MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on March 6, 1991, at 3:05 p.m.

ROLL CALL

Members Present:

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

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

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

HEARING ON SJR 9

Presentation and Opening Statement by Sponsor:

SEN. R. J. PINSONEAULT, Senate District 27, St. Ignatius, stated that this resolution speaks for itself. The health program in this country is a disgrace. For a nation that has such capability, who can put a man on the moon and do the things that we do technically, if we could deliver a health care system with the same preciseness and deadly destruction in Desert Storm, the nation would be far better off. The National Health Care Program has been an issue of discussion for a long time.

Proponents' Testimony:

P.J. Hennessy, Board of Montana Senior Citizens Association, stated that she has been a Montana resident for 15 years. During that time she has struggled to provide quality health care for those populations who lack health insurance. The population of Montanans who lack health insurance is relentlessly increasing. Over 140,000 Montanans lack health insurance and the basic health care it affords. It is time to turn to the federal government. We need their help to solve the foremost domestic issue of equity and justice we face today as Americans. We need a program of national health insurance. She submitted a packet. **EXHIBIT 1**

Tim Harris, Deputy Director, Montana Independent Living Project, Helena, submitted written testimony. **EXHIBIT 2**

Doug Campbell, Montana Senior Citizens Association, submitted written testimony. **EXHIBIT 3**

Leroy Keilman, Yellowstone Retired Teachers Association, Montana Senior Citizens, submitted a testimony and a cartoon. **EXHIBIT 4**

Colette Baumgardner, Democratic Women's Caucus, State Senate and House of Representatives, stated that the Caucus are in favor of this resolution.

Bonnie Lambert, small business, stated that she has been in business for four years and has no employees. She purchased health insurance for her husband, son and herself, this a minimum coverage policy which does not include dental or eye care. We are very healthy, in the past four years she has filed one small emergency claim. She pays $135 a month. This policy keeps them from losing their house in event of a medical catastrophe. As a business person she has to think twice about hiring someone, she considers health insurance for employees part of the compensation package. She cannot afford to buy health insurance for another person.

Robbie Ford, AFSCME, submitted written testimony for **George Hagerman, Executive Director of Montana Council #9, American Federation of State, County, and Municipal Employees (AFL-CIO). EXHIBIT 5**

Marion Hellstorm, Director, Montana Senior Citizens Association, submitted written testimony. **EXHIBIT 6**

Marcia Diez, Montana Low Income Coalition, stated that there are two programs that are going to be cut back, low income people are going to be hurt further. This is more reason that we need a national health care plan. AFDC related medically needy programs is being cut out for parents and grandparents that are taking care of AFDC eligible people. This will resolve in more people giving up part time jobs, giving up children to foster care, and going on Medicaid and AFDC. They are also cutting back medical,

which is more than case management. It is a cut back in services and its a cut back to the most disadvantaged people in our society. This will mean loss of hearing aids, eye glasses and medicine, because they will only treat acute and not chronic conditions.

John Ortwein, Montana Catholic Conference, submitted written testimony. **EXHIBIT 7**

Diane Sands, Montana Women's Lobby, stated that this country is in the midst of a very serious crises in terms of acceptable and affordable health care. The development of a national health care policy is critical for the provision of those services.

Jim Ahrens, President, Montana Hospital Association, submitted written testimony. **EXHIBIT 8**

Paulette Kohman, Director, Montana Council for Maternal and Child Health, stated that they are in support of this resolution.

REP. ROLPH TUNBY, stated that the time has come that the government is going to have to become involved. We have such a patchwork of federal, state and private that it isn't working. Stated that we spend 22 to 25 cents out of every health care dollar for administration.

REP. SHEILA RICE, submitted a petition. **EXHIBIT 9**

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

SEN. PINSONEAULT stated that one of things that is being included in this resolution that it involve a single payer system of health care. One of the things that the Native Americans living on the reservation take the most pride in is that they have a health care program provided to them by the Public Health Service. The problem is not the cost of the national health plan, rather it is the cost of not having such a plan.

EXECUTIVE ACTION ON SJR 9

Motion/Vote: **REP. HANSEN MOVED SJR 9 BE CONCURRED IN.** Motion carried 17-3 with **REPS. BOHARSKI, KASTEN and LEE** voting no

HEARING ON HB 950

Presentation and Opening Statement by Sponsor:

REP. VIVIAN BROOKE, House District 56, Missoula, stated that this bill is the Montana Family Policy Act. This bill sets up a state policy to support and preserve the family as the single most

power for insurance social development, mental and physical well being of Montana's children. This bill emphasized support for family services, activities and programs that promote prenatal care, parenting education, parent aids, visiting nurses, well family medical screening, child care, and family recreation. HB 950 supports intensive help for children and families in crises and tries to break down the walls that keep agencies, groups and programs from working together.

Proponents' Testimony:

Dennis Taylor, Board Member Montana Council for Families, stated that Montana needs its children and families to be helped and secured for today and for the future. Too many of Montana's children live in desperation experiencing little hope for the future. These children and teens struggle with poverty, abuse and neglect, alcoholism, drug abuse, and emotional problems and much, much more. These children and youth and their families must be our concern today.

Fred Fischer, Prevention Coordinator for the Attorney General's office, Department of Justice, stated that about 40 from across the state were involved in alcohol and drug prevention areas and met to discuss how they impact the traditions in their communities as well across the state. This was in preparation for the Montana's Caring for Kids Conference so we could get people from across the state to identify and go back to their communities and start working on this. The goal of this prevention program develops strategies that will impact the negative conditions and impact families and communities across the state like domestic violence, child abuse, alcohol and drug problems, and teenage pregnancy. We have the beginnings of a movement toward the collateral efforts that are outlined in HB 950. The guidelines in HB 950 that family support and preservation should be the guiding philosophy of state agencies.

John Madsen, Department of Family Services, submitted written testimony. **EXHIBIT 10**

Dr. Thomas D. Carlin, Psychiatrist, Helena Section Montana Committee for the Emotionally Disturbed Children, stated that we need more early diagnosis, early intervention, early prevention, working with the families in order to help children to strengthen the family so that we do not face some of the problems and situations that we find now in our schools.

Tom Olson, Director, Department of Family Services, stated that in the section of the bill that calls for an oversight committee, the activities are being served quite well by the state advisory council. There is legislative representation on those councils.

Jeanne Kemmis, Montana Council for Families, submitted written testimony. **EXHIBIT 11**

Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health, submitted written testimony. **EXHIBIT 12**

Kenneth Moore, Moderator, Christian Church in Montana, submitted written testimony. **EXHIBIT 13**

Elizabeth Roeth, Montana Children's Alliance and Healthy Mothers/Healthy Babies, submitted written testimony for **Joan-Nell Macfadden, Chairperson, Children's Committee of Mental Health Association of Montana. EXHIBIT 14**

Helen Costello, Service Coordinator, Montana Post Adoption Center, submitted written testimony. **EXHIBIT 15**

Bud Solmonsson, Montana Council for Families, submitted written testimony for **Robert W. Moon, President, Montana Public Health Association, Board of Directors, Montana Council for Families. EXHIBIT 16**

Kathy McGowen, submitted written testimony for **Kenneth Taylor, MA,** submitted written testimony. **EXHIBIT 17**

Judy Garrity, Montana Children's Alliance, submitted written testimony. **EXHIBIT 18**

Judith Carlson, Montana Chapter National Association of Social Workers, submitted written testimony. **EXHIBIT 19**

Mike McGrath, Lewis and Clark County Attorney, stated that he very strongly supports this bill.

Robert Deaton, Professor, Department of Social Work, University of Montana, and District Chair, Child Abuse Program, Exchange Clubs of Idaho and Montana, submitted written testimony. **EXHIBIT 20**

Mike Males, Children's Trust Fund, stated that child abuse prevention funding locally has an inadequate amount of money.

Diane Sands, Montana Women's Lobby, stated that they are in strong support of HB 950.

John Ortwein, Montana Catholic Conference, submitted written testimony. **EXHIBIT 21**

Dale Grace, Office of Public Instruction, stated that they are in support of HB 950.

Colette Baumgardner, Democratic Women's Caucus, State Senate and House of Representatives, stated that the Caucus is in support of this bill.

Barbara Ranf, USWest Communications, submitted written testimony. **EXHIBIT 22**

Opponents' Testimony:

Sam Sperry, Chief, Vital Records and Statistics Bureau, Department of Health and Environmental Sciences, submitted written testimony. **EXHIBIT 23**

Dorothy Traxler, self, submitted written testimony. **EXHIBIT 24**

Gloria Rourk, Mothers of America, stated she opposes HB 950 because the DFS functions are not aiding, but victimizing children and their families. She has been a licensed foster parent in Montana for five years. She has two biological children of her own and she has a foster child that she has adopted that is developmentally disabled. This bill would empower DFS with extra powers to render children and their families helpless and finally the burden already heavily left to taxpayers.

Questions From Committee Members:

REP. JOHNSON asked Ms. Kohman why she wanted to take out section 5 and 6. **Ms. Kohman** stated that the funding for section 3 is nowhere in the act. Section 5 is simply funding section 4, which is the legislative interim committee.

REP. JOHNSON stated that there is a substantial fiscal note to the bill of $280,000. If we don't have the other funding, where would we get $280,000. **Ms. Kohman** stated that we have many different ways of funding many different things and this committee unfortunately doesn't have any answers to the funding problems, but only with the way to spend it.

REP. WHALEN asked who this bill would apply to. **Mr. Olson** stated that this bill is designed for all children and families in the State of Montana.

REP. WHALEN asked how are these families that need care going to be identified. **Mr. Olson** stated that they will be identified through the Healthy Start Program.

REP. WHALEN asked who will be doing the identification and what is the criteria for identification going to be.

REP. RUSSELL she worked as a medical social worker in a small hospital for a number of years. As part of the medical grounds, every morning they covered every single patient that was in the hospital. If any high risk individuals were in the hospital and we were afraid so the social worker was appraised immediately. Is this in place in Montana. **Ms. Kohman** stated that in different communities where there are volunteer programs who perform the service.

Closing by Sponsor:

REP. BROOKE stated that the questions raised in regards to the birth certificate fee. There are needs for many services in our educational system, social service, and our justice system for the results of real problems with child abuse and neglect in dysfunctional families. Prevention is a very valid manner in which we could go as a state. This birth certificate fee will help us start towards prevention. This is a realistic way to go. There are several states that are funding prevention of child abuse and neglect programs through birth certificate fees.

HEARING ON HB 728

Presentation and Opening Statement by Sponsor:

REP. BOB REAM, House District 54, Missoula, stated that this bill is a result of the Montana Hunger Coalition. He is astounded by the extent of this problem in Montana. HB 728 provides a policy in the State of Montana is to make food programs and nutritional services available to all who are in need of these programs. The Hunger Coalition brings together what is handled in different state agencies and coordinating the activities of those agencies and the people that work in those programs. When we talk about hunger, we are not only talking about quantity of food, but quality. Poor diet is the leading cause of chronic diseases among the poor and particularly among our Native American population. However, no agency has the responsibility to see that programs have nutritional education and are established.

Proponents' Testimony:

Minkie Medora, Montana Hunger Coalition, submitted written testimony. **EXHIBIT 25**

Paul Miller, Montana Hunger Coalition, submitted written testimony. **EXHIBIT 26**

Joan A. Duncan, Montana Foodbank Network, submitted written testimony. **EXHIBIT 27**

Arlene Templer, Confederated Salish and Kootenai Tribe, submitted written testimony. **EXHIBIT 28**

Mary A. Musil, Chair, State Study on Hunger, Board of Directors, League of Women Voters of Montana, submitted written testimony. **EXHIBIT 29**

David Host, Missoula Food Bank, stated that his family is living proof that the WIC food stamp programs, that this bill would enhance, operate as social and economic medicines.

Linda Melick, Central Montana Medical Center, submitted written testimony. **EXHIBIT 30**

Pete Brekhus, Acting Administrator, Central Montana Medical

Center, submitted written testimony. EXHIBIT 31

D. Elizabeth Roeth, Director, Healthy Mothers/Healthy Babies, Chair, Montana Children's Alliance, submitted written testimony. EXHIBIT 32

John Ortwein, Montana Catholic Conference, submitted written testimony. EXHIBIT 33

Boni Braunbeck, County Director, Fergus County Human Services, submitted written testimony. EXHIBIT 34

Deb Bjorsness, Montana Deaconess Medical Center, Great Falls, submitted written testimony. EXHIBIT 35

Paulette Kohman, Director, Montana Council for Maternal and Child Health, stated their support in HB 728.

Seth Lang, Montana Public Interest Research Group, stated their support to HB 728.

Bud Solmonsson, Director, Montana Council of Families, Montana Children's Alliance, stated their business is promoting health families, one major distractions the family has is being hungry and not having education.

Jerome Loendorf, Montana Medical Association, stated that this is one of the best appropriation bills and they support it for the reasons previously given.

Diane Sands, Montana Women's Lobby, stated their support to HB 728.

Judith Carlson, submitted written testimony for Doug Campbell, President, Montana Senior Citizens Association. EXHIBIT 36

Colette Baumgardner, Democratic Women's Caucus, State Senate and House of Representatives, stated their support to HB 728.

Harley Warner, Montana Association of Churches, submitted written testimony. EXHIBIT 38

Opponents' Testimony:

Sheryle Shandy, Executive Director, Billings Food Bank, submitted written testimony. EXHIBIT 37

Terry Egan, MSU Extension Agent, Expanded Food and Nutrition Education Program, submitted written testimony. EXHIBIT 39

Questions From Committee Members: None

Closing by Sponsor:

REP. REAM stated that a physician is necessary for working with this advisory council. The advisory council is made up of many volunteers and agency people that come together to provide the coordination that is necessary to make most effective use of the resources we have available in Montana. Those resources are tremendous. There are approximately $100 million of federal money that goes into various food programs in Montana, like WIC program, food stamp program, the commodity program, elderly, school hot lunch program and daycare supplemental fee. In addition, Montana has tremendous private sector ethics.

HEARING ON SB 168

Presentation and Opening Statement by Sponsor:

SEN. STEVE DOHERTY, Senate District 20, Great Falls, stated that the problems as far as landfills and the contamination of bowl water is something that we need to address. This bill is also pro business. There are some people who are in the diaper business and we need to remove the barriers that they have encountered in practicing their trade. This is an entire legislative prerogative. The rules were adopted about ten years ago and nothing has been done to them since. There is no scientific basis to discriminate between cloth diapers and disposable diapers. This legislation has been enacted in Washington, Oregon and Vermont.

Proponents' Testimony:

Carolyn Brinkley, self, stated that she was surprised to see that there was a law governing the use of cloth diapers in daycare centers. Submitted written testimony. **EXHIBIT 40 & 41**

Jon Wade, Diaper Exchange, Missoula, stated that this motion is inappropriate and legally questionable proposal of lawsuit. This bill increases volume of solid waste. It increases the extensive parents that force the purchase of disposable diapers. The current statute defines hazardous waste in a manner that includes raw sewage. Presently, Montana regulations permit disposable hazardous of waste to only a class one disposable sight. Our current health regulations which govern communicable disease control and daycare implicitly acknowledge that proper handling of raw sewage is to dispose of in a public sewage system or appropriate private septic system. Without a explanation another health regulation as far as daycare is to use disposable diapers on children under the age of two.

Janet Ellis, Montana Audubon Legislative Fund, submitted written testimony. **EXHIBIT 42**

Chris Kaufman, Montana Environmental Information Center, stated that the worst part of this is that disposal diapers are items that are made to be thrown away after they have been used one time. Next to newspapers and food and beverage containers, the

most common single item in a landfill is disposable diapers. They make up 2% or 3% of the solid waste. The answer would be to ban the use of disposable diapers, this bill does nothing close to doing that sort of thing.

Kate Cholewa, Montana Womens Lobby, stated that the Women's Lobby represents a variety of child care organizations and they rise in support of this bill.

Kay Frey, RN, PNP, Health Consultant, Child Care Resources, submitted written testimony. **EXHIBIT 43**

Janet Bush, Child Care Resources, submitted written testimony. **EXHIBIT 44**

Corrine Hilde, Child Care Services Coordinator, submitted written testimony. **EXHIBIT 45**

Opponents' Testimony: None

Informational Testimony:

Judith Gedrose, Department of Health and Environmental Sciences, submitted written testimony for **Ellen Leahy, Health Officer, Missoula County. EXHIBIT 46**

Questions From Committee Members:

REP. CROMLEY asked what is the purpose of this bill. **SEN. DOHERTY** stated that there was an attempt in Missoula to see how this would work out, and it did work out. There has been some problems that if this bill fails people will try to make sure that we don't use cloth diapers.

Closing by Sponsor:

SEN. DOHERTY stated that it is within the legislative prerogative to express an intent. The intent would be that we are not mandating use, we are saying you can use them and telling the health department to devise rules that will not be areas to their use, but will provide for safe use.

EXECUTIVE ACTION ON SB 168

Motion/Vote: **REP. SQUIRES MOVED SB 168 BE CONCURRED IN.** Motion carried 19-1 with **REP. KASTEN** voting no.

HEARING ON HB 696

Presentation and Opening Statement by Sponsor:

REP. JIM RICE, House District 43, Helena, stated that this bill will extend funding for statewide genetics program for the next two years. This is one of the most valuable programs in all of

state government. It identifies and addresses genetic disorders before birth. This has become a very successful program and because of the high quality of the personnel involved it has had international impact.

Proponents' Testimony:

Chad Smith, Shodair Hospital, submitted written testimony. **EXHIBIT 47**

Dr. John M. Optiz, submitted written testimony. **EXHIBIT 48**

Joan Fitzgerald, Administrative Director, Department of Medical Genetics Shodair Hospital, submitted written testimony. **EXHIBIT 49 & 50**

Walt Schopfer, self, stated that he is a parent of a developmentally disable son with Down Syndrome who is currently a senior in high school. In 1970 when his son was born, they were not aware of any genetic services that were available. In 1981 they moved to Billings and through the Center for Handicapped Children they were put in touch with Shodair Hospital and the Montana Genetics Program. His son was scheduled with one of the geneticists in 1986, which was the first time they had an opportunity to ask questions and have a lot of our questions answered. About a year ago their son developed a life threatening blood disorder and through the support of the geneticist at Shodair Hospital they were put in contact with physician who is currently doing research with this type of blood disorder. The genetics services with this program has to a lot to offer the State of Montana.

Jeanette McCormick, self, submitted written testimony. **EXHIBIT 51**

D. Elizabeth Roeth, Chair, Montana Children's Alliance submitted written testimony. **EXHIBIT 52**

Robert W. Moon, President, Montana Public Health Association, submitted written testimony. **EXHIBIT 53**

Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health, submitted written testimony. **EXHIBIT 54**

Jim Ahrens, President, Montana Hospital Association, stated that they have consistently supported this bill over the years and they do so again.

Jerome Loendorf, Montana Medical Association, stated that they have been supporting this bill since it has been before the legislature.

Mike Stephen, Montana Nurses Association, stated that they full heatedly support this incredible genetic program. It is

extremely worthwhile to all citizens in Montana.

Dr. Jeffrey Stickler, Montana Academy of Pediatrics, stated his support to HB 696.

Jack Casey, Administrator, Shodair Children's Hospital, submitted written testimony. **EXHIBIT 55**

Opponents' Testimony:

SEN. TOM HAGER, self, stated that he opposes the funding mechanism to this bill. He is in support of the genetics program.

Tanya Ask, Blue Cross and Blue Shield (BCBS), stated that in the past BCBS has been a proponent to this bill and the funding mechanism. This session, BCBS can no longer do so. We have been told that this would be a temporary funding measure. In 1985, it was noted that if it sun setted, in two years the program should adapt and fall during the next biennium on the General Fund appropriation clause. In 1987, it was noted that they had to ask one more time for this particular funding mechanism because the Governor had frozen all new programs so it could not be introduced in the executive budget. In 1989, it was noted that at that point the bill was going to part of the executive budget and was going to go through the full appropriations process as all of the state programs do, however, because of the change in administration, there was not an opportunity to get it into the Governor's budget at that time.

Tom Hopgood, Health Insurance Association of America, stated that it is difficult to oppose a bill like this, it is difficult to oppose a bill that is beneficial to children and it is difficult to lobby against a bill that is supported by friends, neighbors and members of the same community.

Larry Akey, Montana Association of Life Underwriters, Independent Insurance Agencies, stated that there is a statewide impact of this bill and it ought to be paid for statewide. If we don't pay for it statewide, we need to be honest with ourselves. What we have is a sales tax on consumers.

Ron Ashabraner, State Farm Insurance, stated his opposition to HB 696.

Jacqueline Terrell, American Insurance Association, stated that we oppose the funding mechanism to this bill. It was with difficulty and reluctance that she opposes this bill. She has a nephew who was born with Down Syndrome and has spent many years caring for him from time to time. This is a worthy program, but she has to oppose this bill because it is one of four that this legislature is considering which speaks to fund specific worthy program through various kinds of assessments for increased taxes on specific kinds of insurance policies. The cost of the premium

that has been set for an insurance policy should be directly related to the risk that is being insured. When this kind of tax assessment is opposed on a given insurance policy, it skews the cost of that policy disproportionately with the risk.

Questions From Committee Members: None

Closing by Sponsor:

REP. J. RICE stated that this bill is going to the Appropriations Committee. It has gone to Appropriations previously until this session. In previous sessions the Administration at that time elected to not include this in the base budget, but to have the bill come in separately. The Appropriations Committee will make the decision whether to include this in the base budget or to allow the bill to continue as is. All through those steps of the stages, they have elected that this is the best way to do that. In 1990, 763,785 Montanans contributed to this program. That is a fairly broad base amount of citizens of this state that have contributed to this. More people contribute to this program than pay taxes. Dr. Opitz mentioned the one base that saved $1.2 million so that this program would be in effect. This program was not in effect and the insurance companies who opposed this bill got one of those bills, they would be asking for this bill to be passed so that they would then have this program in effect so they can avoid those kind of cases in the future.

EXECUTIVE ACTION ON HB 696

Motion/Vote: **REP. J. RICE MOVED HB 696 DO PASS.**

Discussion:

REP. RUSSELL asked if the appropriation system and the executive branch would consider adding this on to that budget. **REP. J. RICE** stated that he seriously doubts that.

Vote: Motion carried 17-3 with **REPS. BOHARSKI, CROMLEY and KASTEN** voting no.

HEARING ON HB 937

Presentation and Opening Statement by Sponsor:

REP. JESSICA STICKNEY, House District 26, Miles City, stated that this bill is a child care funding bill.

Proponents' Testimony:

Kate Cholewa, Montana Women's Lobby, submitted written testimony. **EXHIBIT 56**

Boyce Fowler, Department of Family Services, stated that last session appropriated $60,000 per year for DFS to implement the

Resource and Referral Grant Program.

Colleen McGuire, Child Care Advisory Council, stated that they have had the opportunity to review the efforts and the work of the Resource and Referral Program and have found that this program should be continued to fund this program.

Kathy Campbell, MABC, stated that resource and referral is simply to increase the quality, quantity and acceptability of child care in the United States.

Barbara Ranf, USWest Communications, stated their support for HB 937.

Montana Alliance for Better Child Care, stated their support for HB 937.

Judith Carlson, Director, Human Research Development Council, stated their support for HB 937.

Sylvia Dauforth, Child & Family Program, stated that their program has been an honor program in Eastern Montana. It has great value to Custer County and they are expanding to Rosebud County and possibly other counties in Montana.

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: **REP. STICKNEY** close on HB 937.

ADJOURNMENT

Adjournment: 9:15 p.m.

Angela Russell
ANGELA RUSSELL, Chair

Jeanne C. Krumm
Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 3-6-91

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

CS05HUMSER.MAN

3-7-91
JDA

HOUSE STANDING COMMITTEE REPORT

March 7, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Joint Resolution 9 (third reading copy -- blue) be concurred in .

Signed: _____
Angela Russell, Chairman

Carried by: Rep. Kadas

HOUSE STANDING COMMITTEE REPORT

March 7, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 168 (third reading copy -- blue) be concurred in .

Signed: _____
Angela Russell, Chairman

Carried by: Rep.

9:10
3-7-91
JDB

HOUSE STANDING COMMITTEE REPORT

March 7, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 696 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

EXHIBIT 4
DATE 3-6-91
HB SJR9

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624

(406) 443-5341

RESOLUTION FOR A NATIONAL HEALTH CARE PLAN
INFORMATION SHEET
For the 1991 Legislature

BACKGROUND: The Montana Senior Citizens Association supports a resolution petitioning the United States Congress to adopt a National Health Care Plan. This resolution is based on a proposal by "Physicians for a National Health Program", to provide universal access, comprehensive care (including long term care), and choice of physicians, to be administered at a state level with a single-payer system. Passage of a resolution would demonstrate state-wide support and compliment similar efforts in the surrounding states.

QUESTION: WHAT'S WRONG WITH OUR HEALTH CARE SYSTEM?

The U.S. spends more on health care than any other nation in the world regardless of how it is measured. Health care costs in Montana increased per capita by 140% from 1980 to 1990. By the year 2000 they are expected to increase an additional 128%. Not surprisingly, everyone has experienced skyrocketing premiums and businesses are put at a disadvantage with their foreign competitors who spend less on health care.

Despite all the increases in health care spending, the Governor's office estimates that 20% of Montanans have no health coverage. As a result, some do not seek medical care when it is needed. But even Montanans who have some type of health coverage often take a chance and put off going to a doctor to avoid paying high deductibles.

It is estimated that as many as one million people were denied health care last year in the U.S. because they could not afford to pay for it. In some of our larger cities, private hospitals have shut down emergency rooms so they won't have to provide as much uncompensated care. In rural communities, hospitals struggle to stay open. People with a history of health problems are often faced with pre-existing exclusion clauses in their policies or have to resort to high risk insurance pools with high premiums and large deductibles. Also hurt are people who have to pay large out-of-pocket expenses for prescription drugs. Finally, families are becoming impoverished by the costs of long term care.

In contrast, Canada provides quality health care to everyone, including long term care, while spending much less per person. Since the enactment of national health care in the 60's, Canada has more effectively controlled health care inflation, while providing a longer life span and a lower infant mortality rate than the U.S. Polls indicate that, unlike the U.S., Canadians strongly approve of their health care system.

Critics trying to discredit the Canadian system usually point to the waiting lists, which are caused by lack of high-tech equipment. Since the US already has such equipment, waiting lists need not be a problem. The goal for the U.S. should be to redirect more money towards health care and away from administration and billing.

Who's To Blame? Part II

Should the Private Health Insurance Industry Be Eliminated?

In our last *Health Letter* we discussed a survey by *Modern Healthcare* magazine which asked consumers, employers, hospital executives, and doctors the question "Who is most responsible for the high cost of health care?" We noted that nobody blamed the private health insurance industry, because that wasn't one of the survey's choices. Yet, the private insurance industry is largely to blame for both skyrocketing costs and plummeting access to health care in the U.S. This month, *Health Letter* takes a close look at the problems inherent in financing health care with multiple private insurers by summarizing internist Dr. Thomas Bodenheimer's article "Should We Abolish the Private Health Insurance Industry." Dr. Bodenheimer is a member of Physicians for a National Health Program, and his article appeared in *The International Journal of Health Services* last year (Vol. 20 , No. 2, 1990).

According to Dr. Bodenheimer, there are five major problems with the private insurance industry: it significantly contributes to health care inflation, wastes billions in marketing and administrative costs, is unfair to many groups in society (particularly the sick, poor, and aged), undermines the positive features of HMOs, and has undue financial and political power, which it uses to influence legislation and to prevent the U.S. from adopting a single-payer national health plan.

Health Care Inflation

For the last 40 years the private health insurance industry has fostered an unrelenting health care inflation (between 5 and 13 percent each year) unequalled in the world. The burden of inflation falls primarily and disproportionately on the sick, elderly, and poor — many of whom forego necessary care because of prohibitive costs — and on wage earners. Wage earners pay for inflation with higher social security deductions for Medicare, higher income taxes for Medicaid, higher health insurance co-payments, deductibles and premiums, and reduced wages as employers shift the rising cost of health care benefits onto workers.

The insurance industry fosters inflation through its reimbursement mechanisms and pluralistic structure. Until recently, Blue Cross paid hospitals according to "reasonable costs," and Blue Shield paid physicians "usual and customary" fees. If a hospital wished to build a new wing or cardiac surgery unit, the loan payments for that capital expenditure were added to their "reasonable costs." The result was an inflationary overexpansion of the hospital sector to the point where nearly 40 percent of all hospital beds in the U.S. are empty. Physicians enjoyed the most generous reimbursement system in the world, and were even allowed by Blue Shield to charge higher fees to patients above a certain income level. The inflationary reimbursement principles of "reasonable costs" and "usual and customary" fees were later built into the Medicare and Medicaid programs, with the result that their costs quickly exceeded expectations. Commercial insurers also followed the Blues' lead and passed along in premiums whatever providers charged.

Commercial insurers had little incentive to control costs because they benefitted from rising prices and premiums. Much of the profit of commercial insurers comes from investments, and inflation increased the flow of funds available for investment. Besides, with 1500 competing health insurance firms, no single company could control inflation.

The U.S. pays a heavy toll for financing health care with multiple private insurers. Between 1980 and 1989 medical costs in the U.S. rose from 9.2 to 12.0 percent of gross domestic product, in contrast to Canada's rise from 7.4 to 8.9 percent. Canada was able to dampen medical inflation (and insure all residents) because it eliminated private insurers and established a single public payer in each province 20 years ago, in 1971. Financing care with a single payer allows the provinces to set and enforce health care expenditure budgets, a prerequisite for cost control.

In the 1980s there was a backlash against the insurance industry's failure to control costs. In the absence of a single payer to control inflation, both private insurers and government payers instituted cost control policies that reduced access to health care, and increased bureaucracy and administration. Insurers raised co-payments and deductibles to discourage people from getting care, and hired an army of utilization reviewers to scour every episode of health care in an attempt to trim benefits. The percentage of the poor covered by Medicaid dropped from 65 to 37 percent over the decade, and Medicare now pays less than half of the medical bills of the elderly.

