MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on March 19, 1991, at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

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

HEARING ON SB 256

Presentation and Opening Statement by Sponsor:

SEN. JOHN "J.D." LYNCH, Senate District 34, Butte, stated that this bill was originally part of an insurance commissioners cleanup to SB 16. The largest health provider in the State of Montana, Blue Cross & Blue Shield (BCBS), has around 50% of all of the business of insurance. BCBS made an agreement with one hospital and excluded the agreement with this hospital in Billings without ever contacting the other hospitals. BCBS said if you sign the agreement then BCBS will give you a discount. BCBS will guarantee that every single person covered by BCBS will come to your office and will hurt the other offices. The

availability of service is threatened by the present operations of PPOs in the state. They could make the same agreement with the drug stores and they could make the same agreement with the local hospitals. The costs are lower in rural hospitals than they are in the larger hospitals. The truth is that if the costs would have been lower at another hospital had they been to the hospital, but BCBS made the deal with the other hospital in Billings. They are not worried about the lower cost. The opponents will say that this should be done because other states really aren't doing that. The most recent example is the state of Wyoming. The issue is about fairness and having an equal opportunity. This idea of exclusive discount only to one hospital is anything but fair. This bill does not gut PPOs.

Proponents' Testimony:

James Ahrens, Montana Hospital Association, submitted written testimony. **EXHIBIT 1**

Jim Poquette, President, Saint Vincent Hospital and Health Center, submitted written testimony. **EXHIBIT 2**

Joel Lankford, Vice President, Columbus Hospital, stated that SB 256 will not drive up costs for health care. Columbus Hospital has its own insurance plan. In 1989 the ratio raised 6%, but the whole cost of the plan went up 25%. The point of this whole issue is that we are not talking about cost control, we are talking about this bill. Regardless of the existence of providing this bill, the hospitals of Montana are more than interested in seeing this bill and finding out what is available. The real issue is public policy. The central issue is the exercise of monopolistic powers by a certain business in our state. Is it good public policy to allow insurance companies to punish providers for management decisions. Is it good public policy to allow a provider to monopolize in marketing in conjunction with the insurer for the death of a provider. We will set up an exclusive PPO with a monopolistic power, BCBS, they have half of the business of people that actually pay their bills.

Joseph Hanser, Banking Industry, Self, stated that in Montana's existing situation, the PPO does not provide for a competitive rate structure. It provides for enhancement of quality health services. In the long run it will have a detrimental effect of both. The arrangement was not competitively bid or negotiated by two parties. They will impact the quality of health service primarily in the event that myself or family were to receive an intention from the preferred provider, our only alternative is to incur the financial penalty to going to one of the competition. Outside of incurring that financial penalty, our only other course would be to write letters to the insurance company or to the provider, which from his perspective would have real effect. If the present situation continues to go unchecked, this would allow for a monopoly relation of the health care services and

deterioration of the quality of health services in communities served by PPOs. If you recommend the support to this bill that all providers can compete on an equal basis for the business in the community, the rates established by the PPOs would be competitive with the experience of the group insured plan. The existence of the PPO could actually be enhanced in that they would have the opportunity to the group insurance plan and solicit their business. They could obtain the information from the insurance company on the demographics of the group. The preferred provider could then offer to the group number maintenance health services, enhance medical services, follow up services, or user discounts. This would be a much more beneficial situation than to have a financial penalty.

Jerry Jerina, Administrator, Trinity Hospital, Wolf Point, stated that he fears exclusive contracts when he doesn't have a chance to participate. In Montana there are 50 hospitals in communities by themselves who are not competing with anybody but each other. If exclusive contracts are allowed in the state, we are going to start limiting access to the rural hospitals. When we start taking business away from each other in rural areas, sooner or later the hospital that we took business away from is no longer going to survive. When we have limited access to health care, how far are we going to have to drive for primary care.

David Cunningham, Director, Rimrock Foundation, submitted written testimony. **EXHIBIT 3**

Mike Rupert, President Chemical Dependency Programs of Montana, Executive Director, Boyd Andrew Chemical Dependency Care Center, stated that the real issue in this bill is do we want to allow the insurance industry to dominate and dictate the entire health care industry in the state. One argument they will present is that this bill will negate the positive financial benefits for PPOs. This makes no sense, if there are two hospitals in Billings, and one has this arrangement the other will go out of business. If you only have one health care provider in Billings, that is conducive to lower costs. If you have three providers all providing a set fee, the net effect when the contracts are negotiated, is the prices went down. This bill will lower health care costs.

Bob Jones, Wheatland Memorial Hospital and Nursing Home, submitted written testimony. **EXHIBIT 4**

Candice Sellers, President, Family Health Plan, Inc., submitted written testimony. **EXHIBIT 5**

Barry Kingfield, Executive Vice President, Community Medical Center, Missoula, stated that they support SB 256.

Dave Barnhill, Deputy, Insurance Commissioner, stated that they support the bill.

John Delano, Montana Medical Association, stated that they are in favor of SB 256 without amendments.

Opponents' Testimony:

SEN. DELWYN GAGE, Senate District 5, stated that he was originally the sponsor of this bill. We are aware of what is happening with the PPO situation in saving people money on their insurance premiums. We don't know what will happen if we change that. We are proposing amendments, as were proposed in the Senate. St. Vincent Hospital indicated that they weren't asked about the PPO arrangement and that the other hospital did have the opportunity. If you go into an area and there is more than one provider, each provider has the opportunity to participate in a PPO proposal.

Cal Winslow, Deaconess Medical Center, stated that the preferred provider arrangements under the present statute provides competitive prices. That in fact, is something that the state has interment appropriate. That is why you have the statutes presently. HMOs will never work in the State of Montana because of our rural nature and PPOs are only going to work in some areas because of the employers basis in those areas. This works in a competitive environment and does provide an opportunity to provide for competitive prices. If you do not want that, that is what this legislation does. Of the results of the PPO in place today, 15% discounts the premiums for those industries that buy health insurance for their employees, which is 50% less. There are 180 groups that are now in Montana health care, they are all in Yellowstone County. 130 of those groups of employers have less than 10 employees. The few dollars that they can save in health care premiums are substantial in keeping the business afloat. The proponents say that with open access, PPOs will work. Discounts are given because of marketship, if there is no marketship, there is no incentive to have any discounts, and there won't be any discounts. Deaconess Medical Center is happy to compete in whatever environment this legislature feels is best for Montana. Please be clear that if this PPO is, in fact, the desire of the Legislature to do away with, the other kinds of arrangements between hospitals and providers are also done away with. Good health care is important to all Montanan's. Lets stop start passing legislation that gives it direction so Montana can continue to go forward in some direction to provide the best kind of health care at a reasonable rate.

Steve Brown, Blue Cross & Blue Shield (BCBS), stated that PPOs do work and do provide significant savings to the health insurance consumer. The unfortunate thing about the existing PPO is that we have been unable to give those PPOs some distance in the other working areas in the state. Both hospitals in Missoula declined to enact a PPO agreement that would result in significant savings to the health insurance consumers. Ask the people who pay health insurance bills, ask the employers who are buying health insurance for their employees, whether they prefer PPO

arrangements. The first PPO agreement in Billings contains a penalty for members of that PPO if they go to another hospital. When they stand there and say that it is bad for Deaconess and BCBS to use that kind of incentive to get people to take their business to Deaconess, on the very first page it declines St. Vincent's PPO agreement, a similar penalty provision. He submitted amendments. **EXHIBIT 6**

Tom Hopgood, Health Insurance of America, submitted written testimony. **EXHIBITS 7 & 8**

Dick Fellows, First Interstate Bank System of Montana (FIBS), stated that his organization owns and operates seven banks in Montana and employs approximately 500 people in the state, half of which reside in Yellowstone County. In July 1990, FIBS accepted a preferred survivor arrangement with the Deaconess Medical Center in Billings that was offered in part with BCBS group health plan for employees residing in Yellowstone County. This PPO arrangement will save our employees and organization approximately $80,000 in premiums during the first year of this arrangement. This is only half of our employees in the state. We fully expect a similar decrease in our claims experience in the same period. As is the case with many employers in Montana, we have experienced significant increases in the cost of our group health plan during the past few years. Initially, we address these increases by shifting some of the cost to our employees through higher deductibles, higher out of pocket limits and decreased plan benefits. We recognize the burden that is placed on employees, as a result, we began to review more innovating approaches that control our health plan costs. Our PPO arrangement along with other costs contained provisions of our insurance contract and are very important to us as employers in controlling the cost of our benefit plan. As employers, we prefer not to limit the choice of our employees in selecting health care providers, but we are realistic and understand that this choice has a cost. When FIBS first viewed the PPO arrangement that was offered by BCBS, we asked that our employees outside of Yellowstone County not be included because of our concern with rural hospitals. BCBS indicated that the PPO option, with the Deaconess Medical Center in Billings, would not be available outside of Yellowstone County. The survival of these rural hospitals is important to FIBS since we have banks in three of these small communities. We feel it would be a serious mistake restricting the abilities of employees in Montana to work with insurance companies in negotiating contracts with health care providers. This proposed legislation would not directly eliminate the ability of insurance companies to negotiate PPO contracts, but would merely allow any other willing provider to match the terms and conditions of a negotiated PPO agreement. As a practical matter, it is unlikely that a PPO agreement would be consummated because the health care provider in this case, would not be insured of any volume of business to offset price concessions that would be made. Without this legislation, each provider has the option and the opportunity to negotiate with

employers and insurance carriers on their own PPO arrangements. It is not appropriate that the government could limit the ability to negotiate and contract in order to better control significant contracts for many employers of Montana.

David Hartman, Montana Education Association, submitted written testimony. **EXHIBIT 9**

James Tutwiler, Montana Chamber of Commerce, stated that the Chamber strongly opposes this bill.

Gorden Englert, Risk Manager, Yellowstone County, stated that we do need competition in our state.

Joyce Brown, Chief of Employee Benefits Bureau, Department of Administration, submitted written testimony. **EXHIBIT 10**

Terry Mammenga, Tractor & Equipment Co., Billings, stood in opposition of this bill.

Gary Richard, Self, Billings, stood in opposition of this bill.

Questions From Committee Members:

REP. BOHARSKI asked why the insurance commissioner is in support of this bill. **Mr. Barnhill** stated that the Preferred Provider Act was enacted by the Montana Legislature in 1987. This act was added after a National Association of Insurance Commissioners model law. This contains a willing provider statute. This statute provided that in setting up a PPO insurer or health service corporation. We had to give do consideration to the cost of health services, the availability of health services and also the quality of health services. Montana law specifically authorized health insurers and health service corporations to pick and choose any provider with whom they wanted to do business without any criteria. This does not require that an insurer negotiate or enter into an agreement with any specific provider or any class of providers. Thus, under current law, an insurer can choose a provider whose services are inferior to those of other providers.

REP. BOHARSKI asked if there was an act of consideration given to the quality of health care and the availability of health care. **Mr. Barnhill** said no. The National Association of Insurance Commissioners model law contained that the states might consider a stronger willing provider statute. The stronger provision is pertinent to Montana because a preferred provider is accreditated upon the provider receiving increased volume of business in return for acceptance of lower payment of fees. This would work in a heavily populated state or where the state has growing population.

REP. SQUIRES asked if both of the hospitals in Missoula had the privilege of bidding or discussing PPOs. **Mr. Kingfield** stated

that they were offered an opportunity to discuss this with BCBS. In those discussions they were offered exclusive preferred buyer arrangement. They were not interested in this at that time. **Mr. Hogan** stated that they were never contacted by BCBS. As soon as it was announced he called BCBS and told them they were willing to read the terms and conditions of the contract and BCBS indicated that they wouldn't be able to do it.

REP. SPRING asked if the two hospitals in Billings get the same break. **Mr. Poquette** said no.

REP. STRIZICH asked what the effect the amendments would have on the willing provider provision of the bill and what effect do they have on the selection and criteria. **Mr. Enzerie** stated that the first amendment states "unfairly discriminate", which you either you discriminate or you don't. The willing provider language, which is the heart of the bill has been deleted under these amendments. You do not have the right to meet the same terms and conditions. There is some criteria about bidding, but it doesn't indicate that you have to take the lowest bid. At the end of the bill, there is a new section on insured and that looks like an arrangement where you get to let BCBS play. In looking at the title of the bill, it looks like something that wasn't contemplated.

REP. JOHNSON asked what is the number of people involved in the PPO. **Mr. Butler** stated that approximately 6,500 consumers of the BCBS Deaconess PPO in Billings.

REP. JOHNSON asked if the total number of consumers might be in the same area that would be insured in some other area. **Mr. Barnhill** stated that there approximately 100,000 people in the Yellowstone County area. Then you can break them down in terms of Medicare, Medicaid, Indian Health Services, BCBS, commercial health insurance, and no insurance.

Closing by Sponsor:

REP. LYNCH stated that this is more than just looking at things. The bill is in good shape. Hi is not in the middle of the squabble in Billings, this goes far beyond the city limits of Billings and far beyond hospitals. This PPO provision is willing to provide for such things as chemical dependency centers. The deal will be made with one business and the operations will be that others are completely shut. This bill is intact and it should be passed as is.

HEARING ON HB 978

Presentation and Opening Statement by Sponsor:

REP. JOHN PHILLIPS, House District 33, Great Falls, stated that this bill is asking SRS to allow Medicaid patients to reside in personal care services. If you have a Medicaid patient moving

out of the hospital, health care would be the best thing for that patient, instead of moving the patient directly into a long term health care facility. The long term facility may be half the price. The whole objective that I have is maybe we can save some money.

Proponents' Testimony:

Jean Johnson, Executive Director, Montana Association of Homes for the Aging, submitted written testimony. **EXHIBIT 11, 12 & 13**

Robert Westermen, Administrator, Cambridge Court Community, Montana Association of Home for Aging, stated that Cambridge Court provides retirement housing for approximately 85 Montana Senior Citizens, half of which receive personal care from the staff that work there. Personal care homes in Montana are designed to enhance the independence and the dignity of our elderly citizens. We pick up a vital component of cost effective long term care for these people. When it gets to the point where these people can no longer care for themselves there is a need for something. That need is filled by personal care communities in Montana. The purpose of this bill is to show what these people don't need might be placement in a facility where the care is too high for their needs. It is our moral obligation to allow our elderly people to have access to the least restrictive environment possible as they go through the aging process. It is also our moral obligation to not place a person who doesn't need to be in a high level care environment.

Rick Tucker, Personal Care Facilities, stated that the quality of life and the fact that these people are unable, at this present time, to move into a personal care center and have Medicaid pay a portion of it for those who cannot afford it, but have to go into a nursing home.

Jim Ahrens, President, Montana Hospital Association (MMA), stated MHA supports this bill as an experiment. Some of MMA hospitals do have personal care units and they work very well. They can almost double the people that they bring in on the first day, because people are seeking a solution.

Rose Hughes, Montana Health Care Association (MHCA), stated that MHCA supports HB 978. Some of MHCA facilities also offer personal care services. This is one more piece of continual care for elderly and disabled persons. She submitted amendments. **EXHIBIT 14**

Opponents' Testimony: None

Questions From Committee Members:

REP. KASTEN asked how people in nursing homes become eligible for Medicaid. **Ms. Hughes** stated that if they are in a personal care bed and receive personal care services, they are not eligible to

receive Medicaid coverage. They need to be in a bed that is licensed for skilled or intermediate nursing care in order to receive Medicare coverage.

REP. KASTEN asked if one nursing home can be licensed for two different services. **Ms. Hughes** stated that the licensure for facilities that she knows of are licensed for 50 beds that are skilled to intermediate and 10 beds for personal care. You can provide personal care in a nursing home bed that would be within your licensure because of a lesser level of care.

REP. SQUIRES asked if we are going to find ourselves in the same situation as having to assist the people that are on Medicaid to pay the nursing homes for the services. **Mr. Hughes** stated that it wouldn't surprise her at all. Medicaid does not traditionally pay the cost of the care. The Legislature seems to be looking for funding for these people other than General Fund.

REP. SQUIRES asked if the amount of money that is charged in a personal care home is within the financial payback of Medicaid. **Ms. Hughes** stated that personal care facilities fees are normally less than in a nursing home. Today's Medicaid rate in a nursing home would probably pay for care in a personal care facility.

REP. JOHNSON asked what are the rates in Cambridge Court. **Mr. Westerman** stated that it ranges from $700 per month to a high of $1,700 per month. This amount would not be dictated by the care, but dictated by the size and configuration of the apartment that you are using.

