MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

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

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: None

HEARING ON SB 340

Presentation and Opening Statement by Sponsor:

Senator Williams stated that this bill was an act to revise and continue the certificate of need laws; to exempt hospitals from certificate of need requirements in certain circumstances; and providing an effective date.

Testifying Proponents and Who They Represent:

Rep. Bob Marks
Jim Aherns, Montana Hospital Association
Rep. Dave Brown
Richard Brown, Liberty County Hospital
Hollis LeFever, M.D.
Jerry E. Jurena, Trinity Hospital
Sandra Erickson, Montana Associated Physicians
Grant Winn, Missoula Community Hospital
Jerry Beaudette, Sheridan Memorial Hospital
Ed Sheehy, National Association of Retired Persons
Lawrence McGovern, Montana Associated of Physicians
James T. Paquette, St. Vincent Hospital and Health Center
Jerry Loendorf, Montana Medical Association
John Guy, St. Peter's Hospital
Jack Casey, Shodair Hospital

Proponent Testimony:

Rep. Bob Marks stated that health care costs are high. The federal government gave up on certificate of need in 1986. The National Health Planning Act was scheduled to be re-authorized as early as 1981 but it never was. Congress merely funded it with the

continuing resolution year after year until 1986 when it said enough is enough. Each year the federal participation in certificate of need activities grew smaller and smaller until it finally faded away. In Montana the agency with certificate of need once employed over 16 FTE's and now that the federal government has ceased, it is budgeted at less than 5 FTE's and it is staffed even less than that. It is time to have the competitive market to reduce health care costs. If health care facilities engage in unwise, unneeded, overly expensive procedures which their communities cannot support with utilization, let them pay the consequences. Rep. Marks stated that it is his belief that not many health care facilities would be willing to take that risk. Self regulation will prevail. This bill removes hospitals from the certificate of need and hospitals are less in need of capital regulation than are other providers. If hospitals are taken from certificate of need this year, and extend the certificate of need for the other health care facilities, and watch very carefully to see if the doom and gloom results which proponents of certificate of need say will result, the next session can come back in and place hospitals in under the certificate of need law. If costs go down in two years the legislature should start thinking about reducing the scope of certificate of need even further.

Jim Ahrens stated that the Montana Hospital Association represents 54 hospitals and 31 attached nursing homes throughout the state. It has been characterized as a compromise bill and it is just that. It is the compromise between those who want no certificate of need for anyone and those who want certificate of need forever for all providers. This bill extends certificate of need for two years and exempts hospitals for certain services. Exhibit 1.

Rep. Dave Brown stated that he was convinced that after visiting with the hospitals in his area, that this legislation is imperative. Certificate of need does nothing but drain dollars from hospitals operating budgets. Quality of care is not the issue, trying to regulate competition amongst a sector. Rep. Brown also stated that he wondered why there is such a push in the other areas to retain certificate of need. Is there some intent to maintain a monopoly situation and prevent private competition in the certificate of need area. That is a very real question that the committee should consider. If just hospitals are out of this bill, then this bill should die.

Richard Brown stated that as an administrator of a small rural hospital, it does not allow him to make unwise business decisions regarding programs and

business and capital investments. When the decision is made to pursue new programs to consider equipment purchases or building projects, hospital go through very methodical processes of their own to determine the need and feasibility. Hospitals must make decisions on capital investments and programs in a very business-like manner. Exhibit 2.

Hollis LeFever, M.D. stated that the certificate of need law does not certify need, it certifies legal and political power to serve sociopolitical pressures. It does not limit cost to patients and taxpayers. It only limits availability; availability of needed services. Exhibit 3.

Jerry E. Jurena stated that if the intent of certificate of need is to assure quality, it has missed the boat. If it is to restrict the access of health care and limit the technologies associated with building or remodeling, then it is working, if certificate of need is an asset, why hasen't other industries introduced this type of restrictive legislation? Exhibit 4.

Sandra Erickson stated that certificate of need process guide Montana in development and growth based on the documented need of those services. Montana treatment facilities have witnessed unbridled growth n neighboring states and they have ultimately resulted in reduced quality of care, reduced occupancy rates, reduced treatment options and left the field of chemical dependency treatment in shambles. Exhibit 5.

Grant Winn stated that in Missoula there was a hospital that received a certificate of need that was not needed and ultimately was absorbed by another hospital. A certificate of need was submitted last year for an expansion of the hospital with absolutely no opposition and the application itself was $28,000.00. Certificate of need for hospitals has been a waste.

Jerry Beaudette stated that this bill is a step towards total elimination of the certificate of need process. Mr. Beaudette also said that within a year of the completion of the facility his community had under way, all 20 beds were full and have been so ever since. This is a step closer towards total elimination of the certificate of need process.

Ed Sheehy said that he supported this bill.

Lawrence McGovern stated that he supported this bill.

Jim Pacquette stated that there is no proof that certificate of need law reduces costs to the consumer;

there is supporting documentation that certificate of need legislation raises costs of operation to hospitals and that certificate of need law is a clear restraint of trade and hinders the ability of hospitals to function in the free marketplace. Exhibit 6.

Jerry Loendorf stated his support of this bill.

John Guy stated that he supported this bill.

Jack Casey stated his support of this bill.

Testifying Opponents and Who They Represent:

Rose Hughes, Montana Health Care Association
Chuck Butler, Blue Cross and Blue Shield
Wilbur Rehman, Montana Nurses Association
Mona Jamison, Rocky Mountain Dependency Center
Fred Patton, American Association of rEtired Persons
Joan Ashley, Cooney Convalescent Hospital
Steve Waldron, Mental Health Center
Mike Cahill, Granite County Hospital

Opponent Testimony:

Rose Hughes stated that it was with reluctance that she spoke in opposition against this bill because the association would not be thrilled if it failed. Ms. Hughes then proposed some amendments to the bill. A packet was also presented which contained information on the high cost of deregulation; the move at the federal level to reinstate certificate of need; excess capacity and high costs and the unconstitutionality to exempt hospitals. Exhibit 7.

Chuck Butler stated that Blue Cross and Blue Shield supports the continuation of certificate of need with the amendments. The hospital community should be included in the certificate of need process. As Montana's largest insurer of health care, it is known first hand the effect of these rising costs on the people of Montana. Health care costs are one of the fastest if not the fastest growing expenses for employers and employees in our state and country. Mr. Butler stated that the health care insurers have lost money because they could not charge enough in the last three years to cover the actual costs that have been paid out.

Wilbur Raymond stated his support of the certificate of need process. If the bill were amended to include hospitals it would be a good bill. If certificate of need were done away with we would have a brighter future for the cost of health care. That is not true. The issue is really the issue of public involvement and public trust.

Mona Jamison stated that she supports this bill however, the issue of compromise was discussed. How can we compromise among ourselves and not have everyone mad in terms of the bill as presented. The amendments were supported as proposed. The amendments make clear that if hospitals do get into providing the other services, that it is the legislature's intent that the initial provision of those services or expansion that they do comply with certificate of need.

Fred Patton stated that this would not slow the rate of health care costs there would be duplication of expensive equipment and facilities. There would be no longer any rational planning of health care facilities.

Joan Ashley supports the amendments of this bill.

Steve Waldron stated his support of the amendments.

Mike Cahill stated his opposition of the bill.

Questions From Committee Members: Rep. Gould asked Ms. Erickson why she was afraid of competition and Ms. Erickson stated that there would be a need for affordable chemical dependency treatment and that there is an increase every year of people being admitted for the first time.

Rep. Good asked Mr. Robinson about the Wyoming situation regarding certificate of need and also questioned the constitutionality.

Rep. Simon asked Mr. Aherns about swing beds and long term care. and Mr. Aherns said that if a hospital did in fact want to expand to a swing bed facility they would be required to complete a certificate of need. Rep. Simon then again asked where this was read in the bill and Mr. Aherns said it was contained on page 4, section h. Rep. Simon then stated that this bill excludes the exemption of hospitals in section (1) (i).

Rep. Russell asked Mr. Aherns about health care facilities.

DISPOSITION OF SB 340

Motion: Rep. Simon made a Motion to BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. Simon made a Motion to move the Statement of Intent. A vote was taken on the Statement of Intent and all voted in favor. Motion carries.

Recommendation and Vote: A vote was taken TO BE CONCURRED IN WITH A STATEMENT OF INTENT. All voted in favor. Motion carries.

Closing by Sponsor: Senator Williams closed on the bill.

HEARING ON SB 124

Presentation and Opening Statement by Sponsor:

Senator Hager stated that bill was an act prohibiting a long term health care facility from refusing to admit a person to the facility solely because that person has aids or any other HIV-related condition.

Testifying Proponents and Who They Represent:

Bob Johnson, Montana Public Health Association
Mary Beth Frideres, Montana Aids Coalition
Sandy Hale, Montana Women's Lobby
Ann McIntyre, Human Rights Division
Wilbur Rehman, Montana Nurses Association

Proponent Testimony:

Bob Johnson stated that every hospital and nursing home in the state in coming years in Montana will be faced with the responsibility for admitting people with Aids. The staffs of these institutions have been trained in universal procedures that will allow them to treat Aids effectively and to protect the staffs of those institutions. There is virtually no health reason why any institution should be allowed to refuse to admit somebody who has Aids based upon health reasons.

Mary Beth Frideres supports this bill. There is no medical or scientific reason why we cannot take care of people with this infection. Technology has advanced and is appropriate and available to take care of people. There are procedures to be put in place to take care of individuals and there is no reason to discriminate on the basis of HIV infection for providing health care.

Sandy Hale stated that they endorse measures to prevent the human and economic loss relating to Aids. They support the adoption of a strong and comprehensive state level Aids policy including provision for the adequate resources and funding for prevention, education and direct care; opposition for mandatory testing; provisions for informed consent, adequate counselling and confidentiality in conjunction to HIV antibody testing. Exhibit 8.

Anne McIntyre stated that she had amendments to supply for the committee. The Human Rights Division has taken the position that these laws prohibit discrimination against someone who has an HIV related condition. This interpretation is similar to the position taken by

the federal courts and agencies in interpreting federal handicap laws. Exhibit 9.

Wilbur Rehman stated that he supports this legislation.

Testifying Opponents and Who They Represent:

None

Opponent Testimony:

None

Questions From Committee Members: Rep. Squires asked Mr. Johnson if there will be many to care for in Montana with Aids and Mr. Johnson stated that there would not.

Rep. Good asked Ms. McIntyre about the amendments, the impact of the bill and the public accommodations for these patients.

Rep. Russell asked Ms. McIntyre about the president in this kind of language in other kinds of statutes in other states and Ms. McIntyre stated that the laws of other states have been interpreted in the courts and by agency interpretation to include HIV related conditions.

Rep. Simon asked Ms. McIntyre regarding the amendment, would this broaden this act so that it would also pertain to employment and Ms. McIntyre stated that it would indeed pertain to employment.

Closing by Sponsor: Rep. Hager closes on the bill.

DISPOSITION OF SB 124

Motion: Rep. Brown made a Motion to BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. McCormick made a Motion to move the amendments. Rep. Simon spoke against the amendments. A vote was taken on the amendments and all voted against the amendments with the exception of Reps. Russell and McCormick. Motion fails.

Recommendation and Vote: A vote was then taken to BE CONCURRED IN. All voted in favor. Motion carries.

HEARING ON SB 129

Presentation and Opening Statement by Sponsor:

Senator Manning state that this bill was an act to ensure that parents fulfill the duty to support their children by providing for a presumptive obligation of support in certain

legal proceedings; to require consideration to Uniform Guidelines to establish a minimum support level; to require paternity child support orders to include a provision covering health insurance in certain cases; to provide for child support collection through automatic income withholding; to grant the Department of Revenue the authority to charge fees in cases in which an obligor's failure or refusal to pay support requires the Department to act and providing an applicability date. Senator Manning also supplied amendments. Exhibit 10.

Testifying Proponents and Who They Represent:

Jim Smith, Human Resource Development Council
Mignon Waterman, Montana Association of Churches
Judith Carlson, Montana Association of Social Workers
Christine Deveny, League of Women Voters
Rep. John Cobb
Brenda Nordlund, Montana Women's Lobby
Marsha Dias

Proponent Testimony:

Jim Smith stated that sends a message that if you make a baby, baby you will be responsible for the financial well being until that child reaches adulthood. No maybe baby, you are responsible.

Mignon Waterman stated that parents, mother and father alike, should assume financial responsibility for their children. It is only through strict child support decrees and enforcement that adequate child support can be ensured. Exhibit 11.

Judith Carlson stated that this includes not only married fathers who are divorced or mothers but also there is the cases of paternity action is taken. Most people may not be aware but when a young woman applies for AFDC she must name the father of her child so no matter what the legal status is, an action will be taken in court requiring that support be made.

Christine Deveny stated that only one third of all single mothers receive the full amount of their court awarded child support. Exhibit 12.

Rep. John Cobb spoke of the amendments and of his support of this bill. Exhibit 13.

Brenda Nordlund presented the committee with the guide for determination of child support obligations which was prepared by the Montana Child Support Advisory Council. Exhibit 14.

Marsha Dias stated her support of this bill.

Testifying Opponents and Who They Represent:

None

Opponent Testimony:

None

Questions From Committee Members: Rep. Brown asked Mr. McCray about the obligor notice and how employers will be informed and Mr. McCray said that booklets will be sent out to every employer in the state.

Rep. Blotkamp asked Mr. McCray about out of state fathers and the acquisition of health insurance .

Rep. Whalen asked Ms. Nordlund about the number of divorces and the number of children and Ms. Nordlund stated that if one out of four parents are self employed and the number of children that are involved in divorces in 1988 then approximately 3/4 of the children who affected by divorce will benefit by this bill because their parents are employed rather than self employed.

Rep. Squires asked Mr. Smith about the amendments.

Rep. Boharski asked Mr. McCray about withholding sanctions and Mr. McCray stated that the originals language came from was an add in during the last session. If for some reason the attorneys who drafted the papers, they did not want the process to stop.

Rep. Simon asked Mr. McCray about the acceptance of an application and how there might be a time frame and how the Department would need to adopt immediate withholding and put money into a trust account. Mr. McCray stated that the provision originated from the Minnesota statutes. The reason is for timeliness. Get the support obligation being paid as soon as possible as soon as the order is entered. It requires the clerk of courts to provide copies of the decree. With that the custodial parent submits the application. Meanwhile the money for the child is coming in automatically.

Closing by Sponsor: Senator Manning closes on the bill.

HEARING ON HB 741

Presentation and Opening Statement by Sponsor:

Rep. Harper stated that this bill was an act entitled: "The Montana hospital cost containment commission act; creating a

Montana hospital cost containment commission; empowering the commission to set and regulate the rates of Montana hospitals and to require annual reports from those hospitals; providing for the appointment of commission members; empowering the commission to fund all of its costs by making assessments against hospitals subject to its jurisdiction and providing an immediate effective date.

Testifying Proponents and Who They Represent:

Gardner Cromwell, American Association of Retired Persons
Wilbur Rahmer, Montana Nurses Association

Proponent Testimony:

Gardner Cromwell stated that from 1976-83, hospital costs in Montana had risen 195% and that in that period the ranking of expense per adjusted admission had arisen from 41st in the nation to 1st.

Wilbur Rahmen supports this bill and says it is the publics right to know and the publics involvement in health care planning and costs.

Testifying Opponents and Who They Represent:

Jim Aherns, Montana Hospital Association
Jerry Levitt, Montana Hospital Rate Reveiw System
Shane Roberts, St. Luke's Hospital
Ed Sheehy, National Association of Retired Persons
Earl Laury, Missoula Community Hospital
Dale Jessup, North Valley Hospital
Leonard Brewer, M.D.
John Bartos,

Opponent Testimony:

Jim Aherns said that bill was by far the most troubling bill to be introduced this session. It is troubling for hospitals because it places tremendous new burdens on them at a time when many are struggling to remain open another day. It should be troubling to all Montanans because it produces a threat to the future viability of the health care delivery system in the state. Exhibit 15.

Jerry Levitt stated that the rates charged patients are both equitable to the patient and hospital. Montana's hospital rates are among the lowest in the nation.

Shane Roberts stated that 65-85% of the hospital business is prospectively set through medicare, medicaid, worker's compensation and in some cases Indian health services. The rates are already set. This commission would have not say over that.

Ed Sheehy stated his opposition of this bill.

Earl Laury stated that rates are now set by 600 trustees of the hospitals in the state of Montana. Those are representative citizens of the cities in which those hospitals occur.

Dale Jessup stated that the commission may cost more to run per year than the budget set forth by the hospitals it is going to regulate.

Leonard Brewer, M.D. stated that he was in opposition to this bill.

John Bartos stated his opposition to this bill.

Questions From Committee Members: Rep. Gould asked Mr. Grant if the Board meeting were open to the public and Mr. Grant stated that they were.

Closing by Sponsor: Rep. Harper closed on the bill.

ADJOURNMENT

Adjournment At: 7:20 p.m.

REP. STELLA JEAN HANSEN, Chairman

SJH/ajs

M0307.min

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date 3/3/89

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

3/4/89
10:30 AM
BGP

STANDING COMMITTEE REPORT

March 4, 1989
Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging report that SENATE BILL 124 (blue reading copy) be concurred in.

Signed: _____
Stella Jean Hansen, Chairman

[REP. SQUIRES WILL CARRY THIS BILL ON THE HOUSE FLOOR]

510945SC.HBV

STANDING COMMITTEE REPORT

March 4, 1989

Mr. Speaker: We, the committee on Human Services and Aging report that SENATE BILL 340 (blue reading copy), with statement of intent included, be concurred in as amended.

Signed: _____
Stella Jean Hansen, Chairman

[REP. MARKS WILL CARRY THIS BILL ON THE HOUSE FLOOR]

And, that such amendment read:

1. Page 1.
Following: line 16
Insert: " STATEMENT OF INTENT

It is the legislature's intent to exclude acute care hospitals from certificate of need requirements, except in certain limited circumstances that are enumerated in subsections 50-5-301 (1) (h) and 50-5-301 (1) (i). The provision by a hospital of services under either of those subsections is intended to include construction, conversion, or expansion of bed capacity."

TESTIMONY BEFORE HOUSE HUMAN SERVICES AND AGING COMMITTEE

ON

SENATE BILL 340

BY

MONTANA HOSPITAL ASSOCIATION

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS JAMES AHRENS; I AM THE PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. THE ASSOCIATION REPRESENTS 54 HOSPITALS AND 31 ATTACHED NURSING HOMES THROUGHOUT THE STATE. THE MONTANA HOSPITAL ASSOCIATION SUPPORTS SENATE BILL 340. IT HAS BEEN CHARACTERIZED AS A COMPROMISE BILL, AND IT IS JUST THAT. IT IS THE COMPROMISE BETWEEN THOSE WHO WANT NO CON FOR ANYONE, AND THOSE WHO WANT CON FOREVER FOR ALL PROVIDERS. THIS BILL EXTENDS CON FOR TWO YEARS AND EXEMPTS HOSPITALS FOR CERTAIN SERVICES.

THE ASSOCIATION I REPRESENT DOES NOT FAVOR CON. WERE IT POLITICALLY ACHIEVABLE, WE WOULD PREFER TO SEE CON SUNSET IN ITS ENTIRETY. HOWEVER, WE RECOGNIZE THAT OTHER PROVIDERS MAY NOT SHARE OUR DISTASTE FOR CON. RATHER THAN PROVOKE A CONFLICT, WE DECIDED TO RESPECT THE WISHES OF THOSE PROVIDERS AND SUPPORT A BILL THAT WOULD CONTINUE CON FOR THEM, BUT SIMPLY EXEMPT HOSPITALS. THE CON PROTECTION, THE CON FRANCHISE, WOULD STILL BE EXTENDED TO NURSING HOMES, INPATIENT CHEMICAL DEPENDENCY AND INPATIENT PSYCHIATRIC TREATMENT FACILITIES AS WELL AS TO HOME HEALTH AGENCIES, HOSPICES, PERSONAL CARE SERVICES AND INPATIENT REHABILITATION SERVICES. MORE THAN THAT, IF A HOSPITAL WANTED TO ENGAGE IN ANY OF THESE PROTECTED SERVICES, IT WOULD HAVE TO OBTAIN A CON.

EXHIBIT 1
DATE 3-3-89
HB 340

YOU HAVE NO DOUBT HEARD A LOT ABOUT CON IN THE LAST FEW WEEKS. THE WITNESSES THAT FOLLOW ME WILL TELL YOU MORE OF THE REASONS WHY CON IS NOT NECESSARY FOR HOSPITALS. THEY HAVE TRAVELED TOO FAR FOR ME TO GIVE THEIR TESTIMONY, SO I WILL MAKE MY RE MARKS BRIEF AND CONFINE THEM TO THE REASONS WHY THIS IS THE CON BILL YOU SHOULD VOTE FOR--WITH NO AMENDMENTS. THIS IS A GOOD BILL AND IT NEEDS NO AMENDMENT.

THERE WERE TWO CON BILLS INTRODUCED IN THE SENATE. THE FIRST ONE, SENATE BILL 217, SIMPLY REMOVED THE SUNSET PROVISION OF EXISTING LAW, SO THAT CON WOULD CONTINUE INTO PERPETUITY. HOSPITALS WERE NOT INVITED TO PARTICIPATE IN THE CRAFTING OF THAT BILL. WE WERE SIMPLY TOLD, "YOU WILL BE IN CON...FOREVER."
SENATE BILL 217 NEVER MADE IT OUT OF COMMITTEE, BECAUSE THE SENATE PUBLIC HEALTH COMMITTEE SAW THE WISDOM OF 1) REMOVING HOSPITALS FROM CON AND 2) ESTABLISHING A SUNSET PROVISION.
THE COMMITTEE BELIEVED THAT IT WAS NO LONGER NECESSARY FOR HOSPITALS TO BE SUBJECT TO CON. THEY BELIEVED THAT THE COMPETITIVE MARKET USHERED IN BY THE MEDICARE PROSPECTIVE PAYMENT SYSTEM PROVIDED MORE EFFECTIVE COST CONTROL THAN CON EVER DID. THEY BELIEVED THE FEDERAL TRADE COMMISSION REPORT THAT STATED CON, BECAUSE IT INHIBITED COMPETITION, ACTUALLY DROVE UP HEALTH CARE COSTS, AND THEY BELIEVED THE REPORT FROM THE LEGISLATIVE AUDITOR OF MONTANA WHO, AFTER STUDYING CON FOR TWO YEARS AT THE DIRECTION OF THE LEGISLATURE, CAME TO THE CONCLUSION THAT "IT IS DIFFICULT TO ASCERTAIN WHETHER MONTANA'S CON PROGRAM HAS BEEN EFFECTIVE ENOUGH TO CONTINUE BEYOND JUNE 30, 1989." THE COMMITTEE FELT IT WAS NECESSARY TO RETAIN A SUNSET PROVISION BECAUSE A SUNSET DATE PROVIDES FOR A PROGRAMMED REVIEW OF CON. A

PROGRAMMED REVIEW OF CON IS NECESSARY BECAUSE 1) THE EFFECTIVENESS OF THE PROGRAM IS STRONGLY QUESTIONED AND 2) THE RELATIONSHIP BETWEEN REGULATORS (THE CON AGENCY) AND THE REGULATED (THE NURSING HOME AND CHEMICAL DEPENDENCY INDUSTRIES) DESERVES LEGISLATIVE OVERSIGHT TO PROTECT THE PUBLIC INTEREST. THE LEGISLATIVE AUDITOR COULD NOT SAY THAT CON WAS EFFECTIVE. ALL OF THE ROCKY MOUNTAIN STATES HAVE TERMINATED THEIR CON PROGRAMS AND THEY HAVE BEEN JOINED BY A NUMBER OF OTHERS. WE HOPE IN TWO MORE YEARS THERE WILL BE STUDIES THAT ENABLE US TO SAY DEFINITIVELY THAT CON DOES NOT WORK, THAT IT IS AN EXPENSIVE AND BURDENSOME PROGRAM WHOSE SOLE PURPOSE IS TO DOLE OUT FRANCHISES TO PROVIDERS WHO DO NOT WANT TO COMPETE.

THE SENATE PUBLIC HEALTH COMMITTEE KILLED SENATE BILL 217 AND FOUGHT BACK AN ATTEMPT TO AMEND SENATE BILL 340 BY REMOVING THE SUNSET AND PUTTING HOSPITALS BACK IN. ON THE SENATE FLOOR, THE PROPONENTS OF SENATE BILL 217, ATTEMPTED TO OVERTURN THE ADVERSE COMMITTEE REPORT. THEY FAILED. ON SECOND READING OF SENATE BILL 340, THE PROPONENTS OF SENATE BILL 217 ATTEMPTED TO AMEND THIS BILL BY REMOVING THE SUNSET AND BY WIDENING THE NUMBER OF SERVICES FOR WHICH A HOSPITAL MUST OBTAIN A CON. BOTH AMENDMENTS FAILED AND THE BILL PASSED SECOND READING 48-0. IT PASSED THIRD READING 49-1, THE ONE SENATOR VOTING AGAINST IT, VOTING SO BECAUSE HE WANTED CON TO SUNSET IN ITS ENTIRETY.

YOU MAY HEAR SOME PEOPLE TESTIFY TODAY THAT TAKING HOSPITALS OUT OF CON WILL HAVE A HARMFUL EFFECT ON THE MEDICAID BUDGET. THOSE WHO MAKE THAT CLAIM DO NOT UNDERSTAND THE REIMBURSEMENT SYSTEM FOR MEDICAID. MEDICAID REIMBURSES HOSPITALS FOR INPATIENT SERVICES ON THE BASIS OF DIAGNOSTIC RELATED GROUPS

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(DRGs). THIS IS A FIXED RATE PAYMENT SYSTEM BY WHICH EVERY HOSPITAL IN THE STATE RECEIVES THE SAME PAYMENT FROM MEDICAID FOR PROVIDING CARE. SRS SETS THE WEIGHTS FOR DRGs. THAT IS, SRS DETERMINES IF, SAY GALL BLADDER SURGERY SHOULD BE PAID AT A RATE TWICE THAT OF A TONSILLECTOMY. THE LEGISLATURE IS RESPONSIBLE FOR GRANTING ANNUAL INCREASES TO THE DRG PRICE, BUT IT CANNOT EXCEED THE AMOUNT SET BY THE FEDERAL CONGRESS ACCORDING TO ITS AUTHORITY IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982.

THESE PRICES ARE SET WITHOUT REFERENCE TO ACTUAL HOSPITAL COSTS. SO, MEDICAID PAYMENTS ARE SET BY SRS AND THE LEGISLATURE. INCREASES IN COST ARE DO TO AN INCREASE IN UTILIZATION AND CASE COMPLEXITY. BOTH OF THESE FACTORS ARE BEYOND OUR CONTROL.

FURTHERMORE, SRS HAS NEVER SHOWN ITS CONCERN FOR CAPITAL REGULATION DURING THE ACTUAL CON PROCESS. NOT ONCE IN THE LAST FOUR YEARS HAS SRS TESTIFIED ON A HOSPITAL CON APPLICATION. THE CONTENTION THAT TAKING HOSPITALS OUT OF CON WILL RAISE THE ROOF ON THE MEDICAID BUDGET IS SIMPLY BASED ON MISINFORMATION.

THIS IS A GOOD BILL. IT IS THE COMPROMISE BILL. WE URGE YOU TO ACCEPT IT AS IS. I WOULD BE HAPPY TO SPEAK TO ANY SUGGESTIONS FOR AMENDMENT, IF ANY ARE MADE. HOSPITALS DO NOT WANT TO BE UNDER CERTIFICATE OF NEED. IF OTHERS DO, LET THEM.

State of Montana

Office of the Legislative Auditor

REPORT TO THE LEGISLATURE

CERTIFICATE OF NEED PROGRAM

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

This report provides information regarding the Certificate of Need program and identifies areas for legislative consideration.

Direct comments/inquiries to:
Office of the Legislative Auditor
Room 135, State Capitol
Helena, Montana 59620

88P-33

EXHIBIT 1
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Chairman Hanson and Committee Members:

I am Richard Brown, Administrator of Liberty County Hospital and Nursing Home, an 11-bed acute care and 40-bed skilled nursing facility located in Chester. I have been the administrator of that facility for eleven years. Currently I am serving as Chairman of the Montana Hospital Association.

I am here today to speak in support of Senate Bill 340 (Williams) which would continue Certificate of Need (C.O.N.) and exempt hospitals from most services, all equipment and all construction. This bill would still require C.O.N. for swing beds, long term care beds, psyche, rehab and chemical dependency services. The bill in its present form addresses the concerns of most health care provider organizations.

As the Administrator of a small, rural hospital I am in a position that does not allow me to make unwise business decisions regarding capital investments. When the decision is made to pursue a new program, consider an equipment purchase or building project, hospitals go through a very methodical process of their own to determine need and feasibility. Hospitals must make decisions on capital investments and programs in a very business like manner. The questions asked by hospital administrators as they determine the need for these projects or programs, are the same questions asked in the C.O.N. application. This duplication only adds to the rising cost of health care and creates another obstacle in the efforts of hospitals to run an efficient operation.

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I don't deny that health planning is beneficial but the needs within our individual communities and around the state will determine whether or not additional health care facilities should be constructed or whether additional equipment should be purchased for providing services. I have had occasion to go through the C.O.N. process for program change and equipment purchases. Those incidents were time consuming, and expensive use of resources, and in my opinion a duplication of process. In addition these programs were delayed for implementation until the application could go through a lengthy, unnecessary cycle. In essence the entire process is very ineffective. Our decision to pursue these projects was driven by the needs of the residents we were serving. Nothing was done frivolously or without thought. That type of approach would only lead to the eventual demise of our hospital.

The Certificate of Need process is no longer effective for Montanas' hospitals. Ideally the sunset of the C.O.N. law would be in the best interest of health care organizations throughout the state. I do however support Senate Bill 340 in its' current form and urge the passing of this Bill. Any amendment to the Bill would only dilute the intent of the Legislation.

Thank you for your consideration.

EXHIBIT 2
DATE 3-3-89
HB 340

629 NE MAIN - P. O. Box 150
Ph. (406) 538-7778

HOLLIS K. LEFEVER, M.D. FAAFP
LEWISTOWN, MT. 59457

DIPLOMATE AMERICAN BOA
OF FAMILY PRACTICE

I speak in favor of SB 340. The certificate of need law does not certify need, it certifies legal and political power to serve sociopolitical pressures. It does not limit cost to patients and taxpayers. It only limits availability; availability of needed services. I have spent 31 years trying to bring patients and services together in Montana.

The certificate of need law 50-5-301, part 3, may be referred to as the State Franchise Bill, it was initially conceived to prevent unnecessary duplication of health care facilities, equipment and services that would result in extra cost to the health care recipients or the public through the expenditures of tax funds. The law has failed miserably to accomplish these goals and is no longer a necessary obstacle in the provision of health care in Montana. Indeed, the bill has never proved cost saving measure and has cost the health care industry in Montana literally millions of dollars as well as the tax payers of Montana who are spending over a quarter of a million dollars annually just to keep the State Department funded to oversee the certificate of need law. Onl a third of the expense for the operation of the State Department responsible for the enforcement of this law is paid by health care providers. Even so, the amount paid by health care providers is a considerable burden to each health care facility attempting to improve it's ability to provide current state-of-the-art health care. The bill has been demonstrated to invite bias, excessive socioeconomic & politica pressures, and to not only hamper the effort at facilities to provide needed services but to saddle the patients in our facilities with tremendous extra cost involved in funding the certificate of need process. Indeed, Montana is remiss in not having repealed this law much sooner. We are the only Rocky Mountain State to still have such a law in the books. Our neighbors Arizona, Colorado, Idaho, New Mexico, Utah, and Wyoming do not have such a law. California, Texas, Kansas, and Minnesot have rejected this type of legislation. The law includes, among other undesirable elements, a restraint of trade. The Federal Trade Commission reported that CON grants a franchise and inhibits competition and thereby increases health care costs. In September of 1986, Congress suspended all funding for CON and CON related agencies because it did not reduce cost. The Federal Government, through the Medicare Program does not pay hospitals according to the money they spend. Hospitals are reimbursed according to the diagnoses of the diseases they care for. Excessive expenditures to care for those diseases would only jeopardize the hospitals financial stability. No additional federal reimbursement would be received because the hospital expended unnecessary funds to provide facilities, services, or equipment. The DRG law ended that. Indeed the only rational way to justify expenditures in the 1989 scene of health care and all the demands that are made for cost containment and quality

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care, is to allow individual facilities to make capital investment decisions based upon community needs, availability of the service in the area, the volume of the potential demand for the service, and the ability of the health care consumer to pay for the service so that the facility will be able financially to continue to provide the service with the reimbursement it can obtain for it. Having considered these factors and made an intelligent decision, health care facilities administrations and boards should not be hampered by second guessing at a State level, particularly when that second guess, namely the CON review process, is so costly and time consuming & comparatively uniformed about local needs.

What are these costs? First of all, there is a major cost simply to file the application with the State to obtain a certificate of need. Second, there are large costs in obtaining legal and financial feasibility studies to accompany the application, and third, there are great costs in time and services of institutional personnel to gather all of the data and information needed to submit a CON application. And, let's don't forget that while all of this is going on (a process which has been proven to take months and even years in Montana) that service is being denied to the patient's in the area and the revenue from that service is being denied the facility which is trying to survive in this age of economic realities in the health care field. Twelve States have eliminated this type of legislation so that the health care industry was deregulated. Those areas have not seen excessive growth in the provision of services for acute care.

I have been watching the needs and the attempts to meet these needs in Montana since 1958. I have been in the private practice of medicine. I have tried to deal with these problems as a physician admitting patient's to acute care hospitals in Glendive and in Lewistown. I have tried to provide services while serving as President of the Medical Staff and Boards of these hospitals, I have watched the health care needs in the State as past president of the Montana Medical Association, and I have heard the certificate of need presentations as I served on the area health council. I have watched the frustration and humiliation of hospital administrators presenting applications where the cost of the applications far exceeded the cost of providing the service. I have watched patients in communities do without needed services either because of denial under the certificate of need law, or the fear of denial, or the fear of the expense in attempting to obtain a franchise to provide a much needed facility, service or equipment. The small hospitals in which I work and the smaller hospitals than that, don't have tens of thousands and hundreds of thousands of dollars to spend on legal fees, surveys and application fees. They have a hard enough time scraping together the dollars to buy a piece of X-ray equipment or to set up a surgery suite or to create a certain type of acute care bed that is critically needed. I well remember our committee hearing the applications of a facility where

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twice as much money was spent obtaining a certificate need as was needed to move an X-ray unit from a Physician's office into the hospital. This was not only absurd, it was unconscionable in this day and age of limited funds and almost unlimited health care needs for our citizens. Now that the certificate of need is determined by the State Department of Health & Environmental Science, some of the steps have been eliminated but it has not reduced the cost, uncertainty, and erroneous decisions that could be avoided if the CON law were simply allowed to die at this time. We have seen the State approve CON's for facilities when those of us in the health care industry watched with dismay and could not believe that they could have been approved, and at the same time we have watched the State deny CON's only to have them overturned in court. How long will you, our respected Legislators, perpetuate this folly? If indeed you feel that long term care facilities and psychiatric and drug abuse services would proliferate without the law, then accept Senator William's compromise bill, Senate Bill 340. But, please remove the hobbles from the feet of those of us who are trying to provide health care services to the acutely ill in Montana. Eliminate certificate of need restrictions for acute care facilities and providers in our State.