High Administrative Costs

"Our medical system is the most bureaucratic in the world if measured by the tons of paperwork generated per transaction. For every $100 in health care, we buy $25 worth of pluralism—accountants, advertisers, marketers and financiers."
Health Economist Uwe Reinhardt

The private health insurance industry dramatically increases administrative complexity in the U.S. health care system. Private insurance consumes 12 percent of premiums for overhead and profits. In comparison, the overhead costs for public payers such as Medicare and Medicaid are around three percent, while the figure for the Canadian provincial insurance plans is under one percent. The U.S. also wastes more on billing and administration in hospitals, nursing homes, and physicians' offices, all of which are made exceedingly com-

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plex by the existence of 1500 different private insurers. Overall, billing, administration, and insurance overhead accounted for 22 percent of total U.S. spending for health care in 1983, well above the Canadian and British figures of 13.7 percent and 11.1 percent respectively.

Since then, policies aimed at containing costs have increased the bureaucratic share of health expenditures in the U.S. to one-quarter of the total bill. Almost $90 billion could have been saved in 1987 alone (enough to expand access to care to all Americans) if the U.S. was as administratively efficient as Canada.

Insurance Industry Unfair to Many Patients

"The AIDS crisis points out the fundamental flaw in our insurance system. Those who most need access to health insurance are least able to get it."
Gay Rights Advocate Benjamin Schatz

According to Bodenheimer, societies can choose between two opposing principles in their method of financing health care:

(a) the principle that health care is a right and all people should have equal access to appropriate care regardless of income, place of residence, or health status; and (b) the insurance principle that people get what they (can) pay for.

If a society views health care as a right it establishes financing that insures access to care for the poor, by charging them less, and for the sick, by not charging them more than healthy people with similar incomes. If a society chooses the insurance principle, then people pay premiums based on their "risk group." Older adults, and persons who have experienced a major illness in the past, pay higher premiums than young healthy persons because they are at greater "risk" of needing health care. People with chronic diseases such as AIDS or cancer are uninsurable. Lower-income families pay the same premiums as wealthier families, since premiums are set according to risk, without regard to income. As a result, the poor, sick, and elderly have less access to health care than others in society.

Although the "insurance principle" is dominant in the U.S., employer-sponsored group health insurance, Medicare, and Medicaid have somewhat blunted its unfairness in the past, expanding access to low-income workers, the elderly, and the impoverished. However, inflation and changes in the economy have eroded these buffers over the last decade, causing the number of people without health insurance to skyrocket to 37 million. Minorities, low-income wage earners, and the elderly are particularly hurt by the lack of a right to health care.

The public does not support the "insurance principle." In fact, there is overwhelming public sentiment that health care should be a fundamental right in the U.S. Over 75 percent of Americans polled in 1968, 1975, and 1978 felt that health care should be a "right" to which people are entitled to as citizens, rather than a privilege that must be earned. In a 1988 Harris poll, 90 percent of the public responded that everyone should be entitled to care "as good as a millionaire could get." Yet, health care in the U.S. is increasingly a privilege.

Insurance Companies Undermining Positive Features of HMOs

The insurance industry is in transition. As health costs rose in the 1970s, many large employers dropped their commercial insurance and took over the task of administering health care benefits themselves. By 1985 more Americans were directly insured by their employer than by either Blue Cross/Blue Shield or commercial insurers. In an attempt to control costs employers also turned to "managed care" options, using utilization review, preferred providers, and HMOs to cap health care spending.

On the lookout for new markets, the insurance industry is diving into HMOs to replace the diminishing group employee market. Aetna, Prudential, and Connecticut General already control some HMOs, and Metropolitan Life is poised to enter the field in the 1990s. Although HMOs were originally designed to improve the delivery of medical care, their positive features are increasingly undermined. They were developed to be

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THE PUBLIC CITIZEN HEALTH RESEARCH GROUP
Health Letter

Editor ..... *Sidney M. Wolfe*
Managing Editor ..... *Phyllis McCarthy*
Staff Researchers ..... *Ida Hellander*
Joan Stieber
Carol Bosken
Consumer Specialist ..... *Durrie McKnew*
Publications Mgrs ..... *Sharon M. Greenspan*
Dana Hull
Circulation Mgr ..... *Sara Pausley*
Proofreaders ..... *Ana Radelat*
Carla Atkinson

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EXHIBIT 1
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PESTICIDES ARE EVEN MORE HARMFUL TO CHILDREN THAN ADULTS

Our children are growing up in an atmosphere filled with pesticides. Toxic chemicals are in the air they breath and the food they eat; on the floors and lawns of their homes and schools; and on the fur of the pets they cuddle. In 1988, 2.6 billion pounds of pesticides were sold in the United States, of which, 80 million pounds were sold for indoor residential use. In 1990, the General Accounting Office of Congress estimated that 67 million pounds of herbicides were sold for home lawn care. In a recently completed survey of residential pesticide use, the Environmental Protection Agency (EPA) found traces of up to 10 different pesticides in the air of randomly sampled homes. In the majority of homes more than three pesticides were detected.

This widespread residential use of pesticides is a particularly important problem because people are potentially being exposed for a lifetime. Young children are more sensitive to the adverse effects of pesticides than adults because important organ systems are not fully developed at birth. The infant's liver and kidneys are both less able to remove poisons from the blood stream and excrete them. This means that any given dose to a child persists and/or builds up faster than it would in an adult. In addition, the barrier between the blood and brain is immature in young children and allows more toxic material to get to the brain than would occur in an adult. If a toxin blocks development of the central nervous system at an early stage, mental abnormalities may be permanent, as can be seen after exposure to small amounts of lead. Lastly, children may be more susceptible to the action of cancer producing agents. Children's habits also predispose them to the toxicity of pesticides. Young children, especially toddlers, live close to the ground, and the air they breathe is only a few feet off the floor. It has been shown after indoor spraying, that the concentrations of pesticide in the air one foot off the ground are triple the concentrations found in the adult's breathing area. Skin contact through crawling or hugging pets that have been sprayed for fleas also occurs. It is notable that a child's body skin area is greater, relative to its body weight, than an adult's. This provides a larger area for absorption of poisons relative to the blood volume that the poison will be diluted by once it is absorbed. The exquisite susceptibility of children to pesticides is illustrated by a report of acute poisoning in three-week-old twins. In this case the infants became ill approximately 12 hours after the apartment *next door* had been treated. Neither the parents nor older siblings became ill, and the authors speculated that the infants were affected because they were in the house all day or because of their age.

In addition to skin and inhalation exposure, children have a relatively high oral intake of pesticides. The high incidence of accidental poisonings is well known.

Blame, *from page 9*

efficiently organized group practice environments, emphasizing primary care, prevention and quality control. However, they are increasingly becoming "purely financial structures...nothing more than a second generation of private health insurers," according to Dr. Bodenheimer.

Financial and Political Power of the Insurance Industry

The insurance industry has tremendous financial and political clout in the U.S. In 1981, the assets of the U.S. insurance industry, over $700 billion (now $1.4 trillion), exceeded the combined worldwide assets of the nation's 50 largest industrial corporations. Scores of lobbyists influence legislation in favor of the insurance industry in every state; in 1981 there were 60 insurance lobbyists in Massachusetts alone.

The insurance industry has a powerful influence on national legislation as well, and stands in the way of health care reform in the U.S. In the 1960s Blue Cross had a large impact on Medicare legislation and its administrative regulations. In the mid-1970s Senator Edward Kennedy was pressured to abandon his original proposal for a government-run national health plan, in favor of a plan with a major role for the private insurance industry.

According to the polls, a majority of Americans (67 percent) now report they would prefer a Canadian-style national health program. Recognizing the problems inherent in financing health care with multiple private insurers, Canada largely eliminated the private health insurance industry when they established their single-payer national health plan in 1971. Canada's reform has allowed it to provide care to all residents for far less than the U.S. currently spends on health care.

In the 1990s, the largest opposition to adopting a Canadian-style health plan in the U.S. will be from the private insurance industry.

WHAT YOU CAN DO

If you support a Canadian-style national health plan in the U.S., we urge you to write or phone your state representative and senators. If everyone who supports such reform makes their views known, legislation creating a single payer national health program is more likely to pass. ❑

EXHIBIT 1
DATE 3-6-91
SB 9

Ambulatory Care at MCCHD

Indigent Care Clinic—105 Adult Visits [1987-88]

Financial Coverage

No Coverage	60%
Medicaid	18
Medicare	2
General Assistance	8
Private Insurance	8
NASA (Native American Service Association)	4
	100

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Ambulatory Care at MCCHD

Indigent Care Clinic □ 105 Adult Visits [1987-88]

Age

< 50	94%

Diagnoses

Acute Minor Illness	67%
Admin, ETOH, Misc.	13
Pregnancy	8
Health Maintenance	4
Chronic or Complex	3
Other	5
	100

Care

Intensity (estimate)

90040	brief	60%
90050	limited	36
90060 +		4
		100

Quality (estimate)

High	
RN/NP Alone	76%
RN/NP + MD-On-Site	7
RN/NP + MD Referral	16
Indeterminate	1
	100

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General Characteristics of The Underinsured and Uninsured

33% of the uninsured are children

73% of the uninsured are under the age of 35

35% belong to families with incomes below the poverty level*

64% belong to families who earn less than two times the poverty level.

3 out of 4 uninsured are workers or their dependents.

Most uninsured live in families of the full-time, full year worker.

Part-time employees are often not eligible for employee health benefits.

Many uninsured work for small employees in low wage jobs.

These employers don't have financial resources to contribute to an employee health plan.

* Poverty level as of Feb. 16, 1989 for a family of:

1 - $5,980
2 - $8,020
3 - $10,060
4 - $12,100
5 - $14,140
6 - $16,180
7 - $18,220
8 - $20,260

↑ mediccaid eligibility
from 46% to 133% 1989
presumptive eligibility
Categorically
general relief [medical program]

Information taken from: Claxton,G.(1986) Framework and Analysis. Facilitating Health Care Coverage for the Working Uninsured. National Governors Assoc. Center for Policy Research.

1.- Community responsibility
- minimum standard
- Medicaid

1
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Ambulatory Care at MCCHD

Indigent Care Clinic

	1987	1988
Visits (Exclude shots, etc.)	3991	4842
Age		
0-18	53%	45%
19+	47	55
Financial Coverage		
No Coverage	72%	82%
[>185% Poverty]	[18]	[34]
Private Insurance	2	1
Medicaid	19	→ 14
Medicare	1	1
General Assistance	7	3
	101	101

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Needs of the Medically Indigent
Current Trends in U.S.

I. Uninsured and Uncovered: **Up**

1983 33,000,000
1987 37,000,000 (⅔ of these unemployed)

II. Employed but Uninsured: **Up**

1982 14,000,000
1985 17,000,000 (¾ of these with family income $10,000)

III. Percent of Poor Covered by Medicaid: **Down**

1977 65%
1985 35%

IV. Unsponsored Care by Hospitals: **Up**

1980 $2.9 billion
1984 $5.7 billion

V. Ability to Shift Costs of Unsponsored Care: **Down**

VI. Transfers of or Refusals to See Indigent Patients: **Up**

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Indeterminate	1
	100

EXHIBIT 1
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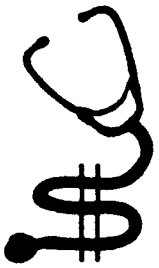
How Bad Is It?

A billion seconds ago, Don Larsen was pitching a perfect game in the World Series. A billion minutes ago, Hannibal was crossing the Alps with his troops. A billion hours ago, the Earth was a cold, solid piece of rock. And a billion dollars is what the United States spent on health care since 9 a.m. yesterday.

Sen. Alan K. Simpson, R-Wyo.



In the brain-numbing world of health-cost inflation, that is how one senator says he helps people relate to the problem — and he's low-balling it.

One need not be too dramatic to find scary statistics about the state of health care in the United States. Consider just the following:

- **Inflation.** Americans spent $604.1 billion on health care in 1989, according to the Department of Health and Human Services (HHS), up 11.1 percent from 1988. Health-care costs have grown faster than overall inflation in every year since 1980 and faster than any other segment of the economy every year since overtaking housing costs in 1981.
- **The federal budget.** At the same time, federal health programs consumed 14.7 percent of federal expenditures in 1989, up from 14.1 percent in 1988 and 11.7 in 1980. After interest on the national debt, Medicare, the federal program that provides health-care coverage for the elderly and disabled, is the fastest growing portion of the federal budget and will cost $123.8 billion in fiscal 1992. If unchecked, Medicare's portion will exceed those of Social Security or defense, the two largest items in the federal budget, soon after the turn of the century.
- **The bill to business.** Costs are skyrocketing for employers as well. According to a survey released Jan. 28 by Foster Higgins & Co., a New York benefits consulting firm, companies paid 21.6 percent more to provide workers with health insurance in 1990 than in 1989, and costs have risen by almost half (46.3 percent) over the past two years.
- **Americans without insurance.** Yet while health-care costs are exploding, more and more Americans are going without needed care. An estimated 31.5 million to 37 million Americans lack health insurance coverage, and a study published in January in the Journal of the American Medical Association found that patients lacking insurance were up to three times as likely to die in the hospital as those with insurance and were less likely to undergo expensive medical procedures.
- **Long-term care.** Simultaneously, the "graying" of America is expanding the need for expensive long-term care, either in the home or in an institution. By the year 2030, the number of Americans over age 65 — those most likely to need long-term care — is projected to double, while the number of "old old" individuals, those over age 85, will balloon from 2.5 million to as many as 12 million. Assuming those estimates are correct and that disability rates remain unchanged, the number of people requiring long-term care will nearly double from 7 million to 13.8 million, and the number requiring nursing home care will almost quadruple, from 1.5 million to 5.3 million.

—Julie Rovner

Democrats and Republicans on Capitol Hill refer to as the "deafening silence" from the Bush administration.

Lawmakers and their aides say President Bush could totally change the dynamic, much as he did on clean air legislation when he introduced his own comprehensive bill in 1989. When the president gets behind something, says Sen. John D. Rockefeller IV, D-W.Va., who chairs one of two Finance Committee health subcommittees, "it sends all kinds of important signals."

But while Bush gave health-system reform some passing references in both his 1990 and 1991 State of the Union messages, his advisers have recommended that he not push for legislation until a consensus forms.

"The candidate who made universal access to health care a central theme of his campaign did not win the 1988 election," wrote former White House domestic policy adviser Dr. William L. Roper in the Winter 1989 Health Affairs journal.

In that article, Roper, who has since departed to take the helm of the Centers for Disease Control, wrote that health care was not yet mature as an issue. "Everyone wants someone else to pay for a solution. That is not a realistic basis for policy," he said.

Others say the White House is not addressing the issue because the general public is not yet demanding it. "Most Americans are satisfied with their health coverage," says a House Republican health staffer. Until White House officials "see a political utility to it," the staffer adds, "they're not going to do it."

In the meantime, Bush is talking only in broad terms. In last year's State of the Union address, Bush ordered Health and Human Services (HHS) Secretary Louis W. Sullivan to lead a review by the president's Cabinet-level Domestic Policy Council of various recommendations for improving "the quality, accessibility and cost of our nation's health-care system."

That review has not yet occurred, largely because those recommendations — from the Steelman commission as well as a task force within HHS — have not yet been made.

Sullivan, asked about the progress of the review at a Feb. 4 news conference, replied that "health-care reform is proceeding apace," and mentioned that he is also waiting for the proposal from the nation's governors.

Bush mentioned health again in this year's address to Congress on Jan. 29, promising "new prevention initiatives." However, the accompanying fact sheets put out by the White House revealed that at least two of those "initiatives," a breast and cervical cancer screening program for low-income women and mammography coverage for Medicare recipients, would put into effect laws Congress passed in 1990. *(Screening legislation, 1990 Weekly Report, p. 2593; mammography, p. 3719)*

The catastrophic-costs debacle also taught Bush an important lesson: Be careful what you recommend, because Congress may give it to you — but in a radically altered form. President Ronald Reagan originally proposed catastrophic health insurance in his 1986 State of the Union. But when Congress began working on it, as

show willingness to move off their own positions. The reason is that, as with many maladies, the diagnosis is often simpler than the cure. No one has come up with a prescription that is not too bitter for someone else to swallow.

"We just see a lack of resolve on the part of any to make moves aside from advancing the interests of their own individual constituencies," says Dr. James Todd, executive vice president of the American Medical Association.

Several eagerly awaited proposals are overdue — including ones from the nation's governors, the American Hospital Association, organized labor, and a Social Security advisory panel headed by Deborah L. Steelman, who advised presidential candidate George Bush on domestic policy. They are hung up, sources say, as much by the sheer magnitude of the problem as by its politics.

"It's hard to get people to understand just how complex this all is," says Calvin P. Johnson, legislative representative for the AFL-CIO.

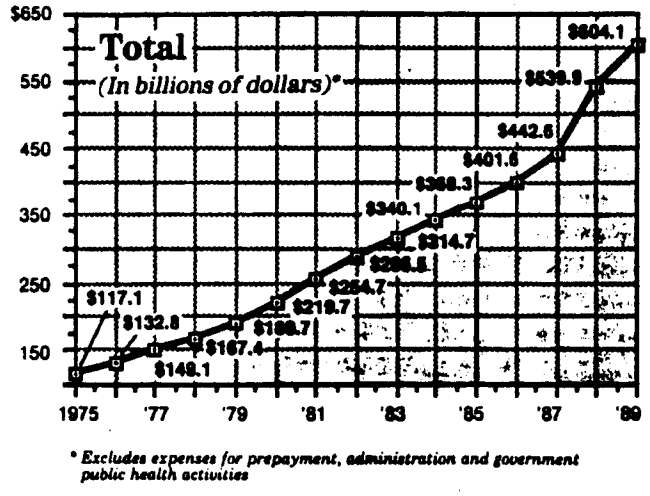
Efforts to revamp the system are further complicated by the constricted federal budget, which thwarts major new spending initiatives.

And the plain truth is that, for the Bush administration as for most politicians and their voters, making changes in health care is not a priority. Poll after poll shows that Americans are highly dissatisfied with the health-care system, but few say they are willing to pay more to make it well. And until the voters demand it, experts say, change remains unlikely.

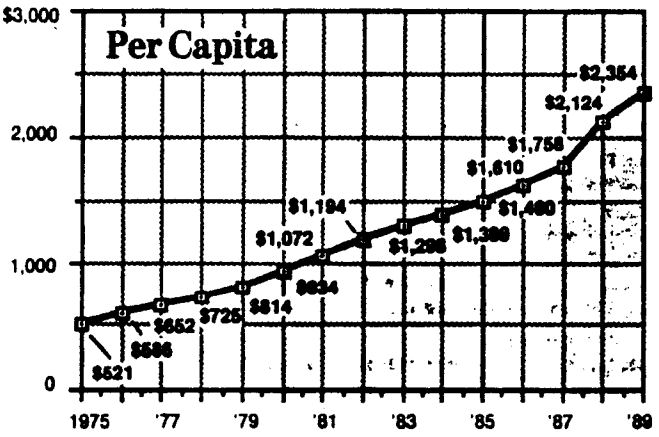
"Nobody ever gets beat for not addressing health care," says Arkansas Gov. Bill Clinton, a Democrat.

Health Cost Boom

All Spending— Government and Private



* *Excludes expenses for prepayment, administration and government public health activities*



SOURCE: Health Care Financing Administration

Congress' Tentative Steps

That is not to say that some key lawmakers aren't going to try.

Senate Majority Leader George J. Mitchell, D-Maine, fresh off last year's victory in passing the first clean air bill in a decade, has made health-care reform his next policy goal. *(Story, p. 421)*

And the nation's governors, whose last major effort on Capitol Hill culminated in passage of an overhaul of the nation's welfare system, hope to have their proposal ready to bring to Congress by August. *(Story, p. 416)*

There is a chance Congress will take some significant, if less ambitious, steps this year — most probably on regulatory legislation aimed at requiring health insurers not to discriminate against certain classes of people. Such a bill could win enough votes if only because it would not bite the federal budget.

But given the conflicting pressures on Congress, prospects for a wide-ranging overhaul of the health-care system seem dim. "My hunch is that 1991 and federal health-care legislation will be all talk and virtually no action," says Gradison, who is ranking Republican on the Ways and Means Subcommittee on Health.

The lack of consensus has created a chicken-and-egg problem on Capitol Hill. If Congress made it clear that it intended to move forward on health-system reform, some say, it could force the players to the table.

Health-care reform is "no different from clean air — a very contentious issue that had us deadlocked for 10 years," says Henry A. Waxman, D-Calif., chairman of the House Energy and Commerce Subcommittee on Health and the Environment. The clean air consensus, he said, only "started to jell once it was clear there was going to be a bill."

But even some lawmakers who would support such action are loath to move forward without a consensus, especially after having been burned so badly by the quick repeal of the 1988 Medicare Catastrophic Coverage Act. After passing the largest-ever expansion of Medicare, Congress in 1989 backed off after a grass-roots backlash over the program's financing splintered the consensus behind the plan. *(1989 Almanac, p. 149)*

That experience spooked members of Congress, suggests Gradison, one of the co-authors of the ill-fated program. "I think it has had a major effect, especially on those closest to the development of legislation," he says.

Agrees Stark, another co-author: "We're not about to go in and give something to someone unless we're damn sure they want it and are willing to pay for it."

No President

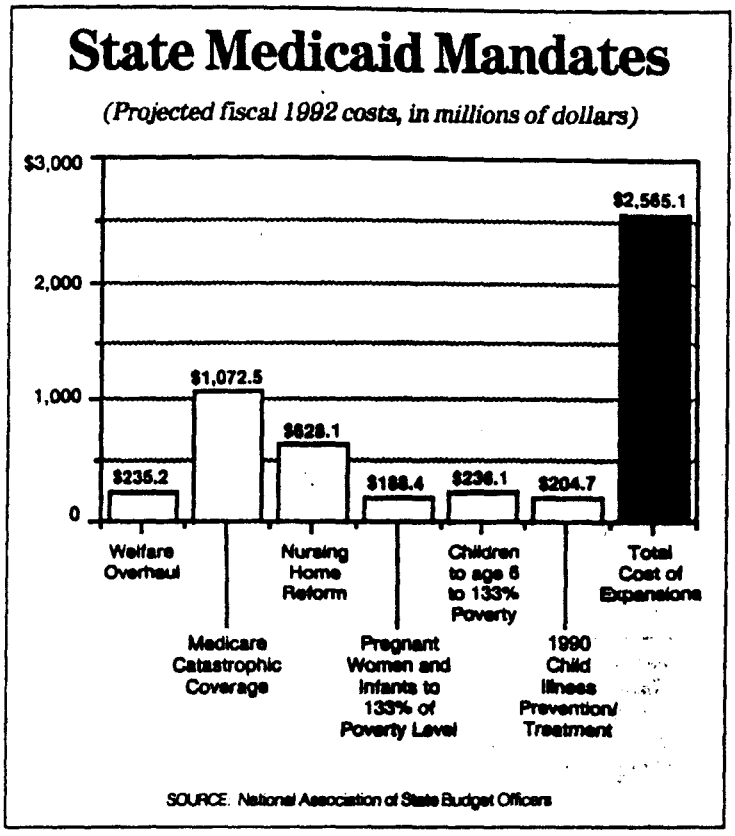
No small obstacle to achieving a consensus on health issues is what

. . . From Burdensome Medicaid Mandates

"I'm sympathetic to the fact that governors have severe budget problems," said Henry A. Waxman, D-Calif., chairman of the House Energy and Commerce Subcommittee on Health and the Environment, and a prime mover behind the mandates. Waxman said he was overruled by the Senate and the White House when he proposed that the federal government pick up the full cost of new expanded Medicaid coverage for low-income elderly.

Still, he said, "I see no valid reason to deny children who would be covered by these mandates access to care long overdue already."

Said an aide to Senate Finance Chairman Lloyd Bentsen, D-Texas: "Mandates wouldn't be necessary if [states] were doing what they should have been doing in the first place."



The governors also cannot expect aggressive support from the White House. Although President Bush expressed sympathy for the governors' position in a meeting Feb. 4, Health and Human Services Secretary Louis W. Sullivan later that day told reporters that the administration was unlikely to get involved.

"This is a proposal that must be taken by [the governors] to the Congress," Sullivan said. "I'm not in any position to take their ball in their game and play it for them."

Welfare Reform Set Precedent

Now that the governors have been brought to the health-policy table, they hope to use the same strategy that helped them shape a major welfare overhaul in 1987-88.

Then, the governors reached a consensus, molded it into a policy statement, consulted as that policy was built into legislation and helped lobby it to fruition with the 1988 Family Support Act. *(1988 Almanac, p. 349)*

This time, many of the players will be the same. NGA Chairman Booth Gardner, D-Wash., head of a 15-member task force, has tapped as task force vice chairs Govs. Clinton and Castle, both of whom co-chaired the welfare rewrite effort.

And lawmakers involved in the welfare effort also make health policy. "Welfare reform helped forge relationships that will pay off here," Clinton says.

But welfare reform was relatively simple compared with the problems ailing the health-care system.

For instance, state governments had launched programs that served as models for moving recipients off welfare and into jobs. "We're five to eight years away from that" in health-system reform, says NGA Executive Director Raymond C. Scheppach.

And as with health reform at the federal level, consensus is not easily achieved. As a starting point, Gardner is working on a two-prong plan he hopes to have ready for the NGA's August meeting in Seattle.

The first prong would be what NGA officials describe as "a guidebook," a collection of what individual states can do to try to make health care more accessible and affordable.

For example, several states are experimenting with "all-payer" plans, in which purchasers of medical services (employers, governments and insurance companies) form a bargaining unit and negotiate prices with providers of the services (hospitals and doctors).

Prong two would focus on dealing with Congress and the White House about long-term changes in Medicaid. Among the options are using Medicaid to cover all children, regardless of income, or to cover all poor families, regardless of whether they qualify for other welfare.

Governors say the long-term plan could boost their credibility as they press their case to delay the mandates.

"I think we can go to the Hill forever, and if we say, take these mandates off and give us flexibility and we'll do it better, it won't happen," says Florida Democratic Gov. Lawton Chiles, who as a senator voted in favor of many of the mandates.

"The way to stop it is to make it clear to Congress that we are serious about long-term structural reform," Clinton says. "We have to convince them that we're willing to do our part through Medicaid."

—Julie Rovner

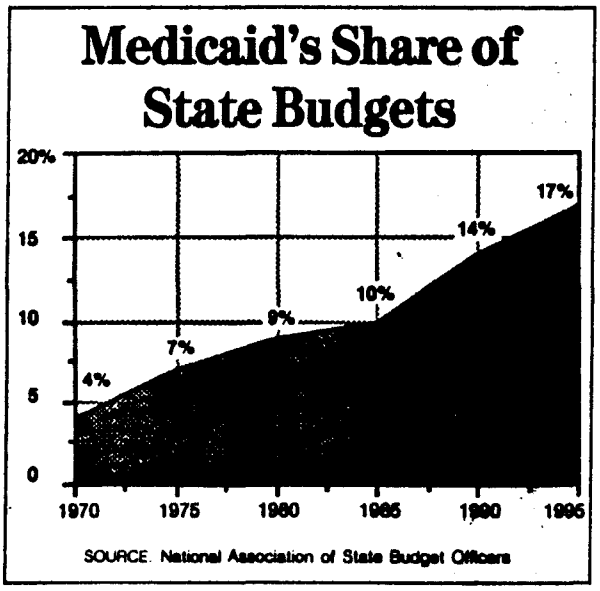
EXHIBIT 1
DATE 3-6-91
SB 9

Governors Ask Congress for Relief . . .

For the vast majority of policy-makers, the health-care "crisis" is ill-defined and lurks beyond the horizon. But for the nation's governors, the crisis is immediate and can be summed up in one word: Medicaid.

Indeed, while governors play a role in many aspects of the nation's health-care system — from regulating insurance to licensing health professionals — it is the spiraling costs of Medicaid, the joint federal-state health program for the poor, that has brought state executives to the health-reform debate.

The governors ultimately want to present to Congress a proposal to overhaul Medicaid to make it provide needed services at a reasonable cost and perhaps to make it part of a systemwide restructuring.



But in the short run, governors are up in arms about the proliferation of "mandates" from Congress, requirements that Medicaid coverage be extended to certain populations or offer specific services.

Since 1987, Congress has required states to give Medicaid coverage to more pregnant women, infants and young children, as well as to certain elderly Medicare beneficiaries with low incomes. In 1988, Congress enacted legislation that required states to extend Medicaid coverage to families leaving welfare for jobs. And in the 1987 budget-reconciliation bill, Capitol Hill approved an overhaul of the way Medicaid regulates nursing homes.

Suggestions for some of the changes, particularly extending coverage to more pregnant women and children and the welfare extensions, came from the governors. But now, governors say, they cannot keep up with the added costs.

"We need to get a handle on the Medicaid mandates or else some of us are going to go broke," said Arkansas Gov. Bill Clinton, D, at the winter meeting of the National Governors' Association (NGA) on Feb. 3 in Washington.

Two days later, the governors without dissent approved a policy statement asking Congress to grant them a two-year reprieve from putting into effect new Medicaid mandates for children and the elderly that were included in the fiscal 1991 budget-reconciliation bill. *(Provisions, 1990 Weekly Report, p. 4018)*

"States must have some immediate relief from the real and pressing problems presented by the Medicaid program if they are to move forward on long-term solutions," said the statement.

The statistics show why governors are so upset. In 1980, according to the NGA, Medicaid spending accounted for 9 percent of state budgets overall. By 1990 that had risen to 14 percent. And by 1995, state Medicaid spending is projected to more than double, rising from $31.4 billion in fiscal 1990 to $66 billion.

