MINUTES OF THE MEETING
HUMAN SERVICES AND AGING COMMITTEE
50TH LEGISLATURE

January 22, 1987

The meeting of the Human Services and Aging Committee was called to order by Chairman Budd Gould at 12:30 p.m. on January 22, 1987 in 312D of the State Capitol.

ROLL CALL: All members were present.

CONSIDERATION OF HOUSE BILL 126:

REP. HARPER introduced the bill. He presented several amendments that provided a guarantee that further funding would not be requested. He pointed out that Gardner Cromwell, a law professor, authored the bill. Specific provision was made that said "subject to available funding". Other amendments following "transportation" strike "that guarantees" and insert "providing". He said the intent of the amendment is the same. Rep. Harper said this was a priority of American Association of Retired Persons (AARP). He pointed out that over 42 percent of people over 65 were near or below the poverty level.

PROPONENTS:

JOE UPSHAW, chairman of the state legislative committee of AARP, spoke in support of the bill. He said this bill would enable the state of Montana to act on behalf of older citizens. (Exhibit 1)

GARDNER CROMWELL discussed the legislation. He pointed out that there were 23 states with departments on aging with similar legislation.

ELMER HAUSKIN, member of AARP from Helena, discussed his involvement in the preparation of HB126. He urged the committee to pass the bill on behalf of the aging people. (Exhibit 2)

ROGER POORE, employee of Rocky Mountain Development Council in Helena, testified in support of HB126. He said area agencies on aging were created by the 1973 amendments of the Older Americans Act. He said the role of the agency was to plan, coordinate, and advocate for the comprehensive delivery system for older people. He mentioned the goals of the Older American Act to secure the maximum independence and dignity for older persons. He said that HB126 would provide, within the statutes of the state of Montana, the

coordination and planning responsibilities of the state unit on aging.

DOUG CAMPBELL, from Missoula representing Montana Senior Citizens Association, testified in support of HB126.

CHARLES BRIGGS, state aging coordinator in the Governors office, conveyed the support of the Governor's Advisory Council on Aging of the proposed legislation.

OWEN WARREN, member of the 1986 Legacy Legislature, spoke in favor of HB126.

OPPONENTS: There were no opponents.

CONSIDERATION OF HOUSE BILL 128:

REP. HANSEN, House District 57, presented HB128 on health cost containment. She explained the bill was the result of the Legacy Legislature. She said the bill excluded anyone who is a trustee of a health care facility or manages the money of the facility to serve on the board. Health care facilities are defined and the responsibility of the board would be under the Department of Administration with the Department of Revenue collecting the fees. She presented an amendment from the Department of Revenue which would specify how the fees would be collected.

PROPONENTS:

ENID SIMPSON discussed the importance of the bill. She pointed out the need for the bill in reducing the health care costs. She said that people avoid health care due to lack of money, but the hospitals have empty beds. The commission could be a communication center between the providers and consumers. She said the acceleration of health care costs shows the need for a commission.

JOE UPSHAW, representing AARP, spoke in support of HB128. He pointed out the need for control over the rapidly escalating medical costs in Montana. (Exhibit 3)

ELMER HAUSKIN, representing AARP, commented about the health care costs when under Medicare.

SCOTT WALKER, a private citizen from Polson, testified about the importance of the bill and the problem of health costs in society. He pointed out companies handling health care for profit. He said that multiple units put an over charge on the top of all the local costs to run the headquarters. He suggested to define competitive rates. (Exhibit 4)

OWEN WARREN, a member of the 1986 Legacy Legislature, spoke in favor of HB128.

TOM HOPKIN, representing the Health Insurance Association of America, discussed concerns over the cost of medical services. He said the association considers the bill to be a viable control on the cost of medical services.

EARL RILEY, with the Montana Senior Citizens Association, said the group was interested in methods to contain the spiraling costs of health care. He said that self regulation and voluntary restraints are not working when medical costs are rising at 2 1/2-3 times the rate of the inflation.

KEN MORRISON, representing the Department of Revenue, spoke about concerns of the department that they may not be able to collect the fee. He urged the committee to look at the bill to consider rule making authority, penalties and interest, and other requirements.

OPPONENTS:

JAMES F. AHRENS, president of the Montana Hospital Association, testified in opposition to HB128. He said that health care is expensive and that hospital and doctor costs for a major surgical procedure or nursing home care have major financial implications. He stated that this bill would not lower health care costs in the state. He said the bill would insure that the costs increase. The fiscal note states that it is not accurately possible to estimate the increased expenditure necessary to fund the commission activities. He pointed out the start up costs for the commission would be enormous. He said there would be duplication of services and the commissions would be adversaries and the final result would be the patient would pay for the unnecessary commission. (Exhibit 5)

JERRY LEAVITT, executive director of the Montana Hospital Rate Review System, spoke in opposition to the bill. He said there was a need to define terms. He pointed out the importance of what has happened as a result of rate controls on hospitals in other states. He said that hospitals today are able to provide the finest diagnostic and curative procedures. He concluded there was no reason for the state of Montana to impose another level of beauracracy on health care providers when the probable result would be greater provider costs. (Exhibit 6)

ROSE SKOOG, executive director of the Montana Health Care Association, opposed HB128. She discussed the rates and how they were set and who purchases the services. She pointed out the largest purchaser of services in nursing homes was

the state of Montana in the Medicaid program. She said they are regulated by that agency and rates set the SRS. She pointed out that 35 percent of facilities do not receive from the Medicaid program a rate adequate to cover their actual costs. She discussed the funding of the commission at a time when the regulatory burdens are increasing and money decreasing.

JERRY LOENDORF, representing the Montana Medical Association, summarized about non-profit hospitals. He discussed non-profit hospitals and the volunteers working there that would include rate setting.

CHARLES BRIGGS, state aging coordinator in the office of the Governor, discussed the recommendations that had resulted from the review of the issue of rate regulation in 1985. He said a regulatory system was not recommended unless other methods of cost containment were not effective or failed. (Exhibit 7)

REP. HANSON closed on HB128. She pointed out that health care costs have become a rich man's luxury. She said Montana had a below average income and health care insurance would not be afforded especially by young people.

QUESTIONS FROM THE COMMITTEE:

REP. NELSON asked about the appropriation by the legislature for the commission. Rep. Hanson clarified that start up money would be needed to get the commission going.

REP. KITTSELMAN said he was concerned about the start up costs, the salaries of commissioners, and the need for actuarial expertise.

EXECUTIVE SESSION OF HOUSE BILL 36:

REP. MCCORMICK moved to DO NOT PASS on HB36. Rep. Cody seconded the motion.

REP. CORNE' made a substitute motion to DO PASS HB36.

REP. SANDS moved to amend the bill, page 4, line 16 and 17, to strike the words "1991" and replace it with "1995". He said the time frame proposed in the bill was too short. He explained that if someone wanted to become a registered nurse they would have to begin their education this fall in order to meet the deadline described in the bill. He said since the bill was future oriented, additional time was needed to prepare for the program.

The question was called on the amendment. The motion PASSED.

REP. CORNE moved a substitute motion DO PASS AS AMENDED.

REP. KITTSELMAN pointed out that a nurse can go through a three year program and be an RN in another state and would not be able to practice the trade in the state of Montana if the bill passed. He pointed out that this would deprive people their livelihood.

REP. HANSON said a system was needed that would enable nurses to progress to a baccalaureate degree.

REP. MCCORMICK pointed out that some people had been in nursing for thirty years with much experience without a degree.

REP. SIMON moved to TABLE HB36.

CHAIRMAN GOULD called the question to TABLE HB36. The motion FAILED.

The question was called on the motion DO PASS AS AMENDED. The motion FAILED.

REP. MCCORMICK moved DO NOT PASS AS AMENDED. The motion PASSED 16-2.

EXECUTIVE ACTION ON HOUSE BILL 90:

REP. MCCORMICK moved to DO NOT PASS HB90.

REP. CODY pointed out that SRS, in their over zealousness, have hurt adults, children, and the family structure with accusations on people who are innocent. She said more information and common sense are needed.

The question was called. The motion DO NOT PASS HB90 PASSED with one NO vote by Rep. Sands.

EXECUTIVE ACTION ON HOUSE BILL 126:

REP. KITTSELMAN moved to DO PASS HB126. Lee Heiman read the amendment that would make the bill subject to available funding. The question was called. The motion PASSED unanimously. REP. KITTSELMAN moved to DO PASS AS AMENDED. The motion PASSED unanimously.

EXECUTIVE ACTION ON HOUSE BILL 128:

REP. HANSON recommended that the Department of Health study health care cost containment.

REP. KITTSELMAN moved to create a study commission resolution.

REP. GILBERT said it was not necessary to set up a committee to study the same question being studied elsewhere.

REP. HANSON moved to TABLE HOUSE BILL 128. The motion PASSED unanimously.

ADJOURNMENT: There being no further business the meeting was adjourned at 3:04 p.m.

BUDD GOULD, Chairman

dt/1-22HS

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date JAN. 22, 1987

NAME	PRESENT	ABSENT	EXCUSED
REP. BUDD GOULD, CHAIRMAN	X		
REP. BOB GILBERT, VICE CHAIRMAN	X		
REP. JAN BROWN	X		
REP DUANE COMPTON	X		
REP. DOROTHY CODY	X		
REP. DICK CORNE'	X		
REP. LARRY GRINDE	X		
REP. STELLA JEAN HANSEN	X		
REP. LES KITSELMAN	X		
REP. LLOYD MC CORMICK	X		
REP. RICHARD NELSON	X		
REP. JOHN PATTERSON	X		
REP. ANGELA RUSSELL	X		
REP. JACK SANDS	X		
REP. BRUCE SIMON	X		
REP. CAROLYN SQUIRES	X		
REP. TONIA STRATFORD	X		
REP. BILL STRIZICH	X		

STANDING COMMITTEE REPORT

January 22, 19 97

Mr. Speaker: We, the committee on HUMAN SERVICES AND AGING

report HOUSE BILL NO. 36

☐ do pass
☒ do not pass

☐ be concurred in
☐ be not concurred in

☒ as amended
☐ statement of intent attached

REP. R. HUDD GOULD, Chairman

NURSING LICENSURE REVISION

(AMENDMENTS)

1. Page 4, line 16.
   Strike: "1991"
   Insert: "1995"

2. Page 4, line 17.
   Strike: "1991"
   Insert: "1995"

FIRST 2 WHITE

_____ reading copy (_____)
color

ROLL CALL VOTE

HUMAN SERVICES AND AGING COMMITTEE

DATE JAN. 22, 1987 BILL NO. HB # 36 NUMBER 1

NAME	AYE	NAY
REP. BUDD GOULD, CHAIRMAN	✓	
REP. BOB GILBERT, VICE CHAIRMAN	✓	
REP. JAN BROWN	✓	
REP. DUANE COMPTON	✓	
REP. DOROTHY CODY	✓	
REP. DICK CORNE'		✓
REP. LARRY GRINDE	✓	
REP. STELLA JEAN HANSEN	✓	
REP. LES KITSELMAN	✓	
REP. LLOYD MC CORMICK	✓	
REP. RICHARD NELSON	✓	
REP. JOHN PATTERSON	✓	
REP. ANGELA RUSSELL	✓	
REP. JACK SANDS		✓
REP. BRUCE SIMON	✓	
REP. CAROLYN SQUIRES	✓	
REP. TONIA STRATFORD	✓	
REP. BILL STRIZICH	✓	
TALLY	16	2

Secretary Chairman

MOTION: REP. MC CORMICK moved that HB # 36 DO NOT PASS AS AMENDED - the motion CARRIED with 16 favorable and 2 opposing votes.

