MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN BILL BOHARSKI**, on January 20, 1993, at Room 104.

ROLL CALL

Members Present:

Rep. Bill Boharski, Chair (R)
Rep. Bruce Simon, Vice Chair (R)
Rep. Stella Jean Hansen, Vice Chair (D)
Rep. Beverly Barnhart (D)
Rep. Ellen Bergman (R)
Rep. John Bohlinger (R)
Rep. Tim Dowell (D)
Rep. Duane Grimes (R)
Rep. Brad Molnar (R)
Rep. Tom Nelson (R)
Rep. Sheila Rice (D)
Rep. Angela Russell (D)
Rep. Tim Sayles (R)
Rep. Liz Smith (R)
Rep. Carolyn Squires (D)
Rep. Bill Strizich (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Alyce Rice, Committee Secretary

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

Committee Business Summary:
Hearing: SB 6, SB 7, SB 34, SB 43
Executive Action: HB 144, HB 118

HEARING ON SB 6

Opening Statement by Sponsor:

SENATOR DENNIS NATHE, Senate District 10, Redstone, said SB 6 is a bill defining the role and mission of the Montana State

Hospital at Warm Springs. The role of the Warm Springs facility is to provide intensive inpatient psychiatric services as one component in a comprehensive continuum of publicly and privately provided programs that emphasize treatment in the least restrictive environment. The mission of the Warm Springs facility is to stabilize persons with severe mental illness and return them to the community as soon as possible if adequate community-based support services are available.

Proponents' Testimony:

John Shontz, Public Policy Coordinator, Montana Mental Health Association, said the bill recreates the mission of the state hospital. It is a hospital that will provide intensive in-patient psychiatric treatment. The hospital is not a dumping ground for the courts to put people because there is no other place to put them. For many years people have been committed to the Montana State Hospital and Warm Springs. With the changes in the bill, people will be admitted to the Montana State Hospital and Warm Springs.

Kathy McGowan, Montana Council of Mental Health Centers. Written testimony. **EXHIBIT 1**

Opponents' Testimony:

None

Questions From Committee Members and Responses:

REP. MOLNAR asked **Mr. Shontz** where the people that are brain injured and don't belong in the hospital would go. **Mr. Shontz** said the legislature should consider establishing a program to help the brain-injured.

REP. BERGMAN asked **Mr. Shontz** where he thought the brain injured belonged. **Mr. Shontz** replied he was not a medical expert. He said several neighboring states have major rehabilitation centers. **REP. BERGMAN** asked if the brain injured could be rehabilitated. **Mr. Shontz** said many of the Boulder River School residents have been moved into communities and have become far more self-sufficient than they were in the institution.

REP. SMITH asked **Mr. Shontz** what the options were for brain-injured people who would be moved from the hospital; would they be moved into group homes? **Mr. Shontz** said brain-injured patients in the hospital don't have to be moved the day after the bill passes. He said Community Hospital in Missoula has a twenty-six bed facility which cares for the brain-injured. The legislature should look at what options there are.

CHAIRMAN BOHARSKI asked **Mr. Shontz** if he could foresee a net reduction of patients at the hospital over a period of time as a result of the legislation. **Mr. Shontz** said the patients at the

hospital would not be long-term residents. After treatment patients would be moved into community-based settings when appropriate. There may be more of a need for in-patient psychiatric care than there is now, or there may be less.

REP. MOLNAR asked **Mr. Shontz** if the legislation radically changed the original charter of the hospital. **Mr. Shontz** said the hospital's mission has changed because it will become an in-patient psychiatric hospital.

Closing by Sponsor:

SEN. NATHE said the legislation is a step in the right direction.

HEARING ON SB 7

Opening Statement by Sponsor:

SEN. DENNIS NATHE, Senate District 10, Redstone, said SB 7 is in response to various groups in Billings who are providing food, shelter, and clothing to the homeless. A large percentage of the homeless are mentally ill. Many of the homeless have money in the bank but are so confused they don't know it's there. The providers of these services feel they should have a seat on the Regional Mental Health Corporation Boards. The providers are dealing with mental illness and want to have some input into the strategy the programs that are being developed.

Proponents' Testimony:

Kathy McGowan, Montana Council of Mental Health Centers (MCMHC), said the council opposed the original version of the bill, but now agrees with the amended version of SB 7. **EXHIBIT 2**

John Shontz, Public Policy Coordinator, Montana Mental Health Association (MMHA), said the MMHA had also opposed the original version of the bill, but agrees with the amended version of SB 7.

Opponents' Testimony:

None

Questions From Committee Members and Responses:

REP. JOHN BOHLINGER asked **Ms. McGowan** what the council found objectionable in the original version of the bill. **Ms. McGowan** said this bill was more of a solution to a localized problem and not a statewide problem. The bill provided for problem solving at the local level without making statutory changes.

REP. SIMON asked **SEN. NATHE** about his statement that the providers of the homeless services really wanted to have a seat on the board. He said the bill seems to reduce the odds of them being included on the board. The ratio of board members is now one out of five instead of two out of three from this group. **SEN. NATHE** said that was a compromise in order to keep the bill alive. It does change the odds, but they still have a chance to get on the board.

Closing by Sponsor:

SEN. NATHE closed.

HEARING ON SB 34

Opening Statement by Sponsor:

SENATOR DOROTHY ECK, Senate District 40, Bozeman, said SB 34 creates an interagency coordinating council for state prevention programs and services for children and families in Montana. This bill establishes a council which would be made up of the Director of Family Services, the Director of the Department of Health and Environmental Sciences, the Director of the Department of Corrections and Human Services, the attorney general, the Director of the Department of Social and Rehabilitation Services, the Superintendent of Public Instruction, the presiding officer of the Montana Children's Trust Fund Board, two persons appointed by the governor who have experience related to the private or nonprofit provision of prevention programs and services, and the Administrator of the Board of Crime Control. The bill requires the council to provide for collaboration among the programs, to look at how cooperative partnerships could be developed and plan for financing the programs.

Proponents' Testimony:

Jean Kemmis, Montana Council for Families. Written testimony. **EXHIBIT 3**

Fred Fisher, Board of Crime Control, said SB 34 creates a prevention policy for the state. HB 18 establishes the Montana family policy act. The Montana family policy act provides guiding principals for state agencies and private nonprofit groups who are involved in prevention and treatment services for children and families. HB 18 lays the groundwork for the shared vision of human services in Montana. SB 34 provides an additional critical element in the creation of a prevention policy for the state. SB 34 is the action statement for the Montana family policy act. In the past several years in Montana, commonly held practices constituted the prevention policy. In the issues of children and families common practices create unnecessary and destructive turf considerations. Resources, both

financial and human, are too precious to let turf considerations be a common practice in the state. SB 34 requires agency heads and elected officials in the private sector to come together to develop a policy which supports all prevention efforts in a way that is coordinated and comprehensive. He urged support of SB 34. **EXHIBIT 4**

Richard Kerstein, Department of Family Services (DFS), Montana Children's Trust Fund Board (MCTFB), said the need for coordinated prevention planning has become evident. There is a network in Montana of private and public agencies interested and supportive of prevention activities. SB 34 provides the structure for those agencies to meet and engage in collaborative planning. He encouraged support of SB 34.

Dennis Taylor, Deputy Director, Department of Justice (DOJ), said one of **Attorney General Joe Mazurek's** six priorities for the DOJ is to strengthen the department's commitment to youth issues. In these difficult economic times in Montana, social service, mental health, education, justice, and law enforcement agencies must work together on prevention issues which focus combined energies and resources on fragile families and children before problems develop. State coordination, coupled with a similar commitment to coordination at the community level, can direct our limited resources to do the most good. He said **Attorney General Mazurek** urged support of SB 34.

Nancy Coopersmith, Office of Public Instruction, said prevention is an important part of education. She said **Superintendent Nancy Keenan** strongly supports the creation of a council which the bill would support. The council would provide a formal vehicle for continued collaboration and coordination between state agencies.

Judith Gedrose, Department of Health and Environmental Sciences. Written testimony. **EXHIBIT 5**

Elizabeth Dane, Montana Chapter, National Association of Social Workers. Written testimony. **EXHIBIT 6**

Darryl L. Bruno, Administrator, Alcohol and Drug Abuse Division. Written testimony. **EXHIBIT 7**

Jeana-marie L. Fiumefreddo, Student, University of Montana. Written testimony. **EXHIBIT 8**

Sharon Hoff, Montana Catholic Conference said the Montana Catholic Conference supports SB 34. **EXHIBIT 9**

Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health (MCMCH), said MCMCH supports SB 34.

REP. TIM DOWELL, House District 5, Kalispell, expressed his support of SB 34.

Opponents' Testimony:

None

Questions From Committee Members and Responses:

REP. BRUCE SIMON said he was concerned about the coordination of six different agencies sharing minimal costs. He said the bill states the governor's office may assist in providing staff and budgetary administrative and clerical services. He said it didn't sound as if the Office of Public Instruction and the Department of Justice and other agencies under the governor's control would be contributing. He thought the language in the bill should be changed to make the funding situation clearer. He asked **SEN. ECK** for her opinion. **SEN. ECK** said the staffing money should be able to come out of the $6,000,000 in prevention money that is now available. She said she didn't think there would be any problems with collaboration and coordination between the agencies. **REP. SIMON** asked **SEN. ECK** how she felt about putting a sunset provision on the council effective four years from now so the council could be reviewed to see how well it is doing. **SEN. ECK** agreed. **REP. SIMON** asked **SEN. ECK** why the legislative branch was excluded from the council. **SEN. ECK** said the legislative branch doesn't run programs.

REP. BOHLINGER asked **Mr. Fisher** if there were other organizations that could be approached for part of the funding effort. **Mr. Fisher** said Montana 4-H would provide up to 26 percent of the up-front cost to staff the interagency council. He said there is a fiscal note attached to the bill for $5,460 in FY 1994 and $8,460 in FY 1995. There has also been discussion about different agencies pooling discretionary funds to complete the funding.

CHAIRMAN BOHARSKI asked **Ms. Kohman** if she was confident that the money needed would be there and the fiscal note wouldn't be needed. **Ms. Kohman** said only one staff person is needed and one of the members of the prevention caucus would probably donate one of their staff. She said she felt the departments would provide money. Most of the members will be made up of department directors, who won't be paid per diem.

Ms. Kemmis said the principal goal is to do away with the fiscal note if at all possible. Several directors of the agencies involved said they would pick up the costs shown on the fiscal note. A letter of agreement has been drawn up for that purpose.

Closing by Sponsor:

SEN. ECK said this is a major effort launching a collaborative program to deal with our youth. Direction and coordination is needed from the state level.

