# MINUTES

## MONTANA SENATE
## 54th LEGISLATURE - REGULAR SESSION

## JOINT SELECT COMMITTEE ON HEALTH CARE

**Call to Order:** By **CHAIRMAN STEVE BENEDICT**, on March 7, 1995, at 5:35 p.m.

### ROLL CALL

**Members Present:**

Sen. Steve Benedict, Chairman (R)
Rep. Scott J. Orr, Vice Chairman (R)
Sen. Dorothy Eck (D)
Sen. Mike Foster (R)
Rep. Duane Grimes (R)
Sen. Judy H. Jacobson (D)
Sen. Ken Miller (R)
Rep. Bruce T. Simon (R)
Rep. Carolyn M. Squires (D)
Rep. Carley Tuss (D)

**Members Excused:** None

**Members Absent:** None

**Staff Present:** Susan Fox, Legislative Council
David Niss, Legislative Council
Jennifer Gaasch, Committee Secretary

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

**Committee Business Summary:**

Hearing: This was concerning the following bills: HB 511, HB 542, SJR 14, HB 405, SB 405, HB 531 and HB 560.
Executive Action: None

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The nature of the meeting was to have public input on all of the bills mentioned above and then questions would be asked by the committee members. Executive Action would be taken at a later date.

Discussion:

**CHAIRMAN BENEDICT** said he would like to know how the members of the committee would like to handle proxies.

**SENATOR MIKE FOSTER** said due to the circumstances that they could use written proxies for the votes in committee.

**CHAIRMAN BENEDICT** replied he would not have any problem with that. If they worked with blanket written proxies that would be fine.

**Motion:**

**SEN. FOSTER MOVED** to allow the use of written proxies to cast their votes.

**Vote:**

The **MOTION CARRIED UNANIMOUSLY.**

**Discussion:**

**CHAIRMAN BENEDICT** said the sponsors were notified about their bills and they were told they would not be required to open and close on their bill. He said they would take testimony from the public on different groups of bills and then after everyone has had a chance to testify, the committee members would ask questions.

**Public Testimony:**

**SENATOR EVE FRANKLIN, SD 21,** said she hoped they could put together a good package that would create some change.

**Arlette Randash** said SB 194 would not be considered by the committee, but it needs equal consideration and scrutiny just as HB 511 does. If the committee is going to investigate new directions of health care, SB 194 should be given consideration because it calls for the diminishing of the Montana Health Care Authority as created by SB 285. Its sponsor realized socialized medicine results. She said a decision would not be complete if SB 194 and HB 511 were not on the table.

**Jack Molloy, a member of the Health Care Authority**, said he would like to address the issues of the Health Care Authority as in SB 405. He said as far as the Montana Health Care Authority has been a wonderful exercise in listening to the people of Montana and has done a good job of being objective. He said they are at the cross roads and nationally there is a void which is being filled by cooperative efforts. He said it is too early in the process to back the stake out of an authority position in determining the health care services, needs and systems it supplies to its citizens. He said the Health Care Authority realized that they lack Montana specific data. They are not funding things in a matter that will give them legitimate data. He said it was important that the legislature send a message to the vulnerable populations of Montana that they do matter. He said voluntary purchasing pools would enlarge the base of health

insurance which would make it more available and more affordable. He said SB 405 does a good job of organizing the needs of voluntary purchasing pools. They feel the medical savings accounts are one way to encourage people to become insured. He said they need to have a way to measure the affects of those things. He said for that reason it is necessary for a Health Care Authority body that is fully funded by the state who is going to hold the industry to its obligations to the people of Montana if necessary. He said it was not a way for the state to take over health care. He said the only objective party that should oversee that should be the state.

**Laurie Ekanger, representing the Governor's office,** she said the Governor did support continuation of the Health Care Authority. It is in the budget to continue it and primarily to continue the collection of the data base. She said urged them to continue the data base function. **Laurie Ekanger** said the Governor's office supports the concept of Purchasing Pools. They think HB 405 looks like a good approach. There may be some need to protect those people who pay into a Purchasing pool. Concerning Medical Savings Accounts they felt HB 560 was the cleanest approach to start out.

**Ed Grogan, representing the Montana Medical Benefit Plan, Montana Medical Benefit Trust and the Montana Business and Health Alliance,** stated the Montana Health Care Authority knows the business and it gave government control of the health care. He said they did not want to see any more government control and therefore supports **REPRESENTATIVE JOHNSON'S** bill which is HB 511. On the Voluntary Purchasing Pools he favors HB 405 and disagrees with SB 405. He said SB 405 was adding more government control. He said that was too high a number for a small group. Concerning Medical Savings accounts, they support HB 531 and are against HB 560. Perhaps there could be a compromise of the 2 bills. They like the $3,000 limit in HB 560. He suggested all of the premium dollars to all be paid with Montana tax free dollars and then go over and above that to $500 a year per person or more to be put in the medical savings accounts. He said they looked at Medical Savings Accounts as a cost saving device being able to bind a persons insurance and pay the deductibles and co-payments with free tax dollars.

**Tom Hopgood, representing the Health Insurance Association of America (HIAA),** said concerning Medical Savings Accounts they have no opposition to the bills that had been introduced or to the concept of the Medical Savings Accounts. He said that was not a cure of all of the problems, but it is an alternative to take advantage of. Concerning Purchasing Pools one of the things that has to be addressed in order for health care to be reformed is cost. He said health insurance reform is not necessarily health care reform. They have to address the cost of health care. The Purchasing Pool concept is a cost containment measure. The have endorsed both HB 405 and SB 405. The HIAA believes they should infuse into the Purchasing Pool statute a great deal of

flexibility to allow innovation into the market place and allow cost cutting. They would lean more toward HB 405.

**Larry Akey, representing the Montana Association of Life Underwriters,** he said they represented around 700 professional insurance agencies. He said there needs to be some official body that would continue to look at health care in Montana. He said concerning Purchasing Pools they believe they will serve to contain costs in the market place. They need to look at both HB 405, and SB 405 and recognize that they were having licensed insurance agents selling licensed insurance products through a different marketing mechanism. He said they question if there needs to be further layers of regulation and whether those layers of regulation will in fact serve to reduce the cost controlling capabilities of the Purchasing Pools. They think the mechanism in HB 405 probably has a greater chance of success in the market place. If they believe there needs to be further regulation in the market place, please remember they are talking about licensed insurance agents selling licensed insurance products. Concerning Medical Savings Accounts, they think they are a concept worth exploring. They could not believe they will cure all of the problems that exist in the state. They think HB 560 does have a few modest advantages over HB 531. HB 560 also has some problems that HB 531 does not. Medical Savings Accounts are to allow individuals to buy health insurance with free tax dollars. It could be more adequately accomplished by making health insurance premiums fully deductible. He said there are at least 3 bills going through the system that do that. He urged the committee to endorse both Purchasing Pools and Medical Savings Accounts.

**Susan Good, representing Heal Montana,** said concerning the Montana Health Care Authority, SJR 14 was a creative and practical solution to that. She said concerning Purchasing Pools they are in support of HB 405. Whether a person chooses the threshold of a Purchasing Pool to be 1,000 or 750 or 862 does not really matter when they get to the point of when they have the group assembled the group drops below whatever number has been selected, at which point does the group cease to be a pool? She suggested there should be a formula developed to spell that out because it had never been addressed. Concerning Medical Savings Accounts, the concept is the centerpiece of the Heal Montana project. She said when an individual uses their own money for health care they are going to be more careful in the way they spend that money. HB 531 and HB 560 should somehow be combined in a way that the best concepts of both are employed. She said they would help come up with solutions to the problems that face all Montanans.

