MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By J.D. Lynch, Chair, on February 12, 1993, at 10:00 a.m.

ROLL CALL

Members Present:

Sen. J.D. Lynch, Chair (D)
Sen. Chris Christiaens, Vice Chair (D)
Sen. Betty Bruski-Maus (D)
Sen. Delwyn Gage (R)
Sen. Tom Hager (R)
Sen. Ethel Harding (R)
Sen. Ed Kennedy (D)
Sen. Terry Klampe (D)
Sen. Francis Koehnke (D)
Sen. Kenneth Mesaros (R)
Sen. Doc Rea (D)
Sen. Daryl Toews (R)
Sen. Bill Wilson (D)

Members Excused: None.

Members Absent: None.

Staff Present: Bart Campbell, Legislative Council
Kristie Wolter, Committee Secretary

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

Committee Business Summary:
Hearing: SB 331
Executive Action:

HEARING ON SB 331

Opening Statement by Sponsor:

Senator J.D. Lynch, Senate District 35, opened on SB 331, stating it is a legitimate bill which requires and asks for a "willing provider" which was passed in the legislature 2 years ago. He went over the background of the "willing provider". He stated in 1991, the Insurance Commissioner brought before the Business and Industry Committee a "house cleaning" bill. He stated there was a section (Section 16) in the old bill which was a controversial

item. He stated Section 16 said there ought to be, for the public interest, a "willing provider" clause in the law, so Preferred Provider Organization's (PPO's) would not be able to overpower competition. He stated the old bill was amended, and section 16 was removed so it could pass Committee. He and Senator Gage then drafted SB 331 which would allow for a "willing provider". Senator Lynch stated Blue Cross/Blue Shield (BCBS) and Deaconess Hospital entered into an agreement which stated all people under the insurance plan of BCBS would receive a reduction if they used the Deaconess. Senator Lynch stated the opposing hospital should have had an opportunity to review the agreement and place a bid. Senator Lynch stated SB 331 would address the consumer, allowing him or her to have a choice as to where they want to go for treatment. Senator Lynch stated the "willing provider" clause would allow the person seeking medical help to go where they want without having to pay extra. Senator Lynch stated the problem with PPO's is the radius to which they can extend, and they could possibly put the small town hospitals out of business. He stated the "willing provider" is a fair issue and it won't increase medical costs.

Proponents' Testimony:

Tom Ebzery, Saint Vincent Hospital, stated SB 331 is not "one hospital against another." He stated Saint Vincent is not opposed to manage care, but how it is used. He stated the Healthlink program was an exclusive agreement between BCBS and Deaconess Hospital (Exhibit #1). He stated BCBS did not seek bids from providers in the community or offer to negotiate with available hospitals or offer to contract with anyone other than Deaconess hospital. He stated BCBS would not allow Saint Vincent's to participate, even though St. Vincent's was able to agree to the same terms of the contract as Deaconess. He stated the "willing provider" statute states:

> "If another provider is willing to meet the terms and conditions of the established PPO, they may do so."

Mr. Ebzery stated Governor Stephens had added an amendatory veto which read:

> "The objectives of SB 256 are laudable, allowing willing providers the need for turning positions established in PPO agreements. The effect, however, of this bill on health care costs is unknown."

Mr. Ebzery stated St. Vincent went to court to obtain the agreement between BCBS and Deaconess after St. Vincent tried to approach BCBS and attain a PPO. The District Court stated there was no retroactivity clause written into the statute and there was no statutory language saying the legislation applied to the agreement which was in place at the time of the statute. Mr. Ebzery stated SB 331 will apply to agreements which were entered

into prior to the effective date of the 1991 amendments. He supplied the Committe with a sheet of premiums by the various health care insurance providers (Exhibit #2). He supplied the Committee with written testimony in support of SB 331 (Exhibit #3)

David Cunningham, CEO, Rimrock Foundation read from prepared testimony in support of SB 331 (Exhibit #4).

Ron Burnam, physician and President of Montana Associated Physicians, stated the concern of physicians is the lack of choice given to the consumer without the willing provider act. He stated the PPO's cause a restriction of the ability of the physicians to practice in a location which is efficient and convenient for the physicians. He stated physicians have reasons for choosing one provider over another, but may be forced into a relationship in which they aren't happy for financial reasons. He stated SB 331 would protect the patient's right to choose while meeting the objective of lowering health care costs because the terms of the contract would be the same for all participants. He stated the offering of a choice to the client would enhance the attractiveness of the program and improve its salability. He stated since the Healthlink program is closed, nobody can say it is saving any money. He stated there is concern BCBS will allow the HMO's to have a closed panel of doctors.

Paul Hanson, CEO Bighorn County Memorial Hospital and Nursing Home, stated he supported SB 331. He stated every provider should have the opportunity to compete for available health care contracts, which may reduce the costs of available health care services to the Montana residents. He stated without SB 331, insurance companies could develop exclusive rule networks. He stated exclusive PPO's may increase referrals of patients away from rural hospitals to urban hospitals and jeopardize the life of many rural hospitals. He stated the smaller hospitals have no control over negotiations with large insurance companies which has a PPO with a larger hospital because of volume reasons.

Jim Smith, Montana Psychological Association, expressed his support of SB 331. He stated psychologists are willing to compete, but would not like to see others "squeezed out" by a dominant carrier.

Jerry Jurena, Administrator, Trinity House and Faith Lutheran Home, Wolf Point, read from prepared testimony in support of SB 331 (Exhibit #5).

Bonnie Tippy, Montanan State Pharmaceutical Association, expressed her support of SB 331. She stated PPO's leave pharmacies out of agreements and could effect competition and price control.

Larry Curran, Saint James Hospital, Butte, stated his support of SB 331 for the same reasons as the previous proponents. He

stated SB 331 would be legislation for today and the future of health care.

Jerry Loendorf, Montana Medical Association, stated his concern was rural health care. He stated the report of health care for Montana, issued October 7, 1992, indicates there are 26 counties with 3 or fewer physicians and 9 counties with no physician at all. He stated the PPO's could make it such that these counties lose their physicians.

Mona Jameson, Montana Chapter, Physical Therapy Association, stated her support of SB 331. She stated SB 331 was a consumer bill because it allowed for competition, access and choice.

Jerry Connelly, Physical Therapist, spoke from prepared testimony in support of SB 331 (Exhibit #6).

Mary McEwen, Montana Clinical Mental Health Counselors, stated her support of SB 331 for the reasons already stated. She added that in the mental health field it is important for the patient to have a choice of their counselor because of the relationship between the patient and the therapist.

Jim Paquette, President and CEO, Saint Vincent Hospital stated he felt strongly in support of SB 331.

Pat Melvey, Rimrock Foundation, stated his support of SB 331.