HEARING ON SB 43

Opening Statement by Sponsor:

SEN. STEVE DOHERTY, Senate District 20, Great Falls, said SB 43 gets rid of the sunset provision on HB 405. He said HB 405 amended Montana's health care provider lien law.

Proponents' Testimony:

Jim Ahrens, President, Montana Hospital Association. Written testimony. **Exhibit 10**

Jerry Loendorf, Montana Medical Association, said the genesis of HB 43 was the Montana Hospital Association. The bill is designed to ensure that the person who does the work gets paid for it. When the insurer makes the payment, whether it is made to the physician, nurse, another health care provider, or the hospital, the payment is the same amount that would be paid to the patient. That is because the insurer has a contract which states its obligations. This bill also ensures that the cost to people who pay is not increased because some people choose not to pay.

Tom Ebsery, Attorney, St. Vincent Hospital and Health Center, Billings, Montana said SB 43 makes the one health service corporation in Montana, Blue Cross and Blue Shield, subject to the lien act. The hospital physician lien law only controls who gets the payment. It can't be used as leverage to sign a contract with Blue Cross and Blue Shield. There is no reason to exempt an insurance company which controls nearly one-half of the health insurance market. He stated one hundred ten physicians in Billings strongly support this bill.

Mona Jamison, Montana Chapter of the American Physical Therapy Association (MCAPTA), said the health service corporation, Blue Cross and Blue Shield, should be included in the lien act as a matter of fairness. **Ms. Jamison** said the opponents to the bill will say it will drive health care costs up. MCAPTA believes the bill provides the most expedient way to keep costs under control.

REP. BOHLINGER, House District 94, Billings, said Blue Cross and Blue Shield of Montana (BCBS) writes over fifty percent of the commercial health care insurance in Montana. They were exempted from the lien act prior to 1991 which gave them a significant advantage over other commercial insurers. For example, if a BCBS patient was to direct their health claim payments to a physician or a hospital, unless the hospital or physician agreed to grant BCBS a discount, BCBS would send the payment to the patient. BCBS has a strong leverage in this respect. As a result, the physician or hospital would be forced to track down the patient in order to collect the payment, and increasing collection efforts increases operational costs. He urged passage of SB 43.

Steve Browning, Attorney, Montana Hospital Association, said everyone is acutely concerned about health care costs. Health care costs have to be controlled. He urged support of SB 43. **EXHIBITS 11 and 12**

Bonnie Tippy, Montana Chiropractic Association (MCA), said MCA supports SB 43.

Opponents' Testimony:

Joyce Brown, Chief, Employee Benefits Bureau, Department of Administration. Written testimony. **EXHIBIT 13.**

Steve Turkiewicz, Executive Vice President, Montana Automobile Dealers Association, Secretary, Montana Automobile Dealers Insurance Trust, said the association has tried over the past few years to employ cost containment measures. In that time health care costs went from $2,000,000 to $4,000,000 being paid to health care providers. He urged the committee not to pass SB 43.

Rosana Skelton, Montana Contractors Health Care Trust (MCHCT), said the legislation is anti-consumer and makes keeping health care costs down impossible. MCHCT opposes SB 43.

Tanya Ask, Blue Cross And Blue Shield of Montana (BCBS), said in order to receive reimbursement from BCBS, physicians have to be members. Physicians must accept the BCBS allowance as full payment for their service. The benefit to the physician is direct reimbursement. For example, if a physician charges $100 for a particular service, BCBS allows $90 for that service. As part of the contract, the physician will accept $90 for that service as full payment. The patient benefits by saving $10. The BCBS cost containment program is a physician cost containment program and has been very successful. In 1991 the cost containment program saved BCBS members, as well as the consumer, $4,000,000. SB 43 allows the privilege of membership without the obligations. The physicians contracts have been an important cost containment measure in the state of Montana. If HB 43 passes, the consumer will pay the additional $4,000,000.

Informational Testimony:

CHAIRMAN BOHARSKI said HB 43 would be continued on Friday, January 22, 1993 because some of the people from out of town who wanted to testify were not notified in time.

Questions From Committee Members and Responses:

REP. BOHLINGER asked **Tanya Ask** how much money hospitals and physicians write off when they are unable to collect because the insured received the check and chose not to pay the hospital or physician. **Ms. Ask** said no hospital has lost any money from BCBS patients because BCBS makes direct payment to the hospitals.

BCBS also makes direct payment to all member physicians.

REP. HANSEN asked **Ms. Ask** if a patient didn't belong to a health group that had a contractual arrangement with the hospital and physician, and the physician's charge for the service was $100, what would the patient have to pay. **Ms. Ask** said the patient would probably be charged $100 unless the physician decided to write off the $10 and then they would pay $90.

REP. RICE asked **Mr. Ahrens** if other states had lien acts and if so how many. **Mr. Ahrens** said approximately 10 to 20 states have lien acts.

CHAIRMAN BOHARSKI asked **Ms. Ask** how many physicians in Montana were not participating in BCBS. **Ms. Ask** said approximately two hundred physicians do not participate in BCBS. **CHAIRMAN BOHARSKI** asked **Ms. Ask** how many hospitals were currently participating in BCBS. **Ms. Ask** said fifty-four hospitals in Montana are participating in BCBS. According to the 1981 contracts, every hospital in Montana is a BCBS hospital. **CHAIRMAN BOHARSKI** referred to **Ms. Ask's** testimony that the legislation would increase costs which would be passed on to the patients. He asked if there had been any changes since HB 405 passed two years ago to quantify her statement. **Ms. Ask** said a number of providers have probably continued with their contract pending the final outcome of HB 405, knowing that there was a two year sunset on the legislation. She said it wasn't known how many physicians may decide to cancel their contract if the lien continues. **CHAIRMAN BOHARSKI** asked **Ms. Ask** if she knew of any liens that had been filed. **Ms. Ask** said there had been a number of liens filed under the act and the total amount was approximately $1,500,000.

REP. SIMON asked **Ms. Ask** what percent of payments sent out by BCBS go directly to patients instead of the providers. **Ms. Ask** said she didn't know the percentage because it was a relatively small portion. **REP. SIMON** asked for a ballpark figure. **Ms. Ask** said about 10% or less.

Closing by Sponsor:

SEN. DOHERTY said SB 43 will help keep costs down. He said if physicians, hospitals, chiropractors, and physical therapists don't get paid by a certain amount of people, they will have to raise their rates in order to make up the loss and the consumers will have to pay for the loss. That is the cost shifting that should be avoided. SB 43 is a pro-consumer bill.

EXECUTIVE ACTION ON HB 144

Motion: **REP. TIM DOWELL MOVED HB 144 DO PASS.**

Discussion: None

Motion/Vote: **REP. DOWELL** moved to adopt the amendments. **EXHIBIT 14.** Voice vote was taken. Motion carried unanimously.

Motion/Vote: **REP. DOWELL MOVED HB 144 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

Vote: **HB 144 DO PASS AS AMENDED.**

EXECUTIVE ACTION ON HB 118

Motion: **REP. SIMON MOVED HB 118 DO PASS.**

Discussion: **CHAIRMAN BOHARSKI** explained the amendments to HB 118. He said he had two amendments. He said if the first amendment didn't pass, he would present the second amendment.

Motion/Vote: **CHAIRMAN BOHARSKI** moved to adopt the first amendment. **EXHIBIT 15.** Roll call vote. Motion failed 7 to 7.

Motion: **REP. ANGELA RUSSELL** moved to adopt the second amendment.

Motion: **REP. SIMON** made a substitute motion to reconsider the first amendment.

Discussion: **REP. SIMON** said if the committee adopted his motion, he intended to call for a motion to recess the executive action until all the committee is present because several of the absent members had expressed an interest in the outcome of the bill. **CHAIRMAN BOHARSKI** said he would adjourn instead.

Vote: **DO PASS AMENDMENT #1 TO HB 118.** Voice vote was taken. Motion carried unanimously.

ADJOURNMENT

Adjournment: 7:45 p.m.

Wm E Boharski

WM. E. BOHARSKI, Chair

Alyce Rice

ALYCE RICE, Secretary

WB/ar

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING **COMMITTEE**

ROLL CALL **DATE** 1/20/93

NAME	PRESENT	ABSENT	EXCUSED
REP. BILL BOHARSKI, CHAIRMAN	✓		
REP. BRUCE SIMON, VICE CHAIRMAN	✓		
REP. STELLA JEAN HANSEN,V. CHAIR.	✓		
REP. BEVERLY BARNHART	✓		
REP. ELLEN BERGMAN	✓		
REP. JOHN BOHLINGER	✓		
REP. TIM DOWELL	✓		
REP. DUANE GRIMES	✓		
REP. BRAD MOLNAR	✓		
REP. TOM NELSON	✓		
REP. SHEILA RICE	✓		
REP. ANGELA RUSSELL	✓		
REP. TIM SAYLES	✓		
REP. LIZ SMITH	✓		
REP. CAROLYN SQUIRES	✓		
REP. BILL STRIZICH	✓		

HOUSE STANDING COMMITTEE REPORT

January 21, 1993

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 144 (first reading copy -- white) do pass as amended .

Signed: Wm E Boharski

Bill Boharski, Chair

And, that such amendments read:

1. Title, line 6.
Strike: the second "AND"
Insert: ","
Following: "53-7-301,"
Insert: "53-19-101, and 53-19-102,"

2. Page 6.
Following: line 25
Insert: "Section 3. Section 53-19-101, MCA, is amended to read:

"53-19-101. Purpose. The legislature, in recognition of needs of persons with severe disabilities and of the desirability of meeting those needs on a community level to the extent of available funding and in order to reduce the need for institutional care settings, establishes by this part a community program to assist persons with severe disabilities ~~in living~~ to live and ~~functioning~~ function independently. This program implements Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, et seq.), as may be amended, for persons with severe disabilities in Montana."

Section 4. Section 53-19-102, MCA, is amended to read:

"53-19-102. Definitions. As used in this part, the following definitions apply:

(1) "Community home for persons with severe disabilities" means a facility licensed by the department of family services, as provided for in 52-4-201 through 52-4-205.

(2) "Department" means the department of social and rehabilitation services established in 2-15-2201.

(3) "Disability" means a permanent physical or mental condition recognized as a disability by Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, et seq.), as may be amended.

(4) "Live and function independently" means to have control over one's life based upon a choice between acceptable options in a manner that minimizes reliance upon others for making decisions and conducting activities of daily living.

~~(4)~~ (5) "Person with severe disabilities" means the same as "individual with severe handicaps" as defined in the federal Rehabilitation Act of 1973 (29 U.S.C. 706(15)(B)), as may be amended. The term includes an individual whose ability to function independently in family or community or whose ability to engage or continue in employment is so limited by the severity of his physical or mental disability that the services provided under this part are required in order for the individual to achieve a greater level of independence in functioning in family

or community or in engaging in or continuing in employment."

