MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN STEVE BENEDICT**, on March 9, 1995, at 5:30 p.m.

ROLL CALL

Members Present:
Sen. Steve Benedict, Chairman (R)
Rep. Scott J. Orr, Vice Chairman (R)
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: Sen. Dorothy Eck (D)

Members Absent: None

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

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

Committee Business Summary:

Hearing:	This was a meeting where public testimony was given on HB 446, HB 531, HB 533, SB 322, SB 341, HB 85, HB 202, SB 62, SB 74, and SB 376
Executive Action:	None

{Tape: 1; Side: A.}

Public Testimony:

Kate Cholewa, representing Montana Women's Lobby, said on HB 446, page 3, defined at the top of the page "A health benefit plan may not define a pre-existing condition more restrictively that these items." In (b) it talks about an ordinarily prudent person seeking medical advice. On (c) they have pregnancy existing on the effective date of the coverage of the insured person. She said they would like to see pregnancy not treated any differently than other pre-existing conditions. An ordinarily prudent women

if they trace her date of pregnancy back to a week before her policy went into effect she is an ordinarily prudent person with a pre-existing condition who would have still sought medical advice for that condition. They would like to see pregnancy not treated differently.

Tom Hopgood, representing the Health Insurance Association of America, said he would like to address HB 446 and had amendments they would like to offer to that bill. **(EXHIBIT #1)** He said the amendments were mostly technical. On line 5, page 3, they think that would be a good idea to strike that so they do not write a pre-existing condition on pregnancy. He said the bill sets a pre-existing condition for a health benefit plan, look back for 3 years, exclude it, then for a period of 12 months. It is a little better than it is for other types of disability policies which are on the market. He said he had some amendments to propose. **(EXHIBIT #2)** He said this bill said once a pre-existing condition is covered under a health insurance policy they, can transfer their health insurance policy to another company and they would not have to satisfy the pre-existing condition again. There is a provision in HB 533, Section 3, page 2, which would address the spread of premium increases. When a person becomes ill some health insurance companies have taken that person's premiums and increased them because of adverse claims experience. In Section 3, the only thing that should increase an individual's policy is an increase in his/her age. Any other reasons to increase that policy have to spread across the entire market. The company cannot take revenge on a person for getting sick. The way the bill was originally written it would apply to group policies. The thought was that group policies were already sufficiently covered under the small group act. He said the amendments would take care of that. He said they had one amendment prepared for HB 531. **(EXHIBIT #3)** He said that amendment was on page 7, line 30, and has to do with the disclosure requirements. Health care insurers and producers are to provide, at the point of application, a set of materials continuing on page 8. They think that is a lot of material. What it appears they really want is a general history of what is going on with the premiums to particular policies. They feel by the company providing a general narrative of what has gone on with the companies premiums over the past 5 years would be sufficient for that. He said they were still discussing things between the interested parties.

Claudia Clifford, representing the State Auditor's Office and the Commissioner of Insurance's Office, said was going to address HB 446, HB 533, and SB 322. The goal is to address portability. They key to understanding portability is whether or not they can even get their next policy. She that is what the issue of guaranteed issue is about. These bills deal with pre-existing conditions. She said in current law, a pre-existing condition is a problem that has occurred, there is a medical diagnosis, it is something that is documented. In one of the bills they add a definition of what pre-existing means. It would be what any

prudent person would have sought treatment for. That makes it more difficult for the consumer. It is hard for them to seek recourse if they disagree with the insurance company. It is not in the best interest. There is the look back period issue. How far back in someone's history do they look back and say this is a condition which they are either not going to cover or treat differently. In current law it is a 5-year look back period. One of the bills says they would only look back 3 years, but it then deals with rider conditions. It segregates some of the pre-existing conditions. It says that some pre-existing conditions are bad enough that they will not only apply a 12 month waiting period, but they want to note those conditions in the contract and make them wait longer on getting coverage for that. That kind of rider condition in one of the bill says that they will not cover those conditions for 4 years. The insurance company would argue that if they could not rider some conditions, especially in individual policies, they would probably choose to reject that person all together. Riders are not currently dealt with in law. Riders are not allowed because they are not dealt with and all the law says is that if a person has a past medical problem they can only have a 12 month medical problem. They need to deal with riders somehow if they are going to be allowable. If a person has a condition that has not been ridered, the bills have what is an attempt to waive the 12 month waiting period. If a person has had previous coverage and they did not have much of a lapse in coverage they do not have to go through the 12 month waiting period. That is very important for portability and as a good move in the bills. One bill says that the lapse in coverage can be only 30 days and another bill says 60 days. There is also a difference as to when that applies. They recommended they put in the 60 days and that they make it to that date of application. The day of application is controlled by the consumer. Companies vary on how quickly they can issue policies. She said if the idea was not to restrict any more on a person when they are going to their next policy then riders do not do that. Currently, if they leave the bill unamended, insurance companies can look back in someone's past history back to birth and rider any condition. They recommended that they apply the same look back period to riderred conditions as they do to the other pre-existing conditions of 3 years. They acknowledge that there is a complex issue of riders when they move to another policy. Companies have different underwriting policies. The new company may want to rider a whole new set of conditions. When they had the first policy there was only one ridered policy and when they go to the next policy there may be 4 or 5 different riders. Do they want to allow that or do they want to address that there would be no more riders in the next policy. In response to a question regarding which bill she was referring to, **Claudia Clifford** replied essentially she was talking about all three bills at one time. She said they support the concepts in all three bills of improving pre-existing conditions and improving portability. She said with the issue of riders when going to a new policy they want to allow consider that if they have a rider condition on their first policy for 4 years and they have had that policy for

2 years, when they go to the new policy do they receive the same kind of credit that they got from pre-existing conditions and they only have to fulfill 2 more years of a rider condition. She said, dealing with the retroactive applicability of a bill they believe to retroactively to allow for riders is unconstitutional under contract law. She said she had a copy of the GOP health plan in the news. **(EXHIBIT #5)** She offered amendments to SB 322 **(EXHIBIT #5)**, HB 446 **(EXHIBIT #6)**, and HB 533 **(EXHIBIT #7)**.

