EXHIBIT 14
DATE 2/5/07
SB 323

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Dear Senator :

Please do not support the **DEREG** of health care in Great Falls. **Vote NO on SB 323.**

On October 16, 2006 after spending $90,000.00 and conducting an issue-focused analysis the Attorney General denied Benefis' request to repeal the COPA. The monopoly's request to operate without regulatory restraint and oversight was rejected. In his recent denial, the AG concluded:

> "C. **Conclusion. The Department [of Justice] finds that there is not sufficient evidence to conclude that increases in competition have eliminated the need for regulation over inpatient hospital services. Accordingly, repeal of the COPA at this time would not further the purposes of Montana Code Ann. § 50-4-601.** The Department will continue to monitor competitive developments in the marketplace that may justify modification, amendment or repeal of the COPA. Such action may be necessary due to the rapidly changing health care services market in Great Fall."

The Attorney General addressed the very assertions that Benefis is making to you now. Less than 4 months after his ruling, Benefis is asking you to override the AG's substantive analysis and allow it to operate without the regulatory oversight that was the basis for approval of the Deaconess-Columbus merger in 1996. Moreover, without providing any guidance or standards to support termination of the COPA, SB 323 simply allows a COPA to terminate 10 years after its issuance

As we know, an unregulated monopoly can deny access to health care and drive customer costs up ---- all for the financial gain and benefit of the monopoly. You are being asked to allow Benefis to control the health care market in Great Falls. Certainly, a 20 bed hospital is not "competition" for a 500+ bed hospital. The COPA assures greater access to health care and more choice for consumers. In Montana, where markets are small, regulatory oversight has been shown to be the best way to keep provider costs down. The small amount of competition that exists in Great Falls at this time does not justify the termination of the COPA and its regulatory oversight.

VOTE NO ON SB 323!

Thank you

Mona Jamison, Lobbyist for
Central Montana Surgical Hospital

GREAT FALLS CLINIC

Setting the Record Straight: Healthcare Deregulation in Montana
Beware of SB323

I. What was the COPA's primary purpose?

A. Enacted in 1995, the purpose of the Certificate of Public Advantage ("COPA") statute was to provide the state, through the Department of Justice, with direct supervision and control over the implementation of mergers and consolidations among health care facilities. It was the intent of the legislature that supervision and control over the implementation of these mergers substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the mergers state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws.

B. COPA legislation is what allowed the two Great Falls' hospitals that competed with each other, (the Columbus Hospital and the Montana Deaconess Medical Center), to merge into one hospital without violating state and federal antitrust laws. The COPA required state regulation over the monopoly and established criteria to reflect natural competition. The two competing hospitals were allowed to merge into one, now known as Benefis Healthcare ("Benefis"), as long as the newly created monopoly agreed to be regulated and supervised by the Montana Attorney General.

C. On October 16, 2006, after spending $90,000 and conducting an issue-focused analysis the Attorney General denied Benefis' request to repeal the COPA. The monopoly's request to operate without restraint and supervision was rejected.

D. In his recent denial, the Attorney General concluded, "The Department finds that there is not sufficient evidence to conclude that increases in competition have eliminated the need for regulation over inpatient hospital services. Accordingly, repeal of the COPA at this time would not further the purpose of Montana Code Ann. § 50-4-601. The Department will continue to monitor competitive developments in the marketplace that may justify modification, amendment or repeal of the COPA. Such action may be necessary due to the rapidly changing health care services market in Great Falls."

II. A 20-bed hospital is not competition for a 500+ bed healthcare monopoly.

A. **ASSERTION** – Benefis asserts that Central Montana Hospital creates competition for Benefis that justifies eliminating regulatory oversight.

B. **TRUTH**– Central Montana Hospital is only a 20 bed hospital and has never operated at its 20 bed capacity. It would take years and a greatly expanded facility for Central Montana Hospital to provide impacting competition to Benefis'.

C. **TRUTH** - Great Falls Clinic physicians continue as they always have to admit sick patients to Benefis. Currently, there is no other option for most patients. Benefis is the only hospital in Great Falls where patients can receive services for Labor and Delivery, Intensive Care, Vascular Surgery, specialized Neurosurgery, Neonatology, Gastroenterology and Pulmonology. Patients and physicians have no choice for full-service hospital care in Great Falls. Benefis is the only option.

D. **TRUTH** - The COPA protects physicians and their patients from actions by Benefis to limit or cancel privileges for physicians practicing and treating patients at Benefis – these actions include such things as economic credentialing, exclusive contracting, unfair insurance steerage, excessive employment of primary care physicians etc.

III. Even with regulatory oversight, Benefis thwarts local efforts to lower costs to patients.

A. **ASSERTION** – Benefis criticizes the Great Falls Clinic-Blue Cross Blue Shield ("GFC-BCBS") partnership, authorized by Montana law to provide healthcare to patients at a lower cost.

i. **TRUTH** – MontanaCare is a 50/50 joint venture between the Great Falls Clinic and BCBS, which was formed to improve the quality of and access to health care by making care available at a lower cost. MontanaCare's focus is on medical management and the quality of care rendered to patients. The products often associated with MontanaCare are offered by BCBS under BCBS's HMO Montana managed care license.

ii. **TRUTH** - Montana law authorizes an HMO to provide or arrange for the provision of health care services through an arrangement with a limited group of providers, known as a "provider panel." An HMO's network must meet the network adequacy and quality assurance standards established by Montana law.

iii. **TRUTH** – Benefis has been a participant in the MontanaCare network for 10 years.

iv. **TRUTH** – As of June 2006, 292 physicians within the MontanaCare service area, including 59 non-GFC Great Falls physicians, participate in BCBS's managed care networks and products.

v. **TRUTH** – While Benefis criticizes the GFC-BCBS partnership to provide lower costs to patients, Benefis reduced its discount to MontanaCare enrollees soon after purchasing an ownership interest in the New West Health plan which is a competitor to the partnership.