EXHIBIT # 1
DATE 1-20-93
SB 6

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME Kathy McGowan BUDGET SB 6

ADDRESS 324 Fuller Ave., Helena, MT

WHOM DO YOU REPRESENT? MCMHC

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS:

SB 6 is consistent with MCMHC's philosophy ~~with~~ that a strong inpatient component is critical to a sound, efficient mental health system.

HR:1991
CS16

EXHIBIT 2
DATE 1/20/93
SB 7

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME Kathy McGowan **BUDGET** SB 7

ADDRESS 324 Fuller Ave., Helena, MT

WHOM DO YOU REPRESENT? MCMHC

SUPPORT V **OPPOSE** _____ **AMEND** _____

COMMENTS:

MCMHC opposed original version of the bill, but proponents and opponents agreed to amendments. Support amended version.

Original opposition:

1) Poor public policy to plead for statutory changes to correct a problem of a local nature

2) Trend is to downsize Boards — not to increase —

HR:1991
CS16

EXHIBIT 2
DATE 1-20-93
HB SB 34

SENATE BILL 34: AN ACT CREATING AN INTERAGENCY COORDINATING COUNCIL FOR STATE PREVENTION PROGRAMS

Testimony of Jeanne Kemmis, Montana Council for Families, 728-9449

As Senator Eck mentioned, the interim Subcommittee on Children and Families was charged with studying, among other issues, methods of interagency coordination of programs.

The interim Subcommittee reports from its study that "[s]ignificant research links child abuse and neglect and juvenile delinquency with a host of other family and community problems, including substance abuse, teenage pregnancy and school dropout rates."

It says that "Montana's limited and fragmented prevention resources have all too often produced random, small-scale, and short-lived prevention programming that may not represent the best that can be accomplished with available resources."

As part of its study, last spring the Subcommittee hosted a policy development forum for state and local government officials, nonprofit representatives and community leaders. Participants at the forum expressed a strong desire to expand and improve prevention activities in this state.

Discussion leader Dr. Charles Bruner, policy associate with the National Conference of State Legislatures' Children, Youth and Families Program, summed up the work of the conference by saying a "vision for fundamental reorientation on serving children and families was very well articulated [by forum participants]; the group saw the need for a broadly inclusive interfacing human service system."

Speaking from his experience as an Iowa State senator, Bruner talked about research conducted in his state focused on female heads of AFDC households. Their profiles, he said, showed the presence of multiple risks to success for their whole families, such as generational child and spouse abuse, alcoholism, and the lack of educational attainment.

These people love their children, he said, and have hopes for their families, but they have real needs for comprehensive management of the stresses in their lives. These needs cross into many public service areas. We need to collaborate, he said, if we are to achieve the broadest goals for these families.

Bruner suggested there needs to be a top-down and a bottom-up commitment -- in the form of concrete agreements worked out among agencies -- to collaborate over time to do things better. Workshop participants felt that with interagency collaboration at the state level, local communities could be

given responsibility for designing the specific mechanisms they feel will work best for families in their areas.

After analyzing efforts to reform children's services nationwide, the Education and Human Services Consortium reports -- in two invaluable documents -- that most states initiate reform by first establishing an interagency group of some sort -- it can be a task force, commission, or council -- but it is a group through which state policymakers direct agencies to plan together to address child and family needs.

The recently released Montana Children's Agenda endorses creation of the Coordinating Council. You will find that recommendation on page 1 of the agenda, under a subtitle: Working Smarter: Setting Goals, Coordinating Efforts, and Improving Management.

The introduction says that "[w]ith its network of different public and private agencies, divisions, task forces and employees, Montana is rich in potential resources for children. But we cannot work efficiently toward common goals without shared understanding of problems, common goal setting and coordination of our efforts. These proposals share the common thread of improving the way we work together in improving Montana's climate for children."

The interim Subcommittee recommended creation of an Interagency Coordinating Council for Prevention and proposes through Senate Bill 34, at section 1, subsection (2)(a) that the council be charged with developing "through interagency planning efforts a comprehensive and coordinated prevention program delivery system."

The Montana Council for Families encourages your support for this measure as an esstential first step toward reinventing this state's approach to the problems of children and families.

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Developing a State Prevention Policy

Prevention practitioners rarely think about policy. It seems somehow out of the scope of their normal operation. Yet without strong prevention policy the field will be relegated to second class status forever. Without policy, prevention will be limited to efforts conducted out of the goodness of people's hearts. Without strong policy, prevention will not be conducted on a large enough scale to make a community-wide, statewide, nationwide difference in behaviors.

Policy sets direction. Policy guides. Policy specifies what people should do and frames approaches that should be used. To establish prevention policy is to institutionalize prevention.

Policy and Practice

Webster defines "policy" as (1a) prudence or wisdom in the management of affairs, (2a) a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions, (b) a high-level overall plan embracing the general goals and acceptable procedures, especially of a governmental body.

In contrast, "practice" is what actually happens. Schools, for example, have philosophies and mission statements that endeavor to build healthy self-perceptions in students, yet many practices in schools have the opposite effect.

Commonly accepted practices constitute unwritten policy, though they're not often considered as such. Having no prevention policy leaves only prevailing practices to dictate what the policy is unless something makes it change.

Is it policy to spend 0.1% of human service budgets on prevention? This approximates what Vermont was spending on prevention when we first examined it prior to 1983. It may have tripled since then to a whopping 0.3%. Each state should know what percentage of its budget is spent on prevention and what percentage is supplied by the federal government. Those percentages constitute current policy.

Most prevention programs can barely scrape together enough money to survive. I can think of only two ways that prevention will ever become a priority: those in positions of authority can voluntarily decide to change them, or a policy must be made that tells people what to do. People will not often voluntarily change practices that they are used to. They need motivation to change. It is often much more realistic to create policy that dictates practices.

State Prevention Policy

States have policies, written or unwritten, that dictate prevention practice.

Each state needs to determine if it has a policy for prevention. Does the state take any responsibility for preventing problem behaviors, or does it spend tax dollars primarily for rehabilitation and treatment after problems have occurred? Are state agencies required in any way to assist local communities in organizing or funding prevention efforts?

If the answers to these questions are disquieting, an attempt to legislate prevention might be in order. The theory is that if a state is not presently taking responsibility for prevention, it probably won't start

unless it's required to. An alternative approach would be to help those in power to become so excited about prevention that they will make it a priority. Both approaches have merit, but which is more likely to succeed? Perhaps a combination of the two would be best.

Policy Guidance

The first question in considering prevention policy is "To what end?" What should a policy accomplish? What should be its guiding principles?

The next question: "Is it needed?" Are there people who would benefit from prevention policy? Which people?

These questions are a starting point: "At what level would it be best for policy to reside?" There are many levels at which state policy can occur. In approximate descending order of authority, some of these levels are:

- legislation
- executive order
- agency policy directive
- legislative resolution
- proclamation
- task force recommendation

Consideration of these possibilities suggests another question: "Whom do we most want to be affected by our policy?" In other words, whose way of conducting business do we most want to alter? Some possibilities might be

- the legislature
- funding sources
- all relevant state agencies
- an individual state agency
- a coordinating body
- community agencies
- community groups
- schools

Finally, we must consider what we want to affect specifically. For example:

- funding
- joint sponsorship or collaboration
- agency rule definition, clarification, revision
- technical assistance or training
- planning
- implementation
- evaluation
- research
- oversight responsibility
- input on guidelines, policies, practices
- accountability
- enforcement

The answers will be different for each state. But it is important to know specifically what we want if we embark on creating prevention policy.

Can You Legislate Prevention?

Some people believe that legislating prevention is like legislating morality. But in cases where existing practices are not always conducive to the best prevention practice, where the health and well-being of citizens is not always promoted by existing practice, or where existing practices don't serve to reduce the problems of concern to society, then prevention legislation might be considered as a practical option.

The state of Vermont was faced with this dilemma. The desired result was for the state to take set policy for prevention. Vermont chose the legislative route to accomplish this. A law requiring state agencies to contribute to a "state prevention plan" and conduct implementation practices consistent with that plan was, to some of us, a very exciting proposition.

The Vermont Story: The First State to Pass Prevention Legislation

In April 1983, the Vermont legislature passed what later became known as Act 79. In April 1986, a Children's Trust Fund provision amended Act 79, and $150,000 was allocated for "community-based prevention programs that have shown to be effective for juveniles." (Note: Many states have "children's trust funds," but few, if any, are attached to other prevention policies.)

Other states may wish to examine Vermont's legislation to adapt it to their own purposes.

Why Legislation? The Function of Law

Webster defines "law" as "a rule of conduct of action prescribed or formally recognized as binding or enforced by a controlling authority." Laws are to be obeyed and followed, but anyone who has ever driven down a highway at the speed limit as other cars whizzed by understands there is a bit more to it than that.

The ultimate purpose of a law is to affect behavior. For behavior to be truly affected, however, three factors must be considered:

1. the law itself
2. enforcement—if people disobey the law and they're not punished, behaviors don't change
3. the perception or beliefs of those required to comply—if people believe they won't get caught, or believe the law is no good, they will not comply and behaviors won't change

The implication is that a law only takes us so far, but it provides us with a solid foundation from which to proceed.

Vermont's Prevention Law

The key sections of Vermont's prevention law (Act 79 of 1983) provide:

- a definition of primary prevention [§1051(2)]
- a description of the state primary prevention plan [§1054(a)]
- responsibilities assigned to state agencies and departments [§1055]; and
- establishment of the Children's Trust Fund [§1056(a)]

The pertinent parts of Act 79 of 1983, as amended in 1986 (33 VSA 1051-1057), read as follows:

Sec. 1. Policy and Purpose (Note: This section was added in 1986)

It is the policy of the general assembly to encourage community involvement in the development of effective primary prevention programs which promote the health and increase the self-reliance of Vermont children and their families. The general assembly recognizes the far-reaching value, both social and financial, of community-based programs which reduce the need for long-term and costly rehabilitation services. These preventive programs seek to eliminate the likelihood of irreparable damage that can arise from interrelated social problems such as child abuse and neglect, domestic violence, alcohol and drug abuse, juvenile delinquency and other socially destructive behaviors. Therefore a children's trust fund is established for the purpose of providing funds for primary prevention programs.

1051. Definitions

As used in this chapter:
(1) "Council" means the Children and Family Council for Prevention Programs.
(2) "Primary prevention" means efforts to reduce the likelihood of juvenile delinquency, truancy, substance abuse, child abuse and other socially destructive behaviors before intervention by authorities.

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1052. Children and Family Council for Prevention Programs

(a) A Children and Family Council for Prevention Programs is established. The council shall consist of 21 members who shall be appointed by the governor with the advice and consent of the senate for three-year terms. . . . Consideration shall be given to the selection of persons who will adequately represent the interests of the beneficiaries of the primary prevention programs . . . .

