MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN SCOTT ORR**, on February 14, 1995, at 3:00 P.M.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. John Johnson (D)
Rep. Royal C. Johnson (R)
Rep. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)
Rep. Carolyn M. Squires (D)

Members Excused:

Rep. Betty Lou Kasten (R)

Members Absent:

None

Staff Present: David Niss, Legislative Council
Susan Fox, Legislative Council
Vivian Reeves, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Secretary wrongly stated the hearing date as January 14. The date of the hearing is February 14, 1995.

Ian Marquand, Montana TV Network, Room 2, State Capital, Helena, Montana filmed the hearing for news coverage only.

Committee Business Summary:

Hearing: HB 548, HB 531, HB 466, HB 533, HB 511
Executive Action: None

HEARING ON HB 548

Opening Statement by Sponsor:

REP. BILL CAREY, House District 67, Missoula, sponsored HB 548 which is an act providing for the Montana Health Security System and for creating an integrated or single-payer payment mechanism for health care services. **EXHIBIT 1**

Proponents' Testimony:

Doug Campbell, District 11 Director of the Montana Senior Citizens Association, Missoula, spoke in support of HB 548. **EXHIBIT 2**

Don Judge, representing the Montana State AFL-CIO, spoke in support of HB 548. **EXHIBIT 3**

Polly Walker, member of the Montana Senior Citizens Association (MSCA) and the Legacy Legislature, Polson, Montana, spoke in favor of HB 548. **EXHIBIT 4**

Tom Bilodeau, Research Director of the Montana Education Association (MEA), spoke in support of HB 548. **EXHIBIT 5** He commented on the fiscal costs of the lack of health care reform on Montana's public schools. He said, "indeed, health care cost is going up so fast, school district budgets cannot compete with it." He added, "it is a clear, unmistakable impact on the schools itself, and it has devastating impacts in both large and small districts across the state." Attached is the testimony of **Steve Henry, President of Billings Education Association, February 5, 1993,** which describes the Billings Education Association self-funded health insurance plan. **EXHIBIT 5, PAGE 4** He stated that there are likely more uninsured teachers in Montana today than a few years ago. The MEA determined through an internal review that the Single Payer Health Care Reform was the best way to assure choice of provider, access to all and cost containment over the long term. **Mr. Bilodeau** referred to the final report of the Montana Health Care Authority (MHCA) entitled Statewide Universal Health Care Access Plans, pages 17 and 41. **EXHIBIT 6**

Dan Edwards, International Representative with the Oil Chemical Atomic Workers International Union (OCAWIU), also was a member of the Health Benefit Plan Committee which dealt with insurance problems of the small employer, spoke in support of HB 548. He indicated "that because of a business that my union had...that the horror stories that you hear about the Canadian system simply are not true. No, it's not perfect. Yes, it has problems, but I can assure you they are far smaller problems than those faced by many of our citizens in this state of Montana." He shared the personal example of having to watch his cholesterol and in the process of changing medications he had some blood tests for HDL, LDL, etc. Referred by his doctor, he went to a laboratory in

Kate Cholewa, representing the Montana Womens Lobby, stated that the Womens Lobby supported Universal Coverage Single Payer Plan in 1993 and support it today.

Willa Dale Evans, Montana Senior Citizens Association, Roundup, Montana, said "we passed SJR9 three sessions ago...let's get this show on the road. Let's become the leader from Montana for National Comprehensive Health Care Single Payer System. Thank you." **EXHIBIT 13**

Opponents' Testimony:

Tom Hopgood, representing the Health Insurance Association of America, strenuously opposed HB 548. He referred the Committee to page 43, Section 83, and submitted "that is not going to fair too well in this legislative session" due to the 10% income tax surcharge to fund this program. In Section 86, there is a 7.3% payroll tax on this program. In Section 90, there is a 6.75% corporate income tax surcharge. In Section 91, there is an additional tax of 18 cents per package of cigarettes. In Section 92, 12.5% additional tax. **Mr. Hopgood, representing the Montana Beer and Wine Wholesalers,** opposed HB 548, indicating that Section 93 contains a tax of $4.30 per barrel of 31 gallons of beer. Section 94 contains a liquor fund tax. Section 95 contains a health security fund tax of 27 cents per liter on table wine. Section 96 contains a coal health security fund tax. Section 97 contains an oil and gas health security fund tax. Section 98 contains a metalliferous mines tax. Section 99 contains a gambling machine licensing tax. Section 100 contains an accommodations tax.

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, and the Montana Business and Health Alliance, stated that Medicare and Medicaid was established in 1966 "which was the first large step the Americans took into socialized medicine...for people over 65, later people that were disabled and we provided health care for very poor people." Since 1966, health care costs have increased over 800%. Previous to 1966, health care costs stayed in line with the rest of inflation. **Mr. Grogan** said, "I cannot imagine how much more it is going to go up" if the socialization of health care has already caused a rise of 800% in the last 27 years, and if we continue this socialization by contributing with the entire population. He emphasized "that socialization has caused this tremendous cost spiral; it is not the solution." **Mr. Grogan** stated that he attended a seminar in Missoula presented by a lady from Vancouver, British Columbia who talked about "how we should express a mass exodus from British Columbia and Alberta into the United States because things have become so disproportionately expensive up there." Milk is $4.41 a gallon and gasoline is almost $3.00 a gallon in Vancouver. Her income taxes are in excess of 50% and they pay a tax for their health care. He emphasized that about 80% of her money went towards taxes. Because she is an American and her husband is a Canadian, they

Billings for the blood tests. "Those blood tests cost me $68." After doing some "detective work on my own, and when I had to do the second batch to see if the medication was working, I went and had those same tests done which were forwarded to the same laboratory except through one of these overnight, walk-in type clinics. And the exact same testing cost me $35."

Bruce Rukstad, Chairman of the Exxon group of the OCAWIU, Billings, Montana, spoke in favor of HB 548. **EXHIBIT 7**

Lonny Harmon, Health Care Activist from the Conoco group of the OCAWIU, Billings, Montana, spoke in support HB 548.

Russell Hill, representing Montana Trial Lawyers Association, spoke in support of HB 548 and also "the concept of Universal Access in comparison to what's being called Incremental Health Care Reform." He had three comments on Section 22 of HB 548 concerning subrogation. **Mr. Hill's** third comment was lost due to changing sides of the cassette tape.

{Tape: 1; Side: 2}

Lois Hove, representing the Montana League of Women Voters, supported HB 548. **EXHIBIT 8**

Marion Hellstern, Treasurer and District 1 Director of the Montana Senior Citizens Association, representing Phillips, Valley, Roosevelt, Daniels, and Sheridan counties, strongly supported HB 548. **EXHIBIT 9**

Edmund Caplis, representing Montanans for Universal Health Care (MUHC), a coalition representing consumer groups ranging from the Montana Hemophilia Society to the Montana Chapter of Physicians for a National Health Plan, urged support of the Health Security Act. **EXHIBIT 10**

Madelyn Cameron, representing the Montana Senior Citizen's Association, Great Falls, Montana, supports the Single Payer Plan. **EXHIBIT 11**

Janet Robideau, Chair of the Montana People's Actions Health Care Task Force (MPA), represented the MPA, the community and labor organizations of the Montana Community Labor Alliance (MCLA), Missoula, Montana, spoke in support of HB 548. **EXHIBIT 12**

Diane Sands, Vice President of Missoula Partnership Health Center, Chair of the Legislation Committee, Missoula, Montana, spoke in support of HB 548. "The Missoula Partnership Health Center is a public health clinic which serves several thousand uninsured Missoula citizens." **Ms. Sands** stated that "single payer is an excellent way to achieve the goals of comprehensive, affordable, accessible, high quality, health care services for all. We'd like to thank **REP. CAREY** for carrying this bill and we urge your passage."

plan to move back to the United States as soon as possible "because they can't afford the socialization of anything else."

Steve Turkiewicz, Secretary to the Montana Automobile Dealers Association (MADA) Insurance Trust (an insurance trust offered to the employers and employees of Montana's new car and truck dealers) opposed HB 548. He stated that the MADA had been in business since 1947 and billed "about $4 million a year to buy health insurance benefits for over 4000 Montanans." He stated that after **President Bill Clinton** made the "dramatic offering of his health care reform last year," there were a number of documents, polls and formulas available to see how this would be paid for and how it would affect individual employers. "I took the liberty to send that to each of my members." **Mr. Turkiewicz** stated that one of his members wrote at the bottom, "since my costs go down, whose go up?" At that time **Mr. Turkiewicz** did not have an answer for him. However, he stated that he knew the answer "after **Mr. Hopgood** finished reading the list of costs of new taxes Montanans would be forced to pay on this bill." **Mr. Turkiewicz** urged the Committee to look at page 50, Section 101, line 19 and quoted, "the provisions of [Section 1 through 82, 101, 104, and 105] may not be amended except to further its purposes by a statute passed by a vote of two-thirds of each house or upon approval by the electorate." He added, "this piece of legislation is fraught with mischief. We urge a Do Not Pass on this bill."

Riley Johnson, representing the National Federation of Independent Business (NFIB), reported to the Committee that the "NFIB traditionally sets its position of pro or con by a ballot of its 8,900 members every year." He indicated that on the ballot, members chose from the following: Single Payer Plan, Regulated Multiple Payer Plan, Progressive Insurance Reform and Cost Savings Approach, or no approach at all and to leave it alone. He said, "Single Payer Plan got 3% of our membership vote, so we stand in opposition to this bill."

David Owen, representing the Montana Chamber of Commerce, urged a Do Not Pass on this bill.

Robert White, representing the Bozeman Chamber of Commerce, opposed HB 548 "because Montana has the second highest nominal income tax in the nation. We have the second highest property tax with respect to income. We have the highest personal property machinery tax. If we add more to taxes we're not going to see the businesses, we're not going to see the employment, we're not going to see the labor to pay for this bill."

Paul Gorsuch, representing Project Heal, said, "while we would agree with many of the criticisms of our current system, we would say that the miseries of our neighbors to the North should not be our miseries." He indicated a February headline from the Calgary Herald which read, "More Health Care Cuts Predicted For The Alberta System"; another headline listed the physicians leaving

Alberta to come to the United States, which affects the quality and availability of health care in that Province. **Dr. Gorsuch** stated that this is not an isolated event and indicated a stack of notebooks about two feet tall "filled with over 1,000 articles detailing from 1989 to 1994 some of the problems in the Canadian health care system." He read excerpts from a February 1989 article in MacLeans, "the Canadian equivalent to our Time Magazine," detailing many of the problems and shortages in the Canadian health care system. He stated, "that while we have problems in our system, the problems of the Canadian system are not our solution."

Arlette Randash, representing Eagle Forum, and on behalf of Laurie Koutnik for the Christian Coalition, opposed the Single Payer Plan "because we have seen the danger to human life; not only for the unborn, but for the infirm, the handicapped and the elderly." She said, "the Montana Health Care Authority, I believe, has definitively said that it is not financially feasible." She urged a Do Not Pass for HB 548. She said, "we applaud the efforts of those who are bringing forth incremental efforts to address health care problems. **[REPS.] TOM NELSON, ROYAL JOHNSON, SCOTT ORR, PEGGY ARNOTT** all have bills up that we're going to be hearing and we applaud their efforts to protect human life in those measures."

Questions From Committee Members and Responses: None.

Closing by Sponsor:

REP. CAREY closed by thanking the committee for a good hearing and stated that the proponents spoke from the point of view of the consumers, and the opponents spoke generally from the point of view of the insurance industry. He said, "We need to take a look at that dichotomy." He stated that when "they talk about increased taxes, they're not talking about the benefits that would flow from the Single Payer system." **REP. CAREY** read excerpts from the Health Care Authority's report of October 1, 1994, page 39. **(Refer to Exhibit 6, cited earlier)** He said, "I submit to you that the Health Care Authority has documented the rational basis for us promoting the Single Payer Plan and I therefore would draw your attention to the fact that when they talk about increased taxes we need to talk about increased benefits. . . . I hope as legislators, we're not scared away by anecdotal references, in fact very misguided references, to the HCA's work." He urged the Committee to give HB 548 a realistic consideration.

{Tape: 2; Side: 1}

HEARING ON HB 531

CHAIRMAN ORR relinquished the chair to **VICE-CHAIRMAN CARLEY TUSS** so he could present this bill as sponsor.

Opening Statement by Sponsor:

REP. SCOTT ORR, House District 82, Libby, Montana, sponsored HB 531, known as the "Heal Montana bill," and the "Medi-Choice bill." He stated that many portions of this bill are duplicative; it includes portability, renewability, preexisting conditions and medical savings account. **REP. ORR** stated that HB 531 is unique in that there are some portions that deal with disclosures of premium history, disclosures of doctors' charges, and public disclosures of hospital charges.

Proponents' Testimony:

Paul Gorsuch, representing Project Heal, Great Falls, Montana, spoke in support of HB 531. He stated that the ideas to this bill were first presented in response to the question of what was meant by market-oriented reform. "Since then we've maintained the basic ideas of that first inquiry although the proposal has been characterized in a number of different ways by different participators in the debate." He urged the Committee not to look at those characterizations, but to look at the substance of the bill. Insurance should be renewable; the sick should not be singled out and dropped from coverage, or the insurance rates increased to the point of being forced out of the market. **Mr. Gorsuch** stated that this bill resolves that problem and makes insurance renewable. Insurance should be affordable and remain affordable when changing jobs. High-risk individuals have difficulty finding health coverage. This bill provides a package for high-risk individuals which is affordable for most and definitely a better benefit than is available to them now. This bill contains Medical Savings Accounts which would spur accountability, responsibility, and a healthy motivation to look at the costs of health care services. When proposing a market-oriented system, it's essential to have price information. Without price information, or if price information is only available to large groups, the individual has little chance for competing or finding cost-effective services. This bill solves that problem by making price information available to everyone. **EXHIBIT 14**

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, the Montana Business Health and Alliance, said that HB 531 is an extremely good bill. It guarantees portability and renewability for all Montanans. It makes good health insurance accessible to everyone. It holds both insurers and providers accountable by requiring full disclosure of policies and prices. And finally, through the use of Medical Savings Accounts it addresses the affordability problem. **EXHIBIT 15**

Mike Schweitzer, M.D., representing Billings Anesthesiology, P.C., Billings, Montana, spoke in support of HB 531. **EXHIBIT 16**

Rob Hunter, masters degree in health administration, and has worked in the field of health benefits and managed health care for the past ten years, spoke in support of HB 531. **EXHIBIT 17**

Arlene Reichert, Great Falls, Montana, a former Democratic legislator and a Constitutional Convention Delegate, spoke in support of Medi-Choice legislation.

Dr. Cheryl Reichert, Pathologist, Director of the Laboratory, McLaughlin Research Institute, Great Falls, Montana, spoke in support of HB 531. She said that "most folks in Montana talk about the last best place with the emphasis on best. For the purposes of this brief discussion, I'd like to emphasize last. Because by being a little bit behind the times we have the opportunity to profit from both the successes and failures of what's happened elsewhere; and possibly to make a detour." She stated that the complexities of health care boil down to one point, and that is of control. **Dr. Reichert** said, "Whoever pays for health care is going to control the system. Would it be a governmental bureaucracy with all of its inefficiencies? ...that's not what I want for my family. Not that inefficiency. Not that over-utilization that comes with the illusion that health care is free. Would it be a mega-monopoly of business people; something that I fear even more." This has happened in other markets where doctors are being delisted because they spent too much time with the patient, or don't order enough tests. And doctors were rewarded for spending less money on their patients. "That's not the kind of system that I want." She stated that control should belong to the individual. **Dr. Reichert** said, "health care shouldn't be that much different from other kinds of services. We need to arm the public and the patients with information that will allow them choice and control. The Medical Savings Plan is one way to start them on that path. It's your choice. We hope it'll be Medi-Choice." **EXHIBIT 18**

Cari Reichert, owner of Image Concepts, an advertising and graphic design firm in Missoula, Montana, spoke in support of Medi-Choice. She has studied the plan and personally named the plan. She provided brochures for which she donated her time to name the plan, give it a slogan and design the logo. **EXHIBIT 19** She said, "The fundamental principal behind Medi-Choice is the freedom to choose. To choose what hospitals I go to, what doctors I go to, and which insurance carriers I choose to use. I want a plan that is based on free market reform, one that is driven by competition, quality and value. Let's remodel our health care system through Medi-Choice."

John Heetderks, physician, Bozeman, Montana, urged the Committee to adopt HB 531. He said Medi-Choice is a fine bill. It is the result of a lot of time and effort by some very good people, who have looked at this plan carefully. This plan is being adopted by other states. **Dr. Heetderks** indicated that his father was an old-fashioned country doctor, who served his patients in the Gallatin valley for 51 years. During the Great Depression, his

father cared for his patients whether or not they could pay him for his services. "His unselfish care was appreciated. People paid what they could; sometimes with cash, but often with pies, cakes, potatoes and chickens. Many couldn't pay him anything. But they trusted my father. There were no lawsuits, even though he wasn't perfect and made mistakes in his patient care. I was privileged to work with my dad in our medical practice in Bozeman for 15 years before he died. . . . Together we span 77 years of patient care. I'm in my 40th year of medical practice. As our society has gradually decayed, so has health care." **Dr. Heetderks** shared some of the vast and tragic changes in doctor-patient relationship and health care delivery. Firstly, there has been a progressive loss of the patient's free choice in selection of a personal physician. This is to be accelerated by the White House managed care plans and Medicare. He added that Medicare has become the model for health insurance underwriters. He stated that patient recovery from illness or injury is critical to the trust relationship between the patient and physician. Secondly, **Dr. Heetderks** stated that patients have been robbed of personal responsibility for their own health care. Many patients exercise no responsibility for the cost or quality of their health care. Too frequently they go to the emergency room when they could have gone to their physician's office. "Why not go to the emergency room they say; after all, they're not paying the bill and have no concern about who pays the bill. They have no sense of responsibility about expense of their health care." This drives health care costs up. **Dr. Heetderks** said the adoption of Medi-Choice will result in less cost to the government, to the taxpayer, and even to the patient. Better health care will result; care which both the patient and their physician participate in.

Elizabeth Reichelt, Great Falls, Montana, spoke in support of HB 531 for all the reasons previously stated because "I believe in the benefits to all Montanans." She stated that both her husband and herself are both self-employed, both in their forties, and both uninsurable due to previous existing conditions. She stated that she has been unable to find insurance that would allow out-of-pocket payment for coverage of preexisting conditions and cover catastrophic illnesses. "We are currently covered for the next 12 months through a COBRA plan from my former employer. After that a catastrophic illness, heart disease or cancer could wipe out everything that we have built over all these years." She strongly urged the Committee to pass the Medi-Choice plan.

Kent Merselis, a self-employed real estate developer and consultant, Bozeman, Montana, stated that skyrocketing premiums have gotten out of control. He stated that one reason he left industrial relations to become a self-employed individual was because of the high cost of employee health care premiums. He said, "I'm concerned not only about myself, but for my children. ... Will they be able to afford health care when they have their own families ten years from now?" He stated that any plan which encourages tax free savings accounts to be established for

payment of minimal medical expenses will quickly do away with the evasive attitude that prevails in the United States regarding medical bills for auto insurance. That is to "let the other guy pay for it. Madam Chairperson, I am the other guy. And I'm tired of paying the penalty." He urged the Committee to enact HB 531. He said, "If we can pass this bill, it'll do away with millions of dollars that go in to support the medical insurance staff" for the shuffling of paper for minor claims.

Jerome Loendorf, representing the Montana Medical Association, stated that "this bill could be presented as several bills and I'd just like to say if it was, we'd support each one of them." He commented on the provision in HB 531 which provides for a basic health care plan. He stated that plan set forth would draw some arguments and differences. He said, "The key thing to remember here is this plan is not the only plan an insurer can offer. An insurer is required to offer this plan, but can offer any other plans that it believes it can market in this state." He commented on the provision which would require doctors to disclose their charges to people who requested them. He said, "we have to recognize that if we want the system to change, we have to be part of the change and except changes proposed by others."

Raymond Fowler, M.D., Anesthesiologist, Great Falls, Montana, commented that many physicians will be testifying. "When you look at physician support for this bill, I'd like to make it clear that physicians have often been accused of being very self-serving and doing what's in their own best interests in respect to their pocketbooks. I'd like to point out that if this Medi-Choice plan is enacted, which I strongly support...it's going to result in the very judicious use of medical services and in some way will probably result in decreased financial revenues for most physicians because patients will be more careful in their utilization of medical services. The conclusion here is that all of the physicians that support this bill are doing so against their own financial interests."

Dr. Peter Horst, Urologist, Great Falls, Montana, stated that because of child care needs in 1991, he had hired a 53-year-old woman with a history of Crohn's disease to provide full-time care for his daughter. As a benefit, **Dr. Horst,** provided health care insurance which cost $325 a month with a $500 deductible. She had previously been part of a group insurance plan in Colorado, and the only insurance that she could get was as a single person. He indicated that her premiums first increased to $375 at which point her deductible was increased to $1000; and then her premiums increased to $397 with a $2000 deductible in four years. Over those four years, she's never had a claim that would have been paid for by her health care insurance. She's had no hospitalizations. She did have some neurological problems last year which resulted in about $1500 worth of studies, none of which were covered by her health care insurance. He indicated that if Medi-Choice were in action four years ago, she would have

had money accumulated into her medical IRA which would have paid for her outpatient radiographic studies for neurologic symptoms, and she would have a reasonable deductible and reasonable premium. He said, "I support this bill."

Ron Kunik, insurance agent since 1981, founded the Montana Business and Health Alliance, the Montana Medical Benefit Plan, stated that HB 531 comes closest to true reform. He stated that HB 531 gives health insurance accessibility to all Montanans. He stated that Montana Medical is the only insurer here testifying for this. He indicated that if HB 531 is passed, then amendment of SB 285 should be repealed. **EXHIBIT 20**

John Mendenhall, self-employed businessman, Great Falls, Montana, strongly supported HB 531. He stated that the other plans "seem to be increasingly convoluted complex efforts to thwart the immensely powerful invisible hand of the marketplace, and I think the events of the past 30 to 40 years ought to teach us a little respect for the power of the marketplace."

Tamela Vander Aarde, M.D., Anesthesiologist, Great Falls, Montana, urged the Committee to support HB 531. She said it is a well thought out bill that enjoys grassroots support and she stated that it represents true reform. **EXHIBIT 21**

Dr. Jeanne Garcia, Great Falls, Montana, spoke in support of HB 531 with the following amendment: "to increase inpatient mental health benefits from 14 inpatient days to 21 inpatient days, and also increase the yearly maximum to $11,000."

Richard Tappe, Executive Director of the Montana Right to Life Association, urged the Committee's support for HB 531. He stated that reform is necessary. He said, "HB 531 does preserve genuine choice and gives people in the market the opportunity to determine what's going to happen in our health care system in Montana."

Dean Randash, NAPA Auto Parts, a small business employer in Helena, Montana, spoke in support of HB 531. **EXHIBIT 22**

Robert Wynia, a native Montanan, born in Plentywood and grew up in Poplar, and spent the last 32 years in Great Falls, Montana. He stated that he had the privilege of serving on the Committee that has studied the Medi-Choice bill for the past two years. "We've met every week [and] we have measured the pros and cons ... to the point that we feel that we have covered most of the basic problems and we request your support of HB 531."

John Vandenacre, representing himself, an insurance agent since 1978, stated that as an agent, the most common objection to purchasing a health insurance plan is the cost. He indicated that the Small Employer Group Health Reform Act compounds that problem rather than alleviating it. "Medi-Choice...goes a long way toward addressing the affordability without penalizing a

small segment of society such as the Small Employer Reform Act does." He urged the Committee's support for HB 531.

Shirley Rasmussen, Stevensville, Montana, stated that she has personally created her own family medical savings account 12 years ago. She said, "it works; the system that is within this plan does work exactly the way that they wanted it to, and that you become more involved with the health of your own family and your own responsibility." She stated that significantly decreased her dependence on the doctor. Her account had been used twice in 12 years with six children. **EXHIBIT 23**

Allen Lanning, Attorney, Great Falls, Montana, spoke in support of HB 531 on behalf of himself, his family, his business, and his employees. He said, "this is the best piece of health care reform proposal I've seen yet, and I urge you to support it."

J. R. Chipman, President of Benefit Innovations, Missoula, Montana, spoke in support of HB 531.

Jay McKean, retired farmer, Roberts, Montana, spoke in support of HB 531.

Ray Gowen, retired engineer, Great Falls, Montana, spoke in support of HB 531.

David Owen, Montana Chamber of Commerce, specifically endorsed the Medi-Save portion of the bill.

Arlette Randash, representing Eagle Forum, and on behalf of Christian Coalition of Montana for Laurie Koutnik, spoke in support of HB 531.

Susan Good, representing Heal Montana, spoke in support of HB 531.

<u>Opponents' Testimony</u>:

Tanya Ask, representing Blue Cross Blue Shield of Montana (BCBS), stated that the primary concern is that this is not necessarily true comprehensive reform of the insurance industry. She indicated that six of the eight items addressed by this bill, however, do address insurance reform. She stated firstly, that this proposal does not have guaranteed issue of insurance coverage, like the Small Group Reform Bill does. She reminded the Committee that New Section 2 through 6 applies not only to individual, but to group insurance. **EXHIBIT 24**

Ms. Ask commented that the basic benefits plan (page 3) has a high level of deductible, however, the level of co-insurance included in this basic plan is 80%. She stated that a number of insurance contracts written in Montana have a lower level of co-insurance allowing more individual responsibility such as 75-25

or 70-30, where the individual is responsible for maybe 30% of their health care expenses.

Ms. Ask advised that when considering basic, also consider that particular amount. **Ms. Ask** commented on covered expenses dealing with usual and customary charges, page 3, line 21. She inquired if this would require an insurance company to pay usual, customary and reasonable? "What about insurance companies, or health service corporations, or HMOs who might reimburse on a different system, such as the capitation system, recognizing that things are changing within the insurance industry as well? Would those still be allowed?"

Ms. Ask questioned the scheduled list of benefits for transplants on page 4 because certain dollar amounts are specifically included. She indicated that medical technology is changing very rapidly; the types of transplants that people receive change rapidly and these dollar amounts may not apply in two years. "There may be things that will be transplanted in two years that we have not even contemplated." She urged not including scheduled benefits in legislation. She stated that HB 531 attempts to cover mental illness and chemical dependency, but mental retardation has also been included as an illness; it is not an illness.

Ms. Ask indicated that on page 5 there are a number of services specifically excluded in statute. She questioned the wisdom of specifically excluding services in statute. One exclusion in particular, on page 7, is the exclusion for complications to a newborn unless no other source of coverage is available. Under all other health insurance in Montana "newborn coverage is a required benefit; here you are specifically excluding that coverage, but it would be included for every other insurance coverage."