Opponents' Testimony:

Cal Winslow, Montana Deaconess Hospital, stated SB 331 is like "stopping a train wreck from happening with a hundred cars full of manure." He stated health care reform would not happen without some changes and some pain. He stated there would be no savings to the employer trying to supply health insurance without PPO's. He stated there are two bills which address health care reform in the 1993 legislature. He stated one of them addresses workers compensation and is sponsored by Senator Harp (SB 347). He stated SB 347 calls for "managed care in the area of workers compensation". He said the bill reads as follows:

> "Preferred Provider Organizations - In order to promote cost containment of medical care provided for development of PPO's by insurers is encouraged."

Mr. Winslow stated Senator Franklin's bill stated "managed care has got to be encouraged." He stated PPO's address the issues of the uninsured, and if the competition wants to have a say in the matter, they should arrive at a better arrangement. He stated PPO's would not hurt rural hospitals, because the PPO is in Yellowstone County and has no impact on anyone outside of the county. He stated PPO's didn't hurt St. Vincent's and added St. Vincent's had the best year they have had in history. He stated

BCBS would not be hurt by the deletion of PPO's. Mr. Winslow stated SB 331 would injure 200 employers in Yellowstone County, and 12,000 people who have reduced rates because of negotiations. He stated SB 331 is "anti-consumer and anti-business." He stated the proponents are concerned about what might happen with managed care and the "potential shift" of business.

Gordon Englert, Employee Benefits Coordinator, Yellowstone County, stated he opposed SB 331. He stated SB 331 doesn't address rural America; it is limited to Billings. He stated there are substantial reductions because of participation in PPO's. He stated because of Healthlink, there has been a 40%-50% reduction in claims in the first two years of the program. He stated he was speaking on behalf of the consumers and the employers who can no longer afford to pay the premiums. He stated SB 331 would provide no incentive for the preferred hospital or organization to offer reduced rates. He stated the concept behind PPO's is to gain "market share".

Warren Patrick, Tire Rama, stated he was a consumer of Healthlink, and it had afforded him savings of 12% over the past two years. He stated the savings have been passed on to his 200 employees. He stated he supported SB 331.

Steve Turkiewicz, Executive Vice President, Montana Auto Dealers Association (MADA), stated the employees in his corporation cannot afford the premiums on their health care policies. He stated MADA set up a PPO and one of the consumers in his association lodged an FTC complaint, claiming anti-trust action of the MADA. He stated SB 285 enabled "health care providers and consumers to enter into agreements involving lower costs, or greater access or quality than otherwise available." He stated Senator Yellowtail's bill (SB 267) allows for purchasing pools to collectively contract with providers for discounts. He stated HB 508 calls for basic and standard health benefits plans, both of which must include selective contracting with hospitals, physicians and other health care providers. He stated SB 347 calls for the formation of PPO's to control costs. He stated all the efforts for reform would be undermined by SB 331.

Chuck Butler, Blue Cross/Blue Shield, spoke from and provided prepared testimony on SB 331 (Exhibit #7). He read from a letter to the Attorney General (Exhibit #8) and supplied charts (Exhibit #9).

Bob Doolen, Senior Vice President, Deaconess Hospital Association, stated SB 331 is an anti-consumer proposal. He stated reform is going to come from new kinds of relationships with the providers, such as PPO's. He stated SB 331 would not apply to the larger employers who are in self-funded groups. He stated there was a need for the free enterprise system and open competition among health care providers by giving consumers and employers an opportunity to control their health care costs.

Tom Hopgood, Health Insurance Association of America, stated he opposed SB 331 said he would be available to answer questions from Committe members.

Larry Akey, Montana Association of Life Underwriters, stated he opposed SB 331.

Richard Jacobs, Controller, Trucking Company, Billings, stated he was in support of PPO's and opposed SB 331.

Clyde Bailey, Executive Director, Montana Senior Citizens Association, stated he opposed to SB 331.

Greg Van Horssen, State Farm Insurance Company, stated he opposed SB 331.

Questions From Committee Members and Responses:

Senator Kennedy asked Mr. Butler what the cost to a consumer would be if they decided not to utilize their PPO. Mr. Butler stated the consumer would have a 25% cost savings if they use the Deaconess.

Senator Lynch asked Mr. Winslow if a person who works for the city got to choose which provider they preferred when the agreement was entered into. Mr. Winslow stated the company made the decision, not the employee.

Senator Lynch asked Mr. Hopgood what he would like to add to the hearing. Mr. Hopgood stated the PPO law is intended as a cost containment measure which was developed by the National Association of Insurance Commissioner (NAIC). He stated the law is in effect in many other states without the "willing provider" language in it, and there has been no evidence the legislation has driven anyone out of business in any of the states.

Senator Rea asked Mr. Butler if a person who had employees all over the state could use a different hospital than St. Vincent's. Mr. Butler stated the Healthlink program is limited to the Billings and Yellowstone county area.

Senator Christiaens asked Mr. Turkiewicz if the PPO agreement was "asking for an anti-trust suit." Mr. Turkiewicz stated he could not answer the question.

Senator Lynch asked Mr. Butler when BCBS entered into the deal with Deaconess Hospital if they approached St. Vincent's and asked them for a bid. Mr. Butler answered "no."

Senator Christiaens asked Mr. Butler if there was a "bidders conference" between the two hospitals. Mr. Butler stated a "bidders conference" was not needed in the Billings area at the time of the arrangement.

Senator Klampe asked Mr. Winslow to clarify the terminology in the letter which stated, "The PPO's can enhance the choice of providers" and define the difference between HMO's and PPO's. Mr. Winslow stated a HMO is an organization where the participant pays a fee and is placed in a group, and the practice is done in the group. He stated a PPO is an arrangement with a preferred provider for market share and to offer discounts. Mr. Winslow deferred the question on the terminology regarding the PPO's to Mr. Butler. Mr. Butler stated a PPO would allow insurance companies to negotiate the best deal with a provider. He stated the consumer may make a choice as to whether they want to take advantage of the cost savings.

Senator Toews asked Mr. Patrick if he would be willing to work with a PPO without a willing provider clause, and cut the original PPO by 5%. Mr. Patrick stated he would be willing to bid on such an arrangement.

Senator Gage asked Mr. Doolen how long the average PPO contract lasts. Mr. Doolen stated they lasted three years. Senator Gage asked Mr. Doolen what happens when the contract expires. Mr. Doolen stated he wasn't sure because of pending legislation.

Senator Gage asked Mr. Butler for a comparison of rates between 1991 and 1993 and from those under a PPO agreement and those not under such an agreement. Mr. Butler stated he would find the information and get it to Senator Gage. Senator Gage stated he felt the people not under PPO's were subsidizing the PPO's.

