MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN STEVE BENEDICT**, on March 13, 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:	None
Executive Action:	HB 511, HB 542, SJR 14, HB 405, SB 405, HB 560, HB 85, HB 202, SB 62, and SB 74

{Tape: 1; Side: A.}

EXECUTIVE ACTION ON SJR 14

Motion:

SENATOR JACOBSON MOVED amendments **(EXHIBIT #1).**

Discussion:

SENATOR JACOBSON replied the amendments were to make the bill palatable to everyone. She went through **EXHIBIT #1.** She said

she was trying to make the bill as simple as possible. It does not change anything except the wording is more clear.

CHAIRMAN BENEDICT asked if she could explain how the language would be on page 2, lines 8-10.

Susan Fox replied, "Whereas the Montana Health Care Authority has developed a list of alternatives to a single payer and multiple payer plan that provide several approaches to health care reform in Montana". She said all except the word "provide", all of that new language that is underlined and capitalized would be struck.

SEN. JACOBSON replied the amendment was taking out a lot of the "whereas" that are not necessary.

SENATOR MIKE FOSTER asked if **SEN. JACOBSON** was proposing to eliminate lines 23-25 on page 1.

SEN. JACOBSON replied the reason was there were people who were offended by that because if they were to include what people were presently paying for health care costs, probably those costs were not exactly what was stated in SJR 14. She said she did not see any need for it and therefore removed it. SJR 14 was causing them to fulfill their duties under the language in the present statutes. The rest of the "whereas" phrases seemed to be offending others and so that was also removed.

REPRESENTATIVE SIMON said he was not sure why they wanted to strike things in the resolution. Line 23 on page 1, maybe those numbers offended someone, but those were the numbers used by the Health Care Authority report.

SEN. JACOBSON replied they were, but they are not needed in the resolution. She was trying to bring it to what was needed and to keep it as unoffensive as possible. On line 22, they talk about the goals so that "whereas" was not needed either. As far as the costs were concerned they already decided that they were not going to do that. She said she was trying to keep the resolution to what they were supposed to do.

REPRESENTATIVE TUSS said line 23 on page 1, said without that particular "whereas", there would be no basis for the subsequent "whereas". Line 27 of the subsequent "whereas" says there is insufficient state funds at this time.

SEN. JACOBSON replied that was taken out. All of that was taken out.

SENATOR ECK said she would not have any objection of leaving all of those on line 2 in the resolution. She said ERISA is still a problem and the goal of affordable access is an a laudable goal.

REP. SIMON replied he would have an amendment to add another "whereas".

Vote:

The **MOTION FAILED** 4 to 6 by Roll Call Vote with **SEN. FOSTER, REP. GRIMES, SEN. MILLER, REP. TUSS, REP. ORR, and SEN. BENEDICT** voting no and **SEN. ECK, SEN. JACOBSON, REP. SIMON, REP. SQUIRES** voting yes.

Motion:

SEN. JACOBSON moved amendments striking lines 23-30 on SJR 14.

Discussion:

CHAIRMAN BENEDICT replied that the amendment would be striking lines 23-30 and leaving in lines 1-5 on page 2 and the amendments would be the same.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Motion:

REP. SIMON MOVED an amendment in the form of a "whereas" in the resolution to say that the people of Montana appreciate the hard work and dedication of the members of the Health Care Authority and the work that they did over the past 2 years.

Discussion:

CHAIRMAN BENEDICT asked if David Niss would tell them how the amendment would read when it was written.

David Niss replied "Whereas, the Health Care Authority and the staff of the authority have devoted significant time to study the issue of health care reform in Montana and countless hours to making their report to the Legislature...."

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Motion:

SEN. JACOBSON MOVED SJR 14 **AS AMENDED.**

Vote :

The **MOTION CARRIED UNANIMOUSLY.**

Discussion:

SEN. JACOBSON said SJR 14 would go to the House and requested that **REP. SIMON** carry SJR 14. **REP. SIMON** will carry **SJR 14.**

EXECUTIVE ACTION ON HB 511

Motion:

SEN. JACOBSON MOVED amendments to HB 511. **(EXHIBIT #2)**

Discussion:

SEN. JACOBSON said the earlier part of the amendments concern in Section 1, where it says the people of Montana have evaluated a i rejected both the single payer and multiple payer plans. She said that was not exactly correct and it is in conflict with some of the things in SJR 14. She said on the back side of **EXHIBIT #2** there is a new Section 2, which is amendment #6.

CHAIRMAN BENEDICT replied they were striking lines 21 after subsection (1) through "however" on line 23, and starting with "The public" .

SEN. JACOBSON replied that was correct, but it says "The Legislature and the public".

CHAIRMAN BENEDICT replied it says "The Legislature and the public have" rather that "has also". On line 24, they are striking "supports" and inserting "support".

SEN. JACOBSON replied that saying that the people have evaluated and rejected is going a little too far so this is a little more reflective of what they are doing. The rest of the amendments clean up the language. There is also the new section to talk about the health care policy.

SEN. FOSTER said that he would like to segregate amendment #6 from the first 5 amendments because they were dealing with two separate issues.

Motion:

SEN. JACOBSON MOVED the amendments 1-5 on **EXHIBIT #2.**

Discussion:

SEN. FOSTER said it was an accurate statement on lines 21, 22 and part of 23.

REP. SIMON said he thought that was an accurate statement. He asked if they could separate #1 from the #1-5.

SEN. JACOBSON replied she understood. She said there was a very active group of senior citizens who are wed to the single payer plan and this almost implies that the people of Montana have voted and rejected the issue. She said that was not true. To

put that in statute and say that the people of Montana have evaluated and rejected to the plans, people could really object to that if they saw that in law without ever having that vote or anything else. She was trying to alleviate a problem.

REP. SIMON said if they would be more comfortable since they struck the public if they would say the Legislature.

SEN. JACOBSON said they did not accept or reject anything. It was just saying that they had the plans and they voted on them. She said that would be consistent with SJR 14 to not go so far as to say people have accepted and rejected. This would be in statute.

SEN. ECK replied she would rather strike the first sentence entirely, but if they were going to leave one in, she would rather say "The Health Care Authority and the Legislature have evaluated both the single payer and the multiple payer plans".

CHAIRMAN BENEDICT replied they would just vote on amendments #1-#5 and then other amendments could be offered.

Vote:

The **MOTION CARRIED** 6 to 4 by Roll Call Vote (#2) with **SEN. ECK, SEN. FOSTER, SEN. JACOBSON, SEN. MILLER, REP. SQUIRES, and REP. TUSS** voting yes and **REP. GRIMES, REP. SIMON, REP. ORR, and SEN. BENEDICT** voting no.

Motion:

SEN. JACOBSON MOVED amendment #6 on the backside of **EXHIBIT #2.**

Discussion:

REP. SIMON said he wanted to put something in there to make sure there was an emphasis on public health. He said the health promotion and preventative services were in there, but he did not see anything on public health. He asked if they could do that.

CHAIRMAN BENEDICT said he was not very comfortable putting in statute that Montanans should have access to health care services they need without having to incur excessive out-of-pocket expenses, which was (a) on page 2 amendment #6.

REPRESENTATIVE SQUIRES said she was interested in public health, but if they put two ideas in one bill somehow one of them would lessen itself. They should not try to put two missions in one health care advisory and they might lose public health emphasis. **SENATOR MILLER** asked on subsection 2 (h), what is the intent?

SEN. JACOBSON said the whole discussion they had on small group and purchasing pools was to say that they were not going to put a community rating as was done in New York, but they would try to

do things in a gradual way and try to make sure they are not unfavorably impacting things as they go along. She said it was a mild way of doing health care reform.

REPRESENTATIVE ORR replied he was also uncomfortable with some of the language in that. He said he would like to also amend in something with public health. He was wondering if someone wanted to comment about amending HB 542 into HB 511.

REPRESENTATIVE ROYAL JOHNSON said he did not have any problem with that as long as they were not things that might inhibit the passage of the bill. He said the public health bill has a lot of merit, but he was not sure where it would fit in. He said he would leave that up to the staff. He said he did not have any problem as long as it did not jeopardize HB 511.

SEN. ECK said they need to discuss if they were going to consider HB 542 separately. She said it needed to go on its own.

REP. SIMON said a lot of the issues in HB 542 are very laudable and fit with what they are talking about. He said he would like to see the committee send the bill through the process and at least get it to the Appropriations Committee to see if there is funding for that. There is a lot of money involved in that bill because it creates another board. He said as a result of that he wanted to make sure there was language in HB 511 that puts an interest in public health in the event that HB 542 never makes it all the way through the process.

CHAIRMAN BENEDICT asked **REP. SIMON** if he was comfortable with the public health connotations in HB 511 because it does not actually refer to public health services.

REP. SIMON replied he had not particularly found public health in HB 511. He said there were preventative services and health promotion and others. He said he did not see the actual words public health. He said he was also uncomfortable with (a).

SEN. ECK said she believed they could amend the bill if they wanted to do what **REP. SIMON** did by putting in (c) Health promotion and preventative health services and public health services. She said **SENATOR WATERMAN** was present and asked her to comment about what would be preferable.

SENATOR WATERMAN said there was discussion about putting it together with HB 511. She said there was discussion that there was funding in HB 2 that might be utilized to meet the needs in HB 542. She said that HB 542 does not match as well with HB 511 and it would be better to go on its own.

Peter Blouke, Director of SRS, said he was aware of $300,000 currently in HB 2 in general fund and corresponding federal authority for medicaid match. He said all of that money was not needed for the specific purpose that **REPRESENTATIVE COBB** put it

in. There would be funds available in HB 2 assuming that the reorganization goes through to do many of the things that are contained in HB 542.

CHAIRMAN BENEDICT said that because HB 511 was not a substitute for HB 542 and it was just a statement of health care policy, they should focus on that.

SEN. JACOBSON replied they took that state health care policy out of that other bill because they felt it would be appropriate for Montana to state what their health care policy was.

REP. ORR said he was concerned about amendment #3. He said it said regardless of what health care strategy the Legislature or the Advisory Council came up with, everyone was to continue doing whatever it was that they were doing in the certain areas. He said that was their job as a Legislature to adopt policy and they should not be telling people to ignore what they say.

SEN. JACOBSON said #3 was trying to say that they need to increase the emphasis of education of consumers and that was a goal of the Medical Savings Accounts. A person was not going to be a good consumer unless they had some information on what health care costs, what the comparisons might be, what a certain doctor charges for what. She said they need to continue to educate consumers so they are better health care consumers.

REP. SIMON asked if **REP. ORR** would be more comfortable with that language. He said there are a lot of good things in #3. He said really what they were doing was adopting a lot of health care insurance reform measures. He said instead of saying "health care reform strategy" say "health care insurance reform strategy" because that was what they were working on.

REP. ORR said that would help.

CHAIRMAN BENEDICT said there was a conceptual amendment to insert "insurance" between "care" and "reform" on the second line on subsection 3.

REP. R. JOHNSON said he shared that concern. He said if they start on line 4 and strike everything above that and say "The Legislature recognizes the need to increase emphasis on education of consumers" rather than saying "regardless of what the Legislature does".

CHAIRMAN BENEDICT asked if anyone wanted to offer that. They would be striking lines 1,2, and 3, and starting on line 4 state "The Legislature recognizes the" and lead to increase emphasis of education to consumers of health care services.

Motion:

REP. ORR MOVED those amendments.

Discussion:

SEN. JACOBSON asked where they would be starting.