Most of that increase is due to health cost inflation in general. But the governors say federal mandates are a big part of the problem and perhaps the only element they can change. Over five years, requirements imposed by Congress since 1987 will cost the states an estimated $2.6 billion and could go as high as $17.4 billion through fiscal 1995.

Although the federal government pays a larger share of Medicaid costs than do states (exact percentages vary by state, but the overall average is 55 percent federal and 45 percent state), Medicaid costs are a much bigger portion of state budgets. And most states, unlike the federal government, must balance their budgets. New money for Medicaid must be taken from other programs, or states must raise taxes.

In Delaware, for example, said Republican Gov. Michael N. Castle, "in a year when my budget is going up by 1 percent, Medicaid is going up by 25 percent."

The situation is made even more desperate by the recession, which is squeezing state budgets by lowering revenues as more people are losing jobs and qualifying for Medicaid and other income assistance. And Washington's mandates make it tougher for governors and state legislators to set their own spending priorities.

"The lion's share of growth in my state is already allocated by federal mandates," said Republican Gov. John Ashcroft of Missouri, vice-chairman of NGA. If the states should operate as laboratories to experiment with novel solutions to social problems, Ashcroft said, the federal government "needs to stop pilfering our laboratory equipment."

Pessimistic Outlook

The resolution the governors approved Feb. 5 is not the first missive in the spat between Congress and state executives over Medicaid mandates. That came in 1989, when 48 governors signed a letter calling for Congress to refrain from enacting new mandates for two years. *(1989 Almanac, p. 171)*

Congress ignored that request, adding new coverage requirements for women, children and the elderly in both the fiscal 1990 and 1991 budget-reconciliation bills.

Initial reaction from Capitol Hill lawmakers suggests a similar fate for the most recent plea.

EXHIBIT 2
DATE 3-6-91
HB SJR 9

My name is Tim Harris. I am the Deputy Director of the Montana Independent Living Project in Helena. I have been associated with the Project for nearly six years. The Project provides a variety of services to people who are disabled. Our services are intended to enhance the independence of those we serve.

An issue we encounter frequently is one of unemployment. Statistics show that two of three people with disabilities are not employed. The reasons for that are numerous, but one that stands out is the lack of adequate health care insurance for the disabled worker. While receiving a monthly income subsidy, a disabled individual can qualify for state supported medical insurance, either through Medicaid or the Medically Needy program. If that individual has health related issues that are costly, there is a disincentive to find employment as long as he/she has good medical insurance from the state. Most private insurance companies have pre-existing condition clauses which delay coverages for up to one year which leaves the responsibility for medical costs for that year with the individual. In many instances, those costs would be beyond the reach of entry level salaried employees. Many ask, "Why should I go to work and risk losing medical benefits for a salary and health insurance package which will not meet my medical and other needs?"

I would like to tell you about my own situation. My wife, Judy, and I have four children. Judy uses a wheelchair due to paralysis from the waist down. Our son, John, who is fifteen, has diabetes and is insulin dependent. I had polio as a child and use braces and, occasionally, a wheelchair. Because of the potential for high health care costs in our family, finding private insurance which provides adequate coverage at reasonable costs is not unlike finding a solution to the tax problems in Montana. Apparently impossible. I am currently covered by a group conversion policy which costs $597 per month, has a $2500 per person deductible, and a $5000 family deductible. This deductible, however, is a two-person deductible, which means that two people must meet the deductible before it applies to the whole family. It is not inconceivable that I could pay out over $10,000 in medical expenses in one year and still not qualify for insurance coverage. Ladies and gentlemen, I cannot afford to pay out over $10,000 for medical expenses. I doubt that many of us here could. The problem of adequate, reasonably priced health care insurance is not isolated to families with disabilities, or to seniors, or to people who are on low or fixed incomes. It is a problem that belongs to all of us. And we are the ones who will have to find the solution.

EXHIBIT 2
DATE 3-6-91
HB SJR9

Mr. Douglas W. Campbell,
1618 Sherwood Street,
Missoula, MT 59802

Tuesday 22 January 1991

Dear Doug:

You recently asked me a very timely question. Why do I support s system of national health care? After some fifty years experience as a medical student, Navy physician, Veterans Administration experience, private practitioner, numerous hospital affiliations, diagnostic and therapeutic radiologist, and member of a large multi-specialty clinic, I feel this extensive experience permits me to express myself on this subject with some value. About half of those years my income was from "private" medicine and the other half by Federal pay, either military or VA. Eight years were in a private solo general practice in rural Pennsylvania where the fees were low but always paid, be it by cash, chickens, produce, or labor. Very little was ever paid by insurance since the "Pennsylvania Dutch" were never enthusiastic about that mode of payment.

I am happy to have retired from the litigious practice of medicine today. It was a pleasure to practice in the Navy and the Veterans Administration where there is a perpetual protective umbrella for the physician who follows good practices and leads a morally decent life. The rural Pennsylvania people were also a decent, hard working group of people who did not try to supplement their income by frivolous litigation. This is not true in Montana or many other places today and medicine is no longer a pleasurable way to earn a living.

But this is not my main reason to look favorably on a system of National Health Care. The present system is almost out of control and becoming more chaotic every year with a patchwork of "Band-Aid" measure designed to correct other corrections. It is becoming top-heavy with administrators, third party interests, greedy doctors, lawyers, and insurers. Medicine has long become too expensive for the poor as well as most of the middle class. Much money is wasted on hopeless and terminally ill patients, very immature births, and very elderly patients. It has become imperative for a worker to keep his or her job if only to keep the health insurance that goes with that job.

This brings up another point. We are losing employment to foreign competition because our employers cannot make a product that is able to compete in price with overseas manufacture where the health costs are being subsidized by foreign governments (really by the foreign workers through their government's taxation). The American manufacturer is operating under a severe financial handicap. Lee Iacocca has said the health insurance plan enjoyed by Chrysler employees adds $800.00 to the cost of every car made by Chrysler. If this is true, how can Chrysler possibly compete with Mazda, Volkswagon, Renault, Jaguar, or Volvo?

Physician's fees are out of control. Office overhead is excessively extravagant and over-employment is commonplace. There is far too much duplication of hospitals and expensive equipment within each community. Pharmaceuticals are being priced beyond the ability of the patient to pay for even simple remedies. Drugs manufactured within the United States are often being sold overseas for a fraction of the local price, and drugs manufactured in Europe often sell for several times more in the US than they do in Europe.

While a national health plan would create new problems, I doubt if they would be worse than that which exists today. At best, everyone would be able to obtain medical care. At worst, the plan would be over-utilized by both patients and avaricious doctors and hospitals. There is nothing to prevent correction of the problems as they appear and some type of rationing of service may be called for. During my recent trip to Great Britain and Scotland, I visited a clinic and hospital in Edinburgh. Although the physicians there have numerous complaints, none would prefer our system although they might be willing to try the Canadian system. Compared to the general population in Edinburgh, they were amongst the upper income group and were generally very well respected as physicians. I spoke with many people on the street in London and in several hotels elsewhere. There was general satisfaction with the system, no major complaints except for long waits for routine or non threatening illness or problems. *The Wait* seems to be their way of preventing over-utilization.

FRANK AND ERNEST

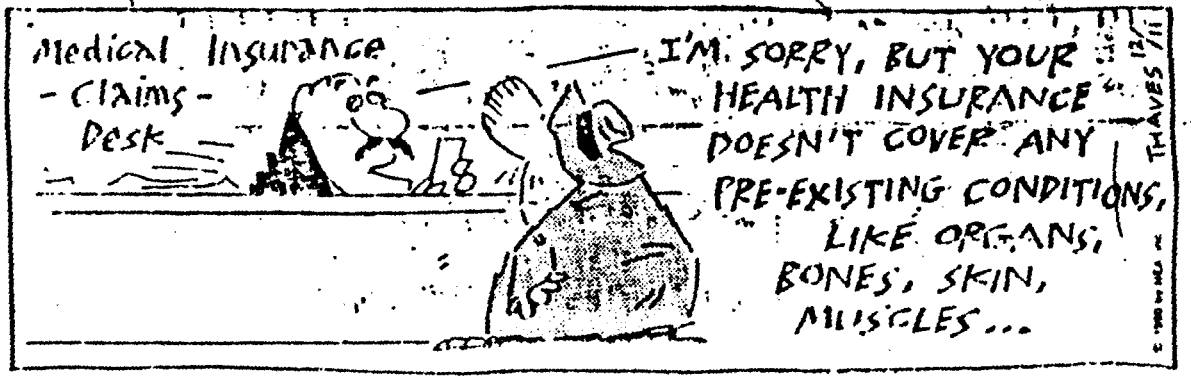


EXHIBIT
DATE 3-6-11
HB SJR9

EXHIBIT 3
DATE 3-6-91
HB BUR9

Perhaps one of the disasters in American medicine is the *Health Insurance Industry*. It works hand in hand with the legal profession. Higher claims lead to higher insurance rates. It is all a percentage game. When an insurance company charges a physician or hospital a fee based on actuarial experience and earns 5% for handling claims, it is reasonable to assume their profits are much greater when the claims are much greater since the actuarial costs become much greater. Insurance companies hire many lawyers. Many of them get to become the executives and management of their companies. When the doctor pays $2000. for $100,000 of malpractice insurance in 1960, the insurance company earning 5% makes $100, but in 1990, with higher awards, that same doctor must buy $1,000,000 of insurance and the insurance company, still making 5% makes $50,000. Of course they like the larger awards as long as the doctor pays the larger premium. Of course they warn him *"Never go bare"*. Perhaps if every physician went "bare", it would put an end to the frivolous litigation and particularly the "contingency" lawsuits that lawyers accept.

There are many young men and women in our country who are unemployed or between jobs who have no medical insurance. The cost of private insurance today is far more than they can afford. Hence, they create a burden on doctors and hospitals because they are unable to pay their own way. The physician usually writes this off at the end of a year or two. However, the hospital must pass this cost along to some other source such as general expenses paid by government or insurance companies making other patients or their employers pay these unrecovered losses. This becomes an unfair but necessary operating expense.

Our present system worked before the days of expensive treatment, expensive technology, and overwhelming costs of litigation and insurance. It cannot work today. While government has never been known to be a model of efficiency in running anything, it could hardly do worse than the way things are now. I would like to see the matter of health care removed from the control of the insurance industry. Take them out completely. Extend Medicare A and B in some form to everyone, eliminating Medicaid. Hire the idled insurance workers under some state system under Federal control and guidance, possibly similar to the Canadian method. As problems develop, let Congress and Dept. of Health & Human Services make the corrections necessary.

Sincerely,

Andrew McKane, M.D.

Andrew McKane, M.D.
5195 Elk Ridge Road,
Missoula, MT 59802

Tel: 406-543-8664

EXHIBIT 7
DATE 3-6-91
HB SJR

This is the story of Ronald and Princess Taber, a young Missoula couple caught up in our unfair and inefficient health care system. The birth of their second child in 1990 left them with $10,000 in hospital and doctor bills that they though would be covered by insurance through Ronald's employer.

Unfortunately, before the birth of their baby Ron's employer had changed insurance companies from Blue Shield-Blue Cross to The Traveler's. They had worried about this change of insurance companies but the company secretary assured them that she had checked with Blue Shield-Blue Cross and they said she would be covered.

When the baby came the doctor had to do a caesarean section because it was a breach birth. Seven days in the hospital at a room charge of $700 a day for Princess and nearly $300 a day nursery charge, even though the baby spent nearly all of the time with this mother, plus other charges resulted in the $10,000 bill.

When the bills were presented to Blue Shield-Blue Cross, the insurance company refused to pay. Their new policy with Travelers only pays for an illness and pregnancy, of course, is not considered an illness.

The result was that the hospital insisted they must make $500 a month payments on their bill. There is no way they could make payments of that size and still

have money to live on, especially as Ron's job as a welder is not always full time.

The hospital began to attach Ron's paychecks and take half of his earnings each time. As this left them with little money to live on they had no alternative but to declare bankruptcy.

An additional irony to this case is that when their other child was born the same thing happened. Ron's employer was changing insurance companies at that time also and they were not covered for the birth of the second baby. Fortunately it was a normal birth and cost only $3000 so they were able to handle the cost although it was a hardship.

What kind of country do we live in that allows things like this to happen to our young people who are struggling to make decent lives for themselves, while we spend hundreds of billions of dollars bailing out failed banks and savings and loans which have been plundered by greedy management?

This is not an isolated incident, these situations are occurring every day in all part of this country. The only answer is to have a national health insurance plan that covers all of our citizens.

EXHIBIT 5
DATE 3-6-91
SB SJR9

MONTANA STATE COUNCIL No. 9

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES
Affiliated With A.F.L.—C.I.O.

March 6, 1991

Chairperson, Committee members, my name is George Hagerman, Executive Director of Montana Council #9, of the American Federation of State, County and Municipal Employees, AFL-CIO.

I rise today as a proponent of Senate Joint Bill #9 (Creation of National Health Care).

As we all know many Montanans are being priced out of the basic right to health care insurance even while they continue to work for a living. Many people who are unemployed, disabled, aged, children and pregnant women do not have the money or qualify for government sponsored health care programs.

Premiums are going up coverage is being reduced, too many Montanans have to choose between basic needs, housing food, school, etc. or paying about 1/3rd of their income for inadequate health insurance.

This bill is a step in the right direction to help remedy these sad facts.

I strongly urge all of you to support this bill for all Montanans.

Thank You

EXHIBIT 6
DATE 3-6-91
HB SJR 9

"OUR AILING HEALTH CARE SYSTEM Many of us cannot afford to get sick" is the title of an article in the AMERICAN LEGION MAGAZINE For Dec. 1990.

An article in the WALL STREET JOURNAL for 1/29/91 states" U.S. Companies are losing the war on health costs.

Despite intense cost-containment efforts, corporate medical bills soared 21.6% last year after a 20.4% jump in 1989, says A. Foster Higgins & Co. in its annual health-costs survey. Health benefit costs amounted to a whopping 26% of corporate earnings, the survey found."

Another paragraph states: "According to the survey, medical-plan costs per employee rose to $3,161 last year from $2,600 in 1989 and 46.3% above 1988levels of $2160. If costs continue rising at the current rate, medical benefits woule rise to $22,000 per employee by the year 2000."

"PUBLIC HOSPITALS ARE OVERLOADED SURVEY SHOWS, an article in the WALL STREET JOURNAL for 1/30/91 states: The National Association of Public Hospitals which compiled the study, said that hospitals are so crowded and financially pinched they are eliminating services and turning away patients who aren't seriously ill."
The article goes on to state: "Uninsured patients accounted for more than half--52%--of outpatient visits and 30% of inpatient days at public hospitals in 1988.

42% of public hospitals fees weren't paid in 1988, up from 22% in 1982. State and local subsidies covered only half of those unpaid charges." The unpaid charges are simply passed on to those who can pay in the form of higher charges.

With public hospitals curtailing services for lack of funds, emergency rooms closing down, and health care costs rising dramatically, an increasing number of people are being left without any health care.

It is high time the United States joined the rest of the industrial nations and established a National Health Care Program with single payer system covering everybody. I hope this committee will pass SJR 9.

I am leaving some back up material along with my testimony for the committee.

Marion Hellstern

EXHIBIT 6
DATE 3-6-91
HB SJR9

DATE 3-6-91
HB BURG

Medical Costs Soar, Defying Firms' Cures

By Ron Winslow 1/29/91
Staff Reporter of The Wall Street Journal

U.S. companies are losing the war on health costs.

Despite intense cost-containment efforts, corporate medical bills soared 21.6% last year after a 20.4% jump in 1989, says A. Foster Higgins & Co. in its annual health-costs survey. Health-benefit costs amounted to a whopping 26% of corporate earnings, the survey found.

Companies cite large catastrophic-illness claims, increased use of mental-health and substance-abuse services and overall medical-price inflation as factors behind the rise. Other major causes are increased use of medical services as well as the practice of doctors and hospitals to increase charges to private-sector bill payers to offset underpayments from federal Medicare and Medicaid programs.

The continuing sharp rise is distressing news to the legions of companies that have invested time and money in a variety of cost-containment strategies in recent years, and the problem isn't likely to get better soon. Both the recession and the Persian Gulf war portend further troubles for corporate health budgets.

The problem is "systemic," says John Erb, managing director at the benefits consultant and author of the study. "We've thrown all the cost-management techniques that we can invest, buy or create at it, and we're not even touching it."

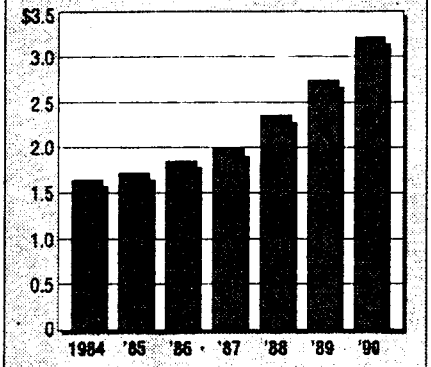
According to the survey, medical-plan costs per employee rose to $3,161 last year from $2,600 in 1989 and 46.3% above 1988 levels of $2,160. If costs continue rising at the current rate, medical benefits would rise to $22,000 per employee by the year 2000.

Carl Schramm, president of the Health Insurance Association of America, an industry trade group, describes the Foster Higgins numbers as high and says his organization's own survey puts the magnitude of the increase at 14% to 15%. "I'm not arguing with the trend," Mr. Schramm says. "The problem is serious, no matter whose statistics you use."

The results are likely to accelerate the trend of companies to adopt so-called managed-care techniques to control costs, and to ask employees to share more of the health-care burden. Last year, employees paid an average of $33 a month for single coverage, up $10 from 1989, and $89 for family benefits, a $20 jump. Nearly every company in the survey said it expects to increase employee contributions over the next three years.

Escalating Health Costs

Total health benefits* in thousands of dollars per employee



*Includes medical, dental and vision plans, and costs for health maintenance organizations.

Source: A. Foster Higgins & Co.

But the survey also reflects a lack of resolve at many companies to effectively address the problem, says Uwe E. Reinhardt, a health economist at Princeton University. "They really haven't bitten the bullet," Prof. Reinhardt says. "At some point this has to come to a head."

A recent study by the Health Insurance Association found that 77% of companies with more than 100 employees continue to offer among their coverage options traditional indemnity, or fee-for-service, health plans, which have proved resistant to most cost-control efforts.

About half of such companies offer prepaid health maintenance organizations, or HMOs, and 24% have preferred provider organizations, or PPOs (networks of doctors and hospitals that provide care at discount rates). While they vary widely in performance, HMOs and PPOs are considered cost-effective approaches to medical care, but about 70% of U.S. employees are covered under traditional plans.

Budget cuts in federal Medicare and Medicaid programs are a major cause of rising corporate costs as doctors and hospitals increase prices charged to private-sector payers. Yesterday, the American Hospital Association said that in 1989, the shortfall from the Medicaid program alone amounted to $4.3 billion.

"With the war [in the Persian Gulf] going on and Congress in no mood to tax, Medicare and Medicaid are going to try to shift more costs to the private sector," Prof. Reinhardt predicts. "Unless companies defend themselves against it through PPOs or competitive bidding, they're going to eat it."

But even these solutions are becoming part of the problem. As more companies negotiate prices with providers, more costs are shifted to payers who lack such arrangements. "You end up playing a little bit of the government's game-shifting costs to the next weakest player," says Walter Maher, director of federal relations at Chrysler Corp. One result is that smaller businesses increasingly bear the brunt of spiraling costs.

"We're not going to control costs in this country until we have all the payers—public and private—working in concert," Mr. Maher says.

Meanwhile, the recession probably also contributes to corporate cost increases. "The slide toward recession generally stimulates the use of medical services by employees," Mr. Erb says. "If you're uncertain about having your job, any elective stuff you need to get done, you're going to get done before you lose your job."

Layoffs can reduce absolute health costs, of course, along with other employee expenses, but companies generally let younger—and healthier—people go first. "That leaves the medical plan with an older, sicker population, which drives health costs up faster," Mr. Erb says.

Foster Higgins says it surveyed 1,955 companies and public-sector employers whose health plans cover 11 million employees. The data were gathered in September, and the results are based both on actual numbers and projections. The report also found that:

— Total health-plan costs — including dental, vision and HMO plans, as well as medical benefits—rose 17.1% in 1990 to $3,217 per employee from $2,748 in 1989.

—Use of so-called utilization-review programs to hold use of medical services in check increased to 81% of participants from 73% a year ago, even as half of the companies surveyed said such programs have little or no effect on cost-control efforts.

—The mining and construction industry had the highest rate of increase, at 37.6%, while utilities had the highest per-employee cost, at $4,296. The best performers were wholesale and retail employers, whose costs rose just 8.2% in 1990 to $2,323 per employee.

4/30/91 TE

EXHIBIT 6
DATE 3-6-91
SJR9

Public Hospitals Are Overloaded, Survey Shows

By HILARY STOUT
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — The nation's urban public hospitals are crumbling under the strain of treating AIDS, drug addictions, gunshot wounds and a growing number of uninsured patients, according to a survey of public hospitals.

The National Association of Public Hospitals, which compiled the study, said that hospitals are so crowded and financially pinched they are eliminating services and turning away patients who aren't seriously ill. The report said a declining proportion of hospitals' revenues come from Medicare, Medicaid and local government subsidies, leaving many hospitals with operating losses.

Public hospitals are important because they serve as safety nets for many of the nation's poorest citizens and the 33 million Americans without health insurance who don't have access to other health-care services.

In a survey of its 100 member hospitals, to which 67 responded, the nonprofit association found:

—Sixty-three percent of the public hospitals had operating losses in 1988, and the average deficit was $19.6 million.

—Uninsured patients accounted for more than half—52%—of outpatient visits and 30% of inpatient days at public hospitals in 1988.

—Forty-two percent of public hospitals fees weren't paid in 1988, up from 22% in 1982. State and local subsidies covered only half of those unpaid charges.

—Occupancy rates averaged 82% in 1988, compared with 66% for other short-term general hospitals. At some public hospitals, occupancy rates topped 100%.

—Emergency-room visits at public hospitals averaged 71,026 in 1988, compared with 14,484 emergency-room visits at other short-term general hospitals.

"Our safety net hospitals are on the very front line of the war against poverty," said Bernard Weinstein, the association's chairman and former commissioner of the Westchester County Medical Center in New York. But as a result, he said, "they're disproportionately affected by drug addiction, AIDS, gang violence, and a large number of uninsured patients."

The number of AIDS, or acquired immune deficiency syndrome, patients at the hospitals surveyed more than tripled between 1985 and 1988. The 67 member hospitals responding to the survey treated 19% of the AIDS patients nationwide in 1988, the study said.

visits at the public hospitals were drug-related, according to the survey. One Saturday night last September, 24 of the emergency-room patients at Harbor-UCLA Medical Center in Los Angeles were treated for effects of drug or alcohol use.

While hospital occupancy rates are declining nationwide, many urban public hospitals are woefully overcrowded, according to the report. At Harbor-UCLA Medical Center, obstetrics patients are relegated to beds in the hall, and the average maternity stay is less than a day, according to Larry Gage, president of the public hospitals' association.

U.S. Medicine Appears Costly, Researchers Say

9/27/90

Consumers Here Pay Twice As Much as Canadians For Same Service Level

By Ron Winslow
Staff Reporter of The Wall Street Journal

U.S. consumers pay doctors more than twice as much as their Canadian neighbors do for the same amount of health services, a new study says.

But researchers found that the higher fees for U.S. doctors don't translate to comparably higher incomes because they have higher overhead costs and a lighter workload than Canadian physicians do.

The study, in today's New England Journal of Medicine, adds to an emerging body of research that questions whether the U.S. gets its money's worth from the world's most expensive health-care system. Last spring, researchers reported that death rates in U.S. and Canadian hospitals were similar for a variety of procedures while expenditures for hospital care were 25% to 50% higher.

The new study, by Victor Fuchs, a Stanford University health economist, doesn't directly address quality of care. But it does challenge some standard assumptions about differences between the two systems. Advocates for overhauling the U.S. health-care system consider Canada an important model.

"The study will be very influential in the health policy debate," says Uwe Reinhardt, an economist at Princeton University. "And [we] will have continued research that tries to get at the question, what are Canadians actually missing?"

Overall, U.S. health expenditures are 38% higher per capita than in Canada, based on 1985 government and insurance industry health-care data, the study says. The researchers focused only on money spent for physician services—including doctor visits, fees for tests and surgery, nursing support, equipment and office supplies—to make their comparisons.

They found that the U.S. spent $347 per capita on physician services, while Canada spent $202. For medical tests and surgical procedures, the U.S. spent $193 per capita, 2.8 times higher than the Canadian figure of $69. The difference in expenditures for office and hospital visits was much smaller: $154 in the U.S. and $133 in Canada. Physician fees for all services were 2.4 times higher—and up to 4.5 times higher for some procedures—in the U.S.

A spokesman for the American Medical Association said the doctors' group hadn't had time to evaluate the report. The AMA has generally opposed adopting a Canadian system, but it won't evaluate well in the larger and more diverse U.S. population.

The Canadian system, funded principally from taxes, caps physician fees and establishes a health-care budget. This results in waiting lines for many elective procedures that critics say amounts to rationing or restricting care.

The study found that U.S. citizens get only about three-quarters the amount of services per capita that Canadians do a "striking refutation of the hypothesis that lower spending in Canada is achieved by providing fewer services," Mr. Fuchs, and a colleague, James S. Hahn, say in their study.

Canadian physicians provide about 1.5 times more patient evaluation and management services—such as physicals and other routine care—than U.S. doctors. This reflects the fact that Canada has a much higher proportion of general practitioners over specialists than the U.S., and that Canadians are fully insured. More than 31 million Americans lack health insurance and millions of others lack coverage for primary care. Canadian specialists have a heavier workload as well: The researchers estimated there are about 40% more "procedure-oriented physicians" in the U.S., but that Canadians do about 20% more procedures per capita.

Mr. Fuchs said that after adjusting for differences in specialties, net income of U.S. doctors was 35% higher than their colleagues in Canada, which he said accounted for only a relatively "small portion" of higher physician fees. Overhead for billing, a more cumbersome process in the U.S. with dozens of private and public third-party payers, as well as nursing staff, malpractice insurance and other administrative costs also help explain why U.S. residents get fewer services per dollar than Canadians.

General practitioners and family physicians deliver two-thirds of routine care in Canada, while internists, pediatricians, psychiatrists and other specialists deliver the rest. "In the U.S. the proportions are reversed," the authors say. Whether this difference in "intensity of care" means a difference in quality isn't clear.

The researchers analyzed data for both nations for 1985. A smaller sample, comparing Iowa and Manitoba, as well as an update using 1987 data turned up some variations in statistics, but confirmed the broader trends.

Lockheed Unit's EPA Job

CALABASAS, Calif. – Lockheed Corp. said a unit received two contracts from the Environmental Protection Agency with a combined value of about $200 million over five years.

Lockheed said the contracts are for environmental monitoring and remote sensing services at the agency's Environmental Monitoring Systems Laboratory in Las Vegas. Lockheed said the work would be performed by its Houston-based Lockheed Engineering & Science unit.

NEW PEOPLE'S MEDICAL SOCIETY BOOK REVEALS THE SECRETS OF SAVING MONEY ON HEALTH CARE

CAN YOU AFFORD TO GET SICK?

Can you *afford* to get sick?

If, for example, you were suddenly hospitalized or disabled, could you afford to pay for the hospital room, doctors, nurses, therapists, surgery and medications – bills that could run into the tens of thousands?

Come to think of it, can you afford to *stay well*? Can you easily afford the cost of vitamins, health insurance, over-the-counter drugs, and routine office visits?

Let's face it. In America today, good health is getting to be a luxury – like yachts and limousines.

But not anymore! Because now you can beat the system and get high-quality health care at a fraction of what you're currently paying for it.

How? With GETTING THE MOST FOR YOUR MEDICAL DOLLAR – a new book from your friends at the People's Medical Society.

And because you are a loyal member of the People's Medical Society, a copy of this book has been reserved in your name in advance of publication. To claim it, all you have to do is send in the coupon below and you'll save more than 10% off the bookstore price.

DO YOU BELONG TO ONE OF THESE HIGH-COST GROUPS?

Did you know that the average American family now spends nearly $2,200 a year on health care? "Medflation," if you will, rises more than three times faster than the overall cost-of-living. Drugs go up 12% a year. Office visits rise nearly 10%. The daily cost of a typical hospital room is now $264!

Senior citizens, of course, take the brunt of these increases. With Medicare premiums going up drastically, seniors now spend *one-fifth* of their income on health care. But you don't have to be elderly to be vulnerable to high medical costs.

Did you know, for example, that women of child-bearing age and their children are the single largest users of the health care system? That 37 million Americans have no health insurance at all and must pay out-of-pocket for medical care? That many companies nowadays are increasing co-payments, reducing benefits, and even dropping health insurance altogether?

START SAVING MONEY TODAY

But you don't have to be victimized by the high cost of medicine. Whether you use the system frequently or hardly at all, you can start saving money today with GETTING THE MOST FOR YOUR MEDICAL DOLLAR. In it, you'll find all the tricks, tactics and techniques for paying less . . . and getting more:

In CHAPTER ONE, for example, you'll learn the single most important questions to ask a doctor. And a simple way to verify your doctor's credentials.

CHAPTER TWO tells you how to save money by choosing the proper health-care setting. Will you spend less by going to a "Doc-in-the-Box" instead of the Emergency Room? Which is better, a community hospital or a major medical center?

CHAPTER THREE will show you how to "cover your assets" with health insurance. You'll learn how to avoid insurance you don't really need . . . and how to choose intelligently from the "cafeteria" of health benefits offered by your employer.

Spending less on drugs is the subject of CHAPTER FOUR, but that's small potatoes compared to what you'll learn in CHAPTER FIVE – how to save money in the doctor's office and hospital. The 20 most common surgeries and some cheaper alternatives. How to spot errors in a hospital bill. And how to cut costs in the hospital from admission to discharge.

