MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT

Call to Order: By **REP. BOB BACHINI, CHAIRMAN,** on February 1, 1991, at 8:00 A.M.

ROLL CALL

Members Present:

Bob Bachini, Chairman (D)
Sheila Rice, Vice-Chair (D)
Joe Barnett (R)
Steve Benedict (R)
Brent Cromley (D)
Tim Dowell (D)
Alvin Ellis, Jr. (R)
Stella Jean Hansen (D)
H.S. "Sonny" Hanson (R)
Tom Kilpatrick (D)
Dick Knox (R)
Don Larson (D)
Scott McCulloch (D)
Bob Pavlovich (D)
John Scott (D)
Don Steppler (D)
Rolph Tunby (R)
Norm Wallin (R)

Staff Present: Paul Verdon, Legislative Council
Jo Lahti, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Announcements/Discussion: Executive Action taken on HB 331, HB 348, and HB 362. HB 350 and HB 405 were heard.

EXECUTIVE ACTION ON HOUSE BILL 331

Motion: **REP. TOM KILPATRICK moved HB 331 DO PASS. He also moved adoption of amendments EXHIBIT 1.**

Discussion: **REP. KILPATRICK** explained this has a Statement of Intent which is required because rule-making authority is granted to the department of justice. He further explained the amendments. This would stop the random giving out of vehicle owner's names if a vehicle owner sent in writing a request to the vehicle licensing department that his name not be given out

randomly to just anybody. This was checked by the **Polk Company** and accepted.

Vote: **Amendments were unanimously adopted.**

Motion: **Motion HB 331 AS AMENDED DO PASS.**

Vote: **HB 331 DO PASS AS AMENDED passed with REPS. WALLIN and STEPPLER voting NO.**

EXECUTIVE ACTION ON HOUSE BILL 348

Motion: **REP. BENEDICT moved HB 348 DO PASS.**

Discussion: **REP. LARSON** asked how is **REP. GERVAIS** going to treat tribal crafts from those of other reservations? Will they be treated as out-of-state crafts or foreign manufacturer because each tribe considers itself as a tribal nation? **REP. BENEDICT** explained in the body of the bill it says 'imitation American Indian Arts' which answers that question. They are trying to get only original arts and crafts.

REP. HANSON thought the testimony indicated it does not stop an Indian operating a machine that generates this material regardless of who owns the company.

REP. BACHINI stated the Committee went through the definition on this, and imitation Indian Arts or Craft articles means those made by machine or made wholly out of synthetic or artificial materials which are not made by Indian labor or workmanship. **REP. HANSON** agreed. What happens if a machine on a reservation makes them?

REP. McCULLOCH didn't think the bill was really addressing the definition of Indian Art. That seems to be fairly well defined. We should speak to the bill which talks about displaying a sign indicating that something may be an imitation product. There is no problem with a definition of what Indian Art is.

REP. BACHINI reminded the bill defines the authentic from the imitation.

REP. ELLIS explained a seller of Indian Art would segregate the authentic from the imitation Indian Arts and Crafts he displays and sells. He thought HB 348 was a good idea. Another seller of authentic Indian crafts in his area was very much in favor of this bill.

Motion/Vote: **Motion HB 348 DO PASS passed unanimously.**

EXECUTIVE ACTION ON HOUSE BILL 362

Motion: **REP. CROMLEY moved HB 362 DO NOT PASS.**

Motion/Vote: REP. PAVLOVICH make a substitute motion HB 362 Be Tabled. Motion carried with REPS. WALLIN, STELLA JEAN HANSEN, AND CROMLEY voting NO.

HEARING ON HOUSE BILL 350

Presentation and Opening Statement by Sponsor:

REP. BOB PAVLOVICH, HD 70, Butte, sponsor, passed out amendments to HB 350, **EXHIBIT 2.** The senior citizens in Butte presented this bill to him and asked him to carry it. It has been heard before. The purpose of this bill is to control health care costs and make health care more affordable for senior citizens. It is an act to prohibit health care providers from refusing to accept medicare assignments; to provide a penalty for violations of this act; repealing Section 53-5-901, MCA; and providing an effective date.

Everyone is aware that health care costs have been skyrocketing. Seniors have been especially hard hit spending a disproportionate amount of their income on health care. Doctors' fees for Medicare patients have increased dramatically. The backers of this bill recognize HB 350 is not the total solution to controlling health care costs, but it is an important immediate first step. This is not a new bill, it has been introduced in the last two sessions. The people who asked him to introduce it have also asked that two amendments be made. The first amendment to the bill includes a means test whereby physicians would be required to accept Medicare assignment only for recipients with incomes of $25,000 or less for a single person, and $32,000 or less for a couple. That is the first amendment. These figures are the same as the Social Security taxable income guidelines. Determination would be made by physicians. As an end situation when physicians question a person's income, they would have to write to request proof of income.

The second amendment which is on Page 2 would exclude all family care and general practitioners. Included in the amendment on Page 2 "residing in counties with five or fewer physicians" should be included. This includes most rural counties.

The third amendment on Page 2, line 5 requiring imprisonment in the county jail was stricken from the bill. Section 4 is a repealer of the old law. HB 350 tightens the old law up. On Page 2, Section 3 the notice required is new. Each health care provider shall post a copy of Sections 1 and 2 in a conspicuous area in his place of business as notice to Medicare beneficiaries concerning their rights under Sections 1 and 2.

Proponents' Testimony:

Jeff Kirsch, Families United for Senior Action of Families U.S.A., which is a national nonprofit organization working with Senior organizations throughout the country including the Montana Senior Citizens Association, works on health issues with a focus

on the problems of older Americans and their families. He was taking the place of **Ron Hollick, Director of Families U.S.A.** The burdens of younger people trying to care for their parents who have acute illnesses and trying to struggle with the problems of long-term care are becoming more visible. He is glad to see this situation being treated seriously.

One of the key challenges facing all of us today is controlling soaring health care costs. The system is out of control, and everyone is trying to achieve a level of affordability for consumers, but also for business and government, and that is going to be a key challenge for the 90s as we try to deal with health care costs in all their manifestations. Those who try to run businesses and those who work for businesses know what is being faced in terms of rising health insurance costs. It is a challenge everyone is going to have to face and will be struggling with for many years to come.

Today we are looking at one aspect of that health care cost increase. The Medicare program nationally has been struggling to afford to provide critical care to over thirty million older people and people with disabilities. It is doing a very good job within a system where the health care costs are out of control. The program runs extraordinarily efficiently, only 2.7 cents out of each Medicare dollar is used for administration, the rest goes to pay for benefits.

Medicare is also trying to control costs in other ways besides administration. They are trying to control the costs that go to providers, hospitals and doctors and are trying to do that by reworking fee schedules, the amount of reimbursements that doctors and hospitals receive. As you can imagine, that is a mammoth task both substantively and politically. The goal has been to come up with a fair way of treating physicians and other providers as well as treating elderly consumers. That is everyone's goal. The Seniors in this room, the organization he works with, all share the goal of fairness in fees. We all want our doctors to be paid fairly so they give us the kind of care we need so they can spend the necessary time with us to provide the care we need. Doctors very strongly want to be compensated for that time so they can practice medicine the way they were trained and the way they want to. They want to do the job right, we want them paid fairly to do the job right.

We also want Medicare to establish fair fees that make the program work well, and Medicare has undertaken that complex task through what is called the Physician Payment Review Commission (PPRC) which has worked very hard over the last three or four years to come up with a payment scheme that makes sense for doctors and makes sense for the system. They have recognized there has been real unfairness in the fee schedule. Some doctor's procedures and some specialties have been overpriced and have been getting reimbursements that have been more than is fair relative to other physicians who spend time with patients doing

diagnosis, taking history, and other kind of consultative services. The PPRC has worked very hard to correct that and has a new fee schedule that will be going into effect to do that. It has been an extensive panel of physicians, economists, and other technicians who have done this complex work to try to figure out how different procedures are valued within the context of medical delivery. (See **EXHIBIT 2-1**)

The result has been to even out reimbursements for doctors upgrading the underpaid physicians and readjusting what they considered overpriced procedures. Essentially they have upgraded the time and tasks involved in providing primary care, and have readjusted and lowered the fees for certain highpriced specialties procedures. For example, urban doctors in areas with more than 25,000 people will see their medical fees go up by 28%. The physicians practicing in rural areas with less than 25,000 people will see their medical fees go up by 34%. There will be a concomitant reduction in the fees provided for certain highpriced procedures. Simply put, we are looking for Medicare to establish fair fees that should become a fair charge to patients. After all, what is the point of establishing a fair fee, going through this mammoth task of deciding what a fair fee is, and then letting doctors charge whatever they want and pass along those costs to consumers.

Doctors may not like the fees they get, but it is their job to fight that out with the Medicare program through their organizations. He has never known the American Medical Association to need much help in figuring out how to lobby within the United States Congress. There is a chance today to try to figure out what a fair payment is to doctors, and more precisely to figure out what a fair charge is for patients. Keep in mind what has happened to the elderly health care costs over the last several years. As you will see, elderly consumers are much more threatened economically than physicians.

In 1988 the elderly per capita out-of-pocket costs were about $2,400. It is now higher because these costs are going up by about two times the rate of inflation. Those out-of-pocket costs include Medicare Part A and B deductibles. Part A is now $628 the first day of hospitalization, and Part B deductible for physician costs is $75 a year. Elderly consumers also have to pay co-insurance which pays 20% of physician charges. They have to pay premiums for Part B Medicare which is now about $30 a month; they have to pay for billed amounts that are above Medicare's rates; they have to pay for private insurance. About 70% of all elderly consumers also buy MediGap protection to try to fill in some of these gaps; and they also have to pay for a substantial number of costs that are not covered by Medicare, for example, eye glasses, prescription drugs, dental care, and all the long-term care costs - nursing home and home care costs are not covered by Medicare. The total amount they are paying, now about $2,500-$2,600 a year out of pocket is 2.5 times more than they were paying in 1980. Between 1980 and 1988 elderly health care spending increased 1.5

times faster than the income of elderly people. The Medicare premiums and the deductibles alone have increased by 200% between 1980 and 1989, going from $344 a year to over $1,000 a year.

The main concern obviously is the bulk of seniors who have moderate to low incomes. 14,000 elderly people in Montana have incomes below the official poverty guideline. Another 16,000 elderly people in Montana have incomes between the poverty line and 1.5 times the poverty lines, a full half of all Seniors have incomes below twice the poverty line. For an individual the poverty line is a little over $6,000 a year.

At the same time, let's look at physicians. Nationally, physicians' incomes have gone up an average of 7.1% a year for the last ten years. During that same time the incomes of all the rest of us have only gone up 4.1%, so physicians generally have done quite well compared to the rest of us. Nationally, in 1989 the average net income (income after all expenses except taxes) for physicians was $142,000 a year here in the Mountain Region. That was up from the previous year by 7.5%, and in 1988 in non-metro areas the average income was $120,000 a year.

How have doctors treated patients financially? In 1989 there was $10.7 million in charges going to elderly consumers beyond that which Medicare paid. Almost $11 million in what we call overcharges. In addition, of all the claims going into Medicare, 45% of those claims were overcharges as opposed to 21% nationally. The average of those overcharges was over 27%, so for many consumers having surgery or other highpriced procedures, the overcharges were very high.

Only 23% of the doctors in Montana accept assignment for all their patients which means they agree to accept as payment in full the Medicare rate of reimbursement, then the elderly person pays 20% of that. Nationally, the figure is 45%, so compared to the national norm, Montana doctors are not shouldering their burden. Only two states in the country had worse records in this regard than the physicians in Montana.

Despite assertions from physicians that they take care of their low income patients, nationally over a third of elderly people below the poverty line were overcharged by their doctors, and over half with incomes below twice the poverty line were overcharged. This has been an issue for years, there have been a lot of voluntary programs that have not worked very well. The general accounting office of Congress found the voluntary programs have had only a minimal effect on assignment rates and out of pocket costs. They also found the mandatory programs that are in five different states have not caused problems alleged by physicians including access problems and increases in volume of services.

No one is suggesting what is being considered here is easy. It is a very tough choice, and an especially tough choice politically.

That is being found in all different states and in the Congress. It is not really an economic issue for doctors especially because they are exempting from this requirement the most vulnerable doctors. It really is an issue of whether or not you and your colleagues around the country have the political will to take the first steps in controlling health care costs. Doctors simply just don't want to be told how to run their businesses. But it is not like all businesses, Medicare provides a good portion of doctors' incomes and the elderly are dependent on that. They can't choose to have less care, they need the care they take, so the stakes for Seniors here are very high.

This compromise proposal seems to be very well crafted. The sponsor has done a really good job of trying to reflect a lot of concerns, and the Committee's task very simply is to balance the factors and try to protect your most vulnerable constituents.

Elsie Lee, Great Falls, said health care costs have been skyrocketing, and they continue to increase. See **EXHIBIT 2-2.** She urged the Committee to vote for Medicare Overcharge Management or the MOM bill as it is called.

Marion Hellstern, representing the Montana Senior Citizens Association, Hinsdale, MT spoke in favor of HB 350. Health care is a major problem for Senior Citizens. See **EXHIBIT 2-3** which he read to the Committee. Since Medicare allowances are based on doctor's charges, there is no reason for medical overcharges. He hoped the committee would support this Medicare control of costs bill.

Jeanette Stevenson, Hobson, member of M.S.C.A., said in the past MSCA has always opposed a means test. It is their contention that Medicare is an insurance and not a welfare program. People should not have to display their income tax statements to prove they are eligible for medical care. The doctors wouldn't want to do this to prove they were so poor they couldn't take Medicare patients. Although not happy about doing so, MSCA offered an amendment to HB 350 whereby a lot of Seniors will automatically become eligible without having to sign up for another program that will have vastly higher rates of participation if it is accepted as payment. Twenty-three percent of Montana physicians are all that participate. There are only two states with lower percentages. Doctors say they accept assignment on a case-by-case basis. MSCA would like to get the percentage of doctors accepting Medicare up to the national average. Unfortunately, HB 350 will not make Montana a leader in accepting Medicare assignments, but it may do something to do away with the $10.6 million overcharge. It may bring it closer to a national average. She urged the Committee to support the MOM bill. It will not go as far as they would like it to, but it will be a step in the right direction, and will mean a lot of additional medical help for many people.

Elmer Fauth, member of the MSCA Board of Directors resides in Great Falls, MT. The MSCA recognizes the MontShare Program has

helped some Seniors and is better than no program at all, but as a voluntary program it has limitations. See **EXHIBIT 2-4.** Not all physicians and only a small percentage of eligible Seniors has participated. MontShare as it currently exists has income guidelines which are too low, and as long as MontShare is a voluntary program many people will not sign up.

By helping Seniors on Medicare, they are also helping their kids, their grandkids, our future generation because a good many Seniors are paying the health premiums for their kids, grandkids, etc. because young people just cannot afford to pay the premiums when working for such low paying part-time jobs. He urged the Committee to vote for Medicare Overcharge Management.

Margaret Fleming, Butte, supports HB 350. She is the former manager of Social Security offices, and now retired. The rising costs of medical care, including those costs of the Medicare program under Social Security, prompts her appearance. Seniors are spending 1.5 times more of their income on health care costs now than they were just ten years ago. The projected increase of costs for the Medicare program predict these costs are going to rise in the future. Many doctors at the present time accept assignment at their discretion for needy patients. **EXHIBIT 2-5**

On fixed income with limited ability not only physically but in opportunities to supplement that income by working and, as the statistics from the taxation committee shows, with limited resources in the way of savings, very few IRAs are owned and handled by Seniors, there is no comparison about the need for passage of HB 350. Butte Montanans with a true sense of justice are rising to ask for this help for Seniors. It is an idea whose time has come. Medicare is a help to the nation. As earlier witnesses have testified, it started out ostensibly to provide 75% of medical care costs, but deplorably much less than that is provided in Montana now. She urged very strongly support for HB 350.

Many objections have been faxed into the Committee on the bill. Many of the objectors are doctors, and doctors' wives. They have a right to dissent and protect their interests. She presented many, many petitions **EXHIBITS** 3 which were not faxed. They were taken by people who are caring and who believe in HB 350 and are asking for support of this bill. There are hundreds of these petitions coming in from Butte and the rest of Montana, and although there may be some strong, vocal, well-financed opponents, you have a majority of the Seniors of Montana who are asking you to support them as the Seniors have supported Legislators. She asked for favorable action on HB 350.

Doug Campbell, President of the Montana Senior Citizens Association, Missoula, summarized the points which have been made. **EXHIBIT 4.** Although strongly opposing means testing they will compromise if it will mean more doctors will accept assignment. However,they will not accept a voluntary program such

as MontShare which sets a program so low and requires Seniors to sign up for another program in order to participate. MontShare was started by Montana physicians two years ago in response to proposed mandatory assignment legislation. It has benefitted only a small percentage of Seniors. Rural doctors wouldn't be affected by accepting assignment. The MSCA has compromised their position and exempted all Family Care and General Practitioners in counties with five or fewer doctors. HB 350, the MOM bill, will help control health care costs and make health care more affordable. **EXHIBIT 4-A.**

Tim Harris, Deputy Director of the Montana Independent Living Project, Helena, addressed the issue of Medicare assignment as it pertains to people receiving Social Security Disability Insurance. **EXHIBIT 5.** People on Disability have high medical bills and are unable to find health insurance to cover Medicare deductibles because they are disabled, consequently medical costs are a very large part of their meager incomes. He urged passage of this legislation.

Jim Haggerty, Senior Citizen from Miles City, said to date the MSCA has received petitions endorsing this legislation from 19 Senior Citizen Centers around the state, with more coming in each day. He presented many petitions to the Committee **EXHIBITS 6.**

Christian MacKay testified on behalf of Don Judge representing the Montana State AFL-CIO. The AFL-CIO nationally is in support of a National Health Care policy which would extend medical coverage to all individuals, regardless of age. See **EXHIBIT 7.** Health care providers should charge no more than the Medicare approved rates. He urged HB 350 be given a DO PASS recommendation.

Marcia Dias, Montana Low Income Coalition, feels the health situation in this country has become a national tragedy. There is no other Western industrialized country that denies people necessary medical care. Seniors are often denied necessary medical expenses because they rely on Medicare but they are unable to pay the differences between medical charges and the Medicare payments. Low income Seniors, like many other low income people, often neglect their health, their nutrition, suffer from inadequate heating, and in general experience unnecessary stress because of exorbitantly high medical costs. In keeping with preserving human dignity and regarding our elderly with the respect they deserve, she urged HB 350 be passed.

Rev. Phil Caldwell, Great Falls, representing NAACP and himself, supports HB 350.

Leroy Keilman, representative for the National Federation of Federal Employees, Yellowstone Retired Teachers Association, Experimental Aircraft Association, and quite a few other organizations he has worked for, said these are not only Seniors' organizations but some are young peoples' organizations. They see

the handwriting on the wall and they need this bill passed.

Lowell M. Rasmussen, MSCA, Sheridan County, President of the Golden Years Club, was with the forum for Hospitals, Doctors, etc. at the Rainbow Hotel last summer in Great Falls. He didn't want to discredit the doctors, but they asked for and said they were entitled to 100% more than Medicare is paying. He agrees with them because their skill is way past that of 1940, their equipment in the hospitals is way above that of 1940, but the price of wheat in 1940 was $3, it is now only $2+ and parity is closer to $9 in comparison. The agricultural industry is the greatest industry in Montana and in the nation. Will the doctors accept a fair playing surface and accept one-third of Medicare pay for their services?

Lloyd Anderson, East Helena, is President of four counties MSCA, and affiliated with other organizations. They are all in favor of this bill.

Opponents' Testimony:

Jerry Loendorf, Montana Medical Association, departed from his prepared remarks **EXHIBIT 8** and addressed himself more to the arguments that have been made. He addressed **Mr. Kirsch's** testimony who had testified accurately that only 22% of Montana physicians are participating physicians, that is, they accept assignment in all cases no matter what the wealth of the patient is. The implication is that only 22% of the Medicare patients are accepted on an assignment basis. That's not true. If you look at the Governor's Health Services Availability Advisory Council report for this year on which **REPS. DARKO** and **MERCER** represented the House of Representatives, it says "presently only 22% of Montana physicians are participating physicians and accept assignments on all patients". It also says: "Yet 70% of all physicians' bills for the elderly care have been submitted accepting assignment". What wasn't pointed out was that although only 22% of the physicians accept assignment in every case, all of the others choose to accept assignment on a case-by-case basis so they accept assignment, too, but not in every case.

Another factor was a lot of national and regional income figures on physicians were given. If those national and regional physicians' income figures were applicable in Montana, we wouldn't have 18 towns now without physicians. The other thing those averages really distort is they do not take into account the big disparity in physicians' incomes. A heart surgeon might make a half million a year, but the family practitioner and the internist, those people on the front lines as the primary care physicians who treat most of the elderly and treat most of our routine needs, don't make anything near that amount of money. They may be making something around $45,000 a year.

Testimony stated physicians' incomes have a wide range. What Medicare reimburses from state to state has a wide range. Montana

is one of the states that has the lowest amount of Medicare reimbursement. Some people received cheaper medical services in Montana than out-of-state services cost. Medicare pays much more in some other states even when assignment is accepted.

He demonstrated how Medicare works on a board. For a doctor accepting assignment: assume the amount of the bill is $100. Medicare approves a certain amount for payment. It is usually near 70% of that amount. Medicare does not pay that amount, but pays 80% of that amount, so of the $100 it will send the physician a check for $56. The doctor will have to collect from the patient through the patient's insurance, or if the patient doesn't have insurance, then the patient has to pay directly the other $14. Assuming a physician doesn't accept assignment: on a $100 bill the amount approved by Medicare again comes back at $70. Medicare in this instance pays the physician nothing, it does pay the patient the $56, and the physician can then collect from the patient, if he can, the additional $44. The physician takes a risk in doing that because he may be dealing with a patient who cannot pay or may not be able to pay, and if he doesn't accept assignment, there is no sure way he is going to get paid even the $56 which is just a little over half the bill.

Since 1984 the amount to be billed to a Medicare patient, even the total amount of the bill, is less than what would be billed to a person under 65. In 1984 beginning July 1 there was a freeze put on Medicare rates for those nonparticipating physicians who didn't elect to accept assignment in all cases. That freeze remained in effect until January 1, 1987 when the freeze was lifted and another limiting factor called Maximum Actual Allowable Charges (APPLICABLE) was placed on the charges. During that period of time, the fees billed to Medicare were allowed to rise from 1-3%. The physicians' costs soared at a significantly higher rate than that, so the increased billing for a particular service went up for all persons $125-$135, so the original amount billed the Medicare recipient has always been less since the freeze came into effect in 1984. Beginning January 1, 1991, Congress has done away with the APPLICABLE and has placed other limitations on physicians' charges. Eventually they are going to get to a fee schedule and what we are talking about here today will be all academic. The law is in place and it is going to take effect and be phased in over a period of years. That is in effect how Medicare has worked. It is very complex, and this has been a very summarized look at it.

The fairness issue has to be considered. The MontShare program has tried to do so, but the Legislature always needs to help the people in need and tries to do so whether they are under 65 or over 65. This bill at least as originally drafted, provides a subsidy to the most wealthy in this country and that cannot be justified, particularly because of the cost shifting which burdens someone less able to pay whose bills go up even more than they ordinarily would. So it is necessary to distinguish between Seniors who earn substantial sums and those who are in the

poverty level areas. As a practical matter anybody who is under that level whether assignment is accepted or not, that would be the amount paid.

The next thing is how the bill affects the entire health care delivery system in Montana. It is tough to get a handle on just why Montana is losing physicians or they are not being replaced as they retire. There are a number of contributing factors that go into this. One mentioned in the Governor's Report was low Medicare and Medicaid reimbursement rates in Montana. Both of those are factors the Legislature can address. This bill doesn't address that and would just acerbate the problem.

Another reason it is difficult to get physicians into Montana today is if the national income figures were accurate, these people could earn two or three times as much elsewhere as they might make practicing in Montana. The other financial factor they have to deal with is that a physician is usually about 30 years old when he completes his training. He has roughly seven years more of education and training after he finishes college. At that time he may be married and have a couple of children. His college debt may be as much as $75,000, so he starts at 30 that far behind. He has to buy a house, get his practice set up. He starts with way more debt than most people start with. If you continue to cut the opportunity to earn a good income in Montana, Montana becomes a less attractive place for a physician to practice.

The Montana Medical Association tried to address the problems of Senior Citizens who could not get assignment by starting what they called the "MontShare program". **EXHIBITS 9.** This program asked physicians to voluntarily accept assignment of all Seniors whose income was at or below 150% of the poverty level. Last year that was increased to 200% of the poverty level. To date there are 5,434 Seniors now participating in the MontShare program. It is an entirely honorary program, all a person has to do is come in to the physician and indicate he is under those income levels. The Montana Medical Association took a survey with regard to the MontShare program this fall **EXHIBIT 9A.** It asked three principal questions of the Seniors.

Van Kirke Nelson, M.D., practices Obstetrics and Gynecology in Kalispell. He served on the last two Governor's committees on Health Access Care, and under Governor Stephens, Chairman of the Health Services Availability Advisory Council. The report of the Council was sent to the Committee members **EXHIBIT 10.**

He objected to previous testimony using national generalities and trying to associate them with Montana. Discussion initially was with the PPRC, Physician Payment Reform Commission. Fees were insinuated to be up 24-34% - this is incorrect. This does not start until 1992 and won't be completed until early 1994. Montana physicians have not seen any part of that. He is a nonparticipating physician. His fees by law since 1984 have gone up less than 5% for Senior Citizens. The out-of-pocket fees for

Montana citizens is one of the lowest in the country. It is $400 less in Montana than it is nationally. In 1988 the last time the Department of Revenue kept figures, they stated the average income for physicians is $80,000 which is a long way from $142,000, and includes specializing physicians. As far as mandatory assignment it is true 23% of Montana physicians accept assignment, however, the acceptance on a case-by-case basis is very high.

In the last 30 years, 31 counties in Montana have lost 20% of their population, and with that they have lost their physician population. Eighteen counties have no physicians, 22 counties have no obstetrical care. **EXHIBIT 11** This Legislature is increasing Medicaid compensation for obstetrical care. There has been consideration for investment tax credits in rural areas as physician incentives to come to communities as they try to address problems that have been sadly lacking because of inadequate compensation and high costs for liability insurance. With high tort costs, poor compensation, physicians in Montana gave up obstetrics. There has been a 45% loss of obstetrical providers in rural areas. What is the cost to Montana? Montana has next to the lowest neo-natal death rate in the United States, it is 4.8%, but Montana has dropped to 32nd mortality rate for the first year of life. If a mother delivers in her county of residence, the chance of her child living past the first year of its life is twice as good as if the child is born out of her county of residence.

The healthy Senior Citizen can travel and go where he wants, but what if he is ill? What if he no longer has a resident physician? Compensation in rural areas is not very much. An office visit in Montana averages $16, in Arizona it is $44. He can't recruit a physician in Kalispell to join in the practice of obstetrics. He provides 60-70% of the obstetrical care for his two partners in the Flathead to Medicaid patients because other physicians have dropped out of the provision of such care. They can't afford the liability insurance, where the compensation is not there. It is not only the rural areas that have an access to health care problem. He and his partners have quit the practice for Medicaid, they are all approaching 60, who picks up the slack in both areas?

Dr. John Heetderks, Bozeman, opposes HB 350. This bill has support from many Senior Citizen groups. He also is a Senior Citizen. Medical care is costly. The Medicare program is very costly. There are a lot of reasons for that. With the high tech equipment today illnesses can be determined without surgery in many cases. But those machines are very expensive. Office equipment is also very costly. Many office machines cost in excess of $25,000 which has to be passed on. The cost of taking care of people is very great. HB 350 seeks to alleviate some of this cost of Medicare by loading that cost on health care providers and the physicians. He cares for a significant proportion of older patients on Medicare. There is a very great

difference between the fee he charges Medicare patients and what he charges non-Medicare patients. $32 for first office visit for non-Medicare patients, follow-up visits are $26. Medicare through the APPLICABLE allowable fee allows him to charge $23.35. That APPLICABLE is not constant, it varies from physician to physician. Medicare will pay him $18.68, so he bills the patient for the difference. That is called an overcharge, but it is not an overcharge at all. Many of the older patients require more of his time than the younger patients. Many physicians do accept Medicare on a selective basis, and know their patients well enough to know who has financial hardship and they are not asked for that difference. They simply take assignment.

MontShare is available and they have a fair number of patients who are on that program. All they have to do is ask for that MontShare card and they get it.

There are a lot of older people who are not represented here this morning who can afford to pay that $4.67 which is the difference between what Medicare allows him to charge and what he actually bills these patients since he does not accept assignment, the so-called overcharge. They can afford to pay that, and they don't mind paying it. They are the most compliant patients they have for paying their bills. Mandatory assignment would make it an economic necessity to reduce his load of Medicare patients. This bill is being pushed by people who are self-serving and it will backfire. It is hard to attract a physician to Montana, and if there is mandatory assignment on Medicare it will be virtually impossible to get a young physician to come to Montana. The patients are deprived of the physician of their choice, and when that happens the quality of medical care is going to go down for those people. They will have to go to somebody who is not their choice, and will be hurt by that.

Medicare is a hassle and when it becomes more of a hassle as it would through mandatory assignment, there will be a lot more physicians retiring. Particularly those physicians who are taking care of the bulk of the Medicare patients, and who have the skills to do so. Medicare does not pay for the benefits patients should receive. Medicare takes a long time to pay. Mandatory assignment could push physicians to an early retirement making for a loss of medical access. He encouraged voting against HB 350.

Edwin L. Stickney, MD, Montana Medical Association and himself, has been in general and family practice in Montana since 1955 in Broadus, rural Montana, and Miles City. He holds this truth to be self-evident: A 64-year old person currently not eligible but in need deserves mandatory assignment from his doctor, while a 65-year old patient who is a millionaire does not deserve mandatory assignment, and therein lies the fundamental in that critique of the Medicare system. Medical care paid for through governmental programs must be tied to need, and not specifically just because a person is 65. People must not be given a free ride under

government programs when they are able to take care of themselves financially. Ten years ago a comparable program was put into place where those below certain guidelines automatically received assignment. The MMA didn't participate, but they automatically accepted assignment, and it worked very well.

Presently when he sees a Medicare patient, he routinely accepts assignment on all those who need this help. He exercises the prerogative not to accept assignment on patients for whom this care is not a hardship. No one in need of assignment is refused. In essence, by passing this law you would be saying to him and other members of his profession we don't trust you to make these decisions and insist that you accept assignment on all Medicare patients, poor or rich. Further you are saying if you do not accept assignment, we will treat you as a felon, putting you in jail for up to one year, fining you up to $2,000. He doesn't believe the implications of what is being done to what used to be an honored profession is understood. He knows of no other profession or vocation in this country which is treated in such a discriminatory fashion.

