MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 1, 1993, at 1:00 p.m.

ROLL CALL

Members Present:
Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Laura Turman, Committee Secretary

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

Committee Business Summary:
Hearing: SB 166, SB 118, SJ 11
Executive Action: None.

HEARING ON SB 166

Opening Statement by Sponsor:

Sen. Tom Towe, Senate District 46, said the Committee heard a bill last hear concerning the scope of practice of occupational therapists, and the physical therapists objected to it. Sen. Towe said there was strong disagreement among these two groups. They were asked to work out their differences, and return to the Legislature. There is an amendment on Page 3, Lines 7-13, and another on Page 4, Lines 3-5, and this provides for general agreement.

Proponents' Testimony:

Mary Churchill, Occupational Therapist, Great Falls went over the changes in SB 166. Mona Jamison provided the agreed upon amendments. (Exhibit #1)

Connie Grenz, Occupational Therapist, Helena, provided written testimony. (Exhibit #2)

Janet Bauer, Occupational Therapist, Great Falls, said she was the Occupational Therapy Chair for the Joint Task Force which addressed the issue of a physical agent and modalities. Ms. Bauer provided a copy of the Task Force Report, (Exhibit #3), and the Task Force's testimony in support of SB 166. (Exhibit #4). She said the Task Force reached unanimous agreement on the proposed language pertaining to the use of physical agents and modalities.

Ricky Rosen, Montana Occupational Therapy Association (MOTA), stated her support for the Task Force report and SB 166, and provided written testimony. (Exhibit #5)

Mary Krenik, MOTA, stated her support for the Task Force report.

Kathy Hill, Montana Physical Therapists Association, stated her support for the Task Force report.

Gail Wheatley, President of the Montana Physical Therapists Association, said she "happily" agreed to all the amendments proposed to SB 166. Ms. Wheatley said there is unanimous agreement regarding the use of a physical agent as well as continuing education requirements. She said SB 166 serves everyone's best interests as well as the public's.

Linda Botten, Occupational Therapist, Bozeman provided a letter of support for SB 166 from the Bozeman Medical Community. (Exhibit #6) She also provided a letter from the Occupational Therapy Associates in support of SB 166. (Exhibit #7)

Carrie Deneschek, Physical Therapist, Missoula and Legislative Chair for the Montana Chapter of the American Physical Therapy Association, said they agree to SB 166 with the amendments proposed today.

Mary Krenik, Occupational Therapist and member of the Task Force, provided written testimony. (Exhibit #8)

Lynn Davis, Occupational Therapist Licensing Board, said the Board supports SB 166.

Informational Testimony:

Mona Jamison, representing the Montana Chapter of the American Physical Therapy Association, said there are some concerns regarding the amendments which were agreed to just before the

hearing today. She said she would prepare them for the Committee before the Committee takes Executive Action on SB 166.

Greg Duncan, said that a consensus such as this one leaves the physical therapists and the occupational therapists "not entirely happy with the way things are." He thanked the Committee for its time.

Questions From Committee Members and Responses:

Chairman Eck requested the assurance that representatives from both the physical and the occupational therapists would be present when the Committee takes Executive Action on SB 166.

Closing by Sponsor:

Sen. Towe closed.

HEARING ON SB 118

Opening Statement by Sponsor:

Sen. Tom Towe, Senate District 46, said SB 118 deals with personal care facilities. Sen. Towe said a client of his was taking care of an elderly person, and was unable to receive a foster care license because the license did not cover the type of care she was providing. The Department of Health said there is no law authorizing the Department to give this kind of license because it is not available. SB 118 would create a license for facilities that care for elderly individuals who need a little more care than they would receive in a licensed foster care facility. In this type of facility, there are generally 2-5 individuals needing assistance, less comprehensive than what is provided in a nursing home, living in a home setting. Sen. Towe said that doctors would sign written recommendations for these individuals to this type of home setting. The theory of SB 118 was to outline the general structure of personal care facility with 2-5 residents (Category B), and personal care homes with 6 or more residents (Category A). This bill is an attempt to save money and to make elderly citizens more satisfied with the care provided. Sen. Towe called the Committee's attention to the Fiscal Note because licensing all the adult foster care homes would cost the Department of Health more money, and the General Fund may have to spend extra money because of a federal law specifying those who can and who cannot receive assistance under foster care. To avoid losing federal funds, the foster care revision is deleted, and the Fiscal Note is nullified except for the $25,000.00 needed for rule-making. An updated Fiscal Note has been requested.

Proponents' Testimony:

Mike Craig, Department of Health, provided written testimony, (Exhibit #9) pertaining to the amendments to SB 118. (Exhibit #10).

Opponents' Testimony:

Doug Blakley, State Long Term Ombudsman, Office on Aging, said SB 118 is confusing. Consumers have problems finding care below the nursing care level because it is difficult to know what needs the different facilities meet. For most people, a nursing home is the equality of a "death sentence", and they will do anything to avoid going to one. They may need care that personal care providers cannot deliver, and the cost of these homes may be more than the cost of a nursing home. Mr. Blakely said some of the original intentions of SB 118 were good, and he supports the idea of personal care homes not needing a certificate of need. The cost of the certificate may cause people not to get the certificate. The providers in nursing homes have a lot of professional training, while providers in foster care homes or personal care homes do not have any training requirements. Mr. Blakley said it would better to combine levels of care rather than creating a new level and the Department of Health should be able to regulate facilities.

Informational Testimony:

Rose Hughes, Executive Director of the Montana Health Care Association which represents nursing homes and some personal care facilities in Montana, said they are neither for nor against SB 118. They do not want to discourage the availability of services that might be available if the licensure were appropriate. Ms. Hughes said they did have concerns regarding safety, but SB 118 states that the Department of Health will set standards, rules and regulations concerning the care provided. She said the facilities may not be very different than a nursing home, but the terminology should not be confused.

Questions From Committee Members and Responses:

Sen. Christiaens asked Sen. Towe if the current duties of the Department of Health and the Department of Family Services couldn't be consolidated. Sen. Towe said that is what the original plan was, but there were two problems. First, to change the name "adult foster care" to "personal care facility," additional obligations are incurred by federal law to reimburse with general fund dollars. Second, the Department of Family Services does not charge much to administer that program now, and

the Department of Health would charge extra. Therefore, the adult foster care license was left under the Department of Family Services, and a personal care facility was created which will have a new license.

Sen. Christiaens asked Nancy Ellory about language being put in the MedicAid budget requiring that individuals be placed in the least restrictive environment.

Nancy Ellory, Administrator of MedicAid Services Division, said "it is right in line" with other proposals. Individuals in these facilities are eligible for MedicAid, but Medicaid does not reimburse the facility cost. It was not viewed as cost effective because the current license law states that individuals in personal care homes do not have nursing needs. They support alternatives to having individuals enter nursing homes, but they are concerned about safety standards.

Chairman Eck asked Nancy Ellory if it would be more likely to receive a reimbursement waiver with a different category of personal care homes. Ms. Ellory said it would increase the chances, but they would prefer a way to reimburse without a waiver under an approved state-wide plan.

Sen. Christiaens asked Mike Craig about licensing of personal care facilities currently taking place. Mike Craig said there were 27 currently licensed personal care facilities.

Sen. Christiaens asked Mr. Craig if under SB 118, the number of licensed facilities would increase to 186. Mr. Craig said that was not the case if the amendments were to pass.

Sen. Christiaens asked Mr. Criag if the amount for each survey for licensure is $1049.00. Mr. Craig said the Fiscal Note for SB 118 is based upon the original language.

Sen. Klampe asked Mike Craig if the Department of Health had the ability to regulate and require standards of care for personal care facilities. Mr. Craig said standards already exist for personal care, and SB 118 would require more standards regarding education requirements.

Sen. Klampe asked if the Department of Health had the money to provide for the new standards. Mr. Craig said there was not a separate fund for rule-making.

Sen. Klampe asked if the Department of Health could absorb the costs. Mr. Craig said it would be difficult.

Closing by Sponsor:

Sen. Towe said that originally he did want licenses to be combined, but that was financially difficult. Sen. Towe pointed

out that a physician must provide a signed statement agreeing to the resident's admission to a personal care home, guaranteeing that people are not inappropriately placed in these homes. Sen. Towe also pointed out that the Department of Environmental Sciences is specifically directed to promulgate rules protecting the individuals covered by the new licenses. He said there would be no fiscal impact to the general fund. He also said he had received many letters from family members of personal care residents who are happy with the care they are receiving, and they can afford the home care. This kind of personal care facility is needed.

HEARING ON SJ 11

Opening Statement by Sponsor:

Sen. Bill Wilson, Senate District 19, Great Falls, said SJ 11 urges Congress to regulate the cost of prescription drugs. 69% of Montana's senior citizens spend over $100.00 per month on prescription drugs. The cost of prescription drugs has increased much faster than the rate of inflation, and it hurts those individuals on fixed incomes.

Proponents' Testimony:

Bonnie Tippy, Montana State Pharmaceutical Association, distributed copies of hospital invoices from the east coast which notes the price hospitals and stores paid for prescription drugs. (Exhibit #11) Ms. Tippy said the consumers are the ones who really suffer, and it isn't the pharmacies who are increasing the prices on prescriptions, it is the pharmaceutical manufacturers. The Association has written amendments (Exhibit #12), stating that Congress should amend the Robinson-Patman Act in order to end the exemption that pharmaceutical manufacturers have in this area.

Roger Tippy (Exhibit #13) said that the Robinson-Patman Act stated that a seller or manufacturer who would sell goods to different customers must justify prices by volume. Mr. Tippy said the Robinson-Patman Act has failed to stick to pharmaceutical manufacturers because of non-profit exemptions which apply to hospitals. Retail community pharmacies argue that if the manufacturers are not selling at a loss to hospitals, or other non-profit buyers, and still making money, why are community pharmacists being charged a higher price. The amendment suggests that the non-profit bulk purchasers are realizing large profits.

Verner Burtelson, Montana Legacy Legislature, provided written testimony. (Exhibit #14)

Chet Kinsey, Chair of the local Montana Senior Citizen

Organization, said they supports SJ 11 with the amendment because they feel there are many abuses in the system regarding the high cost of prescription drugs.

Ed Sheehy, retired federal employee, said he supports SJ 11. Insurance carriers through the federal government now have preferred provider coverage for pharmacists which reimburses 80% of the cost for prescription. He feels that there is a need for price control.

Clyde Dailey, Executive Director of the Montana Senior Citizens Association, said the Association supports SJ 11 with the amendments. There is also HB 355 being carried in the House which addresses posting of prices.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

Sen. Christiaens asked Roger Tippy about the Clayton Anti-Trust Act, and the Robinson-Patman Act and the exemption for non-profit groups. Roger Tippy said the non-profit exclusion from the Robinson-Patman Act is not the only weakness in pricing that community pharmacists see. However, it has been viewed in a very broad manner and may have been abused by the manufacturers.

Sen. Towe asked Bonnie Tippy who she represented. Ms. Tippy said she represented the Montana State Pharmaceutical Association, the community pharmacists in Montana.

Sen. Towe said he assumed they support SJ 11 with the amendment. Ms. Tippy said it was the contention that the problems with the prices of prescription drugs are not the responsibility of community pharmacy.

Sen. Towe said he generally agreed with that contention, but he said changing the Robinson-Patman Act will not change manufacturers pricing "overnight", and we "should not let them off the hook." Ms. Tippy said the stronger the amendment, the happier the community pharmacists are.