REP. ORR said it would strike the first three lines of #3, and insert "The Legislature".

SEN. JACOBSON said they did not want to say the "Health Care Advisory Council, Health Care Providers" ?

REP. SIMON replied no, they would just strike that sentence.

SEN. MILLER said to support the entire amendment he would have to have (a) and (h) stricken. He said that (h) was too broad. He said he understood the intent, but it could be interpreted many ways.

SEN. FOSTER asked if **SEN. MILLER** was making a motion to strike (a) and (h)?

Motion:

SEN. MILLER MOVED to strike (a) and (h).

Discussion:

REP. SIMON replied there was already **SEN. JACOBSON'S** amendment and there was also **REP. ORR'S** motion.

CHAIRMAN BENEDICT replied there was also mention of inserting public health under health promotion and preventive health services at (c) in amendment #6.

REP. ORR replied that could be in his motion.

Vote:

The **MOTION BY REP. ORR CARRIED UNANIMOUSLY.**

Motion/Vote:

SEN. MILLER MOVED to strike subsection (a) of amendment #6 **EXHIBIT #2.**

The **MOTION CARRIED** with **SEN. JACOBSON, SEN. ECK, REP. TUSS, and REP. SQUIRES.**

Motion:

SEN. MILLER MOVED to strike subsection (h) of amendment #6 **EXHIBIT #2.**

Discussion:

SEN. JACOBSON said they were just stating the policy of the state and they were trying to minimize any desirable impacts. She said she preferred to leave it in.

REP. SIMON replied that it said some important things. He supported leaving it in.

CHAIRMAN BENEDICT replied he felt that way also. He was looking at minimizing those impacts.

SEN. MILLER said he did not know how they were going to determine that. He said that was what his concern was.

Vote:

The **MOTION FAILED** with **SEN. MILLER** voting yes.

Motion/Vote:

The **MOTION** was made to amend HB 511 with amendment #6 on the backside of **EXHIBIT #2** which was made previously by **SEN. JACOBSON.**

The **MOTION CARRIED UNANIMOUSLY.**

Motion:

CHAIRMAN BENEDICT MOVED HB 511 AS AMENDED.

Discussion:

REPRESENTATIVE GRIMES asked if they dealt with the mix of the committee. He said he said he thought there should be a larger number of legislators and fewer other members.

CHAIRMAN BENEDICT replied that he disagreed and the mix was fine the way it was. The more legislators that are on there and the less public involvement they have the more open they are for criticism.

SEN. FOSTER asked if **REP. SIMON** intended to propose amendments to bring in some of HB 542.

REP. SIMON said it had already been done by adding that in (c) of the amendment #6.

Vote:

The **MOTION TO CONCUR IN HB 511 AS AMENDED. SENATOR JACOBSON** would carry HB 511.

EXECUTIVE ACTION ON HB 542

Motion/Vote:

REP. SIMON MOVED TO **DO PASS** HB 542.

The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON HB 405

Motion:

REP. GRIMES MOVED HB 405.

Discussion:

CHAIRMAN BENEDICT replied that if they were to pass HB 405 they would not pass SB 405.

Motion:

SEN. JACOBSON MOVED amendment to HB 405. **(EXHIBIT #3)**

{Tape: 1; Side: B.}

Discussion:

REP. GRIMES asked if they could explain that amendment because he was trying to think of an example of where they would exclude someone based on their occupation.

Mike Craig, representing the Montana Health Care Authority, said if they use occupation it could be used to exclude a group. He said that voluntary purchasing pools can end up excluding groups that are a high risk occupation, such as loggers.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Discussion:

SEN. JACOBSON said there was an amendment proposed by **Claudia Clifford. SEN. JACOBSON** said that HB 405 has no regulation by the insurance commission. She said there should be some protection for the consumers. The amendment suggested HB 405 would comply with the provisions of title 33, chapter 17, part 6.

Claudia Clifford, representing the Insurance Department, said that would suggest the purchasing pools to part 6 of their codes which dealt with administrators of insurance plans. She said the amendment would have the third party administrators register with their office. There was a certification process that could be waived if they are a business that currently exists. She said they just wanted to know who they were. She said there was a fiduciary tie between the insurer and the company so if there was any problems with the purchasing pool administrator's handling of the money, the company would be responsible.

CHAIRMAN BENEDICT asked if they had rulemaking authority under chapter 17 to access fees for the registration.

Claudia Clifford said there was a fee of $100 when they register as an administrator.

Motion :

SEN. JACOBSON MOVED amendment #3 on because they have already taken care of #1 and #2.

Discussion:

CHAIRMAN BENEDICT said the people that sell the insurance are already regulated. He said other than another $100 did not do that much good.

REP. SIMON said if looking at the copy of the code, it talks to the administration and not the selling of insurance.

CHAIRMAN BENEDICT said it was another regulatory burden that was maybe not necessary because the people who represent the insurance companies when forming the purchasing pools were already regulated.

SEN. ECK said she remembered people saying that they preferred HB 405, but they should add something to the bill that regarding the responsibilities.

CHAIRMAN BENEDICT said he did not see where it speaks to solvency or anything really like that. It was to see who was out there. They already basically know who was selling insurance. He said he did not see where it was necessary.

SEN. ECK asked if she could address the fiduciary question.

Frank Cote said they were trying to address that an unlicensed individual can set up the purchasing pool. He said they must eventually purchase insurance through licensed agents. They were trying to get at the unlicensed person who might set up a pool that they have no authority over.

CHAIRMAN BENEDICT asked how would they take premiums if they were unlicensed.

Frank Cote said that they could sell through an agent, but they could collect the premiums and present them on to an agent for the company.

REP. SIMON asked if the pool has not been formed, then would it really fall under this any how.

Frank Cote said they were talking about after they pool was formed. Someone can form a pool and be the administrator of the pool and go out and find an agent which will sell the insurance to the pool. They have regulatory authority over that agent and the insurance company, but not over the administrator of the pool. If the money was coming into the pool and the pool was supposed to pass it on to the agent or the company, that may or may not happen. If it did not happen, there is not ability to go after the administrator of that pool if they are unlicensed.

Larry Akey, representing the Association of Life Underwriters, said there was the issue of whether or not there would be an unlicensed administrator collecting money and funnelling it through an agent back to the company. Because both the agent that markets the product and the product itself are fully regulated, it seems like there is no need for another level of regulation. He said he did not disagree if the committee wanted to adopt the rules to register and require some minimal reporting to the commissioners office, but to bring the administrator of the pool under the third party administrator statute was really intended for self-funding organizations and not fully underwritten products. He said this may be too much. There is not going to be the ability to go out and collect a lot of money because there was not going to be a product to collect the money on.

CHAIRMAN BENEDICT asked if he would rather see the amendments of his. **(EXHIBIT #4)**

Larry Akey said those were the type of reporting requirements that would be less obtrusive than requiring the pool administrator to register as a third party administrator.

Vote:

The **MOTION FAILED** with **SEN. JACOBSON, SEN. ECK, REP. TUSS and REP. SQUIRES** voting yes.

Motion :

CHAIRMAN BENEDICT MOVED an amendment on page 3, line 1, section 2, subsection 2, following "any" restore "small". He said that he was not sure why it was deleted. Page 2, line 30, after "employers" strike "with more that 25 eligible employees".

Discussion:

REP. SIMON said the reason the language is that way is because it was felt that if they limit it to employers that have less that 25 employees they leave 1,000 eligible employees in there it would make it difficult for some of the pools because most of the employers in Montana are small business and some may have more that 25. It was felt to allow the inclusion of some businesses so that they can reach the goal of 1,000 eligible employees and they might want to bring in a few employers that may have 100 employees in order to reach the goal of having a purchasing pool of 1,000 eligible employees. He objected to the amendment.

Steve Turkiewicz, representing Montana Auto Dealers and the Montana Association of Health Care Purchasers, said they wanted amendment #1. That was on page 3, line 1. The concern they had on the language of amendment #2 is on page 2. The concern was on the 25 employees. That is the definition they are looking at, at the top level of the small employer definition. The would like to see something that tied it to the small employer availability act language to assure them that they could have small employers and also employers also that are outside that and not get into what they have for an excepted individual. He said the key was something along the line larger than the small employer as defined. They were concerned that if the language was changed it would not match with the act. They were looking for something that was larger than defined or not defined in the small employer group.

CHAIRMAN BENEDICT said he would ask to have the amendments segregated.

REP. SIMON said on line 18 of page 2, the House struck "small" employer and then "may except employers of more than 25 employees" and went on to strike "small" employers over there because if they put small employers in there it may not exclude employers that otherwise meet the requirements.

CHAIRMAN BENEDICT said they still had "small" employers on line 29.
David Niss said it was codified in part 18 where that definition applies.

SEN. JACOBSON said with the amendments are they saying this applies to small group and the way it was defined currently was 3-25. They are trying to open the top end up for groups of more that 25, but not less than 3.

Susan Fox replied that was her understanding. The amendment on page 3, line 1, **Larry Akey** could address because in the testimony, someone called it an inadvertent amendment, "small". She said it was not included in what **Mr. Akey** presented to the committee, but because the editors brought it up she asked him if it was in or out and he made the comment on the spot.

REP. ORR said the Montana Association of Health Care Purchasers gave them amendments and on the second page the first half of that page deals with that problem. He said that it seems to contradict themselves. He asked him to speak to that also.

Larry Akey said the **Susan Fox** was correct when she explained it. If they leave the language "small" stricken from page 3, line 1, they create a guaranteed issue requirement for employers of larger than 25. He said that would put the purchasing pool at a disadvantage relative to the market place. He said they amendment was to put "small" back in.

SEN. JACOBSON said in effect they were saying that people could come into the purchasing pool and the high end even if they do not move to 25 they will be fully underwritten or they may be fully underwritten.

Larry Akey said the way that it was presented to the committee after coming from the House, they could not be underwritten. The Health Care Purchasing Association is asking for that freedom.

SEN. JACOBSON said if they were going to do that for the top end, why do they not let individuals in.

Larry Akey replied that was a different issue. The motion for people purchasing insurance as individuals is different than the motivation for people purchasing insurance as groups. If they allow individuals in, they open up for the potential of adverse selection. He said if they were going to allow individuals in on a fully underwritten basis and that the pool could exclude them for health concerns then adverse selection could maybe be avoided.

SEN. JACOBSON said she disagreed because when they get into groups as small as 3 to 25, they are talking about family members a lot of the time and many of those people are probably purchasing insurance for themselves and not the market place.

Vote:

The **SEN. BENEDICT MOTION to amend page 3, line 1, in section 2 be CARRIED UNANIMOUSLY.**

Discussion:

CHAIRMAN BENEDICT WITHDREW THE MOTION on the second amendment.

He submitted an amendment concerning the registration of the pools. **(EXHIBIT #4)**

Motion/Vote:

SEN. FOSTER MOVED the amendments **(EXHIBIT #4)** . The **MOTION CARRIED UNANIMOUSLY.**

Motion/Vote:

SEN. FOSTER MOVED DO PASS HB 405 **AS AMENDED.** The **MOTION CARRIED UNANIMOUSLY.**

SEN. JACOBSON would carry SB 405.

EXECUTIVE ACTION ON SB 405

Motion/Vote:

SEN. JACOBSON MOVED TO TABLE SB 405. The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON HB 560

Motion:

REP. SIMON MOVED to **DO PASS** HB 560.