Ms. Ask commented on the preexisting waiting period on page 6; as it is written an individual could meet three months and then have no preexisting waiting period any longer. She indicated that most insurance contracts require 12 months. "The idea of portability is once you've met your 12 months then you don't have to meet another preexisting waiting period." **Ms. Ask** questioned the 45-day written notice of the health insurer in the event the individual has not paid their health insurance premiums, page 6. She stated that the individual is covered during those 45 days and emphasized that this is free coverage. She stated this is not free. "It's free to the individual here, but somebody else is going to pay the tab, and that is the rest of us who are covered by health insurance."

Ms. Ask questioned subsection 4, page 7, allowing an individual employee the opportunity to choose to remain on their former employers health insurance contract even though they work for a new employer who offers health insurance. She indicated that this may pose a problem. **Ms. Ask** questioned the conversion cap

of 150% of the average premium being charged by the five largest insurers in the state of Montana (page 7).

{Tape: 2; Side: 2; Comments: Tanya Ask, BCBS of Montana is testifying.}

She indicated that some may write only catastrophic, other carriers may write a very rich level of benefits. She stated that 150% of that average could be very problematic. **Ms. Ask** commented on modifying the time period an insurance company can look back when determining preexisting conditions (page 8). "Under current law it is now five years. Under this particular provision it would be only 24 months." However, the way this provision is written it would only "apply to Yellowstone Community Health Plan of HMO, and Blue Cross Blue Shield of Montana. What about the commercial carriers?"

Ms. Ask referred to page 9 and stated that New Section 5--"the commissioner not to prohibit premiums based on loss ratio guarantee"--needs clarification as it is unclear what this provision is meant to address. **Ms. Ask** commented on the standardized claim form, New Section 6, page 9. She agreed that there needs to be more administrative simplification, that there does need to be a standardized claim form and standardized procedures for filing those claim forms. However, this particular provision does not allow for standardized claim form for hospital services, the UB92. It does not allow a standardized claim form for dental services.

Ms. Ask stated probably the biggest problem deals with the expansion of the Comprehensive Health Care Association (CHCA). She indicated that the CHCA was established by this legislature to deal with individuals who could not get coverage otherwise in the individual market. It was meant to be an insurer of last resort. She stated that the CHCA is a state program which is subsidized by the state and by insurance companies. The CHCA would be expanded under this proposal; more people would be covered, premiums would be capped at 150% making it more affordable to some. "But, who pays for it? The answer is those people who have individual and small group coverage... because it is subsidized through an assessment against all insurance companies doing business in this state according to the premium volume they write." She stated that large employers are able to self-insure, thus avoiding this particular type of assessment and this type of program. "It is again being borne on the back of a few." **Ms. Ask** questioned the fining capability in the event that information is not disclosed. She stated that more information needs to be made available to health consumers. She stated that "the fine for insurance companies is $1000 and we found it interesting that the fine for providers is $500."

Mona Jamison, representing the Montana Speech, Language, and Hearing Association comprised of Speech Pathologists and Audiologists, and representing the Montana Dietetic Association comprised of Nutritionists, opposed the basic plan and the

specifics contained on pages 3 and 4 of HB 531. She provided amendments. **EXHIBIT 25** She spoke about the failure to include nutrition services, speech pathology and audiology services in the basic plan. She stated that these services not only prevent further disease, but also provide cost containment. She indicated that the services listed under these amendments would require that it be under a case management plan with the therapy required by the referring physician. She stated that these services are not very expensive and affect some of the other diseases listed. **Ms. Jamison** indicated that this is the only section of HB 531 that she opposed. She said, "I believe if these amendments are made it will be a better basic plan dealing with the needs of individuals."

John Flink, representing the Montana Hospital Association, spoke in opposition to HB 531, Section 18. **EXHIBIT 26**

Tom Hopgood, representing the Health Insurance Association of America, which is composed of the other half of the insurance market not represented by BCBS, stated that he agreed with the comments made by **Tanya Ask** from BCBS. **Mr. Hopgood** commented on page 6, subsection 2. He understands it to mean that you don't have to comply with the preexisting condition in a policy if at any time you have had some sort of qualifying coverage. I don't think this was intended. He commented on "dumping uninsurable people into the comprehensive risk pool under the Montana Comprehensive Health Association." He indicated that this may result in some discrimination problems, perhaps under the American Disabilities Act.

David Hemion, representing the Mental Health Association of Montana, opposed HB 531. He commented on the benefits dealing with mental retardation on pages 4 and 19. He questioned the inclusion of mental retardation with the benefits for mental illness and chemical dependency. **Mr. Hemion** suggested amending this as 21 days of hospitalization for mental illness and chemical dependency ... with no annual cap on that benefit. As in **REP. NELSON'S** bill that there be a two to one trade for partial hospitalization, that there be a $2000 annual outpatient benefit. He suggested that mental retardation not be included in that same benefit section and if it is to be included in the plan to be included separately.

Marty Onishuk, Vice President for the Montana Alliance for the Mentally Ill, stated that mental illnesses are brain diseases and in this bill they are discriminated against because they are pulled out separately than other brain diseases like Alzheimer's, Parkingson's, epilepsy and multiple sclerosis.

Larry Akey, representing Montana Association of Life Underwriters, and on behalf of the Independent Insurance Agents of Montana, stated that a number of provisions contained in **REP. ORR'S** bill are good provisions and commented on several of the sections within HB 531, concerning benefit design considerations,

the cap on premium rates on conversions. **Mr. Akey** said that placing caps on the provision of medical services would be appropriate because that's where the real cost-drivers are. Insurance premiums are the symptom of the underlying costs.

Mr. Akey stated that **REP. ORR'S** approach in addressing preexisting conditions in HB 446 is much better than the approach taken in HB 531. He suggested removing the preexisting condition provisions from HB 531, and amending it with the preexisting condition provisions of HB 446. He stated that like others in the insurance industry, "we're not sure exactly what Section 5 means." There is concern that if companies start using loss ratio guarantees as the basis directly or indirectly for determining premiums on individual policies, the whole mechanism of insurance would be lost, which is the pooling of risks. He commented on Medical Savings Accounts, and changes in the Montana Comprehensive Health Association plan.

Mr. Akey commented on pricing data and stated that it is important to provide price information to customers. He raised a concern about the wording and stated that he was unclear about the process for fining an agent $500, how it will be determined if, in fact, the agent received the information from the insurance carrier, who will make the determination, and how it will be addressed. He urged the Committee to give HB 531 a Do Not Pass recommendation.

Mary McCue, representing the Montana Clinical Mental Health Counselors Association (MCMHCA), an association of licensed professional counselors, spoke in opposition to HB 531. She stated that she had the same concerns as expressed by **David Hemion.** She said the association supports the benefit scheme for mental health that is contained in **REP. TOM NELSON'S** bill and **SEN. CHRISTIAENS'** bill. She indicated that the MCMHCA had worked on the coverage for mental health with insurers and other providers groups for the past two years.

Tom Bilodeau, Research Director of the Montana Education Association, opposed HB 531.

Unknown author, written testimony, EXHIBIT 27

<u>Questions From Committee Members and Responses</u>:

REP. BEVERLY BARNHART inquired about Medicaid in the working core.

CHAIRMAN ORR deferred the question to the lobbyist.

VICE CHAIRMAN TUSS inquired of **REP. BARNHART** if her question dealt specifically with HB 531.

REP. BARNHART indicated that she was unsure. However, it was in the packet and mentioned "Medicaid in the working core and that we will be getting another bill."

VICE CHAIRMAN TUSS inquired as to which bill this information references.

Susan Good stated that the bill references **REP. ROGER. DEBRUYCKER'S** bill from last evening.

REP. RICHARD SIMPKINS stated his concern that hospitals don't wish to provide pricing information, and inquired what the problem is in standardizing the information to be provided in one location.

Mr. Flink replied that the hospital's position has supported greater disclosure of consumer information. [Some of his comments were not audible on the tape.]

REP. SIMPKINS clarified that hospitals do not object to providing data, but that the hospitals don't know which data is to be collected and in what format.

Mr. Flink answered that they would endorse the collection of meaningful data.

REP. SIMPKINS requested clarification of the figures on preexisting conditions.

Mr. Akey indicated that some amendments would be presented for preexisting conditions.

REP. TOM NELSON indicated page 1, line 19 through line 24 about any group or blanket policy. He inquired if this bill only applies to individual insurance.

David Niss replied that he did not think that was the intent, and suggested discussing that further.

<u>Closing by Sponsor</u>:

CHAIRMAN ORR stated that HB 531 is primarily a product of the work that Heal Montana/Project '94 has been doing for the last two years. He stated that many of the questions brought out by the opponents had been addressed just in the last couple of days since this came out of drafting. He indicated that the majority of those will be in amendments for Executive Action. In closing, **REP. ORR** said, "this is market-based reform and I would ask for your passage."

VICE CHAIRMAN TUSS turned back the chair to **CHAIRMAN ORR.**

HEARING ON 466

Opening Statement by Sponsor:

REP. NELSON, House District 11, Billings, Montana, stated that HB 466 amends the Small Employer Health Insurance Availability Act adopted by the 1993 legislature. The four central principles encased by the Small Employer Health Insurance Availability Act are as follows: 1) The elimination of "cherry-picking" in the small employer market by insurance companies; 2) Prohibit insurance companies from cancelling an insurance policy (group insurance) because an insured employee gets sick; 3) To make health insurance portable in the small employer market; and 4) To establish reasonable restrictions on the premiums that an insurance company may charge.

REP. NELSON stated that HB 466 retains all of those principles, and will accomplish four things. Firstly, HB 466 clarified the benefit design of the basic and standard plans, which companies must guarantee issue under the law. Under the language of HB 466, the basic plan must have at least the level of benefits spelled out in Section 5 of the bill. He stated that HB 466 makes it clear that the Commissioner of Insurance may not require benefits in the standard plan other than the mandated benefits the legislature has specifically adopted.

REP. NELSON stated that the Commissioner cannot require coverage for abortion services. However, a company may include abortion in its standard plan if it so wishes, thus making abortion optional on the marketplace. These changes in benefit design are intended to make the guaranteed issue plans more affordable without sacrificing the quality of the coverage. Secondly, HB 466 makes it clear that an employee can choose to reject an offer of coverage from a small employer. It is clarified in Section 4 of HB 466 that an employee may reject coverage and the insurance company can still provide coverage for the remaining employees. Thirdly, HB 466 makes it clear that the rating provisions of the Small Employer Act does not give the Commissioner prior approval of premium rates or rating methods.

REP. NELSON said the Commissioner says he doesn't want prior approval; the insurance companies don't want the Commissioner to have prior approval. Fourthly, HB 466 expands the definition of assessable carrier for the purposes of the reinsurance pool. This just returns language which was used in SB 285 last session. The intent of the Small Employer Act was to make the pool as broad as possible. HB 466 includes the state's health plan, the university system, and other self-funded public plans in the definition of assessable carrier. He indicated that these public entities don't like this idea. He indicated that it is a question of public policy. **REP. NELSON** asked, "Shouldn't these public entities help address the social needs of Montanans, or not?" **REP. NELSON** stated that HB 466 takes government out of the process a little bit giving the free market a little more say. He

stated that HB 466 retains the elimination of "cherry-picking," guaranteed renewability, portability, and reasonable rating restrictions, which most people would agree are good reforms. He urged the Committee to give a Do Pass recommendation.

Proponents' Testimony:

Tom Hopgood, representing the Health Insurance Association of America (HIAA), spoke in support of HB 466. He indicated that the HIAA supported the Small Group bill. "What happened in the interim, however, was something that we were not always in such full agreement with." He stated that **REP. NELSON'S** bill provides a legislative remedy to what has been done to this Act in the interim.

{Tape: 3; Side: 1.}

Robert White, representing the Bozeman Chamber of Commerce, spoke in support of HB 466. He stated that the intent of the Small Group plan was to get people covered. He stated that HB 466 will correct the problems that kept the Small Group plan...from getting people covered. He urged support for HB 466.

Susan Good, representing Heal Montana, spoke in support for HB 466.

Tanya Ask, representing Blue Cross/Blue Shield of Montana (BCBS), stated that BCBS of Montana supports HB 466 for the same reasons previously stated by **Mr. Hopgood.** She said, "There is an awful lot right with the Small Group reform; there are some things that do need correction and we feel that this particular piece of legislation goes to correcting those particular problems." She specifically mentioned that BCBS of Montana has repeatedly received questions and concerns from employers in Montana concerning the definition of an eligible employee. She said, this particular provision does allow the employer within guidelines of 20 to 40 hours to set what he wants to be the definition of eligible employee within his group, so long as it applies to everyone within that group. She stated that the benefit modifications in HB 466 "are very good modifications.

Greg Van Horssen, representing State Farm Insurance Companies in Montana, spoke in support of HB 466. He provided proposed amendments and written testimony. **EXHIBIT 28, PARTS A & B**

Claudia Clifford, State Auditor's Office and the Commissioner of Insurance Office, stated the "Commissioner supports this legislation as it responds to the concerns that have been voiced about the law as we've implemented it and there are many good aspects to the changes that are being made in this bill. The Commissioner doesn't agree with all the changes, but there are many worthwhile changes as we've been trying to apply a model law to Montana." A technical concern with HB 466, on page 2, basic benefit plan has been defined as a plan that is lower in cost

than a standard plan. She stated that this is a technical problem for agents in how they're going to sell a plan to a consumer. If the plan has not been priced ahead of time, there is not a good way to tell whether a plan that's close in benefits to a standard plan actually will be more expensive or less expensive for that consumer. She said, "we won't as a department be able to certify a plan as a guarantee issue plan," and the agent won't know when marketing the plan whether or not the plan is a guarantee issue plan; that would come later when the consumer buys the plan. For this reason "we used a value system for valuing the benefits;" then any plan that had benefits valued at less that the standard plan would be considered a basic plan. This way a plan could be certified ahead of time that a plan was guarantee issue; the agent could sell ahead of time and market as a guarantee issue plan. She said it was a simpler system for the consumer to understand. **Ms. Clifford** said, "we ask for your consideration in that one change."

Sam Hubbard, Montana Health Care Authority (MHCA), stated that the MHCA strongly believes that the principles of small group reform that were included in SB 285 are very important to an ongoing sequential health care reform process in Montana. He stated that HB 466 does a good job of maintaining those principles. He urged a Do Pass vote on HB 466.

Tom Ebzery, Attorney, representing the Yellowstone Community Health Plan, Billings, Montana, spoke in support of HB 466. He indicated that in New Section 6, page 14, that there is no reference to HMOs. In the existing rules the Commissioner has done a good job of pointing out the intricacies of an HMO by rule making. He requested that this rule making be maintained, or in the event that a new rule making occur, that it include the HMO concept and some of the concepts behind that such as the use of co-payments, which are scheduled to be worked on.

David Hemion, representing the Mental Health Association of Montana, spoke in support of HB 466 and recognize that there are changes made to the benefits for mental illness that were derived at through the process of compromise. He stated that in some cases the inpatient benefits were lowered, but that the benefits for outpatient and partial hospitalization were increased. "We think that helps to address mental illnesses when they begin to occur with more of a benefit, thereby hopefully preventing the need for additional hospitalization."

Mona Jamison, representing the speech pathologists and audiologists, and the Montana Dietetic Association, spoke in support of HB 466 with the inclusion of the amendment provided. She stated that nutrition therapy services under a case management plan, referred by a physician would, according to the actuary, increase a premium 25 cents for an individual, and 50 cents for a family of four. She said, "in reality, I just think it'll be a better basic plan to provide these kinds of services." **EXHIBIT 29**

Sharon Hoff, representing the Montana Catholic Conference, spoke in support of HB 466 and agreed with **Ms. Jamison** that preventive pieces really need to be a part of this. They are an important part of keeping health care costs down.

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, and the Montana Business and Health Alliance, spoke in support of HB 466. **EXHIBIT 30**

Vern Petersen, Fergus County Commissioner, served the past eight years on the Board of Directors of the Montana Joint Powers Trust (MJPT). The MJPT is the method by which 45 Montana counties and school districts provide health benefits to approximately 3,000 employees and their dependents for a total of about 7,200 covered persons. He stated MJPT is a non-profit entity, established in 1989 by a group of 12 counties which have self-funded their health benefit plans. **Mr. Petersen** stated concern that HB 466, on page 1, line 29, amends MCA 33-22-1803 Subsection 3, to include within the definition of assessable carrier the self-funded disability insurance plans provided by political subdivisions of the state. **Mr. Petersen** stated his belief that this change would reduce the level of benefits which political subdivisions provide their employees, but also could eliminate self-funding as an option for providing such benefits. Self-funding has been widely accepted among political subdivisions because through self-funding employers can provide at a lower cost a broader range of and better benefits to their employees than they can through buying a policy from a commercial carrier. He stated that it makes no sense through needless regulation to increase the cost of self-funding. He stated that the MJPT retention costs run from 6% to 9%. He indicated that the stated purposes of the Small Employer Health Insurance Availability Act is to promote availability and coverage, correcting abusive rating practices, and limiting the use of preexisting condition exclusions. He said political subdivision plans generally are liberal in the level and availability of these benefits. Political subdivision plans have their own reinsurance; it should not be forced to subsidize a reinsurance pool for commercial carriers when the purpose of the pool is to compensate commercial carriers for taking the risk they historically avoided, and self-funded plans accepted. A very likely result of this inclusion in this legislation is the elimination of one or more alternatives small employers have for providing benefits to their employees. He respectfully requested the Committee to amend HB 466 to exclude political subdivisions of this state. He provided written testimonies from Hill County and Blaine County. **EXHIBIT 31**

Mr. Rick Larson, Employee Benefit Management Services, Billings, Montana, a third party administrative company which works with government subdivisions, stated that they endorse the amendment to the Small Group Reform Act if they can get the amendment to exclude as an assessable carrier the government subdivisions. FThere are a couple of reasons for that. Firstly, the Joint

Powers Trust is a VEBA trust (Voluntary Employee Beneficiary Association). **Mr. Larson** said taking funds out of a trust to provide benefits for anything other than members of that trust is illegal. Secondly, is the government subdivisions ability to raise income. "If they go into a plan and they have a funding level that's already established and they can't come back and assess ... they have a couple of choices; they can reduce benefits or terminate benefits and pay the assessment. He stated that it would not be a wise move to include them as an assessable carrier.

Joyce Brown, representing the State Employee Benefits Plan, Department of Administration, stated concern of including public sector plans as assessable carriers. She provided written testimony. **EXHIBIT 32**

Larry Akey, representing Montana Association of Life Underwriters (MALU), and the Independent Insurance Agents of Montana, stated that the MALU has supported Small Group Reform from the outset. He commented on some of the amendments proposed before the Committee in this hearing. "The amendment proposed by State Farm requiring that the reinsurance mechanism be actuarially sound makes sense to us." Concerning the Commissioner's amendment changing lower cost to lower value, **Mr. Akey** indicated that his legislative committee could not reach a decision on which was best. He stated that the proposals "to expand the definition of assessable carrier is really a public policy decision. Should you decide to go with the direction that **Mr. Petersen** and **Mr. Larson** and **Ms. Brown** have indicated to you to leave political subdivisions out of the definition of assessable carrier, that is a public policy decision and is certainly an appropriate one for this legislature to make." **Mr. Akey** indicated that the four specific amendments proposed by **Mr. Grogan** which are listed on **EXHIBIT 30** don't cause him much concern. He asked the Committee to consider the amendments and give HB 466 a Do Pass recommendation.

Ron Kunik, spoke in support of HB 466.

Jerome Loendorf, representing the Montana Medical Association, spoke in support of HB 466.

<u>Opponent's Testimony:</u>

Dean Randash, NAPA Auto Parts, spoke in opposition to HB 466 because "the insurance agent is ordered under a penalty of law to restrict the sale of Underwritten Health Insurance Policies from the 3 to 25 employee groups. The agent can only offer to sell a government mandated Guaranteed Issue insurance policy in the price range between the standard and basic plan." He stated that "Montana wage earners who by circumstance are employed in the 3 to 25 employee group are being discriminated against and denied the right to purchase a legal insurance product that is available

to all other Montana citizens, and that is of Underwritten Health Insurance." **EXHIBIT 33**

{Tape: 3; Side: 2.}

REP. LIZ SMITH, House District 56, Deer Lodge, Montana, stated her agreement with **Mr. Randash's** testimony. She voiced concern for the very small businesses even though they have a choice to opt in, or opt out of this coverage. She remarked hearing over the weekend, "I guess I'd only need to hire somebody part-time, now." She stated that there would be fewer insured people. She stated that reinsurance does not apply to the existing groups until 1997 ... and the government is requiring that the small employees pay for the uninsurable employees. She remarked with concern that this is another unfunded mandate. **REP. L. SMITH** said, "I just don't know why we really truly can't consider a broader reinsurance pool." She indicated that other states have withdrawn the 1991 mandate for just reasons and suggested this be taken into strong consideration. She highly commended the Committee, **REP. TOM NELSON** and **REP. BRUCE SIMON** for their work on these issues. She asked the Committee to oppose the mandate. She said that we need to continue to formulate creative ideas to develop a plan that everybody would be proud of in Montana.

Questions From Committee Members and Responses:

REP. SIMON stated that assessments out of the risk pool, if they were to be required, would be assessed against all of the carriers currently offering disability and group disability, excluding the Montana University system and self-funded plans, a political subdivision of the state. He indicated that those assessments would be based on premium and apportioned according to their level of total premium. **REP. SIMON** inquired how an assessment would be made on a self-insured plan. He stated that a self-insured plan pays the cost, not a premium.

REP. NELSON said, "you're right. There is no premium; there is only cost." He indicated that "there would be premium for reinsurance...but that is not what we're looking at." **REP. NELSON** deferred the question to anyone who may have an answer.

REP. SIMON stated that he'd redirect the question to anybody who could answer the question.

Ms. Clifford stated that as a state employee, there is a premium paid for her and there is a stated amount that pays for the family and each additional individual. She said that may not apply to every self-funded group. She indicated that it would probably be necessary to study each self-funded group categorically to determine an equitable method of assessing them.

REP. CAROLYN SQUIRES stated that **Mr. Akey** agreed with all of the amendments, but did not mention **Ms. Jamison's** amendment. She inquired what **Mr. Akey** thought about **Ms. Jamison's** amendment.

Mr. Akey replied that he had not seen **Ms. Jamison's** amendment prior to today. He stated that if the Committee and the legislature believe that dietetic services and speech pathology are components of a basic health insurance plan, then they should be included in the basic plan of this bill. He cautioned the Committee that dietetic and speech services are not part of the mandated benefits that the large groups currently offer. If dietetic services and speech pathology are added to this bill, "you would be creating a new mandate on the small employer marketplace that you wouldn't have for market roots."

REP. SQUIRES inquired if in-home health care was included in this basic plan or not.

Mr. Akey said, "I'd have to get the bill in front of me to say. I'd be happy to do that, or I can visit with you."

REP. SQUIRES inquired about home infusions, stating that it is a lot cheaper to medicate the individual at home on an antibiotic-type situation rather than in the hospital. She also noted that outpatient rehabilitation is covered, and inquired about inpatient rehabilitation.

Mr. Akey said, "I believe that the basic benefit plan is defined in this bill as essentially Montana Comprehensive Health Association plan with modifications in pre-principle areas," such as the inclusion of: organ transplants, well-child care (page 2), and compromise language on mental health and substance abuse. He could not recall whether those specific items were included or not. He indicated that he would have to look at the bill, and that he would be happy to visit with her about it.

REP. BARNHART indicated that the trouble she was encountering with the bill was comparing it to what changed the mandates, as compared to what the basic health plan is now. She inquired if **REP. NELSON** had that information available.

REP. NELSON replied that he did not have that information handy.

REP. BARNHART indicated that she would like to look at that information. **CHAIRMAN ORR** suggested looking at that during Executive Action.

REP. SIMPKINS indicated that **REP. NELSON** had the opportunity to rewrite the program plan. He inquired about the logic of maintaining the basic plan and the standard plan. **REP. NELSON** replied that it's always been that way, but change is part of reform. That's why there are opponents and proponents; it's hard to change.

REP. SIMPKINS said he does not understand why "this plan is called this plan because it's more than this plan."

REP. NELSON deferred to **Mr. Akey.**

Mr. Akey said the standard plan and the basic plan are the two plans that a small employer carrier is required to guarantee issue. He stated that a carrier may offer other plans on the marketplace which are not guaranteed issue plans. **Mr. Akey** clarified that the intent behind the standard plan and the basic plan in the Small Employer Health Availability Act was to offer a range of guaranteed issue products on the marketplace. He added, if a carrier chooses to offer a plan that's more benefit rich than the standard plan then that would not be a guaranteed product, that would be a product that could be fully underwritten.

Closing by Sponsor:

REP. NELSON said, "It's been a good hearing, and a long hearing." He referred to **Mr. Grogan's** amendment "about opening up the window so that they can come back in." **EXHIBIT 30**
He said the issue of fairness is important and stated, "If we don't do that we become punitive," and that would not be good government.

REP. NELSON disagreed with **Mr. Randash's** statement, fourth paragraph and said "38.4% of employers pay some portion of the health insurance premium. He asked, "38.4% in relationship to what?" **EXHIBIT 33** He stated that with group insurance, insurance companies will not issue a group policy unless the employer participates in paying a portion of the premium which is generally 75% of the employee's premium. He indicated that the employee would pay the rest. He stated that **REP. L. SMITH'S** comment on part-time employees is well taken. As he recalled, the current definition of a full-time employee is an employee working 30 hours. He indicated that HB 466, would amend the definition to read the employer can determine what those numbers of hours can be when he purchases the plan and he can set that anywhere between 20 and 40 hours. He indicated that this would stop the practice of employing two part-time employees to fill one job.

HEARING ON 533

Opening Statement by Sponsor:

REP. PEGGY ARNOTT, House District 20, Billings, Montana, stated HB 533 is an act relating to the health benefits plan providing for portability of health benefits plans by requiring insurers to waive certain time periods acceptable to preexisting conditions and requiring certain increases in charges to be distributed proportionately among all plans of an insurer. She indicated HB 533 came as a response to the heightened awareness of health care concerns; indicating that it would be irresponsible to do nothing. She said, this bill is the heart of response to health care concerns. She indicated that New Section 1 includes the definition of a health care insurer, what an individual health

care benefit plan is, and explains that this bill does not apply to small group or large group coverage. Previous coverage is defined in subsection 3. Portability is referred to in New Section 2. She explained that New Section 2 states that once an individual has satisfied a waiting period for qualifying for insurance, then after that have maintained coverage, they do not have to satisfy this waiting period again. New Section 3 states that insurers can raise premiums based on age, but other increases such as extremely high medical costs cannot be placed solely on the individual. The cost must be distributed proportionately throughout the contract holders. This is a basic premise of insurance; to spread the cost out evenly.

Proponents' Testimony:

Tom Hopgood spoke in support of HB 533 with some minor changes which will be explained by **Tanya Ask.**

Tanya Ask, Blue Cross/Blue Shield of Montana (BCBS), provided the Committee with proposed amendments. **EXHIBIT 34** She stated that the first amendment gives a new definition to "block of business," and this term will be used under the rating portion of this particular act. Amendment 2 would clarify that "health care insurer" means "disability insurer, health service corporation, or health maintenance organization." Item 3 addressed a question under small group reform and in other situations concern portability of coverage. Amendment 3 deleted the phrase "standard health benefit plan" because it was "applicable to the small group reform portion of insurance law." She reminded the Committee that these particular reform provisions will apply to individual insurance. On page 2, amendment 5, the premium distribution which **REP. ARNOTT** is concerned about is that an individual's claims experience within the individual marketplace, that it not adversely affect that individual's rates.

