MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 8, 1993, at 1:00 p.m.

ROLL CALL

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

Members Excused: Sen. Hager

Members Absent: None.

Staff Present: 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 262, SB 290
Executive Action: SB 121

Chairman Eck said that instead of two separate hearings, there will be one hearing on both SB 290 and SB 262.

HEARING ON SB 290, SB 262

Opening Statement by Sponsor:

Sen. Chris Christiaens, Senate District 18, said SB 262 provides continuity of health care coverage for any preexisting condition of an individual previously covered by insurance or another health plan. Preexisting exclusions and waiting periods tend to deny or limit coverage for health conditions that predate the new insurance plan. Screening individuals on their health status and occupation, age, and gender increase administrative costs by attempting to keep high-risk individuals out of group insurance systems. The result is a shift of costs to programs that all

consumers pay for. SB 290 is a community rating insurance plan which sets a rate based upon the average health cost of an entire community or pool of consumers. Sen. Christiaens said he sees SB 262 and SB 290 as essential parts of health care reform plans, Sen. Yellowtail's bill, or Sen. Franklin's bill.

Proponents' Testimony:

Allyn Christiaens, Montana's People's Action, said he would primarily address SB 290. Mr. Christiaens provided written testimony. (Exhibit #1)

Michael Regnier, Advocacy Coordinator for SUMMIT Independent Living Center, provided written testimony for SB 290 and for SB 262. (Exhibit #2) (Exhibit #3)

Joy Miles, Job Opportunities and Basic Skills, said the program she works with single parents receiving AFDC for their children helping them go back to work. They have Medicaid insurance while they are on AFDC, but they go to work for minimum wage jobs and without additional training, they are stuck at this level. After one year, Medicaid is cut off, regardless of their income. Very often, these jobs have no insurance, and if they do, rates are unaffordable. Ms. Miles has seen people who found employment back on AFDC because they cannot afford the insurance they needed.

Secky Facione, International Union Representative for the Hotel Employees and Restaurant Employees Union, said they support SB 262 and SB 290. The vast majority of the people she represents are low income women who have no health insurance even though they are employed and working under union-negotiated agreements. Part of the problem is that small businesses cannot afford insurance, and another problem is that the people she represents cannot afford the co-payments. A third part of the problem is that individuals are excluded from insurance when they change jobs because of preexisting conditions. Ms. Facione said the passage of these bills would help Montana workers and businesses.

Dorinda Orrell, board member of Coalition of Montanans Concerned with Disability and the Montana Independent Living Project, said that because of pesticide poisoning she received six years ago, she became a quadriplegic. Before she was eligible for assistance, she went broke. Now she is on Medicare and Medicaid and would like to go back to work, but she cannot go back to work now because she would lose her benefits, upon which she is completely dependent, even if she went to work part-time. Ms. Orrell said that if she did manage to go back to work, she would be excluded from benefits for six months to a year, during which she would most likely become sick again. SB 290 and SB 262 will allow individuals in similar situations to go back to work without risking their health.

Clyde Dailey, Executive Director of the Montana Senior Citizens Association, said he supports SB 290 and SB 262. No insurance reform was included in SB 267 because these types of reform deserve their own debate. The Association feels that these two bills are comprehensive and necessary. Mr. Dailey said continuity of coverage is important.

Dr. Quinton Hehn, Montana Clinical Health Counselors Association, said the Association supports both SB 262 and SB 290. Dr. Hehn told of a Missoula counselor with a disabled daughter, who sent the daughter to a health care facility 3000 miles away rather than face the catastrophic health costs associated with surgery. He told of a Missoula woman who took on her husband's health care coverage until their divorce. Because of a preexisting condition, she was not able to continue with her original health care coverage. Some of his clients are on Medicaid but fear that they will be unable to afford any other coverage when they find jobs.

Jim Meldrum, Montana Independent Living Council, said that individuals with disabilities are locked into certain jobs, and they are unable to receive insurance otherwise. Their employers cannot change health insurance companies because the disabled individuals will be excluded. Mr. Meldrum said that currently he has no health insurance. Because of a preexisting condition, his new insurance company requires a one year waiting period. He said he could not afford to take advantage of COBRA and continue with his original coverage. The Council would like to see the Americans with Disabilities Act include no discrimination among insurance companies, and supports both SB 262 and SB 290.

Lory Simms, said his wife contracted cancer and the behavior of Blue Cross was unethical and probably illegal if not incompetent. Mr. Simms said Blue Cross ignored letters of request for information, used improper terminology, and sent the Simms false contracts to support their position. They sought legal help and found that Blue Cross's interpretation would stand up in court. If taken to court, the Simms risked revocation of their policy. Mr. Simms said the IRS will assess him a 10% penalty for using his retirement funds to pay medical bills rather than declaring bankruptcy. He said he and his wife are tied to Blue Cross because his wife is uninsurable anywhere else. Decent health insurance must contain portability and continuity clauses, and a single payer system is the most desirable.

Chester Kinsey, Montana Senior Citizens Association, said the Association supports SB 262 and SB 290. Mr. Kinsey provided written testimony. (Exhibit #4)

Mark Brewer, Missoula, urged the Committee to support SB 290. Mr. Brewer provided written testimony. (Exhibit #5)

Staci Riley, Montana Federation of State Employees and the Montana Federation of Health Care Employees, urged the Committee

do pass SB 262 and SB 290.

Christian Mackay, Coordinator for Montanans for Universal Health Care, and a Montana citizen with a preexisting condition, urged the Committee's strong support of both SB 262 and SB 290. They are an important part of overall health care reform which was outlined in Sen. Yellowtail's bill, SB 267.

Sheila James, Missoula, provided written testimony. (Exhibit #6)

Lee Parks, Missoula, provided written testimony. (Exhibit #7) Ms. Parks also provided written testimony from Mike Mayer who could not attend the hearing. (Exhibit #8)

Evy O'Leary, Missoula, said because of a car accident seven years ago, she is uninsurable. She asked that the Committee pass both SB 262 and SB 290.

Opponents' Testimony:

Larry Akey, Montana Association of Life Underwriters, said life and health insurers are "on the front line of the health care crisis in Montana." Mr. Akey said he would let the insurance companies respond to the way those companies work. The Association supports the concept of improved access and more affordable health care coverage, however they do not support SB 262 or SB 290. He said making health insurance like other types of insurance is a "disingenuous claim," because insurance assesses and manages risk, and in over 80% of health insurance claims, the consumer decides to access the medical system. With other types of insurance, the payment is agreed upon by the insurer and the insurance company. With health insurance, the payment mechanism is "cost plus" -- whatever the provider decides. There are attempts to manage those costs, but the Legislature has repeatedly struck those down. Mr. Akey said the consumer can decide what to do with the proceeds of life or auto insurance, but with health insurance, the payee is the health care provider. The only way the consumer can access that policy is by receiving medical care from that provider. The purpose of insurance is to spread the risk, and the only way to do this is through actuarily fair rates. Under SB 262, health insurance rates would be further subsidized. Mr. Akey said the proponents for SB 262 want a prepaid plan for medical consumption. To lower the rates for high-risk individuals, other's rates must be raised which drives out healthy individuals, and it drives small groups to self insure. This leads to adverse selection, because an increasingly "risky" pool is left. The Association believes in insurance portability, but SB 290 sets up a situation where an individual only has to pay for one-third of their medical coverage because insurance is automatically reinstated after six months. Society has a responsibility to provide health care for those who cannot afford it, but it should be through

subsidization of health care payments, not through SB 262 or SB 290 because these bills will have a regressive effect in the marketplace. The Association asked that the Committee give SB 262 and SB 290 do not pass recommendations.

