ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
April 20, 2006
3:06 p.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Carl Gatto
Representative Vic Kohring
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Paul Seaton, Vice Chair
Representative Tom Anderson

OTHER LEGISLATORS PRESENT

Representative Max Gruenberg, Jr.

COMMITTEE CALENDAR

HOUSE JOINT RESOLUTION NO. 36
Urging the United States Congress to support the granting of official Observer Status to the Republic of China at the World Health Assembly Annual Conference to be held at Geneva, Switzerland, in May 2006.

- MOVED CSHJR 36(HES) OUT OF COMMITTEE

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 JOINT RESOLUTION NO. 30
Relating to public health and a prevention compact.

- SCHEDULED BUT NOT HEARD

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."

- SCHEDULED BUT NOT HEARD

PREVIOUS COMMITTEE ACTION

BILL: HJR 36
SHORT TITLE: TAIWAN: WORLD HEALTH ASSEMBLY
SPONSOR(s): HEALTH, EDUCATION & SOCIAL SERVICES

04/10/06	(H)	READ THE FIRST TIME - REFERRALS
04/10/06	(H)	HES
04/20/06	(H)	HES AT 3:00 PM CAPITOL 106

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
03/28/06	(H)	Heard & Held
03/28/06	(H)	MINUTE(HES)
04/13/06	(H)	HES AT 3:00 PM CAPITOL 106
04/13/06	(H)	-- Meeting Canceled --
04/20/06	(H)	HES AT 3:00 PM CAPITOL 106

WITNESS REGISTER

AARON DANIELSON, Intern
to Representative Peggy Wilson
Alaska State Legislature
POSITION STATEMENT: Presented HJR 36 on behalf of the House Health, Education and Social Services Standing Committee, which Representative Wilson chairs.

REPRESENTATIVE BOB LYNN
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Spoke as the prime sponsor of HB 287.

BOB URATA, MD, President,
Board of Directors

Bartlett Regional Hospital
Juneau, Alaska
POSITION STATEMENT: Testified in opposition to HB 287.

RICHARD COBDEN, Orthopedic Surgeon
Fairbanks, Alaska
POSITION STATEMENT: Testified in support of HB 287.

BRIAN SLOCUM, Administrator
Tanana Clinic
Fairbanks, Alaska
POSITION STATEMENT: During hearing of HB 287, expressed the need to focus on taking care of sick people, spending the community's health care dollars for the critical needs, and trying to move from the business of maximizing hospital profits at the expense of the rest of the health care system.

MIKE POWERS
Fairbanks Memorial Hospital
Fairbanks, Alaska
POSITION STATEMENT: Testified on HB 287.

DAVID GILBREATH, CEO
Central Peninsula General Hospital
Soldotna, Alaska
POSITION STATEMENT: Testified in opposition to HB 287.

DENNIS MURRAY, Chair
Alaska State Hospital and Nursing Home Association Legislative Committee
Juneau, Alaska
POSITION STATEMENT: Expressed concerns with HB 287.

JEREMY HAYES, Representative
Advanced Medical Centers of Alaska
Fairbanks, Alaska
POSITION STATEMENT: Testified in support of HB 287.

CHARLIE FRANZ, CEO
South Peninsula Hospital
Homer, Alaska
POSITION STATEMENT: During hearing of HB 287, expressed the need to maintain the current CON law.

JOHN BRINGHURST, CEO
Petersburg Medical Center
Petersburg, Alaska

POSITION STATEMENT: Testified in opposition to HB 287.

ELIZABETH RIPLEY, Director
Marketing and Public Relations
Mat-Su Regional Medical Center
Palmer, Alaska
POSITION STATEMENT: Testified in opposition to HB 287.

PAUL FUHS, Lobbyist
Alaskans for Medical Choice and Competition
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 287.

LAURIE HERMAN, Regional Director
Government Affairs
Providence Health & Services - Alaska
Anchorage, Alaska
POSITION STATEMENT: Testified in opposition to HB 287.

ROD BETIT, President
Alaska State Hospital and Nursing Home Association
Juneau, Alaska
POSITION STATEMENT: Testified on HB 287.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 3:06:57 PM. Representatives Gatto, Cissna, Gardner, and Wilson were present at the call to order. Representative Kohring arrived as the meeting was in progress.