Ms. Ask stated that the only thing that would affect the individual's rates is change in age and overall utilization within that block of business. Premium distribution would be spread across the entire block of business; it would be spread proportionately across everybody who has that particular contract type in Montana. She stated that the purpose of insurance is to spread risk. On page 3, New Section 5 applies to applicability. The purpose is to ensure the phase in. The effective date would be January 1, 1996, and this particular requirement of portability would apply to all contracts entered into or renewed on or after January 1, 1996, to allow a phase in, to allow those costs to be treated proportionately, to also allow the phase in of that distribution of cost impact.

Susan Good, representing Heal Montana, spoke in support of HB 533 and the amendment proposed by **Tanya Ask.** She stated their gratitude to **REP. ARNOTT** for HB 533 for two reasons. Firstly, she stated the average person changes employment seven times, usually during his lifetime, and that portability prevents job-

lock. This is important in our mobile society. Secondly, she indicated that HB 533 would prevent extremely high premium rates at a time of catastrophic illness or injury. She said, "we believe that people will keep their insurance longer, and that will benefit us all."

Dean Randash, NAPA Auto Parts, spoke in support of HB 533. **EXHIBIT 35**

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, the Montana Business and Health Alliance, requested that the wording be clarified in Section 2, indicating that maybe it could be construed as guaranteed issue for the individual.

Larry Akey, representing Montana Association of Life Underwriters, supported HB 533.

Mike Craig, representing the Health Care Authority, stated that the biggest concerns voiced by the public in 1994 was the portability and coverage issue. He stated that the HCA strongly endorsed the concept of dealing with this issue, and supported HB 533.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

REP. SIMPKINS indicated Section 2, and inquired about the wording "30 days prior to the effective date of new coverage. He questioned the 30 days, indicating that this would be an extremely short period of time to require no insurance.

Ms. Ask, BCBS, indicated that this had been discussed and stated that if an individual does have a preexisting condition, they are going to want assurance that they have full continuity of coverage without a break. "This does allow a small break in coverage and still allows them to carry their preexisting waiting period with them." However, if there is a medical problem, most people will either go with a COBRA continuation, a conversion, or if they are on individual coverage, they're going to pay their premiums until they have their next coverage in place because most people will not want a lapse in coverage. This does allow up to a 30-day lapse in coverage.

REP. SIMPKINS said, "We're assuming that they're coming off a plan that falls under COBRA?"

Ms. Ask, BCBS, answered, "It could, but it could also fall under something else that might fall under the other conversion provision." She stated that it allows portability from another conversion plan; if they are leaving a group situation and they

are buying individual; if they are moving from one individual to another; and that this particular provision allows other portability from Medicaid to an individual product.

REP. SIMPKINS inquired about an employee who quits for 6 months "to raise the kids," and if that person gets sick during that time, he sees "no attempt to say that the employee continue to pay the premium ... to maintain their own self-paid plan, "which would be similar to COBRA," and then they get hit in 30 days.

Ms. Ask stated that this addresses one market only; it is to allow portability into the individual marketplace, if the individual chooses to buy into that market. However, if an individual employee wants a COBRA continuation, they would have that option if it is available from their employer. If COBRA is not available from their employer, the individual would still have the ability to have an individual conversion if they are under an insured plan.

REP. SIMPKINS inquired about spreading the cost over an entire block of business.

Ms. Ask stated that this is not designed to be a comprehensive insurance or a comprehensive health care reform piece. It is only designed for the individual market. "There have been some companies in the past who have decided that they no longer want to write individual coverage totally in a state, or they no longer want to write a specific block of business, or they no longer want to write group insurance in the state," which has happened frequently. She indicated that several years ago, some carriers decided that they no longer wanted to write specific blocks of group insurance in a state, and they did leave their people high and dry. She indicated that this bill was not designed to "tell an insurance company that you must continue to do business in the state of Montana and you must continue to write certain types of policies." She indicated "that's still been left available to the marketplace to decide what's going to happen with that."

REP. SIMPKINS stated "portability doesn't mean too much when you refer to a conversion." He indicated that any conversion plans he knows of "were bad and expensive," stating that "it doesn't leave much of an option." He asked what the objection to change that to 60 days was, to at least give the person "time to breathe."

Ms. Ask stated that there is another bill being considered in the Senate which does have 60 days. "Part of the reason for 30 days is that there has been continuity throughout the code with other types of provisions which have to do with enrollment for infants." Newborn coverage is required under all insurance contracts in Montana. However, if that infant is going to continue to receive coverage, the infant must be enrolled in that particular contract, individual or group, within 30 days. She

said that 30 days is a standard. She commented that currently, there is absolutely no dictate by anybody that an insurance company must write in the individual marketplace. This is something that insurers who do operate in the individual marketplace are interested in doing for the overall good of health care reform.

REP. SIMPKINS stated that he wanted to understand the 30 days.

Ms. Ask said it says 30 days until the effective date of the new contract. She stated that most insurance agents, if they are enrolling somebody on the fifteenth, will in all likelihood, inform them that the coverage will be effective on the first of the next month.

Closing by Sponsor:

REP. ARNOTT thanked the Committee for a good hearing and stated that **REP. SIMPKINS'** questions are pertinent and certainly valid. She stated that HB 533 addresses portability and is a direct response to meet the need of those seeking insurance. As insurance stands today, the sick or injured face dramatically increased insurance premiums. In effect, they are priced out of the market; this bill addresses that very issue. She stated that when HB 533 becomes effective, insurers would not be able to selectively raise premiums on just one individual without problems. Instead, they would have to distribute the premium increases proportionately. This is cost-sharing. Insurers cannot change the rules after an illness has occurred. Another issue addressed by HB 533 is that if an individual has qualified for insurance and maintained coverage ... they do not have to go through another qualifying period. She stated that HB 533 is a response to the need for access to health care coverage for the individual, and answers some of the problems that have long faced health insurance. She urged a Do Pass motion on HB 533.

* * * * *

At this point in the meeting **REP. NELSON** made a motion to pass HB 533, if the Committee would like to take executive action.

CHAIRMAN ORR stated that the Committee could take executive action. He indicated some concern about the effective date and suggested that the Committee wait before taking executive action.

REP. SIMPKINS stated that he would make a motion to amend HB 533 to read "60 days."

CHAIRMAN ORR indicated that the Committee needed to work that out before taking executive action.

REP. NELSON said, "you can request the future executive date on an application for insurance 60 to 90 days."

REP. SIMPKINS said, "you can, but you're not guaranteed coverage until after that time."

REP. NELSON indicated that "it can go about 90 days."

CHAIRMAN ORR "overruled" and asked the Committee to wait until Thursday to take executive action.

HEARING ON 511

{Tape: 4; Side: 1.}

Opening Statement by Sponsor:

REP. ROYAL JOHNSON stated that HB 511 is an attempt to inform the people of Montana "that we know that the health care problems aren't going away." He indicated that the health care situation is not going to "rectify" itself. He stated that HB 511 will change the Health Care Authority to Health Care Council. New Section 1, page 1, line 19, the public does recognize a continued need for evaluation and analysis of Montana's health care system. Line 21, the emphasis is on affordability and access to the health care business. Line 22, to continue the public-private partnership in order to develop initiatives regarding health care reform to be presented to the 1997 legislature.

He stated, The health care advisory council shall monitor and evaluate implementation of recent health care reform initiatives, including small group insurance, and all of the others you can read yourself in that particular paragraph." He stated that the health care advisory council would consist of ten members to be selected by May 1, 1995 because "it is imperative to keep this ball rolling on health care reform," and not to let this situation wait until October. He indicated that the ten Committee members will consist of four legislative members, five members representing a health care planning region to be selected by the governor, and one member representing the executive branch to be appointed by the governor.

Page 2, line 12 will be changed to read, "Legislators, and regional board who represent health care planning regions who want to serve on the health care advisory council shall apply to the president of the senate, speaker of the house, or governor, respectively, for a position on the council. He stated that the applicants should be knowledgeable about health care and be willing to commit the substantial time required to serve on the council. He stated that the previous Health Care Authority spent hours and hours of volunteer time on it as witnessed by the stack of books he indicated.

REP. JOHNSON commented on New Section 3 that "we want to appropriate enough money ... to make sure that they can have at least ten meetings," noting that they will have a little time off

for Christmas and New Year's. He indicated that the health care advisory report should come out by October, so that it can be put into the 1997 budget in the event an acceptable program is developed.

New Section 5 discusses the powers and duties of the health care advisory. He noted, however, that the health care advisory is not limited to the topics specified here; other topics may be added later. He indicated the reporting date of October 1, 1996 and stated that the date has to do with the budget.

Page 7 of HB 511 discussed the administration of the state health plan and the state agency to administer the program and indicated that this will be the Department of Social and Rehabilitative Services (SRS), because SRS has been represented throughout this time on the Health Care Authority, at least as an ex-officio member, and they understand the issues.

He discussed the repealers on page 8 of HB 511. He stated that one prepared amendment which has to do with the regional boards. He reiterated that health care will not take care of itself. He stated that the Health Care Authority suggested the health care resource management plans, the unified health care data base which he indicated could be put back in during executive action. He said the SRS will assume that particular function. He stated that the cooperative agreements process was taken out, and that perhaps it should be put back in.

Proponents' Testimony:

Susan Good, representing Heal Montana, spoke in support of HB 511. She agreed with **REP. R. JOHNSON** that the health care crisis is not going to go away. She cited an article from the Great Falls Tribune, "Senate Democrats Today Warning That Health Care Costs Will Rise Dramatically In The Next Decade." It stated, "Federal projections show the cost of health care now about one trillion dollars will double in a decade." **Ms. Good** said, "That kind of trickle-down comes to us." She quoted from the article, "between 1988 and 2001, the percentage of Americans who get health insurance through their employers will drop from 67% to 55%." She indicated that Heal Montana and the Hospital Association are already working on tasks for them.

Chuck Butler, representing Blue Cross/Blue Shield of Montana, spoke in support of HB 511 and said the expense that the 1993 legislature expended on the Health Care Authority was tremendous in value.

John Flink, Montana Hospital Association, spoke in support of HB 511. **EXHIBIT 36**

Tom Ebzery, Attorney, representing St. Vincent's Hospital and Health Center, Billings, Montana, spoke in support of HB 511, stating that "the time has come to take a look at this from a new

perspective. I think the work that the Authority accomplished is admirable, but I think it is time to move to a different type system." He spoke in appreciation of **REP. R. JOHNSON'S** willingness to keep open the idea of topics in a rapidly evolving situation, indicating that some creativity would be welcome.

Max Davis, Lawyer, representing the Columbus Hospital, Great Falls, Montana, endorsed **Mr. Flink's** the comments. **Mr. Davis** spoke in support of HB 511 and urged the Committee to include language that preserves the certificate of public convenience process. This is vitally important because the federal government takes an active interest in health care mergers and cooperative agreements through either the Federal Trade Commissioner or the United States Department of Justice. He stated, what's going on in Great Falls is relatively new to Montana; it's not new on a national level. He stated that the federal government has some limitation on its capabilities to involve itself in the process and gives great deference to the state's involvement in the collaborative or merger process of health care. He indicated that the federal government is willing to allow the states to take a lead position. He said, by preserving the certificate of public convenience public advantage process in some forms as an active involvement of Montana, either through the Health Care Authority or the Department of Justice, would be a big step in preserving and ensuring that important health care decisions be made in Montana, not Washington, D.C. "It is a healthful and productive step to preserve the certificate process in legislation."

Ed Grogan, representing the Montana Medical Benefit Plan, the Montana Medical Benefit Trust, the Montana Business and Health Alliance, spoke in support of HB 511. He stated that it would be good to "change the Health Care Authority to the Health Care Advisory Council; we think it would be even better if it repealed the amendment."

Opponents' Testimony: None

Informational Testimony:

Mike Craig, Health Care Authority (HCA), spoke as neither an opponent nor a proponent. He stated that 50-4-304 is the current provision in SB 285 for health resource management plans. He indicated that judging from the list of repealers in HB 511, that "maybe 50-4-304 should be repealed as well, unless you want to keep a health resource management plan function around." He informed the Committee that the health resource management plan function was by far the most expensive activity that the Health Care Authority did all year, as well as very time intensive. He stated that whoever is responsible for the health resource management plan function needs to commit considerable time and effort into actually inventorying the health resources in Montana on an annual basis, and use that information in working out some provision in terms of guidance for determining the appropriate

level of care for communities. He indicated that the process is complex and resembles a health planning function.

Mr. Craig stated that he would be very happy to work with **REP. R. JOHNSON** on this. **Mr. Craig** indicated on page 7, Section 9, actually puts comprehensive health planning back into the Department of Health, which is where it was prior to SB 285. The function of the comprehensive health planning, then, was discretionary. The Department of Health currently does a state health plan only for the purposes of certificate of need. He said there is a provision in statute that allows for that to continue.

Mr. Craig stated if the HCA is not going to assume comprehensive health planning and the very certain planning functions that naturally go with it, including resource management plans, they ought to repeal this bill as well. **Mr. Craig** corrected **REP. R. JOHNSON** stating that this actually doesn't put it in SRS; it keeps it at the Department of Health and the Department of Health doesn't want it if it's not going to be funded, so it probably won't be funded. Secondly, if they don't have a health resource management plan, good database, data collection and analysis functions, and other provisions such as health insurer cost management, he suggested to get rid of it all, or at least come up with some sort of strategy to put it all together, working with SRS to determine what they want for data collection, health resource management, and comprehensive health planning.

Mr. Craig said, "those things really should be talked about together and we'd be very, very pleased to work with you and offer some guidance in how that should go forth." **Mr. Craig** stated that the Health Care Authority disagrees with page 1, line 17, stating, "We do not believe that the people of Montana have rejected" the single payer nor the multiple payer plan. He stated that the Authority believes that they are good plans, but they cost too much.

Closing by Sponsor:

REP. R. JOHNSON thanked everyone for their input, especially those from the Health Care Authority. He stated that one thing he did not mention was that the Health Care Authority and the new council would have a meeting before June of 1995, to give the new council some orientation and direction. **REP. R. JOHNSON** stated that he had visited with **Dorothy Bradley**, Chair of the Health Care Authority, before he had submitted this bill, who suggested that this was a reasonable way to continue the effort. **REP. R. JOHNSON** stated that he had also visited with **Sam Hubbard**, and received a lot of suggestions from him. **REP. R. JOHNSON** stated that he saw no problem with taking these suggestions and adding them into the bill, as the Committee chooses, during executive session. He indicated that section 50-4-304 had been changed as an amendment which has been passed around to the members of the Committee.

ADJOURNMENT

Adjournment: 7:58 P.M.

SCOTT ORR, Chairman

VIVIAN REEVES, Secretary

SO/vr

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL DATE 2-14-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Scott Orr, Chairman	✓		
Rep. Carley Tuss, Vice Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. John Johnson	✓		
Rep. Royal Johnson	✓		
Rep. Betty Lou Kasten			✓
Rep. Tom Nelson	✓		
Rep. Bruce Simon	✓		
Rep. Dick Simpkins	✓		
Rep. Liz Smith	✓		
Rep. Carolyn Squires	✓		

EXHIBIT 1, Page 1 of 2
DATE Feb. 14, 1995
HB 548

February 14, 1995

Introductory Remarks on HB 548

("An Act Providing for the Montana Health Security System")

Good Afternoon Mr. Chairman and Members of the Committee. For the Record my name is Bill Carey. I represent HD 67 in the "Garden City" of Missoula.

Mr. Chairman I would like to express my appreciation for your help in making sure this important hearing would take place today.

I am sponsoring HB 548, which is an Act providing for the Montana Health Security System and for creating an integrated (or "Single Payer") payment mechanism for health care services, for the following reasons:

I believe that all Montanans have a fundamental right, an inalienable right, if you will, to the highest quality health care and I take it as an acknowledged fact that approximately 100,000 Montanans are currently denied that basic human right.

I also believe that the publicly-funded health security system delineated in this bill will promote the rational allocation of health resourcesand will, therefore, provide health care services to all Montanans at the lowest possible cost and with the greatest posssible benefits. This bill, when fully implemented, will ensure that Montanans will no longer be forced to spend a disproportionate share of their incomes on health care services.

Fundamental health care reform, Mr. Chairman and members of the committee, is one of the most important public policy issues of our time. The public, therefore, through its direct involvement and through its elected representatives, must exercise effective direction and oversight of health care spending. I believe this bill will accomplish that critically important public policy goal.

The need for fundamental and comprehensive health care reform will not go away. The need for reform will, in fact, inexorably grow as each year passes without it.

In my view the most productive approach to achieving genuine health care reform, is to dispassionately employ our intellects and problem solving abilities in creative partnership with our heart's unerrring compass: our common humanity informs us that

our families, our friends, our neighbors and all of our fellow citizens deserve health care security.

And finally, Mr. Chairman and members of this committee, I believe that whatever ought to be, can be. We can and we will eventually achieve genuine health care reform because it is the right thing to do, the sensible thing to do and the wise thing to do.

Single payer is a powerful idea whose time will come just as it has already come in other developed democracies. I urge this committee to hasten that day!

I look forward to an informative hearing and I reserve the right to close.

Thank you.

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 · HELENA, MONTANA 59624

(406) 443-5341

EXHIBIT 2, Page 1 of 3
DATE Feb. 14, 1995
HB 548

TESTIMONY OF DOUG CAMPBELL
HEARD BEFORE (H) HUMAN SERVICES AND AGING
FEBRUARY 14, 1995

Mr. Chairman and members of the committee. My name is Doug Campbell. I am District 11 Director of the Montana Senior Citizens Association and I reside in Missoula. I am here to speak in support of this bill. #548

In 1993 we supported SB 267 which would have provided comprehensive universal health care for all Montanans and under a single payer system. We deferred this bill to SB 285 and supported ~~the~~ THAT bill, which was drafted by the citizens' committee appointed by Senator Max Baucus in 1992 to find a way to provide comprehensive universal health care for al of Montana's citizens. Senate Bill 285 passed with almost no opposition and established the Montana Health Care Authority, a five member board later appointed by the governor. The Authority was to study health care needs in Montana, insurance reform and establish a data base for needed information. The Health Authority was also charged with drafting two bills for presentation to the 1995 Legislature; one for a single-payer health care system and one for a modified multi-payer plan. Both were to provide universal coverage. As I am sure you know, this did not happen, as the Health Authority

declared both plans dead some three months before the legislature was to meet.

In the meantime, the health care crisis has continued to grow, both in Montana and the nation. more than one million persons nationally continue to join the ranks of the uninsured each year. After last year's disastrous attempt to pass a national health plan, it is obvious that we cannot expect any meaningful health care reform from Congress in the near future. Apparently it will be up to the states to lead the way if we are to get real health reform, and we would like to see Montana in the forefront of this movement. A number of states worked for single-payer universal health care plans in their 1993-1994 state legislatures. Although they were not successful, they are redoubling their efforts in their current and upcoming legislative sessions. Some of these states are: Maine, Maryland, Massachusetts, Colorado, New Mexico and California. The citizens of these states are convinced, as we are, that the only logical answer to our health care crisis is a comprehensive universal plan with a single payer system and strict cost controls. We do not maintain that the government must be the single-payer, but it must be the collector of revenues. The often used argument, that we can't afford it, does not hold up when you consider that the other industrialized countries of the world have universal health care for all of their citizens and do it at a cost of one half to two thirds of what we spend per capita and we have about 40 million with no health insurance.

The health care industry led all U.S. industries in making money in 1994. The industry has the highest 5 year annual

return on equity at 17.3% and 17.9% over the past 12 months. As long as the private insurance industry controls health care in the U.S., we will never have health care reform or affordable care. The CEO's of these companies are receiving obscene amounts of compensation, and it comes from our premiums. For instance: R.E. Compton, chairman, president and CEO of Aetna Life and Casualty with a salary of $1,325,000 in 1993 and long term compensation of $947,000. S.E. Weill, chairman and CEO of Travelers in 1993 received $4,291,000 in salary and bonus, plus an incredible $48,518,000 in long term compensation. We cannot afford these costs added to our health care. These and many other insurance companies spent hundreds of thousands of dollars last year to defeat national health care and in contributions to congressional candidates on key committees. these are some of the reasons we ask you to pass this legislation. Thank you.

Doug Campbell

Montana State AFL-CIO

Donald R. Judge
Executive Secretary

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

EXHIBIT 3
DATE Feb. 14
HB 548

TESTIMONY OF DON JUDGE ON LC1092 (HB 548)
BEFORE THE SELECT COMMITTEE ON HEALTH CARE, FEBRUARY 14, 1995

Mr. Chairman, members of the committee, for the record, my name is Don Judge and I'm appearing here today in behalf of the Montana State AFL-CIO in support of LC1092.

By the looks of the proposals regarding health care reform coming before the legislature this year, you'd think that the health care crisis is over. There is no suggestion of impending doom hanging over our heads, in fact, there is some cry for repeal of those few small steps that were taken in the last legislature. Gone is the hue and cry for something to be done, because some would have us believe that there is no longer a need for health care reform.

Mr. Chairman, members of the committee, nothing could be further from the truth. We believe that this nation's, and this state's, health care crisis is yet to subside, and, in fact, is growing rapidly. Let's take a look at a few of the statistics:

In 1965, each individual paid an average of $204 per year for health care... In 1993, that had risen to $3,540... more than $14,000 for a family of four!

In 1965, total public and private expenditures for health care was approximately $41.6 Billion... In 1993, that total had ballooned to almost $1 Trillion ($939.9 Billion).

In 1965, health care costs consumed 5.9% of our nation's Gross National Product... In 1993, almost 14% of GNP was devoted to health care costs.

Last year, more than 37 million Americans had no health care insurance coverage whatsoever, tens of millions more were underinsured... Nothing has been done to alleviate that situation.

Last year, more than 100,000 Montanans were without health care insurance coverage, thousands more were inadequately insured... Nothing has been done to alleviate that situation.

Those who are without health insurance wait until illness is so serious -- and expensive to treat -- that they must go to our hospital emergency rooms -- the most expensive place for treatment -- where the taxpayers pick up their inflated health care costs... Nothing has been done to alleviate that situation.

More than half of the uninsured in this country are working Americans... people who regularly go to work but whose employers, or jobs, don't provide health insurance or pay enough to allow individuals to purchase their own insurance.

One in five working Americans experience "job lock" a situation in which they cannot afford to better themselves by leaving a job which does provide insurance and risking not being able to get reinsured.

America's health care system is the most expensive in the industrialized world.

America's infant mortality rate is among the worst in the industrialized world, and is approaching third-world rates.

America's lack of effective cost controls costs our health care system 60% more to administer than Canada's and 90% more than Britain's.

Mr. Chairman, I could go on about the problems with our nation's health care system. But the bottom line is... the system IS broken... and something should be done to fix it.

Behind all of these statistics lie the faces of real people. One in five Montana children will grow up in poverty, without adequate health care, sufficient nutrition or preventative medical attention. When they become adults, this lack of attention to their basic needs will only exacerbate our nation's health care crisis.

As the population of our nation and our state continues to age, fewer and fewer retirees will be able to afford appropriate health care attention and their needs will be addressed by higher taxes and inadequate services provided by government, at both the state and national level.

Most Americans, and Montanans live only one paycheck away from financial disaster. Most Americans and Montanans who have health insurance get it through their jobs. More and more jobs are being created which no longer offer access to health care.

Each day, thousands of Americans lose their health care coverage, and you need only to look around you to see some of those victims. Ask the small farmer or rancher if they believe the health care crisis is over. Ask the small business owner if they believe the health care crisis is over. Ask our unions if we believe the health care crisis is over. Ask your state and local governments if they believe the health care crisis is over. We believe you'll find a resounding NO to that question.

LC1092 offers you a chance... albeit a slim one... to address the needs of tens of thousands of Montanans. With it you can provide Montanans the essential elements of true health care reform:

Affordability
Accessibility
Portability
Cost containment
Choice of provider
Administration simplification
Hope for the future

Clearly, we aren't holding out any great hopes that this legislature is going to adopt a single payer system for Montana. But we can hope that you give this legislation serious consideration. We can hope that you will lift the veil of complacency from those who suggest that the crisis is over. We can hope that you'll take seriously the pending crisis awaiting you, your kids and all Montanans. And we can hope that you'll engage in a meaningful dialogue about seeking a solution... before it's too late... before too many more Montanans face the choice of either eating or seeking treatment.

Mr. Chairman, members of the committee, most union members are covered with health care plans. But over the years we have seen the costs rise, the deductibles increase, the coverage shrink, and in too many cases, the plans dropped, because we can no longer afford to pay the freight for those who can't access adequate health care coverage. It's time for this madness to end, it's time for you to find a solution.

We urge your favorable consideration of LC1092. Thank you.

(HB548)

EXHIBIT 4
DATE Feb. 14, 1995
HB 548

RE HB ~~551~~ 548 - Polly Walker
Polson (MSCA)

I Rise to ~~favor~~ HB ~~551~~ 548 + Legacy Res.
The Health Care Authority
Board was created to ~~~~
develop two Health Care Bills.
One, the single Payer as
introduced By Sen. Bill Yellowtail
and A multiple Payer system
as introduced by Sen. Eve
Franklin.

The Results of their work
has produced a so-called
single Payer plan that has
~~little~~ little or no resemplence
to the Yellowtail bill ~~as~~ originated
by the Montana Senior Citizen
Association & the Legacy Legislators.

Further more the current
Chairman of the MHCA Bd
at ~~one~~ meeting made a motion
that the single payer part of their
charge be dropped as impratical.
This is Adequate evidence they have
over.

Departed too far from their original charge to be a viable continuing entity.

EXHIBIT 5 Page 1
DATE Feb. 14, 1995
HB 548

Montana Education Association

1232 East Sixth Avenue • Helena, Montana 59601 • 406-442-4250
1-800-398-0826 (Toll-free) • Fax: 406-443-5081

MONTANA's HEALTH SECURITY ACT

HB548 – Representative Carey (1995)

MEA Testimony of February 14, 1995
Tom Bilodeau -- MEA Research Director

Over recent decades and with few exceptions, health care cost inflation has risen at twice -- and often three times -- the rate of general inflation. Reflecting the impact of "cost-shift" from the increasing number of uninsureds to insured groups, as well as other causes, the rate of health insurance premium inflation has grown even more rapidly than the rate of medical cost inflation.

In most instances, private sector employer's revenues and public sector agency or school budgets have not grown at anything close to the rate of growth in health care cost. Almost invariably, employers have reduced their relative share of insurance premium costs required by group insurance plans. However, even as employers reduced their relative share of premium cost, employer paid benefit costs have consumed an increasing share of their operating costs. Simultaneously, employees have foregone wage increases in an often unsuccessful attempt to maintain health benefit protections and -- at the very same time -- increased their out-of-pocket cost for health care. See: MEA Today article of October, 1993 (attached.)