Tanya Ask, Blue Cross/Blue Shield of Montana said she did not know the circumstances of Mr. Simms' case. Blue Cross/Blue Shield does support continuity of coverage but this should be done in conjunction with comprehensive health care reform. The laws currently in effect do not effect the entire marketplace, and SB 262 and SB 290 will effect a smaller and smaller portion of the health care market because individuals and groups will be able to leave the insured marketplace, and move to self insured, federally preempted insurance mechanisms. The Employment Retirement Income Security Act (ERISA) preempts state law in the administration and how certain state laws are enforced. Any group that is ERISA preempted will be excluded from SB 262 and SB 290 as well as mandates. That currently amounts to 40% of the marketplace, and could rise if these two bills pass. SB 262 could pose a problem because it would allow state programs with high-risk individuals to purchase private health insurance to pay for them. Medicaid must purchase a health insurance policy to pay for high-risk individuals covered by Medicaid. Also, this bill allows an individual to change from a high deductible policy to a low deductible policy if they knew a service were needed. SB 290 poses some problems and must be looked at in the overall concept of health care reform. Consumers must be conscious of the costs the health care they are using. SB 290 would preclude rating based on lifestyle choice which may impact one's health, such as smoking. Healthy lifestyle discounts are frequently requested. SB 290 precludes age ratings which means that individuals under the age of 30 would see an increase of 65.7% while an individual over 60 would see a decrease of over 49.4%. The individuals over 60 use more health care services, and the individuals under 30 may drop their coverage, leading to adverse selection. Another concern of this bill is how it will impact those who want different types of coverage, eye, dental, high deductible, or low deductible. Ms. Ask stressed that the Committee consider the impact of federal laws.

Tom Hopgood, the Health Insurance Association of America, said the Association strenuously opposes SB 262 and SB 290. Mr. Hopgood said much of the proponents' testimony addressed bills other than SB 262 and SB 290. These two bills will not reduce the cost of health insurance, and they will not raise the number of individuals who have health insurance. The cost will be raised for those individuals who currently pay the least for coverage, and these are the people who are going to correspondingly drop out of the market. They will self insure themselves on an individual basis. The cost for the individuals who stay in the market will increase. Mr. Hopgood said 61% of those with health insurance will have an increase in premiums. Self-insured do not have to comply with these bills, which includes the state insurance fund. Mr. Hopgood said SB 267 and

SB 290 are bills with no viable purpose, and he urged the Committee give them a do not pass recommendation.

Steve Turkiewicz, Executive Vice-President of the Montana Auto Dealers Association (MADA), said the MADA insurance trust was formed in 1948 by the Association members. Currently, 1900 employees and their families are covered by the trust. The medical cost for these 1900 employees has gone from 2 million to 4 million dollars in the past four years. As a result, premiums for the insurance has gone up. SB 262 and SB 290 makes the trust assume responsibility for new members. Mr. Turkiewicz said both bills should receive do not pass recommendations.

John Cadby, Montana Bankers Association, provided written testimony (Exhibit #9). Mr. Cadby said a few years ago they were approached by several Wyoming banks which joined the Montana Bankers insurance trust. The Montana banks are subsidizing the Wyoming banks because of a Wyoming law that states their rates cannot be raised by more than 15%. Because of this situation, they will have to change to a self insured program.

Helen Gonsowski, provided written testimony. (Exhibit #10)'

Greg Van Horssen, State Farm Insurance Companies, said they oppose both SB 262 and SB 290. State Farm opposes any bill limiting their potential to assess risks and adjust premiums accordingly. Mr. Van Horssen said it is their duty to maintain low premiums, and SB 262 and SB 290 will result in increased premiums for the majority of their share holders. For this reason, State Farm asks for a do not pass recommendation on both these bills.

Questions From Committee Members and Responses:

Sen. Mesaros asked John Cadby if there were laws similar to those in Wyoming in other states. Tom Hopgood said there were more than 20 other states that had adopted small group reform laws.

Sen. Christiaens asked Helen Gonsowski if they would not insure an individual in their small group if that individual had a catastrophic problem. Ms. Gonsowski said they will offer renewal of coverage at the end of their current plan.

Sen. Christiaens asked Ms. Gonsowski if her group would not take a group of three if one individual had a preexisting condition. Ms. Gonsowski said a group of three would have to qualify for their benefits.

Sen. Christiaens asked Ms. Gonsowski if there were a preexisting condition, they may not be able to qualify because of price. Ms. Gonsowski said that was correct.

Sen. Christiaens asked Ms. Gonsowski how she argued in favor of

her testimony. Ms. Gonsowski said that if there were a preexisting condition limitation on their plan of less than 20 individuals, they would not be able to continue to insure groups of that size. The elimination of the preexisting condition clause alleviates them from that risk management, and without that management, they would be unable to offer benefits to small groups.

Sen. Christiaens reminded Ms. Gonsowski that the majority of Montana's businesses fall under this category. Ms. Gonsowski said she was aware of that.

Chairman Eck asked Ms. Gonsowski to what extent members of their group would be disinclined to hire an individual with obvious health risks. Ms. Gonsowski said she is not privileged to the hiring practices of the employers who subscribe to their program.

Chairman Eck asked Ms. Gonsowski if there were different rates for different groups, so that if one member of a group incurs some high expenses, the rates for the group will increase. Ms. Gonsowski said yes. She said they do have a "pooled program" for some of the smaller groups. They are making the move towards community rating, however they have an insurance plan specifically developed for their small groups of less than 20 employees. This plan does have a preexisting conditions limitation for the first 365 days of coverage.

Sen. Klampe asked Allyn Christiaens about losing groups which fall under the ERISA exemption to SB 262 and SB 290. Jim Fleshman said it takes 75-100 people to self insure, and these bills apply to groups of 25 and under.

Sen. Klampe asked Mr. Fleshman if he were saying the ERISA exemption was not a problem. Mr. Fleshman said most of the groups in Montana are not self insurable because they are too small.

Sen. Klampe asked Mr. Fleshman if he would respond to the ERISA problem. Mr. Fleshman said they did not have any solutions to it, but the industry is very interested in straightening it out because they don't like the fact that there are growing numbers of people insuring themselves.

Sen. Klampe asked Allyn Christiaens to address the ERISA problem. Mr. Christiaens said alleviating the ERISA problems is a priority of the Clinton Administration. Much of the ERISA problems depend on the actions of the federal government. Mr. Christiaens said they would hope there would be waivers so that SB 262 and SB 290 could be addressed on a state-wide level.

Sen. Klampe asked Larry Akey about "hidden taxes" in SB 262 and SB 290. Mr. Akey said the hidden tax is the rate increase for those individuals who are forced to remain in the risk pool because of health conditions or because they can't afford to

change policies. It is a tax on those who remain with private insurance.

Sen. Klampe asked Larry Akey if he were referring to adverse selection. Mr. Akey said he was.

Chairman Eck asked Riley Johnson about his support of a national package. Mr. Johnson said the group was the National Health Insurers Association (NHIA). He said a package of health legislation was evolving that they feel will address health care problems. SB 262 and SB 290 do not pertain to that package.

Chairman Eck asked Mr. Johnson if he were referring to the House Bill to be sponsored by Rep. Russell Fagg. Mr. Johnson said that was correct.

Chairman Eck asked Mr. Johnson if he were going to support that bill. Mr. Johnson said he had not yet seen the bill, but he would probably support it.

Chairman Eck asked Larry Akey if a comparison of the bills could be drawn up. Mr. Akey said he would be happy to, and would speak with Chairman Eck after the meeting to determine which bills should be included in the comparison.

Chairman Eck asked Larry Akey how many bills there were. Mr. Akey said there were a number of bills that address insurance reform in some way.

Closing by Sponsor:

Sen. Christiaens said the uninsured people who need coverage are a major problem in Montana. He said much of the testimony sounded like it did during the debate over non-gender insurance. Experienced rating, giving lower insurance rates to younger, healthier individuals, and basing rates on individual groups, whose rates increase as they grow older or the group changes will be covered by SB 262 and SB 290. Everyone needs to be insured, and these two bills are part of a total reform package which needs to be done in Montana. Sen. Christiaens said self insurance is not a real issue regarding these bills, and it is not necessarily the answer.

EXECUTIVE ACTION ON SB 121

Discussion:

Sen. Franklin said she asked Diane Wickham, Executive Secretary of the Board of Nursing, to come and answer questions regarding the liability and the delegation of nursing tasks. Also, the issue of Licensed Practical Nurses, and how SB 121 affects them.

Sen. Franklin provided copies of the Administrative Rules of the Delegation of Nursing Tasks (Exhibit #11), and an article (Exhibit #12)

Chairman Eck asked Diane Wickham to address the two issues. Ms. Wickham said a group worked on the rules regarding the delegation of nursing tasks. They allow an unlicensed individual to do a task which is already being done, but will be done under the supervision of a nurse. This will not hurt LPN's jobs, but will provide more employment for LPN's because these tasks are currently being done without a nurse, and there will have to be a nurse present to supervise teaching.

