MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **CHAIRMAN DUANE GRIMES**, on February 15, 1995, at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Duane Grimes, Chairman (R)
Rep. John C. Bohlinger, Vice Chairman (Majority) (R)
Rep. Carolyn M. Squires, Vice Chairman (Minority) (D)
Rep. Chris Ahner (R)
Rep. Ellen Bergman (R)
Rep. Bill Carey (D)
Rep. Dick Green (R)
Rep. Antoinette R. Hagener (D)
Rep. Deb Kottel (D)
Rep. Bonnie Martinez (R)
Rep. Brad Molnar (R)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)
Rep. Susan L. Smith (R) (arrived late to the meeting)
Rep. Loren L. Soft (R)
Rep. Kenneth Wennemar (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Jacki Sherman, Committee Secretary

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

Committee Business Summary:

Hearing:	HB 507, 504, 539, 509, 532
Executive Action:	HB 507 TABLED
	HB 522 TABLED
	HB 532 TABLED
	HB 481 POSTPONED
	HB 385 DO PASS AS AMENDED
	HB 468 DO PASS
	HB 555 TABLED
	HB 153 TABLED
	HB 492 TABLED
	HB 504 DO PASS
	HB 539 DO PASS AS AMENDED
	HB 509 DO PASS AS AMENDED

{Tape: 1; Side: A; Approx. Counter: 000; Comments: n/a.}

HEARING ON HB 507

Opening Statement by Sponsor:

REP. JIM ELLIOTT, HD 72 Trout Creek, introduced HB 507. He said the bill dealt with an approach to make health care more affordable. It would require a health service corporation, such as Blue Cross/Blue Shield, to offer similar policies to those people moving to Montana who were under a previous policy. He discussed the reasons for bringing the bill before the Legislature. He explained that the insurance companies would not drop coverage simply because someone moved out of state. He noted the problems encountered even with COBRA after termination. The conversion with Blue Cross is the going rate for six months and then they may charge 150% of the top group rate. He pointed out that Blue Cross would argue that every Blue Cross organization is a separate entity. However, although this is true, the consumer sees Blue Cross as a nationwide network of health insurers. Most people that have this insurance expect that their policy is portable. Conversions are subject to waiting periods, pre-existing conditions, higher premiums or turn downs.

Proponents' Testimony:

Michael Downey, Helena, discussed his past health coverage with Blue Cross/Blue Shield and his past medical condition. **EXHIBIT 1** His health coverage paid for health problems until he returned from Vermont where he had finished graduate school. He pointed out that although Blue Cross as a provider is required to transfer coverage, the conversion policy they offered was inferior and exorbitantly expensive. The only other option was to apply as a new subscriber subject to exclusions on pre-existing conditions. The conversion policy is too expensive and the exclusions of pre-existing conditions make the policy worthless. Without insurance, he could possibly be forced to rely on services financed by the public because Blue Cross avoids their conversion obligations. He pointed out that the system is set up to exclude people who need coverage the most.

Opponents' Testimony:

Tanya Ask, Blue Cross/Blue Shield of Montana, testified in opposition to the bill. She pointed out that some of the problems were insurance-regulated at the state level. This regulation gives 50 different sets of rules under which insurance companies operate. Blue Cross/Blue Shield is a system, however it consists of 69 separate companies. Blue Cross/Blue Shield of Montana operates only in the state of Montana and complies with the laws of this state. Each state has a unique set of insurance

regulations. A number of states, including Vermont, have open enrollment.

She pointed out that in Montana there are a number of people that want the ability to individually underwrite risk. She said they are moving away from that in the small group marketplace, which is not the rule in the individual marketplace right now. What happens to a health service corporation in those instances, is that everyone comes in to open enrollment. There is a similar level of benefits in the state of Montana, which does not apply to commercial carriers such as AETNA. Additionally, she noted another item is that Blue Cross/Blue Shield is not the only health service corporation in the state of Montana, there is one other at the present time.

Insurance laws differ from state to state which have a tremendous impact on the way companies do business. They do medically underwrite on the individual market. Conversion contracts are made available and are more expensive than traditional coverage. Health service corporations are capped at 150 percent on conversion rates. Commercials must offer conversions but are not capped.

Ms. Ask pointed out some potential problems with the bill. The first, as the bill was written, is that it does not require that an application be made within 30 days, but rather 31 days after residency has been met. It is possible to have a lengthy break in coverage and the law would still apply. The second problem she pointed out is that similar coverage is not available. For example, an individual may move to Montana that has been covered under a group contract which varies significantly. Other states have a variety of extensive managed care networks available which is not offered in Montana.

Ed Grogan, Montana Medical Benefit Plan, Montana Medical Trust and the Montana Business and Health Alliance, spoke against the bill. He addressed the AETNA insurance and the portability issue. He said the Montana Medical Benefit Plan is the other health service corporation doing business in Montana. He said if this bill passed it would force them to take customers from other Blue Cross/Blue Shield companies in other states in which they have no affiliation.

Questions from Committee Members and Responses:

REP. BRUCE SIMON asked **Tanya Ask** about the purpose of disclosure of pre-existing conditions and if that was in place so the company did not have to pick up coverage for a year or was that there so someone doesn't wait until they have a pre-existing condition and then want coverage. **Ms. Ask** replied the reason for the exclusion is that insurance is for the purpose of buying a contract to cover losses that are unexpected. She pointed out a problem of portability with pre-existing waiting periods and a problem within the industry that is being attempted to correct

with health care reform. The problem that many people encounter when they remain continuously covered and they move from one contract to another or from one group to another and having to wait a pre-existing waiting period.

REP. SIMON asked why a person would have to go through re-qualification when they had been on a plan. **Ms. Ask** clarified the conversion plan for those moving into the state. Because individual insurance is medically underwritten there are two options: 1) they can be underwritten and then given a full range of products or 2) can be given a conversion contract which does not require any medical underwriting. It acknowledges that there is a health problem and it does offer that coverage.

REP. JOHN BOHLINGER asked about the nationwide status of Blue Cross/Blue Shield and their franchise agreements. **Ms. Ask** replied that Blue Cross/Blue Shield is an association. The name can be used as long as certain criteria is met. However, each company is a separate and distinct legal entity. One thing they do in unison is have the ability to transfer claims back and forth between plans, such as if someone were hospitalized in California, but has a plan in Montana. The association does not delineate the types of products to be sold so each plan develops their own types of products. The regulation of this product is different since it is regulated at the state level.

CHAIRMAN DUANE GRIMES asked if the issue of portability was studied by the Health Care Authority. **Ms. Ask** replied that this was part of the issue. A guaranteed issue is a policy that is issued, which is available now in the small group market, where a policy must be issued regardless of an individual's health condition. The second issue of portability of coverage and portability of the pre-existing waiting period is being addressed in **REP. PEGGY ARNOTT'S** bill. She said that there had been concern about the guaranteed issue which says any insurance company operating in the state of Montana must accept any individual regardless of health condition if they work for a small employer in this state.

Closing by the Sponsor:

REP. ELLIOTT closed on the bill. He explained that the insurance industry is the only major business not regulated by the federal government. It is regulated by the state. Because of that Blue Cross/Blue Shield has a better deal than nationwide companies because they can pick and choose amongst those people moving in and out of their market. He pointed out this bill would provide an incremental approach. Blue Cross/Blue Shield insures 48% of the covered insured in Montana. They have 36% of the small group market and 19,000 individual policies. He asked if they are on record as favoring portability in the group market, then why are they not in favor of portability and guaranteed issue in the entire market. He pointed out that Vermont has total portability

and guaranteed issue and a community rating which has proved to be successful.

{Tape: 1; Side: B; Approx. Counter: 000; Comments: n/a.}

HEARING ON HB 504

Opening Statement by Sponsor:

REP. JOHN COBB, HD 50, presented HB 504. He explained the bill would require the Department of Social and Rehabilitation Services and the Department of Labor and Industry to adopt rules to govern the use of personal assistants for people with disabilities.

Proponents' Testimony:

Barbara Larson, Coalition of Montanans Concerned with Disability, testified in support of the bill. **EXHIBIT 2** She said HB 504 would provide two directions with each department to create a model program to allow a person with disability to act as the employer of a personal assistant. They would be able to make decisions regarding who to employ, terms of employment, length of employment and other matters. The bill would be exempt from the Nurse Practice Act for a select few who have a one-on-one relationship developed with their physician or other health care professional who would detail what aspects of their care of skilled nursing procedures would be done by their personal care attendant at the direction of the individual with disability.

She pointed out that the bill would result in lower administrative costs. It would allow the personal assistant to provide routine health maintenance activities. This bill would also allow for a family representative to be involved. She submitted the NCIL (National Council on Independent Living) Position on Personal Assistance Services. **EXHIBIT 3** She also submitted "Recommendations for Self-Directed Personal Assistance Service Program" **(EXHIBIT 4)** and letters of support from **Joe Harrington, Billings; Mike Mayer, Missoula; David A. Smith, MSW, Social Services/Clinical Director, Rural Institute on Disabilities, University of Montana; Alexandra Elders, Missoula; and Peter Leech, MSW, Missoula. EXHIBIT 5**

Sheila Jamen, Missoula, testified in support of the bill. She employed a personal care attendant and was able to self direct her care for over a year. She said this has been successful for her and was very important.

Paul Peterson, Missoula, testified in support of the bill. He pointed out the problems he encountered in using personal care attendants. The importance of the bill would be the control over their own lives that people with disabilities want. **EXHIBIT 6**

Michael J. Regnier, President of the Coalition of Montanans Concerned with Disabilities, testified in favor of HB 504. He pointed out that Westmont, the single statewide vendor for PAS in Montana had as high as a 400% turnover rate, which means the entire staff of personal assistants would change as often as four times a year. The number is now around one time per year, so there are very few trained personal assistants available. He pointed out common problems of abuse and neglect and the lack of control the disabled had over the situation. The bill would improve the situation for the consumers to have control over who they hire and supervise without relying on some bureaucratic administrative service provider. **EXHIBIT 7**

Ralph Martin presented written testimony from **Ernie Pepion** in support of the bill. **Mr. Pepion** pointed out the need for dignity and independence. **EXHIBIT 8**

Joyce DeCunzo, Department of Social and Rehabilitation Services, Medicaid Division, spoke in support of the bill. She said the department supports the bill, since the creation of this program would provide disabled Montanans the opportunity to take control of very personal services, which is in line with promoting self-sufficiency and preserving dignity. **EXHIBIT 9**

Dorinda Orrell, Belgrade, testified in support of the bill. She pointed out the variety of different individuals that took care of each of her personal needs. There were so many people involved with her care, each with separate rules and defined territories, that she was disoriented. She just wanted to hire someone she could trust without interference from the state. **EXHIBIT 10**

James Meldrum, Montana Independent Living in Helena, testified in support of the bill.

Sharon Anderson, Montana Advocacy Program, spoke in support of the bill.

REP. BILL CAREY and **REP. JOHN BOHLINGER** asked to be listed as proponents.

Informational Testimony:

Jean Ballantyne, RN from Billings and member of the State Board of Nursing, said the board's position was neutral on HB 504. She discussed concerns about potential harm to the consumer. The bill would allow personal assistants to provide functions that are subject to regulation by the Board of Nursing. She pointed out that cost savings could ultimately increase costs due to complications that result from a lack of nursing attention. **EXHIBIT 11**

Ms. Ballantyne submitted testimony from **Nancy Heyer, RN, President of the Board of Nursing. EXHIBIT 12**

Opponents' Testimony:

Patricia Goudie, RN, Sun River and a former rehabilitation nurse, testified in opposition to the bill. She pointed out the health maintenance activities are tasks that fall under the Nurse Practice Act for good reasons. Medication administration, bowel and bladder management and wound care are more than tasks that someone can be trained to perform. Nurses do more than perform tasks, they monitor and assess patients' response to treatment. The bill would allow uneducated and untrained persons to perform urinary catheterization or medication injections with no knowledge of the possible consequences of infection or complications. She said the bill would cut costs at the expense of public safety. **EXHIBIT 13**

Barbara Booher, Executive Director of the Montana Nurses Association, representing 1,400 registered nurses in Montana, spoke in opposition to HB 504. She pointed out that although the intent of the bill was to allow persons with disability the independence to employ personal care attendants of their choice, in essence, it would grant any untrained individual immunity from the Board of Nursing to allow the practice of nursing without a license. **EXHIBIT 14**

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Questions from Committee Members and Responses:

REP. BOHLINGER asked **Mr. Regnier** about the difficulties in getting personal care attendants provided through Westmont. **Mr. Regnier** replied that the bill would provide choice and management over the personal care attendant by the consumer. **REP. BOHLINGER** asked if he could describe the process to help the consumer hire someone as a personal care attendant to provide continuity of service. **Mr. Regnier** explained that their facility in Missoula operates a training center for the personal care attendant. The services include communication skills, conflict resolution and training of particular tasks and routines.

REP. BOHLINGER asked if that facility was able to train the attendants in some of the nursing functions that the opponents say are beyond the scope of the attendants. **Mr. Regnier** said they did not provide that training directly, but was geared instead toward those types of tasks that can be trained by a registered nurse or a rehabilitation person. He emphasized the training provided was for a low level of expertise involved in the tasks.

REP. BOHLINGER noted the differences in costs of registered nurses at $67.51 per visit as opposed to the functions of a personal care attendant of $11.03 per hour. **Mr. Regnier** replied that it was an obvious cost savings to consumers around the state.

REP. BRUCE SIMON asked **Ms. Goudie** about patients being routinely taught by their physician to do self-injections or other types of maintenance. **Ms. Goudie** replied that patients and their families are usually taught those things in rehabilitation centers. However, sterile techniques must be followed. Families are often immune to something in their own home but when someone comes in from outside, the chance for infection is much greater.

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REP. LIZ SMITH asked about liability. **Ms. Booher** replied that models from other states--Kansas, in particular--the liability is assumed by the person who is employing the care provider.

Closing by the Sponsor:

REP. COBB said the issue was not about saving money but rather control over their own lives. He closed on the bill.

{Tape: 2; Side: A; Approx. Counter: 258; Comments: n/a.}

HEARING ON HB 539

Opening Statement by Sponsor:

REP. LOREN SOFT presented HB 539. He read violations that were in statute for selling tobacco products to youth. **EXHIBIT 15** He pointed out that no one had ever enforced these violations under this statute. He said that even though law enforcement has many other pressing concerns, that this needs to be looked at because it represents one of the most deadly and expensive health care issues faced today. He discussed the statistics that former Surgeon General C. Everett Coops said "should alarm anyone who is concerned with the future health of today's children." Annual deaths from smoking are 434,000, which are more than the combined deaths of alcohol, car accidents, fires, AIDS, drugs, suicides, and homicides combined. About 75% of people using tobacco, use it before the age of 18. Tobacco is a "gateway drug" to those using illicit drugs. He pointed out that all states ban the sale of tobacco products to children under the age of 18, but it was a serious problem on how to enforce that.

He described the Montana Teen Institute which is a program where teens get involved with issues and leadership training projects. The teens and an adult will go buy cigarettes from a store and if they say they will not sell to underage persons or ask for their ID that will be great. However, if they sell to the teen, then the adult will be there to hand out literature and materials about the effects of tobacco. They do this three times as a compliance check. On Page 2 of the bill, subsection (4((a), it states what happens if there is a violation of the offense.

Proponents' Testimony:

Jennifer Brannon, Montana Teen Institute at Helena High School, testified in support of the bill. She represented 40-60 kids and discussed the surveys they had conducted in the past few months on tobacco accessibility. She said that 38% of Helena merchants sold to minors. Her own experience resulted in 100% never asking for an ID and she could also purchase alcohol. Also 100% of vending machines could be accessed for tobacco.

Rick Bender, Roundup, testified in support of the bill. He said he was a survivor of cancer, directly related to his use of tobacco snuff. He started at age 12. He said these laws are unenforceable, even though tobacco kills more people in the state of Montana than homicides or traffic fatalities. The bill would allow this to become enforceable and would get teens involved.

Tim Solomon, Sheriff from Hill County, testified in support of the bill. He said he has been helping with the study. He pointed out that this was not a sting, but rather an education to work with the merchants.

Casey McKinney, aged 15 and a freshman at Havre High School, testified in support of the bill. He described how easy it was to obtain cigarettes. He said there were youths as young as eight years old that were just starting to smoke. **EXHIBIT 16**

Mamie Linn, Director of Communities in Action, testified in support of the bill. She represented a statewide network whose mission is to prevent and reduce high-risk youth behaviors such as tobacco use. She said they were involved with community education concerning tobacco accessibility with youth. The legislation is necessary to promote continued proactive change.

Robert Watson, student at Helena High School, testified in support of the bill. He said tobacco was one of the leading causes of death among adults in Montana caused by its easy access. Because of such easy access to tobacco and smokeless tobacco, many of Montana's youths are becoming addicted at an early age. The average age for addictions to tobacco products is 13.

Nancy Walker spoke in favor of the bill. She described her loss of family members due to lung cancer. She has vocal cord and neck cancer and was given two years to live. She began smoking at age 8 and at 13 and in earnest at 16. As a result of smoking, she breathes through her neck with a trachea. She has no sense of smell or taste. She has lost her husband to divorce and son, because they could not handle the circumstances of her life. Smoking affects the entire family.

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Ms. Walker described the hardships she has experienced. Her son is 16 and smokes and is able to purchase cigarettes anywhere in Great Falls. She said her son thought he could just try smoking with his friends, but did not realize that he could not simply quit. **Ms. Walker** is the chairman and founder of the Vocal Cord Club in Great Falls, representing 39 members. She described financial problems with insurance companies which would not pay and left her $154,000 in debt.

SEN. STEVE BENEDICT, SD 30, spoke in favor of the bill. He pointed out that in order to preserve federal funding, the bill should be passed.

SEN. CHRIS CHRISTIAENS, SD 23, Cascade County, testified for the bill. He also serves on the Governor's Council for Chemical Dependency and they support the bill. The department is required to conduct tobacco surveys to insure compliance and reducing the availability of tobacco products. The effects of the use of tobacco are widely demonstrated.

Mona Jamison, American Lung Association, testified in support of the bill. She pointed out the current enforcement mechanism requires a county attorney to prosecute. This bill becomes an administrative mechanism rather than involving the county, county funds or county prosecutors. The Department of Corrections already has to do compliance checks under a federal grant in order to maintain funds. She described the fees and penalties in the bill. She pointed out this bill enables teens to participate in the administrative mechanism.

Jeff Siebert, student at Skyview High School in Billings, spoke in favor of the bill. He said that chewing tobacco among youth is socially acceptable. He estimated that 35-40% of students at Billings High School smoke regularly. He discussed his activities with the Montana Teen Institute where they visited Billings merchants and tried to buy tobacco products. About 60% of those merchants sold them tobacco products.

Jerry Loendorf, Montana Medical Association, testified in favor of the bill. He referenced the Weekly Reader, which is read in elementary school. It is owned by K-3 Communications, the unit of Crobert, Cravis and Roberts which is the largest shareholder of R.J.R. Nabisco, a cigarette manufacturer. A recent issue discussed smokers' rights and some of the difficulties the tobacco industry was having with regard to smoking restrictions. He pointed out the concern when there was no mention of the adverse affects from tobacco. This is an appeal to the young and a direct target of tobacco advertisers.

Robin Morris, Executive Director of Havre Encourages Long-range Prevention (HELP), spoke in favor of the bill. She pointed out that youth are getting conflicting messages. When tobacco products are against state law and not allowed by parents, merchants go ahead and provide them at $1.75 a pack.. **EXHIBIT 17**

Brenda Gross, special ed teacher and vocational advisor at Skyview High School and MTI leader, spoke about the importance of peer pressure and teens working together as a team.

David VanDermark, Billings, spoke on behalf of the 5,000 members of the American Cancer Society and urged the committee to pass the bill.

Rachael DeLong, student from Helena High School, said HB 539 would help reduce the ability to buy tobacco by her peers.

Bob Edwards, American Lung Association and the Montana Teen Institute in support of HB 539. He pointed out the degradation that occurs to students who begin smoking. **EXHIBIT 18**

Steve Shapiro, Montana Nurses Association, supported the bill.

Terry Curry, a retired smoker, said they need to give the same attention to tobacco sales and use as they give to alcohol abuse.

Connie Jungman, Executive Director of the Montana Dental Association representing 500 member dentists across the state, spoke in support of HB 539.

Marsha Armstrong, Department of Corrections and Human Services, supported the bill. **EXHIBIT 19**

Charlotte Maharg, supervisor in the **Department of Revenue** charged with the administration of this law, spoke in support of the bill because it clarifies in a better manner the enforcement of the statute.

Kerry Campbell, employed with the **American Lung Association,** spoke in support of the bill. She referred to an incident at a convenience store where the clerk did not agree with the law and therefore, would continue to sell tobacco products to minors. **EXHIBIT 20**

John McCrae, American Lung Association, said the bill would prevent these kinds of packets with the single cigarettes from entering the state. It would also prevent kids from accessing collectors cigarettes with the camel figure on the front.

John Schneider, respiratory therapist from Great Falls and representing the Montana Society for Respiratory Care, stood in support of the bill.

Vince Superell, a respiratory care practitioner, spoke in favor of the bill.

Mike Biggins, Director of Respiratory Services at Community Medical Center, supported the bill.

Kate Walsh, Deaconess Medical Center, Billings, supported the bill. She said she lost a husband to cancer.

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Opponents' Testimony:

Jerome Anderson, an attorney from Helena and lobbyist for the tobacco industry since 1971, testified in opposition to the bill. He said he had a substantial history of all the legislation on the subject that has passed through the Legislature in the past. He said the tobacco industry fully and completely supports the proposition that tobacco products should not be sold or distributed to anyone under 18 years of age. The use of tobacco products should be an informed decision made by an adult. He discussed the historical aspects of the present law and the "18 year old" bill since 1989. He pointed out that there was resistance against overregulation on this issue. The present law has been in effect since October 1993. Sixteen months is not enough time to let that act work.

He believed the present act is adequate and provides for signage at the point of sale to the public, it prohibits sale to those under 18, it covers vending machines, requires cigarettes be sold in sealed packages, provides punishment, provides for enforcement at the local level, and provides for statewide uniformity of law.

He noted that Brad Griffin, the registered lobbyist for the Montana Retailers' Association, advised Mr. Anderson to tell the committee his association opposed the bill. The present act is not incapable of being enforced. He pointed out some provisions in the bill that were unclear and created a marketing and manufacturing problem. Also, any license suspension or revocations would require meetings with the Department of Corrections or Revenue taking place in Helena rather than in the town where the merchant is located. He objected to the education fee which is not necessary since the state receives federal money for this type of education activity.