Senator Gage asked Senator Lynch about the sunset clause on the 1991 legislation. Senator Lynch stated Governor Stephens had placed the sunset provision on the bill after it had passed both houses. Senator Gage asked what the vote was on the original legislation. Senator Lynch stated the original legislation passed 38 to 12 in the Senate and 83 to 17 in the House.

Senator Gage asked Carol Roy, State Auditors Office. if BCBS gets service fees for medicaid or other areas which they don't write services for. Ms. Roy stated BCBS has 48% of the market in 1991 for strictly insured plans only.

Senator Mesaros asked Mr. Butler if there were any other PPO's in Montana other than the one in Billings. Mr. Butler stated there were, and one of them was BCBS which was for the Federal employees. Senator Mesaros asked for clarification on whether the problem was specific to the Billings area. Mr. Butler stated the willing provider law was passed and there were no other hospitals interested except in the Billings area. Mr. Butler added the "willing provider" law in Indiana is under repeal at the current time.

Closing by Sponsor:

Senator Lynch stated BCBS made themselves out to be an "insignificant insurance company in Montana" and that was not true. He stated BCBS has such control, there is "nobody in the ball game" with them. He stated the comparison is the same as St. Patrick's grade school playing the Dallas Cowboys. He stated SB 331 would allow for competition because it would allow competitors to come into the market. He stated the intent of the original legislation was the same as SB 331, but BCBS found loopholes. He stated SB 331 addressed all of Montana, including rural Montana. He stated BCBS would take advantage of the law as it now stands and make the competition obsolete. He stated if the PPO's put everyone else out of business, they would have complete price control. He stated there have been PPO's put into effect since the 1991 legislation. He stated he was a consumer and in favor of SB 331 because it is "pro-consumer" and he asked the Committee for a Do Pass recommendation.

ADJOURNMENT

Adjournment: 11:50 a.m.

SENATOR J.D. LYNCH, Chair

KRISTIE WOLTER, Secretary

JDL/klw

ROLL CALL

SENATE COMMITTEE Business & Industry DATE 2/12/93

NAME	PRESENT	ABSENT	EXCUSED
Senator Lynch	✓		
Senator Christiaens	✓		
Senator Bruski-Maus	✓		
Senator Gage	✓		
Senator Hager	✓		
Senator Harding	✓		
Senator Kennedy	✓		
Senator Klampe	✓		
Senator Kuehnke	✓		
Senator Mesaros	✓		
Senator Rea	✓		
Senator Toews	✓		
Senator Wilson	✓		

FC8

Attach to each day's minutes

Billings Gazette May 5, 1991

Health-insurance law in effect

Healthlink partnership may be forced to include rival St. Vincent Hospital

By PAT BELLINGHAUSEN
Of the Gazette Staff

An exclusive partnership between Deaconess Medical Center and Blue Cross and Blue Shield of Montana may have to expand to include St. Vincent Hospital.

A new law requires "preferred provider organizations" to include every "willing" hospital — not just one.

Senate Bill 256, signed into law last week by Gov. Stan Stephens, is designed to protect consumers, according to State Auditor Andrea Bennett, who proposed the legislation. Most other states have similar laws, she said.

The bill was a direct response to gripes against Healthlink, the preferred provider organization (PPO) launched last summer in Billings. Healthlink offers businesses reduced Blue Cross group insurance rates because of negotiated fees with Deaconess. Employees covered by Healthlink receive reimbursement for a higher proportion of their hospital bills when they go to Deaconess. The plan will pay less if these employees go to another hospital for care they could have received at Deaconess.

"We had all kinds of consumer complaints," Bennett said Friday in a telephone interview from Helena. She received calls from people who wanted to go to Catholic St. Vincent Hospital because of their religion, from people worried that St. Vincent would go out of business, and from smaller hospitals complaining that they might close because Healthlink was drawing away patients.

Blue Cross and Blue Shield writes about 50 percent of the private health insurance sold in Montana, making it the state's largest insurance carrier, Bennett said.

"It was my fear that they also would become the largest provider of health care," she said. "It was my fear that they would corner the market."

The Gazette was unable to reach the Blue Cross in Helena Friday for comment.

St. Vincent Hospital lobbied for SB 256. Deaconess lobbied against it. Each hospital maintained that its position is in patients' best interest. "We believe it's an anti-consumer bill," Bob Doolen, Deaconess senior vice president for administration and finance, said Friday. "It would tend to take away competition."

Healthlink has become a successful product for Blue Cross, James Carlson, the company's Billings manager said recently.

It now covers 6,000 Yellowstone County people in contracts with more than 200 employers, Carlson said recently. The insurance plan is available only in Yellowstone County, a condition required by Deaconess to avoid drawing patients from small hospitals in outlying areas.

Carlson said Blue Cross has offered Healthlink to groups of three to 25 employees at a discount of 13.8 percent over its regular small group rates. The Healthlink discount for larger groups varies from 10 percent to 15 percent.

Most Healthlink accounts are employers who switched from conventional Blue Cross plans, but "there's been a fair amount of new business that's been written, too," Carlson said. The county, for example, switched from another insurance carrier to Healthlink.

Deaconess is pleased with Healthlink, Doolen said. Blue Cross has done a good job marketing the new product, and there are more Healthlink participants than Deaconess expected. Doolen said the hospital is analyzing information on Healthlink, but expects that it has brought in more patients because of the number of participants.

Yellowstone County itself is Healthlink's largest customer. County risk manager Gordon Englert said last week that the plan has saved the county more than $100,000 since it began on June 1, 1990. "We projected about a 15 percent savings in overall coverage. Based on 10 months' experience, that is about what we're saving."

The County Commission contracted with Healthlink last year and could seek new bids again this year. "We don't see any reason to at this point," Englert said.

Englert said most county employees have used Deaconess for their hospital care, but some have chosen St. Vincent.

Ever since Healthlink started, St. Vincent has offered to adjust charges so patients wouldn't have any higher out-of-pocket expense at St. Vincent than they would at Deaconess.

Because Healthlink pays St. Vincent less, the hospital writes off the difference — about $1,000 on a $5,000 bill, which is the "average discharge" — according to Mark Burzynski, vice president for finance.

"We've probably kept 150 patients we would have lost," Burzynski said. "We have lost 150 patients. We have 300 affected patients we can track.

"This is expensive for us," Burzynski said. "But it helps us cover our overhead. Our average discharge is worth $5,000. You just can't let that kind of business go down the street."

PPOs are a creation of the '80s trend toward managed care in health insurance. They usually involve a contract between an insurer and health care providers who agree to provide certain services for a negotiated fee.

The number of PPOs operating in the United States grew from 572 in 1987 to 685 in 1989, according to the Health Insurance Association of America. A few PPOs went into business in the Northern Great Plains states, but later ceased operations. No PPOs were listed in Wyoming, Montana, Idaho or the Dakotas as of 1989.