Sen. Towe asked Ms. Tippy if she were referring to the unit price paid by a non-profit organization which can be high because of their exemption to the Robinson-Patman Act. Ms. Tippy said that was correct, and the amendment gives Congress the direction that Montana would like to see it go.

Sen. Towe asked Verner Burtelson if he objected to strengthening

the amendment to make sure it does not address only the Robinson-Patman Act. Mr. Burtelson said they would be "delighted."

Chairman Eck asked Bonnie Tippy if she would share information concerning proposed pharmaceutical cost containment to be used in strengthening the resolution. Ms. Tippy said she had not seen President Clinton's plans in this area.

Closing by Sponsor:

Sen. Wilson closed.

ADJOURNMENT

Adjournment: Chairman Eck said Executive Action on SB 166 and SB 145 would be put off until Wednesday, February 3. Chairman Eck adjourned the hearing.

Dorothy Eck

SENATOR DOROTHY ECK, Chair

Laura Turman

LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-1-93

NAME	PRESENT	ABSENT	EXCUSED
CHRISTIAENS	✓		
HAGER	✓		
KLAMPE	✓		
MESAROS	✓		
RYE	✓		
TOWE	✓		
FRANKLIN	✓		
ECK	✓		

FC8

Attach to each day's minutes

SENATE HEALTH & WELFARE
EXHIBIT NO. #1
DATE 2-1-93
BILL NO. SB 166

Proposed Amendments to SB 166

Submitted by the Montana Chapter of the American Physical Therapy Association

~~1. Page 10, Lines 24 & 25~~
~~Following: "temperature,"~~
~~Strike: "sound, or electricity."~~

2. Page 11, Line 23
Following: "of"
Strike: "an"
Insert: "a qualified"

3. Page 12, Line 8
Following: "hand"
Insert: "to restore and enhance hand function"

4. Page 12, Line 17
Following: "and"
Strike: "in"

1. page 4, line 3
Following: "assessing"
Strike: "functional performance"
Insert: "work"
Following: "through"
Strike: "exercise, range of motion and use of ergonomic principles;
Add: "Occupational therapy intervention including education and instruction, activities to increase and improve general work behavior skills, job site evaluation, on-the-job training and evaluation, development of work related activities, and supported employment placement;

5. page 3, lines 7-13
Following: "applying" on line 7
Insert: "splints or selective adaptive equipment and training in the use of upper extremity prostheses or upper extremity orthotic devices"
Delete: "rehabilitative" ~~that~~ on line 10 through and including "devices" on line 13

6. page 12, line 14
Following: ["section
Strike ~~(2)~~
Insert (1)(c)]

7. page 18, line 18
Following: "section 11"
Strike: ~~(2)~~
Insert: ~~(2)(c)~~ (1)(c)

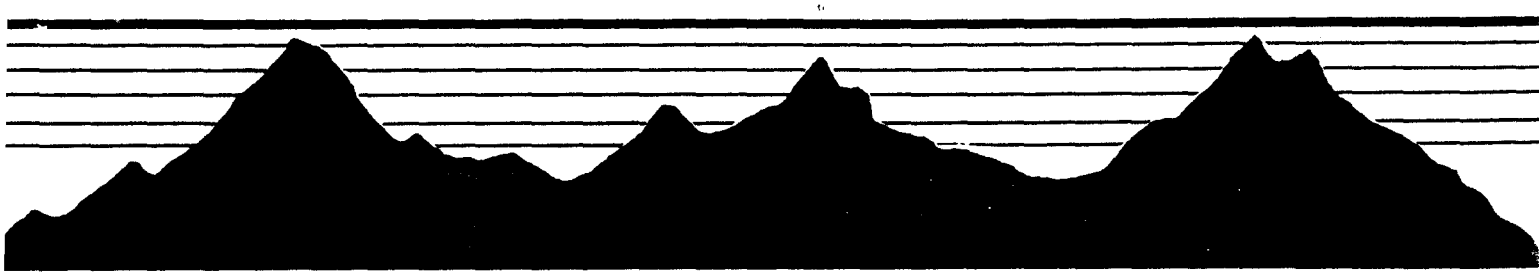
(4) 7. page 7, lines 15-21
(See Amendment # 5)

8. page 7, line 24
(5) Following: "cognitive,"
Insert: "psycosocial"

9 page 11, line 5
(9) Following: "of"
Insert: "selected"
Delete: "modality"
Insert: "modalities"

(6) (7) 10. page 8, lines 11-23
See Amendment # 1

(8) ~~11~~. 11. page 10, line 20
Following: "and"
Strike: "in"



MONTANA OCCUPATIONAL THERAPY ASSOCIATION

My name is Connie Grenz. I am an occupational therapist. I work here in Helena. I specialize in infants, and feeding and swallowing abnormalities. I presently serve as Member-at-Large on the executive board of the Montana Occupational Therapy Association.

In 1985 the occupational therapists requested and were granted professional licensure to protect the consumer from unqualified persons. That was the beginning of my relationships with legislators, lawyers, and the MT Physical Therapy Association. The Montana chapter of the APTA challenged the legality of the licensure law to allow SRS/Medicaid to reimburse OTs for "modalities." SRS/Medicaid has been reimbursing OTs for the use of modalities for over 25 years. In 1990 an attorney general's review was requested and on Jan. 11, 1991 Mark Racicott finalized his interpretation specifically stating "Occupational Therapists are not permitted by Montana law to employ heat, cold, air, light, water, electricity, or sound as therapeutic agents."

Fortunately the Board of Occupational Therapists and the Department of Commerce Lawyers had already drafted language for legislation to clarify the use of physical agent modalities by occupational therapists. Representatives of the Montana Chapter of the Physical Therapy Association strongly objected to the use of such broad language. Admitting that this was a "turf" battle they made efforts to significantly restrict the practice of occupational therapy. Occupational therapists have worked within that restricted scope of practice for two (2) years. The Occupational Therapy Licensure Board has worked diligently to ensure educated therapists not overstep these limitations.

For the past two years a select group of occupational and physical therapists have worked to prepare language to present to you today which will adequately define the use of physical agent modalities by occupational therapists.

I believe that the majority of occupational and physical therapists in this state work as a team sharing knowledge and developing treatment plans to best provide for their patients. I know that there are many areas of overlap innately a part of our treatment approaches, and that usually we recognize our individual abilities and limitations with high professional ethics. There are 160 licensed occupational therapists and 350 licensed physical therapists and still great areas of Montana where persons are unable to receive either service within 100 or 200 miles.

SENATE HEALTH & WELFARE
EXHIBIT NO. #2
DATE 2-1-93
BILL NO. SB 166

I wish to recognize high professional ethics among Occupational Therapists in Montana. Not one consumer complaint has been processed by the board in 7 years. The purpose of licensure is not only to protect patients from unprofessional care but also to assure the care they receive will be the best care available in light of the then current standards. It also imposes upon practitioners the responsibility of assuring that licensure does not impede or prevent the growth of the practice in response to advances in science, technology, and therapeutic methods. Please note not one claim has been filed against an occupational therapistfor injury to a patient with a physical agent modality in the nation, and I remind you that of the 47 jurisdictions regulating occupational therapy only one restricts the use of modalities and that is due to physical therapy legislative restrictions.

Therefore I implore you to support SB 166 to legally clarify the use of physical agent modalities by occupational therapists. It is in the best interest of the patient to provide the highest quality of treatment of which we are capable.

Thank You!

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 2-1-93
BILL NO SB 166

ORIGINAL

REPORT

OF

MONTANA OCCUPATIONAL THERAPY - PHYSICAL THERAPY TASK FORCE

This Task Force originated in the fall of 1990 to discuss concerns of both Occupational Therapy and Physical Therapy professions regarding the issue of occupational therapists incorporating the use of physical agent modalities into their scope of practice. Two meetings were held in 1990: on October 27 and on December 8. The Montana Occupational Therapy Association (MOTA) introduced a bill during the 1991 Montana Legislative Session, which generated much opposition from Montana physical therapists and was amended during Senate Sub-committee meetings. That amended version, which was not particularly satisfactory to either profession, will "sunset" July 1, 1993. The 1991 Senate Sub-committee members strongly encouraged the Task Force to continue working to reach an agreement on the issue of occupational therapists using physical agent modalities in their practice.

The Montana Occupational Therapy - Physical Therapy Task Force began meeting again on Aug. 3, 1991 to discuss proposals for occupational therapy legislation to be introduced during the 1993 Legislative Session and has held regular meetings since then, to-wit: Nov. 2, 1991; Feb. 1, 1992; June 6, 1992; Aug. 8, 1992; and Nov. 7, 1992. During the Aug. 8, 1992 meeting, essential agreement was reached regarding proposed 1993 OT legislative language. An additional meeting was held on Sept. 22, 1992 in Great Falls with two occupational therapy and two physical therapy Task Force members present to discuss feedback from the Montana Physical Therapy Chapter's Board of Directors re: language developed from the Aug. 8, 1992 Task Force meeting.

There was a change in the Physical Therapy membership on the Task Force in 1992 due to a change in the state Physical Therapy Chapter's Presidency and to one PT Task Force member planning to move out of state. Members on the Task Force during 1992 have been:

Occupational Therapy: Chair, Janet Bauer, Great Falls occupational therapist, graduate of University of Minnesota; Mary Krenik, Billings occupational therapist and certified hand therapist, graduate of University of North Dakota; Krista Keiper, Great Falls occupational therapist (and previously a certified occupational therapy assistant), graduate of Colorado State University; Rickie Rosen, Billings occupational therapist, graduate of Colorado State University, President of MOTA.

Physical Therapy: Chair, Tim Redfern, Hamilton physical therapist, graduate of Mayo Clinic; Rich Gajdosik, Director of Physical Therapy Dept., University of Montana, Missoula, graduate of Kentucky PT school, Masters from University of Cincinnati, and PhD from University of North Carolina; Kathy Hill, Great Falls physical therapist, graduate of University of Washington, Seattle; Gail Wheatley, Great Falls physical therapist, President of Montana Chapter of APTA.

All members were present at the final Task Force meeting on Nov. 7, 1992, during which agreement was reached on those portions of the proposed 1993 OT legislation that pertain to use of physical agent modalities. Although other changes in the OT Practice Act are proposed and have been discussed during Task Force meetings, those changes are not part of the charge given to the Task Force. The Task Force members have communicated information presented and discussed during meetings to their respective professional association members and feedback from members to the Task Force, through regularly scheduled formal meetings, an informal meeting, and written communication.

Although there is not 100% membership approval for the unanimous Task Force agreement re: OT legislation regulating use of physical agent modalities, the Task Force members have met and communicated in good faith to represent concerns of both Occupational Therapy and Physical Therapy professions re: protection of Montana consumers and competent practice by licensed health care professionals. Therefore, the Occupational Therapy bill presented to the 1993 Montana Legislature does reflect unanimous Task Force support for appropriate and reasonable regulation of licensed occupational therapy personnel in the use of physical agent modalities.

Thank you for the opportunity to assist in dealing with this difficult health care issue in Montana.

Sincerely,

Occupational Therapists

Chair, Janet Bauer

Janet Bauer OTR/L

MOTA President, Rickie Rosen

OTR/L.

Physical Therapists

Chair, Tim Redfern

Timothy R. Redfern, P.T.