**Tanya Ask, representing Blue Cross Blue Shield of Montana,** she said they feel they feel the Health Care Authority process has been a very valuable process for the State of Montana. She urged that should be continued. Voluntary Purchasing Pools are a good concept to health with affordability of health care. It is part of the answer. They like HB 405 and can work with SB 405. They

urge an open process and feel that HB 405 will give that a more open process. She said she would like to address the 1,000, there is not a number that they can point to and say that will do it. She said 1,000 was put in there because they wanted to have a large enough number so there can be some attrition and still have a viable mechanism. That number is 1,000 eligible employees, not 1,000 people. She said the numbers would remain relatively constant. She said they urge them to consider a large enough number. Medical Savings Accounts do have a place in the health care reform equation. It does encourage individual responsibility. They have raised some questions in the drafting of HB 560. They will work on those problems. She passed out testimony for 2 days. **(EXHIBIT #1 and #2)**

**Dean Randash, representing NAPA Auto Parts,** read his written testimony. **(EXHIBIT #3)**

**Bob Turner, representing the Department of Revenue,** said he would like to address Medical Savings Accounts. He said the effective date on the bills should apply retroactively. They should also make sure that there are no double benefits. He said if they decide that a person can withdraw a certain amount out of the Medical Savings Account and put it into an IRA, that is another benefit and a double benefit. He said if during the time that money is in the Medical Savings Account and it is taken as an exclusion by the taxpayer and is put into a mutual savings account, what happens if the taxpayer takes a loss? Does the taxpayer get to use that loss, or is that lost because it was already taken as an exclusion? He said it would be a lot easier to administer if there was a maximum amount of contributions that could be made as an exclusion on the tax return.

**CHAIRMAN BENEDICT** replied he would like the Department to come to the committee with possible amendments or things they need to fix in the bill.

**Bob Turner** replied they would do that.

**John Flink, representing the Montana Hospital Association,** read his written testimony. **(EXHIBIT #4)**

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**Claudia Clifford, representing the State Auditor's Office, the Commissioner of Insurance, and the Commissioner of Securities Office,** said the commissioner served on the Health Care Authority and said that although insurance reform is needed, insurance reform is not comprehensive health care reform. There is a need for a good data base of information in order for the legislature to address other aspects of insurance reform, they support any legislation with adequate work on a data base. She read her

written testimony which included proposed amendments. **(EXHIBIT #5)** She stated they had talked with **REP. SIMON** about the amendments and he had agreed with them.

**Frank Cote, the Deputy Insurance Commissioner,** said that Purchasing Pools could be beneficial in the market place. Both of the bills could help consumers get affordable health care insurance. HB 405 has very little regulation in it. SB 405 has some more regulation. The committee must decide how much regulation would be needed. He said the committee should require the registration of the Purchasing Pools. He said the Purchasing Pools manager should have some fiduciary responsibility so the consumers would be protected. He submitted **(EXHIBIT #6).**

**Tom Ebzery, representing Yellowstone Community Health Plan,** said they supported the Health Care Authority a few years ago, but a few weeks ago he supported the Health Care Advisory Council and had some suggestions on how that might be composed. He said on page 1 of the bill, they had talked about listing a lot of things to do. He said he had a problem with going out and bringing in people from all over the state. He recommended that there be a legislative committee as the advisory committee. He said HB 511 should go forward and the work that has been done, the certificate of public advantage over in the Department of Justice should continue. He said they were an HMO and every time they see a bill that comes up on small group or HB 531 those are plans set up for indemnity plans. HMO's are based upon co-payments and they would like to give them input in terms of schedules. He asked that they will keep managed care and HMO's in mind because they just do not fit under the circumstances.

**Riley Johnson, representing the National Federation of Independent Businesses,** said they agreed with **Tanya Ask** on the procedures in the past on the Montana Health Care Authority. He said they supported HB 511 and that it is time they take that experience and make it voluntary. He said they agreed with **Riley Johnson** in that the composition be looked at. They feel they are confident in the legislators. They would like the composition looked at and changed to a primary legislative committee. The problem they had about the data base was the detailing of what it would be used for and what it really would mean. He said regarding Voluntary Purchasing Pools, primarily HB 405 addresses the issue. He said it has a few things to work out and they would help in that effort. He said Voluntary Purchasing Pools give them cost reduction. He said on Medical Savings Accounts, they think that is affordability and responsibility. He said they support HB 560. They would like to see HB 511 to eliminate the Montana Health Care Authority, HB 405 for Voluntary Purchasing Pools, and HB 560 for Medical Savings Accounts.

**David Owen, representing the Montana Chamber of Commerce,** said the Chamber supported the creation of the Montana Health Care Authority. He said he does not have a specific suggestion on what form that authority would take in the future. He said concerning Purchasing Pools they were going to be important and he encouraged them to be voluntary, etc. He said they believe in that concept.

**Keith Kovash, representing the Montana Association of Health Care Purchasers,** read his written testimony. **(EXHIBIT #7)**

**Anita Bennett, representing the Montana Logging Association,** said they have found that the Health Care Authority did bring forth a lot of information. They have concerns of the process of bringing forward that information. She said they never discussed what the cost was to the consumer and to the employer, and the bottom line as to access of services. Guaranteed issue and affordability are not compatible. She said in regards to Voluntary Purchasing Pools, HB 405 seems to be more conducive to a better competitive arena and arrangement. They are a fully insured health insurance program. In regards to Medical Savings Accounts, they see that as an important step in regards to the timber industry people. She said those accounts would assist them in having accessibility of their own dollars put into the medical arena as they are needing the services at that point in time.

**SENATOR JUDY JACOBSON, SD 18, Butte,** said there was a lot more regulation in SB 405 and they could work some of that out together. She said SB 405 does allow individuals to participate. She said with small group, there would not be a guaranteed issue if those people were not eligible for small group. The could participate in a Purchasing Pool. The Purchasing Pool could certainly disallow them. One of the biggest problems is they have self-employed and young people in the state who cannot participate in any plan at all. She said SB 405 would not allow groups or individuals to be excluded based on their occupation. That is not included in HB 405. She passed out a summary sheet. **(EXHIBIT #8)**

**REPRESENTATIVE GRIMES** asked **Larry Akey** what were the downside to and the upside of individuals included in these bills regarding Purchasing Pools? **Larry Akey** said that there were both upsides and downsides to including individuals in a Purchasing Pool. There is a fundamental difference between individuals purchasing insurance and small employers purchasing insurance. There is a different motivation. Individuals are usually purchasing insurance because of an anticipated health risk. They are motivated by their health concerns. Employers are generally motivated by a concern in the labor market. They want to attract the best quality of employees they can. If they start putting individuals into pools they have strong potential for adverse selection. He said initially they ought to look at Purchasing

Pools fully for employers so they do not have that potential for adverse selection. That would drive the cost up. **REP. GRIMES** said **Mr. Akey** expressed some concerns about HB 560. He asked **Mr. Akey** to explain those concerns. **Mr. Akey** said HB 560 was more tightly crafted than the Medical Savings Account portion of HB 531. Under HB 531 an account administrator was defined as an employer. Under HB 560 an account administrator may be an employer who has a self-insured plan. Under HB 531 they have said a self employed individual was an employee. Does that also made that self-employed individual an employer, if it does, then there would be a self-employed individual acting potentially as his or her own account administrator. He said the definition of dependent in HB 560 is more in line with the kinds of definitions they use in the insurance industry. The definition of a dependent in HB 531 is a definition that looks like the tax code. He said they were talking about a health-related product and so it would make sense to them to have dependent defined in the Medical Savings Account bill more in line with the health care product that in the line of the tax code. HB 560 speaks to a specified dollar amount that could be contributed to a Medical Savings Account. It is important to recognize if they want to have deductible insurance premiums they may want to address that in a separate issue than Medical Savings Accounts. HB 531 has a nebulous amount that could be contributed to a Medical Savings Account based on premiums plus deductibles plus the co-payments they would have for a $1,000 deductible health insurance policy. There is nothing in the bill that says there is a specified dollar amount that could be contributed to the Medical Savings Account.