About 37 million of our young couples with children do not have the funds to carry health insurance. At the same time it has been estimated that well over one-half of the income in this country belongs to people who are over 65 years of age. We should concentrate more of our resources on the youth of our nation while still serving the needs only of those over 65 who need help. These are fairness issues.

The other aspect talked about is access to medical care. You know that in Montana there is no surplus of doctors and never has been. He predicts that if this mandated bill carries, the supply of doctors who are willing to practice in Montana will be further decreased thus lowering the access and quality of medical care. He fervently hoped this would not happen.

Anne Murphy, MD, Missoula Primary Care Physician, General Internist at the Western Montana Clinic, which is a group of 50 practicing physicians in Missoula, is a member of the Executive Committee of the Clinic, and is chairperson of the Department of Internal Medicine. She is not a member of the MMA. Her practice involves the general medical care of adults. She is certified as having special training in geriatrics. She is also the medical director of the Village Health Care Nursing Home in Missoula.

On the face of it it would be very difficult for many to vote against this bill. It is clear health care costs are rising, Seniors on limited incomes are putting out more of their incomes for health care. Seniors are an important part of the population, and as a political group they are incredibly well organized. She works with and for large numbers of people over 65 and feels she has firsthand knowledge of their concerns. She is adamantly opposed to HB 350. She has been in practice for eight years in Montana and represents the other end of the spectrum in speaking

for physicians. She has spoken to and received letters from others in multiple positions in and around Missoula and throughout Western Montana that she is sharing. Their letters will speak for themselves. **EXHIBITS 12** She is speaking for herself today.

This bill would disproportionately hurt low income Seniors compared to those with larger incomes. It would do this by limiting their access to primary care physicians, which is what she is. Primary Care Physicians are your family doctors, but they include people trained in family practice programs, they include general practitioners and a larger percentage of general internists. They are the main access that Seniors and all patients have to a very complex health care system. They meet and talk with, diagnose, counsel and reassure thousands of patients throughout Montana. Their work is extremely time consuming. The average Primary Care Physician in and around Missoula works sixty to seventy hours a week. They cannot possibly adjust to the dramatic loss of income this bill would represent.

To drive Primary Care Doctors out of business, particularly in rural areas, is the absolute impact of this bill. For Medicare purposes the City of Missoula because of the 1980 census is considered a rural area when talking about rural compensation as opposed to Billings which is considered an urban area. Montana clearly has a shortage of Primary Care Physicians, particularly in the rural areas, including Missoula. There is no doubt HB 350 would further add to the already significant shortage of Primary Care Physicians to serve the Senior population. A physician to do heart surgery may be available, but Seniors will find it increasingly difficult to have access to the Health Care System. Coordination and comprehensiveness of care will no doubt suffer.

The second reason she is against this bill is that what it attempts to do is already being done to a large degree through the MontShare Program. The Program facilitates the ability of low income Seniors whose yearly incomes are less than $12,000 for an individual or less than $15,000 for a couple to obtain insurance. The amendment would increase those numbers which would include 90% of Montanans if it were accepted. It does not change this bill. If Jeff Kirsch's figures are correct for incomes for Montana Seniors, then 50% of Montana Seniors should already qualify for the MontShare Program. She suggests everyone, including Senior Citizen Associations, should work hard to encourage Seniors to make use of that system. People fill out a form; compared to Medicare, it is extraordinarily simple. People fill out this form by taking figures from their IRS statements, they send it in, no one questions whether it is true or not and they are sent a Gold Card. The Clinic in which she works has 50 physicians representing about one-third of the physicians in Missoula. They provide comprehensive care and all of them accept the MontShare Program. Ninety percent of physicians in Western Montana probably accept the MontShare Program.

Medicare financing - If she bills $100 which is her usual fee for a service, Medicare has Maximum Allowable Actual Charge (APPLICABLE) which is generally about 80% of her fee. An assigned fee is $60 of that $100 which means that if you forced her to take mandatory Medicare assignment, she will be accepting 60 cents on every dollar that she bills a Senior. That would be fine if her overhead weren't between 50 and 60%. The overhead at the Clinic, and they are a more efficient group by virtue of the fact they can effect cost savings because they are large group, was 52%. Three years ago it was 66%. A letter from a group of four family practitioners in Missoula shows an overhead of 60% of their revenues charged. That means she will be working for free for her time spent for Seniors. She now does that for a large percentage of MontShare patients. It is not fair to ask her to do that for all people over the age of 65.

Cost shifting to younger populations has already occurred, it will only get worse. That represents that $100 service fee. The reason it is $100 instead of $90 is because of the decreasing revenues from Medicaid and Medicare for patients in all of their practices. Medicare pays forty cents on the dollar, although there is some effort to increase that this year. From a business standpoint it is much easier to respond to a change that occurs over 5 to 10 years than it is to respond to a change that occurs overnight. Much of what the Seniors are asking to be done today has been done and will continue to be done at the federal level. There really is no reason for the State Legislature to get into this stickywicket and have to try to do this in Montana particularly doing this overnight. It will be very difficult for individual Primary Care Physicians to adjust to this.

The medical profession in Montana is not unsympathetic to problems occurring for Seniors and people of all ages with regards to access to good health care. Many are party to significant efforts to equitably develop a system whereby those who truly cannot afford to pay for health care still have adequate access. Missoula County has a joint effort by the Joint Hospital Committee for indigent health care. This Committee is attempting to assure that all people in Missoula, whether they have health insurance or not, whether they are on Medicaid or not, have adequate access to Primary Care and such specialty services. This is a voluntary effort sponsored by physicians and hospitals trying to address some of these problems.

This bill is unnecessary, unfair, and worst of all it does not accomplish what it sets out to do. She passed out letters from physicians in Missoula. **EXHIBITS 12.**

Dr. Maurise K. Johnson, Internist from Kalispell, MT. Her grandfather graduated from the University of Toronto, School of Medicine in 1881, came to Havre, MT and set up his shingle. There has been a doctor in her family ever since, and no matter what is done today, she is not leaving. The ramifications of HB 350 should be looked at because there is already a crisis in

providing adequate primary care especially to rural areas. Kalispell is considered to be a rural area. **EXHIBIT 13**

Fred Patten, American Association of Retired Persons, said the AARP is in opposition to HB 350. **EXHIBIT 14.** They are very much against means testing because administration is costly, rapidly rising physician services would continue unabated and merely be shifted to those with incomes above the specific level of need. Patients who need assignment would be viewed as less desirable and would probably be put aside, so they are very much against this assignment bill and urge a Do Not Pass.

Jim Ahrens, President of the Montana Hospital Association, said the twist on this for hospitals is recruitment. If they lose one more doctors just because another barrier has been put in place, which HB 350 will do, it will make it even tougher to bring doctors into this State. **REP. PAVLOVICH** has addressed this to some degree when the amendment says five doctors per county exemption so that helps. Nevertheless specialists are still being recruited in rural areas and they are very, very difficult to get. If Montana becomes known as an assignment state, that is another barrier to be overcome when trying to get people in to practice.

Peter D. Berger, Administrator of The Havre Clinic, Havre, said in the past two years 23% of the Primary Care doctors along the HiLine have left or are in the process of leaving now. **EXHIBITS 15** Of the 7 hospitals in the area one has announced it will close now. Another is very likely to close this year. There are two others which are very likely to close in the next couple of years, all due to physician departure. There are other states that require Medicare participation. Most of the states positioned to participate in Medicare can charge as much as twice what a physician in Montana can whether the Montana doctor participates or not. Most Montana Primary Care physician fees are restricted by law to the lower third in the nation which is why Montana doctors participate at a lower rate than the national average. By tightening the screws on the medical professions 60% of the hospitals in the nation, and in Montana a greater percent than that, are trying to recruit Primary Care doctors. Fifty-seven percent of hospital administrators in the nation believe their hospital will close within five years. Applications to medical schools are at an all-time low.

Medical residencies, especially the Primary Care residencies that most Montanans need are not receiving enough applicants to fill openings. Doctors are opting in ever increasing numbers, for the reasons already heard, to work in larger centers and subspecialties where they can have an 8-5 workday just like everyone else and go home and see their kids every once in awhile. Our communities are unsuccessfully competing with thousands of small cities all across the nation for a very limited number of doctors interested in a small town life and practice. By passing bills such as this one we are ensuring our

communities will be unable to attract competent medical professionals in the not too distant future.

The bill as amended does exempt counties with less than six doctors. A medical community of four or five doctors is not large enough to maintain the broad range of services that are needed to provide modern medical care. It can only exist if it is well assisted by medium size medical facilities in some of our larger towns. By decimating those facilities as HB 350 will do, the small counties will also go even if the bill is passed as amended. As amended it requires doctors to check their patients' incomes in addition to all the other things these people have to do when working 60-70 hour weeks. You are going to make them policemen and tax auditors as well.

Our health care system needs to be changed drastically. Far too much of what we pay for them never ends up going for what we want, but this bill is not the answer. He would appreciate a vote against it.

Gloria Hermanson, Executive Director of Montana Academy of Ophthalmology, Helena, MT, stands in opposition to HB 350. **EXHIBIT 16** indicates statistics on the number of Ophthalmologists who are currently involved with MontShare and accept assignment.

John Gordon, Past President of the Montana Medical Group Management Association, spoke on their behalf. The gist of his comments address federal legislation and regulation of the health care industry that has been in place for some years now and continues unabated. However, physicians under these programs have had at least an opportunity to assess and adjust their practices in a time frame which allows a somewhat more prudent and rational change to occur in their practices. In stark contrast enactment of HB 350 would constitute an immediate and severe impairment to physicians' ability to reasonably address both horns of their current dilemma, namely, an expanding of a multitude of issues and rapidly escalating costs of doing business. Allow the businesses of medical practice the opportunity to continue to adjust to current regulatory requirements.

Joe Laktan, Physician from Kalispell, opposes HB 350 more on the basis of being a small business owner than as a physician. He, too, is tired of seeing health care insurance premium costs skyrocket. There is no question that this bill as presented would just shift the health care total from one group to another. It would do nothing to decrease the global health care costs. It was said that all Seniors are spending a greater percentage of their income for health care than they did many years ago, so is everyone else. MontShare should be a very viable program. It is very private, there is nothing that could be demeaning about it. Absolutely no questions are asked at any point in time.

He agrees recruitment is a problem. It is not a scare tactic, it is a very real problem. They have also been recruiting for a

third person but the amount they can offer a new person coming in is just not appealing. For these reasons and those already stated he opposes HB 350.

Robert Pfeffer, Great Falls, MT opposes HB 350. He had just returned to Montana. It is very expensive to go to medical school. Many of the students went into primary care specialties in rural health care and there is plenty of need for them in small communities in our area. There is no real strong incentive to come to Montana when they can meet their personal and financial needs easier and better someplace else.

Dawn Wong, Internal Medicine Associates Group of five physicians, opposes HB 350.

Gary Kiner, Bozeman, opposes HB 350.

There were many other persons in attendance. See the Visitor's Registers. Also many **EXHIBITS 00** are attached.

Questions From Committee Members:

REP. LARSON asked why MontShare is not working. **Mr. Campbell** explained Seniors have to sign up for it. Organizations did more than the physicians themselves did to promote that program. They took brochures to district meetings, had them displayed at the state convention. This is not what they would prefer, but it is better than nothing. He can't answer the question. **Mr. Loendorf** said when the Montana Medical Association took its survey, they listed comments and they were favorable. They don't get complaints.

REP. STELLA JEAN HANSEN stated we have had a lot of testimony that this will drive doctors out of Montana. In your estimation has this happened? **Mr. Kirsch** said five states have mandatory assignment, they lowered the rates doctors can charge. The General Accounting Office found that doctors were not leaving and access to health care is not suffering. Montana is different. The sponsor has recognized the rural problem and made exemptions. Vermont is a rural state very similar to Montana and has a means test. They haven't found doctors leaving or has an access problem been caused. That is the only history available.

REP. BENEDICT said a lot of guess work testimony has been heard about access to health care. Could someone give the Committee some independent figures? **Nancy Ellery, Administrator of Social and Rehab Services,** said 18 Montana counties do not have physicians and there are even more counties without doctors who deliver babies. In terms of use this will impact all Medicare and Medicaid. As to access, it will only make a bad situation worse.

REP. CROMLEY was concerned about Section 5 exempting licensed physicians in counties with five or fewer licensed physicians.

REP. DOWELL asked how many physicians left Massachusetts, the first state to have mandatory assignment? **Dr. Nelson** said 8 out of 10 leave that state because of mandatory assignment.

REP. WALLIN said many hospitals are closing because of lack of doctors. Those communities will never have a doctor if they are closed. A hospital in a community is very expensive. There are three or four hospitals on the ropes, one will close in March. It will take money to get it going again, and no doctor will be recruited to get it going once it is closed.

REP. STELLA JEAN HANSEN said **Dr. Nelson** stated that the PPRC has not gone up but they indicated that it will. **Mr. Kirsch** said the schedule goes into effect in 1992. It is prepared and broken down to specifics. It is all available. Through this offer some physicians could get more for their services where resources going into various procedures were undervalued in the present system. They reworked the fee schedule. Once you know the relative value of the service, then it has to be looked at as to what the correct fee should be. Congress has to set those. That is a separate issue. Those fees have to be fair. Medicaid pays somewhere about one-half of what Medicare pays.

REP. McCULLOCH asked if the applicable chart fees were based on 100 different physician fees? **Mr. Loendorf** said they looked at the actual charge that a particular physician normally charges in that area, and what a group of physicians in the same area charges, and took the lower of those.

REP. ELLIS asked how the level of income was arrived at. A young couple raising their family doesn't make that much. **Mr. Campbell** explained the figures were based on the threshold where federal income tax begins to be applied to Social Security benefits which is $25,000 for a single person and $32,000 for a couple. Eighty percent have incomes below those ranges.

REP. SCOTT asked if pride had anything to do with enrollment in MontShare? **Mr. Campbell** said they asked doctors to ask citizens to accept MontShare. People feel if it is a bill they owe it. They should not be subjected to that much overcharge.

REP. TUNBY said several mentioned Montana is dominated by Medicare. How do they set those rates? **Mr. Loendorf** did not know. **REP. TUNBY** said historically fees in other parts of the country were voluntarily frozen and if you are allowed a fee increase, you get 1-1/2% of $15 against 1-1/2% $32 according to the OBER fee schedule. It is added to a cost of liability. Some are overcompensated for their services.

REP. BENEDICT said AARP opposes this bill. How many citizens do you represent? **Mr. Patten** answered roughly 110,000.

REP. STEPPLER asked which are the 18 counties that don't have doctors, and some of the other counties that are losing their

doctors? **Ms. Ellery** will leave a map that certifies those problem areas.

REP. SCOTT stated the population loss Montana has suffered has caused physicians to leave, and when they leave a hospital closes then all the providers are lost.

REP. BACHINI said this is a very serious problem in Washington, D.C. These are the people who we have to address and turn around. They just have not lived up to their obligation to provide health care. People should write their Senators and urge them that cost of health care is one of the most important things for Senior citizens, and very important to young people in providing insurance for their families.

Closing by Sponsor:

REP. PAVLOVICH said **Mr. Patten of AARP** spoke against mandatory assignment when they had previously approved of it. **EXHIBIT 17** We have heard there is a declining population in our area. Maybe that is because there are no conveniences there. Why has the population declined? Farmers are leaving because they are getting less than $3 for their wheat. There are only a few people over 5,000 who belong to MontShare. Maybe people are really too proud to belong. Nationally 70% of the physicians accept Medicare at all times. Only 55% sometimes accept Medicare in Montana. HB 350 exempts Family Care Practitioners also. Senior citizens don't have any insurance because a policy costing $86 now costs $500. If other changes are required by the Committee, they can be made in Executive Session.

HEARING ON HOUSE BILL 405

Presentation and Opening Statement by Sponsor:

REP. NORM WALLIN, HD 78, Bozeman, Gallatin County, sponsored HB 405 which is very crucial to hospitals of Montana. It is an Act providing that benefits payable by health service corporations are subject to the physician, nurse, physical therapist, occupational therapist, chiropractor, dentist, and hospital lien act; amending sections 71-3-113 and 71-3-1118, MCA; and providing an immediate effective date. He explained the Physician Lien Act that is now in the law requires that health insurers provide payment for a patient, and that patient has a right to assign that benefit which would establish a lien on the check that comes from the health insurers as a protection to the hospitals to be sure they get paid. The "health insurer" is the insurance company that provides the coverage. A "health provider" is a hospital that provides the care. "Health service corporation" basically is the Blue Cross/Blue Shield of Montana. This bill brings them into compliance with the health insurers to protect the hospitals so they would get paid for their services. **EXHIBIT 18**

The purpose of HB 405 is to make clear that the Physician Lien

Act applies to health service corporations which is the Blue Cross as well as all other health insurers. As the law currently stands, physicians, nurses, physical therapists, occupational therapists, chiropractors, dentists, and hospitals have lien rights for insurance benefits received from all health insurers except for the health service corporations. These rights arise from the Physician Lien Act. This proposed amendment is to level the playing field for health service corporations, other health insurers, and health care providers with respect to the Physician Lien Act. No logical reason exists for treating health service corporations any differently from other insurances for purposes of the Physician Lien Act. In 1987 the Legislature made health service corporations subject to the Montana Insurance Code. In function, health service corporations are identical to other health insurers in fundamental respects. They should be treated identically under the Physician Lien Act.

Today the argument may be raised that making health service corporations subject to the Physician Lien Act will somehow increase health care costs. This reasoning has no basis in fact. The Physician Lien Act requires the insurer who has received notice of a lien to pay the health care provider directly rather than paying the person who is insured. The effect of this is to insulate health care providers from people who receive insurance benefits but do not pay their bills. If an insurer receives notice of a lien and refuses to pay the health care provider directly, it is liable to the health care provider for the fair value of the medical services provided. Nowhere does the Physician Lien Act allow health care providers to charge excessively for their services. The amendment **EXHIBIT 19** excludes from the provisions of this act such things as life insurance companies.

In 1987 when the Physician Lien Act **EXHIBIT 20** was last amended, the concern was raised that the Lien Act might be applicable to disability insurance, life insurance, and pension benefits, and other insurance proceeds that were not paid for reimbursement for medical services. Therefore this amendment was added exempting these types of insurance from the Physician Lien Act. The purpose of this amendment is to make absolutely clear that the intent of the 1987 Legislature that the exclusion of disability insurance was meant to apply to periodic payments of insurance to replace lost wages and the like, such as Workmen's Compensation. Disability insurance according to the legislative history of this Act should not mean amounts received in direct reimbursement for medical services otherwise the provisions of the Physician Lien Act relating to insurance would make no sense.

One of the reasons health service providers feel HB 405 is necessary is that Montana's sole health service corporation, Blue Cross/Blue Shield is the only insurer they know of that refuses to honor assignment of benefits. Thus even if a person directs Blue Cross/Blue Shield to pay the health service provider

directly, Blue Cross/Blue Shield will not comply, they will only pay the health service provider directly if it has a contract with the health service provider. There is no reason why Montana's sole health service corporation should be treated any differently from any other health insurers when it comes to paying health service providers directly. The Physician Lien Act should be amended to expressly include health service corporations such as the Blue Cross.

Proponents' Testimony:

Gary Kenner, Administrator of the Bozeman Deaconess Hospital, spoke in favor of HB 405 dealing with the Hospital Lien Law which involves assignment of benefits from patients to health care providers. The Montana State Supreme Court recently ruled that because Blue Cross is a health service corporation, it is not subject to the Lien Law like other insurance companies. This is not fair for a health service corporation to have the right to ignore a properly executed assignment of benefits between a patient and a health provider. Blue Cross may well argue they are serving the patient's best interests by using this special treatment under the law to force health care providers into discounts, thus saving Blue Cross and the patient money. In reality when one payor group gets a discount, some other payor picks up the difference in higher rates. This cost shifting is not fair to the segment of patients having to pick up the difference. The patient should have the right to assign his benefits under a prepaid health plan to a health care provider. His insurance company should be forced to honor that policy if that is his wishes. There are no other third party payors the hospital deals with that have the option of accepting or rejecting assignment of benefits. For the sake of all patients served, for the sake of all health providers, and in the name of fairness he asked support for this bill.

Jim Ahrens, President of the Montana Hospital Association, said they have 58 member hospitals and most support this legislation. This simply amends the Physician Lien Law to include health service corporations under it. It is necessary to do this to maintain an equitable business climate for all insurance companies in the State of Montana. HB 405 allows health care providers to secure payment of insurance proceeds for medical services rendered in good faith. The ability of the health care provider to obtain a lien on insurance proceeds is comparable to the rights of other businesses in Montana. Health care providers should have the ability to obtain this lien against insurance proceeds paid by a health service corporation. Current law allows health care providers to obtain this lien for all other insurance companies but not for health service corporations. Blue Cross/ Blue Shield argues they should not be held under the same law as other insurance companies. Interestingly this company is a major participant in the health insurance market in Montana. **EXHIBIT 20**

Like all Montanans they are concerned about health care costs. Exempting Blue Cross from the Lien Law provides leverage in negotiating contracts with hospitals. There is no question about this. If a provider is not willing to sign a contract with Blue Cross, the health care provider will not receive insurance payments directly from Blue Cross Corporation. Blue Cross operates differently in Montana under the current regulation anyway. This means the provider must go through additional billing and collection efforts to obtain payments, and this activity will increase health care costs and may also increase bad debts as people spend for health care insurance premiums but do not pay for the expenses they have incurred although they have been reimbursed for them from the health insurer. Passage of HB 405 will not increase health care costs in general; it is simply doing business in the same way as with another company who is an insurer in the State.

Costs for labor and equipment incurred by health care providers are not dependent on whether payments are received directly from the insurance company or from individuals. Passage of this bill will actually help them hold down some of the costs by reducing the potential bad debts. They really urge the Committee's consideration of this bill and ask support for its passage. He left **EXHIBIT 22** for the Committee's information.

John Guy, President of St. Peter's Hospital in Helena, not to duplicate testimony already given, simply stated they also favor support of HB 405.

Dave Barnhill, Deputy Insurance Commissioner, also supports HB 405 on the theory of leveling the playing field.

Tom Ebzery, St. Vincent Hospital and Health Center, Billings, supports the bill for the same reasons.

Jack Casey, Administrator of Shodair Childrens' Hospital in Helena, also supports passage for HB 405.

Dr. John Heetderks, Bozeman, supports passage of this bill.

Opponents' Testimony:

John Alke, Helena Attorney, appeared on behalf of Blue Cross/ Blue Shield. He asked the Committee when in Executive Session on HB 405 to look at the Section on Lien Statutes and read the title of the part, "liens of physicians, nurses, physical therapists, occupational therapists, chiropractors, dentists, and hospitals in personal injury claims". There has been a Physician Lien statute in Montana since 1931, the purpose of which was clear and obvious: plaintiffs who go to the judge for awards use as a critical component for their awards the costs of their medical expenses. That is an element of their damages. The State found the plaintiffs were settling with the casualty insurance carriers. Part of the settlement included the specials, the

medical expenses incurred by the claimant, but after taking the money from the casualty insurance the plaintiff was not paying the hospital or doctor bills. In 1979 the Montana Hospital Association came to the Legislature and asked for some amendments to the Physician Lien Statute. It was very unclear what those amendments were to do. He read March 13, 1979, minutes of the Senate Judiciary Committee which was considering the Montana Hospital Association's amendments. Appearing at that hearing was **Chad Smith** representing the Montana Hospital Association, who "stated that he had had experience working with the present lien laws. Over the years he said there are some problems. He said the companies doing business in the State of Montana had been very cooperative. He said there are a number of companies that do not do business in Montana and that is where the problem basically lies. He stated this is an improvement of the law and he would endorse it." There were no further proponents, and no opponents. Senator Anderson questioned if this goes on life insurance benefits. Mr. Smith, lobbyist for the Montana Hospital Association, said "No, just on casualty." The problem was that the language they had brought was broader than just on casualty, but after the Montana Hospital Association testified it was just on casualty, the Legislature amended the bill the Hospital Association provided.

That amendment is essentially subsection (2) of HB 405, and it is an exemption of the Physician Lien Law. Look at subsection (3) which the hospitals are asking to be amended. It says "This part does not apply to any benefits payable under a policy of life insurance or group life insurance, a contract of disability insurance,". What is a contract of disability insurance? Under Montana law all health insurance is a contract of disability insurance.

It has been represented the sole purpose of this bill is to level the playing field between Blue Cross and the commercial carriers. That is absolutely and fundamentally untrue. The commercial carriers are right now exempt by the very language the proponents of this bill are also trying to strike out, but don't mention in the title of the bill, they are exempt. He is astounded that **Mr. Barnhill** would testify that the purpose of this bill is to level the playing field between Blue Cross/Blue Shield and other insurers. He litigated a case that went to the Montana Supreme Court. He has letters from the Insurance Commissioner's office to attorneys representing doctors that state all contracts of disability insurance are exempt from the Physician Lien Law. He would like to present those letters as an Exhibit to this Committee.

What this bill is about, and the proponents have touched on it, is whether Blue Cross/Blue Shield or any other disability insurer should be permitted by contract to review the reasonableness of charges that are charged to Montanans by providers of health care. To understand that, it is important to go back and look at Blue Cross and Blue Shield. There was a merger in 1986 and they

are now one company. Blue Shield, which actually was Montana Physician Service, was a company formed by the medical profession, controlled by the medical profession, and was set up to provide prepaid benefits and reimbursements because there really weren't any at the time it was set up in 1946. The doctors who set up Blue Shield knew they had a problem, and part of the problem was certain members of their profession pursued the profit motive with a bit too much vigor. To stop that they set up a system where they went out and got physicians to enter into contracts with Blue Cross and Blue Shield, and in that contract the physician would agree to accept what Blue Cross and Blue Shield determined to be a reasonable charge. What they actually did was collate all of the charges from all of the physicians in Montana, and said if incoming charges are above 90% of what the doctors in the State are charging, they would only pay 90% of those charges, and as part of that contract the member physician specifically agreed he would accept the payment from Blue Cross/Blue Shield in full, and would not balance bill his patient. He would accept Blue Cross/Blue Shield payment in full for his charges.

Why would any rational doctor do that? The doctors who set up Blue Shield knew what was important to the medical profession and what was important was cash flow. A member physician got the right to direct bill Blue Shield. The contracts that Blue Cross/Blue Shield enter into with the subscribers specifically state that if you go to a member physician, that member physician gets to bill Blue Cross/Blue Shield directly. If, on the other hand, you go to a nonmember physician, Blue Cross/Blue Shield sends you the check and the physician or the hospital must pursue the patient for payment. This is the medical profession that set this up, and it works because the doctors have a choice, and the hospitals will have a choice. They can either decide they want to bill everything the market will bear regardless of whether Blue Cross/Blue Shield or any other disability insurer thinks it is reasonable, or they can have the right to direct bill. That situation on the physician's side has existed since 1946.

No one has ever contended the Physician Lien Law applied to Blue Cross/Blue Shield until last year. A group of doctors thought they have a way to get the benefits of membership, direct payment, without the obligations of membership which they agree to accept as payment in full. The device they came up with was to say the Physician Lien Law applies to the payments Blue Cross makes for medical care. Never mind if the purpose of the Lien Law is for personal injury. They won in the District Court. He appealed to the Montana Supreme Court. They argued about cost containment, explained the whole thing to them, and asked the statutes be interpreted reasonably. The very narrow opinion the Court rendered, and the Court is obligated to render a narrow opinion, is Blue Shield was not an insurer when the Lien Law was passed, and the Lien Law applies to insurers, therefor it doesn't apply. Now Blue Shield has been defined as an insurer, as a disability insurer, but the Court said that doesn't matter. It

didn't reach the question argued in the Supreme Court, but all disability insurers are in fact exempt.

How did hospitals get involved in this? Blue Cross was formed by the Montana Hospital Association. There is quite a bit of difference between the hospital side and the doctors' side. Every hospital is a member of Blue Cross, but there also has never been a significant cost containment feature in the membership contracts that Blue Cross had. Why? For many, many years the hospitals controlled Blue Cross. Also it was the nature of the hospital. All hospitals until recently were nice sleepy little community things. They were run by a board, sometimes they made money, sometimes they didn't. If they ran out of money, they went to the community and got some more. That is not the case any more. The urban hospitals in Montana, and the Montana big city hospitals are not run that way, they are now run by highly competent, highly skilled professional administrators. They actively and aggressively market for business. They are highly profitable. The big city hospital in Montana almost without exception is not only earning a profit, it is earning millions of dollars in profits. **EXHIBIT 23** Last year Blue Cross went to the 12 large urban hospitals and said they wanted in their membership contracts when a contract is entered into with you, to sit down and negotiate a prospective payment schedule. A schedule of payments that you will accept as payment in full, and you will agree to be bound by those payments as long as the contract is in effect. If the hospitals think that is wrong, they cannot be member hospitals, but they want the benefit of being member hospitals without any of what have traditionally been the obligations at least on the physicians side. They want to direct bill, but they don't want anyone suggesting they should agree to a fixed series of payment schedules. They are coming to the Legislature to seek the same unfair advantage that the doctors went to the Supreme Court for and for which they lost.

This bill provides a simple choice. Is it wrong for Blue Cross/ Blue Shield or any other disability insurer on behalf of its subscribers to try to negotiate stable flat hospital rates? Is it wrong to try to do something to try to stop the soaring costs of health care? If you think that is wrong, you vote for HB 405. On the other hand if you think it is appropriate for insurance companies on behalf of their subscribers to try to sit down with the largest providers of hospital service in the State and simply negotiate prospective payments, payments they will agree to accept during the period of the contract as payment in full; if the containment or attempt to contain soaring health care costs is right, you have no choice but to vote No.

It is very important to understand that all disability insurance companies are exempt. If there is any question that is the case, he will be happy to sit down and draft an amendment that makes clear what actually already is clear, that all providers of health disability insurance are exempt. **EXHIBIT 24**

Michael Sherwood, Attorney in Missoula, appeared on behalf of the Montana Trial Lawyers Association to oppose HB 405. **Mr. Alke** made two points that are pertinent to his testimony. They support **Mr. Alke's** position, but beyond that, the first point he made was to look at the title of this bill. It involves a physician lien in a personal injury situation, and secondly, you do have a choice in this case. This bill now allows a physician lien on a life insurance policy. That means if you were to die as a result of an accident and you left a $100,000 life insurance policy to your children which, by contract, would be paid by your life insurance carrier to your children, the physicians, hospitals, and other health care providers would now have a benefit that no one else in the State enjoys. They would be able to file an action, a claim against your estate in order to recover any costs that were incurred by you as a result of injuries prior to death. In addition, it would be able to take part or all of that $100,000 from your children. That was not the intent of the bill then or when it was initially enacted. As has been pointed out, it is not good public policy now.