{Tape: 3; Side: A; Approx. Counter: 000; Comments: n/a.}

Mr. Anderson said the bill on Section 6, line 30, page 4, removes state preemption. In 1993, the Legislature recognized the need for the development of the uniform law enforcement across the state. He explained if local entities are allowed to pass more restrictive legislation than the state act, there would be too much variation and chain stores operating in Montana would find it difficult to comply from place to place. He pointed out that the bill needed a fiscal note and should be held up until one is available. The bill does not have any reporting requirements to conform to federal acts.

Page Dringman, Philip Morris Tobacco Company, testified in opposition to the bill. She noted that she would need to see the

amendments before opposing the entire bill. She noted that there was an underlying premise that people should take responsibility for their actions and have the ability to make choices when it comes to tobacco consumption. She does not support the sale of tobacco products to minors. She addressed section 5, page 4, about the compliance requirements.

Although three dry runs with teenagers doing inspections with supervisors was talked about, her copy of the bill had the Department of Corrections and Human Services conducting compliance checks with the code sections directly or by contract or other means. She said this made it clear that the department had the authority. She asked if the provision would allow contracts with private advocacy groups or with individuals who were philosophically opposed to the use and sale of tobacco products. She said with some procedural safeguards relative to the use by minors she would not be opposed to the section. However, as it currently reads, the provisions should be narrowed and the enforcement authority specifically set forth. The rights of the licensee to protest the findings of violation are already severely curtailed under this bill. There is no recourse to Montana's administrative procedures act until after a fourth violation. She suggested this be clarified in the bill. The reliability of evidence should be ensured, such as the delegation of authority, plus law enforcement supervision as well as parental consent if minors are to be used in a sting operation.

She said that Philip Morris understands the concerns regarding youth access to tobacco products and they would potentially support this bill if there were procedural safeguards because they do realize that enforcement appears to be a problem.

Mark Staples, Montana Wholesale Distributors Association, testified in opposition to the bill. Just because there is a good philosophy, theory or morality does not mean the bill is necessary or can't be improved. He shared concerns about underage smoking and did not believe there is a conspiracy to encourage it. He said he also represented the Montana Tavern Association and has been involved from the "stingee" end. He discussed the sting operation.

He pointed out the bill's "three dry runs" were really a first offense as a dry run, the second offense which looks like a $500 fine, and the third offense is the suspension of the license. He noted that there did not appear to be an appeal route in the bill. He suggested there be more of an official interaction such as the 80% violations, which the county authorities should be willing to prosecute.

Larry Akey, Smokeless Tobacco Council, testified in opposition to the bill. He said the council believes that tobacco is an adult product and does not condone the use of its product by people under the age of 18. The bill appears to be a youth access bill, however, it should be workable for everyone. This is an example

of people trying to use youth access as an excuse for an expanded anti-tobacco agenda. He pointed out things that would make the bill better. The assessment conference should be in the retailers' home town should there be some standards of evidence or process for the assessment conference. The content of the tobacco education program should be defined. Conducting inspections by other means should be defined. The bill needs to be worked on.

John Delano said he supported the intent of the bill. He directed the committee to open some packets called "It's the Law." The program and folder is from Colorado. He explained that Philip Morris has been putting out these materials for some time. **EXHIBIT 21**

Questions from Committee Members and Responses:

REP. SIMON asked **REP. SOFT** about the amendments on Page 2, line 13, and what the penalties would be for failure to post signs. **Ms. Jamison** replied that if someone failed to post signs as required by the statute they would just get a notice of violation that would not proceed to the education assessment fee or to license suspension. She clarified that a cigarette license is necessary in order to sell cigarettes which is the Department of Revenue's business. The penalty for failure to post the sign is a notice of violation and it is based on the integrity of the merchant. **EXHIBIT 22**

REP. SIMON said that under current law, failure to post a sign is punishable by $100. Striking that language would remove that requirement and reduce that leverage to a simple warning from the department. **Ms. Jamison** replied that this needed to be fair to the merchant. **REP. SIMON** said the remaining violations refer to 16-11-305, but he was referring to 16-11-304 which is already current language.

REP. SIMON noted that this bill had two departments mixed in. **Ms. Jamison** discussed the federal grant that was in place for tobacco education so the Department of Corrections is involved, however, if it is the third time around under law it is the Department of Revenue that can issue and suspend cigarette licenses.

{Tape: 3; Side: B; Approx. Counter: 000; Comments: n/a.}

REP. SIMON said that the bill would put a burden on people that own a multiple of facilities. **Ms. Jamison** said that if the owner is not responsible for the employees, then they would encourage and facilitate sales to minors. She said the structure is extremely generous to the employer in giving them six opportunities to correct the situation.

REP. BOHLINGER asked about the appeals process. **Ms. Jamison** replied that the due process issue in Section 1 of the bill, line

18, is the provision which provides administrative hearing for revocation of the license. Page 4, lines 3-10, deal with the violation and referral for suspension of license is pursuant to 16-11-144. She pointed out that the assessment process is informal, but is a way of letting people make their case without hiring lawyers. It provides for a written and tape recorded record which is due process.

REP. BOHLINGER asked **Mr. Anderson** to comment about the due process in the document. **Mr. Anderson** said that due process is violated in this bill. Part of the bill on page 3, lines 14-21, addresses the assessment and collection of the tobacco education fee. That fee is $500 dollars. The assessment conference is held and this is not a contested case as defined in the Montana Administrative Procedure Act which takes away the right of appeal and due process. The license suspension proceeding under subsection 8, lines 22-26 on page 3, is a proceeding to determine whether or not the license should be suspended, whether a property right should be taken away and whether the person should be prevented from engaging in a lawful occupation. The last sentence in that provision said it is not subject to administrative or judicial appeal pursuant to the Montana Administrative Procedure Act.

Closing by the Sponsor:

REP. SOFT closed on the bill. He said the present law has not been enforced and is not adequate.

HEARING ON HB 509

Opening Statement by Sponsor:

REP. SHIELL ANDERSON said HB 509 was intended to make health care more affordable to Montanans. He explained this bill would authorize mergers and consolidations of health care facilities and if they could prove that they can consolidate and not increase health care costs, then the Health Care Authority could give them a certificate of public advantage which will prevent them from being the subject of anti-trust litigation. He passed out amendments to the bill. **EXHIBIT 23**

This would make the program self-funding where the mergers or consolidators would pay for the authority to review their application for certificate of public advantage as well as on-going costs for follow-up of compliance in terms of that agreement. The amendments should eliminate the need for any fiscal notes. The coordinating functions will go to the Attorney General's Office rather than the Health Care Authority. This will help hospitals merge if they want to without being subjected to anti-trust litigation. This process will help them better serve the public.

Proponents' Testimony:

Max Davis, lawyer from Great Falls representing Columbus Hospital, testified in support of the bill. He also represents **Montana Deaconess Medical Center,** the other hospital in Great Falls. He said the two hospitals have been engaged in intensive and on-going discussions leading to the hopeful consolidation of those two facilities. In the process, they have been very interested in the statutes that are under consideration. The statutes did not address what they wanted them to. Hospital consolidation is not new on a national level. Pressures about health care are leading hospitals to look at doing innovative things to meet the challenges in a volatile and changing health care climate.

He pointed out that any kind of changes like this are subject to federal review by the Federal Trade Commission or the Department of Justice. Since there are so many of these happening around the country, the federal commission picks and chooses which ones to become involved in. The way the federal government looks into a facility is by a subpena, which then costs a half of million dollars for a facility to respond. This cost is undesirable to any facility. If the state takes an active role in a consolidation effort in listening to whether it is a good idea or not, the federal government may choose not to become involved. He suggested that these decisions are better made in Montana through either the Health Care Authority or to the Attorney General's Office.

William Downer, past Chief Executive Officer of Columbus Hospital and presently senior executive and consultant on this project, testified in support of the bill. He said they feel it is critical for the public, who utilizes the facility, to be involved in the decision-making process. The benefits to the public outweigh any potential danger to competing hospitals.

Kirk Wilson, CEO of Montana Deaconess Hospital, said that hospital mergers reduce costs by eliminating the part of the cost structure that doesn't affect patient care, which is administrative overhead. Only through mergers can they eliminate administrative overhead effectively. The state would enjoy better rates for their employees as well as citizens and small employers.

Jerry Loendorf, Montana Medical Association, testified in support of the bill. He pointed out the anti-trust laws were complex and it would be easy for people to unknowingly violate them. Also, this would be very costly. He discussed the Great Falls situation where the hospitals are merging. He said this merge would probably comply with integration requirements needed for a group to get around Section 1 of the Anti-Trust laws which prohibits contracts and restricts the trade. But if this happened, they would be the only hospital left in town. Would they then be in violation of Section 2, which prohibits

monopolization? The U.S. Supreme Court decided that hospitals could contract with providers to provide a specific service in that hospital and exclude all other providers. However, in Jefferson Parish, Louisiana, where the case was decided, there were 20-40 other hospitals.

{Tape: 4; Side: A; Approx. Counter: 000; Comments: n/a.}

Mr. Loendorf continued. The violations are felonies for hospitals which are corporations and can be fined up to $1 million. For individuals it is $100,000 and three days in jail. The civil suits are worse. A negative verdict can mean $300,000 to $500,000, but the judge would triple that since that is a requirement of the law. He discussed the anti-trust suit he had been involved in which lasted seven years and is still on-going, even though he is no longer involved. The costs of those suits are horrendous; "if you win, you lose." He gave an example of costs. He said the bill makes an exception in the anti-trust law, so where state's regulate, the anti-trust laws don't apply. This is substituting regulation for competition, which the anti-trust law promotes.

Mike Craig, Health Care Authority, testified in favor of the bill. He said the Health Care Authority agrees that this is one piece of SB 285 that ought to continue. The Authority agreed with including the additions that this bill does in terms of anti-trust. Keeping it at the state level with the expertise of the Attorney General's Office makes for a strong potential for cost containment.

Sharla Hinman, Manager of Geriatric Programs at Montana Deaconess Hospital, testified in support of the bill. She urged passage of the bill with the amendments to give Montana the opportunity to decide what is best.

Allyn Christiaens, a clinical laboratory scientist at Columbus Hospital in Great Falls, testified for the bill. He commented about the long-term outlook of employees, which would be a savings of jobs. The area has been losing population and the service area for both hospitals have been dwindling in numbers because of the decrease in population in outlying areas. Cuts in federal reimbursements for services will result in a loss of services.

Opponents' Testimony: None

Questions from Committee Members and Responses:

REP. L. SMITH asked **Mr. Downer** about other mergers such as Missoula and if this was because of the anti-trust laws. **Mr. Downer** replied that these types of negotiations are delicate and can break down over a variety of things. Missoula discussions continue, but their circumstances are different. This legislation would enable them to have the state of Montana

monitor their activities. **REP. SMITH** asked what the positions were. **Mr. Downer** replied that some positions are opposed because change is hard to accept. Some are opposed because they think competition is the only way to deal with issues in health care, just as it is in other businesses. Some people are concerned that the hospital would become part of a Catholic system. He pointed out that this issue was about managing change. Hospital administrators know that change is coming. They try to see as many years down the road as possible and to protect the best interests of the community. The hospital would be in a position to provide retraining, reasonable severance and out-placement assistance. This would be worked out through attrition, so would involve very few people.

REP. SMITH asked if through the consolidation movement, there was more potential for HMO providers. **Mr. Downer** replied those things were coming to Montana. He pointed out that they would not deal exclusively with any single group which would include physicians, though not those employed by the hospital such as pathologists and radiologists.

REP. KOTTEL asked **REP. ANDERSON** if this bill meant an approval for consolidation or merger or was it just allowing for this to be held at the local level. **REP. ANDERSON** said that was correct. It was establishing the process whereby the Health Care Authority, or as an alternative, the Attorney General's Office can deal with it. He said it would allow for parties who were opposed to this or were proponents could submit their information and then the Health Care Authority may or may not grant the certificate of public advantage. **REP. KOTTEL** asked if costs incurred by the state for handling this certificate would be the applicant's responsibility. **REP. ANDERSON** replied that was the intent of the amendments.

REP. CAREY asked **Max Davis** of Great Falls about partnerships with groups of doctors. **Mr. Davis** replied that physicians could form partnerships as they do, but there are other types of cooperative ventures that providers may envision such as forming integrative delivery systems, HMOs or other things. There is great uncertainty if these types of partnerships may implicate the anti-trust laws. The purpose of this would be to provide a level of protection and assurance that would help prevent these catastrophic transaction costs.

REP. HAGENER asked **Max Davis** if there were others in Montana that were affected by the legislation. **Mr. Davis** replied the facilities affected mostly are those communities that have two hospitals. There are a whole range of provider facilities that are affected such as nursing homes which would be covered.

Closing by Sponsor:

REP. ANDERSON closed on the bill. He said this would help reduce health care costs to Montanans.

{Tape: 4; Side: A; Approx. Counter: 600; Comments: n/a.}

HEARING ON HB 532

Opening Statement by Sponsor:

REP. BILL TASH, HD 34, presented HB 532. He explained the bill would redefine the mental illness treatment law and clarify the involuntary administration of medication and would provide a termination date. He pointed out lines 14 and 15 on Page 2, which is important to the bill. Page 3, line 25, is existing law but discusses the emergency situations. He explained that Page 6, lines 2, 3 and 4, are also the gist of the bill.

Proponents' Testimony:

Paul Stahl, Deputy Attorney, Lewis and Clark County, testified in support of the bill. He said this is one of five bills being sponsored by the County Attorney's Association. This is a concern of county attorneys that needs to be addressed. He presented amendments prepared by the Mental Health Association and a handout that appeared in the Montana Standard that explains part of the reason why medication is important. **EXHIBITS 24 and 25**

He said this deals with community commitment, not at Warm Springs or in a criminal setting for people who have committed crimes. People have been de-institutionalized and, as a result, local communities have an influx of people with a mental illness. Community commitments are for thirty days and people do not have to be seriously mentally ill, only mentally ill. There are temporary dates that will sunset the bill at a certain time if it does not work. The law needs to be changed for the ability to use medications differently. People would not have to be forced to go to Warm Springs Hospital. Instead, there would be a way for the community to get them to take medications if that will help them not become seriously mentally ill. He discussed a case where a person was committed four times in one year to Warm Springs. The person became stabilized and released to the community. Then they would not take their medication and be committed again.

{Tape: 4; Side: B; Approx. Counter: 000; Comments: n/a.}

Mr. Stahl continued. He said that intervention often came too late to help people and this bill would allow intervention earlier when basic personal needs are not being taken care of to provide help and assistance. He discussed the amendment for medicating a person to stop them from deteriorating, that medication may be involuntarily administered by whatever reasonable means. He pointed out that physical force is often used and necessary when people take medication. The amendment by the Mental Health Association says that if there is an

involuntary medication finding, it needs to be made by a physician rather than just a social worker who often are the witnesses. When going to court, this doesn't mean a psychiatrist is needed or a medical doctor. It is too expensive and often there are four commitments a week in this town and it doesn't work too well when issuing subpoenas to doctors. It allows the doctor to present a letter that can be introduced by the social worker.

Mr. Stahl recommended passage of the bill with amendments. He said there would be testimony that this infringes upon personal freedoms. He noted that he had struggled with this issue for a long time and there are times when Society has a right to infringe on personal freedoms. These are people that need to be prevented from becoming seriously mentally ill and at times are a danger to other people. This will provide community treatment for those people that need it since they can no longer be put in Warm Springs State Hospital.

Marty Onishuk, vice president for Montana Lions for the Mentally Ill, testified for the bill. She said this issue was important for family members that need help. The issue of civil rights verses the need for treatment is a concern. Family members, when they are ill, are not rational. This is something that should not be done all the time or unlimited. She discussed critical issues that can result from a mentally ill person not taking their medication. She noted that there had been abuses in the past where medication was used to subdue somebody because that was the easiest way to handle someone.

She suggested in the language a history of how the medications worked in the past should be a part of the physician's statement. Also, a history of having gone off medications should be reviewed. She said they don't always blame some of the people for quitting medications because of the nasty side affects that can occur. These are not medications to be used lightly, therefore, it is so important to be done under a physician's order and knowledge. It would be helpful to have a signed, advance medical directive for the person to know about when they are well, since this is a cyclical disease.

Dan Anderson, Administrator of the Mental Health Division, Department of Corrections and Human Services, spoke in favor of the bill. The concept of the bill is similar to HB 41 which allows the administration of involuntary medication to people who are actually sent to the state hospital. The people covered by HB 532 are people who are under what is called "community commitment." The process is reserved for rare occasions to require someone to take medication. When a person has reached a level of mental illness when the state has to step in and require that treatment be submitted, medication, which is one of the most effective treatments, should be one of the options that the judge has when considering the situation.

David Hemion, Mental Health Association of Montana, spoke in support of HB 532. He said this is a practical issue to be able to work with people that have mental illnesses, where they are with their families, with friends and often in employment and not have to resort to hospitalization as the only way to treat their mental illnesses. The amendment would allow a greater degree of information to the court that the treatment that is being ordered is appropriate. It allows treatment to proceed without a delay. If there is a contested case then the respondent, through their attorney, has the right to subpoena the physician to testify. However, in cases where there is not contest, help can be available immediately to those that need it.

Jim Driscoll, Montana Psychological Association, recorded their support for HB 532 with the amendments.

Opponents' Testimony:

Andree Larose, a staff attorney for the Montana Advocacy Program, testified in opposition to the bill. She explained the program advocated rights of persons with disabilities. She said this was an unwarranted expansion of the power of the state over an individual. She pointed out problems with the bill including deficient legal standards, a bypass of the due process requirements and the forcing of medications upon bodily integrity. She suggested that people with mental illness be provided a full array of treatment options and support services such as community-based treatment, housing in the community or mobile crisis teams. She said there should not be an overriding justification for forcibly injecting medications into a person's body. **EXHIBIT 26**

Kelly Moorse, Executive Director of the Mental Health Board of Visitors, testified in opposition to the bill. She said the difficult dilemma faced by families and friends when their loved ones are experiencing a psychotic episode are recognized. However, alternatives, such as Advanced Directives, would better address these issues. She discussed concerns with the bill. The bill conflicts with informed consent rights. She noted the concerns about side effects to medicine which ranged from minor irritations to severe muscular side effects to irreversible damage to the central nervous system. She pointed out that the therapeutic relationship between consumers and their doctors may be jeopardized by administering medications with "whatever means are reasonably necessary." The patient's response to future medical needs could be damaged. **EXHIBIT 27**

John McCrae testified in opposition to the bill as a private citizen. He has served as an advocate for a mentally ill person for seven years. He described people he knew that had a mental illness that were forced on medication and could not talk to him. They lived through agony and were not able to communicate regarding concerns on various issues. Even after a day or more, the people could not respond. He asked the committee to oppose

the bill because it takes away the dignity and rights of people with mental illness.

Questions from Committee Members and Responses:

REP. GRIMES asked **Mr. Stahl** about the due process, client's rights and the constitutionality issue. **Mr. Stahl** replied that generally this proposal was not unconstitutional, but there are different levels of due process and rights and this proposal does not violate this. He said this was a way of doing things. Review committees are hard to do in a community setting when considering transients. He asked, "How do you get a medical background? How do you stop them from deteriorating until they become dangerous?"

{Tape: 5; Side: A; Approx. Counter: 000; Comments: n/a.}

REP. L. SMITH asked **Mr. Hemion** about the Advanced Directives when regarding the ability to medicate under these circumstances. **Mr. Hemion** replied that people with mental illness, when they are in a stable condition and competent enough to make a decision about what kinds of medication are appropriate for them as they see it. But they have an onset of illness and they are not able to make that decision, then something can be done about it.

REP. SMITH asked if some mental health group could encourage this issue with the families and members to establish something. **Ms. Larose** replied that they would encourage the Advanced Directives when the person is stable where they can say they do or do not want medications. **REP. SMITH** noted the potential that exists for the mentally ill becoming criminal for their behavior. Points to consider with transient people are the lack of a medical background or side effects that can occur.

REP. SOFT asked **Mr. Stahl** about some of the suggestions by **Ms. Larose** that might strengthen the bill, such as adding that the medication is medically appropriate, that there is an overriding justification for the involuntary administration of medication and see if there is other appropriate treatment is offered or provided. **Mr. Stahl** said he could agree to one out the three but he had concerns about the others. One concern is that they provide different kinds of treatment and say that they've tried it before. This is an issue of cost. He said for example, a person from God's Love (a homeless shelter in Helena) that has urinated in the First Bank Lobby, "what do you do with him? Do you let him wander around the community while giving him counseling?" Some types of treatment don't work until someone becomes stabilized. "What do you do with a person if there is no place to keep them." He said that medically appropriate is great, however, overriding justification is obscure and would end up being decided in the Supreme Court.

Closing by the Sponsor

REP. TASH closed on the bill. He discussed a few points that came out in the testimony. He said the focus was on the need for these people to be treated. The ones that are transients are apt to be detrimental to themselves and Society and something should be done about them. It is important to provide local services because that is where the first level of care will be more effective. The overriding justification issues are left up to the discretion of the attending physician.

HEARING ON HB 522

Opening Statement by Sponsor:

REP. CARLEY TUSS, HD 46, presented HB 522. She explained the bill would provide respiratory care as part of the services provided by home health care. She said it was mandatory that insurance companies offer home care. By expanding the definition, if a physician ordered respiratory care, then the insurance company could pay for that. It will not only pay in a home care setting but will pay for respiratory treatments in an outpatient rehab setting, skilled nursing setting or a hospice setting. This will allow people to move from a less acute setting to a home-like setting or an extended care setting.

Proponents' Testimony:

Michael Biggins, Director, Respiratory Services at Community Medical Center, Missoula, a respiratory therapist and a consumer of health care insurance company products, testified as a proponent. This will decrease expenditures for health care. He described an experience with a patient in Missoula who was ventilator- dependent. The cost for four hospital admissions for four consecutive months totalled $70,000. The same woman who was moved to a rest home received respiratory care for a cost of $5,000. He discussed the handouts entitled, "Saving Money and Lives" and other articles. **EXHIBIT 28**

Kate Welch, Deaconess Medical Center, Billings, discussed cases of moving patients into more cost effective settings. She described the summary of charges for one patient where the price of the rooms was $213,000. Respiratory therapy was $53,000. For the large price spent on this man's care, three of those months he was stable and could have been moved. They could have bought him a respirator and a limousine to transport him back and forth to the nursing home. The patient eventually died. She described another case where the patient was trained to take care of himself at home successfully. **EXHIBIT 29**

John Fenner, an education coordinator for respiratory care at Montana Deaconess Center in Great Falls, testified for the bill. He is president for the Montana Society for Respiratory Care. He

said that millions and millions of dollars can be saved by providing home care for respiratory patients. He pointed out that this would also save a lot of money for the insurance companies. **EXHIBIT 30**

{Tape: 5; Side: B; Approx. Counter: 000; Comments: n/a.}

Mike Craig, Montana Health Care Authority, spoke in support of the bill.

