

ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE

March 28, 2006

3:06 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Vice Chair
Representative Tom Anderson
Representative Carl Gatto
Representative Vic Kohring
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Peggy Wilson, Chair

COMMITTEE CALENDAR

HOUSE BILL NO. 287

"An Act amending the certificate of need requirements to apply only to health care facilities and nursing homes located in a borough with a population of not more than 25,000, in the unorganized borough, or in a community with a critical access hospital."

- HEARD AND HELD

HOUSE BILL NO. 426

"An Act relating to medical assistance eligibility and coverage for persons under 21 years of age."

- BILL HEARING POSTPONED TO 3/30/06

HOUSE BILL NO. 467

"An Act relating to the administration of prescribed remedies and dietary supplements by a nurse."

- BILL HEARING POSTPONED TO 3/30/06

HOUSE BILL NO. 468

"An Act relating to disclosure of employment information on a medical assistance application and a hospital intake report; and requiring the Department of Health and Social Services to prepare and publicize a report pertaining to employers who do not provide health insurance."

- BILL HEARING POSTPONED TO 3/30/06

CS FOR SENATE BILL NO. 177(HES)

"An Act eliminating the prohibition on the use by certain licensed professionals of titles or descriptions of services that incorporate the terms 'psychoanalysis,' 'psychoanalyst,' 'psychotherapy,' 'psychotherapeutic,' or 'psychotherapist.'"

- BILL HEARING POSTPONED TO 4/4/06

HOUSE CONCURRENT RESOLUTION NO. 25

Supporting consistent regulation of district and statewide correspondence programs; and encouraging the Department of Education and Early Development to remove student allotment restrictions on all correspondence students.

- BILL HEARING CANCELED

HOUSE CONCURRENT RESOLUTION NO. 35

Relating to establishing March 2006 as brain injury awareness month.

- BILL HEARING CANCELED

PREVIOUS COMMITTEE ACTION

BILL: HB 287

SHORT TITLE: MEDICAL FACILITY CERTIFICATE OF NEED

SPONSOR(S): REPRESENTATIVE(S) LYNN

04/27/05	(H)	READ THE FIRST TIME - REFERRALS
04/27/05	(H)	HES, L&C, FIN
03/28/06	(H)	HES AT 3:00 PM CAPITOL 106

WITNESS REGISTER

REPRESENTATIVE BOB LYNN
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Spoke as the prime sponsor of HB 287.

NANCY MANLY, Staff
to Representative Bob Lynn
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: During hearing of HB 287, answered questions.

REPRESENTATIVE JOHN COGHILL
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Spoke as a co-sponsor of HB 287.

JIM LYNCH, Director
Human Resources
Fairbanks Memorial Hospital
Fairbanks, Alaska

POSITION STATEMENT: Testified in opposition to HB 287.

ROBERT GOULD, Finance Officer
Operations
Fairbanks Memorial Hospital
Fairbanks, Alaska

POSITION STATEMENT: Testified in opposition to HB 287.

NORMAN STEPHENS, Chief Executive Officer
Mat-Su Regional Medical Center
Palmer, Alaska

POSITION STATEMENT: Testified in opposition to HB 287.

DEBORAH KILEY, Nurse Practitioner (NP)
Anchorage, Alaska

POSITION STATEMENT: Testified that the state would be better served by allowing a level playing field and fostering competition by eliminating the subsidy of existing facilities when new construction isn't allowed.

STEPHEN SUTLEY, Oral Surgeon
Alaska Oral & Maxillofacial Center
Fairbanks, Alaska

POSITION STATEMENT: During hearing of HB 287, testified that the CON keeps competition out of Alaska and limits the doctors and services that could come to Alaska.

DON ROBERTS
Kodiak, Alaska

POSITION STATEMENT: Testified in opposition to HB 287.

GREG POLSTON, Physician
Advanced Medical Centers of Alaska
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 287.

GLEND A SMITH

Eagle River, Alaska

POSITION STATEMENT: Testified in support of HB 287.

JIM TAMAI, Orthopedic Surgeon

Advanced Medical Centers of Alaska

Fairbanks, Alaska

POSITION STATEMENT: Testified in support of HB 287.

THOMAS PIPER, Principal

MacQuest Consulting

Jefferson City, Missouri

POSITION STATEMENT: Testified in opposition to HB 287.

FRED BROWN, Chairman

ASEA/AFSCME Local 52

Health Benefits Trust;

Secretary, Alaska Health Care Cost Management Corporation;

Secretary, Fairbanks Central Labor Council

Fairbanks, Alaska

POSITION STATEMENT: Testified that the Fairbanks Central Council believes it's time to change the current law regulating the CON.

ALAN GROSS, Orthopedic Surgeon

Juneau Orthopedics

Juneau, Alaska

POSITION STATEMENT: Testified in support of HB 287.

SAM KORSMO, Chief Operating Officer

Alaska Open Imaging Center (AOIC)

Wasilla, Alaska

POSITION STATEMENT: Testified that AOIC's success shows that doctors and their patients appreciate having the choice to access quality service and the commitment to [lower] costs.

JEREMY HAYES, Representative

Advanced Medical Centers of Alaska

Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 287.

ACTION NARRATIVE

VICE-CHAIR PAUL SEATON called the House Health, Education and Social Services Standing Committee meeting to order at [3:06:45 PM](#). Representatives Gatto, Kohring, Gardner, Cissna, and Seaton

were present at the call to order. Representative Anderson arrived as the meeting was in progress.

HB 287-MEDICAL FACILITY CERTIFICATE OF NEED

3:07:09 PM

VICE CHAIR SEATON announced that the only order of business would be HOUSE BILL NO. 287, "An Act amending the certificate of need requirements to apply only to health care facilities and nursing homes located in a borough with a population of not more than 25,000, in the unorganized borough, or in a community with a critical access hospital."

3:08:16 PM

REPRESENTATIVE BOB LYNN, Alaska State Legislature, as prime sponsor introduced HB 287 paraphrasing from the following written statement [original punctuation provided]:

Thank you for hearing HB 287 today. I'm the prime sponsor of this bill, and Representatives Coghill, Chenault, and Kohring are co-sponsors. As a matter of disclosure, I'm also a prime sponsor of an Initiative on Certificate of Need issues, along with Representative Kohring and Mr. Paul Fuhs, which has been certified. The principal difference between the bill and the initiative, is that the initiative pertains to every place in Alaska, and my bill pertains only to places with a population exceeding 25,000. But I want to focus on the bill because that initiative is not before us, the bill is.

I would ask the committee to consider this bill from three different, but complementary, viewpoints.

Protect traditional American free enterprise;
Increase availability of medical care; and
Create potential cost savings for patients and worker's compensation costs, and even administrative costs to the state.

Personally, I think protecting free enterprise is as American as apple pie. If we want to go in business together, we shouldn't have to go "hat in hand" to the government and beg for a Certificate of Need. It shouldn't matter whether that Certificate of Need is

for a hot dog stand, a pizza parlor, or a medical facility. The free market should decide if a health care facility, or any other business, is needed - not some self-serving government bureaucracy. A Certificate of Need, in effect, and for example, gives Anchorage and Fairbanks hospitals a de facto government monopoly. We need more competition, not less. Free enterprise motivates excellence, encourages lower prices through competition, and in the long run benefits consumers.