Of course, the best way to save money on health care is to get it free. That's why CHAPTER SIX talks about your medical entitlements and how to qualify for them, while CHAPTER EIGHT gives you a complete directory of telephone numbers to call for free medical advice and assistance.

SAVE MONEY AND STAY HEALTHY TOO!

GETTING THE MOST FOR YOUR MEDICAL DOLLAR can improve your health too. Because consumers who know how the system works not only pay less, but they get better care than those who passively accept whatever drops on their medical plate.

Written in a lively, upbeat style, GETTING THE MOST FOR YOUR MEDICAL DOLLAR is jam-packed with tips, hints, money-saving ideas, handy charts, and guidelines. It's easy to use, fun to read, and loaded with real-life examples . . . many of them submitted by PMS members like yourself.

THE BOOK *YOU* HELPED TO WRITE!

In fact, you and your fellow PMS members helped us write this book with the hundreds of phone calls and letters we receive each week from members who have been ripped off by the health care system . . . or who have figured out ingenious ways to beat it.

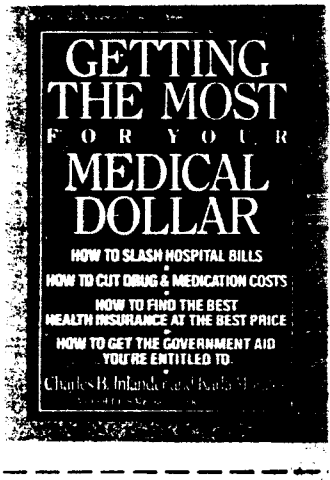
Authors Charles Inlander (President of PMS) and Karla Morales (Communications Director) used dozens of true stories taken from PMS files to write this book . . . and now they want to return the favor with a special deal:

SAVE $2 BY RESERVING YOUR COPY IN ADVANCE

As a member of the People's Medical Society, you are entitled to receive an advanced copy of GETTING THE MO$T FOR YOUR MEDICAL DOLLAR for just $12.95. That's a savings of $2 – or more than 10% – off the bookstore price. But please hurry. To guarantee that price, we must have your order *before* the book goes to press.

Remember, a copy of GETTING THE MOST FOR YOUR MEDICAL DOLLAR has *already* been reserved in your name. All you have to do to claim it is fill out the reservation certificate below and return it to us today:

PMS MEMBERS SAVE 10%



MONEY-SAVING RESERVATION CERTIFICATE

I want to claim my copy of GETTING THE MO$T FOR YOUR MEDICAL DOLLAR **before** it goes to press. I understand that as a member of the People's Medical Society I will pay $2.00 less for this book than the general public—a savings of more than 10% off the bookstore price.

☐ **I want _____ copies of GETTING THE MO$T FOR YOUR MEDICAL DOLLAR @ $12.95 each.**

Order total		**$_____**
UPS or first class shipping & handling	**+**	**$ 3.00**
TOTAL DUE		**$_____**

☐ **Check enclosed—payable to the PEOPLE'S MEDICAL SOCIETY**

☐ **Money order enclosed**

☐ **Charge my** ☐ **VISA** ☐ **MasterCard**

Account number **Expiration date**

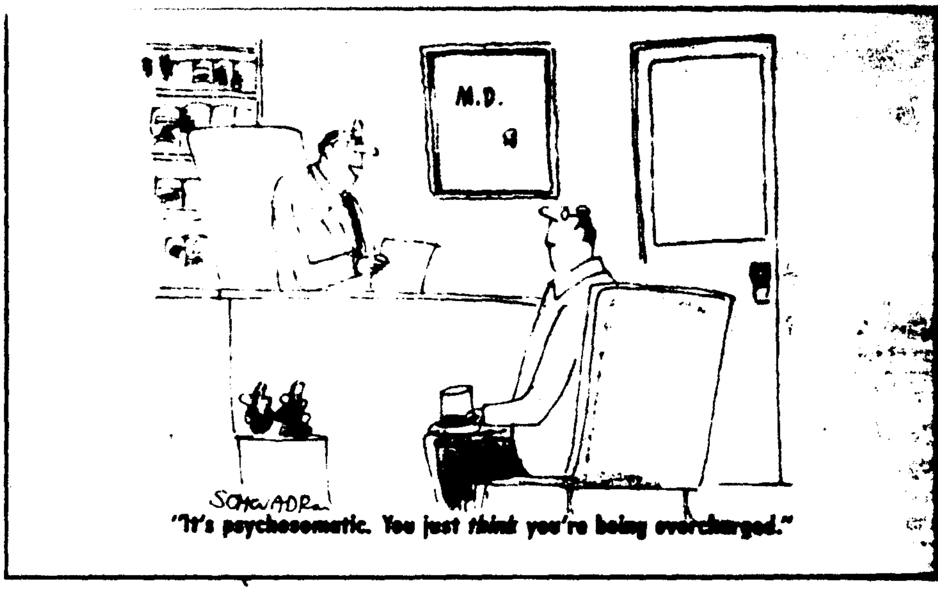
Signature (required for all charge orders)

SHIP TO: Name _____

Address _____

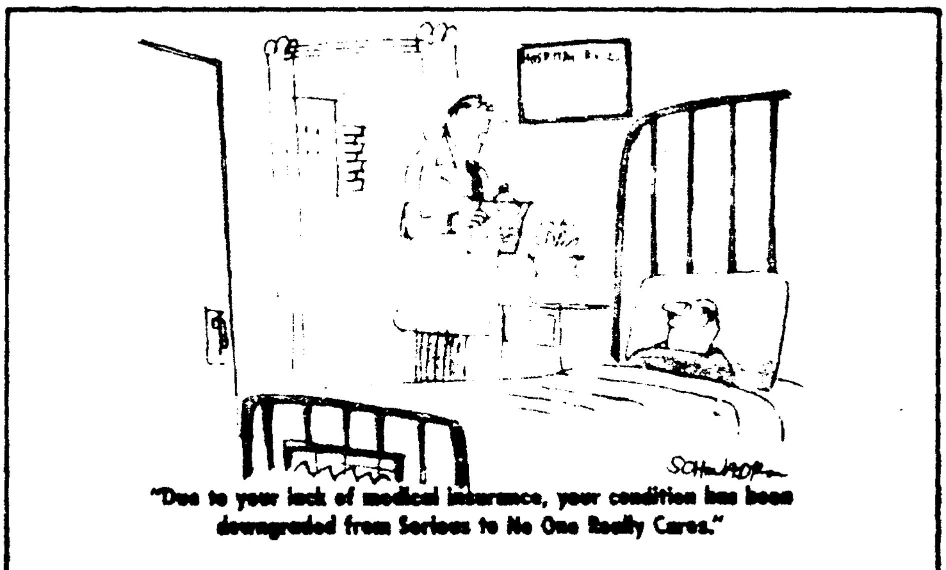
City _____ **State** _____ **Zip** _____

Detach this coupon and mail with payment to:



"It's psychosomatic. You just *think* you're being overcharged."

Peoples Medical Society Newsletter 2/91



"Due to your lack of medical insurance, your condition has been downgraded from Serious to No One Really Cares."

Peoples Medical Society Newsletter 2/91

"The word is INTENSIVE."

Senior Voice 1/2 '84

EXHIBIT 1
DATE 3-6-91
HB SJR9

Montana Catholic Conference

March 6, 1991

MADAM CHAIRMAN RUSSELL AND MEMBERS OF THE COMMITTEE

I am John Ortwein, Director of the Montana Catholic Conference. I represent the two Roman Catholic Bishops in the State of Montana in matters of public policy.

The Catholic Health Association in its 1986 statement entitled: No Room in the Marketplace: The Health Care of the Poor, makes the following statement: The government has already demonstrated that its programs can substantially improve the delivery of health care services to the poor and the elderly. Both groups achieved dramatic improvements in access to health care following the 1965 introduction of Medicare and Medicaid....Despite these impressive gains, more than 34 (now 37) million Americans remain uninsured for all or part of the year...this requires the immediate attention of various levels of government.

The Montana Catholic Conference supports SJR 9.

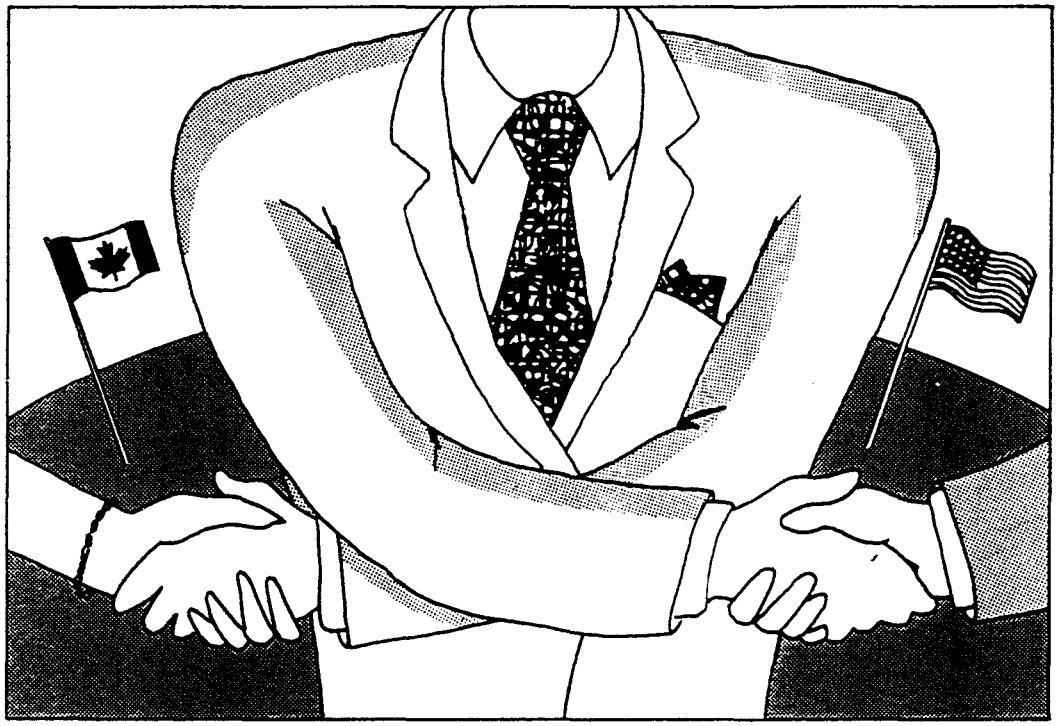
Tel. (406) 442-5761 P.O. BOX 1708 530 N. EWING HELENA, MONTANA 59624

CARE & SHARE

EXHIBIT 8
DATE 3-6-91
HB SJR9

TWO SYSTEMS IN PARALLEL:

HEALTH CARE IN THE WEST



BANFF PARK LODGE

BANFF, ALBERTA

APRIL 10–12, 1991

Washington State Hospital Association

Alberta Hospital Association

MANITOBA HEALTH ORGANIZATIONS INC.

IDAHO HOSPITAL ASSOCIATION

MONTANA HOSPITAL ASSOCIATION

SASKATCHEWAN HEALTH-CARE ASSOCIATION

BCHA

EXHIBIT 9
DATE 3-6-91
SJR 9

The Yellowstone Valley Retired Teachers Association met on January 11, 1991, at the King's Table in Billings, Montana. President Jack Johnson presided. The following is an excerpt From the Minutes of that meeting:

Leroy Keilman moved that the Yellowstone Valley Retired Teachers' Asoociation back the following State Legislation--

1. Resolution for a National Health Care Plan; and
2. Pass a low that all Montana doctors who accept Medicare Assignment also accept Medicare Fee Schedule for the full charge."

Seconded and passed."

Ellen C. Ready

Ellen C. Ready, Secretary
Yellowstone Valley Retired
Teachers' Association

1013 Ann's Place
Laurel, MT 59044

7
3-6-91
SJR 9

Endorsement of
Nat. Health Care Resolution.

Whereas - 37 million Americans have no health Ins. protection whatsoever; and
Whereas - an additional 50 mill. Persons are underinsured. and
Whereas - The U.S. health care system is expensive and inefficient and denies many in need of care of proper care.
Therefore we the Seniors of Whitefish, urge the Mont. legislators to pass the resolution on national health care petitioning Congress to establish a national health care system with a single payer system.

Mildred Harris
1220 Wisc Ave
Whitefish, Mont.
862-4514

Exhibit 9 also contains 47 pages of signatures supporting SJR 9. The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

EXHIBIT 10
DATE 3-6-91
HB 950

DEPARTMENT OF FAMILY SERVICES

STAN STEPHENS, GOVERNOR

(406) 444-5900

STATE OF MONTANA

P.O. BOX 8005
HELENA, MONTANA 59604

TESTIMONY IN SUPPORT OF MONTANA FAMILY POLICY ACT HB950
MONTANA FAMILY POLICY ACT

Submitted by John Madsen
Child Protection Specialist of the Department of Family Services

As a state we value families. They have always been the foundation of our society and they remain the key to its future. The family is the single most powerful influence for ensuring childrens healthy social development and mental and physical well being but most families require support at some point when raising their children. The family plays the critical role in preparing the next generation to be a productive part of society.

As the child protection agency in this state we see the many ways that families can hurt rather than nurture their children. Quoting from The National Commission on Child Welfare and Family Preservation A Committment to Change " we are witness to the failure of a system that intends and seeks to help protect children from abuse and neglect and prepare families to care completely for their children."

Family needs often are multiple and interdependent. Failure to meet the needs of a family in one area often exacerbates its needs in another. Poor health can contribute to welfare dependency; school failure can lead to teenage pregnancy; substance abuse can contribute to child abuse; unemployment can lead to a sense of hopelessness and suicide; homelessness can exacerbate mental health disorders; poverty, and especially persistent poverty, can contribute to many other social service needs.

This interdependence and the need for interdependent solutions to family concerns are coming into much greater public focus. State lawmakers, aware of specific program expenditures in programs such as AFDC, Medicaid, substance abuse treatment, juvenile delinquency, foster care, and job training, are beginning to ask what the costs are of helping individual families and to seek ways to allocate funds better to meet those families' needs. A major challenge for states is to coordinate and restructure service delivery so that the appropriate needs of families can be met.

EXHIBIT 10
DATE 3-6-91
HB 950

Current service systems almost exclusively serve families and children in acute crisis: drugs, physical and sexual abuse, serious physical and mental health difficulties, teen age pregnancy, juvenile delinquency. Some crisis are exacerbated by social and ecomonic ills such as poverty, homelessness, and substance abuse; some are brought on by emotional, behavioral, and developmental childhood conditions. Whatever the causes, public children's services system see more children and families in crisis than they did several years ago.

In DFS resource priorities have shifted dramatically. Between 1982 and 1990 the number of children involved in abuse and neglect referrals has increased over 135%. During that same period the number of children entering the foster care system has increased dramatically and the average length of stay in care has also increased. As a result DFS has moved from an agency that provided services to families to an investigative and case management agency. Prevention and intervention service provision has become almost non-existent. Resource allocation by necessity has shifted to the out-of-home care system at the expense of prevention and intervention. We know DFS must change our strategies to help families properly protect and nurture their children. However, the challenges we face encompass more than just our agency or the child welfare system.

All of our systems must begin to change to meet the needs of children and families before they get to the acute crisis stage. In most communities there are few if any prevention or early intervention programs. There are exceptions and they are very effective but there are not nearly enough. The various agencies of state government as they effect families and children in communities by providing services set up programs that are designed to meet a specific problem ie child protection teen pregnancy, juvenile delinquency, drug abuse. Current structures do not encourage or support these community programs to begin working together to help solve the problems of families before crisis. Many of them are viewed as big brother intervention and are viewed by the public intrusive. The new approaches must be voluntary and might need to be provided by private providers.

State government must begin to look across agency and program lines to solve the problems. They must begin to help communities help families.

Creative new intervention strategies must involve mental health, education, health, juvenile services, law enforcement, social services, economic services, civic and business groups and the general public. The legislature is the one cross cutting system to all of these other systems.

EXHIBIT 10
DATE 3-6-91
HB 950

The family policy act is the beginning of some of the steps necessary. It articulates that families are important; that prevention and early intervention is necessary rather than waiting for the crisis to emerge. It further says that the state shall help communities build the capacity to help families and further that state agencies shall work together to help families.

We strongly urge your support of the bill.

adsup\lbe\hb950\jm

EXHIBIT
DATE 3-6-91
HB 950

SUMMARY OF THE HAWAII HEALTHY START PROGRAM

The 1984 Hawaii Legislature authorized the Healthy Start Pilot Program for prevention of child abuse and promotion of optimal child development. Hawaii is now in the process of expanding the program to cover all areas of the state. The statewide system is a cooperative effort of the Department of Health and Human Services and seven private agencies.

Prevention of abuse is seen as a key componet in a comprehensive system assuring every child's positive development in the critical first five years. The Healthy Start Program is a family-focused interdisciplinary approach to prevention of child abuse and the promotion of positive child development in the families most as risk. The stated purposes of the statewide system are to:

* Identify all at-risk families in hospitals at the time of birth.

* Provide voluntary home-based support services to all at-risk families with newborns.

* Coordinate early with Child Protective Services after detection of danger to a child.

* Integrate with pediatric health services to assure well child care and positive early child development.

* Address the urgent and long-term needs of the family through links to community resources -- food banks, housing programs, child care, substance abuse and spouse abuse services, literacy and job training.

The benefits of the program are:

* Prevention of child abuse for at least 95% of at-risk children served by the program. 175 of the infants served during the Hawaii pilot project were at least one yer of age by the end of the three-year period; among this population there was no abuse for 100% and no neglect for 98%.

* Systematic and early involvement of health, social and education agencies in support of the at-risk family -- a group often considered hard to serve.

* Reduction of costs of child abuse and related services, both in this and later generations.

* Reduction of downstream social costs for problems associated with child abuse: physical handicaps, school failure, juvenile delinquency, substance abuse, mental illness, spouse abuse, and imprisonment.

* Reduction in related social problems. Research findings on families receiving intensive new parent services report fewer subsequent pregnancies, more consistent use of health services and job training, lower dependence on welfare, and greater success in completing school and securing employment.

EXHIBIT 12
DATE 3-6-91
HB 950

Montana Council for Maternal and Child Health

The Voice of the Next Generation in Montana's State Capitol

2030 11th Ave., Suite 10 Helena, MT 59601 (406) 443-1674

TESTIMONY FOR THE HOUSE HUMAN SERVICES COMMITTEE
Supporting HB 950 with amendments
Wednesday, March 6, 1991

The Montana Council for Maternal and Child Health. a non-profit public policy research, education, and advocacy organization, supports the Montana Family Policy Act as justified in the preamble and as presented in Section 2 of HB 950. This policy provides a philosophical framework, which can be utilized by state agencies in establishing consistent internal policies and programs.

The policy would guide family services agencies in shifting from intervention to prevention, from later to earlier intervention, from out-of-home care to in-home treatment of family dysfunction, from punitive to curative measures for families in crisis. These shifts would benefit not only the child but society as a whole.

As a member of the Children's Alliance and endorser of the Children's Agenda, the Montana Council for Maternal and Child Health supports Sections 1 and 2 of HB 950.

Section 3, while it is not a part of the Children's Agenda, is a useful project which has been successful in reducing child abuse and neglect in a number of other states. If it is to be effective, however, it needs an appropriating.

The Council opposes sections 5 and 6 of HB 950, which would charge a fee for recording the birth of a child by filing the birth certificate. This will have a chilling effect on the filing of birth certificates. Excusing children whose births are funded by Medicaid will not eliminate the burden on other poor families who are not Medicaid-eligible, and would amount to a regressive "birth tax" disproportionately affecting the working poor.

Birth certificates serve two purposes. First, of course, is to provide the child with a record of the birth. But the second purpose of the birth certificate is to provide detailed data about the health of both mother and child, which are vital to assessing and planning for the health of mothers and children in Montana.

It is the job of the state to collect and maintain accurate birth and death records. It is the obligation of the birth attendant or parent to file the birth certificate with the state. Nothing should interfere with this essential process.

Paulette Kohman
Executive Director

Paulette Kohman

EXHIBIT 13
DATE 3-6-91
HB 950

First Christian

First Love ❤ is Forever

Kenneth W. Moore
Pastor

To: Committee Members
Re: Support of HB 950

As Moderator of the Christian Church (Disciples of Christ) in Montana I wish to express my strong support of the "Family Policy Act". We have adopted as our denominational priority in Montana the strengthening of families. The family is the basic institution of society through which our children's sense of well-being and self-esteem are developed and nurtured. It is in families that children best learn these qualities which are essential to a healthy, productive and independent life in adulthood.

It is in the best interest of Montana, we believe, to continue to develop public policies and programs to support and strengthen family life.

Today children make up the most impoverished segment of American society and are often subject to cruelty, abuse and neglect. We believe that those social attitudes and practices that tolerate and condone violence toward children will only change if our society as a whole undertakes the responsibility to establish and implement prevention policies, programs and procedures. Those programs and servies will have the greatest efficacy that support, respect, empower and strengthen the parent and thus enhance the whole family's ability to function in a healthy, productive way.

While we support the excellent language of this piece of legislation, we have some concern about its provision to tax birth certificates. It was not very many years ago that the churches maintained all the the records of births and deaths as well as baptisms. It would be unfortunate to add a tax for what was for so many centuries performed for free. We need to fund a wide range of family support services which should be part of General Fund allocations rather than adding a series of special taxes.

On a positive note, this bill's provision for home-based rehabilitation services where appropriate would not only be very cost effective but would serve to strengthen and perserve the family.

I urge your support of HB 950

Sincerely,

Kenneth W. Moore

Kenneth W. Moore
Moderator
Christian Church in Montana

EXHIBIT 17
DATE 3-6-91
HB 950

Mental Health Association of Montana

A Division of the National Mental Health Association

State Headquarters • 555 Fuller Avenue • Helena, Montana 59601 • (406) 442-4276

Working for Montana's Mental Health

March 6, 1991

Madam Chair and Members of the Committee,

For the record, I am Joan-Nell Macfadden, Chairperson of the Children's Committee of the Mental Health Association of Montana.

We urge you to support House Bill 950. This bill is clearly about prevention. U. S. Secretary of Health/Human Services, Dr. Lewis Sullivan states, "I want to make it (prevention) a national obsession." HB-950 helps us to begin to make prevention, as a part of our continuum of care, a priority in this state.

Let's talk about dads for a minute. This project provides an opportunity for early intervention for young, high-risk dads who don't know how to handle babies and who often react with uncontrollable anger to situations they can't control. This pilot project is a great opportunity for reaching the moms and dads we read about in our newspapers. In the October 8, 1990, Time magazine article, "Do We Care About Our Kids", it states: "To walk through death row in any prison is to learn what child abuse can lead to. According to attorneys who have represented them, four out of five death row inmates were abused as children." It is encouraging to note that in the Hawaii Healthy Start Program, 95% of the parents voluntarily accepted home visits when they were suggested as compared to the resistance these parents might have shown at a later date.

We are paying great amounts of money in Montana to take troubled children out of their homes when they are adolescents and almost beyond help. As a matter of fact, in 1988 Montana had 59 children in out-of-state placements. On January 29th we had 65 children out of state. One would assume that we have not made any strides in this area.

EXHIBIT 14
DATE 3-6-91
HB 950

MONTANA POST ADOPTION CENTER

Testimony by Helen Costello, Service Coordinator, Montana Post Adoption Center, in support of HB 950, The Montana Family Policy Act.

Child welfare experts agree that the number one trauma for children is to be separated from their biological parents.

The number two trauma for a child is multiple temporary care; i.e. "foster care drift".

With that in mind, it is evident that every effort must be made to preserve families. Family in-home preservation services should be as prevalent as are the out-of-home placement services.

When out-of-home placement is necessary, family reunification and permanent family services are essential. Permanent family services must recognize the need for continuing a connection with the biological family.

Children have little or no say in these matters. Their future is in our hands. The Family Policy Act will provide advocacy in their behalf.

P.O. BOX 634, HELENA, MT 59624 406-449-3266

EXHIBIT 16
DATE 3-6-91
HB 950

montana public health association

Since 1918

Testimony before the House Human Services and Aging Committee
HB 950
March 6, 1991

Madame Chairperson and Members of the Committee: I am Robert W. Moon, President, Montana Public Health Association and member of the Board of Directors for the Montana Council on Families. For the record, I am registering support for HB 950.

Our children deserve the most enriching, supportive environment available to promote a healthy, productive and satisfying life. The core element to help assure children have the opportunity to receive optimal care and nurturing is through the family. Families who will take the responsibility to teach, provide, love and care...who will build relationships that last a lifetime.

Montana can save money by preserving families! And HB 950 allows the establishment of a state policy that defines government's role, not as a payor for high cost residential care for children, but as a partner with Montana communities in creating a system of community-based prevention and support services. This bill establishes services that could cut in half the cost of expensive institutional care, and, more importantly, allows the majority of troubled children to remain in their homes.

HB 950 also describes a system for identifying high-risk families who need community-based support. The Montana Public Health Association has a long tradition of supporting efforts that go upstream to identify the cause of costly log jams in our health and human service system, rather than continually pouring our resources into pulling the logs out of the water. Preserving families is a true act of prevention and will stem any future log jams made up of our very own children.

EXHIBIT 17
DATE 3-6-91
HB 950

Written testimony
of

Kenneth C. Taylor, MA

For HB 950; The Montana Family Policy Act

Since 1961, with brief interludes, Montana has been my home. I have come of age and now approach middle age in our magnificent empire. During the past two years I have been professionally involved in Drug and Alcohol Abuse prevention efforts in Montana. I am writing this testimony as a concerned Montanan, the opinions expressed here are mine alone.

There is much agreement both among academics and ordinary citizens that families are central to healthy communities and healthy societies. Also emerging is the realization that families are far more fragile than we once thought. Communities which lack resources, neglect developing the resources they already have or which deny the need to address problem behavior only contribute to familiy crises. It is easy to blame a decline in the family for increased youthful abuse of alcohol and other drugs. However, it is difficult to make a direct correlation between the strength of a family and the abuse of alcohol and other drugs. Still, strong families and strong communities are better able to deal with youthful experimentation. For this reason, if no other, there is good reason to actively support families.

Within the Montana prevention community, I see an emerging consensus around common core issues. There is a sense that whether you are talking about teen sexuality, alcohol and other drug abuse, student achievement, youth in need of supervision, or child abuse you are addressing a common set of problems which involves the use of a common set of strategies. Part of that common set of strategies involves identifying the stresses being put on Montana's families. Another important aspect of prevention is development of a comprehensive, coordinated and communitywide program of activities and attitudes. Central to this emerging consensus is finding ways to strengthen families.

Actions are now being taken to develop regional and state networks tying together the existing networks working on narrowly focused remedial issues. While we don't see the end of activities directed at specific concerns around teen sexuality, alcohol and other drug abuse, student achievement, youth in need of supervision, or child abuse, we do see the development of more active sharing of resources and eventual development of innovative new programs. An important part of this process is recognition on the part of state government that state agencies and state policy can contribute to the development of strong families and healthy communities.

DATE 3-6-91
HB 950

MONTANA CHILDREN'S ALLIANCE

P.O. Box 876, Helena, Montana 59624 (406) 449-8611

HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

SUPPORT FOR HB 950

March 6, 1991

The Montana Children's Alliance is in support of Sections 1 and 2 of HB 950.

The Alliance met in June of 1990 to identify issues which would be placed in the 1991 Children's Agenda. The Montana Family Policy Act was selected as one of these issues and was subsequently endorsed by the 47 organizations which support the Agenda. Members of the Montana Children's Alliance agreed that a Family Policy Act was needed as a guide for framing policies/ programs which would effectively respond to the needs of children and families in Montana. The Alliance did not discuss the issues which appear in Sections 3 through 6 of HB 950 and will remain neutral on those sections.

The structure of the American family has changed significantly within the past few decades. For example:

- In 1950, 60% of American families had a working father, a homemaker mother and at least 2 children who all lived together. Today, only 7% of families fit that profile.

- In 1960, one out of five preschoolers were in need of child care because their single custodial parent or both parents were in the workforce. Today, 50% of preschoolers are in need of child care and that number is expected to grow to 70% or 80% by the year 2000.

- Our nation's workforce is shrinking at the same time the number of retirees is growing. In the year 2000, there will be 4.1 million fewer young adults (age 18-24) than there were in the 1980's -- a decline of 14%. We expect that these fewer young people will be adequately prepared to join a workforce which more and more demands technical competence and critical thinking skills.

Neither public nor private agencies always respond effectively to these changing profiles. Too often we remain rooted in philosophies of what families "should" be rather than what they are and, consequently fail to develop the strengths and capabilities which are inherent in all families.

The Family Policy Act will provide an effective guide for framing policies and programs for Montana's children and families. We urge you to support sections 1 and 2 of this bill.

Respectfully submitted,

Judy Garrity

Judy Garrity

Children's Agenda

DATE 3-6-91
HB 950

NASW Montana Chapter
National Association of Social Workers

9440 Hodgman Canyon
Bozeman, MT 59715
(406) 586-8070

Testimony on HB 950
To Establish State Policy on Children and Families

March 6, 1991
Committee on Human Services & Aging

Madam Chair, members of the committee, I am Judith H. Carlson representing both the MT Chapter, Natl Association of Social Workers and the MT Federation of Big Brothers/Sisters. Both organizations rise in strong support of HB 950.

I encourage you all to read closely the "whereas" paragraphs of this bill. They provide strong testimony to the need for a family policy for Montana. As a social worker, I have seen children severely ravaged by their families, abused, neglected, beaten and rejected. Still, the family is the basis for a child's emotional and psychological being. The child's family leaves lasting marks, for better or for worse. Foster care, provided by those modern day saints, foster parents, can still only be a second-best to being cared for and by one's own biological parents. Our state policy must state that everything possible should be done to keep children in their own homes first; only as a last resort should children be removed from their own parents.