HJR 36-TAIWAN: WORLD HEALTH ASSEMBLY

3:07:37 PM

CHAIR WILSON announced that the first order of business would be HOUSE JOINT RESOLUTION NO. 36, Urging the United States Congress to support the granting of official Observer Status to the Republic of China at the World Health Assembly Annual Conference to be held at Geneva, Switzerland, in May 2006.

3:07:55 PM

AARON DANIELSON, Intern to Representative Peggy Wilson, Alaska State Legislature, presented HJR 36 on behalf of the House Health, Education and Social Services Standing Committee. He

paraphrased from the following statement [original punctuation provided]:

- Taiwan does not have direct access to the information that is disseminated in the World Heath Assembly [WHA] meetings. The World Health Assembly is the top body of the World Health Organization [WHO].

- Taiwan can be introduced as an Official Observer status, something that there is precedent for. The Red Cross, Palestine Liberation Organization, Red Crescent and the Order of Malta are several of the organizations that have been recognized as a "health entity" and given Official Observer status.

- This process of being given Official Observer Status also side-steps the thorny sovereignty. This process does not recognize Taiwan as separate entity from China.

- China has opposed Taiwan's attempts to enter the WHO as a member and as an official observer. They have allowed Taiwan to attend WHO meetings on Avian Influenza in Japan and other cities, but has denied Taiwan's entering a similar conference in Beijing China.

- The Alaska House passed a similar resolution in 2003 as [House Joint Resolution] 28, urging the U.S. to endorse Taiwan's request to be granted observer status.

- The U.S. Congress has also passed similar resolution to support the efforts of Taiwan to gain Official Observer Status into the WHA.

- The WHA Director can extend Official Observer status to Taiwan itself, without a vote.

- On June 2004, Pres. Bush signed into law S2092, that supports Taiwan's bid to enter the WHA. Every April 1st, the State Dept. is to submit a report to Congress on their efforts to gain Taiwan access to the WHA. House passed a similar one on April 21st. Both passed unanimously.

3:11:24 PM

REPRESENTATIVE GARDNER asked whether the Peoples Republic of China opposes this action.

MR. DANIELSON responded that Taiwan originally requested a full membership, in 1997. However, China vigorously opposed full membership, which it views as a threat to the sovereignty policy of "one China." China has maintained opposition to Taiwan entering even under observer status, although it has allowed Taiwan to attend two separate WHA meetings regarding the avian influenza.

3:12:43 PM

REPRESENTATIVE GARDNER moved Amendment 1, which read:

> Page 2, line 8;
>
> Delete "Condoleeza"
> Insert "Condoleezza"

There being no objection, Amendment 1 was adopted.

3:13:45 PM

REPRESENTATIVE CISSNA moved to report HJR 36, as amended, out of committee with individual recommendations and the accompanying zero fiscal note. There being no objection, CSHJR 36(HES) was reported from the House Health, Education and Social Services Standing Committee.

HB 287-MEDICAL FACILITY CERTIFICATE OF NEED

3:14:22 PM

CHAIR WILSON announced that the final 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."

3:15:01 PM

REPRESENTATIVE BOB LYNN, Alaska State Legislature, speaking as the prime sponsor of CSHB 287, paraphrased from the following statement [original punctuation provided]:

> During the last hearing, opponents testified at length against the bill to almost the entire HESS committee.

However, due to other legitimate commitments, when it came time for people to speak before the committee in favor of the bill, there was only one committee member present! Therefore, for all practical purposes, this will be really the first time the committee will have an opportunity to hear both sides of the issue – so I want to thank you for hearing the bill today.

I know that some of you have concerns that need to be addressed, and that's what the committee process is for. So let me try to put myself in your shoes, if I can, and ask, "What possible reasons are there for not moving this bill out of this committee and along through the Judiciary and Finance Committees?"

1. Let me ask. Would it harm patients to repeal the Certificate of Need law? No! Like you, I would never want to harm patients. Patients would not be harmed. In fact, patients would likely benefit from greater availability of facilities – and that usually means lower costs.