Secondly, people suffering health problems need more choice of medical providers, not less. When I get sick, I want to be able to choose my own caregiver - and not have the government limit my choices with some Certificate of Need. When I go shopping for a computer, things usually turn out better, if I have several different dealers and models to choose between. Of course, finding the medical provider with the best service, and with whom we have the most trust is infinitely more important, and perhaps even aids one's successful recovery.

Third, medical costs in Alaska are reaching crisis levels, and it hurts everybody. Passage of this bill should help lower the escalating costs of Worker's Compensation, and the overall costs of medical care for the state, companies, and families. Typically, monopolies increase costs. Competition lowers costs. That's Economics 101.

Lastly, there has been some major differences of opinion over fiscal notes - what is legitimate to include, and what is not. For example, the original fiscal note for the initiative - almost identical to my bill, except for no population exemption - came in at an incredible 41 million bucks. When questioned, we were told that the fiscal note would be about half that figure - saved \$20 million with one question. Good thing we questioned it. And, as you will hear from witnesses, that figure is also unrealistic, and way on the high side. This bill should not be compromised with unsustainable fiscal notes - that's inappropriate and not fair.

In summary, please evaluate this bill on its merits. Those merits pertain to the medical availability,

choice of health provider, legitimate cost savings to all concerned, and especially the time-honored principles of American free enterprise. HB 287 is my designated priority legislation, and your support of this bill is respectfully requested.

I would ask that you call next upon Mr. Paul Fuhs for a more in-depth discussion of this bill and especially fiscal note questions which I am sure you'll be wanting to hear about.

[3:13:34 PM](#)

REPRESENTATIVE GATTO moved to adopt CSHB 287, Version 24-LS0611\Y, Mischel, 2/13/06, as the working document.

REPRESENTATIVE KOHRING objected, and asked whether the proposed committee substitute (CS) is acceptable to the sponsor.

REPRESENTATIVE LYNN replied yes.

REPRESENTATIVE KOHRING removed his objection.

VICE CHAIR SEATON, upon hearing no other objection, announced that CSHB 287, Version Y, was before the committee.

[3:14:12 PM](#)

REPRESENTATIVE KOHRING stated support for HB 287, and related that competition is going to be the key with regard to the cost [and quality] of medical service. Representative Kohring expressed concern with regard to the fiscal note, especially since it suggests that the opponents of the legislation may be attempting to kill the legislation with a greatly inflated fiscal note.

REPRESENTATIVE LYNN said that he didn't want to assign motivation to anyone because the legislation proposed changing the current situation and change is often uncomfortable for some. He noted that the committee packet should include correspondence regarding how the fiscal note was derived.

[3:16:35 PM](#)

REPRESENTATIVE GARDNER related her understanding that the issue addressed in HB 287 is a national issue. She requested that the sponsor provide some history of the certificate of need (CON).

REPRESENTATIVE LYNN noted that his interest began in April 2004 when he introduced legislation on the issue. With regard to the specific history of the CON, Representative Lynn deferred to others present. In further response to Representative Gardner, Representative Lynn related his understanding that the CON was a national mandate some years ago and states followed at which point the federal mandate was removed and the certificate of need remained in many parts of the country.

[3:18:29 PM](#)

REPRESENTATIVE CISSNA mentioned that she has heard comments that seem to indicate that those in support of this legislation are good people while those who don't support it aren't. Therefore, she expressed hope that this legislation would rise or fall on its own [merits].

[3:19:43 PM](#)

REPRESENTATIVE GATTO pointed out that HB 287 doesn't eliminate CON, but merely amends it. He then inquired as to whether there are significant differences between the original legislation and Version Y.

[3:20:02 PM](#)

NANCY MANLY, Staff to Representative Bob Lynn, Alaska State Legislature, explained that Version Y was brought forward in order to keep the nursing homes and residential psychiatric treatment centers as part of the CON program. The aforementioned is part of the initiative. In further response to Representative Gatto, Ms. Manly specified that Version Y includes a title change to add the language "residential psychiatric treatment centers". On page 1, line 7, and on page 2, line 4, the reference to subsection (g) was added. On page 2, line 6, the language "facility under AS 47.32 was added. Subsection (g) on page 2, lines 13-15, was added as was the language "and residential psychiatric treatment centers" on page 2, line 29. Finally, on page 3, line 1, the language "except for nursing homes and residential psychiatric treatment centers" was added.

[3:22:07 PM](#)

VICE CHAIR SEATON pointed out that the committee packet should include the fiscal note dated 3/16/06 for Version Y.

[3:22:24 PM](#)

REPRESENTATIVE GARDNER said if the notion that providing health care is a business such that marketplace rules should apply and that competition will lower prices, why would nursing homes and residential psychiatric centers be exempt from the provisions of HB 287.

REPRESENTATIVE LYNN related his belief that it's best to move with what is possible to pass the House and the Senate. He opined that [Version Y] is a step in the right direction.

[3:23:28 PM](#)

REPRESENTATIVE JOHN COGHILL, Alaska State Legislature, speaking as a co-sponsor of HB 287, informed the committee that the residential psychiatric treatment facilities are primarily public pay, which is why it's probably not bad to leave the government in charge of the number of beds it will make available. He indicated that it's a similar situation with nursing homes.

[3:24:21 PM](#)

REPRESENTATIVE CISSNA surmised that the sponsor believes that hospitals should be in the private sector and should be in competition.

REPRESENTATIVE LYNN said he believes in competition.

REPRESENTATIVE CISSNA highlighted the requirement of hospitals to be open 24 hours a day and see anyone who walks in. She asked if anyone providing the same services as hospitals would be required to do the same.

REPRESENTATIVE LYNN said it would depend on the facility. He did say that to compete in the marketplace, a facility would have to offer similar services.

[3:26:26 PM](#)

REPRESENTATIVE COGHILL, in further response to Representative Cissna, acknowledged that emergency rooms are mandated to take all patients and due to that hospitals receive an extra "bump" on the Medicaid rate. He informed the committee that there are other ways that [hospitals can use Medicaid money to a greater

advantage than most other businesses. He acknowledged that hospitals use different business models, but in Alaska most are nonprofit.

[3:27:31 PM](#)

VICE CHAIR SEATON highlighted that this legislation addresses expenditures over \$1 million.

[3:27:36 PM](#)

REPRESENTATIVE CISSNA asked if there are supporting documents regarding whether the federal funding is cost effective and actually does cover the expenses such that it's an even playing field.

REPRESENTATIVE COGHILL said that he could provide the committee information with regard to the Medicaid rate issues. With regard to the cost effectiveness, he acknowledged that it's debatable.

[3:28:27 PM](#)

REPRESENTATIVE KOHRING related his understanding that there are a large number of physicians who support this concept of eliminating or at least reducing the CON.

REPRESENTATIVE LYNN agreed, and added that the CON is one manner in which the medical challenges the state faces could be addressed.

[3:29:49 PM](#)

REPRESENTATIVE KOHRING inquired as to what other states are doing with the CON.

MS. MANLY related that approximately 36 states continue to have the CON, although there seems to be much movement toward removing CON programs.