1053. Council; Duties

(a) The council shall assist state agencies and the departments in the development, improvement and coordination of primary prevention programs and activities at the state and local levels. In providing this service, the council shall:
(1) acquire and provide pertinent research data and technical assistance related to the development and practice of primary prevention programs;
(2) develop a state primary prevention plan that coordinates and consolidates the primary prevention planning efforts of the state agencies and departments specified in the act;
(3) evaluate and prepare recommendations on the prevention policies and programs developed and implemented under the act and submit such recommendations on or before January 1 to the governor and the senate and house committees on health and welfare and appropriations.
(b) Administer the children's trust fund as provided in sections 1056 and 1057.
(c) . . . the council may apply for and receive federal and private funds, or any combination thereof in order to accomplish the purposes of this chapter . . .

1054. The State Primary Prevention Plan

(a) **The state primary prevention plan shall provide for the use of state resources in ways that will strengthen the commitment of local communities to altering conditions which contribute to delinquency or other problem behaviors, so that the burden of state-funded treatment and crisis-oriented service programs will be reduced. The plan shall set forth specific goals, objectives, and key result areas and shall include proposals to integrate and build upon successful methods of primary prevention.**
(b) . . . by July 1 . . . the council shall submit a prevention plan to the governor and to the senate and house committees on health and welfare and appropriations. **Such plan shall incorporate and consolidate the proposals and recommendations for primary prevention developed by:**

(1) the department of education
(2) the agency of human services, including all departments
(3) the department of motor vehicles . . .
(c) . . .
(4) the office of the attorney general
(5) the agency of development and community affairs
(6) the department of employment and training
(7) the department of public safety
(8) the department of forests, parks and recreation
(d) By July 1, 1986, and biennially thereafter, the council shall revise the state primary prevention plan which shall be submitted to the governor and the senate and house committees on health and welfare and appropriations.

1055. Implementation

The specified state agencies and departments shall formulate primary prevention policies and implementation practices that are consistent with the state primary prevention plan. Such policies and practices shall be targeted to specific goals, objectives and key result areas.

1056. The Children's Trust Fund

(a) **A children's trust fund is established for the purpose of providing funds for community-based primary prevention programs that have been shown to be effective for juveniles.** The fund shall be maintained by the agency of human services.
(b) The fund shall be comprised of revenues from the following sources: (1) any private donations made by individuals or organizations to the fund for the purposes of the act; (2) when authorized by the general assembly, funds appropriated directly or combined with other funds appropriated for services or programs having purposes consistent with primary prevention; (3) funds received from the federal government as matching funds or other funds for the purposes of the act; (4) funds held, donated to or acquired by any state agency for purposes generally consistent with the purposes of this chapter and transferred at the direction of the governor to the children's trust fund. All interest accrued or generated by revenue in the fund shall remain in the fund and be available for the payment of grants awarded therefrom.

1057. Trust Fund Programs

(a) The council shall plan, implement and encourage primary prevention programs. The secretary of human services and the council shall solicit proposals for grant awards from public and private persons and agencies. The council shall evaluate the proposals and submit to the secretary its priorities for awarding and funding grants . . .
[Note: (c) and (d) go on to describe the evaluation criteria for grants and the grant awarding process.]
(e) The secretary of human services in conjunction with the council shall develop guidelines for the coordination of programs and the application for the distribution of assistance from the children's trust fund.

1058. Annual Report

Annually, prior to January 15, the council shall submit a report of its activities for the preceding fiscal year to the governor and to the general assembly. The report shall contain an evaluation of the effectiveness of the programs and services financed or to be financed by the children's trust fund, and shall include an assessment of the impact of such programs and services on children and families.

The key policy provisions of this law are sections 1054(a) and 1055. These are very carefully crafted statements designed to guide the best possible direction for prevention programming at the state level.

How the Vermont Legislation Came to Pass

The Vermont legislation did not happen overnight. The purpose of detailing Vermont's experience is so that other states can learn what process we used, learn through our mistakes, and to suggest some principles in trying to get legislation passed.

In 1978, a committee of the Vermont Juvenile Justice and Delinquency Prevention Advisory Group (JJDPAG) observed that the state of Vermont had no policy for delinquency prevention and that nearly all state resources were devoted to dealing with problems that arose only after young people had broken the law. The committee concluded it was unlikely anything would ever change unless the state committed itself to a policy that would prevent young people from committing crimes in the first place.

The JJDPAG appointed a prevention policy task force. The problem was that no task force member had enough time to devote to this complex effort. As such, funds were requested to hire someone who could provide the needed time and energy. Before developing policy, the task force believed it should conduct a study to determine whether there was "support for delinquency prevention as a proper activity for state policy and program development." The Vermont Legislative Council, an independent organiza-

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TESTIMONY REGARDING SENATE BILL 34
INTRODUCED BY SENATOR ECK
Human Services and Aging Committee
January 20, 1993

Chairman Boharski and members of the committee, I am Judith Gedrose, Chief of the Preventive Health Services Bureau of the Department of Health and Environmental Sciences..

Public Health is a collection of diverse programs but the unifying theme has always been prevention. DHES is committed to prevention.

* Health education teaches healthy life-styles which prevent chronic disease
* Communicable disease control prevents further spread from identified cases
* Low birth-weight prevention ensures babies are born with all systems ready to function optimally
* Clean water and air prevent both communicable and chronic diseases

Even when primary prevention fails, secondary prevention is important.

* Babies with cleft palates need to have special feeding methods to prevent malnutrition until the clefts are repaired
* Pregnant women living where nitrites in water are elevated, need to consume another source of water and give their newborns water from another source to prevent anemia
* People with diabetes can prevent lower limb amputation with diligent podiatric care

Creation of an interagency coordinating council for state prevention programs would be very beneficial to the whole prevention effort.

The Montana Food and Nutrition Council created in the last legislative session is similar and has proven very beneficial.

The bottom line is "prevention saves treatment dollars". AIDS is a preventable disease. The life-time cost of one case is now $102,000. Tuberculosis is a preventable disease. The average cost of one case is $15,000. Cardio-vascular disease, stroke, smoking related disease, environmentally caused diseases are all preventable. An investment in prevention is a sound investment.

Dept. of Health & Environmental Sciences

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SYNOPSIS OF PREVENTION ACTIVITIES AT DHES

AIDS PROGRAM Services/contractual support education, monitoring, counseling, testing and treatment.

STD Prevention/intervention services and contractual support in sexually transmitted diseases.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION Prevention of unnecessary illness, disability and death through projects in health promotion and education, nutrition, dental health and behavioral risk surveillance.

COMMUNICABLE DISEASE CONTROL AND EPIDEMIOLOGY Legislatively mandated services in the prevention and control of contagious diseases.

MONTANA COOPERATIVE CENTER FOR HEALTH INFORMATION Comprehensive cooperative interagency center for health data collection and health policy analysis.

IMMUNIZATION Disease surveillance and outbreak control, enforcement of school/daycare immunization standards, and vaccine to public clinics for the control of vaccine preventable diseases.

FAMILY/MATERNAL & CHILD HEALTH BUREAU Consultation/guidance to public health departments and schools, provides prevention services such as well child care and immunizations.

FAMILY PLANNING Services to prevent unplanned pregnancies and promote sexual health.

CHILDREN'S SPECIAL HEALTH SERVICES Referral, case management and payment of services for special needs children and their families to prevent or alleviate disabling conditions.

WIC Nutrition services/education for healthy pregnancies and growth and development of children birth to age five.

PERINATAL PROGRAM Local MIAMI projects and statewide consultation to promote optimal birth outcomes and reduce infant mortality.

CHILD NUTRITION Nutrition/education for children and adults in day care agencies.

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Chairman Bohanski
and Members of the Committee

I am Elizabeth Dane, (Exec. Dir.) representing the Montana Chapter of the National Association of Socialworkers. Our State chapter has a membership of over 350 social workers, many of whom work with the children and families who will be directly affected by the outcome of this bill.

I want to speak in support of the Interagency Coordinating Council for Prevention

"At risk" is a term we hear very frequently when we talk about prevention programs.

It is a term that carries great weight - because we do know so much.

We know that prenatal + perinatal screening, (before birth and after birth screening and Diagnosis via Health

important clues to

* nutrition affecting brain growth + dev which in turn affects school performance, and later abilities to hold a job.

- early needs where medical intervention can prevent ma consequences of ~~this~~ developmental delays - debilitating
- ~~early~~ & mental health problems where intervention can prevent future neglect and abuse.

fragmented, separated families are not inevitable - we have the programs, such as Healthy Start, that we have seen radically change the patterns of abuse + neglect that start so early.

→ True choices for vulnerable families involves the option to prevent harm to one another physically + psychologically.

The costs if we don't act

We must ask our mental health centers
- our foster care providers
- our special educators in the classroom
- our juvenile detention work
- our [illegible]

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MONY ON SENATE BILL 34
CORRECTIONS AND HUMAN SERVICES
L AND DRUG ABUSE DIVISION

ther to provide
that is necessary.
g Council
tribal in
the best job
t cost
& most
nities

ent of this bill to provide for closer cooperation and
ıts involved in providing alcohol and drug abuse
n services. This would be accomplished by developing
of Department heads and elected officials.

for the Alcohol and Drug Abuse Division (ADAD) of
and Human Services, I think this is an important
ork and good thinking which led the Joint Interim
lies to propose this legislation. We at ADAD certainly
ı among the various agencies involved in prevention.

ıls of ADAD to find ways to more closely work with
ith private non-profits, in developing effective
revention coordinating council is a good way to bring
is that part of the charge to this council would be to
n strategy, based on the best available research.

ıol and other drug abuse field are learning through
ctive approaches are broadly based and require a
of every segment of a community. In turn, those
arefully thought out system of informational and
ıe state level. Important to this comprehensive
ating there is common ground AOD prevention, child
cy, drop-out, and juvenile delinquency. Simply put,
approaches have limited effect. New approaches to
al, focusing on single issues. What is needed are
approaches designed to the meet the developmental
targeted. This in turn means there is a need for a
sciplinary approach.

gencies spend close to 4.5 million dollars on AOD
at joint programming, there is no unified plan or
figure, mostly federal dollars, does not include
rograms which are either specifically health or youth
quency, and teen pregnancy. Simply given the net
productivity, and the consequences for our young
ıot developing a well thought-out state program.

prevention coordinating council can address is
ovision of prevention programming. Currently there
al agencies and non-profits to work closely together
veloping support services and providing training.
grant writer can help start any number of programs
ommunity needs, but which are not solidly grounded

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What this also means is that in the absence of a well designed training system, basic courses are repeated time and time again. New information which would benefit communities is slow in reaching these communities. Further, organizational skills, which are the backbone of effective programs, are undeveloped. This promotes ineffective management of programming resources.