Hollis K. Lefever, M. D.

Signatures of Concurrence:

Administrator, Central Montana Hospital

Medical Staff - Central Montana Hospital

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Trinity
HOSPITAL
(406) 653-2100
315 Knapp Street, Wolf Point, Montana 59201

HOUSE HUMAN SERVICES AND AGING COMMITTEE

During the 1989 session, you will be dealing with legislation concerning Certificate of Need (CON). The legislation concerning CON will range from maintaining its current strucuture to letting it sunset. It is my belief as a rural hospital administrator, who has been involved with three (3) building projects sinice 1976, to let it sunset. It is my belief that the current legislation regarding CON is time consuming, costly and can be restrictive. It is my intent to share with you my thoughts about the CON.

First, let me review the process we, as healthcare administrators, must go through for a building project or major remodeling process.

1) Internal Planning
   a) list problems and ideas
   b) develop solutions

2) Hire professional planners or architects

3) Present plans and ideas to local community

4) Secure funding and local support

5) Hire professionals to develop CON application

6) Submit to CON Board and request hearing date

7) Present application to CON Board

8) If there is no contention - start project.

If there is contention or questions, this can be for a variety of reasons, i.e., local study differs from state plan which uses averages, or there may be political roadblocks. The CON application process starts over.

1) Application is redone or revised

2) Re-submitted to CON Board

3) Re-schedule hearing with CON Board

4) Present application to CON Board

5) If no contention - start project.

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In my experiences, the CON application has been an unnecessary burden which does not assure quality as an outcome. I would like to recap each briefly.

1) Nebraska. Project to decrease hospital bed size, increase emergency room facilities and remodel obstetrics, surgery and physical therapy.

   Questions were raised if we had done sufficient planning and did the community support the project.

   RESULT - delayed project by six (6) months and created additional cost. On second hearing, four hundred (400) people traveled to hearing to demonstrate their support, community of 3,000 people. Project had also been approved prior to first CON hearing by a vote of 78%.

2) Wyoming. Project to increase number of nursing home beds and downsize hospital by six (6) beds.

   Questions were raised regarding local statistics, did not conincide with state averages.

   RESULT - project delayed, statistics had to be re-verified and re-submitted. Again, we had additional cost added to project. Problem was local statistics for elderly over 65 were higher than state averages and there was disbelief on the waiting list submitted. Project was approved on second hearing.

3) Wyoming. Project to joint venture with medical staff.

   Question was raised if the hospital and physicians could work together in this arrangement, and if the project was really necessary to provide healthcare in a rural setting.

   RESULT - project delayed, additional costs were added to project. Project approved on second hearing.

   Prior to both Wyoming projects, hospital and physicians held open forums in the community (prior to hearings). Projects were voted on through the 1% sales tax levied to complete the projects. Vote was 70 plus percent in favor of the projects.

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In each case, we had approval by the local community to support and fund projects and there was no outside contention with our projects; however, each project experienced a delay due to the CON process.

The problem that I have experienced with CON are:

1) It is costly - as a result the costs associated with this process are shifted to the consumer in the end.

2) It creates delays - the delays in effect are costly and in some cases the quality (suffers).

3) There are political problems that arise from the process.

4) I believe free enterprise is restricted.

5) Monopolies are created by legislation.

6) If CON is the answer to controling healthcare, why are so many states battling the issue and sunsetting the law.

When one becomes involved in a building process, the CON process becomes another obstacle to cross. It is not spoken of favorably unless it is restricting a competitor.

If the intent of CON is to assure quality, it has missed the boat. If it is to restrict the access of healthcare and limit the technologies associated with building or remodeling, then it is working. One last point, if CON is an asset, why haven't other industries introduced this type of restrictive legislation?

In conclusion, I support Senate Bill 340 (The Williams Compromise) and I am opposed to Senate Bill 217.

Jerry E. Jurena
Administrator/CEO
Trinity Hospital
Wolf Point, Montana

EXHIBIT 21
DATE 3-3-89
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PHONE (406) 727-2512
1-800-367-2511

Providence
Specialists in Family Counseling for
Chemical Abuse and Dependency

SANDRA ERICKSON
DIRECTOR OF MANAGEMENT SERVICES

401 THIRD AVENUE NORTH GREAT FALLS, MT 59401
CUT BANK, MT • CONRAD, MT

Providence
Specialists in Family Counseling for
Chemical Abuse and Addiction Management

HUMAN SERVICE AND AGING COMMITTEE

March 3, 1989

Proponent For SB340 with Amendments

I am here today representing Providence, a family counseling center specializing in chemical abuse and dependency, located in Great Falls. We are a private, nonprofit agency and have been in existence for over twenty years. We have facilities in three counties: Pondera, Glacier, and Cascade.

I am also testifying for Chemical Dependency Programs of Montana, an association of 23 member programs from throughout the state.

I, as an individual program and CDPM are proponents of SB340 because it is the only certificate of need legislation left alive.

Inpatient chemical dependency treatment facilities are required to function within the regulations of CON to maintain an orderly growth in our rapidly expanding industry, there is a reason. **Nationwide an inpatient chemical dependency treatment center opens every three weeks, primarily in hospitals to offset losses in acute care services.** Montana, however has wisely charged the Department of Institutions to assess each county's needs every four years to carefully prepare a comprehensive chemical dependency plan. That comprehensive chemical dependency plan has three objectives:

PRACTICE INCLUDING BUT NOT LIMITED TO:
Assessment & Referral
Interventions
Intensive Outpatient Program
Individual and Group Therapy
Family Therapy
Adolescent and Children Services
Consultation and Education
ACT Program (Montana Court School)

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1) To assist the citizens of Montana in understanding the problems of chemical dependency and efforts currently employed to deal with this problem.

2) To provide a policy document that promotes efficiency, cost effectiveness, and availability of chemical dependency services within the state.

3) To provide information to service providers, other agencies involved with chemical dependency services, state and local government agencies, and the Montana Legislature about the current status and <u>future</u> requirements of chemical dependency programming.

Please note that last sentence: future requirements of chemical dependency programming. This comprehensive planning document and the CON process guide Montana in development and growth based on the documented need of those services. Montana treatment facilities have witnessed unbridled growth in neighboring states, Utah and Minnesota immediately come to mind, that have ultimately resulted in reduced quality of care, reduced occupancy rates, reduced treatment options and left the field of chemical dependency treatment in shambles.

Thankyou and I urge you to pass SB340

I am concerned with the expansion of existing services as well as expansion of new services

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MONTANA
ASSOCIATED
PHYSICIANS INC

1242 North 28th Street
Billings, Montana 59101
406-248-1635
1-800-648-MAPI (6274)

POINT SHEET

1. Montana Associated Physicians, Inc. is an 87 member physician organization based in Billings. (Our practices employ approximately 350 people in addition to our physicians.)

2. Eliminating this expensive, time-consuming and counter-productive Certificate of Need process for hospitals would improve access to medical technology for all physicians, including those in rural areas.

3. Referring physicians from the entire region, as well as their respective patients, should have a choice of services (hospitals).

4. The Federal Trade Commission actively promotes competition in health care. Certificate of Need law can hold the level of services below what the public needs, create a demand for these services and increase prices well beyond what they would have been in a competitive situation. Competition ensures that services will be offered at the lowest possible price, regardless of where the procedure is done.

5. The time has come to let hospitals control their own destiny. Hospital boards and administrators are in a much better position to determine what their communities need and what they can and cannot afford than some governing agency almost 400 miles away.

6. Health care is surely the dominant industry in the state, and considering the state of our economy, I think that we have no choice but to let this component of our economy grow and develop in any way that we can.

7. Because the health care industry, particulary the reimbursement systems, is in such a state of flux, the need for regulatory processes, such as Certificate of Need law, has to be re-evaluated on a regular basis.

8. **In summary, Montana Associated Physicians, Inc. supports Senate Bill 340 without amendments.**

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Saint Vincent Hospital and Health Center

SAINT VINCENT HOSPITAL AND HEALTH CENTER
TESTIMONY OF JAMES T. PAQUETTE BEFORE
THE HOUSE HUMAN SERVICES AND AGING COMMITTEE
MARCH 3, 1989
CERTIFICATE OF NEED LEGISLATION

Chairman Hansen and respected members of this Committee, my name is James T. Paquette and I serve as President and Chief Executive Officer of Saint Vincent Hospital and Health Center, a 280-bed general acute care hospital in Billings, Montana. We have consistently taken a position against Certificate of Need law for hospitals since the changes in Medicare and Medicaid reimbursement went into effect in the mid 80's.

We support the elimination of Certificate of Need law as it relates to hospitals and as it is embodied in Senate Bill 340, without amendments. The Senate showed tremendous support for Senate Bill 340 through a vote of 49 to one, and we ask that the House concur.

Decades ago, Certificate of Need legislation was intended to function as a cost-containment device. When it was first enacted during the early 70's, there was little incentive for hospitals to control their costs. Medicare and Medicaid reimbursed on a cost plus basis, so the more they spent, the more they were reimbursed. With the introduction of the DRG (Diagnostic Related Group) system in the mid 80's, the situation changed dramatically. In this new era, decisions to enter into new services or purchase capital are based upon: 1) demand; 2) ability to command a price in the market sufficient to cover costs and provide margin for capital; 3) ability to deliver quality care. Certificate of Need law is no longer necessary to control costs or excess building.

Proponents suggest that eliminating CON for hospitals will increase Medicaid costs. They claim that hospital service costs are growing faster than any other segment of the Medicaid budget. This growth is not the result of hospitals' increasing their charges, as some proponents of the Certificate of Need process would like you to believe. Hospitals in Montana have been paid a fixed fee per Medicaid admission for inpatient services since October 1, 1987. No matter how much is charged, we are still reimbursed the same amount.

There is no evidence that the absence of Certificate of Need law contributes to higher cost to the patient. Montana ranks 47th out of 51 states (including the District of Columbia) in cost/admission according to data supplied by the Montana Hospital Association. We submit that this is not a result of any regulatory process. A more probable explanation is that hospitals representing 85% of the beds in this state open their rates to a a voluntary review process. Last year average rate increases approved through this process were approximately 7%.

Post Office Box 35200
Billings, Montana 59107-5200
406-657-7000

We touch your life.

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Contrary to some of the stories you have heard, deregulation does not promote unwarranted growth. For example, Wyoming deregulated in May, 1987. At that time, 600 long-term care beds had already been approved under CON law. Since then, approximately 400 of those beds have either been completed or are still under construction. No other capital activity is anticipated for several years. Granted, Wyoming's economy doesn't allow for much activity. But, Wyoming's economy more closely parallels Montana than does Arizona and Utah. It is not valid to compare states with <u>total</u> populations of less than a million with large metropolitan areas of more than 3 million people. The growth rate in Arizona two years ago was almost four times the growth rate of the entire United States. These two states, of course, are cited by proponents of Certificate of Need law as examples where deregulation only fuels unnecessary construction.

The Federal Trade Commission (FTC) actively promotes competition in health care. The Commission has cited the entry barrier created by CON law as a factor <u>significantly</u> contributing to the potential for anti-trust violations.

Proponents of CON law suggest that joint ventures would not occur without a CON process. In Billings, Saint Vincent Hospital has entered into a number of cooperative ventures with Deaconess Medical Center and will continue to evaluate other opportunities. The two hospitals operate a jointly-owned hospice, cancer center, MRI unit and laundry services. These joint ventures were sound business decisions based on months of research and planning. They were not a compromise for a contested CON application.

Senate Bill 340 is a compromise bill. It recognizes the needs of nursing homes, psych hospitals, rehab hospitals, mental health and chemical dependency programs and allows these types of services to remain under the protection of Certificate of Need law.

In summary, we support Senate Bill 340 and ask that the House concur for the following reasons:

1. There is no proof that CON law reduces costs to the consumer.

2. There is supporting documentation that CON legislation raises costs of operation to hospitals.

3. CON law is a clear restraint of trade and hinders the ability of hospitals to function in the free marketplace.

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MONTANA
HEALTH
CARE
ASSOCIATION

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

Senate Bill No. 340 - Certificate of Need

PROPOSED AMENDMENT

Amend Senate Bill 340 as follows:

1. Page 4, following line 15, add a new section (3):

"(3) For purposes of subsection (1) (i), the provision by a hospital of services for ambulatory surgical care, home health care, long term care, inpatient mental health care, inpatient chemical dependency treatment, inpatient rehabilitation, or personal care, includes all activities described in subsections (1) (a) through (1) (h) related to the provision of the enumerated services."

2. Renumber subsequent sections.

Explanation:

This amendment is required to clarify that any activity undertaken by a hospital related to providing long term care and the other services enumerated in section (1) (i) such as adding new beds by construction, expansion or conversion, will require a certificate of need. If another provider, such as a nursing home or chemical dependency treatment facility, would be required to obtain a CON in order to engage in the activity, then a hospital would be treated similarly.

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MONTANA
HEALTH
CARE
ASSOCIATION

36 South Last Chance Gulch, Suite A
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SENATE BILL 340

PROPOSED AMENDMENT TO INCLUDE HOSPITALS IN CERTIFICATE OF NEED PROCESS

Amend Senate Bill 340, as follows:

1. Page 3, line 25, following "~~or~~"
   Insert: "or"

2. Page 4, line 5, following "50-5-101"
   Strike: "; or"
   Insert: "."

3. Page 4, lines 6 through 9,
   Strike: in their entirety.

4. Page 4, line 20, following "~~hospital,~~".
   Insert: "hospital,"

5. Pages 4, lines 24 and 25, and page 5, line 1,
   Strike: in their entirety.

Explanation:

The amendments remove the hospital exemption and make hospitals and all health care providers currently covered by certificate of need a part of the CON process.

The legislation continues to include a two-year sunset for review of the process.

The amendments are necessary to avoid an unconstitutional distinction between hospitals and other health care providers and to maintain some method of controlling hospital costs and duplication of services and equipment.

An Affiliate of
ahca
American Health Care Association

EXHIBIT 6
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MONTANA HEALTH CARE ASSOCIATION

36 South Last Chance Gulch, Suite A
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406-443-2876

SENATE BILL 340 - Exempting hospitals from Certificate of Need

THE HIGH COST OF DEREGULATION...

The Montana Hospital Association's "green sheet" indicates that no study has been released that claims that certificate of need reduces health care costs.

The fact is that studies are available with respect to the states of Arizona and Utah--which have been without CON longer than other states--which indicate that unnecessary services--both hospital and nursing home--have proliferated; that occupancy rates have gone down; and that total health care expenditures have gone up, when CON has been abandoned.

Common sense should tell us all, including the Hospital Association, that when services are duplicated and occupancy goes down, costs go up...and the consumers and taxpayers pay the bill.

The attached newspaper articles should be of interest in that regard.

The "free enterprise" system you're being asked to experiment with is funded with state and federal taxpayer dollars coming from the Medicaid and Medicare programs.

PLEASE SUPPORT SENATE BILL 340 WITH AMENDMENTS TO INCLUDE HOSPITALS IN THE PROCESS.

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An Affiliate of
ahca
American Health Care Association

opinion

The Billings Gazette is dedicate
Billings and Montana while rec
quality of life must be maintai

Keep hospital costs low

The state Senate recently passed Senate Bill 340 with an overwhelming 49-to-1 vote. The bill is now resting comfortably in the House Human Services Committee awaiting a hearing.

GAZETTE OPINION

The measure would allow the expiration of a law requiring hospitals to obtain a "certificate of need" from the state before hospitals could proceed with new services or an expansion of existing services. Essentially, the certificate-of-need law is intended to eliminate duplication of services and, presumably, keep health-care costs down.

In Billings, Deaconess Medical Center officials took one look at the Senate vote, considered the odds and withdrew from adminstrative hearings reconsidering St. Vincent Hospital's proposal to add cardiac surgery to its services.

If indeed SB 340 is a *fait accompli*, then we can safely assume that not only will St. Vincent add cardiac surgery to its list of services, but those hospitals in the state that are in direct competition with each other will — to one degree or another — engage in games of one-upmanship with programs, services and equipment.

Health care in America today is a very expensive business. Monday's Wall Street Journal reports that hospitals in some parts of the country are paying kickbacks to doctors who refer patients to them. Any way you look at it, that unethical practice is just another hidden cost that must be borne by the health-care consumer.

The certificate-of-need law served as a check and balance against costs.

Without it, both Deaconess and St. Vincent have an obligation to keep the high cost of medicine down and the quality of care up. Patients must insist on that.

Applause due

The Yellowstone County Commission held its brainstorming session last week and opened it to the public. That was after Commission Chairman Dwight MacKay's uncertainty over inviting the public.

MacKay and the other commissioners deserve an A-plus not only for allowing the public in but also for developing a mission statement and outlining goals.

The statement is clear and uncomplicated, and the goals intelligent and necessary. We now know how much the commissioners are dedicated toward improving government, and that helps all of us.

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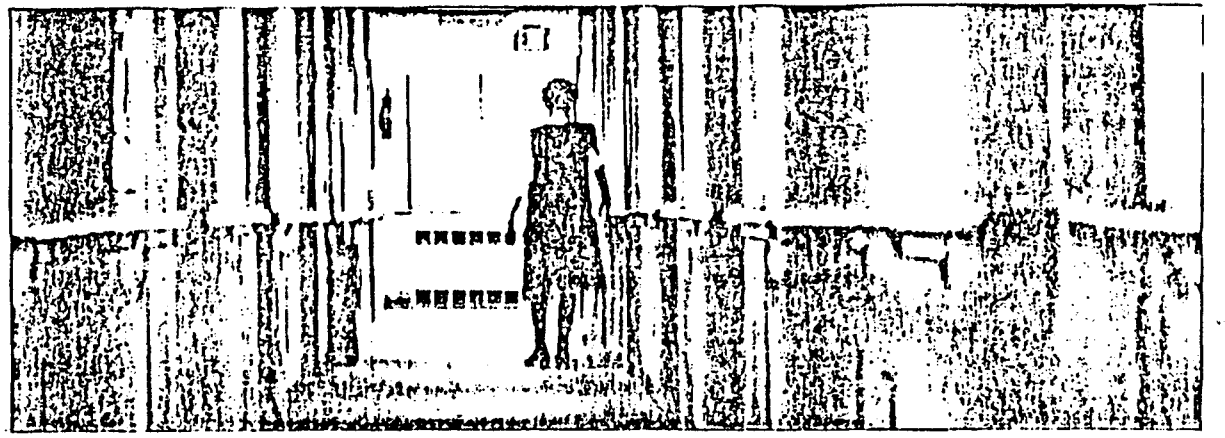
Commentary

Laissez faire sends nursing home tab to public

By William Lambdin



LIBRARY FILE/Rocky Mountain News

Regulations governing the expansion of nursing homes in Colorado expire in July unless the legislature renews them.

COLORADO could see dramatic increases in nursing-home costs if the state legislature deregulates the health-care industry and allows too many nursing homes to be built. Costs to patients and taxpayers could go up needlessly. Quality of care could go down. Just ask Arizona.

The Arizona legislature deregulated nursing homes in 1982. Since then the state has seen a 76% increase in the number of nursing home beds. State Medicaid expenditures have increased by 54% — at taxpayers' expense. Nursing homes struggling to survive because of intense competition have cut staff, food service and other things that lower the quality of care. Arizona Health Department official Marlene Mariani said the state has become "a perfect example of the proliferation of services that will occur when there is a lack of controls."

The few other states that have eliminated controls have had similar problems. Texas had to place a moratorium on Medicaid payments to stop rapid expansion of nursing homes. Utah has seen huge increases in nursing-home construction in the last three years. California is reinstating controls after eliminating them just two years ago.

Colorado's Certificate of Need law that regulates nursing-home expansion will expire this July. If it is not replaced by other controls, several of the big, national health-care chains will expand here just as they did in Arizona. They don't care if too many nursing homes are built. They have millions to invest and figure they can outlast local competitors. Half-empty facilities don't bother them. Through investment tax breaks and other advantages, they have learned how to manipulate the health-care system, skimp on care and end up with a profit. The usual marketplace forces of competition don't apply.

Charles Froelicher knows that. He is a member of Colorado's Health Data Commission that collects information on health-care operations throughout the state. He recently said, "Without question, marketplace forces are not at work in the health-care system." He charges that large corporations are able to create monopolies, increasing rates and making huge profits while treating fewer patients.

How do you make more money if you have fewer patients? You charge each patient more. How can you justify that? Because you have "fixed costs" that must be paid regardless of the number of patients.

Nancy McMahon with the Colorado Health Department explained how this Catch-22 works: A nursing home's costs for building maintenance, mortgage payments and equipment remain the same and must be paid whether it is full or half empty. As the number of patients drops, the cost per patient rises to meet the fixed costs.

The kicker is that most of those higher per-patient costs are passed on to the state through Medicaid increases. As a tax-supported program, Medicaid pays nearly 70% of all the health care given in nursing homes. It is mainly for poor people or the chronically ill who cannot obtain insurance. Increases in their nursing-home bills can cost the state plenty.

A few state legislators realize this. Sen. James Beatty, R-Fort Collins, is sponsoring legislation to continue state controls on nursing homes. He is supported by the Colorado Health Care Association, which represents most of the state's current long-term care providers. CHCA director Arlene Linton says figures show that Colorado doesn't need any more nursing homes: Medicaid admissions are now 200 fewer per month than four years ago. Overall occupancy is down about 1,000 patients. A recent U.S. General Accounting Office report also says that nursing home occupancy rates are declining nationwide.

Beatty's bill may face heavy opposition from health care corporations that want to expand. Their lobby is strong, and deregulation is popular these days. We have deregulated the airlines, banks and other industries. Legislators will be tempted to go along with the trend.

Maybe hospitals and some health-care operations should be deregulated. But not nursing homes at this time. Marketplace forces that encourage improvements through competition are lacking. The experience of other states shows what will happen.

There is one other thing we should remember: The basic principle of all health care is that the public ultimately pays for it — through higher medical bills, increased insurance premiums or more taxes. If you see health-care facilities going up on every corner like filling stations, don't wonder who pays for them when they are nearly empty. You are paying for them.

William Lambdin, Greeley, is author of "Doublespeak Dictionary" and publisher of "Senior Voice," a news magazine for retired people in Colorado and Wyoming.

Wall Street Journal
Monday, Feb 27, 1989

50 CENTS

Warm Bodies

Hospitals That Need Patients Pay Bounties For Doctors' Referrals

The Practice Is Questionable, But It Spreads as Profit From Care Is Threatened

Lack of Enough Sick People

By Walt Bogdanich
And Michael Waldholz
Staff Reporters of The Wall Street Journal

The hottest commodities in the patient-care business these days are patients. Hospitals with empty beds and testing centers with idle equipment are buying. Doctors are selling.

Patients are rarely aware of the under-the-counter market in their bodies. Many physicians are acutely aware of it; some profit and see nothing wrong with it. "I can admit [a patient] to any hospital that I want to for any reason I want," physician David Spinks testified at the 1986 kickback trial of a Texas hospital administrator. "I don't have to justify that to anybody. I can admit . . . because I don't like the color of the carpet [at a competing hospital,] or I don't like my parking spot."

At issue in the trial, however, was the $70 per patient that Pasadena General Hospital was paying Dr. Spinks as a consulting fee whenever he referred a patient to the hospital. The hospital paid in order to keep Dr. Spinks from sending his patients to other hospitals.

FIRST OF A SERIES

Reporters for The Wall Street Journal spent three months examining the buying and selling of patients. The practice of paying kickbacks is widespread and growing, stimulated by public and private efforts to contain the costs of medical care. The efforts have worked to keep some patients out of hospitals and shorten the stays of others. In either case, the result is empty beds in hospitals; the occupancy rate has dropped by 14% in a decade.

"We don't have enough sick people to go around," says Linda Quick, a health planning official in Miami. "That's good news for patients, but not so good for hospital profits."

Physicians have become more vulnerable to financial inducements offered by hospitals and testing centers because the physicians' income is under pressure, too. "Doctors no longer have a blank check to essentially set whatever price they want, and make as much money as they think is reasonable," says Barry Moore, of Hamilton/KSA, a medical consulting group in Atlanta.

Paying for patients helps keep health-care costs up and encourages unnecessary medical services. A Rhode Island physician, Felix M. Balasco, sent 29 people to the hospital for pacemaker implants they didn't need; for taking kickbacks he was convicted in federal court in Providence of Medicare fraud in 1986.

The practice sometimes denies patients higher quality care that they might have received at another hospital. One hospital accused in a physician kickback scheme is Medical Center of North Hollywood, in California, operated by the American Medical International chain. U.S. Health Care Financing Agency reports show that in 1986, this hospital was one of only 2.4% in the nation whose Medicare patients died at a higher-than-predicted rate. The hospital, however, in a letter to federal health officials, says it provides excellent care. The hospital also says its patients are sicker than those in other hospitals.

Of even broader concern, many health-care specialists say, is the new willingness of reputable hospitals—large and small, for-profit and nonprofit—to push ethical boundaries in their search for patients.

There is little doubt that the practice of selling patients is worsening.

Last year, the U.S. attorney in Philadelphia charged nearly 400 area physicians with taking kickbacks to send patients to a medical testing laboratory. It is believed to be the largest single enforcement action ever brought against physicians. This in part prompted Richard Kusserow, inspector general of the Department of Health and Human Services, to warn of a "nationwide proliferation" of kickback allegations in medical testing.

Donald S. Winston, a Houston physician, says kickbacks have been so common at times that American Medical International, the hospital chain, once mistakenly sent him a $50,000 check intended for another physician. The check was delivered some years ago by a bank officer. "I grabbed it out of her hand, locked her in the waiting room, copied both sides, then returned it," Dr. Winston says.

Angry over seeing that check, Dr. Winston filed suit against American Medical's Twelve Oaks Hospital in federal court in Houston. The suit alleges that American Medical secretly paid $1 million to subsidize a physicians' group in return for their patients. Twelve Oaks used the money allegedly to persuade physicians to refer patients for "higher cost hospital services" rather than lower cost out-patient services, according to briefs Dr. Winston filed in court in 1987.

Officials of American Medical declined to be interviewed because the case is pending. In court papers, American Medical doesn't deny making payments to physicians, including Dr. Winston, but says it

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Warm Bodies: Hospitals That Need Patients Pay Bounties to Physicians in Return for Referring Them

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was merely following a legal, industrywide practice of helping physicians build a patient base near hospitals. American Medical says it requires only that physicians who receive payments obtain hospital staff privileges so that they have "the option" of referring patients to Twelve Oaks.

American Medical, however, did admit recently in court filings in California that it is a target of a federal criminal investigation in connection with payments to physicians.

In a lawsuit filed last year in a California state court, Maxicare Health Plans Inc., a health-maintenance organization, accused American Medical of paying $1.2 million to buy patient referrals from a physicians' group, Hawthorne Community Medical Group. Maxicare calls the payments illegal kickbacks, and says they raised medical costs for its patient-members treated at American Medical hospitals.

Maxicare alleges that the chain disguised the payments as financing for office locations for the physicians' group and as consulting fees to the group for reviewing patient care at three of the chain's Los Angeles area hospitals. American Medical, in court papers, has denied any wrongdoing. The Hawthorne group declines to comment.

Patients rarely can count on government to protect them from exploitation. State and federal anti-kickback laws are weak or rarely enforced. Federal law does forbid even indirect kickbacks for referring Medicare and Medicaid patients to hospitals or testing centers. But federal prosecutors say they can't recall a single successful prosecution of a hospital for patient-buying. Many states don't specifically forbid hospitals from paying kickbacks to physicians.

Medical ethics, as defined by the American Medical Association, prohibit direct kickbacks. But the ethical code fails to address the many indirect kickback schemes that are employed. Nor do ethics address the lucrative ownership interests in testing centers being offered to physicians who can effectively guarantee profits by referring patients to the centers.

* * *

The situation at Pasadena General Hospital in 1985 was critical. Operating in a grimy Houston suburb, the aging hospital had been financially hemorrhaging ever since it was purchased in 1983 by American Healthcare Management Inc., a publicly traded owner and operator of hospitals.

The reason was simple: Physicians had suddenly stopped sending their patients. If Pasadena General were to stop the bleeding, it somehow had to change the minds of those physicians.

By 1985, the hospital had such a plan. Straying physicians would be offered a potpourri of financial incentives: profits from a sophisticated X-ray machine but none of the risk; paid committee appointments requiring little work; the possibility of free trips.

"McSHANE: OK.

"FURTH: I'm not rushing you . . . I know you can't predict what may be happening next week, but if - if you have some admissions around Tuesday evening. . . ."

Mr. Furth later explained in testimony that high occupancy would put his boss "in a very, very good mood."

The Fall Guy?

Rick Robinson, a Washington lawyer for American Healthcare and Pasadena General, says: "The company's view was that they didn't approve of any agreement to pay physicians for referrals. And such an agreement, had it existed, would have violated company policy." But Randy Schaffer, a lawyer who represented Mr. Furth, blames American Healthcare for his client's problems.

"He went out and recruited in the manner they suggested, then when it all hit the fan, [they] let him take the fall," Mr. Schaffer says. "They couldn't single my guy out of all the people in the country and make him a felon, because that's the way the industry operated."

Mr. Furth's prosecutor, Linda Lattimore, agrees that Mr. Furth "was just doing what was common in the trade. That's my gut feeling, really."

That's certainly what Mr. Furth thought. "Let's say something should happen to me," said Mr. Furth in one of Dr. McShane's tape recordings. "You also want to know that the next person coming in is going to be doing the same damn thing I'm doing."

* * *

Just days before Mr. Furth spoke of patient-buying in front of Dr. McShane's hidden microphone in Texas in 1985, a similar conversation was taking place more than 1,200 miles away, in a quiet Midwestern town just off the Lake Erie shore.

On a July evening, board members of the nonprofit, tax-exempt Northeastern Ohio General Hospital were meeting in the hospital's community room to act on a gamble to bring in more patients. The plan was for the small, revenue-poor hospital to lend $75,000 to a group of six physicians, the core members of the independent Madison Clinic.

This was to be a special loan: It didn't have to be repaid. All the physicians had to do to get it was promise to admit "not less than 75% of their patients."

One reason for the generosity: In the previous four months Bill Stoerkel, a Madison Clinic physician, had referred less than half the number of patients than he had referred during the comparable months the year before. The hospital couldn't afford such patient losses.

At a board meeting several months earlier, Dr. Stoerkel, representing the clinic, had warned the hospital to talk money quickly if it wished to compete with other hospitals for patients from the clinic.

Conscience and Cash

"Dr. Stoerkel stated that he has walked the halls for a lot of years and it seems as though to get some financial help makes one feel better that the Board is standing behind you," according to hospital board minutes.

muke, president of Jackson & Coker, a national medical consulting firm. He cautions that this might be illegal. It's "really on the leading edge," and "it's, not widespread," Mr. Dismuke says.

More commonly, hospitals simply buy physicians' practices. A 1988 survey of 600 hospitals by Hamilton/KSA, a medical consulting firm, found that 18% were buying physician practices and another 8% were considering it. In some communities, "if you have locked in that supply of patients, then you have assured your future and you have significantly damaged your competing hospital," says Barry Moore, of Hamilton/KSA.

New Rules Sought

Still, says Mr. Kusserow, the Hea and Human Services inspector gener "The physician's patients, in most cas may be totally unaware that the physici has sold his or her practice to the hos tal."

Many of the purchases would be ille under rules proposed by Mr. Kusser Congress requested the rules in hope better defining what it views as an ove broad anti-kickback law. These rules, c rently undergoing a period of public cc ment, could take effect this spring.

More definitive federal law, howev won't eliminate the buying and selling patients. Because so many state laws weak, hospitals can avoid prosecution buying only private patients.

Minnesota authorities, for exam have taken no action against the nonpr Methodist Hospital in Minneapolis for p ing a $2.5 million kickback to the are largest physicians' group, Park Nico Medical Center.

For this kind of money, Methodist H pital wanted no Band-Aid-and-asp cases. Its December, 1986 contract with medical center stipulated that the hosp get 90% of those Park Nicollet patients quiring CT, or computerized tomograp scans; radiation therapy; home care; patient rehabilitation; and selective ou tient surgical procedures. Medicare Medicaid patients were specifically cluded.

Uninformed Patients

The clinic was obliged to send pati over a period of three to five years.

The Hennepin County Medical Soc calls the arrangement unethical. But Minnesota Board of Medical Examin which licenses physicians, has refuse say whether it has even investigated contract. The Minnesota attorney gene office says hospitals can't be held cr nally liable for paying kickbacks to get vate pay patients.

The county medical society conde the deal on two grounds: Pati shouldn't be swapped for financial cor erations, and patients should have b told of the deal but weren't, says the m cal society's Bruce Norback.

James Reinertsen, Park Nicollet's p ident, says he found Methodist's req for a patient quota "peculiar," but along with it because the quality of wouldn't suffer. He says his clinic inst on the right to terminate the contract v out penalty if it alone decided quality anything less than the best available

Terry Finzen, Methodist's presi says increasing competition forced his pital to protect its investments. "We vulnerable," he says.

be seen. A straight swap: patients for money. It was a strategy that ultimately resulted in the indictment of Pasadena General's administrator, Russell Furth, on charges that he violated a federal anti-kickback law.

Although Mr. Furth was acquitted at a 1986 trial, it wasn't because he didn't pay kickbacks; he admits to that. It was just that prosecutors couldn't prove he paid them to get Medicare patients. The trial provided a rare inside look at the seamier side of hospital competition.

Price: $70 a Head

Two flamboyant Houston physicians, Dr. Spinks and Jerry McShane, were central figures. Still in their 30s, they earned about $100,000 a year each. Dr. Spinks drove a Porsche; Dr. McShane, a Jaguar. They jointly owned a rock-and-roll club, a weight-reduction center, a horse-breeding company, and the entity Pasadena General valued most: a thriving clinic.

Drs. Spinks and McShane had been steering almost all their patients to hospitals that directly competed with Pasadena General. Because Drs. Spinks and McShane were such valued prospects, one of Mr. Furth's first acts as Pasadena General's new administrator was to persuade them to switch their referrals. Although there is a disagreement over who broached the subject of kickbacks, each side ultimately agreed on a price: $70 per patient, to be disguised as consulting fees.

Both Drs. McShane and Spinks testified that Pasadena General's previous owners had given them money. "Once a month this check would come, and if you tried to find out much about this check, you couldn't get much information," says Dr. McShane. He says the administrator would only say that it was for "supporting our hospital."

About the time that American Healthcare Management bought Pasadena General, the checks stopped coming. And Drs. McShane and Spinks began referring their patients to other hospitals. To reopen the patient spigot, Mr. Furth testified, his superiors at American Healthcare approved paying kickbacks, so long as they didn't involve Medicare or Medicaid patients.

