MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By **CHAIRMAN JIM BURNETT**, on March 22, 1995, at 3:12 PM

ROLL CALL

Members Present:
Sen. James H. "Jim" Burnett, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. Larry L. Baer (R)
Sen. Sharon Estrada (R)
Sen. Mike Sprague (R)
Sen. Dorothy Eck (D)
Sen. Eve Franklin (D)
Sen. Terry Klampe (D)

Members Excused: Sen. Arnie A. Mohl (R)

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Karolyn Simpson, Committee Secretary

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

Committee Business Summary:
Hearing: HB 509
Executive Action: SB 410

HEARING ON HB 509

Opening Statement by Sponsor:

REP. SHIELL ANDERSON, HD 25, Livingston, said when the Health Care Authority bill was passed in 1993, it allowed Certificates of Public Advantage to be issued to health care facilities that wanted to have cooperative agreements with one another. HB 509 extends that to allow for Certificates of Public Advantage for health care facilities who want to form a merger or consolidation.

When two hospitals decide to consolidate, they apply to the Attorney General for a Certificate of Public Advantage. If they can meet certain terms required by this agreement, they would be able to immunize themselves from state antitrust litigation, which serves 2 purposes. It shows the Federal Government that the

State has an on-going review of this merger, and would probably save the health care consumer money. If hospitals decide to consolidate with or without the Certificate of Public Advantage, they are subject to anti-trust litigation from the Federal level. Some people are under the impression this bill gives an OK to hospitals to consolidate, but it doesn't. It allows them to prove before-hand to show they won't be violating anti-trust statutes in the consolidation.

He said HB 509 is self-funding because the hospitals who wish to consolidate will pay for the agreement and any on-going review.

Proponents' Testimony:

REP. BILL WISEMAN, Great Falls, said this bill is not specifically for Great Falls and does not mention either Columbus or Deaconess Hospital. It is a bill that can be used by the hospitals in Great Falls or any other town in Montana, if the hospitals wish to merge. It does not force hospitals to merge, but is a mechanism the hospitals can use, if they so desire, with the funds coming from the merged hospitals to pay for on-going reviews or monitoring, for as long as directed. This is self-funded and will not cost the State of Montana any money. It is a cost-savings for the citizens of Montana, if there is a city whose hospitals wish to merge.

If they are under the Federal Trade Commission, rather than an agency of the State of Montana, they have to copy a huge number of documents to be sent to Washington, D.C., which costs about $500,000. That kind of documentation is not required to be shipped to Helena, when the Federal Government is not involved in the process. An additional cost would be travel to and from Washington, D.C., which would be much greater than traveling to Helena from any place in the State.

He said the FTE's mentioned in the Fiscal Note are contract FTE's, is an estimate of what might be required to monitor facilities, and no huge bureaucracy will be created. They will be on a consulting basis and will be hired as needed to monitor the merged hospitals.

He said this is just one of many changes happening in the medical profession, with more hospitals than those in Great Falls that are having problems because of decreased hospital income due to low patient census. This bill provides a mechanism for hospitals throughout the State to adjust.

Max Davis, Attorney representing Columbus Hospital, and speaking on behalf of both Columbus and Deaconess Hospitals, Great Falls, said change is coming to health care no matter what and when Managed Care comes to Montana, reimbursements from 3rd-party payers and insurers will go down. Hospitals and physicians are victims of their own success because people spend less and less time in hospitals for procedures that used to require an overnight stay in the hospital, but now are done on an out-patient basis. HB 509 doesn't endorse a merger but provides a local vehicle for a merger hearing for both the opponents and

proponents of a merger. It is better for a level of state regulation for mergers to avoid its being done in Washington, D.C. by some faraway bureaucrats. If they have to deal with the Department of Justice or Federal Trade Commission, there will be a subpoena, which will require the local merging hospitals about a month and $500,000 in legal fees and copying costs to respond to the subpoena, then embark on that process. If money can be saved by having decisions made in Montana, everyone benefits.

Sharla Hinman, employee, Montana Deaconess Hospital, Great Falls, spoke on behalf of herself and many co-workers in support of HB 509. She said in the last 5 years, people who work in the health care field have seen reimbursements go down and in-patient admissions decline. They need a stable viable environment in which to provide care for patients. She said the health care delivery system must change in order to survive and the challenge of providing health care in Montana is vastly different from that in Washington, D.C. She asked for the Committee's support of HB 509 to let Montanans review proposed mergers of Montana facilities.

Dannette Rutherford, employee, Columbus Hospital, Great Falls, spoke in support of HB 509. She said there has been a lot of debate and comment about the proposed hospitals merger in Great Falls and everyone wants to express their opinion and have their questions answered. HB 509 will allow public hearings to be held in Montana, not Denver or Washington, D.C. She said Montanans can better decide the fate of health care in Montana than bureaucrats in Washington, D.C.

Dr. Gary Schumacher, Radiologist, Great Falls, said there are several of his colleagues opposed to HB 509 primarily related to their local activity, but there are physicians in Great Falls who support this. He said he would prefer that government not be involved in medicine at all, but that is not the reality of the situation. If government is to be involved, it is preferable to be at the local level where individuals can be involved more easily and there is greater sensitivity to local needs. He agrees this bill needs to be considered separately from the hospital merger issue in Great Falls.

Laurie Ekanger, representing Governor Mark Racicot, spoke in support of HB 509. She asked for the Committee's support of the bill.

Kirk Wilson, President, Montana Deaconess Hospital, Great Falls, said this bill gives a public forum for proposed hospital merger in Great Falls, retains competition with Billings, Missoula, Salt Lake and Spokane hospitals, but not with each other. He said some hospital mergers have not saved money, but he has a public benefits guarantee that is enforceable by the State to see that they do cut they costs and restrain their prices. He said there is concern this is a jobs issue and some employees may be at risk, but most would rather be in a situation with planned

systematic down-sizing of the work force related to volume and reimbursements, with layoffs through attrition.

Bill Downer, past President, Columbus Hospital, Great Falls, said he is in the process of retiring but is currently working in a consulting capacity. He said this is a Montana bill focused on Montanans. He talked about a proposed hospital merger in Fort Huron, Michigan, where the community was almost 100% in support of the merger of 2 hospitals and the FTC denied it. This is a case where the Government in Washington, D.C. made a decision for a local issue without much regard for the opinion and wishes of the community. He said HB 509 gives the opportunity for the forum to take place in Montana, provided the filing with the Federal Trade Commission will cause them to allow the Montana Attorney General to do that. Without this bill, a review by the Federal Trade Commission or Department of Justice can be guaranteed with the resulting difficulty of people getting to hearings. He handed out a Public Benefits Guaranty. **EXHIBIT 1.**

Steve Browning, representing the Montana Hospital Association, summarized his written testimony in support of HB 509. **EXHIBIT 2.** He said there has been concern expressed about public hearings, but if the anti-trust review process were limited only to the Federal review, there would be less public hearings than under HB 509. He referred to the statute 50-4-603 specifically because it is not in the bill. In the anti-trust sections enacted in 1993, there is extensive public review process with notice, public participation, that is more extensive than that required by federal law. He talked about contracting of services, page 4, lines 9-10, allowed by this Legislation. He said it is assumed that towns which have 2 hospitals will have lower prices than those with only 1 hospital, and sounds good in economic theory, but doesn't seem to happen. Those costs are higher in Montana towns that have more than 2 hospitals, as opposed to those with only 1 hospital, for a variety of reasons, not the least of which is duplication of services.

Tom Ebzery, Attorney, St. Vincent Hospital, Billings, said they have no plans for a merger-consolidation but think this is forward-looking Legislation and support it.

<u>Opponents' Testimony</u>:

Paul Gorsuch, Physician, Great Falls, spoke in opposition to HB 509. He said this bill appears to be a case of special interest or local issue driving state policy. He passed out a packet of materials and talked about each. He said mergers might be good for business but not good for health care, and the cost is really a tax on the sick because the cost is not distributed evenly throughout the community. **EXHIBITS 3A-K.**

Dr. Jack McMahon, President, Montana Medical Association, said they have done a flip-flop on this issue and wanted to explain the reasons. He said physicians are divided on this issue, but

most physicians are opposed to HB 509. He said the ideal situation for a merger would be the hospital administration, citizens, Board of Trustees, physicians, and employees of that institution could get together to discuss the proposed merger. From a physician's standpoint, they would like some anti-trust to protect physicians in some Managed Care situations. They would be willing to wait for Legislation to be written tailored to what they see as the needs of the patients and urged the Committee to turn down this bill.

Tim Nagel, Director, Montana MRI, Billings, spoke in opposition to HB 509. **EXHIBIT 4.** He said he also had letters from individuals in Billings who are opposed to HB 509. **EXHIBITS 5,6,7.**

Jake Allen, General Vascular Surgeon, Great Falls, spoke in opposition to HB 509. He said the merger of the Great Falls hospitals under HB 509 could very costly in legal fees, there is little local support for the merger, and both the Deaconess and Columbus hospitals made record profits last year. **EXHIBITS 8A-Q.**

Dr. James Clough, Great Falls, said he has been practicing in Great Falls for 20 years, is testifying in opposition to HB 509 and has no ties to any group. He said this bill is a transparent attempt by the 2 hospital administrations (Deaconess and Columbus Hospitals) to avoid the scrutiny of the Federal Trade Commission. If this bill becomes law, it may subject Montana and its citizens to a costly legal battle. He said if these hospitals wish to consolidate they should do so under the watchful eye of the Federal agency that has experience with the matters, and makes no sense to create a new State agency which is at risk for legal challenge. He gave some comparative costs for various procedures in Great Falls and hospitals in other states, concluding the procedures in Great Falls are not effective cost management by the administrations of those hospitals.

Sonja Jones, Registered Nurse, Great Falls, spoke in opposition to HB 509. She said this bill eliminates both choice and competition, and gave several costs incurred by the Great Falls hospitals to promote the merger. She said merged hospitals can't guarantee lower prices for patient care.

Erla Green, Great Falls, said she is opposed to HB 509. **EXHIBIT 9.**

Tamela Vander Aarde, said she is opposed to HB 509.

Bob Wyivia, Physician, Great Falls, said he opposes HB 509.

Dr. Jack Olean, Physician, Great Falls, said he did a poll of his patients and most of them oppose the merger of the Great Falls hospitals.

Jack Henshaw, Obstetrician, Great Falls, said he wanted to make some comments about employees ability to speak out, but couldn't do so because of lack of time.

Steve Cross, said he is opposed to HB 509.

Pat Mitchell, employee Montana Deaconess Medical Center, said she supports this bill.

Charles Brooks, representing Billings Chamber of Commerce, said they oppose HB 509 and handed out some information. **EXHIBIT 10.**

Richard Jones said he opposes HB 509.

Dr. Jack Halseth, Physician, Great Falls, said a merger is different from establishing an anti-trust suit. He said they are worried about the rules that will be promulgated.

Questions From Committee Members and Responses:

SENATOR KLAMPE said the Committee heard the Governor's office supported this and the Attorney General is opposed to anti-trust exemptions for the health care industry, then asked **Beth Baker** if she is at this hearing as an opponent.

Beth Baker, Department of Justice, said they have no position on this bill. She said the letter that was referenced was a letter written by several Attorneys General to the United States Congress opposing Federal Legislation that would provide anti-trust exemptions for health care, but it did not deal with State Legislation like this. This Legislation is a continuation of what was done in the 1993 Legislature. The State would have to be involved in supervision of mergers.

SENATOR KLAMPE asked if the Federal Government will maintain the power to review these mergers even if the State assumes these powers.

Beth Baker said the State Action Immunity Doctrine states the Federal anti-trust law will not apply if the State has a clear statement of policy to replace competition with regulation, which this bill would do, and the State actively supervises. There are a number of factors involved in this supervision. The Federal Government could decide the State system of supervision is not adequate, and if the Attorney General doesn't do his job, the merging hospitals could be sued for anti-trust violations.

SENATOR KLAMPE asked if this will end up in court.

Beth Baker said she didn't know.

SENATOR FRANKLIN asked **Beth Baker** to talk more about the type of on-going supervision, legal or what.

Beth Baker said she worked with the Health Care Authority to put together some draft rules for the current Legislation and relied on Legislation from other states who are doing this with theses cooperative agreements. She said active supervision would consist of on-going reporting. The current statute would not change and the Certificate of Public Advantage may not be granted (page 1, lines 14-17) unless the Attorney General finds the agreement will result in lower health care cost, improved access to health care, or increased quality of health care without undue increase in cost. They would look at the cost to the consumer before and after the cooperative agreement, quality of care and access to services. The law provided if the Health Care Authority ever found these conditions didn't exist, they may revoke the agreement.

SENATOR ECK said other hospitals are required to do this kind of reporting, and wondered if there would be comparing prices at the various hospitals.

Beth Baker said she that would probably be one of the factors. She said when there is a merger, they would also look at barriers to entry from other competitors, and whether competitors were prevented from providing that same service in the same geographic area.

SENATOR ECK asked about the barriers to entry and whether it's related to Managed Care or the number of providers would be limited.

Beth Baker said it's not the number of providers, but the patient's access to services, whether it's beneficial to health care consumers, the alternatives to get services elsewhere and if the merger had not happened, there would be access to these services. These are the factors that would be looked at on an on-going basis.

SENATOR BAER asked about the amendments to the bill regarding the fees and the Fiscal Note. He wondered if the fees would off-set the Fiscal Note.

REP. ANDERSON said the Fiscal Note was put together on February 15, 1995, which was prior to the amendments to the bill. He referred to section 7, making this revenue neutral to the State. Because the costs evolved with Attorney General's office, which has the expertise to review the agreement and do the on-going review, the hospitals will pay the Attorney General's office.

SENATOR FRANKLIN said she is concerned about citizens ability to testify.

Dr. Henshaw said during both the community meetings and Chamber of Commerce meetings, people were not able to raise their hands to ask questions, but had to write their question on a card, then someone chooses which questions will be answered. He said it is

very unlikely many people will testify so the ability to get accurate public sentiment is slim.

{Tape: 1; Side: 2}

SENATOR BENEDICT asked **Tom Ebzery** how many physicians he represents in Billings.

Tom Ebzery said he represents 109 physicians in the Billings area.

SENATOR BENEDICT asked how many of those physicians support this Legislation.

Tom Ebzery said the large majority support it.

SENATOR BENEDICT said the Montana Medical Association is now opposed to HB 509 and asked **Tom Ebzery** to respond to this, in terms of the physicians he represents.

Tom Ebzery said he doesn't understand this flip-flop, but they support the bill.

SENATOR SPRAGUE said the Committee had been told health care consumers were going to get less health care at an increased cost because hospital administrators have the responsibility to make the hospital profitable.

Bill Downer said hospitals must have an excess of income over expenses or they will not be able to serve the public.

SENATOR SPRAGUE asked if they sell municipal bonds to finance expansions and additions.

Bill Downer said they had done that.

SENATOR SPRAGUE asked if they were purchased by citizens.

Bill Downer said the bonds were sold through the Montana Health Care Facility Authority and probably citizens would have purchased them because they were offered through various brokerage houses.

SENATOR SPRAGUE asked if a merger would mean running a leaner and meaner operation without less quality.

Bill Downer said all of the administrative functions that are costly could be merged into one (one Board of Directors, one administration staff, and eliminate duplicate administrative support departments) with price controls, and their goal is not to decrease the quality of clinical services.

SENATOR ESTRADA asked **Charles Brooks** why the Chamber of Commerce opposes this bill.

Charles Brooks said they oppose it because there are a lot of small health care businesses in Billings and think they could be affected by this bill.

SENATOR BENEDICT asked **Charles Brooks** to share the survey of the members of the Billings Chamber of Commerce, 1000 members, regarding their opposition to this bill.

Charles Brooks said he can't give that information because he's working under the authority of the Legislative Committee and Board of Directors of the Chamber of Commerce, and he gets his direction from them.

SENATOR BENEDICT asked if this was a unanimous resolution from the Board of Directors.

Charles Brooks said it came through the Legislative Committee to the Board of Directors and they authorized opposition to the bill.

SENATOR BENEDICT asked for a signed statement from all the members and Board of Directors of the Chamber of Commerce.

Charles Brooks said he would the information that comes from the Legislative Committee to the Board.

SENATOR FRANKLIN said she has concern about the Attorney General's position, and asked about if the Citation is a separate issue from the bill.

Beth Baker said the letter was written concerning bills that were pending before the United States Congress to change Federal anti-trust laws.

SENATOR FRANKLIN asked if that citation is not the same issue as State immunity.

Beth Baker said if there are Federal exemptions, the State may get more involved in regulations, but the Attorney General's office does not want to get more involved in regulations. She said the State has no anti-trust act, which is their interest in that issue.

SENATOR FRANKLIN asked **Jake Allen** what is the real issue and referred to his statement about special interests Legislation.

Jake Allen said the special interests to which he referred are proponents of the merger. He quoted the Vice President of Montana Hospital Association as saying this bill was proposed partly with the Great Falls hospitals in mind. He said that makes him conclude this bill was proposed, at least partly, to facilitate the merger in Great Falls.

SENATOR FRANKLIN asked if there was any participate group.

Jake Allen said no.

Closing by Sponsor:

REP. ANDERSON said the Attorney General's opinion addressed the Federal anti-trust law and wants to make the decisions at the State level, rather than the Federal level. It would be more costly with the Federal on-going review and Federal compliance under the FTC. He said there will a system in place at the State level that will, hopefully, be accepted at the Federal level so they won't come in. He said competition is good but an over abundance of infrastructure can't be supported, the health care industry is changing, and we can't afford to keep all of the existing facilities operating. Few mergers are challenged, this is a money savings matter and there are business reasons to consolidate. By passing this bill, the review and discussion is kept at the State level.

EXECUTIVE ACTION ON SB 410

CHAIRMAN BURNETT referred to an Federally Inspected plants and the custom plants in Montana, and said the spread sheet showing the costs. **EXHIBIT 11.** He said he is asking for an amendment to leave custom plants as they are, and require the Department of Livestock to contact the custom plants for sanitation inspections 4 times per year. He said the State travel costs are excessive and could be reduced by contracting with the local Board of Health or veterinarian to inspect and enforce sanitary requirements.

The amendment calls for contracting with local health departments because the Department of Livestock only does sanitary inspections of the custom plants, and don't do meat inspections. **EXHIBIT 12.**

VICE CHAIRMAN BENEDICT assumed the Chair.

Discussion: **SENATOR FRANKLIN** asked **Les Graham** to comment about the amendments to SB 410.