[3:31:28 PM](#)

JIM LYNCH, Director, Human Resources, Fairbanks Memorial Hospital, began by stating that he, too, believes that capitalism and strong economic competition are positive and strong economic theories. However, he opined that the aforementioned theories don't work perfectly nor should they be

applied blindly in every situation. Mr. Lynch then related his strong opposition to HB 287 for several reasons. First, it's a flawed assumption to believe that competition in the health care industry [will decrease costs]. The health care industry is an environment in which the economics aren't normal because there is heavy government subsidy. He opined that in many situations these costs [at hospitals] will increase and wages are likely to increase for technically trained staff that are in short supply within the state, which would inflate the cost of a hospital as well as a stand-alone surgical center. Moreover, it's likely that community hospitals will have to compensate for lost surgical revenue by increasing prices for other services it offers, and thereby resulting in higher overall health care costs for the community. Mr. Lynch highlighted that hospitals see all patients regardless of the patient's ability to pay. On the other hand, surgical centers are likely to only see patients with the ability to pay and the facilities are likely to only provide procedures for which the maximum reimbursement is received from the government or private insurers.

MR. LYNCH then brought forth the issue of self-referral. He informed the committee that historically, hospitals and stand-alone surgical centers are the facilities that sell surgical services while physicians sell their services related to the delivery of health care. The economic relationship between the two groups is complimentary with the hospitals providing the facility services needed by the physicians and the physicians providing the patient referral volume the facility needs. However, the entire relationship will shift when a referring physician acquires personal financial ownership in the free-standing health care facility that competes with the hospital facility. The aforementioned is particularly troublesome in a situation in which the referring physician investor is faced with referring a patient to the hospital facility that he/she doesn't own or the stand-alone surgical center in which he/she has an economic investment. Lastly, Mr. Lynch expressed concern with regard to the small size of the community, 25,000 population base, proposed in HB 287. If one looks nationally, it takes a minimum of about 300,000 people to have an open economic model that can sustain competition, he opined.

[3:36:29 PM](#)

REPRESENTATIVE GARDNER related her understanding then that if a physician has ownership in a stand-alone facility and that physician makes a referral to his/her own facility or the

hospital, the physician has a conflict of interest that can influence the aforementioned decision.

MR. LYNCH replied yes, adding that the issue is the potential increased gain by referring to a facility in which the physician has an investment.

[3:37:12 PM](#)

ROBERT GOULD, Finance Officer, Operations, Fairbanks Memorial Hospital, began by stating his opposition to HB 287. He noted that over the last four or five years he has testified a number of times regarding the impact that elimination or weakening of the CON would have on a community hospital, particularly in Fairbanks. Mr. Gould informed the committee that there are only four areas in health care that continue to make money for facilities, and therefore as a business model the only areas of the hospital that are profitable and competitive are surgery, radiology, pharmacy, and labs. However, the hospitals provide much broader services than just the aforementioned four services and in fact, those services actually pay for the rest of the services the hospital offers.

MR. GOULD related his understanding that the assertion of HB 287 is that by elimination of the CON in communities with a population over 25,000, competition will increase while decreasing the cost. However, he disagreed and pointed out that there is data that supports the hospitals' position that the elimination of the CON will increase the cost of care. He noted that as of February 22, 2006, he performed a survey of two top magnetic resonance imaging (MRIs) [facilities] in Fairbanks in competition with Fairbanks Memorial Hospital. Over the years, each entity has testified that if they were allowed in the market, they would decrease costs. However, of the private MRI [providers] one charges about \$1,700 and the other about \$1,900 for a MRI spine without contrast while the same costs about \$1,400 at the hospital. The aforementioned is the number one procedure in Fairbanks. The second most common procedure is MRI of the brain without contrast. Again, the private providers are higher than the local hospital. Because of the referral pattern and because it's not a pure free market, patients are being driven to facilities with higher costs due to the lack of understanding of the costs and exams. In conclusion, Mr. Gould suggested that if there was a comparison of charges, one will find that in the not-for-profit community hospitals the charges are more than likely much lower than those in the for-profit, privately owned facilities. If HB 287 is passed or the CON is

weakened, hospitals and communities in Alaska will be drastically harmed, he opined.

3:43:02 PM

MR. GOULD, in response to Representative Gardner, explained that under the current reimbursement system facilities are paid the most for surgery, radiology, pharmacy, and labs. That is for those services, the reimbursement is well beyond the cost of the service while for other services there is a much lower reimbursement. The aforementioned is why people want to eliminate the CON and enter the market for the four money-making services. He pointed out that someone won't put in an in-patient mental health unit, an emergency room, or home health care for chronic inebriants or diabetics.

3:44:05 PM

REPRESENTATIVE GARDNER asked if a facility only provided the four money-making services, could it reduce the rates for those services.

MR. GOULD answered yes, in theory. In fact, the [private providers of the four money-making services] ought to be able to offer the services at a lower cost, especially since these private facilities, unlike hospitals, don't have to be open 24 hours a day, 7 days a week, 365 days a year, which means that they don't have to pay a shift differential, overtime, or additional staffing requirements. However, because of the ability to steer patients [and the profit motive], the facility can charge what it desires.

3:45:14 PM

REPRESENTATIVE GARDNER posed a situation in which a self-pay patient in Fairbanks chooses to have his/her radiology procedure performed at Fairbanks Memorial Hospital. She surmised that such a patient is subsidizing other parts of the hospital because the patient is paying a higher cost than the hospital would otherwise have to charge because the charges for the services are set at a level that allows the subsidization of other procedures.

MR. GOULD said that's an accurate statement, but clarified that Medicare and Medicaid set rates for the hospitals. Regardless as to whether it's insurance, private pay, et cetera, the fees are based primarily on what Medicare and Medicaid pay or their

regulations. He reiterated that Medicare and Medicaid pay extremely well in the four areas mentioned earlier and extremely poor in all other areas. "In effect, we're doing exactly what the government has asked us to do, which is charge more because you're going to get paid more in these areas," he pointed out.

3:46:25 PM

MR. GOULD, in further response to Representative Gardner, said that he does have data indicating that removing the CON may increase costs and could provide it to the committee. He noted that this same debate is occurring across the nation in relation to specialty hospitals. Currently, the federal government has a moratorium on specialty hospitals because studies show that they have increased costs and physician-owned hospitals see a reduced number of government patients and more of the commercial insurance payers, which results in an increase in government patients in community hospitals.

3:49:55 PM

NORMAN STEPHENS, Chief Executive Officer, Mat-Su Regional Medical Center, recalled the sponsor's comment that this legislation is Economics 101 and respectfully disagreed because it's not Health Care Economics 101. He informed the committee that he has a master's degree in health care administration and has studied health care financing, which is quite different than traditional financing. Mr. Stephens pointed out that hospitals are a people-oriented business and the product is to hire people to take care of others in a very intensive format. Hospitals are different than manufacturing in which mass production techniques or outsourcing labor drives the costs down. In hospitals, the economics are inherently cost-based. He related that what a hospital charges doesn't make that much difference because the cost structure is really what determines whether the hospital is effective and sustainable. Mr. Stephens highlighted that there is a finite number of people who are being served in an area and adding a second facility to provide some of the services of the hospital doesn't reduce the cost to the community but rather doubles the costs in some respects. Furthermore, since there are tremendous staff shortages, the [private facilities] that don't have to work the hours of a hospital employee cause the hospital to increase its salaries in order to remain competitive. A vicious cycle is created that threatens the stability of a community hospital, and therefore he opposed HB 287 which he said is based on flawed logic and economic theory that hasn't been examined thoroughly. Mr.

Stephens informed the committee that he lived through something similar in Corpus Christi, Texas, where the CON was eliminated and the for-profit corporations came in, which resulted in a number of hospitals closing. Alaska, a relatively small state, is more vulnerable and probably couldn't tolerate the elimination of the CON.