**REPRESENTATIVE SIMON** said there were a lot of amendments that were drafted. He asked how they might proceed to make the amendments available to the interested people. **CHAIRMAN BENEDICT** said they could distribute them tonight. **REP. SIMON** asked **Larry Akey** if **REPRESENTATIVE NELSON'S** bill, for example, or **SENATOR DOHERTY'S** bill that deals with deductibility of health insurance premiums passes and they pass a Medical Savings Account bill also, would a person then not be able to deduct the premiums that they pay and make a contribution to a Medical Savings Account. **Larry Akey** replied that if that were to happen, that a $3,000 cap on Medical Savings Account, would be more sufficient to help pay for the deductible and the co-payments of a policy for which they would have already been able to deduct the premiums. **REP. SIMON** asked **Bob Turner** if Medical Savings Accounts have been referred to as a Medical IRA, and under an IRA arrangement if that was applied to gains or losses based on interest on a regular IRA, how would that be treated as far as the Montana tax codes? **Bob Turner** replied the way it is treated is they put money into a regular IRA and it is put in a mutual fund and it loses money, they do not take a loss at all. They report that when they pull the IRA out. They already took the loss when they took the exclusion when arriving at the net gross income. **REP. SIMON** asked if a Medical Savings Account would be handled differently. **Bob Turner** replied no it would not. He said there is an

amendment put forth by the Department of Revenue so that if they did have a Medical Savings Account and they took out money from that to pay health insurance premiums, that would have to be deducted as an itemized deduction.

**REPRESENTATIVE TUSS** said in **Dr. Molloy's** testimony that he saw great value in collection of data and the utilization of that data. She asked him to give some definition and parameters to that data base and further explanation of how he would see that utilized. **Dr. Molloy** said the issue of the data base was to be one of the next projects of the Health Care Authority. He said there was the component of cost, who was paying for health care in Montana and how much money was being collected from state and federal agencies and where that money was going. From the stand point of providers, they wanted specific data on the cost of care for specific illnesses that they could compare across the state. One set of data is more complex and used to evaluate the health care system and from that data they distill specific data that they would be able to consume as usable and would make it very easy for consumers to compare that data. That has to include the payers of health care, who they are covering, what kind of dollars, and what benefits. He said people who testified said they want more consumer and more personal responsibility for how they spend their health care dollars, but that is very hard to do when there is data missing. The only data that is available is that data the providers or the insurance companies want the consumer to know about. He said they envision a data system to evaluate how the system works and how it is paid for and a system that is compatible for individual use to make their own health care decisions. **REP. TUSS** said it was time for the Health Care Authority to take a deep breath, look backward, and look forward. She said some references need to perhaps reflect the health council as opposed to the health authority. The Health Care Authority now has historical and institutional history throughout the state. How would he envision a transition between the authority and the council considering the data base? **Dr. Molloy** said the past year and a half has been consumed by the mandate of the previous legislation. Early on they realized the data that was available was at best several years old and a lot of it was extrapolated to Montana. It took a lot of time, effort, and expense to get usable data to present the 2 health care plans. He said they would have wished they could have moved forward in the last biennium to develop the data base system. He said those on the authority are uneasy about how raw data can be collected and disseminated and perhaps misused or misrepresented. They feel it is very critical that the knowledge be transported to and utilized in whatever the Health Care Authority or the Health Care Advisory Council or whatever it becomes. That knowledge has to be made available and those people would have to familiarize themselves with that in order to understand what data was necessary.

**SENATOR ECK** said **John Flink** suggested that the committee combine HB 542 into the advisory council. **John Flink** replied he made that suggestion because when he talked to **REPRESENTATIVE TASH** he was concerned with implementation. They felt there might be some way to meld them. He said the goals to improving the public health system in the state are a part of what they want to pursue and maybe the advisory council would be the ones to do that instead of establishing a separate entity out there. . **SEN. ECK** said she would like to know which group it is, is it the Montana Public Health Association that worked on that proposal? **REP. TUSS** replied it was the Department of Health and Environmental Sciences.

**Mike Craig, representing the Montana Health Care Authority,** said the Montana Public Health Task Force was affiliated with the Department of Health and local public health agencies, and their interested parties got that proposal together and brought if forth to the authority. The agree that they do not want to see any duplication, but must be reminded that there is a statutory link between the Department of Health and the local public health agencies. If that is combined with HB 511 there may be some legislation problems. The task force that is created by HB 542 could be dealt with through the new council. Department of Health would still have to be a main player. **SEN. ECK** said she did not understand what the rationale was for putting it into SRS. **Mike Craig** replied the rationale was because of the appearance that HB 511 would be what the majority of the legislature wishes it to happen, that SRS will take the responsibility of supporting the council. They suggested that they strongly encourage the work of data collection to go along with that somehow so that it does not get lost. HB 511 wipes out the Health Care Authority in its entirety including data base.

**REP. SIMON** stated that one of the reasons it was chosen to be put over there is because SRS is already involved in a lot of data collection.

**SEN. JACOBSON** replied that there are data base systems. Western States has instituted a data base. They already have one.

**ADJOURNMENT**

**Adjournment:** 7:45 p.m.

**SENATOR STEVE BENEDICT**, Chairman

JENNIFER GAASCH, Secretary

SB/jg

MONTANA SENATE
1995 LEGISLATURE
JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL DATE 3-7-95

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| SENATOR DOROTHY ECK | X | | |
| SENATOR MIKE FOSTER | X | | |
| REPRESENTATIVE DUANE GRIMES | X | | |
| SENATOR JUDY JACOBSON | X | | |
| SENATOR KEN MILLER | X | | |
| REPRESENTATIVE BRUCE SIMON | X | | |
| REPRESENTATIVE CAROLYN SQUIRES | X | | |
| REPRESENTATIVE CARLEY TUSS | X | | |
| REPRESENTATIVE SCOTT ORR, VICE CHAIRMAN | X | | |
| SENATOR STEVE BENEDICT, CHAIRMAN | X | | |
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Exhibit # 1

# Blue Cross Blue Shield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

EXHIBIT 1
DATE 3-7-95
many bills

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

**Customer Information Line:**
1-800-447-7828

**Charles Butler, Jr.**
Vice President
Government and Public Relations

March 8, 1995

Senator Steve Benedict, Chairman
Representative Scott Orr, Vice Chairman
Joint Select Committee on Health Care
Montana State Legislature
Capitol Building
Helena, MT 59620

Dear Chairman Benedict and Vice Chairman Orr:

Blue Cross and Blue Shield of Montana looks forward to working with you and your committee as we continue to define pieces of the health care reform equation for Montana. We have been a Montana company in business for over fifty years, currently providing health benefits or administration for more than 235,000 Montanans.

Over the last several years we have worked with Former Governors Stephens and Schwinden, and Governor Racicot, their health care task forces, the Authority, doctors, hospitals, allied health care providers, small and large businesses, labor, seniors, individuals, and agents on reforms of our industry and the healthcare delivery system. The goals continue to be not only access but also affordability.

When former Governor Stephens first brought up the idea of insurance market reform, it was to address practices for which the industry was criticized, and which the industry recognized needed to change. We cannot lose sight of those problems. Nor can we lose sight of who we said the detractors would be.