You have the choice to give that money to the physicians and health care providers or to the children of people who have died as a result of an accident. The latter is the better policy. Perhaps the latter course is the only legal policy in the sense that when someone dies and leaves money as a result of contracted insurance relationship to a third party, specifically their children or their surviving spouse, those funds are not controlled by will, they are controlled by operation of the statute and all or a portion of all of those funds are excluded from one's estate. What is being proposed here may in fact be in violation of the probate and estate code of Montana as well.

Patrick M. Driscoll, Attorney in Helena representing the American Council of Life Insurance, reiterated what the previous two speakers had said. The two points he would make would be that this bill might not have just one or maybe two Constitutional problems, in one case violation of the rules. It appears to have a double purpose, the provisions of Section 2 seem to go much further than the drafter might have intended, and applying these liens to life insurance is a separate subject and should be dealt with in a separate bill which they would also oppose. The second point is that this appears to have a potential for resulting in an interference with contract which is a Constitutional problem. That is that the beneficiary of a life insurance policy is entitled to those benefits under the terms of the contract and by assigning or allowing someone to have a lien against those benefits, a lien which appears to be unrelated to the purpose of a life insurance policy, would be creating Constitutional problems. At a minimum, provisions of Section 2 should be stricken from the bill. The American Council of Life Insurance opposes the bill itself.

Questions From Committee Members:

REP. CROMLEY asked if **Mr. Sherwood** or **Mr. Driscoll** had seen the amendments this morning. Neither had. **EXHIBIT 20**

REP. CROMLEY said it looks like the same language was taken out and put back in in the amendment this morning. **REP. WALLIN** said that was put in with a little additional explanation. **REP. CROMLEY** wanted to know why life insurance was taken out of the statute originally. **Katherine Donnelly, an attorney representing MHA,** said the language was taken out of the statute entirely on the Council's own volition. What you see with the amendment is the original intention.

REP. CROMLEY asked if that changes their position. **Mr. Sherwood** said after briefly looking at this amendment, as he understands it, we are now putting life insurance benefits back into the statute as an exemption to the Physician Lien Act. If that is what that amendment is doing, they do not oppose the bill for that reason, and that was the primary concern of his Board of Montana Trial Lawyers Association. **Mr. Driscoll** said he would take the same position. This appears to deal with the two technical problems that were present and obviously deals with life insurance in a satisfactory fashion.

REP. ELLIS said you testified large hospitals were extremely profitable in Montana. **Mr. Alke** left the 1989 earnings report of the 12 large Montana hospitals prepared by Medicare. **EXHIBIT 22** He explained there were two hospitals that had a loss, Kalispell Regional Hospital had a loss of $3,977, and the Missoula Community Hospital had a significant loss of $3.2 million. About half of that loss is associated with a bond defeasance. The other hospitals' profits ranged from $6.2 million to $519,020. Last year St. Peter's Hospital in Helena net profit was $3 million.

REP. ELLIS asked the overall profit for all hospitals. **Mr. Ahrens** said the overall profit for all hospitals in 1989 was 1.8%, hospitals having more than 190 beds it was 4%, so the return on investment in those figures and the overall budget should be looked at. Hospitals with 30 beds and under had an operating negative of 15%. This has to be taken in perspective. For the overall hospitals in Montana it is 1.8%. If all of them were so profitable, we wouldn't have one close each year and we wouldn't have been in here on the last bill. **EXHIBIT 23**

REP. SCOTT asked how he felt about the $5.2 million profit for St. Vincent's Hospital in Billings. Isn't there something about being a nonprofit organization that is a determining factor under which those hospitals operate? **Mr. Ebzery** said he hadn't seen those numbers so doesn't know about their accuracy. It is obviously in the Medicare chart. He thinks hospitals are nonprofit organizations. Some are in business in Billings in the health care field which is a big business. There are 1200 employees in their hospital alone. There may be some profit some years, there is risk in health care, there may be good years and bad. This is not a hospital that is run by the community or the

State, it is a private hospital.

REP. TUNBY asked if the amendments made any difference to you. **Mr. Alke** said the amendments did not affect them at all. They have recognized that all disability insurers are currently exempt, so they are saying they are exempting disability insurers, but are not going to exempt those disability insurers as relates to medical insurance. There is really a number of types of insurance companies that are within the definition of disability insurers. If you bought a policy insuring your income earning potential and were injured that is a contract of disability insurance. But under Montana law a contract of disability insurance is also a health insurance contract, and Blue Cross/Blue Shield is now defined as a disability insurer under Montana law, so the amendments say some disability insurers are out, and some are not out.

REP. TUNBY asked what is your main opposition to the bill? **Mr. Alke** said the only carrot that Blue Cross/Blue Shield has with the hospitals and doctors is the difference between direct payments, the ability to direct bill them, as opposed to have to go after their own patients. If it is legislatively said a nonmember hospital or doctor is entitled to direct payment from the Blues through the device of the Physician Lien Act, they simply won't have any members. There would be no reason for them to become a member because they have what they want without membership, and that would be the end of cost containment.

REP. TUNBY asked elaboration on his side of this. **Mr. Ahrens** said the attorney is right, but they are not members of other insurance companies either, so they are just asking the same playing field be there.

REP. STELLA JEAN HANSEN said this was to require insurance companies pay hospitals and doctors directly rather than paying the patient. Is there any reason if they did not pay directly that they would pay the patient any differently than what they pay you directly? **Mr. Aherns** said the payment would be the same to the hospital or to the person.

REP. ELLIS asked if most insurance companies do pay you? **Mr. Ahrens** said somebody insured with an insurance company other than Blue Cross normally assigns that benefit over and payment is made directly to the hospital. They do not have that option with Blue Cross.

REP. BENEDICT asked if the direct payment that you are seeking through this bill is currently not available to you from Blue Cross unless you are a member of their organization? You want to be able to be paid directly whether you are a member of their organization or not? **Mr. Ahrens** said the answer to both questions was Yes. **REP. BENEDICT** continued if you are not a member of their organization, what incentive do you have to contain costs? **Mr. Ahrens** thought Blue Cross of itself doesn't make you contain

costs, neither does any other insurer. That is an industry situation and all hospitals are cognizant of the increase in costs and are part of this. They also belong to a voluntary rate reducing system which looks at their costs and charges each year. The incentive is that you have to do business reasonably within Montana and some are probably taken aback by large numbers of what would be called profit or surplus, but if you are a $50-60-70 million business you have to have some return. There could possibly be a question of whether those numbers are right for the amount of surplus.

REP. McCULLOCH asked if this would also affect self-funded insurance programs or modified self-insured programs? **Mr. Alke** said it would not, so a self-insurer would have the ability to enter into contracts with hospitals and doctors and do exactly what we are doing, but the Blues would have the prohibition in the statute and could not do it. That is a real important point because more and more of the entire market out there is self-insured, and they are not governed by the State regulatory laws on insurance companies. In many cases they are preempted under federal law from having to comply, so the self insured would get to enter into contracts as they do now, and some of the self-insurance plans they administer now utilize their member doctor agreements. If this law were passed, they would continue to be able to utilize their member doctor agreements, but the Blues couldn't.

REP. ELLIS said there are several ways to weigh profits. One commonly used is profits against gross revenues which was already done by you. Another way to do that is against equity, and without both figures it is very difficult to tell because industries vary tremendously. Do you have any of those figures? **Mr. Ahrens** was not sure they had them but would share those they do have. He did not know.

Closing by Sponsor:

REP. WALLIN said regarding the question of nonprofit status of hospitals, they obviously have to operate for profit to keep the doors open. They are not for-profit institutions. They are not run to pay stockholders any money, there are no dividends declared. There are no chain outfit run hospitals in Montana. He sits on the Board of the Deaconess Hospital in Bozeman and has for 9 years. They accumulate profits but those profits are turned back in investments in equipment to keep pace with new technologies. Profit is not turned into cash, it is turned into equipment for medical care and is a capital investment.

It was inferred by Blue Cross/Blue Shield they reserve the right to check the rates. Hospitals don't set their own rates, they go through review boards outside of their own perimeter. The rates have to be adequate to take care of the hospital's needs to maintain and keep abreast of technologies in order to keep doctors. The money doesn't go into anyone's pockets. Capital

expenditures use up all profit. Rates are the result of one company or firm passing judgment on rates that are approved by an outside board. The rates have to be justifiable and reasonable before they are approved by the Board.

The insurance codes do not apply to this type of bill. We are looking for fair treatment for the hospitals by this one insurance company that the others already provide. The hospital has to have the leverage to be paid direct by the Blues as is done by other insurance companies.

He strongly feels this bill is in order. The Physician Lien Act is a matter of getting assignment, gives hospitals and other health care providers some type of protection against a person who receives health insurance benefits but does not pay his medical bills. Hospitals have this protection unless the person happens to have Blue Cross/Blue Shield insurance; they don't have that protection from them and want it. If the hospital signs the Blue Cross' contract, that contract can be terminated by either side on notice, so it is not a really binding contract. As the law currently stands the Physician Lien Act provides a way for hospitals to receive health insurance payment directly from all health insurers except Blue Cross. That is fundamentally unfair. There really is no difference between Blue Cross and other health insurers when it comes to the intent of the Physician Lien Act, the intent of which is simply to make sure health care providers get their money when the third party is reimbursing the patient for medical costs. This intent applies equally to health service corporations and other health insurers. Blue Cross determines premiums, they write policies and they write checks as reimbursement, so they are an insurance company in the term of other insurance, and they should be subjected to the same Physician Lien Act that the other insurance companies are. This is a fair bill and he would like to have it approved.

ADJOURNMENT

Adjournment: 12:20 p.m.

Rep Bob Bachini
REP. BOB BACHINI, CHAIRMAN

Jo Lahti
JO LAHTI, SECRETARY

BB/jl

HOUSE OF REPRESENTATIVES

BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

ROLL CALL DATE Feb 1, 1991

NAME	PRESENT	ABSENT	EXCUSED
REP. JOE BARNETT	✓		
REP. STEVE BENEDICT	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. ALVIN ELLIS, JR.	✓		
REP. STELLA JEAN HANSEN	✓		
REP. H.S."SONNY" HANSON	✓		
REP. TOM KILPATRICK	✓		
REP. DICK KNOX	✓		
REP. DON LARSON	✓		
REP. SCOTT MCCULLOCH	✓		
REP. BOB PAVLOVICH	✓		
REP. JOHN SCOTT	✓		
REP. DON STEPPLER	✓		
REP. ROLPH TUNBY	✓		
REP. NORM WALLIN	✓		
REP. SHEILA RICE, VICE-CHAIR	✓		
REP. BOB BACHINI, CHAIRMAN	✓		

3:5
2-1-91

HOUSE STANDING COMMITTEE REPORT

February 1, 1991

Mr. Speaker: We, the committee on Business and Economic Development report that House Bill 331 (first reading copy -- white) do pass as amended .

Signed: _____
Bob Bachini, Chairman

And, that such amendments read:

1. Title, line 4.
Strike: "REQUIRING"
Insert: "AUTHORIZING"

2. Title, line 5.
Strike: "NOT DISCLOSE"
Insert: "RESTRICT THE DISCLOSURE OF"

3. Title, lines 6 and 7.
Strike: "TO CERTAIN PERSONS REQUESTING THE INFORMATION FOR COMMERCIAL PURPOSES"
Insert: "UPON REQUEST OF THE VEHICLE OWNER"

4. Page 1, line 10.
Following: line 9
Insert: "

STATEMENT OF INTENT

A statement of intent is required for this bill to provide guidelines for the adoption of administrative rules to implement 61-3-101(8). The department of justice is granted authority to reasonably restrict by rule the dissemination of vehicle registration information if the restriction is requested in writing by the vehicle owner and the department determines the demands of individual privacy clearly outweigh the merits of public disclosure."

5. Page 3, line 20
Following: "may" on line 20
Strike: remainder of line 20 in its entirety
Insert: ", by rule, reasonably restrict disclosure of"

6. Page 3, lines 21 through 23.
Following: "vehicle" on line 21
Strike: remainder of line 21 through line 23 in their entirety

HOUSE STANDING COMMITTEE REPORT

February 1, 1991

Mr. Speaker: We, the committee on Business and Economic Development report that House Bill 348 (first reading copy -- white) do pass .

Signed: _____
Bob Bachini, Chairman

EXHIBIT 1
DATE 2/1/91
HB 331

Amendments to House Bill No. 331
First Reading Copy

Requested by Representative Kilpatrick
For the Committee on Business and Economic Development

Prepared by Paul Verdon
February 1, 1991

1. Title, line 4.
Strike: "REQUIRING"
Insert: "AUTHORIZING"

2. Title, line 5.
Strike: "NOT DISCLOSE"
Insert: "RESTRICT THE DISCLOSURE OF"

3. Title, lines 6 and 7.
Strike: "TO CERTAIN PERSONS REQUESTING THE INFORMATION FOR COMMERCIAL PURPOSES"
Insert: "UPON REQUEST OF THE VEHICLE OWNER"

4. Page 1, line 10.
Following: line 9
Insert: "

STATEMENT OF INTENT

A statement of intent is required for this bill to provide guidelines for the adoption of administrative rules to implement 61-3-101(8). The department of justice is granted authority to reasonably restrict by rule the dissemination of vehicle registration information if the restriction is requested in writing by the vehicle owner and the department determines the demands of individual privacy clearly outweigh the merits of public disclosure."

5. Page 3, line 20
Following: "may" on line 20
Strike: remainder of line 20 in its entirety
Insert: ", by rule, reasonably restrict disclosure of"

6. Page 3, lines 21 through 23.
Following: "vehicle" on line 21
Strike: remainder of line 21 through line 23 in their entirety

EXHIBIT
DATE 2/1/91
HB 350

Amendments to House Bill No. 350
First Reading Copy

Requested by Representative Bob Pavlovich
For the House Committee on Business and Economic Development

Prepared by Tom Gomez
January 31, 1991

1. Title, line 5.
Following: "ASSIGNMENTS;"
Insert: "TO PROVIDE CERTAIN EXEMPTIONS;"

2. Title, line 6.
Following: "A"
Insert: "CIVIL".

3. Page 1, line 10.
Following: line 9
Insert: "NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 4], the following definitions apply:

(1) "Beneficiary" means any person enrolled in the medicare program who is a resident of the state and whose income does not exceed the appropriate base amount defined in 26 U.S.C. 86 for federal taxation of social security benefits.

(2) "Health care provider" means a person, firm, corporation, association, or institution that provides goods or services subject to payment or reimbursement under the federal medicare program in accordance with Title XVIII of the federal Social Security Act (42 U.S.C. 1395, et seq.)."
Renumber: subsequent sections

4. Page 1, line 10.
Following: **"assignment."**
Strike: "(1)"

5. Page 1, lines 19 through 24.
Strike: subsection (2) in its entirety

6. Page 2, line 1.
Strike: "1"
Insert: "2"

7. Page 2, line 4.
Strike: "1"
Insert: "2"

Ex. 2
2-1-91
HB 350

8. Page 2, lines 5 and 6.
Following: "$2,000" on line 5
Strike: remainder of line 5 through "both" on line 6

9. Page 2, line 8.
Strike: "and 2"
Insert: "through 4"

10. Page 2, line 11.
Strike: "and 2"
Insert: "through 4"

11. Page 2, line 12.
Following: line 11
Insert: "NEW SECTION. **Section 5. Exemptions.** Licensed physicians who are family care practitioners or general practitioners located in counties with five or fewer licensed physicians are exempt from the provisions of [sections 1 through 4]."
Renumber: subsequent sections

12. Page 2, line 15.
Strike: "3"
Insert: "5"

13. Page 2, line 17.
Strike: "3"
Insert: "5"

6/1/91

EXHIBIT 2-1
DATE 2/1/91
HB 350

Medicare would give less money to specialists

WASHINGTON (AP) — Federal health officials announced a new Medicare fee schedule Friday giving a bigger share to family doctors and general practitioners but less to surgeons and other specialists.

The government hopes the first major change in how physicians are paid under the 25-year-old health care program for the elderly and disabled will lead more doctors to practice in rural areas and slow their movement into specialties.

"Physician payment reform in large part succeeds in correcting historical price distortions, especially for specialized procedures, which have been traditionally overvalued, and primary care, which has been undervalued," said Gail Wilensky, head of the Health Care Financing Administration.

The change, intended to become final in five months, "sends signals to have doctors more involved in primary care by making it more rewarding," she said.

Medicare serves about 34 million elderly and disabled Americans. Because of its size, its revisions are watched closely and often followed by the private insurance industry.

Instead of basing physicians' payments on prevailing and reasonable charges, as Medicare does now, the program will pay doctors based on a national fee schedule, adjusted only for geographical differences.

The largest increases will go to family physicians and general practitioners, who will see their fees increase 14 percent and 15 percent, respectively, in the first year and 17 percent and 16 percent by 1996.

The biggest decrease will be in fees for ophthalmologists and anesthesiologists. Doctors in these fields will see their Medicare reimbursements drop by 3 percent in the first year and by 16 percent in 1996.

4

EXHIBIT 2-2
DATE 2-1-91
HB 350

TESTIMONY
PREPARED BY ELSIE LEE
FOR
HOUSE BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE

Chairman Bachini and Committee Members.
My name is Elsie Lee. I reside in Great Falls.

Health care costs in Montana have been skyrocketing--if increases continue, they are likely to double during the next 10 years.

Between 1980 and 1988, seniors' health care costs rose 12% each year.

Seniors pay out of pocket 43% of their total health care costs (hospital bills, doctors' bills, prescription drugs, other costs).

On average, seniors spent $2,394 out-of-pocket for health care in 1988, which represents 18% of their income

On average, seniors are spending a larger percentage of their budget on health care now than 25 years ago when Medicare was established.

Every year that there is a failure to control seniors' out-of-pocket share of health costs, they will get deeper and deeper into financial trouble.

By contrast, each year between 1979 to 1983 physician fees for Medicare patients increased 20.6 percent.

Physician incomes have also been increasing. According to the American Medical Association, physicians incomes for this region average over $142,000.

Physician Payment Reform enacted by Congress will also help by adjusting the ~~fee~~ Medicare fee schedule to make it more fair.

The important point is that Physicians will continue to make a good living even when they accept Medicare rates.

We recognize that this bill is not the total solution, but it will be a first step in controlling health care costs and making health care more affordable for a majority of seniors.

I urge you to vote for the Medicare Overcharge Management or MOM Bill.

Health care is a major problem for Senior Citizens. In 1985 people over 60 made up about one sixth of the population but used about 40% of the prescription drugs. They also use around 30 to 40% of the medical care.

EXHIBIT 2-3
DATE 2-1-91
HB 350

Before Medicare Seniors were spending 14 to 15% of their incomes for Medical care. Now with Medicare they are spending 18 to 20% of their income for medical costs due to increased insurance costs, deductables and Doctor's overcharges. Medicare was originally designed to cover 75% of medicare patients health care costs. Now it covers around 40%. Families USA report that people are underinsured if they risk spending more than 10% of their income on health care.

The Department of Commerce reported that in 1989 health costs rose 10.4% and are expected to rise from 10% to 14% through 1995. Social Security checks increased 4.7% in 1990 and 5.4% this year. Health costs escalating at twice the rate of general inflation are pricing Seniors as well as others out of the ability to pay for their health care.

To illustrate why we Seniors are interested in Medicare Assignment I am quoting figures from my Doctor Bills and Medicare statements on my operation for a knee joint replacement last November.

Orthopedic Surgeons billed $2890.28. Medicare allowed $1923.90. 67% of the bill.

C.R.N.A. Associates for anesthesia billed $392.50 Medicare allowed $157.78 or 40 % of the bill. They accepted assignment and my insuraance covered the 22% not paid by Medicare.

Dr. Snider billed $93.65 Medicare approved $74.40. 79%

Dr. Healow billed 355.19. Medicare approved $233.97. 66%

Nakagawa billed $2393. Medicare approved $20.30. 85%

W. R. Bland billed for x rays $51.80. Medicare allowed $25.99. 50% This was an assignment.

St. Vincent Hospital billed $10 for diagnostic lab. Medicare allowed $6.00 or 60%. This was on assignment.

Since my supplemantary insurance with AARP covers only up the amount approved by Medicare as most of the supplementary policies, I have had to pay all the overcharges except from those that accepted assignment. My policy contains a $200 Doctor bill deductable so I paid $1310. 47 of Doctors overcharges. Since Medicare ~~xxxxxxx~~ allowances are based on Doctor's charges, there is no reason for these overcharges and I hope the Committee will support the Medicare Control of Cost Assignment Bill.

Marion Hellstern

Sources of information: Worst Pills, Best Pills, Public Citizen Health Research Group.

MSCA Position paper 1987

Families USA Foundation Report 10/25/90

Health Week

EXHIBIT 2
DATE 2/1/91
HB 350

EXHIBIT 2-4
DATE 2-1-91
HB 350

Exhibit #2-4

TESTIMONY
PREPARED BY ELMER FAUTH
HOUSE BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE
FEBRUARY 1, 1991

Chairman Bachini and other Committee Members.

My Name is Elmer Fauth. I'm a member of the Montana Senior Citizens Association Board of Directors. I reside in Great Falls.

The Montana ~~Montana~~a Senior Citizens Association recognizes that the MontShare program has helped some seniors and is better than no program at all. But as a voluntary program it has limitations--not all physicians and only a small percentage of eligible seniors have participated.

MontShare as it currently exists has income guidelines which are too low and as long as Montshare is a voluntary program many people will not sign up. We suspect that this is partly because people don't know about the program but also because it is one more form which has to be filled out.

Programs like MontShare have been set up all over the country with the primary intent of preventing states from adopting mandatory Medicare assignment bills.

This MOM bill differs from the past because it introduces a means test, but it is better than the MontShare program because it would increase participation while eliminating only the more wealthy seniors. Seniors would not have to sign up for another program but would automatically be eligible. It would be up to physicians to request proof of income in situations where more wealthy seniors were suspected of being above the income guidelines.

We are still opposed to means testing because Medicare is an entitlement program, not a welfare program. We continue to think it is unfair for people to have to present their financial statements to decide if they are worthy of Medicare rates. But we are ready to compromise on this critical point if it will help control health care costs for a majority of seniors. It is important that a the number of Medicare claims where assignment is accepted be increased. Montana shouldn't have one of the lowest rates of participation in the nation.

I urge you ~~not~~ to vote ~~against~~ FOR MOM

By helping Seniors on Medicare we are helping their kids & grandkids (our future generation) because a good many Seniors are paying the monthly premiums for their coverage that ought to be covered by paying out of

DATE 2/1/91
HB 350

SUPPORT OF MEDICARE ASSIGNMENT BILL

I'm Margaret Fleming, Butte. I rise today in support of the Medicare Assignment Bill. I'm a former manager of Social Security offices, retired.

The rising costs of medical care, including those costs of the Medicare program under Social Security, prompts my request for you to support this bill, HB-530. Seniors are spending one and one-half times more of their income on health care costs now than they were ten years ago, and with projected increase of costs for the medicare program, those expenses will rise in the future.

We realize that many doctors do, at the present, consider assignment, at their discretion, for "needy" patients. It has been my experience, however, as an administrator of the Social Security and Medicare programs, that many who could qualify under those guidelines **do not request that help.** They are a generation different from the other groups - fiercely proud of their ability to care for themselves, raised on the notion that Social Security and Medicare are an **earned right**, they do not wish to accept anything that even smacks of "gratuity". I have seen families pay those bills, even at the expense of other necessities of life, until they are then forced to go to welfare aid. I have further seen the traumatic effect such actions then have on these people, a generation that felt it was "the American way", to pay their bills at whatever cost to themselves and their families. From this experience, I have always opposed means testing, but I do support this bill because I believe it will extend Medicare assignment to more people.

I have then seen the effect such independence of spirit has on the young members of those families. Struggling themselves, to buy homes for their families, to pay for their education, they feel the need to divert their funds to help these senior family members. They must feel a great irritation at that stubbornness, but surely they know it is as much a part of their parents' feelings as every other belief they so strongly hold.

It is from this experience that I support the Medicare Assignment bill, and ask you to do likewise. At the present time, 44% of the doctors in the United States accept assignment, though that percentage is smaller in Montana. The medical profession, historically caring for their patients, have a large number who support this issue, even at cost to themselves. I also believe we are also aware that some of the resistance rises from the fear of further government intervention in the practice of their honored profession, for which they have contributed so much money and time in order to serve their fellow human beings.

In spite of knowing all those reasonable objections, I still feel we Montanans must look at the need for affordable medical care for all Americans. A recent American Medical Assocation study gave

statistical data indicating the average income for doctors in the United States. In considering those figures, I believe we must also consider the figures relating to average income for senior. in Montana. On fixed income, with limited ability to supplement that income by working, and as other statistics show, with limited resources in the way of savings, there is no comparison of the need for passage of this bill.

Montanans, imbued with a true sense of justice, are rising to ask for this help for seniors. I believe it is an idea whose time has come. I recognize there will be objections to such passage, some reasonable, some merely to protect a "special status" of more and more income. I saw this at the time that the passage of the Medicare was being strongly supported, and strongly denounced. That, too, was an idea whose time had come. It benefitted not only the beneficiariaries, but the medical profession, as well. Acceptance of assignment of benefits guarantees that the payment comes direct to the physicians.

I urge you, then, to support the passage of HB-530, the Medicare assignment bill.

Margaret Fleming

Exhibit 3 contained 20 pages of signed petitions (see example). The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

3
2-1-91
HB 350

EXHIBIT 3

ENDORSEMENT OF
MEDICARE ASSIGNMENT

WHEREAS medical costs have skyrocketed during the last decade, and seniors spend one and one-half times more of their income on health care costs now than ten years ago; and

WHEREAS we believe that health care costs should be affordable; and

WHEREAS 44% of doctors in the United States have signed up to accept Medicare rates in full payment for their services and since $142,000 is the average income for doctors in the seven-state regional area including Montana, we conclude that, in general, Medicare rates must be considered adequate and reasonable.

THEREFORE, we believe that doctors should not charge the Medicare beneficiary above the Medicare approved rate and should accept assignment; and

THEREFORE, we urge the Montana legislators to pass the bill requiring doctors to accept assignment for their Medicare patients.

NAME	ADDRESS	PHONE
Gertrude Voorhoky	3024 Grand Butte	782-79
Paul Voorhoky	3024 Grand Butte	782799
[illegible]	3320 Sanders	494-41
Mary Mellott	3112 Edwards	494-76
Pat J. Carlin	3219 Bayard	494-507
Leo D Burke	3550 Paxson ave	494-3319
[illegible]	3418 Locust St	782-1445
[illegible]	[illegible]	723-5632
[illegible]	2301 Porter St	723-4066
Warren Stillings	1028 W. Porphyry	782-7920
Eleanor Stillings	" "	"
Robert E Thurmond	Route #3 Butte	782-5105
Helen Bonanno	608 W. Mally	723-8755
Margaret Siemmers	2119 Livingston Ave	443-0678

4
2-1-91
350

TESTIMONY
PREPARED BY DOUG CAMPBELL
FOR
HOUSE BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE
FEBRUARY 1, 1991

Chariman Bachini and members of the Committee.

My name is Doug Campbell, I am the President of the Montana Senior Citizens Association. I reside in Missoula.

I would like to summarize the points which have been made.

First, health care costs are out of control. The Medicare Overcharge Management or MOM bill offers a means for controlling costs and making health care more affordable for a majority of seniors. It isn't a total solution, but it is a step in the right direction.

Second, Seniors are spending more than ever for health care. In spite of Medicare, seniors out-of-pocket costs for health care are three times that of any other age group. Medicare was orginally designed to cover 75% of seniors health care costs. It now covers less than 50%. Average out-of-pocket costs for seniors health care in 1984 was $1055. In 1988 it was $2,394, more than double in only five years. Contrast that with Social Security increases of 3 to 5% a year in that period and realizing that Social Security is the main source of income for most seniors.

Third, by contrast physician incomes have increased. According to the U.S. Select Committee On Aging, physician incomes have increased two to three times the overall inflation rate since 1983.

Fourth, Physician Payment Reform which will take effect in January 1992 will make Medicare fees more equitable. It should be added that physicians were involved in that process.

While it is true that physicians do not make as much in Montana as in many other states - the same can be said for all professions. There are other reasons why people locate in Montana.

Fifth, only two states have a lower percentage of doctors who accept assignment for all Medicare beneficiaries--23% in Montana compared to the national average of 44%.

Similarly, assignment is accepted for 79% of all Medicare claims nationally, while in Montana doctors accept assignment on only 55.5 percent of the claims.

As a result, physician overcharges or balanced billing amounted to $10.6 million 1989.
Sixth, In the past we have alway opposed means testing because Medicare is a health insurance program and was never meant to be a means tested. In 1982 the U.S. Senate voted 70 to 29 to kill an amendment which would have applied a means test to Medicare. We also feel that means testing is degrading. We would never ask physicians to display their incomes to determine which ones are in need of additional Medicare payments.

However, if means testing is needed to increase Medicare assignment we are willing to compromise. But we will not accept a voluntary program such as MontShare which sets the income levels so low and requires seniors to sign up for yet another program in order to participate. the MontShare means tested program which Montana's physicians started two years ago in response to a proposed mandatory assignment legislation has benefited only a small percentage of seniors. As in most states, participation rates have been low.

Finally, there is little evidence to show that rural doctors would be effected as many already accept assignment and are able to make a decent living. None the less we have again compromised our position and exempted all Family Care Practitioners and General Practitioner in counties with five or fewer doctors.

I urge you to vote for the Medicare Overcharge Management or MOM bill which will increase the number of Medicare claims where assignment is accepted and bring Montana closer to the national average. More importantly, it will help control health care costs and make health care more affordable.

EXHIBIT 4
DATE 2/1/91
SB 350

MEDICARE OVERCHARGE MANAGEMENT (MOM) INFORMATION SHEET
House Bill 350

EXHIBIT 4-A
2/1/91
350

WHY IS THIS BILL NEEDED?

Seniors cannot afford the skyrocketing costs of health care. Between 1980 and 1988, seniors health care costs rose 12% each year. On average, seniors spent $2,394 out-of-pocket for health care in 1988, which represents 18% of their income. Every year that there is a failure to control seniors out-of-pocket share of health costs, they will get deeper and deeper into financial trouble. This bill can stop that trend.

WHO WILL BE AFFECTED BY THIS BILL?

The bill will affect physicians who provide services not considered primary care. In other words, specialists who account for most of the large overcharges. Primary care physicians are excluded, as are surgical supply services, hospitals and ambulance services.

The bill only applies to Medicare recipients with incomes less than the social security taxable income guidelines of $25,000 for a single person and $32,000 for a couple. The bill does not apply to Medicaid recipients.

WHY HASN'T MONTSHARE WORKED?

First, only about 15% of the eligible seniors and not all physicians have signed up for MontShare.

Participation rates in the MontShare program are low probably because people don't think about MontShare until they need to go to a doctor and then believe it is too late to sign up. People also don't like to admit that they can't afford medical care and are low income. Others just don't know about MontShare.