Form CS-31
Rev. 1985

STANDING COMMITTEE REPORT

JANUARY 22, 19 87

Mr. Speaker: We, the committee on HUMAN SERVICES AND AGING

report HOUSE BILL # 90

☐ do pass
☒ do not pass
☐ be concurred in
☐ be not concurred in
☐ as amended
☐ statement of intent attached

Rep. R. Budd Gould, Chairman

REVISING LAW ON ABUSED, NEGLECTED, AND DEPENDENT CHILDREN

FIRST reading copy (WHITE color)

ROLL CALL VOTE

HUMAN SERVICES AND AGING COMMITTEE

DATE 1-22-87 BILL NO. HB # 90 NUMBER 2

NAME	AYE	NAY
REP. BUDD GOULD, CHAIRMAN	✓	
REP. BOB GILBERT, VICE CHAIRMAN	✓	
REP. JAN BROWN	✓	
REP. DUANE COMPTON	✓	
REP. DOROTHY CODY	✓	
REP. DICK CORNE'	✓	
REP. LARRY GRINDE	✓	
REP. STELLA JEAN HANSEN	✓	
REP. LES KITSELMAN	✓	
REP. LLOYD MC CORMICK	✓	
REP. RICHARD NELSON	✓	
REP. JOHN PATTERSON	✓	
REP. ANGELA RUSSELL	✓	
REP. JACK SANDS		✓
REP. BRUCE SIMON	✓	
REP. CAROLYN SQUIRES	✓	
REP. TONIA STRATFORD	✓	
REP. BILL STRIZICH	✓	

TALLY 17 1

Secretary Chairman

MOTION: REP. MC CORMICK moved DO NOT PASS on HB # 90 - the motion CARRIED with 17 favorable and 1 opposing vote.

Form CS-31
Rev. 1985

STANDING COMMITTEE REPORT

JANUARY 22, 19 87

Mr. Speaker: We, the committee on HUMAN SERVICES AND AGING

report HOUSE BILL # 126

☒ do pass ☐ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. R. BUDD GOULD, Chairman

OLDER MONTANANS ACT

(AMENDMENTS)

1. Page 2, line 17.
   Following: "provided"
   Insert: " -- subject to available funding"

2. Page 2, line 22.
   Strike: "guarantees"
   Insert: "provides"
   Following: "services"
   Insert: "subject to available funding"

FIRST reading copy (WHITE color)

HB 126

EXHIBIT #1
DATE 1-22-89
HB # 126

MR CHAIRMAN, MEMBERS OF THE COMMITTEE,

I AM JOE UPSHAW OF HELENA, REPRESENTING THE AMERICAN ASSOCIATION OF RETIRED PERSONS. I AM SPEAKING IN FAVOR OF HB 126, A BILL WHICH IS IS PRESENTED FOR THE SOLE PURPOSE OF ENABLING AND EMPOWERING THE STATE OF MONTANA TO ACT ON THE BEHALF OF MONTANA"S OLDER CITIZENS, ~~IN THE EVENT THAT THE FEDERAL GOVERNMENT LESSENS OR ABRIDGES ITS EFFORT TO DO SO.~~ YOU WILL NOTE THAT THE SALIENT FEATURES OF THIS BILL ARE THREEFOLD (1) IT HAS BEEN KEPT AS SIMPLE AND UNCOMPLICATED AS POSSIBLE (2) IT INVOLVES NO EXPENDITURE OF FUNDS. (3) IT IS COMPLETELY NON SELF SERVING FOR ANY INDIVIDUALS, BUREAUS OR ORGANIZATIONS.IT IS JUST A COMMON EVERYDAY GOOD BILL THAT MONTANA NEEDS TO HAVE PASSED.

OF THE SEVERAL ISSUES THAT THE AARP WILL BE ADDRESSING DURING THIS LEGISLATIVE SESSION, THIS IS PERHAPS THE ONE THAT WE FEEL THE MOST STRONGLY ABOUT. OUR GOAL AS AN ORGANIZATION IS TO PRESERVE AND PROTECT THE INDEPENDENCE, FREEDOM, HEALTH, CARE AND DIGNITY OF OUR OLDER MONTANANS. THIS BILL HAS BEEN DEVELOPED BY THE STATE LEGISLATIVE COMMITTEE OF THE AARP, AND, TO AVOID REPITITION, I WOULD LIKE TO ASK MR GARDNER CROMWELL OF OUR COMMITTEE TO DISCUSS THE DETAILS OF THIS BILL. GARDNER IS THE AUTHOR OF THIS BILL, AND AS A RETIRED PROFESSOR OF LAW AT THE UNIVERSITY OF MONTANA, HE IS WELL QUALIFIED TO ADDRESS THE PHILOSOPHY AND MECHANICS OF HOUSE BILL 126.

EXHIBIT XII
DATE 1-20-93
HB [illegible]

WITNESS STATEMENT

NAME ELLEN HAUSKEN BILL NO. HB 126

ADDRESS 120 HIGHLAND HELENA DATE 1-20-93

WHOM DO YOU REPRESENT? AARP

SUPPORT ✓ OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: I am a member of the AARP State Legislative Committee and am employed, presently, Assistant Librarian for AARP and am appointed for the preparation of HB 126. I am also a member of the Legislative Committee.

I urge you to pass this for the benefit of legislators in Montana and Montanans and request and suggest amendments.

HB 128

EXHIBIT # 3
DATE 1-22-87
HB # 128

MR CHAIRMAN, MEMBERS OF THE COMMITTEE,

I AM JOE UPSHAW, REPRESENTING THE ASSOCIATION OF RETIRED PERSONS IN MONTANA. I WOULD LIKE TO BRIEFLY ADDRESS THE INCREASING NEED FOR SOME TYPE OF CONTROL OF THE RAPIDLY ESCALATING MEDICAL COSTS IN MONTANA. THE HEALTH CARE INDUSTRY IS ONE OF THE FASTEST GROWING AND LARGEST INDUSTRIES IN THE AMERICAN ECONOMY. IN 1965 HEALTH CARE EXPENDITURES REPRESENTED 6.1% OF THE GROSS NATIONAL PRODUCT. BY 1985, THIS FIGURE HAD RISEN TO 10.7%, AT THE PRESENT RATE OF SPENDING, 1990 HEALTH CARE EXPENDITURES ARE EXPECTED TO CONSUME MORE THAN 11.3% OF THE NATIONAL ECONOMY. MOREVER, THE RATE OF GROWTH IN MEDICAL CARE PRICES FAR EXCEEDS THE RATE OF GROWTH IN PRICES IN THE GENERAL ECONOMY. BETWEEN 1967 AND 1985 WHEN THE CONSUMER PRICE INDEX FOR ALL ITEMS ROSE BY 222% , THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX INCREASED BY 303% . FURTHER, IN 1985 ALONE, THE RATE OF INFLATION IN THE MEDICAL CARE COMPONENT OF THE CPI WAS ALMOST TWICE THE RATE OF INFLATION IN THE GENERAL ECONOMY. PRELIMINARY FIGURES AVAILABLE FOR 1986 SUGGEST AN EVEN WIDER GAP BETWEEN GENERAL INFLATION AND MEDICAL PRICE INCREASES. THE SAME RAPID RATE OF GROWTH RELATIVE TO GENERAL INFLATION CONTINUES TO BE SEEN IN BOTH THE HOSPITAL ROOM RATE INDEX AND IN THE PHYSICIAN SERVICES COMPONENT OF THE CPI; PRICES FOR PRESCRIPTION DRUGS ARE RISING EVEN MORE RAPIDLY.

IN 1985, MEDICAL OUTLAYS INCREASED BY 8.9% OVER THE PREVIOUS YEAR FOR A TOTAL NATIONAL HEALTH EXPENDITURE OF 425 BILLION DOLLARS. THE 8.9% INCREASE IN 1985 REPRESENTS THE LOWEST ANNUAL RATE INCREASE IN TWO DECADES --- A DECELERATION LARGELY DUE TO THE DECLINE IN THEINFLATION RATE. NEVERTHELESS, HEALTH CARE EXPENDITURES ARE EXPECTED TO RISE A WHOPPING 85% BETWEEN 1985 AND 1990.

THE FIGURES THAT I HAVE CITED INDICATE THAT THERE IS A DEFINITE NEED FOR MONTANA TO ESTABLISH AND MAINTAIN METHODS OF MONITORING AND CONTROLLING THIS PROBLEM. THIS BILL WAS CONCEIVED AS SUCH AN INSTRUMENT THAT CAN BE BENEFICIAL TO BOTH THE PROVIDER AND THE CONSUMER. ~~MRS ENA SIMPSON OF POLSON IS HERE TO EXPLAIN~~

EXHIBIT #1
DATE 22 Jan 87
HB # 128

WITNESS STATEMENT

NAME Scott A. Walker BILL NO. # 128

ADDRESS East Shore Rt. DATE 22 Jan 87

WHOM DO YOU REPRESENT? Myself.

SUPPORT ✓ OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Amend title to include "competitive" between establish and rates (2nd line, 6th word)

(3) Section (1)(b), 3rd line substitute "competitive economic" for aggregate

(2) & Section (2)(e)

"Competitive rates" are the competitive economic costs for each service. Such costs do not include any discounts or monopoly benefits for any service provider.

