MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Stella Jean Hansen, on January 27, 1989, at 3:00 p.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: None

HEARING ON HB 282

Presentation and Opening Statement By Sponsor: Rep. Strizich stated that this bill was an act creating a detention center standards commission; authorizing the commission to adopt standards for detention centers and temporary detention centers; providing for implementation of standards for detention centers and temporary detention centers. Rep. Strizich also stated that this legislation arises out of an awareness that jails in Montana are faced with 21st century problems with 19th century facilities. The bill will create a nine member commission and the bill identifies standards in three primary areas which relate to the running of a jail. These include standards for detention facility maintenance, detention center operation and detention center design. Exhibit 1.

List of Testifying Proponents and What Group They Represent:

Don Crabbe, Montana Board of Crime Control
Bill Fleiner, Montana Sheriff's and Peace Officers Association
Howard Gipe, Flathead County Commissioners Office
Mark Murphy, Assistant Attorney General
Wally Jewell, Montana Magistrates Association

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Don Crabbe supports this bill and stated that the role of the Commission acted as a task force which researched other states in regards to the statutes which they had developed regarding standards for detention facilities. Exhibit 2.

Bill Fleiner supports this bill on behalf of the Montana Sheriff's and Peace Officers Association.

Howard Gipe supports this legislation and said that standards for jails were practically non existent.

Mark Murphy supports this bill and stated that the standards for jails are being set on a national level. An opportunity to upgrade and meet a set of national standards that are being developed currently and the committee which will be developed would be able to meet with the problems which now exist.

Wally Jewell supports this bill and supplied written testimony in Exhibit 3.

Questions From the Committee: Rep. Simon asked Rep. Strizich if there were currently no federal guidelines or standards that would be applicable that local jails could look towards rather than having a state commission and Rep. Strizich stated that there were many suggested standards but a solid set of standards for Montana is what is needed. Rep. Simon then questioned that fact that members of the commission did not appear to have the expertise in construction to be able to put together the kind of standards which were necessary for this type of legislation and Mr. Fleiner stated that when the commission was established they in turn could then make this feasible. Rep. Simon then asked Mr. Murphy stated that if the standards were developed and then a jail is built according to those standards and later it was determined that those standards were not adequate, does the state then assume a level of responsibility for the correction of those inadequacies in the standards and Mr. Murphy stated that the local government is responsible for maintaining an adequate facility.

Rep. Lee asked Mr. Murphy how many staff would be envisioned and Mr. Murphy stated that there would be four; Rep. Lee asked there would be federal funding for this project and Mr. Murphy stated there would not be.

Rep. Blotkamp asked Rep. Strizich how many jails needed to

be upgraded and Rep. Strizich stated that Yellowstone County, Lewis and Clark County, Flathead County, Fort Benton and Shelby.

Rep. Boharski asked Mr. Crabbe questioned the federal grant for funding for the first two years and Mr. Crabbe stated that the money which was received was funding for the task force that put the piece of legislation together, not to fund the development of the standards. Rep. Boharski asked Rep. Strizich the amount quoted on the fiscal note and he stated that it was $151,600.00 for 1990. Rep. Boharski asked Mr. Crabbe if the statutes already existed in the present legislation and if new legislation was necessary and Mr. Crabbe stated that the Board of Crime Control did not develop standards for jails.

Rep. Good asked Rep. Strizich if the commission did become a reality, will this not in effect tell the voters that regardless of what was wanted to come into compliance, this is what you will have to do - is this going to force the hand of the people in the local communities and Rep. Strizich stated that these requirements of the Constitution and current case law.

Closing By Sponsor: Rep. Strizich closes on the bill.

HEARING ON HB 382

Presentation and Opening Statement By Sponsor: Rep. Hansen stated that this bill was an act providing that it is a violation of the Montana Unfair Trade Practices and Consumer Protection Act for a health care provider to refuse medicare assignments; requiring posting of this law in the place of business of each health care provider.

List of Testifying Proponents and What Group They Represent:

Doug Campbell, Montana Senior Citizens Association
Manual Weiner, Massachusetts Senior Action Council
Elsie Lee
Dick Brown, Montana Senior Citizens Association
Elmer Foth, Montana Senior Citizens Association
Tim Harris, Independent Living Center
John Den Herder, Disabled American Veterans
Virginia Jellison, Montana Low Income Coalition
Don Judge, AFL-CIO
Brenda Nordlund, Montana Women's Lobbyists
Nadine Jensen, Montana State Council Nine
Ann Pruanoski, Montana Alliance For Progressive Policy

Sam Ryan, Montana Senior Citizens Association
Mike Sherwood, Montana Trials Lawyers Association
Ed Sheehy, National Association of Retired Employees
Earl Riley, Montana Senior Citizens Association, Exhibit 8
Willa Evans, Roundup Senior Citizens
Jo O'Leary, Harlem Legacy Legislator
Altha Van Aken

List of Testifying Opponents and What Group They Represent:

Van Kirke Nelson, M.D., Montana Medical Association
Carol Erickson
Ronald V. Loge, M.D., American Board of Internal Medicine
Kenneth Eden, M.D.
Jerry Loendorf, Montana Medical Association
John McMahon, M.D., Montana Medical Association
Jim Aherns, Montana Hospital Association
Bill Leary, Governor's Advisory Council
Leona Tolstedt, Montana Medical Association

Testimony:

Doug Campbell supports this bill and states that this legislation is necessary because over the past seven years, the doctors fees for medicare patients have gone up more than twice the rate of inflation. Medicare premiums and supplemental premiums have taken considerable increases. Exhibit 4.

Manual Weiner supports this bill and states that the Massachusetts Senior Action Council is primarily responsible for the law that prohibits physicians for bill their medicare patients more than the reasonable fee as determined by medicare. Exhibit 5.

Elsie Lee supports this bill and spoke of the Mont-Share program which was recently initiated in Great Falls.

Dick Brown supports this bill and spoke of the over charging by physicians. Mr. Brown also spoke of means testing.

Elmer Foth supports this bill and said that the senior citizens needed controls and guidelines to function in the best interest in the majority of the people.

Tim Harris supports this bill and stated that the Montana Independent Living Center provided the necessary support and direct services to individuals with disabilities to allow each person to live as independently as possible. Exhibit 6.

John Den Herder, a proponent of this bill, states that he is a retired health care surveyor and feels that it would be beneficial to have providers accept assignment.

Virginia Jellison supports this bill and stated that this bill is one of our priorities in our legislative package. Exhibit 7.

Don Judge is a supporter.

Brenda Nortlund, supports this bill.

Nadine Jensen supports this bill.

Ann Prounoski supports this bill.

Sam Ryan supports this bill.

Michael Sherwood supports this bill.

Ed Sheehy supports this bill.

Earl Riley supports this bill and supplied Exhibit 7.

Willa Dale Evans supports this bill.

Jo O'Leary supports this bill.

Alpha Van Aken supports this bill.

Earl J. Reill and Richard Brown supplied written witness statements.

Van Kirke Nelson, M.D. opposes this bill and states that he is a non participating physician and also said that most physicians will continue to provide care to all patients. Dr. Nelson also said that the Massachusetts fee schedule, even with compulsory mandatory assignment is greater that Montana and mandatory assignment is not in the best interest of the citizens of Montana. Exhibit 8.

Carol Erickson opposes this bill and stated that she was the administrator of the Missoula Medical Oncology Clinic and stated that there was a very reasonable alternative being proposed by the Montana Medical Association. She said that her clinic fully supported the Mont-Share Program and would be happy to take assignment in a charitable way for elderly persons on fixed incomes who have no other means to pay for their services. Exhibit 9

Ronald V. Loge, M.D., opposes this bill and states that most people do not understand the complexities of medicare regulations and that they are receiving a discounted service and are being undercharged by Montana physicians. Exhibit 10.

Kenneth Eden, M.D. opposes this bill and does accept medicare assignment on all patients and does not address this issue out of personal adverse. Dr. Eden stated that this bill identifies entirely the wrong enemies. It is an oversimplified answer to a very complex problem which has the potential for many more adverse affects than beneficial ones.

Jerry Loendorf opposes this bill and addressed the issue of overcharging. Mr. Loendorf then explained a flow chart for medicare payment to physicians.

John McMahon, M.D. opposes this bill and states that it is exceptionally difficult to suggest that your interests are not the same as the senior citizens when you are just a very few years away from being a senior citizen. There are some very poor assumptions that have been made and have been passed on to many seniors.

Jim Aherns also opposes this bill and said that what we have in Montana is a very fragile situation in rural America. Mr. Aherns spoke of the status of hospitals and the fact that they were greatly intertwined with the physician availability.

Bill Leary neither proposes nor opposes this bill but stated that the Governor's Council made no recommendation regarding the support of opposition to the medicare physicians assignment. Exhibit 11

Leona Tolstedt opposes this bill.

Questions From the Committee: Rep. Knapp asked Mr. Campbell why shouldn't someone pay his full bill if he can afford to do so and Mr. Campbell stated the fact of means testing.

Rep. Brown asked Mr. Campbell about physicians in the rural areas leaving the state if the bill were passed and Mr. Campbell said that a survey had been taken in the rural areas of the physicians and 54% accepted assignment against 20% of the doctors statewide.

Rep. Boharski stated to Mr. Weiner the one of the opponents to this legislation that currently in Massachusetts

with their mandatory medicare assignment legislation that a senior citizen would pay more than the senior citizen in Montana would pay and Mr. Weiner said that the senior citizen would pay more for out of pocket costs. Rep. Boharski said that if a patient went in for a procedure that there was an established grade under medicare the overcharge or the 20% required in Massachusetts was more than were standard paying now in Montana without medicare and Mr. Weiner said that the doctor referred to the fact that medicare had different charges and that in Massachusetts the payments were higher than in Montana. The patient in Massachusetts would pay less than a state with mandatory assignment. Dr. McMahon said that the average amount of excess charge per claim is $33.22 in Massachusetts in 1987 and in Montana it is $28.36. The average amount of co-payment is $28.17 and Montana's is $21.51. The physicians in Montana have gone overboard in attempting to keep down the cost to the patient.

Rep. Squires asked Dr. McMahon about the diagnostic related groupings and Dr. McMahon said that they were strictly related to hospital charges.

Rep. Simon asked Dr. McMahon why there were different amounts charged between a new doctor in the area and a doctor which had been here longer and Dr. McMahon said that it was true. Rep. Simon then stated to Dr. McMahon that he as a physician that has been in practice for longer and has more experience, might be allowed to charge under medicare, less than a young doctor. Dr. McMahon stated that this was true as of two years ago and then the federal government mandating that a new person could not charge any more than the 50% Rep. Simon then asked Mr. Campbell about any assignments or every assignment and Mr. Campbell said that all accept medicare assignment.

Rep. Blotkamp asked Ms. Erickson about the battleground needing to be at the federal level and not at the state level and Ms. Erickson said yes it would.

Rep. Lee asked Mr. Campbell if the AARP supported this legislation and Mr. Campbell said that he did not. Rep. Lee then asked the same question of Dr. Loge and he stated that AARP was opposed to state legislation that would mandate assignment because of their fear for their constituents of lack of access to care.

Closing By Sponsor: Rep. Hansen closes on the bill.

ADJOURNMENT

Adjournment At: 5:30 p.m.

REP. STELLA JEAN HANSEN, Chairman

SJH/ajs

2707.min

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date January 27, 1989

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

JAIL RECODIFICATION COMMITTEE

J. L. 'Pete' Howard, Chair
Teton County Sheriff
Teton County Courthouse
Choteau, MT 59422

Greye Verstraete
ACLO of Montana
P.O. Box 3012
Billings, MT 59103

Rick Ross
Jail Administrator
Yellowstone County Courthouse
Billings, MT 59107

Dwight McKay
County Commissioner
Yellowstone County Courthouse
Billings, MT 59107

Bob Ash, Sheriff
Rosebud County Sheriff's Dept.
Rosebud County Courthouse
Forsyth, MT 59327

Hon. Thomas McKittrick
District Judge
Eighth Judicial District
Cascade County Courthouse
Great Falls, MT 59401

Honorable Delwin Gage
State Senator
P.O. Box 1027
Cut Bank, MT 59427

Hon. Rex Manuel
State Representative
RR 1, Box 42
Fairfield, MT 59436

Joe Gottfried
County Commissioner
Toole County Courthouse
Shelby, MT 59474

Jim Brown
Dept. of Administration
Buildings Codes Division
1218 East 6th Ave.
Helena, MT 59620

Sam Murfitt
Dept. of Health and
Environmental Services
Cogswell Building
Helena, MT 59620

Mark Murphy
Assistant Attorney General
Room 239 - Justice Building
215 North Sanders
Helena, MT 59620

John Connor, Jr.
County Attorney
Jefferson County Courthouse
Boulder, MT 59632

Jim Nugent
Missoula City Attorney
201 W. Spruce
Missoula, MT 59802

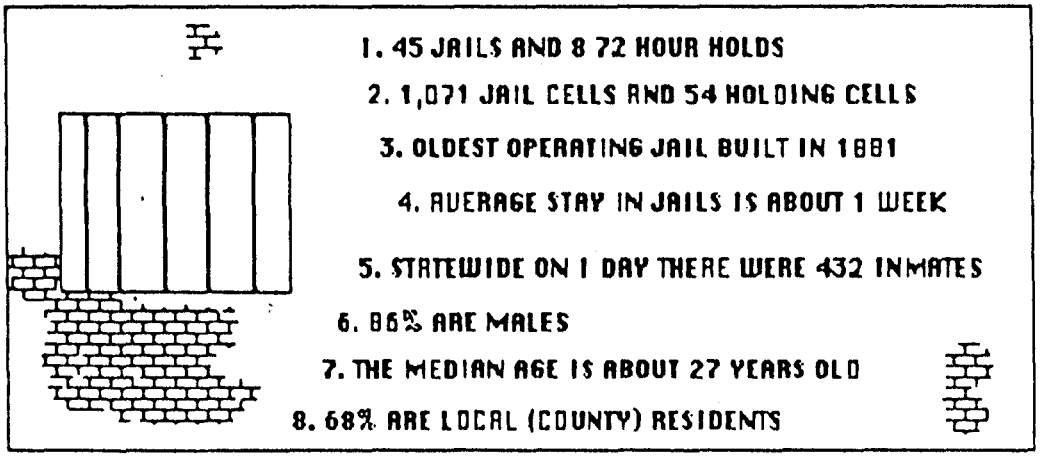
Ted Stolfus
Jail Administrator
Flathead County Courthouse
Kalispell, MT 59901

Mr. Dave Gliko
City Attorney
Civic Center Building
Great Falls, MT 59401

Daniel D. Russell
Dept. of Institutions
Corrections Division
1539 Eleventh Ave.
Helena, MT 59620