[3:54:36 PM](#)

VICE CHAIR SEATON inquired as the size of community that would support a competitive model or a situation in which there is no CON.

MR. STEPHENS said that Corpus Christi, Texas, to which he referred earlier had a population of about 379,000. Once there is a population of 300,000 or over, any one player becomes less vulnerable. In the Mat-Su Valley, he pointed out that the original Valley Hospital Association, a not-for-profit entity that has taken care of the Mat-Su Valley's needs for 70 years, has stacked everything on the new [medical center]. In fact, \$101 million has been spent to build this hospital in the Mat-Su where there is a lot at risk. He noted that there are niche providers hovering to pick off the profitable product lines and programs that the hospital depends upon to make its living. The only way to keep the hospital breaking even or on margin would be to review other areas of the hospital not being provided elsewhere and try to recover the cost in those areas. Mr. Stephens then informed the committee that the Health Care Advisory Board is a nonprofit think-tank group that recently gave a presentation entitled "Overcoming A Ruinous Competition." The presentation highlighted those who are profit-seekers who focus on the lucrative niche markets within the health care industry.

[3:57:39 PM](#)

REPRESENTATIVE CISSNA recalled an economics class she attended in which externalities was discussed. She requested that Mr. Stephens discuss externalities in [the health care industry].

MR. STEPHENS said that he didn't know what externalities are.

REPRESENTATIVE CISSNA explained that externalities are what happen when market systems don't work perfectly.

VICE CHAIR SEATON said that the aforementioned could be addressed during committee discussion.

4:00:31 PM

REPRESENTATIVE GATTO related his understanding that the Mat-Su Regional Medical Center, Fairbanks Memorial Hospital, and the Alaska Regional Hospital are all for-profit hospitals as opposed to government/community hospitals such as Providence Medical Center and Bartlett Regional Hospital. He asked if whether a hospital is for-profit or not-for-profit would change the outlook in relation to CON.

MR. STEPHENS replied no. Although the difference in ownership has to do with what happens to the reserves over revenue, a for-profit hospital provides the same amount of uncompensated and charity care as [nonprofit hospitals]. In fact, Mat-Su Regional Medical Center's charity care is 2.5 percent of gross, which has increased since the company has taken over the hospital. Mr. Stephens said:

We're dealing with the same rules and regulations that pertain to a for-profit hospital, the market pressures are the same; we have the same laws that require us to not ask people whether they have the means to pay. And ... because of being a for-profit hospital, it's even more critically sensitive in a community where we're trying to maintain a good reputation and ensure that we get business from our community. We've got to be very careful about our approach toward being a for-profit and it doesn't change that at all.

MR. STEPHENS, in further response to Representative Gatto, opined that HB 287 does the reverse of leveling the playing field. The legislation allows niche providers who do not have the same obligation to the community to operate freely. Therefore, the constraints of a hospital aren't removed either legally or morally because a facility couldn't maintain itself as a hospital without operating an emergency room all night long. Furthermore, to place hospitals in competition with the 8:00 a.m. to 5:00 p.m. niche operators is not a leveling of the playing field.

4:03:44 PM

REPRESENTATIVE GARDNER inquired as to how the health care costs in Corpus Christi, Texas, compare to costs in other communities of comparable size with or without the CON.

MR. STEPHENS expressed the need to research that, but offered that the costs continue to rise, which he characterized as a national emergency. However, he pointed out that costs in health care are costs that health care sustains; those costs are incurred as the hospital operates and are largely labor and technology costs.

4:05:33 PM

REPRESENTATIVE GARDNER opined that it's generally understood that when new businesses come to town, there's a shakeup from which some survive and some don't. Therefore, she expressed interest in any data about what actually happens with health care costs in a community after the removal of CON.

4:06:09 PM

DEBORAH KILEY, Nurse Practitioner (NP), specified that she is speaking on her own behalf as a nurse, although she is an employee for the Advanced Medical Centers of Alaska. She informed the committee that she has been a nurse for over 30 years and a NP for over 20 years during which quite a number of things have changed. When the CON process was introduced in 1972, it was designed to control costs by stopping the proliferation of all types of medical facilities by requiring review for projects costing over \$100,000. However, restricting building didn't control the cost of health care. "The CON concept has no more application to life in 2006 than \$100,000 medical facility budget will buy today," she said. In fact, the federal government and 20 states have revoked the CON requirements, which she asked the committee to take the first step in doing so as well. Ms. Kiley refuted the myth that only hospitals and community health centers provide for the underserved because in the private sector physicians, physical therapists, nurse practitioners, and other clinicians donate many hours and resources to patients with no or inadequate resources. Therefore, rather than placing artificial barriers before private citizens who have the vision to build and create, the state would be better served by allowing a level playing field and fostering competition by eliminating the subsidy of existing facilities when new construction isn't allowed. "With competition, providers can attract patients by improving their quality of care, improving service to the patient, and/or decreasing costs to payers," she opined. She further opined that patients deserve a choice as to where they receive services.

4:10:49 PM

REPRESENTATIVE CISSNA asked if Ms. Kiley could provide examples of why the CON would cause costs in the health care industry to increase.

MS. KILEY clarified that her testimony was that costs would decrease if more facilities were available.

4:12:29 PM

STEPHEN SUTLEY, Oral Surgeon, Alaska Oral & Maxillofacial Center, opined that the majority of the elderly patients and medically compromised patients that "we" treat at the hospital could be safely be treated in a surgery center for a lower cost. He pointed out that many of these patients receive Medicare and Medicaid and thus treatment in a surgery center versus a hospital would decrease the cost to the patient as well as the state. Furthermore, a number of the patients that require facial reconstruction surgery or orthognathic surgery elect either to not have the surgery at all or to go to Seattle or Portland because of the escalated costs at the local hospital. Many of these patients could be treated at a surgical center. Moreover, facial trauma with fairly simple fractures to the face requiring treatment at the hospital operating room could also be treated safely in a surgery center. Many of these patients have Medicaid or no insurance at all, and therefore face extremely high bills when they are discharged from the hospital. In summary, the CON needs to be repealed, he said. The CON, he opined, keeps competition out of Alaska and limits the doctors and services that could come to Alaska. Congress recognized the problem and has repealed the CON as have many states. Economically, it's costly to maintain the status quo for patients in Alaska. Dr. Sutley explained that the CON increases the cost throughout the state. In fact, the CON, he opined, is only important for those special interest groups who desire it to remain.

4:16:58 PM

VICE CHAIR SEATON inquired as to whether the [Alaska Oral & Maxillofacial Center] takes Medicaid patients. He also asked if the [center] limits the number of Medicaid patients.

DR. SUTLEY answered that he does accept Medicaid patients and has no limits on the number that [the center] takes. He echoed earlier testimony that hospitals are not the only facilities

that give away free care. In fact, Dr. Sutley informed the committee that he [Alaska Oral & Maxillofacial Center] gives away several hundred thousand dollars worth of care every year whether the patient is on Medicaid or merely can't pay his/her bills.

4:17:42 PM

REPRESENTATIVE GARDNER asked if Dr. Sutley works at a surgical center and has privileges at Fairbanks Memorial Hospital.

DR. SUTLEY explained that his business and practice is the Alaska Oral & Maxillofacial Center with which he has one partner. He specified that the Alaska Oral & Maxillofacial Center isn't a surgical center. He also specified that he has full privileges at the Fairbanks Memorial Hospital.