Another serious problem is the absence of coordination at the Federal level, both between agencies and with states. For example, there were eight active grants funded by the Center for Substance Abuse Prevention (CSAP) in Montana in Federal fiscal year 1992. This accounts for 2.1 million dollars. In many cases, this money is being well spent. Unfortunately, there are cases where these funds support programs which have little effect in on going community efforts. In some cases, the federally funded programs are actually disruptive to community efforts. Certainly, 2.1 million dollars spent in a concerted fashion would go a long way to providing effective and efficient prevention programming for all of Montana's children. Speaking with a concerted voice to both Federal agencies and the Montana delegation, this coordinating council could effect positive changes in the development and implementation of federal prevention policy.

One final thought, given the age group in Montana's University system, the research and educational resources available, and the presence of 4-H in every Montana county, there might be real advantages to finding a role for the University system in the coordinating council. Also, while we generally think of prevention in specifically human service terms, you might want to consider the relation of highway traffic safety, Hunter safety and the youth conservation corps in Fish, Wildlife, and Parks, and even bicycle safety in the Office of Public Instruction. After all, after you say no to drugs you have to say yes to something else. We do young Montanans a disservice by not taking seriously their efforts to become responsible, capable young adults with our support. We do not just want to prevent self destructive outcomes, we want to support healthy, responsible life choices.

Submitted:

Darryl L. Bruno
Administrator
Alcohol and Drug Abuse Division

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SENATE BILL 34

Testimony of Jeana-marie L. Fiumefreddo

Mr Chairman and members of the committee, I am Jeana-marie Fiumefreddo, a student at the University of Montana.

I stated in a previous committee hearing, that there were several reasons why my family can be classified as high risk for child abuse. Both my husband, John, and I were raised in abusive homes.

During the year after our daughter, Jessica, was born, John was earning about $600 per month at a minimum wage job, and I was attending Missoula Vo-Tech. We were living well below the poverty line.

Our economic situation, and my inability to handle it, led to increased levels of stress in our family. Our marriage deteriorated. John and I had sworn not to repeat the abuse we had experienced as children, but one swat on the diaper led to another. Pretty soon Jessica was being swatted for the smallest infractions.

We sought out help but were told we did not qualify. Later that winter, an arctic storm hit Montana. As a result of the extreme cold, the battery in our car froze and cracked, making it useless. It would cost $65.00 to replace it, and we didn't have that kind of money. John was unable to get to work and was fired from his job.

We became eligible for AFDC, but that did not cover our living expenses. Over the next year, we spent tremendous amounts of time and energy trying to find other sources of help.

Since John lost his job, we have been involved with AFDC, Food Stamps, Medicaid, HRDC's LEAPP program, Options, the University of Montana, Job Quest, WIC, Head Start, the Missoula Food Bank, Vocational Rehabilitation, and I am seeing a psychologist who has helped me work through much of my childhood trauma.

It is unfortunate that many families have similar stories. We had to be in

extreme crisis before we could get any help. And the resources I managed to discover did not coordinate with each other, making it very difficult to find my way through the human service's delivery system.

My husband recently found a new job, and I will graduate from college in December. If there had been coordination between agencies and a prevention posture taken by this state before or during the precipitating crisis of losing our car, the State could have saved a large sum of money. By being involved right away, we possibly could have cut the years of services needed in half.

We could have survived with supportive services. We could have, and would have continued working, I would have gotten the mental health services and parenting skills needed to provide a nurtuing home to Jessica. And most importantly, Jessica would have been saved from the residual effects of our stress.

I believe that this bill is one more step in the right direction for supporting Montana families, and our children.

What Can We Do?

Individually

As individuals, we can examine our personal commitment to "putting children and families first" in our homes, parishes, and communities. We can make a real effort to spend more time with our families, praying, playing and working together. We can contribute our time and money to programs that serve children and families in our communities. And we can use our voices and votes to help shape a society that allocates resources and enacts policies that support children and families.

In Our Dioceses

Across the Country, dioceses are launching creative local initiatives. They are:

- convening parish and diocesan leaders to coordinate efforts;
- writing local statements on the needs of children and families;
- developing special events and convocations that focus on meeting the needs of children and families;
- starting new programs to serve children and families, including parenting skills training, health care programs, etc.;
- producing media efforts and producing public service announcement to call attention to the needs of children and families;
- launching public policy campaigns to enact local legislation to support children and families;
- as well as many other exciting initiatives.

In Our Parishes

No institution in Catholic life is more important to the Campaign for Children and Families than the parish. Children and families are at the heart of parish life and the parish plays a vital role in supporting families and nurturing children.

In General: We can

- include a quote from *Putting Children and Families First*, in the bulletin;
- plan a Sunday with worship focused on children and families, education on forces which undermine families, and service and advocacy for children and families;
- use the video, *I Am Only a Child* at parish gatherings.

In Worship: We can

- reflect our concern for children and families within the liturgy through prayers of petition, appropriate homilies, a regular or occasional family Mass, etc.
- identify feasts and liturgical seasons that lend them selves to a focus on children and families (e.g. Advent, Christmas, Epiphany).
- turn special collections (e.g. Campaign for Human Development, American Bishops' Overseas Appeal, etc.) into opportunities to educate, preach and respond to the needs of poor children and families.

In Education: We can

- incorporate our concern for children and families into religious education programs and school curricula;
- encourage students to learn about and offer service to poor children and families as part of their religious education program;
- sponsor special projects such as poster contests, essay contests, field trips to local agencies serving needy children, etc.;
- offer adult education on parenting or public issues.

In Social Ministry: We can

- strengthen or start a service program for the parish as a whole, such as providing a regular meal for a soup kitchen
- publicize service opportunities for individuals or families such as "sponsoring" a child from a developing country, or volunteering for a literacy program;
- educate parishioners about public policies that work against children and families.
- involve parishioners in child and family advocacy through a diocesan or state legislative network, a community organization or a letter writing or telephone campaign.

Resources

The best sources of help and ideas for participation in the Catholic Campaign for Children and Families will be your diocesan offices of social action, education, pro-life, family life, liturgy, and others, as well as your diocesan social service agency.

- *Putting Children and Families First: A Challenge for Our Church, Nation, and World.* The statement of the United States Catholic Conference that forms the basis of the Catholic Campaign for Children and Families. Available from the Office for Publishing and Promotion, USCC, 800-235-USCC. (Pub. No. 469-4).

- *The Parish Manual for the Catholic Campaign for Children and Families.* A compilation of resources including the text of the bishops' statement; liturgical aids; bulletin inserts and clip art; and suggestions for integrating this initiative into parish education, social ministry and family support efforts. Available in English (Pub. No. 525-9) and in Spanish (Pub. No. 534-8) from USCC/OPPS (see above).

- *I Am Only a Child.* A compelling introduction to the bishops' statement, this 14-minute videocassette reflects on the state of the world's children. The tape is available in English or Spanish ($24.95 prepaid) from Lumen Catechetical Consultants, Inc., P.O. Box 1761, Silver Spring, MD 20915.

For more information contact the Department of Social Development and World Peace (202/541-3195) or any of the other national offices and organizations involved in the Catholic Campaign for Children and Families.

LA CAMPAÑA NIÑOS Y FAMILIAS ¡Primero CATÓLICA

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"Our nation is failing many of our children. Our world is a hostile and dangerous place for millions of children. As pastors in a community deeply committed to serving children and their families, and as teachers of a faith that celebrates the gift of children, we seek to call attention to this crisis and to fashion a response that builds on the values of our faith, the experience of our community, and the love and compassion of our people."

U.S. Catholic Bishops
Putting Children and Families First

A CATHOLIC CHILDREN AND FAMILIES first CAMPAIGN

In November, 1991, the bishops of the United States issued a statement that called for renewed attention to children and families in our homes, our parishes, our communities, our nation, and our world. *Putting Children and Families First: A Challenge for Our Church, Nation, and World* challenges Catholics and others to engage in "a spiritual and social reawakening to the moral and human cost of neglecting our children." This initiative brings together social justice, family life, human service, pro-life, education and other agendas within our church in a common campaign for children and families.

PUTTING CHILDREN AND FAMILIES FIRST

While many children lead happy, secure, safe lives, too many others in our country and throughout the world do not. Every year, 1.6 million innocent children's lives are destroyed by legalized abortion in the U.S. alone. One in four children in this country lives in poverty. Every day throughout the world, 44,000 children die from poverty, hunger and related problems.

The Catholic community brings to this moral challenge three key assets: the values of the Scriptures where children are seen as blessings, the message of Catholic teaching which calls us to measure society by how children and families fare, and our experience in serving children and their families. We support their spiritual life in our parishes, we educate them in our schools, we care for them in our hospitals, and we provide a wide range of supportive services through our charitable and outreach programs.

While the bishops recognize that our homes, neighborhoods, parishes, and communities are where the most important work to support children occurs, they also recognize the role public policy can play in strengthening or undermining families.

> *"No government can love a child and no policy can substitute for a family's care, but clearly families can be helped or hurt in their irreplaceable roles. Government can either support or undermine families as they cope with the moral, social, and economic stresses of caring for children."*

Further, the bishops decry an unnecessary and unreal polarization about how to help families, which has pitted those who promote more personal responsibility against those who support "family friendly" policies.

> *"The undeniable fact is that our children's future is shaped both by the values of their parents and the policies of our nation...We believe parental responsibility and broader social responsibility, changed behavior and changed policies are complementary requirements to help families."*

CRITERIA FOR NATIONAL POLICY

The bishops suggest seven criteria for pro-family public policies:

- *Put children and families first in the allocation of resources and the focus of public life.*
- *Help; don't hurt. Support policies that strengthen rather than undermine families.*
- *Those with the greatest need require the greatest response.*
- *Empower families. Help families meet their responsibilities to their children.*
- *Fight economic and social forces which threaten children and family life.*
- *Build on the strengths of families; reward responsibility and sacrifice for children.*
- *Recognize that foreign policy is increasingly children's policy.*

THE CALL TO ACTION

Pointing to the many helpless and hopeless children who haunt our world, the bishops call on all of us to turn our values into action on behalf of children and families.

