MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN BILL BOHARSKI**, on March 24, 1993, at 3:00 p.m.

ROLL CALL

Members Present:

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

Members Excused: None

Members Absent: None

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

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

Committee Business Summary:

Hearing: HB 508, SB 285
Executive Action: None

Other Committee Business:

CHAIRMAN BOHARSKI said HB 508 has been amended into SB 285 in its entirety. Both bills will be heard at the same time. **REP. FAGG** will open on HB 508; then **SEN. FRANKLIN** will open on SB 285.

HEARING ON HB 508 and SB 285

Opening Statement by Sponsor of HB 508:

REP. RUSSELL FAGG, House District 89, Billings, said health care is the issue for the 1990's. **SEN. FRANKLIN** has an excellent bill. Both bills will need some amendments. **REP. FAGG** waived his closing statements.

Opening Statement by Sponsor of SB 285:

SEN. EVE FRANKLIN, Senate District 17, Great Falls, said she is not representing any special interest group for SB 285. SB 285 was instigated by citizens who struggle with access to health care and its cost. The bill provides for universal health care access, health care planning, and cost containment. It sets up an infrastructure, which is called the Montana Health Care authority. This authority is non-partisan, which gives the House and Senate majority and minority leaders the ability to choose individuals with expertise in health care, legislators, and other community members for input. The names will be submitted to the Governor, from which he will choose five, to serve on the health care authority. Five health care planning regions will be set up. There needs to be policy that establishes access for people to services basic to their health care needs. Cost containment is probably the most critical issue. The goal is to not exceed the average annual percentage increase in the gross domestic product by 1999. Health care is not cheap. The focus will be on limiting the degree of escalation.

Proponents' Testimony:

Lieutenant Governor Dennis Rehberg said an old anecdote says that people support reform as long as it doesn't change anything. SB 285 does change things. **Lieutenant Governor Rehberg** said when he was newly appointed he traveled to all 56 counties. Health care was the number one issue. There is no greater fear among people in rural communities than not having access to health care, and affordable health care. SB 285 addresses 60 to 70 percent of the issues raised through the Health Care for Montanans project over the last few years. SB 285 is a good bill and has the support of the Governor's office.

Mark O'Keefe, State Auditor, Commissioner of Insurance and Securities, said although the insurance reform portion may not be exactly what he would like to see in the bill, it is a step in the right direction, and he supports it. **Mr. O'Keefe** reviewed the insurance portion of the bill.

Dr. Peter Blouke, Director, Department of Social and Rehabilitation Services, said health care reform touches everyone's lives. Montana's Medicaid system is part of the state's overall health care system. It is subject to the same

inflationary crisis as other components of the health care system. As Medicaid expenditures continue to grow at the same inflationary rate as experienced during the 1993 and 1995 biennium, by FY 1996-1997, Medicaid will require an additional $66,000,000 from the general fund. To put that amount into perspective, $66,000,000 represents the entire general fund budget for Montana State University and the University of Montana combined. The additional $66,000,000 in general fund money is enough to fund the entire biennium budget of 25 state agencies. Montana must design health care reform for Montanans. SB 285 is not a perfect bill, but it represents a good compromise. It is an important first step toward health care reform. **Dr. Blouke** urged the committee to support SB 285.

REP. JIM RICE, House District 43, Helena, said there are problems with our health care system that need to be addressed. Government does have a proper role in regulating health care. Skyrocketing medical costs are bankrupting our state budget, affecting such programs as workers' compensation and social services. As the cost of health care and health insurance increases, many businesses and individuals are unable to afford it. Consumers are not making medical decisions based upon the economics of supply and demand as they do in their other decision making. The medical market place is not conducive to the making of informed economically based decisions. SB 285 presents an ambitious start in health care reform that we need to make now.

Dave Forbes, Pharmacist. Written testimony. **EXHIBIT 1.**

Teresa Henry, Registered Nurse, presented written testimony from **Kathleen Long, PhD, RNCS, FAAN. EXHIBIT 2.**

John Cadby, Montana Bankers' Association, presented amendments to SB 285 and HB 508 changing the definition of "small employer" to include small banks. **EXHIBITS 3, 4, and 5.**

Lawrence White, President, St. Patrick's Hospital, Missoula, supports SB 285.

Jeff Strickler, MD, Helena Pediatric Clinic, Helena. Written testimony. **EXHIBIT 6.**

Jim Ahrens, President, Montana Hospital Association, said the association is in full support of SB 285. **Mr. Ahrens** presented and reviewed amendments to SB 285. **EXHIBIT 7.**

Bill Leary, President, Montana Coalition on Health Care Cost Containment, read excerpts from the Report of the Health Care Cost Containment Advisory Council. **EXHIBIT 8.**

Steve Turkiewicz, Secretary, MADA, Insurance Trust, Board Member, Montana Association of Health Care Purchasers, supported SB 285 and the amendments presented by **John Cadby.**

Wally Henkelman, Registered Nurse, Member, Montana Nurses' Association. Written testimony. **EXHIBIT 9.**

Bill Olson, American Association of Retired Persons. Written testimony. **EXHIBIT 10.**

Christine Mangiantini, League of Women Voters. Written testimony. **EXHIBIT 11.**

Dr. John Gregory, Past President, Montana Medical Association (MMA), supported SB 285. **Dr. Gregory** presented amendments to SB 285, which he said would restore the bill to its original intent. **EXHIBIT 12.**

Larry Akey, Montana Association of Life Underwriters, said section 27, subsection 1, (j), regarding age rating, should be stricken. The association believes the social function for insurance is the accurate pricing of risk. If the only case characteristics insurance companies can look at is age, the social function of health insurance will be wiped out. The insurance provisions are intended to address the issue of access. The provisions in the bill do not address the issue of affordability of health insurance. If this section is adopted without sufficient cost containment measures, the cost of health insurance will increase, not decrease. The insurance provisions in HB 508 and SB 285 only address the access issue, not the affordability issue. The association believes that SB 285 is a significant step in the right direction.

Tanya Ask, Blue Cross and Blue Shield of Montana. Written testimony. **EXHIBIT 13.**

Tom Hopgood, Health Insurance Association of America, said the association supports SB 285.

Elizabeth Dane, Montana Chapter of the National Association of Social Workers, read testimony from **Susan Swinehart, Social Worker** on behalf of the **Montana Mental Health Providers Coalition. EXHIBIT 14.**

Suzy Holt, Montana Task Force for Biomedical Information, presented the task force's report to the Governor. **EXHIBIT 15.**

Verner Bertelsen, Montana Legacy Legislature. Written testimony. **EXHIBIT 16.**

David Owen, Montana Chamber of Commerce (MCC) supported SB 285.

Jamie Doggett, Montana Cattlewomen, supported SB 285.

Mary McCue, Montana Clinical Mental Health Counselors' Association supported SB 285.

Doug Campbell, President, Montana Senior Citizens' Association.

Written testimony. **EXHIBIT 17.**

Lloyd Anderson, Montana Senior Citizens' Association, supported SB 285.

Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health, supported SB 285.

Dale Pfau, Vice President and General Manager, Don's Inc. Written testimony. **EXHIBIT 18.**

Ted Lange, Northern Plains Resource Council, Big Muddy Resource Council said health care reform is of tremendous importance in Montana's rural communities. **Mr. Lange** urged the committee to support SB 285.

Clyde Dailey, Executive Director of the Montana Senior Citizens Association, Chairman, Montanans for Universal Health Care Coalition. Written testimony. **EXHIBIT 19.**

Christian Mackay, Montanans for Universal Health Care. Written testimony. **EXHIBIT 20.**

John Shontz, Mental Health Association of Montana, supported SB 285.

Chet Kinsey, Montana Senior Citizen's Association, supported SB 285.

Don Judge, Montana State AFL-CIO, supported SB 285.

Dr. Robert J. Ardis, MD, Great Falls. Written testimony. **EXHIBIT 21.**

Lloyd Anderson, Montana Senior Citizen's Association, supported SB 285.

Sharon Hoff, Montana Catholic Conference. Written testimony. **EXHIBIT 22.**

Dan Edwards, International Representative, Oil, Chemical & Atomic Workers International Union, AFL-CIO. Written testimony. **EXHIBIT 23.**

Michael Regnier, Advocacy Coordinator, Summit Independent Living Center; Vice President, Coalition of Montanans Concerned with Disabilities, Missoula. Written testimony. **EXHIBIT 24.**

Elmer Kobold, MD, Great Falls. Written testimony. **EXHIBIT 25.**

John Bartos, Administrator, Marcus Daly Memorial Hospital, Hamilton. Written testimony. **EXHIBIT 26.**

William A. Reynolds, MD, The Western Montana Clinic, Missoula.

Written testimony. **EXHIBIT 27.**

Opponents' Testimony:

Mike Schweitzer, Self. Written testimony. **EXHIBIT 28.**

Jim Fleischmann, Montana People's Action (MPA), said MPA supports SB 285, but cannot support the insurance reform provisions. Representatives of the industry have proposed that a certain section of SB 285 be eliminated, which would allow unlimited use of case characteristics in health status. If this is allowed, the industry will continue to medically underwrite people and place them wherever they want on the huge spectrum being created. Medical underwriting will likely be increased, as it has in other states. The insurance industry understands the system they control. The industry can place people any place on the spectrum, from the lowest rate to the highest, and deny them for practically any reason they choose. The section that limits case characteristics to age must be maintained. SB 285 does not allow any circumvention of the state's mandated health benefits; HB 508 does. The insurance industry claims that mandated benefits are the primary force that drive up the cost of insurance. Mandated benefits at their worst, might add 20% to the cost of the insurance premium according to studies across the nation. Other states that reduced or eliminated mandated benefits have had terrible experiences because of high deductibles and limited lifetime benefits. There is no reason to undo years of legislative activity, which firmly establishes mandated benefits as a basic protection which the people of this state should have in their insurance policies.

Paul Gorsuch, MD, Great Falls. Written testimony. **EXHIBIT 29.**

Dale Schaefer, MD, Great Falls, supports health care reform and the general concepts of SB 285, but cannot support the bill as written because it does not allow for alternatives.

Allyn Christiaens, Montana People's Action, supports most of SB 285, but the insurance portions of the bill are blatantly unacceptable.

Tamy VanderAarde, MD, opposed SB 285.

Dan Shea, Montana Low Income Coalition, said the health care authority is being given an impossible task. Cost control must be placed on doctors; otherwise the sky is the limit. **Mr. Shea** said a lawyer told him when **Dr. Gorsuch** appears in court to give a deposition, he charges a fee of $1,000 an hour. Some people working in the health care industry, who are the very backbone of the medical system don't make $1,000 in a month. **Mr. Shea** disputed testimony that there is about an eight to one advantage in Medicaid because for every $1 Montana spends, the federal government pays $8. **Mr. Shea** said for every $1 Montana pays in Medicaid, which will be close to $75,000,000 this year, the

federal government pays approximately $2. The problem with Medicaid is that the doctors, hospitals, and nursing homes have preferential treatment from Medicaid because there are laws in Washington D. C. that allow them to inflate their costs at will. Social and Rehabilitation Services (SRS) wants caps on attorneys' fees in malpractice cases. SRS has not asked for caps on doctors' fees. That is where the problem lies. **Mr. Shea** suggested the previous Director of SRS, recommended huge increases for medical providers. The director was married to a medical doctor. That is conflict of interest. SRS is part of the problem. St. Peter's Hospital had to lay off people because it overexpanded its physical capacity. If the hospital had been required to obtain a certificate of need to build, there is a strong likelihood it would not have built, and all those employees would not have been laid off. This legislature can still enact legislation reenacting the certificate of need. **Mr. Shea** referred to page 26, section 16, subsection (a), of SB 285, regarding the feasibility of maintaining exemptions from the certificate of need process, and said hospitals should be added to the list.

CHAIRMAN BOHARSKI warned the testifiers that personal comments made about the former Director of SRS and people in the audience were out of bounds. In the future, if anyone speaks in such a manner he will stop them.

Tim Mendenhall, MD, Great Falls, opposed SB 285.

Paul Peterson, Consumer, opposed SB 285.

Bonnie Tippy, Montana Chiropractic Association, opposed SB 285.

Informational Testimony:

None

Questions From Committee Members and Responses:

REP. NELSON referred to **Jim Fleischmann's** statement that the insurance industry claims mandated benefits are the primary factor in premiums going up. **REP. NELSON** asked **Mr. Fleischmann** if claims really drive up premiums. **Mr. Fleischmann** said claims do cause premiums to rise.

REP. SIMON said he didn't see anything in the bill regarding consumer education, which is an important link in cost control. **REP. SIMON** asked **SEN. FRANKLIN** if that could be added to section 1 of the bill, to which she agreed.

CHAIRMAN BOHARSKI referred to an earlier question about moving from Medicaid or Medicare to the new small group employment plan and losing pre-existing condition coverage. He asked **Ms. Ask** if subsection b, lines 13 through 23 covered that situation. **Ms. Ask** said there is a definition of qualifying previous coverage on

page 41 of the bill. If someone was previously covered under Medicare or Medicaid and moved to a small group employment plan within 30 days, he/she will be covered.

REP. BOHLINGER asked **Clyde Dailey** why hospitals aren't listed in section 16, page 26, regarding the consideration of maintaining exemptions from the certificate of need process. **Mr. Dailey** said that section is important just to maintain the ability for the commission to look at the certificate of need. Although hospitals are exempted, they are defined within the certificate of need. **Mr. Dailey** said hospitals could be added to the list but wasn't sure that was necessary.

REP. SMITH asked **Dr. Gorsuch** how the unified health plan would be transferable to other states. **Dr. Gorsuch** said reciprocity would be negotiated with other states. **SEN. FRANKLIN** added, for example, currently Blue Cross and Blue Shield of Montana would pay Montana rates if a BCBS consumer from Montana was visiting Washington and needed medical services.

CHAIRMAN BOHARSKI asked **SEN. FRANKLIN** if the Senate had discussed giving the nine-member commission the discretion to study the need for mandated benefits. **SEN. FRANKLIN** said it had not been discussed in the Senate committee but has been discussed with different groups in the industry and people's action groups.

CHAIRMAN BOHARSKI said a conservative estimate of the cost of mandated benefits would be about 10% to 12%. Taking that into consideration, the bill would raise the costs approximately 10%; therefore, he thought it would be a good idea for the commission to review the need for mandated benefits. The NAIC model bill did not have mandated benefits. Now the Senate has taken the position to either take freedom of choice out or leave mandated benefits in. It seems that the commission's hands are tied, trying to come up with a basic plan. Their basic plan is what is already in Montana law. **SEN. FRANKLIN** referred to earlier testimony that if basic plans are too basic, they are not all that valuable.

REP. SAYLES asked **SEN. FRANKLIN** about the political makeup of the people on the board. **SEN. FRANKLIN** said the mechanism needs to be one that finds people who are committed to the content of the discussion, who are not wedded to either politics or personal gain. There are risks involved no matter what choices people make.

<u>Closing by Sponsor</u>:

SEN. FRANKLIN said there is no quick fix. Everyone involved will have to give up something that is probably perceived as very significant to them. **SEN. FRANKLIN** said she would reserve any further discussion until Friday.

ADJOURNMENT

Adjournment: 8:10 p.m.

Wm E Boharski

WILLIAM BOHARSKI, Chairman

Alyce Rice

ALYCE RICE, Secretary

WB/ar

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13

Testimony

ɛed to the Authority:

rged with drafting a statewide universal health ın based on a single payer system and a ɔr a statewide universal access plan based on a .e payer system - both plans will be submitted to ɛo be considered during the 1995 session.

same rate as those serving on state boards and

ıploy a fulltime executive director

ıploy professional and support staff

ased upon regions comprised of counties already ɛhe Department of Health and Environmental Sciences.

ing Boards - one for each region. Each county will tative on the regional board for the region in which ıocated.

