MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON JUDICIARY

Call to Order: By Chairman Brown, on February 17, 1989, at 8:10 a.m.

ROLL CALL

Members Present: All members were present.

Members Excused: None.

Members Absent: None.

Staff Present: Julie Emge, Secretary
John MacMaster, Legislative Council

Announcements/Discussion: None.

HEARING ON HOUSE BILL 699

Presentation and Opening Statement by Sponsor:

Rep. Kelly Addy, District 94, stated that this bill is intended to address the rural health care crisis. From one direction, the federal government is establishing new medicaid and medicare reimbursement rules which make it impossible for rural areas to claim full cost for reimbursement. From the other direction, professional liability insurance premiums have skyrocketed which is forcing many doctors out of rural Montana. This bill sets up an assured compensation fund which essentially allows the Montana Medical Association (MMA) to set up an insurance company to provide coverage to gynecologists and to family practitioners that do obstetrical work. It would provide insurance coverage over $100,000 per incident or $300,000 in the aggregate. By offering that much, insurance rates can be reduced. One of the more controversial points of the bill is a "floating cap" on damages. If the jury were to return a verdict which is in excess of certain guidelines set down in the bill, a judge would review the jury's verdict to determine whether it was affected by prejudice or was not a close adherence to the law than had been considered in the case.

Testifying Proponents and Who They Represent:

Gerald Neely, Montana Medical Association
Van Kirke Nelson, Obstetrician, FCIA
Rex Manual, Mont. Liability Coalition
Michael Sedaj, President, Montana Medical Assoc.
Sharon Dieziger, Mt. Nurses Association
Jim Ahrens, President Mt. Hospital Association
Donna Small, MNA's Legislative Committee
Kay Foster, Chairman, Obstetrical Services Advisory Council

Proponent Testimony:

Gerald Neely stated that the MMA first conducted a feasibility study of the matter in 1987 and made it available to the legislators. The study outlined matters that had been under consideration for a couple of years. There has been a rapid exodus from the rural areas by doctors and it leaves a gap for a broad range of medical services. Mr. Neely stated that as of December 31, 1988, there were 55 family practitioners delivering babies in the rural areas in Montana. The problem now lies in the loss of services instead of high insurance premiums. The access of availability and care of medical services is quickly diminishing. The economic impact on these small communities falls on the hospitals that lose that broad range of fees because the practitioners are not there providing those services. The MMA has looked at the problem of overcharge with respect to insurance in the obstetrical area. Mr. Neely stated that they have gathered information for the legislature on practitioners in Montana. In the survey done on all the Obstetrical practitioners in Montana, it revealed that not one practitioner that is practicing in the obstetrical area has had at least one adverse claim against them in regard to medical practice. There are no repeater physicians in the obstetrical area, but to comply with the point made by the trial lawyers association, Mr. Neely stated they felt it was necessary to exclude those practitioners from any legislation that had a pattern of negligence. A pool has been formed for excess coverage and does not take affect until the physician has reached the $100,000 limit. Mr. Neely stated that the reasons for this are: 1.) The physician must have $100,000 insurance coverage from a current medical liability carrier, this is mandatory if they wish to participate. This will exclude those practitioners that have a pattern of negligence because they will not be able to receive insurance when they are disqualified from their current medical carrier. 2.) It will increase the solvency of the pool of funds that will pay those claims over $100,000 by keeping out those individuals that would give the pool a bad encounter. Mr. Neely stated that the problem with most of the pools, e.g., Workman's Compensation start with the first dollar for coverage, will let anyone in, good and bad.

Mr. Neely stated that the rate of claims against family practitioners is immense. As these family practices decline along with the population, and the births that are declining, the claims against the obstetrical area has gone up. Mr. Neely stated that the way to deal with this is through voluntary arbitration. It allows the individuals, if they choose, to go into arbitration rather than through the tort system. This is important because there are two classifications that are a problem to the insurance system and the legal system: 1.) There is not much damage and an attorney will not take the case because malpractice is too complicated; 2.) No negligence, but is unclear that any damage has been done; and 3.) It will relieve the pressure that is on the tort system. The intent of this legislation is to have a zero fiscal impact to the state, and a full reimbursement to any state agency involved. The funds come from the casualty insurance carriers and the procedure of this will be operated as a charge, the equivalence of a premium tax.

Mr. Neely stated that last session, the legislature passed several tort reform measures that had several problems: 1.) The time that is taken to be put into effect, but there is no guarantee that the benefits will be passed on to the insurance consumer or the public; 2.) The pool generates excess dollars that is a cost savings to; a. to pay back the original capitalizers, b. to go into the voluntary arbitration pool for claims by injured parties. Additionally, this legislation does several unusual things in the area of tort reform: 1.) It instantly gives an immediate major premium decrease; and 2.) If partially successful, it passes on a savings to the injured parties and the insurance companies. Mr. Neely distributed several handouts on actuary data and dollar amounts paid on premiums in the State of Montana. (EXHIBITS 1, 2, 3, and 4).

Van Kirke Nelson spoke on the access of care in Montana and stated that 40 percent of Montana's 11,000 infants are born in rural areas, 1/3 of those practicing obstetricians have left. He stated that compensation does not meet the cost of the services provided (EXHIBIT 5).

Rex Manual stated that the Montana Liability Coalition supports the concept of HB 699, but would like the committee to look into an alternate funding source for the $6.5 million dollar pool. Mr. Manual stated that there are several coal tax funds that could be available for this purpose. Mr. Manual urged the committee's support in the passage of HB 699.

Dr. Michael Sedaj stated that he is currently President of the Montana Medical Association. Mr. Sedaj touched on the personal issues between women and their obstetricians. He

stated that the malpractice premiums are exceeding the cost of the fees charged and urged the committee's consideration in support of HB 699.

Sharon Dieziger stated that she represents the Montana Nurse's Association. Ms. Dieziger commended the support of the MMA and the months of preparation in planning this piece of legislation. Ms. Dieziger stated that Montana is in a position to bring the physicians back to obstetric practice and urged the committee's support (EXHIBIT 6).

Jim Ahrens, President of the Montana Hospital Association stated that this bill is very important for the hospitals. The crisis in the rural areas is very real. Of the 55 hospitals represented, 15 have stopped delivering babies and one more will stop this year. Mr. Ahrens stated that some of the hospitals in Montana are already subsidizing for the malpractice premiums and those are the ones in the worst financial shape. Mr. Ahrens stated that this not only affects the obstetrical crises, but the economy in the State of Montana. Mr. Ahrens urged the Committee to support HB 699 (EXHIBIT 7).

Donna Small is a member of the MNA's Legislative Committee. Ms. Small stated that they have followed the study of the liability and obstetrical crises for several years and felt this piece of legislation is a solid attempt to solve the problem and is fair to everyone. Ms. Small stated that when a patient's access is limited to physicians, they are also being limited to physician's extenders, e.g., nurse midwives who can only practice if they have a collaborating physician.

Kay Foster is Chairman of the Obstetrical Services Advisory Council. Ms. Foster stated that the advisory council has been studying the obstetric availability for 6 months and had delivered the recommendation to Governor Schwinden 4½ months ago. Ms. Foster distributed the recommendation to the Committee and urged their support for HB 699 (EXHIBITS 8, 9, 10 and 11).

Testifying Opponents and Who They Represent:

Terry Treewiler, Attorney at Law in Whitefish, Mt.
Sue Weingartner, Mt. Defense Trial Lawyers
Roger McGlenn, Executive Director of the Independent Insurance Assoc. in Mt.
Jacqueline Terrell, American Insurance Assoc.
Karl Englund, Attorney in Missoula
Michael Sherwood, Montana Trial Lawyers Assoc.

Opponent Testimony:

Mr. Terry Treewiler of Whitefish asked the committee to take into consideration the rights of the innocent victims who have to

participate in this system of justice. In the past 10 years, in the 56 district courts around the State of Montana, a survey was taken on verdict cases, there was only one case that went before a jury trial, and that was in Kalispell. Mr. Treewiler stated that Montana ranks 50th in the nation in the discipline of doctors. Mr. Treewiler read from the MMA and stated that the MMA has never requested a jury trial and has never stated that jury trials were a part of the problem. Mr. Treewiler stated that there are two provisions in HB 699 that give more consideration to the wrong doer than the innocent victim: 1.) Section 15, gives the administrator of the insurance plan discretion on how the settlements will be paid. The victim, or baby who will be dependent upon the parents for the rest of his life, does not have any say in the manner in which the settlement should be paid. 2.) To give the trial judge the discretion to review and reward of non-economic damages and remodify it if it does not conform to the recommended arbitrary schedule.

Sue Weingartner representing the Mt. Defense Trial Lawyers stated that the trial lawyers acknowledge the time and effort placed in drafting this compensation act, but concludes that the organization cannot support HB 699. The concern regarding the patient assured compensation act include: 1.) The complexity of legislation could increase the cost of resolving malpractice claims; 2.) The figures presented and contained in the report by the Governor's availability council, the basic premium for a family practitioner is in the area of $12,500. The physician would pay an additional $6,313 to the state administered fund for coverage in excess of $100,000 for a total premium of $18,818; 3.) MDTL is aware of the substantial out of court settlements in obstetrical cases involving birth related injuries; 4.) MDTL concurs in the majority of the recommendations of the Governor's obstetrical services advisory council has transmitted from Governor Schwinden on November 2, 1988; 5.) There is no runaway of jury verdicts and no history of seven figure verdict cases in OB cases. The insurance companies decision to make substantial settlements were not influenced by a number of recent developments in Montana law relating to medical malpractice, e.g., prior to 1985, family practitioners were generally held to a standard of care. MDLT suggests that the legislature consider re-establishing a locality rule so rural physicians are judged by the scale and learning possessed by other surgeons in good standing practicing in similar localities and circumstances; 6.) prior to 1985, Montana juries were instructed that a physician's conduct must be the proximate cause of the injury before he can be held liable in a medical malpractice action; and 7.) MDTL is generally opposed to laws that limit or cap damages (EXHIBIT 12).

Roger McGlenn stated that he does not represent insurance companies, but the clients to the Montana consumers. Mr.

McGlen stated that their concern is the funding of the increase premium tax as another sales tax on insurance policies. Mr. McGlen stated that the insurance consumer will pay an additional $6 million plus. Mr. McGlen distributed a handout from the Casper, Wyoming Tribune (EXHIBIT 13).

Jacqueline Terrell representing the American Insurance Assoc., stated that they cannot support HB 699, but do concur in the comments of the lawyers, the defense lawyers and the Governor's task force. Mrs. Terrell stated that there could be some constitutional problems presented by this legislation regarding a small problem in the medical profession. By next session this could include neurosurgeon's, orthodontists, etc. Mrs. Terrell stated that the problem with this bill, is the solvency of the fund that is set up. The participation is voluntary with no assurance that it will cover the claims that could be presented to it. She stated that two or three bad experiences could wipe out that fund. Ms. Terrell stated that the solution needs to be more general instead of being targeted towards the one specialty. Ms. Terrell added that Gene Phillips concur in her comments for the National Association of Independent Insurers and Bonnie Tippy's for the Alliance for the American Insurance.

Karl Englund served as a lobbyist for the Trial Lawyers Assoc. for four years and served on the Governor's Advisory Obstetrical Service availability with Kay Foster and Rep. Mercer. Mr. England stated that the committee has a job to do in 72 hours that the Governor's advisory council worked on for 6 months and could not come up with a solution. The MMA tried to develop a solution to the problem and in the process has gone through many changes that ended up with a 47 page bill. Mr. England stated that the bill in the current form does not belong in the codes.

Michael Sherwood representing the Mont. Trial Lawyers Assoc., stated that he is in opposition of the bill, but does support the concept. Mr. Sherwood stated that Montana had 3/10 of 1 percent of the property and casualty market in the United States. He stated that Montana needs to develop a domestic and intrastate agency. Mr. Sherwood distributed a handout on problems previously discussed (EXHIBIT 14).

Neutral:

Alan Cronister, Mont. State Bar Assoc. stated that the State Bar neither supports nor opposes this bill. Mr. Cronister stated that the attorneys in the State of Montana are faced with the availability more so than the insurance rates. The attorneys in Montana got together with attorneys in the surrounding states and formed a self insurance pool, it is voluntary and the rates are about the same. The Mt. State Bar Assoc. standpoint has been strongly behind alternative

dispute procedures. The arbitration procedure in this bill has some fundamental problems: 1.) It is very complicated; and 2.) An expecting woman is required to opt into or out of the secondary pool on her first visit to the doctor. Mr. Cronister asked "what woman is going to able to make an intelligent decision as to whether or not she is going to opt into a secondary pool of funds or the primary pool of funds if she does have a problem and needs compensation". The second problem is the arbitration process on the reliance on the Montana legal medical panel to decide what the womans compensation is.

Questions From Committee Members: None.

Closing by Sponsor: Rep. Addy closed stating that he hoped those that expressed reservation of this bill will give the committee the benefit of their views when this bill gets into detail. Rep. Addy stated there are a number of amendments to this bill. The MMA has been proactive in listening to the concerns and hoped they will participate to make this work. Rep. Addy stated that the whole problem with the medical practice insurance is that Montana's rates are based on a regional basis. The insurance rates in Montana are a billion dollars a year. Rep. Addy stated that this is just the beginning of the work on this bill.

Rep. Brown stated that the Subcommittee Members' appointed to this bill will be: Rep. McDonough, Rep. Wyatt and Rep. Mercer. Rep. McDonough will chair the subcommittee.

HEARING ON HOUSE BILL 587

Presentation and Opening Statement by Sponsor:

Rep. Addy, House District 94, stated that testimony had been heard on this bill the previous day. He stated that HB 587 increases that maximum penalty for a DUI for a third conviction or more to 5 years in prison or a $50,000 fine or both. It lowers the determination to operate a vehicle illegally from .01 to .08.

Testifying Proponents and Who They Represent:

Wally Jewell, Montana Magistrates Assoc.

Proponent Testimony:

Wally Jewell handed in written testimony (EXHIBIT 15) expressing his support of HB 587.

Testifying Opponents and Who They Represent:

Roger Tippy, Executive Secretary for the Montana Beer and Wine Wholesalers Assoc.
Don Larson, Lobbyist for Montana Tavern Association
Marie Durkee, Executive Mt. Tavern's Association

Opponent Testimony:

Roger Tippy stated that this is the first time in Montana history that the industry for beer and wine dealers have opposed a DUI bill. Mr. Tippy stated that alcohol impairs to a degree, but it should not be spoken to as a drunk driving problem. Mr. Tippy stated that there is a study being done to determine the blood alcohol level at or above which any person operating a vehicle should be judged intoxicated (EXHIBIT 16).

Don Larson stated that this bill is a proposed reduction of the BAC level toward the return of prohibition in the state of Montana. He hoped that the citizens of Montana will be given the opportunity to enact legislation to isolate the state from the rest of the union. Mr. Larson stated that there are programs in place to help deal with the abuse of their products, e.g., the Home Free program, No When To Say When program, Designated Driver program, etc.. Mr. Larson stated that his industry is doing everything they can to find a solution instead of being a part of the problem. Lowering the BAC to a .08 would penalize the industry and the social drinker who is a customer and patron, and they are the ones that keep the doors open.

Marie Durkee stated that Ms. Rose Bullock from Basin, Mt. was in the meeting the previous day and had asked Mrs. Durkee to read her testimony before the committee (EXHIBIT 17).

Neutral:

Dan Russell, Administrator for the Division of Corrections, wanted to comment on what the impact would be on the prison population from this bill. He stated that the number of DUI convictions have decreased since 1986 from about 7,638 to current figure of 6,957. The number of three or more DUI convictions during this time has increased from 382 to 557. Given that number at risk, it has been estimated that the most conservative number of people that would come into the Montana prison would be an additional 20 to 30 inmates per year. With 9 other bills before the legislature this session, there would be an increase of 60 - 90 or more inmates, more than what had been projected, which would mean a new housing unit. The fiscal impact of this bill would be about $54,000 the first year and $60,000 the second year.

Questions From Committee Members: Rep. Boharski asked Mr. Larson how much beer it would take to have a .1 BAC level at 175 lbs. and 6 feet tall? Mr. Larson replied that he took the test under a controlled situation where 12 people had sat down and started drinking beer to determine at what point they would reach intoxication or over .01. Rep. Boharski stated that he was told he was too old to take the test, but weighing 162 lbs. and drinking two drinks in one hour he was sober according to the .01 legal, but on the third drink he was considered drunk.

Closing by Sponsor: Rep. Addy closed by stating that the issue is the dividing line between .08 and .01 of those individuals that are wanted on the highway and those who are not wanted on the highways.

DISPOSITION OF HOUSE BILL 587

Motion: Rep. Addy moved HB 587 DO PASS, motion seconded by Rep. Boharski.

Discussion: Rep. Daily spoke against the bill and stated that the main reason that he is against it is because of the mention that was made of the National Academy of Sciences doing a study as to what the blood alcohol content should be. For them to arbitrarily change that .01 does not seem the right thing to do.

Amendments, Discussion, and Votes: None.

Recommendation and Vote: Rep. Daily moved to TABLE HB 587, motion seconded by Rep. Hannah. A vote was taken and CARRIED with Rep.'s Mercer, Rice, and Boharski voting No.

HEARING ON HOUSE BILL 511

Presentation and Opening Statement by Sponsor:

Rep. Mercer, House District 50, started by explaining two extremes of losing property on failure to pay or the extreme of a lot of protection by the court and a period of the right of redemption. He stated that in 1962, trust indentures were developed to give a security interest on property and if payment was not made, an advertise in the paper rather than court to put the property up for sale and when sold, there would be no right to a deficiency judgement. Rep. Mercer stated that there has been some question whether a person that started with a trust indenture if the lender would have the authority to treat it as a mortgage and foreclose through court and give the borrower legal protection given in court. Rep. Mercer stated that the Montana Supreme court has come up with a rule that draws the line that the courts do not have the right to a deficiency judgement if it constitutes residential real property. A trust indenture has been

limited to 15 acres, and a bill has been passed that would raise it to 30 acres. Rep. Mercer stated that if the property is more than 15 or 30 acres, if changed to that, the trust indenture will not have any validity with respect to anyone.

Testifying Proponents and Who They Represent:

Michael Sherwood, Montana Trial Lawyers Assoc.

Proponent Testimony:

Michael Sherwood stated that this bill is good for small borrowers. He stated that there are statutes that would make this bill more clear, but the supreme court is confused about it. Mr. Sherwood feels that this bill does clear up the problem, and that it is designed to protect the residential borrower from foreclosure and deficiency judgments.

Testifying Opponents and Who They Represent:

Michael E. Mckee, President of 1st Federal Savings and Loan of Missoula, 2nd Vice President of Mt. Savings and Loan League, Dir. on Montana Board of Housing
George Bennett, Montana Bankers Assoc.
Chris Kafentzis, Dir. Federal Housing Administration
Bob Pyfer, Montana Credit Unions League

Opponent Testimony:

Michael Mckee stated that the Montana Board of Housing's special mission is to provide housing assistance for the needs of the low and moderate income families of the State of Montana. Mr. Mckee stated that he deals with the single family residential real estate mortgages in western Montana. HB 511 takes every piece of property which would be secured by a deed of trust instead of just residential property. He felt this is bad policy because a lender always looks to the borrowers capacity to repay the debt, e.g. money, assets, etc.. Mr. Mckee stated that this bill would place the criteria on the value of the property for the loan and the borrower could walk away without losing other assets if the payments could not be paid. This bill would hurt first time home buyers, currently they can get by with as little as 3 to 5 percent down payments. If the lender is going to look at the property as a deed of trust as a security, the first time home buyers will be looking at 20 to 30 percent or more down payments to protect the lender in case of default. Mr. Mckee urged the committee to do not pass HB 511.

George Bennett, representing the Montana Bankers Assoc., stated that the banks use mortgages and trust indentures. The choice that the legislature has with this bill is to go back twenty five years or uphold the deficiency judgement unless they can come up with something better. Mr. Bennett stated that there are two things wrong with this bill that the committee is considering: 1.) It reverses the Amsterdam case, which is a decision by Judge Sheehy, who said "even though the trust indenture covers more than the acreage allowed as between the borrower and the lender and makes the borrower pay back the loan"; and 2.) This bill defines a four-plex as residential, as one owner renting three units will be able to walk away from their debt.

Chris Kafentzis, Director of the Federal Housing Administration for the State of Montana stated that the federal government has become concerned over the number of deficiencies in the United States. Montana has a very depressed economy and the inventory in the state is now 550 homes. They are getting homes back at the rate 100 a month, and they are selling about 100 a month. The Dept. has determined that deficiency judgement should and will be sought under appropriate conditions. The four conditions include: 1.) Whether the mortgage ower has defaulted under one or more loans; 2.) The investor who defaults on one or more properties; 3.) Whether it is feasible under state law to seek a deficiency judgement; and 4.) The cost effectiveness factor such as the amount obtainable. Last year their insurance fund paid out $6 billion in claims, and they only collected $2 billion back. The government has become very concerned with this matter and would appreciate any help that the committee can give them.

Bob Pyfer, representing the Montana Credit Unions League stated that they have advised their credit unions to protect against deficiencies and to protect all the credit union owners. To do that they need to not finance too close to the full amount of the loan. His point is that there will be a definite incentive to benefit the consumer to finance closer to the full value of the property.

Neutral:

Bob Pancich of the Board of Investments stated that the Board currently has approximately $150 million in mortgages in Montana. Out of that $150 million there is approximately $46 million in commercial type mortgages. The way the bill reads on deficiencies, there could be some problems in going against the guarantor on any of those kinds of loans. The concerns are, this is not just a banking bill. This does affect the pension funds that the tax payers put money into.

Questions From Committee Members: Rep. Hannah questioned Mr. Kafentzis if he knew what percentage of residential real estate loans in the State of Montana are insured loans by either the FHA, the VA or the secondary market. Mr. Kafentzis estimated that about 40 - 50% are FHA, maybe 5 - 10% is VHA and the remainder secondary market.

Rep. Hannah asked Mr. Pancich if the majority of loans that they buy are insured loans. Mr. Pancich replied no, not presently. About 30% of their mortgage loans on the single family residents are now conventional loans.

Closing by Sponsor: In closing, Rep. Mercer commented that they need to keep things in perspective. When Montana trust indentures were authorized in 1962, in his viewpoint, there was a compromise struck. But since the time of the original compromise, the lenders have constantly chipped away and got more and more. That original compromise where each party gave up something, is now tipping in only one direction.

DISPOSITION OF HOUSE BILL 511

Motion: A DO PASS motion was made by Rep. Mercer, motion seconded by Rep. Hannah.

Discussion: Rep. Hannah stated that he feels there is an important distinction at hand. His experience in the real estate business has been that there has not been a significant increase in rates, fees or in getting loans. Additionally, the majority of the loans that are out there that are bought by the secondary market have a tremendous equity position and the people that are actually at risk are the people from FHA and not the Montana lender. The one that is at risk are the ones covered under this bill. This is a good bill and it restores the law as it was written under the small tract financing act.

Amendments, Discussion, and Votes: Rep. Mercer moved to insert an applicability clause into the bill that states it applies to trust indentures entered into after the date this act becomes effective. Motion seconded by Rep. Addy.

A vote was taken on the suggested amendment and CARRIED unanimously.

Recommendation and Vote: Rep. Mercer moved HB 511 DO PASS AS AMENDED, motion seconded by Rep. Hannah. Motion CARRIED unanimously.

HEARING ON HOUSE BILL 716

Presentation and Opening Statement by Sponsor:

Rep. Fred Thomas, House District 62 stated that this bill would set up the county of Ravalli as a separate judicial district in 1993. The procedure would be to move one of the four judges in the Missoula district into the new district of Ravalli. It is designed to enhance their court system in Ravalli County as well as enhance the service and the availability of their court. They would additionally like to control their own costs. In justifying this want, Ravalli County is 24% of the population of the current district, it is a growth area, it compromises 3% of the state's population, and 3% of all court filings come from Ravalli County. Rep. Thomas commented that he has one minor amendment for the committee's consideration on page 1, line 15, delete "20 judicial districts", insert 21 judicial districts. He believes the citizens of Ravalli would greatly benefit from the passage of this bill and urged the committee's support.

Testifying Proponents and Who They Represent:

Steve Powell, County Commissioner of Ravalli County

Proponent Testimony:

Steve Powell stood in support of HB 716 and commented that it would be a definite advantage for the populous in the prosecution of criminals in the county. He submitted a letter from John Robinson, Ravalli County Attorney to be entered into the record (EXHIBIT 18).

Testifying Opponents and Who They Represent:

None.

Opponent Testimony:

None.

Questions From Committee Members: Rep. Brown questioned Rep. Thomas if there would be any additional cost in this measure. Rep. Thomas stated that it is his opinion that there would be no additional cost. They may, in fact, save some money and be able to concentrate that money on the services that they want their court to provide.

Rep. Eudaily asked what percent of the cases in the fourth judicial district are in Ravalli County. Rep. Thomas responded that he believes that they are about 18% for 1988.

Closing by Sponsor: Rep. Thomas closed.

DISPOSITION OF HOUSE BILL 716

Motion: Rep. Boharski moved HB 716 DO PASS, motion seconded by Rep. Wyatt.

Discussion: Rep. Gould stated that they are also going to have to have a clerk of the court, etc. Their percentages as far as the cases go were not an outstanding number and it will put an additional burden on the other three judges in the fourth judicial district.

Rep. Mercer commented that Lake County use to be part of the fourth judicial district and it is the single most greatest thing that ever happened to Lake and Sanders County to have its own judge. If there is any way to get Ravalli County a judge it will make a great difference to them.

Rep. Eudaily asked if they would in any way be jeopardizing the bill if instead of taking one of the judges away from Missoula County to just get an additional judge for Ravalli County.

Amendments, Discussion, and Votes: None.

Recommendation and Vote: Rep. Daily moved to TABLE HB 716, motion seconded by Rep. Hannah. A voice vote was taken and CARRIED with Rep.'s Stickney, Rice, Mercer, and Boharski voting against the motion.

HEARING ON HOUSE BILL 659

Presentation and Opening Statement by Sponsor:

Rep. Whalen requested the committee to TABLE HB 659 when considering executive action.

Testifying Proponents and Who They Represent:

None.

Proponent Testimony:

None.

Testifying Opponents and Who They Represent:

None.

Opponent Testimony:

None.

Questions From Committee Members: None.

Closing by Sponsor: Rep. Whalen closed.

DISPOSITION OF HOUSE BILL 659

Motion: A motion was made by Rep. Gould to TABLE HB 659, motion seconded by Rep. Nelson.

Discussion: None.

Amendments, Discussion, and Votes: None.

Recommendation and Vote: A vote was taken on the motion to TABLE and CARRIED unanimously.

DISPOSITION OF HOUSE BILL 592

Motion: Rep. Addy moved HB 592 DO PASS, motion seconded by Rep. McDonough.

Discussion: None.

Amendments, Discussion, and Votes: Rep. Darko moved to amend the title and page 2, lines 21-24 (EXHIBIT 19), motion seconded by Rep. Addy.

A vote was taken on the amendment and CARRIED with Rep. Hannah voting against the amendment.

Rep. Rice moved to amend page 1, line 16, change "must" to may, line 20, following "crime", insert . and delete the remainder of the paragraph. Motion seconded by Rep. Stickney.

A vote was taken on the amendment proposed by Rep. Rice and CARRIED unanimously.

Recommendation and Vote: Rep. Darko made a DO PASS AS AMENDED motion, seconded by Rep. Stickney. A vote was taken and CARRIED with Rep. Hannah voting No.

DISPOSITION OF HOUSE BILL 668

Motion: A DO PASS motion was made by Rep. McDonough, motion seconded by Rep. Wyatt.

Discussion: None.

Amendments, Discussion, and Votes: Rep. McDonough moved proposed amendments (EXHIBIT 20), motion seconded by Rep. Nelson.

A vote was taken on Rep. McDonough's amendments and CARRIED unanimously.

Recommendation and Vote: Rep. McDonough moved HB 668 DO PASS AS AMENDED, motion seconded by Rep. Wyatt. Motion CARRIED with Rep. Hannah voting No.

DISPOSITION OF HOUSE BILL 582

Motion: A DO PASS motion was made by Rep. Eudaily, motion seconded by Rep. Darko.

Discussion: None.

Amendments, Discussion, and Votes: Rep. Eudaily moved proposed amendments (EXHIBIT 21), motion seconded by Rep. Gould.

A vote was taken on the proposed amendments and CARRIED unanimously.

Rep. Daily stated that he thinks this is a noble idea; however, his concern is that most people and families now days have multiple cars. From all of the testimony that the committee has heard on drunk driving, the problem is not with the first time offender, but with the second and third. Rep. Daily commented that he doesn't feel that they are solving any problems with this bill, they are just adding something that isn't going to be effective. If they are really serious about passing this bill, they should make it apply only to those second or third time offenders, not the first time offense. They need to remember that different judges behave in different ways, and different judges sentence differently as well.

Rep. Eudaily, in response to Rep. Daily's concern stated that a study was done in California for 15 months after they started using the inter-lock devise. They found that for those not ordered to put on the ignition devise, they had 20% reoccurrence of people convicted of DUI's. For those that were using the ignition devise, there was a 2% reoccurrence of convictions for DUI's. That tells him that it is about 10 times more effective than if they let them go on a probationary license.

Rep. Daily commented that Rep. Eudaily's statistics confirm his last statement. If 2% are out there driving, that means it doesn't work. If it was zero, then they could say that it was effective.

Recommendation and Vote: Rep. Eudaily moved HB 582 DO PASS AS AMENDED, motion seconded by Rep. Gould. Motion CARRIED with Rep.'s Hannah, Nelson, Aafedt, Daily and Boharski voting against the motion.

DISPOSITION OF HOUSE BILL 621

Motion: Rep. Wyatt moved HB 621 DO PASS, motion seconded by Rep. Knapp.

Discussion: None.

Amendments, Discussion, and Votes: Rep. Wyatt motioned to adopt proposed amendments (EXHIBIT 22), motion seconded by Rep. Knapp.

A vote was taken on the amendment and CARRIED unanimously.

Recommendation and Vote: Rep. Wyatt moved HB 621 DO PASS AS AMENDED, motion seconded by Rep. Knapp. A vote was taken and CARRIED with a unanimous vote.

DISPOSITION OF HOUSE BILL 528

Motion: A DO PASS motion was made by Rep. Boharski, motion seconded by Rep. McDonough.

Discussion: None.

Amendments, Discussion, and Votes: Rep. Boharski moved proposed amendments (EXHIBIT 23), motion seconded by Rep. McDonough.

Rep. Daily stated that what they are doing is raising insurance rates by 10 to 14% for judges who are the lowest paid in the U.S., for professors at the University of Montana who are the lowest paid professors in the U.S., as well as for state employees who haven't been given a raise for at least 2 years.

Recommendation and Vote: Rep. Daily made a substitute motion to TABLE HB 528, motion seconded by Rep. Eudaily. A vote was taken and CARRIED with Rep.'s Boharski, Addy, and Brown voting No.

Rep. Boharski moved to reconsider action taken on HB 528, motion seconded by Rep. Hannah. Motion FAILED with Rep.'s Gould, Hannah, and Boharski voting in favor of the motion.

DISPOSITION OF HOUSE BILL 291

Motion: A DO PASS motion was made by Rep. Addy, motion seconded by Rep. Hannah.

Discussion: None.

Amendments, Discussion, and Votes: Rep. Hannah moved to amend page 2, line 4, strike "(a)". Page 2, delete lines 17-24. Motion seconded by Rep. Darko.

A vote was taken on the amendments and CARRIED unanimously.

Recommendation and Vote: Rep. Darko moved HB 291 DO PASS AS AMENDED, motion seconded by Rep. Hannah. A vote was taken and CARRIED unanimously.

ADJOURNMENT

Adjournment At: 1:00 p.m.

REP. DAVE BROWN, Chairman

DB/je

4108.min

DAILY ROLL CALL

JUDICIARY COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date FEB. 17, 1989

NAME	PRESENT	ABSENT	EXCUSED
REP. KELLY ADDY, VICE-CHAIRMAN	X		
REP. OLE AAFEDT	X		
REP. WILLIAM BOHARSKI	X		
REP. VIVIAN BROOKE	X		
REP. FRITZ DAILY	X		
REP. PAULA DARKO	X		
REP. RALPH EUDAILY	X		
REP. BUDD GOULD	X		
REP. TOM HANNAH	X		
REP. ROGER KNAPP	X		
REP. MARY McDONOUGH	X		
REP. JOHN MERCER	X		
REP. LINDA NELSON	X		
REP. JIM RICE	X		
REP. JESSICA STICKNEY	X		
REP. BILL STRIZICH	X		
REP. DIANA WYATT	X		
REP. DAVE BROWN, CHAIRMAN	X		

2-17-89

The Big Sky Country

MONTANA HOUSE OF REPRESENTATIVES

REPRESENTATIVE DAVE BROWN
HOUSE DISTRICT 72

HELENA ADDRESS:
CAPITOL STATION
HELENA, MONTANA 59620

HOME ADDRESS:
3040 OTTAWA
BUTTE, MONTANA 59701
PHONE: (406) 782-3604

COMMITTEES:
JUDICIARY, CHAIRMAN
LOCAL GOVERNMENT
RULES

TO: John Vincent, Speaker of the House

FROM: Dave Brown, Chairman, House Judiciary Committee

DATE: Feb. 17, 1989

SUBJECT: House Bill's 587, 528, 659, 716

The House Judiciary Committee has TABLED HB's 587, 528, 659, 716 on Feb. 17.

DB/je

STANDING COMMITTEE REPORT

February 17, 1989

Mr. Speaker: We, the committee on Judiciary report that HOUSE BILL 511 (first reading copy -- white) do pass as amended .

Signed: _____
Dave Brown, Chairman

And, that such amendments read:

1. Title, line 11.
Following: "RECORDED;"
Insert: "PROVIDING AN APPLICABILITY DATE;"

2. Page 4.
Following: line 18
Insert: "NEW SECTION. Section 4. Applicability. [This act] applies to trust indentures entered into on or after the effective date of [this act]."

STANDING COMMITTEE REPORT

February 17, 1989

Mr. Speaker: We, the committee on Judiciary report that HOUSE BILL 592 (first reading copy -- white) do pass as amended .

Signed: _____
Dave Brown, Chairman

And, that such amendments read:

1. Title, lines 8 through 10.
Strike: "PROHIBITING" on line 8 through "PAID" on line 10
Insert: "PROVIDING FOR A TAX LIEN AGAINST FIRE INSURANCE PROCEEDS"

2. Page 1, line 16.
Strike: "must"
Insert: "may"

3. Page 1, lines 20 through 22.
Strike: ", unless" on line 20 through "future" on line 22

4. Page 2, lines 21 through 24.
Strike: "Fire" on line 21 through end of line 24
Insert: "Tax lien on insured property destroyed by fire. If taxes are due and unpaid on property covered by fire insurance and damaged or destroyed by fire, the government entity owed the taxes has a lien on fire insurance proceeds paid in relation to that property in the amount of the unpaid taxes."

STANDING COMMITTEE REPORT

February 17, 1989

Mr. Speaker: We, the committee on Judiciary report that HOUSE BILL 668 (first reading copy -- white) do pass as amended .