A Grant of Immunity

Mr. Furth testified that he felt kickbacks in any form were wrong. But he said the company assured him that under Texas law he couldn't be prosecuted for such payments.

Under the state law, however, the physicians could under certain circumstances lose their medical licenses for accepting cash kickbacks. So when Drs. McShane and Spinks say they learned that selling patients might be improper, they sought and obtained immunity from state and federal prosecution in exchange for their testimony against Mr. Furth.

At the government's request, Dr. McShane secretly tape-recorded the administrator. On one tape, Mr. Furth shows his apprehension over the possibility that his company's president would find empty hospital beds during an upcoming visit to Pasadena General.

"FURTH: Next week the president of our company is in. Will be here on Wednesday.

J. Dudley Chapman, a physician on the hospital board, wondered how this squared with other things he had heard. According to the board minutes, Dr. Chapman "related a conversation in which Dr. Stoerkel stated he could not admit patients to (Northeastern Ohio General Hospital) in good conscience due to substandard conditions and incompetence."

The hospital did have failings. According to 1987 hospital records, physicians worried about poor lab work and nursing errors, while a private inspection agency found that the hospital hadn't enacted an overall quality assurance plan.

The board decided to investigate the loan plan further, and on this July evening it met to take a final vote. Over Dr. Chapman's objections that buying patients might be illegal, the board voted to execute the agreement, which covered patient referrals until August 1990.

Physician's Explanation

The "loan" agreement didn't specifically exclude Medicare and Medicaid patient referrals, although it is a felony under federal law to knowingly solicit or receive a kickback in exchange for Medicare or Medicaid patient referrals.

Dr. Stoerkel confirms that he sent Medicare patients to the hospital after the clinic got its $75,000. "I don't differentiate one patient from another," he says. But he says he doesn't believe he violated any law. "Most hospitals have arrangements with physicians, one way or another, where they are paying to keep them interested in using their hospital facilities," he says. He also says he never sent patients to the hospital unless they needed hospitalization.

The $75,000 "loan" to the Madison Clinic physicians created problems for the hospital: Other physicians asked for similar payments. In 1986, for example, two other physicians asked the board for a "$30,000 forgiveness loan similar to the Madison Clinic loan," according to hospital board minutes. The loan was granted.

Despite the hospital's attempt to buy physicians' loyalty, it closed three months ago. "The hospital was like the Shah of Iran," says Dr. Chapman. "He bought his power but eventually ran out of money. Here, people were saying give me $75,000, give me this, give me that, until we too ran out of money."

* * *

The word "kickback" isn't fashionable among hospital administrators. They refer instead to "physician practice enhancement" and "physician bonding."

Some enhancement or bonding seems no more malign than ordinary business entertainment. In 1986, Sheridan Park Hospital, near Buffalo, N.Y., offered physicians who admitted 10 or more patients a month a "choice of dinner for two or one round of golf at the Country Club of Buffalo." Sheridan Park has since closed.

Leasing hospital beds to physicians who can, in effect, rent out the beds to patients at a profit seems more questionable. "Let's suppose I lease that bed [to a doctor] for $700, and he is able to bill $800 for that bed, then the doctor picks up $100 for every patient he has," says Bill J. Dis-

* * *

Sidney Wolfe, who heads the consumer-oriented Health Research Group, says hospitals and physicians should get out of the business of buying and selling patients. "Is the purpose first and foremost to deliver the best patient care, or is it to use patients and their health problems as a front for making a lot of money?" Dr. Wolfe asks.

He adds: "If doctors and hospitals are going to act like racketeers, they are going to deserve to be treated like racketeers."

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Move @ Federal level to re-instate CON —

House bill would restrict hospital construction

By Meril C. Kimball
HealthWeek Washington Bureau

WASHINGTON—Rep. Fortney "Pete" Stark, D-Calif., introduced a bill Sept. 7 that would force states to crack down on inefficient hospital spending for new buildings, expansions and purchases of expensive medical equipment.

Hospitals that don't get approval for such expenditures would forfeit Medicare payments to cover these capital costs.

In attempting to revitalize the states' certificate-of-need efforts, the bill also would require states to identify hospitals that should close because of low occupancy rates. However, the measure contains no penalty to force hospital closures.

A trial balloon

Although the bill is a trial balloon that won't be considered until next year at the earliest, its intent is to rein in Medicare's capital payments for major hospital purchases. These payments have risen 76 percent during the past five years, compared with a 17 percent increase in general inflation, according to Stark, chairman of the House Ways and Means Health Subcommittee.

Stark said Medicare's capital payments are projected to rise an average of 11 percent annually through 1993.

"These increases will occur while use of hospital facilities reaches ever-higher levels of inefficiency," he said in a statement. "Over one-third of the hospital beds in the nation which are staffed are standing idle every single day."

Stark added that each empty bed, by conservative estimates, costs $40,000 a year, for a total $14 billion in "wasted resources."

"It certainly does not cost the amount of money Stark is talking about," said

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Bill restricts some spending by hospitals

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one health industry observer. The empty beds are "not staffed, not operated. No one is spending any money on them. They are stand-by capacity."

'A step back'

"This represents a step back into a certificate-of-need program that did nothing to eliminate excess capacity," said Jack Owen, head of the American Hospital Association's (AHA) office here. "We need to let economics dictate capital expenditures."

Stark said the "normal rules of economics do not appear to apply in any meaningful way to hospitals."

He said when Texas relaxed its capital-expenditure review law in 1985, nine new hospitals opened in Houston at a time when the city was in a recession due to falling oil prices. He added that $1.5 billion currently is being spent on hospital construction there, even though occupancy rates have declined to less than 60 percent.

Stark: Medicare capital payments expected to rise 11 percent annually.

Specifically, Stark's bill would:

- Require each state with an urban-hospital occupancy rate below 85 percent and a rural occupancy rate below 75 percent to set up a review system to approve any capital expenditure of more than $1 million or which creates new beds or services. If the state does not set up this system, Medicare would withhold capital reimbursement.

According to AHA data, every state is below those occupancy rates.

- Limit the amount of new capital spending allowed per year in each state but still allow cost-based reimbursement within that limit.
- Exempt rural hospitals from the limits if the state develops a separate health plan to stabilize those hospitals.

Stark's bill has no chance of consideration this year before Congress adjourns in October. But next year, as one congressional aide put it, "Whatever saves money is a viable option—no matter how wild and crazy it may seem." □

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MONTANA HEALTH CARE ASSOCIATION

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SENATE BILL 340 - exempting hospitals from Certificate of Need

DEREGULATION - THE ARIZONA EXPERIENCE....

The following information is excerpted from a report on Arizona deregulation entitled, "A Study of the Impact of Health Care Deregulation on Hospitals, Nursing Homes, and Health Services in Arizona."

Nursing Homes:

	1982	1985	%
Beds	8,313	12,559	+51.1%
(Growth of 51.1% for 3 years, compared to 55.8% for preceding 9 years.)			
Occupancy	92.55	82.8	-10.5%
Gross patient revenues	$124.2M	$224.7M	+81 %
Per capita expenditures	$370.76	$553.81	+53.5%

"In Arizona, nursing home care is provided by the counties. Increasing costs are placing a heavy cost burden on county funds."

Hospitals:

New hospitals	3	
Psychiatric hospitals	1	
Open Heart Surgery	5	.. the number of surgeries increased 18.2% per 100,000 population.
Cardiac Catheterization Labs	3	.. the use rate rose 13.1% per 100,000 population.

MRI systems: Arizona has 9 MRI systems. (Comparison: California with 10 times Arizona's population, has only 18 units.

The state estimated in the report that "consumers are currently expending in excess of $225 million per year for excess hospital capacity.

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A STUDY OF

THE IMPACT OF HEALTH CARE DEREGULATION

ON

HOSPITALS, NURSING HOMES AND HEALTH SERVICES

IN ARIZONA

November 15, 1985

Gloria Heller, Associate Director
Mary Chase, Planner

Office of Planning and Budget Development
Arizona Department of Health Services
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NOTE

The data for this study were provided by the Office of Health Facilities and Economic Review, Arizona Department of Health Services. Within this Office grateful acknowledgement is extended to Fred Bodendorf, Ph.D., Manager, and to Cal Lockhart, Hal Webb, and Doris Evans of his staff.

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IMPACT OF HEALTH FACILITIES DEREGULATION IN ARIZONA

I. HISTORY AND DEREGULATION TIME FRAME

A. Enactment - 1971: Arizona was one of the first few states to enact legislation authorizing Certificate of Need and Rate Review programs and Uniform Accounting and Reporting for Health Care Institutions. The Department of Health Services, established in 1974, received responsibility for the administration of these regulatory programs.

B. Deregulation: The Arizona Legislature terminated Certificate of Need review for:

Nursing Homes: July 15, 1982 (a 41-month period).

Hospitals: March 15, 1985 (an 8-month period). Deregulation included major capital construction projects, new services and high-cost specialty services affected by CON review criteria.

C. Continued Regulation: Arizona's RR and UAR programs are still in place. The RR program requires mandatory participation of health care facilities and provides for voluntary compliance of the applicant with the State's review recommendations. Under RR and UAR programs, all health facility rates and charges are maintained by ADHS for public information and disclosure upon request.

D. Current Status of Post-deregulation System Activity: Very dynamic, with activity in hospital and nursing home construction, bed expansion, freestanding and hospital-based outpatient facilities, tertiary services and rate increases.

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II. NURSING HOMES

A. 1982 Status

1. Nursing Home Facilities: 79 Facilities
2. Beds (All Levels 8,313 Beds
3. Average Occupancy Rate: 92.5% Occupancy
4. Beds/1,000 Population: 24.1 Beds/1,000 Pop. 65 + Years
5. Gross Patient Revenues: $124.2 million
6. Per Capita Expenditures: $360.76 - Pop. 65 + Years

B. Changes in Status: 1982 - Present

1. Permit Applications: A total of 169 nursing home applications have been received since deregulation in July, 1982:

   26 in the last 6 months of 1982;
   47 in 1983;
   55 in 1984;
   41 in 1985 to date

2. Number of Facilities: increased from 79 to 118 nursing home facilities, an increase of over 50% statewide in 3 years, with an average of 11 new facilities per year.

3. Number of Beds: increased from 8,313 beds in 1982 to 12,559 in 1985, an increase of 4,246 beds as of November, 1985. This is a 51.1% increase overall in 3 years, compared to a 55.8% growth in the preceding 9-year period 1974 through 1982.

4. Occupancy Rates: fell from 92.55 in 1982 to 82.8% in 1985, a decrease of 10.5% for the 3-year period.

5. Beds/1,000 Population 65 + Years: increased from 24.5 beds/1,000 to 31.3/1,000, an increase of 27.8% in the 3-year period.

When all proposed construction is completed, Arizona will increase to about 45 beds/1,000 elderly, an 84% increase over 1982. This ratio is approaching the national average of 50 beds/1,000 population; however,

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75.3% of Arizona's beds are skilled nursing, compared to 20% nationally. Therefore Arizona's costs run significantly higher than other states for an equivalent number of beds.

6. Gross Patient Revenues: increased from $124.2 million in 1982 to $224.7 million in 1985, an increase of $100.5 million (GPR) over 3 years an overall increase of 81%.

7. Per Capita Expenditures: The State's population 65 + years increased by about 17% from 1982-1985. During the same period, per capita nursing home expenditures increased by 53.5%, from $360.76 (1982) to $553.81 (1985).

8. Average Revenue Growth: increased by 22.0% per facility, compared with a 8.4% increase in the National Nursing Home CPI for the same period.

9. Average Arizona Rate Increase: stands at 5.6% for the 3-year period. This indicator is down from the 9-year average of 8.7% for the period 1974-1982 due to various market factors, including the surplus of beds and the fact that new facilities are establishing higher initial charges to support current building costs that average between $25,000 and $30,000 per bed.

C. 1985 Permit Activity (Year to Date)

1. Number of existing facilities: 118 Nursing Homes

2. Permit Applications Received: 41 applications

3. Permits Issued to Date: 7 permits

4. Profile of Proposed Construction/Expansion

New Facilities:	1,878 beds,	$49.1 Million
Expansion of Existing Facilities:	308 beds,	$9.2 Million
TOTAL	2,186 beds,	$58.3 Million

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5. Bed Redesignations: 355 beds were redesignated to a higher level of care:

   a. 147 Personal Care to Intermediate
   b. 208 Intermediate to Skilled Care

6. Nursing Home Care for Indigent Patients: In Arizona, nursing home care is provided by the counties. Increasing costs are placing a heavy cost burden on county funds. Although long-term care is not included under AHCCCS, the counties are increasingly using the AHCCCS model by employing a bid process which results in "below-market" cost levels for county patients. The industry's acceptance of this process is in part fostered by the existing surplus of beds and falling occupancy rates.

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III. HOSPITALS

A. 1982 - 1985 Permit Activity

1. Hospital Facilities: 69 facilities in 1982 and 1983, 73 in 1984, and 72 hospitals in 1985. In the past two years, 4 mining hospitals closed and 6 new general hospitals opened, 3 of which were replacement facilities.

2. Permit Applications: A total of 366 permits received for the 4-year period; 86 in 1982, 106 in 1983, 78 in 1984 and 96 in 1985 to date.

3. CON Applications: A total of 39 permit applications were received for the 3-year period; 6 in 1982, 22 in 1983 and 11 in 1984. No CON applications were submitted to the State in 1985 in anticipation of the termination of CON on March 15.

B. 1985 System Performance Status (State Health Plan)

1. Hospitals by Type:

Total	88	Facilities
72 General Acute Nonfederal	10,762	Beds
16 Federal Hospitals	1,927	Beds

2. Growth in Nonfederal Bed Capacity: The statewide bed supply increased in the past 2 years by 833 beds, a 10% increase since 1983.

3. Population Growth/Admissions: Arizona's population grew 15% from 1980-1985. During the same period, hospital admissions increased only 5%, from 355,847 admissions in 1980 to 373,552 in 1984. The rate of admissions is therefore declining.

4. Average Daily Census: remained steady from 1980 (6,337 average inpatient census) to 1983 (6,367 average inpatient census). In 1984, the ADC decreased to an average ADC of 5,934, a decline of nearly 7%.

5. Total Patient Days: remained relatively steady from 1980 (2.36 million patient days) to 1980 (2.33 million patient days). In 1984, there were 2.17 million patient days, a decrease of 10% for the 12-month period.

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6. Average Length of Stay: remained steady, averaging 6.4 days from 1980 through 1983, then decreased to 5.8 days for 1984.

7. Average Occupancy Rate: decreasing statewide. The 1984 rates are 60.1% in Maricopa County, 55.2% in Pima County, and 47.1% for all rural counties combined. The statewide occupancy rate for 1984 was 56.8%.

   Only four acute care hospitals achieved the state standard of 80% occupancy for urban hospitals in the 3-year period 1982-1984. Overall occupancy in the existing hospital system has experienced a recent rapid decline.

8. Beds/1,000 Population: The State standard is 3.2 beds/1,000 population. The 1985 bed ratio currently is 3.7 beds/1,000.

9. Projected Bed Need: The 1985-1990 State Health Plan projects a statewide bed need of 7,827 acute care beds in 1990. Assuming there is no further expansion of the existing system, there will be a projected statewide excess capacity of 2,935 beds in 1990.

10. Estimated Cost of Excess Capacity: Based on the 5-year Consumer Price Index for Hospital and Other Medical Services, 1979-1983, the State estimates that consumers are currently expending in excess of $225 million per year for excess hospital capacity.

11. Impact of DRG System: The Federal Prospective Payment System is clearly having an impact on hospital utilization in Arizona, but we do not yet have definitive data except for year-to-year measurements of system performance. Cost and revenue data and special analyses will be provided when a new computerized system is implemented.

C. 1985 Permit Status (8 Months)

1. Existing System: 72 Facilities, 10,762 Beds

2. Permit Applications: 96 total; 24 prior to termination of CON and 72 after termination.

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3. Total Permit Value: All projects - $255,971,000.

4. Proposed New Facilities: 11 new hospitals

5. Permits Issued to Date: 1 permit (203 beds)

6. Profile of Proposed Hospital Construction:

New Facilities:	1,312	Beds	$196.2 million
Existing Bed Expansion:	328	Beds	54.8 million
TOTAL	1,640	Beds	$251.0 million

7. Change in Permit Status: 4 proposed new hospital construction projects totaling $90 million were filed with the State immediately following termination of CON. These projects were withdrawn by the applicant several months later. The 4 projects included 3 new general acute care hospitals (500 beds), costing $85 million, and 1 new psychiatric hospital (68 beds), costing $5 million, all in the greater Phoenix area. These four projects were recently reinstated by the applicant.

8. Number of Projects Previously Subject to CON: If CON had remained in place, 38 (53%) of the 72 proposed projects filed after March 15, 1985 would have been subject to CON review. The total cost of these projects is $164.75 million.

9. Bed Redesignations: A total of 90 beds have been redesignated as to use:

Med/Surg to SNF	30
SNF to Med/Surg	10
Detox to Med/Surg	8
Substance Abuse to Psych	30
Med/Surg to Pediatric	12

10. Other Activity:

a. There is a great deal of interest in Arizona by consultants nationwide for all kinds of health care projects.

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b. Hospitals are starting to compete in alternative health care settings by purchasing or establishing nursing homes, emergency/urgent care, home health, ambulatory surgery, outpatient clinics. There is evidence these facilities are increasingly used as "feeders" for referral of patients to inpatient hospital care. Some freestanding services competing with hospital-based programs (e.g., 25 home health agencies) have gone out of business in the past two years because they cannot maintain utilization.

c. Some hospitals have purchased land in the outer peripheries of the greater Phoenix metropolitan area, as evidenced by zoning permits and HSA contacts.

d. There is substantial interest by national health care chains in moving into the Arizona market, particularly Phoenix. However, there is interest in both hospitals and nursing homes in all areas of the State.

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IV. HEALTH SERVICES

A. Open Heart Surgery: 5 Permit Applications received, 4 Permits issued to date. The CONs for these projects were either previously denied, withdrawn or deferred until termination of CON. One project is costed at $504,000; the remaining 4 applications indicate no cost since heart-lung machines were previously purchased and the project represents a new service not requiring construction. The addition of 5 new programs has reversed declining utilization: in 1984, HSA I had a 17.9% decline (117 surgeries/100,000 population). In 1985, surgeries increased by 18.2%, to 138.6/100,000. All of the increases came from units not approved under CON.

B. Cardiac Catherization Laboratories: 3 Permit Applications received, 2 Permits issued to date. All CONs for this service had been denied in the past 2 years. In 1983, the statewide use rate was 239.5/100,000 population, and the national use rate was 218.8 procedures/100,000. In HSA I the use rate was 363.4/100,000, increasing by only 2.7% to 373.1 in 1984. After termination of CON, HSA I's rate rose to 421.8, a 13.1% increase. All increased were in units not approved under CON; procedures declined in some existing units which had received CON approval.

C. Physical Plant Expansion: 9 Permit Applications received, 4 Permits issued to date for major expansion or renovation projects. Approximate cost: $31.3 million.

D. Nuclear Magnetic Resonance Imaging Systems: Arizona has 8 operating MRI units in both hospitals and freestanding settings. A 9th system is to be installed in the University of Arizona. Total cost exceeds $14 million.

Comparison - Utah has about 2/3 of Arizona's population, but only 3 units. California has 10 times Arizona's population, and had only 18 as of last summer.

E. Lithotripsy Services: The lithotripser service unit located in a Phoenix medical center serves as a statewide referral center. Two additional units are reported to be in the planning stages.

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V. COST IMPACTS

A. Hospital Rate Increase Proposals: As of October, 1985, 52 Rate Increase Applications were filed by Arizona hospitals since March, 1985, following a rate freeze in effect for 9 months. In addition, 4 hospitals that applied for rate increases in 1984 implemented the new rates during or after the freeze ending March, 1985.

B. Hospital Revenues/Existing Rates: Prior to implementing these rate increases, existing rates for the 56 applicant hospitals generated annualized gross patient revenues of over $1.82 billion. Total State gross patient revenues for all nonfederal hospitals exceeded $2.02 billion in 1984. Total 1984 gross patient revenues for both hospitals and nursing homes in Arizona exceeded $2.25 billion.

C. Hospital Revenue Increases/Proposed Rates: The implementation of the proposed rate increases by the 56 applicant hospitals increased gross patient revenues for 1985 by $109.4 million to a total of $1.93 billion. This represented a statewide revenue increase of over 6%, as of October, 1985.

D. Repeated Hospital Rate Requests in 12-Month Period: 2 private psychiatric hospitals implemented 2 rate increases in 1985 (both hospitals have the same ownership). The compound effect of the 2 rate increases raised revenues for these hospitals by $1.02 million and $990,000, increases of 13.0% and 11.4%, respectively, within a 10-month period.

The State Department has received applications for more than one rate increase within the year from several hospitals. In the last month, 6 hospitals within the State filed for a second rate increase in approximately 7 months. The compounding effect of double rate increases by these hospitals will result in the following revenue increases on an annualized basis:

Hospital	A	-	18.2%
	B	-	19.2%
	C	-	21.3%
	D	-	25.1%
	E	-	30.9%
	F	-	46.3%

The Department expects additional duplicate filings within the calendar year.

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MONTANA
HEALTH
CARE
ASSOCIATION

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340 - IS IT UNCONSTITUTIONAL TO EXEMPT HOSPITALS?

Senate Bill 340 would continue CON regulation to July 1, 1991. However, hospitals would be excluded from the CON requirements while all other health care facilities would be included. No reasons why hospitals should be treated differently from other health care facilities have been put forth. In fact, the proponents of SB 340 stated that all health care facilities should be exempted from CON for the same reasons that hospitals should be exempted.

SB 340 raises a serious constitutional question regarding the denial of equal protection of the laws.

Equal protection of the laws requires that all persons be treated alike under like circumstances. Classification of persons is allowed as long as it has a permissible purpose and the classifying statute has a reasonable relationship to that purpose.

If enacted into law, SB 340 would be reviewed by the courts under the "rational relationship" test - i.e., does a legitimate governmental objective bear some identifiable rational relationship to the discriminatory classification.

There is no identifiable governmental objective in including all health care facilities in CON except hospitals. There is considerable question whether Senate Bill 340, if enacted into law, would withstand a constitutional challenge based on equal protection.

The constitutional infirmity of Senate Bill 340 has obviously been recognized by its proponents as they have included a severability provision in the bill (Section 5). However, if Senate Bill 340, assuming it becomes law, is challenged, it will be because it is applied to a health care facility which must meet CON requirements while hospitals are exempt. If this challenge is successful, there will be no CON in Montana. This of course would not bother the proponents as their stated purpose is to eventually eliminate CON completely. Senate Bill 340 is simply a first, and maybe last step. By exempting hospitals, even though it may be an unconstitutional denial of equal protection to other health care facilities, the end of CON may be ensured.

<u>We urge your support of Senate Bill 340 WITH AMENDMENTS to include hospitals in the process.</u>

An Affiliate of
ahca
American Health Care Association

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M E M O R A N D U M

To: File

From: Patrick E. Melby

Re: SB 340

Date: February 14, 1989

Certificate of need is an exercise of a state government's inherent "police power" to protect public health, safety, and welfare. It is a regulatory program in which a state administrative agency is delegated quasi-legislative and quasi-judicial powers by the legislature to grant or deny a certificate, similar to a permit or license, which is a legal prerequisite to constructing or modifying a health care facility. The rational underlying CON is that for a number of reasons - e.g., the non-profit status of most hospitals, a financing system and patterns of consumer behavior which stifle price competition, some elements of the monopoly behavior, the inability to define and measure "health care" - ordinary market forces will not operate to prevent the duplication of institutional services or the use of resources in an inefficient, uncoordinated, and wasteful manner. The Guide to Health Planning Law (1987) page XX.

Montana's CON law generally applies to all health care facilities as defined in 50-5-101 (19) MCA. A health care facility may not build new beds, add a new health service or make capital expenditures for equipment over $750,000 or for construction over $1,500,000 without a CON.

Senate Bill 340 would continue CON regulation to July 1, 1991. However, hospitals would be excluded from the CON requirements while all other health care facilities would be included. There was absolutely no testimony at the Senate Public Health and Welfare Committee Hearing on Senate Bill 340 to establish a reason why hospitals should be treated differently from all other health care facilities. In fact, the proponents of SB 340 stated that all health care facilities should be exempted from CON for the same reasons as hospitals.

SB 340 raises a serious constitutional question regarding the denial of equal protection of the laws.

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The right to carry on a lawful business is a property right and due process requires that it not be unreasonably or unnecessarily restricted. However, the regulation of the lawful business by the state is a valid exercise of its police power. Equal protection of the laws requires that all persons be treated alike under like circumstances. Classification of persons is allowed as long as it has a permissible purpose and the classifying statute has a reasonable relationship to that purpose. Billings Associated Plumbing, Heating and Cooling Contractors v. State Board of Plumbers, ____ Mont. _____, 602 P.2d 597, 600 (1979).

There is no fundamental right or invidious discrimination involved in Senate Bill 340, therefore, the bill is not subject to the "strict scrutiny" test of equal protection. For this reason, the bill, if enacted into law would be reviewed under the "rational relationship" test - i.e., does a legitimate governmental objective bear some identifiable rational relationship to a discriminatory classification. Cottrill v. Cottrill Sodding Service, _____, Mont. ___, 744 P.2d 895, 897 (1987).

The Supreme Court has stated it succinctly thus:

> A classification that is patently arbitrary and bares no rational relationship to a legitimate governmental interest offends equal protection of the laws. (cites omitted). As we have previously held equal protection of the laws requires that all persons be treated alike under like circumstances.

Tipco Corp., Inc. v. City of Billings, 197 Mont. 339, 346, 642 P.2d 1074, 1078 (1982).

The court in trying to determine the governmental interest in making a classification will generally (1) attempt to ascertain the governmental objective from the face of the statute; (2) review the legislative history; or (3) consider other evidence of what objective the legislature may have had in mind at the time of passing the legislation. See Cottrill v. Cottrill Sodding Service, Supra at 897.

Using the rational relationship test, the Montana Supreme Court has several times found state statutes or city ordinances unconstitutional as a violation of equal protection. In Cottrill v. Cottrill Sodding Service, Supra, the court found that a state statute which excluded from workers' compensation coverage an employer's family member who resided in the employer's household unless the employer

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specifically elected to include the employee, unconstitutional as a denial of equal protection.

In Tipco Corp., Inc. v. City of Billings, Supra, the Supreme Court found an ordinance by the City of Billings which declared uninvited door-to-door solicitation a nuisance punishable as a misdemeanor but exempted local merchants with regular established places of business from its operation as unconstitutional. The City of Billings had argued that the ordinance had a rational relationship to the city's objectives because it could exercise control over local merchants and their uninvited door-to-door solicitations but could not exercise such control over out-of-state firms and their solicitors. The state rejected this rational and found the ordinance unconstitutional.

In Godfrey v. Montana State Fish and Game Commission, ___, Mont. ___ 631 P.2d 1265 (1981) the Supreme Court found a state statute which required a person to be a resident of Montana to qualify for an outfitter license to be unconstitutional. The state argued at page 1268 of 631 P.2d, that the discrimination was justified because:

> The statutes were enacted pursuant to the police power to control the activities of outfitters to ensure the safety of persons utilizing their services within the borders of Montana, to protect private property rights, and to ensure reasonable law enforcement ability in preserving and protecting the wild life of Montana.

The court found that none of the reasons offered to justify the discrimination were persuasive. 631 P.2d 1268.

And the court found a statute which required a non-resident hunter to be accompanied by a licensed outfitter unconstitutional in the case of State v. Jack, ___, Mont. ___, 539 P.2d 726 (1975). The court found the statute unconstitutional even though it was allegedly designed to promote safety for hunters, to foster better protection for private land owners and to provide more effective law enforcement. The court found that the relationship between the statutory classification and its legitimate objectives was tenuous and remote and was, therefore, insufficient to justify the inequities it engendered. See 539 P.2d at page 730.

There is considerable question whether Senate Bill 340,

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if enacted into law, would withstand a constitutional challenge based on equal protection.

The constitutional infirmity of Senate Bill 340 has obviously been recognized by its proponents as they have included a severability provision in the bill (See Section 5). Severability clauses are not included in legislation unless there is a question of constitutionality of part of the bill. The inclusion of a severability clause only provides a presumption that the legislature intended that if the invalid part of the statute is severable from the rest, the portion which is constitutional may stand while that which is unconstitutional is stricken. If, when an unconstitutional portion of an act is eliminated, the remainder is complete in itself and capable of being executed in accordance with the apparent legislative intent, it must be sustained. Montana Automobile Association v. Grely, at page 311 of 632 P.2d.

However, the inclusion of a severability section is no guarantee that the entire act will not be found invalid if a portion of it is constitutional. If a portion of an act is found unconstitutional and the remainder is not complete in itself or is incapable of being executed in accordance with legislative intent, the whole act will be found invalid. North Central Services, Inc. v. Hafdahl, ___, Mont. ___, 625 P.2d 56, 59 (1981).

If Senate Bill 340, assuming it becomes law, is challenged, it will be because it is applied to a health care facility which is not a hospital which must meet CON requirements while hospitals are exempt. It is hard to contemplate a situation where a successful challenge would not invalidate the entire CON procedure. This of course would not bother the large metropolitan hospitals as their primary purpose is to eventually eliminate certificate of need completely anyway. Senate Bill 340 is simply a first, and maybe a last step. By exempting hospitals even though the bill may raise a question of an unconstitutional denial of equal protection to other health care facilities, hospitals ensure the end of certificate of need.

PEM

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MONTANA HEALTH CARE ASSOCIATION

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

For information contact: Rose M. Hughes
Executive Director

SENATE BILL 340 - to remove hospitals from certificate of need process

Hospitals should not be removed from health planning because of their impact on the Medicaid budget. Hospital service costs are growing faster than any other part of the Medicaid budget.

MEDICAID PAID CLAIMS STATISTICS FY87 thru 1/31/89:
(from SRS print out)

Service	FY87	FY88	89 YTD
Inpatient Hospital			
Dollars	$29,861,585	$34,101,800	$12,225,494
Services	2,002,803	2,114,452	658,884
Cost per service	$14.90	$16.12	$18.55
INCREASE COST PER SERVICE		+8.1%	+15%
Outpatient Hospital			
Dollars	$4,667,976	$5,579,224	$2,520,944
Services	456,829	385,220	145,665
Cost per service	$10.21	$14.48	$17.30
INCREASE COST PER SERVICE		+42%	+19%
Physicians			
Dollars	$11,266,278	$12,205,821	$4,945,929
Services	492,417	548,674	224,174
Cost per service	$22.87	$22.24	$22.06
INCREASE COST PER SERVICE		-2.7%	-.8%
Other primary care:			
Dollars	$22,669,745	$23,676,691	$10,655,574
Services	3,010,180	3,609,317	1,538,318
Cost per service	$ 7.53	$ 6.56	$ 6.92
INCREASE COST PER SERVICE		-12.8%	+5.5%

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Service

Nursing home costs:

Dollars	$45,845,522	$48,101,403	$24,708,879
Days of Care	1,278,561	1,317,427	661,771
Cost per day	$35.86	$36.51	$37.34
INCREASE COST PER DAY		+1.8%	+2.3%

SUMMARY

Service	Increase or Decrease in Cost Per Service: FY87 - FY 88	FY88 - 89YTD
Inpatient Hospital	+8.1%	+15.0%
Outpatient Hospital	+42.0%	+19.0%
Physicians	- 2.7%	- .8%
Other primary care	-12.8%	+ 5.5%
Nursing homes	+ 1.8%	+ 2.3%

It is clear that hospital services, both inpatient and outpatient, are the services responsible for the fastest growth rate. The cost per service is growing at a rate that far exceeds inflation, while other health service costs are growing at rates that are less than general inflation.

SUPPORT CERTIFICATE OF NEED FOR ALL HEALTH CARE PROVIDERS, INCLUDING HOSPITALS.

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MEDICAID PAID CLAIMS STATISTICS
As of 1/31/89

Fiscal Year ===>	82	83	84	85	86	87	88	89 YTD
Inpatient Hospital								
Dollars	$14,914,319		$19,024,375	$19,788,000	$26,367,240	$29,861,585	$34,101,800	$12,225,494
Services	104,794		108,980	159,526	1,757,095 **	2,003,803	2,114,452	658,884
	142.32		174.57	124.04	15.00	14.90	16.12	18.55
Outpatient Hospital								
Dollars	$1,875,939		$2,073,039	$2,513,537	$3,563,624	$4,667,976	$5,579,224	$2,520,944
Services	70,023		71,101	82,568	312,029	456,829	385,220	145,665
	26.79		29.15	30.44	11.42	10.21	14.48	17.30
Physicians								
Dollars	$4,796,956		$6,903,045	$7,806,651	$9,547,837	$11,266,278	$12,205,821	$4,945,929
Services	280,149		295,231	345,786	413,511	492,417	548,674	224,174
	17.12		23.38	22.58	23.08	22.87	22.24	22.06
Other Primary Care Costs								
Dollars	$9,334,477		$15,719,720	$16,643,261	$18,445,811	$22,665,745	$23,676,691	$10,655,574
Services	859,106		475,313		2,440,173	3,010,180	3,609,317	1,538,318
	10.86		33.07	—	7.55	7.53	6.56	6.92
Primary Care Costs	$30,921,685		$43,720,179	$46,751,449	$57,924,513	$68,461,584	$75,563,536	$30,347,941
Nursing Home Costs*								
Dollars	$27,196,641		$38,751,232	$39,702,635	$41,859,346	$45,845,522	$48,101,403	$24,708,879
Days of Care	1,043,114		1,241,095	1,221,529	1,230,923	1,278,561	1,317,427	661,771
	26.07		31.22	32.50	34.00	35.86	36.51	37.34

8.1% 15% 42% 14% -2.7 -.8% -12.8% 5.5% 1.8% 2.3%

* Does NOT include Dept. of Institutions Nursing Home costs.

** The definition of units of I/P hospital services was changed in this fiscal year.

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MONTANA
HEALTH
CARE
ASSOCIATION

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SB 340

MEDICAID BUDGET

Effect of each 1% increase in utilization of various health care services:

	1%	10%
Nursing homes	$516,643	$5,166,430
Inpatient Hospital	385,805	3,858,050
Outpatient Hospital	65,942	659,420

An Affiliate of
alhca
American Health Care Association

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Granite County Memorial Hospital & Nursing Home

310 Sansome Street
(406)859-3271

P. O. Box 729
PHILIPSBURG, MONTANA 59858

February 13, 1989

Montana State Legislators
State Capitol
Helena, Montana 59620

Dear Senators and Representatives:

Please be advised that I strongly support the continuation of the Certificate of Need process and believe that it should cover the entire health care field, including hospitals.

I am the Administrator of Granite County Memorial Hospital and Nursing Home in Philipsburg, as well as a member of the Board of Directors of the Montana Health Care Association, so I am very familiar with the Certificate of Need process.

The process eliminates duplication of services and helps hold down health care costs for everyone. Your vote to continue Certificate of Need would be very much appreciated.