EXHIBIT 1
DATE 1-27-89
HB 282

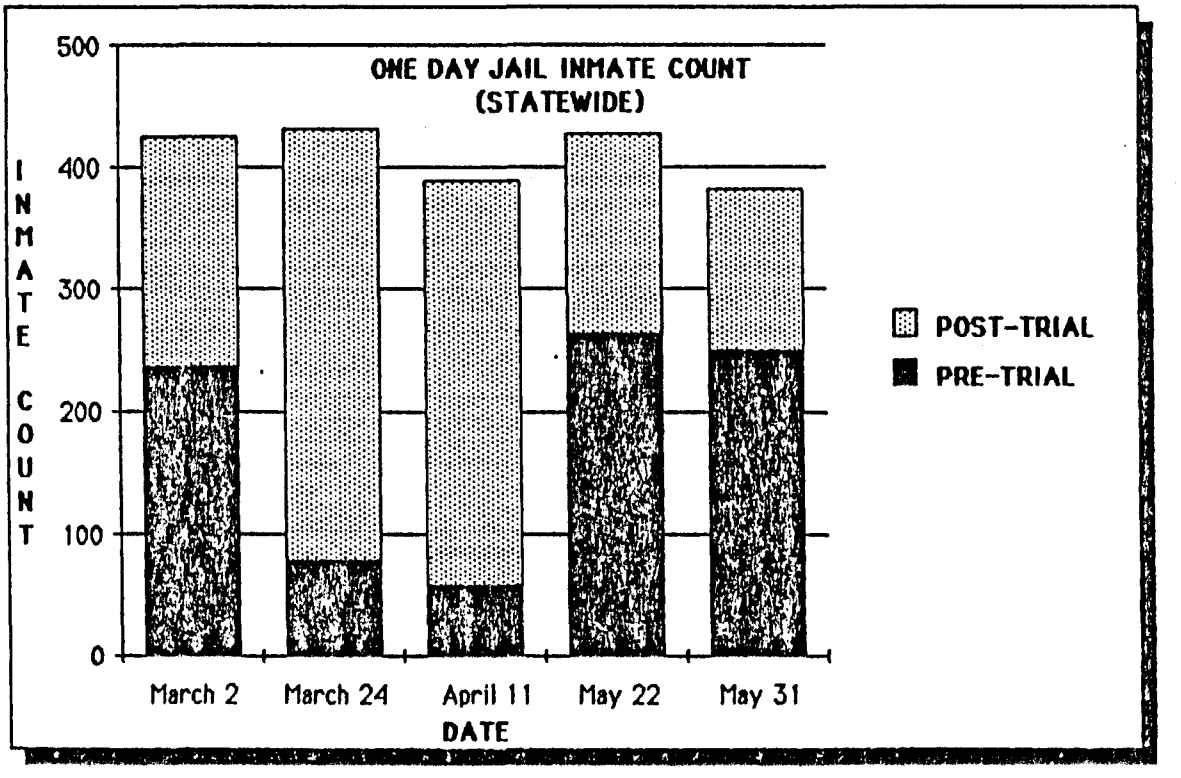
MONTANA JAIL FACTS



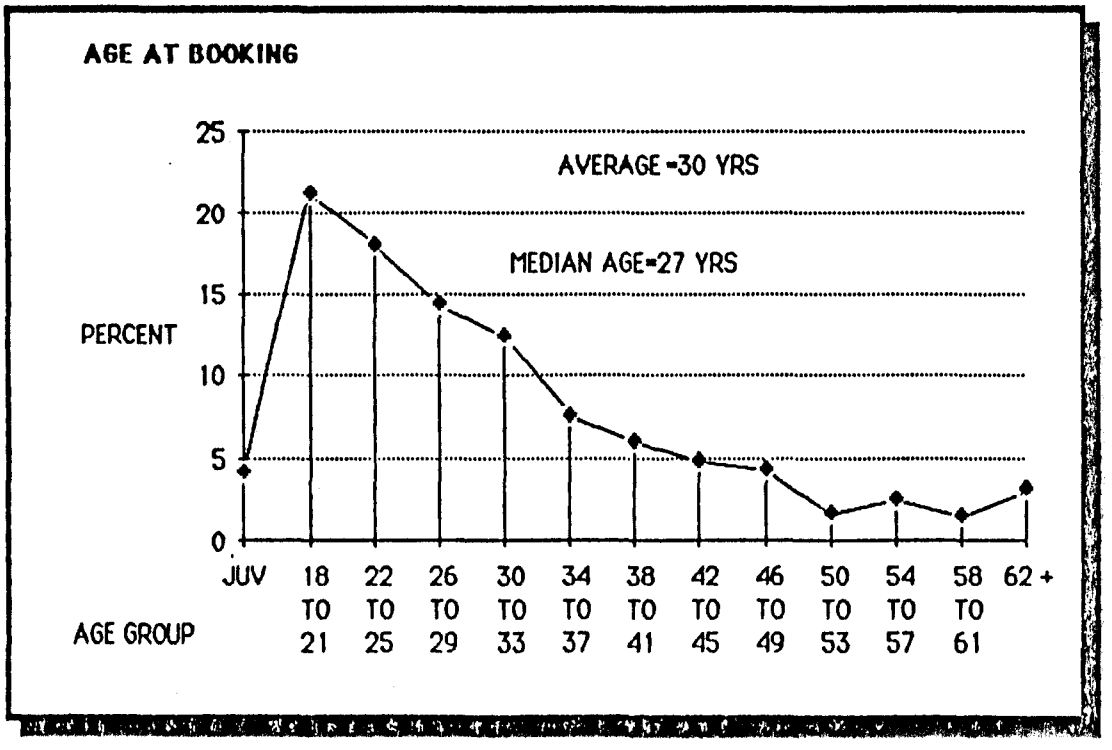
SOURCE : MONTANA BOARD OF CRIME CONTROL

EXHIBIT 2
DATE 1-27-89
HB 282

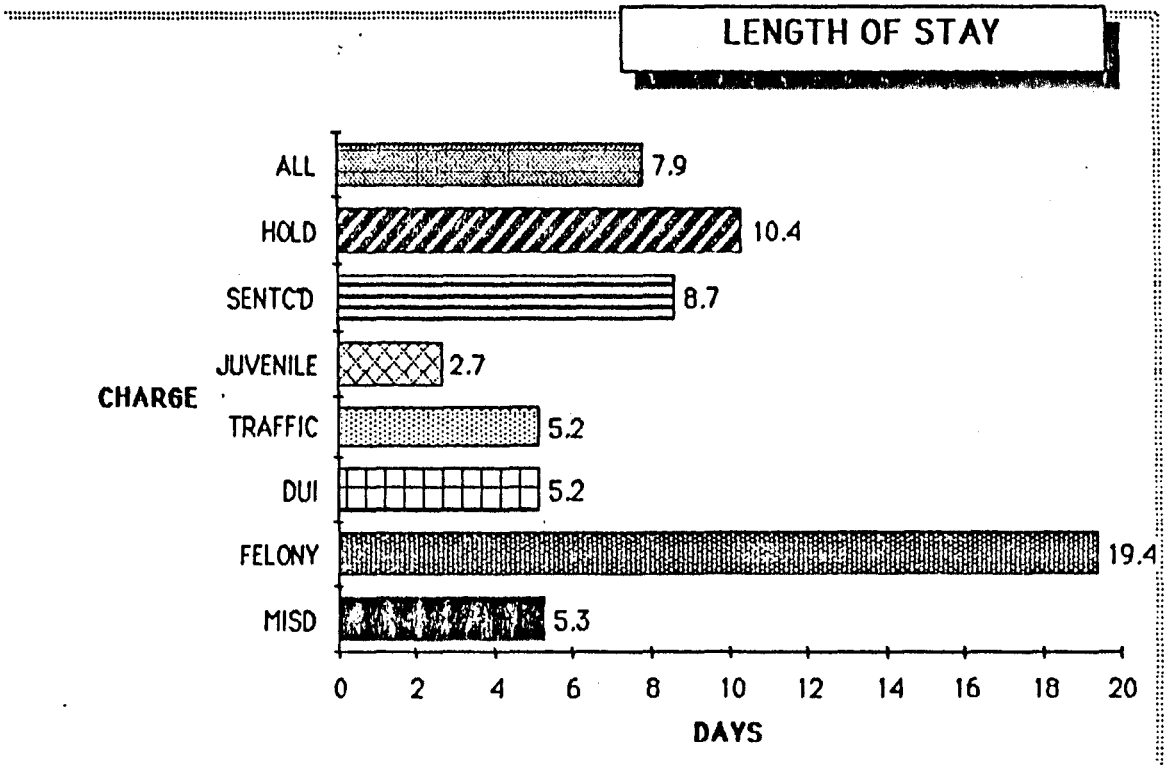
SINGLE DAY JAIL INMATE COUNT--Statewide



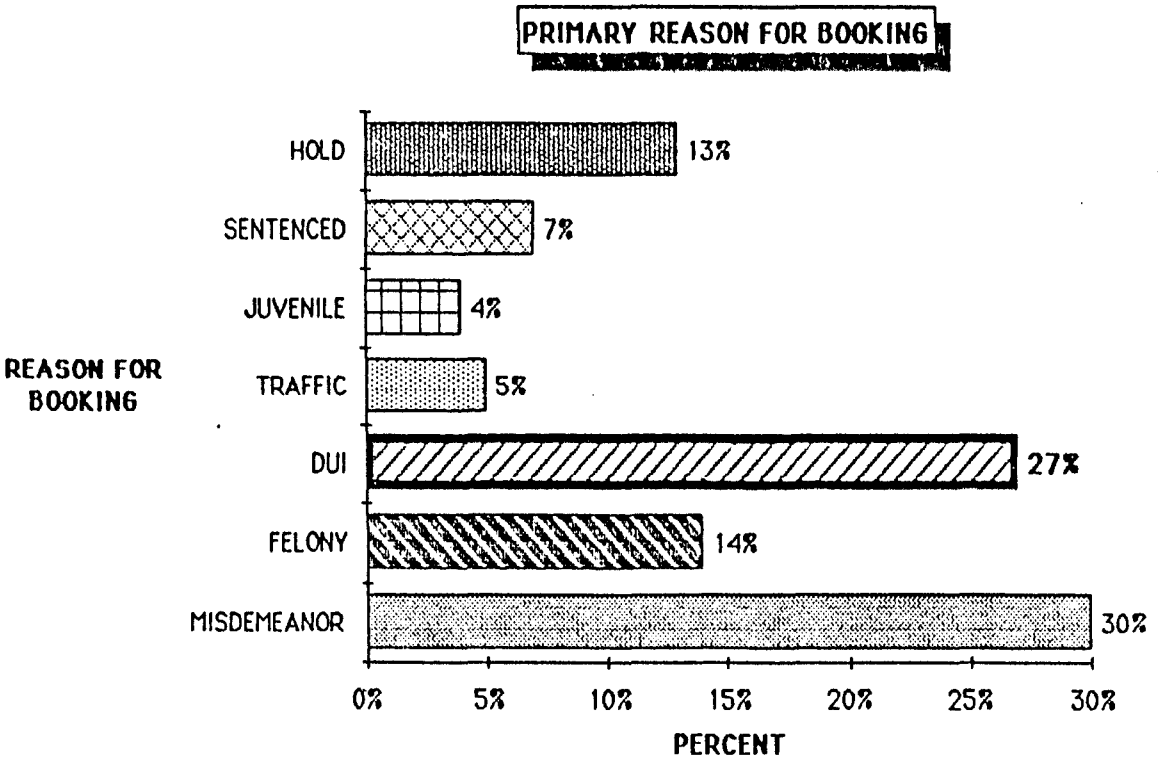
NINE COUNTY JAILS--1984



LENGTH OF STAY



COUNTY JAIL PRISONERS



MONTANA BOARD OF CRIME CONTROL -- SUMMER OF '84

DETENTION CENTER STANDARDS

Suggested Amendments to House Bill 282:

Amendment #1: Change Section 1 reading "certain minimum standards of construction," to "certain minimum design standards,".

Amendment #2: Change Section 3(4)(d) reading "two sheriffs;" to "one sheriff;".

Amendment #3: Add a new Section 3(4)(i) "one police chief."

Amendment #4: Change Section 8 heading reading "Construction standards." to "Design Standards."

Amendment #5: Change Section 8(2) reading "review to determine compliance with adopted standards" to "verification of compliance to design standards."

WITNESS STATEMENT

NAME Wally Jewell ~~BUDGET~~ HB282

ADDRESS 520 TAMARACK HELENA, MT

WHOM DO YOU REPRESENT? MONTANA MAGISTRATES ASSOC

SUPPORT (X) OPPOSE _____ AMEND (X)

COMMENTS: We support HB282 & the creation of a detention standards comm. We would however like to see a limited jurisdiction judge - a city judge or justice of the peace - on this commission.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

EXHIBIT 3
DATE 1-27-89
HB 282

Form CS-34A
Rev. 1985

WHAT IS MEDICARE ASSIGNMENT?

The examples below are for the same medical procedure from a doctor who accepts Medicare assignment and one who does not.

DOCTOR ACCEPTS ASSIGNMENT	
MEDICARE APPROVES	$600
DOCTOR'S BILL	$600
MEDICARE PAYS 80%	$480
YOU PAY 20%	$120

DOCTOR DOES NOT ACCEPT ASSIGNMENT	
MEDICARE APPROVES	$ 600
DOCTOR'S BILL	$1000
MEDICARE PAYS 80%	$ 480
YOU PAY 20% PLUS ALL CHARGES OVER WHAT MEDICARE APPROVES	$ 520

EXHIBIT 4
DATE 1-27-89
HB 382

Montana Senior Citizens Assn., Inc.

WITH AFFILIATED CHAPTERS THROUGHOUT THE STATE

P.O. BOX 423 - HELENA, MONTANA 59624

(406) 443-5341

MSCA: DOUG CAMPBELL TESTIMONY FOR HB 382

This legislation is necessary because over the past seven years doctors fees for Medicare patients have increased at more than twice the rate of inflation. Medicare premiums and supplemental insurance premiums have gone up sharply this year.

Medicare which was originally supposed to take care of 75% of seniors health costs now covers only about 45%.

In 1980 seniors spent 12% of their income for health care and in 1988 it was 18%.

Seniors median income in 1986 was $8,154 and for senior women it was $6,425. Montana°s physicians median income in 1987 after all expenses and before taxes was over $71,000.

Mandatory assignment was one of the five priority bills of the 1988 senior Legacy Legislature and one of the ten legislative priorities of the Governor°s Advisory Council on Aging.

If this is a priority, issue for Montana°s 100,000 plus seniors it would be hard to believe that the legislature would put the financial interests of 1300 physicians ahead of the interests of 100,000 seniors, most of whom live on very modest fixed incomes.

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

EXHIBIT 5
DATE 1-27-89
HB 382

Medicare Balance Billing Law

Fact Sheet

° In October, 1987, the United States Supreme Court let stand Massachusetts' first-in-the-nation law (Chapter 475 of the Acts and Resolves of 1985) prohibiting physicians from billing Medicare beneficiaries in excess of "reasonable charges" established by the federal program.

° Earlier in March, the United States Court of Appeals unanimously affirmed the decision of U.S. District Court Judge Robert E. Keeton upholding the constitutionality of the state statute. The Massachusetts Medical Society and the American Medical Association had challenged the provisions of the Medicare Balance Billing Law, which the Legislature passed in October, 1985.

° Balance billing refers to the physician billing a patient in excess of the Medicare "reasonable charge." The patient must still pay 20% of the "reasonable charge."

Example:	Physician's usual charge:	$150.00
	Medicare "reasonable charge":	$100.00
	Medicare pays:	$ 80.00
	Patient pays:	$ 20.00

The physician may not charge to or collect from the patient the $50.00 difference between the "usual charge" ($150.00) and the Medicare "reasonable charge" ($100.00).

° The Board' Medicare Balance Billing regulations, 243 CMR 2.07 (15), state:

Effective April 20, 1986, if a licensee accepts for treatment a beneficiary of health insurance under Title XVIII of the Social Security Act (Medicare), the licensee shall not charge to or collect from such beneficiary any amount in excess of the reasonable charge determined by the United States Secretary of Health and Human Services.

° The Board's regulations also permit Medicare patients to file complaints against physicians who violate the law and allow the Board to impose a sanction on those violators commensurate with the severity of the violation.

(continued)

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street, Boston, Mass. 02111

MICHAEL S. DUKAKIS
GOVERNOR

PAUL J. LANZIKOS
SECRETARY

January 9, 1989

Mr. Manny Weiner
119 Pleasant St. Apt. 6
Arlington, Mass. 02174

Dear Manny:

I am writing to you in behalf of the Executive Office of Elder Affairs regarding Chapter 475 , Ban on Balance Billing.

With the enactment of Chapter 475 of the Acts and Resolves of 1985, Massachusetts elders are now protected from Medicare Balance Billing. The law went into effect April 20, 1986.

The initial concerns that physicians would leave the state to practice elsewhere and elders would have a difficult time finding care have not materialized. In fact, the number of physicians who have contracted with Medicare in Massachusetts has increased since enactment of Chapter 475.

The Executive Office of Elder Affairs (the State Unit on Aging) has received no complaints regarding the inability to access care due to Chapter 475.

If you have any questions or require additional information, please contact Kathy Glenzel of my staff @ 617-727-7750 ext. 268.

Sincerely,

Paul J. Lanzikos

PJL:KG/ml

MONTANA INDEPENDENT LIVING PROJECT

38 South Last Chance Gulch
Helena, Montana 59601

(406) 442-5755
Toll Free 1-800-233-0805 (VOICE/TDD)

January 27, 1989

RE: House Bill 382

I am Tim Harris and I am employed with the Montana Independent Living Project as a Community Development Specialist. The role of our independent living center is to provide the necessary support and direct services to people with disabilities to allow each person to live as independently as possible.

Some that we serve (consumers) are on Social Security Disability Insurance and are covered by Medicare. They are also on fixed incomes and generally do not qualify for Medicare supplemental insurance because of age nor, since they are disabled, for individual health insurance. Some qualify for state medical or Medicaid but many are over income for that benefit. That means any doctor-related charges above assignment come out of pockets already substantially thinned by costs of day to day living.

All of us are concerned with the rising costs of health care. Somehow, those costs must be controlled by the efforts of each one of us. House Bill 382 is an attempt to help and the Montana Independent Living Project supports its passage.

Thank you.

Tim Harris

Community Development Specialist

EXHIBIT 6
DATE 1-27-89
HB 382

MONTANA
LOW-INCOME
COALITION

P.O. BOX 1029
HELENA, MONTANA 59624
(406) 449-8801
(406) 443-0012

EXHIBIT 7
DATE 1-27-89
HB 382

TESTIMONY IN SUPPORT OF H.B. 382
BEFORE THE
HOUSE HUMAN SERVICES AND AGING COMMITTEE

Madam Chairperson and Committee Members:

My name is Virginia Jellison; I'm the Lobbyist for the Montana Low Income Coalition. The Coalition is comprised of several member based groups, of which one represents senior citizens. We are particulary concerned about low income seniors, who live on fixed incomes and are faced with a daily struggle to make ends meet.

For people, who's only income is Social Security and/or a small pension, the high cost of medical care is particularly troublesome.

One of our most valued resources are our seniors, who have contributed to Montana's economic and social well-being for the majority of their lives. They have supported us, when we were all children, through their work and their contributions to culture and art as they continue to do so in the autumn of their years.

We are a benevolent society that truly cares for its mature people and the Medicare program has been established to ease the burden of health care costs from our seniors. Unfortunately, some health care providers charge more to seniors than the accepted Medicare rate, even though the Medicare rate is based on a fair system.

Because seniors have an adversion to accumulating debt and are usually very frugal people, they will do without needed medical care and become very stressed when ill and unable to pay medical bills. Many seniors will cut their dosage of medicine or not take it at all and often are reluctant to practice preventive medicine, putting off needed surgury or treatment because they are afraid of medical bills accumulating. We thought we had the problem solved when Medicare was established only to find the health providers increasing the cost to seniors by not accepting the Medicare rate for full payment.

MLIC supports H.B. 382 because it requires health providers to accept the Medicare asignment. We urge the Committee to vote for a do pass for H. B. 382. Thank you.

