MINUTES

MONTANA SENATE
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By Chairman J.D. Lynch, on February 19, 1991, at 10:00 a.m.

ROLL CALL

Members Present:

J.D. Lynch, Chairman (D)
John Jr. Kennedy, Vice Chairman (D)
Betty Bruski (D)
Eve Franklin (D)
Delwyn Gage (R)
Thomas Hager (R)
Jerry Noble (R)
Gene Thayer (R)
Bob Williams (D)

Members Excused: None

Staff Present: Bart Campbell (Legislative Council).

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

Announcements/Discussion: None

HEARING ON SENATE BILL 361

Presentation and Opening Statement by Sponsor:

Senator Gene Thayer, sponsor of the bill, stated that this bill clarifies portions of existing law to include and make it specifically clear that airport authorities are included in the immunity portions of the statutes. There has been some confusion on that, and it has lead to a nuisance. The people involved in this industry would rather not be apt to contend with because the airport authorities do manage the airports that are normally owned by the cities or the counties. He asked that the committee be in favor of deleting some language on the bill starting on line sixteen of page nine to line twenty four stopping at section period.

Proponents' Testimony:

Joe Attwood, airport director of Great Falls international airport authority, stated that this legislation was suggested by

the Montana airport managers association. They are unified in the agreement that this legislation would be beneficial and helpful in the conduct of their day to day business.

Mick Taleff, council for the Great Falls international airport authority and a member of the Montana airport managers association, stated that he was the principle person responsible for suggesting these legislative changes. The Montana airport authorities act, which was enacted twenty years ago, has had virtually no changes. The current bill is designed to clarify the treatment of airport authorities as public corporation, and as governmental entities so that the protections that are afforded to other governmental entities are also afforded to the airport authorities. This act is not a revenue bill, it deals solely with airport related treatment under various administrative and procedural rules. It addresses a number of potential problem areas, one being the potential noise claims. Another being the inconsistent treatment which airport authorities are sometimes recorded under the current statutes. This bill will clarify that airports have the authority to dispose of their property in the same matter as the county disposes their property.

Tom Hopgood, representing the Montana association of realtors, stated that they are in full support of the amendments suggested by Senator Thayer which would take out the language about the disclosure of being in a hazard area from the real estate buy/sell agreement.

Opponents' Testimony:

None

Questions From Committee Members:

Senator Gage asked about the top of page ten line two of the bill, he asked the definition of the airport operation area.

Mick Taleff stated that the airport influence area is a relatively small area that extends out the primary runway only. By expanding the definition to an airport operations area, you increase the limit of liability of noise damage.

Joe Attwood stated that airport operations area is defined in a number of federal statutes as runways, taxiways, and other places where aircraft can maneuver it is not broadened in areas past the airport.

Senator Hager asked if the airport authorities act affects all airports except the Billings airport, as he understood Mr. Attwood to say in his testimony.

Joe Attwood stated that it affects all but the Billings airport. Billings airport is a municipal airport, not an airport authority.

Senator Lynch asked if Senator Thayer would explain the new section eighteen of the bill. How much reign does this give to a person that lives in Kalispell, and the airport keeps expanding, they have a beautiful home and all of the sudden their home is

virtually lost in valuation, because nobody wants to move near the airport. Do they have no recourse to recover the loss of their home.

Senator Thayer stated that if the home is within the boundaries of an airport designated area, then they would be excluded from the noise ordanses.

Mick Taleff stated that was the correct reading.

Senator Thayer stated that an airport is an established part of the community, and people know where the airport is.

Closing by Sponsor:

Senator Thayer closed by saying that they are trying to clarify, under the current existing statute, that the airport authority should go under the same immunity that already exists for the other entities.

HEARING ON SENATE BILL 366

Presentation and Opening Statement by Sponsor:

Senator Eve Franklin, sponsor of the bill, stated that this bill provides for all insurance as stated written, delivered, and renewed, all private insurance, and also medicade policies cover according to the American cancer association protocol, that these insurance policies both private and public will cover routine mammography. What are the benefits of mandated health benefits? One is the human level, the human cost level, and the economic value. The national cancer institute stated that the number of incidences of cancer in women has increased thirty two percent between 1982 to 1987. Cancer is the leading cause of death for women thirty five to fifty, breast cancer is the most common in this age group. The cost of a mammogram varies in community to community from fifty dollars to two hundred dollars. This would come in at significantly a lower cost to the insurance companies than the American cancer society estimate of end stage or late stage cancer treatment costs probably sixty five to one hundred twenty five thousand dollars in hospitalization and treatment. Mammography saves lives.

Proponents' Testimony:

Kate Cholewa, representing the Montana women's lobby, spoke in favor of the bill (See Exhibit 2, and Exhibit 2A).

Margaret Onstad, a registered nurse representing the advisory board of the Columbus hospital women's center, stated the Columbus hospital has made mammography and this bill their number one priority this year. Mammography is a proven life saving diagnostic tool. It is extremely important in saving lives and increasing the possibility that surgery can be done. They hope that the passage of this bill will make it available to the low income women through medicade. The statistics do not

have access to mammograms and have a higher death rate and lower success with the surgery. This is not preventive medicine, it is an early diagnostic tool which will help both the women and the insurance companies to avoid the lengthy and traumatic length of recoveries. Margaret Onstad submitted written testimony for Elizabeth Veign (See Exhibit 3).

Kate McDiver, representing herself, stated that her mother died of breast cancer at the age of fifty five on September 5, 1990. She had many lumps from her breast removed, chemotherapy and radiation. A year later, the doctor's found cancer in her bones, liver, lung, and brain. Six months later she died. Her mother was kept from having a timely mammogram, not because she couldn't afford it, but because a bad decision was made from her doctor. Many women can't afford a mammogram, and hesitate to go to the doctor for this reason. One hundred and twenty dollars is a lot of money to some women, but it is a drop in the bucket compared to what her mother's insurance company paid for her two surgeries, three phases of chemotherapy, and two months of at home nurse care.

Representative Angela Russell, stated that after the 1987 session, she found that she needed to go to the doctor. As a result, she had a mastectomy and six months of chemotherapy. She stands before the committee as a survivor of breast cancer. Two years ago her insurance did not cover the mammogram.

Annabelle Richards, representing the Montana division of the American cancer association, stated that in this age of high technology and preventive medicine, it is essential that every woman over the age of thirty five be provided the opportunity in healthcare coverage for the minimum mammography examination regardless of her income or the ability to pay.

Opponents' Testimony:

Tanya Ask, representing Blue Cross Blue Shield of Montana, stated that the their concern is this is the first mandated benefit bill that this committee has heard of this session, however there has been many bills heard in the house. There is going to be an additional bill of well child care presented in the senate on Wednesday. Their concern is that there are a number of mandated benefits already in law. There are so many dollars to go around. The legislature should take a look at the whole mandated issue as a whole, and make a policy decision as to perhaps which mandates need funding.

Larry Akey, appearing on behalf of the Montana association of life and health underwriters, stated that it is important that this committee understands the consequences of expanding the mandatory health benefits (See Exhibit 4 and Exhibit 4A).

Gregory VanHorssen, appearing on behalf of Tom Hopgood who represents the health insurers association of America, spoke in favor of the bill (See Exhibit 5).

Questions From Committee Members:

Senator Thayer asked if we mandate service, and it's in law,

then that would allow healthcare providers to charge anything they want. He asked if Senator Franklin would object to putting a certain amount allowed into the bill.

Senator Franklin replied that she is not necessarily prepared to put a cap on it without a little more information as to the cost. It would be negotiated the same way that coverage is negotiated for any other services.

Senator Kennedy asked Tanya Ask if the price would go up for mandated services.

Tanya Ask replied that the price may go up. There is a broad range in the charges of mammograms. Most insurers will set some kind of usual customary and reasonable charges which they will allow.

Senator Kennedy asked if this is now optional.

Tanya Ask replied that right now this is something that can be covered under a policy should the insurer request it. In certain policies, such as the HMO Montana, it is automatically included.

Senator Thayer stated that one of the proponent's stated that the cost per person per Blue Cross Blue Shield was about forty cents a month for this type of insurance.

Tanya Ask stated that she wasn't sure if Kate got that figure from the local office, or from a national association.

Kate Cholewa stated that it was from a letter she received from an organization called women's network.

Senator Thayer asked that Blue Cross Blue Shield get a cost per person figure locally and not nationally.

Senator Noble asked if the committee would consider getting a fiscal note for this bill.

Senator Lynch stated that he thought that a fiscal note may not be very accurate.

Closing by Sponsor:

Senator Franklin closed by saying that if we can get women in for early care, and early treatment, we will save time, energy, lives, and money. There is an assumption that acute care drives the insurance industry.

EXECUTIVE ACTION ON SENATE BILL 118

Motion:

Senator Noble moved to table senate bill 118.

Discussion:

Senator Noble stated that there are two other laws that could apply to the petroleum products that may or may not be involved in that section. Because this is just a repeat, he would just rather leave it.

Amendments, Discussion, and Votes:

None

Recommendation and Vote:

The motion to table SB 118 passed unanimously.

EXECUTIVE ACTION ON SENATE BILL 242

Motion:

Senator Thayer moved to pass the amendments for SB 242. (See attached copy).
Senator Thayer moved to do pass SB 242 as amended.

Discussion:

None

Amendments, Discussion, and Votes:

The motion to pass the amendments for SB 242 passed unanimously.

Recommendation and Vote:

The motion to do pass SB 242 as amended passed unanimously.