Vince Luparell, a respiratory therapist for the Montana Deaconess Center in Great Falls, spoke in support of the bill.

Dennis C. Alexander, Executive Director, American Lung Association, submitted written testimony. **EXHIBIT 31**

Opponents' Testimony:

Tanya Ask, Blue Cross/Blue Shield of Montana, presented an amendment. Section 1 deals with health service corporations and the way it is worded creates a mandated benefit for health service corporations that are not technically subject to any of the other policy constraints, unlike Section 2 which deals with commercial insurers. Therefore it is creating a different level of mandated benefit for health service corporations. The amendment would clarify that the same level of benefit will be included for health service corporations as with commercial insurers. **EXHIBIT 32**

She commented that any time another type of provider is added to an insurance contract, it is one more type of service that is reimbursed. Health insurance costs are justified for several reasons: the cost of medical services, and the utilization and increases in technology. She noted that some of the statements made by proponents do have merit. For example, Blue Cross and Blue Shield of Montana presently have case management. There are a number of individuals that help identify cases that can benefit from case management. If benefits are not available in a contract, but it looks as though a less costly setting could provide the same type of care, if the patient, the physician and the insurance company all agree, then a modification can be made in the contract to provide those benefits.

Ed Grogan, Montana Medical Benefit Plan and Montana Medical Benefit Trust, testified against the bill. He said their plan does pay for this therapy and it is excellent therapy. The problem with the bill is that it is one more mandate. Every time a mandate is added, it increases costs. An insurer should not deny this benefit, especially in an in-home basis because hundreds and thousands of dollars a day can be saved by treating that patient in home rather than in a hospital.

Informational Testimony:

Mike Craig with the Health Care Authority added a few comments to his previous testimony. He said that health care services should be provided in the least restrictive setting possible. An example of this is respiratory therapy where coverage will be available for services including assessments, education, therapeutic procedures, diagnostic procedures and pulmonary rehabilitation which can be provided in all alternative care sites. The Authority believes that this approach can result in better care for the patient at lower cost. He read this from benefit packages put together last autumn. The bill follows this philosophy and can achieve cost containment. He encouraged support for the bill as amended. **EXHIBIT 33**

Vince Luparell, Montana Deaconess Hospital, said that there is a lot of money to be saved even though there is that added cost for the new mandate to be covered by the insurers. However, the millions of dollars saved outweighs this. Preventative medicine is the best way to go.

Questions from Committee Members and Responses:

REP. BOHLINGER referred to a circular about a patient with a 162-day stay at the hospital with room charges of $1,315/day for a total cost of $558,739. He asked why the insurers would not support these significant cost savings. **Ms. Tanya Ask** replied there were cost advantages. However, Blue Cross and Blue Shield uses case management that identifies those cases that can benefit which they do. If they have Medicare, insurance companies with Medicare supplement insurance must follow Medicare since they pick up where Medicare leaves off. She pointed out the reason they are concerned with the bill is there are some other services which might not be reimbursed for respiratory care. By adding a benefit, this is adding another service that is being covered. This was the point she was trying to make.

REP. L. SMITH asked **John Fenner** about his scope of practice for the practitioner in his role of educational coordinator for Deaconess Medical Center. **Mr. Fenner** replied that in order to be a licensed respiratory care practitioner, attendance at an accredited academic program was necessary. Programs varied from one year to four years. **REP. SMITH** asked if there should be some differentiating between what was allowed to be practiced in a home based environment. **Mr. Fenner** replied that trained practitioners were fully capable of handling these situations.

REP. SIMON asked about the educational requirements under the board for this profession. **Mr. Fenner** said graduation from an accredited respiratory care program was necessary. **REP. SIMON** asked if any of the respiratory care practitioners had independent practices. **Mr. Fenner** replied that to his knowledge, they did not. They are under the direction of a physician or a physician's assistant.

REP. SIMON asked **REP. TUSS** about the list of individuals listed under the insurance including physicians, physician assistants, etc., those people currently listed are independent practitioners. When respiratory care practitioners are added to the list this adds people that do not have an independent practice, but must operate under the orders of someone else. He pointed out that there were others, such as physical therapists, occupational therapists, for example, who are licensed and provide valuable services at lower costs. **REP. SIMON** asked if this bill is allowed, will other professions come forward. **REP. TUSS** replied that she did not think they would. The respiratory care practitioner is included in this list, line 24, page 1. She said there are now independent home care agencies besides the hospitals that disperse respiratory therapists into the community. In addition there are durable medical goods outfits in town that have a respiratory therapist as part of their service.

REP. SIMON said he understood the freedom of choice, however, the language of the section also says that all policies must, for disability insurance, provide the coverage. This starts expanding the list of benefits and they are called mandated benefits. **REP. TUSS** replied that this was current language. These services need to be offered.

REP. SIMON asked if these additional benefits must be provided in the health care insurance policy. **Ms. Ask** said this was one of the first concerns they raised. So long as the benefit is included in the contract, concerning the definition of home health, then it would be a benefit. She said that home health care was a mandated offer in the state of Montana and this would add respiratory care to the end of that. This would be an additional mandated benefit. **REP. SIMON** asked if the bill added this kind of practitioner to the list, how many additional specialties might be coming in next session. **Ms. Ask** said this is one of the questions the insurance industry was concerned with. Every time a new provider is added to the freedom of choice, that includes one more provider-type that is eligible for reimbursement and increasing utilization.

REP. SQUIRES asked about her ability to practice independently and how she would qualify under the list for third-party reimbursement. **Ms. Ask** replied that the way the freedom of choice of practitioners is written it also says "acting within the scope and limitation of the person's practice." She said the question is frequently raised about a provider-type going for an independent license. After that license to practice, then the provider asks to come in under the freedom of choice of practitioners. **REP. SQUIRES** asked if LPNs had done that. **Ms. Ask** replied they had not. The ones that had done that were acupuncturists, nurse specialists, licensed professional counselors, etc.

Closing by the Sponsor:

REP. CARLEY TUSS closed on the bill. She pointed out the tremendous cost savings this would be by allowing people to have respiratory care in the least restrictive setting.

{Tape: 6; Side: A; Approx. Counter: 000; Comments: n/a.}

EXECUTIVE ACTION ON HB 555

REP. SOFT said the bill had not resolved the issues by those concerned.

Motion/Vote: **REP. SOFT MOVED TO TABLE HB 555. The question was called. The motion to table HB 555 passed unanimously.**

EXECUTIVE ACTION ON HB 153

REP. LIZ SMITH said the bill should be tabled. It was to be a follow-up to HB 555 and had to do with disability benefits for midwifery services. The midwifery lobbyist requested the bill be held up. There was concern for the credentialing for midwifery services.

Motion/Vote: **REP. SMITH MOVED TO TABLE HB 153. The motion passed unanimously.**

EXECUTIVE ACTION ON HB 492

Motion/Vote: **CHAIRMAN GRIMES MOVED TO TABLE HB 492. The motion passed unanimously.**

EXECUTIVE ACTION ON HB 385

Motion: **REP. SIMON MOVED HB 385 DO PASS.**

Discussion:

REP. S. SMITH presented an amendment from the Department. She explained this would allow the Health Services to sell their accounts receivable so a private agency could collect the arrears. This would provide a vehicle to do that. She said that **Maryann Wellbank** could explain.

Ms. Wellbank, Administrator of the Child Support Enforcement Division, said this would allow the state to sell arrearages so a collection agency could take over. These would only be AFDC arrearages owed to the state that are currently uncollectible. The ones they are collecting now they would proceed to collect.

Motion/Vote: REP. SMITH MOVED THE AMENDMENT. The motion carried 13-3 with REPS. GRIMES, SQUIRES and HAGENER voting no.

Motion: CHAIRMAN GRIMES MOVED HB 385 DO PASS AS AMENDED. The motion carried 15-1 with REP. SQUIRES voting no.

{Comments: The standing committee report for this bill recorded the vote as 13-3; however, that was for the amendment, not the bill.}

EXECUTIVE ACTION ON HB 468

Motion: REP. SIMON MOVED HB 468 DO PASS.

Discussion:

REP. SIMON presented an amendment. He explained this would expand some of the options that the council might consider, including the possibility of utilizing some existing facilities within the state.

Motion/Vote: REP. SIMON MOVED THE AMENDMENTS. The question was called. The motion to adopt the amendments carried with one no vote by REP. SMITH.

Motion:

REP. BOHLINGER MOVED THAT HB 468 DO PASS AS AMENDED.

Discussion:

REP. L. SMITH asked how much this would cost. **REP. SIMON** said he had the fiscal note but did not sign it. It the department wanted to kill the bill then they should have testified against the bill. The fiscal note talks in terms of operating expenses for the mental health planning and advisory council at a very high price. The fiscal note assumes the facility will not be built in the Deer Lodge Valley, which may not be true.

REP. LIZ SMITH said the plan addresses the mental health field, but is a repetition and a significant cost. The new structure would cost $11 million that would serve 110 people. Renovation to surrounding buildings brings that up to $18 million. If that facility were to be moved somewhere else, it would be about $30 million. **REP. SUSAN SMITH** asked if this were the only vehicle that would stop the $19 million dollar building in Warm Springs. **REP. L. SMITH** said it was not the only vehicle that would stop that, because the Long Range Planning Appropriations Subcommittee had to approve it.

REP. MOLNAR pointed out the high costs.

REP. BOHLINGER referred to lines 19, 20 and 21 in the bill on page 1 regarding the site for the new facility. He agreed with the bill.

REP. SIMON responded to **REP. SMITH'S** concern about the costs of building the facility. He said the figures she had could not be accurate. Some of the facilities would be utilized more for administration rather than for the patients. **REP. SMITH** replied that she had the breakdown of that and the new building was $11 million, $135 per square foot. The additional money has to do with renovation with existing buildings, one of which houses 56 patients. It also centralizes the heating system and renovation of the other buildings. It costs more to move because of the existing buildings that are already being utilized.

Vote: The question was called on HB 468. The motion carried 13-3 with REPS. SQUIRES, LIZ SMITH, and WENNEMAR voting no.

EXECUTIVE ACTION ON HB 507

Motion: REP. BOHLINGER MOVED THAT HB 507 DO PASS.

Discussion:

REP. SMITH said some of these issues were being addressed in the Select Committee on Health Care and they did not believe this bill would do what it should.

Substitute Motion: REP. LIZ SMITH MADE A SUBSTITUTE MOTION TO TABLE HB 507. The question was called. The motion carried on a roll call vote.

EXECUTIVE ACTION ON HB 504

Motion: REP. CHRIS AHNER MOVED THAT HB 504 DO PASS.

Discussion:

REP. BERGMAN said the bill should be passed. He said this was a battle between Medicaid and Westmont. Westmont does not do their job. They have a contract with Medicaid and so they are stuck. Medicaid is not investigating to make sure those people are doing their job.

REP. BOHLINGER said the issue was one of providing people an opportunity to take control of their lives and he urged the committee to vote for this.

REP. GREEN pointed out the people were not incompetent but were just disabled.

REP. SQUIRES noted that this was for a pilot for 50 people so it would not include everybody.

{Tape: 6; Side: B; Approx. Counter: 000; Comments: n/a.}

Vote: The question was called. The motion carried 15-1 with REP. SQUIRES voting no.

EXECUTIVE ACTION ON HB 539

Motion: REP. SOFT MOVED THAT HB 539 DO PASS.

Discussion: **REP. SOFT** presented amendments. He asked **Ms. Mona Jamison** to explain the amendments.

Motion: REP. SOFT MOVED THE AMENDMENTS.

Discussion:

Ms. Jamison said the amendments would help clarify the bill. She said that single cigarettes should not be sold. The amendment #12 addresses the due process portion. If the assessment fee is challenged, then it would be a contested case under the Administrative Procedure Act. This is a concern. Then it becomes a matter of philosophy. Amendment #5 on the dry runs, the first through third offense, is punishable by a verbal notification.

Vote: The question was called on the amendment. The motion to adopt the Soft amendment carried.

Discussion:

REP. SIMON presented an amendment to restore language on page 3, line 9, subsection (4). He pointed out if the merchant has a program in place and have told their employees not to do this, they should not be punished if some clerk ignores their directives and sells to minors. He moved the amendment.

Mr. Niss said there was no civil penalty under subsection (2) but was a penalty for failure to obtain a license. He spoke against the amendment.

REP. GREEN also spoke against the amendment since he felt it would take the heart out of it.

REP. KOTTEL spoke against the bill since there were three warnings that take place prior to any government action.

REP. WENNEMAR spoke against the amendment.

Vote: The question was called on the Simon amendment. The motion failed.

Vote: The question was called on the bill. The motion carried 15-1.

EXECUTIVE ACTION ON HB 532

Motion: REP. BOHLINGER MOVED THAT HB 532 DO PASS.

Discussion:

REP. KOTTEL said she was confused with this bill. She explained that she had worked in the state mental hospital and thought she was doing a good thing. She witnessed a "least restrictive alternative" in a Chicago "mental health ghetto" where people lived on the streets and had nothing in place to help the people. The mentally ill were preyed upon by others.

She pointed out page 2, lines 7-30, subsection (b), each of those is an independent clause, so if someone has a behavior that creates serious difficulty in providing for basic personal needs or protecting the person's life or health needed for health or safety and any of these things treatable with a reasonable prospect of success consistent with least restrictive course of treatment. She noted that a person need not even have a previous involuntary civil commitment, yet this bill would allow the involuntary medication of people on the street.

CHAIRMAN GRIMES asked if she had a copy of the amendment presented by the Mental Health Association. The committee discussed the amendment.

{Tape: 6; Side: B; Approx. Counter: 340; Comments: n/a.}

She replied that if the Mental Health Association rules were accepted, then it would allow taking care of the transient issue with no known medical history. However, it would provide no due process other than a written verification by a physician who does not even attend the hearing.

Motion: REP. HAGENER MOVED THE AMENDMENT.

Discussion:

CHAIRMAN GRIMES asked **Mr. Niss** to respond to **REP. KOTTEL'S** concerns.

REP. GREEN commented that this amendment would be too intrusive.

Mr. Niss explained that it did not appear to deal with transients. For example, being "treatable with a prospect of success" could not be known about a transient.

Motion/Vote: REP. HAGENER MOVED TO TABLE HB 532. The motion to carried 14-2 on a roll call vote.

EXECUTIVE ACTION ON HB 509

Motion/Vote: REP. KOTTEL MOVED HB 509 DO PASS. REP. KOTTEL MOVED THE AMENDMENT. The motion on the amendments carried unanimously.

Motion: REP. KOTTEL MOVED THAT HB 509 DO PASS AS AMENDED.

Discussion:

REP. BERGMAN asked why the hospitals didn't merge in the past. **REP. KOTTEL** replied that the Health Care Authority, when they put this together, deleted the words "merger and consolidation" just because they didn't think about it. Now if any health care provider, more than a partnership, wishes to merge or consolidate, they would be under federal law. By simply amending "merger and consolidation" it allows for any health care provider, any hospital to apply for a certificate of public need for the merger and consolidation. That certificate stops them from being liable under the anti-trust laws. She pointed out that it was good for the community and it stops multi-million dollars worth of liability at the federal level.

REP. SMITH asked about nursing homes merging with another entity. **REP. KOTTEL** replied this covers situations where there is a possibility of a monopoly, for example, if all the nursing homes in the state were to merge they may have to go for the certificate.

Vote: The question was called. The motion carried unanimously.

{Comments: The standing committee report did not record the amendments that were passed.}

EXECUTIVE ACTION ON HB 522

Motion: REP. WENNEMAR MOVED THAT HB 522 DO PASS.

Discussion:

REP. L. SMITH said she was concerned about the other professions that can't practice independently because of the different level of expertise. She said she was not opposed to bringing respiratory care into the home and there was a great need for it.

REP. SIMON opposed the bill because this adds providers to the list that are not an independent practice. Each one on the list adds something to the cost of the insurance as a mandated benefit. He pointed out this would bring a lot more practitioners in asking for the same kind of privileges.

REP. BERGMAN pointed out that respiratory therapists are usually employed by a hospital and how would they be at making house calls.

REP. AHNER asked if home health nurses visited homes.

REP. KOTTEL said the bill was positive. The way they structure themselves, such as a small corporation or inside a home health service, the need for respiratory therapy is ascertainable and is clearly mandated in terms of a doctor's prescription. It is the type of care that could be done at home by someone who is qualified.

{Tape: 7; Side: A; Approx. Counter: 000; Comments: n/a.}

REP. S. SMITH spoke against the bill.

CHAIRMAN GRIMES discussed last session where there were two mandated issues like this. Eventually they all add up and more insurance should not be mandated at this time.

Vote: The question was called. A roll call vote was taken. The motion failed on a tie vote of 8-8.

Motion: CHAIRMAN GRIMES MOVED TO TABLE HB 522. A roll call vote was taken. The vote was 8-8 and remained in limbo.

EXECUTIVE ACTION ON HB 481

Discussion: REP. KOTTEL asked the committee to reconsider the tabling motion on HB 481 since she was not present when that vote was taken. She offered amendments and asked the committee to take it off the table to consider the amendments.

Motion: REP. KOTTEL MOVED TO RECONSIDER HB 481.

Discussion:

REP. S. SMITH said the bill was put on the table for good reason and they did not feel the group was prepared enough and waiting until the next session would give them time to prepare and do the groundwork.

CHAIRMAN GRIMES said the breadth of the prescriptions and drugs that could be applied and the complexities of some of the physical disabilities and illnesses they have and the issue of masking the symptom with drugs were a concern. These issues could easily be overlooked in the psychologists' area because they do not have the background in the other areas.

REP. KOTTEL replied that reasons she wanted to bring the bill off the table was because there was misinformation given by the psychiatrist regarding the psychology program in the military.

They said it was no longer in existence. She found out that the military has a full program for training psychologists for prescribing psychotropic medication, so it is being done. Also the amendment she presented was to have a delayed effective date. She said it would be hard for the board to put this together. The other amendment increased the minimum hours. She discussed the possibility of additional coursework to gain the knowledge.

Substitute Motion: REP. SIMON MADE A SUBSTITUTE MOTION TO INDEFINITELY POSTPONE THE BILL.

Discussion:

REP. MARTINEZ pointed out it was difficult to know side effects of new drugs.

Vote: A roll call vote was taken. The motion to postpone action on HB 481 carried 10-6.

{Tape: 7; Side: A; Approx. Counter: 301; Comments: Meeting adjourned.}

ADJOURNMENT

Adjournment: Approximately 9:15 p.m.

DUANE GRIMES, Chairman

for DEB THOMPSON, Recording Secretary

DG/dt

HOUSE OF REPRESENTATIVES

Human Services and Aging

ROLL CALL DATE 2-15-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. John Bohlinger, Vice Chairman, Majority	✓		
Rep. Carolyn Squires, Vice Chair, Minority	✓		
Rep. Chris Ahner	✓		
Rep. Ellen Bergman	✓		
Rep. Bill Carey			
Rep. Dick Green	✓		
Rep. Toni Hagener	✓		
Rep. Deb Kottel	✓		
Rep. Bonnie Martinez	✓		
Rep. Brad Molnar	✓		
Rep. Bruce Simon	✓		
Rep. Liz Smith	✓		
Rep. Susan Smith Late	✓		
Rep. Loren Soft	✓		
Rep. Ken Wennemar	✓		

HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **House Bill 385** (first reading copy -- white) **do pass as amended.**

Signed: _____
Duane Grimes, Chair

And, that such amendments read:

1. Title, line 7.
Following: "ENFORCES SUPPORT"
Insert: "; AUTHORIZING SALE OF SUPPORT DEBTS;"
Following: "SECTIONS"
Insert: "27-2-201,"
Following: "40-5-226"
Insert: ", 40-5-255"

2. Page 10.
Following: line 28
Insert: "**Section 6.** Section 40-5-255, MCA, is amended to read:
"**40-5-255. Charging off child support debts as uncollectible -- sale of support debts.** (1) Any support debt due the department from an obligor, which debt the department determines uncollectible, may be transferred from accounts receivable to a suspense account and cease to be accounted as an asset. If a warrant for distraint has been filed and the support debt has subsequently been charged off as uncollectible, the department shall issue a release of lien.

(2) At any time after 10 years from the date of termination of the support obligation, the department may charge off as uncollectible any support debt upon which the department finds there is no available, practical, or lawful means by which the support debt may be collected. A proceeding or action under the provisions of this part may not be begun after expiration of the 10-year period to institute collection of a support debt. This

Committee Vote:
Yes 13, No 3.

part may not be construed to render invalid or nonactionable a warrant for distraint issued by the department prior to the expiration of the 10-year period or an assignment of earnings executed prior to the expiration of the 10-year period.

(3) The department may discount and sell to a private collection agency, credit bureau or other private entity any interest that the state and the department may have in the unpaid balance of the support debt created by 40-5-221 and 53-4-248 or assigned to the department under 53-2-613.

(a) The sale shall be by sealed bid to the highest bidder provided that the highest bid is not less than 10 percent of the value of the support debt subject to the sale.

(b) The sale shall be subject to conditions and terms which the department may set out in a sales contract.

(c) The department shall publish notice of the sale in a newspaper having statewide circulation once a week for 4 successive weeks.

(d) Proceeds shall be paid into the state treasury to the credit of the child support enforcement division special revenue fund.""

Renumber: subsequent sections

3. Page 11.
Following: line 17
Insert: "**Section 8.** Section 27-2-201, MCA, is amended to read:

"**27-2-201. Actions upon judgments.** (1) Except as provided in ~~subsection~~ subsections (3) and (4), the period prescribed for the commencement of an action upon a judgment or decree of any court of record of the United States or of any state within the United States is within 10 years.

(2) The period prescribed for the commencement of an action upon a judgment or decree rendered in a court not of record is within 5 years. The cause of action is considered, in that case, to have accrued when final judgment was rendered.

(3) The period prescribed for the commencement of an action to collect past-due child support that has accrued after October 1, 1993, under an order entered by a court of record or administrative authority is within 10 years of the termination of support obligation.

(4) The period prescribed for the commencement of an action to collect past-due child support that has accrued under a support order issued in another state, in a foreign country, or in a tribal court is as provided in subsection (3) or as provided in the law of the issuing jurisdiction, whichever period is longer.""

Renumber: subsequent sections

HOUSE STANDING COMMITTEE REPORT

February 16, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **House Bill 468** (first reading copy -- white) **do pass**.

Signed: _____
Duane Grimes, Chair

Committee Vote:
Yes 13, No 3.

401257SC.Hdh

HOUSE STANDING COMMITTEE REPORT

February 16, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **House Bill 504** (first reading copy -- white) **do pass.**

Signed: _____
Duane Grimes, Chair

D.S.

Committee Vote:
Yes 15, No 1.

