HOUSE FINANCE COMMITTEE
April 23, 2002
1:39 PM

TAPE HFC 02 – 90, Side A
TAPE HFC 02 - 90, Side B
TAPE HFC 02 - 91, Side A
TAPE HFC 02 - 91, Side B

CALL TO ORDER

Co-Chair Williams called the House Finance Committee meeting to order at 1:39 PM.

MEMBERS PRESENT

Representative Eldon Mulder, Co-Chair
Representative Bill Williams, Co-Chair
Representative Con Bunde, Vice-Chair
Representative Eric Croft
Representative John Davies
Representative Richard Foster
Representative John Harris
Representative Bill Hudson
Representative Ken Lancaster
Representative Carl Moses
Representative Jim Whitaker

MEMBERS ABSENT

None

ALSO PRESENT

Representative John Coghill; Representative Lesil McGuire; Elmer Lindstrom, Special Assistant, Department of Health and Social Services; Mike Powers, Administrator, Fairbanks Memorial Hospital; Brian Slocum, Tanana Valley Clinic, Fairbanks; Jerome Selby, Regional Director, Providence Kodiak Island Medical Center, Kodiak; Richard Cobden, MD, Fairbanks; Catherine Reardon, Director, Division of Occupational Licensing, Department of Community and Economic Development.

PRESENT VIA TELECONFERENCE

Carolyn Watts, PH.D., Professor, Health Economics, University of Washington; Jay Kaplan, Vice President, Emergency Services, Banner Health, Arizona; Thomas R. Piper, Director, Certificate of Need Program, Missouri Department Health, Missouri; Dean Montgomery, Staff Director, Health Systems Agency of Northern Virginia (HSANV), Virginia; Kim Pickarel, Market Coordinator, Health South Medical Services Corporation, Anchorage; Dennis Murray, Heritage Place, Kenai; Harry Porter, Fairbanks Memorial Hospital, Fairbanks; Susan McLane, Fairbanks Memorial Hospital, Fairbanks; Karl Sanford, Fairbanks Memorial Hospital Foundation, Fairbanks.

SUMMARY

HB 350 "An Act relating to terroristic threatening."

CSHB 350 (FIN) was REPORTED out of Committee with a "do pass" recommendation and with and four previously published fiscal notes: #1 CRT, #3 LAW, #4 ADM, and #5 COR.

HB 399 "An Act relating to the Uniform Mechanical Code and other safety codes; annulling certain regulations adopted by the Department of Community and Economic Development relating to the mechanical code that applies to certain construction contractors and mechanical administrators; and providing for an effective date."

HB 407 "An Act relating to the Certificate of Need program."

HCR 23 Proposing amendments to Uniform Rule 20 of the Alaska State Legislature; and providing for an effective date for the amendments.

HCR 23 was REPORTED out of Committee with a "do pass" recommendation and with a new zero fiscal note by the Legislative Affairs Agency.

#hcr23

HOUSE CONCURRENT RESOLUTION NO. 23

Proposing amendments to Uniform Rule 20 of the Alaska State Legislature; and providing for an effective date for the amendments.

Vice-Chair Bunde, Sponsor, HCR 23 testified in support of the legislation. He noted that the legislation would amend the Uniform Rules to create a standing House Education Committee. It would reconfigure the House Health, Education, and Social Services Committee to the House Health and Social Services Committee. He noted that "it is a full plate" for one committee. He observed that HCR 23 would not change the Senate HESS Committee. The change would be effective for the next legislative session.

Vice-Chair Bunde noted that it was felt that the Special Committee on Education has proven to be beneficial to the legislative process by facilitating focused committee work on education bills and issues. He noted that while he was chair, the House Health, Education, and Social Services Committee often had to meet five days a week in order to get through the bills before them. He observed that it was sometimes difficult to get a quorum.

Vice-Chair Bunde emphasized that education issues are complex and very important. The workload related to education has become significant and would benefit from the full attention of a permanent standing committee. He observed that HCR 23 is supported by the Association of Alaska School Boards and the Alaska Council of School Administrators.

Vice-Chair Bunde pointed out that during the 22nd Legislature: 119 bills were referred to HESS; 42 bills were referred to the Special Committee on Education; and 33 bills were referred to both committees.

Representative Harris observed the difficulty of getting a quorum and questioned if an additional committee would exacerbate the situation. Vice-Chair Bunde stressed that the new committee would be able to maintain a regular three-day a week schedule.

Vice-Chair Bunde MOVED to ADOPT a zero fiscal note. There being NO OBJECTION, it was so ordered.

Representative Foster MOVED to report HCR 23 out of Committee with the accompanying fiscal note. There being NO OBJECTION, it was so ordered.

HCR 23 was REPORTED out of Committee with a "do pass" recommendation and with a new zero fiscal note by the Legislative Affairs Agency.
#hb407
HOUSE BILL NO. 407

"An Act relating to the Certificate of Need program."

Representative John Coghill, Sponsor, spoke in support of the legislation. He noted that he was motivated by an open market system. He stressed that health care needs to cross over between regulation and the free market economy. He maintained that the consumer (patient) is often left out of discussions. Under current statute, a health care delivery system costing more than $1 million dollars must go through a Certificate of Need (CON) discovery process and authorization with the Department of Health and Social Services. He questioned why government permission should be required to give health care services in certain population and if it is the wisest way to go.

Representative Coghill reviewed the legislation by section. Section 1 provides that a facility may not expend more than a million dollars under specific conditions: for a skilled nursing facility or psychiatric hospital; to increase the bed capacity of a skilled nursing facility; or convert bed care style.

Section 2. Provides that a facility destroyed on site or demolished on site could be replaced without having to acquire a new Certificate of Need and provides that a facility could move to a new site without a new Certificate of Need as long as capacity and categories of services do not change.

