not required to comply. The mandates do apply to the uninsured public because they have to buy them to become insured. Other states are considering the problem of mandates. The bill proposes to exempt the uninsured from mandates, to exempt the uninsured from the state premium tax and to provide for a tax incentive to encourage employers to insure their employees. The proposal will provide a 38% reduction from products now available on the market. The Governor's recommendation is two-fold: It addresses the needs of uninsured Montanans by making a limited benefit disability policy available to the uninsured, and it concentrates on small business. Section two identifies exemptions to the mandates but does not affect mandates on current policies. The proposal does not address the subject of mandates in general. Eligible persons are defined. Minimum benefits are stated and include maternity care, newborn care, well child care up to age two, chemical-mental health treatment, hospital acute care.

Under current law, one of the most expensive mandates is chemical-mental health treatment. The Governor's Health Care Committee carefully considered the ramifications and decided to include a $1,000 minimum benefit in the contract. The stated minimum does not keep a company from including more. The committee thought the area of treatment too important to omit but recognizes the minimum to be insufficient. It hopes that by providing access to the mental health system people will be provided opportunities to explore options for help - such as Alcoholics Anonymous, low-cost counseling programs and support groups. **REP. THOMAS** emphasized that $1,000 is only a minimum.

It is proposed, in the interest of keeping premium cost down, that premiums paid by those eligible for the insurance will not be taxed. Premium tax does not now apply to any health service premium, self-insured premium, Medicare or Medicaid. A tax credit will be available to employers with no more than 20 employees who have not offered insurance to employees within the last 12 months. The tax provision allows $25 per month per

employee if the employer pays 100% of the premium. The employer must pay at least 50% of the premium to qualify and the tax provision is prorated. Application for credit must be made within 36 months. There is no carry-back, carry-forward or payback - only credit against state income tax paid. **EXHIBITS 4,5,6,7,**

Proponents' Testimony:

Julia Robinson, Chair, Program for Governor's Health Care Committee; Director, SRS, said the bill is one of the key pieces in **Governor Stephens'** package. She distributed Health Care for Montanans: Committee Report and Recommendations of Working Committees, the committee's final report. She said health care is the number one social problem in the country and Montana can't wait for the federal government to make changes. Various bills have been proposed since the early 1900's dealing with national health care and none have come out of committee. She sits on various national panels, sees national trends and believes any national system is at least ten years off because of budget problems. States have been challenged to try new ideas in health care. This bill, the first step of the Governor's package, is outlined on pages 4-5, **EXHIBIT 4.** Its goal is to expand private health insurance for working people who are uninsured. She emphasized working people because the bill is not for people who are covered by Medicaid or Medicare - welfare recipients, the disabled and elderly. The basic plan has four minimum benefits emphasizing two areas: preventative services and catastrophic coverage. It gives a tax break to employers.

Philosophically, the program is affordable because it focuses on maternity and well child checkups. As a society, there is an obligation to help insure healthy babies. One of her goals is to help welfare recipients get into jobs better than welfare. If employers are not offering maternity care in their insurance packages because they get a cost break, then there might be subtle discrimination against hiring young women of childbearing age. Without preventative care, societal costs are very high. SRS has undertaken a study of high cost deliveries during the past three years. The results are startling and consistent. In 1988 the state paid for 3,200 Medicaid babies. Of those, 129 - or 4% - accounted for $4.2 million dollars - or 51% of the cost. The other 3,071 deliveries accounted for $4.1 million - 49% of the program cost. For the high risk babies the initial cost is only the beginning: $60,000/year at Boulder, $40,000/year in the community. Although some of the babies will be healthy, the chances of long-term health for most is not good. Medical costs for a lifetime - not including social costs, such as community programs, special education, etc. - are estimated at $400,000 per baby. The best predictor of healthy babies is good prenatal care. Half of the 129 high risk babies received no prenatal care. This problem is being corrected in Medicaid, but working uninsured people will not benefit. It is difficult to document the cost savings and therefore to justify a preventive focus. In

Montana, a child under the age of one dies every three days from health and accident-related causes. Since 1987, Montana has had the highest child mortality rate in the United States.

The mandate for psychiatric care and substance abuse is not enough, but represents a minimum amount. The Pepper Commission, which is cited as a national model, does not address this issue at all. The committee thought it essential because not to address it gives a wrong message. Coverage is really $2,000 because most state and government insurance pays 50%. Although hospitalization expenses could not be covered, the minimum would allow some intervention services. The Governor is committed to evaluate these services and report in two years.

Tax credits are a cost, but the cost is greater if nothing is done: a cost in Medicaid when people can't afford insurance, a cost in cost-shifting and rising insurance rates, a cost in health care cost escalation. Someone pays for the uncompensated cost of care. There is a cost directly to Montana in terms of rural communities having trouble with infrastructure, keeping hospitals and doctors in rural areas, and with industry relocating. When people think of moving here, the first thing they ask about is health care. She has been told she thinks differently from revenue people because she thinks in terms of human costs. High health care costs keep welfare moms on welfare and handicapped people out of jobs. Health care is a right in this country and this Legislature can take a step to move Montana to the forefront in health care reform. **EXHIBIT 8**

Bob Frazier, Project Consultant, Governor's Health Care Committee, said the committee considered current policy and practice in 17 other states before narrowing that number to 8, then finally adopting a plan similar to Virginia which meets the test of affordability. Eighty two percent of the working uninsured in Montana are employed by very small firms. The main reason employers give for not carrying insurance is affordability. Options A through I were considered. The proposed plan uses Sections H and I - "State Mandated Benefits" and "Design Low Cost Policies". Meeting the Health Insurance Needs of Uninsured Small Businesses: Market Research and New Products is submitted for the record. **EXHIBITS 9,10**

J. Riley Johnson, Director, National Federation of Independent Business (NFIB), submitted written testimony, **EXHIBIT 11, 12**

Tom Hopgood, Health Insurance Association of America, commended the Governor. The effect of mandated benefits has been discussed over the past several legislative sessions. Mandated health care benefits keep the cost of health care up. As the cost goes up, people get out of the market. He does not support the inclusion of any mandates whatsoever in the bill. He does support the bill as a conceptual step in the right direction.

Chuck Butler, Vice President, Blue Cross/Blue Shield of Montana (BC/BS-MT), and representing **Alan F. Cain, President and CEO, BC/BS-MT,** said **Mr. Cain** was unable to attend the hearing, but submitted testimony. **EXHIBIT 13**

As a member of the Governor's committee, BC/BS-MT enthusiastically supports the bill. BC/BS-MT currently provides health care coverage or administrative services for over 207,000 Montanans. That number has declined from over 147,000. For the most part the 40,000 are accounted for not by competitors, but are people who have dropped health insurance coverage altogether. Rapidly increasing health care costs and utilization of services have forced dramatic increases in the cost of available plans. It has not been uncommon for premium costs to go up 35% over the past several years. The average hospital charge per day in Montana was $500 in 1986; today it is over $900. At the same time, the average charge per admission was $2,300; by the end of 1991 it will be over $5,000. Escalation in health insurance premiums has produced a situation where over 141,000 Montanans are without health insurance. A large segment of those are employed by small employers who can't afford to contribute to benefit plans. BC/BS-MT's main competitor is no longer other insurance companies, but "no insurance whatsoever". Many employers would offer coverage if premiums were affordable. BC/BS-MT currently offers a product known as "Essential Care". Over 6,000 contracts of the "bare bones" policy have been sold in the last 12 months. It is designed to sell for $150 per month for family coverage. Those purchasing the product are very pleased they can afford the limited benefits. The individual is required to pay many routine services. Catastrophic losses are covered. This bill offers significant incentives for insurance companies to deliver low-cost benefits for the small premium market. Limiting benefits and restrictive mandates will cause an increase in the number of Montanans covered with private health insurance. The bill represents a starting point.

John W. Flink, Director, Montana Hospital Association, commended the committee. He said the problem is graphically illustrated by the amount of uncompensated hospital care. In 1989, $20,000,000 was uncompensated which represents a $5,000,000 increase in the last 5 years. The cost is paid in higher charges and assessments for someone. MHA believes a minimum basic benefits package will reduce the number of uninsured.

James Tutwiler, Montana Chamber of Commerce, said he would not restate testimony. He urges favorable consideration.

Susan C. Witte, Chief Legal Counsel, State Auditor's Office & Commission of Insurance, said **David Barnhill, Deputy Commissioner of Insurance** served on the committee but was unable to attend the hearing. He has identified his concerns about the bill to the committee and **REP. THOMAS**. Primarily he is concerned that the bill exempts all carriers from the premium tax, with is the

direct tax of 2-3/4% on all premiums written in Montana. He feels there is no public policy reason why carriers, including health service corporations, should be exempt. He urges amendment of Section 5 to insure premium tax applies to all carriers, including health service corporations. The money goes to the general fund. **Mr. Barnhill** is also concerned that the policies be underwritten to insure they get back guarantee association protection.

Opponents' Testimony:

Dr. Quint Hehn, Missoula, Montana Mental Health Counselors Association (MHCA), said it was a difficult to make a decision to testify against low-income people as he has been concerned about low-income people as long as he can remember. Health care is a major concern - but mental health is at the top of the list. The committee appointed to consider this bill did not include any mental health professionals. He fears the safety provisions intended for small companies with 20 or fewer employees will be eroded later to effect a general down-grading of policies. A major concern is the omission of a "freedom of choice" clause which might dictate the mental health care provider. His biggest concern is that the bill is not in the best interest of low-income workers.

As a counselor, he has the lowest sliding fee schedule in Missoula - sometimes $5 per session which, in actuality, is often not collected. Over the last 2-1/2 years, he has had 52 low-income clients not on Medicaid from whom he has collected $1,105.84 - or $21.25 per client. His point is that the bill would obviously benefit him personally.

The bill is purported to be designed primarily for the benefit of low-income families who are generally young, often single parents or dependent children from broken homes, and coming from a lower socio-economic background. They have generally less education and higher rates of dysfunctionality in their families. Their coping skills to face everyday problems are lower and their levels of stress are higher. Financial stress alone has been listed as one of the primary problems in divorces and remarriages. More than most people, low-income people need full mental health services. He viewed mental health as a cornerstone of his life and his physical health. Research indicates up to 80% of all physical illness is attributed directly or indirectly to mental health as diseases are brought on or exacerbated by psychosomatic forces. This is one of the reasons why employers have started to implement health and wellness programs in their businesses.

He compared mental health to the AIDS virus: AIDS devastates someone's life eventually bringing death. There are ways of transmittal which are fairly specific. Mental health problems - stress, depression, alcoholism, anxiety - don't just devastate someone physically, they devastate every part of life and in many

cases also result in death. Transmittal is not specific, but spreads causing problems in the work place and in families. Everyone can think of families with alcoholism, drug, gambling problems or other mental illness which affect family members. We know the affected person suffers, others suffer, and the patterns are repeated. **Mr. Hehn** gave as an example a family he now treats with a history of incest on both sides of the family for four generations. Mental health problems are predictably expected to be repeated generation after generation unless there is treatment. Research points to a tremendous potential for returns of 500-600%. This bill limits our potential savings. Proponents have talked of the high societal cost of people who delay medical treatment. Delaying mental health treatment has the same effect. Often the delay in mental health treatment will result in physical disorders - from heart disease to liver problems (related to alcoholism) - as well as worsening mental health symptoms. Family members will also suffer physical and mental disorders. **Mr. Hehn** gave an example of one Missoula family with 6 children which has cost Montana approximately $700,000 in social services and medical costs since 1973 - from gunshot wounds to appendix and tonsil operations; $100,000 per family member. He said that cost-to-date was only the tip of the iceberg because the situation keeps getting worse. It started as one family consisting of a mother with six young children. Now three children are alcoholic, and there are eleven grand- or great-grandchildren. Of the eleven, nine are living in alcoholic and violent homes. Every home has a history of domestic violence. Montana will face costs with this family down the line. A $5,000 investment in any 100 children like these with a return of a 20% success rate would save $25,000,000 over a couple of generations. **Mr. Hehn** said it is time to put an end to some of these family-generated problems and mental disorders and to save ourselves and the insurance companies millions of dollars - while saving the affected people from lifetimes of tragedy and pain.

Bob Bakko, Director, Northwest Counseling Centers, Billings and Bozeman, said he represented a multidisciplined group of licensed psychologists, licensed professional counselors and licensed social workers. He is not opposed to catastrophic health care but opposes the mental health provision. Referring to previous testimony relative to the self-insured plan which currently insures state employees: **Kathleen Prince** filed a recent lawsuit where the state was found to discriminate. The state is paying for mental health care for state employees. Northwest Counseling Centers, in their two locations, see over 600 people each month, 15% of whom pay from $0 to $10 per session. Most of these are single mothers with children, divorced, employed without medical insurance.

Last night, leaving his office at 6:30 p.m., a suicidal walk-in patient reached out for help. The first question right after the status exam at the psychiatric center in Billings was to inquire who was going to pay for treatment. The young man has been

unemployed for 18 months due to depressive illness and has no way to pay for hospitalization. **Joe Rich, Director of the Psychiatric Center in Billings,** said the center lost well over $250,000 last year providing services where payment could not be made. Inpatient facilities for psychiatric care range from $200-$2,000 per day. Based on the terms mandated in HB 693, this young man would have enough money for about one day and two hours.

Outpatient care is the best preventative investment in helping people to adjust to psychological disorders they may suffer. There is a need for at least a stronger minimum in the best interests of Montanans. Mental health is a major medical issue. The best investment is prevention. Mental health patients are not able to pick up the pieces after six or eight out-patient sessions. Most mental health treatment facilities are private businesses and are not financially secure: Sliding fee scales are offered. There are waiting lists to see low-income people - many are months long. By state law, people who are poor or low-income should be able to get services. Montana is basically rural, which creates an additional problem. Many rural areas have no one in private practice and very little access because of the size of the state. A study published in The Billings Gazette rated Montana 48th in the nation in terms of its mental health provision, but didn't consider the private sector. The private sector offers at least 90% of all human services in Montana.

Leonard Cobin, United Mine Workers of America (UMWA), said the concept of the bill was commendable, but UMWA sees problems with parts of it. Large industry may view the bill as a tax break for small companies. Discriminatory practice might result in legal issues. Regarding the lifetime mental health minimum of $1,000, UMWA's experience has shown that insurance carriers will tend to treat that as a benchmark amount; that will be all they will pay. $1,000 will not come close to treating a mental illness. He said in his personal experience he has had four colleagues in the last five years seek help for alcoholism or drug abuse. Expenses in these cases ranged from $7,500 to $15,000. He has had a family member who sought mental health treatment which has resulted in expenses over $7,000. He asked that the mental health mandate be altered.

Mary McCue, Lobbyist, MMHCA, said MMHCA is very concerned that existing coverage will be dropped and that people will be without coverage for the 12 month period established in the bill. She said even now she has heard people speak of the 12 months as a waiting period. Other states do not provide an experiential base from which to predict. He said MMHCA would adamantly oppose any attempt to amend the bill to remove the 12-month requirement. It is difficult to argue against a well-intentioned bill but the fact is that the working committee which developed the plan began last fall, meeting only three times. There was not a single mental health professional on the committee while three committee members represented the insurance industry. He asked that the

committee consider who ultimately pays for untreated mental illness, alcoholism and substance abuse.

REP. REAM, said that it was hard to oppose the bill, but the containment problem and arrogance in the medical profession had to be addressed or the country was headed for socialized medicine. Doctors in the country think they deserve over $250,000 annual salary; in Montana over $150,000, when the average Montana salary is near $15,000. He said he could support the bill if it were amended to read a minimum lifetime benefit of $1,000,000. He said it made him angry to have to address the issue of mental illness because the medical profession has for so long ignored this area of medicine.

He said he questioned the definition of mental illness. He quoted a book by Dr. Joan Borysenko, "Patients of the same age, sex and physical status undergoing the same therapy often fair very differently with the same cancer. While an average time of survival can be determined, some people live much longer than expected and others die far more quickly than predicted. Numerous studies have shown that attitudes may be a mechanism of profound importance in determining the course of at least some cancers." Oncologists who work with psychologists are finding there is success, and in some cases complete cures, for cancers. The Mind-Body Clinic at Harvard University is delving into the area of the connection between mind and body and finding biochemical connections. Much more must be done in the area of mental health to prevent diseases. **REP. REAM** said he was in strong opposition to the implication built into the bill that somehow mental illness is not an illness.

He said that he also was in opposition by reason of personal experience which involves his wife. She was stricken, inexplicably, four years ago. At that time she was a highly successful film maker, writer and screenwriter. The illness was, and remains, debilitating. It was eventually diagnosed as chronic fatigue immune dysfunction syndrome, a disease which has finally become recognized as an illness by the medical profession and the Center for Disease Control. **REP. REAM** referred to a recent article in Newsweek which states one of the symptoms of that viral disease is depression. Although it can always be argued which came first - the disease or the depression, he said in his personal experience it has proven to be a symptom needing psychotherapy as part of the healing process. The illness remains critical, expensive and seriously affects the well-being of his family.

REP. HARRINGTON said, due to time constraints, the bill would go directly to Income Tax Subcommittee where questions would be entertained. He asked the sponsor to close.

Closing by Sponsor:

REP. THOMAS said it was difficult to close at this sensitive point in the hearing, but the issues needed to be addressed. He said he has no debate with mental health providers or the need for mental health care. The bill addresses the problems of Montanans without insurance and high premium costs. 141,000 Montanans have no insurance at all. Reducing costs will allow more people to become insured. Without the bill, not only will people have inadequate mental health coverage, they will have no coverage at all. The committee will be given information resulting from Colorado's experience; people are not changing to a lesser form of insurance. He related the situation to buying a first car: A young person might want to buy the Cadillac in the showroom, but it isn't affordable. Probably he will buy something more modest.

The Governor's committee felt mental health care was so important that it was included as a minimum. If the minimum is not endorsed, people still won't have any coverage. He asked if that really would be better. Referring to the young man given emergency treatment last night in Billings: The first question is who will pay for treatment. The intention is to help people just like that gain access to initial treatment. Maybe in that man had earlier access emergency treatment could have been avoided. Most insurance coverage for mental health is 50%. $84 is the average price of a visit. Dividing $42 into $1,000 results in coverage for about 24 visits which is better access to the system than nothing.

The uninsured Montanan is typically working for a low-paid small business employee, self-employed or unemployed. Costs shifts for acute care drive costs up which makes the problem worse. Premiums rise and fewer people are able to buy insurance. The bill allows a free market system to provide a product for people in need. It blends with it a state-supported tax policy which provides an incentive. The Governor's committee strongly recommends the bill.

Announcements/Discussion: The hearing on HB 121, **REP. JOHN COBB, Sponsor,** is canceled due to lack of time. It will be rescheduled 3/5/91.

ADJOURNMENT

Adjournment: 11:07 a.m.