401300SC.Hdh

HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **House Bill 539** (first reading copy -- white) **do pass as amended.**

Signed: _____
Duane Grimes, Chair

And, that such amendments read:

1. Title, lines 7 and 8.
Following: line 6
Strike: lines 7 through "CIGARETTES;" on line 8
Insert: "PROHIBITING THE SALE OF SINGLE CIGARETTES;"

2. Page 2, lines 8 and 9.
Following: "law." on line 8
Strike: remainder of line 8 thorough "package." on line 9
Insert: "Single cigarettes may not be sold."

3. Page 2, line 13.
Following: "$100."
Insert: "The department may collect the penalty in the manner provided for the collection of other debts."

4. Page 2, line 14.
Following: "16-11-305(1)"
Insert: "or 16-11-307"

5. Page 2, line 19.
Following: line 18
Insert: "(a) A first through third offense is punishable by a verbal notification of violation."
Renumber: subsequent subsections

6. Page 2, line 19.

Committee Vote:
Yes 15, No 1.

411618SC.Hbk

Strike: "first"
Insert: "fourth"

7. Page 2, line 21.
Strike: "second"
Insert: "fifth"

8. Page 2, line 25.
Strike: "third"
Insert: "sixth"

9. Page 2, line 27.
Strike: "fourth"
Insert: "seventh"

10. Page 2, lines 29 and 30.
Strike: subsection (3) in its entirety
Renumber: subsequent subsections

11. Page 3, line 3.
Strike: "(1)(c)"
Insert: "(2)(d)"
Strike: "(1)(d)"
Insert: "(2)(e)"

12. Page 3, lines 17 through 21.
Following: "notice" on line 17
Strike: remainder of line 17 through "records" on line 21
Insert: "of assessment must provide an opportunity for a hearing pursuant to the provisions of the Montana administrative procedure act. Within 30 days from the date the notice of assessment was mailed, the owner or manager shall notify the department of corrections and human services that the owner or manager objects to the assessment and request a hearing pursuant to this section"

13. Page 3, line 22.
Strike: "subsection (8)"
Insert: "subsections (2)(d) and (2)(e)"

14. Page 3, lines 22 through 26.
Following: "determination" on line 22
Strike: remainder of line 22 through "Act" on line 26
Insert: "issued under subsection (6) that a person has violated 16-11-305(1) or 16-11-307, shall not be reheard by the department"

15. Page 4, line 3.
Strike: "fourth"
Insert: "sixth"

16. Page 4, line 5.
Following: "alleged"
Strike: "fourth"

17. Page 4, line 9.
Following: "proceedings, the"
Strike: "fourth"

18. Page 4, line 22.
Following: "contract"
Strike: "or by other means"

19. Page 4, line 27.
Strike: "16-11-306,"

-END-

HOUSE STANDING COMMITTEE REPORT

February 16, 1995

Mr. Speaker: We, the committee on **Human Services and Aging** report that **House Bill 509** (first reading copy -- white) **do pass**.

Signed: _____
Duane Grimes, Chair

Committee Vote:
Yes 16, No 0.

401302SC.Hdh

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE 2-15-95 BILL NO. 385 NUMBER _____

MOTION: _____

amend

NAME	AYE	NO
Rep. Duane Grimes, Chairman		✓
Rep. John Bohlinger, Vice Chairman, Majority		
Rep. Carolyn Squires, Vice Chairman, Minority		✓
Rep. Chris Ahner		
Rep. Ellen Bergman		
Rep. Bill Carey		
Rep. Dick Green		
Rep. Toni Hagener		✓
Rep. Deb Kottel		
Rep. Bonnie Martinez		
Rep. Brad Molnar		
Rep. Bruce Simon		
Rep. Liz Smith		
Rep. Susan Smith		
Rep. Loren Soft		
Rep. Ken Wennemar		

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE _____ BILL NO. _____ NUMBER _____

MOTION: Do Pass HB 468.
Simon

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority	✓	
Rep. Carolyn Squires, Vice Chairman, Minority		✓
Rep. Chris Ahner		
Rep. Ellen Bergman		
Rep. Bill Carey		
Rep. Dick Green		
Rep. Toni Hagener		
Rep. Deb Kottel		
Rep. Bonnie Martinez		
Rep. Brad Molnar		
Rep. Bruce Simon		
Rep. Liz Smith		✓
Rep. Susan Smith	✓	
Rep. Loren Soft	✓	
Rep. Ken Wennemar		✓

HOUSE OF REPRESENTATIVES

In Limbo

ROLL CALL VOTE

Human Services and Aging Committee

DATE _____ BILL NO. 522 NUMBER _____

MOTION: _____

Table

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority		✓
Rep. Carolyn Squires, Vice Chairman, Minority		✓
Rep. Chris Ahner		✓
Rep. Ellen Bergman	✓	
Rep. Bill Carey		✓
Rep. Dick Green	✓	
Rep. Toni Hagener		✓
Rep. Deb Kottel		✓
Rep. Bonnie Martinez	✓	
Rep. Brad Molnar	✓	
Rep. Bruce Simon	✓	
Rep. Liz Smith	✓	
Rep. Susan Smith	✓	
Rep. Loren Soft		✓
Rep. Ken Wennemar		✓

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

In Limbo

Human Services and Aging Committee

DATE _____ BILL NO 522 NUMBER _____

MOTION: DO Pass

NAME	AYE	NO
Rep. Duane Grimes, Chairman		✓
Rep. John Bohlinger, Vice Chairman, Majority	✓	
Rep. Carolyn Squires, Vice Chairman, Minority	✓	
Rep. Chris Ahner	✓	
Rep. Ellen Bergman		✓
Rep. Bill Carey	✓	
Rep. Dick Green		✓
Rep. Toni Hagener	✓	
Rep. Deb Kottel	✓	
Rep. Bonnie Martinez		✓
Rep. Brad Molnar		✓
Rep. Bruce Simon		✓
Rep. Liz Smith		✓
Rep. Susan Smith		✓
Rep. Loren Soft	✓	
Rep. Ken Wennemar	✓	

6 5

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE _____ BILL NO. 532 NUMBER _____

MOTION: Hagener motioned Tabled

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority		✓
Rep. Carolyn Squires, Vice Chairman, Minority	✓	
Rep. Chris Ahner	✓	
Rep. Ellen Bergman	✓	
Rep. Bill Carey	✓	
Rep. Dick Green	✓	
Rep. Toni Hagener	✓	
Rep. Deb Kottel	✓	
Rep. Bonnie Martinez	✓	
Rep. Brad Molnar	✓	
Rep. Bruce Simon	✓	
Rep. Liz Smith	✓	
Rep. Susan Smith		✓
Rep. Loren Soft	✓	
Rep. Ken Wennemar	✓	
	14	2

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Human Services and Aging Committee

DATE _____ BILL NO. 507 NUMBER _____

MOTION: _____

Tabled

NAME	AYE	NO
Rep. Duane Grimes, Chairman	✓	
Rep. John Bohlinger, Vice Chairman, Majority		✓
Rep. Carolyn Squires, Vice Chairman, Minority		✓
Rep. Chris Ahner	✓	
Rep. Ellen Bergman	✓	
Rep. Bill Carey		✓
Rep. Dick Green	✓	
Rep. Toni Hagener	✓	
Rep. Deb Kottel		✓
Rep. Bonnie Martinez	✓	
Rep. Brad Molnar	✓	
Rep. Bruce Simon	✓	
Rep. Liz Smith	✓	
Rep. Susan Smith	✓	
Rep. Loren Soft	✓	
Rep. Ken Wennemar		✓

11 5

Roll Call Vote

HOUSE OF REPRESENTATIVES HB 481

Human Services and Aging

ROLL CALL DATE 2-15-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Duane Grimes, Chairman	✓		
Rep. John Bohlinger, Vice Chairman, Majority	✓		
Rep. Carolyn Squires, Vice Chair, Minority		✓	
Rep. Chris Ahner		✓	
Rep. Ellen Bergman	✓		
Rep. Bill Carey	✓	✓	
Rep. Dick Green	✓		
Rep. Toni Hagener		✓	
Rep. Deb Kottel		✓	
Rep. Bonnie Martinez	✓		
Rep. Brad Molnar	✓ → X		
Rep. Bruce Simon	✓		
Rep. Liz Smith	✓		
Rep. Susan Smith	✓		
Rep. Loren Soft	✓		
Rep. Ken Wennemar		✓	
	10	6	

Kottel motion off table Brad-yes

Simon motion to postpone ✓

- POSTPONED -

EXHIBIT 1
DATE 2/15/95
HB 507

Michael Downey, 527 East 6th Ave. Helena, MT 59601
444-6759(W) - 449-3583(H)

Testimony in support of House Bill #507

Mr. Chairman, members of the committee. For the record my name is Michael Downey. I work for the Dept. of Natural Resources here in Helena. I am here today on leave, testifying as a concerned citizen.

Approximately 10 years ago, at the age of 23, I suddenly started having epileptic seizures. At the time, I was carrying an individual policy with Blue Cross. Three years ago, I underwent brain surgery to correct my condition as an epileptic. The operation was successful, and I have not had a seizure since. That operation cost over $100,000 dollars. Without private insurance, I never could have undergone this procedure, and I would not be here today.

Nine months after surgery, I moved to Vermont to attend graduate school. Fortunately, Vermont requires insurers to transfer **equivalent** coverage, and my post-operative care continued uninterrupted. Then, in September of 1993, I developed lip cancer. Since my policy transferred, I remained protected.

I moved to Montana last May, after finishing graduate school in Vermont. Soon after I arrived, I inquired about transferring my policy with Blue Cross of Montana. As a Blue Cross provider, they are required to transfer coverage, however, the conversion policy they offered was inferior and exorbitantly expensive.

My policy in Vermont provided **80/20 coverage** with $1000 deductible at a **cost of $417.00 per quarter**. Blue Cross of Montana offered a couple of options. The closest coverage to my old policy provided **60/40 coverage** with a $1000.00 deductible at **a cost of $363.00 per month. That is an increase from $1668.00 per year for 80/20 coverage to $4358.00 per year for 60/40 coverage, or in other terms a 260% increase for inferior coverage.** My other option was to apply as a new subscriber subject to exclusions on pre-existing conditions.

Blue Cross requires subscribers to maintain residency. Once I moved, my coverage was **automatically** transferred. I cannot afford the conversion policy they

offered, and my pre-existing conditions are such that coverage with exclusions is all but worthless. I have since lost my individual coverage. I am left without any coverage for health problems related to my past conditions. Blue Cross of Montana has effectively circumvented its conversion obligation as a Blue Cross provider by pricing conversion out of reach of the average policy holder.

I currently work for the state of Montana, but the state policy excludes pre-existing conditions for one year. My position with DNRC is only temporary, through June of this year. If I am unable to secure new employment with the State, a very real possibility, my health insurance options are limited and expensive. Any new coverage will carry a pre-existing exclusion. I am healthy today. I see a neurologist on a yearly basis, and my five year survival rate as a result of cancer is better than 95%. I am not a burden on the health care system, but I am at risk. I am exactly the type of individual that needs to maintain uninterrupted health insurance.

I am not a deadbeat and I pay my bills. I have done all I can to continue my insurance coverage. In spite of my efforts, I have lost the insurance I need. If I develop health problems related to my pre-existing conditions, I will likely be forced to rely on services financed by the public because Blue Cross has managed to avoid their conversion obligations. The system is set-up to exclude people who need coverage most.

Blue Cross presents itself as one big family. In my family, we take care of each other. I urge you to support this legislation. Thank you for this opportunity to testify. I would be happy to answer any questions you may have.

Michael Downey

EXHIBIT 2
DATE 2/15/95
HB 504

Coalition of Montanans
Concerned with Disabilities

P.O. Box 5679
Missoula, MT 59806
(406) 721-0694

February 15, 1995

Chairman Duane Grimes
House Committee on Human Service and Aging
Capitol Station
Helena, MT 59620

RE: House Bill No. 504: Personal Assistance Reform Bill

Dear Chairman Grimes and Members of the Committee:

The intent of this legislation is to make available to people with disabilities who require personal assistance services the option of directing their own care through a self directed service model which recognizes the consumer as employer. Further, this legislation will promote cost savings in the Medicaid-funded personal assistance service program through two primary mechanisms. First, persons participating in the self directed program will not require the oversight, supervision, and control by a medically-oriented provider agency, as is currently practiced in the PAS program administered by West Mont. Lower administrative and nursing intervention costs will provide cost savings. Second, the act will allow personal assistants to perform routine health maintenance activities, judged by a physician or health care professional to be safe for that individual to receive, to be performed by a personal assistant rather than by licensed nurses as required by current state law. Personal assistant wages are considerably lower than those of LPN's or RN's, which translates into additional money saved.

It is important that committee members understand a few key issues in considering this legislation. First, the self directed service model is not designed to meet the needs of all people currently receiving personal assistance services in the state of Montana. It is targeted for those individuals who have the capacity and the desire to direct their own services to do so without the intrusion in their daily life imposed by an outside agency. For these individuals, this legislation opens the door for increased independence, dignity, and freedom from unnecessary bureaucracy and intervention in their day to day lives. On the other hand, it is well recognized that many individuals have neither the skills, nor the desire to participate in a self directed program. This bill would do nothing to prevent such individuals from receiving the current, more medically-oriented personal assistance services through an agency-based model, as currently seen in the West Mont program.

Second, it is important to understand that the self directed personal assistance model, while not a medical model, does address a fundamental need to insure that the basic health and safety needs of participants are met. Some health care professionals may argue that without ongoing nurse supervision and extensive training of personal assistants that individuals' health will be jeopardized. This is not the case. The major protection against this occurrence lies in the definition of health maintenance activities as defined in the legislation. On page four, lines 14 - 18, the bill clearly spells out that "health maintenance activities" to be performed by personal assistants are those activities in the opinion of the physician or other health care professional for the person with a disability that could be performed by the person if the person were physically capable and if the procedure can be safely performed in the home. Also, on page one in the statement of intent for HB 504, the legislation reads (lines 20 - 23) that before a person with a disability would be allowed to act as an employer, the person must also have a plan of care approved by a physician or health care professional, stating what aspects of the disabled person's care the personal assistant may be assigned. In short, only those health maintenance activities which the health care professional and the consumer agree on which may be safely performed will be included under the tasks which personal assistants may provide.

Third, consumer responsibility is a key concept in a self directed personal assistance service model. The administrative rules to be adopted by the Department of Social & Rehabilitation Services and the Department of Labor should provide avenues for consumers to receive training in management of personal assistants if the consumer is in need of such support, and should in addition provide for assistance in the training of personal assistants if necessary. Once trained, however, consumers are responsible for ensuring that their personal assistants work as directed and perform to their satisfaction. The consumers, not a provider agency are responsible for ensuring that their needs are met.

Fourth, it should be noted that many other states have established self directed personal assistance programs which recognize the consumer as employer of personal assistants as opposed to an agency-based model. Kansas, South Dakota, California, Oregon, and New York are among the states which have successfully implemented self directed services.

The National Council on Independent Living (NCIL), in its position on personal assistance services, recognizes key features of the model which is being suggested for Montana. The following are quotes from the NCIL position paper.

* "The PAS users choice, direction and control in selecting, training, scheduling and supervising their personal assistants must be maximized in all management options."

* "All models must be non-medicalized and community based to the greatest extent possible."

* "State issues such as medical and nursing practices acts and personal

EXHIBIT 2
DATE 2-15-95
HB 504

assistants registry acts must be resolved so that health-related tasks such as medication dispensation and injection and catheterization can be performed by unlicensed personal assistants under the direct control and supervision of PAS users when that is the choice."

Further, HB 504 reflects the recommendations for a self directed personal assistance service program which were developed in the fall of 1994 by the Missoula work group established by Montana Department of Social and Rehabilitation Services in order to obtain feedback on reform of Montana's personal assistance service program. Copies of both the working group recommendations and the NCIL position statement of personal assistance services are attached.

On a final note, we would like the committee to consider an amendment to the bill as introduced which would also allow for an "immediately involved representative", such as a parent or guardian, to assume the responsibilities of consumer control in the self directed model if the consumer is unable to direct his or her own care. This provision was inadvertently overlooked as the draft language of this legislation was developed. By allowing family members or guardians to serve in the capacity of the responsible consumer, the state will realize even greater cost savings as more individuals are able to participate in the self directed program.

Respectfully submitted by:

Barbara Larsen

Barbara Larsen,
Coalition of Montanans Concerned with Disabilities

EXHIBIT 3
DATE 2/15/95
HB 504

NCIL

NATIONAL COUNCIL

ON

INDEPENDENT LIVING

POSITION ON

PERSONAL ASSISTANCE SERVICES

NATIONAL COUNCIL ON INDEPENDENT LIVING

POSITION ON PERSONAL ASSISTANCE SERVICES

April 1994

THE NATIONAL COUNCIL ON INDEPENDENT LIVING

The National Council on Independent Living (NCIL) is the only grassroots national organization run by and for people with disabilities. Almost everything NCIL has accomplished to date has been due to the tireless energy and total commitment of NCIL members, the Governing Board and individual volunteers across the nation. In just ten years, NCIL has established itself as THE national voice of the Independent Living Movement, Centers for Independent Living (CILs), and people with disabilities who are leading the disability rights movement.

Centers for Independent Living are community-based, non-residential, nonprofit corporations which are governed and controlled by people with different types of disabilities. CILs provide at least four core services to a cross disability population: individual and systems advocacy, information and referral, independent living skills training, and peer counseling.

There are more than 300 consumer-controlled CILs in the United States today.

NCIL, along with other national disability-related organizations including American Disabled for Attendant Programs Today (ADAPT), the World Institute on Disability (WID), and the Consortium for Citizens with Disabilities (CCD), has been at the forefront in promoting the adoption of a national policy to establish a national Personal Assistance Services (PAS) program. NCIL and other groups committed to a national PAS program are firm in the belief that a national PAS program should have substantial input and influence >from consumers of the service at the governance level and that a national PAS program should be consumer directed and controlled to facilitate the full implementation of the vision of the Americans with Disabilities Act of 1990.

BACKGROUND ON PERSONAL ASSISTANCE SERVICES

Almost 12.6 million Americans require some assistance from another person with daily living tasks such as dressing, eating, toileting, housekeeping, remembering to take medications, balancing a checkbook, and other everyday activities, according to WID. This assistance is called Personal Assistance Services. A study conducted by Families USA reports that 64% of people needing such assistance were not able to get it last year. National long term

services policy is biased in favor of institutionalizing people who need such assistance rather than assisting them in their own homes and/or communities. This bias is reflected in the fact that the federal government spends 82% of federal long-term services funds on nursing homes ($28.4 billion), six times as much as on home and community-based services $4.6 billion). In addition, states that receive Medicaid funding are mandated to finance nursing home confinement for low income people, but have no such requirement for financing Personal Assistance Services for the millions of people with disabilities who could be independent in their homes and communities with such assistance. As a matter of fact, a state must go through a difficult waiver process to get permission from the federal government in order to direct any of its Medicaid funding to home and community-based services. Currently, many states that do have the waiver are cutting back home and community based services including Personal Assistant Services because of tight budgets. Stereotyping attitudes on the part of many people who cannot conceive of people with disabilities living in the community with Personal Assistance Services along with powerful lobbying efforts by the $60 billion nursing home industry have perpetuated this institutional bias for too long.

NCIL POSITION ON PERSONAL ASSISTANCE SERVICES

NCIL's basic position on Personal Assistance Services is that the institutional bias on the part of the federal government and state governments must be reversed and that people of all ages with all types of disabilities must have the option of obtaining assistance with daily living in their homes and communities through a national consumer-controlled Personal Assistance Services program. In addition to cost savings, the dignity, quality of life, and productivity of people with disabilities would be enhanced. Americans with all types of disabilities and all citizens of the United States deserve no less.

NCIL believes that a national Personal Assistance Services program must have certain characteristics in order to meet the needs of people with disabilities in their homes and communities most effectively and efficiently. These characteristics are spelled out below and further delineate NCIL's position on Personal Assistant Services.

Definition of PAS

Personal Assistance Services refers to assistance from another person or persons with tasks in the home or community which people with disabilities would typically by able to do for themselves if they did not have a disability and includes assistance with various types of cognitive, physical, mental and sensory tasks.

Types of PAS

NCIL believes the following comprehensive range of Personal Assistance Services must be available:

Personal services including, but not limited to, assistance with bathing and personal hygiene (including menstrual care), bowel and bladder care (including catheterization), dressing and grooming, transferring, eating, medications and injections, and operating respiratory equipment and other assistive devices.

Household services including, but not limited to, assistance with meal preparation, light and heavy cleaning, laundry, repairs, and maintenance.

Community services including, but not limited to, assistance with shopping, employment, education, participation in community and civic affairs, and leisure.

Cognitive services including, but not limited to, assistance with money management, scheduling, planning, cuing, and decision making.

Communication services including, but not limited to, interpreting, reading, and writing.

Mobility services in and out of the home including, but not limited to, escorting and driving.

Assistance with infant and child care.

Security and safety-enhancing services including, but not limited to, assistance with monitoring alarms and arranging for periodic in-person or telephone contacts.

NCIL further believes that although many of these services do not meet the traditional definition of "medical necessity" and will not result in medical improvements to the disabling conditions, their provision is necessary for people with disabilities to maintain their health and to prevent secondary disabilities and illnesses.

Program Models

Personal Assistance Service users must be able to choose freely from an array of PAS program models ranging from a voucher or direct cash payment model in which consumers totally manage their own PAS without medical supervision and the necessity of a burdensome, costly administrative structure to a contract agency model in which an agency assumes varying degrees of responsibility for managing the PAS.

The PAS users choice, direction and control in selecting, training, scheduling and supervising their Personal Assistants must be maximized in all management options.

The PAS users choice, direction and control of administrative tasks including, but not limited to, determining pay rates, withholding taxes, and paying benefits must be maximized in all management options.

All models must be non-medicalized and community-based to the greatest extent possible.

State issues such as Medical and Nursing Practices Acts and Personal Assistant Registry Acts must be resolved so that health-related tasks such as medication dispensation and injection and catheterization can be performed by unlicensed Personal Assistants under the direct control and supervision of PAS users when that is the choice.

Coverage and Eligibility

NCIL believes that PAS coverage must extend to people of all ages with all types of disabilities including cognitive, sensory, mental and physical disabilities and that eligibility criteria must not discriminate based on age, type of disability and/or any other factor unrelated to need. NCIL's position is that individuals must be eligibility for a national PAS program if they experience a functional disability of a temporary or permanent nature resulting from injury, aging, disease or congenital condition which limits their ability to perform one or more of life's major activities including, but not limited to dressing, bathing, grooming, getting around both inside and outside the home, eating, preparing meals, shopping, cleaning house, communicating, understanding, controlling emotions, and performing cognitive tasks such as problem solving and processing information.

Eligibility criteria must be developed that do not exclude people based on age; type of disability; onset of disability such as congenital, injury, disease, or later age onset; and health, family status, race, national origin, cultural background, religion, gender, sexual preference and/or geography.