Section 3. Requires the department to adopt regulations to set a time limit for the department to determine that an application is complete.

Section 4. Requires the department to set a time limit by which public hearings must be held. It also requires the department to approve or deny an application within 120 days of the date the department determined the application was complete.

Section 5. Places all Certificate of Need applications under the same standards of review that currently exist for nursing home beds.

Sections 6 and 7 addresses issuance and the rights of a temporary Certificate of Need.

Section 8 addresses the suspension of a Certificate of Need.

Section 11 provides for the development of a comprehensive health plan.

Representative Coghill observed that limitations to the health plan were placed in section 13:

(1) is not intended by the legislature to be updated periodically;

(2) shall be prepared by the Department of Health and Social Services by January 1, 2003, and a copy of it shall be given by the department to the legislature by that date; and

(3) shall be prepared by using staff and other resources of the department that are generally available to perform the duties of the department without an additional appropriation specifically designated for preparation of the plan or without an additional appropriation to fund the indirect effect on existing personnel or resources.

Representative Coghill maintained that populations of 55,000 or more should be open to a freer market. He acknowledged that the size is arbitrary. He emphasized that the non-profit organization world is over-running the for profit world. He inferred that non-profits could indulge in price fixing and that it leaves room for discussions of impropriety. He stated that he would not be opposed to the elimination of section 11.

Vice-Chair Bunde clarified that the high fiscal costs are associated with section 11.

CAROLYN WATTS, PH.D., PROFESSOR, HEALTH ECONOMICS, UNIVERSITY OF WASHINGTON, testified via teleconference in opposition to the legislation. She has done research and

taught in the area of health economics and health policy for the past 26 years. She has also written widely on issues involving the organization of health care markets, including several pieces on Certificate of Need, one for the Washington State Legislature.

Ms. Watts urged the Committee to proceed with extreme caution. She maintained that the stakes are very high, both for Alaska's Medicaid budget and for access to basic services such as obstetrics and prenatal care for the populations, particularly the low-income populations, served by sole community hospitals.

> As an economist, I believe in competition. However, competition delivers good results in markets that can support many buyers and sellers where all consumers can afford to pay their way. Competition at its best does a good job of catering to the desires of buyers with money. It does nothing for people without the ability to pay. This is not the situation in single hospital communities. Here patients have no alternative if the only hospital cannot survive financially because another provider has entered the market to do only the profitable services.
>
> Competition can lower prices in some markets. However, the only prices that get lowered are for those consumers and services the sellers want to serve (at a profit). Sellers won't compete to serve Medicaid or charity patients — but competition will erode the ability of charitable hospitals to serve these patients if they take away the potential for cross subsidization.
>
> The Alaska State budget is in trouble. Medicaid funds are in trouble. Cross subsidization of Medicaid and charity services with insurance funds paid for profitable services essentially allows the state to shift some of the financial burden of its Medicaid obligation to the private sector. Competition that lowers the prices of profitable services to insured patients benefits insurance companies at the expense of the state Medicaid budget. The hospital's financial obligations around basic services such as obstetrics and prenatal care to low income Medicaid or uninsured patients will not be reduced as outpatient surgery centers and other niche providers enter the market. In

the absence of funds generated through cross subsidization, the hospital will either have to raise its prices to Medicaid or fail financially, resulting in major access dilemmas not just for Medicaid patients but for all the residents of the community.

Finally, Certificate of Need does not prohibit competition. It simply provides a structure and a public process through which competition can be monitored, guided, and shaped to be constructive rather than destructive. The free market, after all, brought us Enron.

Ms. Watts urged legislators to study the issue carefully before they dismantled the public process that supports the health care infrastructure of Alaskan communities and maintained that Certificate of Needs does not inhibit competition.

Co-Chair Mulder questioned if the state of Washington has a Certificate of Need process and whether it had changed over the last decade. Ms. Watts affirmed and noted that the process has changed, but the process of the Certificate of Need has remained allowing public discussion around what the community's infrastructure would look like.

Co-Chair Mulder noted that there is a closed opportunity into the Alaskan market, which has caused frustration. He questioned if it is easier in the state of Washington. Ms. Watts observed that the idea behind the process is not as a prohibition, but as a careful introduction into the market. Proposals that provide choice and are good for the market without harming the basic infrastructure go through without a lot of discussion. Certificate of Need allows for alteration of projects. It provides a forum for public discussion. Without a Certificate of Need process there is no way to monitor or assure promises are kept. There is a process by which the product can be monitored and shaped. Co-Chair Mulder summarized that the process is open and occurs in the public discussion. Ms. Watts agreed.

Vice-Chair Bunde clarified that Ms. Watts is a paid witness through the Fairbanks Memorial Hospital.

In response to a question by Representative Whitaker, Ms. Watts noted that market forces cater well to the people who have resources but not to those that cannot pay or are

represented by agencies like Medicaid that cannot pay market rates. The competition is around the profitable patients and services. No one wants patients that cannot pay or that come with less than market rates, as do Medicaid patients in most states.

JAY KAPLAN, VICE PRESIDENT, EMERGENCY SERVICES, BANNER HEALTH, ARIZONA, testified via teleconference in opposition to the legislation. Mr. Kaplan practiced emergency medicine for 21 years [in New Jersey] and in the state of Arizona for the past year. He referred to the Certificate of Need process in New Jersey, which was implemented to prevent duplication of services and increased costs. The hospital in which he worked was not allowed to initiate an open-heart program because of the affect on nearby urban inner city hospitals. Another suburban hospital was allowed to open due to political maneuverings. A major urban area hospital in the vicinity of the new open-heart clinic now has a $40 million dollar shortfall and increased uncompensated reimbursements.