Les Graham, representing Montana Meat Processors Association, said the amendments are for the custom-exempt plants, which are those that don't take continuous inspection for retail or wholesale movement of the product, to be inspected by area veterinarians or county health officers who are would be under contract with the Department of Livestock to do sanitary inspections, thus reducing per diem and mileage costs. He said most of the travel is in Eastern Montana because the retail establishment inspectors are not in that area.

SENATOR FRANKLIN asked if he is comfortable with this.

Les Graham said the Federal Government would have to give permission for that to happen, under the Federal Meat Inspection

Act, but there would be strings attached to it and probably would be more cumbersome. They need an outline of enforcement in case of infractions, which is already in place at the Department of Livestock, and for that reason they oppose the changes proposed by SB 410 and amendments.

SENATOR BURNETT referred to a letter from the Department of Livestock and position descriptions for plant inspections. He said the inspectors used to be in the Board of Health that are now under the Board of Livestock. He wants them to contract the services to decrease the travel and resulting expense.

SENATOR ECK asked how much will be saved.

SENATOR BURNETT said the savings would be about $50-60,000.

Motion/Vote: **SENATOR BAER moved the amendments to SB 410 DO PASS. The motion FAILED on a TIE VOTE.**

Motion: **SENATOR BURNETT moved SB 410 DO PASS.**

Discussion: **VICE CHAIRMAN BENEDICT** said there are several from plants in his area who are opposed to this bill. He said he has heard from meat cutters and their customers, who are opposed to SB 410 because they like the present system, and don't want to have anything to do with the Federal Inspectors.

SENATOR ECK agreed, saying it is important to keep inspections as is, but contracting out does make sense. But this is an area where the options need to be examined because this is an area where $1 million is spent providing inspections services to an industry and the State recoups nothing from them. She said if money can't be recouped in the way of fees, the industry needs to be directed to find ways for the State to recoup the money spent.

SENATOR BURNETT said the Department is already contracting services and has a grade 20 administrator which is a half-time FTE, a bureau chief grade 16, compliance officer grade 14, a label specialist, plus contracted infectors and veterinarians.

Motion/Vote: **SENATOR BURNETT made a substitute motion to TABLE SB 410. The motion CARRIED with SENATORS SPRAGUE and ESTRADA voting NO.**

SENATOR FRANKLIN asked **Nancy Heyer** to make a comment about the amendments to HB 407.

Nancy Heyer, President, Board of Nursing, said they prefer to leave HB 407 tabled because it is unnecessary, but if the Committee chooses to untable it, they could live with the amendments, which they worked on.

ADJOURNMENT

Adjournment: 4:45 PM

SENATOR JIM BURNETT, Chairman

KAROLYN SIMPSON, Secretary

JB/ks

MONTANA SENATE
1995 LEGISLATURE
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL DATE 3/22/95

NAME	PRESENT	ABSENT	EXCUSED
LARRY BAER	X		
SHARON ESTRADA	X		
ARNIE MOHL			X
MIKE SPRAUGE	X		
DOROTHY ECK	X		
EVE FRANKLIN	X		
TERRY KLAMPE	X		
STEVE BENEDICT, VICE CHAIRMAN	X		
JIM BURNETT, CHAIRMAN	X		

SEN:1995
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EXHIBIT NO. 1
DATE 3/22/95
BILL NO. HB 509

Columbus Hospital
500 Fifteenth Avenue South
Great Falls, Montana 59405
406 727-3333

Montana Deaconess Medical Center
1101 Twenty-Sixth Street South
Great Falls, Montana 59405
406 761-1200

GREAT FALLS HOSPITAL CONSOLIDATION

PUBLIC BENEFITS GUARANTY

In order to insure to the maximum extent possible that the consolidation of the two Great Falls, Montana hospitals actually delivers the public benefits that form its basic rationale, the boards of directors of Columbus Hospital ("Columbus") and Montana Deaconess Medical Center ("MDMC") are prepared to commit on behalf of the new consolidated hospital to the initiatives, evaluation criteria and enforcement mechanisms set forth below:

1. Immediate Price Freeze, Future Price Adjustments and Future Price Review:

   A. During the first year after the effective date of the consolidation, the consolidated hospital shall not increase its prices for any services or procedures offered by Columbus and MDMC during the previous year. This price freeze is guaranteed to be implemented unless there is some unpredicted significant change in the reimbursements paid by government third-party payers (such as a real reduction in Medicare or Medicaid reimbursements) or some other extraordinary event.

   B. During the four subsequent years following the price freeze, the consolidated hospital will commit to limit its annual price increases to no more than the increase in the federal government's consumer price index (CPI) over the five year period beginning on the effective date of the consolidation. The hospital will if possible hold any price increase below this maximum amount. This cap on price increases is guaranteed subject to the same limited caveat set forth in the previous paragraph.

   C. The consolidated hospital will commit to contract with Montana Rate Review for no less than ten years from the effective date of the consolidation, and to abide by its decisions on price increases during that period, so long as there is no material change in the ownership or operation of Montana Rate Review. Should such a change occur, the hospital will agree to negotiate in good faith towards participation in some other similar organization that is involved in the review of hospital prices and price increases.

2. Cost control and savings:

A. The consolidated hospital will commit that, during the first five years following the effective date of the consolidation, total hospital costs for the consolidated hospital will be reduced by at least five percent below the costs of Columbus and MDMC, combined, during the year immediately preceding the consolidation. Specifically, over the first five years (on a cumulative basis), the consolidated hospital will guarantee that its costs per "adjusted patient day" will be less than or equal to 95% of such costs on the effective date of the consolidation. The hospital's costs shall be: (i) adjusted for severity changes and service changes or enhancements, and (ii) deflated for increases in the unadjusted medical market basket index over the same five year period. New hospital costs that are caused by state or federal regulation, or any other unanticipated extraordinary costs, shall not be considered.

B. Over the first five years following the effective date of the consolidation, the consolidated hospital shall reduce the number of its licensed acute care beds from 486 to no more than 300.

3. Community health:

A. The consolidated hospital will establish and provide funding for the operation of a Community Health Council (the "Council"). The Council will consist of twelve representatives. The following five organizations each will be entitled to at least one permanent representative: the hospital, the hospital's medical staff, the City/County Health Department, the Great Falls public school system, and the local military community. The remaining seven representatives will come from the other social and health agencies serving the community, and will be selected by the five permanent representatives. The purpose of the Council will be: (i) to establish community health goals and strategies, (ii) to coordinate services of various health providers, and (iii) to review and comment on the annual report and strategic plan of the hospital.

B. The consolidated hospital will continue the charitable services that Columbus and MDMC presently provide at no less than current levels. This commitment shall include funding for the Council, funding for other charitable programs and the provision of medical services for low-income persons.

EXHIBIT 1
DATE 3-22-95
HB 509

4. Contracting:

A. The consolidated hospital will commit to negotiate in good faith with all third-party payers and will not discriminate against any health plan that seeks to do business in Great Falls.

B. The consolidated hospital will not enter into arrangements with any payor that prevent or impede non-discriminatory access to the facility by any other payor.

5. Physician relationships: The consolidated hospital will not seek to restrict the ability of any physician not employed by the hospital to provide services or procedures at other hospitals.

6. Status: The consolidated hospital will remain a not-for-profit hospital with a community-controlled, self-perpetuating governing board.

7. Reporting and enforcement procedures:

A. For the first five years following consolidation, within ninety (90) days of the end of the consolidated hospital's fiscal year (and beginning no earlier than one year following the effective date of the consolidation), the consolidated hospital will commit to submit to the State of Montana an annual public report measuring the hospital's performance against the criteria set forth in this agreement. In particular, the report will address the hospital's financial performance, patient trends and statistical comparative information.

B. The consolidated hospital will cooperate with the State in any review of the report the State seeks to undertake, and will respond to reasonable requests by the State to clarify or amplify any portion of the report or to provide business records to substantiate any portion of the report. The consolidated hospital will encourage the State, within ninety (90) days of the delivery of the annual report, to issue public findings concerning the hospital's compliance with this agreement. The public findings would provide a report to the citizens of Montana concerning the hospital's compliance with these commitments.

C. The consolidated hospital will agree to pay for the State's costs in connection with the annual review referenced in the preceding paragraph in an amount to be agreed upon.

D. In order to permit the State to assess the consolidated hospital's compliance with this guaranty, the consolidated hospital will commit to provide the State with reasonable access to the hospital's business records. Upon reasonable notice, the State or its representatives will be allowed to inspect all non-privileged books, ledgers, accounts, correspondence, and other records or documents in the hospital's possession, custody or control, so long as the purpose of the inspection is to assess the hospital's compliance with the guaranty. In addition, upon reasonable notice, the State or its representatives will be allowed to interview the hospital's officers regarding the hospital's compliance with the guaranty.

E. The consolidated hospital will seek to negotiate an appropriate formal document incorporating these various commitments, which document will provide the State all usual enforcement powers, including the power to seek equitable and injunctive relief, to enforce compliance with the agreement in any court of competent jurisdiction. Columbus and MDMC will agree to pay for the State's costs incurred in connection with the execution of this document, in an amount to be agreed upon. In addition, should any litigation result in a court issuing a final order finding that the consolidated hospital has committed a material violation of the terms of such agreement, the hospital will commit to pay the State's costs, including its reasonable attorney's fees, in connection with any such litigation.

MHA MONTANA HOSPITAL ASSOCIATION
1720 NINTH AVENUE • P.O. BOX 5119
HELENA, MT 59604 • 406.442.1911

Testimony by the
Montana Hospital Association
before the
Senate Public Health, Welfare & Safety Committee
March 22, 1995

The Montana Hospital Association represents 55 acute care hospitals and Medical Assistance Facilities. Forty-five of these also provide nursing home services.

The Montana Hospital Association strongly supports HB 509. We do so because it would give hospitals an important tool in their effort to reduce their costs.

All over Montana, hospitals and other health care providers are exploring ways to reduce the duplication of health care services. For example, hospitals in northwest and north central Montana are hoping to develop networks that will enable them to provide health care services more cost effectively. The hospitals in Great Falls believe that significant savings can be achieved by merging their operations. A number of other communities are developing physician-hospital organizations.

However, one of the major barriers to these efforts is the threat of anti-trust sanctions.

Two years ago, the Legislature took a major step toward addressing this problem. The Legislature created a process for certifying and monitoring collaborative projects by hospitals to ensure that they will not reduce access and quality or raise the cost of health care services. Projects that pass the scrutiny of the Department of Justice would be awarded a Certificate of Public Advantage.

This statute is based on the doctrine of "state action immunity". Under this doctrine, states are allowed to pre-empt federal enforcement of antitrust laws, provided they meet certain tests set forth in a number of court cases.

The Department of Justice has drafted regulations to implement Montana's law, but is awaiting action on this bill before going through the final rulemaking process.

HB 509 addresses the next level of hospital activity: consolidation and merger. This bill would enable hospitals that want to merge to go through this same certification and monitoring process.

This bill is important because it sets up a process for reviewing mergers in Montana—not in Washington, D.C. As a result, merger proposals would be analyzed in the context of Montana's health care system. Moreover, that analysis is almost certain to be far less expensive.

This bill initially also would have enabled physicians and other health care providers to apply for a Certificate of Public Advantage. However, this provision was deleted by the House Appropriations Committee.

MHA hopes—and expects—that in the next session, the Legislature will extend this opportunity to physicians—particularly larger groups of physicians. Such an expansion would enable physicians and hospitals to develop even more cost-effective arrangements for providing health care services.

We urge your support for HB 509. Thank you.

March 22, 1994

Montana Senate Public Health Committee--**Testimony Regarding HB 509**

Five Problems with HB 509

1-Is this a case of a local issue driving State Policy?

2-HB 509 opens the door to:

Further Bureaucratization of our Health Care System

OR

Costly Federal-State conflict

3-Montana's Attorney General and 35 other states have already expressed opposition to antitrust exemptions for even not-for-profit health care providers, in 1993.

4-Cooperative Ventures do not require antitrust exemption.

5-There is little evidence that the mergers or acquisitions envisioned in HB 509 benefit consumers. The experience is often just the opposite, hospitals profit and consumers pay.

Paul Gorsuch, Great Falls (761-3181)

EXHIBIT 3B
DATE 3/22/95
BILL NO. HB509

Columbus Hospital
500 Fifteenth Avenue South
Great Falls, Montana 59405
406 727-3333

Montana Deaconess Medical Center
1101 Twenty-Sixth Street South
Great Falls, Montana 59405
406 761-1200

MEMORANDUM

TO: All Columbus Hospital Employees

FROM: Consolidation Coordinating Committee

RE: **LEGISLATIVE IMPERATIVE**

DATE: Friday, March 17,1995

If you are supportive of HB509, your immediate action is requested. This bill, sponsored by the Montana Hospital Association, would provide a mechanism for Montanans to decide for themselves what is best for Montana, in terms of medical care.

Each and every employee supportive of HB509 needs to call or write their state representatives before HB509 faces a full House vote as early as this Saturday or sometime next week. (A list of Cascade County Representatives and House Leadership is attached)

At your first available moment please call the Cascade County representatives and ask for their support of HB509.

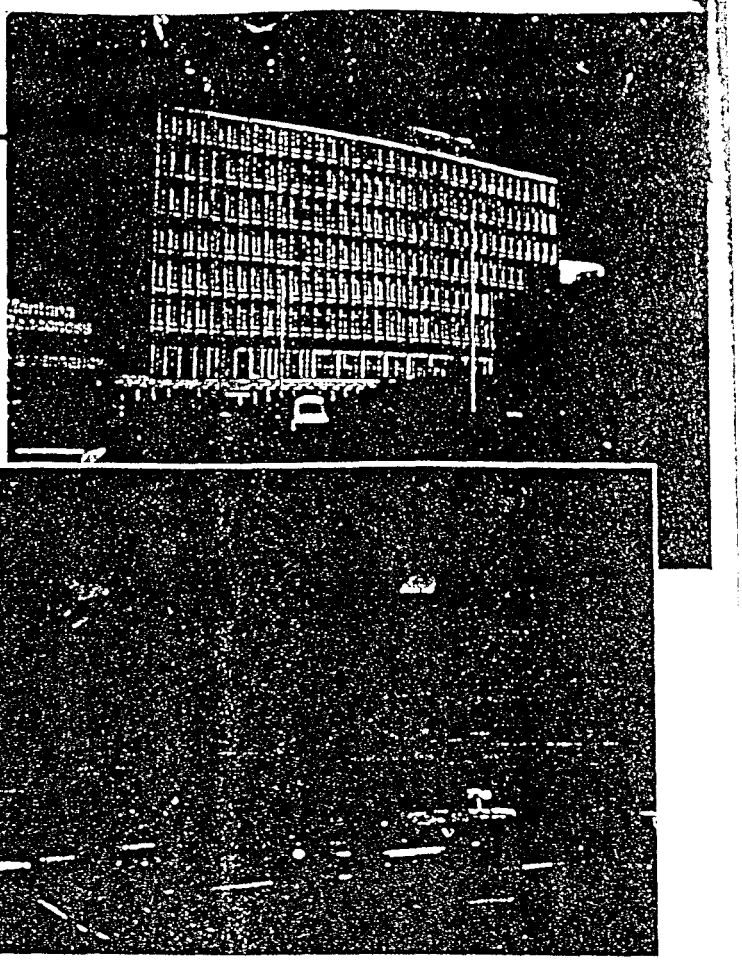
Assistance and additional information is available in the Public Relations department, extension 5621.

Please call TODAY and write your representatives in the near future. Employee support is a critical link in our legislative efforts.

Thank you.

Modern Healthcare
The week in healthcare

Mont. hospitals asking state for immunity



The two hospitals in Great Falls, Mont., are lobbying for state antitrust legislation.

Two Montana hospitals essentially are taking out an antitrust insurance policy to protect their proposed merger from federal antitrust regulators.

The hospitals, whose merger would give them a monopoly in their market, are lobbying for a new state law that would immunize them from state antitrust laws and, in theory, do the same against federal antitrust laws.

The hospitals are 255-bed Montana Deaconess Medical Center and 139-bed Columbus Hospital. They're the only two hospitals in Great Falls, a city of 56,000 some 90 miles north of Helena, the state's capital.

After nearly a year of internal and external study, the hospitals last November signed a letter of intent to merge. With the help of the Arthur Andersen national consulting and accounting firm, they concluded that a merger would allow them to improve care, increase services and control costs better than if they remained competitors.

Both hospitals are profitable. In 1993, Montana Deaconess earned $2.2 million on revenues of $68.1 million, according to

Antitrust

HCIA, a Baltimore-based healthcare information company. Columbus earned $2.5 million on total revenues of $45.1 million that year, HCIA said.

The hospitals had intended to file required pre-merger notification documents with the Federal Trade Commission in January for antitrust clearance. But the filings were delayed and are on hold.

What apparently changed the hospitals' collective mind was a change in the federal government's oversight of mergers in two-hospital towns.

"Obviously, our decision wasn't made in a vacuum," said Maxon Davis, Columbus Hospital's attorney.

Until last year, neither the FTC nor Justice Department had ever challenged a hospital merger in a two-hospital town. Since 1990, the agencies had allowed at least 11 mergers to take place with little or no resistance (Dec. 6, 1993, p. 44).

But the government changed its stance on small-market hospital monopolies in 1994, when the FTC challenged deals in Pueblo, Colo., and Port Huron, Mich., and the Justice Department challenged a deal in Dubuque, Iowa.

The hospitals in Pueblo and Port Huron scrapped their plans before the antitrust complaints went to court, and the Dubuque case is pending in federal district court.

With the government's toughened enforcement approach, the Great Falls hospitals, with the help of the Montana Hospital Association, have turned to the state Legislature to push their cause.

On behalf of the hospital association, a bill was introduced on Feb. 9 that would expand a 2-year-old law that permits healthcare providers to apply and obtain "certificates of public advantage" for collaborative ventures from a new state healthcare authority.

To obtain a certificate, providers have to show a proposed venture likely would improve access or quality or lower costs. Providers that are awarded certificates have to file annual reports with the authority to demonstrate their ventures are doing what they said they would. Certificates can be yanked from providers whose ventures aren't living up to their promises.

In theory, providers obtaining certificates are not only exempt from state antitrust laws but also exempt from federal antitrust laws under the state action immunity doctrine.

Under the doctrine, which has developed through case law, activities permitted or encouraged by the state and supervised by the state are exempt from federal antitrust scrutiny.

At least 18 states have passed similar laws, according to a report released last year by the General Accounting Office. But, the report said, few hospitals have attempted to take advantage of them to put together deals that federal investigators may find illegal.