Sen. Mesaros said his question revolved around the nurse retaining liability for the unlicensed individual performing the tasks. Ms. Wickham said the nurse retains the liability for the nursing, because the nurse is not delegating the nursing, the nurse is delegating a task. The tasks do not require nursing judgements to be made. The nurse is responsible for delegating, teaching and supervising. The unlicensed person retains responsibility for accepting the responsibility, or for not doing what they were taught to do.

Sen. Mesaros asked if the Board of Nursing had established a laundry list of tasks which could be delegated. Ms. Wickham said the Board would determine a laundry list for now. The Board wants to start small and build after there has been evaluation.

Sen. Klampe asked if the language Page 8, Line 16, referring to Licensed Nurses meant LPN's. Sen. Franklin said it did.

Sen. Klampe asked Sen. Towe if LPN's would be at risk for liability as well as RN's, and how serious this would be if LPN's were not covered by malpractice. Sen. Towe said negligence law states that if someone is negligent in performing their duty, they could be liable. So, if an LPN negligently delegated authority, they could be liable.

Diane Wickham said the LPN is under the same amount of liability as a Registered Nurse, but the LPN can only delegate within his or her scope of practice.

Sen. Klampe asked Ms. Wickham if 100% of LPN's were covered by malpractice insurance. Ms. Wickham said it is an individual choice. The employer covers nursing, and many nurses do not carry their own liability policy. They are not required to do so.

Sen. Franklin said there is professional responsibility, and some nurses carry liability above and beyond what the employer has.

Sen. Christiaens recalled a case in Great Falls where there wasn't adequate nursing staff to cover a patients tube feeding needs. The only way the child could stay in the program was if

the family came in and gave the tube feeding. Sen. Christiaens asked Diane Wickham if a nursing staff was required to be present at all times. Ms. Wickham said the current statutes prohibit unlicensed individuals from performing nursing. Homes such as Easter Seal are required to provide adequate staff for nursing. Tube feeding is considered to be a nursing function, and a nurse cannot delegate this. If delegation were allowed, a staff member could be taught to do the tube feeding, and then would periodically supervise.

Sen. Christiaens asked Ms. Wickham if the nurse maintained liability for the person doing this job. Ms. Wickham said the nurse retains liability for the nursing and for the decision to delegate that task to a particular individual. The rules state that a nurse cannot require anyone to make a nursing judgement.

Motion:

Sen. Towe moved the amendment previously presented to SB 121.

Discussion:

Sen. Towe said the last sentence would be struck, and "by increasing license fees as necessary" would be added after the word "chapter".

Vote:

The motion carried unanimously.

Motion/Vote:

Sen. Christiaens moved SB 121 DO PASS as amended. The motion carried unanimously.

ADJOURNMENT

Adjournment: Chairman Eck said there would be an informational hearing at 6:30 on Wednesday, February 10th. Chairman Eck adjourned the hearing.

Dorothy Eck

SENATOR DOROTHY ECK, Chair

Laura Turman

LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-8-93

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

FC8

Attach to each day's minutes

SENATE STANDING COMMITTEE REPORT

February 9, 1993

MR. PRESIDENT:
We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 121 (first reading copy -- white), respectfully report that Senate Bill No. 121 be amended as follows and as so amended do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Page 3, line 10.
Following: "physician,"
Insert: "nurse specialist,"

2. Page 3, line 14.
Strike: "nurse specialist,"

3. Page 7, line 25.
Strike: "and"
Following: "nurse-anesthetists"
Insert: ", and clinical nurse specialists"

4. Page 8, line 18.
Following: line 17
Insert: "(8) The board may fund additional staff, hired by the department, to administer the provisions of this chapter by increasing licensing fees as necessary."

-END-

M- Amd. Coord.
JB Sec. of Senate

TESTIMONY ON SENATE BILL NO. 290

BEFORE MONTANA SENATE COMMITTEE ON PUBLIC HEALTH, WELFARE, AND SAFETY

PREPARED FOR MONTANA PEOPLE'S ACTION

BY

ALLYN E. CHRISTIAENS

FEBRUARY 8, 1993

Chairman Eck and Members of the Committee, my name is Allyn Christiaens and I thank you for allowing me the opportunity to speak to you today on behalf of Montana People's Action (MPA) supporting Senate Bill 290. As you heard last Friday during testimony on Senate Bill 267 introduced by Senator Yellowtail and as you well know, the health care system in Montana as well as the whole country is in dire straits and must have major reform undertaken in as timely a fashion as possible. As State vice-chairman of the board of Montana People's Action, I am all too aware of the desperate circumstances in which our membership of primarily low and moderate income persons exist, for these are the people that cannot afford the insurance coverage that so many individuals take for granted. Through our information and membership canvass, that visits approximately 50,000 Montana homes annually, we have identified one overwhelming fear that haunts the poor and working folks of this state, that is, 'How can we afford health insurance that provides so little coverage, is expensive even when we don't use it, and costs us more when we do use it?'. Many of these people have done the only thing they could do, drop their coverage and hope that fate doesn't find them, that is, if they were fortunate enough to even have insurance.

Exhibit #1
2-8-93
SB-290

MPA applauds the comprehensive measures sponsored by Senators Franklin and Yellowtail for they are focusing the attention of the Legislature, the Governor, and the citizens of Montana on the critical need for health care reform. Should SB 267 (the Yellowtail single payer bill) pass then our insurance reform bills would be unnecessary and moot. Should SB 285 (sponsored by Sen. Franklin) be the chosen method of comprehensive health care reform, the bills Sen. Christiaens has brought before you today are essential. We feel strongly that the insurance reform portion of Sen. Franklin's bill should be significantly strengthened. Sen. Franklin's bill prescribes a several year process to achieve comprehensive health care reform. However, during this period we need to provide our citizens with immediate health insurance relief. SB 290 is the strongest insurance reform measure to come before you this session.

This bill would require insurers to use community rating in establishing premiums for coverage under a policy or contract of health insurance. In addition, it would provide a guaranty for issuance and renewal of health insurance and establish requirements and limitations for insurers that cease doing business as providers of health insurance. Community rating is a rating methodology in which the premiums for all persons covered by a policy are the same, based on the entire pool of risks covered by the

policy without regard to age, sex, other demographics, geographical factors, health status, occupation, claims experience, or duration of coverage. In other words, community rating is the way insurance premiums used to be set about 20 years ago.

In the past two decades several factors brought about the use of extensive medical underwriting that is currently used by most insurers doing business in Montana. The major reason for the use of medical underwriting, however, was that it was much more lucrative for insurers to cull the higher risk individuals from their risk pools. Medical underwriting establishes various rates for purchasers of insurance depending upon age, sex, occupation, claims experience, and the other factors listed above with the ultimate result of unaffordable or unattainable coverage. Compounding the access problems associated with medical underwriting is the insurer's administrative costs incorporated into insurance policies. According to A.M. Best's Company's data for 1989, for every dollar the commercial insurance industry paid in claims in 1988 nationally, the industry spent 33.5 cents for administration, marketing, and other overhead expenses. Thus, not including profits, the commercial insurance industry spent <u>fourteen times</u> as much on administration, overhead, and marketing per dollar of claims paid as did the

Medicare system, and eleven times as much per dollar of claims paid as the Canadian national health system. In 1993 the situation has only gotten worse. Had an efficient public program such as Medicare or the Canadian system provided the same amount of benefits, consumers and businesses served by the commercial insurers would have saved $13 billion nationally and $36.9 million in Montana. The $36.9 million difference between what it cost commercial insurers and what it would have cost a public program to provide the same amount of benefits would have been sufficient to provide insurance coverage to 31,367 people in Montana!

