MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Sen. Dorothy Eck, Chair, on February 5, 1993, at 1:00

ROLL CALL

Members Present:
Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Tom Gomez, Legislative Council
Laura Turman, Committee Secretary

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

Committee Business Summary:
Hearing: SB 267
Executive Action: None.

HEARING ON SB 267

Opening Statement by Sponsor:

Sen. Bill Yellowtail, Senate District 50, said health care is not a luxury, but in Montana one in eight individuals, approximately 141,000 are presently without health care. Health care is at the root of many of Montana's budget problems. SB 267 is a "bold approach to health care reform." Simply put, it is a move directly to a single-payor health care reform, and it offers such features as universal coverage, portability, accessibility, it is comprehensive, it calls for claims simplification, and it has a great deal of regional input from consumers and providers. 30% of the general fund is dedicated to health care, and Medicaid grows approximately 22% annually making it responsible for much

of the supplemental costs facing the legislature.

Proponents' Testimony:

Peter Blouke, Director of the Department of Social Rehabilitation Services, said he comes before the Committee representing Governor Marc Racicot. Mr. Blouke said the Governor supports many of the concepts included in SB 267, but the Governor supports Sen. Franklin's bill to be introduced later. This is not a democratic or republican issue, not low-income or senior citizens; it is an issue that confronts all Montanans, and it cannot become divisive. Mr. Blouke said Medicaid is not out of control, health care is out of control and the Governor is committed to working with all parties involved.

Christine Mangiantini, League of Women Voters, said the League commends Sen. Yellowtail's efforts on this issue. The League supports a system which provides access to a minimum level of care for all residents and controls health care costs. The ability of a patient to pay for services should not be a consideration. The League supports policies conducive to equitable distribution of services, economical delivery of care, and advancement of medical technology.

Clyde Dailey, Montana Senior Citizens Association, speaking on behalf of Montanans for Universal Health Care, provided written testimony. (Exhibit #1)

Christian Mackay, Montana Alliance for Progressive Policy, provided written testimony. (Exhibit #2)

Bill Olson, State Legislative Committee for the American Association of Retired Persons (AARP) provided written testimony (Exhibit #3)

Dr. Patricia Hennessey, Missoula, went over Page 2, Page 3, Page 4, and Page 5 of the Montana Health Dollars Databook. (Exhibit #4) Dr. Hennessey said Montana has the resources to finance a state-based system, but it is important to act before the system crashes.

Doug Campbell, Montana Senior Citizens Association, provided written testimony. (Exhibit #5)

Janette Stevenson, Montana Senior Citizens Association, provided written testimony. (Exhibit #6)

Pam Egan, Executive Director of the Montana Family Union, AFL-CIO, provided written testimony. (Exhibit #7)

Steve Henery, Montana Education Association, provided written testimony. (Exhibit #8)

Marty York, Missoula teacher, said she is member of state-wide insurance trust board. The trust was formed by educators and administrators to provide quality health care at affordable prices. Ms. York said that cost containment has not become a realized goal. The growing rate of uninsured on a local level, and a failed piecemeal approach to contain costs are her main concerns. It is imperative that Montana adopt a single-payor program, one that is supported by Montanans for Universal Health Care. She urged the Committee to support SB 267.

Bruce Rukstad, Oil, Chemical and Atomic Workers, provided written testimony. (Exhibit #9)

Kate Cholewa, Montana Women's Lobby, provided written testimony. (Exhibit #10)

Christina Medina, Montana Low-Income Coalition, provided written testimony. (Exhibit #11)

Verner Burtleson, Montana Legacy Legislature, provided written testimony. (Exhibit #12)

Wilbur Rehman, Communications Director for the Montana Federation of Teachers, Montana Federation of State Employees, and the Montana Federation of Health Care Employees, said he strongly supports SB 267. He addressed Section 14 dealing with a certificate of need, stating that he has observed the lack of revenue and regulatory oversight of the health care system. There is no requirement for a certificate of need for new facilities and hospitals because the legislature eliminated that requirement. Mr. Rehman said that issue should be reevaluated because there needs to be a "mechanism for rationality" for the system. Hospital rates are set by a self-regulating rate review authority, which allows for no public input.

Susan Swinehart, licensed social worker and psychotherapist in Helena, said she appears on behalf of the Montana Chapter of the National Association of Social Workers. Ms. Swinehart provided written testimony. (Exhibit #13)

Leesa Klesh, Program Director for Montana Farmers Union, provided written testimony. (Exhibit #14)

Nina Cramer, Montana People's Action, provided written testimony. (Exhibit #15)

Dean Harrmon, BOD Roosevelt Memorial Hospital, provided written testimony. (Exhibit #16)

Veronica Brown, President of the Montana Council of Hotel Employees and Restaurant Employees Union, provided written testimony. (Exhibit #17)

Melvin Potter, President of the Montana Federation National

Association of Retired Persons, said he supports SB 267.

Don Judge, Executive Secretary of the Montana State AFL-CIO, urged the Committee to pass SB 267. Mr. Judge provided written testimony. (Exhibit #18)

Jim Meldrum, Montana Independent Living Project, provided written testimony. (Exhibit #19)

Greg Eklund, Acting Executive Director of the Montana Democratic Party, provided written testimony. (Exhibit #20)

Marciana Garay, Leo Pocha Clinic/Helena Indian Alliance, provided written testimony. (Exhibit #21)

Harley Warner, Montana Association of Churches, urged the Committee's support of SB 267.

Al Schmitz, Northern Plains Resource Council, urged the Committee's support of SB 267.

Jim Stevens, small business owner, said he supports SB 267.

Tom Ryan, self, said he is a member of the AFL-CIO and the Montana Senior Citizens Association. Mr. Ryan said would provide written testimony. He said he runs into frustration when he visits senior citizens, as well as professional people who are upset at "the flow of paper."

Opponents' Testimony:

Wally Henkelman, Clinical Nurse Specialist, Great Falls, said he represents the Montana Nurses Association. Mr. Henkelman provided written testimony. (Exhibit #22)

Jim Ahrens, President of the Montana Hospital Association, provided written testimony. (Exhibit #23)

Marcel Loh, Chief Executive Officer of North Valley Hospital in Whitefish, said he was not testifying against health care reform. Rather, Mr. Loh appealed to the Committee to recommend legislation that will insure thorough research into the policies made to reform the health care system. SB 267 contains many good recommendations, but there are also revisions that limit thorough study of various alternatives such as the single-payor system. It is important that the Committee keep in mind that the health care system is a process, and the state of control must be known when altering the process. Mr. Loh said SB 267 falls short of the thorough research process, and too focused on the regulation of bureaucracy. He urged the Committee to consider SB 285 as a better bill to solve Montana's health care crisis.

Chuck Butler, Vice-President of Blue Cross/Blue Shield of Montana, provided written testimony. (Exhibit #24)

Lorna Franks, Farm Bureau, said SB 267 sets up a new bureaucratic program because it is government run. Farm Bureau policy rests on several principles; promotion of personal wellness, minimal government intervention, tax policies encouraging individuals to plan for future health care needs, direct government financial assistance for individuals who are unable to pay for health care needs, and government programs that properly compensate providers. Ms. Franklin said Montana should not rush into health care reform with such a comprehensive bill as SB 267. Farm Bureau proposes a market-base reform that allows for the greatest amount of individual decision making for recipients and providers of health care.

Russ Ritter, Director of Cooperative Government Affairs of the Washington Companies from Missoula, said the Companies support health care reform. Mr. Ritter said the beginnings exist to solving health care reform problems, but the Washington Companies feel that a single-payor system is not in their best interest.

Jack Meloy, President of the Montana Medical Association, and Great Falls physician, said the Association reluctantly opposes SB 267. Dr. Meloy said he is appreciative of Sen. Yellowtail's efforts, but some specific parts of the bill concern him. These parts include mandated global budgeting, and the imposition of the budgeting mechanism by a health care authority for each hospital in Montana. Freezing health care expenditures would result in rationed health care. If universal access is adopted, expenditures will have to increase. Everybody agrees that changes must be made, but Dr. Meloy urged the Committee consider that the debate is not over yet and now is not the time to reduce our options.

Tom Hopgood, Health Insurance Association of America, said SB 267 is a single-payor bill. Mr. Hopgood said a single-payor system runs the risk of creating an enormous bureaucracy. Many groups advocate a Canadian-style public health insurance system. Mr. Hopgood said he would provide Committee members with pages 16-19 of a booklet published by the Health Insurance Association of America. He read the final paragraph of page 19, which stated that each state, for a state-wide single-payor system, would have to increase total tax revenues by 70%.

Bonnie Tippy, Montana State Pharmaceutical Association, said the Association has some specific problems with SB 267 relating to pharmaceutical care. Page 6, Subsection 5 does not include pharmacists under the definition of "health care provider." Ms. Tippy said that pharmacists are not just dispensers of drugs, they are health care providers, and they do not want to be "cut out of the system." There are federal and state mandates requiring pharmacists to keep extensive patient profiles as well

as council every individual who comes to their pharmacy. The standard of pharmaceutical care continues to escalate. Also, the Association feels pharmacists should qualify as a "bargaining group."

Ms. Tippy said pharmacists should have a part in health care reform and SB 267. She also pointed out anti-trust language on Page 39 and suggested that language be added stating that a health care authority may not approve an arrangement favoring one profession over another for the provision of services. One third of Americans are turning to alternative health care providers.

Martin Miles, physician from Great Falls, says that although he supports changes in the health care system, SB 267 has some provisions which concern him. First, an expanded bureaucracy which can be very expensive. Second, tort reform which is not mentioned in SB 267 which has a major impact on the high cost of health care in Montana.

Mona Jamison, Montana Chapter of the American Physical Therapy Association, said it is very difficult to oppose SB 267, and the Association supports health care reform. Access should be provided to all regardless of income, and cost containment is a major issue. The Association does have some concerns with SB 267 including, the organization and structure proposed on Page 8 because there is no system of accountability. Another agency of state government will be set up, but it will not have the accountability to the chief executive that the others do. Ms. Jamison said the funding mechanism of SB 267, Page 28 and Page 11, must be more specifically detailed. Ms. Jamison urged the Committee to consider accountability to the chief executive, and to make sure that the budget will not run out. The definition of "out-patient" on Page 12 does not include physical therapy services. Ms. Jamison said frequently out-patient services are less expensive and at the same quality as in-patient services.

Informational Testimony:

John Burke, said he does not support or oppose SB 267. He said he had no health insurance and is now homeless, living in his car. Mr. Burke said there is a three-month waiting period for eligibility of health care services.

Questions From Committee Members and Responses:

Sen. Christiaens asked Sen. Yellowtail about how SB 267 impacts the sovereign nations of the Native Americans. Sen. Yellowtail said Montana Indians residing on reservations are served by the Indian Health Service which is part of the U.S. Public Health Service. The health care authority will have to consider this and other federal programs.

Sen. Klampe asked Sen. Yellowtail why there is no fiscal note for SB 267. Sen. Yellowtail said the fiscal note is under preparation, and it will be provided to the Committee.

Clyde Dailey said the health authority will be given two years to come to the next legislative session with a range of recommendations for funding.

Sen. Towe called Jim Ahrens' attention to the definition of "single-payor" on Page 27 which provides "a uniform set of benefits". Sen. Towe asked how this could happen without a single-payor system. Mr. Ahrens said there could be a uniform set of benefits without a single-payor system.

Sen. Towe asked Mr. Ahrens if he supported a uniform set of benefits. Mr. Ahrens said there must be a basic benefit package to bring about health care reform.

Sen. Towe asked Mr. Ahrens if he thought this could be done without a single-payor system. Mr. Ahrens said yes.

Sen. Towe asked Mr. Ahrens if he though Montana would eventually end up with a single-payor system. Mr. Ahrens said he would prefer to wait to see what happens with the current system before a single-payor system is adopted.

Sen. Towe asked Clyde Dailey about one management plan with a purchasing pool, Sections 9 and 16. Mr. Dailey said the purchasing pool was included in SB 267 because collective bargaining agreements had to be recognized, a benefit package that would attract ERISA employers had to be drafted.

Sen. Franklin asked Mr. Dailey if the first pieces of legislation would be seen by the legislature in November 1994, for enactment in 1995. Mr. Dailey said there are several schedules. He said legislation regarding claim forms would be seen in January 1994.

Sen. Franklin asked Mr. Dailey when the actual single-payor plan would go into effect. Mr. Dailey said as soon as the funding mechanism passed the legislature.

Sen. Franklin asked Mr. Dailey when that would be. Mr. Dailey said in two years.

Chairman Eck asked for the proponent from Roosevelt County Hospital to state his concern. Dean Harmony said the single-payor system is preferable because it is consumer oriented and allows for more efficient global budgeting which would save 13% of health care expenditures.

Closing by Sponsor:

Sen. Yellowtail said the Committee will soon have to choose the

direction the legislature must pursue regarding health care reform. A comparison chart will be provided to the Committee that will assist in analyzing the two health care reform bills. Sen. Yellowtail provided the time line for SB 267. (Exhibit #25) Sen. Yellowtail said there is no real commitment to change from the health care industry representatives. The Committee has seen the public demand change and the industry says, "no change." Sen. Yellowtail provided a cartoon illustrating this. (Exhibit #26) Sen. Yellowtail said health care is already rationed by the individual's means to pay for it. This system will not increase the cost currently spent on health care costs in Montana. Sen. Yellowtail proposed that SB 267 will eliminate an enormous insurance, hospital, doctor and clinic bureaucracy. The question is "do we mean to enact health care reform, or will we continue with business as usual."

ADJOURNMENT

Adjournment: Chairman Eck said input from everyone was needed for both bills regarding health care reform. Chairman Eck recognized Willa Dale Evans, who has been working on health care reform since 1939. Chairman Eck encouraged those present not to give up, and adjourned the hearing.

