MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN STEVE BENEDICT**, on March 8, 1995, at 5:30 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: There was public testimony given on the following bills: SB 330, and HB 466
Executive Action: None

{Tape: 1; Side: A.}

Public Testimony:

Mona Jamison, representing the Montana Association of Speech, language, and Hearing, and also the Montana Dietetic Association, stated she was going to talk about the Benefit package. She said they feel left out and the economic benefits of including nutrition services and speech pathology in a basic plan are important, are significant and provide cost savings. She said they were suggesting that nutrition services when referred by a physician under a case management plan should be included. She

said some of the therapy that could be provided could foreclose the need for later more extensive therapy or surgery. She said like the dietician, the speech pathologist fees are low. They are basic traditional medical services that help the patient and hopefully save some of the services at the end. She asked for an expansion. She said she was asking what constitutes a basic plan that they consider the low cost services. She asked that they consider those services. **(EXHIBITS #1, #2, and #3)**

Connie Grenz, representing the Montana Occupational Therapy Association, read her written testimony **(EXHIBIT #4)** and handed in another testimony **(EXHIBIT #5).**

Maggie Newman, a member of the Health Care Authority, said she said that 43 states have instituted some type of small group reform. 38 of the states have guaranteed issue, 43 have guaranteed renewal, 41 have guaranteed affordability, 39 have rules on pre-existing conditions, and 28 states have set up reef insurance pools. She said small group reform should not be repealed. It is badly needed. She said that modifications should be done to the plan as it currently stands. She said that it should not be thrown out. In order to give small employers and employees of those people power they need to enable Purchasing Pools. She suggested that the enabling of one Purchasing Pool initially is a wiser way to go. Purchasing Pools work better with a large number of people. The most recent version of the bill on pre-existing conditions where there is a 5 year look back period, a 12 month pre-existing condition period, and a 4 year rider period, she said the insurers and the health care providers of Montana who crafted this and it is not fair that anyone should have to wait 5 years to get coverage for a health care plan that they need coverage for. She said a more reasonable approach would be 2 year look back period. SB 376 seems to be a reasonable bill. When they have small group reform, many small groups try to self insure. They have to ensure that the people who are self insuring have the financial ability to pay claims for their insurance. The way things are now, they can do whatever they want. No one has any say over how they form MEWAS except the federal government. She stated they supported the insurance fraud bill, SB 341. She hoped it was properly funded.

Melody Ferrara, said she was a female who was 42 years of age, has a college degree and worked for a small group employer. She said she has a disease that may cause other problems and she was denied health insurance from her employer because of the disease. She is a single mother with one child in college and another going in the fall. She said before she was divorced she was covered under her former husbands insurance. After the divorce she did not carry his policy. She was given the choice of going to another company to work who would directly insure her or to stay with the company she was with. She chose to stay with the company because of financial stability. In 1992 she lost all of that stability because she had an accident. Eventually she had

to look at the option of filing bankruptcy. She said she spent many hours working overtime. She worked a night job. She made payment schedules with all of the people she owed money. She said the major reason there is a bankruptcy currently is because of medical bills. She said she did not create her disease. She is an asset to her employer and finally realized that she was an asset and they were going to lose her if they did not get an insurance plan for her. They took out a plan called MCHA from Blue Cross Blue Shield and they paid for it. She said in December 1993 they said she received a letter from MCHA saying she would no longer be discriminated against because of her health. She said only one month later she was faced with the possibility of that law being repealed. She believed that the law should not be repealed. Small group employers lose a lot of people because they can not give them health insurance. By not leaving the Small Group Employer Act reform in tact, they have only gone backwards. Since then her situation has changed again. She has gotten married and she has 2 expensive companies. She said she will never again be left with the possibility of not having insurance and become owing thousands and thousands of dollars. She said she did not know the answers, but they are on the right track by having the Health Care Reform Act. They must make insurance available for all the working force. She said she was not asking for free rides. She was asking that they make insurance affordable to every working person by letting the Small Group Employer act continue.

Mary McCue, representing the Montana Clinical Mental Health Counselors Association and the Montana Mental Health Association, the Psychological Association, and the Montana Chapter of the National Association of Social Workers, read her written testimony. **(EXHIBIT #6)**

Sharon Hoff, representing the Montana Catholic Conference, stated they supported the Small Business Health Insurance Act. They support **REPRESENTATIVE NELSON'S** bill. She said they also supported the increased benefits for the mental health issues. She said that putting all of the sick people in one group would be the wrong thing to do. For them traveling with and supporting the most vulnerable in their society is a key piece for them. she urged them to continue to support the small employer plan.

Kenneth Eden, an internist in Helena, said as a primary care physician and someone who could say that the vast majority of the primary care physicians in Montana support small group reform as it was written by their committee with months of public input and it would be a grave mistake to repeal that.

Dean Randash, an employee of NAPA Auto parts, a small business, read his written testimony. **(EXHIBIT #7)**

Tom Ebzery, representing the Yellowstone Community Health Plan, read his written testimony. **(EXHIBIT #8)**

Shirley Rasmussen, a small group employer from Stevensville, read her written testimony. **(EXHIBIT #9)**

{Tape: 1; Side: B; Approx. Counter: 5.2.}

Public Testimony:

Ron Kunick, a life underwriter, read his written testimony. **(EXHIBIT #10)**

Tom Hopgood, representing Health Insurance Association of America, said health insurance reform does not necessarily mean health care reform. He said they addressed the individual problem of the uninsurable. In 1993 the insurance industry was under attack for not providing insurance to people. They came up with the Small Group Act which was tailored to fit Montana. It required guaranteed issue in the small group market, 3-25 people. It required that if a person changed jobs within the market they could take their health insurance with them. It would be guaranteed renewable at replaced premium restrictions on it. They said when that bill was under debate that it was an accessibility bill, not an affordability bill. When they do guaranteed issue, it is going to cost. He said the 1993 Legislature should be commended for when they passed the Small Group Act. He said the law says, as a condition of transact in business in this state with small employers. Each small employer carrier shall offer to small employers at least 2 health benefit plans. One plan must be a basic health benefit plan and one plan must be a standard health benefit plan. If they want to buy a standard plan or a basic plan a company conducting business in the small employer market in the state of Montana has to sell a person that plan. He said he was sure the commissioners office would be interested in knowing which companies were not issuing plans that are by law required to be guaranteed issue. He said to the rate increase the only statistics he had seen from the two largest companies in the state, as he understands it they have not yet increased their rates due to guaranteed issue. He said he could not say they will or it will not. He said Blue Cross Blue Shield's rates have not gone up, and John Alden's have gone up 3 to 4%. He said he was moving to a resolution of the issues. There are some adjustments that need to be made.

Larry Akey, representing the Montana Association of Life Underwriters, he said they supported the Small Employer Health Availability Act in the 1993 session. They tried to make it clear that the act if in acted without cost containment measures would result in some potential increase in premiums. He said the purpose of the act was availability and not affordability. He said they see guaranteed issue as a corner stone to insurance reform. He said if they eliminate guaranteed issue, what is the meaning of portability. He said if they do not have guaranteed issue, forget the concept of Voluntary Purchasing Pools. He said

they do not really know what the impact of the act would be because they have only had it effect for 3 months. He said the biggest problem seems to be benefit design. He showed a chart. **(EXHIBIT #11)** He said on the chart on the side that says benefit design, that is a conceptual figure. There is a big heavy line drawn across the middle that is the current level of mandated benefits. There is a dashed line below that where the comprehensive health benefits are currently. That is not a very good plan as all the other plans. He said before the Small Employer Act all of the plans that are currently in place had at least the level of mandated benefits, and all of those plans were fully underwritten. He said when they adopted SB 285 they established the Health Benefits Plan Committee. They ended up with the definition of the standard plan, the definition of a basic plan. The standard plan was a pretty nice plan. The basic plan had to include all of the benefits that were contained in the statute. The took a block of the market place and said that would be guaranteed issue. **REPRESENTATIVE NELSON'S** bill was introduced. It would take the guaranteed issue block and move it down a little bit. It would take out some of the benefits in the guaranteed issue plans. It lowered the ceiling or the standard plan. It lowered the floor for the basic plan. He said once the House Health Select Committee completed its work on HB 466 they ended up with the fourth column. They had a little narrow band of guaranteed issue policies called the uniform benefit plan and the reason there is a question mark over that narrow band is because the House Health Select Committee did not have a chance to finish its work on HB 531. They do not know what that benefit policy would look like. He said everybody agreed it was going to be a little bit less than the current level of mandates and a little bit more benefit rich than the comprehensive health association benefits and everything above that and above the level of the current mandated benefits would be fully underwritten. They would return to the days before the Small Employer Health Availability Act for all of those out of the market place and for those people who could not get underwritten at the level prior to SB 285 they created uniform benefit plan guaranteed issue it and take all the unhealthy people and all the sick people and ship them down into a benefit package that was fairly lean. If that is what the Legislature wants to do, then that is a step backward and they will with draw their support for HB 466. They would initiate support for HB 194 or HB 155. They believe that HB 466 as it is currently not only is it not very good public policy, it is worst public policy prior to what they have had prior to the passing of SB 285. He said they do not want to do that. He said the fifth column was ways they could try to accomplish some of the goals of the people who say they need to have a lower cost policy in the market place, some of the goals of the people who say they need to have a uniform plan that all companies have to offer so there is comparison across the market place. He said they can get there. He said people with diverse views are starting to listen to each other.

Tanya Ask, representing Blue Cross Blue Shield of Montana, said the cost of health care is reflected in the cost of insurance premiums. They need to work on affordability. She said before they would offer a quote, under small group the first few months they were out there, they had to have it reviewed by an underwriter because the quote they have was the quote that would stay with that policy and they wanted to make sure that it was correct. Since then they have software to do it themselves. She was reading from her testimony. **(EXHIBIT #12)** She passed out some conceptual amendments, **(EXHIBIT #13)** She asked that they issue carefully because the issues are very complicated.

Tanya Ask said she wanted to introduce a couple of letters of people who had positive experiences with small group insurance. **(EXHIBIT #13 & #14)**

Bob Benson submitted his written testimony. **(EXHIBIT #15)**

Susan Good, representing Heal Montana, stated the problems that were before them are accessibility and affordability. She said 1.8% of the respondents of a study were not able to purchase health insurance in the previous 5 years because they did not qualify. She said small group reform has addressed the accessibility issue and it has solved it. The Montana Health Care Authority has said repeatedly that the reason that people do not have health insurance is because they cannot afford it. She said the insurers all supported small group reform in 1993. SB 285 was a reaction to that. She said they have examined other areas of health care reform that might be advantages. The uniform plan in Heal Montana feels that the playing field is leveled between individuals and insurance may become more affordable for everyone. She said they have a long way to go, but they are going to get to a solution. As they discuss the plans every time a benefit or provision is added everyone agrees that it would drive up the cost. She said that for every 5% a premium increase 13% of the people drop out of the market. The people who leave are those who are the least at risk. The old and sick are left. She said if guaranteed issue should stay, that another plan should be offered in the market place that would be underwritten and affordable. Their group is willing to consider anything to solve those problems.

Greg VanHorssen, representing State Farm Insurance, read his written testimony. **(EXHIBIT #16)**

{Tape: 2; Side: A; Approx. Counter: ; Comments: Mr. VanHorssen was cut off when the tape was changed.}

Mark O'Keefe, the State Auditor and the Insurance Commissioner, said the small group legislation they were talking about was written by consumers, providers, insurers, and an insurance

regulators from across the country. He said he called some one in Washington D.C who was the policy counsel for small group reform nationally. He said she told him 43 states have passed it. He said they were amending the bill to take guaranteed issue provisions in the original bill and expanding them upwards. He said generally they have found in states similar to this that there has been a great deal of stability under the small group market place. In states where only 2 policies were guaranteed issue, because no one was buying the basic plans because the were creating a sick persons pool. He said guaranteed issue was doing what they always thought it would do. It helps some people and it hurts others. He said the benefit is that the small business's rates will not go up so high in the future. There are caps and they can plan for the future. The policy council said that rates have not jumped drastically in the states that have adopted the small employers policy. He said the debate about the plans and what is going to be in the plans is what is going to be the hardest. He said they were trying to put together quality health care plans. He said the cornerstone of small group reform is guaranteed issue. He said without guaranteed issue, forget portability, purchasing pools, pre-existing conditions, and forget insurance reform has any kind of solution in the market place. If people who cannot buy health insurance who need it then they have health insurance for the healthy and the people who are sick, are still going to get health care and that cost will be passed along to the healthy who are paying the premiums. That is where they will be if they go into a situation without guaranteed issue. He said his benefit level was what benefit level was the market going to force employers into. He said a lot of people were going to gravitate toward the lowest cost policies. If that happens are they creating two classes of citizens in Montana in terms of what health care benefits are paid for. He said small group reform was a private sector solution to a private sector problem. He said they will give them some amendments.

Brian Zinz, the CEO of the Montana Medical Association, said they support continuation of the Small Employer Health Insurance Availability Act. He said they would like to give it a chance.

Anita Bennett, representing the Montana Logging Association, stated that when they look at an association and the services that are rendered to their members they differ from association to association. She said they look at the industry and the people they serve. At the initial start of their program they did underwrite groups from 1 to 9 in a fashion which they could get some type of a group purchasing pool arrangement available to their members. As of January 1 associations under the availability act are guaranteed issue. She said they cannot do health care reform and guaranteed issue on a group of 1. They are required to do guaranteed issue in groups of 1. They are concerned how that will impact them. She said they also cover Workers' Compensation on that. She said they were covering the owner/operator. She said they were looking a survival of an

industry, but also affordability. She said they were working out there and have been for 13 years and they were concerned how it would effect the timber industry.

John Vandenacre, an insurance agent since 1978, said the cost would even be cheaper after guaranteed issue. He said the objection they get from people who purchase insurance is not availability, it is affordability. He said with guaranteed issue did not involve cost. He said it was going cost more. He said availability is dictated by affordability. They can have the very best available, but if it is not affordable, who would purchase it. He said the rich or the severely unhealthy can afford it. He said he does not believe guaranteed issue is the cornerstone of health insurance reform. He said some groups might actually experience a decrease in rate temporarily. Companies who have individually experienced rated groups over the past have increased the premium because of health problems in a particular group if they can get another company to come in and underwrite that group the premium is going to be much less because it would be at the current market place. It is not going to stay there. Someone is going to have to pay those costs. He said it would be a short term effect for a long term problem. He suggested that every time they force people to pay more they were going to have less people who could afford to buy and less people covered under insurance.

Claudia Clifford, representing the Insurance Commissioners Office, said she had some amendments to HB 466, some fact sheets and the latest list of companies that have declared that they want to be small group carriers and those companies that have been approved as carriers. **(EXHIBITS #17, #18, #19, and #20)**

Larry Petty, an independent insurance representative, said he supported HB 285 as it was implemented. He said they would be going back to square one and that would be wrong. He said his feeling is to offer the best possible coverage to his clients. He said it was too new to see what the impact was going to be. He said there were a lot of people who would be insurable if they could afford it. He said everybody who has insurance was paying for those who are not insured. He said there were some positive things that could be done to the present bill. He said he did not think guaranteed issue is not meaning that there cannot be a pre-existing clause condition.

Ed Grogan, representing Montana Medical Benefit Plan and the Montana Medical Benefit Trust, said it that he read a study on the price increase of the first 12 states that adopted small group. It went up because of MEWAS. He said the rates had not come up a lot and the were increased because of federal law and not state law. He said no one has talked about a new effective date on HB 466. He said they asked to allow a new effective date to allow an insurer if they can live with the new rules better than the old ones to come back into the market if they wanted to.

They would like to see the size of the group go from "3-25" to "3 or more". They think if it is good for small groups, then it would be good for all groups. The original MEIT Auto Act that they worked on in 1992 was written to say that there would be a basic plan and a standard plan. All other plans would be underwritten if the underwriter declined the group. Then they must offer them a guaranteed issue plan. In Montana they have said they must offer them a guaranteed issue plan unless they have offered them a plan that is more money. He said he would like to see that allow underwritten plans to exist.

Peter Blouke, the Director of SRS, said the Governor believes the concepts contained in the small group reform are good concepts however there are some changes they would like to see made and they would propose amendments.

SENATOR JUDY JACOBSON, SD 18, said that SB 380 came in moving the numbers from 1 to 100 and it was amended to 3 to 50. She said as they talk through that they will discuss those numbers. They are currently at 3 to 50. She said she was concerned about the bottom part on the chart that was handed out by **Larry Akey.** She said she was also concerned about the standard plan on that chart. Insurance carriers have been out there selling the standard plan and some people have purchased that plan. What happens to the people who are now covered under the standard plan and the standard plan drops when they get through. Would they be grand-fathered in, are they guaranteed issue at the top level? How are they going to handle that issue? She said that over the transmittal break a lady had said she was excited about the SB 285 that was passed and **SEN. JACOBSON** had to tell her that they had passed a law to repeal small group which she had just purchased. The lady wrote "As owners of small business we had been afraid to carry an employee health insurance plan until legislation of 2 years ago made it possible to do so without the risk of an employee or their family member becoming seriously ill and driving the rates up so high that it might jeopardize our business. At this time we small employers have the option of covering our employees and ourselves without the risk of having our rates being raised dramatically or being dropped because of high utilization of our benefits. No longer can an insurance deny coverage to any small group because of a high employee. It is not mandatory that a small business offer health insurance it is just feasible for more of us to do so." She was encourage the legislature to keep that in place and she found it helpful to her family, herself and her employees. She said she would not carry health insurance at all if she cannot be covered under small group. She said it was a Blue Cross Blue Shield carrier she purchased from.

Lloyd (Sonny) Lockram Jr., representing Montana Contractors Health Care Plan, said approximately 47% of the people with health care insurance are getting it through some type of employer based insurance. They felt that most employers in the state of Montana would provide health care benefits if they could

afford it. The MEWAS were created under the Employee Retirement Income Security Act of 1947. ERISA does not mandate benefits. When an employer provides employee benefits and is also applicable to training a pension, it protects the participants and takes exclusive jurisdiction of those benefits for the federal government. It protects the beneficiaries and their benefits with two primary focal points. It dictates that those trust funds can be used exclusively for the benefit of the participants. The demur clause which says they can provide those benefits, but they cannot be deemed an insurance company. He said they tried for 2 sessions to amend the Montana preventing waste law. That law at that said unless they were a union contractor they could not provide benefits. On the second failure through United Industry one of their employers of the Montana Contractors Association filed a suit agair t the Commissioner of Labor, Mike Cooney and the State o Montana in federal district court in Billings. He passed a copy out to the committee members. **(EXHIBIT #21)** On page 14, it would give them some sense of ERISA. He said through their trust they have set up a benefit plan. They have 51 firms and $1,600 employees covered over $5,000 spouses and dependents. He submitted a copy of that plan. **(EXHIBIT #22)** It is a $150 deductible, $300 deductible per family, $8020 for insurance to $4,000, lifetime benefits up to $1 million. It includes dental, vision, life and short term disability. It is employer paid. The cost of that coverage is $192 per month. Included in their plan with their design they have guaranteed issue for all blue-collar workers. They reserve the right to underwrite management of the highly compensated. The plan was designed for hourly workers. They have pure community rating. One rate statewide, single, married, family, that is the rate. It is employer paid. They have portability. They have a one time 12 month pre-existing condition. Once that is satisfied it can not occur again. Those four issues they set up when they designed the plan and they did it on their own. They succeeded through their employers on a voluntary basis of achieving what they are trying to accomplish for all employers in the state. Employers, if they can afford it will provide health care. They have cost advantages. They do not have to pay for advertising, commission and there is no profit involved in their plan. They are not subjected to the state mandated benefits. He said the general premise that has been indicated is that in the absence of mandating that statute certain particular benefits, no employer will purchase them. He said that was not true. Even though they are not subjected to the state mandate benefits they have adopted many of them. Those they have not adopted they have provided what they believe is a better alternative to the mandates. He said since 1988 their premiums have increased a net of 18% with the employers on their plan.