The roughly 30 cents-per-dollar-of-claims-paid difference in administrative, overhead and marketing expenses between commercial insurers and public programs did not by better health care. In order to lower its risk of paying claims and increase its chances of earning profits, each insurer spends vast amounts on underwriting, marketing, and denying claims. Underwriting divides people into narrowing segments (or rate bands) based upon their probable need for medical care. The irresistible motive for using rate bands is that each time and insurance company can find a segment likely to need medical care, it can charge higher rates or deny coverage altogether, lowering its risk of paying claims. Insurance companies spend a great deal of

money on marketing, aggressively competing with each other to insure those segments which underwriting has determined to present the least risk and are consequently the most lucrative. Since the companies have so little control over medical expenditures and fees, the rely on expensive internal bureaucracies to reject claims submissions from groups and individuals once they are insured.

To the insurance companies this system is rational and indispensable but to Montana and the nation, this system is <u>irrational and dispensable.</u>

SB 290 would not allow any of these rate bands, but rather would require insurers to set premiums at the same rate for all purchasers of coverage. Last May, Governor Stephens' Health Care for Montanans Task Force recommended multiple rate bands as much as 40% above and below the average rate to be used in community rating. Senator Franklin's bill on health care reform contains community rating with single rate bands of 25% above and below the established community rate. The Franklin bill when fully implemented by 1995 would still allow insurers to charge rates that are 25% higher than the lowest rate. Finally, the Franklin bill applies only to the small group market of groups with 3 to 25 employees.

There is strong consensus that health insurance reform is necessary at both the national and state level. Governor Stephens' Health Care for Montanans Insurance Reform Committee, former President Bush's Task Force on Health Care Reform, Sen. Baucus' Health Care Committee, Blue Cross/Blue Shield, Montana People's Action, and many other groups all believe that community rating and continuity of coverage are essential components of health insurance reform. However, there are widely varying views about what types of these reforms should be implemented.

The community rating proposals advanced by the insurance industry have all relied heavily on establishing rate bands, and applying rating reforms to the small group market. Montana People's Action feels that these interpretations of community rating are more hybridization of medical underwriting than true community rating. For two major reasons, Montana People's Action does not believe that either of these approaches provides Montanans with the insurance reform they need and deserve.

First, there is a growing body of evidence that rate bands exacerbate the problem that community rating is designed to cure; extensive medical underwriting.

Other states have had such variants of community rating and have found it woefully inadequate in resolving the excessive administrative overhead that insurers incur. In May of 1992 in the Health Benefits Letter (which I will attach to my testimony), the Connecticut version of community rating with rate bands was critiqued. This Letter, which is a publication for health care benefits purchasing groups for business, states: "The **Hartford Courant** proclaimed that the (Guaranteed Access) law would "make health insurance cheaper and more accessible to uninsured residents..." " but, "Now there has been sufficient time to make a preliminary assessment of the law's enactment, and it is increasingly clear that the law is simply not working. The uninsured are still uninsured, insurance costs are higher than ever before and all kinds of unintended consequences - like much more intensive underwriting - have manifested themselves in the market". The publication goes on to say "These rating practices are now being applied to all groups with 1 to 25 employees, and are now being use by all carriers in the market, including those which previously applied community rating. Medical underwriting has intensified in Connecticut. There is now so much emphasis on determining who should be reinsured for pre-existing medical conditions, that one (insurance) agent has described the process as a "medical witchhunt" ".

There are increasing numbers of reports that small employers are beginning to base hiring decisions on the health of an applicant ... and there are reports that larger employers are dumping high risk employees into the reinsurance pool by creating small group subsidiaries. All of these problems are reflective of the liberal use of rate bands by the insurance companies.

In other words, rate bands have not worked to bring about better access or more affordable coverage, but have only lead to more extensive medical underwriting.

Second, In a State where many citizens are self-employed and in which many businesses have less than 3 employees, it does not make sense to limit insurance reform to small groups of 3 to 25 employees. Such an approach would eliminate thousands of Montanans from receiving the benefits of health insurance reform.

The citizens of Montana are excited that the legislature is tackling health care reform. However, given the powerful interests that stand to lose the most as we move to cost containment and universal access, many are skeptical that anything will be done.

You have before you during this legislative session much of what is necessary to build a strong foundation for long term comprehensive reform. Montana People's Action believes that this foundation starts with true health insurance reform and not the hybrid proposals being advanced by the insurance industry. We call on you to pass SB 290 and to incorporate its essential parts into any comprehensive health care reform which you pass in this session. Those parts include true community rating and applying true insurance reform to the individual as well as the small group market. By passing SB 290, insurers would be forced to compete for our business based upon how well they manage risk and not on how well they avoid risk.

Montanans need help NOW! True insurance reform will cost the state nothing and will provide immediate relief to thousands of citizens as we proceed with comprehensive reform.

Health Benefits Letter #29

...covering state, federal and private-sector developments in health benefits reform

Guaranteed Issue in Connecticut: Early Results Not Encouraging

Two years ago, a Blue Ribbon Commission's report resulted in the enactment of Guaranteed Access small group insurance in Connecticut.

The Hartford Courant proclaimed that the law would "make health insurance cheaper and more accessible to uninsured state residents... As many as 60,000 of the state's 250,000 people without insurance would likely become covered under the legislation... Insurance lobbyists touted the measure as a model for the nation and a citizen action group called it a promising step toward covering all state residents."

Now there has been sufficient time to make a preliminary assessment of the law's enactment, and it is increasingly clear that the law is simply not working. The uninsured are still uninsured, insurance costs are higher than ever before and all kinds of unintended consequences - like much more intensive underwriting - have manifested themselves in the market.

What follows is a report on the nature of the small group health insurance market in Connecticut one year after the Guaranteed Access law has become fully operational.

EFFECT ON THE MARKET

New Business Rates

"Street rates" have virtually no meaning in the market anymore. Carriers are now providing quotes for groups only after they go through underwriting.

Insurance agents are frustrated with the new rating practices. They cannot know going into any sales situation whether they will be able to save the group money. Until they complete medical applications on everybody, submit the group, and wait for an underwriting decision, there is simply no way of knowing what rates the group will be quoted.

These rating practices are now being applied to all groups with 1 to 25 employees, and are now being used by all carriers in the market, included those which previously applied community rating.

Before the enactment of the law, an insurance agent knew in advance if it would be accepted for coverage by a particular carrier. Now, the agent knows that the group can get placed, but does not know whether the group will save any money.

Underwriting

Medical underwriting has intensified in Connecticut. There is now so much emphasis on determining who should be reinsured for pre-existing medical conditions, that one agent has described the process as a "medical witchhunt."

Full medical applications must now be taken on all employees in the 1 to 25 market. One agent had to complete and submit 80 health applications to get rates from 4 carriers for a 20-person group.

It often takes weeks, even months, to get a final quote back from an insurance company.

As with the rating practices, underwriting is now being done by carriers that never used to. Even Blue Cross and Blue Shield of Connecticut has established an underwriting department. There have been reports that Blue Cross has spent $4 to $5 million to establish an underwriting department.

Renewals

The law is having significant effects on renewal rates, even this early in the program.

All groups with 1 to 25 employees are essentially being experience rated to the maximum extent allowed by the law.

Also, for the first time, many groups are getting "demographic adjustments" to reflect differences in industry, geography, age, family status, and size of groups.

(Please turn to page 4)

On The Inside:

- Two Computer Giants Feature Prevention, Cost Sharing, PPOs, in Benefit plans. Page 2
- The Connecticut Small Group Guaranteed Access Law: Some Key Components. Page 4
- Two Studies Find Premium Hikes With Guaranteed Issue, Rate Limits. Page 5
- Highlights from the Congressional Record. Page 6

(Continued from page 1)

The effect is that small groups are getting tiered to a much greater extent than before. Connecticut's agents report renewal rate increases ranging from 0% to 60%.

Benefit Plans

Carriers that used to serve part of the small group market must now serve it all. As a result, some of these carriers make available only the plans mandated by the state to those groups which they previously did not serve. For example, carriers that did not make their "name brand" plans available to 1- and 2- person groups still don't; instead, they offer these groups only the state mandated plans. Because pricing of these basic plans is left to the carrier, the carriers can effectively price themselves out of markets they don't want to be in.

Gaming

There are increasing numbers of reports that small employers are beginning to base hiring decisions on the health of an applicant. There are also anecdotal reports that larger employers are dumping high risk employees into the reinsurance pool by creating small group subsidiaries. One observer called this tactic the "Three Sick Guys Company."