The MOM bill would automatically make people eligible. They wouldn't have to sign up before going to a doctor. However they will have to state whether their income is above or below the income guidelines which are $25,000 for a single and $32,000 for a couple. Physicians do not have to accept Medicare rates for wealthy seniors even though 23% of physicians already do.

HOW WILL THE MOM BILL AFFECT PRIMARY CARE PHYSICIANS?

The procedures most often performed by primary care physicians in an office or home visit are excluded from this bill. The bill is aimed at specialists who account for most of the Medicare overcharges and receive the highest compensation. According to a representative of the Montana Medical Association some higher paid specialists are making as much as $500,000. It was also claimed that the primary care physicians are making significantly less than the $80,000 average income. For this reason primary care procedures have been excluded from the bill.

HOW WILL THE MOM BILL AFFECT PHYSICIANS IN RURAL AREAS?

Since rural physicians mostly provide primary care, the bill will have little affect on physicians in rural areas. Attracting primary care physicians to isolated rural areas will continue to be a problem, but this bill is unlikely to be a determining factor in a physician's decision about where to locate. In fact, states which have enacted much more comprehensive laws (laws requiring all physicians to accept Medicare rates) have actually had an increase in the number of physicians.

The Physician Payment Reform which will revise fee schedules and make them fairer for rural areas will also help. The revised rates will go into effect in January 1992.

WHAT PERCENTAGE OF MEDICARE CLAIMS SUBMITTED ARE ACCEPTED ON ASSIGNMENT?

According to the Health Care Financing Administration, in Montana only 55% of Medicare claims are accepted on assignment as compared to the national average of 79%. Only four states have a poorer record.

WHAT ADVANTAGES DOES THE MOM BILL HAVE OVER MONTSHARE?

Participation among seniors and doctors will be higher because all physicians will participate and seniors will automatically be eligible. As a result, the MOM bill will more effectively reduce the $10.6 million in Medicare overcharges without hurting "lower income" doctors. At the same time, physicians will continue to be able to charge "wealthy" seniors more.

Ex. 4 A
2-1-91
HB 350

House Bill 350

2-1-91
350

My name is Tim Harris and I am the Deputy Director of the Montana Independent Living Project. I would like to address the issue of Medicare Assignment as it pertains to people receiving Social Security Disability Insurance. Many folks with disabilities who are receiving Disability Insurance are on fixed incomes which are low. Most of the consumers we serve who are receiving Disability Insurance must rely on as many of the state , county and local subsidy programs they can qualify for in order to live from day to day. We all suffer from shrinking spending power, but those of us who are employed seem to be able to maintain level with the cost of living. People who are disabled and on Disability, however, find it increasingly difficult to stay even close to the rising costs of living. Besides that, people with disabilities cannot find health insurance to cover Medicare deductibles because they are disabled. Consequently, medical costs, which tend to be high among the disabled anyway, must come out of a pocket that is not very deep and is full of holes.

I urge you to consider passage of this legislation. Thank you.

Tim Harris
Montana Independent Living Project
38 S. Last Chance Gulch
Helena, MT 59601

Exhibit 6 contained 26 pages of signed petitions (see example). The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

House Business & Economic Development

EXHIBIT 6
DATE 2-1-91
HB 350

ENDORSEMENT OF
MEDICARE ASSIGNMENT
(also known as MEDICARE OVERCHARGE MANAGEMENT)
(or MOM)

WHEREAS medical cost have skyrocketed during the last decade, and seniors spend one and one-half times more of their income on health care costs now than ten years ago; and

WHEREAS we believe that health care costs should be affordable; and

WHEREAS doctors fees have increased two to three times the rate of inflation during this period; and

WHEREAS 44% of doctors in the United States have signed up to accept Medicare rates in full payment for their services and since $142,000 is the average income for doctors in the seven-state regional area including Montana, we conclude that, in general, Medicare rates must be considered adequate and reasonable.

THEREFORE, we believe that doctors should not charge the Medicare beneficiary above the Medicare approved rate and should accept assignment; and

THEREFORE, we the seniors of Fairview Sr. Citizens

urge the Montana legislators to pass the bill requiring doctors to accept assignment for their Medicare patients.

NAME	ADDRESS	PHONE
Elizabeth [illegible]	Fairview, MT.	777-3451
Kathryn Allen	" " "	747-5129
Alice M. Shaw	" " "	747-3569
Doris E West	" " "	744-5469
Leona Thorman	" "	547-5398
Eloina Amick		747 5747
Gladys Emby	Fairview, MT	744-5940
Lena Damm	" "	747-5655
Bill Damm	" "	" "
Connie Kilgore	Fairview, MT.	747-2320
Ralph Norby	Sidney, MT	482-2651
Hazel [illegible]		[illegible]
[illegible]	" "	[illegible]-5501
Hertha [illegible]	" "	744-5512
[illegible]	" "	744-5512
Bernice Ha[illegible]	Sidney, MT.	482-2781
[illegible]		747-5520

Please return to MSCA, P.O. Box 423, Helena, MT 59624

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2-1-91
350

DONALD R. JUDGE
EXECUTIVE SECRETARY

110 WEST 13TH STREET
P.O. BOX 1176
HELENA, MONTANA 59624

(406) 442-1708

February 1, 1991

Honorable Bob Bachini, Chairperson
Business and Economic Development Committee
Montana House of Representatives

Dear Rep. Bachini:

On behalf of the more than 24,000 members of the Montana State AFL-CIO, we urge your support of HB350. Nationally, our organization is on record in support of a National Health Care policy which would extend medical coverage to all individuals, regardless of age. Unfortunately, that time has yet to come.

In the meantime, the only medical protection available to many older workers is Medicare. But, when physicians charge more than Medicare will pay, many seniors avoid receiving necessary care, or face financial ruin and loss of independence. Since 45% of all Medicare claims in Montana have excessive charges, it is only fair to senior citizens that health care providers charge no more than the Medicare approved rates.

Senior citizens in Montana deserve health care insurance that pays for their health services. Please support senior citizens by encouraging health care providers to "accept assignment".

We urge you to give this bill a do pass recommendation.

With best regards, I am

Sincerely yours,

Donald R. Judge, Executive Secretary
Montana State AFL-CIO

cc: Sheila Rice
Joe Barnett
Steve Benedict
Brent Cromley
Tim Dowell
Alvin Ellis Jr.
Stella Jean Hanson
H.S. "Sonny" Hanson
Tim Kilpatrick
Dick Knox
Don Larson
Scott McCulloch
Bob Pavlovich
John Scott
Don Steppler
Ralph Tunby
Norm Wallin

DATE 2/1/91
HB 350

Final Draft

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

January 27, 1989
Friday

M E M O R A N D U M

TO: ALL MONTANA LEGISLATORS

FROM: MONTANA MEDICAL ASSOCIATION

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

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

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

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

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

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

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

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

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

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

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

Ex. 8
2-1-91
HB 350

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Sincerely,

J. Michael Sadaj, M.D.
President

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

Van Kirke Nelson, M.D.
Past President

JMS/JWM/VKN:le

Enclosures

Kalispell Ob-Gyn Associates, P.C.

2/1/91
350

OBSTETRICS GYNECOLOGY INFERTILITY

AN KIRKE NELSON, M.D.
OHN L. HEINE, M.D.
ELLIS M. SOWELL, M.D.

PLOMATS OF THE AMERICAN
OLLEGE OF OBSTETRICS AND
YNECOLOGY

October 5, 1988

Hal Rawson
Medicare Intermediary
Blue Cross/Blue Shield
Box 4309
Helena, Mt. 59604

Dear Hal:

In the enclosed article published Monday evening as the lead article in the Kalispell Daily Inter Lake, I, with 80% of Montana's physicians, are alleged in a report released by HCFA to an advocacy group, "Citizen Action", have as "non-participating physicians" submitted claims to Medicare in excess of allowable charges in 45% of the Medicare claims filed, totaling 360,187 claims. This overcharge reportedly is $10.2 million representing "over-payment" of $28.36 per claim, putting Montana 47th among the states in the percentage of claims having excess charges.

This office has never received a denial letter for any senior citizen that we have cared for.

Under the Freedom of Information Act please advise immediately the number of Medicare claims filed in the questioned year of 1987 by our office, Kalispell Ob-Gyn Assoc., and its three physician members, myself, Van Kirke Nelson, M.D., John L. Heine, M.D., and Ellis M. Sowell, M.D.

Further, the number of cases that we as a group of non-participating physicians have "over-billed" for, the specific case and the specific dollar amount for each case.

I am enraged, as are my partners, and will request that the Montana Medical Association immediately request their members to seek consumer information; and if not readily provided by Blue Cross/Blue Shield as the Medicare intermediary, will seek to have the association retain counsel to initiate a class action suit brought by the physicians of Montana to gain this information.

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

Hal, as a source for my ire please find the described clipping from the front page of the October 3rd Daily Inter Lake here in Kalispell. There is no mention in that article--that the length of stay and cost per illness for Montana's seniors is one of the lowest in the nation, that the physician compensation for Medicare is much less than compensation for the same services in many urban areas, and that the majority of us are providing basic laboratory fees at no cost. Further 87% of non-participating physicians in Montana are accepting assignment on a case-by-case basis.

Let's call a spade a spade!

I look forward to your response to the above questions.

Thank you.

Cordially,

Van Kirke Nelson

Van Kirke Nelson, M.D.
VKNjw

Encl.

Gyn Associates, P.C.

OBSTETRICS GYNECOLOGY INFERTILITY

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

DIPLOMATS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

October 26, 1988

Citizens Action
1300 Connecticut Ave. NW
#401
Washington, D.C. 20036

Dear Sirs:

I read with interest your recent news release which appeared in several Montana papers and nationwide regarding "Physician Overcharge" to the Medicare recipient. The report left a lot of unanswered questions, and I would like your help, if you can, with the answers to the following questions.

In your introduction, you relate that all charges are in excess if over and above the approved Medicare rate, which is the lowest of three amounts, the customary charge, the prevailing charge, and the actual charge, which obviously will be the prevailing charge which is at the 75th percentile of the customary charge--firmly establishing that compensation is less in many cases than the cost of providing that service. Is it fair then to label a fee charged by a non-participating physician as excessive, if compensation is less than the cost of the service?

Nowhere in your news releases in Montana did you mention that the length of stay and cost per illness for Montana seniors is one of the lowest in the country. You obviously have access to those records, and would you please rate Montana as you have done so in other ways.

Further, you did not make any mention that Part B beneficiaries throughout the United States pay the same monthly premium, yet compensation for the same service in Montana is considerably lower than it is in Florida, New York, California and other major urban areas. Would you please rate Montana physicians in this regard as to compensation.

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

On Page 6 of your report, you relate that the average excess charge per beneficiary is $95 in fiscal year 1987. Would you please advise as to the average excess charge per beneficiary for Montana's seniors.

Also would you please advise as to the average out-of-pocket expense for Montana's seniors as it relates to health care in your latest statistics available.

You further related that the average physician income was $119,500. Would you please advise as to the average income of Montana physicians and your source of that information.

You state that doctors earn on the average about $60,000 per year from Medicare. Our practice is an active obstetrical and gynecologic practice, and 3% of our gross income is from the Medicare recipient. Would you please advise what the average Montana physician earns from Medicare per year, and what percent of this do you include as excess charge?

Further you relate to income of $60,000, and you imply that as net. What statistics do you utilize for the average operating cost for an office, and how much of that $60,000 is for overhead, and how much of it relates to net income?

In regard to diagnostic tests, I think that it is only fair to advise you that the majority of Montana physicians do not bill the Medicare recipient for simple office procedures, hematocrits, urine analysis, and stool occult blood tests--all of which have costs, but none of which are compensated for by Medicare. For the most part they are provided at no charge to the patient.

It is interesting to note that the same system that you feel physicians should accept on behalf of all of their senior citizens, (Medicare benefits), is the same system which slowly and methodically is allowing the closure of rural hospitals because of inadequate compensation to those facilities, making its continued operation impossible---with those same senior citizens having to travel increasing miles for care.

Certainly John Melcher's U.S. Senate Special Committee on Aging has recognized these problems. Why don't you?

EXHIBIT 8
2/1/91
350

Montana's physicians are concerned about their senior citizens, and those too who have not reached this status. We have an obligation to be fair to all and so also to you.

I do very much look forward to answers to the above questions. Thank you very much.

Cordially,

Van Kirke Nelson

Van Kirke Nelson, M.D.

VKNjw

CITIZEN ACTION

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

November 3, 1988

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

Dear Doctor Nelson:

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lorraine Driscoll

Lorraine Driscoll

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2/1/91
350

MEDICARE

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

P.O. Box 4310
Helena, Montana 59604

October 25, 1988

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

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

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

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

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

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

I hope this information has been satisfactory for your needs.

Sincerely,

Hal Rawson

Harold L. Rawson
Vice President
Planning and Government Programs

HLR:ml

cc: Brian Zins, MMA, without enclosures

Enclosure

15-010

Blue Cross
and
Blue Shield
of Montana

2/1/91
350

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

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

Reply to Helena Division

November 28, 1988

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

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

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

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

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

Sincerely,

Hal Rawson

Harold L. Rawson
Vice President
Planning and Government Programs

HLR:cb

17-16

Kalispell Ob-Gyn Associates, P.C.

2/1/89
350

OBSTETRICS GYNECOLOGY INFERTILITY

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

DIPLOMATS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

February 3, 1989

Brian Zins
Executive Director
Mt. Medical Assoc.
2021 11th Ave. Suite 12
Helena, Mt. 59601-4890

Subject: Mandatory Assignment

Dear Brian:

Late this afternoon, I visited with Molly Monroe of Great Falls, Mt., the Montana co-ordinatory for the AARP. An extraordinarily illuminating conversation.

Mrs. Monroe was present at the hearing on House Bill #382, and did not represent the AARP as a proponent because--"The AARP does not support mandated assignment for Montana".

She further advised that she spoke with representatives, and the chairman, both before and after the hearing, and that they were advised that the AARP does not support mandatory assignment in Montana. Further, that she had spoken prior to the hearing with many of the proponents and advised them that they could not speak for the AARP and that they were speaking on their own behalf. Further, she presented the Legislative Committee with a written statement opposing mandated assignment in Montana. Further, that the AARP did not oppose MONT-SHARE.

Their concern, and the reason for not supporting mandated assignment is "concern of access to care".

Van Kirke Nelson, M.D.

EXHIBIT 8
DATE 2/1/91
HB 350

AARP

1988-1989
MONTANA STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mrs. Molly L. Munro
4022 6th Avenue South
Great Falls, MT 59405
(406) 727-5604

VICE CHAIRMAN
Mr. Fred Patten
1700 Knight
Helena, MT 59601
(406) 443-3696

SECRETARY
Mr. John C. Bower
1405 West Story Street
Bozeman, MT 59715
(406) 587-7535

February 17, 1989

The Honorable Stella Jean Hansen
Montana House of Representatives
State Capitol
Helena, MT 59620

Dear Representative Hansen:

I have before me copies of letters dated February 3, 1989, written by Dr. Van Kirke Nelson to you and to Brian Zins. I understand that both copies were sent to me with your permission and with the request that I reply to them.

With reference to the letter to Brian Zins, I could be facetious and say I do not know the Mrs. Monroe to whom Dr. Nelson refers, since my name is Molly MUNRO. However, to set the record straight, I was not present at the hearing on HB 382 nor was our lobbyist, Fred Patten. We did not attend the hearing because the Montana State Legislative Committee of AARP has taken no position on the bill. We neither support nor oppose HB 382. Our decision to take no position was based on our concern for access to physician care for our senior citizens.

As you may remember, when I was in Helena on January 10, 1989, I spoke with you briefly in the House lobby and informed you at that time that we would not be testifying at the hearing because we had taken no position on the bill. Several other legislators asked me that day about mandatory assignment and I told them exactly what I had told you.

Please be aware that the State Legislative Committee researched and discussed the issue of mandatory assignment thoroughly before voting to take no position on the issue. Doug Campbell, Vice President of the Montana Senior Citizens Association, spoke to our Committee at one of our meetings, and I also discussed the issue with Dorothy Bompart, the executive director of the association. I do not present written statements and directions to the Committee--each member makes up his own mind and votes accordingly; as chairman, I have no vote. After the Committee vote and decision to take no position, I informed Ms. Bompart of that decision. If there are other proponents of the bill, I am unaware of who they are, and not knowing, I could hardly advise them not to speak for AARP.

Dr. Nelson has erroneously interpreted our not taking a position to mean non-support of, or opposition to, HB 382. Those are two very different concepts. He makes the same erroneous conclusion with regard to the MONT-SHARE program. The State Legislative Committee neither supports nor opposes the program. We feel this is a private relationship between patient and doctor. If an eligible senior wants to take part in the program, that is his right. The program is a means-testing program; in other words, it determines who does or does not get the benefits, and AARP policy does not support means-testing.

In Dr. Nelson's letter to you, he included a copy of the AARP position with regard to mandatory assignment. While AARP supports mandatory assignment on the federal level, it's approach on the state level is very cautious and is to be decided on a state-by-state basis. Because Montana is a rural state and we have many underserved areas, it is questionable that our State Legislative Committee would get backing from the national staff to support mandatory assignment. However, each state legislative committee makes that decision for itself.

Albeit for a different reason, (the high cost of liability insurance), we have seen what has happened in Montana with access to prenatal and obstetrical care. Doctors in Great Falls have many patients who live 200 to 400 miles away that must come here to obtain BASIC obstetrical care. A doctor in a rural area who delivers only a few babies a year cannot afford the high cost of the liability insurance. Who is to say that a similar situation could not arise if assignment were mandated and doctors found they could not afford to keep their practices open if they must rely on Medicare reimbursement which no pays approximately 60% of the cost of providing care. On the other hand, who is to say that it definitely would happen? Therein lies the dilemma and the reason for our taking no position on the issue.

There is no doubt that the present Medicare reimbursement rate to physicians in rural Montana is woefully unfair and inadequate. Reform of physician payment is a must. AARP is actively pursuing such reform on a federal level. I will be attending a special briefing on this issue in Washington, D.C. on February 26-March 1. I would be most happy to share any insights I gain with you upon my return if you are interested.

I appreciate your concern and the opportunity to clarify the statements made by Dr. Nelson in his letters. For whatever reasons he chose to misinterpret my telephone conversation with him, it certainly is not in the best interest of solving the problem of high physician charges which are a major concern to our seniors. Rather, it tends to set up an adversarial situation which benefits no one in the end.

Again, thank you for your concern. If I can be of any further assistance, please call me at 727-5604.

Sincerely yours,

Molly Munro

Molly Munro
Chairman, Montana State
Legislative Committee

cc: Dr. Van Kirke Nelson
Mr. Brian Zins
Miss Dorothy Bompart

Kalispell Ob-Gyn Associates, P.C.

DATE 2/4/91
HB 350

OBSTETRICS GYNECOLOGY INFERTILITY

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

DIPLOMATS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

February 22, 1989

The Honorable Stella Jean Hansen
Mt. House of Representatives
State Capitol
Helena, Mt. 59620

Dear Representative Hansen:

I am in receipt today of a letter from Mrs. Molly L. Munro, and enclosed please find my response to her.

I commend your interest and concern for the seniors of our state, and certainly this is an interest shared by many of us. I believe Mrs. Munro's letter clearly spells out her concerns and those of the AARP as it does the concerns of the majority of physicians in Montana.

The information that I sent to you and those of your committee was as I interpreted them from our phone conversation and supported by information provided to me by the AARP in Washington.

As Mrs. Munro points out in her letter, the problem is not with the system in Montana but with the system as administered by the federal government. That is where the thrust of our endeavors should be placed, both by you as a representative of Montana's citizens, and myself and Mrs. Munro as advocates for those citizens.

I commend you for all your hard work. I know that it is not easy and with little compensation, either monetarily or by "thanks". Though I do not necessarily agree with you on all issues, I will defend your right to your opinion as I know you will mine. All best wishes for the remainder of the session.

Cordially,

Van Kirke Nelson, M.D.

VKNjw

Kalispell Ob-Gyn Associates, P.C.

EXHIBIT 8
DATE 2/4/91
SB 350

OBSTETRICS GYNECOLOGY INFERTILITY

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

DIPLOMATS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

February 22, 1989

Molly Munro
4022 Sixth Ave. S.
Great Falls, Mt. 59405

Dear Mrs. Munro:

I am in receipt of your letter dated February 17th to Representative Stella Jean Hansen. I appreciate the copy. First of all, please accept my apology for misspelling your name.

In reference to our conversation, I understood you to say that you were at the hearing on House Bill #382, and that you had chosen not to testify as a proponent, but that you had talked with several of the legislators. In reviewing my letter to Representative Hansen and those of her committee, I do not believe that I erroneously interpreted the position of the AARP, as I quoted and provided copies of the statement that I received from AARP in Washington, D.C. I don't believe that I stated that the AARP supported MONTSHARE, and I do remember your statement that the AARP looked on this as "means testing". You did state though that they would not oppose it.

Molly, I certainly did not mean to "misinterpret" our telephone conversation, because as you state, that is not to the best interest of you as the representative for senior citizens, or myself as a representative for physicians. We do not choose to be adversarial, as we share the same common interest-that being the provision of the best health care at an affordable price to not only seniors but to every Montana citizen.

I would hope that we can work together to a common solution of our problems. It would have been nice to know the stand of the AARP prior to this hearing instead of trying to solve it afterwards. Fairness works two ways.

Thank you very much and please let us share each other's concerns.

Cordially,

Van Kirke Nelson, M.D.

VKNjw

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

EXECUTIVE
COMMITTEE

FOR YOUR INFORMATION—
From the Executive Office
Montana Medical Association

8
DATE 2/1/21
HB 350

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

May 5, 1989
Friday

TO: EACH MONTANA SENIOR CITIZEN CENTER

RE: MONTSHARE GOLD CARD PROGRAM

Dear Fellow Montanans:

The Montana Medical Association has been working with senior citizens, local hospitals and physicians of the Great Falls area to develop a program to assist the elderly who cannot afford the medical care they need. The result is the "MontShare Gold Card Program." In essence, the program identifies needy Medicare beneficiaries and encourages physicians in private practice to accept assignment for the medical services they furnish these people.

The program has been running as a pilot project the past few months in the community of Great Falls. It does indeed appear to have met with support and success in that community. Information letters, such as this, and applications/brochures have been forwarded to all practicing physicians in Montana and to all hospitals. The program is a formalization of a principle the Montana Medical Association feels has existed for years in the practice of medicine, namely, that physicians have given and should continue to give compassionate and special consideration to those unable to afford needed care.

To qualify for the MontShare Gold Card, a senior citizen must complete an application (copies enclosed) showing income less than $9,000 for an individual and $11,000 for a couple (these figures are 150% of the current federal poverty level). The application for the program is on an honor system and does not require verification of income.

Upon completing the application, the MMA will issue an official MontShare Gold Card. The card is intended to save needy senior citizens from the possible embarrassment of having to make special payment arrangements when they seek medical treatment, especially when more than one doctor, test, treatment or drug is involved. When a senior citizen presents a MontShare Gold Card to a physician, his staff will know the holder has already met the predetermined financial criteria for acceptance of the assignment.

It is also noted that commitment to the program does not preclude a physician in private practice from accepting assignment on an individual basis for any other beneficiaries not screened by the program but for whom the physician believes such arrangements are merited.

Physicians who cooperate with the MontShare Program are still responsible to collect the co-insurance charge of 20% of their allowable charge on all claims and any deductibles.

We therefore ask your assistance in having available at your senior citizen center a supply of the enclosed application/information brochures to distribute to senior citizens who believe they would like to apply to the program. We believe that through this mutual cooperation senior citizens in this category will indeed be assisted in obtaining medical care which they may require.

Should you wish to obtain additional applications or have questions, please telephone, toll free, the Montana Medical Association at 1-800-662-9287.

Enclosed also for your use in promoting the program are three stand up cards for placement as you believe appropriate.

We do sincerely appreciate your cooperation and we do express all best wishes.

Sincerely,

J. Michael Sadaj, M.D.
President

G. Brian Zins
Executive Vice President

GBZ:le

Enclosures

Kalispell Ob/Gyn Associates
210 Sunnyview Lane
Kalispell, MT 59901

Office Hours
Monday-Friday 9:00 a.m.-5:00 p.m.

Appointment and Emergency
Phone: 752-5252

To Our Medicare Patients

by Van Kirke Nelson, M.D.

Since the inception of Medicare, this office has cared for all Medicare recipients that have sought our medical services, regardless of an individual's ability to pay. Because of a belief that other age groups should not subsidize a specific group for the cost of their medical care, we have chosen to be "non-participating" physicians, i.e., we do not accept assignment on all Medicare patients.

We do believe in the dignity of age, and realize that many of our elderly patients are placed at financial risk due to unanticipated medical costs. With this in mind, this office has been active in originating and will support the new Montana Medical Association program—"MONT-SHARE." This program identifies, without means testing, simply by application that the applicant has a yearly income of less than $9000 per year per single person, or $11,000 per married couple. Upon completion of the application, with the above statement, a MONT-SHARE card will be issued to the applicant by the Montana Medical Association. This card, when presented to this office or any of the more than 90% of Montana physicians accepting MONT-SHARE cards, will entitle the recipient to be billed only for what Medicare will pay. If you have any questions about this new program, please feel free to contact our office. For an application, call the MMA at 1-800-MMA-WATS.

Taking The Pressure Off

Some women who take calcium for their bones may be helping their hearts, too. Recent research suggests that dietary calcium may be important in the prevention and control of high blood pressure, at least in certain people.

In one study, for instance, women who took calcium supplements along with their high blood pressure medicine had lower pressures than women who took the medication alone.

A word of warning, though: it's always wise to consult a physician before beginning any dietary supplements.

About Sodium

If you are trying to cut down on your sodium intake, you need to know that about 75% of the sodium in your diet comes from processed foods. Only 15% of the sodium is added during preparation and serving. The other 10% occurs naturally in the foods we eat.

What's Average?

For an American woman, "average" means she's 5'4" tall and weighs 144 pounds.

The Women's Letter

Kalispell Ob/Gyn Associates — Spring 1989

Van Kirke Nelson, M.D. • John L. Heine, M.D. • Ellis M. Sowell, M.D.

Hormones Deserve Some Respect

Female hormones are blamed for ills ranging from premenstrual tension to postpartum depression. But they also deserve credit for helping maintain good health and body function.

Two hormones are particularly important to women: estrogen and progesterone. Estrogen helps keep a woman's reproductive organs, bones, skin, and heart healthy. Progesterone prepares the lining of the uterus for implantation of a fertilized egg.

But that's not all. Hormones play important roles throughout a woman's life.

Puberty. Hormones trigger changes in the reproductive organs and stimulate outward signs of maturation.

Menstruation. During every menstrual cycle, estrogen and progesterone signal the lining of the uterus to thicken. If no pregnancy occurs, these hormone levels drop, and the lining is shed each month as menstrual fluid.

Pregnancy. If pregnancy does occur, however, progesterone levels stay high.

Menopause. Eventually the ovaries start to produce less estrogen. As a result, menstruation gradually ceases.

Relax About Pelvic Relaxation

Pelvic relaxation refers to a gradual weakening of the vaginal muscles that support the uterus, bladder, and rectum. This weakening is most common in women past menopause, but it can also occur in younger women following childbirth or injury.

Pelvic relaxation can lead to a variety of problems:

Uterine prolapse—a "dropped" uterus that descends into the vagina

Cystocele—a bulging of the bladder through the vaginal wall

Rectocele—a bulging of the rectum through the vaginal wall

Urinary stress incontinence—weakness of the muscle that closes the bladder

Symptoms can range from a feeling of pressure in the lower back, abdomen, or vagina to chronic constipation and urine leakage.

Sometimes the vaginal muscles can be strengthened by special exercises, thus relieving symptoms. If you are experiencing problems associated with pelvic relaxation, ask us about the success of treatment through exercise or surgery.

Remember The Scout Motto?

"Be prepared" is good advice for patients, too. To help us give you the best care, follow these tips:

- Jot down questions or problems you want to discuss and bring the list to your appointment.
- Know the date of your last menstrual period. Tell us if any changes have occurred in your cycle.
- Help keep your health records current by informing us of changes involving contraception, sexual activity, and medications—both prescription and over-the-counter. Be honest and give complete information.
- Be sure you understand our instructions. Write things down.
- Most important, keep in touch with us. Your feedback helps us provide better care to you.

STANDARD COPY GOES HERE — PER SAMPLE NEWSLETTER YOU HAVE.

EXECUTIVE COMMITTEE

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

Orpha

M

From 1A

cations at either hospital.

The applications will be reviewed by the MMA staff, which mails out the gold cards that seniors present when seeking care. Seniors need not provide any financial information beyond that provided on the application, and the program is on the honor system "because we think senior citizens are trustworthy," Allaire said.

Applications for the MontShare gold card are being sent to senior citizens already registered at existing programs at Montana Deaconess Medical Center and Columbus Hospital to help them with hospital bills, and other seniors can pick up appli-

upcoming 1989 session.

Doctors

because the Montana Senior Citizens Association lobbied the 1967 Montana Legislature for a law requiring doctors to accept Medicare assignments from all senior citizens. McKenna said he thinks the "mandatory acceptance" bill will be offered again by senior groups in the

- 2C.

Tyson fights in February/1B

Bush bans questions/10C

Great Falls TRIBUNE

Friday, December 16, 1988 | Great Falls, Montana | No. 217 — 104th Year | 35¢

Pilot program may improve elderly health care

By PETER JOHNSON
Tribune Staff Writer

With the cooperation of the two Great Falls hospitals and the support of local senior citizens, the Montana Medical Association launched a pilot program Thursday to help low- and moderate-income senior citizens with their doctor's bills.

At a press conference in the senior citizen center, Dr. Francis Allaire of Great Falls, immediate past president of the MMA, said more than 90 percent of the Montana doctors polled plan to participate in the "MontShare Gold Care Program," which is expected to be expanded statewide within a month.

Officials estimated that about 2,000 Great Falls senior citizens, or one-fifth of the city's elderly population, will meet the income guidelines, and senior citizens applauded the doctors' plan as a favorable first step after they spent the last few years trying to get physicians to accept more Medicare assignments.

Under the program, participating doctors will accept Medicare reimbursement for treating patients 65 and over if those patients' income is not greater than 150 percent of the federal poverty level — an annual income of $9,000 or less for individuals and $11,000 or less for couples.

Under federal law, senior citizens still would be required to pay an annual deductible of $75 each year, plus a co-payment. Essentially, Medicare sets prescribed rates for different medical treatment and pays 80 percent of that cost, with senior citizens paying the remaining 20 percent, the co-payment.

The sticking point has been that most doctors contend that the Medicare rates have been set at 70 percent or less of actual cost, so many have refused to automatically accept all Medicare patients.

Doctors could not afford to accept such low payments if they had a lot of senior patients, Allaire said, but it isn't the fault of senior citizens who need Medicare assistance in paying their bills.