We will address these and specific issues as we go through some of the legislation which will be taken up by your committee. The legislation falls into three broad areas:

**Insurance Reform:** SB194, SB322, SB380, HB446, HB466, HB531, HB533.

**Market Reform:** SB376, SB405, HB405, HB531, HB560.

**Health Care Reform:** SB194, SB341, HB511, HB531.

Insurance Reform

These bills include action not only on small group reform, but also individual market reforms.

Insurance reforms were meant to address the following concerns:

1. Portability of coverage so individuals would not have to meet a new preexisting waiting period each time they or their employer changed coverage;
2. No cancellation or nonrenewal of coverage except for nonpayment of insurance premiums, addressing a concern that some insurers would only cover an individual until they became sick or submitted a claim; and
3. Access to the benefit market through anti-cherry-picking legislation called "guaranteed issue." We said when this consumer protection was first proposed for small groups that not everyone in our industry would agree with it, and as in other states where niche-marketing cherry pickers have complained about having to manage risk, you have received complaints here.

It was with the full knowledge and support of most members of the Insurance Access Committee that Governor Stephens included these provisions in his proposal for health care reform which Representative Tom Nelson originally proposed in the 1993 Legislature. These changes have been enacted by thirty-seven other states, including many of our neighbors like Wyoming, North Dakota, and Idaho.

HB446 by Representative Orr modifies the way insurance companies apply preexisting waiting periods on both individual and group benefits. Companies could only look back for three years when determining whether a condition is preexisting. Currently companies by law can look back up to five years.

The bill also acknowledges and restricts a current industry practice, used primarily in the individual market, of exclusionary riders. This allows an individual with a medical problem, which will probably be an expense in the near future (such as a bad knee needing surgery), to still get coverage for everything else. Without these riders, coverage would most likely be denied. Under this bill, the exclusionary rider could only be put in place for up to four years.

HB533 by Representative Arnott provides a mechanism for portability of time already met on preexisting waiting periods. Already part of small group reform, an individual moving into the small group market can waive the preexisting condition clauses so long as the person has been continuously covered. This bill allows that portability feature to apply going into the individual market as well.

SB322 by Senator Jacobson is similar to HB533, providing portability of waiting periods met into the individual market.

Small Group Reform

SB194 by Senator Baer repeals small group reform. We are opposed to repeal. We believe the reforms passed in 1993 are the right thing to do. We believe it was well-thought-out, and was discussed at length prior to, during, and since the 1993 session.

EXHIBIT 1
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many bills



There are problems with the way small group reform was implemented, and we think HB466 is the appropriate mechanism to address these problems. HB466 by Representative Nelson modifies the small group access law. There are some changes we believe the Joint Committee may wish to make in this bill as passed by the House to make it stronger, particularly in the area of benefit design.

We prefer the idea of a standard benefit design, which contains a higher level of benefits, and basic benefit designs, which are leaner, being made available on a guaranteed issue basis. The Insurance Department would not establish the type of benefits which will be included, but would establish the level of patient responsibility. The floor for basic benefit designs would be the plan set by the Montana Comprehensive Healthcare Association coverage, as amended by SB431, if that bill passes.

In addition, a modification proposed by the House would be considered, the development of a leaner plan called the Uniform Benefit Plan which all insurers in the state would offer, but would not be subject to guaranteed issue. The Uniform Plan would serve as the basis of comparison for consumers who want to look at similar benefits from one company to another. This approach also addresses a concern raised by HEAL Montana that there should be a lower-priced level of benefits available on a nonguaranteed issue basis.

Under this approach there would be several products available on both a guaranteed issue and nonguaranteed issue basis, some developed by the marketplace and others, such as the Uniform Benefit Plan, serving as a point of price comparison. The products represent the range of choice the market wants from leaner to richer levels of benefits.

There are problems with the Uniform Benefit Plan as it is currently proposed in HB531 which HEAL Montana has said they are willing to address. Those are mentioned in the attached letter dated March 2.

SB380 by Senator Jacobson as amended expands the current small group reform applicability from the current 3-25 employee size to businesses with up to 50 eligible employees.

HB531 by Representative Orr, which contains many reform recommendations, is addressed in the enclosed letter.

Individuals with medical problems who work for small business and members of their families who may have an ongoing illness should not be discriminated against when purchasing health insurance. This practice of cherry-picking only the healthy workers and their families was outlawed by the Small Group Insurance Act. It should not be allowed to creep back into the Montana marketplace. Problems with Small Group can be fixed as suggested above.

Market Reform

HB405 by Representative Nelson and SB405 by Senator Jacobson both deal with the concept of insurance purchasing pools. The House version is preferred by business and insurance. While providing the mechanism to band together for more economies of scale, it does not introduce additional regulatory criteria, as is required by the Senate version. Market protections, however, are included.

SB341 by Senator Holden contains reforms and improvements in the Montana Comprehensive Healthcare Association insurance program of last resort. This approach is preferable to the approach taken by HEAL Montana. A caveat on benefit design--for each benefit added, there is a corresponding cost to the benefit.

SB376 by Senator Christiaens addresses regulation of multi-employer welfare arrangements or MEWAs, self-funded employee health benefit arrangements which currently do not undergo state solvency scrutiny, nor do they comply with state market conduct criteria. This proposal is a start to some of the protections which need to be in place. More should be done, such as application of certain protections such as newborn coverage, contract disclosure, privacy protection, and insurance market reforms like noncancellation/nonrenewal prohibitions and guaranteed issue.

Health Care Reform

HB511 by Representative Johnson addresses concerns that we continue incremental reform recognizing problems continue for most Montanans with health care cost and access.

We look forward to working with you on these issues and any other proposals you review.

Sincerely,

Charles Butler, Jr.
(406) 444-8263

201TA303.1H/hcb
Enclosures
cc: Joint Committee Members

Exhibit #2

Blue Cross Blue Shield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

Charles Butler, Jr.
Vice President
Government and Public Relations

EXHIBIT 2
DATE 3-7-95
SB many bills

March 2, 1995

Senator Steve Benedict
Chair, Joint Select House-Senate
Health Care Committee
State Capitol
Helena, MT 59620

RE: HB 531

Dear Mr. Chairman:

House Bill 531, introduced by Representative Scott Orr, was heard by the Health Select Committee before transmittal. This proposal represents the HEAL Montana approach to health care reform.

At the hearing, we raised a number of concerns with this approach. As chair of the new joint House-Senate Health Care Committee that will consider legislation and issues contained in it, we wanted to share our concerns with you. The concerns are in three parts: Definition of a uniform health benefit plan and insurance market reforms, general concerns, and data disclosure considerations.