Big Brothers/Sisters programs around the state show one of the ways to strengthen and improve a child's well-being while remaining in their own homes. It is a very effective prevention program. It provides single parents with help in their parenting responsibilities. Big Brothers/Sisters help to shoulder some of the work giving parents some relief and support. This is often just what is needed to maintain the child in his or her own home.

What this bill is about is strengthening families so that children can stay with their own parent or parents if at all possible. There will, no doubt, always be some situations in which children must live apart from their parents for a little while or a long while. But in many cases, if parents get the help <u>they</u> need, they are able to give to their children what <u>they</u> need.

I was interested to read lately about a four year study by David Fanshel of children who had been in long term foster care provided through the Casey Family program. This is a private child care agency started in Seattle by Jim Casey who was also the founder of United Parcel Service. This study was published in the Fall of 1990. The children in the study were abused or rejected by their own parents and placed in Casey Family permanent foster homes. Mr. Fanshel found a direct causal link between early physical abuse of the boys in the study with delinquency and later adult criminality. He was surprised at the strength of the correlation between early abuse and later criminal activity. It seemed very clear.

EXHIBIT 19
DATE 3-6-91
HB 950

A child who is abused is very likely to become an adult who abuses, a criminal.

So what has to happen is to prevent the early abuse. And that can be done through those services enumerated in this bill. Services such as these cost money and this bill will cost money.

We hear tell that the state has no more money to spend on new programs. We say - spend it on prevention or spend it on treatment or incarceration. It costs $547/year for a boy to have a Big Brother/Sister. It costs about $27,000/ year to keep a boy in Pine Hills. And it costs about $60,000/year in a treatment center or later in prison. Let's save that money. Let's be sensible and save our money while we save our children.

We urge your support of HB 950 both here in this committee and in the appropriations process. Consider speaking with your colleagues on the appropriations committee to urge them to maintain or increase appropriations to the Department of Family Services for early intervention, for family-based services, and for support services to families and children at risk of breakup. There is nothing you can do in your 90 days here that is more important than to insure that our families are strengthened and that our children are safe, healthy and happy.

Thank you.

Judith H. Carlson, ACSW
442-7462

EXHIBIT 20
DATE 3-6-91
HB 950

University of Montana

Department of Social Work
Rankin Hall
University of Montana
Missoula, Montana 59812-1046
(406) 243-5543

March 5, 1991

Representative Angela Russell
House Human Services Committee
Montana State Legislature
Helena, MT 59604

Dear Representative Russell:

I urge you and the committee to fully support HB 950, a resolution and act calling for the creation of a comprehensive Montana Family Policy.

The nation and the state have never developed formal public policy on families. As a result, many families are left vulnerable to serious problems and a maze of uncoordinated services have sprung up over the years.

We currently spend over $21 million in out-of-home care of children in desparate situations, yet I estimate that less than $200,000 is spent annually across the state in prevention of child abuse.

We require that every family take care of its own members, but not every one is given the opportunity to do so. Children are vulnerable in a society that does not guarantee their most basic, minimal needs.

The faculty and students in the UM Social Work Department strongly support family policy, the development of prevention programs, and the full coordination of child and family services. We are currently collaborating with the Department of Family Services and Social and Rehabilitation Services on several important projects.

The Exchange Clubs of Montana and Idaho have as their primary service focus, the prevention of child abuse. We join the Montana University System and the state agencies in the formation of comprehensive policy for Montana's families.

Sincerely,

Robert Deaton

Robert Deaton
District Chair, Child Abuse Programs,
Exchange Clubs of Idaho and Montana
Professor, Department of Social Work
University of Montana

EXHIBIT 21
DATE 3-6-91
HB 950

Montana Catholic Conference

HB 950
THE MONTANA FAMILY POLICY ACT
MARCH 6, 1991

MADAM CHAIRMAN RUSSELL AND MEMBERS OF THE COMMITEE

I am John Ortwein, representing the Montana Catholic Conference.

The family is our primary national resource. Its strength is our nation's strength. History demonstrates that the family is the most effective institution for nurturing children,and for developing within children all the biological, psychological, intellectual, and spiritual capacities which produce a mature, loving human being..

Today, the family is the victim of neglect. The family is not so much under attack as it is taken for granted. Where there has been governmental action which touched upon family life, it has usually been piecemeal,and ill-thought-out. The time has come to adopt a better approach. We should be bold about the central place of the family in our state's life.

HB 950, the Montana Family Policy Act, does just that.

The Montana Catholic Conference supports HB 950.

a program

Tel. (406) 442-5761 P.O. BOX 1708 530 N. EWING HELENA, MONTANA 59624

CARE & SHARE

EXHIBIT 22
DATE 3-6-91
HB 950

HB 950 - March 5, 1991
House Human Services and Aging Committee
Barbara Ranf - U S WEST Communications

Madam Chair, my name is Barbara Ranf and I represent U S WEST Communications. I was asked by the Montana Council for Families if I would briefly review with this committee the findings and conclusions that led the U S WEST Foundation to initiate its early childhood initiative as you consider HB 950.

The U S WEST Foundation handles the charitable contributions of all U S WEST companies. We provide grants in our 14 state service region.

Several years ago, we announced an educational initiative to support innovative, long-term solutions to the problems facing our educational system.

Our efforts focussed on K-12 and higher education, but we soon realized we had left out an important component.

We were finding that:

- many youngsters leave school unprepared because that's the way they went in.

And fueling that issue was:

- the rising number of working women who have preschool children.
- the declining conditions of young children in this country.
- and growing evidence that effective early childhood interventions can make a positive difference.

That prompted us to expand our commitment to education by establishing a new strategic focus on early childhood education.

We looked at policies and programs across the country aimed at young children, particularly those at-risk of educational, social and economic failure. We also conducted interviews with early childhood educators, health and social services providers, advocates and policy makers in five targeted states.

These five states, of which Montana was one, were selected from the 14 states we serve as we looked at the "AT RISK" indicators.

Young children in those five states are most at-risk of

- being born into poor faimiles.
- being born to mothers, who received no or late pre-natal care, and thus, most likely to be low-birthweight or to die before the age of one; and
- being born to teenage mothers, the vast majority of who are not married and poor.

During our interviews in the five states, we heard repeatedly of the need for parent resource and training programs; programs for all parents, but particularly those who are disadvantaged. For the most vulnerable families, where there is indication of alcohol and/or drug abuse, or in rural settings where centralized programs are infeasible, the need for home-based services was stressed.

We also found that the two biggest road blocks to early childhood education efforts were:

- a lack of funding for program innovation and expansion.
- and a lack of information, training and technical assistance.

Over the next three years we - through the U S WEST Foundation - will be working to establish and evaluate model early childhood parent education programs -- increase information, training and technical assistance services -- and support dissemination of that information.

EXHIBIT 2
DATE 3-6-91
HB 950

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

STAN STEPHENS, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

FAX # (406) 444-2606

HELENA, MONTANA 59620

TESTIMONY PRESENTED BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

March 6, 1991

HB 950 - ESTABLISHING STATE POLICY RELATING TO CHILDREN AND FAMILIES

The Department of Health and Environmental Sciences has several concerns about possible technical or mechanical defects of HB 950 as introduced.

I would like to refer the committee to the five items listed in Section VI of the fiscal note prepared by the department and to briefly summarize those items.

Current practices in the implementation of 50-15-201 MCA places the responsibility for the actual filing of a birth certificate with the hospital for in-hospital births. For out-of-hospital births, the person certifying the live birth is responsible for the filing of the certificate. This is typically a physician, a midwife or a parent. This bill is not clear regarding responsibility for the filing fee.

This bill does not adequately address the current status of the local registrar system in Montana as it relates to local registrar ability in determining the medicaid status of mothers of new-borns and the ability of local registrars to implement sound accounting procedures.

This bill could jeopardize the filing of a birth certificate in those instances where the responsible person either cannot or will not pay the filing fee. In these cases, the child, as well as his/her parents, would be subjected to substantial inconvenience in future years.

In addition to these technical concerns, the department would like to direct the committee's attention to one other area of concern. This is in regard to a clarification of the local registrar system in Montana.

The department utilizes 58 local registrars as agents of the department to conduct birth and death registration at the county level in Montana. Local registrars are private citizens providing a service to both the state and to the residents of their respective counties. Many local registrars perform these services without compensation and, in fact, may operate the "business" from their homes.

EXHIBIT 23
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HB 950

It is true that some local registrars are employed by county government and some are elected county officials, but these occurrences are coincidental and bear no relationship to their duties as local registrars.

Local registration and local registrars make it possible for birth and death certificates to be available to County Clerk and Recorders, and therefore to county residents, in a timely manner. Local registrars provide assistance to county residents in processing delayed filings of birth certificates, assistance in having corrections made to filed certificates, assistance in legitimation and paternity matters, and assistance in securing a birth certificate rapidly to facilitate the procedures regarding the adoption of a new-born. Any disruption of the local registration process due to new duties imposed on the system with which it is not prepared to cope might have negative impact on the availability of these services at the local level.

Presented by:

Sam Sperry
Chief, Vital Records and Statistics Bureau
Department of Health and Environmental Sciences

EXHIBIT 24
DATE 3-6-91
HB 950

OPPOSE #950

Members of the Committee:

My name is Dorothy Traxler, Missoula, Montana.

My interest is this bill is as a mother who has raised her children, a former teacher, volunteer contributor to several children's organizations and continued supporter of strong families, which are the very fundamental cornerstone of a healthy society and a strong America.

I've studied this bill and am appalled that it is even being introduced. In political science classes, it is the dream that the bourgeois family be replaced by the powers of the State; whereas: many of the "whereas" in this bill may be correct, but the passing and implementing of this bill would add yet another layer of bureaucracy to an already over-loaded and under-funded State.

It would not be long before legislation was initiated that would, in effect, eliminate the family.

Legislation is being worked on right now in Sweden to overturn the problems of that welfare country. This bill, quote, "to guide government actions in relations to children and families", is a mock up of that welfare state.

The name "Healthy Start" is a misnomer. We lived in Hawaii when this program was instituted. It is not a cradle to the grave program; it is a "mother's womb to the tomb" program. To the mothers in Hawaii, it is disturbingly evident the State has exceeded its powers - interfered in the family institution and controls the children. If this bill is patterned after Healthy

EXHIBIT 24
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HB 950

Start from Hawaii, it will do the same here.

I respectfully ask the committee to carefully consider how many times "the State" is in this bill, the section on collaboration, and note the additional fee for registration is exempt for those already on the State welfare list.

Thank you very much,

Dorothy Traxler

EXHIBIT 25
DATE 3-6-91
HB 728

TESTIMONY IS SUPPORT OF HB 728 BY MINKIE MEDORA

THE MONTANA ACCESS TO FOOD AND NUTRITION ACT REQUESTS:

1. A STATE COUNCIL TO MONITOR ACCESS TO FOOD & NUTRITION
2. A STATE PUBLIC HEALTH NUTRITIONIST
3. START-UP FUNDS FOR WIC SERVICES IN ALL COUNTIES
4. START-UP FUNDS FOR SCHOOL FOOD PROGRAMS.

THIS BILL DOES NOT REQUIRE STARTING NEW FOOD PROGRAMS.

THE BILL PROMOTES BETTER, MORE EFFICIENT USE OF EXISTING FOOD ASSISTANCE PROGRAMS

THE BILL PROMOTES COORDINATION OF SEVERAL PUBLIC AND PRIVATE PROGRAMS THAT WORK ON THEIR OWN AT PRESENT

FUNDING FOR INCREASED FOOD ASSISTANCE COMES FROM FEDERAL $$

A SMALL INVESTMENT OF STATE DOLLARS WILL BRING LARGE RETURNS OF FEDERAL MONEY

INCREASED USE OF FOOD PROGRAMS WILL REDUCE HUNGER AND MALNUTRITION

INCREASED USE OF FOOD PROGRAMS WILL ENHANCE LOCAL ECONOMY AND AND HELP CREATE NEW JOBS.

A STUDY BY THE MONTANA HUNGER COALITION CLEARLY SHOWS THAT:
- HUNGER IS A SERIOUS, <u>UNRECOGNIZED</u> PROBLEM IN MONTANA
- IF NOT CORRECTED, HUNGER AND MALNUTRITION WILL INCREASE
- CHILDREN ARE AT THE HIGHEST RISK FOR HUNGER IN THE STATE

LACK OF ADEQUATE FOOD AND NUTRITION LEADS TO LONG-TERM, CHRONIC DISEASE FOR WHICH THE STATE PAYS IN HEALTH CARE DOLLARS

EXHIBIT 26
DATE 3-6-91
HB 728

MAJOR FINDINGS FROM A STUDY OF HUNGER IN MONTANA*

1) The incidence of hunger (lack of access to adequate food) increased in all counties of Montana in recent years.

2) Households highest at-risk for hunger are those in the child-rearing stage with below-poverty level incomes.

3) Eighty-two percent of 64 food/nutrition providers from across the State indicated hunger was a problem in their local communities; 42 percent indicated hunger was a "major problem."

4) Food/nutrition providers anticipate an increase in the incidence in hunger in the near future, especially for larger families, as a result of worsening local employment opportunities.

5) Over one-half of 6,581 households in one study indicated they had run out of food the previous year due to lack of money; 64 percent of households with children had run out of food due to lack of money.

6) Only 41 percent of 11,790 below-poverty households in a second study participated in the food stamp program.

7) Seventy percent of all households that did participate in the food stamp program ran out of food stamps by the third week of a month - a finding which explains the high pressure experienced by food banks at the end of each month.

8) Forty percent of 11,790 below-poverty households studied participated in none of the following food/nutrition programs: food stamps; Women, Infants, and Children (WIC); Aid to Families with Dependent Children (AFDC); Medicaid; Supplemental Security Income; or General Assistance.

9) Citizens of Montana during the 1980s were generous with their financial and volunteer support in food bank, soup kitchen, and congregate feeding programs.

10) Food/nutrition providers indicated that the "stigma of welfare" inhibits many needy persons and families from utilizing available food and nutrition programs.

11) Food/nutrition providers indicated they have not been able to adequately meet the hunger needs in their communities for several reasons: complicated forms and stringent eligibility requirements in federal programs; insufficient staff, space, and equipment; and lack of knowledge of available services on the part of many needy households.

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*HUNGER IN MONTANA. A Report by the Montana Hunger Coalition. October 1990.

EXHIBIT 21
DATE 3-6-91
HB 728

Hunger is in Montana too:
Support Your local Food Bank.

MONTANA FOODBANK NETWORK

Good Afternoon,
Chairwoman Russell and members of the Committee:
My name is Joan A. Duncan.

I stand before you today to speak in support of HB 728, as a member of the board of directors of the Montana Food Bank Network, and Executive Director of Helena Food Share, the local food bank and provider of emergency food help in the greater Helena Area.

Eight years ago the Montana Food Bank Network came before the Montana Legislature reguesting funds to establish a technical resource service for emergency food providers. At that time in 1983 the 16 operating Food Banks in Montana did not know of each others existence. Today over 80 agencies including food banks, pantries, soup kitchens, homeless shelters and non-profit daycares are linked by the Food Bank Network. Coordination was essential to our growth of providing direct service of food distribution to our agencies. The efforts of our volunteer programs must also be coordinated with all public and private food assistance programs as the number of Montanans we serve continues to increase, cooperation of available services is critical to assist those in need. Therefore the Montana Food Bank Network supports HB 728 and recognizes the necessity of a hunger council, a public health nutritionist and expansion of WIC to all Montana counties.

Thank you.

TESTIMONY

ARLENE TEMPLER

HB 728

3-6-91

1. On the Flathead Indian Reservation our Elderly population is reaching 90% obesity with the rest of the population close behind.

2. In 1940 our Tribe had 4 cases of diabetes, now we have over 200 cases on the registry and still increasing dramatically. Native American adults in Montana have 3.6 times more diabetes than non-Indians. We have very high rates of blindness, amputation, and kidney failure as a result of this disease. The medical literature is very clear about the fact that the definitive treatment for NIDDM is DIET and exercise. Even when pills and/or insulin are used, diet is still considered the mainstay of treatment.

3. Nutritional factors contribute to at least 5 of the 10 leading causes of American Indian deaths-heart disease, cancer, cirrhosis and diabetes.

4. Non-insuling diabetes is the second leading cause of out-patient visits in the Indian Health Service, second only to the common cold.

5. In Montana Indians, 30% of people with non-insulin diabetes are diagnosed under age 40 compared with less than 5% in the non-native population.

6. Traditional foods have been displaced by those rich in refined carbohydrates.

7. On the Flathead Reservation, Indian households participate in the Commodity Program, Food Stamps and the Title VI and Title III Meals Program.

8. Indian diets and the intake of most nutrients are largely contributed by Commodity Foods, Federal Food Programs.

9. Reservations have the Food Programs. Some Reservations don't have dollars for a nutritionist or nutrition education. USDA disallows funding for nutrition education. The Meal Programs are so under funded that their main concern is to just get food on the table.

10. The food source, without the education or guidance has created health problems on the Reservation. A State Nutritionist could work with the USDA commodity Programs to provide product fact sheets, nutrition related disease fact sheets, nutrition guideline and lobby for nutritional improvements or legislative action, in conjunction with the Tribes.

11. If the State won't allow the Reservation dollars, then they should provide the nutrition education and disseminate the information to us. They must be responsible. If the State promotes or coordinates Food Programs to fight hynger, they should be aware that nutrition needs are as important as food needs.

12. IHS dollars to not meet nutrition related needs. Access to food alone is not going to be the answer. This is short-term solutions.

13. Just creating Food Programs isn't the answer. Health and nutrition education with a food source is!!!

DATE 3-6-91
HB 728

March 6, 1991

Representative Angela Russell
Chair, Human Services and Aging Committee
Montana State Legislature
Helena, MT 59620

Madame Chair and Members of the Committee,

I am Mary Musil from Helena. I am representing the Montana League of Women Voters. The League of Women Voters of Montana supports this bill.

In 1988, we chose hunger as the topic for our two-year statewide study. Local leagues across the state met to try to understand how it is that people in our communities could experience hunger in the midst of presumably adequate food resources and adequate means to deliver it. We are testifying today in favor of this bill, because of what we have learned about hunger in this state. We have examined the federal, state and local government roles in the problem, and the private citizen roles, and we think this bill accurately describes a proper state role in providing and protecting public health.

The U.S. League of Women Voters-Education Fund provided the seed money for the 'Hunger in Montana' research study that you have a copy of. One of the responsibilities of the state in the area of public health, is to collect data, and assemble it for public review and planning. This HB 728, provides a mechanism to begin doing that.

Widespread hunger and food-related disease is evidence of a public failure. Providing access to adequate food and promoting nutritional health of citizens, are public responsibilities.

If we are going to use federal food programs as our mainline resource to provide for the ongoing daily food needs of our low income people, and if we are also going to use these programs to provide nutrition education to our children and elderly, then we must be responsible for what these programs do and don't do.

Federal food programs are not the result of rational health planning. Instead, they are the result of political, economic and social forces. We, as a State, have to promote and deliver these programs in such a way as to reduce hunger among our people.

We have observed that within state government, people administering one food program are strangers to those administering another. The absence of communication, coordination and planning is, we think, a major cause of hunger in Montana.

In the judgement of the League of Women Voters, this bill provides the tools to help ourselves improve access to existing food and nutrition resources for Montana people.

Sincerely,

Mary A. Musil
Chair, State Study on Hunger
and Member, Board of Directors
The League of Women Voters of Montana

EXHIBIT 30
DATE 3-6-91
HB 728

CMMC CENTRAL MONTANA MEDICAL CENTER
408 Wendell Avenue • P.O. Box 580 • Lewistown, Montana 59457 • Phone (406) 538-7711

TO: Human Services and Aging Committee
House of Representatives
SUBJECT: HB 728

The Supplemental Food Program for Women, Infants, and Children, W.I.C., helps low income pregnant and breastfeeding women, women who recently had a baby, and infants and children (up to age five).

W.I.C. benefits include: 1) nutrition assessment, education and counseling; 2) supplemental, highly nutritious foods; 3) access to health care programs and referral to private and public prenatal and pediatric care providers.

Central Montana Medical Center began offering W.I.C. services in Fergus County in 1988 - starting at a caseload of zero. Currently we are serving 222 clients/families. Some of these families, approximately 30, are from outlying counties.

But, because of distances, expense of travel, access to transportation, and other financial limitations, many more families/potential clients are not being served.

The families that are not served are not receiving the assistance needed to provide adequate nutrition for many mothers, infants and children. These potential clients are not benefiting from services which could be provided if funding is available. Benefits include the improvement of pregnancy results, the decrease in infant mortality, and a healthy start in life for many infants and children who have poor and/or insufficient diets.

This is the reason that Central Montana Medical Center is supporting the expansion of the W.I.C. program to include services provided within each of the following counties. If funds are made available we would administer services to these adjacent counties - Judith Basin County, Wheatland County, Golden Valley County and Petroleum County.

Thank you for your time and consideration.

Sincerely,

Pete Brekhus
Acting Administrator
Central Montana Medical Center

Linda Melick, R.D.,L.N.
Director, Fergus W.I.C. Program

EXHIBIT 30
DATE 3-6-91
HB 728

CMMC CENTRAL MONTANA MEDICAL CENTER
408 Wendell Avenue • P.O. Box 580 • Lewistown, Montana 59457 • Phone (406) 538-7711

March 5, 1991

Angela Russell, Chairman
Human Services and Aging Committee
House of Representatives
Capital Station
Helena, MT 59620

RE: House Bill #728

Dear Ms. Russell:

Central Montana Medical Center has been involved with the WIC Program (Supplemental Food Program for Women, Infants and Children) for approximately three years. This program helps low income pregnant and breast feeding women, women who recently had a baby and infants and children (up to age five).

We have been furnishing these services to qualifying residents of Fergus County. I am writing to express the support of the CMMC Governing Board and Administration to expand this program to include the counties of Judith Basin, Wheatland, Golden Valley and Petroleum.

Benefits of this program includes the improvement of pregnancy results, the decrease in infant mortality, and a healthy start in life for infants and children who have poor, insufficient diets. Since these counties contain a significant number of people who could potentially benefit from this program and are not now being serviced, we think we are in a good position to furnish these services to these counties.

Again, we urge your support in expanding the WIC Program to these counties.

Sincerely,

CENTRAL MONTANA MEDICAL CENTER

Pete Brekhus
Acting Administrator

DATE 3-6-91
HB 728

MONTANA CHILDREN'S ALLIANCE

P.O. Box 876, Helena, Montana 59624 (406) 449-8611

HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

SUPPORT FOR HB 728

Date: March 6, 1991

The Montana Children's Alliance, whose members include individuals and organizations who have a primary interest in children and their unmet needs, supports HB 728. This bill provides for accessibility to food programs and nutritional services and funding for nutrition programs.

Many of Montana's most vulnerable citizens, pregnant women and children are going hungry and lack adequate nutrition.

1990 Hunger Coalition Survey states:

* 31% of house holds with children stated that their children were hungry because of lack of food in the home.
* Only 41% of "below Poverty" households were participating in the food stamp program.
* Only 40% of eligible women, infants and children participate in the WIC Program.
* WIC services are not currently available in all counties in the state.
* 42% of service providers indicated that hunger was a major problem in their communities.

Community forums were held in 16 communities in the last 3 months for the Baby Your Baby Campaign. The campaign encourages communities to assist pregnant women in having a healthy pregnancy. In each of these communities, pregnant women going hungry and not having nutritional food were identified as barriers to a healthy pregnancy outcome.

WE MUST BE ASSURED THAT MONTANA'S PREGNANT WOMEN AND CHILDREN HAVE ADEQUATE FOOD AND NUTRITIONAL SERVICES!

The Montana Children's Alliance strongly encourages you to support HB 728.

Respectfully submitted,

D. Elizabeth Roeth
Chair

DATE 3-6-91
HB 728

Montana Catholic Conference

HOUSE BILL 728
MARCH 6, 1991

I am John Ortwein representing the Montana Catholic Conference.

The Montana Catholic Conference supports HB 728.

In his testimony before the platform committees of the Republican and Democratic parties in 1988, Frank Monahan of the United States Catholic Conference offered the following testimony.

"Hunger is a growing national scandal that this nation should not tolerate. Everyone has a right to a sufficient amount of food to live his or her life in dignity. We call for a national policy aimed at securing this right and making the elimination of hunger a national priority. We support the necessary increases and program changes in the food stamp, child nutrition, Women, Infants and Children Program, and the Temporary Food Assistance Program to meet more effectively the nutritional needs of hungry malnourished Americans."

Mr. Monahan was speaking of the national scene. As a member of the Montana Hunger Coalition for the past several years I have come to learn that hunger is not just a national issue, but very much a "State of Montana" issue as was reported to you prior to the start of this legislative session in the extensive report of Paul Miller of the University of Montana Department of Sociology.

We ask you to give your full support to HB 728. Help us to combat hunger in Montana.

Tel. (406) 442-5761 P.O. BOX 1708 530 N. EWING HELENA, MONTANA 59624

DATE 3-6-91
HB 728

FERGUS COUNTY
HUMAN SERVICES
Centennial Plaza • 300 First Ave. No. • Suite 201
Lewistown, Montana 59457
(406) 538-7468

March 4, 1991

John Ortwein, Executive Director
Montana Catholic Conference
P.O. Box 1708
Helena, MT 59624

Re: WIC

Dear Mr. Ortwein:

I have been in contact with the County Commissioners in Petroleum, Wheatland, and Golden Valley Counties this past month regarding the potential to expand the WIC program into those counties. They whole-heartedly support such an event, and all feel strongly that the WIC program is a vital program in our rural communities. The Lewistown WIC program would be able to expand their services to those additional counties, and we have office space which could be used monthly to set up satellite WIC office.

There is a need for the program in the above counties, and recipients of public assistance have been referred to Livingston, Helena, Big Timber and Lewistown with the absence of local availability.

Sincerely,

Boni Braunbeck
County Director III
Wheatland, Golden Valley, Petroleum
Musselshell, Fergus and Judith Basin
Counties

Montana Dietetic Association
P.O Box 1197
Helena, Montana 59624

Testimony In Support of House Bill 728

March 6, 1991

Madam Chairperson, members of the committee, my name is Deb Bjorsness. I am a licensed Nutritionist employed by The Montana Deaconess Medical Center in Great Falls. I appear here today as the President of the Montana Dietetic Association and behalf of the 200 members of the Association.

The Montana Dietetic Association supports HB 728 because it would initiate state leadership to improve health through better nutrition. While millions of federal and private dollars are spent in our state to feed the needy, little is done to promote improved diets and nutrition for the needy. Improved nutrition for low income citizens will reduce the risk of chronic disease and ultimately reduce the costs of health care. House Bill 728 would not only improve the access of the needy to food programs but would begin state efforts to improve the diets of those who use the food programs.

Montana is one of only three states that does not have an office or a person responsible for promoting sound nutrition. The Montana Dietetic Association believes that a program to address adequate nutrition to prevent chronic disease is a fundamental public health service a state should provide it's citizens.

DATE 3-6-91
HB 728

TESTIMONY FOR HB 728

Having a wife who is a volunteer worker at the Missoula Food Bank, I am fairly familiar with the problem of hunger in Missoula County.

The number of people served by the Missoula Food Bank has grown from 5,100 in 1985 to 22,068 in 1990. The number of people who were helped jumped from 5,100 to 15,825 in the first three years of operation. This increase may be due to a growing visibility in the community. There still continues to be a nearly 10% increase each year since.

A disturbing statistic is that over 45% of those receiving food are under the age of 18. These are children in their growing years when proper nutrition is very critical to their becoming healthy adults and being able to function normally in the work place and society as a whole. This is a problem that needs to be addressed.

I urge the passage of HB 728. Thank you for your time.

Doug Campbell

Doug Campbell

President of Montana Senior Citizens Association

EXHIBIT 38
DATE 3-6-91
HB 728

Montana Association of Churches

MONTANA RELIGIOUS LEGISLATIVE COALITION • P.O. Box 745 • Helena, MT 59624
PHONE: (406) 442-5761

WORKING TOGETHER:

American Baptist Churches of the Northwest

Christian Churches of Montana (Disciples of Christ)

Episcopal Church Diocese of Montana

Evangelical Lutheran Church in America Montana Synod

Presbyterian Church (U. S. A.) Glacier Presbytery

Presbyterian Church (U. S. A.) Yellowstone Presbytery

Roman Catholic Diocese of Great Falls - Billings

Roman Catholic Diocese of Helena

United Church of Christ Mt.-N. Wyo. Cont.

United Methodist Church Yellowstone Conference

Date Submitted: March 6, 1991

Bill Number: HB 728

Submitted by: Harley E. Warner

Chair, members of the committee, for the record I am Harley E. Warner. I represent the Montana Association of Churches.

We express our grave concern over the toll that economic conditions have taken on those unable to work and those living on a fixed or very limited income. Two groups of Montana citizens are the hardest hit by these condition, children and seniors.

The study conducted by the Hunger Coalition indicates even some rural Montanans have run short of food during the last couple of years.

We feel that the implementation of the ideas contained in House Bill 728 will help to overcome some of these problems.

The Montana Association of Churches therefore rises in support of House Bill 728.

EXHIBIT 38
DATE 3-6-91
HB 728

Memo to: Human Services and Aging Committee

Re: HB 728 Montana Access to Food and Nutrition Act (Hunger Bill)

From: Sheryle Shandy (Executive Director, Billings Food Bank) Sheryle Shandy

While it is given there are hungry people in Montana, there are also a great many people working both professionally and individually on their behalf. Access to food and programs which provide basic needs is a goal being shared by many.

There is a very real need to provide hot breakfasts and lunches to our children; we need to make the Women, Infant & Children Program, commodity programs, food stamp and general assistance programs, health care programs and all human service programs easily accessible and available for all those in need. The $10,000 earmarked for promoting hot meals in the school would be well spent.
My personal concern is that the referenced bill does little to provide services to the folks who need them. The requested appropriations amount to $242,957. Using the Children's Agenda figures presented by this group, $66,000 was targeted for the WIC program to expand it to the six remaining counties presently not served, the balance would appear to fund two state positions: Nutritionist and Advisory Council coordinator.