Testimony
Montana Senior Citizens Association
President Earl Kelly

It is doubtful that younger citizens are being forced to help pay for health care provided to medicare patients. Indeed the younger people are, according to reliable reports unable to even pay their own bills. There are some forty million of them without insurance. How could they possibly be billed for more when they are unable to pay anything on their own bills. It seems evident that the opposite is happening. This suggests that these overcharges to seniors are making up the money being lost to providers when they treat the destitute younger people. One doctor I visited is treating quite a few of these unfortunate people without charging. This is admirable and certainly to his credit, I am sure many doctors do this. If charity work is necessary for them to do this, they should not be asked to work for nothing. In a country such as ours with its remarkable feats of technology and high standard of living, it certainly should not be necessary for people to forego health care. I'm not here to engage in a shouting match about doctor's income as it compares with the seniors and others. Rather we are at the forefront to insist that our doctors are paid well to compensate them for their expertise and the training expenses they encounter. The facts show that we are facing disaster with the health care system, especially medicare. The moneys paid out by medicare will exceed that of social security within twenty years. If the present trend continues, by the year 2013 or sooner it will reach two trillion dollars yearly. The economic system will

EXHIBIT 7
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HB 382

simply not support this figure as it is presently structured. I am not trying to blame these doctors for the increase, but we feel that passing the medicare assignment bill is a first step toward dealing with this problem. Constraints must start someplace and this bill will help to secure affordable health care for seniors. As long as charges above the medicare reasonable fee are allowed there will be no effort or reason to address these inequities.

Senior citizens from all across the country are working on this problem and are anxious and willing to participate in a solution for all American citizens. We do not expect a free lunch nor do we want to impose on the health costs and financial needs of younger Americans.

Let's work together on this. we believe it is time to start by passing this legislation.

Petition To get doctors to accept Medicaid assignments

Jan 17- 89

1	Oliver Rock	Terry mt Box 486
2	Erma Schwartz	Fallon Mont Box 175
3	Paul Rotter	Terry Mont
4	Martin Wolf	Terry Mont
5	Lucy Renn	Terry Mont
6	Paul Renn	Terry, Mont
7	Jacob J Schwartz	Fallon Mont
8	Richard Stebbins	Terry, Mont
9	Fred Hoeger	Terry MT
10	Ruby Lavender	Terry mt
11	Art Lavender	Terry mt
12	C Ratfie	Terry, Mont.
13	Evelyn McGee	" "
14	P D Wallace	" "
15	Frances Maddox	Terry, mt, Box 520
16	Darlene Shumaker	" "
17	Grace Faith	
18	Pauline Brown	Terry Mon.
19	Martha Schneider	Terry, Mont.
20	Merle Stebbins	Terry.
21	Dolores Rambur	— —
22	Martha Kiffer	— —
23	Mabel Loomis	" "
24	Elizabeth Dobbin	" " Box 455
25	Rose Fusler	
26	Dolores Madsen	Terry
27	Esther Kogele	Terry

EXHIBIT 7
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Petition To get doctors to accept Medicare assignments

28	Robert McMakin	Fallon, Mt.
29	Fred J Kaul	Fallon Mt.
30	Carl Hass	Glendive, Mt
31	Marie Hass	Glendive Mt.
32	Edna Atkinson	Fallon. Mt.
33	Lisa Damm	Fallon Mt
34	Ed Stirbel	Fallon Mt
35	Adolph Schott	Fallon. Mt.
36	Ida Schott	Fallon Mt.
37	Sayloje Gaub	Fallon. Mt.
38	John Lapp	Fallon mont
39	Mae Lapp	Fallon Mont.
40	Evelyn McMakin	Fallon Mt.
41	Henry Gaub	Fallon mont
42	Joe M Gaub	Fallon Mont
43	Erna Stickel	Fallon Montana
44	Albert Stickel	Fallon Montana
45	Mary Twitchell	" "
46	Emma Gebhardt	Fallon, Mt
47	Pete Schaaf	Fallon Mt
48	Anna Huber	Fallon, Mont
49	Reuben Buechler	Fallon Mont

MONTANA MEDICAL ASSOCIATION

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Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
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January 27, 1989
Friday

M E M O R A N D U M

TO: ALL MONTANA LEGISLATORS

FROM: MONTANA MEDICAL ASSOCIATION

THE FACTS ABOUT MANDATORY ASSIGNMENT (participation) VERSUS ASSIGNMENTS ON A CASE BY CASE BASIS (nonparticipation).

On Monday, October 3, 1988, a vitriolic attack against Montana physicians appeared in most Montana dailies, the attack by a senior citizens group calling themselves "Citizen Action."

This release stated that the 81% of Montana physicians who do not accept assignment (on a case by case basis) had excessively billed their patients 10.2 million dollars, or $28.36 per claim, which they advised totaled 360,187 claims. Interestingly, they admitted in the article that the average national overcharge was $38.11.

Massachusetts, "the cradle of liberty," with legislated mandatory assignment, was singled out as the best state because only 3% of Massachusetts physicians over billed, even though they admit that Massachusetts physicians receive more money for services rendered than do Montana physicians, even after mandatory assignment.

They state "among Montana physicians, 19.9% have agreed to abide by fee schedules established by Medicare, which ranks Montana forth-ninth among the states based on percentage of physicians who have agreed to do so with only Idaho at 14.9% and the high, Alabama, with 73.5%. Massachusetts, by legislative action, made participation in the Medicare assignment program mandatory though only 45.9% voluntarily agree to be "participating physicians." Since that time, one-third of Massachusetts physicians have left the state, have terminated practice, or are planning to do so with many physicians terminating services because compensation no longer covers the cost of providing that service.

EXHIBIT 8
DATE 1-27-89
HB 382

In the Citizen Action release of October 3, 1988, they admit that every senior citizen in the United States, those over age 65 who are participating in Part B of Medicare, pay the same monthly premium of $24.80 after a deductible of $75 and 20% of the Medicare approved fee for each claim. Medicare pays 80% of the approved rate on each claim. In their description they fail to mention that Medicare approved fees vary in these United States and that the Medicare approved fees in Montana are one of the lowest in the nation and frozen since 1984.

They admit that Medicare determines the Medicare approved rate based on the 1984 fee schedule and pays the lowest of three amounts, whichever may be the customary charge, and the actual charge. The prevailing charge is paid based on the 75th percentile of the customary charge in a carrier service area of locality and is usually the value used in determining payment. Therefore, doctors who accept Medicare assignment, accept payment on the basis of the 75th percentile of their 1984 charges, plus an occasional 1-2% incremental increase which has been made since 1984.

If the physician not accepting assignment charges more than this "approved" rate, he is guilty of "excess charges," i.e., any fees in addition to the 20% copayment, which in no case can be greater than his 1984 fee.

In the same news release, physicians are accused of earning high incomes and receiving much of their income from Medicare. The average physician income in the United States is reported as $119,500.

In correspondence with Citizen Action, they could not give the average Montana physician income, which with a simple call to the Department of Revenue is reported at $80,700, unchanged from 1985-87. We are also accused of "fee increases estimated at 8% yearly for the last seven years--about twice the rate of inflation." The cost of overhead, malpractice insurance, etc., has increased. But how can this affect the senior citizens--the individuals making this demand for mandatory assignment when their physician fees have been frozen since 1984.

Further, "the average physician 'earns' about $60,000 per year from Medicare, but on direct questioning they admit that this is not earned income but gross revenue, and that they 'have no figures' for Montana. Likewise, the average 'nonparticipating' physician receives an additional $7,400 in 'excess charges' on average, though likewise these figures are not known for Montana."

In response to a letter from me, Lorraine Driscoll, writing for Citizen Action, states:

> "In response to your question about Montana doctor fees compared to those in the rest of the country, we did not try to gather data on that, not did we try to gather data on differences in the cost of providing services in the different states.
>
> "It is difficult to calculate the average excess charge for Medicare beneficiaries for each state because most recent Medicare beneficiary population data available from HCFA reflects calendar year 1985.
>
> "Further, you ask for the average out-of-pocket health expenses for Montana seniors, but unfortunately that data is not available on a state by state basis.
>
> "In response to your question about Montana doctor incomes compared with those in the rest of the country, we would have liked to include such figures, but they are not available.
>
> "Regarding your question of how much the average Montana physician receives from Medicare, it is impossible to calculate that figure without first finding the number of doctors in Montana who provide Medicare services.
>
> "In response to your question about rural hospitals closing and the crisis this is creating in some rural parts of the country, we are very concerned about that problem. In fact, one of our state groups recently released a study which included a discussion of the declining number of beds in the state (reflecting rural hospital closing) as a serious problem."
>
> And the caveat--"as you know, those interested in improving our health care system are presented with the constant balancing act among cost, access and quality. Obviously, efforts to improve one of those values may lead to problems in another area."

In a letter from Hal Rawson, Vice-President, Blue Cross and Blue Shield of Montana, in charge of their planning and government programs and administrative agent for Medicare in Montana, he writes:

> "that the response from Citizen Action" was evasive due to lack of data to respond to your questions."

Unfortunately, that is the nature of today's limited statistical data base. He goes on to state:

> "My best analysis of the communications problems still lies in an inability to fully understand the meaning of what is considered an 'over-billed' charge. During this last decade, HCFA and (Congress) have been controlling health care costs by imposing freezes and suppressed inflation index factors far below the general CPI and medical index.
>
> "This year, the index adjustment was 1% and 3% for general and primary care services respectfully. Therefore the current charging pattern cannot parallel the suppressed allowances as determined by Medicare. We've always had difficulty in conveying an understanding of Medicare's lower reimbursement compared to billed charges. Since the reimbursement is a suppressed factor by design, it therefore becomes Medicare allowance as determined by government benefit guidelines. It can be and is often construed that the Medicare payment represents a universally acceptable 'reasonable fee' for the going rate. Unfortunately, that is not the case." See attached letter.

Subsequent to this report, a mandatory Medicare assignment bill (H-382) has been introduced by Stella Jean Hansen of the Montana House of Representatives. Her bill is based on information provided "Citizen Action." We believe this information questionable in validity based on the above correspondence from Citizen Action.

Nowhere is there reference to the fact that 39 states allow greater Medicare compensation than does Montana. There is no reference that the average length of hospital stay in 1987 in the United States was 6.6 days, but in Montana 5.2 days. Nor that the pt. days per 1,000 population in the U.S. is 918 vs. 669 pt. days in Montana, or that the cost of illness in Montana is one of the lowest in the nation.

Physicians who practice medicine in Montana are here for the same reason that many of you are here. Each of you and each of us could do much better financially living in a state other than Montana.

But because we live here is no reason to penalize us. The above document again has demonstrated that although all Medicare patients under Part B coverage pay the same premium, compensation to Montana physicians is much less. That, coupled with slow, low Medicaid reimbursement, a high "premium indigent" population without funds but not eligible for Medicaid, coupled with high malpractice premiums and cost of overhead, do create reservations among new physicians looking at Montana as a place to practice.

Most physicians will continue to provide care to all patients. If the cost of a service becomes greater than the compensation for that service, there is only a limit to what the physician can cost shift to the paying public and third party payor. To cost shift for the senior who is able to pay the bill, even though "Citizen Action" calls it an excess charge, is not just to you who are paying the bills.

As you will recall, this Association earlier forwarded to you information about MontShare. This is a voluntary program with a pilot project having been undertaken in Great Falls. The program at this time is operating very well and is indeed helping people in that community. As you will recall, cooperating physicians agree to accept assignment for those seniors who qualify under the MontShare Program; the qualifications based upon an honor system that an individual has less than $9,000 annual income or a couple has less than $11,000 annual income.

Please remember that the Massachusetts fee schedule, even with compulsory mandatory assignment is greater than Montana. Mandatory assignment is not in the best interest of the citizens of Montana.

Thank you.

Sincerely,

J. Michael Sadaj, M.D.
President

John W. McMahon, M.D., Chairman
Committee on Legislation

Van Kirke Nelson, M.D.
Past President

JMS/JWM/VKN:le

Enclosures

Blue Cross
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Reply to Helena Division

November 28, 1988

Van Kirke Nelson, M.D
Kalispell Ob-Gyn Associates, P.C.
210 Sunny View Lane
Kalispell, Montana 59901

The response from "Citizen Action" was evasive due to lack of data to respond to your questions. Unfortunately, that's the nature of today's limited statistical data base.

My best analysis of the communications problem still lies in an inability to fully understand the meaning of what is considered an "overbilled" charge. During this last decade, HCFA (and Congress) have been controlling health care costs by imposing freezes and suppressed inflation index factors far below the general CPI and Medical care index. This year, the index adjustment was 1% and 3% for general and primary care services respectively. Therefore, the current charging patterns cannot parallel the suppressed allowances as determined by Medicare. We've always had difficulty in conveying an understanding of Medicare's lower reimbursement compared to billed charges. Since the reimbursement is a suppressed factor by design, it therefore becomes Medicare's allowance as determined by government benefit guidelines. It can be and is often misconstrued that the Medicare payment represents a universally acceptable "reasonable fee" or the going rate. Unfortunately, that is not the case.

In our private business, we determine our allowances based upon an array of customary charges and select the 90th percentile to represent our "prevailing" ceiling payment. In many cases, the 90th percentile can reflect the vast majority of customary billed charges. One might find above the 90th percentile some charges significantly higher, but still, extenuating circumstances can often justify in the physician's own mind why differences in charges are billed. Therefore, trying to determine "excessively" billed charges is quite difficult under most circumstances.

I'm not sure what one could do at this point to rectify the misunderstanding that has occurred. At least, if we receive any further correspondence from this source, these viewpoints can be expressed.

Sincerely,

Hal Rawson

Harold L. Rawson
Vice President
Planning and Government Programs

HLR:cb

17-16

CITIZENACTION

November 3, 1988

1300 Connecticut Avenue, NW
#401
Washington, DC 20036
(202) 857-5153

Van Kirk Nelson, M.D.
Kalispell Ob-Gyn Associates, P.C.
210 Sunny View Lane
Kalispell, Montana 59901

Dear Doctor Nelson:

Thank you for your letter in response to our study regarding excess doctor charges to Medicare beneficiaries. You posed many questions, and I have answered those for which we have data.

In response to your question regarding the Medicare formula, you state that it often reflects the prevailing charge as the lowest of the three. As you know, if the actual charge and the customary charge are repeatedly higher than the prevailing charge, that will, over time, increase the customary charge, and therefore, the prevailing charge -- to reflect local charge amounts.

Second, our study did not attempt to cover length of stay and cost per illness -- primarily because we intended this study to cover only Part B concerns. As you may know, the Robert Wood Johnson Foundation recently found that inability to pay adversely affects access to doctor care. Therefore, it was our intention to focus the study on Medicare doctor charges.

In response to your question about Montana doctor fees compared with those in the rest of the country, we did not try to gather data on that, nor did we try to gather data on differences in the cost of providing services in different states. As you might guess, any such data which we might have collected would have been difficult to report fairly without a very serious analysis. However, we understand that the Physician Payment Review Commission is looking at many of those issues.

It is difficult to calculate the average excess charge per Medicare beneficiary for each state because the most recent Medicare beneficiary population data available from HCFA reflects calendar year 1985. However, using 1985 data on beneficiary population and the FY1987 excess charge amount would result in this calculation: $10,213,528 / 67,012 to equal $152.41 per beneficiary. HCFA expects to have calendar year 1986 population data available in another week or so.

You asked for the average out-of-pocket health care expenses for Montana seniors, but unfortunately, that data is not available on a state-by-state basis. The House Aging Committee came up with the national figure which we referred to in our study, but neither they nor any other group we are aware of has state data.

In response to your question about Montana doctor incomes compared with those in the rest of the country, we would have liked to include such figures, but they are not available. The AMA makes national physician net and gross figures available each year, and also releases figures on regional income as well as income by specialty. However, the AMA has not made public state-by-state income figures available nor are they available through any other source.

Regarding your question of how much the average Montana physician receives from Medicare, it is impossible to calculate that figure without first finding the number of doctors in Montana who provide Medicare services. That number is not available from HCFA; perhaps you would be able to get it from your Medicare carrier and calculate it yourself.

Regarding your question about the average doctor receiving $60,000 per year from Medicare, we did not state that that reflected net income. We simply said that doctors earned that amount per year from Medicare.

Finally, in response to your question about rural hospitals closing and the crisis this is creating in some rural parts of the country, we are very concerned about that problem. In fact, one of our state groups recently released a study which included discussion of the declining number of beds in the state (reflecting rural hospitals closing) as a serious problem. Our other state groups may release similar data in their states.

As you know, those interested in improving our health care system are presented with a constant balancing act among cost, access and quality. Obviously, efforts to improve one of those values may lead to problems in another area, yet that should not imply that we refrain from making any necessary improvements -- rather that we become increasingly knowledgeable about the impacts of any such changes so that we can weigh the costs and benefits. Furthermore, there is no evidence that limiting physician excess charges would have a negative effect on access to care. In fact, in Massachusetts, there has been no demonstrated reduction in access to care.

Thank you for your letter and the opportunity to respond to your concerns.

Sincerely,

Lorraine Driscoll

Lorraine Driscoll

Please return to
Sam Pike Nelson

THE SENIOR CITIZENS' 2.7 BILLION DOLLAR PHYSICIAN SUBSIDY:

EXCESS PHYSICIAN CHARGES UNDER MEDICARE PART B

A Citizen Action Report

October 3, 1988

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Citizen Action is a 1.75 million member national citizens organization with affiliates and allies in 24 states working to give people a stronger voice in the economic and political decisions that affect their daily lives.

Citizen Action
1300 Connecticut Ave., N.W. #401
Washington, D.C. 20036
(202) 857-5153

INTRODUCTION

For the past several years, Citizen Action's 24 state organizations have been hearing from their senior citizen members that excess doctor charges are a serious financial burden for them - especially when they become ill. In an effort to determine the scope of the problem, Citizen Action conducted the following analysis.

Using data obtained primarily from the Health Care Financing Agency, (and other sources noted in the study) we have transcribed and/or calculated figures regarding the amount and percentage of excess charges, the amount of physician income obtained from Medicare, senior spending on health care costs, and other relevant information.