Discussion:

CHAIRMAN BENEDICT said there was a 3 page set of amendments. **(EXHIBIT #5)**

Motion:

REP. SIMON MOVED the AMENDMENTS (EXHIBIT #5)

Discussion:

David Niss said that paragraphs 1-3 were only to conform to the remainder of the amendments. They have added "or a dependent of the employee or account holder" throughout the amendments because they had not made it consistent through the bill that the Medical Savings Accounts could be used for health care expenses of dependents also. He said paragraphs 5 and 6 on the first page go together. Those let the employer contribute both the Medical Savings Account and to a health care insurance policy established by the employer.

CHAIRMAN BENEDICT said the employee would be getting a benefit from the money employer was paying for premiums on a catastrophic policy.

REP. SIMON said that subsection 4, on page 2, would explain that.

David Niss went through the amendments. He said the language on line 8, providing for the exception as in subsection 4, is being stricken because it is not really an exception, but is excess language. The language in 10 is to make that there is no limitation on the amount of money that could be deposited into the account as long as the exclusion for the principal that was

deposited could not exceed $3,000. It was an exclusion for determining Montana adjusted gross income.

CHAIRMAN BENEDICT said if they deposit $5,000, they would only get credit for a $3,000 exclusion.

Bob Turner, representing the Department of Revenue, said there was a limit of $3,000, but there is not a limit on the interest. The interest is also excluded out of the present law. It would be $3,00 plus the interest income. Page 7, line 11, subsection (i), it says principal and income. The $3,000 is the principal and income from that Medical Savings Accounts, if there is interest. He said they could have a principal contribution of $3,000 and any interest on top of that $3,000 would be excluded.

CHAIRMAN BENEDICT asked if that was the way he wanted it to be.

David Niss said that **Bob Turner** should look at the amendments paragraph 11.

Bob Turner said that was what he was seeing because it says the principal and interest.

REP. SIMON said he had not intention of excluding the interest from being sheltered. He said it was like an IRA and as long as it was being used for the appropriate purpose he would not object with the idea that the interest would also be sheltered. He said if they were to take the money out for nonmedical purposes they would be subjected to a penalty.

David Niss said the issue was if the $3,000 was a limitation on the exclusion of the principal or a limitation on the exclusion of the principal and income. He said the amendment makes clear that the $3,000 was a limitation only on the exclusion of principal. He said that paragraph was offered by the Department of Revenue because they had a concern that if they were excluding any amount of income on a yearly maximum $3,000 of principal, they were concerned whether there was any implication there that losses to the account could also be excluded and paragraph 12 of the amendments makes clear that losses are never to be excluded. Paragraph 14 of the amendments says if a person wins the lottery of inherits a great deal of money and deposits it as principal into the account, $3,000 in principal can be excluded per year.

REP. SIMON said he was thinking about those people who's income fluctuates from year to year and if they have a good year they could put aside more that the $3,000, but they could never take a tax break for more that $3,000 for any given year.

David Niss said paragraphs 15, and 16 were only for clarity. paragraph 17, makes clear that they are not just talking about interest in the pass book. Paragraph 18 is the dependant amendment for clarity purposes. Paragraph 19 is to clarify that there are three categories of money withdrawn from the account.

The first is money withdrawn for health care or long term care which can be withdrawn and spent tax free at any time. The second is the withdrawals on the last business day for any purpose, which is taxed as ordinary income. The third is for a withdrawal anytime except those mentioned that is both taxed as regular income and subject to the 10% penalty. He said all of the amendments on the third page are for clarity. Paragraph 28 makes it clear that it applies to the current tax year.

Motion:

REP. SIMON MOVED the amendments. **(EXHIBIT #5)**

Discussion:

CHAIRMAN BENEDICT asked if the concerns of the Department of Revenue had been answered.

Bob Turner asked if the maximum included $3,000 plus interest.

REP. SIMON said no.

David Niss said he had understood the intent to be that the $3,000 limit was to be a limit for the purposes of a deposit and exclusion of the principal only and any income on the $3,000 would be excluded. The amendments provide that any amount of money can be deposited into the account. $3,000 is excluded worth of principal per year and any amount of interest on that principal.

SEN. ECK said the effect would be that they could always exclude $3,000 and eventually might be able to exclude another amount of interest.

REP. SIMON said they would only have a large exclusion if a person had acquired a large sum of money. He said a person had accumulated that kind of money they would be moving toward a goal of being able to provide for long term care.

SEN. ECK said she was concerned about the total tax expenditure. She said they would need a new fiscal note to know what the impact would be.

REP. SIMON replied it may, but he did not think it would be a serious problem. He said he did not think it would change the fiscal note.

CHAIRMAN BENEDICT said the fiscal note was $3.1 million dollars in 1996 and in 1997 it was $15.5 million dollars. He asked if **Mr. Turner** agreed with what they were discussing.

Mr. Turner said that $24,000 on the lottery portion of the bill, would occur interest that would also be deductible each year along with the $3,000.

CHAIRMAN BENEDICT said the it would only be the interest on the $3,000 of that $24,000.

SEN. JACOBSON said they were setting up a situation where people could put an unlimited amount of money in there that will accumulate interest and will not be tax deductible and they should look at what will happen in the future. She said the federal government may move on this same sort of situation and it might double the numbers of people and the fiscal note may be larger than they expected.

CHAIRMAN BENEDICT said this bill if it comes out of this committee would go to the Senate floor and it has never had a hearing.

REP. SIMON said this was an $18 million dollar bill.

CHAIRMAN BENEDICT said he was looking at the $15.5 million in fiscal 1997.

REP. SIMON said they have to apply the assumption that only 20% of them would use the program so the net revenue impact was only $3.1 million.

CHAIRMAN BENEDICT said that was in tax year 1996 which would be fiscal year 1997.

Bob Turner said they were correct about the $3.1 million, but since the effective date was changed it would be about $6 million dollars.

SEN. JACOBSON on number 14 of the assumptions of the fiscal note, she was assuming that they could take out money for long term care without any penalty.

Motion:

SEN. ECK MOVED the amendments that allow the addition of interest and one-time lottery be segregated from the amendments. She wanted to allow no more than $3,000 per year. She said she liked the concept, but had problems that they are putting millions of dollars into that tax expenditure and they are unwilling to do anything for children and low income persons.

Discussion:

REP. SIMON asked if they were segregating them.

CHAIRMAN BENEDICT replied that was correct.

SEN. ECK said to limit them to $3,000 per year.

SEN. JACOBSON said that would be what **SEN. ECK** was going to try to do if it was segregated.

Vote:
(for segregation of the amendments)

The **MOTION CARRIED UNANIMOUSLY.**

Discussion:

CHAIRMAN BENEDICT said they would have the amendments minus the segregated amendments.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Discussion :

SEN. ECK said those amendments were not in the bill yet.

REP. SIMON said that he did move all of the amendments and so they needed to vote on his motion and **SEN. ECK** is speaking against the second half of his motion. He said he wanted to speak in favor of it. He said it was rare that someone would put a lot of money into a Medical Savings Account, but they should have that option. He said the tax advantage for people to put money in without the federal is relatively small. He encourage to vote for the second half of his amendment.

{Tape: 2; Side: A.}

REP. GRIMES asked if **REP. SIMON** feels that it furthers some of the criticism that it was reverse incentive and it may further the concept of not fully utilizing the dollars that are in the accounts.

REP. SIMON said he did not see it that way. That is a separate issue. He said people utilize medical care when they need it.

SEN. JACOBSON said she was uncomfortable with no cap on the bill. It seems like she could go out and set up an account and put $20,000 in there and be given credit for $3,000 and she did not understand about the tax dollars.

CHAIRMAN BENEDICT said he wanted to make sure that if someone put $100,000 into the account, they would get an exclusion on the principal on the $3,000 and they would also be able to exclude all of the interest on the other $97,000.

Bob Turner replied that was correct.

David Niss replied that was correct.

Vote:

The **MOTION CARRIED** 6 to 4 by Roll Call Vote with **SEN. FOSTER, REP. GRIMES, SEN. MILLER, REP. SIMON, REP. ORR and SEN. BENEDICT** voting yes and **SEN. ECK, SEN. JACOBSON, REP. TUSS, and REP. SQUIRES** voting no.

Motion/Vote:

REP. SIMON MOVED to strike (c) on page 1, lines 22 and 23 so that a broker dealer or an investment advisor would not be an account administrator. The **MOTION CARRIED** with **REP. GRIMES** voting no.

Discussion:

CHAIRMAN BENEDICT said that his daughter was in a wheelchair and was a quadriplegic and durable medical was hard to come by. He wanted to tie something in that has to do with the $2,000 threshold for assets that a disabled person can have to qualify for medicaid to exclude this, a Medical Savings Account would not count toward that $2,000 exclusion.

Peter Blouke said he was not sure if they could do that under federal regulation. He said what is counted as an asset is generally driven by the federal medicaid laws. He said he would check to see if there would be some way to exclude it.

CHAIRMAN BENEDICT replied it would not just have to be for wheelchairs, but Medicaid does not and will not always pay for things. He said maybe they could pass a conceptual amendment that would be contingent on federal law.

Peter Blouke said they could do that.

Motion/Vote:

CHAIRMAN BENEDICT MOVED the conceptual amendment. The **MOTION CARRIED UNANIMOUSLY.**

Motion:

REP. SIMON MOVED HB 560 **AS AMENDED.**

Discussion:

SEN. ECK she asked if they were going to put a contingency voidness provision in the bill.

REP. SIMON said he was not familiar with that procedure. He asked if they have to identify specific cuts in Hb 560.

CHAIRMAN BENEDICT said they would have to identify specific cuts in HB 2.

REP. ORR said this was a small enough amount that it needs to have a contingent voidness clause. Those will be prioritized as to what they can afford. He said it would be proper to attach the clause.

REP. SIMON said he did not have any disagreement with that.

Motion/Vote:

SEN. ECK MOVED to attach a contingent voidness clause in HB 560. The **MOTION CARRIED UNANIMOUSLY.**

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON HB 202

Motion:

REP. SIMON MOVED HB 202 **DO PASS.**

Motion/Vote:

REP. SIMON MOVED a contingency voidness clause. The **MOTION CARRIED UNANIMOUSLY.**

Motion:

CHAIRMAN BENEDICT MOVED an amendment to cut the bill in half and make it a 50% deduction rather than 100% to cut down on the fiscal note.

Discussion:

SEN. ECK said that for $9 million they could cover all children and pregnant women up to 200% poverty which would mean that access would be run greatly. She said this would provide fairness to those people who have insurance, but if they are not doing anything on the other end then she did not know if she could support that.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Discussion:

CHAIRMAN BENEDICT said the Department of Revenue had some amendments to offer.

Bob Turner read and explained **(EXHIBIT #6).**

Motion/Vote:

CHAIRMAN BENEDICT MOVED the amendments **(EXHIBIT #6)**. The **MOTION CARRIED UNANIMOUSLY.**

Motion/Vote:

REP. SIMON MOVED HB 202 **DO PASS AS AMENDED.** The **MOTION CARRIED** 9 to 1 by Roll Call Vote with **SENATOR ECK** voting no.

EXECUTIVE ACTION ON HB 85

Motion/Vote:

REP. ORR MOVED TO TABLE HB 85. The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON HB 62

Motion/Vote:

REP. SIMON MOVED TO TABLE SB 62. The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 74

Discussion:

CHAIRMAN BENEDICT said SB 74 would allow the deduction of insulin or prescription drug medical drug payments.