He called the MontShare program a reasonable compromise to help recognize and treat "truly needy seniors."

While many individual physicians are accepting Medicare patients on a case by case basis, MontShare "will save patients the embarrassment of being interrogated about their income levels," Allaire said.

Senior citizen Frank McKenna said the program won't completely smooth ruffled senior feathers, "but is a big step in a right direction." He said it will particularly help moderate-income seniors who make too much money to qualify for the low-income Medicaid health insurance program.

MMA executive director Brian Zins agreed, saying some moderate income seniors with a few assets, such as a house and savings, now must get rid of those assets before they can qualify for Medicaid to handle mounting medical bills.

Senior citizen Charlie Follick also liked the plan, calling it, "the best Christmas present some of us can have."

After the meeting, McKenna said he thinks Montana doctors were prodded into the voluntary program to help low and moderate seniors

See DOCTORS, 2A

Study finds drop in state hospitals' death rate

By BOB ANEZ
Associated Press Writer

HELENA — Montana hospitals have fared well again in a federal study of death rates for elderly Medicare patients, which shows that none of the hospitals had rates exceeding government projections.

Issued Thursday by the Health Care Financing Administration of the U.S. Department of Health and Human Services, the report lists 12 of 62 hospitals with death rates below the expected range in 1987. That compares with only five of 69 hospitals surveyed the year before.

Columbus Hospital in Great Falls had the lowest rate among large hospitals.

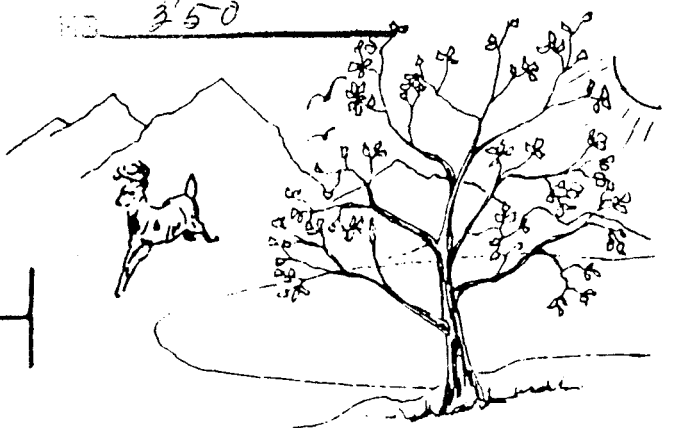
The annual report was strongly criticized by the medical community when it was released to the public for the first time a year ago. Hospital officials and medical organizations complained that the figures distort death rates and offer no real measure of quality health care for the elderly.

Some of the same comments were repeated this

See HOSPITALS, 2A

TREASURE STATE HEALTH

VOL. 34 NO. 3 SUMMER, 1985 MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES



Latest Available Figures on Health Care Costs Show Montanans Fare Better Than Rest of U.S.

The latest available health care figures present an interesting economic profile for Montanans and others in the United States.

First of all, the good news is that the rate of increase in costs has decreased for the nation and markedly for Montanans. **The bad news is the costs of staying healty continue to accelerate by the millions in the state and billions in the nation, running far ahead of inflation.**

But, for Montanans, at least the per capita cost per year is far cheaper than for the average U.S. citizen — $350 less, in fact.

Additionally, individuals in this state, on the average pay 29.1% less for hospital costs in a year; physician costs for Montanans is an even better deal and we spend less than half as much in this category as our national counterparts; and, our annual dental bill is 32.6% cheaper for each of us than the country's average.

Also, we get by with far less cost individually for drugs and drug sundries at $58 per year compared to $97 national average.

When it comes to eyeglasses and appliances though, the costs even out for Montanans and the rest of the nation with identical average annual costs per capita of $25.

The only major division of health care which costs Montanans more than residents of the rest of the country is nursing home and home health care, where we pay 111% of the national average.

Now, here's a look at all the figures in detail:

Montanans spent $906.3 million for health care in 1983, the most recent year for which figures are available. That was 9.7 percent more than the $825.9 million total for 1982; however, the rate of increase from 1981 to 1982 had been 20.3 percent.

The national rate of increase was 10.3 percent with total U.S. expenditures of $355.4 billion in 1983 compared to $322.3 a year earlier. Once again, however, the rate of increase was slowed from the 12.3 percent of the previous year.

For the individual Montanan, health care costs totaled $1,109 in 1983 while the national per capita figure was $1,459, so this state's citizens paid 24 percent less for their health care than the country's average individual cost.

Nevertheless, Montana's per capita expenditure was up 7.7 percent and the national figure was 6 percent higher.

Differing methods of accumulating and presenting the figures make it impossible to determine if the wide variance in state versus national per capita expenditures means Montanans are that much healthier and require less care, get more care for their health dollars, or if their total costs are determined differently.

The Montana figures are provided in a report compiled by Albert Niccolucci of the health planning and resource development bureau of the Montana Department of Health and Environmental Sciences.

The continuing acceleration of Montana and national health care expenditures — both nearly three times the 1983 inflation rate of 3.8 percent — add emphasis to efforts by state and national governments to control such costs.

• Hospital costs again topped both state and national lists, accounting for 38.5% of Montanans' total costs and 41.4% of the $355.4 billion total national health care expenditures. Montanans' $349.3 million expenditure in this category represents $428 per person and the national expenditure of $147.2 billion for hospital care equals $604 per person.

• Physicians' services, still the second most costly item both state and nationally, accounted for $112.6 million in Montana, or 12.4% of the total costs; and $69 billion nationally, 19.4% of that total. Per capita it was $283 nationally and slightly less than half of that at $138 for Montana.

• The third highest category of health care expenditures — state and national — cost Montanans $106.7 million, or 11.8% of the total, for nursing home and home health care. Nationally, the figure was $28.8 billion, only 8.1% of the total. It is the only one of the major areas more costly per capita for Montanans at $131 each than the national per person expenditure of $118.

• Dental services, at $21.8 billion nationally and $49.4 million in Montana, accounted for 6.1% of the national expenditures and 5.5% in Montana. Again the per capita cost was much higher on a national basis at $89 than the state's $60.

The remainder of Montana's health care expenditures for 1983, by type, amount, and percentage of the total, are:

Research and construction of medical facilities, $57.2 million, 6.3%; expenses for prepayment and administration, $52.4 million, 5.8%; drugs and drug sundries, $47.4 million, 5.2%; other professional services, $44.3 million, 4.9%; government public health, $37.6 million, 4.2%; other health services, $28.6 million, 3.2%; and eyeglasses and appliances, $20.8 million, 2.3%.

When it comes to the source of the funds to pay these health care expenditures, Montanans paid

(Continued on Page 2)

3/1/91
350

the daily Inter Lake
KALISPELL, MONTANA MONDAY, OCTOBER 3, 1988 35 CENTS

Group says Medicare overpaid $2.7 billion

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

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

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

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

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

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

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

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

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

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

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

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

Those required co-payments amounted to $25.99 for each of the

MONTSHARE

2-1-91
350

A new program called **MONTSHARE**, which will improve access to medical care for seniors experiencing financial difficulties, has been initiated by local physicians, hospitals and the Montana Medical Association.

Under **MONTSHARE**, physicians are asked to accept Medicare assignment for seniors over the age of 65 who have incomes of less than 200% of the poverty level. Income ceilings for the **MONTSHARE** program are $12,000 per person and $15,000 per couple.

Participants are responsible only for Medicare deductibles, co–payments, and non–covered services. Although some physicians already accept Medicare assignment on all patients, formal application for **MONTSHARE** is advised in case of referral to another physician who is affiliated with the program.

Q: What does it mean when a physician accepts assignment?

A: Accepting assignment simply means that a physician agrees to accept Medicare's reimbursement (plus the co–payment and deductible) as payment in full. Physicians also agree to handle the necessary claims processing.

Q: What materials do I need to have my income verified?

A: The program is entirely on the honor system. Complete only the application form.

Q: What recourse do I have if my application for MONTSHARE is rejected?

A: MONTSHARE features an appeal process. Applicants who think they are eligible for the program but have been determined ineligible should request an appeal form from the program at 1–800–662–9287.

Q: What should I do if my MONTSHARE card is lost or stolen?

A: Report the loss to the program at 1–800–662–9287. A duplicate card will be issued to you.

How to take part in MONTSHARE:

1. If your physician already accepts Medicare assignment in all cases, you already enjoy the benefits of **MONTSHARE.** However, you should apply for **MONTSHARE** in the event you are referred to other physicians taking part in **MONTSHARE.** First, estimate your annual income from all taxable and non–taxable sources, such as Social Security, dividends and interest, capital gains, pension plan retirement benefits, and disability income. You are eligible if you are over 65 and your income is less than $12,000 a year, or if you and your spouse's combined income is less than $15,000 a year. You are also eligible if you are disabled and presently on Medicare and meet the above income requirements.
2. Visit any physician's office or hospital during normal business hours to obtain an application. If you are certified as eligible for **MONTSHARE** you will be issued a membership card which you may present to any physician cooperating with the program.
3. Carry your card with you, and present it each time you receive health care services from a physician cooperating with **MONTSHARE.** You pay for only the Medicare deductible, co–payment, and non–covered services. Physicians are required by law to collect these amounts.

Commonly asked questions about MONTSHARE:

Q: What payment am I still responsible for as a MONTSHARE enrollee?

A: MONTSHARE enrollees are financially liable for the same items as other Medicare patients. These include:

– deductible
– co–payments
– non–covered services (i.e., prescription drugs, most nursing home and long–term care)

Q: Should I enroll in MONTSHARE if I receive Medicaid and carry a current Medicaid card?

A: No. Medicaid features more comprehensive health care benefits at a lower financial liability to enrollees.

Q: Can I replace my Medicare supplemental health insurance with MONTSHARE?

A: No. Most Medicare supplementals sold in Montana cover the federally–required patient co–payment. Since **MONTSHARE** enrollees retain responsibility for the co–payment, it may be wise to keep your current supplemental policy to cover these expenses. It is best to check the details of what your plan covers with a benefits specialist or insurance representative. 10/90

9A
2-1-91
SB

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

MONTSHARE ENROLLEES RESPOND TO QUESTIONNAIRE

In November of 1990, the Montana Medical Association mailed a questionnaire to the then enrolled 5,128 MontShare participants. As of December 31, 1,829 questionnaires were returned for a 46% response.

Sixty-seven percent indicated they have used the program and of those having used the program, 96% stated they were satisfied. In answering whether or not their physician accepted the MontShare Goldcard, 91% indicated their physician did honor the Goldcard.

The fourth question asked for any comments and those received ranged from: "I have not used this card," "I think this is a great program," "My physician doesn't accept Medicare," to "Please send more information."

A copy of the questionnaire is attached herewith.

EXHIBIT 7A
DATE 2/11/91
SB 350

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

November 13, 1990
Tuesday

M E M O R A N D U M

TO: EACH MONTSHARE ENROLLEE

FROM: EDWARD P. BERGIN, M.D.
PRESIDENT

Dear Fellow Montanan:

The Montana Medical Association is committed to see that our state's senior citizens are receiving needed quality health care. It is hopeful that you can assist us in reviewing the MontShare program by completing the questionnaire on the bottom of this page.

May we request that you answer the following four questions and return this page in the enclosed post-paid return envelope.

We do indeed thank you and we do express all best wishes.

---

1. Have you used the MontShare Program?

_____ Yes _____ No

2. Are you satisfied with the MontShare Program?

_____ Yes _____ No

3. Does your physician accept the MontShare Gold Card?

_____ Yes _____ No

4. Any Comments:

_____

_____.

Return to:

Montana Medical Association
2021 Eleventh Avenue
Helena, MT 59601

Your Name and Address:
(Optional)

_____

_____

1 page

February 6, 1991

FROM: Jack L. Davis, M.D., Chairman
Ad Hoc Committee

RE: Liaison Blue Cross/Blue Shield (Medicare)

TO: Van Kirke Nelson, M.D.

Dear Dr. Nelson:

In request to your analysis regarding a current amendment to the HB-350 Mandatory Medicare Assignment Bill, it is my understanding that an amendment has been produced which would exempt the CPT codes 9000 to 9010.

These codes cover only those office visits for both new and established patients with medical problems.

These codes <u>do not</u> include services to patients in hospitals, either new or in hospital follow-up, services to patients in skilled nursing facilities, intermediate care facilities or long term care medical facilities or rest homes. In addition, these services completely exclude services in the emergency department, immunization, preventative medicine, and virtually all forms of therapy including renal, gastroenterology, ophthalmology, cardiovascular, pulmonary, allergy, and neurological procedures.

In addition, the services of chemotherapy for cancer are totally excluded, as well as physical medicine and dermatology.

It should also be pointed out that services to the most critically ill patients, ie: those critical care services are totally excluded from the CPT categorizations. From the standpoint of anesthesia, all anesthesia and all forms of surgery, irrespective of what they may be, including both major and minor surgery, are totally excluded from these CPT classifications.

It should be pointed out that in health care delivery, while the services in the office do make up a portion of care provided to the Medicare recipient, that the vast majority of all health care services provided by physicians is totally uncovered by this amendment, including those which are stipulated in detail above. It would be catastrophic to the general front line practitioner and primary care physician, as well as all of the surgical and medical sub-specialties to eliminate all of these services and would do potentially severe harm to the Medicare recipient, denying them access for the above services.

Sincerely yours,

Jack L. Davis, M.D.
JLD:jjs

EXIBIT # 10 CONSISTS OF A 24-PAGE REPORT WHICH MAY BE FOUND IN ITS ENTIRETY AT THE MONTANA HISTORICAL SOCIETY, 225 NORTH ROBERTS, HELENA, MT 59620. (PHONE: 406-444-4774.)

House Business & Econ. Development
10
2-1-91
350

REPORT AND RECOMMENDATIONS

THE GOVERNOR'S HEALTH CARE SERVICES AVAILABILITY ADVISORY COUNCIL

Submitted by members:

Sen. Paul F. Boylan, Bozeman
Sen. Loren Jenkins, Big Sandy
Charles Butler, Jr., Blue Cross/ Blue Shield, Helena
Larry E. Riley, Esq., Missoula
John Bartos, Hospital Admin., Hamilton
Mrs. Laura Grinde, Health Care Professional, Lewistown
Jim Hoyne, M.D., (Emergency Medicine), Clancy
Van Kirke Nelson, M.D. (Obstetrician), Kalispell,
Rep. Paula Darko, Libby
Rep. John A. Mercer, Polson
Leonard A. Kaufman, Ph.D., The Doctors Agency of Montana, Billings
Chadwick Smith, Esq., Helena
Mrs. Peggy Guthrie, Health Care Professional, Choteau
Jimmy L. Ashcraft, M.D., (Family Practice), Sidney
Gordon K. Phillips, M.D., (Obstetrician), Great Falls
Ex-officio member: Julia Robinson, Dir. Department of Social and Rehabilitation Services, Helena

Van Kirke Nelson, M.D., Chairman

Kalispell Ob-Gyn Associates, P.C.

OBSTETRICS GYNECOLOGY INFERTILITY

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

DIPLOMATS OF THE AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

February 1, 1991

11
2-1-91
350

HB 350 - MANDATORY ASSIGNMENT

Business and Economic Development

Bob Bachini, Chairperson
Sheila Rice, Vice-Chairperson

Members: Barnett, Benedict, Cromley, Dowell, Ellis, Hansen, Hanson, Kilpatrick, Knox, Larson, McCulloch, Pavlovich, Scott, Steppler, Tunby, Wallin.

Today you have heard testimony for and against House Bill 350 in regard to mandatory assignment, both sides with creditable concerns. As a physician, an obstetrician/gynecologist, I have witnessed the erosion of access to obstetrical care to the point that there are 22 Montana counties without physicians who deliver babies, 18 of them without any physicians whatsoever. Though Montana has one of the lowest neonatal death rates in the nation (second), it is 32nd in the nation in infant mortality (death in the first year of life). If you deliver outside of the county of your residence in Montana, your infant, in the first year of life, has twice the chance of being included in that statistic (Reed/McBroom, University of Montana). Is it possible that this same statistic correlates with other age groups and is it possible that it could be a real issue with further erosion of care through decreased access and the necessity of driving longer distances for care?

This Legislature has and is recognizing the problems related to obstetrical care and lack of providers through proposed improvements in tort reform, consideration of investment tax credits for physicians in rural areas, increased compensation for obstetrical/pediatric Medicaid recipients and physician subsidies in rural areas; all with the attempt to stabilize and ultimately increase access to obstetrical care.

My practice is more Medicaid driven, perhaps 50-60%, and only 6% Medicare. To a physician, a family practitioner or internist, in a rural area with an aging population, perhaps 60-70% are Medicare recipients. The presence of physicians in rural areas is obviously dependent on generating enough income to survive in

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

that rural area. Survival will definitely be effected by passage of mandatory assignment with its resultant further erosion of providers and loss of access to care to the aging population in rural Montana. Congress has recognized the inequity of their Medicare payment schedule for the same services from state to state, and in 1992, will implement the resource based relative value schedule that will make mandatory assignment, participating and non-participating physicians, history.

Today you have seen and heard from a group of Senior Citizens from Helena with access to care from many providers and may be the case if your constituents were from an urban area. To those of you who serve constituents in rural areas with limited providers, what are the risks if mandatory assignment is passed? Will your physicians survive in your community? Will they have to be subsidized by your already "strapped" hospital? Or will they simply leave. What are your chances of physician recruitment these next two years if mandatory assignment becomes a reality?

I believe it is very significant that Mr. Fred Patten, Legislative Chairman of the Montana Chapter of the AARP (American Association of Retired Persons), an organization representing 111,000 Montana Senior Citizens, stood today before you and opposed mandatory assignment in Montana because of their concern for access to care to Montana Senior's in not only rural but urban areas as well.

Certainly his concern for urban areas is borne out in access to the Medicaid obstetrical patient in the larger cities where the care of the majority of those patients is borne by a few. (Our office provides care to the 60-70% Medicaid eligible pregnancies in Kalispell and surrounding area.)

That the medical profession has concern for Montana Senior Citizens has to be evident by the MontShare program which has 5,000 enrollees, accepting assignment as payment in full to those at or below 200% of the federal poverty level. Only two years ago the Montana Legislature recognized 57% of the federal poverty level as the eligibility level for Medicaid and now, under OBRA-89, 133% of the federal poverty level for eligibility.

Montana can ill afford the loss of any more physicians or the loss of provision of services - even for two years - when mandatory assignment becomes obsolete. Please do not make this a <u>political issue</u>, but consider the health and access to care for those constituents you serve and all of the people of the State of Montana.

Thank you.

Van Kirke Nelson

Van Kirke Nelson, M.D., Chairman

The Governor's Health Care Services Availability Advisory Council

DATE 2/4/91
HB 350

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

February 6, 1991
Wednesday

HB 350 Mandatory Assignment

Dear Representative Rice:

We have just received an amended copy of HB 350 dated February 5, 1991 with the NEW SECTION. Section 5. Exemptions

Obviously, at this late date it will be difficult to get physicians in your respective communities to advise you of the impact to their practice and to the community in which they reside.

Let me share with you some very major concerns.

1. What surgical specialist would come to Montana with mandatory assignment?

2. What will happen to your family/general practitioner/Internist in rural areas, many of which are have a difficult time making ends meet.

3. What will this do to access of care if the cost of providing the service is greater than the compensation?

The bill still has a means test for seniors and physicians will not inquire of their patient if they fit within the guidelines of the law. Are the "Montana Senior Citizens" going to do the means test?

Enclosed is a copy of the CPT Code and the services that are exempted. This does not cover basic hospital care or any care beyond simple visits.

Is this legislature going to provide medical care in the communities that lose physician services and if not, what of the seniors, ill or any of your constituents that have to travel long distances because of the loss of providers and at what cost? Please again, consider this bill very carefully and again the concerns of the AARP about access to care.

Thank you.

Cordially,

Van Kirke Nelson, M.D.
Chairman, Governor's Health Care Services Availability Advisory Council

EXHIBIT 11
DATE 2/1/91
HB 350

Revised Spring 1978

MEDICINE

PROCEDURES

OFFICE MEDICAL SERVICES

(see Introduction for definitions and examples of levels of service)

NEW PATIENT

99000 Brief service

99010 Limited service

99015 Intermediate service

99017 Extended service

99020 Comprehensive service

ESTABLISHED PATIENT

99030 Minimal service

99040 Brief service

99050 Limited service

99060 Intermediate service

99070 Extended service

99080 Comprehensive service

HOME MEDICAL SERVICES

NEW PATIENT

90100 Brief service

90110 Limited service

90115 Intermediate service

•**90117** Extended service

ESTABLISHED PATIENT

90130 Minimal service

90140 Brief service

90150 Limited service

90160 Intermediate service

90170 Extended service

HOSPITAL MEDICAL SERVICES

NEW AND ESTABLISHED PATIENT

INITIAL HOSPITAL CARE

90200 Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records

90215 Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records

90220 Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records

SUBSEQUENT HOSPITAL CARE

90240 Brief service

90250 Limited service

90260 Intermediate service

90270 Extended service

WESTERN MONTANA CLINIC, P.C.

515 WEST FRONT STREET
MISSOULA, MONTANA
59802

TELEPHONE ~~(406) 721-5600~~
TOLL FREE 1-800-525-5688

2/1/91
350

January 31, 1991

TO: House Business Committee

RE: HB 350

We, the undersigned, are adamantly opposed to House Bill 350 because it will limit access to good health care for seniors.

We agree with and support the comments and suggestions of Dr. Murphy.

T D Murphy
L.F Whitney
L.F. Whitney
Mary Langenderfer
G F Walter
Eric F Berglund

H Eric Hughson MD.
J H Reiter MD
W.B. Bekemeyer MD
John Trauscht MD.
Peggy Schlesinger MD

Exhibit 12 also contained 10 letters opposing HB 350. The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

January 27, 1991

13
DATE 2-1-91
HB 350

Dear Sir:

Enclosed is an article on the Crisis of Rural Health Care. It elaborates concisely what a problem inadequate reimbursement becomes in recruiting personnel and the far reaching and destructive consequences this problem levies on all our communities. Unfortunately a day of reckoning is at hand, which I fear will harm Montana greatly, particularly if you do not give a great deal of careful thought to the consequences of the effects of forcing physicians to accept mandatory assignment.

In the eight or so years, since Medicare began ratcheting down Medicare fees and shifting the burden of its obligations for health care to private pay patients, hospitals and doctors, there has been a serious decline in applications for Medical School slots. When I applied in 1974 there were 20 applications for every slot, now despite decreasing class sizes, there are less than two applications for every slot. Combined with this is the fact that the average medical student graduates from medical school with $75,000 debt to repay, with interest that is not even tax deductible. (This is no secret if you just read Time or Newsweek). During the same period of time, medical students have increasingly entered residency programs that will lead to the more lucrative specialties, most of them simply by economic need in order to be sure that they can pay their debts. This has left the primary care residencies with only two thirds of their slots matched and consequently, there are that many fewer general practitioners, pediatricians, and internists available to fill the needs of America's many communities. When Montana's reimbursement is at one of the lowest of the fifty states it is no wonder that the majority of these physicians look elsewhere to settle. <u>It is because of the genuine and serious lack of access to the most basic of primary care services that the national AARP does not support mandatory assignment in predominantly rural states.</u>

It has been a long acknowledged problem, east of the mountains that many communities have not been able to recruit physicians and you may assume that it doesn't apply

to Kalispell or the Flathead Valley. In that assumption you would be dead wrong. Kalispell Regional Hospital has worked with medical recruiters for over eight years in the hope of adding a second Neurosurgeon to this community, because no one can be on call every night forever, but they have been unsuccessful. The Kalispell Orthopedic Clinic spent several thousands of dollars bringing orthopedists to this community this past year in hopes of attracting new partners, so that the primary care practitioners would not have to send so many of their patients out of this community for basic orthopedics, but so far non will relocate her because with Medicare reimbursement as it is, they can earn four times as much elsewhere, in equally beautiful communities. In spite of years of teaching young residents in Family Practice, that rotated through their clinic, Dr. Wildgen and Dr. Gould have been unable to attract new partners or sell their practice to other family practitioners; in the end, Dr. Gould has retired without turning his practice over to a younger doctor, anyway. After six years of taking my own call and building a practice in Internal Medicine, I have been looking for a partner to join me and in the past year I have attracted two candidates; the first had a large medical school debt and a five year old son with cerebral palsy who has and will continue to require multiple surgeries, the other is a young woman with a new baby who plans to be the bread winner of her family, while her husband raises their daughter. Both of these candidates have opted to go elsewhere for far better salaries than I could ever offer. In the meantime we cannot recruit replacements for the increasingly aging population of general practitioners that we will continue to loose to retirement in the Kalispell and Whitefish communities.

It is easy to say that Medicare reimbursement is inherently unfair to rural areas, it is harder to get people to listen to the facts about the implications of this reimbursement, that without adequate reimbursement there will be no access to care let alone quality of care. In the last legislative session, testimony was presented to the legislature that over 50% of Montanans family physicians earned less than $35,000 a year. (This information was from the State Department of Revenue's own figures.) While this would represent a fortune to many of our citizens, it is a fraction of the over $100,000 a year that these doctors would earn if they received only the national average for this profession. It is no wonder that the newer doctors do not take any offers to recruit them to Montana seriously. Moreover, you should be aware of the physicians our communities have lost and are at risk to loose if Mandatory Assignment is passed. Two years ago Dr. Winship, a greatly respected specialist in Infectious Diseases, threw in the towel and relocated to New York, because he wouldn't put up with the hassles of Medicare reimbursement. Dr. Betty Kuffle, an Internist in Whitefish, closed her practice, because of the impossibility of fair reimbursement and the unending burden of paperwork for medicare, taking a job in

Arizona, where she will make four times as much money as I do, in half the scheduled hours and no Call hours, (Her letter to the community as to why she left is on record in the Whitefish Pilot, if you care to look it up). Needless to say, I am increasingly discouraged about recruiting a partner into this professional climate and I have been informed, on more than one occasion, that the members of Kalispell Diagnostics, would all relocate out of state, due to the impossibility of meeting their overhead with mandatory assignment.

In the meantime, I am a participating physician in the Montana Medical Association's Gold Card program. Any senior citizen who fills out the application stating that they need to have their physicians accept assignment, qualifies for this program and upon presentation of the gold card receives accepted assignment by all participating physicians, without any questions being asked. Can any truly needy senior citizen show that they need medicare accept assignment when this program exists?

In my office I accept assignment on a case by case basis, which turns out to be a simple majority of my patients. However, the overhead costs of delivering this care exceed the reimbursement that I receive, and the cost of that care ends being defrayed by the increased fees levied on my private pay patients. In short, while medicare patients make up 60% of my patient load, that portion of my practice generates only 40% of the fees and the overhead of practicing is 60% on all comers. A simple office visit in Scotsdale, Arizona will generate $47 if a physician accepts assignment. In Montana accepting assignment will bring only $21. When I see three seniors in an hour, taking twenty minutes to give them the quality of time to discuss their problems, review their medication and exam, if I accepted assignment on all seniors, regardless of need I would not be able to stay in practice, because I would have to pay out $10 to taxes, $10-11 dollars to my R.N., and $5-10 for just the liability insurance portion of my other expenses, before paying my receptionist, the electricity bill or for any supplies. It is no wonder that several physicians have said they would either leave Montana or not see Medicare patients at all if Mandatory Assignment is passed.

The Congress has undertaken to pass a physicians' fee reimbursement reform package in the past year, if implemented it will phase in fees that will ultimately result in uniform physicians fees where there will be no balance billing to Medicare patients, with the intent to improve reimbursement to primary care providers, particularly in rural areas because of the long established discrimination in reimbursement which threatens the right of every citizen to obtain medical care. The current Mandatory Assignment bill under consideration, threatens all Montanans with further loss of **ACCESS TO MEDICAL CARE**, by undermining that entire reform process.

I plan on attending AAUW legislative review in February and look forward to discussing this very serious issue with you at that time. Thank you for your time and efforts on my behalf in reading this lengthy letter, I can only hope you understand how seriously I take the issue of ACCESS TO CARE.

Sincerely,

Marise K. Johnson, M.D.

Uno had started his label in 1982, more as a way to release records by local bands he liked than to make money. "Since its inception, Popllama's been makeshift and shoestring," he admits. "My lack of business ability makes me want to keep it small because it's really more fun that way."

The base for the business was Uno's experience as a musician and soundman. Business concerns became a more pressing matter when bands such as the Fellows began to take off. Suddenly, he had to deal with promotion and distribution, the key elements in getting records, tapes and CDs into retail stores. Whereas a major record label might control its own distribution, independent labels rely on independent distributors, which can be painfully slow in returning sales revenue. Uno admits his lack of interest in dealing with distribution problems cost him record sales. Popllama has since signed distribution agreements with California's Frontier Records.

For someone uninterested in running a business, Uno's situation was complicated: He was running a recording studio on the side. But as Popllama began to establish a name in national markets, Egg Studios developed its own identity in Uno's basement, and the combination worked well. The studio provided a steady flow of cash, allowing Uno to concentrate on his first love, music. "The studio pays for my bad habit of having a record label," he says.

Egg Studios is a 8-track recording operation that splits its time between recording bands marketed by the Popllama label and musicians paying for their own projects.

Steve Lawson Productions also began as a small-scale studio, with Lawson's wife in the front office and Lawson operating an 8-track tape deck in the back. But instead of recording bands to market under a label, Lawson ran a successful studio for several years before recording bands. He had produced commercials for KING Radio until a change in management led him to set up his own production company. "I figured I'd take 40 percent to 50 percent of my KING clients with me," he says. "I ended up taking 100 percent."

With an established client base, Lawson had little trouble attracting business. Then, the 1982 addition of a second studio led Lawson into recording music. Initially, the room generated little income because of the impoverished state of local musicians. "All the really good music people in Seattle at the time were broke," he recalls.

He hit upon the idea of offering lower rates in the evening, so bands could record inexpensively. He hired a young engineer/producer named Terry Date, giving him free rein if he could keep the room busy. Date hit paydirt with Metal Church in 1984. But after its first album, the group was signed to Elektra Records. None-

► 25

Exhibit #13

by Karen Franklin

Photos by
Phil Schofield

13
2-1-91
SSD

Country communities afflicted by shortage of medical services

rural doctor crisis

When Dr. Michael Luce completed his Army service 10 years ago, he started looking around for a small town where he could put down roots and open a family practice. His search ended in Dayton, Washington, a tiny farm community, population 2,600, about 30 miles east of Walla Walla. In a town like Dayton, Luce reasoned, he could practice a full range of medicine, from treating sore throats to delivering babies.

For the first five years, everything went according to plan. The Luce family melded into the community as the physician took up his office practice and rounds at the 26-bed Dayton General Hospital. But then the country doctor's dream began to fall apart.

The nationwide epidemic of farm foreclosures had been gathering speed, and physicians en masse were rejecting the bad economic conditions in the countryside. Vacancies left by retiring doctors could not be filled. Dayton, as a result, now has only two full-time physicians left, barely enough to keep the hospital going.