Montana school expenditures for general fund "benefits" -- largely composed of the employer's payment toward health/medical insurance premiums -- increased 31% between FY91 and FY94 (from $38.4m in FY91 to $50.6m in FY94). Growth in the school's benefit cost was three times the rate of student enrollment growth and more than twice the rate of growth in total general fund school expenditures. The end result is that school expenditures for benefits consumed 7.9% of total expenditures in FY94, or 1.2% more of total expenditures than they did in FY91. By eating more of the expenditure pie, less remains for wages, smaller class sizes, technology, education program improvements or other purchases.

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DATE Feb. 14, 1995
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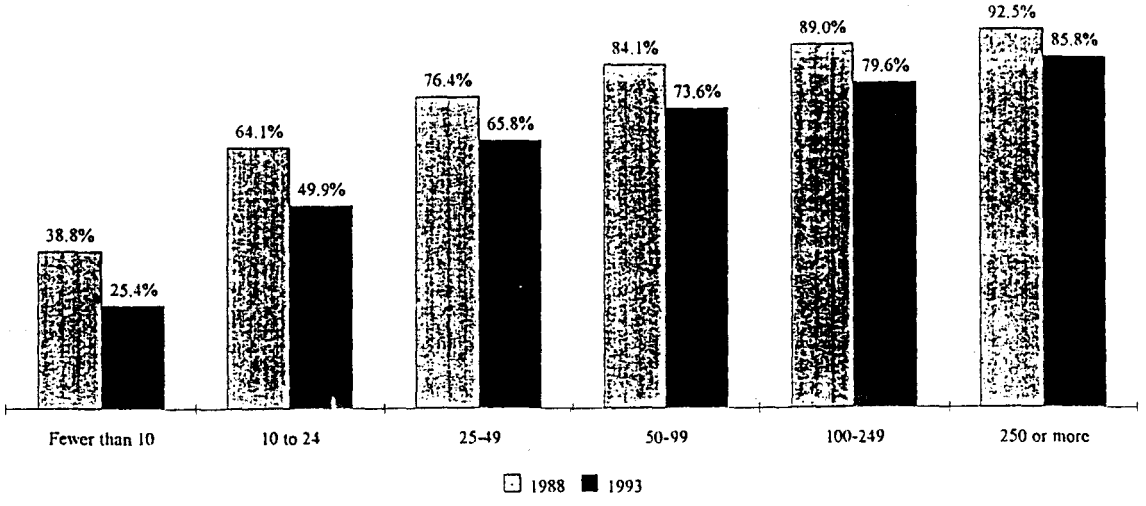
The impact is devastating on both large, well-managed, self-funded plans (see the attached testimony of Steve Henry, President -- Billings Education Association President) or small groups. In Billings and Huntley Project, rapid medical cost inflation strains school budgets and limits the take-home pay of school employees. In Culbertson or Florence-Carlton, the same dynamic ultimately undermines and in then eliminates the group health plan altogether. Our experience in Montana's schools is clearly part of a national, public and private sector experience.

Worker Access to an Employer Sponsored Health Plan has declined since 1988. Especially among small firms' employees.



MEA's commitment to substantive and broad-based health care reform led MEA to an internal policy debate concerning health care reform conducted during the later 1980s. By 1992, our organizational commitment to comprehensive reform led us to be among the founding members of Montanans for Universal Health Care (MUHC). Working with MUHC and other interested parties during the 1993 regular legislative session, MEA endorsed Senator Eve Franklin's bill (SB285) establishing the Montana Health Authority. Over the last two years, MEA and MUHC continued our work with the Health Authority and Regional Boards and their staff and stand before you today committed to the accomplishment of meaningful, comprehensive health care reform for all Montanan.

MEA members subscribe to the idea that the greatest efficiencies in reform of our health care system can be achieved through a tax-supported, single-payer health care network. A single-payer system is the simplest system, offers the most options for individual choice, is best able to bring about cost containment without diminishing the quality of service, and has the greatest potential for economies of scale and achieving universal coverage for all Montanans. Accordingly, we support Representative Carey's Health Security Act for Montana and urge this committee to recommend a "do pass" on HB548.

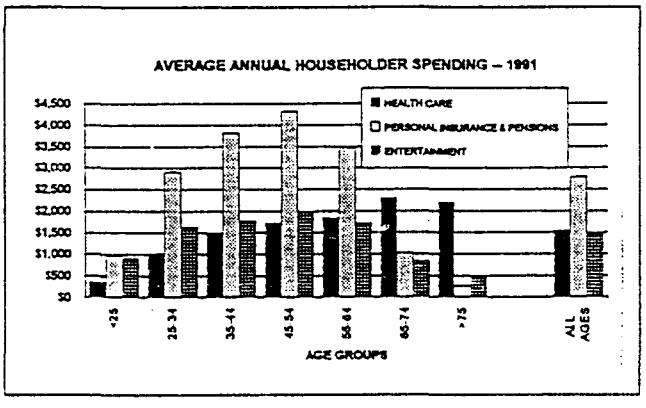
EXHIBIT 5, page 3
DATE Feb. 14, 1995
HB 548

Health Care Reform Reaches Center Stage

By: Tom Bilodeau — MEA Research Director

The "health care crisis" and reforming our health care and insurance system are now center stage political issues. No other set of issues so dominates national and state level policy discussions, impacts both private and public sector balance sheets, or so directly affects our pocketbooks and daily lives.

The US government recently confirmed what most of us already knew — health care and related insurance spending is the fastest growing category of household spending. Indeed, for householders age 65 or older, health and insurance expenses are the single largest component of the monthly budget.



For all-age householders, Americans out-of-pocket spending for medical services is now $1,554 each year for medical services ($555 for medications, $344 for supplies and $656 for health insurance). If other personal insurance (e.g. life or LTD) and pension costs ($2,787) are added in, householders are spending more on benefits than on any other single item of expenditure.

Although the dollar values are slightly lower, the situation in Montana appears similar to the nation as a whole. Survey data for Montana households using medical services in 1991, indicate that the median expenditures for health care was $1,415.

And then we could add in the cost of insurance. MEA data indicate that the average annual premium cost of full-family health insurance for Montana school districts was $4,236 (or $353 per month) for the 1992-93 year. Of that premium cost, the employer paid an average of $2,832 ($236 per month), while the employee paid for one-third of the family premium cost or $1,404 ($117 per month) during 1992-93. While the situation is somewhat better in some districts, it is clearly far worse in others — particularly those with small insurable groups.

Consider the current bargaining situation confronted by one MEA local association. The insurance carrier notified the district that full-family premiums would increase substantially — to $715 per month, or $8,580 for the coming year! The district maintained that its share of this premium cost should remain capped at slightly less than the cost of the single employee premium. Accordingly, an employee needing full-family insurance would be required to spend about $5,000 for out-of-pocket premium cost during the 1993-94 year! Under these circumstances, it's understandable that employees are thinking about working someplace else, are forever searching for alternative health care protection, consider dropping group health plan coverage, and even contemplate the odds of personal financial or medical catastrophe by going without insurance.

Montana Households with Out-of-Pocket Health Care Expenditures

(Excluding health/medical insurance costs)

	All Respondents	All Insureds	Private and Other	Medicare Medicaid	Uninsured Persons
Expenditures for prescription medicines, 1991					
Percentage of households	84%	86%	86%	87%	72%
Median total expenditure	$130	$135	$115	$200	$95
Expenditures for doctor services, 1990-1991					
Percentage of households	93%	95%	95%	95%	85%
Median total expenditure	$575	$560	$565	$550	$725
Expenditures for hospital services, 1990-1991					
Percentage of households	56%	54%	55%	50%	66%
Median total expenditure	$710	$710	$745	$585	$710

Source: Bureau of Business and Economic Research, The University of Montana

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Montana Education Association

1232 East Sixth Avenue • Helena, Montana 59601 • 406-442-4250
1-800-398-0826 (Toll-free) • Fax: 406-443-5081

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

STEVE HENRY, President
BILLINGS EDUCATION ASSOCIATION

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

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

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

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

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

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

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

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Statewide Universal Health Care Access Plans

State of Montana
Health Care Authority
Report to the Legislature
October 1, 1994

(comb-bound)

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My name is Bruce Rukstad. I rise to speak in favor of Single Payer Health Plan. I am married and have three children. Last year my son was diagnosed with a Ewing Sarcoma, a cancer of the bone, so I have first hand knowledge of the medical and insurance industries. Fortunately, unlike many others, we escaped personal bankruptcy, because my wife and I both have insurances through our respective employers to help us combat over $150,000.00 in medical bills. (For which, by the way, we pay along with our employers about $800.00 a month.)

The bureaucracy, the duplication, and the waste of manpower that we have experienced dealing with our insurance companies is mind boggling. One of the biggest attributes of the Single Payer plan is that it reduces this bureaucracy in an industry that contrubutes nothing to health care.

There is only one plan that incororates the basic principles for health care-universality, comprehensivess, affordability, freedom of choice, and public accountability. That plan is the Single Payer Health Plan. I urge you to vote in favor of this plan.

Thank You,

Bruce D. Rukstad

Bruce Rukstad

League of Women Voters
of Montana

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MONTANA LEAGUE OF WOMEN VOTERS WRITTEN TESTIMONY ON THE SINGLE PAYER HEALTH CARE BILL

My name is Lois Hove. I am vice-president of the Montana League of Women Voters.

The League supports this single payer bill. Our position of support comes out of a nationwide grassroots study of health care done over the past four years.

The League supports comprehensive health care that prevents cost shifting. At present costs of the uninsured are being shifted to those who are insured.

The League supports a comprehensive health care which would cover pre-natal care for all women. At present those who are uninsured have a difficult time getting pre-natal care. This often leads to premature births and low birth weight babies. Good pre-natal care can also save the life of the mother.

The League supports a fair comprehensive health care. Many employers now pay very high costs to cover their employees. Under this bill all employers would pay at the same rate so that the uninsured costs would not be shifted to those employers who are presently covering their employees.

A comprehensive health care plan would make it easier for women with children to get off welfare. Many women find they cannot live on a minimum wage without health care for their children and thus end up back on welfare.

The Montana League of Women Voters favors a DO PASS on this measure.

Lois Hove
416 Westview Drive
Missoula, MT 59803

I am Marion Hellstern, Treasurer and District 1 Director of the Montana Senior Citizens Association representing Phillips, Valley, Roosevelt, Daniels, and Sheridan Counties.

I strongly support setting up a "Single Payer" Health Care System in Montana which covers all the people in Montana and is administered by a Health Care Authority elected by the people of Montana from districts similar to the Public Service Commission and local Health Care Boards also elected by the people in each district. This would give consumers a chance to be elected and to take part in the administration and planning of the health care system. Our present system is the costliest in world by cost per capita, percentage of gross nation product, and total dollar amount and and we have over 40 million people without any health care insurance at all while all the other industrial nations with the exception of South Africa take care of all their people. In spite of paying more the United States ranks 12h in life expectancy and 21st in infant mortality.

Something must be done to control the skyrocketing cost of health care which has been going up at over three times the rate of general inflation pricing more and more people out of the market each year leaving 140,000 Montanans without any insurance. Competition has not been effective in keeping Health care costs down and in fact it has contributed to increasing costs by inducing the purchase of much more high priced technical equipment than is justified or necessary. The around thirty health insurance companies doing business in Montana has not resulted in lower insurance costs. In fact the companies have been taking in and average of one third more than they have been paying out. The number of Insurance companies plus all the government Health care

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programs has resulted in a blizzard of paper work which results in highest administrative cost of any country in the world. In fact the Government Accounting Office issued a report which shows that the United States could save enough administrative costs by adopting a "Single Payer" system to cover all the uninsured and have a 3 billion dollar surplus.

Health care is more like a utility with competition costly and impractical especially in the sparsely populated areas of Montana. Since the present system is entirely geared to curing and not preventing illness, prevention must be a major part of any practical and economical system. This can best be accomplished by an elected Public Health Authority and locally elected boards to create a practical and economical system.

It is high time the United States joins the rest of the world in establishing a health care system covering everybody. A "Single Payer" system is the only sound logical way to stop the skyrocketing costs and upset the present system the least. Since we are already spending more money than any other nation, finding the money is not the problem. The problem is making effective use of the money we are now spending. I strongly urge the Montana Legislature to make Montana the first state to adopt a sound, logical "SINGLE PAYER" Health Care System.

Marion Hellstern

Marion Hellstern
Box 447
Kendall MT 59241

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Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 · HELENA, MONTANA 59624

(406) 443-5341

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TESTIMONY OF MARION HELLSTERN
HEARD BEFORE (H) HUMAN SERVICES AND AGING
FEBRUARY 14, 1995

I am Marion Hellstern, Treasurer and District 1 Director of the Montana Senior Citizens Association representing Phillips, Valley, Roosevelt, Daniels, and Sheridan counties.

I strongly support setting up a "Single-Payer" Health Care System in Montana which covers all the people in Montana and is administered by a Health Care Authority elected by the people of Montana from districts similar to the Public Service Commission and local Health Care Boards also elected by the people in each district. This would give consumers a chance to be elected and to take part in the administration and planning of the health care system. Our present system is the costliest in the world by cost per capita, percentage of gross national product, and total dollar amount, and we have over 40 million people without any health care insurance at all while all the other industrial nations with the exception of South Africa take care of all their people. In spite of this, the United States ranks 12th in life expectancy an 21st infant mortality.

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fact, it has contributed to increasing costs by inducing the purchase of much more high priced technical equipment than is justified or necessary. The around thirty health insurance companies doing business in Montana has not resulted in lower insurance costs. In fact the companies have been taking in an average of one third more than they have been paying out. The number of insurance companies plus all the government health care programs has resulted in a blizzard of paper work which results in highest administrative cost of any country in the world. In fact, the Government Accounting Office issued a report which shows that the United States could save enough administrative costs by adopting a "single-payer" system to cover all the uninsured and have a three billion dollar surplus.

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Testimony of
Edmund J. Caplis
on
The Montana Health Security Act

Chairman Orr, members of the committee, for the record I am Edmund Caplis , representing Montanans for Universal Health Care (MUHC), a coalition representing consumer groups ranging from the Montana Hemophilia Society to the Montana Chapter of Physicians for a National Health Plan. We believe comprehensive reform is the only way to achieve health care reform that provides care to all Montanans in an affordable, high quality way. To quote some health insurance lobbyists, " Insurance reform is not health care reform." From what I have observed over the last several weeks we have met in this committee I have seen no discussion of cost containment, or ways to bring those who cannot afford insurance into the health care system. What I have seen is insurance reform but without cost containment. Without cost containment there is no process to stop health care costs from rising at twice the rate of inflation and nothing to stop premiums from keeping pace with this cost.

We have been informed that a market base system will fix our health care problems. From our point of view the current system is market based and the market has failed. Since the turn of the century we have made attempts to fix the health care system but we continue to put a fix here and patch there. It is time that we look toward a comprehensive shift in health care policy. The Health Security Act is the first step in a shift to patient centered, quality, affordable health care.

We urge your support of the Health Security Act.

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A Historical Perspective

- "Hazards of sickness, accident, invalidism and old age should be provided for through social insurance."
  —Theodore Roosevelt, 1912

  "Un-American"
  —Woodrow Wilson, 1912

- "Program to deal with major hazards . . . of life."
  —F. D. Roosevelt, 1932

  ". . . would jeopardize Social Security."
  —Committee on Economic Security, 1932

- "Right to adequate medical care"
  —Harry Truman, 1945

  "Socialist and Communist idea"
  —American Medical Association, 1945

- "Health care for everyone"
  —L. B. Johnson, 1964

  "Health care for the elderly and poor"
  —L. B. Johnson, 1965

- "Face a massive crisis . . . breakdown . . . things do not have to be this way."
  —Richard Nixon, 1974

  "22 health reform bills introduced into Congress"
  —political differences, 1974

- "Market forces"
  —Reagan/Bush, 1980-92

  "Domestic-policy, social initiatives killed . . ."
  —deficit, 1980-92

Background: Factors Driving Health System Reform

■ Overview...

- Cost, access, quality
- Perverse economic incentives
- Social momentum
- Worldwide competition
- Un- and under-insured
- Political reactions

■ Some Specifics...

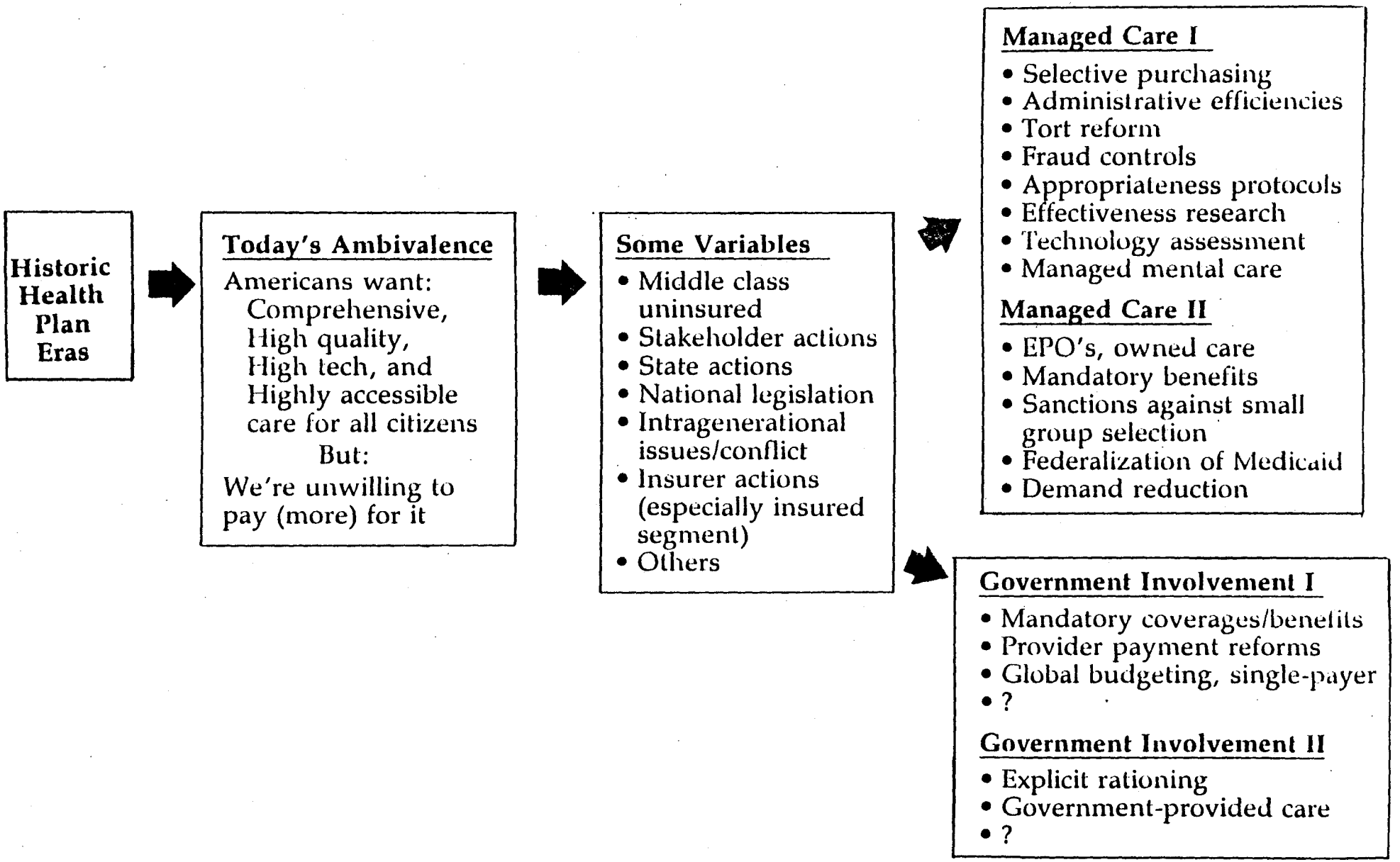
Access	Cost	Quality
• 39 million Americans without insurance	• One trillion dollars in 1994 • 15% of GDP • 30% more than any other country • 20-30% is waste	• U.S. ranks: 19th — Infant mortality 21st — Life expectancy (males) 16th — Life expectancy (females)

■ A Sad Realization...

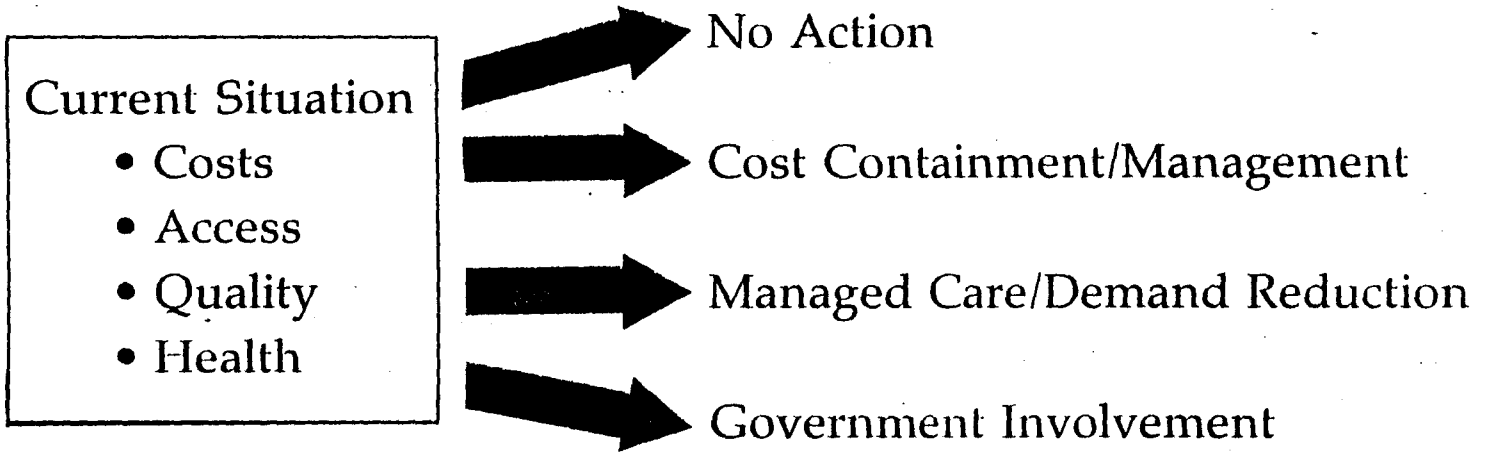
"The problem with the American health-care system is not that we need to spend more money. The problem is we're spending too much money in wasteful and inefficient ways."

George J. Mitchell (D-ME)
Senate Majority Leader
Meet the Press, April 18, 1993

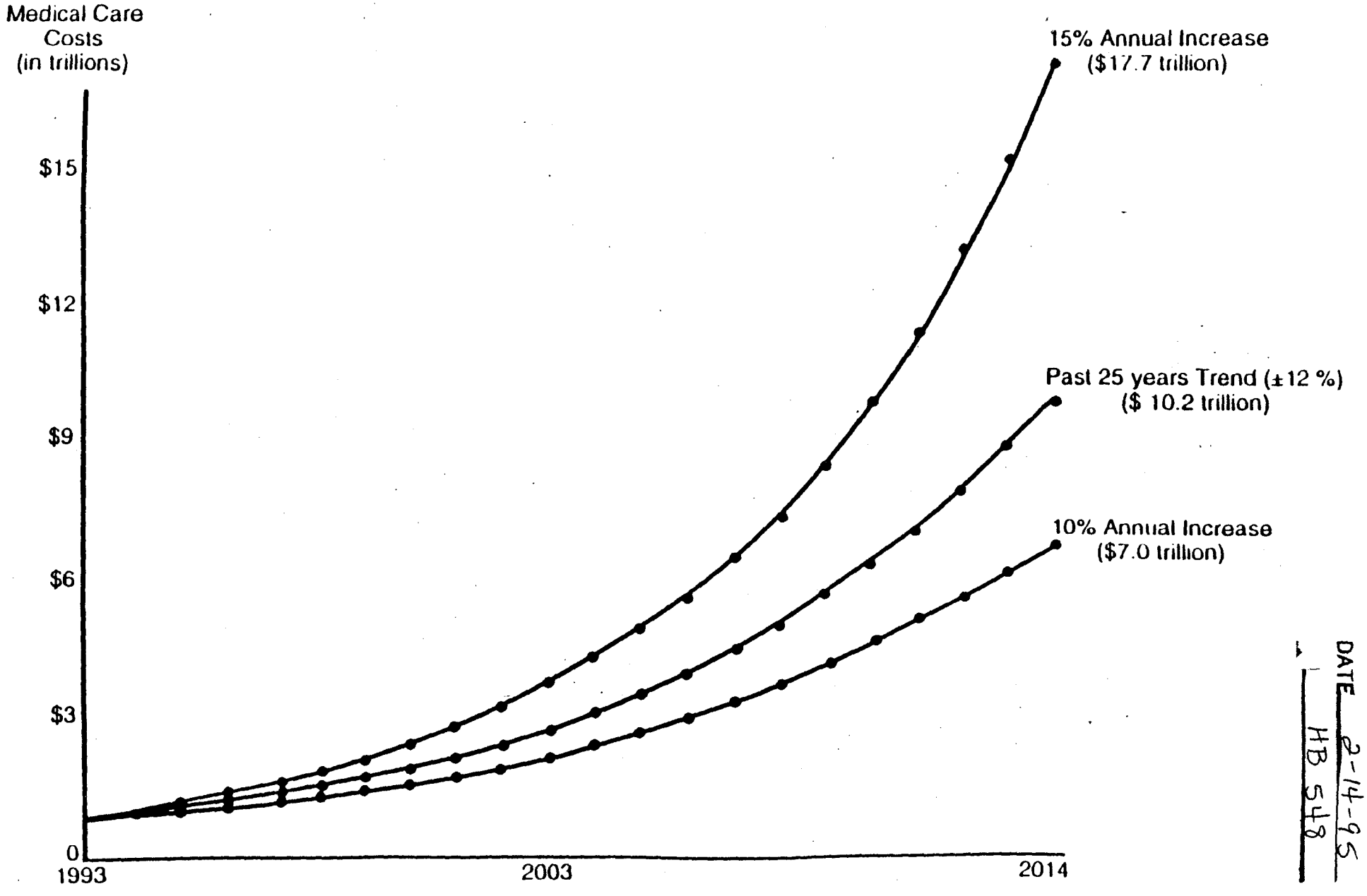
Present and Future Health Plan Directions



Overview of Strategic Approaches



Future Health Care Costs
(direct costs only, projected)