Using this data, we have examined several trends and compared them with Congressional action regarding the Part B (doctor reimbursement) program. After analyzing this information, we have proposed a solution for effectively dealing with the problem of excess doctor charges to Medicare beneficiaries.

DESCRIPTION OF MEDICARE PART B

The Medicare Part B program pays primarily for doctor services. It also covers lab and other diagnostic tests, ambulatory services, and durable medical equipment, but doctor services represent about 85 percent of all Part B claims. Beneficiaries include people who are 65 years of age or older and those who receive Social Security disability benefits (after a waiting period) -- if they decide to enroll in Part B.

Medicare beneficiaries pay a monthly premium of $24.80 -- which covers 25% of program costs. This premium rises annually with program cost increases. Beneficiaries also pay an annual deductible of $75.00, and 20% of the Medicare approved fee for each claim. (Medicare pays 80% of the approved rate on each claim). Also, beneficiaries pay the full cost of all services not covered by Medicare Part B (including drugs, eyeglasses, and hearing aids).

For each service, Medicare determines the Medicare approved rate, which is calculated using a complicated formula to determine the lowest of three amounts: the customary charge, the prevailing charge, and the actual charge. The customary charge is the charge most frequently made by that doctor for that particular service; the prevailing charge is the 75th percentile of the customary charges in a carrier service area or locality; and the actual charge is the amount on the individual claim.

Doctors who accept the Medicare approved rate (also referred to as the assigned rate) accept the Medicare reimbursement of 80% of the approved cost and the patients' 20% co-payment as payment in full. The patient is charged no additional fees under an assigned claim. Doctors who formally sign up with Medicare to accept the Medicare assigned rate as full payment for all patients all the time are said to "accept assignment" and to be "participating physicians".

Doctors who submit "unassigned claims" can charge their patients excess charges -- fees in addition to the 20% co-payment. Such excess charges represent a significant hardship for many senior citizens -- particularly those of low- and moderate-income and those who are ill and may be facing numerous doctor bills.

FINDINGS: EXCESS CHARGES TO MEDICARE PATIENTS

I. EXCESS CHARGES ARE WIDESPREAD AND COSTLY

In 1987, Medicare Beneficiaries Paid $2.7 Billion in Excess Charges:

These charges by doctors and other Part B providers exceeded the Medicare approved rate for services.

The Average Excess Charge was $38.10:

For Medicare beneficiaries who were charged fees above the Medicare approved rate, the average overcharge in 1987 was $38.10 per claim. This more than doubled the standard out-of-pocket cost for beneficiaries of $25.99 (representing 20% of the Medicare approved rate on an average claim).

Nearly One Out of Every Four Medicare Part B Claims Includes Excess Charges:

Nationally, the number of claims with excess charges was 70,273,432 in FY 1987. This represented 23% of all Part B claims. The percentage of claims with excess charges ranged from 3% in Massachusetts to 51% in Wyoming.

II. FEW DOCTORS AGREE NOT TO CHARGE PATIENTS EXCESS CHARGES

Only 37 Percent of Doctors Have Formally Agreed to Accept the Medicare Rate as Full Payment in All Cases:

In 1985, the federal participating physician program was established to encourage greater acceptance of Medicare rates as full payment from their Medicare patients. As an incentive, physicians who join receive slightly higher reimbursement rates from Medicare. When the program was instituted at the start of FY 1985, 29 percent of doctors signed up to participate. Unfortunately, the participation rate grew to only 37% of physicians by 1988. This means that Medicare beneficiaries who see the remaining 63 percent of non-participating physicians are faced with trying to negotiate with their doctor about whether or not their bill will include an excess charge.

The percentage of participating physicians ranges from a high of 73.5% in Alabama to a low of 14.9% in Idaho.

III. EXCESS CHARGES ADD TO THE HIGH COST OF HEALTH CARE FOR SENIOR CITIZENS

Excess Charges Can Mount Quickly for Seniors Who are Sick:

The average excess charge per beneficiary (among those not eligible for Medicaid) was $95 in FY 1987. Some beneficiaries are able to avoid excess charges altogether by seeing participating physicians. However, other beneficiaries -- particularly those who are very ill and need to see a doctor often or require high cost doctor services such as surgery -- may face thousands of dollars in excess charges.

Seniors Already Pay High Health Care Costs:

According to the House Aging Committee, in 1986, the average senior paid $1,850 per year out-of-pocket for health care. This amounts to more than 15% of income for the average senior. Also, according to House Aging, seniors pay a great percentage of doctor costs out of pocket. In fact, even with Medicare, seniors paid 55.5% of all doctor bills out of pocket in 1984.

The Medicare Catastrophic Bill Does Not Cover Excess Charges:

The recently passed catastrophic bill will protect seniors from the high costs of long hospital stays, prescription drug costs, and spousal impoverishment, while also covering health care costs for seniors in poverty. However, it will not protect at all against excess doctor charges.

IV. PHYSICIANS EARN HIGH INCOMES AND RECEIVE MUCH OF THEIR REVENUE FROM MEDICARE:

Doctor Income is High - Particularly Compared with Senior Incomes

In 1986, the average physician net income was $119,500 (New York Times, 11/22/87) By contrast, the average senior citizen's income was $12,074. Average income for older women was even lower -- just $9,195.

Physician median income is not available, but senior median income in 1986 was $8,154, and among senior women, median income was $6,425. (All senior income figures are from the U.S. Census).

Doctor Fees Are Increasing Steadily

Nationally, doctor fees for all services have increased by eight percent each year for the last seven years -- about twice the rate of inflation. (Data is not available regarding the amount of physician fee increases under Medicare).

Even Without Excess Charges, Doctors Earn About $60,000 Per Year From Medicare:

Most physicians treat Medicare patients. In FY 1987, those doctors received an average income of about $60,000/year in Medicare payments (including Medicare's and the enrollee's share of reasonable charges) - not including excess charges. This, of course, was in addition to their other patient income.

Non-Participating Physicians Receive an Additional $7,400 in Excess Charges From Their Medicare Patients, on Average:

Doctors who are not participating physicians (those who can bill patients excess charges) receive, on average, an additional $7,400 per year in excess charges to seniors.

V. LEGISLATIVE AND REGULATORY ACTION HAS HAD AN IMPACT ON REDUCING EXCESS CHARGES

The Number and Amount of Excess Charges Have Slowed Significantly Only in Response to Congressional Action:

Since FY 1983, the number of claims with excess charges has hovered around seventy million per year. By far, the most significant drop - from 75 million to 65 million -occurred in FY 1985. This was the year that marked the beginning of the participating physician program - which took effect October, 1984.

The amount of excess charges over the past several years has hovered around two and a half billion dollars per year. The only drops in excess charges occurred in FY 1985 (coinciding with the participating physician program and the physician fee freeze) and again in FY 1987 -- when the government instituted specific limits on the amounts of excess charges physicians could bill patients.

The Percentage of Assigned Claims (Claims in Which the Medicare Rate Is Accepted as Full Payment) Increased When Congress Legislated the Participating Physician Program and the Requirement that Lab Claims Cannot Include Excess Charges:

In 1968 (the first year data was collected) the percentage of assigned claims was 59.0% -- today, the rate is just 71.7% (FY 1987). This means that more than one-fourth of all claims are still unassigned -- and 83% of such claims include excess charges.

The most significant increase in the percentage of assigned claims occurred in FY 1985, when Congress established the participating physician program which offers higher reimbursements and other significant benefits to doctors who sign up and also mandated that clinical diagnostic lab tests performed by labs be

submitted as assigned claims. There was another spurt in the percentage of assigned claims when Congress mandated in 1986 that doctors cannot collect excess charges for diagnostic tests which they did not perform or supervise.

By Far, The State With the Highest Percentage of Assigned Claims (Claims Without Excess Charges) Is The Only State with a Law Preventing Doctors From Billing Excess Charges To Any Medicare Patients:

Massachusetts has the highest percentage of assigned claims (97%). This is because Massachusetts is the only state which requires that all "medical doctors" accept the Medicare assigned rate as payment in full for all Medicare patients. The law took effect in April, 1986.

The Only State Which Passed Legislation For a Voluntary Plan to Discourage Excess Charges Did Not Meet its Goals, So The Program Was Changed to a Mandatory System the Following Year:

Connecticut was the only state to pass legislation establishing a voluntary program to urge physicians to accept the Medicare assigned rate as full payment. (The plan protects low- and moderate-income seniors only). The 1987 law established specific goals involving the percentage of doctors who would sign up for the program and the percentage of claims which would be assigned -- and it included a clause that if the guidelines were not met in any quarter, the program would become mandatory. Within the first year, it was clear that the goals were not being met, and the law became mandatory in July, 1988.

POLICY IMPLICATIONS

This study reveals that in FY 1987, Medicare beneficiaries paid a whopping $2.7 billion dollars in excess fees for doctor visits and other Part B services -- fees above and beyond their normal doctor expenses. Virtually all of these excess charges were for doctor visits.

In FY 1987, of claims with excess charges, the average excess charge was $38.10. When this is added to the average co-payment amount of $25.99 per claim, the average out of pocket cost on a claim with an excess charge was $64.09. This amount represents an out of pocket cost which was 146% higher than the co-payment alone.

The typical senior citizen cannot afford to pay these excess charges. In 1986, median senior income was $8,154, and among senior women, median income was $6,425. Currently, seniors pay 55.5% of their doctor costs, and on average, pay $1850 per year out of pocket for all medical bills. If doctors were prohibited from charging seniors amounts in excess of the Medicare approved rate, the burden of doctor bills would be reduced significantly for millions of senior citizens. In addition to reducing the financial squeeze for seniors, this greater affordability of doctor visits might also allow some seniors to seek earlier medical care when needed.

Recommendation: Passage of Legislation to Prohibit Doctors from Charging Excess Fees to Medicare Patients.

Although federal regulatory changes have limited the number and the amount of excess charges somewhat, the most effective solution has been legislation which mandates that doctors charge patients only the Medicare approved rate. Massachusetts is the only state which has such a law protecting all Medicare beneficiaries. It was signed by Governor Michael Dukakis in 1986. Connecticut, Rhode Island, and Vermont also have similar laws which protect low and moderate income seniors and which took effect more recently.

Citizen Action supports enactment of a federal law to require mandatory Medicare assignment for all physicians. Such legislation has been introduced in each of the past three Congresses, but the Administration has opposed those measures.

In the interim, we also support state programs similar to the Massachusetts law. As part of a national campaign to reduce health care costs and improve access to health care services, over the past several years, Citizen Action organizations in more than a dozen states have been organizing for passage of laws to prohibit excess doctor charges under Medicare. Those states include Connecticut, Florida, Illinois, Iowa, Maryland, Massachusetts, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, and Washington.

State	Excess Charges Paid By Medicare Beneficiaries	Number of Claims With Excess Charges	Percentage Claims with Excess Charges (Ranked - Best to Worst)		Average Amount of Excess Charge Per Claim (Ranked - Best to Worst)		Average Amount of Co-Payment Per Claim
Alabama	$26,234,654	840,353	16%	(10)	$31.22	(21)	$23.03
Alaska	$1,947,413	28,092	27%	(27)	$69.32	(51)	$37.13
Arizona	$51,303,970	1,262,901	33%	(37)	$40.62	(41)	$28.79
Arkansas	$16,103,681	629,751	19%	(12)	$25.57	(7)	$23.22
California	$291,677,320	6,323,449	20%	(14)	$46.13	(47)	$31.45
Colorado	$34,481,560	931,215	34%	(39)	$37.03	(35)	$22.22
Connecticut	$33,834,188	850,024	19%	(13)	$39.80	(40)	$20.74
Dist. of Col.	$21,807,316	516,482	16%	(6)	$42.22	(18)	$29.28
Delaware	$3,694,392	120,115	13%	(9)	$30.76	(43)	$21.99
Florida	$208,646,046	5,811,822	25%	(24)	$35.90	(30)	$28.56
Georgia	$51,556,712	1,332,080	23%	(18)	$38.70	(37)	$25.74
Hawaii	$8,110,591	221,850	24%	(21)	$36.56	(33)	$23.76
Idaho	$16,000,299	531,942	58%	(51)	$30.08	(16)	$18.74
Illinois	$138,166,181	3,056,739	29%	(32)	$45.20	(45)	$28.80
Indiana	$61,561,606	1,674,657	30%	(34)	$36.76	(34)	$23.51
Iowa	$35,836,677	1,256,896	34%	(38)	$28.51	(12)	$17.07
Kansas	$11,422,438	504,576	21%	(16)	$22.64	(4)	$19.96
Kentucky	$30,425,412	991,519	24%	(23)	$30.69	(17)	$22.17
Louisiana	$49,277,549	1,019,294	24%	(20)	$48.34	(49)	$29.43
Maine	$4,509,994	240,776	15%	(8)	$18.73	(2)	$18.46
Maryland	$17,048,603	513,162	14%	(7)	$33.22	(25)	$28.17
Massachusetts	$4,099,473	245,129	3%	(1)	$16.72	(1)	$23.98
Michigan	$38,890,009	1,188,830	9%	(4)	$32.71	(24)	$23.24
Minnesota	$52,735,334	1,369,223	42%	(45)	$38.51	(36)	$26.08
Mississippi	$20,725,979	643,673	23%	(17)	$32.20	(23)	$22.06
Missouri	$66,756,857	2,148,268	30%	(35)	$31.07	(20)	$24.41
Montana	$10,213,528	360,187	45%	(47)	$28.36	(11)	$21.51
Nebraska	$20,871,443	614,115	34%	(40)	$33.99	(28)	$18.16
Nevada	$5,202,674	110,641	13%	(5)	$47.02	(48)	$37.11
New Hampshire	$12,362,287	432,232	36%	(41)	$28.60	(14)	$18.22
New Jersey	$116,048,460	2,825,958	28%	(29)	$41.07	(42)	$27.69
New Mexico	$13,097,556	364,072	31%	(36)	$35.98	(31)	$24.22
New York	$292,745,625	5,475,262	20%	(15)	$53.47	(50)	$28.36
North Carolina	$61,102,809	1,949,482	24%	(22)	$31.34	(22)	$20.29
North Dakota	$13,553,310	401,962	45%	(48)	$33.72	(27)	$22.44
Ohio	$139,372,562	3,585,901	29%	(33)	$38.87	(38)	$24.87
Oklahoma	$55,284,798	1,293,949	39%	(44)	$42.73	(44)	$25.01
Oregon	$35,694,622	1,328,590	44%	(46)	$26.87	(9)	$21.05
Pennsylvania	$52,746,967	1,580,206	8%	(3)	$33.38	(26)	$26.56
Rhode Island	$2,791,990	111,889	6%	(2)	$24.95	(5)	$20.75
South Carolina	$20,767,456	820,913	26%	(25)	$25.30	(6)	$35.59
South Dakota	$12,232,264	395,254	48%	(49)	$30.95	(19)	$20.06
Tennessee	$56,126,283	1,552,293	29%	(30)	$36.16	(32)	$24.62
Texas	$195,565,071	4,284,343	27%	(26)	$45.65	(46)	$27.95
Utah	$9,153,581	320,948	29%	(31)	$28.52	(13)	$22.35
Vermont	$3,827,203	191,763	27%	(28)	$19.96	(3)	$15.73
Virginia	$33,826,770	1,144,247	23%	(19)	$29.56	(15)	$22.66
Washington	$62,157,374	2,227,715	39%	(43)	$27.90	(10)	$20.66
West Virginia	$15,093,036	385,952	19%	(11)	$39.11	(39)	$23.82
Wisconsin	$54,573,478	2,089,495	36%	(42)	$26.12	(8)	$20.10
Wyoming	$5,664,873	159,102	51%	(50)	$35.61	(29)	$19.73
NATIONAL	$2,677,798,222	70,273,432	23%		$38.11		$25.99

Source: Department of Health and Human Services, Health Care Financing Administration

Percentage of Participating Physicians by State

State	Calendar Year 1988	1988 Ranking
Alabama	73.5%	1
Alaska	37.5%	25
Arizona	38.7%	20
Arkansas	50.9%	7
California	48.5%	9
Colorado	24.9%	46
Connecticut	22.8%	47
Delaware	37.4%	26
Dist. of Col.	33.5%	31
Florida	30.6%	35
Georgia	32.5%	33
Hawaii	53.7%	5
Idaho	14.9%	51
Illinois	36.4%	29
Indiana	36.8%	27
Iowa	43.7%	14
Kansas	60.0%	2
Kentucky	46.4%	11
Louisiana	29.5%	38
Maine	42.4%	15
Maryland	38.5%	22
Massachusetts	45.9%	13
Michigan	38.3%	23
Minnesota	25.4%	45
Mississipi	30.1%	36
Missouri	29.5%	37
Montana	19.9%	49
Nebraska	48.2%	10
Nevada	46.0%	12
New Hamsphire	28.4%	39
New Jersey	28.2%	41
New Mexico	25.9%	44
New York	28.4%	40
North Carolina	40.7%	17
North Dakota	30.8%	34
Ohio	41.8%	16
Oklahoma	27.9%	42
Oregon	32.8%	32
Pennsylvania	36.6%	28
Rhode Island	55.0%	3
South Carolina	37.6%	24
South Dakota	17.6%	50
Tennessee	54.9%	4
Texas	26.0%	43
Utah	50.4%	8
Vermont	38.5%	21
Virginia	39.1%	18
Washington	35.4%	30
West Virginia	53.2%	6
Wisconsin	39.0%	19
Wyoming	20.1%	48
NATIONAL	37.0%	

SOURCE: Dept. of Health and Human Services, HCFA

MEDICARE PART B OUT OF POCKET COSTS
FY 1983 - FY 1988

	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988
Average Co-Payment/Claim	$24.87	$25.75	$25.01	$25.42	$25.99	N/A
Average Overcharge	$33.95	$35.74	$39.16	$39.05	$38.11	N/A
Monthly Premium	$12.20	$14.60	$15.50	$15.50	$17.90	$24.80
Deductible/Yr	$75.00	$75.00	$75.00	$75.00	$75.00	$75.00

8

EXECUTIVE COMMITTEE

—FOR YOUR INFORMATION—
From the Executive Office
Montana Medical Association

Medicare Assignment Legislation Proposed

There is growing support behind proposed legislation to limit the amount health care providers can charge to Medicare beneficiaries. The Montana Senior Citizens Association (MSCA) will introduce legislation into the 1989 Montana Legislative Session that will prohibit health care providers from charging Medicare beneficiaries under Part B more than Medicare's approved rates.