REP. JOHNSON asked why Medicare is not in the bill. **Ms. Hughes** said Medicare is an age triggered mechanism. There are a lot of people who need placement at an earlier age. Medicaid is triggered by the resources. **Mike Henshew, Medicaid Services, Long Term Care Programs,** stated that Medicare is a federal program so we can't influence what they will pay for.

REP. JOHNSON asked how the Medicaid program works. **Mr. Henshew** stated that the way Medicaid works is that we have to approach the federal government for a waiver of some of their regulations to give us the authority to do this pilot. If they approve that, they give us the authority to spend that money as long as we have state General Fund money to match.

REP. MESSMORE asked how many residents go to a nursing home facility from Cambridge Court on a monthly basis. **Mr. Westerman** said approximately four.

REP. MESSMORE asked if this bill will help this situation. **Mr. Westerman** stated that this bill would not address that situation. Possibly 15% of the people who leave Cambridge Court move to a nursing home do so because their finances have run out.

<u>Closing by Sponsor</u>:

REP. PHILLIPS stated that this is a pilot program to see if we can save money. It is real simple that if we can keep someone in a $700 bed, instead of a $2,300 bed, and give them a little more dignity and freedom to move, then we have done something.

HEARING ON SB 366

Presentation and Opening Statement by Sponsor:

SEN. EVE FRANKLIN, Senate District 17, Great Falls, stated that this bill deals with prevention of disability, disease and disfigurement. This bill will require that health insurers cover preventive mammography examinations according to protocol outlined by the American Cancer Association. National Cancer Institute states that the incidence is 32% breast cancer, which is the leading cause of death for women between the age of 35 and 50. Breast cancer is the most common malignant in this age group. American women have a 1 in 10 chance of developing breast cancer. It is felt that mammography is one of the best tools that we have to detect some of the smallest tumors that can be presented. She submitted written testimony. **EXHIBIT 15.** When you look at costs, you need to look at the high cost of surgery, radiation, and inpatient care. Compare that to a range of $50 to $150 in this state for preventive mammography.

Proponents' Testimony:

REP. RUSSELL stated that breast cancer is a very serious disease. It is one of the most frightening things a woman can hear. She was diagnosed as having breast cancer in 1987. Prior to that time, she had a baseline mammography. She was employed, but her insurance did not cover it. She had surgery immediately and then had six months of chemotherapy. Since then she has learned that the incidence was high. The fact is that there are many women who are embarrassed to talk about breast cancer. Mammography is important for women in saving lives. In Billings there was a high number of breast and cervical cancer detected among Native American women. The hospital's concerns were that many of these women are going to physicians at a later period. As a result, the Indian people have gotten together and have federal and private dollars for a special program just to do mammographies on the Cheyenne and Crow reservations. In the last few months they have identified two individuals, which may not seem like a lot, but it is saving two lives and saving a lot of money in the long run.

Kate Choleva, Montana Women's Lobby, submitted written testimony. **EXHIBIT 16**

Rosetta Kamiroski, American Cancer Society, submitted written testimony. **EXHIBIT 17 & 18**

Margaret Onstead, Registered Nurse, Womens Center Board, Columbus Hospital, stated that they support this bill. By discovering

breast tumors in its early development a woman can choose several options of treatment and often avoid a disfiguring amount of surgeries. It allows a woman to be involved in early treatment and to have control in an otherwise uncontrollable situation. These factors effect a long range recovery in a very positive way.

Nadine Copley, Coordinator, Support Group for Breast Cancer Patients, Helena, stated that this bill should be enacted because the incidence of breast cancer has risen in men.

Elizabeth Veign, Women's Center Coordinator, Columbus Hospital, submitted written testimony. **EXHIBIT 19**

Kathy Canipolli, Montana Nurses Association, stood in support of SB 366.

Annabelle Richards, American Cancer Society, stood in support of SB 366.

Sharon Howard, Women's Center Board, Columbus Hospital, stated that no argument can effectively be presented that negates mammography as a leading technology for early diagnosis of breast cancer. Women are asking you to consider the ramifications of not having technology primarily by removing a major barrier of insurance companies not paying for this procedure. It follows logically that to reduce mortality and the high risk in relation to breast cancer that your support of this bill is necessary.

Mike Stephen, Montana Nurses Association (MNA), stated that while MNA members stand ready to provide a basic health care to individuals throughout the state, MNA are very strong on prevention. This particular bill is in regard to the highest incidence of breast cancer and the importance of early detection and also early monitoring. MNA feels that this is very important for Montanan's to be involved in.

Jim Ahrens, President, Montana Hospital Association, stated that his wife had breast cancer and having been through that, he would much rather pay an increase premium and allow other people to live and to enjoy life than to not have it covered.

JoAnn Roberts, Don't Gamble With the Future, stated that she would support any reasonable measure such as that proposed by the American Cancer Society that would pay for mammograms. She was able to speak today because of early detection of breast cancer four years ago.

REP. CHAR MESSMORE stated that she would like to go on record as supporting SB 366.

Stephen Speckart, M.D., Missoula Medical Oncology, submitted written testimony. **EXHIBIT 20**

Opponents' Testimony:

Tanya Ask, Blue Cross & Blue Shield, stated that this is a good bill and follows the American Cancer Society's recommendations as far as screening. BCBS feels that this is very important. There are some mandates that do deserve very serious consideration. There are only so many dollars that go around for health care. The dollars here are small, if you add one mandate on top of another those dollars add up. There are some products available in Montana which do recognize the work of preventative medicine, such as mammography.

Tom Hopgood, Health Insurance Association of America, stated that there are accumulated costs on mandated benefits. There are worse mandated coverages that the committee could consider. He reiterated the previous testimony.

Larry Akey, Montana Association of Life Underwriters, stated they oppose this because of the fact that this is another mandated coverage. If we were in an ideal world from the beginning to develop what coverages should and should not be mandated by the State, this is probably one that we could support. Because we have simply allowed mandates to accumulate, this association has taken a position to oppose all additional mandates.

Questions From Committee Members:

REP. MESSMORE asked what impact will this bill have on self insured entities. **Mr. Hopgood** stated that this bill will have no effect on self insured entities.

REP. MESSMORE asked what would be the best move for large groups of people who are covered by self insured entities. **Mr. Hopgood** stated that this is a provision of a federal ERISSA statute.

Closing by Sponsor:

SEN. FRANKLIN stated that on page 2, line 13, it states that a minimum $50 limit must be made available. It should be a minimum payment and must be made available for each mammogram performed. The bottom line is that the insurance providers generally have data to tell us how much more money it is going to cost us on our premiums, but noone is able to really give us data on how much it is going to save us. Acute care drives the health care industry and drives the health insurance industry as we know it. We have to drag the health insurance and health care industry behind us. As we march toward prevention, we will do this. Medicaid says that they are already covering preventive mammograms when requested.

HEARING ON SB 277

Presentation and Opening Statement by Sponsor:

SEN. DELWYN GAGE, Senate District 5, Cut Bank, stated that this bill modifies the membership of the Governors Developmentally Disabilities Planning and Advisory Council.

Proponents' Testimony:

Greg Olson, Developmentally Disabilities Planning & Advisory Council (DDPAC), submitted written testimony. **EXHIBITS 21 & 22**

Chris Valinkety, Developmentally Disabilities Planning & Advisory Council (DDPAC), stated that she lobbies on behalf of 46 non-profit providers and consumers of services for the developmentally disabled (DD).

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

SEN. GAGE closed on the bill.

HEARING ON SB 393

Presentation and Opening Statement by Sponsor:

SEN. "ED" JOHN KENNEDY, Senate District 3, Kalispell, submitted written testimony. **EXHIBIT 23**

Proponents' Testimony:

Roger Tippy, Pharmacy Association, submitted written testimony. **EXHIBIT 24**

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

SEN. KENNEDY stated that professional pharmacies have accepted the mandates and realized the importance of patient counseling.

ADJOURNMENT

Adjournment: 5:40 p.m.

Angela Russell
ANGELA RUSSELL, Chair

Jeanne C. Krumm
Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 3-19-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN	✓		
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		

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EXHIBIT
DATE 3-19-91
SB 256

MHA MONTANA HOSPITAL ASSOCIATION

1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

Testimony by
James F. Ahrens, President
Montana Hospital Association
before the House Human Services & Aging Committee
March 19, 1991

The Montana Hospital Association supports SB 256.

MHA supports this bill because of our concern about the impact of PPOs on the availability of health care services in Montana's small communities.

All of us are concerned about rising health care costs. In some cases, preferred provider agreements can help hold down health care costs. But PPOs are only effective in urbanized states where there is a large population concentration and an ability to shift a volume of patients.

In rural areas, PPOs could force small hospitals to close their doors. It's a lot different in Manhattan, Montana -- where a nearby hospital provides the only access to medical treatment -- than in Manhattan, New York where patients can choose from a wide variety of health care options.

In Montana's rural communities, a major insurer like Blue Cross/Blue Shield could pressure a community hospital to join its insurance plan -- and if they don't, the patient could be forced to go out of the community for hospital care.

A PPO network in a rural area could pit one community against another in a deadly competition. The loser in that kind of battle would be the community residents who lose access to nearby health care services.

SB 256 would protect hospitals from such unfair competition.

It would amend the Preferred Provider Act of 1987 to:

- Permit all providers who meet an insurer's "terms and conditions" to participate in the PPO arrangement;
- Guarantee consumers' free choice of physicians and hospitals; and
- Prohibit exclusionary PPO arrangements.

MHA urges the committee to approve SB 256.

Thank you.

EXHIBIT 2
DATE 3-19-91
SB 256

SAINT VINCENT HOSPITAL AND HEALTH CENTER
TESTIMONY IN FAVOR
OF THE
"WILLING PROVIDER ACT"

Saint Vincent Hospital and Health Center supports the "Willing Provider" Act, SB 256, and asks your concurrence. The bill received widespread support in the Montana Senate. For its third reading, the vote in favor of SB 256 was 38 - 12. It was supported by both Democrats and Republicans principally because it is "pro-consumer".

We want to emphasize that this legislation does not "outlaw" preferred provider arrangements or PPOs, but rather, insures that consumers, patients and businesses purchasing health care have access to hospitals, physicians, dentists, etc. who are willing to meet the terms and conditions set forth by either the purchaser or the insurance company representing the employer. The main point I want to make here is that the issue of maintaining access between consumers and those willing and able to contract with them to provide service is maintained.

We would all agree that our objective is to keep health costs

down. However, there is nothing to insure that insurance companies are basing their contracting decisions on hospital or physician cost effectiveness or quality under the current situation. SB 256 will insure that.

SB 256 could actually improve current preferred provider arrangements inasmuch as it will insure that health care consumers and providers such as physicians and hospitals, have access to one another. A middleman such as Blue Cross cannot arbitrarily redirect business to the detriment of the consumer and/or employer. SB 256 will improve access for consumers and insure employers receive competitive rates.

The second point I want to make is that this type of law is necessary in a rural state such as Montana. Some may argue that this is only an issue in the communities where there are two hospitals. However, this issue affects all providers of health care, not just hospitals, but also physicians, dentists, chiropractors, optometrists, etc., and hence, is even more important to the smaller communities in the state. Wyoming passed "Willing Provider" legislation last year, principally

because of rural concerns, according to Senator Gary Yordy of Cheyenne, the bill's chief sponsor. Yordy told us that in his opinion PPO's were here to stay, so it is important for the legislators to focus on who they serve - and that is the consumer. By this legislation, we will insure that more Montanans may participate in preferred provider organizations. In Wyoming, this legislation was essentially unopposed except by Blue Cross/Blue Shield.

As you know, it is very often difficult to recruit health professionals such as physicians, optometrists, dentists, etc. to practice in rural communities. With the potential threat of exclusive physician agreements, that recruitment will become even more difficult. In both Wyoming and Montana, because of Blue Cross/Blue Shield's sheer size, it maintains the ability to carve out physicians. Those excluded, unfortunately, will be forced to abandon their practice in already under served rural areas.

Wyoming is not alone. Eleven (11) states have enacted "Willing Provider" legislation, seven of which are rural in nature:

Indiana
New Hampshire

Nebraska
North Dakota
New Mexico
Utah
Wyoming.

Why so many? In urban states or areas, there are many providers such as hospitals, physicians, dentists, etc., none of which dominate the market. The same is true of health insurance companies. In a state like Washington or Illinois, no insurance company dominates the market. Any provider can maintain exclusive agreements without threat to their continued existence. Unfortunately, as the State of Wyoming recognized, that is not the makeup of Montana. Here, Blue Cross/Blue Shield, in figures released by the State's Insurance Department for 1989, wrote commercial premiums totalling $163 million out of $333 million, or approximately 50%. The second largest company wrote only $12 million. A handout is included in my testimony which illustrates this point.

The third issue is cost. Opponents have argued that this legislation will cause costs to increase. Blue Cross/Blue Shield and its allies maintain that this legislation will cause health care costs to rise. This simply has not occurred in rural states

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SB 256

with Willing Provider statutes. Four out of the five rural states with Willing Provider laws, rank 41st, 46th, 47th and 48th in terms of per capita health care costs, easily among the lowest in the country. Even Indiana, with some large metropolitan areas, ranked 32nd. The point is that these laws do not drive up health care costs. In fact, health care spending in these states is very low compared to the remainder of the United States:

RANK

	1980	1990
Indiana	32	32
New Hampshire	43	41
New Mexico	49	46
Utah	47	47
Wyoming	48	48

Another argument heard over the last several weeks is that if this legislation is enacted, physicians and hospitals would have little incentive to enter into preferred arrangements and give discounts because other providers will be able to meet these conditions. The point being made is, what incentive do hospitals have to control their costs? Currently there are only nine states in the country with health care costs on a per capita basis lower than the State of Montana. We would submit to you that, through safeguards such as voluntary rate review, health

care costs can be maintained. The issue of providers not willing to participate in contracting is simply not true. Yellowstone County has two very good examples of that. Both the Billings School District #2 and the Indian Health Services have been able to secure favorable rates from both Billings hospitals. These preferred provider arrangements have saved each of these organizations significant amounts on their health insurance costs. Both Indian Health Services and Billings School District #2 asked for and received discounted rates from both Billings hospitals. Neither were satisfied with just discounted rates; they wanted to preserve freedom of choice for their beneficiaries as well. That was a much more significant benefit: Savings coupled with choice. If approached on a reasonable basis, providers will willingly participate with employers to help them contain their health costs.

Montanan hospitals did not become the fifth lowest state in terms of costs per admission through exclusive PPO arrangements. They have been constantly endeavoring to lower the cost to patients and employers through such programs as:

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* Ask-A-Nurse - a free medical consultation service. There's no charge for this service and it prevents patients from making an unnecessary trip to the Emergency Room and/or physician's office. This saves companies like Blue Cross lots of money.
* Prenatal care to expectant mothers and delivery care at whatever rate they can afford. That saves insurance companies and the State of Montana money.
* Through the LifeCare program, many legislators themselves are cost effectively helped with wellness, minor emergency and/or occupational care. That saves Blue Cross money. LifeCare is keeping people healthy and "nipping problems in the bud".
* Hospitals actually cooperate with insurance companies to review the accuracy of bills and control utilization. Hospitals do all the "leg work". This is saving insurance companies money.
* In the personnel area, hospitals are relying more and more on volunteers because they cannot afford to hire someone; hospitals are consolidating positions to eliminate labor costs; 3 hospitals in Montana have received a Robert Wood Johnson grant to restructure patient care. Hospitals are restructuring personnel to reduce costs.
* Hospitals are working with employers and insurance companies to shorten their stay in the hospital through same day admissions, same day surgery and/or utilization review.

This list could go on for some time. The point, however, is that hospitals are responding to helping employers and insurance companies control health care costs. No one forced hospitals to do this. They did it on their own volition. That's why Montana

is one of the very lowest health care cost states in the United States.

The fourth issue that needs to be addressed is choice. Health care is a very personal choice - one that should be agreed upon between the physician and patient. This can best be illustrated by each of us asking ourselves with whom or where would we trust the care of our parents, spouse, children, siblings, etc. When you are faced with critical decisions regarding their health, would you like an insurance company dictating which physician and/or hospital could care for those close to you? You would want care delivered by the physician and/or hospital that held your confidence and trust. Without SB 256, you could well lose that choice.

Finally, you may have received letters from insurance agents or companies in opposition to this legislation. I would ask two questions of each letter writer or witness: 1) Are you a Blue Cross agent or affiliated with Blue Cross? If the answer is yes, then their purpose of writing or testifying is obvious; if no, ask the second question. (2) How possibly can a company such as yours with less than 3 percent of the Montana health premium

market, be concerned about a Willing Provider statute? Most likely, policies written by other insurors in the State of Montana would not be exclusive, and therefore, the so called "Willing Provider" Act should be of little concern.