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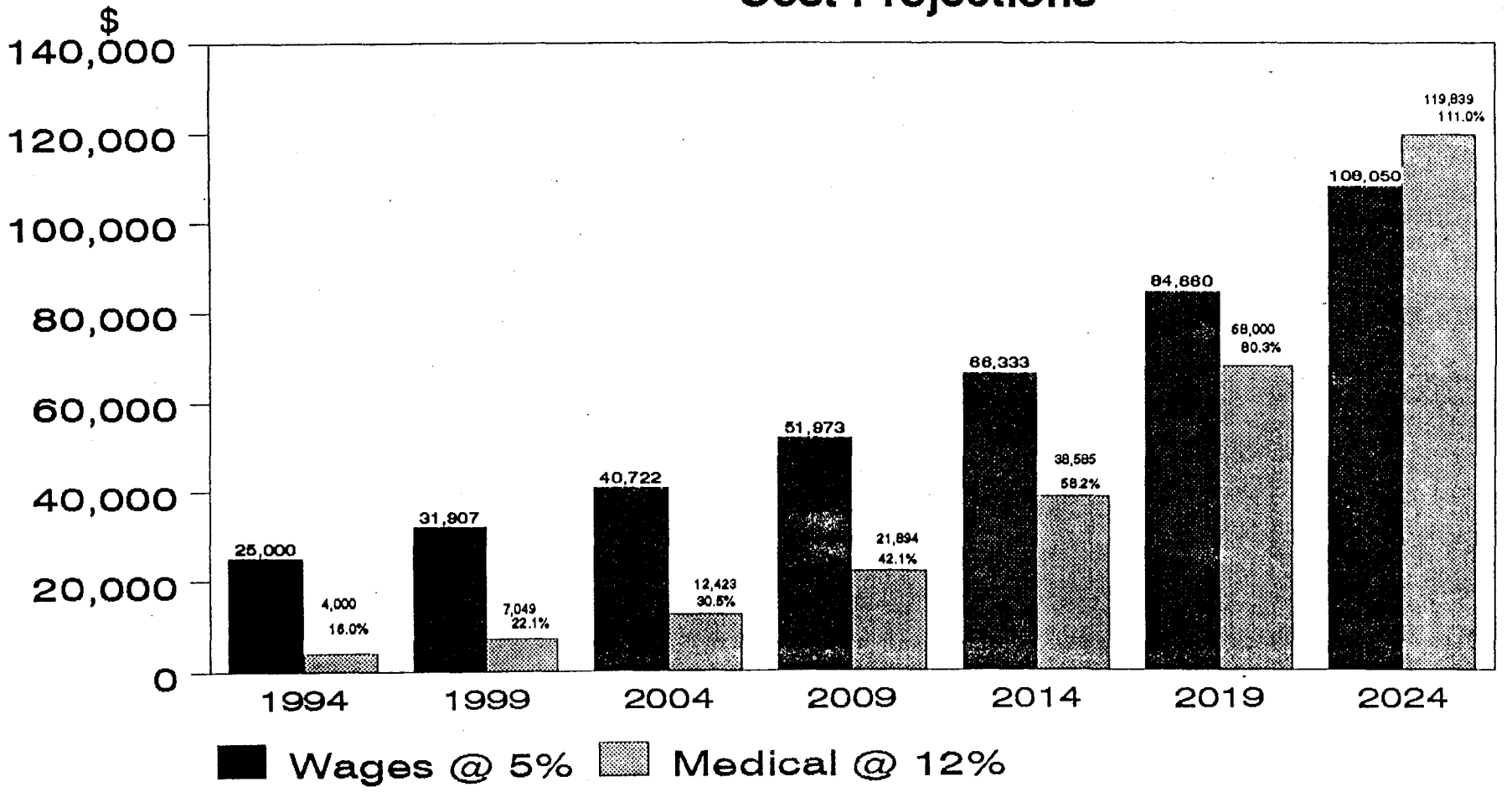
Comparison of Wage and Medical Cost Projections



Source: Health Research Institute, Walnut Creek, CA

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MONTANANS FOR UNIVERSAL HEALTH CARE

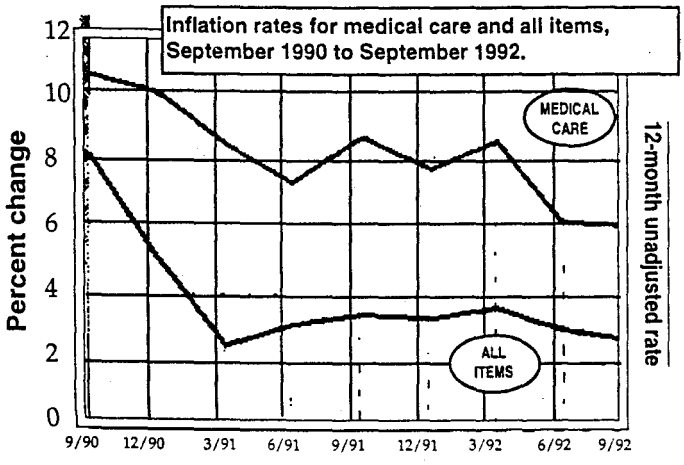
WHY DO WE NEED "SINGLE-PAYER" HEALTH CARE REFORM?

Almost anyone who has recently needed health care or experienced America's health care and insurance system first-hand will tell you that something is wrong — seriously wrong. Both health care providers and policy-makers in Montana will tell you the same thing.

Here's a sampling of the many problems now recognized with our current health care system.

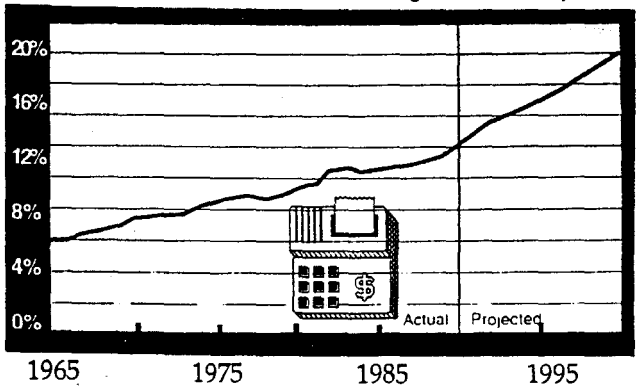
• **140,000 (1 in 5) Montanans don't have health insurance and among children even fewer are insurance covered. Among the "developed world" we are unique in having state-of-the-art health care providers and facilities that aren't economically accessible to a fifth of our population!**

• Annual rates of "medical cost inflation" continue to grow at two and sometimes three times the general or overall rate of inflation.



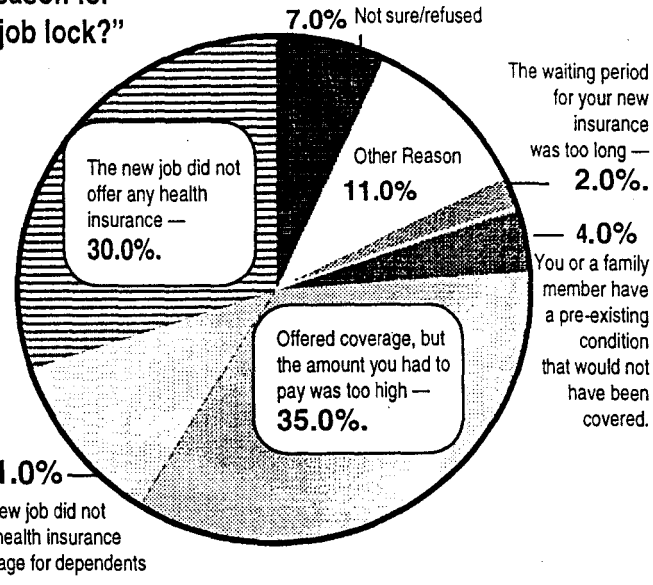
• Nationally, health care spending exceeds 12% of the gross national product (a measure of the total value of goods and services produced). We spend almost twice as much for health care as other industrial countries.

National health expenditures as a share of gross domestic product.



• One in five Americans report that they are "locked" into their current job for economic or personal reasons — a majority of these "job-locked" Americans say that the "main reason" they can't even consider changing employment is for fear of losing health insurance coverage or benefits.

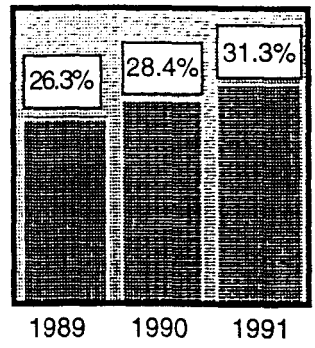
What is the main reason for "job lock?"



• Employers report insurance administration costs eating up 15 to 20% or more of premium costs at the very time that their health care/insurance premium cost for employees consumes a larger share of potential profits each year.
(See graph to right.)

• As much as 40% of both our national and state deficits can be attributed to rising health care costs.

Estimated percentage of annual net profits that employee health care costs represent, 1989-1991.

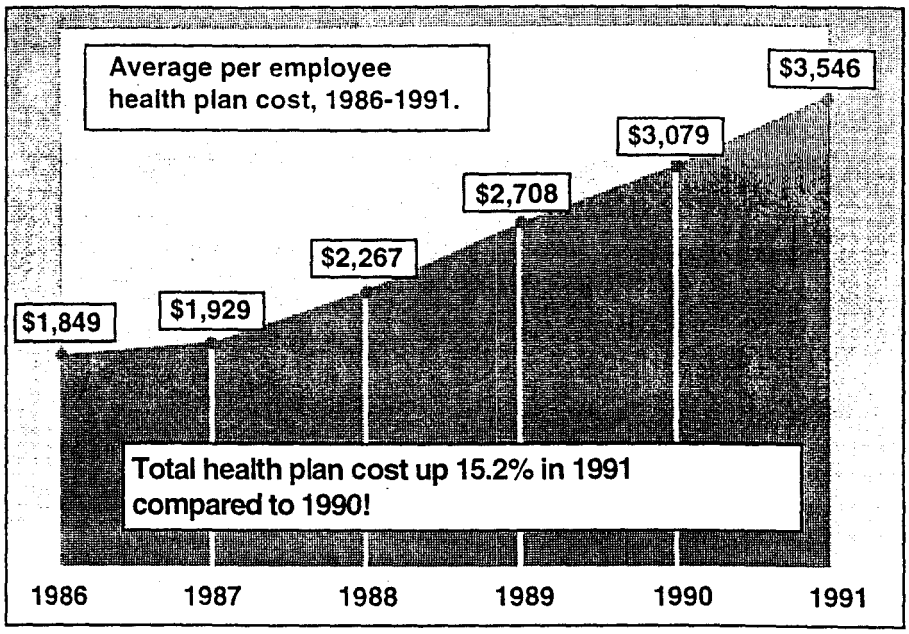


Graphs reprinted from MEDICAL BENEFITS Panel Publishers, Inc. 1992.

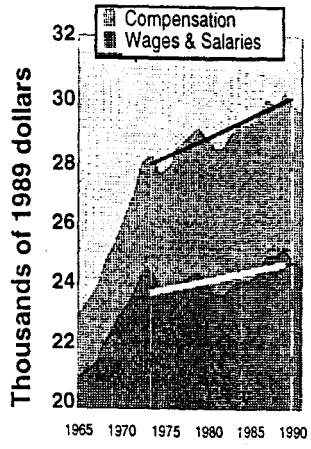
• Average health care cost per employee is now more than $3,500 per year — that's up $500 from last year (+15%) and almost twice the cost of just five years ago! (See graph at right.)

• While employees — at the very same time — see insurance benefit packages being reduced and wage increases disappear under rising out-of-pocket health care costs.

(See graph below.)



Inflation-adjusted compensation and wages per full-time employee: actual data and 1973-1989 trends.



The current health care "system" is simply unworkable and virtually out of control. Piecemeal solutions simply won't do when one considers the many stakeholders in modern health care. Those stakeholders include everyone from the doctors, clinics and hospitals, to the pharmaceutical companies and distributors. The group also includes consumers such as senior citizens, the unemployed and those employed either with or without employer paid benefits. The list goes on — as many as fifteen hundred insurance companies nationwide and countless other interest groups.

After nearly two years of study, members of the Montanans for Universal Health Care (MUHC) have come to the conclusion that only comprehensive health care reform can meet the needs of all Montanans. MUHC proposes a single-payer health care system that can expand health care to every Montanan while saving millions of dollars and without causing rationing or a decline in the quality of health services provided.

MUHC Believes Health Care Should Be a Right, Not a Privilege

Montanans for Universal Health Care — MUHC believes that access to quality health care is a right, and that a person's income or employment status should not be a factor indeciding whether necessary medical treatment will be provided.

MUHC's mission is to build a broadbased coalition of health care providers and consumers — everyone from educators, senior citizens, small business operators, to ranchers and farmers, representatives of low income persons and the unemployed. Our goals are to:

❦ *educate ourselves, the public and our public officials;*

❦ *develop and lobby for enactment of a workable, state health plan; and*

❦ *implement, by 1996, a single-payer health plan for Montana which satisfies MUHC's ten criteria of an effective health care policy.*

Montanans for Universal Health Care

PO Box 423 • Helena, MT 59624
(406) 443-5341 • Fax: 442-1316

- Montana Senior Citizens Coalition
- Oil, Chemical & Atomic Workers (OCAW) Billings & Laurel Locals
- Montana AFL-CIO
- Montana Alliance for Progressive Policy
- Hemophilia Society of Montana
- Montana Federation of Teachers & State Employees
- Montana Labor Alliance — Missoula
- Montana Low Income Coalition
- Montana People's Action
- Montana Physicians for a National Health Plan
- Montana Women's Lobby
- Hotel, Restaurant and Bartender Employees Union

MSCA FACTS:

FACTS ON THE MONTANA HEALTH SECURITY ACT SPONSORED BY BILL CAREY (D - MISSOULA)

Comprehensive health care reform critical to the future of our state

The pressures of health care costs are felt not only in the work compensation system, but throughout our state government. Currently, over 30% of all state government expenditures go to health care related costs. Medicaid payments alone are rising at a rate of 15% annually. If left unchecked, rising health care costs could bankrupt this state.The Health Security Act offers a comprehensive plan for reform exclusively tailored for Montana.

Montana Health Care Authorities Responsibilities

The Health Security Act requires the Health Care Authority (MHCA) to become responsible for health care policy. This responsibility directs MHCA to establish and maintain a universal system of care for all Montanans:

- ∞ Maintain a standard benefit package of medical care.
- ∞ Maintain Eligibility Standards
- ∞ Contract with third parties to administer the integrated payment system.
- ∞ Prepare annual budgets for the system.
- ∞ Negotiate reimbursement levels with providers.
- ∞ Provide a system of statewide and regional health care planing
- ∞ Develop a comprehensive Montana health care information system
- ∞ Implement cost containment mechanisms
- ∞ Create a resource management plan

How much will this Co$t

The revenue required for the Health Security System is already within the our current health care system. The Health Security System will reallocate the dollars within the current system. Individuals would pay into the system instead of their insurance company. The savings created by a centralized and standardized claim system would allow uninsured Montanans to be brought in the system. 1.1 billion dollars would be shifted from insurance companies to the health security system. As Medicare, Medicaid, and other payors are brought into the system, annual savings of the system should increase to over $543 million dollars by the year 2005. In its report to the Legislature the Montana Health Care Authority projects the difference between a single payer system and no reform in 1996 would be $17.5 million dollars.

All heath care information will be in one place

The health security act will establish a comprehensive health care data base. The data base will provide information needed to formulate the resource management plan, determine the capacity and distribution of existing resources, and identify the state's health care needs. The data base will also evaluate the effectiveness of intervention programs on improving patient outcomes, compared costs between various treatment settings and approaches and provide information to consumers and purchasers of health care. Rules will be established to guarantee confidentiality.

The Resource Management Plan - the backbone of reform

A health resource management plan is essential to comprehensive reform . The Authority will identify Montana's health care needs and available resources and equitable allocate these resources, so that all Montanans will have access to a to affordable, quality health care. Each universal access plan will contain a health resource management plan which prioritizes Montana's health care needs. The resource management plan will focus on cost containment plus primary and preventive health care. This plan will be based on recommendations made by the regional planning boards.

MSCA

MONTANA SENIOR CITIZENS ASSOCIATION

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- Annual rates of "medical cost inflation" continue to grow at two and sometimes three times the general or overall rate of inflation.
- Nationally, health care spending exceeds 12% of the gross national product (a measure of the total value of goods and services produced). We spend almost twice as much for health care as other industrial countries.
- One in five Americans report that they are "locked" into their current job for economic or personal reasons — a majority of these "job-locked" Americans say that the "main reason" they can't even consider changing employment is for fear of losing health insurance coverage or benefits.
- Employers report insurance administration costs eating up 15 to 20% or more of premium costs at the very time that their health care/ insurance premium cost for employees consumers a larger share of potential profits each year.
- As much as 40% of both our national and state deficits can be attributed to rising health costs.
- Average health care cost per employee is now more than $3,500 per year — that's up $500 from last year (+15%) and almost twice the cost of just five years ago!
- While employees — at the very same time — see insurance benefit packages being reduced and wage increases disappear under rising out-of-pocket health care costs.

The current health care "system" is simply unworkable and virtually out of control. Piecemeal solutions simply won't do when one considers the many stakeholders in modern health care. Those stakeholders include everyone from the doctors, clinics and hospitals, to the pharmaceutical companies and distributors. The group also includes consumers such as senior citizens, the unemployed and those employed either with or without employer paid benefits. The list goes on — as many as fifteen hundred insurance companies nationwide and countless other interest groups.

After nearly two years of study, members of the Montana Senior Citizens Association (MSCA) have come to the conclusion that only comprehensive health care reform can meet the needs of all Montanans. MSCA proposes a single-payer health care system that can expand health care to every Montanan while saving millions of dollars and without causing rationing or a decline in the quality of services provided.

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Single-Payer Health Care Reform

A single-payer system of health care can be based upon the three guiding principles of the Canadian system: Universal coverage for all citizens; uniform reimbursement rules; and system-wide spending controls. Administrative savings from these three principles would be enough to extend health care access to the 37 million Americans currently without insurance and more than 50 million underinsured.

• **Financing:** Under a single-payer approach, the government would pay health care costs for all citizens primarily with revenues from payroll or income taxes, or a combination of both, replacing insurance premiums and existing public programs. Modest co-payments and deductibles might also be applied as in some of the Canadian provinces. Initial increased expenditures would be countered by administrative savings from billing one insurer and would help to cover the cost of insuring those individuals previously without coverage.

A study done by IN HEALTH magazine found that Canadian citizens spent $18 a year for "administrative costs" while American citizens spend $95 — a total of $20 billion more than we could have spent with the single-payer system. Savings would also result from the elimination of insurance companies and government programs such as Medicare, Medicaid, Veterans Administration, Indian Health, etc.

While taxes would be higher, these taxes would simply replace the $2,050 we spend annually per person on health care in the form of monthly premiums, co-payments, payroll deductions and out-of-pocket expenses. Canadians pay for their health care once a year in taxes and get more medical care for an average of $600 less than Americans spend. The United States spent $640 billion on health care last year and still had 87 million people either without coverage or underinsured. Under a Canadian plan, the United States would have covered everyone for $365 billion.

• **Delivery:** Under the Canadian system, an individual is allowed to choose his or her own doctor and hospital. Doctors choose where they want to practice and are then paid on a fee-for-service basis. Most single-payer proposals would also follow suit, with some versions encouraging the use of HMOs and other managed care plans, typically subject to government regulation.

Stories of Canadians on long waiting lists for emergency care are false according to the General Accounting Office of Congress: "Patients with immediate or life-threatening problems need rarely wait for services, but waiting lists for elective surgery and diagnostic procedures may be several months long."

All health care must be rationed to some degree. The issue is on what basis it should be done: ability to pay, or severity of need?

• **Comprehensive benefits:** In addition to hospitalization and physician services, a single-payer plan would most likely provide for other medically necessary health and preventive services including mental health, long-term institutional and home health care.

Some services, however, would not be covered by single-payer in the interest of cost containment. In Canada, for instance, provincial insurance does not cover dental care, eyeglasses, prescription drugs, ambulance service or private hospital rooms so many Cana-

dians end up buying some private insurance. A policy to cover all these things runs about $30 to $40 a month. This is not unlike American insurance which just covers 74 percent of the costs of doctors' services, 39 percent of dentists' services and 25 percent of prescription drug charges. The rest is paid out-of-pocket.

• **Cost control:** Government or government-created panels at the federal and state levels would set spending targets or caps, negotiate fee schedules for doctors and global budgets for hospitals and monitor the use of high-tech equipment and procedures. Incentives for cost shifting would also be eliminated since the insurer could no longer refuse to insure high-risk individuals.

Because Canadian investment in new technology is limited, more money is available for **preventive** care for all citizens. Subsequently, Canadians live an average of two years longer than Americans. Canadian heart patients also have a 20 percent higher survival rate than Americans even though they have fewer surgical procedures. Infant and maternal mortality are also lower in Canada because of a greater emphasis on pre-natal care, not on equipment to help premature children survive after the fact.

In the United States, decisions about the purchase of new technology are made by individual hospitals seeking a competitive advantage in the marketplace. This often leads to a proliferation of high-cost technology.

• **Quality assurance:** Adoption of a single-payer system allows for standards to be established to govern patient care in all medical settings. A patient grievance procedure would be set in place emphasizing mediation instead of litigation. For those individuals who saw the need to take a grievance to court, the establishment of an "English rule" (loser pays winner's court costs) could be used to keep extraneous suits out of the legal system, thus keeping malpractice costs down.

• **Pros:** The most important aspect of the single-payer approach is its universality of coverage and identical benefits for all citizens. Caps on spending also guarantee slower increases, while more efficient administrative processes by a single insurer eliminate exorbitant marketing and managerial costs. Single-payer would also replace the cost shifting practices currently used by insurance companies with a more rational — and progressive — financing scheme.

The Canadian model also illustrates the speed with which a national health care plan might be adopted. In less than ten years after the introduction of the Saskatchewan system, all ten Canadian provinces had a single-payer system.

• **Cons:** The single-payer proposal may run into problems with costs control if there are no limits on the treatments that doctors can prescribe in a fee-for-service setting. Single-payer will also initially cost more to implement than some of the insurance-based reforms currently in Congress because coverage would be extended to the uninsured. The tax financing to assure universal coverage also means a major redistribution of costs. The exact price tag for the program depends on what services would be covered under it, but a report by the GAO estimates coverage for the nation's uninsured to be $64 billion and the administrative savings from a single-payer system to be $67 billion. The government and insurance agencies <u>are</u> spending the money for right now for a universal health care plan. The key is redirecting it effectively.

Snappy Answers to Sticky Health Care Questions

The following are some of the most common asked questions and misinformed comments about a single payer health care system. Montana Senior Citizens Association is proud to present some snappy answers to those sticky questions.

??? The U.S. has the best health care system in the world. It doesn't need to be changed.

!!! The U.S. undoubtedly has the best and latest medical technology and many of the world's finest physicians. But at the same time we have nearly 40 million people with no health insurance, including 140,000 Montanans, and 50 million underinsured. Two million chronically ill can't buy insurance. Millions of Americans are one health care emergency away from bankruptcy.

??? What is the Canadian system?

!!! Canada's national health insurance program covers everyone. Each province administers its own program offering basic coverage, plus additional services varying from province to province. It is called single-payer because the provincial government pays health care providers from federal and provincial taxes.

??? How can the Canadian system provide health care for all yet spend less per person than the U.S.

!!! There are several reasons:

(1) elimination of paperwork through a single-payer system (a doctor bills one insurance pool, which reimburses doctors for services);

(2) provider fees are controlled by annual negotiations with the insurance pool;

(3) investment in high technology is limited, e.g. only one MRI is allotted for a certain area instead of all the hospitals in a region having MRIs.

??? Can Canadians choose their own doctors?

!!! Yes. In fact, Canadians have more freedom to select a primary care physician than Americans who belong to a HMO or managed care plan and must select a doctor from a prepared list.

??? People have to wait in line to see a doctor in Canada. Heart patients die while waiting to have surgery.

!!! *Emergencies are taken care of immediately.* There are waiting lines for non-emergencies, just as in the United States where we may have to wait two to twelve weeks or more for an appointment. In the U.S. you don't even get in line unless you can pay. Many doctors will not see Medicaid patients. Canadian heart patients have a better survival rate (20% higher than U.S. patients) even though they have fewer surgical procedures.

??? Canadians come to the U.S. for surgery all the time. Their system doesn't work.

!!! This is American Medical Association (AMA) propaganda. Some heart patients come to the U.S. for surgery but most prefer to wait in Canada. A few Canadian provinces have agreements with U.S. hospitals to take heart surgery patients at

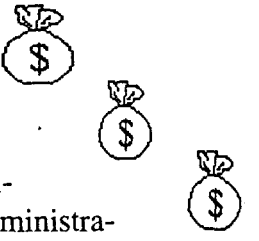
prevailing Canadian rates for those services. A recent *USA Today* study found that a great number of our citizens in eastern border states go to Canada for the excellent and inexpensive health care. If the Canadian system doesn't work, why do polls show that only 5% of Canadians would prefer our system of health care? Canadian statistics for infant mortality, child mortality and life expectancy are better than ours.

??? Canadians flock to the U.S. to shop because their taxes are incredibly high.
!!! Taxes are higher in Canada but they also get more for those taxes - health care with small or no premiums and no co-payments. An article in the *Great Falls Tribune* titled, "Canadians flocking to the U.S. but not for health care" showed that 95% of Canadians say they would not exchange their health care system for ours.

??? If the U.S. had a single-payer system, what would happen to the insurance industry?
!!! The insurance companies would be out of the health business, which is only a small part of its operations. However, the insurance lobby is very powerful and works with the AMA to defeat the idea.

??? Aren't the doctors opposed to a national system?
!!! Doctors are not a monolithic group. The Physicians for a National Health Program (PNHP) is a leader in the single-payer reform movement. The 68,000 member American College of Physicians has endorsed it also. However, the American Medical Association which represents less than half of U.S. physicians is opposed to the single-payer system and is spending a lot of money on a negative publicity campaign about the Canadian systems shortcomings.

??? There is no free ride. Who is going to pay for a single-payer system? And won't we have to pay more to insure all the uninsured?
!!! The increased expenditures would be offset by savings from reduced administrative costs. A GAO report estimates universal coverage to cost $64 billion and the administrative savings through a single-payer system would be $67 billion. Savings would result from the inclusion of insurance companies and government programs such as Medicare, Medicaid, Veterans Administration, Indian Health, etc. Therefore, there would be more than enough money without increasing present expenditures.



Funding options include taxes and/or nominal premiums which would replace private insurance premiums, deductible and out-of-pocket expenses. The taxes could come from personal income taxes, payroll and corporate taxes. Overall health care expenditure would be reduced for most individuals.

??? What will the increased taxes do to American competitiveness?
!!! Countries which are now providing health care for its people already are beating the pants off us in the world marketplace. American companies are finding the health insurance costs are adding to their inability to remain competitive. Lee Iacocca, Chrysler chairman, said, *"American industry cannot compete effectively with the rest of the world unless something is done about the great imbalance between health care costs in the U.S. and national health care in virtually every other country."*

??? How would a single-payer system affect the malpractice situation?
!!! We would still need legislation to reform malpractice problems. One approach is a mediation system whereby the doctor, patient and an unbiased third party try to resolve the problem before it reaches the courts. Malpractice is not as responsible for the high medical costs as the medical profession would like us to believe.

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??? What about malpractice in Canada?