Signed: _____
Dave Brown, Chairman

And, that such amendments read:

1. Page 2, line 4.
Following: "disease."
Insert: "The term does not include vital statistics information gathered under Title 50, chapter 15."

2. Page 2, line 24.
Strike: "15"
Following: "17"
Strike: ","

3. Page 3, line 21.
Strike: "again"
Insert: "by the person or entity it is released to"

4. Page 4, line 9.
Following: "who"
Insert: "knowingly"

STANDING COMMITTEE REPORT

February 17, 1989

Mr. Speaker: We, the committee on Judiciary report that HOUSE BILL 582 (first reading copy -- white), with statement of intent included, do pass as amended .

Signed: _____
Dave Brown, Chairman

And, that such amendments read:

1. Title, line 13.
Following: ";"
Strike: "AND"

2. Title, line 15.
Following: "MCA"
Insert: "; AND PROVIDING EFFECTIVE DATES"

3. Page 4, line 3.
Following: "restriction"
Strike: ", which"

4. Page 4, line 4.
Following: "2"
Strike: remainder of line 4 through "conviction" on line 7

5. Page 4, line 22.
Following: "."
Strike: remainder of line 22 through "." on line 24

6. Page 6, line 23.
Following: "restriction"
Strike: ", which"

7. Page 6, line 24.
Following: "2"
Strike: remainder of line 24 through "conviction" on page 7, line 2

8. Page 7, line 17.
Following: "."
Strike: remainder of line 17 through "." on line 19

9. Page 16, line 3.
Following: line 2
Insert: "NEW SECTION. Section 10. Effective dates.
(1) [Sections 8 and 9] and this section are effective on passage and approval.
(2) [Sections 1 through 7] are effective July 1, 1990."

STANDING COMMITTEE REPORT

February 17, 1989

Mr. Speaker: We, the committee on Judiciary report that HOUSE BILL 621 (first reading copy -- white) do pass as amended .

Signed: _____
Dave Brown, Chairman

And, that such amendment read:

1 Page 2, line 19.
Following: "~~provider or~~"
Insert: "including an agent or employee of the health care provider or"

STANDING COMMITTEE REPORT

February 17, 1989

Mr. Speaker: We, the committee on Judiciary report that HOUSE BILL 291 (first reading copy -- white) do pass as amended .

Signed: _____
Dave Brown, Chairman

And, that such amendments read:

1. Page 2, line 4.
Strike: "(a)"

2. Page 2, lines 17 through 24.
Strike: lines 17 through 24

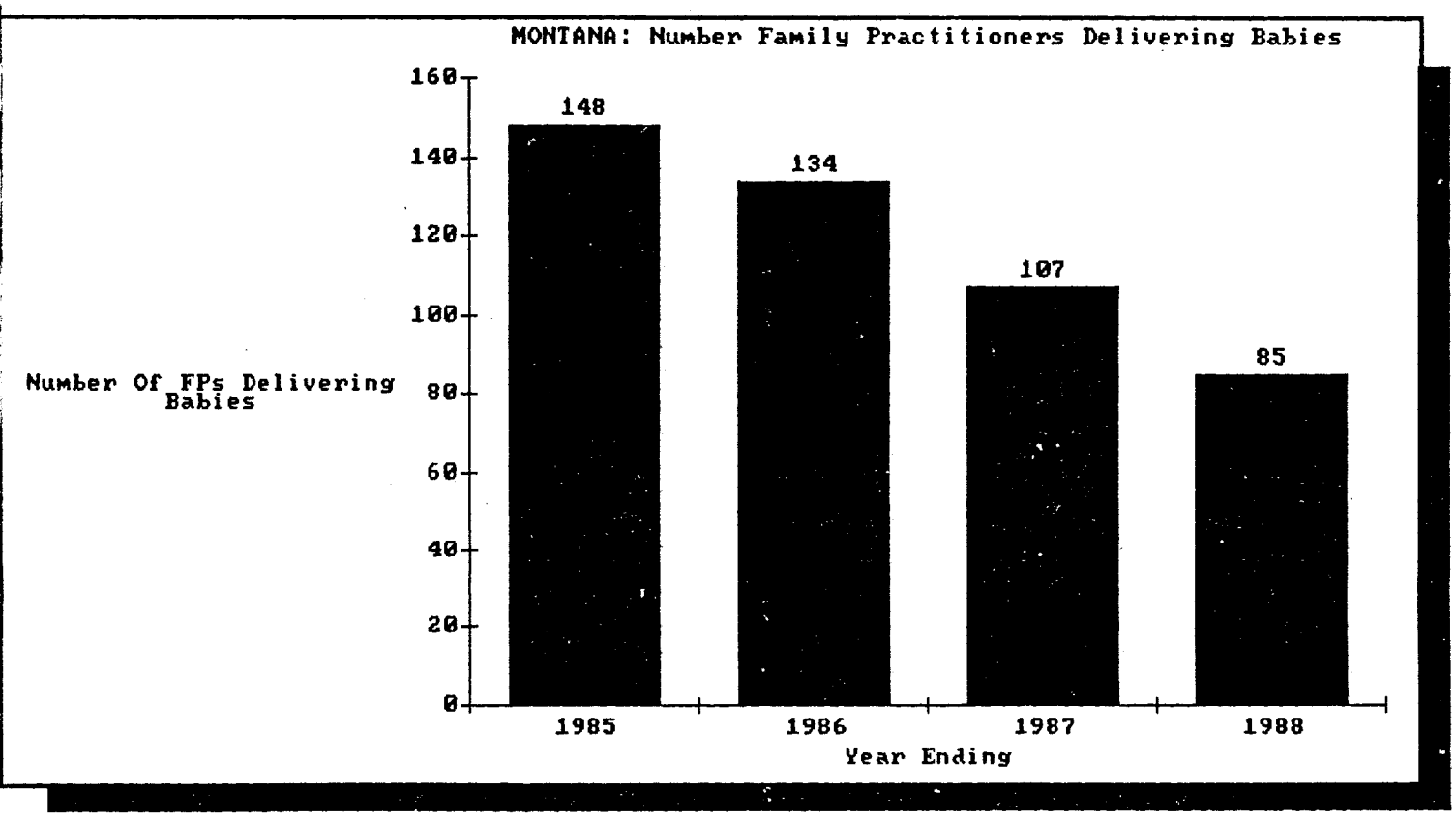
THE LOSS OF FAMILY PRACTICE OBSTETRICAL SERVICES IN MONTANA

MONTANA OBGYN

Number Of Family Practitioners Delivering Babies: Urban And Rural Montana, Year-End 1985 Through Year-End 1988

	1985	1986	1987	1988	Percentage Change '85 - '88
URBAN	51	45	37	30	- 41.2 %
RURAL	97	89	70	55	- 43.3 %
TOTAL	148	134	107	85	- 42.6 %

Rural Montana Excludes: Helena, Bozeman, Butte, Billings, Great Falls, Missoula & Kalispell. Academy Of Family Practice Survey & Montana Medical Association Supplemental Survey.



URBAN MONTANA

Montana Family Practice Physicians Doing Obstetrics: 1987 -1988

Academy Of Family Practice Survey - Dr. Paul Donaldson

Montana Medical Association Supplemental Survey

MONTANA OBGYN

End Of Year	Number Physicians Delivering Babies	Percentage Change
1987	37	--
1988	30	- 18.92 %

URBAN MONTANA

End 1987 NUMBER	End 1988 NUMBER	NAME	Delivered Babies At End Of 1987	1988	CITY
1	1	Gilboy G	Yes	Yes	Butte
2		Graham G	Yes	No	Great Falls
3		Juergens A	Yes	No	Great Falls
4	2	Nelson ROC	Yes	Yes	Great Falls
5		Ross J	Yes	No	Great Falls
	3	Miller	No	Yes	Great Falls
6	4	Johnson M	Yes	Yes	Great Falls From Choteau
7	5	Weitz B	Yes	Yes	Billings
8	6	Tisdale	Yes	Yes	Billings
9	7	Girolami	Yes	Yes	Billings
10	8	Gromko W	Yes	Yes	Missoula
11	9	Hubbard D	Yes	Yes	Missoula
12	10	Marks R	Yes	Yes	Missoula
13	11	Nevin D	Yes	Yes	Missoula
14		Thompson D	Yes	No	Missoula
15	12	Burkholder J	Yes	Yes	Helena
16	13	Crichton J	Yes	Yes	Helena
17	14	Donaldson P	Yes	Yes	Helena
18	15	Goodwin R	Yes	Yes	Helena
19	16	Maher J	Yes	Yes	Helena
20		Norris T	Yes	No	Helena
21	17	Shepard R	Yes	Yes	Helena
22	18	Strekall M	Yes	Yes	Helena
23	19	Werner K	Yes	Yes	Helena
24	20	Whitesitt R	Yes	Yes	Helena
25	21	Batey W	No	Yes	Helena From Hardin
26	22	Center D	Yes	Yes	Bozeman
27		Cunningham JM	Yes	No	Bozeman
28	23	Hildner T	Yes	Yes	Bozeman
29		Kurtz C	Yes	No	Bozeman
30	24	Patterson J	Yes	Yes	Bozeman
31	25	Novick T	Yes	Yes	Bozeman
32	26	Ramsey L	Yes	Yes	Bozeman
33	27	Armstrong J	Yes	Yes	Kalispell
34	28	Lavin J	Yes	Yes	Kalispell
35		Palchak A	Yes	No	Kalispell
36	29	Oehrtman P	Yes	Yes	Kalispell
37	30	Malnar S	Yes	Yes	Kalispell

RURAL MONTANA

Montana Family Practice Physicians Doing Obstetrics: 1987 -1988

Academy Of Family Practice Survey - Dr. Paul Donaldson

Montana Medical Association Supplemental Survey

MONTANA OBGYN

End Of Year	Number Physicians Delivering Babies	Percentage Change
1987	70	--
1988	55	- 21.0 %

RURAL MONTANA

End 1987 NUMBER	End 1988 NUMBER	NAME	Delivered Babies At End Of 1987	1988	CITY	Number Left
1		Batey W	Yes	No	Hardin To Helena	
2	1	Ostahowski G	Yes	Yes	Hardin	
3	2	Whiting R	Yes	Yes	Hardin	2
4	3	Ashcraft J	Yes	Yes	Sidney	
5	4	St John R	Yes	Yes	Sidney	2
6	5	Ashcraft W	Yes	Yes	Hamilton	
7	6	Stewart R	Yes	Yes	Hamilton	2
8	7	Genich M	Yes	Yes	Ronan	
	8	Dempses J	No	Yes	Ronan	2
9	9	Beever C	Yes	Yes	Dillon	
10		Hunt K	Yes	No	Dillon	
11	10	Thomas R	Yes	Yes	Dillon	2
12	11	Bell G	Yes	Yes	Glasgow	
13		Dean P	Yes	No	Glasgow	1
14		Book E	Yes	No	Townsend	0
15		Coriell E	Yes	No	Polson	0
16	12	Bennett A	Yes	Yes	Chester	
17	13	Buker G	Yes	Yes	Chester	2
18	14	Berberet S	Yes	Yes	Lewistown	
19		Thompson F	Yes	No	Lewistown	1
20	15	McLaughlin D	Yes	Yes	Red Lodge	1
21	16	Kelley J	Yes	Yes	Havre	
22	17	Nolan M	Yes	Yes	Havre	
23	18	Richardson B	Yes	Yes	Havre	
24	19	Booth T	Yes	Yes	Havre	4
25	20	Bosshardt D	Yes	Yes	Whitefish	
26	21	Johnson J	Yes	Yes	Whitefish	
27	22	Miller R	Yes	Yes	Whitefish	
28	23	Miller W	Yes	Yes	Whitefish	
29	24	Fowler R	Yes	Yes	Whitefish	5
30	25	Miller J	Yes	Yes	Columbia Falls	
31		Pitman D	Yes	No	Columbia Falls	
32	26	Hannon R	Yes	Yes	Columbia Falls	
33		Hope	Yes	No	Columbia Falls	2

(OVER)

RURAL MONTANA

End 1987 NUMBER	End 1988 NUMBER	NAME	Delivered Babies At End Of 1987	Delivered Babies At End Of 1988	CITY	Number Left
34	27	Bunt C	Yes	Yes	Poplar	
35	28	Deutsch J	Yes	Yes	Poplar	
36	29	Holmes C	Yes	Yes	Poplar	
37	30	Holmes W	Yes	Yes	Poplar	
38	31	Nicholson C	Yes	Yes	Poplar	5
39	32	Caparoso B	Yes	Yes	Sheridan	
40	33	Googe S	Yes	Yes	Sheridan	2
41	34	Harkness J	Yes	Yes	Glendive	
42	35	Martin I	Yes	Yes	Glendive	
43	36	Thorne R	Yes	Yes	Glendive	3
44	37	Stanchfiled R	Yes	Yes	Shelby	1
45	38	Nielsen C	Yes	Yes	Wolf Point	1
46		Crawford J	Yes	No	Harlem	0
47	39	Exley J	Yes	Yes	Absarokee	1
48	40	Fitz M	Yes	Yes	Scobey	1
49	41	Odegaard R	Yes	Yes	Browning	1
50		Hufman S	Yes	No	Libby	
51	42	Rice G	Yes	Yes	Libby	
52	43	Gurther G	Yes	Yes	Libby	2
53	44	Jackson R	Yes	Yes	Big Timber	
54		Walker W	Yes	No	Big Timber	1
55		Johnson MA	Yes	No	Choteau To GF	0
56	45	King D	Yes	Yes	Belgrade	1
57	46	Kuntzweiler D	Yes	Yes	Boulder	1
58	47	Segnitz R	Yes	Yes	Culbertson	1
59	48	Meyer J	Yes	Yes	Conrad	
60		Vargo P	Yes	No	Conrad	
61	49	Robertson C	Yes	Yes	Conrad	2
61		Michels F	Yes	No	Harlowton	
62		Shiotani G	Yes	No	Harlowton	0
63		Miles M	Yes	No	Ennis	0
64	50	VanNice R	Yes	Yes	Laurel	1
65		Smith S	Yes	No	Superior	0
66	51	Davis V	Yes	Yes	St. Ignatius	1
67	52	Espeland D	Yes	Yes	Baker	1
68	53	Neteboum D	Yes	Yes	Livingston	1
69	54	Stoner G	Yes	Yes	Plentywood	1
70	55	Wendell T	Yes	Yes	Deer Lodge	1

All Montana: Remaining Obstetrical Services At End of 1988

MONTANA OBGYN

All Montana: Remaining Obstetrical Services At End of 1988

	Family Practice With Obstetrics	Obstetricians Gynecologists	Total
Urban	30	51	81
Rural	55	12	67
TOTAL	85	63	148

City	Number Of Practitioners Delivering Babies: Obstetricians	Family Practice	Total
1. Great Falls	8	3	11
2. Helena	4	10	14
3. Missoula	13	4	17
4. Bozeman	5	5	10
5. Butte	3	0	3
6. Billings	11	3	13
7. Kalispell	8	4	12
8. Whitefish	1	5	6
9. Miles City	2	0	2
10. Havre	1	4	5
11. Glasgow	1	1	2
13. Livingston	0	1	1
14. Hamilton	1	2	3
15. Polson	1	0	1
16. Forsyth	1	0	1
17. Sidney	1	2	3
18. Circle	2	0	2
19. Hardin	0	2	2
20. Ronan	0	2	2
21. Dillon	0	2	2
22. Glasgow	0	1	1
23. Chester	0	2	2
24. Lewistown	0	1	1
25. Red Lodge	0	1	1

(OVER)

26. Columbia Falls	0	2	2
27. Poplar	0	5	5
28. Sheridan	0	2	2
29. Wolf Point	0	1	1
30. Shelby	0	1	1
31. Absarokee	0	1	1
32. Scoby	0	1	1
33. Browning	0	1	1
34. Libby	0	2	2
35. Big Timber	0	1	1
36. Belgrade	0	1	1
37. Boulder	0	1	1
38. Culbertson	0	1	1
39. Conrad	0	2	2
40. Laurel	0	1	1
41. St. Ignatius	0	1	1
42. Baker	0	1	1
43. Plentywood	0	1	1
44. Deer Lodge	0	1	1
45. Glendive	0	3	3

MONTANA OBGYN

THE COST OF MEDICAL MALPRACTICE INSURANCE EXCEEDING THE INCOME FROM THE DELIVERY OF BABIES

Montana OBGYN

Number of 1987 Deliveries By Number Of Family Practitioners In Rural Areas

Volume Of Deliveries	Number Physicians Doing Volume	Cumulative Number Of Physicians
1 - 5	3	3
6 - 10	8	11
11 - 15	6	17
16 - 20	12	29
21 - 25	3	32
26 - 30	3	37

Academy Of Family Practice Survey, 1988. Dr. Paul Donaldson, Helena. Exclusive Of 7 Major Montana Cities & Higher Volumes In Rural Areas

MONTANA OBGYN "Tail" To Buy

Income From Deliveries Less OBGYN Portion Of Insurance (Exclusive Of Other Insurance, Expenses Or Taxes On Income) 1989 - 1993 - Average Family Practitioner Doing Obstetrics - $ 1 Million/ $ 3 Million Coverage

Number Of Deliveries	Annual Income From Deliveries	Annual OBGYN Part Of Insurance	Annual Net Before Other Insur, Exp. & Tax
10	$ 8,163	$ 21,270	$ - 13,107
20	$ 16,326	$ 21,270	$ - 4,944
30	$ 24,490	$ 21,270	$ 3,220
40	$ 32,653	$ 21,270	$ 11,383
50	$ 40,816	$ 21,270	$ 19,546

(Over)

Montana Carrier Rates

FAMILY PRACTICE WITH OBG AND OBGYN

Changes In Major Commercial Carrier Rates - Montana 1982 - 1989

Occurrence And Claims-Made With "Tail" Endorsement (Occurrence Equivalent) - $ 1 Million /$ 3 Million Coverage - Annual Prem. Plus One-Time Cost Of After-Reported Claims

Year	Company	Family Practice With Obstetrics	Obstetrics OBGYN
1982	AETNA	$ 5,907	$ 11,551
1989	ST. PAUL	$ 28,050	$ 110,449
	UMIA	$ 26,241	$ 54,772
	DOCTORS CO	$ 37,584	$ 70,270
	ICA	$ 26,022	$ 91,080

Primary Rate x "Tail" Factor = Total Cost. Various "Tail" Factors Are: St Paul, 1.65, UMIA 1.30, Doctors Co, 1.80, ICA 2.00.

MONTANA OBGYN

Montana Medical Liability Insurance Rates - Family Practice With Obstetrics - No 'Tail' Costs - 1989 Thru 1993 - $ 1 Million $ 3 Million

	CARRIER			
YEAR	St Paul	UMIA	Doctors Co	ICA
1989	$17,000	$20,185	$20,880	$13,011
1990	$19,380	$23,011	$23,803	$14,833
1991	$22,093	$26,232	$27,136	$16,909
1992	$25,186	$29,905	$30,935	$19,276
1993	$28,712	$34,092	$35,265	$21,975

MONTANA OBGYN

Montana Medical Liability Insurance Rates - Family Practice With Obstetrics - No 'Tail' Costs - 1987 Thru First Quarter 1989 - $ 1 Million/$ 3 Million

	CARRIER				
YEAR	St Paul	UMIA	Doctors Co	ICA	Average
1987	$16,164	$12,646	$17,748	$12,392	$ 14,738
1988	$17,000	$21,475	$20,880	$13,011	$ 18,092
1Q 1989	$17,000	$20,185	$20,880	$13,011	$ 17,769

1989 Rates Announced Only For UMIA and Doctors Co. Other Carriers Make 1989 Rate Announcements At Later Date.

Montana Physicians Involved In OBGYN Claims

MONTANA OB/GYN CLAIMS, 1977 - 1988

Total Physicians Involved In OB/GYN Claims: Rate Of Change In Filings

Period	Number Of Phys W/ Claims	Annual Average # Phys	Percent Increase
1977-1980	13	3.25	-- %
1981-1984	74	18.50	469 %
1985-1988	122	30.50	65 %
Number Physicians With Claims	209		

Records Of The Montana Medical Legal Panel. OB/GYN Claims (Allegations Only) Involving Family Practitioners and Obstetricians. Includes Physicians From Other Specialties Involved In OB/GYN Claims.

MONTANA OB/GYN CLAIMS, 1977 - 1988

REPEATER PHYSICIANS: Physicians Still In Practice Where An Expert Panel Found An Indication Of Negligence (Averse Claim)

ONE OR MORE CLAIMS Where Indication Of Physician Negligence	Number Of Different Physicians	Number Of Physicians Not Now In Practice	Number Of Physicians Still In Practice
Zero Adverse Claims	102	23	79
One Adverse Claim	34	8	26
Two Adverse Claims	4	4	0
Three Or More Adverse Claims	0	0	0
	140	35	105

Source: Records Of Montana Medical-Legal Panel, Closed Claims From 1977 - 1988. Thirty-Seven physicians who were delivering babies in 1988 have not had any claims.

MONTANA OB/GYN CLAIMS, 1977 - 1988

FAMILY PRACTICE PHYSICIANS WITH CLAIMS AGAINST THEM - OB/GYN AND NON-OB/GYN CLAIMS

Percentage Change In Number Of Claims Filed Using Four-Year Averages

Period	Number Of Physicians	Average Per Year	Percentage Change
1977-1980	21	5.25	-- %
1981-1984	95	23.75	352.4 %
1985-1988	107	26.75	12.6 %
Total	223		

Records Of The Montana Medical Legal Panel. OB/GYN Claims (Allegations Only) Involving Family Practitioners and Obstetricians. Excludes Physicians From Other Specialties Involved In OB/GYN Claims.

MONTANA OB/GYN CLAIMS, 1977 - 1988

OB/GYN PHYSICIANS WITH CLAIMS AGAINST THEM - OB/GYN AND NON-OB/GYN CLAIMS -

Percentage Change In Number Of Claims Filed Using Four-Year Averages

Period	Number Of Physicians	Average Per Year	Percentage Change
1977-1980	7	1.75	-- %
1981-1984	38	9.50	443 %
1985-1988	69	17.25	82 %
Total	114		

Records Of The Montana Medical Legal Panel. OB/GYN Claims (Allegations Only) Involving Family Practitioners and Obstetricians. Excludes Physicians From Other Specialties Involved In OB/GYN Claims.

MONTANA OBGYN

Montana Hospitals Involved In OBGYN Claims

Montana Medical Legal Panel

OBGYN CLAIMS: Number Of Claims Filed Against Hospitals - Four Year Increments

Years	Total Number Hospitals In OBGYN Claims
1977 - 1980	3
1981 - 1984	23
1985 - 1988	34
TOTAL	60

Records of Montana Medical Legal Panel

Montana Medical Legal Panel

RATE OF NEGLIGENCE: OBGYN CLAIMS: Percentage Of Claims Filed Against Hospitals Where Experts Found There To Be Some Indication Of Negligence - Four Year Increments

Years	POTENTIAL NEGLIGENCE RATE % Claims Adverse To Hospitals In OBGYN Claims
1977 - 1980	50%
1981 - 1984	20%
1985 - 1988	19%

Records of Montana Medical Legal Panel - Closed Claims Only.

Montana Medical Legal Panel

OBGYN CLAIMS: Number Of Different Hospitals Involved In Claims

Number Times In OBGYN Claim	Number Different Hospitals
Once	11
Twice	3
Three Times	4
Four Times	3
Five Times	0
Six Times	0
Seven Times	1
Eight Times	0
Nine Times	1
	23

Records of Montana Medical Legal Panel. Open Claims Without Regard To Disposition Of Claim

1987 Hospital Association Survey - Summary Of Results

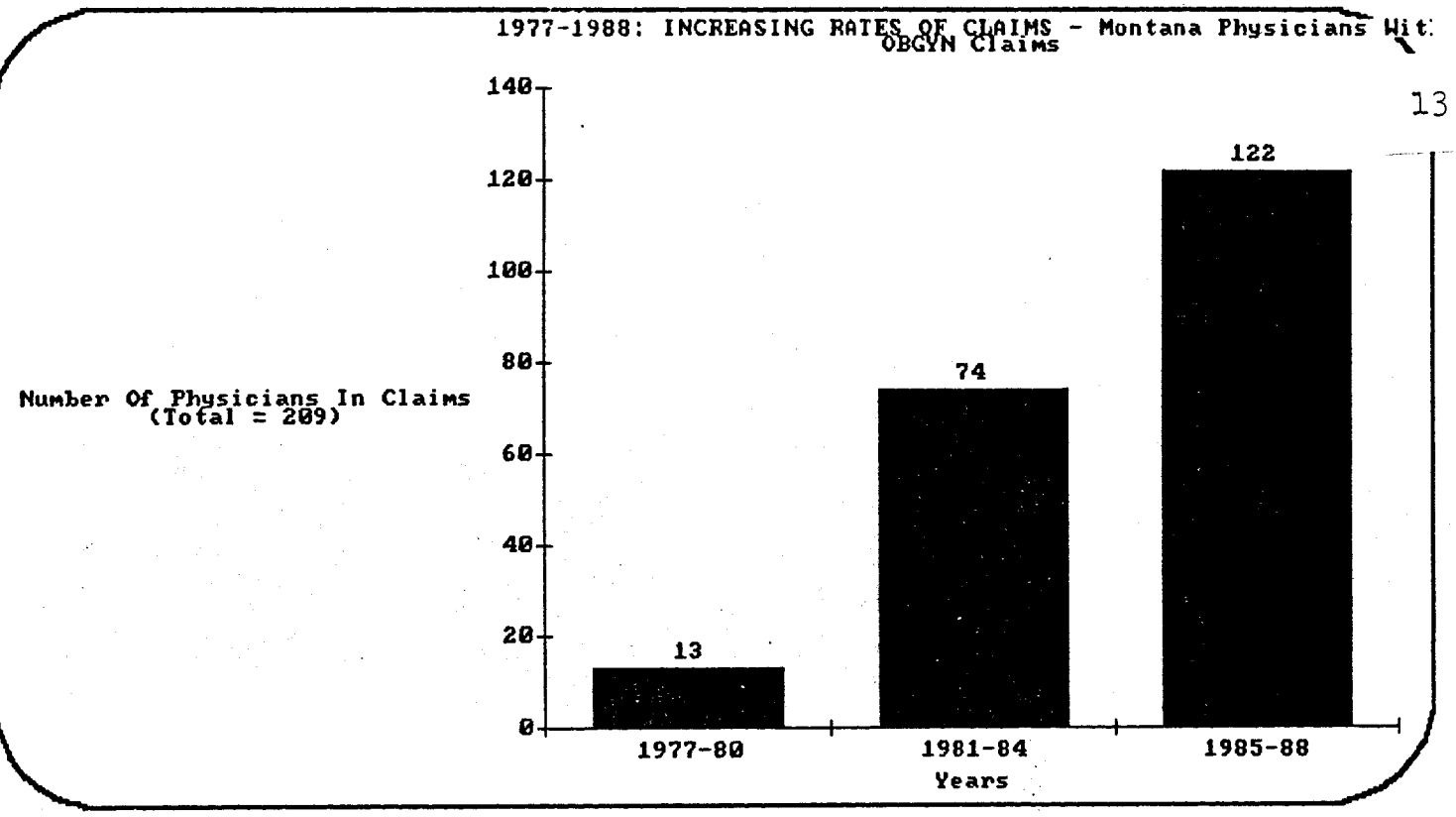
EXTENSIVE TERMINATION OF OBSTETRICAL SERVICES. Over one-half of physicians performing obstetrical services in the responding hospitals in 1986 recently terminated their obstetrical services or have indicated tha they intend to soon do so.

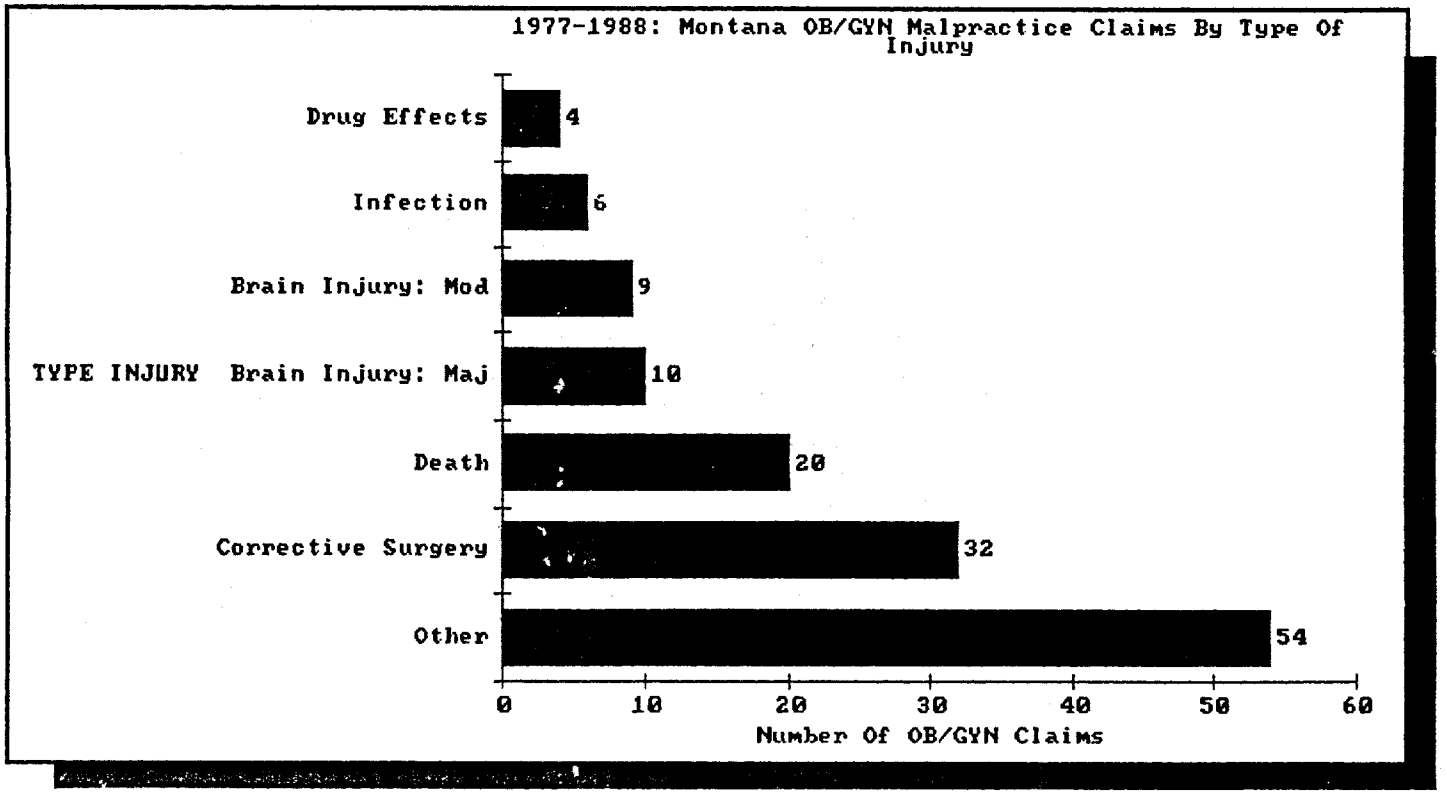
FUTURE PROSPECTS FOR HOSPITALS. An added 24% of hospitals providing obstetrical services will not have any remaining physicians to do obstetrical services if physicians continue to stop obstetrical services at the rate they have indicated.

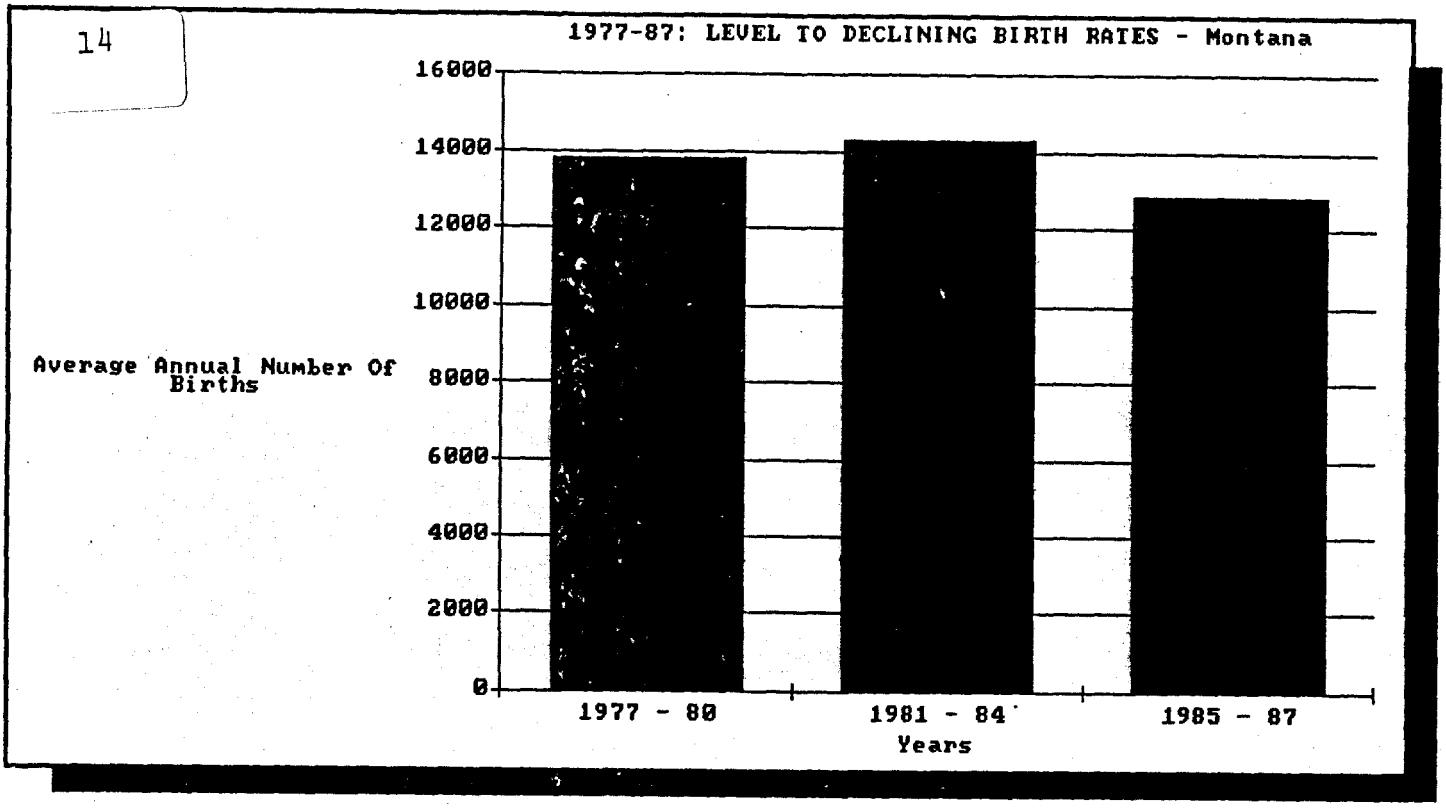
A total of 49% of the responding hospitals who provided obstetrical services at the time of the survey indicated that "YES" they might close o sharply curtail their operations if they had their ability to provided obstetrical services curtailed and if they lost revenue from their obstetrical units, nursery and pediatrics area.