EXHIBIT
DATE
HB

TESTIMONY IN OPPOSITION TO HOUSE BILL 128 BEFORE MONTANA HOUSE HUMAN SERVICES AND AGING COMMITTEE

Testimony presented by Montana Hospital Association

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, FOR THE RECORD MY NAME IS JAMES F. AHRENS, PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. THE MONTANA HOSPITAL ASSOCIATION REPRESENTS 55 HOSPITALS, 32 OF WHICH HAVE ATTACHED NURSING HOMES. I AM APPEARING BEFORE YOU TODAY IN OPPOSITION TO HOUSE BILL 128.

HEALTH CARE IS EXPENSIVE. THERE CAN BE LITTLE DOUBT OF THAT. HOSPITAL AND DOCTOR COSTS FOR A MAJOR SURGICAL PROCEDURE OR THE COSTS OF SEVERAL MONTHS STAY IN A NURSING HOME HAVE MAJOR FINANCIAL IMPLICATIONS. YES, HEALTH CARE IS EXPENSIVE, BUT THIS BILL WILL NOT LOWER HEALTH CARE COSTS IN MONTANA. IN FACT, HOUSE BILL 128 WILL INSURE THAT HEALTH CARE COSTS WILL INCREASE IN THE NEXT TWO YEARS. THE FISCAL NOTE THAT ACCOMPANIES THE BILL STATES "IT IS NOT POSSIBLE TO ACCURATELY ESTIMATE THE INCREASED EXPENDITURES THAT WOULD BE NECESSARY TO FUND THE COMMISSION'S ACTIVITIES. NOR IS IT POSSIBLE TO ACCURATELY PREDICT THE FEE THAT REGULATED FACILITIES WOULD PAY TO FUND THE COMMISSION".

THE FISCAL NOTE GOES ON TO SAY THAT THE ONLY COMMISSION SIMILAR TO THE ONE CREATED UNDER THE PROPOSED LAW IS IN NEW JERSEY. THE TOTAL ANNUAL BUDGET TO SET RATES IN NEW JERSEY IS $1.4 MILLION. THE NEW JERSEY COMMISSION REGULATES 90 ACUTE CARE FACILITIES. THE MONTANA BILL WOULD REGULATE 60 HOSPITALS, 99 LONG-TERM CARE FACILITIES AND 8 OUTPATIENT SURGICAL FACILITIES. THE NEW JERSEY COMMISSION HAS BEEN IN EXISTENCE SINCE 1978, AND SETS RATES FOR ONLY HOSPITALS. THE MONTANA BILL WOULD REGULATE ALMOST TWICE AS MANY FACILITIES AND WOULD HAVE TO ESTABLISH THREE SEPARATE REVIEW METHODOLOGIES. THE START-UP COSTS OF THE COMMISSION WOULD BE ENORMOUS, PERHAPS AS GREAT AS $2 MILLION PER YEAR, USING NEW JERSEY AS A BENCH MARK. I BELIEVE THE COSTS WOULD AT LEAST TOTAL $1 MILLION PER YEAR.

RATES WOULD NOT BE SET UNDER THIS BILL UNTIL JANUARY 1989. THE COSTS TO THE COMMISSION WOULD BEGIN IMMEDIATELY. REGULATED PROVIDERS WOULD FINANCE THE ACTIVITIES OF THE COMMISSION FOR A FULL YEAR AND A HALF BEFORE THE FIRST RATE IS APPROVED. COSTS WOULD BE INCURRED BUT THERE WOULD BE NO CORRESPONDING BENEFIT.

REGULATED PROVIDER COSTS WILL ALSO GO UP AS THEY ARE FORCED TO REVISE ACCOUNTING POLICIES AND PROCEDURES TO COMPLY WITH THE UNIFORM REPORTING REQUIREMENTS OF THE COMMISSION.

ALL OF THE COSTS INCURRED IN FUNDING THE COMMISSION AND IN CHANGING OPERATING PROCEDURES MUST BE CONSIDERED IN SETTING SUBSEQUENT RATES. THESE COSTS WOULD NOT BE INCURRED IF THE HEALTH CARE COST CONTAINMENT COMMISSION DID NOT EXIST.

ON JANUARY 18, 1985 GOVERNOR TED SCHWINDEN CREATED THE HEALTH CARE COST CONTAINMENT ADVISORY COUNCIL BY EXECUTIVE ORDER NUMBER 2-85. GOVERNOR SCHWINDEN RECOGNIZED THAT THE HIGH COST OF HEALTH CARE WAS A PROBLEM AND CITED THE NEED TO DEVELOP A PARTNERSHIP AMONG HEALTH CARE CONSUMERS, PROVIDERS AND PUBLIC AGENCIES TO CONTAIN HEALTH CARE COSTS. HE CHARGED THE COUNCIL WITH STUDYING THE PROBLEM AND MAKING RECOMMENDATIONS TO HIM. THE ADVISORY COUNCIL STUDIED THE COMPLEX ISSUES SURROUNDING HEALTH CARE COSTS FOR TWO YEARS, AND LAST THURSDAY, ONE WEEK AGO, ISSUED ITS REPORT.

THE INTRODUCTORY LETTER WRITTEN BY COUNCIL CHAIRMAN, KEN HICKEL, STATES "WE REALIZE THAT MAJOR PARTS OF THE PROBLEM RESULT FROM FORCES BEYOND MONTANA'S CONTROL," AND THAT "HEALTH CARE COST CONTAINMENT WILL NOT OCCUR OVERNIGHT". IN DESCRIBING THE FACTORS CONTRIBUTING TO HEALTH CARE COST INCREASES, THE REPORT CITED:

1. INFLATION IN THE GENERAL ECONOMY (ESPECIALLY 1979 - 1983)

2. LABOR COSTS
3. TECHNOLOGY
4. DEMOGRAPHICS - THE AGING OF THE POPULATION
5. INAPPROPRIATE USE OF HEALTH CARE SERVICES
6. COST SHIFTING
7. MEDICAL MALPRACTICE/DEFENSIVE MEDICINE.

THESE ARE THE CONTRIBUTING CAUSES OF HEALTH CARE INFLATION. HOUSE BILL 128 DOES NOTHING TO ATTACK ANY OF THESE CAUSES. RATE REGULATION SYSTEMS REDUCE OR REALLOCATE THE PAYMENTS MADE TO PROVIDERS, BUT THEY DO NOT CHANGE THE FUNDAMENTAL CAUSE AND BEHAVIOR OF COST.

THE GOVERNOR'S ADVISORY COUNCIL REPORT DOES MAKE SEVERAL RECOMMENDATIONS THAT ATTACK THE ROOT CAUSE OF HEALTH CARE COSTS. NOWHERE IN THE REPORT DOES THE COUNCIL RECOMMEND REGULATING THE RATES OF HEALTH CARE PROVIDERS. THE COUNCIL MEMBERS DID HOWEVER, DISCUSS THE TOPIC. ON FEBRUARY 18, 1986, THE COUNCIL MET IN BILLINGS AND DISCUSSED THE ISSUE FULLY. THE MINUTES OF THAT MEETING SHOW THE DEPTH OF THE DISCUSSION. THREE PAGES OF THE MINUTES ARE DEDICATED TO THIS AGENDA ITEM. THE MINUTES SHOW SENATOR PAT REGAN FINALLY MOVED, AND THE COUNCIL UNANIMOUSLY APPROVED THE FOLLOWING, "AT THIS TIME, THE COUNCIL IS UNWILLING TO RECOMMEND A REGULATORY SYSTEM, BUT HOPES THAT OTHER ALTERNATIVE DELIVERY SYSTEMS WILL BRING ABOUT COST CONTAINMENT".

SOME OF THE FACTORS WHICH CAUSED LARGE INCREASES IN HEALTH CARE COSTS HAVE BEGUN TO MODERATE. THE SLOW-DOWN IN INFLATION HAS REDUCED THE PRICE SPIRAL OF GOODS AND SERVICES FOR WHICH HOSPITALS MUST PAY. THE LOWERING OF INFLATION HAS REDUCED THE LEVEL OF PAY INCREASES FOR OUR EMPLOYEES. INAPPROPRIATE USE OF HEALTH CARE SERVICES HAS ALSO DECREASED DUE TO THE JOINT EFFORTS OF THE GOVERNMENT, THIRD PARTIES, BUSINESS AND HEALTH CARE PROVIDERS.

FOR THE FIRST TIME IN RECENT HISTORY, TOTAL INPATIENT REVENUE ACTUALLY DECLINED IN MONTANA HOSPITALS IN 1985, INPATIENT REVENUE DROPPED BY 0.8 PERCENT FROM THE PREVIOUS YEAR. LESS EXPENSIVE, MORE EFFICIENT OUTPATIENT CARE INCREASED BY 15.7 PERCENT, AS MEASURED BY REVENUE. INPATIENT REVENUE AND OUTPATIENT REVENUE ADDED TOGETHER INCREASED A TOTAL OF 1.6 PERCENT IN 1985 OVER 1984. IN 1984 TOTAL GROSS PATIENT REVENUE INCREASED 3.8 PERCENT OVER 1983. THIS IS WHAT HOUSE BILL 128 WOULD REGULATE -- RATES (WHICH TRANSLATE INTO REVENUE). A 1.6 PERCENT INCREASE IN 1984 AND 3.8 PERCENT INCREASE IN 1983.

ACCORDING TO THE RECENTLY PUBLISHED 14TH ANNUAL STATE-BY-STATE SURVEY OF HOSPITAL DAILY SERVICE CHARGES PUBLISHED BY EQUICOR (EQUITABLE HCA CORPORATION), MONTANA RANKS 44TH AMONG THE FIFTY STATES AND THE DISTRICT OF COLUMBIA IN AVERAGE CHARGE PER STAY. THE AVERAGE CHARGE PER STAY IN MONTANA, ACCORDING TO THE SURVEY, WAS $2,922. THE U.S. AVERAGE CHARGE PER STAY WAS $3,840. THAT IS $918 MORE THAN THE MONTANA AVERAGE. MONTANA'S AVERAGE IS 24 PERCENT BELOW THE NATIONAL AVERAGE.

MONTANA'S HOSPITAL CHARGES ARE LOW AND, IN RECENT YEARS, THE RATE OF HOSPITAL CHARGE INFLATION HAS BEEN LOW. THIS EXCELLENT RATE PERFORMANCE DID NOT COME ABOUT BECAUSE OF A SEVEN MEMBER RATE COMMISSION OVERSEEING THE SETTING OF HOSPITAL RATES. IT IS THE RESULT OF MANY FORCES ONE OF WHICH IS THE DESIRE TO GIVE MONTANAN'S THE BEST HEALTH CARE PRODUCT AT THE BEST PRICE. MONTANA HOSPITALS ARE GOVERNED BY SOME 550 HOSPITAL TRUSTEES. THESE TRUSTEES SERVE WITHOUT COMPENSATION ON HOSPITAL BOARDS AND ACT AS THE REPRESENTATIVES OF THE COMMUNITY. HOSPITAL BOARDS REVIEW HOSPITAL BUDGETS. HOSPITAL BOARDS APPROVE HOSPITAL RATES AND CHARGES. YOU, YOUR FRIENDS, NEIGHBORS AND RELATIVES WHO SERVE ON HOSPITAL BOARDS REVIEW THE EXPENSES AND REVENUES OF COMMUNITY HOSPITALS IN MUCH GREATER DETAIL THAN ANY RATE COMMISSION COULD HOPE TO.