Sincerely yours,

GRANITE COUNTY MEMORIAL HOSPITAL
AND NURSING HOME

Mike Kahoe

Mike Kahoe, Administrator

MK/me

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McCONE COUNTY
HOSPITAL
P.O. BOX 47
CIRCLE, MONTANA 59215

Montana Senators and Representatives
c/o Rose Hughes
Montana Health Care Association
36 South Last Chance Gulch Suite A
Helena, Montana 59601

February 13, 1989

Dear Honored Senators and Representatives:

RE: SB 340

I would like to make known my opposition to Senate Bill 340, regarding the exclusion of hospitals from the Certificate of Need (CON) process.

The CON process was developed to apply to all healthcare facilities and to effectively control their growth in a positive manner. As you are well aware, health care financing is an important and complicated issue. In order for the CON process to have the desired effect on health care spending, it must apply not only to nursing homes but also to hospitals. I would be disappointed to think that short term personal interests are being substituted for long term planning and benefits.

As an administrator of both a hospital and nursing home, I urge you to study this issue and consider opposing Senate Bill 340.

Thank You,

Sincerely,

Nancy A. Berry
Administrator

cc: Cecil Weeding

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Dahl Memorial Hospital Association

P.O. Box 46

Ekalaka, Montana 59324

February 28, 1989

Rose Hughes
Executive Director
Mt. Health Care Assn.
36 S. Last Chance Gulch, Suite A
Helena, Montana 59601

Dear Rose:

Certificate of Need legislation has plagued health care providers in all the states in which I have been an administrator, mainly Montana and North Dakota.

I have always felt that the CON law has accomplished most of what it was designed to do. I'm only for the CON law when it effects all providers in the same manner. It now appears there are certain forces that think the large hospitals should be exempt from the CON law.

It is the feeling of myself and the Board of Directors, Dahl Memorial Healthcare Association that there should be a CON law and that providers should be subjected to it in the same manner.

Thank you.

Sincerely,

Paul K. Longden,
Administrator

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Glacier County Medical Center

802 2nd St. SE
Cut Bank, MT 59427
(406) 873-2251

February 14, 1989

TO: All Montana Senators and House Representatives

We support the Certificate of Need process. All health care facilities should have the same requirements.

Sincerely,

MACK N. SIMPSON
Administrator

EXHIBIT 7
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HB 340

PHONE (406) 637-5511

Prairie Community Hospital & Nursing Home

312 SOUTH ADAMS AVE.

P.O. BOX 156 • TERRY, MONTANA 59349-0156

February 13, 1989

Bill Good
Montana Health Care Association
Last Chance Gulch
Helena, Montana 59601

Dear Mr. Good:

In reference to Senate Bill # 340 entitled "An Act to Revise and Continue the Certificate of Need Laws", we feel that hospitals should be included in the cerficate of need process along with other health care facilities.

Sincerely,

James R. Mantz

James R. Mantz
Administrator

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ROOSEVELT MEMORIAL HOSPITAL AND NURSING HOME

P.O. Drawer 419 CULBERTSON, MONTANA 59218 (406) 787-6821

TO: Members of the Montana Legislature

FROM: Paul Hanson, Administrator

DATE: February 24, 1989

RE: SB 340

As the Administrator at Roosevelt Memorial Hospital and Nursing Home I would ask that you support Senate Bill 340.

I have conferred with Rose Hughes, President of the Montana Health Care Association and I concur with her understanding of that Bill and give her my full support.

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MONTANA
HEALTH
CARE
ASSOCIATION

36 South Last Chance Gulch, Suite A
Helena, Montana 59601
406-443-2876

SENATE BILL 340 - exempting hospitals from CERTIFICATE OF NEED

CERTIFICATE OF NEED IS THE ONLY PROTECTION THE STATE OF MONTANA HAS IN PLACE TO PROTECT CONSUMERS FROM THE HIGH COSTS ASSOCIATED WITH UNNECESSARY INVESTMENT IN HEALTH CARE FACILITIES AND DUPLICATION OF SERVICES.

DEREGULATION LEADS TO EXCESS CAPACITY AND HIGHER COSTS.

Let's look at the "Utah experience."

The following are all excerpts from a report on Utah deregulation entitled "An Examination of the Long Term Care Industry in Utah", released in September, 1988.

"There has been rapid growth in the number of long term care beds in Utah since the repeal of Certificate of Need."

> 1,445 new beds were added and occupancy dropped from 90% to 75%.

"The increase in beds demonstrates that the market was not successful at guarding against excess capacity and overbuilding."

"A lower occupancy rate increases the per patient cost of care."

"Where the influx of providers and new beds are most prominent is in the area of new free-standing psychiatric hospitals. Since January 1, 1985, eight new free-standing psychiatric hospitals have been built in the state for a total of 550 new licensed beds. ...Although one or two psychiatric hospitals may actually have been needed, it is generally thought that there is now a substantial excess of such beds..."

"The increase in beds in the above areas demonstrate that the market was not successful at guarding against excess capacity and overbuilding."

"Per unit costs increase with declining occupancy. Fixed costs, such as housekeeping, mortgage payments, and equipment, remain constant regardless of occupancy. ...As occupancy declines, these costs must be spread over a smaller number of patients."

"If Medicaid expenditures on long term care are not controlled, the

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number of individuals served or the number of services provided by the Medicaid program will have to be reduced."

"An even more serious concern lies in the realm of quality of care. ...The care a facility provides just before it goes under is likely to be of dubious quality. Even before reaching that point, facilities may be cutting corners in the areas of food, staffing, wages, and benefits...."

"In addition, there is the problem of relocating patients when a facility closes. This is very traumatic and destroys adjustments or relationships the patient has made..."

"In many states where Certificate of Need has been repealed without employing a moratorium or other restrictive mechanism, there has been considerable growth in the long term care bed supply and a corresponding decrease in occupancy. Low occupancy rates increase the per patient cost of providing care."

You are being asked to abandon your concern for patients, consumers, and taxpayers, and to risk major increases in the Medicaid budget, to satisfy a few hospitals which find certificate of need inconvenient.

PLEASE SUPPORT SENATE BILL 340, WITH AMENDMENTS TO INCLUDE HOSPITALS IN THE PROCESS.

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AN EXAMINATION OF THE LONG TERM CARE INDUSTRY IN UTAH AND THE FUTURE IMPLICATIONS TO CERTIFICATE OF NEED

by

Heidi M. Brich
Graduate Student
Arizona State University

Presented to

Suzanne Dandoy, M.D., M.P.H.
Executive Director
Utah Department of Health

Rod L. Betit
Director
Division of Health Care Financing

September 1, 1988

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I. EXECUTIVE SUMMARY

This paper examines the current condition of skilled and intermediate care facilities in Utah. It traces the Certificate of Need program, repealed in 1984, and evaluates the future implications for the long term care industry in the State. The report also assesses how other states are meeting the challenges posed by a projected increase in the number of people requiring long term care services within the context of limited resources. It is recommended that the State move to limit construction while fostering the growth of competitive forces.

Information for this report was collected from a variety of resources. A computer search and a review of the professional literature was completed, a telephone survey of every state was made, and interviews were conducted with a number of people in Utah on all sides of the long term care and Certificate of Need issues.

The Utah Certificate of Need program was an outgrowth of the federal health planning movement. Section 1122 and Certificate of Need were designed to control health care expenditures by discouraging or preventing "unnecessary" investment in health facilities. This was justified because it was argued that the market was unable to control health care costs.

Utah had a program to review capital expenditures from 1974 through 1984. During this ten year period the supply of beds in hospitals and nursing homes was tightly controlled. Emphasis later shifted from a "health planning" approach to an "open market" strategy for controlling rising costs. Implementation of free market forces and price competition was seen as an innovative way to control the growth of health care costs. The Certificate of Need law was repealed as a component of this policy.

There has been rapid growth in the number of long term care beds in Utah since the repeal of Certificate of Need. While Certificate of Need was in place, only 99 additional long term care beds were approved. Following the repeal of the program there was a net increase of 216 beds in 1985, 644 beds in 1986, and 585 beds in 1987. The large increase in beds has caused the average nursing home industry occupancy rate to plummet from almost 90 percent to 75 percent. The increase in beds demonstrates that the market was not successful at guarding against excess capacity and overbuilding.

A lower occupancy rate increases the per patient cost of care. At the same time other factors, including the nursing shortage, past and future changes in staffing requirements, and patients with heavier care needs, have increased operating costs for nursing homes. During this period there have been only small increases in the Medicaid flat rate paid to nursing homes. The financial situation of the industry as a whole has deteriorated. If the growth continues this condition will worsen.

If the current trend is allowed to run its it course, it will bring about the closure of a number of nursing homes, relocation of patients, and diminished quality of patient care due to cuts in expenditures for food, activities and staffing. There may also be a negative impact on the Medicaid budget. A worsening of the financial situation in nursing homes will increase the pressure on the preadmission screening program to allow more patients into facilities and on Medicaid to increase the rate paid for care. This money may have to come from programs designed to provide care to other indigent and ill people.

Other states are also working to control Medicaid expenditures for long term care. In some states, controlling the supply of long term care beds is viewed as an effective means of controlling expenditures. States with strong regulatory agencies have high average nursing home industry occupancy rates. States with little or no regulation tend to have a lower average census. There are difficulties associated with both very high and very low nursing home occupancy rates.

The Certificate of Need programs vary widely from state to state. The programs are effective and more readily accepted where there is a longstanding interest in government regulation. This attitude is not present in Utah.

A Certificate of Need program would be very expensive and difficult to reinstate. There are additional concerns about the program such as its cost, the length of the appeals process, and the impact of political influence. At this time, reinstating a capital expenditure review program is unlikely to be politically successful or desirable.

The most effective strategy to handle the situation in the long term care industry is a plan to provide relief from incessant construction while assessing the feasibility of price competition. Prohibiting new construction will halt the sharp decline of occupancy rates, allowing facilities to better cover costs. A pilot project will allow nursing homes in a small area to compete for new Medicaid admissions on the basis of quality and price of care. At present, competitive forces are not at work in the long term care market. This pilot project will lay the foundation for future competition. Such a move addresses the current situation while adhering to the policy of promoting competition as a way of controlling cost.

Other recommendations in the report include collecting more relevant demographic and utilization data, increasing funding to nursing schools to increase enrollment, encouraging the development of private long term care insurance, and investigating other innovative ways to finance long term care.

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II. INTRODUCTION

Since the repeal of Certificate of Need in Utah in 1984 there have been a number of changes in the long term care industry. The number of nursing home beds has increased rapidly. Operating costs of nursing homes have risen. A serious shortage of nursing personnel has developed. If conditions continue to worsen, there may be a serious impact on the quality of care in nursing homes and on the overall Medicaid budget. The purpose of this paper is to examine the prevailing conditions in the long term care industry in the state of Utah, the Certificate of Need program, and the experience in other states, and to evaluate possible solutions.

Section three reviews the background of the Certificate of Need program. It outlines the political roots of the program, evaluates its success, and describes Utah's innovative approach to control health care costs. Section four traces the developments since the repeal of Certificate of Need. Areas where there has, and has not, been a flurry of construction are examined. It also looks at possible explanations for the rapid growth in long term care beds for the elderly in Utah. Section five describes the factors present in the long term care market. It notes those elements distinguishing long term care from a competitive market. In section six the long term care industry is investigated. The factors increasing operating costs for nursing homes are examined, and the reasons why this is of concern to State Government and the Medicaid program are highlighted. Strategies other states use in an attempt to balance the competing goals of assuring access while providing low cost and high quality care are described in section seven. Every strategy has accompanying difficulties. Section eight notes the difficulties in reinstating a Certificate of Need program at this time in the state of Utah. Although it did control bed supply and many states still have such a program, reintroducing such a program at this point in time would be likely to encounter a great deal of political opposition and also be expensive. Since it is not an appropriate time to revive a capital expenditure review program, other strategies to deal with the problems posed in long term care are examined in section nine. The options are outlined and a solution consistent with the concern over the current situation and consistent with Departmental policy is proposed. Section ten covers the need for information in order to make decisions in the future, and section eleven specifies some issues which should be investigated further. Section twelve cites the resources used in completing this research.

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III. BACKGROUND OF CERTIFICATE OF NEED

The Certificate of Need program had its roots in the health planning movement. One of the first moves toward comprehensive health planning was the Hospital Survey and Construction Act of 1946, commonly referred to as the Hill-Burton Act. It provided funds for construction of health care facilities. Initially, a bed/population formula was used to identify underserved areas. In 1966, the "Comprehensive Health Planning Act" was passed, which was intended to assess health service needs and make changes. The program was given little authority to actually bring about these changes, however.

Under Section 1122 of the 1972 Social Security Act Amendments, a state-optional program could be adopted to review capital expenditures proposed by health care facilities. If states gave a negative recommendation, reimbursement for capital costs associated with the project were withheld under Medicare and Medicaid. This was not always an effective deterrent, since the amount of Medicare and Medicaid funding received by institutions varied, as did the size of the penalty. In some cases there were only very weak penalties if an institution went ahead with the project without approval. States also began to define their own certificate of need programs to review the provision of new services and the construction or major renovation of health care facilities. Certificate of need programs generally had broader coverage than 1122 programs and also carried more substantial penalties for noncompliance.

The first certificate of need (CON) program was begun in New York in 1964. The "National Health Planning and Resource Development Act of 1974" was passed in 1975. It made funding available for state planning activities, and authorized the creation of State Health Planning and Development Agencies (SHPDAs) and Health System Agencies (HSAs). These agencies were put in place to prepare comprehensive health plans which were then to be used in the CON review process. This Act effectively required states to implement CON programs according to federal standards. If they did not, states lost federal funding for state health planning and health resource development. "By January 1975, 46 states and the District of Columbia had certificate of need, Section 1122, or both."[1]

CON programs were designed to discourage or prevent what was deemed by the planning agencies as "unnecessary" investment in health facilities. Health facility construction and capital expenditures were reviewed on the basis of community need, not demand. The need for such a review was supported by citing areas of "market failure" in health care. Market failure occurred because: there was little or no information available to consumers about price or quality, third party

[1] James B. Simpson, "State Certificate of Need Programs: The Current Status," American Journal of Public Health 75 No. 10 (October 1985): 1225.

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reimbursement shielded consumers from the cost of health services, and the physician (not the patient) often determined when care was necessary and where the care would be given. CON programs were also used to control health expenditures by controlling bed supply, capital investments in new equipment, and new services. The rationale for controlling supply to control costs was supported by research that indicated there was supply induced demand for hospital beds. [2] (Roemer's law: A built bed is a filled bed). CON programs included provisions for public hearings and administrative and judicial appeals.

Utah agreed to review capital expenditures in 1974. In 1976, the Utah Health Planning and Resource Development Act was passed. The Act created a local Health Systems Agency, and a State Health Planning and Development Agency. By 1979 a CON program complying with federal standards, the "Utah Pro-Competitive Certificate of Need Act," was enacted. This replaced 1122 review. The Act was amended and reenacted in 1981 and 1983.

The Certificate of Need program in Utah did a good job of controlling bed supply. It was much less successful in controlling major capital equipment purchases or the provision of new services. The focus of the program on controlling beds forced hospitals to diversify in areas not as tightly controlled. See Appendix 1.

After the Reagan Administration came into office in 1980, emphasis was shifted from health planning to market forces. The "National Health Planning and Resources Development Act" expired in 1982.

In February, 1983, the Utah Department of Health published a statement of health policy entitled, A Prescription for Health Care Costs in Utah. The report noted that health care costs in Utah were lower than in the rest of the nation, but that the rate of increase was greater. The strategy recommended dealing with rising health care costs by establishing "price competition as the controlling factor in the health care market" and allowing market forces to take over. It recommended discontinuing the CON program. The report also noted, "most health economists believe that the establishment of price competition in any given area will take between six and eleven years. Because of this fact there has always been concern that the strategy will be dropped before it has a chance to develop." The Certificate of Need program was terminated by the State Legislature on December 31, 1984.

[2]M. Roemer and M. Shain, Hospitalization Under Insurance (Chicago: American Hospital Association, 1959).

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IV. IMPACT OF DEREGULATION

The repeal of Certificate of Need legislation was based on the premise that the free market could more efficiently control health care costs than could regulation. Some argued that free market forces were not in place in areas of the health care market. In order to establish price competition, several important changes in the environment were proposed in A Prescription for Health Care Costs in Utah. These included establishing health insurance plans with "a financial incentive to consider costs at the time health care is purchased," and making information about the cost and quality of health care available to consumers.

It was hoped that the free market forces already in place would be sufficient to deter overinvestment once the control of certificate of need was lifted. Establishing price competition was expected not only to control health care costs but also to increase efficiency in the market. Copayments and deductibles were to be introduced into third party reimbursement to make consumers more aware of the cost of care. As consumers became more conscious of the cost of their health care, they were expected to want to become more informed before making choices. The Utah Health Cost Management Foundation (a coalition of business and industry) and the Utah Department of Health were directed to publish information on health care cost trends in the early years, and information about the relative quality of health care sold by individual and institutional providers in the later years.

Since the termination of CON, overbuilding has not been a problem in the area of intermediate care facilities for the mentally retarded, where there have been additions of only a few beds, or for general acute care hospitals. No new acute care hospitals have been built since the repeal of CON. Where the influx of providers and new beds are most prominent is in the area of free-standing psychiatric hospitals. Since January 1, 1985, eight new free-standing psychiatric hospitals have been built in the State for a total of 550 new licensed beds. The majority of these beds were built along the Wasatch Front. Although one or two psychiatric hospitals may have actually been needed, it is generally thought that there is now a substantial excess of such beds. Occupancy rates are low for most of these facilities. At the time of this report, Medicaid was not reimbursing for psychiatric care provided in free-standing facilities. However, the pressure for Medicaid to cover care in this setting was mounting.

Prior to the demise of CON in 1984, few new nursing home beds had been approved by the review agency. Virtually no beds were approved between 1979 and 1983. From January, 1983 through December 31, 1984, 99 additional beds were approved. In 1985 there were 159 new geriatric nursing home beds built. There were also 129 beds converted to geriatric use, but 27 beds were lost for a net increase of 261 beds. The growth escalated in 1986. In that year, 635 new beds were built, and 31 hospital beds were converted to "transitional" care, although 22 beds

were lost or converted, for a net increase of 644 beds. The year 1987 showed similar growth with 615 new licensed geriatric beds, although 30 beds were lost for a net increase of 585 beds. The expansion may be slowing now. In the first six months of 1988 were additions of 19 new beds, and the conversion of 14 hospital beds to transitional care. In 1988, 42 beds that were geriatric care beds were converted to other use, and 53 beds are no longer licensed, for a net decrease of 62 beds. However, plans have been submitted to the Bureau of Facility Licensure for 324 new beds, 120 of which are currently under construction. As of May 1, 1988, there were 1,721 empty SNF or ICF beds in the State.

Utah has a lower long term care bed to population ratio than most other states. It also has a smaller proportion of the elderly population residing in institutions. Nationally, 5 percent of the elderly over age 65 reside in nursing homes, while in Utah the figure is only 3.5 percent. If potential investors look only at the absolute number of beds instead of historical utilization and current occupancy rates, Utah may still be perceived as an attractive market. There is the danger of an explosion of long term care beds in the next several years if there are no steps taken to restrict growth. An indication that there are more beds than needed is the declining occupancy rate of the nursing homes as a whole. Statewide average occupancy rates, which were running around 90 percent in 1983, were 75 percent in June, 1988,

The increase in beds in the above areas demonstrate that the market was not successful at guarding against excess capacity and overbuilding. The long term care area of the health care market has several features which distinguish it from a competitive market.

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V. MARKET CONDITIONS OF THE LONG TERM CARE INDUSTRY

In Utah the market for long term care is not a competitive market, but a monopsony. The Medicaid program is the principal buyer. In May, 1988, Medicaid supported 67 percent of the ICF/SNF and 97 percent of ICF/MR patients in the State. As the principal buyer, Medicaid does not have free access to the competitive market. Medicaid pays all certified providers according to a predetermined formula based on historical property costs and levels of care. Providers currently do not bid for the provision of services and Medicaid does not contract for only the number of needed beds. In addition, there is an almost complete lack of price sensitivity in the market.

Medicaid reimburses nursing homes on a flat rate schedule. Since the introduction of the flat rate in 1982, there has been only a 4.2 percent average annual increase in the reimbursement rate. Included in the schedule are differentials for historical property costs, return on equity (frozen at the 1981 level), and varying levels of care. Otherwise, all facilities receive the same reimbursement for Medicaid patients. There is no leeway for nursing homes to raise the price for Medicaid patients and no incentive to charge less than what Medicaid pays. Medicare will cover some skilled nursing care, but only makes up 2 percent of nursing home reimbursement nationally. Private insurance accounts for less than 1 percent of national nursing home expenditures. Out-of-pocket payment from individuals and their families comprises the balance of nursing home reimbursement. Most nursing homes do charge private patients higher rates than Medicaid patients.

Medicaid in Utah does not charge patients copayments or otherwise have them share the cost of care once they are eligible for coverage. Therefore, patients are not sensitive to the cost of care, and price does nothing to deter unnecessary utilization. A preadmission screening program is in place to make certain that individuals receiving care truly need it. There are no incentives for patients to shop for care on the basis of cost, nor is there objective information published on the quality of care provided in any given institution. The Federal Health Care Financing Administration (HCFA) will soon publish results from Medicare/Medicaid nursing facility survey reports, listing deficiencies for individual nursing facilities. The seriousness of the deficiencies may not be clear to the average reader, however. In addition, the nursing home industry maintains that the survey results are subjective and inconsistent.

Private pay patients are more sensitive to price, yet they represent only a small segment of the market. In addition, private pay patients may become Medicaid patients when their assets are diminished. Once they begin spending down their assets, it makes little difference what the facility costs, because the patient's share will be the same regardless of cost. Thus, there are no rewards built into the system for cost conscious behavior on the part of the consumer. The principal buyer pays a flat rate to all facilities, and long term care facilities must accept the rate Medicaid pays, or choose not to accept Medicaid patients at all.

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VI. INSTITUTIONAL FACTORS

Several factors are increasing the operating costs for nursing homes: demands for higher wages caused by the nurse shortage, past and future increases in staffing requirements, and patients with heavier care needs. Since the repeal of Certificate of Need, the average census has declined from 89.8 percent in 1983, to 75.21 percent in May, 1988. Excluding the State Training School, the average ICF/MR census was 88.78 percent in 1988. Per unit costs increase with declining occupancy. Fixed costs, such as housekeeping, mortgage payments, and equipment, remain constant regardless of occupancy. Semifixed costs such as nursing salaries will remain constant within a certain operating range due to staffing requirements. As occupancy declines, these costs must be spread over a smaller number of patients.

The number of people entering nursing homes in Utah has been growing at a steady rate of one to two percent per year, limited in part by a very effective preadmission screening program. All Medicaid patients, and all patients who are expected to apply for Medicaid eligibility within 90 days, are required to undergo the Patient Assessment Evaluation.

Historically, only 3.5 percent of the population over age 65 in Utah live in nursing homes compared with 5 percent nationally. Factors associated with nursing home placement include extreme old age, living alone, lack of informal support from relatives or friends, the availability of community services, and difficulty with the activities of daily living. The lower percentage of Utah elderly in institutions could be due to a number of these factors or other influences.

Utah also has a lower number of beds per 1,000 population than the national average. This low bed to population ratio is appealing to investors, and may be an important factor attracting individuals and corporations to this area to build new nursing homes. There is a potential explosion of long term care beds from investors who view this as a lucrative potential market. As more beds are built, industry wide occupancy declines, there is pressure to fill the empty beds. This strains the preadmission screening program which is working to make sure only appropriate placements are made. Based on the national average of 5 percent, Utah seems to have a shortage of long term care beds. However, if the Utah average is used, a different picture emerges. Using the historical average of 3.5 percent of the population over age 65 in Utah in nursing homes, 1980 census data projected forward, and a target occupancy rate of 90%, it is projected that 6,060 SNF and ICF beds are needed in 1988. This will increase to 6,488 in 1990 and 7,337 in 1995. In June, 1988, there were 6,784 total licensed geriatric nursing care beds in the State—an excess of 724 beds. There were 324 additional beds in planning stages. If these beds are the only additional beds built, and the others remain, a surplus of beds will exist until 1994. See Appendix 2.

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Looming on the horizon is another potential threat of bed expansion. Its source is the significant number of free-standing psychiatric hospitals built following the repeal of Certificate of Need here. All but one of these hospitals have a very low patient census and are experiencing financial difficulties. They were all built to nursing home specifications, so there is a potential for 496 beds in psychiatric hospitals to be converted quickly to provide long term care. Hospitals are also exploring the possibility of converting areas to long-term care to ease their occupancy problems. Two hospitals have already converted wings to "transitional care." Hospitals can more easily channel patients with subacute needs into their own wings rather than into nursing homes for skilled nursing care. Hospitals would then be creaming off the more lucrative Medicare patients, leaving nursing homes less revenue to cover operating costs.

Another issue affecting the long term care industry is the nurse shortage. In an effort to attract more nurses, "hospitals, nursing homes, and other employers have increased starting salaries and initiated incentives to attract nurses."[3] The situation has a more severe impact on nursing homes than on hospitals because nurses typically are not trained to provide long term care and lack experience in the long term care setting. In addition, the wages and benefits long term care institutions are able to offer are lower than those paid by hospitals. "Registered nurses (RNs) earn an average of 35 percent less in nursing homes than in hospitals."[4]

Preliminary results from the 1987-88 Utah Registered Nurses' Licensure survey of 2,000 RNs who were eligible for relicensure but chose not to retain their Utah license, approximately 200 chose to work in a field other than nursing and 900 worked as RNs, but not in Utah. It is estimated that 78 percent of licensed Utah nurses are working as nurses in the State. Few nurses are inactive in the work force. The national unemployment rate for nursing is below one percent.

The nurse shortage causes concern about the care an institution is able to provide. According to the American Health Care Association, "The nurse shortage is clearly handicapping our ability to provide quality care."[5] By October 1, 1990, facilities will be required by the federal government to have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty 24 hours per day, 7 days per week. These requirements passed by Congress will further exacerbate the nurse shortage.

[3]Diane Blake, "Nurse Shortage Has Broad Implications," Pro Re Nata, 10 No. 2. (March/April 1988).

[4]American Health Care Association, Issue Paper, "Eliminate Restrictions on Labor Costs for Nursing Staff"

[5]Ibid.

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Because of high turnover, there is no longer a stable, constant work force providing care to the elderly and chronically ill individuals in nursing facilities. Especially when the patient is confused or disoriented, familiar faces and a set routine can be comforting. Stability of the staff is a necessary component to high quality care, which declines sharply with excessive turnover. In addition, nurses are leaving positions just when they have completed the training process. "High turnover among workers and growing use of temporary employees have affected patients, too."[6] This disrupts the continuity of care patients receive.

According to some Utah nursing home administrators, there is also a shortage of qualified nurses' aides. This is a view shared by Congress which included in 1987 legislation a provision that nurses' aides must be certified and a registry established. This is likely to make it more difficult for facilities to locate and hire aides, even though Medicaid will be required to cover the cost of implementing this policy. If Congress raises the minimum wage, this will have an even stronger impact on long term care institutions. Not only will it be expensive to pay aides more, but there is a ripple effect. Wages for other staff members will also have to be increased. This may exert extreme financial pressure on nursing homes. This problem is further exacerbated by the decline in the population age group (17-25) which typically fills these positions.

The characteristics of the patients are also changing. The typical nursing home resident is becoming older and needs more care. In the past, nurses had only a few patients with heavy care needs and could concentrate their time with these patients. Today, heavier care needs, in both hospitals and nursing homes, cause nurses to spread their care more thinly among a group of very elderly or ill patients.

The new beds built in Utah since 1983 have surpassed the current demand for care, resulting in declining occupancy rates. This increases the per patient per day cost of care. Nursing homes are competing with each other to staff facilities with nurses and nurses aides. This competition will intensify as the new federal staffing requirements are implemented.

A 1986 report on the profitability of nursing homes showed that on average reported revenue was in excess of costs. Exact data on nursing home profitability since then is not available. However, according to Dennis McFall, President of the Utah Health Care Association, 12 facilities have filed for Chapter 11 bankruptcies in 1988.

The declining financial viability of nursing homes and the increasing number of empty beds put financial pressure on the Medicaid

[6]Milt Freudenheim, "Nursing Homes Face Pressures that Imperil Care for Elderly." New York Times Saturday, May 28, 1988.

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program. There will be a greater push by the homes to increase the reimbursement rate paid and to allow more people to enter nursing homes to fill the empty beds.

However, the Medicaid budget and the State budget are limited. Unless more funding becomes available, increasing expenditures in one area force cutbacks to be made in other areas. If Medicaid expenditures on long term care are not controlled, the number of individuals served or the number of services provided by the Medicaid program will have to be reduced.

An even more serious concern lies in the realm of quality of care. The elderly, chronically, and mentally retarded persons in nursing facilities often do not have the ability to defend themselves or to safeguard their rights. The care a facility provides just before it goes under is likely to be of dubious quality. Even before reaching that point, facilities may be cutting corners in the areas of food, staffing, wages, and benefits. These changes may be difficult to detect from the outside, but may make an enormous difference to the individual eating the food or relying on a staff member.

In addition, there is the problem of relocating patients when a facility closes. This is very traumatic and destroys any adjustments or relationships the patient has made. In smaller communities, the nursing home that closes may be the only one within 100 miles, so the patient is removed from friends and family.

The Nursing Home Profitability report noted that "a typical operation should maintain a floor of 80 percent occupancy" and recommended that "in order to maintain a healthy industry, the State should monitor this status and, perhaps, take action to discourage new facilities from entering the marketplace until levels are stabilized."[7]

[7]Peat Marwick, Study of Nursing Home Profitability for the State of Utah December, 1986.

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VII. STATE STRATEGIES

The Medicaid program is administered differently by each state. Consequently, there is wide variation across programs. The percent of the Medicaid budget devoted to long term care ranges from 26 to 65 percent in the states. In Utah, 31 percent of the Medicaid budget goes to long term care. Medicaid is the principal source of financing for institutional long term care, and long term care makes up the largest single component of the Utah Medicaid budget. Each state's program has evolved within a specific regulatory environment and has its own unique challenges, but every state is faced with the dilemma of striking an appropriate balance between cost, quality and access.

States have approached the challenge of controlling the rate of growth of long term care expenditures in a number of different ways. One strategy is to restrict the number of beds available. This is based on the assumption that as the supply of beds increases there is increasing pressure to fill them (Roemer's law). Certificate of Need programs and moratoriums on construction are the primary methods used to restrict bed growth. States may also try to signal the industry to limit expansion by limiting the number of beds Medicaid will certify. If construction of facilities intended only for privately paying patients is still permitted, there is the potential that there will then be pressure on the state to allow the beds to later become Medicaid certified after they are built.

States which have strong CON programs and have been successful in controlling bed supply, tend to have high average occupancy rates and concerns about access to care. When the average industry occupancy rate is at or above 95 percent, finding appropriate beds for patients can be difficult. Medicaid patients and patients with heavy care needs may suffer discrimination. In some states there are large backlogs of patients in hospitals awaiting nursing home placement. It costs a great deal more to pay for hospital stays than to finance the more appropriate nursing home care. In such a "seller's market" the facility can essentially choose which patients to admit because beds are in short supply. Private pay patients and patients with lighter care needs may be preferred.

To tackle this problem, some states have implemented a case mix reimbursement system for Medicaid patients. Such a system provides higher reimbursement rates for patients with heavier care needs so there is an incentive to accept these patients. Other states enact laws designed to prevent Medicaid or heavy care patients from discrimination. In some states separate waiting lists for private pay patients and Medicaid patients are outlawed. In two states there is an "equalization law." If a facility is certified for Medicaid, it cannot charge private patients more than it charges Medicaid patients. This slows down the "spend down" process. Facilities may, however, take only private pay patients and charge higher rates.

In many states where Certificate of Need has been repealed without employing a moratorium or other restrictive mechanism, there has been considerable growth in the long term care bed supply and a corresponding decrease in occupancy. Low occupancy rates increase the per patient cost of providing care. An exception is New Mexico where low reimbursement for capital expenditures and an imputed occupancy have kept overbuilding in check. Freezing the property reimbursement rate at the 1981 level in Utah, however, has not seemed to discourage growth. The result of overbuilding is increased pressure to fill beds and to raise Medicaid rates. Just as in Utah, market forces have not come into play quickly following the repeal of CON in other states.

In Arizona there was rapid long term care facility growth immediately following the repeal of CON. According to Hazel Chandler, Arizona Department of Health Services, recently there have been four total bankruptcies in nursing homes, four facilities have closed due to financial difficulties, and another four have been closed due to licensure difficulties (which she believes had their roots in financial difficulties). Occupancy rates in Arizona have now increased. They were 68 to 70 percent a year ago, and are now 80 to 82 percent. Ms. Chandler believes the rate will reach 90 percent by this time next year and that the industry will stabilize.

At the opposite extreme, New York has a very formal, effective, CON program. The program was so effective, in fact, that some argue there is now an overall shortage of long term care beds. The long term care occupancy rate is over 95 percent. There is a backlog of hospitalized patients waiting for nursing home placement and 2,000 people are placed out-of-state. Similarly, Nevada, which has retained CON, has an occupancy rate of 96 to 98 percent, and has some patients placed in Utah.

A moratorium may be aimed at controlling the growth of Medicaid expenditures. In some states such a move is used to restrict institutional growth while more emphasis is put on home and community based care. For example, in Wisconsin when a facility closes, funding goes to individuals being cared for in the community.

A moratorium on construction or licensure is more effective than a Medicaid moratorium. In Minnesota, a Medicaid moratorium went into effect in 1983. Between 1983 and 1985, 1,000 new beds were built. In 1985, a moratorium on licensed beds was put into place; since then virtually no new beds have been built. In Wisconsin there was a moratorium on construction from 1981-83. Now there is an absolute cap on the number of long term care beds available. (The absolute number cannot increase beyond the 1983 level.) Wisconsin has seen a gradual reduction in the number of beds.

Texas has a moratorium on Medicaid contracted beds. Issuing the moratorium seemed to create a panic mentality. There were several conditions under which facilities could be granted an exception to the

moratorium: 1) adding ten new beds or ten percent of the total beds, 2) facilities granted CONs prior to September 1, 1985, 3) facilities with capacity of less than 60 licensed beds, 4) if the applicant had a previous Medicaid contract, or 5) if an applicant had demonstrated "substantial commitment" which included expenditures of $25,000. The number of net approved beds under all of these exceptions totaled 17,432! There were so many exceptions granted, the moratorium was of little immediate use. Texas will not experience a "real" Medicaid moratorium until the loopholes are closed in 1989. Since the moratorium does not affect licensing, additional beds for private pay patients are still being built. The Texas experience demonstrates that is important to limit the number of exceptions to as few as possible.