Dorothy Eck
SENATOR DOROTHY ECK, Chair

Laura Turman
LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-5-93

NAME	PRESENT	ABSENT	EXCUSED
CHRISTIAENS	✓		
HAGER	✓		
KLAMPE	✓		
MESAROS	✓		
RYE	✓		
TOWE	✓		
FRANKLIN	✓		
ECK	✓		

FC8

Attach to each day's minutes

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-5-93
BILL NO. SB 267

MUHC

SB 267
TESTIMONY BY CLYDE DAILEY ON BEHALF OF THE
MONTANAS FOR UNIVERSIAL HEALTH CARE.
SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
FEBURARY 5,1993

Madam Chair and Members of the Committee:

My name is Clyde Dailey and I am the Executive Director of the Montana Senior Citizens Association and the Chair of the The Montanans for Universal Health Care Coalition (MUHC), a coalition representing over 100,000 Montanans. I am here today to speak in support of Senate Bill 267. The Montanans for Universal Health Care was formed over one year ago to begin to look at solutions to the crisis in health care in our state. The solution was a statewide universal health care plan which resulted in the legislation you see before you today. The legislation was based on the ten criteria that we have just passed out to you and the bill draft was submitted in July of last year. The product Senate Bill 267, is by far the most comprehensive reform package that this session of the Legislature will see. When MSCA and the coaltion brought the Vermont plan to Montana some twenty months ago, it was viewed as radical reform. But as I'm sure you are aware, this is now the common form for the major health

care reform proposals. The main features include the creation of a heatlh authority, resource management plan, a database, and regional planning boards.

The key to our legislation is that we as a coalition had agreement that there must be an ultimate goal. The goal is a single-payer universal health care plan for the state of Montana. It is our belief that any reform, including a limited or regulated multi-payer, will ultimately lead to a single-payer system. From our perspective, it is better to plan for that eventuality now, rather than backing into a one-payer system. It is necessary to point out that as a coalition we must emphasize that this legislation specifically states that this may be a non-governmental entity.

Can we imagine a time when:

Hospitals will get paid for what they do-- where they will not have to play games with 15 different insurance companies in order to take in more money than it actually costs, in order to break even on the treatments they did not get paid for.

Insurers will not try to micromanage the treatment and reimbursement for hospitals.

A time when there is no bad debt and no paperwork for providers. These changes are possible with true reform.

It is clear is that we are in a state of crisis in our health care system in Montana and nationally. You will hear that we must study which direction our health care system should go for another two years. We have studied this problem since 1939. To continue to study it, while the system melts down around our ears, is a mistake. We must be bold. We must take the reform package to the citizens of Montana and seek their input but not in the form of a study. We have an opportunity to design our own system if we do it now. If we study for two more years, then we are very likely to end up with a one-size fits all mandate from the federal government. An important feature of SB267 is representation from every county within the five regions accross Montana. But the primary feature on which this legislation revolves is the resource management plan. We must know where the dollars are coming from and where the dollars are going in order to make the best decisions about how to contain costs and how to budget globally. I can only say in conclusion, senators, be bold. The urgency of reform requires bold and innovative action. Don't study it , do it. We have an historic opporutinity. Let's make use of it. Montana has

2-5-93
SB-267

been a leader before. Let's be a leader again. Thank you for yor time and consideration.

Montana Alliance for Progressive Policy

P.O. Box 961 Helena, MT 59624 (406) 443-7283

TESTIMONY OF CHRISTIAN MACKAY ON SENATE BILL 267 BEFORE THE SENATE PUBLIC HEALTH, WELFARE, AND SAFETY COMMITTEE. February 5, 1993

Madam Chairwoman, members of the committee, for the record my name is Christian Mackay. I'm here today on behalf of the Montana Alliance for Progressive Policy, a state wide coalition of labor, conservation, education, senior citizens, women, low-income groups, and Native Americans. MAPP's long-term goal is to create a socially just, economically stable and environmentally sound future for the state of Montana.

MAPP is a coalition of non-profit organizations, small businesses if you will. These organizations are being hit hard by ever rising cost of health insurance. Recently, the Montana Senior Citizens Association conducted a survey of fifteen groups in Montana. Only five of the fifteen groups surveyed provided some form of health insurance coverage to their employees. The rest were either self-insured or unable to afford any kind of coverage. The numbers gathered by MSCA showed that between the years 1988 -1991, insurance premiums increased an average of 78% for individual coverage and 76% for couples and family coverage. Number of employees covered ranged from 2 to 24.

The result of this is that many non-profits and small businesses are being forced to choose between providing health insurance for their employees or greater service and additional staff.

Loss of small group health insurance coverage is not confined to small businesses or non-profit organizations. Montana farmers and ranchers are becoming unable to cover their families, not to mention their employees. I grew up on a family ranch south of Roscoe, MT. The ranch bought small group insurance coverage in 1980. At that time, we were able to cover 12 people for $325 per month. The group is now down to 3 people with monthly premiums of $650. That is an increase of 800% on a per person basis.

The universal coverage of Senate Bill 267 is vital to Montana's current small group holders - farmers, ranchers and small business people. Without it, employers will continue to be priced out of the market, forced to drop coverage, and the 140,000 Montanans without access to health care will continue to grow. I urge your passage of SB 267.

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-5-93
BILL NO. SB 267

MONTANA STATE LEGISLATIVE COMMITTEE

AARP

Bringing lifetimes of experience and leadership to serve all generations.

CHAIRMAN
Mr. Gene Quenemoen
606 Frank Road
Belgrade, MT 59714
(406) 388-6982

VICE CHAIRMAN
Mrs. LeDean B. Lewis
6425 Timber Trail
Helena, MT 59601
(406) 458-6195

SECRETARY
Mr. Robert J. Souhrada
915 - 13th Street West
Columbia Falls, MT 59912
(406) 892-4642

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 2-5-93
BILL NO SB 267

Montana AARP State Legislative Committee
1992-1993 Position Paper

STATE HEALTH CARE REFORM

POSITION: **The goal is to reform state health care and long term care incorporating AARP's Health Care America approach of providing health care for all. Until the state system achieves such reforms, the Montana State Legislative Committee will support incremental legislative steps to achieve this reform.**

PROBLEM: Too many people in Montana have no health insurance or at best are under-insured. This applies to young, elderly, retired and employed people as well. ("Reforming the Health Care System: State Profiles" -- Pages 79-81.)

Due to "cost-shifting" in an effort to pay for the uninsured, health care insurance costs are becoming prohibitive.

Billing and related paper work detract from the services of professionals and the hospitals. Additional personnel are required for clerical and administrative work. Duplication of paper work is also an on-going problem.

SOLUTION: State health care reform requires:

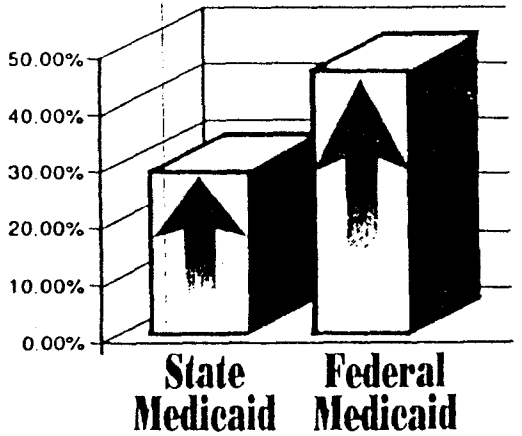
1. Incentives to employers, particularly small business, to provide health care insurance for their employees.
2. Coverage for all Montanans to abolish the need for "cost-shifting."
3. Consolidated billing allowing professionals to treat patients and not be bogged down with undue paperwork.
4. Establish a continuum of services emphasizing in-home care through custodial long term care.

CONTACT: Bob Souhrada, State Legislative Committee Member
915 13th Street West, Columbia Falls, MT 59912
(406) 892-4642

MT 8/31/92 - **POSPAPER.005**

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 2-5-93
BILL NO. SB 267

Uncontrolled Medicaid Spending



+ STAGNANT State Economy =

Depletion of all other State Programs

The original is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Montana Health Dollars Databook by HPAG / Missoula

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624

(406) 443-5341

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-5-93
BILL NO. SB 267

TESTIMONY OF DOUG CAMPBELL
HEARD BEFORE (S) PUBLIC HEATLH, WELFARE & SAFETY
FEBRUARY 5, 1993

Madame Chairperson and members of the committee. My name is Doug Campbell. I am president of Montana Senior Citizens Association and I reside in Missoula. I am here to speak in support of Senate Bill 267.

As I am sure you are all aware, health care costs at both the state and national level have gotten completely out of control over the past decade. This has been a major cause for the large deficits of both state and federal governments. President Clinton has said that if health care costs cannot be controlled, then the federal deficit cannot be reduced, and I am sure that would also apply to Montana. One of the major problems the state legislature has to face this year is workman's compensation. About 47% of that problem is the cost of health care. If you could get control of that large cost item, it would certainly help solve the problem. That is what this bill will do -- provide universal coverage for all Montanans and put strict controls on cost. The bill also would establish a single-payer system because it is our belief that is the only way to solve the problem of the bureaucracy and the horrendous amount of paperwork which is

stifling our health care system today. It is no coincidence that of all the industrialized countrieds of the world with universal health care, and that includes all except the U.S. and South Africa, that almost all have the single-payer system. They have found that to be the most efficient and cost effective.

Universal health care has been the top priority of the Montana Senior Citizens Association for the past five years, and the number one priority bill of the 1992 Senior Legacy Legislature was one to establish a universal health care plan for all Montanans and with a single-payer system. That legacy bill is the basis for this coalition bill I am speaking in support of. On behalf of Montana's 100,000 plus seniors and the 141,000 Montanans with no health insurance, I ask your support for this bill.

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624

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SENATE HEALTH & WELFARE
EXHIBIT NO 6
DATE 2-5-93
BILL NO SB 267

TESTIMONY OF JEANETTE STEVENSON
HEARD IN (S) PUBLIC HEALTH, WELFARE & SAFETY
FEBRUARY 5, 1993

I am Jeanette Stevenson from Hobson and vice-president of the Montana Senior Citizens Association. I wish to thank you for considering our bill and to thank you all of you who were here in the last session for your support of Senate Resolution 9 which recommended congress adopt a single-payer national health care plan, which passed the Senate without opposition.

That resolution was the first step. Now, we are ready for the next step -- putting into place a Montana single-payer health care plan.

You are all aware of the health care problem. You have read the figures that the United States spends more on health care than any other industrial country, yet we have 36 million people uninsured. You also know that Montana is no shining light with 141,000, 20% of our citizens, without health insurance. Yet Montanans spent $2 billion on health care in 1991.

The Montana Senior Citizens Association is a member of Montanans

for Universal Health Care, a coalition of the Montana Education Association, the MT Farmers Union, the AFL-CIO, the Montana chapter of the Physicians for a National Health Plan, Montana Low Income Coalition, Montana Women's Lobby, Montana Alliance for Progressive Policy, and Montana People's Action.

We believe a single-payer health care system is important to the economy of Montana. It would help contain the increasing health costs and the pressure they put on our deficit.

As you study our bill and compare it to other health care proposal, you will find ours to be simple yet comprehensive. It institutes trong cost containment through limiting providers fees, global budgeting and elmination of paperwork.

Thank you again and remember, Montana is depending on you.

Montana Family Union
AFL-CIO

110 West 13th Street
P.O. Box 1176
Helena, Montana 59624
406-442-1727

Don Judge
President

Pam Egan
Executive Director

The Associate Membership Program of the Montana State AFL-CIO

TESTIMONY OF MONTANA FAMILY UNION ON SB 267
SENATE COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY, FEBRUARY 5, 1993

Madam Chair, members of the Committee, for the record, my name is Pam Egan. I am the Executive Director of the Montana Family Union, AFL-CIO. I am here today in strong support of Senate Bill 267.

Because the Montana Family Union is specifically directed at Montanans who do not have access to unions in their workplace, we represent many workers whose employers provide absolutely no health insurance. We also represent Montanans who are retired, work primarily in the home, are unemployed, or are students. Again, these members have no access to employer provided health care coverage.

As an associate membership program, we can only refer our uninsured members to the best basic care coverage plan our research has found available. Unfortunately, that's just not enough.

To help us take a look at what the current "free market" health care delivery system offers to those people not covered under a group plan, I've provided you a copy of the rate schedule for the primary care plan to which we refer our uninsured members.

Imagine you are a single mother of two, working for $5 an hour, $800 per month, before taxes.

For you and your two children, basic coverage costs more than $110.00 per month, almost 14% of your income. Because this is only a basic care plan, it covers only hospitalization and a few out-patient surgical services.

Office visits, prescriptions, dental care and eye-care are not covered. So, for example, if one of those two dependent children gets strep-throat, the money for an office visit and prescription comes out of your paycheck. Or maybe the child doesn't see the doctor at all.

If we estimate conservatively, that same family faces a $300 per month rent bill, $50 per month in utility bills, and $110 per month for hospitalization coverage. They then have less than $340 per month before taxes left for everything else -- day-care, food, clothing, transportation, and all other medical expenses.

For our sample family, insurance -- and therefore medical care -- is a luxury. It is the first expense to go.

For this family, and for the one in five Montanans who have no health care coverage, the current system simply doesn't work.

The Montana Family Union believes that health care is a right, not a privilege reserved for those who can afford it. Fair health care reform must contain the elements of **universal access, global budgeting, protection for retirees**, and **fair financing**. Senate Bill 267 will move us in that essential direction. We respectfully urge your strong support of SB 267.

SENATE HEALTH & WELFARE
EXHIBIT NO 7
DATE 2-5-93
BILL NO SB 267

Montana Family

Union

AFL-CIO

110 West 13th Street
P.O. Box 1176
Helena, Montana 59624
406-442-1727

Don Judge
President

Pam Egan
Executive Director

The Associate Membership Program of the Montana State AFL-CIO

Essential Care Rates

Offered through Blue Cross/Blue Shield of Montana

AGE	SUBSCRIBER RATE	SPOUSE RATE
Under 24	42.32	45.34
Age 25-29	45.38	48.70
Age 30-34	49.32	53.04
Age 35-39	55.66	60.02
Age 40-44	63.36	68.50
Age 45-49	73.96	80.14
Age 50-54	80.18	86.98
Age 55-59	90.82	98.70
Age 60+	106.26	115.70
One child	*30.62*	
Two+ children	*61.24*	

Example: Monthly premium for married couple in different age categories are averaged by age:

Subscriber: Age 43
Spouse: Age 39
82 / 2 = 41

Age 41 rate for subscriber: $ 63.36
Age 41 rate for spouse: $ 68.50
$131.86 – plus child rate for any dependents

Premiums for single members relate directly to age of the member on the effective date of coverage and will be modified by age according to the schedule of in-force rates thereafter.

rates effective July 1, 1992

Labor wants nothing for itself that it would not willingly share with others.