Eligibility criteria must not include disincentives for employment and/or marriage.

Eligibility must not be based on income factors although cost-sharing is acceptable based on a sliding income scale.

No person must be forced into or kept in an institution because of the denial of PAS.

Governance of a National PAS Program

NCIL believes that the views of PAS users must be paramount in the design, delivery, and evaluation of a national PAS program.

PAS users must be decisively and formally involved and represented at all levels of policy determination, planning, program design, and implementation of a national PAS program.

Any national and/or state governance mechanisms must include PAS users in substantial decision-making roles.

Any national PAS program that gives states the flexibility to plan, design, and implement state PAS programs must require each state to: 1) develop a long range three to five year plan to be updated annually which delineates the state's PAS philosophy, program design, and implementation and evaluation plans, and 2) establish a policy board consisting of at least 51% PAS users with a broad range of disabilities which has the authority to sign off the required state plan and updates jointly with the lead agency. Such policy boards must be independent of state agencies and must have adequate staff and budgets to carry out the assigned responsibilities.

NCIl believes that whatever national program design and funding mechanisms are employed, states should be required to adopt the definition and provide the basic services, program models, coverage and eligibility criteria, governance mechanisms, and grievance and appeal procedures cited in this position paper in order to provide uniform coverage for people with disabilities across the states.

NCIL further believes that a gradual phase in of a PAS program would be desirable in order that a PAS infrastructure can be developed to meet the demand.

Financial Consideration

NCIL believes that financing mechanisms and regulations for a national PAS program should in no way reflect a bias toward institutionalization and away from Home and Community Based Services.

Cost-sharing and/or tax credits must be part of a national PAS plan based on a sliding scale relative to income, but with a cap on out-of-pocket consumer expenditures at a percentage of income and/or on tax

credits. The families of children who receive PAS benefits must be treated the same as direct PAS users in terms of cost-sharing and/or tax credits.

There must be no unfavorable differential federal PAS match requirement from states relative to any other long-term service program.

Any benefits, including direct vouchers/cash, derived by PAS users must not be treated as disposable income nor counted as income for the determination of eligibility for other statutory benefits/services.

Federal and state governments must clarify tax withholding and Personal Assistant benefit requirements for PAS users and providers.

Long-term services insurance reform should be undertaken in conjunction with a national PAS program which addresses standardized benefits packages and elimination of pre-existing condition exclusions.

No one who receives PAS benefits at the time of adoption of a national PAS program must lose the benefits they are receiving.

Appeal and Grievance Procedures

NCIL believes that a national PAS program must include a uniform appeal/grievance procedure independent of funders, providers, and assessors which has an expeditious time-line and which provides expenses for the use of advocates and/or legal counsel by PAS applicants/users or their families.

Conclusion

NCIl believes that unnecessary institutionalization is a deplorable waste of both human and financial resources and that a national consumer-controlled non-medical model PAS program must be adopted to help assure the elimination and/or avoidance of such waste.

EXHIBIT 4
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RECOMMENDATIONS FOR SELF-DIRECTED PERSONAL ASSISTANCE SERVICE PROGRAM

I. ESTABLISH "CONSUMER AS EMPLOYER" MODEL

Self-Directed Individual, Option A:

The consumer directs his or her own care:

1. the consumer, as employer, is responsible for:

   a. interviewing applicants to be the in-home care provider
   b. selecting the in-home care provider
   c. training the in-home care provider
   d. supervising the in-home care provider
   e. maintaining accurate time logs of the in-home care provider
   f. terminating the in-home care provider

2. Provider Agencies, as payroll agents, are responsible for:

   a. timely payment of the in-home provider
   b. deducting social security, income tax, unemployment insurance, worker's compensation, health insurance
   c. recruitment of applicants for in-home care providers
   d. training the consumers to be employers
   e. assuring a proper standard of care
   f. assistance in the training of in-home care providers at the request of the consumer
   g. initial assessment of PAS needs and ongoing authorization of additional PAS hours

3. SRS, as program administrator, is responsible for:

   a. establishing and monitoring contracts with provider agencies
   b. developing provider agency eligibility criteria and performance standards
   c. providing prompt payment of provider agency claims
   d. maintaining a third party grievance procedure for consumers of both self-directed and agency based programs
   e. identifying provider agencies statewide

Individuals who are not self-directed, but have an immediately involvement representative, Option B:

1. The representative assumes responsibilities of consumer under Option A, above.

2. Provider agencies and SRS assume same responsibilities as in Option A, above.

ISSUES:

1. Numerous states, including Kansas, South Dakota, and Oregon have established self directed PAS programs. In order to implement a "consumer as employer" model in Montana, it may be necessary to change current Department of Labor laws. Please refer to attachments regarding Oregon's statute and the issue sheet describing employment in Kansas.

2. It is vital that the provider agencies to be established as payroll agents operate in a truly consumer orientated manner, thus insuring a truly self directed PAS service program.

3. There is a need for statewide availability for consumers to participate in the self directed program. While statewide availability is the ideal, the self directed model should not be disallowed if statewide coverage cannot be established.

4. Administrative responsibilities of SRS with the addition of a self directed component should not increase greatly since the agency will also be administrating numerous agency-based providers with the expansion to a multivendor system.

II. OFFER SELF-DIRECTED OPTION TO BOTH HOME & COMMUNITY BASED SERVICE (WAIVER) RECIPIENTS AND STRAIGHT MEDICAID RECIPIENTS

ISSUES:

1. There will be two levels of service with this model - waiver has more flexibility with social and other PAS services allowed. Not ideal situation.

2. Include initial assessment and authorization of additional PAS hours in duties of provider agencies.

III. REFORM NURSE PRACTICE ACT TO ALLOW PA'S TO PROVIDE "HEALTH MAINTENANCE" DUTIES IN ADDITION TO ROUTINE PERSONAL ASSISTANCE, HOMEMAKING, COMPANION-TYPE, AND COGNITIVE-ASSISTANCE TASKS.

1. "Attendant Care services" means those basic and ancillary services which enable an individual in need of in-home care to live in the individual's home and community rather than in an institution and to carry out functions of daily living, self-care and mobility.

2. "Basic services" shall include, but not be limited to:

   a. getting in and out of bed, wheelchair or motor vehicle, or both;
   b. assistance with routine bodily functions including, but not limited to: health maintenance activities; bathing and personal hygiene; dressing and grooming; and feeding, including preparation and cleanup.

3. "Ancillary services" means services ancillary to the basic services provided to an individual in need of in-home care who needs one or more of the basic services, and include the following:

   a. homemaker-type services, including but not limited to, shopping, laundry, cleaning and seasonal chores;
   b. companion-type services including but not limited to, transportation letter writing, reading mail and escort; and
   c. assistance with cognitive tasks including, but not limited to managing finances, planning activities and making decisions.

4. "Health maintenance activities" include, but are not limited to, catheter irrigation; administration of medications, enemas and suppositories; and wound care, if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home.

EXHIBIT 4
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ISSUES:

1. Legislative change is large project, coming up quickly.

2. Cost savings with less nursing intervention.

3. Expect major opposition from Board of Nursing.

IV. INCREASE ATTENDANT WAGES

ISSUES:

1. Less administrative expense with self-directed model - use savings for increased wages.

2. Possible difference in wages for self directed versus agency based personal assistants is potential for problems.

V. ALLOW CONSUMER FAMILY MEMBERS TO RECEIVE REIMBURSEMENT FOR PROVIDING PA SERVICES

ISSUES:

1. In rural areas, family members are often the only persons available to provide PA services.

2. A waiver will be needed from HCFA to change definitions of immediate family member to be reimbursed.

EXHIBIT 5
DATE 2/15/95
HB 504

Joe Harrington
2291 Avenue C #6
Billings, MT 59102

Chairman Dwayne Grimes
House Committee on Human Services and Aging
Capitol Station
Helena, MT 59601

February 15, 1995

Dear Chairman Grimes:

My name is Joe Harrington and I am a thirty year old male. As a result of a car accident about ten years ago, my spinal cord was injured at T3-4. The nerves that once controlled my left arm and shoulder were also damaged, in that the seat belt which saved my life, tore the nerves from my spinal cord. The bottom line of all this is that at present I only have the use of one hand and will need a wheelchair for the rest of my natural life. In addition to needing a costly mobility aid, the accident also left me physically unable to perform certain basic tasks for myself, like dressing, getting in and out of bed, some household chores, and toileting. For these duties I must depend upon help from another person, often referred to as a Personal Care Attendant (PCA).

I was a fortunate citizen of Yellowstone County to be involved in the Self-Directed Care Pilot Program from its inception. This was very much a learning experience for me, in that I was given an opportunity to exercise authority over aspects of my life which had, in the past been given to someone other than myself. This program gave me a great deal more control and confidence over my own life and made me feel as if I could accomplish more; because even though I still wasn't able to perform these tasks by myself, I was at least directly responsible to see that my needs were met.

I also graduated from college during this time, and feel as if I must give some credit for that to the Pilot Program. I graduated with a BSED in Elementary Ed. and later returned to school and got my certification in Special Ed. (funding for both of these endavors were largely underwritten by Vocational Rehab). I needed to get out of bed at five a.m. in order to make it to school by eight when I student taught, and I know the higher wages PCA's were paid under the Pilot Program helped in that regard.

I am writing this letter in response to H.B. #504, which could have a very positive impact on my life. As I understand the proposed bill, it would ask the state to

extend employment responsibilities to qualified persons with disabilities under a self directed model.

I don't think I can fully express what this type of freedom and control over my own life would mean, but suffice it to say, it would help a whole lot. I'm not knocking WestMont, so I don't want this to sound like a put-down. I'm grateful that it exists and under a contract from the state they pay people which help me with things which I'm unable to do. However, it usually takes one to two weeks from the time I find, interview, and send an applicant to WestMont (where they are interviewed again and must go through training classes), before they can work with/for me.

This bill could change some of the apprehension for me and that would be an added bonus. It would also increase my personal duties and responsibilities, but when balanced with a greater amount of control over my own life, it would be well worth it and I look forward to the challenge.

I'm presently working, and it feels good to be a more productive member of society. If, however, one of my helpers quit unexpectantly, I might not be able to get to work and could lose my job. I feel that being able to fill gaps in my PCA coverage more quickly would really help me remain employed and contributing to the tax base.

Another area in my life that this amendment could effect positively is in regards to my bowel program. Presently, an LPN is required to do this, and I feel this a waste of money. In the past, my PCA's performed this for me (under my direction) and this was less of a hassle for me. It's bad enough needing help with such a private act in the first place, but having two people around (an LPN and a PCA) seems like even more of an injustice.

Thank you for your consideration in this matter.

Sincerely,

Joe Harrington

EXHIBIT 5
DATE 2-15-95
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February 15, 1995

Mike Mayer
2370 Village Square
Missoula, MT 59801

Chairman Duane Grimes
House Committee on Human Services and Aging
Capitol Station
Helena, MT 59620

Dear Chairman Grimes and Members of the Committee:

I am unable to attend the public hearing in person today but appreciate the opportunity to submit written testimony for your consideration.

I urge you to pass House Bill 504 because I feel that it does much to enhance the independence of Montanans with disabilities who require personal assistance services. I am quadriplegic and have been utilizing personal assistance services for the past 18 years. I am not a Medicaid recipient, and have no other insurance coverage for my personal assistance services, so I pay for my services out of my own pocket. I am considered by the Internal Revenue Service to be a household employer, employing domestic servants. As such, I am responsible for not only the recruitment, training, management, and supervision of my personal assistants, I also have the responsibility for withholding and paying taxes, filing payroll reports, and other administrative tasks.

I am very thankful that I have the ability to manage my own personal assistants and that I am not forced to participate in the Medicaid-funded personal assistance program as it currently exists in this state. Individuals on that system have little or no control over selecting, training, or managing their own personal assistants. House Bill 504 would allow those individuals on Medicaid who receive personal assistance services the same option to manage their own day to day care. People who have the desire and the ability to manage their own services must be given the opportunity to do so. By allowing them to direct their own personal assistance services, the state of Montana will realize cost savings in addition to allowing them more independence and dignity in their day to day routine.

Imagine if you will a situation in which you require assistance but have virtually no control over selecting who comes into your home to help you with very personal and intimate tasks such as bathing, personal hygiene, bowel and bladder care, and other daily functions. How would you feel if you were unable not only to select who comes into your home, but also to control when and how certain tasks are performed. A person should not have to give up such basic rights simply because the state is paying for the

services. The self directed service system which HB 504 would establish would allow other Montanans who receive Medicaid funding the option of being in charge of their daily lives.

I know that certain health care professionals, most probably licensed nurses, will come before this committee and argue that people with disabilities will be put in jeopardy if there is not ongoing nurse supervision and extensive training and certification of personal assistants. They will probably argue that certain tasks, such as bowel and bladder care, wound care, and other basic procedures should only be performed by licensed nurses. They will cite a medical need for requiring ongoing nurse supervision and/or restriction of certain tasks to the realm of licensed nurses only.

This argument does not hold water. Montana's current nurse practice act allows for gratuitous nursing performed by friends or members of the family. As long as friends or family members work without pay, they can provide virtually any nursing service or procedure without restriction or limitation by the nurse practice act. If it were simply a matter of medical necessity, it seems logical that the nurse practice act would not allow any specialized procedures to be done by persons other than licensed nurses. Since the nurse practice act currently allows friends and family members to perform the type of tasks which HB 504 is recommending, it makes perfect sense that trained personal assistants be allowed to do these same procedures at the direction of a person with a disability.

In closing, I thank you for the opportunity to provide written testimony and encourage you to vote yes this important piece of legislation.

Sincerely,

Mike Mayer

Montana University Affiliated RURAL INSTITUTE ON DISABILITIES
52 Corbin Hall, The University of Montana, Missoula, MT 59812

Vietnam Veterans' Children's Assistance Program
634 Eddy Avenue, The University of Montana
Missoula, MT 59812
(406) 243-4131 or 1-800-882-2703
FAX (406) 243-2349

EXHIBIT 5
DATE 2-15-95
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February 14, 1995

The 1995 Legislature of Montana
House Committee on Human Services and Aging Members
The Capitol
Helena, Montana

Dear Representatives,

I am writing to you regarding House Bill No. 504 that you will begin formally discussing on Wednesday, February 15, 1995. As I am unable to attend your committee meeting, I have thus chosen to provide you input through this format. Thank you in advance for taking the time to review my comments.

As a little background and to hopefully give justification of my concerns on this bill I offer the following: I have a Master of Social Work degree, and have been working in my chosen profession for over 20 years. A major portion of this time has been spent assisting individuals improve their living conditions and working on goals toward achieving their fullest potential in life. Specific to these goals have included enabling and empowering individuals to pursue educational endeavors, vocational interests, and basic home-based services, rather than institutional care.

In addition, for nine and 1/2 years I worked as a Long Term Care Specialist for SRS, Medicaid Services(1984-1993). In this capacity, I evaluated individuals for appropriateness in living in their own home environment with specific helping agents. Among these helping agents were personal assistance services, which is the crux of House Bill No. 504. It is my opinion, based on approximately 5,000 cases I was actively involved with, during my tenure with SRS, that the "self-directed model" of control by the consumer was a valid and appropriate course then and even more so today. This bill moves the deinstitutionalization of individuals and self-actualization of individuals with special challenges further along the continuum of care concept.

Therefore, I would like to ask that you give all due consideration to the passage of House Bill 504. In conclusion, I would be more than happy to appear at any future hearings on this bill and share past experiences that may be pertinent toward a positive decision in this matter.

Sincerely,
David A. Smith

David A. Smith, M.S.W.
Social Services/Clinical Director

February 13,1995

Alexandra Enders
P.O.Box 7792
Missoula, MT 59807

Representative Duane Grimes
Chair, House Committee on Human Services and Aging
Montana Legislature
Helena, Montana

Dear Mr. Grimes,

I would like to express my support for House Bill 504, which improves Personal Assistants for Montanans with Disabilities. As a Montana licensed Occupational Therapist, I believe that the changes this bill would cause would be in the best interest of citizens with disabilities who need personal assistants to function independently, as well as in the best fiscal interest of the state. It is undoubtedly less costly for people with disabilities to manage their own assistants, whenever they are capable of doing so. In addition to being a more fiscally responsible option, this approach also gives individuals more control of their lives. They do not have to arrange their schedules awaiting a "skilled visit" from a nurse to carry out a bowel program, for example. They can more fully participate in the regular activities of life -- employment, school, etc, when they can arrange for their personal care, like bowel and bladder care, to flexibly fit with the outside demands on their time. One should not have to organize one's life around the times a nurse can come to your home to help you take care of basic bodily functions; especially when one is capable of supervising these activities oneself.

Not every individual may be prepared to manage and supervise a personal assistant. However, individuals who are capable of supervising their assistants should be permitted, even encouraged, to do so. The underlying principle for deciding if a task can be safely accomplished, should be: if the individual did not have a functional limitation, would they be able to perform this task independently. For example, people with spina bifida, even youngsters, are frequently taught to do their own intermittent catheterization. Many people with a spinal cord injury can safely and competently insert and remove their own foley catheter. If however, the cord injury is above C-6, the person's hands are affected so they will probably not have the hand function to manipulate the apparatus (NB there are exceptions to this, disability levels or diagnosis should never be used as rules for deciding if and when any indivdual is capable of self-directed care.) The individual should be able to supervise an assistant to do this task. The assistant acts as a replacement for the individual's hands. The individual with the disability assumes responsibility, just as they would if they were using their own hands to do the task.

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In the past I was an occupational therapist in California. Individuals in the counties I worked in had the option to manage their assistants even in such tasks as bowel and bladder care. My experience with this approach toward self-directed functional support to daily living tasks is very positive. There were times when I worked with individuals to help them train their own assistants. (A nurse or therapist can be a useful adjunct trainer if and when that might be needed, but should not be required to certify the ability of any particular individual to self-direct and manage their personal assistants.) There were times when I observed experienced individuals mentoring less experienced people with disabilities in personal assistant management techniques. You might contact Peter Leech at the MonTECH program in Missoula (406/243-4597) for more information about the efficacy of peer training and mentoring. Mr. Leech is a social worker, who himself has a disability. Mr. Leech has developed and taught peer counselling and peer mentoring techniques for more than 20 years.

Again, I would like to restate my support for House Bill 504. If there is more information I can provide, please feel free to contact me at 406/726-3809.

Respectfully,

Alexandra Enders

Alexandra Enders, OTR/L

Peter Leech, M.S.W.
5190 Old Marshall Grade
Missoula, MT 59802
406-549-3239

February 13, 1995

Representative Duane Grimes, Chairman
House Committee on Human Services and Aging
House of Representatives Chambers
Capitol Station
Helena, MT 59620

Dear Mr. Chairman, Vice-Chairman and Members of the Committee:

RE: HB-504

I am a Clinical Social Worker with over 31 years of experience working in the field of physical rehabilitation, independent living skills and assistive devices for people with disabilities. I am also a person with a disability acquired almost 39 years ago, which requires me to use a wheelchair for mobility. I am writing today to request your support of HB-504, a Bill to govern self-directed personal assistance services for people with disabilities.

This Bill will allow those people with disabilities who are able, to manage their own personal assistance services at considerable savings of costs over the system currently in place.

As a person with a disability, I can state emphatically that being able to schedule the personal assistance services I needed according to my schedule, rather than some agency's schedule, was essential for me to be able to attend college and graduate school and develop the marketable skills necessary for me to return to work.

In my work over the years, I have seen too many good plans for education, training and self-sufficiency end in frustration and failure because the plan for personal assistance services supported dependence rather than independence. A self-directed program will support the efforts of people with disabilities to achieve independence.

I encourage you and members of the committee to explore the cost-benefits of such a program and recommend a "do-pass" vote to the House of Representatives.

Very truly yours,

Peter Leech

Fax Transmittal Memo # of Pages 1

To: Jim Meldrum	From: Peter Leech
Co.: MILP	Co.: MonTECH
Dept.:	Phone # 243-5676
Fax # 442-1612	Fax # 243-4730

RCFX14

EXHIBIT 6e
DATE 2/15/95
HB 504

Paul Peterson
6216 Longview Drive
Missoula, MT 59803
(406) 251-6070
(406) 728-1630 (W)

February 15, 1995

Chairman Grimes
House Committee on Human Services and Aging
Capitol Station
Helena, MT 59620

Chairman Grimes and members of the committee:

I used personal assistants for about 8 years in the past and would like to see HB504 approved by this committee.

A group of people with disabilities and others in Montana have been trying to make reforms with regards to the Medicaid personal assistance program. We have attempted to work with SRS and the Board of Nursing as well as the Department of Labor with only limited success. We have had success with SRS and support from the Department of Labor, but have not had so with the Board of Nursing.

I had taken on the roll of communicating with the Board of Nursing and have repeatedly had trouble getting phone calls returned and was even told that in order to get a copy of regulations pertaining to nursing delegation I would have to send in a written request. I sent in a list of suggested changes in delegation before the last set of rules hearings on delegation and heard nothing in return. Rather than allowing people to have more control over their lives, things have gotten worse.

We are here before this committee today because of this history, some of it dating back to 1986 or earlier.

This bill is important because people with disabilities want control over their own lives. We recognize that the costs of Medicaid are rising and this threatens services that are needed by us and others. This bill will help reduce administrative costs by eliminating some of the middle persons. This legislature is the one advertised as the one to turn control over to the people. Here is your chance to do it.

Thank you for your attention. i again ask you to pass HB504.

Sincerely,
Paul Peterson

Paul Peterson

EXHIBIT 7
DATE 2/15/95
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Coalition of Montanans
Concerned with Disabilities

P.O. Box 5679
Missoula, MT 59806
(406) 721-0694

February 14, 1995

Chairman Duane Grimes
House Committee on Human Services and Aging
Capitol Station
Helena, MT 59620

re: Personal Assistance Services reform--HB 504

Dear Chairman Grimes and Members of the Committee:

I am testifying today as the state President of the Coalition of Montanans Concerned with Disabilities, or CMCD. CMCD is Montana's state-wide disability rights coalition, and we have worked with disability leaders throughout the state in the design of this bill. It has been a long time in the making, and is based on the experience of people with disabilities throughout the country who use Personal Assistance Services, or PAS. It represents what many other states have done in their respective Legislatures to solve many of the problems people with disabilities have faced concerning PAS. We have had these same problems in Montana for years, and have heard time and time again the legitimate complaints consumers of these services have experienced. It is that the state of Montana act to resolve these problems, and the Legislature can go a long way toward doing that by passing this bill.