CHAIRMAN BENEDICT asked if he could explain the changes in SB 376 as opposed to current law.

Mr. Lockram replied that SB 376 brings to the state insurance commissioner what they think is legitimate regulation of MEWAS. They stay away from the mandates and the insurance clause, but what they are conceding to in SB 376 they think there is a legitimate public concern and public policy. The state of Montana has a right to regulate the MEWAS to the solvency issue. That is what is specifically addressed in SB 376. He submitted that they presented a perfect compromise in SB 376.

Jerry Driscoll, representing Montana State Building Construction Trades and Employee Benefit Management System, the difference in MEWAS between the type **Sonny Lockram** has and union MEWAS, are the administration. He said they are successful because there is not adverse selection. He said they do not have any state mandates although they do follow some, they do not have to. He said any group of employers can form a MEWA. Administrative cost for most of them are between 6% and 9%. The trustees job as administering the programs are to look out for the best interest of the participants. He said profitability and advertising commissioner are not allowed by federal law. He said he thought SB 376 should pass. He said there was a resolution in congress that if passed would make SB 376 mute.

Bob Bachini, speaking on behalf of Linda Mirante who is the manager for Gallatin Medical Association, said they supported SB 376 as it was presented in the Senate committee.

Gary Spaeth, the chief counsel in the State Auditors office, said they worked on SB 376 and he has done a lot of research. He said it was a broad legal field and he would be available to answer any questions.

Mark O'Keefe, the State Auditor and the Insurance Commissioner, said they thought the compromise bill that was up they thought it was a progressive bill in terms of Montana's MEWAS and their willingness to come forward and say they ought to have solvency standards as well. In Montana there has not been the problems with MEWAS as in other states. This bill allows them to keep the scam artists out of that MEWA nitch in the market place. He said they were concerned with the consumers and their troubles with MEWAS. He said they can only send them to the Department of Labor to handle their complaint. He said there is the concern of the protection of the consumers. He recommended the bill.

{Tape: 2; Side: 2}

CHAIRMAN BENEDICT said they brought SB 376 in not because they wanted to know if it should pass or not, but to get some information on how MEWAS work and where the dividing line is between the potential workings of good small group and where it becomes to high and MEWAS would be more appropriate.

Tanya Ask, representing Blue Cross and Blue Shield, said she did not have her testimony prepared for this topic and asked to keep the record open for the following evening. She said they would like some further consideration for additional questions. She said there were some things that needed to be worked out. The issue is real concern to people in the health industry. She said the health insurance industry is a regulated market and a lot of those regulations do not apply when they move outside of that arena. She said that single self employed groups do have a lot of latitude. She said MEWAS have the ability to impact small group. They can have a MEWA which may decide it wants to have some less level of protection. They could have a MEWA that did not meet the standards that had been set. She said she would like to bring those types of issues on that bill.

(EXHIBITS #23-#28 were given to the committee members before and after the meeting.**)**

Questions from the Committee:

REPRESENTATIVE SIMON said that **Mr. Driscoll's** MEWA did not follow state mandates. He asked if he could address that and the wellness issue. **Mr. Jerry Driscoll** replied that they provide $200 per participant which would be the insured person, their wife, and children each, that they could use for anything not subject to deductible.

REP. SIMON asked **Mark O'Keefe** what the heart of small group was? **Mark O'Keefe** replied that was guaranteed issue. **REP. SIMON** asked if community rating would be the soul. He said he did not mention community rating, but it seems as if they have to work together or they end up with a situation where there is guaranteed issue but the ratings go out-of-sight for anyone who has a claim and they essentially do not have guaranteed issue. He asked if he would agree with that. **Mark O'Keefe** replied he thought that was true. He said in regards to the comments from Washington D.C. was that the basic benefit that the markets get with the guaranteed issue is that smoothing out of the rate over time. He said he liked to stay away from the term of community rating because some of the people who use examples of how small group reform failed in New York and that was pure community rating. He said they have modified community rating. **REP. SIMON** said that he spoke in terms of not wanting to establish a class of those that would be in the lower class benefits and those that would be in the upper class benefits. He was concerned that the risk that they run would be creating 2 classes of Montanans. He said would that not be a greater risk than having 2 classes of both which are insured. **Mark O'Keefe** replied those 2 classes already exist. The question for the legislature becomes at what level of benefits do they want Montanans covered under the insurance. He said the interim committee came up with was that if they were going to take mandated benefits off then they ought to do it for a sound economic reason for the policy holder. He

said under the situation they have now the emotional arguments will start. He said he is not against that.

REPRESENTATIVE GRIMES asked if he could get the phone number of the lady in Washington D.C who he talked to. **Mark O'Keefe** replied he would give him that.

REP. GRIMES asked where does small group leave off in the currents statutes and what they are trying to do in some of the bills and where does MEWA pick up and if there is something that they are mandating something on the state level that affects ERISA approved MEWA policies, then are they violating ERISA standards? **Tanya Ask** replied the state could not circumvent ERISA. ERISA is a federal law. Not all MEWAS are ERISA qualified plans. She said the concern they have is there is a given level of state regulation and there are a number of groups able to get outside of state regulation which may not be ERISA qualified. Large employers are able to self insure and adequately handle their risk. Moderate size employers begin to decide they want to insure when the cost of regulation begins to impact them directly. Small employers are normally not able to self insure. They can get into a MEWA situation where they with other employers with unlike interests decide they want to self insure. They may or may not be ERISA qualified. If they are ERISA qualified there are going to be certain provisions of state law which can still apply and there are other provisions which do not apply. Their concern is that they get into that arena and there are so many regulations imposed on the insurance industry that all the healthy risks decide they want to self insure, they have defeated the entire purpose of small group reform and circumvented state regulations. That is a worst case scenario. **REP. GRIMES** asked if she was indicating by self insuring they are moving to MEWA. **Tanya Ask** replied not necessarily. Some groups may be large enough that they can self insure. Other groups are smaller and may run the risk if they decide to self insure.

SENATOR JUDY JACOBSON asked **Tanya Ask** if their carrier had been selling the standard plan, how does she envision the transition if they mover the standard plan down to a leaner plan? **Tanya Ask** replied they would keep people on that product for a period of time an phase out to other products so there are fewer products being carried. She said that is usually about 5 years. **SEN. JACOBSON** asked what the purpose would be in her mind of moving that down to a leaner plan? **Tanya Ask** replied the reason would be to address a lot of the concerns that had been raised. The overall question of affordability. That was a fairly healthy benefit plan. There would still be a lot of products in that range to allow a lot of people to choose among. They are ball park figures. There are a lot of products that would be available. **SEN. JACOBSON** asked if that standard plan is just an option, why lower it? **Tanya Ask** replied it is because they want to have some bench marks that are available in the market place. She said the reason is they want a little lower bench mark. **SEN. JACOBSON** said that small group was for availability and

purchasing pools are for affordability. If they lower that standard plan to make it more affordable and they put purchasing pools into place, is it not very possible that the standard plan could have been very affordable once the purchasing pools got up and running. **Tanya Ask** replied it is possible that would then lower the cost of that particular plan even further. Purchasing pools are designed to help with part of the administrative expenses that one sees under insurance policies and that can run any where from 10% to 15% more in the small group market. They would see a savings and that savings was not going to be a continuous savings. **SEN. JACOBSON** said there are 2 cost savings. One is administrative cost savings and the other is the delivery system savings. **Tanya Ask** replied depending on how the purchasing pools decide to form and within the purchasing pools how those employers decide they want to negotiate those benefits once they get into integrated delivery systems and management of health care, more of those savings are going to be on the way.

ADJOURNMENT

Adjournment: 9:00 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 3-8-95

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		

EXHIBIT 1
DATE 3-8-95
SB 330, HB 466

Exhibit #1

AS YOU READ THIS NOTE, MONTANANS ARE LOOSING INSURANCE COVERAGE AS A RESULT OF MONTANA'S SMALL GROUP INSURANCE REFORM!

EXAMPLE 1

I just presented a medical insurance quote to a contractor with 17 employee's. The "new business" rates looked acceptable. As underwriting began, we learned that one employee was recovering from lung cancer surgery. We were informed that, under Montana's small group reform, the insurance company could and would rate up premiums on every member of the group 67% (to cover the risk associated with costs below the reinsurance pool's $25,000 attachment point).

What behaviors does this rate-up encourage?

1. If the employer offered no current health insurance plan, would he or she be interested in adding group coverage---knowing that his competitor down the street had insurance costs that were 50% lower?

2. Knowing that large rate-ups are possible, how important will health conditions become in the hiring decision of this employer?

3. If the employer buys the coverage will wages go up or down? How do the 16 employees who "suffer" because of this absurd rates feel about accepting a job from the competitor who can afford to offer significantly better benefits and wages?

4. If the employer rejects coverage, where will employees get it? If the employer has a current plan, the current carrier has a monopoly--the employer cannot shop for more competitive insurance products.

Current small group reform increases the number of uninsured and hurts small employers who have inadvertently hired a "sick person." As currently structured, it will discourage employers without coverage from adding it.

EXAMPLE 2

A retailer with 15 employees currently offers no group coverage because over half of all employees are covered by their spouse or have a quality individual plan. Instead of double covering employees with a duplicative group insurance plan, the retailer provides employees $150 in benefit credits that can be used to purchase individual insurance, pay for daycare or out-of-pocket medical, dental or vision expenses, or invest in their 401(k) plan. Because these credits are provided under a cafeteria plan (regulated under federal law), neither the employer and employees are taxed for these benefits.

BUT, the current Montana small group reform program considers these employer provided credits (that are often not used for medical insurance) **as if they were a contribution to medical insurance** making the entire employer benefit plan and its employees subject to reform-against their will.

Here's the result:

1. A new employee, wanting to purchase individual insurance, was turned down by the carrier SIMPLY BECAUSE THE EMPLOYER WAS CONTRIBUTING TO THE PREMIUM.

2. The employer cannot institute a group plan because participation rates would be so low that group carriers would reject their application.

3. If the employer wishes to continue their contribution to benefits, **the dollars will be taxed to the employer and the employee** (contrary to the provisions of current federal law) at a composite rate of nearly 50% while their competitor down the street pays no tax just because they have a group plan under small group reform.

With these onerous new taxes imposed by Montana's small group reform, will this employer continue their contribution to benefits? If the contribution is stopped, will employees drop their medical insurance because it is too costly?

Montana's current small group reform will not bring un-covered employers into the group insurance fold---it will discourage them, especially if their group contains a "sick" person. But, these were the very groups the law was intended to help. It wont work.

Additionally, the current reform package discourages any employer wishing to contribute to the cost of employee benefits under cafeteria plans---shifting more costs to employees.

JR Chipman
Benefit Innovations, Inc.
PO Box 5474
Missoula, MT 59806
406-542-0208

EXHIBIT 2
DATE 3-8-95
SB 330, HB466

Exhibit #2

MSHA

MONTANA SPEECH-LANGUAGE AND HEARING ASSOCIATION

March 8, 1995

Senator Steve Benedict and Members
of the Select Committee
Capitol Station
Helena, MT 59624

Dear Senator Benedict:

I am writing to urge your committee to include both speech pathology and audiology services in any basic health care package.

The need for speech pathology services often arises in acute care situations. Should a patient suffer a stroke that affects his comprehension and/or expression, a speech pathologist is often involved immediately to assess the patient, to consult with the physician and to serve as a resource to the family. In this instance, the speech pathologist may also be asked to assess the patient's swallowing to determine if they are an aspiration risk.

Speech pathologists are also called in cases of head injury to assess a patient's cognitive abilities and to begin retraining as soon as possible. Speech pathologist services are often called upon also in acute onset of symptoms in patients with progressive neurological disorders such as Parkinsons or ALS.

Physicians find audiology services vital when they have to administer potentially ototoxic medications and they need their patients monitored on a daily or weekly basis. Audiologists are often involved in extensive evaluations with patients who have an acute onset of dizziness, ringing in the ears or sudden hearing loss. Audiological assessments can reveal potential brain tumors and/or the presence of other diseases and are invaluable in the physician's diagnostic procedures.

Early intervention upon physician referral ultimately proves to be a cost savings to the consumer. With treatment and monitoring, patients are able to return to work and to the state and federal tax roles.

Thank you for your serious consideration of this matter.

Rosemary S. Harrison

Rosemary S. Harrison
Legislative Liaison
Montana Speech and Hearing Association

FROM

Exhibit #3

EXHIBIT 3
DATE 3-8-95
SB 330, HB 466

MONTANA DIETETIC ASSOCIATION
P.O. Box 1197
Helena, Montana 59624

March 3, 1995

To: Senator Steve Benedict, Chair-Joint Committee on Health Care
Montana Legislature
Capitol Station
Helena, MT 59624

From: Susan Adams, MS, RD, President of the Montana Dietetic Association
206 N. Grand
Bozeman, MT 59715 Phone: (406)-586-8992

Dear Senator Benedict and Members of the Joint Committee on Health Care,

I am writing concerning the Small Business Insurance Plan for Montana. I urge you to support including medical nutrition services in the benefits package designed for Montanans. The services would be covered only under a physician's referral and/or under a case manager's approval. Medical nutrition therapy has been documented as cost-effective and more importantly provides quality care as part of standards of good medical practice (Medical Nutrition Services: Nutrition Therapy Saves Health Care Dollars: Documentation from a Rural State, Fall 1993). The provider of these services is the registered dietitian, licensed in the state of Montana.

We propose that the disease/medical conditions covered would include:
1. Diabetes Mellitus
2. Malnutrition/Trauma
3. Renal Disease
4. High-Risk Pregnancy
5. High-Risk Pediatrics
6. Cardiovascular Disease
7. Gastrointestinal/ Endocrine Diseases
8. Cancer
9. Eating Disorders

Actuaries have demonstrated that inclusion of nutrition services would cost $.25 per person and $.50 per family of four. The benefits of these services measured against the costs of transplants and other high cost services cannot be overstated.

As President of the Montana Dietetic Association, I represent over 200 registered dietitians in our state. We urge you to add our cost-effective, low technology and high quality nutrition services to the Small Business Insurance Plan.

Sincerely,

Susan Adams, MS, RD

Exhibit #4

MONTANA OCCUPATIONAL THERAPY ASSOCIATION

EXHIBIT 4
DATE 3-8-95
SB 330, HB 466

TO: Joint Committee on Health Care
Honorable Representatives and Thomas Nelson

I'm here to represent the Montana Occupational Therapy Association and speak on behalf of the health care consumers and their concerns regarding House Bill 466 and it's changes in the small employer health plan.

As an occupational therapist and part of a network of over 200 occupational therapists in the state of Montana, we have grave concerns about the exclusion of this very important health rehabilitation provision.

Occupational therapy was initially considered a very important basic service included in the initial plan developed by the health care authority and the state auditor Mark O'Keefe. Why now should it be excluded ? Without it's specific mention listed along-side of physical therapy, this service will be overlooked and not considered a basic service for consumers.

Occupational therapy is a primary service in an individual's rehabilitation process. We are currently covered by all major payers, Medicare, Medicaid, Worker's Compensation, Blue Cross/Blue Shield and many managed care plans.

Occupational therapists provide services to hospitals, home health agencies, schools, clinics and private clinics. Occupational therapists provide services to individuals recovering from physical disabilities, mental conditions, trauma and acute injuries. We are responsible for rehabilitating individuals to become more independent and return to the mainstream of living and returning individuals to work after their injury, thus saving thousands of dollars to the consumers by minimizing prolonged disabilities.

Please consider this very important issue and include and specifically mention occupational therapy along with physical therapy in this very important amended small employer plan.

Thank you for your assistance.

Connie L Grenz, OTR/L

Connie Grenz, OTR/L

Linda Botten, OTR/L

Linda Botten, OTR/L

OCCUPATIONAL THERAPY ASSOCIATES, P.C.
BOZEMAN AND LIVINGSTON

Exhibit #5

EXHIBIT 5
DATE 3-8-95
SB 330, HB 466

TO: Joint Committee on Health Care
Honorable Representatives and Thomas Nelson

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Thank you for your assistance.

Connie L. Grenz, OTR/L

Connie Grenz, OTR/L

Linda Botten, OTR/L

Linda Botten, OTR/L

BOZEMAN AND LIVINGSTON
206 N. GRAND AVENUE, BOZEMAN, MT 59715
(406) 586-3716 • FAX (406) 586-4869

Bozeman, MT (406) 586-3716, FAX (406) 586-4869 • Butte, MT (406) 782-1407, FAX (406) 782-1407
Helena, MT (406) 449-8920, FAX (406) 449-8920 • Livingston, MT (406) 222-3363, FAX (406) 222-3363

Exhibit #6

McCUE LAW FIRM

STEPHEN R. McCUE
MARY KELLY McCUE

34 WEST SIXTH AVENUE, SUITE 1-C
POST OFFICE BOX 4416
HELENA, MONTANA 59604

406/443-4455
FAX 406/443-1592

EXHIBIT 6
DATE 3-8-95
SB 330, HB 466

March 8, 1995

TO: Members
Joint Select Committee on Health Care Issues

FROM: Mary K. McCue, lobbyist Mary McCue
Montana Clinical Mental Health Counselors Ass'n

Re: House Bill 466/House Bill 531: Health insurance coverage for mental illness, alcoholism, and drug addiction

This evening I am addressing you on behalf of my own client, the Montana Clinical Mental Health Counselors Association (licensed professional counselors), and also the Mental Health Association of Montana, the Montana Psychological Association, and the Montana Chapter of the National Association of Social Workers.

We are concerned with the issue of health insurance coverage for mental health care. With regard to the minimum benefits that must be included in a health insurance plan and an association plan, we urge you to adopt the level of coverage which was originally included in HB 466. This level of coverage reduces the present number of mandated inpatient days from 30 to 21 days per year; allows a two-for-one trade of hospitalization days for partial hospitalization days; and provides for up to $2,000 annually for outpatient mental health treatment and up to $1,000 annually for outpatient chemical dependency treatment.

This is the level of coverage for mental health care which our associations have been pursuing during the past interim. It was developed by consensus of our health care provider and consumer groups, health insurers, and Montana hospitals. We believe the continuum of mental health care model contained in this plan will provide more effective and efficient care for mental health patients than the present coverage levels.

We also urge you to include, as part of small employer health insurance reform, the definition of mental illness which we developed through compromise among our groups, insurers, and hospital representatives. This definition is contained in SB 339, the bill introduced by Sen Chris Christiaens which revises the mandated mental health benefits.

Thank you for allowing us to address you about these issues.

Exhibit #7

EXHIBIT 7
DATE 3-8-95
SB 330, HB 466

Special Select Committee on Health Care
March 8, 1995
Dean M. Randash

The authors of the "Small Business Health Insurance Availability Act of 1993" and the Montana Insurance Departments's rules has made "Guaranteed Issue" insurance available, rather than affordability, a cornerstone in the insurance reform structure. The guaranteed issue benefit is a benefit that is never utilized by anybody that is currently paying health insurance premiums. Rather, the guaranteed issue benefit is utilized only by people that have not paid and are not currently paying any health insurance premiums but have extensive and severe potential and actual medical expenses. These people did not choose to purchase health insurance for what ever reason, be it affordability or lack of immediate need and now as a result of an accident or illness, find themselves needing extensive and immediate medical care but are uninsurable. One other possible reason is that a person's health insurance company discontinues the policy after the person became ill. For whatever reason there are currently 83,000 employees in Montana that do not have health insurance.

Montana Department of Insurance rules positions these uninsurable people to have the same level of coverage as the 27,000 low wage policyholders in the 3 to 25 employee group that are currently insured. This is a very benevolent act of kindness on their part. The problem is the tactics used by this law and the rules that mandate that the insurance company and agent under a penalty of law is ordered to restrict legal underwritten health insurance coverage to this small employee pool only. This restriction forces employees that can only afford a health insurance policy up to the value of the Standard Plan to be confined to purchase only this government ordered "Guaranteed Issue" mandated benefit policy.