4:18:38 PM

REPRESENTATIVE GARDNER related her understanding that there are some hospitals that don't allow surgeons to perform surgery at the hospital if they perform surgery at a private surgical center.

DR. SUTLEY said that he wasn't familiar with such a scenario.

4:19:14 PM

DON ROBERTS began by stating his opposition to HB 287. He opined that health care services aren't best delivered on a competitive basis because competition results in winners and losers. In such a situation what happens with all the losers, he asked. "Basically, I think it ultimately reduces the availability of quality health care services and sacrifices effective services on the alter of administrative efficiency," he opined. However, if the desire is to control health care costs, one must determine where hospitals are spending their money. Therefore, he suggested that the committee consider including the state's version of the federal form 990 and a socioeconomic report. He also expressed the need for there to be some commitment from the community as to how agencies could incorporate the resources of other physicians and facilities to offset the costs of service and include the viability of service. He expressed concern with regard to the references to "health care service" because it doesn't explain whether it's a health care service that keeps one healthy or a crisis, treatment, or recovery service. Furthermore, there is no

knowledge as to how much of "this" would be in the administrative costs. Even more troubling is the definition of "person" as per 7 AAC 7.07.900(a)(14) includes the following: health maintenance organizations (HMOs), foundations, trusts, estates, the state, political subdivisions or other legal entities, as well AS 01.10.060(8), which specifies that a "person" includes corporations, companies, partnerships, firms, associations, organizations, businesses, trusts as well as a natural person. He opined that there are philosophical and moral problems when a government creates entities and gives them the same authority of the entities that created [government].

[4:23:36 PM](#)

GREG POLSTON, Physician, Advanced Medical Centers of Alaska, stated support for HB 287. He opined that by removing the CON, access to health care will increase in Alaska for Alaskans and costs will decrease. He informed the committee that currently he sits on the state Medicaid committee, on both the drug utilization review committee as well as the pharmacy and therapeutics committee. In working with those two committees, Dr. Polston said that he has reviewed the cost and attempted to maximize care. With regard to the testimony that niche physicians are trying to push this legislation through, he strongly disagreed. In fact, in the 21 states that have eliminated the CON, health care costs haven't been impacted and competition has allowed competition such that hospitals aren't in monopoly situations. He informed the committee that he has a report from the commissioner of DHSS that discusses a number of projects [that would be considered] if the CON was removed from the state. In reviewing the list, Dr. Polston said he became very excited with regard to the various new facilities [and services] that would be provided in the state. He related that it appears that over 200 beds could be provided, a cardiac hospital, and a substance abuse hospital. Furthermore, the economics of building these centers, in terms of jobs provided, would also make the state a stronger place in which to work and live.

[4:26:56 PM](#)

DR. POLSTON, in response to Vice Chair Seaton, specified that Advanced Medical Centers has facilities located in Anchorage, Fairbanks, and the Mat-Su Valley. He noted that he has also done work in the Kodiak hospital in the past.

[4:27:21 PM](#)

REPRESENTATIVE GARDNER asked if Dr. Polston has any documentation to support his statement that in the 21 states that have eliminated the CON, health care costs haven't been impacted.

DR. POLSTON related that the committee packet should contain a report from the Washington Policy Center, which was prepared by Mr. Barnes who should be on-line to testify. Additionally, he said that he has a report that was prepared by the Florida State University Law Review "stating some of those questions that you have."

[4:28:24 PM](#)

GLENDIA SMITH, speaking as a patient advocate and mother of a special needs child, began by relating that over the years attempts to lower the cost of health care have resulted in cuts to the much-needed services for those with disabilities. Furthermore, she said that she has seen much documentation relating that the CON hasn't been successful in containing health care costs and thus she questioned why the CON would continue to exist. She highlighted that Alaskans don't have access in this state to the specialists that are needed, which costs the state a lot of money to send patients out of state for treatment. Ms. Smith opined that [HB 287] is a way to improve the rising costs of health care in the state and help many in the process rather than filling the pockets of a few. She concluded by noting her appreciation in regard to what the committee can do to move HB 287 forward.

[4:31:59 PM](#)

JIM TAMAI, Orthopedic Surgeon, Advanced Medical Centers of Alaska, informed the committee that during his 14 years as a practicing physician in Fairbanks he has had the opportunity to become familiar with the health care structure in the Interior. One of the weaknesses in the Interior, he opined, is that there is only one specific health care facility that offers a broad range of services, including inpatient and outpatient care as well as surgical services. The aforementioned is Fairbanks Memorial Hospital, which is a strong hospital. However, the community could benefit by opening up opportunities for alternative access to health care, in particular in the form of outpatient ambulatory surgical center services. Having more than one facility, he highlighted, [is of importance] since the terrorist attacks of September 11, 2001. Dr. Tamai then related

his firm belief in a free market economy and his support in HB 287. He then indicated the need for there to be alternative facilities.

[4:35:26 PM](#)

VICE CHAIR SEATON asked if Dr. Tamai had any information with regard to the population level necessary to support a general hospital that provides 24 hour service, outpatient surgery, and imaging services.

DR. TAMAI replied no, but related his belief that it would depend upon the size of the hospital and the number of full-time employees. In further response to Vice Chair Seaton, Dr. Tamai related his belief that if Fairbanks' population was one-quarter the size of its current population, it could possibly support a hospital, imaging center, and an ambulatory surgical center. He explained that he believes it would be possible because Fairbanks, even a smaller Fairbanks, would be the closest regional hospital in the Interior area outside the Fairbanks North Star Borough.

[4:37:31 PM](#)

REPRESENTATIVE GATTO posed a situation in which there is no facility, and inquired as to whether it would be in the community's best interest to not have the CON or to protect one good facility.

DR. TAMAI maintained his belief that the community would still be served best with competition and choices for patients.

[4:39:35 PM](#)

REPRESENTATIVE GATTO pointed out that the government does provide for monopolies, such as an electric company. However, the government regulates the company. Representative Gatto opined that the CON was similar, in that the regulation for the single service was the CON. Therefore, he inquired as to whether monopolies can work so long as they are regulated by government.

DR. TAMAI maintained that competition makes everyone work harder, better, and more efficient. He expressed concern that complacency may breed where monopolies exist.

[4:42:01 PM](#)

THOMAS PIPER, Principal, MacQuest Consulting, informed the committee that he has been the director of the CON in Missouri for over 21 years and is currently working with the Department of Health in Seattle, Washington. He noted his opposition to HB 287. He then directed the committee's attention to the PowerPoint entitled, "National CON Perspective and Experience Impact Report of Deregulation", which is included in the committee packet. He then referred to the slide entitled, "The CON Matrix of 2005 Relative Scope and Review Thresholds: CON Regulated Services by State" and pointed out that although Alaska has one of the broadest programs, it ranks near the top. However, were HB 287 to pass, Alaska's rank would fall with only long-term care.

MR. PIPER then turned to the situation in Ohio, which is a state for which there is the best information with regard to what happened immediately after deregulation of CON. He informed the committee that the Ohio General Assembly started the three-year repeal of the CON in 1995 after having a CON for 20 years for most services. All facilities, services, beds, capital, and equipment save long-term care were taken out of review. Over the three-year phase out, 17 services, in total, were taken out of the CON process. He pointed out that Ohio is one of the few states that doesn't have hospital licensure, but rather the services are all handled under joint commission surveys and national reviews, except the psychiatric and obstetrical services. He pointed out that there are free-standing services in Ohio, most of which are licensed and have quality review. However, licensure nor quality review were barriers to market entry to establish new services or the expansion of such services.