EXECUTIVE ACTION ON SENATE BILL 366

Motion:

Senator Thayer moved to amend SB 366 (See attached amendments).
Senator Noble moved that SB 366 do pass as amended.

Discussion:

Tanya Ask stated that she had called the actuary at Blue Cross and Blue Shield for a figure of how much it would cost per person for the cost of mandatory mammogram coverage, it came to approximately $10.20/year.
Senator Noble stated that he thinks that there should be a dollar limit to this bill. He stated that there should maybe be a limit of fifty dollars.
Senator Lynch stated if you set a dollar limit on a bill, you will see that bill every session to change that dollar limit, simply because of inflation.
Senator Thayer stated that if we have to keep bringing those bills back that deal with mental and health it is worth it.

Amendments, Discussions, and Votes:

The amendments for SB 366 passed 7 to 2 votes.

Recommendation and Votes:

SB 366 as amended passed 8 to 1 votes.

EXECUTIVE ACTION ON SENATE BILL 248

Motion:

Senator Kennedy moved to amend SB 248.
Senator Noble moved to do pass SB 248 as amended.

Discussion:

None

Amendments, Discussions, and Votes:

Bart Campbell went over the amendments (See attached copy).
Senator Thayer asked about the iii amendment, would mean that all offerings would have to go before the commissioner.
Bart Campbell stated no, paragraph 8A puts that back.
Senator Lynch asked if this is a new power that is given to the commissioner.
Bart Campbell the filing form can be approved or disapproved. They took out the language giving the commissioner the ability to raise or lower the amount of numbers of people.
Senator Lynch asked why the commissioner would deny an application.
Robyn Young stated that they must be able to prove that it is necessary to protect the public for an offering that would tend to lead to fraud.

The amendments for SB 248 passed unanimously.

Recommendation and Votes:

SB 248 as amended passed unanimously.

ADJOURNMENT

Adjournment At: 11:50 a.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

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JDL/dia

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB248 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Kennedy
Motion: To AMEND

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB248 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: DO PASS AS AMENDED

1987

Amendments to Senate Bill No. 248
First Reading Copy

For the Committee on Business and Industry

Prepared by Bart Campbell
February 18, 1991

1. Title, line 6.
Strike: "INCREASING" on line 6 through "THE" on line 7
Insert: "CREATING A NEW"

2. Page 4, line 6.
Strike: "25"
Insert: "10"

3. Page 4, line 10.
Following: "~~and~~"
Insert: "and"

4. Page 4, line 17.
Strike: "; and"
Insert: "."

5. Page 4, line 18 through 25.
Strike: subsection (iii) and (b) in their entirety
Renumber: subsequent subsections

6. Page 5, line 1.
Following: "(c)"
Strike: "The" on line 1 through "remuneration." on line 9
Insert: "any transaction pursuant to an offer made in this state directed by the offeror to not more than 25 persons, other than those designated in subsection (7), during any period of 12 consecutive months if:

(i) the seller reasonably believes that all the buyers are purchasing for investment;"

(ii) no commission or other remuneration is paid or given directly or indirectly for soliciting any prospective buyer; provided, however, that a commission may be paid to a registered broker-dealer if the securities involved are registered with the United States securities and exchange commission under the federal Securities Act of 1933, as amended; and

(iii) the offeror applies for and obtains the written approval of the commissioner prior to making any offers in this state and pays a filing fee that must accompany the application for approval. The commissioner may deny an application.

Amendments to Senate Bill No. 366
First Reading Copy

For the Committee on Business and Industry

Prepared by Bart Campbell
February 19, 1991

1. Page 2, line 5.
Strike: "dollar limits,"

2. Page 2, line 7.
Following: "generally."
Insert: "A minimum $50 limit must be made available for each of these services."

Amendments to Senate Bill No. 242
First Reading Copy

For the Committee on Business and Industry

Prepared by Bart Campbell
February 19, 1991

1. Title, line 14.
Strike: "AND"
Following: "90-3-301,"
Insert: "AND 90-3-524,"

2. Page 4, line 7.
Strike: "June 30, 1993,"

3. Page 12, line 7.
Following: line 6
Insert: "**Section 7.** Section 90-3-524, MCA, is amended to read:

"90-3-524. Research and development project loan agreement -- specific requirements -- payback. In addition to the loan agreement provisions described in 90-3-522, a research and development project loan agreement must be structured as contracted debt with the following terms:

(1) The agreement must include provisions calling for a payback of at least two times the original loan amount paid as a percentage of the income stream derived from the sale or other commercialization of products or processes developed with the board's financing. This percentage rate may not exceed 5%.

(2) The payback on a research and development project loan for a technology transfer and assistance project may be made pursuant to subsection (1) or may be realized in terms of indirect benefits related to the goals and criteria of the program. No more than 10% of the board's annual allocation of research and development funds may be used for technology transfer and assistance projects.""
Renumber: subsequent sections

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 3/19/91 Bill No. SB366 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams		X
Senator Kennedy	X	
Senator Lynch		X

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: Thayer TO AMEND

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB366 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	Y	
Senator Gage		X
Senator Hager	X	
Senator Noble	X	
Senator Thayer	Y	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: DO PASS AS AMENDED

1987

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 19th day of February, 1991.

Name: Mick Taleff

Address: 610 Linden, Great Falls, Mt

Telephone Number: 406-761-4800

Representing whom?

Montana Airport Managers Assn

Appearing on which proposal?

S.B. 361

Do you: Support? X Amend?_____ Oppose?_____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 14 day of Feb, 1991.

Name: MJ Attwood

Address: 2800 Terminal Dr.
Great Falls MT 59401

Telephone Number: 7273404

Representing whom?
Mont. Airport Mngrs. Assn.

Appearing on which proposal?
SB 361

Do you: Support? ✓ Amend?_____ Oppose?_____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

DATE 2/18/91

COMMITTEE ON Business & Industry

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Margaret Ohstad	Columbus Hospital Women's Center	HB366	✓	
Rosann Konigsfeld	St. Dns Comm. Office	366	✓	
Kate McDer	self	366	✓	
M J Attwood	self	361	✓	
Kate Cholewa	MT Womens Lobby	366	✓	
Gregory VanHorssen/Tom K Hopgood	HIAA	366		✓
Gregory Van Horssen/Tom K Hopgood	Montana Association of Realtors	361	✓	
Paulette Kohman	MT Council of Maternal Child Health	366	✓	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	361		X
Vicki Cocchiarella	HD 59	366	✓	
M.J. Sherwood	MTLA	361		✓ Immunity

(Please leave prepared statement with Secretary)

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 19th day of February, 1991.

Name: Annabelle Richards

Address: 1735 Highland

Telephone Number: 442-1906

Representing whom?

Montana Division of American Cancer Association

Appearing on which proposal?

SB 366

Do you: Support? ✓ Amend?_____ Oppose?_____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this ____ day of _____, 1991.

Name: MARGARET ODSTAD

Address: RS RANCH
CANTER, MT 59420

Telephone Number: 134-5472

Representing whom?
COLUMBUS HOSPITAL WOMENS CENTER

Appearing on which proposal?
HB 366

Do you: Support? ✓ Amend?_____ Oppose?_____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB 242 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: DO PASS AS AMENDED

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB 242 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: TO AMEND THE AMENDMTS

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB242 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Thayer
Motion: To AMEND

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 2/19/91 Bill No. SB118 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Noble Motion: To TABLE

1987

ROLL CALL

Business&Industry COMMITTEE

DATE 2/19/91

____ LEGISLATIVE SESSION ____

NAME	PRESENT	ABSENT	EXCUSED
Senator Bruski	X		
Senator Franklin	X		
Senator Gage	X		
Senator Hager	X		
Senator Noble	X		
Senator Thayer	X		
Senator Williams	X		
Senator Kennedy	X		
Senator Lynch	X		

Each day attach to minutes.

SENATE BUSINESS AND INDUSTRY COMMITTEE

February 19, 1991

SENATE BILL 366

TESTIMONY IN OPPOSITION

HEALTH INSURANCE ASSOCIATION OF AMERICA

TO: Chairman and Members of the Committee

FROM: Tom K. Hopgood

I am testifying this morning on behalf of the Health Insurance Association of America (HIAA). The HIAA is not Blue Cross/Blue Shield. The HIAA is a trade organization composed of the majority of the health insurance companies operating in the United States and in the state of Montana.

HIAA opposes Senate Bill 366; not because mammography is an ineffective way to detect cancer; it may very well be effective. HIAA opposes this bill not because of its potential positive impact on a few Montanans but because of the guaranteed negative effect that this additional mandated coverage will have on many Montana insurance consumers.

Senate Bill 366 will require private insurers in the state of Montana to provide coverage for mammography. If the Legislature passes this bill, it will be adding to an already long list of mandatory coverages in Montana. Remember, with each mandate that this Legislature passes, it is guaranteed that the price of health insurance will increase.

Senate Bill 366 will not affect all Montanans equally. Senate Bill 366, like other mandated insurance coverages, will only be a mandate for private insurers. Under federal law, companies with self-insurance health care plans are exempt from these state regulations and virtually all large companies and a large percentage of medium size companies are now self-insured. Nor is the state of Montana required to include these mandates in the insurance that it provides for its employees. As a result, the burden of mandated benefits falls heavily on the employees of small firms and on

Montanans who purchase individual and family policies. In other words, the burden of these mandated benefits falls on those who are least able to afford them.