This process is often referred to as "Medicare Assignment". If a health care provider accepts Medicare's approved rates of which Medicare thenpays 80% of the bill, and the patient is responsible for the remaining 20%.

However, many health care providers charge above Medicare's approved rates which means greater out-of-pocket costs to patients. Only 19.9% of physicians in Montana have agreed to accept Medicare Assignment for all Medicare beneficiaries. Montana's rate is one of the lowest in the nation. The national average of physicians accepting assignment for all beneficiaries is 37%.

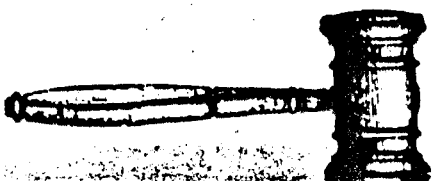
The proposed legislation will protect elderly and disabled Medicare patients from being overcharged by prohibiting health care providers from charging patients more than Medicare's approved rates. It will also require health care providers to post a summary of the law in public view. Failure to comply with this act would be deemed a violation of the Consumer Protection Act and carry a fine of not more than $500 for the first violation.

Physicians' fees for Medicare patients increased at an average of 20.6% each year from 1979 through 1983 and have been increasing at least two times the rate of inflation since then.

The Medicare program was originally designed to cover 75% of health care costs for beneficiaries but now cover less than 45%. Medicare beneficiaries are paying more out-of-pocket for health care now than they were before Medicare was created.

MSCA realizes that many physicians accept Medicare Assignment on a case-by-case basis, based on their judgment of the patient's need. However, MSCA does not believe that Medicare beneficiaries should be reduced to bargaining for health care when a reasonable fee has already been established by Medicare. Seniors and the disabled are too proud to beg for health care. Many will simply forego medical treatment until much too late, or go without other basic necessities in order to pay a medical bill.

MSCA believes its time to take action to stop the increasing costs of health care.



EXECUTIVE COMMITTEE

R YOUR INFORMATION—
rom the Executive Office
ontana Medical Association

The Big Sky Country

MONTANA HOUSE OF REPRESENTATIVES

REPRESENTATIVE STELLA JEAN HANSEN

HOUSE DISTRICT 57

HELENA ADDRESS:
P.O. BOX 50
CAPITOL STATION
HELENA, MONTANA 59620-0144
HOME PHONE: (406) 442-8191
BUSINESS PHONE: (406) 444-4800

HOME ADDRESS:
841 WOODFORD STREET
MISSOULA, MONTANA 59801
PHONE: (406) 549-3492

COMMITTEES:
BUSINESS & LABOR
HUMAN SERVICES
LOCAL GOVERNMENT

16 December 1988

RECEIVED
DEC 20 1988
MONTANA MEDICAL ASSOCIATION

Dear Fellow Legislator:

This letter is to let you know about a bill which I will be introducing in the 1989 session. This bill is very important to and has the support of the great majority of Montana's 120,000 senior citizens. Enclosed is an Information Sheet about the bill.

The purpose of this bill, the Medicare Assignment bill, is to require all providers of health care for Montana Medicare recipients to charge no more than Medicare approved rates. THE 1988 LEGACY LEGISLATURE VOTED THIS MEDICARE ASSIGNMENT BILL AS ONE OF ITS FIVE PRIORITY BILLS FOR PASSAGE BY THE 1989 LEGISLATURE. It also has the support of the Governor's Advisory Council on Aging.

I hope I can count on your support for this legislation. I realize that this bill will be opposed by the Montana Medical Association but believe that the rights of 120,000 Montana seniors outweigh the rights of health care providers to overcharge these seniors for necessary medical care.

Please let me know if you have any questions or if you would like to help.

May you and yours have a happy holiday season.

Cordially yours,

Stella Jean Hansen

MEDICARE ASSIGNMENT INFORMATION SHEET

for the 1989 Montana Legislature

BACKGROUND: The Medicare Assignment bill would make it a misdemeanor for a health care provider to charge Medicare patients more than the approved Medicare rates. Medicare (the federal health care insurance program for Social Security recipients) sets its approved rates after a review of what health care providers are actually billing for specific services and procedures. The federal government encourages health care providers to "accept assignment" - that is, to charge no more than Medicare approved rates.

Those providers who do not accept assignment can charge over and above those rates and bill the senior citizen directly. In Montana, physician overcharges averaged $28 per bill, a total of $10.2 million in 1987 (according to Citizens Action.)

This legislation provides for penalties under the Consumer Protection Act in Montana. These are not heavy penalties but would put the state on record as encouraging all physicians and other providers to accept Medicare Assignment.

Question: Why are Montana seniors so concerned about this issue?

Only three states have a worse record than Montana for the percentage of doctors who accept Medicare assignment. Nationally, 37% of physicians participate as compared to less than 20% in Montana. The percentage of Medicare claims with excessive charges nationally was 23% while in Montana it was 45%.
(1987 statistics)

Question: Do other states require health care providers to accept Medicare Assignment?

Yes. In Massachusetts, it is required that physicians accept it as a condition of being licensed. This law has been upheld as legal through the courts. Vermont, Rhode Island and Connecticut all have a mandatory assignment program. Governor Cuomo is proposing a mandatory assignment program for New York.

Question: Don't most physicians accept assignment if their patient is unable to pay more?

Probably. But this puts the doctor in the position of being a welfare worker and passing judgement on his or her patient's ability to pay. It also puts the senior citizen in the position of being a second class citizen who must ask for special treatment. Most seniors will not ask for help nor admit to being on a low income. Those seniors who are affluent can make it o.k. but the "means test" hurts most those it hopes to help.

The Montana Medical Society has proposed a program of means testing. But Medicare is a national health insurance program and not meant to be reduced to a welfare program. This view was upheld in 1982 when the U.S. Senate voted 70 to 29 to kill an amendment to apply a means test to Medicare Assignment.

Question: If doctors can't charge well-to-do seniors more, then they'll have to shift those costs to the younger people; is that fair?

A fair price for a service or procedure should not be based upon the income of

the patient. Doctors probably have adequate incomes without any shift of costs. In 1984, AFTER ALL EXPENSES AND TAXES, 46% of Montana doctors had net income between $50,000 and $100,000 and 20% had net incomes in excess of $100,000.

Question: Wouldn't a law like this amount to price fixing?

No. It will only apply to those health care providers who treat Medicare patients. A physician can choose not to treat Medicare patients but we don't think many would make that choice.

Question: If all physicians in Miles City are now accepting assignment, why cannot the rest of our Montana physicians?

Good question.

Question: Why all the emphasis on physicians when the bill applies to all health care providers?

Although the bill will pertain to chiropractors, optometrists, physical therapists, and all other health care providers, most people are the most concerned about being able to pay their personal doctor's bills. The majority of Medicare Part B claims are for physician services, and it is the M.D.'s who have been the most reluctant to accept assignment.

Question: Don't Supplemental Health Insurance policies cover all the extra costs?

No. Most policies cover only the deductibles and the 20% patient co-payment.

SUMMARY: Social Security recipients now pay lots for health care and medical costs in the past ten years have increased at more than twice the overall inflation rate. Supplemental health insurance premiums have been increased as much as 60% this year. AARP's most popular supplemental policy is being increased from $25.95 to $40.50 per month per person. And Part B Medicare premiums are going up again January 1 to $31.90 per month. There continue to be deductibles and, of course, the patient always pays the 20% of the Medicare approved rates directly or with supplemental insurance.

In 1987 the out-of-pocket health costs for the elderly averaged $2,394 per person or an average of 18% of their income. In 1980 the out-of-pocket health costs to Medicare recipients was nearly 13% of their income while in 1988 it is estimated to be over 18% (source: House Select Committee on Aging, 10/21/88). So the seniors ARE paying a big share of their own bills.

The Medicare Assignment bill will go a long way toward maintaining the dignity and independence of our senior citizens. It is one bill the 1989 Legislature can pass which will not cost any tax dollars and yet will be a big benefit to the seniors of this state.

Information Sheet prepared by the Montana Senior Citizens Association, PO Box 423, Helena, MT 59624. Phone: 443-5341.

12/15/88

CITIZENACTION

November 3, 1988

300 Connecticut Avenue, NW
#401
Washington, DC 20036
(202) 857-5153

Van Kirk Nelson, M.D.
Kalispell Ob-Gyn Associates, P.C.
210 Sunny View Lane
Kalispell, Montana 59901

Dear Doctor Nelson:

Thank you for your letter in response to our study regarding excess doctor charges to Medicare beneficiaries. You posed many questions, and I have answered those for which we have data.

In response to your question regarding the Medicare formula, you state that it often reflects the prevailing charge as the lowest of the three. As you know, if the actual charge and the customary charge are repeatedly higher than the prevailing charge, that will, over time, increase the customary charge, and therefore, the prevailing charge -- to reflect local charge amounts.

Second, our study did not attempt to cover length of stay and cost per illness -- primarily because we intended this study to cover only Part B concerns. As you may know, the Robert Wood Johnson Foundation recently found that inability to pay adversely affects access to doctor care. Therefore, it was our intention to focus the study on Medicare doctor charges.

In response to your question about Montana doctor fees compared with those in the rest of the country, we did not try to gather data on that, nor did we try to gather data on differences in the cost of providing services in different states. As you might guess, any such data which we might have collected would have been difficult to report fairly without a very serious analysis. However, we understand that the Physician Payment Review Commission is looking at many of those issues.

It is difficult to calculate the average excess charge per Medicare beneficiary for each state because the most recent Medicare beneficiary population data available from HCFA reflects calendar year 1985. However, using 1985 data on beneficiary population and the FY1987 excess charge amount would result in this calculation: $10,213,528 / 67,012 to equal $152.41 per beneficiary. HCFA expects to have calendar year 1986 population data available in another week or so.

You asked for the average out-of-pocket health care expenses for Montana seniors, but unfortunately, that data is not available on a state-by-state basis. The House Aging Committee came up with the national figure which we referred to in our study, but neither they nor any other group we are aware of has state data.

In response to your question about Montana doctor incomes compared with those in the rest of the country, we would have liked to include such figures, but they are not available. The AMA makes national physician net and gross figures available each year, and also releases figures on regional income as well as income by specialty. However, the AMA has not made public state-by-state income figures available nor are they available through any other source.

Regarding your question of how much the average Montana physician receives from Medicare, it is impossible to calculate that figure without first finding the number of doctors in Montana who provide Medicare services. That number is not available from HCFA; perhaps you would be able to get it from your Medicare carrier and calculate it yourself.

Regarding your question about the average doctor receiving $60,000 per year from Medicare, we did not state that that reflected net income. We simply said that doctors earned that amount per year from Medicare.

Finally, in response to your question about rural hospitals closing and the crisis this is creating in some rural parts of the country, we are very concerned about that problem. In fact, one of our state groups recently released a study which included discussion of the declining number of beds in the state (reflecting rural hospitals closing) as a serious problem. Our other state groups may release similar data in their states.

As you know, those interested in improving our health care system are presented with a constant balancing act among cost, access and quality. Obviously, efforts to improve one of those values may lead to problems in another area, yet that should not imply that we refrain from making any necessary improvements -- rather that we become increasingly knowledgeable about the impacts of any such changes so that we can weigh the costs and benefits. Furthermore, there is no evidence that limiting physician excess charges would have a negative effect on access to care. In fact, in Massachusetts, there has been no demonstrated reduction in access to care.

Thank you for your letter and the opportunity to respond to your concerns.

Sincerely,

Lorraine Driscoll

Lorraine Driscoll

MEDICARE

Medicare Part B Carrier
Call Toll Free 1-800-332-6146

P.O. Box 4310
Helena, Montana 59604

October 25, 1988

Van Kirke Nelson, M. D.
Kalispell Ob-Gyn Associates, P. C.
210 Sunny View Lane
Kalispell, MT 59901

This letter is in reply to your Freedom of Information request letter dated October 5, 1988.

Our staff has extracted from our payment files the basic payment information related to submitted and allowed charges for fiscal year 1987. We've made an assumption that the AP release, which this request apparently relates to, was compiled based upon fiscal year (October-September) as opposed to calendar year statistics.

Since the request is asking for non-participation (non-assigned) data, to preserve confidentiality of patient records, we've removed all references to beneficiary name and HIC numbers. However, at the end of the remaining printout, a summary depicts the differences in assigned and non-assigned reimbursement.

The detail of the records does not provide an easy mechanism to deduce that you had or didn't have incidences of "overcharging" your patients. The mere fact that you have elected to be non-participating restricts you to the range of "Maximum Allowable Actual Charges". Specifically, MAAC statuatory provisions prohibit a non-participating physician's office from charging more than what MAAC limits allow. Therefore, you'll note from past reimbursement situations there is sometimes a zone of disallowance between the billed charge up to a MAAC and Medicare's reimbursement.

Therefore, in your analysis, you may have to question if this zone of disallowance is viewed by your office as an overbilled charge or simply a limitation of Medicare's benefits. One may have to go to the Congressional Record to determine if Congress intended for anything less than (or exceeding) a MAAC to be considered an overcharge.

I hope this information has been satisfactory for your needs.

Sincerely,

Hal Rawson

Harold L. Rawson
Vice President
Planning and Government Programs

HLR:ml

cc: Brian Zins, MMA, without enclosures

Enclosure

15-010

REVIEW OF SELECTED PROVIDER INFORMATION ON MY DATA FROM MEDICARE 10/1/86 through 9/30/87.

"Submitted charges" are the customary charges based on 1984 fee schedule with two 1% increases granted subsequent to that date.

"Allowed charges" are also called the "prevailing charge". It represents the 75th percentile of the charges submitted within a speciality (OB-Gyn #16) calculated in a complicated way as follows: The prevailing charge is always based on the charges for the previous year, waited for frequency, arrayed from lowest to the highest--the final product adjusted to the Medicare Economic Index. In this office's case, that fee allowed in 1984 with two 1% increases since 1984. An example for determining the prevailing charge would be taking 5000 services (same code), 1402 doctors charging $5.00, 1515 doctors charge $6.00, 1680 charging $7.00 and 803 charging $8.00. Take 75% of 5000 equals 3750 and adding 1402 plus 1515 plus 1680 would give you 4197 cases with 3750 patients falling into that group, and hence the prevailing fee--$7.00. Medicare will then pay 80% of that $7.00. Again the prevailing charge is taken from the frozen since 1984.

The "actual charge" is the charge that is submitted currently on claims for this immediate year which will be again with the 1% increase if Medicare okayed it which they did.

Blue Cross
and
Blue Shield
of Montana

Helena Division
404 Fuller Avenue • P.O. Box 4309
Helena, Montana 59604
(406) 444-8200

Great Falls Division
3360 10th Ave. South • P.O. Box 5004
Great Falls, Montana 59403
(406) 791-4000

Reply to Helena Division

November 28, 1988

Van Kirke Nelson, M.D
Kalispell Ob-Gyn Associates, P.C.
210 Sunny View Lane
Kalispell, Montana 59901

The response from "Citizen Action" was evasive due to lack of data to respond to your questions. Unfortunately, that's the nature of today's limited statistical data base.

My best analysis of the communications problem still lies in an inability to fully understand the meaning of what is considered an "overbilled" charge. During this last decade, HCFA (and Congress) have been controlling health care costs by imposing freezes and suppressed inflation index factors far below the general CPI and Medical care index. This year, the index adjustment was 1% and 3% for general and primary care services respectively. Therefore, the current charging patterns cannot parallel the suppressed allowances as determined by Medicare. We've always had difficulty in conveying an understanding of Medicare's lower reimbursement compared to billed charges. Since the reimbursement is a suppressed factor by design, it therefore becomes Medicare's allowance as determined by government benefit guidelines. It can be and is often misconstrued that the Medicare payment represents a universally acceptable "reasonable fee" or the going rate. Unfortunately, that is not the case.

In our private business, we determine our allowances based upon an array of customary charges and select the 90th percentile to represent our "prevailing" ceiling payment. In many cases, the 90th percentile can reflect the vast majority of customary billed charges. One might find above the 90th percentile some charges significantly higher, but still, extenuating circumstances can often justify in the physician's own mind why differences in charges are billed. Therefore, trying to determine "excessively" billed charges is quite difficult under most circumstances.

I'm not sure what one could do at this point to rectify the misunderstanding that has occurred. At least, if we receive any further correspondence from this source, these viewpoints can be expressed.

Sincerely,

Hal Rawson

Harold L. Rawson
Vice President
Planning and Government Programs

HLR:cb

17-16

MONTANA HOSPITALS

AT A GLANCE

HOSPITAL PROFILES

Montana has sixty-five hospitals to serve its residents. The vast majority (55) of them are locally operated, not-for profit general hospitals distributed in every corner of the state. Three of the hospitals specialize in either children, adolescent or adult psychological disorders and chemical dependency. Six are federally owned and operated exclusively for either veterans, Indians, or military personnel and their dependents. One is owned and operated by the State of Montana.

Most of Montana's hospitals serve rural populations and, due to demographics and geography, they are necessarily small. More than 78 percent of Montana's hospitals are smaller than 90 beds and almost 54 percent are smaller than 30 beds in size. More than 90 percent meet the federal designation of being rural hospitals.