SEN. ECK asked if there were amendments to the bill.

Susan Fox said there was a proposed Department of Revenue amendment.

Motion/Vote:

REP. ORR MOVED TO TABLE SB 74. The **MOTION CARRIED** with **SEN. ECK, SEN. JACOBSON, REP. TUSS and REP. SQUIRES.**

Discussion:

CHAIRMAN BENEDICT said they would have executive action on the rest of the bills on Thursday night.

EXHIBIT #7 was given to the members before the meeting.

ADJOURNMENT

Adjournment: 8:08 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 3-13-95

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		

SENATE STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your Joint Select Committee on Health Care having had under consideration HB 405 (third reading copy -- blue), respectfully report that HB 405 be amended as follows and as so amended be concurred in.

Signed: _____
Senator Steve Bendict, Chair

That such amendments read:

1. Title, line 5.
Following: ";"
Insert: "ASSIGNING THE COMMISSIONER OF INSURANCE CERTAIN DUTIES REGARDING VOLUNTARY PURCHASING POOLS;"

2. Page 3, line 1.
Following: "~~small~~"
Insert: "small"

3. Page 3, line 2.
Following: "experience"
Insert: ", occupation,"

4. Page 3, line 30.
Insert: "

NEW SECTION. **Section 3. Commissioner powers and duties -- application for registration -- reporting insolvency.** (1) The commissioner shall develop forms for registration of an organization as a voluntary purchasing pool.

(2) An organization seeking to be registered as a voluntary purchasing pool shall make application to the commissioner. The commissioner shall register an organization as a voluntary purchasing pool upon proof of fulfillment of the qualifications provided in [section 2].

(3) The voluntary purchasing pool shall provide an annual report and financial statement to the commissioner containing sufficient detail in order that the commissioner may determine whether:

(a) the operation of the voluntary purchasing pool is fiscally sound; and

(b) the voluntary purchasing pool is bearing any risk.

(4) The annual report of the voluntary purchasing pool must disclose its total administrative cost in the same manner and on the same basis as insurers.

(5) If an examination of the annual report and financial

statement indicates that the voluntary purchasing pool fails to meet the qualifications of [section 2], the commissioner may suspend or revoke the registration of the voluntary purchasing pool. An action to suspend or revoke the registration of the voluntary purchasing pool is subject to the provisions of Title 2, chapter 4, part 6.

(6) If an examination of the annual report and financial statement indicates that the voluntary purchasing pool is insolvent, the commissioner shall maintain jurisdiction of the purchasing pool for the purposes of protecting the interests of the pool participants and the insurers writing the disability insurance."

Renumber: subsequent section

5. Page 4, line 1.
Strike: "Section"
Insert: "Sections"
Following: "2"
Insert: "and 3"
Strike: "is"
Insert: "are"

6. Page 4, line 3.
Strike: "section"
Insert: "sections"
Following: "2"
Insert: "and 3"

-END-

SENATE STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your Joint Select Committee on Health Care having had under consideration HB 511 (third reading copy -- blue), respectfully report that HB 511 be amended as follows and as so amended be concurred in.

Signed: _____
Senator Steve Benedict, Chair

That such amendments read:

1. Page 1, lines 21 through 23.
Following: "(1)"
Strike: the remainder of line 21 through "However," on line 23
Insert: "The legislature and"

2. Page 1, line 23.
Strike: "has also"
Insert: "have"

3. Page 1, line 24.
Following: "The"
Insert: "legislature and the"
Strike: "supports"
Insert: "support"

4. Page 2, line 3.
Insert: "

NEW SECTION. **Section 2. State health care policy.** (1) It is the policy of the state of Montana to continue to investigate and develop strategies that result in all residents having access to quality health services at costs that are affordable.

(2) It is further the policy of the state of Montana that:

(a) Montana's health care system should ensure that care is delivered in the most effective and efficient manner possible;

(b) health promotion, preventative health services, and public health services should play a central role in the system;

(c) the patient-provider relationship should be a fundamental component of Montana's health care system;

(d) individuals should be encouraged to play a significant role in determining their health and appropriate use of the health care system;

(e) accurate and timely health care information should play a significant role in determining the individual's health and appropriate use of the health care system;

(f) whenever possible, market-based approaches should be

relied on to contain the growth in health care spending while attempting to achieve expanded access, cost containment, and improved quality; and

(g) the process of health care reform in Montana should be carried out gradually and sequentially to ensure that any undesirable impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

(3) The legislature recognizes the need to increase the emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only those services to the consumer that are reasonable and necessary.

(4) [Sections 1 through 7] may not be interpreted to prevent Montana residents from seeking health care services not otherwise recommended or provided for as a result of the provisions of [sections 1 through 7]."
Renumber: subsequent sections

5. Page 9, line 28.
Strike: "6"
Insert: "7"

6. Page 14, lines 14 and 15.
Strike: "6"
Insert: "7"

7. Page 14, lines 16 and 17.
Strike: "10"
Insert: "11"

8. Page 14, lines 18 and 19.
Strike: "18"
Insert: "19"

9. Page 14, line 26.
Strike: "7"
Insert: "8"
Strike: "20"
Insert: "21"

10. Page 14, line 27.
Strike: "22"
Insert: "23"
Strike: "24"
Insert: "25"

11. Page 14, line 28.
Strike: "8"
Insert: "9"
Strike: "19"
Insert: "20"

12. Page 14, line 30.
Following: "1"
Insert: ", 2(4), and 3"
Strike: "7"
Insert: "8"

-END-

HOUSE STANDING COMMITTEE REPORT

March 14, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **House Bill 202** (first reading copy -- white) **do pass as amended.**

Signed: _____

Steve Benedict, Chair

And, that such amendments read:

1. Title, line 4.
Following: "FOR"
Insert: "ONE-HALF OF"

2. Title, line 6.
Strike: "AND"
Insert: ","
Following: the second "DATE"
Insert: ", AND A CONTINGENT VOIDNESS PROVISION"

3. Page 1.
Following: line 17
Insert: "(c) one-half of premium payments for medical care as provided in subsection (7);"

4. Page 3, line 11.
Following: "(7)"
Insert: "one-half of"
Following: "payments"
Insert: ", except premiums deducted in determining Montana adjusted gross income,"

5. Page 3, lines 12 and 13.
Strike: "or made" on line 12 through "federal law" on line 13

6. Page 3.

Committee Vote:
Yes 9, No 1.

591501SC.Hbk

Following: line 17
Insert: "(9) For the purpose of subsection (7)(a), deductible medical insurance premiums are those premiums that provide payment for medical care as defined by 26 U.S.C. 213(d)."

Renumber: subsequent subsections

7. Page 3, line 27.
Strike: "(9)"
Insert: "(10)"

8. Page 4.
Following: line 2
Insert: "NEW SECTION. **Section 3. Contingent voidness.** In order to maintain a balanced budget, because [this act] reduces revenue, it may not be transmitted to the governor unless a corresponding identified reduction in spending is contained in House Bill No. 2. If a corresponding identified reduction in spending is not contained in House Bill No. 2, [this act] is void."

-END-

HOUSE STANDING COMMITTEE REPORT

March 14, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **Senate Joint Resolution 14** (third reading copy -- blue) **be concurred in as amended.**

Signed: _____
Steve Benedict, Chair

Carried by: Rep. Simon

And, that such amendments read:

1. Page 1, line 19.
Strike: "ONLY"

2. Page 1, line 23 through page 1, line 30.
Strike: page 1, line 23 through page 1, line 30 in their entirety

3. Page 2, lines 8 through 10.
Strike: "RECOMMENDATIONS TO IMPLEMENT"
Insert: "several approaches to"
Following: "Montana"
Strike: remainder of line 8 through "MERITS." on line 10
Insert: "; and
WHEREAS, the members and staff of the Montana Health Care Authority have devoted significant time to studying the issue of health care, and the people of Montana appreciate their hard work and dedication."

-END-

Committee Vote:
Yes 10, No 0.

591508SC.Hbk

HOUSE STANDING COMMITTEE REPORT

March 14, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **House Bill 542** (first reading copy -- white) **do pass.**

Signed: _____

Steve Benedict, Chair

Committee Vote:
Yes 10, No 0.

591505SC.Hbk

HOUSE STANDING COMMITTEE REPORT

March 14, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **House Bill 560** (first reading copy -- white) **do pass as amended**.

Signed: _____

Steve Benedict, Chair

And, that such amendments read:

1. Title, line 8.
Following: "OF"
Insert: "AN EMPLOYEE OR ACCOUNT HOLDER OR A DEPENDENT OF"
Following: "THE"
Insert: "EMPLOYEE OR THE"

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

3. Title, line 10.
Following: "MCA"
Insert: "; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE, A RETROACTIVE APPLICABILITY DATE, AND A CONTINGENT VOIDNESS PROVISION"

4. Page 1, line 22 and 23.
Strike: subsection (c) in its entirety

5. Page 2, line 18.
Following: "employer"
Insert: "or for a dependent of the employee"

6. Page 2, line 25.
Strike: "either"
Strike: "or"

Committee Vote:
Yes 10, No 0.

Insert: ","

7. Page 2, line 26.
Following: "employee"
Insert: ", or to both the account and the policy or program"

8. Page 3, line 2.
Following: "interest"
Strike: "are"
Insert: "or other income is"

9. Page 3, line 7.
Following: "holder"
Insert: "or a dependent of the employee or account holder"

10. Page 3, line 8.
Strike: "Except as provided in subsection (4), an"
Insert: "An"

11. Page 3, lines 8 and 9.
Strike: "may deposit into an account in 1 year and"

12. Page 3, line 10.
Following: "funds"
Insert: "and interest or other income on those funds"

13. Page 3, line 12.
Following: "."
Insert: "An employee or account holder may not deduct pursuant to 15-30-121 or exclude pursuant to 15-30-111 an amount representing a loss in the value of an investment contained in an account."

14. Page 3, line 14.
Strike: "allowed by"
Insert: "excluded pursuant to"

15. Page 3, line 15.
Following: "."
Insert: "An employee or account holder who deposits more than $3,000 into an account in a year may exclude from the employee's or account holder's adjusted gross income in accordance with 15-30-111(2)(j) in a subsequent year any part of $3,000 per year not previously excluded."

16. Page 3, line 21.
Following: "(6)"
Strike: the remainder of line 21.

17. Page 3, line 22.
Strike: "liability."
Insert: "The employee or account holder who establishes the account is the owner of the account. An employee or account holder may withdraw money in an account and deposit the money in another account with a different or with the same account administrator without incurring tax liability."

18. Page 3, line 27.
Following: "interest"
Insert: "or other income"

19. Page 4, line 3.
Following: "holder"
Insert: "or a dependent of the employee or account holder"

20. Page 4, lines 4 and 10.
Following: "."
Insert: "Money withdrawn from an account pursuant to this subsection must be taxed as ordinary income of the employee or account holder."