I KNOW THAT MANY SENIOR CITIZENS ARE CONCERNED ABOUT HEALTH CARE COSTS. THEY SPEND A HIGHER PROPORTION OF THEIR INCOME ON MEDICAL CARE THAN DOES THE REST OF THE POPULATION. THE MONTANA HOSPITAL ASSOCIATION IS SYMPATHETIC TO THEIR PLIGHT AND IS INTERESTED IN WORKING WITH SENIOR CITIZENS TO INSURE THEIR ACCESS TO NEEDED HEALTH CARE SERVICES. HOWEVER HOUSE BILL 128 WILL DO NOTHING TO LOWER THE OUT-OF-POCKET EXPENSE TO MEDICARE-AGED PERSONS. HOSPITALS ARE REIMBURSED ON THE BASIS OF DIAGNOSTIC RELATED GROUPS (OR DRGs) FOR MEDICARE SERVICES. MEDICARE REIMBURSES HOSPITALS A FIXED, PREDETERMINED AMOUNT FOR EACH DRG. IN SOME SENSE, YOU COULD SAY THAT MEDICARE ALREADY HAS HOSPITAL RATE CONTROL UNDER ITS DRG SYSTEM. THE MEDICARE BENEFICIARY, ON THE OTHER HAND, MUST PAY A MEDICARE DEDUCTIBLE OF $520 FOR THE FIRST DAY OF HOSPITAL CARE. IF HE OR SHE STAYS IN THE HOSPITAL LONGER THAN 60 DAYS, HE OR SHE MUST PAY MEDICARE COINSURANCE OF $130 PER DAY BETWEEN THE 61ST AND 90TH DAY. THESE AMOUNTS ARE SET IN WASHINGTON, D.C., NOT BY HOSPITALS. THESE SUMS ARE COLLECTED BY HOSPITALS, BUT THEY ARE SET BY CONGRESS. IN 1986 THE DEDUCTIBLE INCREASED 23 PERCENT. IN JANUARY 1987 IT INCREASED ANOTHER 6 PERCENT. HOUSE BILL 128 WILL DO NOTHING TO REDUCE THE MEDICARE DEDUCTIBLE AND COINSURANCE. ONCE AGAIN, HOSPITALS DON'T SET THE MEDICARE DEDUCTIBLE AND COINSURANCE RATES. HOSPITALS CAN ONLY COLLECT THEM OR WRITE THEM OFF.

THIS IS THE WRONG BILL AT THE WRONG TIME. HOSPITALS ARE MAKING GREAT STRIDES IN CONTAINING THEIR COSTS. WHILE HEALTH CARE IS EXPENSIVE, IT IS RICH WITH VALUE. THIS BILL WOULD SEEK TO DO WITH A SEVEN MEMBER COUNCIL AND A STAFF OF ECONOMISTS, ATTORNEYS, ACCOUNTANTS, CLERKS AND SECRETARIES, WHAT HOSPITALS ARE DOING BY THEMSELVES. HOSPITALS WARILY APPROACHING THE ADVERSARIAL PROCEEDINGS DESCRIBED IN THE BILL, SHOULD IT PASS, WILL COME ARMED WITH CPAs AND ATTORNEYS. IN THE END, THE SEVEN MEMBER COMMISSION WILL APPROVE RATES THAT ARE

ABOUT THE SAME AS THOSE APPROVED BY THE 550 HOSPITAL TRUSTEES. BUT IT WILL COST MORE TO APPROVE THE RATES. HOSPITALS, NURSING HOMES AND AMBULATORY CARE FACILITIES WILL FUND THE COMMISSION. THEY WILL PAY FOR THE ECONOMISTS, ATTORNEYS, ACCOUNTANTS, CLERKS AND SECRETARIES. PROVIDERS WILL ALSO PAY FOR THEIR OWN ACCOUNTANTS AND ATTORNEYS. IN THE FINAL ANALYSIS, IT IS THE PATIENT WHO WILL PAY FOR THIS UNNECESSARY COMMISSION.

I THANK YOU FOR YOUR ATTENTION AND STRONGLY URGE YOU TO VOTE AGAINST HOUSE BILL 128.

Facts About Montana Hospitals

ALL HOSPITALS
STATEMENT OF REVENUE AND EXPENSES

	1983	1984	1985	% Change 1984/1983	% Change 1985/1984
REVENUE					
Inpatient Revenue	316,089,384	324,249,067	321,637,742	2.6%	-0.8%
Outpatient Revenue	50,524,873	56,247,377	65,061,459	11.3%	15.7%
Total Gross Patient Revenue	366,614,257	380,496,444	386,699,201	3.8%	1.6%
Deductions From Revenue	55,183,729	55,418,990	41,282,849	0.4%	-25.5%
Total Net Patient Revenue	311,430,528	325,077,454	345,416,352	4.4%	6.3%
Other Operating Revenue	7,791,962	7,688,429	8,532,821	-1.3%	11.0%
Total Revenue	319,222,490	332,765,883	353,949,173	4.2%	6.4%
EXPENSES					
Payroll Expenses	151,491,040	159,464,313	164,045,675	5.3%	2.9%
Employee Benefits	23,322,627	25,442,763	29,146,162	9.1%	14.6%
Professional Fees (medical)	12,239,711	10,597,645	9,938,098	-13.4%	-6.2%
Professional Fees (audit, legal)	4,060,340	4,577,628	4,272,260	12.7%	-6.7%
Depreciation Expense	15,096,503	18,023,503	21,770,863	19.4%	20.8%
Interest Expense	8,626,067	9,276,430	12,876,524	7.5%	38.8%
All Other Expenses	88,666,116	91,487,838	97,482,905	3.2%	6.6%
Total Nonpayroll Expenses	152,011,364	159,405,807	175,486,812	4.9%	10.1%
Total Expenses	303,502,404	318,870,120	339,532,487	5.1%	6.5%
Gain (Loss) from Operations	15,720,086	13,895,763	14,416,686	-11.6%	3.7%
Nonoperating Revenue (gov. appr., mill levies, etc.)	1,648,831	1,268,052	1,898,420	-23.1%	49.7%
Nonoperating Revenue	5,436,784	9,149,876	6,922,562	68.3%	-24.3%
Revenue Less Expense	22,805,701	24,313,691	23,237,668	6.6%	-4.4%

ALL HOSPITALS
STATEMENT OF DEDUCTIONS FROM REVENUE

Medicare Discounts	31,564,605	31,860,311	18,052,601	0.9%	-43.3%
Medicaid Discounts	4,711,991	4,588,162	5,738,075	-2.6%	25.1%
Blue Cross Discounts	229,969	380,366	278,893	65.4%	-26.7%
All Other Discounts	1,359,615	1,431,178	1,127,089	5.3%	-21.2%
Total Contractual Adjustments	37,866,180	38,260,017	25,196,658	1.0%	-34.1%
Bad Debts	14,030,649	14,192,819	13,504,722	1.2%	-4.8%
Charity	2,307,229	1,752,951	1,580,520	-24.0%	-9.8%
Other Deductions	979,671	1,213,203	1,000,949	23.8%	-17.5%
Total Revenue Deductions	55,183,729	55,418,990	41,282,849	0.4%	-25.5%

ALL HOSPITALS
FINANCIAL INDICATORS

	1983	1984	1985	% Change 1984/1983	% Change 1985/1984
Cost per Case	$2,067	$2,280	$2,556	10.3%	12.1%
Outpatient Percent of Gross Patient Revenue	13.8%	14.8%	16.8%	7.3%	13.8%
Deductions from Revenue Percent	15.1%	14.6%	10.7%	-3.2%	-26.7%
Uncompensated Care Percent of Gross Patient Revenue	4.7%	4.5%	4.2%	-4.3%	-6.7%
Medicare Charges Percent of Gross Patient Revenue	38.9%	38.8%	38.3%	-0.4%	-1.3%
Medicaid Charges Percent of Gross Patient Revenue	5.8%	5.2%	5.9%	-9.6%	12.0%
Employee Expense Percent of Total Expense	57.6%	58.0%	56.9%	0.7%	-1.9%
Capital Expense Percent of Total Expense	7.8%	8.6%	10.2%	10.3%	18.6%

ALL HOSPITALS
UTILIZATION INDICATORS

	1983	1984	1985	% Change 1984/1983	% Change 1985/1984
Admissions	126,568	119,191	110,507	-5.8%	-7.3%
Inpatient Days	681,034	617,800	555,844	-9.3%	-10.0%
Average Length of Stay	5.38	5.18	5.03	-3.7%	-3.0%
Percent Occupancy	56.5%	50.8%	45.8%	-10.2%	-9.8%

ALL HOSPITALS

Figure 4.1
LENGTH OF STAY

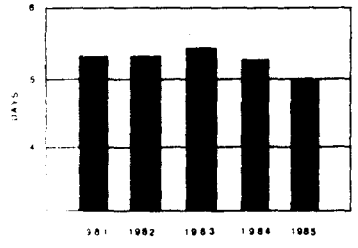


Figure 4.2
TOTAL HOSPITAL EXPENSES
PERCENT CHANGE

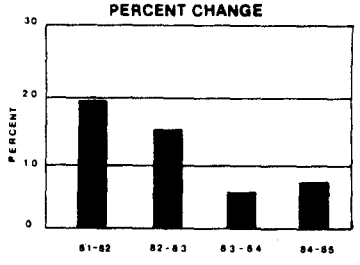


Figure 4.3
ADMISSIONS
PERCENT CHANGE

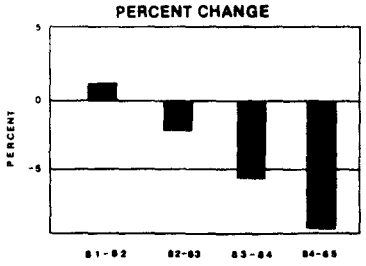
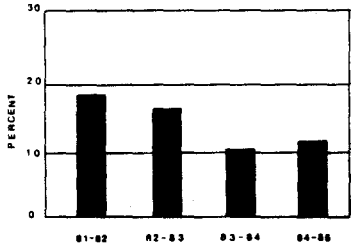


Figure 4.4
COST PER CASE
PERCENT CHANGE



AVERAGE LENGTH OF STAY
U.S. AND MONTANA
1980 - 1985

Year	United States	Percent Change	Montana	Percent Change
1980	7.6	0	5.2	1.0
1981	7.6	0	5.3	1.9
1982	7.6	0	5.3	0
1983	7.6	0	5.4	1.9
1984	7.3	3.9	5.2	-3.7
1985	N/A	N/A	5.0	-3.8

Source: *Hospital Statistics*, American Hospital Association, Chicago, 1981 - 1985.