This deceptive method forces what the department call "voluntary support" and collection of the funds necessary to pay the medical bills of the newly insured sick people. For those that can afford a policy with a greater value than that can purchase any underwritten plan they want and therefore, not have to contribute to the guaranteed issue expense. The hook is this, the Insurance Department's rules say that a person can purchase an underwritten policy as long as the underwritten policy has a higher price. When the guaranteed issue plan increases price because of the additional sick people's medical expenses it is only a matter of time until the guaranteed issue plan will exceed the price of the underwritten plan. When this happens the person will have to buy government ordered guaranteed issue policy or go without health insurance. In the mean time the price of the premiums will have exceeded affordability and large numbers of families will have to drop coverage.

Lets look at the sections of the law, prior to HB-466, that come into play here to have structured such personally dominating insurance reform. There are three sections that address true across the board reform:

- 33-22-1808 - Establishment of classes of business.(risk class)
- 33-22-1809 - Restrictions relating to premium rates.
- 33-22-1810 - Renewability of coverage.

It takes 7 sections to implement and oppressively fund the "Guaranteed Issue" insurance. They are as follows:

- 33-22-1804 - Availability and scope.(Locks in the 3 to 25 employee group individuals)
- 33-22-1811 - Availability of coverage - required plans.(Establishes the confinement group to be between the basic value and standard plan value)
- 33-22-1812 - Health benefit plan committee - recommendations.(This committee suggests what all the the mandated benefits should be.)
- 33-22-1813 - Standards to ensure fair marketing.(Orders agents to police and contain the 3 to 25 employee into the guaranteed issue policy pool.)
- 33-22-1818 - Small employer carrier reinsurance program - board membership.(This is the mechanism that gives the department of insurance and the insurance companies the ability to comfine most of the

cost of this government ordered plan to the 3 to 25 employee pool only.)

- 33-22-1819 - Program plan of operation - treatment of losses - exemption from taxation.(This allows the bureaucracy to administer the guaranteed issue program, the allowance of additional reimbursement in the event of cost overruns, and exempts the reinsurance committee from taxation.)
- 33-22-1821 - Waiver of certain laws.(This exempts the standard and basic plans from certain laws that all others have to comply with.)

There are 200,000 insured wage earners in Montana but only 27,000 make up the 3 to 25 employee insurance pool. This 27,000 will be paying most of the additional medical expenses. This will destroy their affordable health insurance. Large numbers of currently insured small business families will be force to drop coverage.

HB-466, the Nelson Bill, greatly helped the small business employee by relieving the Insurance Department of any involvement in assigning the benefits by repealing 33-22-1812 - Health benefit plan committee. Since the benefits of the policy have been reduced so to the premium price of the policy is reduced. The needed Simkins amendment eliminated the employee from being sandwiched between the basic and standard plan by establishing one uniform plan. This uniform plan would be adequate to cover all medical needs without frills.

Montana being a compassionate society can provide for these circumstances of the uninsured. However, let us not reward those that are able to afford health insurance in times of good health but choose not to purchase it, while penalizing a small group of wage earners that are and have struggled to meet each and every health insurance premium. On behalf of 27,000 small business employees I ask this committee for two more changes to accomplish two things: affordability and guaranteed issue health policies.

1. Amend this uniform plan to accept only the uninsurable person or family unit thereby allowing the rest of the employees in this companies employment to retain their present plan. The uninsurable person or family's premium should be set at for example 150% of what that the policy price in the employment group would be.

2. Repeal 33-22-1818 - Small employer carrier reinsurance program. The cost of the plan would then be assessed across all carriers and policies in Montana not just the 27,000 small business employees.

Handling, in this special way, high medical risk people that have not invested in health insurance prior to their accident or illness would eliminate the "cherry picking" problem. The high medical risk person would be able to get the financial assistance that is needed while not bankrupting the small business insurance pool. This new approach would be respectful of the personal freedom and integrity of each and every small business person while optimizing the continued affordability of health insurance.

Thank you

Exhibit # 8

RE: **RELATIVE BENEFIT VALUATION**
STANDARD INDEMNITY PLAN VERSUS STANDARD HMO PLAN

EXHIBIT 8
DATE 3-8-95
SB 330, HB 46

Yellowstone Community Health Plan utilizes a methodology called "Relative Benefit Valuation" for comparing health insurance benefit packages. The methodology was developed by the actuarial firm of Milliman and Robertson. The methodology starts with $1,000 worth of health care dollars allocated over the various services (inpatient, outpatient, physician, etc.) for the Yellowstone County area. This starting point is then adjusted for limits in coverage, deductibles, coinsurance percentages, copayments, utilization and maximum out of pocket dollars.

From the perspective of an enrollee, the relative value of the standard indemnity plan as mandated in SB285 is 779 versus a relative value of 952 for the HMO standard package of benefits. The HMO standard plan represents a 22% better benefit to the enrollee. The major differences are attributed to:

1) The indemnity plan has a $250 deductible that has to be met before any benefits are paid. The HMO plan has coverage from the first day the benefit is used.

2) After the deductible has been satisfied, the indemnity plan pays 80%. The 80% is in effect until the insured individual has spent $1,250 out of pocket. This means that the insured person has to incur $5,250 in medical costs before the insurance pays 100%. This combination of deductible and coinsurance decreases utilization, therefore decreasing the value of the benefit to the enrollee.

3) The HMO has a copayment of $200 associated with an inpatient hospital stay. It is conceivable that an enrollee could reach the maximum $1,250 out of pocket with one extended hospitalization. If this occurred, all benefits would be paid at 100% for the balance of the benefit year.

4) The HMO has a $10 copayment for physician office visits. If the enrollee utilizes this benefit only, it would take 125 office visits to reach a maximum out of pocket for the year. This copayment increases utilization because it is affordable to visit the doctor for $10. This increases the value of the benefit to the enrollee.

5) The HMO standard plan has no copayment for non-emergency outpatient hospital services. This is contrasted with the standard indemnity plan. With the indemnity plan, any outpatient hospital services are subject to the deductible and coinsurance. This significantly increases the benefit to the HMO enrollee.

6) Both plans cover prescription drugs. The indemnity plan covers drugs the same as any other benefit. The insured person has to satisfy the deductible first and then the insurance will reimburse 80% of the cost. The HMO standard plan has a $5 copayment for generic drugs. This difference contributes to the enrollee's increased value from the HMO coverage.

7) Both the indemnity and HMO plans require 100% coverage for physical exams, well baby exams and mammograms.

The purpose of this illustration is to help increase the understanding of the differences in benefits between indemnity plans and HMO's. Both appear to have the same benefits, but in theory the HMO's philosphy of copayments versus deductibles and coinsurance makes it a better benefit to the enrollee. However, a better benefit for the enrollee needs to be paid for by someone.

EXHIBIT 9
DATE 3-8-95
SB 330, HB 466

Exhibit #9

TESTIMONY OF SHIRLEY RASMUSSEN SMALL GROUP EMPLOYER FROM STEVENSVILLE TO THE JOINT SENATE/HOUSE JOINT HEALTH CARE SELECT COMMITTEE

Mr. Chairman, members of the Committee, a few weeks ago I testified before the House Select Committee on health care reform as a proponent of HB 155. After that meeting I had a short discussion with State Auditor Mark O'Keefe in which I told him that I was going to apply for coverage with my group to all 7 companies that he said were participating and I'd prove to him it would cost more. To date I have received quotes from 4 of those companies. (Tell them about the seventeen certified companies that are now on the list.)

The four companies that I have received quotes from so far are BC/BS of MT, The Principle Mutual Life Insurance Company, Home Life Financial Assurance Corporation, and John Alden. Copies of their quotes are attached. For purposes for comparison I have also attached a copy of a quote from a company that is not participating with the small group reform. As I applied at all of these companies none of them would give me an initial quote for state mandated standard plan, they all told me they would not give me quotes until I had been refused their underwritten plans. I had to insist, I had to say, but I need a quote just for comparison. My group is essentially healthy, there was one that is currently pregnant, there was one with mitral valve (which is covered on our current plan), but essentially all were healthy so who knows what the rates would have been if there would have been some sick among us and from there you will see from these papers that all of the quotes or statements given the standard plan would be from 35% to 50% more.

In conclusion, my reason for presenting this information to you today was to encourage you as you amend Representative Nelson's bill, please do everything you can to help lower the cost for the small group in Montana.

Quote from "Small Business Health Insurance Reform", statement from Mark O'Keefe's office. Goals of reform include:

Tell about BC/BS quotes - illegal -

RASMUSSEN FARM

ILLUSTRATION #110-03021404233
DATE 03/02/95

IEA GROUP BENEFIT PROGRAM -- UNDERWRITTEN BY THE PRINCIPAL MUTUAL LIFE INSURANCE COMPANY
MONTHLY PREMIUM ILLUSTRATION FOR AN APRIL 01, 1995 EFFECTIVE DATE
CENSUS ASSUMPTIONS

EMPLOYEE NAME	AGE	MED COV TYP	DNT COV TYP	DLE XS	CL	EMP LIFE INS	LIFE& AD&D COST	DEP LIFE COST	CLS	STD BEN	STD COST	CLS	LTD BEN	LTD COST	EMPLOYEE MED	EMPLOYEE DENT	DEPENDENT MED	DEPENDENT DENT	TOTAL
D RASMUSSEN	50	E		N M	1	15000	7.80	0.00	0	0	0.00	0	0	0.00	136.82	0.00	0.00	0.00	144.62
S RASMUSSEN	48	E		N F	1	15000	5.25	0.00	0	0	0.00	0	0	0.00	111.35	0.00	0.00	0.00	116.60
D ROBINSON	39	ES3C		Y M	1	15000	2.10	0.77	0	0	0.00	0	0	0.00	81.15	0.00	290.78	0.00	374.80
J ERHART	25	ES1C		Y M	1	15000	1.65	0.77	0	0	0.00	0	0	0.00	75.49	0.00	180.34	0.00	258.25

	TOTAL PREMIUM		AVG. PREMIUM (FOR COMPARISON ONLY)	
LIFE & AD&D	$	16.80	$	0.28 PER $1000
DEPENDENT LIFE	$	1.54	$	0.77 PER UNIT
SHORT TERM DISABILITY	$	0.00	$	0.00 PER $10
LONG TERM DISABILITY	$	0.00	$	0.00 PER $100
EMPLOYEE MEDICAL	$	404.81	$	101.20 PER COVERED EMPLOYEE
EMPLOYEE DENTAL	$	0.00	$	0.00 PER COVERED EMPLOYEE
DEPENDENT MEDICAL	$	471.12	$	235.56 PER COVERED DEP UNIT
DEPENDENT DENTAL	$	0.00	$	0.00 PER COVERED DEP UNIT
TOTAL PREMIUM	$	894.27		

FINAL PAGE 2

talked with Regional rep. from Principal Financial Group - 3-7-95 - A.M.

I asked specifically for a quote for the State Mandated ~~Plan~~ Standard Plan for small business for this particular group - This was my answer and it is a quote:

"The only time we will give a rate quote for the state mandated Standard Plan is when your group will not fit in our other plans from underwriting. And if we did rate you it would be with the 120% rate - It would be much much higher than the rates I've given you. 35 to 40% higher.

EXHIBIT 9
DATE 3-8-95
SB 330, HB 466

agent Jim Dover - Victor
Blue Cross/Blue Shield

	Small Grp. Std. Ind.	2pt.	Fam.
Small Grp. Std.	179.60 per enrollee		467.00 -
Advantage	115.10		299.30 -
Health First	146.90		381.90 -
Sec	192.60		500.80 -

Initial quotes from BC/BS guessing that my group falls into level 30. Again the agent would not offer the Standard Plan unless we were refused by underwriters for any of their other plans.

Small Group Standard numbers show 50% higher.

HOME LIFE FINANCIAL ASSURANCE CORPORATION
ESP PREMIUM DETAIL BY EMPLOYEE

Group Name: THE RASMUSSEN FARM No: P00675 Effective Date: 04/01/95

E O	LIFE VOLUME	LIFE PREMIUM EE	LIFE PREMIUM DEP	WEEKLY INCOME BENEFIT	INCOME PREMIUM	MEDICAL PREMIUM EE	MEDICAL PREMIUM DEP	DENTAL PREMIUM EE	DENTAL PREMIUM DEP
1	15,000	7.28 Dan				111.56	91.92	14.97	17.26
2	15,000	4.93 Jerry				80.96	217.92	11.96	31.44
3	15,000	7.28 Dennis				111.56	92.23	14.97	15.80
4	15,000	4.64 Shirley				111.56		16.28	
		+ 24.00 life benefits				+ 415.64			
		+ 30 fee							

State Mandate Plan + In talking to John on 3-6-95, he told me. "I can get a quate for you on your State Mandated Plan but it will take me about a week. We don't offer that plan initially until you have been declined for coverage on any of our other plans. Then we would offer the State Mandated Plan. Quite frankly, our company doesn't even want us to offer any State Mandated plans their coverage stinks and we don't need the unhealthy.

I asked if he could still get me a quate for that plan. Even if it was an initial estimate with just looking at general info and not research all the health conditions. He would try to have me something by Wednesday.

C:\0295CEN\ P00675-1 VERSION 03/02/95-7

Printed on Recycled Paper

HOME LIFE FINANCIAL ASSURANCE CORPORATION
ESP PREMIUM DETAIL BY EMPLOYEE

Group Name: THE RASMUSSEN FARM No: P00675 Effective Date: 04/01/95

E NO	LIFE VOLUME	LIFE PREMIUM EE	LIFE PREMIUM DEP	WEEKLY INCOME BENEFIT	INCOME PREMIUM	MEDICAL PREMIUM EE	MEDICAL PREMIUM DEP	DENTAL PREMIUM EE	DENTAL PREMIUM DEP
1	15,000	7.28	Dan			111.56	91.92	14.97	17.26
2	15,000	4.93	Jerry			80.96	217.92	11.96	31.44
3	15,000	7.28	Dennis			111.56	92.23	14.97	15.80
	15,000	4.64	Shirley			111.56		16.28	
		+ 24.00	life benefits			+ 415.64			
		+ 30	fee						

EXHIBIT 9
DATE 3-8-95
SB 330, HB 466

State Mandate Plan - In talking to John on 3-6-95, he told me "I can get a quote for you on your State Mandated Plan but it will take me about a week. We don't offer that plan initially until you have been declined for coverage on any of our other plans. Then we would offer the State Mandated Plan. Quite frankly, our company doesn't even want us to offer any State mandated plans their coverage stinks and we don't need the unhealthy.

I asked if he could still get me a quote for that plan. Even if it was an initial estimate with just looking at general info and not researching all the health conditions. He would try to have me something by Wednesday.

C:\0295CEN\ P00675-1 VERSION 03/02/95-7

MONTANA MEDICAL BENEFIT TRUST P.O. BOX 518 KALISPELL, MT 59903
MAJOR MEDICAL BENEFITS $1,000,000 MAX RATE SCHEDULE EFFECTIVE JANUARY 1, 1995

GROUP PLAN PRICE LIST

150-300-500 Ded.
CP @80%
NON CP @70%

1000-2500 Ded.
CP @90%
NON CP @70%

	SINGLE		EMPLOYEE & SPOUSE		FAMILY		EMPLOYEE & ONE CHI	
	$150 DED	$300 DED	$150 DED	$300 DED	$150 DED	$300 DED	$150 DED	$300 DED
UNDER 30	98.00	75.00	218.00	194.00	292.00	236.00	186.00	141.00
30-34	102.00	89.00	236.00	200.00	313.00	243.00	191.00	155.00
35-39	116.00	91.00	256.00	229.00	349.00	275.00	204.00	157.00
40-44	133.00	109.00	275.00	236.00	353.00	292.00	2 .00	176.00
45-49	149.00	126.00	282.00	257.00	361.00	301.00	237.00	193.0
50-54	155.00	132.00	297.00	262.00	368.00	314.00	243.00	198.00
55-59	169.00	163.00	308.00	290.00	397.00	325.00	257.00	229.0
60-64	219.00	195.00	404.00	355.00	511.00	426.00	307.00	262.0

	$500 DED	$1000 DED	$500 DED	$1000 DED	$500 DED	$1000 DED	$500 DED	$100 DED
UNDER 30	66.00	48.00	166.00	132.00	202.00	165.00	125.00	91.00
30-34	75.00	61.00	171.00	152.00	210.00	181.00	134.00	104.0
35-39	77.00	64.00	195.00	157.00	235.00	194.00	136.00	107.0
40-44	96.00	75.00	203.00	169.00	251.00	200.00	155.00	118.0
45-49	108.00	2X 88.00	218.00	172.00	259.00	209.00	167.00	131.0
50-54	117.00	91.00	224.00	178.00	269.00	229.00	177.00	134.00
55-59	146.00	123.00	264.00	228.00	294.00	251.00	205.00	166.0
60-64	169.00	135.00	303.00	242.00	364.00	307.00	228.00	178.0

Jerry - BASE RATE Dennis Shirley & Son

Total #299 + 20 admin. = 319

574 + 20 admin. = 594

	$2500 DED	DENTAL	$2500 DED	DENTAL	$2500 DED	DENTAL	$2500 DED	DENTAL
UNDER 30	34.00	$17.00	93.00	30.00	117.00	46.00	64.00	30.00
30-34	42.00	VISION	106.00	VISION	127.00	VISI	7	VISION
35-39	48.00	$9.00	110.00	13.00	134.00	1	78	.00
40-44	53.00	SHORT TERM	120.00	SHORT TERM	141.00	SHORT TERM	83.00	SHORT TERM
45-49	62.00	DISABILITY	126.00	DISABILITY	147.00	DISABILITY	92.00	DISABILITY
50-54	71.00	& EWCEC	143.00	& EWCEC	161.00	& EWCEC	102.00	& EWCEC
55-59	85.00	ON BACK	156.00	ON BACK	176.00	ON BACK	116.00	ON BACK
60-64	96.00		172.00		215.00		126.00	

Exhibit #10

EXHIBIT 10
DATE 3-8-95
SB 330, HB 466

Mr. Chairman and members of this committee, my name is Ron Kunik. I am a life underwriter, and I have been an agent since 1981.

I founded MMBP in 1989. I am probably one of a select, few who have expertise in the insurance field in all aspects: as an agent, as a founder of an insurance company, claims, underwriting, and marketing.

I would like to thank this committee for the opportunity to testify on the bill submitted by Representative Tom Nelson.

I would also like to commend Rep. Tom Nelson on his work, attempting to amend SB285.

However, it doesn't begin to go far enough.

1st - Section #2, 33-22-1804 is amended as to payroll deduction or list bill premium are no longer subjected to SB285. Section C 106-125-162 of IRS code is still subject to SB285. This part should be amended to read, "IF AN EMPLOYER DOES NOT CONTRIBUTE ANY MONEY TOWARD THE HEALTH INSURANCE PREMIUM AND THE EMPLOYEES BUY INDIVIDUAL INSURANCE POLICIES, THEY CAN BE PAID FOR THROUGH A CAFETERIA PLAN SET UP BY AN EMPLOYER."

Reasons - If an employee pays his dependent premium with after tax dollars, he must make $260.00 or more to pay a $200.00 premium.

Section 125 of the IRS code means that any benefit, if paid for by an employer and is **a legal deduction,** it is still deductible if paid for with salary reduction through cafeteria 125. Therefore, the employee would only have to make $200.00 to pay a $200.00 premium instead of $260.00 plus dollars.

What should also be done is - Everyone, including the Health Care Authority, states that they can't figure out how to get more employers to provide, or help provide health insurance for their employees. It is simple - using a Cafeteria 125 premium only plan, (p.o.p.) - Assume an employee and their dependent's premium is $250.00. Assume the employer can't afford to pay all of the premium. The employee can take a salary reduction of $150.00. The employee pays no income tax (state nor federal) on that money. Nor does he or the employer pay social security on that money.

The employer in Montana does pay Workman's Comp. and Unemployment on that money.