IV. Benefis has demonstrated that it will use its monopolistic powers to negatively impact the delivery of healthcare in Great Falls.

A. Economic Credentialing: this is a hospital's refusal to grant hospital staff privileges to a physician because the physician:

i provides health care services at,

ii has an ownership interest in, or

iii occupies a leadership position on the medical staff of a health care facility.

a. Dr. Thomas Warr, Medical Oncologist was removed from position as Medical Director for Benefis' Peace Hospice of Montana. Dr. Warr is the only Great Falls physician certified in hospice and palliative medicine by the American Board of Hospice and Palliative Medicine

b. Dr. Jeffrey Stephenson, Radiation Oncologist was denied medical privileges at Benefis due to Benefis' exclusive contract for Radiation Oncology and because he is a member of the Great Falls Clinic/Clinic Cancer Care medical staff. Dr. Stephenson cannot attend his own patients, and his considerable skills are unavailable to new patients who need them.

c. Drs. Tamim Khaliqi and Kevin Kelly, Pain Management Specialists were denied medical privileges at Benefis.

B. Recruitment: Benefis has lured several physicians from the Great Falls Clinic to its employment in an attempt to change referral patterns from the Clinic to Benefis.

i. A Medical Oncologist was paid a significant amount of money in addition to a paid Medical Directorship to join the Benefis Healthcare/Sletten Regional Cancer Center. These monies are in addition to the physician's regular income through seeing patients.

ii. Two Pulmonologists were recruited away from the Great Falls Clinic in 2006.

iii. Benefis has also attempted, unsuccessfully, to lure a cardiologist and our new oncologist away from the Clinic.

C. Anesthesia: As of July 2, 2007, Benefis has threatened to deny anesthesia services to Great Falls Clinic physicians and their patients.
   i. At Benefis' request, the COPA allowed Benefis to enter into mutually exclusive agreements with anesthesiologists. This approval through the Attorney General, however, was not approval for changes in anesthesia services at Benefis that will be discriminatory, restrain competition, and violate the COPA.
   ii. Benefis has been using Anesthesia Associates of Great Falls (AAGF) to provide all anesthesia services in its hospital.
   iii. GFC was notified that after April 1, 2007 (since changed to July 2, 2007) Benefis will not provide anesthesia services in its hospital through AAGF or any other anesthesiologist for GFC physicians and their patients.
   iv. This same group of anesthesiologists uses its contract with Benefis to block needed specialty areas from having privileges at Benefis and blocked the utilization of Certified Nurse Anesthetists in the hospital.

D. Patient Steerage: Benefis mandates its ER docs to see and steer all patients who come to the ER to see its physicians even if the patient requests their own physician.
   i. Section 5.5 of the COPA provides that Benefis "shall not enter into any exclusive contracts with any health care provider by which it requires...only one physician or group of physicians to provide particular services at Consolidated Hospital." Section 6.5 deals specifically with emergency room referral and prohibits Benefis from using "employment, the location of a physician group or practice, or the location where patients will receive any necessary follow-up care."

E. Other Overstepping by the Benefis Monopoly:
   i. Failure to oversee quality and correct billing practices from their subsidized or exclusively contracted physicians.
   ii. Spending community funds in unnecessary building projects and by purchasing physicians at a significant premium and impact to the market.
   iii. Influencing referral patterns from surrounding hospitals thru the Northcentral Montana Medical Alliance.
   iv. Having patients admitted to "observation units" which are pre op prep rooms, when the hospital is full, despite the fact these are not licensed beds and may have only one nurse to 10 patients.

V. Benefis continues to operate as a monopoly. At the time the hospitals merged, it was found to be in the best interest of the patients of Great Falls that the monopoly have regulatory oversight. It is still in the best interests of the patients of Great Falls that regulatory oversight of Benefis continue in order to assure that increases in competition are allowed to grow. SB323 will result in:

- Reduced services and even elimination of unprofitable service lines;
- Exclusive contracts to non-Clinic physicians;
- Economic credentialing to restrict privileges of Great Falls Clinic doctors;
- Unfair dealings with insurers, requiring that all testing be done at Benefis or care be provided by physicians affiliated with Benefis;
- Elimination of the revenue cap resulting in immediate price increases.

EXCERPT FROM:

BEFORE THE DEPARTMENT OF JUSTICE
FOR THE STATE OF MONTANA

In the matter of the	)	
application for a certificate	)	**AMENDED**
of public advantage by the	)	**FINDINGS OF FACT,**
Columbus Hospital and Montana	)	**CONCLUSIONS OF LAW,**
Deaconess Medical Center,	)	**AND CERTIFICATE OF**
Great Falls, Montana.	)	**PUBLIC ADVANTAGE**

III. BACKGROUND

("Tr."); and (11) Applicants' Jan. 23, 1996 Response to Comments ("Comments Response").

In 1993, the Montana legislature created the Montana Health Care Authority and charged it with, inter alia, reviewing and approving cooperative agreements between health care facilities. The Authority was given power to issue a COPA if it found that the cooperative agreement was "likely to result in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement." 1993 Mont. Laws ch. 606, § 39.

When the Health Care Authority was abolished in 1995, these duties and responsibilities were transferred to the Department of Justice. 1995 Mont. Laws ch. 378, §§ 19, 21. In addition, the statute was extended to cooperative agreements among physicians and was further amended to authorize a COPA for mergers and consolidations among health care facilities or physicians. 1995 Mont. Laws ch. 526, §§ 2-3 (codified at Mont. Code Ann. §§ 50-4-602, -603). The standard for issuance of a COPA also was amended,and the statute now authorizes the granting of a certificate if "the department finds that the [consolidation] is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs." Mont. Code Ann. § 50-4-603(2).