Regional Board Membership - will be done by the

ional Boards - advise the Authority, funded by grants .ority, will draft a health resource plan for the ɔe involved in consumer education.

collection. If appropriate planning and cost easures are going to become reality, then appropriate ɔe collected. Various state agencies collect data but data often are not shared with other programs. various programs and various health care providers using different formats. A central authority needs to ɔle for all data collection so that appropriate ın be made. Finally, all parties - providers and well - need appropriate data upon which to base their

all payer system. This is a confusing term but as I it, it essentially means that all payers i.e. private - must pay the same rate for similar health care ndered. This real issue here is "cost shifting" which ɛovided for equitable reimbursement to health care In other words, too often hospitals and other health lers have to subsidize, for example, Medicaid patients, ɡ either private pay or privately insured individuals ler to break even and/or stay in business. I have heard al CEO state that he believed his hospital could charge less for services rendered to privately insured patients programs would pay actual cost.

EXHIBIT 1
DATE 3/24/93
SB 285

Finally, a few additional thoughts. Some people will ask for a market based medical system as an option. There is, in my opinion, no such system. But, more importantly, the United States has tried to allow a health care market system to function. However, health care information or knowledge is far too complex to allow for a market based system to function. Especially so when the end user i.e. the patient, does not, in most cases, pay for the services provided. It is not like buying a car or groceries at the market. As I see it, the bottom is this - whether health care professionals are paid via fee for service or salary, the concept of a "professional person" is such that the needs of a client (patient) are placed above those of the person providing the service.

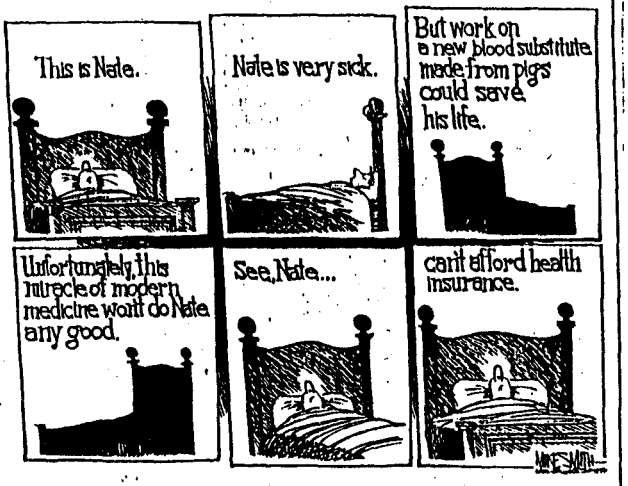
Thank you for the opportunity to share my views with respect to SB 285.

EXHIBIT 1
DATE 3/24/93
SB 285

HEALTH CARE

There must be a remedy for this diseased system

By DAVE FORBES



Who is to blame for the shortcomings of the U.S. health-care system? People often point the finger of blame at the government and lawyers. But the facts simply don't support blaming those sectors of society for the imperfections of the health-care system.

With respect to the government, the Medicare program commenced in 1966 as a basic health insurance program for the elderly. Before then many elderly went without adequate health care. While many health care professionals opposed this federal plan as socialized medicine, most knowledgeable people would agree that this program was needed and has been quite soundly managed.

With respect to lawyers, it is my belief that the court system through malpractice suits has done more to upgrade standards of the health-care professions than have professional societies or the professions themselves. Everyone wants his own lawyer to be meaner than a junkyard dog but the other guy's lawyer should be afraid to sue.

What of the U.S. health-care system? Are there better systems present in other countries? Maybe. Is our system, on balance, serving society as we might expect? Maybe and maybe not. Remember the phrase — "It depends on whose ox is being gored"?

Most of us do not know or even have any idea of the cost of various health-care procedures. Why? Because we do not pay for these procedures, at least not out of our own pockets. One of the most clever strategies ever put in place by any industry was the creation of the third-party pay system (health insurance) with the consumer and the provider being the first and second parties and the fiscal intermediary (which processes the claims) being the third party. Also, keep in mind that most of us would generally consider insurance as protection from unforeseen circumstances, such as fire and auto damage. However, you can be quite certain that you will be in need of medical care sometime during your lifetime. So it appears that health insurance is really not insurance but a system of payment of society's health care expenditures (that is, except for the approximately 37 million Americans who have no health insurance). Also, we don't pay taxes on these benefits, as we do for our salaries or wages.

Who ultimately pays for health care? You and I do, of course, but most of us do not need to budget much, if any, of our disposable income for health care like we do for housing, food, clothing, education, transportation, etc.. If you work for state government, like I do, then taxpayers pay the monthly health insurance premiums. If you work in the private sector and if you are fortunate enough to work for an employer who provides you with health insurance as a fringe benefit, then the consumers who buy your goods or services pay for your health insurance premiums as part of the purchase price of those goods and services.

I have no quarrel with the health insurance industry but I do refer to the present system as "the anesthetic on our pocketbooks." That is to say that if you and I do not directly pay for our medical care, then do we care about the level of prices charged for these medical care services? The answer in both cases is we do not.

If value is received by health-care consumers for medical services rendered then why should we be alarmed if health-care expenditures are approximately 12 percent of our gross national product? No good reason as far as I can see. It is not the health-care system's fault that we have a large federal deficit or that the savings and loan industry bailout will cost us billions or that Saddam Hussein is a lunatic.

I was born in the mid-'40s, and when I was a youngster polio was feared by my parents. Medical care was inexpensive but there was not much medical care available to purchase. Since then our society has spent billions on research and to state that there is now much more medical care available than there was years ago is one of the great understatements of all time. New technology costs money, lots of money, and of course, all of us want the best for ourselves and our families.

What is the answer? I do not know. Funerals are cheap compared to health care. Do we want to turn the clock back to where the physician spent much of his or her time consoling patients because there was little medical care available? Years ago people died at younger ages and it appeared to be at a lesser cost to society.

I doubt that we want to turn the clock back to those times. It seems to me that if we can find money to bail out the savings and loan industry and to successfully fight Desert Storm then we can find ways to work together as consumers, providers, federal and state governments and the health insurance industry in order to provide health care to all our citizens.

Dave Forbes is dean of the School of Pharmacy & Allied Health Sciences at the University of Montana.

EXHIBIT 2
DATE 3-24-93
SB 285

S.B. # 285

Testimony of Kathleen Ann Long, PhD, RNCS, FAAN
presented by Theresa Henry, MS, RN

HEALTHMONTANA HEARING BEFORE THE HUMAN SERVICES AND AGING COMMITTEE OF THE MONTANA HOUSE OF REPRESENTATIVES
March 24, 1993

Honorable Committee Members:

I am Teresa Henry and I am presenting testimony on behalf of Kathleen Long, who is unable to be present. Dr. Long is a registered nurse, certified for advanced practice nursing. For the past 12 years, she has been involved in direct patient care and nursing education in Montana. She served as a co-chair of the Citizen's Committee which assisted in drafting the HealthMontana legislation.

Her testimony is as follows:

I would like to speak to you about the cost containment aspects of the bill. The following background facts may be helpful to you as you consider the cost containment issue.

- In October, 1992, the Congressional Budget Office reported that lack of restraint in the health care industry, unless changed, will cost this nation $1.7 trillion by the year 2000.

  In 1965, health care costs consumed 6% of our Gross Domestic Product; that percent grew to 12 in 1990 and is projected to be 18% by the year 2000.

- If uncontrolled, national health care costs are anticipated to increase by $500 billion between 1990 and 1995, and this will occur while over 60 million Americans are without adequate health care (National Leadership Coalition for Health Care Reform) -- a situation which ultimately results in tremendous social costs due to lost productivity and eventual reliance on social welfare programs.

- Despite these enormous expenditures, we do not have an enormously successful health care system. It is true that millions of persons receive highly sophisticated, technologically advanced health care. However, our health care is not fairly or equitable delivered; a fact which is readily apparent in many areas of Montana.

  - In a recent comparison with ten other developed nations, the United States ranked last in the delivery of primary health care -- that is health promotion, disease prevention and early intervention -- precisely the type of health care that is most cost-effective (National League for Nursing, 1991).

  - Many diseases once thought eradicated, such as tuberculosis and measles, are now reaching epidemic proportions.

I expect that what is of most interest to you are facts which are specific to Montana.

- Over the last 10 years, the average Montana family's spending on health care rose 382% faster than wages.
- Business spending for health insurance coverage rose by more than 280%.
- Medicaid spending has become the fastest growing sector of Montana's budget, now consuming over 15% of the general fund.
- Despite these expenditure increases, over 100,000 Montanans are not covered by any type of health care program.

Clearly, something is very wrong with the status quo.

Cost containment tends to be a distasteful aspect of any bill. It conjures up notions of governmental interference. It is certain to be opposed by those whose incomes may be affected.

Nevertheless, I believe the facts speak for themselves. Cost containment is an essential part of any health care reform bill. The HealthMontana bill offers a rational, phased-in approach to cost containment. It provides for a five year period of adjustment to bring costs into line with the Gross Domestic Product, and allows for consideration of factors such as population increase and unanticipated provider costs. The bill specifically addresses advance budget planning to prevent precipitous closures of health care facilities or loss of health care services. The cost containment measures proposed in the HealthMontana bill, including the global budgeting provisions, have been extensively studied at the national level, and have been found to be appropriate and effective. Global budgeting is necessary for cost containment. Reimbursement based on the service provided, rather than the discipline of the provider ensures cost-effective delivery of health care.

In summary, HealthMontana's cost containment provisions require us to live within our means while improving access to the most cost-effective forms of health care.

Each constituency involved in health care -- consumers, payers, and providers -- will be required to make compromises if we are to reform and improve health care delivery in Montana, and ultimately throughout this nation. As you weigh this difficult matter, I trust in your ability to discern vested interests. Those who oppose health care reform, including cost containment, should bear the burden of justifying the outrageous costs and inadequate service in our current system.

Health care reform in Montana is both an ethical imperative and an economic necessity. The HealthMontana bill is a comprehensive, well-reasoned approach to such reform.

Thank you for allowing me the opportunity to speak, and for your work on this critically important issue.

EXHIBIT 3
DATE 3-24-93
SB 285

PROPOSED AMENDMENTS TO SENATE BILL 285

AMEND SECOND READING BILL, Section 24, subsection (24), page 42 of bill, lines 7-16 as follows:

(24) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation , or that are members of an association that has been in existence for one year prior to (the effective date of this act) and that provides a health benefit plan to the employees of its members as a group, are considered one employer.

EXHIBIT 4
DATE 3-24-93
HB 508

PROPOSED AMENDMENTS TO HOUSE BILL 508

AMEND INTRODUCED BILL, Section 3, Definitions, subsection (24), page 9 of bill, lines 12 to 21, as follows:

(24) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation , or that are members of an association that has been in existence for one year prior to (the effective date of this act) and that provides a health benefit plan to the employees of its members as a group, are considered one employer.

EXHIBIT 5
DATE 3-24-93
285

PARTICIPATING BANKS IN MONTANA

United Bank, Absarokee
Bank of Baker, Baker
Belt Valley Bank, Belt
Big Sky Western Bank, Big Sky
Citizens Bank & Trust, Big Timber
First Boulder Valley Bank, Boulder
First Citizens Bank, Bozeman
Blackfeet National Bank, Browning
First Citizens Bank, Butte
Stockmens Bank, Cascade
Western Bank, Chinook
Citizens Bank, Choteau
First Security Bank, Deer Lodge
Farmers State Bank, Denton
State Bank & Trust Co., Dillon
Dutton State Bank, Dutton
First National Bank Ekalaka
First Madison Valley Bank, Ennis
First National Bank, Fairfield
First State Bank, Froid
First National Bank, Geraldine
First Fidelity Bank, Glendive
Citizens State Bank, Hamilton
Little Horn State Bank, Hardin
Continental National Bank, Harlowton
First National Bank, Hinsdale
First National Bank, Hysham
First Security Bank, Laurel
First National Park Bank, Livingston
First State Bank, Malta
Manhattan State Bank, Manhattan
Flint Creek Valley Bank, Philipsburg
Montana National Bank, Plentywood
First Citizens Bank, Polson
Traders State Bank, Poplar
U.S. National Bank, Red Lodge
Richey National Bank, Richey
First Security Bank, Roundup
Lake County Bank, St. Ignatius
Citizens State Bank, Scobey
First Valley Bank, Seeley Lake
First United Bank, Sidney
State Bank, Townsend
Ruby Valley National Bank, Twin Bridges
First National Bank, White Sulphur Springs
Western National Bank, Wolf Point
Farmers State Bank, Worden

PARTICIPATING BANKS IN WYOMING

Frontier Bank, Cheyenne
Western Bank, Cheyenne
Converse County Bank, Douglas
Dubois National Bank, Dubois
State Bank, Green River
Bank of Laramie, Laramie
Riverton State Bank, Riverton
First State Bank, Thermopolis

EXHIBIT 5
DATE 3/24/93
SB 285

REPORT NO. DHC518H — LIMITED LIABILITY GROUP PAID BASIS REPORT FOR GLUG 02H68 — PAGE NO. 4,037 — RUN DATE: FEB 05 93

POLICY NO. 24-02H68 — ST BANKERS ASSOC GRP BF, 1 N LAST CHANCE GULCH, HELENA MT 59601 — REPORT SEQUENCED BY: POLICY NO., EXP COMB CODE, SERVICE OFFICE, FROM 2/91 THRU 1/93, PAGE 1 OF 1 — POLICY NO. 24-02H68

REG SERVICE OFFICE	COMB CODE	PRODUCT	RISK	FUNDING METHOD	SPECIAL LINES	EFFECTIVE DATE	CANCEL DATE	RATE RENEWAL DATE
MINNEAPOLIS	0225	HEALTH/MEDICAL	RETEN	LIM LIAB		1/01/90		10/01/92

****

H E A L T H A N D A C C I D E N T

DATE	ENROLLMENT COUNT	MEDICAL PREMIUM	+ DEPOSIT	= TOTAL FUNDS	PAID CLAIMS FROM DEPOSIT FUNDS	+ FROM INS. CO. FUNDS	= TOTAL CLAIMS	DRAFT COUNT	MEDICAL CLAIM RATIO	AD & D PREMIUM	AD & D CLAIMS
02/91	789	150,550	0	150,550	0	96,254	96,254	344	63.9	0	0
03/91	783	148,654	0	148,654	0	77,335	77,335	253	52.0	0	0
04/91	785	149,921	0	149,921	0	104,679	104,679	374	69.8	0	0
05/91	780	147,672	0	147,672	0	95,582	95,582	340	64.7	0	0
06/91	773	147,757	0	147,757	0	62,936	62,936	345	42.6	0	0
07/91	774	147,756	0	147,756	0	88,882	88,882	420	60.2	0	0
08/91	779	147,945	0	147,945	0	95,399	95,399	419	64.5	0	0
09/91	773	148,025	0	148,025	0	91,348	91,348	345	61.7	0	0
10/91	785	150,342	0	150,342	0	128,780	128,780	501	85.7	0	0
11/91	785	148,044	0	148,044	0	144,025	144,025	464	97.3	0	0
12/91	788	149,045	0	149,045	0	134,359	134,359	486	90.1	0	0
SUB TOTAL	781A	1,635,711	0	1,635,711	0	1,119,579	1,119,579	4,291	68.4	0	0
MEMO ITEM		110,059 TD									
01/92	787	152,972	0	152,972	0	91,648	91,648	491	59.9	0	0
02/92	819	22,409	130,839	153,248	101,632	46,277	147,909	445	96.5	0	0
03/92	783	20,219	123,398	143,617	183,117	12,802	195,919	344	136.4	0	0
04/92	774	21,400	126,831	148,231	144,641	40,665	185,306	413	125.0	0	0
05/92	745	20,625	122,434	143,059	45,419	33-	45,386	361	31.7	0	0
06/92	746	20,659	122,548	143,207	131,556	1,015-	130,541	373	91.2	0	0
07/92	716	20,173	120,152	140,325	118,554	0	118,554	448	84.5	0	0
08/92	735	20,336	120,831	141,167	187,490	104-	187,386	354	132.7	0	0
09/92	716	20,173	120,152	140,325	83,135	0	83,135	293	59.2	0	0
10/92	716	20,173	120,152	140,325	93,222	24,643	117,865	590	84.0	0	0
11/92	734	20,463	121,821	142,284	101,250	3,026	104,276	465	73.3	0	0
12/92	731	20,359	120,939	141,298	78,318	4,793	83,111	489	58.8	0	0
SUB TOTAL	750A	379,961	1,350,097	1,730,058	1,268,334	222,702	1,491,036	5,066	86.2	0	0
01/93	731	20,359 *	120,939	141,298	137,676	0	137,676	595	97.4	0	0
SUB TOTAL	731A	20,359	120,939	141,298	137,676	0	137,676	595	97.4	0	0
GRAND TOT	764A	2,036,031	1,471,036	3,507,067	1,406,010	1,342,281	2,748,291	9,952	78.4	0	0

EXHIBIT 6
DATE 3-24-93
SB 285

HELENA PEDIATRIC CLINIC

Elizabeth P. Gundersen, M.D.
Jeffrey H. Strickler, M.D.
John A. Reynolds, M.D.