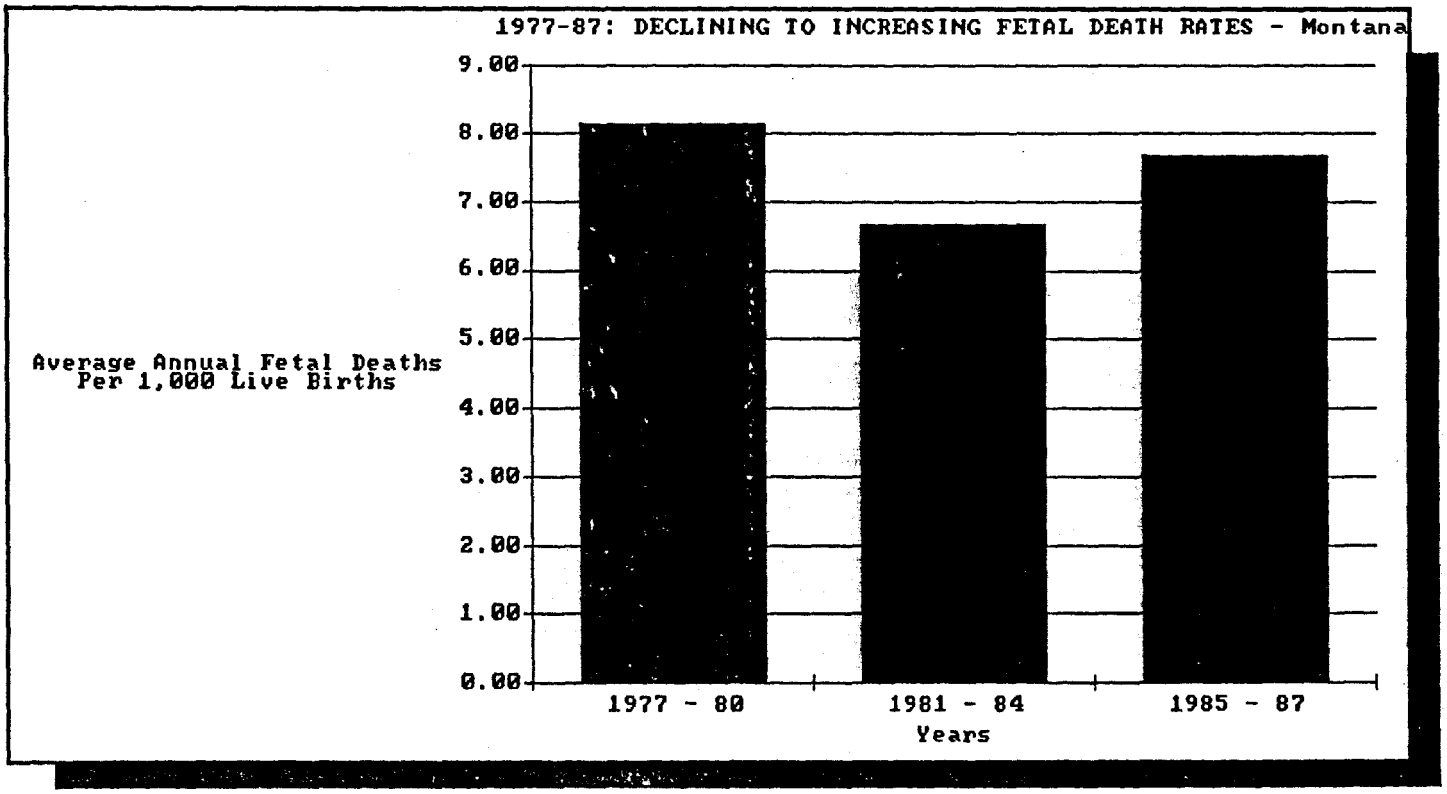
ABILITY OF PATIENTS TO SAFELY REACH NEAR-BY HOSPITALS. Hospitals were asked whether, when a patient came to them, how many provided full obstetrical services or were within 30 minutes of a hospital which did, the time when emergency procedures ought to be undertaken in problem pregnancies.

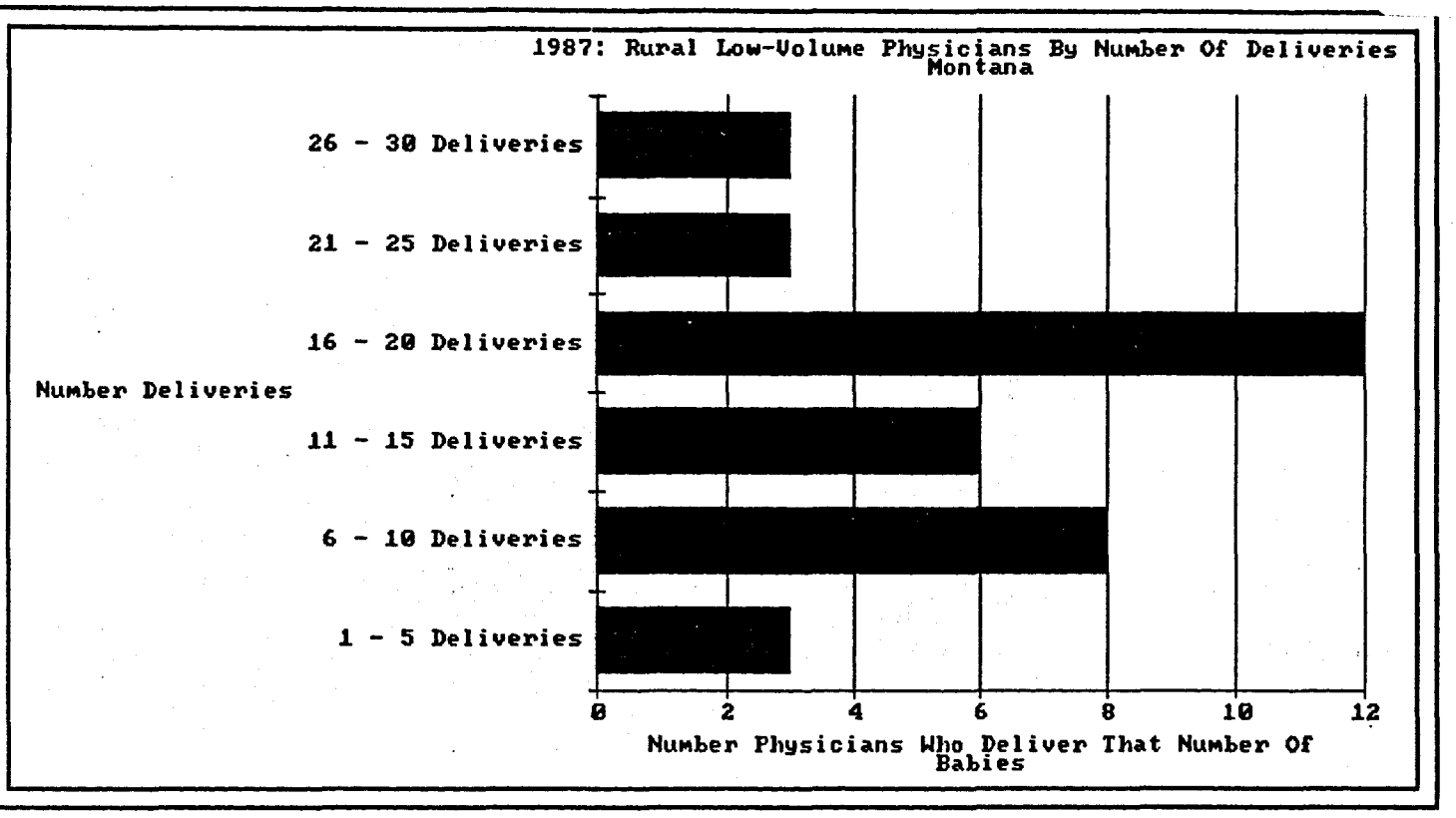
About 32% of the hospitals responding to the survey either provided a full range of obstetrical services or were within 30 minutes driving time of one that did.

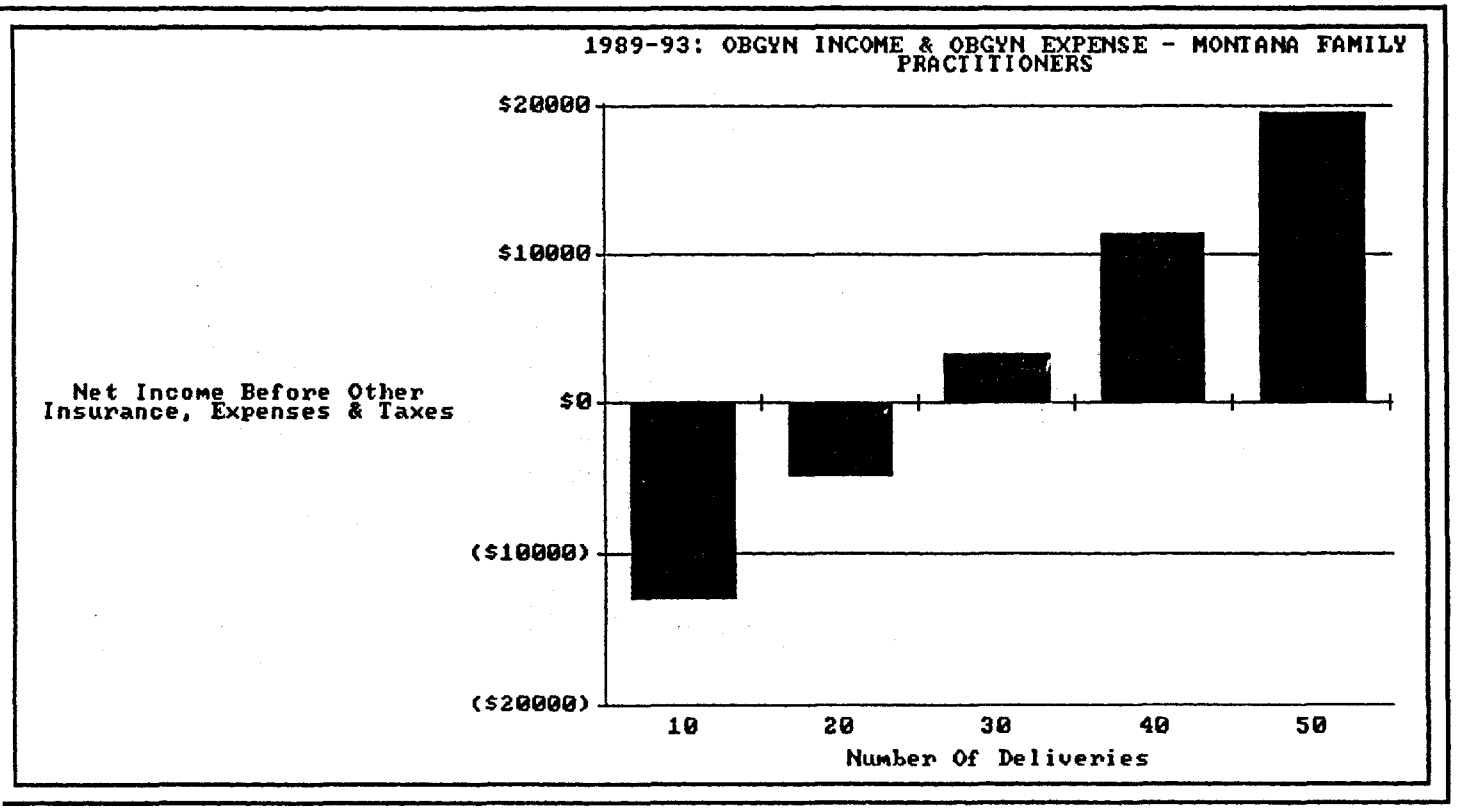

1977-1988: INCREASING RATES OF CLAIMS - Montana Physicians Wit
OBGYN Claims
Number Of Physicians In Claims
(Total = 209)
140
120
100
80
60
40
20
0
13
74
122
1977-80
1981-84
1985-88
Years

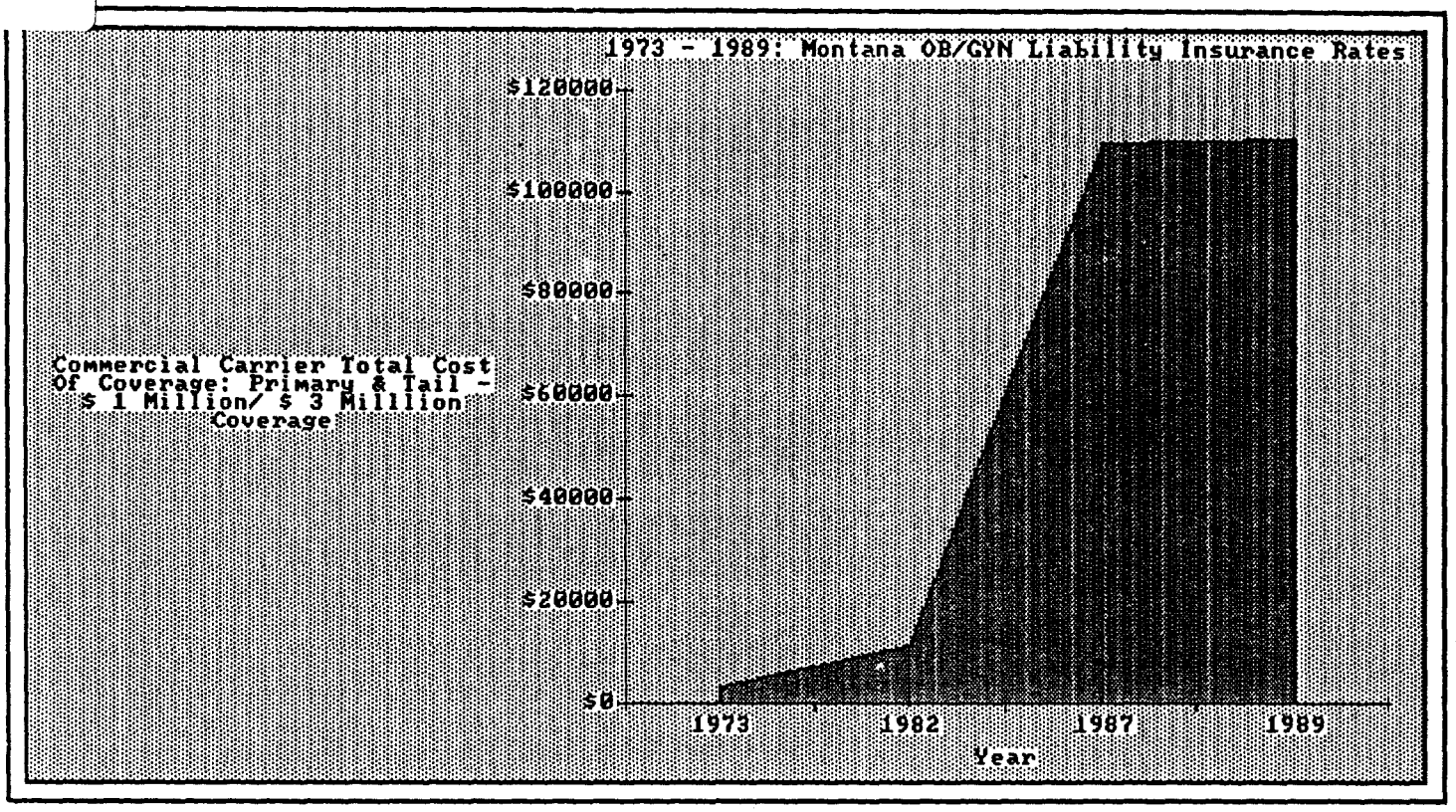

1977-1988: Montana OB/GYN Malpractice Claims By Type Of Injury
TYPE INJURY
Drug Effects
Infection
Brain Injury: Mod
Brain Injury: Maj
Death
Corrective Surgery
Other
4
6
9
10
20
32
54
0
10
20
30
40
50
60
Number Of OB/GYN Claims

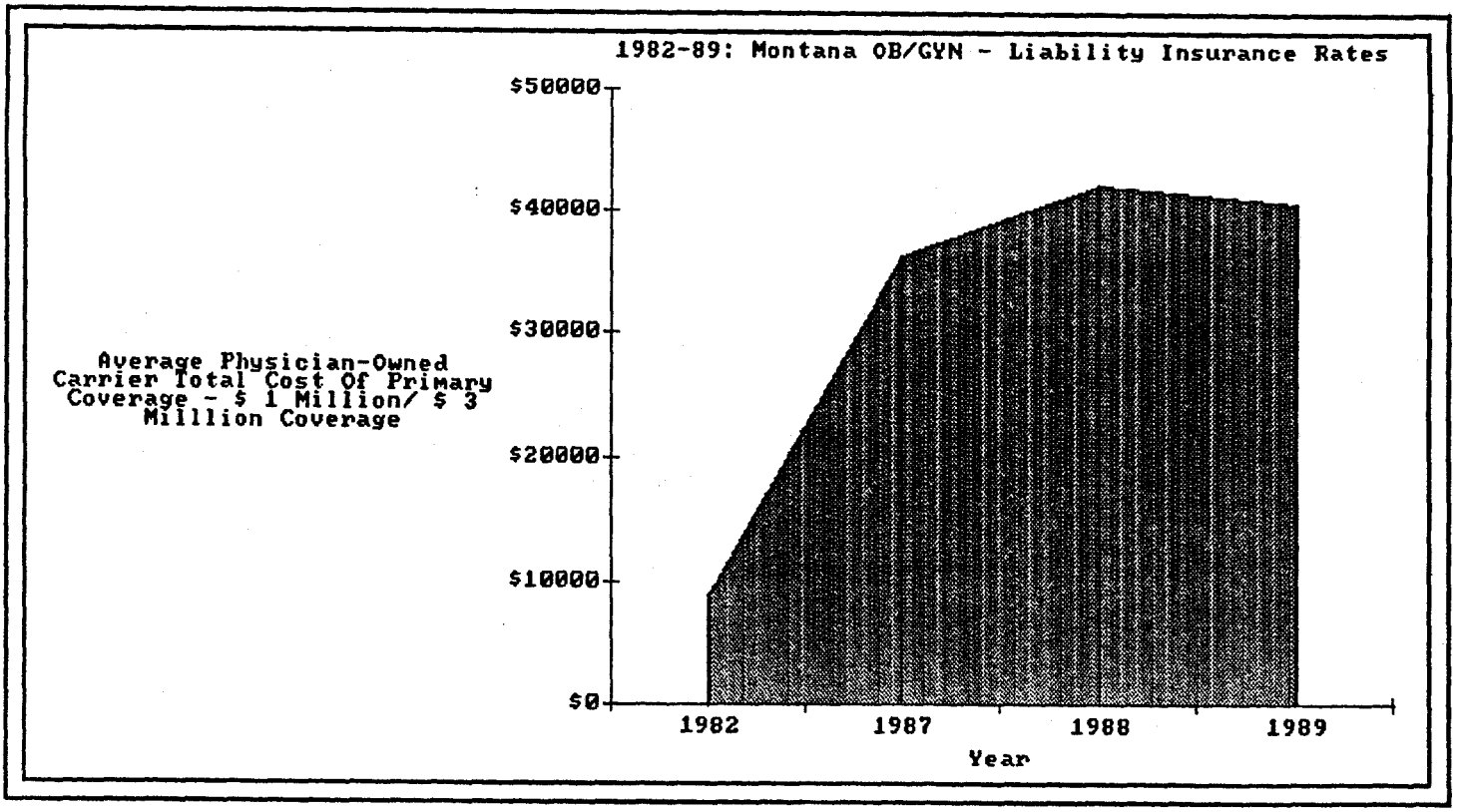

1977-87: LEVEL TO DECLINING BIRTH RATES - Montana
Average Annual Number Of Births
16000
14000
12000
10000
8000
6000
4000
2000
0
1977 - 80
1981 - 84
1985 - 87
Years


1977-87: DECLINING TO INCREASING FETAL DEATH RATES - Montana
Average Annual Fetal Deaths Per 1,000 Live Births
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
1977 - 80
1981 - 84
1985 - 87
Years


1987: Rural Low-Volume Physicians By Number Of Deliveries
Montana
26 - 30 Deliveries
21 - 25 Deliveries
16 - 20 Deliveries
11 - 15 Deliveries
6 - 10 Deliveries
1 - 5 Deliveries
Number Deliveries
0
2
4
6
8
10
12
Number Physicians Who Deliver That Number Of Babies


1989-93: OBGYN INCOME & OBGYN EXPENSE - MONTANA FAMILY PRACTITIONERS
$20000
$10000
$0
($10000)
($20000)
Net Income Before Other Insurance, Expenses & Taxes
10
20
30
40
50
Number Of Deliveries


1973 - 1989: Montana OB/GYN Liability Insurance Rates
Commercial Carrier Total Cost Of Coverage: Primary & Tail - $ 1 Million/ $ 3 Milllion Coverage
$120000
$100000
$80000
$60000
$40000
$20000
$0
1973
1982
1987
1989
Year


1982-89: Montana OB/GYN - Liability Insurance Rates
Average Physician-Owned Carrier Total Cost Of Primary Coverage - $ 1 Million/ $ 3 Million Coverage
$50000
$40000
$30000
$20000
$10000
$0
1982
1987
1988
1989
Year

1977-88: DECLINING RATES OF POTENTIAL NEGLIGENCE - Montana
Physicians With OBGYN Claims
Percentage Of Montana Physicians With Finding Adverse To Physician
60%
50%
40%
30%
20%
10%
0%
1977 - 80
1981 - 84
1985 - 88
Years

MONTANA OB/GYN CLAIMS, 1977 - 1988

DISTRIBUTION OF CLAIMS - CONSIDERING PANEL DISPOSITION
Number Of Physicians And Number Of OB/GYN Claims Which They've Had - Whether An Expert Panel Found An Indication Of Negligence

Number Of Claims Where Indication Of Physician Negligence	Number Of Different Physicians	Number Of Physicians Not Now In Practice	Number Of Physicians Still In Practice
ONE OR MORE CLAIMS			
Zero Adverse Claims	102	23	79
One Adverse Claim	34	8	26
Two Adverse Claims	4	4	0
Three Or More Adverse Claims	0	0	0
	140	35	105

Source: Records Of Montana Medical-Legal Panel, Closed Claims From 1977 - 1988. Thirty-Seven physicians who were delivering babies in 1988 have not had any claims.

KEY MEDICAL-LEGAL-INSURANCE DATA: The Relative Importance Played By Various Factors In Contributing To The Loss Of Obstetrical Care In Montana: 1981 - 1986

OBSTETRICS

Montana Medical-Legal-Insurance Changes, 1981-86

CATEGORY BY MAGNITUDE OF CHANGE	% Change 1981-1986
Number Of People Filing OB/GYN Claims	240.0%
Number Of Physicians With OB/GYN Claims	233.3%
FAMILY PRAC W/ OBGYN Insurance	200.3%
FAMILY PRAC, Claims Against	100.0%
OB/GYN Insurance	46.7%
Change In Number Fetal Deaths/1000 Live Births	27.1%
Change In Number Births	- 11.1%
Change In Number Physicians Delivering Babies	- 20.6%
Change In Rate Of Potential Negligence: % Physicians With Claims Where Holding Adverse To Physician As To Total Closed Claims	
FP W/ OB & OBGYN Physicians	- 83.4%

Compilation From Records Of Commissioner Of Insurance, Carrier Interviews, Panel Records, And Department Of Health & Environmental Science.

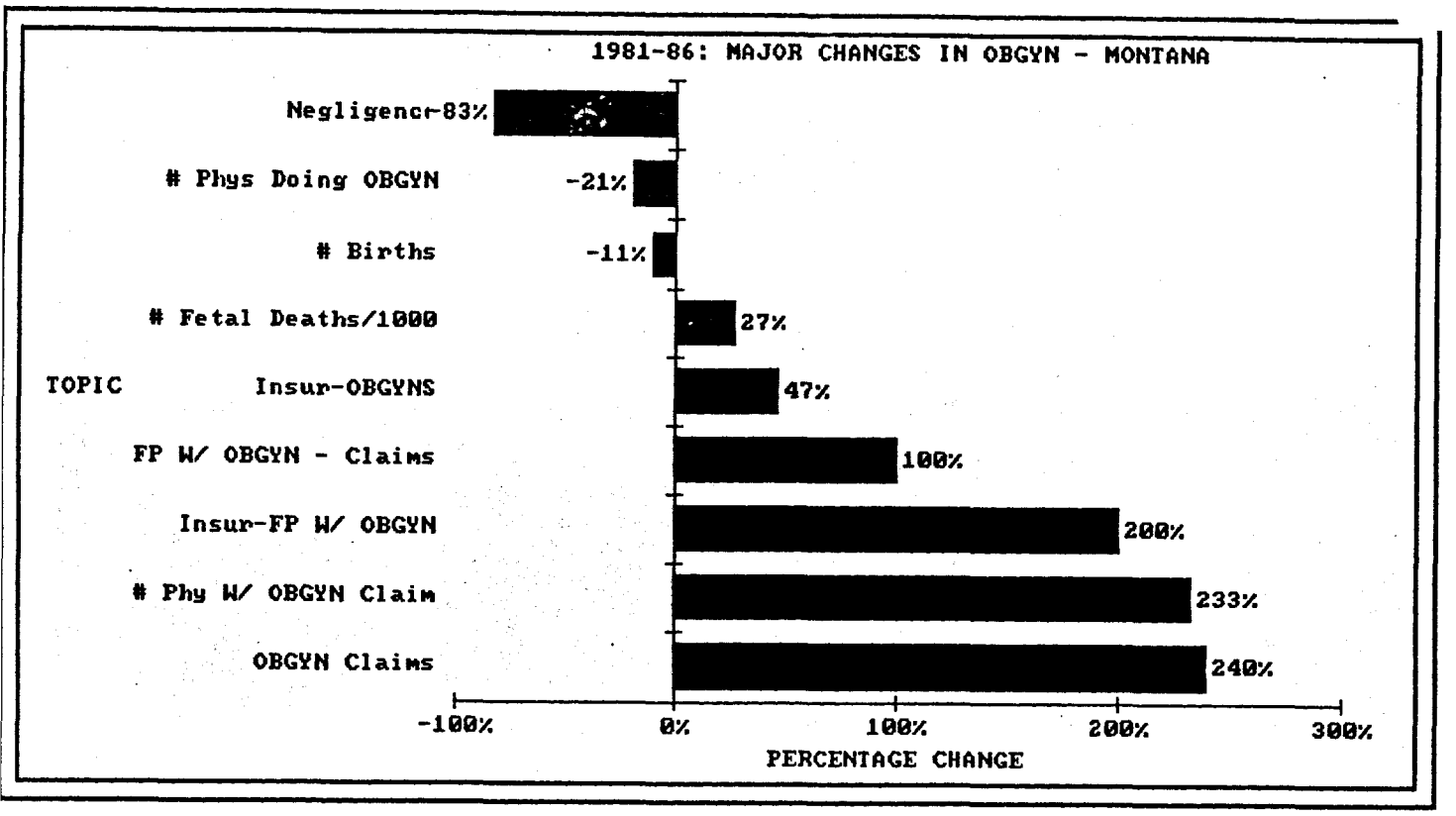
(OVER)

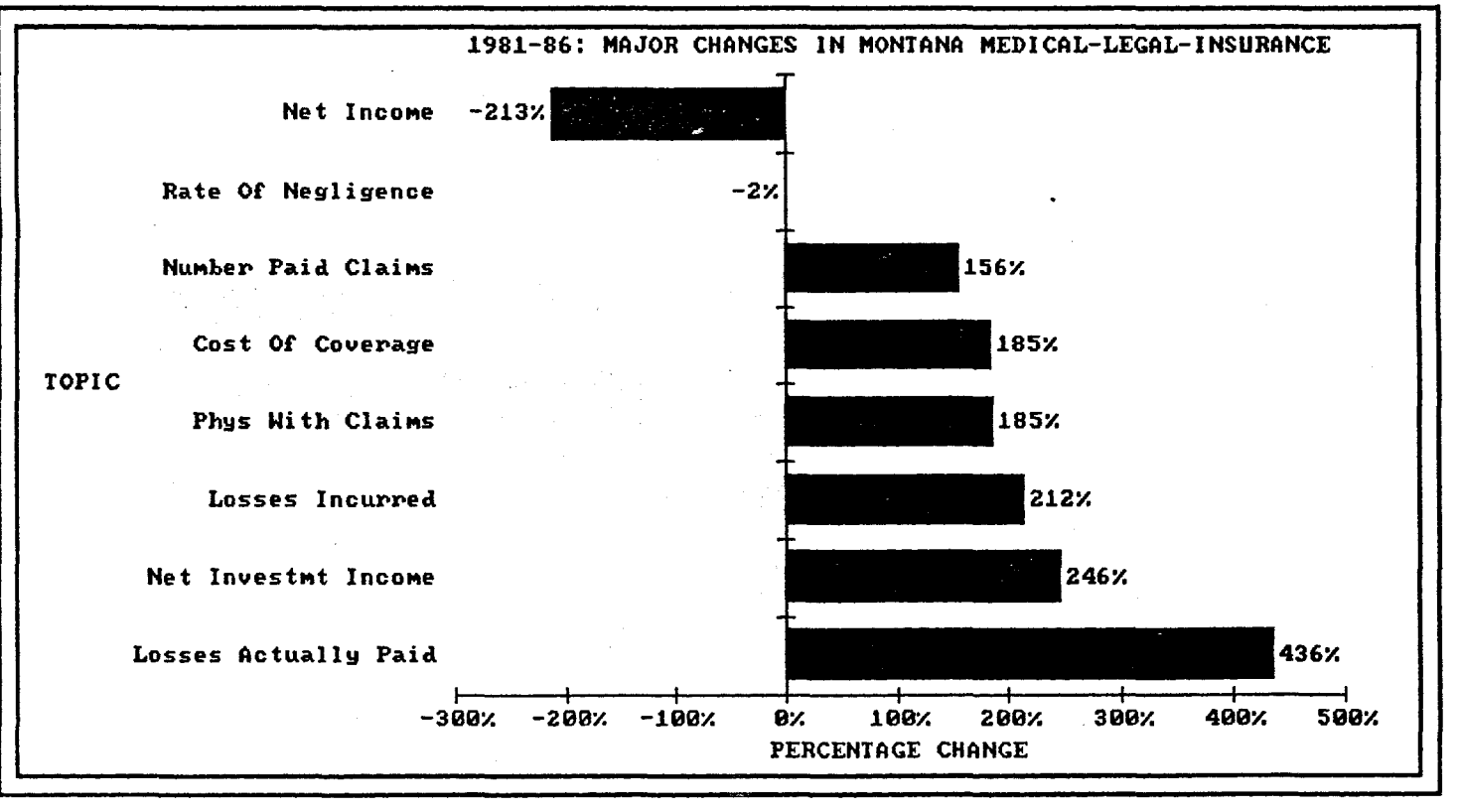
ALL MONTANA PHYSICIANS

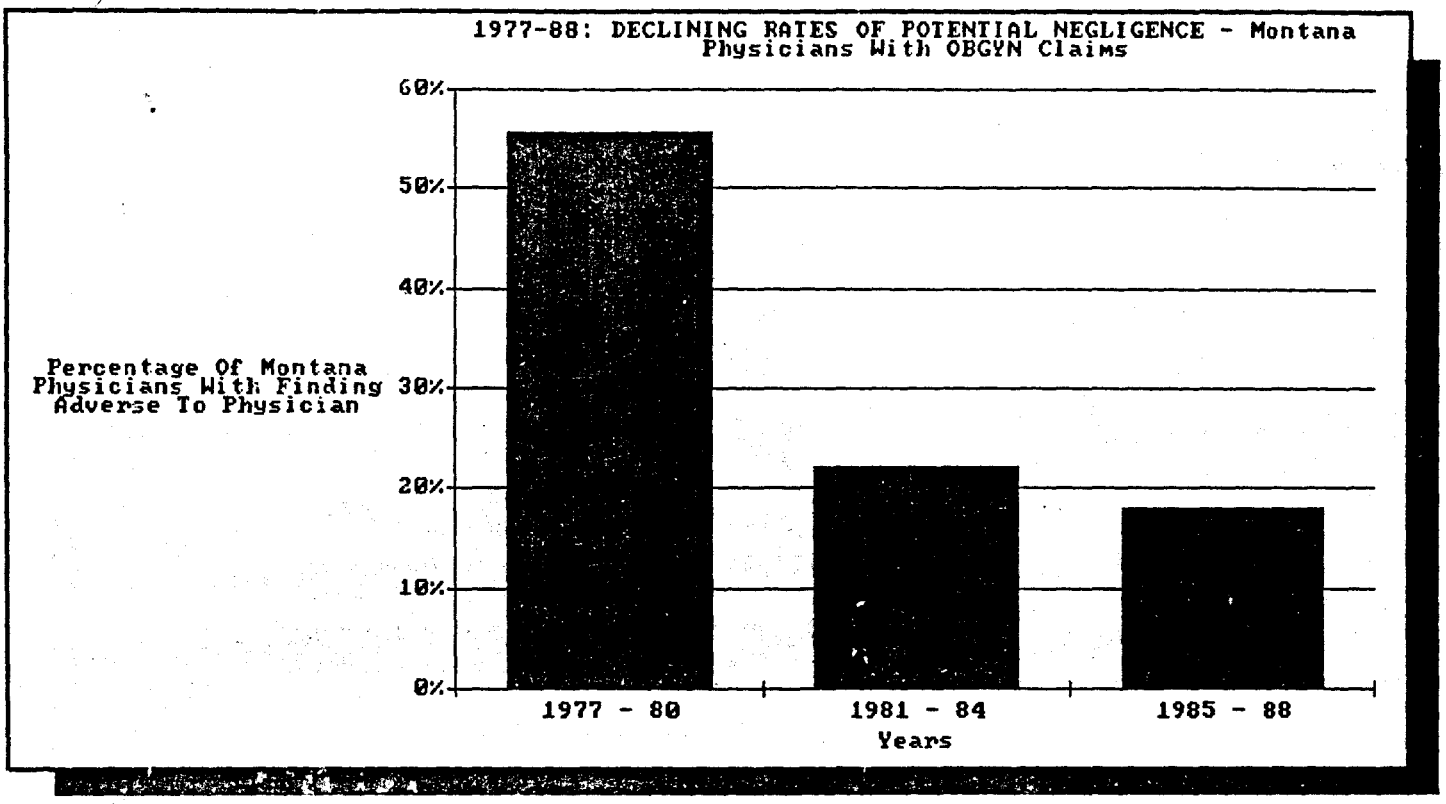
Montana Medical-Legal-Insurance Changes, 1981-86