Luce has been recruiting for five years. But he has been unable to attract the one or two partners he needs to help defray his demanding workload and increasing costs. Making matters worse, he was forced to give up his obstetric and surgery practices when his malpractice insurance premium reached $15,900 a year, a figure his patient load could not sustain. "I've had to redo my goals to convince myself to stay," he says.

THROUGHOUT THE RURAL Pacific Northwest, and in like areas around the country, there is a severe shortage of health care providers. The reasons point to a complex combination of policy decisions and economic circumstances, but the end product is simple: Medical care in rural America is fast becoming a scarce commodity. Many rural residents—one-quarter of the nation's population lives in rural areas—no longer have

access to adequate medical care.

The health care crisis in the United States is now the subject of considerable debate, but the problem is especially acute in rural areas. The ratio of physicians to patients in small towns runs about 60 percent behind the physician-to-patient ratio of urban centers. In the smallest towns, those with fewer than 2,500 residents, the disparity widens. In 107 Oregon towns of under 2,000 residents, for example, there were no physicians in 1988, according to an Oregon Medical Association survey.

The increasing difficulty of recruiting physicians to rural towns is a fundamental problem on which many others hinge. Fears of professional isolation, long hours and bad economic circumstances are just some of the deterrents.

"Medical students are more interested in lifestyle than devoting their entire lives to medicine," notes Dr. Mark Oberle, assistant dean for public health practice at the University of Washington School of Medicine. "They're less interested in night calls and more interested in group practice. It's difficult to do a group practice in rural areas, and solo practices are going extinct."

Self-employed private practitioners still provide the bulk of rural medical care. Country doctors shoulder the full cost of malpractice insurance themselves, cover all the overhead expenses and respond to all the night calls and emergencies. Many see more patients and put in longer hours than their urban counterparts, many of whom work for corporate health maintenance organizations or in group practices.

Perceived disparities between urban and rural living standards also hinder efforts to attract physicians. Recruiting firms often inflate the asking price to lure physicians into underserved areas. "Our recruiting firm wouldn't even consider a starting salary less than $85,000," Luce says. "No one in Dayton has ever made that much as a doctor."

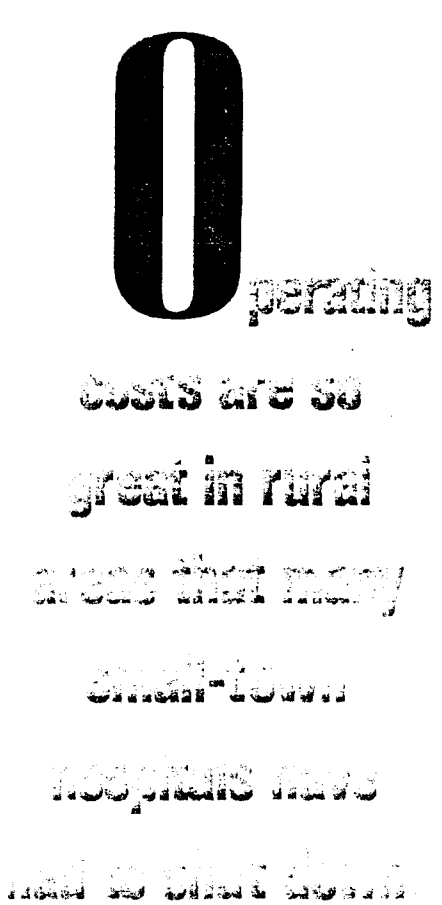
But actual salary differences between urban and rural practitioners are negligible, according to a study by University of Washington researcher Dr. Kate Riley. In a survey of recent family practice graduates from the University of North Dakota, Oregon Health Sciences University and the University of Washington, Riley found that average income ranged between $58,000 and $59,000, regardless of community size. On the other hand, benefits packages were notably better among urban respondents, Riley reports.

Complicating the recruitment problem are quality-of-life concerns that extend to physicians' spouses, who are themselves likely to be on a career track. "When you recruit a physician, you're recruiting a husband and wife, and most physicians' [spouses] are also professionals," notes Peter House, associate director for regional affairs at the University of Washington's medical school. "While there may be a need for a family physician, there may not be as much need for a lawyer or a bioengineer."

The problem is doubly hard in areas with depressed economies and limited professional opportunities. In rural areas throughout the Northwest, for example, the decline in the timber industry has removed an important economic staple, making timber-dependent communities less attractive for starting careers. During the '80s, rural unemployment rates outpaced urban unemployment, raising problems for the medical establishment.

Not only is it difficult to recruit doctors to economically depressed rural towns, it is also more costly for them to work there. Poor rural residents are hard-pressed to pay for costly health insurance and the loss of paying patients reduces the viability of medical practice.

Rural populations are not only poorer, they are also older—the result of young people leaving the country for the city. While the nation's elderly account for 12 percent of the population, they compose more than 25 percent of rural residents. As a result, rural doctors depend more heavily on Medicare payments than urban doctors, notes a staff report by the Senate Special Committee on Aging.



Although poor and elderly people often have more complicated and more expensive medical problems, federal Medicare and Medicaid reimbursements no longer meet the rising costs. Under a new federal reimbursement system begun in 1984, payments are now based on the average cost of treating each diagnosis, rather than on the real cost of care in individual cases. In rural hospitals, the patient populations are often too small for the costs to average out.

"Medicare's reimbursement policies have contributed to eroding the financial viability of rural hospitals," says the Senate report. The system fails to recognize "the vulnerability of low-volume small rural hospitals to a payment system which leaves them at complete risk for fluctuations in admissions and costs."

Exacerbating the problem, Medicare uses a reduced fee schedule to repay rural hospitals, based on the inaccurate assumption that wages and costs are lower. In fact, rural hospitals receive 36 percent less money from Medicare than urban hospitals for identical treatments, according to a report by the National Rural Health Association and the National Association of Community Health Centers. As a result, in 1986, urban hospitals made an overall profit on Medicare patients, while rural hospitals suffered losses. One out of four rural hospitals had losses of at least 18 percent, according to the Senate Special Committee on Aging. In the worst cases, hospitals lost as much as 45 percent on Medicare cases.

AGGRAVATING THESE costs are soaring premiums for malpractice insurance, which have risen so high they have priced many medical services—thus many doctors and even many hospitals—out of the market. The high cost of insurance is especially hard to bear for self-employed private practitioners.

Obstetrical patients have been among the victims hardest hit by the high premiums. In Washington, family practitioners can pay as much as $10,000 a year for malpractice insurance, depending on their volume of baby deliveries. For obstetricians, the cost jumps to $15,000 to $25,000, according to Steve Meltzer, director of the Eastern Washington Area Health Education Center. In some parts of the country, premiums have risen dramatically over the last five years.

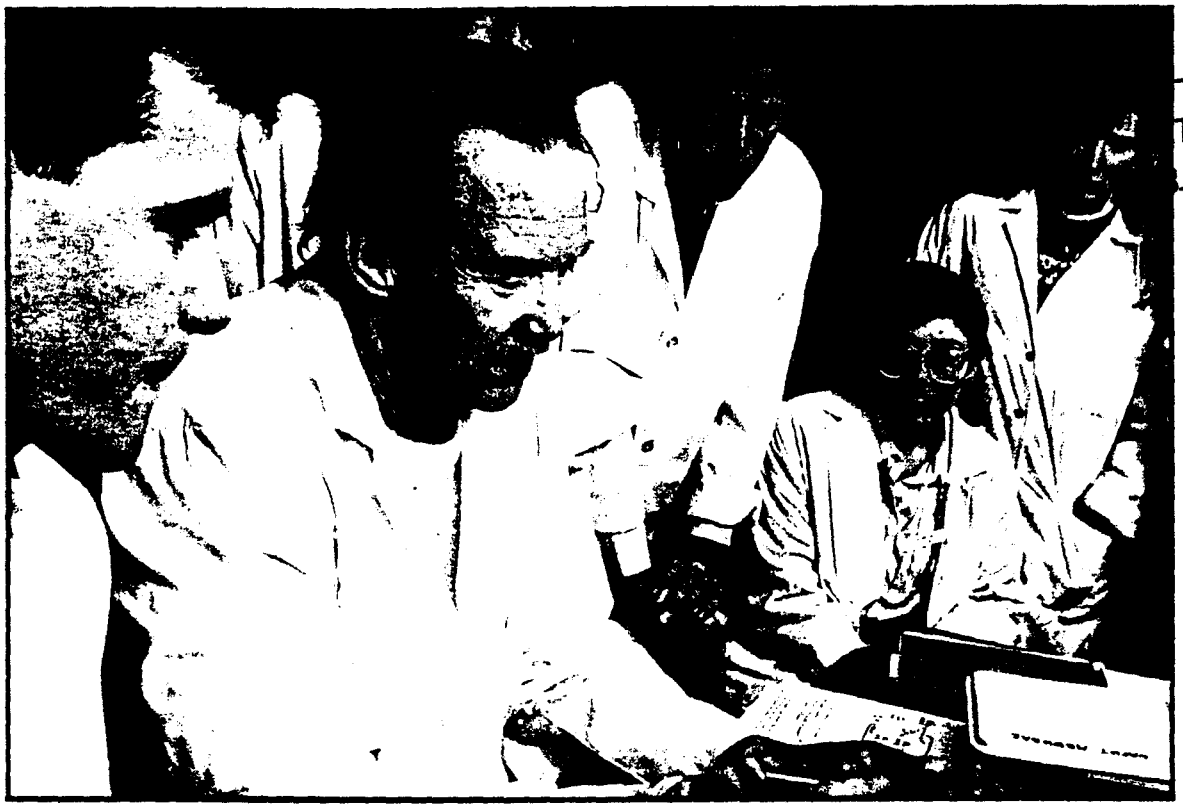
As a result of these liability costs, the number of physicians willing to continue offering obstetric services has dropped precipitately. "I used to do a dozen or more deliveries a year," Luce says. "But it was financially impossible to afford the $7,000 for the insurance."

Between 1984 and 1986, the number of family physicians providing obstetrical

Ex. 13
2-1-91 HB 350

Dr. Michael Luce

Despite the frustration of a five-year search for partners, Luce is reluctant to give up on the call to rural practice. But he has seriously considered leaving.



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care in the state of Washington fell by 15 percent, Meltzer says. Nationally, the figures are more alarming. Fully 63 percent of family physicians across the country dropped their obstetrical practices between 1983 and 1988, specifically "to minimize malpractice risks," reports the National Rural Health Association.

Operating costs are so great in rural areas that many small-town hospitals have had to shut down. During the Reagan era, some 160 rural hospitals closed, and 600 more were facing the possibility of going under. The Northwest has suffered closure rates as high as 10 percent. In Montana, six out of 61 rural hospitals closed in the last six years. In Idaho, three out of 38 rural hospitals shut down between 1980 and 1988. And in Oregon, 10 out of 78 hospitals closed in the 1980s, seven of 10 in rural areas.

"In addition to reimbursement woes, small rural hospitals are inexorably tied to the physicians in their communities," notes an Oregon Medical Association report on rural medicine. "Without an adequate medical staff, a hospital cannot offer services to its patients."

Staff shortages extend to all health care professions, including pharmacists, physicians' assistants and nurses. The nurse shortage is acute in urban and rural areas. Low salaries and limited professional opportunities—particularly compared with other options available to women—have driven many away from the profession, touching off a scramble for the limited number of nurses in the labor pool.

Rural health care settings are paying dearly. Nine percent of the nation's rural hospitals have reduced the number of available beds as a direct result of the nurse shortage, according to the Department of Health and Human Services.

"The rural nursing shortage may grow even faster than the national shortage, as rural health care facilities with inadequate resources find it increasingly difficult to compete for nurses in the face of increased demand for their services," says the National Rural Health Association report.

"Part of the problem is there are more jobs, better jobs and better hours in urban hospitals," says Loyd Kepferle, director of the Idaho Rural Health Education Center. In Oregon, 35 percent of 1990 nursing vacancies were in rural hospitals, though those hospitals contained only 21 percent of the state's hospital beds, according to the Oregon Medical Association.

To help small towns desperate to keep their hospital doors from closing and their doctors from leaving, the federal government recently began awarding grants to needy medical centers. In 1990, more than 500 applications came in from 43 states, and the government gave out $9.4 million of its $18 million appropriation. Twelve hospitals in Idaho, Oregon and Washington together received nearly $600,000 to improve recruitment efforts and medical services.

But federal money is scarce and unpredictable. Rural health advocates, not seeing a government bailout in the offing, have asked the education establishment to promote family medicine and rural practice more aggressively. "Something is not getting instilled at the right level," says Leah Layne, executive director of the Columbia Basin Health Association, a nonprofit organization in Othello, Washington, that provides health care to low-income, uninsured patients. "Idealistically, medical students begin with the right reasons to go into medicine, but somewhere along in the process, that idealism is lost. Something is getting lost in the translation."

Adds Michael Luce: "Family-practice training is still conducted in the big city hospitals almost completely. That kind of training doesn't teach students to practice without a lot of consultants. Establishing the option of rural-track training is helpful."

But educators point to a number of existing medical school programs aimed

Rural-track training

The University of Washington's satellite medical program at the WSU campus exposes students to the specific needs of small-town practice.

specifically at promoting careers in rural medicine. The University of Washington, for example, offers medical training at satellite campuses in Washington, Alaska, Montana and Idaho (the WAMI program) "expressly to address underserved areas, specifically rural areas," says Dr. Ron Adkins, former assistant dean for the University of Washington at its remote site at Washington State University, in Pullman.

Students in the program can take some of their residency training in small-town doctors' offices, instead of teaching hospitals. "If students do some of their medical education outside the big cities, they're more likely to practice in the outback," Adkins says. "What doesn't work is standing before students and telling them to practice in rural areas."

For medical schools to boost rural practice, they must first increase their own enrollment, which has been dropping rapidly for the past several years. At the same time, enrollment among women is increasing, but "rural practice, in general, appeals more to men than to women," researcher Kate Riley reports.

Federal programs provide some help. The National Health Services Corps offers medical school scholarships and loan repayments in exchange for an obligation to practice in a federally designated underserved area. Many remote areas, such as Indian reservations, rely on the corps for their medical care.

The corps saw hard times during the Reagan administration, which cut its funding to zero. But in 1990, the House and Senate passed legislation to reactivate the corps.

"The National Health Services Corps allows people to get to medical school who otherwise couldn't take on a $50,000 debt," says Luce. "But they've also got to want to practice rural medicine, and that means exposing them to rural areas, showing them that rural docs are not just a bunch of Bozos who couldn't cut it in the city."

Federally sponsored Area Health Education Centers (AHECs) help provide that exposure. Some 100 centers in 38 states work with professional medical associations, educational institutions and communities to train and recruit medical students and other health professionals for rural—and in some cases inner city—practice, says Steve Meltzer, the AHEC director for Eastern Washington.

The Eastern Washington AHEC began a student placement program in 1989, for example, to set up rural rotations for medical, dental, nursing and pharmacology students. By the second year of the program, the number of participants had doubled, from 26 to 53.

Despite the merits of these federal pro-

▶ 25

◀16

grams, which have existed since the early 1970s, rural health care problems are accelerating. The Washington and Oregon legislatures recognized the worsening public health climate in 1989 by enacting sweeping aid packages.

The Oregon legislation authorized full-cost Medicaid reimbursements to rural hospitals, tax incentives to health professionals practicing in rural areas, the state's first AHEC program, and a scholarship and loan repayment program. Washington provided financial assistance to medically underserved rural areas, a statewide plan to enhance nursing education, and an education-loan-repayment program.

The lengths to which health care providers have had to go simply to continue offering care illustrate how desperately these efforts are needed. Since two physicians retired from Othello, Washington's Columbia Basin Health Association in the last two years, Leah Layne has been searching for three doctors to replace them and to meet her growing needs. She is currently offering a $500 a month stipend to students in their third year of residency who agree to work for one of the association's clinics upon graduation.

"After our senior physicians, who had been here 14 and 16 years respectively, retired, the physician pool to replace them was not out there," Layne explains. "People who could practice in rural areas, who embraced our philosophy of serving the poor and the medically indigent and, most important, who were trained to work 150 miles from the nearest tertiary-care facility—the resource pool wasn't there."

Dr. Michael Luce in Dayton shares Layne's frustration. In the past five years, he has interviewed a dozen serious candidates to add to his practice, but so far, all have declined to come to Dayton. "A fellow we interviewed last month still has us on his list, but if he says no, we're back to where we started—or worse, because when we started we still had OB and general surgery," Luce said in November.

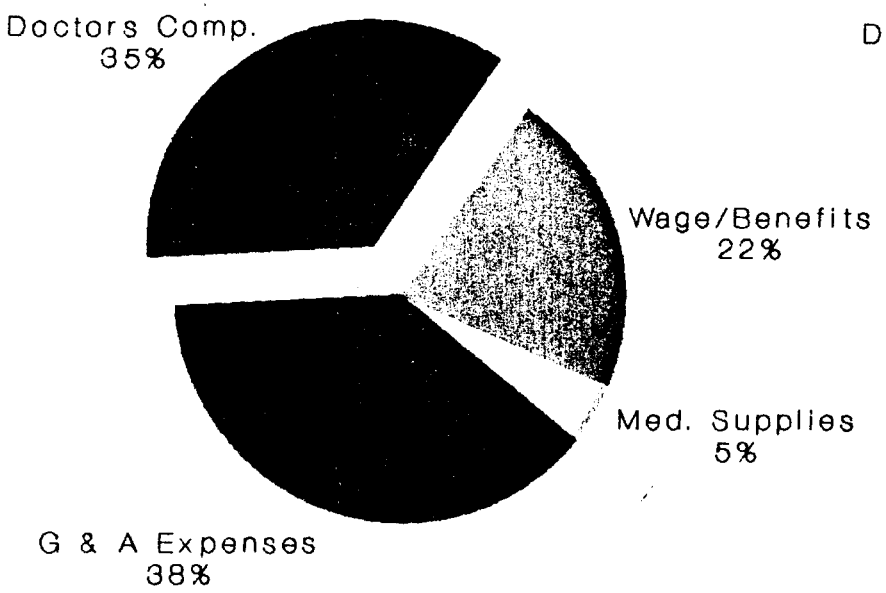
Meanwhile, Luce continues working solo, typically 12 hours a day. "I've thought about leaving, quite seriously at times," he says. But Luce is still there. He is reluctant to give up on the call to rural practice—the peaceful setting, getting to know the patients, doing preventive, as well as diagnostic, care. Most of all, there is a sense of reward. "My bias is that practicing in the boonies, without a lot of support, without a lot of consultants and specialists, is a far greater challenge." ●

Karen Franklin is a freelance writer who lives on Vashon Island, Washington.

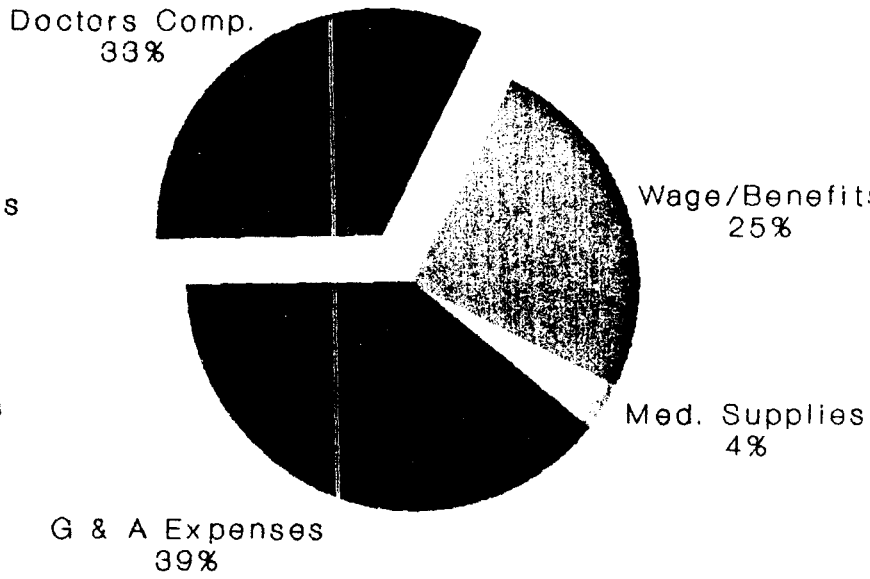
KALISPELL MEDICAL OFFICES

Expense Analysis

EXHIBIT 13
DATE 2-1-91
HB 352



1988

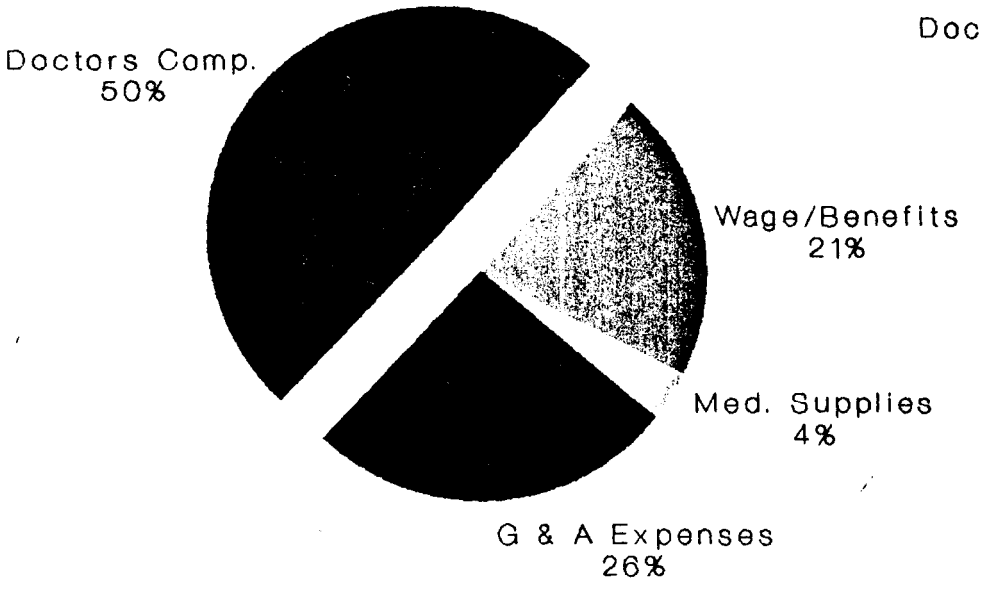


1989

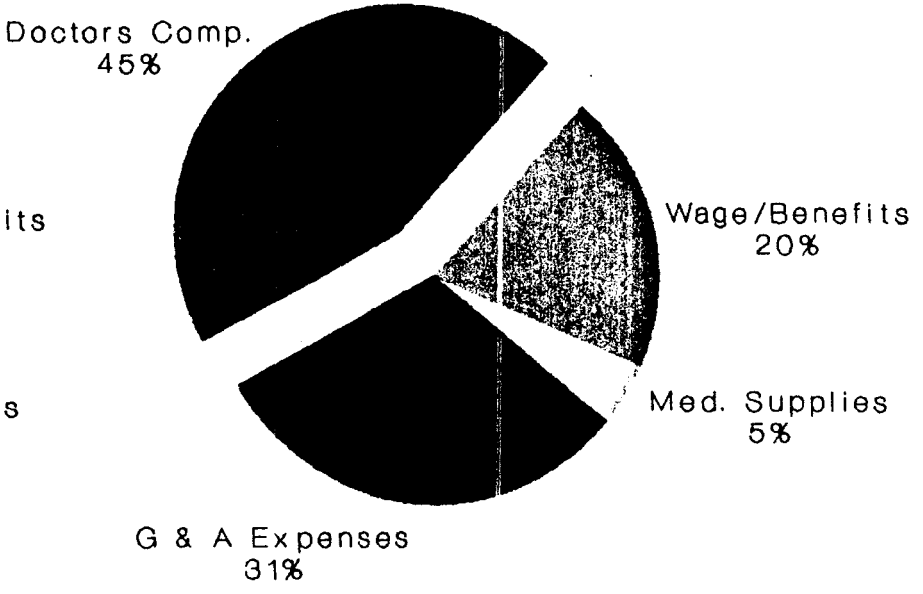
Prepared by Clark & Torgerson, CPAs

KALISPELL MEDICAL OFFICES

Expense Analysis



1986



1987

Prepared by Clark & Torgerson, CPAs

EXHIBIT 13
DATE 2-1-91
HB 35D

Medicare Accept Assignment

Three limited (20 minute) visits per hour.
Medicare allows $21.53 each.
Medicare pays $16.88
Co Payment $4.65

$21.53
$21.53
$21.53
$64.59 total/ 1 hour

Expenses/1 hour

$10.00 taxes/hour
11.00 R.N./hour ($18.00 if replaced by PROHS temporary R.N.)
5.00 clerk/hour (my billing clerk in a specialist as well as costs me more per hour than this)
8.00 medical typist/hour
22.50 Liability insurance ($7.50/each visit for three visits)
6.00 cost of billing ($2.00 to generate each bill for visit, exclusive of processing medicare.)
$62.50/total/hour

BEFORE PAYING FOR ;
Workman's Compensation
Social Security
Unemployment
Pensions
Gas
Water
Electric
Cleaning/Janitorial
Supplies
Repairs
New Equipment
Continuing Education for all Staff (Physicians, Nurses, Clerks)

PATIENT POPULATION SEEN AT KALISPELL MEDICAL OFFICES
Medicare 60% of the patients seen
40% of the fees generated
60% of the overhead across the board

Limited office visit (routine):
Private Pay $35.00
Medicare $21.53
Medicaid $14.95

Ex. 13
2-1-91
HB 350

Names of Physicians in the Flathead Valley Over 60 Years of Age			Date of Birth
James Kiley, M.D.	age 65		10/16/25
Logan Rogers, M.D.	age 67	(locum tenens)	03/05/23
Alfred Swanberg,M.D.	age 67		04/22/23
Jerome Wildgen, M.D.	age 66		12\24\24
LeGrande Phelps,M.D.	age 60	(Libby)	12/17/30
Forest Scroeder,M.D.	age 64	(Eureka)	11/01/26
Bruce Allison, M.D.	age 69		07/01/21
James Armstrong,M.D.	age 61		11/18/29
Geroge Gould, M.D.	age 70	ret. Jan.1991	08/18/20
M.E.K. Johnson, M.D.	age 72		05/23/18

total number 10 in active practice that will eventually need to be replaced as they retire.

Whitefish
Wilfred Miller, M.D. age 59 ret. Jan. 1991

There are three more primary care physicians in active practice in their 50's. How will this valley replace them? How can smaller communities like Cutbank, Shelby, & Baker be able to compete if the Flathead Valley can't compete for the shrinking pool of primary care doctors coming out of training?

Three internists have come to Whitefish and left after starting practices, in the same number of years.

Exhibit 13 also contained 6 letters opposing HB 350 from Kalispell physicians. The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

Exhibit 14
2-1-91
HB 350
Exhibit #14

AARP

Bringing lifetimes of experience and leadership to serve all generations.

MONTANA STATE LEGISLATIVE COMMITTEE

CHAIRMAN
Mr. Fred Patten
1700 Knight
Helena, MT 59601
(406) 443-3696

VICE CHAIRMAN
Mr. Paul Stengel
Route 2, Box 3040
Miles City, MT 59301
(406) 232-0016

SECRETARY
Mrs. Dorothy Fitzpatrick
Box 174
Sunburst, MT 59482
(406) 937-2451

FEBRUARY 1, 1991

TO : BUSINESS AND ECONOMIC DEVELOPMENT COMMITTEE.

FROM : FRED PATTEN - AMERICAN ASSOCIATION OF RETIRED PERSONS.

RE : HOUSE BILL #350 - PROHIBIT HEALTH CARE PROVIDERS FROM REFUSING TO ACCEPT MEDICARE ASSIGNMENTS.

THE AMERICAN ASSOCIATION OF RETIRED PERSONS IS IN OPPOSITION TO THIS BILL. WE FEEL THAT MEDICARE ASSIGNMENT IN MONTANA AT THIS TIME BECAUSE OF THE RURAL NATURE OF MOST OF MONTANA THAT ASSIGNMENT WOULD NOT BE TO THE BEST INTERESTS OF ALL AGES OF MONTANANS. ACCESS TO CARE IS A VERY CRITICAL CONCERN FOR RURAL MONTANANS. WE TRAVEL MANY MILES TO GET FROM PLACE TO PLACE IN OUR STATE . WHEN WE ARE NOT SICK OR THERE IS NOT A MEDICAL EMERGENCY THIS TRAVEL IS ACCEPTED BUT IF ONE OF THE SMALLER COMMUNITIES LOSE A DOCTOR AND THE TRAVEL IS HUNDREDS OF MILES WHAT IS THE FEELINGS OF THE INDIVIDUAL WHO HAS A MEDICAL EMERGENCY? THIS BILL DOES NOT PROVIDE ANY EXEMPTIONS FOR MEDICALLY UNDER SERVED AREAS AND THIS APPLIES TO MOST OF OUR STATE. THE 1989 LEGISLATIVE SESSION DID PROVIDE THAT DOCTORS MUST POST A NOTICE IN THEIR OFFICE STATING IF THEY ACCEPTED MEDICARE ASSIGNMENT. THIS NOTICE GIVES THE PATIENTS A CHOICE. IF THE DOCTOR DOES NOT ACCEPT MEDICARE ASSIGNMENT THEY HAVE THIS INFORMATION AND CAN GO TO A DOCTOR WHO DOES ACCEPT ASSIGNMENT.

A.A.R.P. URGES A DO NOT PASS ON HOUSE BILL #350.

EXHIBIT 15
DATE 2/1/91
HB 350

Don Luettjohann, D.O.
925 West 10th Street
Havre, Montana 59501
(406)-265-6325

To All Members on the House Business and Economic Development Committee

Dear Committee Members:

I am a board certified orthopedic surgeon living and practicing in Havre. I moved to Montana eight years ago away from Michigan, a state intent upon regulating the general welfare by mandate.

Your committee has a proposal before it to mandate acceptance of Medicare fees as final and full payment. Using the data base of PCUSA on my computer, I looked at Montana's section. Montana mens' life expectancy is 70.47 years while the women's expectancy is 77.76 years. In 1986 there were 1,381 doctors licensed in the state with a distribution of 593 people per physician. In 1986 we had a work force of 229,000 men and 178,000 women. In 1988 our unemployment rate was 4.7% and the average annual pay was $16,438. Our tax rate over 48,000 is 11%. We have a population age breakdown of 5.5% of men over the age of 64 and 7.1% of women over the age of 64 or a population of 12.6% in the Medicare age range. I do not have any figures on the financial health of that 12.6% of presumed retirees. A large percentage of my Medicare age patients have a winter home in the Mesa, Arizona area.