THE REINSURANCE POOL

Special Health Care Plan

Like many states, Connecticut tried to deal with the affordability problem by enabling uninsured small employers to buy "bare bones" plans. Also like many states, Connecticut created barriers to purchase, the most important being that a given group had to have been uninsured for two prior years. And, like most other states, the "bare bones' plans have failed to make a dent in the ranks of the uninsured.

The Special Health Care Plan was targeted at low income, uninsured small groups (fewer than 10 employees). While Connecticut decided not to waive the application of mandated benefits, the Special plan was supposed to reduce premiums by reimbursing providers only 75% of Medicare allowable charges.

As of February 29, 1992, only 258 individuals in the target market had become insured through this program.

Reinsurance Pool Enrollment

The Reinsurance Pool was created as a way for carriers to share equitably in the cost of bringing high risk individuals into the system. Rather than fully subject themselves to the unpredictable cost consequences of guaranteed issue, carriers would be permitted to "cede" risks to the reinsurance pool. The cost of the high risk individuals in the reinsurance pool would be charged

THE CONNECTICUT SMALL GROUP GUARANTEED ACCESS LAW: SOME KEY COMPONENTS

Carriers which serve the small group market must serve the entire small group market; i.e., all small groups with 1 to 25 employees. Self-employed people are their own employees; therefore, self-employed, 1-person groups must be guaranteed access.

Every carrier can offer as many plans in the market as it wishes, but it must guarantee issue a small employer health plan or a special health care plan benefit plan (depending on the nature of the group) to any small group which wishes to purchase one.

The carrier must apply group accept-or-reject underwriting to its "name brand" plans. The small employer health plan and special health care plan benefit plans must be offered to any group which is rejected for the "name brand" plan and coverage must be issued if desired.

All new additions to groups must be guaranteed issued regardless of the plan initially sold to the group. Previously satisfaction of pre-existing condition limits must be credited.

Rates for groups with the same characteristics and the same plan of coverage can vary by as much as 2:1 due to duration, claims experience or health of the group. The carrier can vary rates by plan design and case characteristics as it sees fit.

A carrier may increase rates by as much as 20% per year based on duration, claims experience or health of the group. This can be added on top of the group's case characteristics and the other rules in new business rate.

While groups and individuals can be "ceded" to the reinsurance pool, the reinsurance board establishes the reinsurance premiums and the amount of claims cost which the carrier must keep for each risk per year.

SENATE HEALTH & WELFARE
EXHIBIT NO 2
DATE 2-8-93
BILL NO SB 290, SB 262

1. Ms. Chairman, members of the committee, my name is Michael Regnier.

For about the past year, I have worked as a leader in Montana People's Action on the health care task force. The task force is clearly in strong support of this bill as well as SB 290.

My full-time job is as the Advocacy Coordinator for SUMMIT Independent Living Center. The state Independent Living advisory council is also in support of these bills because of their potential benefit for members of the disability community, some 135,000 strong in Montana.

The third hat I'm wearing is as the state vice president of the Coalition of Montanans Concerned with Disabilities, which is a new organization of people with disabilities, their families, friends, and supporters which currently has chapters in Bozeman, Helena, and Missoula, with several other chapters forming around the state as we speak. CMCD is also strongly in support of both SB 262 and 290.

2. Today I'd like to tell you of some of the barriers faced by people with disabilities that are a direct result of the lack of any reasonable access to health insurance. I'm not here today to try to tug at your heartstrings, but to simply inform you of the struggles people with disabilities, as well as any Montanan trying to obtain necessary health care, go through in trying to access the care they need. But the circumstances of people with disabilities in this realm is somewhat unique.

We represent perhaps the most clearly defined group of people who fit into the category of people with "pre-existing conditions," because, by definition, we all have at least one. And we are nearly always denied access to the private insurance market, primarily because of two factors. The first is that we simply cannot purchase private policies because of our disabilities the vast majority of the time; we are either denied coverage outright or priced out of the market. The second problem we face is that our only other form of access to private insurance is through the workplace, as insurers are not allowed to deny coverage to anyone who signs onto a group insurance policy as soon as an individual begins a new job. However, since we have historically faced substantial discrimination in the job market, over two thirds of people with disabilities are unemployed, and less than 15% work full-time. Because of systems involved in vocational rehabilitation which are yet largely ineffective, those who do work are often only able to obtain low paid, entry-level employment that typically does not offer health insurance benefits.

Those of us who are lucky enough to obtain coverage are forced to endure waiting periods of three months to two years, during which many of us would surely endure significant medical setbacks, if not face the very real possibility of death due to untreated, but nonetheless very treatable, medical problems. Remember that it is only in the very recent past that many people with a range of different disabilities survived for any length of time. This very adequately speaks to the trap in which most of us find ourselves. We are entangled in the "golden handcuffs" of public insurance coverage and the poverty that is the basis of our eligibility for these programs.

While it is true that people with disabilities represent perhaps the most dramatic example of the barriers faced by those with pre-existing conditions, these very significant obstacles stand in the way of any Montanan with any pre-existing condition, no matter how minor, who simply wishes to obtain reasonable health insurance coverage and get on with his or her life.

3. The impact of this untenable situation on the lives of Montanans is very real. People who wish to work and participate in their communities are frustrated in their attempts to do so, though they have a great deal to contribute. Rather than having the opportunity to become tax-paying, contributing members of society, they are forced to either endure considerable financial hardship or watch as their neighbors pursue the American dream, which they know will surely pass them by.

And from the perspective of potential employers, the problem becomes even more complex. Though the recently passed Americans with Disabilities Act makes it illegal for employers to discriminate against people on the basis of their disabilities, they face a terrible dilemma when choosing between hiring two qualified candidates for employment, one with a disability and one without. While they may wish to offer a job to a qualified individual with a disability, they know they face the very real possibility of increased health insurance rates for all of their employees if they hire a person with a disability, even though that person may be the most qualified for the job. We know for a fact that much employment discrimination takes place because of the discrimination that is routinely and legally undertaken by private insurance carriers. Clearly, this defeats the primary purpose of the ADA, which is designed to eliminate discrimination of the basis of disability and return people with disabilities to the social and financial independence which is only possible through gainful employment.

4. This is why Senate Bill 262, with its specific references to the specific types of previous coverage which will be the high watermark for subsequent coverage that must be offered by insurers, is the strongest possible type of continuity of coverage in the private insurance market. Further, by not limiting continuity of coverage to the small group market, i.e., groups of 3 to 25, this bill will allow individuals, or non-group customers to obtain coverage as well. Due to the large number of very small businesses in Montana, this will not, in turn, eliminate those employees from any possibility of obtaining health insurance. In addition, this measure will eliminate a great deal of the cost-shifting that occurs when those who cannot afford to obtain insurance receive medical treatment for which they are unable to pay. We all know that this debt is not simply written off by health care providers, but is passed on to the taxpayer and those who can afford to pay for medical care.

5. For all these reasons, we urge the members of this committee to pass SB 262, but not for these reasons alone. We feel that this bill very much represents the ideals of fairness, justice, and equality for which all Montanans and American citizens strive. It is critical that we get beyond these barriers if we are to be able to get on with our lives. Thank you very much for your time and attention.

EXHIBIT NO. 3

DATE 2-8-93

BILL NO. SB 290, SB 262

1. Ms. Chairman, members of the committee, my name is Michael Regnier. I work as the Advocacy Coordinator for SUMMIT Independent Living Center, and represent Montana People's Action and the Coalition of Montanans Concerned with Disabilities.

2. I would like to reiterate the strengths of SB 290 that have been described. First, the measures concerning continuity of coverage contained in SB 262 are useless unless people are able to afford insurance coverage in the first place, as well as having guaranteed access and guaranteed renewability of insurance coverage.

3. And again, Montanans need strong individual or "non-group" community rating, given the nature of our state and the large number of very small employers who do not have enough employees to constitute a small group of three or more. Without this type of community rating, many Montanans will continue to be left out in the cold as far as insurance coverage is concerned.

4. Another problem which will need to be considered at length by the members of this committee is that of "rate bands." If rate bands are allowed in insurance reform, it is obvious that people with disabilities and those with other pre-existing conditions will end up in the highest rate bands. We will undoubtedly continue to see more of the same, and the maintenance of the present discriminatory status quo practiced every day by insurance carriers in Montana. The presence of rate bands will simply add new types of medical underwriting to current practices, and continue to drive up administrative costs which are already far too high.