MR. PIPER then drew the committee's attention to "Ohio Hospitals Closed since Deregulation", which relates that before 1997 there were 214 licensed hospitals. However, after deregulation, the number of hospitals dropped to 206 with a commensurate loss, almost 7,000, in the number of beds. The next slide, "Detail of Hospitals Opened since Deregulation" relates that 19 new hospitals were established for a total of 829 beds. Overall, there was a decline as evidenced in the slide entitled "Hospital Bed Decline since Deregulation." Still, cardiac catheterization increased since deregulation, although per state law it can only be performed in a hospital setting. An increase in [facilities offering] open heart surgery also occurred after deregulation. With regard to imaging services, in 1995 there were 23 mobile or free-standing MRIs, which increased to 126 new MRI units in 1999

while 65 more intended to come on-line. In 1995 there were 35 hospitals with in-house MRIs and after 1999 almost all hospitals had a MRI. Mr. Piper then highlighted the increase in radiation therapy facilities since deregulation as was the case with ambulatory surgery facilities and outpatient dialysis centers.

[4:50:51 PM](#)

MR. PIPER identified the main characteristics of deregulation in Ohio as follows: a significant loss of inner city hospitals; a substantial increase in ambulatory surgery facilities and other freestanding facilities; and more competitive hospitals. He then pointed out that the elimination of the CON is in sharp contrast to those areas where work is going forward to improve the CON, such as in Washington, Maine, and North Carolina. Turning attention to the slide entitled, "Balance Regulation and Competition: Protect Community Interests", he informed the committee that over 50 percent of the money going into health care comes from public sources such as Medicare, Medicaid, and other third-party sources. He opined that it might be a much better situation if pricing and quality information were available for patients. However, the price of individual health care services isn't available. Furthermore, often the patient isn't the person purchasing the services because the physician is making the decisions and the employer/government is actually purchasing the health insurance for the employee if the individual is even covered. Therefore, it's necessary to have better community-oriented health services and facility plans, pricing and quality information to consumers, and maintenance of a public forum for a broad range of services. The goal isn't to reduce the scope of services to long-term health care only, he stated. Mr. Piper concluded by relating that there is good reason to maintain the current system in Alaska, which he characterized as a system that really works.

[4:54:35 PM](#)

VICE CHAIR SEATON highlighted that the slides illustrate a decrease in the number of hospital beds, but a general increase in the number of hospitals that provide various treatments. He asked if Mr. Piper has any information with regard to the cost of procedures when the CON was in place and after it was eliminated.

MR. PIPER answered that recent reports from Ohio relate that costs have escalated steeply, although there has been no reporting of the real costs. In fact, it has been almost

impossible to determine the impact of the elimination of the CON versus other changes.

[4:55:47 PM](#)

VICE CHAIR SEATON requested that Mr. Piper provide the committee with any information he receives in relation to the costs associated with the elimination of the CON.

[4:56:14 PM](#)

REPRESENTATIVE ANDERSON inquired as to who is paying Mr. Piper to testify today.

MR. PIPER answered that he has testified voluntarily, although he noted that last year he was under contract with DHSS to help improve the CON program.

[4:57:05 PM](#)

REPRESENTATIVE ANDERSON asked, "Do you find that this balance, this swaying of public policy occurs in all the states where the CON arises in legislation?"

MR. PIPER replied that it does in the vast majority of states because the value of the CON has been repeatedly questioned. He emphasized the difficulty with health care, which is expensive and doesn't play by the same rules as other services and goods since it isn't a commodity. Furthermore, Alaska is unique in many ways with several large population centers and areas in which a hospital is barely [remaining open]. At the same time, CONs or similar programs don't stop competition, he said. Moreover, Alaska's new regulations are based on excellence in performance so that if a new applicant/entrant to the market can meet the performance expectations, that applicant/entrant will be approved. He said that Alaska's system is based on very competitive values, and therefore he opined that Alaska has taken steps to make Alaska's CON more responsive although he acknowledged that it's not perfect.

[5:00:18 PM](#)

VICE CHAIR SEATON inquired as to whether Mr. Piper had any data with regard to the size of population under which the CON wouldn't fulfill its purpose and the system would more easily lend itself to a more competitive model.

MR. PIPER responded that he knows of no such model. He related that in practice he has seen that the larger the population, the greater the need for an oversight into the market in order to ensure quality entrants and achievement among the participants. In the health care industry it's well known that the more that's done, the better the quality and thus there need to be minimum utilization standards for excellence and to hold down the mortality figures.

5:02:08 PM

REPRESENTATIVE CISSNA returned to the Ohio example, and inquired as to how many, if any, medical school hospitals or county hospitals there were and the outcome of those [after the elimination of the CON]. She then inquired as to whether there is any transparency in Ohio with regard to the costs of health care, before and after the elimination of the CON.

MR. PIPER, in response to the first question, said that he would contact folks in Ohio for that information. With regard to transparency, he related his belief that there are new efforts to improve the situation in Ohio with regard to the transparency of costs. He indicated that the Ohio Office for Health Policy appears to have published some data on the hospitals.

5:04:05 PM

REPRESENTATIVE GARDNER, referring to the number of hospitals that have closed in Ohio since deregulation, asked if it's possible that the CON was an artificial support for hospitals that weren't needed, and therefore the decrease in hospitals was the result was a natural consequence of removing the artificial environment.

MR. PIPER opined that the CON has been referred to as an enfranchiser of services that are currently in existence, which he said he believed to be the case in Ohio. However, one must keep in mind that the CON doesn't protect those hospitals because the hospitals have to "pass muster" to ensure that they had a certificate to provide those services. Mr. Piper related that he was told that some of the hospitals were on the verge of closure [before the elimination of the CON], and therefore the closures were probably a combination of factors. Health care is not cleanly dissected with regard to regulation and fee changes and thus overlaps are difficult to differentiate.

5:06:05 PM

REPRESENTATIVE GARDNER surmised from the slides of the Ohio situation that more facilities opened up with the elimination of the CON. However, the data presented doesn't speak to the reason for competition, which is its impact on quality and price of services.

[5:07:19 PM](#)

FRED BROWN, Chairman, ASEA/AFSCME Local 52, Health Benefits Trust; Secretary, Alaska Health Care Cost Management Corporation ("The Coalition"); Secretary, Fairbanks Central Labor Council, provided testimony on HB 287, paraphrasing from the following prepared statement [original punctuation provided]:

I am making this statement on behalf of the Fairbanks Central Labor Council, which has taken the position that the current state law requiring a Certificate of Need from the Alaska Department of Health and Social Services, before expending more than \$1,000,000 towards improving or building a health care facility, is counter-productive to providing cost effective health care for Alaskans. It is also inconsistent with the cherished American principles of competition and free enterprise.

The Fairbanks Labor Council is affiliated with eighteen unions representing approximately 5,500 union members in Interior Alaska. These union members work in the public and the private sectors, in construction and in the service industries, and on large government contracts as well as for small business owners. Many of these members are married and have families. All have an interest in maintaining access to affordable health care.