DAN HARRINGTON, Chair

LOIS O'CONNOR, Secretary

DH/lo

HOUSE OF REPRESENTATIVES

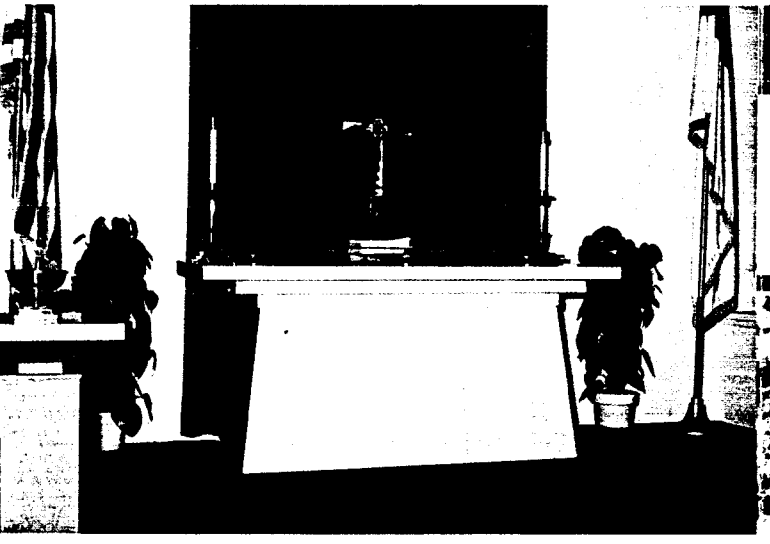
TAXATION COMMITTEE

ROLL CALL **DATE** 2-22-91

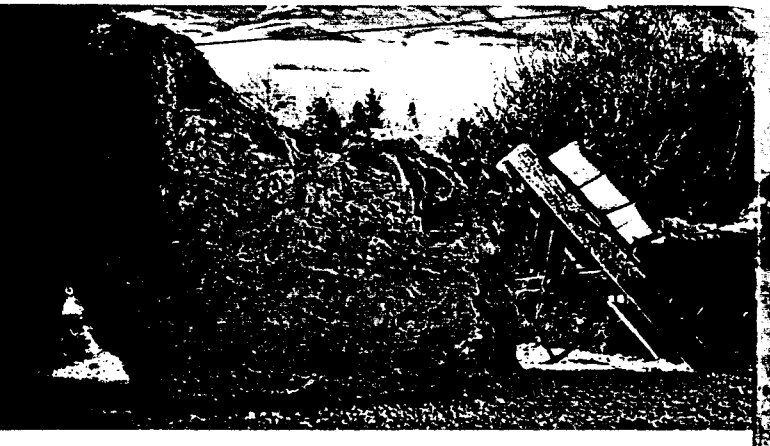
NAME	PRESENT	ABSENT	EXCUSED
REP. DAN HARRINGTON	✓		
REP. BEN COHEN, VICE-CHAIRMAN	✓		
REP. BOB REAM, VICE-CHAIRMAN	✓		
REP. ED DOLEZAL	✓		
REP. JIM ELLIOTT	✓		
REP. ORVAL ELLISON	✓		
REP. RUSSELL FAGG		✓	
REP. MIKE FOSTER	✓		
REP. BOB GILBERT	✓		
REP. MARIAN HANSON	✓		
REP. DAVID HOFFMAN	✓		
REP. JIM MADISON	✓		
REP. ED MCCAFFREE	✓		
REP. BEA MCCARTHY	✓		
REP. TOM NELSON	✓		
REP. MARK O'KEEFE	✓		
REP. BOB RANEY	✓		
REP. TED SCHYE		✓	
REP. BARRY "SPOOK" STANG	✓		
REP. FRED THOMAS	✓		
REP. DAVE WANZENRIED	✓		

EXHIBIT 2-22-91
HB699

MONTANA TRAVERTINE



Travertine is also an excellent medium for dimensioned building materials. This church altar was built from white, polished, diamond sawed travertine. This same material is used for fireplace hearth stones and mantles. The usual thickness for dimensioned slabs is 2¼", but they can be cut to specifications. This product is sawed, filled and either sanded down or polished depending on personal preferences. Dimensioned stone also comes in bouquet, coral, and gold travertine.



Travertine boulders and chips are very helpful and beautiful when used for landscaping. When used either together or separately, they produce an exciting effect.

Travertine is a durable, natural, building stone. Once the stone is layed up, it requires little, if any maintenance or upkeep. It is found in a variety of colors, ranging from white to shades of pinks and reds to shades of yellows and golds. It is quarried according to color, and personal preferences are easily met.

LIVINGSTON MARBLE AND GRANITE WORKS

711 E. PARK ST.

LIVINGSTON, MONTANA 59047

PHONE: 222-1342

DATE RECEIVED		OPERATOR #
		EXHIBIT 2
		DATE 2-22-91
		HB 699

STATE OF MONTANA — DEPARTMENT OF REVENUE
STATEMENT OF NET PROCEEDS OF MINES
FOR YEAR ENDING DECEMBER 31, 19 89

NP #1

Name: Livingston Marble
Address: P.O. 851
Livingston 59047
Telephone: (406) 222-1342

Name of Mine:
County:
Sec: Twp: Rge:
School District:

Name, Title, Address & Phone of Person in Charge of Mining Operations in Montana:

Name, Title, Address & Phone of Person in Charge of Tax Matters in Montana:

Type of Mineral: Travertine

GROSS VALUE:

1924.51	Tons	$ 113	Per Ton	$	
	Other	$	Per	$	
			Gross Value	$	217,470

DEDUCTIONS: (From Page 2)

1)	Cost of Extracting Ore	$
2)	Royalties	$
3)	Cost of Transportation to Mill/Reduction Works	$
4)	Cost of Sale of Ore	$
5)	Cost of Reduction or Milling	$
6)	Cost of Marketing & Conversion into Money	$
7)	Cost of Construction, Repairs & Betterments To Mine	$
8)	Cost of Repairs & Replacements To Reduction Works	$
9)	Depreciation of Reduction Works	$
	Total Deductions	$ 157,361
	Net Proceeds	$ 60,109
		# 18,600 +

Under penalties of perjury, I declare that I have examined this return and to the best of my knowledge and belief the information contained herein is true, correct, complete and in compliance with applicable Montana statutes and regulations.

(Signature of Principle Officer or Agent) (Date)

Est

DATE DUE: On or Before March 31st

MAIL TO: Montana Department of Revenue
Natural Resources & Corporation Tax Division
Mitchell Building
Helena, Montana 59620

Livingston Marble & Granite Works

ESTABLISHED 1907

— DEALERS IN —
ALL NATURAL STONE PRODUCTS
MONUMENTS AND MARKERS

PHONE 222-1342
NIGHT 222-0621 — 222-2719 — 222-0389

PO Box 851
711 EAST PARK ST.
LIVINGSTON, MONTANA 59047

EXHIBIT 3
DATE 2-22-91
HB 699

1/12/91

Dear Orville,

I am enclosing correspondence re Net Proceeds Tax. Our company was audited by Joyce Hefferneder of the Dept. of Revenue in the fall of 1988. In the spring of 1989, during the legislative session, she informed me that our company owed about $ 75,000.00 in back taxes for the net proceeds. Pete Story then arranged a meeting for Shonna and me with Ken Nordtvedt.

In our meeting with Mr. Nordtvedt, the three of us learned that the Department had added travertine to the list of valuable minerals covered under the Net Proceeds in the fall of 1988. Mr. Nordtvedt waived tax liability and told us the rule process would be reopened regarding travertine as a taxable mineral as per letter of April 26, 1989. To my knowledge the Department never reopened the rule process. However, the Department apparently still holds the view that travertine is a taxable mineral. (See letter dated 11/20/90).

To determine legislative intent re net proceeds, I have spoken with legislators, both present and past, Democrat and Republican. To a man, they have been surprised that travertine is a taxable mineral. It is our contention that the legislature did not intend to tax travertine under the Net Proceeds tax.

I also, spoke with Steve Marshall of the U.S. Forest Service, Minerals and Geology Management, Washington, D.C. He told me that travertine is a common and unlocatable mineral. One cannot file a travertine claim such as one would file for a locatable

mineral. It falls in the same category as sand and gravel re the US Forest Service.

As you are aware travertine is used primarily as a building stone, but we sell everything from garden boulders to furniture. Presently there are four of us on the payroll. Our gross sales for 1990, which was a good year, were less than $ 300,000. Our accountant lists some of the difficulties the Net Proceeds Tax would create for us in the attached letter. In my view it would be inequitable for the Department to tax us unless it, also, taxes our competitors. Since our competitors produce rough stone such as moss rock, it will be difficult to locate them, much less, tax them.

I would like to see the legislature clarify the meaning of "valuable" in the Net Proceeds section. Even here rock has value and it could probably be construed as a "mineral".

But my primary concern is decorative stone, most specifically travertine. Our primary competition in our "value added" products such as polished tile is not domestic but foreign. Montana is rich in stone; but without tax incentives the commercially viable deposits will sit in their natural state for another three billion years due to development and transportation costs. A section in the law exempting decorative building stone from Net Proceeds would be a step in the right direction.

Sincerely yours,

P.S. I have no quarrel with the RITT.

Ex 3
2-22-91
HB 699

State of Montana

Stan Stephens, Governor

Department of Revenue
Denis Adams, Director

Natural Resource and Corporation Tax Division
Jerry Foster, Administrator

November 20, 1990

CERTIFIED RETURN RECEIPT REQUIRED

Livingston Marble & Granite Works
P.O. Box 851
Livingston, MT 59047

RE: Net Proceeds of Mines, Production Years 1988-1989

Dear Greg Strong:

This letter is to inform you that we have not received your Net Proceeds of Mines returns for the year(s) ending 1988-1989, returns were sent to you on April 26, 1989. Per audit agreement Net Proceeds Tax for the production year 1980-1987 was not to be assessed, however Net Proceeds would be filed beginning with the production year 1988.

Please complete the enclosed returns, and send them to this office by December 31, 1990.

If you have any questions please don't hesitate to contact this office at (406) 444-2441.

Sincerely,

Cheryl L. de Montigny

Cheryl L. de Montigny, Tax Examiner
Natural Resource & Corporation Tax Division

Reviewed & Approved by:

Don Hoffman, Bureau Chief
Natural Resource & Corporation Tax Division

EXHIBIT 3
DATE 2-22-91
HB 699

SEP 11 1

DEPARTMENT OF REVENUE

STAN STEPHENS, GOVERNOR

MITCHELL BUILDING

STATE OF MONTANA

HELENA, MONTANA 59620

#3160

April 26, 1989

CERTIFIED RETURN RECEIPT REQUIRED

374925 SEP1489

$690.84

Travertine

Livingston Marble & Granite Works
P.O. Box 851
Livingston, MT 59047

RE: Assessment of Additional Resource Indemnity Trust Tax, Production Years 1983-1987.

Dear Mr. Strong,

This letter and the attached schedules constitute notice of assessment of Resource Indemnity Trust Tax for the above mentioned production years. It is issued in accordance with Section 15-38-110, Montana Code Annotated. The audit adjustments are explained below.

The additional tax due results primarily from using the proportionate profits method to determine a taxable value.

The taxable value was determined using the information which was available from the daily sales journal, production records and expense records. This was calculated by taking the direct mine costs over the total direct costs and multiplying this percentage by the total sales value to arrive at a taxable value for the Resource Indemnity Trust Tax.

The additional tax and interest due is $1,562.47 as shown on the attached schedules.

The Net Proceeds Tax for the production years 1980-1987 will not be assessed pursuant to our conversation with Mr. Ken Nordtvedt, Director of the Department of Revenue. However, this return should be filed prospectively beginning with the production year 1988.

The rule process will be reopened regarding the insertion of the mineral travertine into the rule as a taxable mineral. You will be notified of the hearing so that you may appear to voice any comments you may have.

Rep

You are advised that any protest of this assessment must be filed within 30 days of the date of this notice. An oral hearing and opportunity to present additional evidence relating to this liability will be granted if requested within the 30 day period. If no protest is filed, the assessment becomes final upon the expiration of the 30 day period. All opportunities for administrative remedy will lapse with the expiration of this time period.

Enclosed are the proper tax forms which need to be filed for the Mines Net Proceeds, along with the applicable statutes and regulations.

Sincerely,

Joyce Hefenieder

JOYCE HEFENIEDER, Revenue Agent
Natural Resource & Corporation Tax Division

Reviewed and Approved by:

Don Hoffman /JC

DON HOFFMAN, Chief
Oil, Gas and Royalties Bureau
Natural Resource and Corporation Tax Division

JH/DH/lc

Enc.

Attach.

Livingston Marble & Granite Works

ESTABLISHED 1907

-- DEALERS IN --
ALL NATURAL STONE PRODUCTS
MONUMENTS AND MARKERS

PHONE 222-1342
NIGHT 222-0621 — 222-2719 — 222-0389

PO Box 851
711 East Park St.
LIVINGSTON, MONTANA 59047

EXHIBIT 3
DATE 2-22-91
HB 699

Sept. 7, 1989

Don Hoffman
Natural Resource and Corp. Tax Div.
Mitchell Building
Helena, Mt. 59047

Dear Mr. Hoffman,

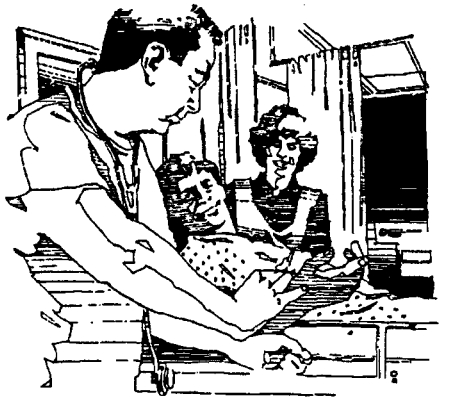
I am enclosing a copy of our accountant's calculations concerning the RITT and a check for $690.84. Our accountant, Mr. Shellenberg, has a greater working knowledge of our business than any other accountant who has represented us. We were his client while he practiced in Livingston. He has spent considerable time at our quarry and plant.

Please let us know if there are any questions or contact him if there is a problem relative to the calculations. Thank you for your cooperation.

Sincerely,

Greg Strong

EXHIBIT 4
DATE 2-22-91
HB 693



HEALTH CARE FOR MONTANANS

■ *GOVERNOR STAN STEPHENS*

■ *AGENCY SPONSORS:*

Dept. of Health and Environmental Sciences, *Dennis Iverson, Director*
Dept. of Family Services, *Tom Olsen, Director*
Dept. of Social and Rehabilitation Services, *Julia E. Robinson, Director*
Dept. of Institutions, *Curt Chisholm, Director*
Governor's Office on Aging, *Hank Hudson, Aging Coordinator*

■ *JULIA E. ROBINSON, CHAIRPERSON*

INTRODUCTION

In the fall of 1990, Governor Stephens appointed a number of working committees to address the problem of access to health care for the uninsured. The committee recommendations were submitted to the Governor in December of 1990.

Upon review of the Final Report, Governor Stephens personally committed to working on successful implementation of the five steps outlined in this summary. Because changing health care is an ongoing process, the final action step is a commitment of executive branch staff and financial resources to continuing the search for solutions to problems in the health care arena.

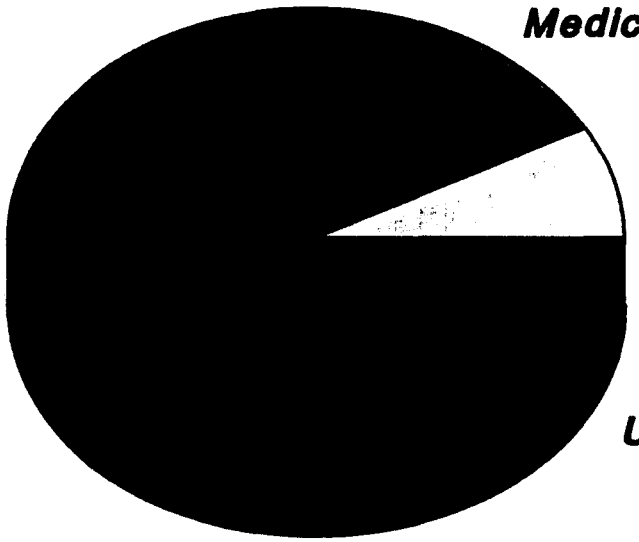
Governor Stephens believes these steps provide positive, appropriate direction for Montana in addressing the complex issue of health care access. They are not a total solution; just a beginning. Also, we must acknowledge that some changes are not possible instate because of the federal design of the Medicaid and Medicare programs. Potential changes in these programs await Congressional action.

(All committee recommendations are contained in the working committees' Final Report on Health Care for Montanans.)

CONTENTS

Copies of the full report are available upon request from the Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604

Health Insurance in Montana
Number of Persons Insured and Uninsured



- Total Population = 804,000
- Private insurance may be underestimated because Medicare enrollees may also have private insurance

EXHIBIT 5
DATE 2-22-91
HB 693

Uninsured hospital patients face tripled risk of mortality

CHICAGO (AP) — Hospital patients who lack medical insurance die at up to triple the rate of similar patients with insurance, a report says, adding to evidence that a person's ability to pay affects one's treatment.

"The fact that we did find such striking trends in in-hospital mortality rates is troubling, is very troubling," said Jack Hadley, who led a team that analyzed hospital records of nearly 600,000 patients.

But not all the variability in death rates is necessarily attributable to differences in quality of care, cautioned Hadley, co-director of the Center for Health Policy Studies at Georgetown University School of Medicine.

"It could be that people with private insurance are being discharged to a nursing home or a hospice" to die, he said in a telephone interview from Washington, D.C. "Without insurance, they may stay in the hospital."

Also, he said, the uninsured possibly "didn't get the care they needed before they came in, or they waited too long."

However, the findings "point to the possibility of there being a real health consequence of not having health insurance," Hadley said.

"There are people who have argued that everybody who needs care in life-threatening situations gets it, and that the (biggest) problem (with the U.S. health-care system) is overuse of services," he said.

"This study questions that point of view," said Hadley, whose findings were published in Wednesday's Journal of the American Medical Association.

Hadley's group studied the records of 592,598 people hospitalized nationwide in 1987. It compared uninsured and privately insured patients, excluding Medicaid patients because of widely different payment policies state-to-state.

In 13 of 16 patient groups matched for age, sex and race, researchers found the uninsured were sicker when they arrived at the hospital, as evidenced by their 44 percent to 124 percent greater likelihood of dying at that time.

Even after leveling these differences statistically, the in-hospital death rates were 1.2 to 3.2 times higher among uninsured patients in 11 of the 16 groups, the researchers said.