The purpose of the COPA act is to "control[] health care costs and improv[e] the quality of and access to health care" by providing the state, through the Department, "with direct supervision and control over the implementation of cooperative agreements, mergers, and consolidations among health care facilities and physicians . . . for which certificates of public advantage are granted." Mont. Code Ann. § 50-4-601. The COPA process is intended to "substitute regulation of facilities and physicians . . . for competition between facilities and

physicians . . . , and . . . this regulation [is meant to] have the effect of granting the parties to the agreements, mergers, or consolidations state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws." Id.

Montana is among roughly half the states in the country that have adopted "state action immunity" statutes to immunize certain health care collaborations from antitrust scrutiny. General Accounting Office, *Federal and State Antitrust Actions Concerning the Health Care Industry* (Aug. 1994) (GAO Report). Such statutes are designed to contain costs by allowing providers to develop more efficient delivery systems without the "chilling effect" of the threat of antitrust enforcement, responding to the argument that "traditional antitrust analytic methods inappropriately preclude certain types of potentially beneficial arrangements." J. Teevans, *State-Action Immunity: Immunizing Health Care Cooperative Agreements* 3 (Alpha Center Dec. 1995). The objective of Montana's COPA act, like those in other states, is "to make health care more affordable to" the state's residents. Minutes, House Human Servs. & Aging Comm., 2/15/95 at 15 (comments of bill sponsor Rep. Anderson). The measure was intended to provide a mechanism for 5 health care facilities in the state to adjust to changes in the industry and respond to decreased revenues due to trends such as lower patient census numbers. Minutes, Sen. Pub. Health, Welfare & Safety Comm., 3/22/95 at 2 (testimony of Rep. Wiseman). It was the intent of the legislature that mergers and consolidations, which are subject to the jurisdiction of federal antitrust enforcement authorities, be reviewed at the state level rather than subject to decisions by the federal government affecting the health care of Montanans. Id., 3/24/95 at 7-8 (comments of Sen.Benedict).

Health care mergers and consolidations are sharply rising in the United States, as the industry attempts to respond to lower utilization rates and managed care pressure to bring down costs. More than 200 hospital mergers were announced in 1995, up from 50 in 1990. B. Gruley & L. McGinley, "Rebuke in Dubuque," *Wall Street Journal*, Jan. 4, 1996, at A1. That included a record 43 hospital mergers in the third quarter of 1995, nine of which involved acquisitions by the for-profit Columbia/HCA Healthcare Corp. 14 *Business & Health* No. 1 at 9 (Jan. 1996). The Pew Health Professions Commission recently predicted that market pressures will force the closure of up to half of the nation's hospitals by the year 2000. 7 *Washington CEO* No. 1 at 21 (Jan. 1996).

Although both the Federal Trade Commission and the United

States Justice Department have jurisdiction to review mergers and acquisitions, those agencies challenged fewer than 4% of the 397 acute-care hospital mergers they reviewed between fiscal years 1981 and 1993. (GAO Report at 2, 6.) The COPA process is intended to ensure that a hospital merger will be immune from challenge but subject to ongoing supervision by the State of Montana, through the Department. Mont. Code Ann. § 50-4-622; Mont. Admin. R. 23.18.106.

BEFORE THE DEPARTMENT OF JUSTICE
FOR THE STATE OF MONTANA

In the Matter of the Application by Benefis Healthcare for Repeal of the Certificate of Public Advantage	**FINDINGS OF FACT**

SECTION ONE

This matter is before the Department of Justice ("Department") pursuant to Section 17.3 of the Certificate of Public Advantage (COPA) issued by the Department of Justice on July 9, 1996, which states that, "[w]ithin ten years following the effective date of this COPA, the Department shall conduct a review to determine the extent to which these Terms and Conditions should be maintained, modified, amended or repealed in order to further the purposes of Mont. Code Ann. §§ 50-4-601 to -623." The purposes of this legislation are "controlling health care costs and improving the quality of and access to health care." Within 90 days following the commencement of that review, the Department shall issue findings of fact supporting its decision to maintain, modify, amend or repeal any of these Terms and Conditions." Review began on July 15, 2006, and these findings are being issued within the 90-day timeframe.

I. PROCEDURE

Prior to commencing the ten-year review, the Department requested input from Benefis concerning its views on "the extent to which the terms and conditions of the COPA should be maintained, modified, amended or repealed." Benefis submitted a

proposal on April 20, 2006, recommending repeal of the COPA upon its ten-year anniversary. Notice of a public hearing to receive public comment was disseminated through the newspaper and television media in May 2006. On June 27, 2006, a public hearing was held in Great Falls, Montana, in which various members of the public gave testimony in favor of discontinuing or retaining the COPA. A transcript of the hearing and Benefis's April 20, 2006, letter was placed on the Department's website. Written comments were received by July 10, 2006, to which Benefis was given an opportunity to respond by August 15, 2006. Fifty-eight written comments from concerned and interested members of the consumer and professional medical communities were received. There were 38 commenters at the public hearing on June 27, 2006. The Department representatives interviewed various commenters in the month of August 2006.

II. COMMENTS

The comments may be briefly summarized as follows:

A. For Elimination of the COPA

Benefis's arguments for repealing the COPA may be summarized as follows:

1. The COPA is no longer needed as a substitute for price competition to maintain lower costs because the increase in competition after 1996 has replaced the need for regulation.

2. The COPA is no longer needed to insure that the objective of cost containment has been met. Benefis states that cost reductions mandated by the COPA's

revenue cap have been achieved and incorporated into the lower prices. Also, because a large portion of Benefis's revenues are fixed reimbursement from Medicare and Medicaid, Benefis will be forced to maintain lower costs.

3. The COPA is no longer necessary to ensure access to the medical services specified in the COPA since Benefis asserts it will continue to provide these services.

4. The COPA is no longer needed to assure quality of care because ongoing quality assurance monitoring by private organizations and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will remain in place without the COPA.

5. Benefis is resolved to continue to pass on low costs to the community, to provide high-quality care.

In addition to Benefis, many others submitted comments supporting repeal of the COPA. These comments by and large, repeated the arguments made by Benefis.