Alaska's Union Health plans have struggled to continue providing valuable health benefits despite the increasing cost of health care. In communities with only one health care provider, the lack of competition has kept health care costs significantly higher than in communities where competition exists. The State has encouraged monopolistic activities by sole source health care facilities, by creating significant barriers to entry to competitive facilities.

In sum, the Fairbanks Central Council believes the current law regulating Certificates of Need does not well serve the needs of our union members and their families, nor does it serve the needs of many other Alaskans who seek affordable health care. It is time to change that law.

[5:10:52 PM](#)

MR. BROWN, in response to Vice Chair Seaton, related his experience that generally the cost of hospitalization and hospital treatment in Anchorage is substantially less expensive than in Fairbanks. He offered to provide specific data with regard to specific procedures.

[5:12:18 PM](#)

REPRESENTATIVE GARDNER asked if Mr. Brown's references to the cost of the CON program referred to administering the program.

MR. BROWN clarified that he meant that when there is competition, the Health Benefits Trust is able to contract for much less expensive coverage because of the ability to commit the volume of patients that allows a volume discount. However, that opportunity doesn't exist in Fairbanks and thus the [Health Benefits Trust] supports competition as occurs in Anchorage.

[5:13:08 PM](#)

ALAN GROSS, Orthopedic Surgeon, Juneau Orthopedics, stated support for HB 287 and relayed that the vast majority of the local medical providers support eliminating the CON. He characterized the CON as outdated and said that it's a protector of large hospitals and doesn't protect or enhance the quality of care. Frequently, physicians in Juneau lose patients to Seattle for quality of care and cost reasons. Dr. Gross informed the committee that he and other physicians attempted to create a single-room procedure center for patients with minor procedures. The aforementioned would be cheaper than the hospital and would be convenient for patients and physicians alike. However, the existing CON law caused the facility to be denied, specifically because the net present value of the lease was included in the \$1 million cap. With the current definition and interpretation, it's difficult to build much more than an "out house." Dr. Gross then informed the committee that there is a plastic surgeon in town who can't compete with the facilities in Seattle because of the hospital's refusal to create a package deal,

which is done for aesthetics in hospitals in the Lower 48. With regard to providing care to the indigent, Dr. Gross opined that it doesn't make a difference whether the care is provided at the surgical center or the hospital, it will be provided. He related that time and again, he has come across quality issues at Bartlett Regional Hospital that he believes could be solved if there were a small procedure center for orthopedics and other certain fields. One of our desires for a facility of this type was to provide quality, which the CON stymies. Therefore, he strongly urged the committee to pass HB 287.

[5:18:01 PM](#)

REPRESENTATIVE COGHILL asked whether a small surgical center would be considered a niche provider. He further inquired as to how a surgical center in Juneau would work with the local hospital.

DR. GROSS said that even with a [surgical center], at least half of his practice would be done through the hospital in its operating room. He related that he would see a surgical center as for minor outpatient procedures. He recalled a medical staff meeting last year when the issue of economic credentialing arose. Economic credentialing is a situation in which a hospital can sanction a physician for being in competition with a hospital. The medical staff resoundingly passed a resolution against supporting the aforementioned while a member of the hospital board argued that competition would be good for the hospital to keep it honest and provide quality care, although it would hurt Bartlett Regional Hospital economically at first.

[5:20:26 PM](#)

DR. GROSS, in response to Vice Chair Seaton, said that he absolutely believes the competitive model works in a community with a base population of 30,000. He noted that the catchment in Juneau would be closer to 50,000. In further response to Vice Chair Seaton, he related his belief that no one would attempt to form a surgical center in a town such as Petersburg where surgery is only performed once every two months. Therefore, he said he supports the capitalistic approach in which the market [determines what it can bear].

[5:21:22 PM](#)

SAM KORSMO, Chief Operating Officer, Alaska Open Imaging Center (AOIC), paraphrased from the following written statement [original punctuation provided]:

Thank you for allowing me to speak to this committee. My name is Samuel J. Korsmo. I am the Chief Operating Officer of Alaska Open Imaging Center with locations in Wasilla, Anchorage, Soldotna and Fairbanks. Today we have 4 Doctors, 54 employees in 4 imaging centers.

As a physicians group in the radiology profession, our business has prospered on the core value of SERVICE. We bring referring physicians alternatives in the outpatient imaging needs that place care and compassion to their patients. We have introduced new technologies that are saving Alaskan lives such as open imaging, web-based imaging services and positron emission tomography (PET). Responding to our leadership, other providers also finally made these services available.

We have been in operation in Anchorage, Wasilla and Kenai for the past few years and in all these areas, the local hospitals have embarked on major expansion projects, showing that we were not a detriment to their operations. Our success shows that doctors and their patients appreciate having the choice to access our quality service and our commitment to costs reduction.

We recently opened a facility in Fairbanks and have achieved the same level of support and appreciation from the community. Unfortunately, after two rulings by Commissioner Jackson that Alaska Open Imaging Center is a physicians' group not covered by Alaska's CON laws, Banner Health Corporation through Fairbanks Memorial Hospital has filed a lawsuit against the department and AOIC seeking to shut down our operation and to restrict Fairbanks consumer access to quality, affordable health care services.

This is just another example of how Alaska's CON laws are being abused to the detriment of Alaskans and why it should be done away with. We do not use public money to build our facilities and when state funds are spent on Medicaid Services at AOIC the charges are

substantially less than hospital charges for the same procedure.

MR. KORSMO added that AOIC doesn't self-refer and thus it totally competes with other entities. "We have no way of self-referral," he stated. He continued to paraphrase from the following written testimony [original punctuation provided]:

The hospitals say they need monopoly pricing because they take low income patients thru no pay/low pay charity and such. I am here to tell you we provide more than our fair share at 18% of gross revenues in 2005 and preceding in 2004 at 15%. I believe that this may be even higher than those services provided by hospitals.

Thank you and I will be glad to answer any questions.

[5:24:53 PM](#)

REPRESENTATIVE COGHILL asked if there is a level of pay that AOIC receives that may be better or worse than that of hospitals.

MR. KORSMO informed the committee that AOIC will service any patient [from] any referring physician, even after hours and on weekends. With regard to the pay difference, Mr. Korsmo said that there is a structure that's completely different from what AOIC receives in reimbursements from Medicaid and Medicare. He explained that hospitals receive facility charges, which are a contracted amount to the state that's received in addition to the flat fee that's set by the department or the Centers of Medicaid and Medicare Services (CMS). The hospitals would receive four charges in addition to the flat charge whereas for an ambulatory or surgical center only the flat fee applies.

[5:26:39 PM](#)

REPRESENTATIVE COGHILL surmised then that AOIC wouldn't have physicians or technicians that work with AOIC and a local hospital at the same time.

MR. KORSMO said that actually that has occurred. He pointed out that AOIC's physicians are credentialed in two other hospitals in the state.

[5:27:28 PM](#)

MR. KORSMO, in response to Vice Chair Seaton, said that AOIC has no desire to enter small communities because it makes more sense for those people to travel for the services. Mr. Korsmo said that he, too, believes in the capitalistic, competitive markets, but he indicated that dismantling the CON will be a process that may include protecting the small communities.