And, the federal protection allegedly extended to healthcare collaborative ventures under the state laws has never been tested in court.

Still, in Montana, hospitals want their law to be extended to hospital mergers, which weren't explicitly mentioned in the original 1993 statute.

John Flink, vice president of the Montana Hospital Association, said the pending legislation to expand the law to hospital mergers was introduced, in part, with the Great Falls deal in mind.

Although Flink acknowledged that federal antitrust enforcement hasn't been a problem in Montana to date, he said it's better to have protection.

"A number of hospitals are collaborating, but they have an underlying fear that antitrust will be a problem if they go too far," he said.

Flink said the odds of the current law being expanded to hospital mergers are "fairly good." Montana's legislative session is scheduled to end on April 20.

If the bill doesn't pass, the two Great Falls hospitals will take their chances.

"We'll push ahead anyway if there's no legislation," Davis said. "We'll try a new approach."—David Burda

HB 509 intends that state action remove the risk of federal antitrust liability.

What does this mean?

The Federal Trade Commission has said the following on p. 8, paragraph 4 of the attached document:

"The law sets two requirements for state action to remove the risk of federal antitrust liability for private actions such as these cooperative agreements among health care providers. First, the actions must be taken pursuant to a clearly articulated state policy to displace competition; and second, the state must actively supervise the policy. The "active supervision" requirement means that supervision must extend to specifics of implementation. The Supreme Court has said that the purpose of the requirement is to ensure that the state has determined the specific details of a scheme that supplants competition; the mere potential for a state supervisory action is not enough. Applying this requirement to health care, it has been held that an authorizing certificate would not confer antitrust immunity, in the absence of post-certificate regulation of the conduct to ensure that is was consistent with the state's policies."

What would be included in the "active supervision" requirement of the law?

The Supreme Court has said the following on page 2 of the attached document:

"4. . . . actual state involvement, not deference to private price fixing arrangements under general auspices of state law, is precondition for immunity form federal law."

"5. . . . Purpose of active supervision . . . is to determine whether state has exercised sufficient independent judgment and control so that details of rates or prices have been established as product of deliberate state intervention, not simply by agreement among private parties;"

"6. . . . insistence on real compliance with both parts of state-action immunity test will serve to make clear that state is responsible for price fixing it has sanctioned and undertaken to control"

"7. . . . must show that state officials have undertaken necessary steps to determine specific of price-fixing or rate setting scheme; mere potential for state supervision is not adequate substitution for decision by state"

Lead Report

Antitrust

LITTLE ACTIVITY SEEN UNDER STATE LAWS GRANTING ANTITRUST IMMUNITY

There has been a "remarkable lack of activity" under the laws adopted by 20 states to offer protection from federal antitrust enforcement for health care mergers or joint ventures, according to Robert M. Langer, an attorney with Wiggin & Dana, Hartford, Conn.

So far, only Minnesota and Maine have received and approved applications under their state antitrust exemption laws, according to a survey of state attorneys general conducted by Langer's firm. The survey covers activity under the state laws up to December 1994.

The Minnesota health department July 22, 1994, approved the application of HealthSpan Systems Corp. for an antitrust exemption regarding the merger of two large hospital systems in the Minneapolis/St. Paul area.

In Maine, the Department of Human Services Aug. 30, 1993, allowed Maine Medical Center and Mercy Hospital, both in Portland, to share the services of a magnetic resonance imaging machine.

Problems Under State Laws

Lack of activity under the state laws can be attributed in part to extant questions about whether state laws actually provide antitrust immunity, and what is the requisite level of state supervision if they do, attorneys told BNA.

Health care attorneys who are crafting collaborations thus far have forfeited the promise of greater flexibility under state antitrust laws for greater certainty under federal antitrust laws, attorneys told BNA.

"The federal antitrust laws are not generally intrusive on your daily life. Once you get through it, it's done. And only a small percentage of matters are being challenged by federal antitrust agencies," said Phillip A. Proger, Jones Day Reavis & Pogue, Washington, D.C. "Why trade that for continuing state regulation, which tends to be difficult and troublesome?"

State laws—most enacted within the last two or three years—are based on the state action doctrine to federal antitrust laws. Under that doctrine, federal antitrust laws bow to state regulatory programs that supplant competition with state regulation. A 1992 U.S. Supreme Court decision interpreting the doctrine—*Federal Trade Commission v. Ticor Title Insurance Co.* (112 S.Ct. 2169 (1992))—underscored the requirement that state supervision must be active and ongoing.

Antitrust immunity under state law depends partly on whether state regulators have resources available to actively supervise the collaborations, Langer pointed out in remarks to the National Health Lawyers Association's antitrust conference Feb. 16. Prior to 1994, Langer was Connecticut's assistant attorney general in charge of Antitrust and Consumer Protection for 20 years.

Ongoing Review Requirement

Ongoing review could require "a significant outlay of money for [attorneys'] clients to obtain the state's blessing," Langer said.

Ellen S. Cooper, a Maryland assistant attorney general and chief of its antitrust division, said, "Active supervision is a big price a health care provider has to pay to get antitrust immunity. Why would a provider want to subject himself to that? It's a fairly costly proposition because it has to be ongoing and real, more than providing just a site for reports to be filed." Cooper is also chairwoman of the National Association of Attorneys General working group on health care.

Cooper told BNA that the state's costs to provide adequate supervision was one issue she raised when a similar bill was filed in Maryland. No state antitrust bill was passed.

"I don't understand why states have been so eager to embark on passing state antitrust exemptions," Cooper said. "There was a lot of pressure from health care providers on the Legislatures to set up a structure. They were concerned about liability. But most joint ventures have not been challenged."

Minnesota Approves One Application

Lack of activity under Minnesota's antitrust exemption law could reflect that consolidations and joint ventures are very carefully analyzed before they come to fruition, according to Paul R. Kempainen, assistant attorney general for Minnesota and manager of the antitrust division.

The application of the state antitrust exemption law resulted from a challenge by the state attorney general to the proposed merger of two large hospital systems in the Minneapolis/St. Paul area, Kempainen said.

In 1992, the AG filed a complaint in federal district court to prevent the merger of Health One Corp. and Lifespan Inc., arguing the merger would have reduced competition, according to Kempainen.

The state argued the resulting hospital system — HealthSpan — would have accounted for 30 percent to 40 percent of the hospital market in the Twin Cities area, said Kempainen, who also is a member of the NAAG health care working group. The litigation was settled, pursuant to a consent judgment, which authorized the merger if the new corporation applied to the commissioner of health for an antitrust exception.

In the antitrust exemption application proceeding, HealthSpan entered an agreement with the state AG that features: a prohibition on entering exclusive provider contracts for the calendar years 1994 and 1995; stringent limits on inpatient revenue growth at

HealthSpan's metro area hospitals (stricter than required by statute); and regulation to guarantee that cost savings are passed on to unaffiliated third party payers and consumers.

The state also ordered HealthSpan to submit an attestation of compliance with the agreement by independent auditors, and summary schedules and exhibits which identify its spending levels and actual annual growth rate. HealthSpan also will provide periodic reports to the Department of Health based on information collected on quality of care and meet with the department to develop such reporting requirements.

The merger had the potential to generate $31.5 million in cost savings, "which are not likely to be realized absent the proposed arrangement," according to the commissioner's final order.

Merging entities "see that the alternative to competition is strict state regulation. And they say, 'Maybe it's [competition] not so bad.' They were thinking there was an easy way out but the price was too high," Kempainen told BNA.

Little Activity In Maine

"It would be tempting to say the statute is not necessary because there has been only one application but it's hard to measure. There just isn't enough data," said Stephen L. Wessler, Maine's assistant attorney general, director, public protection unit.

Under Maine's Hospital Cooperation Act of 1992, a hospital may negotiate and enter into cooperative agreements with other hospitals in the state if the likely benefits resulting from the agreements outweigh any disadvantages.

"The actual formal activity [under the law] has been pretty minimal. Some transactions would've been filed except that our office has given feedback that there was no significant [antitrust] problem," Wessler told BNA.

In the first and only application under the law, the state attorney general negotiated conditions by which Maine Medical Center, its affiliate, MMC Medical Services Corp., and Mercy Hospital, in Portland, could share the services of an MRI machine.

Maine Medical Center operates a fixed-base MRI. Medical Services operates outpatient and physician diagnostic services at several Portland locations. Mercy uses a mobile MRI unit, once a week.

Medical Services proposed acquisition of a fixed-base MRI to provide services to MMC inpatients, Mercy patients, and outpatients. Benefits purported included:

- higher quality of care through better interpretation of MRI scans;
- more timely provision of MRI services to inpatients;
- greater assurances against overutilization;
- avoidance of duplication of hospital resources; and,
- increased opportunity for additional uses of MRI technology.

The Maine Division of Program Analysis & Development noted that there were several reasons why increasing MMC's capacity to provide MRI services would not adversely impact patients, payers, or providers.

MMC deals mostly with large buyers who can dictate the level of reimbursement they will pay for outpatient MRIs; numerous providers existed as potential providers; and ease of entry into the market was clear, DPAD said in its preliminary review of the proposal.

The state AG reviewed the certificate of public advantage required by the exemption law, approving it on certain conditions. The conditions imposed revenue controls for non-governmental payers; the revenue target limit could be increased at prescribed intervals; Medical Services could reserve three MRI units per day; and no exclusive payer contracts were allowed.

In addition, the AG required that Medical Services could not bar a contracted physician from providing similar services elsewhere; that net revenues reduce the financial requirements of Maine Medical Center, determined by the Maine Health Care Finance Commission; that Medical Services adopt charity care policies; and that adequate records be maintained. If conditions were breached, the AG would undertake remedial measures.

Requirements Under Ticor Unclear

Among *Ticor's* thorniest problems are whether active supervision of an approved merger or joint venture must be ongoing and what benchmark level of state supervision triggers immunity, Langer said.

"What does it [*Ticor*] require other than approval of the transaction at the time it takes place? The issue is completely unclear," Langer told BNA.

The phrase "ongoing regulation," in *Ticor* may be read to refer to the particular restraint at issue in the case — price regulation, he said. In a merger or joint venture, however, the transaction which displaces competition is a new entity, he said. Unless the new entity is altered, it is plausible to argue under *Ticor* that immunity attaches once active supervision of the restraint—the merger or joint venture—results in approval of the transaction, Langer said in his written remarks.

"It's an absolutely fascinating problem in the middle of change of the market place," he said, adding that other reasons for little activity under the laws are that states have not adopted regulations that would satisfy the continuing review criteria and often don't have enough resources to provide ongoing review.

The ideal case to clarify the question of ongoing supervision would be one in which a merger or joint venture was approved in a state that had no ongoing regulatory review requirement, Langer told BNA. The merger would receive a collateral attack either by a competitor or the Justice Department, FTC, or the state, and the issue would be framed precisely, he said.

A chart showing activity under state antitrust exemption laws, prepared by Wiggin & Dana, Hartford, Conn., is in the Text section of this issue.

—By Jeannine Mjoseth

Published by THE BUREAU OF NATIONAL AFFAIRS, INC., Washington, D.C. 20037

STATE*	ACTIVITIES COVERED	PROVIDERS COVERED	STATUTE(S)	ACTIVITY, IF ANY
North Dakota	Joint ventures	Hospitals, physicians and other health care providers	Health Care Provider Cooperative Agreements, August 1993 (1993 North Dakota Laws ch. 261); 1993 N.D. Adv. Legis. Serv. S.B. 2295	None
Ohio	Joint ventures	Hospitals	Sections 3727.21 to 3727.24 of House Bill 718, October 1992 (1992 H. 718, Ohio Revised Code Ann. sec. 3727.21 (Baldwin)); 1992 Ohio Laws 209	None reported
Oregon	(1) Joint ventures (2) Exchange of price information physicians forming managed care organizations providing care under workers' compensation laws	Hospitals (for heart and kidney transplants and related services only)	Senate Bill 681, 1993 Oregon Legislative Assembly, August 1993 (1993 Oregon Laws c. 769); Or. Rev. Stats. 656.260 et seq.	None reported
South Carolina	Cooperative agreements	Hospitals, physicians and other health care providers and purchasers	South Carolina Health Care Cooperation Act, Sections 44-7-500 through 44-7-590 of the Code of Laws of South Carolina.	None reported
Tennessee	Joint ventures	Hospitals	Hospital Cooperation Act of 1993, May 1993 (1993 Tennessee Public Acts ch. 311)	None
Texas	Joint ventures	Hospitals	An Act Relating to Cooperative Agreements Among Hospitals, September 1993 (1993 Texas Sess. Law Serv. ch. 618 (Vernon)	None
Washington	(1) Cooperative agreements	Rural hospital districts	Act relating to cooperative activities of local governments (1992 regular session), March 1992 (1992 Washington Laws ch. 161);	None reported
	(2) Cooperative agreements	Health plans, health care facilities including hospitals, health care providers including physicians	Washington Health Services Act of 1993, April 1993 (1993 Washington Laws ch. 492)	rulemaking pursuant to the legislation is not yet complete; the attorney general's office anticipates at least three applications upon the completion of rulemaking
Wisconsin	Joint ventures	Hospitals, physicians, and other health care providers	1991 Wisconsin Act 250 Regarding Health Care Cooperative Agreements, September 1992 (1991 Wisconsin Laws Act 250)	None

* Connecticut and Maryland both have had legislation involving comprehensive hospital review mechanisms for a substantial period of time. Thus, neither state is included in either the chart or the text. The Iowa Health Insurance Purchasing Cooperative Project, 1993 Iowa Acts Ch. 158; Iowa Code § 96.3.10 has also been excluded

Text

ACTIVITY UNDER STATE ANTITRUST EXEMPTION LAWS

APPENDIX B

STATE*	ACTIVITIES COVERED	PROVIDERS COVERED	STATUTE(S)	ACTIVITY, IF ANY
Colorado	Joint ventures	Hospitals	The Hospital Efficiency and Cooperation Act, July 1993 (1993 Colorado Sess. Laws p. 1888, Colorado Rev. Stat. Sec. 24-12-2701 (1993))	None
Florida	Joint ventures	Certified rural hospitals and other certified rural health care providers	Health Reform Act of 1993, April 1992 (1993 Florida Laws Ch. 93-1299); Fla. Stat. Ann. §§ 395.304	None
Georgia	Mergers	Specified hospitals	The Hospital Authorities Law, July 1991 (1993 Georgia Laws p. 1020)	None reported
Idaho	Joint ventures	Hospitals, physicians and other health care providers	Session Law Chapter 281 Regarding Idaho Health Care Planning Act, July 1994 (1994 Idaho Sess. Laws ch. 283)	No funding for implementation authorized. No activity
Kansas	Mergers and joint ventures	Hospitals, physicians and other health care providers	Health Care Provider Cooperation Act, House Bill 2709, April 1994 (1994 Kansas Sess. Laws 1531; Kan. Stat. Ann. § 65-468 et. seq.	None
Maine	Joint ventures	Hospitals	Hospital Cooperation Act of 1992, April 1992 (1991 Main Laws c. 818, sec. 1; Maine Rev. Stat. Ann. ch. 805-D (West 1993)); Me. Rev. Stat. Ann. title 22 § 1881-7	One Application to date
Minnesota	Mergers and joint ventures	Hospitals, physicians, and other health care providers	The Minnesota Integrated Service Network Act, May 1993 (1993 Minnesota Laws c. 345, art. 6, sec. 14; Minnesota Stat. Ann. sec. 62J.29 (West 1994))	One application submitted and approved
Montana	Joint Ventures	Hospitals and some other health care providers	An Act Providing for Universal Health Care Access, October 1993 (1993 Mont. Laws ch 606)	No major activity anticipated
Nebraska	Joint ventures, and allocation, consolidation, or referral of patients, services, and facilities	Hospitals and other health care facilities	The Health Care Facility-Provider Cooperation Act, April 1994 (1994 Nebraska Laws 1227)	None
New York	Joint ventures or cooperative agreements	Hospitals, physicians and other health care providers serving rural areas	Sections 2958 to 2958 of Senate of Senate Bill 6224 and Assembly Bill 9934, December 1991 (1993 New York Laws ch. 731)	None
North Carolina	Joint ventures	Hospitals	Hospital Cooperation Act of 1993, July 1993 (1993 North Carolina Sess. Laws c. 1291; 1993 N.C. Adv. Legis. Serv. 529 § 5.2	None

*Source: Robert M. Langer, Wiggin & Dana, Hartford, Conn. Prepared for presentation to the National Health Lawyers Association antitrust conference. Reprinted with permission from NHLA and Langer.

RE: HB 509

EXHIBIT NO 36
DATE 3/22/95
BILL NO HB509

...e suit would "attack the validity of third-party ...ntracts requiring sales below cost—thereby injuring ...mpetition" in violation of the California Unfair Practices Act, he explained. It would seek damages, he noted, "on behalf of pharmacies that have lost business because of these contracts as well as consumers who have paid higher cash prices because of the price-shifting resulting from such below-cost contracts."

Discriminatory pricing suits attempt "to curtail the pharmaceutical industry's arbitrary pricing practices, which cause community pharmacies and their patients to pay substantially higher prices," according to Marshall. "Unfortunately, the abolition of discriminatory pricing would not likely affect the ability of health-payers to continue to reimburse at below-cost rates."

Marshall described discriminatory pricing suits as attempts to "level the playing field" and the CPA's planned predatory pricing suit as an effort to ensure everyone "plays by the same rules." Both causes "are necessary and vital to the long-term survival of community pharmacy services," he insisted.

"Pharmacies contracting to provide below-cost reimbursement simply cannot afford to staff appropriately," Marshall pointed out. "The third-party payer benefits at the expense of everyone else—pharmacy owner, employee pharmacists, and patients."

35 STATES URGE CONGRESS TO AVOID ANTITRUST EXEMPTIONS IN HEALTH CARE REFORM

In light of their first-hand knowledge that antitrust law provides the "flexibility needed to implement major reforms," 35 state attorneys general on Nov. 9 urged leaders of the House and Senate to resist calls for enactment of special exemptions and "to ensure that any health care reform package permit antitrust laws to apply to health care markets."

Through antitrust enforcement, the 35 states asserted, ...e public interest in competitive markets is furthered. ...y protecting competition, the antitrust laws promote ...ficiency, innovation, low prices, better management, ...d greater consumer choice, and compensate those injured ... anticompetitive acts. At the same time, antitrust ...w permits joint ventures and other collaborative ...ctivities that benefit the public."