EXHIBIT 6
DATE 2-22-91
HB 693

EXHIBIT 7
DATE 2-22-91
HB 693

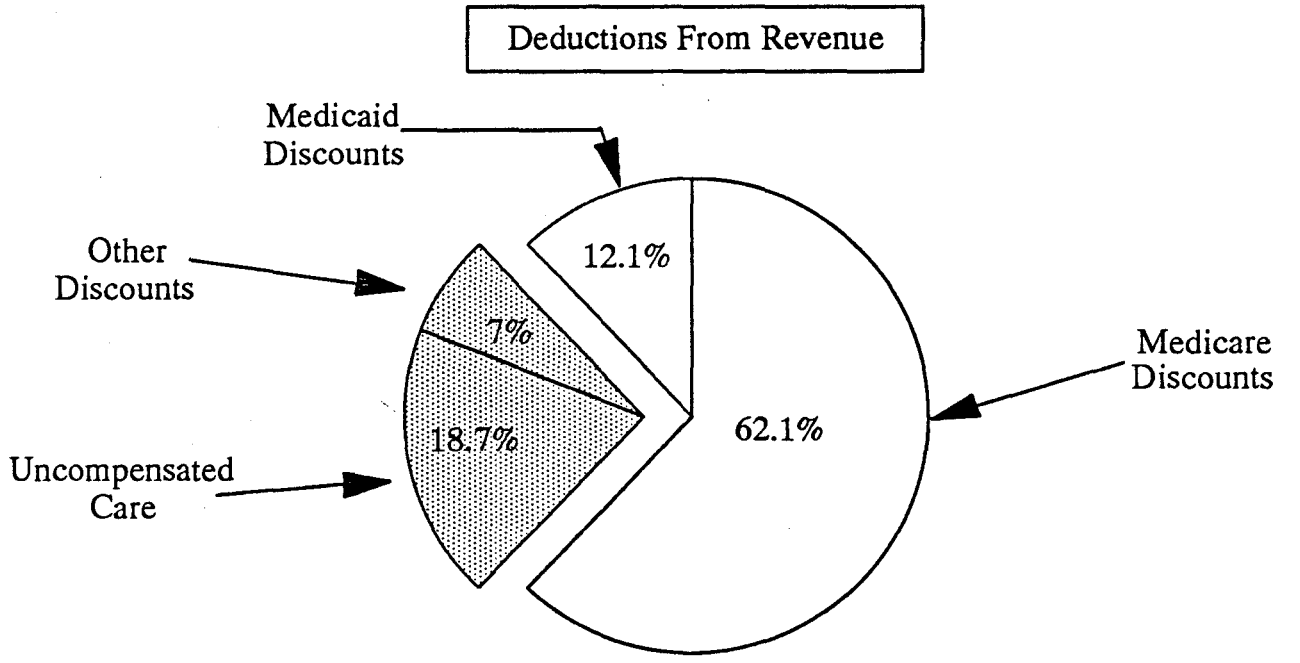
Montana Hospital Data - 1989

Deductions from Revenue		
Medicare discounts		67,080,658
Medicaid discounts		13,078,292
Uncompensated Care	(27,780,263)	20,228,253
Other discounts		7,552,010
TOTAL Deductions from Revenue		$107,939,213
Hospital Admissions		
Medicare		38,742
Medicaid		10,107
All Other		51,771
TOTAL		100,620
Outpatient/ER Visits		
Outpatient		465,221
Emergency		230,279
TOTAL VISITS		695,500
Deductions as a percent of Revenue		
Inpatient	78.5%	84,732,282
Outpatient	21.5%	23,206,931
TOTAL		$107,939,213
Uncompensated care and other discounts		
Inpatient		21,807,794
Outpatient		5,972,835
TOTAL		$27,780,263

Uncompensated care and other discounts	
Per non-medicare, non-medicaid Admission	$421.24
Per All Admissions	$216.73
Per Outpatient/ER Visit	$ 8.59

The hidden tax of cost-shifting, driven by the failure of Medicare and Medicaid to reimburse hospitals for the actual cost of providing services and the cost of uncompensated care, leads to higher care costs for consumers. That tax was $842.10 per admission in 1989. The tax per non-medicare, non-medicaid admission for uncompensated care was $421.24.

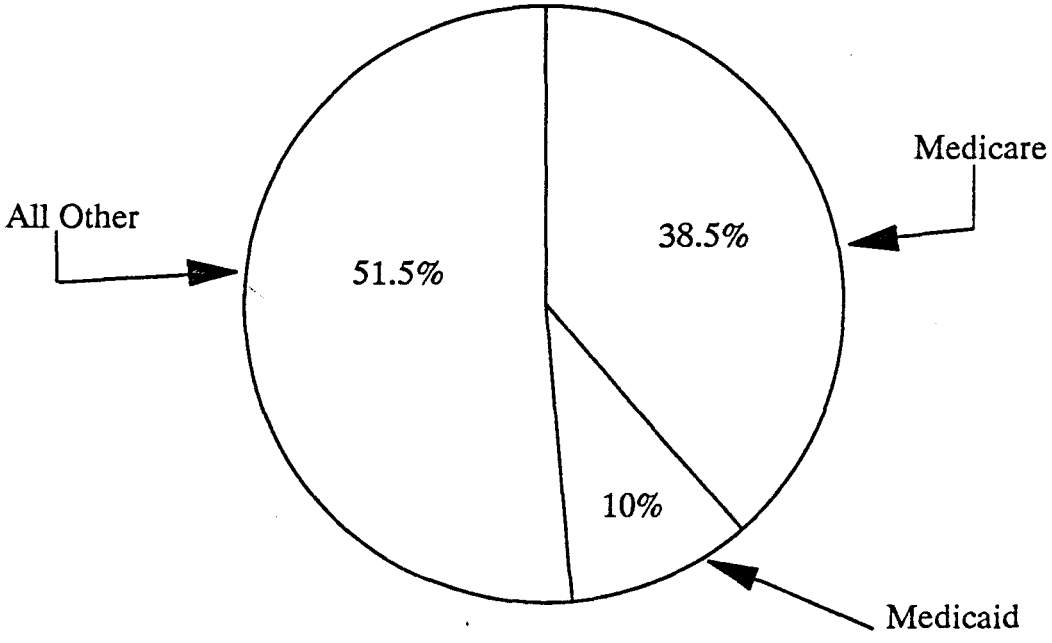
Montana Hospital Data - 1989



Medicare Discounts	67,080,658
Medicaid Discounts	13,078,292
Uncompensated Care	20,228,253
Other Discounts	7,552,010
Total Deductions From Revenue	$107,939,213

Montana Hospital Data - 1989

Hospital Admissions

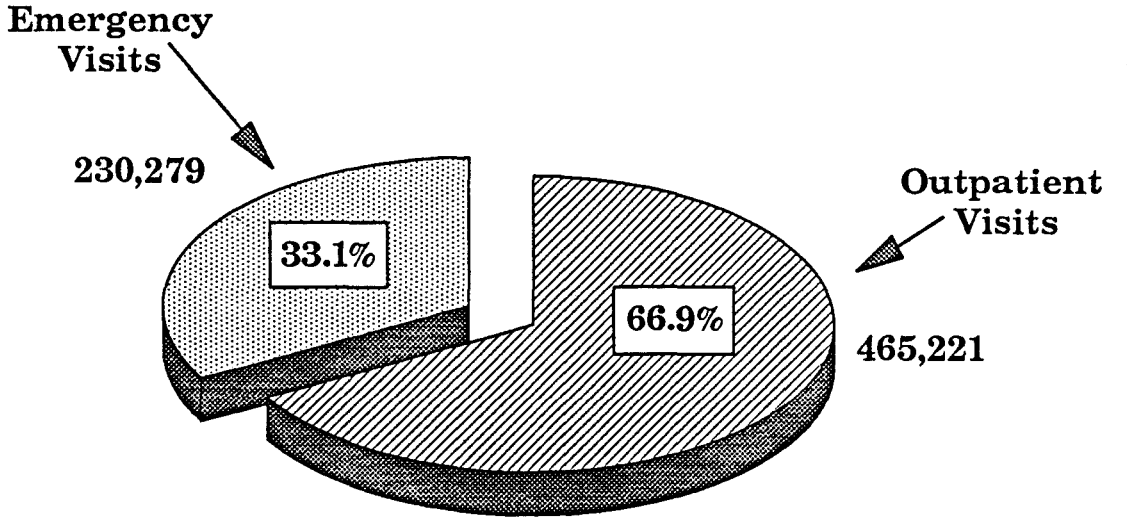


Medicare	38,742
Medicaid	10,107
All Other	51,771
TOTAL	100,620

EXHIBIT 7
DATE 2-22-91
HB 693

Montana Hospital Data - 1989

Outpatient/ER Visits



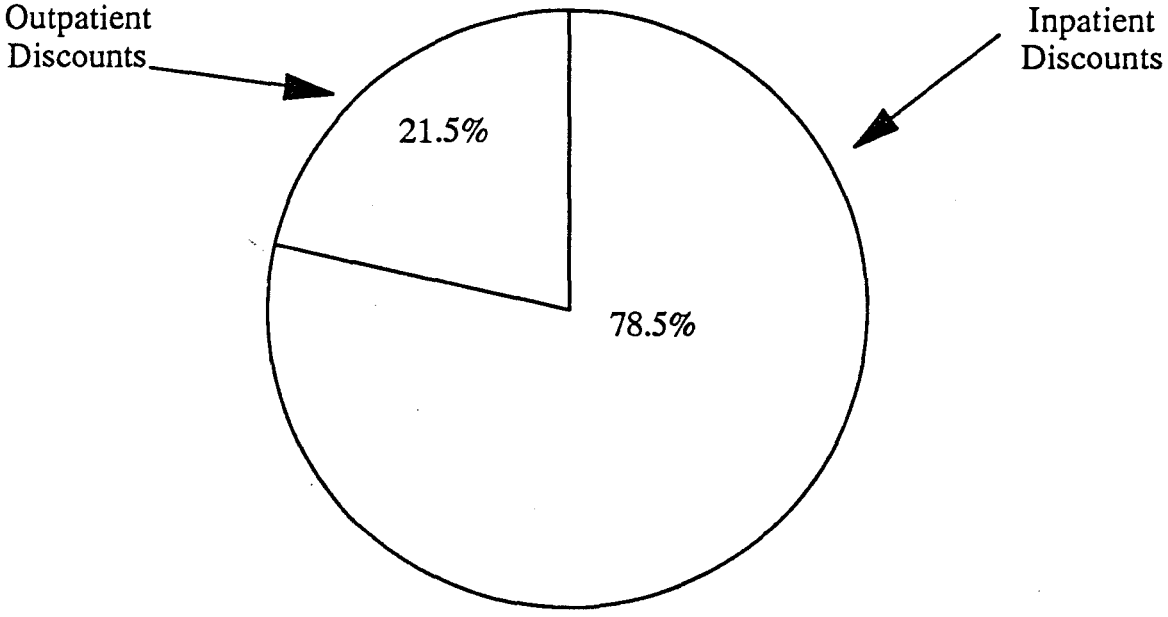
Outpatient/ER Visits

Outpatient	465,221
Emergency	230,279
Total Visits	695,500

Ex. 7
2-22-91
HB 693

Montana Hospital Data - 1989

Uncompensated Care and Other Discounts



Inpatient	21,807,794
Outpatient	5,972,835
Total	$27,780,263

While many people think we've been close to solving our health care problems through a national system, we have not been. We've debated the issue since before World War I (1907) with no results. In fact, Congress has never allowed a national health care bill out of committee.

EXHIBIT 8
DATE 2-22-91
HB 693

Health Care for Montanans: Committee Report and Recommendations of Working Committees

Submitted to Governor Stan Stephens by:
Julia Robinson, Chairperson
and the Governor's Health Care Committees

Report Prepared by: Bob Frazier, Project Consultant

With federalism has come new responsibilities for the states. It has become quite apparent that if people in Montana want positive changes in health care, we will have to make them as a state.

For more information contact: Julia Robinson, Director
Social & Rehabilitation Services
(406)444-5622
Nancy Ellery, Administrator
Medicaid Services Division
(406)444-4540
PO Box 4210
Helena, MT 59604

require between 75 and 80% of the costs be borne by employers. Plans such as those recommended by the Pepper Commission actually impose a form of taxation on employers who don't provide health insurance. Without some tax relief tradeoff these plans will most likely force small businesses to hire more "part-time" workers to get around these proposals.

G. UNIVERSAL HEALTH INSURANCE - This approach has often been suggested although no real progress has been made since the discussion was initiated in the early 1900's. Montana should not hold out hope that national health care coverage will come any time soon.

H. ALTER STATE MANDATED BENEFITS - Health insurers claim and in some cases rightly so that mandated coverage drives the cost of health care much higher than it need be. Insurers question the value of some services provided by health care professionals, however, there has been no information what the cost savings would be if some mandates were lifted. Most analysts agree however that the preventative and maintenance mandates have a positive impact on the health care system and should not be lifted.

I. DESIGN LOW COST POLICIES - This method allows exemptions in health care coverage presently offered by employers. It most likely will come with higher deductibles or copayments and often has aspects of managed care or HMO coverage. While it may not be the final answer, it does provide a starting point for those needing insurance.

Please Note:

Solutions H and I were the combined choice of the committee who dealt with the uninsured population's needs. The plan they developed is outlined in the next section.

EXHIBIT 9
DATE 2-22-91
HB 693

I. UNINSURED MONTANANS - PART 1

As previously mentioned, Montana has 141,000 people who don't have health insurance. Their lack of coverage and access to medical care causes not only great difficulties for them but also for the insured population and the State of Montana. As most of us know someone will eventually pick up the tab, whether it be through cost shifting, increased premiums or sending the bill to the State. It is therefore important to examine some of the potential solutions to the crisis that is growing on a daily basis within the health care area. They are as follows:

A. ENCOURAGE PEOPLE TO USE FEWER MEDICAL SERVICES BY WRITING HIGHER DEDUCTIBLES INTO POLICIES - This proposal has two distinct sides. While higher deductibles may discourage unnecessary services usage, there is a danger that people will postpone necessary treatment. This postponement could make more costly procedures necessary or for some people could be too late.

B. INSTITUTE MANAGED CARE - Managed care includes formal programs that monitor the quality of treatment and determine whether the care is appropriate for the patient's condition. Managed care institutes some of the control doctors have objected to in national health insurance plans. It also has created the health care cost management business, one of the fastest growing segments of the health care industry. Managed care may eventually be an answer to health care costs.

C. ESTABLISH RISK POOLS - While many states have set up risk pools for persons who can get no health insurance coverage due to medical conditions, the pools suffer from two striking problems. The pools are often extremely expensive and many have long waiting lists that require up to a year to receive coverage. Montana is presently one of the states offering such a pool.

D. EXPANSION OF MEDICAID COVERAGE - Nationally, Medicaid covers 70% of everyone under poverty guidelines. Today, Montana now covers 51%. One proposal is for everyone up to 200% of poverty be able to "buy" Medicaid coverage. The "buy" portion of this proposal would comply a sliding scale of purchase with the state and/or federal government being a financial partner in the policy's purchase.

E. REFORM INSURANCE COMPANY PRACTICES ON WAITING PERIODS AND PRE-EXISTING CONDITIONS - This proposal would eliminate exclusion riders for certain health conditions.

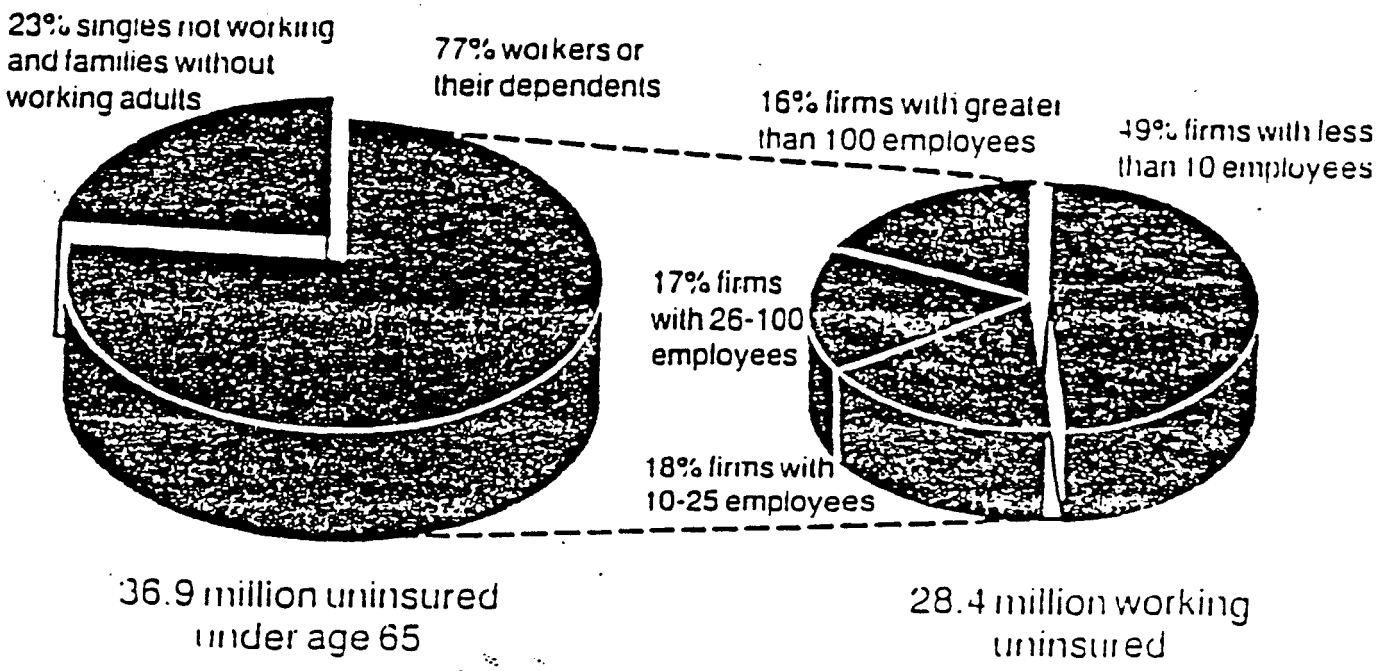
F. REQUIRE ALL EMPLOYERS TO OFFER COVERAGE - Many state and federal proposals exist that would require employers to carry health insurance on their employees. Most proposals consider employees "full-time" at about 20 hours per week. Many

Appendix I

The following charts and graphs provide further information about the United States uninsured population.

CHART 1

Nearly Half of the Working Uninsured Are Employed in Very Small Firms



Source: Derived from NCHSR analysis of NMES data, first quarter, 1987.

(United States statistics)

TABLE 6
Reasons Reported by Small Employers For Not Offering Health Insurance to Their Employees

Factors in Decision Not to Offer Insurance	Alabama (Birmingham)	San Diego	Denver	Maine (Brunswick)	Wisconsin (4 Counties)
Cost:					
Too Expensive	64.7	69.0	56.1	49.2	77.6
Firm Not Sufficiently Profitable	25.0	41.0	—	31.4	44.8
Workforce Considerations:					
Many Employees Insured Elsewhere	67.3	49.0	46.5	35.6	63.1
Employees can be Hired Without Providing Insurance	42.8	33.0	57.6	19.6	44.9
High Employee Turnover	19.0	22.0	23.2	13.6	19.0
Employees Don't Want It	39.1	25.0	16.0	12.7	43.9
Insurance Market:					
Company Turned Down: Too Small	25.0	22.0	19.2	10.3	*
Cannot Find An Acceptable Plan	22.8	32.0	24.5	14.7	31.5
Lack of Information/ Difficulty Judging Plans	17.9	19.0	16.9	16.0	31.6
Employees Cannot Qualify: Preexisting Conditions	11.3	10.0	8.6	7.9	24.1
Company Turned Down: Type of Business	11.4	7.0	2.9	*	*

*Survey did not ask this question.