Consumers have complained, with little response, for years about a number of issues. Westmont, the single state-wide vendor for PAS in Montana, used to have an annual turnover rate of about 400%; though I do not know the exact current figure, the last estimate I heard was approximately 100%. This means that the entire staff of Personal Assistant's used to turn over completely four times a year, and now this occurs once a year. This virtually guarantees that very few trained Personal Assistants will ever enter a person's home, and that consumers will constantly be in the process of hiring and training new PA's. This bill would substantially improve that situation by allowing consumers to hire, fire, train, manage, and supervise their own PA's, thus allowing them a much greater ability to control and manage these most personal and intimate services being provided to them in their own home, without relying on some bureaucratic administrative service provider to do it form them.

This will also allow consumers the ability to fire Personal Assistants who mistreat them, steal from them, come to the job under the influence of alcohol or drugs, fail to show up to get them out of bed in the morning, or put them to bed at night, or who otherwise abuse or neglect them. We have heard such complaints for years throughout the state on a fairly regular basis, and we know that such problems continue to this day. Passing HB 504 would very effectively address many of these problems, and we know that these measures have worked well in other states.

These are very basic services that are routinely performed by people such as myself, who have the physical ability to perform these tasks independently. They are routinely performed by family members for people with disabilities who do not have the physical ability to perform these tasks themselves. They require no formal medical training, and are regular taught to people with disabilities and family members in a very short time in every rehabilitation center in the country. Why should Montana's laws deny this option to hundreds of people who can easily train their own PA's to perform these services safely and efficiently? And who should the taxpayers of Montana be forced to pay licensed nurses two or three times the cost of these services when their level of training and expertise is completely unnecessary for the performance of these simple tasks? It seems to me that we went into this session with a clear mandate from the voters that this Legislature was to cut bureaucracy and costs wherever they could reasonably be cut, and to get the government off the backs of the citizens of Montana. Passing HB 504 would do both, while maintaining and enhancing the quality of care available to Montanans who need these services and wish to remain as independent as possible in their communities. We strongly urge the Committee to pass this bill for the benefit of all the people of Montana, especially for those who simply wish to live their lives as independently as they can and with as little interference as possible.

Sincerely,

Michael J. Regnier

Michael J. Regnier
President, CMCD

mjr

EXHIBIT 8
DATE 2/15/95
HB 504

Chairman Grimes
House Committee on Human Services and Aging

My name is Ernie Pepion, I would like to give my support to House Bill 504, the bill that allows personal care attendants to perform certain duties that are now restricted by the nurse practitioner law. I am a quadriplegic and require daily assistance of a personal care attendant, which the self-directed program of WestMont provides me with. The self-directed program allows me to hire my own personal care attendant and terminate them as well.

In 1972, while in rehabilitation, I was told I had to be independent and learn to instruct other individuals about duties that I could not perform on my own. One of these duties was my bowel care program, and from 1972 until April of 1993 I trained my personal care attendants in this procedure. I had absolutely no problems health related or otherwise. In April of 1993 WestMont, my personal care attendant contractor, started enforcing the Nurse Practitioner Law and problems have been occurring. Since that time I have been restricted from using personal care attendants to assist me and forced to have a nurse come into my home to do my bowel program every other day. On weekends a different nurse comes, who is on a time constraint, and is not sensitive to my bodily needs. Often my weekend bowel care is incomplete.

My nurse, who comes in to do my bowel care every other day costs extra, not only to myself but to the taxpayer as well. I make a $2 co-payment for each visit, which amounts to $30 a month. This situation also forces me to be more dependent by having more people involved in my personal care than I need. This situation sometimes leads to voluntary bowel movements. This is not only embarrassing, but it takes away from my sense of dignity and independence. It also could eventually lead to major skin breakdown, which would lead to an expensive hospitalization.

I believe that more self-directed programs which allow a personal care attendant to perform bowel care and other duties as listed in the new self support bill HB 504 should be implemented. This would give the individual more independence and be less expensive. Since the personal care attendants wages are just above minimum wage it is extremely important that we carefully screen for personal care attendants who will be responsible, dependable and committed to the individual's care.

Sincerely,

Ernest Pepion

Ernie Pepion

EXHIBIT 9
DATE 2/15/95
HB 504

TESTIMONY OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES BEFORE THE ~~HUMAN SERVICES APPROPRIATIONS SUB-COMMITTEE~~ House Committee on Human Services and Aging
(Re: HB 504)

The Department supports HB 504. House Bill 504 provides direction to both the Department of Social and Rehabilitation Services and the Department of Labor to develop rules governing personal assistant services, specifically relating to a self-directed service model. It also requests that persons with a disability who direct their own care be exempted from the nurse practice act.

The Department has been working closely with a group of disabled individuals to develop a self-directed program which incorporates the national trend of empowering a person with a disability to arrange for and direct the use of a personal care attendant. The creation of this program would provide disabled Montanans with the opportunity to take control of very personal services, which is in line with promoting self sufficiency and preserving dignity.

The Department, as they have in the past, is willing to work with the Department of Labor to establish guidelines for this 'consumer as the employer' model of care. The Department is dedicated to developing this program with respect to protection and safety of the consumer, caregiver and the community.

By allowing these individuals to be exempt from the Nurse Practice Act, we are returning the control of these very personal services, back to the consumer. A person with a disability, is currently not able to over see such activities of daily living without the intervention of a skilled nurse. A person without a disability has control over these types of tasks. The Department supports the exemption of self directed participants from the Nurse Practice Act.

On behalf of the Department of Social and Rehabilitation Services, I urge you to pass HB 504.

Joyce DeCunzo
Medicaid Services Division

EXHIBIT 10
DATE 2/15/95
HB 504

Chairman Grimes
House Committee on Human Services and Aging

Members of the committee, It is my hope that my testimony today will be valuable as you decide, in part, the fate of HB 504

Eight years ago a nightmare became my reality as I lay in a hospital bed, a quadriplegic after surgery. Two years later my property and bank account were depleted. The walk to state agencies began. My once independent lifestyle had come to an abrupt and unexpected end.

I became dependent on the state and required help from three different state agencies for a variety of services. Case management provided me with house keeping services. My personal care attendants assisted me with bathing, dressing, and other personal needs. Registered nurses were also required to do things like clipping toenails, checking blood pressure and administering prescribed medication. Because there were so many people involved with my care and their territories so strictly defined, I was left very disoriented. Every individual service group had their rules. My delemma was, "who could do what" in my own home?

I just wanted to have my needs met with the least amount of hassle and confusion. Then, as now, I would like to be able to hire someone I trust, without any interference from the state.

Thank you for listening to my concerns

Sincerely

Dorinda Orrell
P.O. Box 265
Belgrade, MT 59714
406-388-4411

EXHIBIT 11
DATE 2/15/95
HB 504

February 15, 1995
TESTIMONY HB 504

My name is **Jean Ballantyne.** I am a registered nurse from Billings and serve as a member of the Montana State Board of Nursing. As you are aware, the Board of Nursing exists to protect the public health welfare and safety in all matters related to nursing. The Board of Nursing is taking a position of neutrality on HB 504. On behalf of the Board, I am offering for your consideration these comments and concerns.

This bill was introduced without the input of the Board of Nursing. There has been no dialogue about this issue between the Board of Nursing and Department of SRS.

This bill asks that Personal Assistants utilized by persons with a disability be allowed to perform functions which are subject to regulation by the Board of Nursing. Such nursing functions that are named in the bill under "health maintenance activities" include urinary systems management, bowel treatments, administration of medications, and wound care. As you are aware, the Board of Nursing was given statutory authority from the 1993 legislature to write rules for the delegation of nursing tasks. Under current board rules, delegation of the task of administering medication is allowable in specific settings (the home is one such setting). However, the delegation rules do require that the administration of medications be supervised by a licensed nurse. Rules for the delegation of additional nursing tasks have not been developed. This does not mean that the Board of Nursing will not do so. These issues require thoughtful consideration and input from many interested parties. Always in such deliberations, the board of nursing's considerations are focused on the protection of the public.

HB 504 would exempt from the nurse practice act personal attendants who are performing nursing tasks when such an attendant is employed by a disabled person. While on the surface such an arrangement may seem acceptable in terms of promoting independent living for the disabled, we would caution you that there is a negative side. Cost savings derived from providing less nursing care can ultimately increase costs due to complications that result from a lack of nursing attention. Please ask yourselves: With no license to lose, how will attendants who engage in misconduct in their duties be held accountable...other than to lose their jobs and go on the to the next unsuspecting vulnerable person?

We hope that you are able to see that the Board of Nursing does not view this issue as one of nursing turf; rather we express our caution to you and our concern for the potential of harm to the consumer.

Thank you for your consideration of these comments.

Jean Ballantyne MNRN

EXHIBIT 12
DATE 2/15/95
HB 504

TESTIMONY
NANCY HEYER, RN, PRESIDENT
MONTANA STATE BOARD OF NURSING
HB 504 [redacted]

Jean Ballantyne will read my testimony into the record. I am out of state and unable to be with you today.

My testimony is based upon Board discussion held on February 14 per conference call. Our members received word of this bill by reading about it in the newspaper. Please consider the following:

Just last week I stood before you to tell you of another bill which was drafted and introduced without prior discussion with the Board. In November, I received through my work, a copy of a document prepared by SRS which describes a model of delivery of care in which "disabled" persons would be able to self-direct their care by personal attendant. There was a November Board meeting. Since this document has been around for some time with an acknowledgment that the Board of Nursing would strongly oppose, I must raise the question why SRS did not see fit to come to that Board meeting or others prior to that time to discuss this. Since SRS participated fully in the development of SB 121, Delegation of Nursing, and had been told numerous times that adding nursing tasks beyond Administration of Medications was entirely possible and probable should the rules be successfully implemented . I also point out to you that just because the Board issues rules to Delegate, this is not a mandate for all institutions or nurses to participate in Delegation. This bill forces SRS clients to participate in one model of care.

This bill sets up a model of care for ALL 'disabled' persons. No more than hospital or nursing home care is the "only" model for care, but our citizens can be best served when different models of care are provided to fit their needs as their function deteriorates or improves. SB 121 makes this bill unnecessary. As outlined last week, the Board's intent on SB 121 was to improve access to care in settings or situations where there is little nursing care available. "Disabled" folks live in all kinds of settings, some where there is a full staff of licensed nurses. Their competency in choosing, training and directing non-licensed personnel to fulfill all of their physical needs could be highly questionable in some cases.

This bill includes Section (a) through (d). There is a list, often called a "cookbook" or menu of activities. Nurses, if involved in the care, supervise and direct non-licensed persons to do what they must do. We are opposed to any list of activities to be listed in the Practice Act. This does not improve the durability of any list because of changing technology. We have particular issue with: (b)iii "Health Maintenance Activities: defined in the proposed amendment to the Practice Act. It is my duty to tell you:

Urinary Systems Management: Could range from a Foley catheter placed into the urethra under sterile conditions on Quadriplegic clients: who can easily suffer from Autonomic Dysreflexia, a life-threatening situation, since a stroke can occur. Is this common? Last week in my agency two disabled gentlemen landed in the hospital for such a syndrome which resulted directly from a -ROUTINE Catheter change. This could also mean inserting a sterile catheter into the urethra of a disabled child, and it could also mean inserting a catheter into an incision into the abdomen called a Suprapubic Catheter. In all cases, sterility is not even the main issue, but the knowledge and understanding of the Neurological system..to make the decision whether to NOT perform a task is quite more complicated.

Wound care could be anything from removing a dirty dressing..sterile or unsterile from any human wound. Wound care also requires a method which we remove the old tissue and clean it out by a process of "debridement." It is often painful to a person not paraplegic, however can you imagine the consequences of debriding a wound of a paraplegic who cannot feel the pain, but might get an infection of the bone from poor sterile technique. Bowel treatments?....perforations and pain often occur from a wide variety of bowel care programs.

I submit to you these considerations which are reasonable:

Care should foster independence in the least restrictive environment, with an absolute mandate that if Nursing tasks are required, Nurses perform them and supervise them.

SRS needs to ensure prompt, adequate continuous services regardless of who they say the employer is...who is ultimately responsible?

Review of such activity needs to be conducted by nurses if nursing procedures are being done by personal attendants. The purpose would be to evaluate ongoing appropriateness of this care.

Social Workers, Occupational Therapists and other providers never should be responsible for Nursing activities of unlicensed persons.

"Disabled" should have an established grievance process so they can report problems.

EXHIBIT 12
DATE 2-15-95
HB 504

If the client is the employer, does he get sued for wrongful termination if he decides to "fire" his personal caregiver? SRS pay the settlement? Any self-directed model should allow the clients to make responsible choices including preferring a licensed nurse to perform these duties. There are ethical responsibilities of the payer too.

The care environment should be safe for the client AND the caregivers, one which is free from abuse, neglect or inappropriate care.

Who will determine the competency of the individuals performing the care?

Are consumers qualified to competently choose a non licensed person?

A Self-Directed model of care is not for everyone, and should include clearly specified responsibilities of ALL parties involved in the caregiving process, including the clients, caregivers, provider and payer.

In summary, I assure you that the Board of Nursing has a tough job. The practice of Nursing in America does believe to a certain limit, individuals who are capable of doing so should be able to self-direct care. The Board of Nursing cannot protect the public from itself but WE do have a duty to develop rules and laws which will do this. How do these frail, disabled folks know if they are capable of self-directing care, and who do they turn to when that system fails? They admit to the hospital, or they have to go into a long term care facility. When things go wrong, the nurse is called in to fix the problem. This is no way to take care of our most vulnerable citizens.

Do not hesitate to ask questions of Board members or staff present.

I am grateful for your time.

Respectfully submitted.

EXHIBIT 13
DATE 2/15/95
HB 504

HOUSE OF REPRESENTATIVES
54TH LEGISLATURE

House Human Services & Aging COMMITTEE

WITNESS STATEMENT

Please Print

NAME Patricia Goudie RN BILL NO. HB 504

ADDRESS 31 Sun River - Cascade Rd Sun River MT DATE 2-15-95

WHOM DO YOU REPRESENT?

SUPPORT ____ OPPOSE X AMEND ____

COMMENTS: Health Maintence Activities as defined in Section 2, subsection 3, b, ii, are tasks that fall under the Nurse Practice Act, for good reason. Medication administration, bowel and bladder management, and wound care are more than "tasks" that one can be "trained" to perform. In actuality, the theory and educat that nurses receive are what protect the patient's health and well-being. Nurses do more than perform "tasks"; they monitor and continually assess the patient's response to treatment. They combine this observation with their education, skills and professional judgement to ensure the patient's safety and appropriate response to treatment. This bill would allow uneducated and minimally, or ~~uneducated~~ untrained, persons to perform such invasive procedures as urinary catheterization, medicati injections, and sterile dressing changes with no knowledge of the possible consequences of infection or complications that may resu from improper technique. It seems that th intent of this bill is to cut costs at the expense of public safe trained, licensed, accredited persons to reduce cost is not

EXHIBIT 14
DATE 2/15/95
HB 504

Montana Nurses' Association

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

February 15, 1995

TO: Barbara Booher, MNA Executive Director

FROM: Linda Henderson, RN, Commission on Nursing Practice

RE: HB504

Although the intent of this bill is to allow persons with disability the independence to employ personal care attendants of their choice, in essence it is granting any untrained individual immunity from the Board of Nursing to allow the practice of nursing without a license.

Personal care attendants are usually untrained, unskilled individuals hired by SRS to provide assistance with activities of daily living to disabled individuals. The assistance currently provided by these individuals consists of activities that do not fall under the auspices of nursing. HB504 presumes that a disabled individual is skilled at providing "urinary system management, bowel treatments, administration of medications and wound care" for themselves if they were only physically able, and that they would be able to appropriately direct a personal care attendant to provide this care. This seems to be a very broad assumption. After all, the law requires nurses to receive a minimum of 18 months of education from already qualified nurses to perform these activities. Is it realistic to think that disabled individuals will have the level of knowledge required to instruct personal care attendants so that care can be delivered in a safe and effective manner?

Is this bill in the best interest of the disabled individual? The person with a disability may think that they're getting what they want by being able to more directly impact their own care through the direct hiring process. But they may be getting more than what they bargained for if they themselves do not understand or are not able to effectively communicate how to perform the above listed procedures.

This bill appears to definitely be in the best interests of the Department of Social and Rehabilitative Services. They intend to legislate nursing practice away from nurses and effectively eliminate the need for nurses to serve this population. Will we next be seeing policies that eliminate reimbursement for home health nursing for Medicaid recipients?

EXHIBIT 15
DATE 2/15/95
HB 539

Part 3
Youth Access to Tobacco Products Control Act

16-11-301. Short title. This part may be cited as the "Youth Access to Tobacco Products Control Act".

History: En. Sec. 1, Ch. 569, L. 1993.

16-11-302. Definitions. For the purposes of 16-11-301 through 16-11-308, the following definitions apply:

(1) "Distribute" means:

(a) to give, deliver, sample, or sell;

(b) to offer to give, deliver, sample, or sell; or

(c) to cause or hire another person to give, deliver, sample, or sell or offer to give, deliver, sample, or sell.

(2) "Health warning" means a tobacco product label required by federal law and intended to alert users of the product to the health risks associated with tobacco use. The term includes warning labels required under the Federal Cigarette Labeling and Advertising Act and the Comprehensive Smokeless Tobacco Health Education Act of 1986.

(3) "License" means a retail tobacco product sales license.

(4) "Person" means a natural person, company, corporation, firm, partnership, organization, or other legal entity.

(5) "Tobacco product" means a substance intended for human consumption that contains tobacco. The term includes cigarettes, cigars, snuff, smoking tobacco, and smokeless tobacco.

History: En. Sec. 2, Ch. 569, L. 1993.

16-11-303. License for retail sale of tobacco products. (1) A person may not sell tobacco products at retail, whether over the counter, by vending machine, or otherwise, without a license obtained from the department of revenue.

(2) A license for the retail sale of tobacco products may be obtained from the department of revenue.

(3) The fee collected by the department must be deposited in the general fund.

History: En. Sec. 3, Ch. 569, L. 1993.

16-11-304. Signs. A retail seller of tobacco products shall conspicuously display, at each place on the premises at which tobacco products are sold, a sign that is to be provided without charge by the department of revenue that states: "Montana law prohibits the sale of tobacco products to persons under 18 years of age."

History: En. Sec. 4, Ch. 569, L. 1993.

16-11-305. Sale or distribution of tobacco products to persons under 18 years of age prohibited. (1) A person may not sell or distribute a tobacco product to an individual under 18 years of age, whether over the counter, by vending machine, or otherwise.

(2) If there is a reasonable doubt as to the individual's age, the seller shall require presentation of a driver's license or other generally accepted identification that includes a picture of the individual.

History: En. Sec. 5, Ch. 569, L. 1993.

16-11-306. Sales from tobacco vending machines. Tobacco products may be sold through a vending machine only in:

(1) factories, businesses, offices, and other places not open to the general public;

(2) places to which individuals under 18 years of age are not permitted access;

(3) places where alcoholic beverages are sold and consumed on the premises; and

(4) places where the vending machine is under the direct supervision of the owner or an employee of the establishment. The sale of tobacco products from a vending machine under direct supervision of the owner or an employee of the establishment is considered a sale of tobacco products by that person for purposes of 16-11-305.

History: En. Sec. 6, Ch. 569, L. 1993.

16-11-307. Distribution of tobacco products in other than sealed packages prohibited. A person may not distribute a tobacco product for commercial purposes in other than a sealed package that is provided by the manufacturer and that contains the health warning required by federal law.

History: En. Sec. 7, Ch. 569, L. 1993.

16-11-308. Penalties. (1) Failure to obtain a license as required by 16-11-303 or to post signs as provided in 16-11-304 is punishable by a civil penalty of $100.

(2) A person who violates 16-11-305(1) may be punished by a civil penalty of $100. A subsequent violation within 1 year is punishable by a civil penalty of $200. A third violation is punishable by a civil penalty of $300 if two violations occurred within the 2-year period prior to that violation. A fourth violation is punishable by a civil penalty of $500 if three or more violations occurred within the 2-year period prior to that violation.

(3) A person who violates 16-11-307 is guilty of a misdemeanor and upon conviction is liable for a civil penalty of not more than $100 for the first violation. A subsequent violation is punishable by a civil penalty of not more than $200. A third or subsequent violation is punishable by a civil penalty of not more than $500.

(4) A license holder is not subject to a civil penalty under subsection (2) for a violation by his employee or agent if the sale was without the knowledge of the license holder and the license holder shows that the license holder had in place a system to prevent violations of 16-11-305(1).

(5) The county attorney of the county in which a civil penalty is imposed under subsection (2) shall inform the department of revenue of the imposition of the penalty.

History: En. Sec. 8, Ch. 569, L. 1993.

16-11-309 and 16-11-310 reserved.

16-11-311. Local regulations. A local government may by ordinance adopt regulations on the subjects of 16-11-301 through 16-11-308 that are no more stringent than 16-11-301 through 16-11-308.

History: En. Sec. 10, Ch. 569, L. 1993.

16-11-312. Rulemaking authority. The department of revenue may adopt rules to implement 16-11-301 through 16-11-308.

History: En. Sec. 11, Ch. 569, L. 1993.

EXHIBIT 15
DATE 2-15-95
HB 539

EXHIBIT 16
DATE 2/15/95
HB 539

Testimony - HB539
Casey J. McKinney, 15
1015 14th Avenue, Havre, MT 59501
1-406-265-5923

Wednesday, 2/15/95, State Capitol, Room 104, 3:00 p.m.

Mr. Chairperson, Committee members, Good Afternoon. I am Casey McKinney, a Freshman at Havre High School, and I am here to support House Bill 539. I became involved in prevention when McGruff taught me about how my body could become dependent on something that could end up harming me, give me smelly breath and burn holes in my clothes -- I was 7 years old. I have volunteered ever since, as a youth leader during HELP Camp, by remaining involved in school prevention organizations, and by choosing to live a healthy lifestyle. Recently I participated in a Youth Tobacco Access Survey. I, along with my peers, was able to purchase tobacco products over 50% of the time from merchants. At the same time we were able to purchase 100% of the time from vending machines. One of the females that participated in the survey was told by a male merchant that she was so cute he would knock 25 cents off the price of the cigarettes! The youth that participated in this survey were 14 and 15 years old! Just this past week I learned of a young male, who I know personally, that was introduced to tobacco by a slightly older peer -- he is only 8 years old. So you see the current youth access laws simply are not working. To remedy this situation I urge you to support House Bill 539, which will place the point of purchase responsibility on those licensed to sell tobacco products.

EXHIBIT 17
DATE 2/15/95
HB 539

Testimony - HB539

Robin E. Morris, Executive Director
Havre Encourages Long-range Prevention (HELP)
Post Office Box 68, Havre, MT 59501
1-406-265-6206

Wednesday, 2/15/95, State Capitol, Room 104, 3:00 p.m.