After shelling out large sums of money annually for health insurance, no one enjoys reaching into their pocket or their savings for additional dollars for health care--old or young. But as long as people demand the use of the latest technology, the latest drug break throughs in the treatment of disease and the surgical successes that we can provide, the medical market will channel vast sums of money through our economy. The old notion that money can not buy good health is not entirely true. When you stop to really think about it, what in life is really enjoyable if you do not have good health?

Despite the common perception of physicians being rich, excessively privileged, and arrogant to the needs of the consumer, I want you to look at the "business of medicine" as it is seen through the eyes of those who do the "vendoring". I am not going to belabor the obvious draw backs to a physicians life in regards to family or other personal committments nor to the fact that our earnings are over a 65+ hour work week including holidays and multiple hospital emergency room call backs.

As a business, 6 to 7% of my business billings are ignored and unpaid by my customers. Most of these unpaid and uncollected bills are by customers who show up in the emergency room at inconvenient times of the night or on weekends when my store would like to be closed. Unlike other businesses, I have to open up when the phone rings and I can not demand payment for my services if the customer doesn't have or want to pay for the services. In a merchants store, a customer can shop the aisles and put whatever he wants in the cart, but the goods can not leave the store until some arrangement is agreed upon for payment. My

customers when they break a leg or an arm often need xrays and appliances to splint, cast, rehabilitate, and speed their recovery--but they leave my store freely with the goods and sometimes without even a thank you. My time and my skills are my main assets, but there are goods in my inventory that are routinely stolen through nonpayment.

From year to year I sell my services to the state medicaid insurance at a volume to my total services of 10 to 12% percent. They demand a discount though on my services that ends up costing me money since the actual money for my services is less than the cost I incur for the privilege of providing them. I am supposed to provide this as a service to the community.

Twenty percent of my practice involves business with Workman's Compensation. Between wrenched backs, mangled limbs caught in machinery, twisted ankles, and the broken bones from falls--the business volume is substantial. The profit margin is just above break even. If I considered the unreimbursed time of claim forms and attorney inquiries into the equation, this segment of my business might be a wash at no loss and no profit.

Thirty-seven percent of my business is with graying Americans. They represent a large utilization of my skills. Their bodies are breaking down and many of their parts are in need of serious repair or replacement. Some of them are only going to live a few more years and I ask them if the risks and the surgery pain are worth the trouble. None of these individuals though really knows exactly how long she or he will live. None want to forego the relief of pain their arthritis or deformities is causing them. They don't express concerns that the cost of an operation will leave less for their children to inherit and many are not paying for the business of surgery anyway--the government is paying for it. These people want relief. They want to remain as independent of others for transportation and care as possible. They want to live in their own homes and plant gardens at ninety-five years of age. They want home health care to come visit them and take their blood pressure. They want a walker and an electric chair to help get them up onto their feet and a bathroom rail to assist them in getting off of the toilet. We have the materials and know-how for replacing a bad joint and they want one. The plugged arteries in their heart can be bypassed and if they can get that operation with balloons, well that would be just great. And the home health or county nurse can drop in and look at the incision and change their bandage because all their children work or have things to do. Their eyesight is failing because of catarracts but these can be taken out and artificial lens put in. Hearing aids are much better, smaller, and covered by Medicare.

Through a system of percentiles of what physicians charged four years ago, I am allowed to charge 80% of that calculated amount though my payment from Medicare is less than that amount. I keep expecting government officials like senators and representatives to average their pay from four years ago and allow that they ought to get 80% of that amount but in fairness to the budget and the country for the actual amount of work that they put out would draw out only 65%. I know that is going to happen because these public servants want to do something to help balance the budget. (But I digress..)

EXHIBIT 15
DATE 2/4/91
HB 350

To this point 39 percent of all my business activiy is at a marginal rate of break even. Of the Medicare population, 10% will also be on Medicaid and no further payment will be possible. Another 10% of the Medicare population of my business will have no other means to pay me more either even if I took them to court. But 80% of 39% or 31% will have some means to pay part or all of the difference in the services they wanted provided to them. I will come back to this 80% of the graying Americans.

The remaining 24 percent of my business comes from working people who have insurance or pay for their expenses out of pocket. Over the past 8 years as my malpractice insurance, fire insurance, office premises insurance, workman's compensation insurance, payroll tax enactment, base salaries for employees, social security rates, and last but by no means least-- medical insurance on my own family and my employees have done anything but go down. I have a computer and each year as I plan a budget and add the net increases I know I will have in expenses by allowing for a cost of living in my employees wages, the effect ripples across the spreadsheet with the various business taxes associated with those raises. Add the amount of malpractice premium increases and other insurance costs to be in business then divide that total known increase by a formula of how the business produces revenue and it soon is obvious that the 24% of working men and women and the 80% of the 37% of Medicare have to pay for these increases if my business is to exist. And I have not even considered any pay increase for me, the boss.

I have not added any pay raise for me in the eight years that I have been in Montana. I was not sophisticated enough to even understand what impact the Medicaid and State Workman's Compensation payment rate were making until 1985 when I purchased my first computer and Lotus 1-2-3. Now that I own a computer and a spreadsheet here is what the bottom line for a doctor in Montana looks like:

All increases in business expenses--wages of employees, insurances, new medical equipment, medical meetings, literature, pension plans for doctors and employees must be cost shifted to the 24% of working people and the 80% of Medicare recipients. If the Medicare population is relegated to the status of break even, then the business of medicine can not turn a profit worthy of the efforts put into the business.

First, physicians must maintain a level of medical expertise. Medical meetings are a costly expense. Fifty hours per year are required by my college of Orthopedics to remain in good standing. These meetings are held in large convention centers which are well served by airlines and in populous areas. I must travel to Great Falls and sleep overnight in order to catch a plane at 7:30 AM if I want to avoid the vagarities of the weather and ensure I make the flight. This costs money both ways in lost business while I am away from my practice and in expenses of getting to the meetings--airfares, airport parking, shuttle bussing to the meeting, lodging, the cost of the courses. The only effective cost cutting I can do is with meals. The cost of these meetings must come with funds left over after other basic business expenses.

Second, as a business employing less than 25 employees, I am

forced to pay the greatest insurance premiums for myself and my employees. I have no alternatives except not to have insurance.

Third, as a business I can only pass on a certain amount of my expense increases each year because third party insurers want to hold their costs (which are my revenues) to a minimum. They don't want to pay for the others who have no insurance, are free riding, and non responsible for their health.

Fourth, as a physician when my children reach college age they will be denied college assistance because I am a doctor. My medical degree is synonymous with affluence. Yet if there is to be no profit in the business how can there be planning for my children's education or a pension plan since I am not working for any business but my own? I could argue that I should be entitled to a government pension as equivalent to a US Senator's or Representatives since I am really already a government employee providing pro bono services to 7 percent, state services to 12 percent, and federal services to 37 percent (and steadily increasing).

And fifth, add the spectrum of physicians costs as that for disability and life insurance. We have taken on substantial burdens for our offices, equipment, and our employees and their dependents are subject to our financial health. I feel obligated to have disability insurance on myself to cover not only my family's needs but those of employees salaries in the event of a temporary incapacitation and this expense comes out of whatever profits there are.

As a Montana business providing orthopedic services I have to be able to remain profitable or reevaluate the equations that determine the cash flow of my business. Should I just say no to an unprofitable segment of my business, save on the expenses by reducing my hours, my hospital coverage, say no to all Medicaid but the most life-threatening? Should I insist on payment before services to eliminate the percentage of nonpayers whose costs spill over to those who do pay? Should I move to a state where Medicare balance billing is permitted? Should I just stop doing surgery, drop my malpractice insurance, and do insurance and disability examinations? These are the questions Montana businesses will ask themselves as medicine continues to look to the bottom line.

Massachusettes mandated acceptance of Medicare as payment in full, but Massachusettes doctors are the country's highest paid. Montana physicians are not. In addition to losing physicians from their state, it still seems unfair to say that a doctor could not bill his millionaire patient for the balance of his bill not covered under Medicare. Medical care is still a privilege. This type of legislation makes medical care a right.

People have the right to smoke. People have the right to decide if they want to purchase health insurance. This type of legislation says that those who choose unhealthy life styles are entitled to have their bills paid by the government and not be responsible for themselves. This bill penalizes those of us who do pay for insurance and act responsibly. Living is a constant selection of choices: Do I go on a cruise or do I have a gallbladder operation? Do I smoke and risk cancer, emphysema, heart disease, more colds and time lost from work or do I spend

my money on remaining healthy or something else that I want? We should all choose to give ourselves more spending money by dropping our insurance and spending the difference on smokes so that we can need medical more often, sooner, and for chemotherapy, heart surgery, and portable oxygen.

What are the issues here?
One issue could be that people feel they already pay enough for health care and they want a cap on their health care expenditures. Does cutting physicians salaries accomplish this? Mandating Medicare acceptance removes varying degrees of profitability from medical practices depending on their patient mix. Doctors provide the services in terms of rendering care and making medical miracles happen, but what part of the pie does our payments really represent?

For argument sake lets say that no one over the age of 80 should have a heart bypass surgery, hip or knee replacement, or catarract surgery unless he or she paid for it out of their own pocket. Lets say that handrails at home in the bathroom and walkers should be bought by families instead of Medicare. Terminal cases of cancer should die at home with home health care nurses checking periodically on IV sites and training family members how to protect tubes and administer medicine. Chronic smokers with end stage lung disease should buy their own oxygen set ups for in home use instead of billing the rest of us for a life of burnt cigarette butts. When grandma or mom is ill and feeling poorly, one of her children will have to stay at home with her. We can't have admissions for adult babysitting. After a broken hip and the patient is ambulating safely the patient goes home Wednesday or Thursday instead of Saturday when the children are off of work and someone can come and get the relative. How much could we save?

Montana legislators are taking the easy way out by alienating Montana doctors and making us pay for the sins of medical success. We can make people live longer, remain mobile longer act as adult daycare centers, and buy every medical aid ever invented because it is covered under Medicare. We can and we have been. Our patients demand it because their neighbor got it and the social security office told them they were due these things. Society has grown accustomed to expecting the tab to be picked up by the government--the government of working people whose taxes pay the bills.

I challenge you legislators to look at the problem and see the culprit. The criminal is us---those of us who expect everything to be given to us. Those of us who insist that our last few years be dependent upon the resources of the government to pay for our hips, hearts, eyes, medical gizmos, and conveniences. If congress said "No, I am not going to pay for that. If you want it, you pay for it yourself." Then society would be more reflecting in what it now asks for so casually. Probably fewer of us would smoke. We would have to develop more responsibility for our own welfare. Yes, the rich would go to the front of the line but they are in the front of any line offering goods or services available for consumption. Prices might actually come down if not artificially supported by government Medicare payments. Medicare is nothing more than a price support with its own inflationary spiral. Taking away benefits is undoubtedly unpopular. It would

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take courage to say "We can't support cradle to grave health care without stiff taxes and a degree of socialism not experienced before". But as a physician I already pay my share of taxes, I provide free care to a large segment of people and now you want me to pay more for you to consume. Thank you, no.

And if you take away the balance billing will you issue doctors tax credits in the amount of free care that we physicians now provide? Will you organize a health care provider to take in all physicians and physicians employees and give us medical insurance at a deep discount as a preferred provider of medical services? Will the state establish a pension plan for Montana physicians and give tuition preference to physicians children at state schools come college time? Will the state provide adequate sustenance to physicians and their families if a doctor contracts AIDS? Will the state set limits on malpractice insurance premiums or consider lowering physicians workman compensation rates and payroll taxes? If you do decide to mandate acceptance of Medicare as payment in full, then Montana legislators, physicians will need just this kind of financial assistance.

I would urge careful study of this proposal and a nay vote. The business of medicine in Montana is more fragile than popular perceptions allow.

The easy target is doctors: affluent, privileged, envied, electorally ineffective at the polls. But wouldn't it be scary if the current dissatisfaction rate among physicians widened further? Fifteen years ago according to a recent medical publication, 66 percent of physicians encouraged their children to go into medicine while today 70 percent of physicians now ACTIVELY DISCOURAGE their children from following in their footsteps. Wouldn't it be scary if these same graying, politically powerful and voting Americans had fewer options because doctors had to go out (out of state or out of the medicine business) and get a job to support their families?

Retiring Americans have more money and resources than their parents. If cradle to grave social coverage for living is a goal then lets raise the taxes on everyone who is going to benefit. If this is what people want, people should pay for it. You don't punish the cow for providing the milk--and yet that is what we have here.

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DATE 2/1/91
HB 350

HAVRE CLINIC, P.C.

(406)265-7831 in MT (800)821-6361
20 W. 13th St., P.O. Box 7348
Havre, MT 59501

January 30, 1991

Representative Bob Bachini
State Capitol
Helena, MT 59620

Dear Representative Bachini:

I write in regards to several bills that will soon come before you. These bills all have to do with the ability of Montana physicians to continue to live and work in our State. I realize that statement may sound like a certain amount of bravado, but the record in northcentral Montana is quite clear. Since the last legislative session, there have been five primary care physicians who have decided to leave. Those five constitute about 23% of the original total primary care physicians in our area. There have been NONE to come into the area, despite aggressive (in fact, desperate) recruiting efforts. At least two hospitals are teetering on the edge of financial failure, and one is likely to close while you are in session.

You will be faced with several decisions regarding the role of physicians in Montana. I hope you will remember that, as you continue to diminish the ability of Montana physicians to practice in an acceptable manner, you will also diminish their number as well.

The following bills come to mind:

HB350 — This bill requires all doctors to participate in the Medicare program. It effectually reduces their ability to charge for services rendered to levels set by the Federal government. Those levels are almost TWICE AS HIGH in other states as they are in Montana. Why should a physician practice in Montana when he can charge twice as much for the same service somewhere else? I can quite guarantee you that his costs are not twice as high. If seniors are upset with Medicare coverage, they should be angry at the Federal government, who makes them subsidize the care provided to others.

SB152 — This bill makes permanent the current status of lay midwives. I am quite strongly opposed to this bill for several reasons: First of all, the whole concept is structurally flawed -- it makes second class citizens out of our infants, the people who should be cared for best. Secondly, it completely eliminates the possibility that the lay midwife

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would have competent medical backup. The malpractice premiums for a family practitioner to do obstetrics are about $15,000/year. If he does four deliveries per month, his insurance costs $375 per delivery. By sending more deliveries to lay midwives, you are ensuring that the doctor will be unable to help if there's a problem, and out of practice should he choose to risk the attempt.

LC1390 This bill brings the State into compliance with Federal law regarding Medicaid payments to physicians and hospitals. Obviously, I support it, and hope you do, too. It allows SRS to comply with Federal law, and gives doctors a small shot in the arm.

In the final analysis, your votes on these matters will come down to whether you believe that medical care can continue to exist for all Montanans. If you believe that the decline in physician numbers is irreversible, you can plan for that process (and, perhaps, hasten it) by continuing the current trends. On the other hand, if you believe that Montanans should have the same access to high quality health care that everyone else has, please vote accordingly on the issues above.

I will be happy to answer any further questions on these matters.

Sincerely,

Peter D. Berger
Administrator

PDB/kg

EXHIBIT 15
DATE 2/1/91
HB 350

HAVRE CLINIC, P.C.

(406)265-7831 in MT (800)821-6361
20 W. 13th St., P.O. Box 7348
Havre, MT 59501

January 29, 1991

Representative Bob Bachini
State Capitol
Helena, MT 59620

Dear Representative Bachini:

I have written you earlier regarding thoughts on Medicare participation and the current legislative bill to require same. Do you think it a reasonable policy for Medicare to direct the third parties who handle Medicare payments to delay payments? Currently there have been administrative processes sent down from Washington which directs Medicare claims to be paid after 66 days rather than 18 days. I find this inappropriate and would hope legislation could be drafted to demand that insurance companies process and respond to claims within 21 days after their receipt, be they health insurance, life insurance, disability insurance, etc. There is no greater frustration than to strictly and methodically pay their premiums (or had their social security deducted) on a regular basis, finding out that the party who received such premiums (or taxes or social security payments) will respond to a claim via a double standard of behavior. It is simply not acceptable and should be corrected, if not nationally, at least within the state of Montana.

Sincerely,

Robert T. Henderson, M.D.
President & CEO

RTH/kg

EXHIBIT 15
DATE 2/1/91
HB 350

HAVRE CLINIC, P.C.

(406)265-7831 in MT (800)821-6361
20 W. 13th St., P.O. Box 7348
Havre, MT 59501

January 30, 1991

Representative Bob Bachini
State Capitol
Helena, MT 59620

Dear Representative Bachini:

I am writing in regards to House Bill 350 which would mandate acceptance of Medicare assignment by physicians.

As you undoubtedly know, the Medicare segment of our population is, as a class, the most financially viable group of people in this country. A number of people over 65 are not well off and in fact many are poor. For these people, physicians are already accepting assignment, but certainly should not be required to do so for people who can well afford to pay their medical bills. Whether or not a physician accepts assignment should be decided on a case-by-case basis. I would estimate that I accept assignment on 30-40% of my Medicare patients already.

For internists like myself who have a large Medicare patient practice, mandatory acceptance of assignment would be one more financial burden to bear. Those of us practicing medicine in rural Montana, are already reimbursed at a much lower rate than physicians in other parts of the country. Medicare rates are particularly low in Montana.

Finding primary care physicians in rural Montana has become an extremely difficulty proposition. Northcentral Montana has lost a number of physicians in the last few years, and efforts to recruit primary care physicians has been, by in large, futile. Should mandatory acceptance of Medicare assignment be voted into law, finding physicians for rural Montana will become ever more difficult.

Thank you for your time.

With best regards,

Robert C. McCroskey, M.D.

RCM/kg

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DATE 2/1/91
HB 350

HAVRE CLINIC, P.C.
6
(406)265-7831 in MT (800)821-6361
20 W. 13th St., P.O. Box 7348
Havre, MT 59501

January 29, 1991

Representative Bob Bachini
State Capitol
Helena, MT 59620

Dear Representative Bachini:

House Bill 350 regarding Mandatory Medicare assignment is an absurdity. Rural health care providers and rural health care facilities are not going out of business and closing up shop because of exorbitant profits gleaned from the current health care delivery system.

Medicare already establishes maximum fees and maximal allowable charges. In many instances the actual payments Medicare will make on charges delivered in metropolitan areas or on both coasts of this country are higher than our total fees are.

Further ratcheting down of this system is not going to solve a single problem for anyone as private payers and others will simply have to continue to take up more of the slack if bills such as this pass.

Sincerely,

Robert T. Henderson, M.D.
President & CEO

RTH/kg

EXHIBIT 15 P.11
DATE 2/1/91
HB 350

HAVRE CLINIC, P.C.

(406)265-7831 in MT (800)821-6361
20 W. 13th St., P.O. Box 7348
Havre, MT 59501

January 29, 1991

Representative Bob Bachini
State Capitol
Helena, MT 59620

Dear Representative Bachini

This letter is to express my opposition to House Bill 350 requiring mandatory Medicare assignment. I, as a physician and an American, feel this is unfair to be told how much I can or cannot charge for any given service, Although there are Medicare recipients that are in significant financial distress, there is a much larger majority of Medicare recipients who have the means to pay for their medical care. Most of the physicians in Montana at this time do participate in MONTSHARE which means essentially we will accept assignment on anyone that requests it by simply filling out a form indicating that their income level is below 150% of poverty level. It should be pointed out we do not in any way research these peoples applications, thus we take their word at face value.

I perceive some problems for the general population should HB-350 be passed. (1) I suspect there will be a backlash of physicians who would decrease seeing Medicare patients. This would, of course, decrease medical availability in a state that already suffers from this problem. (2) Medical care for non-Medicare patients would rise, shifting more of the burden unfairly to the non-Medicare population.

In closing, I would like to reiterate medical care and Medicare assignment is available to those Medicare recipients that request and need this. It is not fair, however, to expect some of the more wealthy Medicare recipients, to receive a discount on medical care while the cost is unfairly shifted to other portions of the population. Finally, I think it is unfair for physicians singly to be told how much they can charge for a service in respect to the fact reimbursement sometimes is less than the cost of providing the service. Very few segments in our free enterprise society are singled out and told how to conduct their own private business.

Sincerely,

Michael D. Nolan, M.D.

MDN/kg

EXHIBIT 15
DATE 2/1/91 P.17
HB 350

HAVRE CLINIC, P.C.

(406)265-7831 in MT (800)821-6361
20 W. 13th St., P.O. Box 7348
Havre, MT 59501

January 30, 1991

Representative Bob Bachini
State Capitol
Helena, MT 59620

Dear Representative Bachini:

I am writing in regard to House Bill 350 which would mandate acceptance of Medicare assignment by physicians.

As you undoubtedly know, the Medicare segment of our population is, as a class, the most financially viable group of people in this country. Rural health care providers and rural health care facilities are going out of business and closing up shop because of exorbitant profits from the current health care delivery system.

Medicare already establishes maximum fees and maximal allowable charges. In many instances, the actual payments Medicare will make on charges delivered in metropolitan areas or on both coasts of this country are higher than our total fees are.

Northcentral Montana has lost a number of physicians in the last few years. Should mandatory acceptance of Medicare assignment be voted into law, finding physicians for rural Montana will become ever more difficulty. I therefore, urge you to vote against House Bill 350.

Thank you for your time.

Sincerely yours,

James E. Elliott, MD

JEE/kg

EXHIBIT 15
DATE 2/1/91
HB 350

Northern Montana Orthopaedic

& Sports Medicine Institute

Paul G. Bizzle, D.O.

January 29, 1991

Bob Bachini, State Representative
State Capital Building
Helena, MT 59601

Dear Senator Hockett:

The Montana Medical Association recently provided a memorandum indicating that the legislature is entertaining the House Bill HB 350 which requires mandatory Medicare assignment for physicians in the state of Montana. I am strongly opposed to this Bill. I had recently moved to Montana from the Common Wealth of Pennsylvania where similar legislation has been introduced and although this legislation has not passed it was one of the deciding factors in my determining to move to Montana from Pennsylvania. I would hate to be forced to leave this state, because of problems of this nature. I do not feel that this Bill is in the best interest either of your constituents or of the physicians whom it would directly affect. I can assure you that Medicare's payment for most services rendered is quite inadequate and in fact I have participated with Medicare for the six years prior to this and have only this year withdrawn from the Medicare program specifically because the Medicare reimbursements are so poor and they limit my ability to even meet my basic overhead. I would hate to have to decline to take care of Medicare patients all together, but at some point in the future this may become necessary. Your support in opposing and defeating HB 350 would be greatly appreciated.

Sincerely,

Paul G. Bizzle, D.O.

PGB/be

845 Fifth Street • Havre, Montana 59501 • 406-265-9691

EXHIBIT 15
DATE 2/1/91
HB 350

Sweet Medical Center

P.O. Box 309 — 419 Pennsylvania
CHINOOK, MT 59523
(406) 357-2294

January 28, 1991

Senator Robert Bachini
State Capital
Helena, MT 59620

Dear Representative Bachini;

This letter is written to voice my opposition to House Bill #350, which would mandate Medicare assignment by physicians in the state of Montana. Certainly on the surface, and at first glance, this would appear to be a very beneficial bill to the senior citizens in this state. However, as one looks beyond the superficial ramifications of this bill, I believe that ultimately it will lead to decreased opportunities for the senior citizens of the state of Montana, to be assured access to quality medical care.

I currently practice in Chinook. I am employed by the Sweet Medical Center here in Chinook. Sweet Medical Center is a non-profit community medical center. We currently operate on a very tight budget. We do everything that is possible to keep costs as low as possible, not only the Medicare patients, but to all of the patients in the community. We do participate in the Montana Medical Association's MontShare program, which does extend the benefit of accepting assignment to those persons in our community who have shown a financial hardship, due to their income limits. We also work on a case by case basis with those who come to our office and present specific needs to us that would certainly help their situation by our accepting assignment.

Mandated assignment of Medicare benefits from all Medicare beneficiaries would certainly put this facility in jeopardy. The amounts payable under assignment through Medicare would, in most cases, not compensate us adequately to even provide cost at a break even point. But, we are a not for profit organization, a break even must be maintained in order for cash flow to be adequate to continue to keep the facility operating. It is my deep concern that requiring acceptance of assignment on all Medicare patients would lead to similar hardships in many physicians' offices throughout the state of Montana. One must remember that with Montana being such a rural state, that Medicare benefits paid to physicians in Montana are already lower in those paid to those paid to counterparts in more urban states. Mandated acceptance of assignment on all Medicare beneficiaries would certainly create a situation where I'm afraid we would see many Montana physicians seeking practice opportunities elsewhere.

In tight financial times, such as the nation is currently experiencing, one understands the pressures brought to bear, to keep costs down. I believe myself the majority of Montana physicians are working extremely hard to keep costs down, again, not only to Medicare patients beneficiaries, but to all patients that we

see in the state. I certainly agree, it is imparitive to do all that can be done to keep medical costs in line, but I feel mandating assignment of Medicare benefits is a step that will lead to a much more difficult medical situation in this state.

I would appreciate your careful consideration of this piece of legislation, and your opposition to it.

Sincerely,

Stan Jett, M.D.

SWJ/rb

cc: Representative Francis Bardanouve
Senator Greg Jergeson

Exhibit # 16

MONTANA ACADEMY OF OPHTHALMOLOGY

23 S. LAST CHANCE GULCH ▲ HELENA, MONTANA 59601 ▲ (406) 449-2334

EXHIBIT 16
DATE 2/1/91
HB 350

TESTIMONY ON HB 350
February 1, 1991

Mr. Chairman, Members of the Committee

I am Gloria Hermanson. I live in Helena and am the Executive Director for and represent the Montana Academy of Ophthalmology.

Ophthalmologists are medical doctors licensed to practice medicine and surgery, specializing in all aspects of eye and vision care. Montana Academy members constitute about 98% of ophthalmologists in the state.

MAO opposes mandatory medicare assignment. Many seniors on medicare have more than adequate resources to pay for their own health care. Mandatory assignment forces middle-aged, middle-class workers to subsidize health care for many who don't need to be subsidized. For Montana's low-income seniors, Montshare is working well.

Earlier this week we conducted a telephone poll of our membership. We were able to make contact with 86% of our practicing physicians. Of those, 90% participate in Montshare. The remaining 10% accept assignment on a case by case basis or on surgery.

The Academy views mandatory medicare assignment as a reckless solution to a non-problem. It would be detrimental to available quality health care in Montana by driving practicing physicians out of state and would serve little purpose.

We urge you to kill this bill.

TELEPHONE POLL RESULTS:
Academy Members - 40
Retired - 4
Unable to reach - 5
Participate in Montshare - 28
Accept assignment on case by case and all surgery - 1
Accept assignment on surgery only - 1
Accept assignment on all claims - 1

EXHIBIT 17
DATE 2/1/91
HB 350

AARP

June 5, 1990

Van Kirke Nelson, MD
210 Sunnyview Lane
Kalispell, Montana 59901

Dear Dr. Nelson:

This letter responds to your request for A.A.R.P.'s views on mandatory assignment in relation to the newly enacted Medicare fee schedule (R.V.S.).

A.A.R.P. historically supported mandatory assignment in conjunction with adoption of a resource based fee schedule. We supported the OBRA '89 fee schedule provisions and remain committed to achieving mandatory assignment when the new fee schedule is fully implemented in 1996.

At the same time, we continue to support state efforts to ban balance billing when the available evidence suggests that access to care will not be jeopardized by such a ban. Relevant evidence includes voluntary assignment and participation rates and the supply and distribution of physicians.

Past analysis of these factors led us to not support proposals to ban balance billing in Montana.

Montana still lags far behind the nation in participation and assignment rates. In 1989, only 21.5% of Montana physicians signed participation agreements (compared with about 41% on average for the nation) and 54.6% of covered charges were assigned (compared with 80.6% on average for the nation). Beneficiaries in Montana were collectively billed $10,639,818 above the total allowed amount by Medicare.

According to 1986 data from the American Medical Association, nine counties were without a physician and the ratio of active physicians per population was less than the national average.

While possible loss of access to care remains a concern, the new fee schedule - once it is fully phased in - should significantly reduce the possibility that physicians would refuse

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DATE 2/1/91
HB 350

to see Medicare patients if balance billing were prohibited. Government projections show that under the new fee schedule total Medicare payments in Montana will increase three percent, G.P.s and Family Physicians will see payments rise 28%, while internists will experience an 11% increase, assuming no change in their volume and mix of services. Furthermore, doctors practicing in health manpower shortage areas will receive a 10% bonus on top of their new allowed fee. Clearly, the financial incentive to take Medicare patients will increase in future.

Since the new fee schedule is widely viewed as fair and objective, we believe there is no justification for balance billing above this fair fee. Further, increased fees will also mean increased coinsurance and possible increases in Medigap premiums to keep pace. Rural beneficiaries should not be further burdened with the out of pocket costs associated with balance bills.

I hope this clarifies our views on the matter.

Sincerely,

Shelah Leader

Shelah Leader, Ph.D.
Sr. Policy Analyst

cc: Fred Patten
Don Daughetee

Exhibit 00 consisted of 35 letters opposing HB 350. The originals are stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

EXHIBIT 18
DATE 2/1/91
HB 405

TESTIMONY

If Blue Cross says they are now writing their insurance policies at prices which could change if this bill is passed, we say we have no objection to that. That is their decision to make. Their sales in 1989 were $162,957,526 premiums for accident and health coverage - at least one half of the total in the state. The next in line, only $12,481,653, was Prudential Insurance Company of America. I suggest Blue Cross is in a good position to absorb some costs - much more than the hospitals. Their rates are only passed after audit by the Montana Hospital Review Committee.

Hospitals in all but three cities of Montana are "Sole Providers", that is, there are no other hospitals providing acute care in other communities. Obviously, they must provide health care to everyone that doctors admit as patients. They do not have the option of refusing care to anyone that requires care. They end up with a lot of patients who can not pay and some who are not worthy of credit. This is the reason for this bill. Hospitals have to be paid by all who can pay.

That is why the Physician Lien Act was passed in 1987. In that act, the legislature made Blue Cross subject to the Montana Insurance Code. Since Blue Cross is identical to health insurers in fundamental respects, they should be treated identically under the Physician Lien Act. It is the right of a patient to assign his insurance claims to a hospital and it

requires the insurance company to write the check to the hospital.

You wont find anything else in this bill. It places all on the same playing field - the same language used by Mr. Barnhill of the Insurance Division in his testimony at the hearing.

The hospital or hospitals in your communities are probably the largest employer in town and it is in the communities' best interests to keep them operating. HB 405 is a key in that effort so I hope you can see the whole picture as I do, serving on our Hospital Board now and for the past eight plus years!

We are elected to write laws that are fair to all and to correct statutes that are unfair. This bill addresses fairness and places Blue Cross under the same law as the other insurers.