1300 N. Montana Ave.
Helena, Montana 59601
Phone 406/449-5563

24 March 1993

To: Chairman and Members of the House Human Services and Aging Committee

From: Jeffrey H. Strickler, M.D.
past president, Montana Academy of Pediatrics
member, national AAP Council on Government Affairs

Re: S.B. 285

I speak as a member of the Montana Chapter of the American Academy of Pediatrics in support of this bill. The pediatricians have lobbied for many years in Washington, D.C. for universal access to care for all children and pregnant women and for the expansion of preventive health services. We are very pleased with this bill by Sen. Franklin as it incorporates all of the tenets of our effort. For this alone, your children's doctors urge its passage.

However, I am here also to speak to the concept of cost containment and global budgeting. We cannot continue with business as usual. The fiscal realities of our society demand that we establish priorities in the delivery of health care and revise the way we pay for it.

I have supporting letters from other officers in our organization, Dr Dan Harper of Missoula, Dr. Dennis McCarthy of Butte, and Dr. Jim Feist of Bozeman, but let me give you a personal example. I am a member of a four person pediatric group here in Helena and recently finished a review of our year end 1992 business. Last year we recieved 51% of all revenues as cash payments - no Medicaid, not insurance. This is out of pocket expense for parents. Fifty one percent! How are we going to insure proper preventive services and immunizations for our children when so much of the expense falls directly on young parents? How can we say that we have a system that provides access to care when insurance doesn't cover this much of the cost of pediatric care? And, worse, these figures don't reflect the children who never came in to my office because their parents couldn't afford it!

We must restructure the delivery of health care. If we are to have universal access to care and an emphasis on prevention, we cannot have an open checkbook. A global budget is mandatory to establish these new priorities. To do so without a budget is just bad business practice, and would be improper for you as stewards of the taxpayer's dollar.

Please maintain a strong cost- containment and global budget provision as you give SB 285 a do pass recommendation.

DANIEL A. HARPER, M.D.
Pediatrics and Neonatology
2825 Fort Missoula Road
Missoula, MT 59801

Phone 721-0858

EXHIBIT 6
DATE 3/24/93
SB 285

March 19, 1993

Jeffrey Strickler, M.D.
1300 North Montana Avenue
Helena, MT 59601

Dear Dr. Strickler,

I support Senate Bill 285 which is dedicated to improving health care for Montanans. The present situation in Montana is clearly not adequately able to meet the needs for women and children in particular. I strongly endorse the importance of universal access and strongly endorse the concept of preventative health care for our children. If in order to achieve a reprioritization of our health care dollars global budgeting is necessary, then I would support global budgeting.

Sincerely,

Daniel A Harper MD

Daniel A. Harper, M.D.

Butte Pediatric and Teen Clinic
diseases of children & adolescents
630 west mercury
butte, montana 59701
dennis j. mc carthy m.d.
linda j. rogers m.d.
cynthia edstrom m.d.
elaine stasny m.d.

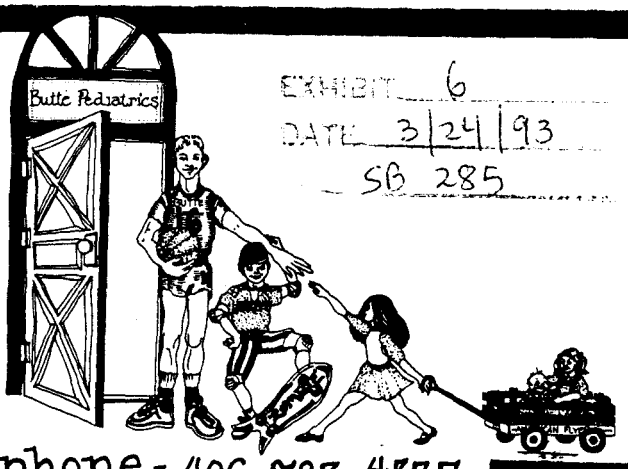


EXHIBIT 6
DATE 3/24/93
SB 285

phone - 406-723-4337

March 18, 1993

Jeff Strickler, M.D.
1300 North Montana Avenue
Helena, MT 59601

Dear Jeff:

Pursuant to our phone conversation today, I acknowledge my support of Eve Franklin's Health Bill. To achieve one of the ends of universal access to preventative pediatric care, a global budget with obvious cost constraints on the other end must be considered. I am, thus, also in support of this part of the package.

If you or any of the legislators have specific questions they would like to direct to me, please do not hesitate to call or write.

Yours truly,

Dennis J. McCarthy, M.D.

DJM/rb

EXHIBIT 7
DATE 3-24-93
SB 285

MHA Antitrust Amendments

Amendments to Senate Bill No. 285
Third Reading Copy

Requested by Sen. Towe
For the Committee on Human Services and Aging

Prepared by David S. Niss
March 23, 1993

1. Title.
Page 2, line 9
Following: "ACT;"
Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY;"

2. Page 6.
Following: line 5
Insert: "(6) A statement of intent is also required for this bill because [section 44] requires the authority to adopt rules implementing [sections 37 through 44]. The rules adopted by the authority must specify the form and content of applications for certificates of public advantage; details of the reconsideration, revocation, hearing, and appeal processes; and such other matters as the authority determines necessary. The rules adopted by the authority must also provide the authority with direct supervision and control over the implementation of cooperative agreements between facilities."

3. Page 7, line 14.
Following: "20"
Insert: "and 37 through 44"

4. Page 7.
Following: line 18
Insert: "(3) "Certificate of public advantage" or "certificate" means a written certificate issued by the authority as evidence of the authority's intention that the implementation of a cooperative agreement, when actively supervised by the authority, receive state action immunity from prosecution as a violation of state or federal antitrust laws.
(4) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory

facilities or procedures; or other services customarily offered by health care facilities."

Renumber: subsequent subsections

5. Page 10.
Following: line 15
Insert: "(8) The attorney general is an ex officio, nonvoting member of the authority only for the purpose of the authority's approval or denial of certificates of public advantage, supervision of cooperative agreements, and revocation of certificates of public advantage pursuant to [sections 37 through 44]."

Renumber: subsequent subsection

6. Page 22, line 17.
Strike: "shall"
Insert: "may"
Following: "legislation"
Insert: "in addition to [sections 37 through 44]"

7. Page 73.
Following: line 8
Insert: "NEW SECTION. **Section 37. Finding and purpose.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of [sections 37 through 44] is to provide the state, through the authority, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws.

NEW SECTION. **Section 38. Cooperative agreements allowed.** A health care facility may enter into a cooperative agreement with one or more health care facilities.

NEW SECTION. **Section 39. Certificate of public advantage -- standards for certification -- time for action by authority.** (1) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed agreement, a description of the scope of the cooperation

contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The authority may not issue a certificate unless the authority finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the authority denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the authority not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The authority shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application. When considered necessary or appropriate by the authority, it may hold a public hearing on the application.

NEW SECTION. **Section 40. Reconsideration by authority.** (1) If the authority denies an application and refuses to issue a certificate, a party to the agreement may request that the authority reconsider its decision. The authority shall reconsider its decision if the party applying for reconsideration submits the request to the authority in writing within 30 calendar days of the authority's decision to deny the initial application.

(2) The authority shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The authority shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the authority must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

NEW SECTION. **Section 41. Revocation of certificate by authority.** (1) The authority may revoke a certificate previously granted by it if the authority determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the authority without giving notice and an opportunity for a hearing before the authority as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the authority within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the authority shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the authority, the agreement for which the certificate was issued is terminated.

NEW SECTION. **Section 42. Appeal.** A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the authority to deny an application for a certificate or a decision by the authority to revoke a certificate. A revocation of a certificate pursuant to [section 41] does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

NEW SECTION. **Section 43. Record of agreements to be kept.** The authority shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to [section 37 through 44]. A party to a cooperative agreement who terminates the agreement shall notify the authority in writing of the termination within 30 days after the termination.

NEW SECTION. **Section 44. Rulemaking.** The authority shall adopt rules to implement [sections 37 through 43]. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by [sections 37 through 43], and appeals; and

(3) to effect the active supervision by the authority of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect."

Renumber: subsequent sections

8. Page 73, lines 10 and 12.
Following: "20"
Insert: "and 37 through 44"

9. Page 73, line 17.
Strike: "37,"
Insert: "44, and 45,"

EXHIBIT 8
DATE 3-24-93
SB 285

Report of the Health Care Cost Containment Advisory Council

State of Montana
January 1987

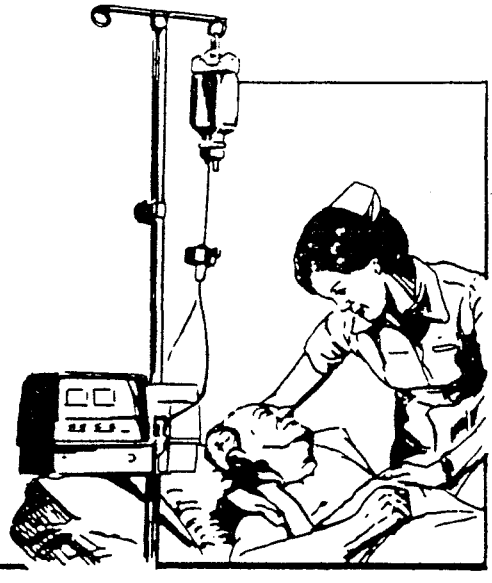


EXHIBIT 9
DATE 3-24-93
SB 285

Montana Nurses' Association

P.O. Box 5718 • Helena, Montana 59604 • 442-6710

TESTIMONY ON SB285 Before the House Human Services and Aging Committee: "An act Providing for Universal Health Care Access, Health Care Planning, and Cost Containment ....".

BY: Wally Henkelman, RN, member of the Montana Nurses Association and a Clinical Nurse Specialist practicing in Great Falls.

The Montana Nurses Association (MNA) is the professional organization and authoritative voice of Registered Nurses in Montana representing approximately 1400 members across the state in a variety of health care and educational settings. All of the programs of MNA have as a primary goal the provision of quality health care for the citizens of Montana.

SB285, which has been presented after an enormous amount of collaborative effort by a committee with a diversity of professional backgrounds has three major purposes:

Increasing access to health care for Montanans

Maintaining or increasing the quality of health care

Maintaining or decreasing health care costs

Both the body of the bill (sections 1-21) and the "Small Employer Health Insurance Availability Act", (sections 22-36) specifically address all of these areas in a very positive manner. These

purposes are certainly consistent with the goals of our association and deserve our support.

There are those who will propose to the committee or on the House floor that the bill be amended. In your consideration of those suggested amendments I urge the committee to ask three questions:

1. Does the amendment increase access to health care services ?
2. Does the amendment address the quality of health care services ?
3. Does the amendment help control the costs of care ?

I suspect that the explicit or implicit focus of most amendment proposals will not be related to those issues, but to possible limitations on reimbursement for health care services or products. We must all be aware, however , that significant health care reform must include cost containment which we know from experience has not been successful without limitations on reimbursement.

MNA strongly supports SB285 and urges you to forward this historic piece of legislation to the floor with a "do pass" recommendation.

EXHIBIT 10
DATE 3-24-93
SB 285

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

SECRETARY
Mrs. Florence R. Coslet
312 Cook Street
Lewistown, MT 59457
(406) 538-2674

AARP Testimony
Health Care Bill SB 285
House Hearing March 24, 19

Mr. Chairman & Members of The Committee:

For the record, my name is Bill Olson and I am a member of the State Legislative Committee of AARP(American Association of Retired Persons). AARP has approx.110,000 members in the State of Montana-one for every eight persons in the state. AARP members are 50 years of age or older.

On behalf of the AARP State Legislative Committee, I appear in support of SB 285. This piece of legislation is extremely important to the citizens of Montana as it is the initial step in much needed Health Care Reform.

On a National level, AARP has developed a plan known as Health Care America. Providing health care for all is the primary goal of the plan, as it should be for any health reform plan. AARP's Health Care America calls for a multiple payor system as opposed to a single payor plan. SB 285 provides for the authority to recommend plans for both types, as outlined in Section 5,lines 11-24 on page 12. This concept we support.

The bottom line is that Health Care Reform legislation as proposed in SB 285, is urgently needed and AARP urges your committee's favorable consideration.

Thank you.

William Olson

EXHIBIT 10
DATE 3/24/93
SB 285

MONTANA STATE LEGISLATIVE COMMITTEE

AARP

Bringing lifetimes of experience and leadership to serve all generations.

CHAIRMAN
Mr. Gene Quenemoen
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(406) 388-6982

VICE CHAIRMAN
Mrs. LeDean B. Lewis
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SECRETARY
Mr. Robert J. Souhrada
915 - 13th Street West
Columbia Falls, MT 59912
(406) 892-4642

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**

EXHIBIT 10
DATE 3/24/93
SB 285

MONTANA STATE LEGISLATIVE COMMITTEE

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(406) 538-2674

AARP

Bringing lifetimes of experience and leadership to serve all generations.

HEALTH CARE REFORM

AARP'S KEY MESSAGES

For more information contact
Barbara Herzog, Director
AARP Health Care America
601 E. Street, N.W.
Washington, D.C. 20049
Phone (202) 434 2277

- Cost Containment: Across-the-board limits on the amount of money we, as a nation, pay for all health care services (e.g., hospitals, doctors, nursing homes and other health care providers). Cost containment should apply to both Medicare and non-Medicare services.

- Universal Access: All Americans should be able to receive health care--both prevention and treatment, including prescription drugs--when needed, and have adequate financial protection against health care costs.

- Long-term Care: Individuals, of any age, should have access to long-term care--either home/community-based or nursing home services--when they are needed, without fear of impoverishment.

- Fair Financing: Financing of the health care system should be equitable, broadly based, and affordable to all individuals.

- Comprehensive Reform Legislated in a Package: Implementation of comprehensive reform, including long-term care, should be based on a comprehensive package that is enacted all at once, but could take effect over time.

Compare against tape.

EXHIBIT 11
DATE 3-24-93
SB 285

Mister Chairman and members of the Committee my name is Christine Mangiantini and I am the registered lobbyist for the League of Women Voters.

Statewide and nationally the League supports legislation that

1. provides access to a minimum basic level of care for all residents

2. a system that controls health care costs

3. the ability or lack of a patient to pay for services should not be a consideration to receiving necessary medical care

4. support health care policies that include equitable distribution of services, efficient delivery of care, advancement of medical research and technology.

Senate Bill 285 encompasses all of these positions and provides an opportunity for the medical community, the insurance industry, and Montana residents to come together and craft health care legislation that meets the needs of our taxpayers.

Let us not sacrifice this opportunity ~~by giving way to special interests whose vision is parochial and short-term.~~

Mister chairman and members of the Committee before you today is the vehicle to change the way we do business in the health

care industry--for everyone and for the long-term.

The League of Women Voters urges passage of Senate Bill 285.

Thank you.