I don't feel we have the funds available to create more bureaucracy. If this amount were available, it should be directed at direct services.. it could be leveraged into over $500,000's worth of food, as an example.

I urge this committee to take time to examine the real needs in our State. Ask low-income folks if they would feel this a prudent investment.

The Governor may want to have a committee of volunteers to act as advisors to him on hunger issues. This should be an effort by folks concerned enough to give their time freely to help create a hunger-free Montana, and there should be voices from low-income folks being heard. There is a need to amplify their voices, not speak for them.

Thank you for giving this issue your thoughtful consideration.

I would also urge a thorough examination of proponents to determine if they have the power to commit their respective organizations to this particular piece of legislation.

Sheryle Shandy

EXHIBIT 39
DATE 3-6-91
HB 728

To: Health and Human Services Subcommittee
Re: House Bill 728 "Montana Access to food and Nutrition Act"
From: Terry Egan, M.S., C.H.E Terry Egan
MSU Extension Agent- Expanded Food and Nutrition Education Program (EFNEP)

Many professional and lay people working with limited income families are concerned about hungry Montanans gaining access to food and food programs.

I am concerned that this bill will do little to help alleviate their plight. The bill has a couple of strong points, but overall the funding for this bill will go to create a bureaucracy that will have little direct effect on hungry Montanans. Instead, this bill will create a state advisory council with a large budget and little or no power or authority to make any change. It also has no mechanism to promote change. One reason for this lack of a mechanism or system to change is because the bill's proponents did not involve many people or organizations who directly serve hungry people. Local food bank directors, agency directors and MSU Extension Service personnel were not involved in the decision making process to determine what are the needs of hungry Montanas and how can their needs be met.

The bill does have some positive, direct service aspects. Promoting the school food programs with non-participating schools may get free or reduced lunches to children in need of food. Expanding the WIC (Women, Infants and Children) program to all counties will provide food to families , who are at high nutritional risk. The Children's Agenda showed the cost of this program to be approximately $33,000 a year. The dollars for food are supplied by the USDA and the $33,000 is the cost to get personnel and services offered.

Since the WIC program will only cost $33,000, that means that $82,075 will be spent to fund one (1) position and for a seven (7) panel board to meet? This seems outrageous when the amount of food or services being offered for hungry Montanans is only a total of $43,000. Can we afford to spend $82,000 for a discussion of hungry Montanans when we could use more of that money to feed hungry Montanans?

I ask the committee to get accurate costs of each part of this bill in order to make an informed decision on the costs of each program. I also ask the committee to encourage the proponents to reach beyond their own circle of friends and allies to understand what they can really do to address the problems of the hungry and access to food programs. Include more food bank directors in local areas, directors of programs who give out food boxes and the MSU Extension Service, which offers free food and nutrition education programs in many counties , before making decisions on how these agencies can or will assist hungry Montanans. Finally, let's fund access not discussion.

Ex. 40
3-6-91
SB 168

The Choice

A babyhood's worth of diapers for your baby: cotton vs. disposables.

You can see why people are wondering where those mountains of trash are going to go in our countryside.

You can also guess how the expense of disposables mounts.

But our photo can't show the difference to your baby between soft, breathable cotton

You also can't see how easy our service makes it for you to give your baby the many advantages of cotton. (When we deliver a beautifully clean and fresh supply of our cotton diapers every week, all you do is put the used ones in the hamper we provide. We do the rest. *No rinsing. No fuss. No trash.* And a special freshener keeps your household from smelling "diapery.")

For far less than the cost of disposables, you can know you're doing the best both for

EXHIBIT 40
DATE 3-6-91
HB SB168

-STORICAL PERSPECTIVE
- We were all raised in cloth diapers. Early day cares, including WWII centers used cloth diapers by necessity.
- Early 1980's states passed laws prohibiting the use of reusable diapers.
- Dr. Stephen Hadler, Epidemiologist, CDC, states "no scientific evidence to support the disposable diaper decision, no consensus of opinion among CDC professionals"
- CDC task force early 1980's prepared guidelines for control of communicable disease in day cares. NO MENTION OF DISPOSABLE DIAPER PREFERENCE, only of hygiene requirements.
- 1991 - Still NO PUBLISHED SCIENTIFIC EVIDENCE TO SUPPORT THE PRESENT LAW.

ENVIRONMENTAL IMPACT
- 18 million disposable diapers thrown away annually.
- Disposables consume 75,000 metric tons of NON-RENEWABLE petroleum-based plastic and 1.3 million tons of wood pulp every year.
- Disposables a) create 3 times the manufacturing waste of cotton diapers
  b) require 6 times the energy to manufacture
- Plastic and pulp industry effluents contain numerous hazardous compounds such as dioxins.
- If ALL children were again diapered in cloth, waste water load would be less than .5% of municipal waste water.

DISPOSAL-SOLID WASTE
- Disposables result in 90 times the solid waste of reusable diapers (4-5 million tons/year)
- 414 tons of soiled diapers discarded nationwide every hour.
- Solid waste generated by cloth diapers enters sewage waste stream. Disposable diapers and contents either a) enter landfill or unnecessary risk to groundwater and to
  b) compound roadside and park litter persons who frequent the area.
- More than 100 different enteric viruses are known to be excreted in human feces, including polio and hepatitis. These viruses can live for months after the stool has passed from the body.
- Montana has no uniform regulation for disposal of feces. Feces becomes "sewage", and, thus subject to regulation, only when waterborne, as when flushed. Disposal of adult feces in plastic bags would be frowned upon as a health hazard.
- World Health Organization recommended separation of urine and feces from other solid waste in 1970.
- Packages of disposables specifically instruct user to empty feces into toilet, or rinse diaper prior to disposal. This is rarely done. In fact, "immediate disposal" (i.e. not rinsing or otherwise handling soiled diapers) is mandated by Montana laws. STATE LAW INSTRUCTS DAY CARE OPERATORS TO USE A PRODUCT INCORRECTLY.

COST
- On average, even using diaper service, family saves $4.00/child/week using cloth diapers.
- Assuming 2 year diaper lifetime, disposables cost $1716, diaper service $1170, home-washed cotton $299.
- Cotton diapers save parents $546-$1417 for each child.

MEDICAL ADVANTAGES
- Many physicians and nursing groups feel that babies diapered in cotton suffer less diaper rash. This includes the King County Nurses Association, Seattle, and Dr. William Weston, Professor of Dermatology and Pediatrics, University of Colorado.
- Superabsorbent disposables tend not to be changed often, may cause baby's skin temperature to heat up and so develop a rash or infection. Some worry about possibility of toxic shock.

surfaces, and toys. Frequent hand-washing, and isolation of convalescing children.
- Expert opinion that diaper type is not the issue - hygiene is. Those sharing the opinion include:
  a) Arnold Smith, M.D., Pediatric Infectious Diseases, Children's Orthopedic Hospital, Seattle
  b) David Addis, M.D., Parasitology, CDC
  c) Janice Boase, R.N. Epidemiologist, King County Health Dept.
  d) Anna Helm, Environmental Health, Multnomah County Health Dept.
  e) Susan Schoenfeld, R.N., M.S.P.H, Epidemiologist, Vermont Department of Health.
- Most recent publications by CDC relating to infectious disease prevention in day cares mention hygiene, but not diaper type.
- SB 168 IS SUPPORTED BY EVERY PHYSICIAN IN MISSOULA WHO CARES FOR INFANTS AND CHILDREN.

RECENT LEGISLATION

- 1990 - 24 states and numerous municipalities submitted legislation, regulation, or consumer education measures aimed at reducing the use of disposable diapers.
- Maine successfully reversed its laws to allow the use of cloth diapers in day care centers. NO EPIDEMIOLOGIC INCIDENTS have ensued. (Rep. Mary Cathcart, sponsor)
- 1991 - Amongst other proposed legislation:
  Washington state introduced SB 5687, to ban the sale and disposal of disposable diapers.
  New York proposed legislation to distribute information to new mothers about solid waste and environmental ramifications of disposable diapers.

MONTANANS HAVE AN OBLIGATION TO PROTECT NATURAL RESOURCES FOR FUTURE GENERATIONS. MANY PARENTS ARE OPTING TO USE CLOTH DIAPERS - TO CLEAN UP THEIR WORLD ONE DIAPER AT A TIME. SB 168 WILL ALLOW THAT TO HAPPEN.

REFERENCES:

1. "Diapers in the Waste Stream: A Review of Waste Management and Public Policy Issues" Carl Lehrburger, 1988
2. "Diapers: Environmental Impacts and Lifecycle Analysis," Carl Lehrburger, Jocelyn Mullen, C.V. Jones, January 1991.
3. World Health Organization, "Solid Waste Disposal and Control" WHO Chronicle, vol. 26 no. 4
4. Weston, W. (1985). Practical Pediatric Dermatology, 2nd Ed.
5. Memos by King County Nurses Association. "Hazards Posed by the Improper Disposal of Disposal Diapers," "Diaper Rash", "Figuring the Cost of Diapering" 1989
6. Black, R.E., et al. "Handwashing to prevent diarrhea in day care centers." American Journal of Epidemiology. 113:445, 1981
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8. Pickering, L.K. "Giardia Lamblia", Peds. Clinics of North Am. Vol 35, No. 3, June '88
9. Pickering, L.K. "Diarrhea in day care centers" Pediatric Infectious Disease. Vol. 1, No. 1 p.47
10. Pickering, L.K. "Occurrence of Giardia Lamblia in children in day care centers." J. Peds.Vol. 104, No. 4, p. 522
11. Pickering, L.K. et al. "Diarrhea caused by Shigella, rotavirus, and Giardia in day-care centers: Prospective study." J. Peds. Vol. 99, No. 1, pp. 51-56.
12. Chorba, T.L. "Control of a Non-foodborne Outbreak of Salmonellosis: Day Care in Isolation"

EXHIBIT 41
DATE 3-6-91
SB 168

February 4, 1991

To: The chairman and members of the Human Services and Aging Committee

From: Missoula area physicians

Re: SB 168 - allowing the use of cloth diapers in day care centers.

We, the undersigned physicians support Senate Bill 168, which would allow the use of cloth diapers in licensed day care centers. We find the sanitation guidelines for their use more than adequate to protect the good health of the children and the day care workers. Further, the experience of Missoula area day care centers (notably Loving Care and Community Hospital Day Care) has proven that cloth diapers can be used safely and without incident in a day care setting. This is a positive step towards reducing Montana's solid waste and de-emphasizing disposable items in general.

Many young parents today choose to use non-disposable diapers. Some make this choice out of environmental concern, and the wish to create a better world for their children; some simply cannot afford the expense of disposable diapers. SB 168 will allow these parents the freedom to return to work, yet continue to use cloth diapers. It also will allow day care operators the option of running their centers in accordance with their environmental beliefs.

Donald, R. Nevin, M.D.	Greg Moore, M.D.	Tim Carte, M.D.
Judy McDonald, M.D.	Bruce Hardy, M.D.	Kathleen Rogers, M.D.
Eric Kress, M.D.	Daniel Combo, M.D.	Charles Bell, M.D.
Terence Calderwood, M.D.	Robert Shields, M.D.	Ted Laine, M.D.
Duncan Hubbard, M.D.	Daniel Harper, M.D.	Lance Hinther, M.D.
R. D. Marks, M.D.	David Westphal, M.D.	

EXHIBIT 42
DATE 3-6-91
SB 168

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME Janet Ellis **BILL NO.** SB 168

ADDRESS _____ **DATE** March 6, 1991

WHOM DO YOU REPRESENT? MT Audubon [redacted] Legislative Fund

SUPPORT X **OPPOSE** _____ **AMEND** _____

COMMENTS: _____

We support Senate Bill 168 as an important step to begin the change in thinking required by managers of day care centers and the parents who bring their children to them. To have discouraged the use of non-disposable diapers has contributed to the national landfill problem. The United States now spends about 300 million dollars per year to discard disposables.

One baby will use about 6000 disposable diapers, compared to 36 cloth diapers during the two and a half years he or she wears them. These disposables may take as long as 500 years to decompose. This information comes from the Update on Diapers, published by the Center For Policy Alternatives in Washington D.C.. We must begin now to reduce input to our landfills and this bill takes down one barrier to that goal. Please vote a "do pass" on Senate Bill 168. Thank you.

HR:1991
CS15

EXHIBIT 43
DATE 3-6-91
SB 168

To: Members of the Public Health Committee.

From: Kay Frey, RN, PNP
Health Consultant
Child Care Resources

Re: Senate Bill 168

I am pleased to support prospective legislation that would allow use of cloth diapers in child care centers. As a health consultant for an agency which provides training and support services (including health care guidance) to Missoula Child care providers, I have been concerned for some time with the environmental impact of the current regulation requiring centers to use disposable diapers for children. With approximately 5000 children in day care sites in Missoula County alone the generation of non-biodegradable waste from disposable diapers is tremendous.

I am confident that allowing day care centers the CHOICE of cloth or disposable diapers will be of health benefit rather than health consequence to this community.

If this legislation passes, I would be pleased to assist in the disbursement of the necessary guidelines to the local day care provider community.

Sincerely,

Kay Frey RN PNP

Kay Frey, RN, PNP
Health Consultant
Child Care Resources

EXHIBIT 44
DATE 3-6-91
SB 168

Child Care Resources

P.O. Box 7038 • Whittier School • Worden Ave. & Phillips • Missoula, Montana 59807
728-6446

February 4, 1991

To: The chairman and members of the Public Health Committee

From: Janet Bush, Child Care Resources

Re: SB 168 - allowing the use of cloth diapers in day care centers.

As one familiar with all the day care facilities in the Missoula area, I support Senate Bill 168, which would allow the use of cloth diapers in licensed day care centers. I find the sanitation guidelines for their use more than adequate to protect the good health of the children and the day care workers. I feel that the toilet training guidelines described in the bill are realistic and in keeping with modern pediatric advice. Further, the experience of Missoula area day care centers (notably Loving Care and Community Hospital Day Care) has proven that cloth diapers can be used safely and without incident in a day care setting.

Many young parents today choose to use non-disposable diapers. Some make this choice out of environmental concern, and the wish to create a better world for their children, some simply cannot afford the expense of disposable diapers. SB 168 will allow these parents the freedom to return to work, yet continue to use cloth diapers. It also will allow day care operators the option of running their centers in accordance with their environmental beliefs.

Sincerely,

Janet Bush

Janet Bush,
Child Care Resources.

EXHIBIT 45
DATE 3-6-91
SB 168

Community

Community Medical Center
2827 Fort Missoula Road
Missoula, MT 59801
(406) 728-4100

January 31,1991

Dr. Brinkley
400 McLeod
Missoula, Mt. 59801

Dear Dr. Brinkley,

I am writing a statement of support for the issue that is now in the legislature; namely that the waiver that is now required by the health department for facilities who use cloth diapers be eliminated. Child care homes and centers should have free choice as to whether they prefer to use cloth or disposable diapers.

Sincerely,

Corrine Hilde

Corrine Hilde
Child Care Services Coordinator

MISSOULA COUNTY
CITY-COUNTY HEALTH DEPARTMENT
301 W. ALDER
MISSOULA, MONTANA 598
(406) 721-57

Doug

46
3-6-91
SB 168

February 26, 1991

Honorable Representative Angela Russell
Human Services and Aging Committee
Montana House of Representatives
Capitol
Helena, MT 59620

Dear Representative Russell,

I am writing regarding SB 168 which proposes a direct change to the Administrative Rules to allow daycare centers to use non-disposable diapers.

I am in support of allowing daycare centers to use non-disposable diapers as long as the soiled diapers are handled in a manner that does not compromise public health. I am not in support of a legislative change to an administrative rule as any future changes would necessarily encumber the legislature. Therefore, I propose one of two options be adopted, either of which could allow for safe use of non-disposable diapers in daycare settings:

1. Amend SB 168 into a resolution dictating that departments allow the use of non-disposable diapers in daycares and amend the administrative rules accordingly, OR;

2. Amend SB 168 to include language about safe handling of soiled non-disposable diapers including the need to immediately deposit the diaper in a non-permeable, covered container and follow with commercial laundering. Daycare operators should not rinse, self-launder, or return soiled diapers to parents as these activities can promote the spread of disease.

Thank you for your consideration of these points.

Sincerely,

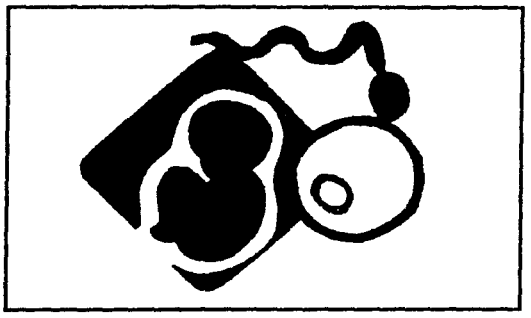
Ellen Leahy
Health Officer

Exhibit # 47
3-6-91 HB 696

THE

MONTANA MEDICAL GENETICS PROGRAM
AT SHODAIR HOSPITAL

840 Helena Avenue
Helena, Montana 59601
1-800-447-6614 (406)444-7530



What is genetic counseling?

Genetic counseling gives information about birth defects or genetic disorders. The defect or disorder may be present in an individual, child, or other relatives. Our staff analyzes the family history and does diagnostic testing if needed. We then explain details of the disorder including inheritance, options, and treatment. Counseling is available during or before pregnancy. We also provide emotional support.

Who should have genetic counseling?

- A woman who will be age 35 or older at the time of delivery;
- Anyone with questions about medications, cigarettes, alcohol, or other exposures during pregnancy;
- Anyone who has a child with a birth defect, learning or growth problems, or genetic disorder;
- Individuals with a birth defect, genetic condition, or a relative with one;
- A woman who has had two or more miscarriages or a stillborn baby;
- Individuals with cancer or a cancer-prone family.

How can I get genetic services?

For an appointment or information, simply call 1-800-447-6614 and ask to speak with a genetic counselor. Genetic services are available statewide.

How much will it cost?

This depends on which services are necessary. No one is denied services because of financial circumstances. We bill insurance, Medicaid, Handicapped Children's Services, and private payors.

Other services available:

- Our laboratory tests the mother's blood to screen for an open spine defect, Down syndrome, and other problems in the fetus;
- In the unfortunate event that a baby is miscarried or stillborn, we can examine the baby to find out why it was lost. We do grief counseling and give information for future pregnancies;
- Other genetic tests are available as necessary;
- Our library has information in everyday language about many genetic conditions.

Exhibit # 47
3-6-91 HB 696

Montana Medical Genetics Program

Genetic Services are Vital for Montana

The Montana Medical Genetics Program (MMGP) is administered by the Department of Medical Genetics at Shodair Hospital through a contract with the Department of Health and Environmental Sciences (DHES). In addition to this funding, the program receives support from fees collected for clinical services, from third-party payment for the services, and from Montana Children's Home and Hospital Foundation. The MMGP provided genetic services to approximately 3300 Montanans at Shodair Hospital and through a statewide network of outreach clinics in 1989.

Current Need

In industrialized countries, over one-half of all human morbidity and mortality is due to genetic disorders, imposing an enormous economic cost on the population.

Congenital malformations are the number one cause of infant mortality and survivors face a lifelong risk of handicap, suffering, and maladjustment as well as transmission of their condition to offspring.

One-third of pediatric admissions to hospitals are due to conditions with a genetic cause.

Fifteen to twenty percent of the population, approximately 112,000 to 150,000 Montanans, are affected by or at risk of transmitting a genetic condition.

There are an estimated 40,000 carriers for cystic fibrosis in Montana alone.

A substantial proportion of chronic disorders of adult onset such as diabetes, hypertension, heart disease and cancer are genetically predisposed.

Expense of Genetic Conditions

The average yearly cost for a teenager with Down syndrome at home is $24,213 and in an institution is $42,728.

Using 1987 dollar figures, the U.S. expends $8 billion per year for individuals with chromosome abnormalities. With an incidence of 5.6/1000, there were approximately 67 infants born in Montana with untreatable chromosome conditions at an estimated lifetime cost of $25 million.

On the average, an individual with cystic fibrosis requires hospitalization numerous times per year at a cost of $7,262 per admission. Average cost for non-cystic fibrosis individuals is $2,912 with similar pulmonary problems.

Lifetime costs for a person with typical severe spina bifida (in 1985 dollars) are $250,000.

Parents of handicapped children are more than twice as likely to divorce and abuse occurs more often when there is a retarded child in the family.

Reimbursement for Clinical Services

The average patient receiving services requires four to five hours of time; 60-90 minutes is actually spent with the patient; the remainder is spent in complex preparations and follow-up for which no billing mechanism exists. Collection for fees covers only *38%* of personnel costs.

Solutions

Comprehensive genetic counseling will prevent unnecessary abortion of normal babies perceived to be at high risk by ill-informed parents and will allow confident reproduction by those previously fearful of having further affected children.

Early diagnosis of a genetic condition will facilitate appropriate management. For example, early diagnosis of familial hypercholesterolemia leads to effective treatment and prevents costly bypass surgery and early death of the affected individuals.

Continued funding for genetic services will ensure statewide access for Montanans to timely diagnosis, genetic counseling, and patient care.

(Please see more Medical Genetics information on page 10.)

MONTANA MEDICAL GENETICS PROGRAM: Problems and solutions

The Montana Medical Genetics Program (MMGP) is administered by the Department of Medical Genetics at Shodair Hospital through a contract with the Department of Health and Environmental Sciences (DHES). In addition to this funding, the program receives fiscal support from fees collected for clinical services and from the Montana Children's Home and Hospital Foundation. The MMGP provided genetic services to approximately 3300 Montanans at Shodair Hospital and through a statewide network of outreach clinics in 1989.

Problem 1. Current Need

In industrialized countries, over 1/2 of all human morbidity and mortality is due to genetic disorders, imposing an enormous economic cost on the population.

- Congenital malformations are the number one cause of infant mortality and survivors face a life-long risk of handicap, suffering, and maladjustment as well as transmission of their condition to offspring.

- One third of pediatric admissions to hospitals are due to conditions with a genetic cause.

- Fifteen to 20% of the population, approximately 112,000 to 150,000 Montanans, are affected by or at risk of transmitting a genetic condition.

- There are an estimated 40,000 carriers for cystic fibrosis, an inherited genetic disorder, in Montana.

- A substantial proportion of chronic disorders of adult onset such as diabetes, hypertension, heart disease and cancer are genetically predisposed.

Problem 2. Expense of Genetic Conditions

- The average yearly cost for a teenager with Down syndrome at home is $24,213 and in an institution is $42,728.

- Using 1987 dollar figures, the U.S. expends $8 billion per year for individuals with chromosome abnormalities. With an incidence of 5.6/1000, there were approximately 67 infants born in Montana with untreatable chromosome conditions at an estimated lifetime cost of $25 million.

- On average, an individual with cystic fibrosis requires hospitalization numerous times per year at a cost of $7,262 per admission. Average cost for non cystic fibrosis individuals is 2,912 with similar pulmonary probblems.

- Life time costs for a person with typical severe spina bifida (in 1985 $) are $250,000.

- Parents of handicapped children are more than twice as likely to divorce and abuse occurs more often when there is a retarded child in the family.

Problem 3. Reimbursement for Clinical Services

- The average patient receiving services requires 4-5 hours of time; 60-90 minutes is actually spent with the patient; the remainder is spent in complex preparations and follow-up for which no billing mechanism exists. Collection for fees covers only 38% of personnel costs.

Solutions:

1. Comprehensive genetic counseling will prevent unnecessary abortion of normal babies perceived to be at high risk by ill-informed parents and will allow confident reproduction by those previously fearful of having further affected children.

2. Early diagnosis of a genetic condition will facilitate appropriate management. For example, early diagnosis of familial hypercholesterolemia leads to effective treatment and prevents costly heart surgery and early death for affected individuals.

3. Continued funding for genetic services will ensure statewide access for Montanans to timely diagnosis, genetic counseling, and patient care.

Summary: Genetic services are vital for Montana

Accurate, readily accessible genetic services are a sensible choice for the State. The loss of services would require Montanans to travel large distances out of state for care at an exorbitant cost. Available services serve to educate individuals about their risk of handicap and alternative methods for reproduction (e.g. artificial insemination, adoption) can be explored.

Lodair Genetics Clinics 1990
held at:

EXHIBIT 47
DATE 3-6-91
HB 696

Sidney
Miles City
Billings
Bozeman
Crow
Butte
Great Falls
Kalispell
Missoula
Browning
Butte cleft
Msla cleft
Great Falls cleft
Billings cleft
Billings Hemoph.

EXHIBIT 48
DATE 3-6-91
HB 696

HB696: AN ACT TO CONTINUE FUNDING FOR THE MONTANA MEDICAL GENETICS PROGRAM

Testimony by Dr. John M. Opitz, M.D., M.D.(hc), D. Sci.(hc)
Chairman, Department of Medical Genetics, Shodair Hospital Clinical Professor of Pediatrics and Medicine (Medical Genetics), University of Washington; Adjunct Professor of Medical Genetics and Pediatrics, University of Wisconsin-Madison; and Adjunct Professor of Biology (Genetics), History, Medicine (WAMI) and Veterinary Science, MSU, Bozeman.

Date: 6 March, 1991, House Human Services and Aging Committee

History:

Genetic services have been provided in Montana since Dr. Pallister established a Genetics unit at Boulder in 1961 under the Department of Institutions; when Dr. Pallister retired from Boulder in 1976 that unit closed and the Board of Trustees of Shodair Children's Hospital asked him to establish a Genetics and Birth Defects unit at Shodair. This was and still is the only Medical Genetics unit in Montana. In 198- this became the Department of Medical Genetics of Shodair Hospital.

In 1985 the 49th legislature passed HB430 which established and funded 50-19-211 MCA - the voluntary genetics program (Montana Medical Genetics Program). This "program includes, but is not limited to, the following services:

1.) Follow-up programs for newborn testing, with emphasis on the counseling and education of women at risk for maternal phenylketonuria;

2.) comprehensive genetic services to all areas of the state and all segments of the population;

3.) development of counseling and testing programs for the diagnosis

and management of genetic conditions and metabolic disorders; and

4.) development and expansion of educational programs for physicians, allied health professionals, and the public with respect to:

a.) the nature of genetic processes;

b.) the inheritance patterns of genetic conditions; and

c.) the means, methods, and facilities available to diagnose, counsel, and treat genetic conditions and metabolic disorders."

Thus, I need to stress that the Montana Medical Genetics Program is a service, not a research program. We are serious about the teaching provisions of the law so long as they don't interfere too extensively with our service obligations. The scholarly or scientific work we do is done on our own time. The time I spend editing the American Journal of Medical Genetics is reimbursed by the publisher.

In 1987, the 50th legislature re-appropriated funds for the program under HB716 with the same insurance premium-tax funding mechanism by a 3:1 vote. In 1989 Blue Cross/Blue Shield supported HB402 for the continuation of the Montana Medical Genetics Program under the same funding mechanism. We are asking for your favorable consideration of HB696 under this same funding mechanism to continue the Montana Medical Genetics Program for another 2 years on the basis of the need for and the merits of the program.

Need for the Program:

The weekend of March 3,4 this year I worked with the Finance and Legislative Committee of the Mountain States Regional Genetic Services Network to define our goals, objectives and working agenda for the coming year. Our goal is: "To work toward assuring accessible, available and affordable genetic services as an integral part of health care in this

region." In the history of American medicine this is a late development; in most Western European countries genetic services have been an integral part of the health care plan for the greater part of the century. By avoiding this commitment in America and concentrating rather on basic science and applied agricultural genetics, America escaped most of the consequences of eugenics; the concept of "genetic counseling" was not introduced into America until 1948, and modern clinical genetics (as a merger of medicine, biochemistry, cytogenetics and human genetics) did not begin till 1959. I have been an enthusiastic part of American clinical genetics since its beginnings in 1959, and at the invitation of my friend Dr. Philip D. Pallister have practiced clinical genetics in Montana, part-time since 1963, full time since June of 1979. During that time we have witnessed three historical developments of greatest importance to Montana Medical Genetics.

First - the enactment of the "Javits bill" - the National Genetic Disease Act, which supported the development of the Montana Medical Genetics Program at $100,000.-/year for 4 years (1981-1984).

Second - the distancing of the Reagan and Bush administrations from the Javits bill provisions so that as of 1984 federal funding of the National Genetic Disease Research, Educational and Service Program ceased; a small amount in indirect funding is available through the so-called SPRANS grants of the Bureau of Maternal and Child Health. One of these grants supports the activity of the Mountain States Genetic Services Network, another the genetic services of Dr. Susan Lewin of The Montana Medical Genetics Program to Disadvantaged Minorities at Lodge Grass and at Browning; this is a Maternal Child Health Grant which pays for 30% of her salary for another 1 1/2 years.

Third - the rise of molecular biology as an integral part of modern medicine and as one of the most important determinants that is beginning to and in the near future will drive the demand for services from the Montana Medical Genetics Program.

No one questions in the slightest the continuing great need of Montana for funds to support the Montana Wheat and Barley Program. May I remind you that in 1990-1991 $1,450,000.- was appropriated for the Wheat and Barley Committee, $200,000.- more than the previous year, 38% going for research (mostly to MSU) and funded by an assessment of 1.5 cents per bushel where the grain is first sold. After adding the budgets of the Montana Wheat and Barley and Poultry and Livestock programs, the comparison with the Montana Medical Genetics Program is quite impressive, especially since none of the funds for the Medical Genetics Program are used for research, only service (or "Extension", if you will).

In Montana, no less than in the rest of the nation, some 15-20% of the people are in need of a genetic service, whether that is diagnosis, counseling, prenatal diagnosis, chromosome studies or fetal pathology; this means 123,000 to 164,000 persons in Montana, including 40,000 alone who are carriers of cystic fibrosis. Because of limited staffing we can serve only a small fraction of this need per year.