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VIII. DIFFICULTIES WITH REINSTATING CON

While in place, the Certificate of Need program in Utah was successful in restricting the long term care bed supply. Between 1979 and 1983, there was a net increase of only 20 acute care beds along the Wasatch Front, and virtually no new long term care beds were approved. In 1983 and 1984, 99 new long term care beds were constructed. These were allowed due to the adoption of a "modified flat rate" reimbursement system for nursing homes.

CON programs that exist today vary widely by state and have differing goals and objectives as well as differing levels of power to make and enforce decisions. "Even after minimum Federal standards were enacted, there continued to be substantial variation among States in the scope of coverage, thresholds, review procedures, due process requirements and sanctions incorporated in their individual certificate of need programs."[8] A major policy goal for such a review program is controlling health care costs. Other goals include "preserving quality of medical care and preventing geographic and income related maldistribution of institutional health services,"[9] and to "reward and protect facilities that internally subsidize socially desirable but unprofitable lines of business such as indigent care."[10]

Since CON is a regulatory measure, it tends to have more support and be more successful in areas where the philosophy of government intervention has a strong foundation. This has not traditionally been the case in the state of Utah.

There are concerns with CON programs. Existing providers who already have a substantial market share may be able to sway the decisions of the planning agencies and use the process to protect their own investments. When major investments or new services require review, the health facility or provider that is awarded the certificate of need is virtually guaranteed a franchise. This may cause companies to submit "defensive proposals" for expansions or new services just to keep up with, or to hinder, potential competitors. "Applications may be filed as a means for preempting applications by competing institutions when, in fact, the applicant is not seriously interested in following through with the project."[11] Such moves increase the cost to the system and lengthen the review process.

[8] U.S. DHHS, "Panel B. State CON Experience: Program Aims and Policy Issues." Certificate of Need Program Review February 1982, p. 9.

[9] Simpson, p. 1225.

[10] Simpson, p. 1225.

[11] Andrew F. Coburn, "Deregulating Entry Controls in Health Care: A Cautionary Note," Presented at Main Health Care Association Symposium, "Competition vs. Regulation" September 10-12, 1986.

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Another difficulty is that regulatory agencies may not be able to review thoroughly all projects, due to staffing and financial constraints. The program can be expensive and cumbersome for the state and for the applicant. Large, wealthy health care corporations can spend a considerable amount of money to prepare and defend requests. "A large and politically strong institution may easily convince an understaffed and underfinanced CON agency not to incur costs required to develop a compelling refutation. Accordingly, the agency will adopt the path of least resistance, that is approval."[12] Even if denied, those with the resources are able to zealously pursue the appeal process. In the case of competing applications, or batched proposals, the appeal process may drag on for years. This leaves smaller health care institutions, without the financial and time resources to wage a major legal battle, or groups lacking political clout at a disadvantage.

At this time, memories of the earlier difficulties with the CON system are still fresh in Utah. The process was becoming longer and more complex. It was generally perceived as effective in controlling bed supply but less effective in other areas. The term "Certificate of Need" still engenders the memory of a program disliked by many, making it difficult to reestablish such a program.

If a capital expenditure review program is to be reinstated in Utah in the future, it would have to be less cumbersome and expensive than the previous CON system. The criteria used to determine the number and location of beds would need to be explicit and fair. Once a decision, based on the bed need criteria, is made, there should be no provision for appeal of the decision, only appeals based on the procedures followed in the course of review. It would also have to be simplified so that it would not be too expensive for the state or for the applicant.

Currently there are 12 states with no capital review program in place: Arizona, California, Colorado, Idaho, Kansas, Louisiana, Minnesota, New Mexico, South Dakota, Texas, Utah and Wyoming. Indiana dropped CON review for hospitals but retained the program for nursing homes. Texas currently has a moratorium on new Medicaid certified long term care. South Dakota implemented a moratorium on licensing new nursing home beds which coincided with the July 1, 1988, sunset date of CON. Louisiana had never had a CON program, but at the time of this writing a CON program had passed the House and Senate in Louisiana and was awaiting the Governor's signature. The program would apply only to nursing homes.

Beginning in 1983, the Utah Department of Health set forth a policy to promote price competition to control the health care market. It was estimated by most economists that 6 to 11 years would be needed to

[12]David S. Salkever; and Thomas W. Bice, "The Impact of Certificate of Need Controls on Hospital Investment." Milbank Memorial Fund Quarterly/Health and Society (Spring 1976): 190.

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establish the necessary market conditions. Before a capital expenditure review program is reinstated, this new policy should be given time to work and its effectiveness in controlling the market should be evaluated. Once this has been done, it may be appropriate to reinstate capital review statewide, or in the areas where the market is not effective. The competitive policy should not be abandoned, however, until it has been given a fair chance to develop.

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IX. STRATEGIES TO BE EXAMINED

Any strategy to influence current conditions should have the objective of controlling cost while assuring access and high quality care for Medicaid patients.

The first option is simply to do nothing. If the current pattern is extended into the future, a likely scenario is as follows: the number of long term care beds will continue to grow, average occupancy rates will continue to decline, per unit costs will continue to rise, some nursing homes will be forced out of business, patients will have to be relocated, and the quality of care will decline. Access to care for patients will probably continue to be very good because nursing homes will need to fill empty beds. Empty beds may also allow Medicaid to provide only minimal increases in the flat rate.

A second course is to inject competitive forces into the market to foster price competition. Medicaid could contract only for the number of beds needed and allow nursing homes to submit their best bids. If such a strategy were to be followed, it would be extremely important to specify the minimum standards of care required. This strategy should serve as a signal to the industry that Medicaid will not support continued growth.

The third direction is to return to a regulatory measure, such as CON or a moratorium, to check the unrestrained growth. This would allow time for the demand for beds to catch up to the supply. There are difficulties in reinstating a capital review program like CON. The Health Systems Agencies have been dismantled. Policy makers in Utah do not favor government regulation, and past experiences with CON have left negative perceptions of this program.

The most effective strategy to handle the situation in the long term care industry is to give the industry relief from the incessant construction while assessing the feasibility of price competition. The market, as suggested by the Peat Marwick study, may need some time to stabilize. The first step is to place a Departmental moratorium on new construction or conversion of beds until the next legislative session. During this period the Department could design a competitive bidding experiment. The experiment will take place in a limited area and only involve Medicaid patients newly admitted to nursing homes. It would be designed to see if price competition in the long term care market can control cost while assuring access and high quality care for Medicaid patients.

During the legislative session a moratorium on the construction of, or conversion to, skilled and intermediate care beds could be passed. A legislative moratorium on construction and the competitive bidding project would go into effect at the same time. The moratorium would restrict new facilities from entering the market to halt the decline of occupancy rates.

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Under the moratorium, only projects which had approved architectural plans and evidence that they had funded construction contracts prior to the date of the Department-initiated moratorium would be allowed to complete their projects under an exception to the moratorium. Nursing home beds proposed, built, or converted after that date would not be approved, licensed, or certified to care for long term care patients. This is to prevent corporations or individuals from "slipping in under the wire."

The rural swing bed program, which originally allowed hospitals with 50 or fewer beds to temporarily convert a few beds to provide long term care under Medicare, should be exempt from the moratorium. The program will be extended to include hospitals with up to 100 beds. Further easing of the requirements for "swing beds" should be carefully watched, however. It is important to assess whether the program is extending to the point where "swing beds" are substituting for nursing homes. If this happens, swing beds also should be included under the moratorium. Conversion of beds in general acute care hospitals, psychiatric hospitals, and other specialty hospitals to provide long term care should be included under the moratorium.

An integral portion of the plan is the implementation of a pilot project in competitive bidding. It may be necessary to apply to the federal government for a waiver of the freedom of choice requirement. This should be done as soon as possible.

The Department of Health also needs to begin collecting data on new admissions to nursing homes, to determine how many beds for which to contract initially. The Department will want to contract with the top ranked bids based on quality of care and price. The department will contract only for the number of beds needed in the area for the pilot project, so that the contracting providers will be assured of high occupancy rates. Currently the Department does not maintain records on the origin of new admissions. Patients may be readmitted for a number of reasons, including excessive leave of absence, hospital stays, change of ownership of the facility, and roll over to Medicaid coverage. There is currently no distinction made between admissions which are actually readmissions, and admissions of patients who are new to the system. These data will be needed before the actual number of contract beds can be determined. A conservative estimate of the number of new admissions by county should be made, based on the data collected. This information will then be available in time to send out the requests for proposals.

The number of patients involved in the project should be large enough to assure high occupancy rates for the facilities which successfully bid for the beds but not so large that the facilities not participating in the project are affected dramatically. The fall in occupancy in nonparticipating homes should be halted by the effect of the moratorium and by allowing some new Medicaid patients to be admitted. Nonparticipating facilities will be able to maintain current patients and also accept private patients, patients supported by Medicare, and patients not assigned to the demonstration project.

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The pilot project also needs to take place in an area with a reasonable number of facilities. If the project were restricted to an area with only a handful of nursing homes, certain homes would be singled out for failure if their bids are not successful. A large enough number of nursing homes needs to be included so that the impact of the project will be to allow the nonparticipating facilities in the area of the project to retain current occupancy rates and to allow for occupancy to increase slowly over the next few years. A slow increase in occupancy should also occur in areas outside the pilot study. Facilities participating in the pilot study will increase their occupancy rates more quickly. A possible location for the pilot project would be Davis and Weber counties. Patients with a legal residence in these counties should be randomly assigned to either the demonstration project or a control group. A percentage of patients large enough to increase occupancy in the number of top bidding facilities would then be assigned to the pilot project. Those not assigned could enter a facility of their choice.

The freedom of choice waiver may not be needed if facilities which either do not bid or are not awarded a contract are allowed to participate at the awardee rate if they can assure the same level of quality. If this approach is chosen, it may be possible to include a greater percentage of new admissions in the project.

Before the project and the legislative moratorium go into effect, the Department of Health would issue Requests for Proposals, based on the Maricopa County, Arizona, model, with modifications for the structure of the present system in Utah. Facilities which provide intermediate and skilled nursing care would be allowed to bid. Intermediate care facilities for the mentally retarded (providing care levels of IMR-1, IMR-2, and IMR-3) will be excluded from the pilot project. The levels of care to be bid on will be: SNF-2, ICF-1, and ICF-2. Facilities participating in the project may also provide SNF-1 level care, but it will be excluded from the demonstration and the payment will be individually negotiated as it has been in the past.

Proposals should not be accepted from facilities where there is a history of major and substantiated violations of patient care standards, if this history can be verified, nor from those institutions with very poor facility survey track records. The type and maximum number of deficiencies allowed in the last two surveys will be specified to assure a level of high quality care. For example, if a skilled facility has had deficiencies in two conditions of participation in the last two surveys, a decertification action or an intermediate sanction reported in the last two surveys, it will not be allowed to participate. Complaints should also be investigated, and an excessive number of substantiated complaints should also exclude providers from participating in the project. It is important to keep in mind that the project must be designed to encourage price competition at an acceptable level of quality. Bids received which are below what is reasonable to provide acceptable care should be rejected.

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Separate from the Department, a Ceiling Rate Committee should be established. This committee will be independent of the Department of Health, so that it is clear that the Department is not setting rates for the project. The Committee members should include individuals with expertise on nursing home costs and accounting, but should not be affiliated with any nursing home. The committee will establish ceilings for reasonable charges for care. Facilities bidding below the ceilings should be given preference.

The evaluation and selection of facilities by the Department should be final and not subject to review. The Department may reject any and all proposals submitted in response to the Request for Proposal. Contracts for those facilities successful in the bid will be finalized to coincide with the legislative moratorium.

If the number of new patient admissions (not included in the exceptions) exceeds the number of beds available in contracting facilities, the Department will then complete contracts with a facility or facilities ranked next according the quality and price guaranteed in their bids.

The Department of Health will monitor each facility's compliance with and performance under the contract. Either party may terminate the contract with 90 days prior written notice. The Department will have the right to terminate the contract upon 24 hours notice if it deems that the health or welfare of a patient is endangered.

When the project begins, all new admissions will be screened to see if the patients should be included in the project. Several categories of patients will be excluded: patients who had previously financed their care privately but now qualify for Medicaid, patients who were Medicaid supported in a facility but had to be readmitted due to a hospital stay or an excessive leave of absence, and patients transferring from one nursing facility into the demonstration site. If the patient is to be included in the pilot project, she or he would be randomly assigned to the control or the experimental group. If a patient is assigned to the experimental group, she or he will be given the choice of any of the facilities which were successful in their bids and have completed contracts with the Department. If assigned to the control group, the patient will be able to choose any facility certified by Medicaid.

The preadmission screening process and continued stay review currently required for all Medicaid patients will also be required for all patients in the project. Facilities outside the geographic area of the project and those which either did not bid or were not chosen to participate in the project will continue to be reimbursed under the Medicaid flat rate.

The pilot project and the moratorium should be evaluated annually. The effect of the moratorium, its success in preventing construction, and its impact on access to care should be reviewed. If necessary,

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amendments or revisions should be proposed. The pilot project should be examined to determine if it is cost effective for Medicaid, if high quality care standards are being maintained, and if access to care for Medicaid patients has been safeguarded. Patients, families of patients, and advocates of patients in both the experimental and control groups should be surveyed about their perception of care, and the results should be compared. Evaluations of care standards should be conducted by the Department. If necessary, changes in policies or procedures should be recommended. The impact of both moves on the Medicaid budget should also be assessed.

After two years, both the demonstration and the moratorium should be examined to determine if market forces are in place. If so, the moratorium should be discontinued. The moratorium should remain in place if market forces are not yet present. Evidence that competitive forces are in place include: (1) the extension of competitive bidding to the entire Medicaid system, or (2) use of selective contracting or competitive bidding by another payor such as a carrier of private long term care insurance.

If, at any time, average industry occupancy rates are at or above 92 percent for three consecutive months, the moratorium should be removed. If the competitive forces fail to take root, the moratorium would have a sunset date in six years regardless of the prevailing market conditions. If the moratorium has successfully prevented building, by this time the projected demand for beds should have caught up with supply.

If it is determined that the moratorium and competitive bidding project are to continue, the Department will again submit Requests for Proposals. If a facility which participated in the first part of the project does not participate in the continuation, patients in the facility will be given the choice to remain in that facility or to be relocated. If a patient chooses to remain in the facility, reimbursement will be made consistent with that for Medicaid patients not participating in the project. Periodically, patients in noncontracting facilities should be canvassed to determine if they would be interested in moving to a lower cost facility. The project should not be discontinued without also lifting the moratorium. Lifting of the moratorium, however, should not necessarily end the competitive bidding project.

This demonstration will foster the development of competitive forces. It includes a small experimental group of facilities which receive contracts for new admissions, while retaining the traditional Medicaid payment mechanism for the control group. It also allows the projected need for long term care beds to catch up to the current supply through a moratorium on new construction.

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X. NEED FOR ADDITIONAL INFORMATION

No matter what strategy the Department follows, there is an increasing need for accurate information about the long term care environment to be collected, analyzed and made public. It is important to gather, maintain, and analyze demographic data. Projections of the number of long term care beds needed in the future should be made, based on historical utilization of specific groups. These projections should take into account the growing proportion of the population over age 85, the number of elderly living alone, the changing social environment (more women in the work force which makes them less available to care for elderly relatives). The main factors which lead to institutionalization including a high level of functional disability and the loss or absence of informal support in the community such as spouses and children.[13] The projections should be made available to the public and to potential developers after a moratorium is lifted.

The Department must also collect information on admissions to nursing homes, including patient origin and destination, previous nursing home and Medicaid utilization, and level of care.

The Department of Health already collects information on occupancy rates of nursing homes. This information, too, should be made available to potential developers. After the moratorium is lifted, the State should require any developer who wants to build a new nursing home, increase or decrease bed capacity, or convert beds from or to any long term care use, to give written notice. Included should be a very brief description of the project (number of beds) and a cost estimate. This information should also be made available to the public.

[13]Judith R. Lave, "Cost Containment Policies in Long-Term Care," Inquiry 22 (Spring, 1985): 11.

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XI. ADDITIONAL RECOMMENDATIONS

An area of serious concern is the nursing shortage. It is increasing the cost of providing care, raising concerns about quality of care, and increasing the stress on already overworked nurses. Such stress multiplies the burnout rate and makes the profession less attractive to potential nurses, further exacerbating the shortage. In confronting this issue, there are several areas where improvements are needed: the image of the nursing profession, opportunities for advancement, working conditions, recognition for achievement, and relationships with administrators and physicians. Overcoming these difficulties goes beyond the scope of this paper. However, encouraging projects between nursing schools and nursing homes may help to ease the difficulty of long term care facilities in attracting nurses. In addition, Utah is the only state in the nation where the applicants to nursing school exceed the number of slots available. Increasing funding to nursing schools and providing incentives to increase enrollment are important first steps toward a long range solution.

Even though the Medicaid program is likely to remain the dominant buyer of long term care services in the future, the State should still support the development of private financing alternatives. Nationally, approximately 20 percent of all elderly will be in nursing homes for some period of time. Since the risk of needing long term care is spread evenly over the population, it is logical to pool the risks of needing such care through the use of long term care insurance.

Private long term care insurance would allow individuals to contribute a small amount over time to protect themselves against the eventuality of needing long term care. Availability of such insurance could slow the rate of increase in spending on long term care by Medicaid. In order to make purchasing long term care insurance attractive, the state must first educate residents of Utah about the potential need for long term care. Many people still believe that Medicare, Medigap, or private insurance will cover the costs of a long term nursing home stay. In reality, these sources account for less than three percent of the payment for long term care! People must also be encouraged to purchase policies at a young age, so the policies will be affordable. Objective consumer information about available long term care policies must then be made public. Some long term care policies now available are fixed in both premiums and pay out. Although a pay out rate of $35 a day may help to cover the cost of a nursing home stay in 1988, when the typical individual would need the coverage in the year 2010, when the daily charge could have increased to $450.[14] Such a benefit does little to cover the future cost of care. The State should

[14]Timothy M. Smeeding, and LaVonne Straub. "Financing Retiree Health Care: Who Pays What and When?" Prepared for the Southern Economic Association Meetings, New Orleans: November 1986.

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sponsor an educational campaign highlighting the potential need for long term care, the lack of financing by other payors, and the factors to consider in purchasing long term care insurance policies.

Innovative ways to provide and finance long term care will be needed for the State to cope with the challenges of an aging population. New ideas and demonstration programs should be investigated. Currently there are demonstration projects underway to test the innovative idea of a Social Health Maintenance Organization (S/HMO). It is worthwhile to investigate developing such a program in the state of Utah. All aged, blind, and disabled Medicaid recipients could be enrolled in such a program. S/HMOs would take responsibility for acute, home health, nursing home, and other social and medical services. The S/HMO would be paid on a capitation basis. As an HMO it may be able to establish contracts with hospitals and nursing homes to purchase care at a discount. The success or failure of the demonstration projects in other states should be monitored. There are several obstacles to be overcome in establishing such a program which makes it a long range solution.

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XII. BIBLIOGRAPHY

Ad Hoc Committee on Certificate of Need. "An Evaluation of the Michigan Certificate of Need Program." February 19, 1987.

American Health Care Association "Eliminate Restrictions on Labor Costs for Nursing Staff." Issue Paper.

American Health Care Association, "Reauthorize Nurse Education Act." Issue Paper.

Blake, Diane. "Nurse Shortage Has Broad Implications." Pro Re Nata 10 No. 2 (March/April 1988).

Brich, Heidi M. An International Perspective on Long Term Care for the Elderly unpublished Honors Thesis.

Brown, Lawrence D. "Common Sense Meets Implementation: Certificate of Need Regulation in the States." Journal of Health Politics, Policy and Law 8 No. 3 (Fall, 1983): 480-494.

Burda, David. "Hospital Construction Boom not Expected Despite End of Some State CON Programs." Modern Healthcare (November 6, 1987): 134.

Cherskov, Myk. "Hospitals Hurdle CON Barriers Differently." Hospitals (May 20, 1986): 89.

Cherskov, Myk. "Planning Agencies' Futures, Funds Uncertain." Hospitals (June 20, 1986): 79-80.

Christianson, Jon B.; Hillman, Diane G.; and Smith, Kenneth R. "The Arizona Experiment: Competitive Bidding for Indigent Medical Care." Health Affairs: 87-103

Coburn, Andrew F. "Deregulating Entry Controls in Health Care: A Cautionary Note." Presented at Health Care Association Symposium, "Competition vs. Regulation" September 10-12, 1986.

Feder, Judith; and Scanlon, William. "Regulating the Bed Supply in Nursing Homes." Milbank Memorial Fund Quarterly/Health and Society 58 No. 1 (1980): 54- 88.

Friedman, Emily. "Medi-Cal Contracting: Model or Mayhem?" Hospitals (August 1, 1984): 74-78.

Friedman, Emily. "When the Mainstream Becomes a Trickle." Hospital Forum (July/August): 9-17

Freudenheim, Milt. "Nursing Homes Face Pressures that Imperil Care for the Elderly." New York Times Saturday, May 28, 1988.

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Greenberg, Jay N.; Leutz, Walter; Ervin, Sam; Greenlick, Merwyn; Kodner, Dennis; and Selstad, John. "The Social/Health Maintenance Organization & Long Term Care." Generations (Summer 1985): 51-55.

Hekman, Ellen L. "State Efforts At Health Care Cost Containment." National Conference of State Legislatures September, 1984.

Heller, Gloria; and Chase, Mary. "A Study of the Impact of Health Care Deregulation on Hospitals, Nursing Homes and Health Services in Arizona." November 15, 1985.

Howell, Julianne R. "Evaluating the Impact of Certificate of Need Regulation Using Measures of Ultimate Outcome: Some Cautions from Experience in Massachusetts." Health Services Research 19 No. 5 (December, 1984): 587-613.

Illinois Health Care Cost Containment Council. "Report of the Illinois Health Care Cost Containment Council to the Governor and the Illinois General Assembly on the Effectiveness of Certificate of Need Review." October 27, 1987.

Intergovernmental Health Policy Project. "Health Issues Affecting the Elderly." January, 1987.

Kinzer, David. "The Decline and Fall of Deregulation." New England Journal of Medicine 318 (January 14, 1988): 112-116.

Kolb, Deborah S.; and Krueger, Deborah J.; "Controlling Expansion of the Nursing Home Industry: Effects of Prospective Payment Systems on Capital Formation." Topics in Health Care Financing (Spring, 1984): 77-89.

Larkin, Howard. "Deregulation Spurs Market Information Demand." Hospitals (December 20, 1987): 58.

Lave, Judith, R. "Cost Containment Policies in Long-Term Care." Inquiry 22 (Spring, 1985): 7-23.

Legislative and Budget Finance Committee. "Report on a Study of Pennsylvania's Certificate of Need Program." February, 1987.

Luke, Ronald T. "Elimination of Determination of Need Regulation of Psychiatric Hospitals in Indiana." February, 1987.

Luft, Harold S. "Competition and Regulation." Medical Care 23 No. 5 (May, 1985): 383-399.

National Governors' Association. "State Long Term Care Reform: Development of Community Care Systems in Six States." April, 1988.

EXHIBIT 7
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Neuschler, Edward. "Medicaid Eligibility for the Elderly in Need of Long Term Care." Health Policy Studies, National Governors' Association. September, 1987.

Pierce, Robert M. "Major Health Issues for States: 1986." Presented to the National Conference of State Legislatures, February, 1986.

Peat Marwick, Study of the Nursing Home Profitability for the Nursing Home Industry in the State of Utah December, 1986.

Popko, Kathleen, SR; and Patrick, Laskey, W., SR. "The Social/HMO: Is it Feasible in a Community Hospital Setting?" Hospital Progress (October, 1987): 50-53.

Rivlin, Alice M.; and Wiener, Joshua M. "Who Should Pay for Long-Term Care for the Elderly?" The Brookings Review (Summer, 1988): 3-9.

Salkever, David S.; and Bice, Thomas W. "The Impact of Certificate of Need Controls on Hospital Investment." Milbank Memorial Fund Quarterly/Health and Society (Spring 1976): 190.

Schramm, Carl J. "Revisiting the Competition/Regulation Debate in Health Care Cost Containment." Inquiry 23 (Fall, 1986): 236-242.

Scott, Denman H.; Tierney, John T.; Waters, William J.; Williams, Donald C.; and Donahue, John X. "Certificate of Need: A State Perspective." Rhode Island Medical Journal 70 (August, 1987): 341-345.

Shain, M.; and Roemer, M. Hospitalization Under Insurance (Chicago: American Hospital Association, 1959).

Shortell, Stephen M.; and Hughes, Edward F.X. "The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients." The New England Journal of Medicine 318 No. 17 (April 28, 1988): 1100-1107.

Simpson, James B. "Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control." Indiana Law Review 19 No. 4 (1986): 1025-1127.

Simpson, James B. "State Certificate of Need Programs: The Current Status." American Journal of Public Health 75 No. 10 (October, 1985): 1225- 1229.

Sinclair, Sara V. "The Licensed Nursing Shortage in Nursing Homes." Presented to the National Commission on Nursing, New Orleans: April 15, 1988.

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Smeeding, Timothy M.; and Straub, LaVonne. "Financing Retiree Health Care: Who Pays What and When?" Prepared for the Southern Economic Association Meetings, New Orleans: November 1986.

Thomas, Constance. "State Health Notes." Intergovernmental Health Policy Project No. 67 (October, 1986): 1-12.

Utah Department of Health. A Statement of Health Policy: A Prescription for Health Care Costs in Utah February, 1983.

United States Department of Health and Human Services. "The Availability of Nursing Home Beds for Private Pay Patients and the Certificate of Need Issue." HCFA May 18, 1987.

United States Department of Health and Human Services. "State CON Experience: Program Aims and Policy Issues." Certificate of Need Program Review February, 1982.

United States General Accounting Office. "Health Care Facilities: Capital Construction Expenditures by State." August, 1986.

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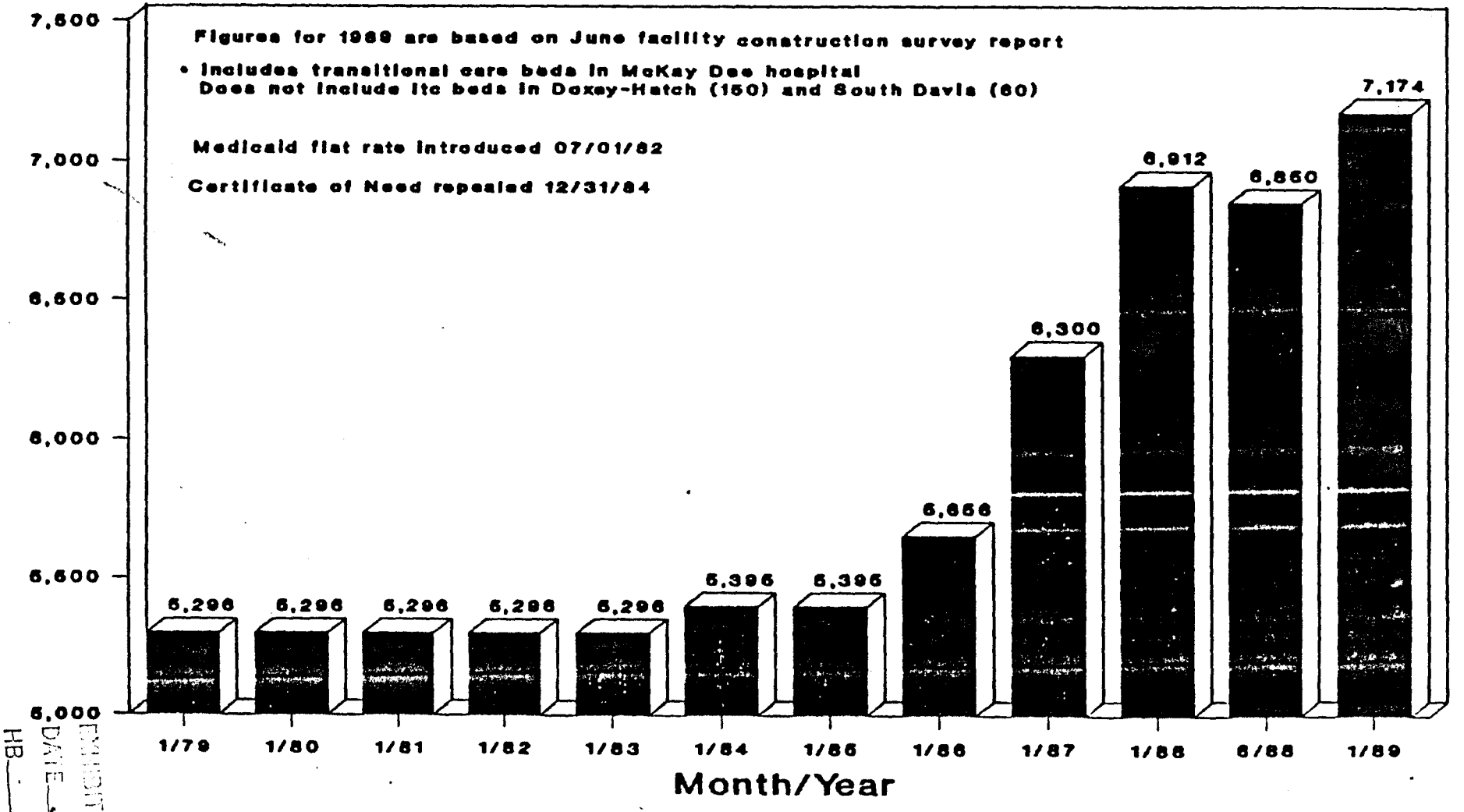
Net Change in Geriatric Beds



APPENDIX I

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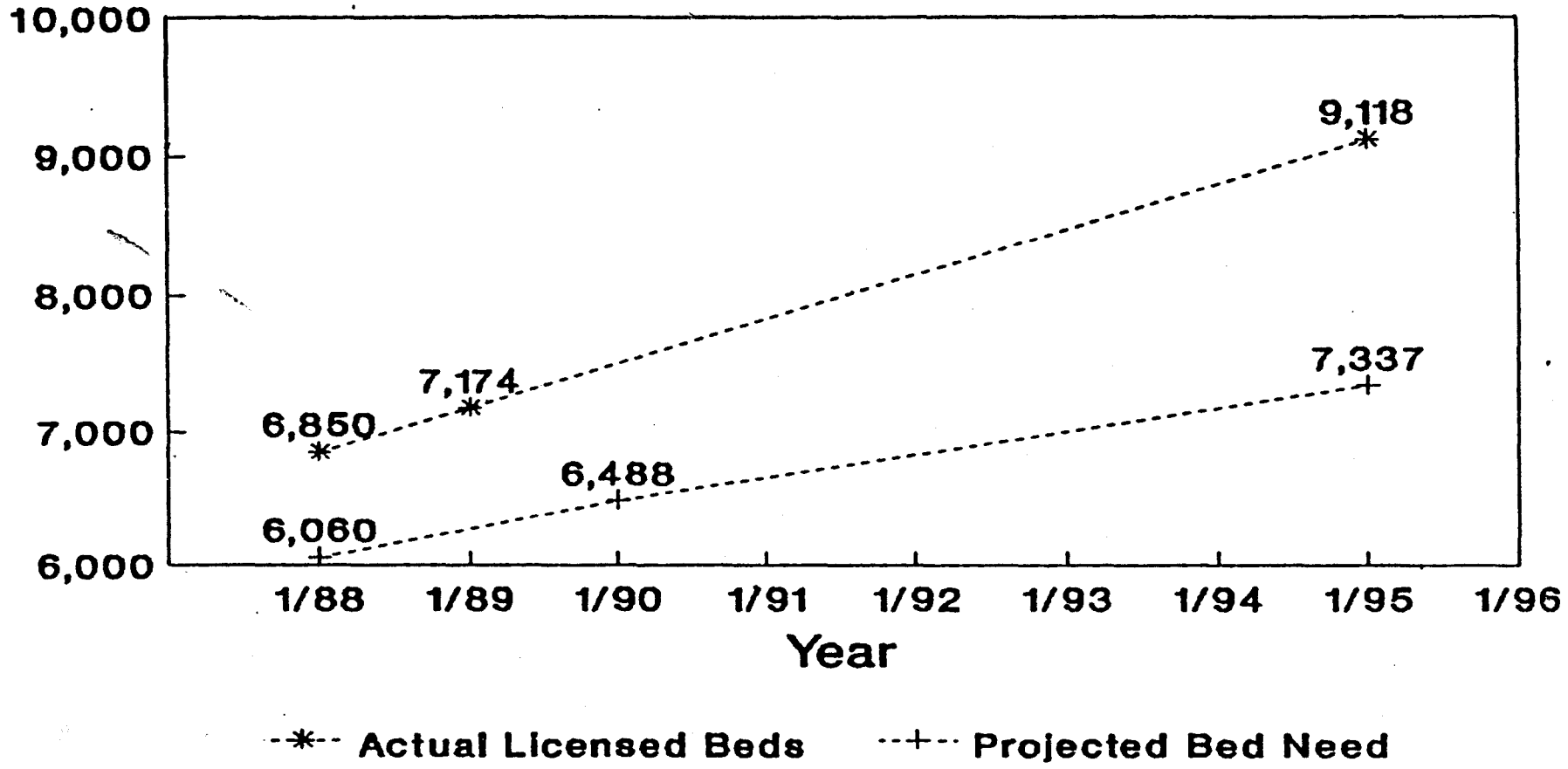
Projected Number of Beds Required for those 65 and Older



Based on historical utilization rates and 90% occupancy.

