MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - SPECIAL SESSION

JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **REP. JOHN COBB, CHAIRMAN**, on November 17, 1993, at 1:20 P.M.

ROLL CALL

Members Present:
Rep. John Cobb, Chairman (R)
Sen. Mignon Waterman, Vice Chairman (D)
Sen. Chris Christiaens (D)
Rep. Betty Lou Kasten (R)
Sen. Tom Keating (R)
Rep. David Wanzenried (D)

Members Excused: NONE

Members Absent: NONE

Staff Present: Lisa Smith, Legislative Fiscal Analyst
Lois Steinbeck, Legislative Fiscal Analyst
Connie Huckins, Office of Budget & Program Planning
Doug Schmitz, Office of Budget & Program Planning
Alberta Strachan, Committee Secretary

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

Committee Business Summary:

Hearing: **CHAIRMAN COBB** stated that the agenda consisted of testimony from the Montana Department of Labor and Industry and the Montana Department of Health and Environmental Sciences.

Executive Action: NONE

HEARING ON DEPARTMENT OF LABOR AND INDUSTRY

Lisa Smith, Legislative Fiscal Analyst stated that the recommendation is to eliminate the silicosis program which would be from the general fund of $73,102.00 in FY94 and $280,854.00 in FY95. **EXHIBIT 1.**

Laurie Eckanger, Commissioner, Department of Labor and Industry

said that the silicosis program was enacted in the 1930's and came to the Department three years ago when the State Fund was turned into an independent insurance company. The administration is proposing to introduce companion legislation to repeal this statute in conjunction with the budget.

Chuck Hunter, Administrator, Employment Relations Division, Department of Labor and Industry discussed the eligibility requirements and the difference in spouse benefits, the administrative cost data and the annual survey of silicosis in the present program. **Mr. Hunter** also distributed a silicosis count, past and projected chart. **EXHIBIT 2 and 3**

Questions were raised in the committee regarding the silicosis program.

Doug Schmitz, Department of Budget and Planning, stated that the Budget Office tried to determine cost shifting to other units of government; through that process that it appeared that eligibility requirements were not being met on an ongoing basis. The Department has since worked on the question and is trying to solicit information at this time. Compliance with statutes in making eligibility determinations was of issue.

Laurie Eckanger then spoke to members of the committee of the Department's organizational chart. **EXHIBIT 4** The major initiatives which the Department has been working on include Workers' Compensation reform which added fourteen positions to the Department. The targeted job training programs were also a result of the recent session. These included a special project for offenders, people with multiple barriers and a special project for dislocated workers.

Chuck Hunter then addressed of the Workers' Compensation reforms; and some of the major pieces of legislation regarding medical cost containment, safety culture act, data base act and coalition. Concerning the medical cost containment, an advisory group was established which looked at eligibility criteria. This was the certification process which set up the managed care organization and which received more of the complicated medical claims. The first draft of the rules has been completed; it does contain controversy because many of the subjects argued in the session about limiting access and forcing people in various kinds treatment centers. The rules will be finalized by March 1994 which would allow organizations who wanted to become MCO's enter into that certification process. The safety task force is an advisory council. Rules will be established by the first of January 1994 to specify what employers must do to enact the safety programs in each location. The data base bill has been working with national groups on an electronic data interchange. Montana is tied in with a network of other states to build a system for national comparative purposes. With this task force adopted, the first two EDI formats are established. There will be standard reporting for insurers and electronic data sharing

primarily between the Department of Labor and the State Fund. A benefits booklet would be provided to insurance companies. The Department of Labor is working with the State Fund, the Department of Justice and the Citizen's Advocate Office to coordinate the fraud hot line information.

Ingrid Danielson, Apprenticeship & Training, Department of Labor and Industry, spoke about the implement and design programs. One of these programs was for offenders which would reduce the population of the Montana State Prison. A task force was established to serve 250 inmates in the prison and pre-release centers and offenders in the diversionary programs. A program to aid persons with multiple barriers was established. This program was responsible for initiating the Custodial Parent Program. A program was also initiated in the state for dislocated workers.

REP. CAROLYN SQUIRES, (D) District 58, Missoula, stated that people will not show up who are currently enrolled in some type of retraining. There are 190 enrolled in the Project Challenge Program. Those dollars have all been committed to individuals in retraining. The specific amount of money allocated is $44,000. The money has been used extremely well for the individuals who have participated in the program.

HEARING ON DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

CHAIRMAN COBB stated that the agenda would consist of the health care authority, the MIAMI Program, Residency Program and the Renal Program.

Lisa Smith stated that the executive recommendation in the budget is to reduce the appropriation for the Health Care Authority by $150,000.00. The Health Care Authority was established in SB 285 and the appropriation is in HB 145.

Connie Huckins, Office of Budget and Program Planning, stated that the recommendation is to take $150,000.00 from the general fund.

Sam Hubbard, Executive Director, Health Care Authority, stated that there is a lack of access to health care for a significant percentage of the population, too much specialization resulting in inadequate primary care, too little emphasis on preventive services and wellness and high administrative costs and inefficiencies. **Mr. Hubbard** then stated that their program mission consists of control of the growth in health care spending; promotion of a universal health care access; development of unified health care data base focusing on costs and usage of health care; the encouragement and facilitation of consumer education regarding the efficient and effective use of health care resources and the maintenance and improvement of the quality of health care services. Work task areas have been established for background research and problem definition; universal health care access; health care planning; cost

containment; public participation and community education; regional health planning boards; intergovernmental relations; program management and administration. **EXHIBIT 5**

Paul Gorsuch, M.D., a physician from Great Falls, stated that SB 285 was not a study bill. There are too many assumptions and unanswered questions in the bill to justify the expenditure. Alternatives to government control have been specifically excluded from the bill, again without any consideration of merit. **Dr. Gorsuch** then outlined several options to save money, including eliminate funding; narrow the focus of the authority's reform proposals; broaden the options available to the authority in that more focused reform; and sunset the health care authority. **EXHIBIT 6, 7, 8, 9, 10, 11**

Bob Wynia, M.D., stated that $1.5 million could be taken out of the budget. Considerable consideration must be given to discontinuing this program. Medicaid and Medicare in the state of Montana are 17th in the nation for costs. The private care system is 44th in the nation.

Jim Ahrens, Montana Hospital Association said that for the past two years, Healthcare Montana, consortium of Blue Cross/Blue Shield of Montana, the Montana Hospital Association and the Montana Medical Association has devoted its energy and resources to bringing about comprehensive reform to Montana's health care system.

Tanya Ask, Blue Cross/Blue Shield of Montana re-emphasized the fact that cuts beyond those proposed by the Governor's office would not be acceptable. It is very important for the people of Montana to have the opportunity to control their own destiny.

Alan Lanning, Attorney from Great Falls, stated that the entire budget of the health care authority should be cut. This would save untold billions in the long run.

Christian McKay, Coordinator, Montanans For Universal Health Care with the coalition of several consumer groups, stands in support of the same position of Blue Cross/Blue Shield and the Montana Hospital Association and supports the administrations recommendation for the budget cut. He would resist any attempts at a full scale cut of this appropriation.

Paulette Koleman stated that there was nothing in SB 285 to suggest that the legislature has addressed the issues of consumerism, free choice, and a multi payer system.

Clyde Dailey, State Auditor's Office, stated his opposition to any cuts.

Russell Hill, Montana Trial Lawyers Association, stated his opposition.

Robert J. Robinson, Director, Department of Health and Environmental Sciences, gave a summary of the status of MIAMI expansion in 1995. **EXHIBIT 11, 12, 13, 14**

Marty Onishuk, Montana Alliance for the Mentally Ill, opposes this reform.

SEN. EVE FRANKLIN, (D) District 17, Great Falls, stated her opposition to the proposals.

Ed Coplis, Montana Senior Citizen's Association said that the association opposes any cut to the authority.

Barbara Booher, Montana Nurses Association recommended no cut in the funding of the health care proposal.

Steven L. Pilcher, Environmental Sciences Division, Department of Health and Environmental Sciences, presented a permit status summary which included the Air Quality Bureau, Solid and Hazardous Waste Bureau, Water Quality Bureau, and the Occupational and Radiological Health Bureau. **EXHIBIT 15. Mr. Pilcher** also presented information on the issues and accomplishments of the Environmental Sciences Division which included the Natural Resource Damage Program, Air Quality Bureau, Solid and Hazardous Waste Bureau, Water Quality Bureau, and Occupational and Radiological Health Bureau. **EXHIBIT 16**

Written testimony was also supplied by **Walt Dupea, Tax Equity Action Movement, EXHIBIT 17; Montanans For Better Government, EXHIBIT 18; Charles Butler, Jr., Blue Cross/Blue Shield, EXHIBIT 19.**

ADJOURNMENT

Adjournment: 4:50 P.M.

REP. JOHN COBB, Chairman

Alberta Strachan, Secretary

JC/as

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING SUB-COMMITTEE

ROLL CALL DATE Nov. 17, 1993

NAME	PRESENT	ABSENT	EXCUSED
REP. JOHN COBB, CHAIRMAN	X		
SEN. MIGNON WATERMAN, VICE CHAIR	X		
SEN. CHRIS CHRISTIANS	X		
REP. BETTY LOU KASTEN	X		
SEN. THOMAS KEATING	X		
REP. DAVID WANZENRIED	X		

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EXHIBIT 1
DATE 11-17-93
SB HUMAN SERVICES

53rd LEGISLATURE - SPECIAL SESSION
November - December 1993

HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE

Tentative Schedule*
Chairman: John Cobb
Vice Chairwoman: Mignon Waterman

Meeting Room 108

Secretary:
LFA Staff: Lois Steinbeck 444-5386
Lisa Smith 444-5837

♦ Agency Order - Tentative Dates ♦

Day	Time	Date	Topic/Agency/Program
Wednesday	1:00	11-17	Department of Labor and Industry
Wednesday	2:00	11-17	Department of Health and Environmental Sciences
Thursday	8:00	11-18	Joint Meeting with Institutions and Cultural Education in Room 325
			Department of Social and Rehabilitation Services-- Reductions in Mental Health Services
Thursday	10:00	11-18	Reconvene in Room 108 - Continue SRS Hearings
Friday	8:00	11-19	Department of Family Services
Friday	1:00	11-19	Committee Decisions

Latest update: 10/12/93

*A more detailed hearing schedule will be available November 1, 1993.

Please call Representative John Cobb (562-3670) if you or your group wishes to present testimony to the subcommittee.

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HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE SCHEDULE
for November 17, 18, & 19th Room 108

1. The usual course of action will be:
   a. proposed cuts or spending increases by the Department or others
   b. any comment from fiscal analyst
   c. questions or comments by committee
   d. public testimony
   e. action to be taken Friday at 1 p.m. in room 108

2. Breaks will be taken occasionally for about 10 to 15 minutes and will be at the call of the Chair or committee. (Usually breaks are taken after 1 1/2 to 2 hours of hearings).

Wednesday November 17

1:00 p.m. **Department of Labor and Industry**
   a. Governor's proposed cuts on Silicosis program
   b. Other cuts
   c. Update on Department programs, goals problems, successes and plans for next regular session.

2:00 p.m. **Department of Health and Environmental Sciences**
   a. Governor's proposed cuts on Health Authority

2:30 p.m. Other cuts or increased spending
   a. MIAMI program
   b. Residency program
   c. End Stage Renal program

3:00 p.m.
   a. Presentation of reorganization plan by the department
   b. Update on all permit backlogs and time frame for eliminating backlogs
   c. Update on staff hiring and reorganization
   d. Update on moving to new building
   e. Update on departments programs, problems, successes
   f. Update on changes to departments goals
   g. Possible change in budgeting in appropriations of departments environmental division

4:30 p.m. Other business, possible executive action plan for friday at 1:00 p.m.

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Thursday November 18th **SRS Budget Cuts and Spending Increases**

8:00 a.m. Joint meeting with Institutions and Cultural Education (Location to be announced) Room 312-1

1. Governor's proposed cuts
   a. Limit the number of mental health services
   b. Limit number of day treatment services
   c. Capitate mental health services to adults

2. Possible changes in hearing budgets of all mental health programs and juvenile justices programs by legislature

10:00 a.m. 1. Overview of information requested at Aug. meeting by the committee
2. Update on medicaid growth rates

a. Possible major changes to control overall growth rates from managed care, expansion of HMOs, contracting out programs, provider taxes.

10:40 a.m.
   a. Overview of long term care in Montana report
   b. Changes possible for long term care in Montana
   c. Law changes
   d. Expansion of home health, at risk, waiver programs
   e. Regulation changes if necessary
   f. Medicaid cost recovery projections

11:10 a.m. Update on Welfare Reform
   a. Department of SRS
   b. Comments by public
   c. Comments by County welfare directors/employees
   d. Possible changes in day care, waivers, SSI, others
   e. Changes in child support
   f. Update on AFDC growth rate

12:00 Lunch

1:00 p.m. Governor's proposed cuts in optional services

(Whether the committee hears all the proposals first or takes public testimony after each proposal depends on the time available and the number of people to testify.)

   a. Changes possible at national level for health care reform that will affect optional services by SRS
   b. Reduction or elimination of some services
      eliminate adult podiatry services
      eliminate adult hearing aids and audiology services
      reduce adult physical, speech, occupational therapy services

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eliminate adult eyeglasses and optical services
eliminate adult denture and dental services

2:30 p.m. Co-payment Increases
- a. Pharmacy co-pay
- b. Increase co-pay limit
- c. Increase co-insurance on inpatient hospital stays

3:10 p.m. Break

3:20 p.m. Limit services for medically needy to primary and preventative care

4:00 p.m. Reduce outpatient hospital reimbursement

4:30 p.m. Reduce limit on personal care services

5:00 p.m. List of possible executive action to be taken Friday at 1:00 p.m. and any informational requests by committee for SRS

Friday November 19th

8:00 a.m. Nursing home reductions
- a. Delay implementation of nursing home property reimbursement changes
- b. Implement a special income limit for nursing home eligibility

9:00 a.m. **Department of Family Services**
- a. Update on informational requests by the committee from the Aug. meeting
- b. Presentation by Legislative Auditor on Juvenile Justice System and response by Department
- c. Update on actions taken by committee and department since regular session
- d. Problem areas and successes
- e. Plan for next session

10:00 a.m. Possible cuts - Big Brothers and Sisters

11:00 a.m. Other possible changes, Pine Hills, Mountain View

12:00 Lunch

1:00 p.m. Executive Action

2:30 Close business, other business, informational requests

MJB3:mb:Cobb11-8.rpt

EXHIBIT 2
DATE 1-17-93
SB HUMAN SERVICES

Silicosis Presentation

I. History

Program enacted in 1937m was managed by the Department of Public Welfare until 1961 - then to Workers Comp

Pays benefits to silicosis victims and surviving spouses

Eligibility - must have silicosis
must have been Montana resident for past 10 yrs
can't have income of over 150 per month
can't have OD benefits over $200 per month

upon death, benefits can go to surviving spouse, so long as spouse is unmarried

Difference in spousal benefits:

in 74 session, legislature extended benefits to surviving spouses, for deaths after 3/14/74 they provided no benefits for spouses widowed prior to that date

in 75 session, benefits were extended to spouses widowed prior to that date, but at only 50%