B. Comments for Retention of the COPA

The Department received and considered a variety of comments opposing repeal of the COPA for the following reasons:

1. Benefis does not face competition for inpatient services because it is the sole full-tertiary hospital provider in the service area. The competitive changes identified by Benefis do not affect competition for inpatient services.

2. Without the COPA revenue regulation, there is no check on the rate increases that Benefis can charge to private payors. The fact that approximately

two-thirds of Benefis's revenues are derived from the government means there is a greater incentive for Benefis to increase prices paid by private payors and individuals with insurance or private resources.

3. The COPA does not threaten Benefis's financial viability.

4. The COPA is necessary to prevent Benefis from eliminating services.

5. Eliminating "open staff" requirements of the COPA will result in Benefis denying hospital privileges to Great Falls Clinic physicians for economic reasons, i.e., through use of economic credentialing.

6. Eliminating the COPA-mandated referral policy will result in Benefis unfairly steering patients to its own service and equipment providers.

7. Failure to maintain the revenue cap will result in higher costs for patients.

8. Benefis's challenge to the Central Montana Hospital needs to be resolved before going forward with the decision to discontinue the COPA.

9. The COPA is needed to prevent Benefis from eliminating important services like the Emergency Room, air ambulance and other services.

10. The COPA has not prevented Benefis from improving its financial performance, health and viability. Under the COPA, Benefis has been able to substantially increase gross and net revenues, generate significant profits and expand its campus substantially.

11. Certain services would be made unavailable in the community because of the market power Benefis has over inpatient services.

SECTION TWO

Pursuant to Section 17.3 of the COPA, the Department makes the following findings based upon its review of the materials and information submitted by Benefis in support of its request to repeal the COPA; written public comments; the information presented at the public hearings on June 27, 2006 in Great Falls; and, the evaluation conducted by the Department's consultants, as well as additional information submitted by Benefis and other interested parties in response to inquiries from the Department.

Section 17.3 of the COPA provides that "within ten years following the effective date of this COPA, the Department shall conduct a review to determine the extent to which these terms and conditions should be maintained, modified, amended or repealed in order to further the purposes of Montana Code Ann. §§ 50-4-601 through 603." The purposes of the COPA legislation are "controlling health care costs and improving the quality of and access to health care."

I. MODIFICATION OR AMENDMENT OF THE COPA

Following the adoption of the COPA in 1996, the Department made several modifications to the COPA in response to changing conditions in the market for health care services. On December 6, 2002, Benefis filed a petition with the Department requesting several modifications it claimed were necessary to adjust for changes in the

health care industry that resulted in increased costs to Benefis not anticipated when the Revenue Cap Model was adopted in 1996.

On April 4, 2003, the Department issued a Decision granting many of the requested modifications. The Department modified the COPA to increase the inflation factor in an amount necessary to provide sufficient funding to Benefis and to ensure quality health care. The Department also granted Benefis's request to allow exclusive contracts with anesthesiologists, to modify the annual survey requirement and to eliminate the annual reporting requirements in Sections 1.5-2, 1.5-3, and 1.5-4 of the COPA.

Neither Benefis nor any other interested party submitting comments to the Department during its ten-year review of the COPA has proposed or requested that the COPA be modified or amended. Data produced to the Department by Blue Cross Blue Shield of Montana (BCBSMT) confirms that for the nine-year period following implementation of the COPA in 1997, Benefis's net prices have been consistently lower than the prices charged by the three other large Montana hospitals. Benefis has been able to offer lower prices to consumers while maintaining healthy profit margins.[1] Benefis

[1]The profit margin on operating income for Benefis Healthcare (excluding subsidiaries and investment income) was approximately 4.5 for 2005. That solid financial performance (and the substantial capital renovations and technological improvements made by Benefis during the past nine years) demonstrates that the COPA has not prevented Benefis from successfully responding to increased competition in the past. Benefis does, however, raise legitimate concerns about the impact of "specialty hospitals" that may justify modification of the COPA as the nature and extent of the competition becomes more certain.

continues to provide access to all medical services offered as of December 31, 1995, as required by Section 4.1 of the COPA. Based on these findings, the Department concludes that the COPA revenue cap regulation is achieving the statutory purpose of "controlling health care costs" while maintaining access to health care.

Accordingly, pursuant to Section 17.3 of the COPA, the Department determines that there is no present need to modify or amend the Terms and Conditions of the COPA "in order to further the purposes of Montana Code Ann. §§ 50-4-601 to 603."

II. REPEAL OF THE COPA.

In response to the Department's request for recommendations concerning the Ten Year Review required by Section 17.3, Benefis proposed that the COPA be repealed in its entirety. Benefis contends that the COPA is no longer needed as a substitute for price competition to maintain lower costs because the increase in competition after 1996 has replaced the need for regulation.

A. Increased Competition Generally

The Department agrees with Benefis's assertion that there have been significant increases in competition for certain health care services provided by Benefis. In 2005, the joint venture between Benefis and the Great Falls Clinic to provide outpatient surgery services was terminated. The Great Falls Clinic opened a new facility that competes directly with Benefis in several service areas including outpatient surgery, laboratory, radiology, non-invasive cardiology, gastroenterology, and other services. It should be noted that he Great Falls Clinic and Essentia may expand their cardiology program in the

near future. The Great Falls Clinic also opened a cancer center in 2005 that competes with Benefis for cancer-related medical services. That same year the Clinic sold a one-third interest in its surgery center to Essentia Health, a large Minnesota-based national health/hospital system.

In addition to the competition from the Great Falls Clinic and Essentia, Benefis contends that it also faces competition from other medical destination centers around Montana, as well as outside the state. Benefis contends that "because of the growth of providers in competition with Benefis over the last ten years, the COPA is no longer needed as a substitute. The competitive marketplace has now stepped in and competitive pressures will only continue to increase in the future."