Mr. Kaplan noted that the state of Arizona is seeing a rise in specialty hospitals and boutique health care services that are planned and developed by for profit groups to attract paying, insured patients, especially those requiring surgical procedures, which have a higher profit margin. He noted that Arizona has a serious medical problem with overcrowded emergency departments: with a lack of access and 8 - 10 hour weights. It is difficult to get on-call physicians to care for Medicaid and uninsured patients. He argued that eliminating the Certificate of Need process would not increase access and competition or lead to reductions in cost. Not for profit hospitals have a mandated social responsibility to care for all patients. He argued that Medicaid patients are not accepted at for profit hospitals. He maintained that elimination of the Certificate of Need process would threaten the viability of the safety net [for low income patients] and begin a health care arms race with the elimination. Studies have shown that the unbridled ability of services result in unnecessary procedures and surgeries, which increase cost. He stressed that health care premiums would be raised, leading to more people that cannot afford insurance and maintained that the Medicaid and uninsured population would swell. More facilities would also strain the shortage of nurses and technicians, which would lead to increased labor

costs. He concluded that elimination of the Certificate of Need process would not lower costs or help physicians.

THOMAS R. PIPER, DIRECTOR, CERTIFICATE OF NEED PROGRAM, MISSOURI DEPARTMENT HEALTH, MISSOURI, testified via teleconference in opposition to the legislation. He is the director of the Missouri Certificate of Need program. He reviewed changes in the Missouri system since 1979. The Missouri program has evolve and change in many ways:

> 1979 - Original Certificate of Need law passed. 1983 Establishment of the Nursing Home Moratorium established.
>
> 1988 - Expenditure minimums raised, but Federal funding discontinued.
>
> 1991 - Parking facilities, utility systems and others waived from review.
>
> 1996 - Acute care sunset passed by Legislature effective 12/31/01.
>
> 1999 - Long-term care replacements and purchase of beds established.
>
> 2001 - The sunset took affect and acute care review ended except for new hospitals. Ambulatory centers have not been reviewed; long term care, residential care and major medical equipment over $1 million dollars in any location have continued to be reviewed.
>
> 2002 - Two bills have been introduced that, HB1717 and SB 1087, which would restore and strengthen acute care review.

Mr. Piper observed that hospitals were split for many years, but are now united with the intent to reform the Certificate of Need process. Proposed bills would cover both acute and long-term care with zero thresholds for first-time services, but broaden flexibility for service expansion and replacement. The basic rationale is to protect established community services while restraining double-digit inflation in health care premiums and Medicaid costs. The impact of deregulation has been jolting in the number of new ambulatory surgery and diagnostic imaging centers, plus major hospital expansions. He argued that the

fiscal impact cannot yet be measured accurately, but emphasized that it could not come at a worse time with state budget cuts of over $500 million dollars and federal limitations on reimbursement. Mr. Piper observed that:

> Such funding problems are being experienced everywhere in our country. As I have monitored CON activities nationally over the last 13 years, and watched the demise of managed care, we have seen CON stabilize in 36 states and the District of Columbia. Missouri has streamlined their Certificate of Need process; many other states that repealed their Certificate of Need programs subsequently reenacted them, such as Indiana, Minnesota, Wisconsin. Louisiana started a Certificate of Need program in 1991. Pennsylvania reformed their program and continues the activities under licensure. There have been efforts in Texas and Kansas to restore Certificate of Need programs.

Mr. Piper emphasized that state oversight of health care persists because public funds pay for over two-thirds of the health care services, and maintained that competition doesn't work in health care; health care is part of the caring community, not a commodity. He stressed that public/private partnerships with community health planning and oversight continues to be the best investment. He reiterated that competition does not work in health care and that state oversight is important.

Co-Chair Mulder questioned Mr. Piper's statement that public funds pay for over two-thirds of health care services. Mr. Piper clarified that his statistics were based the national number: 68 percent.

Chair Mulder noted that his biggest concern is the impact on the state's Medicaid budget. Mr. Piper thought that there would be an impact on the state of Alaska Medicaid system. He suggested that there would be a rapid expansion of surgery centers and nursing homes. Medicaid would be impacted because patients would be divided between providers.

Co-Chair Mulder noted that proponents justify the legislation based on the anticipated growth of population in the state of Alaska; in five years there would be an additional 55,000 in population; and more facilities would translate into more opportunity.

Mr. Piper pointed out that the planning component must occur to look at the expanding population and determine where and which services should be provided. Planning is needed along with regulation.

Co-Chair Mulder asked if there were comparisons with Montana or other states with similar demographics to Alaska. Mr. Piper did not have information on states with similar demographics to Alaska.

Vice-Chair Bunde asked who is the ultimate arbitrator in Missouri. Mr. Piper explained that there is a health facilities review committee, which is a 9-member panel appointed by the governor and legislature. There are 4 legislators on the body. The committee prepares and analyzes information consistent with a set of regulations that help to plan for what is needed and then compare for feasibility. He observed that acute care review in Missouri is poised to pass, which would strengthen the Certificate of Need process in Missouri.

Vice-Chair Bunde maintained that Certificate of Need regulations in Alaska have been handled arbitrarily. Mr. Piper noted that a Certificate of Need technical advisory committee with 73 members helped the state to streamline and rewrite their rules. They have been able to reduce times and costs by 20 – 40 percent.

Representative Coghill noted that the legislation tightens up Certificate of Need requirements for a school nursing facility, psychiatric hospital or nursing and psychiatric facility. These facilities would be under the Certificate of Need requirements in communities under 55,000.