The economic cost to Montanans of the genetic disease in our population is staggering; at a conservative estimate of 54% of the health budget, this comes to approximately $1000.-/person/year, compared to that 75 cents per health-insured person is a trivial sum indeed!

EXHIBIT 48
DATE 3-6-91
HB 696

Cost of the Program

No clinical genetics program anywhere pays for itself through fees and third party payments. That is because clinical genetics is an extremely labor-intensive activity with heavy requirements for library and information services which generate virtually no income, and because of the need to see many patients and families unable to pay a part or any portion of their bill. We receive no support from the universities with whom we are affiliated, and Shodair Hospital is no longer able to offset our annual budget deficit.

Staffing:

The success of the Program is due not only to the support by Shodair but due to the extraordinary quality, qualifications and stability of our staff. In "hard" budgetary terms we have 2.2 physicians, 2 genetic counselors, 2/3 FTE medical technologist, 2 support staff and 5 cytogenetics staff persons including our newly appointed Cytogenetics Lab Director, Dr. Jean Priest, formerly Professor of Pediatric Genetics at Emory University, and author of a standard textbook on the subject.

In comparison with neighboring states we are understaffed rather than overstaffed, e.g.

	Montana	Utah
Population	820,000	1,600,000 (2x)
Area (sq. m.)	147,046	84,899 (60%)
Geneticists	2.2	4.4
Counselors	2.0	2.6 (in Genetics)

In 1991, we have scheduled 44 field clinics in Billing, Great Falls, Browning, Missoula, Lodge Grass, Bozeman, Butte, Kalispell, Sidney and

Miles City; that means our staff will spend 91 days and 24,818 miles on the road this year - a fraction of the effort expended by the staff in Utah where most population is concentrated in one area.

Progress

Our Progress and Financial Reports are filed annually with and available from the DHES and document dramatic increases over recent years in demand for services at a stable staff and funding level. These reports do not tell the whole story - namely, that in many respects our Program is unique in the nation in virtually all respects - whether that is in prenatal diagnosis, cytogenetics, library services, fetal pathology, cancer genetics, computerization, or linkage with regional programs. We are able to capitalize on the many strengths of this program by e.g. enlisting the collaboration of Dr. Enid Gilbert's Pediatric Pathology Program at the University of Wisconsin which provides over $150,000.- of free services to us per year, the ability to consult, for free, hundreds of experts in the field throughout the world, and to have access to the latest advances in the field through the American Journal of Medical Genetics.

Alliances:

Out of our work has come a very strong alliance between the Montana Medical Genetics Program and the health care providers in Montana, and state, county, municipal, university and numerous voluntary agencies to provide the best possible medical genetic care for the people of Montana so that in as few cases as possible no child is conceived in vain or has to live in pain because of a birth defect or hereditory disease.

Program Support

The Montana Medical Genetics Program has or is anticipating support of:

° The Department of Health and Environmental Sciences who award the contract for the Montana Medical Genetics Program.

° The Montana Chapters of:

- The American College of Obstetrics and Gynecology;
- The American Academy of Pediatrics;
- The American Hospital Association;
- The American Public Health Association;
- The American Nurses Association.

° The Montana Perinatal Association

° Child and Family Services of Montana

° The March of Dimes - Birth Defects Foundation

° The Montana Center for Handicapped Children

° The Developmental Disabilities Council of Montana

° The Montana Children's Alliance

° The Maternal-Child Health Council

° The Montana Medical Association

and many other organizations and individuals who are writing and appearing in support of this legislation and Program.

Cost-Benefit Considerations:

No price can be set on a human life. Our strong preference is to think of the benefits bestowed by the Program on Montana in terms of the conceptions, pregnancies and births of normal individuals that we have encouraged over the years through our activities. Nevertheless, benefit-to-cost ratio studies of genetic services have been published, and

show that clinical genetics is by far the most cost-effective form of preventive medicine, in some cases, leading to ultimate savings of thousands of dollars in cost for every dollar invested; a lesson, I am sure, that is not lost on the health insurance industry. The calculations of such cost-benefit ratios are somewhat abstract exercises. However, more concretely I should like to tell you about a 17-year-old boy from Northern Montana who was referred to us recently for genetic counseling with Wilson disease. Wilson disease is a recessive disorder which is lethal without treatment. The boy was being treated with penicillamine pending a liver transplant at the Mayo Clinic. Before our evaluation, his 21-year-old brother and 13-year-old sister had been evaluated clinically and by a lab test, and on the basis of these results their parents were told that these sibs were unaffected. After our evaluation it was found that the lab test was inadequate to rule out the diagnosis and we recommended additional tests which showed that both are also affected with Wilson disease. Even though clinically asymptomatic, both are now being treated with penicillamine which may prevent deterioration and need for a liver transplant (with estimated cost of $1.2 million for both) and will allow them to live a normal and productive life.

Quality Assurance:

Our program complies with all Quality Assurance requirements of the Joint Commission on Hospital Accreditation. We have had peer reviews in clinical genetics and our labs are fully licensed, certified and accredited.

Pro-Life Assurance:

Genetic services encourage the conception and birth of normal individuals and, in 96% of the time, reassure pregnant women after prenatal diagnosis that they are carrying a normal child, avoiding termination if genetic services had not been available.

Finally, I must stress that this is primarily the Montana, not the Shodair Medical Genetics Program, since the contract to provide the services is awarded competitively after submission of a grant application.

We should like to request your favorable consideration of HB696.

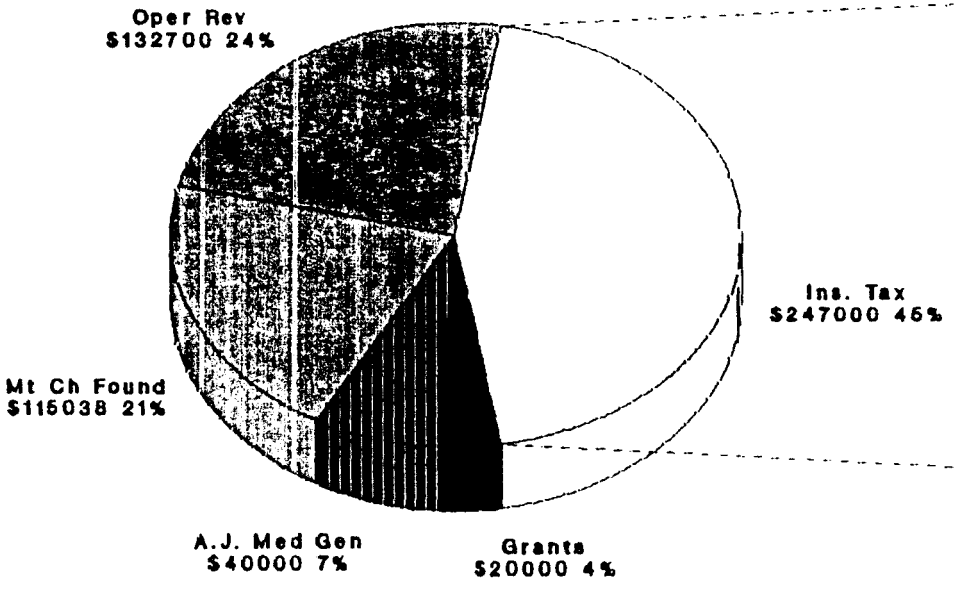
Respectfully submitted,

John M. Opitz, M.D.

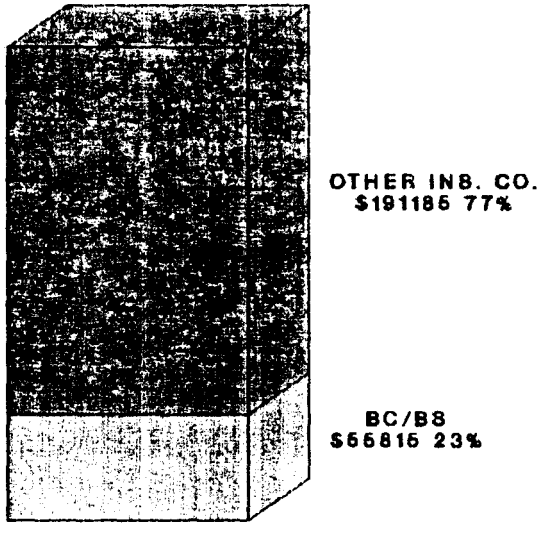
Director, Montana Medical Genetics Program

Shodair Hospital
Department of Medical Genetics

State of Montana
Contract



Funding Sources



Ins. Co. Breakdown

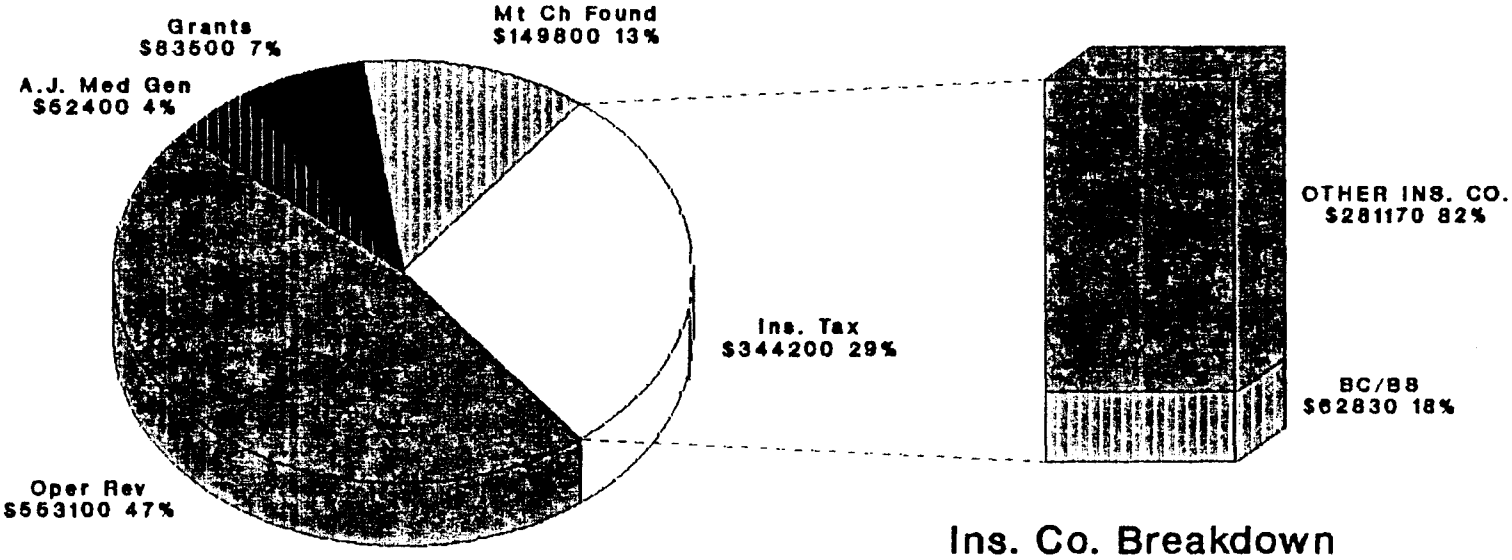
Total Budget FY '86 = $554,738

Data Source: Insurance Commissioners office

EXHIBIT 44
DATE 3-16-91
HB 696

Shodair Hospital
Department of Medical Genetics

State of Montana
Contract



Ins. Co. Breakdown

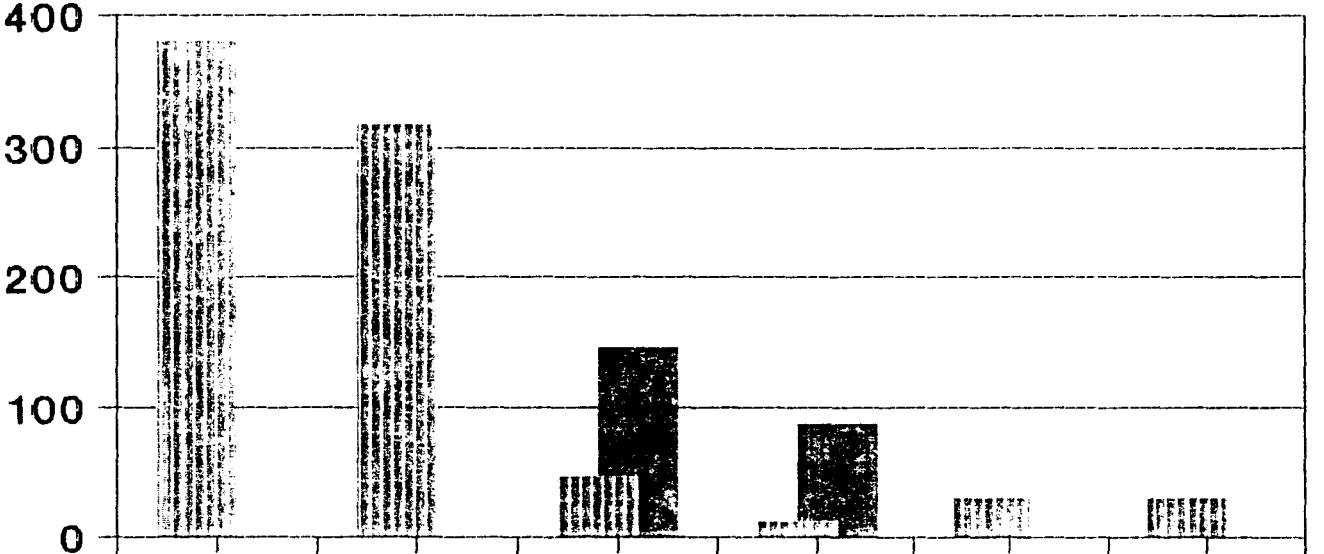
Funding Sources

Total Budget FY '91 = $1,183,400

Data Source: Insurance Commissioners office

HB 101

% Increases in Funding
Effect of .75 on Insurance Industry



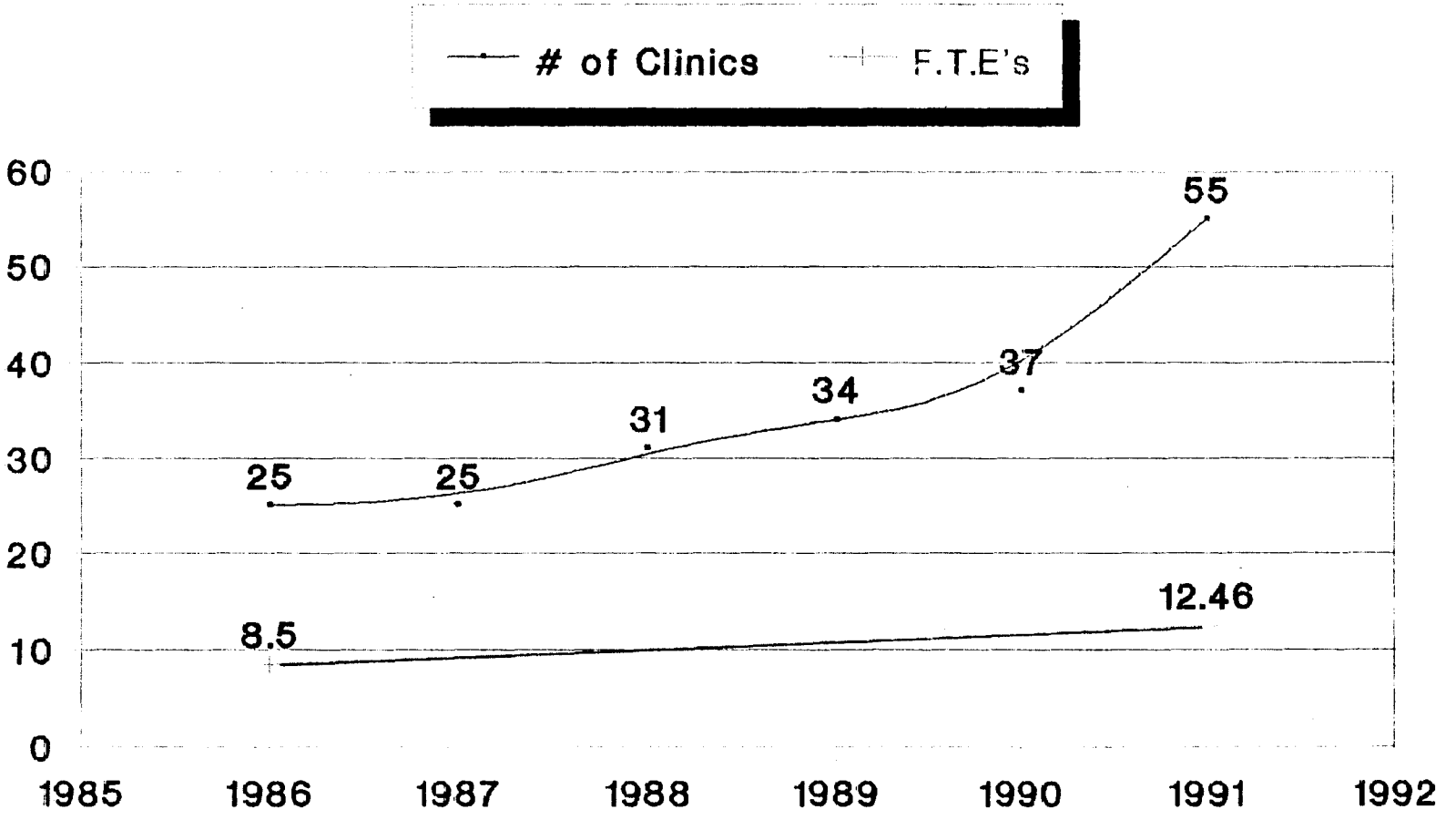
	Oper Revenue Grants		Other Insur	BC/BS	Mt. C. Fd	AJ Med Gen
At .75/insured			146.55	87.62		
FY '86 vs '91	380.8	317.5	47.07	12.57	30.22	31