CATEGORY BY MAGNITUDE OF CHANGE	% Change 1981-1986
Carrier Loss Monies Paid Claimants	436.3%
Carrier Net Investment Income	245.6%
Carrier Direct Losses Incurred	212.3%
Carrier Defense Fees & Costs	193.0%
Number Of Physicians With Claims	184.9%
Physician Premium Plus Tail Costs	184.5%
Carrier Paid Losses As % Earned Prem + Invest Income	161.1%
% Carrier Paid Claims To Total Claims	156.8%
Carrier Number Paid Claims	155.6%
Carrier Aver/Paid Claim Dollars	109.9%
Carrier Earned Premiums	82.9%
Physician Primary Insurance	82.9%
Carrier Non-Defense Expenses	54.3%
Change In Rate Of Potential Negligence: % Physicians With Claims Where Holding Adverse To Physician As To Total Closed Claims	
All Physicians	- 1.8%
Change In Carrier Net Income For Montana Medical Malpractice	- 213.0%

Compilation From Records Of Commissioner Of Insurance, Carrier Interviews, Panel Records, And Department Of Health & Environmental Science. Data Involves All Physician Medical Malpractice In Montana Unless Otherwise Specified


1981-86: MAJOR CHANGES IN OBGYN - MONTANA
Negligence-83%
Phys Doing OBGYN
-21%
Births
-11%
Fetal Deaths/1000
27%
TOPIC
Insur-OBGYNS
47%
FP W/ OBGYN - Claims
100%
Insur-FP W/ OBGYN
200%
Phy W/ OBGYN Claim
233%
OBGYN Claims
240%
-100%
0%
100%
200%
300%
PERCENTAGE CHANGE


1981-86: MAJOR CHANGES IN MONTANA MEDICAL-LEGAL-INSURANCE
Net Income
-213%
Rate Of Negligence
-2%
Number Paid Claims
156%
Cost Of Coverage
185%
TOPIC
Phys With Claims
185%
Losses Incurred
212%
Net Investmt Income
246%
Losses Actually Paid
436%
-300%
-200%
-100%
0%
100%
200%
300%
400%
500%
PERCENTAGE CHANGE


1977-88: DECLINING RATES OF POTENTIAL NEGLIGENCE - Montana Physicians With OBGYN Claims
Percentage Of Montana Physicians With Finding Adverse To Physician
60%
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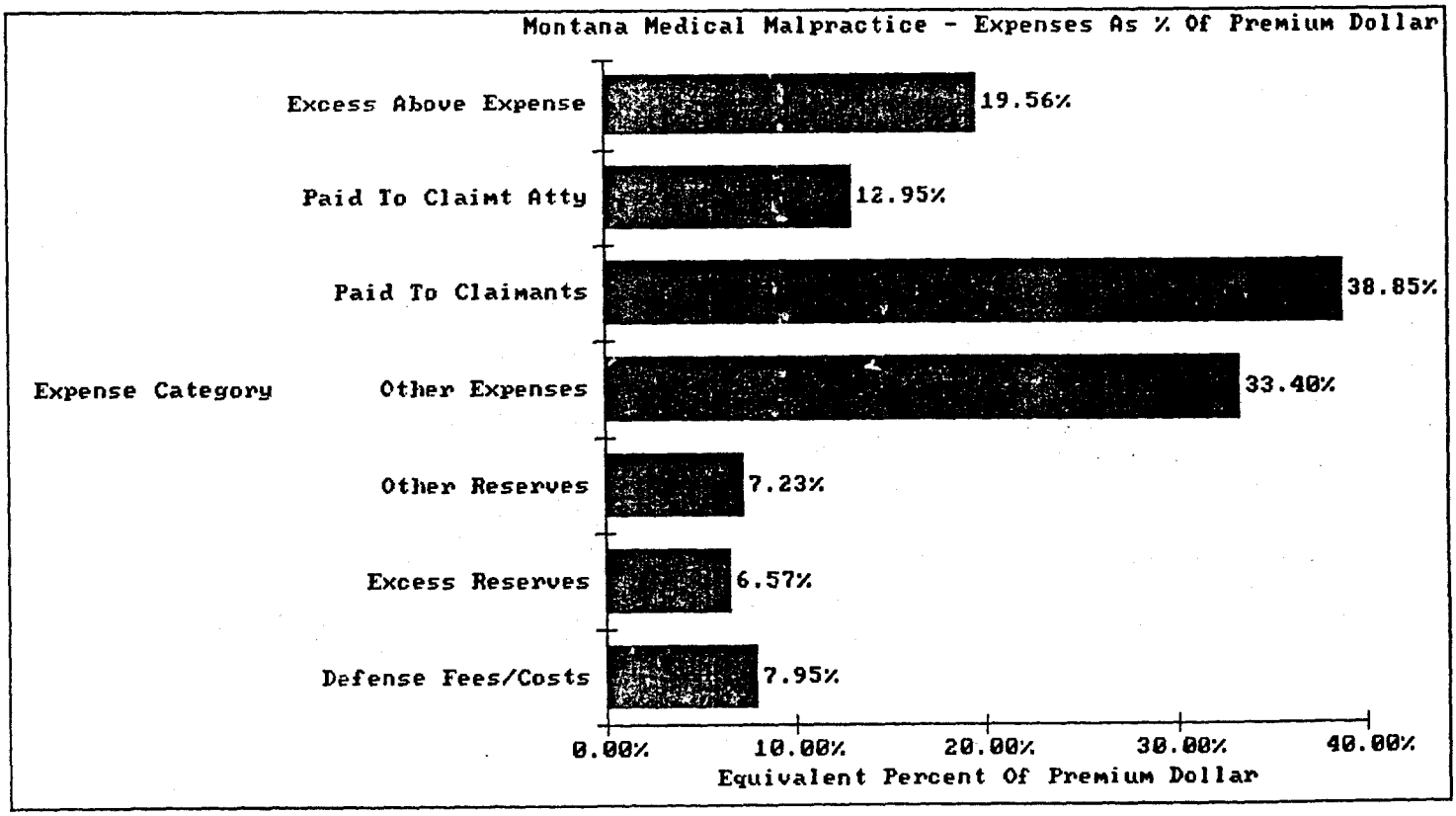
20%
10%
0%
1977 - 80
1981 - 84
1985 - 88
Years


Montana Medical Malpractice - Expenses As % Of Premium Dollar
Expense Category
Excess Above Expense
19.56%
Paid To Claimt Atty
12.95%
Paid To Claimants
38.85%
Other Expenses
33.40%
Other Reserves
7.23%
Excess Reserves
6.57%
Defense Fees/Costs
7.95%
0.00%
10.00%
20.00%
30.00%
40.00%
Equivalent Percent Of Premium Dollar

UNDERWRITING GAINS & LOSSSES - NET INCOME & LOSSES: The Montana Experience In Medical Malpractice - 1981 Through 1986

MEDICAL MALPRACTICE, 1981-1986, MONTANA

Montana Underwriting Gains And Losses

Year	PREMIUMS EARNED	LESS: Deductions Losses Incurred	LESS: Deductions Expenses Incurred	UNDERWRITING GAIN OR LOSS
1981	$3,503,295	$2,485,454	$1,341,039	($323,198)
1982	$3,395,211	$4,871,378	$1,432,732	($2,908,899)
1983	$3,643,015	$4,253,573	$1,616,124	($2,226,682)
1984	$3,774,040	$992,319	$1,880,432	$901,289
1985	$5,039,701	$9,141,623	$2,059,645	($6,161,567)
1986	$6,389,076	$6,853,865	$2,315,231	($2,780,020)
	$25,744,338	$28,598,212	$10,645,203	($13,499,077)

Data From Annual Statements of Carriers On File With Montana Commissioner of Insurance And Carrier Records.

MEDICAL MALPRACTICE, 1981-1986, MONTANA

Montana Net Gains And Losses

Year	UNDERWRITING GAIN OR LOSS	INVESTMENT INCOME	NET INCOME/LOSS
1981	($323,198)	$575,637	$252,439
1982	($2,908,899)	$741,930	($2,166,969)
1983	($2,226,682)	$761,940	($1,464,742)
1984	$901,289	$951,742	$1,853,031
1985	($6,161,567)	$1,802,609	($4,358,958)
1986	($2,780,020)	$1,989,179	($ 790,841)
	($13,499,077)	$6,823,037	($6,676,040)

Data From Annual Statements of Carriers On File With Montana Commissioner of Insurance And Carrier Records.

BEFORE RESERVES - EXCESS DOLLARS OVER EXPENSES AND ACTUAL PAID LOSSES: The Montana Experience In Medical Malpractice - 1981 Through 1986

MEDICAL MALPRACTICE, 1981-1986, MONTANA

Net Gains And Losses On Paid Losses Before Investments And Reserves For Unpaid Claims

Year	PREMIUMS EARNED	LESS: Deductions		NET BEFORE INVESTMENTS & RESERVES
		Losses Paid Out	Expenses Incurred	
1981	$3,503,295	$615,492	$1,341,039	$1,546,764
1982	$3,395,211	$1,032,814	$1,432,732	$929,665
1983	$3,643,015	$2,270,483	$1,616,124	($243,592)
1984	$3,774,040	$2,270,084	$1,880,432	($376,476)
1985	$5,039,701	$3,844,661	$2,059,645	($864,605)
1986	$6,389,076	$3,300,783	$2,315,231	$773,062
	$25,744,338	$13,334,317	$10,645,203	$1,764,818

MEDICAL MALPRACTICE, 1981-1986, MONTANA

Excess Income Over Expenses And Actual Paid Losses Before Reserves For Unpaid Claims (Actually Pending or Anticipated)

Year	NET BEFORE INVESTMENTS & RESERVES	INVESTMENT INCOME	BEFORE RESERVES: EXCESS INCOME OVER EXPENSES AND ACTUAL PAID LOSSES
1981	$1,546,764	$575,637	$2,122,401
1982	$929,665	$741,930	$1,671,595
1983	($243,592)	$761,940	$518,348
1984	($376,476)	$951,742	$575,266
1985	($864,605)	$1,802,609	$938,004
1986	$773,062	$1,989,179	$2,762,241
	$1,764,818	$6,823,037	$8,587,855

Data From Annual Statements of Carriers On File With Montana Commissioner of Insurance And Carrier Records.

BREAKDOWN OF CARRIER INCOME & EXPENSES: The Montana Experience In Medical Malpractice - 1981 Through 1986

Breakdown Of Carrier Income & Expenses
1981 - 1986 Montana Medical Malpractice - As Percent Earned Premium And Investment Income

Expense Category	Dollars	Percent Earned Premium & Investment Income
Defense Fees & Costs	$ 2,046,051	6.28%
Excess Reserves	$ 1,691,551	5.19%
Other Reserves	$ 1,861,531	5.72%
Other Incurred Expenses	$ 8,599,153	26.40%
Payments To Claimants And Their Attorneys		
Claimants $10,000,738		30.71%
Attorneys $3,333,579 (25%)		10.24%
	$13,334,317	40.95%
Excess Over Expenses Paid And Anticipated Losses	$ 5,034,773	15.46%
	$32,567,376	100.00%

Data From Annual Statements of Carriers On File With Montana Commissioner of Insurance

Breakdown Of Carrier Income & Expenses
1981 - 1986 Montana Medical Malpractice - As Equivalent Percent Earned Premium Only [$25,744,338]

Expense Category	Dollars	Percent Earned Premium
Defense Fees & Costs	$ 2,046,051	7.95 %
Excess Reserves	$ 1,691,551	6.57 %
Other Reserves	$ 1,861,531	7.23 %
Other Incurred Expenses	$ 8,599,153	33.40 %
Payments To Claimants And Their Attorneys		
Claimants $10,000,738		38.85%
Attorneys $3,333,579		12.95%
	$13,334,317	51.80%
Excess Over Expenses Paid And Anticipated Losses	$ 5,034,773	19.56%

Data From Annual Statements of Carriers On File With Montana Commissioner of Insurance. Total Percentage Exceeeds 100% Because Of Investment Income.

EXCESS DOLLARS OVER EXPENSES, ACTUAL PAID, AND PROPER RESERVES
The Montana Experience In Medical Malpractice - 1981 Through 1986

MEDICAL MALPRACTICE, 1981-1986, MONTANA

Carrier Dollars In Excess Of Expenses, Paid Losses, And Current Anticipated Losses

Excess of income over all expenses and amounts paid out		$ 8,587,855
1986 Incurred Losses	$ 6,853,865	
1986 Losses Paid Out	3,300,783	
Unpaid Losses - Claims In Adjustment And Claims Incurred But Not Reported		3,553,082
Excess Over Expenses Paid Losses And Anticipated Losses		$ 5,034,773

RESERVING ADEQUACY

Current Reserve Redundancy: Montana Medical Liability Carriers - Montana Only

Type Carrier	Dollars
All Carriers	$ 1,691,551
Commercial Carriers	434,935
Physician-Owned Carriers	1,256,616

Data From Annual Statements of Carriers On File With Montana Commissioner of Insurance

DOLLARS PAID OUT TO PATIENTS: Actuarial Indicators Of Pure Premium Required Of Pool Participants

Pure Premium Loss Costs, 1989, $ 1 Million Coverage	
Obstetrician\Gynecologist:	$ 32,000
Family Practitioner With Obstetrics:	$ 17,000

DOLLARS PAID OUT TO PATIENTS - 1981 Through 1986 - All Montana Medical Malpractice Carriers

The absolute number of dollars paid out on claims and the absolute number of claims upon which there is payment has been steadily increasing since the early 1980's:

Year	Actual Paid Losses	Number Paid Claims	Average Paid Loss
1981-1982	$1,648,306	116	$14,210
1983-1984	$4,540,567	131	$34,661
1985-1986	$7,145,444	286	$24,984
	$13,334,317	533	$25,017

Compilation From Records Of Commissioner Of Insurance, Interviews With Carriers

DOLLARS PAID OUT: Closed Claim Obstetrical Survey
From Attorney-Carrier Interviews

Survey Number	Dollars Paid To Injured Party & Attorney	
	TOTAL AMOUNT	AMOUNT ABOVE $ 100,000
1	$ 0	$ 0
2	65,000	0
3	350,000	250,000
4	0	0
5	451,041 [1]	351,041
6	125,000	25,000
7	0	0
8	260,000	160,000
9	0	0
10	0	0
	$ 1,251,041	$ 786,041

SUMMARY OF RESULTS:

Number Of Closed Claims:	10	
Number Of Paid Claims:	5	
Number Of Paid Claims Above $ 100,000	4	
Number Of Unpaid Claims:	5	
Total Indemnity Paid In Obstetrical Claims		$ 1,251,041
Average Indemnity Per Paid Claim:		$ 250,208
Total Indemnity Paid Above $ 100,000 As Percent Of Total Indemnity Paid		62.8%

[1] Lump sum of $ 125,000 plus structured $ 1,249.34 per month for claimant and $ 562.00 per month for attorney, over 180 months.

DOLLARS PAID OUT TO PATIENTS - The Utah Medical Insurance Association History, 1982 - 1987 (Earlier Years Not Written In Montana)

Comparison	Indemnity Paid	Expenses Paid	Total Paid
Average All Claims	$ 29,930	$2,512	$32,443
Average Paid Claims	$ 61,524	$3,718	$65,242
Average Paid Claims Where Amt Paid Greater Than $ 15,000	$133,400	$6,828	$140,228
Average Family Prac Obstetrical Claim	$191,598	$8,295	$199,893

Compilation From Computer Printouts Of Utah Medical Insurance Association

Closure Year	Indemnity Paid	Expenses Paid	Total Paid	Number Paid	Average Total
1982-1983	$175	$0	$175	1	$ 175
1984-1985	$385,081	$35,837	$420,918	13	$ 32,378
1986-1987	$722,168	$57,117	$779,285	23	$ 33,881
	$1,107,424	$92,954	$1,200,378	37	$ 32,442

Compilation From Computer Printouts Of Utah Medical Insurance Association

Actual Paid Claims - Utah Medical Insurance Association

1982 - 1986, Montana Medical Malpractice Claims Only

Claim	Indemnity	Expense	TOTAL	Incident Year	Closure Year
1	$175	$0	$175	1982	1982
2	$260,000	$16,590	$276,590	1982	1985
3	$0	$4,344	$4,344	1982	1984
4	$0	$0	$0	1983	1985
5	$547	$2,993	$3,540	1983	1984
6	$0	$0	$0	1982	1986
7	$0	$3,392	$3,392	1983	1985
8	$0	$690	$690	1983	1984
9	$0	$0	$0	1983	1984
10	$1,000	$746	$1,746	1984	1984
11	$0	$1,599	$1,599	1983	1984
12	$123,196	$0	$123,196	1984	1985
13	$260	$0	$260	1984	1984
14	$78	$3,490	$3,568	1984	1984
15	$37,500	$12,773	$50,273	1984	1986
16	$37,500	$0	$37,500	1984	1986
17	$22,500	$8,813	$31,313	1983	1986
18	$17,500	$10,526	$28,026	1984	1986
19	$500,000	$1,259	$501,259	1984	1986
20	$0	$1,993	$1,993	1985	1985
21	$0	$4,238	$4,238	1983	1986
22	$15,000	$371	$15,371	1985	1987
23	$0	$5,450	$5,450	1982	1986
24	$0	$819	$819	1982	1987
25	$0	$0	$0	1982	1986
26	$7,500	$0	$7,500	1984	1986
27	$0	$0	$0	1986	1986
28	$2,168	$0	$2,168	1984	1986
29	$0	$637	$637	1983	1986
30	$0	$3,400	$3,400	1986	1987
31	$0	$291	$291	1984	1987
32	$0	$1,217	$1,217	1986	1987
33	$0	$865	$865	1986	1987
34	$5,000	$0	$5,000	1986	1987
35	$8,500	$125	$8,625	1984	1987
36	$69,000	$4,664	$73,664	1984	1987
37	$0	$1,668	$1,668	1984	1987
	$1,107,424	$92,954	$1,200,378		

COMPARISON - THE MONTANA MEDICAL ASSOCIATION PROPOSAL VS. OTHER STATES WITH COMPENSATION FUNDS

COMPARATIVE ANALYSIS: MMA PROPOSAL VS. OTHER STATES

1. PRIMARY PURPOSES

	MONTANA MEDICAL ASSOCIAT	TYPICAL OTHER STATE
Immediate Stop & Reversal Of Loss Of Certain Services	Yes	No
Immediate Reduction In Overall Insurance Cost To Physicians Who Are Covered	Yes	Yes
Increased Predictability Of Damages Payable To Injured Parties	Yes	No
Reduction Of Costs Associated With Legal System	Yes	No
Reduction Of Number Of Claims Which Go To Court	Yes	No
Long-Term Stabilization Of Insurance Costs And Availability	Yes	Yes
Affirmative Program Of Reduction Of Number Of Injuries From Malpractice (Risk Management)	Yes	No
Benefits Of Savings From Program Required To Include Patients	Yes	No
SCOPE: Limited To Doctors Who Deliver Babies	Yes	No

COMPARATIVE ANALYSIS: MMA PROPOSAL VS. OTHER STATES

2. KEY FEATURES (Continued)

	MMA	OTH STATES
COVERAGE: Permits Doctors Who Are Uninsurable Bad Risks To Participate	No	Yes
NON-ECONOMIC DAMAGES: Provision For Scheduled Non-economic Damages Proportional To Severity Of Injury/Life Expectancy	Yes	No
ALL DAMAGES: Deals With Under- And Overcompensation Of Injured Parties Under Current System	Yes	No
SAVINGS FROM LEGISLATION: Mandates Savings Be Paid Back To Patients And People Funding Program	Yes	No
SOLVENCY: Required To Be Actuarially Sound	Yes	No
TORT REFORM: Major Key Measures Related To Solvency In Place Or In Bill	Yes	Varies

PATIENT COMPENSATION FUNDS: LEVEL OF INSURANCE COVERAGE REQUIRED FOR PARTICIPATING PHYSICIANS - "TRIGGER POINT" FOR FUND INVOLVEMENT

State With Compensation Fund	Trigger Point For Fund Involvement: Claims Above The Following Amount[1]
Florida	$ 150,000
Indiana	$ 100,000
Kansas	$ 200,000
Louisiana	$ 100,000
Nebraska	$ 100,000
New Mexico	$ 100,000
Pennsylvania	$ 200,000
South Carolinia	$ 100,000
Wisconsin	$ 200,000

[1] Each fund has the indicated per claim limit and also an aggregate limit per participant for claims in any one year. The standard limits are $ 100,000 per claim and $ 300,000 aggregate or $ 200,000 per claim and $ 600,000 aggregate.

WHEN TORT REFORM WORKS, SO DO EXCESS-COVERAGE FUNDS

Of the seven other states that have excess-coverage malpractice funds similar to Pennsylvania's (Indiana, Kansas, Louisiana, Nebraska, New Mexico, South Carolina, and Wisconsin) only one finds itself in a comparable crunch. That's Kansas, and the situation there may be even more troublesome.

The surcharge for Kansas' Health Stabilization Fund had been pegged at 105 percent of each physician's malpractice insurance premium until several months ago. But then the state Supreme Court declared the major elements of a tort reform package unconstitutional, throwing the entire malpractice situation in the state into disarray.

Actuaries commissioned to estimate the impact of the court action on the fund decided that the surcharge needed to be raised to 155 percent immediately. But because the fund's administrator is able to spread increases over future years, a stopgap surcharge of only 125 percent was set.

"This is nothing more than a calculated risk," says Chip Wheelen, public-affairs director of the Kansas Medical Society. "If things continue to go as they have been, there's no doubt the surcharge will have to rise again soon—and dramatically."

The triple-digit surcharges come on top of recently approved hikes in premiums, ranging from 15 percent for St. Paul policyholders to 54 percent for those with Medical Protective policies.

The Kansas Medical Society is promoting an as-yet-undrafted amendment to the state constitution to allow tort reform, but it's considered unlikely to win the two-thirds majorities in both houses of the legislature that are required just to put the matter before the voters. "Most members are either lawyers or members of what I call the lawyers' fan club," Wheelen says.

In New Mexico, by contrast, a combination of tort reform and an *optional* patient compensation fund have worked together to keep malpractice premiums reasonable. The price of a basic $100,000-per-occurrence policy ranges from $1,900 for a Class 1 physician to $25,000 for a Class 8 surgeon with a clean record. The surcharge for the excess liability coverage is pegged by law at 33 percent—and doctors are free to decide if they need it.

Nearly all of South Carolina's private practitioners get their $100,000 worth of basic coverage through a statutory joint underwriting association, and an unlimited amount of excess coverage from the state's Patient Compensation Fund. The fund's surcharge is based on a sliding scale, ranging from 100 percent for a first-year participant down to 40 percent for a physician who's been covered for four years.

Total malpractice insurance premiums are kept low, according to the fund's executive director, Cal Stewart, "because we're a small, rural state, and our citizens don't think in terms of suing the doctors who take care of them." And when they do sue, he adds, an aggressive defense usually results in a victory for the doctor. Last year, Stewart adds, the Patient Compensation Fund tried 65 cases to conclusion—and won 63 of them.

In Indiana, like Kansas, fund surcharges are 125 percent. But the state medical society's general legal counsel, Ronald Dyer, says that although there's some discontent with the increasing surcharge, premiums in most of the state are kept low by effective tort reforms.

Nebraska's surcharge is 45 percent, down from 50 percent last year. The Nebraska fund was started in 1976 with an initial surcharge of 50 percent, but it dropped over the years to 10 percent, then rose again to 50 percent when the state legislature raised the maximum coverage from $500,000 to $1 million. Officials expect it to drop back as the fund becomes healthier, says William Schellpepper, executive director of the Nebraska Medical Association.

ing mandatory surcharges," DiGiovanni notes, "the ultimate effect may be to motivate the legislature to come up with a more balanced system."

Deputy Cat Fund Director Dianne Merlino agrees that the legislature may hold the key to the solution of the problem of Pennsylvania's malpractice premiums. "If any doctors have objections to the way the surcharge works," she says, "their quest should be with the legislature, not the courts." ■

Medical Malpractice Insurance Rates: States With Compensation Funds

COMPARATIVE RATES - Montana With Compensation Fund States

Montana And Indiana: Obstetrics/Gynecology

1985 Rates - $ 500,000 Coverage - Occurrence And Mature Claims-Made With Tail Cost (Equivalent Occurrence)

Montana			Indiana		
Primary Coverage	Tail Coverage	Total Coverage	Primary Coverage	Tail Coverage	Total Coverage
$ 11,540	$ 15,002	$ 26,542	$ 11,380	$ 0	$ 11,380

Source: Insurance Rate Cards, Annual Reports And Underwriting Departments. U.S. General Accounting Office, Medical Malpractice: Insurance Costs Increased But Varied Among Physicians And Hospitals. September, 1986.

COMPARATIVE RATES - Montana With Compensation Fund States

Obstetrical Insurance - Montana Versus States With Compensation Funds: Coverage Of $ 1 Million

State	Coverage	Primary Cost	Tail Cost	Total Cost
Louisiana	Occurrence	$ 11,310	$ 0	$ 11,310
Pennsylvania	Occurrence	$ 20,196	$ 0	$ 20,196
Nebraska	Claims-Made	$ 11,289	$ 14,676	$ 25,965
Montana	Claims-Made	$ 31,525	$ 40,983	$ 72,508

COMPARATIVE RATES - Montana With Compensation Fund States

Obstetrical Insurance - Montana Versus States With Compensation Funds: Coverage Of $ 500,000

State	Coverage	Primary Cost	Tail Cost	Total Cost
New Mexico	Occurrence	$ 10,627	$ 0	$ 10,627
Montana	Claims-Made	$ 26,495	$ 34,444	$ 60,939

COMPARATIVE RATES

Obstetrical Insurance - Indiana Versus States Without Funds: 1980 - 1986

State	% Change In Premiums
Indiana	116 %
California	140 %
New York	345 %
Florida	395 %
North Carolina	547 %

SOLVENCY FACTORS ASSOCIATED WITH THE PATIENT ASSURED COMPENSATION ACT

Certain significant steps were taken to reduce the likelihood of any dollar shortage in the "pool" created by the Patient Assured Compensation Act, far beyond that usually undertaken by legislation in this area.

A very extensive analysis was undertaken of why some pools or carriers have done better or worse than others. That analysis was fruitful and those variables which alter the financial viability of an enterprise were isolated and dealt with by this bill, each of which is very significant in tending to lessen the likelihood of any fund shortage, most of which are over and above those matters recognized by the actuary:

1. USE OF EXCESS POOL AND NOT ZERO DOLLAR COVERAGE. Some pools and carriers have difficulty because they provide coverage from the first dollar on, increasing the chance of unanticipated administrative costs and substantial increases in low-level claims.

A coverage mechanism which is not triggered until a moderately-high level is reached has less uncertainty attached to it and places most expenses with the primary carrier -- underwriting, claims investigation, major legal, etc. -- and only involves two or three claims per year to be reviewed by the pool, at a low administrative cost.

2. MANDATORY LOWER LIMITS OF CARRIER COVERAGE. Nearly all pools or commercial insurance carriers do not have strict underwriting requirements and end up with a bad "selection" of insureds: virtually anyone in a class can participate. Unlike other excess pools, there is a strict requirement that a participating physician be insured for the first $ 100,000.

Unlike other pooling enterprises, the bulk of that insurance will be provided by physician-owned mutuals, who have exceptionally strict underwriting standards.

The likelihood of a "bad" doctor getting into and staying in the pool are significantly reduced, even though this is not assumed by the actuary. This "bad selection" is one of the most serious problems facing any insurance mechanism: a run of bad claims from an insured.

3. LIMITED SCOPE OF POOL. The pool extends only to two specialties: Family Practice and Obstetrics.

As a result, the total claims and dollars involved is not great compared to including all insureds or all physicians, which means that total administrative costs and payouts or percentage shortfalls of the same by the pool will not involve huge dollar amounts. For example, for the first few years, current staff of the Montana Medical Legal Panel will easily be able to administer the pool on a day-to-day basis.

A class of parties seeking compensation in the form of young parents with children is also a class which is likely to have far less fraud associated with the claim process, and hence is more viable.

4. SUCCESSFUL "TORT REFORM" IN PLACE OR IN THE LEGISLATION. There is a strong connection between the success of an excess pool involving medicine and the "tort reform" measures either in place or in the measure itself.

The combination of what is already in place in Montana plus what is in the bill adds up to a further assurance that the frequency and severity of claims will not be greater than anticipated for in the capitalization and rate-setting for the pool, above and beyond that which the actuary has calculated.

One of the major components involves the quantification or making objective the currently subjective non-economic damages such as "pain and suffering", resulting in predictable levels of payouts which can then be financed in advance of the time of payout. Also, to the extent that, for example, just a few claims go into the voluntary-entry, binding arbitration program, significant dollars savings are available above and beyond those calculated by the actuary.

5. REQUIREMENT OF ACTUARIAL SOUNDNESS AND AN IN-DEPTH ACTUARIAL ANALYSIS. Most pooling enterprises which have had any degree of difficulty have had it because there was too few dollars of start-up capital: they were on a "pay-as-you-go" basis, not fully-funded, and were not required to be actuarially sound from the start.

By the provisions of the bill, this enterprise must be actuarially-sound from the start.

A competent international firm of actuaries -- currently involved in the management of pooling mechanisms like that contemplated by this legislation and generally experienced in the formation of professional liability carriers -- was hired to provide a range of available levels of start-up capital and annual "premium" payments into the pool, consistent with the required actuarial soundness.

From those available alternatives, the selection was made for a level of start-up capital which would provide the highest available likelihood of solvency. Additionally, a contingency factor was loaded into the annual charges for the pool, to further avoid unknown contingencies.

As a further assurance of sufficient capital being available for all contingencies, assumptions were used which were weighted in favor of a high level of solvency. For example, while tort reform measures have computable impacts on the reduction of the amount of dollars needed, in order to be conservative, a very low weight was assigned to this type of variable, i.e. to the extent the assumption is off, it likely to be off in the direction of over-funding.

A level of participation was assumed which is highly unlikely to be met given the numbers of physicians currently in Montana. That is, if the level of participation is lower than likely or even than expected, the result of that low level of participation is over-funding of the enterprise, i.e. having more money on hand than is indicated as necessary to pay claims and expenses. Most enterprises make the big mistake of being under-capitalized when participation is lower than expected.

6. RISK PREVENTION AND QUALITY OF CARE. The long-term goals of strong risk prevention and strong quality of care are addressed in the legislation by the creation of a continuing Obstetrical Advisory Council, which will work with these complex and long-term measures.

Also addressed are expanded efforts involving physicians who have repeated claims against them where there is an indication of negligence, in the enforcement, reporting, and surcharging stages.

The combined effect of these measures are designed to reduce the frequency and severity of future claims beyond that which the actuary has assumed will be the case, i.e. these measures are further cushions against solvency problems for the pool.

7. POWER TO "RE-INSURE" PART OF THE RISK. Provision in the bill is made for the pool's ability to "re-insurer" or pass off a large part of the risk to another insurer, such as Lloyds of London, thus moderating the "peaks and valleys" of payouts which can ocur with fluctuations in claims frequency and severity.

8. POWER TO DEFER SOME PAYMENTS. If, during the course of a year, there are indications that the pool is not sound, then the payment of certain future damages, such as those unrelated to out-of-pocket medical expenses, can be deferred for a time period to allow a correction of any deficiencies.

Medical Liability Problems Which Need Solving - Provisions In The Montana Medical Association Legislation Which Help Solve Them

Major Problem Area	Mechanism In MMA Bill To Help Solve Problem
Current Level of Cost Of Insurance Coverage	Immediate premium reduction from new law via reduced limits of insurance, with part of savings funding the compensation fund on an annual basis, the amount retained by the doctor being the immediate reduction in cost of insurance. The pool covers claims up to the high limits previously covered by insurance.
Ever-Increasing Cost Of Coverage	"Tort" reform connected with pool With purpose being to make pool even more solvent and to keep the cost of funding it stable. Tort reform only applies to claims which occur after the effective date of the law, and not to then-pending cases. These measure involves the quantification of non-economic damages by relating them objectively to the seriousness of the injury and the life expectancy of the injured party, thus providing predictability to the amount to be paid out.
Over-Reserving By Insurance Carriers	1. Utilization of pool over low limits, so high levels of insurance are not under control of carriers, but under control of pool managers. 2. Lower amounts needed for reserves because of increased predictability of damages, by tying non-economic damages like pain and suffering to objective factors related to severity of injury and life expectancy.
Avoidance Of Initial Pool Coverage By "Bad" Doctors	Minimum levels of insurance required for any doctor to participate in pool, thus uninsurable bad risk doctors not able to participate, of benefit to pool and patients.
Montana Rates Not Based On Montana Experience	Utilization of pool over low limits, so high levels of insurance are not under control of carriers, with annual assessment based on Montana experience, consistent with actuarial soundness.
Avoidance Of Injuries From The Negligence Of Physicians	Risk prevention and quality of care measures designed to reduce the number of medical injuries and which require surcharges and licensure review where there are patterns of negligence

Major Problem Area	Mechanism In MMA Bill To Help Solve Problem
Constitutional Problems With "Tort Reform" Legislation of doctors who deliver babies	1. Bill provisions balanced and not one-sided; 2. No provision treats more seriously injured parties more harshly than less seriously injured; 3. Bill limited to problem
Offsetting Benefits To Patients To Help Justify Any Claim Of Impositions From Bill And Make Legislation Much More Constitutional	1) Portion of savings from successful pool passed on to patients; 2) only insurable doctors participate; 3) risk prevention and quality of care measures in bill, to reduce future incidents.
Cost Of "Tail" Coverage From Dropping Insurance Limits	Included in cost of coverage paid on annual basis.
Cost Of "Tail" Coverage Upon Termination Of Practice In Montana, Death, Retirement, Etc.	Available under same terms as low limits policy. If required to be purchased, purchased at lower pool cost.
Public And Pool Protection From Pool Participants Who Develop A Pattern Of Negligence	Board of Medical Examiners required to determine if action against physician is necessary. A summary of actions taken is required to be published. Pool annual assessment partially on the basis of the number and type of claims.

GOALS OF THE MONTANA MEDICAL ASSOCIATION IN CONNECTION WITH THE LOSS OF OBSTETRICAL SERVICES

General Goals: Solutions Must

- support access to all levels of obstetrical health care, including but not limited to stemming the flow of doctors from the practice of obstetrics
- encourage improvements in the quality of health care in general and specifically the quality of pre-natal care;
- enhance, not impair, the physician-patient relationship;
- resolve medical malpractice claims promptly, proportional to the injury;
- provide reasonably predictable outcomes for such claims;
- operate any program efficiently and fairly, with due regard for the constitutional rights of all involved.

General Legislative Goals: A Legislative Solution Which

- Immediately reduces the cost of insurance and provides
- Increased predictability of how much is likely to be paid out on medical malpractice claims, so that the funds can be properly raised from those who pay for such damages;
- Increased settlement of claims at levels proportional to damages suffered by injured parties
- Required pass-through of insurance savings to those who foot the bill for the solution, including patients.
- Risk prevention, increased quality of prenatal care, and sufficient oversight of physicians who are negligent, to reduce the number of medical malpractice claims
- Mandatory low levels of insurance for participating physicians
- Other specific benefits to claimants with injuries which are not currently available, which outweigh any potential infringement of constitutional rights caused by the legislation or its application.