If we changed the law in Montana, to say that this money is not subject to Work. Comp. and Unemployment, and the employer must use his saving toward the health premium, I think you would see a lot more employers offering to buy health insurance (especially blue collar workers)

EXAMPLE OF TAX SAVINGS TO EMPLOYERS: (example: Truck Drivers)

$ 250.00 Health Premium
- 60.00 Employer Pays
— 150.00 Employee Salary Reduction

$ 40.00 Approx. tax savings if employer does not have to pay Work.Comp/Unemployment on the $150.00 salary reduction.

Employer mandated to apply tax savings to employee health premium. ($60.00 + $150.00 + **$40.00** = $250.00)

The cost to the state is minimal since Work.Comp. and Unemployment would only pay benefits on the income received after salary reduction.

We should also remove the re-insurance pool and board from SB285.

Since this bill of Rep. Nelson has in it to use the MCHA Plan with some modification for the Basic Plan, we should also use it for the funding.

Why have two risk pools? All insurers should be assessed for any short-fall by the amount of business done in this state.

As it is now written, in the re-insurance pool, an insurance company must pay the first $5000 in claims plus $20,000 of the first $100,000 in claims, plus the insurer must pay on one person 5 times the individual re-insurance rate. The problem with this is as follows:

-Person (age 45), has a bad heart with $100,000 in claims.
-Insurer puts person into re-insurance pool.
-Insurer has to pay $25,000 **+ re-insurance premium.**

If you had only 40 people, it would constitute **over** a million dollars in losses.

We should amend 33-22-1811 to read, "AN INSURER CAN ELECT NOT TO INSURE A GROUP IF THAT GROUP IS ALREADY INSURED. HOWEVER, THE INSURER MUST DECLINE OR ACCEPT THE WHOLE GROUP THAT IS CURRENTLY INSURED UNLESS THAT PERSON IS ELIGIBLE FOR THE RISK PLAN."

In my opinion (and many of my colleagues), there is no doubt that there are a large number of people who are covered by BC/BS who are paying in very large premiums and have very large claims. Many of these people will no doubt move from BC/BS to the lower cost insurers.

The other insurers, whom are domiciled out of state, will suffer significantly large losses. If these losses become too great, and I believe they will, these insurers have the option to bail out with 180 days notice. **History indicates that** they have done so in years past.

They bailed out even though they had been underwritten. When the

EXHIBIT 10
DATE 3-8-95
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losses came - they left. Under SB285 these losses will come a lot faster. With the bail out option in SB285, they can afford to try it and see what happens.

I believe that the winner in all of this is BC/BS. They are going to lose their high claims groups and, I believe, end up making a fortune.

If the out of state competitors bail out, that leaves only two companies doing business in Montana. Them and us. I do not believe that this is in the best interest of Montana.

Now, as to portability, SB285 has very limited portability.

SB285 says that if you go to work for another employer, you can keep your insurance only if the new employer has health insurance. What if the new employer has no group insurance? Then you are out of luck.

What if the new employee has a heart attack and can't work? Then he has no insurance.

BC/BS will tell you that you can have a conversion plan. That is true if you can afford it. For instance, an **individual** - age 45 - with a $750.00 deductible, 70/30 co-insurance with the blues is $403.00 per month for 6 months, then approx. $500 per/mo. for the next 12 months.

I don't consider that affordable.

SOME OTHERS INSURERS OFFER VERY LOW BENEFITS ($75.00 A DAY FOR ROOM & BOARD)

That almost guarantees the person would have to drop their health insurance. Montana Medical is the only company that I know who has true portability. **TRUE PORTABILITY MEANS YOU CAN TAKE IT WITH YOU!**

Assume that a person aged 45, has a small group plan with a $500. deductible - 80/20 - coinsurance. The MMBP premium is $259. a month for **family**. This employee has a heart attack and can no longer work. This employee is guaranteed that he and his **family** can convert to an individual plan at the same price as any other person at that age would have so long as they remain in state. If they move out of state, the rate would go up a maximum of 50%.

The premium on this conversion to individual plan for the family would be $301.00. Compare that to the BC/BS **individual** cost of $403.00 per/mo.for the first 6 months, and $500 per/mo. for the next 12 months **This still does not cover the family on the Blues, that would be an additional premium.**

I know of numerous insurance agents (many who are life underwriters) who believe that rates must be affordable for the consumer and commission is secondary. These agents are also for true insurance

reform with affordable rates, but do not believe SB285 does this.

SB 285 does not address the need for universal access nor can it be addressed in Small Group Health Insurance Reform.

I don't understand why we aren't addressing true insurance reform (affordable) for all Montanans. They are surely entitled.

Another thing that needs to be addressed is the current definition of pre-existing condition by the Insurance Commissioner's office. It is defined as if you haven't been to a doctor, then it isn't a pre-existing condition. Example: A woman finds that she's pregnant, takes a home test, buys health insurance, then goes to the doctor. The insurance company has to pay. This has already happened, we have had to pay these maternity claims.

When I first decided to pursue putting together an affordable health plan for Montanan's, I also decided that certain practices by insurers need not be incorporated by the plan:

1) Mandated Employee Participation
2) Mandated Employer Contribution
3) Mandated Hours Worked
4) Group Size

I felt that this was wrong, and we did not mandate any of the above. Most insurers had occupational classifications where they would either rate-up or decline certain professions.

We did not do that either. We provided full portability, they did not. I was told, "you can't do this," it would be cost prohibitive. We have been in business 6 years and did not have a rate increase in 1995, who was right?

Under SB285, we would have to discontinue doing this. Is this fair to Montanans?

Mr. Chairman and members of the committee, I am not educated in the ways of how to be a good lobbyist.

I can only speak the truth with the knowledge in my brain and sincerity from my heart.

Before you pass this bill, please consider;

1) 33-22-1818 is repealed and a new section is put in as I have outlined.
2) The portability issue is addressed.
3) The definition of pre-existing condition is addressed.
4) 33-22-1811 is amended.
5) 33-22-1804 is amended.
6) and take into consideration my other thoughts.

EXHIBIT 10
DATE 3-8-95
SB 330, HB 466

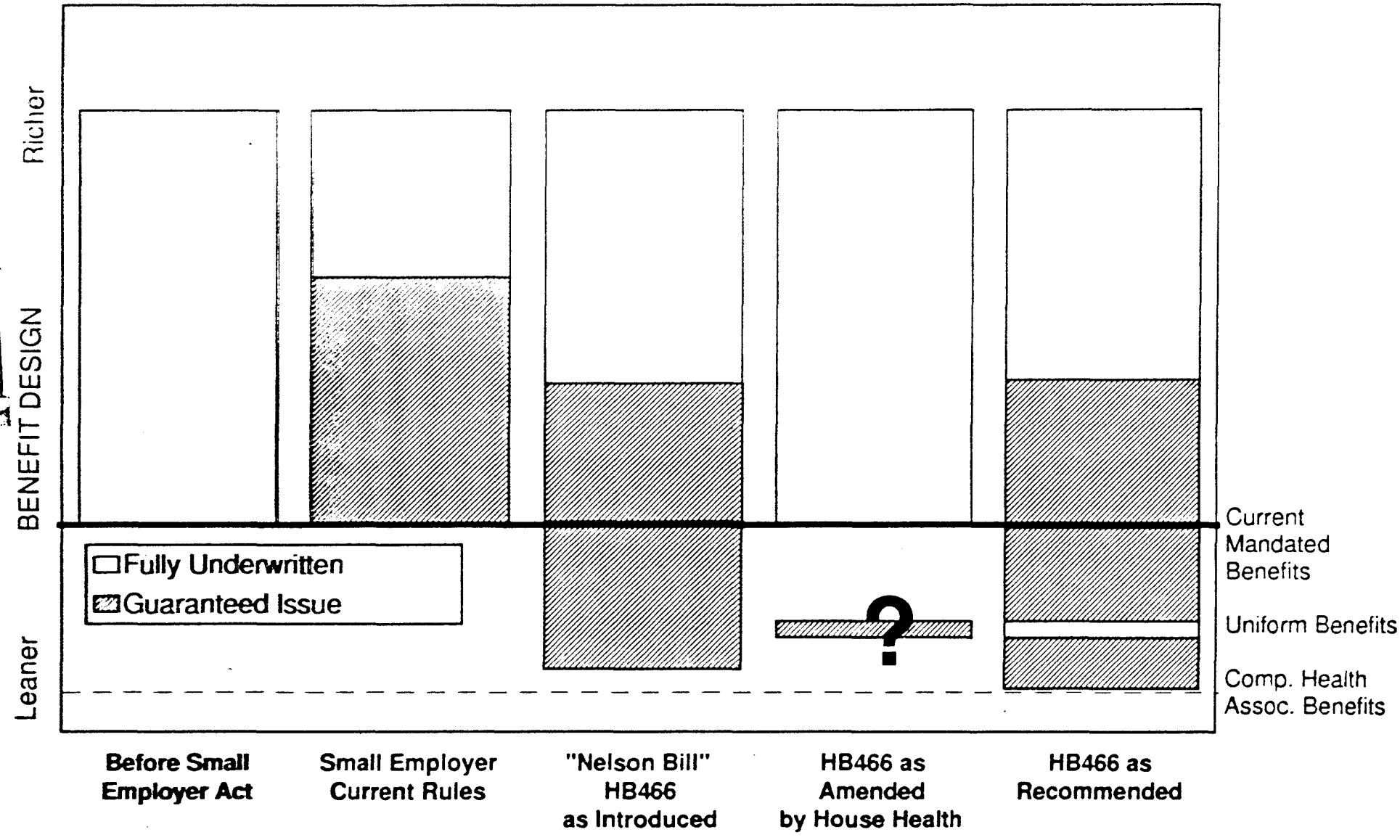
Thank You,

Ron Kunik
2511 MT Hwy 35
Kalispell, MT 59901

Exhibit # 11

EXHIBIT 11
DATE 3-8-95
SB 330, HB 466

Alternative Benefit Designs in the Small Employer Market



ALTER.PRS

FROM: LARRY AKEY

Exhibit #12

EXHIBIT 12
DATE 3-8-95
SB 330, HB 466

Joint Select Committee on Health Care

Testimony – Small Group Reform

Tanya Ask, Blue Cross and Blue Shield of Montana
March 8, 1995

Blue Cross and Blue Shield of Montana is a health service corporation licensed to provide health care benefits. We have been in business in Montana for over 50 years. This is the only state in which we are licensed to provide health care benefits. Working with many others -- from employers and seniors to labor and providers, to a number of our competitors -- we are committed to positive change of our industry.

You have already heard the problems the Small Employer Availability Act was meant to address. What has happened since December 7, 1994? We have written 91 new groups in the market with 550 contracts. Over 50 of these groups would have had some problem getting coverage prior to December 7. Twelve individuals now covered within these groups would not have been covered prior to small group. This is the human factor, and together, you by passing the law, and we as an industry by implementing the law, have done the right thing.

I do have amendments to present today. They are draft and the benefit design is still subject to negotiation.

Exhibit #13

EXHIBIT 13
DATE 3-8-95
SB 330, HB466

House Bill 466
Proposed Amendments
March 7, 1995

DRAFT

1. Page 1, Line 11
   Following: "CONTENT OF"
   Insert: "UNIFORM"

2. Page 2, 10, and 11
   Delete: New [(5)] in its entirety
   Insert:

   "Basic health benefit plan means a health benefit plan developed by a small employer carrier which is a lower cost plan than the standard health benefit plan. The basic health benefit plan must provide at least the level of benefits required by 33-22-1521 as that section reads in the effective date of SB341 or, in the event that SB341 does not pass, December 31, 1994. A basic health benefit plan is not subject to any other law that requires the inclusion of a specific category of licensed health care practitioners, nor is it subject to a law that requires the coverage of a health care service or benefit. A small employer carrier may, however, include benefits which are above those required by 33-22-1521 because that section may be amended by SB341."

3. Page 2, Lines 15 and 16
   Following: "corporation"
   Delete: "AND"
   Following: "organization"
   Insert: ", and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple welfare arrangement."

4. Page 3, Lines 2 and 3

Delete: New [(10)] in its entirety

5. Page 5, Line 6

Following: "[(UNIFORM)]"

Insert: "or"

Following: "plan"

Insert: "s"

6. Page 5, Line 9

Following: "[(UNIFORM)]"

Insert: "or"

Following: "plan"

Insert: "s"

6. Page 6, Line 3

Following: "[(26)]"

Insert:

"'Standard health benefit plan' means a health benefit plan developed ~~pursuant to 33-22-1812~~ by a small employer carrier. The commissioner may by rule establish minimum levels for annual deductible charges, coinsurance or copayment, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or copayment, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health benefit plan established by the commissioner may be different for a health benefit plan that includes a restricted network provision than for a health benefit plan that does not include a restricted network provision. The commissioner shall not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, Chapters 22, 30, or 31 specifically require coverage for the benefit."

EXHIBIT 13
DATE 3-8-95
SB 330, HB 466

House Bill 466
Proposed Amendments
March 7, 1995

7. Page 6, Line 3

Following: "means a health benefit plan"

Delete: Remainder of section

Insert: "as defined in new Section (the new Section is Amendment 12.)"

8. Pages 10, 11, and 12, Section 4

Delete: All references to [THE UNIFORM BENEFIT PLAN (Section 3) as provided in House Bill 531.]

Restore: All [ ] material originally in Section.

9. Page 20, Lines 19 and 20

Remove: Contingent Repealer, and remove references to "Committee" throughout

10. Page 20, Lines 22-27

Remove: New Section 9 in its entirety

11. Pages 20 and 21, Lines 29 through 1

Restore: New Section 10, renumber

12. New Section.

"Uniform Benefit Plan" - All individual carriers of disability insurance and all carriers of group disability insurance as defined by 33-18-1803(i) must offer a Uniform Benefit Plan that provides the benefits specified in this section.

a. The benefits for an insured must, subject to the other provisions of this section, be equal to at least 50 percent of the covered expenses required by this section in excess of an annual deductible that is not less than $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage may

be subject to a maximum lifetime benefit, but the maximum may not be less than $1 million.

b. Covered expenses for the following services and articles when prescribed by a physician:

(i) hospital services;

(ii) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(iii) use of radium or other radioactive materials;

(iv) oxygen;

(v) anesthetics;

(vi) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3) (c) (i);

(vii) services of a physical therapist;

(viii) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(ix) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(x) rental or purchase of medical equipment, which must be reimbursed after the deductible has been met at the rate of 50 percent, up to a maximum of $1,000;

(xi) prosthetics, other than dental;

(xii) services of a licensed home health agency, up to a maximum of 180 visits per year;

(xiii) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration.

(xiv) medically necessary, nonexperimental organ transplants of the following

major organs, limited to a maximum of $150,000 in a lifetime, with an additional $10,000 to be paid for costs associated with the donor:

a. kidney

b. pancreas

c. heart

d. heart/lung

e. liver

f. bone marrow

g. cornea

(xv) pregnancy, including complications of pregnancy;

(xvi) routine well baby care;

(xvii) sterilization;

(xviii) immunizations;

(xix) mental health and chemical dependency as provided for in [Senate Bill 339];

(xx) outpatient rehabilitation therapy;

(xxi) foot care for diabetics;

(xxii) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(xxiii) travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

(c) A Uniform Benefit Plan must meet the requirement of Title 33, Chapters 15 and 22, except for Parts 1801-1820, and 1822.

Codification instruction - New Section _____ must be codified in Title 33, Chapter 22, Part 1.

Exhibit #13

RONAN TELEPHONE COMPANY
512 MAIN STREET SOUTHWEST • RONAN, MONTANA 59864
(406) 676-2751 • FAX NO. (406) 676-8089

February 8, 1995

Re: Small Group health insurance reform

To whom it may concern:

We write in support of the real benefits that the small employer health insurance act has provided to our company. We have realized a decrease in our group health insurance premium that was both unexpected and unheard of no matter how much we shopped around. We are in full support of the new criteria used to rate a group of our size and feel it will, in part, allow us to continue to offer a benefit package to our employees.

This act also assures us of the ability to change carriers and coverage regardless of individual medical conditions and this security is very important to us and our employees. We fully support the benefits offered by the adoption of this act.

Sincerely,

Judith G. Preston
Vice-President

Exhibit #14

March 8, 1995

Glacier Insurance & Financial Strategies

17 First Avenue East • Kalispell, Montana 59901 • 406 752-8693 • FAX 406 756-8897

To: Members of the Joint Committee on Health Care
Capital Station
Helena, MT 59620

Re: Small Employer Health Insurance Act

EXHIBIT 14
DATE 3-8-95
SB 330, HB 466

Dear Legislator;

I am co-owner of Glacier Insurance and Financial Strategies, located in Kalispell. I am writing to you as an employer providing a variety of benefits for our employees. Our group has 15 full-time employees.

In the past years, our insurance premiums rose at levels above medical inflation. We understand the reason was that we paid a surcharge for the medical conditions of our employees. This resulted in raising deductibles and lowering coinsurance to the point that it was a 50/50 plan. Prior to changing benfits and carrier on January 1st, our employees did not appreciate the group medical benfits we offered, and the cost was escalating higher than we expected.

In the past years we shopped for coverage with a few reputable carriers, but to no avail. They all declined to offer coverage at any rate, due particularly to one medical condition that one of our valued employees has. We were forced to deal with our in-force carrier in price and benefit negotiations since no other carrier was interested, at least until recently.

On January 1st we chose a carrier that had declined us coverage in the past. With the new carrier we could have saved substantial premium dollars, but instead, chose to increase benefits. We now offer a dual option medical plan with 80/20 co-insurance and many first-dollar benefits. Our employees, once again, appreciate their medical benefits plan.

It is because of the Small Employer Health Insurance Act that we were able to accomplish this change. We, as small group employer, are in support of the reform measures outlined in SB 285. They allow us a level of comfort as we look forward to the future and the changes we will inevitably face.

Please support such reform measures as you review the conflicting bills before you.

Sincerely,

Lynn St.Pierre
Vice President

Insuring Montanan's dreams for over 50 years

Exhibit # 15

EXHIBIT 15
DATE 3-8-95
SB 330, HB 466

March 7, 1993

TO: SENATORS: STEVE BENEDICT
DOROTHY ECK
MIKE FOSTER
JUDY JACOBSON
KEN MILLER

REPRESENTATIVES: SCOTT ORR
DUANE GRIMES
BRUCE SIMON
CAROLYN SQUIRES
CARLY TUSS

FROM: BOB BENSON, CERTIFIED HEALTH CONSULTANT, REPRESENTING GLACIER INSURANCE AND FINANCIAL STRATEGIES, KALISPELL

SUBJECT: SMALL EMPLOYER HEALTH INSURANCE ACT (AKA: SB285)

Please accept this as an appeal to your good judgement as you debate issues pertaining to this widely contested issue. Our agency is in support of good reform measures intended to ensure that our clients have coverage available to them whether they be employer or employee.

SB 285 accomplished many things that are seemingly unacceptable to a few outspoken individuals. It eliminated, to some degree, "job lock". Job lock is the event that happens when an employee develops a medical condition which makes he/she uninsurable. That employee will not leave employment, even to better her/himself, because of fear of losing coverage. The portability guarantees in SB 285 solved that problem, giving the employee more freedom.

In the past, employers with unhealthy employees were stuck with their carrier. Now, because of the advent of Small Group Reform, they have the option of changing carriers without having to satisfy new waiting periods for pre-existing conditions, regardless of the medical conditions of the employees.

Some legislators have been concerned about the cost issues, hearing that rates will increase by leaps and bounds. This has not been our experience since the passage of the law on 12/7/94. I have tried to be brief in the following examples of our good and bad experiences since the passage of the bill. You will be quick to notice that many good stories outweigh the few bad.

SMALL GROUP EXPERIENCES / THE GOOD NEWS:

1. Accounting firm (new group for us) rated on 12/1/94 and again on 1/1/95 (under new SB285 rules) received a 37% lower rate for the same benefits for the 1/1/95 effective date. Why? Because the medical conditions within the group were weighted to a lesser degree in the rating process.