A PPO can involve various types of health care providers, including hospitals and doctors. The new Montana law will apply to all PPO arrangements, but the legislative debate focused on Healthlink, which has Deaconess as its only preferred provider. Healthlink participants can go to any doctor and receive the same coverage they'd get under any other Blue Cross plan.

Although SB 256 clearly applies to all new PPOs, interpretations may vary about how it might affect Healthlink because it was in business before the law was enacted. Burzynski at St. Vincent said legislators intended for the measure to apply to Healthlink.

Auditor Bennett said the new law wouldn't require any change in the Deaconess-Blue Cross agreement, but would require Blue Cross to offer the same arrangement to St. Vincent.

Before the governor signed SB 256, he added one amendment: a sunset in 1993. The preferred provider issue could be debated again in the next Legislature.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 1
DATE 2/12/93
BILL NO. SB 351

ACCIDENT & HEALTH

RANK	INSURER NAME	1991 DIRECT A & H PREMIUMS WRITTEN IN MT
1.	Blue Cross/Blue Shield of MT	$158,119,053
2.	Principal Mutual Life Ins. Co.	13,562,280
3.	Prudential Ins. Co. of America	13,042,939
4.	Bankers Life & Casualty Co.	9,987,173
5.	Mutual of Omaha Ins. Co.	7,997,477
6.	John Alden Life Ins. Co.	7,393,046
7.	State Farm Mutual Auto In. Co.	7,135,502
8.	Federal Home Life Ins. Co.	6,812,720
9.	Travelers Ins. Co. (Life Dept.)	6,355,878
10.	United of Omaha Life Ins. Co.	6,080,778
11.	Capitol American Life Ins. Co.	3,613,162
12.	CUNA Mutual Ins. Society	3,427,671
13.	Pioneer Life Ins. Co. of Illinois	3,345,364
14.	Combined Ins. Co. of America	3,257,438
15.	Universe Life Ins. Co.	3,001,386
16.	Equitable Life & Casualty Ins. Co.	2,792,088
17.	Union Bankers Ins. Co.	2,757,315
18.	United American Ins. Co.	2,514,895
19.	Life Investors Ins. Co. of America	2,450,241
20.	Physicians Mutual Ins. Co.	2,379,671
21.	Lincoln National Life Ins. Co.	2,235,824
22.	Safeco Life Ins. Co.	2,190,013
23.	New York Life Ins. Co.	2,107,471
24.	American Travellers Life Ins. Co.	2,006,186
25.	Standard Life & Accident Ins. Co.	1,948,948

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 2
DATE 2/12/93
BILL NO. SB 331

TESTIMONY OF ST. VINCENT HOSPITAL - SB 331
SENATE BUSINESS & INDUSTRY COMMITTEE
FEBRUARY 12, 1993

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 3
DATE 2/12/93
BILL NO. SB 331

Mr. Chairman and Members of the Committee:

I am Tom Ebzery from Billings and as in 1991, I represent St. Vincent Hospital.

A review of the minutes of the 1991 hearings in both the House and Senate show strong support from hospitals (with one exception) physicians, and other providers. This strong group of providers is back here again--dispelling the myth that this is a 2-hospital bill.

My testimony is designed to provide information as to what has occurred since 1991 and to respond to questions or statements raised by Blue Cross and Deaconess Hospital which are probably well ensconced in waste baskets all over the capitol.

What is this bill about?

In 1987, the Montana Legislature passed the Preferred Provider Agreements Act. That law permits health care insurers to enter into agreements with health care providers in which the providers accept negotiated fees as payment for services.

On May 1, 1990, Blue Cross entered into a preferred provider agreement with Deaconess Medical Center of Billings, Inc. The contract is known as HealthLink.

Blue Cross/ Blue Shield did not seek bids from providers within the community, offer to negotiate with available hospitals or ultimately offer a contract to St. Vincent Hospital. Even after the program was announced, Blue Cross/Blue Shield refused

to discuss Saint Vincent's participation in it. Instead, Blue Cross, the dominant health care insurer in the market, carved out Saint Vincent from HealthLink. Saint Vincent and Deaconess are the two major hospitals in Billings, Montana.

Concerned about the exclusive nature of preferred provider agreements, the 1991 Montana Legislature enacted Chapter 714, Laws of 1991 (Senate Bill 256), adding the willing provider amendment. The Willing Provider Amendment was taken from the Indiana statute and states basically if another provider is willing to meet the terms and conditions of the established PPO, he may do so. After strong votes in both the House and Senate, then Governor Stephens added an amendatory veto. Let me quote a bit from his message.

> The objectives of SB 256 are laudable; allowing willing providers to meet the terms and conditions established in Preferred Provider Agreements, the effect of this bill on health care costs is unknown.
>
> SB 256 also raised several fundamental issues about health care in Montana such as access to high quality health care services in rural communities, the role of preferred agreements in controlling health care costs and the effect of Preferred Provider Agreements on rural communities. Because of the importance of these issues it is appropriate to evaluate the impact of this bill after two years.

What happened next was that on May 6, 1991, St. Vincent Hospital informed Blue Cross of its desire to participate as a willing provider in HealthLink. Blue Cross refused to even show them the agreement.

St. Vincent went to court to obtain the agreement and the District Court remarkably held that despite clear legislative intent on what this bill was to correct, the statute didn't specifically state that this law applied to existing agreements. Our second feature of the bill is found on page 5 with a curative provision clearly stating that this willing provider amendment apply to agreements entered into prior to

Exhibit #5
2-12-93
SB-331

the effective date of the 1991 amendment--in essence a "retroactivity clause."

When Blue Cross/Blue Shield declined to show the agreement, it highlighted a problem that needed to be addressed. How does a potential willing provider know if he wants to participate if he cannot review the terms and conditions? Thus the language on page 3, lines 18-35 and page 4, line 1.

Has the Willing Provider Amendment resulted in higher health costs? Absolutely not--it hasn't been given a chance to work.

Should other providers be concerned about exclusive PPOs? The answer is a resounding yes, so long as a single dominant insurance carrier has the potential to carve out hospitals, physicians, chemical dependency centers and other providers. That is why this bill is before you.

Is this bill anti-competitive? No. Blue Cross talks about competition--Did it bid HealthLink competitively? No. Just who is anti-competitive?

In its brief to the court, lawyers from Blue Cross referred to HealthLink as the "freedom of choice" program. I ask you what kind of "freedom" one has: Use Deaconess only or not get a discount on premiums. That's freedom of choice?

Does this language chill the incentive to do PPOs? Absolutely not. St. Vincent and others have entered into PPOs over the past two years knowing full well that those agreements were subject to willing provider language.