OCCUPANCY RATES
UNITED STATES, MONTANA AND MOUNTAIN STATES REGION
1980 - 1985

— Occupancy Rate Percent —

Year	United States	Montana	Mountain States Region
1980	75.6	55.2	69.8
1981	76.0	56.5	70.6
1982	75.3	57.9	69.7
1983	73.5	56.5	67.3
1984	69.0	50.8	61.9
1985	63.6*	45.8	N/A

Source: *Hospital Statistics*, American Hospital Association, 1980 - 1985.

**Economic Trends*, American Hospital Association, Spring 1986. Data from national sampling of hospitals rather than nationwide survey as *Hospital Statistics* data.

Figure 3.1

AVERAGE LENGTH OF STAY

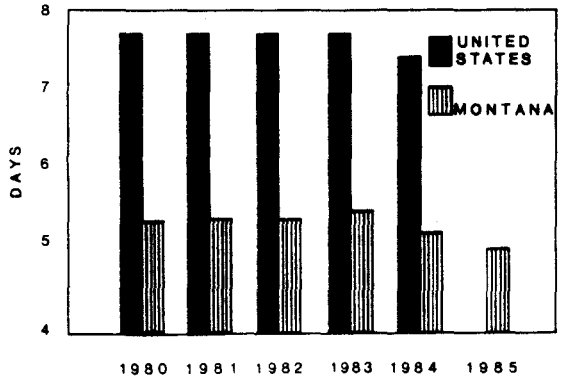
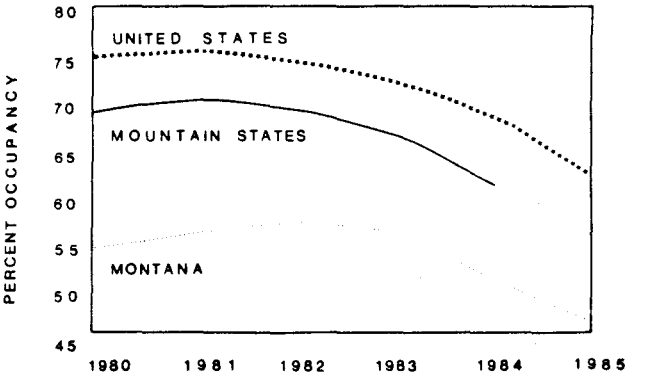


Figure 3.2

OCCUPANCY RATE 1980 - 1984



EXPENSE PER ADJUSTED PATIENT DAY
1980 - 1985

Year	United States	Percent Increase	Montana	Percent Increase
1980	245.12	12.8	$235.21	11.4
1981	284.33	16.0	282.08	19.9
1982	327.37	15.1	332.08	17.7
1983	369.49	12.9	384.29	15.7
1984	411.10	11.3	440.12	14.5
1985	N/A	N/A	508.06	15.4

Source: *Hospital Statistics*, American Hospital Association, Chicago, 1981 - 1985.

EXPENSES PER ADJUSTED DISCHARGE
(COST PER CASE)
1980 - 1985

Year	United States	Percent Increase	Montana	Percent Increase
1980	1,851	12.8	1,231	13.4
1981	2,171	17.3	1,495	21.4
1982	2,501	15.2	1,770	18.3
1983	2,780	11.5	2,067	16.8
1984	2,995	7.4	2,280	10.3
1985	N/A	N/A	2,556	12.1

Source: *Hospital Statistics*, American Hospital Association, Chicago, 1981 - 1985.

Figure 3.3

EXPENSES PER ADJUSTED PATIENT DAY

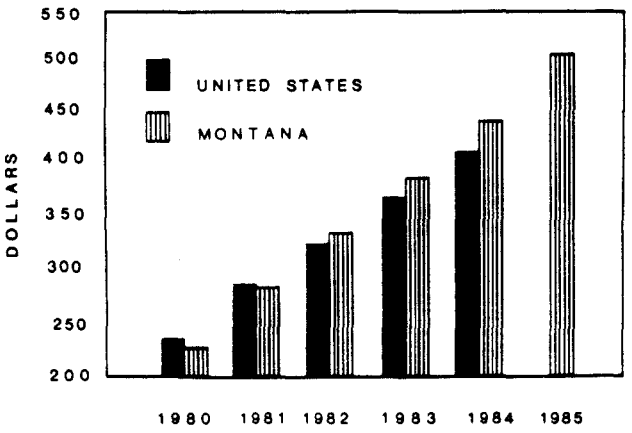
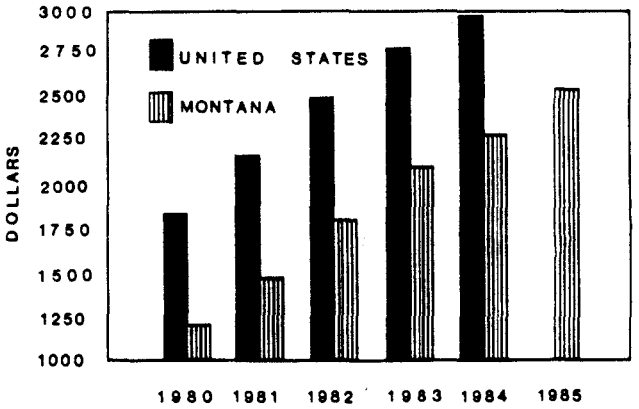


Figure 3.4

EXPENSES PER ADJUSTED DISCHARGE



November 1986

STATE PUBLISHING CO. HELENA, MONT.

Minutes
Governor's Advisory Council on Health Care Cost Containment
February 18 - 19, 1986, 9:00 a.m.
Marillac Auditorium, St. Vincent's Hospital
Billings, Montana

Present: Chairman, Ken Hickel; Council members, Bill Murray, Chuck Gilder, Carlene Crall DeVeau, Jack Noble, Dr. John T. Molloy, Alan Cain, Dennis Taylor, Senator Pat Regan, Rep. Cal Winslow, J. Robert Sletten, Terry Screnar, Don Pizzini; Governor's Office, J. Michael Pichette, Diana Spas.

February 18:

1. Chairman Hickel called the meeting to order at 9:00 a.m. Council members and assembled guests introduced themselves. Two new appointees, Dr. John T. Molloy and Donald Pizzini, have been added to the Council. Chairman Hickel asked how best to proceed with issue discussion papers. Senator Regan suggested the Council assume that all papers had been read and discuss each in order.

2. Long Term Care Continuum: Chairman Hickel noted that guest Charles Briggs was the only work session participant present and suggested that discussion begin with Council Option #1: "Direct the State Aging Plan to make a concerted effort at educating people at risk (elderly, disabled, handicapped) concerning long term care alternatives. Education and coordination of services must be a top priority." No discussion was forthcoming; the Chairman moved on the discussion of option #2: "Direct appropriate state agencies (Social and Rehabilitation Services, State Health Plan, State Aging Plan, Board of Housing, etc.) to promote the continuum of service by giving it top priority. For example, the Board of Housing
ɔr funding of appropriate long term care housing."

NOTE: Pages 1, 14, 15 & 16 have been photocopied.

had been discussed with the Board of Housing
ɔbtained. Charles Briggs replied that the
ɔeen contactec. Senator Regan said that she
ɔider this interesting concept, but there might
ɔght-after Board of Housing monies.

he had had informal discussions with both Herb
ɔn Aging (SRS). The Council could provide
te agencies on this option. Chairman Hickel
ɔw up on his discussions with these entities and
#3: "Promote development of services by providers,
ɔy consumers, through financial incentives. A
ɔoject is recommended to explore possibilities,
such as the partial funding of respite care and/or adult day care, in order to avoid or postpone nursing home costs." Mr. Briggs couldn't recall how this option was formulated. Diana Spas suggested that it was seen as a way to encourage use of less expensive alternatives to institutional care.

Steve Waldron reminded the Council that quality of indigent care must be ensured. Is the focus of the Council to save health care costs for all persons or just the state? Alan Cain replied that the same delivery systems would serve both indigent and paying persons.

The motion was passed.

Charles Briggs asked the disposition of Option #1. John Bebee replied that his office would take care of this.

Mr. Briggs described the history and intent of his paper, "Alternative Delivery and Rate Regulation." Chairman Hickel stated that several states had passed rate regulation and then rescinded it. He recommended continuing discussion after a short break (2:15).

The meeting resumed at 2:30. Mr. Briggs said he would make a copy of Ena Simpson's comments available to Diana Spas. Chairman Hickel asked which states have rescinded rate regulation. Mr. Briggs replied that Colorado and Illinois have, but had not allowed sufficient time to prove efficacy.

Rep. Winslow stated that the push for rate regulation had been prior to the establishment of DRG's. Rate regulation is now unnecessary and could actually harm senior citizens. Alan Cain added that rate regulation activity had been recommended during a highly inflationary period. Utilization is down now and the industry has reacted favorably. DRG's and co-payments have moderated usage and costs. Anecdotal evidence shows that rate regulation hasn't done much to contain costs and would be detrimental to rural hospitals. He agreed with Rep. Winslow that it is unnecessary. Terry Screnar cautioned that rate regulation would make change in the health care system more difficult and would be counter-productive.

Chairman Hickel asked if the Aging Council would be discussing this on 2/26/86.

Mr. Briggs answered that the February 26 forum is dedicated to dealing with Medicare issues. The AARP is still pushing for rate regulation. It's helpful that DRG's may be containing costs, but the rate regulation statistics on costs and utilization are compelling. DRG's haven't mitigated the concern of seniors; Legacy Legislature will develop proposals for the 1987 Legislature. Rep. Winslow suggested the Council needn't act on this, as the Legacy Legislature will continue to push for it. Guest Mary Uber confirmed this.

Bill Murray stated that Medicare DRG's are fixed; the focus should be on federal, not state, regulations. Dennis Taylor asked if an all-payers DRG system is desirable. Tony Wellever answered that four states have Medicaid waiver DRG-based systems. HCFA is looking for more capitated systems.