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 2-5-93
BILL NO. SB 267

Montana Education Association
1232 East Sixth Avenue • Helena, Montana 59601 • 406-442-4250

FEBRUARY 5, 1993
BEFORE THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
SB 267

STEVE HENRY, PRESIDENT
BILLINGS EDUCATION ASSOCIATION

The Billings Public Schools initiated a partially self-funded health insurance plan in 1983. The structure of the plan as well as plan changes are guided by an employee committee that has proportional representation from all employee groups. I have served on this employee insurance committee almost continuously since its inception. The plan is administered by a third party administrator, Employee Benefit Management Services. The plan provides coverage for approximately 2,000 employees and retirees. With dependents, there are over 4,000 persons covered under this plan. Outside of state government and universities, the Billings school group is probably the largest public insurance group in the state.

During the decade that the Billings self-funded plan has been in existence, the committee has instituted nearly every cost containment measure available in the industry. We have pre-admission certification, we have wellness programs, we have required second opinion on surgical procedures, we have requirements for outpatient surgery, we have incentives for the use of generic drugs, we have dropped initial accident benefit coverage, and we have entered into PPO arrangements with medical providers. During this time the plan deductibles have risen from $75 for individuals and $150 for a family to $250 for individuals and $500 for a family. Out-of-pocket maximums have risen accordingly.

Despite all of these measures, the district-paid cost for insurance has doubled during this ten-year period. However, in 1983 the district's cost paid the entire premium for full family coverage under composite rate structure. Today the district's payment only pays for coverage for the employee under a differentiated premium schedule. Employees with dependents pay the additional premium amount out-of-pocket. Had we maintained full family coverage with a composite rate structure, the premium today would be over 300% of the 1983 cost.

Even with all of these cost containment and cost shifting measures, the plan has experienced serious operational funding problems. During the 1990-91 and 1991-92 school years, the plan had some extremely high claims. In one year, eight claims totalled over one million dollars. These spikes in the claims experience, plus the rising inflationary spiral of health care costs, placed the self-funded plan in a very precarious financial position. The situation was only rectified by the district making an extraordinary reserve transfer into the fund and a special payroll assessment was paid by every employee.

I believe the Billings School District's experience demonstrates that even large employers with a thousand or more employees are not immune from the catastrophic problem resulting from today's health care "system." Skyrocketing inflation in the cost of providing health coverage has become the number one issue in employee relations. A few years ago, the question was "should monies be placed into increased health care costs or in salary increases." Today, the question is "can we afford health coverage at all."

We have strived to make our insurance plan work for the past ten years. However, no amount of change in the structure or funding levels seems to allow the program to get ahead. I feel the only viable long-term solution to this problem for all people, rural or urban, public sector, private sector, self-employed, unemployed and retired, is to provide a single payer health plan to all citizens of the state.

On behalf of the Billings Education Association and the Montana Education Association, I urge your support of SB 267.

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 2-5-93
BILL NO. SB 267

REMARKS BY OIL, CHEMICAL AND ATOMIC WORKERS INTERNATIONAL UNION (OCAW) BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY, FEBRUARY 5, 1995.

Madam Chair., members of the committee, for the record my name is Bruce Rukstad. I am the President of OCAW Local 2-470 out of Billings, Montana. I rise to speak in favor of SB 267.

In 1989, the Executive Board of the Oil, Chemical and Atomic Workers International Union endorsed the National Health Program, sponsored by the Physicians for a National Health Program. The program is a single payer system that is modeled after the Canadian plan.

The reasons for this endorsement were many and varied. Because my time is short today I would like to focus on one of those reasons. For those of us in unions, rising health care costs have become a major concern at the bargaining table.

As premiums rose in the early 1980's, employers and unions got together under the banner of "cost containment". A variety of cost control programs were initiated, like mandatory second opinions, utilization review and managed care programs. But, their effect was minimal as insurance companies continued to raise premiums. Employers are now bargaining hard and with a fair amount of success to shift health costs onto workers.

For example, since 1985, OCAW members working at Chevron in California have seen their share of the Hospital/Medical Insurance premium increase by 47 percent - up to $169.50 per month for family coverage. In other words, these members are required to devote the equivalent of almost a dollar an hour in hard-earned wages, based on a normal 40 hour work week, to get decent medical care for themselves and their families.

In other major jurisdictions of our union like the chemical industry and the pharmaceutical industry, the trends are in the same direction although the starting points are different.

Once, we defined success in negotiations as an expansion of benefits; now we define it as <u>maintenance</u> of benefits without new out-of-pocket expenses for workers.

SB 267 provides us with the mechanism necessary to secure a legislative solution that truly does solve the critical issue of soaring benefit costs for our members. For this reason I would ask that you support SB 267.

Thank you.

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 2-5-93
BILL NO. SB 267

MONTANA WOMEN'S LOBBY

February 5, 1993
Testimony of Kate Cholewa
Senate Committe on Public Health, Welfare, and Safety

The Montana Women's Lobby supports comprehensive health care reform to ensure that all women and families have access to a full range of affordable and high-quality preventative, diagnostic, and treatment services.

I would like to share a bit of our history with you to explain why we have broadened from working on incremental insurance reform to supporting comprehensive health care reform as addressed by SB 267. When the Women's Lobby was founded in 1982, we found that women and families were charged significantly more for health insurance than men, and that coverage typically excluded more female-related health conditions. We successfully championed passage of a law in 1983 which prohibits sex discrimination in insurance rates and benefits. This law resulted in substantial rate reductions for women and families buying individual coverage, averaging 14% for families and 24% for single women. We are glad the law is saving women and families several hundred dollars per year; but due to rapidly rising costs, this one reform alone is not enough to make health care coverage affordable and accessible to everyone. More sweeping reform is needed.

Women and their families have a particular need for major change. Montana women earn on average about half what men do and are concentrated in low-wage, small business and part-time jobs that are least likely to provide health coverage as an employee benefit.

When the Women's Lobby decided to become involved in comprehensive health care reform, we spent most of a year studying alternatives. We conducted workshops with our board of directors and other groups to analyze the choices and determine which alternative would best meet the needs of Montana women and children. We agreed we wanted an approach that would simultaneously address access for everyone, provider choice, comprehensiveness, quality, efficiency, administrative waste, and cost containment concerns. It was important to Lobby members that universal access include coverage of alternative methods of health promotion, treatment, and care. The consistent conclusion in every workshop—regardless of participants' party affiliation—was that a single-payer system as proposed in SB 267 is the only approach that will effectively address all these concerns. We also agreed we would like to see a shift in orientation from the predominant focus on treatment of illness to promotion of wellness through a multi-faceted approach to health which would encourage the voluntary adoption of healthy lifestyles. This would be possible through SB 267.

The Montana Women's Lobby strongly supports SB 267 as a practical and necessary approach to health care reform in Montana.

Montana
Low-Income
Coalition

PO Box 1029
Helena, MT 59624
(406)449-8801

Concerned Citizens Coalition
825 Third Avenue South
Great Falls, Montana 59402

Helena Indian Alliance
436 North Jackson
Helena, Montana 59601

Montana Alliance for
Progressive Policy
324 Fuller Avenue
Helena, Montana 59601

Montana Legal Services
Employee Association
801 North Main
Helena, MT 59601

Mt. Senior Citizens Association
PO Box 423
Helena, MT 59624

Tri-County Advocacy Council
827 3RD Street
Havre, MT 59501

SENATE HEALTH & WELFARE
EXHIBIT NO. 11
DATE 2-5-93
BILL NO. SB 407

Senator Eck and Members of the Committee:

My name is Cristina Medina, Executive Director of the Montana Low-Income Coalition also will be representing the No-Income people if HB #427 and 309 passes. Many of our constituents do not have basic medical care because they are not eligible for medicaid or because they make too much money or the paltry sum they receive in welfare plus the added restrictions cannot pay certain medicines or the doctor visits. They are then forced to decide to let go of their health until they are at death's door and are brought to the emergency room. The poor in this state are being crucified by the enormous budget cuts in Human Services specifically the medically needy program which many of our recipients rely on for care. Please give them a ray of hope and vote in favor of this bill. This bill will save lives, improve their health and it would be one less worry for them to deal with. My final comment is that healthcare for all is a basic right and this state needs to take the initiative in taking care of all its citizens and not the privileged few.

SENATE HEALTH & WELFARE
EXHIBIT NO 12
DATE 2-5-93
BILL NO. SB 267

S.B. 267. Universal Health Care - Sen. Yellowtail -

Madam Chairman, members of the Public Health, Welfare and Services Committee.

I am Verner Bertelsen, today I represent Montana Legacy Legislature.

Montana Legacy Legislature in their session last May, 1992 chose as their number One priority: Universal Health Care! We strongly support S.B. 267. S.B. 267 has several features which we believe make it superior to other plans being considered.

It is essential that we provide more and better preventive health care - a dollar spent in preventive care can save thousands in future costs. It is essential that all Montanans be assured of access to health Care. It is essential that being poor should not deprive Montanan of proper health Care. It is essential that we begin to get control of medical costs including prescription costs - We are praying for Universal Health care but not getting it.

Montana Legacy Legislature believes every Montanan should be covered by a health care plan - We believe now

to ~~institute such a plan~~ such a plan - Gen Yellowtail we support you in this effort and members of this Committee we ask for your support of Senate Bill 267 —

Thank you.

Verner Bertelsen
Lobbyist - Legacy Legislature
1800 Wynne Ave.
Helena, Mt

SENATE HEALTH & WELFARE
EXHIBIT NO 13
DATE 2-5-93
BILL NO SB 267

NASW MONTANA STATE CHAPTER

National Association of Social Workers 555 Fuller Avenue Helena, MT 59601 (406) 449-6208

TESTAMONY FEBRUARY 5, 1993

MADAME CHAIR AND MEMBERS OF THE COMMITTEE, MY NAME IS SUSAN SWINEHART. I AM A LICENSED SOCIAL WORKER AND A PSYCHOTHERAPIST. I HERE TO TESTIFY ON BEHALF OF THE MONTANA CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS STRONGLY ENDORSE SB 267 WHICH PROPOSES A UNIVERAL SINGLE PAYER HEALTH CARE SYSTEM FOR MONTANA. THIS PROPOSED LEGISLATION IS SIMILAR IN INTENT AND SCOPE TO THE NATIONAL HEALTH CARE PLAN WHICH THE NATIONAL ASSOCIATION OF SOCIAL WORKERS HAS PRESENTED FOR CONSIDERATION AT THE NATIONAL LEVEL (A COPY OF A LIST OF THE BASIC COMPONENTS OF THAT PLAN IS ATTACHED TO MY WRITTEN TESTIMONY).

ALTHOUGH WE SUPPORT SB 267 AND WE UNDERSTAND THAT THIS LEGISLATION IS INTENDED TO ADDRESS BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE NEEDS, WE ARE CONCERNED THAT SB 267 DOES NOT SPECIFICALLY STATE THAT MENTAL HEALTH CARE NEEDS ARE INCLUDED. IT HAS BEEN OUR EXPERIENCE THAT WHEN MENTAL HEALTH CARE NEEDS AND COVERAGE ARE NOT EXPLICITELY IDENTIFIED, BUT ARE SUPPOSED TO BE IMPLICITE IN THE TERM "HEALTH CARE" THEN MENTAL HEALTH CARE IS OVER LOOKED. ACCORDINLY, WE HAVE SOME SPECIFIC AMMENDMENTS TO SUGGEST WHICH I WILL ONLY IDENTIFY BY EXAMPLE HERE, BUT WHICH ARE LISTED IN DETAIL IN THE WRITTEN TESTAMONY I SUBMITTED.

WE PROPOSE THAT SECTION 4 (3) REGARDING THE COMPOSITION OF THE HEALTH CARE AUTHORITY BOARD BE AMENDED TO READ, "EACH MEMBER SHALL BE KNOWLEDGABLE IN A DIFFERENT ASPECT OF HEALTH CARE OR

MENTAL HEALTH CARE. THREE MEMBERS MUST BE HEALTH CARE OR MENTAL HEALTH CARE CONSUMERS". ADDITIONALLY, SECTION 7 (1) WHICH DISCUSSES THE STATE HEALTH RESOURCES MANAGEMENT PLAN BE AMENDED TO STATE, "THE STATE PLAN MUST IDENTIFY THE HEALTH CARE AND THE MENTAL HEALTH CARE NEEDS IN MONTANA". A SIMILAR CHANGE NEEDS TO BE MADE IN SECTION 12 (1) AND (b) REGARDING THE HEALTH CARE DATA BASE AS FOLLOWS, "THE AUTHORITY SHALL MAINTAIN A HEALTH CARE AND MENTAL HEALTH CARE DATA BASE" AND "TO IDENTIFY HEALTH CARE AND MENTAL HEALTH CARE NEEDS AND DIRECT HEALTH CARE AND MENTAL HEALTH CARE POLICY". SECTION 17 (3) (c) WHICH DISCUSSES THE BENEFITS TO BE PROVIDED UNDER THE UNIVERAL ACCESS PLAN SHOULD BE AMENDED TO READ "UNIFORM HEALTH AND MENTAL HEALTH BENEFITS". IN ADDITION, SECTION 28 (4) (a) REGARDING THE ESTABLISHMENT OF THE REGIONAL HEALTH CARE PLANNING PANELS SHOULD BE AMENDED TO INCLUDE MENTAL HEALTH CONSUMERS AMONG THE FIVE CONSUMER MEMBERS AND (4) SHOULD BE FURTHER AMENDED TO INCLUDE A MENTAL HEALTH PROVIDER IN ADDITION TO A PHYSICAL HEALTH PROVIDER. THIS COULD BE ACCOMPLISHED BY EITHER CHANGING ONE OF THE "HEALTH CARE PROVIDERS" IN (4) (b) TO A "MENTAL HEALTH CARE PROVIDER" OR BY ADDING A NEW (f) WHICH WOULD PROVIDE FOR THE INCLUSION OF AT LEAST TWO MENTAL HEALTH PROVIDERS. SECTION 30 (1) (a) REGARDING THE DUTIES OF THE REGIONAL PANELS SHOULD BE AMENDED TO READ, "DEVELOP REGIONAL HEALTH CARE AND MENTAL HEALTH RESOURCE PLANS THAT MUST ADDRESS THE HEALTH CARE AND THE MENTAL HEALTH CARE NEEDS OF THE REGION, ADDRESS THE DEVELOPMENT OF HEALTH CARE AND MENTAL HEALTH CARE SERVICES".