Larry Akey, representing the Montana Association of Life Underwriters, said they supported HB 446 and HB 533 when they were before the House Select Committee on Health Care. They support the amendments proposed by **Tom Hopgood.** He said it is true that an ordinarily prudent person does add a new standard or reintroduces a standard to the statute on pre-existing conditions. He said they did not feel that was a necessary part of the statute when the look back period was 5 years. They felt it was important to bring that standard back in if the were going to change the look back period to 3 years. They believe the rider language as it is currently contained in HB 446 as amended in the proposed amendments by **Tom Hopgood** are good and solid rider exceptions. He said there was an issue of retroactivity. That is a danger that a force to find a retroactive application of the statute unconstitutional. However retroactive applicability does solve a major problem that was in the market and will remain in the market. Riders were commonly used in insurance policies prior to a departmental interpretation about 1 ½ years ago. There are a number of policies out there today that have riders on them. They are concerned without retroactive applicability that an insurance company in the future find itself in court over that rider. They suggest a better way would be to not strike the section on retroactive applicability and the question of its constitutionality is to add a section on severability. They think that would address the issue should the courts find that they cannot retroactively apply those provisions they would not have to throw out the entire statute. They support tax deductibility of insurance premiums. They asked that they treat individual premiums, premiums written by self-employed individuals in the same way they would treat health insurance premiums in a corporation or another business. They would like to see health care treated as a deductible expense from the first dollar across the board, but that would be very expensive. It is up to this committee and this Legislature to see how much tax fairness they can afford in the area of health care. He said HB 202 was the bill that addresses insurance premiums. They would at a minimum ask that they address HB 202. SB 376 is an effort to regulate multiple employer welfare arrangements (MEWA). He said there are two reasons that insurance agents care about the regulation of multiple employer welfare arrangements. One is that they have a direct impact with the way they do health care reform in the state of Montana. The tighter things are in the regulated market, the higher they raise the limit on the number of employees in a small employer group under the small employer act. He said the more likely it will be that they will see

leakage into the self-funded market because those self-funded plans are exempted from mandated benefits and other provisions of the state insurance code. He said to the extent that they have multiple employer welfare arrangements out there that are not regulated or are very weakly regulated they are concerned that any efforts they make to provide health care reform will only end up forcing people into the unregulated market and escaping all of the things the Legislature currently is trying to accomplish. Insurance agents that market products for unregulated MEWAS may be exposing themselves financially since they are selling products for what is essentially an unauthorized insurer. Their A and O coverage probably will not cover the consequences of any financial insolvencies. It is important for the agents who are offering MEWAS that they have some sort of regulation on the books so that exposure is not there. He said that SB 376 was considered the great compromise. He said there were 2 groups that were not involved in striking that compromise. There are groups that might like to form MEWAS, but under that bill they would be prohibited. Insurance companies and insurance agents were also not involved. He asked that they give SB 376 some scrutiny. He said the supporters of SB 376 would have the people believe that they did not have to accept any form of regulation and that ERISA wipes out any efforts of the state to regulate multiple employer welfare arrangements. He said it is true that they cannot touch a single employer self-funded plan. He said ERISA says they cannot touch fully-insured MEWAS. He said they cannot regulate them except by regulating the insurance companies that provide them insurance. They cannot touch MEWAS that have been exempted by the Secretary of Labor and there are none of those in Montana. They cannot touch MEWAS that are also employee welfare benefit plans. ERISA defines what an employee welfare benefit plan. MEWAS that are not also employee welfare benefit plans can be regulated by state insurance codes. They supported SB 376 in the Senate with promise to work to strengthen it. There are three areas that the committee should look at. SB 376 sets up a dual track. It says that 4 MEWAS that currently exist. For MEWAS asking for a certificate of authority do not have to comply with demonstrating to the commissioner that they are financially solvent. New MEWAS do have to do that. SB 376 sets up a bona fide association as one of the requirements of being a MEWA. That says they can not form a new bona fide association and create a MEWA for 5 years. The bill creates certain exceptions and exemptions from the insurance laws. The compromise does provide some coverage by the insurance laws. He said on page 8, section 14, title 33, chapter 8, of SB 376, they say that they are going to comply with that except for the fact that they do not want to comply with 33-18-242. 33-18-242 is the section of the statute that gives an individual that has been injured by an insurance company an independent cause of action. They think if it is good for the insurance companies it is good for multiple employer welfare arrangements that are not also employee welfare benefit plans. They ask that they would also consider extending some of the sections of the insurance code to MEWAS. They have said in SB 376 that they are willing to subject

themselves to examinations, but not to approval of forms. It seems that they need both. They exempt themselves from contract language. One of the sections they are willing to comply with is privacy and information chapter. All of those are things the committee should look at and they would submit amendments in those areas. They think there should be some disclosure to the people who are receiving their health care through multiple employee welfare arrangements. They think a MEWA should disclose on the face of the policy or contract that it has with its insured that it is a multiple welfare arrangement that is not an insurance company and that it is not covered by all the guarantees of the statute affecting insurance companies and it is not covered by the guarantee association. He said they are issues they need to address if they are going to report out SB 376. They can either make it clear that SB 376 only applies to those MEWAS that are also employee welfare benefit plans and that all the laws of insurance in Montana affect those MEWAS that are not also employee welfare benefit plans or they can work to tighten up SB 376 in the ways he recommended.

Susan Good, representing Heal Montana, read her written testimony. **(EXHIBIT #8)**

Tanya Ask, representing BlueCross BlueShield of Montana, said they supported HB 446 and agree with the proposed amendments. They support HB 533 and agree with the proposed amendments. She said riders were important because in the individual market place is not a guaranteed issue market place. Riders allow individuals that might not get coverage to be able to get coverage for everything else accept that riderred issue. She said they supported the retroactive applicability. They feel there are problems due to the way that particular provision had been interpreted over the last year. She said she would like to comment on having portability of the riders. She said under riders, those individuals are not guaranteed issue. Even though that would allow portability in the individual market it does not say that say that an insurance company would necessarily going to take that risk. Insurance companies have different underwriting criteria. One may accept someone with a rider and anther may not accept that without a rider. She said she said the Comprehensive Health Care Authority is a pool of last resort. They have been in the process of making the benefits better under state law. She said they were trying to move those benefits up. She said that they would like to do that and they are asking to keep the potential cost in mind. They would like SB 341 that contains other provisions that the board felt changes were necessary to in order to make the operation more viable. Tax deductibility will be decided on the overall financial constraints on Montana. She said they have endorsed HB 202 dealing with strictly the deductibility of premiums for individuals. She said this was an area of concern by small businessmen who had their own individual contracts. They would like the same benefit as larger groups have. She said they would support SB 376 with the attached amendments. They would like those types of arrangements to be on

equal footing. There are already new potential to be on equal footing with those already in the self funded multi-employee welfare arrangement market place. The amendments provide basic protection such as privacy protection, newborn coverage and other things that Montana's previous legislatures have felt were important. ERISA qualifying MEWAS are precluded from some portions of state law, but not every single MEWA is.

{Tape: 1; Side: B; Approx. Counter: .1; Comments: Tanya Ask was cut off while she was talking.}

She said this legislation grants a certificate of authority. That is a license to be an insurer. When they are licensed as an insurer, consumers think it is an insurance company that is subject to all of the regulations of the state and the protection are afforded thereby. She said they were concerned with the certificate of authority. She asked that they take a look at the way it was written because they feel it may preclude some people from becoming a MEWA until the have been a bona fide association for a period of 5 years. She said there are things that people feel they cannot live with under the insurance regulation. She said one of those things was a form filing requirement. The insurance department reviews the benefit agreements that Montana consumers would receive. Another was how the contract would be laid out so that people would have an idea what the benefits under that contract would be. Another was a law that regulated how insurance companies, health service organizations, HMO's, and others conduct utilization review. She said there were very strict requirements put on there for the benefit of Montana consumers. They asked that the particular set of amendments be given careful consideration.