Hospital Types

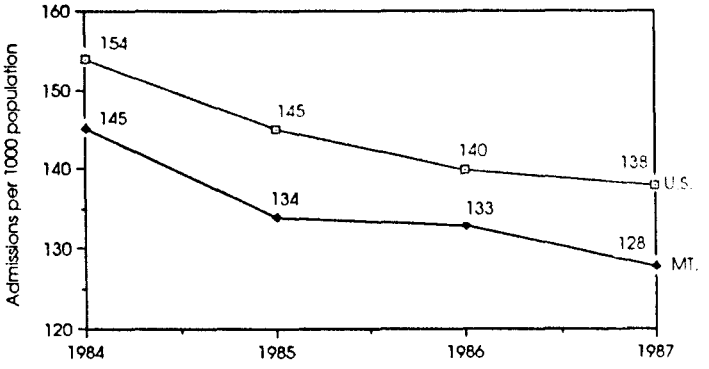
Total number of Montana Hospitals	65
Bed Size	
190 and more beds	6
90-189 beds	8
30-89 beds	16
Fewer than 30 beds	35
By Primary Service	
General Acute Care	55
Urban (by Federal Designation)	4
Rural	51
Pyschiatric	3
Federal	6
Hospital/Nursing Home Combined Facilities	33
By Ownership	
Private, Not-For-Profit	41
County or District	14
For-Profit	3
Federal	6
State	1

HOSPITAL UTILIZATION

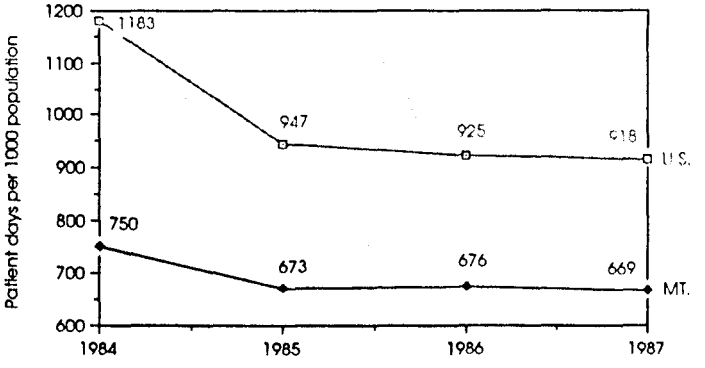
The information in this section of the report is based upon the results of a survey of 1987 utilization and financial data for 56 general, acute care hospitals. The survey was co-sponsored by the Montana Hospital Association, the Montana Department of Health and Environmental Sciences and the American Hospital Association.

Admissions and patient days per 1,000 people is a common measure of the efficiency of a health care system. In the aggregate, hospital costs are most effectively controlled by reducing inpatient utilization. Montana's utilization per 1,000 people closely follows the national trend, however, Montana began the four-year period 6 per cent below the national admissions rate, and 37 per cent below the patient days rate.

Admissions per 1000 Population



Patient Days Per 1000 Population



MONTANA HOSPITAL ASSOCIATION

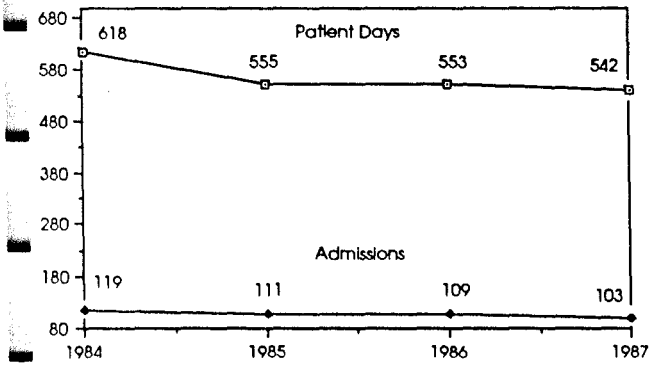
Why is Montana's rate of admissions relatively close to the national rate, but its rate of patient days relatively distant from the national rate? It is because of Montana's ow average length of stay. Length of stay is how long a erson stays in the hospital per admission. It is a function f the degree of illness and the efficiency of treatment. Because Montana hospitals treat virtually all medical conditions, it is likely the efficiency and effectiveness of treatment which produces low lengths of stay. The shorter the period of time a person is in the hospital, the less the cost.

AVERAGE LENGTH OF STAY

Year	Montana	United States
1984	5.2	6.4
1985	5.0	6.3
1986	5.1	6.3
1987	5.2	6.6

The number of admissions and patient days and, subsequently, hospital occupancy rates, have declined in each of the four years in Montana hospitals. This has been a consequence of the new Medicare payment system, changes in medical practice, the emphasis on outpatient care as a less costly alternative to hospitalization, and innovations in medical insurance coverage such as second surgical opinions and preadmission certification.

Admissions and Patient Days
Montana 1984-1987



HOSPITAL OCCUPANCY RATES BY BED SIZE
1984-1987

	1984	1985	1986	1987
All Hospitals	50.8%	45.8%	45.74%	46.2%
190 and more Beds	64.6%	58.9%	55.4%	55.9%
- 189 Beds	55.0%	51.7%	51.5%	51.9%
- 89 Beds	33.8%	28.7%	30.8%	35.7%
Fewer than 30 Beds	30.1%	24.0%	30.2%	26.2%

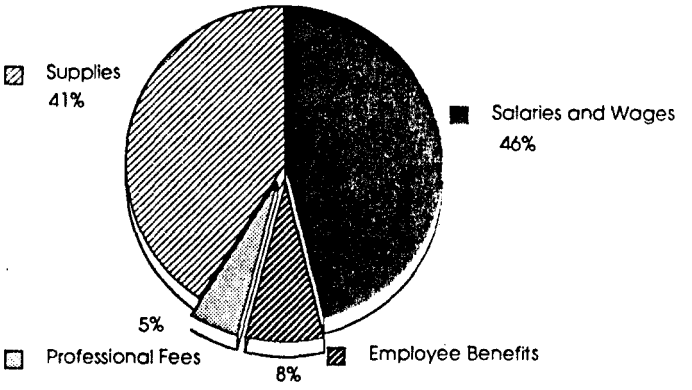
HOSPITAL FINANCE

ECONOMIC PROFILE

Not only are Montana hospitals the focal point for health care delivery in their communities, but they play a major role in local economics. Montana general hospitals employ almost 9,000 full-time equivalents across the state, making the hospital industry one of the state's largest and most stable employers. Almost 1,200 physicians also serve on the medical staffs of hospitals. Hospitals indirectly provide additional jobs for construction workers, delivery people, government workers and other personnel.

In 1987 total hospital expenditures in Montana were $384 million. How hospitals spent their money illustrates the important contribution made by the hospital industry.

Hospital Spending



More than half of the $384 million total hospital expenditure was paid directly to employees and their families in the form of salaries and wages, and employee benefits. Studies estimate that an individual's personal income is spent between two to five times before it leaves the community. For example, money that is spent on the family's groceries is used by the store to pay for it's salaries and utilities. Using the most conservative estimate of two, hospitals contributed $360 million, through their employees, to the economies of local Montana communities.

Hospitals are also a market for locally and regionally produced goods and services. Hospitals require a full range of supplies; from food to pharmaceuticals; from office equipment to medical supplies; and services, including accountants, attorneys and architects, in addition to physicians.

HOSPITAL COSTS

The double digit rate of cost increase which plagued the health care industry for much of the seventies and early eighties came to an abrupt halt in 1984. In 1984, the rate of increase in total hospital costs was approximately one-third the rate of the previous year. Since 1984, Montana hospitals have averaged a rate of cost increase of about six percent. In 1987, the hospital inflation rate dipped by almost a full percentage point from the previous year.

STATE COMPARISONS

The source of the twelve tables contained on this page is the **State Policy Data Book '88,** a publication of State Policy Research, Inc. The **Data Book** lists the ranking of all of the states, and the national average. For this report, the highest ranking tate, the lowest ranking state, the national average, and the rankings of the four states contiguous to Montana (North Dakota, South Dakota, Idaho and Wyoming) are listed in addition to Montana.

Neonatal Mortality Rates
Deaths per 1,000 Live Births (1985)

Rank	State	Number
1	Delaware	10.6
	Nat'l Average	7.0
27	Wyoming	6.4
28	Idaho	6.3
43	North Dakota	5.4
44	South Dakota	5.4
49	Montana	5.0
50	Nevada	4.8

Yearly Malpractice Premiums for Physicians in Obstetrics/ Gyneology (1987)

Rank	State	Amount ($)
1	Florida	76,400
13	Idaho	40,300
16	Montana	39,800
24	Wyoming	31,700
	Unweighted Average	31,514
38	North Dakota	18,600
39	South Dakota	18,600
50	Vermont	NA

Percent of Nonelderly Population Without Health Insurance (1985)

Rank	State	Percent
1	Oklahoma	25.3
11	Idaho	21.2
17	Montana	18.4
20	South Dakota	17.7
	Nat'l Average	17.4
48	North Dakota	NA
50	Wyoming	NA

Infant Mortality
Infant Deaths per 1,000 Live Births (1985)

Rank	State	Number
1	Delaware	14.8
6	Wyoming	12.2
	Nat'l Average	10.6
26	Idaho	10.4
27	Montana	10.3
32	South Dakota	9.9
48	North Dakota	8.5
50	Rhode Island	8.2

Medicaid Recipients Per 1,000 Population (1985)

Rank	State	Number
1	California	12.8
	Nat'l Average	8.5
35	Montana	5.7
37	North Dakota	5.4
41	South Dakota	4.8
46	Wyoming	3.9
47	Idaho	3.9
50	Arizona	0.0

Accidental Death Rates per 100,000 Population (1984)

Rank	State	Rate
1	Alaska	85.7
3	Wyoming	59.1
4	Montana	56.8
13	South Dakota	48.4
14	Idaho	47.7
20	North Dakota	46.1
	Nat'l Average	39.3
50	Rhode Island	27.2

Percent of Infants Whose Mothers Received Late or No Prenatal Care (1985)

Rank	State	Percent
1	New Mexico	13.4
	Nat'l Average	5.7
13	South Dakota	5.6
17	Idaho	5.4
29	Wyoming	4.3
33	Montana	4.1
47	North Dakota	2.5
50	Iowa	2.1

Medicaid Payments Per Capita (1985)

Rank	State	Number ($)
1	New York	427
8	North Dakota	171
	Nat'l Average	157
23	South Dakota	133
30	Montana	116
46	Idaho	76
49	Wyoming	55
50	Arizona	0

Physicians per 100,000 Population (1985)

Rank	State	Number
1	Maryland	334
	Nat'l Average	220
37	North Dakota	168
41	Montana	155
46	South Dakota	143
47	Wyoming	140
49	Idaho	133
50	Mississippi	126

Percent of Eligibles for the Women, Infant & Children (WIC) Program Who Were Served (1987)

Rank	State	Percent
1	Vermont	81.3
4	Wyoming	63.7
10	North Dakota	52.1
	Nat'l Average	44.6
27	Montana	43.0
37	South Dakota	39.9
49	Idaho	31.7
50	Hawaii	27.2

Average Medicaid Spending per AFDC Child Adjusted for Price Differences (1984)

Rank	State	Amount ($)
1	North Dakota	766
5	South Dakota	643
15	Wyoming	503
	Nat'l Average	441
28	Idaho	401
35	Montana	343
50	Arizona	0

Community Hospital Beds per 1,000 Population (1984)

Rank	State	Number
1	North Dakota	7.7
2	South Dakota	6.5
4	Montana	5.6
	Nat'l Average	4.3
34	Wyoming	3.9
38	Idaho	3.6
50	Alaska	2.3

DAILY INTERLAKE 10/25/87

Bias toward urban hospitals threatens rural care — report

MISSOULA (AP) — A bias in Medicare toward urban hospitals threatens to close hundreds of rural hospitals, including some in Montana, according to a new report by the U.S. Senate Special Committee on Aging.

The report says federal Medicare reimbursement policies have placed an unfair burden of proof on rural hospitals to show that their costs equal those of urban hospitals, rather than requiring urban hospitals to justify higher payments.

The difference in reimbursement caused the average small rural hospital with fewer than 50 beds to lose money on its Medicare patients, the report said.

While the elderly make up 12 percent of the U.S. population, they account for more than 25 percent of the population in rural areas, making rural hospitals even more dependent on Medicare payments.

"We, of course, would do better if the pay-back rate were the same," Mike Billing, administrator of Clark Fork Valley Hospital in Plains told the Missoulian. "Urban hospitals get much more for broken hips than we do, even though we have the same technology and fix the hips just as well, the same way."

Congressional reaction to the report could come too late for Sweet Grass Community Hospital in Big Timber, where administrator Karen Herman said if the 15-bed hospital doesn't raise $25,000 by the end of November, it will be forced to close.

"We play it day by day," she said, "I never know until the end of the month when I get the Medicare payment whether I will be able to meet payroll."

Getting the same reimbursement as urban hospitals would be a big help, Herman said Monday. "It's our biggest problem," she said. "Seventy percent of my patients are on Medicare."

The report recommends that Medicare:

—Eliminate the 14.5 percent difference in what it pays urban and rural hospitals for the same procedure.

—Conduct annual wage surveys for rural areas.

—Simplify the process hospitals use to qualify for financial aid when they have large declines in the number of patients.

The report also recommends that Medicare eliminate the geographic differences in payments for physicians' services and that more training programs be set up and funded to encourage health professionals to work in rural areas. Shortages of doctors and nurses also are a problem in rural areas.

"This would be a major step in correcting these problems," said Jim Ahrens, president of the Montana Hospital Association.

The health of rural hospitals is particularly acute in Montana, where all but eight of the state's 82 hospitals have fewer than 100 beds, most have fewer than 50 beds, and half of all hospitals in the state operated in the red in 1987.

"The findings of this report shock even those most familiar with the rural health care problem," Sen. John Melcher, D-Mont., chairman of the committee on aging, said in a press release issued here.

The recommendations are only advisory because the aging committee has no legislative authority, but Melcher urged that the rural health-care crisis rank high on the agenda of the next Congress.

A spokeswoman for the American Hospital Association in Chicago said Monday that the committee's recommendations are almost identical to those the AHA board adopted in February.

In 1987, 40 rural hospitals and 39 urban ones shut down. Between 1980 and 1987, 364 community hospitals closed, of which 163 were rural.

"What we've been seeing is between 1980 and 1985, the majority of hospitals that closed were small urban hospitals," said Sylvia Boeder of the AHA. "In 1985, we started to see a shift and more rural hospitals began to close."

Continued from front page

Health Care for Montanans

Improving health care for Montanans has been a top priority for me again this year. Montanans, like other Americans who live in more sparsely populated regions of the country, are often neglected by federal health officials who focus too much on urban health problems. As a member of the Health Subcommittee, I've written legislation to help our health officials and community hospitals provide better care to you.

The Baucus Rural Health Care bill adjusts Medicare reimbursement formulas to compensate for the ference between small community hospitals and g urban medical centers. In general, hospitals purchase much of the same expensive equipment and need to have well trained staff. Small community hospitals in Montana have fewer patients over which to spread their costs. That means higher costs for all of us, and tighter budgets for our hospitals struggling to provide good health care to Montana families.

My legislation requires the federal government to pay its fair share of hospital costs and not favor big city hospitals over our own. This will help keep Montana's community hospitals healthy for all of us.

Attracting good people to Montana to provide health care is also part of the bill. Nearly 60% of our counties are classified as "health manpower shortage areas." My legislation will raise incentive payments used to attract doctors to small communities.

Rural Economic Development

Montanans are leaving their home at an alarming rate – over 16,000 since 1985. Families are being driven away because our economy is not creating jobs at home. This trend must stop.

As Chairman of the Rural Economy Subcommit-

U.S.-Canada Trade Agreement

A bill making the U.S.-Canada Trade Agreement take effect January 1, 1989, is expected to receive overwhelming approval in Congress and be signed into law by the President. The trade agreement creates a free trade zone between the United States and Canada by eliminating tariffs and quotas between the two countries.

A key provision of the bill is the Baucus-Danforth amendment, which requires the U.S. to take a tough stance against Canadian subsidies, which were not covered under the original agreement. Without the amendment Montana's natural resource industries faced devastating competition and lost jobs because of subsidized Canadian imports. For example, the ASARCO smelter in Helena would have to compete against a subsidized Canadian smelter. Under the Baucus-Danforth Amendment, if Canada does not eliminate the subsidy, ASARCO can seek to impose an offsetting duty.

The leadership of Montana's natural resource industries helped me write the amendment. With it, the U.S.-Trade Agreement will help lower all barriers to trade – subsidies included. Not just duties and quotas. And that is an agreement that works for, not against, Montana.

Heads and Tails Over the Centennial

To help celebrate Montana's statehood, I have introduced legislation to authorize a commemorative coin to mark the centennial celebration of Montana and five other western states. The coin will have the regional centennial logo on one side and a combination of the busts of Thomas Jefferson and Lewis and Clark on the other. It will be available in 1989 for approximately $150. Twenty dollars of the cost will be returned to the U.S. Treasury to help reduce the federal deficit.