APPENDIX 2

EXHIBIT 1
DATE 3-3-89
HB 340

PETITION

940 Signatures.

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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PETITION

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SIGNATURE	PRINTED NAME	ADDRESS
Rev. John J. Linehan	Our Lady of Guadalupe,	523 29th St Billings
Jack Olson	JACK OLSON	324 S. [illegible] Livingston
Ray H. Walsh	RAY H. WALSH	3230 AVE B BILLINGS Mt
Walburga Walsh	WALBURGA WALSH	3230 Ave B - Blgs, Mt
Agnes Miesaloski	Agnes Miesaloski	719 No Nowlan, Glendive Mt
Phyllis [illegible]	330 3rd Ave S. Wolf Point Mt 59201	
[illegible] Bucard	3247 Grand Coulee - Billings 59105	
Eva Riddlinger	3323 - [illegible] Blgs 59101	
[illegible] Schaff	3 Monroe	
Caroline Staley	4834 Central Blgs	
Rosie Kraft	7428 [illegible] Rd. Blgs 59106	
Diane [illegible]	8640 Lauzon Lane Blgs 59106	
Fredda Edeburn	1732 Ave. C Blgs, Mt	
William E. Wright	William E. Wright	1515 Warren Ave, Sheridan Wyoming 82801
Natalie E. Wright	Natalie E. Wright	1515 Warren Ave. Sheridan, Wyo, 82801
Sister John Regis Lesser	Sister John Regis Lesser	1241 N. 30th Billings MT 59101
Jane Schafer	Jane Schafer	1111 3rd St. West Billings, MT
Betty Stammen	Betty Stammen	339 Wicks Ln Blgs.
Carol Ask	CAROL ASK	210 MH 208 Kalispell, MT
Larry M. Stammen	LARRY STAMMEN	2006 Orchard Ln Billings
Milo Schindele	Mario Sc	2146 Beloit Billings
Maxine Schindele	Maxine Schindele	2146 Beloit Blgs
Ruth M. Tillotson	RUTH M TILLOTSON	3003 Remedy Heights Blgs
Betsey Brittain	BETSEY BRITTAIN	2416 Elm St
A. Katherine Doss	A. Katherine Doss	1204 Bruce Blgs Mt
Harriet Shuyler	Harriet Shuyler	4114 Morgan
Lois M. Pavek	Lois Pavek	1346 Hawthorne Ln Blgs
Harriet Scriver	HARRIET SCRIVER	149 Erickson Ct
Kim Cahill	Kim CAHILL	2925 Kincaid Rd.
Irene E. Lester	Irene Lester	2917 Terry.
Carol Atchison	Carol Atchison	8 Dillman Rd, Roundup

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PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	[illegible]	[illegible] 59102
S. Frances Burt	S. Frances Burt	2156 Dallas Dr. 59102
Kathie L Riggs	Kathie L. Riggs	911 Poly, 59102
Linda Varela	Linda Varela	P.O. Box 15 Ballantine 59
Gay Engleman	Gay Engleman	2021 St. John - 59102
Pat Ellison	Pat Ellison	105 Sky Ranch 591
David Healow	David G Healow	2525 Irving Pl 59102
Gayle Staley	Gayle Staley	1607 21ST West
Rita Turley	Rita Turley	114 White Circle 59102
Betty V. Miller	Betty V. Miller	1109 Delphinium Dr. 5910
James T Paquette	James T Paquette	1109 Toole Ct. B. Illings 59102
Jane Moses	Jane Moses	245 Avenue F Billings 59102
Callen K. Northam	Callen K. Northam	3034 Ave F. Billings MT. 5910
Rick Palagi	Rick Palagi	2411 River Oaks Billings MT 59102
Jennifer Smith	Jennifer Smith	1437 Ave E Billings 59102
J.K. Engleman	J.K. Engleman	2021 St Johns Blgs.
Lisa P. Wojtech	Lisa P. Wojtech	112 Hilltop Blgs. 591
Steven P. Shandera	Steve Shandera	2903 Kincaid Rd
Mike Nicholes	Mike Nicholes	2425 Howard Blgs
Chere' S Allan	Chere' Allan	2235 Dallas Blgs 591
Sandy Stepper	Sandy Stepper	3301 Stonewall Blgs
Cheryl Oliver	Cheryl Oliver	1294 yellowstone #C4 59102 Billings Mt. 59
Reagan Litzsinger	Reagan Litzsinger	833 Mossman Blgs 59102
Linda Olsen	Linda Olsen	P.O Box 20111 Blgs 59107
Mark A. Buczynski	Mark A. Buczynski	1132 Dezphinium
William J. Pfingsten	William J. Pfingsten	1690 Lakehills.
Lindi Funston	Lindi Funston	1517 9th St W. Billings MT 59102
Kathleen Shaw	Kathleen Shaw	3107 South 68 ST West
Deborah Kvale	Deborah Kvale	3346 Racquet Drive Billings
Bob Hazard	Bob Hazard	4644 N. Woodhaven Billings 5910
Jill Penwell	Jill Penwell	1422 Colton - Billings

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PETITION

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SIGNATURE	PRINTED NAME	ADDRESS
M. Wolf	Mary Wolf	2446 Terry
M. Zimmerman	Mark Zimmerman	1306 Wicks Lane Billings Mt
B. Mesteth	Beth Mesteth	
[illegible]	David Dunn	427 Poly
[illegible]	Dorothy Semmann	824 Moon Beam Lane
Lynnie Polly	Lynne Polly	3021 E. MacDonald
[illegible]	Darlene Weinreth	21 Alma
Jan Christensen	Jan Christensen	107 Wyoming Ave
Della Bender	Della ~~Bell~~ Bender	4331 Mitchell Ave
Cindy Tingle	Cindy Tingle	17 King Henry
Tammy Klienfelt	Tammy Klienfelt	1337 St Johns
Monica Weinzetl	Monica Weinzetl	536 Parchill Dr.
Karen Kolacny	KAREN KOLACNY	4058 Riverside Rd
Jean Holden	JEAN HOLDEN	1027 3rd Ave
Carolyn West	Carolyn M. West	5334 Roland Dr.
Sister Alice Mary Kiernan	Sister Alice Mary Kiernan	11.27 Kelly Dr.
Janet L. Keller	Janet L. Keller	5216 Rimrock
Aileen Stewart	Aileen Stewart	605 Lake Elmo Rd. Bgs
Marilyn J. Julian	Marilyn J Julian	RT 1 Box 78 Jol.
Helen DeTienne	Helen J DeTienne	115 Alderson Rd
Barb Weberg	Barbara Weberg	405 Normandy I
Milous Repka	Milous REPKA	3315 Harlow
Judy Procise	Judy Procise	6907 Grey Wolf Steps
James E. Clovadetscher	James E. Clovadetscher	620 Declaration Dr.
Mary St John	Mary St John	2517 Virginia Lane Biggs.
Janet Stricklett	JANET STRICKLETT	2032 Howard
Sharon Tripp	SHARON TRIPP	626 Brookwood.
Katherine Myers	Katherine E. Myers	710 Agate H
Phyllis L. LeDesma	Phyllis L. LEDESMA	20 CHARLENE S
Deborah Senn	Deborah Senn	2501 Miles
Annette Fisher	Annette Fisher	517 Riverside F
Candie Larson	Candie Larson	332 Phillip

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SIGNATURE	PRINTED NAME	ADDRESS
Dan Boehler	Dan Boehler	2441 Howard, Billings
David Peraler	David Peraler	4243 Ph. Hip St Billings, MT
Janet Wagner	Janet Wagner	2794 Phyllis Circle So
Jack Gallagher	JACK GALLAGHER	2023 WILSHIRE/BLGS, MT
Nancy McDonald	Nancy McDonald	116 1/2 N. 22nd Blgs MT
Elora Lake	Elor. A Lake	1203 North 24th
Jerry L. Bentzen	Jerry L. Bentzen	720 Howard #D Big MT
Patty Fuchs	Patricia Fuchs	3014 Parkhill Dr.
David M Huntley	David M Huntley	PO Box 251 Worden MT
Wanda R. Gallentine	Wanda R. Gallentine	2316 Alderson #3 Blgs,
Wilma Peterson	WILMA PETERSON	370 Rosemont Blgs. MT
Doug Stoddard	Doug Stoddard	2924 4th Ave So.
Fern Dillinger	FERN DILLINGER	373 Windsor Circle
Dan Rogers	Dan Rogers	2331 Hillcrest
Kurt McCaulay	KURT McCAULAY	1007 1/2 North 30th St
Bob Fannon	Bob Fannon	1731 Yellowstone Ave
Michael Howell	MICHAEL HOWELL	4803 HAZELNUT AVE
Rudy A. Mockel	RUDY A. MOCKEL	393 Caravan
Sr. Rita Orleans	SR. RITA ORLEANS	1241 North 30th
Spencer Smith	Spencer Smith	1690 Lakehills Drive
Virginia A. Kern	VIRGINIA A. KERN	4304 So Frontage
Sister Marian Berry	Sister Marian Berry	1233 N. 30th St. Billings MT
Sister Valerie McGeough	Sister Valerie McGeough	142 Wyo. Ave. Blgs. MT
Lynn Massey	Lynn Massey	3806 Slalom Billings
Dora May Abbey	Dora May Abbey	3301 Stone Billings, MT
Helen M. McPhee	HELEN M. McPHEE	2721 GLENWOOD LN
Phil Tilley	Phil Tilley	721 Cross Billings MT.
Evelyn Johnson	EVELYN JOHNSON	2839 Chester Billings
Sue Bradshaw	Sue BRADSHAW	801 Oak Billings
Anne Sloan	Anne SLOAN	3614 Otis Lane
Sister Vincent McKiernan	SR Vincent McKiernan	142 Wyo Ave. Blgs.

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SIGNATURE	PRINTED NAME	ADDRESS
Sister Jane Ellen Fury	Sister JANE ELLEN Fury	1241 North 30 TC
Janet L. Olsen	Janet L. Olsen	415-56th St W. Billings MT
Margaret Lubke	MARGARET LUBKE	27 Wildwood
Eleanora Shain	ELEANORA SHAIN	411 So. 31st St.
Sandy Jo Hilby	Sandy Jo Hilby	2222 Aldersen B. Billings
Dorothy Strobbe	DOROTHY STROBBE	304 Alkali Ck. Rd. R7 " "
Marjorie Fiedler	Marjorie Fiedler	11408 Vaughn Ln. " "
Jenny Lee Hernandez	JENNY LEE HERNANDEZ	4440 MORGAN AVE Blgs, Mt
Kaye Clark	KAYE CLARK	21 Walnut Bowe Blgs Mt
Jeanne Meeks	JEANNE MEEKS	2308 ELM St. Blgs. MT
Dolly Homme	DOLLY Homme	4116 Terry Ave. Blgs. MT
Julie Larson	Julie Larson	103 Saddle Tree Pl. Blgs. MT.
Mary M Maggard	MARY M MAGGARD	1147 Yellowstone Ave
Gerry Paler MD	Gerry Paler MD	409 Yellowstone Blgs
Voni L. Fletcher	VONI L. FLETCHER	1124 No. 23rd ST
Marie M. Fritsch	MARIE M. Fritsch	1935 Yellowstone Ave
Donna M. Riggs	Donna M. Riggs	544 Calhoun Ln.
Mary E Munsell	MARY MUNSELL	69 Balsam Circle, Miles City
Elisa Bustos	ELISA Bustos	4415 Stone Ave BILLINGS
Marilyn Sulenes	~~54 Shadow~~ MARILYN SULENES	54 Shadow Rd
Kathryn I Jones	Kathryn I. Jones	Box 21257 Blgs
Connie M. Tipton	Connie M. Tipton	542 Beverly Hill Blvd Blgs
Wanda L. Hartman	Wanda L. Hartman	4225 Clevenger Ave
Lesley L. Granzow	Lesley L. Granzow	515 WYOMING, LAUREL
Maxine Berger	MAXINE BERGER	769 Fallon Ln
Lorraine Russell	LORRAINE RUSSELL	50 Bagley Court
Jeanne Kahle RN	Jeanne Kahle	3127 38th W Billings
Cynthia J Schubert	597 Acorn Place	Billings MT 59102
Paul Hartman	PAUL HARTMAN	BILLINGS MT
Ranlee Speakman	RanleeSpeakman	1489 Rosebud Lane Billings MT
Deborah J. Tierney	Deborah S. Tierney	2304 22nd St W 59102

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SIGNATURE	PRINTED NAME	ADDRESS
Ellen E. Herminghaus	Ellen E. Herminghaus	420 Barbara Ln.
Edith P. Allan	Edith P. Allan	110 Locust
Ellen G. Gibb	ELLEN G Gibb	1040 No 29 ST
[illegible]	Cary A Ostermiller	1151 Lake Elmo Rd
Catherine A. Benner	Catherine A. Benner	521 Finley Circle
Sharon A. Tininenko	Sharon A. Tininenko	P.O. Box 21318
Kathleen Bouchee	Kathy Bouchee	521 Grand
Marie Freidt	MARIE FREIDT	820 Wellington E Blgs.
Maude Dodge	MAude Dodge	4444 Clevenger, Blgs
Sylvia Duncan	SYLVIA DUNCAN	615 NORTH 24TH
Joyce Fletcher	JOYCE FLETCHER	723 Ave C, Billings
Rose Senn	ROSE SENN	2619 6th avenue
[illegible]	ALICE KOBER	1039 N. 26 Street
Jean D. Boyer	Jean D. Boyer	2537 Wyoming Ave.
Donald J. O'Neill	Donald O'Neill	2909 Ottawa Butte
Marian O'Neill	Marian O'Neill	2909 Ottawa St. Butte
Marie Sullivan	Marie Sullivan	808 Waukesha Butte, MT
Mary Jo Miller	Mary Jo Miller	3724 Marathon Drive
Nanci Bergman	Nanci Bergman	346 Wyoming, Blgs
Elsa D. French	ELSA D. FRENCH	429 No 33rd Apt 205
Betty L. Eichhorn	Betty Eichhorn	5678 Raven Rd. Helena, Mt
Ethel Ellis	Ethel Ellis	Broadus, Mnt.
[illegible]	Robin Wickham	[illegible]
Betty Grayson	Betty Grayson	215 North 14th St
A. Leischner	Ann Leischner	613 Forrest Ave Laurel, Mt
Kim Love	Kim Love	1306 Lewis BLGS MT. 59102
Audrey Hensiek	Audrey J Hensiek	3031 Boulder #B-8 Billings, MT 59102
Marie Roll	Marie Roll	718 Haugen St, Blg
Mary Hanks	MARY HANKS	1130-N 23rd ST Blgs
Karen Starling	Karen Starling	3563 Cambridge Blgs
Doris C. Hamilton	Doris Hamilton	234 Ave C - Billings

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SIGNATURE	PRINTED NAME	ADDRESS
Marge [illegible]	Marge [illegible]	Billings, Mt.
Barbara B. Bales	BARBARA B. BALES	820 DURLAND - BL
Bill Lund	Bill Lund	Box 31 Red Lodge Mt
Ed Ryan	Ed Ryan	458 Constitution Ave, Billings
Thelma Peterson	Thelma Peterson	1339 Lynn Ave Bl
Timothy K. Singer	Timothy K. Singer	2020 13th W. Blgs
Terry Biggs	Terry Biggs	3406 Lakama Blg.
Cole L. Phipps	COLE L. PHIPPS	3015 8th Ave N #3 Blgs MT
Mary M. Maggard	MARY M MAGGARD	1147 Yellowstone
Ed Manlies	Ed MANLIES	4520 Murphy
Shirley M. Mouat	SHIRLEY MOUAT	825 Parkhill Drive
Suzanne Hart	SUZANNE HART	1030 N. 30th
Hilda Weaver	Hilda Weaver	946 1/2 N. 30th
Felix Webb	Felix S. Webb	#6 Heatherwood
Mary Webb	MARY L WEBB	" "
John R. Butler	John R. Butler	525 O'Malley Dr.
Thelma O'Donnell	Thelma O'Donnell	1017 Elder Lane
Raymond J. Leone	Raymond J Leone	3016 Rimrock Road
Claire Shields	CLAIRE SHIELDS	840 TERRY AVE.
Charles Shields	Charles W. Shields	3295 Granger Ave E. Blgs
G. Shields	G. W. SHIELDS	840 Terry
Eva M. Sheffek	EVA M. SHEFEK	3849 Mallard
John Tretin	JOHN TRETIN	909 WICKS LN,
DeAnn Downs	DeAnn Downs	Molt, Mont.
Gloria Hardy	GLORIA HARDY	Billings Mt.
Mary A. Ballard	MARY A. BALLARD	Shepherd Mt
Angela M Reichert	Angela M Reichert	1741 Cody Dr, Blgs
Bonnie P. Price	Bonnie P. Price	132 Wyoming
Dawn M. Stuart	DAWN M. STUART	331 Bohl
Connie L. Dyke	CONNIE L. DYKE	971 Neptune
Evelyn E. Hanson	Evelyn E. Hanson	Box 216 - Joliet, Mt

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SIGNATURE	PRINTED NAME	ADDRESS
Mary Ann Dugan	Mary Ann Dugan	3933 Agate Highway
Jack A. Dugan	Jack A Dugan	" "
Earl Ayers	Earl T. Ayers	1703 Crawford Dr.
[illegible]	George Kenler Kenlen	2120 Hallowe Circle
Joyce Fries	Joyce Fries	320 Memorial Pl #3 Billings
Timothy D. Foster	Timothy D. Foster	3020 1st Ave N. #12
Barbara Codden	Barbara Codden	2218 Golden Blvd
[illegible]	Katherine Franchett	2703 Green [illegible]
John Justin Sullivan	John Justin Sullivan	1140 Ponderosa #122
[illegible]	208 Kilborne / 505 Chancellor Ave	→
Terry Palin	Terry Palin	1620 Janie St. Blgs
Shelley O'Leary	Shelley O'Leary	2020 [illegible] Dr. Blgs
Ken Toland	Ken Toland	1916 N. 23rd
Theresa Lubke	Theresa Lubke	3021 11th Ave N.
Helen Jean Robinson	Helen Jean Robinson	Box 284 [illegible] Mt
[illegible]	[illegible]	[illegible]
Julia Jacobson	Julia Jacobson	283 Nubias Pl Blgs
Jesse D. Downey	2011 11th Ave N Blgs, Mt 59101	
R. Lois Ryan	R. Lois Ryan	1304 [illegible] Dr
Steve Meeks	Steve Meeks	2208 Elm
Linda Baugh	Linda Baugh	2441 Teton Ave. 59102
Margaret S. English	Margaret S. English	808 S 32nd Billings, MT
Dorothy E. Hash	Dorothy E. Hash	1112 Kootenai, Blgs MT
Michelle Shue	Michelle Shue	1136 [illegible] Ave., Blgs MT
Christine O'Leary	Christine O'Leary	1020 N 29 Blgs MT
Lance R. Hendricks	Lance R. Hendricks	1340 Lonesome Pine
Beverly Tieszen	Beverly Tieszen	1627 Yellowstone
Angela Ehresman	Angela Ehresman	815 Wyoming Ave
George Frassa	George Frassa	3303 Racquet Drive
Kathy M. Langworthy	Kathy M Langworthy	3215 56th St. West
Ethel C. Hayden	Ethel C. Hayden	2132 Trails End 591[illegible]

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SIGNATURE	PRINTED NAME	ADDRESS
Mary P. Schneider	MARY P. Schneider	919 Ave E Billings Mt.
N. L. Schneider	N.L. Schneider	919 Ave E Billings 59
Herman Ostwald	Herman Ostwald	1018 [illegible] 59[illegible]
H. K. VanSickle	H.K. VanSICKLE	992 Burlington [illegible] 59[illegible]
Lynette Fox	Lynette Fox	Rt. 1 Box 35[illegible] [illegible]
Shirley Koshlar	Shirley Koshlar	1912 11th Ave [illegible]
Jim Becker	JIM BECKER	1838 [illegible] Ct. [illegible]
Greg Brunstetter	Greg Brunstetter	1628 Valley Drive Laurel
Betty McCallum	Betty McCallum	1209 [illegible] St
Elizabeth Grass	Elizabeth Grass	27 Clark - Blgs 59[illegible]
Viola Ruddy	VIOLA Ruddy	1115 [illegible]
MaryDell Ellis	MaryDell Ellis	Broadus 593
Gerald Ellis	GERALD ELLIS	BROADUS 5931[illegible]
Tim Castro	Tim CASTRO	1313 [illegible]
Nancy Jensen	Nancy Jensen	1230 [illegible] 591[illegible]
Stacy L. Padden	Stacy Padden	PO Box 47 Park City 5910[illegible]
Kenneth P. Nelson	Kenneth P. Nelson	2112 Lyndale Billings 591[illegible]
Mike Ryan	Mike Ryan	2938 St. Johns 5910[illegible]
Tammy Lee Searles	TAMMY LEE SEARLES	3981 Granger Ave E. #13 [illegible]
Charlotte Fannon	Charlotte Fannon	1731 Yellowstone 591[illegible]
Pamela C. Pace	Pamela C Pace	2830 Oakland #27 5910[illegible]
Cindy Hash	Cindy Hash	1423 Grand Ave 59102
Elton Lassiter	Elton Lassiter	1236 Reece Dr 59105
Carol Petrowitz	Carol Petrowitz	619 Ave B Blgs.
Marge Biegle	Marge Biegle	3030 [illegible] Lane
M. Sablich	MARCIA SABLICH	3039 Demaret Place
Margaret Martin	Margaret Martin	4443 Palisades Park
Michael A. Lester	Michael A. Lester	2917 Terry Ave
B Schultz	B Schultz	1016 McKinney [illegible] Billings
Ron Schrank	Ron Schrank	6942 Shepherd P Shep.
Mr. + Mrs. Frank (Anna) Von Lutherne		934 Center Ave Billings

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SIGNATURE	PRINTED NAME	ADDRESS
Pete Jones	Pete Jones	36 McKinley
Kim Frank	Kim Frank	500 Custer Billings
Darlene Lucas	Darlene Lucas	1507 Belvedere Dr
Frances Vincelette	FRANCES VINCELETTE	2304 MILES AV
Lee Myers	LEE MYERS	31-36th St. W.
Linda E. Myers	Linda E. Myers	31-36th St. W. Bgs
Yvonne Stoltenberg	YVONNE M. STOLTENBERG	1240 HARVARD
Sister Dorothy	SISTER DOROTHY	1134 N 31
Adam L. Schuyler	ADAM L. SCHUYLER	2615 MONTANA AVE SO.
		1741 Wicks Lane Bldgs.
	1741 WICKS LANE	BILLINGS, MT
David Hoegh	DAVID HOEGH	581 Dickinson Rd.
Herbert Tilley	HERBERT TILLEY	511 N. 30th ST.
Mary Kelley	Mary Kelley	Greycliff Wyo
Geraldine T. Mulkey	Geraldine Mulkey	Miescity
Laura Weber	LAURA WEBER	2416 Shiloh Blgs
Ed Krafft	Ed Krafft Jr	7428 Newburn Dr.
Adeline Bunn	Adeline BUNN	2227 Ash
Sandra K. Almond	Sandra M Almond	3206 Alpena Ave.
James K. Almond	James K. Almond	3206 Alpena Ave.
James P. Campbell	James P Campbell	622 Oakmont Ln
Kelly Campbell	Kelly Campbell	622 Oakmont Ln
Billie O. Walker	Billie O Walker	35 Prince Albert
Gene Harn	Gene Harn	428 Custer
Frances Hecker	Frances Hecker	Melstone, MT
Victoria M. Wunn	Victoria Wunn	910 16th St W #226
Valerie J. Geist	VALERIE J. GEIST	274 Suburban Drive
Aletha Diedrich	Aletha Diedrich	1423 8th St W Blgs
Dianna Pawlson	DIANNA PAWLSON	2519 Cook Blgs.
Penny Barnard	Penny Barnard	RT 1 LAUREL MT
James A. Borer	James A. Borer	609-18th W. Blgs

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We, the undersigned, do hereby support the passage of SB [illegible] - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of [illegible] Montana Hospital Association. This bill recommends the elimination of CON [illegible] for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	[illegible]	[illegible]
[illegible]	Erna Beehm	[illegible]
[illegible]	Loretta I. [illegible]	[illegible]
Elizabeth Lohrenz	Elizabeth Lohrenz	2403-10th Ave. N.
Julia Bell	Julia Bell	[illegible]
[illegible]	Virginia S. Bradley	[illegible] Shepherd MT 5904[illegible]
John P. Bradley	John P. Bradley	[illegible] Shepherd MT 59044
Wilbur A. Sheels	Wilbur A. Sheels	[illegible] Shepherd [illegible]
Patricia T. Peterson	Patricia T. Peterson	310 [illegible] Billings MT 5910[illegible]
M. Horn	Marie Horn	[illegible]
Mary Beth Ebel	Mary Beth Ebel	709 E. Main Laurel MT 59044
[illegible]	W. Lex [illegible]	Roundup
[illegible]	[illegible]	"
[illegible]	[illegible]	Roundup MT
[illegible]	John A Matovich	[illegible] MT 595[illegible]
Rose M. Matovich	Rose M. Matovich	[illegible] MT 59538
Geraldine Cross	Geraldine Cross	16 [illegible]
Linda Dice	Linda Dice	5857 [illegible] [illegible] MT 59[illegible]
Fred Eschenbe	Fred Eschenbe	[illegible]
Timothy Birkle	Timothy Birkle	Billings MT 59105
[illegible]	Al [illegible]	Bil MT 105
Barbara Wiley	Barbara Wiley 2829 Poly	Billings MT 59102
Joan Bummer	Joan Bummer	1841 Arcadia Dr. Billings MT 59102
Zada Liming	Zada Liming	804 Parkhill Billings, MT 59102
Kent T. Swift	Kent T. Swift	1232 St Johns Billings MT 59102
James O. Falcon	James O. Falcon	2619 Broadwater Billings MT 5910[illegible]
Dona M. Kruse	Dona M. Kruse	576 Railroad Hwy Huntley, Montana 59[illegible]
Scott McCallum	Scott McCallum	1814 Crist Dr Blg. MT 59105
L. Armstrong	Lorraine Armstrong	2722 Beartooth Dr. Bl[illegible] 5910[illegible]
Eloise Nead	Eloise Y Nead	707 Howard Ave
Ila White	ILA WHITE	1638 Howard Ave. 59[illegible]

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SIGNATURE	PRINTED NAME	ADDRESS
Dorothy J. Metz	Dorothy J. Metz	Billings
Norma B. Johnson	Norma B. Johnson	Billings
Marjorie E. Solmond	MARJORIE E. Solmond	Blgs.
Jessie B. Boyce	JESSIE B. BOYCE	Blgs
Margaret E. Shoff	MARGARET E. SHOFF	Billings
Florence N. Wodnik	FLORENCE WODNIK	Billings
Mary E. Larson	MARY E. LARSON	Billings
DeeAnne McElgren	DeeANNE McELGREN	Blgs
Roberta Sullivan	Roberta Sullivan	Billings
Robert J. McDermott	Robert J. McDermott	BILLINGS
Charlotte B. Smith	CHARLOTTE B. SMITH	Billings
LaVerne L. Dahl	LaVERNE L. DAHL	Billings
Edith Carlson	EDITH CARLSON	BILLINGS
Mary Nelson	MARY NELSON	Billings
E. Jeanne Erickson	E. JEANNE ERICKSON	Billings
~~Charlotte Carter~~	~~Charlotte Carter~~	~~Billings~~
Jean Wallis	Jean Wallis	Billings
Claire Conter	CLAIRE CONTER	Billings
Monica Chesarek	Monica Chesarek	Billings
Jane M. Hosted	JANE M. HOSTED	Blgs
Elenor Walton	ELENOR WALTON	Blgs
Constance Piccioni	Constance Piccioni	Blgs
Lorraine Tarmann	Lorraine Tarmann	Blgs
Dorothy Leone	Dorothy LEONE	Blgs.
Elsie Fergus	ELSIE FERGUS	"
Edith Allan	Edith P. Allan	"
Jean Honer	Jean Honer	Blgs.
Louise H. Back	Louise H. Back	
Sister Amy Willcott	Sister Amy Willcott	Billings
Shirley J. Watson	Shirley J Watson	Billings

340 DJT 1-30-89

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Mary Jane Burt	MaryJane Burt	[illegible] Billings, MT 59102
Ron Fisher	Ron Fisher	2225 Willowbrook Billings, mt 59102
Sandra McKee	Sandra McKee	[illegible]
Phyllis Forney	Phyllis Forney	[illegible]
Barbara Allen	Barbara Allen	[illegible]
Gladys S. Deutscher	GLADYS S. DEUTSCHER	739 ALEB
Don Buckley	Don Buckley	4129 King Ave East Billings MT 59101
Lynne Kennedy	Lynne Kennedy	1027 Wyoming Billings MT 59102
Jane Wheeler	JANE WHEELER	[illegible] Billings MT 59102
Barbara Tidwell	Barbara Tidwell	[illegible]
J. Swaboda	J. Swaboda	[illegible]
FAY MARSH	FAY MARSH	3020 Parkhill Dr.
JIM HEINS	JIM HEINS	438 Beverly Hill Blvd. 5911
Connie Mason	CONNIE SMASON	[illegible]
Gary Hoffmann	GARY HOFFMANN	3759 LAVA CIR 59102
Janice Tormasky	Janice Tormasky	3298 Shenandoah Dr

EXHIBIT 7
DATE 3-3-89
HB 340

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Lucie Hunsell	Lucie Hunsell	[illegible]
Mary Eggum	Mary Eggum	Box 246 Wisdom
Sally Crawford	Sally Crawford	[illegible]
Mildred Warren	Mildred WARREN	215 [illegible]
Joan Fifield	JOAN Fifield	1538 Howard

EXHIBIT 7
DATE 3-3-89
HB 340

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	[illegible]	[illegible]
Ken Burt	KEN BURT	1516 Cook
Judy Burt	Judy Burt	1516 Cook

3 -

EXHIBIT ____

DATE ____

HB ____

SURGICAL ASSOCIATES, P.C.
GENERAL, VASCULAR AND THORACIC SURGERY
MEDICAL ARTS CENTER • 1230 NORTH 30TH STREET
BILLINGS, MONTANA 59101-0181

JOHN J. McGAHAN, M.D.
ELMER E. KOBOLD, M.D.
JOHN H. COOK, M.D.
JOHN D. MIDDLETON, M.D.

TELEPHONE: (406) 252-8494

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[signature]	John J. McGahan	3104 Gregory
[signature]	ELMER E KOBOLD	2500 Emerson Pl
[signature]	JOHN D MIDDLETON	5432 [illegible]
[signature]	John H Cook	1827 Mulberry
[signature]	DONNA L. EGAN	1226 Harvardville
[signature]	Bonnie L. Whitman	3637 Jersey
[signature]	Doris L. Madison	214 Custer
[signature]	George E Birkman	2616 Golden Blvd
[signature]	Evelyn L. Hoflin	2616 Golden Blvd
[signature]	JuliAN STENSON	2112 Wyoming

EXHIBIT____
DATE____
HB____

DONALD GREWELL, D.O.
Family Practice
Medical Arts North
1232 North 30th Street
Billings, Montana 59101
Telephone (406) 256-1135

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
D Grewell MD	Donald H Grewell M.D.	Billings, MT 1232 N. 30th St
B Lacer	B Lacer	105 School Dr. Bbs
Susie Lacer	Susie Lacer	4313 Zephyr Billings
Katrina Schuld	Katrina Schuld	1715 Patricia Blvd

EXHIBIT ____
DATE ____
HB ____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Ramona Turnbull	RAMONA TURNBULL	2009 Rockhill Dr. Billings
Joyce E Shammel	Joyce E. Shammel	417 Governors Blvd
[illegible]	[illegible]	[illegible]
Gayle Langlois	Gayle Langlois	1523 Wicks Ln.
Romona Ward	Romona Ward	233½ Lewis Ave.
S. P. Taylor	S. P. TAYLOR	11216 Jackrabbit Dr.

EXHIBIT ____

DATE ____

HB ____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Jane M Brosseau	JANE BROSSEAU	Phys, Mont

EXHIBIT ____

DATE ____

HB ____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Richard Anderson MD	Richard Anderson	1230 N 30th ST
Carmen L Taggart	Carmen Taggart	2223 N 30th St Apt 3
Barbara [illegible]	Barbara [illegible]	[illegible]
[illegible]	[illegible] Harris	921 [illegible]
Janet A. Evans	Janet A. Evans	5235 Billy Casper

EXHIBIT ____
DATE ____
HB ____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Neal B. Sorensen	NEAL B. SORENSEN	1230 N. 30 [illegible]
Celie Benjamin	Celie Benjamin	1230 N 30 Billings
Pamela J. Schied	Pamela J. Schied	1230 N 30 Blgs
Phyllis Whitesell	Phyllis Whitesell	733 Ave F [illegible]
J. Patrick Byorth	J. PATRICK BYORTH	1230 N. 30th [illegible]
Benjamin Marchello	Benjamin T. Marchello, MD	1230 N 30th [illegible]
[illegible]	Peggy Bellcamp RN	1230 N 30th Bl[illegible]
Shirley Wyse	Shirley Wyse RD	1230 N 30th Blgs
Dawn Laemmle	Dawn Laemmle	PO Box 97 Huntley [illegible]
[illegible]	[illegible]	[illegible]
Marion Tebay	Marion Tebay	2035 Yellow[illegible]
[illegible] MD	Paul Kuefler	1230 N 30th Billings Mt
Sandy Vincent	SANDY VINCENT	2646 HLHS [illegible]
[illegible]	Debra Gloor	2913 Custer B[illegible]
Paula Ludlum	Paula Ludlum	3118 Marguerite B[illegible]
Gloria Jansma	Gloria Jansma	7583 Keller Rd Laurel MT 590[illegible]
[illegible]	Rita [illegible]	[illegible] 590[illegible]
Lawrence Faught	LAWRENCE FAUGHT	2522 CLARK

EXHIBIT ____

DATE ____

HB ____

PETITION

Page [illegible]

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Neil E Meyer, MD	NEIL E. MEYER	[illegible] Billings, Montana
Connie L Kenny	CONNIE L KENNY	440 Burlington, Billings, Mt
Kim M Dodman	Kim M Dodman	707 Moss Agate, Billings, Mt

EXHIBIT_____

DATE_____

HB_____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation <u>for hospitals only</u>.

SIGNATURE	PRINTED NAME	ADDRESS
[signature]	Kenneth O. LeRohl	2939 Millice Ave B[illegible]
[signature]	Susan L. Wambolt	434½ [illegible] MH
[signature]	Kathryn J. Newman	440 Josephine Dr. Bl., MT
[signature]	Renee K. LeRohl	2939 Millice Av Blgs
[signature]	Brad [illegible]	[illegible]
[signature]	DAVID MYERS	1903 CAMDEN Blgs
[signature]	Fred Schneider	3827 Curry Circle
[signature]	Barbara Merrill	1823 [illegible]
[signature]	MARGARET L. [illegible]	1833 [illegible]

EXHIBIT ___

DATE ___

HB ___

PETITION

We, the undersigned, do hereby support the passage of SB 540 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible signature]	MARY JO GREGORY	[illegible] Blgs, MT
[illegible signature]	Pat Shard	1575 [illegible] Blgs
[illegible signature]	Karen Novasio	1602 Clark Blgs
[illegible signature]	LINDA LUSE	405 Westside Dr. - Blgs
[illegible signature]	Nancy Terkildsen	1647 [illegible] Pl. Blgs
[illegible signature]	Brenda L Nagel	718 N 22 St Blgs 59
[illegible signature]	CHARLENE SPEER	1506 [illegible] Blgs
[illegible signature]	CAROL D ALLEN	[illegible] WASHINGTON St. Blgs
Linda G. Rand	LINDA G. RAND	3829 RIMROCK RD. BLGS
[illegible signature]	EDWARD H BROOKS	[illegible] Blgs 59
[illegible signature]	MARY KRENIK	7135 [illegible] St 5910
Darla Huebner	Darla Huebner	4216 Caravan Blgs 59
Rosemary Olive	Rosemary Olive	4903 Haynes Rd Shepherd 59
Becky K. Turner	Becky K. Turner	2315 Central Ave #1 5910
Kathy Bennett	Kathy Bennett	283 Aswan Pl. 59105
[illegible signature]	Kick Mackley	2420 Howard 59102
[illegible signature]	Renee Lowbee	725 Wyoming 5910
Connie Jones	Connie Jones	3517 [illegible] Blgs 5910

EXHIBIT ______

DATE ______

HB ______

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	[illegible]	[illegible]
[illegible]	JOAN CLARK	805 CLARK Bl
[illegible]	[illegible]	[illegible]
[illegible]	John S. Lindsey JR	Hughes MT
[illegible]	N Tomaszook	Billings MT
[illegible]	Marlene Taucher	[illegible]
[illegible]	[illegible]	[illegible]

EXHIBIT ___

DATE ___

HB ___

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation **for hospitals only**.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	L.J. Bertagna	2920 Rowan Dr. Blgs.
[illegible]	Dee Crane	1909 Brammel Dr.
Hildegarde Greenburg	Hildegarde Greenburg	715 N. 39th
Gary Mollet	GARY Mollet	1040 Wiloma, BLGS.
Mary Jo MacIntyre	Mary Jo MacIntyre	3254 Granger Ave. E.
Elsie Heidema	ELSIE Heidema	3809 Bluebird Rd.
Frances C. Allen	FRANCES C. ALLEN	119 FALLOW LANE APT 24
Patricia M. Buski	Patricia M Buski	43 Wicks City Blgs
Ronald W. Calkin	R.W. CALKIN	1205 BENCH Blvd
Gertrude M. Calkin	Gertrude M. Calkin	1205 Bench Blvd.