Once again, Saint Vincent Hospital recognizes the value of Preferred Provider Arrangements, but, also recognizes the destructive capability of exclusive arrangements in rural states, particularly when one health service corporation is so large and so dominant. Such ability to direct health care through a PPO can be destructive to hospitals, physicians, both urban and rural, unless other willing providers are allowed to meet the PPO's terms and conditions.

Please support the "Willing Provider" Act, SB 256. It will protect Montana citizens' ability to choose the provider with which they are most comfortable, the provider in which their confidence has been well placed in the past. This legislation focuses on the "little guy" - not the insurance company that is so dominant within Montana that it can effectively direct patient care - direction that should be coming from the patient and the

patient's physician. As a state, we need to recognize the wisdom in Wyoming's legislation which was designed to keep physicians in a rural state.

Thank you.

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ACCIDENT AND HEALTH

RANK	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%
	CUNA MUTUAL INS. SOCIETY	$2,624,780	0.79%
	WASHINGTON NATIONAL INS. CO.	$2,265,449	0.68%
	PIONEER LIFE INS. CO. OF ILLINOIS	$2,258,121	0.68%
	NORTH CENTRAL LIFE INS. CO.	$1,984,760	0.60%
	NORTH AMERICAN LIFE AND CASUALTY	$1,984,129	0.60%
	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

EXHIBIT 2
PER CAPITA HEALTH SPENDING
SB 256

RATE CONTROLS / SUPPLEMENT
an economic analysis service for healthcare management

VOLUME 14, NUMBER 12A DECEMBER 15, 1990

Last month we discussed the report presented by two consumer groups, Families USA and Citizen Action. While the reports focused on a proposal for National Health Insurance, some of the supporting data was interesting and useful. Pages 5-7 are self-explanatory.

PER CAPITA HEALTH SPENDING

	1980 Amount	1980 Rank	1990 Amount	1990 Rank	2000 Amount
Massachusetts	1,284	1	3,031	1	6,890
California	1,186	4	2,894	2	6,584
New York	1,257	2	2,818	3	6,408
Nevada	1,109	8	2,757	4	6,272
Rhode Island	1,184	5	2,707	5	6,153
Connecticut	1,148	6	2,699	6	6,136
North Dakota	1,066	12	2,661	7	6,051
Illinois	1,093	11	2,619	8	5,953
D.C.	1,241	3	2,586	9	5,882
Michigan	1,097	10	2,569	10	5,840
Missouri	1,033	16	2,568	11	5,837
Kansas	1,057	13	2,548	12	5,792
Pennsylvania	1,021	17	2,536	13	5,763
Ohio	1,039	15	2,493	14	5,667
Minnesota	1,110	7	2,480	15	5,641
Hawaii	993	20	2,469	16	5,619
Nebraska	1,016	18	2,452	17	5,576
Wisconsin	1,097	9	2,449	18	5,567
Maryland	1,041	14	2,436	19	5,541
Florida	962	22	2,427	20	5,520
Colorado	996	19	2,415	21	5,496
Alaska	921	31	2,367	22	5,390
Iowa	993	21	2,351	23	5,343
South Dakota	952	24	2,322	23	5,278
Oregon	940	26	2,312	25	5,260
Washington	929	29	2,311	26	5,253
Alabama	924	30	2,286	27	5,201
Delaware	960	23	2,268	28	5,160
Tennessee	952	25	2,262	29	5,145
New Jersey	930	28	2,224	30	5,056
Arizona	848	39	2,211	31	5,031
* Indiana	919	32	2,201	32	5,004
Texas	915	33	2,192	33	4,987
Louisiana	940	27	2,185	34	4,972
Maine	870	36	2,175	35	4,945
Oklahoma	906	34	2,139	36	4,867
West Virginia	843	41	2,088	37	4,752
Virginia	863	37	2,076	38	4,724
Georgia	883	35	2,072	39	4,714
Montana	859	38	2,059	40	4,686
* New Hampshire	813	43	1,981	41	4,505
Vermont	815	42	1,956	42	4,448
Arkansas	844	40	1,944	43	4,423
Kentucky	806	44	1,875	44	4,266
North Carolina	773	45	1,833	45	4,170
* New Mexico	711	49	1,792	46	4,078
* Utah	741	47	1,784	47	4,062
* Wyoming	714	48	1,756	48	3,996
Mississippi	759	46	1,751	49	3,984
Idaho	708	50	1,726	50	3,928
TOTAL	$1,016		$2,425		$5,515

* "WILLING PROVIDER" STATES

DATE 3-19-91

RANK	STATE	ADMISSIONS	DAYS	EXPENSES (THOUSANDS)	EXP/DAY	EXP/AMDIT
1	MISSISSIPPI	391,312	2,407,494	1,424,376	$590	$3,640
2	SOUTH DAKOTA	94,480	581,713	410,881	$710	$4,350
3	KENTUCKY	531,588	3,299,417	2,324,127	$700	$4,370
4	ARKANSAS	335,459	2,194,816	1,472,091	$670	$4,390
5	MONTANA	102,883	550,423	473,364	$860	$4,600
6	WYOMING	50,984	240,650	236,914	$980	$4,650
7	ALABAMA	591,028	3,793,522	2,803,412	$740	$4,740
9	WISCONSIN	647,711	3,582,334	3,074,184	$860	$4,750
8	SOUTH CAROLIN	400,623	2,570,072	1,901,976	$740	$4,750
10	WEST VIRGINIA	278,728	1,720,173	1,346,226	$780	$4,830
11	IDAHO	91,951	489,749	445,041	$910	$4,840
12	KANSAS	302,255	2,054,174	1,480,873	$720	$4,900
13	OKLAHOMA	384,456	2,547,827	1,890,628	$740	$4,920
14	IOWA	379,091	2,600,697	1,915,548	$740	$5,050
15	TENNESSEE	792,544	5,093,533	4,010,635	$790	$5,060
17	NORTH DAKOTA	97,376	674,244	506,362	$750	$5,200
18	NORTH CAROLIN	775,971	5,392,792	4,036,155	$750	$5,200
16	VIRGINIA	703,114	4,549,550	3,653,328	$800	$5,200
19	NEW JERSEY	1,115,688	8,156,674	5,802,621	$710	$5,200
21	LOUISIANA	607,285	3,764,562	3,173,830	$840	$5,230
22	TEXAS	1,969,224	12,053,750	10,670,967	$890	$5,420
20	INDIANA	709,878	4,609,784	3,849,839	$840	$5,420
23	MARYLAND	554,781	3,723,347	3,007,115	$810	$5,420
24	VERMONT	57,625	384,443	315,360	$820	$5,470
25	NEBRASKA	182,738	1,250,925	1,010,808	$810	$5,530
26	NEW MEXICO	153,081	843,168	850,760	$1,010	$5,560
27	MAINE	145,846	1,032,196	830,075	$800	$5,690
28	OREGON	305,085	1,575,398	1,741,027	$1,110	$5,710
29	WASHINGTON	476,920	2,587,933	2,732,025	$1,060	$5,730
30	MINNESOTA	519,132	3,080,346	2,987,757	$970	$5,760
31	UTAH	171,154	909,426	989,382	$1,090	$5,780
32	ARIZONA	397,520	2,146,302	2,312,730	$1,080	$5,820
33	NEW HAMP	123,382	754,879	723,244	$960	$5,860
34	OHIO	1,525,619	10,140,342	9,037,414	$890	$5,920
	U.S.	30,968,558	207,277,919	183,241,828	$880	$5,920
35	MISSOURI	732,947	5,101,346	4,398,663	$860	$6,000
36	COLORADO	330,990	1,875,203	2,024,535	$1,080	$6,120
37	FLORIDA	1,609,436	11,033,533	9,935,655	$900	$6,170
38	PENNSYLVANIA	1,772,955	12,997,282	11,088,175	$850	$6,250
39	ILLINOIS	1,473,462	9,912,766	9,241,600	$930	$6,270
40	HAWAII	94,196	637,581	595,844	$930	$6,330
41	RHODE ISLAND	124,420	930,282	788,259	$850	$6,340
42	DELAWARE	81,301	557,485	517,870	$930	$6,370
43	NEVADA	112,892	675,894	729,014	$1,080	$6,460
44	MICHIGAN	1,096,168	7,538,197	7,565,891	$1,000	$6,900
45	CALIFORNIA	2,983,032	17,433,110	20,775,575	$1,190	$6,960
46	NEW YORK	2,329,965	21,434,640	17,155,260	$800	$7,360
47	CONNECTICUT	355,730	2,699,863	2,692,607	$1,000	$7,570
48	MASS.	800,369	6,107,894	6,159,899	$1,010	$7,700
49	ALASKA	38,683	187,799	302,294	$1,610	$7,810
50	D.C.	173,800	1,367,695	1,382,878	$1,010	$7,960
51	GEORGIA	554,781	3,723,347	4,466,734	$1,200	$8,050

Source: AHA 1989 Data Survey

Post-It™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Mark Furzynski	From Bob Olsen
Co. Admin.-St. Vincent	Co. MHA
Dept. Hosp.-Plng	Phone # 1-800-351-3551
Fax # (657)-7698	Fax # 443-3594

EXHIBIT 2
DATE 3-19-91
SB 256

MHA MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT. 59604 • (406) 442-1911

Questions and Answers on SB 256 -- PPO Willing Provider Bill

1. **What is a PPO?**
The Preferred Provider Organization statute was passed in 1987 and allows health care insurers such as Blue Cross/Blue Shield and AETNA to negotiate and contract with health care providers such as hospitals, doctors and treatment centers.

2. **What does SB 256 do?**
SB 256 allows a Willing Provider (hospital, doctor, mental health clinic, chemical dependency clinic, etc.) to meet the same terms and conditions established by the health care insurer and enables more consumers to participate.

Is there any precedent for this?
Yes, 11 states have Willing Provider statutes, seven of them are rural states like Wyoming.

3. **Why is Willing Provider language needed?**
Two specific reasons:

1) Montana is a rural state with struggling hospitals in non-urban areas. An arrangement to exclusively direct business away from one hospital to another or one doctor to another without allowing others to meet the same terms and conditions discriminates against both the patient and doctor or hospital.

2) Blue Cross/Blue Shield is the dominant heath insurer in Montana (50% of accident and health policies in Montana) and a competing doctor or hospital could be financially crippled by being excluded.

4. **Opponents say this bill will cause premiums to increase.**
Blue Cross/Blue Shield uses this line everytime it opposes a bill. Information obtained to date indicates no problems with the Willing Provider statutes. Health care costs in Wyoming and Montana are among the lowest in the nation.

5. **Opponents say SB 256 would gut or eliminate PPOs, particularly for small groups?**
A Willing Provider bill will not in itself eliminate PPOs. PPOs are based on large volumes and volume shifts. The success of any PPO will depend on its cost competitiveness and the number of people who are enrolled.

6. **What about the State Plan?**
Montana state employees are covered by a self-insured fund. Blue Cross/Blue Shield adminsters the fund through a contract with the state. The state plan is not a PPO and Blue Cross/Blue Shield does not insure state employees.

7. **Has anyone been excluded yet?**
Yes. In the Billings market, one hospital has been excluded from participating in the PPO.

8. **Will PPO's affect rural hospital?**
Although Blue Cross/Blue Shield has said that it isn't interested in trying PPO's in rural areas, the law allows them to do so. There is no patient volume to shift in rural areas.

   Exclusive PPOs in urban areas may increase the referral of patients away from rural hospitals to urban hospitals. Rural hospitals cannot afford to lose local patients they now serve.

9. **Does this Bill have anything to do with limiting the cost of providers?**
Reducing insurance payments does not reduce the cost to provide health care services. Hospitals unable to reduce their costs will shift the payment burden to other payers.

   In Montana, hospitals have little control over negotiations with a large insurance company like Blue Cross/Blue Shield.

EXHIBIT 3
DATE 3-19-91
HB 256

RIMROCK FOUNDATION®

Leading Quality Addiction Treatment in the Northern Rockies

TESTIMONY IN SUPPORT OF SB 256
DAVID W. CUNNINGHAM, CEO

The bill before you today represents one of the most important pieces of legislation ever to confront small healthcare providers in Montana. It can virtually mean our continued existence or our demise.

Blue Cross in particular is expending large amounts of money and effort to convince you that exclusive arrangements, called Preferred Provider Agreements, are really in the best interests of low cost medical care and therefore you should not support this Willing Provider Bill.

Let me tell you what exclusivity may mean in the absence of this bill, over the long haul. Blue Cross has 44% of the market share in Montana and, in meetings with the Montana Chemical Dependency Programs this fall, indicated they only wanted three chemical dependency providers in their PPO. With a 44% market share, you don't have to be a rocket scientist to see the impact upon the rest of the providers, should Blue Cross choose only three state-wide.

The experience around our country from exclusivity has been monopoly...once a group with a large market share obtains exclusive agreements, they have a monopoly and become a destructive anti-competitive force. Under these conditions, initial price reductions designed to make them attractive, disappear and costs again increase.

We submit that an exclusive monopoly in a rural state like Montana with relatively few providers to begin with, has no merit. Small businesses in our state are needed and should be supported with this legislation, and not subjected to the threat of demise by one insurance company with a large market share and the "enticing promise" of short-term cost-savings.

Please level the playing field and pass SB 256!

1231 N. 29TH ST. P.O. BOX 30374 BILLINGS, MT 59107 (406) 248-3175 (800) 227-3953 U.S.A./CANADA

EXHIBIT 4
DATE 3-19-91
SB 256

x

Wheatland Memorial Hospital
and Nursing Home

530 - 3rd Street N.W.
Box 287
Harlowton, Montana 59036
406-632-4351

WHEATLAND MEMORIAL HOSPITAL AND NURSING HOME

TESTIMONY IN FAVOR OF "SB 256"

MARCH 19, 1991

Wheatland Memorial Hospital and Nursing Home in Harlowton would like to support SB 256. The "Willing Provider Act" is crucial to viability and survival of rural hospitals in Montana.

Rural hospitals are at a critical crossroads. In a large, sparsely populated state like Montana, our outlying hospitals are crucial to the health needs and financial stability of our communities. The two biggest problems facing rural hospitals are money and physician availability. SB 256 helps us in both of these problems.

The bigger urban hospitals supply all Montanans with major medical services, but can't handle all the basic medical needs of Montana. When a major insurance company forms an exclusive PPO alliance with a bigger, urban hospital, it can direct patients from their own rural hospital to the urban facility.

In a small rural facility like Wheatland Memorial, doctor recruitment and retention is an ongoing problem. The potential consequences of a preferred provider agreement in a large, urban hospital would be to reduce the market share available to our local hospitals and physicians. IF the people lose their right to decided where to get their basic health care, the small facilities will not survive.

In rural medical facilities especially, health care costs to the

Wheatland Mem. Hospital & Nursing Home

EXHIBIT 4
DATE 3-19-91
SB 256

patient are wide ranging and unique. A large percentage of rural hospitals are subsidized by County or Hospital District funds. The people living in these outlying areas already have a substantial investment in their local health care thru these subsidies. When a major insurance company steers patients to a "preferred provider" in an urban center, these people waste their investment in their local hospital. If this happens, is a PPO really saving the people of Montana money?

Another issue is the fact that the patient who needs to travel some distance to a "preferred provider" facility must take time off from work and pay travel costs. These expenses for basic health care can reduce the value of a PPO to the rural Montanan.

SB 256 would allow rural facilities to continue providing affordable, quality health care to their communities.

Thank you.

EXHIBIT 5
DATE 3-19-91
SB 256

TESTIMONY OF CANDACE SELLERS, PRESIDENT
FAMILY HEALTH PLAN, INC.
IN FAVOR OF SB 256, THE "WILLING PROVIDER ACT"

House Committee on Human Services and Aging
March 19, 1991

I am testifying on behalf of Family Health Plan, in favor of SB 256 "Willing Provider" Act because, from our perspective, managed care defined as solely provider discounts for steerage, is not a viable long term solution for minimizing health care costs. Furthermore, PPO's that are not evaluating the average costs per discharge for their contracted hospitals may, in fact, be providing financial incentives for plan participants to use a facility that is *more costly*, even with a discount, than a neighboring facility. For example, in 1988, Family Health Plan determined through claims analysis that costs at St. Vincent Hospital in Billings were on average 10% less than Billings Deaconess Medical Center for similar procedures. Therefore, had Deaconess elected to participate in Family Health Plan, their level of discount would have needed to be at least 10% better than St. Vincent's, to truly cause a cost benefit for employers participating in the Plan. With SB 256, both hospitals' rates would be available to an insurance company or employer; without SB 256 arbitrary decisions can be made.