Benefis also argues that the COPA is no longer needed to further the purposes of "controlling health care costs and improving the quality of and access to health care" because "the cost savings from consolidation have been achieved and cost containment measures will continue to be in place." See, 4-20-06 letter from Neil Ugrin to the Montana Department of Justice at page 4. According to Benefis, roughly two-thirds of its patient revenues are paid by Medicare and Medicaid, "payors that do not pay for services based on Benefis' charges; rather they establish their own payments rates." Benefis asserts that when "two-thirds of a hospital's volume drives cost decisions, there is little need for another mechanism to do so."

BCBSMT submitted comments in opposition to Benefis's request to repeal the COPA. BCBSMT asserts that "conditions in the marketplace have not changed to the extent that competition would promote reductions in cost and improvements in access

and quality better than does the agreement or transaction at issue." BCBSMT further asserts that Benefis's argument that increased competition has eliminated the need for regulation "is focused upon physician networks and outpatient services, making little or no mention of inpatient hospital services or its role as the sole tertiary hospital in the service area." According to BCBSMT, the "competition" Benefis identifies is not significant competition and has little, if any, effect on its inpatient rates. BCBSMT also states that "the Attorney General should take notice that Benefis is involved in litigation aimed at eliminating much of the competition presented as justifying repeal of the COPA." See, BCBSMT 7-7-06 Comments at page 4.

B. Competition for Inpatient Services

The Department agrees with Benefis's contention that the relevant inquiry for purposes of determining whether repeal of the COPA is justified is whether "the growth in providers in competition with Benefis over the last ten years" has eliminated the need for a COPA to "serve as a substitute for competition." Benefis's 4-20-06 Proposal Letter at H. As BCBSMT points out, however, the increase in competition necessary to justify repeal must include competition for inpatient hospital services.

Benefis has identified several developments in the market for health care services in the Great Falls area which have the potential to act as a competitive restraint on the provision of inpatient hospital services by Benefis. The most significant developments, however, have only recently occurred, and the viability and competitive impact of those changes cannot be adequately evaluated until uncertainties in the evolving marketplace are resolved.

1. The Great Falls Clinic

The Great Falls Clinic recently opened a large specialty clinic building in Great Falls to compete with Benefis in the areas of outpatient surgery, radiology, laboratory, non-invasive cardiology, gastroenterology and cancer-related services. It is not yet clear, however, the extent to which that competition can be used by health insurers and other consumers to negotiate lower prices for inpatient hospital services. For example, BCBSMT claims that Benefis's power over inpatient hospital services is evidenced by the fact that as of July 1, 2005, "Benefis reduced its previous 10% discount on services to only 3%, a 7 point increase in rates without any consideration of the volume of business provided by BCBSMT to Benefis." BCBSMT Comments at page 6. Benefis argues that it offered BCBSMT a 15% discount if it would open its Montana Care Plan to all physicians, not just physicians affiliated with the Great Falls Clinic. In a competitive market, Benefis's position would reflect a type of "selective contracting" that is consistent with competition. The Department finds, however, that the increase in competition from the Great Falls Clinic, by itself, does not provide a sufficient basis for eliminating COPA regulation over inpatient hospital services.

The Great Falls Clinic has expressed an intention to develop a regional cardiovascular program including invasive cardiology and surgery in the near future. The inpatient and outpatient competitive impact of implementing this program is unknown.

2. Central Montana Hospital

The Central Montana Hospital provides a direct source of competition for Benefis. The future status and viability of that competition, however, remain uncertain pending the

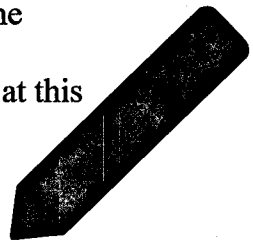
outcome of litigation over the licensing of that facility. Shortly after the Great Falls Clinic and Essentia announced plans to jointly operate Central Montana Hospital as a for-profit inpatient/outpatient competitor, Benefis filed an action in Montana District Court requesting injunctive relief to prevent the Montana Department of Public Health and Human Services from issuing a license to Montana Health Partners, a Montana limited liability company owned by Essentia and the Great Falls Clinic. On March 23, 2006, the District Court denied Benefis's motion for a preliminary injunction. The Montana Supreme Court affirmed that decision on October 4, 2006. The Supreme Court emphasized that its decision "is not intended to express and does not express any opinion about the ultimate merits of the individual issues or the case."

The merits of Benefis' argument--that the challenged transaction violates Montana law and constitutes a type of competition that the Montana legislature has determined is harmful to the public interest--are not before the Department at this time. Until that challenge is resolved, however, the Department cannot conclude that this potential source of competition provides a sufficient basis for repealing the COPA under existing market conditions.

3. Hospitals Outside of Great Falls.

Hospitals outside Great Falls may also compete with Benefis for inpatient services in certain geographic areas. To properly evaluate the existence and extent of this potential source of competition, the Department would need access to patient discharge information for hospitals outside of Great Falls. The Montana Hospital Association (the private entity that receives and maintains such information for all Montana hospitals)

declined the Department's request for this information, citing the confidentiality concerns of participating hospitals. Benefis also requested this information but was unable to obtain the consent of the other hospitals necessary to permit public disclosure. The Department elected not to pursue efforts to compel production of the information at this time due to uncertainty over the future of the Montana Central Hospital.



C. **Conclusion**

The Department finds that there is not sufficient evidence to conclude that increases in competition have eliminated the need for regulation over inpatient hospital services. Accordingly, repeal of the COPA at this time would not further the purposes of Montana Code Ann. § 50-4-601. The Department will continue to monitor competitive developments in the marketplace that may justify modification, amendment or repeal of the COPA. Such action may be necessary due to the rapidly changing health care services market in Great Falls.

Dated this ____ day of October, 2006.