FY '86 vs '91 At .75/insured

DATE 3-11-91
HB 640

STATEWIDE GENETICS PROGRAM

Shodair Children's Hospital

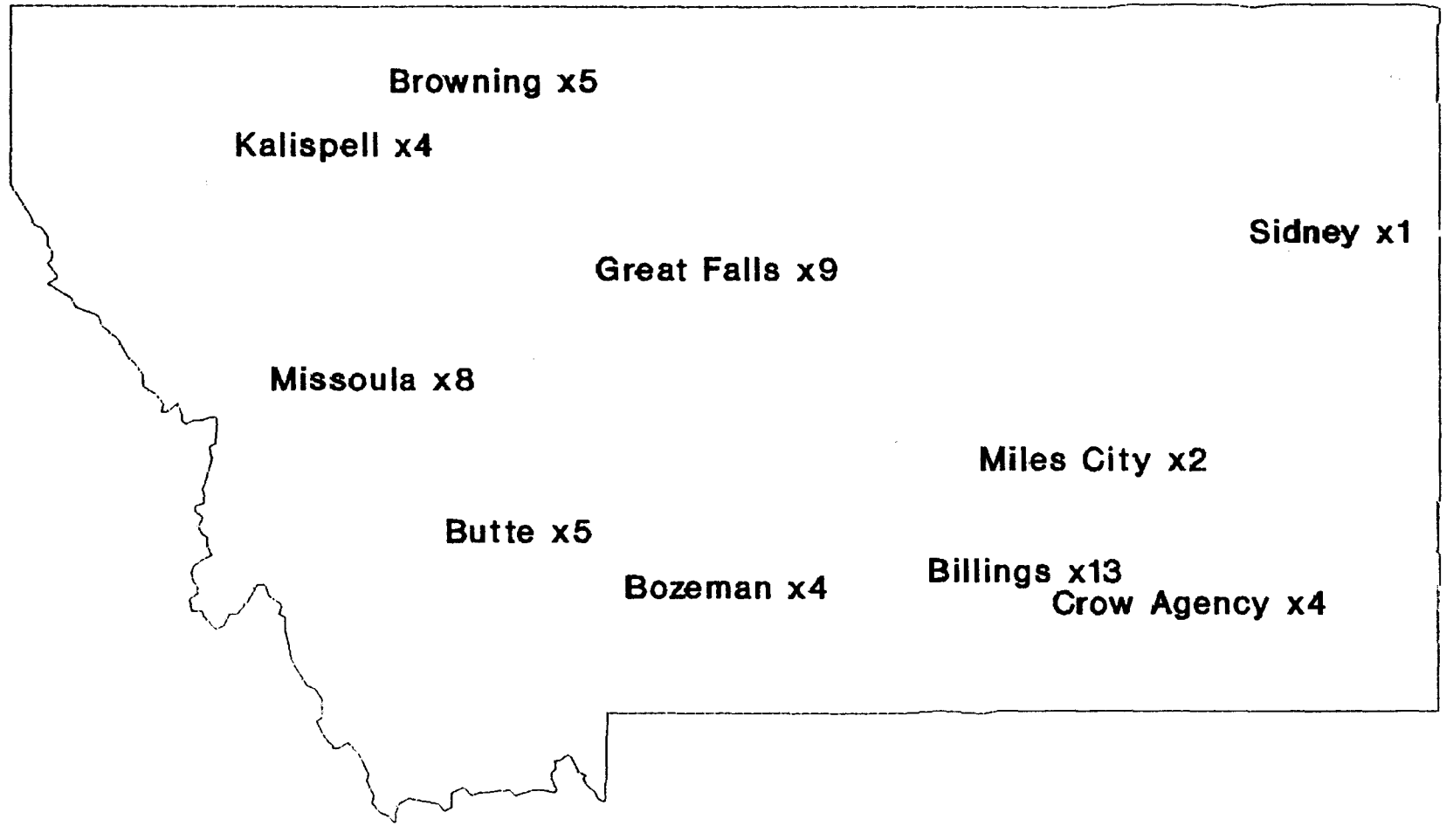


120% Increase In the # of Clinics

46.59% Increase in F.T.E.'s

EXHIBIT 1
DATE 3-4-91
HB 696

STATEWIDE GENETICS PROGRAM



55 Clinics Scheduled for FY '91

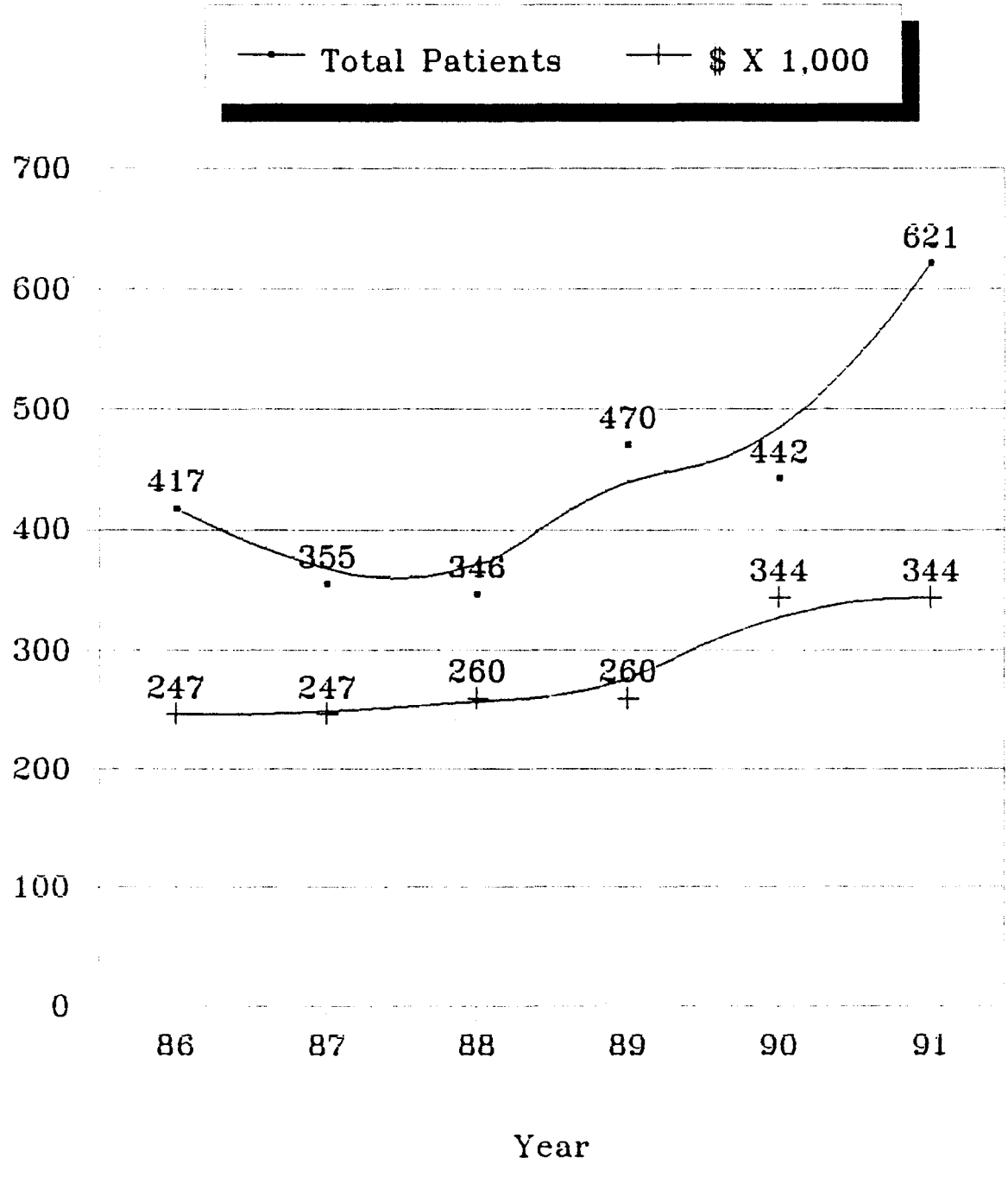
EXHIBIT 44
DATE 3-6-91
HB 696

EXHIBIT 44
DATE 3-6-91
HB 696

SHODAIR CHILDREN'S HOSPITAL

Total Patients

Workload vs Funding



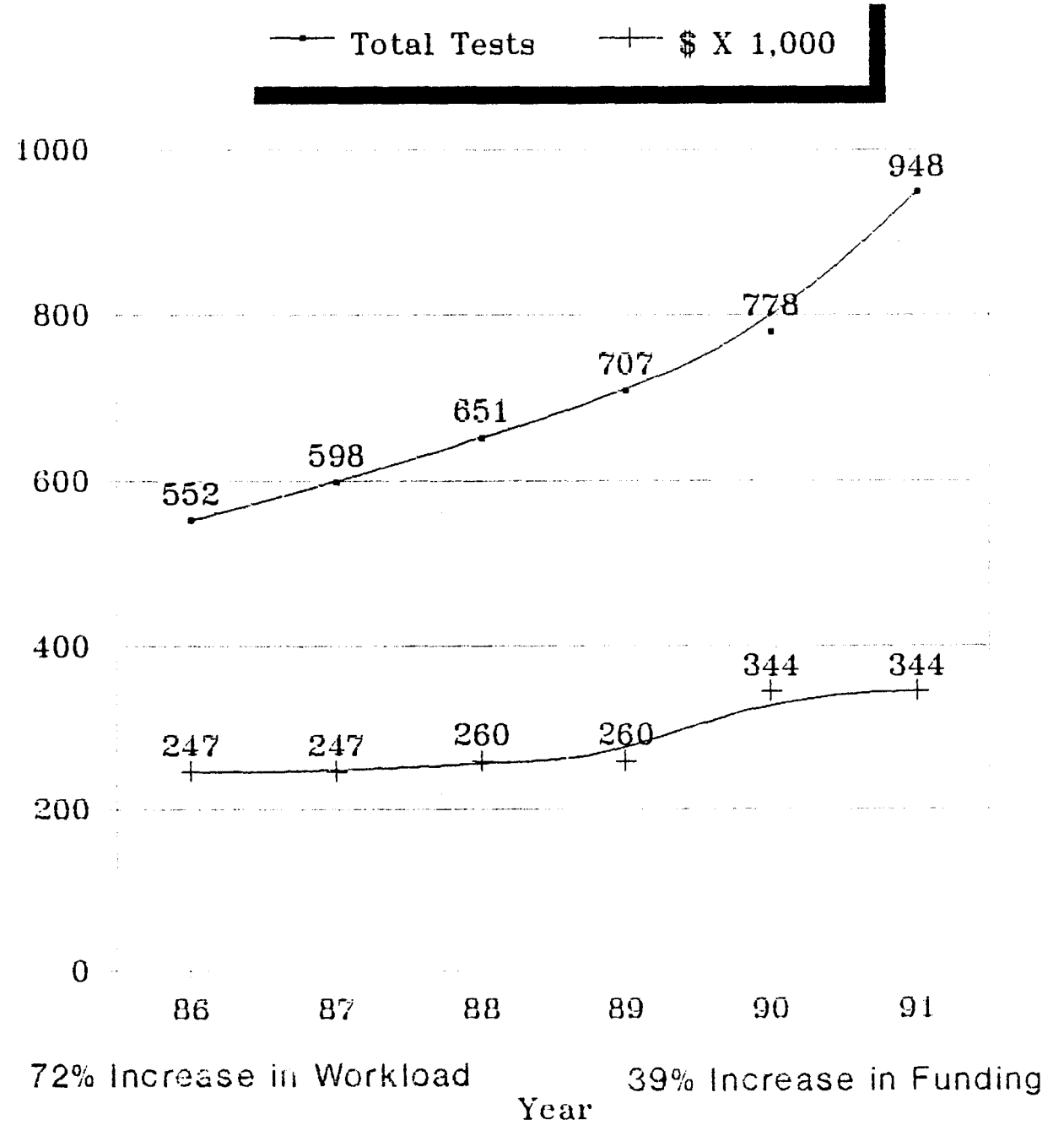
Projected thru FY '91

EXHIBIT 49
DATE 3-6-91
HB 696

SHODAIR CHILDREN'S HOSPITAL

Cytogenetics Laboratory

Workload vs Funding



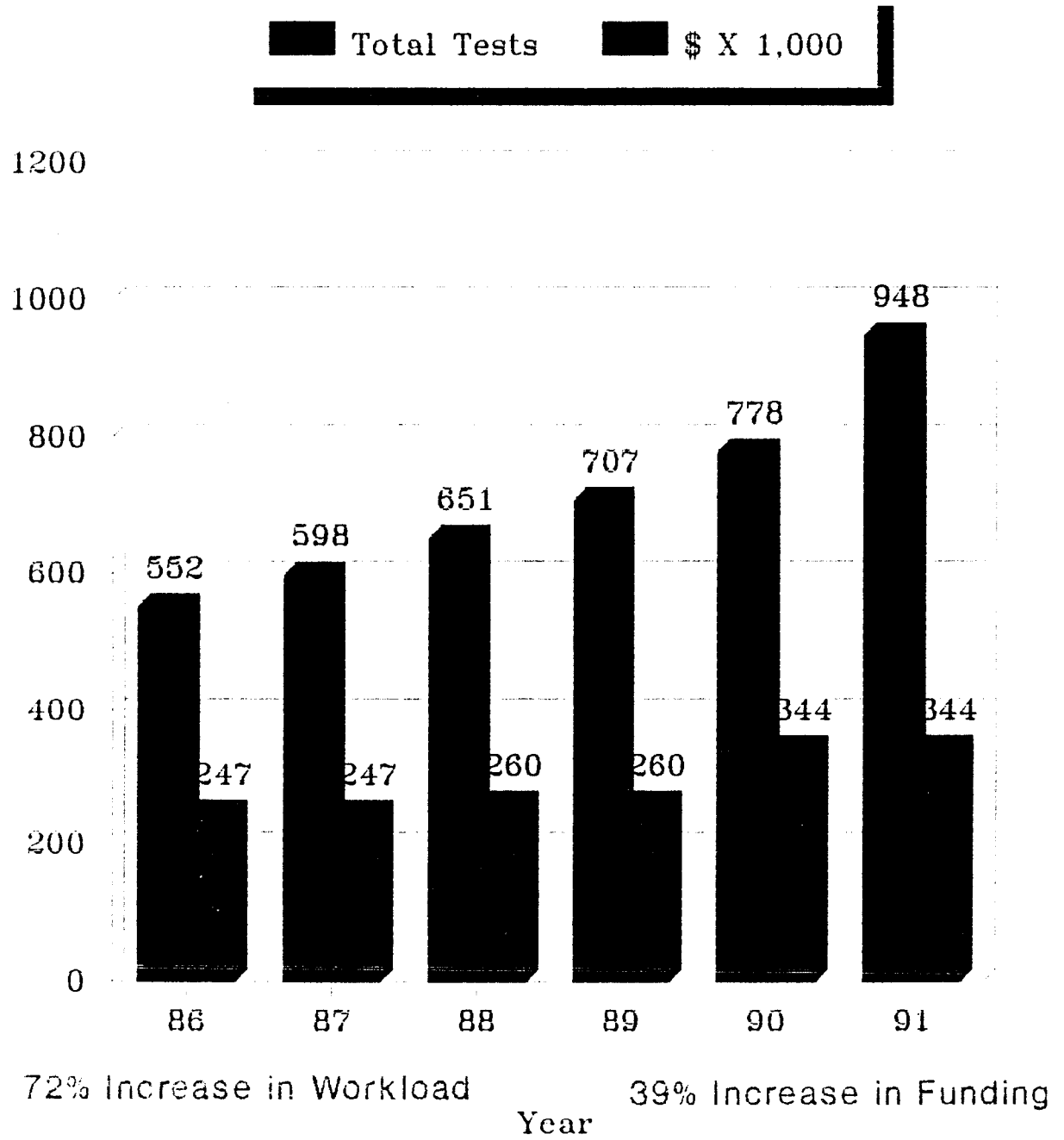
Projected thru FY '91

EXHIBIT 49
DATE 3-6-91
HB 696

SHODAIR CHILDREN'S HOSPITAL

Cytogenetics Laboratory

Workload vs Funding



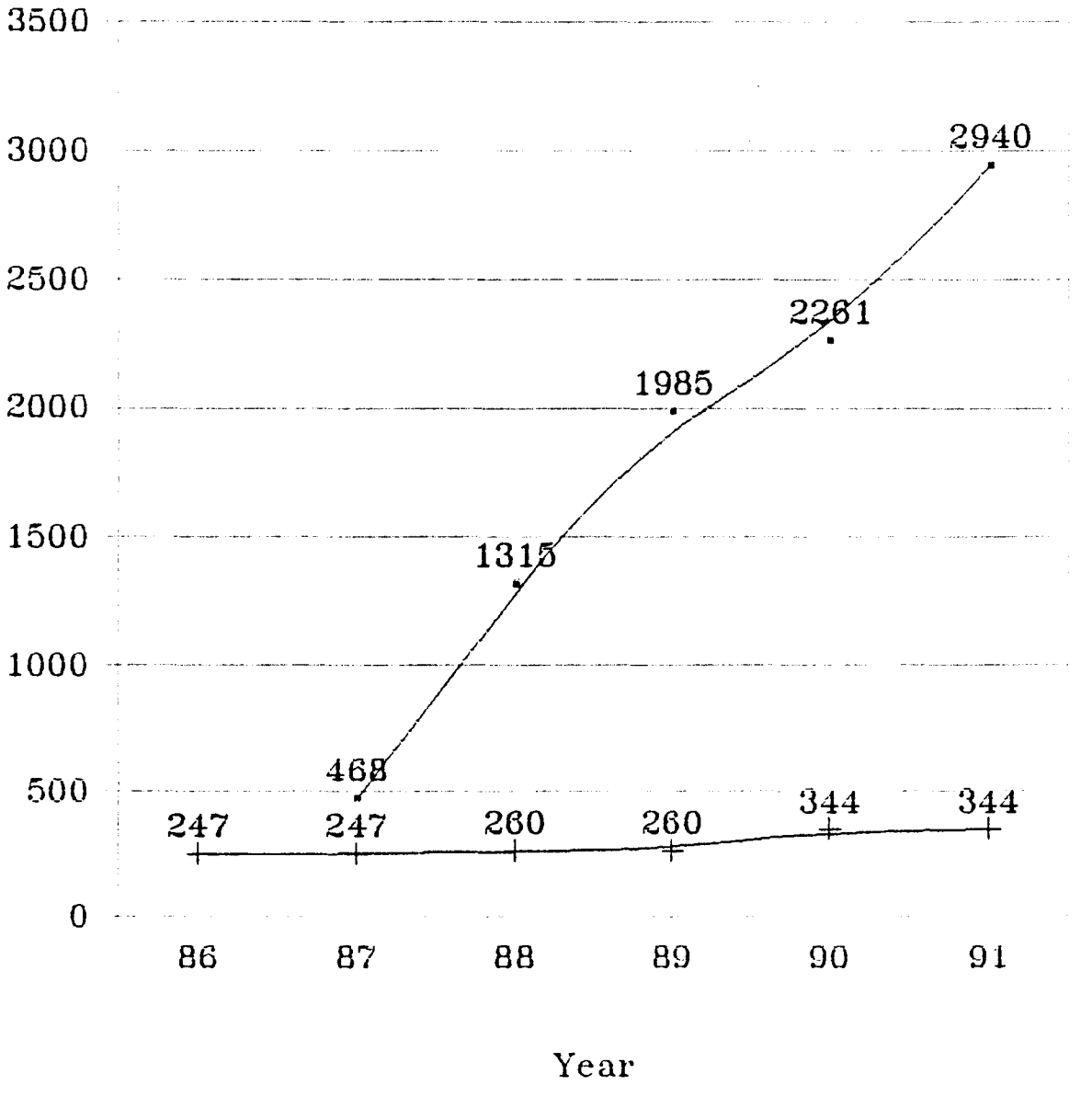
Projected thru FY '91

EXHIBIT 44
DATE 3-6-91
HB 696

SHODAIR CHILDREN'S HOSPITAL

AFP Laboratory

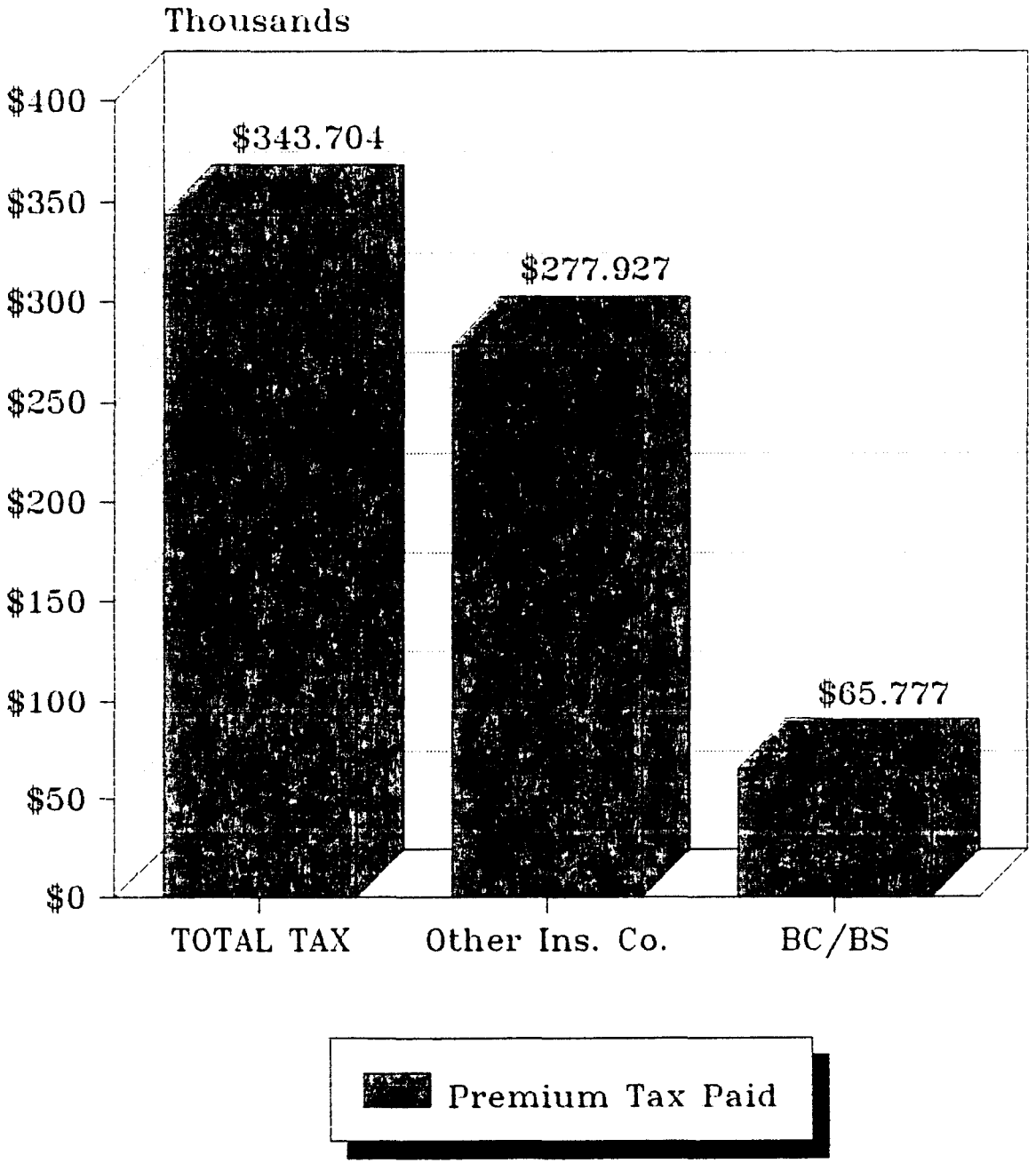
Workload vs Funding



Projected thru FY '91

EXHIBIT 49
DATE 3-6-91
HB 696

Shodair Hospital
Department of Medical Genetics



Data Source: Insurance Commissioner

3-6-91

Exhibit 50 contains 13 clippings about Shodair's genetic clinics. The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

EXHIBIT 51
DATE 3-6-91
HB 696

March 1, 1991

TO: Montana State Legislature

FROM: Jeanette McCormick
Choteau, Montana

I am writing this letter in support of Shodair Hospital and it's genetics testing program.

My first contact with Shodair came in 1987 following my amniocentesis. The results of the amnio showed that my child would be born with Down Syndrome. The options were presented to me and my husband, and we chose to continue tbe pregnancy. We feel very fortunate to have had this knowledge five months in advance of our son's birth. It gave us the chance to deal with our emotions so that when Meade was born it was a "joyful" occasion. It also gave me the time I needed to find out all I could about Down Syndrome so that I could plan a course of early intervention for him and anticipate any medical problems that he might have.

Recently I underwent a chorionic villi sampling (CVS) to determine the genetic health of my unborn child. The CVS, a relatively new procedure that can be done early in the pregnancy, is yet another diagnostic tool for older pregnant women such as myself to gain advance awareness of any genetic conditions that might exist in their unborn children. I am pleased to report that my child is chromosomally normal, so I now can relax and enjoy the last months of my pregnancy.

The people I have dealt with at Shodair have been both knowledgeable and compassionate. The reputation of the genetic's staff is respected not only statewide, but internationally. Montana should be proud to have such a fine facility and staff located in their state. The services Shodair provided for me were invaluable, and I hope that the Legislature will make it possible for them to continue to offer their excellent and necessary services to others.

Sincerely,

Jeanette McCormick

END

5C
3-6-91
696

MONTANA CHILDREN'S ALLIANCE

P.O. Box 876, Helena, Montana 59624 (406) 449-8611

HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

SUPPORT FOR HB 696

Date: March 6, 1991

The Montana Children's Alliance, whose members include individuals and organizations who have a primary interest in children and their unmet needs, supports funding the Montana Medical Genetics Program.

The Montana Medical Genetics Program provides an excellent program for Montana's mothers, children and families. The program provides services Montana citizens would have to travel long distances to obtain out of state. The Montana Medical Genetics Program conducts visiting clinics in a number of communities in the state providing Montana citizens with access to quality genetic services.

The genetic counseling and care of genetic problems are services essential in planning a pregnancy and reducing birth defects.

The Montana Children's Alliance wholeheartedly asks your support for HB 696.

Respectfully Submitted,

D. Elizabeth Roeth
Chair

montana public health association

Since 1918

EXHIBIT 53
3-6-91
696

Testimony Before the House Human Services and Aging Committee
HB 696
An Act to Continue Funding for the Statewide Genetics Program
March 6, 1991

Madame Chairperson and Members of the Committee: I am Robert W. Moon, President of the Montana Public Health Association. For the record, the Montana Public Health Association (MPHA) is in support of HB 696.

Advances in genetic knowledge and technology along with changes in family size and social values have greatly affected prenatal care in this state. Diagnostic methods in the preconception and pregnancy phase play an important role in providing families, who choose to have such information, with a more informed basis with which to make reproductive decisions. With increased utilization of technologies, such as ultrasonography and amniocentesis, the downward spiral of infant deaths can continue.

With the rapid advances now occurring in genetic screening and diagnosis, genetic disorders are important in all phases of the life cycle. The role of genetic components of common human diseases such as coronary heart disease, hypertension, certain cancers, and mental illness is widely appreciated. The need for genetic services in Montana, including clinical evaluation, diagnosis, counseling, specialized laboratory testing, treatment and referral, and public and professional education will continue to grow. We are truly fortunate to have the high quality expertise available in such a rural environment.

The MPHA supports the public health implications of genetic services by:

1. improving the accessibility and availability of quality genetic services.
2. increasing the role of consumers in policy making regarding the provision and utilization of genetic services.
3. coordinating professional education to ensure widespread quality service delivery.
4. increasing the role of public health agencies in referral and appropriate long-term follow-up services.
5. increasing awareness of the knowledge of genetic disorders and ways to treat and prevent them.
6. and, raising the issues of public policy which require debate and consensus for integration into public health services.

If Shodair Hospital's Department of Medical Genetics can assure these services, MPHA is in full support of HB 696.

5A
3-6-91
696

Montana Council for Maternal and Child Health

The Voice of the Next Generation
in Montana's State Capitol

2030 11th Ave., Suite 10 | Helena, MT 59601 | (406) 443-1674

TESTIMONY FOR THE HOUSE HUMAN SERVICES COMMITTEE
In Support of HB 696, Statewide Genetics Program
Date: March 6, 1991

The Montana Council for Maternal and Child Health. a non-profit public policy research, education, and advocacy organization, supports HB 696, permanently funding the Montana Medical Genetics Program.

The Montana Medical Genetics Program has clearly proved its effectiveness. It has brought genetic services to the widely scattered communities of rural Montana, and has enabled state-of-the-art diagnostic testing, which was previously available only out-of-state, to be within reach of every Montana citizen, regardless of ability to pay.

The benefits for Montana go far beyond the benefit to the individual mother, father, or child who is spared some of the suffering caused by genetic abnormalities through early diagnosis and treatment. By working to identify and prevent genetic problems, and to facilitate early intervention for children born with genetic abnormalities, this program contributes to the ability of Montana's next generation to grow into a strong and capable work force for the future.

It is time for this program to be incorporated permanently into the Department of Health and Environmental Sciences budget, with a permanent revenue source.

Thank you for your attention.

Paulette Kohman

Paulette Kohman
Executive Director

EXHIBIT 55
DATE 3-6-91
HB 696

STATE AUDITOR
STATE OF MONTANA

Andrea "Andy" Bennett
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

March 5, 1991

Mr. Jack Casey, Administrator
Shodair Children's Hospital
840 Helena Avenue
Helena, MT 59604

Dear Mr. Casey:

We are able to provide you with the following information in answer to your recent inquiry concerning Genetics Program Charge collections.

This charge is imposed on private health insurers, health service corporations, and the state group health self-insurance plan. In fiscal year 1989, the charge was assessed at the rate of 35 cents per Montana resident insured under any individual or group policy as of February 1, 1989. As a result of a change enacted by the 1989 legislature, the rate was 45 cents per Montana resident covered as of February 1, 1990, in fiscal year 1990. Our office collected $267,629 in fiscal year 1989 and $343,704 in fiscal year 1990 under this law. This means that a total of 764,654 Montana residents were covered under the policies of the reporting insurance organizations as of February 1, 1989, and 763,785 were covered as of February 1, 1990. Because some Montana residents are covered under the policies of more than one insurer, these figures do not indicate the number of Montanans with health insurance.

If we can provide additional assistance, please contact me.

Sincerely,

Russell Ehman

Russell Ehman
Insurance Examiner

RE/flo(5092)

MONTANA WOMEN'S LOBBY

P.O. Box 1099 Helena, MT 59624 406/449-7917

56
3-6-91
HB 937

Kate Cholewa
Montana Women's Lobby
Re: HB 937

Child care is increasingly becoming one of the foundational services of our society. To care for our children, we need money. To get money, we must work. To work, we need child care. The question as to whether one should have children one can't afford becomes mute once the child is there. The reality is that there are single parent households and households wherein both parents must work to pay the costs of tending for a family. Affordable, safe child care provides a nurturing environment for the child and allows a parent to live with less stress which, in turn, leads to better parenting. Down in the Appropriations Subcommittee for Human Services, I heard a lot of money going to help children victims of child abuse as well children perpetrators of crimes. Many references were made to helping families so that these problems might never arise. Child care helps families live with self-esteem, nourishment, and prosperity.

I feel the need to include the foresaid because, having sat down in Appropriations for Human Services the first half of the session, I realize how tight money is and how numerous are the needs. But child care effects women, children, men, and all races. Poor child care resources fattens the budget with the costs of alcohol programs, crime rehabilitation programs, etc. Without quality child care, which is a family support program, the house of cards collapses.

I will leave the explaining of most of this bill to others. I would like to make just one point:

The Resource and Referral Program you see listed as #2 in section 3 needs the $100,000 to continue its services to the community. The Appropriations Subcommittee on Human Services intended to fund this program. It was discovered only later that the funding provided only funded DFS and SRS's contracted services with the R & Rs. The R & Rs as a community services program has no funding source from July 1 until sometime in November.

HOUSE OF REPRESENTATIVES

1062

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. SJR 9

DATE 3-6-91 SPONSOR(S) Sen. Pinsoneault

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
John ORTWEIN	MT. CATHOLIC CONF.	SJ9		X
Doris Fortin	M.S.C.A.			+
Elmer Faith	M S C A			X
Helen McKnight	M S C A			X
Alyce W. Miller	M S C A			X
Alice Campbell	M S C A			X
Dorothy Hellstern	M S C A			X
DAVID HOST	Self			X
Arlene Tryde	CS & KT			X
JUDITH CARLSON	MSCA			X
Doug Campbell	MSCA			X
Chet Kinsey	M S C A			X
Marion Hellstern	MSCA			X

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

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SJR 9

DATE 3-6-91 SPONSOR(S) PINSONEAULT

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
ELSIE FOX	MT. S.C.A.	✓	
Tim HARRIS	MONT. INDEPENDENT LIVING PROJECT - HELENA	✓	
LEROY Keilman	yellowstone Retired teachers EAA Mt Senior Citizens - NARFE NFFE	✓	
Margaret Henry	NARFE, MSCA	✓	
Riley Johnson	NFIB		X
Lloyd Anderson	37 E. Helena [illegible]	✓	
Bobbie D. Ford	AFSCME	✓	
[illegible] Sands	[illegible]	✓	
Paulette Kohman	MT Council for Mat & Child Health	X	
Florence Marshall	MSCA	X	
Bonnie Lambert	Small Bus.	X	
MARSHALL MAYER	DSA	X	
Colette Baumgardner	Demo. Women's Caucus	✓	

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 950

DATE 3-6-91 SPONSOR(S) Rep. Vivian Brooke

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
R. Elizabeth Roeth	Montana Children's Alliance	950		X
R. Elizabeth Roeth	Healthy Mothers/Healthy Babies	950		X
JOHN ORTWEIN	MT CATHOLIC CONFERENCE			X
Barbara Ranf	US West Communication	950		X
John Madsen	Dept. of Family Service	950		X
Sam SPERRY	Dept. of Health	950	X	
JUDITH CARLSON	MT Ch NASW + BB/S			X
Jack TRAXLER	4403 Gharrett Av Missoula	950	X	
Dorothy Traxler	Eagle Forum -	950	X	
Nancy Coopersmith	OFFICE of Public Instruction	950	~~X~~	X
Alma Roark	Mothers of America	950	X	
Douglas B. Roark	TAX PAYER	950	X	
MIKE MALES	Children's Trust Fund	950	~~X~~	X

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. 950

DATE 3-6-91 SPONSOR(S) Brooke

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Della Sandoval	University of Mont			X
Jennifer Pinkerton	U of Montana			X
Bob Deaton 2710 [illegible] Msla	" "			X
Sandy Grogan	U of Montana			X
Jeanne Kemmis	Montana Council for Families			X
Maralyn A. Kailey	U of Montana			X
Billie Warford	MT Alliance for Better Child Care	737 950		X
Dr. Tom Cavlin	Montana Committee Emotionally Disturbed			X
Helen Costello	Montana Post Adopt Cent			X
Judy Garrity	Mt. Children's Alliance			X
Diane Sands	MT Women Lobby			X
Ken Moore	Christian Ch. in MT			X
MIKE MCGRATH	L&C CNTY ATTY	950		X

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

HOUSE OF REPRESENTATIVES

3063

VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. 950

DATE 3-6-91 SPONSOR(S) BROOKE

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

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
DENNIS M. TAYLOR	MT COUNCIL FOR FAMILIES	950		X
STEVE WHITE		950	X	
Coleen Baumgardner	Democratic Women's Caucus	950		✓
Bud Solmonson	MT. Council for Fam	950		✓
Tom Olsen	DFS	950		✓

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

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 728

DATE 3-6-91 SPONSOR(S) Rep. Bob Ream

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
HARLEY WARNER	MONTANA ASSOCIATION OF CHURCHES	X	
Robert Lamphere	Montana Food Bank Network Montana Hunger Coalition	X	
DAVID HOST	SELF/Missoula Food Bank	X	
STEPHAN LANGDON	MONTANA PUBLIC INTREST RESEARCH GROUP	x	
MARY MUSIL	MONTANA LEAGUE OF WOMEN VOTERS	X	
D. ELIZABETH ROETH	MONTANA CHILDREN'S ALLIANCE	X	
	Healthy Mothers, Healthy Babies	X	
Paul Miller Univ. of MT.	MT. Hunger Coalition		
Kathy Rucker	MT Dietetic Assoc.		
Deb Bjorsness	MT Dietetic Assoc	X	
Vicki Cowboy	MT Dietic Assoc.	X	
Linda Melick	Central Montana Medical Center Lewistown	X	
NANCY FORBES	DIRECTOR - G.F. Comm. Food Bank		
Gene Huntington	Hunger Coalition	X	

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HOUSE OF REPRESENTATIVES
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Human Services + Aging COMMITTEE BILL NO. HB 728

DATE 3-6-91 SPONSOR(S) Rep. Bob Ream

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
John ORTWEIN	MT CATHOLIC CONFERENCE	X	
Arlene Templer	Confederated Salish & Kootenai Tribe	X	
Joan Bowsher	L&C County WIC	X	
Nicki Nedens	MT. Hunger Coalition	X	
Doug Campbell	Mt Senior Citizens assoc.	X	
Mabel L. Howard	" " " "	X	
Sharon Hoff Box 1729 Helena MT 59624	Diocese of Helena	X	
Diane O'Loughlin Box 1729 Helena 59624	Diocese of Helena	X	
Diane Sands	Mt Women's Lobby	X	
Paulette Kohman	Mt Council for Maternal & Child Health	X	
Colette Baumgardner	Demo. Women's Caucus	✓	
JOAN A. DUNCAN	Mt Food BANK NetWORK	✓	
Kristin Page	MontPIRG	✓	

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Human Serv. & Aging COMMITTEE BILL NO. HB728

DATE 3-6-91 SPONSOR(S) Rep Bob Ream

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Bud Solmonsson	MT. Council for Families	✓	
Jerome T Loendorf	Mt. Med-assn	✓	

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HOUSE OF REPRESENTATIVES

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Human Services & Aging COMMITTEE BILL NO. SB 168

DATE 3-6-91 SPONSOR(S) Sen. Doherty

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NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
CAROLINE BRINKLEY	SELF	168		✓
JUDITH GEDROSE	Dept of Hlth & Env Sci	168	Neutral	
Margaret Flowers	NARFE & SCA	~~SB 9~~		–
Diane Sands	MT Womens Lob			✓
Steve Doherty	SD #20			✓
JON WADE	Self	168		✓
Janet Ellis	MT ~~Audubon~~		~~✓~~	✓
Kate Cholewa	MT Womens Lobby			X
Chris Kaufmann	MEIC	168		X

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. SB 696

DATE 3-6-91 SPONSOR(S) Rep. Jim Rice

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NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
D. Elizabeth Roeth	Montana Children's Alliance	696		X
D. Elizabeth Roeth	Healthy Mothers, Healthy Babies	696		X
John M. Opitz	Self	696		X
Walt Schoffer	Self	696		X
Kimberley Achizzani	Self	696		X
Joan FitzGerald	Self	696		X
Susan Lewon	Self	696		X
Robert E. Priest	"	696		X
Joan H. Priest	self	696		X
Katherine Berry	self	696		X
Tom Hagen	self	696	X	
John Madsen	Self	"		X
Virginia L. Thompson	Self	"		X

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services **COMMITTEE** **BILL NO.** 696

DATE 2-6-91 **SPONSOR(S)** Jim Rice

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

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Carol Mills, PhD	Self	696		X
Maurine Ferguson	Dept of Health	696	~~X~~ neutral ~~X~~	
Tom Hopgood	Health Ins Assoc Amer	696	✓	
Jacqueline N. Terrell	Am. Ins. Assoc.	696	✓	
Chris Valenkamp	DD Lobbyist	696		✓
Tanya Ask	Blue Cross & Blue Shield	696	✓	
Linda Hauck	Self [redacted]			
Janice Phillips	Self	696		✓
Mary Tinsley	Self	696		✓
Paulette Kohman HLW	Mt Council for Maternal & Child Health	"		✓
Rich Hopkins, M.D.	Self	696		✓
Todd Wampler	Self	696		X
LARRY ACEY	MT ASSOC OF LIFE UNDERWRITERS	696	X	

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. HB 696

DATE 3-6-91 SPONSOR(S) Rice

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
ROGER MCGLENN	IIAM	696	X	
Mike Stephens	MT Nurses Assn.	696		X
Bon Ashabraner	State Farm Ins	696	X	
CHAD SMITH	SIDNEY HOSP	696		X
[illegible]	MT Hospital Assoc	696		X
Dobrinkoff	Sholan Hosp	696		X
[illegible]	MT Med Assn	696		C

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HOUSE OF REPRESENTATIVES

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VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 937

DATE 3-6-91 SPONSOR(S) Rep. Jessica Stickney

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Kate Cholewa	MT Womens Lobby	937		X
Judith Carlson	HRDC Dir Assn			X
Colleen McGuire	Child Care Advisory Council			✓
Boyce Fowler	DFS			
Kathi Campbell	MABC	937		✓
Lori Fearon	MCCA	937		✓
Billie Warford	MT Alliance for Better Child Care	937		✓
John Madsen	Self			X
Diane Person	2 MCCA HAEYC	937		✓
Janet Brooke	MABC	937		✓
Janet Bush	MABC	937		X
[illegible]	Mt Womens Lobby			X
Sylvia Danforth	Child + Family - DEAP	937		X

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. 937

DATE 3-6-91 SPONSOR(S) Fisher Stickney

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Barbara Ranf	U S WEST, Inc	937		✓
R. Elizabeth Roth	Healthy Mothers/Healthy Babies	937		✓

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