I would suggest to this committee that Senate Bill 366 be analyzed according to its possible effects and its guaranteed effects. If Senate Bill 366 is passed, it will require coverage for a service requested by all woman 35 years of age and older. It will require this coverage despite the fact that no evidence exist that the service saves lives for women under the age of 50 (Preventing Disease Beyond the Rehetoric, O'Malley, Fletcher & Morrison, Journal of the American Medical Association, April 12, 1987). Thus, the benefit of Senate Bill 366, for at least some woman, is at best speculative.

But what will happen with certainty is this: if this bill passes, the cost of health insurance in Montana will go up. Currently, it cost me $322.30 a month to insure my family against the calamity of the cost of serious illness or accident. I do not have the cadillac of insurance plans. I have the closest thing that I can get to crisis avoiding, high deductible, low cost health insurance. But the cost isn't low. Why? Because of insurance mandates. Each additional mandate cost additional money. The additional mandate represented by Senate Bill 366 will cost additional money.

Now, I pay roughly $3,867 per year for a no-frills policy. In many ways, I am fortunate. I am a lawyer with a busy practice in the capitol city. I am not getting rich, but I make enough to keep the mortgage paid and food on the table. Although it is not cheap, I can afford the health insurance that I have. That is not true of everyone. In fact, I don't believe it is true of most folks. The average "Joe", that little guy, the single mother with a couple of kids who works in a retail store, all of them, if they have my plan, must pay $322.30 per month. Can they afford it? Can someone who earns $20,000 a year and supports 2 kids afford $3,867 a year for health insurance? What about the additional cost of additional insurance mandates? How do these folks deal with the increased cost of insurance with each mandate?

I will tell you how they deal with them. The biggest health insurer in this state is not any one of my clients. The biggest health insurer in this state is not Blue Cross/Blue Shield. The biggest health insurer in this state is no insurance at all.

No one in this room will say that it is a good thing to be without health insurance. Yet, each time the price of health insurance rises due to additional mandatory benefits, a few more Montanans will be forced to go without health insurance. As of 1988, between 16,000 and 23,000 Montanans were without health insurance as a direct result of insurance mandates much like Senate Bill 366. National Center For Policy Analysis Report, 1988.

Because of mandates like Senate Bill 366, 16,000 to 28,000 Montanans cannot afford basic health insurance coverage. Because of mandates, 16,000 to 28,000 Montanans do not have coverage for a gall bladder surgery, a heart surgery, or their child's broken leg. And, with each additional mandate that this Legislature adds, more Montanans will go without health insurance. For this reason, the continued addition of coverage mandates in Montana must stop.

Let there be no doubt about it; Senate Bill 366 is a mandatory coverage bill. Senate Bill 366 will result in an increase in the price of health insurance. Senate Bill 366, regardless of the positive goals that its drafters contemplated, will have a guaranteed effect of driving even more Montanans from the insurance market.

For these reasons, HIAA request a Do Not Pass recommendation from this committee.

- End -

FACTS ABOUT MANDATED HEALTH BENEFITS

Presented by the Montana Association of Life Underwriters

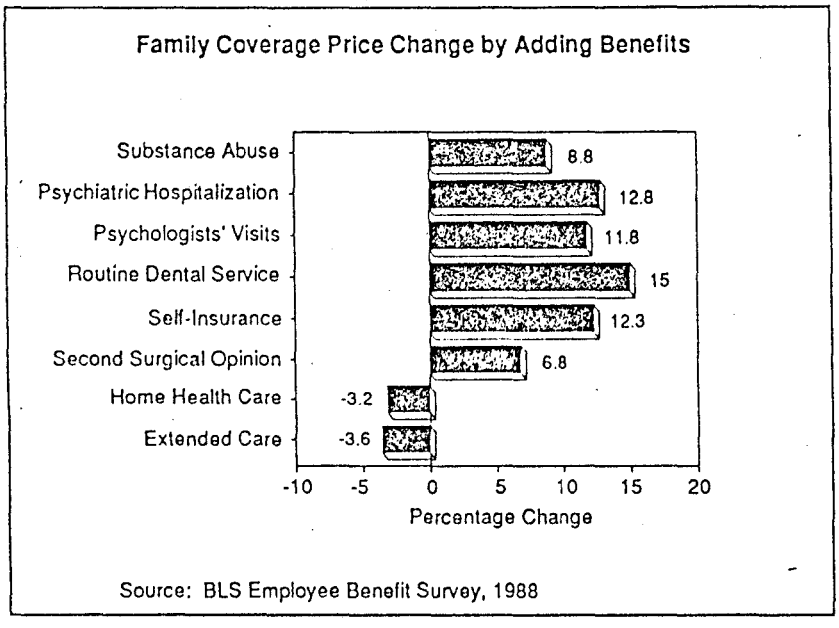
- Montana ranks third in the region in the number of mandatory health coverages. Adoption of the mandatory benefit proposals before 1991 Legislature will move Montana to the top of the list. (See chart on back.)

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 4
DATE 2/14/91
BILL NO. SB366

North Dakota	24
Washington	21
MONTANA	**20**
Oregon	16
Colorado	13
Utah	13
South Dakota	12
Wyoming	8
Utah	7

Fifteen of the twenty mandates on the books in Montana today have been adopted since 1981. At least six **new** mandated benefits are before this Legislature.

- Mandated benefits drive up the cost of health insurance. The following graph shows the national average percent premium change for family coverage that results from adding each specific benefit.



For example, adding substance abuse coverage increased family premiums by 8.8% on average.

- More than 141,000 Montanans have no health insurance at all. An estimated 22,000 of these (and perhaps as many as 28,000) lack health insurance solely **because** of the benefits already mandated by state law. Adding new mandates will only drive the price up further, forcing even more people to lose their health insurance, and leading to a phenomenon called "adverse selection."

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 3
DATE 2/19/91
BILL NO. SB366

TESTIMONY IN SUPPORT OF SB-366

To require health insurance providers to provide coverage for minimum mammography examinations

My name is Elizabeth Veign and I reside in Great Falls. I am a Registered Nurse and the Coordinator of the Columbus Hospital Women's Center in Great Falls. As a health professional who is actively involved in providing preventive health services to women, I urge you to support SB-366 because it will literally help save women's lives as well as contribute to cost savings for breast cancer treatment.

Breast cancer is the most common malignancy in women aged 35-50. Very few health threats create the physical and emotional turmoil for a woman that breast cancer does. We are currently experiencing an epidemic of breast cancer in the United States and one in four women who develop the disease die from it.

Mammography is important in saving lives! It detects breast tumors while they are very small and often before the cancer has spread. Such early detection of tumors often means that conservative surgery which spares the breast will be the treatment of choice.

In my work with women, I have found that a primary reason why they do not get routine mammograms as recommended by the American Cancer Society, and as stipulated in SB-366, is the cost. Poor women have higher cancer rates and are more likely to die from breast cancer because Medicaid does not cover routine mammograms.

The insurance industry and Medicaid have not responded to the opportunity to incur less costs for breast cancer treatment and to help save lives because they will not voluntarily provide coverage for minimum mammography examinations. On behalf of all the women we serve through our Women's Center, I urge you to support SB-366 which will require that insurance carriers and Medicaid provide coverage for minimum mammography examinations.

Columbus Hospital • 500 15th Avenue South • Post Office Box 5013 • Great Falls, Montana 59403 • (406) 727-3333

MONTANA WOMEN'S LOBBY

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

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 2
DATE 2/19/91
BILL NO. SB366

Kate Cholewa
Montana Women's Lobby
Re:SB 366

One out of nine women will develop breast cancer. An even greater number will detect a lump and require follow-up care. Both these situations result in a both emotional and financial crises for the whole family. Mammography screenings allow for early detection of cancer and can save both money and lives.

According to the American Cancer Society, an early detected cancer costs, on average, $10,000-$15,000 to treat. Breast cancer in its later stage costs approximately $45,000-$125,000 to treat, and the woman probably will die. Thus, mammographies, through early detection, can realize a savings of at least $50,000 per patient in treatment costs. It may also save the woman's life.

How much will it cost to save $50,000 in treatment costs? Blue Cross/Blue Shield says the cost of adding full reimbursement for mammographies is "less than $.40/individual/month." Is your mother's, wife's, and daughter's life worth forty cents a month?

I understand that for some of you the problem is with the idea of mandating coverage. However, when the state of Maine chose to review mandates in insurance coverage, mammographies were excluded from the list for review because of the importance and necessity of these screenings. There also is precedence for this kind of coverage: Most carriers nationally actually reduce premiums for non-smokers on the premise that prevention is more cost effective than paying for illness and the final stages of cancer. Breast cancer is more common than lung cancer in women; it is more likely to be a cause of death for women. Yet, women are not protected through insurance coverage for it, much less receive reduced premiums for those who regularly are screened. We believe this to be discrimination.

When you vote on SB 366, you weigh the value of a woman's life against a philosophical position regarding the mandating of insurance coverage. I should hope that this is not a difficult decision.

women's network

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 2A
DATE 2/19/91
BILL NO. SB 366

Sue Mullins
Executive Director
NCSL Women's Network

1807 250th Avenue
Corwith, Iowa 50430
515/583-2156
515/583-2192 (Fax)

February 18, 1991

To: Members of the Business and Industry Committee,
The Honorable J. D. Lynch, Chairperson

From: Sue B. Mullins
Executive Director
NCSL Women's NETWORK

Re: SB366 -- Mandatory Insurance Coverage of Screening Mammograms

Senators:

Yours is the heavy responsibility of weighing the value of a woman's life against a philosophical position regarding the mandating of insurance coverage.