2. Renewal group received a 17% rate decrease because of favorable industry and other favorable rating characteristics.

3. Able to bid on a small group with two diabetics. Normally this group would be a decline, but new regs allowed us to offer attractive benefits and rates. The group has flexibility / choices.

4. New group of 4 with a cancer case diagnosed in 10/94. Because of guarantee issue, this person was able to purchase coverage. The only other option was the MCHA plan at almost twice the cost, and far worse benefits.

5. Currently rating a group with a heart problem and a cancer case diagnosed three years ago (remission). Normally this would be a decline, but now we have guarantee issue plans. None of the employees have any health coverage now. In the absence of this bill the two risks could only buy the MCHA plan.

6. Currently rating a group with a child of 11 that underwent heart valve transplant last year. Guarantee issue, with minor rate modifications for the health conditions allows us to offer plans to this group. Definitely a decline in the past.

7. Current group with a carrier that imposes health statement underwriting on new hires. The child of a valued new employee was declined due to diabetic condition. The employee was notified by the carrier that now the child can be added because of Small Group Reform. This has been done, and at a time when the employee was looking for a job with a larger employer so that coverage would be extended to his child.

8. Current prospect has opportunity to buy group coverage for $65 per employee per month, when they are now averaging $100-$110 per month for individual plans. Rates have not gone up because of SB285.

9. Current group can add employee who's wife has cancer at a rate of $280 per month as compared to their old individual rate of $600 per month.

10. Current group, with employee who has Multiple Sclerosis, could not find an interested carrier in the past. On 1/1/95 changed to a carrier at 10% lower premiums and better benefits. Employer and employees were pleased.

We have seen a few more cases where a new hire with pre-existing medical conditions has been enrolled on the new employer's medical plan and the new hire was given portability of coverage from the new hire's individual plan. In one instance, through no fault of the insured, there was a 28 day lapse of coverage, but the new law protected her portability, and pre-existing conditions (pregnant) because the lapse was less than the allowed 30 days. The maternity will be covered.

EXHIBIT 15
DATE 3-8-95
SB 330, HB 466

SMALL GROUP EXPERIENCES / THE BAD NEWS:

1. A current group of ours renewed on 3/1/95. Their group size allowed them the choice of being treated as a "small group", or not. If they are to be treated as a small group, they would face a 17.5% increase. If they did not, the increase would be just a bit less, approx. 14%. If they did not, they would continue to impose health statement underwriting on new hires. They elected to take the greater increase and willingly accept the conditions of the Small Group Health Insurance Act. One primary reason for doing so was because of the protections to the employer and employees in the future. This is listed in the "bad news" category because of the amount of increase.

2 A physicians group of 4 employees recently accepted a 28% increase. The increase was due solely to the bad rating of the industry. Medical provider groups are among the worst. No other carrier was able to offer a more attractive plan for less money. Other bad industries include logging, mining, service stations, etc..

These are our experiences of the past 90 days, since the effective date of the Small Group Health Insurance Act. We hope that it sheds some light on the practical side of this argument, that is that the law has worked.

STANDARD PLAN VS. BASIC PLAN:

Somewhere along the line someone has convinced many legislators that the Standard Plan, designed primarily by the Insurance Commissioner, is too rich in benefits and will be unaffordable. On the contrary, the Standard Plan is priced 7% less than our most popular group benefits package. This will be an attractive plan given the opportunity to sell it to prospective clients. It is a comprehensive plan and one that should not be scrapped.

MONTANA HEALTH CARE AUTHORITY:

The issues addressed here are not of as great a concern to us as Small Group Reform. SB 194 was intended to take the teeth out of the Authority's authorities. This is more an issue involving providers, underserved areas of the state, and the recommendations to resolve access to medical care problems. We would suggest that medical providers would be the best source of information and opinions in this regard.

We do not want the two issues to become entangled and confused, but we fear that they already have. SB 194 has done an great job of entangling two unrelated issues, those being the Small Employer Health Insurance Act, the other being the duties and recommendations of the Montana Health Care Authority. Please remember to treat each as a separate issue.

PLEASE REMEMBER THAT THOSE OPPOSING SMALL GROUP REFORM DO NOT REPRESENT THE MAJORITY, THEY REPRESENT ONLY A SMALL SEGMENT OF INSUREDS IN THIS STATE. OUR THANKS FOR YOUR DEDICATION AND ATTENTION TO THESE ISSUES INVOLVING HEALTH CARE.

Exhibit #16

EXHIBIT 16
DATE 3-8-95
SB 330, HB 466

TESTIMONY
BEFORE THE JOINT HEALTH CARE COMMITTEE
REGARDING SMALL EMPLOYER GROUP HEALTH ISSUES
MARCH 8, 1995
Room 325
5:30 p.m.

Chairman Benedict, Members of the Joint Committee on Health Care:

On behalf of the State Farm Insurance Companies operating in Montana, I would like to thank the members of this Committee for allowing me to provide this written testimony as a supplement to my oral testimony given on this date.

As you know, State Farm remains very interested in the development of the small employer group health program in Montana to the extent that the program could have a significant impact on State Farm policyholders across the state. For this reason, State Farm would like to take this opportunity to offer testimony on Representative Nelson's House Bill 466 and would also like to address some concerns as they relate to the rules promulgated under the Small Employer Health Insurance Availability Act of 1993.

Relative to other entities currently offering health insurance products to Montana's consumers, State Farm has a relatively small presence in Montana. However, State Farm does serve a number of group health insurance consumers in the state and is very eager to continue to accommodate those groups in any way possible. In addition, State Farm does serve a number of insureds in Montana with individual health insurance policies and believes that this Committee's actions in the area of small

employer group health insurance could have significant impacts on State Farm's ability to serve both its group and individual policyholders.

As the Small Employer Health Insurance Availability Act and the rules promulgated thereunder developed, State Farm has become concerned about several areas of the program. Primarily, State Farm, in reviewing the program benefits and funding mechanisms has become concerned about the actuarial soundness of this new program and the funding of any shortfalls that the program may experience.

I have spoken, on behalf of State Farm, to many members of this Committee as well as other insurance industry representatives and the Montana Department of Insurance regarding State Farm's concerns as outlined above. Early in this legislative session, State Farm learned that Representative Nelson would be bringing a bill to amend the Small Employer Health Insurance Availability Act in some fashion. State Farm approached Representative Nelson with our concerns and he was gracious enough to amend House Bill 466 to address those concerns.

The amendments placed on House Bill 466 accomplish two things. First, the amendments require a regular review of the Small Employer Group Health Insurance Program to determine whether that program is actuarially sound. This review is to take place by the Reinsurance Board on an annual basis. Based on the results of this annual review, it is assumed that premiums and/or reinsurance rates would be adjusted accordingly.

EXHIBIT 16
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Secondly, the amendments would add assurances to insurance carriers who do not participate in the small employer group health market that they will have a limited exposure for assessments to fund program shortfalls. By way of explanation, the small employer group health program is funded by a combination of three mechanisms: (1) policy premiums; (2) reinsurance; and (3) assessments on "assessable carriers". Under the current statutory language of the program, in the event that premiums and reinsurance are insufficient to cover losses in the group health market, then, all "assessable carriers" are assessed equally in order to make up program shortfalls. By definition, an "assessable carrier" includes all providers of group or individual policies of health insurance in this state. In other words, even if a carrier chooses not to operate in the group health market in Montana, it can still be assessed for losses in that program. State Farm believes that, to the extent that a carrier participates and (hopefully) financially benefits from the small employer group market, that carrier should also share in any shortfalls that the program might experience. By the same token, if a carrier does not participate in the small employer group program (thereby gaining no benefit from the program) that carrier should not be required to make up any shortfalls in the program.

State Farm takes the position that, to the extent that a carrier of individual health products does not offer group health products in the state, its exposure as an "assessable carrier" should be limited for any shortfalls that exist in the small

employer group program. For this reason, State Farm strongly supports the amendment in Representative Nelson's bill which limits the assessment on this type of carrier to 5% of that carrier's underwriting profit on its individual lines. State Farm believes that this type of cap on an individual carrier's exposure for program shortfalls is very important in allowing an insurer to forecast its potential exposure in the Montana market. It is unlikely that an insurer looking to Montana as a potential market place of individual products would be willing to enter this market place without being able to forecast what its assessments might be for shortfalls in this program. The type of safeguards reflected in the amendatory language to House Bill 466 are critical both in the current small employer group program and should remain in the plan irrespective of any modification that this committee and the legislature might make to the program.

State Farm would also like to take this opportunity to discuss a couple of concerns regarding the rules that have been promulgated under the small employer group program. It is important to note that State Farm currently does not offer group health products in Montana. However, State Farm is very eager to continue to serve its existing group policyholders in this state. This ability to continue to service its product may evaporate under the existing small employer group rules.

Under the rules adopted pursuant to the small employer group program, specifically Rule 6.6.5050, A.R.M., if an insurer chooses not to participate in the program, that insurer can only

continue to service its existing policies and provide coverage under those policies for a period of three years. This means that should State Farm, or any other insurer, choose not to operate under the small employer group program, that in December of 1997, that carrier must discontinue covering whatever small groups it might have left in Montana. State Farm suggests that, so long as a company is simply servicing existing small groups without marketing additional small group plans, it should be allowed to accommodate and service those policyholders. State Farm asks your favorable consideration on this suggestion.

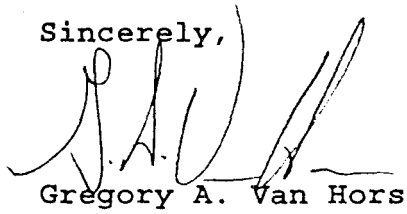
Finally, that same rule also provides that a carrier who chooses not to participate in the small employer group program "shall be precluded from operating as a small employer carrier for five years." By my reading of the rules, this decision whether or not to participate in the small employer group program must have taken place by December 7, 1994. Therefore, under the express language of the rules, an insurer who has not indicated an intent to participate in the small employer group program cannot do so until some time in the year 2000.

State Farm believes that this five-year prohibition is quite unreasonable given the significant changes that have and certainly will take place in the small employer group program during the 1995 legislative session. Given the relative unknowns regarding the final product that this legislature will turn out, this five-year prohibition is a significant penalty to insurers who have not yet decided to participate. Additionally, the five-year

prohibition will almost certainly have a negative impact on Montana consumers by limiting their choices in this market place. For these reasons, State Farms asks this Committee to consider addressing these particular rules in its deliberations.

On behalf of State Farm, I thank you for allowing me the opportunity to submit both oral and written testimony on these important issues. State Farm, as always, looks forward to the opportunity to work together with this Committee in formulating workable legislation to the benefit of Montana consumers.

Sincerely,



Gregory A. Van Horssen

GVH/vjz

EXHIBIT 17 Claudia Clifford
DATE 3-8-95
SB 330, HB 466 Exhibit #17

INSURANCE COMPANIES DECLARED TO BE IN SMALL GROUP MARKET

These are the insurers declared to be participating in the small business health insurance market in Montana. Those certified as small group carriers currently can offer insurance plans to small businesses. Those companies that are not yet certified may not have submitted policies to the Montana Insurance Department or their policies are being reviewed.

Company *(32 companies to date)*	Certified as Small Group Carrier as of 3/8/95
Aetna Life Insurance Co.	
American Chambers Life Insurance Co.	X
American National Insurance Co.	X
Bankers United Life Assurance Co.	X
Best Life Assurance Company of California	
Blue Cross Blue Shield of Montana & HMO	X
Celtic Life Insurance Co.	
Centennial Life Insurance Co.	
Connecticut General Life Insurance Co.	
Continental Life and Accident	
CUNA Mutual Insurance Society	X
Fortis Benefits Insurance Co.	X
Glacier Community Health Plan Inc.	
Golden Rule Insurance Co.	
Home Life Financial Assurance Corp.	X
John Alden Life Insurance Co.	X
John Hancock Mutual Life Insurance	X
Life Investors Insurance Co of America	X
Monumental Life Insurance Co	
National Group Life Insurance Co.	
New York Life Insurance Co.	X
PFL Life Insurance Co.	
Pioneer Life Insurance Company of Illinois	
Principal Mutual Life Insurance Co.	X
Security Life Insurance Company of America	
Time Insurance Co.	X
Travelers Insurance Co.	X
United of Omaha Life Insurance Co.	X
United World Life Insurance Co.	X
Universe Life Insurance Co.	X
Western Mutual Insurance Co.	
Yellowstone Community Health Plan	

Claudia Clifford
Exhibit #18

EXHIBIT 18
DATE 3-8-95
SB 330, HB 466

Amendments to House Bill 466
Offered by the State Auditor's Office
Department of Insurance
03/08/95

1. Restore House Bill 466 to its introduced form.

Add the following amendments to the introduced bill (pages and line numbers below refer to introduced version of the bill).

2. Page 2, line 5.
Following: "that is"
Strike: "a"
Following: "lower"
Strike: "cost plan"
Insert: "in benefits"

4. Page 5, line 2.
Following: "health benefit plan"
Strike: ", provided that the policy has been in effect for a period of at least 1 year"

Claudia Clifford
Exhibit #HB 19

Small Business Health Insurance Reform

Fact Sheet

EXHIBIT 19
DATE 3-8-95
SB 330, HB 46

State Auditor Mark O'Keefe

What is Small Business Reform?

Small business health insurance reform is consumer-oriented reform designed to make health insurance more available to Montana's small businesses (with 3 to 25 employees working full time or 30 or more hours a week).

This reform was overwhelmingly endorsed by the 1993 Montana Legislature. Lawmakers included the small business insurance reform provisions in Senate Bill 285, the major health-care measure of the last regular legislative session.

The legislation authorized State Auditor Mark O'Keefe, as Montana's insurance commissioner, to appoint the five-member Health Benefit Plan Committee. The committee, with input from the public, health-care providers, the insurance industry, and small business representative, was charged with designing standard and basic health benefit packages that can be marketed on a ***voluntary*** basis to the state's small businesses. *(Businesses are not required to participate in this program.)*

Goals of small business insurance reform include:

- ☐ Promoting availability of health insurance, regardless of a business' health status or claims experience;
- ☐ Preventing abusive rating practices and requiring disclosure of rating practices to purchasers;
- ☐ Establishing rules on renewability of coverage;
- ☐ Limiting use of pre-existing condition exclusions; and
- ☐ Improving the overall fairness and efficiency of the small employer health insurance market.

Small business reform is not something new. In fact, more than 35 states have adapted the National Association of Insurance Commissioner's model small group act to their particular circumstances. Montana has done the same, with a free-market twist.

Standard and Basic Plans

The Health Benefit Plan Committee designed two health benefit plans: a basic (lower-cost) plan and a standard plan. Both plans include all state-mandated benefits and maternity coverage.

The plans provide for *portability* of coverage and *guaranteed issue*. That means that workers aren't subject to pre-existing condition exclusions if they leave a job and move to another with small business coverage *(portability)*, and that insurance companies can't reject a group for coverage because of its health history or for any other reason *(guaranteed issue)*.

Insurance carriers that offer small business plans (basic and standard plans) are required to accept all groups, including groups that formerly couldn't get health insurance for their employees. Companies can still underwrite other health plans.

This move is intended to make small group health insurance more accessible to small businesses.

The committee designed specific benefits to be in every standard plan sold by insurers. The committee recommended a free-market approach to basic plans, allowing insurers to offer a variety of products. The Montana basic plans allow many current policies to serve as basic plans, thereby ensuring portability of coverage and guaranteed issue.

The committee also devised a preventive care package of benefits based on medical knowledge and common sense. The preventive care package, included in the standard plan, includes well-child care beyond the age of two, age-appropriate check-ups, appropriate care linked to family medical history and maternity care reimbursed as a preventive care item rather than as an illness.

The plans are discussed on the back page.

Consumers now can buy standard and basic plans. Small businesses should check with their insurance agents about policy availability.

(more)

How the Plans Work

Insurers are able to offer a single standard plan and at least one basic plan. Policies are not sold by the state; they are sold by private insurance carriers that participate in the small business market. Businesses are not required to participate.

Businesses wishing to do so can continue their current policies, which may qualify as basic plans under the small business reform act. Or they can apply for other plans. The new law provides businesses and consumers with more choices.

Notice of cancellation of policies must be given at least 180 days prior to termination of coverage. The insurance commissioner will assist small employers whose policies have been cancelled under certain conditions in finding replacement coverage.

Special Features

☞ Employers and consumers can renew their coverage -- renewability is guaranteed -- unless they fail to pay premiums, commit fraud, or make misrepresentations.

☞ Premium rate increases are capped, and premium variations are limited among similar groups and limited between groups.

☞ Pre-existing condition exclusions are limited: Pre-existing conditions are covered after 12 months, and if an individual is continuously covered, no pre-existing condition exclusion period applies.

Standard Plan

The standard plan must offer state-mandated and maternity benefits.

It includes:

- ❒ An annual deductible of $250 for an individual, $500 for family coverage;
- ❒ Coinsurance payments, after the deductible is met, of 20 percent for the insured;
- ❒ Maximum out-of-pocket expenses of $1,250 a year for individuals and $2,500 per family;
- ❒ Maximum lifetime benefits of $1 million;
- ❒ 20-percent coinsurance payments for the insured for prescription drugs;
- ❒ First-dollar coverage (no deductible or copayment) for a package of preventive-care services, such as well-child care from birth to age 20, prenatal care, mammographies, pap smears, health exams, health counseling, and age-appropriate physical exams;
- ❒ Four visits a year to a practitioner of choice, with patient copayment limited to $25 per visit; and
- ❒ Policies issued to any group that applies.

Basic Plan

Any health benefit plan that has benefits that cost less than the benefits of a standard plan will qualify as a basic health benefit plan. All basic (lower-cost) plans must include all state-mandated and maternity benefits. Under this approach, employers and consumers can select from a variety of basic plans and shop for the deductible, coinsurance, and maximum out-of-pocket levels that meet their particular needs. The theory behind the basic plan is to allow the free market to dictate the components of the policies. All basic plans will be issued to any group that applies for one.

???s Contacts ☎

If you have questions about small group health insurance reform, please call the State Auditor's Office at 1-800-332-6148, or write, P.O. Box 4009, Helena, Mt., 59604-4009.

EXHIBIT 20
DATE 3-8-95
SB 330, HB 466

Senator Clifford Exhibit # 20

Small Business Health Insurance Reform

Small Employer Health Insurance Availability Act

The Small Employer Health Insurance Availability Act, passed by the 1993 Montana Legislature, is based on a model act designed by the National Association of Insurance Commissioners and adopted in similar form by 33 other states.

The NAIC developed the model act in consultation with insurers and agent associations, consumer groups and small business representatives.

Small business health insurance reforms, contained in Senate Bill 285, were tailored to the Montana market by state lawmakers. The small business health insurance reforms were, in essence, an industry solution to problems faced by small businesses that couldn't, for one reason or another, get health insurance. The act is a private-sector solution to a private-sector problem.

"I'm no insurance expert," Bozeman businesswoman Sunny Mavor told the Bozeman* Daily Chronicle, *"but it looks to me like it's a step in a good direction."

The reforms are backed by such groups as the Health Insurance Association of America, Blue Cross Blue Shield of Montana, National Federation of Independent Business/Montana, Independent Insurance Agents Association of Montana, Montana Association of Life Underwriters, National Association of Independent Insurers, Montanans for Universal Health Care and the Montana Hospital Association.

Elements of Reform

Small business health insurance reform is designed to make health insurance more available to Montana's small businesses (with between 3 and 25 employees working 30 or more hours a week).

The legislation authorized State Auditor Mark O'Keefe, as insurance commissioner, to appoint the five-member Health Benefit Plan Committee. The committee, with input from the public, health-care providers, insurance industry, small business representatives and consumer groups, was charged with designing standard and basic health benefit packages that can be marketed on a *voluntary* basis to the state's small businesses. ***(Businesses are not required to participate in this program.)***

Goals of reform include:

- ❒ Promoting availability of health insurance, regardless of a business' health status or claims experience;
- ❒ Preventing abusive rating practices and requiring disclosure of rating practices to purchasers;
- ❒ Providing for renewability of coverage;
- ❒ Limiting use of preexisting condition exclusions; and
- ❒ Improving the overall fairness and efficiency of the small employer health insurance market.