MONTANA PHYSICIANS SERVICE
SELECTED PROVIDER HISTORICAL DATA
FOR : 10/13/88
MED-186

PROVIDER NUMBER - 000000971
PROVIDER NAME - V KNELSON M D
SELECTION CRITERIA :
FOR SERVICE DATES: 10/01/86 TO 09/30/87
ALL PLACE OF SERVICE ALL
TYPE OF SERVICE ALL
PROCEDURE CODE ALL

REQUESTOR: G139

F I	FROM DATE	TO DATE	CLM TYP	P L	T Y	PROC CODE	NUM SVC	SUBMIT CHARGES	ALLOWED CHARGES	AC	EOMB	DEDUCT AMOUNT	UNIT CHARGE	POSSIBLE PAYMENT	DATE PAID	CONTROL NUMBER
N	08287		N	0	6	90040	1	$15.00	$14.90	R2		$0.00	$14.90	$11.92	09157	724651003-00
E	09017		N	0	6	90060	1	$35.00	$21.20	R2		$75.00	$21.20	$16.96	09227	725450206-00
E	09017		N	0	F	78300	1	$125.00	$97.50	R2		$75.00	$97.50	$78.00	09227	725450206-00
A	09087		N	0	6	90015	1	$40.00	$40.00			$0.00	$40.00	$32.00	09247	725950438-00
A	09107		N	0	F	78300	1	$125.00	$97.50	R2		$0.00	$97.50	$78.00	09247	725950438-00
H	09147		N	0	6	90040	1	$20.00	$14.90	R2		$0.00	$14.90	$11.92	10067	726651046-00
E	09177		N	0	6	90060	1	$35.00	$21.20	R2		$0.00	$21.20	$16.96	10307	729350643-00
E	09177		N	0	F	78300	1	$125.00	$97.50	R2		$0.00	$97.50	$78.00	10307	729350643-00
K	09177		N	0	2	57511	1	$66.00	$36.50	R2	9	$0.00	$36.50	$29.20	10167	728170121-00
E	09227		N	0	6	90060	1	$35.00	$21.20	R2		$0.00	$21.20	$16.96	10207	728151419-00
E	09227		N	0	F	78300	1	$125.00	$97.50	R2		$0.00	$97.50	$78.00	10207	728151419-00

TOTAL NUMBER OF BENEFICIARIES	-	81
TOTAL NUMBER OF SERVICES	-	205
TOTAL OF SUBMITTED CHARGES	-$	19099.00
TOTAL OF ALLOWED CHARGES	-$	13051.20
TOTAL OF DEDUCTIBLE AMOUNT	-$	3359.54
TOTAL PER UNIT/SERVICE CHARGE	-$	13051.20
TOTAL OF POSSIBLE PAYMENT	-$	10441.71

TOTAL NUMBER OF ASSIGNED	-	8
TOTAL ASSIGNED ALLOWED CHARGES	-$	936.45
TOTAL NUMBER OF NON ASSIGNED	-	117
TOTAL NON ASSIGNED ALLOWED CHARGES	-$	12114.75
TOTAL OVER-UTILIZATION COUNT	-	4
TOTAL OVER-UTILIZATION SERVICES	-	4
TOTAL OVER-UTILIZATION CHARGES	-$	225.00

submitted charges 19099.00
less co-payment 2423.00 (no compensation)
16676.00
allowed charges 13051.20
"excess charge" 3624.80 ÷ 205 = 17.68 per case

deductible (co-payment) 3359.54 ÷ 205 = 16.39

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KALISPELL, MONTANA MONDAY, OCTOBER 3, 1988 35 CENTS

Index

Group says Medicare overpaid $2.7 billion

WASHINGTON (AP) — The nation's 31 million Medicare beneficiaries paid $2.7 billion in doctor bills over and above the charges the government considered reasonable last year, a citizens advocacy group said today.

That breaks down to an average of $38.11 for each of the 70.3 million doctor bills processed by the federal program that included what is known in Medicare jargon as "excess billing."

Those 70.3 million claims were 23 percent of the total doctor bills submitted to Medicare in fiscal 1987, the last year for which records are complete.

The excess billing claims came from the 63 percent of the nation's doctors who have not agreed to abide by fee schedules set by Medicare.

Broken down by state, the percentage of claims with excess charges ranged from 3 percent in Massachusetts to 51 percent in Wyoming.

In Montana 45 percent of medicare claims involved excess charges that totaled $10.8 million, according to the advocacy group Citizen Action.

There were 360,187 claims in Montana with excess charges during fiscal 1987, averaging $28.36 in overpayments per claim and putting Montana 47th among the states in the percentage of claims having excess charges, according to figures compiled by the group from records of the Health Care Financing Administration.

Among Montana physicians, 19.9 percent have agreed to abide by fee schedules established by Medicare, which ranks Montana 49th among the states based on the percentage of physicians who have agreed to do so, the citizens' group said.

Although federal health officials and Congress have instituted a series of programs designed to encourage doctors to follow the Medicare scale, there is no national rule requiring them to do so.

The percentage of physicians who voluntarily follow the Medicare fee schedule ranges from 73.5 percent in Alabama to 14.9 percent in Idaho.

Doctors in Massachusetts are barred by state law from billing their patients more than the Medicare scale, and only 45.9 percent of them have agreed voluntarily to join Medicare's roster of "participating physicians" who "accept assignment."

Medicare beneficiaries are required to pay 20 percent of the amount charged even by those doctors who "accept assignment" — that is submit bills that adhere to the Medicare fee standard.

Those required co-payments amounted to $25.99 for each of the 70.3 million claims that also contained excess billing.

STEPHEN F. SPECKART, M.D.
WILLIAM C. NICHOLS, M.D.

Hematology, Oncology, Internal Medicine

January 23, 1989

Senator William Norman
State Capitol
Helena, MT 59601

Dear Senator Norman:

I am writing to voice my opposition to proposed legislation that I am told is being presented by Representative Stella Jean Hanson. This legislation is essentially another attempt to force physicians to take Medicare assignment on all patients of Medicare age.

As a practicing oncologist, I want to point out that Medicare has many gross discrepancies built into the system. One of these discrepancies labels a subspecialist cancer physician, like myself, as a general internist, which means that a limited office visit could be charged by an internist to care for an elderly person with a cold and I would, also, receive the same amount to care for another elderly person with a cancer spread throughout their body, causing significant pain, organ dysfunction and possibly the threat of death. I personally can only see between eight and 10 patients per day and I have to pay a staff of 12 ancillary people to deliver quality cancer care in an outpatient setting to Montanans. Since the Medicare system does not want to rectify or acknowledge the fact that dealing with cancer is much more difficult than dealing with ordinary disease, I am placed in a very difficult position of providing cancer care for the elderly person with a limited amount of return for a maximum amount of effort on my part. Oncologists in other parts of the country who have to practice under a forced assignment schedule, either have to shift charges to non-Medicare patients or have to radically curtail the amount of time and effort to deal with cancer in the elderly population. Unfortunately, both of these would be forced upon us if you consider this bill as presently stated.

There is a very reasonable alternative being proposed by the Montana Medical Association. We fully support the Mont-Share Program and would be happy to take assignment in a charitable way for elderly persons on fixed incomes who have no other means to pay for our services. We do see a very large proportion of elderly patients who have financial security and have means of paying for the time and effort that we put into their care and, on that basis, I don't think it is fair to impose legislation when nonlegislative alternatives that are preferable have been proposed and are workable.

I do appreciate your time and consideration of this issue. Again, I am totally against the legislation being proposed by Representative Stella Jean Hanson.

Sincerely,

William C. Nichols, M.D.

WCN/jlp

EXHIBIT 9
DATE 1-27-89
BILL 382

MISSOULA MEDICAL ONCOLOGY, P.C.
621 West Alder • Missoula, Montana 59802 • Phone (406) 728-2539

90017	OFFICE VISIT, EXTENDED SERVICE, NEW PATIENT					87.58	1	
90020	OFFICE VISIT, COMPREHENSIVE SERVICE, NEW PATIENT	111.10	82.80	78.70	2	113.33	1	
90020	OFFICE VISIT, COMPREHENSIVE SERVICE, NEW PATIENT					113.33	1	
90030	OFFICE VISIT, MINIMAL SERVICE, ESTABLISHED PATIENT					13.70	3	
90040	OFFICE VISIT, BRIEF SERVICE, ESTABLISHED PATIENT	25.50	16.90	16.00	2	25.76	1	
90040	OFFICE VISIT, BRIEF SERVICE, ESTABLISHED PATIENT					25.76	1	
90050	OFFICE VISIT, LIMITED SERVICE, ESTABLISHED PATIENT	35.00	23.40	22.20	2	36.06	1	

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CPT-4

DATE PRINTED 11/17/88 MONTANA PHYSICIANS SERVICE PAGE 28

PROVIDER ID : 000001151 PROVIDER PRICING PROFILE
PROVIDER NAME: S FSPECKART M D
PROVIDER ADDR: 621 WEST ALDER MISSOULA MT 59801
SPECIALITY : 11 LOCALITY: 001

--TOS-- SSA	CRR	PROCEDURE CODE	DESCRIPTION	CUSTOMARY CHARGE	PREV CHARGE FOR PAR	PREV CHARGE FOR NON-PAR	SR	MAAC	SR
1	6	90050	OFFICE VISIT, LIMITED SERVICE, ESTABLISHED PATIENT					36.06	1
1	6	90060	OFFICE VISIT, INTERMEDIATE SERVICE, ESTABLISHED PATIENT	35.35	28.40	27.00	2	41.21	1
1	6	90060	OFFICE VISIT, INTERMEDIATE SERVICE, ESTABLISHED PATIENT					41.21	1
1	6	90070	OFFICE VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT	45.90	42.70	40.50	2	46.36	1
1	6	90070	OFFICE VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT					46.36	1
1	6	90080	OFFICE VISIT, COMPREHENSIVE SERVICE, ESTABLISHED PATIENT					77.28	3
1	6	90100	HOME VISIT, BRIEF SERVICE, NEW PATIENT					28.85	4
1	6	90110	HOME VISIT, LIMITED SERVICE, NEW PATIENT					28.04	4
1	6	90115	HOME VISIT, INTERMEDIATE SERVICE, NEW PATIENT					40.80	9
1	6	90130	HOME VISIT, MINIMAL SERVICE, ESTABLISHED PATIENT					29.36	3
1	6	90140	HOME VISIT, BRIEF SERVICE, ESTABLISHED PATIENT					30.91	3
1	6	90150	HOME VISIT, LIMITED SERVICE, ESTABLISHED PATIENT					36.06	3
1	6	90160	HOME VISIT, INTERMEDIATE SERVICE, ESTABLISHED PATIENT					38.95	4
1	6	90170	HOME VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT	50.00	43.40	41.20	4	46.42	9
1	6	90170	HOME VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT					46.42	9
1	6	90200	BRIEF HISTORY AND EXAMINATION,HOSPITAL					56.67	1
1	6	90215	INTERMEDIATE HISTORY AND EXAMINATION,HOSPITAL	86.70	67.90	64.50	2	87.58	1
1	6	90215	INTERMEDIATE HISTORY AND EXAMINATION,HOSPITAL					87.58	1
1	6	90220	COMPREHENSIVE HISTORY AND EXAMINATION,HOSPITAL	111.10	95.00	90.20	2	113.33	1

						Medicare Approved Charge		
90017	OFFICE VISIT, EXTENDED SERVICE, NEW PATIENT					87.58	1	
90020	OFFICE VISIT, COMPREHENSIVE SERVICE, NEW PATIENT	111.10	82.80	78.70	2	113.33	1	
90020	OFFICE VISIT, COMPREHENSIVE SERVICE, NEW PATIENT					113.33	1	
90030	OFFICE VISIT, MINIMAL SERVICE, ESTABLISHED PATIENT					13.70	3	
90040	OFFICE VISIT, BRIEF SERVICE, ESTABLISHED PATIENT	25.50	16.90	16.00	2	25.76	1	
90040	OFFICE VISIT, BRIEF SERVICE, ESTABLISHED PATIENT					25.76	1	
90050	OFFICE VISIT, LIMITED SERVICE, ESTABLISHED PATIENT	35.00	23.40	22.20	2	36.06	1	

EXHIBIT 9
DATE 1.27.89
HB 382

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CPT-4

DATE PRINTED 11/17/88 MONTANA PHYSICIANS SERVICE PAGE 28

PROVIDER ID : 000001151 PROVIDER PRICING PROFILE
PROVIDER NAME: S FSPECKART M D
PROVIDER ADDR: 621 WEST ALDER MISSOULA MT 59801
SPECIALITY : 11 LOCALITY: 001

--TOS-- SSA	CRR	PROCEDURE CODE	DESCRIPTION	CUSTOMARY CHARGE	PREV CHARGE FOR PAR	PREV CHARGE FOR NON-PAR	SR	MAAC	SR
1	6	90050	OFFICE VISIT, LIMITED SERVICE, ESTABLISHED PATIENT					36.06	1
1	6	90060	OFFICE VISIT, INTERMEDIATE SERVICE, ESTABLISHED PATIENT	35.35	28.40	27.00	2	41.21	1
1	6	90060	OFFICE VISIT, INTERMEDIATE SERVICE, ESTABLISHED PATIENT					41.21	1
1	6	90070	OFFICE VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT	45.90	42.70	40.50	2	46.36	1
1	6	90070	OFFICE VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT					46.36	1
1	6	90080	OFFICE VISIT, COMPREHENSIVE SERVICE, ESTABLISHED PATIENT					77.28	3
1	6	90100	HOME VISIT, BRIEF SERVICE, NEW PATIENT					28.85	4
1	6	90110	HOME VISIT, LIMITED SERVICE, NEW PATIENT					28.04	4
1	6	90115	HOME VISIT, INTERMEDIATE SERVICE, NEW PATIENT					40.80	9
1	6	90130	HOME VISIT, MINIMAL SERVICE, ESTABLISHED PATIENT					29.36	3
1	6	90140	HOME VISIT, BRIEF SERVICE, ESTABLISHED PATIENT					30.91	3
1	6	90150	HOME VISIT, LIMITED SERVICE, ESTABLISHED PATIENT					36.06	3
1	6	90160	HOME VISIT, INTERMEDIATE SERVICE, ESTABLISHED PATIENT					38.95	4
1	6	90170	HOME VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT	50.00	43.40	41.20	4	46.42	9
1	6	90170	HOME VISIT, EXTENDED SERVICE, ESTABLISHED PATIENT					46.42	9
1	6	90200	BRIEF HISTORY AND EXAMINATION,HOSPITAL					56.67	1
1	6	90215	INTERMEDIATE HISTORY AND EXAMINATION,HOSPITAL	86.70	67.90	64.50	2	87.58	1
1	6	90215	INTERMEDIATE HISTORY AND EXAMINATION,HOSPITAL					87.58	1
1	6	90220	COMPREHENSIVE HISTORY AND EXAMINATION,HOSPITAL	111.10	95.00	90.20	2	113.33	1

RONALD V. LOGE, M.D., F.A.C.P.
DIPLOMATE OF THE AMERICAN BOARD OF INTERNAL MEDICINE
DIPLOMATE IN GERIATRIC MEDICINE
401 BARRETT
DILLON, MONTANA 59725

TELEPHONE (406) 683-6861

January 27, 1989

Human Service and Aging Committee
The Montana House of Representatives
The Capitol Building
Helena, MT 59620

EXHIBIT 10
DATE 1-27-89
HB 382

RE: HB 382, Mandatory Assignment Bill

I am testifying to voice my concern over the purpose and goals of your Mandatory Medicare Assigment Bill. I am an internal medicine specialist and geriatrician from Dillon and have had a medical practice in Montana for the past eight years. My primary work involves caring for the elderly. Although I accept Medicare assignment on all my patients, I am vigorously opposed to proposals that require this of all physicians for all Medicare patients. As alleged by the Montana Senior Citizens' Association, the premise of this bill is that Montana physicians "overcharge" senior citizens and that this bill would correct that.

Unfortunately, this group has provided you with misleading and incorrect "facts". It is clear that they do not understand the complexities of Medicare regulations, nor do they recognize that rather than being "overcharged" by Montana physicians, they are receiving a discounted service and are being undercharged by Montana physicians. Although lengthy, this summary, I hope, will shed some light on these issues.

The current approved Medicare rates are based on profiles of charges in years past, not present. Consider also that Medicare reimbursement rates were frozen in the middle 1980s and have since been allowed to rise only at 1% to 3% per year with temporary cuts last year of 2.324% in compliance with Gramm-Rudman. Medicare determines a Maximal Allowable Actual Charge (MAAC) for every procedure for every physician. This is the same or more than the "approved" amount and is also based on past fee profiles, not current charges. By law already a non-participating physician cannot charge more than the MAAC but your bill would put physicians in violation of the Consumer Protection Act if the physician billed the MAAC amount, a federally-determined acceptable charge. This bill would not even find this MAAC charge acceptable since you would require all physicians to accept the "approved" amount. I know most senior citizens don't realize the difference between "approved" amounts and the MAAC.

In nearly all cases the amount that a physician can charge a Medicare patient is less than non-Medicare patients. When compared to common insurance carriers such as Blue Cross-Blue Shield, the amount approved

by Medicare is typically less than the amount approved by Blue Cross. All physicians recognize the lower profile inherent in treating Medicare patients but Medicare recipients and the general public are usually unaware of this difference.

Let me provide an actual example. Both a 64-year-old and a 65-year-old person carry Blue Cross insurance and the 65 year old also has Medicare. They are both seen for a similar medical problem. The charge for the office visit for the 64 year old is $25.00 and for the 65 year old is $17.81 (because of MAAC). Blue Cross approves $25.00 for payment for both people, but Medicare only approves $14.00 for the Medicare recipient. However, because of present regulations the Medicare patient cannot be billed for more than $17.81. He will be responsible for 20% of the $14.00 plus $3.81 (the difference between MAAC and "approved" amount), for a total of $6.61. His Blue Cross co-insurance reimburses him only for 20% of the Medicare approved amount, or $2.80. The patient remains responsible for $3.81. Under your bill, the physician could not collect this $3.81. Why should this be a consumer protection violation when the largest insurance carrier in the state approves $25.00 for the non-Medicare patient and the physician has billed only what Medicare has determined to be an acceptable MAAC charge? Medicare is by virtue of these limits a discounted system for senior citizens when they receive care from both participating and non-participating physicians. Medicare recipients are not being "overcharged" in our present system.