MMA Obstetrical Legislation: Estimated Savings To Participating Physicians

TOTAL FIVE-YEAR DOLLAR SAVINGS WITH LEGISLATION

Specialty	No Tail Endorsement	Tail Endorsement
Family Practice With Obstetrics		
Utah	$ 30,000	$ 35,000
Doctors Co	$ 27,000	$ 34,000
St. Paul	$ 41,000	$ 57,000
OBGYN		
Utah	$ 65,000	$ 76,000
Doctors Co	$ 42,000	$ 52,000
St. Paul	No Policyholders Left In Montana	

EXHIBIT 2.
DATE 2-17-89
HB 699 - ADDY

Who's Going to deliver Your Baby?

THE LOSS OF OBSTETRICAL SERVICES IN MONTANA

revised

An Innovative Proposal

prepared by the Montana Medical Association

EXHIBIT - 3.
DATE 2-17-89
SB 699- ADDY

Who's Going to deliver Your Baby?

THE LOSS OF OBSTETRICAL SERVICES IN MONTANA

An Innovative Proposal

prepared by the Montana Medical Association

Actuarial Considerations for the Formation of a Patients' Compensation Fund in Montana

EXHIBIT 5
DATE 2-17-89
HB 699 - ADDY

Kalispell Ob-Gyn Associates, P.C.

OBSTETRICS GYNECOLOGY INFERTILITY

VAN KIRKE NELSON, M.D.
JOHN L. HEINE, M.D.
ELLIS M. SOWELL, M.D.

DIPLOMATS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

February 17, 1989

Dear Representative:

This letter is being written to you as a lawmaker, and as an individual whose vote is very important. I apologize for the fact that this letter is duplicated, but nevertheless, if you ponder its contents you will appreciate its importance to your constituents, your neighbors, and members of your own family. I am writing this letter as a past president of the Montana Medical Association and member of Governor Schwinden's Obstetrical Liability Advisory Panel, and a practicing obstetrician/gynecologist in Kalispell, Montana.

Through vital statistics available to us and to you through governmental agencies, and the Montana Dept. of Health and Environmental Sciences, the neonatal death rate in Montana is the second lowest in the nation at 4.8 deaths per thousand deliveries; while the national average is 11-12 deaths per thousand. Access to care for all obstetrical patients is in the top one-third of states, while the length of stay and cost per illness rates as one of the lowest in the United States.

Despite the above, the cost of malpractice insurance in Montana rates as one of the highest in the nation. Four years ago this office had liability insurance with limits of $2/4 million. Our insurance premium has become of such magnitude that we reduced our limits to $1/3 million coverage. This year, our insurance premium for the three of us will be $117,115.68--an increase of $18,000 since I stood before you in this room two years ago. You might say---if it's too much, just go bare. Responsible physicians do not go bare because we feel that if we make a mistake that is indeed malpractice, the patient should be compensated. Compensated yes---enriched no.

210 Sunny View Lane - Kalispell, Montana 59901 Telephone 406-752-5252

EXHIBIT 5
DATE 2-17-89
HB 699

The practice of medicine in Montana does not generate the type of revenue to pay premiums of this nature. Statistics are available from the Montana Dept. of Revenue that very clearly demonstrates that the income of Montana physicians is considerably less than the national average. Then who pays? Certainly it can't be the Medicaid recipient, as SRS compensation for Medicaid has been frozen since 1982. It won't be the senior citizen over age 65, whose fees have been set by Medicare with essentially a freeze, likewise since 1982. Then it comes down to the consumer in between. It's called "cost-shifting", but you can only cost-shift so much to your patients already strapped by a burdeoned economy.

We are told many reasons for our high premiums: Greedy insurance companies, greedy attorneys, and bad doctors. If obstetrical care is so bad, why is Montana one of the safest places to have a baby. In addition, "bad care" usually generates increased costs. Yet the per capita health care costs in Montana is 24% less than the rest of the nation.

Montana physicians, I do believe, will not deny care because of inability of an individual to pay for care. Certainly statistics bear that out. I do not believe that you will see a scene in Montana as enacted two years ago in Florida when emergency rooms were shut down in large hospitals because of excessive malpractice premiums. However, denial of care is coming to Montana in a different way. If the cost of providing a service becomes too excessive, then the service will cease to be provided. Such is the case with obstetrics. In Montana, many physicians have already given up the practice of obstetrics, with the loss of physicians becoming acute in rural Montana. Rural physicians can no longer afford the existing medical liability insurance premiums. There is absolutely no question that many providers are being driven from the market place and seriously limiting access to care in Montana. The non-availability of care has and is closing down obstetrical departments in hospitals, with the only choice of the patient in that rural area to drive long distances with its attendant risks.

In northwest Montana where I practice, we have seen the loss of total services in Plains, all but one physician in Polson, five physicians in Kalispell, several in Whitefish--including the only obstetrician/gynecologist in that community, and a loss of physicians in Libby.

EXHIBIT 5
DATE 2-17-89
HB 699

I, and those of us who practice obstetrics, see the only solution to be through meaningful tort reform. California, as a result of their liability crisis, passed excellent tort reform laws. These laws were sustained on appeal through their Supreme Court. Their increase in liability premiums has averaged 1% a year.

Montana medicine is doing its utmost to keep costs down and to provide access for medical services to all Montana citizens. We no longer control access to care when our liability premiums exceed the compensation for those obstetrical services. The continued access to care of the obstetrical patient in Montana to their own physician in their own community is in your hands.

I appreciate very much the time and the effort that each of you spend in resolving Montana's complex problems. Thank you.

Cordially,

Van Kirke Nelson

Van Kirke Nelson, M.D.

VKNjw

EXHIBIT 5
DATE 2-17-89
HB 699

LIABILITY PREMIUM

KALISPELL OB-GYN ASSOC., P.C.
VAN KIRKE NELSON, M.D., JOHN L. HEINE, M.D.
ELLIS M. SOWELL, M.D.
210 SUNNYVIEW LANE
KALISPELL, MONTANA 59901

93-48
929

12913

PAY [illegible] DOLLARS

DATE	TO THE ORDER OF	GROSS AMOUNT	FED. W/H	F.I.C.A.	STATE W/H	NET AMOUNT
2/16/89	The Doctors Company	Malprac Prem.				142,115 68

DESCRIPTION

KALISPELL OB-GYN ASSOCIATES

Van Kirke Nelson, MD

FIRST INTERSTATE BANK of Kalispell, N.A.
KALISPELL, MONTANA

1, 1988 Thru March 31, 89

⑈012913⑈ ⑆092900480⑆ 10⑈901⑈0⑈

facsimile

THIS FACSIMILE CHECK REPRESENTS THE MEDICAL LIABILITY INSURANCE PREMIUM FOR THIS OFFICE OF THREE PHYSICIANS, AND INCLUDES THE 18% DISCOUNT AVAILABLE THROUGH MEMBERSHIP IN THE MONTANA MEDICAL ASSOCIATION. WITHOUT THIS DISCOUNT, OUR PREMIUM WOULD BE $142,824. THE COVERAGE IS FOR $1/3 MILLION LIMIT OF COVERAGE, AND REPRESENTS THE MATURED LEVEL FOR OUR PRACTICE. THIS OFFICE FORMERLY HAD $2/4 MILLION LIMIT OF COVERAGE, BUT DROPPED THE LIMITS BECAUSE OF INABILITY TO AFFORD.

EXHIBIT 5 (2)
DATE 2-17-89
HB 699

COST OF TAIL COVERAGE

KALISPELL OB-GYN ASSOC., P.C.
VAN KIRKE NELSON, M.D., JOHN L. HEINE, M.D.
ELLIS M. SOWELL, M.D.
210 SUNNYVIEW LANE
KALISPELL, MONTANA 59901

93-48
929

12912

PAY INSURED CHECK TO BOOT PROOF ONLY DOLLARS

DATE	TO THE ORDER OF	GROSS AMOUNT	FED. W/H	F.I.C.A.	STATE W/H	NET AMOUNT
2/16/89	The Doctors Company	Tail Coverage				210,801.00

DESCRIPTION

FIRST INTERSTATE BANK of Kalispell, N.A.
KALISPELL, MONTANA

KALISPELL OB-GYN ASSOCIATES
Von Kirke Nelson, M.D.

⑈012912⑈ ⑆092900480⑆ 10⑈901⑈0⑈ Facsimile

THIS FACSIMILE CHECK REPRESENTS THE COST TO THIS OFFICE FOR TAIL COVERAGE SHOULD THE THREE OF US TERMINATE OUR PRACTICE. IT IS BASED ON 180% OF OUR PRESENT PREMIUM ($117,115.68).

EXHIBIT 5
DATE 2-17-89
HB 699

THE DOCTORS' COMPANY MONTANA PREMIUM RATES AS OF APRIL 1, 1988

SPECIALTY	$500,000/$1.5 Million Limits of Coverage				$1/3 Million Limits of Coverage				$2/4 Million Limits of Coverage			
	Year 1	Year 2	Year 3	Year 4 (Mature)	Year 1	Year 2	Year 3	Year 4 (Mature)	Year 1	Year 2	Year 3	Year 4 (Mature)
ADMINISTRATIVE MEDICINE	$1,480	$2,336	$3,016	$3,308	$1,828	$2,884	$3,724	$4,084	$2,340	$3,692	$4,768	$5,228
ALLERGY/IMMUNOLOGY	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
ANESTHESIOLOGY	5,920	9,344	12,056	13,216	7,300	11,524	14,868	16,300	9,344	14,752	19,032	20,868
CARDIOLOGY (invasive)	6,656	10,504	13,552	14,360	8,208	12,952	16,712	18,324	10,508	21,260	21,392	23,456
CARDIOLOGY (non-invasive)	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
CERTIFIED NURSE-MIDWIFE (additional named insured—direct supervision)	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
CERTIFIED NURSE-MIDWIFE (additional named insured—indirect supervision)	8,508	13,428	17,328	18,996	10,492	16,560	21,368	23,428	13,432	21,200	27,356	29,996
COLON & RECTAL SURGERY	6,656	10,504	13,552	14,860	8,208	12,952	16,712	18,324	10,508	21,260	21,392	23,456
DERMATOLOGY	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
DERMATOLOGY (suction assisted lipectomy)	5,920	9,344	12,056	13,216	7,300	11,524	14,868	16,300	9,344	14,752	19,032	20,868
DIAGNOSTIC RADIOLOGY	3,180	5,020	6,476	7,100	3,924	6,192	7,988	8,760	5,024	7,928	10,228	11,216
EMERGENCY MEDICINE	6,656	10,504	13,552	14,860	8,208	12,952	16,712	18,324	10,508	21,260	21,392	23,456
ENDOCRINOLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
FAMILY/GENERAL PRACTICE (minor surgery—no Obstetrics)	3,328	5,252	6,776	7,428	4,104	6,476	8,356	9,160	5,256	8,292	10,700	11,732
FAMILY/GENERAL PRACTICE (no surgery-hospital care)	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
FAMILY/GENERAL PRACTICE (restricted major surgery—no Obstetrics)	6,656	10,504	13,552	14,860	8,208	12,952	16,712	18,324	10,508	21,260	21,392	23,456
FAMILY/GENERAL PRACTICE (with Obstetrics)	9,248	14,596	18,832	20,648	11,404	18,000	23,224	25,464	14,596	23,040	29,728	32,596
GASTROENTEROLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
GENERAL MEDICINE (restricted)	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
GENERAL SURGERY	8,284	13,072	16,868	18,492	10,216	16,120	20,800	22,804	13,076	20,636	26,628	29,196
GYNECOLOGY (major surgery)	8,284	13,072	16,868	18,492	10,216	16,120	20,800	22,804	13,076	20,636	26,628	29,196
HAND & FOOT SURGERY	9,248	14,596	18,832	20,648	11,404	18,000	23,224	25,464	14,596	23,040	29,728	32,596
HEMATOLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
INFECTIOUS DISEASE	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
INTERNAL MEDICINE	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
NEONATOLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
NEPHROLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
NEUROLOGY	3,328	5,252	6,776	7,428	4,104	6,476	8,356	9,160	5,256	8,292	10,700	11,732
NEUROSURGERY	17,756	28,020	36,152	39,632	21,896	34,552	44,580	48,872	28,028	44,228	57,064	62,556
NUCLEAR MEDICINE	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
NURSE PRACTITIONER	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
OBSTETRICS & GYNECOLOGY	17,296	27,292	35,212	38,604	21,328	33,656	43,424	47,608	27,300	43,080	55,584	60,944
ONCOLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
OPHTHALMOLOGY (major surgery)	3,328	5,252	6,776	7,428	4,104	6,476	8,356	9,160	5,256	8,292	10,700	11,732
OPHTHALMOLOGY (minor surgery)	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
ORTHOPEDIC SURGERY	12,576	19,848	25,608	28,076	15,508	24,476	31,580	34,624	19,852	31,332	40,424	44,324
OTOLARYNGOLOGY (major surgery, facial cosmetic plastic surgery)	8,508	13,428	17,328	18,996	10,492	16,560	21,368	23,428	13,432	21,200	27,356	29,996
OTOLARYNGOLOGY (major surgery, no facial cosmetic plastic surgery)	6,656	10,504	13,552	14,860	8,208	12,952	16,712	18,324	10,508	21,260	21,392	23,456
PATHOLOGY	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
PEDIATRICS	3,328	5,252	6,776	7,428	4,104	6,476	8,356	9,160	5,256	8,292	10,700	11,732
PHYSICAL MEDICINE & REHABILITATION	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
PHYSICIAN'S ASSISTANT	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
PLASTIC SURGERY	9,248	14,596	18,832	20,648	11,404	18,000	23,224	25,464	14,596	23,040	29,728	32,596
PSYCHIATRY	1,480	2,336	3,016	3,308	1,828	2,884	3,724	4,084	2,340	3,692	4,768	5,228
PULMONARY MEDICINE	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
RHEUMATOLOGY	2,660	4,200	5,420	5,944	3,280	5,180	6,684	7,332	4,200	6,632	8,560	9,386
SURGICAL SPECIALTY (office practice, minor surgery & procedures only)	3,328	5,252	6,776	7,428	4,104	6,476	8,356	9,160	5,256	8,292	10,700	11,732
THERAPEUTIC RADIOLOGY	6,656	10,504	13,552	14,860	8,208	12,952	16,712	18,324	10,508	21,260	21,392	23,456
THORACIC—CARDIOVASCULAR SURGERY	8,284	13,072	16,868	18,492	10,216	16,120	20,800	22,804	13,076	20,636	26,628	29,196

EXHIBIT 5
DATE 2-17-88
HB 699

Doctors to deliver babies may be endangered species

By CHARLES S. JOHNSON
Tribune Capitol Bureau

HELENA — Without some major changes soon, the number of Montana doctors who deliver babies will continue to plummet, particularly in rural areas, because of soaring malpractice insurance rates, speakers said at a conference Thursday.

Dr. Robert St. John, an obstetrician from Butte, estimated that half of the state's family practitioners who now deliver babies will have quit that part of their practice by the end of the year. The problem is especially acute in rural areas of Montana, he said.

"There will be areas bigger than New England with nobody delivering babies," he told an audience of 140 people at a conference entitled: "Montana's Crisis in OB Care: Perceptions and Solutions."

St. John also estimated that 10 percent of the state's 100 obstetricians, doctors who specialize in treating pregnant women and delivering babies, will have quit their practices by the end of the year.

"The bottom line is that pregnant women in this state are losing access to medical care," said Dr. Donald Espelin, chief of the state Health Department's Preventive Health Services Bureau.

Dr. Van Kirke Nelson, past president of the Montana Medical Association, told how he paid $300 a year for malpractice when he arrived in Kalispell in 1962 as the city's first fully trained obstetrician and gynecologist. Today, Nelson said he and his two partners pay a combined bill of $53,430 a year in obstetrical malpractice premiums.

Yet over the same 25-year period, Nelson said the infant and fetal death rates in Montana have dropped sharply, with the state ranking among the best nationally, even though obstetrical malpractice insurance rates have soared here. He attributed the improved birth records largely to improved and increased medical technology available.

As these rates continue to rise, more and more physicians, particularly in rural areas, will give up delivering babies, Nelson said. This will force rural hospitals to close their obstetrical and newborn departments and perhaps even the hospitals themselves, he predicted.

As evidence, Nelson cited a survey being taken by the Montana Hospital Association. Fourteen of the 30 hospitals that have responded so far said they would be forced to sharply curtail their services or even close if they could no longer deliver babies because of the lack of physicians and loss of money.

If these rural hospitals stop delivering babies, pregnant women will be forced to drive many miles, often in inclement weather, for medical care and to have their babies delivered, he said.

Nelson questioned whether Montana's health and birth statistics would continue to improve if women are forced to travel such distances, when obstetrical emergencies can happen in a matter of minutes.

David Cornell, administrator of Montana Deaconess Medical Center in Great Falls, said the decision by rural hospitals and physicians to no longer deliver babies imposes a great burden on larger hospitals in Great Falls, Billings and Missoula.

"We in Great Falls are not overjoyed at the potential increase in business," Cornell said, pointing to the increased risk posed by such a trend.

He said quality of health care is increased by having medical care available in someone's home community.

Attorney John Warner of Havre, president of the State Bar of Montana, said that with costly advances in medical technology, "It's hard, if not impossible, to have the care in Culbertson, Wolf Point and Scobey that you're going to have in Billings." Because rural hospitals can't afford much of this medical technology, it is easier to establish liability in malpractice lawsuits in places like Scobey than in Billings, he said.

One possible reform, Warner said, would be to return to the community standard for judging liability. But he warned that such a system would mean that a couple having "a bad baby" in Scobey could receive nothing in a malpractice suit, while a couple in Billings might obtain more than $1 million.

EXHIBIT
DATE 2-17-89
HB 699

8A Great Falls Tribune Tuesday, January 5, 1988

Survey says loss of obstetrics may force hospitals to close

By CHARLES S. JOHNSON
Tribune Capitol Bureau

HELENA — Nearly half of the Montana hospitals that delivered babies in 1986 may be forced to close or sharply curtail services because of the lack of physicians and lost revenue from obstetrical services, a survey of hospitals shows.

The survey, conducted by the Montana Medical Association and Montana Hospital Association, is not complete yet. So far, 64 hospitals representing 52 percent of the state's hospitals and 59 percent of the hospital beds, have responded.

The partial results are being released today in Billings at a meeting of the insurance subcommittee of the Governor's Council on Economic Development in Billings. Dr. Van Kirke Nelson of Kalispell will be discussing the results as he testifies on behalf of the Montana Medical Association.

Nelson said Monday that he fears that the final survey results may be even more "devastating."

The Medical Association has been pressing for Gov. Ted Schwinden to call a special session of the Montana Legislature to address issues involving the rapidly climbing costs of medical malpractice insurance for doctors delivering babies. Some physicians in rural areas have said they no longer will deliver babies because of the high malpractice insurance costs.

The partial survey results show that 15 hospitals responding or 48 percent said they might be forced to close or sharply reduce services because of unavailability of physicians and if they lose money from their obstetrical units, nursery and pediatrics areas.

These hospitals weren't identified in the partial survey but will be when the final results are published in the coming weeks, Nelson saisd.

If these obstetrical services are dropped, pregnant women will have to seek medical care elsewhere, Nelson said.

And if hospitals close, jobs will be lost, hurting Main Street businesses in these towns, he said.

The hospital survey shows that nearly half of the physicians who delivered babies at the responding hospitals in 1986 have recently quit their obstetrical practices or are seriously considering doing so soon.

It showed that 45 physicians out of 163 doctors practicing in the hospitals that responded have recently ended their obstetrical practices.

An additional 20 percent of the physicians practicing in these hospitals — or 32 doctors — have said they may soon terminate obstetrical services.

The survey also explored the ability of pregnant women to safely reach hospitals for Cesarian-section births. It noted that experts warn that the operation must be performed within 30 minutes of when the birth complications develop, or a medical malpractice liability can occur.

The average time to the nearest hospital for all of those delivering babies in Montana in 1986 was 32 minutes, based on a driving speed of 65 mph, the report said. The nearest hospitals providing obstetrical services ranged from being 2 minutes to 83 minutes away.

But 13 percent of the hospitals providing obstetrical services in 1986 do not have the capabilities for C-section births, according to the survey.

The survey also found that 23 percent of the responding hospitals that deliver babies were providing some sort of subsidy to obstetrical doctors for their medical malpractice insurance.

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■ Wilderness silver mines / PAGE 14

MONTANA WESTERN

Obstetrics cutback defies simple solution

By GREG LAKES
of the Missoulian

HAMILTON — For rural Montana doctors to stay in the baby business, they have to have affordable malpractice insurance. And for insurance companies to slow spiraling rates, they have to be able to predict their costs.

No one is proposing laws to eliminate compensation to victims of malpractice. But two proposals would take at least some awards out of the hands of juries, remove them from a system critics say is little better than a lottery, and inject some predictability into costs.

The so-called Virginia plan, under study and tentatively endorsed by Andrea Bennett, state auditor and insurance commissioner, would allow some claims to be decided in a no-fault system of compensation.

Another plan, released recently by the ontana Medical Association, would award malpractice victims predetermined damages, and require doctors to carry a minimum level of malpractice insurance, with additional coverage provided by a pool.

Either plan would require adoption by the Legislature, and backers of both want a special session early next year.

The Virginia plan, to take effect in that state Jan. 1, takes out of the courts damage claims for severe neurological injuries resulting from birth, some of the most expensive awards when decided by juries.

If a baby's injury meets the legal definition, and if it was born at a participating hospital and attended by a participating doctor, the parents can file a claim.

A panel of physicians decides if the claim is valid, and refers it to the same Virginia board that handles workers' compensation cases. The board determines the award.

The system pays medical, hospital, rehabilitative and custodial expenses of the infant, plus living expenses after age 18. It notifies the state's licensing boards of all claims, a deterrent to negligence if the doctor or hospital want to keep their licenses.

A May 1987 article in the Virginia Hospital Association's magazine conceded that officials are uncertain if fees paid into the program's pool will, be enough to cover awards, but lauded the plan as a test to fine-tune a system that may also work for other high-risk areas of medicine.

Bennett and staff have yet to decide which state agency in Montana would handle claims, what the projected costs might be, or if Montana insurers would agree to put a lid on costs, as did Virginia's.

It would automatically refer claims to Montana licensing boards for investigation. Those state licensing boards are now reviewing past claims to weed out those doctors and hospitals most often at fault.

"We can't continue to pay for those doctors and hospitals that are the culprits," Bennett said.

In Virginia, participating doctors pay $5,000 a year, non-participating doctors pay $250, and hospitals chip in $50 per delivery, up to $150,000 a year. Bennett is still examining potential costs in Montana, but said the ratio between doctors' and hospitals' rates would be similar.

The Montana Medical Association proposal has two key aspects: One would allow mothers to buy 'trip" insurance on their first prenatal visit, that would automatically pay them specified amounts for specified injuries, without going to court.

The other would fundamentally change the state's legal system. Juries would decide only if a doctor was negligent. Damages would be based on "economic loss," the cost of caring for a child injured at birth.

Awards for pain and suffering, and attorney fees, would be a set proportion of the economic loss at proportions that vary with the severity of the injury.

All claims would be reviewed by the state's existing medical legal panel before they go to court, affording claimants a chance then to opt for arbitration. And the plan calls for notifying the Board of Medical Examiners of all claims, to track doctors and hospitals chronically accused of malpractice.

Actuarial reports predict the plan could lower obstetrical malpractice premiums by 52 percent the first year.

Numbers define dilemma

Brian Zins, president of the Montana Medical Association, estimated that one-third of the state's 312 family-practice physicians have dropped obstetrics care in the past year due to rising insurance premiums. He said as many as 60 percent could stop delivering babies by the first of the year.

"There will be areas bigger than New England with nobody delivering babies," said Dr. Robert St. John, a Butte obstetrician, who added that 10 percent of the state's 100 obstetricians may quit their practices by the end of the year.

Dr. Van Kirke Nelson, past president of the Montana Medical Association, told a conference in Helena Friday he paid $300 a year for malpractice insurance when he arrived in Kalispell in 1962. Today, he and his two partners pay a combined bill of $53,430 a year in obstetrical malpractice premiums.

A survey by the Montana Academy of Family Physicians last month reported that of 132 doctors questioned, 42 percent had stopped delivering babies and another 14 percent expect to drop the service by June.

The survey also showed that the average annual malpractice insurance premium for Montana obstetricians has jumped from $15,700 two years ago to $42,900 this year. Family practicitioners who deliver babies have seen their average rate climb from $5,000 to $11,300.

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DATE 2-17-89
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Nelson warns governor's panel of OB crisis

BILLINGS (AP) — A state-run insurance plan is needed to assist doctors who are being overwhelmed by rising malpractice insurance costs for baby-delivery services, a governor's panel was told Tuesday.

"Obstetrics is the tip of the iceberg," Dr. Van Kirke Nelson of Kalispell told the insurance committee of the Governor's Council on Economic Development.

"And perhaps as we seek a solution in the problem facing it today, the solution can be passed on to solving problems in other disciplines of medicine as it affects availability of care."

Gerald Neely, an attorney representing the Montana Medical Association, and state Auditor Andrea Bennett suggested developing new insurance plans to substitute for the present legal-insurance system.

Committee Chairwoman Kay Foster said Gov. Ted Schwinden wants recommendations from her committee by Feb. 15. There has been talk of a special legislative session to consider the OB crisis and other matters, but Schwinden today said he is not yet convinced of the need for such a session to address the OB problem and property tax freeze concerns.

Doctors and medical groups have been saying for several months that the skyrocketing cost of insurance for obstetrical care is causing many doctors to stop delivering babies.

In the Flathead Valley, a Columbia Falls doctor announced he had stopped delivering babies last summer. But North Valley Hospital on Jan. 1 started operating obstetrics clinics in Whitefish and Columbia Falls, using the services of local doctors. The arrangement relieves doctors of having to pay insurance premiums and is expected to keep most of them in the baby-delivering business.

Neely urged the panel to adopt an MMA proposal that calls for legislative action, including a state-run insurance plan that mandates low-cost payouts and a pool of money to cover claims above the limit.

Bennett proposed a no-fault plan that could settle claims outside the courts, thus making compensation to injured parties more predictable. Lawyers would not share in the awards, she said.

The plan would not allow lump-sum payments to the injured, but rather smaller payments for services rendered to treat whatever injury was suffered.

Mae Nan Ellingson of the Montana Health Facility Authority wondered if insurance premiums paid by Montana doctors are based on Montana claims or national claims. If they are based on national claims, she said, a self-insurance trust fund created by the state is a possible solution.

Nelson suggested an additional tax on tobacco to finance such a self-insurance fund.

Nelson reported on a survey that indicated that almost half of the Montana hospitals that delivered babies in 1986 may have to close or curtail obstetric services because of lost revenue from the specialty.

The survey conducted by the Montana Medical Association and the Montana Hospital Association is not yet complete.

The partial survey results dramatize the severity of the problem.

The 33 hospitals responding to the survey represent 52 percent of Montana's 64 hospitals and 59 percent of available hospital beds.

Of those responding, 15 said they may be forced to close or sharply reduce services because of unavailability of physicians and lost income from their obstetrical units, nursery and pediatrics areas.

The hospitals were not identified in the partial survey but will be when final results are published, Nelson said.

The survey also said that nearly half the physicians who delivered babies in 1986 either have quit their obstetrical practice or are considering it.

Of 163 physicians responding, 45 already have quit obstetrical work and an additional 32 say they may soon.

Nelson said the final survey results may be even more devastating.

Broers sent

John Broers, owner of the Stanton Creek Lodge near Essex, was sentenced Tuesday to three years in the Flathead County Jail — six consecutive six-month terms.

District Judge Bart Erickson handed down the sentences because Broers violated the terms of suspended sentences on five prior misdemeanor assault convictions and a charge of criminal mischief.

Flathead County Attorney Tom Esch asked for the revocation based on Broers' testimony during his recent felony assault trial. Broers

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Lack of prenatal care endangers health of rural mothers, babies

By CATHERINE A. SIEGNER
of the Missoulian

Administrators and physicians at Missoula's Community Hospital are concerned the medical malpractice crisis will bring women from miles around to the emergency room, ready to deliver.

And, they say, with fewer rural doctors delivering babies, chances are these women won't have had the advantage of regular prenatal care.

"From the viewpoint of the baby, one of the highest correlations with a good outcome is early and consistent prenatal care," says Dr. Dan Harper, a Missoula pediatrician and medical director of the hospital's neonatal intensive care unit.

"We're extremely worried in western Montana now because there are mothers who live very far away from here — 100, 150 miles away — who can no longer get prenatal care at their local hospital or doctor, and we just know that those mothers aren't going to be coming here for the prenatal care that they need," he says.

Hospital executive director Grant Winn says he anticipates increased risk to the patient and her baby without prior care.

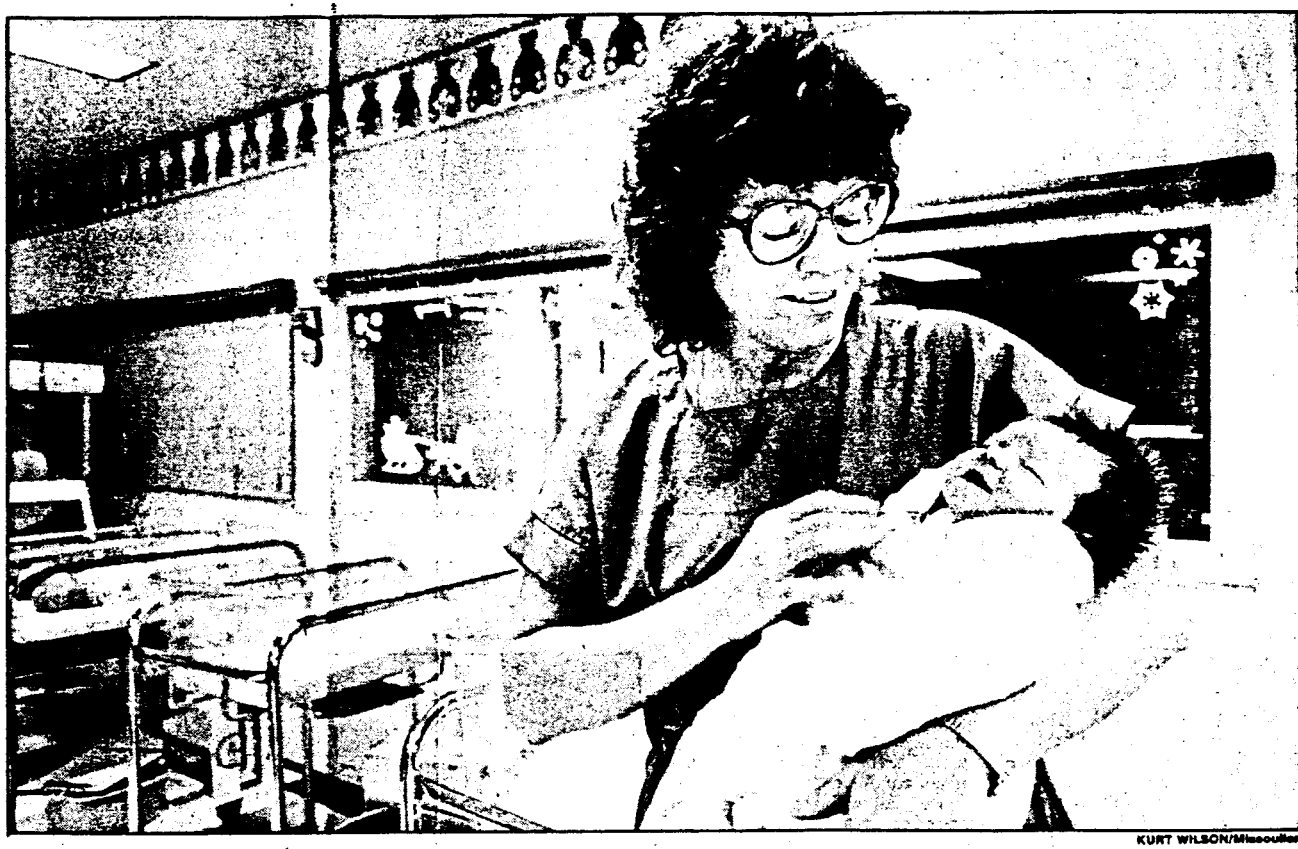
"There is increased risk to the mother who hasn't had prenatal care, and no one knows what went on, and she shows up here," he says, adding, "Physicians aren't crazy about taking patients who they know nothing about and who've had no prenatal care at all."

Another risk is a trip here during wintry weather when a woman is in labor, Winn notes.

"What I fear is the icy road between Plains and Missoula," he says.

Just 16 Missoula physicians are continuing to deliver babies, says Dr. Craig W. McCoy, medical director of the obstetrical unit at Community, and that total will decrease by two next year.

Ten of those left are obstetricians and six are family practice physicians, he says, adding, "There were three or four others (family practitioners) who were (delivering) and are not now."



KURT WILSON/Missoulian

Rita Devlin, a registered nurse at Community Hospital, cradles a newborn Saturday. With fewer rural doctors delivering babies, expectant parents from outlying areas must drive to a larger city for delivery and newborn care.

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DATE 2-17-89
HB 699

Baby hospitals declining

HELENA (AP) — Almost half the Montana hospitals that delivered babies in 1986 may have to close or curtail obstetric services because of lost revenue from the specialty, a survey indicates.

The survey conducted by the Montana Medical Association and Montana Hospital Association is not yet complete, but Dr. Van Kirke Nelson of Kalispell said he planned to discuss the partial results this week at a meeting in Billings.

Nelson appeared before the insurance committee of the Governor's Council on Economic Development on Tuesday.

Obstetrical care has become a major controversy in Montana because doctors, facing skyrocketing malpractice insurance rates, are abandoning the field, which runs a high risk of lawsuits.

The medical association has called on Gov. Ted Schwinden to convene a special session of the Montana Legislature to address the issue.

Partial survey results dramatize the severity of the problem.

So far, 33 hospitals have responded to the survey, representing 52 percent of Montana's 64 hospitals and 59 percent of available hospital beds.

Of those responding, 15 said they may be forced to close or sharply reduce services because of unavailability of physicians and if they lose money from their obstetrical units, nursery and pediatrics areas.

The hospitals were not identified in the partial survey, but will be when final results are published, Nelson said.

—Montana—

Hospitals subsidize insurance premiums for Hamilton doctors

HAMILTON (AP) — Directors of the hospital here have decided to pay part of three local physicians' insurance premiums so that they will continue to deliver babies.

Richard Atkins, administrator of Marcus Daly Memorial Hospital, said the move is aimed at offseting spiraling rates for obstetrical malpractice insurance, increases that would have forced two of Hamilton's three medical doctors to stop delivering babies when their policies expire early next year.

Jim Ahrens, president of the Montana Hospital Association, said an October survey showed 12 hospitals, all of them with less than 50 beds, are subsidizing their doctors' insurance premiums.

Fifty-four of the state's 60 hospitals responded to the survey, Ahrens told the Missoulian newspaper, but he would not release the names of individual hospitals.

Rising rates for medical malpractice insurance, especially in obstetrics, has prompted an exodus of Montana doctors out of the baby business. An estimated 50 percent of family practitioners have stopped delivering babies, and the figure is expected to climb to 60 percent by the end of the year, according to Brian Zins, executive director of the Montana Medical Association.

When doctors stop delivering babies, Zins said, they must purchase so-called tail coverage, insurance that would cover lawsuits arising from past deliveries. That one-time premium costs up to twice the annual malpractice premium. As insurance premiums increase, so does tail coverage, and many doctors are getting out of obstetrics now before quitting becomes even more expensive.