Standard and Basic Plans

The Health Benefit Plan Committee designed two health benefit plans: a basic (lower-cost) plan and a standard plan. Both plans include all state-mandated benefits and maternity coverage.

Portability and Guaranteed Issue

The plans provide for *portability* of coverage and *guaranteed issue*. That means that people aren't subject to preexisting condition waiting periods if they have had previous coverage and sign up for a small business health insurance plan *(portability)*; and insurers can't reject a group or any eligible individual for coverage because of health history or for any other reason *(guaranteed issue)*.

Insurers offering basic and standard plans are required to accept all groups, including groups that formerly couldn't get health insurance for their employees. Companies can still underwrite other health plans.

Free Market Approach

The committee designed specific benefits to be in every standard plan sold by insurers. The committee recommended a free-market approach to basic plans, allowing insurers to offer a variety of products. The Montana basic plans would allow many current policies to serve as basic plans, thereby ensuring portability of coverage and guaranteed issue.

The committee also devised a package of preventive-care benefits based on medical knowledge and common sense. This package, contained in the standard plan, includes well-child care beyond the age of two, age-appropriate checkups, appropriate care linked to family medical history and maternity care reimbursed as a preventive care item rather than as an illness.

How the Plans Work

Since December 1994, all small business insurance carriers offer the single standard plan and at least one basic plan. Policies are not sold by the state; they are sold by private insurers that participate in this market. Businesses are not required to buy this insurance.

Businesses can continue their current policies, which may qualify as basic plans, or apply for other plans. The new law provides more choices.

Notice of cancellation of policies must be given at least 180 days prior to termination of coverage. The insurance commissioner will assist small employers whose policies have been cancelled under certain conditions in finding replacement coverage.

Special Features

☞ Employers and consumers can renew their coverage -- renewability is guaranteed -- unless they fail to pay premiums, commit fraud, or make misrepresentations.

☞ Premium rate increases will be capped, and premium variations limited. Rates no longer will be based on the health status of employees, or dependents, in the group.

☞ Pre-existing condition exclusions will be limited: Pre-existing conditions will be covered after 12 months, and if an individual is transferring from another health insurance policy, no pre-existing condition exclusion period will apply.

Standard Plan Provisions

The standard plan must offer maternity benefits and all state-mandated benefits.

It will include:

❒ An annual deductible of $250 for an individual, $500 for family coverage;

❒ Coinsurance payments, after the deductible is met, of 20 percent for the insured;

❒ Maximum out-of-pocket expenses of $1,250 a year for individuals and $2,500 per family;

❒ Maximum lifetime benefits of $1 million;

❒ 20-percent coinsurance payments for the insured for prescription drugs;

❒ First-dollar coverage (no deductible or copayment) for a package of preventive-care services, such as well-child care from birth to age 20, prenatal care, mammographies, pap smears, health exams, health counseling, and age-appropriate physical exams;

❒ Four visits a year to a practitioner of choice, with patient copayment limited to $25 per visit; and

❒ Policies issued to any group that applies.

Basic Plan Provisions

Any health benefit plan that has benefits that cost less than the benefits of a standard plan will qualify as a basic health benefit plan.

All basic (lower-cost) plans must include maternity benefits and all state-mandated benefits.

Under this approach, employers and consumers can select from a variety of basic plans and shop for the deductible, coinsurance, and maximum out-of-pocket levels that meet their particular needs.

The theory behind the basic plan is to allow the free market to dictate the components of the policies.

All basic plans will be issued to any group that applies for one.

Other Plans for Small Businesses

Insurers still can underwrite some plans, meaning they can accept or reject applicants based on a person's or group's health status.

These plans must be richer in benefits than the standard plan.

Montana Small Employer Health Reinsurance Program

Because small business health insurance reform requires insurance carriers to provide coverage (guaranteed issue) to all eligible employees and dependents, a program was established to guarantee insurers a source of reinsurance. (Reinsurance is an agreement between two or more insurance companies by which the risk of loss is proportioned.)

The Montana Small Employer Health Reinsurance Program consists of a nine-member board with representatives from the five insurance companies that write the most small business health insurance in Montana. A sixth insurance company is represented along with a small employer, a consumer, and a health care provider.

This board sets premium rates for reinsurance. If premiums do not cover program costs, the board can assess all health insurance carriers doing business in Montana. Assessments are based on a carrier's line of business for large-group, small-group and individual health insurance coverage. Exempt from assessment are health plans for state employees and the university system, and self-funded health insurance plans provided by a political subdivision of the state. (Connecticut, which had one of the first reinsurance programs in the nation, has assessed carriers a fraction of 1 percent of the $515 million base in the last 3.5 years.)

Administrative work for the reinsurance program is handled by Travelers Insurance Co., which performs similar duties for reinsurance programs in 18 other states.

DATE 3-8-95
SB 330, HB 466

Montana Business Health Coverage Survey

Small Business Health Insurance Reform on Target, Survey Reveals

A survey conducted in the summer of 1994 confirmed what the 1993 Legislature and Montana Insurance Department only presumed to know -- that small businesses are less likely to provide health insurance coverage to employees than large businesses.

The statewide survey, conducted by the State Auditor's Office in conjunction with the state Department of Labor and Industry, found that less than half -- 47 percent -- of small businesses (between 3 and 25 employees) surveyed said they provided health insurance coverage to their workers. Meanwhile, 83 percent of large businesses (26 or more employees) reported they provided health insurance coverage to their workers.

The survey also revealed that health insurance costs are higher for small businesses.

Highlights

Percent of Large and Small Businesses Offering Health Insurance Coverage

Small Employers	47%
Large employers	83%

Percent of Each Class of Firms That Offer Insurance Coverage

500 employees or more	88.9%
100 to 499 employees	90.6%
26 to 100 employees	81.1%
3 to 25 employees	47%

Other survey highlights:

- The lack of health insurance generally is more concentrated in lower-wage, seasonal industries that employ part-time workers;
- Eighty-nine small firms and 40 large firms reported being refused group health insurance coverage by insurance companies in the last five years (employees working for small firms were almost four times more likely to be denied coverage by insurers than those working for large firms);
- Health insurance premiums for all businesses surveyed rose 8.5 percent faster than the rate of inflation over the last five years;
- 38.4 percent of small firms reported making some type of coverage contribution for employees, compared with 73.7 percent of large firms reporting making some type of coverage contribution; and
- Small firms pay more in premiums than large firms, with the average monthly insurance premium for individual health employee coverage for 1994 at $176.15 for small businesses, compared with $149.85 for large businesses.

The survey was conducted by the state labor department's Research and Analysis Bureau, which handles statistical research for Montana and the U.S. Bureau of Labor Statistics. The survey has a margin of error of 1.5 percent.

Surveys were sent to 7,807 of the 25,166 private industry employers in Montana. Two mailings of the survey were sent. Phone follow-up was done to clarify some of the data items.

5,919 responses were received, including duplicate responses. After duplicates were deleted, usable responses totaled 4,949.

Small Business Insurance Reform in Other States

Small business health insurance reform is not an effort unique to Montana. About 34 states have adapted the National Association of Insurance Commissioner's model small group act to their particular circumstances.

As the National Underwriter magazine noted in a November 14, 1994 report on U.S. health care, "For the past several years small group insurance reform has been at the forefront of states' efforts to expand access to health insurance coverage." The Intergovernmental Health Policy Project at the George Washington University notes that almost every state has enacted some form of small business health insurance reform. And, as experts point out, the reform is intended to remedy problems with insurance coverage availability, not affordability.

Since May 1991, Connecticut has been working with small business health insurance reform. 8,963 Connecticut small businesses, previously uninsured, had purchased small group plans as of June 1994, and sales remained strong among 44 of 48 small group carriers surveyed.

The surrounding states of Idaho, North Dakota, South Dakota and Wyoming all have instituted some sort of small business health insurance reforms similar to Montana's.

Commonly Asked Questions About Small Business Health Insurance Reform

Q. Will this reform cause rates to skyrocket and prompt healthy individuals to drop coverage?
A. Hopefully, not. This legislation was designed by the National Association of Insurance Commissioners, in close consultation with insurance companies and agent groups, as a way to help more small businesses get health insurance coverage. Rates in this market will no longer be based on the health status of individuals in the group, so some groups will see rates go down. Overall, rates may go up slightly to cover the costs of guaranteed issue. One major Montana insurer estimates the cost of guaranteed issue to be eight percent of premium.

Q. The law allows basic plans to be exempt from any or all of the mandated benefits. Why were all the mandated benefits left in basic plans?
A. In designing the basic plan, the Health Benefit Plan Committee carefully considered the issue of exempting the basic plan from the mandated benefits. The committee's actuary estimated the cost of the mandated benefits to be eight percent of premium. The committee felt that the Legislature had passed the mandated benefit laws for good reason. Basic and standard plans were designed with the flexibility that if the Legislature repeals or adds a mandated benefit, it will automatically change the plans.

Q. Can a small employer offer individual policies to employees?
A. No, a small business must buy a small group policy. The practice of companies selling individual policies through an employer has been stopped to prevent insurance companies from "cherrypicking" the healthy individuals. However, individuals who work for small businesses can always directly buy an individual policy.

Q. Is an employer required to offer coverage to ***every*** employee if a small group plan is purchased?
A. No. Coverage must be offered to employees who work 30 hours or more a week and the dependents of these employees. Employers decide whether to make the insurance available to anyone else. Some insurance companies have their own restrictions on coverage for part-time employees.

Q. Are dependents guaranteed coverage through small group plans?
A. Yes, the dependents of employees who work 30 hours or more a week will not be turned down for insurance. If they have previous coverage when changing to a small group plan, no waiting periods for preexisting conditions will apply.

Q. Will only a small portion of Montana employees have to pay the costs related to the reinsurance program?
A. No. The costs of the reinsurance program are paid through premiums from insurance companies that choose to buy the reinsurance coverage. Assessments on insurance companies pay for costs not covered by premiums. Insurance carriers are assessed based on their total premiums from individual, large and small group health insurance sales, which is a broad assessment base.

EXHIBIT 20
DATE 3-8-95
SB 330, HB 466

Q. Can a small business buy health insurance plans other than the standard and basic policies?
A. Yes. Insurance carriers can offer health plans that they continue to "underwrite." Applicants can be refused coverage for these plans, but must be offered basic and standard plans as an alternative.

Q. Does this reform make insurance coverage of abortion a new mandated benefit?
A. No. Mandated benefits are separate laws that affect all policies sold in the state. Coverage of abortion is part of the standard plan, but it is the only plan that must include this benefit. Consumers who object to this benefit can purchase a policy with out the benefit.

Q. How does a small business qualify?
A. Any business with between three and 25 employees who work 30 hours or more a week qualifies for a small group health insurance policy and cannot be refused. Not every employee must enroll, but insurance companies are allowed to have minimum participation requirements set by the carrier.

Q. Do mandatory maternity benefits have anything to do with this reform?
A. No. The Montana Supreme Court ruled 7-0 in December 1993 that under the state's nongender insurance law it is discriminatory to exclude maternity benefits or have a separate rider policy for that coverage under a major medical insurance policy. Like all policies sold in Montana, maternity benefits are included in the basic and standard plans.

Q. Is there a minimum amount employers must contribute to paying the premium for small group plans?
A. The law does not require a minimum contribution from employers, but some insurance companies do, which is permissible.

Q. Can a small group stay on the health insurance plan acquired before the reform went into effect?
A. Yes. The law does not require small businesses to buy the new basic and standard plans.

For more information, call the Montana Insurance Department at 444-2040 in Helena, or 1-800-332-6148.

INSURANCE COMPANIES DECLARED TO BE IN SMALL GROUP MARKET

These are the insurers declared to be participating in the small business health insurance market in Montana. Those certified as small group carriers currently can offer insurance plans to small businesses. Those companies that are not yet certified may not have submitted policies to the Montana Insurance Department or their policies are being reviewed.

Company *(31 companies to date)*	Certified as Small Group Carrier as of 1/31/95
Aetna Life Insurance Co.	
American Chambers Life Insurance Co.	
American National Insurance Co.	
Bankers United Life Assurance Co.	X
Best Life Assurance Company of California	
Blue Cross Blue Shield of Montana & HMO	X
Celtic Life Insurance Co.	
Centennial Life Insurance Co.	
Continental Life and Accident	
CUNA Mutual Insurance Society	
Fortis Benefits Insurance Co.	X
Glacier Community Health Plan Inc.	
Golden Rule Insurance Co.	
Home Life Financial Assurance Corp.	X
John Alden Life Insurance Co.	X
John Hancock Mutual Life Insurance	X
Life Investors Insurance Co of America	X
Monumental Life Insurance Co	
National Group Life Insurance Co.	
New York Life Insurance Co.	X
PFL Life Insurance Co.	
Pioneer Life Insurance Company of Illinois	
Principal Mutual Life Insurance Co.	X
Security Life Insurance Company of America	
Time Insurance Co.	X
Travelers Insurance Co.	X
United of Omaha Life Insurance Co.	X
United World Life Insurance Co.	X
Universe Life Insurance Co.	X
Western Mutual Insurance Co.	
Yellowstone Community Health Plan	

FEB 2 6 1991
Exhibit #21
EXHIBIT 21
DATE 3-8-95
SB 330, HB 466

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MONTANA

BILLINGS DIVISION

UNITED INDUSTRY, INC. and its subsidiaries, and WILLIAM LEE WIX, Plaintiffs, THE MONTANA DEPARTMENT OF LABOR AND INDUSTRY and its Commissioner MIKE MICONE, Defendants.	CV 89-67-BLG-JFB MEMORANDUM OPINION AND ORDER

Presently pending before this Court are cross Motions for Summary Judgment in this declaratory judgment action. For the reasons set forth below, plaintiffs' Motion is granted, defendants' Motion is denied, and defendant-intervenors' Motion is also denied.

Facts and Procedural Background

Plaintiffs filed this action seeking a declaratory ruling, pursuant to 28 U.S.C. §2201 and Rule 57, Fed.R.Civ.P., that a provision of Montana's prevailing wage statute for public construction projects is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. ("ERISA"). Montana's Little Davis Bacon Act, otherwise known as the Montana Prevailing Wage Act, provides in part that:

> [a]ll public works contracts . . . must contain a provision requiring the contractor to pay the standard prevailing rate of wages, including fringe benefits for health and

Submitted by Lloyd Lockerman Jr.

> welfare and pension contributions and travel allowance provisions, in effect and applicable to the district in which the work is being performed.

Mont. Code Ann. §18-2-403(2). Another provision of this Act directs that "[w]henever the employer is not [a] signatory party to a collective bargaining agreement, those moneys designated as negotiated fringe benefits shall be paid to the employee as wages." Mont. Code Ann. §18-2-405 ("Section 405" or "§405").

Plaintiff United Industries and some of its subsidiaries are not signatories to collective bargaining agreements, but they do participate in ERISA-approved employee benefit plans administered by the Montana Contractors Association. Plaintiff William Wix is an employee of Pioneer Ready Mix, a United Industries subsidiary that is not a signatory party to a collective bargaining agreement. Plaintiffs contend that §405--requiring non-signatory parties to collective bargaining agreements to pay fringe benefits in the form of cash wages--violates ERISA, which provides a uniform and comprehensive body of federal law to govern employee fringe benefits, including welfare and pension plans. They contend, among other allegations, that Montana's statutory scheme impermissibly dictates that funds originally earmarked for contribution to ERISA benefit plans must be paid to their employees directly as cash wages. Thus, plaintiffs assert that §405 imposes additional conditions, not contemplated by

Congress, on those employers who participate in ERISA benefit plans but who have not signed collective bargaining agreements.

In moving for a declaratory judgment that §405 is preempted, plaintiffs originally named as defendants only Montana's Department of Labor and Industry, and its Commissioner who is charged with administration of the law ("the State"). On October 30, 1989, however, this Court granted a Motion to Intervene brought by the Montana District Council of Laborers and International Union of Operating Engineers, Local 400 ("Unions"). In so ruling, this Court found that the Unions had an interest in "preserving [Montana's] statutory scheme" and the "resulting competitive edge" favoring union employers over those employers who use non-union labor. See Order of October 30, 1989, at 4-5.

Discussion

This Court finds that it has original jurisdiction to decide this declaratory judgment action pursuant to 28 U.S.C. §1331. See generally Hydrostorage, Inc. v. Northern California Boilermakers Local Joint Apprenticeship Committee, 891 F.2d 719, 725 (9th Cir. 1989), cert. denied, 111 S.Ct. 72 (1990); Stone & Webster Engineering Corp. v. Ilsley, 690 F.2d 323, 327-28 (2d Cir. 1982), affirmed, 463 U.S. 1220 (1983). Furthermore, the Court finds that a "substantial controversy" exists between the parties, who have adverse and immediate legal interests at stake, depending on the outcome of this

action. See National Basketball Asso. v. SDC Basketball Club, Inc., 815 F.2d 562, 565 (9th Cir.), cert. dismissed, 484 U.S. 960 (1987); Nuclear Engineering Co. v. Scott, 660 F.2d 241, 251-52 (7th Cir. 1981), cert. denied, 455 U.S. 993 (1982).

All parties have moved for summary judgment. Rule 56(c), Fed.R.Civ.P., states that summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." The parties agree that the question of preemption is a purely legal dispute that may be decided on motions for summary judgment, based upon affidavits and stipulated facts.

Having carefully considered the briefs, arguments, and materials on file, the Court is now prepared to rule.

A. ERISA's Preemption Provision.

ERISA "established a comprehensive federal statutory scheme designed to protect two types of 'employee benefit plans': 'pension' plans and 'welfare' plans." Retirement Fund Trust of Plumbing v. Franchise Tax Board, 909 F.2d 1266, 1269 (9th Cir. 1990) (footnotes omitted). Because Congress intended to create a uniform body of law in this field, ERISA contains a broad preemption provision, "whereby federal law 'will supersede any and all State laws insofar as they may now or

hereafter relate to any employee benefit plan' under the Act." Id. quoting 29 U.S.C. §1144(a) (footnote omitted).1/

The scope of ERISA's preemption provision is one of the most widely litigated issues in labor law. As an initial matter, any analysis of preemption issues "must be guided by respect for the separate spheres of governmental authority preserved in our federalist system." Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 522 (1981). In passing ERISA, the Supreme Court has held that "Congress did not intend to pre-empt areas of traditional state regulation." Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985). Yet, ERISA clearly contemplates some preemption of state law. 29 U.S.C. §1144(a).

To strike the proper balance between respect for the states' traditional police powers and ERISA's preemption provisions, the Ninth Circuit Court has devised a two-prong test to determine whether preemption of a state law is appropriate. A state law may be preempted if it both (1) "relates to" and (2) "purports to regulate," directly or indirectly, an employee benefit plan. Hydrostorage, 891 F.2d at 729; Local Union 598, Plumbers & Pipefitters Industry Journeymen & Apprentices Training Fund v. J.A. Jones Constr. Co., 846 F.2d 1213, 1218 (9th Cir.), affirmed, 488 U.S. 881

1/ ERISA contains some specific exceptions to this broad preemption provision. See 29 U.S.C. §1144(b). None of these exceptions apply to the instant case.

(1988). The parameters of this two-pronged test are explained more fully below.

1. State laws that "relate to" ERISA plans.

Generally, "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825, 108 S.Ct. 2182, 2185 (1988)(citation and emphasis omitted). A state law that directly affects the administration of ERISA plans is therefore preempted. Id. This is true even if the state law does not explicitly mention ERISA plans, and it is true even if the state law advances ERISA's underlying purposes. Id., at 2185-86 ("Legislative 'good intentions' do not save a state law within the broad pre-emptive scope of §514(a) [29 U.S.C. §1144(a)].").