Family Health Plan, Inc., is one of nine subsidiaries of Metrocare National, a Portland, Oregon, based health care holding company. As a corporate entity we have in excess of two million members participating in a variety of managed health care programs. We believe that managed care is essential to the continued viability of our current health care system, but certainly is not meant as a means to adversely affect the financial well being of a community's health care providers.

EXHIBIT 5
DATE 3-19-91
SB 256

Effective managed care should be considered a partnership between payors, providers, and employers; all parties interested in the provision of quality health care services at a reasonable price. Payors and employers are looking for ways of minimizing their health care expenditures without compromising the level of service their members/employees receive. Exclusive PPO arrangements can decrease a member's benefits. In large metropolitan communities employers are prepared, and can afford to limit the number of providers available in a health plan without severely restricting choice. With the availability of hundreds of physicians and hospital beds, urban PPO's have had a positive impact on competition by directing volume to more efficient providers. This, *coupled with utilization management programs*, has brought documented savings to health insurance plans.

However, in a rural state like Montana, where the number of health care providers is already limited and one large insurance carrier has the financial clout to dictate terms, there is certainly a risk of eliminating competition which is bound to ultimately increase costs, decrease an employer's benefits, and potentially adversely affect quality.

EXHIBIT 6
DATE 3-19-91
SB 256

PROPOSED AMENDMENTS TO SENATE BILL 256
Submitted by Blue Cross and Blue Shield of Montana

1. Page: 1
Line: 5
Following: "INSURERS TO"
Insert: "MAKE AVAILABLE THE OPPORTUNITY TO"

2. Page: 1
Line: 8
Following: "PROVIDER AGREEMENT,"
Insert: "TO REQUIRE PROVIDERS TO GIVE HEALTH CARE INSURERS AND SELF INSURERS AN OPPORTUNITY TO ENTER INTO PREFERRED PROVIDER AGREEMENTS;"

3. Page: 2
Line: 8
Following: "These terms and conditions may not"
Insert: "unfairly"

4. Page: 2
Line: 14
Following: "discrimination."
Strike: the remainder of line 14 through line 17
Insert: "(3) Before entering into an agreement with one or more providers under subsection (1), a health care insurer shall:
(a) Identify the geographic service area in which a proposed preferred provider agreement is to operate and the nature of the health care services to be provided; and
(b) Identify the providers of services for which a preferred provider agreement is contemplated within the geographic service area.
(4) In the event there is more than one provider identified by the health care insurer as a provider of services within the geographic service area, the health care insurer shall give all identified providers in the geographic service area an opportunity to submit a proposal for a preferred provider agreement.
(5) A preferred provider agreement for hospital services may not include as a part of its geographic service area a county in which there is only one hospital unless:

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(a) The hospital agrees to enter into a preferred provider agreement; or
(b) The service covered by the agreement is not available at the hospital."

Renumber all subsequent subsections.

5. Page: 2
Following: Line 23
Insert: "(7) This part does not require that an insurer enter into agreements with any specific provider or class of providers.

"NEW SECTION. Section 2. Before entering into an agreement with one or more self-insured groups, a preferred provider shall give disability insurers and health service corporations operating within the proposed geographic service area an opportunity to submit a proposal for a preferred provider agreement."

Renumber all subsequent sections.

6. Page: 2
Line: 25
Following: "passage and approval"
Insert: "and applies to any preferred provider agreement entered into after the effective date of [this act]."

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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

BUREAU OF COMPETITION

May 30, 1989

The Honorable John C. Bartley
Massachusetts House of Representatives
State House
Boston, Massachusetts 02133

Dear Mr. Bartley:

The staff of the Bureau of Competition of the Federal Trade Commission is pleased to present its views on Massachusetts Senate Bill 526, entitled "An Act Providing For Accessibility To Pharmaceutical Services."[1] S. 526, if enacted, would require prepaid health benefits programs that include coverage of pharmaceutical services, and provide those services through contracts with pharmacies, either to allow all pharmacies to provide services to program subscribers on the same terms, or to offer subscribers the alternative of obtaining covered pharmaceutical services from any pharmacy they choose.

S. 526 appears intended to guarantee consumers greater freedom to choose where they will obtain covered pharmacy services. Thus, on quick inspection, it might be viewed as pro-competitive. For the reasons we discuss below, however, S. 526 actually may reduce competition in the markets for both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health benefits programs that they believe best meet their needs. The bill also appears to conflict with previously enacted statutes in Massachusetts that authorize the formation and operation of prepaid health care programs whose efficient operation is predicated on limiting the number of health care providers -- including providers of pharmaceutical services -- that may participate in such programs.

We believe that competition in the market for prepaid health care programs assures that subscribers to such programs will have access to a sufficient number of providers of pharmacy services. However, even if the legislature concludes that such access needs to be assured through regulation rather than market competition, there are means to achieve that aim that would be substantially less restrictive of competition and consumer choice than the provisions of S. 526. For these reasons, S. 526 appears likely to have as its primary effect the protection of some pharmacies from an aspect of marketplace competition, at the expense of consumers.

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[1] These comments represent the views of the staff of the Bureau of Competition of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

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I. Interest and Experience of the Federal Trade Commission

The Federal Trade Commission is empowered under 15 U.S.C. § 41 et seq., to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health professions, to the maximum extent compatible with other state and federal goals. For more than a decade, the Commission and its staff have investigated the competitive effects of restrictions on the business arrangements of hospitals and state-licensed health professionals.

The Commission has observed that competition among health care prepayment programs and among health care providers can enhance consumer choice and the availability of services, and lower the overall cost of health care. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[2] As part of its efforts to foster the development of procompetitive health care programs, such as HMOs, which involve selective contracting with a limited panel of health care providers, the Commission has brought several law enforcement actions against anticompetitive efforts to prevent or eliminate such programs.[3] The Commission also has supported federal "override" legislation that would have exempted PPOs from restrictive state laws and regulations that

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[2] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion); See also Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effect on Competition vi (1977).

[3] See, e.g., American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982) and 100 F.T.C. 572 (1982)); Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Medical Staff of Doctors' Hospital of Prince George's County, No. C-3226 (FTC consent order issued Apr. 14, 1988; Eugene M. Addison, M.D., No. C-3243 (FTC consent order issued Nov. 15, 1988).

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restrict or prevent the development of PPO programs, such as "freedom of choice" or "any willing provider" provisions, which prevent PPOs from selectively contracting with a limited panel of providers.[4] The Commission's staff, on request, also has submitted comments to federal and state government agencies explaining that various regulatory schemes would interfere unnecessarily with the operation of such procompetitive arrangements.[5]

II. The Proposed Legislation

S. 526 requires that "every carrier . . . providing or offering any group medical or other group health benefits contract or insurance which also provides or offers coverage for pharmaceutical services"[6] must provide those pharmaceutical

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[4] See Statement of George W. Douglas, supra note 2; Letter from James C. Miller III, Chairman, Federal Trade Commission to Representative Ron Wyden (July 29, 1983) (commenting on H.R. 2956).

[5] The Commission's staff has submitted comments with respect to a state prohibition of exclusive provider contracts between HMOs and physicians, noting that such a prohibition could be expected to hamper procompetitive activities of HMOs, and deny consumers the improved services that such competition would stimulate. Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, Federal Trade Commission, to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986). Similarly, the staff submitted comments to the Department of Health and Human Services suggesting that, in view of the procompetitive and cost-containment benefits of HMOs and PPOs, proposed Medicare and Medicaid anti-kickback regulations should not be written or interpreted so as to prohibit various common contractual relationships that HMOs and PPOs have with limited provider panels. Comments of the Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics Concerning the Development of Regulations Pursuant to the Medicare and Medicaid Anti-Kickback Statute at 6-13 (December 18, 1987).

[6] There is some question as to the applicability of S. 526 to different types of third-party payors of health care benefits. For example, it is not entirely clear whether S. 526 would apply to programs offered by commercial insurance companies. On the one hand, the bill does not specify insurance companies in its enumeration of the types of firms that are included within the meaning of "carrier." On the other hand, the bill amends chapter 175 of the Massachusetts General Laws, which deals with accident and health insurance, and refers to "any group . . . health benefits contract or insurance which also provides or offers

services through one or more of four types of arrangements specified in the bill: (1) direct provision of those services "in-house" by employees of the carrier; (2) contracts with groups of pharmacy services providers, with the proviso that "all eligible" providers be given an opportunity to participate on the same basis; (3) contracts with "select provider[s]," but with the requirement that the carrier also must offer subscribers an alternative whereby they may obtain pharmaceutical services from "a participating provider organization or group, which gives all tangible pharmacy providers[7] an opportunity to participate"; and (4) use of an "affiliated non-profit clinic pharmacy."

Options (1) and (4) describe the ways that group or staff model HMOs -- which provide services to subscribers only at a few centralized locations -- typically operate. Thus, these types of HMO programs, which are in the minority in most states in both number of plans and number of subscribers, probably would be largely unaffected by S. 526.[8] Most prepaid health care programs, however, do not provide covered services at only a few locations. Consequently, these programs would have to offer their covered pharmaceutical benefits through one of the other two options provided in S. 526. Because of this, S. 526, if enacted, may affect a large number of prepaid health care programs and their subscribers.

III. Analysis of S. 526

S. 526 may make it more difficult, or even impossible, for many third-party payors to offer, and consumers to select, programs including pharmaceutical coverage that have the cost savings and other advantages of prepaid health care programs that limit the number of providers that may participate in the

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coverage for pharmaceutical services." (emphasis added). Similarly, although the bill states that covered "carriers" include health maintenance organizations, medical service corporations, and nonprofit hospital service corporations, the statutes that authorize and regulate these entities indicate that they are not subject to the state insurance laws, of which Chapter 175, which S. 526 amends, is a part. See Mass. Gen. Laws Ann. ch. 176G, § 2 (West 1987); ch. 176C, § 2 (West 1987); ch. 176A, § 1 (West 1987).

[7] The term "tangible pharmacy provider" is not defined in the bill.

[8] Some of these HMOs could be affected if, for example, they provide pharmaceutical services through an affiliated clinic pharmacy that is not non-profit.

program.[9] To understand why S. 526 could have such adverse effects requires some explanation of how competition operates in the markets for health care services and prepaid health care programs, and the interrelationship of these markets.

A. The Market for Pharmaceutical Services and the Prepaid Health Care Market

Providers of pharmacy services compete for the business of patients who need to have their prescriptions filled. Subscribers of prepaid health care programs that provide coverage for prescription drugs represent an increasingly important source of business for pharmacies.[10] One way in which pharmacies compete for this segment of business is by seeking arrangements with payors that give them preferential, or even exclusive, access to a program's subscribers. Payors offer such preferential or exclusive arrangements to selected pharmacies (often pharmacy chains or networks of independent pharmacies) that offer the payor the lowest prices and best service. The payors include incentives in their subscriber contracts (e.g., lower deductibles and copayments) for subscribers to use the selected pharmacies or, in some cases, pay for services only if they are obtained at a contracting pharmacy. This assures the selected pharmacies of more business volume than if those subscribers spread their purchases among many providers.

This increased volume permits the pharmacies to take advantage of economies of scale, such as quantity discounts for large volume purchases, and to reduce their normal markup over cost for each prescription filled under the program. Third-party

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[9] Some payors may even cease offering coverage for prescription drugs at all, if the costs of complying with any of the options in S. 526 are too high for them to make such coverage available to subscribers at a competitive premium level.

[10] In 1987, payments by private insurance for "drugs and medical sundries" were $4.7 billion of the $34.0 billion total spent for those items that year. S.W. Letsch, et al., "National Health Expenditures, 1987," 10 Health Care Financing Review 109, 115 (Winter 1988). Industry representatives estimate that, currently, about one-third of the $23.6 billion consumers spend on prescription drugs are paid for by third-party programs. Statement of Boake A. Sells, Chairman and Chief Executive Officer, Revco Drug Stores, Inc., quoted in 11 Drug Store News 109 (May 1, 1989). Total expenditures for drugs and medical sundries are projected to increase to $42.1 billion by 1990. Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, Department of Health and Human Services, "National Health Expenditures, 1986-2000," 8 Health Care Financing Review 1, 25 (Summer 1987).

payors find such arrangements attractive because pharmacies compete to offer lower prices and additional services. These benefits, in turn, help make the payor's programs more competitive in the prepaid health care market.[11] In addition, administrative costs to the payor may be less in this type of arrangement than where the payor must deal with all or most of the pharmacies doing business in a program's service area. Similarly, it may be easier for a payor to implement cost-control programs, such as claims audits and utilization review, where it has a limited number of pharmacies whose records must be reviewed.

Subscribers who choose these programs benefit to the extent that the lower pharmaceutical costs offered by the contracting pharmacies are reflected in lower premium costs. Subscribers selecting such programs make a conscious choice that, for them, the benefits of lower premiums, lower deductibles and copayments, and perhaps broader coverage, outweigh whatever minor inconvenience they may encounter from having a more limited choice of pharmacies. Nor are subscribers likely to face inadequate access to providers, including pharmacies, despite a program's use of a limited provider panel. Subscribers can change payors or programs, and obtain their health care coverage from another source that offers a better alternative, if the service availability in a particular program is insufficient or inconvenient. Subscribers' ability to "vote with their feet" if they are dissatisfied provides the necessary incentive for payors to assure that subscribers are satisfied with their access to covered health care services.

B. Effects of S. 526 on the Market for Pharmaceutical Services and on the Prepaid Health Care Market

S. 526, if enacted, may make it difficult or impossible for many payors to offer subscribers prepaid health care programs that have the cost and coverage advantages described above. As mentioned previously, the in-house and affiliated clinic pharmacy approaches are feasible only for a few types of programs. One of S. 526's remaining options is to open the program to all pharmacy firms or groups willing to contract on the same terms. Without the expectation of obtaining a substantial portion of subscribers' business, however, contracting pharmacies may be unable to achieve the scale economies that permit them to offer lower price terms or

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[11] In the event that competition among prepaid health care programs or among providers of pharmaceutical services is reduced, for example by regulatory constraints, the benefits associated with permitting prepaid health care programs to enter into arrangements with a limited number of health care providers may be diminished.

additional services to payors. Moreover, since any pharmacy would be entitled to contract with a payor on the same terms as other contracting pharmacies, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals. Since all other pharmacies could "free ride" on the first pharmacy's proposal, innovative providers of pharmacy services probably would be unwilling to bear the costs of developing a proposal. This provision of S. 526 therefore may substantially reduce competition among pharmacies for this segment of their business.

The higher prices that some programs would have to pay for pharmacy services, as well as the increased administrative costs, would be expected to raise the premiums that those payors must charge for programs that include pharmacy benefits, or might force them to reduce their benefits in order to avoid raising premiums. Either of these effects could reduce some payors' ability to compete, since their programs would be less attractive than before relative to other programs whose operations, and costs, would remain unaffected by S. 526.

The disadvantages to subscribers of requiring payors to open their programs to all pharmacies may include higher premium costs or the loss of broader coverage provisions, including lower deductibles and copayments for pharmacy services, that programs otherwise could provide due to the cost savings obtained through limiting provider participation.[12] Thus, requiring payors to allow all pharmacies to participate in their programs may either raise prices to consumers or eliminate the choice they otherwise would have to select a program that gives them certain coverage and payment benefits in exchange for agreeing to limit their choice of pharmacies. Subscribers already may select other types of prepayment programs, such as indemnity insurance, that do not limit the pharmacies from which they may obtain covered services. Thus, requiring open pharmacy participation may reduce the number and variety of prepayment programs available to consumers without providing any additional consumer benefit.

The final option for payors under S. 526 is to offer subscribers, in addition to any program that limits pharmacy participation, an alternative under which subscribers essentially would be entitled to use any pharmacy. This option also gives subscribers little additional choice, since they already may choose a program that does not limit where they may obtain covered pharmaceutical (and other) services when they select a prepaid health care program. Moreover, complying with this

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[12] Even if an employer pays the entire premium cost of its employees' coverage, higher premiums could represent a loss to consumers since those monies could be used to pay for additional coverage or other employee benefits.

option of S. 526 may entail substantial administrative burdens and expenses for payors. As discussed previously, the pharmacy costs and administrative expenses of an "open-panel"[13] program are likely to be higher than those where the provider panel is limited. Consequently, either the premiums for the payor's open-panel alternative would need to be higher, or the benefits reduced. Since subscribers who enroll in prepaid health care programs that limit provider participation do so in order to obtain the cost and coverage advantages that such programs provide, it is questionable whether many of those subscribers would opt for an alternative that eliminated those advantages with regard to pharmacy benefits.