The 35 states reviewed many recent significant cases involving anticompetitive mergers, price fixing, group boycotts, and tie-ins in health care markets pressed by state attorneys general and the FTC. Based on this enforcement experience, these 35 states "have serious reservations about granting antitrust exemptions to segments of the health care industry. Because the interests of industries and their customers may diverge, the antitrust laws operate as the primary safeguard against collusion and other anticompetitive conduct. For this reason, we support the Administration's proposal to repeal the McCarran-Ferguson antitrust exemption for health care insurers."

Even if supplicants for exemption are not-for-profit providers, the 35 states urged congressional leaders "to place a very heavy burden on those who advocate special antitrust treatment to demonstrate why such treatment is needed to improve health care delivery and insurance systems."

In the event the health care industry gets a broad federal exemption, states would feel compelled to regulate in those exempted areas, and such regulation may be too rigid and impinge on federalism principles. After they cited seven states for enacting comprehensive health care reform, the 35 states warned that enactment of a federal exemption "would limit the diversity of these valuable efforts."

The 35 states lauded the efforts of the Justice Department and FTC in providing guidance through the *Antitrust Enforcement Policy Statements in the Health Area*, released on Sept. 15, and their pledge for rapid reviews of transactions with competitive implications. "States should similarly be able to take into account local conditions, as they evolve, in determining what is in the best interests of consumers."

Although they favor efforts "to reduce business uncertainty," the 35 states "oppose federal antitrust exemptions for insurers and health care providers. Exemptions deter the goals of health care reform by limiting the state flexibility and shielding agreements among providers that raise prices, stifle innovation, and restrict consumer choice. The antitrust laws have been instrumental in fostering innovation and efficiency, and in reducing prices in the United States economy; they will foster innovation, efficiency, and consumer choice under a new health care system."

The Nov. 9 letter was sent by the attorneys general of Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada; New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.

These states sent their joint letter to the Chairs and Ranking Minority Members of the House Committees on Appropriations; Armed Services; Banking, Finance and Urban Affairs; Budget; Education and Labor; Energy and Commerce; Government Operations; Judiciary; Merchant Marine and Fisheries; Post Office and Civil Service; Small Business; and Ways and Means. The joint letter also was sent to the Chairs and Ranking Minority Members of the Senate Committees on Appropriations; Armed Services; Banking, Housing and Urban Affairs; Budget; Finance; Governmental Affairs; Judiciary; Labor and Human Resources; and Small Business. The states' letter also was sent to the Chairs and Ranking Minority Members of the Joint Economic and Taxation Committees.

On 11/9/93, MT AG joined 34 other states in opposing health care antitrust exemptions.

Paul GORSUCH
761 31 81 GReat Falls

Regarding Cooperative Efforts by Hospitals.

"The agencies have never challenged an integrated joint venture among hospitals to provide specialized clinical or other expensive health care services."

page 35 of *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, Issued by the U.S. Department of Justice and the Federal Trade Commission, September 27, 1994.

Modern Healthcare
WEEKLY BUSINESS NEWS
Dec. 5, 1994

THE WEEK IN HEALTHCAR

Appeals court OKs Cape Coral merger

VHA region weighing managed-care unit

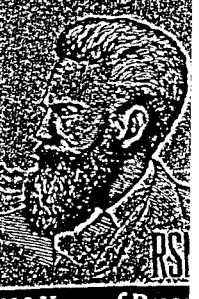
Beginning page 2

What savings?

Critics say payers reap little benefit from hospital mergers

Page 38

Page 4



RSNA convention roundup

100 Years of Progr

Do mergers work?

New study questions hospital industry's claim of benefits to consumers

By Jay Greene

Most hospitals that merged between 1985 and 1987 improved their profitability by reducing expenses, increasing gross and net patient revenues and boosting ancillary services markup rates, a new study said.

These findings seem to contradict the hospital industry's claim that mergers help reduce healthcare costs to consumers. While mergers may help reduce the merged hospitals' own expenses, most hospitals increased their charges after merging, the study found.

The study, which reviewed 36 hospitals that merged into 18 institutions, was conducted for MODERN HEALTHCARE by Health Care Investment Analysts, Baltimore (See related story, p. 28, for methodology and chart).

It's the first study to measure performance before and after hospital mergers since Medicare's prospective pricing system was implemented in 1983.

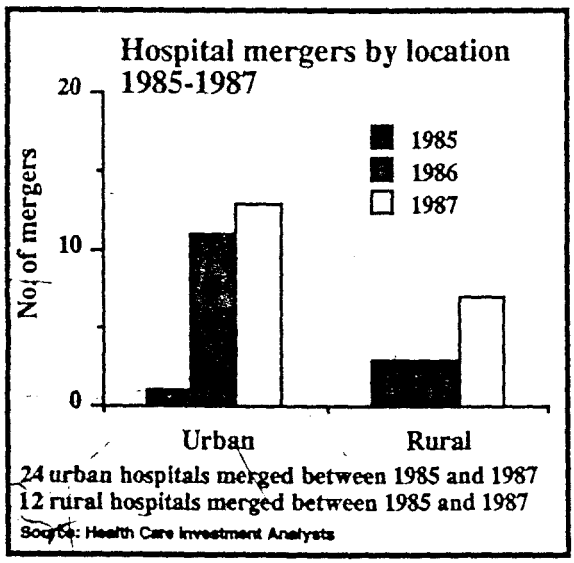
Increased market share. In a subgroup of 20 hospitals that merged into 10 facilities in 1987, the study also found that hospitals with the largest market shares before merging were able to increase their market shares at their competitors' expense in the year after a merger.

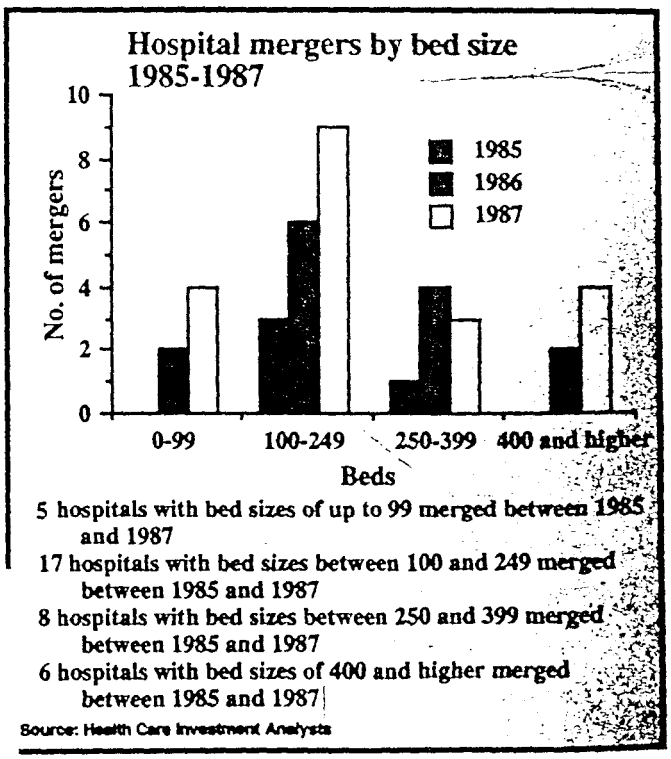
Six market leader hospitals also were able to increase their net patient revenues and markup rates more than the study group because they commanded greater market power and could control pricing more effectively, the study found.

In two 1987 mergers, the merged hospitals became the community's sole provider, thus eliminating competition.

Overall, the 18 merged hospitals were able to reduce expenses 1% to 2% annually primarily because per bed admission increases enabled them to spread their fixed costs over more patients, the study found.

The hospitals also increased their





Cascade County Medical Society
M. L. MARGARIS, M.D.
401 - 15th Avenue South #201
Great Falls, MT 59405

SENATE HEALTH & WELFARE
EXHIBIT NO 3K
DATE 3/22/95
BILL NO HB 509

ON MARCH 8, 1995 A JOINT MEDICAL STAFF MEETING WAS HELD TO DISCUSS THE PROPOSED HOSPITAL MERGER. FOLLOWING THAT MEETING, A BALLOT WAS DISTRIBUTED TO LOCAL PHYSICIANS AND STAFF PSYCHOLOGISTS TO DETERMINE THE MEDICAL COMMUNITY'S OPINION REGARDING THE PROPOSED MERGER. AS OF 7 PM ON MARCH 20, 139 BALLOTS WERE RECEIVED, REFLECTING A 70% RESPONSE RATE. THE BALLOT WAS DESIGNED TO MEASURE EACH INDIVIDUAL'S OPINION BOTH BEFORE AND AFTER THE MEETING. THE RESULTS OF THIS POLL, SPONSORED BY THE CASCADE COUNTY MEDICAL SOCIETY, ARE AS FOLLOWS:

	BEFORE MEETING	AFTER MEETING
IN FAVOR OF MERGER/CONSOLIDATION	29%	32%
OPPOSED TO MERGER/CONSOLIDATION	45%	47%
UNDECIDED	23%	19%
NO RESPONSE	3%	2%

MANY RESPONDENTS CHOSE TO MAKE COMMENTS, WHICH WERE HELPFUL. THESE WILL BE PRESENTED AT A FUTURE MEETING. THE CASCADE COUNTY MEDICAL SOCIETY WISHES TO THANK ALL THOSE WHO ATTENDED THE JOINT MEETING AS WELL AS THOSE WHO RETURNED THEIR BALLOTS FOR THIS OUTSTANDING RESPONSE.

M. L. Margaris MD

M. L. MARGARIS, M.D.
PRESIDENT

Cascade County Medical Society
Official Business

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 3/22/95
BILL NO. HB509

MONTANA MRI

MAGNETIC RESONANCE IMAGING CENTER
MAMMOGRAPHY • ULTRASOUND

1099 North 27th Street Billings, Montana 59101

Phone 406-256-8100
Fax 406-256-7100

Kathleen Ryan, M.D.
Radiologist/Medical Director

Timothy Lee Nagel, M.S.
Director / General Partner

March 22, 1995

Public Health Welfare & Safety
Montana State Senate
Capitol Station
Helena, Montana 59620

To the committee, RE: HB-509 Opposition

Please consider the elimination of HB-509 (Mergers & consolidations of Health Care Facilities) via a do not pass recommendation. The proposed legislation extends existing law by first, extending cooperative agreements to include mergers & consolidations, and second, the potential inclusion of providers (implying physicians). Please be aware that the provision of "certificates of public advantage" and their associated antitrust protection may adversely affect Montana overall. Our state is critically dependent upon small business, and any legislation which limits antitrust enforcement is not in the best interest of our state and it's small business community.

Montana health care facilities are already currently able to merge, or jointly acquire specialized equipment, under Federal Anti-Trust guidelines. The FTC simply applies simple common sense requirements in an effort to encourage fair competition. The proposed legislation specifically compromises these safeguards. HB-509 attempts to justify it's actions by indicating that a certificate may not be issued unless the consolidation or merger; 1) "is likely to result in lower health care costs", or 2) " is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs. These objectives are obtainable without this legislation.

Adoption of this legislation also implies that the state will have to substitute regulation in the absence of competition. This required mandate for active supervision creates an associated funding mandate for appropriate supervision, and also puts the state at risks with respect to potential future litigation. Also, most probably agree that increased bureaucracy and regulation seldom support true competitive cost containment mechanisms.

Existing law provides for the implementation of cooperative agreements to achieve some of this bill's stated goals. Such cooperative agreements are certainly not as threatening to small business as proposed mergers. In addition, should approved cooperative agreements later be proven counter productive, they could be reversed. A major consolidation or merger provides a far different scenario once approval has been granted.

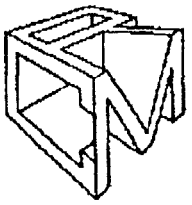
This proposed legislation puts every small business health care facility in Montana at risk. Such risk endangers current facilities, and potential future facilities. Thus, significant basic concepts associated with free market enterprise and associated cost containment mechanisms are at risk. Our facility has already demonstrated advantages associated with a competitive market place, and done so under difficult circumstances. Lower priced imaging services are available, service availability or access has been vastly improved, and a new specialized physician has been brought to the community. In addition, a much needed highly capital intensive health care service has been provided to the local community, without the utilization of scarce community hospital funding. Such scarce funding is now extended and available for utilization in other required areas.

Thank you for your consideration of our concerns and a do not pass recommendation for HB-509.

Sincerely,

Timothy Lee Nagel

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 3/22/95
BILL NO. HB 509



CRM, Inc.

2520 17th Street West • Billings, Montana 59102 • Phone (406) 245-5704

March 22, 1995

Public Health, Welfare, and Safety Committee
Montana State Senate

Attn: Sen. James Burnett
Sen. Steve Benedict
Sen. Mike Sprague
Sen. Sharon Estrada

Re: Opposition to HB-509

CRM runs a medical service bureau serving hospital-based physicians in four states. As such, we have had ample opportunity to observe the chaos engendered by the current highly fragmented health care system in Montana. This chaos is aggravated by the attempts at vertical integration being pursued by the larger health providers such as hospitals and some HMO type organizations. Accordingly, we oppose Bill 509.

Sincerely yours,

Judith K. Jurist

Judith K. Jurist
Treasurer

TOTAL P.01

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 3/22/95
BILL NO. HB 509

NORTHERN ROCKIES SURGICENTER

1020 NORTH 27TH STREET
BILLINGS, MONTANA 59101
(406) 248-7186

March 22, 1995

Public Health, Welfare, and Safety Committee
Montana State Senate

Attn: Sen. James Burnett
Sen. Steve Benedict
Sen. Mike Sprague
Sen. Sharon Estrada

Re: HB-509

Northern Rockies Surgicenter opposes this bill since it endangers every independent small health care facility in Montana. Such endangered facilities include ambulatory surgical centers such as ours, independent imaging centers, pain clinics, and others.

If vertical integration is pursued voluntarily by all affected parties on a level playing field, one could argue some advantage to this bill. However, past history in Billings and other larger Montana cities demonstrates that the concentration of economic power in large hospitals results in the demise of independent health care facilities. Unfortunately, this leads directly to increases in health care costs. Our facility has done a great deal to retard increases in costs for outpatient surgery in Billings despite opposition from both hospitals. However, if we were to disappear as a result of this flawed bill, costs of outpatient surgery would escalate markedly in Billings.

Thank you for your attention.

Sincerely yours,

John M. Jurist, Ph.D.
President

SWEENEY & HEALOW

Attorneys at Law
Suite 202
1250 15th Street West
Billings, Montana 59102

Kevin T. Sweeney
James P. Healow

Tel. (406)256-8060

March 22, 1995

Public Health, Welfare & Safety Committee
Montana State Senate
Capitol Station
Helena, MT 59624

Re: HB 509

Dear Senators:

I understand there is pending before you an amendment to HB 509 which proposes to exempt hospitals from the state antitrust laws. HB 509 is offensive in its own right, but the amendment is especially offensive. This amendment definitely would be a benefit to hospitals–but at the undeniable expense of their patients. A situation which already exists in Billings demonstrates how this amendment, if passed, will harm Montana citizens.

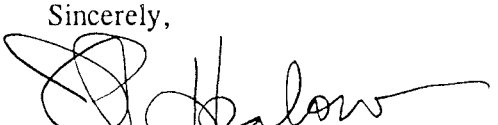
On September 1, 1992, St. Vincent's in Billings closed its anesthesia department, and implemented a price fixing scheme for the sale of anesthesia services. As a result, anesthesiology services at St. V's immediately increased by 10%, within 4 months they increased almost 10% more, and only two antitrust suits caused cancellation of a third rate increase. This whole time, the anesthesia rates at Billings Deaconess, where some competition exists, were not increasing. St. V's has more than 8000 cases involving surgical anesthesia each year–meaning 8000 citizens per year are being price gouged. If this amendment is adopted, the legislature will have deprived patients of any defenses against avaricious and over-reaching hospitals.

Regarding the bill as a whole, it should come as no surprise to the senators that monopolies do not lower or maintain prices, they raise them. This bill, aside from creating yet another cumbersome bureaucracy at a time when the public has been demanding the elimination of bureaucracy, gives hospitals a license to steal. It will not serve the best interests of the citizenry. If the bill has any logical appeal, that appeal is limited to small communities where there are some economies of scale to be realized from associations among the very limited numbers of medical providers. Those economies of scale do not exist in Billings, Missoula, and Great Falls. If the Legislature wishes to sanction such associations in small communities, that goal very easily may be realized by limiting the applicability of HB509 (and HB511) to medical providers who do not treat patients in interstate commerce.

I particularly appeal to Senators Sprague and Estrada to oppose the bill and the amendment. I appeal to Senator Estrada as one of her constituents. I appeal to Senator Sprague on behalf of the thousands of patients, many of whom live in his district, who over the past 2½ years have been cheated out of millions of dollars by a price fixing hospital.

Thank you very much for your consideration of the foregoing in deliberating this very dangerous legislation.

Sincerely,



SENATE HEALTH & WELFARE
EXHIBIT NO. 8A
DATE 3/22/95
BILL NO. HB509

JAKE J. ALLEN, M.D., F.A.C.S.
General and Vascular Surgery

North Central Montana Professional Bldg. - Suite 109
400 - 15th Avenue South ● Great Falls, Montana 59405 ● (406) 727-9042

Dear Senator:

This letter and packet is in reference to House Bill 509. This bill would allow hospitals to obtain "certificates of public advantage" in order to merge. This would bypass the Federal Trade Commission and Justice Department applications. Jim Flink, vice president of the Montana Hospital Association, said the pending legislation to expand the law to hospital mergers was introduced, in part, with the Great Falls deal in mind. The two hospitals are essentially taking out an antitrust insurance policy to protect their proposed merger from antitrust regulators.

It should be noted that on November 9, 1993, the Montana state attorney general united with thirty-four other state attorneys general to resist calls for enactment of special exemptions and to "to ensure that any healthcare reform package permit antitrust laws to apply to healthcare markets."

Through antitrust enforcement, the thirty-five states asserted, the public interest in competitive markets is furthered. By protecting competition, the antitrust laws promote efficiency, innovation, low prices, better management, and greater consumer choice, and compensate those injured by anticompetitive acts. At the same time, antitrust law permits joint ventures and other collaborative activities that benefit the public.

The thirty-five states reviewed many recent significant cases involving anticompetitive mergers, price fixing, group boycotts, and tie-ins in healthcare markets pressed by state attorneys general and the FTC. Based on this enforcement experience, these thirty-five states have "serious reservations about granting antitrust exemptions to segments of the healthcare industry. Because the interest of industries and their customers may diverge, the antitrust laws operate as the primary safeguard against collusion and other anticompetitive conduct."

The federal protection allegedly extended to healthcare collaborative ventures under the state laws has never been tested in court. The merger of the Great Falls hospitals under HB 509 could prove to be very costly to Montana in legal fees.