The Women's NETWORK of the National Conference of State Legislatures asks that you be true to Montana's recognition of individual worth and support SB366, which mandates insurance coverage of screening mammography examinations for women, following guidelines established by the American Cancer Society.

NETWORK understands that the insurance industry opposes mandates simply because they are mandates. NETWORK also recognizes that scientific studies show that the incidence of breast cancer has steadily increased in this nation; today, one of every nine women will be diagnosed as having breast cancer. A simple mammography can disclose that cancer at least 2 years before physical examination can detect a tumor. NETWORK is aware that you understand that there is no cure for breast cancer. NETWORK understands your recognition of the fact that, the earlier the detection, the greater the chance that a woman will not die a prolonged, agonizing death that results not only in in incredible suffering for the wife and mother, but also in suffering for the family and expense both fiscally and emotionally for her family.

NETWORK recognizes that early detection, through mammography screening, saves lives and saves money for families, for business and industry (because treatment of later-stage cancers is so much more expensive) and for the State.

The women legislators across this nation ask that you vote "yes" on SB 366. An informed vote, based on facts, not blind philosophy, follows the trust your constituents have placed in you.

Council Report [redacted]

FROM MSLA. MED. ONCOLOGY 02.18.1991 12:54 P. 1

Missoula Medical Oncology

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 1
DATE 2/19/91
BILL NO. SB 366

Hematology, Oncology, Internal Medicine
Stephen F. Speckart, M.D
William C. Nichols, M.D
Judy I. Schmidt, M.D

FAX FORM

Date: 2/18/91

To: Vivian Brook

Company:

From: Judy Schmidt, MD

Pages Sent Including This Page: 12

With respect to detection of breast cancer, including cases diagnosed within the first 5 years after entry into the study, breast cancer rates of 2.03 per 1000 person-year and 1.94 per 1000 person-year were reported in the total study and control groups, respectively.[29] The breast cancer detection rate was lower in women in the study group who refused screening (1.58 per 1000 person-years) than women in the control group. The relative contribution of mammography alone to detection was 14.4% for women under 50 years of age and 37.6% for women 50 years of age or older at the time of diagnosis. Of the breast cancers detected by abnormal mammograms alone, 21% had evidence of axillary node involvement. Of those detected by clinical examination alone, 25% had evidence of node involvement, and of those detected by both clinical examination and mammography, 52% had evidence of axillary node involvement.

Screening, including mammography, led to earlier detection of breast cancers. Twelve percent of the cancers detected in the study group were intraductal with a favorable prognosis, compared with 7% of the cancers detected in women in the control group. Evidence of later cancers with spread to the axillary nodes was observed in 55% of cancers detected in the control group, 80% of cancers detected in screened women in the study group, 61% of cancers detected in unscreened women in the study group, and 48% of cancers detected in women in the study group who were screened but whose cancers were detected at intervals between or following the HIP study screenings.[29]

The four annual screenings with two-view mammograms and clinical examinations reduced breast cancer deaths in women in the study group compared with those that occurred in women in the control group. The number of deaths from breast cancer diagnosed within 5 years of study entry at 5 years of follow-up for women in the study and control groups were 39 and 63, respectively, and at 16 years of follow-up, 121 and 155, respectively.[29] The rationale for including only those cancers detected within 5 years of study entry is that cancers detected after this period would not have been detected in the screening program and their inclusion attenuates the effects of screening on mortality reduction. Although the number of deaths was lower in women in the study group than in women in the control group at both 5 and 16 years of follow-up, the differences in the number of deaths observed between women in the study and control groups decrease with time—from 38% at 5 years to 22% at 16 years.[29]

In addition to comparison of the number of deaths observed in study and control group women, differences in survival rates also can be compared. Both *lead-time bias* (lead time gained in cases detected through screening that extends the time interval from detection to death) and *length-time bias* (tendency of screening to detect cases of cancer that have longer periods of preclinical disease) can distort case survival rates and require consideration in interpretation of the differences observed between case patients and control patients. Shapiro et al[29] adjusted their findings for 1 year of lead time.

Study findings also indicated that screening mammography led to earlier detection of breast cancers and, consequently, better survival in women who were screened. Cumulative survival rates per 100 women at 5, 10, and 14 years of follow-up for screened women with HIP screening program–detected breast cancers were 87, 64, and 55, respectively, and they were better than those observed in women in the control group of 60, 46, and 40, respectively. Women who were screened but had their cancers detected outside the program (screened but nonscreening-detected or interval cancers) were observed to have survival rates similar to those observed in women in the control group who had no screening. In addition, at three follow-up times (5, 10, and 12 years), the highest survival rates were observed for women whose breast cancers were detected by mammography alone; after 12 years of follow-up, 68% of these women were still surviving compared with 56% of women whose cancers were detected by clinical examination alone.[29]

With regard to the effects of breast cancer screening on age-specific mortality rates in women 50 years or older, deaths from breast cancer diagnosed within 5 years of study entry were observed to be lower in the study group than in the control group at both 5 and 16 years of follow-up. The number of deaths in the study and control groups at 5 years of follow-up were 20 and 43, respectively, and at 16 years of follow-up, 72 and 94, respectively.[29] However, in women aged 40 to 49 years at the time of entry into the study, after 5 years of follow-up, 19 breast cancer deaths were observed in the study group compared with 20 deaths in the control group.[29] After 16 years of follow-up, the number of deaths in the study group was 49 compared with 61 deaths in the control group. A number of the women who were in the 40- to 49-year age group at the time of entry into the study were 50 years of age or older at the time of diagnosis of breast cancer, and, when adjustment for age at the time of diagnosis is taken into consideration, the number of deaths among women aged 45 to 49 years in the study and control groups did not differ. There were too few deaths in the 40- to 44-year-old age group to assess differences in numbers between the study and control groups.[29]

An important consideration regarding comparisons of numbers of deaths in women in the study and control groups within specific age groups is noted by Shapiro et al.[29] The HIP study sample size was determined to examine differences in mortality between the total number of women in the control and study groups and not within smaller subgroups of women (ie, women aged 40 to 49 years). Therefore, the observation of no statistically significant reduction in mortality in screened women 40 to 49 years of age could be due to the study power being too low to detect existing differences in mortality between control and study group women in this age group.

Habbema et al[34] also reported findings from an analysis of 14 years of follow-up mortality data from the HIP study. To take lead-time differences between the study and control groups of women into consideration, they included all breast cancer cases diagnosed within 7 years after the start of the study—a period that included about 3.5 years following the last screening examination. They report percentage mortality reductions in women aged 40 to 44, 45 to 49, 50 to 54, 55 to 59, and 60 to 64 years of 31%, 14%, 22%, 19%, and 27%, respectively. They used the goodness-of-fit χ^2 application to test for homogeneity of mortality effects across all age groups and observed equal effects across all age groups. This finding was not changed after correction for different numbers of breast cancer cases in the study and control groups. The authors conclude that there is no evidence for an age gradient of effectiveness of screening in reduction of breast cancer mortality.

Chu et al[35] describe their findings for an analysis of all breast cancer cases, including nonhistologically confirmed cases, diagnosed within the first 6 years after entry into the HIP study. After 20 years of follow-up, they report a statistically significant reduction in breast cancer mortality in women aged 40 to 49 years in the study group using either the Fisher's Exact Test ($P = .018$) or the logrank test ($P = .020$). As in earlier studies, the probability of dying of breast cancer is assumed to be the product of the probability of developing

100 000) to estimated mortality (per 100 000) in all BCDDP participants aged 35 to 49, 50 to 59, and 60 to 74 years at the time of entry into the study of 0.89, 0.76, and 0.74, respectively. Although results of tests to assess the statistical significance of these findings are not currently available, the findings suggest reduced breast cancer mortality after 9 years of follow-up in screened women 35 to 49 years of age as well as in women 50 years of age and older.

Nijmegen Project

Verbeek et al[29] report findings from a case-control study that used breast cancer cases from the Nijmegen, the Netherlands, population-based breast cancer screening program collected from its beginning in 1975 through 1981. Single-view mammography (a lateromedial projection) every 2 years was the only screening examination used in this program. Women born between 1910 and 1939 (aged 35 to 65 years, n = 23 000) were invited for a first screening, and all women born before 1940 (n = 30 000) were offered three additional screenings. Case patients included all female residents of Nijmegen who died of breast cancer between 1971 and 1981 and whose breast cancer had been diagnosed after their first invitation for screening; 46 breast cancer deaths met these case criteria. Five control patients of the same year of birth as the case patients who had been invited for screening and who had not died of breast cancer at the time when the case had died were selected for each case. The risk of death from breast cancer, estimated by the odds ratio, in the screened vs the unscreened women was 0.48 (95% confidence interval [CI], 0.23 to 1.00). The upper limit of the CI of 1.00 may be due to the relatively small numbers of cases available.

Swedish Two-County Study

In 1977, the Swedish National Board of Health and Welfare initiated a study "to determine the effectiveness of mass screening with single-view mammography to reduce breast cancer mortality."[30] The trial was initiated in two counties in Sweden, Kopparberg and Östergötland, and included 134 867 women aged 40 to 74 years who were randomly assigned to study and control groups. Study group women aged 40 to 74 were offered the usual care, 13% of women in the control group had mammograms in 1984. Breast cancer cases were identified through the Swedish national cancer registration system, and death information was available from the National Bureau of Statistics.