Massachusetts already has recognized the benefits of programs that limit participation by providers, including pharmacies, by enacting various statutes that authorize the formation and operation of such programs. Just last year, Massachusetts adopted legislation authorizing "preferred provider arrangements,"[14] which permits payors offering such programs to contract selectively with health care providers, including providers of pharmaceutical services,[15] so long as selection of those providers is based "primarily on cost, availability and quality of covered services."[16] In addition, the legislature adopted statutory provisions authorizing nonprofit hospital corporations, medical service corporations, HMOs, and commercial insurance companies to "establish, maintain, operate, own, or offer" preferred provider arrangements approved by the Insurance Commissioner. Similarly, for more than a decade, Massachusetts has, by statute, authorized the formation and operation of HMOs, which provide services to subscribers through selected health care providers with whom the HMO generally has a contractual agreement. Adoption of S. 526 would appear to be anomalous in

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[13] An "open-panel" program does not restrict the number of providers that may participate in it, although all participating providers must agree to the program's payment terms and other requirements of participation. Other programs, such as indemnity insurance, do not even have participation agreements with providers, so that subscribers may obtain covered services from essentially any licensed provider of those services.

[14] Mass. Gen. Laws Ann. ch. 176I (West 1989 Supp.)

[15] The statute defines "health care providers" as including, among others, registered pharmacists, persons licensed to engage in the sale, distribution, or delivery, at wholesale, of drugs or medicines, and stores registered and licensed for transacting retail drug business. Ch. 176I, § 1, referencing Mass. Gen Laws Ann. ch. 112 (West 1983 and 1989 Supp.).

[16] Ch. 176I, § 4.

light of these statutes, since it might prevent many such programs from operating, at least with regard to covered pharmacy services, in the ways envisioned and authorized by existing statutes.

Finally, if the legislature concludes that subscribers who voluntarily select health care prepayment programs that limit their choice of pharmacies nevertheless require additional regulatory protection to assure that they have adequate sources for pharmacy services, alternatives exist that are less restrictive of competition and less harmful to consumers than S. 526's approach. For example, the state could require payors to demonstrate, as part of their current regulation under the insurance laws, that their programs provide adequate access to services for their subscribers, leaving the payors free to decide precisely how to meet the requirement. This approach would meet the concern that subscribers have adequate access to services, while leaving the payors free to compete for subscribers on the basis of how successfully they please subscribers in providing such access. In fact, this type of approach is similar to what Massachusetts appears to have adopted in authorizing the establishment and operation of preferred provider arrangements and HMOs.[17]

In summary, we believe that S. 526 may reduce competition in the markets for both prepaid health care programs and pharmaceutical services provided to such programs. As a consequence, it may raise prices to consumers and unnecessarily restrict their freedom to choose health benefits programs that they believe best meet their needs.

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[17] Mass. Gen. Laws Ann. ch. 176I, § 2(c) (West 1989 Supp.) provides that preferred provider arrangements must meet "standards [apparently to be promulgated by the Commissioner of Insurance] for assuring reasonable levels of access of [sic] health care services and geographical distribution of preferred providers to render those services." Massachusetts law requires HMOs to include in their subscriber contracts information on "the locations where, and the manner in which health services and any other benefits may be obtained." Mass. Gen. Laws Ann. ch. 176G, § 7(4) (West 1987). These HMO subscriber contracts are subject to disapproval by the Insurance Commissioner if "the benefits provided therein are unreasonable in relation to the rate charged," (Ch. 176G, § 16) and the Commissioner is authorized to promulgate rules and regulations as necessary to carry out the provisions of the act. (Ch. 176G, § 19).

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We hope these comments are of assistance.

Sincerely yours,

Jeffrey I. Zuckerman
Director

Spencer's research reports
on employee benefits
January 19, 1990

DOL Publishes Book On Private Pension System

Assets of the private pension system grew six times faster than the whole U.S. economy between 1950 and 1987, according to a book published by the Department of Labor's Pension and Welfare Benefits Administration (PWBA).

The book, entitled *Trends in Pensions*, includes discussion of pension coverage, asset reversion, pensions and mergers, investment performance, retiree benefits, the funding status of private pension plans, and statistical comparability of eight international pension systems. In addition, the book provides statistical data on Social Security, governmental retirement programs, individual retirement accounts, and privately purchased annuities.

The book's analyses of major trends and current policy issues found the following:

- private pension assets grew at a rate almost six times faster than the total financial assets of the whole economy, increasing from $17 billion in 1950 to nearly $2 trillion in 1987;
- private pension coverage remained relatively stable for 15 years at 53% of full-time workers, but more workers enjoyed dual coverage from a supplemental defined contribution plan;
- plans and participants in supplemental defined contribution plans rose dramatically from 1975 to 1985, with supplemental coverage increasing from 21% to 40% of all plan participants;
- four-fifths of all plans had sufficient assets to pay accrued benefits upon termination in 1985, compared to less than 35% of plans in 1974;
- the association between pension terminations and corporate takeovers stems more from a trend toward efficient corporate restructuring than accessing pension assets; and
- vesting increased from 48% of primary plan participants in 1977 to 56% in 1985.

The book also contains 200 statistical tables on a broad range of plan financial characteristics.

The 500-page book was developed by the PWBA's Office of Research and Economic Analysis. Articles and data were contributed by research analysts from other government agencies and the private sector.

Copies of the book may be purchased for $14 from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. The stock number is 029-000-00427-7.❑

Survey Indicates Employers, Employees Are Satisfied With Preferred Provider Organizations

The American Association of Preferred Provider Organizations (AAPPO) has announced the findings of its recent survey of employee health care benefits. According to AAPPO chairman Jim Kent, the results of the survey confirm the association's premise that there is high employer and employee satisfaction with the PPO concept.

Approximately 24% of the 638 companies involved in the survey offered a PPO to their employees. Of that number, 77% said they were either very or somewhat satisfied with their health care provider.

The primary reason given for employer satisfaction was the PPO's ability to control benefits costs for their firms. Deductibles and copayments were named by 87% of the respondents as the methods the companies themselves used to control costs.

The survey was conducted in the country's 49 largest metropolitan areas. The responding companies were equally divided between service and manufacturing, with employee populations ranging from 50 employees to 10,000 employees.

"The satisfaction of their employees was cited as the second most important reason for the purchasers' satisfaction with their PPO," Mr. Kent noted. "In fact, when choosing a health care plan, 62% of the respondents rated employee satisfaction as very important to the decision process, and another 25% said employee satisfaction was at least somewhat important," he said.

"Of the respondents not offering a PPO, 19% had tried but rejected a PPO within the last two years. One of the reasons offered was that they sensed the costs were too high, a surprising response in light of the reasons given by PPO users for their high degree of satisfaction," Mr. Kent stated.

For more information, call the AAPPO at (312) 644-6610, extension 3270.❑

EXHIBIT 9
DATE 3-19-91
SB 256

March 19, 1991

SENATE BILL 256
BEFORE HOUSE HUMAN SERVICES & AGING COMMITTEE

Testimony of David Hartman
Montana Education Association

IN OPPOSITION TO SB 256

Senate Bill 256 will effectively eliminate preferred provider agreements in Montana between employee groups, their employers and health care providers. It does so by requiring that the terms of preferred provider agreements must be opened up to all health care providers who are willing to meet the terms of the agreement as to charges for services.

Preferred provider agreements are possible only because health care providers are willing to discount the cost of their services in return for being guaranteed a block of business from an identified group of employees or other consumers in return for the discounted price.

Preferred provider agreements have become increasingly popular nationwide because they help to control the escalating cost of health care services.

By giving other health care providers equal access to this block of business, the incentive for discounted rates is destroyed, thus no more such arrangements because the block of business is no longer guaranteed to any health care provider.

SB 256 will see the end of preferred provider agreements in Montana and will add to the inflationary spiral in health care costs. This bill unfairly restrains consumers, employees and employers as they struggle to control the cost of health care services.

Proponents of this bill in the Senate included a spokesperson for Montana's rural hospitals who expressed concern about the future of these small institutions. While our rural hospitals may be in trouble financially, their troubles are not the result of preferred provider agreements, which focus upon urban areas where there is competition in the health care industry, whether the competition is between physician clinics or hospitals. To be both effective and possible, preferred provider agreements exist where there is competition between providers for customers. This isn't the case in our smaller communities which have only one hospital and usually only one physician clinic.

-OVER-

The fact of the matter is, the most vocal proponents of SB 256 are representatives of health care providers in our major urban areas who lost out to the competition in a preferred provider arrangement. The next time around, these providers can sharpen their pencils in negotiations on preferred provider agreements and hope to secure the block of consumer business which now goes to a competing provider, whether that provider is an urban clinic, an urban hospital, or an urban chemical dependency treatment center.

The cost of health care and insurance for health care is the result of three forces: Cost of services x quantity of service x type of service. Preferred provider agreements give consumers, employees and employers the opportunity to address the first force: Cost of service.

Hundreds of preferred provider agreements exist nationwide, including several in Montana. I urge the Committee to continue permitting consumers ways to explore means by which they can control health care costs and the costs of health insurance premiums and contributions. I urge your "Do Not Pass" action on SB 256.

EXHIBIT 10
DATE 3-19-91
SB 256

DEPARTMENT OF ADMINISTRATION

STATE PERSONNEL DIVISION

STAN STEPHENS, GOVERNOR

ROOM 130, MITCHELL BUILDING

STATE OF MONTANA

(406) 444-3871

HELENA, MONTANA 59620

Testimony in opposition to SB256
before the House Human Services Committee

Madam Chairman, members of the Committee, I am Joyce Brown, Chief of the Employee Benefits Bureau, Department of Administration, which administers the State employee health plan. Following is an outline of my testimony.

The State Health Plan, which is a self-insured plan, does not currently participate in any Preferred Provider Organizations (PPOs). We oppose this bill because we want to preserve the option to do so in the future.

SB256 would effectively gut statutes providing for PPOs before they have a chance to form, and PPOs are regarded by many health plan administrators as the most effective health care cost control mechanism available.

HOW DOES SB256 GUT PPO LEGISLATION? It requires a health insurer to extend PPO agreement terms and conditions to any health care provider willing to accept them. **ISN'T THIS ONLY FAIR?** No, a PPO is an agreement in which an insurer offers a larger share of the health market in exchange for reasonable prices. If the insurer must offer the same terms and conditions to all health care providers the insurer can't promise a larger share of the health care market -- the carrot and any incentive to enter a PPO agreement is lost.

Imagine what kind of bids for services the State would receive if those bidding on state services knew that they could be included in any contract with the successful bidder?

If you agree with the following premises, I think you will agree that SB256 is bad public policy:

1. Health care costs cannot continue to rise at current rates.

   Increases are fueling a destructive spiral: individuals and employers are being priced out of the health care market which results in cost shifting to the remaining insureds which forces still more into the ranks of the uninsured or underinsured.

   The State health plan is similar to other employer plans in that funding has not kept pace with cost increases forcing benefit cuts and cost shifting to plan members.

2. Since neither federal or state government show signs of controlling costs, the task is left to consumers in cooperation with their third party payer (their insurance company or claims processor for self-insured groups).

3. Market forces -- the ability and willingness of consumers to pay as a control on costs is already tenuous when it comes to the health care industry.

> Health care providers determine what medical services are needed and what the costs will be. Consumers generally do not have the expertise to refuse unnecessary services, nor do they have any power to negotiate reasonable rates except through their insurer.

4. The last thing that is needed is a bill that further restricts the ability of health insurers to control run away costs.

EXHIBIT 11
DATE 3-19-91
HB 978

Montana Association of Homes for the Aging
P.O. Box 5774 • Helena, MT 59604 • (406) 443-1185

HB 978

Testimony prepared by the Montana Association of Homes for the Aging for the House Human Services Committee March 19, 1991

The Montana Association of Homes for the Aging represents homes for elderly Montanans who, because of their own choice or because of events beyond their control, must select another "home" for their remaining years. For the most independent individuals, it is usually the retirement home and for those in need of skilled care, it is the nursing home. There is a third, little known alternative — the personal care home. Right now, there are 25 personal care homes in Montana, licensed by the Department of Health and Environmental Sciences and serving about 500 individuals.

Personal care homes offer 24-hour supervision and assistance with the activities of daily living — dressing, bathing, walking, perhaps reminders to take their medication — but does not offer skilled nursing care. While personal care homes are open for anyone, they are most appropriate for those individuals who really cannot live independently and who really do not need skilled nursing care.

Evidently, pc homes are filling a need: besides the 25 that exist now, the Certificate of Need process — which regulates the growth of personal care homes just like it does nursing homes — is processing requests for 521 additional beds representing new construction, conversion and additions in 16 communities.

The situation we have in Montana is that right now, the federal government does not allow Medicaid reimbursement in personal care homes — although it does allow reimbursement for personal care services delivered in a home setting and for the purpose of keeping folks out of the more expensive hospital or nursing home. This service is called the community based waiver.

The Health Care Finincing Administration, which implements Medicaid for the federal government, obviously recognizes the wisdom in providing only the level of care that is actually needed: the Omnibus Budget Reconciliation Act of 1990 contains language that appears to expand the possible locations in which personal care services may be provided. Effective October 1, 1994, Medicaid reimbursment will be allowed "in a home or other location; but not including such services as furnished to an in-patient of a hospital or nursing facility." If this legislation holds, it opens the door to the possibility of Medicaid reimbursement in licensed pc facilities in late 1994. Obviously, since the option does not become available for three years, any exploration of personal care facility Medicaid reimbursement sooner than that would require the state to seek a waiver of some of the current regulations governing personal care facilities.

EXHIBIT 11
DATE 3-19-91
HB 978

HB 978 would authorize the Department of Social and Rehabilitation Services to seek that waive and to conduct a pilot program limited to a total of 100 beds in no more than four facilities. We are asking for an appropriation from the general fund of $60,000 to leverage federal funds for a total of $213,523. Our study will provide early information about reimbursement levels and procedures. Our study will develop good pre-admission screening procedures. Our study will suggest the Medicaid utilization potential. Most important, it will test consumer satisfaction and, at the same time project the impact on the demand for services.

The logic and the importance of the pilot program is to test the waters so that the 1995 Legislature can make a more informed decision about whether or not to open the corral. We propose coming to the 1993 Legislature with a preliminary report and to the 1995 Legislature with a full report.

We are not going to make early claims about one day cutting the Montana long term care budget in half. We are not even going to say funding personal care homes will save the state hundreds of thousands of dollars. It may. It may not. If the 1995 Legislature choses to offer the option, the pool of eligible Montanans will no doubt increase. On the other hand, if they can be served for less than half the cost, that will result in a saving. In the end, it may be nothing more than a wash. But. We will be serving more needy Montanans in a more appropriate setting and in that setting, if we can keep those people with others like themselves — with people who do not need nursing care —, if we can keep them active and as independent as possible, we <u>may</u> be able to slow down and delay their need for skilled care. And that will save more than money; that will enhance the quality of life for those folks who are so important to all of us — our elderly.

MONTAHA has been studying this issue for nearly two years. While we fully support our nursing homes, we also support the concept of personal care homes. We believe they are a natural bridge between a retirement home for the independent and a nursing home for those who need skilled care. We have worked hard to develop a proposal that would be acceptable to the SRS, HCFA, and DHES. Thanks to the staff at the SRS Medicaid Services Division, who provided tremendous technical support and assistance, we believe that HB 978 meets that criteria.

HB 978 was conceptually approved by Governor Stephens and adopted as a part of his Health Care for Montanans Program. Unfortunately, that program was finalized after the Governor's budget had been submitted and our request for $60,000 was therefore not included in his budget proposal. We realize that you have had before you many, many requests for programs that cost money and that HB 978 may look like "just one more." It isn't and we sincerely hope you will approve of our efforts to provide appropriate housing for Montana's Medicaid-eligible elderly and handicapped folks. Thank you for the opportunity to be heard.

EXHIBIT 12
DATE 3-19-91
HB 978

Montana Association of Homes for the Aging
P.O. Box 5774 • Helena, MT 59604 • (406) 443-1185

A Profile of Personal Care Facilities in Montana prepared by the Montana Association of Homes for the Aging as testimony before the House Human Services Committee

March 19, 1991

- 25 licensed personal care facilities in Montana provide a total of 577 beds. The smallest has 5 beds; the largest has 82. Privately owned and operated; licensed and surveyed by the State Department of Health and Environmental Sciences.