DEAN MONTGOMERY, STAFF DIRECTOR, HEALTH SYSTEMS AGENCY OF NORTHERN VIRGINIA (HSANV), VIRGINIA, testified in opposition to the legislation. He noted that HSANV is a private non-profit corporation, which does health services research and planning, under contract, for both public and private entities. They have conducted a number of CON and related planning studies in Virginia and elsewhere over the last two decades. He noted that he has more than *25* years experience in this field.

Mr. Montgomery stated that:

The merits, and necessity of CON and related planning have been debated in Virginia, with varying degrees of intensity, every year since 1986. The Virginia experience may be instructive and of use as you consider changes to Alaska's program. After years of debate, most covered service in Virginia was deregulated in 1989. Among acute care services, planning controls were kept on only hospital beds, operating rooms and open-heart surgery. Following deregulation, there was an immediate proliferation of new services (notably, CT, MRI, radiation therapy, cardiac catheterization). The resulting increase in capital expenditures, and the sharp decrease in average program use/volumes and the associated revenue loss at established programs. led the state legislature to reimpose planning controls three years later, in 1992. Controls were reimposed on all of the services that had been deregulated in 1989. It took between 7 and 8 years for average program volumes to return to 1989 levels. Virginia has been a rapidly growing state during the last decade: 2 percent a year. Were this not the case, the negative effects of deregulation would have been even greater and longer lasting.

This experience notwithstanding, CON has been debated annually (during each general assembly Session), since the re-imposition of controls in 1992. To date there has been no significant change in the program. Although there is a strong lobby in favor of the deregulation, particularly of surgery centers, diagnostic-imaging services, specialized cardiac services, cancer treatment Centers, and similar services that can be operated profitably outside of community hospitals.

The CON' debate has centered on three broad issues: (1) on the economic effects of deregulation, particularly for community hospitals, (2) on the access to care implications, especially l hr the medically indigent and Medicaid patients, and (3) on the quality implications, notably for specialized surgical and other tertiary care services.

To date (the 2002 general assembly session ended recently), the legislature has not deregulated again because the evidence and testimony indicate that:

- Community hospitals would lose critical revenue from the loss of a large percentage of the services on which they make a profit (e.g., ambulatory surgery, diagnostic imaging, cardiac catheterization) and use to subsidize losses in necessary hut unprofitable services;

TAPE HFC 02 - 90, Side B

- In some cases, and perhaps in many, the loss of this revenue would undercut the economic viability of the hospital upon which a community, or a specific population, is dependent;

- Many community hospitals would he unable, or less able, to provide necessary emergency services and services to the medically indigent and to Medicaid patients, without a substantial increase in Medicaid payments;

- Cost of deregulation to community hospitals is estimated, at minimum, to be tens of millions of dollars annually, and perhaps several hundred million, depending on the categories of services removed from regulation; and

- Although there have been sustained negotiations over several years, to date the legislature has been unwilling or unable to appropriate monies or to increase Medicaid payments to offset a significant part of these losses to essential community hospitals, or to otherwise level the playing field to offset the inherent advantages in proprietary ambulatory surgery centers and other diagnostic and treatment centers, if they were deregulated.

Mr. Montgomery concluded that:

> Virginia hospitals are highly dependent on ambulatory surgery and diagnostic imaging revenues to offset losses in a number 01' essential but unprofitable services they are required to provide. The same is true of most essential community hospitals elsewhere,
>
> Deregulation should occur, only after careful study of

the economic and service implications, particularly the cost to community hospitals.

In response to a question by Vice-Chair Bunde, Mr. Montgomery acknowledged that some services performed by hospitals are profitable. These services are used to subsidize services that do not make money.

KIM PICKAREL, MARKET COORDINATOR, HEALTH SOUTH MEDICAL SERVICES CORPORATION, ANCHORAGE, testified via teleconference in support of the legislation. She observed that Medicaid patients seen in an ambulatory surgery center are charged an average of $310 dollars less for the same surgery done in an acute care facility. She observed that they are able to offer 23-hour service for patients that need an extended stay. Very rarely are these patients sent to the acute care facility. She argued that out patient surgery would be done by teams that specialize in out patient surgery. She maintained that this would improve patient outcome, reduce time under anesthesia, reduce risk and lessen time in the operating room. She emphasized that competition is needed in the state of Alaska.

Co-Chair Mulder question whether the Medicaid budget would be affected. Ms. Pickarel acknowledged that there may be an affect but maintained that it would balance out. She pointed out that non-profits that do not pay taxes provide indigent care.

In response to a question by Co-Chair Mulder, Ms. Pickarel explained that patients could remain up to 23 hours. They could not care for the patient beyond 23 hours because they are not an acute care facility.

Representative Hudson noted that it has been a community goal to have a broad base hospital with as many specialties as possible. He questioned the impact on hospital services.

Ms. Pickarel explained that out patience care allows the surgery to be completed, cost and time efficiently. She maintained that patients and physicians would not be bumped by emergency needs. There are many facets of acute care facilities that would not be compromised.

Co-Chair Mulder observed that there is a frustration with the process among those that are attempting to enter the market through the Certificate of Need process. Ms.

Pickarel agreed. Co-Chair Mulder questioned why they have not advocated for streamlining the process. Ms. Pickarel observed that discussions have occurred regarding the building of a data site to compare data.

Co-Chair Mulder stressed that a more open process would resolve some of the issues. Ms. Pickarel agreed.

Representative Foster observed that Valley Hospital is legally and ethically bound to cover any patient that comes to them. He observed that Valley Hospital had unreimbursed care of $4 - $5.5 million dollars. Ms. Pickarel noted that 12 percent of their care was to indigents.