Chairman Hickel asked if Mr. Briggs were talking only about rate regulation for the indigent and elderly, or for all people. Mr. Briggs referred to his paper's discussion of the all-payer principle. The ultimate intention of the paper is to discourage cost shifting.

Terry Screnar said definition of "all-payer" is a problem. California said all insurers could use a DRG-type reimbursement system. How would rate regulation affect negotiations for alternative delivery rates? Overall costs suffer when rates are regulated. Alan Cain agreed rate regulation interferes with competition of alternative delivery systems. Mr. Briggs felt that lack of statistics on sparsely populated rural states is a problem.

Chairman Hickel asked if rate regulation affects mandated benefits. Alan Cain replied it does not.

Mr. Briggs suggested that HMO's/PPO's should still be able to negotiate direct hospital payments. Terry Screnar questioned the incentive to hospitals to do this.

Alan Cain reminded the Council that it would take a large bureaucracy to regulate Montana's sixty hospitals. Mr. Briggs stated the system would function like the Public Utilities Commission but on a larger scale. An appointed gubernatorial commissioner would oversee activities. Rep. Winslow asked how such a commission would deal with per procedure costs in disparate areas. Hospitals would need additional staff for this enormous task.

Alan Cain cautioned that court trials would be inevitable and expensive.

Tony Wellever pointed out that there is no single model for rate regulation. He related experiences of several other states, and asked if rate regulation had really controlled rising costs and the reasons for them. Alan Cain added that rate regulation doesn't control utilization; the problem isn't always unit costs, but the aggregate costs.

Senator Regan expressed concern at cost shifting and the health care industry affiliation of previous speakers. Costs skyrocketed when no incentive existed to contain them. Free enterprise doesn't exist in health care. She chose not to recommend rate regulation at this time, preferring to see the effects of alternative delivery systems. She reiterated concern at cost shifting, although she acknowledged that artificial caps don't work well. She cautioned that the Council needs to gather data and act if costs should again rise without restraint. Alan Cain agreed and suggested Senator Regan phrase this as a motion.

Chuck Gilder offered the suggestion that the rationale for regulation of public utilities and interstate travel has been lack of competition. Airline de-regulation brought about lower prices through competition. Rate regulation merely added another layer of bureaucracy. Costs are impossible to monitor. He rejected any form of regulation.

Jack Noble added that an all-payer system would victimize the elderly whose Medicare/Medicaid costs are now shifted to others. Rate regulation doesn't change actual hospital costs; these must be paid somewhere, perhaps by the elderly.

Charles Briggs replied that some rate review commissions serve as public forums. He read from Ena Simpson's paper; a public forum is necessary for discussion between provider and consumer. Statistics show that the elderly often postpone getting services until they develop acute conditions.

Dr. Molloy related an agreement in Great Falls between AARP and Deaconess for acceptance of Medicare assignment as payment in full. He has met with seniors seeking a similar agreement with physicians, and has asked if any have been refused care. None have, but fear it anyway. Is this a real issue? Chairman Hickel replied that newspaper articles say refusal is occurring.

Dr. Molloy suggested that DRG's cause patients to be discharged if another condition (aside from that on which admission was based) is found, but that patients can be re-admitted later. Rep. Winslow related that he'd had calls from people complaining of precipitate releases. Dr. Molloy added that some physicians hesitate to admit patients to the hospital. However, DRG's are not all bad; many people are capable of leaving early. Alan Cain agreed that, in the past, patients have stayed on longer than necessary.

Charles Briggs commented that Montana Senior Citizens Association had negotiated the Senior Care Program agreement in Great Falls. The costs are not shifted; the number of enrollees offsets lower rates. Mary Uber added that AARP had been involved, also. Bill Leary stated that so far, it looked as if Deaconess had made a wise decision. The Medicare deductible problem must be resolved federally. Seniors should present legislation to Congress to reduce or eliminate deductibles, but chances of passage are neglible in this administration. Sen. Baucus tried to cut the deductible increase and failed.

Guest Mike Wood suggested that Sen. Regan was articulating public concern over the "cost plus" reimbursement formula and health care inflation which was twice the CPI. Rate regulation is grasping at straws; it doesn't address the causes of the cost crisis. The core is utilization and extent of care; everyone wants more quality care. As the population ages and technology continues to develop, both demand and costs will continue to rise. We've been insulated in the past by third party payers. Sen. Regan expresses the frustration over the cost plus formula.

Sen. Regan moved that the Council continue to express its concern that cost containment be achieved, rather than cost shifting. At this time, the Council is unwilling to recommend a regulatory system, but hopes that other alternative delivery systems will bring about cost containment. If this doesn't happen, more formal actions will be considered. This motion was passed. Jack Noble reiterated the four components of Sen. Regan's motion.

9. Senator Regan suggested postponing discussion of indigent care and pursuing discussion of Case Management instead.

Chairman Hickel asked for Mike Wood's comments. Mr. Wood related that 15% of people use 85% of health care costs. Case management is a promising means of controlling heavy users' costs. The tendency has been to deliver excessive and unnecessary treatment. DRG's address this somewhat. Chairman Hickel asked for the relationship of case management to medical review. Mr. Wood replied that case management is an active process of care managed with the aid of health care professionals not directly involved in providing that care. Medical review is retrospective.

EXHIBIT
DATE
HB

TESTIMONY OF THE MONTANA HOSPITALS RATE REVIEW SYSTEM BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING ON HB 128 JANUARY 22, 1987.

Mr. Chairman, members of the committee, my name is Gerald Leavitt. I am the Executive Director of the Montana Hospitals Rate Review System. I am here to speak in opposition to House Bill 128 which would create a commission to establish rates for medical facilities.

I would like to segment my remarks into five basic categories, i.e., need (?), experience in other states, business aspects, examination of rates, and the MHRRS.

Before I begin it is necessary to define certain terms so we will all be speaking the same language. I will use the term "charge" to be synonymous with rates. It is the amount of money a health care provider requires to provide a given service to a patient or client. Cost is to be defined as either the cost to the provider to render a given service or as the gross amount to be paid by a payor. You can see that charges of the provider become the costs of the payor.

Need(?). Most persons responsible for the payment of statements for services tend to look at that bill in somewhat of a vacuum. It is evaluated on the basis of change since the last bill, compared to some other bill for an unrelated service, looked at from the viewpoint of emotionalism - "its too darned high" (no matter what the amount), or in the case of government agencies and insurers the cost is exceeding the amount which was budgeted thus requiring increased taxes, increased premiums, or the spector of paying for fewer services. I would submit that, while all of the above have some degree of validity, the most important comparison is to see how montana's providers of health care services compare with their counterparts across the nation. At this point I must state that I will be referring to hospitals only since that is our area of expertise. By any comparison, charges for a hospital stay, average charge per capita, individual charges, etc., Montana ranks in the lower eight percent nationwide.

Experience in other states. Approximately ten years ago nearly half of the states had in place, or pending, some form of "rate controls" on hospitals and/or other health care providers. Today that number has been approximately halved. The survivors may generally be classified as states having big populations and large metropolitan areas. The majority of those are also the ones which had health care costs in the upper ten percent nationwide. Why did those which are no longer utilized cease to be in existence? From our examination it would appear three causes are primary. Cost to administer the programs, for the results gained, were excessive, bureaucratic inefficiency resulted in numerous court battles, and results which indicated

no gains had been made from the standpoint of "cost savings" were evident.

Business aspects. A provider of health care services is no different than any other business providing services and goods to a consuming public. In the simplest terms - there must be as much money coming in as there is going out. When that equation is not met, the provider faces bankruptcy and closure. A large number of Montana hospitals do have a form of "escape valve" which has kept their doors open while others would have closed. I refer to county tax subsidies. However, it is obvious that no matter from where funds are received, the equation must be met. Limiting the amount of charges is not a magic wand that also reduces the cost to the providers in the rendering of their services.

Rates. The rates charged by Montana hospitals have been rising faster than the national average. But why? A portion relates to cost shifting. Cost shifting is the term used to indicate that when someone pays less for a service, someone else must pay more to generate the same amount of revenue to the seller. Rates go up to balance the scales. Everyone is charged the higher amount but not all pay 100 percent of that charge. The result is a larger "discount" to those able to receive it and higher charges to those who are not. A second reason for a greater rate of increase is the simple fact that many of Montana's hospitals have come into the twentieth century as relates to improved technology. Not long ago our hospitals were woefully short of the now recognized tools of the trade. Today most are able to provide the finest diagnostic and curative procedures. This has been costly both in terms of equipment and the highly trained personnel to operate them. Montana's hospitals could have restrained their costs by practicing techniques of ten or twenty years ago, but neither they nor the public they serve desires or deserves that.

The MHRRS. The System is a nonprofit, voluntary organization which had its beginnings in 1972 and which was created to control provider charges. To do this, the System utilizes three basic concepts. First, the facility must justify its costs which then becomes the basis for its rates. Secondly, the result must be equitable, i.e., A fairness in balance is to be achieved. It would serve no one if rates are established at a level so low that the provider is bankrupted nor would it be advantageous to permit rates so high the consumer would face the same specter. The third basic premise is based on the acronym "TANSTAFL." The translation is "there ain't no such thing as a free lunch" recognizing that costs of providing a service must be recovered if that service is to be continued.

Participation in the MHRRS is voluntary. Once a facility has joined, compliance with decisions of the System Board of Directors is mandatory. A participant may withdraw, but not with out living with the board's decision for at least one year.

Approximately two thirds of montana's hospitals have joined in this effort demonstrating their commitment to better management and control through the sentinel effect of our organization. It has not been our intent to glorify our existence through press releases informing the public of reductions or eliminations of rates as the result of board action. We have continuously striven to act as allies in the process of cost containment, not as adversaries attempting to out-do each other in budget increase/decrease games. We believe we have succeeded in getting montanan's the biggest bang for their health care buck.

Our organization utilizes no tax dollars for its operation. All costs of MHRRS are funded through fees to its participants.

In conclusion, it is our belief there is no need for the State of Montana to impose another level of bureaucracy on our health care providers when the probable result will be greater, not fewer provider costs. The basic rule of business operation does not recognize that legislated charge control will also reduce provider costs - it simply shifts them to someone else. A reduction in income below cost results in the reduction and/or elimination of service. Montana ranks low in the lowest quartile of nationwide charges and an organization to control rates and not requiring tax monies or government regulation is already in place. I must repeat - there has been no valid proposition put forth that would justify the creation of the law and regulations proposed by H.B. 128.

Thank you for your attention.