Boards

5 H.C. Planning Regions — Rep. from each county to represent

p. 15 · cost containment.

(R's) Rehberg - for

Sect. 30 - Reinsurance ~~Bd~~. Pool

Jim Rice

(portability - allowing consumer to switch coverage among small insurers.

EXHIBIT 12
DATE 3-24-93
SB 285

MMA PROPOSED AMENDMENTS TO SENATE BILL 285

Page 13, Line 18
Following: {Section 5}
Insert: "should consider"
Strike: "must contain"

Page 15, Line 1
Following: "plans"
Insert: "should consider"
Strike: "must contain"

Page 15, Line 16
Following: "authority"
Insert: "may consider:
Strike: "shall include"

Page 16, Line 21
Following: "plan"
Insert: "should consider"
Strike: "must contain:

Page 20, Line 2
Following: "plan"
Insert: "should consider"
Strike: "must contain"

Page 21, Line 11
Following: "authority"
Insert: "should consider"
Strike: "must include"

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

EXHIBIT 13
DATE 3-24-93
SB 285

TESTIMONY ON SB 285
Before House Human Services and Aging

Presented by Tanya Ask
Blue Cross and Blue Shield of Montana
March 24, 1993

Blue Cross and Blue Shield of Montana has worked hard over the last two years with a number of other Montana groups, institutions, businesses and individuals towards real health care reform for the citizens of our state. Health care costs and utilization have expanded beyond our abilities to pay. Hospitals, doctors, counselors, patients and insurers all need to be a part of the solution.

We testified in favor of Senate Bill 285 in the Senate, and have told a number of you and your fellow representatives of our continuing support for this bill. While issues such as practice parameters, prioritization of services, allocation of health care resources and the like deserve extensive discussion and careful deliberation, I will address two facets of this bill--Cost Containment and Health Insurance Reform.

In discussions we had with many of you last December, we at Blue Cross and Blue Shield of Montana stated our support for the type of insurance reform contained in Senate Bill 285. (Attached is a copy of the White Paper developed jointly by the Montana Hospital Association, the Montana Medical Association and Blue Cross and Blue Shield of Montana which identifies these reforms.) While this reform measure imposes insurance reform on the small group marketplace immediately, and studies reform for the entire marketplace to be reviewed by the Legislature in 1995, this approach is important. The vast majority of Montana employers are small businesses. We can correct some of the problems in the insurance marketplace now, begin reform now by imposing portability of coverage; allowing insurers to cancel or nonrenew coverage, **NOT** because of the health risk or claims experience of a groups or an individual within a group, but only for reasons like nonpayment of premiums; imposing rate bands on rates charged for coverage, shrinking the difference in premiums between one group and another; and guaranteeing access to health insurance coverage regardless of an individuals health status.

We have also stated that this reform is not without a cost. As you narrow the difference in rates between healthier groups and those with more health problems, many people are going to see an

increase in the cost of health insurance. That's what happens when you truly spread risk, not just insure those in good health. You need to be aware of this cost.

The small group reform proposed here will have even greater price ramifications to employers without meaningful health care cost control. Insurance prices are a symptom of the overall problem - price increases for services coupled with increased demands for services and utilization of those services by all of us. Without controlling those costs, the price we pay will only increase in direct proportion.

There is a major problem with Senate Bill 285 as it comes to you from the Senate. Subsection (j), lines 7-9 on page 48 needs to be removed. This section currently allows only one case characteristic - age - to be used in determining the premium rates for a group. That would mean the only characteristic that could be used in developing a rate for a group would be the age of the members in the groups without allowing consideration of any other demographic information about the group. This would result in an overnight return to community rating - a move that Montana small businesses could not absorb financially overnight. Subsection (j) also presents internal conflicts with other portions of the bill. We propose an amendment removing this provision and renumbering the subsequent provision to prevent this disaster. The sponsor of the bill has agreed she will not oppose this amendment.

We urge the passage of this very important bill with the amendment to remove section (j) on page 48.

EXHIBIT 13
DATE 3/24/93
SB 285

Blue Cross and Blue Shield of Montana

Amendment to Senate Bill 285

PROPOSED AMENDMENT

SB-285

Page 48, lines 7 through 9, Strike: "(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner."

Page 48, line 10, Strike : (k)
Insert : (j)

END OF AMENDMENT

HEALTHCARE MONTANA II

EXHIBIT 13
DATE 3/24/93
SB 285

WHITE PAPER

The following paper presents the proposed policy positions for HEALTHCARE MONTANA, a collaborative effort of Blue Cross and Blue Shield of Montana, the Montana Hospital Association and the Montana Medical Association. These positions were proposed and considered by a number of discussion groups at Healthcare Montana at Big Sky in June and again at Healthcare Montana II in Billings. Once approved by the Steering Committee and recommended to the respective sponsoring organizations' boards, the proposed policy positions will form the basis for the development of legislative proposals and organizational programs for health care reform in the state.

The paper addresses the seven common health care reform questions identified by Robert J. Blendon, Jennifer N. Edwards and Andrew L. Hyams in their article entitled "Making The Critical Choices," published in the May 13, 1992, edition of the Journal of the American Medical Association. The responses represent the sponsoring organizations' thoughts going into the September 19 and 20 meeting in Billings, and a synthesis of the thoughts of those attending that meeting. Some of the questions have been modified slightly to suit the circumstances in Montana.

1. **Should everyone be guaranteed access, by law, to a health insurance plan?**

   Yes. The goal is that every Montanan should have access to a basic benefits package.

   It is recommended that the State Legislature in 1993 create an independent board to make recommendations to the 1995 Legislature on several aspects of health care reform: these would include universal access, cost controls, and the definition of what is included in a basic benefit package. Such a package should emphasize preventive services and primary care. The design must also encourage improved consumer awareness in the use of health care resources. Recommendations also should be made concerning whether or not to cover long-term care, and if so, what level of service to cover and at what point in the reform transition process, and what level of mental health services should be included. The proposed position of HEALTHCARE MONTANA on coverage of these services is stated below under item 5.

   The independent board must consist of physicians, hospitals, payers, consumers, and should be no more than five members.

2. **How do we provide universal coverage?**

   The objective of universal coverage is to avoid cost shifting, which has led to the imbalance in health care financing.

   Several options are being debated at the national level, including a single-payer option, a "play or pay" option, an employer mandate or "mandated play" option, and an individual responsibility option often referred to as the "consumer choice" option.

None of these options has won overwhelming support from the HEALTHCARE MONTANA Billings conference participants. The single-payer option, especially if the payer is the government, received very little support in this process. The "play or pay" option is viewed as being a back door to single payer governmental program and, consequently, has not generated support either. There is a level of support for the notion of individual responsibility, and some have recommended a tax-based system of funding with non-governmental or private sector payer to administer the programs; others have suggested a "mandated purchase" option where all individuals would be responsible for obtaining coverage either through their employers or on their own.

Based on the input from the discussion groups, the "mandated play" option remains the option with the most support. Several elements must be included with this option, however, such as:

- tax relief for small businesses that can demonstrate that this is an undue burden for them to meet;
- tax-based support for gap coverage for those not eligible for employer coverage;
- inclusion of the self-employed under the mandate;
- employer-employee cost sharing;
- means testing for the portion of payment falling to individuals;
- the identification of reasonable benefit package, given the burden that this could represent; and
- the request for an ERISA exemption to include all private plans in the state.

The determination of the best option, given the circumstances in the state, might be referred to the proposed advisory board.

The Steering Committee recommends the following additional steps in order to assure true and effective universal coverage:

- **Antitrust Reforms**

  Allowances are needed in current antitrust laws to encourage cooperative efforts between and among health care providers. State legislative action could be a short-term goal.

- **Tax Reform and Other Efforts**

  Special emphasis must be placed on providing incentives to small businesses to obtain insurance. Tax credits may not be effective because many small businesses may not end the year with a profit and, hence, a tax liability to which to apply such credits. Thus, tax deductions for premium expenses, tax subsidies, insurance pools and other mechanisms should be developed that address the Montana small business environment.

- **Insurance Reforms**

  Reforms in insurance underwriting and marketing practices are essential to the success of health care reform. There is broad agreement that the following reforms should be enacted:

  - a gradual move to community rating;
  - elimination of preexisting conditions clauses;

- elimination of medical underwriting;
- a prohibition on cancellation or nonrenewal "for medical reasons"; and
- portability so that employees can carry coverage from one job to another.

For health benefit plans regulated at the state level, these would be short-term goals requiring legislative action; for plans covered under ERISA, these would be long-range requiring federal waivers which should be pursued as quickly as possible. To achieve total insurance reform, ERISA programs must be incorporated into these proposals.

- **Public and Private Health Insurance Pools**
  Insurance risk pools or health plans would spread the cost of health care across the entire population. These pools in Montana could generate a large enough pool to achieve better overall rates for many small businesses, the self-employed, and individuals in the private market, while also expanding insurance coverage.

  Medicaid and State Medical also should be incorporated into the statewide pool. These may be long-range goals because the public pool would require a federal waiver from Medicaid rules as well as Montana legislature approval.

- **Community Networks**
  Networks, such as those envisioned in the reform proposals of AHA and the Blue Cross and Blue Shield Association, should be considered as a way to achieve universal access, control costs, and address specific health care needs of given communities. These networks, made up of hospitals, doctors, allied health care providers and insurers would provide coordinated health care for patients at the local level. Patients would use the network for all covered services.

- **Federal Health Insurance Programs**
  Medicare, the VA, the Indian Health Service and CHAMPUS should be pooled with those individuals not insured in the workplace in a state-wide public or private pool. This is a long-range goal that would require action by Congress.

3. **How do we address access to and availability of services in the rural environment?**

We must assure access to, and availability of, primary health services in rural Montana. We also must realize that funding is limited for new technologies and specialized services in all locations of the state.

Several strategies have been identified for assuring rural access, including:

- increasing the supply of health care professionals in rural areas by
  - emphasizing primary care services,
  - encouraging the use of more mid-level practitioners and creating in-state training programs for mid-level practitioners,
  - providing financial incentives to aid recruitment and retention, including loan repayments for physicians and more efficacious use of specialists through incentives for specialists to visit these areas,
  - encouraging more satellite clinics,

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- expansions of MAFs and other alternative hospital models, and
- support for federal efforts to provide incentives to encourage training of more primary care physicians and fewer specialists;

- greater use of telecommunications and computers to extend medical care and continuing education to rural areas;

- preference for investment in emergency transport systems over investment in rural health care facilities; and

- establishment of urban-rural hospital/physician networks and coalitions.

The three sponsors have traditionally supported the family practice residency program. A feasibility study is currently being conducted, and we need to await those study results before proceeding. Some concerns were raised at the September conference about the number of graduates eventually settling in Montana and the program's cost.

4. **How will we pay for guaranteed access to health care?**

We believe funding should be as broad-based as possible.

The following sources were supported for funding guaranteed access to health care:

- broad-based state tax reform that would generate additional general fund revenue for health care services;
- consumer cost-sharing through significant copayments, deductibles, partial employee payment of insurance premiums and penalties paid by those who do not obtain health insurance;
- money saved by instituting administrative reforms (single-billing), practice parameters, tort reform and other elements of cost containment identified below in item 6;
- an hourly-based employer tax used to pay a portion of the health insurance premium;
- an increase in the "sin tax" on alcohol and tobacco products; and

The Steering Committee recognizes the need for additional research to refine these methods of funding.

5. **What health benefits should be covered by the plan, and how should patients' financial participation in service purchase be included?**

We believe a basic level of benefits should include preventive services and encourage patient financial participation in the purchase of health care services.

- **Basic Benefits**
  The recommendation to cover basic benefits was made above in item 1. To assist in defining basic benefits, the participants considered the Oregon approach to prioritizing services.

There was a strong sense of support for a logical approach to prioritizing services along the lines, if not in the same fashion as, the Oregon plan, especially given its strong emphasis on prevention and primary services. It was felt that such a process would be essential in the effort to gain control over health care expenditures, while being as nonpolitical as possible.

The positions of participants on other coverage issues were:

- **Defining "Necessary Care"**
  The participants were very wary of an attempt to define what is "necessary." The desire was to rely more on the national outcomes research efforts than to set up a state system to define it. In the meantime, it was felt that using an Oregon system would help identify the most necessary care of all that is available without subjectively labeling specific procedures necessary or not.

- **Covering Long-Term Care**
  There was strong sentiment against inclusion of LTC in the basic benefits program at this time. The reasons varied from the costs involved to the suggestion that it is not as much a health problem as a social problem. If and when it is covered, emphasis should be given to noninstitutional forms of care, such as home health care, respite care, etc.

- **Covering Mental Health**
  Agreement existed that mental health benefits should be included in the basic benefits package, but with several restrictions. Mental health services should be included in the prioritization process; prevention services and "primary care" mental health services should be defined, if possible. Also, emphasis should be on outpatient services, greater use of peer counselling and support groups at the workplace and in the community and tighter credentialing of the various categories of counselors and the like.

6. **How should health care costs be controlled?**

We can no longer operate as though we are in a world of unlimited financial resources. Ending cost shifting, instituting financial incentives to eliminate marginal care, and establishing practice parameters, are long-term goals. During the 1993 Legislative session, several measures should be considered:

- **Statewide Planning Structure**
  Participants discussed the Steering Committee's recommendation for state and regional planning bodies. While they saw both pros and cons with these planning bodies, they were supportive of the need for such a mechanism. They were together similarly in their caution that such bodies need to be more productive than the former HSAs and be as nonpolitical as possible, with them appointed and structured in such a way as to minimize partisan politics. Also, many supported the concept of local decision-making to the extent feasible within state limits, whatever they may be.

- **Tort Reform**

The Steering Committee believes that tort reform is an integral part of cost containment, and includes, but is not limited to;

- a limitation on the amount of noneconomic damages;
- mandated periodic payment on future damages;
- reverse sliding scale limits on contingency feels;
- expert witness qualification;
- extension of the "Good Samaritan" rule to ERs; and
- making countersuits available for frivolous claims and reciprocal attorney fees.

- **Other Cost Saving Strategies**

  The Steering Committee endorses other cost containment strategies, such as:

  - establishing fee schedules for physicians and allied providers;
  - establishing practice parameters;
  - reducing the number of services offered, more effectively controlling resource utilization;
  - making administrative reforms (e.g., single-billing, electronic claims submission);
  - providing mixed incentives or mixed reimbursement packages for physicians;
  - improving information management (e.g., reducing cost of hospital services through development of benchmarks); and
  - networks/partnerships of physicians, hospitals and other providers and payers to provide coordinated care and reimbursement mechanisms, possibly using primary care physicians to initiate the coordination.

- **Fixed Spending Limits**

  The notion of operating within a fixed amount of money for health care in the state was accepted (although the term "global budgeting" was not recommended), provided that local control was retained over individual health care decisions. Expenditure targets were more acceptable to those not supportive of a fixed state budget, especially as an interim measure to get to a fixed budget. Mandatory rate setting to keep within a fixed state budget was recommended by one group; elimination of cost shifting and use of RBRVS were suggested by others. This area would be incorporated into the independent board's study process.

7. **Who should administer this health plan?**

A majority of the discussion groups opted in favor of an independent public/private entity, along the lines of the PSC. All agreed that it should be a body with a relatively small number of members, broadly representative of the state's citizens, appointed to longer terms to avoid political realignments with each new administration, and selected from nominations from both the provider and consumer sectors. Some suggested specific formulas and structures, and these suggestions should be considered by the Task Force as it develops a recommended structure.

EXHIBIT 13
DATE 3/24/93.
SB 285

Blue Cross and Blue Shield of Montana

Amendment to Senate Bill 285

PROPOSED AMENDMENT

SB-285

Page 48, lines 7 through 9, Strike: "(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner."