Tabar et al[31] report breast cancer detection and mortality findings for the period 1977 through 1984, with an average length of follow-up of 6 years. Detection rates for invasive breast cancers in study and control group women were 18.7 and 10.5 per 1000 women, respectively. Rates of invasive cancers that involve axillary nodes were 8.6 per 1000 in the study group and 4.5 per 1000 in the control group. The detection rates for intraductal and in situ cancers were 1.3 and 0.4 per 1000 in study and control group women, respectively. In women aged 70 to 74 years at the time of entry into the study, the risk of detection of a stage II or more advanced cancer was significantly reduced by 25% in screened women compared with nonscreened women (relative risk, 0.75; 95% CI, 0.65 to 0.87).

The relative risk of death from breast cancer in screened vs nonscreened women was 0.69 (95% CI, 0.51 to 0.92). This finding indicates an overall approximate reduction in breast cancer of 30% following single-view mammography at 2-year intervals in women under 50 years of age and at 3-year intervals in women 50 years of age or older. The relative risk of death from breast cancer in screened vs unscreened women who were 50 to 74 years of age was 0.61 (95% CI, 0.44 to 0.84). As the authors note, the reduction in the risk of death from breast cancer in women aged 50 years and older following mammography every 3 years was similar to that observed in the HIP study in this age group following annual mammography.

After an additional year of follow-up, Tabar et al[32] report an overall breast cancer detection rate of 15.3 per 1000 in the study group and 18.1 per 1000 in the control group. Rates of invasive cancers that involve axillary nodes and or dissemination were 4.1 per 1000 in the study group and 5.0 per 1000 in the control group. The detection rates of intraductal in situ cancers in study vs control group women were 1.4 per 1000 and 0.4 per 1000, respectively. The relative risk of stage II or more advanced breast cancer at the time of diagnosis in screened cancers differed in women 40 to 49 years of age compared with women 50 years of age or older is of particular interest.[32] In women aged 40 to 49 years, the rate of interval breast cancers during the first postscreening year was 40% of that observed in control women, and in the second postscreening year the rate of interval cancers rose to 70% of that observed in control women in the same age group. These observations indicate that the effect of screening with single-view mammography is quickly lost in women under 50 years of age. In contrast, very few interval breast cancers were observed during the first 2 postscreening years in women over 50 years of age. However, during the third postscreening year, the rate of interval cancers in women 50 years of age or older was 50% of the rate observed in women in the control group. This observation indicates that loss of screening effect in women 50 years of age or older does not occur until the third year after screening.

Tabar et al[32] note that the survival of women with interval cancers in both the HIP study and in their study is similar to that observed in the control group, indicating that breast cancer mortality will be lower in screened women when additional interval cancers are prevented. In this study, over 50% (18/23) of the deaths from breast cancer in women 40 to 49 years of age were due to cancers detected in intervals between screenings. In addition, in older women (50 years of age and older), a higher proportion (37 of 101) of breast cancers occurred in women who were offered but refused screening, indicating the importance of good compliance in breast cancer screening programs.

Based on their observations, the authors make the following mammographic screening recommendations[32]:

> We recommend annual two-view mammography screening in women aged 40 to 49, for whom the maximum interval between screening examinations should not exceed 18 months. For women over the age of 50, screening should be performed biennially and the interval should not exceed two years; little benefit would be gained by screening more frequently than every two years. A high participation rate is essential to the success of any screening program.

Utrecht Study

Collette et al[33] report observations [illegible] control study that evalu-

breast cancer and the conditional probability of dying of breast cancer given its occurrence. In earlier analyses,[31,32] the Poisson method was used to assess the effects of screening on the probability of dying of breast cancer. However Chu et al[33] assume that the impact of a screening program is a reduction of the probability of dying of breast cancer and that because of randomization in the HIP study, the probability of developing breast cancer should be nearly equal in study and control group women. Therefore, use of the Poisson method to assess the statistical significance of observed differences in mortality between study and control groups is overly conservative.

These authors also note a stage shift in breast cancer in women aged 50 to 64 years; more stage I cases and fewer stages II, III, and IV cases were noted among the cancers detected in the study than in the control group women.[33] Although a stage shift of equal magnitude was not noted in women aged 40 to 49 years, the proportion of noninvasive cancers within stage I was increased in breast cancers diagnosed in the study compared with control women in this age group.

Breast Cancer Detection Demonstration Project (BCDDP)

Between 1973 and 1981, a total of 283 222 women were screened in the BCDDP funded by both the National Cancer Institute and the American Cancer Society and conducted in 29 centers in 27 locations throughout the United States.[34] Each center recruited approximately 10 000 women who were offered, without charge, an initial and four subsequent annual breast cancer screenings. The screenings consisted of a combination of medical history, clinical breast examination, two-view mammography, and thermography. Instruction in self-examination of the breasts was given and participants were encouraged to perform it monthly. Thermographic screening was discontinued in 1977 due to its low sensitivity.[35] In addition, because of questionable benefit in women under 50 years of age and concerns about radiation-exposure risks, in late 1976 mammography in women under 50 years of age was limited to those assessed by history and physical examination to be at high risk of breast cancer.[36]

The BCDDP was a breast cancer screening program. The project did not include a comparison group of women who did not receive mammographic screening. In the absence of a comparison group, BCDDP-derived incidence and mortality data are frequently compared with breast cancer incidence and mortality observations made in the Surveillance, Epidemiology and End Results program of the National Cancer Institute.

Approximately 51% of all women who participated in the BCDDP study completed all five of the offered screening examinations.[37] The screening program detected 4443 tissue-confirmed breast cancers in 4257 women. These women are being followed up to determine their mortality experience. Three additional groups of BCDDP participants are being followed up: approximately 24 000 women with breast biopsy results that were benign; approximately 9000 women who did not comply with referrals for breast biopsies; and 22 023 women who were not referred for biopsy nor received follow-up recommendations.[38]

Of the 4443 breast cancers recorded in 1981 among the BCDDP participants at the end of screening, 8557 were detected in the BCDDP screening centers and 886 were diagnosed outside the BCDDP centers.[39] Age-specific breast cancer detection rates per 1000 annual screenings increased with age from 2.0 in women aged 40 to 44 years to 6.6 in women aged 70 to 74 years. Forty-two percent of the cancers in the BCDDP study were detected by mammography alone compared with 34% of the cancers detected in the HIP study. The higher rate in the BCDDP study compared with the HIP study reflects improvements in mammography technology since the HIP study. Fewer cancers in women 40 to 49 years of age (35%) than in women 50 to 59 years of age (42%) were detected by mammography alone. This observation may be the result of the restriction of use of mammography in younger women in the mid-1970s, as well as the lower sensitivity of mammography in detecting early breast cancers in younger women.

Fifty-nine percent of all noninfiltrating cancers were detected by mammography alone compared with 6% by clinical examination alone, indicating the greater usefulness of mammography to detect cancers early in their natural history. Minimal cancers (noninfiltrating and infiltrating cancers of ≤ 1 cm) constituted approximately 33% of all cancers detected in women aged 35 to 39, 40 to 49, 50 to 59, and 60 years or older. In regard to the detection of interval cancers, the rates were higher in younger women. This finding is significant, for it suggests that breast cancers in younger women may grow more rapidly and hence require shorter screening intervals for their detection.[40]

Seidman et al[41] report findings for years 4 through 11 of follow-up of the 4240 women with breast cancers detected among participants of the BCDDP. Of detected cancers, 14% were intraductal in situ, 74% were invasive, and 10% were unspecified. Seventeen percent of the BCDDP screening-detected cancers were intraductal in situ compared with 9% of the cancers detected in women between their BCDDP screenings, which indicates a shift toward detection of interval cancers at a later stage in their natural history. An allowance of 1 year of lead time was used in calculating cumulative survival rates, and length-time bias was noted by the authors to be of little significance in regard to survival. *Relative cumulative survival rates* (observed survival rates adjusted for normal life expectancy) were also calculated in this analysis.

Cumulative 5-year relative survival rates for breast cancers in women under 50 years of age and 50 years of age or older at the time of diagnosis were 91% and 89%, respectively. In women under 50 years of age compared with women 50 years of age or older, cumulative survival rates for intraductal in situ cancers were 99% and 98%, respectively. The cumulative relative survival rates for invasive cancers in women under 50 years of age compared with women 50 years of age or older were 88% and 87%, respectively. The observed BCDDP survival rates for invasive breast cancers were higher than those observed in the Surveillance, Epidemiology and End Results program, in which the 5-year survival rate was 76% in women who were under 50 years of age at the time of diagnosis and 74% in women who were 50 years of age or older at the time of diagnosis.

Morrison et al[42] reported breast cancer incidence and mortality in the BCDDP among women aged 35 to 74 years at the time of their enrollment. After 9 years, the cumulative incidence of breast cancer was 1.84 times that expected, based on the Surveillance, Epidemiology and End Results program data. Observed vs expected (from Surveillance, Epidemiology and End Results data) ratios of age-specific incidence (age at entry into the study) for women aged 35 to 49, 50 to 59, and 60 to 74 years were 1.30, 1.36, and 1.36, respectively. The higher incidence in women enrolled in the BCDDP study may be due to the self-selection of women into the study (ie, women who feared they might have breast cancer may have been more likely to participate and/or screening may have diagnosed breast cancers that would have gone undetected at 9 years in unscreened women).

Morrison et al[43] also reported 9-year ratios of cumulative mortality (per

such examinations; these women do not constitute a valid group of control patients for the screened women in the study group. In addition, from 26% to 30% of women in the study group did not have mammograms, which may have led to an underestimation of mortality reductions in screened women.