!!! According to the Mt. Medical Association (MMA), in 1989, Montana's family practicioners paid about 23% of their gross income on liability insurance. Malpractice costs in Canada are only 10% of the U.S. costs for several reasons.

(1) Patients in Canada don't have to sue to get money for future medical care.
(2) Lawyers can't get contingency fees so they are less likely to sue.
(3) Since no money changes hands between doctors and patients, there is less tendency to handle problems by suing.
(4) The malpractice insurance companies, which are owned by the doctors, evaluate the merits of each case and settle all

weak cases while fighting the ones where they think there wasn't really malpractice. This tends to give the impression that if a case goes to court then there's a good chance the suit is not justified.

??? How can we win against the insurance and medical lobbies?

!!! We believe that there is strength in numbers. Congress is going to take action and if the people clearly indicate that they want comprehensive reform, e.g. a single-payer system, Congress will choose what the people want. We must tell our Congressmen that we will not vote for their political health if they don't vote for our health care needs — a single-payer system.

??? If the main problem with U.S. health care is the 37 million uninsured, why not simply add a government health insurance program to cover those people? Why abolish private insurance?

!!! First, the extension of government health insurance to the uninsured will do nothing to stop the escalating costs of care, and will thus be extremely expensive. Billions of dollars could be saved by simplifying the bureaucracy now needed in the U.S. to attribute costs to individual patients and to bill a multiplicity of payers. One thing that public agencies seem to do well is run insurance programs. U.S. Social Security insurance runs at very low overhead. Overhead costs in the Medicare program are also low, about 3% of total costs. Similarly, insurance overhead in Canada's national health program consumes only2.5% of total costs. When Saskatchewan experimented with allowing a private firm to administer their insurance fund, their overhead costs nearly tripled.

Second, a program targeted only to cover the uninsured would separate health insurance for the poor from private health insurance for the remainder of the population. A unified health insurance program for all people would mean that health care, like Social Security, would have the political support it needs to resist cutbacks.

Third, extending coverage to the uninsured would do nothing for the tens of millions who are underinsured - those with insurance plans that have high copayments and deductibles, or don't cover some important services. Five million women between 18 and 44 have insurance policies that won't cover maternity care. We need a universal health care plan to cover everyone.

??? I have a great insurance policy. My job pays for it, it covers everything with a small deductible. We shouldn't scrap a good thing.

!!! You're lucky. Many people have $500 or $1,000 deductibles. Some people have limits on what their insurance will cover: a catastrophic illness will bankrupt them. Currently, rising health care costs are the leading cause of personal and small business

bankruptcies in the U.S. More and more employees have to pay substantial portions of their insurance out of their paycheck, and deductibles, copayments, and uncovered services are going up as their employers try to cut the costs of employee health benefits.

??? What are the basic differences between the British National Health Program and the Canadian system?

!!! The British system is one where the M.D.'s are on salary paid by the government and hospitals are funded and owned by the government. The Canadian system is based on private practice, fee for service and mixed ownership of facilities, but is federally mandated, funded, and administered on the provincial level. This means that theCanadian system has the advantage of providing cost control via government funding administration while the patient still has a choice of doctors and facilities.

??? If the U.S. or Montana were to enact universal health care, what would happen to people who travel overseas and require medical care?

!!! Currently, Medicare recipients must buy a special insurance policy which would cover them in the event they require medical carewhile overseas. Coverage of overseas medical care by private insurance companies varies widely among individual policies. Canadians requiring medical care outside of their country have the provider bill the Canadian health plan which pays for the cost of the procedure if it were performed in Canada. In general, most providers will accept what the Canadian health plan pays as payment in full for their services. In many European countries, foreigners requiring routine medical care are not even billed by the provider.

??? I live in a rural area. Will I have to travel long distances for medical care under a universal health plan?

!!! *No.* Under a universal health plan, global budgets to health care providers would assure rural *and* urban hospitals the funds necessary to maintain their services. Hospitals in rural areas would continue to provide routine medical care and be assured payment for their services. What would change is that rural hospitals would no longer have to compete with urban hospitals in the accumulation of hi-tech equipment to keep their doors open. Not every hospital needs ALL of the latest and most advanced medical equipment to give their patients quality care. Patients requiring hi-tech procedures would receive the appropriate treatment in more urban areas much like they do now.

??? If Montana enacts a universal health care plan, all of the sick people in the area will move here.

!!! This was not the experience of Saskatchewan, the first Canadian province to initiate a universal health care plan. In fact, statistical studies done in the U.S. regarding welfare benefits and other "free" services have shown repeatedly that families move primarily to secure employment, not handouts. This argument is the latest "scare tactic" used by certain health care providers who have a lot to lose if health care becomes a right, not a privilege. Also, a Montana universal health care plan would do much to attract business to the state since employers would not have to worry about whether or not they can afford to insure their employees.

☞ **The information in this booklet was compiled by the Montana Senior Citizens Association from information provided by the Montana Senior Citizens Association and the Oil, Chemical, and Atomic Workers Health Care Info Manual. If you have any questions on the information presented, or want more detail please contact Montana Senior Citizens Association at 406/443-5341**

HB 548

EXHIBIT 11
DATE Feb. 14, 1995
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My name is Madelyn Cameron and I am a member of Montana Senior Citizen's Association, and our main thrust is Universal Health Care - Single Payer Plan.** I have as have many Senior Citizens gone to Canada and have listened to panels of Doctores, nurses, hospital adminstrators, educators and others. These professionals explained why they liked their Single Payer Plan. I have talked with many Canadian citizens and they are all proud of their Health Insurance. Do they have to wait for some procedures? Yes, just like we do in this country. Do they have a choice of Doctors? Yes. Are there abuses? Yes - but every man, woman and child is taken care of. Their health care is special, it's the cement that makes a nation out of a people. When we're sick we hold out our hands to one another and nobody asks are we insured or not.

As you know the United States is the only country in the industrial world except South Africia that does not have Universal Health coverage.

Uwe Reinhardt a Political Economist at Princeton University who is a well known authority on Health Care said, "When I lived in Germany because I wouldn't join the Hitler Youth Group we literally lived in a tool shed. We got drinking water from a creek - we stole food and fuel to exist, I grew up as a pauper, but when anyone in my family got sick, we had dignity because we had rights that came with our insurance card. We had the right to be treated respectfully, because the Doctor was paid whether he treated me or a rich kid." Germany has had Health Care for everyone for over 100 years.

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We are spending over 14% of our Gross Natl. product on Health Care and yet 39 million people are not covered. Germany and Canada are spending only 9% of their Gross Natl. Product and every man, woman and child are covered; no one falls between the cracks.

I believe the State of Montana should have it's own Single Payer Plan. We should get a waver from the Federal Government in the areas we are now paying for: Medicare, Medicade, V.A. Insurance, Indian Health and Insurance to the Military and their families. We might have to march on Washington to do it, but let's try.

We have been in bondage to the Big Insurance Companies and the American Medical Assn. long enough. We want to be set free. This would be your shining ~~houw~~ hour.

I know you have all heard or seen Dr. Timothy Johnson on T V. He is medical editor of ABC/ He is not only a Doctor but also an ordained minister. He said this is not a political issue, this is a moral issue. "We need political leadership to get everyone together, and say we are not going to leave this room, we are not going to leave this process until we find a way of providing Health Care for everybody and that"s what it's going to take."

I know you are proud of being an American, America land of the free and home of the brave." But are you brave enough, are you brave enough to stand and say, yes I will help this to happen.

** But I am not only speaking for Senior Citizens - I am speak- for those who cannot speak for themselves, the Mentally Ill, the Uninsurable - those who cannot afford to come to Helena and speak for themselves, and for those who must hold down two jobs "to get by" and will never be able to buy insurance.

EXHIBIT 12
DATE Feb. 14, 1995
HB 548

MY NAME IS JANET ROBIDEAU AND I LIVE IN MISSOULA, MONTANA. I CURRENTLY CHAIR THE MONTANA PEOPLE'S ACTION HEALTH CARE TASK FORCE AND I'M HERE TODAY REPRESENTING THE MEMBERS OF MPA AS WELL AS THE COMMUNITY AND LABOR ORGANIZATIONS WHO MAKE UP THE MONTANA COMMUNITY LABOR ALLIANCE.

HEALTH CARE COSTS ARE CURRENTLY THE MAJOR COSTS DRIVING OUR STATE'S BUDGET PROBLEMS. WITNESS THE INTENSE DEBATE THAT IS CURRENTLY GOING ON IN THIS LEGISLATURE ABOUT THE MEDICAID PROGRAM.

THE DETRACTORS OF THE CANADIAN SINGLE PAYER SYSTEM ARGUE THAT IT IS CONTROLLED BY A MONOLITHIC ENTITY - GOVERNMENT - AND THAT PEOPLE HAVE TO WAIT IN LINE TO RECEIVE THEIR CARE.

THE IRONY OF THIS THAT THIS IS EXACTLY WHAT AMERICANS (AND CANADIANS) CURRENTLY FACE. FIRST, OUR HEALTH CARE SYSTEM IS CONTROLLED BY A MONOLITHIC ENTITY - THE INSURANCE INDUSTRY. SECOND, WE ARE INCREASINGLY BEING FORCED TO WAIT IN LINE AS INSURANCE COMPANIES FORCE US INTO MANAGED CARE PROGRAMS THAT HERD PATIENTS THROUGH LIKE SO MANY CATTLE.

THE MEMBER ORGANIZATIONS OF THE MONTANA COMMUNITY LABOR ALLIANCE BELIEVE THAT THE ONLY WAY FOR MONTANANS TO RECEIVE COST-EFFECTIVE QUALITY HEALTH CARE IS FOR OUR STATE TO ADOPT A SINGLE PAYER SYSTEM.

AND THIS LEGISLATURE, AS THE BODY RESPONSIBLE FOR BOTH BALANCING OUR BUDGET AND ULTIMATELY DEVELOPING A STATE HEALTH CARE SYSTEM, SHOULD BE TAKING A SERIOUS LOOK AT A SINGLE PAYER SYSTEM.

WE URGE YOU TO LOOK AT THE FACTS AND TO PUT THE MYTHS ASIDE. SINGLE PAYER IS NOT SOCIALIZED MEDICINE - IT IS SOCIAL HEALTH INSURANCE. LOOK AT IT LIKE MEDICARE FOR THE ENTIRE POPULATION.

EXHIBIT 13
DATE Feb. 14, 1995
HB 548

MONTANA SENIOR CITIZENS ASSOCIATION ACCLAIMS SENATE JOINT RESOLUTION NUMBER NINE

JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA URGING THE UNITED STATES CONGRESS TO ENACT LEGISLATION TO PROVIDE A NATIONAL HEALTH CARE PROGRAM FOR ALL THE CITIZENS OF THE UNITED STATES.

WHEREAS, 37 MILLION AMERICANS ARE WITHOUT HEALTH INSURANCE COVERAGE OF ANY KIND; AND
WHEREAS, COSTS OF MEDICAL CARE ARE RAISING TWICE AS FAST AS THE RATE OF INFLATION; AND
WHEREAS, PER CAPITA HEALTH CARE COSTS IN MONTANA ARE EXPECTED TO INCREASE FROM $2,059 IN 1990 TO $ 4,686 IN 2000; AND
WHEREAS, 20% OF ALL PEOPLE IN MONTANA HAVE NO HEALTH INSURANCE, AND AN EVEN LARGER PERCENTAGE ARE UNDERINSURED; AND
WHEREAS, OUR CURRENT HEALTH CARE SYSTEM IN THIS COUNTRY IS A PATCHWORK OF PRIVATE AND GOVERNMENT PROGRAMS THAT ARE BOTH EXPENSIVE AND INEFFICIENT, WITH 23 CENTS OF EVERY HEALTH CARE DOLLAR SPENT FOR ADMINISTRATION AND BUREAUCRACY; AND
WHEREAS, AS HEALTH CARE COSTS RAISE, EMPLOYERS ARE LESS AND LESS ABLE TO PAY FOR HEALTH INSURANCE FOR EMPLOYEES, RESULTING IN NEGOTIATION DEADLOCKS, STRIKES, AND FURTHER RESTRICTIONS ON ACCESS TO HEALTH INSURANCE FOR AMERICA'S WORKING CLASS CITIZENS; AND
WHEREAS, THE COST OF EMPLOYER HEALTH CARE RAISED BY 18.6% IN 1988 AND BY 20.4% IN 1989; AND
WHEREAS, FAMILIES ARE BECOMING IMPOVERISHED PAYING FOR THE COSTS OF LONG-TERM CARE; AND
WHEREAS, PRESCRIPTION DRUG COSTS IN THE LAST DECADE HAVE INCREASED AT MORE THAN TRIPLE THE GENERAL RATE OF INFLATION; AND
WHEREAS, INFANT MORTALITY RATES ARE CLIMBING IN THE UNITED STATES, ESPECIALLY AMONG POOR PEOPLE; AND
WHEREAS, POOR PEOPLE ARE BEING TURNED AWAY FROM HEALTH CARE; AND
WHEREAS, PREVENTABLE DISEASE IS ON THE RISE IN THE UNITED STATES, ESPECIALLY AMONG THE POOR; AND
WHEREAS, PREVENTABLE DISEASES, SUCH AS MEASLES, MUMPS, RUBELLA, WHOOPING COUGH, AND POLIO, ARE INCREASING AMONG CHILDREN BECAUSE THEY LACK ACCESS TO MEDICAL CARE; AND
WHEREAS, THE DEATH RATE FROM PREVENTABLE CAUSES IS ON THE RISE IN THE UNITED STATES; AND
WHEREAS, A NATIONAL HEALTH CARE PROGRAM WOULD PROVIDE QUALITY, COMPREHENSIVE HEALTH CARE TO ALL CITIZENS OF THE UNITED STATES; AND
WHEREAS, ALL MEDICALLY NECESSARY SERVICES WOULD BE PAID UNDER A NATIONAL HEALTH CARE PROGRAM, ELIMINATING THE PATCHWORK OF EXISTING PRIVATE AND GOVERNMENT HEALTH CARE PROGRAMS; AND
WHEREAS, UNDER A NATIONAL HEALTH CARE PROGRAM, HEALTH CARE PRACTITIONERS WOULD MAINTAIN THEIR PRIVATE PRACTICE AND PATIENTS WOULD HAVE THE FREEDOM TO CHOOSE THEIR OWN PHYSICIAN OR HOSPITAL.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA THAT THE LEGISLATURE OF THE STATE OF MONTANA URGE THE UNITED STATES CONGRESS TO ENACT LEGISLATION TO PROVIDE A NATIONAL HEALTH CARE PROGRAM FOR ALL THE CITIZENS OF THE UNITED STATES.

BE IT FURTHER RESOLVED, THAT CONGRESS INCLUDE IN A NATIONAL HEALTH CARE PROGRAM:

(1) A SINGLE-PAYER SYSTEM FOR THE PAYMENT OF HEALTH CARE; AND

(2) COVERAGE FOR BASIC HEALTH CARE, INCLUDING LONG-TERM CARE.

BE IT FURTHER RESOLVED, THAT THE SECRETARY OF STATE SEND A COPY OF THIS RESOLUTION TO THE PRESIDENT OF THE UNITED STATES, THE SPEAKER OF THE UNITED STATES HOUSE OF REPRESENTATIVES, THE PRESIDENT OF THE UNITED STATES SENATE, AND EACH MEMBER OF THE MONTANA CONGRESSIONAL DELEGATION.

EXHIBIT 14
DATE Feb. 14, 1995
HB 531
Paul Gorsuch

HEAL
MONTANA
The Montana
Health Education
Alliance

Volumn 95, Issue 2-January 1995

MEDI☆CHOICE

The Plan YOU Choose

(unbound report)

Current Status of the HEAL Montana Health Reform Proposal

P.O. Box 111
Great Falls, MT
59403
(800) 720-3181

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EXHIBIT 15
DATE Feb. 14, 1995
HB 531

MONTANA BUSINESS & HEALTH ALLIANCE
Over 2300 members statewide
founded in 1989 by Montanans to provide low cost health benefits for small Montana businesses and individuals
P.O. Box 548
Kalispell, Montana 59903-0548
(406) 756-3444

NOTES FOR PRESENTATION ON PROJECT HEAL BILL HB531

HURRAY! FINALLY I HAVE THE OPPORTUNITY TO BE VERY POSITIVE ABOUT SOMETHING!! HB 531 IS A GIANT STEP IN THE RIGHT DIRECTION IF WHAT WE'RE AFTER IS FREE MARKET REFORM OF OUR HEALTHCARE SYSTEM!

IN THE RECENT PAST I HAVE HEARD STATE AUDITIOR MARK O'KEEFE STATE THAT INSURANCE REFORM IS NOT ALL THAT IS NEEDED AND IS ONLY PART OF THE HEALTH CARE REFORM EQUATION. WE AGREE!!

HB 531 IS A GIANT INCREMENTAL STEP TOWARD HEALTH CARE REFORM! IT CONTAINS INSURANCE REFORM THAT GUARANTEES PORTABILITY AND RENEWABILITY FOR ALL MONTANANS. IT MAKES GOOD HEALTH INSURANCE ACCESSIBLE TO EVERYONE. IT HOLDS BOTH INSURERS AND PROVIDERS ACCOUNTABLE BY REQUIRING FULL DISCLOSURE OF POLICIES AND PRICES. AND FINALLY, THROUGH THE USE OF MEDICAL SAVINGS ACCOUNTS IT ADDRESSES THE AFFORDABILITY PROBLEM.

I STRONGLY URGE YOU TO PASS HB 531, AND BECAUSE THERE IS NO FURTHER NEED FOR SMALL GROUP REFORM AFTER YOU PASS THIS BILL, I ALSO STRONGLY URGE YOU TO PASS REPRESENTATIVE LIZ SMITH'S HB 155 WHICH REPEALS THE AMENDMENT.

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY.

ED GROGAN

EXHIBIT 16
DATE Feb. 14, 1995
HB 531

Billings Anesthesiology, P.C.

Mike Schweitzer, M.D. Pres.
David Khoe, M.D. V. Pres.
Steve Kriner, D.O. Sec-Treas.
Bruce Coan, M.D.
David Daines, M.D.
Brian Harrington, M.D.

P.O. Box 1859
Billings, MT 59103
(406) 259-1686

Rod Lee, M.D.
Brian McGuire, M.D.
Tom Robinson, M.D.
Paula Roos, M.D.
Nancy Sweeney, M.D.
Marvin Warren, M.D.

2/13/95

Representative Scott Orr
Chairman - MT House Select Committee on Health Care
Capitol Station
Helena, MT 59620

Dear Chairman Orr and Members of the Committee :

We offer our support for HB 531. We feel strongly that this health system reform will benefit our families, our patients, and those we work with every day. We urge you to pass this Bill.

We enthusiastically support the concepts of insurance portability, renewability, and simplification of insurance processing forms. Tax equity for health insurance enhances the ability of individuals and small businesses to afford health insurance premiums. This will increase the number of Montanans who have health insurance all year long.

Medical Savings Accounts would reduce the cost of insurance and expenditures for routine medical needs dramatically if insurance were used only for major medical expenses. The current tax law for income set aside in a tax-exempt account for medical expenses encourages a "use it or lose it" approach. This approach increases demand for medical services and costs when we should be promoting savings and efficient use of the health care system.

Amending the Montana Comprehensive Health Insurance Association Plan would expand the benefits for Montanans with pre-existing or high-risk illnesses. Currently the premiums are too high and the benefits too low.

Pricing information on insurance companies, hospitals, and physicians will help consumers evaluate their health care purchases. This is essential to promote value-conscious behavior and personal responsibility.

Please give deliberate consideration and support to this important Bill which could significantly reduce the costs of health care for most Montanans. Thank you.

Sincerely,

Mike Schweitzer, M.D.
President

EXHIBIT 17
DATE Feb. 14, 1995
HB 531

Testimony in favor of HB 531

Madam ~~Mr.~~ Chair~~man~~, members of the Committee, my name is Rob Hunter, ~~and I am testifying as a proponent of the MediChoice Plan, HB 531.~~ for the record Before stating my reasons for encouraging you to support ~~this bill~~ HB 531 I think it is important that that I briefly describe my experience, not to draw attention to myself but rather so that the members will appreciate the perspective I have on this matter. .

I have a masters degree in health adminstration, and for the past ten years have worked in the field of health benefits and managed health care. I have assisted in the development of an HMO, and have some experience in virually every funtion of this type of managed care organization. I have been involved in or personally directed the development of numerous preferred provider arrangements in the Pacific Northwest, have managed a third party administration firm, have developed and managed a utilization management and case management program, have developed a small group health insurance program, have assisted in the development of a community based purchasing coalition, have assisted in the development of four managed care organizations for management of workers compensation cases, have participated in a public process to reform small group health insurance, and over the past two years in my capacity as an independent consultant have assisted various employers, insurers and providers in ~~various~~ programs and endeavors to control healthcare cost and quality. In other words, I have a work-a-day familiarity with market-based health care reforms.

During the past several years, particularly as the healthcare reform debate heated up, I wondered if anyone could or would design a plan for reform which was based on incentives rather than penalties, which would be more of a carrot and less of a stick. We know from experience that the market responds rapidly to carrots - look at the growth of self-funding under ERISA preemption over the past 20 years, and particularly the last 10. It has exploded, and whether one likes ERISA preemption or not, there is no arguing the fact that the market loves it and has prospered under it.

I can tell you that it is relatively easy, even and perhaps especially with very good intentions, to design reforms that are coercive and choice reducing, although it is obviously more difficult to ~~persuade affected parties to subject themselves to such reforms~~ implement these reforms. Conversely, I was not optimistic that any of us working alone or together would be able to design a plan for reform which would infuse the health care finance system with real market-based economics and incentives. And then I was introduced to MediChoice.

I heard several people comment over the past two years that the sponsors of MediChoice were anti-reform. They clearly were not supportive of many of the reforms which were then under serious consideration. But I wonder if we were unable to appreciate a true market based reform because our perception had been developed in a debate that was dominated by an abundance of what we might call "big stick" reforms.

You will hear much better descriptions of the details MediChoice than I could offer from others here today. I am therefore going to confine my comments to ~~a brief comparison or two and~~ to address potential arguments against the bill. ~~My comparisons will be based on an alternative reform that is close at hand, which is my only reason for referring to it.~~

delete from oral only

Several weeks ago I stood before this Committee to argue for repeal of the small employer health availability act. My comments were not offered without appreciation for some of the finer points of the Act, like portability, guaranteed renewability, and the assurance that persons with genetic or congenital diseases or healthcare problems could not be refused access to coverage. My position was based on my opinion that the Act would be inflationary, that the Act's admission that it failed to address affordability was not a badge of honor but rather a critical defect which over time would reduce access. By contrast, MediChoice directly and I think very effectively addresses the affordability issue by increasing the consumers' responsibility for his or her purchase choices. That is the essence of market-based reform.

The Availability Act further forced most small insurers out of our market because it required them to assume the same risks as large insurers but on a much smaller income base. This result is analoguous to a statutory requirement that small banks issue loans with as much risk as any loan a large bank might issue, and is as threatening to the policyholders of small insurers as this type of banking reform would be to depositors at small banks. MediChoice, by comparison, does not attempt to manipulate the insurance market, but rather is designed to expand market choices.

If I was going to argue against MediChoice I might choose to list shortcomings which, though they may only be technicalities, given enough volume might distract you from the bottom line performance. I have not consulted with the sponsors in the development of this plan, and so I do not stand here to testify that it is either technically pure or in need of imediate amendment. I only want to remind you that it is headed in the right direction and like any other bill passed by this legislature will be perfected over time.

Another ~~line of attack~~ change might be that without federal deductibility the plan is seriously deficient and won't work. That is ~~like~~ arguing that no carrot is better than anything except the biggest carrot. The plan surely would have a greater impact if supported by federal deductibility, but it will definitely have some favorable net effect with the State deduction alone.

Finally, one might argue that the plan for improving and expanding the Comprehensive Health Association as the last resort for coverage is a plan for creating a second class citizenry when it comes to health insurance. We need to remember that we have a second class right now called the uninsured. What MediChoice does is improve the lot of these persons by providing affordable, good value coverage that is not presently available to many of them through the Association plan or otherwise. ~~I might add that the Association plan, as modified by MediChoice,~~ would not represent a reduction in coverage for a ~~number of people I know who are presently covered in the private sector.~~

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MediChoice is not the final solution, but it is the beginning of a very promising solution. I my years of working in the field and both watching and participating in the reform debate I have seen no other reform as promising as this. I offer this endorsement with full recognition that if it is as successful as I ~~hope~~ hope it will be, it could reduce the need for some of my consulting services. I might have some regrets, but Montanans in general will not - please support HB 531.

about that, but this Committee, this legislature

1/27/94 **From the readers' advocate** Great Falls Tribune

Here is my advice on medicine...

GUEST COLUMN
Cheryl Reichert

For the past three months, I have served as the readers' advocate on the Tribune Editorial Board. It's been a rewarding experience, and I now have a much better appreciation for the challenges of journalists. I was invited to join the editors to provide a local physician's perspective into health system reform, and now that my rotation is completed, I was asked to share a few parting thoughts.

Our health care delivery system is undergoing the most rapid and comprehensive change within our lifetime, and decisions made today will affect medical services for generations to come. While there is a temporary "time-out" at the national level, this process of restructuring will continue with the 1995 Montana Legislature and locally through a series of deliberations studying the consolidation of the Columbus Hospital and the Montana Deaconess Medical Center.

Although those who currently have access to health care are generally pleased by the quality of services, there is a consensus of opinion that the economic basis of our health care system is in need of reform. In addition, better access is needed for those who would like to be insured but can't afford the premiums. Unacceptably high health care costs have bankrupted individuals and made the products of American corporations less competitive in the global marketplace.

No one would set out to design our present patchwork system of health care, with insurance coverage that drops patients with pre-existing conditions when they change jobs, hospitals that shift costs from under-compensated government programs to the private sector and from outpatients to inpatients, complex billing claims that generate a blizzard of mostly unintelligible paperwork, governmental agencies that employ an army of over-zealous inspectors and bureaucrats seeking to justify their existence, and hovering malpractice attorneys whose very presence encourages the costly defensive practice of medicine.

Although the specifics of health system reform are incredibly complex, the underlying philosophical issue is readily understood — whoever pays the tab will control the service. Given the government's track record of inefficiency, high costs, and the predictable over-utilization of services that are perceived to be free, a government-run single payer system is unlikely to provide the high quality, responsive care that many Americans have come to expect. I find the alternative of government-legislated business monopolies even less palatable, inasmuch as this profit-motivated system is designed to reduce access to specialists and provide fewer diagnostic tests, resulting in delayed therapeutic interventions. At risk are the trusting, long-term relationships between doctors and patients, replaced by impersonal "doc-in-the-box" interactions with interchangeable providers.

There is another alternative that guarantees that individuals and families will be given the right to choose which doctor, which insurance carrier, and which hospital best suits their needs. Free-market reform will provide consumers with the knowledge and incentives to make prudent health care decisions. Part of these goals can be accomplished through tax-exempt individual medical savings accounts or through vouchers for the medically uninsured. These "medi-save" accounts are to be supplemented with renewable, portable, high deductible catastrophic private health insurance. Because medisave accounts accrue to the individual, frivolous expenditures are discouraged. Patients could be financially rewarded for certain cost-effective preventive health care measures, such as vaccinations and prenatal visits.