EXHIBIT____

DATE____

HB____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Kathy Berscheid	Kathy Berscheid	111 Hickory Blgs
Frederick Kahn	Frederick Kahn	3003 W. MacDonald
Ronald E Burnam	Ronald Burnam	5506 Billy Casper Dr
Judith V Burnam	Judith V. Burnam	5506 Billy Casper
Jeanne M. Meyer	Jeanne M. Meyer	3501 Windmill Cir
Marilyn Wheeler	Marilyn Wheeler	1220 Clark
A Echeverri	Arturo Echeverri	3114 Lee Ann
Kelly Castro	Kelly Castro	4644 [illegible]
Vickie Martin	Vickie Martin	3573 St. Johns
Lori Hodges	Lori Hedges	3254 Granger Dr
[illegible]	[illegible]	[illegible]
William H Smoot	William H. Smoot	1145 N. 29th
Tammy H Bauer	Tammy H. Bauer	1123 N. Broadway
Richard E Hurd	Richard Hurd	1120 N 31st St
Thomas P Thigpen MD	Thomas Thigpen	2506 Wildwood B.

EXHIBIT ___
DATE ___
HB ___

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[signature]	L. T. McGowan	Billings MT
[signature]	[illegible]	Billings MT
[signature]	Marlys Meyer	Billings MT
[signature]	Nancy Bankey	Billings MT
[signature]	[illegible]	[illegible]
[signature]	[illegible] Marcotte	[illegible]
[signature]	Brenda Kapp	Blgs MT
[signature]	Hanson Selby	Blgs MT
[signature]	Patrick Grimsley	Blgs MT
[signature]	Mitch Gallagher	Blgs MT

EXHIBIT ___

DATE ___

HB ___

PETITION

We, the undersigned, do hereby support the passage of SB 390 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	[illegible]	[illegible]
[illegible]	N. V. KOLPIN	3012 Forest [illegible]
[illegible]	[illegible] GILLETTE	2930 [illegible] Blvd
[illegible]	R T WUERTZ	416 [illegible]
[illegible]	D. R. LAMPHEAR	717 4th Ave, Laurel MT
[illegible]	J. L. KNIGHT	605 [illegible]
[illegible]	W. G. SHARP	116 1911 [illegible]
[illegible]	[illegible]	[illegible]

EXHIBIT ______
DATE ______
HB ______

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible signature]	HAROLD B. MUELLER	2141 [illegible]
[illegible signature]	[illegible]	[illegible]
[illegible signature]	TRYGVE AURE	1169 PRICKETT LN. BLGS MT
[illegible signature]	JERRY DAWSON	3206 37½ ST. W.
[illegible signature]	H.F. Grosgebauer	[illegible]
[illegible signature]	MALGER MAGUIRE	[illegible] KING AVE E BLGS MT 59
[illegible signature]	W. J. Koski	3941 [illegible] Drive Blgs MT 591
J.T. Loran	Jacob T. Loran	3202 North [illegible] Blgs 591
Donald J Powers	DONALD POWERS	4537 TOYON DR BLGS 5910

EXHIBIT ______

DATE ______

HB ______

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
William B Lyons	William B. Lyons	234 Fair Park Dr
Gerald L. Murphy	Gerald L Murphy	420 Nelson Dr

EXHIBIT ____

DATE ____

HB ____

PETITION

We, the undersigned, do hereby support the passage of SB 346 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Cheryl Oliver	Cheryl Oliver	1254 yellowstone #C4
Kasey A Jones	Kasey Jones	41029 Robbins hollow
George Angeles	GEORGE ANGELES	2010 Northridge Billings MT
Bernice Larson	BERNICE LARSON	3114 Silver Sage Trail Billings MT
Marg McPhail	Marg McPhail	4439 Audubon Way Billings
Sue Zeeck	Sue Zeeck	484 Crumspring
Chloe Houchen	CHLOE HOUCHEN	1824 Colonial Dr
Martin Fisher	MARTIN FISHER	1116 N 30th Bldg
Sue K. Kranz	Sue K. Kranz	1351 Hardrock Lane Bldg
Deborah Brown	Deb Brown	411 Stillwater
Enid Jensen	ENID JENSEN	165 Windsor Cano Bldg
Troy Scribner	TROY SCRIBNER	2040 Burnstead #20
Jeanne Kahle	Jeanne Kahle	3127 38th W Bldg MT
Jo Oberweiser	Jo Oberweiser	7105 Applewood Rd Shepherd MT 590
Ardella Mack	Ardella Mack	1218 Fox St W Billings MT 5910
Joanne Card	Joanne Card	2207 Pueblo Dr
D. Eugene Fletcher	D. Eugene Fletcher	1119 Primrose Billing MT 59105

EXHIBIT

DATE

HB

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
[illegible]	[illegible]	[illegible]

EXHIBIT ____

DATE ____

HB ____

PETITION

We, the undersigned, do hereby support the passage of SB [illegible] - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
W Tom Orr	W Tom Orr	4600 Cove Rd RT 10 Billings, MT. 59101
William D. Reefle	WILLIAM D REEFLE	1732 CLARK AVE BILLINGS MT. 59102
LeRoy E. Stewart	LeRoy E. Stewart	1734 Central Billings, MT 59102

EXHIBIT ____

DATE ____

HB ____

PETITION

We, the undersigned, do hereby support the passage of SB [illegible] - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Kirk Hodges	KIRK HODGES	2040 BURNSTAD Ave, Bi
[illegible]	[illegible]	[illegible]
James C Young	James C YOUNG	133 Ave B Bigs
Kathy Kirkpatrick	Kathy Kirkpatrick	[illegible]
Douglas C Harlan	Douglas C Harlan	36 Harlan Bigs
[illegible]	[illegible]	[illegible]

— (647) to here —

EXHIBIT ____

DATE ____

HB ____

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Diane J. Taylor	DIANE TAYLOR	3221 ARVIN, BLG.
[illegible]	Linda [illegible]	3019 6th AVE N. #3
Theresa Baaisted	Theresa Baaisted	2931 Mantle Dr.
Ron Jones	Ron Jones	4629 Robbie
Debra McKeen Sparks	Debra McKeen Sparks	710 Moccasin
Mabel Brewer	MABEL BREWER	10 Birchwood
Vivian Norskog	VIVIAN NORSKOG	2016-13th ST. W.
Ellen Stroebe	Ellen STROEBE	2107 [illegible] St
Margaret A. Bayne	MARGARET A. BAYNE	3308 [illegible]
Louise Michels	Louise Michels	Box 426 Laurel, MT
Deborah d. Murari	Deborah d. Murari	3932 3rd Ave S Bills, MT 59101
Ruth Harvey	Ruth D. Harvey	2207 Spruce St.
Anne M. Hill	Anne Hill	1930 Forest Pk Dr
Kay Wilson	Kathryn Wilson	1146 Delphinium Dr.
Margaret Thomas	Margaret Thomas	2531 Lewis Ave
John J. McGahan	John J. McGahan	3104 Gregory Dr
Louise Murray	Louise Murray	105 Ave E.
Sr. Kate Dorsey	Kate DORSEY	210 So 34th Blg
Pam Bromenshenk	Pam Bromenshenk	510 Suttler Circle
Evelyn Funk	Evelyn Funk	3009 Illinois St
Donald Brown	Donald Brown	1043½ Terry
Evelyn C Svingen	Evelyn C Svingen	2730 Downer Ln
Bruce A. Abbott	BRUCE A. Abbott	2026 Ave D Billings
Hazel Henry	Hazel Henry	906 1st ave - Laurel

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Robert A Dobson	ROBERT A. DOBSON	4509 Audubon Way, Billings
Betty Jo Robson	BETTY JO ROBSON	521 Coliseum Billings
Arthur J Berube	ARTHUR J. BERUBE	508 Ave C Billings
David A. Schopp	DAVID A. SCHOPP	406 West 8th Laurel MT
LaTisha D Wells	LaTisha D. Wells	3285 Canyon Dr #73 B
Duane D Halverson	DUANE D HALVERSON	4116 Juneau Dr Billings
Claudia K Sieler	CLAUDIA K SIELER	3336 CLARK - BILLINGS, MT 59
Victoria Lee Bailey	Victoria L. Bailey	529 West G. Rd. Huntle 5903
Linda Waska	LINDA WASKA	4510 Morgan Ave Blgs
Sister Anita Sullivan	SISTER ANITA SULLIVAN	608 Wyoming Blgs
Sister Linda Dean	Sister Linda Dean	216 N 31st. Blgs
Sister Mary Ann Theisen	Sister Mary Ann Theisen	608 Wyoming Blgs 59
Irene Aure	Irene Aure	620 Hillview 59
Barbara Husehy	BARBARA HUSEHY	2001 Dolor Rd,
Kathleen A Warren	KATHLEEN A WARREN	916 15th ST. W- Bi 59
Louella Rhodes	LOUELLA RHODES	517 KALLEN Bill 59
Helen Uffelman	Helen Uffelman	Box 2380 Hardin
Debbie Greenfield	Debbie Greenfield	364 Aristocrat Bil

EXHIBIT

DATE

HB

EXHIBIT____
DATE____
HB____
Page 42 of ___

PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE	PRINTED NAME	ADDRESS
Wayne R. Mulkey	WAYNE MULKEY	Kinsey Rt. Miles City
Benito Miranda	BENITO MIRANDA	1441 GRANITE
Mary O. Butler	MARY O. BUTLER	525 O'Neil
Virginia Tenge	VIRGINIA TENGE	943 [illegible]
JOHN E TENGE	JOHN E. TENGE	✓
Ross Lemire	Ross Lemire	3010 Brentwood
Sylvia Turco	Sylvia Turco	2223-24th St W
Rita C. Lemire	Rita C Lemire	3010 Brentwood
Jo A. Albin	Jo Albin	[illegible]
Esther [illegible]	Esther [illegible]	2038 Colton Blvd
Dinny Bennett	Dinny Bennett	Box 2350 Colstrip MT
Cindy Bennett	Cindy Bennett	Box 2350 Colstrip MT
Amelia C. Hadley	AMELIA C. HADLEY	2526 [illegible]
Jennifer Vashro	JENNIFER VASHRO	1101 N. 24th
Jeanne M Meyer	JEANNE M MEYER	1108 Sunnyview Ln #
Tom Hartung	Tom Hartung	211 Broadwater
Linda Quintrell	Linda Quintrell	1134 Harvard
Dorita Adolph	Dorita ADOLPH	203 Parkhill
Laura J Padke	Laura J Padke	2013 Ave D
Beverly Dunn	Beverly Dunn	603 [illegible] Ave
Sister Mary Antoinette Thomas	Sister Mary Antoinette Thomas	608 Wyoming
Sister Mary Ann Petrich	SISTER MARY ANN PETRICH	216 N. 31st Bl
Sister Rosemary Kolich	SISTER ROSEMARY KOLICH	2703 Gregory Drive
Sister Mary Kallman	Sister Mary Kallman	216 North 31 Street
[illegible]	[illegible]	[illegible]

MONTANA WOMEN'S LOBBYIST FUND

P.O. Box 1099 Helena, MT 59624 406/449-7917

Testimony in Support of SB 124
Before House Human Services Committee
March 3, 1989

Madame Chairwomen and members of the committee,

My name is Sandy Hale and I appear on behalf of the Montana Women's Lobby in support of SB 124.

Montana Women's Lobby endorses measures to prevent the human and economic loss relating to AIDS. We support the adoption of a strong and comprehensive state-level AIDS policy including:

1. Provision for adequate resources and funding for prevention, education and direct care;

2. Opposition to mandatory testing;

3. Provisions for informed consent, adequate counseling and confidentiality in conjunction with HIV antibody testing; and

4. Protection for infected and high risk individuals from discrimination.

By prohibiting HIV-related condition discrimination in health care facilities, we are taking one step to assure that those who desperately need care, will not be shut out, because of fear, ignorance or a misguided sense of invulnerability.

Like it or not, the people that will be protected by this bill are not strangers, but our sons and daughters, our uncles and aunts, our brothers and sisters. They are the people who need to be close to caring families and support systems as they struggle to survive in the face of a momentarily insurmountable disease. We must voice our intolerance of discriminatory practices against AIDS victims, whether in workplace, our schools or the admissions office of a health care facility.

Montana Women's Lobby applauds Senator Hager's sponsorship of SB 124 and urges a "do pass" recommendation from this committee.

EXHIBIT 8
DATE 3-3-89
HB 124

House Committe on Human Services and Aging
Testimony of Anne L. MacIntyre, Administrator
Human Rights Division
In support of Senate Bill 124

I support Senate Bill 124 but would like to propose some amendments.

Title 49 of the Montana Code already has provisions which prohibit discrimination on the basis of handicap in employment, housing, public accommodations, education, financing and credit transactions, and government services. The Human Rights Division has taken the position that these laws prohibit discrimination against someone who has an HIV-related condition. This interpretation is similar to the position taken by the federal courts and agencies in interpreting federal handicap laws. I am concerned that if the legislature carves out one area, such as health care facilities, to say that providers cannot discriminate on the basis of an HIV-related condition, it could open the door to an argument that the existing discrimination laws do not protect persons with HIV-related conditions.

The amendments I have prepared would clarify that any HIV-related condition is considered to be a handicap for purposes of the Human Rights Act (Title 49, chapter 2, MCA), which is the most comprehensive state law prohibiting employment discrimination. This would provide for a consistent approach between state and federal law. The amendments also have the advantage of making sure an enforcement mechanism exists so that persons with HIV-

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related conditions can file complaints with the Human Rights Commission if they are denied admittance to a health care facility. This would be the case because a health care facility would be considered a "public accommodation" for purposes of §49-2-101(17), MCA. Under the bill as it presently exists, the only enforcement mechanism would be for the Health Department to seek an injunction.

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Amendments to Senate Bill 124
Third reading copy
Requested by Human Rights Division

Prepared by Anne L. MacIntyre
March 3, 1989

1. Page 1, line 7.
Following: "HIV-RELATED CONDITION;"
Insert: "ESTABLISHING THAT AIDS AND OTHER HIV-RELATED CONDITIONS ARE CONSIDERED TO BE PHYSICAL HANDICAPS FOR PURPOSES OF DISCRIMINATION LAW;"

2. Page 1, line 12.
Following: "facility"
Insert: ", including admissions,"

3. Page 1, lines 16 through 18.
Strike: Subsection (a) in its entirety
Insert: "(a) For the purposes of subsection (1) and the laws prohibiting discrimination set forth in Title 49, an HIV-related condition is considered to be a physical handicap."

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Manning

Amendments to Senate Bill No. 129
Third Reading Copy

For the Committee on

Prepared by Greg Petesch
February 21, 1989

1. Page 27, line 4.
Following: line 3
Insert: "NEW SECTION. **Section 18. Coordination.** If [this act] and SB 70 are both passed and approved, the amendment to 40-4-204, MCA in SB 70 is void."
Renumber: subsequent sections

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Montana Association of Churches

MONTANA RELIGIOUS LEGISLATIVE COALITION • P.O. Box 745 • Helena, MT 59624

March 3, 1989

CHAIRWOMAN HANSEN AND THE HOUSE HUMAN SERVICES COMMITTEE:

I am Mignon Waterman of Helena and I represent the Montana Association of Churches.

We support the concept embodied in SB129 that parents, mother and father alike, should assume financial responsibility for their children. It is only through strict child support decrees and enforcement that adequate child support can be ensured.

Once again, we believe recommendations like this will help reduce public assistance costs in Montana while not adversely hurting Montana's low income individuals.

We support the concept of SB129.

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Senate Bill 129
House Human Services Committee
March 3, 1989
LWVM Contact: Chris Deveny
442-2617

Madam Chair, members of the committee, my name is Christine Deveny, here today representing the League of Women Voters of Montana, and here to support Senate Bill 129.

In keeping with its historic involvement with the issue of child welfare, the National League of Women Voters recently completed an extensive study of the unmet needs of our nation. The study draws attention to the fact that only one-third of all single mothers receive the full amount of their court-awarded child support. In many cases that child support payment could be the major financial resource that keeps households headed by single parents from needing AFDC payments to meet basic living needs. Those households with limited financial resources are the ones who most need dependable, regular child support payments to enable them to be self-sufficient without relying on AFDC payments.

The provision of Senate Bill 129 requiring automatic withholding of child support payments is a positive step toward ensuring that non-custodial parents meet their financial responsibilities toward the support of their dependant children. Assurances that adequate child support payments will be made on a regular schedule should reduce the number of households that need AFDC assistance.

The League strongly supports the changes in Section 1 subsection 2 that call for the courts to consider the child's medical needs and day care costs when setting child support payment amounts. The cost of quality child care and medical expenses can be a significant porportion of the overall amount needed to provide for a child, and must be considered when setting child support payments.

The League of Women Voters urges the committee to give a "do pass" recommendation to Senate Bill 129. Thank you.

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SECTION 1. Section 40-4-204, MCA, is amended to read:

40-4-204. Child support - orders to address health insurance - warning of withholding procedures. (1) In a proceeding for dissolution of marriage, legal separation, maintenance, or child support, the court may order either or both parents owing a duty of support to a child to pay an amount reasonable or necessary for his support without regard to marital misconduct, after considering all relevant factors including:

(a) the financial resources of the child;

(b) the financial resources of the custodial parent;

(c) the standard of living the child would have enjoyed had the marriage not been dissolved;

(d) the physical and emotional condition of the child and his educational needs;

(e) the financial resources and needs of the noncustodial parent; and

(f) the medical or health insurance needs of the child as required under subsection (3) and the financial ability of the parent to provide such insurance; and

(g)~~(f)~~ for the purposes of determining a minimum amount for support, the amount received by children under the AFDC program, as defined in 53-2-702.

(2) If the court does not order a parent owing a duty of support to a child to pay any amount for the child's support, the court shall state the reasons for not ordering child support.

(3) Each district court judgment, decree, or order establishing a final child support obligation under this title and each modification of a final order for child support must include a provision addressing health insurance coverage in the following cases;

(a) If either party has available through an employer or other organization health insurance coverage for the child or children for which the premium is partially or entirely paid by the employer or organization, the judgment, decree, or order may contain a provision requiring that coverage for the child or

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children be continued or obtained.

(b) In the event that health insurance required in a child support judgment, decree, or order becomes unavailable to the party who is to provide it through loss or change of employment or otherwise, that party must, in the absence of an agreement to the contrary, obtain comparable insurance or request that the court modify the requirement.

(c) All temporary child support orders must contain a provision requiring the party who has health insurance in effect for the child or children of the parties to continue the insurance coverage pending final disposition of the case.

(d) The parties may by written agreement provide for the health care coverage required by this section, subject to the approval of the court.

(e) Unless otherwise provided in the decree, the health care coverage required by this section is in addition to and not in substitution, in whole or in part, for the child support obligation.

(f) If the department of revenue is enforcing a support order for a child pursuant to Title IV-D of the Social Security Act, upon notice by the department, the non-custodial parent shall obtain and maintain health insurance coverage as provided in this subsection. Such insurance must be provided even though it may reduce the amount of the child support obligation determinable under this section, or have the effect of reducing the non-custodial parent's ability to pay the child support as ordered. Unless the noncustodial parent is already required to provide insurance coverage by court order, this insurance is in addition to:

(i) Any order requiring a parent to maintain insurance;

(ii) Any agreement that the other parent will maintain insurance; or

(iii) Any failure of the decree, order or modification to require insurance coverage.

The non-custodial parent shall provide to the department the name of the insurance carrier, the policy identification

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names(s) and number(s), the name(s) of the person(s) covered, and any other pertinent information regarding coverage.

~~(4)---Each-district-court-judgment-or-order-establishing-a child-support-obligation-under--this-title,--whether-temporary-or final,--and--each--modification--of--an--existing-order-for-child support-entered-after-October-1,--1985,--must--include--a-warning statement-that--if-the--obligor-is--delinquent-in--the-payment-of support,--the---obligor's--income---may--be---subject--to--income withholding-procedures--under-Title--40,-chapter--5,-part-3-or-4. Failure-to--include-a--warning-statement--in-a--judgment-or-order does-not-preclude-the-use-of-withholding-procedures.~~

(4) Each district court judgment or order establishing either a child support obligation or an insurance obligation as provided under this section, whether temporary or final and each modification of an existing order for child support or insurance coverage must include:

(a) in the case of a child support order or modification entered after October, 1, 1985, a warning statement that if the obligor is delinquent in the payment of support, the obligor's income may be subject to income withholding procedures under Title 40, chapter 5, part 3 or 4;

(b) in the case of an order for insurance or modification of an order for insurance entered after October 1, 1989, a statement that if the child is or becomes a recipient of public assistance, and the insurance coverage is being enforced by the department of revenue, then failure to maintain insurance coverage or failure to provide information to the department regarding the insurance coverage may result in the imposition of sanctions under 40-5-208.

(c) The failure to include either statement in a judgment or order does not preclude the use of withholding procedures or sanctions.

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SECTION 2. Section 40-5-208, MCA, is amended to read:

40-5-208. Medical support obligation enforcement. (1)(a) In all proceedings initiated pursuant to this part, the department must require parents obligated to pay child support to secure and maintain health insurance coverage for each dependent child, ~~at a cost not to exceed 5% of net income~~, whenever such health insurance is available through their employment, or other group health insurance plan. However, if a court of competent jurisdiction has entered an order establishing a current support obligation and has ordered the obligated parent to secure and maintain health insurance coverage for each dependent child, the department shall enforce the obligation as ordered by the court.

(b) The obligor shall provide to the department the name of the insurance carrier, the policy identification names(s) and number(s), the names(s) of the person(s) covered, and any other pertinent information regarding coverage.

(c) Such insurance must be provided even though it may reduce the amount of the child support obligation which may be established under this part.

(d) Every order for child support established under this part shall contain a statement to the effect that failure to obtain and maintain health insurance coverage, or failure to provide information to the department regarding the insurance coverage may result in the imposition of sanctions under this section. Failure to include the warning does not preclude the imposition of sanctions.

(2) If the department determines: ~~that an obligated parent has failed to maintain health insurance coverage required by the order of a court of competent jurisdiction or an administrative agency empowered to enter such order;~~

(a) that an obligor has failed to obtain or maintain health insurance coverage required under 40-4-204;

(b) that an obligor has failed to obtain or maintain health insurance coverage under this section; or

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(c) that an obligor has failed to provide information required under either this section or 40-4-204, the department ~~it~~ may issue a notice commanding the parent to appear at a hearing held by the department and show cause why a sum of not more than $100 should not be assessed for each month health insurance coverage is not secured or maintained~~;~~ or for each month information is not provided.

(3) If the department finds, after hearing or failure to appear, that health insurance coverage has not been secured or maintained ~~in--accordance-with-the-court-or-administrative-order~~, or the obligor has failed to provide the information as required, the department may assess against the ~~obligated-parent~~ obligor not more than $100 for each month health insurance coverage has not been secured or maintained~~;~~, or for each month information has not been provided. Such amount may be enforced by any administrative remedy available to the department for the enforcement of child support obligations including warrant for distraint provided for in 40-5-241, and income withholding, provided for at Title 40, chapter 4, part 4.

~~(3)--Whenever-an-obligated-parent-who-has-been-served-with notice-under-this-section-appears-before-the-department-and-shows that-health-insurance-coverage--in-accordance--with-the--court-or administrative-order;~~

~~(a)-has-been-secured-and-maintained-continuously-since-the date-of-the--order;--the--department--shall--dismiss--the-pending action;-or-~~

~~(b)---has-not--been-secured-or-continuously-maintained-but such--coverage--is--presently--in--effect;--the--department-shall suspend-the-pending-action-for-a-period-of-12-months;~~

~~(4)---At-the--end-of-the-suspension-period;-the-department may-schedule-a-hearing;--If-at-this-hearing-the--department-finds that-during-the-suspension-period-health-insurance-coverage;~~

~~(a)----has--been--continuously--maintained;-the-department shall-dismiss-the-pending-action-and--the-obligated--parent-will not-be-assessed-under-this-section;-or~~

~~(b)---has-not-been-continuously-maintained;-the-department~~

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may-enter-a-final-order-requiring-the-obligated-parent-to-pay-the sum--assessed--in--accordance--with--this--section-for-each-month coverage-was-not-maintained.

(4)~~(5)~~ Any amounts collected pursuant to this section must be returned to the general fund to help offset expenditures for medicaid.

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GUIDE FOR DETERMINATION OF CHILD SUPPORT OBLIGATIONS

Prepared by

Montana Child Support Advisory Council

October 1, 1985

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DATE 3-3-89
HB 129

I

Introduction

The statutory standards for determining child support obligations in Montana are contained in M.C.A. Sections 40-4-204 and 40-6-116 for dissolution of marriage proceedings and paternity actions. Although these standards offer broad guidance to persons involved in the establishment of child support obligations, the standards do not explain how to apply the standards to specific child support actions. The major purpose of this guide is to produce a uniform and equitable approach to applying the standard that is predictable, reasonable, simple to calculate, and which reflects the duty of both parents to support their children commensurate with their ability.

The economic principles underlying this guide are founded upon a formula developed by the Institute for Court Management of the National Center for State Courts.[1] In concept, the formula is based on economic evidence that the costs of a child can be accurately depicted as a proportion of family income consumption. This proportion remains relatively consistent but does change predictably with changes in the level of household income and with the number and ages of the children. The formula, in turn, converts this data into percentages of net family income which are computed into a child support obligation.

This guideline calculates child support as a share of each parent's income estimated to have been spent on the child if the parents and child were living in an intact household. If one parent has custody, the amount calculated for that parent is presumed to be spent directly on the child. For the non-custodial parent, the calculated amount establishes the level of child support. For cases with split custody, or extensive sharing of physical custody, each parent's share of child support becomes the basis for determining his or her legal child support obligators.

II

Use Of The Guideline

The guideline is designed for proper application to a broad range of cases and therefore is intended only to create a rebuttable presumption of the reasonableness of the child support obligations. As is true with any system, the application of this guide may not produce a child support payment that is fair or adequate in every instance. In applying the guide as a baseline from which to proceed, the parties or the court may make adjustments either upward or downward to reflect a particular inconsistent circumstance. The burden of showing why such deviation from the guide should be made, will be on its proponent. Any departure from the guide should be accompanied by a written statement which gives the reasons for deviation form the guide's direct application.

III

Determination of Child Support Amount

Part 1. Determination of gross income for each obligor parent.

In the determination of child support obligations the explicit policy of this guideline is to make available for the benefit of the child(ren) sufficient funds to provide the standard of living the child would have enjoyed had the marriage not been dissolved. Accordingly, all income, from whatever sources, including business expense account payments for meals and automobiles to the extent that they provide the parent with something he or she would otherwise have to provide, will constitute gross income. Also to be included are such income as pensions, dividends, interest, trust income, proceeds from contracts, and so forth.

AFDC and other welfare benefits being received by an obligor parent are not to be included as income. In those cases where obligor parents are receiving Veterans Administration Disability, Supplemental Security Income, or other private disability benefits, they should be required as part of any court ordered support obligation to apply for those program benefits their children are entitled to receive. Depending on case-by-case circumstances, these benefits may replace in whole or in part any child support obligation.

All income should be annualized and copies of the last two years' tax returns should accompany financial statements as well as current wage stubs. Such annualization and examination of a two year period will provide a normalized pattern of income-producing abilities. Without such examination a temporary period of present unemployment or underemployment may indicate an unwarranted low amount of income available for support.

Part 2. Imputed or attributed income.

A particular problem exists for obligor parents who are voluntarily unemployed or underemployed. It is the policy of this guide that a parent will be excused from making a financial contribution only if he or she is physically or mentally incapacitated.

In cases where the obligor parent is not working or is not working at full earning capacity, the reasons for such a limitation on earnings should be examined. If the reason is a matter of choice, the local job market should be reviewed to determine what a person with the obligor parent's trade skills and capabilities could earn. Those typical earnings can then be imputed to the obligor parent for use in this guide. This approach is most useful when the obligor parent has a relatively stable and recent work history. The approach can also be used when the obligor parent has minimal skills and no work history by ascribing earnings based on a minimum wage for a full work week.

Alternatively, when the obligor parent is remarried to a person who is fully employed, and the obligor parent elects to stay at home as homemaker for the new spouse, a dollar value may be set which shall be considered as that obligor's parent's income. The value for homemaker services should be assessed at no less than the federal minimum wage level for a forty hour week.

Part 3. Income of current spouses.

Stepparents and other adult household members are not generally responsible for the support of children of prior marriages or relationships. Consequently, these guidelines do not take into account income from other adults who may reside with either of the separated obligor parents. However, for subsequent modifications of initial support awards, due consideration may be given the effect of shared expenses. That is, a current spouse's income might be counted as reducing the obligor parent's living expenses and might, therefore, increase on a case-by-case basis the amount of income available for child support.

Part 4. Assets as income.

Actual or imputed income may not be by itself an adequate measure of the obligor parent's ability to pay child support. The obligor parent, for example, may have savings, life insurance, vehicles, real estate, (other than permanent home), collections, and other assets in amounts unrelated to income. Unless account is taken of these holdings, preferential treatment will be given the obligor parent and the child(ren) will correspondingly be denied a share. This is not to imply that there must be a forced sale of these assets but that their dollar value be counted in determining funds available for support. Consequently, an amount equal to two (2)

[1]For a detailed explanation of the economic evidence see Robert G. Williams, *Development of Guidelines for Establishing and Updating Child Support Orders* (National Center for State Courts; Denver, June 1985).

percent of the total value of the obligor parent's assets is to be added each month to that parent's total monthly income. The obligor parent can later decide whether, in fact, to liquidate assets or to make other expenditure adjustments to compensate.

The assessment of assets should exclude from consideration such non-income and non-depreciable producing assets of "reasonable" value such as a permanent home, farm land, furnishings, and one automobile. Also excluded should be income producing assets such as real property in the form of a farm or business, vehicles, tools, or instruments used to produce a primary source of income.

Part 5. Determining net income available for support.

The implementation of the policy of keeping primary focus on the needs of the child(ren) requires that from each obligor parent's income only a minimum of exclusions be allowed. Therefore, from gross income only the following are subtracted as deductions: federal and state income taxes; FICA; union dues, retirement contributions, uniforms, etc., which are required as a condition of employment and are not reimbursed by the employer; legitimate business expenses; and health insurance if the benefits are maintained for the obligor parent's dependents, including the child(ren) of the action at hand.

Child support payments owed for children of the obligor parent not of the union between the parents in this case which are actually being paid are being withheld from the obligor parent's wages by involuntary wage assignment or other similar legal process, may be excluded from gross income to the extent that such withholding actually occurs.

Deductions made by an employer from the obligor parent's wages for credit unions or merely for the convenience of the obligor parent will not be recognized.

Where income has been imputed to a stay-at-home homemaker, the permissible deductions will not be permitted since none are being made.

Part 6. Application of the formula.

For ease of use, the formula is manifested by a table which has a series of percentages differing by income level, number of children, and age of children. To determine child support from this table, the net income of the two parents is added together. This sum is then compared to the income level column, and the line showing the number and age of the children to arrive at a percentage figure. This percentage is then applied separately to each parent's income to establish in dollar amounts the support obligation for each parent.

For example, father and mother are divorced. Neither has remarried. Father nets $7,849 annually; mother nets $6,600. The combined income is $14,448. Their only child, age 2, lives with mother. Referring to the table, child support is calculated as 19.7%, a support obligation of $128.85 results for father and $108.35 for mother. Since mother is the custodial parent, the $108.35 is retained by her. It represents the amount that is presumably spent directly on the child in the custodial household. The obligation of $128.85 per month incurred by the father is payable as child support to the mother.

Part 7. Custody arrangements.

Under these guidelines a total child support obligation is calculated separately for each parent without initial regard to custody. Subsequent to such determination, in sole custody arrangements the custodial parent for all the children will retain his or her share of the support obligation and the non-custodial parent pays his or her share to the custodial parent. If there is split custody of the children, each parent shall retain the share of the total child support owned to the child in his or her custody and pay the difference, if any, to the other parent for children in the other parent's custody.

When the obligor parents share joint physical custody (both parents have custody of the children more than 30% of a 365 day period), to avoid unnecessary transfers of funds, the "pay over" of each parent for the year should be determined by multiplying the monthly support obligation times the number of months the parent has custody. If one parent's yearly obligation is greater than that owed by the other, the excess amount shall be divided by 12 and paid monthly over the year.

For example, Parent A's support obligation is $300 per month and Parent B's obligation is $100. Parent A has custody for 4 months of the year and Parent B has the child for the remainder. Thus, over a year, Parent A would pay to Parent B $300 times 8 months or $2,400; and Parent B would pay Parent A $100 times 4 months or $400. Accordingly, Parent A owes $2,000 per year more than Parent B owes to Parent A. To meet this obligation, Parent A should pay to Parent B $166.66 per month ($2,000 divided by 12 months).

For cases involving joint physical custody, the table presumes that direct expenses are incurred in approximate proportion to the duration of physical custody. This presumption should be reviewed carefully in the application of the table since some expenses may not be borne proportionately. For example, the parent having custody of the child during the major part of a school term may incur additional expenses for clothing, books, recreation, and so forth. Adjustments may be made in the amounts calculated from the table to reflect any such disparity.

Part 8. Age adjustments.

Studies of household expenditure patterns have found that spending levels for children are related to their age. The table makes provisions for only two age brackets: 0-11 and 12-17. This is based on a general consensus that expenditures increase markedly for children in the twelve to seventeen range. The table thus has an advantage of concentrating higher child support awards during the teen years when the need for augmentation or "teenage premiun" is greatest.

When the ages of the children require use of more than one line from the table, locate the per-child percentage from the correct age grouping and then divide the percentage by the number of children to get the percentage of the obligor parent's income allocated to that child.

For example, the combined net income of the parents of a 7 year old child and a 14 year old is $20,000. The percentage for two children age 7 is 27.1% which is divided by two to arrive at a figure of 13.55% of net income for the 7 year old child. Likewise, the percentage for two 14 year olds is 33.5% which yields an obligation of 16.75% of net income for the other child thus the total obligation would be 30.3% of the parent's net income.