Third, 96 of the breast cancers detected in study group women were in women who were not screened with mammograms, and 90 were detected in women between screenings. Of the 68 deaths in the study group women, 51 occurred in either nonscreened women or in women with interval cancers. Both of these observations may have led to underestimation of the true effects of mammographic screening on reductions in breast cancer mortality.

FINANCIAL COST

The financial cost of mammography is greater than that usually associated with screening tests recommended for use in the general public. In a recent American Cancer Society survey,[36] although 68% of primary care physicians agreed with the American Cancer Society guidelines for breast cancer detection in asymptomatic women, only 11% reported that they followed the recommendations. The most frequently reported reason (39%) for not following the mammography recommendations was that mammography is too expensive.

A number of cost-benefit analyses of mammographic screening programs have been done. However, as the analyses are based on different assumptions that are frequently not made clear, it is difficult to compare the divergent findings of these analyses.

Eddy et al[36] estimate that if 25% of all women aged 40 to 49 years were screened in the year 2000, the cost (in 1984 dollars) for screening, follow-up of false-positive tests, and continuing care would be approximately $408 million. Treatment costs for preventing later-stage breast cancers are projected to save about $6 million, resulting in a total screening expense of approximately $402 million in the year 2000. In 1984 dollars, this estimate is based on a mammography cost of $80 and a cost of $900 for a workup of a mammogram with abnormal or suspicious results. The estimated marginal expense per year of life saved was approximately $22 350.

The total annual cost of the two-county Swedish screening program is also available.[36] These data are not specific to the 40- to 49-year-old age group, and the expense of screening mammography is approximately one fourth to one third of that in the United States and that used by Eddy et al.[36] The annual cost of a screening unit that evaluates approximately 15 000 women per year was estimated at $814 000, based on $21 per screening visit. The total cost of a national mammographic screening program in Sweden was estimated to range from $27 million per year (yearly screening of all women aged 40 to 74 years with double-view mammography) to a low of $8 million (mammographic screening every 2 years in women aged 40 to 74 years with single-view mammography). The cost per year of life saved was estimated at $8400.

Moskowitz[40] calculated the total screening cost for the HIP program was $4 072 200, based on $45 for each mammogram. This total also includes an estimate of $312 000 for time lost from work for screenings, as well as of $835 200 for follow-up of false-positive screening examinations. If women in the HIP study had not been screened, 37 additional breast cancer deaths would have occurred. Expenses associated with these deaths would have included treatment ($2 220 000), short-term disability costs ($926 640), long-term disability costs ($1 710 720), and job-replacement costs ($712 800). Screening was estimated to have saved a total of $1 497 960, with a cost-effectiveness ratio of 0.73. The cost per cancer found in the HIP study is estimated to be $23 403 and the cost per breast cancer death averted is estimated to be $128 400.

Finally, as noted by Dodd,[9] if one assumes that the cost of a mammogram is approximately $50 per examination, and all women over 40 years of age in the United States were screened, the total annual cost would be approximately $2 659 500 000, in 1986 dollars. Third-party coverage of costs of screening mammography in asymptomatic women in the United States is increasing.[40] While Medicaid does not routinely cover costs of screening mammography in asymptomatic women, Medicare coverage is scheduled to begin in 1990.[41] A number of employee health programs and health maintenance organizations also provide coverage.[42]

CONCLUSIONS

Periodic mammographic screening of asymptomatic women has been shown to reduce breast cancer mortality. Evidence for its effectiveness in women 50 years of age and older is strong. Evidence for effectiveness of mammographic screening in women 40 to 49 years of age is growing. Questions regarding age-specific, optimal screening intervals continue to be addressed, and as additional data are collected in the Swedish, Canadian, and United Kingdom studies, more informed responses to such questions, including the comparative effectiveness of self-examinations, physical examinations, and mammography, as well as cost-effectiveness based on high false-positive rates, should be possible.

The most recent findings from the Swedish, two-county study indicate that to minimize interval cancers, women aged 40 to 49 years should be screened with two-view mammography at no longer than 18-month intervals, whereas women 50 years of age or older need to be screened no more frequently than every 24 months. Given these new findings, the current recommendation for annual screening in women over 50 years of age may be subject to change to a less frequent interval as more data become available. In addition, as more data become available, recommendations for screening may be changed to every 12 to 18 months for women aged 40 to 49 years.

Data regarding costs and benefits presented herein indicate that the cost of mammographic screening has presented reservations regarding policy recommendations for use in the population at large. However, serious efforts are currently under way to lower these costs.

RECOMMENDATIONS

The Council on Scientific Affairs recommends the following:

1. The AMA participate in and support the efforts of professional, voluntary, and governmental organizations to educate physicians regarding the role of screening mammography in reducing breast cancer mortality.

2. The AMA remain alert to new epidemiologic findings regarding age-specific breast cancer mortality reduction following mammographic screening.

3. Until more epidemiologic data become available, the AMA recommend annual screening mammograms and clinical breast examinations in asymptomatic women 50 years of age or older.

4. In light of the uncertainty based on current scientific data regarding an optimal screening interval in asymptomatic women aged 40 to 49 years, the AMA at the present time support a recommendation for screening mammograms and clinical breast examinations at 1- to 2-year intervals in asymptomatic women in this age group.

5. Given the high charges for screening mammography, the Board of Trustees through its Council on Medical Service identify explanations for the wide variability in charges for mammographic examinations.

6. Each facility that performs

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Use of Risk Factors in Counseling Patients

*Susan M. Love, MD**

One of the more difficult tasks the clinician is called upon to perform is educating and counseling his or her patient about risk factors. Part of the problem is that few of us are epidemiologists, so we are not always sure how to interpret the mountains of data and reports that are published in scientific journals and reported in headlines in the media. Our attempts to simplify are often misleading and can have significant consequences for an individual woman. It is important that we are very precise about what the data really demonstrate and that we accurately describe for the patient how it relates to her.

Three kinds of risk are commonly used in describing breast cancer: absolute risk, relative risk, and attributable risk. Each is derived differently and has different interpretations and applications.

Absolute risk is the rate of occurrence of cancer or mortality from cancer in a general population. It can be expressed either as the number of cases for a specified denominator (that is, 50 cases per 100,000 annually) or as a cumulative risk up to a specified age. The cumulative risk is the source of the 1 in 10 lifetime figure that has been emphasized so much. Certain assumptions are made in reaching this figure, however. First, it assumes that the risk of getting breast cancer is the same in all women. Second, it assumes that a woman will live to age 110.[3] Therefore, saying 1 in 10 women will get breast cancer in their lifetime does not mean you can count 10 women in a room and one of them will get breast cancer. What it means is that if you take ten 25-year-old women who have the same risk of getting breast cancer, and if they all live to age 110, then the chances are that one of them will have gotten breast cancer during her lifetime. This figure will be an overestimate for the woman with no risk factors and an underestimate for the one with risk factors but no help at all to the 40-year-old woman who is sitting in your office.

The risk of breast cancer at any one time depends largely on the age of the woman. For the average woman, it is approximately 1/1000/year at

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With respect to detection of breast cancer, including cases diagnosed within the first 5 years after entry into the study, breast cancer rates of 2.03 per 1000 person-year and 1.94 per 1000 person-year were reported in the total study and control groups, respectively.[8] The breast cancer detection rate was lower in women in the study group who refused screening (1.58 per 1000 person-years) than women in the control group. The relative contribution of mammography alone to detection was 14.4% for women under 50 years of age and 37.6% for women 50 years of age or older at the time of diagnosis. Of the breast cancers detected by abnormal mammograms alone, 21% had evidence of axillary node involvement. Of those detected by clinical examination alone, 25% had evidence of node involvement, and of those detected by both clinical examination and mammography, 52% had evidence of axillary node involvement.

Screening, including mammography, led to earlier detection of breast cancers. Twelve percent of the cancers detected in the study group were intraductal with a favorable prognosis, compared with 7% of the cancers detected in women in the control group. Evidence of later cancers with spread to the axillary nodes was observed in 55% of cancers detected in the control group, 30% of cancers detected in screened women in the study group, 61% of cancers detected in unscreened women in the study group, and 48% of cancers detected in women in the study group who were screened but whose cancers were detected at intervals between or follow- from 38% at 5 years to 22% at 16 years.[11]

In addition to comparison of the number of deaths observed in study and control group women, differences in survival rates also can be compared. Both *lead-time bias* (lead time gained in cases detected through screening that extends the time interval from detection to death) and *length-time bias* (tendency of screening to detect cases of cancer that have longer periods of preclinical disease) can distort case survival rates and require consideration in interpretation of the differences observed between case patients and control patients. Shapiro et al[12] adjusted their findings for 1 year of lead time.

Study findings also indicated that screening mammography led to earlier detection of breast cancers and, consequently, better survival in women who were screened. Cumulative survival rates per 100 women at 5, 10, and 14 years of follow-up for screened women with HIP screening program–detected breast cancers were 87, 64, and 55, respectively, and they were better than those observed in women in the control group of 60, 46, and 40, respectively. Women who were screened but had their cancers detected outside the program (screened but nonscreening-detected or interval cancers) were observed to have survival rates similar to those observed in women in the control group who had no screening. In addition, at three follow-up times (5, 10, and 12 years), the highest survival rates were observed for women whose breast cancers were detected by mammography alone; after 12 years of follow-up, 88% of these women were still surviving years of age or older at the time of diagnosis of breast cancer, and, when adjustment for age at the time of diagnosis is taken into consideration, the number of deaths among women aged 45 to 49 years in the study and control groups did not differ. There were too few deaths in the 40- to 44-year-old age group to assess differences in numbers between the study and control groups.[8]

An important consideration regarding comparisons of numbers of deaths in women in the study and control groups within specific age groups is noted by Shapiro et al.[8] The HIP study sample size was determined to examine differences in mortality between the total number of women in the control and study groups and not within smaller subgroups of women (ie, women aged 40 to 49 years). Therefore, the observation of no statistically significant reduction in mortality in screened women 40 to 49 years of age could be due to the study power being too low to detect existing differences in mortality between control and study group women in this age group.