Although 12,000 people in Yellowstone County may be participating in HealthLink--this is out of over 125,000 in the county--this ignores the fact that probably double that number would participate if both hospitals were involved.

Exhibit 3
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If opponents to the bill state that a subcommittee last year recommended that the Willing Provider Amendment sunset--I only respond that its action was taken with little debate, the recommendation was ignored by the full steering committee, and was not recommended by the Governor last October.

In summary, this law needs a chance to work: It is necessary and a safeguard that providers will not be placed in jeopardy by one dominant insurer.

RIMROCK FOUNDATION®

Leading Quality Addiction Treatment in the Northern Rockies

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 4
DATE 2/12/93
BILL NO. SB 331

TESTIMONY
SB 331, Preferred Provider
David W. Cunningham
Chief Executive Officer

Two short years ago the Montana legislature listened to the testimony of healthcare providers like Rimrock Foundation and understood just how important it is to the delivery of rural healthcare that all providers have the opportunity to deliver the most cost effective care they can. You refused at that time to allow healthcare monopolies because you could see the potential destructiveness to our system of healthcare in this state.

This bill before you today is also about free competition. It says that lower cost healthcare providers will be allowed to compete in the healthcare market place. Let's take Billings as a specific example. Currently, Rimrock Foundation competes directly with Deaconess Hospital in serving eating disorder patients in our region. Our costs of $400 a day are 1/3 the Deaconess cost of approximately $1200 per day. Should Blue Cross be allowed an exclusive monopoly in our region, ie, a PPO, the Rimrock Foundation would not be allowed to compete in the marketplace for eating disorders and, as a result, patients would pay 2/3's more for eating disorder treatment. To be paid by Blue Cross, Rimrock would be assessed a 25% penalty surcharge.

It seems to me that there are several advantages to the public to have a willing provider provision in our statutes.

A. People should have the choice as to which provider they wish to go to for their healthcare services. They should not be penalized for going to a provider who is willing to meet the insurers terms, but who has been excluded from entering into a preferred provider agreement.

B. A willing provider provision will prevent an insurer from exercising a market monopoly over our healthcare market as it exists today.

C. Allowing an insurer to exclude a willing lower cost provider from entering into a preferred provider agreement could potentially endanger the economic vitality of all of our small rural hospitals.

D. Lastly, most of our hospitals and healthcare facilities in Montana are not for profit institutions. To allow an insurer to exclude these facilities from participating in a preferred provider arrangement, could seriously damage them financially and the possible loss of such a facility to a community would be extremely detrimental.

This bill preserves the intent of your original legislation which is crucial and only clarifies that the law you already passed was intended to apply to all providers and to correct what was an attempt at a monopoly in the Region III healthcare planning district.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 5
DATE 2/12/93
BILL NO. SB 331

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

February 11, 1993

Senator J.D. Lynch
Montana Senate
Department of Business and Industry

Re: Senate Bill 331

The Honorable Senator J.D. Lynch:

As a rural hospital in Northeast Montana, my concern is that you vote to let us remain as willing providers.

I have already been approached twice in the last year regarding preferred provider arrangements. In both cases our hospital was given an opportunity to continue to provide services in our area.

Granted, as a rural primary provider, I can not offer all the services of Billings or Williston. However, I can offer many services at competitive prices.

What I am concerned about is, as a rural hospital, if we are not given a chance to provide primary services on an equal basis in our area we, the rural hospitals, will be squeezed out of existence. When we no longer provide care in our areas, the cost of healthcare will increase. The increase will be two fold:

1) There will be less competition from the rural areas.
2) The people in rural areas will spend more time and money to receive basis healthcare.

Please remember the small hospitals provide a lot of primary care in the rural areas at a reasonable cost. Consider the availability of healthcare in rural Montana when rural hospitals are no longer in existence.

Please vote yes on Senate Bill 331.

Sincerely,

Jerry E. Jurena
Administrator

FIRST Physical THERAPY

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 4
DATE 2/12/93
BILL NO. SB 331

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- *Hydrostatic Weighing*
- *Job Task Analysis*
- *Joint Mobilization*
- *Occupational Health*
- *Pain Control*
- *Pediatric Physical Therapy*
- *Prevention Programs*
- *Soft Tissue Mobilization*
- *Sports Medicine*
- *Stress Management*
- *Swim Exercise*
- *Work Hardening*
- *Work Injury Care*
- *Work Tolerance Screening*

partners
JEROME B. CONNOLLY, P.T.
LORIN R. WRIGHT, P.T.

☑ *Billings, MT 59101,*
1027 North 27th Street
406-245-6513

☐ *Red Lodge, MT 59068,*
1 S. Oakes, P.O. Box 430
406-446-1112

☐ *Laurel, MT 59044,*
319 N. 1st Ave.
406-628-8440

February 12, 1993

TESTIMONY IN SUPPORT OF SB 331

My name is Jerry Connolly. I am a physical therapist residing in Billings. I am founder and co-owner of First Physical Therapy, a private physical therapy practice which has offices in Billings, Laurel and Red Lodge. Our practice is an independent, physical therapist-owned, private practice. First Physical Therapy employs 24 people and provides services to between 200-300 patients per week. We are affiliated with no hospitals. In Billings specifically, we are independent of both of the hospitals which respectively and historically have resided on opposite sides of this issue.

I appear today in support of SB 331. This bill which extends the willing provider legislation of 1991 is good legislation. It is good because it benefits the health service consumers of the State of Montana. And it does so in three ways:

1. It fosters competition among providers;
2. It instills consumerism in health care selection;
3. It preserves freedom of choice.

While encouraging competition among providers is important, perhaps more important to some is the preservation of the freedom of choice of the consumer to decide among providers who are willing to provide the same service for an equal or lower price. That is a freedom highly valued by Montanans and not one not easily surrendered.

This legislation takes the next natural and necessary step and that is one which allows the willing provider to inspect the agreement with which that provider is competing. Without such a provision the effects of this progressive legislation are mitigated and in reality rendered meaningless.

As an independent private physical therapy practice, First Physical Therapy is proud of its 17 year reputation of providing a low cost, high quality rehabilitation services throughout south-central Montana. Without legislation like SB 331, however, First Physical Therapy would be unable to effectively compete with the larger entities that are able to negotiate advantageous and exclusive arrangements with

Exhibit #6
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SB-331

insurers. Without SB 331, consumers are, in effect, then encouraged to obtain their (in our case, physical therapy) services from a ***higher*** cost provider. Of course, this is not consistent with the cost-containment efforts that are currently needed and necessary in regard to health care reform.

While Health Maintenance Organizations (HMOs) are not now a predominant factor on the scene of the Montana's health care delivery system, it is apparent that this type of provider is emerging. For that reason, I would also suggest to the committee that if this legislation does not currently apply to HMOs as well as PPOs (and I think it does not) that it be amended at this time to do so.