2. Let me ask. How can hospitals afford to care for the indigent at no cost, if they are unable to recoup those costs by charging extra at hospital profit centers? Well, first of all, anyone who makes that argument is admitting that some patients are being overcharged. It reminds me of the logic of the sign on a well-known bar in Anchorage that proclaims, "We cheat the other fellow and pass the savings on to you!" Secondly, as at least one of you heard at the previous hearing, a lot of medical providers in all categories do – in fact – provide charity care for the indigent. Charity is a virtue. Overcharging the fortunate is – well – "overcharging," and you can call that what you will.

3. Let me ask. Have you considered the fact that, if the bill before us today doesn't pass, that it opens the door to an Initiative that has already been certified by the Lieutenant Governor? The difference between the bill and the Initiative is that the bill applies only to communities of 25,000 or more, and the Initiative affects every place in Alaska, regardless of population. As a co-sponsor of that Initiative, I can tell you that we wanted the Initiative to apply only to places with a population of 25,000 or more

like the bill before you today – but that was not, I'm sorry to say permitted by law, as interpreted by the administration. The bottom line is, the bill before you today may address some of your concerns better than the Initiative. If the bill passes, the initiative will be dropped.

4. Let me ask. What about the big dollar fiscal note attached by the administration? Well, as expected, health care monopolies, and others with vested interests, have responded the only way they can – by attaching humongous fiscal notes to both my bill and the initiative. To paraphrase Ronald Reagan, "There they go again!" I can also tell you, we have yet to obtain any verifiable – or even commonsense – data for the fiscal note. There are experts here today ready to testify on what is, and is not, a reasonable fiscal note – and you would be better served to hear from them rather than me.

5. Let me ask. Is it a good thing for large hospitals to have a monopoly provided by the state? There's a Principle involved here – and the Principle is not and should not be socialism or Marxism, the Principle is free enterprise. It's informative that someone who wrote an editorial in today's Daily News opposing my bill has written a book that's part of a series of "studies in Marxism!" Good Principles – and I believe free enterprise is a good Principle have, by definition, a wide application. We don't choose worthy Principles in a some kind of philosophical cafeteria line – "We'll take this Principle, but not that Principle." That said, the least we can do, if we decide to keep the current discriminatory system, is to call the Certificate of Need exactly what it is – a "Certificate of Monopoly."

In conclusion, Madame Chair and Members of the Committee, I urge you to consider carefully all sides of this debate. But please don't be afraid to challenge the status quo. I urge you to let the bill run the entire committee process to which it has been referred: the 7 legislators of your HESS committee, the 7 members of the Judiciary Committee, and the 11 members of the Finance Committee, so that at least 22 legislators will have enjoyed a fair opportunity to

evaluate, make any changes to the bill, and vote as they may.

I think HB 258 [287] is a good a timely bill, otherwise I would not have sponsored it - and it is, in fact my priority legislation for this session. Thank you.

3:20:05 PM

BOB URATA, MD, President, Board of Directors, Bartlett Regional Hospital, testified in opposition of HB 287, paraphrasing from the following written statement [original punctuation provided]:

I'm Bob Urata MD, a family physician, born and raised in Wrangell, Alaska and have lived in Juneau since 1984. I am here as President of the Board of Directors of Bartlett Regional Hospital to speak against HB 287 which would be detrimental to the public.

The certificate of need (CON) program in Alaska was started in 1976 to protect the public's interest in health care by controlling health care costs, promote quality of care and access to care. It has become one of the most comprehensive programs in the US covering up to 26 out of possible 30 services.

One of the most important aspects of the CON program is that it is an open public process. In order to assure order and fairness in health facility and health service planning, public input is a must. Everyone is affected, everyone should have a say in how things develop.

HB 287 targets communities in Alaska over 25,000 people which mean only 6 communities will be affected, one of them is Juneau. Our 57 bed hospital will be adversely affected financially with the removal of the CON process. With removal of the CON process, an ambulatory surgery center or a diagnostic imagining center would be built by an entrepreneur, "cherry picking" the highest paying patients seriously reducing revenue and crippling the operations of the hospital which needs to stay open 24 hours and 7 days a week. This would lead to shortages of critical staff which in turn lowers quality. Fees will need to

increase to cover loss of revenues. It is well known that in health care economics “supply drives demand”, that is the more supply, the higher the demand and thus spending. Competition in health care does not lead to lower fees or costs but increases it, because consumers do not shop for health care and they lack information to make the economic health care decisions. Providers control supply and can determine demand. Finally a third party like private insurance or Medicaid/Medicare pays the charges. Providers have no incentive to lower fees. So with higher capacity come higher health care costs. The CON process is needed to guide this because health care and services as a marketplace do not follow the usual rules of an ordinary economic commodity.