Habbema et al[14] also reported findings from an analysis of 14 years of follow-up mortality data from the HIP study. To take lead-time differences between the study and control groups of women into consideration, they included all breast cancer cases diagnosed within 7 years after the start of the study—a period that included about 3.5 years following the last screening examination. They report percentage mortality reductions in women aged 40 to 44, 45 to 49, 50 to 54, 55 to 59, and 60 to 64 years of 31%, 14%, 22%, 19%, and

SB366

SENATE BUSINESS & INDUSTRY
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FREEDOM OF CHOICE IN HEALTH INSURANCE

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APPENDIX A

A model of the market for health insurance is described as follows. The demand for health insurance in state i at time period t is given by the equation

$$(1) \quad P^d_{it} = \alpha_0 + \alpha_1 Q^*_{it} + \alpha_2 M_{it} + \alpha_3 U_{it} + \alpha_4 GSP_{it} + u_{1it}$$

where P^d is the maximum price consumers will pay, Q* is the equilibrium amount of health insurance, M is the number of mandated benefits, U is the unemployment rate, GSP is the gross state product per capita, and u_1 is an error term.

The supply of health insurance in state i at time period t is given by the equation

$$(2) \quad P^s_{it} = \beta_0 + \beta_1 Q^*_{it} + \sum_{j=2}^{4} \beta_j R_{jit} + \sum_{j=5}^{18} \beta_j \left(\frac{OUT}{TOT}\right)_{jit} + \beta_{19} TAX_{it} + \beta_{20} M_{it} + u_{2it}$$

where P^s is the minimum price sellers will accept, R_j is a binary variable indicating the presence or absence of rate regulation of type j, $(OUT/TOT)_j$ is the percent of total state output produced in industry j, TAX is indirect business taxes per capita; and u_2 is an error term.

Partial Adjustment Model

Equilibrium in the health insurance market in state i occurs when supply equals demand. That is when $P^s_{it} = P^d_{it}$ or when the premium price the buyers are willing and able to pay is equal to the premium price providers are able and willing to accept.

We know that equilibrium is not achieved instantaneously in the health insurance market. Equilibrium is reached by a combination of accommodations by suppliers and demanders of health insurance. One way to express the process of reaching an equilibrium is through a partial adjustment process. That process of adjustment can be symbolized as $Q_{it} - Q_{i,t-1} = \gamma(Q^*_{it} - Q_{i,t-1})$, where $0 \leq \gamma \leq 1$. This means that the adjustment moves toward the equilibrium value Q* over a period of

The left hand side of (5a) is the percentage of people who are uninsured. In our estimation process we multiply both sides of the equation by POP. The result is POP - Q = POP - $(A_0 + A_1M + A_2U + ...)$ or $-Q = -(A_0 + A_1M + A_2U + ...)$. This means that all of the parameters in our model are identified, but the signs have been reversed. In other words, what causes a higher percent of people to be insured causes a lower percentage to be uninsured.

Under conventional assumptions concerning the statistical nature of the stochastic disturbance terms u_{1it} and u_{2it}, ordinary least squares regression is an appropriate estimation technique. Under these conditions our methods lead to consistent and asymptotically efficient estimates of the model's parameters.

The estimated model is obtained by replacing Q^*_{it} in equation (5) by

$$(6) \quad \frac{(Q_{it} - (1-\gamma)Q_{i,\,t-1})}{\gamma}$$

which yields

$$(7) \quad Q_{it} = (1-\gamma)Q_{i,t-1} - \frac{\gamma(\alpha_0-\beta_0)}{\alpha_1-\beta_1} - \frac{\gamma(\alpha_2-\beta_{20})}{\alpha_1-\beta_1}M_{it} - ... + \left(\frac{\gamma}{\alpha_1 - \beta_1}\right)(u_{2it} - u_{1it})$$

In this case Q_{it} represents the observed percent of people without health insurance and the u's are normally distributed, with

$E(u_i) = 0$, var $(u_i) = \sigma^2$ and cov $(u_i, u_j) = 0$.

Variable	Definition and Data Source
NHINS	Percent of non-elderly population with no health insurance for 1985 and 1986. (Employee Benefit Research Institute, Issue Brief, May, 1987; and May, 1988.)
MANDATES	Number of mandated health care benefits required by various states. (Blue Cross and Blue Shield Association, Office of Government Relations, State Services Department, January, 1988.)
Rate Regulations: EAUTH IAUTH IAUTHNO	Three binary variables indicating the nature of the rate regulations prevailing in the states (i.e., explicit authority to regulate premium rates, implicit authority to regulate rates, and no implicit authority to regulate rates). Note: a fourth variable (no explicit authority to regulate rates) was dropped. (Price and DeLaney/NCPA.)
PCGSP	Per capita gross state product. (Department of Commerce, Survey of Current Business, May, 1988.)
PCTAX	Per capita indirect business taxes. (Department of Commerce, Survey of Current Business, May, 1988.)
Structural Variables:	Gross state products by industry. Note: federal military was dropped. (Department of Commerce, Survey of Current Business, May, 1988.)
FARMS	Farms.
AGRI	Agricultural services, forestry and fisheries.
CONSTR	Construction.
MINE	Mining.
DURABLES	Manufacturing - durable goods.
NDURABLES	Manufacturing - nondurable goods.
TRANSP	Transportation and Public Utilities.
WTRADE	Wholesale trade.
RTRADE	Retail trade.
FINANCE	Finance, insurance, and real estate.
SERVICES	Services.
FEDGOV	Federal civilian government.
STLCGOV	State and Local Government.

Our results show that the single most significant factor contributing to the growing number of uninsured people is mandated health care benefits. According to our data, approximately 37 million people have no health insurance. We estimate that 14 percent of them, or a total of 5.2 million people, are without health insurance as a direct result of state mandated health care benefits.

In terms of economic markets, the coefficient $(1-\gamma)$ has a large t-statistic which is to be expected if the insurance market is slow to adjust to equilibrium. In our case the adjustment is very slow About four percent in any disequilibrium gap is closed in one year. This means that state regulations (mandates and rate regulations) produce inefficient allocations of resources. Consumers and suppliers cannot adjust to their desired level of insurance purchase and sales.

The rate regulation variables are the only other variables where specific coefficients had separately identifiable effects. We did not expect any of these variables, nor the industry structural variables, to have individually quantifiable influences on the percent of people uninsured. We did expect unemployment, gross state product and indirect business taxes to have identifiable impacts. When all of the economic factors in the model are included, unemployment does not have a separate effect. Higher state income is associated with lower levels of people without health insurance, as we expected. Also, higher indirect business taxes are consistent with higher percentages of people without health insurance. We do not make any claims concerning the interpretation of these individual coefficients. However, one can see part of the economic process in action. For example, of the structural variables, wholesale trade has the highest t-statistic. It is well known that wholesale and retail trade plus services have relatively low rates of health insurance coverage. In addition, the federal government has high coverage. Our model is in agreement with these facts. We also note the relatively high value of the coefficient of determination after correcting for degrees of freedom. The model and the data seem to be consistent.

We were not satisfied with a single result, even if that result was dramatic. Our results seem to indicate that we have slow adjustment to equilibrium. It might be possible to obtain confirming results by reestimating reduced form annual models where the year to year changes are not present.

Annual Models

We reestimated two additional annual versions of the model. The first model is for 1985 and the second is for 1986, the most recent year for which data are available. The results are as follows:

Parameter Estimates: 1985 Annual Model

EQUATION: 2

DEPENDENT VARIABLE: NHINS85 (Percent of people without health insurance in 1985)

TOTAL OBSERVATIONS: 47 DEGREES OF FREEDOM: 26

R**2: .94888226 RBAR**2: .90956093

SSR: 989012.41 SEE: 195.03574

DURBIN-WATSON: 1.93276861

No.	Label	Coefficient	Stand. Error	T-Stastic
1	CONSTANT	121.5406	61.66898	1.970854
2	MANDATES85	.2402324	.1102901	2.178187
3	UNEMP85	.6824406	.4773556	1.429628
4	EAUTH	-3.310617	2.642282	-1.252939
5	IAUTH	-6.814506	3.375479	-2.018827
6	IAUTHNO	-4.255663	2.601649	-1.635756
7	PCGSP85	-.3718421	.6054451	-.6141633
8	PCTAX85	-5.867217	4.390963	-1.336203
9	FARMS85	-93.86216	65.94504	-1.423339
10	AGRI85	-128.0080	382.4854	-.3346743
11	MINE85	-42.70966	57.32271	-.7450739
12	CONSTR85	2.336543	87.13869	.0268140
13	DURABLES85	-130.7575	53.94302	-2.423993
14	NDURABL85	-126.3279	70.07460	-1.802764
15	TRANSP85	-202.7656	76.73359	-2.642462
16	WTRADE85	58.28214	65.25377	.8931613
17	RTRADE85	10.32106	167.1523	.0617464
18	FINANCE85	-119.1641	70.94300	-1.679716
19	SERVICES85	-93.33781	64.92925	-1.437531
20	FEDGOV85	-222.8615	92.66268	-2.405083
21	STLCGOV85	-142.3675	90.73053	-1.569125