Tim Filz, a attorney with the Brown law firm in Billings and represents an number of MEWAS, he said he would talk about SB 376. He said a MEWA was a Multiple Employer Welfare Arrangement. Any time two or more employers get together and provide welfare benefits for their employees that is a MEWA. He said the exception to that is if the employers are related or controlled entities. He said ERISA says that state law cannot regulate employee welfare benefit plans. ERISA says that not withstanding that prohibition states can regulate insurance companies. The states can heavily regulate insurance companies even though there is an impact on a welfare benefit plan. Any employer that adopts a plan to provide health benefits for its employees is a welfare benefit plan whether that is fully insured or self funded. The state or the federal government says that Montana cannot directly regulate any employer to the extent that they provide welfare benefits to their employees. The federal government says that the state can regulate the insurance companies. The federal government says that the states can regulate multiple employer welfare arrangements to the extent that those requirements are not inconsistent with ERISA. ERISA says that under no circumstances can the state label, call, or describe a welfare benefit plan as an insurance company. That means if they have a

welfare benefits plan, it is not an insurance company and it can not be regulated as an insurance company. A single employer or certain types of multiple employer plans are also welfare benefit plans. He said the MEWA bill in defining what entities are allowed to register as MEWAS is limited to those kinds or arrangements which would qualify under ERISA as welfare benefit plans. A welfare benefit plan which would involve multiple employers is limited to arrangements that are either single industry, of if there is a bona fide employment-related bond between the employers. He said if there is that kind of relationship, then they would be a welfare benefit plan under ERISA entitled to ERISA pre-emption.

ERISA says you can regulate MEWAS if they do not violate ERISA and if they are not called insurance companies. That is the reason they allow a little bit of regulation, not a lot. He said they can be regulated if they are done consistent with the fundamental concepts and not inconsistently with ERISA. With the MEWA legislation they have defined what MEWAS are which is not currently done. They provide for a certification process. MEWAS that do not come through the process are going to be ruled unauthorized insurers. The bill provides for minimum reserves and for minimum funding. That is very crucial. It provides for reporting requirements. The act provides for penalties for MEWAS that do not comply and provides for remedies in the form of liquidation procedure for a MEWA. They agree to that regulation because it will ensure that only good, viable, healthy MEWAS exist. He said there is a dual tract because there are a number of MEWAS out there and they are not sure how many individuals are being provided benefits under existing MEWAS. They think that by coming up with some rules, such as an association must be in existence for at least 5 years prior to sponsoring a MEWA. They think that is a sound rule, but would like it to be around 2 or 3 years. They exempted existing MEWAS because if there is a MEWA that was formed 4 ½ years after the association was formed and was providing benefits to 500 individuals, are they going to say that they were going to disallow that MEWA that otherwise would meet the requirements. He said they need to say that the ones that were in existence before then can meet the requirements they will allow them to exist. They do not want to encourage the rush to form MEWAS. They are not strongly against disclosure. He said the kind of language in 33-11-1047 with respect to risk retention groups is probably an appropriate type of language to use. He said that they did agree to have all of the Fair Practices Act provisions incorporated into the MEWA bill except for the private cause of action. That is because ERISA provides a private cause of action for individuals agreed by a welfare benefit plan. He said the states can regulate MEWAS, but if it is inconsistent with ERISA. ERISA provides a comprehensive private cause of action and in having done that it is inconsistent for the state to have to create an independent private cause of action. There are things that are allowed under ERISA that are not allowed under a claim against an insurance company.

Lloyd Lockrem Jr., representing the Montana Contractors Health Care Trust, said he would like to address section 33-18-242. He said the primary function of ERISA is to protect the participant once an employer has decided to have employee benefits. He said ERISA does require full disclosure. He said "U.S. district courts have exclusive jurisdiction over civil and criminal action brought under Title 1 of ERISA. Except that cases pertaining to benefit recovery brought by participants may also be brought in state courts. U.S. district courts have jurisdiction to grant relief without respect to the amount in controversy or the citizenship of the parties. The court may decide who shall pay the court costs and legal fees. If you as a participant are successful the court may order the person you have sued to pay these costs. If you lose the court may order you to pay these costs and fees for example that finds your claim frivolous. In addition to creating rights for the plan participant, ERISA imposes duties upon the people who have the responsibility for the operation of the employee benefits plan. The people who are on the plan are called your fiduciaries of the plan and have a duty and in the interest of you and other planned participants. No one else including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA." He said they have set up a review procedure and each time they sit, they sit not as an employer, but as a trustee representing the participant. Legal action to recover lost benefits under this plan may not be brought until they have gone through the administrative procedure. They do not have to appear, but they always have that right. He submitted if and when the insurance industry provides employee benefits at affordable costs to employers in Montana who genuinely want to provide benefits, particularly health care, MEWAS will go away. He said they would commit to the committee if there was any possibility to resolution between the parties they would pledge to work towards that.

Jerry Driscoll, said he had heard a statement made that it was not known if there was any plan approved by the Secretary of Labor. Under the definition, collectively bargained, or by rural electric, or by rural telephone cooperatives are exempted from any state regulation. There are probably 29 of them so far that were approved by the United States Secretary of Labor. He said MEWAS work best when the group of employers form this and then they provide health insurance to their employees and there is portability between the employers because of the skills normally needed by those employers and the employees of anyone can transfer within that. It does not matter what the employer is, it is the skill that they want. The insurance is then portable between the employers. He said there should be some commonality of the employers.

CHAIRMAN BENEDICT replied that he understood there were some amendments that people would like to propose and they would like to have the amendments before executive action.

Lloyd Lockrem replied they would get them the amendments as soon as they could. He said he was trying to resolve an issue that has been in there.

Diane Ruff, representing Associated Employers of Montana, read from a handout. **(EXHIBIT #10)**

Gary Spaeth, the Chief Council at the State Auditor's Office, said the MEWAS they had come in contact with serve the people well. There are some that are not in Montana that have caused problems. When a MEWA goes insolvent that is where the problem occurs. He said that was what the bill was set up for. How to insure solvency. He said there is a MEWA scam business in other places. He said they were concerned if they did not have some control, it would happen in Montana. He said there are 22 cases that are the leading cases that are in a small area. He said they could either proceed to litigate a lot of issues or they could have a chilling effect. The major concern was solvency. He said the bill does what they set out to do. He said they did not want to seek to have extensive regulation for the fact that they are not in a regulatory climate. He said they looked at approval of forms and paper concerns which are important ways to regulate, but the are not equipped with staff to do that. He said this was a good starting point on regulating MEWAS. He said they do not even have a list of the MEWAS in Montana. He said the amendments **(EXHIBIT #11)** have been approved. He said they need a statement of intent because they set up a solvency standard, but if they become insolvent they did not put in the liquidation provisions of the statute and they have to adopt them by rule. The other provisions allow flexibility.