MIKE McGRATH
Attorney General

ATTORNEY GENERAL MIKE MCGRATH
STATE OF MONTANA

FOR RELEASE: October 16, 2006

CONTACT: Judy Beck, 444-5774

McGrath Decision Upholds DOJ Monitoring of Benefis Healthcare

HELENA – In a decision (PDF) released today, Montana Attorney General Mike McGrath upheld Department of Justice oversight and monitoring of inpatient hospital services at Benefis Healthcare in Great Falls. In the decision, McGrath found that "there is not sufficient evidence to conclude that increases in competition have eliminated the need for regulation over inpatient hospital services."

In 1996, the Department of Justice approved the merger of Columbus Hospital and the Montana Deaconess Hospital to form Benefis Healthcare, finding that consolidation was likely to result in lower health care costs or improved access to health care or higher quality health care without any undue increase in health care costs.

The department's approval of the Benefis merger came with extensive conditions including regulations to ensure that savings from the merger were passed on to consumers, and that both the scope and quality of services previously offered by the two hospitals were maintained.

McGrath's decision noted that the Certificate of Public Advantage (COPA) issued to Benefis in 1996 was designed to control health care costs and improve both the quality of and access to health care.

The COPA also contained a provision that the Department of Justice conduct a review within 10 years of the effective date of the COPA to determine the extent to which the terms and conditions should be maintained, modified, amended or repealed.

In April 2006, Benefis proposed dissolving the COPA and ending the attorney general's oversight, citing the increase of providers in competition with Benefis in the market for medical care in north-central Montana. The Department of Justice held a public hearing June 27 in Great Falls, and a public comment period closed in July.

Statistics provided to the DOJ by Blue Cross Blue Shield confirm that, during the nine-year period following implementation of the COPA, Benefis' net prices have been consistently lower than the prices charged by the three other large hospitals in Montana. During that same time, Benefis has maintained healthy profit margins.

"That solid financial performance (and the substantial capital renovations and technological improvements made by Benefis during the past nine years) demonstrates that the COPA has not prevented Benefis from successfully responding to increased competition in the past," McGrath wrote.

McGrath agreed with the hospital's assertion that there have been "significant increases in competition for certain health care services provided by Benefis" and noted that the DOJ will continue to monitor competitive developments that may justify the modification, amendment or repeal of the COPA.

"Such action may be necessary in the future due to the rapidly changing health care services market in Great Falls," he wrote.

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18, is the provision which provides administrative hearing for revocation of the license. Page 4, lines 3-10, deal with the violation and referral for suspension of license is pursuant to 16-11-144. She pointed out that the assessment process is informal, but is a way of letting people make their case without hiring lawyers. It provides for a written and tape recorded record which is due process.

REP. BOHLINGER asked **Mr. Anderson** to comment about the due process in the document. **Mr. Anderson** said that due process is violated in this bill. Part of the bill on page 3, lines 14-21, addresses the assessment and collection of the tobacco education fee. That fee is $500 dollars. The assessment conference is held and this is not a contested case as defined in the Montana Administrative Procedure Act which takes away the right of appeal and due process. The license suspension proceeding under subsection 8, lines 22-26 on page 3, is a proceeding to determine whether or not the license should be suspended, whether a property right should be taken away and whether the person should be prevented from engaging in a lawful occupation. The last sentence in that provision said it is not subject to administrative or judicial appeal pursuant to the Montana Administrative Procedure Act.

Closing by the Sponsor:

REP. SOFT closed on the bill. He said the present law has not been enforced and is not adequate.

2/15/95

HEARING ON HB 509

Opening Statement by Sponsor:

REP. SHIELL ANDERSON said HB 509 was intended to make health care more affordable to Montanans. He explained this bill would authorize mergers and consolidations of health care facilities and if they could prove that they can consolidate and not increase health care costs, then the Health Care Authority could give them a certificate of public advantage which will prevent them from being the subject of anti-trust litigation. He passed out amendments to the bill. **EXHIBIT 23**

This would make the program self-funding where the mergers or consolidators would pay for the authority to review their application for certificate of public advantage as well as on-going costs for follow-up of compliance in terms of that agreement. The amendments should eliminate the need for any fiscal notes. The coordinating functions will go to the Attorney General's Office rather than the Health Care Authority. This will help hospitals merge if they want to without being subjected to anti-trust litigation. This process will help them better serve the public.

Proponents' Testimony:

Max Davis, lawyer from Great Falls representing Columbus Hospital, testified in support of the bill. He also represents **Montana Deaconess Medical Center,** the other hospital in Great Falls. He said the two hospitals have been engaged in intensive and on-going discussions leading to the hopeful consolidation of those two facilities. In the process, they have been very interested in the statutes that are under consideration. The statutes did not address what they wanted them to. Hospital consolidation is not new on a national level. Pressures about health care are leading hospitals to look at doing innovative things to meet the challenges in a volatile and changing health care climate.

He pointed out that any kind of changes like this are subject to federal review by the Federal Trade Commission or the Department of Justice. Since there are so many of these happening around the country, the federal commission picks and chooses which ones to become involved in. The way the federal government looks into a facility is by a subpena, which then costs a half of million dollars for a facility to respond. This cost is undesirable to any facility. If the state takes an active role in a consolidation effort in listening to whether it is a good idea or not, the federal government may choose not to become involved. He suggested that these decisions are better made in Montana through either the Health Care Authority or to the Attorney General's Office.

William Downer, past Chief Executive Officer of Columbus Hospital and presently senior executive and consultant on this project, testified in support of the bill. He said they feel it is critical for the public, who utilizes the facility, to be involved in the decision-making process. The benefits to the public outweigh any potential danger to competing hospitals.

Kirk Wilson, CEO of Montana Deaconess Hospital, said that hospital mergers reduce costs by eliminating the part of the cost structure that doesn't affect patient care, which is administrative overhead. Only through mergers can they eliminate administrative overhead effectively. The state would enjoy better rates for their employees as well as citizens and small employers.