II. Handout

III. Administrative Cost Data

1/10th of 1 position	3028.00
operating expenses	1284.00

IV. Annual survey

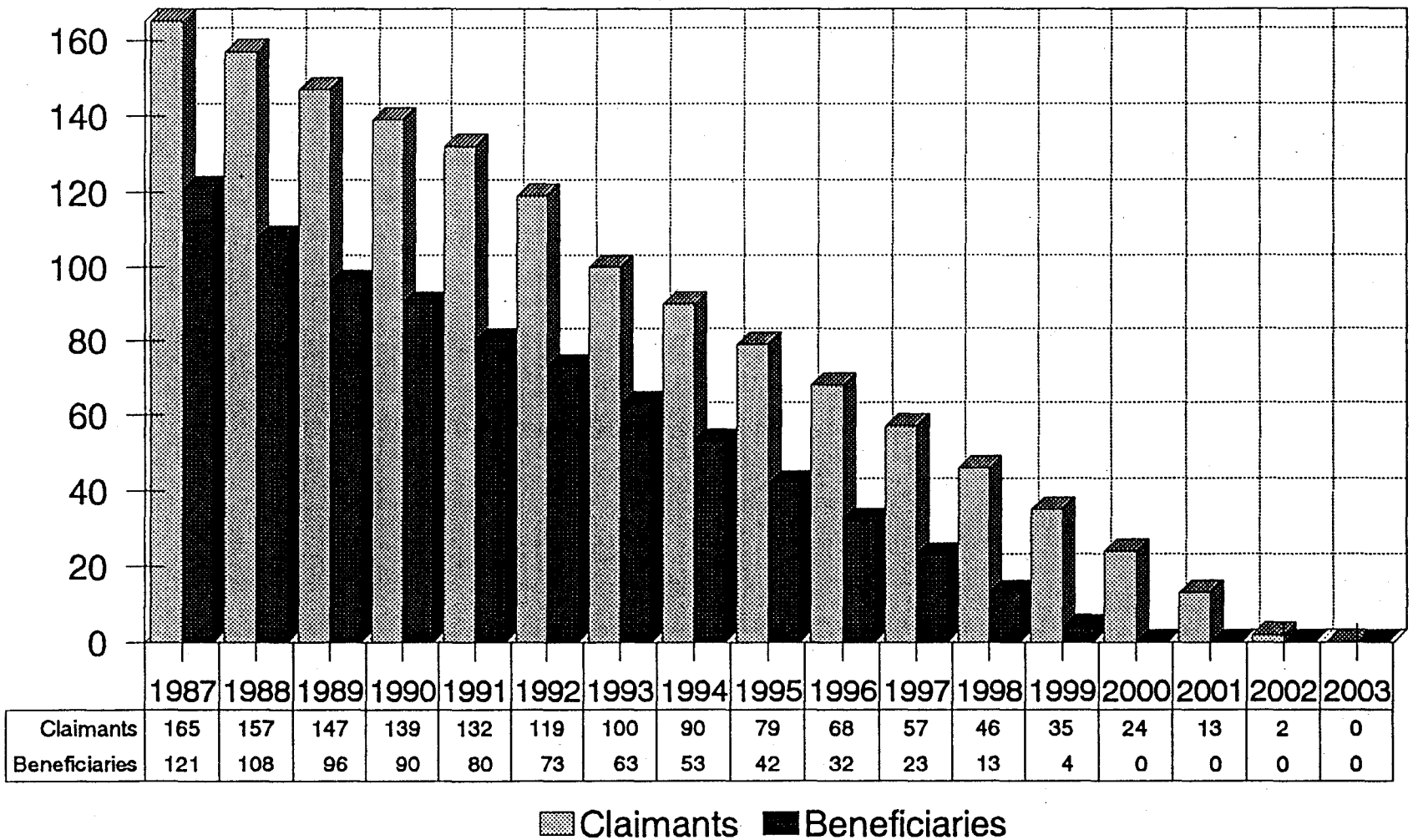
Annual survey of benefit recipients done to

verify addresses
changes in marital status
employment and income
signature

verify people are still living by:
checking statewide obits

Silicosis Count, Past & Projected

Trend Analysis, WW 9/30/93



	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Claimants	165	157	147	139	132	119	100	90	79	68	57	46	35	24	13	2	0
Beneficiaries	121	108	96	90	80	73	63	53	42	32	23	13	4	0	0	0	0

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EXHIBIT 3
DATE 11-17-93
SB HUMAN SERVICES

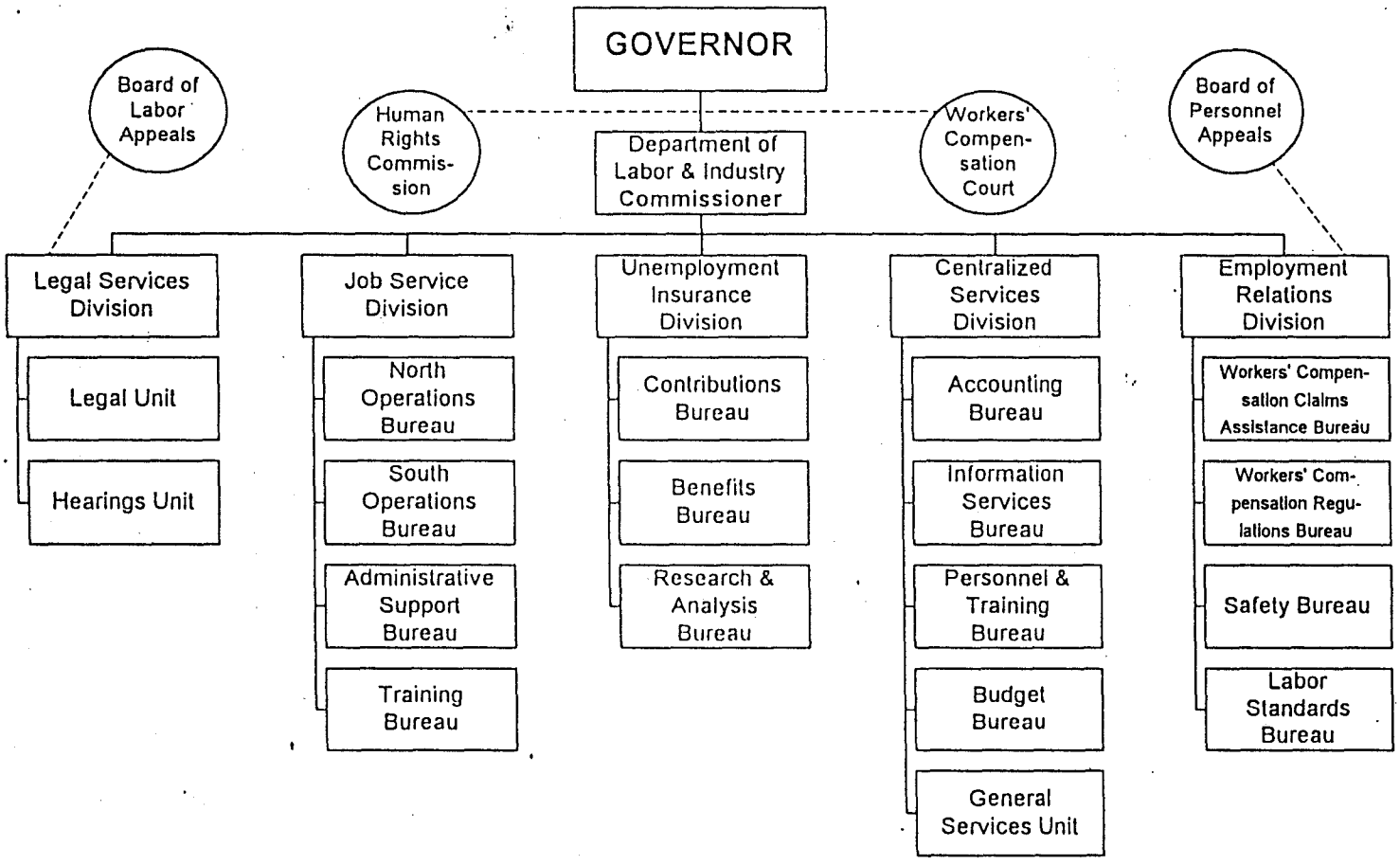

EXHIBIT 4
DATE 11-17-93
SB HUMAN SERVICES

EXHIBIT
DATE 11-17-93
SB HUMAN SERVICES

November 17, 1993

MONTANA HEALTH CARE AUTHORITY

WORK PLAN SUMMARY

1993 - 1995

Montana Health Care Authority
28 North Last Chance Gulch
P.O. Box 200901
Helena, Montana 59620-0901
Telephone: 406/443-3390 • Fax: 406/443-3417

November 1, 1993

EXHIBIT 6
DATE 11-17-93
SB HUMAN SERVICES

11/17/93-Paul Gorsuch Jr., M.D.

WHY CUT FUNDING TO SB285?-3 POINTS AND 4 SUGGESTIONS

1-Not a "study" bill: -Section 1, page 8 (lines 5-11)
-Definitions, Section 2, paragraph 7, page 10 (lines 18-21)
-Sections 5, 6, 7, 8

1.5 million expenditure for the state to develop and sell to the public a financing mechanism for a completely state run centrally controlled health care system. It assumes that the state should run the health care system (public & private) and then asks the Authority to develop two financing mechanisms to implement the same set of centrally imposed controls.

Any conceivable health care need, resource, facility, or records are subject to state control under any plan implemented.

A few examples of what is required by law under any option offered: Section 7 pages 18, 19, 20.

-cost containment targets
-global budgeting
-rationing system ("system for limiting demand")
-a method of monitoring compliance with the cost targets
-expenditure targets for facilities and providers
-disincentives (penalties) for exceeding targets

2-There are too many assumptions and unanswered questions in the bill to justify the expenditure.

For example: the disadvantages or merits of the cost control features listed above have not even been listed much less debated. It is not the Authority's mandate to consider those issues, but only to develop a method to impose them. Regardless of how current Authority members may feel about them we have know way of knowing what future members may think or do and the law does require these features.

Unquestioned Assumptions

-should the government run the entire health care system?
-should government control extend to the private sector, i.e. should the system be socialized?
-who should make the choice between health care use of dollars and other uses (for individual health care)--the individuals affected or third parties?
-should the health care system be politically controlled?

Unanswered Questions

-Have any of the cost control features required in the bill been demonstrated to be effective in any other state or country?
-Are individual rights threatened by this bill? In addition to how state control would effect the availability of medical care, costs, etc., consider the problems raised by the mandated Data Base-Statement of intent, paragraph D, page 5, lines 5-16; AND Section 19, subsection 2 pages 35-line 25 & 36-lines 1-21.
-Are the individual's ability to exercise those rights threatened by the bill?

-Does the State's record Work Comp. and Medicaid indicate that they will be successful in promoting quality, extending coverage, and controlling costs, if given authority over the whole system?
-Will this be a waste given the uncertain nature of federal action. Consider the Texas super collider collapse.

3-Alternatives to government control have been specifically excluded from the bill; again without any consideration of merit.

Is public opinion so overwhelmingly in favor of state run health care that a 1.5 million expenditure to develop a state run plan is warranted? Is public opinion for socializing the system so overwhelming that any reference to market incentives, consumer preferences, or individual choice should be specifically eliminated from the bill: page 7, lines 17-22
page 15, lines 20-21
page 17, lines 15, 16, & 23
page 19, line 10.

OPTIONS TO SAVE MONEY

A. Eliminate the funding.

A single payer option has already been proposed and is available for the legislature's consideration (the Yellowtail bill). A market oriented model draft proposal is already available for consideration (Keeping the Promise) in 1995. No doubt a Montana customization of that proposal is being worked on already.

These two options are already available at almost no cost.

B. Narrow the focus of the Authority's reform proposals.

Example: The state's biggest problems are Medicaid and the uninsured. Medicaid is the fastest growing area of health expenditures nationally. There are a multitude of reform options being considered around the country-none yet proven effective. If the state cannot control just Medicaid costs, it will not be able to succeed in any larger proposal for reform. Why not ask the Authority to propose plans only for Medicaid reform? Such a narrowed focus would still address the biggest problems and the largest state expenditures without extending government control into the private sector. This could save money by a number of mechanisms:

-a smaller more realistic task for the Authority would require less money to develop and implement.
-the need for the regional boards would be greatly diminished or eliminated. If the regional boards were eliminated this would save money.
-Any proposal adopted could be observed for success or failure prior to state wide implementation.

C. Broaden the options available to the authority in that more focused reform.

Example: Reinsert the options for considering market incentives, consumer preferences, and individual choice previously eliminated from

the bill. Change the required mandates of sections 5, 6, 7, 8, 11, and 19 to options for consideration. This would allow the Authority to include only those ideas they feel are warranted, but to consider all if they choose to do so. Simpler legislation would be easier to develop and implement thereby saving money. In addition we might get a better cheaper plan.

D. Sunset the Health care Authority.

If a new bureaucracy is to be established, then surely it should not automatically be funded on a continuing or indefinite basis, unless it can demonstrate that it is worth the money.

COMPARING MONTANA

		Most Expensive State			Montana		Least Expensive State			Natl Average
	Year	State	Total $	Rank	Total $	Rank	State	Total $	Rank	
Income										
Per Capita Personal Income	1991	Conn	26,022	1	15,675	38	Miss	13,328	50	19,092
Health Care										
Per Capita Total Health Care Payments	1991	Conn	3,874	1	2,135	41	Miss	1,714	50	2,751
	1980	Conn	1,285	1	812	42	Miss	647	50	1,014
Per Family Total Health Care Payments	1991	Conn	9,312	1	4,910	44	Miss	4,158	50	6,535
	1980	Conn	3,252	1	2,009	41	ID	1,806	50	2,572
Medicaid Cost per Recipient	1991	Conn	5,994	1	3,037	17	AZ	268	50	2,725
Work Comp Benefit Payments per Civilian Laborer	1989	Maine	555.03	1	378.50	7	Ind.	103.24	50	277.04
Health Rank & Score	1993	Utah 16.27		1	20.50	7	Florida 33.36		50	

Source: As listed by Morgan Quinto Corporation in *Health Care State Rankings 1993*; & *State Rankings 1993*. P.O. Box 1656, Lawrence, KS 66044. (800) 457-0742.