WE BELIEVE THAT THESE CHANGES WILL CLARIFY THAT MENTAL HEALTH CARE IS INCLUDED IN THE UNIVERSAL

HEALTH CARE PLAN FOR MONTANA. THANK YOU VERY MUCH FOR YOU TIME AND ATTENTION TO MY COMMENTS. IT IS APPARENT THAT A CONSIDERABLE AMOUNT OF WORK HAS BEEN INVESTED IN PREPARING THIS PROPOSED LEGISLATION FOR WHICH THE NATIONAL ASSOCIATION OF SOCIAL WORKERS WISHES TO THANK THE DRAFTERS.

NASW National Health Care Plan

In response to our nation's severe health care crisis, the NASW developed a National Health Care (NHC) plan that fundamentally restructures our costly and inefficient health system and provides every American with comprehensive health and mental health services, including long-term care.

The basic components of the NHC Plan include:

- A single-payer health system administered by the states under federal guidelines.
- Universal access for all U.S. residents regardless of race, national origin, income, religion, age, sex, sexual preference, language, or geographic residence.
- Freedom to choose from among any of the participating public and private providers.
- Expansion of public health functions for disease prevention and health promotion.
- Care coordination services to ensure appropriate and cost-efficient health care.
- No cost-sharing, except for a modest room and board fee based on income for nursing home care. The plan allows limited cost-sharing based on income, if necessary, to control excess utilization.
- Global budgeting for states with expenditure targets by category of services.
- Global budgeting for hospitals and prospective payment options for other health facilities, with state regulated funds for capital expansion and purchase of highly-specialized equipment.
- Negotiated fee schedules for physicians and other health care practitioners.
- Emphasis on community-based health and mental health services, including home health care for those in need of long-term care, regardless of age.
- Health planning at all levels to ensure more efficient utilization and equitable distribution of health resources.
- Financing primarily through a dedicated federal tax on personal income and a federal employer payroll tax. Additional sources of revenue include state contributions, earmarked estate taxes, and higher taxes on alcohol and cigarettes.
- Quality assurance standards for all health care providers with federal and state responsibility for data collection, evaluation and monitoring of appropriate treatment and utilization.
- Targeting of essential health and mental health services for underserved populations.
- Expanded federal support for training/education of health/mental health professionals and allied personnel.
- Continued support for basic biomedical and mental health research, and research efforts that will improve the delivery of cost-conscious, quality health care.
- Support for medical malpractice reform.

MONTANA FARMERS UNION

Frank "Bud" Daniels, President

300 River Drive North
P.O. Box 2447
Great Falls, MT 59403-2447
Phone 406 • 452-6406
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TESTIMONY IN SUPPORT OF:
SENATE BILL 267 – SPONSORED BY SENATOR YELLOWTAIL
MONTANANS FOR UNIVERSAL HEALTH CARE – SINGLE PAYER BILL

Good Afternoon. Madame Chairman and committee members, my name is Leesa Klesh and I am the Program Director for Montana Farmers Union. Montana Farmers Union is a general farm organization representing about 4000 rural families across the state. As a general farm organization we are involved with farm income issues, agricultural issues and social issues that affect our members. Health Care is one issue that is of grave concern to all of our members - young and old. Farmers pay the full cost of health care because they have to insure themselves and often their employees. The injustice of the current for profit Health Care system is that, although you can not afford to pay the outrageous health insurance premiums, if you own anything of value you can't afford to be without it because of the enormous ever increasing Health Care costs. For farmers and ranchers, this means that they must pay the health insurance premiums, if at all possible, to protect the land that provides their livelihood.

We currently have young farm and ranch families that are having to choose between providing health insurance or groceries for their families. One family I talked with last week pays $450.00 per month for health insurance and in order to keep their premium at this amount, were forced this year to a policy doubling their deductible. Some of our older members are paying $800.00 to $1,000 per month for health insurance. A member couple in central Montana had been paying health insurance for 25 years when the wife became ill and needed heart surgery in 1990. Their insurance premium was $280 per month in 1989 before the surgery and by 1992 their monthly premium had skyrocketed to $870.00. Their insurance premiums literally tripled in a three year period.

It is estimated that if changes are not made soon, nationally, the average American family will pay $14,000.00 per year for Health Care by the year 2000. (Families, USA - Lewin, ICF 1980 - $2520, 1991 - $6500, 2000 - $14,000) In the state of Montana in 1992 Dollars by the year 2000 the average Montanan family will spend almost $9,000 ($8,981) on Health Care (Families, USA, October 1992 issue with state breakdowns). This literally means that more and more Americans will simply not be able to afford Health Care.

Rising costs of Health Care and insurance premiums, lack of access to quality care in rural communities, shortages of doctors and nurses in outlying areas are just some of our concerns. There have been six rural hospital closures across the state in the last five years (Jordan, Ekalaka, Circle, Big Timber, Terry, St. Ignatius - per the Montana Hospital Association). Insurance premiums alone are

rising as much as 50% per year. Because of the monumental changes necessary to correct the current system, Montana Farmers Union actively supports comprehensive Health Care reform for the state of Montana.

In our commitment to serve our membership, this past year, we have worked with both **Senator Baucus' Montana Citizen's for Health Group** and **Montanans for Universal Health Care** to assist in the development of comprehensive Health Care reform plans. We believe the two most important components vital to real reform are:

Universal access: assuring all Montanans will have a right to quality basic health care at an affordable price.

Cost containment: controlling health care costs through global budgeting, cooperative regional planning and efficient use of resources.

Today, we are here to support Senate Bill 267 sponsored by Senator Yellowtail. We believe a single payer system for Montana would provide quality health care for all Montanans in a cost effective manner.

We urge you to recommend to your fellow legislators to pass legislation this session to begin the process of Health Care reform.

- END -

THE TIME IS NOW TO BEGIN THE PROCESS OF HEALTH CARE REFORM.

Basic Health Care should be the right of every Montanan!

TESTIMONY
NINA CRAMER, MONTANA PEOPLE'S ACTION
BEFORE THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
FEBRUARY 5, 1993

SENATE HEALTH & WELFARE
EXHIBIT NO. 15
DATE 2-5-93
BILL NO. SB 267

MADAME CHAIRWOMAN, MEMBERS OF THE COMMITTEE:

MY NAME IS NINA CRAMER AND I AM THE CHAIRWOMAN OF THE MONTANA PEOPLE'S ACTION STATE BOARD OF DIRECTORS. MPA CURRENTLY HAS OVER 7,500 LOW- AND MODERATE-INCOME FAMILY MEMBERS AND DONORS IN OVER 40 MONTANA COMMUNITIES.

LIKE MANY OTHER MEMBERS OF OUR ORGANIZATION, MY FAMILY IS NOT ADEQUATELY COVERED BY HEALTH INSURANCE. I AM A SINGLE MOTHER OF THREE CHILDREN AND WHILE I AM FORTUNATE TO HAVE COVERAGE FOR MYSELF, MY THREE GIRLS HAVE NO HEALTH COVERAGE AT ALL.

I OWN MY HOME, I HAVE A JOB, I PAY MY TAXES AND YET HEALTH CARE COVERAGE IS STILL NOT AVAILABLE TO MY CHILDREN. I WOULD LIKE TO HAVE A REGULAR FAMILY DOCTOR.

HOWEVER, I HAVE BEEN FORCED TO USE EMERGENCY ROOMS FOR SIMPLE AILMENTS BECAUSE IT IS THE ONLY PLACE THAT I KNOW I CAN GET CARE FOR THEM WITHOUT INSURANCE. I EARN TOO MUCH TO GET MEDICAID FOR THEM, YET I DON'T EARN ENOUGH TO BE ABLE TO PROVIDE THEM WITH INSURANCE COVERAGE.

I'D LIKE TO THINK THAT LIVING IN AMERICA - THE GREATEST NATION IN THE WORLD - THAT THE KIDS OF A HARDWORKING PARENT LIKE MYSELF WOULD HAVE THE RIGHT TO ADEQUATE HEALTH CARE. BUT HEALTH CARE IS INCREASINGLY AVAILABLE TO ONLY A PRIVILEGED FEW.

AS YOU MAY KNOW, MONTANA PEOPLE'S ACTION HAS WORKED WITH SEN. CHRISTIAENS TO DEVELOP THE STRONGEST HEALTH INSURANCE REFORM LEGISLATION WHICH THIS LEGISLATURE WILL CONSIDER. YOU CAN MAKE OUR REFORMS UNNECESSARY AND IRRELEVANT - WITH OUR BLESSING - BY DOING THE RIGHT THING: PASSING THIS BILL.

SENATE HEALTH & WELFARE
EXHIBIT NO. 16
DATE 2-5-93
BILL NO. SB 267

2-5-93

My name is Dean Harmon. My family and I have farmed and ranched near Bainville for over 30 years. About ten years ago I was appointed to serve as a board member for Roosevelt Memorial Hospital in Culbertson. Today I am representing Roosevelt Memorial as a trustee.

At this time there are two significant health care reform bills which will be heard, SB 267 and SB 285 which has been endorsed by M.H.A., M.M.A., and Blue Cross of Montana. Both of these bills are patterned structurally after the Vermont Plan.

There is one fundamental difference that I wish to address. SB 267 directs the Health Care Authority to design a single payer system. SB 285 directs the Health Care Authority to design two systems: a single payer and a multi-payer system, one of which will be selected for implementation.

A single payer system is best for two reasons. It is consumer oriented and it would allow for more efficient "Global Budgeting" which could save 13% of health care expenditures.

We must be careful when considering enlarging an existing bureaucracy or establishing a new one. It must be given the direction to maximize efficient use of taxpayer dollars and minimize influence from special interest groups. A single payer health care system will best give that direction.

Significant, substantial, and fundamental health care reform is needed now.

Feb.1, 1993, Senator Kent Conrad, ND said "If we simply rearange the deck chains on the Titanic, it won't do the job."

Rep. John Dingell, Michigan said "Either we will change it or it will change us."

"Those who do not participate will be trampled by it."

Senator Jay Rockaferrer said "If there is not health care reform by us we will be handed Canada's or Great Britain's by the Americn public by the turn of the century."

Regarding Global Budgeting, Senator Rockageller said "We need it and we are going to get it, like it or not."

"We must understand the inevitability of major structural reform."

In May of 1990, Marcia Desmond of the American Hospital Assoc. reported 89% of Americans said "Fundamental change is needed."

Voters in the 1992 election indicated in one poll, that health care was then the third most important reason for candidate selection. In another poll it had the second highest priority.

The need for health care reform is immediate. You are encouraged to make the decisions that will make a defference for all Montanans.

I urge a do pass on SB 267.

Dean Harmon,

Chairman Board of Trustees R.M.H.

SENATE HEALTH & WELFARE
EXHIBIT NO. 17
DATE 2-5-93
BILL NO. SB267

Testimony - SB267
Veronica Brown
President, Montana State Council of HERE
Billings, Montana

Mr. Chairman and members of the committee, my name is Veronica Brown from Billings. I am the President of the Montana State Council of the Hotel Employees and Restaurant Employees Union. This council represents over 1300 workers in eight Montana communities. I am also one of the uninsured in Montana.

I first want to thank Senator Yellowtail for having the courage to introduce this bill, which will make such a difference for working Montanans and for Montanans who want to work.

Because HERE represents workers in the service industry, I feel compelled to address my remarks as it relates to workers in this sector. Generally the workers' in this industry are single mothers, trying to put food on the table. In some cases they have health insurance, but most do not. Ask your next waitress if he or she has health insurance - chances are they'll say no. Small employers in this industry often times can't afford to provide health insurance to a largely part-time workforce; and those larger employers who can afford to provide insurance often don't because the cost cuts to largely into the profit margin.

When these workers are faced with a health problem the only option often is to quit a job to qualify for Medicaid. I know many women throughout this state who want to work but can't because they would loose their health benefits. A system that forces parents to stay on state assistance for fear that they or a child will fall ill simply does not work. We - the lawmakers and citizens - must have the courage to demand that health care be granted to all no matter what income bracket they fall in.

We must revamp a system that says that a broker deserves health care but not a cook. We should be appalled and ashamed by a system that says a lawyer's daughter is entitled to insurance but not a waitress's son. We must stop health care form becoming another way of defining the "haves" and the "hnve nots."

If a Universal Health Care bill passes, we will see citizens from all corners of this state working harder to find a job. If a Universal Health Care bill passes, a job won't be a barrier to health care. If a Universal Health Care bill passes, one more economic barrier in this state will be struck down.

I urge you to support the hard working men and women across this state who take on some of the most difficult and demanding jobs. Have the courage and foresight to support this bill. Please do the right thing and give Senate Bill 267 a do pass recommendation.

Montana State AFL-CIO

Donald R. Judge
Executive Secretary

110 West 13th Street, P.O. Box 1176, Helena, Montana 59624 406-442-1708

SENATE HEALTH & WELFARE
EXHIBIT NO. 18
DATE 2-5-93
BILL NO. SB 267

TESTIMONY OF DON JUDGE ON SB 267
SENATE PUBLIC HEALTH, WELFARE AND SAFETY, FEBRUARY 5, 1993

Madam Chair, Members of the Committee, for the record, my name is Don Judge. I'm here today on behalf of the Montana State AFL-CIO to lend our support to Senate Bill 267.