5. And finally, every year that we wait to implement significant and meaningful insurance reform in Montana is another year that we and our neighbors must endure unnecessary financial and human hardship. We strongly urge you to pass SB's 290 and 262 so that we can get back to the business of managing risk rather than avoiding it as well as stopping the unfair and discriminatory practices that we currently see being forced onto the people of Montana. Thank you again for your time and attention.

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 2-8-93
BILL NO. SB 162, SB 290

Chet Kinsey
Chairman Golden Nuggets Local MSCA

Insurance corporations are
with out conscience or honesty

We hear many complaints
from our members. Being dropped
after many years of paying
premiums, not only in Health
Insurance. Some companies
drop people because of age
or having an illness.
They make excessive raises
in premiums.

Blue cross as an example
use a lots of premium money
to oppose Comprehensive Health
Care — The pad up-costs with
excive high executive salaries

TESTIMONY OF MARK BREWER
BEFORE THE SENATE PUBLIC HEALTH COMMITTEE
FEBRUARY 8, 1993
IN SUPPORT OF SENATE BILL 290

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-8-93
BILL NO. SB 290

My name is Mark Brewer, I live in Missoula, and I am an unemployed Certified Nursing Assistant.

Late last year I was diagnosed with arthritis of the spine. Naturally I had no health coverage because of the incredible cost of health insurance. My wife, who is also a Certified Nursing Assistant, also had no coverage at the time.

As a part of her recently-negotiated union contract, my wife and her fellow workers can now get insurance through their employer, a nursing home. We pay too much for a policy that provides too little coverage, but at least she has some form of insurance.

When we applied to put me on her policy, her company informed her employer that they would be unable to cover me because I have a pre-existing condition. Consequently, I will have to wait twelve months before they will consider my application. And if her company does accept me after twelve months - which seems highly unlikely - they undoubtedly will not cover anything that relates to my arthritis.

It is clear to me that insurance companies are only interested in covering the healthy - or that part of the rest of us that is healthy.

I urge you to pass Senate Bill 290 so that those of us who are not healthy can still have access to health insurance. After all, if you aren't a pre-existing condition now, you undoubtedly will be someday.

Dear Legislators,

My name is Sheila James. I support the Montana People's Action Health Care Reform bills # 262 and 290

At the present time I'm on Medicaid.

I would like to look for full-time employment in the near future. But working full-time would cut my Medicaid benefits.

Since I was born with cerebral palsy, I have been labeled as having a 'pre-existing condition, thus making it impossible to find any affordable medical coverage.

I would need to find a plan that would cover home care personal needs, therapy & prescription medications.

Sheila James
Missoula MT

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2-8-93
BILL NO. SB262, SB290

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 2-8-93
BILL NO. SB262, SB290

Dear Legislators,

For years I was a single parent. I worked seasonal jobs which generally were low pay- I barely could afford basic living costs, child care etc and health insurance was only briefly considered as it would have cost over $250.00 for the both of us. I would not have dropped from the insurance low risk pool because I was never in it unless my employer paid it. Most of my employers did not pay it for me & never for my child. You see I didn't need insurance because I was only one lay a step from poverty anyway and had nothing to loose by being indigent & then getting on Medicaid. I believe that most of the young & healthy uninsured are a lot like me and would not purchase health insurance unless it is cheap & or mandated. I support SB 262 and SB 290 because it is only fair that if a person chooses to insure that it be done without discrimination and cover what it needs to.

Lee Parks

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 2-8-93
BILL NO. SB 262, SB 290

2/7/93

Dear Legislators:

I am writing to share my personal experience in the hope that you will gain a better understanding of the problems faced by Montanans with disabilities who try to obtain health insurance. Some brief background information may be useful.

In 1976 I received a spinal cord injury in an automobile accident which left me quadriplegic. I use a manual wheelchair for mobility and require some assistance every day to help me with activities of daily living -- dressing, bathing, transferring from bed to wheelchair, cooking, & some housekeeping. This assistance is provided by personal care attendants whom I employ and pay from my own pocket. I do not require prescription drugs, but I do use a number of medical supplies each day. My overall health is excellent, in fact probably better than the average person my age (37).

In 1978 I began college at the University of Montana in Missoula, and graduated with a bachelor's degree in Classics in 1983. Through my college years I subsisted on my Social Security Disability Insurance benefits of $ 350 per month. The Montana Medically Needy program helped me qualify for Medicaid, which paid virtually 100% of my medical expenses.

I returned to work full time in 1985, taking a job at Summit Independent Living Center in Missoula.

When I returned to work my Medicaid benefits were cut off, as was my SSDI check. Returning to work was very frightening because of the loss of Medical coverage. At that time in 1985, I calculated that I would have to maintain an annual salary of at least $16,000 just to maintain my O.T.B, pay my living expenses and meet my medical costs. I did have group health insurance coverage through my employer Summit, which was at that time affiliated with a much larger organization, Community Medical Center. While the health insurance did not cover my attendant care costs, it did help with some medical supplies, equipment, and prescriptions which I had at the time. This coverage was short-lived, however, because Summit separated from its parent organization, and was not able to continue the same group policy beyond an 18 month grace period allowed by Federal regulations.

Shortly after Summit separated from Community Medical Center, I became Executive Director of Summit. One of my first tasks as Director was to obtain a new group policy for health insurance to cover our employees. This became a very frustating effort, because Summit was repeatedly turned down for group health coverage due to my and a few other employees' disabilities. Many companies even refused to take an application, stating that they would not cover a group which

had members with disabilities because we were "high risk." To make a long and frustating story short, Summit finally did obtain a group health insurance policy, although I was not able to get coverage through the group. With my application in the pool, we were denied the policy; without it the company did write a policy, even though there were other employees on staff with disabilities. I felt and continue to feel very much singled out and discriminated against because my disability is viewed as "high risk" making me virtually uninsurable despite my overall good health.

I have tried repeatedly to obtain an individual health insurance policy, but have been denied each time. My only recourse has been the "High Risk" pool administered by the Montana Comprehensive Health Association plan which has to cover me. The premium is $215 per month with $1000 annual deductible and $5000 annual stop loss. The policy is essentially only good for major medical coverage, and does not cover the majority of expenses which I incur every month. I continue to spend well in excess of $500 each month for my attendant care and medical supply costs. I am proud to be able to support myself although the financial burden of my medical costs is quite high. What frightens me is the very real possibility that my medical coverage is wholly inadequate if I should have some severe

Exhibit # 8
2-8-93
SB-262 + SB-290

medical complications and the very real possibility that I could lose my independence in the community and incur devastating medical bills (the lifetime limit on my MT. comprehensive insurance Policy is $250,000).

People with disabilities must have adequate health care coverage to escape the trap of poverty and dependency and to become independent, productive members of society. The present system of health care and health insurance coverage is woefully inadequate to this end. Change is vital if we are to succeed.

I am hopeful that the "Continuity of Coverage" and "Community Rating" proposals endorsed by Montana People's Action will make it possible for Montanans with disabilities to acquire basic health insurance coverage and be able to maintain the same level of coverage from job to job. I strongly encourage you to support these two vital steps in reforming health insurance in our state.

Sincerely,

Mike Mayer
2370 Village Square
Missoula, MT 59801

TO	INITIAL	CHECK	NAME
John		For Your Information	
Cheri		Mail Copy To	2-4-93
Tempi		Handle It	
Alex		Return Original To	

SENATE HEALTH & WELFARE
EXHIBIT NO 9
DATE 2-8-93
BILL NO SB 262, SB 290

MONTANA BANKERS ASSOCIATION
1 N. Last Chance Gulch
Helena, MT 59601
(406)443-4121

January 25, 1993

Mark O'Keefe
State Auditor
Mitchell Building
Helena, MT 59620

RE: HEALTH INSURANCE

Dear Mark:

MBA and other major trade associations in Montana have had group health medical plans for their members and employees and families for many years. We extended our coverage to banks in Wyoming 4 years ago.