The hospital at Hamilton will pay the obstetrics portion of malpractice insurance for Drs. Randy Stewart, Walker Ashcraft and Michael Lawler, Atkins told the Missoulian.

Stewart planned to quit obstetrics when his current policy expired Jan. 1. Ashcraft was to stop Feb. 1, and Lawler would have been the only obstetrician for all of southern Ravalli County, the newspaper said.

Atkins would not say what the non-profit hospital's cost would be, but said it likely won't be reflected in higher rates for patients.

"If we have a profitable year, we will just accept it as an unusual expense," he said. "Our operating picture to this point isn't glowing, but we felt we could absorb it."

Atkins said chipping in on insurance premiums is a one-year test for the hospital, a period officials hope will be long enough to find more permanent solutions, possibly through the legislative route.

EXHIBIT 5
DATE 2-17-89
HB 699

"Who is going to deliver my baby?"

by James C. Ryan

When Dr. Van Kirke Nelson was a student in medical school, a maxim told to him by one of his professors was that patients pick their physician based on "three A's", ability, availability, and affability. Today, with the ever-growing threat of escalating malpractice premiums looming over the medical community, affordability must be added to the list, according to the Kalispell obstetrician. Though the medical profession as a whole is concerned about the future of practicing their chosen specialities, Nelson is especially worried about the new "A", and how it will impact on his specialty - obstetrics - and the future of such care statewide.

"Obstetrics is just the tip of the iceberg, and perhaps as we see a solution to the problem facing us today, the solution can be passed on to solving problems in other disciplines of medicine as it affects the availability of care," Nelson explains.

He continues that a few years ago, the most dramatic problem facing physicians was availability of malpractice insurance, with several carriers having pulled out of the state. Now the most pressing issue is "affordability". "As malpractice premiums increase, so do the costs to the consumers - the patients, and that is exactly what is happening here in Montana."

Nelson relates that many Montana physicians are now faced with premium costs that they are unable, or unwilling to pass on to their patients. "When this happens, the physician usually ceases the provision of that service," Nelson explains. "And if that service is no longer available to the patient's community, then they are forced to seek care elsewhere." Though insurance premiums for Montana obstetricians have risen dramatically in the past few years, the U.S. Surgeon General has recently released facts showing the quality of obstetrical care in the state is "excellent". The Big Sky State has a neonatal death rate of only five thousand births, making it one of the lowest in the nation. The surgeon general also reports that the percentage of women receiving early prenatal care, including Medicaid, ranks Montana in the top third of the states.

While Nelson recites the top-notch record of those delivering obstetrical care in Montana, he also points out that since he arrived in the state in 1962, his malpractice premiums for the obstetrical portion of his practice have risen from $300 to $17,810 per year. Should he ever wish to leave the practice of obstetrics, he would have to pay the hefty sum of $39,096 for "tail coverage", for those claims that might arise at some point in the future.

One major problem Nelson sees in the practice of obstetrics in Montana is that it is "labor intensive". He has one set fee for his obstetrical patients, and his office schedules between 3500 and 4000 OB visits per year. "Add to the cost of providing that service the present cost of liability insurance, and you would, based on compensation and cost efficiency, probably terminate the service," he continues.

In the same vein, Medicaid births in Montana in 1987 represented 28% of all deliveries. Medicaid compensates a physician in Montana $619 for complete prenatal care - delivery and post partum care. The cost to many physicians in Montana for their liability insurance alone averages to $700-900 per delivery. Not only does the Medicaid payment schedule not cover the doctor's costs, much less any profit, it is usually the Medicaid patient who represents the "high risk" patient in the practice. Not only does the physician have to pass on the cost of delivering a Medicaid recipient to the rest of the patients, but because of the high risk factors in this group, and the higher incidence of complications, the physician is at greater risk for future medical liability litigation.

Nelson, the immediate past president of the Montana Medical Association, goes on to point out that the medical association is actively pursuing alternative means of insurance so that physicians can continue to provide a service at an affordable cost, and so that the mothers-to-be in Montana will not have the concern as to "who will deliver my baby?"

EXHIBIT 6
DATE 2-17-89
HB 699

I am Sharon Dieziger and I represent the Montana Nurses Association. I'm here to speak in support of HB 699.

We commend the efforts of the Montana Medical Association and the months of preparation, planning, and thought put into this piece of legislation. We believe they have made a concentrated effort to negotiate the areas of controversy.

There is no question that we have an O. B. crisis in Montana. Action to begin to address ~~that~~ problem must begin now in this legislative session. We have a serious problem -- We cannot leave things as they are. We need to do something now to assure that physicians can begin to return to Obstetrical Practice. This is the first effort we have seen for this endeavor. I urge you to support HB 699.

7.
2-17-89
HB 699

Great Falls Tribune Sunday, February 5, 1989

The isolation ward

A Tribune special report on health care in rural Montana

IHS not insulated from rural health-care trouble

Being part of the federal bureaucracy does not insulate the Indian Health Service from rural health problems, says the Montana area director.

Duane Jeanotte, of the IHS office in Billings, says he too is dealing with personnel shortages, inadequate funding and problems of isolation and long distances to health care.

Roughly 40,000 Montanans, many of them from rural areas, receive their health care each year from Indian Health Service programs.

Jeanotte said his agency "most definitely" feels the stress of other rural facilities in recruiting workers. That was especially bad the past few years before pay increase gave them $70,000 to $100,000 a year.

Ideally, he said, the Billings office would like to have at least 44 doctors on staff throughout the area.

"But at any point in time, we're looking for two or three more," Jeanotte said, adding that a full-time staff member has been added to his office specifically to recruit doctors.

In the past, many physicians took out federal loans or received grants during medical school and repaid the government by working on reservations or at other federal institutions. One program, the National Health Service Corps, which placed nearly 65 percent of its physicians in rural settings, is being dismantled, according to the National Rural Health Association.

Jeanotte said the agency has experienced similar problems recruiting nurses, pharmacists and other health workers.

"Last year was especially bad for nurses," he said. "We seem to have weathered that for now — the pay increase helped — but with all the national trends with nurses, I'm sure we'll be hard hit again."

And Jeanotte admits there are other factors that make recruitment difficult.

"We have some extreme problems, for a variety of reasons," he said. "For one thing, there's almost no jobs or activities for spouses and we don't have the educational or social opportunities of cities."

Cultural differences between Indians and non-Indians also frustrate the process, he said. "There are a whole host of factors that have to do with our lifestyle," he said. "Some people adjust better than others. And, I think some just don't adjust."

While federal funding to the IHS has remained the same, Jeanotte said his office has seen drastic increases in demand for services and the costs charged by non-IHS providers.

"We're headed for a very difficult time; We're in very dire straits concerning resources," he said.

AIDS new challenge for small hospitals

Last summer, a transient male was brought to the Glacier County Hospital in Cut Bank for treatment. Unexpectedly, the staff was dealing with its first AIDS victim.

The man was placed in an isolated room, where he was treated for five or six days. He was then transferred to a Great Falls hospital.

"By some standards, the staff may have overreacted a little," said Mac Simpson, hospital administrator, about a half year after the incident. "But mostly I'm just very, very proud of everybody here and how they handled the whole situation. I don't think anybody in town even knew we had an AIDS patient here."

AIDS, the common term for acquired immune deficiency syndrome, is a growing health threat, with no known cure. It is most commonly transmitted through sexual contact or by contaminated needles. There have been reports, however, of some health care workers contracting the disease from contact with an infected patient.

Most rural hospital administrators contacted by the Tribune say they have not yet seen their first AIDS patient.

"I suppose it's just a matter of time, and we're going to have to start gearing up for that, eventually," said Les Urvand, administrator of the Phillips County Hospital in Malta. "But even if we never get an AIDS patient, the whole problem will consume a lot of health care dollars, just because we have to be prepared for it."

In Chester, hospital administrator Richard Brown said the fear of AIDS may be as difficult to deal with as the disease itself.

"We've not dealt with it (AIDS) directly yet, but I've had several of my staff say that if we had one (AIDS patient), they'd quit before they'd work," Brown said.

Further, he believes fears about AIDS have caused personnel shortages in some areas.

In Shelby, administrator Warner Bartelson says he believes small towns may see an influx of AIDS victims who decide to return to their home towns to die.

Richard Chiotti, the state AIDS program supervisor, said hospital administrators need to educate their staffs about AIDS and handling patients afflicted with the disease.

He said his office offers basic information and the Area Health Education Center in Bozeman can help with specifics of treatment.

Chiotti suggested that hospitals of all sizes should have an AIDS plan and a policy for employees.

Hospitals can't be exclusionary or discriminatory or they may face charges by the Human Rights Commission, he said.

Commuting keeps specialist up in the air to serve patients

SHELBY — Gary Andregg is a circuit rider of the skies over northcentral Montana.

The 50-year-old nurse anesthetist pilots his single-engine plane between five hospitals in five counties to administer anesthetics.

Andregg shrugs off attention to the wide area he covers, saying simply: "I'm mentally better off doing this than being in a large hospital."

Andregg, his wife, Karen, and their four children were convinced to move to the area 15 years ago by friends at the Toole County Hospital in Shelby, who said the hospital was in desperate need of someone to handle anesthetics.

"We said we'd come for a couple of years and try to put something together," he said.

What he put together was a coordinated schedule between hospitals in Shelby, Cut Bank, Conrad, Choteau and Chester for his services.

A nurse anesthetist, who typically has at least two years experience working in a hospital and the equivalent of a master's degree, does essentially the same kinds of work as an anesthesiologist, without being a physician. Andregg said nurse anesthetists administer about 65 percent of the anesthetics in this country. He said he is licensed to perform the same procedures as those done by an anesthesiologist.

Each hospital in his area has set up a different day for surgeries that are not emergencies. If he only has to travel to one town a day from his home south of Shelby, he may go by road.

But on any given day, it would not be unusual for two or three of the towns to have surgery because of the emergencies that arise, he said.

Because of the vast distances he must cover — it's about 130 road miles between Choteau and Chester, 20 minutes by plane — it's often easier to fly. That's especially true when the roads are icy.

In three of the towns — Shelby, Cut Bank and Choteau — Andregg leaves cars at the airfields so that he may drive to the hospital.

In Chester and Conrad, the airports are within a mile of the town, he said. "I need the exercise, and it's just a little jog to the hospital."

Keeping schedules straight and handling emergencies on short notice and in the middle of the night is challenging, and can sometimes be chaotic.

"It's fun, but you couldn't do it if all the hospitals weren't real patient and cooperative," he said. "And I really couldn't do it without my wife at home by the phone, keeping everything in order."

Andregg said one of the joys of his job is working with people he considers his neighbors.

"Just about every day you do surgery, you know the people you're working on," he said. "It makes your work very important to you."

But Andregg said he would not be able to survive without all five hospitals. No one of the hospitals could keep him busy and he must do different procedures to keep his skills honed.

Also, with malpractice insurance rates running about $1,000 a month, Andregg said he "absolutely must" work at all five facilities to pay for insurance and still make a profit for himself. Andregg must pay the insurance rate no matter how many or how few surgeries he performs in a month.

Andregg said five other nurse anesthetists have left Montana in the last 18 months because of the malpractice rates.

Andregg says he and his family have embraced their Montana lifestyle and spend as much of the time as they can skiing and enjoying the outdoors. But they also like an occasional change of scenery.

This summer, as they did three years ago, Gary and Karen Andregg will head to Honduras, where they volunteer their services for poor people.

Karen Andregg will act as a scrub nurse for her husband and they will assist a physician performing cleft-palate and lip surgeries. Andregg said the patients, who often recover outside on the lawn with only their families to watch over them, "are so happy to have whatever we can provide — it's one of those really rewarding experiences."

Centers geared to small towns

Montana is the test state for a new program to guarantee emergency and short-term health care in isolated communities where the hospital has closed, or is in danger of closing.

The state has been awarded $100,000 in federal funds to help set up Medical Assistance Facilities in five communities, according to Jim Ahrens, president of the Montana Hospital Association.

The MAFs would treat ill or injured patients for up to four days. Patients would be transferred for more care.

Though physicians would oversee medical procedures, most care would be delivered by physician assistants and nurse practitioners, he said.

The rules for MAFs would require that a physician, physician assistant or nurse practitioner be on duty or on call 24 hours a day and be within one hour of the facility. If a patient is admitted by a physician assistant or nurse practitioner, the supervising doctor must be contacted within 25 hours.

"This is a different approach for a hospital association to take, because these aren't hospitals," Ahrens said. "But we're seeing small hospitals close and we've got to do something to help these communities."

Though the sites for the first five pilot MAFs have not yet been chosen, he said the towns that had their hospitals close are "obviously anxious to be considered" and have the closed buildings available for use.

The hospital association is taking applications from communities interested in an MAF.

According to the guidelines established for the facilities, the placement area must be in a county with fewer than six residents per square mile or be more than 35 road miles from the nearest hospital.

Communities selected as MAF sites will be named later this spring, he said.

New professions ready to step in for doctors

Shortages of doctors and nurses in rural areas may be alleviated by mid-level health care professionals, such as physician assistants and nurse practitioners, representatives of those groups say.

"Some places have been trying to get doctors for years, but they just can't attract physicians to these small towns," said Jim Reid, secretary of the Montana Academy of Physician Assistants. "Physician assistants can do a good job filling in the holes, giving these towns some sort of care they can depend on."

Cathy Caniparoli, president of the state's Nurse Practitioner Special Interest Group, agreed that rural areas especially could benefit from such professions as nurse practitioners.

"We can offer a lot to many, many communities," Caniparoli said recently. "We can handle all the common health care needs — physical exams, colds, ear infections — the type of things most people use the health-care system for."

The Montana Hospital Association, working to establish Medical Assistance Facilities or immediate care-type centers in different communities, has suggested using physician assistants and nurse practitioners in those facilities. Supervising physicians would oversee their work.

Physician assistants and nurse practitioners perform work that is more extensive than that done by nurses, but less so than by physicians. Pay in both professions ranges from $25,000 to nearly $40,000 per year.

Physician assistants, commonly known as PAs, typically spend at least two years in college, then 24 months in medical programs, Reid said.

> "If you're going to have a revolutionary concept for a health-care facility, what good is it if you have to go 80 miles down the road to get your medicine."
>
> — Jim Reid
> Montana Academy of Physician Assistants

There are 28 PAs in Montana, with practices scattered throughout the state. In Broadus, Ekalaka, Jordan and West Yellowstone, PAs are the sole health-care providers.

The 76 nurse practitioners in Montana are required to be registered nurses, plus have at least one more year of medical training and have passed a national exam.

Caniparoli and Reid both say people in their fields are able to help patients with most broken bones, infections, flus, cuts or minor injuries requiring stitches or cleansing, examinations and blood pressure checks. Except when they may be assisting a physician, they do not normally deliver babies, perform surgery or handle severe injuries.

Both professions currently have bills before the Legislature seeking the right to prescribe medication, with a physician's consent.

"If you're going to have a revolutionary concept for a health-care facility, what good is it if you have to go 80 miles down the road to get your medicine," Reid said.

"We're looking for a joint agreement between nurse practitioners and physicians, where prescriptions are written under a physician's name and supervision," Caniparoli said. "It would be a lot more feasible for a nurse practitioner to go out into a rural or isolated community and provide health care if we can provide medication along with that."

Under both proposals, the physician could work out an agreement in advance with the PA or nurse practitioner to prescribe certain medications in given circumstances.

Both groups say that if they can prescribe medication — which is allowed in at least 19 other states — they will be able to recruit more professionals to Montana and work to alleviate health-care shortages.

Despite their apparently similar goals, PAs and nurse practitioners admit there has been a strain between their professions.

Nurse Practitioners and the Montana Nurses Association have both complained that part of the legislation proposed by the PAs would establish that nurses must take orders from PAs.

"They are not licensed, that is a concern," Caniparoli said of PAs. "That raises all kinds of accountability and liability issues that are not very clear."

Reid said the proposed legislation provides for licensing of PAs.

Reid said that in 19 states where nurses have challenged a PA's right to give orders, 17 different opinions by attorneys general have determined that PAs are authorized to instruct nurses. He added that in many states, PAs and nurses have worked together to resolve their differences and provide better health care.

EXHIBIT 7
DATE 2-17-89
HB 699

Nurse shortage requires expensive, short-term solutions

For several years, patients at the Frances Mahon Deaconess Hospital in Glasgow have often been cared for by temporary "rent-a-nurses." Those nurses may come from anywhere in the country and may stay from a few weeks to a few months. Their service is expensive.

But Patricia Nessland, director of nursing at Glasgow, said using the temporary nurses is preferable to shutting down hospital wards, which may be the only alternative if the nursing shortage becomes too great.

"Last summer, I was very frightened we would have to close ICU (the intensive care unit); we just didn't have the staff," Nessland said. "It really was frightening when you think of it in terms of yourself. If my dad or husband had a heart attack, they'd have to go all the way to Billings or Great Falls to get care."

To avoid closing the unit down, Nessland turned to a nurse rental agency.

Aside from their salaries, which range from $14 to $18 dollars an hour, the hospital must also pay for transportation, lodging and a fee to the agency.

Last year, the hospital spent about $40,000 on rent-a-nurses and their fees, Nessland said.

"That would have paid the salary of at least one more person and maybe another half," she said.

Nationally, there is an 11 percent vacancy rate of nurses in hospitals — a number that could grow to 15 percent in coming years. In Montana, the figure is closer to 9 percent, according to a recent survey by the Montana Hospital Association.

Shortages of nurses have been attributed to several factors, including the proliferation of other career fields for women, who have typically filled the nursing ranks. Nursing is seen by some as a high-stress occupation with relatively low pay. Some nurses have also complained about a lack of respect from doctors and hospital administrators. There is also a question as to what role the fear of AIDs plays in recruiting people into hands-on health fields.

Some administrators say the shortage is often felt more severely by small, rural hospitals, where there may only be five or 10 nurses on staff. The loss of one or two of them can throw the operation into turmoil.

"How do you recruit a person to the boondocks? That's the problem" says Lorraine Stilwell, director of nursing at the Pondera Medical Center in Conrad, who said she would like to hire at least one more nurse.

Stilwell said she has advertised throughout the state and nation.

"For the thousands of dollars I've put out, I haven't had one positive return," she said.

Her sentiments are echoed by Terri Klein, director of nursing at the Teton Medical Center in Choteau.

Klein, who is looking to hire two nurses, has been recruiting at any college in the area with a nursing program, through newpapers ads in Great Falls, Rapid City, S.D., Fargo, N.D., and other papers in Montana and at any jobs fairs in the area.

"I haven't received a single reply," Klein said. "I'm running out of creative ideas."

Administrators point to several factors that make recruiting nurses to rural communities especially frustrating:

— **Differences in duties.** According to Ann Shannon, dean of the College of Nursing at Montana State University: "Nurses in rural areas handle multiple roles, which has its own stress. The nurse has to be able to move from a critical care room where someone has just had a heart attack, to an obstetrics ward to deliver a baby, then off to the emergency room to handle a car accident victim. It's a very, very demanding role."

Stilwell agrees, saying that many nurses are trained at large schools, where there is a lot of hi-tech equipment and everyone is encouraged to find a speciality.

"When they come out here and see all of the different areas they have to work, well, it just blows their mind," Stilwell said.

There are, however, some nurses who prefer the diversity of work in a small facility. Administrators say they try to retain these nurses by paying salaries nearly competitive with larger institutions.

— **The spouse dilemma.** More than 95 percent of nurses are women, many of them married. Moving to a small town to work often means finding a job for a husband, as well.

Nessland said she has found that if the spouse wants to work, the hospital is probably out of luck.

Stilwell says she has had the same frustration in Conrad, where, despite all her recruiting efforts, "the only new nurses I've got, have been when some man moves here and his wife happens to be a nurse — it just doesn't work the other way around."

At MSU, Shannon jokingly says she's been half tempted to hold "marriage classes or quarterly dances with guys from the ag school" so that more nurses will be paired with men returning to rural communities.

— **The social scene.** Nurses just graduating from school tend to be younger women, many of them single. While it may be easier to recruit them because they are single, it may be more difficult for other reasons, administrators say.

"It's real hard for us to bring in a young woman from outside the community," says Richard Brown, administrator of the Liberty County Hospital in Chester. "We can't offer the night life, the social life, the shopping. We don't even have a movie theater or a bowling alley here."

— **Attitudes toward women.** At MSU, Shannon says studies by graduate students indicate that young women moving into rural communities sometimes must deal with negative stereotypes and may find it difficult to become part of tightly knit social groups. She said this may be especially difficult for single women.

The nursing shortage has been felt by more than just the hospitals. Nursing programs at Montana schools have been scaled back in the past three years. Despite that, Shannon says she is still finding it difficult to recruit nursing school faculty.

Last summer, five of eight positions at MSU's Great Falls campus were empty. "I wasn't sure until well into September that we'd even be able to hold school there," she said.

Several nurses were hired and "we just pieced it together," but she said there are still at least six vacancies among the 40 staff positions at MSU. "We have absolutely no candidates" despite heavy recruitment, Shannon said. "It's going to be worse this coming year."

Larger city hospitals are both friend, foe

Administrators of rural hospitals say they depend on nearby city hospitals — to a point. To the point, that is, at which those city hospitals pose a threat to their own business.

The administrators say there is a fine line between the help that may be offered by larger facilities and the competition they represent. For now, however, representatives of several rural hospitals say they generally have good working relationships with larger health centers in the state.

"Big Sandy and I think most of the Hi-Line have good rapport with Great Falls," said Jay Toth, until recently the administrator of the Big Sandy Medical Center. "There are just a lot of things we can't do in small hospitals and if they weren't there to back us up, a lot of patients wouldn't stand a chance."

Toth and others say one of their main concerns is that they get patients back for recuperation.

"As long as they (city hospitals) play fair and send patients back to us that we send to them, I don't see any problem," Toth said.

In Cut Bank, Glacier County Medical Center administrator Mac Simpson said there had been "some local resentment" when Columbus Hospital in Great Falls opened an outreach clinic in Cut Bank in late 1986. Simpson's predecessor, Jerry Hughes, had called the clinic a "railroad" to haul patients to Great Falls.

Columbus had defended the clinic as a means of providing specialized care to the community. Bonnie Paynich, who was affiliated with the clinic, said specialists who visited the community on a rotating basis had many patients and were usually able to treat them in their home town.

But despite continued attempts, Columbus was unable to attract a full-time physician to staff the clinic.

> "Big Sandy and I think most of the Hi-Line have good rapport with Great Falls. There are just a lot of things we can't do in small hospitals and if they weren't there to back us up, a lot of patients wouldn't stand a chance."
>
> — Jay Toth, past administrator, Big Sandy Medical Center

Paynich said that without a physician, the clinic was forced to close in early 1988.

Simpson said his hospital now has good relations with Columbus. He said he is certain that many people from his community receive their health care in Great Falls. He attributes at least some of that to Cut Bank's inability to retain doctors. He said if patients establish a relationship with a doctor elsewhere, they will likely keep seeing him or her.

It is hard to determine how many patients are lost from Shelby to Great Falls or elsewhere, said Warner Bartelson, administrator of the Toole County Hospital. "But it is a very big concern," he said.

"In many ways, it's a positive movement, like with a cardiac patient, or someone we can't provide care to," he said. "The trouble comes if they (bigger hospitals) don't send the patient back for follow-up care, which we can provide just as well, or better."

He said people may be more comfortable in their home town hospitals, "where their family is close and the people taking care of them are their neighbors."

While Bartelson said the clinic established by Columbus Hospital in Cut Bank had been "a really bad move, as far as most of us are concerned," he added that in recent years he has seen no such problem.

"I don't think they're actively recruiting our patients away from us," Bartelson said. In fact, he noted, "we probably need them a lot more than they need us."

He said larger cities are able to provide expertise in specialty areas. For example, the Toole County Hospital has a contract with the Deaconess Medical Center in Great Falls for the services of a dietitian and with Columbus Hospital for a pathologist.

"That's where the real benefits can be and that's where I hope things are evolving," Bartelson said.

Kirk Wilson, president of Deaconess in Great Falls, said he and his staff are "well aware of the situation these small hospitals are in" and are trying to be sensitive to their needs and concerns.

"We've got to find ways to make them successful because our destinies are intertwined," Wilson said. "But we've got to let them set the agenda. They know better what they need from us."

He agreed that larger facilities can help by expanding some speciality services in outreach programs. Wilson said electronics will play a larger role in the future, with specialists able to provide long-distance consultations and help in diagnosing problems.

But hospitals of all sizes must be prepared for big changes, Wilson stressed. A growing number of surgical operations do not require hospitalization and improvements in health care mean patients spend fewer days in the hospital.

"In 10 years, Montana Deaconess may be a big emergency room" where only "exotic neurosurgery and open-heart procedures" are performed in the hospital, he said. This trend will "further deteriorate these small facilities" and may force some to become clinics or emergency rooms, with nursing homes attached.

Obstetrics care precarious for rural mothers-to-be

Every morning, 19 year-old Mary Jacquot checks the weather report and road conditions from her home in Lincoln.

Nine months pregnant, Jacquot faces an 80 mile drive on mountain roads to her physician in Missoula and the hospital where she plans to have her second child. She is painfully aware of the OB crisis.

In 1986, more than 200 obstetricians and family practitioners delivered babies in Montana. The number is down to about 120, and dropping, according to the Montana Medical Association.

Small, rural communities have seen the greatest impact, and nearly one fourth of the state's 56 counties offer no delivery services. The MMA says 19 more counties are in danger of losing obstetrics care.

Jacquot's first child, born a year and a half ago, was delivered by her husband and her sister, a nurse, in Florida. She said she would have preferred a home birth for her second child.

"But in Florida, if anything went wrong, I was only 10 miles from a doctor and a hospital," she said. "Here in Lincoln, we're 80 miles from Missoula, 90 miles from Great Falls and about 60 miles to Helena."

On the lonely stretch of road between Jordan and Circle in eastern Montana, 22 year-old Michelle Ramsbacher is four months pregnant. Her monthly prenatal visits entail a 110 mile drive to Miles City.

"Sometimes, it's kind of scary," she said. "I try not to think about it too much, but you wonder whether you'll make it to town on time."

Two years ago, Ramsbacher could have delivered her baby 30 miles away, in Jordan. But the town has since lost its only physician and the hospital has closed.

Last year, then Gov. Ted Schwinden formed an advisory council to study obstetrics. After seven months, the council concluded the shortage of obstetrics care could be traced to "skyrocketing malpractice insurance rates, a variety of tort-related issues and inadequate Medicaid reimbursement rates."

The council said the problem is "widespread and worsening, especially in rural areas." Among the worst effects reported were the "possible increase in the number of low birthweight babies, the factor most closely associated with infant mortality."

According to the National Commission to Prevent Infant Mortality, prenatal care, which may prevent low birthweight conditions, may cost as little as $100. The lifetime costs of caring for a low birthweight baby may reach $100,000.

Brian Zins, executive director of the Montana Medical Association, says the hefty increases in malpractice insurance rates for physicians who deliver babies is a major contributor to the OB crisis.

Insurance rates for obstetrical care in 1973 ranged from $1,900 to $3,500 per year. By last year, the rates had soared to a range of $20,000 to $67,000.

Rates are not based on the number of deliveries performed so a doctor must deliver a lot of babies to pay the premiums, Zins said. The state Department of Social and Rehabilitative Services estimates a doctor must deliver 50 babies a year just to "break even."

Those in the medical and insurance industries say one reason rates are increasing is that lawsuit damages are increasing. Gary Neely, a Billings attorney specializing in medical liability, wrote recently: "A doctor who delivers babies now has a 50 percent chance of having a claim against him or her every two years."

Zins says tort reforms are necessary to alleviate the glut of lawsuits and the hopes of some people that they may "get rich quick" by suing a doctor.

"Unfortunately, most tort reform takes six to 10 years before you see the effects," he said. "We can't wait that long; we need help now."

A recent congressional study recommended that the federal government help in extending malpractice protection to rural and migrant health center physicians, but did not elaborate on a plan.

Some doctors are also dropping obstetric care from their practices because they are not reimbursed enough from Medicaid, the federal/state program that reimburses physicians for care given to poor people.

In 1986, the average physician's fee for a normal delivery in Montana was $778, while the fee for a Caesarean birth averaged $1,098, not including hospital costs. Last year, the average physician fees were $1,150 and $1,512, respectively.

According to an obstetrics advisory council report, Blue Cross and Blue Shield would reimburse physicians up to $1,175 last year for a normal birth. Medicaid, however, reimbursed only $619. The Medicaid reimbursement rate for this year will be $622.

"What it comes down to is, if you have a significant Medicaid practice, you've got a significant problem," Zins said. "You can't afford to do it."

EDITOR'S NOTE: Last Tuesday, Mary Jacquot and her husband drove through a blizzard from Lincoln to her doctor's appointment in Missoula. The doctor induced labor and the Jacquots had a health baby girl.

State panel suggested remedies

A committee that spent more than half a year studying the state's obstetrical crisis concluded that there is "no single perfect solution."

But the 15-member Obstetrical Services Availability Advisory Council, formed by then Gov. Ted Schwinden, did issue a list of suggested remedies last October. Short-term measures included:

- Raise Medicaid reimbursement to physicians to $1,000, from the 1989 level of $662. The report suggested such an increase "will encourage doctors considering leaving the practice not to do so, although it is not anticipated that doctors who have stopped delivering babies will begin delivering them again."
- Speed the Medicaid application process so women may begin prenatal care immediately.
- Extend Medicaid eligibility for pregnant women to 150 percent of the poverty level, from the current 100 percent, so that more women may be reached. Also, expand Medicaid outreach and education programs. Noting the correlation between problem pregnancies and tobacco use, the council recommended funding the increased services with a tax increase on tobacco products, to be matched with federal funds.

Other measures suggested by the council included:

- Consider legislation to reduce liability insurance premiums for doctors who deliver babies. The council suggested the Legislature consider proposals by the Montana Medical Association to establish a pool, or catastrophic fund, for certain coverage. Part of the funding would come from a set fee per delivery, paid by a doctor or hospital. The proposal would also set some guidelines for tort reform and establish an arbitration system for patients.
- Consider alternative methods of medical malpractice liability insurance rate-setting.
- Small hospitals could encourage physicians to remain in their communities by helping pay a portion of the doctor's malpractice premiums and making the doctors employees of the hospitals.
- Give full disclosure to patients regarding the risks of pregnancy and availability of care.

The council included three physicians, two attorneys, two insurance brokers, four legislators, a hospital administrator and three members from the public.

Hospital learns costly lesson on recruitment

BIG SANDY — When Dr. Patrick Murphy announced he was retiring from his 20 year medical practice in Big Sandy, local hospital administrator Jay Toth knew he faced the painful ordeal of trying to recruit a physician to rural Montana.

Later, there would even be a threat of closing the hospital if a doctor were not found.

Murphy was the only doctor in town and his departure in September left the eight-bed Big Sandy Medical Center dependent on physicians willing to travel more than 30 miles from Havre to keep the doors open. Toth knew if the hospital were forced to close, people would not only lose emergency medical care, but the community would lose 42 jobs and a quarter-million-dollar yearly payroll.

Toth spent a full year writing letters and proposals to doctors who had expressed interest in rural practices. He quickly learned what he was up against.

"They all want mountains," he said. "They all want to live in the middle of Glacier Park and make lots of money. That just doesn't happen out here."

He said many of the doctors turned down the offer "when they realized they couldn't drive to the theater in their Mercedes here — instead they'd probably be stuck in a snowbank in their pickup."

It's also a matter of recruiting spouses, he said.

"A lot of the doctors we talked to were willing to work here," he said. "But it was their wives we had to sell. Rural Montana doesn't have a lot to offer some people, especially wives with a career of their own or interests in big city activities."

Toth recently left Big Sandy for an administrative job in Alaska, but before leaving signed on a physician who will arrive in Big Sandy this month. The hospital guaranteed the new physician wages of about $90,000 a year for three years, as well as pay his malpractice insurance and office expenses the first year. The doctor has agreed to stay for three years.

Interviewed in December, Toth was in the middle of a running battle with the state Department of Health and Environmental Sciences, which was threatening to shut his hospital if he did not have a doctor by the end of January.

"We're being harassed by the Department of Health," Toth said at the time. "They've practically become a police force, just out to harass us."

He said the community "has been in an uproar" about the possibility of losing the hospital, which was remodeled a few years ago. "I think Big Sandy's prepared to take it to court, if need be," he said. "We've been around long enough to know that once you lose a hospital, you don't get it back."

Jacqueline McKnight, chief of the department's Licensing and Certification Bureau, acknowledged the department had found some deficiencies at the hospital, including lack of a physician within 15 or 20 minutes of the hospital. "That is a problem for continued licensure as a hospital," she said.

At the end of January, the department made a recommendation to close the facility, but said if the doctor arrived as planned this month, the action probably would not be carried out.

Toth said the issue never would have been raised if rural areas weren't facing a shortage of doctors.

"Anymore, the only people we can attract are the granola types, you know, people who see themselves as missionaries working out here," he said. "To a certain extent, money is not the issue; rural living is."

Prognosis gloomy for many rural hospitals

Of Montana's 39 rural hospitals, only six broke even or made a profit last year. The other 33 operated in the red.

The financial health of many of the state's smaller facilities is reaching a critical stage, and the prognosis for a quick cure is not good, according to Jim Ahrens, executive director of the Montana Hospital Association.

"Hospitals all across Montana are having problems, but you see it most in the rural areas," Ahrens said.

He pointed to Big Timber, where the hospital was forced to hold a fund-raising drive in November to meet its monthly payroll. An infusion of donations has at least temporarily stabilized the hospital's situation.

But rural hospital administrators say such efforts only provide Band-Aids to wounds that require much greater attention. They point to a host of problems that have combined to turn black ink red:

- The number of patients is dropping because of decreased population and technology that allows many procedures to be done outside the hospital or with a shorter hospital stay.

When the Toole County Hospital was built in 1981 in Shelby, there were regularly more patients than the 20 beds available. Now, on a typical day, fewer than half the beds are filled.

That trend is the same in most rural hospitals in the state, where the occupancy rate averages about 30 percent. Even with fewer patients, hospitals must maintain housekeeping, dietary, nursing and lab staffs.

> "Every year requests from staff for new equipment come to over $300,000. At best, I can generate $80,000 to $100,000. It's becoming increasingly difficult to keep up with the demands of technology. But if you don't, your clients will go elsewhere for care."
>
> — Richard Brown, Liberty County Hospital

Decreases in population also mean decreases in a county's tax base, which can hurt those rural hospitals that receive county subsidies.

"A real issue for us is the price of oil," said Mack Simpson, head of the Glacier County Medical Center in Cut Bank. "It's sad to say, but we depend on it. When oil prices are up, so are taxes. We just do a lot better."

The property tax freeze mandated by Initiative 105 has also made it difficult for counties to increase financial support to their hospitals.

- Medicare reimbursement shortfalls are seen as one of the biggest drains on budgets. The federal program, which serves primarily the elderly, reimburses hospitals for care given qualifying patients.