ELMER LINDSTROM, SPECIAL ASSISTANT, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, provided information on the legislation. He observed that the department is a payer of health care through the Medicaid program: 1 of 6 Alaskans. The state is the major payer for long-term nursing home care (85 percent) and psychiatric care. The state pays about 20 percent for other types of acute care. The state is interested in assuring that Alaskans have access to primary care and in preserving and expanding health care. Alaska has worked to maintain rural facilities. The Certificate of Need program is in administered by the Department of Health and Social Services and operated by one person. He referred to the state health plan compiled in 1984 and noted that it has not been updated. He observed the lack of available information.

Representative Hudson questioned if the Certificate of Need application covers the cost of their review. Mr. Lindstrom did not know if there was a charge. Representative Hudson spoke in support of a fee.

Co-Chair Mulder noted that there are frustrations surrounding the openness of the program. He questioned if the department would consider revamping the process. Mr. Lindstrom indicated that the department would be open to discussion. He observed that the process is similar to the regulatory process, which allows public hearings and public testimony.

Vice-Chair Bunde suggested that it is a large responsibility to place on a single person. He asked for further information regarding section 11.

Mr. Lindstrom reviewed the legislation. Section one repeals and reenacts existing law to make a distinction between communities with populations below and above 50,000. He noted that the department is not comfortable with the approach and pointed to the lack of data. He acknowledged that the market in Anchorage is different than in smaller communities, but emphasized that they do not have data to indicate the affect of unbridled competition in Fairbanks, Mat-Su or other areas that make the cut-off. They do not endorse the cut-off provision. He explained that the intent is to treat psychiatric beds similarly to long-term care beds. Long-term beds cannot be built, remodeled or converted without a CON. The state is the [primary] payer for these facilities. The department supports this provision.

Mr. Lindstrom reviewed section 2, which relates to the replacement of health care facilities. He observed that many small facilities in small communities are hanging on. The CON process requires communities to ask what sort of health facilities are needed and what can be afforded. He suggested that the legislature look at the issue of long-term care beds, nursing home beds, and psychiatric beds where the state is the primary payer.

Mr. Lindstrom continued his review of the legislation. He observed that the department is comfortable with section 3, time limits. Section 4 provides technical cleanup. Section 5 provides new standards of review for Certificates of Need. The Department supports the approach contained in the legislation, which applies nursing home standards to all types. He stressed that nursing home standards are better and more objective.

Mr. Lindstrom observed that section 11 was an amendment offered in the House Health and Social Services Committee, which would direct the department to prepare a state health plan. The department is not capable of doing the facility piece of the plan. Section 11 was later modified by section 13, which would suspended the provision for periodic updates, place a January 2003 deadline, and require the work to be done without any additional resources. He stressed that the department would update the plan without additional resources if they could. The department needs additional resources to implement [the legislative intent]. The department's fiscal note for the plan was not carried forward. The remaining $4 - $5 million dollar fiscal note

reflects the cost to the Medicaid program if facilities were built without going through the Certificate of Needs process. He observed that the fiscal note is the department's best estimate, which is based on assumptions that would be made by private business outside of the department.

MIKE POWERS, ADMINISTRATOR, FAIRBANKS MEMORIAL HOSPITAL, testified in opposition to the legislation. He observed that patients do not decide where they will be emitted. The physician makes the choice. He observed that 93 percent of Alaskans are covered by some type of insurance. Government generally pays for 45 percent of a patient's hospital stay: 15% Medicaid and 30% Medicare. He maintained that entrepreneurs will say "no" to programs like: homecare, trauma, chemical dependency, neonates and chronic inebriates. He asserted that entrepreneurs would say "yes" to imaging and surgery and entrepreneurs in the lower 48 would say "yes" to cardiology, imaging and surgery. Hospitals are required by law and mission to handle all comers, at all times. If a patient calls their physician after hours they are told to go to the hospital. He pointed out that every Alaskan town but Anchorage is a one-hospital town. This does not add choice. He pointed out that technicians that move to outpatient care would use the equipment. He emphasized that the healthcare "choice" is largely the producer's, not the consumer's. The physician, not the patient, wrestles with the question: "Do I admit to hospital where I am not a shareholder; or Do I admit to a surgery center where I am a shareholder?"

Mr. Powers responded to testimony that surgery centers are 20% less expensive. He observed that the Alaska Surgery Center in Anchorage charges $600 dollars more per cataract, $400 dollars more for carpal tunnel procedure, and other surgeries.

Representative Davies questioned if Mr. Powers was comparing "apples to apples". Mr. Powers explained that the comparison was to the technical component. A professional charge would be additional. He assumed that the surgical charge would be the same.

Mr. Power concluded that "deregulation" sounds great, but that it does not lead to healthcare competition because the physician maintains their "state-licensed monopoly on admitting privileges." He emphasized that Alaska is facing

double-digit health inflation, small businesses are seeing health premium increases of 20% to 30%; surgical volumes are flat in Fairbanks and Juneau. He stated that it is ironic that the state would consider eliminating one of the cost control mechanisms available. He suggested the formation of an "honest" study group to include the best elements of "competition" where appropriate and the best protection of regulation.

Co-Chair Mulder questioned if Mr. Powers would support a new formula that is more open. Mr. Powers stated that he would. He emphasized that there needs to be a solution. He estimated that it costs them $10 thousand dollars to do a CON. He stated that he would support a study group.

Representative Hudson stressed the need for an updated health plan.

BRIAN SLOCUM, ADMINISTRATOR, TANANA VALLEY CLINIC, FAIRBANKS, testified in Juneau. He disagreed with statements by Mr. Power that the prices in ambulatory surgery centers are higher than in hospitals. He explained that the federal government says that an ambulatory surgery center has to charge the patient one of eight different charges. The dollars that can be charged for services at an ambulatory surgery center range from a low of $242 dollars to a high of $962 dollars. The doctor's charges are added to the base. The hospital bills from a more expansive menu, but cannot charge for the doctor. In an ambulatory surgery center the whole bill is lumped together. He noted that the federal government stated in the November 11, 1999 federal register that the use of ambulatory surgery centers nationwide, since 1982, has saved hundreds of millions of dollars in Medicare and Medicaid charges. The law prevents charges at ambulatory surgery centers from being more than at a hospital.