**Uniform Health Plan and Insurance Market Reforms**

There are numerous problems with Sections 2-4 as written. New Sections 2-6 apply to both group and individual insurance. Many large and not-so-large employer groups self-insure and are therefore not subject to these requirements. If more burdens and regulations are added, more employers will opt out of the regulated market to self-insurance.

a. The outline for the basic or uniform benefit plan should address issues, not attempt to legislate contract language. Actual language appears to be dictated in this legislation.

b. The Basic or Uniform Benefit Plan on page 3 contains 80/20 coverage; this is not basic, but actually pretty rich. If the attempt is to get more individuals covered by providing a lower cost alternative, a scaled-back approach should be explored.

c. Covered expenses use a usual, customary, and reasonable (UCR) reimbursement system--what about other payment systems:

- Managed care

- Capitation - fixed payment - amount
- Diagnostic Related Groups (DRGs)
- Resource-Based Relative Value System (RBRVS)--professional services reimbursement methodology

d. Benefits are scheduled for transplants--what if costs change or new transplants become norm? Benefit levels should not be scheduled in statute.

e. Disability insurance covers illness/accidents. Coverage for mental illness does not include mental retardation, which is a condition, not an illness that improves with treatment.

f. Specifically excluded medical expenses or services are listed. Again, why not allow traditional contract exclusions to apply? As an example, exclusion (G) is for complications to a newborn, unless no other source of coverage is available. If this is the basic plan that will be offered, it should cover newborns just as all other insurance in state must under regular insurance law.

g. Section 4 (2) requires only a three-month waiting period before full coverage is available, not the standard 12 months allowed elsewhere in insurance law.

h. Section 4, Lines 26 and 27 give individuals who don't pay their premiums 45 days of free coverage . . . We all know nothing is free, and the rest of us will pay.

i. Subsection 4 appears to allow an employee to elect to stay on his or her former employer's group plan even after going to a new place of employment with its own benefit plan. Conversion contracts, even at higher rates, don't pay the full cost of coverage. Capping the premium will mean small businesses and individuals pick up the tab.

j. A conversion cap of 150 percent of premium charged by the five insurers who write most individual policies is mandated, but these contracts may provide extremely different individual benefit levels.

k. Section 8 deals with preexisting look-back period of only 24 months. This only applies to Yellowstone Community Health Plan and Blue Cross and Blue Shield of Montana, not to the rest of the marketplace as written.

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**General Concerns**

a. We're not sure what New Section 5 on page 9 does. This section is entitled "Commissioner Not to Prohibit Premiums Based on Loss Ratio Guarantee."

b. There is a problem with standardized claim form mentioned. This does not allow the traditional hospital form, the UB 92, to be used or accepted, nor is the standard dental form recognized. Also, what about including Workers' Compensation and Medicaid in standardization to further streamline administration?

c. Health benefits are being expanded for the MCHA--sick pool--a subsidized, state-sponsored pool. When designed, it was never intended to be low cost but was designed to be the pool of last resort. Subsidized by the insured market--individuals and small employers. Please note that many large employers such as government entities and hospitals self-insure--they are not part of assessment.

**Data Considerations**

Considerable sensitive cost and pricing information is to be made available to any person, not just those shopping for services. What is now illegal under antitrust laws would be legal, the banding together of providers to compare, and potentially set, prices. The temptation is for providers to discover that their prices are lower than their peers and to raise them.

Subsections 2 and 3 address health care providers and hospitals. Each are given 30 days to respond to requests for current charge information. If an individual is shopping for a health service, 30 days is usually too long to wait for the information. There is nothing about past charge experience for a given service, or the history of bundling or unbundling charges, which can lead to a significant distortion in the cost of a service.

Subsection 4 requires about twice the information from insurers. Some of the general marketing information is already available because of marketplace demands, but serious problems exist with sharing proprietary pricing information with our competition. In fact, a recent Supreme Court case to which Blue Cross and Blue Shield of Montana was a party dealt with a demand for and protection of that sort of proprietary information.

Information such as this has a great deal of value to the developer of the information. This is probably a state appropriation of private property without compensation.

There is also a significant difference in fines between insurers and all other data providers who fail to provide information as required. Insurers are fined $1,000 for each failure to

provide information and providers are fined $500.

I urge your serious consideration of these concerns as these reform proposals move through the process.

Sincerely,

Charles Butler, Jr.
(406) 444-8263

201CB301.1K/jmm
cc: Representative Scott Orr, Committee Vice Chairman
House Speaker John Mercer
Members of the Committee
Susan Good
Peter Blouke

Exhibit # 3

EXHIBIT 3
DATE 3-7-95

Combined Select Health Committee
March 7, 1995
Dean M. Randash - NAPA Auto Parts

Subject: MSA accounts

I would like to share my experience concerning my own creation of "MSA" accounts that took place before I even knew or understood what MSA accounts were.

In 1980 I was approached by Blue Cross Blue Shield to let them our group health insurance. We had an employee meeting to discuss the features and benefits of the deductible plan that we were currently on and the HMO plan the agent was selling. During the meeting the number one complaint of each employee was that they were not able to come up with the deductible when it was needed. The agent capitalized on that fact and really worked the sale concerning the small co-pay amounts.

The employees decided that they wanted this HMO Blue Cross Blue Shield program. Over the next three years the premiums increase over 75%. To compensate I was forced to charge 25% of the employee premium back to the employee. In March of 1994 I had enough, knowing the insurance company was playing pricing games, because we had no major medical claims, I went health insurance shopping. All employees agreed on the John Alden insurance even though they were not the cheapest. The new group premium was 42% lower than Blue Cross Blue Shield, in fact it brought our premiums down to the same level that we had been paying three years earlier.

I still needed to a address the problem of the $250.00 deductible. What I did was to take the dollars we saved in the premium reduction and placed it in a separate account receivable account for tracking purposes. At any time during the year the employee can submit a copy of a medical bill and we will write a check up to the deductible amount. Since it is their money it is necessary to return what ever amount is left in the account to them at the end of the premium year.

I can see from talking with them and in my own experience that this has done two things. One is made it possible for them to meet the deductible with out fear of where the money is going to come from. The other thing is it has made them, along with myself, far better managers of our health care spending since it was our money being spent.

As an new advocate of this concept, HB-531 seems to me to better addresses the amount of dollars eligible to be placed in the MSAs. HB-531 also seems to have better flexibility toward the total medical and insurance expenditures inclusion toward the total dollars per a given year.. HB-560 with a fixed amount could be a real problem for larger families. One thing that I didn't see in either plan is the treatment of a married couple filing jointly being treated fairly and equably in comparison to filing separately.

Exhibit # 4

MHA MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

EXHIBIT 4
DATE 3-7-95

**Testimony by the**
**Montana Hospital Association**
**before the**
**Joint Select Committee on Health Care Issues**
**March 7, 1995**

***The Future of the Health Care Authority***

My name is John Flink and I am vice president of the Montana Hospital Association. MHA represents 55 hospitals and Medical Assistance Facilities. In addition to providing acute care services, 45 of these facilities also provide long-term care services.

Two years ago, the Legislature recognized that serious problems afflict our state's health care system, and—with the enactment of SB 285 and the creation of the Health Care Authority—began the process of fixing these problems.

MHA strongly supported SB 285, and we have strongly supported the work of the Authority over the past 18 months. And we believe it is critical that the Legislature build on the Authority's work in the upcoming biennium.

As we look ahead to the next two years, we want to call your attention to several policies and issues that we believe must be addressed:

- **The problems that led to enactment of SB 285 have not gone away.** In fact, they are getting worse. Continued reductions in Medicare and Medicaid reimbursement have forced hospitals and other providers to shift even more of their costs to privately-insured patients, thus forcing increases in health insurance premiums for working families. Massive reductions in the Medicare and Medicaid program—as envisioned by some in Congress—would accelerate this cost-shifting. Meanwhile, the numbers of uninsured and underinsured Montanans continue to grow.

- The changes now occurring in the health care delivery system—the movement toward coordinated and managed care—will accelerate in the next biennium. These changes could result in savings to both privately- and publicly-insured persons. But to realize these savings, we must take a new look at the health care regulatory environment, removing barriers to coordinated care.

- We must continue to work toward achieving two principles: (1) **increasing the number of Montanans who have health insurance coverage** and (2) **reducing the cost of that coverage.**

- The Achilles heel of our efforts to address access to health care services and their cost is **data.** We certainly can't design and implement a comprehensive data system in the next biennium, but we can begin to make some decisions about what data is needed, how it should be collected and how it should be used. We also need to look at what information consumers need to make more informed decisions.