Persons Not Covered by Health Insurance in 1991

National Total = 35,445,000 Uninsured

RANK	STATE	UNINSURED	%
1	California	5,750,000	16.22%
2	Texas	3,755,000	10.59%
3	Florida	2,496,000	7.04%
4	New York	2,206,000	6.22%
5	Illinois	1,361,000	3.84%
6	Ohio	1,147,000	3.24%
7	Virginia	1,002,000	2.83%
8	North Carolina	990,000	2.79%
9	Pennsylvania	954,000	2.69%
10	Georgia	885,000	2.50%
11	Louisiana	869,000	2.45%
12	New Jersey	838,000	2.36%
13	Michigan	835,000	2.36%
14	Alabama	749,000	2.11%
15	Indiana	721,000	2.03%
16	Tennessee	644,000	1.82%
17	Massachusetts	633,000	1.79%
18	Maryland	625,000	1.76%
19	Missouri	611,000	1.72%
20	Arizona	607,000	1.71%
21	Oklahoma	579,000	1.63%
22	Washington	518,000	1.46%
23	Mississippi	507,000	1.43%
24	Kentucky	476,000	1.34%
25	South Carolina	465,000	1.31%
26	Oregon	422,000	1.19%
27	Minnesota	406,000	1.15%
28	Wisconsin	396,000	1.12%
29	Arkansas	385,000	1.09%
30	New Mexico	335,000	0.95%
31	Colorado	334,000	0.94%
32	Kansas	295,000	0.83%
33	West Virginia	287,000	0.81%
34	Connecticut	249,000	0.70%
34	Iowa	249,000	0.70%
36	Utah	238,000	0.67%
37	Nevada	232,000	0.65%
38	Idaho	184,000	0.52%
39	Nebraska	137,000	0.39%
40	Maine	135,000	0.38%
41	New Hampshire	112,000	0.32%
42	Montana	104,000	0.29%
43	Rhode Island	96,000	0.27%
44	Delaware	94,000	0.27%
45	Hawaii	82,000	0.23%
46	Vermont	74,000	0.21%
47	Alaska	69,000	0.19%
48	South Dakota	68,000	0.19%
49	Wyoming	53,000	0.15%
50	North Dakota	48,000	0.14%
	District of Columbia	136,000	0.38%

Source: U.S. Bureau of the Census
unpublished data

Medicaid Cost per Recipient in 1991

National Per Capita = $2,725 per Recipient*

RANK	STATE	PER CAPITA
1	Connecticut	$5,994
2	New York	5,577
3	New Hampshire	4,898
4	New Jersey	4,437
5	Massachusetts	4,344
6	North Dakota	4,319
7	Rhode Island	4,014
8	Indiana	4,003
9	Minnesota	3,702
10	Delaware	3,671
11	Maryland	3,565
12	Maine	3,561
13	Wisconsin	3,537
14	South Dakota	3,435
15	Idaho	3,184
16	Alaska	3,123
17	Montana	3,037
18	Colorado	3,011
19	Nevada	3,005
20	Iowa	2,930
21	Nebraska	2,915
22	Ohio	2,812
23	Vermont	2,782
24	Virginia	2,756
25	Louisiana	2,690

RANK	STATE	PER CAPITA
25	Pennsylvania	$2,690
27	North Carolina	2,679
28	Oklahoma	2,673
29	Kansas	2,642
30	Hawaii	2,606
31	Oregon	2,531
32	Wyoming	2,450
33	South Carolina	2,426
34	Arkansas	2,417
35	Georgia	2,411
36	Utah	2,408
37	Illinois	2,387
38	Florida	2,358
39	Kentucky	2,284
40	Michigan	2,283
41	Washington	2,235
42	Missouri	2,221
43	Tennessee	2,130
44	New Mexico	2,113
45	Texas	2,043
46	Alabama	1,997
47	West Virginia	1,912
48	California	1,886
49	Mississippi	1,607
50	Arizona	268
	District of Columbia	4,456
	Puerto Rico	122

Source: U.S. Department of Health and Human Services, Health Care Financing Administration

Unpublished data

**For fiscal year ending September 30, 1991.*

EX 6
11-17-93
HUMAN SERVICES

Medicaid Recipients in 1991

National Total = 28,279,781 Recipients*

RANK	STATE	RECIPIENTS	%
1	California	4,019,084	14.21%
2	New York	2,461,537	8.70%
3	Texas	1,728,629	6.11%
4	Ohio	1,299,285	4.59%
5	Pennsylvania	1,277,428	4.52%
6	Florida	1,248,883	4.42%
7	Illinois	1,144,272	4.05%
8	Michigan	1,112,533	3.93%
9	Georgia	746,241	2.64%
10	Tennessee	697,411	2.47%
11	North Carolina	667,203	2.36%
12	Massachusetts	651,056	2.30%
13	Louisiana	640,562	2.27%
14	New Jersey	614,073	2.17%
15	Kentucky	525,497	1.86%
16	Washington	506,279	1.79%
17	Missouri	503,310	1.78%
18	Mississippi	469,684	1.66%
19	Virginia	442,073	1.56%
20	Minnesota	421,738	1.49%
21	Wisconsin	415,942	1.47%
22	Indiana	415,167	1.47%
23	Alabama	403,255	1.43%
24	South Carolina	375,233	1.33%
25	Maryland	362,520	1.28%

RANK	STATE	RECIPIENTS	%
26	Arizona	313,142	1.11%
27	Oklahoma	304,659	1.08%
28	Arkansas	284,674	1.01%
29	West Virginia	283,708	1.00%
30	Connecticut	271,903	0.96%
31	Oregon	263,303	0.93%
32	Iowa	261,419	0.92%
33	Colorado	223,444	0.79%
34	Kansas	209,329	0.74%
35	Rhode Island	163,704	0.58%
36	New Mexico	161,995	0.57%
37	Maine	150,623	0.53%
38	Nebraska	133,751	0.47%
39	Utah	129,274	0.46%
40	Hawaii	91,162	0.32%
41	Vermont	70,699	0.25%
42	Idaho	70,060	0.25%
43	Montana	63,615	0.22%
44	New Hampshire	59,684	0.21%
45	Nevada	59,296	0.21%
46	South Dakota	57,145	0.20%
47	North Dakota	52,539	0.19%
48	Alaska	51,288	0.18%
49	Delaware	50,680	0.18%
50	Wyoming	36,804	0.13%
	District of Columbia	100,065	0.35%
	Puerto Rico	1,201,199	4.25%

Source: U.S. Department of Health and Human Services, Health Care Financing Administration

Unpublished data

**For fiscal year ending September 30, 1991.*

Medicaid Expenditures in 1991

National Total = $77,048,353,128*

RANK	STATE	EXPENDITURES	%
1	New York	$13,728,452,104	17.82%
2	California	7,578,546,773	9.84%
3	Ohio	3,653,431,706	4.74%
4	Texas	3,532,103,915	4.58%
5	Pennsylvania	3,436,164,827	4.46%
6	Florida	2,944,357,129	3.82%
7	Massachusetts	2,828,315,291	3.67%
8	Illinois	2,731,167,804	3.54%
9	New Jersey	2,724,720,584	3.54%
10	Michigan	2,540,086,697	3.30%
11	Georgia	1,799,296,327	2.34%
12	North Carolina	1,787,569,509	2.32%
13	Louisiana	1,723,278,206	2.24%
14	Indiana	1,661,776,563	2.16%
15	Connecticut	1,629,898,556	2.12%
16	Minnesota	1,561,303,611	2.03%
17	Tennessee	1,485,247,776	1.93%
18	Wisconsin	1,471,011,102	1.91%
19	Maryland	1,292,245,064	1.68%
20	Virginia	1,218,430,424	1.58%
21	Kentucky	1,200,294,186	1.56%
22	Washington	1,131,408,143	1.47%
23	Missouri	1,117,882,322	1.45%
24	South Carolina	910,287,195	1.18%
25	Oklahoma	814,372,251	1.06%
26	Alabama	$805,455,097	1.05%
27	Iowa	765,942,643	0.99%
28	Mississippi	754,917,219	0.98%
29	Arkansas	687,966,888	0.89%
30	Colorado	672,796,175	0.87%
31	Oregon	666,526,383	0.87%
32	Rhode Island	657,057,749	0.85%
33	Kansas	552,987,169	0.72%
34	West Virginia	542,490,046	0.70%
35	Maine	536,347,763	0.70%
36	Nebraska	389,846,429	0.51%
37	New Mexico	342,245,846	0.44%
38	Utah	311,339,546	0.40%
39	New Hampshire	292,351,687	0.38%
40	Hawaii	237,529,281	0.31%
41	North Dakota	226,937,494	0.29%
42	Idaho	223,048,358	0.29%
43	Vermont	196,715,470	0.26%
44	South Dakota	196,305,653	0.25%
45	Montana	193,229,100	0.25%
46	Delaware	186,056,982	0.24%
47	Nevada	178,169,850	0.23%
48	Alaska	160,194,502	0.21%
49	Wyoming	90,177,377	0.12%
50	Arizona	83,871,151	0.11%
	District of Columbia	445,856,191	0.58%
	Puerto Rico	146,135,200	0.19%

Source: U.S. Department of Health and Human Services, Health Care Financing Administration

Unpublished data

**For fiscal year ending September 30, 1991.*

EX 6
11-17-93
HUMAN SERVICES

Persons Not Covered by Health Insurance in 1989

National Total = 33,385,000 Uninsured

RANK	STATE	UNINSURED	%
1	California	5,577,000	16.71%
2	Texas	3,770,000	11.29%
3	Florida	2,169,000	6.50%
4	New York	2,121,000	6.35%
5	Illinois	1,162,000	3.48%
6	Pennsylvania	1,088,000	3.26%
7	Georgia	964,000	2.89%
8	Ohio	912,000	2.73%
9	North Carolina	889,000	2.66%
10	New Jersey	782,000	2.34%
11	Michigan	776,000	2.32%
12	Louisiana	732,000	2.19%
13	Virginia	698,000	2.09%
14	Indiana	668,000	2.00%
15	Alabama	665,000	1.99%
16	Oklahoma	630,000	1.89%
17	Tennessee	619,000	1.85%
18	Missouri	614,000	1.84%
19	Arizona	580,000	1.74%
20	Washington	562,000	1.68%
21	Massachusetts	495,000	1.48%
22	South Carolina	491,000	1.47%
23	Kentucky	476,000	1.43%
24	Maryland	467,000	1.40%
25	Colorado	443,000	1.33%

RANK	STATE	UNINSURED	%
26	Mississippi	436,000	1.31%
27	Wisconsin	414,000	1.24%
28	Arkansas	410,000	1.23%
29	Oregon	400,000	1.20%
30	Minnesota	366,000	1.10%
31	New Mexico	321,000	0.96%
32	Connecticut	260,000	0.78%
33	West Virginia	250,000	0.75%
34	Kansas	229,000	0.69%
35	Iowa	206,000	0.62%
36	Nevada	176,000	0.53%
37	Nebraska	162,000	0.49%
38	Idaho	158,000	0.47%
39	Utah	151,000	0.45%
40	New Hampshire	141,000	0.42%
41	Montana	120,000	0.36%
42	Maine	113,000	0.34%
43	Delaware	104,000	0.31%
44	Alaska	89,000	0.27%
44	Rhode Island	89,000	0.27%
46	Hawaii	79,000	0.24%
47	South Dakota	76,000	0.23%
48	Wyoming	58,000	0.17%
49	North Dakota	56,000	0.17%
50	Vermont	49,000	0.15%
	District of Columbia	120,000	0.36%

Source: U.S. Bureau of the Census
unpublished data

Policy Analysis

No. 197 September 23, 1993

Routing

EXHIBIT 7
HUMAN SERVICES
SUBCOMMITTEE
11-17-93

EXHIBIT
DATE 11-1
SB HUMAN S
Sub

LABORATORY FAILURE: STATES ARE NO MODEL FOR HEALTH CARE REFORM

by Michael Tanner

Executive Summary

While the media are focusing primarily on the debate in Washington, an intense battle over reforming health care is under way in America's state capitals.

Nearly every policy debated at the national level is also being debated in the state capitals or is being put in place. Many of the state plans are being hailed as models for national health care reform.

Unfortunately, reforms at the state level have generally relied on increasing government control rather than expanding market choices. A review of nine states' reforms reveals a host of negative consequences: insurance premiums increase; access to medical care is not improved; jobs are lost; spending on Medicaid goes up; insurance companies leave the market; and medical care is explicitly rationed.

Although many of the problems with our health care system can be addressed only at the federal level, there is much the states can do to lower the cost of and increase access to medical care. Specifically, states could take steps to deregulate the health care industry, including eliminating mandated benefits, repealing certificate-of-need requirements, and lifting restrictions on what nonphysician practitioners' are allowed to do.

The debate at the state level and the experience of programs already introduced provide important guidance by showing the failure of many of the concepts most eagerly debated at the national level. Congress should learn from the states' mistakes.

Michael Tanner is director of health and welfare studies at the Cato Institute.

CATO INSTITUTE

November 17, 1993

EXHIBIT 7
DATE 11-17-93
SB HUMAN SERVICES

MONTANA HEALTH CARE AUTHORITY

GOVERNOR'S PROPOSED REDUCTIONS TO 1993-1995 APPROPRIATION*

	1993-94	1994-95	TOTAL
LONG TERM CARE STUDY	0	25,000	25,000
DATA BASE MANAGER	0	40,000	40,000
PRESCRIPTION DRUG STUDY	0	20,000	20,000
MISC. OPERATING EXPENSES	15,000	0	15,000
REGIONAL BOARD SUPPORT	35,000	15,000	50,000
TOTAL REDUCTIONS	50,000	100,000	150,000

*IN ORDER OF MHCA BOARD PREFERENCE.

HUMAN SERVICES

PROJECT 94

Medical Independence for All of US

Project 94
Great Falls, Montana
1-800-720-3181

The Issue

Quality, access, and cost control within the health system will require bold approaches that enable and encourage individuals to take more responsibility for personal health care decisions. Growing dependency on third parties or government is neither good medicine nor good economics. Individuals and health care providers should remain free of coercion; retaining the right to contract freely with any individual or group they choose for their needs. Dr. William Mayo of the Mayo Clinic observed: *"the best interest of the patient is the only interest to consider"*. Will government bureaucrats or health purchasing cooperatives have the same priorities? Will you be able to hold them accountable?

The Organization

Project 94 was organized in Great Falls, Montana in February 1993. We are a coalition of individuals and groups of varied backgrounds advocating health system reform in which no one would be financially ruined by health care needs. We support a system which draws on the traditional American strengths of compassion, individual freedom, and responsibility. We are convinced that:

- Individuals, not bureaucracies should control access to high quality, basic health care.
- Basic health care coverage should be affordable, portable, and accessible to all.
- The freedom to choose your provider must be preserved.
- The high quality of U.S. health care must be maintained.
- These reforms are best accomplished by empowering individuals with a market oriented system.

Our goal is to communicate the free market reform alternatives, as opposed to costly government dependency.

We maintain an extensive and growing collection of articles and speaking materials relating to health systems around the world. Much of it is difficult to obtain. The collection is available to any group or individual. If you have a special interest we will check our library for you or attempt to research your request if we do not have it. Call us to make arrangements.

The Program-Comprehensive Patient Oriented Reform

We want to be as specific as possible, but obviously have to

generalize in this format. Call us for more details.

Tax Fairness

- Allow individuals tax credits or deductions for health care insurance purchases.
- Establish Medical Savings Accounts (MSA's); tax free, lifetime, personal savings accounts that can be used only for medical expenses. After medical needs were met they could be rolled over into retirement funds, first home down payment, or college (if you save it you keep it).

Medicaid Reform

- Cash credits to purchase health insurance & care.
- A specified amount must be used to purchase a family health care policy.
- Employers could buy into the program to provide coverage during a transitional stage.
- Cash refunds could be given for utilizing only a percentage of yearly benefits.
- Incentives for preventive and child care.

Health Insurance Reform

- Small employer basic policy.
- All policies Renewable & Portable.
- Plain language reform of policy and price information with "up front" knowledge of what your insurance will pay.
- Administrative Changes.
- Mandated Benefits Review.
- Protection from unknown increases in future premium rates.

The Uninsurable

- Direct Subsidies.
- State Risk Pools.
- Per condition deductible &/or tax credits for "free care".

Long Term Care

- Medical Savings Accounts.
- Establish long term care insurance that cannot be terminated & includes less restrictive preexisting conditions.
- Protection from reduction in benefits due to inflation.
- Protection from unknown increases in future premium rates.
- A non forfeiture provision offering to the consumer a specified value if the plan should lapse.