Page 48, line 10, Strike : (k)
Insert : (j)

END OF AMENDMENT

EXHIBIT 14
DATE 3-24-93
SB 285

TESTIMONY BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

MARCH 24, 1993

MISTER CHAIRMAN AND MEMBERS OF THE COMMITTEE, MY NAME IS SUSAN SWINEHART. I AM A LICENSED SOCIAL WORKER AND AM HERE ON BEHALF OF THE MONTANA MENTAL HEALTH PROVIDERS COALITION. THIS COALITION OF APPROXIMATELY 500 LICENSED SOCIAL WORKERS, PSYCHOLOGIST AND PROFESSIONAL COUNSELORS ~~ARE~~ IS SUPPORTIVE OF SB 285 AND WE URGE THE COMMITTEE'S APPROVAL OF THIS LEGISLATION WHICH WILL BEGIN THE PROCESS OF INSURING THAT ALL MONTANANS HAVE ACCESS TO AFFORDABLE, QUALITY HEALTH SERVICES AND WILL MOVE TO IMMEDIATELY ADDRESS THE PROBLEM OF SMALL EMPLOYER ACCESS TO HEALTH INSURANCE FOR EMPLOYEES

ALTHOUGH WE SUPPORT SB 285 AND WE UNDERSTAND THAT THIS LEGISLATION IS INTENDED TO ADDRESS BOTH THE PHYSICAL HEALTH CARE NEEDS AND THE MENTAL HEALTH CARE NEEDS OF MONTANANS, WE ARE CONCERNED THAT SB 285 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 EXPLICITLY IDENTIFIED, BUT ARE SUPPOSED TO BE IMPLICIT IN THE TERM "HEALTH CARE" THEN MENTAL HEALTH CARE IS OVERLOOKED. ACCORDINGLY, IF THE COMMITTEE CONSIDERS OTHER AMENDMENTS TO THIS BILL, WE HAVE ONE NEW DEFINITION AND TWO TECHNICAL AMENDMENTS TO PROPOSE THAT ADDRESS THESE CONCERNS.

WE PROPOSE THAT SECTION 2. DEFINITIONS BE AMENDED BY THE ADDITION OF A NEW PARAGRAPH (10) AT LINE 22 ON PAGE 8 WHICH WOULD DEFINE

THE TERM HEALTH CARE. NEW PARAGRAPH (10) WOULD READ "HEALTH CARE" MEANS BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

IN ADDITION, WE PROPOSE THAT THIS DEFINITION ALSO BE USED IN THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT, THIS COULD BE DONE BY AMENDING SECTION 24 TO ADD A NEW PARAGRAPH (27) AT LINE 21 ON PAGE 42. NEW PARAGRAPH (27) WOULD READ "HEALTH CARE" MEANS BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

LAST, WE ARE CONCERNED THAT NOT ONLY PHYSICAL HEALTH CARE BUT ALSO MENTAL HEALTH CARE BE CONSIDERED BY THE COMMITTEE RESPONSIBLE FOR RECOMMENDING THE FORM AND LEVEL OF COVERAGE TO BE MADE BY SMALL EMPLOYER CARRIERS (SECTION 31 PAGE 67). THIS COMMITTEE INCLUDES HEALTH CARE PROVIDERS, BUT AGAIN, WE ARE NOT SURE THAT THIS INCLUDES MENTAL HEALTH CARE PROVIDERS. ACCORDINGLY, WE PROPOSE THAT THE DEFINITION OF HEALTH CARE PROVIDER CONTAINED IN SECTION 2 PARAGRAPH (6) BE MADE A PART OF SECTION 24. THIS COULD BE DONE BY AMENDING SECTION 24 TO ADD A NEW PARAGRAPH (28) AT LINE 21 ON PAGE 42, WHICH WOULD CONTAIN THIS DEFINITION. THIS MAKES IT CLEAR THAT HEALTH CARE PROVIDERS INCLUDES ALL PROVIDERS OF HEALTH CARE WHO ARE LICENSED, CERTIFIED OR OTHERWISE AUTHORIZED BY THE STATE. SINCE MENTAL HEALTH PROVIDERS ARE SO LICENSED, THEY COULD BE PARTICIPANTS IN DETERMINING COVERAGE TO BE MADE AVAILABLE. WE SEE THAT THIS IS PARTICULARLY IMPORTANT IN THE LIGHT OF SECTION 33 (PAGE 69) OF THIS PROPOSED LEGISLATION, WHICH APPEARS TO EXEMPT THE INSURANCE MADE AVAILABLE TO EMPLOYEES OF SMALL EMPLOYERS UNDER THE BASIC HEALTH BENEFIT PLAN FROM THE REQUIREMENTS OF THE EXISTING MANDATED SERVICES.

WE BELIEVE THAT THESE CHANGES WILL CLARIFY THAT MENTAL HEALTH CARE IS A PART OF THE SCOPE OF THIS LEGISLATION. WE WANT IT TO BE CLEAR THAT MONTANA RECOGNIZES THE RELATIONSHIP BETWEEN BEING HEALTHY PHYSICALLY AND HEALTHY EMOTIONALLY AND [redacted] TO THE [redacted] AND [redacted] BUT ALSO THE HEALTH OF THEIR EMOTIONS.

I APPRECIATE YOUR ATTENTION TO MY COMMENTS AND AM AVAILABLE FOR ANY QUESTIONS YOU HAVE. THANK YOU VERY MUCH.

EXHIBIT 14
DATE 3/24/93
SB 285

EXHIBIT 15
DATE 3/24/93
SB 285

Report to the Governor

Montana Task Force

BIOMEDICAL INFORMATION

Montana Task Force

February 1993

EXHIBIT 16
DATE 3-24-93
SB 285

S.B. 285 - Create a Montana Health Care Authority -
Sen. Eve Franklin - Room 312 - 3:00 p.m. Wed. -

Mr. Chairman, members of the Human Services and Aging Committee -

I am Verner Bertelsen, today I am representing the Montana Legacy Legislature -

Among the five priority pieces of legislation proposed by Montana Legacy Legislature their first choice was legislation for Universal Health Care. Montana senior citizens feel that it is imperative that Montana develops a system of care for all of its citizens - Our present system is not working - thousands of Montanans are not receiving adequate health care. Preventive health care, which would pay for itself many times over, is woefully lacking. Inadequate pre-natal and early childhood care is costing us not only in huge medical expenses but in tragic human costs - Medical costs are rising alarmingly, administrative costs are eating too much of our health budget, drug costs are skyrocketing? Now is not a moment too soon to begin to get a handle on our health care system -

This legislation is the result of

it is also the result of considerable compromise - ~~We strongly~~ The Montana Legislature strongly urges your support of S. B. 285.

EXHIBIT 17
DATE 3-24-93
SB 285

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624

(406) 443-5341

TESTIMONY OF DOUG CAMPBELL
HEARD BEFORE (H) HUMAN SERVICES & AGING
MARCH 24, 1993

Mr. Chairman and members of the committee my name is Doug Campbell. I live in Missoula, and I am president of Montana Senior Citizens Association. I am here to speak in support of SB 285. This legislation, which could provide universal and affordable health care for all Montanans, is the result of a bi-partisan citizens committee which, after several meetings and much deliberation, drafted this bill. Over the past couple of years, the citizens of Montana and the nation have been, not asking but demanding that somehting be done to address the health care problems of soaring medical costs, unaffordable health insurance and the 37 million of our citizens without any health insurance.

Now that President Clinton has granted the necessary waivers for Oregon to persue their state health care reform plan and has indicated his willingness to let other states experiment with their own plans for health care reform, it is very important that SB 285 be passed in its present form. Let's put Montana in the forefront of the health care reform movement. SB 285 passed the Senate by a vote of 49 to 0, and if I was a

member of this committee, I would not want to go home and try to explain to my constituents why I voted to kill this bill or weaken it with a series of amendments. On behalf of myself and our senior organization, I ask that you vote to pass SB 285 in its present form. Thank you.

EXHIBIT 18
DATE 3-24-93
SB 285

HEALTHMONTANA
SB 285

Mr Chairman & members of the committee

My name is Dale Pfau. I am Vice-President and General Manager of Don's, Inc. Don's, Inc. is a Central Montana small business consisting of three retail stores. I urge you to support SB 285 ~~in its present form~~ and to fend off any attempts to weaken the bill.

I strongly believe that the two most important factors in health care reform are universal access and cost containment. SB 285 is a start toward addressing the issues of, universal access for all Montanans, the burgeoning cost of health care in the state budget and will give small businesses involved with the purchasing of health care for their employees a reprieve from spiraling costs.

Along with my involvement in Don's, Inc., I have also been involved with Central Montana Medical Center in Lewistown for eleven years as a member of its governing board, three of which I served as president. During this time I have seen first hand the nightmares that so many uninsured Montanans experience when budgeting to pay for just their general health problems, notwithstanding what so many must live through when catastrophe strikes.

At present, Don's, Inc. pays for health coverage of all full-time employees. However, this coverage does not exempt us from having health insurance nightmares take place within our midst. Even though we have been fortunate enough to grow our family business from a GI tent in 1947 to almost 20,000 square feet of retail selling space, today we have fewer full-time employees than we had thirty years ago. The reason for this is not that we do not want full-time employees, full-timers tend to be a more efficient use of wage dollars, but that health care alone for these fewer full-time employees currently costs us in excess of $25,000.00 per year. This represents 1.52 % of our gross sales. The percentage of health care to gross sales just five years ago was .77 %. The difference in these two figures represents a significant change for us when current costs of doing business in the State of Montana are added. Even though our business has out performed inflation virtually every year of its existence by a considerable margin, we continually fight to push the same percentage of dollars to the bottom line. Because of these escalating health care costs to our business, our many part-time employees fall through the cracks and do not receive from us nor can they afford adequate health insurance. Thus, many are subjected to the nightmares of affording to pay for their health care, or they just entirely ignore their health problems until it is too late.

All data that I can locate shows that coverage for small gross sales businesses in Montana generating between 1% and 3% net profit

For these reasons I urge you to take the first step toward controlling the costs of health care in Montana and providing universal access to its citizens by supporting SB 285.

EXHIBIT 19
DATE 3-24-93
SB 285

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624

(406) 443-5341

SB 285
TESTIMONY BY CLYDE DAILEY ON BEHALF OF THE
MONTANAS FOR UNIVERSAL HEALTH CARE.
HOUSE HUMAN SERVICES AND AGING COMMITTEE
March 24,1993

Chairman Boharski 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 speaking in support of Senate Bill 285. As you have already heard, the main features include the creation of a heatlh authority, resource management plan, a database, and regional planning boards.

I am here today to address the regional planning boards and the health care planning regions as created by SB 285. We felt this is a key component of this legislation as it will provide for a comprehensive planning that will take into account the large population and geographic diversity that we have within Montana. We felt it was absolutely crucial to have local input for constructing a universal health care plan and specifically making recommendations about how resources should be

expended. With the cost containment goals set forth in this legislation, it was clear that local input was imperative in order to make intelligent decisions about how to manage the estimated two billion dollars currently in Montana's health care system. The vehicle for this decision making process will be the regional boards. The regional boards will be responsible for submitting an annual budget to the health authority. They will be responsible for revising the regional plan annually and holding public hearings within each region. A major component of these regional boards will be to seek input from the public as well as to educate the public as to how and why these resource allocation decisions are being made. The regional resource management plan for each of the five regions will be formulated and submitted to the five member health care authority for each of the five regions in order to establish a total health care budget in the state of Montana. The regions have been established based on a model provided by the Department of Health and Environmental Sciences that is in common use for many other planning activities for the state of Montana. An important feature is the ability of a county to petition to the health authority to be moved into another planning region. This process simply requires a written request by the board of county commissioners to be removed from a health care planning region and added to another

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region. The authority will grant the petition if it appears by the evidence presented that the county's health care interests are more strongly associated with another region.

It is clear is that we are in a state of crisis in our health care system in Montana and nationally. 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, representatives, be bold. The urgency of reform requires bold and innovative action. We have an historic opportunity. Let's make use of it. Montana has been a leader before. Let's be a leader again. Thank you for your time and consideration.

EXHIBIT 20
DATE 3-24-93
SB 285

MONTANANS FOR UNIVERSAL HEALTH CARE

"To assure affordable, accessible health care for all" Christian Mackay, Coordinator

TESTIMONY OF CHRISTIAN MACKAY BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE ON SENATE BILL 285 - MARCH 24, 1993

Mr. Chairman, members of the committee, for the record my name is Christian Mackay. I am speaking today on behalf of Montanans for Universal Health Care, a coalition of teachers, senior citizens, labor, low-income groups, women, physicians, ranchers and farmers. We are here in strong support of SB 285.

Montanans for Universal Health Care came about because of a deep concern and a shared interest among its member groups on health care reform. The majority of groups have independently endorsed single-payer health care reform.

Early in this session, Montanans for Universal Health Care supported Senator Yellowtail's single payer bill, SB 267. We have not changed our position that a single-payer health care system is the best reform option. The political realities being what they are, it became evident that SB 285 would be the vehicle for reform in this session. We were able to compromise. Portions of Sen. Yellowtail's bill were amended into SB 285. Some examples are: specific health care policy for the state of Montana; several features that each statewide access plan must contain; specific components of the state health resource management plan, and individual county representation on the regional planning panels.

The compromise that was reached maintained the integrity of SB 285 and gave a forum for single-payer reform. Above all SB 285 is a health care reform plan designed by Montanans for Montanans. We cannot wait for the federal government to hand down an inappropriate one-size-fits-all scheme that doesn't work for this state.

It is a widely accepted fact that health care costs are the driving force behind the state budget crisis. This state must take the first step to reform this year. I urge all members of this committee to not only pass this bill, but to do your part to see that it is adequately funded. I urge your passage of SB 285.

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

EXHIBIT 21 3/3
DATE 3-24-93
SB 285

Robert J Ardis MD
One 16th Ave South
Great Falls, MT 59405-4108
March 25, 1993

House Human Services Committee
c/o Aylice Rice
Capitol Station
Helena MT 59620

To the Committee,

At the request of Aylice Rice, secretary of the Committee, I am writing down my comments at the hearing on March 24th, 1993 concerning SB 285, the Eve Franklin Bill.

I am a taxpayer and a voter. I represent only myself. I am a physician. I was a general practitioner in Wolf Point for 2 years. That lifestyle was too brutal so I went back to school. I am now an anesthesiologist in Great Falls. I work approximately 60 hours per week now. The hours are much less brutal (usually). As an anesthesiologist I am a relative bystander in the "health care access" problem. I have never refused my services to any patient.

Everyone agrees we have a problem. No one knows the answer. The problem is that we spend too much money on health care and yet not everyone has access to care. I have 3 general comments.

First, I hear no criticism of the general quality of medical care. The quality of the system is good. The access to the system is skewed.

Second, we all seem to agree that we need to provide medical care to those who presently have no access to the system. And we need to do it while cutting overall costs. Twenty percent cost savings with twenty percent more coverage. A big challenge.

Third, no one yet has looked at the long term health care effects of our aging population base. What will it be like when the baby boomers retire. I am a baby boomer. If you take the medical access problem of today and look at what the problems will be in 25 years (assuming no changes are made), you will think today's problems are easy. I hope SB 285 addresses the health care problems of the next 5 years. I hope SB 286 ages gracefully and is still valid in 25 years. Otherwise it is just another quick fix.

As I try to read and understand SB 285 I note several things. Some are good, some are bad.

First, the bill talks about single payor and multiple payor health care plans. I see the words "must contain" used frequently. I hope the phrase "must contain" means "must at least contain this...., but may additionally consider....". Specifically, I think other options than single and multiple payor plans should be able to be investigated. Perhaps a market-based system is more cost-effective. Perhaps it isn't, but you won't know if you don't check it out. Perhaps medisave accounts could be used to raise insurance premium deductibles. Perhaps practice guidelines could be established so there is less need to practice defensive

medicine. I think some health insurance policies should be standardized - it is currently very difficult to comparison shop. I know that first hand because I recently decided my health insurance cost was too high and I tried to compare different companies policies. I think the patient should always be responsible for some co-payment of his medical bill. A patient's interest and involvement in his medical care increases as his out-of-pocket expenses increase. Indeed, that is the reason we are here today. So I think SB 285 must look at as many options as they can. We are idea shopping and idea comparing right now. There must be a mechanism to allow the as-yet-unthought-of-good-idea to rise to the surface and be tried.