> *"We hope the Catholic community will become a persistent, informed and committed voice for children and families, urging all American institutions from neighborhood associations to the federal government to put our children first."*

DIRECTIONS FOR PUBLIC POLICY

NATIONAL POLICY DIRECTIONS

1. Protect the lives of children by opposing abortion and government funding of abortion.
2. Protect family members from abuse by prohibiting pornography, reforming family services, and increasing support for adoption and foster care.
3. Promote decent jobs at decent wages, and support adequate job training.
4. Reform the tax laws to help families cope with the high cost of raising children -- e.g. a children's tax credit.
5. Provide for poor children through adequate welfare benefits and policies that promote family stability, not separation.
6. Promote family-friendly workplace policies such as family and medical leave protection.
7. Promote equal opportunity in education, affirmative action in employment and nondiscrimination in housing.
8. Promote quality education by offering programs like HeadStart, and vouchers or tax credits that allow school choice.
9. Support basic nutrition programs like food stamps and the Women, Infant and Children (WIC) program.
10. Extend quality health care to all, beginning with our children and their mothers.
11. Support housing, planning, and zoning policies that promote affordable housing.
12. Provide appropriate medical, educational, rehabilitative and social services for persons with disabilities, and ensure full implementation of the Americans with Disabilities Act.
13. Embrace a "children first" principle in cases of divorce, and strengthen child support enforcement policies.

INTERNATIONAL POLICY DIRECTIONS

1. Meet the basic needs of children throughout the world, including shelter, food, health care, education, and the elimination of child labor, children in military service, and other exploitative practices.
2. Shape U.S. economic policies that include:
   - an international trading system that discourages the exploitation of children by ensuring that poor countries receive fair prices for their exports;
   - a foreign aid program that places emphasis on the needs of children and families rather than security and military interests;
   - a global financial system that recognizes the economic and social costs to families of developing countries' massive external debt, and pursues ways to relieve it equitably and realistically.
3. Oppose coercive population and abortion policies and discrimination against women.

MHA MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

Myths & Facts
SB 43
Extension of the Health Care Lien Law

Opponents of SB 43 want you to believe a vote for this bill is a vote for higher health care costs. Just because the opponents equate SB 43 with higher hospital costs doesn't make it so.

Don't be fooled. No one wants higher health costs. Study the facts before you vote. The facts indicate that a vote for SB 43 is really a vote to hold down health care cost increases.

What is the Health Care Lien Act?

The Health Care Lien Act, enacted in 1979, allows hospitals, physicians and other health care providers to file liens against health insurers. Hospitals file liens against insurers to ensure that they get paid for treating patients covered by the insurance company's plan. Filing a lien is a simple, efficient way to make sure patients pay for the health care services they receive.

Until 1991, the largest insurer in Montana, Blue Cross and Blue Shield of Montana, was not covered by the lien act. In 1991, legislators broadened the statute to cover Blue Cross/Blue Shield.

The 1991 legislation included a sunset provision, under which the statute will expire April 17, 1993. The sunset was added to provide time to determine whether the lien act fulfilled its purpose. SB 43 would remove the sunset provision.

What is the solution to health care cost increases?

Comprehensive health care reform is the only way to control health care costs. MHA, Blue Cross/Blue Shield, the MMA, seniors and consumers have agreed on such a bill and will offer it during this session. The bill would include a comprehensive cost control strategy aimed at holding annual health care cost inflation to the annual increase in the gross domestic product by 1999.

Will repeal of the lien act lower health care costs?

No. Repeal of the lien act would allow Blue Cross and Blue Shield to lower the amount it pays hospitals. But defeat of SB 43 would have no effect on overall health care costs. Hospitals don't have large profit margins that allow them to absorb these losses. The average profit margin for all Montana hospitals last year was 0.2 percent. When insurers shortchange hospitals, hospitals have to raise charges for other patients to make up the losses.

Will repeal of the lien act raise health costs?

Yes. Defeat of SB 43 could force hospitals to collect patient payments directly from patients, which would require them to increase their administrative staff and, most likely, result in reduced revenue. Higher hospital administrative costs and lower hospital revenues from patients will add further pressure on hospitals to raise rates.

Does the lien act require Blue Cross/Blue Shield to pay more than it believes it should to hospitals?

No. The lien act is a strong incentive for BC/BS to negotiate with hospitals for fair contracts for the services provided to their policyholders. Once BC/BS and a hospital agree to a contract for hospital services, payments are made according to the rates negotiated by both sides. Hospitals accept the payment as payment-in-full.

Are hospitals the only entities with lien rights?

No. Liens have been part of the Montana statutes for decades. They are commonly used method for ensuring that providers of services are paid fairly. Examples of other statutory lien holders are farm laborers (71-3-401), loggers (71-3-601), threshers (71-3-801), agisters (71-3-1201), hotel keepers (71-3-1401), etc.

Are all other health insurers -- besides Blue Cross/Blue Shield – subject to the lien act?

Yes. This bill ensures that Blue Cross/Blue Shield will be treated like all other health insurers in Montana. It keeps a level playing field among health insurers. All must comply with the terms of the hospital lien act.

How often do health care providers file liens against insurers?

Not often. For hospitals and physicians who are under contract with Blue Cross and Blue Shield, BS/BS pays claims directly to the providers of services. SB 43 would not change that system for paying claims.

If no one uses liens, why is SB 43 so important?

The lien act gives hospitals a way to ensure that they get paid for the services they provide. Without this protection, insurers could pay patients directly, a much more costly way to collect patient payments. Without the lien statute, insurers also could offer to pay unacceptably low prices for treating their policyholders, and hospitals would have no bargaining power.

EXHIBIT 11
DATE 1-20-93
SB 43

ACCIDENT & HEALTH

RANK	INSURER NAME	1991 DIRECT A & H PREMIUMS WRITTEN IN MT
1.	Blue Cross/Blue Shield of MT	$158,119,053
2.	Principal Mutual Life Ins. Co.	13,562,280
3.	Prudential Ins. Co. of America	13,042,939
4.	Bankers Life & Casualty Co.	9,987,173
5.	Mutual of Omaha Ins. Co.	7,997,477
6.	John Alden Life Ins. Co.	7,393,046
7.	State Farm Mutual Auto In. Co.	7,135,502
8.	Federal Home Life Ins. Co.	6,812,720
9.	Travelers Ins. Co. (Life Dept.)	6,355,878
10.	United of Omaha Life Ins. Co.	6,080,778
11.	Capitol American Life Ins. Co.	3,613,162
12.	CUNA Mutual Ins. Society	3,427,671
13.	Pioneer Life Ins. Co. of Illinois	3,345,364
14.	Combined Ins. Co. of America	3,257,438
15.	Universe Life Ins. Co.	3,001,386
16.	Equitable Life & Casualty Ins. Co.	2,792,088
17.	Union Bankers Ins. Co.	2,757,315
18.	United American Ins. Co.	2,514,895
19.	Life Investors Ins. Co. of America	2,450,241
20.	Physicians Mutual Ins. Co.	2,379,671
21.	Lincoln National Life Ins. Co.	2,235,824
22.	Safeco Life Ins. Co.	2,190,013
23.	New York Life Ins. Co.	2,107,471
24.	American Travellers Life Ins. Co.	2,006,186
25.	Standard Life & Accident Ins. Co.	1,948,948

EXHIBIT 10
DATE 1-20-93
SB 43

Part 1 — General Provisions

71-3-101. Definitions.
71-3-102. How liens created.
71-3-103. No lien for claim not due.
71-3-104. Lien by agreement.
71-3-105. Lien on future interest.
71-3-106. Extent of lien.
71-3-107. Prior liens.
71-3-108. Lien or contract for lien transfers no title.
71-3-109. Certain contracts void.
71-3-110. Enforcement of obligation by creditor.
71-3-111. Creation of lien not a personal obligation.
71-3-112. Holder of lien not entitled to compensation.
71-3-113. Priority of liens.
71-3-114. Priority of purchase money mortgage.
71-3-115. Order of resort to different funds.
71-3-116. Redemption.
71-3-117. Right to redeem.
71-3-118. Rights of inferior lienor.
71-3-119. Lien accessory to performance.
71-3-120. Effect of partial performance.
71-3-121. Extinction by sale or wrongful conversion.
71-3-122. Lien extinguished by statute of limitations.
71-3-123. When restoration extinguishes lien.
71-3-124. Filing costs and attorneys' fees to be recovered on foreclosure of liens.
71-3-125. Filing of agricultural lien statements.
71-3-126 through 71-3-130 reserved.
71-3-131. Acknowledgment of lien satisfaction — penalty.

Part 2 — Federal Tax Liens

71-3-201. Short title.
71-3-202. Uniformity of interpretation.
71-3-203. Execution of notices and certificates.
71-3-204. Federal liens — place of filing.
71-3-205. Duties of filing officer.
71-3-206. Fees.
71-3-207. Prior filings of tax liens and notices.

Part 3 — Liens for Salaries and Wages

71-3-301. Priority when assignment of property made.
71-3-302. Priority in case of death of employer.
71-3-303. Priority in cases of execution or attachment.
71-3-304. Service of notice.
71-3-305. Proceeding if claim disputed.
71-3-306. Preferred claims — no dismissal of original action without consent.
71-3-307. Liens not affected prior to four months of claim.

Part 4 — Farm Laborers' Liens

71-3-401. Who may have lien — priority.
71-3-402. How lien obtained.
71-3-403. Repealed.

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71-3-412. Requirements to be bona fide purchaser.
71-3-413. Parties.
71-3-414. Judgment and execution.
71-3-415. Sale of property to satisfy lien.
71-3-416. Penalty for destroying means of identification of property.

Part 7 — Crop Liens for Seed or Grain and Liens for Hail Insurance

71-3-701. Lien for seed or grain.
71-3-702. Priority.
71-3-703. How to obtain lien.
71-3-704. Acknowledgment of satisfaction of lien — penalty.
71-3-705. Destruction of records — when allowed.
71-3-706 through 71-3-710 reserved.
71-3-711. Lien for hail insurance.
71-3-712. How lien obtained.
71-3-713. Acknowledgment of satisfaction of lien — penalty.

Part 8 — Threshers' Liens

71-3-801. Who may have lien — amount.
71-3-802. How lien obtained.
71-3-803. Repealed.
71-3-804. Priority.
71-3-805. Who considered owners.
71-3-806. Parties.
71-3-807. Limitations of actions.
71-3-808. Acknowledgment of satisfaction of lien — penalty.
71-3-809. Rules of practice.
71-3-810. Destruction of records — when allowed.

Part 9 — Crop or Grain Liens for Spraying or Dusting

71-3-901. Who may have lien — amount.
71-3-902. How lien obtained.
71-3-903. Repealed.
71-3-904. Priority.
71-3-905. Who considered owners.
71-3-906. Parties.
71-3-907. Limitations of actions.
71-3-908. Acknowledgment of satisfaction and discharge of lien — penalty.
71-3-909. Rules of practice.

Part 10 — Labor and Material Liens on Oil and Gas Wells and Pipelines

71-3-1001. Definitions.
71-3-1002. Lien for labor and materials furnished for use on leasehold for oil and gas purposes or pipelines.
71-3-1003. Lien for labor or supplies furnished for contractor.
71-3-1004. How lien perfected.
71-3-1005. Enforcement of liens — duty of county clerks.
71-3-1006. Liens have priority.
71-3-1007. Priority.
[illegible] for contractor subject to simple contract.