Bob Turner, representing the Department of Revenue, said he would address tax deductibility which included HB 85, HB 202, SB 62, and SB 74. He said he would like to give an idea of what is presently allowable in Montana law. **(EXHIBIT #12)** He addressed each bill and gave amendments that included an explanation of the amendments at the bottom of the page. **(EXHIBITS #13-16)**

Rick Larson, representing EBMS, said his company is Employee Benefit Management Services and they are in the business of administering employee benefit plans for single and multiple employer welfare arrangements. He said a lot of the protection comes under the Department of Labor and under ERISA. He said a lot of the things that are not covered in the bill are covered under federal law. He urged the passage of the bill with minimal amendments.

REPRESENTATIVE PEGGY ARNOTT, HD 20, said she was the sponsor of HB 533. She said in HB 533 the premium increases must be

distributed proportionably. She said insurers would not be able to selectively raise premiums on one individual with health problems. The would have to distribute the premium increases proportionally. It would make it so no one would be penalized for getting sick. She said the requirement that an individual has qualified for an insurance once they have done that and maintained coverage they do not have to go through another qualifying period. This bill is a small step forward. The 30 days was amended in committee. She said that was an acceptable length of time as amended.

Ed Grogan, representing the Montana Medical Benefit Plan and the Montana Medical Benefit Trust, said they Montana Medical Benefit Trust was a fully insured MEWA and the Montana Medial Benefit Plan provides the insurance for that MEWA. He said there are reams and reams of federal legislation and Department of Labor rules on MEWAS and before they were to make any dramatic changes, they should have a lawyer check to make sure they were not violating laws. He said the present law as in 33-22-110 says it is not a pre-existing condition unless they have seen a doctor. He said people are sick before they go see a doctor. The new rules allow for a ordinarily prudent person would determine whether or not the condition was pre-existing condition when filling out their application. The problem with waiting to see a doctor is they have had 3 claims that they have had to pay in the last year because it is only in the last year that it has applied. He said the law as it stands lets people with pre-existing conditions purchase insurance. He said previous to this year riders had allowed in Montana. They have said that riders and pre-existing condition are one in the same and they could only have a rider for 1 year. The changes are to make it so that they could not have riders. The law says 4 years and they believe that there should be no limit on the length of time for a rider. He said to put a 4 year limitation on a rider would be the same as saying that they would have to deny that person coverage. He said the new language in the bill that says a person can basically go 60 days without insurance and then sign an application should say that they be out of the market only 30 days and if they have an application within that 30 days period they would still be qualified. They support tax deductibility and any bill pertaining to that.

EXHIBIT #17 was passed out to the committee.

CHAIRMAN BENEDICT said he would open it up to anyone who wanted to address health care in general.

Tanya Ask, representing BlueCross and BlueShield of Montana, said she would like to address cost containment and early intervention and prevention. A group of people who have not been present are children who are not insured and not covered by Medicare or Medicaid. The Caring Program for Children sponsored by the Caring Foundation of Montana. This program is a private effort that is a cooperative effort on the part of physicians,

hospitals, insurance agents, physician assistants, nurse practitioners and the whole health care community as well as individuals and groups around the state. She said the program was a non-profit program which was started 1 ½ years ago. She said the idea was that frequently children do not receive primary preventive health care benefits when their parents are in transition. The program provides benefits for well child visits, regular office visits, x-ray lab services, and out-patient surgery. It is not designed to be 100% coverage, but it is designed to take care of most of the services that most children need. The cooperation of health care providers is important because those who participate in the program receive a lower level of reimbursement to cover the children. They know that they are going to be paid for taking care of that child, they will not have to worry about deductibles or co-payments, and that takes care of an administrative burden. This program has provided benefits for over 600 children in Montana. The reason they are bringing the program to the committee is to notify them that the more dollars that come in the more they have to help the children. They are bringing the idea of a public private initiative. The idea would be to have a match and that there are so many public dollars before private dollars are put in.

Jeffrey H. Strickler, M.D., read his written testimony. **(EXHIBIT #18)**

{Tape: 2; Side: A.}

CHAIRMAN BENEDICT said that there was not a vehicle for this issue in the legislature. The wisdom of the people that chose the bills that came into this committee were such to take the bills that were alive in the process. He said that these presentations could best be made to the appropriations committee if **SENATOR DOROTHY ECK'S** bill made it to that process. He thanked them for making those concerns.

Questions from the Committee:

None

ADJOURNMENT

Adjournment: 7:55 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 3-9-95

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		

FROM: TOM HOPGOOD

Exhibit #1
3-9-95

HIAA/MALU/BC&BS
AMENDMENTS
HB 446

1. Page 3, line 1.
   Following: "person;"
   Insert: "or"

2. Page 3, line 4.
   Following: "person"
   Strike: "; or"
   Insert: "."

3. Page 3, line 5.
   Strike line 5 in its entirety.

4. Page 3, line 6.
   Following: "hospital"
   Insert: "expense"

5. Page 3, line 7.
   Following: "policy"
   Insert: ", contract,"

6. Page 3, line 7.
   Following: "certificate"
   Strike: ", a subscriber contract or a contract of insurance"

7. Page 3, line 7.
   Following: "provided by a"
   Insert: "health insurer,"

8. Page 3, line 8.
   Following: "service corporation or"
   Strike: "a"

9. Page 3, line 8.
   Following: "health maintenance"
   Strike: "subscriber contract"
   Insert: "organization"

10. Page 3, line 14.
    Following: "INSURANCE MAY"
    Strike: "EXCLUDE"
    Insert: "contain a provision which excludes"

11. Page 6, line 13.
Insert:

"NEW SECTION. Section 5. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

12. Renumber subsequent sections.

From: Tom Hopgood
Exhibit #2
3-9-95

HIAA/MALU/BC&BS
AMENDMENTS
HB 533

1. Page 1, line 19.
   Following: "CONTRACT"
   Strike: "PRODUCT TYPE"
   Insert: "filed and approved by the Commissioner pursuant to 33-1-501 and"

2. Page 1, line 20.
   Strike: "TYPE OF"

3. Page 1, line 23.
   Following: "CORPORATION,"
   Strike: "OR"

4. Page 1, line 23.
   Following: "ORGANIZATION"
   Insert: "or a fraternal benefit society"

5. Page 1, line 26.
   Following: "issued"
   Strike: "or delivered for issue"
   Insert: "for delivery"

6. Page 1, line 26.
   Following: "individual"
   Strike: Lines 27 and 28.

7. Page 1, line 29.
   Following: "self-"
   Strike: "insured"
   Insert: "funded"
   Following second: "self-"
   Strike: "insured"
   Insert: "funded"

8. Page 2, line 8.
   Following: "FOR"
   Strike: "if the insurance or plan has been in effect for a period of at least 1 year"

9. Page 2, line 11.
   Following: "FOR"
   Strike: "if the plan has been in effect for a period of at least 1 year"

10. Page 2, line 22.
    Following: "charges for"
    Strike: "a group or"
    Insert: "an"

11. Page 2, line 24.
Following: "charges for"
Insert: "individual"

12. Page 3, line 8.
Following: "means a"
Strike: "health care insurer as defined in 33-22-125"
Insert: "disability insurer, a health service corporation, a health maintenance organization or a fraternal benefit society"

13. Page 3, line 29.
Following: "chapter 22, part"
Strike: "1"
Insert: "2"

14. Page 3, line 30.
Following: "chapter 22, part"
Strike: "1"
Insert: "2"

15. Page 3, line 30.
Insert: "(3) The provisions of Title 33, Chapter 1, parts 3 and 7, apply to [Section 3]."

Exhibit #3
3-9-95

AMENDMENT TO HB-531

DISCLOSURE BY INSURERS

1. Page 7, Line 30.

Following: "(7)"

Strike: Line 30 through page 8, line 16.