Nevertheless, not every state law that touches on ERISA benefit plans will be preempted. "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983); see also Retirement Fund Trust, 909 F.2d at 1274; J.A. Jones Constr. Co., 846 F.2d at 1220. Thus, the Ninth Circuit Court recognizes that a "'neutral' state law of general application with a 'tangential' impact on a plan does not 'relate to' ERISA and is not preempted." Retirement Fund Trust, 909 F.2d at 1280-81.

2. Laws that "purport to regulate" ERISA plans.

The second prong of the Ninth Circuit Court's test for preemption of a state law under ERISA requires that the state law must "purport to regulate" the administration of ERISA plans. "A law purports to regulate a plan if it attempts to reach in one way or another the terms and conditions of employee benefit plans." Hydrostorage, 891 F.2d at 729 (citing J. A. Jones, 846 F.2d at 1218 and Lane v. Goren, 743 F.2d 1337, 1339 (9th Cir. 1984)). Although the criteria for judging whether a statute "purports to regulate" ERISA plans is not entirely clear, the case law reveals that the Courts must examine both (1) the plain language of the statute for explicit references to ERISA, and (2) the overall effects that the statute may have on administration of ERISA plans. See, e.g., Retirement Fund Trust of Plumbing, 909 F.2d at 1281; Hydrostorage, 891 F.2d at 730.2/

2/ Even though the words "purport to regulate" may imply that a statute's explicit purpose must be to affect an ERISA plan before it may be preempted, the case law clearly indicates that a statute may implicitly "purport to regulate" ERISA plans, and therefore may be preempted. The Supreme Court, in fact, consistently demands that the lower courts look at the effects of state laws on ERISA plans, even when the laws are outwardly silent with respect to ERISA. See, e.g., Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10, 13 (1987) (examining the possible effects of state law on employer's administration of ERISA plan, especially whether state law would unduly complicate plan administration); Metropolitan Life, 471 U.S. at 739 (recognizing that indirect state actions bearing on ERISA plans may encroach on areas of exclusive federal jurisdiction); Alessi, 451 U.S. at 525 (examining effects of workers' compensation law on employer administration of ERISA plan).

Thus, even though a state law may be outwardly silent with respect to its impact on ERISA plans, the law will be preempted--it will be held to "purport to regulate" ERISA plans--if it unduly influences the administration of ERISA plans. Ethridge v. Harbor House Restaurant, 861 F.2d 1389, 1404 (9th Cir. 1988) (ERISA preempts only those state laws affecting administration of covered plans); Nevill v. Shell Oil Co., 835 F.2d 209, 212 (9th Cir. 1987) ("[S]tate law is preempted if the conduct sought to be regulated by the state law is part of the administration of an employee benefit plan."). As the Second Circuit Court observed,

> What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit.

Howard v. Gleason Corp., 901 F.2d 1154, 1157 (2d Cir. 1990) (quoting Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 146 (2d Cir.), cert. denied, 110 S.Ct. 57 (1989)).

B. Preemption of §18-2-405, M.C.A.

Turning to the facts of this case, ERISA will only preempt §405: (1) if §405 "relates to" ERISA benefit plans, and (2) if §405 "purports to regulate," either directly or indirectly, ERISA benefit plans. Hydrostorage, 891 F.2d at 726; J.A. Jones Constr. Co., 846 F.2d at 1218. "A law 'relates to' an employee benefit plan . . . if it has some connection with or reference to such a plan." Mackey, 108 S.Ct. at 2185.

Clearly, §405 does not make explicit "reference to" ERISA plans. It speaks only generally of the need for non-union employers to pay "negotiated fringe benefits" as cash wages. For the same reason, §405 does not explicitly "purport to regulate" ERISA plans.

Because the language of §405 is silent with respect to its relationship to ERISA plans, the Court may only find that the state law is preempted (1) if it has some indirect, but significant, "connection with" ERISA benefit plans, and (2) if the overall effect of §405 is to influence the administration of such plans. In application, these two factors merge. The Ninth Circuit Court acknowledges that when a Court finds that a state law influences the administration of ERISA benefit plans, and thus "purports to regulate" them, the state law necessarily has a "connection with" ERISA plans. J.A. Jones Constr. Co., 846 F.2d at 1218. The Court will therefore focus its inquiry on the effects of §405 on the administration of ERISA benefit plans in Montana.

One effect of §405 on employers who are not signatory to collective bargaining agreements is to discourage their participation in ERISA plans. See Affidavit of Lloyd Lockrem, para. 17. Employers using non-union labor who wish both to comply with §405 and to participate on behalf of their employees in ERISA benefit plans must pay fringe benefits twice. Section 405 requires that they pay the fringe benefits in cash wages; ERISA contemplates that the employer will pay

the fringe benefits as contributions to welfare and pension plans. Thus, non-union employers who comply with state law and who participate in ERISA plans are inevitably placed at a competitive disadvantage compared to employers using union labor. See Affidavit of Joel T. Long, para. 11. Their costs of providing fringe benefits is higher.3/

"A statute which mandates employer contributions to benefit plans and which effectively dictates the level at which those contributions must be made has a most direct connection with an employee benefit plan." J.A. Jones Constr. Co., 846 F.2d at 1219 (emphasis added). Because §405 is a mandatory statute and participation in ERISA plans is voluntary, non-union employers faced with paying fringe benefits twice as a result of the state law will choose not participate in ERISA plans if they want to remain competitive with employers using union labor in bidding for public works projects. See Affidavit of Joel T. Long, para. 23. Thus, although §405 does not mandate specific employer contributions to ERISA benefits plans, it does "effectively dictate the level at which those contributions" will be made by employers using non-union labor: The level of contribution will be zero.4/

3/ Both the State and the Unions explicitly recognize that §405 effectively compels employers using non-union labor to pay fringe benefits twice, if they also wish to contribute to ERISA plans. See Commissioner's Brief in Support of Motion for Summary Judgment, at 6; Brief in Support of Unions' Motion for Summary Judgment, at 12.

4/ A drop in non-union employer contributions to ERISA plans is a simple, straightforward economic consequence of §405,

Because §405 will cause non-union employer contributions to ERISA benefit plans to drop, §405 will significantly influence and directly affect the administration of some ERISA plans--it may even cause some plans to fail for lack of funding. This will have a direct effect on "the primary administrative functions of [ERISA] benefit plans." Howard, 901 F.2d at 1157. The Court therefore finds that §405 has a "connection with" and implicitly "purports to regulate" ERISA plans. For this reason, the Court holds that §405 is preempted to the extent that it requires employers who are not signatory to collective bargaining agreements to pay those fringe benefits in cash wages that they would otherwise contribute to ERISA employee benefit plans, as defined by 29 U.S.C §1002 and elsewhere in ERISA.

The Court also believes that preemption of §405 is warranted on a separate ground. Because §405 permits employers who are signatory to collective bargaining agreements to make

4/ not an unsubstantiated fact, as the State and Unions argue. Furthermore, the Court rejects the State's and Unions' contention that §405 should not be preempted because its primary effect is to raise the cost of doing business for employers who use non-unionized workers, and that this is not a sufficient reason for preemption. While §405 may in fact raise some employer costs, it will necessarily have a direct effect on employers' contributions to ERISA plans as well. Because of the double payment problem, employer contributions to ERISA plans will inevitably drop. This effect on the plans themselves, not the employers' costs of doing business, constitutes the Court's principal concern.

fringe benefit contributions to ERISA benefit plans without incurring extra cash wage costs, the Montana statute creates: (1) incentives for employers to sign collective bargaining agreements to reduce the cost of paying fringe benefits under both ERISA and §405, and (2) incentives for employees to unionize so they are not subject to higher income taxes on fringe benefits paid only as cash wages. See General Electric Co. v. New York State Department of Labor, 891 F.2d 25 (2d Cir. 1989), cert. denied, 110 S.Ct. 2603 (1990) (fringe benefits paid as cash may have less value to employees than ERISA plan contributions). Standing alone, ERISA itself favors neither employer-created ERISA benefit plans nor union-sanctioned ERISA plans; the federal statute is neutral. The effect of the Montana law is to advance a goal that Congress has not endorsed in ERISA: it turns ERISA's employee protection provisions into a mechanism to foster a more heavily unionized workforce. Congress clearly did not have this goal in mind when it passed ERISA. See generally H.R. Conf. R. No. 93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 5038, 5038-39 (ERISA designed to regulate administration of all private pension plans uniformly). For this reason, the Court believes that §405 must also be preempted. Fort Halifax Packing Co., 482 U.S. at 8 (purpose of Congress is the "ultimate touchstone" in ERISA preemption analysis); Shaw, 463 U.S. at 98 (ERISA preempts those laws affecting the underlying

purpose of the Act).5/

In finding that ERISA preempts §405, the Court rejects the State's and the Unions' argument that §405, as part of Montana's prevailing wage statute, is a neutral law of general applicability. These parties argue that the fundamental purpose of the statute is to ensure that "all workers receive the same contribution toward fringe benefits, regardless [of] whether a collective bargaining agreement, an employment contract or a benefit plan exists." See Brief in Support of Commissioner's Motion for Summary Judgment, at 7. Thus, the State and Unions maintain the §405 is analogous to a minimum wage law, and merely represents an exercise of Montana's traditional police powers. In short, they argue that §405 is a "neutral" statute, that has only an incidental effect on ERISA plans, if, in fact, it has any effect at all.

The Court generally agrees that Montana's prevailing wage statute is not preempted by ERISA. Section 18-2-403(2), M.C.A., for example, requiring public works contractors to pay their employees the "standard prevailing wage" including fringe benefits, is a valid expression of the state's interest in protecting local wage standards. As mentioned above, "Congress

5/ The Court recognizes that §405 was originally enacted in 1931, well before Congress passed ERISA. Nevertheless, ERISA's preemption provision applies to "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Retirement Fund Trust, 909 F.2d at 1269 (quoting 29 U.S.C §1144(a)).

did not intend to preempt areas of traditional state regulation" in passing ERISA. Metropolitan Life, 471 U.S. at 740.

Nevertheless, §405 goes beyond a traditional manifestation of Montana's police powers and is not a "neutral" statute. By its very terms, §405 treats the fringe benefit contributions of employers using union labor differently from the fringe benefit contributions of employers using non-union labor: "Whenever the employer is not [a] signatory party to a collective bargaining agreement, those moneys designated as negotiated fringe benefits shall be paid to the employee as wages." Mont. Code Ann. §18-2-405. Section 405 clearly discriminates between employers using a unionized workforce and employers using non-union labor. The Court therefore rejects the State's and Unions' contention that ERISA does not preempt §405 because it is a neutral law of general applicability.

Conclusion

ERISA preempts any state law that "relates to" and "purports to regulate," either directly or indirectly, employee health, welfare, and pension plans. The Court finds as a matter of law that §18-2-405, M.C.A., discourages fringe benefits contributions to ERISA plans by employers using non-union laborers. As a consequence of these lower contributions, the administration of ERISA plans in Montana will be directly affected. Thus, §405 has a sufficient

connection with, and effect on, the administration of ERISA benefit plans to warrant preemption under 29 U.S.C. §1144(a).

Furthermore, by allowing employers using unionized labor to contribute freely to ERISA plans, while requiring employers using non-unionized laborers to pay fringe benefits in cash before making ERISA plan contributions, §405 turns ERISA's provisions into a device to promote unionization of Montana's workforce. Congress expressed no such preference for union labor in passing ERISA, and Montana law cannot indirectly inject such a goal into a federal statutory scheme. Section 405 must be preempted for this reason as well.

In so ruling, the Court limits the preemptive effect of ERISA to those fringe benefits that implicate the concerns of the federal statute--employee welfare benefit plans and employee pension plans. Montana may still require those employers who are not signatories to collective bargaining agreements to pay other fringe benefits as cash wages.

For the foregoing reasons,

IT IS ORDERED that plaintiffs' Motion for Summary Judgment be and hereby is granted. Section 18-2-405, M.C.A., is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144(a) to the extent that it requires employers who are not signatories to collective bargaining agreements to pay as cash wages any health, welfare, and pension benefits that they would otherwise contribute to

federally approved ERISA benefit plans, as defined by 29 U.S.C. §1002 and elsewhere in ERISA.

IT IS FURTHER ORDERED that defendant's and defendant-intervenors' Motions for Summary Judgment be and hereby are denied.

The Clerk is directed forthwith to notify counsel for the respective parties of the making of this Order.

Done and dated this 19th day of February, 1991.

James F. Battin
Senior U.S. District Judge

ORDER\8967\02

AO 450 (Rev. 5/85) Judgment In a Civil Case

FEB 20 1991

EXHIBIT 21

DATE 3-8-95

SB 330, HB 466

FILED, ENTERED AND NOTED IN CIVIL DOCKET
FEB 25 1991
LOU ALEKSICH, JR., CLERK
By [signature] Deputy

United States District Court

DISTRICT OF MONTANA - Billings Division

UNITED INDUSTRY, INC. and its subsidiaries, and SILLIAM LEE WIX,
Plaintiffs,

vs

THE MONTANA DEPARTMENT OF LABOR AND INDUSTRY and its Commissioner MIKE MICONE,
Defendants.

JUDGMENT IN A CIVIL CASE

CASE NUMBER: CV 89-67-BLG-JFB

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

THAT PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT IS GRANTED, AND THAT DEFENDANT'S AND DEFENDANT-INTERVENORS' MOTIONS FOR SUMMARY JUDGMENT ARE DENIED.

FEBRUARY 25, 1991
Date

LOU ALEKSICH, JR.
Clerk

[signature]
(By) Deputy Clerk

Exhibit #22
3-8-95

MCA HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

Including
Dental and Vision Benefits

for YOU and YOUR
dependents

July 1, 1994

The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Exhibit #23

State of Montana

Marc Racicot, Governor

EXHIBIT 23
DATE 3-8-95
SB 330, HB 466

Department of Revenue
Mick Robinson, Director

Income and
Miscellaneous Tax Division
Jeff Miller, Administrator

DATE: March 8, 1995

TO: Senator Steve Benedict, Chairman
Joint Select Committee on Health Care Issues

FROM: Robert Turner, Bureau Chief
Income & Misc. Tax Division

RE: Medical Savings Accounts

In my testimony on Tuesday, March 7, I addressed several policy areas that need to be considered by the committee when reviewing House Bills 560 and House Bill 531. These are as follows:

* **Effective Date and what tax years the bill apply to.** This has been addressed in Representative Simon's proposed amendments of HB 560.

* **Whether or not a taxpayer should receive a double benefit.** If a medical savings account is used for medical expenses or insurance premiums, those expenses should not also be allowed as an itemized deduction. This has been addressed in Representative Simon's proposed amendments of HB 560. However, if the income is rollover and allowed to be taken as a deduction for an individual retirement account, there is a double benefit. This has not been addressed.

* **Any losses incurred in a medical savings account should not be allowed.** Since the income that produced the loss was not taxed, the loss from the account should not be allowed to offset any other taxable income. Otherwise this would be a double benefit. This has been addressed in Representative Simon's proposed amendments of HB 560.

* **Have a clear maximum amount that a person can deduct in a medical savings account per year.** It would be easier for taxpayers, tax preparers, account administrators and the Department if there was a maximum amount that a person could exclude to a medical savings account.

Attached are amendments are proposed amendments and I will be glad to work with the committee to develop any others they desire.

Amendments to House Bill 560
Introduced Copy

Prepared by Department of Revenue
3/ 8/95 2:32pm

1. Page 5.
Following: line 11
Insert: "6) If annual contributions to the account exceed the $ 3,000 tax exclusion provided for in [Section 4], the account administrator shall provide an annual statement to the account holder showing the gain or loss for the year on the amount of contribution in excess of the annual tax exclusion."

REASON FOR AMENDMENT: These amendments would provide individual account holders with documentation of losses they may claim for tax purposes. Under the terms of the bill, an account holder is not allowed a deduction for contributions which fall within the $3,000 annual tax exclusion. However, an employer or account holder may contribute more than $3,000 during a year to a medical savings account. For example an account holder may elect to contribute $10,000 during a given year to such an account. In that event, if the investments made by the account administrator resulted in a loss during the tax year, the account holder would be entitled to claim a loss in excess of the $3,000 exclusion, or in other words the loss concerning the remaining $7,000 could be an allowable deduction. This amendment would give the account holder the documentation to properly track and claim that deduction.

** This amendment is incorporated in Representative Simon's amendments to House Bill 560, prepared by David Niss, as amendment number 11.

EXHIBIT 23
DATE 3-8-95
SB 330, HB 466

Amendments to House Bill 560
Introduced Copy

Prepared by Department of Revenue
3/ 8/95 2:28pm

1. Title, line 9.
Following: "PENALTIES;"
Strike: "AND"

2. Title, line 10.
Following: "15-30-111, MCA"
Insert: "AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE"

3. Page 8.
Following: line 14
Insert:

"NEW SECTION. **Section 10. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 11. Retroactive applicability.** [This act] applies retroactively, within the meaning of 1-2-109, to tax years beginning after December 31, 1994."

REASON FOR AMENDMENT: These amendments provide an immediate effective date and retroactive applicability date.

** These amendments are incorporated in Representative Simon's amendments to House Bill 560 that were prepared by David Niss as amendments numbers 2, 3 and 28.

Amendments to House Bill 560
Introduced Copy

Prepared by Department of Revenue
3/ 8/95 2:25pm

1. Page 7, line 13.
Following: "taxpayer"
Insert: "provided the amount does not exceed $3,000 for each medical care savings account"

REASON FOR AMENDMENT: To provide a specific limitation on the amount of contribution to a medical care savings account that may be excluded for tax purposes. This amendment will ensure easier administration of such accounts for income tax purposes.

** This amendment was <u>not</u> incorporated in Representative Simon's amendments to House Bill 560.

Exhibit #24

EXHIBIT 24
DATE 3-8-95
SB 330, HB 466

AMERICAN HEALTH LINE
50-STATE REPORT ON HEALTH REFORM ACTIVITIES
WINTER 1995

With the help of our sources, who were very generous with their time, AHL is pleased to provide you with our fourth overview of state health reform activity. The compilation is intended to provide highlights rather than be all-inclusive. If you know of other activities or efforts that should have been included, please let us know.

In the past, we have received many requests for permission to distribute copies of our update. The answer is "Yes!" but please be sure to cite "AMERICAN HEALTH LINE, Alexandria, VA, 703-518-8700" on all copies and let us know if your distribution will be more than 10 copies off-site.

This supplement to the AMERICAN HEALTH LINE was prepared by Sharon Schieffer, Clay Seigle, Jessica Liberman and was edited by Sara Knoll and Marla Bolotsky. For further details on these and other initiatives, search APN/ACCESS.

ALABAMA

1995 POLITICAL LANDSCAPE: The previous governor, Jim Folsom, is a Democrat.

GOVERNOR	HOUSE	SENATE
Fob James (R)	74 Democrats	23 Democrats
(elected '94)	31 Republicans	12 Republicans

Gov. Fob James (R)
State Capitol
600 Dexter Avenue
Montgomery, AL 36130
(205) 242-7100

Dept. of Health
Normandale Shopping Center
Montgomery, AL 36111
(205) 613-5300

Dept. of Insurance
135 South Union Street
Montgomery, AL 36130
(205) 269-3550

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624
(205) 242-5600

Health Care Reform Task Force
144 Normandale Arcade
Montgomery, AL 36111
(205) 613-5318

LEGISLATIVE SESSION: 4/18 - 7/31.

TASK FORCE/STUDY GROUPS: The Health Care Reform Task Force, which was formed by the State Committee on Public Health to make recommendations to the governor, has six subcommittees that have been meeting to address issues including increased access for rural residents, improved data collection, insurance reforms, a health purchasing cooperative, cost containment and workforce training. The task force is expected to finalize its report by the end of January; its recommendations will then be sent to the State Committee of Public Health and then to Gov. Fob James (R).