[5:28:50 PM](#)

JEREMY HAYES, Representative, Advanced Medical Centers of Alaska, stated support for HB 287 and paraphrased from the following written statement [original punctuation provided]:

In 1982, less than 8 years after the Federal CON mandate, the Federal Government acknowledged the failure of its Certificate of Need laws to reduce health care costs and repealed the mandate altogether. Almost 25 years later and with a health care environment completely different than that of the original CON era, Alaska's Certificate of Need remains and is as ineffective as it was more than 2 decades ago. But rather than repeal or scale back our CON regulations like many states, Alaska has made them even more stringent. In 2006, Alaska is the 2nd most regulated health care state in the country and has costs that are 40% higher than the national average.

We support repealing our CON laws as Alaska continues to see some of the most expensive health care in the country continue to rise. The rising cost of medical care in Alaska is hurting our families, raising workers compensation costs, putting health care insurance out of economic range for individuals and companies, and raising Medicaid costs in our state.

While the Certificate of Need process was initially implemented with the intent to control health care costs and prevent duplication of services, it has failed in that regard while instead driving prices up, restricting consumer's medical choices, and protecting hospitals from potential competitors who could accomplish the very goal the CON program strives for ... lower health care costs.

Alaska's CON program no longer serves the public's interest, if indeed it ever did. The stated purpose

of the program is to foster a health care system that controls costs and meets changing conditions. Yet to succeed such a system requires the very flexibility the CON is designed to prevent. In a state experiencing growth and demographic change, the CON law prevents providers from adapting to the changing needs of the community effectively.

This Bill, if passed, would have a tremendous economic effect on the residents of Alaska in the form of huge health care savings. We feel its time that Alaskan's are given an answer to their quest for affordable health care?

Cost

Since the 1980's when states were released of their obligation from the federal government to maintain CON laws, numerous studies have examined the change in health care costs as states eliminated those laws. *If Certificate of Need laws were "working" as advertised, then one would expect to see a rise in costs in states where CON laws were eliminated. But in fact this is not the case. One of the most widely referenced studies was written by Duke University professors Christopher Conover & Frank Sloan and was published in the *Journal of Health Politics, Policy, and Law*. They found that output restrictions which resulted from CON laws led to higher not lower costs, and higher profits for the hospitals. The authors point out that CON laws resulted in higher costs per day and per admission in states with CON regulations, along with higher hospital profits. So, in states where CON laws remain, patients are charged more money, more often than in states that repealed the law. Simply put, the result of repealing CON regulations is lower health care costs for the people of that state.

Studies throughout the US have arrived at similar conclusions: the data indicates that a program designed to reduce costs, improve quality, and promote access has not achieved any of these goals. *In addition, the 14 states with no CON laws (which are home to more than 1/3 of Americans), show no higher rate of health care costs or spending due to lack of such laws.

In states with less restrictive Certificate of Need programs, hospitals are increasingly facing competition from ambulatory surgery centers which offer minor surgical procedures that do not require an overnight stay. These facilities offer the same surgery as a hospital but at a significantly lower price. It is one of the ways the market is adjusting to make health care delivery more efficient and cost effective. Established hospitals in heavily regulated CON states like Alaska however, use the CON law to prevent such facilities from opening in their city, thus blocking access to health care choice and lower costs to the consumer.

The Certificate of Need program's chief goal is to reduce health care costs, something it has not been successful in accomplishing. There has been no evidence that CON regulation lowers the cost of health care in Alaska; a fact which alone should be sufficient reason to repeal a law specifically designed with that aim in mind.

Competition

There is possibly no proposition in economics that is more accepted than the idea that if you want to reduce the cost of something, you foster an environment that encourages open competition and entrepreneurship while discouraging monopolistic practices. It is as faulty to think that limiting the supply of health care facilities can reduce health care costs as it would be to think that oil prices could be lowered by producing less oil.

Competition brings lower prices, more convenience, better quality, and new technology and innovations. Hospitals with CON protection have a franchise monopoly which provides no incentive for it to exercise cost control or better services. The owners of these existing facilities can charge inflated prices for their services which continues to raise costs by restricting the entry of cost-effective providers into the market.

Facility duplication is at the heart of competition. Indeed, the very definition of a monopoly market is one where there is no duplication. And this is why consumers in monopoly markets lose; they are denied

the option of turning to others who are providing "duplicated" services when monopoly providers act like monopolists.

Market forces generally allocate society's resources far better than government planning. Everyday experience shows that when the market is free to operate under minimal government control, the result is abundant, quality service at a low price.

Conclusion

In reality, the continuation of CON regulations cannot be justified either theoretically or empirically. In fact, from the perspective of sound economics, the reverse is true. If one desired to devise a policy for any market whose purpose would be to reduce efficiency, raise costs and prices, and reduce quality, Alaska's existing CON program would be highly recommended.

In researching countless journals and published articles, one is hard pressed to find even one article that asserts that CON laws succeed in lowering health care costs. One thing CON studies have done is elicited a remarkable evaluative consensus ... that they don't work.

Over the last 2 decades, the Federal Trade Commission has done several studies on the impact of CON laws both nationally and for specific states. The FTC's consistent conclusion can be summarized in its most recent study released jointly with the Department of Justice in July 2004. The agencies believe that CON programs can pose serious competitive concerns. They found that where CON programs are intended to control health care costs, there is considerable evidence that they actually drive prices up by fostering anti-competitive barriers to entry. Their report goes on to say that evidence does not support the view that CON regulations reduce the costs of providing health care services and urges states to consider whether such programs best serve their citizens health care needs.

There's a reason Congress repealed state CON requirements just a few years after mandating them.

There's a reason 14 states which make up over 1/3 of our countries population have completely repealed their CON laws.

And there's a reason why 6 additional states have repealed every part of their CON regulations save for long-term care facilities...

They don't work at controlling health care costs! If they did we wouldn't have some of the costliest health care in the nation.

[5:37:24 PM](#)

MR. HAYES, regarding Mr. Lynch's concerns about self-referrals, said that worse than a facility that does self-referrals is a facility that has a monopoly. A facility with a monopoly doesn't have to self-refer because it already receives the business/referral. With regard to Mr. Gould's testimony that costs would rise with the elimination of the CON, per a sampling he did of various facilities, such a tactic could be used by the supporters of this bill in the same way and does not really serve to prove anything, Mr. Hayes said. In fact, DHSS's fiscal note relates that the cost of surgical centers is lower than the cost of hospitals. With regard to Mr. Stephens' notion that elimination of the CON would only work in states with large populations, he pointed out that the states of Idaho, Kansas, New Mexico, North Dakota, South Dakota, Utah, Wyoming, and others have been successful at repealing CON laws. With regard to charity care, Mr. Hayes agreed with earlier testimony that it's provided by many providers in each service area. The difference is that besides hospitals, those facilities that provide charity care aren't subsidized "to the tune of \$25 million a year by the government." Moreover, if surgery centers were paid for charity care and received additional federal funding from Medicare, they could afford to operate the same hours as hospitals.

[5:40:33 PM](#)

MR. HAYES, in response to Representative Coghill, agreed to provide the study by Duke University to the committee. In further response to Representative Coghill, Mr. Hayes said that he doesn't work with a hospital. He then turned to Representative Gardner's comment regarding some physicians being denied access to hospital privileges because they attempted to open their own surgical facilities, but were denied. He said

that in Fairbanks Dr. Nancy Cross has been denied privileges in such a situation.

[5:42:21 PM](#)

VICE CHAIR SEATON suggested that he would appreciate Dr. Cross addressing that herself.

[HB 287 was held over.]

[5:42:42 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at [5:43:37 PM](#).