The CON process maintains or improves quality of care. An example is limiting cardiac surgery in communities so that there is no excess capacity. Cardiac surgeons need to do a certain number of cases to maintain proficiency. If there are too many cardiac surgery centers in a community, then quality gets worse.

Studies that support my position may be found in the American Health Planning Association web page at www.ahpanet.org. There studies by the 3 American car companies show that in states with CON, health care costs per person were 33% to 164% lower than those without. Ford Motor found that inpatient, outpatient, MRI [magnetic resonance imaging], and CABG [coronary artery bypass graph] charges were 10-39% cheaper in states with CON compared to those with none. Charges in Freestanding Ambulatory Surgery Centers in 1999 were about 20% lower in states with CON than those without CON.

Looking at quality, CABG Mortality was about 20% lower in CON states than in those states without CON in Medicare beneficiaries in 1994-1999.

It is my opinion the CON process should continue for all Alaskans because it protects the public’s interest by providing a public forum for important health care service and facility planning, maintains accessibility to health care services, maintains quality health care, and helps with cost containment.

3:27:19 PM

REPRESENTATIVE GATTO encouraged Dr. Urata [leaving to attend to a patient] to provide a means, probably via telephone, for questions during the meeting.

3:27:53 PM

RICHARD COBDEN, Orthopedic Surgeon, stated support for HB 287, adding that he has done quite a bit of research on the subject of the legislation. He related that he had quite a bit of experience with the CON when he worked in California. In fact, he was part of a task force that eventually lead the California legislature to drop the CON almost 25 years ago. In California, the costs averaged 10-50 percent higher when the CON was in place than when it was absent.

DR. COBDEN then turned to Fairbanks, which he characterized as a monopolistic system, with only one hospital and thus if a patient can't get into the Fairbanks hospital, he/she must travel to Anchorage. Also, in Fairbanks there is a group of physicians who are denied privileges at Fairbanks Memorial Hospital because it holds an exclusive contract for certain procedures to be supplied to the hospital by one physician. Furthermore, the cost of services at Fairbanks Memorial Hospital is very high. For example, the cost of a knee replacement device from the company and to the hospital was $3,000 while the hospital patient was charged $16,000. The patient protested, but was told that the aforementioned was the average markup for devices at Fairbanks Memorial Hospital.

DR. COBDEN related that his primary concern with having one hospital is that in the event of a large scale catastrophe/disaster, there is no alternative locally. To continue this monopoly at Fairbanks Memorial Hospital is leading to a possible catastrophe in itself. From the last hearing, Dr. Cobden recalled testimony likening health care to a national monopoly much like utilities of electricity, gas, and water that the testifier indicated should be preserved as such for efficiency. In response, Dr. Cobden emphasized that health care is an essential service and it doesn't make sense to have it so centralized without alternatives. For example, he questioned whether food should be required to be distributed by one grocery store. Dr. Cobden opined that the CON is obsolete and should be dropped.

3:33:47 PM

DR. COBDEN, in response to Representative Gardner, specified that currently he is a practicing orthopedic surgeon who works in the Advanced Medical Centers of Alaska.

3:34:28 PM

REPRESENTATIVE GATTO addressed Dr. Cobden's comment that a utility is a service and monopolies are established for the benefit of citizens. The aforementioned appears to work. However, if Bartlett Regional Hospital was subjected to intense competition and/or cherry picking and it were to close due to its inability to function, [the community/state] would be worse off than if the hospital was protected. He asked if that would be the case.