MT APTA Chapter President, Gail Wheatley

Gail Wheatley PT

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 2-1-93
BILL NO SB166

TESTIMONY IN SUPPORT OF S.B. 166

A task force of 4 Occupational Therapists and 4 Physical Therapists was re-established after the 1991 Legislative Session and met formally 6 times (Aug. 3, 1991, all members present; Nov. 2, 1991, 2 Physical Therapists not present; Feb. 1, 1992, all members present; June 6, 1992, 2 Physical Therapists not present; Aug. 8, 1992, one Physical Therapist not present; and Nov. 7, 1992, all members present), with one informal meeting with 2 Occupational Therapists and 2 Physical Therapists held in Great Falls (on Sept. 22, 1992).

During early meetings, discussion took place on a variety of subjects, to-wit:

1) Changes in the referrals and treatments in Occupational Therapy practice;

2) The need to establish educational requirements and to establish "sufficient proof" to demonstrate competency by Occupational Therapists using physical agent modalities;

3) Concern by Physical Therapists re: defining the parts of the body on which Occupational Therapists would apply physical agent modalities;

4) Establishing the intent of the Task Force, with Occupational Therapists stating that the task is to develop and come to an agreement on language regarding the use of physical agent modalities by Occupational Therapists for the Occupational Therapists to present to the 1993 Legislature and with the Physical Therapists stating that their role is to offer suggestions and comments, but not to actually develop language, that they feel no legal pressure from the Legislature and no legal mandate to follow to come to an amicable agreement, and that they need to see all of the language proposed for the bill, not just the portions relating to the use of physical agent modalities;

5) Reviewing the work of the Occupational Therapy Licensure Board in developing rules to implement the law that was passed in 1991;

6) Request by the Physical Therapists to define the term "purposeful activity";

7) The possibility of a grandfather clause;

8) Defining physical agent modalities and separating or delineating superficial from deep types of physical agent modalities;

9) Using national standards to develop state language.

Aug. 8, 1992 Task Force Meeting

The Occupational Therapists presented language with changes made in response to the discussion and concerns from the June 1992 Task Force meeting. After the Physical Therapists had reviewed the language, they stated their comments and concerns regarding all of the language in the bill. After a break to review those comments, the Occupational Therapists presented alternatives in the language to address the Physical Therapists' concerns. The meeting was adjourned with an agreement on the language that the Physical Therapists stated would probably be adequate for 90% of Occupational Therapists and Physical Therapists in Montana.

The revisions from the meeting were incorporated into the language, with copies sent to the Task Force members and to Montana Occupational Therapists. The Occupational Therapists then conducted state-wide meetings to review the proposed language and to obtain a vote on support of the language. There are 165 licensed Occupational Therapy personnel in Montana; 136 (82%) were contacted individually to vote. Results were: 109 (80.2%) were in support; 9 (6.6%) voted against; and 18 (13.2%) did not respond.

After the Task Force meeting, Gail Wheatley, President of the Montana APTA Chapter, sought feedback from the Chapter's Board of Directors; that feedback was included in a memo from Ms. Wheatley to the Task Force members dated Sept. 10, 1992. This memo contained several areas of concern throughout the proposed language. The Occupational Therapists drafted a memo, dated Sept. 18, 1992 to Ms. Wheatley to address those concerns, including information on the definition of Occupational Therapy established by the American Occupational Therapy Association's Representative Assembly in 1992. Additionally, a meeting was held on Sept. 22, 1992 in Great Falls with the 2 Occupational Therapists and 2 Physical Therapists on the Task Force from the Great Falls area. Additional language changes were agreed to as a result of those memos and the meeting.

The Physical Therapists held their state meeting at the end of September, 1992, during which the members present voted on accepting or rejecting the language for the Occupational Therapy bill (language which had been agreed to at the August Task Force meeting and which had had a couple of additional changes made after the less formal discussion in Great Falls). Per Ms. Wheatley's letter of Oct. 8, 1992, at the Physical Therapists' State meeting, the agreed-upon language was rejected, and 2 of the 4 Physical Therapy Task Force members (Gail Wheatley and Rich Gajdosik, with input from other Physical Therapists) developed substitute language.

Also, at this state meeting, the Physical Therapy Task Force members were told by the Chapter's membership that they had no authority to discuss changes in the Occupational Therapy Practice

Exhibit #4
2-1-93
SB-166

Act not related to physical agent modalities, although the Physical Therapy Task Force members had stated at nearly every Task Force meeting that they needed to see all of the language and had, in fact, agreed to changes on non-modality issues at the Aug. 8, 1992 Task Force meeting.

Nov. 7, 1992 Task Force Meeting

The Task Force members met for a lengthy discussion regarding only the portions of the proposed language dealing with physical agent modalities. There was final unanimous agreement on the sections and definitions directly applicable to Occupational Therapists using physical agent modalities. The bill now includes delineation of parts of the body on which either superficial or sound and electrical physical agent modalities may be used; it includes a listing of areas of knowledge needed to demonstrate competency; it includes an established number of hours needed to gain that knowledge to use physical agent modalities; and it establishes testing by an independent certification commission as one method to prove part of the competency requirements.

I am very pleased to report that the Task Force, after much deliberation, discussion, and exchange of information and on behalf of both the Occupational Therapy and Physical Therapy state professional associations, did reach unanimous agreement on the issue of physical agent modalities, which is the issue that brought us before you two years ago. The other changes that we have made in our Practice Act do not expand the areas of practice previously listed in our Practice Act. The changes were made to correspond to our national association's definitions, and they are supported by basic education consistently required in all accredited Occupational Therapy programs.

Sincerely,

Janet Bauer OTR/L

Janet Bauer, OTR/L
Occupational Therapy Chair, Task Force

ADDITIONAL TESTIMONY IN SUPPORT OF S.B. 166

Because the Physical Therapists on the joint Occupational Therapy - Physical Therapy Task Force had no authority to deal with the changes in the Occupational Therapy Practice Act which do not relate to physical agent modalities (changes which were made to interweave the national definition of Occupational Therapy into the existing wording of our Practice Act), a formal letter, dated Nov. 11, 1992, was written to Ms. Wheatley (after the Nov. 7, 1992, Task Force meeting) to request feedback from the Montana APTA Chapter's Executive Committee on the other changes. Ms. Wheatley's letter to the Occupational Therapists in response to that request (dated Nov. 19, 1992) after the Montana APTA Chapter's Executive Committee met indicated two areas of concern, to-wit:

1) Section 4 (d) designing, fabricating, or applying rehabilitative technology such as selected orthotic devices and providing training in the functional use of assistive technology and upper extremity orthotic or prosthetic devices

Per Ms. Wheatley's letter of Nov. 19, 1992, the Physical Therapists want designing, fabricating, or applying orthotic devices limited only to the upper extremity . Our original Practice Act stated this as designing, fabricating, or applying splints or selective adaptive equipment and training in the use of upper extremity prosthetics or upper extremity orthotic devices. The original Occupational Therapy Practice Act, that has existed since 1985, does not limit designing, fabricating or applying splints to only the upper extremity, although it does use the word "splint" instead of "selected orthotic device". Following are the definitions of splint, orthotics, and orthosis (from Miller & Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Third Edition)

A) Splint: a rigid or flexible appliance for fixation of displaced or movable parts.
B) Orthotic: serving to protect or to restore or improve function; pertaining to the use or application of an orthosis.
C) Orthosis: an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve function of movable parts of the body.

A change in the words to align the definition of Occupational Therapy contained in Montana law with the American Occupational Therapy Association's definition of Occupational Therapy neither changes nor expands what Occupational Therapists do in this area of practice. What the Physical Therapists are suggesting is a restriction in an area of Occupational Therapy practice that has not been previously restricted to only the upper extremity.

Exhibit #4
2-1-93
SB-166

The Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapist states as part of program Content Requirements under the category of Occupational Therapy Process the following: " ... **therapeutic adaptation for accomplishment of purposeful activities (occupation): family/caretaker training, environmental adjustments, orthotics, prosthetics, assistive devices, equipment, and other technologies".**

The American Physical Therapy Association's Standards and Criteria for Accreditation of Physical Therapy Education Programs does NOT state in any of the criteria for a Comprehensive Curriculum that Physical Therapy students receive training in orthotics, prosthetics, or splints as an element of uniform basic education. The Montana Physical Therapy Practice Act (MT Title 37 Chapter 11) also does NOT state the term orthotics or splint as a specific treatment procedure allowed in the practice of Physical Therapy.

How can a profession that neither includes orthotics in its basic education nor states orthotics as a part of their practice in this state demand that another profession which does include orthotics in its basic educational requirements be restricted in the use of orthotics? Perhaps the vague term "rehabilitative procedures" that the Montana Physical Therapy Practice Act uses has been interpreted by Physical Therapists to mean orthotics. I, however, feel that the Physical Therapists need to prove that they have basic educational requirements, standardized across the nation, in the area of orthotics and prove that the Occupational Therapy basic educational requirements do not adequately cover orthotics before they make an argument that they are more qualified than Occupational Therapists to make lower extremity or foot orthotics.

2) 4 (i) enhancing and assessing functional performance and work readiness through exercise, range of motion, and the use of ergonomic principles

This language was agreed to at the Aug. 8, 1992, Task Force meeting. However, per Ms. Wheatley's letter of Nov. 19, 1992, the Physical Therapists want language that restricts Occupational Therapists in return to work programs to treat only within the context of a team or to work only with upper extremity injuries because of a lack of educational background to independently work with people with spinal or lower extremity dysfunction.

The Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapist states that Content Requirements shall include, in the area of Biological, Behavioral, and Health sciences: " Structure and function of the **human body** including anatomy, kinesiology, physiology, and neurosciences. ... The etiology, clinical course, management, and prognosis of congenital, developmental, acute, or chronic disease processes and

traumatic injuries; and the effect of such conditions on human functioning throughout the life span. ..." The educational essentials are not limited to structure, function, or effect of injury of the upper extremity only; rather, the educational essentials cover the entire human body. As to working only as a member of a team in return to work programs, if you believe that that is the most effective way to deliver services to Montana consumers, then I would suggest that all recognized members of a Work Program team must also have their Practice Acts amended to state the same restriction of not working alone and only working as part of a team. During a telephone call from Gail Wheatley on Jan. 5, 1993, she stated that Work Hardening is a "dead issue".

During a discussion with Gail Wheatley on Jan. 20, 1993, after the Montana APTA Chapter held a state meeting during the weekend of Jan. 15, 16, and 17, 1993, Ms. Wheatley stated that the Physical Therapists have developed amended language for the Occupational Therapy Practice Act concerning the previously stated two issues. After repeatedly stating during Task Force meetings that the role of the Physical Therapists is NOT to develop language for the Occupational Therapists, apparently the Physical Therapists do, indeed, feel that they are more knowledgeable about the education of Occupational Therapists and what Occupational Therapists are qualified to do than Occupational Therapists. Since no specific language has been shared by the Physical Therapists, only patronizing assurances that the Occupational Therapists will be happy with the language, I can not state at this time if, in fact, the Physical Therapists' version of how Occupational Therapists may practice in the areas of splints and orthotics and Work Hardening programs truly reflects Occupational Therapists' unique role in quality health care.

It is disconcerting that the Physical Therapists seem to periodically change their attitude toward these issues. One wonders what the true motives are in this "policing" of the Occupational Therapy profession - is it a "turf battle", as one Physical Therapist stated during a Task Force meeting, or is it truly concern for the quality and efficacy of health care for Montana consumers?