TABLE 7
Portion of Premium Paid by Employers for Full-Time Employees and for Dependents

Portion of Premium Paid by Employer	Arizona (Statewide)		San Francisco		Denver		Maine (Brunswick)		New Jersey* (15 Counties)		Wisconsin (4 Counties)	
	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.
All	54.1	23.2	79.0	32.0	73.6	37.9	65.0	38.8	84.0	62.0	64.5	52.8
Some	21.7	10.1	17.0	14.0	21.4	14.6	25.8	41.4	14.0	10.0	31.1	31.1
None	24.3	66.7	2.0	50.0	5.0	47.5	9.2	19.8	2.0	8.0	4.4	16.2

*For dependent coverage in New Jersey, 20 percent reported "not applicable/ineligible" or "don't know."

Plan Features

INSURANCE PROJECT	SERVICE DELIVERY NETWORK[1]	DEDUCTIBLE	COINSURANCE CAP, OUT-OF-POCKET MAXIMUM	MAXIMUM BENEFIT AMOUNT	PRE-EXISTING CONDITION CLAUSE[2]
Alabama: Basic Care Private Option—A	Network model HMO of public and private hospitals and private physicians	$100 per individual per contract year, $300 per family	$1,080 per person per year—deductible plus coinsurance $3,240 per family	Unlimited (Limited benefit package)	12-6-12
Alabama: Basic Care Public Option—B	Network model HMO of publicly supported hospitals and county primary care clinics	Same as above	Same as above	Same as above	Same as above
Arizona: Health Care Group Option One	Network model HMO in 2 counties, IPA in 1 county	None	$4,000 per person per year participant's coinsurance	$250,000 per person per year	12-12 for inpatient services (pregnancy: normal delivery not covered for 10 months from enrollment)
Arizona: Health Care Group Option Two	Same as above	None	None	$250,000 per person per year	Same as above
Arizona: Health Care Group Option Three	Same as above	None	None	$20,000 per person per year	Same as above
Arizona: Health Care Group Option Four	Same as above	$2,000 per individual per contract year	$2,000 maximum out-of-pocket per person per year	$250,000 per person per year	Same as above
Denver: SCOPE	EPO, co-payments waived for low-income persons using publicly-supported hospitals	Inpatient care—$250 per individual per calendar year, $500 per family. Outpatient prescription drugs—$50 per year	$2,750 per person per year deductible plus coinsurance, $5,500 per family	Unlimited (Exceptions: mental health, substance abuse, hospice care, convalescent care, person over 70)	3-3-6 employee 3-3-12 dependent
Florida: Florida Health Access Standard Option	IPA model HMO, (nonprofit)	None	$1,500 per person per calendar year—total copayments, $3,000 per family	Unlimited	None
Florida: Florida Health Access High Option	Same as above	None	Same as above	Unlimited	None
Maine: MaineCare	IPA model HMO	None	None	Unlimited	Exists 90 days after enrollment, but does not apply to pregnancy
Michigan: Blue Cross Blue Shield Option	Blue Cross/Blue Shield affiliated providers, indemnity plan	$100 per individual per calendar year, $200 per family	$1,100 per person per year deductible plus coinsurance, $1,200 per family	$1,000,000 per person—lifetime benefit, all causes	6-6 for groups 4 or less (pregnancy—at least 270 days from enrollment), no clause for groups 5 or more
Michigan: Blue Care Network Option	Mixed model HMO, staff and network components	None	None	Unlimited (some benefits limited)	None
Tennessee: MedTrust	HMO including clinics and physicians from Tenn. Primary Care Network	None	$500 per person per year or $1250 per family maximum out-of-pocket	Unlimited	6-3-12
Utah: Community Health Plan	Network model HMO including community health centers and private physicians	None	None	$1,000,000 lifetime benefit maximum all causes	Conditions for which medical advice was received 24 mo. before enrollment, or treatment for 12 mo., are covered at 50% for first 12 mo.
Washington: Basic Health Plan	Variety of staff, network and IPA model HMO's	None	None	Unlimited	6-12

[1] Service Delivery Network Abbreviations: HMO — Health Maintenance Organization EPO — Exclusive Provider Organization IPA — Individual Practice Association

[2] Pre-existing condition clause: Numerals refer to time periods in months unless otherwise noted, e.g. 12-6-12 means that if the person received treatment for a condition within 12 months before enrollment, that condition would not be covered until the person has been treatment-free for six continuous months while insured, or has been enrolled for 12 continuous months. A 12-12 plan would eliminate the treatment-free clause.

Monthly Premiums for an Adult Employee Age 35[1]

INSURANCE PRODUCT	SINGLE		FAMILY[2]			REQUIRED EMPLOYER CONTRIBUTION
	MALE	FEMALE	2-PERSON OR COUPLE	3-PERSONS	4 OR MORE PERSONS	
Alabama: Private Option—A	73.96	73.96	186.32	186.32	186.32	50% of single premium
Alabama: Public Option—B	45.07	45.07	110.86	110.86	110.86	50% of single premium
Arizona[3]: Option One	82.02	82.02	160.79	259.89	259.89	None required
Arizona[3]: Option Two	93.73	93.73	183.81	298.12	298.12	None required
Arizona[3]: Option Three	90.14	90.14	176.98	276.87	276.87	None required
Arizona[3]: Option Four	55.43	55.43	108.88	180.12	180.12	None required
Denver[4]: SCOPE	51.94	71.54	148.47	148.47	148.47	25% of single premium
Florida: Standard Option	72.52	72.52	145.82	198.95	198.95	50% of single premium
Florida: High Option	82.42	82.42	162.72	226.11	226.11	50% of single premium
Maine: MaineCare						
Unsubsidized (201% + FPL)	91.71	91.71	183.42	274.23	274.23	50% of unsubsidized rate
Subsidized (101-125% FPL)	64.55	64.55	129.10	174.93	174.93	
Michigan[5]: Blue Cross Blue Shield Option						
Unsubsidized (201% + FPL)	118.06	118.06	271.03	283.93	283.93	33.3% of unsubsidized rate
Subsidized (101-200% FPL)	78.71	78.71	180.69	189.29	189.29	
Michigan[5]: Blue Care Network						
Unsubsidized (201% +FPL)	112.56	112.56	261.00	277.90	277.90	33.3% of unsubsidized rate
Subsidized (101-200% FPL)	75.04	75.04	174.00	185.27	185.27	
Tennessee: MedTrust	48.71	48.71	97.43	131.53	131.53	$30.00 per month
Utah[6]: Community Health Plan	63.57	73.75	137.32	159.36	187.88	$30.00 per month
Washington[7]: Basic Health Plan						
Unsubsidized (200% +FPL)	95.00	95.00	190.00	295.00	295.00	N/A—sold directly to individuals
Subsidized (100-124% FPL)	19.00	19.00	38.00	55.00	55.00	
AVERAGE FOR ALL PRODUCTS:						
Using Unsubsidized Rates						
Mean	78.46	80.44	168.32	220.51	222.41	
Standard Deviation	22.50	21.00	49.49	64.73	63.21	
Using Subsidized Rates						
Mean	66.45	68.44	142.75	185.41	187.31	
Standard Deviation	19.80	19.44	40.83	63.31	62.90	

[1] Rates are for premiums in effect as of March 31, 1989. Maine, Michigan and Washington states offer direct premium subsidies for low-income enrollees. Unsubsidized rates are for persons with incomes above 200 percent of the federal poverty level (FPL) and subsidized rates for those just above 100 percent FPL.

[2] Assumes a 2-person group is made up of employee & spouse age 35 and that a three or four person group has two adults plus children.

[3] Arizona: rates for Maricopa County

[4] Denver: rates for Denver area

[5] Michigan: rates for Genessee County

[6] Utah: rates for groups of less than 15 employees

[7] Washington: rates are statewide averages

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Coverage of Selected Benefits in 15 Health Insurance Plans*

Always Covered (15 products)
■ **Doctor's Office Visits** Alabama Plans A & B: limit to 6 visits/year Denver: $15 copayment or 50% coinsurance if procedure performed Utah: $20 copayment for specialists ■ **Outpatient Diagnostic X-Ray and Laboratory Testing** Alabama Plans A & B: $300/year maximum ■ **Outpatient Surgery including doctor's charges and facility charge** Alabama Plans A & B: $50 copayment for facility Utah: $75 copayment for facility ■ **Well Baby Care** ■ **Ambulance** Alabama Plans A & B: covered only if admitted to hospital Denver: $100 limit for ambulance only ■ **Emergency Room** Copayments ($25-$50) charged by two-thirds ■ **Hospital Inpatient including semiprivate room and board, miscellaneous charges, surgeon's fees, anesthesiologist's fees, doctor's visits in the hospital and prescriptions** Alabama Plans A & B: 10 days/year limit, $20/day copayment Florida Standard: $100 copayment days 1-5 Denver: 50% coinsurance Tennessee: $200 copayment per admission Utah: $150 copayment for days 1-4 Washington: $50 copayment per admission
Almost Always Covered (14 products)
■ Outpatient Routine Physicals ■ Outpatient Immunizations ■ Outpatient Physical Therapy Alabama Plans A & B: $2,000/year limit Denver: 50% coinsurance Maine: short-term therapy only, must improve significantly in 60 days Tennessee: 10 visits/year limit Utah: $20 copayment, must treat within 60 days of onset ■ Private duty nursing in the hospital

Coverage of Selected Benefits in 15 Health Insurance Plans*

Usually Covered (10-12 products)

- **Outpatient Prescriptions (12 products)**
  Typically charge copayment of $3-$10
  Denver: 50% coninsurance, separate deductible of $50/year
  Maine: available only as a rider

- **Home Health Visits (11 products)**
  Denver: 50% coinsurance, 100 visits/year limit
  Tennessee: 60 visits/year limit

- **Routine Hearing Exams and Eye Exams (10 products)**

Sometimes Covered (6-8 products)

- **Convalescent Care, Skilled Nursing Facility (8 products)**
  Denver: 50 days/year limit per related cause, cover at 50% hospital room and board rate
  Florida Standard & High: 20 days/year, $25/day copayment for Standard
  Maine: 100 days/year limit
  Tennessee: 100 days/year limit
  Michigan Network: $25/day copayment

- **Mental Health - Outpatient (8 products)**
  Typically limit either number of visits (20 most common) or dollar amount ($1,000 or $2,000)
  Tennessee: available only as a rider

- **Mental Health - Inpatient (7 products)**
  Most have high copayments per day ($100-$200) or 50% coinsurance for limited number of days (usually 30 days)
  Tennessee: available only as a rider

- **Hospice Care (6 products)**
  Denver: 50% coinsurance, 6 month limit

Least Frequently Covered (1-3 products)

- Durable Medical Equipment (3 products)

- Prosthetic and Orthotic Appliances (2 products)

- Podiatry (1 product)

- Genetic Testing and Counseling (1 product)

*Table 9 lists benefits included in 15 insurance plans offered or approved by Health Care for the Uninsured Program projects. Limitations on these benefits are shown, including coinsurance rates of greater than 20 percent paid by the enrollee, copayments of greater than $10, and ceilings on the number of visits or total charges.

House Taxation 10
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FINAL DRAFT
10/4/90

MEETING THE HEALTH INSURANCE NEEDS OF UNINSURED SMALL BUSINESSES: MARKET RESEARCH AND NEW PRODUCTS

October 1990

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1350 Connecticut Avenue, N.W.
Suite 1100
Washington, D.C. 20036

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I would especially like to acknowledge the contributions of two scholars who assisted the Alpha Center in analyzing these materials. Roger Formisano, Ph.D., Professor of Risk Management and Insurance at the Graduate School of Business at the University of Wisconsin-Madison, guided our analysis of the market research data. Ann Costello, Ph.D., Associate Professor in the Department of Insurance and Finance at the University of Hartford, assisted us in compiling uniform profiles of the insurance and HMO plans offered by the projects.

W. David Helms, Ph.D.
President
Alpha Center

MEETING THE HEALTH INSURANCE NEEDS OF UNINSURED SMALL BUSINESSES: MARKET RESEARCH AND NEW PRODUCTS

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INTRODUCTION

In 1986, The Robert Wood Johnson Foundation established the Health Care for the Uninsured Program (HCUP) to support the development and implementation of new public/private financing arrangements at the state and local level which would improve access to care for the uninsured. At that time, new research revealed that nearly two-thirds of the estimated 37 million uninsured were employed persons or their dependents, and that over half of these working uninsured were part of small businesses with 25 or fewer employees. In the absence of major new federal or state programs to address the uninsured problem, the demonstrations established under HCUP focused on expanding and refining the existing employment-based insurance system in order to provide coverage for uninsured small businesses and individuals.

The Foundation awarded a total of 15 grants to states and nonprofit organizations. (See Appendix I for list of these grantees). Fourteen of the projects sought to develop new health insurance mechanisms for small businesses or individuals, and one project is offering a health insurance brokering and information service. Of the 14 seeking to develop an indemnity or managed care product, 10 reached the enrollment phase.

Most of the projects conducted surveys of small employers, in order to understand more thoroughly the nature of their small business market. They used the resulting marketing research data in designing new and innovative insurance products for currently uninsured small groups. This monograph provides an analysis of these survey data and the insurance products being developed by the demonstration projects.

This report has four sections. The first part summarizes 12 surveys of small employers as a basis for identifying the special characteristics of the small employer market. The second section analyzes 15 health insurance products designed or approved by these demonstration projects. This is followed in the third section by a discussion of three product design innovations -- limiting the provider network, limiting benefits, and requiring major cost sharing -- that can reduce insurance premiums. Concluding, the fourth section reviews the range of approaches that will be needed to expand insurance coverage widely through our employer-based system.

SUMMARY OF SURVEYS OF SMALL EMPLOYERS

We examined data from 12 independent surveys of small employers conducted or sponsored by projects funded under The Robert Wood Johnson Foundation's Health Care for the Uninsured Program. (See Appendix II for a list of the survey reports.) Our analysis focuses on common questions posed by the surveys in five broad categories: (1) characteristics of small firms that do not offer insurance, (2) characteristics of employees in these non-insuring small firms, (3) reasons reported by employers for not providing insurance, (4) employer contributions toward premiums for employees and dependents, and (5) sample plans offered to employers.

The survey instruments, administered between early 1987 and January 1989, vary because they were designed to meet the unique information needs of individual projects. For example, the definition of a small firm ranged from firms with ten or fewer employees in Utah to firms with 100 or fewer employees in Wisconsin. The geographic scope of the surveys also varied from a single metropolitan area to several regions within a state to entire states. A variety of survey methods were used including telephone surveys (used by a majority of projects), direct mail (used by approximately one-third of the projects) and face-to-face interviews of employers (used by one project). A number of projects followed-up their screen surveys with focus groups or interviews of small employers.

The broad variation in the type and structure of the data collected from the projects made pooling of the data impossible. Rather than aggregating all the data, this report provides a side-by-side comparison of responses to common questions posed by the projects in order to characterize small employers and their interest in health insurance.

Characteristics of Small Firms That Do Not Provide Health Insurance To Employees

The likelihood of a small employer offering health insurance to employees is related to a number of characteristics of the firm, including firm size, type of industry, extent of employee turnover, and proportion of part-time workers. It is also seen that the majority of firms reporting to be uninsured have never offered insurance to their employees. While most small employers learn about health insurance through agents and brokers, a significant portion do not have a regular source of information regarding health insurance.

The survey data reveal that the likelihood that a firm will offer insurance to employees declines as the size of the firm decreases, and a high percentage of firms with fewer than 10 employees are not insured as shown in Table 1. While 98 percent of larger firms with 100 or more employees offer coverage to employees, approximately 80 percent of firms with 10-19 full-time employees offer insurance, only two-thirds of firms with 5-9 employees offer insurance, and about half of those with 1-4 employees offer insurance. The lack of insurance among the "microfirms," which we define as less than 10 employees, is a very significant concern given that these businesses constitute approximately 49 percent of the total population of the working uninsured,[1] as shown in Chart 1 on the following page.

TABLE 1
Size of Firms That Offer
Health Insurance to Employees

No. of Full-Time Employees**	Denver %	Maine (Brunswick) %	Utah (Salt Lake City) %	Wisconsin (4 Counties) %
0	26.0	11.5	23.0	30.2
1-4	52.0	41.0	54.0	39.0
5-9	67.0	66.0	85.0	61.9
10-19	82.0	84.0	*	78.7
20-49	*	*	*	86.8
50-99	*	*	*	97.6

* Survey did not measure firms in this size category.
**"Full-time" is generally defined as working 30 or more hours per week.

[1] P. Short, et.al., A Profile of Uninsured Americans: National Medical Expenditure Survey, Research Findings 1, (DHHS Publication No. DHS 89-3443), (Rockville, MD: NCHSR/HCTA, Public Health Service, September 1989), p. 13.

Exhibit # 10
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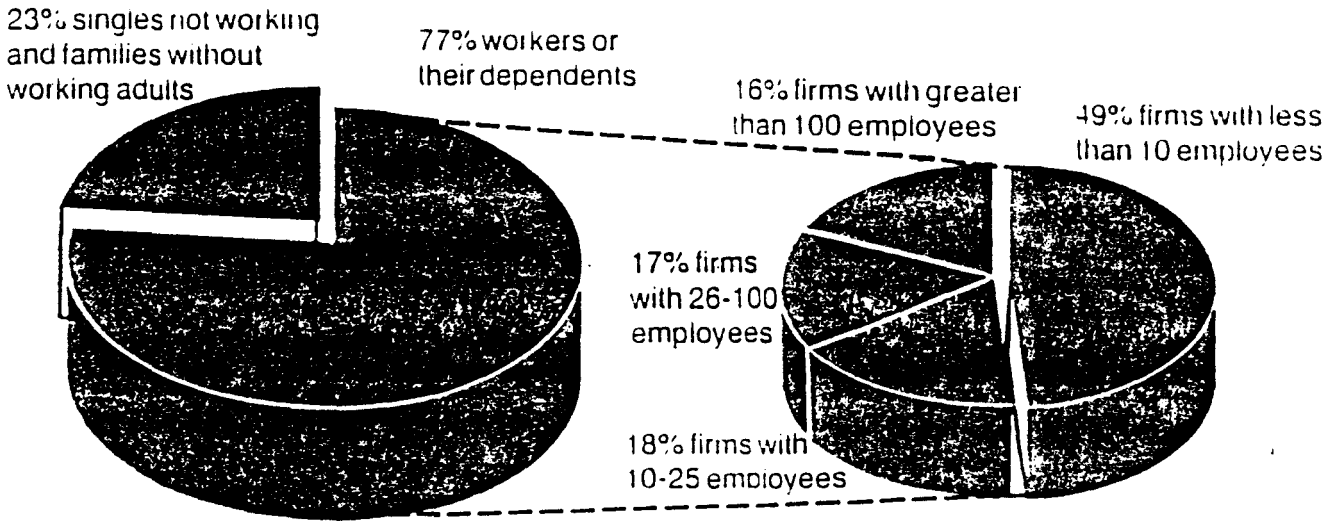
CHART 1

Nearly Half of the Working Uninsured Are Employed in Very Small Firms



36.9 million uninsured under age 65

28.4 million working uninsured

Source: Derived from NCHSR analysis of NMES data, first quarter, 1987.