Rural Care (medical shortage area)

- Loan repayment for physicians (alternative of deductions or tax credit for "rural service").
- Medical Enterprise Zones (MEZ's) for regulatory relief.
- The community would set regulatory standards for:
  - -qualified mid-level practitioners
  - -hospitals
  - -ownership of health care facilities (with full disclosure)
  - -tax credits, deductions, write-offs.

Your Part

GET INFORMED! No matter what your views, we urge you to become educated about this issue. It WILL affect you and your loved ones. We will all need medical care sometime.

Call Project 94 for more information about any health care system. We will do our best to help.

Call us if you want to help, want to participate in one of the great controversies of this century, or just talk. Whatever your abilities and time constraints may be, we have a way for you to participate.

Project 94
Medical Independence
1-800-720-3181

HUMAN SERVICES

PART 1

Senate Bill 285

&

Your Health Care

The Montana Solution
or
bureaucratic central planning and control?

Project 94
P.O. Box 111
Great Falls, MT 59403
1 800 720-3181
Local 761-3185

A New Health Bureaucracy

SB 285 establishes and empowers a new state bureaucracy to regulate Montana's health care system. It will dramatically affect your future.

The bill excludes market oriented solutions and requires a state run health care system. It is a one way road to pervasive state management. One and a half MILLION dollars are approved to enable a "central committee" and five dependent "regional planning boards."

The Montana 1993 legislature naively and overwhelmingly passed SB 285; creating, in 86 pages, seven new state entities and mandating at least six new studies--at taxpayer expense.

Two Plans-One Theme

The Health Care Authority, aka "the Authority", is charged to develop, according to mandated criteria, "single payer" and "regulated multi payer" systems. The bill mandates the same requirements of each proposed system; effectively eliminating proposals which would not put the state in complete control. A choice between the two pretentious "systems" is to be debated during the 1995 legislature.

State Regulation Required

Additionally, it is THE entity to control health care access, financing, and resources in Montana. "The Authority" is a permanent entity serving as a central control committee for any proposal offered. "The Authority" will approve wage and price controls, impose rationing schemes, limit public AND PRIVATE expenditures, penalize violations of "cost containment targets", and is REQUIRED to approve the mandatory regional "management plans" (sections 6, 7, 8, 11).

These service limiting regulations (euphemistically referred to in the bill as "global budgets, cost containment targets, expenditure targets, monitoring compliance", etc.) are required by SB 285 and will create more shortages of medical services.

Market Incentives Excluded!

To insure total state committee control; all references to considering "incentives for market control", "an individual's choice of services", and the "preferences and needs of the health care consumer" were INTENTIONALLY AND SPECIFICALLY ELIMINATED from the draft bill (pages 7, 15, 17, 19).

Regardless of how well intentioned the members of the

Health Care Authority may be, we believe no government agency should ever be placed in such a position of complete control over the lives and medical options of Montana citizens.

The State's Record

Beside the issues of citizen's liberty and good medicine, Montana's record of controlling costs in public programs does not justify entrusting the state with our entire health care system. Consider two of our current state run programs :

–"work comp." payments per laborer in 1989 were the 7th highest in the country[1] ;
–Medicaid cost per recipient was 17th highest in the nation in 1991[2].

Apparent reform came to Workers' Compensation by applying more stringent state controls. Workers now have limited provider choices and further restrictions are likely.

The costs of Workers' Compensation and Medicaid are out of control DESPITE years of state mandated reimbursement rates.

Outside the state controlled systems, Montanans spent relatively little in per capita total health care, 9th lowest nationally in 1991. Montana has been rated 7th best in the nation for 22 categories of health care and costs.[2]

Failed Solutions

The two options of SB 285 have been tried elsewhere. The results?
–increased costs via taxes and premiums.
–diminished access via waiting lists or rationing.
–continued urban/rural inequalities.
–unresolved quality issues.
–lives lost as a consequence[3-10] .

SB 285 will guarantee more government failure. There are problems. Reform is needed. But we can solve the problems by creating a real market, privatizing Medicaid and Workers' Compensation, and NOT socializing the rest of the system.

Government has created our current health care problems. Now it's telling the citizens to "give us a bit of your freedom and we will take care of you". Benjamin Franklin said *"those that would give a little freedom for a little security will lose both and deserve neither"*. That is an eternal truth.

Save $1.5 Million

SB 285 should be addressed by eliminating its funding as a part of the 1993 special session. Better options are available. We deserve them.

These conclusions are the result of extensive research of the literature, not idle editorializing. If you want these references or information about REAL reform, contact:

Project 94-HEAL Montana.
1 800 720-3181

References in brief:

1. State Rankings 1993; Morgan & Quitno Corporation, Lawrence, Kansas; pages 177, 97.
2. Health Care State Ranking 1993; Morgan & Quitno Corporation, Lawrence, Kansas; pages 287, 201, intro.
3. Goodman, W; "Canadian Health Insurance:.." Georgia Public Policy Foundation Issue Analysis, Atlanta; Feb. 1992.
4. "Health Care Benefits Survey 1991" part 2 "Managed Care Plans" A. Foster Higgins Company, 1992.
5. "The Effects of Managed Care on Use and Costs of Health Services," Congressional Budget Office staff memorandum, June 1992.
6. "Study: Managed Care No Cost Cure-All," Atlanta Constitution, May 12, 1993.
7. Goodman, J; "Managed Competition-Too Little Competition," Wall Street Journal, Jan. 7, 1993.
8. Tanner, M; "Laboratory Failure: States Are No Model For Health Care Reform"; Policy Analysis No. 197, Sept 23, 1993; Cato Institute, Washington, D.C.
9. Goodman, J & Musgrave, G; "Twenty Myths About National Health Insurance" Policy report # 166, December 1991; National Center for Policy Analysis, Dallas, Texas.
10. Haislmaier, E; "Why Global Budgets and Price Controls Will Not Curb Health Costs" Heritage Foundation Backgrounder # 929, Washington, D.C.

HUMAN SERVICES

Senate Bill 285

Frequently Asked Questions & Answers about:

the State plan for Your health care options.

Project 94
P.O. Box 111
Great Falls, MT 59403
1 800 720-3181
Local 761-3185

Q What is SB 285?
A This law passed by the 1993 Montana legislature empowers a Health Care Authority (The Authority) to regulate health care availability, access, costs, rationing and future investments, public and private. Section 1. "...it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency...". The Authority will also propose two financing plans for the 1995 legislature to vote on.

Q Isn't it just a "study bill"?
A No. The onerous "Authority" and its mandates are established! Section 3... "(1) There is a Montana health care authority". It is here permanently and empowered to function in an ongoing manner. Six other "boards" are mandated as well (also political appointees).

Q Isn't it "non political"?
A "The Authority" consists of political appointees by law. They in turn determine the method of appointment for members of the subordinate "regional boards". Each of the "boards" will compete for money and resources allocated by "the Authority". The region with the most influential board will "win" the greatest share of any current year's allocation of funds and improvements.

Section 3... "(3) The authority consists of five voting members appointed by the governor... "

Q Why not see what they propose?
A The options are a meaningless choice between two similar systems called "Single Payer" and "REGULATED Multi-payer". Either option must contain the same 'cost control' and management features. Thereby, enabling "the Authority" to control All aspects of health care provision, investment, resources, and availability, regardless of its name.

Each statewide plan must contain, "global budgeting", controlled capital expenditures, penalties for violating "expenditure targets", and a rationing system (Sections 5, 6, 7, 8).

Section 7 (3)(b) empowers the "Authority" to develop and approve rationing schemes-"...the system may include prioritization of services that allows for consideration of an individual patient's prognosis...".

Anyone reading the bill will see what they are going to come up with.

Q Is it temporary?
A "The Authority" is a permanent central committee with the "Regional Boards" acting as subordinate local extensions. Unless rescinded by a future legislature, it is mandated and empowered to function indefinitely.

Q How much will it cost?
A In the short run it will cost 1.5 MILLION DOLLARS just to establish a bureaucracy. In the intermediate future the "Authority's" budget and personnel needs will

surely grow and the SB 285 mandate for "guaranteed issue" will have the same effect it always does: higher costs and fewer choices. In the long run the cost is immeasurable. Allocation decisions will increasingly be politically motivated. Rationing will result in needless suffering, treatment delays, and lives lost.

Q How will it affect my health care?
A If you are healthy you obviously will not notice the change in "Health Care". However, you will notice that your choice of insurance plans will be fewer and more expensive and your preference for (or against) a particular "provider" or institution is likely to be limited. There will gradually be fewer options and increasing delays for care when you need more intensive care.

Q How will it affect my health insurance?
A The "guaranteed-issue" portion of SB 285 alone will increase your premiums. 50% increases in the second year, tapering to 38% higher in subsequent years are consistent with recent studies[1]. Even liberal groups project that under guaranteed-issue restrictions, 50% of small groups see premiums go up, 15% see decreases and 35% see no change. In other words 50 losers for every 15 winners.[2]

Q Don't we need the data it is supposed to gather?
A Your personal health data will be collected by the state. Stored in a computer and electronically accessible there will be constant reassurances of its security. In an ideal world that would be no problem. In the real world it could be used to plan your future medical care, be used for political blackmail to "reallocate" a region's funding, determine if you are fit to work without seeing you, statistically manipulate segments of the population or even encourage genetic engineering to create healthier citizens to control future costs.

What good for you as an individual will occur with the state accessing your PERSONAL medical records? Will you have the right to keep your records out of the data system rather than accept government assurances of privacy? The state has it's own interests in mind here. It's "big brother" and it isn't right.

Q How will Clinton's plan affect the Health Care Authority?
A Establishing "the Authority" in Montana now, enables only the state to function as a channel for future health care distribution. The Authority will exists as an unaccountable state bureaucracy, the only functioning entity in Montana to control our health care system. It will exclude the possibility of "the market" functioning to provide service to the population. It is well known that governments do not operate efficiently. That is one reason for liberty and a market economy in the first place.

Q What choice do we have?
A Reforming the system so that individuals are empowered to act freely in a real market is possible. No one need be financially ruined by such a system. Medical Savings Accounts allow individuals to keep control of their personal earnings used to pay for health care. Renewable, portable insurance, and subsidies when the costs are too high are additional ideas which leave you in control. No big pools of taxpayer's money to pillage. No one deciding what's right for you, but yourself.

The idea that people should depend on government as their provider is a dangerous delusion rampant among elected officials. They may be perfect today, but what about tomorrow?

It's your money, you should decide how to spend it. SB 285 is an enabling bill for bureaucratic control of your life. Like all efforts to control personal decisions for the "public good" it is wrong, it is bad medicine and it will not work. SB 285 should be killed in the 1993 special session.

Call Project 94-H.E.AL. for more information: 1 800 720-3181.

1) "Variation by Duration in Small Group Medical Insurance Claims," American Society of Actuaries, 9/5/91; as quoted by CATO analysis No. 197, p 6.
2)"Two Studies Find Premium Hikes with Guaranteed Issue, Rate Limits," Health Benefits Letter, no. 29 (5/21/91) as quoted by CATO analysis No. 197, p 7.

An Individual Approach

by

Project 324

Summary of Medicaid Reform

A Montana grassroots group, Project 94, is working on state health system reform. This is a summary of the Medicaid portion of that reform. It is based on *Keeping the Promise* developed by the American Legislative Exchange Council.

Our premises are that individual responsibility and control are the best means of assuring quality care; and that the best means of doing so are through a market oriented approach rather than an egalitarian redistribution of services. Physicians are all too familiar with the detrimental effects on patient care of third party intrusions via Medicaid, Medicare, or "managed care". The level of such intrusions is becoming increasingly outrageous as the patient relinquishes control of his health care dollar. Attempts to substitute individual doctor-patient decisions with decisions imposed by remote third party bureaucrats are increasingly commonplace. Those rationings follow secret proprietary parameters, and are made by people with no responsibility to the patient, and minimal qualifications, if any.

The proposal is based on a voucher system. We will briefly outline the rationale, proposal, and our solutions to the most frequent objections. The amount we spend per Medicaid recipient in Montana exceeds per capita total health care payments as shown in the Table 1. The corresponding national averages are also shown. The primary problems are those of the rest of the country (*i.e.* increasing price of Medicaid, cost shifting, and decreasing access).

TABLE 1-YEAR 1991	Montana	National Average
Per Capita Total Health Care Payments	$2,135	$2,751
Per Family Total Health Care Payments	$4,910	$6,535
Per Medicaid Recipient Total Health Care Payments	$3,037	$2,725

Source: As listed by Morgan Quinto Corporation in *Health Care State Rankings 1993*; & *State Rankings 1993*. P.O. Box 1656, Lawrence, KS 66044. (800) 457-0742.

Under the proposed system each Medicaid recipient would receive a publicly financed voucher for a fixed sum. In the Montana example $2,800 would be a workable amount. With that voucher the individual could purchase only medical insurance or services. If he did so wisely he would have money left over. That money would be kept in his account, but again could initially only be used for approved medical expenditures. Any over payments by insurance or billing errors by providers which the individual discovered would also be put into his account. That money could be used to pay deductibles or purchase insurance, but if unused would accumulate in the account along with the yearly government deposit of the voucher. If an individual did not make a choice to purchase insurance then he would be assigned to a default policy by the state.

If the individual eventually got off Medicaid for a specified time (say 5 years) the money in the account would be his to use with some restrictions. First, no money could ever be withdrawn for non medical uses, unless the financial contingencies of future medical needs were provided for; sufficient money would have to remain in the account to pay insurance premiums, deductibles and establish a savings program for eventual long term care and insurance. Money could then be withdrawn from the account for approved needs like first home down payment, college, et cetera, without penalty. Money could be withdrawn for non approved uses (again only if the medical contingencies were provided for), but would then be subject to penalties.

We would also suggest that the accounts be tax free as this would provide additional incentives to save money in the accounts and since this is only fair given the huge tax advantages awarded corporations when they purchase health insurance for their employees. We would not advocate

that only the purchases be tax free or deductible as this promotes spending; our goal is to promote savings.

The most common objection to this plan is that people are too stupid to make prudent choices. Of course the Rand Health Insurance Experiment repudiates that idea and a summary of its conclusions is attached. Also if someone does not make a choice they are placed in the default plans.

The second most common objection is that this would discourage preventive care or inhibit parents from obtaining necessary care for their children or themselves. Again the Rand study disputes the view that bureaucratic or third party decisions will necessarily be superior to those made by individuals acting in their own interests. However, the vouchers and accounts could be structured so that expenses for proven cost effective measures or care for dependents would not diminish the voucher or amount remaining which would be placed into the account.

The advantages of this system are the fixed annual budgeting, elimination of cost shifting, and moving the poor from dependency to self sufficiency. It would preserve the integrity of the doctor-patient relationship. We would truly be giving the poor a "leg up" instead of a crutch and a ration card.

High risk patients could be directly subsidized by the government in addition to receiving their vouchers. This would be much less regressive than community rating, would not penalize those with healthy habits, and would preserve the financial incentives for individuals to choose healthy lifestyles.

This plan would not immediately solve the problems of long term care, but it would start the savings for it. Also this plan is part of a more general proposal to overhaul the system, which for brevity's sake has not been included.