21. Page 4, line 6.
Strike: "and"
Insert: "or"

22. Page 4, line 21.
Following: "annuity"
Insert: "for the long-term care of the employee or account holder or a dependent of the employee or account holder"

23. Page 4, line 23.
Following: "expenses"
Insert: "or for a long-term care insurance policy or annuity"

24. Page 4, line 24.
Strike: "are"
Insert: "is"

25. Page 4, line 28.
Following: "holder"
Insert: "or a dependent of the employee or account holder"

26. Page 5, line 2.
Following: "annuity"
Insert: "for the employee or account holder or a dependent of the employee or account holder"

27. Page 7, line 12.
Following: "expenses"
Insert: ","
Following: "[section 2]"
Insert: ", of the taxpayer or a dependent of the taxpayer"

28. Page 7, line 13.
Following: "taxpayer"
Insert: "or a dependent of the taxpayer"

29. Page 8.
Following: line 11
Insert: "NEW SECTION. **Section 9. Account not to be treated as asset for purposes of eligibility.** If allowed by federal law, the principal and all interest or other income contained within an account established in accordance with [sections 1 through 7] may not be treated as an asset of the employee or account holder or as an asset of a dependent of the employee or account holder for the purposes of eligibility for the Montana medicaid program."

Renumber: subsequent section

30. Page 8, line 13.
Following: "instruction."
Insert: "(1)"

31. Page 8.
Following: line 14
Insert: "(2) [Section 9] is intended to be codified as an integral part of Title 53, chapter 6, and the provisions of Title 53, chapter 6, apply to [section 9].

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.

NEW SECTION. **Section 12. Effective date.** [This act] is effective on passage

and
approval.

NEW SECTION. **Section 13. Contingent voidness.** In order to maintain a balanced budget, because [this act] reduces revenue, it may not be transmitted to the governor unless a corresponding identified reduction in spending is contained in House Bill No. 2. If a corresponding identified reduction in spending is not contained in House Bill No. 2, [this act] is void."

-END-

3/13/95

Scott Orr has my proxy vote on bills in the Health select committee

Ken Mills

3/13/95
HEALTH CARE

I GIVE MY PROXY TO
DUANE GRIMES.

I Give my proxy to
Scott Orr. He went
to Salt Lake.

I give my proxy
to Duane Grimes
or Scott Orr.

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

DATE 3-13-95 BILL NO. SJR 14 NUMBER 1

MOTION: Senator Jacobson's amendments (Exhibit #1) to SJR 14.

	NAME	AYE	NO
2	SENATOR DOROTHY ECK	X	
3	SENATOR MIKE FOSTER		X
4	REPRESENTATIVE DUANE GRIMES		X
5	SENATOR JUDY JACOBSON	X	
6	SENATOR KEN MILLER		X
7	REPRESENTATIVE BRUCE SIMON	X	
8	REPRESENTATIVE CAROLYN SQUIRES	X	
9	REPRESENTATIVE CARLEY TUSS		X
→ 1	REPRESENTATIVE SCOTT ORR, VICE CHAIRMAN		X
10	SENATOR STEVE BENEDICT, CHAIRMAN		X

SEN:1995

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

DATE 3-13-95 BILL NO. HB 511 NUMBER 2

MOTION: Senator Jacobson moved amendments #1-#5 on Exhibit #2.

NAME	AYE	NO
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

SEN:1995

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

DATE 3-13-95 BILL NO. HB 560 NUMBER 3

MOTION: To accept the rest of Rep. Simon's amendments.

NAME	AYE	NO
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	

SEN:1995

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

DATE 3-13-95 BILL NO. HB 202 NUMBER 3

MOTION: Do Pass As Amended

NAME	AYE	NO
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	

SEN:1995

Exhibit #1
3-13-95

Amendments to Senate Joint Resolution No. 14
Third Reading Copy

Requested by Senator Jacobson
For the Joint Select Committee on Health Care

Prepared by Susan Byorth Fox
March 13, 1995

1. Page 1, line 19.
Strike: "ONLY"

2. Page 1, line 23 through page 2, line 5.
Strike: page 1, line 23 through page 2, line 5 in their entirety

3. Page 2, lines 8 through 10.
Strike: "RECOMMENDATIONS TO IMPLEMENT"
Insert: "several approaches to"
Following: "Montana"
Strike: remainder of line 8 through "MERITS" on line 10

Exhibit #1

Exhibit #2
3-13-95

Amendments to HB 511

1. Page 1, line 21.
Following: "(1)"
Strike: the remainder of line 21 through "However," on line 23.

2. Page 1, line 23.
Following: "However,"
Insert: "The legislature and"

3. Page 1, line 23.
Strike: "has also"
Insert: "have"

4. Page 1, line 24.
Following: "The"
Insert: "legislature and the"

5. Page 1, line 24.
Strike: "supports"
Insert: "support"

6. Page 2, line 4.

Insert: **NEW SECTION. Section 2. State health care policy.** (1) It is the policy of the state of Montana to continue to investigate and develop strategies which result in all residents having access to quality health services at costs that are affordable.

(2) It is further the policy of the state of Montana that:

(a) Montanans should have access to health care services they need without having to incur excessive out-of-pocket expenses;

(b) Montana's health care system should insure that care is delivered in the most effective and efficient manner possible;

(c) health promotion and preventive health services should play a central role in the system;

(d) the patient-provider relationship should be a fundamental component of Montana's health care system;

(e) individuals should be encouraged to play a significant role in determining their health and using the health care system appropriately;

(f) accurate and timely health care information should play a significant role in guiding health care resource allocation, utilization, and quality of care decisions, both by consumers and providers;

(g) wherever possible, market-based approaches should be relied on to contain the growth in health care spending while attempting to achieve expanded access, cost containment and improved quality; and

(h) the process of health care reform in Montana should be carried out gradually and sequentially to ensure that any undesirable impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

(3) It is further the policy of the state of Montana that regardless of whether or what form of a health care reform strategy is adopted by the legislature, the health care advisory council, health care providers, and other persons involved in the delivery of health care services need to increase their emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only services to the consumer that are reasonable and necessary.

(4) Nothing in [this act] may be interpreted to prevent Montana residents from seeking health care services not otherwise recommended or provided for as a result of the provisions of [this act].

Renumber subsequent sections.

Exhibit #3
3-13-95

Amendment to HB 405

1. Page 3, line 2.
Following: "experience"
Insert: ", occupation,"

Exhibit # 4
3-13-95

AMENDMENTS TO HOUSE BILL 405

1. Page 3, following line 29.
Insert: "NEW SECTION. Section 3. Commissioner powers and duties -- application for registration -- reporting -- insolvency. (1) The commissioner shall develop forms for registration by an organization as a voluntary purchasing pool.

(2) An organization seeking to be registered as a voluntary purchasing pool shall make application to the commissioner. The commissioner shall register any organization as a voluntary purchasing pool upon proof of fulfillment of the qualifications provided in [section 2].

(3) The voluntary purchasing pool shall provide an annual report and financial statement to the commissioner with sufficient detail that commissioner may determine that:

(i) the operation of the pool is fiscally sound; and

(ii) the pool is not bearing any risk.

(4) The annual report of the voluntary purchasing pool shall disclose its total administrative cost in the same manner and on the same basis as insurers.

(5) If an examination of the annual report and financial statement indicates the voluntary purchasing pool fails to meet the qualifications of [section 2], the commissioner may suspend or revoke the registration of the purchasing pool. An action to suspend or revoke the registration of a voluntary purchasing pool is subject to the provisions of Title 2, chapter 4, part 6.

(6) If an examination of the annual report and financial statement indicates the voluntary purchasing pool is insolvent, the commissioner shall maintain jurisdiction of the purchasing pool for the purposes of protecting the interests of the pool participants, and the insurers writing the disability insurance."
Renumber subsequent sections.

Exhibit # 5
3-13-95

Amendments to House Bill No. 560
First Reading Copy

Requested by Rep. Simon
For the Select Committee on Health Care

Prepared by David S. Niss
March 2, 1995

1. Title, line 8.
Following: "OF"
Insert: "AN EMPLOYEE OR ACCOUNT HOLDER OR A DEPENDENT OF"
Following: "THE"
Insert: "EMPLOYEE OR THE"

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

3. Title, line 10.
Following: "MCA"
Insert: "; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE"

4. Page 2, line 18.
Following: "employer"
Insert: "or for a dependent of the employee"

5. Page 2, line 25.
Strike: "either"
Strike: "or"
Insert: ","

6. Page 2, line 26.
Following: "employee"
Insert: ", or to both the account and the policy or program"

7. Page 3, line 2.
Following: "interest"
Strike: "are"
Insert: "or other income is"

8. Page 3, line 7.
Following: "holder"
Insert: "or a dependent of the employee or account holder"

9. Page 3, line 8.
Strike: "Except as provided in subsection (4), an"
Insert: "An"

10. Page 3, lines 8 and 9.
Strike: "may deposit into an account in 1 year and"

11. Page 3, line 10.

Following: "funds"
Insert: "and interest or other income on those funds"

12. Page 3, line 12.
Following: "."
Insert: "An employee or account holder may not deduct pursuant to 15-30-121 or exclude pursuant to 15-30-111 an amount representing a loss in the value of an investment contained in an account."

13. Page 3, line 14.
Strike: "allowed by"
Insert: "excluded pursuant to"

14. Page 3, line 15.
Following: "."
Insert: "An employee or account holder who deposits more than $3,000 into an account in a year may exclude from the employee's or account holder's adjusted gross income in accordance with 15-30-111(2)(j) in a subsequent year any part of $3,000 per year not previously excluded."

15. Page 3, line 21.
Following: "(6)"
Strike: the remainder of line 21.

16. Page 3, line 22.
Strike: "liability."
Insert: "The employee or account holder who establishes the account is the owner of the account. An employee or account holder may withdraw money in an account and deposit the money in another account with a different or with the same account administrator without incurring tax liability."

17. Page 3, line 27.
Following: "interest"
Insert: "or other income"

18. Page 4, line 3.
Following: "holder"
Insert: "or a dependent of the employee or account holder"

19. Page 4, lines 4 and 10.
Following: "."
Insert: "Money withdrawn from an account pursuant to this subsection must be taxed as ordinary income of the employee or account holder."

20. Page 4, line 6.
Strike: "and"
Insert: "or"

21. Page 4, line 21.
Following: "annuity"
Insert: "for the long-term care of the employee or account holder

EXHIBIT 5
DATE 3-13-95

or a dependent of the employee or account holder"

22. Page 4, line 23.
Following: "expenses"
Insert: "or for a long-term care insurance policy or annuity"

23. Page 4, line 24.
Strike: "are"
Insert: "is"

24. Page 4, line 28.
Following: "holder"
Insert: "or a dependent of the employee or account holder"

25. Page 5, line 2.
Following: "annuity"
Insert: "for the employee or account holder or a dependent of the employee or account holder"

26. Page 7, line 12.
Following: "expenses"
Insert: ","
Following: "[section 2]"
Insert: ", of the taxpayer or a dependent of the taxpayer"

27. Page 7, line 13.
Following: "taxpayer"
Insert: "or a dependent of the taxpayer"

28. Page 8.
Following: line 14
Insert: "NEW SECTION. **Section 10. {standard} Retroactive applicability.** [This act] applies retroactively, within the meaning of 1-2-109, to tax years beginning after December 31, 1994.

NEW SECTION. **Section 11. {standard} Effective date.** [This act] is effective on passage and approval."

Exhibit #6
3-13-95

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).

NationsBusiness
The Small Business Adviser

Sexual Harassment: Reducing The Risks

The Importance Of Buy/Sell Agreements

New Moves To Cu
Federal Regulati

The Power Of Poolin

Voluntary purchasing groups for health insurance are proving to be good medicine for small companies.

COVER STORY

The Power Of Pooling

By Roberta Maynard

While Congress talked health-care reform to death last year, Edward Regan became part of a quiet revolution that is changing the way small companies and their workers buy health insurance. Regan, president of Performance Audio in San Francisco, joined a purchasing pool and immediately cut his company's monthly insurance costs 42 percent without sacrificing the quality of coverage.