- Costs range from $400 to $1405, with at least one larger facility offering "packages" of specialized, additional services for additional charges.

- Majority of personal care residents are private pay. DHES estimates that only 5 to 10 percent of pc residents are eligible for Supplemental Security Income (SSI). SSI is a federal program that provides monthly payments to aged, blind and disabled individuals. Individuals receiving SSI, and living in personal care facilities in Montana, receive a state supplement of $94.00 toward the cost of the facility.

- Located in: Billings (2); Bozeman (3); Great Falls (2); Hamilton (1); Hot Springs (1); Kalispell (1); Laurel (2); Lewistown (2); Livingston (2); Malta (1); Miles City (1); Missoula (5); Sidney (1); and Townsend (1).

- Certificate of Need regulates the growth of pc beds in Montana. In 1989 and 1990, CON requests totaled 521 beds and represented new construction, conversion and additions to existing structures in 16 communities — 7 of those communities do not now have pc facilities.

- Interestingly, communities with the most existing pc facilities — Billings and Missoula — seek to add even more. The CON break down: Stevensville; Billings (3); Fort Benton; Helena; Lewistown (3); Chester; Miles City; Missoula (7); Wolf Point; Corvallis; South Park County; Hamilton; Bozeman (2); Conrad; Sidney; and Laurel.

• • •

62% of the personal care facilities in Montana (13) responded to a survey conducted by the Montana Association of Homes for the Aging in late December, 1990. The following information is taken from that survey and reflects only those 13 facilities that responded to the survey:

- 6 homes are best described as serving primarily independent elderly needing very little personal care, but may need medication reminders.

- 8 homes are best described as serving marginally frail elderly needing assistance in at least 2 of the activities of daily living, such as bathing and dressing.

- 1 home is best described as serving the frail elderly needing assistance in most or all of the activities of daily living, including medication reminders.

- The 13 homes responding said that an average of 21% of their residents can be considered totally independent.

EXHIBIT 12
DATE 3-19-91
HB 978

Personal Care profile/page 2

- The statewide average size of the 25 licensed Montana homes is 23 beds.
- The average vacancy factor of those responding appears to be very low with some reporting 100% occupancy year around. While most had some type of waiting list, none had a long list.
- Price range of those responding is from the low: $440 (average low is $664) to the high: $1438 (average high is $984).
- The "oldest" pc home in Montana has been in operation 36 years; the "newest" is 1 year. The average time in business is 12.9 years.
- An average-size single bedroom is 139 sq ft. The state regulation requires each single bedroom to be at least 100 sq ft and each multiple bedroom (no more than 4 individuals) shall offer at least 80 sq ft per individual.
- All of the facilities have at least 1 common room (not counting the dining room), most have 2 and the larger homes have 4 or more. Suprisingly, 3 homes do not have common rooms that are accessible to wheelchair residents; all the others do.
- Death is the most frequent reason for residents leaving a facility; the second most frequent is to return to their own home; third most frequent reason was moving in with family members; fourth was entering nursing homes. The average length of stay in the 13 homes is 2.8 years.
- In 1990, 31 residents in the homes responding to the survey left to enter a nursing home; in 1989 that number ranged from 1 to 21 with an average of 7.75 residents.
- 1 facility claimed 7 residents entered a nursing home in 1990 because they ran out of funds and there was no other housing alternative for them. In the 4 years prior to 1990, the numbers were much smaller but someone made the comment that the numbers for his facility have been "quite substantial" over the years.
- Transportation to doctor's office, physical therapy, barber/beauty shop, downtown, community functions, and recreation is the service most frequently offered by those homes responding to the question. Other services include religious and social activities.
- 5 homes hire an activities director; only 2 of those are on a full-time basis. Several cite "not enough money" as the reason why they don't hire an activities director.
- Several homes bring in home health agencies to provide special services to residents who need special care.
- 10 responding homes employ from 1 to 26 full time employees (average 8.66). Nearly every home reported spending from 50% to 90% of their annual budget in their own community with the remainder spent within Montana.
- $840,000 was the largest budget of the 7 homes providing that information; $10,500 was the smallest budget. The average budget for the 7 homes is $127,214; the total was $890,000.
- 3 of those responding said Medicaid reimbursement would make "running a personal care facility easier." (The question did not refer to Medicaid reimbursement.)
- An unusually high percentage of residents are regularly visited by family members, ranging from 100% to a low of 40% — the average is 84%.

EXHIBIT 13
DATE 3-19-91
HB 978

MONTANA STATE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
HEALTH SERVICES DIVISION
Cogswell Building
Helena, MT 59620 August, 1990

LICENSED PERSONAL CARE HOMES

ILD - Initial Licensure Date

FACILITY	No. of Beds
Countryside Elderly Care 3320 Ravalli Place **BILLINGS**, Montana, 59102 Tel: 652-3727 Joyce D. Hill, Manager LIC NO. 5010 EXP. 07/21/91	10
Westpark Village Retirement Center 2351 Solomon Avenue Tel: 652-4886 Donna Krum, Director LIC NO. 4827 EXP. 01/01/91 ILD 01/01/87	50
Hamilton House 9420 Haggerty Lane **BOZEMAN**, MT 59715 Tel: 586-9459 Donald E. & Margo M. Hamilton, Managers LIC NO. 4964 EXP. 06/24/90 ILD 06/24/86	8
Hillcrest Health Center 1201 Highland Blvd. **BOZEMAN**, MT 59715 Tel: 587-4411 Lotus L. Thorsen, Manager LIC NO. 4971 EXP. 06/30/91 ILD 06/30/84	10
King's Retirement Home 871 Bozeman Trail Road **BOZEMAN**, MT 59715 Tel: 587-7763 Debbie King, Administrator LIC NO. 4870 EXP. 03/07/91 ILD 03/07/89	8

FACILITY	No. of Beds
Cambridge Court 1109 6th Avenue North **GREAT FALLS**, MT 59401 Tel: 727-7151 Robert Westerman, Manager LIC NO. 4856 EXP. 02/15/91 ILD 02/15/86	77
Montana West Retirement Home, Inc. 1009 3rd Avenue North **GREAT FALLS**, MT 59401 Tel: 452-6302 Linda D. Flaherty, Manager LIC NO. 4848 EXP. 01/31/91 ILD 02/26/86	37
Kahlwood Hospitality Home 534 Skalkaho Hwy. **HAMILTON**, MT 59840 Tel: 363-2401 Lynn Wood, Administrator LIC NO. 4805 EXP. 12/14/90 ILD 12/14/88 do not issue new license...9/27/90	6
The Discovery Care Center 601 Tenth Avenue **HAMILTON**, MT 59840 (1200 Shakespear, Missoula MT 59802) mailing address Tel: 363-2273 Patricia Sjolie, Administrator LIC NO. 5023 EXP. 08/07/91 ILD 08/07/90	20
Hot Springs Convalescent Center (Personal Care) Drawer U **HOT SPRINGS**, MT 59845 Tel: 741-2992 H. Kent Ferguson, Administrator DON: Shirley Kontos, R.N.	5

Friendship House, Inc. 20
606 2nd Avenue West
KALISPELL, MT 59901
Tel: 257-8375
Mrs. Willie Allen, Director
LIC NO. 4915 **EXP.** 04/30/91
ILD 05/30/87

Laurel Care Center (PC) 5
820 Third Avenue
LAUREL, MT 59044
Tel: 628-8251
Phil Gorby, Administrator
LIC NO. 4765 **EXP.** 10/11/90
ILD 10/11/88

Twin Cottage Care Center 7
717-719 West First Street
LAUREL, MT 59044
Tel: 628-2115
Betty L. Asplin, President
LIC NO. 5083 **EXP.** 10/11/91
ILD 10/11/88

The Governor's House 8
316 8th Avenue South
LEWISTOWN, MT 59457
Tel: 538-3769
Derree Bauman, Administrator
LIC NO. 4791 **EXP.** 10/05/90
ILD 07/18/88

Valle Vista Manor (PC) 26
402 Summit Avenue
LEWISTOWN, MT 59457
Tel: 538-8775
Gerald Butcher, Administrator
LIC NO. 4945 **EXP.** 06/30/91
ILD 06/30/88

The New Frontier Personal 82
Care & Retirement Center
121 South Third
LIVINGSTON, MT 59047
Tel: 222-6102
Clara Gillard, President
LIC NO. 4871 **EXP.** 02/24/91
ILD 02/24/86

Sessions Homestead 10
3185 A Park Road, Rt. 62
LIVINGSTON, MT 59047
Tel: 222-2706
Ms. Terry Sessions,
Administrator
LIC NO. 4872 **EXP.** 03/10/91
ILD 03/10/89

Good Samaritan Country Home 28
117 South 9th West
MALTA, MT 59538
Tel: 654-2535
Ms. Corinne White, Administrator
LIC NO. 4952 **EXP.** 06/18/91
ILD 06/18/86

TLC of Miles City, Inc. 9
2607 Main
MILES CITY, MT 59301
Tel: 232-7988
Joyce Conley, Director
LIC NO. 4934 **EXP.** 04/24/91
ILD 04/24/86

Flor Haven Home 12
433 South 3rd Street West
MISSOULA, MT 59801
Tel: 542-2598
Philip M. Dandrea, Director
LIC NO. 4873 **EXP.** 03/05/91
ILD 03/05/86

Hawthorne House 35
1811 South 7th West
MISSOULA, MT 59801
Tel: 543-4055
Kenneth E. & Johan K. Daniels,
Administrators
LIC NO. 4638 **EXP.** 06/11/90
ILD 06/11/86

Hillside Place 23
4720 ½ - 23rd Avenue
MISSOULA, MT 59803
Tel: 251-5100
Connie Thisselle, Administrator
LIC NO. 4806 **EXP.** 11/30/90
ILD 11/30/86

EXHIBIT 13
DATE 3-19-91
HB 978

censed Personal Care Homes

FACILITY	No. of Beds	FACILITY	No. of Beds

Maplewood Manor 27
1300 Speedway
MISSOULA, MT 59802
Tel: 549-8127
Robert W. Hanley, Manager
LIC NO. 4828 **EXP.** 01/06/91
ILD 01/06/86

Village Senior Residence 26
2815 Old Fort Road
MISSOULA, MT 59801
Tel: 549-1300
Robert L. Froisness, Manager
LIC NO. 4942 **EXP.** 06/06/91
ILD 06/06/90

The Inn at Crestwood 18
410 Third Avenue S.W.
SIDNEY, MT 59270
Tel: 482-5229
Donald J. Rush, Administrator
LIC NO. 4814 **EXP.** 11/07/90
ILD 11/07/89

Broadwater County Rest Home 16
Personal Care
P.O. Box G
TOWNSEND, MT 59644
Tel: 266-3711
Kathern Ragen, Manager
LIC NO. 4874 **EXP.** 03/19/91
ILD 03/19/87

EXHIBIT 14
DATE 3-19-91
HB 978

MONTANA HEALTH CARE ASSOCIATION AMENDMENTS TO HOUSE BILL 978

Amend House Bill No. 978, introduced bill, as follows:

1. Amend page 1, line 15, following "disabled to"
   Delete: "avoid"
   Insert: "delay"

2. Amend page 1, line 15, following "placement in"
   Delete: "long-term"
   Insert: "skilled and intermediate"

3. Amend page 1, line 18,
   Delete: "alternative to placement in long term care facilities"
   Insert: "important service"

4. Amend page 1, line 21, following "provided in"
   Delete: "long-term"
   Insert: "skilled and intermediate"

5. Amend page 1, lines 23 and 24,
   Delete: lines 23 and 24 in their entirety
   Insert: "of personal care facility services for the elderly and disabled."

6. Amend page 2, line 2, following "admittance to"
   Delete: "a long-term care facility;"
   Insert: "skilled and intermediate care facilities;"

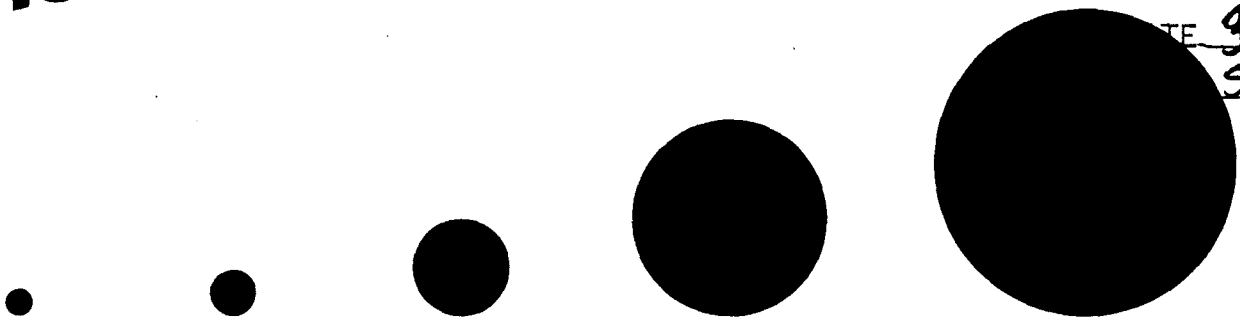
7. Amend page 2, line 25, following "person"
   Insert: "and allowed within the facility's licensure"

8. Amend page 3, lines 8 and 9
   Delete: Lines 8 and 9 in their entirety
   Renumber: subsequent subsections

9. Amend page 5, line 1
   Insert: "(ii) the cost of providing personal care facility services;"
   Renumber: subsequent subsections

ACTIONFACT

EXHIBIT 15
DATE 3-19-91
SB366



Average size of lump found by regular mammograms

Average size of lump found by first mammogram

Average size of lump found by women practicing regular BSE (breast self-examination)

Average size of lump found by women practicing occasional BSE

Average size of lump found by women untrained in BSE

Source: The Breast Health Program of New York; *Health After 50*, December 1990

EXHIBIT 16
DATE 3-19-91
SB 366

MONTANA WOMEN'S LOBBY

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

Kate Cholewa
Montana Women's Lobby
Re:SB 366

One out of nine women will develop breast cancer. An even greater number will detect a lump and require follow-up care. Both these situations result in a both emotional and financial crises for the whole family. Mammography screenings allow for early detection of cancer and can save both money and lives.

According to the American Cancer Society, an early detected cancer costs, on average, $10,000-$15,000 to treat. Breast cancer in its later stage costs approximately $45,000-$125,000 to treat, and the woman probably will die. Thus, mammographies, through early detection, can realize a savings of at least $50,000 per patient in treatment costs. It may also save the woman's life.

How much will it cost to save $50,000 in treatment costs? Blue Cross/Blue Shield says the cost of adding full reimbursement for mammographies is less than $.40/individual/month. Is your mother's, wife's, and daughter's life worth forty cents a month?

I understand that for some of you the problem is with the idea of mandating coverage. However, when the state of Maine chose to review mandates in insurance coverage, mammographies were excluded from the list for review because of the importance and necessity of these screenings. There also is precedence for this kind of coverage: Most carriers nationally actually reduce premiums for non-smokers on the premise that prevention is more cost effective than paying for illness and the final stages of cancer. Breast cancer is more common than lung cancer in women; it is more likely to be a cause of death for women. Yet, women are not protected through insurance coverage for it, much less receive reduced premiums for those who regularly are screened. We believe this to be discrimination.

When you vote on SB 366, you weigh the value of a woman's life against a philosophical position regarding the mandating of insurance coverage. I hope that this is not a difficult decision.

AMERICAN CANCER SOCIETY® MONTANA DIVISION, INC.

3-19-91
S 3666

FACT SHEET ON COSTS OF MAMMOGRAPHY SCREENING

Breast cancer remains one of the major causes of cancer deaths despite changes in therapy.

Controlled studies in Sweden, the United States and Holland have clearly shown that when mammography screening is performed on women 40 years of age and older, an overall reduction in deaths from breast cancer of 30-35% is found.

Early breast cancers, found by mammography, are highly curable, with survival rates of nearly 100%. Once cancers are palpable as a lump, survival drops to 60-70%, and when the cancer has spread to lymph nodes the survival rates are 50-60%.

Of cancers found by mammography alone, about 12% of patients will have positive lymph nodes. Of cancers which are palpable, 50% will have associated spread to the lymph nodes.

Treatment of insitu breast cancer is usually limited, whereas more advanced cancer requires extensive treatment including surgery, radiation and chemotherapy.

Several cost effectiveness studies have been conducted.