Hospital administrators say the set fees Medicare pays rarely cover the actual cost of caring for the patient. In Conrad, for example, the taxpayers had to subsidize the hospital for $225,000 last year to make up for shortfalls in Medicare reimbursements.

Without a federal remedy, the problem may only get worse, administrators say, because the population is aging and the elderly are the biggest Medicare users.

- Personnel costs have climbed as administrators find it increasingly difficult to compete with larger cities for doctors, nurses and other technical staff.

County commissioners have been forced to hire a professional recruiter to search for a doctor willing to practice in the Toole County Hospital. They have flown in several prospects — at a cost of $2,000 to $3,500 each — only to have them turn down the job. They say it will cost at least $15,000 in recruiting fees if one of the doctors agrees to stay.

Hospitals using "rent-a-doctors" to fill vacancies pay about $3,000 per week. Similar "rent-a-nurse" programs run from $14 to $32 an hour, plus expenses, and are being used in such places as Glasgow, where nurse recruitment has had limited success.

- Equipment costs have jumped with changes in technology and greater expectations from patients.

"Every year requests from staff for new equipment come to over $300,000," said Richard Brown, administrator of the Liberty County Hospital in Chester. "At best, I can generate $80,000 to $100,000. It's becoming increasingly difficult to keep up with the demands of technology. But if you don't, your clients will go elsewhere for care."

A new X-ray machine runs about $150,000; a CAT scan costs $350,000. And equipment needs maintenance and backup systems, mandated by manufacturers and insurance companies wary of lawsuits.

- Insurance costs have increased for hospitals, just as they have for private physicians.

Two years ago in Shelby, the Toole County Medical Center paid $15,000 for its malpractice insurance. Last year, the bill came to $15,000.

"You have to have at least one backup system and maybe two in anything you do, whether you think you need it or not," said Warner Bartelson, Shelby's administrator. "Much of what we do isn't medically required, it's legally required, just to cover ourselves."

Medicare's set fees create moral, fiscal dilemma

SHELBY — Last summer, Grace Luebke spent her last 40 days in the Toole County Hospital, enduring the fierce pain of a cancer that was slowly killing her.

Her physician determined that because of her unstable condition and the constant care and medication Luebke needed, the 71-year-old could not be sent home to die.

After her death, the hospital totaled her bills and submitted a claim of $15,592 to Medicare, which was the only means Luebke had of paying for her health care. But Medicare sent the hospital only $3,247 on the grounds that most people who have Luebke's type of pancreatic cancer are in the hospital an average of six days before they die, according to Warren Bartelson, Shelby hospital administrator.

"We couldn't kick her out; she was dying and needed care," Bartelson said. "But she was a Medicare patient and that meant we'd have to take the loss."

Bartelson said hospital administrators are put "in a real uncomfortable position" when they keep patients longer than Medicare's set average stay. He said even though the patient needs the care, the hospital will "most certainly" lose money.

The Montana Hospital Association reports that hospitals in the state lost more than $18 million in 1987 for uncompensated care, much of it from insufficient Medicare reimbursements.

"I don't think it's an exaggeration to say that we have a crisis here and that Medicare has a role in it," said Jim Ahrens, executive director of the MHA.

> "We couldn't kick her out; she was dying and needed care. But she was a Medicare patient and that meant we'd have to take the loss."
>
> — Warren Bartelson, Shelby hospital administrator

Established by the federal government in 1965 to cover the medical costs of people over age 65 and for some others who receive Social Security disability benefits, Medicare is the only source of health insurance for a growing number of older Americans.

Reacting to skyrocketing health costs in 1983, Medicare began standardizing the amount it would reimburse doctors and hospitals for different types of medical procedures and care. It also established separate rates for rural and urban hospitals, paying 11 to 40 percent less to smaller facilities than what it pays larger facilities for the same care.

Hospital administrators say the problem is twofold: Reimbursement rates have not kept pace with actual costs and the rural differential is placing an unfair burden on small hospitals.

Medicare accounts for about 45 percent of the patients in the Shelby hospital, which is about average in Montana, according to the MHA. Last year, Medicare payments to Shelby were $170,000 less than the actual costs for Medicare patients, Bartelson said.

"You accept what Medicare pays, period," he said. "That $170,000 was an out of pocket loss for us. I'd say the major reason this hospital lost money last year was because of Medicare."

Les Urvand, administrator of the Phillips County Hospital in Malta, added that the problem is made worse by all the paperwork demanded by Medicare.

"When you are reimbursed a dollar, it's not a real dollar because 15 or 20 cents of it is spent on paperwork proving you're spending the money right," said Urvand, whose hospital costs were more than $100,000 above Medicare reimbursements last year.

Urvand and Bartelson both said most hospitals have been forced to hire additional staff merely to process the paperwork required by Medicare.

A recent study by the U.S. Senate Special Committee on Aging bears out those contentions, concluding that "Medicare's reimbursement policies have contributed to eroding the financial viability of rural hospitals."

The study said the level of insurance coverage in rural areas has traditionally been low. That, combined with low occupancy rates, gives rural hospitals less ability to subsidize losses from Medicare patients with revenue from private pay patients.

The study recommends immediate elimination of the rural-urban differential. It said that although some hospitals may be forced to close or change their services "those decisions ... are appropriately made by the rural community itself. They should not result from discriminatory, inappropriate or misguided Medicare reimbursement policies."

In a more far-reaching proposal, the study suggests that when a hospital is the sole health facility in a community, it be reimbursed for actual costs.

The report also suggests Congress establish a clearinghouse for rural health service research, and it recommends the National Center for Health Services Research get $10 million to research rural health.

The issue may be resolved in court before Congress has a chance to make changes. Late last year, the National Rural Health Association filed suit in Washington, D.C., challenging "the unreasonably low Medicare reimbursement to rural hospitals."

According to Robert Van Hook, executive director of the organization, the lawsuit was filed as "a sign of our commitment to solving a problem that may force up to 600 hospitals to close their doors in the next few years."

In Montana, it is unknown how many hospitals face the prospect of closure because of Medicare shortages, says Ahrens of the MHA. But he said the issue is a "hot one" with financially strapped hospital administrators.

"We haven't got much time to revitalize the system," Ahrens said. "Many hospitals in this state are in trouble and not all of them will survive."

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Rural doctor shortage led to more than money

Hospital boards and county commissions in Montana's rural areas will spend hundreds of thousands of dollars this year to attract doctors.

The money is not for salaries. It will be used simply to recruit the physicians — to convince them to come to a town for a year or two, in hopes they will make Montana their home.

In Shelby, where two doctors practice, the hospital is searching for a third. Warner Bartelson, administrator there, said he figures it will cost the county, which runs the hospital, at least $15,000 in fees to a professional recruiter if a doctor agrees to come to Shelby.

Of course, he said, the county may first bring in four or five doctors and their spouses, at a cost of $2,000 to $3,500 each, to see the town and hospital, only to have them decline the job.

"Recruiting a new doc could end up wiping out the reserves of some hospitals," said Harry Simons, Toole County Commissioner.

That fear has struck hospital administrators across the state, especially in northern and eastern Montana, where recruiting has been particularly difficult.

The shortage of rural doctors is a national problem, according to a study released last fall by the U.S. Senate Special Committee on Aging, chaired by then Sen. John Melcher of Montana.

> For rural doctors, life can mean "more calls, more headaches and more responsibility, for less pay."
>
> — Les Urvand, administrator, Malta hospital

According to the study, in 1988 there was a shortage of 1,752 physicians nationwide in rural areas. Further, it said a 1988 survey indicated that as many as 25 percent of rural physicians may retire or leave their communities in the next five years.

A study by the National Rural Health Association concluded that rural communities have a physician to population ratio of less than one-third the national average. Montana ranks 41st with a ratio of 155 physicians per 100,000 people. Much of the state problem is attributed to an increasing number of retiring rural doctors and a decreasing number of younger replacements. At least 36 Montana hospitals are trying to recruit one or more physicians.

Montana administrators point to several factors that frustrate hiring and contribute to the shortage:

- Rural isolation means at least the perception that doctors have fewer opportunities for educational and social activities, fewer opportunities for spouses and fewer opportunities to retain skills when some procedures are performed only rarely.
- While physician pay may be considered high by local standards — often $60,000 to $80,000 — many physicians, particularly specialists, may earn considerably more in large, metropolitan facilities.
- Working hours and conditions are often unfavorable. Many rural doctors are on call 24 hours a day, seven days a week. In many communities, the only time a doctor gets time off is if the hospital agrees to bring in "rent a doctors" for a period.
- Rural physicians often receive lower reimbursement from Medicare and Medicaid for the same procedures performed by their city counterparts.
- Federal programs that place new doctors in rural areas are being scaled back or dismantled. The National Health Service Corps, which offers scholarships to medical students who agree to practice in rural areas, placed 2,595 last year and will place 1,101 this year and 800 next year.

Melcher's Senate report recommended $8 to $10 million for the health service corps. A similar recommendation was made to Congress by the National Rural Health Association and the National Association of Community Health Centers.

The shortage of doctors for rural areas has hit the vast plains of eastern Montana harder than some other rural areas, said Les Urvand, administrator of the Phillips County Hospital in Malta.

"We're competing against urban settings on one hand and pretty mountains on the other," said Urvand.

Malta had had three physicians, but last year lost them all. There is one new physician and Urvand said he is "looking, almost desperately" for another and has spent more than $15,000.

"You need professional help, you just can't do it on your own," he said. "I sent about 200 letters out and only got two lukewarm responses. But these guys know what it's like out here — more calls, more headaches and more responsibility, for less pay."

Meanwhile, Urvand is hiring "rent-a-doctors" from Montana and elsewhere to give his one doctor relief.

"The rent-a-docs are very expensive; I'd say about $3,000 a week," he said. "We've probably spent $200,000 ourselves on rental physicians. If we didn't have a (financial reserve) cushion, we would've been out of business by now."

And with too few doctors, patient loads drop drastically, he said. But the hospital still must maintain its other services — nursing, dietary, maintenance, lab and housekeeping. This keeps medical costs high.

Once patients get used to traveling to Havre, Great Falls or Billings for their health care, "it's real hard to get these people back," Urvand said.

Mack Simpson, administrator of Cut Bank's Glacier Medical Center, said his hospital is also down from three physicians to one.

"It's a threatening situation, no doubt," he said. "If one doctor is on call seven days a week, 24 hours a day."

And, as in Malta, Simpson said if Cut Bank can't take care of its own patients, they will go elsewhere.

"People form habits," he said. "Once they start going to out of town doctors and establish a relationship with them, well, you can see the problem."

Hospitals band together to solve problems

The problems of rural health care are easy to identify: a dwindling of finances, available health workers and population base during a time of increased paperwork and costs. The solutions, however, are not nearly so easy to grasp.

Increasingly, rural hospital administrators are turning to their own ranks to identify and solve the problems that seem to plague them all. They are doing this both by forming rural alliances and by developing their own in-house programs.

One such alliance is ARCH, the Affordable Rural Coalition for Health, funded for three years by a $300,000 Kellogg Foundation grant. The coalition covers health care in Pondera, Teton, Glacier, Toole and Liberty counties.

Now in its third year, ARCH was set up to encourage area health providers to communicate with each other and to educate the public on rural health issues. ARCH has produced community slide shows and brochures, as well as radio and newspaper health spots. The group, which is made up of hospital administrators, health care workers and community members, is also looking to bring in training seminars and conferences.

"Things like sports have created a lot of rivalries and jealousies between our towns, but we're breaking down those barriers," said Lois Crabtree of Choteau, an ARCH board member. "It's been neat to watch this blossom, we're all forming a bond and starting to care about each other."

Funding for ARCH runs out this summer, but board members are studying ways to continue the work.

Another group, the Northern Montana Health Care Alliance, funded by a Robert Wood Johnson grant, is more closely uniting hospitals in Fort Benton, Big Sandy, Havre, Fort Belknap, Malta, Chester and Shelby.

"There's kind of an emphasis on sharing," said Richard Brown, administrator of the Liberty County Hospital in Chester and member of the alliance. "We're going to try to share more services and more educational opportunities."

For example, Brown said several of the hospitals need a physical therapist, but only part time. By working together, they may be able to hire a physical therapist who would be willing to work full time, traveling between hospitals.

> "What it comes down to, is we're trying to help each other survive."
>
> — Richard Brown, administrator, Liberty County Hospital administrator

"What it comes down to, is we're trying to help each other survive," Brown said.

Similar alliances bind hospitals in eastern and western Montana.

In late 1986, Brown began recognizing that his hospital needed more of a financial cushion and a better way of planning for future expenditures. He met with community members, and a four person organizing board began exploring the possibility of setting up a foundation for the Liberty County Hospital and Nursing Home. Formally established in January 1988, the foundation now has a 12 member board representing a handful of area communities. Its initial goal is to raise $1 million, then use the interest for the hospital.

"We have to ensure that there is health care for this area of the Hi-Line, or we're going to see communities dying off," Brown said.

The foundation's first fund raising event last October netted $7,500. A mail request brought in $14,000. Now, board members are trying to identify potential large donors. They are also trying to encourage people to remember the foundation in their wills.

Many Montana hospitals are also setting up in-house programs to recruit doctors, nurses and other personnel. Several hospitals will guarantee a physician a salary of $70,000 to $90,000 for the first year. They may also provide malpractice insurance and office help to a new doctor.

Increasingly, hospitals are establishing loan programs for nurses. If a local student attends nursing school, the hospital will pick up some or all of the education costs. The student then agrees to return to work for a number of years, or else repay the hospital's costs.

Similar programs also encourage nurse aides and licensed practical nurses to further their education and return to a hospital, or attend schools after hours. In Glasgow, the hospital offered one-time bonuses to attract nurses. But, as the nursing supervisor quickly learned, such bonuses should be paid only after a nurse has worked for six months to a year, to avoid immediate turnovers.

EXHIBIT 8.
DATE 2-17-89
HB 699

1833 Iris Lane
Billings, MT 59102
February 17, 1989

TESTIMONY BEFORE THE HOUSE JUDICIARY COMMITTEE ON HB 699.

I am Kay Foster from Billings and I appear as the chairman of the Obstetrical Services Availability Advisory Council appointed by Governor Schwinden in March of 1988. This committee studied and reviewed the obstetrical availability problem you are dealing with this morning for a six month period and delivered its recommendations to the Governor 4½ months ago. A copy of these have been distributed to you. / To quickly summerize them I would like to quote from the remarks I made as the committee made its formal presentation of its report: (a complete copy submitted)

"Our recommendations are NOT easy answers...there appears no quick fix.

Formal proposals were presented to us and addressed. The Infant Compensation Fund...

...low level of reimbursement."

I might comment that my personal review of the bill you have before you began well over a year ago when I was asked by Governor Schwinden to chair a committee to review the need for a special session to immediately address the obstetrical crisis... and review the MMA proposal. We cautioned against this special session effort, stating that a long-term solution "is possible only after the entire Legislature has had the opportunity to become thoroughly familiar with obstetrical malpractice insurance issues".

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The loss of obstetrical services in rural Montana is very real. ✯ I do not envy the task of this committee to attempt to deal with this piece of the possible solution through examination of the current MMA proposal in one weekend, but I do hope you will keep in mind the thoughtful recommendations of the Obstetrical Services Council...reached after months of careful study.

✯ It would be difficult for me to determine whether the questions of these 2 groups still remain regarding the constitutionality, actuarial soundness or administration of the fund because of its constantly changing nature.

EXHIBIT 9
DATE 2-17-89
HB 699

November 2, 1988

GOVERNOR SCHWINDEN -----

I am pleased to present the formal report of the findings and recommendations of the OSAAC.

For 6 months the Council worked to determine the extent and causes of the loss of adequate OB care in the state and, particularly, in its rural areas. The findings document that there are currently 87 Family Practitioners delivering babies in Montana (down from 160 in 1986) and 37 Obstetricians serving pregnant women, most of whom are concentrated in urban areas.

The facts simply stated are:

*Rural populations have declined while medical liability rates for all physicians have risen.

*A physician delivering 20 babies in a small town pays the same liability premium as a similarly rated doctor in a larger area with 100-200 maternity patients a year.

*Most doctors who continue to offer OB services in sparsely populated areas do so because it is one of the more enjoyable parts of their practice and a very necessary service in the community. Payment for care seldom covers even the cost of liability insurance.

WE FEEL that in the short term these doctors must be commended and encouraged to continue this service. The economies of these small towns and the future of their hospitals are greatly impacted by the loss of OB care. For this reason, as well as the overriding social concern for healthy mothers and healthy babies, the State of Montana has an obligation to become involved in assuring an adequate level of care.

Our recommendations are NOT easy answers...there appears no "quick fix".

Formal proposals were presented to us and addressed. The Infant Compensation Fund proposed by the State Auditor appeared too narrow in scope and not to truly address the needs on either a short term or long term basis.

The lengthy Montana Medical Association proposal, and particularly certain portions relating to peer review, disclosure of risk and

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mandatory periodic payment of future damages, merits consideration by the Legislature. Questions continue regarding the constitutionality of some provisions of the plan and the documentation of its actuarial soundness. These prevented the Council from endorsing the concept in its report.

THE BEST SHORT TERM AND LONG TERM SOLUTION WE HAVE FOUND IS IN THE LOWERING OF THE NUMBER OF HIGH RISK PREGNANCIES THROUGH MATERNAL EDUCATION AND ACCESSIBLE PRENATAL CARE.

Montana's medicaid reimbursement rates are among the nation's lowest. The process of qualifying is lengthy and cumbersome. As a result, mothers-at-risk frequently receive little or late prenatal care and physicians are reluctant to treat them because of the high risk of "bad outcomes" and low level of reimbursement.

We recommend:

*Raising the level of Medicaid reimbursement from $662 to $1000 for a normal delivery.
*Adoption of presumptive eligibility to insure early care.
*Extension of coverage to those at 150% of poverty level.
*And, most especially, expansion of education and outreach programs for prenatal and infant care.

These only highlight our findings. We offer to work with you and the next Legislature toward their implementation.

Thank you.

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State of Montana
Office of the Governor
Helena, Montana 59620
406-444-3111

TED SCHWINDEN
GOVERNOR

December 2, 1988

Kay Foster, Chairperson
Obstetrical Services Availability Advisory Council
c/o Jan Clack
Department of Commerce
Helena, MT 59620

Dear Kay:

I wanted to thank you and the Council members for your service on the Obstetrical Services Availability Advisory Council. As I mentioned in our meeting in early November, I believe the Council did an excellent job of dealing rationally with an emotional subject. I know that the Council's work and its report will be valuable to the 1989 legislature as they consider this subject, which is of vital interest to people throughout the state. I have carefully considered the Council's recommendations and included several in my Executive Budget, FY 1990-91.

As you may know, my budget recommendation for the next biennium is relatively "tight". In order to bring revenues and expenditures in line, I have recommended very few new or expanded programs and have reduced agency operating budgets. However, the Council made such a compelling case that I have included additional funding in several areas recommended by the Council:

--increased Medicaid reimbursements. The budget recommendation includes $3,104,510 in general funds ($10.8 million total cost) for the biennium to provide a 2% per year increase in reimbursement rates paid to state medical and medicaid providers. The Department of Social and Rehabilitation Services would be allowed to allocate these funds based on the greatest need for adjustment in specific reimbursement rates. During the current biennium, SRS was appropriated funds to provide a 1.5% reimbursement increase to providers and allocated about one-half of the available funds to prenatal and postnatal care and delivery reimbursement increases. In addition, the budget proposes $100,000 for the biennium be appropriated to SRS for targeted reimbursement increase for Medicaid deliveries.

--increasing the availability of prenatal care. The budget proposes expanding prenatal education and Medicaid coverage for expectant mothers in several ways. In accordance with the federal Catastrophic Care Act,

-more-

the budget includes $5.9 million for the biennium ($1.7 million in general fund) for Medicaid coverage of children under one year of age and pregnant women whose income is less than the poverty level. In addition, the budget includes $65,000 per year of general fund to expand the Department of Health and Environmental Science's prenatal education programs and $50,000 per year additional general fund for Family Planning prenatal counseling.

I join the Council in hoping that the substantial tort reform enacted by the 1987 legislature will bring long-term relief in medical liability insurance premium rates. I also appreciate the careful review that you have given to the proposals dealing with this subject submitted the Montana Medical Association and the Office of the State Auditor and hope the 1989 legislature will consider your comments carefully as it debates these measures.

Once again, thank you for the time and effort you have spent. The people of Montana will, I am confident, benefit as a result.

Sincerely,

TED SCHWINDEN
Governor

OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL

REPORT OF RECOMMENDATIONS
Submitted to the Honorable Ted Schwinden
Governor of Montana

October 1988

EXHIBIT 11
DATE 2-17-89
HB 699

DEPARTMENT OF COMMERCE

TED SCHWINDEN, GOVERNOR
1424 9TH AVENUE

STATE OF MONTANA

(406) 444-3494
HELENA, MONTANA 59620-0401

November 2, 1988

The Honorable Ted Schwinden
Governor of Montana
State Capitol
Helena, MT 59620

Dear Governor Schwinden:

On behalf of the Obstetrical Services Availability Advisory Council, which was created by Executive Order No. 6-88, I am pleased to present to you the council's "Report of Recommendations" regarding the loss of obstetrical care in Montana.

Many groups and individuals presented information and viewpoints to the council. The council is appreciative of their contributions, which were essential to the recommendation process.

The council hopes that you and other policymakers will find these recommendations helpful.

Sincerely,

Kay Foster
Kay Foster
Chairperson

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DATE 2-17-89
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OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL

Medical Profession:

Dr. John T. Molloy
Great Falls, MT

Dr. Van Kirke Nelson
Kalispell, MT

Dr. Jimmie L. Ashcraft
Sidney, MT

Kyle N. Hopstad
Hospital Administrator
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Legal Profession:

Leo Berry
Helena, MT

Karl J. Englund
Missoula, MT

Insurance Industry:

Leonard Kaufman
Billings, MT

Charles Butler, Jr.
Helena, MT

Legislature:

Sen. Joseph P. Mazurek (D)
Helena, MT

Sen. H.W. Hammond (R)
Malta, MT

Rep. John R. Mercer (R)
Polson, MT

Rep. Ted Schye (D)
Glasgow, MT

Public Members:

Kay Foster (Chairperson)
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Marietta Cross, RN
Missoula, MT

Jean Bowman
Helena, MT

Staff:

Office of Research & Information Services
Montana Department of Commerce

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OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL
Report of Recommendations

Background

The Obstetrical Services Availability Advisory Council was appointed on March 11, 1988, by Governor Schwinden. The appointment of the Council was the result of a recommendation by the Insurance Subcommittee of the Governor's Council on Economic Development, which had been studying the obstetrical malpractice insurance crisis in Montana at the request of the Governor and the Montana Medical Association in anticipation of the possible convening of a special session of the Legislature. Finding that the complexity of factors involved in the obstetrical care crisis were beyond the scope of a brief special session, the subcommittee recommended the formation of a broader based council whose charge would be to study in depth the factors contributing to the crisis.

The Obstetrical Services Availability Advisory Council has 15 members, representing the medical and legal professions, the insurance industry, the legislature, and the public.

The PURPOSE of the Council is to:

(a) Examine the extent, causes and effects of the loss of obstetrical care in Montana;

(b) Analyze possible short-term solutions, including but not limited to increased medicaid reimbursement and direct payments for a portion of malpractice premiums related to obstetrical care;

(c) Analyze potential long-term solutions, including but not limited to those proposed by the Montana Medical Association and the State Auditor; and

(d) Recommend, on or before September 30, 1988, preferred short-term and long-term solutions for submission to the 51st Legislature.

^^^^^^

The Council considers the loss of adequate obstetrical services from competent providers and the loss of access to such services in Montana a crisis.

The extent of the crisis is widespread and worsening, especially in rural areas; but urban areas are impacted as well.

The causes of the crisis include the well-publicized problem of skyrocketing malpractice insurance rates, a variety of tort-related issues, and inadequate medicaid reimbursement rates.

The effects of the crisis are many, but combined, can be described as the loss of adequate obstetrical services from competent providers and loss of access to such services in Montana, especially in rural areas.

Among the worst effects are a possible increase in the number of low birthweight babies, the factor most closely associated with infant mortality, and an increase in the human costs and economic costs of babies born at risk.

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OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL
Report of Recommendations

BACKGROUND DATA AND RECOMMENDATIONS

BACKGROUND DATA

The Obstetrical Services Availability Advisory Council met five times between April 1988, and September 1988. In addition to contributing information from their own areas of professional expertise, Council members solicited viewpoints and information regarding access to obstetrical services in Montana and in the nation from concerned individuals and interest groups.

In the interest of the conciseness of its report of recommendations, the Council has declined to reiterate comprehensively in this document the information, data, and arguments and critiques regarding each of the components of the issue of access to obstetrical services. Readers seeking such information are directed to the bibliography of documents and resources. It is sufficient to present selected information and data to illustrate briefly some of the factors that drive the crisis in loss of obstetrical services in Montana.

The number of doctors delivering babies in Montana is declining.

1986	Family Practitioners	160
1987	" "	120
1988	" "	87
1986	Obstetricians	(na)
1987	"	42
1988	"	37

(Source: Montana Academy of Family Physicians; Montana Medical Association)

In January 1988, eighteen of Montana's fifty-six counties were without obstetrical services. Another nineteen counties were anticipating losing obstetrical services "soon."

(Source: Montana Academy of Family Physicians)

In 1982, there were 14,538 births in Montana; in 1987, 12,239 births. Twenty-eight percent of Montana babies are Medicaid babies. By 1990, the national Catastrophic Coverage health plan will raise Medicaid eligibility to 100 percent of poverty level, and the percentage of

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Medicaid babies will increase in Montana.

(Source: Montana Dept. of Health & Environmental Sciences; Montana Dept. of Social & Rehabilitation Services)

Physicians' average global charges in Montana:

Normal deliveries -

1986	$ 778.00
1987	932.00
1988	1,150.00

Caesarean Section -

1986	$1,098.00
1987	1,296.00
1988	1,542.00

Nationwide, the physicians' average global charge is $1,436.00 in 1988.

Blue Cross and Blue Shield of Montana's maximum reimbursement to physicians in 1988 for a normal delivery is $1,175.00. This represents the 90th percentile of all charges submitted in calendar year 1987 by Montana physicians who deliver babies.

Medicaid reimbursement to physicians in FY88 was $619.00, and in FY89 is $662.00 for a normal delivery.

(Source: Montana Blue Cross/Blue Shield; Montana Department of Social & Rehabilitation Services)

Companies providing malpractice insurance to Montana family practitioners who deliver babies in 1988:

St. Paul	26 doctors	29.0%	of total
ICA	10 "	11.5%	" "
UMIA	26 "	29.8%	" "
Doctors' Co.	17 "	19.5%	" "
Truck Ins.	8 "	9.2%	" "
Total:	87 "		

Companies providing malpractice insurance to Montana obstetricians in 1988:

St. Paul	0 doctors		
ICA	0 "		
UMIA	5 "	13.5%	of total
Doctors' Co.	32 "	86.5%	" "
Total:	37 "		

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Premiums for malpractice insurance for family practitioners:

	1987	1988	
ICA	$12,392	$13,011	(no C-section, no high risk)
St. Paul	(na)	$25,000	(with C-section)
UMIA	$12,646	$21,475	"
Doctors' Co.	$19,011	$20,962	"

Premiums for malpractice insurance for obstetricians (Caesarean section included) in 1988:

St. Paul	$66,939
ICA	$44,971
Doctors' Co.	$39,039

In 1973, under the "occurrence" type insurance, family practitioners with obstetrical coverage AND WITH TAIL coverage paid $1,981, and obstetricians paid $3,247.

In 1988, under the "claims made" type insurance, family practitioners with obstetrical coverage and with NO TAIL coverage paid approximately $25,000, and obstetricians paid $39,841.

It is likely that, under the current system, malpractice insurance premiums will continue to increase 10 percent to 20 percent, or more.

Doctors who deliver babies pay the same premium amount regardless of the number of deliveries annually. It is estimated that a doctor must deliver 50 babies annually in order to "break even" with respect to malpractice insurance premiums.

The majority of rural (i.e., population under 10,000) family practitioners deliver less than the number of babies sufficient to cover their liability insurance costs.

In 1986, 83 of the 3,400 Medicaid babies born in Montana each cost over $10,000 during the first year of life.

(Source: Montana Dept. of Social & Rehabilitation Services)

"The lifetime costs of caring for a low birthweight baby can reach $400,000. The costs of prenatal care -- care that might prevent the low birthweight condition in the first place -- can be as little as $400."

(Source: National Commission to Prevent Infant Mortality, "Death Before Life: the Tragedy of Infant Mortality," p.9)

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RECOMMENDATIONS

Having carefully considered the broad spectrum of information, data, and viewpoints, the members of the Council determined that the loss of adequate obstetrical services from competent providers and the loss of access to such services in Montana is a complex crisis having no single perfect solution. Efforts to ameliorate the crisis must be broadbased and sustained, and responsibilities for those efforts must be assumed immediately by state and local government, professional organizations, and the private sector.

Therefore, the Council recommends to the Governor of Montana, the following short-term measures that can be taken to encourage physicians to maintain their obstetrical practices, and long-term measures to address problems of insurance availability and affordability and to improve Montana's medical/legal climate.

Short-term Measures

Regarding Increasing Medicaid Reimbursements -

- Raise the level of Medicaid reimbursement to doctors who deliver babies to $1,000, which is a "break even" amount for doctors delivering babies, and which is approximately 80 percent of the insurance industry's allowance for a normal delivery. It is expected that this increase will encourage doctors considering leaving the practice not to do so, although it is not anticipated that doctors who have stopped delivering babies will begin delivering them again.

- Adopt presumptive eligibility for pregnant women and expedite applications for Medicaid assistance so that early, effective prenatal care is available to Medicaid clients. Further, reimbursement by Medicaid to providers for any services rendered must be guaranteed.

- Extend Medicaid eligibility coverage for pregnant women to 150 percent of the poverty level. (In 1990, by Federal mandate, Medicaid programs will include the population at 100 percent of poverty level.)

- Expand Medicaid's outreach/education/application programs for prenatal and infant care to sites where health providers deliver care, such as state and local health department clinics, hospital clinics, etc.

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Regarding Funding Medicaid -

In seeking a source of funding for increased Medicaid reimbursements for obstetrical services, the Council recognizes the strains on the state budget.

There is considerable evidence that a significant number of Medicaid mothers with complicated pregnancies, which often result in the birth of babies whose health and development are at risk, use tobacco products.

- Because of the correlation between problem pregnancies, tobacco use, and infants born at risk, the Council recommends that the best potential source of increased funding for Medicaid reimbursements for obstetrical services is a tax increase on tobacco products to be matched 70/30 by federal funds.

Long-term Measures

Regarding Reducing Medical Malpractice Insurance Costs -

The Council recognizes the 50th Legislature's tort reform efforts, and believes that those efforts will have a long-term beneficial impact on medical liability insurance premiums. The Council makes these further recommendations.

- Consider legislation that reduces medical liability insurance premiums for doctors who deliver babies. Of the proposals before the Council, the Montana Medical Association proposal published/dated June 1988, warrants careful consideration by the Legislature. The Montana Medical Association proposal seeks: (1) actuarial soundness; (2) provisions for injury prevention in birth-related cases; and (3) provisions for eliminating the uncertainties of the current tort and insurance system. The Infant Compensation Plan, proposed by the Office of the State Auditor, is too narrow in scope, does not adequately address the variety of needs, does not solve the problem on a short-term or long-term basis, and is not viable in the form presented to the Council.

- Consider alternative methods of medical malpractice liability insurance rate-setting.

- Amend current law relating to discretionary periodic payment of future damages of $100,000 or more and make such periodic payments mandatory in obstetrical cases.

Other

- The Council recognizes that some small communities have devised creative, short-term solutions to encourage physicians who deliver babies to remain in those small communities, including paying a portion of the doctors' liability insurance premiums and making the doctors employees of the community hospitals. The Council applauds those efforts and urges other small communities to do the same. The Council recommends cooperation

and financial assistance in the form of matching grants or loans from the Legislature, private insurance carriers and others, in the short term, to keep physicians delivering babies in small communities.

- The Council supports and commends existing maternal/child health programs whose goals are the prevention of low birthweight babies and early access to medical care.

- The Council supports and commends the reform recommended by the Montana Medical Association limiting the liability of doctors who participate in peer review.

- The Council supports and commends the intentions of the Montana Medical Association to study the topic of state examination and certification of physicians practicing in Montana.

- The Council recommends that there be full disclosure to patients of the risks, particularly in rural areas, regarding the availability of and access to obstetrical services.

^^^
^^^ ^^^

The Council extends its appreciation to all the organizations and individuals who contributed to the considerations of the Council, and especially to the Montana Medical Association and to Gerald (Gary) Neely.

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DATE 2-17-89
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OBSTETRICAL SERVICES AVAILABILITY ADVISORY COUNCIL
Report of Recommendations

^^^^^

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TESTIMONY / COMMENTARY / DATA

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Montana Academy of Family Physicians
Montana Department of Social and Rehabilitation Services
Montana Hospital Association
Montana Legislative Council
Montana Medical Association
Montana Midwifery Association
Montana State University, College of Nursing
Neely, Gerald (Gary), Esq.
Office of the State Auditor and Commissioner of Insurance
Saint Paul Fire and Marine Insurance Company
State Bar of Montana
Trieweiler, Terry N., Esq.

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EXHIBIT 12
2-17-89
HB 699

February 16, 1989

Representative Dave Brown and Committee Members
House Judiciary Committee
State Capitol
Helena, MT 59601

RE: House Bill 699 - Patient Assured Compensation Act

Dear Representative Brown and Members of the Committee:

The Montana Defense Trial Lawyers, Inc. (MDTL) acknowledges the considerable time and effort expended in drafting the "Patient Assured Compensation Act" but reluctantly concludes that our organization cannot support HB 699. As you know, members of our organization defend doctors who have been sued for malpractice.

Because the bill was only recently introduced and set for hearing, we are unable to appear before you personally.

MDTL recognizes that rural communities face increased difficulties in operating primary health care facilities and in providing medical services, including obstetrical services, to their residents. One of those problems is the cost of physicians' professional liability insurance coverage related to the rendering of obstetrical services.

The concern MDTL has regarding the Patient Assured Compensation Act include:

1. The proposed legislation is very complex with numerous definitions, guidelines, limitations and complicated administrative and judicial procedures which may, in the long run, increase the cost of resolving medical malpractice claims.

2. According to figures presented by Mr. Neely and contained in the report of the Governor's "Obstetrical Services Availability Advisory Council," the basic premium for a family practitioner without obstetrical coverage is in the area of $12,500. The physician would pay an additional $6,313 to the state-administered fund for coverage in excess of $100,000

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for a total annual premium of $18,818. According to figures presented by the Governor's advisory council, the Doctors' Company in 1988 charged $20,962 for full coverage, including cesarean section coverage. If those figures are accurate, we question to what extent that reduction would enhance the availability of obstetrical services in Montana rural communities.

3. MDTL is aware of a number of substantial out-of-court settlements in obstetrical cases involving birth-related injuries. MDTL doubts that provisions contained in the Patient Assured Compensation Act would have affected the negotiations in those settlements, nor would it have altered the amount of the settlements.