"For me it was fantastic," says Regan, who was preparing to increase his deductible to $5,000 from $1,000 to keep premiums down for himself and his eight workers. "Right off the bat, the premiums dropped, and at renewal they dropped another 6 percent. I'm paying $1,100 a month," just over half of what he was paying before. And the new health plan, an HMO (health-maintenance organization), has no deductible, only a $15 copayment for each office visit.

Regan is one of more than 4,300 small-business owners in California who have voluntarily signed up with the state-sponsored Health Insurance Plan of California since it opened for business in July 1993. The HIPC (pronounced hippie) is a pioneering effort to make health insurance more affordable by giving small firms the kind of group purchasing power long enjoyed by large companies. The immediate savings reaped by Regan were higher than those of most companies that have joined the HIPC, but savings by most firms have been substantial.

The California HIPC offers coverage to all companies with four to 50 workers; the average size so far is 10 employees. In addition to lower costs, the HIPC provides a range of health-plan choices. Statewide, 23 insurers offer a variety of standardized HMOs and PPOs (preferred-provider organizations). Employees, not employers, choose the plan best-suited to their needs and pocketbooks.

While California was the first state to establish a voluntary purchasing pool, or alliance, for private employers, 15 others have either started alliances or changed laws that would have prohibited them. (See the chart on Page 17.) Private alliances, typically run by business groups, are permitted in most other states, according to the Institute for Health Policy Solutions, a nonprofit group in Washington, D.C.

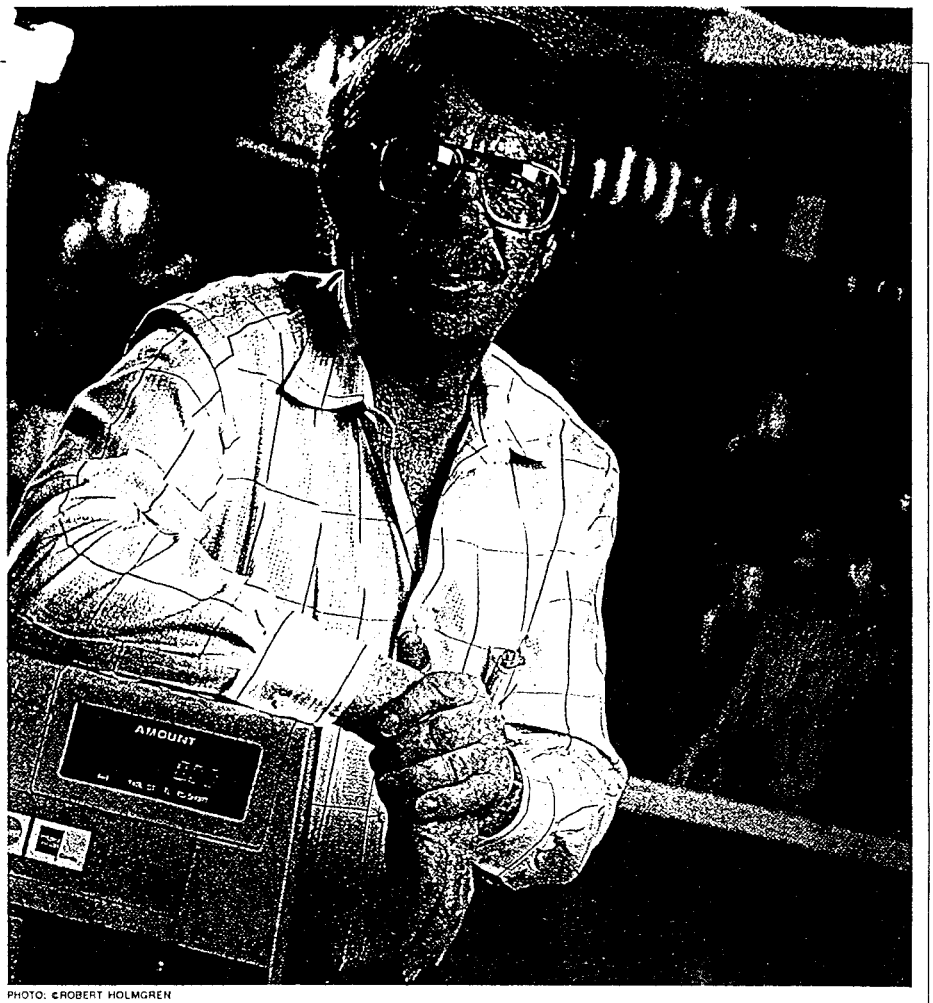


PHOTO: ©ROBERT HOLMGREN

Premium costs dropped *by nearly half for Performance Audio when the San Francisco firm signed up with California's purchasing alliance, says Edward Regan, president.*

The idea of purchasing pools for small firms is not new. For years, trade associations, labor unions, and business groups have offered health plans to their members through pooling arrangements called multiple-employer trusts (METs) and multiple-employer welfare arrangements (MEWAs).

Like METs and MEWAs, the new pooling arrangements are meant to give their members collective leverage in the marketplace to get lower prices. There the similarity ends.

Unlike METs and MEWAs, the new alliances accept all small companies, offer a variety of plans from multiple insurers, and require standardized benefits that allow employees to make clear price comparisons. The consumer-friendly approach to the new alliances prompted one analyst to call them "Price Clubs" for health insurance.

Despite their shared goal of cost cut-

Voluntary purchasing groups are delivering lower health-insurance rates and greater choice for small businesses. You, too, might benefit from this growing trend.

ting through group purchasing power, alliances differ greatly:

Governance: Some are overseen by state agencies, some by private business groups.

Boundaries: Some are regional, others are statewide.

Competition: Some have exclusive territories, and some compete with other alliances.

Prices: Some negotiate rates with insurers, others allow insurers to set their own rates.

Choice: Some allow employees to pick from a menu of health plans, others let employers select which plans will be available to employees.

Here's how these differences play out in several states:

California

The California plan offers an example of maximum state control. The HIPC is administered by an independent state agency that defines the standard benefits offered and negotiates prices with insurers.

For the purposes of setting rates and servicing plans, the HIPC divides the state into six regions. Participating employers must contribute at least 50 percent of the cost of the lowest monthly employee-only plan available; they may buy through an insurance agent for a fixed commission or directly through the HIPC.

Employees may choose any health plan offered in their region. More than 80,000 workers and dependents are currently covered statewide.

Florida

Lawmakers opted for less state control. Legislation passed in 1993 established 11 exclusive regional alliances loosely overseen by the state's Agency for Health Care Administration, but each alliance is administered by a board in its region.

The state's insurance department defines the basic and standard health plans that insurers offer within the 11 regions, called Community Health Purchasing Alliances. Any employer with one to 50 workers may purchase insurance through these groups.

Employers choose which plans to make available to employees. The alliances do not negotiate price with insurers. Employers must purchase plans through insurance agents, whose commissions may vary depending on the plan chosen.

The Florida alliances opened for business in June 1994. On Jan. 1, statewide enrollment was nearly 5,000 businesses—with 22,300 people covered.

Iowa

Iowa took a different approach by simply setting up the regulatory framework to facilitate the formation of private, nonprofit alliances that may have overlapping territories.

The Independent Insurance Agents of Iowa took the lead and launched the Des Moines-based Independent Health Alliance of Iowa last July. The alliance, which provides insurance to individuals and companies of any size, offers a minimum of three insurers and four health-plan designs throughout the state.

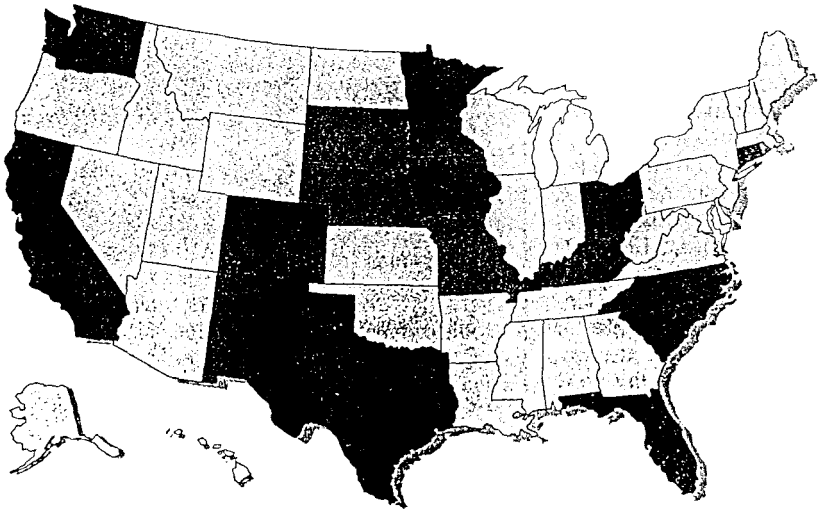
The state established two standard health plans that all insurers must offer within alliances. Employers are required to pay for only 25 percent of the lowest-cost health plan. On Jan. 1, the alliance had 440 participating employers and covered 3,300 people.

The state will soon have a second alliance, started by the Health Policy Corporation of Iowa, which has served self-insured firms since 1982. The corporation's president, Paul Pietzsch, has announced plans to start an alliance for small companies by midyear.

Texas

A 1993 law set up an alliance that covers the state through seven regions. The alliance is private but is administered by a

The Push Toward Purchasing Groups



States that have passed legislation forming or encouraging purchasing groups.

States that have amended existing laws to permit purchasing groups. (Most other states allow private purchasing groups.)

SOURCE: INSTITUTE FOR HEALTH POLICY SOLUTIONS

board appointed by the governor. The same law also laid the groundwork for formation of other private purchasing groups.

Alliances will serve companies with three to 50 workers and will require participating insurers to offer small employers three health plans defined by state law. The statewide alliance began enrolling companies Jan. 1.

New York

In New York, private, business-sponsored alliances are springing up even though the legislature has taken no action to create a state-supported alliance structure.

The Long Island Association has just begun the LIA Health Alliance, available to businesses with three to 50 employees. When enrollment began last December, approximately 3,500 companies were ready to sign up. Firms have the option of buying through insurance agents.

A private alliance in nearby White Plains will soon be operating in Westchester, Rockland, and Putnam counties. The alliance, called the W/R/P-HPPA Ltd., is sponsored by three business organizations and will provide coverage to companies of one or more employees. Insurance agents have the exclusive right to sell health plans through the alliance.

Clearly, business groups and states are doing voluntarily what President Clinton's defunct health-reform plan tried to mandate: Move small businesses into purchasing groups.

What accounts for the sudden popularity of alliances? The idea entered the national health-reform debate during the 1992 presidential campaign. President Bush and candidate Clinton both embraced the idea of managed competition, an approach that relies on the marketplace to drive down costs and improve quality of care. The key to making this happen is the health-insurance purchasing alliance.

Within an alliance, insurers would be forced to compete on the basis of price and quality. Insurers would not be permitted to deny or drop coverage for individuals or groups with costly medical conditions.

States in recent years have facilitated the move to managed competition by enacting sweeping insurance-market reforms that force all insurers to play by new competitive rules that reduce or eliminate risk selection.

Lawmakers recognized that, over time, small businesses were unable to benefit from the basic insurance principle of spreading risks over a large group. Insurers had come to evaluate small firms separately by such factors as claims experience, workers' health status, and even type of business.