Second, I think the idea of portability of insurance coverage is excellent!

Third, while reading SB 285 I see recurring phrases: "caps on expenditures", "global budgets", "cost containment", "negotiated budgets", "provider caps", "unified health care budget". To me it is all the same idea, best summed up in one word I have never seen used. RATIONING. Why don't we admit it and say we need to ration medical care. We already ration care by ability to pay. We all agree that is the problem. Our goal then is to ration medical care by another more equitable means. And yet stay within a decreasing budget. Never, never forget the cost. That is why we are here. I see several ways to ration medical care. I have no idea which is most equitable:

1) Financial resources - the current system
2) Waiting time - everyone is eligible for everything. And they deserve everything. Just take a number and stand in line.
3) Ranked severity of illness - the Oregon approach. 700 medical problems and their associated treatment costs are ranked from most important to least important. The available budget then determines how far down the list you can treat and pay.
4) Level of completeness - I'll use heart disease as an example. If you have chest pain from heart disease there are several things the medical community can do to treat it. The simplest is to tell you "if it hurts, don't do it". You then limit your physical activity, i.e. you don't shovel snow. The next level is to try various medicines, "take these nitroglycerin tablets under your tongue until the pain goes away". The next level is to discover the cause of the pain through various (increasingly expensive) tests up to coronary angiography. The final (and most expensive) treatment is to "cure" the disease with angioplasty or bypass surgery. (That is a somewhat oversimplified example). Do we all deserve "the best" when we are sick?

And so the debate begins. My concern is that the whole problem be debated and all possible options considered. So let us ration health care. Let's make it more cost-effective. Let's make it more uniform. Let's make it more equitable. Let's keep the quality high. And of course, let's keep the cost down. But be careful, all the work is done in the definition of those terms: cost effective, uniform, equitable, quality, cost.

Thank you and good luck,

Robert J Anders

EXHIBIT 22
DATE 3-24-93
SB 285

Montana Catholic Conference

Testimony Senate Bill 285 - Create a Montana Health Care Authority

Chairman Boharski and Members of the Committee

My name is Sharon Hoff representing the Montana Catholic Conference. As Conference Director, I serve as the liaison for the two Roman Catholic Bishops of the State of Montana in matters of public policy.

The Montana Catholic Conference supports SB 285.

CRITERIA FOR HEALTH CARE REFORM:
Formulated by the United States Catholic Conference, the criteria affirm basic health care rights. The criteria include: (1) Universal access; (2) Priority concern for the poor; (3) Respect for life; (4) Comprehensive benefits; (5) Pluralism by encouraging the involvement of the public and private sectors; (6) Equitable financing based on ability to pay; (7) Cost containment and controls that reduce waste and innefficiency and provide incentives for effective and economical use of limited resources; and (8) Quality, which promotes the standards that will help achieve equity in the range and quality of services.

Health care reform is a primary issue facing our state and our nation. Without reform, costs will continue to rise and accessibility will be come more limited. Too many Montana citizens have not health care. SB285 provides a direction to address our obligation to the common good, particularly to the needs of the poor and vulnerable.

Because SB285 meets most of the Conference criteria, we support this legislation and urge do pass consideration.

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

EXHIBIT 2
DATE 3-24-93
SB 285

OCAW
Oil, Chemical & Atomic Workers
International Union, AFL-CIO

Dan C. Edwards
International Representative
P.O. Box 21635
Billings, MT 59104

406 / 669-3253 (Home)

SB 285

Statement of:

Dan C. Edwards, International Representative
Oil, Chemical & Atomic Workers Int'l Union, AFL-CIO
P.O. Box 21635
Billings, MT 59104 669-3253

Statement for the House Human Services and Aging Committee, March 24, 1993, 3:00 p.m., Room 312-2. William Boharski, Chair

****

My name is Dan C. Edwards, International Representative for the Oil, Chemical and Atomic Workers International Union, AFL-CIO (OCAW). OCAW represents over 500 members in the State of Montana, including employees of the Conoco and Exxon refineries in Billings, the Cenex refinery in Laurel, the Montana Refining Company in Great Falls, and Montana Power Company in Cut Bank and Shelby.

This statement is to indicate support for HB 285.

OCAW is a member of the Montanans for Universal Health Care coalition (MUHC). Rather than to take the valuable time of this committee to repeat testimony of others, it will suffice to say that OCAW fully supports the testimony being offered today by MUHC.

Thank you for your consideration of our testimony.

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EXHIBIT 24
DATE 3-24-93
SB 285

HOUSE HUMAN SERVICES AND AGING COMMITTEE
SENATE BILL 285 TESTIMONY
3/24/93

Mr. Chairman, members of the committee, for the record, my name is Michael Regnier. I work as the Advocacy Coordinator for Summit Independent Living Center in Missoula, and am also the state vice-president of the Coalition of Montanans Concerned with Disabilities. Today, I'd like to give you some information regarding the disability community in Montana and how we will be affected by Senate Bill 285, over 502. We strongly support SB 285, not more opposed to the small group insurance reforms in both bills.
According to statistics provided by the Rural Institute on Disabilities at the University of Montana:

* There are and estimated 44 million people with disabilities (i.e., that have one or more chronic or permanent impairment) in the United States; extrapolating from those figures, there are about 120,000 such individuals in Montana.

* Based on an estimate of 10 million people with **severe** disabilities nationally, about 27,000 Montanans would be expected to have severe disabilities.

* Nationally, two separate estimates suggest that the total cost of disability in the U.S. is about $170 billion, or $4000 per person with a disability annually; 51% of this cost is attributed to direct expenditures, while the other 49% is due to lost productivity.

* In Montana, the cost associated with disability could total $480 million annually.

* 1980 Census figures support an estimate of 24% - 33% of the total rural population as having disabilities.

* The 1990 Census regarding mobility/self-care limitations and work disability status show that 4.9% of the adult population in Montana report having mobility/self-care limitations; 13% report having a work disability.

* While only 1.35% of those individuals with mobility limitations in Montana who are in the labor force report being unemployed, a whopping 89.82% are <u>not in the labor market at all</u>.

* According to a study done by the Rural Institute, with a sample population taken from consumer lists from three of Montana's Independent Living Centers and the state disability parking permit list, only 6% of Montanans with disabilities are employed full-time, while another 7% are employed part-time, leaving a total of 87% unemployed.

EXHIBIT 24
DATE 3/24/93
SB 285

d workers in Montana were receiving
ity Insurance, while 7,568 were
Security Income, for a total of
receive some sort of disability
ial Security Administration.

ith SB 285?

the fact that, of those people with
the labor force but who are able or
prospect of losing health insurance
me, is enough of a disincentive to
from the labor market altogether.
disincentive costs Montana many
necessarily, and is largely due to
f disability by insurance carriers
e laws that allow this monumental
nue.

omprehensive approach to studying
Montanans, and while the bill will
o health care for all Montanans
the small group insurance sections
or Montanans with disabilities and
ut disabilities, with respect to
nsurance. We simply cannot afford
for relief.

s that the small group insurance
ended to provide a comprehensive
ordability of health care or health
we believe this statement is

the bill, it continues to connect
employment, effectively trapping
the "golden handcuffs" of public
nd Medicare. Further, "eligible
who work on a full-time basis and
ours or more, effectively shutting
k this number of hours. It should
ding to the State Department of
of 1992, some 15,536 out of 25,433
ntana (not including self-employed
d 4 employees, whereas this bill
of 3 to 25. These numbers were
l, according to the information we
erefore, cover less than half the
state.

at least nine differential rate
much as 25% in either direction
s. I fail to see how this does

differential rates being charged
; the insurance carrier sees fit.

abilities, the bill still allows
12 months for coverage for pre-
, quite literally, the "kiss of
ith a disability wishing to enter
tion, we all have a pre-existing
waiting period to allow people
medical expenses access to the
od. Failing that, as this bill
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dollars a year Montana spends on
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this lack of access to adequate
lead to additional unnecessary
ult from lack of access to primary
stimate we recently heard was an
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sure sore" that could have been
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s to prevent these unnecessary
one of the buzzwords one hears is
in order to control the national
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ll, with its complex rate banding,
d will be unenforceable as well
has been the case in other states
ches. It is guaranteed to drive
lown, in order to fit people into
This is why small group insurance
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e not. And the people of Montana
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pts have already failed miserably

ands, it would be much better for
e bill were deleted entirely and
ich call for true continuity of
were pulled off the table in the
000 people with disabilities in
ll have the courage and good sense

* [illegible] representative [illegible] small group experience [illegible] language in the bill. I just spoke to the [illegible] a representative of disability [illegible] though there are 5000 physicians for [illegible]

EXHIBIT 25 PO
DATE 3-24-93
SB 285

, P.C.
SURGERY
STREET

MEMBER OF
MONTANA
ASSOCIATED
PHYSICIANS, INC.
FAX: (406) 248-1036

EXHIBIT 26
DATE 3-24-93
SB 285

DALY MEMORIAL HOSPITAL CORPORATION

March 22, 1993

n
Services and Aging

of the Committee:

t for the Health Care
eard on Wednesday,
, however, on the five
nded to do the initial
ast one physician
hat it is very important
edicine be involved in

Administrator of Marcus Daly Memorial
am a member of Senator Baucus' committee
I have served on Governor Stephen's
reform, and am a member of the American
onal Policy Board.

tify in support of Senate Bill 285 and
e members and the House do not amend any
particular, access to care and cost
change in health care must be dealt with
sented to this committee, provides the
is change. Special interest groups may
ll down and hamper the ability of the
The present delivery of health care and
e services is bankrupting small community
the cost shifting which is occurring.
age of entitlement programs, on the
their total business. We have met the
shifting to the commercial payers and

trator the past 19 years, I have seen a
very of care.

at Senate Bill 285 will address the needs
h care providers and all Montanans, and

Sincerely,

JOHN M. BARTOS
Administrator

EXHIBIT 27
DATE 3-24-93
SB 285

THE WESTERN MONTANA CLINIC
515 WEST FRONT STREET
MISSOULA, MONTANA
59802
TELEPHONE (406) 721-

March 23, 1993

Representative William Boharski
Chairman House
Human Services & Aging Committee
Capital Station
Helena, MT 59620

Dear Representative Boharski:

I would like to submit testimony for SB-285. I have had great concern and involvement in working on health care reform in Montana. A year ago I spent a two month sabbatical period in Senator Baucus's office in Washington as a health policy fellow, primarily working on health care reform. Since that time I have been a member of Senator Baucus's committee working on a health care reform plan which has evolved into the Eve Franklin Bill, SB-285. I strongly favor the Bill in its present form and particularly want to address the cost containment issue which is absolutely essential for any plan that offers universal coverage for Montanans.

Effective and predictable cost containment cannot be realized without adopting a global budget plan. Budgeting of this sort is working in many other countries. Global budgeting is practiced actually by prepaid plans and HMO's in this country. The negotiations can be satisfactorily arranged to control professional expenses, capital expenses and hospital budgets. They do need annual scrutiny and approval by a State Regulatory Agency in order to equitably use our limited resources. I think everyone would prefer to operate without a global budget, but with the annual inflation rate in health care continuing, drastic measures must be taken. You only have to look at your Medicaid budget to know what it is doing to the State's financial crisis. I would strongly urge you to approve SB-284 without amendment.

I would like to add that I have practiced internal medicine at the Western Montana Clinic for nearly 30 years. I am very concerned about the health care crisis and the need to get a State initiative in place. It is going to take a number of years for a Federal plan to address most of these issues and if we have a working plan in Montana we would be in a much better position to control our own destiny.

Sincerely yours,

William A. Reynolds, M.D.

WAR:cs

EXHIBIT 28
DATE 3-24-93
SB 285

SB 285 Third Reading
House Human Services & Aging

Chairman Boharski, Vice Chairman Simon, and Honorable Representatives of the House Committee on Human Services and Aging

I am Mike Schweitzer. I am a third generation native Montanan. My folks are still active raising cattle in Geyser, east of Great Falls. I have three brothers who own farms - one in Eastern Montana near Forsythe, one on the Highline near Ledger, and one in Western Montana near Whitefish. My oldest brother still has an interest in cattle with my folks. We are raising our children as the fourth generation in Montana. I would like to see my grandchildren grow up in Montana. I am very concerned with the future of Montana and its citizens.

Health Care is a very complex issue. I will only address a few aspects of the entire subject today. I would like to discuss the actual care that will and will not be available to each individual living in Montana. I will explore the limits to access to quality Health Care that Senate Bill 285 may impose on you, your families, and my family in its present form. I will outline some current estimates of the economics of the Health Care Industry and its impact on the State Budget. We will review the results of previous decisions by the state legislature regarding another government sponsored single payor system - Worker's Comp. I will mention a number of specific examples where these decisions drove businesses out of the state or prevented expansion of businesses in Montana costing the people of Montana hundreds of millions of dollars. A review of current approaches to health care, including the very high costs of government sponsored Health Care Plans, will be discussed. Finally, I will propose some amendments to Senate Bill 285 which will permit the authority more freedom to investigate and propose to the 1995 State Legislature two markedly different approaches to solving the complex issues of Health Care in Montana.

There are many excellent ideas in this bill. Initially, I was in favor of it. I came to Helena in February for the first reading of the Franklin Bill in the Committee on Public Health, Welfare & Safety chaired by Senator Dorothy Eck. I signed in as a supporter of the bill. Guaranteed access, portability of insurance coverage regardless of job status, prioritization of services, uniform insurance claims with electronic billing, a study of tort reform, plans for long term care, and a mechanism to gather the vast amount of economic data in order to calculate an actuarial sound estimate of the costs of implementing the plan through 2005 are all superb ideas in SB285. Now only six weeks later I find that I can not, in good conscience, continue to support the bill in its present form.

Montana Public Health Partners Inc., a Missoula Research group, indicates that more than 1.6 billion dollars was spent on health care in fiscal year 1990. If health care expenditure increases by 15% per year, then in 1991 the total projected cost will be 1.84 billion dollars, in '92 - 2.12, and this year, 1993 2.44 billion dollars. If you continue this projection to 1995 when the next legislature will be considering the proposals of the Health Care Authority authorized by this bill, then the estimate would be 3.2 billion dollars. **3.2 billion dollars** is a lot of money. According to a report in the Billings Gazette, Myles Watts (Chairman of the Agricultural Economics Department at Montana State University) the cash receipts for agriculture the past several years has been approximately 2 billion dollars each year. For 1993 the state's farm and ranch income should increase by only 1 %. This means that this year, 1993, the Health Care Industry is Montana's largest industry. This past weekend the Billings Gazette confirmed that Hospitals employed the most Montanans as compared to other industries. This number did not even include all those people employed by other segments of the Health Care Industry such as Physicians, Nursing facilities, pharmacies, and other health related industries. Another report in the Gazette listed the

fastest growing industries in Montana as Health Care and Tourism.

Montana Public Health Partners Inc. listed out-of-pocket expenses by Montanans as 383.4 million or only 23.4% of the total 1.6 billion dollars in 1990. This included co-payments, deductibles, and payments made by individuals directly to health care providers. Employer-based contributions, 26.7 % (438.5 million), included business insurance premiums, worker's compensation, and direct payments to health-care providers by self insured businesses. Public sources, including primarily federal and some state money, was nearly 50 % of the 1.6 billion dollars.

According to a report from HCFA Region VIII in Denver, the Federal share of the over 193 million dollars in Medicaid benefits for fiscal year 1991 was over 170 million dollars or 88%. For every 12 dollars spent by Medicaid for benefits, this state receives 88 dollars of Federal money. That is an incredible seven fold return on our investment by the state.