National application of the idea is feasible based on a sampling of insurance prices from around the country, Table 2. Other reforms would of course be necessary including making all insurance renewable and portable. Consideration could also be given to insurance with a per condition deductible. Pricing information should be widely available and put in a common, understandable form. This would include doctor, hospital, and insurance policies. Insurance policies could have a standardized format and plain language laws applied with clear declarations of what they will pay for a given service. These changes would greatly promote comparisons by patients and businesses. Eventually, they would be able to compare outcomes as well.

These concepts could also be used for all of us through voluntary or compulsory accounts. Such compulsory "provident funds" are the primary means of insurance in Singapore and are used to some extent in other countries as well.

Project 94 feels that we are fighting for basic principles of freedom. Medicine seems a useful tool for those who promote dependency on government and collectivist control, as opposed to independence and moral compassion.

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Summary Presentation for Rand Health Insurance Experiment

Prices Matter-People can Spend Wisely

- The Rand corporation study found that people who had access to free care spent about 50% more than those who had to pay 95% out-of-pocket (up to a maximum of 1,000).
- People with free care were about 25 percent more likely to see a physician and 33 percent more likely to enter a hospital.
- Despite these differences in consumption, there were no apparent differences between the two groups in health outcomes (the one exception being vision).
- The Rand study was conducted from 1974 to 1982. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today.

TABLE 2
The Cost of Catastrophic Insurance Policies ($2,500 Deductible)

	Washington National	Pyramid Life	Time	Union Bankers
Cincinnati: City	1,369.50	1,622.60	1,455.80	2,037.11
Suburbs	1,369.50	1,622.60	1,555.80	2,037.11
Dallas: City	1,836.60	2,135.00	1,975.73	2,688.81
Suburbs	1,680.90	2,049.60	1,871.75	2,688.81
Denver: City	1,525.20	1,878.80	1,663.73	1,819.88
Suburbs	1,525.20	1,878.80	1,663.73	1,819.88
Des Moines: City	1,369.50	1,451.80	1,123.20	1,602.64
Suburbs	1,213.80	1,281.80	1,123.20	1,602.64
Indianapolis: City	1,369.50	1,537.20	1,404.00	1,602.64
Suburbs	1,213.80	1,451.80	1,216.80	1,602.64
Omaha: City	1,525.20	1,451.80	1,404.00	2,037.11
Suburbs	1,213.80	1,366.40	1,216.80	2,037.11
Peoria: City	1,542.00	1,622.60	1,572.48	2,037.11
Suburbs	1,542.00	1,622.60	1,572.48	2,037.11
Portland: City	N/A	1,878.80	1,253.78	2,037.11
Suburbs	N/A	1,878.80	1,164.23	2,037.11
Richmond: City	1,525.20	1,622.60	1,497.60	2,037.11
Suburbs	1,525.20	1,537.20	1,497.60	2,037.11
Scranton: City	N/A	1,964.20	N/A	2,037.11
Suburbs	N/A	1,964.20	N/A	2,037.11

Source: Golden Rule Insurance Co. as cited by Private Medical Care Foundation. Insurance premiums are for husband and wife, age 35, and one child. For this comparison it is appropriate to use rates for one child because group insurance does not price for additional children.

DRAFT MODEL FOR MEDICAID REFORM

Extracted from *Keeping The Promise* by American Legislative Exchange Council.

Additional proposals by Project 94, Great Falls, Montana.
(800) 720-3181

11-17-93
HUMAN SERV

ACCESS TO MEDICAID ACT

{Title, enacting clause, etc.}

SECTION 1. This Act may be cited as **Access To Medicaid Act.**

SECTION 2. Definitions. As used in this Act

(A) "INSURER" means any insurance company authorized to do the business of sickness and accident insurance in this state or any health maintenance organization authorized to operate in this state.

SECTION 3. Purpose

The Legislature hereby enacts the Access to Medicaid Act for the purpose of providing a publicly financed voucher program to provide access to privately-delivered health insurance coverage for residents of this state who qualify for the benefits under Section 4.

SECTION 4. Eligibility Requirements.

(A) The following persons are eligible for coverage under the Program:

(1) Any person who is an AFDC recipient, and;

(2) Any person whose income is equal to or less than one hundred percent (*or insert other appropriate percentage*) of the federal poverty level; and who is not covered under an employer-provided health care plan, as provided in paragraph 3 of this section:

(3) Those persons described in paragraph (A)(2) of this Section whose incomes are equal to or greater than one hundred percent of the Federal poverty level, but not more than one hundred and fifty percent of the federal poverty level (*or insert other appropriate percentage*), shall be required to pay ten per cent of the reimbursable premium amount determined by the Director of Human Services.

SECTION 5. Issuance of Proof of Eligibility Forms.

If the Department of Human Services (*or insert appropriate department*) determines that a person meets the eligibility requirements set forth in Section 4 of this Act, the Department shall issue that person a proof of eligibility form, which entitles the person to coverage under any health insurance or health care policy or contract, offered in accordance with this Act, in the amount of the premium indicated on the form and for a policy or contract period of one year.

SECTION 6. Offering of Policies and Contracts.

If coverage is issued to the individual, policyholder, or contract holder, the insurer shall submit the proof of eligibility forms and a request for reimbursement of premium to the Department of Human Services.

SECTION 7. Standards Applicable to the Policies and Contracts.

The Health insurance or health care policies and contracts for which insurers are eligible shall be provided in accordance with the following conditions.

(A) The cost of the policies and contracts shall not exceed the reimbursable premium amount indicated on the proof of eligibility form.

(B) The policies and contracts are not subject to any previous state mandatory benefits.

(C) Each policy and contract must include the following: (1) all nine of the federal Medicaid mandates; (2) thirty days in-patient care coverage for mental health, mental retardation, and substance abuse; (3) prescription drugs; (4) pre-natal care coverage; and (5) lifestyle incentives with preventive education.

(D) The nine Federal Medicaid mandates as referred in paragraph (C) consist of the following: (1) inpatient/outpatient hospital services; (2) rural health clinic services; (3) other laboratory and x-ray services; (4) nurse practitioners' services; (5) nursing facility services and home health services for individuals 21 and older; (6) early and periodic screening, diagnosis, and treatment for individuals under 21; (7) family planning services and supplies; (8) physicians' services; and (9) nurse-midwife services.

(E) The insurer shall not impose any waiting period for benefits, or otherwise reduce or restrict benefits, for any claim that is the result of a high risk condition.

(F) The insurer shall refund to the insured, in accordance with the program established by the Director of Human Services, (*or appropriate department director*), a portion of the premium for coverage of an eligible person if the total amount of claims submitted by the person is less than the amount of the premium paid, (refund is 50 percent of premium.)

(G) The insurer shall refund to the insured, in accordance with the program established by the Director of Human Services, a portion of the premium for coverage of an eligible person if the person locates any item or service listed on a billing statement, which items or services were not received by, or rendered to, the person. The insurance company would be allowed to collect this amount from the health care provider. (REFUND FOR OVER BILLING, ERRORS, OR SERVICES NOT RENDERED COULD BE 50 percent, 33 percent, OR 25 percent.)

SECTION 8. Reimbursement of Insurers.

Within thirty days after receipt of a valid proof of eligibility form and request for reimbursement from an insurer, the Department of Human Services shall issue payment to the insurer in the amount of the premium indicated on the form.

SECTION 9. Duties of Director; Rule-making Authority.

(A) Within ninety days after the effective date of this act, adopt rules in accordance with this Act that provide for the fair, reasonable, and equitable administration of this program, including provisions relative to procedures for determining eligibility under the program, issuance of proof of eligibility forms by the Department of Human Services, determinations of the reimbursable premium amount, and procedures for the reimbursement of insurers that issue policies and contracts to eligible persons. Rules adopted under this Section shall also include a schedule for the implementation of the program on an incremental basis. The duties of the director shall be:

(B) Administer and implement the program;

(C) Monitor the operation of the program;

(D) Disseminate, to insurer and to the public, information concerning the program and the persons eligible to receive benefits under the program;

(E) Implement a system to provide information and guidance to all persons eligible under the program relative to the program's procedures and the selection of the most appropriate benefits under a health insurance or health care policy or contract;

(F) Implement a program whereby a portion of the premium for coverage, other than coverage for preventive care, of an eligible person shall be refunded by the insurer to the person if the total amount of claims submitted by the person for that coverage is less than the amount of the premium paid for that coverage. (In accordance with Section 7 (F));

(G) Implement a program whereby a portion of the premium for coverage of an eligible person shall be refunded by the insurer to the person if the person locates any item or service listed on a billing statement, which item or service was not received by, or rendered to, the person;

(H) Study and evaluate the operation of the program, and annually submit its findings to the legislature.

SECTION 10. Annual amount of reimbursable voucher.

An independent board shall be responsible for annually determining the premium amount that is reimbursable by the department for both individual and family coverage. This board shall be composed of the Director of Health and Human Services, the Insurance Commissioner, and three other members appointed by the Governor.

SECTION 11. Creation of fund; funding; uses.

(A) There is hereby created in the state treasury a Medicaid Access Fund, which shall consist of all of the following:

(1) Federal Payments received as a result of any waiver of requirements granted by the United States Secretary of Health and Human Services under the Health Care Programs, other than the nursing facility care programs and the intermediate care facility programs for the mentally retarded, established under Title XIX of the "Social Security Act."

(2) State funding in an annual amount equal to the funding appropriated for expenditure in the fiscal year in which this act is enacted for purposes of the (*current state Medicaid program*), other than the nursing facility care programs and the intermediate care facility programs for the mentally retarded. Such money shall increase in proportion to any increase in the Federal Payments received by the plan pursuant to Division (A)(1) of this Section.

(3) All other money appropriated to the fund, interest earned on investments or deposits, grants and gifts made to the fund from public or private sources, or moneys acquired otherwise by the fund.

(B) The fund shall be administered by the Director of Human Services, (*or appropriate director*) and shall be used solely for purposes of reimbursing insurers for the provision of health insurance or health care policies and contracts to resident of this state who are eligible for benefits under this Act.

SECTION 12. Prohibition Against "Dumping".

An employer shall not fail to extend coverage to, or continue coverage of, an employee or his dependents under any health care coverage provided by the employer solely to render the employee or dependent eligible to receive benefits provided under this Act.

SECTION 13. Employer Buy-In.

Employers who hire current Medicaid voucher recipients shall be permitted to provide health care coverage for employee by buying into the remaining term of the Medicaid recipient's health plan. The amount of the plan would be prorated for the number of months remaining in the current year of coverage. The money from the employer buy-in would go directly to the State's Medicaid Access Fund.

SECTION 14. High-Risk Individuals.

Medicaid recipients who have been previously rejected by two or more insurers due to high-risk conditions shall be placed into the state high-risk pool. The difference between the value of the voucher and the high-risk pool premium shall be paid by the state Medicaid program. (*See ALEC's Insurance Pool Act.*)

SECTION 15. {Severability Clause}

SECTION 16. {Repealer Clause}

SECTION 17. {Effective Date}

Project 94 would make the following additions to the proposal:

1 Preventive Medicine Encouragement.

Refunds would be structured so that costs for truly cost-effective services (ex. vaccinations, BP checks, prenatal care) would not diminish the refund.

2 Price Information.

A system of pricing information should be easily available. This would include information to allow comparison of physician charges, hospital charges, and insurance premiums, coverage and payment history. This would have beneficial effects for all individuals; not just Medicaid recipients. The AMA has recently proposed a mechanism for developing such information.

3 Permanent Ownership of Medisave funds.

While an individual was on Medicaid the Medisave funds would remain theirs, but could be used only for medical purposes. If an individual got off of Medicaid assistance for a set number of years the Medisave money could then be rolled over into retirement funds or used for other designated purposes (first home, college), IF there were sufficient funds remaining to meet medical contingencies.

4 Education Requirement.

In order for an individual to qualify for Medicaid they would have to attend a mandatory session instructing them in their options and use of Medisave accounts.

5 Default Setting

Those individuals not attending the educational sessions or who elected not to exercise their choices would be assigned to a default insurance plan designated by the state.

Ideas discussed, but NOT proposed at this time.

- -Baseline H & P info. by P.A., R.N., or M.D.
- -Recipients carry "debit" cards which would give running total of cash refund remaining.
- -should a purchase be mandated? Means of intercepting eligible recipients.

November 17, 1993

The complete copy of this exhibit, Senate Bill 285, is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE, BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN, VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB, CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE, COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE, DOWELL, RUSSELL, STANFORD, TUSS, DOLEZAL, DOHERTY, PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN, WELDON, KENNEDY, WILSON, BARTLETT, SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY; PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY; REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN; REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING; ~~REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH PLANNING REGIONS AND BOARDS~~ REQUIRING DEVELOPMENT OF UNIFORM CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A UNIFIED HEALTH CARE DATA BASE; ~~PROVIDING FOR HEALTH INSURANCE REFORM~~ REQUIRING HEALTH INSURER COST MANAGEMENT PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES RELATING TO ~~VITAL STATISTICS~~ STATE HEALTH PLANNING; PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY; AMENDING SECTION ~~50-15-101~~ 50-1-201, MCA; AND PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

~~A statement of legislative intent is required for this bill because [section 10] requires the Montana health care authority to adopt rules establishing a maximum of five health care planning regions, to establish regional health care planning boards within those regions, and to establish a procedure for selection of regional board members. The legislature intends that the rules establishing the health care planning regions be based primarily upon the geographic health care referral patterns by which health care providers refer patients to specialists or larger health care facilities. These rules should also consider communication~~

REFERENCE BILL: Includes Conference Committee report Dated 4-19-93

EXHIBIT 1 Senate Subcomm. DATE 11-17-93 SB 285

November 17, 1993

KEEPING THE PROMISE

Making Health Care Accessible and Affordable for All Americans

A Comprehensive Health Care Plan for the States

American Legislative Exchange Council

EXHIBIT
DATE 11-17-93
SB HUMAN SERVICES

MIAMI, ESRD AND RURAL PHYSICIANS PROGRAM FUNDING

	FY 93 Actual	FY 94 Budgeted Before Cuts	FY 94 Budgeted After Cuts	FY 95 Budgeted Before Cuts	FY 95* Budgeted After Cuts
MIAMI					
Current Level***	178,024	170,454	170,454	170,454	170,454
Expansion		264,590	158,590	264,590	158,590
RENAL (ESRD)	0	125,000	100,000	125,000	100,000
Rural Physicians**	0	200,000	100,000	200,000	100,000

* FY 94 budget reductions are reflected for FY95 and are used for explanation purposes only. Final FY 95 reductions are subject to department reevaluation prior to July 1, 1994.

** The department will add back $10,000 in FY 94 for the Rural Physicians Program.

*** Includes Miami Council

DEPARTMENT OF
HEALTH AND ENVIRONMENTAL SCIENCES
DIRECTOR'S OFFICE

COGSWELL BUILDING
1400 BROADWAY
PO BOX 200901

STATE OF MONTANA

(406) 444-2544 (OFFICE)
(406) 444-1804 (FAX)

HELENA, MONTANA 59620-0901

11/17/93

To: Representative Cobb and Members of the Human Services and Aging Subcommittee on Appropriations

From: Robert J. Robinson, Director
Department of Health and Environmental Sciences

RE: MIAMI Expansion Status

This is a summary of the status of MIAMI expansion and funding for fiscal years 1994 and plans for expansion in 1995. As you are well aware, the legislature awarded MIAMI an additional $264,590 per fiscal year 1994 and 1995.