Although the major issue of Occupational Therapists using physical agent modalities has been successfully addressed within the Task Force, there is apparently some concern by the Physical Therapists regarding the changes in language that we are making to further clarify and define the practice of Occupational Therapy (defining, delineating, and clarifying the scope of Occupational Therapy practice is something that the Physical Therapists have repeatedly requested). The changes that we have made in our Practice Act not related to physical agent modalities were done to have Montana's legal definition of Occupational Therapy be in line with our national definition. They do not expand the areas of

Exhibit #4
2-1-93
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practice previously listed in our Practice Act. I strongly believe that Senate Bill 166, as presented, (other than the sections dealing with physical agent modalities) is a true reflection of what every Occupational Therapist is qualified to do as a result of knowledge and experience gained during basic education in accredited programs.

Sincerely,

Janet Bauer OTR/L

Janet Bauer, OTR/L
Great Falls, Montana
Occupational Therapy Chair, Task Force

TESTIMONY IN SUPPORT OF SENATE BILL 166

MONTANA OCCUPATIONAL THERAPY ASSOCIATION

My name is Rickie Rosen I am the current president of the Montana Occupational Therapy Association. I work in acute care at Deaconess Medical Center In Billings.

My focus today concerns changes in the O.T. liscensure bill that are not related to physical agent modalities. Because we were requested by the P.T. members on the task force to have our entire bill ready for review at 90% of our meetings, some of the changes were brought about through P.T. suggestion but most are in response to our national O.T. office in accordance with their goal of consistent national language.

Generally speaking, our bill has been arranged differently in form but not content but for the following exceptions.

We added the term interventions and a new section on purposeful activity, which has been an age-old term used by O.T.s since the beginning, to better define our interactions with our clients.

Concerning our section on splinting, we added the terms orthotic to replace the term splint, used as a noun, and we added rehabilitative technology instead of adaptive equipment. Previously, we used the verbs designing, fabricating, and applying splints . We would like to keep those same verbs.

Changes in sections (e) (f) and (g) deal with wording changes that will bring us up to par with the national office. For example, using the term disabled rather than handicapped and taking out the phrase describing the use of crafts and exercises to enhance performance with a replacement that instead provides for the development of emotional, motivational, cognitive, psychosocial, or physical components of performance.

Section (h) focuses on feeding and swallowing skills. Section (i) has been modified to incorporate the area of returning injured workers back

In our previous language we linked range of motion and exercise with administration and interpretation. We feel this new addition allows us to be more dynamic in an area that we are well trained in.

In a quantitative summary, our previous bill was four pages and the one which we present today is seven pages.. The bulk of the additions concerns our use of physical agent modalitys which was what this commitee charged us to iron out.

It is my personal opinion that the work of the task force was very well done and that we have managed not to sacrifice professionalism in our clinical atmosphere. The changes that we have made are representative of our base education and allow us to move into the 21st century and the challenges of health care reform as fellow professionals with other disciplines and leaders of our own profession.

OCCUPATIONAL THERAPY ASSOCIATES, P.C.
PEDIATRIC THERAPY ASSOCIATES, P.C.
BOZEMAN AND LIVINGSTON

February 1, 1993

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2-1-93
BILL NO SB166

Montana State Legislature
Committe for Senate Bill 166
Capital Building
Helena, Montana 59620

Dear Committee Members:

This letter from the Bozeman area Medical Team is in support of Senate Bill 166.

We have had the opportunity to review this important amended sunset bill to allow occupational therapists to use therapeutic agent modalities to the entire upper extremity as an adjunct to purposeful occupational therapy treatment.

We believe that the language amended in this bill specifies specific educational requirements prior to its use and adequately handle safety and competency issues.

We support this as a cost containment measure in the development of health care reform as a means to limit the need to visit a variety of health care providers when treating an upper extremity injury.

We are comfortable with occupational therapists' educational training to support them in treating our patients in need of these services, specifically treatment of the upper extremity.

We also support the following:
1. Occupational therapists' ability to fabricate temporary upper and lower extremity orthotics and splinting.
2. Occupational therapists involvement in ergonomics, job site analysis, work conditioning, work hardening, and functional capacities evaluations of any injury.

Thank you for supporting occupational therapists on this very important health care bill.

Sincerely,

The Bozeman Medical Community

x [signature] M.D.
[signature] CEO
Gloria Larson RN Director of Nursing
John S Diggs MD, PM&R

x [signature] M.D.
Rio Dilsek P.T. MANAGER OF P.T. SERVICES

BOZEMAN AND LIVINGSTON
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Bozeman, MT (406) 586-3716, FAX (406) 586-4869 • Butte, MT (406) 782-1407, FAX (406) 782-1053

OCCUPATIONAL THERAPY ASSOCIATES, P.C.
PEDIATRIC THERAPY ASSOCIATES, P.C.
BOZEMAN AND LIVINGSTON

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 2-1-93
BILL NO. SB166

February 1, 1993

Senator Dorothy Eck
Montana State Legislature
Capital Building
Helena, Montana 59620
Dear Senator Eck:

This letter is in support of Senate Bill 166. The entire staff of Occupational Therapy Associates have worked hard to develop mutually agreed upon language to our amended sunset bill to allow occupational therapists to include therapeutic agent modalities within their scope of practice as an adjunct to occupational therapy treatment. Our practice is comprised of approximately 22 therapists and several contracted therapists including occupational and physical therapists believe strongly in quality, cost effective care. We are all part of a cost containment team effort in health care reform which might mean providing transdisciplinary team therapy to rural areas in the counties we serve. We do not believe in limiting any one profession in terms of modality use as long as the occupational therapist has adequate training to do so. Our hand therapists feel strongly that this new language will improve their ability to practice effective, safe occupational therapy treatment and rehabilitation.

Thank you for your support of this important bill.

Sincerely,

Linda Botten OTR/L.
Linda Botten, OTR/L
President of Occupational Therapy Associates

Christine Petaccia OTR/L
Christine Petaccia, OTR/L

Mary Piper OTR/L
Mary Piper, OTR/L

Dorothy Solyst OTR/L
Dorothy Solyst, OTR/L

Amy Moran OTR/L
Amy Moran, OTR/L

Jennifer Ancans C.O.T.A.
Jennifer Ancans, COTA

Liz Wales, OTR/L

Mary Cater OTR/L
Mary Cater, OTR/L

Linda Barge PT
Linda Barge, PT

Kristie Murphy, COTA/L

Christie Martel, PT
Christie Martel, PT

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SENATE PUBLIC HEALTH, WELFARE & SAFETY
EXHIBIT NO. 8
DATE 2-1-93
BILL NO. SB 166

PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE HEARING RE: SENATE BILL 166

"An act revising certain definitions relating to Occupational Therapy"

My name is Mary Krenik. I am an occupational therapist certified in hand therapy. I am a member of the Montana Occupational Therapy/Physical Therapy Task Force. I would like to briefly discuss hand therapy certification.

Certification is the process by which a nongovernmental agency or association uses predetermined standards to validate an individual's qualifications and knowledge for practice in a defined area. Certification promotes professionalism and helps assure the public that the practitioner has obtained the knowledge and skills to provide confident care. It encourages participation in continuing education and promotes professional development and career advancement.

The hand therapy certification examination is sponsored solely by the Hand Therapy Certification Commission, Inc. There are nine members of the commission composed of Occupational Therapists and Physical Therapists as well as a public member.

The mission of the Hand Therapy Certification Commission is to support a high level of competence in the practice of hand and upper extremity therapy through the development and administration of formal testing and recertification program.

Candidates must meet the following requirements in order to be eligible to take the examination.

1. Must be an occupational therapist or a physical therapist.
2. Must be nationally certified or state licensed for a minimum of five years.
3. Must be practicing in the United States or Canada.
4. Must document 2,000 hours of hand therapy practice.
5. Must complete application with documented proof.
6. Must pay an application fee of $300.00.

The blueprint for the hand therapy certification exam was developed by using the results of a job analysis survey conducted by the American Society of Hand Therapists, in 1985. The blueprint breaks down the items into nine domains of activities, skills, and modalities. The domains are: wounds and scars, edema, pain, neurovascular and neuromuscular, ROM, strength and dexterity, prosthetics and orthotics, work evaluation and conditioning, techniques and modalities. The items are categorized by two cognitive processes: comprehension and application. Comprehension items test recall and accurate understanding of facts. Application items test the candidates ability to interpret data and draw conclusions. I have included a complete copy of the test blueprint with my written testimony.

Exhibit #8
2-1-93
SB-166

Certification is conferred by the hand therapy certification commission for a period of five years. At renewal time a therapist may seek recertification through one of two options. Option #1 successfully completes the certification examination. Option #2 completes the continuing education program which is in accumulation of 80 hours of continuing education credits.

In 1991 there were three certified hand therapists in the State of Montana. Today there are five. All five of us have degrees in Occupational Therapy. We are committed to the professional practice of hand and upper extremity therapy. This commitment extends to our patients, our health care team members, the public and the specialty itself.

Thank you for your support of Senate Bill #166.

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 2-1-93
BILL NO SB118

TESTIMONY FOR SENATE BILL 118
SENATE PUBLIC HEALTH & WELFARE COMMITTEE
February 1, 1993 - by Mike Craig, Licensure Bureau, DHES

Madam Chair, members of the committee, good afternoon. My name is Mike Craig, Bureau Chief, Licensure Bureau, Department of Health & Environmental Sciences. I am here today to support Senate Bill 118.

I wish to start out with addressing the amendments to the bill. The amendments originated from our office with assistance from Legislative Council. The amendments drastically alter one of the two main components of the bill: As originally proposed, the bill would eliminate adult foster care homes and recognize them as personal care facilities under Licensure Bureau jurisdiction, resulting in a licensure consolidation. The amendments eliminate that consolidation and continues licensure of adult foster care under the Department of Family Services.

We simply cannot attempt a restructuring of licensure of both personal care and adult foster care at this time primarily because of the unanticipated fiscal impact to the general fund. Licensure consolidation would in turn allow Social Security income residents of what were adult foster care homes increase their monthly Social Security Supplement if they are now residing in personal care facilities. With the amendments, we believe that the fiscal note changes considerably. First, without having to assume jurisdiction of 120 new facilities at one time, we will be able to deal with facilities one at a time as they approach us for licensure. We do not expect a great influx of the new level of services which would be authorized under the bill, therefore the fiscal impact is unknown at this time.

However, since we were asked, we still maintain that there is an approximate cost to promulgating and adopting rules. There is other legislation that may come before this committee which requires the Licensure Bureau to adopt rules. If there is not a fiscal note attached, it does not mean that there is not a fiscal impact. It just means that we were not asked to provide the information. Our experience has been that rulemaking and its associated costs are not dealt with in the appropriations process. Typically, agencies are assumed to be able to cover those costs within existing budgets. The fiscal note does reflect an estimated cost for rulemaking, whether or not its in our existing budget.

The other main component of the bill directs the department to adopt regulations for a new type of personal care facility. There are some fundamental issues involved here regarding the elderly in Montana. What we are seeing is that current Montana law does not recognize what is happening in the area of adult services. I refer to them as adult services rather than personal care because the changes are occurring in personal care, in adult foster care, in

retirement homes, in adult day care, and in numerous unlicensed facilities. Residents are growing older, becoming more frail, having greater need for medical and nursing services, but, absolutely want to remain where they are at - regardless of how their residence is licensed or who is the licensing authority. The residents and their families or responsible parties are in fact redefining the array of adult services in congregate settings. And, to be expected, providers are tailoring their services to the needs of the consumers, not to the language of the law.

Senate Bill 118, as amended, is a start to honestly dealing with adult services. One thing that has become more apparent than any other element in dealing with this level of care is that if the changes are not recognized at the state level through the law, it is going to keep changing anyway. This bill does allow for the creation of a much greater level of care in congregate living environments. No doubt the residents of this level of care would look no different that nonambulatory patients in nursing homes with few self-care capabilities.