Survey data show that the percentage of small firms which provide health insurance to employees varies considerably across industries as shown in Table 2. Firms in the construction, retail trade, and service industries are the least likely to offer insurance, whereas manufacturing firms, mining firms, and wholesale trade firms tend to have higher rates of coverage. These differences in the coverage rates of various industries reflect variations in the nature of the work and the history or culture of each industry. For example, manufacturing and mining businesses are generally unionized, and unions have historically made health insurance a high priority for their members. Construction and retail businesses use more part-time and seasonal employees, who have not traditionally been offered coverage by employers.

TABLE 2
Industry Type of Small Firms That Offer
Health Insurance to Employees

Industry Type	Denver	Maine (Brunswick)	New Jersey (15 Counties)	Utah (Salt Lake City)	West Virginia (Statewide)	Wisconsin (4 Counties)
Manufacturing	79.5	66.6*	82.0	77.0	79.5	77.4
Mining	76.9	50.0*	—	100.0	83.5	—
Wholesale Trade	73.5	—	81.0	—	74.4	—
Agriculture, Forestry, Fishing	71.4*	30.0*	—	25.0*	73.3	56.4
Transp., Comm., Utilities	50.0*	59.4*	—	73.0	80.4	58.2
Fin. Ins. & Real Estate	62.8	48.8	58.0	54.0	73.0	52.6
Services	59.0	49.7	56.0	58.0	74.5	49.7
Construction	40.8	36.9	60.0	48.9	59.2	48.4
Retail Trade	46.0	—	49.0	—	58.4	—

* The small number of survey respondents in these industries limits confidence in these figures.

The Wisconsin survey confirmed this phenomenon showing that firms with seasonal employment are less likely to offer health insurance to employees than firms with more constant employment. Fifty-six percent of Wisconsin's small firms reporting constant employment offered insurance, as compared to 44.4 percent of small firms reporting some seasonal employment patterns.

The surveys also showed that few small firms offer health insurance to part-time workers. Even those firms that do offer health insurance often exclude part-time employees from receiving coverage, providing it only to full-time employees. In Wisconsin, 83 percent of employers who provide insurance offered it only to full-time employees; only 17 percent offered coverage to both full-time and part-time employees. Small firms that do not offer health insurance to employees generally have a greater proportion of part-time workers than small firms that do offer insurance. For example, the Alabama survey revealed that 25 percent of the workforce of non-insuring small firms in the state were part-time employees as compared to 9 percent of the workforce of firms that offer insurance.

The surveys showed that employment in small firms may not be as unstable, with regards to employee tenure and turnover, as has been previously reported for this market. In Denver, 41 percent of small firms reported no job changes within the last year and another 28 percent reported only one or two changes. In Wisconsin, turnover was similar for both insuring and non-insuring businesses, with 76 percent of employees in insuring firms and 72 percent of employees in non-insuring firms having been employed for more than one year. Similar figures were reported in Birmingham where 77 percent of the workforce of the small firms surveyed had been employed steadily by that firm for more than one year, and 57 percent had been employed for over three years.

It appears that at any single point in time, those firms that are currently uninsured are also chronically uninsured. Surveys showed that most small firms that did not have health insurance had never offered insurance to their employees. Only 9.0 percent of non-insuring small firms in San Francisco and 15 percent in Utah had ever offered coverage to employees before. In addition, it appears that only approximately one-third of small firms that do not offer insurance have recently considered doing so. Most non-insuring small employers surveyed had not investigated various health insurance options within the past two years. In San Francisco, only 33 percent had looked into providing health insurance, and in Wisconsin, 41 percent had investigated health insurance in the past two years.

Unlike larger firms, small firms do not have employee benefits personnel. One of the challenges for reaching this market is how to communicate with the owner, who usually makes the decision about whether or not to offer coverage. These surveys found that agents and brokers are the

major source of information about health insurance for small employers, but that a significant proportion of non-insuring small firms report that they do not have a regular source of information. For example, 19.9 percent of non-insuring small firms in Denver, and 17.5 percent in the Maine sample had no source of information about insurance.

Characteristics of Employees Who Work In Non-insuring Firms

The surveys asked employers to report the age, sex and level of compensation for their employees. Age and sex are used in determining the price of insurance. Wage levels affect an employee's ability to afford premium contributions as well as copayments and deductibles required by many plans.

The workforce of non-insuring small firms is composed of a high percentage of younger employees as shown in Table 3. The percentage of workers age 29 years or less ranged from 29 to 43 percent and those age 39 years or less ranged from 56 to 70 percent in four of the surveys. The Wisconsin survey also reported figures for insuring small employers, but found no major differences between insuring and non-insuring firms in the percentages of workers in each age group.

TABLE 3
Age of Employees in Non-Insuring Small Firms

Age	Alabama (Birmingham) %	Denver %	West Virginia (Statewide) %	Wisconsin (4 Counties) %
16-19	5.4	3.0	2.0	8.9
20-29	24.8	33.0	27.0	34.2
30-39	26.6	29.0	31.0	27.2
40-49	20.4	20.0	23.0	16.6
50-59	14.1	10.0	9.0	7.9
60-64	7.1	3.0	4.5	3.4
65+	1.9	1.0	4.0	1.7

Non-insuring small firms have a higher proportion of female employees than insuring small firms as shown in Table 4. For example, in both Alabama and Wisconsin, over 50 percent of the workforce of non-insuring small firms is female, as compared to around 30 percent of firms that offer insurance. This margin was much narrower in Denver, with the percentage of females in non-insuring firms just slightly higher than insuring firms. The cost of health insurance coverage for women of child bearing age is often higher than the cost of insurance for men in the same age bracket, due to claims for obstetrics and maternity services. This can raise the cost of coverage for businesses with more female employees.

TABLE 4
Percentage of Workforce by Sex in
Insuring and Noninsuring Small Firms

	Alabama (Birmingham)		Denver		Wisconsin (4 Counties)	
Sex	Insuring (%)	Noninsuring (%)	Insuring (%)	Noninsuring (%)	Insuring (%)	Noninsuring (%)
Female	32.0	54.0	40.7	42.8	31.3	51.5
Male	68.0	46.0	59.3	57.2	68.7	48.5

Another characteristic of the employees of small firms is that many tend to be low wage-earners. Small employers hire a high proportion of low-wage workers, with non-insuring small firms hiring more than insuring small firms. In the Wisconsin survey of employers with fewer than 100 employees, approximately one-half of all workers earned $3.35 - $5.99 per hour, which at the time (1987) was just above the minimum wage as shown in Table 5. Non-insuring firms hired 21 percent more workers in this low-wage range than insuring firms.

TABLE 5
Wage Level of Employees in Insuring &
Noninsuring Small Firms

Wage Level Per Hour	Wisconsin (4 Counties)* Insuring	Noninsuring
< $3.35	0.0	3.4
$3.35-5.99	47.7	68.9
$6.00-8.99	32.0	21.7
$9.00-11.99	8.9	1.7
$12.00-14.99	6.9	4.0
$15.00-18.00	4.1	0.0

*Survey of firms with 100 or fewer employees in four Wisconsin counties.

The larger composition of low-wage workers in non-insuring firms may be an influential factor in the employers' decision to not offer coverage. A fixed premium payment represents a higher proportion of the low-wage worker's payroll than that of a high-wage worker, so an employer is less likely to see the value in such an investment for a lower-paid worker who may be less-skilled and easier to replace. An employee's wage level also determines his/her ability to afford coverage, with lower income employees having less income to spend on health insurance than higher income employees. Thus, even if employers offered these employees coverage and contributed toward the cost of their premium, many of these workers may elect to receive cash compensation rather than health insurance coverage.

Reasons Reported By Small Employers For Not Providing Insurance To Employees

When asked why they do not offer health insurance benefits to employees, the number one reason reported by small employers is cost, as shown in Table 6. Small firms typically have lower profits, and thus fewer resources with which to pay the high cost of premiums than larger, more profitable firms. This cash shortage problem can be compounded for thinly capitalized firms or those with seasonal business cycles. In addition, the cost of employee health benefits plans are 10-40 percent higher for smaller firms than for larger firms, according to a study by the Small Business Administration.[2] Thus, higher health benefit costs and lower profits help explain the differences in coverage rates between large and small firms.

The second most prevalent reason given by small employers for not offering insurance is that many of their employees are insured elsewhere, usually under a spouse's plan. As a result, many employers feel that they do not need to offer coverage themselves. This finding was corroborated by the employees of small businesses in Wisconsin. The survey there included not only business owners but also their employees, and confirmed that many small business employees are covered under the health insurance plans of spouses employed elsewhere.

[2]ICF Incorporated, Health Care Coverage and Costs in Small and Large Businesses, prepared for SBA, Office of Advocacy (Washington, D.C.: April 15, 1987), cited by General Accounting Office, Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (Washington, D.C.: May 1990).

TABLE 6
Reasons Reported by Small Employers
For Not Offering Health Insurance to Their Employees

Factors in Decision Not to Offer Insurance	Alabama (Birmingham)	San Diego	Denver	Maine (Brunswick)	Wisconsin (4 Counties)
Cost:					
Too Expensive	64.7	69.0	56.1	49.2	77.6
Firm Not Sufficiently Profitable	25.0	41.0	—	31.4	44.8
Workforce Considerations:					
Many Employees Insured Elsewhere	67.3	49.0	46.5	35.6	63.1
Employees can be Hired Without Providing Insurance	42.8	33.0	57.6	19.6	44.9
High Employee Turnover	19.0	22.0	23.2	13.6	19.0
Employees Don't Want It	39.1	25.0	16.0	12.7	43.9
Insurance Market:					
Company Turned Down: Too Small	25.0	22.0	19.2	10.3	*
Cannot Find An Acceptable Plan	22.8	32.0	24.5	14.7	31.5
Lack of Information/ Difficulty Judging Plans	17.9	19.0	16.9	16.0	31.6
Employees Cannot Qualify: Preexisting Conditions	11.3	10.0	8.6	7.9	24.1
Company Turned Down: Type of Business	11.4	7.0	2.9	*	*

*Survey did not ask this question.

Various characteristics of the workforce and labor market were cited next as important factors in the decision not to offer insurance. First, many small employers stated that they can hire workers without offering health benefits. This factor varies across regions and across industries, often based on the demand for labor and whether the industry has traditionally offered coverage to employees. For example, due to an available labor market, over half of the uninsured small employers in Denver stated that they could recruit and hire employees without providing insurance. A relatively high percentage of employers also report that their employees "do not want" health insurance, possibly because these workers are already insured through another source, or because they prefer cash income over health insurance benefits. High employee turnover was another reason given by employers for not offering coverage.

In addition, a number of small employers reported not offering insurance to employees because of difficulties in negotiating the insurance market. A significant number of employers said that their company was turned down for coverage because the firm was too small to qualify for available insurance plans. Some could not find an "acceptable" plan, while others reported that they had difficulty finding and evaluating different health plans due to a lack of information. A lower percentage of employers reported that they did not offer coverage because their employees could not qualify for various insurance plans due to preexisting medical conditions. A relatively small number of firms were excluded by insurers because of their industry type.

Although most employers cite the high cost of premiums as the most important reason why they do not offer insurance, cost is obviously not the only important factor in their decision. A large percentage of small employers stated that they would not offer coverage even if the employee paid the entire premium. Only 58 percent of small employers in West Virginia and 39 percent in Denver responded that they would be willing to administer a health insurance plan if the employee paid the entire premium. Similarly, when non-insuring small employers in West Virginia were asked if they would be interested in making an affordable health insurance plan available to their employees, 53 percent responded no. This would indicate that even offering a fully subsidized "free" health plan may not be enough to encourage some non-insuring small employers to administer health insurance benefits.

The West Virginia survey also asked small employers who do purchase health insurance for their employees to identify what factors have influenced their decision. The reasons cited most often were to keep employees healthy (78 percent), to help retain employees (64 percent), to increase productivity (60 percent), to remain competitive with similar firms (57 percent), to help recruit employees (47 percent), and to respond to employee demands for coverage (44 percent). Similarly, of the noninsuring small employers in Florida who reported an interest in offering coverage, 59 percent responded that employees "need it," and 22 percent said that they would use insurance to reward productive employees. Thus, while many small employers are deterred from purchasing coverage for a variety of reasons, others see the value in offering health insurance to their employees.

Employer Contributions Toward Premiums For Employees And Their Dependents

Although there is considerable regional variation, a majority of small employers who do offer health insurance pay the entire premium for their full-time employees as shown in Table 7. The

percentage of employers paying the entire premium ranges from 54 percent in Arizona to 84 percent in New Jersey. A smaller percentage of employers, ranging from 14 to 31 percent pay some portion of employee premiums. In all but one survey, the percentage contributing nothing at all was less than 10 percent.

TABLE 7
Portion of Premium Paid by
Employers for Full-Time Employees and for Dependents

Portion of Premium Paid by Employer	Arizona (Statewide)		San Francisco		Denver		Maine (Brunswick)		New Jersey* (15 Counties)		Wisconsin (4 Counties)	
	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.	Emp.	Dep.
All	54.1	23.2	79.0	32.0	73.6	37.9	65.0	38.8	84.0	62.0	64.5	52.8
Some	21.7	10.1	17.0	14.0	21.4	14.6	25.8	41.4	14.0	10.0	31.1	31.1
None	24.3	66.7	2.0	50.0	5.0	47.5	9.2	19.8	2.0	8.0	4.4	16.2

*For dependent coverage in New Jersey, 20 percent reported "not applicable/ineligible" or "don't know."

Small employers are less likely to pay for dependent coverage. In San Francisco, for example, while 79 percent of small employers who offered coverage paid the total premium for their individual employees only 32 percent paid the total premium for dependent coverage. Likewise, while 2 percent paid none of the employee costs for their employees, 50 percent paid none of the dependents' premiums. Across the projects, the percentage of employers paying the full premium for dependents (ranging from 23 percent in Arizona to 62 percent in New Jersey) is substantially lower than the percentages of those contributing the full premium for employee coverage. These data reflect a national decline in the number of employers who provide dependent coverage, a trend which has contributed to increasing the size of the uninsured population in recent years.

A significant portion of employers who currently do not offer coverage were unsure how much they would be willing to spend on employee health insurance as shown in Table 8. In San Francisco, 26 percent said they "don't know" how much they would spend, while in New Jersey 35 percent said it "depends" on other factors. Of those who might purchase coverage, the two surveys found 16-17 percent willing to pay less than $25 per month per employee. The most likely range is $25 - $75 per month with responses from 37.5 percent in San Francisco and 22 percent in New

Jersey. A smaller number would be willing to spend over $75 or more per month, as reported by 20.5 percent in San Francisco and 10 percent in New Jersey.

TABLE 8
Maximum Amount Non-Insuring Employers Would Be Willing To Pay For Insurance (Per Employee Per Month)

	San Francisco*	New Jersey** (15 Counties)
Less than $25	16.0%	17.0%
$25-$75	37.5	22.0
$75 or more	20.5	10.0
Don't Know/Depends	26.0	16.0
Would NOT Buy	N/A	35.0

* San Francisco data collected in February 1988.
**New Jersey data collected in December 1988 - January 1989.

Sample Plans Offered To Employers

In order to get a better idea of what type of benefits small employers want and how much they are willing to pay to obtain these benefits, a few of the projects used focus groups to assess sample health plans and to ask small employers if they would be willing to purchase these plans. Their responses to these plans confirmed that many uninsured small employers are price sensitive with regards to premium costs and want few restrictions on hospital care. In general, small employers want insurance plans similar to those offered by larger employers.

The survey responses reveal that small employers are price sensitive about health insurance premiums. For example, the Wisconsin survey listed four hypothetical major medical plans--two individual policies and two dependent policies. All four plans would require enrollees to pay a $100 deductible and 20 percent of covered charges. The four plans differed only in the amount of the premium. When asked if they would purchase each of the plans, 22.4 percent of employers responded that they would definitely buy the single coverage plan with a $30 premium, while only 12.5 percent would definitely buy the single coverage plan with a $50 premium. Similarly, 18.8 percent of employers would definitely offer the dependent plan with a $75 premium, whereas only 5.4 percent would definitely offer the dependent plan with a $180 premium. Results such as these suggest that providing premium subsidies to the employer may result in more employers providing coverage.

The Tennessee survey's sample plan, which was a lower-cost plan emphasizing routine/preventive care and limiting hospital inpatient care, was unpopular primarily due to its limitations on hospital care. Survey respondents expressed their opinion that hospitalization coverage is one of the critical basic features of a health insurance plan and that they are not interested in a product which substantially limits this benefit. In fact, small employers in San Francisco rated inpatient care as the most important service to cover, with private physician office visits ranked second and hospital emergency room visits ranked third.

The Denver project queried small employers about a sample plan with four features: (1) patient pays a small amount ($5 to $10) for each doctor or clinic visit and the plan pays the rest, (2) patient pays $1,000 for each hospital admission and the plan pays the rest, (3) patient can use only the doctors and hospitals participating in the plan, and (4) pre-existing conditions are excluded from coverage for one year.

About half of small employers surveyed were at least somewhat interested in the proposed plan. The co-payment feature for doctor or clinic visits was regarded most favorably by small employers. The features that employers appeared to be most negative about were the large co-payment for each hospitalization and the restricted choice of providers. It was not surprising that employers who were interested in the proposed plan were more positive about all four features than were uninterested employers.

Denver small employers, both those who provide insurance and those who do not, were also asked how much they would pay for the plan. About a quarter of respondents said they would pay up to $30 per month per employee and about a fifth said they would pay over $60 per month. On average, these employers reported they would pay about $45 per month -- a figure less than half the average monthly premium reported by the small employers in the sample who now provide coverage. Those employees that are not now offering coverage, however, were willing to pay only about $29 per month. This supports the findings of previous surveys that a major reason for small employers not offering health insurance is cost. It also has important implications for pricing an insurance plan if the goal is to penetrate the market of small employers who do not now provide health insurance.

Exhibit # 10
2/22/91 HB 693

KEY FEATURES OF INSURANCE PRODUCTS DESIGNED FOR SMALL GROUPS

In attempting to expand health insurance coverage to the uninsured, policy makers, insurers and providers must decide what type of insurance products should be made available to small employers and individuals. This section describes the service delivery networks, cost sharing provisions, cost containment features, benefits and premiums of 15 insurance products developed or supported by nine demonstration projects participating in The Robert Wood Johnson Foundation's Health Care for the Uninsured Program. According to our analysis, all the plans reviewed here offer a core of basic benefits and virtually all rely on managed care systems for delivering these services. The plans differ significantly, however, in their use of deductibles, coinsurance and copayment mechanisms for sharing costs at the time of service delivery. This section also contrasts the features of plans with the lowest and highest premiums.