1) Data from the HIP study showed that the cost per cancer found was $23,403 and the cost per death averted was $123,400.
2) A model from data from the BCDDP showed, based on a screening fee of $45: if the costs for not screening are considered, the actual cost for each cancer death not averted would be $151,270 compared with a cost of $70,000-$80,000 if screening is done. This results in a net savings of $70,000-$80,000 per cancer death averted with screening.
3) The cost per life each year saved from screening is $2500 for women aged 40-44, $3800 for women aged 50-54 and $6300 for women aged 60-64.
4) The cost of $23,403 for each breast cancer found (by HIP data) compares with the following estimated costs:

17 N. 26th ST., P.O. BOX 1080 BILLINGS, MT 59103-1080 406/252-7111 FAX 406/252-7112

a) $17,000 per cervical cancer detected
b) $23,000-$32,000 for renal dialysis
c) $13,500 for the first year of coronary bypass surgery

5) Moskowitz's cost benefit analysis clearly shows that the cost for screening a large population of asymptomatic women are well within the cost benefit range accepted by other areas within the medical system

A survey of 2500 Virginia primary care physicians including family practitioners, internists and gynecologists found that the major factors which dissuaded their doctors from routinely referring patients for screening mammography were cost and lack of insurance coverage.

In addition to the cost issues one must consider the patient and her family; mammography screening produces fewer deaths from breast cancer and less deforming treatment.

It is not easy to find a way to reduce cancer deaths. Mammography <u>does</u> reduce cancer deaths. When such a method is available and effective, every effort should be made to make it more available and utilized.

State Insurance Laws: Cancer Early Detection Tests

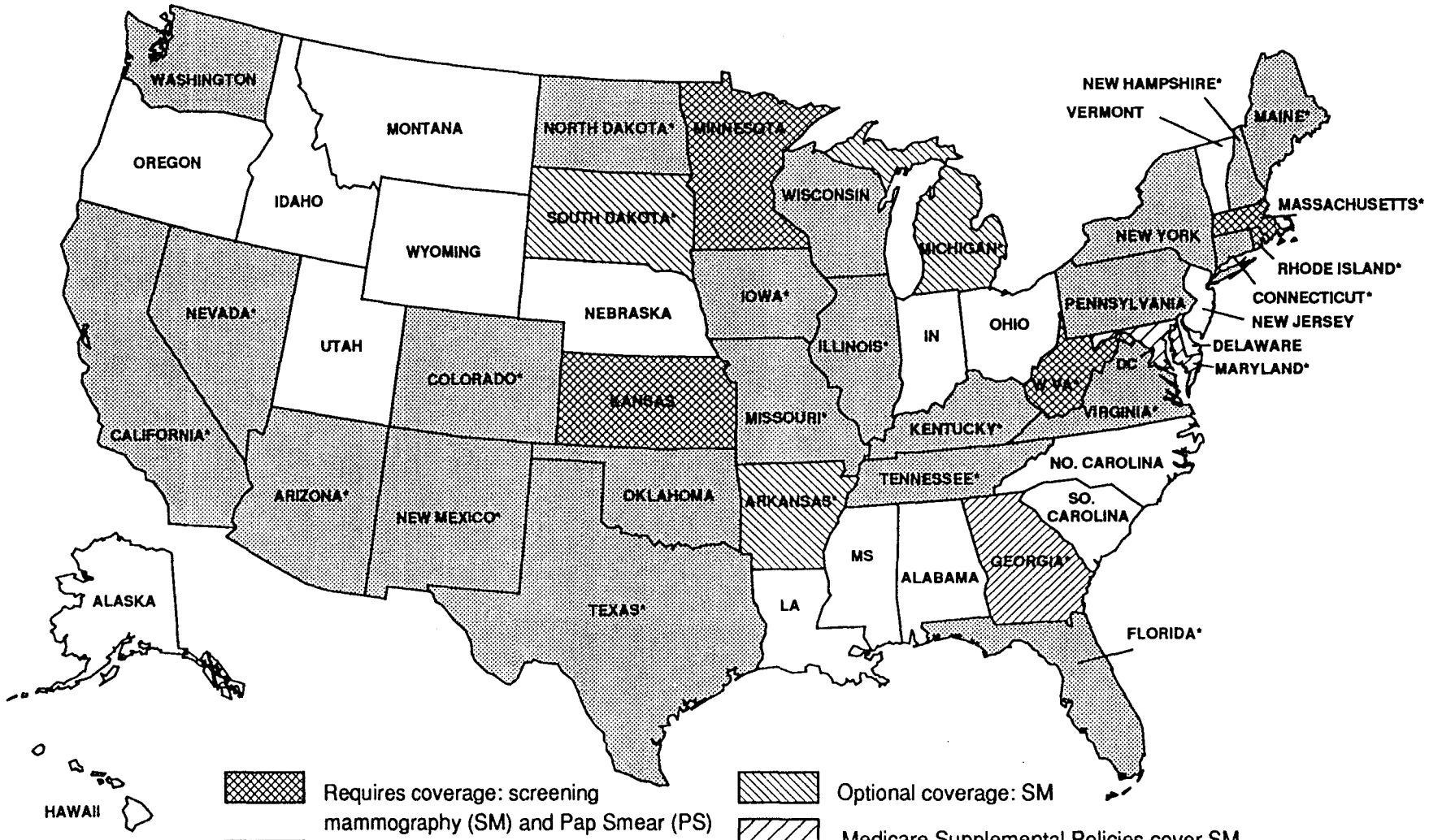


EXHIBIT 18
DATE 3-19-91
SB 366

14
3-19-91
S 366

TESTIMONY IN SUPPORT OF SB-366

To require health insurance providers to provide coverage for minimum mammography examinations

Presented by: Elizabeth Veign, M.N., R.N.,C. - Women's Center Coordinator
Columbus Hospital, Great Falls

As the Coordinator of a women's health program, I frequently do presentations on breast cancer and breast health care for women in the community. At virtually every one of these presentations women tell me that they are confused because health providers, and the media, are telling them that deaths from breast cancer could be reduced by 30% through early detection by mammography, but their health insurance generally does not cover for routine mammography services. Many women know what the American Cancer Society recommendations are for obtaining routine mammograms, but for many of the women that we serve through our Women's Center, it is not fear, but rather the cost of mammography that is a primary barrier in their following through with those recommendations. Other women have told me that because routine mammography is not covered by their health insurance or Medicaid, their physician has felt compelled to fabricate a diagnostic problem, such as "fibrocystic breast disease" or "breast thickening," in order to have the mammogram covered by third party payment. This practice can lead to future difficulty for these women should they later apply for health insurance with another provider. The new provider may deny coverage for breast problems, including mammograms, on the basis of a pre-existing breast condition. And a major factor contributing to the higher death rate from breast cancer in poor women is non-coverage of mammography by Medicaid. Poor women are more likely to have their breast cancer diagnosed in advanced stages, whereas routine mammography could have detected it much earlier.

The message I hear from women is clear, and they make 70% of the health care decisions in this country. They feel it is time for third party payors in our health care system to start providing coverage for those services which can detect disease in its early stages. For it is at this time that care is less invasive, disfiguring, and costly. I applaud those insurance providers who are already voluntarily making moves in this direction. For those providers who are not, and will not voluntarily provide coverage for routine mammography, then we have no choice but to mandate it. On behalf of all the women we serve through our Women's Center, I urge you to support SB-366 which will require that insurance carriers and Medicaid provide coverage for minimum mammography examinations.

DATE 3-19-91
SB 366

Missoula Medical Oncology

Hematology, Oncology, Internal Medicine

Stephen F. Speckart, M.D.
William C. Nichols, M.D.
Judy L. Schmidt, M.D.

February 19, 1991

Senator Eve Franklin
State Capitol
Helena, Montana 59601

Dear Senator Franklin:

I strongly support third party carriers making payment for mammography. Mammography techniques have become exceedingly refined. All national cancer organizations have specific recommendations with regard to when women should have mammography as a standard part of their medical evaluation. The use of mammography yearly saves tens of thousands of lives in this country, as it has been shown that early lesions in mammography cannot be appreciated by other techniques, to include physical exam, and are associated with absence of metastasis and cure. This is opposed to older, larger lesions for which cure would not be available.

In my practice in Missoula I see at least twenty women per year who have tumors detected by mammography alone. This number has been increasing on a yearly basis.

If there is further information you need with regard to this, please let me know.

Sincerely,

S. F. Speckart, M.D.

Stephen F. Speckart, M.D.

SFS/ck

621 West Alder Missoula, Montana 59802 (406) 728-2539

EXHIBIT 21
DATE 3-19-91
SB 277

Montana

DDPAC

Planning For The Future Of Services In Montana

Developmental Disabilities Planning & Advisory Council

Post Office Box 526 Helena, Montana 59624 Phone 406-444-1334

TESTIMONY BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES

Madame Chairman, Members of the Committee, for the record, my name is Greg Olsen. I am the Director of the State of Montana Developmental Disabilities Planning and Advisory Council.

I am here representing the Council in their support of Senate Bill 277.

The State of Montana Developmental Disabilities Planning and Advisory Council is mandated by both State and Federal law. The Council was formed in Montana law in 1971 and currently has 22 Governor-appointed members. The Council is entirely funded through the United States Department of Health and Human Services, Administration on Developmental Disabilities.

The Council's purpose, as stated by Montana law, (2-15-2204 MCA) is:

> **The council shall:**
> **(a) advise the department, other state agencies, councils, local governments, and private organizations on programs for services to the developmentally disabled;**
>
> **(b) develop a plan for a statewide system of community based services for the developmentally disabled; and**
>
> **(c) serve in any capacity required by federal law for the administration of programs for services to persons with developmental disabilities.**

The purpose of SB277 is to bring membership on the Council into compliance with federal law as it relates to the Council membership. Federal law requires that Council membership consist of a specified number and type. The legislation before you today would bring the Council into compliance with existing federal law and allow the Council to meet the federal requirements without violating Montana law.

EXHIBIT 21
DATE 3-19-91
SB 277

NAME	REPRESENTING
STATE AGENCY REPRESENTATION	
Cecilia Cowie	Department of Health and Environmental Sciences
Robert Anderson	Department of Institutions
Julie Robinson	Department of Social and Rehabilitation Services
Robert Runkel	Office of Public Instruction
CONSUMER REPRESENTATION	
Peyton Terry	Region I Council/Consumer Representative
Joyce Curtis	Region II Council/Consumer Representative
Jean Bradford	Region III Council Representative
Vacant	Region IV Council Representative
Tom Price	Region V Council Representative
H.P. Brown	Consumer Representative
Vonnie Koenig	Consumer Representative
Ken Kronebusch	Consumer Representative
Tom Powell	Consumer Representative
LEGISLATIVE REPRESENTATION	
Delwyn Gage	Representative of the Montana Senate
Tim Whalen	Representative of the House
PRIVATE/PROFESSIONAL REPRESENTATION	
Cort Harrington	Attorney Representative
Dr. Allen Hartman	Physician Representative
Darcy Miller	Special Education Representative
Robert Tallon	Psychology Representative
Frank Clark, PhD.	Social Work Representative

MARCH 19, 1991
SENATE BILL 277
GREG. A. OLSEN

EXHIBIT 21
DATE 3-19-91
SB 277

State of Montana
Developmental Disabilities Planning and Advisory Council

PROPOSED CHANGES TO COUNCIL MEMBERSHIP

MEMBER	ACTION
STATE AGENCY REPRESENTATION	
Department of Family Services	ADD
CONSUMER REPRESENTATION	
Consumer Representatives	INCREASE FROM 4 TO 7
LEGISLATIVE REPRESENTATION	
Montana Senate	DECREASE FROM 2 TO 1
Montana House of Representatives	DECREASE FROM 2 TO 1
PRIVATE/PROFESSIONAL REPRESENTATION	
Social Work Representative	ELIMINATE
Special Education Representative	ELIMINATE
Psychology Representative	ELIMINATE
Service Provider Representative	ADDED
University Affiliated Program Representative	ADDED
Advocacy representative	ADDED

EXHIBIT 21
DATE 3-19-91
SB 277

COUNCIL FUNDING

The Council is funded entirely through Federal monies. The current budget of the Council is $350,000.

The Council operates a grant program utilizing 65% of its $350,000 annual funding or $227,500, designed to provide funds for new and innovative projects that will improve services to persons with developmental disabilities. Over the past ten years the Council has provided at least $2.25 million dollars in start up and project funds for the developmental disabilities system in Montana.

Council operating and administrative funds are $122,500 for FY91.