Montana and its neighboring states have the lowest Medicare reimbursement rates in the nation and this explains their having the lowest rate of Medicare physician participation in the nation. Please refer to Appendix A. This document shows that Medicare approved charges are substantially lower than charges to the general population and also that for the same service Montana physicians can bill Medicare just half as much as physicians in the more populous states.

I would also point out that although there is geographic disparity in Medicare physician reimbursement, there is no geographic difference in Medicare recipients' premiums. Therefore, our Montana seniors are subsidizing the higher rates of reimbursement elsewhere. Forcing mandatory assignment only accelerates this disparity and serves neither the senior citizens nor their care-givers.

Senior citizens have medical problems that generally require greater time and expertise than younger people, but Medicare reimbursement does not reflect the special care needed. Because of these factors there is a real concern that some physicians may not choose to treat Medicare patients. This is presently the case with those physicians who choose not to treat Medicaid patients because of reduced reimbusement. Access to care for the elderly may become more restricted in consequence of your bill.

John Rother, executive counsel for the national office of the American Association of Retired Persons (AARP), the nation's largest senior citizen lobby, stated in October 1988 that the AARP doesn't feel that

mandatory assignment should be a state issue since it is a federal and not a state-run program. He expressed concern over loss of access to care with such legislation and instead favored payment reforms such as the Harvard Resource-based Relative Value Scale (RVS) which will probably be presented to Congress this year.

The state of Washington's AARP formed a coalition with physicians in that state to defeat an initiative similar to this legislation because of their concern about loss of access to care.

The largest amount of senior citizens' out-of-pocket health care expenses come from nursing home care, hospitalization medicare deductible payments, high pharmaceutical drug bills and high cost procedures. Only the last item on this list is addressed by your bill. Primary care physicians' charges are not in this high cost list, yet this bill would impact every internist and family practice doctor in the state. Our senior citizens receive the majority of their care from these personal physicians, not from the higher-cost procedure specialist.

The Physician Payment Reform Commission which was created in 1985 to advise Congress on Medicare physician payments will present its recommendations to Congress this year. Their considerations will include RVS (the issue of overpriced procedures) and/or state-by-state Medicare physician expenditure caps. These serious issues will be addressed by Congress this year.

You are probably familiar with the voluntary assignment program developed by the Montana Medical Association known as Montshare to identify the truly financially needy. Eighty-seven percent of Montana physicians accept assignment on a case-by-case basis. Nationwide nearly 70% of Medicare claims are accepted on assignment. Physicians do take into consideration their patients' financial status. The Montshare program will enhance this.

State Representative Paul Ogren of Minnesota stated he would kill legislation similar to yours that he wrote for Minnesota's 1989 legislative session if the state medical society would develop a plan of voluntary assignment. The Minnesota Medical Society then developed such a program which is similar to Montshare.

Besides Montana and Minnesota, thirteen other states and the District of Columbia have instituted voluntary Medicare assignment programs. About eighteen others are considering such plans. Futhermore, mandatory assignment bills have failed in the majority of states where they were introduced.

Because Medicare approved amounts are less than charges to non-Medicare patients, mandatory uniform Medicare assignment would result in further cost-shifting to the non-Medicare population. To compensate for mandated lost income, physicians could be expected to increase their charges to non-Medicare patients. Your non-Medicare constituents should be made aware of the ramifications of legislation which will probably increase their own health costs to subsidize senior citizens.

In addition, Medicare recipients as a group are better insured than the non-Medicare population. Only 20% of Medicare recipients are dependent soley on Medicare for reducing the impact of illness whereas the vast majority of the 37,000,000 uninsured Americans are not in the Medicare age group.

I appreciate your time in considering these issues.

Respectfully submitted,

Ronald V. Loge, MD
401 Barrett
Dillon, MT 59725

APPENDIX A CODE 90050	AVERAGE $	SUBMITTED CHARGES STATE	AVERAGE $	Medicare APPROVED CHARGES STATE
	40.51	ALASKA	27.59	CONNECTICUT
	37.78	NEW YORK	26.53	ALASKA
	31.26	CONNECTICUT	26.08	NEW YORK
	31.16	CALIFORNIA	24.54	WASHINGTON, D.C.
	31.08	HAWAII	23.39	CALIFORNIA
	30.20	WASHINGTON, D.C.	22.14	HAWAII
	28.41	MASSACHUSETTS	21.76	NEVADA
	28.01	RHODE ISLAND	20.61	ARIZONA
	27.84	NEVADA	20.54	MASSACHUSETTS
	26.82	ARIZONA	19.95	MARYLAND
	26.32	NEW JERSEY	19.83	PENNSYLVANIA
	25.56	FLORIDA	19.53	RHODE ISLAND
	25.70	WASHINGTON	19.16	DELAWARE
	25.05	PENNSYLVANIA	19.14	NEW MEXICO
	24.09	OREGON	18.33	OREGON
	23.95	MARYLAND	18.32	WASHINGTON
	23.79	MICHIGAN	18.11	FLORIDA
	23.61	ILLINOIS	17.86	NEW JERSEY
	23.58	NEW MEXICO	17.63	KENTUCKY
	23.25	COLORADO	17.54	INDIANA
	23.20	TEXAS	17.44	OKLAHOMA
	22.78	OKLAHOMA	17.32	WYOMING
	22.64	MINNESOTA	17.29	MAINE
	22.54	LOUISIANA	17.23	WISCONSIN
	22.43	DELAWARE	16.97	ILLINOIS
	22.42	ALABAMA	16.85	MICHIGAN
	22.19	GEORGIA	16.25	NORTH DAKOTA
	22.30	NH VT	16.07	MISSOURI
	21.78	MONTANA	16.05	NH VT.
	21.58	KENTUCKY	15.85	GEORGIA
	21.43	OHIO	15.84	ALABAMA
	21.42	WISCONSIN	15.81	OHIO
	21.16	WEST VIRGINIA	15.63	KANSAS
	21.15	WYOMING	15.13	MINNESOTA
	21.01	INDIANA	14.88	COLORADO
	20.79	IDAHO	14.83	MONTANA
	20.71	MAINE	14.72	VIRGINIA
	20.65	KANSAS	14.55	IDAHO
	20.34	NORTH CAROLINA	14.46	TEXAS
	20.09	TENNESSEE	14.10	LOUISIANA
	20.40	MISSOURI	13.62	NORTH CAROLINA
	29.98	VIRGINIA	13.17	WEST VIRGINIA
	19.94	SOUTH CAROLINA	13.06	SOUTH CAROLINA
	19.73	ARKANSAS	12.97	MISSISSIPPI
	19.50	NORTH DAKOTA	12.96	IOWA
	18.64	UTAH	12.73	TENNESSEE
	18.60	MISSISSIPPI	11.88	UTAH
	18.02	IOWA	11.87	ARKANSAS
	17.58	NEBRASKA	11.64	NEBRASKA

Report of the Health Care Cost Containment Advisory Council

State of Montana
January 1987

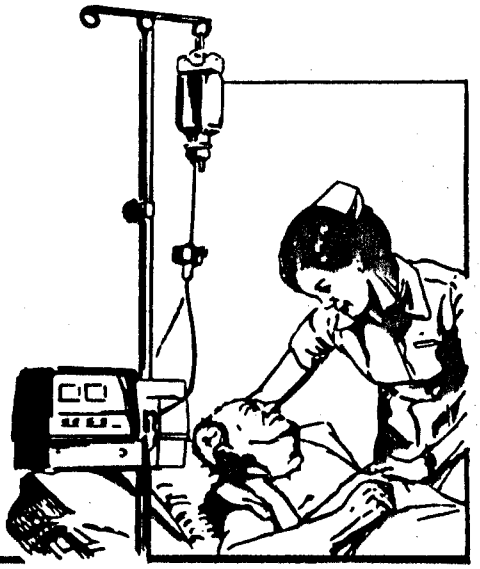

EXHIBIT 11
DATE 1-27-89
HB 382

Testimony HB 382

M & M CLUB

Senior Citizens of Melstone and Musselshell, Montana

JANUARY 18, 1989

TO: Earl Riley
State Pres
MSCA

It has been brought to our attention that the "Mandatory Medicare Assignment" bill has been introduced in the Legislature. By signing this letter, the undersigned Senior Citizens of Melstone and Musselshell, Montana, approve this bill and request your support in its passage in both Houses of the Legislature. Most of our members in this area have limited income and can not afford to pay the medical costs over and above what Medicare allows. Even insurance coverage for these excess charges is becoming quite expensive and prohibitive to some members. Your assistance and help in the passage of this bill will be appreciated.

We thank you for your assistance in helping us.

Clara Mae Speck
Robert Rostad
Katherine Rostad
George T. Walker
Grace Shelton
Leora Longwell
Robert Eikel
James F. Mapell
Elena J Russell
Alexander E Russell
Earl W Sutmore

Ray E. Grebe
Cayuetola H. Grebe
Florence Eike
Mary E. Maxwell
Eiko Stonerod
Robert Stonerod
Bruce Wheatley
Lora Wheatley
John A Richmond
Emelia W Richmond

Augusta, Montana

January 17, 1989

We, the undersigned are in favor of the passage of the bill now before the legislature ---the mandatory acceptance of assignment of Medicare by doctors, of Montana

Margaret Tornall
Mildred & Richard Olson
Cecil V Rita Reed
R. A. KOKMANN - - -
Rick & Bernice Joseph
Vivian Wilson
John Wilson
Susan Williams
Susan L. Butler
Vernon Fordyce
Mabel Hodgkins
Pearl Scherrer
Lucia Conrad
Mary Allen
LeVern Dehl
Margaret Wadsworth
Jessie M. Nett Box 18 Augusta, Mt.
Emma Lou Wendlemuth Bx 146 Augusta, Mt
Pete Gervais
Sophia B. Dawson
Joe Rocha Box 100 Augusta Mt

Augusta, Mt.
Jan 17, 1989

We, the undersigned are in favor of the passage of the Bill now before the legislature — the mandatory acceptance of assignment of Medicare by doctors, of Montana.

Harriett Smith
Geo Larson
Marion Larson
Charley Willard
Frank Larson
Frances Larson
~~Ethel Johnson~~
John Wilson
Dorothy Wilson

WITNESS STATEMENT

NAME Carol V. Fickes BUDGET _____

ADDRESS 621 W. Alder - Missoula

WHOM DO YOU REPRESENT? Missoula Medical Academy of

SUPPORT _____ OPPOSE ✓ AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

WITNESS STATEMENT

NAME Earl J Reilly BUDGET _____

ADDRESS 3129 w/ Shore DR - Helena

WHOM DO YOU REPRESENT? PROPONENT

SUPPORT _____ OPPOSE _____ AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

WITNESS STATEMENT

NAME Nancy Walker BUDGET _____

ADDRESS 119 Pleasant St Arlington Mass 02476

WHOM DO YOU REPRESENT? Mass Senior Action Council

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

WITNESS STATEMENT

NAME Jonas Campbell BUDGET _____

ADDRESS 1618 S Sherwood, Missoula

WHOM DO YOU REPRESENT? MSCA

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

WITNESS STATEMENT

NAME Richard L Brown BUDGET _____

ADDRESS 178 Many Lakes Dr. Kalispell Mt

WHOM DO YOU REPRESENT? MSCA

SUPPORT Yes OPPOSE _____ AMEND _____

COMMENTS: _____

It's really sad that so many half truths can be stated by Dem.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

WITNESS STATEMENT

NAME Alka VanAken BUDGET _____

ADDRESS 220 W. Montana, Livingston MT

WHOM DO YOU REPRESENT? _____

SUPPORT Yes / 387 OPPOSE _____ AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

WITNESS STATEMENT

NAME Toby Brown BUDGET _____

ADDRESS 619 2nd Ave So GF 59405

WHOM DO YOU REPRESENT? Nelson Medical, Inc.

SUPPORT _____ OPPOSE X AMEND _____

COMMENTS: Every Durable Medical Equipment (DME) Oppose this Bill (382).

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

VISITORS' REGISTER

_____ COMMITTEE

BILL NO. HB 782 DATE 1/27

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Bill Fleiner	Montana Sheriffs & Police Officers	X	
MARK MURPHY		X	
Curt Pethy	MT. Sheriffs & Police Assn	X	
Nadiean Jensen	Helena	X	
DON CRABBE	BOARD OF CRIME CONTROL	X	
Howard W Gipe	Flathead Co. Comm	+	
WALLY Jewell	MT. MAGS. ASSOC.	X	

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. HB 382 DATE 1/27/89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Mike Sherwood	MTLA	✓	
Ed Heaney	1731 5th Helena	✓	
Jeanette Pettinson	Helena	✓	
Sheila Dempsey	Helena	✓	
Sam Lee	Great Falls, mt.	✓	
Betty Stimac	Great Falls, mt	✓	
Lawrence L. Stimac	GREAT FALLS MT.	✓	
Minna J. Lundborg	Great Falls Mt.	✓	
Helen Perrine	Hobson, MT.	✓	
Dorothy Darwin	Kalispell "	✓	
Pete Milley	GREAT FALLS	✓	
Wilson Brown	Helena MT	✓	
Gertrude A. Baker	Hobson Mt.	✓	
John M. Vandenberg	E. Helena, Mt	✓	
Edwin Johnson	Helena MT.	✓	
Madeline Burns	Stan for Mt	✓	
Marion Deegan	Stanford, Mt.	✓	
Pauline Johnson	Stanford Mt.	✓	
Mary Reilly	Stanford, Mt.		

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. HB 382 DATE 1-27-89

SPONSOR ______________

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Elma Smith	MSCA	✓	
Carole V. Erickson	Missoula Medical Oncology		✓
Ron Loge	Montana Society of Internal Medicine		✓
Geraldine Stensrud	MSCA	✓	
Irma Antila	MSCA	✓	
Norman H. Walker	Judith River S.C.	✓	
Ray Deegan	Judith Basin Senior C MSCA	✓	
Jean H. Walker	" " " " "	✓	
Marge Phillips	" " " "	✓	
Mildred Zimmer	" " " "	✓	
Carol Barr	" " " "	✓	
[illegible] Boggs	Browning Mt MSCA	✓	
Josephine Harrison	[illegible]	✓	
[illegible]	Glasgow	✓	
[illegible]	Glasgow	✓	
Mary Brown	Malta		
ERIC JOHNSON	MT KAIMIN, RAVALLI REP		
TOBY BROWN	NELSON MEDICAL		X

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

VISITORS' REGISTER

HUMAN SERVICES & AGING COMMITTEE

BILL NO. HB382 DATE 1-27-89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Vina Van Aken	Livingston	✓	
Alitha Van Aken	Livingston	✓	
Willa Mae Evans	Kevin	✓	
Adolph Green	Harlem	✓	
Kathryn Arnold	Harlem	✓	
Earl J Reedy	Helena	✓	
Stella Stark	Harlem	✓	
Jo O'Leary	"	✓	
Isabel Waggoner	Stanford	✓	
Mildred Thurman	Utica	✓	
Helen Baker	Boulder	✓	
Anna McKee	Great Falls	✓	
Phil Paul	Great Falls	✓	
Victoria McPaul	Great Falls	✓	
John Ellsworth	Helena MSU	✓	
Mary Stone	Helena, MT.	✓	
Margaret Schnurr	Great Falls	✓	
Alex Schnurr	Great Falls.	✓	
Ernest Christianson	Great Falls	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES & AGING COMMITTEE

BILL NO. HB 382 DATE 1/27

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
John W. McMahon MD	Helena		X
Nadine Jensen	Helena	X	
Donald L. Harr	Billings		X
Jolene Lorendorff	Helena		—
Jan Faith Nelson	Kalispell		X
BRIAN ELIS	HELENA		X
JUDITH CARLSON	HELENA - MSCA	X	
Virginia Jellison	MCIC - Helena	X	
TIM HARRIS	MONT. INDEPENDENT LIVING PROJECT - HELENA	X	
Jim Mann	HELENA		X
Steve Neher	Kalispell		X

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PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES & AGING COMMITTEE

BILL NO. HB382 DATE 1-27-89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Fred Schumacher	Wolf Point, MT.	✓	
Cyndie Schumacher	Wolf Point Mt.	✓	
Leona Tolstad	628 Hazelgreen		✓
Le Alean Lewis	Helena, Mt.		
Clara Isakson	Glasgow mt.	✓	
Lorraine Stuff	Malta, MT	✓	
Vi Bergan	Malta, MT	✓	
Elizabeth Larned	Kalispell MT	✓	
Alvin E Larned	Kalispell Mt	✓	
Hazel L Hudson	Kalispell Mt	✓	
Dora Dorkin	Columbia Falls Mt.	✓	
Helen Barnhart	Columbia Falls Mt	✓	
Maris R. Brown	Kalispell Mt	✓	
Beth Hoell	Helena, Mt.	✓	
Ron Albertson	Glasgow Mt	✓	
Ben Albertson		✓	
Marion Hellstern	Hinsdale MT 59241	✓	
Chuck Whitworth	Whitefish, MT 59937	✓	
Harry L Dunn	Whitefish Mt 59937	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES & AGING COMMITTEE

BILL NO. HB 382 DATE 1-27-89

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
ELSIE LEE	612 4TH. Ave. S.W.	✓	
Ellen Dee Herder	3333 Evergreen Dr. East Helena	✓	
Vergil Jones	#9 Placer Dr. Roundup	✓	
Sam Byron	700 W Main Helena	✓	
Ann Peuleste	HELENA	✓	
Don Judge	AFL-CIO	✓	
Brenda Nordlund	MT Women's Lobby	✓	
George Poston	Helena MT.	✓	
Ken Eben MD	"		✓

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.