Mr. Slocum observed that Certificate of Need comes from a central planning area of the 1970's when it was felt that one person or a team of people could allocate all the health care resources over the entire state of Alaska. He maintained that there have not been any studies that indicate that the Certificate of Need process works. The Certificate of Need process was intended to control costs by eliminating new facilities and services. He asserted that the CON process is associated with a 20.6 percent increase in hospitals and 9 percent increase in other

healthcare according to a 1998 study. The increases are the result of erecting barriers to entry. Less expensive methods of delivery cannot occur.

TAPE HFC 02 - 91, Side A

Mr. Slocum emphasized that they would not be testifying if the Certificate of Need process worked. He stressed that they have tried to streamline the process. He maintained that the CON program is the "lap dog of the healthcare industry" in Alaska and it keeps people who have a better way of doing business out of the community. He noted that hospitals have never been turned down (19 applications have been approved), but that no entities in competition with hospitals have been granted a Certificate of Need. Twenty-nine states currently have eliminated their CON programs or scaled them back to an extent that it would not cover ambulatory surgery. Alaska is the only state, of the smaller populated states, with a Certificate of Need program. He stressed that there have been lots of studies, which show that nothing bad happens when CON programs are discontinued. A 1999 study, *Certificate of Need Revisited*, concluded that there was no evidence of increasing costs in the 12 states that repealed their CON programs. In 1988, the Duke University Center of Health Policy and Politics performed a study with 16 years of federal data. The study concluded that states that lifted CON did not experience a rise in spending on hospital and physicians' services relative to those that retained it. He emphasized that more facilities were generated in others states that repealed their CON programs, but the total cost to the community stays the same as people "vote with their feet". He noted that hospital profits do not decrease when CON programs are deleted. He added that if hospital profits do not go down then there is no reason for charity care to go down. A study showed that there was no linkage between stringent CON laws and charity care increases. The states that have made the change have found it to be beneficial. He challenged the hospital industry to bring data demonstrating that the deletion of the CON program would make a difference. He estimated that there would be a 20 percent reduction if an ambulatory surgery center were built in Fairbanks.

Co-Chair Mulder observed that Mr. Slocum's testimony conflicted with the previous five speakers. Mr. Slocum acknowledged that the number of facilities would rise if

the CON program were eliminated, but emphasized that it did not mean that the total amount spent by health care consumers would rise. Co-Chair Mulder argued that the cost to the state would increase. Discussion ensued regarding the cost to the state. Mr. Slocum stated that a study by Information Insights in Anchorage (Brian Rogers) showed that it would take 5 years for the impact to be felt. The study showed that a decrease in prices could occur in the first and second years as people prepare for competition. There was a range of possibilities for the third year depending on assumptions: a $20 thousand dollar decrease to the state to a $190 thousand dollar increase. During the fourth, fifth and subsequent years, competition and the opportunity for a new less expensive service would decrease price. The total five-year estimate was a decreasing cost to the state for all operations.

Vice-Chair Bunde questioned if Mr. Slocum had experience applying for a Certificate of Need. Mr. Slocum gave examples of problems within the existing Certificate of Need program. Applicants are told to send four copies of the proposal to a health systems agency that does not exist. Proposals must be consistent with the health care plan, published in 1984, which has pages out of order. There are conflicting directions.

Representative Hudson noted that the Valley Hospital is legally and ethically bound to help all patients that come through their door and questioned if the same applied to Mr. Slocum. Mr. Slocum clarified that there is no legal requirement, but they feel that they are ethically [required to help those that come to them]. They have provided approximately $17.7 million dollars in unreimbursed care in the last three years. Forty-four percent of one doctor's practice is made up of Medicare patients, which pays .27 cents on a dollar.

Representative John Davies asked if costs were being transferred. He summarized that ambulatory surgery centers and hospitals are dealing with the same basic economic problems. He asked if the Medicaid reimbursement rate was the same. Mr. Slocum explained that hospitals operate under a different reimbursement scenario. Hospitals are not capped in the same fashion as an ambulatory center. The intent of the federal government's decision to pay ambulatory surgery centers for Medicare in 1982 was to control those costs. Anything an ambulatory surgery center

can do must go into one of eight different cost charges; these are capped at a maximum rate. Hospitals have more options. He pointed out that hospitals could appear to be cheaper: "you may go in and look at a $10 dollar steak in the hospital, but you don't realize you are going to spend $5 dollars for the potato and $7 dollars of the salad."

RICHARD COBDEN, M.D., TANANA VALLEY CLINIC, FAIRBANKS, testified that he did not like what is happening because of the Medicare practices. Over the last 30 years, there has been a gradual disenfranchisement of patients that cannot pay or are under government programs. This year Medicare will pay approximately one-third of what was paid for the same procedure seven years ago. He noted that his Medicare practice had grown from 5% to 36% because many of his colleagues are giving up Medicare and Medicaid patients. The Tanana Clinic has never refused a patient. As the population shifts away from private practice it is going to come to the large clinics and hospitals. If patients cannot be seen, by a doctor and is told to go to the emergency room, they will pay more. The same treatment for a urinary infection cost $900 dollars at the emergency room and $36 dollars in a doctor's office. Cost shifts when physicians stop seeing certain type of patients. The impact on the state's budget, if doctors refuse to see Medicare and Medicaid patients, would be enormous because patients will start going to the hospital.