In order that the market force of competition can preserve quality and control costs, patients would be granted access to information about fees and about other treatment options. Billing claims would be standardized and simplified. Through a choice of private health insurance plans, individuals (not governments or businesses) would be able to determine in advance of illness how aggressive the treatment options should be in sustaining life.

During the past 18 months Great Falls based "Project Heal Montana" has been working on such a "medi-choice" alternative, in the hopes that this proposal will be seriously debated during the upcoming state legislative session. This plan will require some latitude from the federal and state governments in granting tax-exemptions for "medi-save" accounts and a willingness on the part of Montanans to experiment with a system that is based upon the old-fashioned principles of individual and family responsibility.

Over many decades, Great Falls has evolved into a rather extraordinary medical community, and no one wants to jeopardize the good in trying to create the better. We cannot take a hatchet to our present health care system and expect to end up with anything that is functional, let alone improved. We are fortunate in Montana that we suffer from less of the social pathology (drugs, violence, AIDS) that has precipitated the health cost crisis in other parts of the country.

It is my hope that health system reform in Montana will proceed in an incremental and logical manner and at a measured pace. Before we make irrevocable changes, we would be wise to profit from the successes and failures of other states and other communities that have already begun this process.

Dr. Cheryl M. Reichert is director of pathology at the Columbus Hospital, 500 15th Ave. S., and a board member of Project Heal Montana.

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- consideration of empowering locally-controlled bodies to accredit hospitals and eliminate excessive paper work burdens imposed by national organizations.

4. Expanded Benefits for High-Risk Individuals: Even though Montana has a mechanism for insuring people with preexisting or high-risk illnesses, the premiums are too high and the benefits are poor. Medi•Choice would expand the benefits and increase the subsidy for the current Montana Comprehensive Health Plan. How much to spend in doing this should be arrived at in open debate.

5. Pricing Information: Medi•Choice would establish a clearinghouse to make available and easily understandable the pricing information for insurance, hospitalization and doctors' fees. This is essential to promote value-conscious behavior and personal responsibility.

Such information–including cost comparisons among hospitals–would be publicly available and would help eliminate price gouging.

6. Medicaid: If allowed by the federal government, experimental programs could be implemented in the state that could provide insurance for recipients rather than the state acting as a single payer to manage recipient care.

The Medi•Choice approach means health insurance for all without employer mandates, price controls, state rationing and forced health care alliances.

Your Support is Needed

Project HEAL Montana plans to introduce Medi•Choice during the 1995 Legislative Session. To accomplish this goal, we will be:

- conducting an intensive lobbying campaign at the Legislature
- implementing a state-wide public relations effort
- soliciting more membership and grassroots support
- developing additional support for Medi•Choice by networking with other organizations
- conducting a top-quality actuarial analysis of Medi•Choice
- bringing to Montana nationally known experts in health care to help promote Medi•Choice
- Setting up telephone trees to reach our supporters quickly with timely information

But time is short. As we go to press, town hall meetings promoting government control of health care are happening throughout Montana.

If you want to help to retain your freedom of choice and ensure continued quality health services for you and future generations of Montanans, please support Project HEAL Montana with the most generous donation you find possible to give or by contributing volunteer time.

Whatever you can do to help is very appreciated. Send your donations to Project HEAL Montana or phone our office. We will tell you how you can volunteer or give you names of members in your area you can contact to join the telephone trees.

Project HEAL Montana
P.O. Box 111
Great Falls, Montana 59403

1-800-720-3181

A HEALTH CARE REFORM PLAN

Project HEAL Montana (Health Education ALiance of Montana) 1-800-720-3181

MEDI☆CHOICE

The Plan YOU Choose.

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Project HEAL Montana is a non-profit educational organization dedicated to achieving reforms in health care that will ensure high-quality health care services while preserving individual freedom of choice within a free-market system.

Members of Project HEAL Montana represent a wide cross section of Montanans including health care professionals, politicians, business people, concerned citizens, ranchers, farmers, and others.

We have developed a comprehensive health system reform plan for Montana that we are taking to the Legislature as an alternative to the proposals currently being examined.

P.O. Box 111
Great Falls, Montana 59403

1-800-720-3181

Our Philosophy

A good health care system should, as much as possible, promote individual independence and responsibility while exercising the compassion we all need.

We should avoid the quick fix of establishing government agencies to regulate our health system. Despite the best intentions of many good people, government agencies are limited by the inherent fault of all bureaucracies–centralized decision-making. This process robs individuals of the power and right to make their own health care choices.

Drastic reform measures like the single-payer or multi-payer systems take tremendous risks that have the potential for irrevocable disasters.

Health is not achieved in a day. Improving our health system should be a continuing process keeping what is good and improving upon the rest.

A good system will be compassionate toward people, subsidize the less fortunate and prevent financial ruin from severe health problems while retaining freedom of choice.

Within those bounds, people should pay the real cost of what they get in medical care and health insurance.

Our health care system should give individuals incentives and responsibilities to be healthy, to make their own health choices and be value conscious. Every Montanan must retain the freedom to contract with a doctor, hospital or other health care provider of his or her choice and on his or her terms.

Without freedom of choice, there can be only a growing dependency on government along with ever-rising costs. The economic burden to the people of Montana for the expansion of the welfare state is a burden we cannot afford.

The Medi•Choice Plan

- Renewable, portable and tax deductible health insurance
- Progressive State Health Credits
- Medical Savings Accounts (MSA)
- Simplification through standardized insurance billing and claims clearinghouses
- Expanded benefits for the current Comprehensive Health Plan for high-risk individuals
- Clearinghouse of price information for insurance, hospitalization and doctor fees

1. Insurance: All health insurance should be renewable and portable. Medi•Choice would eliminate "job lock" and guarantee uninterrupted access to health insurance for all Montanans. The same renewability and portability would be extended to dependents.

With Medi•Choice, insurance premiums would be completely tax deductible for everyone.

Progressive Health Credits would be available to those who:

- don't qualify for Medicaid
- are too poor to finance their own health insurance
- have expenses too high to pay.

To supplement the individual's own funds, the state would subsidize them with a voucher system or tax credit. This approach means health insurance for all *without* employer mandates, price controls, state rationing and forced health care alliances. Increased costs here would be offset partially by diminished cost shifting as more families acquire health insurance and health c oph ave .

2. Medical Savings Accounts: The cost of insurance and expenditures for routine medical needs would drop dramatically if insurance were used only for major medical expenses. Medi•Choice incorporates the establishment of tax-free savings accounts for routine expenses.

Current tax law permits employees to set aside income in a tax-exempt account to be used for medical expenses, but these funds must be used by the end of the year or forfeited. This "use it or lose it" feature increases demand for medical services and costs when we should be promoting savings and value. Medi•Choice would require changes to the tax code to allow these funds to roll over or would establish new tax codes to create medical savings accounts.

Most people who currently pay for health insurance could fund an MSA with the premium savings achieved by purchasing low-cost, high-deductible policies rather than the more expensive low-deductible policies. Those having high-deductible policies already would be able to fund an MSA from the savings of fully tax-deductible premiums. Those who are supported or supplemented by the state would achieve their accounts by channeling the state funding to their MSAs.

3. Simplification: Medi•Choice would simplify the management system and reduce costs through:

- standardized insurance billing
- electronic claims submission
- claims clearinghouse
- medical debit cards to draw on MSAs

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Ron Kunik

SUGGESTED AMENDMENTS TO
HB 466 SPONSOR, TOM NELSON
HB 531 SPONSOR, SCOTT ORR

AMEND 33-22-1811

(4) Add (C)

An insurer can elect not to insure a group if that group is already insured. However, the insurer must decline or accept the whole group that is currently insured.

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Pamela Vander Aarde MD
1006 1st Av. S.
Great Falls, MT 59403

Chairman Scott Orr,
House Select Committee on HealthCare
Capitol Building
Helena, MT 59620

Dear Chairman Orr,

I am writing to urge you and your committee to support HB 531. I feel that it is a well thought out piece of legislation that will make health insurance more available to Montanans making it possible for them to avoid financial ruin due to health problems while retaining their freedom of choice. I am in favor of renewable, portable health insurance which this bill requires. It seems to me that when one makes the choice to devote some of their resources to purchasing health insurance they should not loose that choice because their life or career circumstances later change. I also think that medical savings accounts are an excellent idea whose time has come. There are many self employed people in our state who would benefit from this provision. Medical savings accounts allow self-employed people to pay for medical expenses and health insurance premiums with pre-tax dollars just as people who work for employers are already able to do. Medical savings accounts create

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incentives to save rather than spend, to become informed consumers of health care and to engage in healthy lifestyles with an eye toward disease prevention. All of this reduces health care costs while maintaining freedom of choice. Finally, the bill provides for making price information from licensed providers, hospitals and health insurers available to consumers upon request. I realize that this may have a negative financial on me but I am willing to go along with it as part of the package. I urge your strong support of this bill in its entirety.

Sincerely,

Pamela J. VanderAarde MD

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HB-531 - Representative Scott Orr

February 14, 1995

Dean M. Randash - NAPA Auto Parts

I stand in complete support of HB-531. I thank the sponsor and authors for addressing true "Insurance Reform" in such an indiscriminate and just manor. Insurance reform of this magnitude and scope that addresses all these vital Areas of concern while respecting the integrity of life, the individual is profound.

Upon passage of this true "Insurance Reform" legislation I look forward to working with the employees of NAPA Auto Parts in building a "PEACE OF MIND" group health insurance program. The tools in this insurance tool kit, HB-531, will empower each and every employee to be able to attain affordable health insurance coverage for their families. The flexibility will be a tremendous incentive to accomplish increased family insurance coverage.

Please DO PASS HB-531

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Mad[am] Chairman

My statement is only this, I have personally created for myself and those for whom I am responsible for, for [health] insurance coverage, a Medical Savings Account.

Twelve years ago when Blue Cross raised my insurance rates to a point higher than I could pay, I was able to purchase coverage from another Co. ~~We chose a de~~ in spite of being diagnosed with a mitral valve. We chose a $1000 deductible plan. I knew I would be responsible to pay for all my minor medical expenses. I knew I had to have a way to cover that expense should the need arise. With great effort [at that time I was receiving $500 a mo.] I saved my deductible and continued saving until I had saved the co-insurance.

[from our small pensions to maintain my household of 6 children]

Over these 12 years this plan has worked very well.

I have with drawn from that account only to pay medical expenses - 2 times in 12 years -

I am here to say M.S.A - work - People can take care of themselves - We do not need government to pay our bills for us - For ultimately government's ability to pay is contingent upon the ability of you and I to pay enough premiums and taxes -

Health insurance is not a right belonging to everyone and paid for by government - I am not an insurance agent, nor a medical person - I am an individual ~~with a medical insurance does not cost $14,000 a year~~ - diagnosis that makes me uninsurable - My insurance does not cost $14,000 a year - If yours does, I suggest to look for and find the company I found -

I am a farmer and small Business person - ask me if the health care crisis is over and I will give a resounding "yes"! It never did start as some would have you believe -

Don't think for one minute the cost of premiums will go down with a single payer plan!

You have had statements from powerful organizations and companies - that would have you believe a single payer plan would give better coverage more efficiently - I believe the only way that would come together is to mandate coverage - when it is LAW to carry insurance, it is only another tax - It looks to me like taxes have gone up faster than insurance premiums -

I urge you to pass 531 and repeal SB285

777-3062 - Shirley Rasmussen
Stevensville Mt.

EXHIBIT 24
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1--Loss Ratio Guarantee option

Rates on a particular individual health insurance policy form shall be deemed reasonable in relation to the premium and shall be deemed approved upon filing with the Commissioner which meets the requirements of this act. Benefits shall continue to be deemed reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee. This loss ratio guarantee must be in writing, signed by an officer on the insurer, and must contain at least the following:

(A) A recitation of the anticipated loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved.

(B) A guarantee that the actual loss ratios in the State for the experience period in which the new rates take effect and for each experience period thereafter until new rates are filed shall meet or exceed the loss ratio standards referred to in subparagraph (A) above. I the annual earned premium volume in this State under the particular policy form is less than $1,000,000 and therefore not actuarially credible, the loss ration guarantees shall be based on the actual nationwide loss ration for the policy form. I the aggregate earned premium for all states is less than $1,000,000, the experience period shall be extended until the end of the calendar year in which $1,000,000 earned premium is attained.

(C) A guarantee that the actual loss ration results for the State (or national results, if applicable) for the experience period at issue shall be independently audited at the insurer's expense. This audit must be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Commissioner not later than June 30 following the date for filing the applicable Accident and Health Policy Experience Exhibit.

(D) A guarantee that if the actual loss ratio during an experience period is less than the anticipate loss ration for that period, then policy holders in this State shall receive a proportional refund based on premium earned. The total amount of the refund will be calculated by multiplying the anticipated loss ration by the applicable earned premium during the experience period and subtracting from that result the actual incurred claims during the experience period. I nationwide loss ratios are used, then the total amount refunded in this State shall equal the total refund, as calculated above, multiplied by the total earned premium during the experience period from all policyholders in this State who are eligible for refunds and divided by the total earned premium during that period in all states on the policy form.

The refund shall be made to all policyholders in this State who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal $10.00 or more. The refund will include interest, at the then-current accident and health reserve interest rate established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payment must be made during the third quarter of the year following the experience period for which a refund is determined to be due.

(E) A guarantee that refunds of less than $10.00 will be aggregated by the insurer and paid to the Insurance Department of this State.

(F) As used herein, the term "loss ratio" means the ratio of incurred claims to earned premium by the number of years of policy duration, for all combined durations.

(G) As used herein, the term "experience period" means, for any given rate filing for which a loss ratio guarantee is made, the period beginning of the first day of the calendar year during which the rates first take effect and ending on the last day of the calendar year during which the insurer earns $1,000,000 in premium on the form in question is this

State or, if the annual premium earned of the form is this State is less than $1,000,000 nationally. Successive experience periods shall be similarly determined beginning on the first day following the end of the preceding experience period.

(H) As used herein, the term "claims" means only those amounts paid, or to be paid, to satisfy policy benefits.

Severability clause

Repealer clause

Effective date

5--Modified Community Rating on Renewal option

Modified community rating option for rating of renewed policies: All individuals, regardless of their claims experience, geographical location, or occupation, shall receive the same renewal increase unless they have reached a new age plateau. If they have reached a new age plateau, then they will, in essence, receive two rate increases that year. For instance, claims losses for an insurer's individual plans require a 7% increase. All individuals on that plan would receive a 7% increase, plus, if they had reached an age increment (usually 5 years in the industry) of say their 30th birthday during the previous 12 months, they would also be given that age based incremental increase as well.

Explanation of Table 1. The dollar values in Table 1 are the actuarially determined "present value" of long term care. The numbers in the table are rounded; the actual figures fluctuate about $1,000 between the ages of 40-60, but those fluctuations are not reflected in the table. The values in the table mean the following. If at age 41 I had $14,300; that would be sufficient to purchase long term care insurance that would cover me the rest of my life. That purchase would take place in 10 consecutive, annual premium payments; resulting in permanent coverage for long term care. The update of values every 5 years is needed since the market will change in an unpredictable fashion. The cost of an actuarial update will be quite small. This determination which included other jobs for the actuary totaled $450.00.

Table 1[A]

Age (years)	**Dollars**-Cash in excess of this amount may be withdrawn tax free. The amount in this table may be invested in long term care annuities as well.
40 or younger	14,300
41-45	14,300
46-50	14,300
51-55	14,300
56-60	14,300
61-65	16,099
66-70	24,036
71-75	39,906
76 or older	68,510

[A] The amounts in this table shall be updated every 5 years to determine the present value of long term care premiums currently available in Montana; and assuming fund assets earn interest at 6% per year.

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Bill Copy Page Number	Bill Copy section, paragraph, line, etc.	Comment, question, or change.
2	paragraph "2"	Lines 10 & and 11 **SHOULD be changed** to allow experience rating and health status on renewal--It is just that such rate changes must then be distributed as per Section 4, paragraph 6-page 7 lines 25-29. **It would be easiest to strike line 10 (starting with the word "However") through line 12.**
3	paragraph "1" Lines 6-8.	To avoid being interpreted as guaranteed issue, **the following amendment or equivalent must be added: "If the insurer declines to issue coverage they must inform the individual declined of the Montana Comprehensive Health Association Plan".**
3	Basic Plan	Benefits package is negotiable, but decent coverage for catastrophic illness is not. Also abortion must not be mandated in the Basic plan or the Association plan.
5	line 5 item (xxiii)	"other than" should be change to "or"
6	Section 4, paragraph 2.	There is the potential to confuse this to mean that after 90 days all preexisting requirements are met. **The following amendment must be added: "A succeeding carrier, in applying any waiting periods in its plan shall give credit for the satisfaction or partial satisfaction under the prior plan of the time period applicable to a preexisting condition exclusion or limitation period with respect to particular services."**
6	Section 4, paragraph 2	Renewability is not negotiable. The 45 days is.
7	Section 4, paragraph 3-lines 2-4.	Negotiable, but must have similar rates for similar case characteristics.
7	Section 4, paragraph 4-lines 8-15.	Not negotiable.
7	Section 4, paragraph 5-lines 16-24.	Not negotiable except that the 150% may be lower.
7	Section 4, paragraph 6-lines 25-29.	Not negotiable other than opting for the # 1 or # 5 options at the beginning of this fax.
7-8	Section 4, paragraph 7.	Not negotiable except for adding additional reporting requirements.

Bill Copy Page Number	Bill Copy section, paragraph, line, etc.	Comment, question, or change.
8	Section 4, paragraph 8-lines 17-25.	**Negotiable, except that the exclusion period should at a minimum be the 3 year (non cancer) and the 5 year (cancer) we have talked about. You may eliminate the restriction on riders altogether (striking lines 17 through the phrase "due to a preexisting condition" on line 19, if that is useful--this would be the prefered position. The rational for leaving some limits on riders in the bill is purely political from my standpoint.**
9	Section 5, lines 7-9.	Negotiable
9	Section 6, lines 11-19.	Negotiable
10	Section 9.	Not negotiable.
11-12	Section 10	The minimum deductible may be increased. The approved purposes listed on page 12 lines 1-4 may be changed VERY reluctantly. Otherwise not negotiable.
11-12	Section 10 probably between paragraphs 7 and 8 of page 12.	**THE FOLLOWING MUST BE ADDED.** The details may vary, but if someone provides for their long term care then the excess in the MSA must be withdrawable tax free! Here is how the proposal language reads, Table 1 is listed at the beginning of this fax. **D. If the amount in the Medical Savings Account is sufficient to pay long-term care for an expected value of future costs, then the balance may be withdrawn tax free. The amounts necessary are listed in Table 1. If an individual has already paid for their long term care and if the amount in the account exceeds twice the deductible on their insurance, then they may withdraw the excess tax free. If an individual is in the process of paying for their long term care [ex: 5 years into their 10 annual payments] then any amount in excess of the funds needed to pay the remaining payments for long term care PLUS twice the deductible may be withdrawn tax free. MSA funds may be used to purchase long term care or long term care annuities as well.**
17	Section 15, lines 5-13	Not negotiable except that the premium cap may be less than 150%.

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Bill Copy Page Number	Bill Copy section, paragraph, line, etc.	Comment, question, or change.
17	Section 15, line 10, page 17	What is the significance of the word "five" being struck? Why is the original language changed here? I think we prefer the original average as currently listed in the Association plan.
20	Section 16,	Benefits package is negotiable, but decent coverage for catastrophic illness is not. Also abortion must not be mandated in the Basic plan or the Association plan.
20	Section 16, line 14, page 20"	This should be the same as Section 3: page 4, line 26 and page 6, line-6.
21	Section 18	Not negotiable except that **we should amend so that**: 1-if physicians have different fee schedules for different groups then anyone may have access to each or all schedules; 2-if hospitals charge differing amounts to different groups, then those charges should be available also.

Proposed MMA amendments and our position.

Page	Section, line, etc.	Proposed amendment by MMA	We support=yes; We oppose=no.
3	Section 3, line 17 and 18	This indicates a mandatory deductible "not less than 1,000". This is inconsistent with the association plan on page 17 lines 21 and 22. The MMA would like the same provision for each plan.	Yes we would support and would like it to read however the current law does-I cannot find that in my copy of the association plan. They specify a $1,000 deductible, but do not characterize it as either a minimum or maximum.
4	(viii), line 3	Include land or air subject to insurers utilization review	yes
5	(xxii), line 3	MMA wants to propose language to clarify "convalescent home"	yes
5	(xxiii), linee 5-7	Include land or air subject to insurers utilization review	yes
5	(H)	spell out TMJ, Temporomandibular Joint Syndrome	yes
5	(C), line 27	Include land or air subject to insurers utilization review	yes
6	(j), line 8	MMA wishes to strike this line, but they may ask someone else to bring it up.	NO-we oppose.
8	lines 17-20	MMA just wants a consistent definition here and on page 3, line 4.	Don't we all! We support a consistent definition as per earlier discussions.
9	line 2.	MMA want to strike out "an insured group health plan"	We probably agree, but I am not sure who this phrase refers to.
11	Section 10, line 16.	"a $1,000 deductible and may deduct"---should be changed to---"a $1,000 deductible and may ~~deduct~~ exclude"	yes-this is more consistent language.
12 **IMPORTANT**	(7), line 5	"eligible medical expenses, for the"---should be changed to---"eligible medical expenses, ~~for~~ or the"	yes

Proposed MMA amendments and our position.			
Page	Section, line, etc.	Proposed amendment by MMA	We support=yes; We oppose=no.
17	Section 16, lines 21-22	This indicates a mandatory deductible "that does not exceed 1,000". This is inconsistent with the Basic plan on page 3 lines 17 and 18. The MMA would like the same provision for each plan.	Yes we would support, and would like it to read however the current law does--I cannot find that in my copy of the association plan. They specify a $1,000 deductible, but do not characterize it as either a minimum or maximum.
18	(h), line 6	Include land or air subject to insurers utilization review	yes
19	(w), line 8	Include land or air subject to insurers utilization review	yes
19	(viii), line 20	spell out TMJ, Temporomandibular Joint Syndrome	yes
20	line 2, (iii)	Include land or air subject to insurers utilization review	yes

EXHIBIT 24
DATE 2-14-95
HB 531

EXHIBIT 25
DATE Feb. 14, 1995
HB 531

To: House Select Committee on Health Care

From: Mona Jamison, Lobbyist
Montana Speech, Language, and Hearing Association
Montana Dietetic Association

RE: Proposed Amendments to HB 531

1. page 5, line 4
Following: "year;"
Delete: "and"

2. page 5, line 7
Following: "department"
Delete: "."
Insert: ";"

3. page 5, line 7
Following: line 7

Insert: "(xxiv) services of a speech pathologist and audiologist covered under a case management plan of care as directed by a referring physician; and

(xxv) medically necessary medical nutrition services covered under a case management plan of care as directed by a referring physician, including assessment and counseling for the following conditions: diabetes melitus, renal disease, high risk pregnancies, malnutrition, high risk pediatrics, cardiovascular disease, cancer, gastrointestinal disease, and eating disorders."

4. page 19, line 7
Following: "year;"
Delete: "and"

5. page 19, line 9
Following: "department"
Delete: "."
Insert: ";"

6. repeat amendment 3. above and number accordingly

EXHIBIT 26
DATE Feb. 14, 1995
HB 531

Testimony by the Montana Hospital Association before the House Select Committee on Health Care HB 531

My name is John W. Flink. I am vice president of the Montana Hospital Association. The Montana Hospital Association represents 55 hospitals and Medical Assistance Facilities. Forty-five of these also have long-term care facilities.

MHA has one major concern about HB 531: Section 18. Section 18 would require a hospital upon request to "furnish in writing the hospital's current charge for each health care service" it provides.

Hospitals recognize that consumers need to make informed choices about their health care and that they need to assume greater responsibility for the health care services they purchase. But Section 18 is not the way to promote these goals.

We applaud the sponsor for their desire to promote consumer responsibility

First, this requirement would add to hospital's costs. — without providing any mechanism for reimbursement.

Second, information about how much a hospital charges is usually not relevant. For seniors on Medicare, the payment rate is fixed by the federal government—regardless of what a hospital charges. SRS sets the payment schedule for Medicaid beneficiaries.

Charge information is also not relevant for patients covered under a managed care plan, because their plan usually negotiates the price with providers.

In addition, the total cost of receiving medical treatment is affected by several intangibles. For example, a hospital's "room rate" is usually only a small part of the cost for obtaining medical treatment in a hospital. Severity of the illness, a physician's practice patterns, other medical conditions, and the intensity of treatment all affect overall cost.

For these reasons, we urge the committee to reject HB 531.

EXHIBIT 28 Part A
DATE Feb. 14, 1995
HB 466

HOUSE BILL 466

Mr. Chairman, Members of the Committee:

My name is Greg Van Horssen. I represent State Farm Insurance Companies in Montana.

State Farm supports Representative Nelson's House Bill 466 with some amendments that I will be discussing.

State Farm is a mutual company which means that it is a company owned by its policyholders. As such, State Farm's primary responsibility is to its policyholders and I am hopeful that the proposed amendments will address those interests.

State Farm has testified before this committee on previous occasions regarding health issues. As I have previously stated, relative to some of the other proponents to this bill, State Farm is a small player in the group health market.

State Farm offers both group health and individual health products to Montanans, primarily as an accommodation.

Nonetheless, as the small employer health insurance program has developed, State Farm has become concerned about potential shortfalls in the program and the funding source for those shortfalls.

Under the current small employer program, any shortfalls are made up by all carriers of health insurance in Montana, even those insurers who do not participate in the small employer health insurance program.

These amendments do two things, first they amend Section 33-22-1819, MCA by requiring that the program be reviewed annually to ensure that the program is actuarially sound. In other words,

the program must be reviewed to make sure that the premiums are adequate to cover projected losses.

The second amendment simply provides that, for individual carriers who are assessed to make up shortfalls, those carriers are assured a cap of 5% of their profits.

State Farm believes that these amendments will strengthen the health insurance market in Montana by allowing a health insurer the ability to forecast potential exposure for any shortfalls in the small employer health program. With these amendments, State Farm supports Representative Nelson's House Bill 466.

Thank you.

STATE FARM INSURANCE COMPANIES
PROPOSED AMENDMENTS TO HOUSE BILL 466
INTRODUCED COPY

EXHIBIT 28 Part B
DATE Feb. 14, 1995
HB 466

1. Page 14, line 27
Create new Section 7 as follows:

NEW SECTION. Section 7. Section 33-22-1819, MCA, is amended to read:

33-22-1819. Program plan of operation — treatment of losses — exemption from taxation. (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(4) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the

EXHIBIT 28 B
DATE 2-14-95
HB 466

state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(6) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (6).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (6).