FY 1994 - An administrative decrease of $106,000 left $158,590 for expanding MIAMI services. An RFP for local MIAMI projects drew 10 responses. Available funding allowed DHES to contract with five of those.

Status of the $158,590 expansion funds available for FY 1994 is:

Category	Amount	Present status
Local MIAMI project services	$127,820	Contracts signed
Infant Mortality Review (data collection and travel to reviews)	$6,500	Payed as billed. Approximately $1,500 will be expended by end of November
Travel for local project staff and site visits for consultants	$6,500	Approximately $4,500 expended to date
Social worker consultation/support	$2,270	Planned for spring of 1994
RFP support (travel & consultation)	$500	completed
Baby Your Baby project	$15,000	contract signed
TOTAL	$158,590	$147,320 expended and or encumbered to date.*

* MIAMI contracts include statements that DHES will pay for infant mortality reviews as they are submitted, and for travel of project representatives to required meetings. The remaining funds will be spent under those contractual agreements.

The total expansion funds available for FY 1994 have or will be expended by the end of the fiscal year. Additional funds (i.e. $106,000) would be difficult to contract out effectively during the remaining allotted time. The present expansion puts MIAMI services accessible to 74% of the pregnant women in the state. We estimate that we will serve approximately 2,060, or 15% of the pregnant women in the state in FY 1994.

MCH Block Grant Carryover is available to provide some development funds for the projects with viable proposals which were not funded. Those funds are available only for FY 1994. Development funds would be used by the sites to ready themselves to implement care coordination services and develop billing mechanisms for targeted case management services through Medicaid. Full implementation of the developed MIAMI service areas is contingent on availability of funding for local contracts in FY 1995.

FY 1995 - The development sites which will be funded with MCH funds in FY 1994 will be ready for implementation in FY 1995. We estimate the development sites could be funded with $94,500.

Expansion which includes the designated development sites would put MIAMI services accessible to approximately 83% of the pregnant women in the state. With the development sites fully functional, we estimate that MIAMI projects would serve approximately 2,250, or 17% of the pregnant women in the state.

Please call the Perinatal Program at 444-2660 for additional information.

NOTE: CALCULATIONS ON PERCENT WOMEN SERVED ARE BASED ON 1991 STATISTICS.

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STATE OF MONTANA

(406) 444-2544 (OFFICE)
(406) 444-1804 (FAX)

HELENA, MONTANA 59620-0901

MEMORANDUM

TO: Governor Racicot
Lt. Governor Rehberg

FROM: Bob Robinson

DATE: July 1, 1993

RE: DHES General Fund Budget Reductions

Background:

The General Fund appropriation for ongoing programs in FY 94 is $2,647,700 compared to $3,153,261 in FY 93, a $505,000 or 16% reduction.

The appropriation subcommittee, full appropriation committee and senate and finance and claims committee together reduced general fund entirely from the public health laboratory, chemistry laboratory, subdivision review program, and legal services and to a limited degree in the health facilities and health services and environmental sciences divisions. In addition, the department was assessed across the board vacancy savings reductions of 5% and ½% or $81,949 and 16,062 respectively.

As you may remember, on the last legislative day, the appropriation (HB 2) conference committee targeted the department for an additional $250,000 general fund reduction; $50,000 from the director's office and $200,000 from the air quality bureau.

After some maneuvering, the $50,000 reduction was dropped and $192,000 was reduced from the total appropriation; undirected but to be allocated by the department.

In addition to the department's regular program appropriations, the legislature added the following line item appropriations:

MIAMI* Program Expansion	$265,000
End Stage Renal Disease Subsidy	$125,000
Montana Family Practice Residency Program	$200,000

* Montana Initiative for the Abatement of Mortality in Infants

MIAMI advocates lobbied for additional funds to expand the existing $170,000 current level program by 156% to provide services in rural, generally eastern Montana counties.

Senator Hager and other concerned legislators convinced the appropriation subcommittee to reinstate the End Stage Renal Disease Program (previously eliminated during 1992 special session). This program helps dialysis patients pay out of pocket expenses related to dialysis services. No need evaluation is conducted. The funds are distributed on a first come, first served basis and last approximately six months.

Dr. Michels, Director of the Montana Family Practice Residency Program successfully convinced the legislature to contribute $200,000 per year as the state contribution to the program. Other funds are expected from hospitals and medical providers. I believe federal funds are also anticipated.

When the Department began the process of allocating $288,000 in general fund reductions, we determined we could no longer continue across the board percentage cuts because we are gradually crippling all of our programs and will not be accomplishing our statutorily assigned responsibilities.

We have no general fund appropriated for any service or function that is not mandated by law.

As a result, I developed a preliminary recommendation that the general fund reduction be allocated as follows:

Director	3,300
Central Services	5,874
Environmental Admin	7,796
Solid Waste	3,087
Water Quality	0
Health Services	18,843
MCH	5,125
Preventive Health	1,958
Health Facilities	11,028
TOTAL	57,011
MIAMI	106,000
RURAL PHYSICIAN	100,000
ESRD	25,000
TOTAL	288,011

While it is obvious the largest share comes from the line item appropriation, other than MIAMI, neither ESRD or the Residency Program are statutory responsibilities of the state of Montana. MIAMI is a statutory program, but department analysis indicates that the expansion into eastern Montana will not be as rapid or

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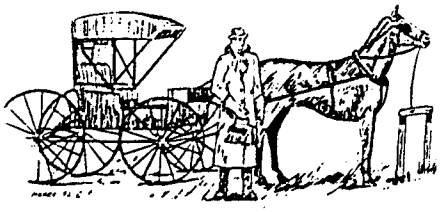
complete enough to use the full expanded appropriation in FY 94. The remaining $159,000 will nearly double the existing program in spite of the proposed reduction.

If reductions are not as proposed above, we must make reductions in other department programs. The alternatives are the Director, the one medical doctor on staff, reducing service for birth and death certificates, elimination of cancer tumor registry, etc. (see General Fund Column on attached budget sheet.)



A tradition of caring...

MONTANA FAMILY PRACTICE RESIDENCY

...receiving the call

EXHIBIT 12
DATE 11-17-93
SB HUMAN SERVICES

UPDATE ON THE STATUS OF THE MONTANA FAMILY PRACTICE RESIDENCY

AUGUST 1993

Frank C. Michels, M.D.
Program Director (Acting)

P.O. Box 35500-554
Billings, Montana 59107

MONTANA FAMILY PRACTICE RESIDENCY PROFORMA

	7-1-93 6-30-94	7-1-94 6-30-95	7-1-95 6-30-96	7-1-96 6-30-97	7-1-97 6-30-98
REVENUES					
STATE OF MONTANA	$130,000	$130,000	$0	$0	$0
DEERING CLINIC CONTRACT	$12,500	$156,250	$250,000	$437,500	$687,500
ST VINCENT					
GME PASSTHROUGH					
DME	$0	$0	$110,187	$155,893	$193,638
IME	$0	$0	$157,313	$261,627	$365,499
CONTRIBUTION	$9,286	$64,278	$57,049	($48,671)	($202,691)
DEAC					
GME PASSTHROUGH					
DME	$0	$0	$101,871	$144,128	$179,024
IME	$0	$0	$196,425	$326,600	$456,164
CONTRIBUTION	$10,549	$73,021	$64,809	($55,291)	($230,259)
YELLOWSTONE TRACK					
GME PASSTHROUGH					
DME	$0	$0	$0	$41,433	$71,959
IME	$0	$0	$0	$34,937	$69,461
CONTRIBUTION	$2,349	$16,258	$14,429	($12,310)	($51,265)
MISSOURI TRACK					
GME PASSTHROUGH	$0				
DME	$0			$37,230	$64,659
IME	$0	$0	$0	$28,528	$56,712
CONTRIBUTION	$2,016	$13,953	$12,384	($10,565)	($43,998)
GRANTS	$143,000	$70,000	$0		
TOTAL INCOME	**$309,700**	**$523,760**	**$964,466**	**$1,341,038**	**$1,616,403**

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HUMAN SERV.

MONTANA FAMILY PRACTICE RESIDENCY PROFORMA

	7-1-93 6-30-94	7-1-94 6-30-95	7-1-95 6-30-96	7-1-96 6-30-97	7-1-97 6-30-98
EXPENSES					
PROGRAM DIRECTOR	$125,000	$128,750	$136,475	$140,569	$144,786
ASSOCIATE DIRECTOR	$28,000	$113,300	$116,699	$120,200	$123,805
FACULTY #1		$103,000	$106,090	$109,272	$112,550
FACULTY #2			$103,000	$106,090	$109,272
FACULTY #3				$103,000	$106,090
R-1S			$165,000	$169,950	$175,048
R-2S				$179,220	$184,596
R-3S					$197,327
.5 ACCOUNTANTS			$15,000	$15,450	$15,914
EXE. SECRETARY	$11,000	$11,000	$22,000	$22,660	$23,340
PHYSICIAN ASSISTANT			$50,000	$51,500	$53,045
BENIFITS	$32,800	$71,210	$142,853	$203,582	$249,155
TOTAL BENIFITS AND SALARIES	**$196,800**	**$427,260**	**$857,117**	**$1,221,493**	**$1,494,928**
TRAVEL	$16,000	$20,000	$24,875	$36,270	$40,000
MALPRACTICE	$12,500	$17,000	$0	$0	$0
RENT	$50,000	$25,000	$25,000	$25,000	$25,000
OFFICE SUPPLIES	$2,000	$2,000	$8,000	$8,000	$8,000
INSTRUCTIONAL	$0	$0	$2,100	$2,300	$2,500
AFFILIATION COSTS	$4,500	$4,500	$6,000	$6,000	$6,000
ACCREDITATION		$5,000			$5,000
COMMUNICATION	$2,400	$3,000	$3,900	$4,500	$5,000
EQUIP COSTS OVER 8 YEARS			$23,775	$23,775	$23,775
OTHER	$25,500	$20,000	$13,700	$13,700	$6,200
ADDITIONAL COSTS	**$112,900**	**$96,500**	**$107,350**	**$119,545**	**$121,475**
TOTAL INCOME	$309,700	$523,760	$964,466	$1,341,038	$1,616,403
TOTAL EXPENSES	**$309,700**	**$523,760**	**$964,467**	**$1,341,038**	**$1,616,403**
NET REVENUE (DEFICIT)	**$0**	**$0**	**$0**	**$0**	**$0**

HOSPITAL CONTRIBUTION COMPUTATION

	DME	IME	SUBTOTAL	FRACTION OF TOTAL
ST V	$193,638	$365,499	$559,138	0.383729
DEAC	$179,024	$456,164	$635,187	0.435921
SID	$71,959	$69,461	$141,420	0.097054
GLAS	$64,659	$56,712	$121,371	0.083295
TOTAL			$1,457,116	1

	7-1-93 6-30-94	7-1-94 6-30-95	7-1-95 6-30-96	7-1-96 6-30-97	7-1-97 6-30-98
NET REVENUE (DEFICIT)	($24,200)	($167,510)	($148,671)	$126,838	$528,213
CONTRIBUTION FROM OR PASS THROUGH RETAINED					
ST.V	$9,286	$64,278	$57,049	($48,671)	($202,691)
DEAC	$10,549	$73,021	$64,809	($55,291)	($230,259)
SID	$2,349	$16,258	$14,429	($12,310)	($51,265)
GLAS	$2,016	$13,953	$12,384	($10,565)	($43,998)

EXHIBIT 13
DATE 11-17-93
SB HUMAN SERVICES

END STAGE RENAL DISEASE PROGRAM

Enrolled 100

- 60 hemodialysis
- 15 peritoneal dialysis
- 25 transplant (1 deceased)

90 different drugs covered at the present time
assistance with dialysis costs and transplant costs

$15,000+ of $100,000 spent at this time (program is just starting to be used, monthly expenses should start to climb.)

EXHIBIT 14
DATE 11-17-93
SB HUMAN SERVIC

DEPARTMENT OF
HEALTH AND ENVIRONMENTAL SCIENCES
CENTRALIZED SERVICES DIVISION

COGSWELL BUILDING
1400 BROADWAY

STATE OF MONTANA

(406) 444-2442 OFFICE)
(406) 444-1804 (FAX)

PO BOX 200901
HELENA, MONTANA 59620-0901

November 1, 1993

Mr. Dave Lewis, Director
Office of Budget and Program Planning
Governor's Office
Capitol Station
Helena, Montana 59620-0803

Dear Dave:

The Department of Health and Environmental Sciences has received $180,000 as a civil penalty under the public drinking water statues and deposited these funds in the State Special Revenue account (02291) as per MCA 75-6-115(2)a.

These funds can only be used to fund public water supply systems and public sewage system operator training programs as per MCA 75-6-115(3).

The Department intends to present a request for spending authority to our legislative sub-committee during the Special Legislative session. This request will be for $60,000 for the biennium in the State Special Revenue Account (02291). These funds will be used for operator and management training for the new owners of the water system serving Butte and training for other new public water suppliers.

If you have any questions or need any additional information you can contact me at 444-2544.

Sincerely,

Robert Robinson, Director
Department of Health and Environmental Sciences

Enclosures
cc: Clayton Schenck, LFA
CFS:jm/obpp9435.ba1

JCC:CdS
90-5-1-1-3751

Washington, D.C. 20530

September 9, 1993

ENVIRONMENTAL PROTECTION AGENCY
SEP 20 1993
MONTANA OFFICE

Clerk of Court
United States District Court
District of Montana
273 Federal Building
Butte, Montana 59701

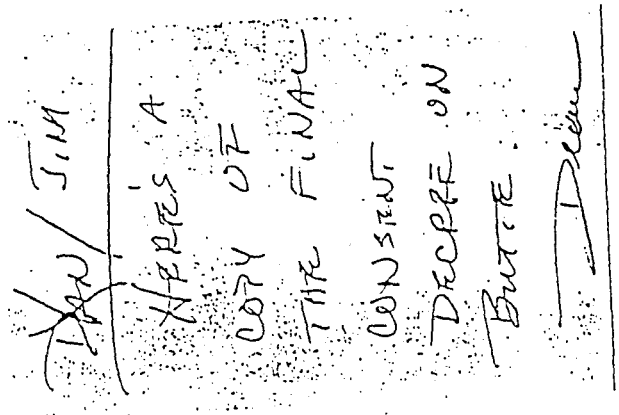
Re: *United States v. Butte Water Co.*, No. CV 91-100-BU-PGH (D. Mont.)

Dear Clerk of Court:

Enclosed for lodging is the proposed Consent Decree which would resolve the United States' claims for civil penalties in this case. It would also resolve the State of Montana's claims for civil penalties, costs and attorneys fees. Also enclosed is the Stipulation and Consent to Intervention by the State of Montana, executed by the parties. The State of Montana will be filing, in Helena on September 10, a Motion for Intervention and a Complaint in this matter.

The proposed Consent Decree requires Butte Water Company to pay to the United States and to the State of Montana a civil penalty of $900,000 for alleged violations of the Safe Drinking Water Act, 42 U.S.C. §§ 300f *et seq.*, the Montana Public Water Supply Act, Mont. Code Ann. §§ 75-6-101 *et seq.*, and the National Primary Drinking Water Regulations. The penalty will be divided between the United States and the State, with $720,000 to be paid to the United States and $180,000 to be paid to the State.