It appears that this bill at present would only apply to the special interests of those proposing a hospital merger in Great Falls. The Cascade County Medical Society has passed a resolution opposing the merger of the hospitals in Great Falls. The Montana Medical Association has passed a resolution opposing House Bill 509. A poll of the combined medical staffs of the hospitals showed that just less than one third of the physicians were in favor of the merger. The Cascade County Commissioners were asked for an endorsement of the merger and, after hearing both sides, decided to table the issue. There is very little community support for this as evidenced only 200 letters of support for the merger from the community after almost a year's campaign and spending over $650,000.

Both hospitals are viable, making record profits in 1994. I would urge you to vote against House Bill 509, which caters to a very narrow special interest group and facilitates a very unpopular hospital merger in Great Falls.

Sincerely,

Jake D. Allen M.D.

INFORMATION OPPOSING THE MERGER OF THE GREAT FALLS HOSPITALS

prepared by Jake J. Allen M.D.

EXHIBIT 8C
DATE 3-22-95
HB 509

CASCADE COUNTY MEDICAL SOCIETY RESOLUTION AGAINST THE MERGER OF COLUMBUS HOSPITAL AND MONTANA DEACONESS HOSPITAL OF GREAT FALLS

Whereas the consolidation of Columbus and Montana Deaconess hospitals of Great Falls, Montana, has been proposed for projected benefits that have not been supported by credible evidence from the healthcare literature;

Whereas the loss of profitability prediction, beginning in 1997, is predominantly based on falling inpatient volumes, and over the last five years despite falling inpatient utilization, healthcare has been the most profitable industry in the United States;

Whereas in actual studies of merged hospitals the rate of increase in hospital charges did not decline but actually rose;

Whereas in "Statements of Enforcement Policy and Analytical Principles Relating to Antitrust," issued by the U.S. Department of Justice and the Federal Trade Commission, September 27, 1994, most hospital joint ventures to purchase or otherwise share the ownership cost of, operate, and market high technology or other expensive healthcare equipment and related services do not create antitrust problems, therein obviating the need to consolidate to share these services;

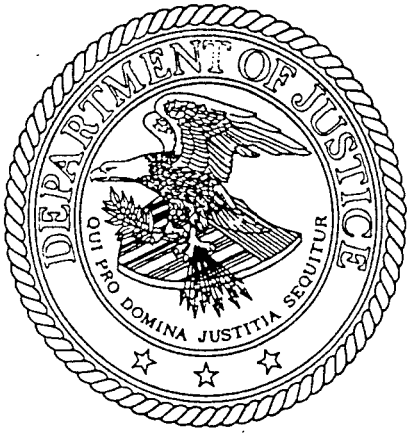
Whereas this proposed consolidation would create a monopoly for healthcare services in this region and given that monopolies have been documented in the healthcare literature to be less responsive to healthcare consumers;

Whereas the consolidation can be predicted to save one to two million dollars a year given the performance of past mergers and would cost ten to seventy million dollars;

Whereas both Great Falls hospitals have been recognized nationally for quality healthcare [the Deaconess hospital has been listed as one of the safest institutions for cardiac surgery as reported by the Wall Street Journal; the Columbus hospital has been listed as among the twenty best hospitals in the western United States as reported in New Choices magazine in 1993], and the consolidation proposal has presented no credible evidence that the consolidation will improve the quality of healthcare;

We, the Cascade County Medical Society, resolve to oppose the proposed consolidation of Columbus and Montana Deaconess hospitals.

Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust



Issued by the
U.S. Department of Justice
and the
Federal Trade Commission

September 27, 1994

2. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL JOINT VENTURES INVOLVING HIGH-TECHNOLOGY OR OTHER EXPENSIVE HEALTH CARE EQUIPMENT

Introduction

Most hospital joint ventures to purchase or otherwise share the ownership cost of, operate, and market high-technology or other expensive health care equipment and related services do not create antitrust problems. In most cases, these collaborative activities create procompetitive efficiencies that benefit consumers. These efficiencies include the provision of services at a lower cost or the provision of services that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase prices without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers. The Agencies have never challenged a joint venture among hospitals to purchase or otherwise share the ownership cost of, operate and market high-technology or other expensive health care equipment and related services.

This statement of enforcement policy sets forth an antitrust safety zone that describes hospital high-technology or other expensive health care equipment joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It then describes the Agencies' antitrust analysis of hospital high-technology or other expensive

3. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL JOINT VENTURES INVOLVING SPECIALIZED CLINICAL OR OTHER EXPENSIVE HEALTH CARE SERVICES

Introduction

Most hospital joint ventures to provide specialized clinical or other expensive health care services do not create antitrust problems. The Agencies have never challenged an integrated joint venture among hospitals to provide a specialized clinical or other expensive health care service.

Many hospitals wish to enter into joint ventures to offer these services because the development of these services involves investments -- such as the recruitment and training of specialized personnel -- that a single hospital may not be able to support. In many cases, these collaborative activities could create procompetitive efficiencies that benefit consumers, including the provision of services at a lower cost or the provision of a service that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase prices without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers.

This statement of enforcement policy sets forth the Agencies' antitrust analysis of joint ventures between hospitals to provide specialized clinical or other expensive health care services and includes an example of its application to such ventures. It does

Changing
Mostly sunny early; cloudy in afternoon. High near 75.
/ 8A

Great Falls TRIBUNE

Thursday, June 2, 1994 | Great Falls, Montana | No. 20— 110th Year | 50¢

Study: Consolidate hospitals

Savings over 5 years: $54.5 million

By JAMES E. LARCOMBE
Tribune Staff Writer

Consolidating the two hospitals in Great Falls would save millions of dollars, eliminate duplication and improve medical care in north-central Montana, a consulting firm says.

Now it's up to the boards of directors at Columbus Hospital and Montana Deaconess Medical Center to act on the recommendation unveiled Wednesday after several months of study.

Consolidation could cost nearly 180 jobs and cause plenty of heartache at the hospitals, which employ about 1,800 workers.

■ Hospitals have philosophical differences to overcome / 5A
■ Changes coming even without consolidation plan / 5A
■ Editorial, 6A

But administrators say uncertain financial prospects and changes in medical care make consolidation an attractive move.

"It's a much better potential scenario than the status quo," said Kirk Wilson, president and chief executive at Deaconess.

The recommendation is based on a study of the hospitals and interviews with about 200 community and business leaders in Great Falls, Arthur Anderson & Co., a big accounting and consulting firm, was paid $230,000 by the hospital boards to do the study, which began in March.

The consultants say setting up one governing board, one management structure, a single medical staff and integrated operations could save $10.9 million per year. Five-year savings could total $54.5 million.

"Those savings are estimated, but

See HOSPITALS, 8A

Consolidation options

Montana Deaconess Medical Center and Columbus Hospital are studying ways to work together. Here's a look at saving under various consolidation plans.

Options	Jobs	Annual operating savings	Capital savings	Total annual savings	Five-year savings
		IN MILLIONS OF DOLLARS			
Status Quo	170	—		—	
Collaboration with shared services	23	$1.2	$0.7	$1.9	$9.5
Consolidation with focused services	126	$5.8	$2.3	$8.1	40.5
Consolidation with acute care at one location	178	$8.0	$2.9	$10.9	$54.5

* Rough estimate based on projected future losses tied to changes in industry.

Source: Montana Deaconess Medical Center, Columbus Hospital — Chris Sykes/Tribune

Tribune Photo by Wayne

Cindy Peterson thinks consolidation with Columbus wouldn't threaten her job as emergency-room nurse at Deaconess because the demand for ER services would decrease. Other employees tell what they think on 5A.

MONTANA

Classified Pages 3-8B

Questions or news tips? Call City Editor Tom Kotynski, 791-1477 or 1-800-438-6600.

Frontier takes off in Montana next month

Delta cuts Helena fares

By The Associated Press and Tribune Staff

Frontier Airlines announced Friday that it will start serving Montana next month with flights from Denver to Bozeman and Missoula.

Service will begin Aug. 5 with two round-trip flights daily, the Denver-based company said. Boeing 737-200 jets with 108 seats will fly from Denver to Bozeman and on to Missoula, then return to Bozeman and Denver.

Frontier Chairman M.C. "Hank" Lund said the flights will help fill a void in jet service.

A day before Frontier's announcement, officials at the Helena airport said Delta Air Lines agreed to reduce fares from Helena. Airport officials hope that will draw the business of some travelers who have been flying out of the Great Falls and Missoula airports to save money.

Lund said Frontier's Montana schedule will be timed for good flight connections out of Denver. The company's discount plans will not have the common requirements of Saturday-night stayovers and the purchase of round-trip tickets, Lund said. Special introductory fares are planned.

Frontier is re-emerging after the airline stopped operating eight years ago and entered bankruptcy. Daily jet service from Denver to North Dakota is scheduled to begin on Tuesday, and the company is looking at other potential markets, including Iowa, Nebraska and additional points in Montana.

The Bozeman and Missoula service will create a total of 15 to 20 jobs in those cities, Frontier Executive Vice President Sam Addoms said Friday. Frontier officials have talked of adding service to Great Falls and Billings at some point. Great Falls lost direct service to Denver when United Airlines pulled out last fall.

In Helena, airport manager Ron Mercer said Delta's reduced excursion fares from the city mean that flying to Denver from Missoula now can cost $60 more than flying from Helena.

"We've had a long-standing problem with fares being cheaper from other cities," Mercer said Thursday. A Helena Chamber of Commerce committee had been lobbying for lower fares. Delta reduced its prices for full-coach, excursion and federal-employee tickets.

It now costs about $630 for the average full-coach fare from Helena to Washington, D.C., according to Mercer's figures. The same trip on an excursion ticket purchased two weeks in advance and with a Saturday-night stay is about $570 round trip, and the government fare is $736.

"We used to pay up to $1,200 to get from Helena to Washington," said Don Whitney, district director for the U.S. Immigration and Naturalization Service. He also is a member of the Helena Chamber of Commerce's Air Service Task Force Committee.

"People in my office do quite a bit of traveling and noticed that often it was substantially cheaper to fly from Missoula or Great Falls than Helena," Whitney said.

Rich Reini, Delta's senior sales representative in Montana, said he wasn't aware of the details of changes to Helena fares. Current fares to Salt Lake City and other destinations are same for both Great Falls and Helena, he said.

"We've asked our pricing people to keep Helena competitive with Great Falls," he said Friday afternoon.

Efforts to contact Joe Attwood, the Great Falls Airport manager, for comment on possible impacts from the fare changes were unsuccessful Friday afternoon.

11/23/94

PSC sues US West, cites service

By The Associated Press

HELENA — The state Public Service Commission filed a lawsuit against US West on Tuesday that alleges the phone company provides inadequate service to its Montana customers and should be fined thousands of dollars.

The suit, filed in state District Court, claimed the company fails to meet state standards for installing and repairing phone service throughout much of the state.

US West "has flagrantly and consistently violated certain service standards adopted by the PSC," the suit said.

The complaint noted the law allows fines of $100 to $1,000 per day for each violation of the service standards. Robin McHugh, chief attorney for the commission, said an estimate of how much in fines may be at stake is not possible until his staff can review detailed US West records.

Crystal Shors, spokeswoman for the company in Helena, said US West officials would not comment on the suit because they had not yet seen it.

"But," she added, "we have taken actions to improve our service and our reviews indicate we're progressing."

The suit came as no surprise; the PSC voted unanimously Oct. 3 to take the utility to court.

The company has blamed many of its delays in providing service on increased demand that has resulted in the need to add an estimated 13,000 phone lines this year alone.

The suit cites violations that occurred between January and July of this year in repair service offices in or around Billings, Bozeman, Butte, Glendive, Great Falls, Hamilton, Helena, Lewistown and Missoula.

Hospital Mergers
some reports
from the literature 1975-1994

Paul Gorsuch M.D.

Mergers and competition

The hospital industry has recently experienced merger activity. This paper examines several actual and proposed mergers. . . . Our focus is on mergers between hospitals in the same market. We conclude that these mergers threaten the competition that exists in most of the markets discussed, and that the claimed efficiency justification for mergers is not convincing.

Blackstone, E. & Fuhr, J; Hospital Mergers and Antitrust: An Economic Analysis, *Journal of Health Politics, Policy and Law* 14(2): 383-403 Summer 1989.

Cost of mergers

Most hospital mergers are sold to the community as a way to reduce service and staffing duplication, consolidate clinical programs, achieve economies of scale and increase profits to invest in new services. But two new studies on hospitals that merge in small markets also indicate most mergers were more costly than expected. . . The expansion of services improved the hospitals' quality and reputations, but it also increased their operating costs.

Greene, J. The costs of hospital mergers, *Modern Healthcare*/February 3, 1992.

Mergers effect on consumers

Most hospitals that merged between 1985 and 1987 improved their profitability by reducing expenses, increasing gross revenues and boosting ancillary services markup rates. . . .

These findings seem to contradict the hospital industry's claim that mergers help reduce health care costs to consumers. While mergers may help reduce the merged hospitals' own expenses, most hospitals increased their charges after merging. . .

Hospitals that increased profitability the most through a merger were the largest and most powerful facilities in their markets. . .Operating expenses per adjusted admission rose 6.7% . . . for market leaders, compared with a 1% decrease for the study group.

One major factor accounting for the increase in gross patient revenues per admission at the merged hospitals was an increase in the markup rate for ancillary services. . .

Merged hospitals increased their markups to 61% above costs the year after a merger and to 69% above costs two years after merger. During the merger year, the markup averaged 55%.

Greene, Jay; Do mergers work? New study questions hospital industry's claim of benefits to consumers. *Modern Healthcare*/March 19, 1990.

Small Market Hospital Mergers 1985 to 1988-OUTCOMES (Modern Healthcare/Feb. 3, 1993)

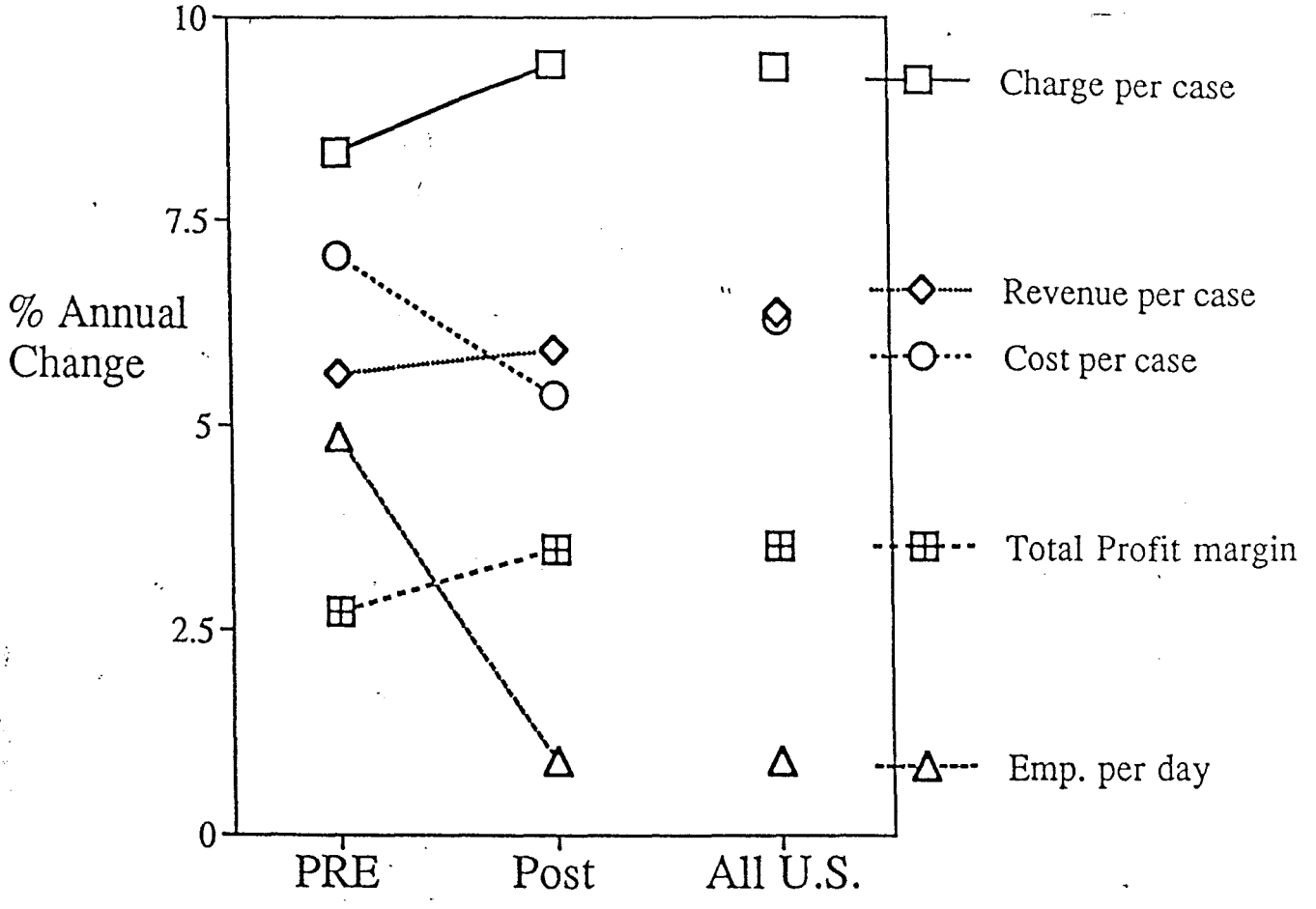
The study indicates hosptials increased prices, reduced annual cost increases, improved occupancy rates and cut capacity to improve profit margins. (All categories except profit margins are % annual change).

YEARS PRE.or POST Merger	Occu-pancy	Charge per case	Revenue per case	Cost per case	Employ-ees per day	Total profit margin
3 PRE	-3.94	6.97	5.48	5.94	1.76	4.10
2 PRE	-3.31	7.52	5.11	5.31	5.56	2.97
1 PRE	-4.06	9.04	5.55	8.43	5.41	2.49
Year of merger	-3.94	9.79	6.39	8.56	6.68	1.30
PRE merger average change	**-3.81**	**8.33**	**5.63**	**5.63**	**4.85**	**2.72**
1 POST	-0.83	11.27	7.33	6.50	-1.88	2.55
2 POST	0.38	8.34	4.68	6.96	2.76	2.11
3 POST	0.03	10.13	6.94	5.85	0.68	3.68
4 POST	0.70	7.94	4.72	2.12	0.16	5.52
Post merger average change	**0.07**	**9.42**	**5.92**	**5.36**	**0.43**	**3.47**
All U.S. hospitals	-1.02	9.38	6.36	6.27	0.89	3.51

SOURCE: Greene, J; **The costs of hospital mergers.** *Modern Healthcare/Februrary 3 1993*: reporting on two studies; one by Cleveland based Robert & Associates looking at 17 hospitals that merged between 1985 and 1990, the second by Baltimore-based Health Care Investment Analysts looking at reports of 14 hospitals that merged between 1985 and 1988.