This legislation, while fostering competition and preserving the patient's freedom of choice, empowers the consumer to be critically selective of quality and price. I urge passage of SB 331.

BlueCross BlueShield of Montana

404 Fuller Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

TESTIMONY

by Chuck Butler
Vice President, Blue Cross and Blue Shield of Montana
before the Senate Business and Industry Committee
Against SB 331

February 12, 1993

Proponents of SB 331 would have you believe this bill is pro-consumer-- it is not! It is as anit-consumer as it gets.

First, when this restrictive law was passed two years ago, proponents said it was needed to protect rural hospitals -- and to make sure Blue Cross and Blue Shield would be fair when it tried to start more Preferred Provider Organizations (PPOs) with hospitals. This law had just the opposite effect.

In fact, this law protected the big city hospitals in Missoula and Great Falls from any broad based PPO contracting that could save lots of money for working men and women and their employers.. If you ask the Montana Hospital Association, which two years ago was a strong proponent of this legislation, I think you'll find no rural hospital in Montana has gone out of business because of our Billings PPO, or any of the other PPOs that exist, including any that involve St. Vincent Hospital.

When the willing provider act was first proposed, St. Vincent's testified, and I quote "The issue of providers not willing to participate in contracting is simply not true." Let me share with you our experience since the act was passed.

In Missoula, we were told by one hospital they weren't interested in a broad based PPO because they didn't want to get into competition with the larger hospital in town. The larger hospital said they weren't interested in a PPO with us, unless we could guarantee their marketshare would increase substantially. With the willing provider statue there are no quarantees.

In Great Falls, where both hospitals have had their share of financial problems as you've read in the papers, there is more competition than in Missoula and the competitive environment is more like that which exists in Billings. So, we tried out the new law in Great Falls. We prepared a request for PPO proposals and sent them to both hospitals. When we held a conference for the two potential bidders, one hospital didn't even bother to show up. The hospital which did had a list of over 40 questions for us. We answered each question, but when the day came for PPO proposals from the hospitals to be submitted, there was no response. Once again the consumers got short-changed.

We have consistently said this is anti-competitive at the expense of the consumer. Unfortunately we didn't convince the '91 legislature of that fact. Maybe this document from the Federal Trade Commission will help.

It has been said that this law is needed because Blue Cross and Blue Shield is so big no provider could negotiate a good deal with us. Let me put that in perspective.

Also, at the hearing this week on health care reform, Senator Eck's committee received a report that showed total spending on health care in Montana in 1990 totaled $1.6 billion, of which $652 million went to hospitals and $320 million went to doctors. By comparison, in 1991 we paid hospitals approximately $71 million and doctors about $50 million. In Billings we paid the two hospitals about $11 million in 1991. That's just a fraction of their total revenues and the total revenues of all the hospitals.

In the absence of government regulation on controls that may be forthcoming in Senator Franklin's or Senator Yellowtail's health care reform bills, one of the most effective private sector ways to control costs is for insurers on behalf of their customers to selectively contract to obtain a lower price.

SB 331 disempowers consumers and all insurers -- not just Blue Cross and Blue Shield -- from negotiating with providers more favorable rates.

Another reason given for this law is to protect St. Vincent's financial health because our PPO was unfair. In the fiscal year that ended when our PPO began in 1990, St. Vincent had a net profit of $4.4 million. Based on the financial report St. Vincent presented to its medical staff for the fiscal year that ended in May of 1992, I think you'll agree our PPO has had absolutely no adverse effect on their bottom line. You could make a case that it's made them more aggressive in the marketplace and more aggressive financially. Let me show you what I mean.

I said at the beginning of my testimony that this is anti-consumer. I hope it's now clear why we so strongly believe that to be the case. Another reason given by proponents for this act is to preserve the patient's choice of provider and to prevent any insurance company from dictating which doctor or hospital could care for you.

Our PPO is sold only in Yellowstone County. Consumers have always had a choice in our PPO. They can select it or decide not to. It's that simple. No one said they had to choose it. If they do, they save lots of money. More than $1 million in premium income this year alone won't be paid by the working men and women and their employers who did select it.

The willing provider is very cleverly drafted legislation. As the FTC says, it invalidates the reason why any provider would negotiate a volume business discount. If anyone is protected by this legislation, it is the provider community.

This bill is about saving money. Without our PPO in Billings, the consumers who selected it would very simply pay a million dollars more in insurance premiums.

We would urge you to vote no on SB 331 and restore our ability to negotiate better prices for the people paying the bills. Thank You!

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

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

February 4, 1993

The Honorable Joseph P. Mazurek
Attorney General of the State of Montana
Justice Building
Helena, MT 59620

Dear Mr. Attorney General:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of maintaining in place the recently-enacted "any willing provider" law, which is set to sunset in July 1993. This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

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

[2] 15 U.S.C. § 41 et seq.

The Commission has observed that competition among third-party payors and health care providers can enhance the choice and availability of services for consumers and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMOs"), that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5] Several of these

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

[4] See, e.g., Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital of Price George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991); see also American Society of Anesthesiologists, 93 F.T.C. 101 (1979); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMOs and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMOs and deny consumers the improved services that such competition would stimulate. See, e.g., Letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

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comments have addressed "any willing provider" requirements for health care service contracts.[6]

II. Description of Montana's "Any Willing Provider" Law.

Montana law permits "preferred provider" agreements between providers of health care services and health care insurers relating to the amounts charged and the payments to the providers.[7] The law apparently extends to agreements with all kinds of health care providers: hospitals, professional practitioners, pharmacies, and other providers of health care services.

The "any willing provider" requirement is a temporary provision, which was adopted in 1991. It requires that an insurer establish terms and conditions to be met by providers wishing to enter such agreements.[8] Any provider willing to meet those terms and conditions must be permitted to enter an agreement with the insurer that set them. This "any willing provider" requirement is set to terminate July 1, 1993. At that time, unless the requirement is extended by legislative action,

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[6] The staff submitted comments to the Massachusetts House of Representatives concerning legislation that would have required prepaid health care programs to contract with all pharmacy suppliers on the same terms (or offer subscribers the alternative of using any pharmacy they might choose), noting that the bill might reduce competition in both pharmaceutical services and prepaid health care programs, raise costs to consumers, and restrict consumers' freedom to choose health care programs. Letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989, commenting on S.B. 526). The staff has submitted similar comments on similar legislation in Pennsylvania, New Hampshire, and California. Letter from Cleveland Regional Office to Senator H. Craig Lewis (June 29, 1990, commenting on S.B. 675); letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992, commenting on H.B. 470); letter from Office of Consumer and Competition Advocacy to The Honorable Patrick Johnston (June 26, 1992, commenting on S.B. 1986).