Wyoming adopted a law requiring health insurers to accept all small groups (banks with less than 25 employees) with no underwriting allowed and increases in premium restricted. As a result, United of Omaha almost terminated the Wyoming banks from our plan and finally agreed to keep them, but restricted the rate increase to 15% compared to a 25% increase for Montana banks.

The enclosed article from National Underwriter, January 11, 1993, cites the disaster this law has had in the state of Connecticut. I sincerely hope Montana does not adopt the same law. If we do, please exempt trade associations group medical plans that have served a very valuable function for decades.

Thank you.

Sincerely,

JOHN T. CADBY
Executive Vice President

JTC:mt

Enclosure

JANUARY 11, 1993 NATIONAL UNDERWRITER
PROPERTY & CASUALTY/RISK & BENEFITS MANAGEMENT

Cover On Demand Would Increase Uninsured: Study

BY STEVEN BROSTOFF

WASHINGTON—Laws requiring health insurers to accept all small group applicants for coverage will increase, not decrease, the number of people without health insurance, according to a study by the Council for Affordable Health Insurance.

"They will raise the cost of coverage for small employers, making health insurance even less affordable, forcing more employers to drop their insurance altogether, and result in more, not fewer, people without health insurance coverage," the Alexandria, Va.-based Council said.

The Council cited the example of Connecticut, which enacted a law in 1990 requiring all insurers operating in the small group market to offer specified insurance plans and accept all small employer groups, regardless of experience.

In addition, the state established a reinsurance pool to spread the cost of guaranteed issue insurance throughout the small group market.

At the time, the Council said, press reports said that the law would reduce the cost of health insurance to the uninsured, and provide insurance to as many as 60,000 of the state's 250,000 uninsured.

Instead, many small employers experienced huge premium increases and the number of uninsured has remained the same, the Council said.

"The Connecticut guaranteed access legislation is, as one observer put it, like a big pot of soup that has been stirred up with no measurable improvement in the small group market," the Council said.

There is virtually no evidence to support claims that guaranteed issue will increase access to health insurance or spread costs more evenly to a greater number of people, the Council said.

Indeed, the Council said, the opposite is true. By driving up the cost of health insurance, the Council said, guaranteed issue will hurt more people than it helps. ◊

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 2-8-93
BILL NO. SB 262

For the record my name is Helen Gonsowski. I am the program director of a group health care plan for K-12 school districts and related entities.

We oppose Senate Bill 262.

Our self-funded program is not-for-profit and has been established to provide affordable group health benefits. The program was designed, in part, to cover persons in a marketplace that otherwise would not have insurance available to them. Of the groups enrolled in the program, approximately half of them are in the small group plan which provides coverage for groups with 20 or fewer employees. Some of the employers providing benefits through our program have staffs with as few as 1 or 2 employees.

Enrollment in the small group plan is subject to the review of medical information of each applicant and dependent. The plan requires that coverage be in place 365 days before pre-existing conditions are covered. This established procedure is extremely important if our program is to continue to provide benefits for these small groups. One catastrophic claim in a small group can dramatically influence future rates of that group. For example, if an individual with a pre-existing condition such as a heart condition or diabetes were allowed to join a group without any limitation for pre-existing conditions, the group may not be able to afford future coverage as a result of the new employee's usage of benefits and resulting rate increase.

Under Section 2 of the bill, an insurer is not allowed to exclude coverage for a pre-existing condition if an individual has had coverage at least six months prior to any new coverage for which the individual might be eligible. Nor is the insurer allowed to obtain medical information on that individual. As stated, this may encourage an individual to waive benefits from a new employer's plan until a medical condition arises or until the allotted time is about to expire. The concept of group health plans is to spread the risk over a large number of individuals. Allowing employees to enroll at their leisure or when a medical

condition presents itself, presents adverse selection to the carrier which ultimately increases rates to the group.

The passage of this bill eliminating pre-exiting conditions clauses for late enrollees and for new groups will seriously affect our program. It will necessitate a change to current underwriting practices and in most likelihood eliminate small groups from being eligible for enrollment in the program, leaving individuals without coverage. Though the intent of the bill is to assure coverage for individuals, this bill will certainly have an adverse effect on our program and eliminate a program that was designed especially for a marketplace that has had difficulty securing coverage.

SENATE HEALTH & WELFARE
EXHIBIT NO. 11
DATE 2-8-93
BILL NO. SB 121

ADMINISTRATIVE RULES
DELEGATION OF NURSING TASKS

DRAFT

DRAFT 4
October 1992

New Subchapter

I. Purpose

1) Every nurse is accountable as an individual for practicing according to the statutes and rules for nursing in Montana. Each nurse is responsible and accountable for the nature and quality of all nursing care provided under her/his direction.

2) A licensed nurse may delegate specific nursing tasks to unlicensed persons in accordance with these rules. Delegating of nursing tasks to unlicensed persons will be task specific, patient specific, and unlicensed person delegatee specific.

3) Nursing tasks which may be delegated in accordance with this section are:

a) administration of medications.

II. Definitions - The following words and terms as used in this chapter have the following meanings.

1) Activities of daily living - The daily routine non-skilled activities performed for grooming, toileting, and ambulation such as bathing, dressing, grooming, routine hair and skin care, meal preparation, feeding, exercising, toileting, transfer/ambulation, and assistance with self-administered medications.

2) Assign - Giving to another person a task within the person's area of service and activity.

3) Delegatee - The person receiving the delegation.

4) Delegation - Transferring to a competent individual the authority to perform a selected nursing task in a selected situation from the delegator's practice.

5) Delegator - The person making the delegation.

6) Supervision - The provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity. Total nursing care

Settings for Delegations authorized +

of an individual remains the responsibility and accountability of the nurse.

7) Unlicensed person - Any individual who is not a currently licensed nurse or does not have a license to perform skills usually performed by nurses. These individuals function in a complimentary or assistive role to the licensed nurse in providing direct patient care or carrying out common nursing functions.

III. Where a Nurse-Patient Relationship Exists, Tasks Which May Be Routinely Assigned

1) By way of example, but not in limitation, the following tasks are ones that may be within the scope of sound nursing practice to be assigned to an unlicensed person. Assignment is determined by the licensed nurse if in her/his nursing judgement the health and welfare of the patient would be protected and the task could safely be assigned to an unlicensed person. Changes in the patient's condition may require that tasks assigned may need to be changed when they can no longer be safely performed by an unlicensed person.

a) Non-invasive and non-sterile treatments unless otherwise prohibited in this section.

b) The collecting, reporting, and documentation of data including but not limited to:

i) vital signs, height, weight, intake and output.

ii) changes from baseline data established by the nurse.

iii) environmental situations.

iv) patient or family comments relating to the patient's care.

v) behaviors related to the plan of care.

c) Ambulation, positioning, and turning.

d) Personal hygiene and elimination.

e) Feeding, cutting up of food, or placing of meal trays.

f) Socialization activities.

g) Activities of daily living.

c) Supervise the performance of the delegated nursing task in accordance with ARM _____.

d) Be accountable and responsible for the delegated task.

e) Evaluate the performance of the delegated task.

f) Document the unlicensed person's competency in performing the task, teaching, supervision, evaluation, and outcome on the patient record.

6) The nursing task delegated by the nurse must be a specific task for a specific patient to a specific unlicensed delegatee in the specific setting.

7) Delegated nursing tasks may not be transferred from one unlicensed delegatee to another, from one patient to another, or from one nursing task to another. The entire process in this section must be carried out for each nursing task, patient and delegatee.

V. Supervision

1) The degree of required supervision by the nurse of the unlicensed person shall be determined by the nurse after an evaluation of appropriate factors involved including but not limited to the following:

a) The stability of the condition of the patient.

b) Training and capability of the unlicensed person to whom the nursing task is delegated.

c) The nature of the nursing task being delegated.

d) The proximity and availability of the nurse to the unlicensed person when the nursing task will be performed.

2) The delegating nurse or another qualified nurse shall be readily available either in person or by telecommunication.

3) Unless otherwise provided in this section or indicated by the situation, the nurse responsible for nursing care of the patient shall make a supervisory visit at least monthly to:

a) Evaluate the patient's health status.

b) Evaluate the performance of the delegated nursing task.