Jerry Loendorf, Montana Medical Association, testified in support of the bill. He pointed out the anti-trust laws were complex and it would be easy for people to unknowingly violate them. Also, this would be very costly. He discussed the Great Falls situation where the hospitals are merging. He said this merge would probably comply with integration requirements needed for a group to get around Section 1 of the Anti-Trust laws which prohibits contracts and restricts the trade. But if this happened, they would be the only hospital left in town. Would they then be in violation of Section 2, which prohibits

monopolization? The U.S. Supreme Court decided that hospitals could contract with providers to provide a specific service in that hospital and exclude all other providers. However, in Jefferson Parish, Louisiana, where the case was decided, there were 20-40 other hospitals.

{Tape: 4; Side: A; Approx. Counter: 000; Comments: n/a.}

Mr. Loendorf continued. The violations are felonies for hospitals which are corporations and can be fined up to $1 million. For individuals it is $100,000 and three days in jail. The civil suits are worse. A negative verdict can mean $300,000 to $500,000, but the judge would triple that since that is a requirement of the law. He discussed the anti-trust suit he had been involved in which lasted seven years and is still on-going, even though he is no longer involved. The costs of those suits are horrendous; "if you win, you lose." He gave an example of costs. He said the bill makes an exception in the anti-trust law, so where state's regulate, the anti-trust laws don't apply. This is substituting regulation for competition, which the anti-trust law promotes.

Mike Craig, Health Care Authority, testified in favor of the bill. He said the Health Care Authority agrees that this is one piece of SB 285 that ought to continue. The Authority agreed with including the additions that this bill does in terms of anti-trust. Keeping it at the state level with the expertise of the Attorney General's Office makes for a strong potential for cost containment.

Sharla Hinman, Manager of Geriatric Programs at Montana Deaconess Hospital, testified in support of the bill. She urged passage of the bill with the amendments to give Montana the opportunity to decide what is best.

Allyn Christiaens, a clinical laboratory scientist at Columbus Hospital in Great Falls, testified for the bill. He commented about the long-term outlook of employees, which would be a savings of jobs. The area has been losing population and the service area for both hospitals have been dwindling in numbers because of the decrease in population in outlying areas. Cuts in federal reimbursements for services will result in a loss of services.

Opponents' Testimony: None

Questions from Committee Members and Responses:

REP. L. SMITH asked **Mr. Downer** about other mergers such as Missoula and if this was because of the anti-trust laws. **Mr. Downer** replied that these types of negotiations are delicate and can break down over a variety of things. Missoula discussions continue, but their circumstances are different. This legislation would enable them to have the state of Montana

monitor their activities. **REP. SMITH** asked what the positions were. **Mr. Downer** replied that some positions are opposed because change is hard to accept. Some are opposed because they think competition is the only way to deal with issues in health care, just as it is in other businesses. Some people are concerned that the hospital would become part of a Catholic system. He pointed out that this issue was about managing change. Hospital administrators know that change is coming. They try to see as many years down the road as possible and to protect the best interests of the community. The hospital would be in a position to provide retraining, reasonable severance and out-placement assistance. This would be worked out through attrition, so would involve very few people.

REP. SMITH asked if through the consolidation movement, there was more potential for HMO providers. **Mr. Downer** replied those things were coming to Montana. He pointed out that they would not deal exclusively with any single group which would include physicians, though not those employed by the hospital such as pathologists and radiologists.

REP. KOTTEL asked **REP. ANDERSON** if this bill meant an approval for consolidation or merger or was it just allowing for this to be held at the local level. **REP. ANDERSON** said that was correct. It was establishing the process whereby the Health Care Authority, or as an alternative, the Attorney General's Office can deal with it. He said it would allow for parties who were opposed to this or were proponents could submit their information and then the Health Care Authority may or may not grant the certificate of public advantage. **REP. KOTTEL** asked if costs incurred by the state for handling this certificate would be the applicant's responsibility. **REP. ANDERSON** replied that was the intent of the amendments.

REP. CAREY asked **Max Davis** of Great Falls about partnerships with groups of doctors. **Mr. Davis** replied that physicians could form partnerships as they do, but there are other types of cooperative ventures that providers may envision such as forming integrative delivery systems, HMOs or other things. There is great uncertainty if these types of partnerships may implicate the anti-trust laws. The purpose of this would be to provide a level of protection and assurance that would help prevent these catastrophic transaction costs.

REP. HAGENER asked **Max Davis** if there were others in Montana that were affected by the legislation. **Mr. Davis** replied the facilities affected mostly are those communities that have two hospitals. There are a whole range of provider facilities that are affected such as nursing homes which would be covered.

Closing by Sponsor:

REP. ANDERSON closed on the bill. He said this would help reduce health care costs to Montanans.

50-4-601. Finding and purpose. The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements and by mergers and consolidations among health care facilities and physicians licensed to practice medicine under Title 37, chapter 3. The purpose of this part is to provide the state, through the department, with direct supervision and control over the implementation of cooperative agreements, mergers, and consolidations among health care facilities and physicians licensed to practice medicine under Title 37, chapter 3, for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements, mergers, and consolidations substitute state regulation of facilities and physicians licensed to practice medicine under Title 37, chapter 3, for competition between facilities and physicians licensed to practice medicine under Title 37, chapter 3, and that this regulation have the effect of granting the parties to the agreements, mergers, or consolidations state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws.

History: En. Sec. 37, Ch. 606, L. 1993; amd. Sec. 12, Ch. 378, L. 1995; amd. Secs. 1, 10, Ch. 526, L. 1995.

50-4-602. Cooperative agreements, mergers, and consolidations allowed. (1) A health care facility may enter into a cooperative agreement with one or more health care facilities. A health care facility may also merge or consolidate in whole or in part with one or more other health care facilities.

(2) A physician licensed to practice medicine under Title 37, chapter 3, may enter into a cooperative agreement with one or more physicians licensed to practice medicine under Title 37, chapter 3.