MEDICAID REFORM: Alabama has applied for a 1915(b) waiver to enroll Medicaid recipients in two Birmingham-area counties in managed care plans and to use the savings to expand eligibility. HCFA requested additional information last year on the managed care providers that would be delivering care. The state is also drafting a waiver for a similar program in Mobile. Both

The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Exhibit #25

EXHIBIT 25
DATE 3-8-95

A MARKET-BASED SEQUENTIAL HEALTH CARE REFORM PLAN FOR MONTANA

State of Montana
Health Care Authority
Report to the Governor
and Legislature

December 16, 1995

The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Exhibit# 26

EXHIBIT 26
DATE 3-8-95

Designing a Health Purchasing Pool for Montana

A Report on the Merits and Possible Design Features of a Collective Arrangement for Purchasing Health Coverage for Smaller Employers and Individuals

Montana Health Care Authority
28 North Last Chance Gulch
P. O. Box 200901
Helena, Montana 59620-0901
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1-800-733-8208
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The original of this document is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Shirley Rasmussen

Exhibit #27

EXHIBIT 27
DATE 3-8-95
SB 330, HB 466

Dear Committee -

I have further to say as I have heard other statements.

The person from Health Ins. Assoc. of Am. - Statement about this bill being "positive social goals".

My statement: we already know the costs of "positive social goals". Our taxes are ridiculous & we are trying to pay for all this welfare and "positive social goals".

The Man from Assoc. of Life Underwriters. Committee on NAIC ~~made~~ created model plan.

My comment: again here is the Washington D.C. think tanks writing laws for us. The people of America has sent a resounding statement to Washington D.C. that they do not ~~want~~ want government involved in our healthcare - so here comes Washington through the back door to the states to do their dirty work.

His ending statement: "I'm confident we can get there!"

My Comment: Get where?

What is beyond tonight. Will the next step be mandatory employers providing insurance for employees. When Small Business start dropping coverage, will they mandate our coverage? If

these quotes I've shown you are illegal and their underwritten plans must cost more, what

does that say for costs of all plans?

I just asked the Vice Chairman of the authority, how they spent $1 million? He said "mostly consultants - consultants from Washington D.C.

My Comment: Just like I said, you are listening to the think tanks of Washington D.C. You are NOT hearing

what people like me are paying - We cannot pay the price!

I dispute Mark O'Keefe's claim that this bill is written by "Consumers" - If his "Consumers" are like the person he kept quoting from Washington D.C., I dispute his definition of "Consumers".

Again in dispute of Mark O'Keefe's statements: All of the example of rate quotes I gave you, shows me (and you) that the Standard Plan IS creating a sick peoples pool! All of the underwritten quotes given to me were less in cost than the Standard Plan - Only the sick people get a quote from the Standard Plan -

As Susan Good showed you with reality numbers - the uninsurable represent 2% of those applying for insurance - You are going to rewrite laws and create a bureaucracy for 2% of the people?! I'm incredulous!

You already have the Comprehensive Health Asso. Benefits - just increase the benefits and create ways to subsidize payment - Don't start another Workmen's

Comp type of fiasco!

Mark O'Keefe said noone has challenged that they have done what the legislature directed them to do ~~with~~ in '93 with SB 285.

I challenge that fact. Every legislator that I have talked to, thought they were only creating a discussion group & with the passage of this bill. This Bill went far beyond what they understood was going to happen.

Leave reform to Insurance Companies - It looks to me like plenty of companies are reforming and meeting our needs with cost controlled - Why doesn't B/C/BS want to reform. It is not a question of the legislature to decide what level of benefits there should be. That question is up to the individual and what he is willing to pay for.

Don't listen to MaryBeth! Listen to your own people.

Only those people attracted to

EXHIBIT 27
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the Standard Plan are those people who do not understand the plan or those who are sick -

I hope you'll listen to Montana - Not Washington!

Exhibit # 28

EXHIBIT 28
DATE 3-8-95
SB 330, HB466

Council for Affordable Health Insurance

FULL COVERAGE

of state health reform legislation

March 3, 1995 Volume 3, Number 5

STATE UPDATE:

Iowa, Wyoming First To Enact Health Insurance Bills

Health insurance reform bills have been signed into law in Iowa and Wyoming. They are the first states to enact insurance reforms in 1995.

Iowa Governor Terry Branstad (R) signed an individual reform bill (SF 84) into law March 2, and Wyoming Governor Michael Sullivan (D) signed SF 34, a small group bill, on February 21.

Iowa SF 84 contains the following provisions:

- Insurers must make available a basic and standard plan to individuals who either have qualifying existing coverage or have experienced a qualifying event within the preceding 30 days.
- Guaranteed renewability.
- Industry-run reinsurance mechanism.
- 100% deductibility for individuals and the self-employed.
- 2-1 rate limitation between blocks of business issued after the effective date of the act.

Highlights of Wyoming SF 34 include:

- Continuation of coverage requirements.
- Guaranteed renewability.
- Uniform claim forms.
- 12/6 pre-existing condition exclusion limitation. Carriers must credit prior coverage if continuous to 90 days prior to the effective date, exclusive of any waiting period.
- Change in the definition of a small employer from 2-25 to 2-50.

Note: Summaries of these bills will be available to full members of CAHI through HotWire (State Conference).

IN THIS ISSUE . . .

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From: Rep. ORR

IN OTHER NEWS . . .

Arkansas: A small group guaranteed issue bill (HB 1354) is pending in the House Insurance and Commerce Committee. The bill would apply to employers of 50 and less, including self-employed individuals. The legislative session has been dominated by debate over any willing provider legislation (SB 299/HB 1564), which was signed into law by Governor Jim Guy Tucker (D) March 1. A high risk pool for the medically uninsurable is also being considered (SB 274).

Indiana: Two insurance market bills have passed their houses of origin. HB 1009 passed the House 2/15 and SB 576 passed the Senate 2/20. HB 1009 contains portability, a 9/9 preexisting condition exclusion limitation, and continuation of coverage provisions. Both bills provide for the establishment of medical savings accounts.

Missouri: SB 318, which contains community rating and mandatory conversion to five state designed benefit plans, was heard in the Public Health and Welfare Committee February 22 and 23. No action was taken.

North Carolina: Four bills (HB 287-290) based on the recommendations of the Health Planning Commission have been introduced. The insurance reform bill is HB 289. It would reduce pre-existing condition exclusion limitations from 1 year to 6 months, provide for portability, require insurers to offer three standard insurance packages, eliminate gender as a rating factor, and subject individual policies to modified community rating. Medical malpractice reforms and Medicaid expansion are also addressed in the package.

North Dakota: HB 1050, which originally contained all of the recommendations of the ND Health Task Force, has been scaled back. Medical savings accounts and guaranteed issue for all small group and individual products have been deleted. The bill retains rating restrictions, Medicaid expansion, and medical malpractice reform. HB 1050 was approved by the House February 15 on a 97-0 vote.

Utah: Governor Mark Leavitt's (R) health care reform bill, HB 305, passed the Legislature before it adjourned March 1. Among other provisions, the bill contains MSAs and open enrollment for individuals and small employers. Amendments were made to delay the effective date for individual open enrollment to May 1997 and decrease the guaranteed issue cap to one quarter of 1 percent per insurer.

Virginia: The Virginia General Assembly approved legislation to give the commonwealth the authority to establish the VA Medical Savings Account Plan February 25. Implementation of the plan is contingent on the passage of federal MSA legislation. The legislation directs various departments to develop parts of the plan. For example, the Department of Medical Assistance Services is required to develop a MSA demonstration project to provide health care services to the working poor and individuals eligible for medical assistance services.

Washington: In response to House Republican's Health Care Reform Improvement Package (SHB 1046), Senate Democrats developed their own proposal, SB 5935. SB 5935 changes some provisions of the WA Health Services Act of 1993, but does not go as far as SHB 1046. The Senate Democrat plan eliminates the employer mandate, but retains premium caps and a "minimum list of benefits" (instead of a uniform benefit plan). SB 5935 was amended and passed by the Senate Health and Long Term Care Committee February 27. The bill is now referred to as PSSB 5935.

Wisconsin: Medical malpractice reform is moving through the Legislature. Bills to cap pain and suffering awards at $350,000 (AB 36), eliminate joint and several liability, and tighten when punitive damages can be awarded (SB 11) are likely to pass. AB 36 has already passed the Assembly.

PENDING LEGISLATION:

Legislative Calendar Update:

Three states have adjourned their 1995 regular sessions: **Virginia** (2/25), **Utah** (3/1), and **Wyoming** (3/2). **Georgia** and **South Dakota** are scheduled to adjourn in the coming week. The **Florida** 1995 General Assembly will convene 3/7.

Introduction deadlines have passed in the following states: AZ, CA, CO, GA, HI, IA, ID, IN, KS, MO, MS, MT, ND, NE, OK, OR, RI, SD, UT, VA, VT and WY. Introduction deadlines in **Arkansas** and **Maryland** are March 5 and 6, respectively.

TRACKING CHARTS

ARIZONA

3/3/95

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 2096		HIPCs	X	X				1/10 introduced. In Banking & Insurance and Health Cmtes.
HB 2145		Gtd. issue					Gtd. issue basic plan to individuals & grps. of 2.	2/22 Committee amendment adopted on House floor.
HB 2146							Provisions for late enrollees.	1/31 passed Banking & Insurance. In Rules Committee.
HB 2284						X	Assesses a penalty for non-medical withdrawals.	2/22 do pass from Senate Health Committee.
SB 1335					X			2/23 Committee amendment adopted on Senate floor.

CALIFORNIA

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
AB 8		GI for inds.					Small employer def. 1-100.	12/5 introduced.
AB 1266				X				2/23 introduced.
AB 1418			X				Limits geographic areas.	2/24 introduced.
AB 1758						X		2/24 introduced.
AB 1759					X			2/24 introduced.
SB 371		GI for inds.					Small employer def. 1-100	2/14 introduced; in Insurance.
SB 484						X		1/17 introduced; in Insurance.
SB 849			X				Effective date for risk adjustment factor.	2/23 introduced.
SB 1149						X		2/24 introduced.
SB 1210						X		2/24 introduced.

FLORIDA

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crd	MSA	Other	Status/Notes
SB 64				12 mo.			Portability	12/22/94 prefiled.

GEORGIA

3/3/95

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 616		Gtd. renew					Portability	
SB 23				X				1/26 passed Senate. In House Insurance Committee.
SB 220		Gtd. issue	Bands	X			Applies to Inds and small groups (2-25).	Referred to summer study committee.

ILLINOIS

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crd	MSA	Other	Status/Notes
HB 231		CHIP					Discounts/subsidies.	1/13 introduced; in Insurance.
HB 680		HIPCs						1/30 introduced; in Executive Cmte.

LOUISIANA

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 20							Freedom of choice of provider.	12/5 prefiled.

MARYLAND

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 8							Def. of employee, small employer.	1/11 introduced; to Economic Matters.
HB 189						X		1/26 introduced; in Ways & Means.

MICHIGAN

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 4016				X				1/11 introduced; in Insurance.
SB 1335	X							12/13 introduced; in Health Policy & Senior Citizens.

EXHIBIT 28
DATE 3-8-95
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MISSOURI

3/3/95

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 50	Single payer							1/4 introduced; in Public Health & Safety.
HB 58	X			X			5 standard plans; malpractice reform	1/4 introduced.
HB 291					X			1/17 introduced.
HB 297							Continuation	2/23 do pass from Science, Technology & Critical Issues Cmte.
HB 506					X		For self-employed.	2/21 heard in Ways & Means.
HB 682						X		2/23 introduced.
SB 259		Gtd. issue		X				1/19 introduced.
SB 300					X			1/25 introduced.
SB 318		Gtd. issue	Cmty rating	X			Individuals; sm. grp 3-500; 5 std. plans.	1/26 introduced; in Public Health & Welfare.
SB 375							May not deny b/c of credit history	2/6 introduced.

NEW JERSEY

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
AB 244					X		For LTC insurance	1/11/94 in Insurance Cmte.
AB 272							Expands standard plans	1/11/94 in Insurance Cmte.
AB 451		Pooling						1/11/94 in Insurance Cmte.
AB 689		Pooling						3/3/94 in Health & Human Services.
AB 1037					X			1/20/94 in Appropriations.
AB 1038					X			1/20/94 in Appropriations.
AB 1515							Inds: Cost sharing	3/10/94 in Insurance Cmte.
AB 2251						X		10/20/94 in Insurance Cmte.
AB 2452		Gtd. renew					Deletes a reason for non-renewal.	1/19 passed Insurance Cmte.
SB 689		Pooling						5/19/94 passed HHS Cmte. as amended.
SB 866							Expands eligibility to buy sm. grp. plans	1/19/95 from Assembly Insurance Cmte.

NEW YORK

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
AB 480							Rate stabilization.	1/4 introduced; in Insurance.
AB 1702					X		For self-employed.	1/24 introduced; in Ways & Means.
SB 69						X		1/4 introduced; in Insurance.

NORTH CAROLINA

3/3/95

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 236							Premium tax repeal	2/20 introduced.
HB 289			X	X			Subjects ind. plans to mod. cmty rating.	2/22 introduced; in Insurance Committee.

PENNSYLVANIA

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 5							Barebones	2/2 introduced; in Insurance Committee.
HB 420		Gtd. issue						1/31 introduced; in Insurance Committee.

SOUTH CAROLINA

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
SB 221							Ind. plans: benefits must be reasonable relative to premiums.	11/21 prefiled. In Senate Interim Cmte. on Banking & Insurance.
SB 228							Freedom of choice of m.h. provider.	Prefiled.
SB 279		High risk pool						Prefiled.
SB 283						X		Prefiled.

TEXAS

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 129						X		1/10 introduced; in Insurance.
HB 369							Amendments to HB 2055 (1993).	1/10 introduced; in Insurance.
HB 489							Continuation.	1/10 introduced; in Insurance.
HB 491				X				1/10 introduced; in Insurance.
HB 1292							Changes definition of small employer.	2/28 reported favorably out of Business & Industry Committee.

SPECIAL REPORTS:

1995 State MSA Legislation

STATE	BILL NO.	NOTES	STATUS
Alaska	HJR 18		2/15 passed Health, Education & Social Services Cmte.
Arizona	HB 2284	Amends '94 law. Assesses a penalty for non-medical withdrawals.	2/9 passed House. 2/22 do pass out of Senate Health Committee.
California	AB 1758		Introduced 2/24.
	SB 484		Introduced 1/17. In Insurance Committee.
	SB 1149		Introduced 2/24.
	SB 1210		Introduced 2/24.
Connecticut	HB 6137		Introduced 1/20. In Banks Committee.
Hawaii	SB 1234		Introduced 1/23. In Consumer Protection Committee.
Idaho	SB 1153		Introduced 2/13. In Commerce & Human Resources Cmte.
Indiana	HB 1009		2/15 passed House.
	SB 261		2/6 passed Senate.
	SB 576		2/20 passed Senate.
Iowa	HSB 51	Study bill.	Not formally introduced.
Kansas	HB 2010		2/28 passed House. In Senate Public Health & Welfare.
Maryland	HB 189		Introduced 1/26. In Economic Matters Committee.
Minnesota	HF 255	Health Care Opportunity Act contains MSAs.	Introduced 1/26. In Health & Human Services Committee.
	HF 270		Introduced 1/30. In Health & Human Services Committee.
	HF 301		Introduced 1/30. In Health & Human Services Committee.
	SF 238	Health Care Opportunity Act contains MSAs.	Introduced 1/30. In Health Care Committee.
Missouri	HB 682		Introduced 2/23.
Nebraska	LB 724	ALEC model bill.	Introduced 1/19. In Revenue Committee.
	LB 788	Governor's bill.	Introduced 1/19. In Banking, Commerce & Insurance Cmte.
New Jersey	AB 2251		Introduced 10/20/94. In Insurance Committee.
New York	SB 69		Introduced 1/4. In Insurance Committee.
Oklahoma	HB 1339		Introduced 1/11.
Oregon	HB 2391		Introduced 2/3.
Rhode Island	HB 5425		Introduced 1/25. In Finance Committee.
South Carolina	SB 283		Introduced 1/10. In Banking & Insurance Committee.
Texas	HB 129		Introduced 1/10. In Insurance Committee.
Utah	HB 305	Governor's bill contains MSAs.	Passed Legislature. Awaiting Governor's signature.
Vermont	SB 14		Introduced 1/4. In Finance Committee.
Virginia	HJR 541	Requests a study of MSAs.	2/4 passed House.
	SB 1035	Contingent upon Federal action.	2/25 passed Legislature. Awaiting Governor's signature.
Washington	HB 1046	Health Care Improvement Act includes MSAs.	2/13 passed House. In Senate Health & Long Term Care.
	SB 5935	Senate Democrat proposal includes MSAs.	2/27 passed Senate Health & Long Term Care Committee.
West Virginia	HB 2056		Introduced 1/18. In Government Organization and Finance.
	SB 55		Introduced 1/17. In Banking & Insurance and Finance.

Source: Christine F. Popolo, Council for Affordable Health Insurance, March 3, 1995.

UTAH

3/3/95

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 305		Open enrolmt				X	Governor's bill.	Passed Legislature. Awaiting Governor's signature.

VIRGINIA

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 2043				X				Passed Insurance Committee.
HB 2298				X				2/3 defeated on House floor.
HJR 541						X	Study	1/23 introduced; in Rules.
SB 1035						X		Passed Legislature 2/25. Awaiting Governor's signature.

WASHINGTON

Bill No.	Universal	Access	Rate Limit	Pre-X	Tax Crdt	MSA	Other	Status/Notes
HB 1028							Delays implementation dates.	1/9 introduced; in Health Care Cmte.
HB 1029							Makes UBP only a recommendation.	2/20 passed House. In Senate Health & LTC Committee.
HB 1046	Repeals mandates					X	Health Care Improvement Act	2/13 passed House. In Senate Health & LTC Committee.
HB 1079			X					1/11 introduced; in Financial Institutions & Insurance.
HB 1592					X			2/23 passed Financial Institutions & Insurance.
SB 5038							Delays implementation dates.	Signed by the Governor.
SB 5935	Must offer min. list of health services			X		X	Senate Democrat proposal	2/27 passed Health Care Cmte. w/ amendments.

DATE March 8, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: _____

PLEASE PRINT

Name	Representing	Bill No.	Support (Check One)	Oppose (Check One)
Maggie Hermann	MT Health Care Authority			
Mary McCue	MT Clinical Mental Health Counselors Assn			
Gloria Hermann	MT Psychol. Assn			
Connie L. Arens	MT Occupational Th. Assn	HB466		
Mark O'Keefe	State Auditor			
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS			
DEON KANO	NAPA Auto Parts			
JOHN VANDENACRE	INS. AGENT			
TOM EBZERY	YELLOWSTONE COMM. HEALTH PLAN BILLINGS			
M Sieson	NEAL MT			
Tom Hopgood	HHH Ins Assoc America			
Tanya Ask	Blue Cross Blue Shield MT			
Don Judge	MT STATE AFL-CIO			

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE March 8, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: _____

_____

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Oppose
Ed Captis	MSCA	SB295	✓	
Larry Petty	Ind Ins Rep			
Bob Buchanan for Linda Meeuts	Gallatin Med Assoc.	SB376	✓	
Sonny Lockran	Mont. Contractors Assn	376	✓	
Jerry Driscoll	mt State Building trades Employee Benefits Management	SB376 systems	✓	
John F Link	MT Hospital Assn.			
Brian Lins	MT. Medical Assn			
Jerome Lindsey	Mt. Med Assn			
Claudia Clifford	MT Insurance Commissioner	SB466	✓	
Ron Ashabraner	State Farm Ins.			
Ed Carney	M.M.S.P./Mont. St.			
SHIRLEY RASMUSSEN	myself			
Steve Brown	Blue Cross-Blue Shield			
Greg Gibson	MMBP			

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE March 8, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: _____

_____

< ■ > PLEASE PRINT < ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
Ron Kurik	Self			
Don Allen	MMBP			
Anita Bennett	Mt Logging Assn.			
Greg Van Horsen	State Farm Ins. Co.			
Gary Spaeth	State Auditor			
Eve Franklin EVE FRANKLIN	S.D. 21.			

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10