To be honest with you, we have seen nonambulatory residents, incontinent residents, residents on medications to control behavior, residents with varying degrees of brain atrophy, residents - on a large scale - who cannot self-administer their own medications, in personal care and in unlicensed settings. In short, we are seeing many violations of current law which prohibit personal care facilities from having non-ambulatory residents, residents in need of medical or physical restraints, and residents who are incontinent.

Under our licensing laws, my only legal option is to require relocation of residents who do not meet the statutory criteria for continued residence in a personal care facility. Then we create the situation where facilities become creative and find ways around the law so that some of their residents may stay where the resident wishes - in the personal care facility. I have required relocation of residents out of personal care as a responsibility of Licensure Bureau Chief. I can tell you its a [redacted] job and I don't relish being informed from family members that I am signing a resident's death warrant because I am causing an unwanted and very traumatic move.

In the Licensure Bureau, we agree that there needs to be some sort of accommodation for the elderly health care consumer to stay where he or she wishes. This really is a fundamental issue regarding freedom to choose. For some of our elderly citizens, it is the issue of aging in the place of choice, even if it also means dying in the place of choice. Senate Bill 118 allows for this aging in place concept to occur in limited settings with acknowledgement by a physician that the setting is appropriate. If nursing services are necessary, as they usually are, they must still be performed by a licensed nurse.

Exhibit D
2-1-93
SB-118

Senate Bill 118 also eliminates Certificate of Need requirements for personal care facilities. Elimination of Certificate of Need review may encourage more of the unlicensed facilities to become legitimized through licensure, especially those who are hesitant to go through the review because of the Certificate of Need fee.

What Senate Bill 118, as amended, does not do is it does not ~~change a thing for any currently licensed personal care facilities; nor does it~~ address the inherent problems of having separate licensure jurisdictions and separate standards in personal care, adult foster care or even retirement homes where we really are seeing that as the services are being redefined, they are becoming very similar in these three settings.

Thank you. I will be available for questions.

SENATE HEALTH & WELFARE
EXHIBIT NO. 10
DATE 2-1-93
BILL NO. SB118

Amendments to Senate Bill No. 118
First Reading Copy

For the Committee on Public Health, Welfare, and Safety

Prepared by David S. Niss
February 1, 1993

1. Title, lines 7 and 8.
Strike: "ELIMINATING ADULT FOSTER FAMILY CARE HOMES;"

2. Title, line 8.
Following: "50-5-227"
Insert: "AND"

3. Title, line 9.
Strike: "50-8-101, 52-3-811, AND 76-2-411,"
Strike: "REPEALING"

4. Title, lines 10 and 11.
Strike: "SECTIONS" on line 10 through "MCA;" on line 11

5. Title, line 12.
Following: "PROVIDING"
Insert: "AN"
Strike: "DATES"
Insert: "DATE"

6. Page 9, line 9.
Following: "~~52-3-303,~~"
Insert: "adult foster care licensed under 52-3-303,"

7. Page 20, line 6.
Strike: "personal-care facilities"
Insert: "adult foster care"
Strike: "50-5-227"
Insert: "52-3-303"

8. Page 21, line 12 through page 25, line 19.
Strike: sections 5 through 8 in their entirety

Renumber: subsequent sections

9. Page 25, line 25 through page 26, line 3.
Strike: "dates"
Insert: "date"
Strike: "(1)" on line 25 through "are" on page 26, line 3
Insert: "[This act] is"

SENATE HEALTH & WELFARE
EXHIBIT NO. 11
DATE 2-1-93
BILL NO. SJ 11

MM1 ORDER NOTES

MCKESSON DRUG

INVOICE DATE 7/24/92 INVOICE NO.

— 1

* ECONOTONE COST PLUS ORDER M

*HAZARDOUS MATERIALS CODE CLASSIFICATIONS LISTED ON REVERSE SIDE

DEPT	ITEM NUMBER	QTY ORD	UN	ITEM DESCRIPTION		STORE RETAIL	UNIT PRICE	DISC X	I D	CODE	EXTENS
BE	2169829	1	EA	AEROBID INHALER SYSTEM	7GM	40.79	2.58*		I	KR	2.58
BA	1615160	1	EA	ALBUTEROL SOL 3ML U/D DEY	25	31.19	12.81*			KR	12.81
IA	3653912	20	EA	ALUPENT SOL 0.4% 2.5ML U/D	25	37.43	32.17			R	643.40
BE	3227246	1	EA	ATROVENT MDI COMPLETE	14GM	24.89	21.39			R	21.39
BE	2701829	1	EA	AZMACORT INHALER	20GM	34.95	28.84			R	28.84
BC	1700178	1	EA	KAON-CL-10 TAB 750MG	100	22.31	18.41			R	18.41
BD	1195916	1	EA	LEVOTHROID TAB 300MCG	100	34.00	9.79*		I	KR	9.79
CA	1974146	1	EA	M.T.E.-5 CONC 10ML 2910 LYP	10	227.45	21.63*			KR	21.63
CA	1317239	1	EA	NITROL OINT TUBE 2%	60GM	9.03	7.45			R	7.45
BE	1749787	1	EA	PROVENTIL INHALER	17GM	20.35	12.54*			KR	12.54
BE	1104975	1	EA	PROVENTIL INHALER REF	17GM	18.76	11.56*			KR	11.56
AD	1927441	1	EA	THEO-DUR SA TAB 300MG	500	124.14	58.28*			KR	58.28
AD	2261121	1	EA	THEO-DUR SPRINK CAP 200MG	100	20.87	9.80*			KR	9.80
AD	1350206	1	EA	THYROID TAB 3GR ARM	1000	243.24	20.09*			KR	20.09
BE	1793215	1	EA	TORNALATE+NEBULIZER	15ML	27.74	2.63*		I	KR	2.63
HO	3655529	1	EA	VANCENASE A/Q NASAL SPR	25GM	28.62	17.62*			KR	17.62
BE	1330083	1	EA	VANCERIL INHALER	16.8GM	26.51	16.34*			KR	16.34
HE	1791102	1	EA	VENTOLIN INHALER	17GM	20.35	17.49			R	17.49
				CASE ITEM FOLLOW							
BE	1183839	6	EA	INTAL NEBULIZER AMP 2ML	120	79.84	68.63			R	411.78

SUBTOTAL	1344.43
NET PAYABLE BY STMT DUE DATE	1344.43
GROSS PAYABLE AFTER STMT DUE DATE	1371.87

LINES	CASES	PIECES
19	1	43

THIS INVOICE IS PAYABLE TO MCKESSON DRUG CO. AT ABOVE ADDRESS. CLAIMS MUST BE MADE WITHIN FIVE DAYS AND SHOW DATE OF INVOICE.

V-P DOLLARS

[redacted]

INVOICE DATE 7/24/92 INVOICE NO. [redacted] PAGE 1

NARCOTIC

*HAZARDOUS MATERIALS CODE CLASSIFICATIONS LISTED ON REVERSE SIDE

DEPT	ITEM NUMBER	QTY ORD	UN	ITEM DESCRIPTION	STORE RETAIL	UNIT PRICE	GP %	I D	CODE	EXTENS
				PAGE 1						
JB	1213933	1	EA	BANCAP HC CAP	500	309.23	254.80 17.6	1	B	254.80

[redacted]

NET PAYABLE BY STMT DUE DATE 254.80

GROSS PAYABLE AFTER STMT DUE DATE 260.00

LINES	CASES	PIECES
1	0	1

THIS INVOICE IS PAYABLE TO MCKESSON DRUG CO.
AT ABOVE ADDRESS. CLAIMS MUST BE MADE WITHIN FIVE DAYS AND SHOW DATE OF INVOICE.

CONTINUED

THIS IS TO CERTIFY THAT ABOVE NAMED ARTICLES ARE PROPERLY CLASSIFIED, DESCRIBED, PACKAGED, MARKED AND LABELED TO THE ADDRESS OF THE DEPARTMENT OF TRANSPORTATION

SSCN 06

9-1-93
SJ 11

INVOICE DATE 7/24/92 INVOICE PAGE 1

CONOTONE COST PLUS ORDER M NARCOTIC

*HAZARDOUS MATERIALS CODE CLASSIFICATIONS LISTED ON REVERSE SIDE

T	ITEM NUMBER	QTY ORD	UN	ITEM DESCRIPTION	STORE RETAIL	UNIT PRICE	DISC I X	D	CODE	EXTENS M
	1213933	1	EA	BANCAP HC CAP	500	309.23	18.59*		KB	18.59

SUBTOTAL	18.59
NET PAYABLE BY STMT DUE DATE	18.59
GROSS PAYABLE AFTER STMT DUE DATE	18.97

LINES	CASES	PIECES
1	0	

THIS INVOICE IS PAYABLE TO MCKESSON DRUG CO.
AT ABOVE ADDRESS. CLAIMS MUST BE MADE WITHIN FIVE DAYS AND SHOW DATE OF INVOICE

V-P DOLLARS

SENATE HEALTH & WELFARE
EXHIBIT NO. 12
DATE 2-1-93
BILL NO. SJ 11

AMEND SENATE JOINT RESOLUTION 11, 1ST READING

1. p. 1, line 12
Strike: lines 12 through 16
Insert:

WHEREAS, many pharmaceutical manufacturers sell the same drug at widely varying prices to different distributors, charging the highest price and making the greatest profit on drugs sold to community pharmacies; and

WHEREAS, classes of drug distributors other than community pharmacies do not often pass on most of their lower prices from pharmaceutical manufacturers but retain much of the differential as profit; and

WHEREAS, the simple principle of the Robinson-Patman Act, that seller's prices to different customers should not vary for other than good commercial reasons, would cure much of what is wrong with pharmaceutical pricing, were that Act not weakened by unduly broad exemptions; and

WHEREAS, the Congress has forced pharmaceutical manufacturers to rebate a portion of the excess profits they realize from differential pricing to the states' Medicaid programs, and these rebates have approached $2.8 million a year to the Montana Medicaid program; and

WHEREAS, extension of Robinson-Patman principles to all pharmaceutical pricing would extend similar benefits to all consumers; and

2. p. 2, line 1
Following: "legislation"
Strike: "regulating"
Insert: "extending the Robinson-Patman Act to (the pricing of drugs) by pharmaceutical manufacturers"

3. p. 2, line 2
Following: "drugs"
Insert: "by pharmaceutical manufacturers"

4. p. 2, line 9
Following: "Services"
Insert: "and to Senator David Pryor of Arkansas"

EXHIBIT NO. 13
DATE 2-1-93
EBA NO. SJ 11

Mario DE MODENA, dba Sixth Avenue Pharmacy, et al., Plaintiffs-Appellants,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants-Appellees.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., Plaintiff-Appellant,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants-Appellees.

Nos. 83-5720, 83-5721.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Nov. 7, 1983.

Decided Oct. 2, 1984.

Retail pharmacies and a nonprofit trade association to which some of them belonged brought separate antitrust actions against health maintenance organizations. Actions were consolidated and the United States District Court for the Central District of California, Irving Hill, J., and pharmacies appealed from a judgment. The Court of Appeals, Poole, Circuit Judge, 662 F.2d 641, reversed in part and vacated and remanded in part. Appeal was thereafter taken from an order of the United States District Court for the Central District of California, Irving Hill, J. The Court of Appeals, Norris, Circuit Judge, held that: (1) drug purchases made by health maintenance organizations for resale to their plan members were exempt from the Robinson-Patman Act; (2) remand was required for determination of whether sales of drugs to nonmembers, constituted de minimis violation of Robinson-Patman Act; and (3) pharmacies failed to establish attempted monopolization or a tying claim.