- Regardless of what form it takes, **there should be a clearinghouse for health care**

**policy** questions. We don't care whether you call it the Health Care Authority, the Health Care Advisory Council, or the office of health policy within the new Social Services super agency—but somewhere in state government there should be a clearinghouse for the discussion of health care policy options.

MHA supported HB 511, sponsored by Rep. Royal Johnson, because, in our view, it is the only realistic vehicle for addressing the problems facing the health care system.

However, we would suggest that you consider several modifications to this measure:

- We would urge you to expand the purpose on page 1, lines 24 to 28 to include monitoring development of systems for providing coordinated care and their impact on the overall cost of health care services.

- Strike Sections 17 through 21 in HB 531—the sections relating to data—introduced by Rep. Orr. As amended in the House Select Committee, HB 511 would require SRS to make recommendations to the Legislature for a comprehensive data system. We feel this is the most responsible way to approach the data issue.

- Incorporate the tasks mandated by HB 542, sponsored by Rep. Tash. Improving the public health programs in the state certainly is consistent with the goals of increasing access and reducing cost. Incorporating Rep. Tash's bill would enable us to pursue those goals, without establishing yet another task force.

- In its report to the governor and the Legislature, the Health Care Advisory Council should be required to recommend legislation for consideration during the 1997 session that would address the twin goals of health care reform: (1) to expand access to health care services and (2) to reduce the growth of health care costs. This report should also include administrative recommendations that would help achieve these goals.

Finally, I want to say that we have mixed feelings about Rep. Johnson's bill. While we see it as the bill with the best chance of passing, we also recognize that it has weaknesses.

For example, without additional staff resources, the Health Care Advisory Council will certainly be limited in the scope of issues it can address. And, while that may be politically popular in this legislative session, it does not help find solutions to some very pressing problems facing the health care system.

Thank you for your consideration.

MHA MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

**Testimony by the**
**Montana Hospital Association**
**before the**
**Joint Select Committee on Health Care Issues**
**March 7, 1995**

## *Medical Savings Accounts*

My name is John Flink, and I represent the Montana Hospital Association.

The Montana Hospital Association gives Medical Savings Accounts a mixed review. On the one hand, we recognize that, with the proper safeguards, MSA's could be a tool in expanding access to health care insurance coverage. We also agree that they could help promote more cost-conscious purchasing of health care services by consumers.

But, on the other hand, we believe there are some other issues that must be carefully weighed before the Legislature endorses this concept:

- For example, who benefits from MSA's? In our view, they would probably benefit Montanans with above average income levels, and, without government subsidies, are not a viable way to extend coverage to low-income individuals and families.

- Secondly, we are concerned that MSA's create the wrong kind of incentive. It is quite possible that MSAholders would choose not to spend their money on preventive services, making them candidates for much more expensive health care services down the road. This concern is particularly important to us as we move toward coordinated or managed care systems.

- Third, we believe any MSA bill must require persons opening an MSA to demonstrate proof that they hold a catastrophic health insurance policy. Without such proof, MSA's would likely lead to even more hospital bad debt.

- Finally, we are concerned that MSA's would attract primarily healthy people, shrinking the risk pool needed to make health care coverage affordable to those in greatest need of health services.

If these concerns are addressed, MHA believes that MSA's can be a tool in expanding access to health care services and promoting greater cost consciousness among consumers.

Exhibit #5

EXHIBIT 5
DATE 3-7-95

STATE AUDITOR
STATE OF MONTANA

*Mark O'Keefe*
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

**Amendments Recommended To HB560**
**Proposed By Securities Department of The State Auditor's Office**

House Bill 560 provides for the creation of medical savings accounts which may be administered by certain enumerated types of entities, including broker-dealers or investment advisers. The unamended bill would require administrators to determine whether expenses submitted by the employee are eligible for payment. There is an inherent conflict between the interests of the broker-dealer or investment adviser and the employee. The broker-dealer would like to retain the employee's funds for as long as possible, while the employee's best interests are served by paying as many eligible expenses as possible. The proposed amendments would require the account administrator's ability to pay all claims submitted by the employee. Because the employee suffers tax consequences if the account is used to pay ineligible expenses, there is no real reason to require the administrator to make this determination. The amendments also make clear that employees are entitled to all the protection afforded by the Securities Act of Montana. Unless House Bill 560 is amended, medical savings accounts would not have the same safeguards that cover other similar broker-dealer or investment adviser accounts.

1. Page 1, Line 23.
Following "30-10-103"
Insert: "and registered as such in this state pursuant to 30-10-201,"

2. Page 4, Line 1.
Following "care."
Insert: "(1) An employee or account holder may use funds held in a medical care savings account only for the purpose of paying the eligible medical expenses of the employee or account holder or the employee's or account holder's dependents, purchasing long-term care insurance or a long-term care annuity, or paying the expenses of administering the account. Funds held in a medical care savings account may not be used to pay medical expenses of the employee or account holder or a dependent of the employee or account holder that are otherwise reimbursable, including medical expenses payable pursuant to an automobile insurance policy, workers' compensation insurance policy or self-insured plan, or another health coverage policy, certificate, or contract."

3. Page 4, Line 1.
Strike "(1)"
Insert "(2)"

4. Page 4, Line 5.
Strike "(2)"
Insert "(3)"

5. Page 4, Line 19.
Strike Lines 19 through 26 in their entirety.

6. Page 4, Line 30.
Following "for"
Strike "eligible medical expenses"
Insert " expenses for which documentation is submitted by the employee or account holder"

7. Page 5, Line 12.
Insert "(7) Nothing in [sections 1 through 7] of this chapter limits the applicability of other state or federal laws which apply to transactions between individuals or entities serving as account administrators and account holders."

Exhibit # 6

EXHIBIT 6
DATE 3-7-95

AMENDMENTS TO HOUSE BILL 405

1. Page 2, line 28.
Following: "experience"
Insert: ","
Strike: "or"

2. Page 2, line 28.
Following "status"
Insert: "or occupation"

3. Page 3, line 22.
Insert: "(9) It shall comply with the provisions of Title 33, chapter 17, part 6."

FROM FRANK COTE

33-17-511. Consideration for services only on written memorandum. A person licensed as an insurance consultant under this part may not receive a fee for examining, appraising, reviewing, or evaluating an insurance policy, bond, annuity or pension or profit-sharing contract, plan, or program or for making recommendations or giving advice with regard to any of the above unless the compensation is based upon a written memorandum signed by the party to be charged and specifying or clearly defining the amount or extent of the compensation. An insurance consultant shall retain a copy of every memorandum or contract for not less than 3 years after those services have been fully performed.

History: En. 40-3345 by Sec. 7, Ch. 144, L. 1975; R.C.M. 1947, 40-3345; amd. Sec. 41, Ch. 713, L. 1989.

33-17-512. Limitation on type of consideration. A licensed insurance consultant may not receive a commission, service fee, brokerage fee, or other valuable consideration for the sale or service of a line of insurance, annuity, security, or pension trust if the consultant has received compensation from the client for consulting services on the same line of insurance, annuity, security, or pension trust sold or serviced within the preceding 12 months.

History: En. 40-3346 by Sec. 8, Ch. 144, L. 1975; R.C.M. 1947, 40-3346; amd. Sec. 42, Ch. 713, L. 1989; amd. Sec. 1, Ch. 215, L. 1993.

Compiler's Comments

*1993 Amendment:* Chapter 215 substituted language concerning limitation on receipt of fees or consideration for former text that read: "A person licensed as an insurance consultant may not receive any compensation, direct or indirect, as a result of the sale of insurance or annuities to or the use of securities or trusts in connection with pensions for a person to whom the licensee has performed a related consulting service for which he has received a fee or contracted to receive a fee within the preceding 12 months."