[7] Mont. Code Ann., Title 33, Ch. 22, Part 17 (1991).

[8] Mont. Code Ann. §33-22-1704 (Temporary). These terms and conditions may not be discriminatory; however, the law permits differences among geographic regions or specialties, or differences among institutional providers, such as hospitals, that result from individual negotiation.

the PPO law will explicitly deny that an insurer must negotiate or enter into agreements with any specific provider or class of providers.[9]

This comment will focus on how "any willing provider" requirements limit contracting between providers and third-party payors, and on how this limitation is likely to affect competition and consumers. The actual effects of Montana's law may be difficult to gauge, because it has been in effect only for a short time. The expectation that the requirement would end soon may have affected how providers and PPOs have dealt with each other. Thus, this comment is based on general principles, rather than Montana's particular experience.

III. Competitive importance of programs using limited-provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMOs and PPOs, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10] In

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[9] Mont. Code Ann. §33-22-1704(3).

[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with permitting hospitals to contract selectively. See, e.g., J. C. Robinson and C. S. Phibbs, An Evaluation of Medicaid Selective Contracting in California, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study

(continued...)

addition, subscribers may benefit from broader product coverage and lower out-of-pocket payments that these cost savings may make possible. Competition among different kinds of third-party payor arrangements, including those that limit provider participation and those that do not, should ensure that cost savings are passed on to consumers. This principle would apply to all types of health care payment programs and health care providers.

Hospitals compete, ultimately, for the business of patients. A hospital may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The hospital may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the hospital of enough patients to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the hospital deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, hospitals compete with each other, offering lower prices and additional services, to get the payors' contracts.

Third-party payors find such arrangements attractive because they benefit from the providers' competition. Lower prices paid to providers could mean lower costs for a third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer limited-provider programs if the competition among providers leads to lower premiums, lower deductibles, or other advantages. Consumer preference for

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[10](...continued)
concentrated on Medicaid experience; however, further studies based on private health insurance experiences confirm these findings. See, e.g., D. Dranove et al., Is hospital competition wasteful? Rand J. Econ., Summer 1992; see also G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Economics 217 (Oct. 1992).

limited-panel programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. Consumers' ability to change programs or payors if they are dissatisfied with service availability would give payors an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors, including PPOs, to offer programs that have the cost savings and other advantages discussed above. Requiring that programs be open to all providers wishing to participate on the same terms may affect both cost and coverage. To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services. Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for PPO business can result in higher prices for services through PPOs. The higher prices for covered services, as well as the increased administrative costs associated with having to deal with many more providers, may raise the prices to subscribers for prepaid health care programs, or may force those programs to reduce benefits to avoid raising those prices.

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Moreover, requiring programs to be open to more providers may not give the consumer benefits from greater choice. Subscribers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, by reducing their competitiveness with other kinds of third-party payment programs, requiring PPOs to grant open participation may reduce the number, variety, and quality of prepayment programs available to consumers without providing any additional consumer benefit.

V. Conclusion.

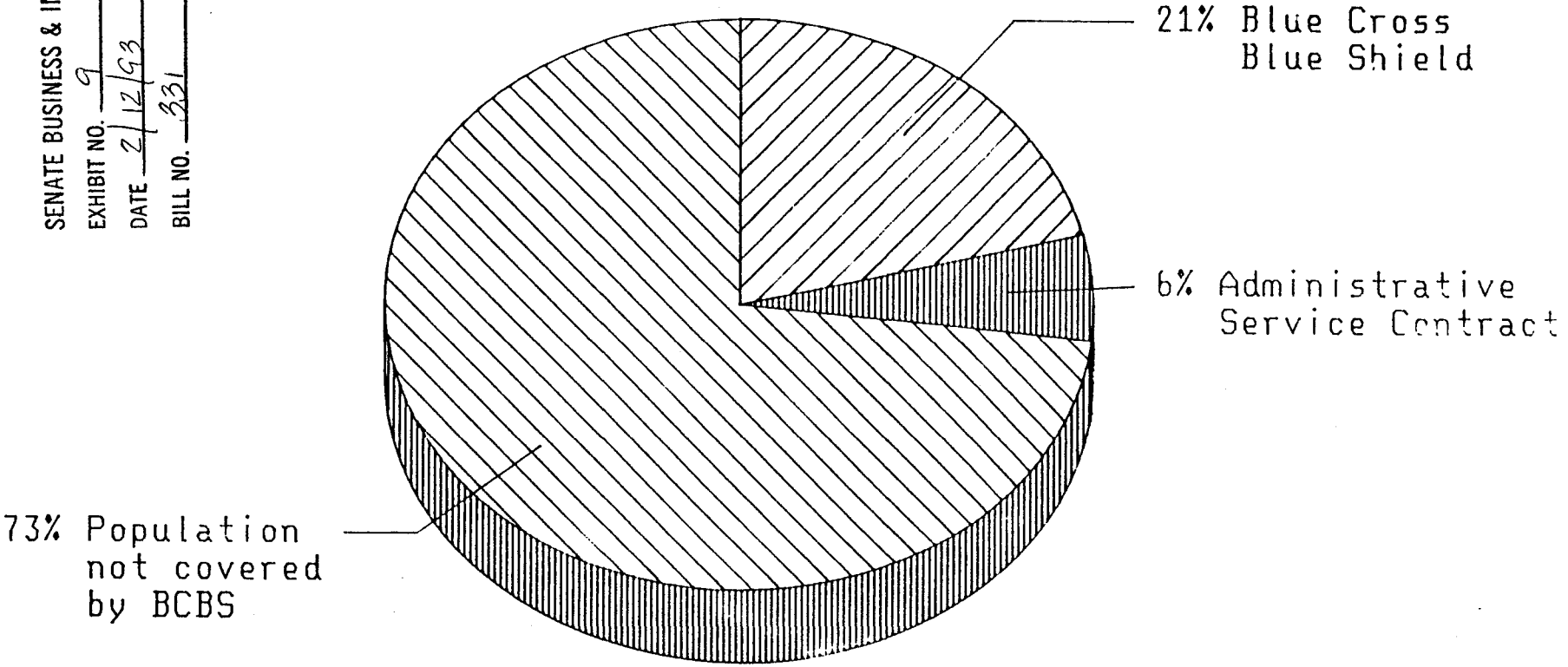
In summary, we believe that "any willing provider" requirements may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