DR. COBDEN agreed that it would be a disaster to close Bartlett Regional Hospital. However, with regard to the suggestion that there would be cherry picking, he questioned whether such would really happen. He then reminded the committee that Medicaid and the state pays a premium of around 24 percent above and beyond the care guarantee of any other institution to the hospital in order to pay for the additional unpaid patients. Furthermore, the charity provided by hospitals is actually less than that provided by private practitioners and other groups. Moreover, the charge that cardiac surgery, a very lucrative procedure for hospitals, would be performed outside of a hospital at an inferior quality is a fallacious argument. No surgeon would perform cardiac surgery outside of a hospital setting. Dr. Cobden clarified, "Nobody is arguing about setting up a new hospital; what we're talking about is surgery centers, which can do outpatient, minor procedures at a low cost in direct competition with hospitals." The aforementioned, he opined, won't seriously impact the bottom line of existing hospitals, including Bartlett Regional Hospital. In fact, most studies have shown that the maximum that a hospital seeks to lose in the event of a competitive outpatient surgery center is 5 percent of the facility's bottom line.

3:39:00 PM

CHAIR WILSON inquired as to the hours of the surgery center [in the area].

DR. COBDEN answered that if a surgery center were built, it would be open on a 12 to 24-hour basis depending on demand. It would not be possible to establish a surgery center that

provided 24-hour care because that requires licensure through the state and the joint commission. When acute patients are kept more than 24 hours, different criteria must be met.

CHAIR WILSON surmised then that a surgery center wouldn't be open for patients to come at any hour. "There might not be as much pro bono work as at a hospital or there might be more for you guys that go to some clinic and give free care. However, there is a difference for the hospitals that have to take everyone that come into that emergency room whether they'll pay a penny or not," she pointed out.

DR. COBDEN acknowledged the difference.

3:40:28 PM

REPRESENTATIVE GATTO returned to the matter of cherry picking and highlighted the cherry picking that occurred when UPS and FedEx entered the postal services. Therefore, he suggested that he would be surprised if a company entered the market and didn't cherry pick.

MR. COBDEN opined that it would be unethical if it happened. With regard to FedEx offering postal services, Dr. Cobden reminded the committee that the postal service didn't have overnight mail. Furthermore, when the postal service faced competition, it increased its services and improved delivery.

3:42:03 PM

BRIAN SLOCUM, Administrator, Tanana Clinic, provided the following testimony:

> It seems to me that all this fighting over certificate of need issues ignores a basic business truth for all health care organizations in 2006, that is that no one ... gets paid enough by Medicare or Medicaid or patients who have no insurance to stay in business for very long. And no one can remain solvent by providing only the basic bread and butter health care services to patients. Frankly, both hospitals and doctors can only remain in business over the long haul by treating some patients who have private insurance that pay more than the federal government pays and pay more than the folks without insurance and by offering other services which pay a little bit better, such as laboratory and X-ray services. So, by doing everything that is

possible to maximize hospital profits you really risk marginalizing the non-hospital components of our entire health care system. That's especially true, I think, of physicians and clinics. And not only is it true of physicians and clinics, but is especially true of those physicians and clinics in Fairbanks.

Our situation here, with respect to doctors, is pretty grim these days. The number of physicians per 100,000 population in Fairbanks is about 179 per 100,000 population. That means that Fairbanks has about 20 percent fewer physicians per capita than Anchorage does and about 40 percent fewer positions per capita than the national average. When you look at how many patients a doctor sees, that translates to about 2,000 patients every week who have no access to care. That is going to get worse as time goes on. One of the things that happens when you have a lack of ... primary care physicians in a community is that the mortality and morbidity rates ... goes up. And that's proven by the state's health department's mortality figures. Frankly, in Fairbanks our mortality is 5 percent higher than the Alaska state average and it's 8 percent higher than the national average across the country. That means that every year about 148 people die needlessly in Fairbanks than would have to have died if we'd had sufficient physicians to have the same death rate as we have throughout the state. And even worse is that about 245 extra needless deaths take place in our community every year compared to what would've happened had we had the national average number of physicians. And as I said, it's going to get worse. More than half of the physicians in Fairbanks these days are over 50 years of age and recruiting new physicians to Fairbanks is becoming increasingly difficult. Part of the reason it's tough to get folks to Fairbanks is, of course, the reputation of Alaska in general and of Fairbanks as being remote and having some tough weather in the winter time. But an increasing part of the difficulty of getting doctors to come to town is that we simply can't compete as an economic place to come and set up practice. The reason that's happened is because much of the restrictions put on physicians by the certificate of need law and frankly, the ... somewhat hostile approach of our local hospital to new doctors and to new services being provided by doctors. It

makes it a difficult place to financially maintain a practice. As a result, we just don't get candidates into town any more. So, frankly, I think the situation in 5 or 10 years is going to be a real disaster.