As a result, many small companies couldn't buy health insurance at any price. Those that did have coverage lived in fear of a single serious illness because it could trigger skyrocketing rates or cancellation of coverage.

To remedy these problems involving access to insurance, states have enacted small-group market reforms that typically apply to companies with two to 50 employees, although a few states include sole proprietors.

Since 1992, most states have enacted reforms that do one or more of the following: protect small companies' ability to purchase health insurance regardless of employees' health status; prohibit insurers from canceling small groups' coverage (except for nonpayment or fraud); guarantee continued health coverage without a waiting period when an employee changes jobs; and limit the ability of insurers to charge different rates for companies of similar size and employee characteristics. (See the chart at left.)

In addition, 10 states have adopted some form of community rating, which bars consideration of health status in setting rates.

These small-group market reforms have laid the groundwork for alliances to test whether restructured competition among insurers would in fact drive down costs while improving quality.

Alliances have other advantages that are highly attractive to state lawmakers. "They are a cheap form of health reform; it costs very little to set one up," says Kevin Haugh, senior policy analyst for the Institute For Health Policy Solutions.

"It also has kind of warm

How States Are Rewriting Small-Group Market Rules

Most Adopt New Requirements For Insurers

	Guaranteed Issue[1]	Guaranteed Renewal[2]	Coverage Portability[3]	Rate Restrictions[4]
Alabama				
Alaska	Yes	Yes	Yes	Yes
Arizona	Yes	Yes	Yes	Yes
Arkansas		Yes		
California	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes	Yes
Delaware	Yes	Yes	Yes	Yes
Florida	Yes	Yes	Yes	Yes
Georgia				Yes
Hawaii				
Idaho	Yes	Yes	Yes	Yes
Illinois		Yes	Yes	Yes
Indiana		Yes		Yes
Iowa	Yes	Yes	Yes	Yes
Kansas	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes
Louisiana	Yes	Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes
Michigan				
Minnesota	Yes	Yes	Yes	Yes
Mississippi	Yes	Yes	Yes	Yes
Missouri	Yes	Yes	Yes	Yes
Montana	Yes	Yes	Yes	Yes
Nebraska	Yes	Yes	Yes	Yes
Nevada				
New Hampshire	Yes	Yes	Yes	Yes
New Jersey	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes
North Carolina	Yes	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	Yes
Pennsylvania				
Rhode Island	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes	Yes
South Dakota		Yes		Yes

1. Guaranteed Issue: As a condition of doing business, insurers must provide coverage to any small group that applies.
2. Guaranteed Renewal: Insurers may cancel a company's coverage only for cause, such as fraud or nonpayment of premiums.
3. Coverage Portability: Workers changing jobs are not required to fulfill a waiting period before being covered for a pre-existing condition.
4. Rate Restrictions: One of several ways to limit or ban consideration of medical conditions in setting or increasing premiums.

SOURCE: INTERGOVERNMENTAL HEALTH POLICY PROJECT, THE GEORGE WASHINGTON UNIVERSITY

EXH. #7 3-13-95

fuzzies associated with it—the idea of people getting together to get a great deal, empowering the consumer, ganging up on the health-care system," Haugh says.

"The notion of plan choice, which didn't exist before, is also appealing," Haugh says. "And in the rapid movement toward managed care where you're taking provider choice away [from individuals], this is a way to give it back to people," by giving them a greater choice of health plans.

Finally, according to Haugh, people feel good about alliances because they are locally based, which enables them to respond to their communities' needs. And they are voluntary, in contrast to the mandated alliances under Clinton's rejected health-reform plan.

Of all the advantages ascribed to purchasing alliances, none appeals more to small-business owners than the lower cost of coverage. Alliances are designed to cut costs three ways:

First, they use their collective bargaining power to win cost concessions, a technique applied with great success by big-business purchasers of health care.

Second, they restructure the marketplace through small-group insurance market reforms and standardized health plans, forcing insurers to wage marketing campaigns based on cost and quality.

Third, they achieve economies of scale for administrative functions, substantially cutting overhead costs.

Studies have shown that as much as 30 to 40 cents of every premium dollar paid by small businesses goes to support an insurer's overhead, according to Richard Figueroa, a deputy director with the state agency that oversees California's HIPC. In contrast, the alliance has held overhead costs to between 12 and 18 cents per premium dollar.

Together, streamlined administration and competitive pressures have allowed the HIPC to offer small companies average cost savings of 5 to 15 percent. Savings for many companies, like Edward Regan's, far exceed the average.

Standardized health plans make price shopping simple and easy for members of the California alliance, Regan says. "It's easy to get an insurance quote on a car or house," he adds, "but with health insurance outside the HIPC, it's hard to sort out what are the benefits of different policies. I don't have time for that. I've got a business to run."

The new Long Island alliance estimates that its prices are 5 to 10 percent below the average range for comparable coverage outside the alliance.

In Florida, the regional alliances have cut premiums an average of 8 percent, and the cost of some plans has fallen by 25 percent.

For Helen Lyon of Kissimmee, Fla., lower cost was a welcome bonus for joining the local alliance. Her primary concern was coverage for cancer treatment. The sole proprietor of Lyon Mailing Specialist, she had health insurance through a trade association. But she switched to the Florida alliance after her insurer refused to pay for the eight chemotherapy sessions that she needed at a cost of $800 each.

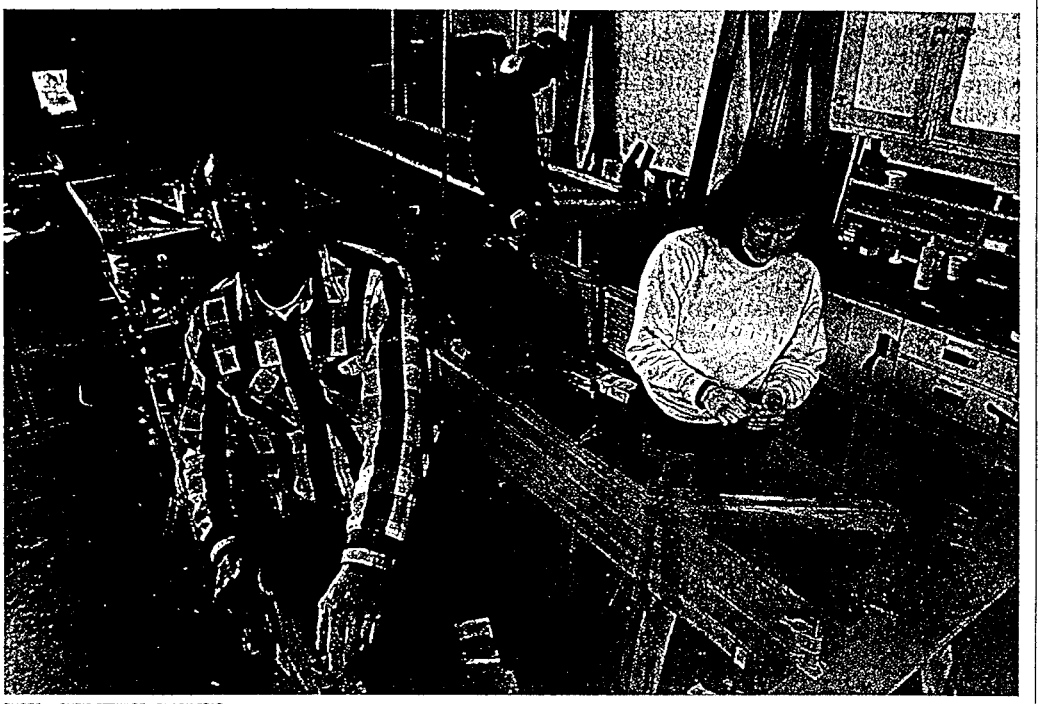


PHOTO: ©CHRIS STEWART—BLACK STAR

Price and choice of plans *available through an alliance persuaded Clark Griffin, left, owner of Griffin Construction, in Iowa City, Iowa, to offer health insurance to his two employees.*

Because she had previous coverage, Lyon was not subject to the prescribed one-year waiting period for pre-existing conditions. Her new HMO plan immediately covered her cancer treatment. She now pays a premium of $165 per month, which is $25 less than she had been paying for what she says was an inferior health plan.

While cutting costs, purchasing alliances want to ensure that they deliver high-quality medicine. "You can't ultimately reform health care based on price alone," says Terry McCorvie, executive director of Florida's District 7 alliance in Orlando, which covers one-fourth of the 5,000 employers that have enrolled statewide. "You have to change the focus from risk to competition based on value."

"We think providers and the risk bearers [insurers] have a responsibility to manage care as well as price," McCorvie adds. "It's a changing paradigm for insurance to be based on efficiency and quality."

Quality won't be left to guesswork. To varying degrees, state laws require alliances to gather information about consumer satisfaction, medical outcomes, and other quality data. Some require report cards to assist consumers in making buying decisions.

Many alliances, at a minimum, plan to survey their members for information on provider care and service, such as length of wait for appointments and ease of collecting on claims.

Regular evaluation of doctors, hospitals, and insurers is another way that alliances expect to promote competition.

Built-in quality measures were a major draw for Katherine Heaviside, president of Epoch 5 Marketing, a public-relations firm in Huntington, N.Y. She was among the first small-business owners who called to inquire about the private alliance that has just been started by the Long Island Association. Heaviside views health insurance as an important benefit for her 20 employees and an essential tool in competing with larger companies for the best talent.

"Cost is probably what's going to get everyone's attention, but what interested me is that they will have a report card on providers," says Heaviside. "We don't want to take the chance of inferior quality by just going with the lowest bidder," she says. Heaviside plans to join the Long

Island Association alliance as soon as her current policy expires.

New alliances, like the one on Long Island, are not alone in trying to recruit small-business buyers. Groups that have catered to large and medium-sized companies are showing interest in expanding into the small-group market.

Of the 90 large-business health-care coalitions that are members of the National Business Coalition on Health, a trade association based in Washington, D.C., more than a dozen are moving toward establishing new HIPC-type alliances to include small groups or are allowing small businesses into their existing purchasing arrangements.

"It is starting to catch on like prairie fire," says Sean Sullivan, the group's president. This new interest in reaching out to small-business groups is partly the result of a higher level of awareness by coalitions, he says, and partly a realistic look at the future. "We feel we have to make the market work for all of us, and small business is a major part of that market."

In Colorado, for example, a cooperative serving only self-insured firms is assessing the feasibility of contracting with five insurers to sell health plans to groups of all sizes. "We think the time is ripe to do this," says Claire Brockbank, vice president of the Colorado Health Care Purchasing Alliance, in Denver. "To include small business means including another half of the business in this community. But there are many hurdles still to cross."

One major concern is whether the number of small companies signing up in the largely rural state would be enough to create the market efficiencies needed to reduce costs significantly. Insurers set their prices in part on the volume of business they can expect.

Says Brockbank: "The question is, 'Can [the alliance] attract anyone?' The products must be cheaper right out of the block—small business will want [lower] cost."

Later this year, a private Milwaukee group that serves large employers plans to launch a new purchasing group for companies of all sizes. "We were challenged by smaller businesses in the community that said we were cost-shifting to them," says Jim Wrocklage, chief execu-

PHOTO: ©BEN VAN HOOK—BLACK STAR

Sole proprietor *Helen Lyon joined a Florida alliance that offers her better coverage at a lower premium.*

Questions To Ask Before Joining A Health-Insurance Pool

1. Is this alliance public, private, or a combination of the two?

Public alliances are administered and financially supported by the states. Some alliances have state-appointed boards, but they function as private entities. Others are run by business groups and get no administrative or financial help from the states.