Insert: "A health care insurer shall provide to any person, upon request, a general history of the cost of its various health benefit plans which are currently filed with and approved by the commissioner pursuant to 33-1-501. Such general history shall include the trend of cost increases or decreases over at least the preceding 5 years, if available, for each of such health benefit plans."

2. Page 21, Line 17.

Following: "(4)"

Strike: Line 16 through page 22, line 4.

Insert: "A health care insurer shall provide to any person, upon request, a general history of the cost of its various health benefit plans which are currently filed with and approved by the commissioner pursuant to 33-1-501. Such general history shall include the trend of cost increases or decreases over at least the preceding 5 years, if available, for each of such health benefit plans."

-END-

FROM: CLAUDIA CLIFFORD
Exhibit #4
3-9-95

GOP Health Bill Builds On ERISA

BY MARY JANE FISHER

WASHINGTON—Leading House Republicans have introduced a major health care reform bill that builds on the foundation of the Employee Retirement Income Security Act.

The bill would preempt state laws, enact targeted health insurance reform and require insurers to cover small employers and their employees.

Majority Leader Dick Armey of Texas joined 14 House members in sponsoring the bill, the proposed ERISA Targeted Health Insurance Reform Act of 1995, H.R. 995, and a companion bill, Targeted Health Insurance Reform in the Individual Market, H.R. 996.

Principal cosponsors were Rep. William F. Goodling, R-Pa., chairman of the Economic and Educational Opportunities Committee, and Rep. Harris W. Fawell, R-Ill., Employer-Employee Relations Subcommittee Chairman. The first subcommittee hearing on the bill will be March 10.

The bill was welcomed cautiously by employee benefit organizations representing Fortune 500 employers—the Washington-based American Association of Private Pension and Welfare Plans and ERIC, the ERISA Industry Committee.

Representatives of the U.S. Chamber of Commerce and the National Association of Manufacturers, both of Washington, and the Self-Insurance Institute of America, Irvine, Calif., warmly endorsed the legislation.

"Large employers can rally around the preservation of ERISA preemption in this bill," said Frank McArdle, a principal and manager in Hewitt Associates' Washington office. "The fact that the Majority Leader endorsed it is a good sign for its prospects, and also that it has so many important cosponsors."

He noted that the effective date of Jan. 1, 1998 of various sections of the bill would give employers time to prepare for a new regime.

The bill contains targeted elements of health insurance reform, including portability, renewability, utilization review, solvency, claims processing and fair rating standards (the latter for fully-insured plans in the small-group market), according to a summary of H.R. 995.

Under the bill, state laws restricting provider health networks, employer health coalitions and insured and self-insured plans would be preempted.

Preexisting-condition restrictions would be barred for those who are continuously covered and choose coverage when they are first eligible.

Coverage would be considered

Cont'd on Page 51

GOP Health Care Reform Bil Builds On ERISA Foundation

Cont'd from Page 4

"continuous" as long as no lapse in coverage is longer than three months or six months for employees "who terminate employment," according to the summary.

Generally, plans could not have more than a three month-six month preexisting exclusion. This means that treatment or diagnoses in the three months prior to coverage could be excluded from coverage for up to six months. Insurers in the small-group market could offer six month-12-month coverage.

Under the bill, states may implement and enforce the nationally uniform standards for insurers but not for group health plans.

States that voluntarily choose to implement the standards would have exclusive authority to enforce them as they apply to insurers and not to group health plans which buy health insurance coverage.

"In this fashion, the traditiona regulation of insurers by the states i preserved while the uniform regula tion of group health plans unde ERISA is not disturbed," according to the bill summary.

A section on Multiple Employe Health Plans was "designed to pre serve well-run, self-insured plans, an to put an end to the fraudulent scam perpetrated by a few bogus union and unscrupulous operators," th summary said.

It would allow certain multipl employer welfare arrangements known as MEWAs, to receive a exemption from the Labor Depart ment to become an ERISA multipl employer health plan, and they woul be would be subject to uniform stan dards under ERISA.

Exhibet # 5
3-9-95

State Auditor's Amendments to Senate Bill 322

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

Exhibit #6
3-9-95

State Auditor's Proposed Amendments to HB 446

1. Page 2, Line 25
   Following: "within"
   Strike: "5"
   Insert: "3"

2. Page 2, line 27 through page 3, line 8.
   Strike: page 2, line 27 through page 3, line 8 in their entirety

3. Page 3, Line 14.
   Following: "MAY"
   Insert: "contain a provision which"

4. Page 3, Line 14.
   Following: "EXCLUDE"
   Insert: "s"

5. Page 3, Line 14.
   Following: "CONDITIONS"
   Insert: "which occured within 3 years preceding the effecting date of coverage of an insured person"

6. Page 6, Line 9
   Strike: Section 4 in its entirety

Exhibit #7
3-9-95

State Auditor's proposed amendments to HB 533

1. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the Commissioner pursuant to 33-1-501 and"

2. Page 1, Line 23.
Following: "INSURER,"
Insert: "a fraternal benefit society"

3. Page 1, Line 26.
Following: "issued"
Strike "or delivered for issue"
Insert: "for delivery"

4. Page 1, Line 27.
Following: "any"
Strike: "discretionary group trust policy"

5. Page 1, Line 29.
Following: "self-"
Strike: "insured"
Insert: "funded"

6. Page 1, Line 29.
Following: "self-"
Strike: "insured"
Insert: "funded"

7. Page 2, Line 8.
Following: "For"
Strike: "if the insurance or plan has been in effect for a period of at least 1 year"

8. Page 2, Line 11.
Following: "For"
Strike: "if the insurance or plan has been in effect for a period of at least 1 year"

9. Page 2, Line 19.
Following: "than"
Strike: "3"
Insert: "6"

10. Page 3.
Following: line 8
Insert: "(3) The Provisions of Title 33, Chapter 1, Parts 1 and 7 apply to this section."

11. Page 2.
Following: Line 20
Insert: "NEW SECTION. Section 3. An insurer shall waive any time period applicable to a rider for the period of time that an individual was covered by a previous policy or certificate, crediting any period of time that was covered by that policy or certificate toward the rider period of the replacing policy or certificate."
Renumber: subsequent sections

12. Page 3, Line 8.
Following "insurer"
Strike: as defined in 33-22-125"
Insert: "disability insurer, a fraternal benefit society, a health service corporation, or a health maintenance organization"

13. Page 3, Line 12
Following: "section"
Strike: "3"
Insert: "4"

14. Page 3, Line 26.
Following: "1"
Delete: "and"
Insert: ","

15. Page 3, Line 26.
Following: "2"
Insert: "and 3"

16. Page 3, Line 28.
Following: "1"
Delete: "and"
Insert: ","

17. Page 3, Line 28.
Following: "2"
Insert: "and 3"

18. Page 3, Line 29.
Following: "Section"
Strike: "3"
Insert: "4"

19. Page 3, Line 30.
Following: "section"
Strike: "3"
Insert: "4"

Exhibit #8
3-9-95

PRE-EXISTING CONDITIONS

The issues of portability and pre-existing conditions are important features of the HEAL Montana program. We support HB 533 and HB 446.