Part 9. Low income parents.

Regardless of the presumptive level derived from the table, an obligor should not be held to his or her full application of the table percentage if to do so would reduce the parent's standard of living below the poverty line. Where this will occur, child support should be established on a case-by-case basis. Except in unusual adverse circumstances, a minimum order of no less than $50.00 should be set in all cases to establish the principle of payment and to lay the foundation for increased orders when the parent's income increases.

Part 10. Health insurance.

Under state law, every decree, judgment or order establishing a child support obligation and every modification of an existing order must include a provision requiring the parents to obtain medical insurance on the child in addition to the child support obliga-

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tion. If health insurance on behalf of the child is carried by a parent, the parent's net cost of the child's share of the premium is allowed as a deduction from gross income.

Insurance deductibles, medical, dental, and optical expenses which are not covered by insurance should be pro-rated between the parents based on the net income of each.

Part 11. Extraordinary medical expenses.

Any extraordinary medical expenses which are likely to be reoccuring during the minority of the child should be pro-rated between the parents and added to the basic child support obligation. Extraordinary medical expenses include physical therapy, special education, mental disorders, and any other uninsured chronic health problems which are likely to occur on a periodic basis.

The amount to be paid each month for extraordinary medical expenses may be determined by adding a monthly average of past costs if future costs are expected to be comparable, or by adding extraordinary medical expenses to the child support obligation on a monthly as-incurred basis with the custodial parent billing the non-custodial parent accordingly.

Part 12. Child care expenses.

Work or training related child care expenses are a mutual responsibility of both parents and are to be apportioned between them based on their respective levels of net income. Because child care expenses may be of indeterminate duration, such expenses are to be considered as a supplement to the child support established by the table and are to be paid only during those times when child care expenses are actually being incurred. For this reason, orders establishing the dollar contribution of a parent toward child care costs should set this amount as a separate item in the order.

Determination of a monthly child care obligation for the purpose of this guide should be heard either upon annualized, average costs of receipted expenses, or, when the history of such expenses are not available, upon estimates based on the average necessary monthly costs of such services.

Part 13. Other dependents.

As regards the treatment of other dependents, this guide uses a "first mortgage" approach in which children of prior marriages or relationships are given priority over subsequent children. This policy is based on reason and economic theory. Both suggest that the problems of inadequate support for children of multiple relationships would be alleviated if parents were discouraged from having more children unless they were capable of contributing adequately to the needs of all their offspring. Consequently, if support is sought for children of a subsequent relationship when there is a preexisting order for a child born from a previous relationship, priority would be given to the earlier children born by subtracting the amount actually paid from the parent's net income base. (See Part 5). This diminishes the amount of parental resources available to support children from the subsequent relationship.

Likewise, when this guide is being used to reevaluate a prior child support order for modification, the position is taken that the parent's prior child support obligations have absolute precedence over the needs of a new family. A parent's plea that his or her new responsibilities are a change in circumstances justifying a reduction in a prior child support award will not serve as a basis for a reduction of support. Creation of the new family is a voluntary act and that parent should decide whether he or she can meet existing support responsibilities and provide for new ones before taking that step.

Part 14. Need for updating.

Even if a support order accurately reflects the needs of the child and the resources of a parent when it is initially set, changes in circumstances that inevitably occur with the passage of time can seriously erode its value and reduce the equity for the parties. As a result, these guidelines recommend that all support orders and support agreements contain a provision for biannual review on instance of either party of the support obligation. The review should be made by reapplication of this guideline. Doing so will take into account changes in all factors considered by the guidelines rather than focusing on only one or two variables.

SUPPORT GUIDELINES TABLE

	$0 – $4,499	$4,500 – $8,499	$ 8,500 – $12,249	$12,250 – $16,499	$16,500 – $19,999	$20,000 – $27,999	$28,000 – $39,499	$39,500 +
One Child								
0-11	21.8	21.8	21.4	19.7	18.0	17.4	16.3	13.6
12-17	27.0	27.0	26.5	24.4	22.3	21.5	20.2	16.8
Two Children								
0-11	33.8	33.8	33.2	30.7	28.0	27.1	25.3	21.1
12-17	41.8	41.8	41.0	38.0	34.6	33.5	31.3	26.1
Three Children								
0-11	42.4	42.4	41.5	38.4	35.1	33.8	31.7	26.5
12-17	52.4	52.4	51.3	47.5	43.4	41.8	39.2	32.8
Four Children								
0-11	47.7	47.7	46.8	43.4	39.6	38.2	35.7	29.8
12-17	59.0	59.0	57.9	53.6	48.9	47.2	44.1	36.9
Five Children								
0-11	52.1	52.1	51.1	47.3	43.2	41.6	38.9	32.6
12-17	64.4	64.4	63.1	58.4	53.4	51.4	48.1	40.3
Six Children								
0-11	55.7	55.7	54.6	50.5	46.2	44.5	41.6	34.9
12-17	68.9	68.9	67.5	62.4	57.1	55.0	51.4	43.1

For children in different age categories, pro-rate based or total number of children. Example: for one child age 7, one age 14, annual income of $18,000; use percentages for two children, divided by two — (28.0 / 2) + (34.6 / 2) = 31.3.

WORK SHEET #1
FOR
DETERMINATION OF CHILD SUPPORT

	Mother	Combined	Father
1. Gross Income (annualized)			
a. earnings			
b. imputed income			
c. percent of asset value			
d. other			
e. TOTAL			
2. Deductions (annualized)			
a. taxes			
b. FICA			
c. union dues			
d. mandatory retirement			
e. mandatory health insurance			
f. child support preexisting			
g. medical insurance paid in behalf of child(ren)			
h. other			
i. TOTAL			
3. Net Available Resources (line 1e minus line 2i)			
4. Combined Total Net Income			
5. Percentage from Table		%	
6. Each Parent's Obligation (line 3 x line 5)			
7. Monthly Support Obligation (line 6 divided by 12 months)			

WORK SHEET #2
FOR
CHILD CARE COSTS

	Mother	Combined	Father
1. Costs of Child Care (annualized)			
2. Net Available Income			
3. Combined Net Income			
4. Pro-rata share (line 2 divided by line 3)	%		%
5. Parent's Share of Costs (line 4 times line 1)			
6. Monthly Child Support Obligation (line 7, Worksheet #1)			
7. Child Support With Child Care Costs (line 5 plus line 6)			

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MONTANA HOSPITAL ASSOCIATION 1720 NINTH AVENUE • P.O. BOX 5119 HELENA, MT 59604 • (406) 442-1911

TESTIMONY ON HOUSE BILL 741

BY

MONTANA HOSPITAL ASSOCIATION

EXHIBIT 15
DATE 3-1-89
HB 741

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS JAMES AHRENS, PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. I REPRESENT AN ASSOCIATION OF 54 HOSPITALS THAT IS UNITED AS NEVER BEFORE IN ITS THEIR OPPOSITION TO HOUSE BILL 741. THIS IS BY FAR THE MOST TROUBLING BILL TO BE INTRODUCED THIS SESSION. IT IS TROUBLING FOR HOSPITALS BECAUSE IT PLACES TREMENDOUS NEW BURDENS ON THEM AT A TIME WHEN MANY ARE STRUGGLING TO REMAIN OPEN ANOTHER DAY. IT SHOULD BE TROUBLING TO ALL MONTANANS BECAUSE IT PRODUCES A THREAT TO THE FUTURE VIABILITY OF THE HEALTH CARE DELIVERY SYSTEM IN THE STATE. IN THE LAST EIGHT (8) YEARS, 621 HOSPITALS HAVE CLOSED IN THE UNITED STATES. WE HAVE LEARNED THAT WHEN A HOSPITAL IN A ONE-HOSPITAL TOWN CLOSES, THE DOCTOR GENERALLY LEAVES TOWN NOT LONG AFTER. WHEN THE DOCTOR LEAVES, THE NURSING HOME CLOSES. NOT ONLY DOES THE TOWN SUFFER FROM THE LOSS OF PRIMARY AND LONG-TERM CARE SERVICES, BUT IT LOSES THE JOBS ASSOCIATED WITH THE HOSPITAL AND THE NURSING HOME. IT LOSES THE ABILITY TO ATTRACT NEW BUSINESSES AND NEW PEOPLE TO THE COMMUNITY. THIS BILL, IF PASSED, WILL CLOSE HOSPITALS IN MONTANA. I BELIEVE IT WILL CLOSE ENOUGH HOSPITALS TO CREATE AN ACCESS CRISIS IN THE STATE. IT WILL DAMAGE THE HEALTH STATUS OF

EXHIBIT_____
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THE POPULATION AND ADVERSELY EFFECT THE ECONOMIC DEVELOPMENT OF THE STATE.

FIRST I WILL TELL YOU WHY I BELIEVE THIS BILL WOULD CLOSE HOSPITALS, AND THEN I WILL EXPLAIN WHY I THINK IT IS NOT NECESSARY.

IN 1987, THE MOST CURRENT YEAR FOR WHICH WE HAVE STATISTICS, AVERAGE PATIENT MARGIN AT ALL MONTANA HOSPITALS WAS 1.7%. PATIENT MARGIN IS CALCULATED BY DIVIDING REVENUE LESS EXPENSE BY GROSS PATIENT REVENUE. A PATIENT MARGIN OF 1.7% MEANS THAT, ON THE AVERAGE, MONTANA HOSPITALS MADE 17 CENTS ON EVERY 10 DOLLARS OF REVENUE. BUT AVERAGES ARE DECEIVING. HOSPITALS WITH FEWER THAN 30 BEDS HAD NET PATIENT MARGINS OF NEGATIVE 15.2%. IN OTHER WORDS, THESE HOSPITALS LOST $1.52 ON EVERY 10 DOLLARS OF REVENUE. TWENTY-FOUR OF 32 HOSPITALS UNDER 30 BEDS LOST MONEY ON OPERATIONS IN 1987. THE COST OF COMPLIANCE WITH THIS BILL COULD PUSH SOME OF THESE HOSPITALS OVER THE BRINK.

LOOK AT WHAT IS REQUIRED OF THESE HOSPITALS BY THE BILL. FIRST THEY HAVE TO PAY A HOSPITAL TAX FOR THE PRIVILEGE OF BEING REGULATED. THEN THEY HAVE TO SUBMIT TO BUDGET REVIEW, UNIFORM REPORTING, AND SPECIAL AUDIT REQUIREMENTS. THEY ARE SUBJECT TO MONEY PENALTIES FOR LATE OR NONCOMPLIANCE. ONE OF THE PROVISIONS OF THE BILL IS THAT IF THE COMMISSION QUESTIONS OR WANTS O VERIFY HOSPITAL DATA, IT HAS THE POWER TO ORDER FULL OR PARTIAL AUDITS "OF ALL RECORDS AND ACCOUNTS" TO CLARIFY OR VERIFY INFORMATION. THESE AUDITS WILL BE PAID FOR BY HOSPITALS.

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AND WHAT KIND OF RATES WILL THIS SYSTEM PRODUCE? THIS IS A RATE SYSTEM KNOWN AS AN ALL PAYER SYSTEM. UNDER IT, ALL PAYERS ARE TREATED EQUALLY, THAT IS EVERYBODY PAYS THE SAME RATES. A PROVISION OF THE BILL IS THAT MEDICARE WILL PAY NO MORE THAN IT WOULD HAVE PAID HAD IT REMAINED UNDER ITS OWN PAYMENT SYSTEM. IF YOU THINK ABOUT IT FOR A MINUTE, YOU CAN SEE WHAT THIS MEANS. IT MEANS ALL PAYERS WILL PAY AT RATES NO MORE THAN MEDICARE RATES. THE SINGLE MOST IMPORTANT FACTOR IN DRIVING SMALL RURAL HOSPITALS TO THE BRINK OF INSOLVENCY HAS BEEN THE MEDICARE PAYMENT SYSTEM, AND THIS BILL SUGGESTS THAT ALL PAYERS PAY ON THIS SAME BASIS. IN THE LAST SIX YEARS, THE MEDICARE MARKETBASKET, THE GOVERNMENT CREATED INDEX OF HOSPITAL GOODS AND SERVICES, HAS GONE UP 28%. MEDICARE RATE INCREASES HAVE GONE UP ONLY 14.9%. THERE IS A 13.1% SHORTFALL BETWEEN COSTS AND REIMBURSEMENT. WHAT ARE THE CONSEQUENCES OF THE SHORTFALL? IN 1986 ALL MONTANA HOSPITALS WROTE OFF $30.6 MILLION IN MEDICARE AND MEDICAID DISCOUNTS. IN A SINGLE YEAR, THAT AMOUNT JUMPED 38% TO $42.1 MILLION IN WRITE-OFFS. IN 1987, MEDICARE AND MEDICAID REPRESENTED 46.5% OF ALL HOSPITAL UTILIZATION. IF ALL PATIENTS HAD TO PAY ON THE BASIS OF MEDICARE RATES, THE WRITE-OFF IN MONTANA WOULD HAVE BEEN $90.5 MILLION IN 1987. ADJUSTING FOR THE CONTINUED SHORTFALL IN MEDICARE PAYMENT RATES THROUGH 1989, I ESTIMATE THAT THE WRITE-OFF WOULD BE $125 MILLION. THAT IS MORE THAN 4 TIMES THE SURPLUS RETAINED BY HOSPITALS IN 1987. MEMBERS OF THE COMMITTEE, AN ALL PAYER SYSTEM THAT PEGS PAYMENT RATES TO MEDICARE COULD CLOSE ALL OF THE HOSPITALS IN THE STATE.

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THERE WERE FOUR ALL PAYER RATE REVIEW STATES. EACH OBTAINED A WAIVER FROM HEALTH AND HUMAN SERVICES TO CONDUCT THEIR PROGRAMS. ONLY ONE STATE, MARYLAND, STILL MAINTAINS THE WAIVER. IN THE THREE STATES THAT CANCELLED THEIR WAIVERS (NEW YORK, NEW JERSEY, AND MASSACHUSETTS) 68 HOSPITALS CLOSED. THIS BILL SAYS THE COMMISSION WILL ATTEMPT TO OBTAIN A WAIVER FROM HEALTH AND HUMAN SERVICES, BUT EVEN IF IT DOESN'T RECEIVE ONE, IT WILL SET RATES AS THOUGH IT HAD ONE.

IS THIS BILL EVEN NECESSARY? EVERYONE AGREES THAT HEALTH CARE IS EXPENSIVE, BUT IN MONTANA WE ARE DOING OUR BEST TO KEEP COSTS LOW. THE PROPONENTS SAY THAT BETWEEN 1976 and 1983 HOSPITAL COSTS ROSE BY 195%. THAT MAY BE TRUE. DURING THAT PERIOD WE WERE ALL LOOKING AT AN OIL EMBARGO, THE IRANIAN REVOLUTION, AND CPI INCREASES OF DOUBLE DIGITS. THE COST OF EVERYTHING GREW AT RATES NEVER BEFORE WITNESSED. BUT SINCE THEN, BEGINNING IN 1984, HOSPITAL COSTS BEGAN TO MODERATE. HOSPITAL COSTS HAVE INCREASED AT AN AVERAGE RATE OF 6.3% AND GROSS PATIENT REVENUE HAS INCREASED AT AN AVERAGE RATE OF 5.5% SINCE 1984. WE SHOULD NOT BE PUNISHED NOW FOR RAPID INCREASES IN RATES SIX YEARS AGO.

FURTHERMORE, THE RATES WE DO CHARGE IN MONTANA ARE, BY COMPARISON, QUITE LOW. MONTANA RANKS 47TH IN THE COUNTRY IN TERMS OF COST PER STAY (EQUICOR). ACCORDING TO THE AMERICAN HOSPITAL ASSOCIATION, MONTANA RANKS 42ND IN MARK-UP RATIOS, A MEASURE OF PROFITABILITY.

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FINALLY, MADAM CHAIRMAN AND MEMBERS OF THE COMMITTEE, I CAN TELL YOU THAT I DON'T LIKE OPPOSING AARP. SENIOR CITIZENS AND HOSPITALS ARE A NATURAL CONSTITUENCY GROUP. THEY ARE OUR LARGEST CUSTOMERS, AND THEY RELY UPON US TO BE THERE WHEN THEY NEED US. THROUGHOUT THE STATE WE WORK CLOSELY WITH LOCAL SENIORS ORGANIZATIONS. THIS BILL IS NOT IN THEIR INTEREST. IF HOSPITALS CLOSE, RURAL HOSPITALS WILL BE THE FIRST TO GO. SMALL RURAL HOSPITALS SERVE A DISPROPORTIONATE SHARE OF THE ELDERLY. IF THESE HOSPITALS CLOSE, THE ELDERLY WILL HAVE TO TRAVEL TO SEEK CARE. MANY ARE NOT ABLE TO TRAVEL. THEY WILL POSTPONE RECEIVING CARE, OR FOREGO IT ALTOGETHER, IF IT IS NOT LOCALLY ACCESSIBLE.

INSTEAD OF FIGHTING AMONG OURSELVES, I SUGGEST WE SIT DOWN AFTER THE SESSION AND HOST A SERIES OF MEETINGS TO DISCUSS OUR MUTUAL CONCERNS.

THIS BILL WILL HURT HOSPITALS, BUT MORE IMPORTANTLY, IT WILL HURT THE ELDERLY AND HURT THE STATE, AND FOR THAT REASON, I URGE YOU TO VOTE DO NOT PASS ON HOUSE BILL 741. THANK YOU.

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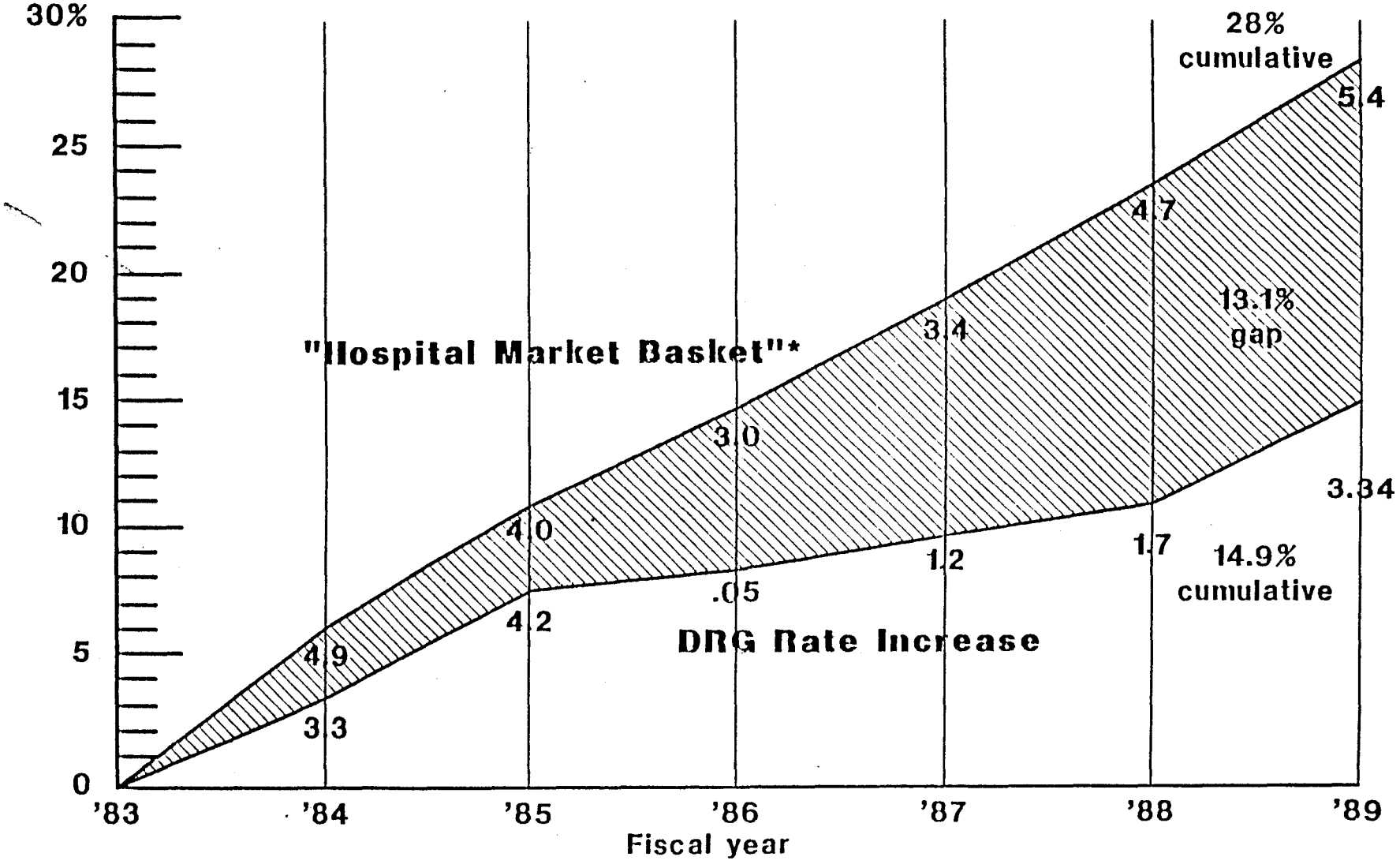
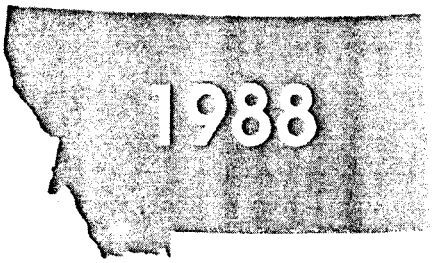
Medicare Payment Rates to Hospitals Aren't Keeping Up With the Cost of Providing Quality Care



AHA Data

*Hospital Market Basket represents the costs hospitals must pay for goods and services, such as nursing, equipment, mortgage, utilities, etc.



MONTANA HOSPITALS

AT A GLANCE

HOSPITAL PROFILES

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

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

Hospital Types

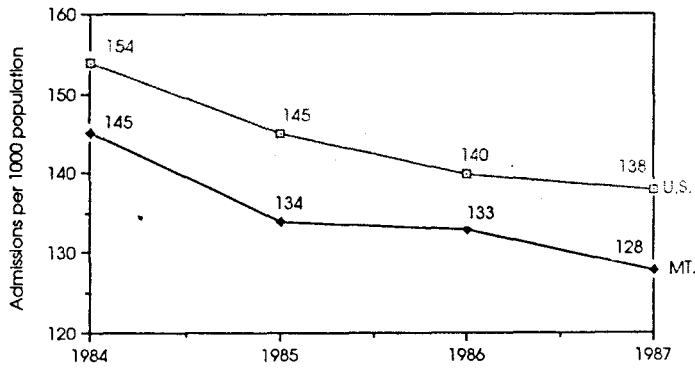
Total number of Montana Hospitals	65
By Bed Size	
190 and more beds	6
90-189 beds	8
30-89 beds	16
Fewer than 30 beds	35
By Primary Service	
General Acute Care	55
Urban (by Federal Designation)	4
Rural	51
Pyschiatric	3
Federal	6
Hospital/Nursing Home Combined Facilities	33
By Ownership	
Private, Not-For-Profit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

HOSPITAL UTILIZATION

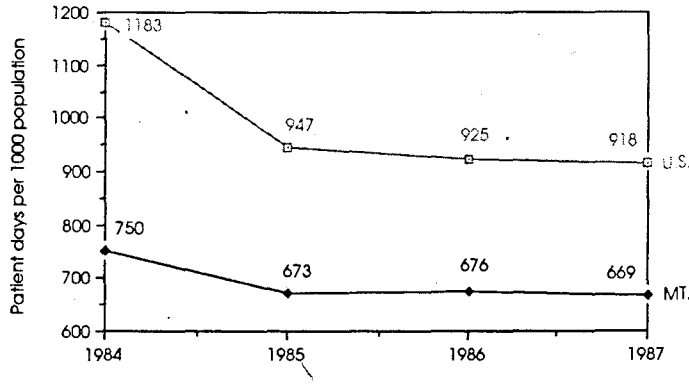
The information in this section of the report is based upon the results of a survey of 1987 utilization and financial data for 56 general, acute care hospitals. The survey was co-sponsored by the Montana Hospital Association, the Montana Department of Health and Environmental Sciences and the American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

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

Admissions per 1000 Population



Patient Days Per 1000 Population



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MONTANA HOSPITAL ASSOCIATION

EXHIBIT 15
DATE 3-3-89
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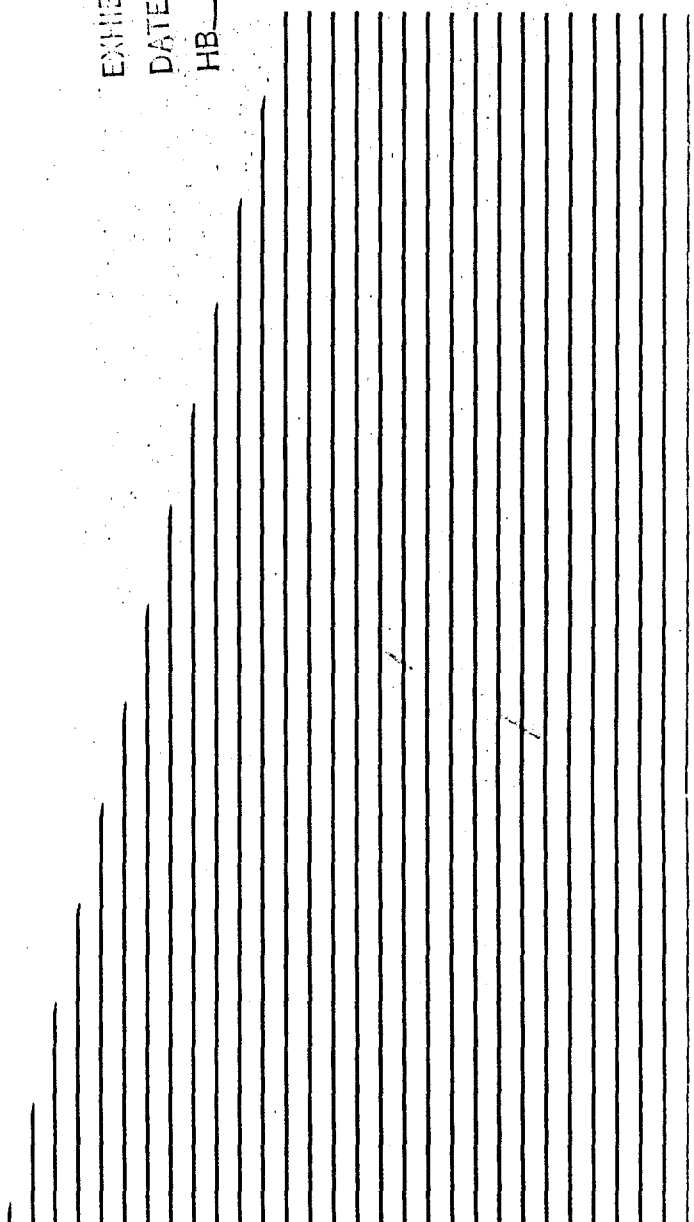
EQUICOR℠

EQUITABLE HCA CORPORATION

1987 Hospital Daily Service Charges

An Annual Report from EQUICOR



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Average Charge Per Stay - State Ranks

	1987 Average Charge Per Stay	1987 Rank	1986 Rank
DISTRICT OF COLUMBIA	7675	1	1
NEVADA	6624	2	7
HAWAII	6426	3	14
CALIFORNIA	6376	4	2
PENNSYLVANIA	5955	5	8
FLORIDA	5655	6	4
ILLINOIS	5186	7	6
ARIZONA	5153	8	11
MISSOURI	5095	9	15
COLORADO	4771	10	24
ALABAMA	4746	11	13
LOUISIANA	4630	12	16
MASSACHUSETTS	4577	13	5
NEW HAMPSHIRE	4571	14	25
CONNECTICUT	4512	15	11
MICHIGAN	4421	16	3
OKLAHOMA	4392	17	26
UTAH	4384	18	43
OREGON	4357	19	10
NEBRASKA	4236	20	38
MARYLAND	4207	21	35
OHIO	4202	22	18
GEORGIA	4160	23	31
TENNESSEE	4150	24	17
TEXAS	4147	25	22
VIRGINIA	4103	26	37
INDIANA	4089	27	41
NEW YORK	4032	28	9
WASHINGTON	3996	29	36
VERMONT	3958	30	30
SOUTH CAROLINA	3939	31	32
KANSAS	3853	32	29
WEST VIRGINIA	3770	33	40
NORTH DAKOTA	3726	34	42
IOWA	3707	35	45
NEW MEXICO	3627	36	20
MINNESOTA	3601	37	28
ARKANSAS	3574	38	24
NEW JERSEY	3510	39	33
KENTUCKY	3509	40	47
NORTH CAROLINA	3291	41	46
MAINE	3219	42	27
IDAHO	3217	43	49
SOUTH DAKOTA	3212	44	51
WISCONSIN	3119	45	39
MISSISSIPPI	3001	46	48
MONTANA	2944	47	44
DELAWARE	2939	48	21
WYOMING	2788	49	50
RHODE ISLAND	2749	50	23
ALASKA	2609	51	19

The isolation ward

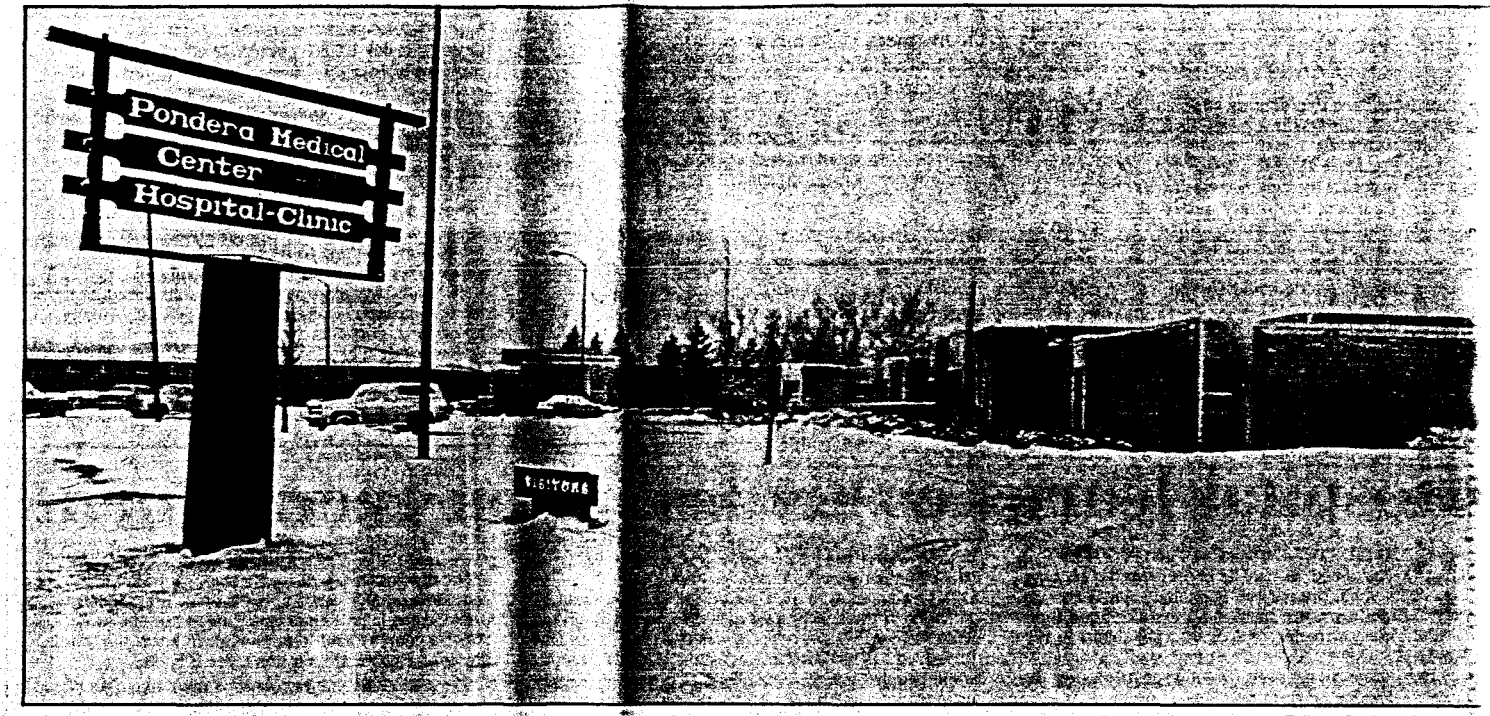
A Tribune special report on health care in rural Montana

Rural isolation intensifies when Montanans — sick, injured or pregnant — must leave their communities to find care.

With hospitals on the brink of financial failure and fewer doctors willing to practice in small towns, the well-being of some Montanans may be put in jeopardy.

In this special report, the Great Falls Tribune examines the fears and frustrations of those enmeshed in the rural health care industry. We identify the problems and attempt to isolate their causes. And finally, we take a look at some of the possible cures.

Stories by LINDA CARICABURU
Tribune regional editor



Tribune Photo by Stuart S. V

Montana's rural hospitals, like this one in Conrad, are struggling to maintain their position as the keeper of the people's health.

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

"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

state, where the occupancy rate averages about 30 percent. Even with fewer patients, hospitals must maintain housekeeping, dietary, nursing and lab staffs

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

about $3,000 per week. Similar "rent-a-nurse" progr 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 equipme 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 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 maintenan and backup systems, mandated by manufacturers a insurance companies wary of lawsuits.

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

Two years ago in Shelby, the Toole County Medic Center paid $15,000 for its malpractice insurance. La

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. SB 340 DATE 3/3/89

SPONSOR

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
[illegible]	Mont Hosp Assoc	✓	
L. McGovern	Mont Assoc. Phys	✓	
[illegible]	Trinity Hospital Whitehall	✓	
Jim Paquette	Saint Vincent Hosp	✓	
Callen K. Northam	Saint Vincent Hospital	✓	
Sandra Erickson	Providence Tx Center-Gt Falls Chemical Dependency Programs of Mt	✓	with ammendment
[illegible]	AARP	Ammend.	
Owen Warren	AARP	Ammend.	
[illegible] Warren	AARP.	Ammend.	
Charles [illegible]	Dept of Health & Environmental Sciences		
Jack Casey	Shodair Hosp.	✓	
[illegible]	Sheridan Memorial Hosp	✓	
[illegible]	[illegible]	✓	
Richard Brown	Liberty County Hospital	✓	
Jean G. Weeks	Volunteer St Pete	✓	
John Guy	St Peter's Hosp	✓	
Joan Ashley	MHCA Cooney Convalescent Home	with ammendment ✓	
Larry Akey	MT. Health Network	✓	
[illegible]	Mt Medical Assn	✓	
[illegible]	Mental Health Center	AMEND	
[illegible] MD	Private medical practice	✓	
Dale [illegible]	North Valley Hospital, Whitefish	✓	
Ann Scott	RMTC	✓ amend	
Rie Bellwood	Private Citizen	amend	

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

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

CS-33

	For	Against
Steve Browning Montana Hosp Assoc	X	