History: En. Sec. 38, Ch. 606, L. 1993; amd. Sec. 2, Ch. 526, L. 1995.

50-4-603. Certificate of public advantage -- standards for certification -- time for action by department. (1) Parties to a cooperative agreement, merger, or consolidation may apply to the department for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed cooperative, merger, or consolidation agreement, a description of the scope of the cooperation, merger, or consolidation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The department shall hold a public hearing on the application for a certificate before acting upon the application. The department may not issue a certificate unless the department finds that the agreement is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs. If the department denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the department not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement. The parties to a void agreement may submit a new application for a certificate based upon a cooperative agreement, merger, or consolidation different from the original application.

(3) The department shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application or within one 90-day extension, which may be granted by the department upon a showing of good cause by the applicants. If the department does not issue a certificate within that time, the application is considered to have been denied. A certificate may be issued subject to terms and conditions, as the department may determine are appropriate, in order to best achieve lower health care costs or greater access to or quality of health care.

(4) Any amendment to a cooperative, merger, or consolidation agreement and any material change in the operations or conduct of any party to a cooperative, merger, or consolidation agreement is considered to be a new agreement and may not take effect or occur until the department has issued a new certificate of public advantage approving the amendment or change.

History: En. Sec. 39, Ch. 606, L. 1993; amd. Sec. 13, Ch. 378, L. 1995; amd. Secs. 3, 10, Ch. 526, L. 1995.

50-4-604. Reconsideration by department. (1) If the department denies an application and refuses to issue a certificate, a party to the agreement may request that the department reconsider its decision. The department shall reconsider its decision if the party applying for reconsideration submits the request to the department in writing within 30 calendar days of the department's decision to deny the initial application.

(2) The department shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The department shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the department must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

History: En. Sec. 40, Ch. 606, L. 1993; amd. Sec. 14, Ch. 378, L. 1995.

50-4-605. Definitions. For the purposes of this part, the following definitions apply:

(1) "Certificate of public advantage" or "certificate" means a written certificate issued by the department as evidence of the department's intention that the implementation of a cooperative agreement, when actively supervised by the department, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(2) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities.

(3) "Department" means the department of justice provided for in Title 2, chapter 15, part 20.

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in the definition of health care facility contained in 50-5-101. The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

History: En. Sec. 19, Ch. 378, L. 1995; amd. Sec. 206, Ch. 42, L. 1997; amd. Sec. 2, Ch. 188, L. 1997.

50-4-606 through 50-4-608 reserved.

50-4-609. Revocation of certificate by department. (1) The department shall revoke a certificate previously granted by it if the department determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the department without giving notice and an opportunity for a hearing before the department as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the department within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the department shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The department shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the department, the agreement for which the certificate was issued is terminated.

History: En. Sec. 41, Ch. 606, L. 1993; amd. Sec. 15, Ch. 378, L. 1995.

50-4-610. Appeal. A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the department to deny an application for a certificate or a decision by the department to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

History: En. Sec. 42, Ch. 606, L. 1993; amd. Sec. 16, Ch. 378, L. 1995.

50-4-611. Record of agreements to be kept. The department shall keep a copy of agreements for which a certificate is in effect pursuant to this part. A party to an agreement who terminates the agreement shall notify the department in writing of the termination within 30 days after the termination.

History: En. Sec. 43, Ch. 606, L. 1993; amd. Sec. 17, Ch. 378, L. 1995; amd. Secs. 4, 10, Ch. 526, L. 1995.

50-4-612. Rulemaking. The department shall adopt rules to implement this part. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by this part, and appeals; and

(3) to effect the active supervision by the department of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect.

History: En. Sec. 44, Ch. 606, L. 1993; amd. Sec. 18, Ch. 378, L. 1995.

50-4-613 through 50-4-620 reserved.

50-4-621. Enforcement by attorney general. The attorney general may bring an action in the name of the state against a person or persons to whom a certificate has been issued in order to enforce any terms or conditions imposed by the department upon the issuance of the certificate, to enjoin the violation of the terms or conditions, or to enjoin any material violation of or deviation from the terms of the cooperative, merger, or consolidation agreement submitted to and approved by the department. The action may be brought in the district court of any judicial district in which a person or persons to whom a certificate has been issued reside or maintain a principal place of business or, with the consent of the parties, in the district court of the first judicial district, Lewis and Clark County.

History: En. Sec. 5, Ch. 526, L. 1995; amd. Sec. 10, Ch. 526, L. 1995.

50-4-622. Reports. If the department issues a certificate of public advantage, the facilities or physicians to whom the certificate has been issued shall submit a report to the department evaluating whether the cooperative, merger, or consolidation agreement submitted to and approved by the department has been complied with during the preceding year and, if applicable, evaluating whether any terms and conditions imposed by the department when it issued the certificate have been met or otherwise satisfied during the preceding year. The report must be submitted annually or more frequently if required by the department. The department shall in turn issue findings as to whether the terms and conditions are being met or otherwise satisfied. The department shall keep copies of all reports and findings based on the reports.

History: En. Sec. 6, Ch. 526, L. 1995; amd. Sec. 10, Ch. 526, L. 1995.

50-4-623. Fees -- statutory appropriation. (1) The department shall establish by rule fees to accompany the filing of an application for a certificate of public advantage and for a report required by 50-4-622. The fees must be reasonably related to the costs of the department in considering applications, evaluating reports, and performing other duties necessary to administer this part. The costs may include the retention of accounting, technical, and legal assistance that the department considers necessary to process applications and reports. The department shall maintain records sufficient to support the fees charged under this section.

(2) The fees must be deposited in an account in the special revenue fund. The account is statutorily appropriated, as provided in 17-7-502, to the department.

History: En. Sec. 7, Ch. 526, L. 1995; amd. Sec. 10, Ch. 526, L. 1995.