People need to be able to take their insurance with them as they change careers throughout their lifetimes. Being able be "benched" for one waiting period should be sufficient, rather than the old ways of starting the clock over each time.

HEAL is interested in the amendments offered by the insurers, and we generally support them, but there is one glitch. Portability will be taken care of for individuals, groups from three to twenty five, and large groups. The segment unaddressed is the two person group. There seems to be no sympathy to lower group to two, and preliminary discussion reveals the difficulties that are peculiar to that set. Addressing that problem should probably be left to another time.

MCHA

MCHA needs serious attention. Its benefits are poor and the premiums exorbitant. Both sides need adjustments. Current premium rates are 150 to 400% of regular premiums. Surrounding states are capped at 125- 135%.

MCHA benefits and its programs were and will continue to be the subject of intense debate at the working meeting. Support SB 31

DEDUCTIBILITY

HEAL is supports HB 202 Tax Deductibility for premiums for health insurance premiums.

M. SUSAN GOOD
HEAL MONTANA
JOINT HEALTH CARE COMMITTEE
MARCH 9,1995

Tonya Ask
Exhibit # 9
3-9-95

Senate Bill 376
Draft Amendments
March 9, 1995

1. Page 1, Line 29 and 30
   Following: "Employers"
   Delete: "that has been in existence for period of not less than five years prior to"

2. Page 2, Line 1
   Delete: "during which time the Association"
   Insert: "which"

3. Page 4, Lines 3 and 4
   Following: "Requirements applicable"
   Delete: "only to arrangements organized after [the effective date of sections 1 through 14]"
   Add: "to all arrangements"

   Line 5
   Following: "arrangements"
   Delete: "formed after [other effective dates of sections 1 through 14]"

4. Page 5, Line 6
   Following: "for review"
   Delete: "and approval by the commissioner"

5. Page 8, Line 19
   Add: "(b) Title 33, Chapter 1, Part 5,"Renumber subsequent sections

6. Page 8, Line 21
   Add: "(d) Title 33, Chapter 15"

7. Page 8, Line 21
   Following: "Chapter 18"
   Delete: ", except 33-18-242"
   Add: "(e) Title 33, Chapter 19; (f) Title 33, Chapter 22, Parts 1, 5, 7, 10, 15, 16, 17, and 18; and (g) Title 33, Chapter 32."

8. NEW SECTION: Section 15 - **Disclosure**

B. 1. The MEWA shall issue to each covered employee a policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided.

2. The evidence of benefits and coverages provided shall contain, in boldface type in a conspicuous location, the following statement: "THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST FUND ESTABLISHED BY A GROUP OF EMPLOYERS (name of MEWA). THE TRUST FUND IS NOT SUBJECT TO ANY INSURANCE GUARANTY ASSOCIATION. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE (name of MEWA)." If the MEWA has excess insurance, the following statement shall be added: "EXCESS INSURANCE IS PROVIDED BY A LICENSED INSURANCE COMPANY TO COVER CERTAIN CLAIMS WHICH EXCEED CERTAIN AMOUNTS."

3. If applicable, the same documents shall contain in boldface type in a conspicuous location: "THE BENEFITS AND COVERAGE DESCRIBED HEREIN ARE FUNDED BY CONTRIBUTIONS FROM EMPLOYERS, EMPLOYEES, AND OTHER INDIVIDUALS ELIGIBLE FOR COVERAGE." (If the MEWA has excess insurance, the following statement shall be added: "EXCESS INSURANCE IS PROVIDED BY A LICENSED INSURANCE COMPANY TO COVER CERTAIN CLAIMS WHICH EXCEED CERTAIN AMOUNTS.") "THIS IS THE ONLY SOURCE OF FUNDING FOR THESE BENEFITS AND COVERAGES."

Exhibit # 10
3-9-95

WHAT IS ASSOCIATED EMPLOYERS OF MONTANA?

Associated Employers of Montana, formerly Associated Industries of Montana, Inc., is a voluntary, non-profit employers resource association whose principal source of operating income is dues paid by members. AEM has provided management support in all areas of the employer/employee relationship to members since 1916. AEM serves as a central source of information and data on a wide variety of employer management needs as directed by the ever-changing regulatory and economic environment in which today's businesses operate. With an experienced, knowledgeable, professional staff, AEM is well-equipped to assist its diverse membership which consists of large and small businesses.

WHY DOES ASSOCIATED EMPLOYERS OF MONTANA SPONSOR A HEALTH BENEFIT TRUST FOR MEMBERS?

As employer provided health benefits became a workforce expectation during the 1950's, the leadership of AEM believed that it would be economically efficient to pool the resources of association members for the purpose of group purchasing of health benefits for themselves and their employees. From 1956 to 1991, the Association provided this membership service through an insured product purchased from Lincoln National Life Insurance Company. While this long-standing relationship proved to be beneficial, very little direct employer input was permitted.

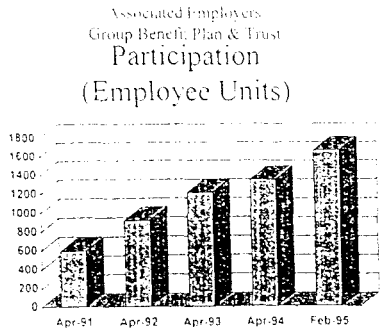
HOW DOES AEM PROVIDE HEALTH BENEFITS FOR MEMBERS TODAY?

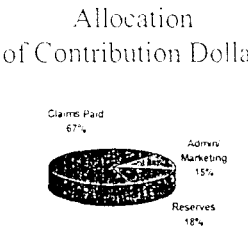
On April 1, 1991, Associated Employers of Montana created the AEM Group Benefit Plan and Trust. This arrangement is a partially self-funded multiple employer welfare arrangement (MEWA) which operates under Federal Department of Labor regulations governed by ERISA (Employee Retirement Income Security Act) statutes.

Double digit rate increases, inflexible underwriting criteria and no opportunity to establish cost effective plan designs forced the ending of the relationship with a traditional form of health insurance coverage. A unique, bold step was undertaken by the AEM Board of Directors to effect control over the upward spiraling costs of employer sponsored health care coverage while at the same time offering plan choices and a quality product to participating Association members.