The proposed Consent Decree will be noticed for public comment in the *Federal Register* for a period of fourteen days, so the Court should not enter the Decree at this time. Once the comment period has expired, we will advise the Court of any comments received, and we will either move the Court to enter the Decree or advise the Court that, based on comments received, we withdraw our approval of the Decree. The same procedure was followed with the Consent Decree for Injunctive Relief in No. CV 92-26-BU-PGH, lodged with this Court on April 24, 1992 and entered on May 15, 1992.



Thank you for your assistance in this matter.

Sincerely,

Acting Assistant Attorney General
Environment & Natural Resources
Division

By: Charles de Saillan
Special Trial Attorney
Environmental Enforcement Section
U.S. Department of Justice

Enclosures (2)

cc: Michael D. Goodstein
Steven B. Moores
Alan J. Morrissey
Max C. Dodson
Dean Chaussee
Katherine J. Orr
Ronald B. MacDonald

JUSTIFICATION

1. The department and USEPA have reached a settlement with Butte Water Company for violations of the Safe Drinking Water Act. The State's portion of civil penalties awarded is approximately $180,000.00 (see attached USDOJ Transmittal Letter). By Montana law (MCA 75-6-115), civil penalties received for violations of the Safe Drinking Water Act must be used for water and wastewater operator training. The department will utilize part of these monies for providing operations and management training to the new owners of the water system serving Butte, and other public water suppliers also currently facing new facility construction and start-up. A contract is in place with Process Applications Inc., a consulting firm, to initiate this training.

   This request seeks a continuing appropriation of $60,000 for FY 1994 and FY 1995 to allow the department to implement a training effort covering plant construction through start-up.

2. This appropriation request makes no present or future commitment for increased general fund support.

3. The services provided by this request are in addition to services provided under current appropriations.

4. Funds from this settlement were not available for considerations by the 1993 legislature. The lawsuit against Butte Water Company and with USEPA was in the process of legal negotiations at that time and neither the outcome nor dollar figure were available until late summer, 1993. Finalization of the settlement is expected by January, 1994.

5. This request will allow the department to implement operational and administrative training for surface water supplies mandated to provide filtration. In the case of Butte's water system, the current owners are under a Consent Decree to have filtration installed and meet new water quality standards by January 1, 1995. Penalties are stipulated in the Consent Decree for failure to meet interim measures or failure to meet drinking water standards after completion of facility construction. Implementing this training effort will provide Butte and other communities facing similar circumstances with extensive preparation for efficient operation, maintenance and management of their completed filtration plants. Without this assistance it will be much more difficult for these communities to effectively anticipate and train for reliable operations. Benefits of this project therefore include both financial and public health protection incentives.

6. No reasonable alternative to this request exists within current level appropriations.

EX 11
11-17-95
HUMAN SERV

7. DHES requests spending authority through state fiscal year 1995. $20,000 of the $60,000 will be utilized in fiscal year 1994. The remaining $40,000 will be utilized in fiscal year 1995. All expenditures will be in contracted services.

EXHIBIT 15
DATE 11-17-93
SB HUMAN SERVICES

ENVIRONMENTAL SCIENCES DIVISION
PERMIT STATUS SUMMARY

Air Quality Bureau (AQB)

Current Backlog - 40 pre-construction permit applications

Comment: The only application lagging behind the statutory review time (60 days from receipt of complete application) is ASARCO and the bureau is communicating with them on it. The remainder are waiting for additional information or under review. The AQB has issued 133 permits (including permit modifications) this calendar year. The AQB Permitting Section has been very successful in doing away with its previous permit backlog and in staying within statutory time limits.

Solid and Hazardous Waste Bureau

I. Solid Waste Management Program

Current Backlog - 15 landfill license applications

Stages of review:

1. Under completeness review.	2
2. Notice of Deficiency (NOD) issued.	6
3. Response to NOD under review.	2
4. Environmental Assessment published.	4
5. EIS under revision.	1

Comments: Review time required from the receipt of a complete application to the issuance of a license ranges from 6 months to 1 year. The time required for an applicant to respond to a Notice of Deficiency (NOD) and the number and content of the public comments received can shorten and/or lengthen the time necessary for application review and approval. The type of review required under the Montana Environmental Policy Act (MEPA) also influences the permit review time.

Each year the program receives approximately 25 applications for licenses during the year. This figure has remained fairly stable over time and no substantial increases or decrease are anticipated.

Current backlog - 19 landfill closure plans

Stages of review:

1. Preliminary plans under review.	2
2. Notice of Deficiency (NOD) Issued.	4
3. Response to NOD under review.	0
4. Plan Approved/Waiting completion of work.	12
5. Closure work complete/Waiting inspection.	1

Comments: The review time necessary after the receipt of a complete closure plan ranges from 1 to 6 months. Factors that influence the time required include the accuracy and detail of the information supplied and the length of time taken by the applicant in supplying information

required in the NODs.

During previous years, the program received approximately five to seven closure plans for review per year. Due to the requirements contained in the new federal and state solid waste disposal regulations, many landfills are planning to close by the April 9, 1994 effective date. In addition to the 19 closure plans currently under review, the program anticipates receiving an additional 22 closure plans during the next 6 to 12 months.

II. Hazardous Waste Program

Current backlog - 7 permit applications

The following table illustrates actions, the units involved and estimated dates of issuance, both current and projected.

Applicant	Operating	Modification	Closure
Ash Grove	BIF 6/97		
Exxon		OELTU 1/94	
MAFB		OB/OD ? (depends on response)	
Flying J			SI 11/93
MRC			LTU 6/94
Conoco			SI 9/94
BN-Somers			SI 9/94
Newttec	RD&D 6/96		
Holnam	BIF 6/98		
Projected Closures			Closure/post closure applications take 18 months to 2 years to process
Projected Modifications		Modifications take 1 to 4 months to process	

Comment: The Hazardous Waste Program is presently involved in seven permit actions. Of these seven, only the Ash Grove application is for an operating permit. That is, the applicant requires the department's approval before the proposed operation can begin.

Two permit actions involve processing modifications to operating permits. The Exxon Billings Refinery has requested a permit modification to allow corrective action at its Old East Land Treatment Unit and Malmstrom Air Force Base has requested a modification to construct and operate an Open Burning/Open Detonation Pit.

The four remaining permit actions involve processing applications for the post-closure care of land disposal units. These are closed units at which the applicant is not active, except to

perform interim status monitoring. The facilities concerned include the Flying J Refinery, Conoco Refinery, Montana Refining Company and the BN-Somers Tie Treating Plant. In the near future, the department anticipates the receipt of two additional operating permit applications. MSE will seek to permit a Research Development and Demonstration Facility at its Butte facility and Holnam will seek to permit a Boiler and Industrial Furnace at its Trident facility.

III. Motor Vehicle Recycling and Disposal Program

Current Backlog - 11 Motor Vehicle Wrecking Facility Applications

Comments: Due to vacancies within the program, only five (5) of the applications are partially processed; the remainder have not been started yet. An average of 122 man hours is involved in processing each application. These hours are spread out over the usual four (4) month time frame it takes to process these from start to finish.

A position within the program currently vacant is in the process of being filled. When the position is filled, the applications will be placed as a priority and the new person will be trained in part by processing these applications.

Trends are that the program is receiving a steadily increasing number of applications yearly (1991= 11, 1992= 15, 1993=18). Processing time has increased due to the implementation of §75-10-516, MCA, and due to the expanded nature of the MEPA informational needs that must be met.

IV. Underground Storage Tank (UST) Program

The UST Program is currently issuing approximately 150 UST installation, modification and removal permits per month. The department's Administrative Rules require permit applications to be reviewed within 30 days of receipt. Our present turn around time is approximately two weeks.

UST installers and removers must obtain a three year term license which is renewed annually. The following number of UST installer/remover licenses have been issued; 1990 - 217, 1991 - 281, 1992 - 352, 1993 - 396. All UST installers/removers originally licensed in 1990, when the UST licensing law first became effective, must be re-examined and provide proof of continuing education this year. The turnaround time for a license renewal without re-examination is approximately five to ten working days. Re-examination requires a minimum of 20 days notice by the applicant prior to the examination date. Licensed applicants can take the examination up to six months prior to the expiration of their license. License exams are offered monthly.

Water Quality Bureau

I. Montana Pollution Discharge and Elimination System (MPDES) Program

Current Backlog - 62 Renewals 12 New Applications

Comments: It will likely be mid - 1994 before the 1993 backlog is completed. New permits will be prioritized, processing those as quickly as possible and as additional new applications come in, process before renewals. We will maximize the use of general permits to the fullest extent possible. MPDES will have 2.0 FTE hired before 11/30/93, which will begin to help backlog as training proceeds. The projected workload includes 122 renewals and 60 new applications for 1994 and 65 renewals and 60 new applications for 1995.

II. Montana Ground Water Pollution Control System (MGWPCS) Program

Current Backlog - 5 Renewals 9 New Applications

Given permit review and public notice requirements, a minimum of 90 days is generally required to process a MGWPCS permit from application to issuance. Anywhere from 20 to 80 hours of staff time may be required to process a permit, less for a renewal and more for a complex permit for new activity. Given the current backlog, the time required to process these permits ranges from 280 to 1,220 hours or 1.7 to 7 months.

III. Stormwater Program

Current Backlog - 150 Applications

It will take about four months to process these applications. We can probably expect to receive 300 - 400 applications per year for a few years until the program levels out to about 200 per year. We are utilizing general permits. We hired 1.0 additional FTE in 10/93, which is beginning to reduce the backlog. We will prioritize permit processing over compliance inspections until the program levels out, in order to keep projects, especially new construction, moving. We are developing a computer database for maximizing efficiency in tracking compliance and grouping inspections.

IV. Drinking Water Program - Plan Review and Subdivision Section

Current Backlog - Approximately 200 Subdivision Applications

Applications are currently being processed within the 60 day review time frames, except for contracted subdivision review with the Flathead County Health Department. They are typically running over the 50 days allowed in the Sanitation in Subdivision Act. Although Flathead County has added staff, the tremendous number of applications prevents them from reviewing the applications in a timely fashion. We will ask them for a plan of action to correct this problem.

Five of the eight subdivision positions are vacant. Of the currently filled positions, one will be vacant for at least a week because of a death in the family. Two ex-employees are taking turns trying to help the Program Assistance hold the program together. The Public Water Supply Program has one vacancy; another position will be vacant at the end of the month.

Contracted consulting services have allowed both programs to improve their backlog of plan review applications. This is an "experiment" that appears to have merit, but the department cannot rely totally upon contracts to perform this important function.

Subdivision Review (fiscal years 1987 - current):

Fiscal Year	Number of Lots
1987	2731
1988	2177
1989	2173
1990	1800
1991	2164
1992	3679
1993	5737
1994	2081 (July 1 through October 31)

EX 1
11-17-93
HUMAN SERV.

Occupational and Radiological Health Bureau

I. Asbestos Program

Current Backlog - 5 asbestos abatement project permit applications pending.

Comment: The current turnaround for these project permits, if everything is in order, is approximately 3-5 days.

EXHIBIT 16
DATE 11-17-93
SB HUMAN SERVICE

ENVIRONMENTAL SCIENCES DIVISION
ISSUES AND ACCOMPLISHMENTS

Natural Resource Damage Program

The Natural Resource Damage Program (NRDP) is pursuing a multi-million dollar claim against the Atlantic Richfield Company (ARCO) for damages resulting from the release of hazardous substances from the Anaconda Company into the Upper Clark Fork River Basin. To date, the program has released three reports on resource injury addressing groundwater, aquatic resources, and terrestrial resources. A compensable damage report is due to be released in December 1993 and the restoration costs damage report will be released in March of 1994.

In March of 1993, the State and ARCO entered settlement negotiations pursuant to a Memorandum of Understanding between the parties. If settlement is not reached by September of 1994, the litigation will resume.

Air Quality Bureau

I. Fees

The AQB has successfully implemented the overall fee program enacted by the 1993 Legislature and is proceeding to fill the additional FTE authorized during the session. Delays in the approval and classification process have given us a late start on recruitment. Further, we continue to find it difficult to recruit experienced people for leadership or management positions due to the salary structure. We are underway with hiring and should have the majority of the vacant positions filled in the next several weeks.

II. State Implementation Plans (SIPs)

The AQB spent considerable effort in writing new sections for the SIP for areas not complying with ambient air quality standards. The SIPs can be broken down by pollutant as follows:

- PM-10: Out of seven nonattainment areas, five plans have been submitted to the Environmental Protection Agency (EPA), one plan (Thompson Falls) is largely complete, and one area (Whitefish) has technical studies and SIP preparation efforts well underway. We are providing additional information to the EPA on most of the areas, but it appears that all of the plans have a good chance of being approved.

- Carbon Monoxide: Missoula has implemented an oxygenated fuels program as required by the Federal Clean Air Act (FCAA). No additional work for either Billings or Great Falls is anticipated. There have been some public health concerns with oxy-fuels in Missoula regarding the use of MTBE as an additive to the fuel. The area is switching to an ethanol additive this winter to see if the concerns are alleviated.

- Sulfur Dioxide: The AQB is working furiously to negotiate an agreement with ASARCO on the SO_2 control plan for the smelter (due date 11/15/93). We plan to continue negotiations until early December in hopes of coming to an agreement; if unsuccessful, we will petition the Board of Health and Environmental Sciences (BHES) in January to adopt our proposed control plan. Going past 12/15/93 exposes the state to sanctions by the EPA.

Preparation of the Billings-Laurel SO_2 SIP is underway, but we are lacking much participation by the affected industries. A meeting sponsored by the Governor on 11/23/93 in Billings is planned to get the parties to the table.

III. Permitting

A significant effort has been invested in development of the new Title V Operating Permit Program to meet Federal Clean Air Act (FCAA) mandates (due to the EPA on 11/15/93). This effort started with a major package of legislation during the 1993 session and continued through rulemaking since the session. During the Legislature and through rulemaking, AQB has negotiated and worked with the Clean Air Act Advisory Committee (CAAAC), a group of interested members of the regulated community, and environmental groups. As a result, we have a consensus on the rules package going before the BHES on November 19, 1993 and are nearing the submittal of our new Operating Permit Program to the EPA.

IV. Compliance and Enforcement

The AQB Compliance and Enforcement Section is undergoing a reorganization to emphasize better service and communications with the public and the regulated community. An AQB position has been assigned to the Polson office to provide a presence and improved service in Western Montana. In addition, a new position is being filled in Billings to support SIP development. Further, section management has been reorganized to create a new managerial position, while retaining our experienced personnel in a senior technical role. We are optimistic that these changes will allow us to improve this very visible aspect of our program.

Solid and Hazardous Waste Bureau

I. Solid Waste Management Program

With the advent of the new federal and state regulations for the disposal of solid wastes, landfill owners and operators are making increasing requests for technical assistance and guidance from the program. Meeting these increased requests mandates that staff time be reduced in other necessary duties such as application and plan reviews, and approvals and compliance monitoring of existing facilities. The increased requests for assistance are expected to continue until landfill owners and operators become more familiar with the requirements of the new regulations. The program will continue to provide as much assistance and guidance as possible without significantly impacting other program duties which are high in priority.

All rule revisions to Montana's solid waste regulations that were needed to comply with the requirements of the new federal Subtitle D rules have been completed. The EPA has reviewed Montana's application and revised regulations for adequacy and has determined that the Solid Waste Management Program is acceptable for approval. The EPA's final notice of program approval should be published in the Federal Register during the first part of December.