Norm Wallin

EXHIBIT 19
DATE 2/4/91
HB 405

Amendments to House Bill No. 405
First Reading Copy

Requested by Representative Wallin
For the Committee on Business and Economic Development

Prepared by Bart Campbell
January 30, 1991

1. Page 2, line 10.
Following: "~~or~~"
Insert: "a policy of life insurance or group life insurance; a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital; or"

EXHIBIT 20
DATE 2/1/91
HB 405

INFORMATION SHEET - HB 405

Amendment to Physician Lien Act

Objective:

To place health service corporations on the same footing as other health insurers for purposes of Montana's Physician, Nurse, Physical Therapist, Chiropractor, Dentist and Hospital Lien Act ("Physician Lien Act" § 71-3-111, et seq.)

Rationale for Amendment:

This amendment ensures that health services providers such as hospitals and physicians have the same lien rights for insurance benefits provided by health service corporations as they have for benefits provided by other health insurers. (Blue Cross/Blue Shield is currently Montana's only health service corporation.) Recognizing the fundamental similarities of health service corporations and other health insurers, the legislature in 1987 made health service corporations subject to the Montana Insurance Code. §§ 33-1-102(3); 33-30-102, MCA. Like the insurance code, no logical reason exists for differentiating between health service corporations and other insurers in the Physician Lien Act.

The purpose of Montana's Physician Lien Act is to establish lien rights for health care providers when a person receiving medical treatment is (1) injured through the fault or neglect of another; or (2) is either insured or a beneficiary under insurance. § 71-3-1112, MCA. Accordingly, with regard to insurance, the Physician Lien Act provides:

> If a person is an insured or a beneficiary under insurance which provides coverage in the event of injury or disease, a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital, upon giving the required notice of lien, has a lien for the value of services rendered on all proceeds or payments, except payments for property damage, payable by the insurer.

§ 71-3-1114, MCA. After a lien is filed with the insurer, if the insurer then ignores the lien and pays insurance benefits directly to the person receiving medical services, the health care provider has a claim against the insurer for "the reasonable value of the services." § 71-3-1117, MCA. The effect of the Physician Lien Act, therefore, is to provide health care providers some protection from financially irresponsible persons who fail to pay for medical services for which they have been reimbursed by insurance.

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2-1-91
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Denying lien rights for insurance benefits received from health service corporations while allowing lien rights for other health insurance benefits is nonsensical. In fact, until recently, many persons assumed that health service corporations were subject to the Physician Lien Act. Last fall, however, the Montana Supreme Court decided the case of Anesthesiology, P.C. v Blue Cross and Blue Shield of Montana, 47 St. Rep. 2015 (Mont. 1990). In the Anesthesiology case, the Court decided no express legislative intent was evident to make health service corporations subject to the Physician Lien Act. Therefore, the court declined to hold that Blue Cross/Blue Shield insurance benefits were subject to the Act.

It is anticipated that Blue Cross/Blue Shield will oppose H.B. 405 because Blue Cross/Blue Shield has always refused to honor assignments by their insureds directing insurance to be paid directly to the health care provider. Blue Cross/Blue Shield will only pay the health care provider directly if it signs a contract with Blue Cross/Blue Shield. To our knowledge, no other health insurer refuses to honor its insured's assignments. If it is clear that health service corporations are subject to the Physician Lien Act, health service providers will have an alternative method for obtaining reimbursement directly from health service corporation insurers. There is no justification for "special treatment" for Montana's sole health service corporation; health service corporations should be subject to the Physician Lien Law in the same manner as other insurers.

Source: Montana Hospital Association

EXHIBIT 21
DATE 2/1/91
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ACCIDENT AND HEALTH

RK	INSURER	1989 DIRECT A & H PREMIUMS WRITTEN IN MONTANA	
1	BLUE CROSS/BLUE SHIELD OF MT.	$162,957,526	48.94%
2	PRUDENTIAL INS. CO. OF AMERICA	$12,481,653	3.75%
3	PRINCIPAL MUTUAL LIFE INS. CO	$11,470,157	3.45%
4	CONTINENTAL ASSURANCE CO.	$7,866,843	2.36%
5	BANKERS LIFE AND CASUALTY CO.	$7,828,448	2.35%
6	MUTUAL OF OMAHA INS. CO.	$5,675,593	1.70%
7	FEDERAL HOME LIFE INS. CO.	$4,933,507	1.48%
8	STATE FARM MUTUAL AUTO INS. CO.	$4,662,290	1.40%
9	JOHN ALDEN LIFE INS. CO.	$4,600,358	1.38%
10	AETNA LIFE INS. CO.	$4,429,966	1.33%
11	UNITED OF OMAHA LIFE INS. CO.	$4,271,658	1.28%
12	TRAVELERS INS. CO.	$3,349,172	1.01%
13	UNION BANKERS INS. CO.	$3,324,206	1.00%
14	AETNA LIFE INSURANCE & ANNUITY CO.	$3,312,481	0.99%
15	LIFE INVESTORS INS. CO. AMERICA	$3,021,522	0.91%
16	COMBINED INSURANCE CO. OF AMERICA	$2,793,424	0.84%
17	UNITED AMERICAN INS. CO.	$2,758,867	0.83%
18	JOHN HANCOCK MUTUAL LIFE INS. CO.	$2,612,540	0.78%
19	PROVIDENT LIFE & ACCIDENT INS. CO.	$2,538,414	0.76%
20	LINCOLN NATIONAL LIFE INS. CO.	$2,394,641	0.72%
21	CUNA MUTUAL INS. SOCIETY	$2,624,780	0.79%
22	WASHINGTON NATIONAL INS. CO.	$2,265,449	0.68%
23	PIONEER LIFE INS. CO. OF ILLINOIS	$2,258,121	0.68%
24	NORTH CENTRAL LIFE INS. CO.	$1,984,760	0.60%
25	NORTH AMERICAN LIFE AND CASUALTY	$1,984,129	0.60%
26	UNIVERSE LIFE INS. CO.	$1,963,762	0.59%
	TOTAL:	$270,364,267	81.20%
	TOTAL PREMIUMS PAID IN MT.IN 1989:	$332,940,480	

SOURCE:MONTANA STATE AUDITOR'S OFFICE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

House Business & Econ. Dev.

EXHIBIT 22
DATE 2/11/91
ID HO5

Jim Abrams

1990 MHA Hospitals At-A-Glance

Montana Hospital Association

EXHIBIT 1
DATE 2/1/91
HB 405

18-Jun-90

SAMPLE HOSPITAL COST ANALYSIS

HOSPITAL NAME	PROV. #	F.Y.E.	# OF BEDS	F.T.E.'S	DISCHARGES				DAYS				TOTAL COSTS	TOTAL REVENUE	CAPITAL COST	BAD DEBT EXPENSE	CHARITY EXPENSE
					TOTAL	PSYCH	REHAB	CDC	TOTAL	PSYCH	REHAB	CDC					
DEACONESS MEDICAL CENTER	27.0004	06/30/89	271	1032.01	9496				68416				62423127	91765048	6843525	3123880	167260
DEACONESS MEDICAL CENTER	27.0004	06/30/88	253	900.37	9575	1008			69951	11088			53522842	79357843	5578855	3308182	0
DEACONESS MEDICAL CENTER	27.0004	06/30/87	253	882.82	9215	935			66245	9286			45376056	64980756	4338245	2832930	0
MISSOULA COMMUNITY HOSPITAL	27.0023	06/30/89	145	628.28	6903		285		29641		7063		30292747	32291740	4012921	485033	28833
MISSOULA COMMUNITY HOSPITAL	27.0023	06/30/88	145	621.00	5202		217		31829		7019		28275494	30111749	3833043	723346	46025
MISSOULA COMMUNITY HOSPITAL	27.0023	06/30/87	145	550.00	5183		112		29945		3656		23912917	26055735	2395417	323042	54485
ST VINCENT HOSPITAL	27.0049	05/31/89	322	1051.70	11463		270		69557		6588		56394380	73301982	7850295	1128720	691455
ST VINCENT HOSPITAL	27.0049	05/31/88	290	893.00	11993		207		70604		6291		52700013	66653419	8535922	1934971	661508
ST VINCENT HOSPITAL	27.0049	05/31/87	290	893.00	13548		210		70184		6371		45950346	57690048	6809819	3081131	650893
MONTANA DEACONESS MEDICAL CTR	27.0012	06/30/89	320	1077.00	11122		222		62198		4819		49754415	57588332	4292445	1355337	61818
MONTANA DEACONESS MEDICAL CTR	27.0012	06/30/88	320	967.00	10641		148	313	61285		4102	5320	47534054	52054812	3537382	977814	153557
MONTANA DEACONESS MEDICAL CTR	27.0012	06/30/87	320	1034.00	8746		113	308	60259		4256	5535	40100083	43819477	2466666	1082524	65486
COLUMBUS HOSPITAL	27.0013	12/31/89	209	704.52	5523		61		35503		1743		33633758	41238719	3005688	866181	0
COLUMBUS HOSPITAL	27.0013	12/31/88	211	677.86	5805		52		34503		1200		31125099	35273186	2999133	901409	0
COLUMBUS HOSPITAL	27.0013	12/31/87	209	600.81	6427		37		38047		1180		28150735	32543556	2543723	979541	0
COLUMBUS HOSPITAL	27.0013	12/31/86	209	637.23	6597		34		37013		1124		26242908	28646883	2588787	673794	0
KALISPELL REGIONAL HOSPITAL	27.0051	03/31/89	113	447.04	5688				24412				22820179	17442565	2598484	820300	0
KALISPELL REGIONAL HOSPITAL	27.0051	03/31/88	113	437.75	5341				25634				19891326	20838947	2606840	606101	0
KALISPELL REGIONAL HOSPITAL	27.0051	03/31/87	117	392.00	5341				26628				16253727	19337040	1598574	516200	0
ST. PATRICK HOSPITAL	27.0014	12/31/89	213	808.70	8058	575			45973	4511			47229707	58000058	8105005	1575379	258021
ST. PATRICK HOSPITAL	27.0014	12/31/88	213	790.87	8610	593			46532	4904			44170945	51259469	7774149	1070985	145236
ST. PATRICK HOSPITAL	27.0014	12/31/87	213	710.75	8011	543		169	46082	4614		3833	38042841	44370063	7445510	1134872	189999
ST. PATRICK HOSPITAL	27.0014	12/31/86	213	671.00	7743	189		523	46027	4601		4019	3369444	38265336	7314254	850476	128231
NORTHERN MONTANA HOSPITAL	27.0032	06/30/89	114	233.38	4250				16653				11835847	14458593	865555	525657	288588
NORTHERN MONTANA HOSPITAL	27.0032	06/30/88	114	222.60	4372				16560				10773685	13437192	794052	628392	192713
NORTHERN MONTANA HOSPITAL	27.0032	06/30/87	114	207.22	4107				14732				8925396	11636238	808583	731001	176837
BOZEMAN DEACONESS HOSPITAL	27.0057	12/31/89	103	235.00	4458				17373				12333944	17493486	2460234	734467	0
BOZEMAN DEACONESS HOSPITAL	27.0057	12/31/88	103	231.70	4216				16724				11338614	16079652	3121648	670104	0
BOZEMAN DEACONESS HOSPITAL###	27.0057	12/31/87	103	201.80	2823				10899				7588539	9967379	2411555	382043	43163
BOZEMAN DEACONESS HOSPITAL	27.0057	04/30/87	103	217.30	4813				16779				11344337	14900033	2883284	696629	67850
ST PETER'S HOSPITAL	27.0003	05/31/89	120	455.01	5963				26070				21744381	27459625	2988448	859545	192593
ST PETER'S HOSPITAL	27.0003	05/31/88	120	441.22	6026				26218				19917199	22575996	2519910	779444	249369
ST PETER'S HOSPITAL	27.0003	05/31/87	120	418.96	6070				26927				18003416	20053927	2339115	372245	379109
ST JAMES COMMUNITY HOSPITAL	27.0017	05/31/89	287	597.49	6768	298			35621	2365			27397573	37772817	2261902	979338	861327
ST JAMES COMMUNITY HOSPITAL	27.0017	05/31/88	287	604.93	7138	308		261	38185	2922		3434	25520466	34948385	1857632	690883	843347
ST JAMES COMMUNITY HOSPITAL	27.0017	05/31/87	287	626.68	7322	277		262	40445	2961		3140	25776347	35872605	1730076	1184476	701290
HOLY ROSARY HOSPITAL	27.0002	09/30/89	112	180.00	2408	116			10372	1126			7893395	10406582	820016	771387	42049
HOLY ROSARY HOSPITAL	27.0002	09/30/88	112	187.00	2467	132			10071	964			7152098	8100443	843248	547637	49405
HOLY ROSARY HOSPITAL	27.0002	09/30/87	112	186.00	2218				10172				6983535	7259715	714659	354420	53410

SAMPLE HOSPITAL COST ANALYSIS (FORM 2)

HOSPITAL NAME	PROV. #	F.Y.E.	HOSPITAL INPATIENT					MEDICARE					FACILITY TOTAL		
			HOSPITAL INPATIENT COSTS	HOSPITAL INPATIENT REVENUE	HOSPITAL /DISCHARGE	COST PER DISCHARGE	REVENUE PER DISCHARGE	MEDICARE COST	MEDICARE CHARGES	MEDICARE /DISCHARGE	MEDICARE /COST PER DISCHARGE	MEDICARE /CHARGE PER DISCHARGE	MEDICARE PAYMENT PER DISCHARGE	PROFIT FROM OPERATION	PROFIT FROM OTHER	NET PROFIT
DEACONESS MEDICAL CENTER	/27.0004	/06/30/89	50874642	76845231	9496	5357.48	8092.38	26740747	43841484	4267	6266.87	/10274.55	6190.45	3671510	2522409	6193919
MISSOULA COMMUNITY HOSPITAL	/27.0023	/06/30/89	15092218	16900859	6618	2280.48	2553.77	5326492	5863295	1141	4668.27	5138.73	4345.94	/-3174548	-55248	/-3229796
ST VINCENT HOSPITAL	/27.0049	/05/31/89	43529010	59157522	11193	3888.95	5285.22	16414991	24693872	3639	4510.85	6785.90	4663.03	1838142	3340050	5178192
MONTANA DEACONESS MED. CTR.	/27.0012	/06/30/89	42075144	51203522	10900	3860.10	4697.57	14875788	19415338	3241	4589.88	5990.54	4729.67	2314367	83636	2398003
COLUMBUS HOSPITAL	/27.0013	/12/31/89	24947667	32681815	5462	4567.50	5983.49	10744751	15106778	2436	4410.82	6201.47	4385.75	/-1234008	2822005	1587997
ST. PATRICK HOSPITAL	/27.0014	/12/31/89	34520478	44306113	7483	4613.19	5920.90	18140088	23366276	3768	4814.25	6201.24	4780.12	193154	2618012	2811166
KALISPELL REGIONAL HOSPITAL	/27.0051	/03/31/89	15652324	17676625	5688	2751.82	3107.70	6347748	8050909	1907	3328.66	4221.77	3617.95	/-1582444	1578467	-3977
NORTHERN MONTANA HOSPITAL	/27.0032	/06/30/89	8554560	11575313	4250	2012.84	2723.60	2779770	4196050	983	2827.84	4268.62	3151.51	64892	1446381	1511273
BOZEMAN DEACONESS HOSPITAL	/27.0057	/12/31/89	6549573	10001057	4458	1469.17	2243.40	3825537	6006510	1384	2764.12	4339.96	3317.56	2362386	1319370	3681756
ST PETER'S HOSPITAL	/27.0003	/05/31/89	14659609	19318900	5963	2458.43	3239.80	6237208	8427933	1993	3129.56	4228.77	3476.82	1574911	136937	1711848
ST JAMES COMMUNITY HOSPITAL	/27.0017	/05/31/89	20749237	29636855	6470	3206.99	4580.66	10290691	15294215	2313	4449.07	6612.28	4515.27	1214849	1360086	2574935
HOLY ROSARY HOSPITAL	/27.0002	/09/30/89	959318	1329345	2292	418.55	579.99	*	3245819	751	0.00	4322.00	3015.58	161200	357820	519020

D

* PROBLEMS WITH INITIAL SUBMISSION OF COST REPORT

★ About $1.7 million relates to a one time loss on bond defeasance.

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HOSPITAL NAME	PROV. #	F.Y.E.	OCCUPANCY RATE	MEDICARE UTIL.	AVERAGE STAY TOTAL	AVERAGE STAY MEDICARE	COST TO CHARGES TOTAL	COST TO CHARGES MEDICARE	MEDICARE PAYMENT TO COST	PAYMENTS MEDICARE TO TOTAL
DEACONESS MEDICAL CENTER	27.0004	06/30/89	69%	53%	7.20	8.48	66%	61%	99%	34%
MISSOULA COMMUNITY HOSPITAL	27.0023	06/30/89	51%	28%	3.41	5.63	89%	91%	93%	29%
ST VINCENT HOSPITAL	27.0049	05/31/89	58%	42%	5.63	7.20	74%	66%	103%	29%
MONTANA DEACONESS MEDICAL CTR	27.0012	06/30/89	52%	40%	5.26	7.16	82%	77%	103%	30%
COLUMBUS HOSPITAL	27.0013	12/31/89	45%	52%	6.08	7.04	76%	71%	99%	33%
ST. PATRICK HOSPITAL	27.0014	12/31/89	61%	53%	5.56	5.81	78%	78%	99%	41%
KALISPELL REGIONAL HOSPITAL	27.0051	03/31/89	59%	46%	4.29	5.93	89%	79%	109%	39%
NORTHERN MONTANA HOSPITAL	27.0032	06/30/89	40%	35%	3.92	5.91	74%	66%	111%	27%
BOZEMAN DEACONESS HOSPITAL	27.0057	12/31/89	44%	41%	3.75	5.00	65%	64%	120%	46%
ST PETER'S HOSPITAL	27.0003	05/31/89	60%	41%	4.37	5.31	76%	74%	111%	36%
ST JAMES COMMUNITY HOSPITAL	27.0017	05/31/89	36%	51%	5.14	7.65	70%	67%	101%	35%
HOLY ROSARY HOSPITAL	27.0002	09/30/89	23%	44%	3.97	5.33	72%	* 0%	* ERR	* 170%

* PROBLEMS WITH INITIAL SUBMISSION OF COST REPORT

EXHIBIT 24 405
DATE 2/1/91 John Alke
HB 405

June 18, 1986

Mr. Michael L. McPherson, General Counsel
Montana Deaconess Medical Center
1101 Twenty-sixth Street South
Great Falls, MT 59405-5193

RE: Health care provider lien

Dear Mr. McPherson:

Thank you for your May 23, 1986, letter. In your letter, you indicate that one may interpret an entire automobile policy under casualty insurance (Section 33-1-206, MCA) without calling the med pay provision "disability insurance". You stated further that even if the med pay provision of an automobile policy were defined as disability insurance, it is not a "contract of disability insurance" but is merely one paragraph of disability-type insurance in a casualty insurance contract. While I agree that the med pay provision of an automobile policy may come within the definition of "casualty insurance", I disagree with your conclusion that an automobile policy is not disability insurance.

The Montana Insurance Code contemplates that insurance coverages may come within the definitions of two or more kinds of insurance, and provides that the "inclusion of such coverage within one definition shall not exclude it as to any other kind of insurance within the definition of which such coverage may likewise be reasonably included." Section 33-1-205, MCA. Because the coverage offered in an automobile policy may reasonably be included within the definition of disability

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Michael McPherson
Great Falls, MT

page 2

insurance, it falls within the exception to the lien act, and health care providers may not file a lien on such a policy. I consequently believe that my staff has applied the proper interpretation to the statutory language in analyzing the problem. I again offer my staff's assistance in correcting the statutory lien language of section 71-3-1118(3), MCA, of the Physicians, Nurses, and Hospital Lien Act of 1979.

With best personal regards, I am

Very truly yours,

71-3-1118(3)

Andrea "Andy" Bennett
State Auditor and
Commissioner of Insurance

AAB/KMI/vf(107)

Exhibit # 24
2/1/91 HB 405

Montana
Deaconess
Medical Center
1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

May 23, 1986

Ms. Andy Bennett
State Auditor and
Commissioner of Insurance
P.O. Box 4009
Helena, MT 59604

Re: Health Care Provider Liens

Enc: Your letter dated May 15, 1986

Dear Ms. Bennett:

Thank you for your consideration of my request to seek an Attorney General's opinion on the confusing statutory language of Section 71-3-1118(3) Montana Code Annotated.

Your letter (copy enclosed for your reference) clearly indicates your intention and reasons not to seek a formal opinion. I appreciate your reasoning and will support any effort your office takes to clarify the confusion created by § 71-3-1118(3) M.C.A.

Your letter did not specifically address how your office will interpret health care provider's liens filed on med pay provisions of an individual's own auto policy.

Section 1-2-102 M.C.A. states a particular intent is paramount to a general intent. Also, § 1-2-107 M.C.A., would allow the Medical Center to continue to file its liens on individual's med pay provisions, because a contrary intention plainly appears in § 71-3-1114(2) M.C.A.

Although the med pay provision may appear to have some disability benefit to the insured, it is, however, not the entire contract. One may interpret an entire auto policy under casualty insurance through § 33-1-206 M.C.A. without the need to call the med pay disability insurance. Even if it could be defined as disability insurance, the auto insurance contract med pay provision is not a "contract of disability insurance," but merely one paragraph of disability type insurance in a casualty insurance contract.

500

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I do not believe your staff has applied the proper interpretation to the statutory language in analyzing our problem. The Medical Center's interpretation certainly seems more reasonable and in line with the legislative intent. Our interpretation would not require any legislative correction.

We will continue to file liens against insured's own med pay provisions under § 71-3-1114(2) M.C.A. I think you will agree the Medical Center's position is within the statutory lien language, and does no damage to any other statutory insurance language.

Sincerely,

Michael L. McPherson
General Counsel

MLMc/lrp

enc.

cc: Victor Moretto
Cal McDaniel

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STATE AUDITOR
STATE OF MONTANA

Andrea "Andy" Bennett
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

May 15, 1986

Mr. Michael L. McPherson
General Counsel
Montana Deaconess Medical Center
1101 Twenty-sixth Street South
Great Falls, MT 59405-5193

RE: Formal Request for Attorney General's Opinion

Dear Mr. McPherson:

Thank you for your March 7, 1986 letter. In your letter, you formally request an attorney general's opinion to determine the appropriate definition for "disability insurance" as that term is used in the Physicians', Nurses', and Hospital Lien Act of 1979 (Lien Act).

"Whenever the meaning of a word or phrase is defined in any part of [the Montana Code Annotated], such definition is applicable to the same order or phrase wherever it occurs, except where a contrary intention plainly appears." Section 1-2-107, MCA. In addition, "[w]ords and phrases used in the statutes of Montana are construed according to the context and the proof usage of the language... ." Section 1-2-106, MCA. The Montana Insurance Code definition of "disability insurance" was enacted in 1959, long before the Legislature enacted the Lien Act. The term "disability insurance" has a meaning within insurance law that I would not want to jeopardize by requesting an attorney general's opinion. I consequently have decided not to request an attorney general's opinion. This office will, however, offer its insurance expertise to amend Section 71-3-1118(3), MCA.

If you have any questions about the contents of this letter, please contact this office. Thank you for your patience in this matter.

With best personal regards, I am

Very truly yours,

Andrea "Andy" Bennett
State Auditor and
Commissioner of Insurance

AAB/KMI/cal/50

Exhibit # 24
2/1/91 HB 405

Montana
Deaconess
Medical Center
1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

March 7, 1986

Andrea Bennett
State Commissioner of Insurance
P.O. Box 4009
Helena, MT 59604

Re: Formal Request for Attorney General's Opinion

Dear Ms. Bennett:

Please accept this letter as a formal request to submit the following questions to the Attorney General for an official opinion:

> Does the language found in § 33-1-207 M.C.A. serve as the appropriate definition for the terms " ... a contract of disability insurance ... " found in § 71-3-1118(3) M.C.A.?
>
> If so, is a health care provider precluded from filing its lien, as seemingly allowed by § 71-3-1114(2) M.C.A. against an injured insured's own auto policy medical pay provisions?

Facts:

A party is injured in a one vehicle accident and is treated by a health care provider. The health care provider files its lien with the injured party's auto insurance company because the service provided was directly related to the one vehicle accident.

State's Position:

The health care provider was informed by personnel in the Insurance Commissioner's office it must release its lien because it violated § 71-3-1118(3) M.C.A. It was explained to the health care provider that the "disability contract" term of § 71-3-1118(3) M.C.A. is defined by § 33-1-207 M.C.A. Because the injured party suffered a bodily injury by accidental means and the party's medical

EXHIBIT 24
DATE 2/1/91
HB 405

pay provision of the party's auto policy will compensate the party, the medical pay provision is disability insurance and therefore not subject to the lien provisions of § 71-3-1114(2) M.C.A. by reason of § 71-3-1118(3) M.C.A. Although the auto policy may also be defined as casualty insurance under § 33-1-206(1)(a) and (b) M.C.A., §33-1-205 M.C.A. indicates it can be defined as both. If the possibility exists to define the provision as disability insurance, it falls within the exclusion and protection against liens of § 71-3-1118(3) M.C.A.

Health Care Providers Position:

If the state's argument is correct, not only would health care providers be prohibited from lien filing under § 71-3-1114(2) M.C.A., but also prohibited from lien filing under § 71-3-1114(1) M.C.A., making those statutes virtually meaningless. Likewise, § 71-3-1115 M.C.A. would have little meaning. When the legislature drafted the lien statutes, it expressed a direct legislative intent for health care providers to have the ability to file liens against this type of insurance coverage (§ 71-3-1115(1) M.C.A. " ... and upon his insurer, if any, against whom liability for injury ... is asserted ..."). The legislature went further and provided recourse to the health care provider should the insurance company not abide by the lien, § 71-3-1117 M.C.A.

The Attorney General should render an opinion to clear up this seeming ambiguity in the definition of insurance coverage. Health care providers depend upon their statutory lien rights in order to secure payment (in some cases the only payment) for the necessary services they provide.

Sincerely,

Michael L. McPherson
General Counsel

MLMc/lrp

cc: David Cornell
Victor Moretto
William Leary, President
Montana Hospital Association

HOUSE OF REPRESENTATIVES
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1 of 6

Business & Econ Dev. COMMITTEE BILL NO. HB 350

DATE Feb. 1, 1991 SPONSOR(S) Rep. Pavlovich

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Robert Pfeffer	Self		✓
6 Cherokee Drive Great Falls MT			
Fred Paden	AARP		✓
M. Gleason	Self		✓
Joseph Lucky	Self		✓
Lenore F. Talieferro	Self	✓	
John A. Mordon	MT. Med/Surg Agent Assoc		✓
Margaret Richardson	MT. Chiropractic Assn		✓
Dr John Heetderks	Bozeman Clinic		✓
Lois Heetderks	Self		✓
LEROY KEILMAN	MSCA - etc	✓	
Jeanette Stevenson	MSCA	✓	
Doug Campbell	MSCA	✓	
Helen Hastings	MSCA		

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Business & Econ. Dev. COMMITTEE Pavlovich BILL NO. HB 350

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
CARL R. SHOUR MD GREAT FALLS, MT	CASCADE COUNTY MEDICAL ASSOC.		✓
PETER BERGER			✓
CHRISTIAN MACKAY on behalf of Don Judge	Montana State AFL-CIO	✓	
~~KEN HARRIS~~ HARRIET M. ROGERS	Self		
LOREN B MCKERROW MD	Self		✓
Bill Olson	AARP		✓
Gloria Hermanson	MT ~~Cattle~~ Academy of Ophthalmology		✓
Vaw Mike Nelson	Physician		✓
Brian Zins	MT. Medical Assn		X
Margaret Summers		✓	
Nels Swanson	MSCFF		
Jim Haggerty	MSCA	✓	
Phil Faul	MSCA	✓	
Judith Carlson	MSCA	✓	

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Business & Econ Dev. COMMITTEE BILL NO. HB 350

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Marcia Dias	MHIC	✓	
Tom Ebzery	St Vincent Hospital		✓
Floyd Anderson	MSCA	✓	
Anne Kalafat	MSCA	✓	
Madelyn Cameron	MSCA	✓	
Olga Higgins	MSCA	✓	
Mabel Howard	M.S.C.A.	✓	
Elizabeth Stimac	MSCA	✓	
LAWRENCE L. STIMAC	MSCA.	✓	
Eunice Eckhart	MSCA	✓	
Mildred Taurman	MSCA	✓	
KENELL M. RASMUSSEN	"	✓	
Dawn Wong	INTERNAL MEDICINE ASSOCIATES		✓
MARGARET FLEMING	MSCA NARFE	✓	

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Leona E. Talbott	Montana Medical Assn. myself & Assn. Any		X
Rev. & Mrs Phillip Caldwell	NAACP AND SELF	✓	
Tim Harris	MILP	✓	
E. L. Stecher	MMA & self		✓
Gloria Stevens	Great Falls Area	✓	
Rita Lindblom	self	✓	
Joyce English	Sr. Citizens		

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Business & Econ Dev. COMMITTEE BILL NO. HB 350

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Glenn Hove		✓	
Dan Gordon	MTMEMA		✓
Anne Murphy MD	Missoula Primary Care Physician		✓
LEROY KEISMAN	Retired ~~Teachers~~ Assn MSE, NFEE, EEA, NHRTE	✓	
Elsie Lee	M. S. C. A.	✓	
Sam Lee	M. S. C. A.	✓	
Jeff Kirsch	Families USA	✓	
~~Stephanie Quayle~~	~~Norm E Wallin~~	~~✓~~	
~~Nathan Quayle~~	~~Norm E Wallin~~	~~✓~~	
Clarice Wallin	Self	✓	

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Bus & Ec Dev. COMMITTEE BILL NO. HB 350

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Jean T Jacobsen	MT. Med Assn	✓	
Gary Kenner	Bozeman		✓

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HOUSE OF REPRESENTATIVES
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Business & Econ Dev. COMMITTEE BILL NO. HB 405

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Jim Wyrock	Bozeman, MT	X	
Jack Casey	Shodair Hospital	X	
Dr & Mrs Tolstedt	Helena ourselves	X	
JOHN GUY	ST. PETER'S HOSPITAL	X	
Dave Barnhill	Insurance dept.	X	
Steve Browning	MT Hosp Ass'n	X	

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Business & Econ. Dev. COMMITTEE BILL NO. HB 405

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GARY KENNER, Bozeman	Bozeman Deaconess Hosp	✓	
Susan Witte	Montana Insurance Dept.	✓	
Tom Ebzery	St Vincent Hospital	✓	
John Alke	Blue Cross / Blue Shield		X
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS		X
STUART BUTLER	Blue Cross + Blue Shield MT		X
Robert E. Lovick	Ruby Valley Hospital	X	

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Business & Economic Develop. COMMITTEE BILL NO. HB 405

DATE 2/1/91 SPONSOR(S) Rep. Hallin

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Michael Sherwood	MTLA		✓
Dr John Hoeft Herbst	Self	✓	
PATRICK M. DRISCOLL	American Council of Life Ins.		✓ amend
Lois Heetderks	Self	✓	

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