HONORABLE CHAIRMAN GRIMES

Mr. Chairperson, Committee members, Good Afternoon. My name is Robin Morris, and I am the Executive Director for Havre Encourages Long-range Prevention. HELP A not-for-profit community-based organization with a 15 year history in alcohol, tobacco and other drug abuse prevention. I have personally been with the H.E.L.P. Committee since 1987. In addition I have had the pleasure of working on prevention at the state level as an appointee to the Governors Interagency Coordinating Council for Prevention Programs, as a Board member for Montana Communities in Action, and as a member of the State Tobacco Coalition.It is an exciting time for prevention...especially in the tobacco field. It is common sense, that if we limit the opportunity for individuals to smoke in public that the number of smokers will decrease. I celebrate with the restaurants, the schools, the public office buildings, and the private employers that have said no more tobacco! However, limiting the opportunities for public tobacco consumption is only half of the solution...the other half involves youth access to tobacco! According to the latest surgeon general's report on smoking and health --adolescence is the most crucial stage in life for preventing tobacco use. The majority of first use of tobacco occurs before age 18. In Montana, the median age for first use of cigarettes is 13 years of age *(Drug Abuse Update, Fall 1994 abstracted)*. I sincerely believe that the key to a healthy lifestyle for these adolescents is abstinence from the illicit use of tobacco, alcohol and other drugs. Tobacco is one of the three "gateway substances" that statistics relate to use of "harder" drugs (as reported by the Center on Addiction and Substance Abuse at Columbia University). Although many adult and youth members from the hi-line in North Central Montana have been working to educate merchants and the public at large about the current tobacco laws, youth are

working to educate merchants and the public at large about the current tobacco laws, youth are still able to purchase tobacco products with the cooperation of 50% of the merchants in our area. This was reinforced during a recent tobacco access survey conducted in Havre. In addition, we learned that several merchants were selling tobacco products, without a state tobacco license to do so, and that the majority of merchants with tobacco vending machines had them placed where they could not be monitored. One unmonitored vending machine sold tobacco, candy, gum and potato chips --all in the same machine! As a result of merchant miscooperation our youth are receiving conflicting messages --Mom & Dad, and the law, state it is illegal and unhealthy for them to purchase and consume tobacco products --yet, Joe Merchant says that will be $1.75. Somewhere along the line, the merchants need to be held accountable! In order for a youth access law to work we will all need to work together. I am not anti-business, but rather anti-youth access to tobacco. The Tobacco Industry has stated that they have no interest or master plan to sell to minors, so lets all get together and support HB539 --that places the responsibility on those issued a license for the sale of tobacco products.

HB. 539

EXHIBIT 18
DATE 2/15/95
HB 539

Ladies and Gentlemen, my name is Bob Edwards and I am here on behalf of The American Lung Association, Montana Teen Institute, and my peers. I would like to see a crackdown on tobacco use by minors. I feel that ~~if this~~ HB 539 bill is past, this dream which I share with many others can be achieved.

Last year I had a friend who had grades above that of the average student. She was in many clubs and participated in many activities. She was fun to be around and had a great outlook on life. This year that very same student has changed dramatically from last year. Her grades have plummeted, she skips classes and her standard of friends has dropped. She comes to school on occasion when she is not skipping with her friends. She comes to school as many others do telling of how she got drunk and how she got a buzz from smoking cigarettes. Her parents do not care that she smokes and in fact they buy cigarettes for her.

Occasionally, while walking down the halls at Helena High you can smell the smoke of the students who smoke in the restrooms. Many students who use tobacco products and our caught are sent to the administrators. The administrators then tell them to be careful were the use it because they could get in trouble. When someone is told this by one of the administrators they should get a clue that there is a problem.

It is not just cigarettes either. Chewing tobacco is a major problem to. Chewing tobacco is heavily used. Students at Helena High can be seen with a can of tobacco in thier pockets or with a chew in thier mouth. Many of the teachers at Helena High don't

even care if students use chewing tobacco in thier classes. I personally find that shocking.

A guy I know has been chewing for many years now. Not long ago he went to the dentist where he was informed that the beginnings of cancer were in his lip. This can and most likely will happen to all of the tobacco users who are not able to quit.

The average age for Montanans to start smoking is 13. In November The Montana Teen Institute in cooperation with the American Lung Association conducted a tobacco accessibility survey to find out if tobacco products could easily be bought by minors. The tobacco Accessibility Survey showed that at almost 100% of the stores in Helena we were able to buy tobacco products.

The average age of the first use of chewing tobacco is 10 years old. Smoking is responsible for one in every five deaths in Montana. More people in Montana die of tobacco use than cancer, Heart disease, AIDS, drug and alcohol abuse, suicide, fire, and homicide combined. Montana adult chewing tobacco usage is twice the national average.

I feel that if this bill is passed that these statistics our educations will be bettered without the distractions of tobacco being used. I would like to thank you for your time and I encourage you to vote in our bill.

EXHIBIT 19
DATE 2/15/95
HB 539

Good afternoon, Chairman Grimes and committee members I am with the Department of Corrections and Human Services, Alcohol and Drug Abuse Division. We are involved with HB 539 for the following reasons:

The Department of Corrections and Human Services has the statutory responsibility to assist all interested public agencies and private organizations in providing education for the prevention of alcohol and other drugs.

We are required by our federal funding to monitor and report on compliance checks to ensure compliance with the youth accessibility law.

We will provide intensive training to the youth under parental supervision and permission before the youth are involved in any surveys. The youth sign a confidentiality statement that the merchant's name will not be made available. As you have heard there are three dry runs before any punitive measures are given. You can see that this is truly an education bill not a punitive bill.

Respectively Submitted,

Marcia Armstrong

Marcia Armstrong

Alcohol and Drug Abuse Division

EXHIBIT 20
DATE 2/15/95
HB 539

Mr. Chairman and members of the committee, my name is Kerry Campbell, I am employed with The American Lung Association. I would appreciate you pass H.B. 539 for the following reason: On February 2, 1995 I stopped at a local Convenience Store in Helena. While waiting in line to pay for my gasoline, I noticed a young boy complaining to his friend that they he would have to settle for SKOAL again because Convenience Store was out of COPENHAGEN. I noticed that the chewing tobacco shelf was displayed in an area such that anyone could easily help themselves. As I waited in line, I looked closely at the boys and decided they were both still young high school students. I also noticed 2 signs that state that Montana Law Prohibits the Sale of Tobacco Products to Persons Under the Age of 18 hanging at the check-out register. The signs were displayed for the customers convenience. I wondered if the clerk would ask for I.D. He did not. The boys left with their chewing tobacco.

I asked the clerk, a young male I'd guess to be in his mid 20's, "Don't you ever card those kids when they buy tobacco?" He informed me that is was "stupid" and that No, he never did (ask for ID).

I pointed to the 2 signs at the counter and informed him that it was against the law to sell tobacco to a minor. Once again, he informed my that it was "stupid" and that if he didn't sell it to them, they'd just go elsewhere to buy it.

At that point, I told him that I worked for the American Lung Association and that we were in the process of making the law stricter on people who did sell to minors. I asked him if his boss would appreciate him selling tobacco to under aged kids.

His final response was that the law was "stupid" and that kids can get tobacco anywhere.

We need to educate merchants on the law and to assure that clerks do not sell tobacco products to youth under the age of 18. H.B. 539 will provide that opportunity. I ask that as a parent with two children, that you pass this bill.

PROGRAM SUMMARY: A Tobacco Product Retailing Program for Retail/Vending Industries

Objectives

- To continue to discourage those who are underage from purchasing tobacco products.
- To reaffirm that the tobacco industry does not want young people to use tobacco products -- and continues to take affirmative steps to reinforce this position.

Theme

The theme of the campaign, which will be incorporated into all program materials, is as follows:

IT'S THE LAW;
WE DO NOT SELL TOBACCO PRODUCTS
TO PERSONS UNDER 18
(OR 19, IF THE STATE LAW DESIGNATES 19 AS THE MINIMUM AGE)

Program Materials

We have designed a package of print and display materials for use by the tobacco product retailer. Materials include:

- A state-specific brochure describing the program and applicable laws. The brochure, in addition to detailing minimum age laws for a state and penalties for violation, provides tips to the retailer and the employee on verification of age, acceptable forms of identification, and how to deal with a customer who becomes upset when asked for identification. The brochure includes a tip sheet on how to verify age, for display at the cash register as a reminder when employees prepare to ring up a sale.
- Storefront and window display signs and point-of-purchase materials, all bearing the program theme: "It's the Law: We do not sell tobacco products to persons under 18." These colorful blue, orange and white signs and decals will assist store owners in reminding employees and customers of the state law and their compliance with it.
- Employee Acknowledgement Form.

Materials are available only in states where the minimum age for purchase of cigarettes is 18 or 19.

EXHIBIT 22
DATE 2/15/95
HB 539

House Human Services & Aging Commmittee
House Bill 539
Sponsor's Amendments

1. Page 2, line 13
Following: "16-11-303"
Delete: "or to post signs as provided in 16-11-304"

Following: "$100."
Insert: "The Department may collect the penalty in the manner provided for the collection of other tax debts."

2. Page 2, line 14
Following: "16-11-305(1)"
Insert: "and 16-11-307"

3. Page 2, line 29
Following: line 28
Delete: lines 29 and 30 in their entirety

4. Page 3, line 22
Following: "subsection"
Delete: "(8)"
Insert: "(2)(c) and (d)"

5. Page 3, line 23
Following: "requirements of"
Delete: "16-11-304"

6. Page 4, line 3
Following: "Upon the "
Delete: "fourth"
Insert: "third"

Page 4, line 5
Following: "alleged"
Delete: "fourth"

Page 4, line 9
Followiing: "proceedings, the"
Delete: "fourth"

7. Page 4, line 27
Following: "16-11-305,"
Delete: "16-11-306"

EXHIBIT 23
DATE 2/15/95
HB 509

Amendments to House Bill No. 509
First Reading Copy

Requested by Rep. Anderson

Prepared by Bart Campbell
February 13, 1995

1. Title, line 8.
Following: "PROVIDERS;"
Insert: "ESTABLISHING FEES FOR APPLICATIONS FOR CERTIFICATES OF PUBLIC ADVANTAGE AND FOR ANNUAL REPORTS;"

2. Page 2, line 17.
Following: "agreement."
Insert: "The parties to a void agreement may submit a new application for a certificate based upon a cooperative agreement, merger, or consolidation different from the original application."

3. Page 3, line 6.
Insert: "

NEW SECTION. **Section 6. ~~Annual~~ reports.** If the authority issues a certificate subject to terms and conditions, the facilities or providers to whom the certificate has been issued shall submit an ~~annual~~ report to the authority evaluating whether the terms and conditions have been met or otherwise satisfied during the preceding year. The authority shall in turn issue findings as to whether the terms and conditions are being met or otherwise satisfied. The authority shall keep copies of all ~~annual~~ reports and findings based on the reports.

The report must be submitted annually or more frequently if required by the authority.

NEW SECTION. **Section 7. Fees.** The authority shall establish by rule fees to accompany the filing of an application for a certificate of public advantage and for ~~an annual~~ reports required by [section 6]. The fees must be reasonably related to the costs of the authority in considering applications, ~~and~~ evaluating ~~annual~~ reports, and performing other duties necessary to administer this part. The costs may include the retention of accounting, technical, and legal assistance that the authority considers necessary to process applications and ~~annual~~ reports. The authority shall maintain records sufficient to support the fees charged under this section."
Renumber: subsequent sections

4. Page 3, line 7.
Strike: "[Section 5] is"
Insert: "[Sections 5 through 7] are"

5. Page 3, line 9.
Strike: "[section 5]"
Insert: "[sections 5 through 7]"

Mental Health Association of Montana

An Affiliate of the National Mental Health Association

State Headquarters • 555 Fuller Avenue • Helena, Montana 59601
(406) 442-4276 • Toll-Free 1-800-823-MHAM • Fax (406) 442-4986

EXHIBIT 24
DATE 2/15/95
HB 532

February 15, 1995

Proposed Amendments to HB 532

Presented by the Mental Health Association of Montana

1. Page 2
   Lines 9-13, strike

2. Page 6
   Line 1, following: "involuntary medication."

   insert: "If involuntary medication is ordered, written verification must be provided by the physician that the medication is appropriate to the diagnosis and presenting symptoms of the respondent."

Let's help America's broken people

A.M. Rosenthal

> Break your mind and you lie there

When I was living and reporting in India, I saw things that hurt my eyes. I saw them every day for years — twisted bodies, rotting bodies, mutilated bodies dragging through the streets.

Faces were attached to the bodies, but usually you did not look at them peering up from the sidewalk or the gutter. That way, it was possible to keep walking past the broken people and their hands.

For all my love and hope for India, I could never escape a sense of anger that any community would allow such degradation. At least, pick them up, pick them up.

Pick them up and tend to them — shouldn't Americans think that as we pass our own broken people in the streets, the men and women who scream or cry as they lie there or try to run from themselves, down the sidewalks and into the roads?

If a person breaks a leg in the street, civil help tends to him quickly — ambulance, doctors, police. Break your mind and you lie there, unless you can show you need help by getting up and pushing somebody into a subway train.

How can this be so? Money, for one thing. Treat them with pills, then discharge them from the hospitals, tell them to take the medicine themselves, close the hospitals. That is why in New York state alone, patients in state mental hospitals have dropped from about 93,000 in the '50s to about 9,000 today.

But one patient in three does not take the pills after his release. He is too mentally ill, too alone — or too many care centers supposed to provide help have been closed.

The American community finds money for taking care of tens of millions — the poor, the aged, the physically ill. Why are there so many mentally ill people cut off from help — at least 10,000 just in New York City's streets?

One reason is that everybody knows physical pain, but the pain that mental disorder can bring is literally unutterable by the suffering and unknown to most of humanity.

A couple of months ago, I had a long cardiac bypass operation. The doctors had said that when I recovered consciousness almost a full day later I might be disoriented by the heavy doses of anesthetics and drugs. I was, for some hours.

I did not understand why all these people around my bed were hurting me, why nobody stopped them. I was not just frightened but in fact [illegible]

not as emotion but as overriding, bottomless pain. The particular agony was that since I did not know why I was being made to suffer so, I could not conceive of the end of suffering.

I catch my breath at the memory of those hours. I will never forget them, I hope, because they gave me a brief taste of the anguish of people who cry in the street because they do not know where their pain is coming from.

Some remain neglected because of the tangle of law and civil liberties that troubles judges, doctors, patients and their families. Under New York state law, a patient has to have an illness that can inflict "serious harm to self or others" before he can be committed.

In the new issue of City Journal, a sophisticated and useful publication of the Manhattan Institute, Prof. Sally Satel, a psychiatrist at the University of Pennsylvania on leave from Yale, says that lawyers and judges often see commitment hearings as a criminal rather than medical proceeding. The goal becomes to avoid incarceration, "not to look out for the person's best interest."

But mental patients and their families particularly need the protection of law. New York's standard of "dangerousness," however, permits severely disturbed people who have not attempted suicide or attacked somebody else to remain in the streets weeping, unfed, without medicine. Professor Satel suggests New York follow 39 other states and adopt a standard of "grave disability" rather than "dangerousness."

That may bring help to some people on the streets but it won't prevent thousands of others joining them there. One essential, for any state, is enough centers to sustain and guide patients who need medicines. Another: for patients who have shown they cannot continue medical treatment voluntarily, a return to hospitalization until they can.

When all that happens, we will no longer have to pass the bodies of people with broken minds, or avert our eyes not to see their faces.

EXHIBIT 25
DATE 2/15/95
HB 532

1/24/95 N
1/25/95
Montana Standard

MONTANA ADVOCACY PROGRAM, Inc.
316 North Park, Room 211
P.O. Box 1680
Helena, Montana 59624

(406)444-3889
1-800-245-4743
(VOICE - TDD)
Fax #: (406)444-0261

EXHIBIT 26
DATE 2/15/95
HB 532

February 15, 1995

Representative Duane Grimes, Chairman
House Human Services and Aging
State Capitol
Helena, Montana 59620

Re: HB 532

Mr. Chair and Members of the Committee:

For the record, my name is Andree Larose and I am a staff attorney for the Montana Advocacy Program. Montana Advocacy Program is a non-profit organization which advocates the rights of individuals with disabilities. We are here to testify in opposition to HB 532.

This bill allows for the involuntary administration of medications to **any mentally ill** individual, not just those who are seriously mentally ill or whose behaviors pose an imminent risk of harm. This is an unwarranted expansion of the power of the state over an individual.

1. This bill is totally devoid of legal standards and factual circumstances which must be met before an order for forced medication can be entered. If this bill is passed, it should be amended to include the legal standards under which such an order can be obtained.

2. Under two U.S. Supreme Court cases, Riggins v. Nevada and Washington v. Harper, a court must find an "overriding justification" to force medications upon a person and that the medication itself is "medically appropriate." This means that, to meet procedural and substantive due process requirements, a full adjudicative hearing with medical testimony would have to be held prior to administering the medications.

3. The forcing of medications is a great intrusion upon bodily integrity. As a matter of public policy, as well as constitutional law, the State should not intrude upon a person's bodily integrity without overriding justification. Potentially, this bill violates the standards of Cruzan v. Missouri Dept. of Health, 497 US 261, 110 S.Ct. 2841 (1990) wherein Chief Justice Rehnquist wrote the following concerning the right to decide treatment issues:

> [N]o right is held more sacred or is more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraint, or interference of others, unless by clear and unquestionable authority of law.

Cruzan, at 2846.

This usually requires a person's health to be in danger prior to stripping the person of personal autonomy. The failure to abide by some undetermined, but not life threatening, standard within this act does not meet this requirement.

4. There is another relevant bill of which this committee should be aware, HB 41. That bill allows an order for involuntary administration of medications for individuals who are seriously mentally ill. Although we continue to believe that bill raises constitutional questions, the bill was passed in the House Judiciary committee with some amendments which provided greater due process protections than are provided in this bill. HB 41 requires a panel review of medications; at a minimum, this bill should require the same.

5. The idea of forcibly administering the medications by any means "reasonably necessary" may allow for the mechanical or physical restraining of the mentally ill person. (See Section 2, page 5, lines 27-30 and page 6, line 6.) That would be inhumane and possibly violative of constitutional substantive due process. (e.g. there are limits imposed by the constitution of how much force you may apply to administer drugs.)

6. **This bill unnecessarily expands the definition of "mentally ill,"** to the extent of including mentally disordered individuals who are having "difficulty in providing for basic personal needs." What does this mean? The prior definition included people whose life or health was not being protected. Does this expanded definition include not taking care of personal hygiene, not getting enough sleep, not keeping a clean house?

7. There is already a mechanism for allowing involuntary administration of medications on an emergency basis for those people who are admitted as inpatients to mental health facilities in the communities (psychiatric hospitals). Section 53-21-162(5)(c)(i).

8. This is a bill which could easily be dubbed an "unfunded mandate" to the counties. A full adjudicative hearing with medical testimony, as is required under the Washington v. Harper case, will be costly.

9. We can appreciate the desire on the part of family members to be sure their loved ones receive the treatment they need to avoid unnecessary hospitalizations or commitments. But we question whether this is the mechanism for accomplishing that goal. There is no magic answer. Medication is only one component of treatment; it should not be considered the panacea. Most people admitted to the state hospital are on medications when they arrive; medications did not prevent commitment for them. And many patients currently at Montana State Hospital have been on medications continuously for years without any prospect of improvement. Until people with mental illness are provided a full array of treatment options and support services (community based treatment, housing in the community, mobile crisis teams, etc.), there is not an overriding justification for forcibly injecting medications into a person's body.

Suggestions

1. Set a standard in the statute which allows an order for involuntary medication only under the following conditions:

   a. The medication is medically appropriate.

b. There is an overriding justification for the involuntary administration of medication.
c. Other appropriate treatment has been provided or offered to be provided to the individual and not been ineffective in eliminating the behaviors or symptoms justifying the involuntary administration of medication.

EXHIBIT 26
DATE 2-15-95
HB 532

This could be included in Section 2, page 6, as subsection (5).

2. Delete the clause on page 5, lines 28-29 which allows the use of "whatever means are reasonably necessary to properly administer the medication." Restore the sentence on page 6, line 6, which states: "No person may use physical force for administer medication." (The order itself may provide the element of coercion being sought here.)

3. Include a requirement for committee review as is required in HB 41, as follows:

> The involuntary administration of medication must be approved by the chief medical officer of the mental health facility and must be reviewed by a medication review committee prior to involuntary administration of medications, or within 5 working days in an emergency situation. The committee must include a patient and at least one member who is not an employee of the facility. The patient and the patient's attorney or advocate must receive notice prior to review, and must have an opportunity to appear before the committee. Involuntary administration of medications authorized by the committee must be reviewed by the committee after the first 7 days of administration of medications, and if continued administration of medications is approved, the treating psychiatrist must conduct a review and submit a report to the chief medical officer at least every 14 days while involuntary treatment continues. Involuntary administration of medications authorized by the committee may not continue for more than 30 days without further review by the committee.

In conclusion, we urge you not to recommend passage HB 532. If you do pass the bill, we urge adoption of amendments along the lines suggested above. Thank you for your time.

Sincerely,

Andree Larose
Staff Attorney

EXHIBIT 27
DATE 2/15/95
HB 532

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS

MARC RACICOT, GOVERNOR

PO BOX 200804

STATE OF MONTANA

(406) 444-3955
TOLL FREE 1-(800) 332-2272

HELENA, MONTANA 59620-0804
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February 15, 1995

Representative Duane Grimes, Chairman
House Human Services Committee
State Capitol
Helena, MT 59620

Representative Grimes and Members of the Committee:

For the record, my name is Kelly Moorse and I am the Executive Director of the Mental Disabilities Board of Visitors. The Board reviews patient care and treatment at state institutions and mental health centers and provides legal services for the mental health consumers who are at Montana State Hospital (MSH). We are here to present our concerns with House Bill 532. We recognize the difficult dilemma families and friends face when their loved ones are experiencing a psychotic episode. We believe other alternatives, such as Advanced Directives, would better help address these issues.

Concerns with HB 532 as presented:

1. The proposed legislation conflicts with informed consent rights.

We believe this proposed legislation which calls for the involuntary administration of medication conflicts with informed consent rights. The doctrine of informed consent applies to every competent adult; it's the cornerstone of the legal safeguards that protect anyone receiving medical treatment. The existence of a mental illness, does not mean a person is incompetent. All adults are presumed competent and remain so unless a court rules a finding of incompetency. Under Section 53-21-162 a health care facility would be required first to undertake a guardianship prior to administering medications. A separate judicial finding of incapacity would be required before a court could order the involuntary administration of medication without consent.Our point is a person is not incompetent because their decision deviates from the advice of doctor or family.

2. It is imperative the administration of medication must be based upon evidence present in court from a medical doctor that medication is medically appropriate.