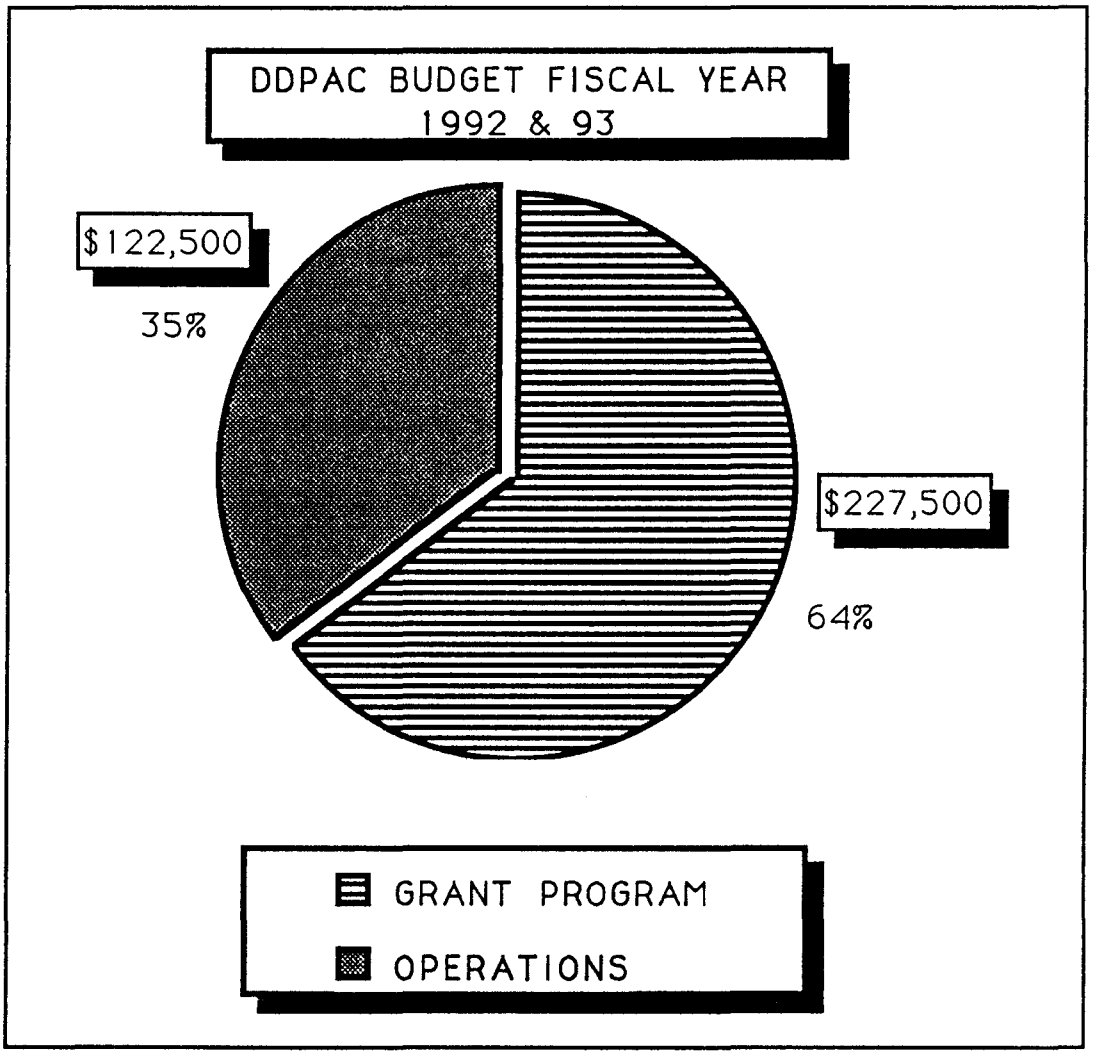


EXHIBIT 21
DATE 3-19-91
SB 277

DDPAC CONTRACTS 1978 THRU 1991 BY TYPE

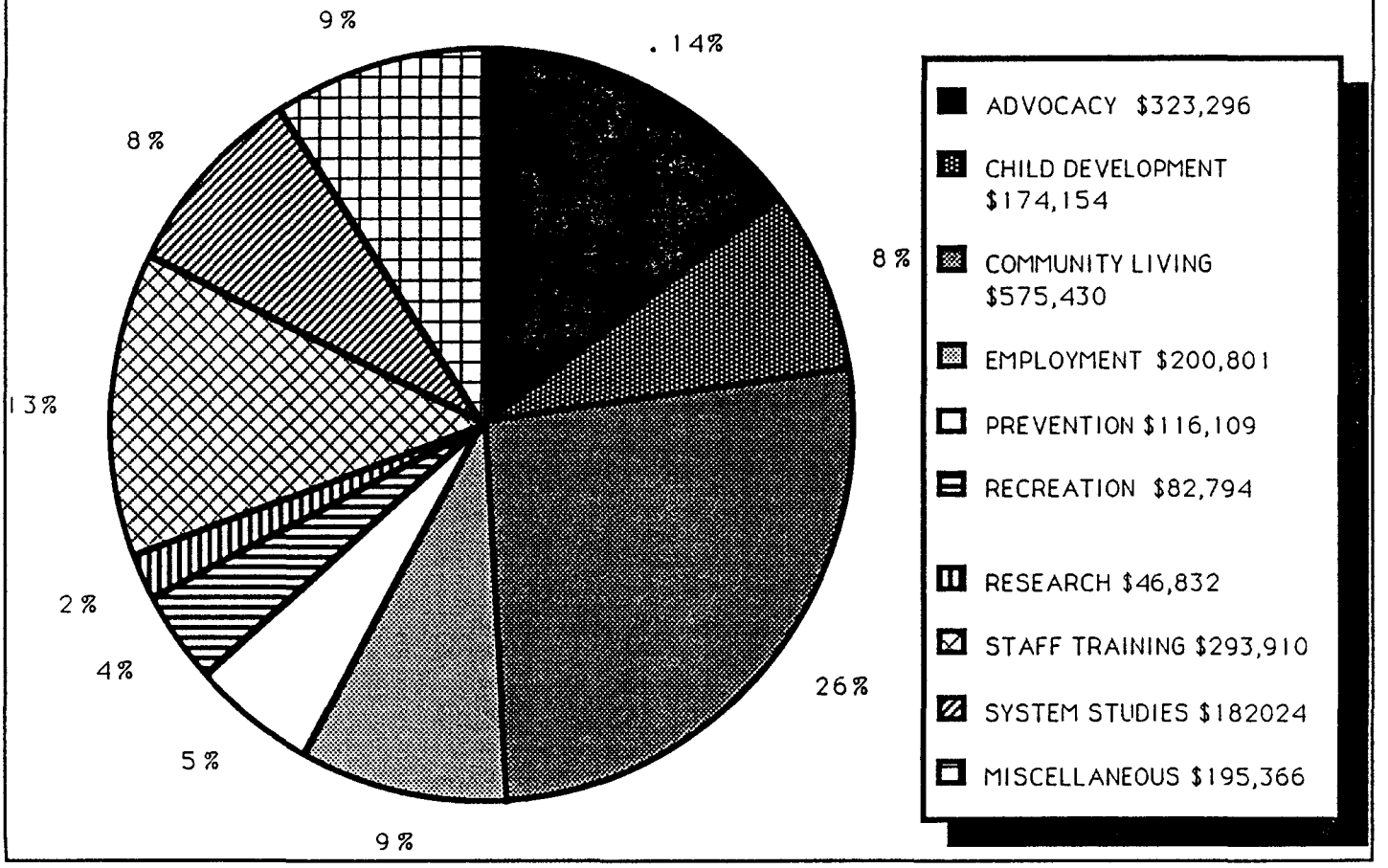


EXHIBIT 21
DATE 3-19-91
SB 277

MEMBERSHIP REQUIREMENTS
of
Developmental Disabilities Planning and Advisory Councils
According to Federal Law 101-496
(The Developmental Disabilities Assistance and Bill of Rights Act)

STATE PLANNING COUNCILS
Section 124

"(3)" Each State Planning Council shall at all times include in its membership representatives of the principal State agencies (including the State agency that administers funds under the Rehabilitation Act of 1973, the State Agency that administers funds under the Education of the Handicapped Act, the State Agency that administers funds under the Older Americans Act of 1965, and the State Agency that administers funds provided under title XIX of the Social Security Act for persons with developmental disabilities, higher education training facilities, each university affiliated program or satellite center in the State, the State protection and advocacy system established under Section 142, local agencies, and nongovernmental agencies and private non-profit groups concerned with the services for persons with developmental disabilities in that State

" (4)" At least one-half of the membership of each State Planning Council shall consist of persons who-

"(A) are persons with developmental disabilities

"(B) are parents or guardians of such persons; or

"(C) are immediate guardians or relatives of persons with mentally impairing developmental disabilities, and who are not employees of a state agency who receives funds or provides services under this part, who are not managing employees (as defined in section 1126 (b) of the Social Security Act) of any other entity which receives funds or provides services under this part, and who are not persons with an ownership or controlling interest (within the meaning of section 1124 (a)(3) of the Social Security Act) with respect to such an entity.

"(5) Of the members of the State Planning Council described in paragraph (4) -

"(A) at least one-third shall be persons with developmental disabilities; and

"(B) (i) at least one-third shall be individuals described in subparagraph (c) of paragraph (4), and (ii) at least one of such individuals shall be an immediate relative or guardian of an institutionalized or previously institutionalized persons with a developmental disability.

EXHIBIT 21
DATE 3-19-91
SB 277

Required Member Agency Under Federal Law	Proposed/Current Agency
Administers funds under the Rehabilitation Act of 1973	*Social and Rehabilitation Services
Administers funds under the Education of the Handicapped Act	*Office of Public Instruction
Administers funds under the Older Americans Act of 1965	Department of Family Services
Administers funds under title XIX of the Social Security Act	*Social and Rehabilitation Services
Higher education training facilities	University of Montana
Each university affiliated program or satellite center in the State	Montana University Affiliated Program Satellite
The State protection and advocacy system	Montana Advocacy Program

* denotes current membership status on the Council according to 2-15-2204 MCA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Region VIII
Federal Office Building
1961 Stout Street
Denver CO 80294

EXHIBIT 22
DATE 3-19-91
SB 277

Greg A. Olsen
Executive Director
Developmental Disabilities
Planning & Advisory Council
111 North Last Chance Gulch
Post Office Box 526
Helena, Montana 59624

Dear Mr. Olsen:

Last Year during the Federal Administration on Development Disabilities program review of the Montana Development Disabilities Protection and Advocacy program conducted in July, it was noted that the Montana Planning and Advisory Council was not in compliance with Public Law 100-246 Sec204, Section 124 "(b)"(3) related to the membership representatives required for the Council. A copy of this section of the law is enclosed.

Our office has been advised that legislation is being introduced to bring the membership of the council into compliance with P.L. 100-146, Sec.204, Section 124, "(b)"(3).

If we can be of any assistance to you in securing the required legislation to bring the council membership composition into compliance please feel free to contact your state liaison Carl Slatt at (303) 844-3106.

Sincerely,

Charles Graham
Director
Office of State Programs

Enclosure

EXHIBIT 22
DATE MAR 15 1991 3-19-91
SB 277

MONTANA ADVOCACY PROGRAM, Inc.

1410 Eighth Avenue
Helena, Montana 59601

(406)444-3889
1-800-245-4743

March 15, 1991

Angela Russell, Chair
House Human Services Committee
Capitol Station
Helena, MT 59620

Re: S.B. 277

Hello, again!

Today I am writing to you regarding Senate Bill 277 which is scheduled to be heard by your committee on Tuesday, March 19, 1991.

Senate Bill 277 has been introduced specifically to modify the membership of the Developmental Disabilities Planning and Advisory Council. This amendment, if passed, will bring Montana in compliance with the Developmental Disabilities Act. P.L. 100-146. My position, or a designee, would be represented on the council under subsection (i) of this bill. Because we are currently out of compliance with the federal regulations, I endorse S.B. 277.

Please do not hesitate to call me if you or any committee member needs additional information.

Sincerely,

Kris Bakula
Executive Director

c: ~~Greg Olsen~~
File

EXHIBIT cc
DATE 3-19-91
SB 277

Montana University Affiliated Program Satellite

University of Montana • Missoula, Montana 59812 • (406) 243-5467

March 14, 1991

Angela Russell, Chair
House Human Services Committee
State House
Capitol
Helena, MT 59620

Dear Representative Russell,

This letter is written to provide my enthusiastic support of Senate Bill 277 which seeks to modify the membership of the Montana Developmental Disabilities Planning and Advisory Council. I am sorry that I will be unable to personally testify to the Committee in support of this legislation due to a prior obligation out-of-state.

The Montana University Affiliated Program funded by the Federal Administration on Developmental Disabilities, recently renamed the Montana University Affiliated Rural Institute on Disabilities (or "Rural Institute" for short), has enjoyed a close and cooperative relationship with the Developmental Disabilities Planning and Advisory Council since our beginning in 1978. SB 277 formalizes that relationship and brings the membership of Montana's DDPAC into compliance with the Developmental Disabilities Assistance and Bill of Rights Act of 1990. For the Rural Institute that relationship extends far beyond compliance with federal legislation. As partners with the DDPAC and the Montana Advocacy Program under the federal Developmental Disabilities Act, membership on the Council provides a mechanism to ensure enduring opportunities for collaboration and sharing information and resources in a regularly established format.

SB 277 not only ensures the durability of the relationship between the Rural Institute and the DDPAC but other sections of the bill provide for balance and fair representation of the important constituencies of our state, particularly consumers, in the planning of services for Montana's citizens with developmental disabilities. The bill also preserves the grass-roots, consumer-oriented interest of the original legislation.

As director of the Montana University Affiliated Program, I urge the Committee's positive response to SB 277. Please let me know if you have any questions or desire further information.

Sincerely,

Richard B. Offner, Ph.D.
Director

EXHIBIT 13
DATE 3-19-91
SB 393

Mme. Chair and Committee:

~~[illegible]~~ Senator Ed Kennedy Kalispell

I introduced Senate Bill 393 at the request of the Montana State Pharmaceutical Association in order to respond to recent changes in the Medicaid law in a way which reflects some new trends in the practice of pharmacy. Today's pharmacist does a lot more than just mix potions or count out pills. The interaction with the patient who comes in to pick up his or her prescription is a very important part of the health care delivery system. Patient counselling helps to avoid adverse interactions between drugs, helps patients understand dosage instructions better, and so forth.

After federal health agencies estimated that incorrect medication was leading to enormous health care costs in terms of extra hospitalization and the like, Congress decided to combat mis-medication by requiring pharmacists to offer to counsel Medicaid patients when they dispense prescriptions. This was included in a provision of the budget bill enacted last October under the nickname of OBRA-90. This law requires each state to include in its Medicaid plan by January 1, 1993 counselling standards which govern the practice of pharmacy with respect to Medicaid patients. Section 1 of my bill is basically the same language Congress used in the OBRA-90 provision, except that it is not limited to Medicaid patients.

It is easy for the Board of Pharmacy to set counselling standards for pharmacists who deal with their patients face-to-face. However, many people now get their medications by mail. They send the prescription to a mail-order pharmacy in New Jersey or somewhere else out of state and a few days later the medicine shows up in the mailbox. Counselling should be available from that mail-order outlet through an 800 number, but the Board of Pharmacy has no current jurisdiction to enforce such a requirement.

Another part of the OBRA-90 mandate for counselling is that drug dispensing done in this remote manner have a toll-free number staffed by competent people a sufficient number of hours each week. Sections 2 through 8 of this bill would give the Board of Pharmacy authority to license out-of-state mail order pharmacy outlets.

EXHIBIT 24
DATE 3-19-91
S 343

Prospective Drug Utilization Review Requirement

(g) DRUG USE REVIEW.-

(1) IN GENERAL.-

(A) In order to meet the requirement of section 1903(i)(10)(B), a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse-misuse.

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information; and

(III) American Medical Association Drug Evaluations; and

(ii) the peer-reviewed medical literature.

(C) The Secretary, under the procedures established in section 1903, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1919, currently at section 483.60

of title 42, Code of Federal Regulations.

(2) DESCRIPTION OF PROGRAM.-Each drug use review program shall meet the following requirements for covered outpatient drugs:

(A) PROSPECTIVE DRUG REVIEW.-(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this title by pharmacists which includes at least the following:

(I) The pharmacist must offer to discuss with each individual receiving benefits under this title or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provisions of such information), the pharmacist deems significant including the following:

(aa) The name and description of the medication.

(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

(cc) Special directions and precautions for preparation, administration and use by the patient.

(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

(ee) Techniques for self-monitoring drug therapy.

(ff) Proper storage.

(gg) Prescription refill information.

(hh) Action to be taken in the event of a missed dose.

(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this title:

(aa) Name, address, telephone number, date of birth (or age), and gender.

(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

(cc) Pharmacist comments relevant to the individuals drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. SB 256

DATE 3-19-91 SPONSOR(S) Sen. Gage

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GARY RICHARDS, Bigs	SELF		X
Terry Mammenga	Tractor & Equipment Co T & E		X
Joseph HANSER	Self	X	
David Cunningham	Rimrock Fdn	X	
DICK FELLOWS	First Interstate BANKS		X
Jeni Cquetto	SAINT VINCENT HOSPITAL	+	
Bob Jones	Wheatland Mem Hosp	X	
Doug Campbell	Community Medical Cent. M.S.W.	x	
Candace Sellers	Family Health Plan	X	
[illegible]	Trinity Hospital Wolf Point	X	
MARK A. BURZINSKI Bus. MT	SELF	X	
Gordon Engert	Yellowstone County		X
Dave Barnhill	Insurance dept.		
Dave Barnhill	Insurance dept.	X	
Elaine Mayadsky	Self	X	
Elaine Mayadsky			

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. SB 256

DATE 3-19-91 SPONSOR(S) Sen Gage

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Vicky Locke	self	X	
DAVID HARTMAN	MEA		X
Pat Melby	Rimrock Foundation	✓	
Steve Brown	Blue Cross-Blue Shield		X
Mike Rogers	CDPM	X	
Cil Wendt	Deaconess Medical Center		X
Mary McCue	Mt Mental Health Counselors Assn	X	
Rose Hughes	Mt. Optometric	X	
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS		X
Joyce Brown	Dept of Administration		✓
JAMES TUTWILER	MT CHAMBER COM		✓
John DeLano	MONT Med Assn	X	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. SB 256

DATE 3/19/91 SPONSOR(S) _____

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Mona Jamison	RMTC	✓	
Joel Lankford	Columbus Hospital	✓	
Jerri Hogan	Saint Vincent Hospital	✓	
David Bamhill	Deputy Insurance Commissioner	✓	
Sam Ebzery	ST Vincent Hosp	✓	
Tom Hopgood	Health Facs Assoc. America		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 978

DATE 3-19-91 SPONSOR(S) Rep. Phillips

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Jerel D. Johnson	Montana Assoc of Homes for the Aging	HB978		✓
Robert H. Wiseman	Montana Assoc of Homes for Aging	HB978		✓
R.G. "Rick" Tucker	Mt Chpr. Facilities	HB978		
Rae Hughes	MT. Health Care Assn			w/ Amends

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HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

1062

Human Services & Aging COMMITTEE BILL NO. SB 366

DATE 3-19-91 SPONSOR(S) Sen. Franklin

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Margaret Overstad	Columbus Hospital Women's Center Board	✓	
Sharon Howard	Columbus Hospital Women's Center Board	✓	
Beth Veign	Columbus Hospital Women's Center	✓	
Kate Cholewa	MT Womens Lobby	X	
Nadine Copley	ACS & Self	X	
BJ Wood	ACS	X	
Roetta Vanlaushy	American Cancer Society	X	
DAVID HARTMAN	MEA	X	
Thomas Roberts	myself	✓	
Kathleen Rogers	Personal Care Home Tournament	✓	
Annabelle Lakeland	American Pain Society	✓	
Tanya ABC	Blue Cross & Blue Shield		mild
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS		✓
Mike Stephens	MT Trauma Assn	X	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. SB366

DATE 3/19/91 SPONSOR(S) Eve Franklin

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Cathy Camparota 1574 Adams Blvd, M.T.	Mont. Nurse Practitioner State Interest Group		
Tom Hopgood	Health Ins Assoc America		✓
A. Russell	HD 99	✓	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. SB277

DATE 3-19-91 SPONSOR(S) Sen. Gage

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GREG A. OLSEN	DDPAC	✓	
CRIS VOLINKATY	DD Lobbyist	✓	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. SB 393

DATE 3-19-91 SPONSOR(S) Sen. Kennedy

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Roger Tippy	Mt St Pharmaceutical Assn.	X	
Tom Hojcod	Health Ins. Assoc. Amer.		✓

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.