33-17-513. Restrictions on insurers recommended by licensee. A person licensed as an insurance consultant under this part may not recommend or encourage the purchase of insurance, annuities, or securities from an authorized insurer in which he or any member of his immediate family holds an executive position or holds a substantial interest.

History: En. 40-3347 by Sec. 9, Ch. 144, L. 1975; R.C.M. 1947, 40-3347; amd. Sec. 43, Ch. 713, L. 1989.

## Part 6
## Administrators

Part Cross-References

Licenses — discrimination in issuance prohibited, 49-3-204.

33-17-601. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 1, Ch. 343, L. 1979; amd. Sec. 10, Ch. 409, L. 1987.

33-17-602. Written agreement required. (1) A person may not act as an administrator without a written agreement between the person and the insurer. The written agreement must be retained as part of the official records of both the administrator and the insurer for the duration of the agreement and for 5 years thereafter. The written agreement must contain provisions that include the requirements of 33-17-612 through 33-17-617 insofar as these requirements relate to the functions performed by the administrator.

(2) The agreement must contain a provision with respect to the underwriting or other standards pertaining to the business underwritten by the insurer.

(3) Whenever a policy is issued to a trustee, a copy of the trust agreement and any amendments to it must be furnished to the insurer by the administrator and be retained as part of the official records of both the administrator and the insurer for the duration of the policy and for 5 years thereafter.

History: En. Sec. 2, Ch. 343, L. 1979; amd. Sec. 11, Ch. 409, L. 1987; amd. Sec. 44, Ch. 713, L. 1989.

33-17-603. Certificate of registration. (1) Except as provided in 33-17-604, a person may not act as or hold himself out to be an administrator in this state unless he holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless he finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) The certificate of registration is renewable annually on July 1. A request for renewal must be accompanied by a renewal fee of $100.

(4) The certificate of registration may be suspended or revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless the certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500.

History: En. Sec. 12, Ch. 343, L. 1979; amd. Sec. 45, Ch. 713, L. 1989; amd. Sec. 8, Ch. 798, L. 1991.

Cross-References

Hearings on decisions of Commissioner, 33-1-701.

Former criminal offenders — consideration in licensing, 37-1-203.

33-17-604. Waiver of certification requirements. The commissioner may waive the requirements of 33-17-603 for any person or class of persons. The factors taken into account in granting a waiver include but are not limited to:

(1) whether the person acting as an administrator is primarily in a business other than that of administrator;

(2) whether the financial strength and history of the organization indicates stability in its continuity of doing business;

(3) whether the regular duties being performed as an administrator are such that the covered persons are not likely to be injured by a waiver of the requirements.

History: En. Sec. 13, Ch. 343, L. 1979; amd. Sec. 46, Ch. 713, L. 1989.

33-17-605. Repealed. Sec. 19, Ch. 409, L. 1987.

History: En. Sec. 10, Ch. 343, L. 1979.

33-17-606 through 33-17-610 reserved.

EXH. #6 3-7-95



33-17-611. Maintenance of information. For the duration of the agreement required by 33-17-602 and for 5 years thereafter, each administrator shall maintain at its principal administrative office adequate books and records of all transactions between the administrator, insurers, and insured persons. These books and records must be maintained in accordance with prudent standards of insurance recordkeeping. The commissioner shall have access to these books and records for examination, audit, or inspection. Any trade secrets contained in the books and records, including but not limited to the identity and addresses of policyholders and certificate holders, are confidential, except that the commissioner may use the information in any proceedings instituted against the administrator. The insurer retains the right to continuing access to those books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and the administrator.

History: En. Sec. 3, Ch. 343, L. 1979; amd. Sec. 47, Ch. 713, L. 1989.

33-17-612. Approval of advertising. An administrator may use only such advertising pertaining to the business underwritten by an insurer as is approved by the insurer in advance of its use.

History: En. Sec. 4, Ch. 343, L. 1979.

33-17-613. Collection of charges and premiums. (1) All insurance charges or premiums collected by an administrator on behalf of or for an insurer and return premiums received from the insurer are held by the administrator in a fiduciary capacity. These funds must be immediately remitted to the person entitled to them or must be deposited promptly in a fiduciary bank account established and maintained by the administrator. If deposited charges or premiums were collected on behalf of or for more than one insurer, the administrator shall require the bank in which the fiduciary account is maintained to keep records clearly recording the deposits in and withdrawals from the account on behalf of or for each insurer. The administrator shall promptly obtain and keep copies of all these records and, upon request of an insurer, shall furnish the insurer with copies of the records pertaining to deposits and withdrawals on behalf of or for the insurer.

(2) The administrator may not pay a claim by withdrawals from the fiduciary account. Withdrawals from the fiduciary account must be made, as provided in the written agreement between the administrator and the insurer, for:

(a) remittance to an insurer entitled to the remittance;

(b) deposit in an account maintained in the name of the insurer;

(c) transfer to and deposit in a claims paying account, with claims to be paid as provided in 33-17-615;

(d) payment to a group policyholder for remittance to the insurer entitled to the payment;

(e) payment to the administrator of its commission, fees, or charges; or

(f) remittance of return premiums to the person entitled to the premium.

History: En. Sec. 5, Ch. 343, L. 1979; amd. Sec. 48, Ch. 713, L. 1989.

Cross-References

Duties of trustees, Title 72, ch. 34, part 1.

**33-17-614. Treatment of payments.** Whenever an insurer utilizes the services of an administrator under the terms of a written contract as required in 33-17-602, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured is considered to be received by the insurer and the payment of return premiums or claims by the insurer to the administrator is not considered payment to the insured or claimant until the payments are received by the insured or claimant. This section does not limit any right of the insurer against the administrator resulting from the administrator's failure to make payments to the insurer, insureds, or claimants.

History: En. Sec. 6, Ch. 343, L. 1979.

**33-17-615. Payment of claims.** All claims paid by the administrator from funds collected on behalf of the insurer shall be paid only on drafts of and as authorized by such insurer.

History: En. Sec. 7, Ch. 343, L. 1979.

**33-17-616. Delivery of documents.** Any policies, certificates, booklets, termination notices, or other written communications delivered by the insurer to the administrator for delivery to its policyholders shall be delivered by the administrator promptly after receipt of instructions from the insurer to do so.

History: En. Sec. 8, Ch. 343, L. 1979.

**33-17-617. Claim adjustment and settlement.** With respect to any policies where an administrator adjusts or settles claims, the compensation to the administrator with regard to the policies shall in no way be contingent on claim experience. This section does not prevent the compensation of an administrator from being based on premiums or charges collected or number of claims paid or processed.

History: En. Sec. 9, Ch. 343, L. 1979.

**33-17-618. Insured persons to be notified of availability of administrator.** Whenever the services of an administrator are utilized, the administrator shall provide a written notice, approved by the insurer, to insured individuals, advising them of the identity of and relationship between the administrator, the policyholder, and the insurer. Whenever an administrator collects funds, the administrator shall identify and state, separately in writing, to the person paying to the administrator any charge or premium for insurance coverage the amount of such charge or premium specified by the insurer for the insurance coverage.

History: En. Sec. 11, Ch. 343, L. 1979.