Affirmed in part, reversed in part, and remanded.

1. Trade Regulation ⇐911

Institution can qualify for nonprofit institution exception from Robinson-Patman Act liability if institution is a nonprofit institution, eligible under the Nonprofit Institutions Act, and made purchases in questions for "own use." Robinson-Patman Price Discrimination Act, 15 U.S.C.A. § 13c; Clayton Act, § 2, as amended by Robinson-Patman Price Discrimination Act and § 3, 15 U.S.C.A. §§ 13, 14.

2. Trade Regulation ⇐911

Fact that health maintenance organizations had to fulfill their need for certain medical services by contracting with doctors who sought a profit did not make the organizations themselves for-profit organizations which would have prevented them from falling within exception to the Robinson-Patman Act created by the Nonprofit Institutions Act. Robinson-Patman Price Discrimination Act, 15 U.S.C.A. § 13c; Clayton Act, § 2, as amended by Robinson-Patman Price Discrimination Act and § 3, 15 U.S.C.A. §§ 13, 14.

3. Trade Regulation ⇐911

Health maintenance organizations are "charitable institutions" within meaning of the Nonprofit Institutions Act. Robinson-Patman Price Discrimination Act, 15 U.S.C.A. § 13c.

See publication Words and Phrases for other judicial constructions and definitions.

4. Trade Regulation ⇐911

Drugs purchased by health maintenance organization for resale to its members were purchased for the health maintenance organization's "own use" within meaning of the Nonprofit Institutions Act and thus qualified for protection from the Robinson-Patman Act created by the Nonprofit Institutions Act. Robinson-Patman Price Discrimination Act, 15 U.S.C.A. § 13c; Clayton Act, § 2, as amended by Robinson-Patman Price Discrimination Act and § 3, 15 U.S.C.A. §§ 13, 14.

5. Trade Regulation ⇐911

Health maintenance organizations' sales of drugs to customers who were not members of the health plan were not protected by the Nonprofit Institutions Act; however, the sales would not be subject to the strictures of the Robinson-Patman Act if the sales were so minor as to be a de minimis violation of the Act necessitating remand for an evaluation of the impact of the nonexempt sales on competition in the retail drug market. Robinson-Patman Price Discrimination Act, 15 U.S.C.A. § 13c; Clayton Act, § 2, as amended by Robinson-Patman Price Discrimination Act and § 3, 15 U.S.C.A. §§ 13, 14.

6. Monopolies ⇐12(1.3)

To establish a claim for attempted monopolization, plaintiff must show that defendant had specific intent to monopolize the market, that there was a dangerous probability that the attempt might succeed, and that defendant committed acts designed to achieve illegal objective of creating a monopoly.

7. Monopolies ⇐28(7.5)

Retail pharmacies could not recover on claim that health maintenance organizations attempted monopolization in the retail drug market since only evidence offered showed merely that the organizations drove hard bargains with pharmaceutical companies and obtained best prices possible, and there was no evidence of predatory intent or that the organizations coerced pharmaceutical companies into harming retail pharmacies. Sherman Anti-Trust Act, § 2, 15 U.S.C.A. § 2.

8. Monopolies ⇐17(2.5)

To establish a tying claim, antitrust plaintiff must first demonstrate that defendant is selling two distinct products as a package and then must show that defendant has sufficient power in market for one product, the tying product, to encourage consumers to buy the tied product when they might not ordinarily do so.

9. Monopolies ⇐17(2.5)

Arrangement between a drug plan and basic health plan offered by health maintenance organizations did not constitute illegal tie-in since organizations did not require that one purchase drug plan to obtain the health plan.

10. Monopolies ⇐28(1.6)

Retail pharmacies lacked standing to challenge alleged arrangement of health maintenance organizations between health plan and drug plan since they were not competitors in market for the tied product of a health plan.

11. Monopolies ⇐17(2.5)

Drug plan and drugs provided under that plan were separate commodities for purposes of the Clayton Act; thus, retail pharmacies could not establish a tying claim against health maintenance organizations which provided drug plan and drugs. Clayton Act, § 1 et seq., 15 U.S.C.A. § 12 et seq.

12. Trade Regulation ⇐911

Drug purchases made by health maintenance organizations for resale to their members were exempt from the Robinson-Patman Act under exception created by Nonprofit Institutions Act. Robinson-Patman Price Discrimination Act, 15 U.S.C.A. § 13c.

Roger Tilbury, Portland, Or., for plaintiffs-appellants.

Jesse Grove, III, San Francisco, Cal., for defendants-appellees.

On Appeal from the U.S. District Court for the Central District of California.

Before BROWNING and NORRIS, Circuit Judges, and KING, District Judge.*

* Honorable Samuel P. King, Chief U.S. District Judge for the District of Hawaii, sitting by designation.

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NORRIS, Circuit Judge:

I. FACTS

Appellants are retail pharmacies located in Oregon and California. Appellees are the related corporations—including regional health plans, regional medical groups, and non-profit hospitals—that make up the Kaiser-Permanente Medical Care Program.

Appellees provide health care in a manner substantially different from the traditional fee-for-service method of health care in which a consumer pays a separate charge for each medical service or good provided by the doctor or hospital. The regional Kaiser Health Plans (HP's) contract with consumers who wish to become members and provide them with medical care in return for monthly dues. Each HP provides this care through two related organizations: Kaiser Foundation Hospitals, a California non-profit corporation which operates the Kaiser hospitals, and one of the eight regional Permanente Medical Groups. In addition, the HP's provide interested members with a "drug plan." Under this plan, for an additional monthly charge, members obtain the right to purchase drugs at little or no cost. They can purchase these pharmaceuticals at a Kaiser hospital or at a pharmacy at a non-hospital location operated by an HP.[1]

In this antitrust action, appellants advance three discrete claims concerning appellees' provision of drugs to HP members. First, they argue that appellees violated the Robinson-Patman Act, 15 U.S.C. § 13, by buying drugs at discriminatorily low prices from pharmaceutical companies and dispensing these drugs to HP members. Second, appellants maintain that appellees are attempting to monopolize the retail drug market in violation of section 2 of the Sherman Act, 15 U.S.C. § 2. Third, they contend that appellants violated section 3 of the Clayton Act, 15 U.S.C. § 14, by tying the sale of drugs to the sale of other health services.

Appellees moved for summary judgment below, and the district court granted the motion on all three claims.[2] Appellants then brought this timely appeal.

II. THE ROBINSON-PATMAN ACT CLAIM

The district court ruled that appellees were not liable for violating the Robinson-Patman Act—even assuming they bought drugs at discriminatorily low prices—because they fall within an exception to that Act created by the Nonprofit Institutions Act.

1. Before 1977, the Kaiser appellees were organized in a slightly different manner. The pharmacies located outside of the hospitals were not operated by the regional HP's but by regional Permanente Service Corporations. These nonprofit corporations were formed because the Internal Revenue Service stated that the regional health plans would not be considered charitable organizations under the Internal Revenue Code if they ran the pharmacies. The Permanente Service Corporations, however, returned all receipts to the HP's less costs and a rate of return on capital. The Service Corporations paid taxes on the amount allocated for rate of return on capital and then paid the amount remaining to the HP's.

In 1977, the Internal Revenue Service declared that its denial of charitable status to health plans which operated pharmacies was erroneous. The Service Corporations were then disbanded and control of their pharmacies transferred directly to the HP's.

Because the Internal Revenue Service stated that the Service Corporations should have been treated as charities for purposes of the Internal Revenue Code and because the Service Corporations engaged only in activities that the HP's currently engage in, we believe the analysis under the Robinson-Patman Act for sales by the Service Corporations is the same as that for sales by the HP's. Consequently, we will treat all sales at pharmacies located outside Kaiser hospitals as being sales made by the HP's even if some of those sales occurred before 1977 and were thus actually made by Service Corporations.

2. Actually, the summary judgment before us is the second one granted by the district court in this case. We reversed the first one—granted in 1978—on the ground that appellants should have received additional time for discovery before the motion for summary judgment was granted. *Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir.1981). On remand, the district court permitted discovery for as long as appellants requested.

[1] The Nonprofit Institutions Act provides, "Nothing in the [Robinson-Patman Act] shall apply to purchases of supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." 15 U.S.C. § 13c. Appellees can thus qualify for this exception if they are 1) non-profit institutions; 2) eligible institutions under the Act; and 3) made the purchases in question for their "own use."

A

[2] The HP's and Kaiser Hospitals are organized as non-profit institutions and would thus appear to meet the first of the Act's requirements. Appellants argue, however, that these institutions are not really non-profit because they are controlled by Permanente Medical Groups, which are for-profit corporations consisting of doctors who provide medical care for members.[3]

We disagree. Both the Internal Revenue Service and the district court found that the Medical Groups do not exert control over the HP's, and given the financial arrangements between the Medical Groups and the HP's, we believe that this conclusion is persuasive. The Medical Groups do not set their own fees. The HP's pay the Medical Groups an agreed upon amount per member per month, and this amount does not vary with the volume of service the group provides to the membership.[4] This fact greatly limits the amount of control the Medical Groups can exercise over the HP's. That the HP's and Kaiser Hospitals must fulfill their need for certain medical services by contracting with doctors who seek a profit does not make the HP's and Kaiser Hospitals themselves for-profit organizations.

B

[3] We next consider whether the HP's and Kaiser Hospitals are eligible institutions under the Nonprofit Institutions Act. With respect to Kaiser Hospitals this question is easily answered. The Act explicitly lists hospitals as eligible organizations. In the case of the HP's, however, the answer is not as simple. The Act does not explicitly list HP's. Thus, we must determine whether such organizations are charitable institutions within the meaning of the Act.

There is no case law concerning which institutions are considered charitable for purposes of the Nonprofit Institutions Act. There is, however, a substantial body of precedent defining the term charitable for purposes of the tax code and the law of charitable trusts. Because the drafters of the Nonprofit Institutions Act wished to protect the same eleemosynary institutions that are given special consideration under the tax and charitable trusts laws, *see* S.Rep. No. 1769, 75th Cong. 3rd Sess. 1 (1938); H.R.Rep. No. 2161, 75th Cong., 3rd Sess. 1 (1938), we believe it is appropriate to refer to these precedents here. Thus, we look to this body of case law for guidance in determining whether the HP's are charitable institutions within the meaning of the Nonprofit Institutions Act.

"The definition of the term 'charitable' has never been static and has been broadened in recent years." *Eastern Kentucky Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1286 (D.C.Cir.1974), *modified on oth-*

3. As already indicated, appellants assert a Robinson-Patman Act claim against all appellees, including the regional Permanente Medical Groups. The Medical Groups, however, do not sell drugs to members. Rather, they prescribe drugs which members purchase at one of the pharmacies operated by either an HP or Kaiser Hospitals. Because the Robinson-Patman Act governs only those who buy and sell at discriminatorily low prices, and not those who indirectly benefit from such purchases, *see* 15 U.S.C. § 13a, appellants' claim against the Medical Groups must fail.