Hospital Merger Outcomes

PRE and POST Merger Averages
(Percent Annual Changes)



(Pre/Post Merger Averages and National Averages)

SOURCE: Greene, J; The costs of hospital mergers. *Modern Healthcare*/Februrary 3 1993: reporting on two studies; one by Cleveland based Robert & Associates looking at 17 hospitals that merged between 1985 and 1990, the second by Baltimore-based Health Care Investment Analysts looking at reports of 14 hospitals that merged between 1985 and 1988.

Lower Costs?

The proposed merger of Columbus and Deaconess Hospitals is being advocated as a means to control healthcare costs to the community and achieve savings.

An analysis of 36 general acute care hospitals that merged into 18 facilities between 1985 and 1987 found that:

- "While mergers may help reduce the merged hospitals' own expenses, most hospitals increased their charges after merging." Hospitals that were more powerful in their markets had the largest markups of charges and actually demonstrated increases in operating expenses.

> Yet the Arthur Andersen & Co. report states that a key factor leading to their recommendation for merger is the community attitude that healthcare costs in Great Falls are already high and that future cost increases should be minimized.

- "Overall merged hospitals were able to reduce expenses 1% to 2% annually primarily because per bed admission increases enabled them to spread their fixed costs over more patients." However, in the subgroup in which the merging hospitals "were the largest and most powerful facilities in their respective markets . . . operating expenses per adjusted admission rose 6.7% . . . compared with a 1% decrease for the 36-hospital study group."

> Yet the Arthur Andersen & Co. report projects savings from a merger of 8% of annual operating costs. This magnitude of savings appears to be unheard of in the published reports of actual savings achieved. Titles of over 1200 articles on Health Facility Mergers form 1975 to 1994 were reviewed.

Sources:

-Greene, Jay; Do mergers work? New study questions hospital industry's claim of benefits to consumers. *Modern Healthcare*/March 19, 1990.

-Report Summary, Study of Community Benefits form Collaboration and Evaluation of Alternative Healthcare Delivery Models; Arthur Andersen & Co., Seattle, Washington May 27, 1994.

Should we rush into a merger?-some distant voices.

"FAILURE IS THE NORM. . . a majority of mergers and acquisitions do not achieve the objectives that the parties hoped to achieve. . . anywhere form 50 percent to 80 percent of all mergers and acquisition fail. In spite of these sobering statistics, business and healthcare leaders search hungrily for the opportunity to take a chance at this risky game."

Source: Kazemed, E. **Why Mergers and acquisitions fail**; *Healthcare Financial Management*, January 1989.

In 1987 Arthur Andersen & Co. participated in a study compiling the views of over 650 panelists consisting of hospital CEOs, chief financial officers, board members/trustees, physicians and others. Titled Multihospital Systems: Perspectives and Trends, the study includes predictions for the future of the nation's health care system. While our system in Great Falls may not parallel the "multihospital systems" in this study it seems reasonable to at least review their thoughts. Significant items in the report's fourth and final section are:

- "Multihospital systems must have clear conflict-of-interest policies."

  Should Arthur Andersen & Co. identify potential conflict of interests for their company if they recommend merger and then are paid for facilitating that process not only for business consultations, but for legal advice on antitrust issues as well?

- "The quality of a system's governing board is the most important key to multihospital systems" future survival and success.
  -Next in importance: improvements in the current Medicare prospective pricing system.
  -Third in importance: gaining competitive advantage through the acquisition of new medical technology/equipment."

- "LEAST important keys to survival and success of multihospital systems.
  -Expansion into foreign markets and gaining competitive through telecommunications were agreed by all panelists.
  -Next least important were merger with/acquisition of other multihospital systems, joint ventures with insurance companies, ."

Source: Multis, Failed merger: a fluke or end of a multi trend? Hospitals, April 20, 1987.

Modern Healthcare
WEEKLY BUSINESS NEWS

Dec. 5, 1994

THE WEEK IN HEALTHCA

Appeals court OKs Cape Coral merger

VHA region weighing managed-care unit

Beginning page 2

What savings?

Critics say payers reap little benefit from hospital mergers

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RSNA convention roundup

Cover story
By Jay Greene

Merger

Research shows merging hospitals may be promising employers more than they can deliver

It's likely 1994 will go down in healthcare history as the year dozens of hospitals claimed they were merging to form integrated delivery systems.

Only time will tell whether these hospitals can work together, and with physicians and other providers, to truly develop networks that can deliver a full spectrum of healthcare services at a reasonable price.

This article explores the post-merger behavior of small-market hospitals and its effect on competing hospitals, managed-care payers and business groups. An upcoming story will explore whether hospitals need greater—or less—antitrust protection to merge. And, in future issues, MODERN HEALTHCARE will present case studies of other merged hospitals.

While more academic research is needed on merged hospitals, several facts are known about their post-merger behavior. In 1990, Baltimore-based Health Care Investment Analysts conducted for MODERN HEALTHCARE the first study exploring the financial implications of hospitals before and after mergers since Medicare's prospective pricing system was introduced in 1983 (March 19, 1990, p. 24).

The study found that merged hospitals didn't pass on efficiency gains to consumers in the form of lower prices. In fact, on average, the 18 merged hospitals increased their prices a total of 9% two years after a merger, compared with a 1% price hike the year before the merger.

The post-merger price increases came even after adjusting for inflation and severity of illness—and after experiencing efficiency gains, the study said.

As a result, hospitals increased profits at higher rates in areas where they had greater market concentration, according to a 1993 American Hospital Association study (Nov. 15, 1993, p. 4).

In a 1992 study, MODERN HEALTHCARE found that one reason hospitals in small markets raised prices was to purchase expensive technology, expand into tertiary services and become regional referral centers to capture more Medicare dollars and patients (Feb. 3, 1992, p. 36).

While the merged hospitals ended their local "medical arms race," a regional race heated up for tertiary care with hospitals as far as 50 miles away, the study found.

In this report, MODERN HEALTHCARE discovered another reason hospitals in smaller communities increased prices at higher rates after a merger: Nobody stepped forward to stop them.

As merged hospitals increased market concentration, they commanded greater market power and were less inclined to deal with businesses or payers seeking discounts.

Without managed care, businesses in smaller communities moved slowly to organize into coalitions that could collectively purchase healthcare services at reduced prices. Only when business groups joined forces and demanded price concessions did merged hospitals agree to reduce prices and pass along savings.

"One of the first things that happens is someone comes the numbers to show that the merger will make a financially wonderful operation... Many benefits to merger are illusory."

SENATE PUBLIC HEALTH & WELFARE
EXHIBIT NO. 29 8/4
DATE 3/22/95
BILL NO. HB 309

Do mergers work?

New study questions hospital industry's claim of benefits to consumers

By Jay Greene

Most hospitals that merged between 1985 and 1987 improved their profitability by reducing expenses, increasing gross and net patient revenues and boosting ancillary services markup rates, a new study said.

These findings seem to contradict the hospital industry's claim that mergers help reduce healthcare costs to consumers. While mergers may help reduce the merged hospitals' own expenses, most hospitals increased their charges after merging, the study found.

The study, which reviewed 36 hospitals that merged into 18 institutions, was conducted for MODERN HEALTHCARE by Health Care Investment Analysts, Baltimore (See related story, p. 25, for methodology and chart).

It's the first study to measure performance before and after hospital mergers since Medicare's prospective pricing system was implemented in 1983.

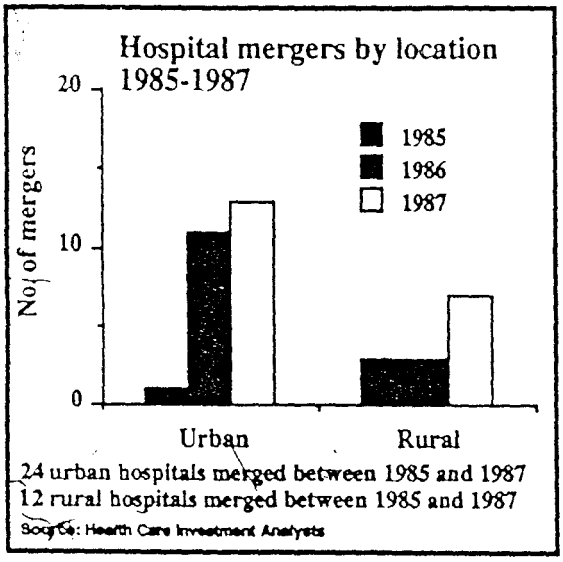
Increased market share. In a subgroup of 20 hospitals that merged into 10 facilities in 1987, the study also found that hospitals with the largest market shares before merging were able to increase their market shares at their competitors' expense in the year after a merger.

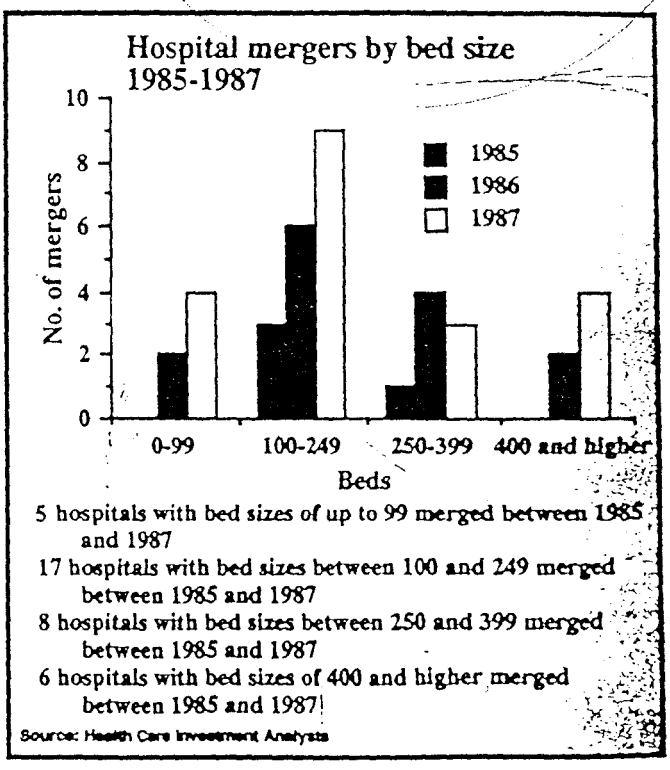
Six market leader hospitals also were able to increase their net patient revenues and markup rates more than the study group because they commanded greater market power and could control pricing more effectively, the study found.

In two 1987 mergers, the merged hospitals became the community's sole provider, thus eliminating competition.

Overall, the 18 merged hospitals were able to reduce expenses 1% to 2% annually primarily because per bed admission increases enabled them to spread their fixed costs over more patients, the study found.

The hospitals also increased their





hospitals' leadership: (1) consolidation of specialized clinical programs offered insufficient cost savings to the partner institutions and still less to the community at large, and promised to weaken care programs more than strengthen them; and (2) the teaching hospitals were providing secondary care at least as economically as the community hospital. The representative nature of these three hospitals and the metropolitan area they serve suggests that the conventional wisdom about hospital program consolidation and merger should be reconfirmed in each specific situation before costly and disruptive actions are initiated.

CONSOLIDATION OF SPECIALIZED CLINICAL PROGRAMS

The assessment of the benefits of collaboration between the two major teaching hospitals focused on the likely impact of moving some or all clinical services, programs and necessary backup support functions from Central Hospital's downtown site to Northern Hospital's more spacious suburban site. Two major conclusions emerged from this evaluation:

1. While the two institutions' costs might have declined somewhat (largely from a reduction in the size of their patient base), there would not have been significant overall savings for the metropolitan area's health care system.
2. The clinical and teaching programs of the two institutions would have been weakened.

Little cost savings for the community

There were two potential sources of cost savings to the two teaching hospitals from the consolidation of some or all their services: (1) from economies of scale in caring for more patients on a single site and (2) from the shift of patients to other institutions.

An overview of the economics of both institutions suggested very limited opportunity to improve the efficiency of clinical services by combining Central's and Northern's departments on one site:

- Nurse and nurse supervisor costs (excluding nurse administration) accounted for 35 percent of total expenses and could be reduced only by lowering coverage ratios then deemed appropriate or by decreasing the number of patients.
- Hotel costs (e.g., dietetics, laundry and housekeeping), accounted for 24 percent of total expenses and were largely tied to patient volumes, with minimal opportunity to leverage fixed costs. (See the discussion of leverage from fixed costs in Chapter 3.)
- Clinical support costs (e.g., laboratory and radiology) accounted for 19

There were two potential sources of cost savings to the two teaching hospitals from the consolidation of some or all their services: economies of scale and the shift of patients to other institutions.

Is the decision to merge really a question of access to capital?

by Daniel M. Cain

SUMMARY. Institutional mergers are not a panacea for hospitals with financial or operating problems, and the apparent advantage of multihospital systems does not lie in their access to capital and human resources. The critical disadvantage of independent hospitals may be the result of attitudes held by governing boards. This article suggests that boards adopt new business tenets, especially regarding accountability, risk, pricing, competition, regulation, innovation, resource management, and purpose.

Perhaps no single theme has been as widely amplified as the impending demise of the independent, voluntary hospital. This conclusion has emerged by comparing the hospital industry to commercial banks and utility-type industries, which are rapidly realigning ownership. The catalyst fueling this transformation is the price competition that is expected to accelerate as the health care industry experiences continued deregulation.

This article looks at ownership consolidations and the competitive advantage of multihospital systems over independent hospitals. It maintains that the adoption of new business tenets is vital if voluntary hospital boards are to retain their leadership function. The best management and capital resources cannot ensure competitive stature if trustee leadership is not applied to the formulation and implementation of strategic plans.

The evolutionary replacement of the independent hospital seems to be the multihospital system, with investor-owned chains serving as the model. The financial success of chains ostensibly resides in their size, capital access advantage, and centralized management. The movement toward consolidation also is supported by a perceived concentration of American business into fewer corporations.

Media attention focused on corporate mergers and acquisitions overshadows an accelerating number of corporate divestitures

Unfortunately, media attention focused on corporate mergers and acquisitions overshadows an accelerating number of corporate divestitures. Industry studies show that the largest concentration of new jobs, the highest return on invested capital, and the greatest productivity per capita are found among well-managed, small and intermediate size companies. Businesses discarded by large conglomerates often flourish under the direction of new ownership; smaller, specialized companies seem more adept than larger ones at responding to rapid changes in their market sectors.

Similarly, large consolidations within the health care industry, such as the merger of Hospital Corporation of America and Hospital Affiliates, Inc., distort the significance of new and emerging investor-owned companies. During the last 12 months, several new companies specializing in home health care and hospital management have tapped the capital markets to fund expanding corporate growth. The consolidation phenomenon in health care will be offset in the 1980s by the simultaneous divestiture of facilities unable to meet heightened corporate earning targets.

Not enough analysis has been conducted to assess whether the investor-owned hospitals are, in fact, more successful than voluntary hospitals in achieving corporate objectives. Industry analyses distil both qualitative and quantitative statistics and attempt to draw universal conclusions. Yet, in some respects, the industry's dichotomy in purpose is comparable to college athletic programs, where admission standards often preclude the recruitment of teams of a national

Daniel M. Cain is vice-president and manager, Health Care Finance Group, Salomon Brothers, Inc, New York City.

lth care delivery system. PPOs are no longer just an experiment combining the st popular traits of HMOs and traditional insurance; they are now part of the instream.

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"Society has much to lose if mergers prevent the desirable effects of competition."

Hospital Mergers and Antitrust: An Economic Analysis

Erwin A. Blackstone, Temple University, and Joseph P. Fuhr, Jr., Widener University

Abstract. The hospital industry has recently experienced substantial merger activity. This paper examines several actual and proposed hospital mergers to determine the extent of competition in the affected markets and the effect these mergers may have on competition. Our focus is on mergers between hospitals in the same market. We define the relevant product and geographic market for hospitals, then develop criteria for evaluating hospital mergers and analyze several merger cases using these criteria. We conclude that these mergers threaten the competition that exists in most of the markets discussed, and that the claimed efficiency justification for mergers is not convincing.

Substantial research findings have recently been published on the role of for-profit enterprise in health care (Gray 1986). Such enterprises have grown largely as a result of mergers. Some studies have been performed on the general characteristics of for-profit hospitals involved in mergers. However, there have been few in-depth studies of particular mergers, and as suggested by Gray (1986), the paucity of such studies is a major deficiency in the literature. The hospital field provides an excellent arena in which to consider the 1984 Department of Justice merger guidelines. For example, Schramm and Renn (1984) point out that many hospital markets already exceed the threshold concentration figure set by the Justice Department. Moreover, given substantial excess capacity, hospital mergers might be justified by cost or efficiency considerations. An efficiency defense became more important under the 1984 guidelines (Bronsteen 1984).

The hospital industry has recently experienced increased merger activity.[1] This paper will consider several hospital mergers to determine the type and extent of competition prevailing in the affected hospital markets. Our focus will be on merg-

The authors thank Robert Broyles, Kenneth Fraundorf, Thomas Getzen, Charles Hall, W. Lynn Holmes, Arnold Raphaelson, Robert Sigmond, and an anonymous referee of this journal for their helpful comments.

1. In 1961 only five hospitals merged. In 1972, 50 hospitals entered into mergers, and in the 1980–1983 period an average of 216 hospitals merged each year (Finkler 1985).

Health Care Reform

Expert shows path to collaborative success

The success of collaborative efforts hinges on 19 key factors, according to a researcher on the subject (see figure).

"Mutual respect, understanding and trust" among the parties involved are the most crucial factors involved in successful collaborative efforts, says Michael Winer-Cyr, senior consultant with the Amherst H. Wilder Foundation, St. Paul, MN.

The foundation, a human services agency, recently prepared an analysis of 18 in-depth research projects on collaboration in all sectors of society. The study defines collaboration as "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals.

"The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards."

One key factor that can make or break collaboration is who you bring together and how you do it, Winer-Cyr said at a recent seminar in Chicago for members of the St. Paul-based InterHealth alliance.

The study found that collaborative efforts will most likely be successful in communities with a history of cooperation and a favorable political and social environment.