71-3-404. Notice to other lienholders.
71-3-405. Limitations of actions to foreclose liens.
71-3-406. Rules of practice.
71-3-407. Parties.
71-3-408. Acknowledgment of satisfaction of lien — penalty.

Part 5 — Construction Liens

71-3-501. Repealed.
71-3-502. Repealed.
71-3-503. Repealed.
71-3-504. Renumbered 71-3-561 by Code Commissioner, 1987.
71-3-505. Renumbered 71-3-562 by Code Commissioner, 1987.
71-3-506 through 71-3-510 reserved.
71-3-511. Repealed.
71-3-512. Renumbered 71-3-535 by Code Commissioner, 1987.
71-3-513. Renumbered 71-3-534 by Code Commissioner, 1987.
71-3-514. Repealed.
71-3-515. Renumbered 71-3-537 by Code Commissioner, 1987.
71-3-516. Renumbered 71-3-551 by Code Commissioner, 1987.
71-3-517. Renumbered 71-3-552 by Code Commissioner, 1987.
71-3-518. Renumbered 71-3-553 by Code Commissioner, 1987.
71-3-519. Renumbered 71-3-563 by Code Commissioner, 1987.
71-3-520 reserved.
71-3-521. Scope.
71-3-522. Definitions.
71-3-523. Who may claim a construction lien — limitation.
71-3-524. Limitation of lien for materials supplied.
71-3-525. Extent of lien.
71-3-526. Amount of lien.
71-3-527 through 71-3-530 reserved.
71-3-531. Notice of right to claim lien required — exemptions.
71-3-532. Content of notice of right to claim lien.
71-3-533. Notice of completion.
71-3-534. Filing with county clerk — notification of owner.
71-3-535. Attachment of lien — filing.
71-3-536. Content of lien notice.
71-3-537. Acknowledgment of satisfaction of lien — penalty.
71-3-538 through 71-3-540 reserved.
71-3-541. Priority among holders of construction liens.
71-3-542. Priority of construction liens as against claims other than construction lien claims.
71-3-543 through 71-3-550 reserved.
71-3-551. Substitution of bond allowed — filing — amount — condition.
71-3-552. Lien discharged upon filing of bond.
71-3-553. Action upon bond — period of limitation exists.
71-3-554 through 71-3-560 reserved.
71-3-561. Parties.
71-3-562. Limitation on actions.
71-3-563. Rules of practice.

Part 6 — Laggers' Liens

71-3-601. Definition of lumber — who may have lien.
71-3-602. Priority.
71-3-603. Extent of lien.
71-3-604. Duration of lien.
71-3-605. How to obtain lien — form of claim.
71-3-606. Claim for lien of landowner exists.
71-3-607. Immaterial defects in claim.
71-3-608. Duties of county clerk.
71-3-609 and 71-3-610 reserved.
71-3-611. Enforcement of lien.

Part 11 — Liens of Physicians, Nurses, Physical Therapists, Occupational Therapists, Chiropractors, Dentists, and Hospitals in Personal Injury Claims

71-3-1101 through 71-3-1105. Repealed.
71-3-1106 through 71-3-1110 reserved.
71-3-1111. Short title.
71-3-1112. Purpose.
71-3-1113. Definitions.
71-3-1114. Liens of physicians, nurses, physical therapists, occupational therapists, chiropractors, persons practicing dentistry, and hospitals.
71-3-1115. Notice of lien.
71-3-1116. Notice of lien — filing with clerk of court.
71-3-1117. Liability for failure to recognize lien.
71-3-1118. Applicability.

Part 12 — Agisters' Liens and Liens for Service

71-3-1201. Who may have lien.
71-3-1202. Priority.
71-3-1203. Enforcement of lien — sale.
71-3-1204. Lien not lost by fraudulent taking of property.

Part 13 — Liens on Real Estate

71-3-1301. Lien of seller of real property — waiver.
71-3-1302. Purchaser's lien on real property.
71-3-1303. Extent of liens.

Part 14 — Hotel Liens

71-3-1401. Lien of hotelkeepers.
71-3-1402. Enforcement of lien.
71-3-1403. Notice of sale.

Part 15 — Miscellaneous Liens

71-3-1501. Lien of factor.
71-3-1502. Banker's lien.
71-3-1503. Officer's lien.
71-3-1504. Judgment lien.
71-3-1505. Lien for rental on frozen food compartments.

71-3-1011. Notice to purchaser of oil and gas. Anything in this part to the contrary notwithstanding, any lien claimed by virtue of this part insofar as it may extend to oil or gas or the proceeds of the sale of oil or gas shall not be effective against any purchaser of such oil or gas until written notice of such claim has been delivered to such purchaser at his residence or principal place of business. Such notice shall state the name of the claimant, his address, the amount for which the lien is claimed, and a description of the interest upon which the lien is claimed. Such notice shall be delivered personally to the purchaser or by registered or certified letter deposited in the United States mail. Until such notice is delivered as above provided, no such purchaser shall be liable to the claimant for any oil or gas produced from the interest upon which the lien is claimed or the proceeds thereof, except to the extent of such part of the purchase price of such oil or gas or the proceeds thereof as may be owing by such purchaser at the time of delivery of such written notice. Such purchaser shall withhold payments for such oil or gas runs to the extent of the lien amount claimed until delivery of notice in writing that the claim has been paid.

History: En. 45-1010 by Sec. 10, Ch. 143, L. 1967; R.C.M. 1947, 45-1010.

71-3-1012. Effect on interest which is less than fee interest. If a lien provided for in this part attaches to an estate less than the fee, forfeiture of such estate shall not impair any lien as to material, appurtenances, and fixtures located thereon and to which said lien has attached prior to forfeiture. If a lien provided for in this part attaches to an equitable interest or to a legal interest contingent upon the happening of a condition subsequent, failure of such interest to ripen into legal title or such condition subsequent to be fulfilled shall not impair any lien as to material, appurtenances, and fixtures located thereon and to which said lien attached prior to such failure.

History: En. 45-1011 by Sec. 11, Ch. 143, L. 1967; R.C.M. 1947, 45-1011(part).

Part 11

Liens of Physicians, Nurses, Physical Therapists, Occupational Therapists, Chiropractors, Dentists, and Hospitals in Personal Injury Claims

Part Cross-References
Assignment of right to periodic installments for certain future damages, 25-9-405.

Acknowledgment of lien satisfaction — penalty, 71-3-131.

71-3-1101 through 71-3-1105. Repealed. Sec. 9, Ch. 532, L. 1979.

Compiler's Comments
Histories of Repealed Sections: 71-3-1101 through 71-3-1105. En. Sec. 1 through 5, Ch. 57, L. 1931; re-en. Sec. 6395.1 through 6395.5, R.C.M. 1935; R.C.M. 1947, 45-1201 through 45-1205.

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(b) any judgment the injured person, his estate, or successors may obtain for injury, disease, or death; and

(c) all money paid in satisfaction of such judgment or in settlement of the claim or cause of action.

(2) If a person is an insured or a beneficiary under insurance which provides coverage in the event of injury or disease, a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital, upon giving the required notice of lien, has a lien for the value of services rendered on all proceeds or payments, except payments for property damage, payable by the insurer.

(3) The lien is subject to the lien of an attorney provided in 37-61-420.

History: En. Sec. 4, Ch. 532, L. 1979; amd. Sec. 3, Ch. 88, L. 1987.

71-3-1113. Notice of lien. (1) A physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital claiming a lien shall serve written notice upon the person and upon his insurer, if any, against whose liability for injury, disease, or death is asserted, stating the nature of the services, for whom and when rendered, the value of the services, and that a lien is claimed.

(2) A physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital claiming a lien upon proceeds or payments payable by an insurer shall serve written notice upon the insurer against whom the lien is asserted, stating the nature of the services, for whom and when rendered, the value of the services, and that a lien is claimed.

History: En. Sec. 5, Ch. 532, L. 1979; amd. Sec. 4, Ch. 88, L. 1987.

71-3-1116. Notice of lien — filing with clerk of court. If an action is commenced for recovery for injury, disease, or death, a copy of the notice of lien may be filed in the office of the clerk of court in which the action is pending, and the filing is notice to all parties to the action.

History: En. Sec. 6, Ch. 532, L. 1979.

71-3-1117. Liability for failure to recognize lien. If any insurer or person, after receiving notice of lien, makes payment on account of injury, disease, or death and the amount of the lien claimed by any physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital has not been paid, the insurer or person is liable to the physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital for the reasonable value of the services.

History: En. Sec. 7, Ch. 532, L. 1979; amd. Sec. 5, Ch. 88, L. 1987.

71-3-1118. *(Temporary)* Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act or the Occupational Disease Act of Montana.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, and hospital services pursuant to the acts referred to in subsection (1).

71-3-1106 through 71-3-1110 reserved.

71-3-1111. Short title. This part may be cited as the "Physician, Nurse, Physical Therapist, Occupational Therapist, Chiropractor, Dentist, and Hospital Lien Act".

History: En. Sec. 1, Ch. 532, L. 1979; amd. Sec. 1, Ch. 88, L. 1987.

71-3-1112. Purpose. The purpose of this part is to establish lien rights for physicians, nurses, physical therapists, occupational therapists, chiropractors, persons practicing dentistry, and hospitals when a person receiving medical treatment:

(1) is injured through the fault or neglect of another; or

(2) is either insured or a beneficiary under insurance.

History: En. Sec. 2, Ch. 532, L. 1979; amd. Sec. 2, Ch. 498, L. 1983; amd. Sec. 2, Ch. 88, L. 1987.

71-3-1113. *(Temporary)* Definitions. As used in this part, the following definitions apply:

(1) "Beneficiary" means a person entitled to insurance benefits.

(2) "Insurance" means a contract whereby a person, the insurer, undertakes to indemnify another, the insured, or pay or provide a determinable amount or benefit upon determinable contingencies. The term "insurer" includes a health service corporation.

(3) "Person" means an individual, a corporation, an organization, or other legal entity. *(Terminates April 17, 1993—sec. 4, Ch. 469, L. 1991.)*

71-3-1113. *(Effective April 17, 1993)* Definitions. As used in this part, the following definitions apply:

(1) "Beneficiary" means a person entitled to insurance benefits.

(2) "Insurance" means a contract whereby a person, the insurer, undertakes to indemnify another, the insured, or pay or provide a determinable amount or benefit upon determinable contingencies.

(3) "Person" means an individual, a corporation, an organization, or other legal entity.

History: En. Sec. 3, Ch. 532, L. 1979; amd. Sec. 1, Ch. 498, L. 1981.