4. A small portion of the payment to the Medical Groups—generally around five percent of the total payment—does not depend solely upon the number of members in the Medical Group's region. This portion is withheld by the HP and paid to the Medical Groups only if appellees meet their yearly financial goals. This system of payment is designed to give the doctors in the Medical Groups an incentive to keep costs low, and it is required by regulations promulgated pursuant to the Health Maintenance Organizations Act. 42 C.F.R. § 110.104(b)(1)(v).

er grounds, 426 U.S. 26, 96 S.Ct. 1917, 48 L.Ed.2d 450 (1976), *cited with approval*, *Abbott Laboratories v. Portland Retail Druggists Assn.*, 425 U.S. 1, 11, 96 S.Ct. 1305, 1313, 47 L.Ed.2d 537 (1976) (concept of the non-profit hospital has expanded over the years). In earlier times, health organizations were recognized as charitable only if they were supported primarily by donations and used those donations to provide health care for the indigent. *Id.* With the emergence of social welfare, insurance, and municipal hospitals, however, the number of poor requiring free or below cost medical services was drastically reduced. This reduction eliminated the rationale upon which the traditional, limited definition of charitable was predicated, resulting in a move towards a less restrictive interpretation of the term in recent years. *Id.* at 1288–89. Now all non-profit organizations which promote health are considered charitable under the law of charitable trusts. *Restatement (Second) of Trusts* § 368, at 246 (1959); G. Bogert & G. Bogert, *Law of Trusts* § 62 (1973). Further, a number of courts have specifically held that health maintenance organizations, such as the HP's, are charitable institutions for tax purposes. *Sound Health Ass'n v. Commissioner*, 71 T.C. 158, 177–81 (1978). Indeed, both the HP's and Kaiser Hospitals are exempt from income taxes as charitable institutions. Given this increasingly liberal interpretation of the term, we conclude that the HP's are charitable institutions within the meaning of the Nonprofit Institutions Act.

C

Finally, we must determine whether the purchases here in question were made for the HP's and Kaiser Hospitals' "own use."[5] Appellants contend that the HP's and Kaiser Hospitals purchased drugs not for their own use, but for the use of others, namely their members. Appellees contend, by contrast, that what they purchase for the use of their members is purchased for their "own use" within the meaning of the Act.

The "own use" issue is conceptually the most challenging aspect of this case because there is so little law in this area; the only relevant case is *Abbott Laboratories v. Portland Retail Druggists Ass'n*, 425 U.S. 1, 96 S.Ct. 1305, 47 L.Ed.2d 537 (1976). In *Abbott Labs*, the Court addressed the question whether sales of drugs purchased at discriminatorily low prices by non-profit, fee-for-service hospitals—hospitals which were not part of a health maintenance organization such as Kaiser—were exempt under the Nonprofit Institutions Act.

In resolving this question, the Court was torn between two competing concerns. On the one hand, the Court was interpreting an explicit exemption from the Robinson-Patman Act that reflected Congress' desire to aid non-profit institutions even when those institutions fulfilled needs beyond those traditionally fulfilled by charities. *Id.* at 13, 96 S.Ct. at 1314. On the other hand, the Court reiterated the maxim that exceptions to the Robinson-Patman Act are to be construed narrowly and emphasized that this exemption in particular was not "to be applied and expanded automatically to whatever new venture the nonprofit hospital finds attractive in these changing days." *Id.*

5. At this point, we can treat the HP's and Kaiser Hospitals as one organization for analytical purposes because whatever is in the "own use" of one part of a health maintenance organization would be in the "own use" of another. After all, whether a member purchases his drugs from a pharmacy run by a regional HP or one run by Kaiser Hospitals doubtless depends on the fortuity of which location is more convenient for the member.

Appellants argue, in effect, that we cannot consider the interest of Kaiser Hospitals in serving members because membership is a matter between the consumer and his regional HP and because the HP's and Kaiser Hospitals are distinct corporations. Appellant's Opening Brief at 12. But appellants have misapprehended the legal relevance of corporate structure. The cases they cite merely stand for the proposition that the presence of two or more corporations acting together is sufficient to satisfy the "combination, contract, or conspiracy" requirement which triggers the substantive provisions of section 1 of the Sherman Act.

The Court resolved this tension by formulating a test which it found "inherent in the language of the statute." *Id.* at 14, 96 S.Ct. at 1314. Under this test, " 'their own use' is what reasonably may be regarded as use *by the hospital* in the sense that such use is a part of and promotes the hospital's intended institutional operation in the care of persons who are its patients." *Id.* (emphasis in the original).

The Court applied this test to ten separate categories of drug sales. The Court exempted sales of drugs to in-patients, emergency room patients, and out-patients for use on hospital premises. The Court also exempted sales to both in-patients and out-patients for take home use, sales to hospital employees and students for their personal use or use by their dependents, and sales to the hospital's medical staff for their personal use or use by their dependents. The Court declined to exempt sales on prescription refills, sales to the hospital's medical staff for resale in private practice, and sales to walk-in customers who were not being treated at the hospital.[6]

Appellants ask us to adopt the categorical rules set forth in *Abbott Labs* wholesale and apply them to this case. This suggestion, however, ignores the manner in which these rules were originally derived and would, if adopted, violate the spirit, if not the letter, of the Supreme Court's decision. In *Abbott Labs*, the Court generated its categorical rules by first determining the basic institutional function of a non-profit, fee-for-service hospital and then deciding which sales fit within this institutional function and which did not. Thus, to follow the true mandate of *Abbott Labs* we should not simply adopt the categorical rules set forth in that decision, but should instead determine the basic institutional function of the Kaiser-Permanente Medical Care Program and then decide which sales are in keeping with this function.

[4] Health maintenance organizations (HMO's), such as Kaiser-Permanente, are designed to provide a complete panoply of health care to their members. *See* S.Rep. No. 129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S.Code Cong. & Ad.News 3033, 3040. *See generally II Report of the National Advisory Commission on Health Manpower* (1967). Whereas fee-for-service hospitals provide health care on a temporary and usually remedial basis to their patients, HMO's provide continuing and often preventive health care for their members. *See* 42 U.S.C. § 300e(b)(1)–(2) (describing a HMO's continuing obligations to its members). Given this extraordinary broad institutional function, any sale of drugs by an HMO to one of its members falls within the basic function of the HMO. Consequently, we must conclude that drugs purchased by an HMO, such as Kaiser-Permanente, for resale to its members are purchased for the HMO's "own use" within the meaning of the Nonprofit Institutions Act and thus qualify for protection under the Act.[7]

6. The language of the Nonprofit Institutions Act speaks only to purchases by institutions for their own use. It says nothing about sales by such institutions. *Abbott Labs*, however, implicitly decided that whether an item purchased at a discriminatorily low price was purchased for the institution's own use depends on whether and how the item was resold. *See generally* 3 E. Kintner & J. Bauer, *Federal Antitrust Law* § 25.9 (1983).

7. HMO's, such as the Kaiser-Permanente, can therefore engage in some sales that would not be allowed if we applied the ten categorical rules formulated in *Abbott Labs* to this case.

For instance, in *Abbott Labs*, the Court held that fee-for-service hospitals cannot purchase drugs at discriminatorily low prices if those drugs are sold to refill a prescription, even if the original prescription was filled as part of an exempt sale. 425 U.S. at 15–16, 96 S.Ct. at 1315. It appears that the Court declined to exempt prescription refills because the basic institutional function of a fee-for-service hospital is to provide temporary medical care for its patients. Refilling prescriptions goes beyond that basic institutional function because it extends the relationship between the fee-for-service hospital and the patient into the indefinite future. *Id.* at 16, 96 S.Ct. at 1315 (A prescription is not for the hospital's " 'own use' forever just because it originated under hospital auspices. We conclude that the statute's limitation has been exceeded when the connection with the hospital has become as attenuated as it is at the refill stage.").

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We believe that this result is in keeping with the intent of the 75th Congress which drafted the Nonprofit Institutions Act. Although the exact intent of Congress is less than crystal clear from a reading of the legislative history, *see* Rosoff & Dunfee, A "Fix" for the Retail Pharmacy: The Supreme Court Redefines Application of the Robinson-Patman Act to Drug Sales by Nonprofit Hospitals, 13 Cal.W.L.Rev. 195, 203 n. 35 (1977), at least one Justice has concluded that the Act was passed because "Congress was primarily interested in directly aiding nonprofit institutions by lowering their operating expenses, but not interested in indirectly aiding such institutions by providing them with the means of raising additional money." *Abbott Labs*, 425 U.S. at 23, 96 S.Ct. at 1318 (Marshall, J., concurring). If that principle is applied to this case, it supports a finding that all drugs purchased by an HMO for resale to its members fall within the Nonprofit Institutions Act. There can be no question that allowing HMO's to purchase drugs that are resold to members at lower prices directly helps the HMO by lowering the operating expense it must incur to provide this aspect of health care to its membership.

We also believe that a finding that drugs purchased by an HMO for resale to its members qualify for protection under the Nonprofit Institutions Act is in keeping with national health care policy. Under *Abbott Labs*, fee-for-service hospitals are exempted from the Robinson-Patman Act when they provide medicine to their patients. If we held that HMO's, such as Kaiser-Permanente, do not qualify for a similar exemption when they provide medicine for their members, fee-for-service hospitals would enjoy a market advantage over HMO's. Congress passed the Health Maintenance Organization Act in 1976, however, to ensure that consumers have a free choice among various methods of obtaining medical care because Congress believed that this was the best way to lower the medical costs that consumers must bear. S.Rep. No. 129, 93rd Cong., 1st Sess., *reprinted in* 1973 U.S.Code Cong. & Ad.News 3033, 3039–40. Accordingly, we decline to interpret the somewhat open-ended language of the Nonprofit Institutions Act in a way which would impinge upon the free choice of consumers of medical goods and services.

[5] Our conclusion that drugs purchased by HMO's for resale to members are purchased for the HMO's "own use" and thus qualify for protection under the Nonprofit Institutions Act does not dispose of appellants' Robinson-Patman Act claim, however. Appellees make some sales to walk-in customers who are not members of a Kaiser-Permanente HP. Under our analysis, those sales are not protected by the Nonprofit Institutions Act. Indeed, appellees concede that these sales are not for the HP's "own use" and thus are not covered by the Nonprofit Institutions Act. Nevertheless, appellees argue that these sales should not be subject to the strictures of the Robinson-Patman Act because the sales are so minor as to be a de minimis violation of the Act. The district court agreed with the appellees, citing to the fact that appellees' sales of drugs to non-members constituted less than one percent of appellees' total sales of drugs.

We do not believe, however, that a court can determine whether or not certain sales are de minimis solely by reference to the percentage of an organization's total sales they constitute. The term de minimis generally refers to the effect of a violation, not to the proportion of a party's conduct which violates the law as compared to that which does not. One percent of appellees' total sales might amount to a substantial dollar volume with a dramatic effect on the ability of the relatively small retail drug stores to compete. We, therefore, remand this case to the district court for an evaluation of the impact of appellees' non-exempt sales on competition in the retail drug market.[8]

As we explained in text, however, the relationship between an HMO and its members is ongoing, not temporary. The relationship thus does not attenuate simply because the member stepped out the door of an HMO hospital some time ago. The HMO is consequently acting within its basic institutional function when it refills the prescription of a health plan member.

III. THE ATTEMPTED MONOPOLIZATION CLAIM

[6] To establish a claim for attempted monopolization, a plaintiff must show that the defendant had a specific intent to monopolize the market, that there was a dangerous probability that the attempt might succeed, and that the defendant committed acts designed to achieve the illegal objective of creating a monopoly. *William Inglis & Sons Baking Co. v. ITT Continental Baking Co.*, 668 F.2d 1014, 1027 (9th Cir.1981), *cert. denied*, 459 U.S. 825, 103 S.Ct. 57, 58, 74 L.Ed.2d 61 (1982).