4. MDTL concurs in the majority of the recommmendations of the Governor's "Obstetrical Services Availability Advisory Council" as transmitted to the Honorable Ted Schwinden on November 2, 1988.

5. It is true, as pointed out by critics of the proposed legislation, that there is no history in Montana of runaway jury verdicts and no history of seven-figure verdicts in obstetrical cases. It is also true, however, that there have been settlements made in cases involving birth-injured children in the seven-figure range. It is inaccurate to suggest that the insurance companies' decisions to make substantial settlements were not influenced by a number of recent developments in Montana law relating to medical malpractice.

For example, prior to 1985, rural family practitioners were generally held to a standard of care based upon the standard possessed by physicians in "similar locations under similar circumstances." The standard was known generally as the "locality rule." The Montana Supreme Court abolished the locality rule in a case entitled Aasheim v. Humberger. Family practitioners are not generally held to the same standard of care as physicians practicing in larger

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communities. MDTL suggest the legislature consider re-establishing a locality rule so that rural physicians are judged by the "skill and learning possessed by other physicians and surgeons in good standing practicing in similar localities under similar circumstances."

6. Prior to October, 1985, Montana juries were generally instructed that a physician's conduct must be the "proximate cause" of an injury before he can be held liable in a medical malpractice action. In a decision dated October 3, 1985 (Kyriss v. Canfield, et al.) the Montana Supreme Court held that where there was more than one factor at play in causing an injury, the jury should be instructed not on the standard of "proximate cause" but on a standard of "legal cause" where the jury had only to find that the physician's conduct was a "substantial factor" in causing the injury in order to impose liability upon the physician. MDTL suggests the legislature consider a return to the "proximate cause" standard in determining a physician's liability where there may be a number of factors to explain a birth-related injury, including inadequate prenatal care by the mother, underlying disease or abnormality of the mother, and other genetic and congenital factors.

7. MDTL has generally been opposed to laws that limit or "cap" damages. There have been exceptions, of course, such as our position in limiting punitive damage awards. Because there have been few jury verdicts in medical malpractice cases and based upon our experience in settling malpractice claims out of court, there does not seem to be sufficient data to suggest that excessive awards are being given to injured people for non-economic damages. There does not appear to be any rational basis for limiting non-economic damages in medical malpractice cases in Montana. If the legislature considers limitations, however, they should be expressed in absolute dollar figures, rather than formulas or combinations thereof.

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8. MDTL does not oppose a plan which would offer mediation or arbitration as an alternative to the traditional tort system for resolving medical negligence claims. MDTL does not oppose a plan which would offer a no-fault approach as an alternative to obstetrical patients but sees significant difficulties and hurdles in funding such as plan--particularly as an alternative to traditional tort resolution of such claims.

We apologize for not being able to appear before your committee to discuss this important issue.

Sincerely yours,

MONTANA DEFENSE TRIAL LAWYERS, INC.

Robert F. James
President

Insurance

Continued from A1

Johnson, chairman of the Senate Judiciary Committee, said his group encountered constitutional problems with the plan which have not yet been resolved.

If the liability fund goes broke and the $5 million isn't repaid, the state money could constitute an unconstitutional payment to individuals, in this case physicians, unless they can be assessed to make up any deficit, he said.

Perry said the doctors don't like the assessment provision, but if the fund does go broke, the state could wind up with an unfunded liability problem "and we can't afford that right now."

Perry said the consultants told the Joint Judiciary Committee that setting up the fund would result in a 5 to 10 percent savings in malpractice insurance costs.

"The bill isn't dead yet," Perry added. "The concept isn't dead, but it doesn't look good right now. We need to be very careful."

Scott, chairman of the Senate Corporations, Elections and Political Subdivisions Committee, said he can't see the benefit of setting up a medical liability insurance pool because the costs would be about the same.

He also noted the state of Florida has a $142 million unfunded liability from its medical insurance pool that will have to be taken care of.

Wyoming Insurance Commissioner Gordon Taylor said he still thinks the liability fund is possible.

"I think it would be very shortsighted on our part if we close the door on it," Taylor said Friday.

Taylor added that he would like to see the 1976 liability fund law repealed. The fund never was set up because the Legislature underfunded it and it would not have been actuarially sound, he said.

Although Scott is sponsoring a proposed constitutional amendment to limit the amount of damages that can be awarded for wrongful death or personal injury — so-called "tort reform" — and a similar bill will be introduced in the House, he isn't optimistic about their chances, either, given prior defeats to similar proposals.

Democratic Gov. Mike Sullivan supported the cap in the past but has been "singularly ineffective" in getting Democratic legislators to go along, Scott said.

The constitutional cap on damages, he said, has become a partisan issue in the Legislature with Democrats and most lawyers "or relatives of lawyers" opposed.

Some alternatives are available, however, and Scott said some legislators are considering reviving and restructuring the medical malpractice review panel law that the Wyoming Supreme Court struck down as unconstitutional last year.

But Scott also questioned whether any tort reform legislation can withstand Wyoming Supreme Court scrutiny.

Meanwhile, he said, only 25 percent of medical malpractice payments go to the injured victims while the rest of the money goes to the insurance companies for administrative costs and sales commissions; for defense costs or to the plaintiff's attorneys.

The system, Scott said, "is a giant ripoff. Society thinks it is buying protection with the tort system, but that isn't so because so much money goes to the system."

Moreover, he said, the system has caused major disruption and damage to the physician-patient relationship which should be a partnership but has become adversarial.

Physicians now practice defensive medicine to protect them in case of lawsuits, Scott said.

"If you go to the hospital, you become a pincushion," he said.

He said the Converse County Commission is paying part of the liability insurance for Douglas obstetricians to keep the physicians in the community and Casper is losing anesthesiologists because of high insurance rates.

"It may be that it will take a real crisis to precipitate action in this [redacted]," Sc[redacted]dded.

Consultant: malpractice liability rates appropriate

By JOAN BARRON
Star-Tribune correspondent

CHEYENNE - A consultant's report says the rates charged by the insurance company that writes most of the medical malpractice liability policies in Wyoming appear to be appropriate.

SCOTT

And two key legislators say it is unlikely the Legislature this session will pass a bill to set up a medical liability compensation pool for doctors and hospitals.

Sen. Charles Scott, R-Natrona, said the report is valuable because it eliminates arguments that medical malpractice insurance rates are an unjustifiable cause of rising medical care costs.

The report on the feasibility of a medical liability compensation pool for the state said The Doctors' Company has about 70 percent of the physician's malpractice market in Wyoming.

The smaller share of the market carried by the other companies, St. Paul Fire and Marine, PHICO and Insurance Corporation of America, shows they are not seriously pursuing the Wyoming medical malpractice market, the report said.

The 1989 Legislature appropriated $60,000 for an independent actuarial feasibility study of a self insurance pool for Wyoming health care providers.

The 1976 Legislature, during the first medical malpractice insurance crisis, created a medical liability compensation fund. But the fund never was set up. The crisis eased when New Mexico Physicians Mutual came into Wyoming and wrote medical liability coverage.

The second crisis erupted about five years ago when the New Mexico company pulled out of Wyoming on grounds it was losing too much money.

The report said Wyoming, with 32 hospitals and 665 physicians, generates more than $9 million in malpractice liability premiums and is large enough to establish a medical liability compensation account.

The consultants recommended the Legislature start the fund with a $5 million "letter of credit."

Sen. John Perry, R-Campbell-

Please see INSURANCE, A14

Casper Tribune
1-14-89

EXHIBIT 13
DATE 2-17-89
HB 699

EXHIBIT 13
DATE 2-17-89
HB 699

A REPORT ON THE FEASIBILITY OF A MEDICAL LIABILITY COMPENSATION ACCOUNT

FOR

THE STATE OF WYOMING

Prepared for: Mr. Gordon Taylor
Insurance Commissioner
State of Wyoming

Prepared by: THE WYATT COMPANY
1900 NCNB Center, Tower II
325 North St. Paul Street
Dallas, Texas 75201
Mr. Arthur E. Parry, Ph.D., C.P.C.U.
Manager
Risk Management Services

Exhibit # 13
2/17/89

THE Wyatt COMPANY

ACTUARIAL SERVICES
COMPENSATION PROGRAMS
ADMINISTRATIVE SYSTEMS
INTERNATIONAL SERVICES
ORGANIZATION SURVEYS

AN INDEPENDENT WORLDWIDE BENEFITS
AND COMPENSATION CONSULTING FIRM

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EMPLOYEE BENEFITS
EMPLOYEE COMMUNICATIONS
RISK MANAGEMENT
INSURANCE CONSULTING
HEALTH CARE CONSULTING

December 21, 1988

Mr. Gordon Taylor
Insurance Commissioner
State of Wyoming
Department of Insurance
Herschler Building
122 West 25th Street
Cheyenne, Wyoming 82002

Re: Medical Liability Compensation Account

Dear Commissioner Taylor:

Attached please find the feasibility study for the Medical Liability Compensation Account. We have enjoyed working on this project with you as well as your staff.

We will be ready to provide clarifications or answer questions as may be desired by you or others.

We appreciate this opportunity to work with your office.

Sincerely,

THE WYATT COMPANY

Richard G. Alford, C.P.C.U., A.R.M.
Consultant
Risk Management Services

Eldon J. Klaassen, F.C.A.S.
Actuary
Risk Management Services

Arthur E. Parry, Ph.D., C.P.C.U.
Manager
Risk Management Services

abp
Enclosures

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SECTION I

EXECUTIVE SUMMARY

This section is provided to the reader to give an overview of the major recommendations and considerations involved in this feasibility study for the Wyoming Medical Liability Compensation Account (herein called "Account"). Each of the items below are discussed in more detail in the text of the report.

1. Size

   Although Wyoming is a relatively small state in terms of population (under 500,000) with approximately 32 hospitals and 650 (exactly 665) physicians, Wyoming generates over $9 million in malpractice liability premiums and is large enough to consider a funding approach such as a Medical Liability Compensation Account. The minimum volume required within the Account for all participants is $1,000,000 if the Account is primary, $1,500,000 if the Account is quota share and $2,000,000 if the Account is excess.

2. Participation

   As indicated above, Wyoming is large enough to consider an Account. The participation from the hospitals and physicians will need to be extremely strong in order to develop enough up front premiums to fund the account. We estimate the following is needed:

   a. Hospitals - A minimum of 25% is needed.
   b. Physicians and Other Health Care Providers - A minimum of 25% is needed.

3. Account Layer and Limits

   The Medical Liability Compensation Account could write the following coverages:

   a. Primary or first dollar coverage for the eligible health care providers.
   b. Excess coverage which would apply to larger claims above a commercially insured or self-insured (for hospitals) layer.
   c. Quota share agreement whereby the Account and one or more commercial insurance carriers would share in the premiums and losses.

An extremely important element in developing the structure of the Account is to determine which of the above three layers is most appropriate for the Account to write. Table 1 at the end of this section provides each of these scenarios and briefly outlines the advantages and disadvantages of each.

We believe that the Account on a primary basis with limits of $100,000 per claim, $300,000 aggregate is the most prudent, cost effective and easily controlled scenario.

Further discussion outlining these layers as well as their advantages and disadvantages is provided in Section V.

4. Mandatory vs. Optional Participation

It may be difficult to make the Account mandatory. However, an optional program will need significant participation from both the physicians and other eligible health care providers and the hospitals.

5. Retroactive Coverage

Currently the State of Wyoming requires all companies writing medical malpractice to offer an extended reporting provision, although the purchase of this is not required. The Doctors' Company, the leading physician insurer writing in Wyoming, offers retroactive coverage with respect to continuous coverage in prior companies. This means that if a physician is currently insured by The Doctors' Company on a claims-made policy and does not purchase the extended reporting provision, we believe it is likely that if The Doctors' Company were to write the excess coverage for the Account, a claims-made gap would not exist.

Doctors' approach, by rule, is to facilitate handling by the current plan of all malpractice claims reported after the effective date of the account.

6. Loss Handling and Loss Control

It is imperative that the Account provide for an even approach to loss handling and loss control. Loss handling involves communications with claimants and potential claimants in a timely and professional manner as well as professional evaluation of claims and settlement of claims involving negligence. In addition appropriate loss handling includes vigorously defending frivolous claims.

Even and mandatory loss control is of uppermost importance in order to significantly reduce the insurance costs of the health care providers in Wyoming. Loss control takes the form of medical professionals reviewing and policing themselves from a clinical standpoint as well as establishing appropriate procedures in other clinically related areas such as the development and maintenance of thorough and accurate patient records, the use of specialists, etc.

7. Cost Savings Anticipated by the Account

The Account can recognize cost savings over commercial premium in the early years with no change in losses assumed. This is because insurance companies typically attempt to retain all of the investment income for profit and contingencies. The Account would not need to do this since it will have the ability to borrow $5,000,000 from the State for contingencies.

We estimate that loss control services will cost approximately 2% of the premium. The allocated loss adjustment expenses will remain approximately equal to the current insurance marketplace and the unallocated loss costs will cost 6% of losses.

8. Constitutional Cap on Awards

The possibility for a constitutional cap on economic and/or non-economic damages in Wyoming involving medical professional liability losses has not been a factor in this report. We understand that if this process were to begin it could take many years to become a reality, if it becomes a reality at all. In our opinion, the existence of a cap would benefit the Account in terms of limiting the Account's exposure to the catastrophic cases, as well as somewhat reducing the likelihood for Account reinsurance. Of course this depends on if the Account writes coverage on a primary or an excess basis.

9. Relationships

We recommend the Account write cover on a primary basis. This recommendation is contingent on a working relationship with one or more excess insurers such as The Doctors' Company and/or St. Paul. If the appropriate working relationship is not effected, the Account may then need mandatory participation from the health care providers and write cover on an excess or primary basis.

10. Wyatt Recommendations

The determination of feasibility is based on a study of:

a. Economy,
b. Providers to be included,
c. Loss costs,
d. Limits,
e. Overhead costs,
f. The value of money at intervals,
g. Program structures available, and
h. Total premium which must be generated.

Based on a study of these factors, a pooling arrangement in Wyoming would be feasible. However such feasibility will require:

a. That rates remain adequate.
b. That participation requirements are met so that sufficient dollars are available within the Account for payment of losses and costs.

c. That the integrity of the Account be preserved to assure on an actuarial basis that all obligations will be met.
d. That funds be invested in a conservative manner for safety and to minimize premium costs.
e. That the fund be subject to minimum risk if at all.

For the Account to be successful, it will need the following:

a. A single, even claims approach and
b. A single loss-control approach.

Whereas requirement a. (an even claims approach) might be met by the utilization of multiple insurance companies at a primary level, most practically it can be accomplished by the Account as the primary writer with one or more excess writers.

Ideally if all staffing were in place within the Account, all handling could be internal. Again, pre-selection of a third party claims and loss control service, preferably that of one excess insurance provider, could permit the establishment of the Account in accordance with both requirement a. and b.

Additionally such an approach could be used to enable the Account to bring additional services in-house over time.

A very important factor in addition to claims and loss-control is the safety of the Account (i.e., the adequacy of the Account to meet all financial obligations).

Safety is based upon:

a. Adequacy of premium charged to reflect average loss costs.
b. Size of fund to protect against significantly varied and advance results.
c. Ability of the Account to withstand multiple large losses.

A major advantage of writing primary coverage of $100,000/$300,000 and quota share options is the reduced impact individual losses could have on the Account. Although individual companies and the entire industry experience significant variability over time in malpractice losses, we have minimized this factor by recommending primary limits and requiring a total first year account premium to be at a specific level. The availability of an additional $5,000,000 (at cost plus interest) from the State, if required, represents complete soundness and safety.

The recommendation by The Wyatt Company would, if approved and implemented, permit an orderly controlled movement into funding of malpractice liability for health care providers at the lowest ongoing cost.

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2/17/89

10. Time Table

We believe the Account could be established and begin writing the coverages for the health care providers on January 1, 1990. This date may be somewhat optimistic although we believe it is a reasonable goal to consider.

11. Summary

We appreciate the opportunity to conduct this study. Although the need for a solution may have been recognized for sometime, inasmuch as this report contains the first outline of a solution it will need to be reviewed and evaluated by those within and outside of government in Wyoming.

We will be pleased to discuss our report with you and/or others within the State of Wyoming at your convenience. We appreciate the confidence placed in The Wyatt Company to conduct this analysis.

Richard G. Alford, C.P.C.U., A.R.M.
Consultant, Risk Management Services
December 21, 1988

Eldon J. Klaassen, F.C.A.S.
Actuary, Risk Management Services
December 21, 1988

Arthur E. Parry, Ph.D., C.P.C.U.
Manager, Risk Management Services
December 21, 1988

Ex. #13
2-17-89

LOSS, LOSS ADJUSTMENT AND OVERHEAD COMPARISON

A. TAXATION

An early decision on the taxability of the Account is suggested. Irrespective of the result of this issue, conservative actuarial principles will result in breakeven projection goals for emerging years.

B. OVERALL COSTS

Loss costs, unallocated loss costs, and overhead are shown below for major malpractice insurers and the Account projections:

1. Loss Costs and Allocated Loss Adjustments

Insurer	National Loss Ratio
The Doctors' Company	87.3%
St. Paul	93.9%
PHICO	107.0%
ICA	95.6%
Proposed Wyoming Account	Based on 87.3% of Doctors'

2. Unallocated Loss Adjustment

Malpractice Industry Average - 5% of losses
Proposed Wyoming Account - 6% of losses (before present value)

3. Overhead

The Doctors' Company	15.9%
St. Paul	17.1%
PHICO	8.5%
ICA	20.2%
Proposed Wyoming Account	12.0%

The above are estimates.

EXHIBIT 14
DATE 2-17-89
HB 699

TESTIMONY OF MICHAEL J. SHERWOOD. MTLA

RE: House Bill 699

The bill has multiple problems even on an objective basis. I have drafted amendments on the fact of the bill and provided 10 copies to Ms. Emge for those of you who wish to wade through the bill.

I suggest that you wait until a subcommittee has an opportunity to work on it.

The amendments address multiple minor problems., These are

1. The name--This is a physicians insurance fund
2. Definitions- all these definitions are very well covered in the law
3. Primary policy limits--Karl Englund will speak to this
4. Time restraints on an unfunded primary pool--3 years
5. The need for monthly rather than annual or semi-annual damage payments.
6. The method for making a claim against the fund--simplified
7. Punitive damages against the fund--same level as any other insurer in the state
8. Settlement--leave options open rather than requiring periodic payments
9. Administration of the fund is delegated to the board as a fiduciary rather than the state.
10. Some of the findings of fact simply aren't based upon reality.

There are three major areas of concern:

1. ARBITRATION

A. The system should provide for a patient opting in rather than out.

B. The arbitrator should be a neutral finder of fact.. The Doctors have a financial interest in the outcome. They contribute to the fund.

C. Linking the damages to work comp makes no sense and can be more simply limited to economic damages, costs and attorney's fees.

2. 'OBJECTIVE' GUIDELINES.

EXHIBIT 14
DATE 2-17-89
HB 699

A. The Montana Jury experience does not warrant these restrictions.

B. Risk of extremely high award can be eliminated by re-insurance above the certain levels.

3. CONTRIBUTION BY PARTICIPATING PHYSICIANS

A. The Billings Oby-Gyn making in excess of $200,000 per year and delivering hundreds of babies pays no more than the Physician in Forsyth who is delivering 2 babies per year.

EXHIBIT 15
DATE 2-17-89
HB 587-Addy

Montana Magistrates Association

16 February 1989

Testimony offered in support of HB587, a bill for an act entitled: "An act increasing the penalty for a third conviction of driving under the influence or driving with an alcohol concentration beyond a certain amount; lowering the alcohol concentration level that is evidence of an offense."

Given by Wallace A. Jewell on behalf of the Montana Magistrates Association representing the judges of courts of limited jurisdiction of Montana.

We support this proposal not because it increases the penalties for third offense DUI to the felony level; rather the Magistrates Association supports this measure because it lowers to a more realistic level the point of presumed intoxication. The National Safety Council Committee on Alcohol and Drugs in 1971 took the position that a blood alcohol content of 0.08% in any driver of a motor vehicle is indicative of impairment in his driving performance. They stated that blood alcohol levels above 0.08% lead to erratic movement, extreme caution or recklessness, failure to anticipate hazards, failure to maintain lane control, and aggressive driving.

For this reason we urge your do pass recommendation of this legislation.

Wallace A. Jewell

Montana
Beer & Wine
Wholesalers
Association
Post Office Box 124 • Helena, Montana 59624 • Telephone (406) 442-4451

Exhibit 16
2-17-89
587- Addy

M E M O R A N D U M

DATE: February 16, 1989

TO: Committee on Judiciary, House of Representatives

RE: House Bill 587 - grounds of opposition

1. A Ø.Ø8 threshold is not based on optimizing both enforceability and deterrence. See the attached excerpt of testimony presented by the Insurance Institute for Highway Safety to the U.S. Senate Commerce Committee last August 2.

2. Congress has referenced this question to the National Academy of Sciences in sec. 9ØØ3 of the Omnibus Anti-Drug Abuse Act of 1988. The National Academy has fifteen months from last November to "conduct a study to determine the blood alcohol concentration level at or above which any individual when operating any motor vehicle should be deemed to be driving while under the influence of alcohol."

Roger Tippy

RT:ah
Enclosure

ROGER TIPPY, Helena
Executive Secretary/Counsel

EXHIBIT 16
DATE 2-17-89
HB 587

STATEMENT OF BRIAN O'NEILL

HEARING BEFORE THE U.S. SENATE COMMITTEE ON COMMERCE, SCIENCE AND TRANSPORTATION

ALCOHOL-IMPAIRED DRIVING

August 2, 1988

INSURANCE INSTITUTE FOR HIGHWAY SAFETY

WATERGATE 600, WASHINGTON, D.C. 20037 (202)333-0770

It's because of this fact -- any amount of alcohol impairs -- that we shouldn't speak in terms of a "drunk driving" problem. Impairment occurs at BACs well below that we think of as drunk. That is, people don't have to be drunk, at least not in the conventional sense of what "drunk" means, to make driving after consuming alcohol unwise. Some people claim that, because this is true, present thresholds defining impairment (typically Ø.1Ø percent BAC) should be much lower, maybe even zero.

But this isn't realistic. We shouldn't set BAC thresholds that probably wouldn't have public support and couldn't be effectively enforced. The fact is, both alcohol and driving are part of our culture. Some mixing of them is inevitable. The question is, how much mixing are we prepared to tolerate? To address this, we have to know what the societal consequences are, in terms of highway deaths and injuries, when varying amounts of alcohol are consumed.

According to the most recent data on the BACs of drivers who have been drinking and then are fatally injured on weekend nights (1Ø pm - 3 am), when the alcohol problem is most acute, only 5 percent have low BACs (below Ø.Ø5 percent), 9 percent have moderate BACs (between Ø.Ø5 and Ø.Ø99 percent), and 86 percent have high BACs (Ø.1Ø percent or more). In contrast, a roadside sample of drivers on weekend nights has shown that, among those who have been drinking, 69 percent have low BACs (below Ø.Ø5 percent), 2Ø percent have moderate BACs (between Ø.Ø5 and Ø.Ø99 percent), and only 12 percent have high BACs (Ø.1Ø percent or more). Drivers with high BACs thus represent only a small minority of all drinking drivers (12 percent on weekend nights) but are disproportionately represented (86 percent) in the drinking driver fatality statistics. It is this group of drivers we want most to remove from our highways, so it is this group on whom our laws and enforcement efforts should continue to be focused.

Public support is always important if laws are going to be effective. We don't want to run the risk of losing support in this case by setting unrealistically low BAC thresholds. And we don't want to dilute our already limited enforcement efforts by greatly expanding the number of offenders. As long as the death and injury problem from alcohol-impaired driving is dominated by the minority of drinking drivers with very high BACs, it makes sense to focus laws and enforcement on this group.

This doesn't mean that the present BAC thresholds defining drinking-and-driving offenses are optimum. It may be that a somewhat lower threshold -- for example, Ø.Ø8 percent as in Canada and the United Kingdom -- would be appropriate. What needs to be studied is, what BAC threshold is appropriate in the United States to achieve optimum enforcement and deterrence? This is the important question, not what blood alcohol concentration produces impairment.

EXHIBIT 17
DATE 2-17-89
HB 587-Addy

February 16, 1989

TO: Rep. Dave Brown, Chairman
House Judiciary Committee
and Members of the Committee

RE: OPPOSITION TO HB587

My husband and I own a small, rural tavern and restaurant in Basin. Because we serve more than the small population of Basin itself, most of our customers must use their cars to get to our place of business.

If we are fortunate enough to receive their patronage, if they have one drink before dinner, maybe a glass of wine with their meal, and an after-dinner drink, under HB587 they risk being at .08 BAC and thereby open to a DUI citation. If HB587 were to pass, this would give those customers just one more reason not to get into their cars and drive to an establishment such as ours. These customers do not abuse alcohol and should not be penalized as if they were among the low percentage of the public who do.

We employ 10 people, one of whom is a handicapped person from the Montana Developmental Center in Boulder. Our tavern is the community center, the school bus pickup (we're open, so the kids have a warm place to wait for the bus), it's the newspaper drop, the gas station, the commercial bus station. We even are baby sitters at times for parents who are volunteers in our area's emergency medical service program, who must immediately respond to calls, night and day, and have no place to safely leave their children.

We are proud that we can offer the employment we do; the services I mentioned are gladly provided free to our community and surrounding area. But, if we are deprived of any more of our income because of laws such as HB587, we simply cannot afford to continue.

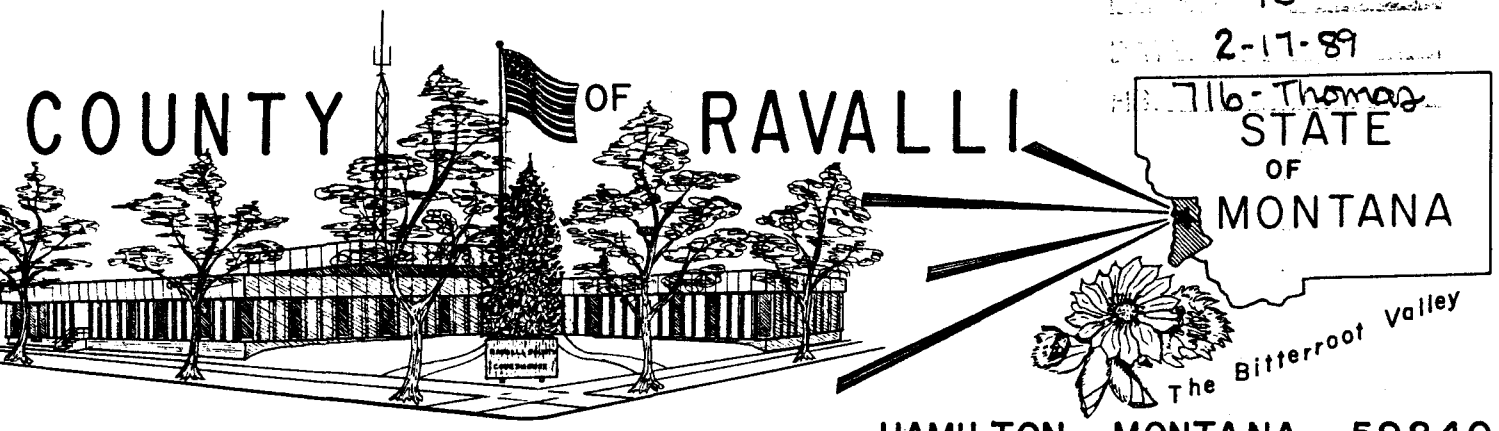
Just because we have a tavern doesn't mean we don't have the same concerns as other citizens for the well-being of our family, our friends and customers, and the people of our community. We are in the LEGAL business of selling a LEGAL product.

Please give small business people like us some relief from bills such as this one that are designed to penalize everyone for the unfortunate few who abuse the products we sell for our livelihood.

Rose Lee Bullock

ROSE LEE BULLOCK
Silver Saddle Bar
Basin, Montana

EXHIBIT 18
DATE 2-17-89
HB 716 - Thomas



HAMILTON, MONTANA 59840

February 14, 1989

TO WHOM IT MAY CONCERN:

Re: Full-time Judge for Ravalli County

Ravalli County is now the eighth-largest population center in the State of Montana. The best-informed sources place the population at or above 25,000 people. With increased population, it is unavoidable that the load on the courts and the justice system has increased.

The caseload in Ravalli County has increased in the County Attorney's Office to a point where it must be prioritized. The civil caseload has also increased, and because of the priority of criminal cases, the civil caseload is beginning to backlog.

Currently, we only have a district judge in the county on the first four Wednesdays of each month for law and motion. This is not satisfactory, as there is a crunch every Law & Motion day.

We need a full-time judge in Ravalli County if we are to provide adequate judicial services to the people of the county.

Very truly yours,

John W. Robinson, Ravalli County Attorney

Marion H. Davis, Ravalli County Commissioner

Jerry L. Allen, Ravalli County Commissioner

Steve Powell, Ravalli County Commissioner

EXHIBIT 19
DATE 2-17-89
HB 592

Amendments to House Bill No. 592
First Reading Copy

Requested by Rep. Mercer
For the Committee on the Judiciary

Prepared by John MacMaster
February 16, 1989

1. Title, lines 8 through 10.
Strike: "PROHIBITING" on line 8 through "PAID" on line 10
Insert: "PROVIDING FOR A TAX LIEN AGAINST FIRE INSURANCE PROCEEDS"

2. Page 2, lines 21 through 24.
Strike: "Fire" on line 21 through end of line 24
Insert: "**Tax lien on insured property destroyed by fire.** If taxes are due and unpaid on property covered by fire insurance and damaged or destroyed by fire, the government entity owed the taxes has a lien on fire insurance proceeds paid in relation to that property in the amount of the unpaid taxes."

EXHIBIT 20
DATE 2-17-89
HB 668

PROPOSED AMENDMENTS TO HOUSE BILL 668 [introduced copy]

1. Page 2, line 4.
Following: "disease."
Insert: "The term does not include vital statistics information gathered pursuant to Title 50, chapter 15."

2. Page 2, line 24.
Following: "chapters"
Strike: "15,"
Following: "17"
Strike: ","

EXHIBIT 21
DATE 2-17-89
HB 582

Amendments to House Bill No. 582
First Reading Copy

Requested by Representative Eudaily
For the Committee on Judiciary

Prepared by Greg Petesch
February 17, 1989

1. Title, line 13.
Following: ";"
Strike: "AND"

2. Title, line 15.
Following: "MCA"
Insert: "; AND PROVIDING EFFECTIVE DATES"

3. Page 4, line 3.
Following: "restriction"
Strike: ",which"

4. Page 4, line 4.
Following: "2"
Strike: remainder of line 4 through "conviction" on line 7

5. Page 4, line 22.
Following: "."
Strike: remainder of line 22 through "." on line 24

6. Page 6, line 23.
Following: "restriction"
Strike: ",which"

7. Page 6, line 24.
Following: "2"
Strike: remainder of line 24 through "conviction" on page 7, line 2

8. Page 7, line 17.
Following: "."
Strike: remainder of line 17 through "." on line 19

9. Page 16, line 3.
Following: line 2
Insert: NEW SECTION. **Section 10. Effective dates.**
(1) [Sections 8 and 9] and this section are effective on passage and approval.
(2) [Sections 1 through 7] are effective July 1, 1990.

22
2-17-89
621

Amendments to House Bill No. 621
First Reading Copy

Requested by Rep. Wyatt
For the Committee on the Judiciary

Prepared by John MacMaster
February 16, 1989

THE AMENDMENTS BELOW ARE IN THE ALTERNATIVE--ONLY ONE SHOULD BE ADOPTED.

1. Page 3, line 1.
Following: "disclosed."
Insert: "This subsection applies to a health care provider providing health care at a private or public school, college, university, or other educational institution."

1 Page 2, line 19.
Following: "~~provider or~~"
Insert: "including an agent or employee of the health care provider or"

EXHIBIT 23
DATE 2-17-89
HB 528

Amendments to House Bill No. 528
First Reading Copy

Requested by Rep. Boharski
For the Committee on the Judiciary

Prepared by John MacMaster
February 16, 1989

1. Title, lines 7 and 8.
Strike: "REQUIRING PROOF OF LIABILITY INSURANCE TO BE SHOWN TO REGISTER A MOTOR VEHICLE;"

2. Page 4, line 6.
Following: "accident"
Strike: "."
Insert: "; or"

3. Page 4, line 7.
Following: line 6
Insert: "(iv) as an alternative to the insurance required in subsections (i) through (iii) above, $100,000 because of bodily injury to or death of one or more persons and injury to or destruction of property of others."

4. Page 8, lines 1 and 2.
Strike: "and" at the end of line 1 and "show proof" at the beginning of line 2

5. Page 8, line 6.
Strike: "and proof"

6. Page 8, line 14, and lines 16 and 17.
Strike: "or proof" on line 14 and at the end of line 16 and beginning of line 17

7. Page 8, lines 23 and 24.
Strike: "and must" on line 23 through "subsection (1)" on line 24

VISITORS' REGISTER

House Judiciary COMMITTEE

BILL NO. HB699 DATE 2/17/89

SPONSOR Addy

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
JOHN DELANO	MMA	X	
Sharon Diezigen	MNA	X	
Peg Manuel Mt. Pro Coalition	Mont. Life Coalition	X	
V. K. NELSON	MMA	X	
John W. McMahon MD	MMA	X	
J. MICHAEL SADAJ MD	MMA	X	
FORTIAN EINS	MT. Medical Ass'n	X	
Jacqueline N. Terrell	Amer. Ins. Assoc.		X
GENE PHILLIPS	N. A. I. I.		X
JAMES W. BORCHARDT	Mt. Ins. Dept.		
Ronna Small	MNA.	X	
KARL EMMONS			X
Terry McGlenn	IIAM		X
Lee Weingarten	Montana Defense Trial Lawyers		X
Mike Sherwood	MTLA		X
Gerald J. Neely	MMA		X
Dan Ahern	Montana Hosp Assoc	X	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

VISITORS' REGISTER

JUDICIARY COMMITTEE

BILL NO. HOUSE BILL 587 DATE FEB. 17, 1989

SPONSOR REP. ADDY

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Donald E Bjertness	City of Billings	✓	
Barbara Moly	L&C Co. SOOR-DUI Task Force	✓	
Wally Jewell	MT Mag Assoc	✓	
Don Larson	M.T.A.		✓
Marie Durkee	"		✓
Roger Tippy	M.B.W.C.A.		✓

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

JUDICIARY COMMITTEE

BILL NO. HOUSE BILL 511 DATE FEB. 17, 1989

SPONSOR REP. MERCER

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
GEORGE T. BENNETT	MONT. BKRS ASSN		X
CHRIS KAFENTZIS	HUD/FHA		X
Bob Pancich	Board of Investments		
MICHAEL E MASKEE	FIRST FEDERAL SAL - MISSOULA		X
CHIP ERDMANN	MT League Savings Inst		X
Bob Pyfer	MT Credit Unions League		X

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

JUDICIARY COMMITTEE

BILL NO. HOUSE BILL 716 DATE FEB. 16, 1989

SPONSOR REP. THOMAS

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Steve Powell	Hamilton, Ravalli Co.	✓	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.