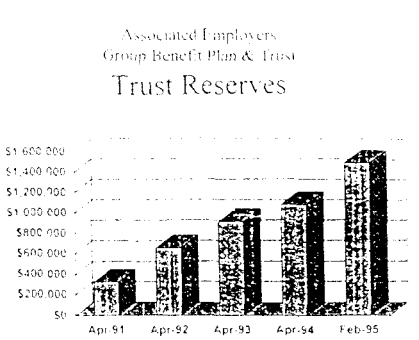
Today, the AEM Group Benefit Plan and Trust is governed by a Board of Trustees who voluntarily and without compensation give of their time and talents to direct the operation of the Trust, and whose companies and themselves participate in the Plan.

THE FOLLOWING GRAPHS SPEAK TO THE SUCCESS OF THE AEM GROUP BENEFIT PLAN AND TRUST:





Associated Employers
Group Benefit Plan & Trust
Plan Year Ending 8/31/94



Diane Reff

GARY SPAETH
Exhibit # 11
3-9-95

Amendments to Senate Bill No. 376

1. Page 1, line 13.
Insert "STATEMENT OF INTENT"

A statement of intent is required for this bill because the bill does not contain any provisions regarding supervision, rehabilitation and liquidation of self funded multiple employer welfare arrangement which fails to maintain the level of reserves as are required by section 8. The rules should be consistent with the provisions of Title 33, chapter 2, part 13 and only modify those provisions to the extent necessary to be consistent with the provisions and purposes of this act.

Page 5, line 24
Following 33-2-514
Insert: ". The commissioner in his discretion may waive the requirement of an actuarial opinion and require a report by an actuarial firm"

Page 7, line 12.
Following 33-2-514
Insert: ". The commissioner in his discretion may waive the requirement of an actuarial opinion and require a report prepared by an actuarial firm and upon a showing of good cause extend the filing date of the report by thirty days"

Exhibit # 12
3-9-95

State of Montana
Marc Racicot, Governor

Department of Revenue
Mick Robinson, Director

Income and
Miscellaneous Tax Division
Jeff Miller, Administrator

DATE: March 9, 1995

TO: Senator Benedict, Chairman
Joint Select Committee

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

RE: Bills Relating To Tax Deductibility

ALLOWABLE MEDICAL ITEMS PRESENTLY UNDER MONTANA LAW

Item	How Allowed	Explanation
Medical & Dental	Deduction	Amount allowed as a deduction that exceeds 7.5% of the taxpayers MT adjusted gross income
Long Term Care Ins.	Deduction - 100%	Under 15-30-121(7), MCA a 100% deduction is presently allowed for long term care insurance.
Health Ins. Prem. paid by employers	Exclusion	Under 15-30-111(2)(h), all health insurance premiums paid by a taxpayer's employer which is included as income under the federal law is excluded from MT adjusted gross income.
Health Ins. Provided By Employers	Credit	Under 15-30-129, MCA, a tax credit is allowed employers who furnish employees with at least 50% of each employees health insurance premiums.

PROPOSED LAW

HB 85	Allows the full deductibility of medical and dental expenses including insurance premiums.

This does need an amendment to clarify the correct section of federal law which would not contain the 7.5% threshold figure. Also an amendment is needed so the bill is not tied to amount disallowed under federal law.

HB ~~22~~ 202 & SB 62

This does allows the deduction of two items: 1) 100% deduction of medical insurance premiums, and 2) excludes income for those taxpayers whose employers whose employers pay their health insurance premiums.

Needs amendments to disallow any double benefit and the second item is presently allowed under Montana law.

SB 74

This bill allows the deduction of prescription drugs and insulin. This needs an amendment that disallows any double benefit.

Exhibit #13
3-9-95

Amendments to House Bill 85
Introduced Copy

Prepared by Department of Revenue
3/ 9/95 2:01pm

1. Page 3, line 16.
Following: "section"
Strike: "213"
Insert: "213(d)"

2. Page 3, line 17.
Following: "section"
Strike: "213"
Insert: "213(d)"

3. Page 3, lines 17-18 .
Following: "amended,"
Strike: "but that are not fully deductible on the federal individual income tax return by reason of the federal medical and dental deduction limitation"
Insert: "notwithstanding the deduction limitations provided in the Internal Revenue Code."

REASON FOR AMENDMENT: The first two amendments clarify that the deduction for medical expenses concerns the **total amount** of the medical and dental expenses listed in section 213(d) of the Internal Revenue Code. The general reference to 213 could be interpreted as including the 7.5 percent floor placed on such expenses by section 213(a) of the I.R.C..

The third amendment is proposed to resolve an amibiguity in the language of this bill and clarify that this legislation is intended to depart from the federal tax code; thereby allowing a taxpayer to deduct the full amount of his or her qualified medical and dental expenses.

Exhibit #14
3-9-95

Amendments to House Bill 202
Introduced Copy

Prepared by Department of Revenue
3/ 9/95 3:26pm

1. Page 1, line 17.
Following: line 17
Insert: "(c) except premium payments for health and medical insurance, provided for in subsection (7);"

REASON FOR AMENDMENT: The purpose of this amendment is to avoid a potential double deduction of health and insurance premiums.

2. Page 3, line 11.
Following: "payments"
Insert: "except those premiums deducted in arriving at Montana adjusted gross income"

REASON FOR AMENDMENT: The purpose of this amendment is to avoid a potential double deduction of health insurance premiums due to pending federal legislation which would allow a 25% health insurance deduction for the self-employed. This amendment would allow only the remaining amount of health premium (after the 25% deduction) to be taken as a deduction. Without this amendment a taxpayer would be able to deduct 125% of their health insurance premiums under this bill.

3. Page 3, line 12.
Following: "(a)"
Insert: "(i)"

4. Page 3 line 13.
Following: "under federal law"
Strike: "and"

5. Page 3,
Following: line 13
Insert: "(ii) for purposes of this subsection, deductible medical insurance premiums are those premiums that provide payment for the medical expenses indicated in section 213(d) of the Internal Revenue Code, and"

REASON FOR AMENDMENTS: These amendments define the type of medical expenses insurance payments that would be deductible under this legislation.

6. Page 3, line 12.
Following: "directly by the taxpayer"
Strike: "or made by an employer for the"

7. Page 3, line 13.
Following: "directly by the taxpayer"
Strike: "taxpayer that are attributed as income to the taxpayer under federal law"

REASON FOR AMENDMENTS: These amendments would avoid a potential double deduction for premium payments that are made by an employer and included in a taxpayer's federal income. Current Montana law already provides a deduction for this income pursuant to 15-30-111(2)(h).

Exhibit #15
3-9-95

Amendments to Senate Bill 62
Introduced Copy

Prepared by Department of Revenue
3/ 9/95 4:04pm

1. Page 1, line 17.
Following: line 17
Insert: "(c) except premium payments for health and medical insurance, provided for in subsection (7);"

REASON FOR AMENDMENT: The purpose of this amendment is to avoid a potential double deduction of health and insurance premiums.

2. Page 3, line 11.
Following: "payments"
Insert: "except those premiums deducted in arriving at Montana adjusted gross income"

REASON FOR AMENDMENT: The purpose of this amendment is to avoid a potential double deduction of health insurance premiums due to pending federal legislation which would allow a 25% health insurance deduction for the self-employed. This amendment would allow only the remaining amount of health premium (after the 25% deduction) to be taken as a deduction. Without this amendment a taxpayer would be able to deduct 125% of their health insurance premiums under this bill.