## Parts 7 through 9 reserved

## Part 10
## Revocation, Suspension, and Penalties

**33-17-1001. Suspension, revocation, or refusal of license.** (1) Except as provided in 33-17-411, after a hearing, which must be held no less than 10 days after advance notice by certified mail, on charges given under 33-1-314(3), the commissioner may suspend for up to 5 years, revoke, refuse

Exhibit #7

# PROPOSED AMENDMENTS TO HB405/SB405

EXHIBIT 7
DATE 3-7-95

## PURCHASING POOLS

Before the Joint Select Committee on Health Care Issues

by the Montana Association of Health Care Purchasers
Keith Kovash, Board Chairman

The MAHCP is a non-profit organization of employers, and associations of employers and employees which espouses and has every intention of actually doing group health insurance purchasing. We believe that purchasers who are too small to successfully negotiate favorable health plan terms and conditions on their own can do so collectively. We applaud your efforts to provide enabling legislation. We see this as one of the very few cost control hopes coming out of this legislative session.

We ask that you seriously consider the following statements of principle and specific recommendations for combining HB405 and SB405. Ours may be the only testimony you receive from purchasers.

**Principle I: Purchasing pools need to be allowed to evolve and self-select workable structures and strategies.** There are numerous models and approaches. No one has the magic bullet, especially for a rural Montana health care environment. The employers and employee groups who are investing in a purchasing pool, who will benefit from its successes and who take the risk for its failure should be the ones determining what approach they think will work best—not the Insurance Commissioner's office as provided by many provisions of SB405.

> **Recommendation:** Adopt HB405 (possibly with some amendments from SB405). This will allow purchasing pools to form and gain some experience. Next session, draw on that experience to craft any additional legislation needed. Take the same incremental approach to purchasing pools you are taking to other aspects of health care reform.

**Principle II: Reasonable fiduciary requirements are appropriate to protect consumers. Purchasing Pools will have fiduciary responsibility for any premiums collected for transmittal to insurance carriers.**

> **Recommendation:** Amend HB405, as needed, to establish the same fiduciary requirements on purchasing pools as on any other non-profit entity which collects funds from members of the public. The MAHCP would be happy to work on such an amendment.

**Principle III: The same (no greater) prohibitions on risk selection as placed on commercial insurance carriers are appropriate.** If insurance reform is to be a reality, purchasing pools cannot be allowed to skim off good risks any more than commercial carriers. If they are to survive, they cannot face greater risk selection prohibitions.

**PROBLEM:** The amendments to HB405 Section 2 (2) created inequity. The last sentence had prohibited purchasing pools from excluding small employers on the basis of claim experience or health status. By striking "small," it now prohibits purchasing pools from excluding any employers on the basis of claim experience or health status. Since commercial insurers can exclude larger employers on this basis, the purchasing pool will pick up all the larger employer groups commercial insurers don't want which could swamp a purchasing pool.

The deletion of the word "small" appears to have been inadvertent, since it was not part of the amendments to the bill worked out by interested parties and submitted by Mr. Akey.

**Recommendation:** Return to the original version or implement the following amendment which we believe better achieves the intent.

Proposed amendment to Section 2 (2):
(2) It establishes requirements for membership. THE VOLUNTARY PURCHASING POOL SHALL ACCEPT FOR MEMBERSHIP ANY SMALL EMPLOYERS AND MAY ACCEPT FOR MEMBERSHIP ANY EMPLOYERS ~~WITH MORE THAN 25 ELIGIBLE EMPLOYEES~~ WHO DO NOT MEET THE DEFINITION OF A SMALL EMPLOYER THAT OTHERWISE MEET THE REQUIREMENTS FOR MEMBERSHIP. ~~However, the voluntary purchasing pool may not exclude any small employers that otherwise meet the requirements for membership on the basis of claim experience or health status.~~ HOWEVER, MEMBERSHIP REQUIREMENTS MAY NOT INCLUDE HEALTH STATUS OR CLAIM EXPERIENCE, OR OCCUPATIONAL GROUP

**Alternate Recommendation:** If the committee feels that a prohibition on risk selection of larger employers is critical, allow rates for larger employers to be modified to reflect the risk.

**Desirable Features of SB405:**

- The requirement that the governing board of a purchasing pool be composed of purchasers.
- The allowance of separate premium structures for small employer groups and larger employer groups.

**Poison Pills in SB405:**

- Unnecessary and potentially debilitating requirements and government regulation.
- The inclusion of individuals and sole proprietors in insurance pools. Employers cannot be expected to take on this additional burden.

EXHIBIT 8
DATE 3-7-96

FROM
SEN. JACOBSON
Exhibit #8

HB 405

1. Allows anybody to establish a purchasing pool with no criteria for governance of the pool.

2. No provision for criteria to prevent a pool from developing membership requirements which exclude employer groups outside of claim experience or health status, such as occupation.

3. No provision for reporting to assess for cost containment objectives or consumer satisfaction.

4. Does not allow self-employed individuals to participate in a pool.

SB 405

1. Requires that the purchasing pool have a board of directors made up of purchasers with a balance between employers and employees.

2. Membership requirements are in addition to those adopted by the Insurance Commissioner and cannot exclude groups or individuals based on occupation.

3. Requires that the pool actively engage in providing information to participants on cost and quality.

4. Allows individuals to participate.

5. Requires financial viability verified through reporting.

6. Requires written plan of operation.

7. Allows risk adjustment for individuals and large groups.

8. Allows for market areas to be established to ensure that a purchasing pool remains operational and sound; does not prohibit competition similar market areas.

9. Provides protections for participants in a pool in the event of insolvency or mismanagement of the pool.

DATE March 7, 1995

SENATE COMMITTEE ON Joint Select Committee on Heath Care

BILLS BEING HEARD TODAY: HB 511, HB 542, SJR 14, HB405, SB 405, HB 531, HB 560

< ■ > PLEASE PRINT < ■ >

| Name | Representing | Bill No. | Check One: Support | Oppose |
|---|---|---|---|---|
| JACK Molloy | Mont Health Care Auth | | | |
| M Sweeney | HEAL-MT | HB560 HB405 SB405 | X | |
| Keith Kambich | Montana Association of Health Care Purchasers | HB/SB 405 | | X |
| LARRY AKEY | MT ASSOC OF LIFE UNDERWRITERS | HB/SB 405 HB531 & HB560 | | |
| Ed Caplis | MSCA | | | |
| FRANK COTE | ST. AUDITOR | | | |
| Claudia Clifford | State Auditor's Office | HB | | |
| Ed [illegible] | MMBP/MABT | | | |
| Tom Hopgood | Health Ins. Assoc. Amo. | | | |
| David Ohrn | MT Chamber | | | |
| Robert Thomas | MT Dept of Revenue | | | |
| Tom Ebzery | Yellowstone Comm Health Plan | | | |
| Riley Johnson | NFIB | | | |

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE March 7, 1995

SENATE COMMITTEE ON Joint Select Committee Health Care

BILLS BEING HEARD TODAY: HB 511, HB 542, SJR 14, HB 405, SB 405, HB 531, HB 560

# < ■ > PLEASE PRINT < ■ >

| Name | Representing | Bill No. | Check One: Support | Oppose |
|---|---|---|---|---|
| Anita Bennett | Montana Logging Assn | HB 531 SCO 405 | ✓ | |
| Mary M. Randock | NARA Auto Parts | HB 531 SCO 405 | ✓ | |
| Charles R. Brooks | Billings Chamber | HB 405 HB 511 | ✓ | |
| Laurie Ekanger | Governors Office | HB 405 HB 511 | ✓ | |
| Tanya Ask | Blue Cross/Blue Shield MT | HB 405 SB 405 HB 511 | HB 560 | HB 531 |
| Eve Franklin | S.D. 21 | | | |
| Jerry Loendorf | Mt Ret Assn | H 531, H 516 H 405, S 405 | ✓ | |
| Keith L. Colbo | Deaconess - Billings | HB 405 | ✓ | |
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REGISTER.F10