[7] We find that appellants failed to raise a genuine issue of material fact on the question whether the appellees engaged in acts designed to monopolize the market for retail drugs. The only evidence offered by appellants in opposing appellees' motion for summary judgment shows merely that the appellees drove hard bargains with pharmaceutical companies and obtained the best prices possible.[9] Appellants offered no evidence of predatory intent, such as proof that appellees coerced pharmaceutical companies into selling drugs to them below cost, or that appellees, in turn, sold drugs to their members below the cost of acquiring the drugs. Nor did appellants present any evidence that appellees coerced pharmaceutical companies into harming appellants. Accordingly, summary judgment was properly granted on this claim.

IV. THE TIE-IN CLAIM

[8] To establish a tying claim, a plaintiff must first demonstrate that the defendant is selling two distinct products as a package. He must then show that the defendant has sufficient power in the market for one product (the tying product) to encourage consumers to buy the other product (the tied product) when they might not ordinarily do so. *See Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641, 648 (9th Cir. 1981).

Appellants claim that appellees have made three such tying arrangements. All of these arrangements involve the drug plan that appellees sell to members. The first alleged tying arrangement is between the drug plan (the tied product) and the basic health plan (the tying product). The second is the converse arrangement between the health plan (the tied product) and the drug plan (the tying product). The third is between the drugs sold at appellees' facilities (the tied product) and the drug plan (the tying product).

[9–11] None of these contentions is meritorious. The first alleged arrangement is not an illegal tie-in because appellees do not require that one purchase the drug plan to obtain the health plan. Appellants have no standing to attack the second alleged arrangement because they are not competitors in the market for the tied product, health plans. *See Aurora Enterprises, Inc. v. National Broadcasting Co., Inc.*, 688 F.2d 689 (9th Cir.1982) (only con-

8. Appellees contend that they would cease sales to non-members if they were certain that doing so would not subject them to liability for violation of state licensing law, state tax law, or state rules of tort liability. This record, however, is not nearly sufficient to demonstrate that the operation of these state laws immunizes appellees' conduct under the standard for antitrust immunity set forth in *California Retail Liquor Dealer's Ass'n v. Midcal Aluminum*, 445 U.S. 97, 100 S.Ct. 937, 63 L.Ed.2d 233 (1980). Nor have appellees made clear why closing the pharmacies to non-members would violate federal tax law, as they assert in their brief.

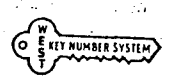
9. To bolster their attempted monopolization claim, appellants filled their opening brief with references to an affidavit by Howard Steinbach. The district court ruled, however, that the information in that affidavit was not admissible because the affidavit contained nothing but conclusory statements and hearsay. We agree with the district court's ruling on this point and consequently do not consider the Steinbach affidavit.

sumers and competitors in the market for the tied product have standing to bring suit). Nor can appellants succeed on their third contention because we have already rejected the theory that a drug plan and the drugs provided under that plan are separate commodities for purposes of the Clayton Act. *Klamath Lake Pharmaceutical Assn. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1288–90 (9th Cir.1983), *cert. denied*, — U.S. —, 104 S.Ct. 88, 78 L.Ed.2d 96 (1983).

V. CONCLUSION

[12] In sum, we affirm the district court's grant of summary judgment with respect to the claim of attempted monopolization and the tie-in claim. We also affirm the district court's conclusion that drug purchases made by appellees for resale to their members are exempt from the Robinson-Patman Act under the exception created by the Nonprofit Institutions Act. We reverse, however, the district court's determination that appellees' sales of drugs to non-members constituted a de minimis violation of the Robinson-Patman Act, and we remand to the district court for reconsideration of this question.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.[10]



10. Appellants also made an emergency motion to strike portions of appellees' Excerpt of Record. We took this motion under submission with the rest of the case.

The portion of the Excerpt of Record which appellants wish to strike served as an important basis for the district court's factual findings in this case. It was thus proper for appellees to include it in their Excerpt of Record. Consequently, appellants' motion is denied.

Charles C. LIVERMORE and Karen Conant, individually and on behalf of all others similarly situated, Plaintiffs-Appellees/Cross-Appellants,

v.

Margaret HECKLER, Secretary of Health and Human Services,* Defendant-Appellant/Cross-Appellee.

Nos. 83-5843, 83-5855.

United States Court of Appeals, Ninth Circuit.

Argued and Submitted Dec. 7, 1983.

Decided Oct. 2, 1984.

Class action was brought challenging calculation of social security income benefits for blind persons and state supplemental program benefits for mixed couples. The United States District Court for the Central District of California, A. Andrew Hauk, J., ruled in favor of plaintiffs on the first issue and in favor of government on second issue, and appeals were taken. The Court of Appeals, Schroeder, Circuit Judge, held that: (1) social security amendments of 1972 grandfathered in all more generous state income-counting rules from prior aid to the blind programs for those who had received benefits under them, and (2) in calculating state supplemental program benefits, for mixed couples, Secretary of Health and Human Services was required to use the prescribed income levels for eligible couples, not the prescribed income level for eligible individuals.

Affirmed in part and reversed in part.

Sneed, Circuit Judge, filed a dissenting opinion.

* Margaret Heckler has been substituted for Richard Schweiker pursuant to Fed.R.App. P. 43.

1. Social Security and Public Welfare ⇐175

In adopting the social security amendments of 1972 and provisions dealing with the calculation of income for blind recipients of supplemental security income who had been receiving amounts under a state plan which was more generous than that required under the federal aid to the blind programs, Congress required state rules to be used in SSI benefit calculation if they would lead to a more generous result for prior recipients who applied for SSI; statute "grandfathered in" all earlier more generous income-counting rules from prior state aid to the blind programs for those who had received benefits under them. Social Security Act, § 1611(h), as amended, 42 U.S.C.A. § 1382(h).

2. Social Security and Public Welfare ⇐175

Grandfather provisions contained in supplemental security income provisions were intended to avoid causing hardship to the blind under the new SSI program. Social Security Act, § 1611(g, h), as amended, 42 U.S.C.A. § 1382(g, h).

3. Statutes ⇐219(1)

Although courts must show great deference to the interpretation given the statute by the officers or agency charged with its administration, the court need not abdicate its own role in deciding questions of statutory interpretation; agency interpretations of statutes are important but they are not controlling in a court's decision.

4. United States ⇐125(18)

Provision of the Social Security Act authorizing judicial review is a broad waiver of sovereign immunity which authorizes injunctive and other relief and not merely prospective relief. Social Security Act, § 205(g), as amended, 42 U.S.C.A. § 405(g).

5. Federal Civil Procedure ⇐189

Because case involved a question of statutory interpretation in which the Secretary of Health and Human Services had taken a final position, so that further administrative appeals would be futile, class of plaintiffs could include plaintiffs who had not yet exhausted administrative remedies. Social Security Act, § 205(g), as amended, 42 U.S.C.A. § 405(g).

6. Social Security and Public Welfare ⇐175

Fact that state of California, in creating categories of recipients of state supplemental program benefits, did not create a category of mixed couples, i.e., couples in which one spouse was eligible but the other was not, did not require Secretary of Health and Human Services, when determining the amount of benefits for a mixed couple to subtract the combined income of mixed couples from the benefits available to an eligible individual; Secretary was required to use the benefit rate for eligible couples. Social Security Act, § 1616(b), as amended, 42 U.S.C.A. § 1382e(b).

Janet Isak Hawley, Baltimore, Md., for plaintiffs-appellees/cross-appellants.

Melinda Bird, Los Angeles, Cal., for defendant-appellant/cross-appellee.

Appeal from the United States District Court for the Central District of California.

Before SNEED and SCHROEDER, Circuit Judges, and CROCKER,** District Judge.

SCHROEDER, Circuit Judge.

Plaintiffs are blind California residents who now receive Supplemental Security Income Benefits (SSI) under 42 U.S.C. §§ 1381–1383c and who, before 1974, received aid under aid to the blind provisions of the Social Security Act, 42 U.S.C. §§ 1201–1206 (1970) (repealed). The SSI benefit for each plaintiff is the difference between the individual's countable income and a standard benefit rate. In this class

** Honorable M.D. Crocker, Senior United States District Judge for the Eastern District of California, sitting by designation.

SENATE HEALTH & WELFARE
EXHIBIT NO. 14
DATE 2-1-93
BILL NO. SJR 11

Madam Chairperson - Members of the Public Health, Welfare & Safety Committee

I am Verner Bertelsen, today I am representing the Montana Legacy Legislature. Legacy Legislature strongly supports S.J.R. 11 calling for control of the pricing of prescription drugs.

Out of the 14 resolutions passed by Legacy Legislature this was their no 1 priority - Seniors of Montana find themselves daily reminded of the oppressive cost of prescription drugs. Many are spending over $100 per month for prescription drugs and some far more - In my own case my wife was spending over $200 per month on prescription drug -

This would perhaps not be quite as disturbing if all evidence did not point to exhorbitant increases in the price of drugs and exhorbitant profits for the pharmaceutical companies. It appears that this may be an opportune time for such a resolution since the new administration seems inclined to lend a sympathetic ear to the problem.

For those who might not be familiar Montana Legacy Legislature -

Exhibit 14
2-1-93
SS-11

from these measures -

Please be aware that all of this was accomplished under a unicameral legislature and in a period of 3 days -

May I again reiterate that of all the problems facing Montana seniors certainly the oppression each of them is under is one of the greatest - Please support H.J. R.11 -

I thank you -

Vernon L. Bertelsen
Lobbyist
Mt. Legacy Legislature
1800 Vienna Ave. Helena
442-3279

It is an organization formed by senior citizens from all over Montana — Montana is divided into several districts from which representatives and senators are elected. These representatives come to Helena for a legislative session in which they consider bills which are presented from all over the state. Separate committees are formed to consider these bills. Those which are passed are presented to the full assembly for their action. They passed 18 bills & 14 resolutions and the selected those private legislation

DATE 2-1-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 118, SB 166, SJ 11

Name (please print)	Representing	Bill No.	Check One: Support	Oppose	other
Verner Bertelsen	Legacy legislature	J.R. 11	✓		
Mike Craig	AITS	SB 118			
Helena Lee	Children Assist Budget	SB 166	X		
Janet Bauer	MT Occ Ther Assn	SB 166	X		
Lynn Davis	O.T. Licensing Board	SB 166	✓		
Mary Churchill	MT O.T. Assn	SB 166	✓		
Becki Kasa	MT. O.T. Assn	SB 166	✓		
Connie L. Hamm	MT OT Assoc	SB 166	✓		
KARLA OAKE	MT OT ASSN	SB 166	✓		
Margo Krenik	MT OT ASSOC	SB 166	✓		
Doug Blakey	Office on Aging	SB 118			X
Gail Wheatley	MT Phys Ther Assoc	SB 166	✓		
Kirk Hanson	MT Assoc Priv Sec PT	SB 166	✓		
Kathy Hill	MT PT ASSOC	SB 166	✓		
Linda Botten	OT ASSOC.	166	✓		
Mona Jamison	Lobbyist MCAPTA	SB 166	✓		

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

DATE 2-1-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 118, SB 166, SJ 11

Name	Representing	Bill No.	Check One Support	Oppose
Bonnie Tippy	MT State Pharmaceutical Assn	SJ 11	✓	
Roger Tippy	MT St Pharmacy Assn	SJ 11	—	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

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