Compiler's Comments
1991 Amendment: In definition of insurance inserted second sentence to include a health service corporation. Amendment effective April 17, 1991.

Termination Date: Section 4, Ch. 469, L. 1991, provided: "This act[] terminates [2 years after the effective date of this act]." Effective April 17, 1991, and terminates April 17, 1993.

71-3-1114. Liens of physicians, nurses, physical therapists, occupational therapists, chiropractors, persons practicing dentistry, and hospitals. (1) Whenever a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital renders services to a person injured through the fault or neglect of another, the physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital, upon giving the required notice of lien, has a lien for the value of services rendered on:

(a) any claim or cause of action the injured person, his estate, or successors may have for injury, disease, or death;

(2) This part does not apply to any benefits payable under a policy of life insurance or group life insurance; a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital; or an annuity contract or to pension benefits payable under a qualified pension plan. *(Terminates April 17, 1993—sec. 4, Ch. 469, L. 1991.)*

71-3-1118. *(Effective April 17, 1993)* Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act or the Occupational Disease Act of Montana.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under a policy of life insurance or group life insurance, a contract of disability insurance, or an annuity contract or to pension benefits payable under a qualified pension plan.

History: En. Sec. 6, Ch. 532, L. 1979; amd. Sec. 1, Ch. 498, L. 1983; amd. Sec. 4, Ch. 88, L. 1987; amd. Sec. 2, Ch. 469, L. 1991.

Compiler's Comments
1991 Amendment: In (3), near middle after "disability insurance", inserted exception clause. Amendment effective April 17, 1991.

Termination Date: Section 4, Ch. 469, L. 1991, provided: "This act[] terminates [2 years after the effective date of this act]." Effective April 17, 1991, and terminates April 17, 1993.

Cross-References
Workers' Compensation Act, Title 39, ch. 71.

Occupational Disease Act, Title 39, ch. 72.

Part 12

Agisters' Liens and Liens for Service

Part Cross-References
Bailments, Title 70, ch. 6.

Acknowledgment of lien satisfaction — penalty, 71-3-131.

71-3-1201. Who may have lien. (1) If there is an express or implied contract for keeping, feeding, herding, pasturing, or ranching stock, a ranchman, farmer, agister, herder, hotelkeeper, livery, or stablekeeper to whom any horses, mules, cattle, sheep, hogs, or other stock are entrusted has a lien upon such stock for the amount due for keeping, feeding, herding, pasturing, or ranching the stock and may retain possession thereof until the sum due is paid.

(2) Every person who, while lawfully in possession of an article of personal property, renders any service to the owner or lawful claimant thereof by labor or skill employed for the making, repairing, protection, improvement, safekeeping, or carriage thereof has a special lien thereon, dependent on possession, for the compensation, if any, that is due to him from the owner or

EXHIBIT 5015
DATE 1-20-93
SB 43

Testimony in Opposition to SB43
before the House Committee on Human Services and Aging

Mr. Chairman, members of the Committee, I am Joyce Brown, Chief of the Employee Benefits Bureau, Department of Administration, which administers the State Employee Health Plan.

As the administrator of an employee health plan, I opposed the passage of the health care providers lien act last session because it threatens one of the few avenues employers have to hold down health benefit costs -- for themselves and their employees. Since, the crisis in Health Care costs is not a partisan problem I hope members of both parties will give this careful consideration.

How can something as innocuous looking as a lien act to allow health providers to place a lien on health insurance proceeds and receive payment directly from an insurer drive up health care costs? Or Why was a sunset put on this bill last session?

1. Health insurance entitles the plan members that pay for the insurance to be reimbursed for covered medical expenses.

2. Health plan members, at their discretion can and do assign reimbursement rights to providers. In that case providers are paid directly by the insurer.

3. Health Plans and their members are willing to exchange this right to direct their insurance proceeds for something they value more -- namely lower out-of-pocket costs. Employee health plans, through their insurer, have, or are in the process of, negotiating payment terms with providers. They offer direct payment in exchange for agreement to accept plan allowances.

A lien act legislatively gives health care providers direct payment so they have to offer no price controls in exchange. It interferes with business agreements that hold down costs.

4. Savings from these agreements are not theoretical, and not confined to large groups. BC/BS has arranged agreements for plan members insured by them. They have established member provider agreements with over 80% of Montana Physicians. Under these agreements Member providers receive direct payment and other benefits of membership in exchange for accepting plan allowances and not billing members for additional amounts. Other insurers and TPAs are entering such agreements.

Last year members of the State Employee Benefit Plan saved $1,281,000 due to member agreements. These were charges that exceeded plan allowances that members did not have to pay because of the physician's agreements to accept allowances. This is an average of $170 per family per year. In brief, the Lien act jeopardizes one of the few cost containment mechanisms known to be working.

EXHIBIT 14
DATE 1-20-93
HB 144

Amendments to House Bill No. 144
First Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
January 19, 1993

1. Title, line 6.
Strike: the second "AND"
Insert: ","
Following: "53-7-301,"
Insert: "53-19-101, and 53-19-102,"

2. Page 6.
Following: line 25
Insert: "**Section 3.** Section 53-19-101, MCA, is amended to read:

"**53-19-101. Purpose.** The legislature, in recognition of needs of persons with severe disabilities and of the desirability of meeting those needs on a community level to the extent of available funding and in order to reduce the need for institutional care settings, establishes by this part a community program to assist persons with severe disabilities ~~in living~~ to live and ~~functioning~~ function independently. This program implements Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, et seq.), as may be amended, for persons with severe disabilities in Montana."

{*Internal References to 53-19-101: None.*}

Section 4. Section 53-19-102, MCA, is amended to read:

"**53-19-102. Definitions.** As used in this part, the following definitions apply:

(1) "Community home for persons with severe disabilities" means a facility licensed by the department of family services, as provided for in 52-4-201 through 52-4-205.

(2) "Department" means the department of social and rehabilitation services established in 2-15-2201.

(3) "Disability" means a permanent physical or mental condition recognized as a disability by Title VII of the federal Rehabilitation Act of 1973 (29 U.S.C. 796, et seq.), as may be amended.

(4) "Live and function independently" means to have control over one's life based upon a choice between acceptable options in a manner that minimizes reliance upon others for making decisions and conducting activities of daily living.

~~(4)~~(5) "Person with severe disabilities" means the same as "individual with severe handicaps" as defined in the federal Rehabilitation Act of 1973 (29 U.S.C. 706(15)(B)), as may be amended. The term includes an individual whose ability to function independently in family or community or whose ability to engage or continue in employment is so limited by the severity of his physical or mental disability that the services provided under this part are required in order for the individual to achieve a greater level of independence in functioning in family or community or in engaging in or continuing in employment."

{*Internal References to 53-19-102: x52-4-202*}

EXHIBIT 15
DATE 1-20-93
HB 118

Amendments to House Bill No. 118
First Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
January 19, 1993

1. Title, line 6.
Following: "ACT;"
Insert: "DEFINING "DAY CARE" TO EXCLUDE CARE PROVIDED BY A PARENT OR OTHER PERSON LIVING WITH THE CHILD AS A PARENT;"

2. Title, line 11.
Following: "PAYMENTS;"
Insert: "ALLOWING A FAMILY DAY-CARE HOME TO PROVIDE CARE FOR CHILDREN FROM THE SAME FAMILY;"

3. Page 1, line 18.
Following: "means"
Strike: remainder of line 18

4. Page 1, line 19.
following: "care for children"
Insert: "provided by an adult, other than a parent of the children or other person living with the children as a parent, on a regular basis for daily periods of less than 24 hours"

5. Page 2, lines 19 and 20.
Strike: "from separate families"

EXHIBIT 16
DATE 1-20-93
HB 118

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL VOTE

DATE 1/20/93 BILL NO. HB 118 NUMBER

MOTION: Adopt Amendment #1

NAME	AYE	NO
REP. BRUCE SIMON, VICE CHAIRMAN	✓	
REP STELLA JEAN HANSEN, VICE CHAIRMAN		✓
REP. BEVERLY BARNHART		✓
REP. ELLEN BERGMAN	✓	
REP. JOHN BOHLINGER	✓	
REP. TIM DOWELL		✓
REP. DUANE GRIMES	✓	
REP. BRAD MOLNAR	✓	
REP TOM NELSON	✓	
REP. SHEILA RICE		
REP. ANGELA RUSSELL		✓
REP TIM SAYLES		
REP LIZ SMITH		✓
REP. CAROLYN SQUIRES		✓
REP. BILL STRIZICH		✓
REP. BILL BOHARSKI, CHAIRMAN	✓	

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. SB6

DATE 1/20/93 SPONSOR(S) Sen. Yellowtail

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Kathy McGowan	MCMHC	✓	
John Shontz	MHAM	✓	
Joy McGrath	MHAM	X	
Barb Booher	Mt. Nurses Assoc.	✓	

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. SB 7

DATE 1/20/93 SPONSOR(S) Sen. Yellowtail

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Peggy Tukens	Helena, MT		
Kathy McDowan	MCMHC		
John Shontz	MHAM	X	
Ray McGrath	MHAM	X	

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HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. SB 34

DATE 1/20/93 SPONSOR(S) Sen. Eck

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Elizabeth Dane	National Assoc. of Social Workers	✓	
DENNIS M. TAYLOR	DEPT OF JUSTICE	✓	
FRED FISHER	Montana Board of Control	✓	
Jeana-marie L. Fiumefreddo	Montana Council for Families	✓	
Nancy Coopersmith	OPI	✓	
Judy Wright	DHES	✓	
Shawna Wetherell (student Nurse C.C.)	"		
SHARON HOFF	MONT. CATHOLIC CONF	✓	
Richard Kerstein	Dept of Family Services Mont. Children's Trust	✓ ✓	
Jeanne Kemmis	Mt. Council for Families	✓	
Judith Gedrose	DHES	✓	
Darrell Bruno	DCHS	✓	
Paulette Kohman	Mt Council Mat & Ch Hlth	✓	

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HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

House Human Services COMMITTEE BILL NO. SB 43

DATE 1/20/93 SPONSOR(S) Sen. Doherty

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Lenn Zaendorf	Mt. Med Assn	✓	
Carol Roy	St. Aud. Office	—	—
Steve Browning	MT Hosp Assn	✓	
Tom Ebzery	St Vincent Hospital	✓	
Barb Booher	Mt. Nurses Assoc.	✓	
Jim Atkins	MT HOSPITAL Assoc	✓	
Rosana Skelton	Mont Contractors Health		-
Steve Turkiewicz	Mt. Auto Dealers Assn Trust		✓
Tanya ABK	Blue Cross & Blue Shield		✓
Chuck Butler	Blue Cross Blue Shield		✓
Mona Jamison	mt. Chapter of P.T. Assoc.	✓	
Joyce Brown	State Personnel Div		✓

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