3. Page 3, line 13
Following: (ii)
Strike: "made by an employer for the taxpayer that are attributed as income to the taxpayer under federal law.

REASON FOR AMENDMENT: This amendment would avoid a potential double deduction for premium payments that are made by an employer and included in a taxpayer's federal income. Current Montana law already provides a deduction for this income pursuant to 15-30-111(2)(h).

4. Page 3, line 13.
Following: "(ii)"
Insert: "for purposes of this subsection, deductible medical insurance premiums are those premiums that provide payment for the medical expenses indicated in section 213(d) of the Internal Revenue Code as that section is interpreted by Treasury Regulations, and"

REASON FOR AMENDMENT: This amendment defines the type of medical expenses insurance payments that would be deductible under this legislation.

Exhibit # 16
3-9-95

Amendments to Senate Bill 74
Introduced Copy

Prepared by Department of Revenue
3/ 9/95 2:36pm

1. Page 3, line 18.
Following: "sources"
Insert: "or is not deducted under 15-30-121(1)"

REASON FOR AMENDMENT: This amendment is proposed to avoid a double deduction for medical expenses. Under current law a taxpayer is allowed to deduct from his or her adjusted gross income all medical expenses allowed under the federal tax code - Section 15-30-121(1), MCA. Senate Bill 74 does not amend that particular section of current law. Thus without this proposed amendment a taxpayer would be allowed to deduct the actual amount of medical expenses as proposed by Senate Bill 74 and the medical deduction allowed under current law.

Exhibit #17
3-9-95

TESTIMONY
STATE FARM INSURANCE COMPANIES
BEFORE THE JOINT HEALTH CARE COMMITTEE
REGARDING HB 533
MARCH 9, 1995
Room 325
5:30 p.m.

Chairman Benedict, Members of the Joint Health Care Committee:

On behalf of State Farm Insurance Companies in Montana, I thank this Committee for allowing me this opportunity to present written testimony regarding some of State Farm's concerns on House Bill 533. Specifically, State Farm's concerns arise from New Section 3 beginning on page 2, line 21 of the bill. With regard to New Section 3(1), we believe that the intent is to apply any rate increase that might occur on an across-the-board basis. However, occasionally the experience indicates that some policies should get less of an increase than others. For example, the experience on a $500 deductible policy may be different than the experience on a $1,000 deductible policy. Therefore, it seems more equitable that rate increases should be reflected accordingly between these two types of policies. Perhaps one option might be to make rate adjustments "form specific" as opposed to across-the-board. In this regard, State Farm suggests that the last sentence of New Section 3 be deleted and that the following sentence be added:

> Increases in premium, certificate, or contract rates for a block of policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately by premium amount to that entire block of policy, certificate, and contract

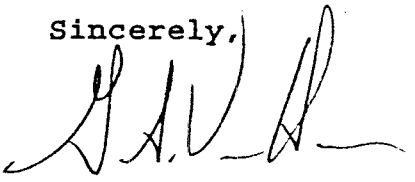
holders of that insurer in the state, except where approved by the commissioner.

State Farm believes that the above language would result in a more equitable distribution of any rate increases required by House Bill 533.

Finally, State Farm would suggest that in New Section 3(2)(ii)(A) the term "hospital confinement indemnity" should be added to that section in order to make it consistent with the wording of New Section 1(3)(b).

On behalf of State Farm Insurance Company, I thank this Committee for the opportunity to provide this written testimony. As always, State Farm looks forward to the opportunity to work together with this Committee in formulating workable legislation which will ultimately benefit Montana's consumers.

Sincerely,



Gregory A. Van Horssen

GVH/vjz

Exhibit #1
3-9-95

Testimony before the Joint Committee on Health Care

9 March 1995

Jeffrey H. Strickler, M.D.

Sen. Benedict and Members of the Committee:

I come before you as a practicing pediatrician in Helena to speak for the needs of children.

The activities of this legislature on the issue of insurance reform are laudable, but do not speak to the health care needs of Montana's children. Of the many "uninsured" that drove the discussion of health care reform last session, the bulk (some say 70%) are children. Of the patients inappropriately using emergency rooms, many are children who cannot get into physicians offices. Preventive health services for children such as immunizations and well baby care can not be addressed by your current efforts because of Federal ERISA exemptions for self insured companies... and this represents about half of the insured children in this state. Every year that we have talked about this "problem" more and more companies have dropped dependents (the children) from their benefits, or have required the employee to pay ever more for protection for the family.

I have practiced pediatrics in Helena for the past 20 years. Let me give you an example of the reality of financing children's health at the Helena Pediatric Clinic. A review of the year's end books for 1994 showed that only 40% of our payments came from insurance, 20% from Medicaid, and a whopping 40% was cash - out of pocket expense for parents. With specialty care and adult medicine, Medicare and greater levels of insurance make cash payments much less - I have heard on the order of 5-10%. From our little clinic we are talking on the order of hundreds of thousands of dollars. Spread out over the state, the out of pocket cost for health care for our children is staggering. And it is the out of pocket expense that keeps parents from seeking care when they should.

Let me close by saying that I did not come here asking only for State help. I am also on the Board of The Caring Program, a volunteer effort that seeks donations to provide health insurance for children of the "working poor". So far with the help of Blue Cross/Blue Shield of Montana we are providing insurance for nearly 500 kids and hope to expand this further. This is only a start, and not a solution, but I would urge you to look at enabling public/private partnerships with efforts like The Caring Program so that more of our children can be assured access to quality health care.

I will not presume to solve this problem for you now. I personally think that all children should be guaranteed coverage. But as you go about your deliberations about insurance reform, remember that the children are being left out, and the children deserve out greatest efforts.

DATE March 9, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: HB 446, HB531, HB533, SB322, SB341, HB85, HB202, SB62, SB74, SB376

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Rick Larsen	EBMS	376	✓	
Tim Filz	AEM	376	✓	
J.H. Strickler	Am Academy of Pediatrics			
Diane R Ruff	AEM	376	✓	
Kate Cholewa	MT Womens Lobby	446		See 1 2c
Susan Good	HEAC	446 533 531	✓	
Larry Akey	MALU	446 533		
Sonny Hoekrem	Mont. Contractors	SB 376	✓	
Bob Bachini for Linda Nelson	Gallatin Med - Bizemen Manager Assoc.	SB 376	✓	
Michael Keedy	MUST	SB 322		X
"	"	HB446	X	
Greg Van Horssen	State Farm Insurance			
Tom Hopgood	HIAA	446 533	✓	
Bob Turnlund	MT Dept. of Revenue Yellowstone Comm Health Plan	HB446 533	✓	

TOM EBZERY

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10

DATE March 9, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: _____

_____

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Steve Yeakel	MT Council for Maternal & Child Health		Caring Programs for Kids	
Tanya Ask	Blue Cross & Blue Shield			
John Flink	MT Hosp. Assn.			

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