Service Delivery Network

The projects overwhelmingly have chosen to use managed care service delivery systems in order to minimize costs, as shown in Chart 2 on the following page. Most of the projects have used health maintenance organizations (HMOs), including group, staff and individual practice association models (IPAs), as the delivery system. The HMOs compensate practitioners using a variety of salary, fee-for-service and capitation mechanisms. These managed care models all require enrollees to seek care first from a "gatekeeper" primary care provider, who judges whether specialist services are required. Only one plan (Michigan Blue Cross/Blue Shield) is a traditional indemnity product, while another (Denver) is an indemnity plan that requires beneficiaries to use an exclusive provider organization (EPO) of physician and hospital services.

Several projects (Alabama, Denver, Tennessee, Utah) have negotiated substantial discounts from hospitals or have made special arrangements for serving low-income enrollees. To lower the cost of delivering primary care services, three projects (Alabama, Tennessee, and Utah) depend on community health centers. These three are also the only ones sponsored by private organizations, with no direct support from state or local governments. For low-income enrollees in the Denver plan, deductibles for inpatient care are waived if they use either of two publicly-supported hospitals.

CHART 2

Plan Features

INSURANCE PROJECT	SERVICE DELIVERY NETWORK[1]	DEDUCTIBLE	COINSURANCE CAP, OUT-OF-POCKET MAXIMUM	MAXIMUM BENEFIT AMOUNT	PRE-EXISTING CONDITION CLAUSE[2]
Alabama: Basic Care Private Option—A	Network model HMO of public and private hospitals and private physicians	$100 per individual per contract year, $300 per family	$1,080 per person per year—deductible plus coinsurance $3,240 per family	Unlimited (Limited benefit package)	12-6-12
Alabama: Basic Care Public Option—B	Network model HMO of publicly supported hospitals and county primary care clinics	Same as above	Same as above	Same as above	Same as above
Arizona: Health Care Group Option One	Network model HMO in 2 counties, IPA in 1 county	None	$4,000 per person per year participant's coinsurance	$250,000 per person per year	12-12 for inpatient services (pregnancy: normal delivery not covered for 10 months from enrollment)
Arizona: Health Care Group Option Two	Same as above	None	None	$250,000 per person per year	Same as above
Arizona: Health Care Group Option Three	Same as above	None	None	$20,000 per person per year	Same as above
Arizona: Health Care Group Option Four	Same as above	$2,000 per individual per contract year	$2,000 maximum out-of-pocket per person per year	$250,000 per person per year	Same as above
Denver: SCOPE	EPO, co-payments waived for low-income persons using publicly-supported hospitals	Inpatient care—$250 per individual per calendar year, $500 per family. Outpatient prescription drugs—$50 per year	$2,750 per person per year deductible plus coinsurance, $5,500 per family	Unlimited (Exceptions: mental health, substance abuse, hospice care, convalescent care, person over 70)	3-3-6 employee 3-3-12 dependent
Florida: Florida Health Access Standard Option	IPA model HMO, (nonprofit)	None	$1,500 per person per calendar year—total copayments, $3,000 per family	Unlimited	None
Florida: Florida Health Access High Option	Same as above	None	Same as above	Unlimited	None
Maine: MaineCare	IPA model HMO	None	None	Unlimited	Exists 90 days after enrollment, but does not apply to pregnancy
Michigan: Blue Cross Blue Shield Option	Blue Cross Blue Shield affiliated providers, indemnity plan	$100 per individual per calendar year, $200 per family	$1,100 per person per year deductible plus coinsurance, $1,200 per family	$1,000,000 per person—lifetime benefit, all causes	6-6 for groups 4 or less (pregnancy—at least 270 days from enrollment), no clause for groups 5 or more
Michigan: Blue Care Network Option	Mixed model HMO, staff and network components	None	None	Unlimited (some benefits limited)	None
Tennessee: MedTrust	HMO including clinics and physicians from Tenn. Primary Care Network	None	$500 per person per year or $1250 per family maximum out-of-pocket	Unlimited	6-3-12
Utah: Community Health Plan	Network model HMO including community health centers and private physicians	None	None	$1,000,000 lifetime benefit maximum all causes	Conditions for which medical advice was received 24 mo. before enrollment, or treatment for 12 mo. are covered [illegible] for [illegible] mo.
Washington: Basic Health Plan	Library of staff, network and IPA model HMO's	None	None	Unlimited	6-12

[1] Service Delivery Network Abbreviations: HMO — Health Maintenance Organization, EPO — Exclusive Provider Organization, IPA — Individual Practice Association

[2] Pre-existing condition clause: [illegible] time periods in months unless otherwise noted, e.g., 12-6-12 means that the person received treatment for a condition within 12 months before

Cost Sharing

As is typical of HMOs, a majority of the plans do not have deductibles, but rather charge fixed-dollar copayments for specific services as the preferred method of cost-sharing, as shown in Chart 2. A few, however, do use deductibles. For example, the traditional indemnity plan (Michigan Blue Cross/Blue Shield) has a standard deductible of $100 per individual or $200 per family per year and coinsurance of 80 percent paid by the plan and 20 percent paid by the enrollee. The EPO-indemnity product (Denver) has a $250 deductible and a 50 percent coinsurance rate on the first $5,000 of expenses and also charges copayments for some outpatient physician visits. Alabama BasicCare (Plans A and B) has a $100 per person deductible with 80/20 percent coinsurance plus copayments for both outpatient and inpatient services, except for prescription drugs. Arizona's Option Four, which is designed to serve as a catastrophic plan, has a deductible of $2,000 per person per year, the highest deductible of any plan.

To protect enrollees from catastrophic claims, nine of the plans have set either an annual coinsurance cap or a limit on the maximum out-of-pocket contribution that an enrollee is expected to pay. The remaining six, however, do not cap out-of-pocket expenses.

Nine plans offer an "unlimited" amount of eight covered services, while six limit their benefits to an annual or lifetime maximum. "Unlimited" generally refers only to medical and hospital services but not to mental health, alcohol or substance abuse services, hospice and convalescent care. Maximum benefit amounts vary with annual limits of $20,000 - $25,000 per person and lifetime ceilings of $1 million per person.

Other Cost Containment Features

In order to reduce the chances that people will decide to enroll in an insurance plan only after they become ill, insurers commonly exclude coverage of preexisting medical conditions for a certain period of time following enrollment. As shown in Chart 2, most of the plans have preexisting condition clauses that limit coverage for 3 to 12 months, however three plans have no restrictions and others allow certain services to be covered during the exclusion period. For example, in the four

Arizona plans, the 12-month exclusion period applies to inpatient hospital services, but not to outpatient services. Similarly, the MaineCare plan, which excludes coverage for most preexisting conditions for 90 days following enrollment, does cover pregnancy-related services during this period.

All 15 plans require enrollees to contact their offices prior to any non-emergency hospital stay; without such prior notification, the benefits would be reduced. Only one plan would require enrollees to seek second opinions for certain surgical procedures.

Benefits

All 15 insurance products cover inpatient and outpatient services, with some containing a wider variety of benefits than others. "Internal" limitations on these benefits include restrictions on the scope of services and cost-sharing requirements. Table 9 highlights internal limitations, including high coinsurance rates paid by the enrollee (greater than 20 percent), large copayments for individual services (greater than $10), and other restrictions on the dollar amount or volume of services.

Examination of these products reveals a core of basic benefits similar to that found in most comprehensive insurance plans. All 15 products cover doctor's office visits, outpatient x-ray and laboratory testing, outpatient surgery, well baby care, emergency care, ambulance services, and basic inpatient hospital services. Notable restrictions include Alabama's limits of six doctor office visits and ten hospital days per year. Denver requires 50 percent coinsurance on hospital stays for the first $5,000 of expenses. Large copayments charged by other plans range from $50 per admission to $150 per day for the first four days.

TABLE 9.1

Coverage of Selected Benefits in 15 Insurance Plans*

Always Covered (15 products)

- **Doctor's Office Visits**
  Alabama Plans A & B: limit to 6 visits/year
  Denver: $15 copayment or 50% coinsurance if procedure performed
  Utah: $20 copayment for specialists

- **Outpatient Diagnostic X-Ray and Laboratory Testing**
  Alabama Plans A & B: $300/year maximum

- **Outpatient Surgery including doctor's charges and facility charge**
  Alabama Plans A & B: $50 copayment for facility
  Utah: $75 copayment for facility

- **Well Baby Care**

- **Ambulance**
  Alabama Plans A & B: covered only if admitted to hospital
  Denver: $100 limit for ambulance only

- **Emergency Room**
  Copayments ($25-$50) charged by two-thirds

- **Hospital Inpatient including semiprivate room and board, miscellaneous charges, surgeon's fees, anesthesiologist's fees, doctor's visits in the hospital and prescriptions**
  Alabama Plans A & B: 10 days/year limit, $20/day copayment
  Florida Standard: $100 copayment days 1-5
  Denver: 50% coinsurance
  Tennessee: $200 copayment per admission
  Utah: $150 copayment for days 1–4
  Washington: $50 copayment per admission

Almost Always Covered (14 products)

- **Outpatient Routine Physicals**

- **Outpatient Immunizations**

- **Outpatient Physical Therapy**
  Alabama Plans A & B: $2,000/year limit
  Denver: 50% coinsurance
  Maine: short-term therapy only, must improve significantly in 60 days
  Tennessee: 10 visits/year limit
  Utah: $20 copayment, must treat within 60 days of onset

- **Private duty nursing in the hospital**

TABLE 9.2

Coverage of Selected Benefits in 15 Insurance Plans*

Usually Covered (10-12 products)

- **Outpatient Prescriptions (12 products)**
  Typically charge copayment of $3-$10
  Denver: 50% coninsurance, separate deductible of $50/year
  Maine: available only as a rider

- **Home Health Visits (11 products)**
  Denver: 50% coinsurance, 100 visits/year limit
  Tennessee: 60 visits/year limit

- **Routine Hearing Exams and Eye Exams (10 products)**

Sometimes Covered (6-8 products)

- **Convalescent Care, Skilled Nursing Facility (8 products)**
  Denver: 50 days/year limit per related cause, cover at 50% hospital room and board rate
  Florida Standard & High: 20 days/year, $25/day copayment for Standard
  Maine: 100 days/year limit
  Tennessee: 100 days/year limit
  Michigan Network: $25/day copayment

- **Mental Health - Outpatient (8 products)**
  Typically limit either number of visits (20 most common) or dollar amount ($1,000 or $2,000)
  Tennessee: available only as a rider

- **Mental Health - Inpatient (7 products)**
  Most have high copayments per day ($100-$200) or 50% coinsurance for limited number of days (usually 30 days)
  Tennessee: available only as a rider

- **Hospice Care (6 products)**
  Denver: 50% coinsurance, 6 month limit

Least Frequently Covered (1-3 products)

- **Durable Medical Equipment (3 products)**

- **Prosthetic and Orthotic Appliances (2 products)**

- **Podiatry (1 product)**

- **Genetic Testing and Counseling (1 product)**

*Table 9 lists benefits included in 15 insurance plans offered or approved by Health Care for the Uninsured Program projects. Limitations on these benefits are shown, including coinsurance rates of greater than 20 percent paid by the enrollee, copayments of greater than $10, and ceilings on the number of visits or total charges.

In general, the products try to minimize inpatient hospital days. They strongly emphasize preventive and primary care to reduce the need for costly acute care services. Routine physicals and immunizations are covered by all but one of the plans (the indemnity plan offered by Michigan Blue Cross/Blue Shield). Most plans also include home health visits (11 or 73 percent) and many offer convalescent care through a skilled nursing facility (8 or 53 percent).

All of the plans offer maternity care benefits including hospital services (room, board and miscellaneous changes), physician services for pre- and post-natal care for the mother, and physician services for the baby during confinement. These services are not listed separately in Table 9, because they are generally subject to the same copayment and coinsurance provisions as other inpatient and outpatient services. One notable exception is the Utah Community Health Plan, which front-loads its copayments for maternity inpatient services by requiring enrollees to contribute $350 per day for each of the first three days of hospital services, with the plan covering all charges from the fourth day on. The plan's regular copayment schedule for non-maternity patients is $150 per day for the first four days of confinement with full coverage from the fifth day on.

Mental health inpatient and outpatient services are high-cost benefits offered by about half of the projects. However, major limitations are imposed by every plan, such as dollar limits of $1,000 or $2,000 per year for outpatient counseling; copayments of $100 to $200 per day for inpatient care, and limits on the number of units of care for both types of services.

Premiums

As the market surveys conducted by these demonstration projects have shown, the primary reason small employers do not offer health insurance to employees is the high cost of premiums. Lowering premium prices was a major objective in designing these plans and that goal greatly influenced the choice of benefits, internal limitations, cost-sharing arrangements, delivery networks, and insurers. Table 10 on the following page profiles the premiums charged by the 15 health plans for a 35-year-old employee. Rates are shown for single male and female employees and for families of varying sizes.

Three projects – Maine, Michigan and Washington – offer direct premium subsidies to low-income persons based on a sliding scale of family income. Persons must have family incomes below 200 percent of the federal poverty level to be eligible for this assistance. All three projects report that a majority of their enrollees fall within the range of 100-200 percent of the federal poverty level. Table 10 includes both subsidized and unsubsidized rates for these three projects.

Comparisons between plans must be made with caution, because the premium rates shown in Table 10 are not indexed to reflect cost-of-living differences or other variables. For example, local factors that influence premiums include the supply of health personnel and facilities, competition between insurers, and state regulation. Premium rates also depend on "indirect" subsidies used by the projects such as administrative and marketing support and discounts from providers.

As of March 31, 1990, the average unsubsidized price of a plan for a single person is $78 per month for a male and $80 for a female (only two plans charge more for women than for men in the 35 year-old-age bracket). Premiums for an adult couple are approximately twice as much, averaging $168 per month. Most plans charge more for larger families, averaging $220 per month for a family of three.

Monthly Premiums for an Adult Employee Age 35[1]

INSURANCE PRODUCT	SINGLE		FAMILY[2]			REQUIRED EMPLOYER CONTRIBUTION
	MALE	FEMALE	2-PERSON OR COUPLE	3-PERSONS	4 OR MORE PERSONS	
Alabama: Private Option—[3]	73.96	73.96	186.32	186.32	186.32	50% of single premium
Alabama: Public Option—[3]	45.07	45.07	110.86	110.86	110.86	50% of single premium
Arizona[4]: Option One	82.02	82.02	190.79	259.89	259.89	None required
Arizona[4]: Option Two	93.73	93.73	193.81	298.12	298.12	None required
Arizona[4]: Option Three	90.14	90.14	176.98	276.87	276.87	None required
Arizona[4]: Option Four	55.43	55.43	108.88	180.12	180.12	None required
Denver[5]: SCOPE	61.94	71.54	148.47	148.47	148.47	25% of single premium
Florida: Standard Option	72.52	72.52	145.82	198.95	198.95	50% of single premium
Florida: High Option	82.42	82.42	162.72	226.11	226.11	50% of single premium
Maine: MaineCare						
Unsubsidized (201% + FPL)	91.71	91.71	183.42	274.23	274.23	50% of unsubsidized rate
Subsidized (101-125% FPL)	64.55	64.55	129.10	174.93	174.93	
Michigan[6]: Blue Cross Blue Shield Option						
Unsubsidized (201% + FPL)	118.06	118.06	271.03	283.93	283.93	33.3% of unsubsidized rate
Subsidized (101-200% FPL)	78.71	78.71	180.69	189.29	189.29	
Michigan[6]: Blue Care Network						
Unsubsidized (201% +FPL)	112.56	112.56	261.00	277.90	277.90	33.3% of unsubsidized rate
Subsidized (101-200% FPL)	75.04	75.04	174.00	185.27	185.27	
Tennessee: MedTrust	48.71	48.71	97.43	131.53	131.53	$30.00 per month
Utah[6]: Community Health Plan	83.67	83.67	167.32	159.36	187.68	$30.00 per month
Washington[7]: Basic Health Plan						
Unsubsidized (200% +FPL)	95.00	95.00	190.00	295.00	295.00	N/A—sold directly to individuals
Subsidized (100-124% FPL)	19.00	19.00	38.00	55.00	55.00	
AVERAGE FOR ALL PRODUCTS:						
Using Unsubsidized Rates						
Mean	73.46	80.44	168.32	220.51	222.47	
Standard Deviation	22.60	17.02	49.49	64.73	63.21	
Using Subsidized Rates						
Mean	66.46	66.44	142.75	185.41	187.31	
Standard Deviation	19.60	19.44	40.93	63.31	62.80	

[1] Rates are for premiums in effect as of March 1, 1989. Maine, Michigan and Washington states offer direct premium subsidies for low-income enrollees. Unsubsidized rates are for persons with incomes above 200 percent of the federal poverty level (FPL) and subsidized rates for those just above 100 percent FPL.

[2] Assumes a 2-person group is made up of employee & spouse age 35 and that a three or four person group has two adults plus children

[3] Arizona: rates for Maricopa County

[4] Denver: rates for Denver area

[5] Michigan: rates for Genessee County

[6] Utah: rates for groups of less than 10 employees

[7] Washington: rates are statewide averages

The Washington Basic Health Plan (BHP) premium can vary widely, depending on the enrollee's income. Unlike all the other insurance products described, the BHP is offered directly to uninsured individuals and does not require employer participation or contribution to the premium. Because employers do not contribute premium payments, the state's subsidy must be large enough to make the plan affordable to low-income individuals and their families. For those with incomes under 125 percent of the federal poverty level, the plan costs just $19 per month for an individual and $55 per month for a family of three or more. For those above 200 percent of poverty, no subsidy is offered, making it among the most expensive for both individuals ($95 per month) and for families ($295 per month).

The two least expensive employer-based plans are Alabama's Public Option B and Tennessee's MedTrust, yet neither project receives direct government funding. Both are priced at less than $50 per month for single employees and less than $140 per month for families of three or more. These prices are even less than the state-subsidized rates for the Maine and Michigan plans. Both rely on deep discounts from providers, especially public hospitals, to achieve affordability. Both plans also offer a limited set of benefits, excluding hearing and eye exams, hospice care, alcohol/substance abuse services and mental health services from their basic benefits packages.

The two most expensive plans available to small businesses are Arizona Option Two and Option Three offered in the Phoenix area, which do not use deductibles or coinsurance and charge only minimal copayments of $5 for outpatient services. Option Two is the project's best selling plan at $93.93 per month for singles and $298.12 for families. Option Three, though it is slightly less expensive ($90.14 for singles and $276.87 for families) is the project's worst selling plan and may soon be discontinued. The major difference is that Option Two has a maximum benefit amount of $250,000 while Option Three has a maximum benefit amount of only $25,000. It appears that small employers in Arizona are willing to pay a higher premium to guard against the risk of catastrophic medical bills.

INNOVATIVE PRODUCT DESIGNS INCREASE AFFORDABILITY

The high cost of insurance is the number one reason reported by small employers for not offering health insurance to their employees. Yet, surveys indicated that those small employers who would consider offering insurance benefits would want a comprehensive benefits plan similar to those offered by large companies. How to reconcile these conflicting objectives of reducing costs while providing adequate coverage is the formidable challenge faced by these demonstration projects.