EXHIBIT # 7
DATE 1-22-87
HB

Minutes
Governor's Advisory Council on Health Care Cost Containment
February 18-19, 1986, 9:00 a.m.
Marillac Auditorium, St. Vincent's Hospital
Billings, Montana

Summary of Actions: (Exc # 8 pg. 2)

1. Two new appointees, Dr. John T. Molloy and Donald Pizzini, have been added to the Council.

2. Long Term Care Continuum: The Council endorses the following recommendations:

   1. Direct the State Aging Plan to make a concerted effort at educating people at risk (elderly, disabled, handicapped) concerning long term care alternatives. Education and coordination of services must be a top priority.

   2. Direct appropriate state agencies (Social and Rehabilitation Services, State Health Plan, State Aging Plan, Board of Housing, etc.) to promote the continuum of services.

   3. Promote development of services by providers, and utilization of services by consumers, through financial incentives. A feasibility study or pilot project is recommended to explore possibilities, such as the partial funding of respite care and/or adult day care, in order to avoid or postpone nursing home costs, where appropriate.

3. Long-Term Care Insurance:

   1. Allow the market to develop at its own pace, with the encouragement of groups such as AARP, Mt. Health Care Association and Montana Association of Homes for the Aging. Provide and encourage public education on the limitations of Medicare/Medicaid and the availability of long-term care insurance.

   2. Study the feasibility of developing incentives and safeguards for the offering and purchase of long-term care insurance.

4. Rural Hospitals:

   1. Develop and promote a model for cost effective accessible rural health care, in concert with other states in the Rocky Mountain area. Attempt to effect necessary changes in federal policy.

   2. Study the possibility of providing incentives for implementation of rural health care models. Examples might include promotion of the development of alternative services (such as those listed [in the discussion paper] as "strategies") and encouraging state agencies to give first preference to such services.

ALTERNATIVE DELIVERY & RATE REGULATION

A discussion of alternative delivery systems, analyzing the potential role of PPOs, HMOs, & all-payers, should also consider mandatory hospital rate review & regulation, which operates in several states. As well, it should be noted that two states have rescinded such regulation.

This option should be studied for several reasons. Foremost is that the 1984 Legacy Legislature made such a proposal a legislative priority for the 1985 Montana Legislature. HB 757, as ultimately introduced in 1985 by Rep. Stella Jean Hanson (Missoula), would have created a Montana Rate Review Commission to set revenue limits governing hospitals & long-term care facilities. One of the reasons it was tabled in committee was to give the Governor's newly-created cost containment advisory council time to explore public & private options to contain health costs. Hence, a hospital rate commission would be one option to study. I am presenting to the council a summary of the primary arguments as posed by proponents of rate regulation in order to elicit discussion. I am not arguing either for or against this option.

Issue: Older Americans are especially burdened by escalating hospital costs. According to AARP (American Association of Retired Persons) studies, in 1981, more than 50% of elderly households had incomes less than $10,000 while less than 20% of non-elderly households were in that income bracket. The elderly comprise only 11.5% of the population, yet incur some 30% of the health costs in the United States.

It is currently a recommendation of major aging organizations, like AARP, that Montana establish a hospital rate-regulatory commission.

Rationale: Mont. Department of Health & Environmental Sciences reported in 1985 that hospital expenses per capita in the state was $397. in 1983, 38th lowest in the country. A study by AARP, October 1985, responded that: 1) Montana has 37th lowest per capita income in the country; 2) Montana hospital cost increases have been "among the highest in the nation over the past years;" 3) Montana growth in hospital expense per adjusted admission (1976-83) was highest in the country, an increase of 195%; 4) Montana per capita hospital expense rose 171%, 1976-83 - "9th highest in the nation." This, they assert, necessitates statutory measures

to control cost acceleration of hospitals in Montana.

Discussion: A rate commission could have jurisdiction & authority over hospital operating charges. It has been recommended there be an operative connection with the state's health planning & CON process, though not necessarily direct CON review responsibilities. (Of the ten states providing for a cost containment commission, a few have a formal role in CON review.) However, it should be noted there is considerable discussion currently that budgetary cutbacks may curtail health planning & certificate of need review.

A commission could have the power to establish & enforce uniform hospital rates, and to exert regulatory power such as imposing sanctions &/or penalties for noncompliance of its rulings, similar to the Montana Public Service Commission. Rule-making authority is implicit.

In most states where operative, commission members are appointed for staggered terms by the Governor. The majority of members should not have financial interest in hospitals, thereby protecting the commission from provider domination. Funding an independent health cost containment commission can be accomplished through a mandated annual assessment of hospital gross revenues.

Of the ten states that have hospital expense increases below the national average (1976-1982), six have mandatory rate regulation:

U.S.	150.4%
Washington	141.3%
Connecticut	133.3
New Jersey	132.0
Massachusetts	129.7
Rhode Island	117.5
New York	95.2

The other states which have rate regulation currently are: Florida, Maine, Maryland, West Virginia, & Wisconsin. Utah & Idaho are other states in Region VIII which considered rate regulation legislation in 1985. Colorado & Illinois have withdrawn their mandatory prospective payment program. AARP argues that a minimum of three years are needed to determine effectiveness of such a system but provide no rationale for the timeframe. The latter two withdrew their review process before that duration.

According to the Johns Hopkins Center for Hospital Finance & Management study which provided the above data, Minnesota is among the ten states below the national average for rate increases, and demonstrates the most competitive growth with 17% of the state's population enrolled in HMO's.

Based on other states' experiences, a cost containment commission should have authority that includes:

* ability to establish & enforce mandatory limits for all payers;
* apply for Medicare & Medicaid waivers for inclusion;
* impose penalties for non-compliance;
* conduct investigations, & subpoena witnesses & documents;
* require uniform accounting procedures;
* prevent discriminatory admission practices;
* prevent hospitals from billing non-physician services to Medicare Part B;
* allow programs like PPOs, HMOs to negotiate direct hospital payment;
* allow hospitals to offer payer discounts only if non-governmental payers are included.

In addition, a commission should have power to develop a prospective payment system for the state, & include not only rate but also budget review, & establishment of revenue limits.

Advocates stress that the key to controlling hospital costs is the **all-payer** principle. Without it, hospitals can shift costs to non-covered purchasers. Federal & state operated facilities should be excluded from commission jurisdiction, however.

In answer to the objection that such a commission - similar to public utility regulation - stifles free-market enterprise, proponents contend that hospitals compete not for patients but the affiliation of physicians. They alone can admit patients.

Would the cost of state regulation be passed on to consumers? Current state & federal reporting requirements could be coordinated, thereby reducing regulatory burden. The central argument by proponents is that savings outweigh costs; eg., Connecticut estimates its review program saved more than $153 million in 1981. AARP argues if non-mandatory states achieved the same average reduction in hospital costs as those regulated in 1982, there would have been a $12 Billion

savings nationally.

Will regulation force even more closure of hospitals than is occuring because of DRGs? AARP claims that Maryland, the state with the the most rigid cost regulation structure, experienced a growth in hospital beds. The hospitals' condition was deemed as improved in: a) net income after taxes; b) operating surpluses; c) long-term debt equity rations; d) operating margins; & e) reduced bad debt. However, Maryland is a fraction of the geographical size of Montana with a significantly larger population. The implication, especially for rural Montana hospitals, needs further study.

The AFL-CIO Committee on Health Care has also drafted model hospital rate regulation legislation. Its commission structure is empowered to cap the annual rate of hospital revenue increase & capital expenditures. It would have authority to monitor quality of inpatient care as well as revenue data; disseminate data on cost & utilization of health care services generally; & establish a hospital revenue surtax to help pay for uninsured or indigent patient care.

In short, there are compeling reasons to consider establishment of a statutory hospital rate review commissionin order to couple cost containment with enhanced quality of consumer utilization.

Review conducted by:

Charles Briggs
Office of the Governor

Comments: Tom Ryan, Council Member

For seniors and others affected by increased costs, co-payments and increased deductibles, a Montana State cap for those falling within these categories should be attempted.

Providers would absorb some of these costs now being absorbed by fixed income consumers. I have not seen the AFL-CIO proposals, as presented by the Charles Briggs "Alternative Delivery and Rate Regulation" paper. I believe the proposals need to be examined.

If in-hospital costs are being shifted to Part B of Medicare, it may be detrimental to the consumer. It will influence the deductibles causing hard-to-meet increases in co-payments. Medicare, Blue Shield, Blue Cross and other insurers should discuss this with consumers, suppliers and legislators.

MONTANA HOSPITAL ASSOCIATION

RATE REGULATION: ANOTHER OPINION

There is a common belief across the United States that health care costs should be controlled. This belief is shared by a broad-based constituency which includes all levels of government, the business community, the insurance industry, the elderly population, individuals and, importantly, health care providers themselves. Health care costs can be controlled if all interested parties work together. Indeed, the inflation rate of health care expense in Montana has already greatly moderated.

The most important weapon in controlling health care cost is knowledge of what creates cost and the behavior costs exhibit. Unfortunately, rather than attempting to gain an understanding of health care costs, some states have taken the dramatic step of regulating rates. Rate regulation systems reduce or reallocate the payments made to providers, but they do not change the fundamental cause and behavior of cost.

Hospital Cost

Throughout the 1970s and early 1980s hospital costs grew nationally at an inflation rate higher than that of the general economy. The factors which caused the cost increases are:

- inflation
- labor costs
- technology
- aging of population
- inappropriate use of hospital services
- cost shifting
- medical malpractice costs

Some, but not all, of these factors have moderated. Inflation in the general economy, as measured by the Consumer Price Index (CPI) is below five percent. The moderation of the CPI has slowed the growth of labor costs. Inappropriate use of hospital services has also decreased due to the joint efforts of the government, third parties, businesses and health care providers. Despite these reductions, other factors conspire to push up costs. Technology still adds 0.5 - 1.0 percent per year to hospital costs, not exclusively in capital costs, but also in instrumentation for new surgical procedures, new drugs, and new or improved medical/surgical supplies. The population continues to age and the elderly use more health services than the younger population. Cost shifting will remain a problem until methods are devised to cope with the problem of indigent care and under-reimbursement. Medical malpractice costs are a major and growing concern. Some hospitals in Montana are facing premium increases for 1986 of 100 - 300 percent greater than the previous year! When all of these factors for 1984 are totaled, hospital costs in Montana, as measured in total net patient revenue (the realizable charges to patients), increased by 4.4 percent. The CPI increase for 1984 over 1983 was 4.3 percent; the Medicare hospital market basket allowance for DRGs was 5.6 percent in 1984. The Montana cost figures

figures for 1985 are not yet available, but, because the trends in the cost factors are the same for the two years, it is expected that the rate of increase will be similarly low.