Exhibit "A"
2-8-93
SB-121

a) pharmacy or authorized prescriber prepared medication via inhalant dispenser.

b) oral medication taken from a prefilled labeled medication holder, labeled unit dose container, or original marked and labeled container from the pharmacy for the patient.

c) oral medication from (ii) above that needs to be measured for liquid medication or a tablet broken for administration provided the nurse has calculated the dose.

d) suppository medication taken from an original marked and labeled unit dose wrapper from the pharmacy for the patient.

VIII. Nursing Tasks That May Not Be Delegated

1) By way of example, but not in limitation, the following are nursing tasks that are not within the scope of sound nursing judgment to delegate to an unlicensed person.

a) Sterile procedures involving a wound or an anatomical site which could potentially become infected.

b) Non-sterile procedures such as dressing or cleansing penetrating wound or deep burns.

c) Invasive procedures such as inserting tubes in a body cavity or instilling or inserting substances into an indwelling tube.

d) Care of broken skin other than minor abrasions or cuts generally classified as requiring only first aid treatment.

e) Removing tubes or other foreign materials.

IX. Patient Health Teaching and Health Counseling

1) It is the responsibility of the nurse to promote patient education and to involve the patient and significant others in implementation of health goals.

2) Unlicensed individuals may provide information to the patient; however, ultimate responsibility for patient health teaching and health counseling reside with the professional nurse as it relates to nursing and nursing services.

SENATE HEALTH & WELFARE
EXHIBIT NO. 12
DATE 2-5-93
BILL NO SB 121

AMERICAN NURSES ASSOCIATION

Position Statement on

Registered Nurse Utilization of Unlicensed Assistive Personnel

Summary: The American Nurses Association (ANA) recognizes that unlicensed assistive personnel provide support services to the RN which are required for the registered nurse to provide nursing care in the health care settings of today.

The current changes in the health care environment have and will continue to alter the scope of nursing practice and its relationship to the activities delegated to unlicensed assistive personnel (UAP). The concern is that in virtually all health care settings, UAP's are inappropriately performing functions which are within the legal practice of nursing. This is a violation of the state nursing practice act and is a threat to public safety. Today, it is the nurse who must have a clear definition of what constitutes the scope of practice with the reconfiguration of practice settings, delivery sites and staff composition. Professional guidelines must be established to support the nurse in working effectively and collaboratively with other health care professionals and administrators in developing appropriate roles, job descriptions and responsibilities for UAP's.

The purpose of this position statement is to delineate ANA's beliefs about the utilization of unlicensed assistive personnel in assisting in the provision of direct and indirect patient care under the direction of a registered nurse.

UNLICENSED ASSISTIVE PERSONNEL

The term unlicensed assistive personnel applies to an unlicensed individual who is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse. The activities can generally be categorized as either direct or indirect care.

Direct patient care activities are delegated by the registered nurse and assist the patient/client in meeting basic human needs. This includes activities related to feeding, drinking, positioning, ambulating, grooming, toileting, dressing and socializing and may involve the collecting, reporting and documentation of data related to these activities.

Indirect patient care activities focus on maintaining the environment and the systems in which nursing care is delivered and only incidently involve direct patient contact. These activities assist in providing a clean, efficient, and safe patient care environment and typically encompass categories such as housekeeping and transporting, clerical, stocking and maintenance supplies.

UTILIZATION

Monitoring the regulation, education and utilization of unlicensed assistive personnel to the registered nurse has been ongoing since the early 1950's. While the time frames and environmental factors that influence policy may have changed, the underlying principles have remained consistent:

- IT IS THE NURSING PROFESSION that determines the scope of nursing practice;
- IT IS THE NURSING PROFESSION that defines and supervises the education, training and utilization for any unlicensed assistant roles involved in providing direct patient care;
- IT IS THE RN who is responsible and accountable for the provision of nursing practice;
- IT IS THE RN who supervises and determines the appropriate utilization of any unlicensed assistant involved in providing direct patient care; and

Attachment I

Definitions Related to ANA 1992 Position Statements On
Unlicensed Assistive Personnel

The ANA Task Force on Unlicensed Assistive Personnel developed the following definitions to clarify the ANA position statements on the role of the Registered Nurse working with unlicensed assistive personnel. These definitions reflect a review of current regulatory, legal practice and professional terminology and are intended to be used only in the context of these position statements.

1. UNLICENSED ASSISTIVE PERSONNEL:

An unlicensed individual who is trained to function in an assistive role to the licensed registered nurse in the provision of patient/client care activities as delegated by the nurse. The term includes, but is not limited to nurses aides, orderlies, assistants, attendants, or technicians.

2. TECHNICIAN:

A technician is a skilled worker who has specialized training or education in a specific area, preferably with a technological interface. If the role provides direct care of supports the provision of direct care (Monitor tech, ER tech, GI tech) it should be under the supervision of a Registered Nurse.

3. DIRECT PATIENT CARE ACTIVITIES:

Direct patient care activities assist the patient/client in meeting basic human needs within the institution, at home or other health care settings. This includes activities such as assisting such as assisting the patient with feeding, drinking, ambulating, grooming, toileting, dressing, and socializing. It may involve the collecting, reporting, and documentation of data related to the above activities. This data is reported to the RN who uses the information to make a clinical judgement about patient care. Delegated activities to the UAP do not include health counseling, teaching or require independent, specialized nursing knowledge, skill or judgment*.

4. INDIRECT PATIENT CARE ACTIVITIES:

Indirect patient care activities are necessary to support the patient and their environment, and only incidentally involve direct patient contact. These activities assist in providing a clean, efficient, and safe patient care milieu and typically encompass chore services, companion care, housekeeping, transporting, clerical, stocking, and maintenance tasks.

5. DELEGATION

The transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome. Example: the nurse, in delegating an activity to an unlicensed individual, transfers the responsibility for the performance of the activity but retains professional accountability for the overall care.

6. ASSIGNMENT:

The downward or lateral transfer of both the responsibility and accountability of an activity from one individual to another. The lateral or downward transfer must be made to an individual of skill, knowledge and judgement. The activity must be within the individuals scope of practice.

Senate Public Health, Welfare,
and Safety Committee
2-8-93
SB 290 and SB 262

The minutes from the meeting of February 8, 1993 contained a packet of letters that supported Senate Bill No. 290 and Senate Bill No. 262. The originals are stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

DATE 2-8-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 290, SB 262

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Stacy Riley	MFT / MFSE	262/290	✓	
Helen Gonsowski	MSSF			✓
Tanya Ask	Blue Cross & Blue Shield	262/290		✓
LARRY AICEY	MALA	262/290		✓
Tom Hopgood	Health Ins Assn. Amer.	262/290		✓
Greg Van Horssen	State Farm Ins.	262/290		✓
Kate Cholewa	MT Womens Lobby	262	X	
Christian Mackay	MTns. for Universal H.C.	262/290	X	
Clyde Dailey	MT. Senior Citizens Assn.	262/290	X	
CHET KINSEY	MSCA	262/290	X	
Melissa Case	Montana Federation HERE	262/290	X	
Mary McCue	MCMHCA Mt. Clinical Mental Hlth Couns	262/290	X	
Steve Turkiewicz	MADA Insurance Trust Mt Auto Dealers Assn	262/290		X

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

DATE 2-8-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 290, SB 262

Name (please print)	Representing	Bill No.	Check One: Support	Oppose
Sheila James	Self MPA	262 + 290	V	
Lee Parks	Self MPA	262 + 290	V	
Tim Meldrum	Independent Living Centers	262	✓	
Joy Miles	Self MPA	262/290	✓	
Jim Fleischmann	MPA	262/290	✓	
M Rader	MPA	262/290	✓	
Grace McCord	MPA	262/290	✓	
Tony Lankhaar	MPA	262/290	✓	
JOHN L. SIMMS	SELF	262/290	✓	
Evy O'Leary	Self	262/290	✓	
Becky Yasciore	HERE Union	262/290	✓	
Richard VanAllen	MPA	262/290	✓	
Allyn Christiaens	MPA	290/262	✓	
William Rossi	SELF	290/262	✓	
Quinton R. Helm	MT Clinics/Montana Health Care Ass'n MCMHCA/Self	262 & 290	✓	
DORINA CORRELL	CMCD/MILP	262 290	—	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10