Dr. Cobden pointed out that the state of Alaska cannot make Congress raise Medicare and Medicaid rates. He stressed that ancillary services help to support non-paying patients in hospitals. He questioned why the same cost shifting option to pay their overhead is being denied in ambulatory surgery centers. If the Tanana Valley Clinic could no longer cost shift it would result in a discontinuation of services. He maintained that there is a catastrophe coming.

Representative Croft questioned if there would be a problem with applying an exemption to the Certificate of Need to those that take all patients.

JEROME SELBY, REGIONAL DIRECTOR, PROVIDENCE KODIAK ISLAND MEDICAL CENTER, KODIAK, testified via teleconference. He asserted that the 55,000-population clause is a showstopper in terms of negative impact on health care for Alaskans. He stressed that the population orientation would say that competition is good in Fairbanks, Mat-Su and Anchorage but

nowhere else in the state. This provision would foster competition in the three medical markets that are the most competitive. Anchorage is already the most competitive medical market in Alaska. He disagreed that the bill addressed competition and maintained that the legislation would shift economic advantage to surgery centers that want to provide only profitable services. Non-profitable services would be left to hospitals. He stressed that quality of care must be a major consideration. He referred to a study, which stated that patient risk of death was 21 percent higher in 18 states that did not have Certificate of Need. He did not think that the level of care was comparable. He maintained that a surgery center, which is staffed from 8 am to 5 pm, cannot be compared to a hospital with a larger staff and emergency services. Hospital services require approximately 3.7 staff to each physician. Surgery centers should be able to provide the same level of care at 30 percent less than a hospital. He maintained that a limit on charges by surgery centers of 30 percent of the prevailing cost for hospital services would level the field. The legislation would shift money away from hospitals, which would "hammer" Anchorage Providence and Alaska Regional hospitals. He asserted that Providence Hospital would lose the ability to continue development of high level health care for Alaskans, such as: neonatal intensive care unit, children's hospital, advanced cancer care, and advanced heart care. There are a number of services that lose money, such as Life Guard, which flies around the state and picks up sick babies and others. He questioned if the state of Alaska would pick up the service if Providence Hospital were no longer able to afford the service. He stressed that the playing field should be equitable if it is changed. The current Certificate of Need program as written is closer to a level playing field than the proposed legislation.

Mr. Selby pointed out that persons that use the facility are going to have pay for the facilities and the state of Alaska and federal government are the biggest payers. He felt that the $4 million dollar estimated impact on the state budget was low. He noted that discussions on costs centered on developed services, not on the remaining services that are not covered at surgery centers. He emphasized that quality is important to make sure that staff is competent. The neonatal unit at Providence, which receives sick babies from around the state, only sees enough cases to barely meet the national standards to keep

their staff qualified and certified. A second neonatal unit would probably result in insufficient numbers at either unit to meet national standards. He summarized that removal of the CON program would be extremely detrimental.

HB 407 was heard and HELD in Committee for further consideration.

#hb350

HOUSE BILL NO. 350

An Act relating to terroristic threatening.

Representative John Davies MOVED to ADOPT Amendment #1:

Sec. 11.56.807. Terroristic threatening in the first degree.

(a) A person commits the crime of terroristic threatening in the first degree if the person sends or delivers a bacteriological, biological, chemical, or radiological substance, or radiological substance with intent to

(1) place a person in fear of physical injury to any person;

(2) cause evacuation of a building, public place or area, business premises, or mode of public transportation; or

(3) cause serious public inconvenience.

(b) In this section,

(1) "bacteriological, biological, chemical, or radiological substance" means a material that is capable of causing serious physical injury;

(2) "imitation bacteriological, biological, chemical, or radiological substance" means a material that by its appearance would lead a reasonable person to believe that it is capable of causing serious physical injury.

REPRESENTATIVE LESIL MCGUIRE recommended that "or an imitation bacteriological or chemical" be added.

Representative John Davies MOVED to Amend Amendment #1 to: "or an imitation bacteriological, biological, chemical". There being NO OBJECTION, #1 was adopted.

Representative John Davies WITHDREW Amendment #2.

Representative John Davies MOVED to ADOPT #3: delete lines 26 and 27 on page 9. Representative McGuire did not object to the amendment. There being NO OBJECTION, it was so ordered.

Representative Foster MOVED to report CS HB 350 (FIN) out of Committee with individual recommendations and with the accompanying fiscal notes. There being NO OBJECTION, it was so ordered.

CSHB 350 (FIN) was REPORTED out of Committee with a "do pass" recommendation and with and four previously published fiscal notes: #1 CRT, #3 LAW, #4 ADM, and #5 COR.
#hb399
HOUSE BILL NO. 399

> An Act relating to the Uniform Mechanical Code and other safety codes; annulling certain regulations adopted by the Department of Community and Economic Development relating to the mechanical code that applies to certain construction contractors and mechanical administrators; and providing for an effective date.

REPRESENTATIVE LESIL MCGUIRE, SPONSOR, spoke in support of the legislation. She observed that the Committee could adopt a proposed committee substitute, which would return the legislation to its original form or adopt the House Labor and Commerce version of the legislation. The House Labor and Commerce version is the product of a compromise. House Bill 399 was created to correct a separation of powers violation. She noted that as the chairman of the Administrative Regulation Review Committee she has reviewed at least 25 issues questioning if the regulations comport with the original intent of the legislation. She noted that HB 399 was the first bill that she has introduced to annul regulations. There are three statutes that reference the Uniform Mechanical Code, which is a trademark proprietary document.