The program has prepared a Draft State of Montana Integrated Solid Waste Management Plan and has completed a 90 day public comment review period of the document. Currently, the comments received are undergoing review and the plan is being revised as necessary to incorporate appropriate suggestions received. Once revisions are completed, all comments will be responded to and the final plan will be submitted to the BHES for adoption. It is anticipated that the final plan will be ready for public distribution early in 1994.

II. Hazardous Waste Program

The issue of incineration of hazardous waste in cement kilns, requiring a Boiler and Industrial Furnace (BIF) Permit continues to be a priority for the agency. An application has been submitted by Ash Grove and is currently under review by the staff. It is anticipated that an additional permit application will be submitted by Holnam, Inc. for a BIF permit for its Trident facility. Nationally, the EPA has undertaken a serious review of its BIF regulations ton ensure that public health and environmental needs are being met. State staff continue to work closely with EPA staff from the regional office on this issue.

III. Motor Vehicle Recycling and Disposal Program

The program just concluded a series of training sessions held for the county motor vehicle recycling & disposal program managers. The Legislative Auditor's office noted in it's recently concluded follow up audit that this was an area that needed to be addressed.

A greater degree of compliance with program requirements is being achieved through increased activity at both the county and state levels. A greater number of chronic violators have been or are being brought into compliance by court actions. As a result of the court actions, a greater degree of "voluntary" compliance is being seen.

Water Quality Bureau

Many individuals within the bureau have been involved in extensive revisions to the Nondegradation rules, made necessary by the passage of SB 401 during the last session. The rule making has generated considerable controversy as people begin to realize the impacts of nondegradation. Meetings with the public were held early this summer to solicit input in the rule making process and a second round of public meeting was held in September. Following citizen and industry input, changes to the proposed rules have been made. Discussions continued with interested groups in October and November with meetings in Helena, Bozeman, Missoula and Billings. Proposed rules will be considered by the BHES at a special meeting on December 17, 1993. The proposed rules will have a significant impact on decisions made by most, if not all, programs within the bureau.

I. Montana Pollution Discharge and Elimination System (MPDES) Program

The MPDES is currently in somewhat of an upheaval and backlogged due to several changes:

A. We have spent a lot of time on the nondegradation rules and need to get the issue resolved so we can carry on with permitting and the rest of the program.

B. We are revising/combining MPDES and MGWPCS rules to recognize the need for department permits for all discharges to state waters and to help us catch up to the EPA policy requiring NPDES permits for hydrologically connected discharges.

C. We are struggling with policy on minimum treatment requirements for old existing mine adits or other recently discovered discharges and what constitutes "natural" in the case of these historical discharges. This needs to be resolved.

D. It seems to be the rule that all of our proposed mining permits are highly scrutinized and challenged by the environmental groups and/or the mining companies and possibly by the EPA. The policy of permitting seeps from waste rock dumps, process ponds, etc. within the mine permit boundary is new to us, and citizen suits on the controversial projects (all big mines) are preventing us from being sure where we're going.

E. We are scheduled to go before BHES with our proposed fee rules Friday, November 19, 1993. We don't know how much controversy to expect.

F. On the brighter side, we've been able to hire 3.0 FTE extra resources to assist in our MPDES and storm water programs. We hope the extra complexities in modern day permitting issues don't cause us to suffer a net deficit in resources so we are worse off than before the hiring.

II. Nonpoint Source and Wetlands Programs

Over the past four years the Nonpoint Source Program has successfully implemented over a dozen watershed / demonstration projects and over 30 information / education projects. Our major focus has been on agriculture, forestry and mining. Each of the watershed projects have demonstrated a reduction of NPS pollution through the implementation of improved management measures. Although it is more difficult to measure success in terms of pollution reduction, the education projects have been implemented statewide and have exposed thousands of landowners, land managers and the public to the causes of and solutions for NPS pollution.

The department has recently submitted a funding proposal to the EPA to continue the program. The proposal contains an additional five watershed and nine education projects.

The development of a statewide wetlands conservation strategy has been delayed by problems in filling the wetlands coordinator position. However, this should be completed by December 1, 1993. The strategy will delineate how the state will carry out an effective and efficient wetlands protection program and how the various entities will coordinate their efforts to conserve important wetland ecosystems. Funding has been secured from the EPA during the past two years to develop the strategy, to monitor water quality in wetlands, to implement wetland education projects and to complete wetland training courses.

The reauthorization of the federal Clean Water Act will have major impacts on both programs. While additional funding is expected to be available to the states, provisions now included in the reauthorization will significantly increase responsibilities and workloads for the states. DHES is planning to meet those demands.

III. Drinking Water/Subdivision Review Program

The biggest issue facing this program is the inability to maintain trained and qualified staff in the subdivision review program. Five of 8 subdivision positions are vacant. The Independent Record recently featured this issue in a front page story. The bureau is using two staff members who previously worked in the program to maintain the review process as well as utilizing contracted services to keep applications moving. Record numbers of submittals in areas such as Flathead County have literally overwhelmed our staff and that of counties under contract to assist us in review.

IV. Municipal Wastewater Assistance Program

This year the program received $9.5 million in federal funding for loans to build new wastewater treatment facilities. Several long standing water quality problems are being addressed using program funds. These include the completion of an advanced treatment plant serving Kalispell and protecting Flathead Lake, construction of a sewage collection system for Evergreen, and sewering much of the south Missoula area.

Occupational and Radiological Health Bureau

I. Radiation Control Section

A shift in industrial X-ray services from by-product materials to X-ray machines and additional activity in the medical community is resulting in a slight increase above normal of X-ray registration. The current rate of increase for registrations is approximately 12% versus a normal rate of increase of approximately 8%. The shift in industrial X-ray is due to the increased Nuclear Regulatory Commission's by-product materials license fees.

Requests for information from citizens regarding radon has increased slightly with the institution of the radon hotline. This is based on observation--percentages are not yet available as the hotline has only been in operation since October 17.

Requests for information and assistance regarding non-ionizing radiation (electromagnetic fields, microwaves, lasers, etc.) have seen a dramatic increase of approximately 300%. The primary interest being electromagnetic fields (EMF's). The requests for information are handled promptly. The requests for assistance are referred to Montana Power in the case of EMF's around electrical generation and transfer equipment. The section cannot assist in other requests for assistance, as no measurement capabilities exist in the state.

Radiation Control rule revisions are expected to be completed by the end of December.

Fax 761-3192 Att. Dr. Paul Gorsuch

TEAM/MONTANA

TEAM - Tax Equity Action Movement Inc.
P.O. Box 2472 Kalispell, MT 59903

EXHIBIT 17
DATE 11-17-93
SB HUMAN SERVICES

November 4, 1993

I am Vice Chairman of TEAM (Tax Equity Action Movement).

We are a state wide organization and are working to have better and more economically operated government. We were active in the 1992 elections and helped defeat several big spending legislators. We worked with six other organizations on petition drive to suspend HB 671 and are now working to make the special session a success for us the taxpayer.

Health Care, Canadian style:

While I was in Canada October 6 through 8, a headline in "The Edmonton Journal" stated: "400 Jobs Cut; $22 Million Cutback Ordered". The article explained the cuts in Catholic hospitals were ordered by the Provincial government and would include shutting down of 82 beds. One has to wonder how this will effect health delivery there?

The same paper talks about when Deputy Premier Ken Kowalski recently had a back pain, he was sent to the head of the line. When the government controls anything, they can cut anyone out of line and put anyone in they want. Just having to wait in line for my health care is repulsive to me.

The "Calgary Herald" October 8 headline revealed: "Hospital Threatens Patients; Foothills Hospital Tells Family To Remove Elderly Woman or Face $1,000-a-day Bills. One official said "If a person don't leave when discharged they could be arrested for trespassing." When government is involved it has ways to force you to follow its edicts.

I know of a lady in Edmonton in her fifties who was told by the system that she is too old for a lung transplant. The government really does have a life or death control over their lives!

These are only three illustrations of the kind of treatment that we will get when government gets involved. There are two basic theories about government. One idea wants government to do everything for us. The other idea is "I want to do what I can for myself". Most of the rest of the world has found that whenever government is involved, it also controls you. I want to control my own life, how about you?

Our last Montana Legislature passed SB 285 to work on a government health care plan for us. There is no place on earth that has as good health care as our country does. We have seen how state government has messed up our workmen's comp. We are also seeing how other countries are doing. Why would anyone think our government would do any different for health care for us? The special session should save about $1.5 million by taking the funding out of SB 285. It will also protect us from government and the situations I have described in Canada!

Sincerely,

Walt Dupea

Walt Dupea Vice Chairman TEAM (Tax Equity Action Movement)
P.O. Box 608, Bigfork, Mt 59911
Phone (406) 837-5751 (evenings) or 837-0052 (days).

EXHIBIT 10
DATE 11-17-93
SB HUMAN SERVICES

MONTANANS FOR BETTER GOVERNMENT (P.A.C.) -- FACT BULLETIN*

The "Better Way:" An Agenda for the Special Session

Introduction

The events of 1993 show that Montanans want more for their tax dollars. Montanans want more productive government -- government that maintains or improves service at lower levels of spending.

Experience across the nation and around the world demonstrates that the productivity of government workers rises when policymakers (1) expand incentives for agencies to cut costs and improve service and (2) give agency managers power to respond to those incentives. This Fact Bulletin explains how the legislature can apply these principles to balance the budget in the 1993 special session.

In its deficit-closing program, the Racicot administration has proposed several expenditure reductions and fund shifts. This Fact Bulletin recommends coupling some administration initiatives with structural changes that will enable government to do more with less. This Fact Bulletin also proposes spending cuts not suggested by the Governor, but proposes no fee increases, reductions in social services, or cost shifts to local government.

Citizens interested in supporting our agenda should contact Montanans for Better Government for details.

An Agenda for the Special Session

* **University system reform.** The Racicot administration has proposed a $12 million reduction in the Montana University System (MUS), but because of greater-than-expected 6-mill revenue and other factors the real reduction will be much less. We believe the $400 million-plus MUS budget could withstand a full $12 million in cuts if there were structural funding change: As of FY 1995, instead of funding the system directly, the legislature should channel general fund money into Montana Higher Education Scholarships for Montana students. Each scholarship would be redeemed at the MUS campus of the student's choice. Students could use scholarships only for a limited duration (e.g., 10 semesters). Full cost for nonresidents would be phased in, and each campus would compete for funds and keep all money it attracts. Heightened competition would force campuses to respond to consumers and implement necessary efficiencies.

  We also favor a constitutional amendment to assure campus-based management, permit Montana private and tribal colleges to compete for scholarships, and send 6-mill levy money into scholarships.

* **K-12 school reform.** As of this date, the administration has proposed K-12 spending cuts of about $11 million. One way to protect -- and raise -- the quality of education in the face of budget reductions is to give moderate and low income families what the wealthy

-over-

have always enjoyed: parental choice of K-12 schools. The financial vehicle of choice would be a refundable tax credit of $1000 for documented educational expenses paid to others. In addition to protecting educational quality, choice would *save state money* (about $17 million in FY 95, under one scenario), *relieve financial pressure on districts with expanding enrollment,* and, after FY 1995, *reduce local property taxes.*

* **DOT reform.** With a non-federal biennium budget of $365 million, the Department of Transportation should play its part in general budget reductions. We believe that DOT could absorb a $10 million cut through certain managerial and operational reforms, such as increased reliance on competitive bidding. Efficiencies need not impact federal funds. Savings should be used to (a) on a 3/5 vote of the legislature, balance the general fund, and/or (b) roll back fuel tax increases.

* **Repeal S.B. 285.** S.B. 285, adopted by the 1993 general session, creates a Montana Health Care Authority and orders it to prepare two plans for centralized state control of health care. The philosophy behind S.B. 285 is a discredited, central planning approach and duplicates efforts at the federal level. Repeal would save $1.5 million now. Avoiding a state takeover of health care ultimately may save human lives.

* **Privatize liquor.** The administration estimates that retail liquor divestment would save $3.5 million. We support this administration initiative.

* **Couple an increase in existing "budget balancing reductions" with fundamental changes in agency operations.** The 1993 legislature's H.B. 2 (the largest appropriation bill) mandated "budget balancing reductions" of one-half of one percent for most agencies. This level is extremely modest compared with levels adopted elsewhere and could be raised if there were basic changes in agency operations. Examples include:

  (1) *Public employee incentive changing.* Amend state Employee Incentive Program to remove award caps, allow awards for ideas regarding personnel and employee's own duties, give agencies strong incentives to adopt money-saving ideas (a percentage of savings), adopt devices to build teamwork, and abolish the incentive awards advisory committee.

  (2) *More competitive contracting.* Abolish or amend various statutory impediments to competitive contracting. Example: §18-7-104, MCA, which mandates that printing contractors must be organized by one of three named unions.

  (3) *Decentralize decision making.* Allow agencies more freedom in deciding how to achieve their missions.

Conclusion: "There is a Better Way. . . ."

The petition suspending the income tax hike (H.B. 671) has given Montana policymakers a historic opportunity to turn to the better way: More productive government at less cost. Adopting the agenda outlined here would be a very good place to start.

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* This is one of a series of Fact Bulletins prepared for Montanans for Better Government (Political Action Committee) by Professor Rob Natelson. If you are interested in joining, or would like more information, contact Montanans for Better Government, 1113 Lincolnwood, Missoula MT 59802, tel. 406-721-2266; FAX 728-2803.

BlueCross BlueShield of Montana

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(406) 444-8200
Fax: (406) 442-6946

EXHIBIT 19
DATE 11-17-93
SB HUMAN SERVICES

November 17, 1993

John Cobb, Chairman
Human Services Appropriation Subcommittee
Montana State Legislature
State Capitol
Helena, MT 59620

Dear Chairman Cobb:

Most Montanans receive the benefits of a very good health care delivery and financing system. That care, however, is not always available to all Montanans at the most appropriate time or at an affordable price. This situation must change.

Over the past several years, Blue Cross and Blue Shield of Montana has been actively working for reform of our health care system. The Montana Health Care Authority is a vital part of any effort to provide greater access and more cost-effective health care for Montana's citizens. We support its efforts, and we strongly oppose any effort to reduce its funding more than the Governor's recommended cuts or to remove any of its authority.

Sincerely,

Charles Butler, Jr.
Vice President, External Affairs

210TAN16.1X/smh

Presented by Tanya Ask,
Blue Cross and Blue Shield

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

HUMAN SERVICES SUBCOMMITTEE DATE 11-17-93

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R E Wyma		
Allen Lanning		
Lora Seabolat		
Barb Bodman	MT. Nurses Assoc.	
Sam Hubbard	Health Care Authority	
Clyde Bailey	State Auditor	
Christian Mackay	MVHC	
Ed Caplis	MSCA.	
Tanya Ask	Blue Cross & Blue Shield of MT	
Paul Smietanka	Mont Podiatric Med Assn	
Don Allen	MT Medical Benefit Plan	
Russell B Hill	MT Trial Lawyers	

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~~Carolyn Squires~~	~~N.O.W.~~	
Paulette Kohman	MCMCH	
James F. Ahrens	MT Hospital Assoc.	
~~Scott~~ Arnold	AFSCME	
Charles Stahl	DHES	

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