This fiscal year 1993 of the estimated 2.44 billion health care dollars, approximately 1 billion dollars of out-of-state money will flow into the state for health care based on projections from the Montana Public Health Partners. This out-of-state money not only helps pay for the medical care of our state's citizens, but also is apparently recycled about seven times in the state economy according to reports in the Billings Gazette. The initial payment to physicians, hospitals, visiting nurse companies, nursing homes pharmacies, and many other health related businesses is usually taxed by the state. This initial payment from out-of-state sources then pays the salaries of many Montanans including nurses, nurses aides, administrators, secretaries, medical technicians, janitors, etc. They use this income to feed, shelter, clothe, educate, and care for themselves and their families. In this process the money that was initially from out-of-state sources is recycled and taxed many times in the state of Montana. There are many ways reform could reduce this out-of-state income. I think it is very important to evaluate not only the expenses of medical care in Montana but also where the money currently comes from that pays these expenses. A reform that results in a bankrupt medical care system similar towhat happened with Worker's Comp, would negatively impact the state budget and the incomes of many Montanans. The economies of medical care reform can not be overlooked and the impact on the economics of both the state and the citizens of Montana should not be underestimated.

Many businessmen have outlined for me many specific cases where businesses, their jobs, and taxable revenue have left the state or avoided Montana because of decisions by the state legislature regarding taxes or Worker's Comp. This cost the people of Montana hundreds of millions of dollars. (See Addendum A) I am concerned that if an additional heavy burden is placed on businesses for health care that the state of Montana and the citizens of Montana will continue to lose business and their resultant capital. This results not only in a loss of state revenue but also in a drain of a very important resource - our children. Many young, bright, energetic, citizens of Montana must leave each year to seek employment.

The current wording potentially **relegates Montanans to substandard medical care.** In an attempt to create a floor of basic medically necessary and effective health care benefits that no Montanan would fall below, the bill has effectively created a ceiling of uniform health care benefits that no one can rise above. If you or your family desires medical care that is not defined in the basic or standard health benefit plans, you will not be able to obtain that care (see pg. 15 section 3 b). A suggested amendment to correct this would be to add on page 19 at the end of section 8 after line 25 a subsection "(i) Nothing in this bill shall constrain Montana residents from seeking health care services not specifically delineated in the health care benefits package."

Even if the desired benefit is included but you wish to receive this care out of state, you may not be able to receive this care. The current Franklin Bill mandates that all payors of health care services pay the same rate public or private (pg.16 section 3 c). If your son or daughter has a medical problem that is currently best treated at a University or special clinic outside of the state, they may refuse to treat your son or daughter. You may well ask, "Why ?" The current Health Plan Mandates a specific payment for a specific service. What if that payment is deemed inadequate by the out-of-state provider? They would be within their rights to refuse to care for your ill child. Already many news publications are documenting the refusal of hospitals and physicians nationwide to care for patients with medical insurance plans with inadequate reimbursement. These are usually Medicare or Medicaid insurance plans - both of course are government sponsored plans with specific and well defined payment for a specific health care service. This is exactly the type of reimbursement plan that the Health Authority must propose to the 1995 legislature.

Leaving the state to seek health care is very common. Former Governor Stevens may not have been able to seek medical care in Washington state under the new Franklin guidelines. You probably have family members or friends who have gone outside the state for medical care. My nephew was in a coma in Whitefish Hospital with extremely high fevers. He was transferred to Denver Children's Hospital. After initially waking up blind, unable to talk or walk, he has recovered completely. My own son was diagnosed with a rare disease, Kawasaki Syndrome when he was two. He had a "Classic Case". These patients at that time often required open heart surgery for bypasses as children. He was diagnosed and treated in one of the few world wide centers that was involved in a research study involving Gamma Globulin. (Gamma Globulin is now the accepted treatment.) Instead of a 10-14 day hospital stay including open heart surgery, he went home in three days at considerably less expense. He recovered 100% without surgery. I doubt that either one of these boys would have been able to receive the same care or have the same excellent results in this new proposed global budget system. Even if we would have been willing and able to pay for the health care out-of-pocket, we may have been prevented by state law mandated by the Health Authority in order to comply with a uniform benefits system capped for provider expenditures and the other cost containment features.

The present plan handcuffs the Health Authority and they must follow the mandates included in the Bill. No flexibility is allowed in the present language. Changing one word on page 13 Section 6 (2) on line 21 from **"include"** to **"consider"** would give the Authority the freedom to choose truly different health care proposals. This one word change could provide a more fair and flexible study and evaluation of the two different health care plans. When the payments for services are well defined and mandated for all public and private payors, this prevents the individual from additional payments. It also takes away any competition. With the current language the multipayor system would collapse into a single payor system because of the cost containment mandates. In fact on pg. 24 it states, "On or before December 15, 1996, the Authority shall report to the legislature its recommendations concerning the feasibility and merits of authorizing the authority to act as an insurer in pooling risks and providing benefits, including a common benefits plan.." Amending this word would allow consideration of truly free market competitive multipayor systems. The Clinton administration seems to be in favor of competitive managed care multipayor systems which would not even be permitted in the current language of this bill.

Chairman Boharski has sponsored the Medisave Bill HB 670. This bill will help return the responsibility of health care to each one of us. The Medisave plan has a built-in incentive to wisely spend the first $3000 annually. Each individual will become an interested consumer of health care. Currently, most money spent on health care in America is "government" or "insurance" money.

People consider these payments to hospitals, physicians, nursing homes, and for other such items as drugs, as 'other people's money'. This is our money disguised as a benefit from a company (resulting in lower true wages) or the government (resulting in higher taxes). The Medisave idea was supported by National Columnist Cal Thomas in the attached Billings Gazette article. He also addressed many of the problems with the Canadian system.

The New York Times has outlined the decline of the Canadian Health Care System. Medical costs in Canada are rising rapidly. Canada regulates hospital budgets and doctors fees in much the same fashion as currently proposed in SB285. Yet it actually costs more per person in Canada than the U.S.A. for health care. The number you most often see quoted for Canadian Health costs is measured using the GNP as the denominator. The Canadian GNP has been rising much faster than the American GNP which has leveled off. As a consequence the comparison is not a true reflection of per capita health care costs. The provinces have been forced into ever larger deficits to pay health bills. The waiting lists for certain surgical procedures in Canada are so long that some patients die before their surgery. Other Canadians come to the U.S.A. for what they believe is **better more accessible medical care.** Do we really want to adopt a system that is failing not only in Canada but also in other socialized experiments?

The March 11th Wall Street Journal has an article which indicates that the most expensive medical care per person in America is provided through Medicare and Medicaid, both government managed health care plans with very low out-of-pocket expenditures. Medicare averaged $5,446 per person. Medicaid averaged $3,565 for medical coverage only. The least expensive medical insurance care per person was provided to those citizens with high deductible insurance plans. Their average cost was $1,333. These individuals were better consumers and spent their money more wisely. The Wall Street Journal concluded that, "The more a person's health care costs are subsidized ("insured"), the more likely they are to drive health spending upward."

In fact we will not be able to participate in any of the national or other state experiments. According to the Fiscal Note attached to this bill we tax payers will probably pay nearly 2 million dollars over the next two years just to study and propose regulations for a health plan that is already so well defined that it does not allow the people of Montana any significant input in the structure of the state plans. As thousands of brilliant minds all over our great nation explore and develop new plans for solving the health care problems, we will be locked into a system with a global budget, a ceiling of basic uniform health care, and an essentially single payor system run by the government. Do we really have so much money in this state that we can spend nearly two million dollars on a heavily biased and limited study to propose supposedly two separate health care plans that are essentially one. I don't think so...

Why not allow and even encourage the Authority and Regional boards the opportunity to explore real alternatives to propose to the 1995 legislature? We can propose the global budget, single payor, heavily regulated uniform benefits plan. Then we can allow some freedom for the authority to observe other states' plans and other proposals from think tanks around the nation as they are developed over the next 6-12 months. These two amendments would permit such freedom in the Authority's approach to these health care issues. If Montana is going to spend 2 million dollars to change its biggest economic industry why not provide two very different plans? What do you have to lose by allowing the flexibility to create two markedly different health care plans ? Montanans can still vote to determine which, if either, plan to adopt .

Thank you for your time and consideration of these two amendments.

EXHIBIT 28
DATE 3/24/93
SB 285

Addendum A

I will mention just a few of the many examples of businesses and capital leaving the state and some of their reasons:

Industrial Plate & Grinding Moved to Sheridan 8 years ago. The company figures that the cost savings from lower Worker's Comp paid for their new building in 5 years

John Bradford - Bradford Roofing says the high cost of Worker's Comp makes it virtually impossible to compete against a Wyoming company. Whereas the Wyoming company pays 7 cents per dollar of revenue, his company pays 65 cents back to Montana for Worker's Comp for each dollar of Revenue

Joel Long - Long Construction builder of two major building projects in downtown Billings and many other smaller projects is no longer involved in major construction projects in Billings. Two of the reasons are Worker's Comp and the tax structure

John Foote a long time Billings resident and real estate investor moved to Arizona

Holly Sugar in Sidney and **Western Sugar in Billings** have many plants in other states that are more profitable because of the high cost of Worker's Comp and other taxes. Neither is building additional plants in Montana.

Sun Mountain Sports an international company with 350 jobs in Missoula, opened a new plant in South Dakota rather than Montana. They have spoken of leaving Missoula because of Worker's Comp and taxes.

 B/y. Gazette 3/11/93

Supersecrets for your health

■ **Question:** What are Hillary Clinton and her friends up to?

THE DIRECTOR OF the Congressional Budget Office, Robert Reischauer, may have pierced the darkness enveloping Hillary Rodham Clinton's secret meetings on health care reform.

Testifying before a House subcommittee, Reischauer said that any effort to bring health care costs under control will mean reduced medical serves for all Americans.

Reischauer said managed care, an overhaul in malpractice litigation and cutting red tape will result in only modest savings. He said that covering the estimated 35 million uninsured will cost $33 billion in 1994 alone. "Someone will have to pay these additional costs," he said. We know who that will be.

"If the savings from health care reform are used first to cover the uninsured," said Reischauer, "and then to reduce the high costs of private payers, not much will be left to reduce the costs of the federal programs."

Reischauer warned that "ending the tax subsidy for health insurance could also raise the number of uninsured," which means we would be back to where we started, but with the quality of health care reduced for everyone.

With so much at stake, it is outrageous that Hillary Rodham Clinton continued to bar the door to the public while she plotted in secret with her radical activist "friends." There are said to be up to 400 people "helping" her, but their names and qualifications are secret.

There can be only one reason for the secrecy. The plan is socialized medicine, and as much effort is going into strategies to mask that fact and to sell it as something else as into reforming the health care system itself.

If government manages health care, it will no longer be the best.

COMMENTARY

Cal Thomas
National columnist

Consider the Canadian health system, which many point to as a model America should follow. Socialized medicine in Canada has brought waiting lists for some surgical procedures. Many Canadian patients come to the United States for what they believe is better and more accessible health care.

Twenty-seven years after universal health insurance was adopted, Canada is now feeling the pinch. Canada uses tax money to pay most medical bills. It also regulates hospital budgets and doctors' fees. Yet, medical costs are rising rapidly, and for the first time patients are being required to pay extra for common medical services.

A New York Times story catalogues the decline in Canada's health care dream. Despite efforts to control costs, revenues in the public sector are not increasing fast enough. While the government once paid half the cost of the health system, it now pays only 30 percent. The provinces have been forced into ever larger deficits to finance health care, which now consumes about one-third of total spending. This contributes to Canada's foreign debt because provincial bonds must be sold abroad to underwrite the deficit.

Would you like to be told by the government which doctor you may see, or do you prefer to make your own choice? Would a surgeon who receives controlled fees have the incentive to increase his knowledge and improve his skills?

"I'm from the government and I'm here to help you" never looked like such an empty promise.

So how do we control medical costs without sacrificing quality care? The answer may lie in eliminating or drastically limiting dependence on third-party health insurance, which is insurance provided by the government, an employer or an insurance company. Most payments to hospitals and doctors involve other people's money. Workers think this is a "benefit" from their employer, but it results in lower wages to the employee.

Instead of third-party insurance, how about trying medical IRAs? Employers now pay, on average, $3,605 annually per worker for employee health plans, not counting employee contributions, according to the Employee Benefits Research Institute in Washington. If the employer put $3,000 annually into an employee medical IRA, which the employee would use to pay the first $3,000 of his medical costs, and bought a health insurance policy with the rest, perhaps adding some money to the pot as a small "benefit," so that all medical expenses above $3,000 would be covered, perhaps the problem could be solved.

The employee would get to keep in the IRA any unspent portion of the $3,000 in a calendar year. As long as it is spent on medical care, including dental care and eye wear, the money remains tax-free. If the employee spends it for anything else, it would be taxed as ordinary income.

Because most people spend less than $3,000 annually on health care and because the medical IRA carries a built-in incentive to spend only when necessary, such a plan could control costs. A medical IRA would also follow an employee to a new job or stay with him if he lost his job, which the current system does not allow.

We don't know if anything like this is being discussed because of the closed-door policy at the White House. Let's open those doors and let the sun shine in.

Along those lines, a federal judge on Wednesday limited the authority of the task force to hold closed meetings.

It is our health and our money, and we have a right to know what Hillary and her "friends" are doing.

EXHIBIT 28
DATE 3/24/93
L SB 285

SB 285 Third Reading
House Human Services & Aging

2/24/93

Chairman Boharski, Vice Chair Simon, and Honorable Representatives of the House Committee on Human Services and Aging :

Suggested Amendments to SB 285

1. Pg. 19 Section 8 after line 25 a new subsection (i)
   Adds: "Nothing in this bill shall constrain Montana residents from seeking health care services not specifically delineated in the health care benefits package."

2. Pg. 13 Section 6(2) line 21
   Following : "must"
   Insert : "consider"
   Strike : "include" on the same line

Mike Schweitzer

SB 285-Testimony of P. Gorsuch M.D., Great Falls, MT 3/24/93

EXHIBIT 29
DATE 3-24-93
SB 285

I am testifying to support amendment then passage of SB 285-the Eve Franklin bill. The bill should be amended for two reasons: it limits the ideas that may be considered for health care reform by the Health Care Authority; and the requirements for any plan (listed in sections 6, 7, 8, 9, 11, and 20) are at best, of questionable value. The specific suggestions for amendment are listed in Table A; the rational for these suggestionns follow Table A.

TABLE A

Section	Page	Line	Current Wording	Proposed Substitution
6	13	18	must contain	should consider
7	15	1 and 16	must contain	should consider
8	16	21	must contain	should consider
9	~~19~~ 20	2	must contain	should consider
11	21	11	must include	should consider
20	33	10	insurer shall:	insurer shall consider:

An alternate to these proposed changes would be to require that the Health Care Authority offer a "market oriented" plan in addition to single and multi payor plans.

The idea of considering options and presenting them by 10/1/94, as the bill requires, is reasonable. However, as currently worded the bill does not allow substantially different options to be considered. Instead it limits debate at the outset and excludes consideration of any ideas not consistent with the predetermined assumptions and outcome it mandates.

It accomplishes this primarily in sections 6, 7, 8, 9, and 11. The opening lines of each of these sections mandate the type of options which may be considered by stating that any plan considered "must contain" or "must include". I would urge you to amend these sections so that those features listed are "considered", but not required unless the Health Care Authority chooses that option. Section 20 should likewise be amended to allow consideration of mandating managed care by the Authority, but not necessarily requiring it. Many believe that managed care is at best a mediocre idea; the Authority should be able to accept or reject those ideas after consideration. Arguments for and against many of the requirements in these sections can be made; including global budgets, controlled capital expenditures, capped provider expenditures, negotiated annual budgets, procedures for health care monitoring, et cetera. The

Authority should be allowed to hear those arguments and make recommendations; not have their position dictated by the bill.

These sections make a myriad of assumptions; not only regarding the general philosophy of Health Care reform (more bureaucratization is better), but also what specific treatments should be allowed. This is done without any discussion regarding the cause of the problems or of alternate solutions. For example, in reviewing 13 published plans for Health Care Reform 10 could not even be considered as options under SB 285 since they do not accept the premises or include the requirements specified in SB 285, see Table 1.