Michael O. Wise
Acting Director

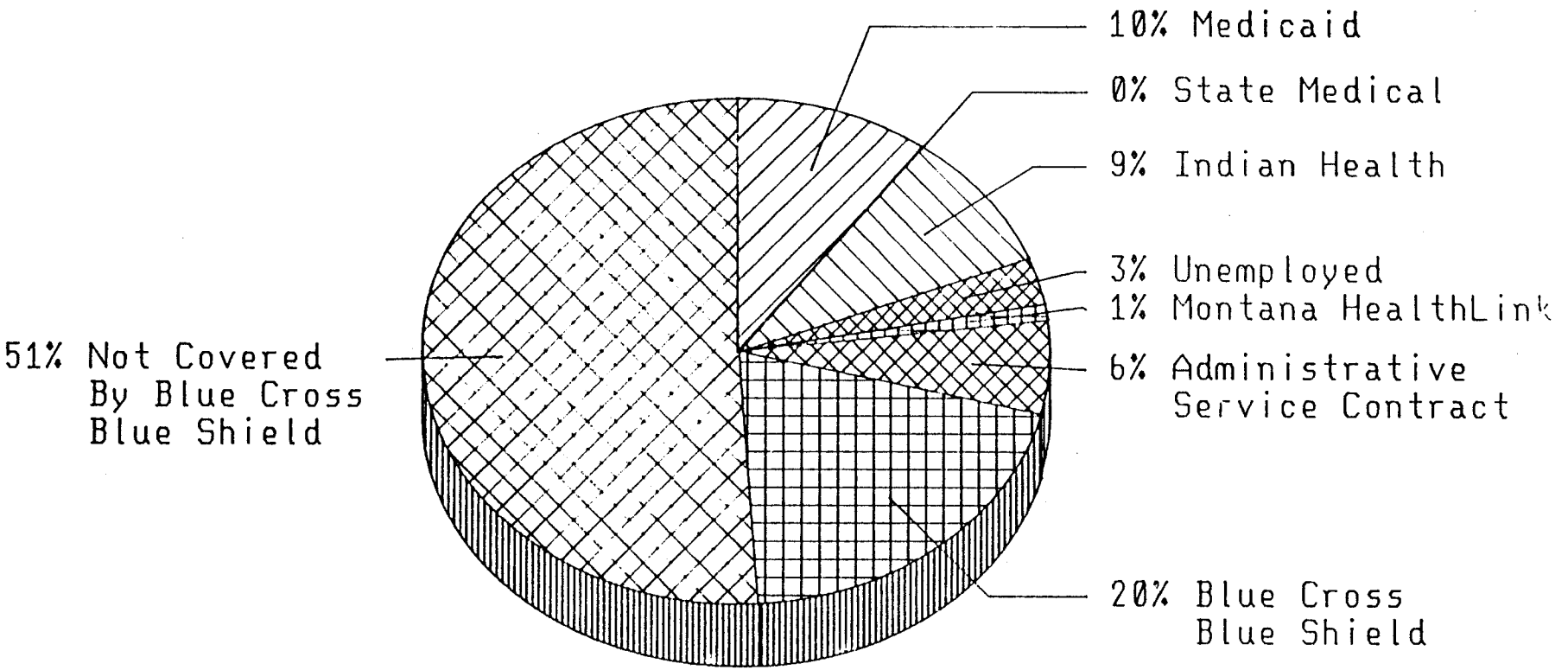
SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 9
DATE 2/12/93
BILL NO. 331

BLUE CROSS BLUE SHIELD OF MONTANA 12/92
Marketshare - By Population



Population:	799,065	State Total (1990 Census)
	-169,640	Covered by BCBSM (*includes Medicare Supplement Products)
	- 46,373	Administrative Service Contract (Administered by BCBSM)
	583,052	

BLUE CROSS BLUE SHIELD OF MONTANA 12/92
Marketshare - By Potential



Population:	799,065	State Total (1990 Census)
	-77,717	Medicaid (SRS 11/92)
	- 3,359	State Medical (SRS 12/92)
	-70,988	Indian Health (Indian Health Serv. "Eligible Population")
	-22,641	Unemployed - Dept. Labor - October statistics
	-175,897	Covered by BCBS (*Includes Medicare Supplement Products)
	-46,373	Administrative Service Contract (Administered by BCBSM)
	-10,856	Montana HealthLink
	408,329	Not Covered by BCBS

FINANCIAL OVERVIEW

The twelve months ended May 31, 1992, were very successful for the hospital financially. Net operating income totalled $9.9 million from gross revenues of approximately $133 million... Due to continued dramatic growth in deductions taken by the Medicare and Medicaid programs, in bad debt expense, and, in charity care, only 68 percent of the hospital's gross charges were actually collected. These revenue deductions grew 1-1/2 times faster than the growth in revenue.

Exhibit # 4
2-12-93
SB-331

Annual Report

to

Saint Vincent Hospital and Health Center

Medical Staff

1992

Annual Meeting
Radisson Northern Hotel
October 6, 1992
6:30 a.m.

DATE 2/12/93

SENATE COMMITTEE ON Business & Industry

BILLS BEING HEARD TODAY: SB 331

Name	Representing	Bill No.	Check One Support	Oppose
Cal Winslow	Deaconess Medical Ct	331		✓
Jim Baquette	Saint Vincent Hospital	331	✓	
Chuck Butler	Blue Cross Blue Shield of MT	331		✓
[illegible]	Blue Cross Blue Shield	331		✓
Tom Ebzery	St Vincent Hosp	331	✓	
Jim Smith	Mt. Psych Assoc	331	✓	
Steve Turkiewicz	MT. Auto Dealers Assn Trust MT. Assoc. Health Care Purchasers	33		✓
Richard J. Jacobs	Steve Nelson Trucking Inc	331		✓
Bonnie Tippy	MT State Pharm Assn	331	✓	
David [illegible]	St Vincent FDN	331	✓	
Jay E Quam	Trinity Hospital	331	✓	
Bob Deschen	Deaconess Medical Ctr	331		✓
Ron Burnam	MAPI - physician	331	✓	
Jerome Connolly	Self - First Plus Trust	331	✓	
Larry Curran	St. James Hosp. Butte	331	✓	
Mona Jamison	MT. Chapter of American Physical Therapy Assn	333	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

DATE 2-12-93

SENATE COMMITTEE ON _____

BILLS BEING HEARD TODAY: SB 331

_____

Name	Representing	Bill No.	Check One Support	Oppose
David W Knauth	St. James Comm. Hosp	331	✓	
Grey Van Horssen	State Farm Ins. Co	331		✓
Callen K. Northam	Saint Vincent Hospital	331	✓	
Warren Patrick	TIRE-RAMA	331		✓
Gordon Engelstad	Yellowstone County	331		✓
Tom Hopgood	Health Ins. Assoc. America	331		✓
Jerome Loendorf	Mt. Med. Assn	331	X	
Randy Cline	Blue Cross Blue Shield	331		✓
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	331		✓
[illegible]	BIG HORN COUNTY MEMORIAL HOSPITAL & NURSING HOME	331	X	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10