The projects utilize three basic product design strategies to lower the cost of their premiums. The first is to limit the provider network, in order to restrict consumer choice, improve the ability to manage patient care, and negotiate favorable rates. Another strategy is to limit the scope of benefits to only a basic set of services. The final approach is to require major cost sharing so that enrollees pay for a significant portion of their care when the services are used. The advantage of these three approaches is that they lower premium costs, but do not require substantial financial resources from the sponsoring project.

A majority of the projects have used these innovations, often in combination with direct and indirect subsidy strategies, in designing their insurance programs for uninsured small employers. However, four projects that do not have access to state subsidy funds for providing premium subsidies or purchasing reinsurance have relied heavily on these strategies, in conjunction with provider discounts, to reduce premiums. The four projects include: Central Alabama Coalition for the Medically Uninsured, University of Alabama at Birmingham; Denver Department of Health and Hospitals; Intermountain Health Care Foundation, Inc. in Salt Lake City and the Tennessee Primary Care Association in Memphis. These projects provide excellent examples of the limited provider networks, limited benefits packages, and major cost sharing.

Limited Provider Networks

The Utah, Tennessee and Alabama projects have all organized limited provider networks that rely on nonprofit community health centers to manage and deliver care. The Intermountain Health Care project has created a new health maintenance organization called the Utah Community Health Plan (UCHP) that utilizes five federally qualified community health centers and two private family

practitioners to deliver primary care services in the Salt Lake City area. UCHP has also received substantial discounts of up to 35 percent from seven participating hospitals that provide inpatient and ancillary services. In Memphis, enrollees in the MedTrust plan must see a physician or nurse practitioner under contract to the Tennessee Primary Care Network, a nonprofit HMO with primary care sites at community health centers. The plan receives discounts of up to 80 percent from the three participating hospitals, which prefer to receive partial payment for treating MedTrust patients rather than nothing for treating the same persons who otherwise would be uninsured. The Alabama project offers small employers the choice of either a private or a public delivery system. The less expensive public option is serviced by an exclusive network of seven adult and pediatric clinics operated by the county health department. The county hospital provides inpatient care at reduced rates with tertiary care available at University Hospital and The Children's Hospital of Alabama. Enrollees in all three of these plans have a limited choice of providers, a trade off that some small employers are willing to make in order to obtain insurance coverage.

Limited Benefits

Alabama's BasicCare is an example of a bare-bones health insurance benefits package that is designed to encourage enrollees to seek preventive and primary care services and to discourage expensive specialty and hospital care. Each member of the plan is limited to six physician office visits and ten hospital inpatient days per year. Modest cost-sharing arrangements, such as an $8 copayment for routine physicals, immunizations and well baby visits, apply to virtually all services. The plan currently does not cover mental health or substance abuse services, and no catastrophic coverage is provided.

The ten hospital inpatient days are covered with a $20 copayment per day. For inpatient professional services, the enrollee must pay 20 percent of the charge after a $100 deductible (limited to three deductibles per family per year). For hospital outpatient surgery, the copayment is $50 per day, and for other outpatient services, including laboratory and X-ray services, $20 per day. The plan covers ambulance services and limited rehabilitation therapy (up to $2,000 per year). prescription drugs are $3 for generic drugs and $8 for brand-name products.

The Alabama project had to get special waivers from the state to implement the program because BasicCare's benefit provisions don't comply with the benefits required of HMOs in the state. For example, the limits on office visits and hospital days are normally prohibited under state regulations. Still, the plan is providing an affordable option for small employers in greater Birmingham.

Major Cost Sharing

Nearly all of the products offered through the Health Care for the Uninsured Program require enrollees to share the cost of their care through either copayments or coinsurance with a deductible. However, the Denver and Utah projects provide the best examples of major cost sharing requirements. Denver offers an indemnity insurance plan, while Utah has created a unique HMO product.

SCOPE (Shared Cost Option for Private Employers) is a comprehensive indemnity insurance product sponsored by the Denver Department of Health and Hospitals and underwritten by United States Life Insurance Company. The plan promotes the use of preventive health care services by charging no copayments or deductibles for routine physicals, well-baby visits, and immunizations. It also provides catastrophic coverage by limiting annual out-of-pocket expenses to $2,750 per person and $5,500 per family. However, deductibles are $250 per person for hospital admissions (up to two deductibles per family) and $50 for outpatient prescription drugs. All inpatient hospital services and selected outpatient services, such as preadmission testing, physical therapy and outpatient surgery, carry a coinsurance rate of 50 percent on the first $5,000 in charges. This coinsurance rate also applies to maternity services for the mother only, whereas all routine services for the baby are free. Mental health and alcohol/substance/drug abuse services, hospice, home health services and convalescent care are all subject to coinsurance. Supplemental accident insurance covers the first $500, with coinsurance of 50 percent on the first $5,000 thereafter.

High deductibles and coinsurance make the SCOPE premiums affordable, but the out-of-pocket burden may be high for some enrollees. To accommodate for this the state's Medical Indigence Fund may subsidize all or part of the inpatient deductibles and copayments for low-income enrollees who use one of two publicly supported hospitals in the Denver area.

In Utah, no deductibles apply, but enrollees are charged substantial copayments for most inpatient services. Under the Utah Community Health Plan, copayments for hospital inpatient services are $150 for each of the first four days, with full coverage thereafter. During the first 12 months of enrollment, the plan pays 50 percent of hospital charges for pre-existing conditions. For maternity care, copayments are $350 for each of the first three inpatient days, with full coverage thereafter. Pharmaceutical products are covered in full after a $5 copayment per prescription, and outpatient surgery after a $50 copayment. Primary care office visits are $10 each and specialist office visits are $20.

The savings generated through the three product design innovations discussed above are being passed on to small employers in the form of lower premium rates. The premium rates for BasicCare Public Option and MedTrust are below the average rates for all 15 HCUP products calculated using the subsidized rates for those projects offering direct premium subsidies as shown in Table 10. Premiums for SCOPE and UCHP are lower than this bench mark in most cases. Unlike the subsidized plans of Michigan, Maine and Washington, which provide below average premiums only for low-income enrollees, the four products that rely most heavily on product design innovations to reduce costs pass the savings on to all enrollees regardless of income.

Thus, limiting the choice of providers, scaling back benefits, and requiring major cost sharing illustrate the tough choices which must be made to develop a more affordable product for the small business market. These product innovations can lower the cost of premiums, but also reduce the extent of coverage and choice of providers. It is a goal of these demonstrations to explore these tradeoffs in developing insurance programs that are a good value for those who are currently uninsured.

CONCLUSION

Motivating small employers who currently do not provide health insurance for their employees to begin purchasing these benefits is a formidable goal that requires special efforts on several fronts. The surveys analyzed in the monograph provide a profile of the small employer market and reveal obstacles that these firms face in trying to obtain insurance coverage. The paper also examines 15 insurance products currently being marketed to small employers and discusses product design innovations that can make premiums more affordable. While product design innovations can reduce premium costs, this approach alone will not address all of the major needs of this market. As Chart 3 on the following page shows, these projects have used a combination of approaches including direct and indirect subsidies as well as innovations in product design to make health insurance more affordable.

Appropriate product design can meet some important needs of small business. For example, because females represent a high proportion of the small employer work force, obstetrics and maternity benefits should be included in the benefits package. In markets with a high proportion of young people (most of whom would require hospitalizations only in the case of a serious accident), a small employer health plan should offer preventive and primary care along with a good catastrophic benefit. The fact that many workers in small businesses earn low wages means that copayments, coinsurance rates and deductibles should be relatively low, or the plan should provide alternatives in the event of high out of pocket expenses. For example, Denver's SCOPE plan waives its high inpatient care deductible for very low-income enrollees who use a publicly supported hospital.

The high cost of insurance premiums is the number one reason given by small employers for not obtaining coverage. To address the cost issue, three other product design innovations – limiting the provider network, limiting benefits, and requiring major cost sharing -- all help lower the cost of insurance premiums. However, these approaches require making tough choices about the extent of coverage and choice of providers allowed by the plan. If the project is unable to cut benefits dramatically, greatly limit enrollees' choice of providers, or require high copayments and deductibles, other resources may be required to lower the cost of insurance enough to make it affordable.

CHART 3

Strategies for Making Health Insurance More Affordable

Project	Insurance Plan Innovations			Subsidy			Link to High Risk Pool
	Limited Benefits Options	Major Cost Sharing	Limited Provider Network	Direct Premium	Indirect: Pooling, Admin., Reinsur.	Discounts From Providers	
Central Alabama: BasicCare	■		■			■	
Arizona: Health Care Group	■		■		■	■	
Denver: SCOPE		■				■	
Florida: FSBHAC			■	■	■	■	
Maine: MaineCare			■	■	■	■	■
Michigan Health Care Access Project				■		■	
Tennessee: MedTrust			■			■	
United Way: Information & Referral Service					■		
Utah Community Health Plan		■	■		■	■	
Washington: Basic Health Plan			■	■			
Wisconsin Health Insurance Maximization Project				■			■

As shown in Chart 3, several projects use subsidy dollars either alone, or in combination with these product design innovations, to make premiums more affordable. Four projects (Maine, Michigan, Washington and Wisconsin) use state funds to directly subsidize premiums for enrollees with family incomes below 200 percent of the federal poverty level. This strategy targets subsidy dollars to those in greatest financial need, but also requires the added administrative burden of determining income eligibility. Using another approach, Florida buys down the cost of dependent coverage, thus mitigating the problem of low employer contributions for dependent coverage.

Indirect subsidies can be used to lower the premiums for all enrollees. Given that an insurer's administrative costs for small group products are much greater than for large group products, subsidizing these costs can substantially lower premiums. Administrative functions carried out by the projects have included conducting market research, designing benefits plans, negotiating contracts with providers and underwriters, pooling small employers into larger risk pools, and screening applications. Another form of indirect subsidy is to purchase reinsurance, which reduces the HMO provider's or indemnity insurer's risk of expensive claims and thereby lowers premiums.

Even if a project has designed an insurance product that provides the coverage small employers need and is affordable, the chances of it attracting a sizeable number of enrollees is very low unless the product is aggressively and intelligently marketed. Survey research showed that while many small employers receive insurance information from agents and brokers, a large fraction of small employers have no regular source of information. Many have never purchased group health insurance. Almost none have full-time benefits managers and few have time to study the complex choices involved in selecting plans and their benefits, and in understanding the language of "HMOs, PPOs, IPAs, etc." Many small business owners have found that they do not need to offer health insurance in order to attract adequate employees and a number purchase individual plans for themselves, rather than group plans for the whole company. Because small employers are not as predisposed to purchasing insurance as large employers, the marketing strategy must be first to sell employers on the idea of group insurance and then sell them a policy.

This report has focused on product design innovations for lowering the cost of insurance premiums. However, as the survey research shows, the special needs of the small employer require additional efforts and resources. The Alpha Center is preparing two other monographs on the creative use of subsidies and on marketing insurance group insurance products to small employers. The demonstration projects under the Health Care for the Uninsured Program are putting these strategies to the test by providing affordable new products for formerly uninsured small businesses.

Appendix I

Health Care for the Uninsured Program Grantees

	Date Enrollment/ Service Began
Projects Reaching Enrollment Phase:	
Central Alabama Coalition for the Medically Uninsured, University of Alabama at Birmingham (BasicCare)	3/27/90
Health Care Group of Arizona	1/01/88
Denver Department of Health and Hospitals (SCOPE)	8/22/89
Florida Small Business Health Access Corporation (FSBHAC)	5/19/89
Maine Managed Care Insurance Demonstration (MaineCare)	12/1/88
Michigan Health Care Access Project	5/1/88
Tennessee Primary Care Association (MedTrust)	3/20/89
Utah Community Health Plan	9/12/89
Health Systems Resources/Washington Basic Health Plan	1/3/89
Wisconsin Small Employer Health Insurance Maximization Project	2/21/89
Project Demonstrating Information and Referral Service:	
United Way of the Bay Area (San Francisco, California)	9/20/89
Projects Not Reaching Enrollment Phase:	
New Jersey Health Care for the Uninsured Project	N/A
San Diego Council of Community Clinics	N/A
South Cove Asian Community Health Insurance Project (Boston, Massachusetts)	N/A
West Virginia Indigent Health Care Services Project	N/A

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Appendix II

Small Employer Survey Reports

Baumgarten, Steven A. and Paul Solomon [Florida], "Summary Report: Group Health Insurance Study," January 1988.

Bay Area Health Task Force [San Francisco], "Small Employer Survey," February 1988.

Center for Public Interest Polling, Eagleton Institute of Politics, Rutgers University [New Jersey], "Employer Provided Health Insurance: A Survey of Small Businesses in New Jersey," April 1989.

Central Alabama Coalition for the Medically Uninsured, "Market Research," October 1988.

Formisano, Roger A. and John D. Neale, "A Survey of Wisconsin Small Business Health Insurance Coverage 1987," September 1987.

The Health Care Group of Arizona, "Summary: Employer Survey," December 1986.

HealthCare Connections, Ltd., "Developing a Managed Care Plan for the Uninsured in Tennessee," May 1987.

Health Policy Unit, Human Services Development Institute, University of Southern Maine, "A Survey of Small Businesses in Site One of the MaineCare Demonstration Project," May 1989.

Intermountain Health Care Foundation, "Utah Small Employer Health Plan Marketing Research," February 1988.

Marine, Susan K. and Judith Glazner, "Survey of Small Employers in the Denver Metropolitan Area," September 1988.

San Diego Council of Community Clinics, "Survey of San Diego Area Employers Regarding Health Benefits," May 16, 1988.

West Virginia University School of Medicine, Department of Community Medicine, "Health Insurance Coverage: A Study of Small Business in West Virginia," September 1988.

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NFIB Montana

National Federation of
Independent Business

TESTIMONY SUBMITTED BY

NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB)

Before: Taxation Committee, Montana House of Representatives
Rep. Dan Harrington, Chairman

Subject: HB 693 -- No-Frills Health Insurance

Date: February 22, 1991

Presented by: J. Riley Johnson, State Director NFIB/Mt.

The National Federation of Independent Business (NFIB), representing over 6,400 small and independent businesses throughout Montana, rise in very strong support for HB-693.

Small business in Montana, indeed small business all across this country, is a victim of a three-tiered problem facing our society today: first, is the rising health care inflation that not only hits us individually but is crushing our employees; secondly, the rising health insurance premiums that are suffocating our lifestyles; and thirdly, the attitude that

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business -- and in particular small business -- can be the lever by which society's leaders can pry out a solution to the devastating health-care crisis facing us today. All these have a common element -- cost!

It's beyond sticker shock; it's premium panic. Over 63% of NFIB's members in Montana today offer some kind of health insurance coverage or participation in health coverage. And 82% of those not providing such medical assistance to their employees state that they would like to provide something. But they can not afford it. Cost is restricting small employers and individuals from the system. The result is that society is picking up a large percentage of that "unfunded liability".

HB-693 offers the first step toward trying to solve this health crisis reasonably. But I must warn you. As you deliberate here this morning and beyond, remember it is NOT benefits...or neat packages...or tax incentives...or social obligation that will motivated Montana's small employers to offer group health plans to their employees. IT WILL BE COST...AND ONLY COST! Of course, there will have to be adequate major medical coverage for catastrophic occasions, but the bottom line will be COST!

And if you begin to pile on mandated benefits, you'll only drive up the costs.

One objection NFIB has with HB-693 is the provision that allows businesses to purchase the new "bare-bones" health program only if they have not had health coverage in the past 12 months. NFIB sees this as discriminatory and a disincentive. The fears

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that businesses with health plans in force today will jump ship, so to speak, and drop cadillac plans for lesser bare-bones plans has just not proven to be the case in other states and cities that have instituted these programs. What you will get are small employers who have reached the limit on health costs and will drop their present plans and go bare for 12 months...these are the fringe cases that you would loose anyway from the system. Don't exclude these folks from participating.

And, finally, attached to this testimony are the survey results of the NFIB's 1990 Montana Ballot Survey on health care. I urge you to seriously consider these results because it is these very small business owners that you will be asking to buy into this program. Without them, all you work here this morning will be in vain. You will have thrown a swell party...but nobody came.

Let's not let this happen. NFIB urges your support of HB=693.

-30-

NFIB Montana 1991 STATE BALLOT

Total Ballots To Members – 6,427

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GENERAL GOVERNMENT

Term Limitation

1. Should the Montana Constitution be amended in order to limit the terms of state senators to two consecutive terms (eight years) and state representatives to four consecutive terms (eight years)?

☐ Yes ☐ No ☐ Undecided

78.0 [2] 18.0 [3] 4.0 [11]

2. Should the Montana Constitution be amended to limit the terms of statewide executive officials (governor, Lt. governor, secretary of state, auditor, and attorney general) to two consecutive terms (eight years)?

☐ Yes ☐ No ☐ Undecided

[1] 76.8 [2] 19.8 [3] 3.4 [12]

Background: Currently, there are 28 states that limit gubernatorial terms, and most of these states also limit the terms of other statewide elected officials. Colorado and California have measures on the ballot for the general election in November 1990, which would limit the terms of both statewide officials and legislators. Oklahoma has already adopted term limitations on its state officials. The President of the United States is restricted to two terms.

Since 1980, 97 percent of the incumbents seeking reelection to the Montana House and Senate have won. Several bills that would have limited the terms of elected officials in Montana have been introduced over the past decade, but none have made it out of committee.

Proponents of the proposed change say that limiting terms would provide for greater competition in the election process by diminishing the power that incumbency has developed. They also claim that it is more important to elect individuals who will carry out a public service by serving in elected office, rather than making elective office a career.

In addition, proponents believe that the longer individuals serve in an elected capacity, the more likely they are to become influenced by the special interests that these officials depend upon to help raise money for their reelections. Furthermore, proponents suggest that term limitations would make elected officials more concerned with solving problems, rather than with simply gaining reelection.

Opponents believe that the adoption of term limitations would deny citizens the right to seek elective office for as long as these individuals are able to convince the voters that they have done a good job. Opponents claim that a limitation provision would foster a higher turnover in elected positions. They suggest it would also lead to individuals being elected who do not have a great deal of experience in running the government and would create a government run by bureaucrats.

PAC Limitations

3. Should Montana prohibit political action committees (PACs) from contributing money to state legislative and Congressional candidates in Montana?

☐ Yes ☐ No ☐ Undecided

[1] 76.2 [2] 19.9 [3] 4.0 [13]

Background: Business, labor, and single-issue groups have formed political action committees in order to advance their programs in the political arena. As a result, PACs have become the major source of funding for incumbents who are running for the Congress and incumbent state legislators.

Proponents of the proposal say that PAC money gives the special interests too much power and the people too little. They maintain that primary campaign financing should come from individuals and the political parties. These proponents argue that both of these groups are more easily identified and accountable than are PAC's.