Building mutual respect in a collaborative effort can take time, especially in communities with no history of joint efforts, Winer-Cyr notes. "You can't just get down to business; you have to get down to knowing each other. Some time has to be built into the process to create a familiarity."

Collaboration is more likely to succeed when participants get their agendas "out on the table" so that everyone's motivations are clear, Winer-Cyr says.

In addition, an "appropriate cross-section of members" must be involved in the deliberations, the researcher says. "The people involved should have the power to make decisions on behalf of the organizations they represent."

In building the structure of the group studying a project, members must be flexible enough to change the way they conduct their business and be willing to adapt their missions to changes in the environment, according to the study.

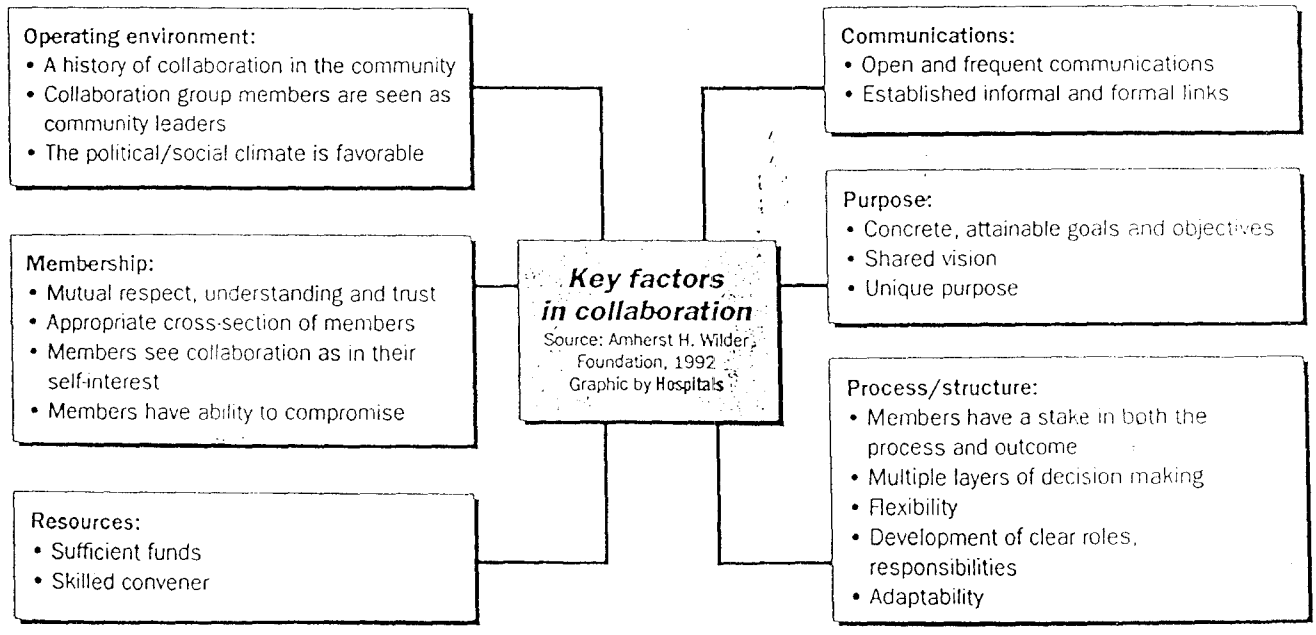
Open communications are vital to any collaborative effort. "Nothing kills a project faster" than not sharing all pertinent information, Winer-Cyr says. "This builds mistrust."

In addition to creating a shared vision or mission, participants must agree on attainable goals that they could not achieve on their own. "If a hospital is already doing a community-based program, and another asks it to collaborate on a community-based program that looks similar, the hospital is going to be disinclined to participate," Winer-Cyr says.

Along with sufficient funding, collaborative efforts need the resources of a skilled facilitator, or "convener." "Most collaborations get started because one or two people have a keen interest in something, and they bring in everybody else," Winer-Cyr says. But these leaders may not make good conveners who keep meetings on track, he cautions.

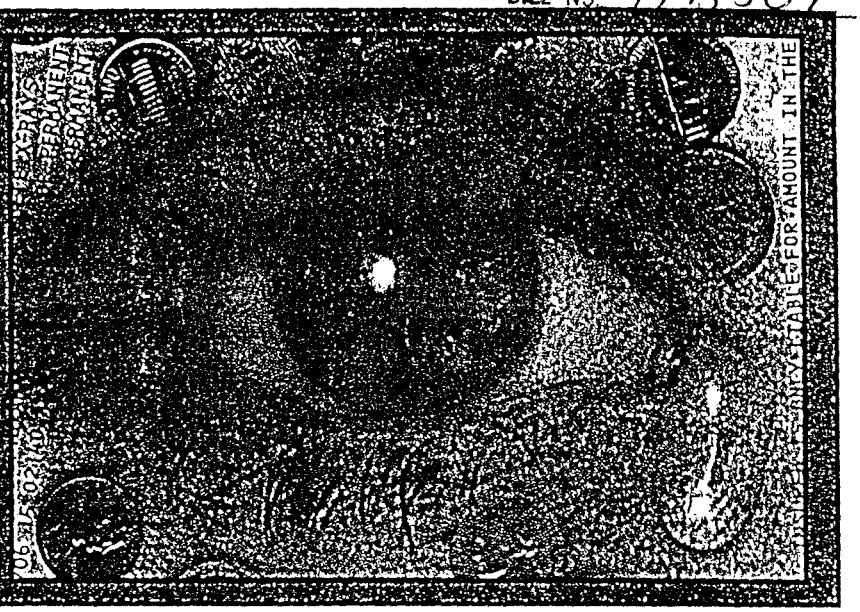
Community care networks, as envisioned by the American Hospital Association, could take five years or longer to develop because of the number of parties involved and the ambitious nature of the projects, Winer-Cyr says. "The question is, who is going to make the leap of faith to sustain the effort with enough resources for five or 10 years?"

For more information on the study, *Collaboration: What Makes It Work*, call the foundation at (800) 274-6024.—*Howard J. Anderson*



Cover story
By David Burda

A profit by any other name would still give hospitals the fits.



Surplus. Excess revenue. Money to reinvest in service to the community. Call it anything but profit.

But, hospitals are generating more of *it* than ever before. They don't want to talk about it because they're afraid someone will take it away.

Having a good year creates additional problems unlike those faced by companies in other industries, whose financial success is cause for celebration. Well-to-do hospitals face employee morale problems, negative press, public misperceptions and discount-hungry payers.

While some hospitals and hospital groups have recognized the benefits of being forthright about earnings, others would rather complain about Medicare and Medicaid cutbacks and managed-care discounts while watching their fund balances hit all-time highs.

"Hospital profit margins have been increasing," said Donald Young, M.D., executive director of the Prospective Payment Assessment Commission, which advises Congress on hospital Medicare payment policies.

Dr. Young attributed rising profits to the ability of hospitals to control their costs of late, as well as continue their practice of billing private payers for Medicare and Medicaid shortfalls.

"The capacity to cost-shift has made up for losses and allowed profit growth," Dr. Young said.

In 1992, aggregate profits earned by acute-care hospitals across the country hit $11.9 billion, up nearly 19% from 1991's total of $10 billion, American Hospital Association data reveal. The 1992 mark is the highest one-year profit total since at least 1983 (See chart, right).

And, according to ProPAC's June report to Congress, hospitals in every bed-size, ownership and geographic category posted aggregate profit margins in the black in 1992.

The AHA's own figures reveal that the percentage of hospitals with negative total profit margins has edged downward to 24% in 1992 from 28% in 1987.

The AHA's hospital revenues and expenditures data for 1993 won't be available until later this year, but based on its monthly survey of a sampling of hospitals, aggregate profits could rise more than 13% to $13.5 billion. If so, that would be the fifth consecutive year of double-digit jumps in profits.

Hospital profit margin figures from a number of other financial reporting services have documented increasing profitability (Oct. 25, 1993, p. 60).

The AHA doesn't publish aggregate hospital profit figures, but it does release aggregate hospital revenues and expenditures in its annual hospital statistics book. Data in the book are based on the AHA's extensive annual survey of all hospitals. The most recent figures come from the survey responses of 5,292 acute-care hospitals.

Bad timing. The enviable earnings come during a period in which the AHA and other hospital trade groups are lobbying against proposed cuts in Medicare spending growth to help fund national healthcare reform.

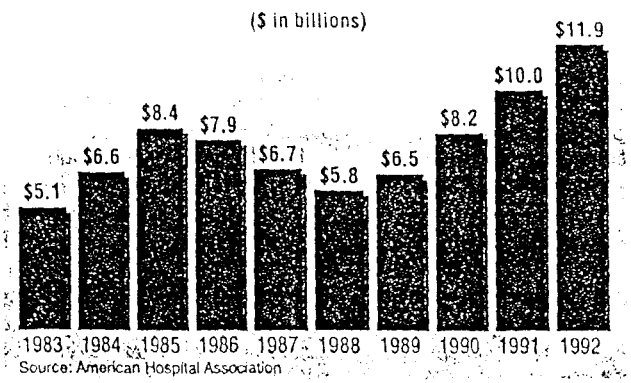
The AHA has sounded the alarm with two commissioned studies from Lewin-VHI, the Fairfax, Va.-based research firm that's gained some notice of late for often reaching conclusions that support the research sponsor's policy positions (Aug. 1, p. 28).

On April 11, the AHA produced a Lewin study that said Medicare under President Clinton's reform plan would pay hospitals just 71 cents for every $1 it cost them to provide inpatient care to beneficiaries by the year 2000.

In 1992, Medicare paid hospitals 89%

U.S. hospital profits

Acute-care hospitals' aggregate annual profits climbed steadily from 1988 to 1992



Source: American Hospital Association

Minn. becomes 1st state to fight not-for-profit hospital merger

Minnesota last week became the first state to challenge a not-for-profit hospital merger when Attorney General Hubert Humphrey III asked a federal court to block the proposed consolidation of LifeSpan and Health One.

The complaint charges that the merger of the two Minneapolis-based healthcare systems will unreasonably restrain trade and "lead to higher healthcare prices, lower quality for consumers or both."

System executives rejected the attorney general's claim that the merger is anti-consumer and vowed to fight the challenge in U.S. District Court in St. Paul. The attorney general is challenging the merger under federal antitrust law.

Gordon Sprenger, LifeSpan's president and chief executive officer, said he was disappointed with the attorney general's decision. He also said the systems expect a favorable ruling from the federal court within six months.

After the systems learned that Mr. Humphrey opposed the merger, executives offered three concessions.

One, the systems agreed to fund a $10 million community-benefit trust fund for five years. The money would be used to fund healthcare services to the poor in underserved areas.

Two, the systems offered not to raise prices for third-party payers above an agreed-upon rate for a certain number of years.

Three, the systems offered to guarantee that savings would total at least $12 million annually.

"They (the attorney general's office) said it wasn't good enough," Mr. Sprenger said.

Deputy Attorney General Thomas F. Pursell said his office pledged not to pursue legal action against the systems if they would delay the merger and apply for an administrative exemption to antitrust laws. The exemption process was approved this year under state legislation aimed at encouraging collaborative efforts to restrain costs.

Mr. Sprenger said the systems rejected that idea when they learned it would take 18 months for the health commissioner to take action. That's largely because the administrative system for reviewing applications is just being established.

Mr. Sprenger

Mr. Humphrey

The attorney general's office also suggested that the systems restructure the merger to reduce market concentration to acceptable levels. "They wanted us to divest one of our major hospitals. That was out of the question," Mr. Sprenger said.

Under the proposed merger, the systems would combine 13 hospitals with about 2,600 licensed beds, which would give the consolidated organization the area's largest market share, with 28% of total admissions.

But Jay Christiansen, an attorney representing the systems, said the market concentration of the proposed merger, as measured by the "Herfindahl-Hirschman Index," which assigns a mathematical value to such concentration, is less than any previous challenge.

In its complaint, the attorney general claims the merger will result in a 203-point increase in the index to 1,739. The HHI, which takes into account the relative size and distribution of companies in a market, is a standard economic measure of market concentration. The HHI can range from zero to 10,000.

Mr. Christiansen said federal agencies have never challenged a hospital merger of less than 2,400 on the HHI scale. For example, the proposed two-hospital merger that was blocked in Rockford, Ill., had an HHI of about 4,000, which was a 2,000-point increase from the hospitals' premerger HHI, he said.

The systems estimate their merger will result in no more than a 100-point increase in the index to 1,500.

Mr. Pursell said HHIs that are close to 1,800 are considered bad for consumers, according to guidelines of the National Assn. of Attorneys General.

"After a certain point, there is too much economic power in too few hands," Mr. Pursell said. "We don't see savings from this merger going to the public."

The U.S. Dept. of Justice in March reviewed the proposed merger and issued no objections.

The differences between the views of the attorney general and the systems is in how they measure market size.

In calculating market concentration, the attorney general considered only the two main counties in the seven-county Twin Cities market and parts of two other counties. That area includes 16 of the 23 hospitals in the seven-county area.

"They defined our market very tightly," Mr. Sprenger said. "They said things like the . . . outlying suburban hospitals are not considered competitors."

The systems' view of the market, however, includes all suburban hospitals, the area's three children's hospitals and other outlying tertiary-care hospitals, Mr. Christiansen said. That area takes in about 30 hospitals.

Mr. Pursell also said the attorney general's office feared allowing the proposed merger to be completed now would undermine the state's recent "HealthRight" legislation, a healthcare reform plan that includes the antitrust exemption process and universal access to healthcare services. He said the office believed a merger of that magnitude should go through the exemption process established under HealthRight.

"We didn't want a merger to slip in before the process is changed," Mr. Pursell said. "We don't think a big power alignment is good for the community."—*Jay Greene*

THE WEEK AHEAD

Week of June 29

MONDAY

National Assn. of Rehabilitation Facilities annual meeting, Chicago. Continues through Thursday.

FRIDAY

Independence Day observed.

SATURDAY

Fourth of July.

Merging hospitals learn costs of fighting antitrust challenge from Justice Dept.

By David Burda

You can fight city hall, but it's not cheap.

That's the lesson learned by Thomas Robertson, president of Carilion Health System, Roanoke, Va.

Carilion operates 609-bed Roanoke Memorial Hospital and more than likely will operate nearby 220-bed Community Hospital of Roanoke Valley.

Since the two Roanoke hospitals announced their consolidation plans in July 1987, the hospitals have spent $2.6 million on various fees to fight the government's challenge of the merger.

"Once the litigation was completed, the expenses have been nominal," Mr. Robertson said.

The pending consolidation of the two hospitals launched the Justice Dept.'s first antitrust challenge of a not-for-profit hospital merger. The government sued the hospitals in May 1988, and a resolution of the case may occur later this year.

The government contends the merger would give the hospitals control of more than 70% of the inpatient business in Roanoke, a concentration of market share that would entice the hospitals into anti-competitive behavior such as arbitrary price increases.

The hospitals, meanwhile, said competition in the market extends far beyond the immediate Roanoke area and beyond strictly inpatient care, which would mean they would control less of the market than the government stated. They also said the consolidation would eliminate excess capacity and duplicative services, generating millions of dollars in operating efficiencies that would be passed along to consumers.

In the most recent legal development, the 4th U.S. Circuit Court of Appeals in Richmond, Va., refused to reconsider its affirmation of a lower court decision upholding the merger (MH, Feb. 12, p. 12). The Justice Dept. must decide before May whether to appeal to the U.S. Supreme Court.

Mr. Robertson said the hospitals had no idea how much the merger litigation would cost.

First, no not-for-profit hospital had ever waged an antitrust battle with the Justice Dept., and the hospitals had no previous case on which to estimate their expenses. Second, the litigation became more complicated and drawn out than expected.

To better manage the litigation costs, Roanoke Memorial established a line item called "merger expenses" in its 1987 annual budget. Roanoke Memorial paid all of the merger-related bills and then billed Community Hospital for half of the expenses.

Mr. Robertson said the expenses fell into six categories: attorneys' fees, consulting fees, economists' fees, public relations, court reporters' fees and market research.

Nearly 60% of the total expenditures have been for attorneys' fees paid to two law firms (See chart).

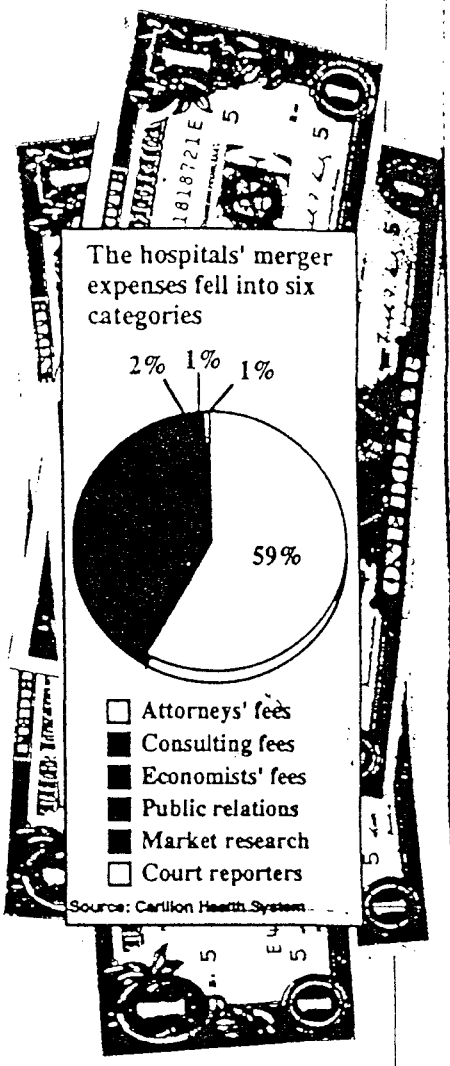
In the area of consulting, the hospitals retained four firms to conduct studies on economic efficiencies generated by the merger. The hospitals also hired three economists to conduct research on the impact of mergers on hospital prices.

In the area of public relations, the hospitals paid for the preparation of court exhibits and audio-visual aids.

"My favorite slide was the one where we compared (Hospital Corp. of America's) presence in the national and international market with Carilion's presence in the Virginia market," Mr. Robertson said. "We wanted to show the judge that we're not competing against the 'little sisters of the poor.'"

Lewis-Gale Hospital in nearby Salem, Va., opposed the merger. The 325-bed hospital is owned by Hospital Corp. of America, Nashville, Tenn.

Other expenses included court fees and market research to determine the reaction of consumers to changes in hospital prices.