America's health care system has been ill for years. Today, it's in critical condition. We're gathered here today to propose taking a giant step towards developing a cure. It's a tall order. Ten years ago, as a nation, we spent $350 billion on health care. Last year that bill came to $839 billion.

In 1980, the average family spent 9 percent of its total income on health care, last year, that rose to 12 percent and is expected to top 16% by the end of this decade. The feverish cost is one symptom of the disease that has infected our entire system...and shifting that cost is aggravating the problem.

When any one of the nation's 37 million uninsured needs medical attention, the cost is shifted to those who do have health insurance. The result is a climbing temperature, the cost rising two to three times faster than other consumer costs...year after year after year. The health care system is a patient which is critically ill and, without drastic surgery, may not recover.

Workers' paychecks have been taking a beating as their employers struggle to maintain health benefits. Workers are forced to pay more of the cost of those benefits even when their pay hasn't kept pace with inflation. And when workers or their families get sick, they find their once adequate "insurance" no longer covers the costs or has even been canceled!

We face a crisis in Workers' Compensation costs. This crisis is substantially driven by rising health care costs, which have gone from 30% of the system's budget ten years ago, to more than 40% today, and is projected to raise to 50% within five years!

We recognize the illness of our system. But what we need is the cure. And, just what kind of health care reform do Montana's workers want?

We want a system that provides comprehensive, quality health care for all at an affordable cost;

We want a guarantee that we can take our insurance with us when we change jobs, as American workers will change jobs, on average, at least five times during their worklife.

We want a system that is financed fairly and that takes the good from our existing delivery system and improves the efficiency and accountability.

Workers know that the problem has been getting worse for years and we don't expect an overnight miraculous cure. But we do plan to insist on certain standards:

We want UNIVERSAL ACCESS a health care system that guarantees that every sick or injured American can get medical care.

We want GLOBAL BUDGETS a system that controls duplication in purchasing and coordinates the medical resources for each community and region so we can put valuable and expensive technology to maximum use. And we want a cap on the annual increase in health care spending.

We need PROTECTION FOR RETIREES AND THOSE IN NEED a health care system that guarantees benefits to retired workers regardless of age. And also to those who are unemployed or on strike or in school.

We want FAIR FINANCING where the cost of health care reform is distributed as broadly and equitably as possible. Workers are opposed to taxation of employee health benefits. They are already sacrificing their income to maintain health coverage and an increased tax burden would shift the burden even more to the working families of this country.

We can resolve this crisis in our current health care system only if we make a unified commitment to finding a resolution. No matter how worthwhile they may be, no collection of piecemeal approaches, from tax credits to malpractice reform will do much to control overall costs. Only a coordinated approach can offer any reasonable hope for a functional solution.

Montanans can have universal health security - if we commit ourselves to get on with the job. To advocate anything less, is to accept the inevitability of continued chaos, in which this state's resources will continue to be misapplied and sucked into a black hole of uncontrollable cost.

There are two bills introduced in this Legislative session that could provide the medicine this struggling system needs. Both bills will move the patient towards recovery.

Today, we're here to recommend that the Montana Legislature give it's favorable consideration to Senate Bill 267, the most comprehensive health care reform proposal to be presented to this session of the legislature. To some, this measure may seem radical. To us, not to do something radical would be irresponsible.

Thank you.

SENATE HEALTH & WELFARE
EXHIBIT NO. 19
DATE 2-5-93
BILL NO. SB 267

February 4, 1993

Members of the Committee. I am James Meldrum. I represent Montana Independent Living Project, located here in Helena. We support Senate Bill 267.

There are about 35,000 people with disabilities residing in Montana. People with disabilities usually experience greater need for health maintenance that the rest of the population. Many people with disabilities have medical needs which require frequent attention such as: daily medication, physical therapy, speech therapy, wheel chair or other assistive devices, home health care needs and other long term assistance.

A major deterrent for a quality of life for people with disabilities is the lack of funds, either personal or governmental, to provide the needed medical treatment. Therefore, some people with disabilities are living a substandard life.

Health insurance reform which will provide basic health insurance coverage for individuals of all ages will be of benefit to individuals who have disabilities.

SB 267 will provide for continuity of insurance coverage for individuals as they move from one employer to another, or the employer changes insurance carriers. I am personally experiencing the gap in coverage for a preexisting condition. Because of my disability, I needed to change my employment last July. I have had continuous health insurance for about 30 years, ten years with my last carrier. My new employer's carrier requires a one year waiting period for preexisting conditions. I looked at the

possibility of exercising my right under my previous carrier to continue for one year paying premiums on just myself. I could not afford the required $296.00 monthly premium. I felt that I could hold out for one year before I needed medical attention for my condition. Now I am holding my breath that I do not have a re occurrence until after the one year waiting period is over. Under this bill. Preexisting condition exemption is limited. and controlled so individuals may change employment. or move with in the State and not feel bound to stay where they are because of the one year waiting period for preexisting conditions.

This bill will also require the study and development of a plan for long term care reform. Many people with disabilities need various aspects of long term care in order to remain in their homes. We would ask that the study for long term care study include a method of payment for services for individuals to live in their community and in their own home.

A reduction in the amount of paper work required for plan member to receive payment. or payment to provider is supported.

This bill also makes health coverage readily available to all people with disabilities.

The formulation of the authority and members of the authority give consumers with disabilities an equal opportunity to be involved in the formulation of Montana's health reform package.

Because of these reasons. I urge for your consideration of this bill and as for a committee recommendation of do pass.

Thank You

MONTANA DEMOCRATIC PARTY

SENATE HEALTH & WELFARE
EXHIBIT NO. 20
DATE 2-5-93
BILL NO. SB 267

Senator Eck and Members of the Committee:

For the record, I am Greg Eklund, Acting Executive Director of the Montana Democratic Party and I stand before you today in support of Senate Bill 267.

Montana, like the rest of our nation, faces a serious crisis in the area of health care. While the deliberations of this session will be largely and appropriately aimed at solving the fiscal crisis facing our state, I think it's equally important to focus attention on the crises of providing affordable and accessible health care to the citizens of this state.

The platform of the Montana Democratic Party speaks clearly on this issue. Our Party believes that comprehensive health care is a right for all Montanans, and not only those who have the financial ability to afford health insurance under our current system. A single-payer system should provide for universal coverage, allow for access, support preventive services, provide for portability of health care coverage and include cost containment measures.

Clearly, the most important goal of any single-payer health care plan is the coverage of all Montanans. With over 140,000 of our fellow Montanans who have no health care coverage, the time is now to make a positive step toward a system that is compassionate and provides universal coverage for everyone.

Thank you for your time. Again, the Montana Democratic Party recommends a do pass on Senate Bill 267.

Marciana Garay 436 Jackson St Helena, MT

madam Chairman and panel.

SENATE HEALTH & WELFARE
EXHIBIT NO. 21
DATE 2-5-93
BILL NO. SB 267

Leo Pecha Clinic.

Service upto 400 Clients a month with a Staff of 12 Vol Doctors.
uninsured homeless - Low income - people who cannot afford Insurance. because of Cost.

this Bill will help people ~~afford good health care~~ go to a doctor without worring about cost. instead of waiting until they are so ill they have no alternative.

this single payer plan will help people get well and stay healthy without worring about the cost.

I have scaw on my tongue because of our elders and low income people and homeless cannot afford to see a health provider because of cost.

please support Senate Bill 267.

SENATE HEALTH & WELFARE
EXHIBIT NO. 22
DATE 2-5-93
BILL NO. SB 267

Testimony on SB #267, "An Act Relating to Universal Health Care Planning, Access, and Cost Containment, ..."

Position: ~~Support with proposed amendments~~ Oppose unless amended

By: Wally Henkelman, RN,MSN, Montana Nurses Association
Great Falls, MT

The need for substantial health care reform in Montana is obvious from the magnitude of the present health care crisis. This detailed and well thought out bill addresses mnany reform needs in great depth and I salute Senator Yellowtail and the authors for their work.

As a health care provider, however, I have a number of concerns that I would like to address involving the powers granted to the Montana Health Care Authority which would be created as a result of this bill.

The first has to do with Section 8; Health Care Expenditure Target -- Unified Health Care Budget (page 14, beginning on line 15) and with Section 11; Health care Provider Bargaining Groups (page 18, beginning on line 11). These provisions give the Authority power to control the wages and salaries of health care providers. Matters of wage and salary for non-government employees has traditionally been and should continue to be a matter of negotiation between employee and employer with government intervention only if the safety of the public is at stake. Allowing this governmental agency such powers would set a dangerous precedent for government control in other non-government matters. Further, since reimbursements to health care employers are controlled by other aspects of the legislation further interference in matters between employer and employee would provide no cost savings.

The second concern has to do with Section 24; Hospital Budget Review (page 35, beginning on line 7) which states that beginning in 1998 the Authority will define hospital budgets. Again, since reimbursements to hospitals are already controlled by other aspects of the legislation this level of involvement in the affairs of non-government entities would result in no additional cost saving benefits. Efforts to control budgets beyond limiting reimbursements would only serve to limit the creativity of hospitals in improving their health care services through alternative sources of revenue such as grants and philanthropic donations.

These changes in the bill would not only make it more palatable to Montana health care providers, but would also simplify the process and possibly reduce state expenses in administration of the program.

also:- Funding of County Health Departments need to be included

SENATE HEALTH & WELFARE
EXHIBIT NO 23
DATE 2-5-93
BILL NO SB 267

MHA MONTANA HOSPITAL ASSOCIATION

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

Testimony on SB 267
by James F. Ahrens, President
Montana Hospital Association
February 5, 1993

Thank you.

My name is Jim Ahrens, and I am president of the Montana Hospital Association. The Montana Hospital Association represents 53 acute care, community-based hospitals around the state.

Like all Montanans, hospitals are deeply concerned about our health care system. We see evidence every day that the current system is afflicted by serious problems.

We know all too well that these problems are undermining our ability to provide high quality and affordable health care to all Montanans.

Because of these concerns, MHA is strongly committed to enactment of a comprehensive health care reform plan in this session on the Legislature.

For more than a year, our association has been working on identifying the critical elements of a health care reform plan. Working with the Montana Medical Association and Blue Cross and Blue Shield of Montana, we arrived at many of the same recommendations as the supporters of this bill.

However, we differ on one key point: SB 267's mandate that the new system be a single-payer system.

MHA strongly supports the other health care reform bill, the one introduced by Sen. Franklin. This bill would require the Legislature to choose between a single-payer and a multi-payer system. We believe this best embodies the goals we hold for reform.

I do not want to dwell on our differences, but rather on the views we hold in common. All of us are committed to comprehensive health care reform, and to universal access and cost containment.

I hope that once the hearings on Sen. Franklin's bill are completed, the committee will tackle the task of developing bill that can go forth with all of our support.

Thank you.

BlueCross BlueShield of Montana

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

SENATE HEALTH & WELFARE
EXHIBIT NO. 24
DATE 2-5-93
BILL NO. SB 267

Testimony before Senate Public Health

2/5/93

Chair Eck and members of the committee, my name is Chuck Butler. I am a Vice President of Blue Cross Blue Shield of Montana. After moving to Montana from Vermont I began to wonder if this day would ever come.

I moved to Montana from Vermont in 1985. Since that time I have gotten to know many physicians, hospital administrators, seniors and others interested in the subject before us today.

But I'll confess after making an unsuccessful effort in 1990 to negotiate the contract BCBSMT has had with hospitals since 1981, I began to seriously question whether or not this day would ever come. Some of you know this history, so bear with me because it is important to the subject of health care reform as proposed in Senator Yellowtail's bill. As Senate Yellowtail said at the Rally, this is a monumental day.

Vermont has been in the forefront of the health care debate for about 20 years. I became involved with it in 1971 when I started writing about health care issues, including health insurance, as a reporter for VPI in 1971. I later joined BCBS of Vermont, worked as Chief of Staff to a former Vermont Governor and then returned to the Blues in 1979.

Vermont has had an active statewide health planning process since the 1960s. For several years I served on the State's Health Policy Council representing the insurance industry. The council had 26 members, representing a broadcross section of the state. Others on the council included a representative from seniors, disabled, children, doctors, hospitals, allied health care providers, the Dean of the Medical School, and legislators. We had a full-time staff and we met at least six times a year. One of our major functions was to review capital expenditures at all of the state's hospitals and nursing homes. Rather than scrapping the council process like was done in Montana a few years ago, because the system didn't work, Vermont strengthened the process in 1981, when it created the Hospital Data Council.

The Hospital Data Council was created to publicly review each hospital's budget and annual expenditures, and to collect data on all hospital based services. Today, more than a decade later, Vermont has one of the best tools for hospital data anywhere in the country. After the council's review of each hospital's annual budget, it issues a report on its findings and often recommends--publicly one might add--ways in which a hospital might trim its budget and avoid duplication of services by working with another hospital in the region. So that when Vermont enacted its latest health care reform measure, it had a 20 year head start on the process that we are now addressing and

trying to play catch up.

I mention that history because you are now being asked to adopt Vermont's health reform act without all the tools the folks in Vermont have had at their disposal for 20 years, and they still lack a good deal of information and data on which to make recommendations on whether Vermont should move to a single payer, government run health care system, or a multi-payer system.

Whichever bill ultimately becomes law in Montana, the Yellowtail bill or the Franklin bill, we would recommend the following:

1- Give the Authority the latitude to do its job. In other words, don't tie the hands of the Authority members or its staff by mandating certain things be included in its work. Set in law the tasks you want the Authority to deal with and give it the latitude to come up with the best solutions based on a thorough review of the options available.

2- Give the Authority the ability to gather data it needs on the availability of care services, inpatient, outpatient, medical, surgical, actual costs versus charges, and give it time to collect this data so it can make decisions based on facts.

3- Establish a base year from which to collect data and secure enough information by a date certain by which the Authority can require the submission of data. Neither this bill nor the Franklin bill sets a date for this to begin.

As an example, in Section 7, which establishes a State health resource management plan, a date of July 1, 1994 is set for the Authority to adopt such a plan. In Section 12, there should be a date set by which the Authority must establish a data base.

When Vermont created the Hospital Data Council it also required all hospitals to be on the same fiscal year. This has made it possible to collect data in a consistent and timely manner and while it might take a couple of years to accomplish, should be incorporated in any health reform.