Earlier this week psychiatrists from throughout the state we before this committee testifying on the complexities of

psychotropic medications. You heard their concerns about the various mental illnesses, the variety of medications and the psychiatrists concerns regarding the side effects. The proper diagnosis and treatment for mental illness requires doctors to be aware of a patient's past history, past diagnoses, the effectiveness of prior treatments and reactions to side effects. The psychiatrists concerns in HB 481 addressed the wide range of side effects of this drugs--ranging from minor irritations to severe muscular side effects to irreversible damage to the central nervous system.

3. The therapeutic relationship between consumers and their doctors may be jeopardized by administering medications with "whatever means are reasonably necessary".

Moreover, we believe the patient-physician relationship will be inhibited and possibly the patients response to any future medical needs. If an order for involuntary medication is in place, the only two medications for persons with a mental illness which can be given by a intramuscular shot are Prolixin and Haldol. These medications may not be the most appropriate for a person, given their history, diagnosis etc. We believe these limitations are clearly not in the best interest of the consumer, nor the doctor.

Given all the concerns we urge your careful review of this proposed legislation and urge a do not pass on HB 532. Thank you.

Sincerely,

Kelly Moorse

Kelly Moorse
Executive Director

EXHIBIT 28
DATE 2/15/95
HB 522

"Saving Money and Lives: Making the Case for Respiratory Care Benefits"
Executive Summary

The Problem

There is an oversight in all Medicare-based health care reform plans that will not only cost millions of unnecessary dollars but also will impede on the quality of life of millions of individuals requiring respiratory and cardiopulmonary care services.

There are several health care reform proposals, including the President's Health Security Act and Congressman Stark's proposal, that utilize Medicare coverage as the basis for their benefits packages. Yet, Medicare coverage for respiratory therapy services outside of the costly hospital setting is extremely limited, if not nonexistent. As a result, these patients remain restricted to the acute care hospital, whether or not their medical condition warrants this level of care.

Medicare's outdated policies were developed in the '60s when respiratory medicine was provided almost exclusively in the hospital. This is no longer the case thanks to advancements in medicine, technology and training.

Any plan not offering benefits more extensive than those now provided by Medicare will fail to recognize the appreciable savings to be had from delivering care in alternate care settings, such as skilled nursing facilities, outpatient and sub-acute care sites, and the home.

The Patients

Respiratory care benefits are needed by millions of individuals with chronic lung and heart problems, ranging from babies with underdeveloped lungs to persons suffering from emphysema, bronchitis, lung cancer, asthma, and cystic fibrosis. And, these respiratory problems are on the rise. The incidence of asthma alone increased 48 percent between 1982 and 1991.

The ability of these individuals to receive cost-effective care in the most appropriate setting is in jeopardy, unless provisions for non-hospital based respiratory care benefits are included in the national health care plan.

The Proof

- **Economic Impact: Saving Money.**
  Allowing for reimbursement of respiratory care services outside of the hospital setting will save money by allowing patients to receive treatment in less expensive settings. For example:

  -- A 1991 Lewin/ICF study estimated that the savings of treating cardiopulmonary patients at home rather than in the hospital would save the health care system more than **$48 million per year**. (Case #1)

  -- A pilot study in Maryland showed that providing home care to respiratory-dependent children resulted in savings of more than **$15,000 per patient per month**. Over 34 mon (Case #5)

EXHIBIT 29 27
DATE 2/15/95
HB 522

REBIL 1/30/95

[redacted] 60741147 M 061 6/29/93 1/21/94 006 INPATIENT

[redacted]
PRYOR, MT 59066

1000 MEDICARE PART A A 517388249T
2000 MEDICAID MONTANA 517 38 8249
9203 IHS CROW SERVICE 517388249

SUMMARY OF CHARGES

550	120	ROOM-BED/SEMI	11856.05
493	200	INTENSIVE CARE/ICU	36136.90
3879	210	CORONARY CARE	213151.05
996	250	PHARMACY	4158.00
260	258	IV SOLUTIONS	1585.90
1837	259	DRUGS/OTHER INJ	12347.4
2418	270	MED/SUR SUPPLIES	83361.0
265	300	LABORATORY	15250.1
110	301	LAB/CHEMISTRY	8750.80
110	305	LAB/HEMATOLOGY	1176.30
12	320	DX X-RAY	1401.70
74	324	DX X-RAY/CHEST	7496.2
2	350	CT SCAN	800.0
20	360	OPERATING ROOM	14239.2
13	391	BLOOD/ADMIN	715.0
4418	410	RESPIRATORY SVC	53216.2
80	420	PHYSICAL THERP	5069.5

BIL 1/30/95

[redacted] 60741147 M 061 6/29/93 1/21/94 006 INPATIENT

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PRYOR, MT 59066

1000 MEDICARE PART A A 517388249T
2000 MEDICAID MONTANA 517 38 8249
9203 IHS CROW SERVICE 517388249

110	440	SPEECH PATHOL	705.05
8	460	PULMONARY FUNC	422.75
2	490	AMBUL SURG	735.00
3481	634	DRUG/EPO< 10,000 UNITS	19996.90
1	730	EKG/ECG	77.60
3	761	TREATMENT RM	353.10
87	801	DIAL/INPT	65737.62

60741147 558739.44

EXHIBIT 30
DATE 2/15/95
HB 522

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
11030 Ables Lane, Dallas, TX 75229, 214/243-2272, Fax 214/484-2720

COST-EFFECTIVENESS OF RESPIRATORY CARE

Increased Need for Respiratory Care Outside of the Acute Care Hospital

Home care services have proven to be an integral part of the health care delivery system and a cost-effective alternative to expensive acute care hospital stays. The aging population, the spread of AIDS and tuberculosis, and advances in medical technology allowing technology-dependent patients to lead more productive lives outside the hospital, will increase the need for the services of trained and educated respiratory care practitioners. Respiratory patients will continue to be discharged from the hospital still requiring care, thereby increasing the demand for respiratory care services in alternate sites.

Overall, government health care policy has not kept pace with the advancement of medical technology and procedures. In particular, this has been the case for respiratory care services. When the Medicare/Medicaid program was first developed, respiratory care was fully recognized as a viable component of hospital services. Coverage and reimbursement for this service in the hospital have never been in question. However, Medicare/Medicaid policy has barely advanced in the past 25 years for respiratory care services rendered outside acute care settings. The scope of respiratory care services has developed significantly beyond the hospital setting. Where respiratory patients were once confined to a hospital bed, the same patients may now be cared for in a skilled nursing facility or in the patient's own home. It is the respiratory care community's recommendation that Congress recognize the role that respiratory care plays in the provision of cost-effective health care in alternate sites.

Respiratory Rehabilitation: A Cost-Effective Alternative

The purpose of rehabilitation is to ameliorate physical and cognitive impairments resulting from illness or injury, and to restore or improve functional ability so that individuals can return to work and lead independent and fulfilling lives. Over 80% of those treated return to their homes, work, schools or active retirement. Pulmonary rehabilitation is designed to stabilize or reverse the effects of pulmonary diseases, such as emphysema, bronchitis, or chronic obstructive pulmonary disease (COPD) (i.e. those

suffering from a degenerative disease of the lungs). One federal program, the Black Lung Program, has, since 1978, recognized the importance of structured outpatient pulmonary rehabilitation programs. The Coal Mine Procedure Manual states,

> "Further, DCMWC (Division of Coal Mine Workers Compensation) believes that properly administered pulmonary rehabilitation will reduce the need for future medical treatment, which would eventually prove more costly to the program."

The respiratory care community believes rehabilitation services must be an integral component of health reform. We caution, however, that a simple extension of current Medicare policy will not clearly encompass respiratory rehabilitation. Any rehabilitation benefit package must clearly enumerate the intended services.

Respiratory Care Saves Money

The scientific evidence on the cost-effectiveness and efficacy of providing respiratory care in alternate care sites continues to grow. The studies documenting cost-effectiveness of respiratory care have varied in methodology, scope, and time frame. The conclusion, however, is still the same: **respiratory care saves money.**

- A 1991 Lewin/ICF economic analysis focused on the effect of the availability of home medical equipment services on the cost of care for patients in three separate diagnostic categories. One of the categories studied was patients suffering from COPD. Lewin/ICF determined that $520 per patient per episode would be saved if a COPD patient was to receive care in the home rather than in the hospital. With an estimated patient population of 93,000 COPD patients per year, savings to the health care system amount to over $48 million per year.

- A recent Gallup survey studied the cost of providing hospital care to chronic ventilator patients. The survey estimates that there are over 11,500 chronic ventilator patients currently in U.S. hospitals costing an estimated $789 per patient per day. This totals over $9 million a day! Once a patient is medically able to be discharged, it takes an average of 35 days to place a chronic ventilator-dependent patient in an alternative care site such as the home or skilled nursing facility. That translates to an excess of $27,000 per patient in unnecessary hospital costs. Outdated reimbursement policies, which limit patients' access to respiratory care services outside the hospital, contribute to discharge delays and their subsequent excess cost.

EXHIBIT 30
DATE 2-15-95
HB 522

- In the early 1980s, the Department of Health, Education and Welfare (HEW) sponsored a study that tracked 775 COPD patients, who received home respiratory services from a qualified respiratory therapist. The results of the study shows that hospital re-admissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for those patients who were re-admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The savings estimated for these 775 patients totaled $1,097,250 (1980 dollars).

- A 1982 conference headed by former Surgeon General C. Everett Koop on home care alternatives resulted in the initiation of three pilot home care studies. One pilot program in Maryland provided home care to respirator-dependent children and compared hospital costs and home care costs. The savings provided by home respiratory care were more than $15,000 per patient per month. Over the 34 month period of the pilot program, $3.1 million in savings were realized due to the availability of home care for these children.

- A 1991 Illinois-based study on ventilator-dependent infants receiving home respiratory care versus hospital-based care saved the state over $4 million during the four-year course of the program.

- A 1989 consensus conference co-sponsored by the AARC, the Food and Drug Administration (FDA), and the Health Resource Services Administration (HRSA) (attended by representatives from more than 60 national organizations and associations) studied the problems associated with the introduction of respiratory care equipment into the home. Practitioners, consumers, and representatives of the federal government that recommended that third-party reimbursement policies should allow home-bound respiratory patients to receive, when necessary, care from respiratory professionals.

- Aetna Life & Casualty developed an Individual Care Management Program for patients suffering from catastrophic illness. The following chart summarizes cost-effectiveness data for home care for these individuals:

Cost Per Month of Hospital Care Compared to Home Care, Selected Conditions

Condition	Cost of Hospital Care	Cost of Home Care	Dollar Savings	Difference
Infant born w/breathing & feeding problems	$60,970	$20,209	$40,761	66.8%
Respiratory distress/oxygen dependency	$36,000	$11,500	$24,500	68.0%
Ventilator-dependent children	$15,742	$ 9,153	$ 6,589	41.9%
Patient requiring respiratory support	$24,715	$ 9,267	$15,448	62.5%
Oxygen-dependent children with a tracheostomy	$12,236	$ 5,304	$ 6,932	56.7%
AIDS patient care	$23,190	$ 2,820	$20,370	87.8%
Pediatric AIDS	$70,153	$16,461	$53,692	76.5%

- Norwalk Hospital in Connecticut conducted a four year study to evaluate the effectiveness of a hospital-based home care program for patients with severe COPD. A comprehensive home care service program was provided to 17 pulmonary patients who previously required frequent hospitalization. The COPD patients participated in a comprehensive respiratory home care program and showed significant decreases in the following:

Hospitalization Admissions	88 pre-program	53 on-program
Hospital Days	1,181 pre-program	667 on-program
Emergency Room Visit	105 pre-program	64 on-program

  Costs for hospitalization, emergency room visits, and home care fell from $908,031 to $802,999 resulting in a savings of $105,032 or $328 per patient per month over the course of 48 months.

- Several research studies conducted in the past several years have compared inpatient care to home care costs for a specific group of patients. The cost savings data for these studies is summarized in the chart below. The information has been aggregated at a monthly level for purposes of comparison.

EXHIBIT 30
DATE 2-15-95
HB 522

Conditions	Per Month Hospital Costs	Per Month Home Care Costs	Per Month Dollar Savings
a. Ventilator dependent adults	$21,570	$ 7,050	$14,520
b. Oxygen dependent children	$12,090	$ 5,250	$ 6,810

(a) Bach, J.R., Intinola, P., Alba, A.S., & Holland, I.E., (1992). The ventilator-assisted individual: cost analysis of institutionalization vs. rehabilitation and in-home management. *Chest, 101* (2), 26-30.

(b) Fields, A.I., Rosenblatt, A., Pollack, M.M. & Kaufman, J. (1991). Home care cost-effectiveness for respiratory technology-dependent children. *American Journal of Diseases of Children, 145*, 729-733.

825 Helena Avenue
Helena, MT 59601-3459
Phone: 406-442-6556
Toll Free: 800-LUNG-USA
Fax: 406-442-2346

AMERICAN LUNG ASSOCIATION®
of Montana

EXHIBIT 31
DATE 2/15/95
HB 522

February 15, 1995

Dear Members of the Human Services and Aging Committee:

The American Lung Association of Montana supports HB 522, which would require insurance companies to reimburse for services provided by respiratory therapists in alternate care sites, such as the home, when deemed appropriate by the patient's physician.

This bill would allow patients with lung disease, if they are medically able, to return to their homes and receive therapy administered by respiratory care professionals, thereby decreasing lengthy and expensive hospital stays. Other services provided through home health care, such as physical therapy and nursing, are now reimbursed by insurance carriers, and this bill would add respiratory therapy to that list of services.

Sincerely yours,

Dennis Alexander

Dennis C. Alexander
Executive Director

When You Can't Breathe, Nothing Else Matters®

Founded in 1904, the American Lung Association includes affiliated associations throughout the U.S., and a medical section, the American Thoracic Society.

EXHIBIT [redacted] 32
DATE 2/15/95
HB 522

HB - 522
Amendments
Presented by Blue Cross and Blue Shield of Montana
February 15, 1995

Page 1

1. Line 14
Following "Section 1"
Strike All of Section 1
Insert: "A health service corporation shall provide, in group and individual insurance contracts, coverage for health services provided by a licensed (1) respiratory care practitioner, provided that the services are prescribed by the attending physician of the insured as part of a written plan of care, ~~if~~ and (2) the health care services that respiratory care practitioners are licensed to perform are covered by the contract."

-END-

20 percent of the cost (i.e., making a 20 percent copayment). For other services, different cost sharing requirements would apply. The maximum amount of out-of-pocket expenses (i.e., deductibles and coinsurance) that an individual would have to pay in a given year would be $1,500. For a family, the maximum for all family members would be $3,000.

Under the capitated managed care plan, individuals would trade some flexibility in provider choice for lower cost sharing. There would be no deductibles or coinsurance if individuals receive care from providers who are part of a given plan's provider network. However, individuals would be required to make small copayments (e.g., $10.00 per office visit) for certain services. Individuals electing to use providers who are not in the plan's network could do so, but would have to pay 20 percent of that provider's bill. Like the fee-for-service plan, annual out-of-pocket spending under the managed care plan would be limited to $1,500 for an individual and $3,000 for a family. Once these limits are reached, no further cost sharing would be required for covered services.

One important feature of both the fee-for-service and managed care benefit packages is their coverage of a comprehensive set of preventive care benefits. This preventive care benefit package, which was developed by the U.S. Preventive Services Task Force, includes coverage without any cost sharing requirement of prenatal care, well child visits and other periodic health exams, immunizations, and a range of laboratory and screening tests that include pap smears and mammograms. (See Appendix B for a detailed description of the preventive care benefits.)

The Authority believes that in rigidly adhering to exact specifications of benefit packages, insurers now tend to make arbitrary decisions resulting in harm to the patient and increased expense. As a more reasonable approach, the Authority recommends that case management be encouraged, if not required, as an important element to promote more cost-effective decisions that also benefit the patient.

An important feature of both single payer benefit packages which relies heavily on such a cost management approach is the Authority's recommendation for parity in coverage between mental health and physical health. The Authority believes that such parity can only be successfully achieved at a reasonable cost under a case management approach. Thus, such a system is a required element of both benefit plans.

The Authority also recommends that whenever possible and appropriate, health care services should be provided in the least restrictive setting possible. An example of this is respiratory care where coverage will be available for services (including assessments, education, therapeutic procedures, diagnostic procedures and pulmonary rehabilitation) which can be provided in all alternate care sites. The Authority believes that this approach can result in better care for the patient at lower cost.

A fuller description of the services that would be included under the single payer benefit package is presented in Table 2. (It is important to note that the benefit package presented under this alternative is primarily for illustrative purposes and could be subject to modification during the rulemaking process which would follow any legislative

Exhibit NO. 13 #

HOUSE OF REPRESENTATIVES
54TH LEGISLATURE

Human Services & Aging COMMITTEE

HB-539

WITNESS STATEMENT

Please Print

NAME Terry Curey BUDGET _____

ADDRESS 5362 N. Mt. Helena Mt. DATE 2-15-95

WHOM DO YOU REPRESENT? _____

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS:

Access to tobacco dispersion needs to be given similar restrictions already mandated for alchohol sales, Tobacco products are responsible in contributing to more health problems resulting in death compared to most legal and illegal drug substances. Our youth must make educated decisions, Our Vendors must take responsibility. I support HB 539, my only wish is that it would have even stronger penalties for violation.

HOUSE OF REPRESENTATIVES
54TH LEGISLATURE

Human Services & Aging COMMITTEE

WITNESS STATEMENT

Please Print

NAME John Gudenkauf BILL NO. H 55-44

ADDRESS 6145 N. Montana DATE 2-15-95

WHOM DO YOU REPRESENT? Bd. Resp Care Providers

SUPPORT X OPPOSE _____ AMEND _____

COMMENTS: _____

W:\DATA\WP\WITNESS.95

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging — DATE 2/15/95

BILL NO. 507 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Michael Downey 527 E. 6th Ave Helena	Self	X	
Ed Caplis	MSCA	X	
Tanya ABIC	Blue Cross Blue Shield		✓
Ed Gregar	MABP		✓

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

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. 504 SPONSOR(S) Cobb

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
ALVIN B Svalstad	AARP	✓	
Jean Ballantyne	Bd. of Nursing	neutral	
Patricia Goudie, Sun River	MT Nurses Assoc.		✓
Ralph E Martin	CMCD	✓	
Shellia Jamen Missoula mt	self	✓	
Barbara Laursen Missoula	CMCD	✓	
Joyce DeCunzo	SRS		
Paul Peterson	self	✓	
Dan L Duell	self	✓	
Sherri Anderson	MT Advocacy Prog	✓	
Jim Meldrum	MILP	✓	
Michael Regnier	CMCD	✓	
Steve Stepanek	MT Nurses		✗

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. H.B 504 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Mary Murger, RN	Self		X
Barbara Booher	MNA		X

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. 522 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Katie Welch 4407 Bowman Dr. Billing	Respiratory Therapist	X	
John Fenner 1212 Ave B NW GT Falls, MT	MT Society for Respiratory Care	X	
Vince Luparell 1804 2 AVE N. GT. FALLS MT.	Respiratory Therapist	X	
Michael Biggins P.O. Box 281 Seeley Lake, MT 59868	Respiratory therapist	✓	
Ed GALLOGLY P.O. BOX 548 KALISPELL	MMBP		✓
TAMMY ASK	Blue Cross Blue Shield		Amend
Mike Craig	Health Care Ath	✓	

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. 539 SPONSOR(S) Sept

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Mona Jamison	American Lung Assoc.	✓	
Darryl Bruno	DCHS - ADAD	✓	
Steve Yeakel	MT Council for Maternal & Child Health	✓	
RICHARD L. BENDER	NO SNUFF	✓	
Jeff Seibert	Skyview MTI	✓	
BRENDA Gross	Skyview High MTI	✓	
Rachael DeLong	Helena High MTI	✓	
Terry Cuny	American Lung Assoc	✓	
Kerry Campbell	American Lung Assoc	X	
Cindy Hayden	American Lung Assn.	X	
Mamie Flinn	MT Communities In Action	X	
ROBIN MORRIS - HAVRE	H.E.L.P. COMMITTEE	✓	
Casey McKinney - Havre	Havre youth tobacco alliance	X	

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. 539 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Chas Mahaffey	DOR	✓ with amendment	
Kim Solomon	Hill County Sheriff	✓	
LARRY AKEY	SMOKELESS TOBACCO COUNCIL		✓
KATE WELCH	Deaconess Medical Center	✓	
Vince Lapovell 1804 Lave N. Gt. Falls	Montana Deaconess	✓	
John Fenner Gt. Falls	" "	✓	
Milly Gutkoski Bozeman	self and MNA	✓	
Peggy Mussehl Boz	MSU Tobacco Cessation Program	✓	
Pat Drummon	Philip Morris		X
JOHN DELANO	" "		+
Jerome Lockwood	Mt. Rural Affairs	✓	

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging — DATE 2/15/95

BILL NO. 532 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
BOB MCCARTHY COURTPLACE, BUTTE	BUTTE-SILVER BOW COUNTY ATTORNEY	✓	
Geri Driscoll	MT. Psychological Assoc.	✓ Adm.	
Andree Larose	Montana Advocacy Program		✓
Dan Ault	DCHS	✓	
Marty Onsbuk	Mon AMT	✓ Amend	
DAVID HEMION	MENTAL HEALTH ASSOC	✓	

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HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. 539 SPONSOR(S) Sapt

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
Connie Jungmann	MT Dental Assn	✓	
Nancy Wallace	Voice Against Smoking	✓	
JEROME ANDERSON	THE TOBACCO INSTITUTE		X
Rachael DeLong	Student HHS MTI	✓	
Robert Watson	Student HHS MTI	✓	
Bill Riley	self	✓	
Jennifer Brannon	Helena High M.T.I.	✓	
Jenny Watson	MTI	✓	
Stan Shapiro	MT Nurses Assn	X	
Olivia Alexander	American Lung Assoc.	✓	
David M. VanDemark	American Cancer Society	✓	
Marcia Armstrong	Corrections & Human Services	✓	
John McCrea	American Lung Assoc	✓	

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

HOUSE OF REPRESENTATIVES
VISITORS REGISTER

Human Services & Aging DATE 2/15/95

BILL NO. 509 SPONSOR(S) Rep Sheill Anderson

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	Support	Oppose
MAX DAVIS - G.F.	COLUMBUS HOSP. + MT DEACONESS MEDICENT.	✓	
Allyn Christiaens	Columbus Hospital	✓	
WILLIAM DOWNER-GTF	Columbus Hospital	✓	
KIRK WILSON	Deaconess Great Falls	✓	
Sheila Hinman	Great Falls	✓	
Don Gifford	Great Falls	✓	
Vince Hyppa ell	Great Falls	✓	
John Fenner	GTF	✓	
Danette Rutherford	Great Falls	✓	
Karla Runkel	Great Falls	✓	
Steve Browning	Helena / Montana Hospital Assn	✓	
Jerome Loendorf	mt. med assn	✓	
Mike Couic	MT Health Care Assn	✓	

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