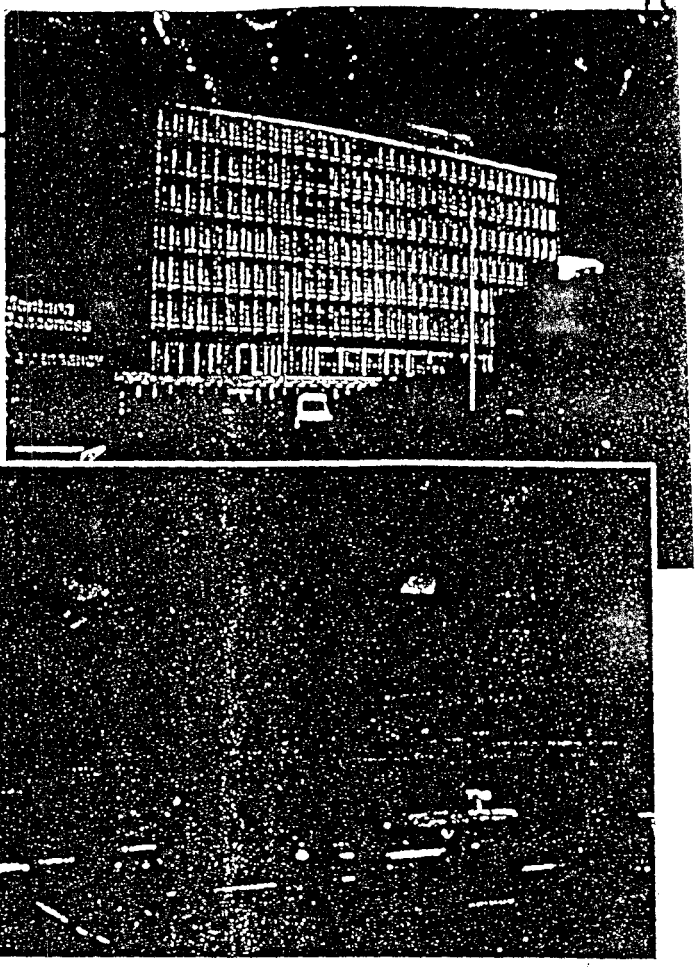


But the $2.6 million doesn't include the costs of complying with the government's requests for documents before the suit, Mr. Robertson said.

To comply with two government requests, the hospitals handed over 150,000 pages of utilization and financial records. Mr. Robertson estimated that the hospitals spent at least $1 per page retrieving, reviewing, copying and submitting the documents.

"Hospitals contemplating a merger like ours should understand that all your files are open," Mr. Robertson said. "There's no end to what the government can subpoena." ■

Mont. hospitals asking state for immunity



The two hospitals in Great Falls, Mont., are lobbying for state antitrust legislation.

Two Montana hospitals essentially are taking out an antitrust insurance policy to protect their proposed merger from federal antitrust regulators.

The hospitals, whose merger would give them a monopoly in their market, are lobbying for a new state law that would immunize them from state antitrust laws and, in theory, do the same against federal antitrust laws.

The hospitals are 255-bed Montana Deaconess Medical Center and 139-bed Columbus Hospital. They're the only two hospitals in Great Falls, a city of 56,000 some 90 miles north of Helena, the state's capital.

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Antitrust

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"A number of hospitals are collaborating, but they have an underlying fear that antitrust will be a problem if they go too far," he said.

Flink said the odds of the current law being expanded to hospital mergers are "fairly good." Montana's legislative session is scheduled to end on April 20.

If the bill doesn't pass, the two Great Falls hospitals will take their chances.

"We'll push ahead anyway if there's no legislation," Davis said. "We'll try a new approach."—David Burda

RE: HB 509

EXHIBIT NO. 8P 49
DATE 3/22/95
BILL NO HB 509

...e suit would "attack the validity of third-party ...tracts requiring sales below cost—thereby injuring ...mpetition" in violation of the California Unfair Practices Act, he explained. It would seek damages, he noted, "on behalf of pharmacies that have lost business because of these contracts as well as consumers who have paid higher cash prices because of the price-shifting resulting from such below-cost contracts."

Discriminatory pricing suits attempt "to curtail the pharmaceutical industry's arbitrary pricing practices, which cause community pharmacies and their patients to pay substantially higher prices," according to Marshall. "Unfortunately, the abolition of discriminatory pricing would not likely affect the ability of health-payers to continue to reimburse at below-cost rates."

Marshall described discriminatory pricing suits as attempts to "level the playing field" and the CPA's planned predatory pricing suit as an effort to ensure everyone "plays by the same rules." Both causes "are necessary and vital to the long-term survival of community pharmacy services," he insisted.

"Pharmacies contracting to provide below-cost reimbursement simply cannot afford to staff appropriately," Marshall pointed out. "The third-party payer benefits at the expense of everyone else—pharmacy owner, employee pharmacists, and patients."

35 STATES URGE CONGRESS TO AVOID ANTITRUST EXEMPTIONS IN HEALTH CARE REFORM

In light of their first-hand knowledge that antitrust law provides the "flexibility needed to implement major reforms," 35 state attorneys general on Nov. 9 urged leaders of the House and Senate to resist calls for enactment of special exemptions and "to ensure that any health care reform package permit antitrust laws to apply to health care markets."

Through antitrust enforcement, the 35 states asserted, ...e public interest in competitive markets is furthered. ...y protecting competition, the antitrust laws promote ...ficiency, innovation, low prices, better management, ...d greater consumer choice, and compensate those injured ... anticompetitive acts. At the same time, antitrust ...w permits joint ventures and other collaborative ...ctivities that benefit the public."

The 35 states reviewed many recent significant cases involving anticompetitive mergers, price fixing, group boycotts, and tie-ins in health care markets pressed by state attorneys general and the FTC. Based on this enforcement experience, these 35 states "have serious reservations about granting antitrust exemptions to segments of the health care industry. Because the interests of industries and their customers may diverge, the antitrust laws operate as the primary safeguard against collusion and other anticompetitive conduct. For this reason, we support the Administration's proposal to repeal the McCarran-Ferguson antitrust exemption for health care insurers."

Even if supplicants for exemption are not-for-profit providers, the 35 states urged congressional leaders "to place a very heavy burden on those who advocate special antitrust treatment to demonstrate why such treatment is needed to improve health care delivery and insurance systems."

In the event the health care industry gets a broad federal exemption, states would feel compelled to regulate in those exempted areas, and such regulation may be too rigid and impinge on federalism principles. After they cited seven states for enacting comprehensive health care reform, the 35 states warned that enactment of a federal exemption "would limit the diversity of these valuable efforts."

The 35 states lauded the efforts of the Justice Department and FTC in providing guidance through the *Antitrust Enforcement Policy Statements in the Health Area*, released on Sept. 15, and their pledge for rapid reviews of transactions with competitive implications. "States should similarly be able to take into account local conditions, as they evolve, in determining what is in the best interests of consumers."

Although they favor efforts "to reduce business uncertainty," the 35 states "oppose federal antitrust exemptions for insurers and health care providers. Exemptions deter the goals of health care reform by limiting the state flexibility and shielding agreements among providers that raise prices, stifle innovation, and restrict consumer choice. The antitrust laws have been instrumental in fostering innovation and efficiency, and in reducing prices in the United States economy; they will foster innovation, efficiency, and consumer choice under a new health care system."

The Nov. 9 letter was sent by the attorneys general of Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.

These states sent their joint letter to the Chairs and Ranking Minority Members of the House Committees on Appropriations; Armed Services; Banking, Finance and Urban Affairs; Budget; Education and Labor; Energy and Commerce; Government Operations; Judiciary; Merchant Marine and Fisheries; Post Office and Civil Service; Small Business; and Ways and Means. The joint letter also was sent to the Chairs and Ranking Minority Members of the Senate Committees on Appropriations; Armed Services; Banking, Housing and Urban Affairs; Budget; Finance; Governmental Affairs; Judiciary; Labor and Human Resources; and Small Business. The states' letter also was sent to the Chairs and Ranking Minority Members of the Joint Economic and Taxation Committees.

On 11/9/93, MT AG joined 34 other states in opposing health care antitrust exemptions.

Paul Gorsuch

of testimony. Desired changes in House Bill 531 seemed to have been obtained.

Your Reference Committee moves that this report be filed.

Resolution #1, Cascade County Medical Society. Your Reference Committee heard testimony that House Bill 509, which the MMA has supported, may not be acceptable to many physicians. House Bill 509 originally included physicians in its anti-trust protective provisions. ~~Physicians~~ have been removed from this bill during its passage through the House. Reinsertion of providers into the bill during its Senate passage is problematic.

Your Reference Committee heard testimony that this bill was designed mainly to facilitate the merger of two Great Falls' hospitals. Evidence was introduced that this merger would not be of benefit to either the community at large or the physicians of Great Falls.

Your legislative committee is aware that anti-trust reform has been a high priority of many Montana physicians. The legislative committee will continue with efforts to achieve some legislative relief for physicians from anti-trust law should the appropriate situation arise.

Your Reference Committee moves that this House adopt Resolution #1 from the Cascade County Medical Society:

> RESOLVED that the Montana Medical Association hereby states its formal opposition to House Bill 509, as amended.

I move that this House also recommend to the legislative committee that they implement a reversal of stance on House Bill 509 as quietly and painlessly for this organization as possible.

This completes the report of the Reference Committee of the whole.

I wish to thank all who provided testimony. I wish to thank Paul Gorsuch, M.D., and Ken Eden, M.D., for their participation in this committee's deliberations.

--John R. Gregory, M.D., Chair

SENATE HEALTH & WELFARE
EXHIBIT NO. 9
DATE 3/22/95
BILL NO. HB 509

HB 509 is a bad bill. Why do the Great Falls hospitals want state action immunity for actions that might be in violation of state or federal or both antitrust laws? The Attorney General's office does not have the trained professional staff to oversee the implementation of this bill, and I believe it will cost considerably more than the proposed amount provided.

The proposed merger of the Great Falls hospitals is not supported by the residents. There will be a monopoly, no choice of care, costs will rise considerably more, which has been proven by other mergers.

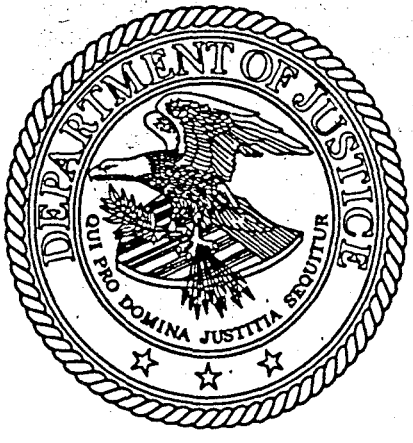
The Federal Trade Commission should have the control over mergers, not the state, as they have the trained personnel necessary to cover all aspects of any proposed merger.

Please vote against HB509.

Erla Green
3341 - 12th Ave. So.
Great Falls, MT 59405
Phone: 453-7262

EXHIBIT 10
DATE 3-22-95
HB 509

Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust



Issued by the
U.S. Department of Justice
and the
Federal Trade Commission

September 27, 1994

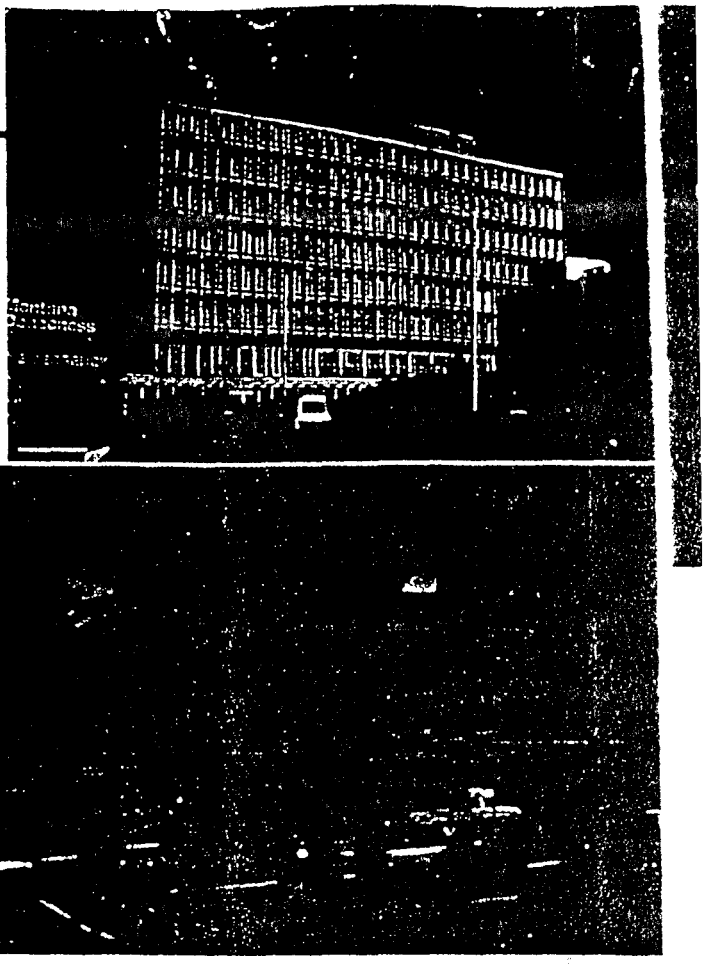
2. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL JOINT VENTURES INVOLVING HIGH-TECHNOLOGY OR OTHER EXPENSIVE HEALTH CARE EQUIPMENT

Introduction

Most hospital joint ventures to purchase or otherwise share the ownership cost of, operate, and market high-technology or other expensive health care equipment and related services do not create antitrust problems. In most cases, these collaborative activities create procompetitive efficiencies that benefit consumers. These efficiencies include the provision of services at a lower cost or the provision of services that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase prices without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers. The Agencies have never challenged a joint venture among hospitals to purchase or otherwise share the ownership cost of, operate and market high-technology or other expensive health care equipment and related services.

This statement of enforcement policy sets forth an antitrust safety zone that describes hospital high-technology or other expensive health care equipment joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It then describes the Agencies' antitrust analysis of hospital high-technology or other expensive

Mont. hospitals asking state for immunity



The two hospitals in Great Falls, Mont., are lobbying for state antitrust legislation.

Two Montana hospitals essentially are taking out an antitrust insurance policy to protect their proposed merger from federal antitrust regulators.

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DEPARTMENT OF LIVESTOCK — MEAT/POULTRY INSPECTION — Program Summary

Budget Item	Base Budget	PL Base Adjustment Fiscal 1996	New Proposals Fiscal 1996	Total Leg. Budget Fiscal 1996	PL Base Adjustment Fiscal 1997	New Proposals Fiscal 1997	Total Leg. Budget Fiscal 1997	Total Leg. Budget Fiscal 96-97
FTE	15.50	.00	1.00-	14.50	.00	1.00-	14.50	14.50
Personal Services	395,519	65,211	52,000-	408,730	67,252	52,000-	410,771	819,501
Operating Expenses	107,816	19,390	0	127,206	20,319	0	128,135	255,341
Equipment	4,655	4,655-	0	0	4,655-	0	0	0
TOTAL COSTS	$507,990	$79,946	$52,000-	$535,936	$82,916	$52,000-	$538,906	$1,074,842
Fund Sources								
General Fund	248,944	39,024	26,000-	261,968	40,509	26,000-	263,453	525,421
State Revenue Fund	5,049	951	0	6,000	951	0	6,000	12,000
Federal Revenue Fund	253,997	39,971	26,000-	267,968	41,456	26,000-	269,453	537,421
TOTAL FUNDS	$507,990	$79,946	$52,000-	$535,936	$82,916	$52,000-	$538,906	$1,074,842

EXHIBIT NO. #11
DATE 3/22/95
BILL NO. SB 410

Amendments to Senate Bill No. 410
First Reading Copy

Requested by Senator Burnett
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan Byorth Fox
March 20, 1995

1. Title, line 5.
Strike: "PROGRAM;"
Insert: "FOR CUSTOM-EXEMPT FACILITIES AND EQUIPMENT; AND
Strike: "81-2-102"
Insert: "81-9-229"

2. Title, lines 5 through 7.
Following: "MCA" on line 5
Strike: the remainder of line 5 through "DATE" on line 7

3. Page 1, line 11 through page 3, line 27.
Strike: everything after the enacting clause
Insert: "

Section 1. Section 81-9-229, MCA, is amended to read:

"**81-9-229. Assignment of inspectors -- contracts with local boards of health.** (1) The chief shall assign inspectors to each official establishment and may assign one inspector to two or more establishments.

(2) ~~No~~ An establishment may not slaughter or process any cattle, buffalo, sheep, swine, goats, or poultry unless there is an assigned inspector present. The hours of the day and days of each week, including holidays or weekends, when the establishment is slaughtering or processing meat must be satisfactorily arranged between the chief and each establishment. Establishments shall pay overtime fees to the board when services are rendered

(3) The chief shall contract with the local boards of health, or a veterinary, for the purpose of inspecting the facilities and equipment of a person exempt as provided in 81-9-218 (2) in order to enforce sanitary requirements.""

DATE 3/22/95

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: HB 509

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Paul Gorsuch	Myself	509		✓
Bob Wyvis	SELF	509		✓
Tamela VanderAarde	myself	509		✓
James Bull	self	509		✓
ERLA GREEN	SELF	509		✓
Sonja Jones RN	self	509		✓
RICHARD JONES	SELF	509		✓
TIM NIGEL	SELF - MONTANA MMI	509		✓
Dave Abel	Self	509		—
F John Allaire	MMA	509		
John R. Halsey MD	MMA	509		✓
Sharla Hinman	Mt Deaconess	509	✓	
PAT MITCHELL	MT DEACONESS	509	✓	
JOHN W. McMAHON M.D.	MMA	509		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.R10

DATE 3/22/95

SENATE COMMITTEE ON PUBLIC HEALTH

BILLS BEING HEARD TODAY: HB 509

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Oppose
MAX DAVIS	Col Hosp/MMMC	509	✓	
Dauphette Rutherford	Col Hosp / MMMC	509	✓	
William J. Jones	Columbus Hosp / MDMC	509	✓	
Jake Allen	Fourth of July club	509		✓
Steve Browning	MT Hosp. Assn	509	✓	
KIRK WILSON	Great Falls Dean	509	✓	
Jim Hinshaw	self - Great Falls	509		✓
Gary Schumacher	self - Great Falls	509	✓	
Jim Clough	self Great Falls	509		✓
Stan Cross	myself	509		✓
Laurie Ekanger	Governor's Office	509	✓	
Tom Ebzery	St Vincent Hospital & Health Ctr	509	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10