2. What size companies are eligible to participate?

Most alliances do not yet accept the self-employed or companies that have only one or two workers. In most states, alliances cover businesses with three to 50 employees.

3. How many insurance plans are available, and are they standardized?

Alliances typically offer a menu of health plans from several insurers. Most are managed-care plans, either health-maintenance organizations or preferred-provider organizations. Benefits are the same in each plan, allowing direct cost comparisons among plans.

4. What is the required employer contribution per employee, and what percentage of the employees must buy health insurance?

While employer participation is strictly voluntary, alliances usually require businesses to pay a certain amount of the cost—either a percentage of the premium or a flat fee. Most base the employer payments on the lowest-cost plan. Typically, alliances require 75 percent of employees to participate as a way to help spread the risks.

5. Does the employer choose the health plan, or do individual employees make the choice?

Many alliances allow employees to choose their own health plan from a menu of approved plans. Others allow the employer to choose which two or three plans will be made available to employees.

6. Who sets the insurance premiums?

Some alliances negotiate rates directly with insurers through a bidding process. In Florida, alliances do not negotiate prices but simply publish rates set by insurers that are certified to sell insurance through the alliances. In general, rates for alliance plans are lower than rates for plans sold outside an alliance.

7. Who handles administration of the plan?

The alliance generally handles enrollment and premium collection, although these functions may be contracted out to a private administrator. Employers receive one bill that consolidates costs for all workers, regardless of the number of plans involved.

8. Must businesses buy through insurance agents? Or can they buy directly from an alliance?

In some states, only insurance agents may sell alliance health plans, for which they receive a commission. In others, employers may also buy directly from the alliance.

9. What kind of information will be provided on doctors, hospitals, and insurers?

Most alliances intend to publish "report cards" that include information on consumer satisfaction, health outcomes, and quality measurements.

10. Is there state oversight of this alliance?

Licensing of private alliances is required only in Iowa, Colorado, and Ohio. However, many states require alliances to be certified, meeting certain minimum standards prescribed by the state. To ask about a particular alliance, call your state insurance department.

tive of the Health Care Network of Wisconsin.

Cost-shifting occurs when large companies negotiate discounted fees from doctors and hospitals. Those providers try to make up lost revenue by charging more to small businesses—the major health-care buyers still paying nonnegotiated prices.

As big-business alliances open doors to small companies, the new small-business alliances are planning to expand. The California legislature this year will consider opening the HIPC to sole proprietors and two-person firms. These groups were excluded from the initial round of reforms because they are regarded as the highest risks. The HIPC already plans to begin accepting companies with three employees in July.

CBIA Health Connections, a private alliance based in Hartford, Conn., is open to groups of three to 50 workers because that was the range established in the state's small-group reform. "We would love to expand in both directions, and we will do that over time," says Philip Vogel, CBIA Service Corp.'s senior vice president.

Fred Barba, executive director of the Long Island alliance, makes it clear he's headed in that direction, too. "We plan to find a way to go after those sole proprietors," he says. "Later we will go after the employer groups with more than 50 employees."

"Cost is probably what's going to get everyone's attention, but what interested me is that [the alliance] will have a report card on providers."

—Katherine Heaviside, President, Epoch 5 Marketing

For all the promise they offer to small business, voluntary alliances are not a cure for all that ails the nation's health-care system. They are not, for example, going to provide coverage to the nation's 40 million uninsured—nearly 14 million of whom work for companies with 25 or fewer workers.

"You can't get there [to universal coverage] from here," says Figueroa of the California HIPC. "I think everybody pretty much agrees on that." In California, for example, only 22 percent of the firms joining the HIPC had not previously offered insurance. That percentage includes new businesses. And, while the HIPC now covers more than 80,000 people, the state has more than 6.4 million uninsured.

There are major barriers to bringing large numbers of previously uninsured small businesses into alliances, according to Catherine McLaughlin, an associate professor of health services, management, and policy at the University of Michigan. Her studies show that the main reason many small firms don't offer health insurance is that their key workers are covered through their spouses' insurance. This is prevalent in communities with large corporate employers.

A second factor is that many low-wage employees prefer receiving higher pay to making less money and getting health insurance. And, third, offering insurance just isn't feasible for some types of businesses, such as those that employ a large number of transitory or seasonal workers.

On a more hopeful note, McLaughlin's

Broad Support For Insurance Reforms

Health-care reform may be down, but it's not out. The new Republican majority on Capitol Hill is committed to a variety of incremental changes, many designed specifically to help small businesses.

Even President Clinton, whose massive plan to overhaul the health-care system suffered resounding defeat last year, has endorsed the idea of limited reforms. In his State of the Union address in January, he asked Congress to work with him on a variety of ideas, many of which had strong backing from Republicans last year.

Chief among them is small-group insurance market reform designed to remove barriers to buying and maintaining health coverage. Under such reforms, insurers could not refuse to sell a policy to any group or individual, nor could they refuse to renew a policy because someone developed a serious illness.

Moreover, insurers would face new restrictions on their ability to exclude pre-existing conditions from coverage. Specific health problems could be excluded for a limited period—six months in most proposals—for first-time buyers. But exclusions would not apply to those who maintain continuous coverage but change policies.

Other proposals that enjoy bipartisan support include:

■ Immediate restoration of the 25 percent health-insurance tax deduction, which expired Dec. 31, 1993, for the self-employed. The House Ways and Means Committee on Feb. 8 approved legislation to restore the deduction and make it retroactive for 1994. Many lawmakers want to phase in 100 percent deductibility for the self-employed, but, under budget rules, they must come up with a way to offset the revenue loss. Only incorporated businesses currently may deduct 100 percent of their health-insurance costs.

■ Medical malpractice reform that would require alternative dispute resolution as a prerequisite to legal action, place a cap on awards for punitive damages, and cap attorneys' fees.

■ Voluntary, small-employer purchasing alliances that would help make health plans more affordable. In his State of the Union address, the president declared: "We ought to make sure that the self-employed and small businesses can buy insurance at more affordable rates through voluntary purchasing pools."

While there appears to be broad agreement on key elements of incremental reforms, the specifics of individual bills are still being worked out.

In the Senate, Majority Leader Bob Dole of Kansas has appointed a new Republican health-care task force to develop a reform proposal.

In the House, the Ways and Means and Commerce committees, both with jurisdiction over health-care reform, are expected to schedule hearings soon. Ways and Means Chairman Bill Archer, R-Texas, already has endorsed insurance market reforms and malpractice reform. Commerce Committee Chairman Thomas J. Bliley Jr., R-Va., plans to introduce a bill that includes these reforms plus medical IRAs—tax-free savings accounts to cover health-care spending.

Republicans and Democrats are motivated at least in part by polls showing strong public support for at least incremental reforms. A recent ABC News/Washington Post poll, for example, found that 84 percent of Americans regard health reform as "important" or "critical."

Even so, if Congress doesn't act before the fall recess, election-year politics will make any type of agreement difficult in 1996.

—Roger Thompson

PHOTO: ©WAYNE SORCE

A private alliance *in New York appealed to Katherine Heaviside, standing, president of Epoch 5 Marketing, because it lets each of her 20 employees choose his or her own plan and provider.*

research shows that 60 percent of the firms not currently interested in offering health insurance might be persuaded to do so if they could join a purchasing alliance.

An alliance made the difference for Clark Griffin, owner of Griffin Construction in Iowa City, Iowa. Through the private alliance he joined last fall, Griffin now provides insurance for the first time for his two employees. He says he was attracted by the wide range of price and plan choices offered. Griffin pays $100 a month toward each employee's plan, roughly half their premiums.

First-time buyers like Griffin clearly will benefit from alliances. But in terms of sheer numbers, alliances probably will have the most impact on small businesses that already buy group insurance. For them, alliances offer the lure of newfound purchasing power in a marketplace where they have had none.

As the small-business demand side of health insurance gets more organized, insurers will experience competitive pressures as never before. "For the first time," says Long Island's Barba, "small-business people will be able to behave like consumers."

But alliances still face an important test. Now that most states guarantee access to health insurance, there is concern among policy experts that voluntary alliances will become magnets for high-risk groups and ultimately fall into a "death spiral" of increasing costs and rates.

This is a nearly universal concern among proponents of alliances and a common criticism of the voluntary-alliance model.

Most alliance directors say they are striving to make their offerings attractive enough to appeal to everyone, not just high-risk groups.

And a few safeguards are in place. Most small-group market reforms include waiting periods of three months to a year for coverage of pre-existing conditions to discourage the purchase of insurance only after illness strikes. Another protective measure is a minimum-participation requirement for employers—typically around 75 percent of eligible employees—to help guarantee that the pool is large enough to level out the risk across the many plans offered.

The most important defense against the death spiral, though, is to ensure that the rules for alliances [illegible] the same as those that apply to insurance policies sold outside the alliances.

"The surest way to kill an alliance is to do something so that the alliance has much more of an open-door policy than the rest of the marketplace," says policy analyst Kevin Haugh. "If you're taking all comers and the rest of the marketplace isn't, you're going to become the magnet for high-risk cases. Where you see the underwriting going on [that is, basing coverage or premiums on medical status] is in states or areas where there aren't requirements that health plans [provide coverage]—basically where there isn't insurance reform.

"We've worked with a number of groups that have tried to set up alliances in the absence of insurance reform," Haugh continues, "and our advice is you're probably committing hari-kari if you [aren't] a little selective about whom you're going to take. Not that you want to, and most of them don't. It's administratively costly, and it's not the image you want to project. But it's better that you stay in business and do some good than go out of business."

It is too early to tell how successful voluntary alliances ultimately will be in achieving their goals, but those involved believe that they are the last, best hope for the market to address the problems of cost and quality for small companies.

"We think it's better to have this done under private market reform, driven by businesses, not by federal or state laws," says Jim Wrocklage of the Milwaukee Health Care Network. "We decided, 'Why don't we step up and play the game on a voluntary basis and have input into setting the guidelines that everyone will live by?' "

Paul Pietzsch, who heads one of Iowa's two private alliances, agrees: "We think this time around it's serious business. The private sector won't have too many more chances to do this."

Resources

The American Academy for Health Purchasing Alliances and Cooperatives, in Washington, D.C., provides analysis, information, and technical assistance on alliances. For information, call (202) 857-0810.

The academy is part of the nonprofit, nonpartisan Institute for Health Policy Solutions. The institute has two reports on purchasing alliances: *Key State Legislative Provisions on Purchasing Alliances* and *A Comparison of Small-Employer Purchasing Alliances.*

The latter provides detailed comparisons of 10 major alliances—in California, Connecticut, Florida, Illinois, Minnesota, New York (two), Texas, Washington, and Wisconsin.

Both reports are $15 for members of any chamber of commerce, higher for others. To order, write the institute at 1900 L Street, N.W., Suite 508, Washington, D.C. 20036, or call (202) 857-0810.

For a free copy of model legislation on private purchasing alliances (titled The Private Health Care Voluntary Purchasing Alliance Model Act), contact the Kansas City, Mo., publications department of the National Association of Insurance Commissioners, at (816) 374-7259.

To order a reprint of this story, see Page 61.
For a fax copy, see Page 26.

DATE March 13, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: HB 511, HB 542, SJR 14, HB 405, SB 405, HB 560, HB 85, HB 202, SB 62, SB 74

** Executive Action **

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