Hospital revenues are designed to exactly match the financial requirements of a hospital. The financial requirements of a hospital are composed of four kinds of costs:

- Operating costs are the cost of providing care to patients. They include the expenses of salaries for nurses and technicians and support personnel such as housekeepers, food service workers and accounting clerks. Operating costs also include the expense of medical/surgical supplies, food, utilities, insurance and so forth.

- Capital costs are the costs of maintaining and accumulating capital. Capital maintenance means that a hospital has the responsibility for maintaining the present value of assets entrusted to it by the community. Simple funding of depreciation is insufficient to maintain capital. To depreciation must be added an amount from the hospital's "surplus." Additionally because technology in the health field is always producing new assets, capital costs must include a component for accumulating capital to purchase new assets. The alternative to capital accumulation is debt financing.

- Social costs are the cost that have been either shifted from society to hospitals or ones that hospitals have assumed for themselves. The financing of indigent care is a primary social cost. Another is the contractual allowance for Medicare/Medicaid. The federal government is attempting to achieve the social goal of reducing the deficit by reducing payments to hospitals. Inadequate payments, like bad debts, become a cost of operating the hospital. Other social costs, such as community education, are also subsumed by this cost category.

- Accounting costs are the costs associated with increases in working capital. A primary accounting cost is the permanent investment in accounts receivable. In the past two years, some hospitals in Montana have seen their days in accounts receivable increase by 50 percent due to government and third party payment policies and procedures.

Hospital revenues must meet these costs. Failure to meet these financial requirements year in and year out will result in the closure of a hospital.

Rate Regulations

If rates are to be regulated in Montana, and if needed hospitals are to remain open, rates must be based upon the full financial requirements of hospitals. Under an all payer rate setting program that follows the

principle of reimbursing the full financial requirements of hospitals, the costs to the system will merely be reallocated. Every payer group will pay its fair share. Presently all payers (with the exception of indigents) pay at or close to their fair share of operating costs. Government payers now only pay the depreciation component of capital cost. The additional cost of capital maintenance and accumulation are borne exclusively by insurance companies and private pay patients. The government payer currently make no contribution to the social costs of a hospital. Only private third parties and private pay patients pay this cost. The same is true for the accounting costs. If everyone were to pay his fair share, the government payers would pay more and the private third parties and individuals would pay less. In order to finance the increase in its contribution, the government would have to increase taxes.

Fair all payer rate control systems merely reallocate costs. Unfair rate control system under-reimburse hospitals. No rate control system affects the cause of cost increases. Rate control programs do not reduce general inflation or labor demands; they, do not interrupt the cycle of innovation and technological advance; they do not stop the population from aging or inappropriately using the hosptial; they do not stop the increase in malpractice premiums; they merely institutionalize the process of cost shifting.

Reducing Hospital Costs

Total hospital costs are composed of two parts: utilization and unit costs. Utilization is a system problem. What incentives or alternatives can be offered to combat high hospital utilization? Wellness programs, larger deductibles, utilization review and outpatient services have reduced utilization. Unit cost is a hospital problem. What can individual hospital administrators do to reduce their expenses? Increasing productivity, group purchasing, and cost awareness programs are strategies employed to reduce unit cost. Controllable expense is being controlled. Hospital administrators need help to control what is now essentially uncontrollable expense - the costs associated with cost shifting and medical malpractice.

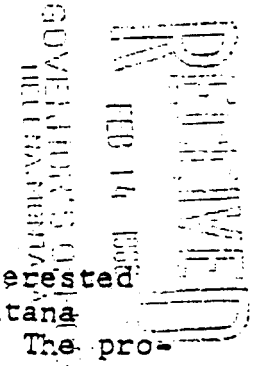
If government, business, third parties, the elderly, individuals and providers work together to control health care costs, it can be done. If any segment only seeks to reduce its health ~~care bill the problem~~ will likely continue. Make no mistake, although the rate of inflation in health care costs is greatly reduced, it is still a ~~problem. It will~~ not be cured, however, by treating the symptoms; we must treat the cause.

TO: Health Care Cost Containment Advisory Council

FROM: Ena Simpson, Sub Committee of Health Promotion
Sub Committee

Date: February 13, 1986

SUBJECT: Discussion Paper No. 8
Alternative Delivery & Rate Regulation



"Health care costs can be controlled if all interested parties work together." This statement from the Montana Hospital Association indicates the need for action. The proposal for the Montana Rate Review Commission would provide the communications between health service providers and consumers to consider rate reviews. The acceleration of health care costs in Montana shows the need for such a commission. This is an important concern of the elderly as well as many others with the result that they are avoiding health services. Many hospitals have empty beds. (cost acceleration serve as disincentive to early diagnosis & care, especially among elderly)

It is premature to think that costs would not be accurately considered. Health service providers would be represented on the commission. Consumers may think technology costs for all the expensive equipment is not needed. There is extreme influence felt for approval of Certifications of Need for expansion of hospital services, and the medical profession duplicates the services in out patient clinics. These costs are reflected in patient charges. The availability of low interest Industrial Revenue Bonds stimulated the construction of new hospitals. Patients look at the expensive, new facilities and see the sturdy brick structures demolished. (older)

The contention that Medicare and Medicaid payments do not cover total costs can be corrected. Several states that use regulation commissions have different systems of paying for the indigent costs. All costs are included in the budgets and approved rates. The aging population is encouraged to reduce costs by second M.D. opinions and checking their charges before payment to avoid overcharges.

It has been suggested that malpractice insurance could be reduced by more effective review to prevent negligence. (peer review) We also need to prevent human misery. Physician licensure should be strengthened and facilities should review physicians credentials. A report on Medical Malpractice Settlements should be required by the Medical Licensure Board.

Industry has promoted regulations to reduce health care costs. The AFL-CIO Committee's proposal indicates cooperation.

We must make every effort to make quality care at affordable costs available to all ages of our Montana population.

The condensed, useful information in the twelve position papers is very much appreciated.

cc: Charles Briggs

a new view

First Citizens Bank of Polson

213 1st St. W. • Polson, Montana 59860 • Phone 883-4358

Informational Grant Material
Outreach Budget

Senior Tips

January 1986

VENTY PERCENT of American adults receive income from nsions averaging $590 monthly, says the Census Bureau.

OVERNMENT DATA show most of the 27 million people er age 65 in this nation are relatively healthy, are not poor and e care of themselves. Most live near at least one adult child. those with disabilities necessitating physical care, 1.4 million in nursing homes while 5.2 million live in their own homes or artments or with family members. Four out of five people over e 65 have at least one surviving adult child. But Americans er age 85 are the fastest-growing group of the population and ee or four generation families are increasingly common. The mber of people needing full-time care is predicted to double tween now and 2020. Between 1960 and 1985, the nation's rsing home bill grew from $480 million to $32 billion. By 90, according to a congressional study, health care costs not vered by insurance will take 20 percent of the incomes of ose over age 65 — up from 15 percent today.

OSPITAL BILLS should be checked before payment. One port shows that 98 percent of hospital bills in an audit over a o-year period held mistakes. The study covered 3,850 bills m hospitals in 41 states. Of those with errors, about 97 per- nt included charges that could not be verified as being for serv- s actually rendered. Once the errors were reported, the bills re reduced by an average of 4.9 percent.

HEN A POWER FAILURE occurs in your home, turn off all ajor appliances. If everything comes back on at once, it could erload the circuits and damage appliances.

TO: Charles Briggs

FROM: Ena Simpson

DATE: February 24, 1986

SUBJECT: Supplement to Remarks for Discussion Paper 8
Alternative Delivery & Rate Regulation

Costs could be reduced if simplified records were used for less paper work. Complaints that reporting forms for Medicare and Medicaid require too much time and the delay in payments is expensive.

The statement of the Montana Hospital Association "Hospital revenues are designed to exactly match the financial requirements of a hospital." The increased number of health service providers that are controlling the administration of health facilities are not non-profit businesses. Some of these are out-of-state chain operations. There has been substantial increases in costs where they control rural hospitals. The patients are paying for the profits and they complain that they can not read the bills. They question the accuracy of the charges.

EXHIBIT # 5
1-22-87
128

WITNESS STATEMENT

NAME Gerald F Leavitt BILL NO. HB 128

ADDRESS 2033 11th Ave, Helena DATE 1/22/87

WHOM DO YOU REPRESENT? Montana Hosp Rate Review System

SUPPORT _____ OPPOSE ✓ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

WITNESS STATEMENT

NAME [illegible] BILL NO. 141

ADDRESS 121 4th Ave Helena DATE Jan 22

WHOM DO YOU REPRESENT? Montana Hospital Assn

SUPPORT _____ OPPOSE ✓ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HOUSE BILL # 126 DATE JANUARY 22, 1987

SPONSOR REP. HARPER

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
[illegible]	[illegible]	✓	
[illegible]	[illegible]		
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	—	
[illegible]	[illegible]	—	
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]		
[illegible]	[illegible]	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. [illegible] DATE [illegible]

SPONSOR [illegible]

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
[illegible]	[illegible]	x	
[illegible]	[illegible]	x	
[illegible]	[illegible]	x	
[illegible]	"		
[illegible]	"		
[illegible]	[illegible]		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HOUSE BILL # 128 DATE JANUARY 22, 1987

SPONSOR REP. HANSEN

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Walker, Scott A	Polson	✓	
MARVALEE FINLAY	DAYTON	✓	
[illegible]	[illegible]	??	
[illegible]	[illegible]		
[illegible]	Lambert		
[illegible]	Lambert	✓	
[illegible]	[illegible]		✓
[illegible]	[illegible]		
[illegible]	[illegible]		✓
[illegible]	[illegible]	✓	
[illegible]	[illegible]		✓
[illegible]	[illegible]	✓	
[illegible]	[illegible]		
[illegible]	[illegible]	✓	
[illegible]	"	✓	
[illegible]	"	✓	
[illegible]	Missoula	✓	✓
[illegible]	[illegible]	✓	
[illegible]	[illegible]	✓	
[illegible]	Helena MMHAI		✓

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

[illegible] Helena area ✓

CS-33 [illegible] MSCA ✓

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 128 DATE Jan 22 1987

SPONSOR [illegible]

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Alice Campbell	812 Sherwood Kalispell MT	X	
[illegible]	[illegible]	—	
Rose Skoog	MT HEALTH CARE		✓
Ken Morrison C	LOR	Amend	
[illegible]	[illegible]		✓
Astrid Crichton	1248 S Willson		✓
Jean T Rankin	[illegible]		—

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.