TABLE 1

Compatibility of the "must contain" mandates of SB 285 with 13 published Plans for Health Care Reform.

NOT COMPATIBLE	COMPATIBLE
SB 285 would Prohibit	**SB 285 would Allow**
The Pepper Commission's Blueprint for Heal Care Reform-*U.S. Senate*[1]	Restructuring Health Care in the U.S.-*D. Nutter, M.D., Northwestern Univ. School of Medicine.*[1]
Health Access America-*AMA*[1]	The 'US Health Act'-*U.S. Representative E. Roybal, Washington D.C.*[1]
Physicians Who Care Plan-*Phys.Who Care*[1]	Liberal Benefits, Conservative Spending-*K. Grumbach, M.D., Phys. for a NatL. Health Program*[1]
Plan to Achieve Universal Health Insurance-*Karen Davis PhD-Dept. of Health Policy & Management, Johns Hopkins University, Baltimore, Md.*[1]	
A Framework for Reform-*the Kansas Employer Coalition on Health*	
Universal Health Insurance-*A.C. Enthoven PhD, Grad. School of Busi. Stanford, Calif.*[1]	
An American Approach to Health System Reform-*John Holahan, PhD, The Urban Institute, Washington, D.C.*[1]	
Health Care Reform-*Steve Butler PhD, Heritage Foundation, Washington, D.C.*[2]	
Keeping the Promise-*the American Legislative Exchange Council*[3]	
State Health Care Reform Under the Clinton Administration-*John Goodman, PhD Nat. Center for Policy Analysis*[4]	

1-JAMA; May 15, 1991, Vol 265, No. 19
2-Critical Issues
3-Keeping the Promise
4-Natl. Center for Policy Analysis

The second reason to amend the bill in this fashion is that the mandates of sections 6, 7, 8, 9, 11, and 20 are of unproven benefit. Despite the popular arguments for these ideas there is considerable evidence that many of these ideas do not accomplish the desired goal. For example consider the ideas of "Global budgets" (as mandated in section 6) and universal access. These are two requirements of the Canadian system and other countries with similar systems. Here are some comments from Canadian observers.

- Twenty-four people died in 1989 while waiting for heart surgery in British Columbia-*Ottawa Citizen, Feb. 4, 1989*

- Patients in British Columbia must wait for up to a year for simple, routine procedures such as cholecystectomies, hip replacements, prostatectomies, and surgery for hemorrhoids.-*Waiting your Turn: Hospital Waiting Lists in Canada*

- In January 1989, extensive waiting lists forced Toronto's well-respected Hospital for Sick Children to send home 40 children awaiting heart surgery.-*Maclean's, Feb. 13, 1989*

- Earlier this month, the Ontario Hospital Association announced that the 224 hospitals in the province are facing massive job cuts and bed closures because the provincial government cannot provide the $630 million needed to maintain the current level services.-*Maclean's, Nov. 25, 1991.*

Are these observations just flukes? The statistics regarding waiting times in British Columbia are listed in Table 2 on the next page.

Finally consider the report in The Wall Street Journal yesterday 3/23/93. David Miller, an 83 year old Winnipeg entrepreneur, was told he would need to wait 6 months to have his hernia repaired. Now "Mr. Miller is teaming up with a U.S. insurer, American Medical Systems of Wisconsin, to offer an escape hatch. For $450 a year, Canadians will be able to buy a policy that will ship them south for treatment whenever the waiting list is 45 days or longer. The policy even covers food and lodging for a loved one, plus airfare. The plan will be unveiled 3/24/93 in Canada, and reportedly the first 200 customers will be doctors." One could argue that the legal "guarantee" of access in Canada is really legal fiction.

Similar arguments can be made for most of the mandated requirements of SB 285. Only an attempt at brevity prevents me

from doing so. The point is not necessarily to persuade you that the Canadian or any other system is bad or good. The point is that SB 285 should not dictate what type of reform the Health Care Authority may consider. There are serious and substantial arguments & evidence against the recommendations SB 285 would mandate. The Health Care Authority should be free to consider and act on all options and arguments in making their recommendations. As currently worded the Authority may only offer plans with essentially one set of options.

Surely it is not in our best interest to limit the ability of the Health Care Authority to consider and recommend various options or to limit them to one set of preconceived ideas. With the mandates of the sections mentioned above there is little significant difference between a single or multi payor system since both would deliver care and control costs by the same mechanisms. We need a bill which has the courage to consider all the options and give Montanans' some real choices. Please amend SB 285.

TABLE 2
WAITING TIMES IN CANADA:
BRITISH COLUMBIA, 1989-1990

Procedure	Average Wait	Longest Wait
Bypass	5.5 months	7 months
Other Open-Heart Surgery	4.9 months	7 months
Hernia Repair	5.7 months	1 year
Cholecystectomy	7.3 months	1 year
Hemorrhoidectomy	6.4 months	1 year
Varicose Veins	8.3 months	1 year
Hysterectomy	3.7 months	7 months
Arthrolasty (hips, etc.)	3.9 months	1 year
Prostatectomy	7.1 months	1 year

Source: Steven Globerman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute) May 190. Quoted by NCPA Policy Report No. 128, December 1991, page 18.

Conclusions published in 1987 by the Canadian government in Canadian Hospital Costs and Productivity:

1-"Canada's hospital expenditures grew at an average annual rate of 15 per cent" (1960 to 1980),

2-"the productivity of hospitals has not improved over the years; instead it declined",

3-"government policies aimed at curbing the excessive growth of health care costs have been of the cut, freeze, and squeeze variety and have not resulted in a basic redesign of the health care delivery system".

Source: 2. Auer, L: Canadian Hospital Costs and Productivity, A study prepared for the Economic Council of Canada. Canadian Government Publishing Centre, Supply and Services Canada, Ottawa, Canada K1A 0S9 1987.

Claude Castonguay, father of Quebec's health care system (the oldest in Canada) has called for privitization and competition in the supply of health services.[6]

SPENDING ON PHYSICIAN SERVICES BY HOSPITAL DISTRICTS[1] IN BRITISH COLUMBIA, 1987-88

Hospital Districts	Total Spending	Specia-lists	OB/GYN	Psychi-atrists	Internists
Urban Districts:					
Vancouver	$345.6	$214.0	$11.5	$14.0	$26.4
Victoria	348.4	211.8	8.5	13.2	25.6
Selected Rural Districts:					
Bulkley-Nechako	211.0	95.9	3.5	0.7	11.2
Cariboo	203.9	96.9	5.8	1.0	9.2
Central Coast	105.4	89.3	4.9	0.5	6.7
Columbia-Shuswap	188.0	88.3	3.5	3.4	9.5
East Kootenay	224.7	99.9	3.1	0.4	7.7
Kitimat-Stikine	193.2	103.9	5.8	0.3	10.0
Mount Waddington	167.2	75.6	6.5	0.9	5.2
Peace River	164.1	76.0	6.4	0.4	3.1
Skeena-Queen Charlotte	188.5	84.8	3.9	0.4	7.8
Squamish-Lillooet	205.7	89.5	6.3	2.0	8.8
Stikine	58.2	17.5	2.0	0.1	2.5
Fort Nelson/Laird	169.3	37.1	2.1	0.3	1.7
Average for all Rural Districts	253.8	138.1	7.2	4.0	7.0

Source: Pacemaker data by Eli Lilly Co. CAT scanner data by NCPA. Chronic renal failure data by Office of Health Economics, *Renal Failure: A Priority in Health?* (London: OHE) 1978, Table 7, p. 30. Data on Canada by Mary-Ann Rozbicki, *Rationing British Health Care: The Cost/Benefit Approach*, Executive Seminar in National and International Affairs, U.S. Dept. of State, April 1978, p. 22. U.S. figures estimated from data by the Department of Health, Education and Welfare. Quoted by NCPA Policy Report No. 128, December 1991, page 13

[1]Based on fees paid to physicians rendering services to patients living in the district indicated, regardless of the area in which the service was performed. All figures are age/sex standardized by regional hospital district and expressed in Canadian dollars.

EXHIBIT 29
DATE 3/24/93
SB 285

SPENDING ON PHYSICIAN SERVICES PER PERSON IN BRITISH COLUMBIA[1]
(1987-1988)

Specialty	Urban[2]	Rural[3]	Urban/ Rural
All Physician Svcs	$347.1	253.8	137.0%
General Practice	132.1	115.7	114.0%
Specialists	214.6	138.1	155.0%
Anesthesia	16.6	6.9	241.0%
Dermatology	5.0	1.8	278.0%
General Surgery	11.9	12.4	96.0%
Internal Medicine	26.3	15.8	167.0%
Neurology	3.9	2.1	186.0%
Neurosurgery	2.2	1.2	183.0%
OB/GYN	11.0	7.2	153.0%
Ophthalmology	16.1	8.8	183.0%
Orthopedic Surgery	8.5	7.1	120.0%
Ontolaryngology	5.1	3.8	134.0%
Pediatrics	5.6	3.8	147.0%
Pathology	44.0	35.0	126.0%
Plastic Surgery	3.2	1.3	246.0%
Psychiatry	13.9	4.0	348.0%
Radiology	30.9	21.6	143.0%
Thoracic Surgery	3.8	0.7	543.0%
Urology	5.7	4.0	143.0%

Source: Arminee Kazanjian et al., *Fee Fractice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1987-88* (Vancouver: University of British Columbia) 1989, pp. 121-176. Quoted by NCPA Policy Report No. 128, December 1991, page 50

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[1]Based on fees paid to physicians for rendering services to patients living in the areas indicated, regardless of the area in which the service was performed. All figures are age-sex standardized and expressed in Canadian dollars.

[2]Greater Vancouver and Victoria regional hospital districts.

[3]Twenty-seven non-metropolitan hospital districts.

INTERNATIONAL HEALTH CARE SPENDING
(Excluding Costs of Adminstration, Hospital Construction and Research and Development)

Country	Spending as a Percent of GNP 1988	Annual Real Growth as a Percent of U.S. 1980-1988	Annual Real Growth Per Capita as a Percent of U.S. Rate 1980-1988
Austria	8.05%	114%	207%
Belgium	7.35	101	187
Canada	8.36	185	263
Denmark	8.35	47	86
France	8.50	225	381
Germany	8.44	158	296
Ireland	9.17	81	108
Italy	7.71	229	412
Japan	6.88	172	268
Luxembourg	6.69	155	270
Netherlands	8.31	38	25
Spain	7.11	70	84
Sweden	9.19	50	76
Switzerland	7.84	156	242
United Kingdom	6.35	102	180
United States	10.19	100	100

Source: Dale A. Rublee and Markus Schneider, "International Health Spending: Comparisons with OECD," *Health Affairs*, Fall 1991, Ex. 3 and 4, pp. 193, 195. Quoted by NCPA Policy Report No. 128, December 1991, page 8.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. HB 508

DATE 3/24/93 SPONSOR(S) Rep. Fagg

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Michael Regnier 1010 Fairview - Missoula	Coalition of Montanans Concerned w/ Disabilities		✓
Paul Peterson 2915 Tyrean Missoula	Concerned w/ Disabilities		✓
[illegible]	M.S.C.A.		
Laurena L White	St. Patrick Hospital	✓	
[illegible]	[illegible]	✓	
Allyn Christians 1410 4th Ave N. Great Falls 59401 MT	Montana People's Action		X
Bob Christensen	Montana People's Action		X
Tom Hopgood	Health Ins Assn America	✓	
Steve TURKIEWICZ	MADA Insurance Trust		
Susan Swehart	MMHPC	[illegible]	✓
LARRY AKEI	MT ASSOC OF LIFE UNDERWRITERS	—	
[illegible]	MEA		✓
[illegible]	Mt. Psych. Assoc.		✓
[illegible]			

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. HB 508

DATE 3/24/93 SPONSOR(S) Rep. Tagg

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Mary McCue	Mt. Clinical Mental Health Counselors Ass'n		✓
Jim Fleischmann	MT People's Action		✓

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

House Human Services COMMITTEE BILL NO. SB 285

DATE 3-24-93 SPONSOR(S) Sen Franklin Eve

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

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Gloria Bladichuk	Richland Co. Commission Mt. Health Com	✓	
Tom Boyce	Montana Senior Citizens	✓	
Doug Campbell	MSCA	✓	
Alice Campbell	MCMHR	✓	
Clyde Dailey	MT. Senior City Assoc	✓	
Christian Mackay	MTns. for Universal Health Care	✓	
Michael Regnier 610 Fairview - Missoula	Coalition of Montanans Concerned w/ Disabilities	✓	
Paul Peterson 2115 Tuneau - Missoula	ic	✓	
Sid Olson	AARP	✓	
BOB ARDIS	myself	partly	partly
Tamy VanderAarde MD	myself		✓
John Gregory	MMA	✓	
DALE PFAU	Don's Inc	✓	
Mike Schweitzer MT	Self		✓

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB285

DATE 3/24/93 SPONSOR(S) Sen. Blue Trenteseau

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Christine Mangrantini Box 613, Helena	League of Wm Voters	X	
Steve Browning	MT Nsg Assn	X	
Mark O'Keefe	State Auditor	X	
Linda Booher	MT. Nurses Assoc.	✓	
JUDITH CARLSON	MT CHP, NAT ASSN SOCIAL WORKERS	✓	
Tanya Box 274	Blue Cross & Blue Shield MT	✓	
Bob Christiansen LOLO MT	Montana People's Action	✓	
Pamela Kelman	MCMCH	✓	
Tim Hopgood	Health Ins. Assoc. Amer.	✓	
Mary McCue	Mt. Clinical Mental Health Counselors Ass'n	✓	
Mary McCue	Mt. Dental Ass'n	✓	
Sim Mendenhall	Physician		X
HARLEY WARNER	ASSOC. OF CHURCHES	✓	
Steve Turkiewicz	MADA Insurance Trust	With Amend	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB285

DATE 3/24/93 SPONSOR(S) Sen. Sue Bartlett

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

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Sean Sweeney	MM HRC	✓	
Elizabeth Dave	NASW Assoc. of Social Workers	✓	
Katharine Donnelly	MHA		
David Owen	MT Chamber of Commerce	✓	
Phil Campbell	MEA	✓	
Don Judge	MT STATE AFL-CFO	✓	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	✓	
R. Ashbaugh	State Farm Ins	✓	
Ted Lange	Northern Plains Resource Council Big Muddy Resource Council.	✓	
Jim Karlee	MONTANA PEOPLE'S ACTION	✓	
Suzy Holt	MT TASK FORCE FOR BIOMEDICAL INFORMATION	✓	
JAMIE ~~Doggett~~	MT Cattlewomen	—	
Sen. Bill Yellowtail	Senator	✓	
Mona Jamison	P.T. Association	✓	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB 285

DATE 3/24/93 SPONSOR(S): Sen Eve Franklin

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Paul Gorsuch MD	self		✓
Dale Schaefer	self		✓
Wally Henkelman RN	Mont. Nurses Assn	✓	
Alvin Ankenstad	OPI	✓	
Allyn Christiaens 1010 4th Ave N Great Falls	Montana Peoples Action	X	
Chet Kinsey	MSCA - MLC	✓	
Tom ERDIC	self	✓	
Teresa Henry RN	Kathleen Long RN Co Chair HithMT	✓	
Vernon Bertsch	Legacy Legislature	✓	
John Wyman	Montana Peoples Action	✓	
Dan Sden	A Citizen's Private Perspective		X
Staci Riley	MFT/MFSE MT Fed Health Employees	✓	
Dr Jeff Stricker	MT Academy of Pediatrics	✓	
Keith L. Colbo	AFL-CIO	✓	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB 285

DATE 3/24/93 SPONSOR(S) Sen. Bill Yellowtail

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

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
J. Shontz	Mental Health Assn / Mt	✓	
Chuck Butler	Blue Cross and Blue Shield of Montana	✓	
Jim Fleischmann	MT People's Action	✓	
Jim Smith	Mt. Psych Assoc.	✓ NOT Section 33.	

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