It is obvious by the turnout today that this bill is supported by many of our state's seniors. But, I would point out that without some very important waivers from our federal government it will not be possible to incorporate ~~over~~ Medicare eligible Montanans to be a part of a single payer system. In view of the fact that President Clinton has made health care reform a focal point for reducing our federal debt, it remains to be seen when and if any waivers that would affect spending money or health care for a significant portion of our population will be forthcoming.

If it's the intent of this legislation to have all Montanans have a uniform set of health care benefits, perhaps we should know what our new President and Congress have in mind for us before we leap head first into something that's not doable. To that end,

Exhibit #24
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Madame Chair, I would urge the committee to contact our senior Senator, Mr. Baucus, who has enormous influence in the Senate Finance Committee, and Congressman Williams, who chairs the House Subcommittee with responsibility for some waivers necessary for us to take total control of Montana's health care delivery and reimbursement system.

If time permits, Madame Chair, I would now like to address each section of the bill, as it is of critical interest to our organization, which insures and administers health care benefits for 215,000 Montanans and through a contract with the federal government administers a program for ~~xxxxxxxxxx~~ Medicare recipients.

First - Section I. (P.4) State Health Care Policy.
We support fully the statement that the policy of the State of Montana should be to ensure all residents have access to quality health care services that are affordable.

2 - Still in Section I, on page 5, we also agree that the State's health care policy should be to improve the quality of health care services to Montanans and to contain or reduce increases in the cost of delivering services.

I must point out here that one very effective means to achieve that goal of controlling increased costs used by us on behalf of a fourth of Montana's population has been significantly weakened by passage of the so-called Hospital and Physician Lien Act, ~~xxxxxxxxxx~~ and contracting with Blue Cross and Blue Shield of Montana may ultimately turn out to have been a much better arrangement than competing with other government financed programs to pay the bills under a government run and financed health care system.

3 - Also in Section I, on page 5, we couldn't agree more with the need to avoid unnecessary duplication of health care facilities and services, and the need to promote a rational allocation of health care resources.

4 - At the bottom of page 7 and top of page 8, we're particularly pleased to see recognition of the need to establish networks of providers for coordinated care through primary care managers chosen by the patient. We currently have the only such network available to Montanans.

5 - With regard to the Health Care Authority Board make-up and compensation outlined in Section 4 on pages 8 and 9, I would add a few comments about Vermont, since this bill is taken pretty much from that state's reform law, and the Franklin Bill resembles in many ways.

First, the Vermont Authority has three Board members -- all appointed by the Governor, and the chair is selected by the Governor. The three members are full time and paid over $70,000

each. They have a staff director and over 25 employees with an annual budget approaching $1 million.

6- Section 8, on pages 14 and 15, requires the Authority to adopt a statewide health care expenditure target by January 1, 1995. Yet, as I mentioned earlier, no statewide data base exists today. Section 12, on pages 20 and 21, calls for the Authority to maintain a health care data base, but sets no date for the base to be established. Because there is no existing data base on statewide health expenditures, it would be asking the Authority to undertake an almost undoable task of establishing a health care expenditure target without available data.

7- Section 9, on page 17, requires each health insurer to prepare a cost management plan that includes integrated systems for the delivery of health care. This section was taken right from the Vermont law, but I'm not sure of its purpose here. The Vermont law requires the Authority to design two universal health law access plans -- a government run program and a multi-payer plan. I can see the value of requiring insurers to spend the time to provide their cost management strategies to this Authority if it were charged with designing two plans for universal access, but since it calls for creation of a single, government run program, I'm not sure this section is necessary.

8- Section 10, on page 18, requires the Insurance Commissioner to adopt uniform claim forms and billing procedures. This too is probably not necessary if the government or some other entity hired by the government is going to be the single payer. Hospitals, doctors, and other providers will be paid a fixed sum under the government system and claim forms would become a thing of the past.

9- Section 15, on pages 23 and 24, contains one of the most critical factors for the success of any statewide reform, whether its a single payer, government run program or a multi-payer program. On page 24, Section 5 gives the Authority power to seek whatever federal waivers it deems necessary to achieve the goal of universal access to health care for all Montanans through a single payer government run system. I addressed this earlier, but can't help but emphasize how important this is to achieving any statewide reform of health care.

10- Section 16, on pages 24 through 27, was also taken straight from Vermont law, and again I'm not sure of its need in view of the single payer approach. This section says the Authority shall establish a Montana Health Care Purchasing Pool to enhance the buying power of health benefit plans for state employees, the University System, local government including cities, towns, counties and school districts, for starters.

11- Under the single payer government run system outlined in Section 17 on pages 27 through 31, the state would be responsible for providing a universal access plan for all Montanans and

Exhibit #24
2-5-93
SB-267

financing it "predominantly through public funds." This would make creation of a Health Care Purchasing Pool unnecessary, since the government will be dictating to consumers how much care you can have and how much all providers will be paid to provide care.

12- I'm a bit surprised by the way long term care has been dealt with in Section 20 on page 32. As everyone knows, this is a costly part of our health care spending today. It would appear that long term care has been separated out of the single payer system and benefits for these services not included in the universal access plan until such time as more data is available on the costs associated with these services.

13- Sections 21, 22, 23, and 24, on pages 33 through 36, set up a health care facilities planning and review panel that will look at all hospital budgets. This is similar to the Hospital Data Council that has been in place in Vermont since 1981, and which gives Vermont some of the best statewide hospital data in the country on which to make decisions about future health care spending.

14- Again, this bill has the cart before the horse.

Without good data, it's next to impossible to set a statewide expenditure target. Yet the bill calls for the statewide health care expenditure target to be set by January 1, 1995, but the facilities review panel doesn't get its first look at hospitals' budgets until October 1, 1995.

In closing Senator Eck, Blue Cross and Blue Shield of Montana has worked hand with the MHA, MMA, Senator Brown, former Gov. Stephens and their new Administration on health care reform. We strongly support health care reform in Montana, Senator Eck, and want to work with you and your committee on this issue. Thank you.

MUHC HEALTH CARE BILL - TIMELINE

SENATE HEALTH & WELFARE
EXHIBIT NO. 25
DATE 2-5-93
BILL NO. SB 267

DATE	EVENT
4/93	MHC Authority established by Legislature
7/93	Board members appointed by Governor
10/93	Executive director and support staff hired by Board
1/94	*Common claims forms implemented by Cmsr of Insurance*
1/94	*Health insurer cost management plans due to Authority*
7/94	MHC purchasing pool established **
7/94	Health resource management plan adopted (every 4 years)
10/94	Public hearings (8) on MHC management plan completed
11/94	Single-payer MHC plan presented to Legislature
1/95	HC expenditure target for 96 presented (non-binding)
10/95	*Proposed hospital budgets for 96 due to Authority (all hospitals)*
10/95	Single-payer MHC plan implemented
1/96	Board presents recommended hospital budgets for 96 (annually)
7/96	Unified health care budget for 97 due (annually)
12/96	Report to Legislature on feasibility/merits of Authority as insurer.
12/96	Report to Legislature on providing universal long-term care
**	12/94 & 12/95 Authority reports to Legislature on status of MHC purchasing pool

MUHC
MONTANANS FOR UNIVERSAL HEALTH CARE
Christian Mackay, Coordinator

SB 267 - MONTANANS FOR UNIVERSAL HEALTH CARE LEGISLATION (1993)

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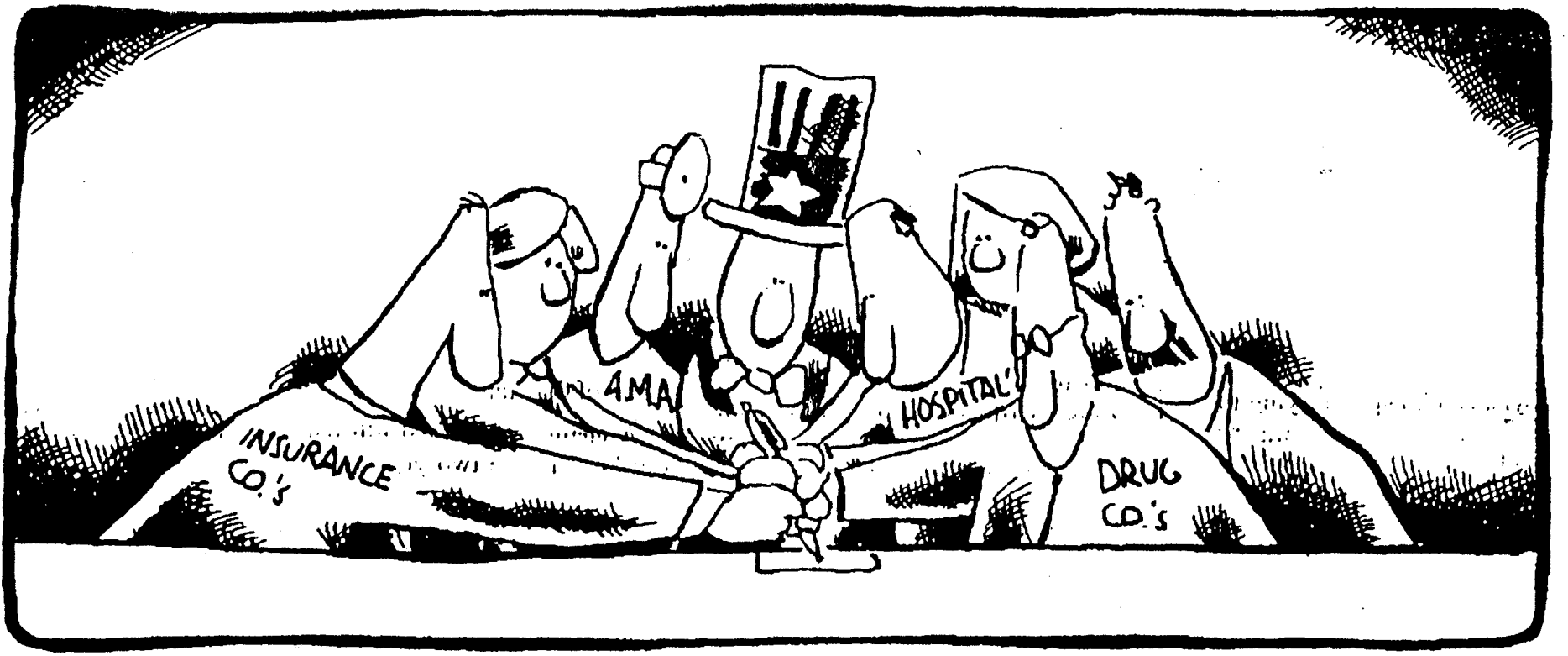
P.O. Box 961 • Helena, MT 59624 • (406) 443-7283 • Fax: 442-1316



MHRRS HOSPITALS INSURERS CONSUMERS WORKING TOGETHER

Montana Hospitals Rate Review System
2033 11th Avenue
Helena, Montana 59601
(406) 443-4540

Exhibit #26
2-5-93
SB-267

MEMORANDUM

Date: February 5, 1993

To: Senate Public Health & Welfare Safety Committee

From: Gerald F. Leavitt, Executive Director

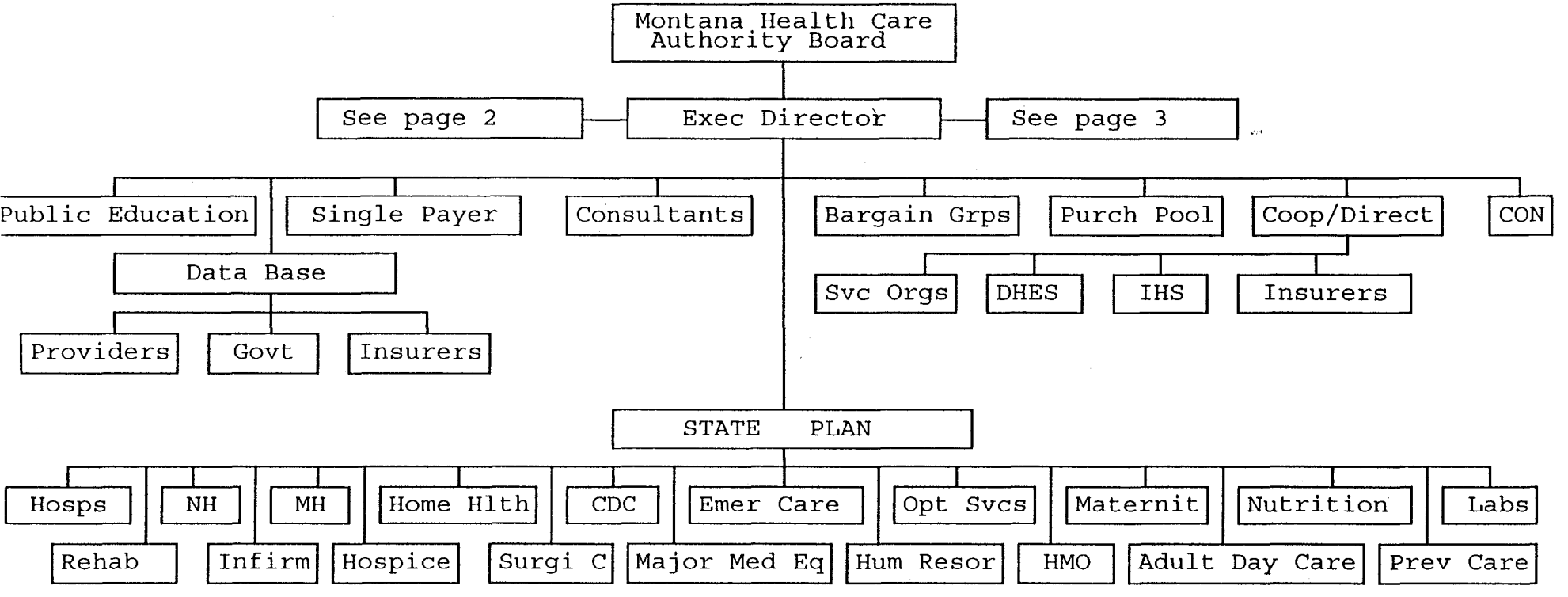
Subject: Senate Bill 267

It is obvious that SB 267 is one of the most comprehensive, far reaching, and costly proposed legislation to ever be considered by Montana's law makers. It is so complex that we have prepared an organization chart of the functions as we interpret the bill. It is attached for your information. We do not state the chart is totally accurate, but rather that primary functions have been shown.