Opponents argue that restrictions on PAC's would violate the right to free speech and would make it too hard for candidates to raise money. They also argue that PAC's allow smaller contributors in labor unions, special-interest groups, and corporations to pool their money so that it has a greater impact on the election process.

Spending Limitations

4. Should Montana limit the amount of money a candidate can spend in order to be elected to a state office?

☐ Yes ☐ No ☐ Undecided

[1] 84.1 [2] 11.6 [3] 4.3 [14]

Background: During each successive election cycle, it is becoming more costly to run for elective office in Montana. State Senate seats for this election year are going as high as $25,000 per candidate, and House seats are costing between $5,000 and $12,000 per candidate. As a result of these increases, lawmakers are eyeing candidate spending limitations in 1991.

Proponents of spending limits say "enough is enough." They argue that getting elected to office should not be a contest to see who can raise the most money.

Furthermore, proponents contend that these excessive costs take away from the individual, overshadow the important issues, and distort a campaign. They maintain that these costs also open up a candidate to pressure from large campaign contributors. These proponents argue that spending limits would allow more people to run for office.

Opponents of such spending limits say

that fund raising is vital to free elections. They suggest that fund raising is a strong indicator of a candidate's ability to represent a constituency.

In addition, opponents believe that it is only through open spending limits that candidates are able to communicate information about their individual abilities — or lack of abilities — to the voters. These opponents say that placing limits on this communication process would result in a poorly informed electorate.

HEALTH INSURANCE

Universal Health Insurance

5. Should legislation be enacted to create a universal, state-government administered health insurance program that would be available to all Montanans?

☐ Yes ☐ No ☐ Undecided

[1] 24.5 [2] 63.1 [3] 12.4 [15]

Background: As the cost of health insurance rises and greater numbers of people are left without coverage, legislators have begun to consider the establishment of a universal health insurance program that would be similar to the Canadian Health Care Plan.

Proponents of the proposal argue that a universal health insurance program would ensure that all Montanans would have adequate access to health care, and that business owners would no longer have to deal with unpredictable health insurance premiums or to face possible mandated health insurance plans.

Opponents argue that such a system of "socialized medicine" would lead to an expensive, bureaucratic state program, such as that for workers' compensation insurance. They contend that a universal health program would need to be financed by ever-increasing taxation, would lead to health-care rationing and shortages, and would be a disincentive to developing medical technologies. Opponents also believe that enactment of a universal health-care program would merely shift the cost of health insurance from premiums to new taxes.

Mandated Benefits Review

6. Should legislation be enacted to provide for a systematic review of the fiscal and social impact of state government-mandated health insurance benefits prior to their adoption?

☐ Yes ☐ No ☐ Undecided

[1] 64.8 [2] 21.6 [3] 15.6 [16]

Background: For many years, Montana lawmakers have enacted laws in order to provide for mandated benefits in health insurance plans, which require health insurance carriers to include certain health services in all medical policies. Examples of these types of mandated benefits include coverage of specific illnesses, such as drug or alcohol dependency or mental and stress disorders. Other mandates require policies to cover specified health-care providers, such as chiropractors and psychologists.

Proponents of the proposed review believe that mandated benefits are helping to drive up the costs of health insurance and are contributing to the growing number of Montanans who are not covered by any health insurance program. They also say that such mandates are depriving employees and employers of the right to determine what constitutes the most appropriate health insurance package for them. These proponents argue that a pre-adoption review could focus on vital fiscal considerations, including the mandate's impact on insurance costs and the use of particular medical services.

Opponents of the review proposal believe that a good selection of these kinds of mandated benefits would save money for employers in the long run. In their view, the broadest possible insurance coverage (both in terms of benefits and health-care provider services) results in early intervention with respect to health-care problems and reduces subsequent insurance claims.

"Bare-Bones" Health Plans

7. Should Montana allow insurance carriers to offer a "bare-bones" health insurance package that is stripped of all state-mandated coverages?

☐ Yes ☐ No ☐ Undecided

[1] 64.8 [2] 18.7 [3] 16.5 [17]

Background: Some legislators who are looking for ways to resolve the health-care cost crisis are examining the idea of "bare-bones" health insurance policies. Seven states have passed similar legislation that allows such health plans in the past year. Such minimal health insurance plans do not contain costly state-mandated coverages.

Proponents of the proposal say that mandates constitute a major portion of the health-care costs to insurance providers. They suggest that it is the high cost of health insurance that prohibits many individuals and employers from purchasing such coverage. These proponents believe that a bare-bones policy would cut health insurance costs drastically and thereby allow for coverage of a greater number of people.

Opponents argue that this proposal is a ploy by employers and insurance companies in order to allow them to not provide adequate health insurance coverage to individuals. These opponents contend that without broad coverages, individuals would ignore some medical disorders until they become major problems, thus resulting in poorer overall health care and ultimately costing more money. Opponents also argue that lower-income people would be the most hurt by bare-bones health polices because they would have to pay more of their gross income for health-care coverage than middle- and upper-income people.

LABOR

Deficit Surcharge

8. Should the legislature continue paying for the unfunded liability in the workers' compensation insurance system with the 28 cents per $100 of gross payroll surcharge on employers?

☐ Yes ☐ No ☐ Undecided

[1] 20.2 [2] 65.3 [3] 14.5 [18]

8a. If you answered "no" to the above question, please indicate your priorities for alternative financing of the unfunded liability in the workers' compensation insurance system. (Select your top three choices.)

1. 44.9 Income tax surcharge
2. 74.7 Employees contribute to surcharge
3. 34.6 Appropriate general fund monies
4. 8.2 Raise WC rates
5. 23.5 Graduate surcharge (not flat rate) [19-21]

Background: The state does not have enough money in its coffers to pay for all of the past workers' compensation (WC) claims as they come due over the next 30 years. This deficit is referred to as the "unfunded liability," which now amounts to over $330 million in today's dollars. The legislature has made numerous attempts to solve the unfunded liability problem, including a special session in May of this year.

To date, the only adopted solution has been a 28 cents per $100 of gross payroll surcharge that has been placed on all employers, even employers that do not use the state's WC insurance fund. This surcharge, coupled with borrowing from the ongoing WC funds, is expected to pay off this deficit in 20 to 30 years. Most legislators who are supportive of small-business want to change this surcharge system in 1991, saying that it is too costly and also unfair.

Proponents of the surcharge argue that

Blue Cross
and
Blue Shield
of Montana

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Great Falls Division
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Great Falls, Montana 59403
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Reply to Helena Division

February 22, 1990

Representative Dan Harrington
Chairman
House Taxation
House of Representatives
Helena, MT 59601

Dear Representative Harrington:

I regret not being able to personally testify today on HB693, legislation that will make it possible to offer more affordable health care coverage to uninsured workers.

I have asked Chuck Butler, a member of my staff who also served on the Governor's Committee that recommended this legislation, and Garth Trusler, Vice President Actuarial, to present my testimony and be available for questions.

We strongly endorse HB693 and hope the Committee will give it a do pass recommendation.

Sincerely,

Alan F. Cain
President and
Chief Executive Officer

cc: Representative Fred Thomas
Chuck Butler

HOUSE BILL 693
TESTIMONY BY
ALAN F. CAIN
PRESIDENT AND CEO
BLUE CROSS AND BLUE SHIELD OF MONTANA
FEBRUARY 22, 1991

My name is Alan F. Cain, President and Chief Executive Officer of Blue Cross and Blue Shield of Montana. I was a member of the Governor's Committee which recommended House Bill 693 and am sorry I could not be present in person for this hearing. We are pleased to appear this morning in enthusiastic support of House Bill 693.

Blue Cross and Blue Shield of Montana currently provides health care coverage or administrative services for over 207,000 Montanans. As we have observed the marketplace in Montana in recent years, we have been alarmed by the number of people who are dropping their health care coverage. We keep track of groups and individuals which leave us to determine the reasons why, and are increasingly finding they are not securing coverage with any other carrier. Rather, they are electing to drop company-sponsored plans, and the overwhelming reason given for the cessation of these plans is that the employer can no longer afford the cost.

Rapidly increasing health care costs and utilization of services have forced the price of the benefit plans we sell up dramatically in recent years. In some years, the cost has risen at an average rate of 35 percent with some groups receiving rate increases far in excess of that figure. To highlight what I mean by rising costs of care, the average charge per day in a Montana hospital to Blue Cross and Blue Shield of Montana in 1986 was $500. Today it is over $900 and we project the charges to go over $1,000 by the end of

this year. At the same time, the average charge per admission was about $2,300 in 1986, and by the end of this year it will be over $5,000.

The escalation of health insurance premiums has produced a situation where recent studies indicate that 141,000 Montanans are not covered by health insurance and are not eligible for Medicare, Medicaid, or some other program of health care coverage. We believe that a large segment of these people are employed by employers who can no longer afford to contribute to their employees' health care coverage, or are not inclined to retain their employer-sponsored plans because of the difficulty they face in responding to large increases in costs almost every year.

It is our belief that many of these employers would offer coverage to their employees if policies were offered in a price range which the employer could afford. We have demonstrated this in the individual market by the tremendous acceptance by the public of our Essential Care product. In January 1990 we commenced offering this limited benefit policy to individuals. It was designed to sell for $150 per month for a family. To date, we have enrolled 6,000 people in this program with more people joining each month. Although the benefits are limited, those purchasing the product seem pleased that they are now able to afford some very basic form of health insurance. While these types of products require patients to pay for many of the routine items of medical services, covered persons are protected from catastrophic losses when they require extended hospitalization or other forms of expensive treatment.

House Bill 693 offers significant incentives for insurers to deliver the same type of benefit plans in the small group market. It should be emphasized that the overwhelming majority of Montana employers are in the small group or under 25 workers range. The limited benefits required by the bill and the limited exposure to mandated benefits, as well as the tax incentive for employers, all would contribute to increasing the number of Montanans who are covered by private health insurance programs.

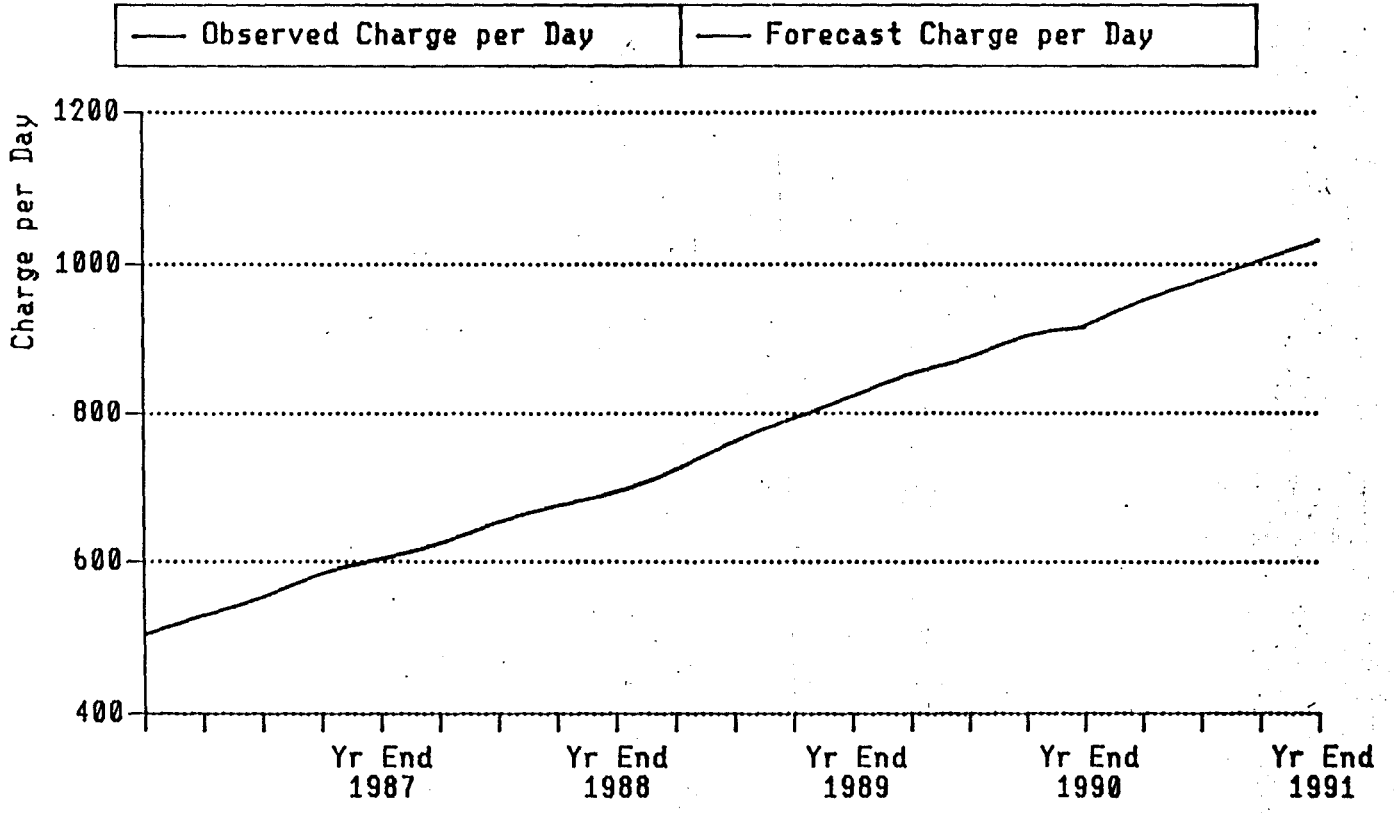
We believe that adoption of this legislation would be a significant move forward in addressing the problems of the uninsured. Many other states have already enacted such legislation, and we believe House Bill 693 is one of the best of the legislative proposals we have reviewed.

In closing, I would like to compliment Governor Stephens for convening the Committee whose deliberations produced what is now House Bill 693. I would also like to compliment Representative Thomas, who is not only the chief sponsor of the bill before you, but also chaired the Governor's committee. We sincerely support a do pass recommendation for House Bill 693.

AFC/sks

T202K

BLUE CROSS AND BLUE SHIELD OF MONTANA
HOSPITAL INPATIENT TRENDS
Charge per Day



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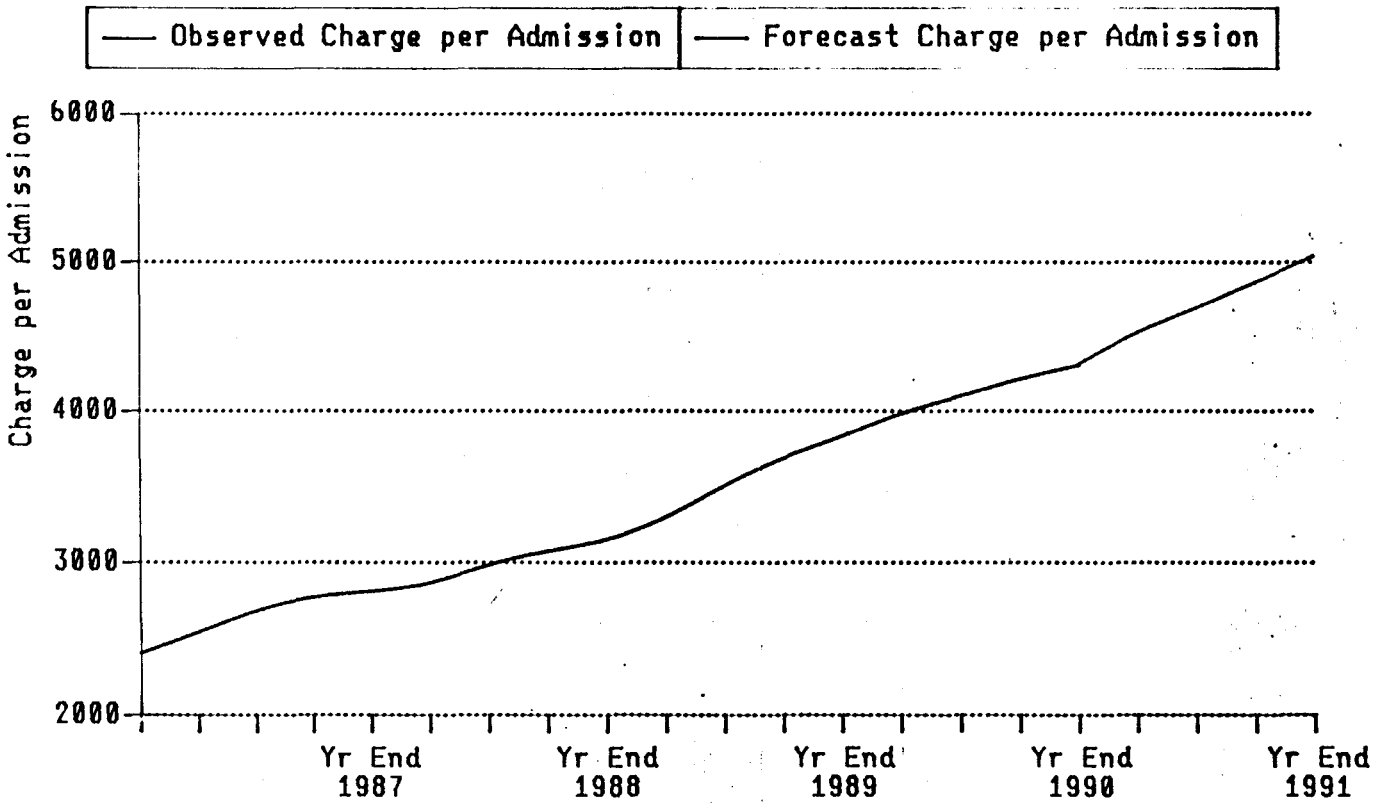
BLUE CROSS AND BLUE SHIELD OF MONTANA
HOSPITAL-INPATIENT TRENDS
Charge per Admission



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DATE 2-22-91
HB 693

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

TAXATION COMMITTEE BILL NO. SB 194

DATE 2/22/91 SPONSOR(S) SEN. TOWE

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE

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

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

TAXATION COMMITTEE BILL NO. HB699

DATE 2/22/91 SPONSOR(S) Rep. ELLISON

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GREG STRONG; P.O. BOX 411 LIVINGSTON, MT. 59047	LIVINGSTON MARBLE & GRANITE. BOX 851; LIVINGSTON, MT. 59047	X	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Taxation COMMITTEE BILL NO. HB 738

DATE 2/22/91 SPONSOR(S) Rep. Elliott

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Gordon Morris	MACo	✓	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

TAXATION COMMITTEE BILL NO. HB69

DATE 2/22/91 SPONSOR(S) Rep. Thomas.

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

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Q. Hahn 415 N. Higgins Msla	MMHCA		✓
Bob Bakko 4147 Wells Pl Blgs, Mt	MMHCA		✓
John W Flink MT Hosp Assoc.	MHA	✓	
Bob Frazier	Govs Health Care Committees	✓	
L H Colvin	UMWA		✓
Tom Hopgood	Hlth Ins Assoc America	✓	
JAMES TUTWILER	MT CHAMBER	✓	
Riley Johnson	NFIB	X	
Ann Prunuske	MAPP		✓
Chuck Butz	BCBSMT	✓	
JC Witte	State Auditor/ INS.	✓	

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