Representative McGuire referred to AS 8.40.270(3) governing the examination of a mechanical contractor applicant. Applicants must be familiar with the following codes: Uniform Plumbing Code, Uniform Swimming Pool, Spa, and Hot Tub Code, and Uniform Solar Energy Code, and the Uniform Mechanical Code. There is a four-year code cycle. In September 2002, the Department of Public Safety made a move

to adopt regulations that would implement the International Mechanical Code. She noted that the Division of Occupational Licensing intended to follow suit.

Representative McGuire pointed out that when the legislature chooses a technical term, as they have with the Uniform Mechanical Code, that those terms are presumed to have the technical meaning. She maintained that a department has decided to make a policy issue based on the actions of another department, which is in violation of law. She pointed out that the Division of Occupational Licensing opted to change their regulations in direct violation to what the legislature placed in statute. She stressed that she indicated to the division that she was willing to work with them and cautioned that there would be an clear issue of the separation of powers and that any change should come through legislation. There are severe arguments regarding the merits of International Code versus Uniform Mechanical Code. She pointed out that people are going to be passionate about what they do and their livelihood.

TAPE HFC 02 - 91, Side B

Representative McGuire stressed that the legislature guides policy and maintained that the change is being spearheaded by one major urban area. The entire state is under the Uniform Mechanical Code. There are people in the business that know the code, which has been changed "overnight" through a regulation.

Representative McGuire noted that the first version would repeal the regulations. She pointed out that the Municipality of Anchorage has postponed the adoption of the International Mechanical Code until May 10th. The second version recognizes that there may be a move to adopt the International Mechanical Code and would test under both.

Representative McGuire discussed the Department of Community and Economic Development's fiscal note for $40 thousand dollars. The department noted in their proposed fiscal note that the state Fire Marshal currently uses the International Code, which would be superceded by the legislation and require new licensing tests that would need to be rewritten. She argued that the bill specifically allows the 1997 test to be given.

Representative McGuire stressed that it would be a bad precedent to allow a department to adopt regulations on the basis of regulations adopted by another department, in direct contrast to statute adopted by the legislature. She maintained that the issue is black and white. There is a law on the books that specifies mechanical code that should not be changed until the legislature adopts a change.

Representative Harris questioned which version of the legislation she supports. Representative McGuire responded that although there is a move to go to the International Mechanical Code, all the participants have not been at the table. She observed that the "little guys" weren't at the table. She supports continuation of the Uniform Mechanical Code until the process has been followed (House Finance Committee proposed committee substitute 22-LS1461\O). She observed that the O version carries no fiscal note.

CATHERINE REARDON, DIRECTOR, DIVISION OF OCCUPATIONAL LICENSING, DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT, spoke to the fiscal note. She explained that she submitted a zero fiscal note to the House Labor and Commerce [the fiscal note was not adopted by the House Labor and Commerce Committee].

HB 399 was heard and HELD in Committee for further consideration.

#hb407

HOUSE BILL NO. 407

An Act relating to the Certificate of Need program.

DENNIS MURRAY, ADMINISTRATOR, HERITAGE PLACE NURSING FACILITY, KENAI, testified via teleconference in opposition of the legislation. He maintained that Alaska should retain mechanisms to evaluate the cost/benefit relationships between the construction of health facilities. He felt that the current threshold was appropriate given the state's role in financing services. He argued that there are no concrete examples where elimination of the CON process in Alaska has resulted in consumer/community benefit. He drew an analogy to public school construction and concluded that more capacity does not necessary generate better pricing and availability. He observed, as a member of the Kodiak Borough Assembly, that parties were brought together through the Certificate of Need process to prevent an

adverse impact on the viability of the Kodiak Hospital by another facility.

HARRY PORTER, FAIRBANKS MEMORIAL HOSPITAL FOUNDATION, FAIRBANKS, testified via teleconference in opposition of the legislation. [Teleconference difficulty occurred; written testimony is included].

> The movement in the state government to change the CON rules alarms me. We have operated as they are presently on the books since we began our community hospital. Reflect for a moment where we came from: 1967 flood, departure of the Sisters of Providence, creation of the Greater Fairbanks Community Hospital Foundation$_1$ various fund drives, constant building arid changes to deliver the best hospital care at the least possible cost. We have done and are continuing to do the job for the Fairbanks community without cost to the state government. We are not receiving an appropriation from the state in 2002. We are not a part of any Senate or House appropriation bill.
>
> Some legislators have expressed the feeling that they do not understand the hospital business. Give us credit for 30+ years of involvement on a daily basis at no cost to anyone gives us an understanding of our local hospital and healthcare needs. Kill those unwarranted CON bills.

Mr. Porter maintained that he has seen first hand what competition can do. He noted that it took 35 years to build the Fairbanks Memorial Hospital.

SUSAN MCLANE, FAIRBANKS MEMORIAL HOSPITAL FOUNDATION, FAIRBANKS, testified via teleconference in opposition to the legislation. She suggested that a working group be appointed to address the Certificate of Need issue. She observed that there is a shortage of nurses; additional facilities would dilute the workforce.

KARL SANFORD, DIRECTOR OF NURSING, FAIRBANKS MEMORIAL HOSPITAL FOUNDATION, FAIRBANKS, testified via teleconference in opposition to the legislation. He noted that the hospital has reinvested, back into the community, $4 million dollars into mental health services over the last two years. He stressed that there is no competition in regards to mental health services because it is not

profitable. Competition is focused on the high cost and low cost services. The impacts of removing these services from the hospital would tremendous. Two other homecare providers disappeared from the Fairbanks community due to a decrease in revenue and an increase of federal scrutiny for Medicare fraud. He questioned if for profit providers were knowingly performing charity care.

HB 407 was heard and HELD in Committee for further consideration.
#
ADJOURNMENT

The meeting was adjourned at 4:30 PM