We believe the total control of all facets of health care provision is an inappropriate function of State government and that the bill, as written, is an intrusion into the operational and management functions of health care providers.

It is also our belief the State of Montana at this time can ill afford the multi millon dollar expenditures to create this mega bureaucracy. Montana's healthcare costs, while not inexpensive, continue to rank among the lowest in the nation.

The purpose of this memo is to transmit the organization chart and to express our opinion of the inappropriateness of SB 267. That having been done - we close to reduce your reading time. The MHRRS will be pleased to meet with your committee or supply information you may desire.


Montana Health Care Authority Board
See page 2
Exec Director
See page 3
Public Education
Single Payer
Consultants
Bargain Grps
Purch Pool
Coop/Direct
CON
Data Base
Svc Orgs
DHES
IHS
Insurers
Providers
Govt
Insurers
STATE PLAN
Hosps
NH
MH
Home Hlth
CDC
Emer Care
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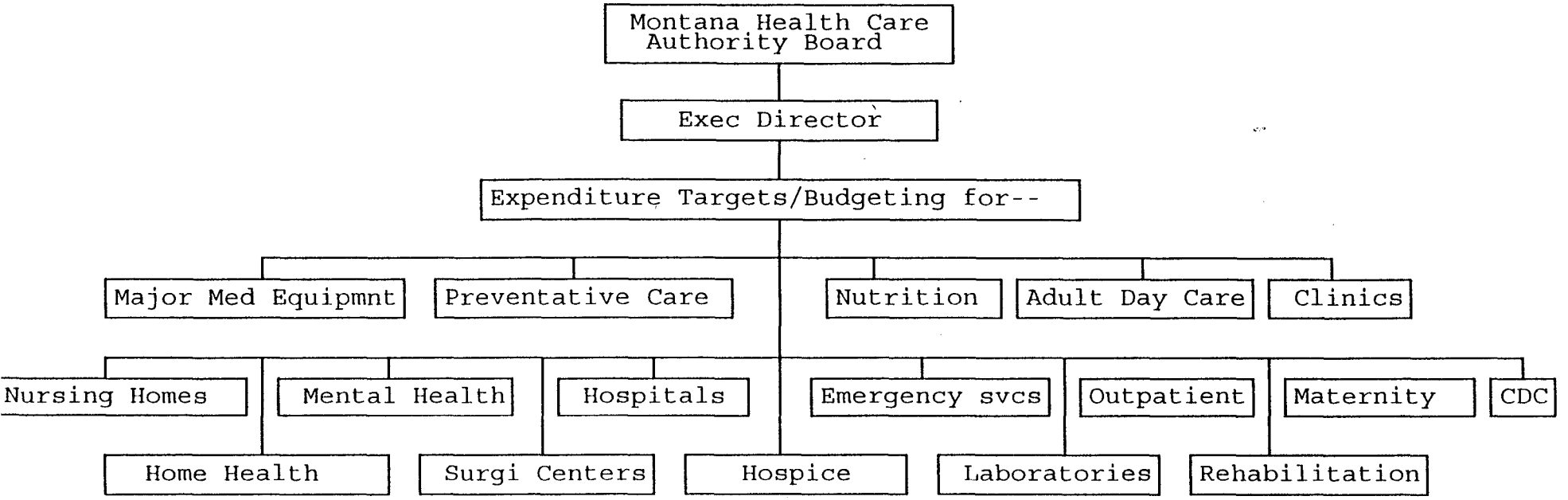

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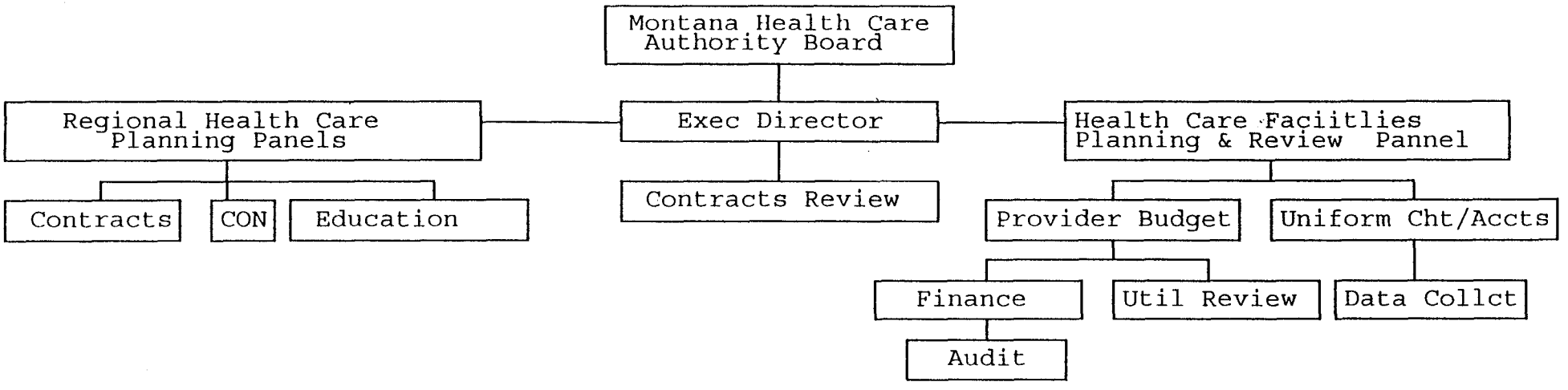
Montana Health Care Authority Board
Regional Health Care Planning Panels
Exec Director
Health Care Faciitlies Planning & Review Pannel
Contracts
CON
Education
Contracts Review
Provider Budget
Uniform Cht/Accts
Finance
Util Review
Data Collct
Audit

Exhibit #26
2-5-93
SB-267

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ATTORNEYS AT LAW
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H. J. LUXAN (1918-1984)
WALTER S. MURFITT
MICHAEL J. MULRONEY
GARY L. DAVIS
DALE E. REAGOR
PATRICK E. MELBY
MICHAEL J. RIELEY
MICHAEL S. BECKER
TOM K. HOPGOOD
GREGORY A. VAN HORSSEN

February 8, 1993

Honorable Dorothy Eck
Chairman
Senate Public Health, Welfare
and Safety Committee
State Capitol
Helena, MT 59620

RE: SB 267

Dear Senator Eck:

As stated in my testimony on SB 267 on February 5, 1993, I am transmitting to you the pamphlet put out by the Health Insurance Association of America entitled "Health Care Financing for All Americans". I ask that you place this pamphlet in the committee minutes having to do with SB 267.

I am also enclosing herewith a copy for your personal reference of pages 13 through 19 of that pamphlet which describes the HIAA's position on various proposals, some of which are being actively discussed in the Montana Legislature. I am providing copies of these pages to each member of the committee under cover of a copy of this letter.

Let me say that the HIAA is very pleased that there is sentiment in this legislative session to do something about health care reform and health insurance. We look forward to being a part of the solution to the existing problems and to working with you and your committee and the Health Care Caucus during the balance of this legislative session and thereafter. We are particularly interested in Senator Franklin's bill and will be appearing in front of your committee in connection therewith.

Thank you for your consideration of this letter and HIAA's pamphlet. If you or any of your committee members

have any questions or comments, please feel free to contact me.

Sincerely,

TOM K. HOPGOOD

for LUXAN & MURFITT

TKH/vjz

Enclosures

cc: Shannon Anderson
Larry Akey
Charles Butler (w/enclosure)
Senate Public Health, Welfare & Safety Committee (w/enclosure)

Exhibit #36
2-5-93
SB-267

Ill-Advised Proposals

HIAA's proposal to expand access to health care coverage is one of several that are currently under discussion. While some of these proposals and strategies may have an immediate appeal, it is important to examine them to make sure that what they promise is not illusory. Some of these approaches would not only destabilize the health care financing market, but would distribute health care coverage unequally.

Among the proposals that should be examined closely—and approached cautiously—are the so-called "play or pay" strategies (which often incorporate "last resort" public programs), community rating, proposals that focus on individual coverage rather than on employer-based coverage, and single-payer systems.

"Last Resort" Public Programs

Public "last resort" or "residual" structures often appear as major elements of broader proposals for extending health care coverage. While residual programs are critical to any comprehensive expansion of the public/private system, they often have been developed without adequate attention to their role vis-à-vis the private market. Many such programs are inherently unstable in their enrollment and fiscal base and lead to undesirable and harmful cross-subsidies between different populations and competing payers. Moreover, inherent structural weaknesses in these programs will lead to the costly substitution of public coverage for private coverage.

Proposals that incorporate a problem-ridden residual public structure for the non-poor include those of the Pepper Commission and the National Leadership Commission on Health Care. Such structures are sometimes called "play or pay."

Under these structures, government would require employers either to "play" (by providing employees with coverage) or to "pay" a fixed tax (a percentage of payroll or of gross revenues); once the employer tax is paid, the employee can then enroll in a "last resort" public residual program. The public policy objective of the "pay" option is to give financial relief to employers that would find it difficult, if not impossible, to bear the full costs of providing health benefits. HIAA strongly supports financial subsidies that are efficiently targeted to those in need. However, we believe that for some employer groups this particular subsidy will fail.

A disproportionate percentage of the employers doing business in localities where health care providers charge high prices—or where health care is delivered inefficiently—will buy into the public program. (It would be economically appealing for these employers to do so because, if they don't enroll, they will have higher costs as a percentage of payroll or revenues.) Because the public program is designed to lose money (only employers who expect their real health care coverage costs to exceed the tax they have to pay will enroll), it will lose heavily. These public sector losses will escalate over time.

Initial losses would either require an immediate transfer of public funds or would precipitate a futile effort to attract lower-cost employee groups by lowering the payroll tax; the program's solvency would be further undermined as premiums for already-enrolled persons were lowered even further beneath actual health care costs. Alternatively, draconian restrictions on provider reimbursement might be adopted to reduce public program costs. This would force an indirect subsidy from private payers: providers would respond by shifting real costs incurred under the public program to their private payers. Private-coverage costs would be driven upward, leading more and more employers to shift to the public program—necessitating higher and higher public expenditures. In essence, government would enter the private marketplace and force major cross-subsidies from its competitors. This would create an inherently unstable marketplace as private-option costs escalated and public sector enrollment grew.

In some areas, then, "play or pay" would lead to major or complete substitution of public for private coverage. This would not occur because the public program was inherently more efficient, but rather because the public program had forced artificial and eventually unsustainable advantages over alternative private plans. This would severely threaten the solvency of an increasing number of providers who would become disproportionately reliant on public program revenues. Ultimately, large public outlays might be needed to sustain providers.

Community Rating

In its simplest form, community rating means that for a given benefit plan in a given state, an insurer establishes a single premium level for an employer group regardless of the geographic area, the age and gender of the employees, the health risks of the employees or of the industry they're employed in.

Community rating proposals sometimes are advanced as a response to the rating practices in the small-employer market. While the market is in need of reform, community rating is ill-advised. A community-rated system could create more uninsured workers as it increases costs for the populations least able and least willing to pay, subsidizes populations with greater incomes who are already more likely to be insured, and substantially increases the risk of insurer insolvency. Community rating also would compromise local accountability for health care cost problems.

The myth is that community rating will reduce the number of uninsured persons by making coverage more affordable. Actually, it will increase the number of uninsured persons, as coverage will become less affordable for most currently uninsured employers and employees. On average, uninsured persons are younger than the insured population and often place less value on insurance. This reflects their lower average health care costs as well as their lower earnings. Further, such low-wage workers tend to be concentrated in firms that are least likely to offer coverage. Younger, uninsured persons and their

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employers will be even less willing to purchase coverage if premiums are raised to a singe community level; a number of insured younger individuals and their employers will drop coverage if the cost is higher than the value they expect to receive and the amount they can afford.

Nationally, 27 percent of full-time, full-year principal earners age 18 to 24 are uninsured; 9 percent of such workers between the ages of 55 and 64 are uninsured. (Source: 1990 CPS.) In addition, workers earn less during the early stages of their working years and employers with high proportions of such low-wage workers are already the least likely to provide health benefits. Of those small firms with a majority of workers earning $10,000 per year or less, only 19 percent offer health benefits. While one in four 18- to 24-year-old full-time, full-year principal earners has a family income below twice the poverty level, only one in ten of such 55- to 64-year-olds has a family income beneath this income level.

Community rating will encourage many small employers who are currently insured to self-insure. Low-risk employers (e.g., those who employ younger populations) will often find it more advantageous to pay premiums reflecting their lower expected health care costs rather than to subsidize heavily the higher risk (e.g., older) populations. The move to self-insurance demonstrates employers' desires to pay premiums that reflect their own costs. Self-insurance should not be viewed as adequate protection against the possibility of large health care costs for employees of a firm that is too small to spread risks safely. Nevertheless, survey data suggest that the number of medium and smaller employers that are self-insuring (almost certainly unwisely), and who are operating outside any formal regulatory structure, is increasing. The result of community rating could well be to increase costs for insured populations and for a growing number of employees without adequate protection, since more and more lower-risk populations will leave the insurance pool.

Community rating can also threaten the solvency of individual insurers. Individual carriers or competitive health plans need some latitude to adjust rates if they are to maintain financial solvency. For a variety of reasons, any given carrier may experience the enrollment of insureds who are, on average, older and sicker than others in the marketplace. If a carrier who has an expensive enrollee population is required to charge one community rate for all clients, it would be put in an untenable position. In order to stay price-competitive, the carrier would charge a lower premium than its average cost experience but it would immediately sustain large losses. If it charged premiums to cover current costs, it would lose its lower-risk clients and be unable to attract new lower-risk clients because its rates would be too high. As the carrier's per-enrollee cost spiraled upward, and its enrollment of average and risk persons declined, it would incur larger and larger losses. With some latitude to adjust rates, such a carrier could set a premium price that would attract new lower-risk groups and thus would improve its ability to spread the costs of higher-risk groups.