Parameter Estimates: 1986 Annual Model

EQUATION: 3

DEPENDENT VARIABLE: NHINS86 (Percent of people without health insurance in 1986)

TOTAL OBSERVATIONS: 50 DEGREES OF FREEDOM: 29

R**2: .94411261 RBAR**2: .90556958

SSR: 1275482.2 SEE: 209.71921

DURBIN-WATSON: 1.69857393

No.	Label	Coefficient	Stand. Error	T-Statistic
1	CONSTANT	89.20582	70.63262	1.262955
2	MANDATES86	.3005725	.1223011	2.457644
3	UNEMP86	1.048330	.5341898	1.962468
4	EAUTH	-4.889916	2.825964	-1.730353
5	IAUTH	-9.836038	3.427377	-2.869844
6	IAUTHNO	-5.681983	2.644034	-2.148982
7	PCGSP86	-.0108217	.7120041	-.0151990
8	PCTAX86	-3.174815	4.296943	-.7388545
9	FARMS86	-110.5493	76.05452	-1.453554
10	AGRI86	-135.9224	378.4848	-.3591223
11	MINE86	-53.38495	67.55392	-.7902568
12	CONSTR86	-18.92929	96.47855	-.1962020
13	DURABL86	-123.1774	59.51452	-2.069703
14	NDURABL86	-113.8465	77.16567	-1.475352
15	TRANSP86	-129.6379	81.58208	-1.589049
16	WTRADE86	36.53968	70.40693	.5189784
17	RTRADE86	146.6216	161.1671	.9097490
18	FINANC86	-112.6120	77.41692	-1.454618
19	SERVC86	-119.2101	68.96267	-1.728618
20	FEDGOV86	-257.1540	104.4142	-2.462826
21	STLCGO86	-64.44493	99.80877	-.6456840

The most striking feature of the results is the stability of our finding across all models.[1] In the two annual models, mandates were highly significant influences in increasing the percentage of individuals with no health insurance. These short-run results show that higher levels of causation may be appropriate. For example, in 1985 our estimate is that each mandate increases the percentage of people with no health insurance by 0.284 compared to 0.167 in the partial adjustment model. The 1986 model results in a coefficient of 0.301. By comparison with the partial adjustment model, the 1986 results would indicate that 4.5 percent of the nonelderly population or 25.2 percent of the noninsured population are uninsured because of mandated health insurance benefit regulations.[2]

In the short-run annual models, unemployment has a much stronger impact on lack of health insurance. Apparently, the generally short-term nature of most peoples' unemployment results in short-term absence of health insurance. However, as time progresses these individuals reobtain or purchase health insurance. State level fluctuations in other measures of economic activity produce unstable results in their impact on health care insurance. The general structure of the state's economic development has a more stable pattern of influence on the provision of health care coverage in comparison to short-run impacts of transitory changes in economic activity. These results are remarkably consistent.

Conclusion

Our overall finding is that the economic process of supplying and demanding health insurance is rational and produces expected results. Economic markets for health insurance are hindered by regulations. The structure of industry within a state, as well as its short-term level of economic activity, influence the number of individuals without health insurance. Health insurance rate regulation also is important.

In terms of statistical reliability, the major determinant of the lack of health insurance is mandated benefit regulations. More mandates mean more people without health insurance. We estimate that between 14.0 and 25.2 percent of those without health insurance have no insurance because of regulations that mandate coverage. That is, in 1986 between 5.2 million people and 9.3 million people had no health insurance coverage because state governments imposed special interest regulations mandating

[1]The model for 1986 has three additional states because in 1986 these states had enough residents who were uninsured as to be statistically significant. These states were thus added to the data base.

[2]See Table A-1.

health insurance coverage. The accompanying table shows the distribution by state. Since the number of mandates is growing, these estimates probably have lower values than the effects of mandates in 1988.

TABLE A-1

	Population Uninsured (Thousands)	Estimates of Uninsured Population Due to Mandates (Thousands)	
		Low[1]	High[2]
ALABAMA	859	42	75
ALASKA	97	5	8
ARIZONA	651	72	131
ARKANSAS	487	40	72
CALIFORNIA	5142	916	1650
COLORADO	450	42	75
CONNECTICUT	345	122	220
DELAWARE	99	4	7
FLORIDA	2242	225	406
GEORGIA	954	80	144
HAWAII	107	10	18
IDAHO	196	6	10
ILLINOIS	1481	185	334
INDIANA	833	78	140
IOWA	295	30	53
KANSAS	299	45	82
KENTUCKY	659	58	104
LOUISIANA	904	78	141
MAINE	145	25	46
MARYLAND	617	205	370
MASSACHUSETTS	605	93	168
MICHIGAN	965	136	244
MINNESOTA	389	129	232
MISSISSIPPI	606	41	74
MISSOURI	714	117	211
MONTANA	134	16	28
NEBRASKA	234	35	62
NEVADA	154	25	45
NEW HAMPSHIRE	101	13	24
NEW JERSEY	825	156	281
NEW MEXICO	325	29	53
NEW YORK	2556	586	1057
NORTH CAROLINA	985	89	161
NORTH DAKOTA	87	10	18
OHIO	1409	218	394
OKLAHOMA	636	37	67
OREGON	478	44	79
PENNSYLVANIA	1185	199	358
RHODE ISLAND	69	8	15
SOUTH CAROLINA	468	33	60
SOUTH DAKOTA	103	9	16
TENNESSEE	826	87	157
TEXAS	3833	389	701

UTAH	253	34	60
VERMONT	69	4	7
VIRGINIA	622	104	188
WASHINGTON	603	102	183
WEST VIRGINIA	295	22	39
WISCONSIN	444	124	224
WYOMING	78	5	9
TOTAL	36913	5162	9301

[1]Based on the equilibrium values of the partial adjustment model.

[2]Based on the 1986 annual model.

ABOUT THE AUTHORS

JOHN C. GOODMAN is President of the Dallas-based National Center for Policy Analysis. He has written widely on health care, Social Security, the welfare state and other public policy issues. He is author of six books, including *National Health Care in Great Britain* and *Regulation of Medical Care: Is the Price Too High?*

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SENATE STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 248 (first reading copy -- white), respectfully report that Senate Bill No. 248 be amended and as so amended do pass:

1. Title, line 6.
Strike: "INCREASING" on line 6 through "THE" on line 7
Insert: "CREATING A NEW"

2. Page 4, line 6.
Strike: "25"
Insert: "10"

3. Page 4, line 10.
Following: "~~and~~"
Insert: "and"

4. Page 4, line 17.
Strike: "; and"
Insert: "."

5. Page 4, line 18 through 25.
Strike: subsection (iii) and (b) in their entirety
Renumber: subsequent subsections

6. Page 5, line 1.
Following: "(c)"
Strike: "The" on line 1 through "remuneration." on line 9
Insert: "any transaction pursuant to an offer made in this state directed by the offeror to not more than 25 persons, other than those designated in subsection (7), during any period of 12 consecutive months if:

(i) the seller reasonably believes that all the buyers are purchasing for investment;"

(ii) no commission or other remuneration is paid or given directly or indirectly for soliciting any prospective buyer; provided, however, that a commission may be paid to a registered broker-dealer if the securities involved are registered with the United States securities and exchange commission under the federal Securities Act of 1933, as amended; and

(iii) the offeror applies for and obtains the written approval of the commissioner prior to making any offers in this state and pays a filing fee that must accompany the application for approval. The commissioner may deny an application.

Signed: _____
John "J.D." Lynch, Chairman

2-19-91
Bud. Coord.

2-19 2:10
Sec. of Senate

SENATE STANDING COMMITTEE REPORT

February 19, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 366 (first reading copy -- white), respectfully report that Senate Bill No. 366 be amended and as so amended do pass:

1. Page 2, line 5.
Strike: "dollar limits,"

2. Page 2, line 7.
Following: "generally."
Insert: "A minimum $50 limit must be made available for each of these services."

Signed: _____
John "J.D." Lynch, Chairman

2-19-91
Amd. Coord.

SR 2-19 3:10
Sec. of Senate

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SENATE STANDING COMMITTEE REPORT

February 19, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 242 (first reading copy -- white), respectfully report that Senate Bill No. 242 be amended and as so amended do pass:

1. Title, line 14.
Strike: "AND"
Following: "90-3-301,"
Insert: "AND 90-3-524,"

2. Page 4, line 7.
Strike: "June 30, 1993,"

3. Page 12, line 7.
Following: line 6
Insert: "Section 7. Section 90-3-524, MCA, is amended to read:

"90-3-524. Research and development project loan agreement -- specific requirements -- payback. In addition to the loan agreement provisions described in 90-3-522, a research and development project loan agreement must be structured as contracted debt with the following terms:

(1) The agreement must include provisions calling for a payback of at least two times the original loan amount paid as a percentage of the income stream derived from the sale or other commercialization of products or processes developed with the board's financing. This percentage rate may not exceed 5%.

(2) The payback on a research and development project loan for a technology transfer and assistance project may be made pursuant to subsection (1) or may be realized in terms of indirect benefits related to the goals and criteria of the program. No more than 10% of the board's annual allocation of research and development funds may be used for technology transfer and assistance projects.""

Renumber: subsequent sections

Signed: _____
John "J.D.J" Lynch, Chairman

2-19-91
Amd. Coord.

SB 2-19 2:10
Sec. of Senate