(c) The board ~~periodically~~ annually shall review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(7) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

(8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(d) Each assessable carrier whose assessment will be based upon individual health benefit plan premiums shall not be subject to an assessment in excess of five percent of underwriting profit in those individual lines.

(9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(10) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(11) The program is exempt from taxation.

(12) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation.

EXHIBIT 28 B
DATE 2-14-95
HB 466

2. Page 14, line 27.
Renumber remaining sections

EXHIBIT 29
DATE Feb. 14, 1995
HB 466

To: House Select Committee on Health Care

From: Mona Jamison, Lobbyist for
Montana Speech, Language, and Hearing Association
Montana Dietetic Association

RE: Proposed Amendments to HB 466

Date: February 14, 1995

1. page 14, line 11
Following: "diabetics"
Delete: "."
Insert: "; and

(v) services of a speech pathologist and audiologist covered under a case management plan of care as directed by a referring physician; and

(w) medically necessary medical nutrition services covered under a case management plan of care as directed by a referring physician, including assessment and counseling for the following conditions: diagetes melitus, renal disease, high risk pregnancies, malnutrition, high risk pedicatrics, cardiovascular diseae, cancer, gastrointestinal disease, and eating disorders."

EXHIBIT 30
DATE Feb. 14, 1995
HB 466

February 10, 1995

Ed Grogan
Pres. & C.E.O
The Montana Medical Benefit Plan
Kalispell, Mt.

Representative Tom Nelson
The House Select Committee on Health
Capitol Station, Helena

Subject: Recommended amendments to HB 466

Dear Representative Nelson:

Next week you will be presenting HB 466 amending THE AMENDMENT. Although we still believe that repeal of the amendment is the best thing for the small business people of Montana, we will support HB 466 and recommend the following amendments:

1. Pg. 6 Item 1c line 8 after "code." insert "However, individuals that choose to have payroll reduction under sections 106, 125, or 162 can do so if the employer does not contribute any premium dollars to their health benefits plan".

2. New section 9: Grace period for insurers (Present section 9 to become section 10.) "Within 30 days of the passage of this bill, the commissioner of insurance must notify all Insurers who have previously withdrawn from the small employer health reform act that they shall be given 180 days from the date of passage of this bill to re-enter the market if they choose to do so".

3. Pg. 14 line 29 delete "3" insert "2".

4. Pg.15 section 9 becomes section 10 Section 10 becomes section 11 section 11 becomes section 12.

Furthermore, we would suggest the following:

We believe there should be a grandfather clause that would allow small businesses that provided insurance for their employees prior to Dec. 7, 1994 to not have to participate in guaranteed issue if choose not to.

We believe there should be a "cap" on the amount to be assessed against the assessable carrier.

We believe that the reinsurance form of spreading the risk (sections 33-22-1818 through 1820) should be repealed and replaced with the Montana Comprehensive Health Association Plan. This would spread the risk to all insurers doing business in Montana whether or not they were participating in the small group marketplace. All health benefit providers including third party administrators and

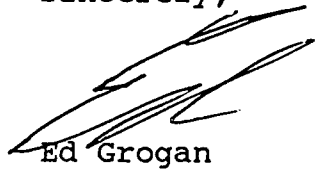
re-insurance companies should be made a part of the assessment needed to keep the MCHA solvent. From an employers perspective, he would be looking at a rate increase only on his high risk employees, and that rate increase would be no more than 50% over his insurers individual plan.

We believe "Class of Business" is poorly defined in 33-22 part 18. We would like to see the commissioners office or the NAIC give us a clear definition of what "Class of Business" means.

We believe that true portability should be part of this plan. True portability, in our estimation, means you can take it with you.

And last, but most important, we would point out to you that the only guarantee in guaranteed issue is that sooner or later, the price will go up for every employee that is affected by "THE AMENDMENT". In spite of what some of our competitors have said, they will still underwrite each group and even though they have stated that their rates are not going up or going up only 4%, we believe that this is their "bottom line" rate. Many small groups will get rates on each and every employee that will be as much as 67% higher than their "Bottom Line" rate!

Sincerely,



Ed Grogan
Pres. & C.E.O.

EXHIBIT 31
DATE Feb. 14, 1995
HB 466

COUNTY OF HILL

STATE OF MONTANA
Havre, Montana 59501

Lloyd Wolery, **Chairman**
Nora Nelson, **Commissioner**
Kathy Bessette, **Commissioner**
[406]265-5481 Ext. 27

February 13, 1995

Scott Orr, Chairman
The Select Committe on Health Care
House of Representatives
Capitol Station
Helena, Montana 59620

Dear Chairman Orr:

We the Hill County Commissioners strongly object to some of the language in HB-466, namely the wording under 33-22-1803(3), MCA, assessable carrier, which includes rather than excludes, state group benefit plans. Hill County instituted a "self-funded" insurance plan over 10 years ago which saved the taxpayers a lot over that period. Our plan was adopted because it provided an outstanding alternative to a commercial plan.

Why would you want to require a political sub-division to contribute to the costs of other plans re-insurance? Our self-funded plan has it's own re-insurance.

This legislation is a very real threat to our ability to continue our self funded benefit plan.

Sincerely,

Lloyd Wolery, Chairman

Nora Nelson, Commissioner

Kathy Bessette, Commissioner

EXHIBIT 31
DATE Feb. 14, 1995
HB 466

BLAINE COUNTY

Chinook, Montana 59523

TO: Representative Orr and Committee Members of the Select Committee on Health Care

As president of the Montana Joint Powers Trust, a self-funded insurance group, I would like to ask you to exclude political subdivision self insured groups from HB 466 or vote against it for the following reasons:

1) not to amend HB 466 to include any self-funded disability insurance plan provided by a political subdivision of the state in regards to the definition of "assessable carrier".

2) We are not profit motivated insurance companies competing in the market place so why make self-funded plans subject to legislation requiring commercial insurance companies to offer various products.

3) By increasing our regulations it will only increase costs or decrease benefits.

4) We reinsure our own plans, so why require political subdivisions to contribute to costs of ther plan's reinsurance.

5) Responsible drafting of legislation, clearly describing who is and is not subject to such legislation is essential.

In closing, I would urge you to exclude political subdivision self-insured groups from this bill or vote against it.

Thank you.

Arthur Kleinjan

Arthur Kleinjan, Chairman
Montana Joint Powers Trust

EXHIBIT 32
DATE Feb. 14, 1995
HB 466

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

MARC RACICOT, GOVERNOR

MITCHELL BUILDING, ROOM 130
PO BOX 200127

STATE OF MONTANA

(406) 444-3871

HELENA, MONTANA 59620-0127

Testimony on House Bill 466
In Opposition to the Redefinition of "Assessable Carrier"

Mr. Chairman, members of the Committee I am Joyce Brown Chief of the Employee Benefits Bureau within the Department of Administration. The Department of Administration's concern is limited to the expansion of the definition of "assessable carrier. This expansion allows the State employee benefit plan, the University System employee benefit plan and other public sector self-insured employee benefit plans to be assessed, or taxed, to cover any losses of the Small Employer Health Reinsurance Program.

You have heard testimony by the Insurance Commissioner's office and the Montana Small Employer Health Reinsurance Board that the reinsurance program is designed to allow insurers in the small employer market to limit their risks for individuals with health problems by reinsuring them. This mechanism is provided because insurers in the small employer market must now cover individuals with poor health status due to guarantee issue requirements.

You have also heard testimony that reinsurance program losses are expected to be minimal or nonexistent because: (1) premiums established for reinsurance will be adequate to cover costs and (2) utilization of similar reinsurance programs in other states has been relatively small. The fact that this is the third attempt to make public sector self-insured employee health plans liable for reinsurance program losses suggest that losses are anticipated.

If losses are anticipated, public sector self-insured employee benefit plans are an inappropriate source of revenue both for reasons of equity and public policy.

EQUITY ISSUES:

1. The State employee plan and, I expect, other public sector plans that are large enough to self-insured provide guarantee issue, portability and group rates to their particular segment of the insurance market. We cover high risk individuals in our segment of the employee insurance market and bear the costs of doing so. It seems only equitable that the costs of covering high risk individuals in the small employer segment of the market should be born by insurers in that market and insurers who profit from avoiding high risk individuals in the larger employer market.

2. The bill allows public sector employee plans to be assessed to fund a program they cannot participate in. These plans are not able to have their high risk plan members reinsured through the reinsurance program.

3. Private sector self insured employee benefit plans are not specified as assessable carriers because of their ERISA exemption. Assessing only public sector self-insured plans treats them differently from their private sector counterparts.

PUBLIC POLICY ISSUE:

4. The reinsurance program has been billed as an industry supported program that requires no public funds. Public self-insured employee benefit plans are funded primarily by public funds and assessing them creates a hidden tax.

EXHIBIT 33
DATE Feb. 14, 1995
HB 466

HB-466 - *Representative Thomas Nelson*
February 14, 1995
Dean M. Randash - NAPA Auto Parts

HB-466 makes definite improvements to the "Small Business Insurance Availability Act." Representative Nelson is to be commended for the elimination of abortion on demand in any plan. He also improved the act substantially by establishing specifically itemized benefits for the Basic and Standard Plan.

The remaining shortcoming of HB-466 is that it does not address the deceptive discrimination that an employee or the employer can not purchase specific health insurance policies available to other employees in our society. The fact is that the insurance agent is ordered under a penalty of law to restrict the sale of "Underwritten Health Insurance Policies" from the 3 to 25 employee groups. The agent can only offer to sell a government mandated "Guaranteed Issue" insurance policy in the price range between the standard and basic plan.

No other employee groups or business classes are included in the government ordered restriction of "Underwritten" health insurance. It further discriminates by mandating that only the employees and employers that are currently purchasing health insurance in this price range are restricted. Those individuals or groups that are able to afford a premium that is more expensive than the standard plan are absolutely free to purchase "Underwritten Policies"

38.4% of employers pay some portion of the health insurance premium. The inverse is that the employees pay the remaining part of the policy. Regardless of the official ownership of the policy the contribution of each employee to the premium gives the employee a right of personal individual ownership. For the state of Montana through legislative mandate to restrict the sale of a legal insurance product to this group of individuals in the advancement of the political agenda of "Guaranteed Issue" is unconscionable if not unconstitutional.

One argument that is put forth in the support of the continuation of this discriminating practice is that the state and other large health insurance groups already have in place "Guaranteed Issue" health insurance. Supposedly this incremental step further advances insurance reforms and puts small business on an even keel. This would be true but a fact that flies in the face of this is that the "Guaranteed Issue" provision of those policies is an agreed upon provision by all parties. "Guaranteed Issue" has not been imposed on those contracting parties by government legislated restrictions of what insurance products they cannot purchase like it has been imposed on the 3 to 25 employee group.

Montana wage earners who by circumstance are employed in the 3 to 25 employee group are being discriminated against and denied the right to purchase a legal insurance product that is available to all other Montana citizens that of underwritten health insurance. We as individuals in partnership with our employers demand that it is our right to exercise our free will in make purchasing decisions free from government laws that restrict our freedom and are discriminator.

I and thousands of hard working wage earners of Montana are outraged at this treatment. We are being discriminately forced by deceptive and coercive means to finance the political agenda of "Guaranteed Issue". This places our present health insurance at the risk of being unaffordable and jeopardizes the security of our families.

"GOVT. IS PLAYING POLITICS WITH THE ECONOMICS OF OUR HEALTH INSURANCE"

"GUARANTEED ISSUE" in the 3 to 25 employee group only is not "INSURANCE REFORM"

The true "INSURANCE REFORM" sections in this act are:

33-22-1808 - **Establishment of classes of business.**
33-22-1809 - **Restrictions relating to premium rates.**
33-22-1810 - **Renewability of coverage.**
33-22-1813 - **Standards to ensure fair marketing**.

These are provisions that will afford true beneficial insurance reform. These along with "Portability" are the corner stone of meaningful "INSURANCE REFORM." These provisions need to be applied indiscriminately regardless of the number of employees.

"GUARANTEED ISSUE" in the 3 to 25 employee group only is not "INSURANCE REFORM."

Please "DO NOT PASS HB-466"
Please Pass HB-155 amended to repeal only sections : 33-22-1804, 1811, 1812, 1818, 1819, 1821(Guaranteed Issue Sections).

EXHIBIT 34
DATE Feb. 14, 1995
HB 533

House Bill 533
Amendments
Presented By Blue Cross and Blue Shield of Montana
February 14, 1995

Page 1

1. Line 13
   Following: ":"
   Insert: " (1) "Block of business" means an individual disability insurance policy certificate or contract product type written and sold to a defined set of individuals by a health care insurer.All individuals covered by that type of policy or contract are considered within that block of business."

2. Line 14
   Following: "means a"
   Delete: "health care insurer as defined in 33-22-125."
   Insert: "disability insurer, a health service corporation, or a health maintenance organization."

3. Line 27
   Following: "provided under the"
   Delete: "standard health benefit plan referred to in 33-22-1811 and 33-22-1812"
   Insert: "plan being applied for"

4. Line 30
   Following: "benefit society"
   Insert: "that provides benefits similar to or exceeding the plan being applied for"

Page 2

5. Line 14
   Following: "distributed proportionately"
   Delete: "by premium amount to all the policy, certificate and contract holders of that insurer in the state."
   Insert: "across the block of business."

Page 3

6. Line 13
   Following "."

Insert: **NEW SECTION. Section 5. Applicability.** (This act) applies to a policy, certificate, or contract of disability insurance and health service membership contract entered into or renewed on or after (the effective date of this act).

7. Line 14
Following "Section"
Delete "5"
Insert: "6"

8. Line 14
Following "1"
Delete " and 2"
Insert ", 2 and 5"

9. Line 18
Insert **NEW SECTION. Section 6. Effective Date.** This act is effective January 1, 1996.

-END-

EXHIBIT 35
DATE Feb. 14, 1995
HB 533

HB-533 - Representative Peggy Arnott

February 14, 1995

Dean M. Randash - NAPA Auto Parts

I stand in support of HB-533. This bill address true "Insurance Reform" concerning "Portability" in a indiscriminate and just manor. It is very much needed and welcomed. Please pass HB-533.

EXHIBIT 36
DATE Feb. 14, 1995
HB 511

Testimony by the
Montana Hospital Association
before the
House Select Committee on Health Care
on HB 511

My name is John Flink. I am vice president of the Montana Hospital Association.
The Montana Hospital Association represents 55 hospitals and Medical Assistance Facilities. Forty-five of these also have long-term care facilities.

The Montana Hospital Association supports this bill because we believe it represents the best vehicle available for keeping alive our effort to reform the health care system.

Two years ago, the Legislature acknowledged that serious problems afflict our state's health care system. In enacting SB 285, the Legislature affirmed that

every Montanan should have access to affordable and high-quality health care services.

MHA strongly supports these principles. We strongly supported passage of SB 285, and we have supported the work of the Health Care Authority over the past 18 months. And, although, MHA doesn't agree with every proposal put forth by the Authority, we believe this process must move forward.

The problems that led to enactment of SB 285 have not gone away. In fact, they have worsened.

Continued cuts in the Medicare and Medicaid program have forced hospitals and other providers to shift more of their costs to privately-insured patients, forcing increases in the health insurance premiums paid by Montana's employers and employees. With more Medicare and Medicaid cuts on the way, this cost-shifting will only grow worse.

EXHIBIT 36
DATE 2-14-95
HB 511

In addition, studies show that the number of uninsured persons continues to rise, fueling further increases in health insurance premiums.

In our view, we must begin to address these problems now. The Authority's analysis and study is an appropriate starting point for the Health Care Advisory Council envisioned by HB 511. We hope that in enacting this measure, the Legislature will reaffirm its support for the principles it endorsed two years ago.

Finally, MHA would like to request that the Committee reinstate the anti-trust reforms enacted in SB 285. We appreciate Rep. Johnson willingness to work w/ us on this.

These reforms were designed to enable hospitals to collaborate with each other—without running afoul of federal anti-trust laws.

Collaboration is an important tool in our effort to control health care costs. In health care—unlike the rest of the economy—competition seems to lead to higher—not lower—costs. By working together—by sharing equipment, services, personnel and programs—hospitals can cut their costs.

We are seeing the beginnings of this kind of collaboration all over the state. Hospitals in the far eastern section of the state have operated as a network for some time. The 10 hospitals in northwest Montana are now in the process of establishing a network, and those in the golden triangle will soon begin a similar process.

In Missoula, hospitals have a long record of collaboration. And, of course, the two hospitals in Great Falls are proposing a merger.

These efforts just scratch the surface. They will add up to significant efficiencies in the health care

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HB 511

system, but even more savings will come with the development of fully coordinated systems of care.

Up to now, the threat of federal anti-trust action has been a barrier to many collaborative efforts.

The Certificate of Public Advantage process established in SB 285 helps to ease this fear. We believe this process should be retained and expanded to cover hospital consolidations. Moreover, in the future, this process should probably be expanded to include integrated delivery systems.

Thank you.

NAME Polly Walker

ADDRESS 609 5th Ave E Polson MT 59860

HOME PHONE 406-883-3594 WORK PHONE ——

REPRESENTING MSCA + Legacy Legislature

APPEARING ON WHICH PROPOSAL? HB 548

DO YOU: SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

See written testimony in in-Box
Joy Campbell #548 For
Norma Kelliher #548

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

NAME Madelyn Cameron

ADDRESS 3017 3rd ave. So.

HOME PHONE 453-5792 WORK PHONE —

REPRESENTING MSCA

APPEARING ON WHICH PROPOSAL? HB 548

DO YOU: SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS:

Written testimony in bop

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

NAME Lois Howe

ADDRESS 416 Westview Drive

HOME PHONE 543-5505 WORK PHONE _____

REPRESENTING MT League of Women Voters

APPEARING ON WHICH PROPOSAL? Single Payer Health Security

DO YOU: SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

See written testimony in box

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

NAME Bruce Rukstad

ADDRESS 2645 Goodman

HOME PHONE 652-4098 WORK PHONE 657-5242

REPRESENTING OCAW

APPEARING ON WHICH PROPOSAL? Single Payer (IC1092)

DO YOU: SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 531

DATE 2/14/5 SPONSOR(S) Rep. Orr

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
John H. [illegible] 68 Wagon Lake G.F.	Self	531		X
Gon Kamt	Self	531		X
Mona Jamison	Mt. Dietetic Assoc. Mt. Speech, Lang. + Hearing Assn.	531	✓	
Richard Tappe	MT Right To Life Assn	531		X
Raymond Gowen	Self	531		✓
John Flink	MT Hospital Ass'n.	531	✓	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS INDEP INSURANCE AGENTS OF MT	531	✓	
Mary McCue	Mt Clinical Mental Health Counselors Assn	531	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 531

DATE 2/14/95 SPONSOR(S) Rep. Orr
Rep. Nelson (HB 466)
Rep. Arnott (HB 533)
Rep. Carey (HB 548)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
JOHN VANDENBERG	SELF	531		X
Dean Roberts	NAPA auto Part	531		X
Dean Roberts	" "	466	X	
Dean Roberts	" "	533		X
Tanya Ask	Blue Cross + Blue Shield	531	X	
David Hunter	Mental Health Assoc.	531	X	
LARRY AILEY	MT ASSOC OF LIFE UNDERWRITERS	531	✓	
Paul Gorsuch	Project HEAR	531		✓
REWynia	SELF	531		X
JANET ROBIDEAU	MPA/MCLA	548 ~~531~~		X
Mike Schweitzer	Billings Anesthesiology	531		X
Kate Cholewa	MT Womens Lobby	531	X	
TOM BILODEAU	MEA	531	X	

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Arlette Randash	Eagle Forum		X
Laurie Koutnik	CC of MT		X
Tom Hopgood	HIAA	531	X

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm Health Care COMMITTEE BILL NO. HB531

DATE 2/14/95 SPONSOR(S) Rep Orr

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NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
John Memberhof Great Falls	Self	538		X
Jeanne Garcia Great Falls	self	531		X
James Bull Great Falls	self	531		X
Ron Coleman Great Falls	Self	531		X
Paul B. Comer Great Falls	Self	531		X
Kathy McGowan	MCMHC	531	X	
James Hinshaw MD Great Falls	self	531		X
Raymond Fowler M.D.	Self	531		X
Jerome Loendorf	[illegible] OSSA	531		✓
Ed Grogan	MMBP	531		✓
David Owen	MT Chamber			X
Wm. Peter Horst	Self	531		X
Robert L. Hunter Billings	self	531		X

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Susan Good Healthcare MT support

Don Allen MMBP Support

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 533

DATE 2/14/95 SPONSOR(S) Rep. Arnott

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Tanya Ask	Blue Cross Blue Shield			✓ as amended
LARRY AKEY	INT ASSOC OF LIFE UNDERWRITERS	533		✓
Ron Kunik	SELF			
Paul Gorsog, 4	Project Heal	533		✓
Mike Schweitzer	Billings Anesthesiology	533		✓
Riley Johnson	NFIB	533		✓
Steve Turkiewicz	MADA Ins Trust	533		✓
Kent Mersveis	Self	533		✓
Steve Ley	MT Soc. Anesthesiologists	533		✓
Beverly Stone	Project Heal	533		
Ron Ullman	Project Heal	533	✓	
Bill Olson	AARP	533		✓
Claudia Clifford	State Auditor's office	533		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 533

DATE 2/14/95 SPONSOR(S) Rep. Arnott

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Tom Hopgood	HIAA	533		✓
Don Allen	MMBP	533		✓
Ed Graham	MMBP	533		✓
Mike Craig	Health Care Auth	533		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB548

DATE 2/14/5 SPONSOR(S) Rep. Bill Carey

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

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Mike Schweitzer	Billings Anesthesiology	548	~	
Terry Minow	MFT/MFSE	548		X
Elsie Fraser	self	348		✓
Tom Bilodeau	MEA	548		X
Ed [illegible]	MABP		X	
Riley Johnson	NFIB	548	X	
David Owen	MT Chamber		X	
Robert White	Boz Chamber		X	
Arlette Randash	Eagle Forum		X	
Laurie Koutnik	CC of MT		X	
Raymond Bowers	Self		✓	

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Single payer Bill

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 548

DATE 2/14/95 SPONSOR(S) Rep. Bill Carey

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Madelyn Cameron	MSCA			✓
Eunice Eckhart	MSCA			✓
Elmer Jaeth	MSCA			✓
Gene B. Hunter	MSCA			✓
Don Judge	MT STATE AFL-CIO			✓
LEROY KEILMAN	MSCA			✓
RUBY "	"			✓
Bill Chigbrow	MSCA			✓
Phil Paul	MSCA			✓
Alice Campbell	MCNHR			✓
Doug Campbell	MSCA			✓
[illegible]	MSCA			✓
Ena Christianson	Legacy Legislature			✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 466

DATE 2/14/95 SPONSOR(S) Rep. Nelson

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Jerome Loendorf	Am. Med Assn	466		✓
Mona Jamison	Mt Speech Lang + Hearing Assn Mt Dietetic Assn	466	✓	✓ with amendments
Susan Good	Heal MT	466		✓
Claudia Clifford	MT State Auditor's	466		✓
Sam Hubbard	MT Health Care Auth.	466		✓
Tom Ebzery	Yellowstone Comm Health Plan	466		✓
John Flink	MT Hosp. Assn.	466		✓
Tom Hopgood	HIAA	466	&	✓
Joy Smith	HD 56	466	✓	
Don Allen	MMBP	466		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 466

DATE 2/14/95 SPONSOR(S) Rep. Nelson

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Ed Grosfield P.O. Box 548 Kalispell	MBAD			✓
Ron Kunik 2511 MT 35 Kalispell	Self			✓
Rick Larson	FBMS	466	✓	
Vern Petersen		466	✓	
Riley Johnson	NFIB	466	~~✓~~	✓
Jayne Brown	Dept of Admin.	466	X	
Margaret				
Tanya ABC	Blue Cross & Blue Shield			✓
Kathy McGowan	MCMHC			✓
SHARON HOFF	MT CATH CONF	466		X
DAVID HEMION	Mental Health Assoc.	466		✓
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS & IIAM	466		✓
Robert White	Bozeman Chamber	466		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Sel. Comm. on Health Care COMMITTEE BILL NO. HB 511, HB466

DATE 2/14/95 SPONSOR(S) Rep. Royal Johnson (HB 511)
Rep. Thomas Nelson (HB 466)

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

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Scott ASAY Bldg	FBMS	466	Y	
SHARON HOFF	MT CATHOLIC CONFERENCE	511	X	
Ron Kunik	S&L	511	~~X~~	Support
Billy Lee Cypress	MSCA			X
Jason Hall	Health Net	511		X
John Fleiss	MHA	511		✓
Tom Ebzery	Saint Vincent Hosp + Health			✓
Don Allen	MMBP	511		✓
Alex Davic	Columbus Hosp. & H	511		✓
Chuck Butler	Blue Cross and Blue Shield of Montana	511		✓
Ed Corrigan	MMSO			✓
Mike Craig	Health Care Auth	511		

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 548

DATE 2/14/95 SPONSOR(S) Rep. Carey

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Margaret Anderson	M.S.C.A	548		✓
LLOYD ANDERSON	( )	548		✓
Mary H. Powers	MCCA	548		✓
Colleen Hoarty	MSCA	548		✓
Harry W Clowes	MSCA	548		✓
Dorothy A. Kenney	MSCA	548		✓
Roger L. Kenney	MBCS	548		-
Jeanette Hamby	Self	548		
Lloyd Warnke	Self	548		
Dan C. Edwards	OCDWIU	548		✓
E Caplis	MUHC			
P. Gorsuch	Project HEAL	548	✓	
Kate Cholewa	MT Nurses Lobby	548		✓

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Tom Hoos HHH 548 ✓

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select. Comm. on Health Care COMMITTEE BILL NO. HB 548

DATE 2/14/95 SPONSOR(S) Rep. Carey

Single Payer System

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
MARIA HEBLSTEIN	MSCA	548		✓
Margaret Henry	Legacy Legislature MSCA	548		✓
Glenn Hove	MSCA	548		✓
Russell M Peterson	M.S.C.A.			
Elsie Lee	M.S.C.A.			✓
Barbara Carter	MSCA			✓
Samuel Lee	MSCA			✓
Willa Dale Evans	M.S.C.A.	548		✓
David Hewitt	Mental Health Assoc.			✓
Melissa Case	Montana Peoples Action	548		✓
R E Wyman	SECF	548	X	
Dave Smith	Partnership Health Center	548		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm. on Health Care COMMITTEE BILL NO. HB 531

DATE 2/14/95 SPONSOR(S) Rep. Orr

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Elisa Frazer	MTNARAL	531	X	
Jay McKeon	Self.	531		X
KENT MERSELIS	Self	531		X
R. JOHN HEETDERKS	BOZ - CLINIC + SELF	531		X
Angela Canning	Self	531		X
Steve Lay	Mt. Soc. Anesthesiologists	531		X
Allen Lanning	self			X
Shirley Rasmussen	individual	531		X
Cheryl Reichert	Medichoice			X
Cari Reichert	Medi-Choice			X
Chris Reichert	"			X
Pamela Vander Aarde MD	self	531		X
Beverly Stone	self	531		X

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