Community rates that do not vary by geographic area compromise local accountability for costs. Such schemes would force lower-cost, more efficient, and often lower-income localities to subsidize higher cost, less-efficient

localities that often have higher per capita incomes. Market pressures to control costs would be muted, as employers who use inefficient provider networks were shielded from the true costs.

Individually Purchased Plans

Some reforms focus on shifting incentives from employer-based insurance to individually purchased plans. These proposals would eliminate the tax provisions that allow employees to exclude from taxable income the amount their employers contribute toward the purchase of health insurance, thereby greatly reducing the incentive for employers to provide coverage. Instead, these plans would mandate that individuals purchase health insurance, and government would provide income-based tax credits to make the purchase of coverage affordable for lower-income persons.

This approach is less efficient than current employer-based group insurance because it is less expensive to market, sell, and administer insurance packages for employers on behalf of large numbers of employees than it is to market them individually. Indirect costs would also be higher. Employers and their benefit consultants now provide beneficial assistance to employees by assessing the suitability, the quality, the accessibility, and the efficiency of providers.

Another drawback to an approach that focuses on individually purchased coverage is adverse selection, a trend individual insurers have long grappled with. As consumers choose from among the different plans available, the healthiest will tend to choose the lower-benefit, lower-cost plans while those with health problems select high-benefit plans. Adverse selection results in considerably higher prices for some consumers. (Most proposals of this type attempt to deal with adverse selection by offering higher tax subsidies to individuals who have lower incomes and/or greater medical needs. It remains unclear, however, whether these subsidies could ever adequately fund the needs of these high-risk populations.)

Moreover, these approaches could erode the major financing source of health coverage. If strong tax incentives for employer-sponsored health insurance are abandoned, many employers will eventually discontinue their contributions. Approximately 140 million working Americans and their dependents now receive health care coverage through the workplace. Employer premium contributions to group health insurance plans total approximately $174 billion (1990). A shift away from employer-based financing would necessitate huge new government outlays to replace much of the financing now provided by employers.

Canadian-Style Public Health Insurance

Many groups are advocating the adoption of Canadian-style public health insurance. In Canada, public health insurance plans run by the provinces cover all residents and are the sole payers for hospital and physician care. Patients

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have free choice of doctors and hospitals and face no out-of-pocket costs at the time of service. Financing comes almost entirely from taxes.

Costs

Public health insurance advocates claim that Canada has controlled health care costs more effectively than the United States because Canada spends a somewhat lower proportion of its gross national product (GNP) on health care than does the United States.

Despite these claims, Canada has not controlled health care cost escalation. Indeed, if trends in health care costs per capita are analyzed, it becomes clear that Canada has not fared better than the United States at controlling cost escalation. From 1977 to 1987, real health care costs per capita grew at an average rate of 4.3 percent per year in Canada, compared to 3.9 percent per year in the United States. The percent of GNP devoted to health care grew more slowly in Canada than in the United States not because Canada controlled health care spending, but because Canada's economy grew faster than ours. Between 1977 and 1987, Canada's GNP per capita grew an average of 2.1 percent per year in real terms, compared to the 1.6 percent per year growth in the United States.

A Lower Standard of Care

Canadians endure long waits for major surgery, and the standard of care is beginning to fall behind. Canadians have to put up with the consequences of government attempts to control costs. Because there are no charges to patients, access to care for "sniffles, sneezes, and splinters" is no real problem in Canada, but some patients in need of serious surgery have to wait months for their operations due to lack of facilities. Modern diagnostic equipment is also in short supply in some provinces, which leads to long waits for such tests as computerized tomography scans and mammograms. Provincial authorities tacitly admit that waiting lines for heart surgery are too long, since they agree to pay for Canadians to have surgery in U.S. hospitals.

This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, bureaucratic budget control discourages innovation, perpetuates existing inefficiencies, and leads to obsolescence.

The strength of the American system is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness. Such responsiveness is clearly not possible when all major resource allocation decisions are made by a government, particularly a government concerned primarily with cost control.

Waste

Controlling health care budgets does not eliminate unnecessary care and waste. While arbitrarily restricting access to expensive high-technology procedures, Canada's provincial health plans make no attempt to determine whether care ordered by physicians is really necessary, despite the large volume of

evidence (in the United States and elsewhere) that a significant proportion of services ordered by physicians are unnecessary, ineffective, or actually counterindicated. Inappropriate care, which may constitute as much as 25 to 30 percent of all care rendered (according to some estimates), is the real cause of waste and excess expense in the health care system.

"One Size Fits All"

Canadians lack choices not of specific doctors and hospitals, but of the overall delivery system and the extent of coverage. In the United States, if an employment-based group chooses to reduce its current outlays for insurance premiums and protect itself only against very major medical bills, for example, it can buy lower-cost insurance.

These choices are not available to Canadian citizens. All must belong to the same system and accept its deficiencies as well as its benefits, unless they choose to be restricted to the very few private hospitals and physicians or to seek care outside the country. Thus, if the government seeks to control costs by restricting the availability of hospital beds or new equipment, citizens who need care must either wait for service or pay privately to go outside the system.

In fact, the Canadian system would be in worse shape if it did not have the United States right next door. Canadians need not spend large sums developing new medical technology. They can wait for the United States to develop it and reap the benefits when it is ready.

Second, the United States relieves the pressures that would otherwise build, and that would require expansion of the Canadian system and additional spending. For example, with few exceptions (e.g., cataract surgery), it is almost impossible for individuals to shorten their waiting periods for surgery within Canada because there are virtually no private hospitals. But Canadians who are willing and able to pay privately to obtain care sooner can come to U.S. hospitals and clinics. In a few instances in which long waiting lists had developed, particularly for heart surgery and lithotripsy, Canadian provinces even agreed to pay for surgery in U.S. hospitals to reduce the backlog. The provinces had no other short-term alternative for reducing surgical waiting lists. If the United States were to adopt the Canadian system, this safety valve for Canadians would no longer exist, nor would there exist one for Americans.

Bigger Government and Higher Taxes

Canadians pay a high price for their public health insurance system and other government-funded services. Excluding defense, the public sector consumes a 30 percent larger share of the total economy in Canada than in the United States (36.7 percent of GNP compared to 28.3 percent of GNP). The net government deficit (across all levels of government) is almost 50 percent larger in Canada when compared to total economic output (Canada's is 3.6 percent of GNP, while the United States' is 2.4 percent of GNP). (These are 1987 figures.)

State outlays would rise dramatically under a Canadian financing structure. In Canada, provincial and local governments contribute 45 percent of total

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national health spending. In the U.S., state and local governments contribute 13 percent. The United States and Canadian federal governments account for virtually identical proportions of total health spending—just under 30 percent in each country.

The share of provincial health spending covered by federal contributions in Canada has declined significantly since 1979. Originally, provincial expenditures were matched by the federal government 50-50. In 1977, the federal contribution was changed to an indexed per capita grant. Then the annual index was cut back. The federal contribution is now frozen at the 1989–1990 per capita level.

The HIAA estimate for implementing public health insurance on the Canadian model (without any additional federal contribution) would require the average state to increase total tax revenues by 70 percent.

Summary

While these proposals may be well intentioned, their shortcomings would become visible were they ever to be implemented. None of these approaches can assure better access to health care coverage—instead, they risk crippling the private market and substituting cumbersome, expensive, and probably ill-fated public programs. HIAA's proposals are directed at effectively blending public and private mechanisms to solve the problems of health care access. For example, instead of using residual public programs to make sure that lower income individuals have coverage, HIAA's proposal concentrates on targeted public subsidies (through the tax code or other mechanisms) that permits people to choose; this "tailoring" of the program gives it a greater chance of success.

Senate Public Health and Welfare Committee
2-5-93
Exhibit #26
SB-267

HEALTH CARE FINANCING FOR ALL AMERICANS

Private Market Reform & Public Responsibility

DATE 2-5-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 267

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Wilbur Johnson	Johnson Advocacy Service		✓	
Bill Olson	AARP		✓	
Dennis McSweeney	Physicians Mgmt Services			✓
Marcel Lok	Montana Hospital Assc			✓
Sally Macmillan	MEA Great Falls Educ Assn		✓	
HARLEY WARNER	ASSOC. OF CHURCHES		X	
Patricia Haness	PNHP		✓	
Craig Campbell	MSCA		✓	
DAN RITTER	MT CHAMBER			✓
Janette Klinteberg	MSCA		✓	
Jennifer Bertelsen	Legacy Legislature		✓	
Wally Henkelman RN	Mont. Nurses Assn			✓
~~Phyllis Gebhardt~~	~~Lobbyist~~ Client		✓	
Rebecca Holman	Montana People's Action		✓	
Wilbur Rehmann	Montana Federation of Teachers		✓	
Allan Wernon	Resident of Montana	267	✓	

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DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: SB 267

_____

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Al Schmidt	NPRC	267	✓	
Ernest O. Redlin Jr.	NPRC	267	X	
Teresa Klasky	MFU	267	✓	
James McGlenn	MILP	267	✓	
Margaret Fleury	NARFE MSCA Legislative Liaison	267	✓	
Marie Crosby	NARFE	267	✓	
Kate Cholewa	MT Nurses Lobby	267	✓	
VERONICA DRAWN	MT. St. Council H.E.R.E.	267	✓	
Marion Hellstern	Hinsdale MT 59241	267	✓	
Alice Harrington	Sr. Citizens C. Wells	267	✓	
LARRY AKEY	MALU	267		✓
Lorna Frank	MT. Farm Bureau	267		X
Muriel Hetterling	Mt. Licensed Health Care	267	✓	
Dan Shea	MLIC	267	X	
Floyd Anderson	MSCA	267	X	
Elizabeth Dane	Nat'l Assoc. of Soc. Wkrs	267	✓	

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DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: SB 267

_____

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Bruce J Rukstad	O.C.A.W	SB267	X	
Mona Jamison	A.T. Assoc			X
Marcia Garay	Lee pacha clinic		X	
Charles Galyean	Gallatin S.S.	SB267	X	
Greg Van Horssen	State Farm Ins Co	SB267		X
Wolfe Dale Brown	MSCA	SB267	X	
SUSAN SWINEHART LSW	NASW	SB267	X	
Don Judge	MT STATE AFL-CIO	SB 267	X	
Steve Henry	BEA	SB 267	X	
SHARON HOFF	MT CATH CONFER	SB267	X	
JACK Molloy	MMA	SB267		X
Christine Kaufmann	League of W.V.	267	X	
Melvin W. Sutter	NARFE	SB267	X	
Pam Egan	MTFU	SB267	X	
JUDITH CARLSON	NASW - MT C	267	X	
Christian Mackay	MAPP. MVHC	SB267	X	

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DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: _____

_____

Name	Representing	Bill No.	Check One Support	Oppose
Russ Ritter	Wash. Corp	267		X
John Burke	myself	267		
Tom Hopgood	Health Ins. Assoc. America	SB267		✓
Bonnee L Tipsy	MT State Pharm. Assn MT Chiro. Assn	SB267		
Chuck Butler	Blue Cross Blue Shield of MT	SB267		✓

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DATE 2/5/93

SENATE COMMITTEE ON PUBLIC HEALTH

BILLS BEING HEARD TODAY: SB 267

Name	Representing	Bill No.	Check One Support	Oppose
M. Kay Elliott	MSEA-Retirees	267	✓	
Augusta Moore	MEEA	267	✓	
Marita L York	MEA	267	✓	
Virginia Egli	MEA	267	✓	
Teresa K. Henry	MNA	267		
Carol Brooks	~~MSU~~ citizen	267		
Betty Thompson	MEA	267	✓	

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DATE _____

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: _____

_____

Name	Representing	Bill No.	Check One Support	Oppose
Ann Ward	U of M	267	X	
Joanne Lucciarelli	—	267	X	
Jolynn McDermott	—	267	X	
Doris Erickson	MSCA ~~MSEU~~	267	X	
Doris Farkas	MSCA	267	X	
Elizabeth Stimac	MSCA	267	X	
Laurence E Stimac	MSCA	267	X	
Jennie Coody	MSCA-	267	X	
Alice Campbell	MCIVHR	267	X	
Alyce W Miller	MSCA	267	X	
A Roy Miller	MSCA	267	X	
Becky Berwick	MSCA	267	X	
Bob Heaton	Milwaukee	267	X	
Doug J Sahlin	MT. Peoples Act	267	X	
[illegible]	———	———	———	———
[illegible]	C.I.F	267		X

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Charles Gallagher Talbertson S.S. 267 (X)

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DATE 2-5-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 267

Name	Representing	Bill No.	Check One Support	Oppose
Betty J. Hess	self	267	✓	
Mary Crum	self	267	✓	
Anne Arthun	self - Mont. Homophobia	267	✓	
Helen Dale	MSCA	267	✓	
Cooper Hymes	Self.	267	✓	
Helen McKnight	MSCA	267	✓	
Ann Garcia	MSCA	267	✓	
John H. Hoppe	MSCA	267	✓	
Janet Kelly	Self	267		✓
Allen Kropp	Roundup			
Robert Freeman	Montana Peoples Action	267	✓	
John Arvish	MPA Missoula	267	✓	
John Wyman	Montan People's Action	267		X
Cathy Ciriparoli	Self	267		X
Wendy Hunter	Self	267		X
Allyn Christiaens	MPA	267	X	

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SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 267

Name	Representing	Bill No.	Check One Support	Oppose
Gene Salamon	MEA	267	✓	
Larry M. Pagett	MCHSEA	267	✓	
Ann M Smith	MEEA	267	✓	
Jane Duncan	MEA	267	✓	
Diane Rose	MEA	267	✓	
Vivian Sullender	MSCA	267	✓	
Vivian Brodzer	MSCA	267	✓	
Della Nelson	MSC	267	✓	
Roy Nelson	MSC	267	✓	
Lloyd Anderson	MSCA	267	X	
Ellen Knoff	MEC	267	X	
Gail Linder	—	267		
[illegible]	—	267		X
[illegible]	—	267		X
Libby Hurtz	MEA	267	X	
Carla Nichols	Sen Bauer	267		

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