We've been focusing so much on hospital profits that we forget that no one delivers health care, except doctors, and nurses, and technicians .... And frankly, I don't understand how the hospitals can keep saying that they make no money. I have had the opportunity to check the form 990, which is the tax returns for our local hospital. It demonstrates that in the period between 1997 and 2004, they made $119 million in profit. I don't know how much more profit an organization like that needs before they can feel safe and let up a little bit on the demand for increasing restrictions on physicians. At last report, at the end of 2004, which is the most recent report available, the local hospital here had $105 million in cash and negotiable securities in their bank account. They're engaged in a $175-$200 million billing campaign. And I'm all in favor of them doing that and I think the whole community is, but one has to ask if it's the best use of funding given the fact that we have too few physicians and too many people dying and we have 15,000 people in our community without any access to care due to lack of health insurance. So, I wish we could focus on the really important things here and that really important thing is taking care of sick people and spending our community's health care dollars where it's really critical and try to get away from this business of maximizing hospital profits at the expense of the rest of the health care system.

3:48:29 PM

MIKE POWERS, Fairbanks Memorial Hospital, informed the committee that the Medicare Payment Advisory Commission recently issued a new study demonstrating the importance of public policy when there are physician-owned entities. Referring to Dr. Cobden's comments, Mr. Powers informed the committee that Dr. Cobden has about half of his schedule open for the next month. The exclusive contract to which Dr. Cobden referred is probably in place for a pain procedure because there is a need for only one interventional pain specialist in the community. Furthermore,

the top procedures of Fairbanks Memorial Hospital are 50 percent less expensive than the surgery center in Anchorage. With regard to a disaster, Mr. Powers reminded the committee that there have been three mass casualties in the late 1980s and [Fairbanks Memorial Hospital] has never had an issue with regard to handling those casualties through surgery and partnership with the military community. Speaking to Dr. Cobden's comment that hospitals perform less charity care than private practitioners, Mr. Powers indicated that he must misunderstand and thus will have to talk with the [Fairbanks Memorial Hospital administration] about that. He related that Fairbanks Memorial Hospital [performs] roughly 8 percent in bad debt, 3 percent in charity, and extensive policies such that the hospital sees all patients.

MR. POWERS then turned to Mr. Slocum's comments regarding Fairbanks Memorial Hospital's approach to physicians, and highlighted that the hospital, over the last three years, has invested $250,000 [in recruiting staff]. Fairbanks Memorial Hospital has an internal medicine physician coming, has recruited an emergency medical technician (EMT), and has brought four physicians into the community.

3:52:19 PM

DAVID GILBREATH, CEO, Central Peninsula General Hospital, began by noting his agreement with Mr. Powers' testimony. He informed the committee that the Central Peninsula General Hospital is a 62-bed acute care hospital with about 450 employees. The hospital serves an area with a population of approximately 35,000. The Central Peninsula General Hospital has net revenues of about $50 million of which about $5 million goes to uncompensated care, charity, and bad debts. Mr. Gilbreath opined that HB 287 could have a huge negative impact on the Central Peninsula General Hospital as well as others in the state.

MR. GILBREATH related that he fully supports competition and free enterprise, but he highlighted that health care is a bit different. He opined that there has to be a level playing field, which this legislation doesn't create because it allows surgery centers, imaging centers, and other niche providers to enter a community with a hospital. The legislation would allow cherry picking and uninsured and underinsured patients wouldn't receive the care needed from the [niche providers] and thus would fall to the responsibility of the community hospital. As is the case in many hospitals, Central Peninsula General

Hospital loses money in the emergency room, obstetrics, and a residential treatment center. The services at the hospital are provided on a 24-hour basis every day and all patients are seen regardless of the ability to pay. If HB 287 were to pass, the margins the hospital requires to stay open could erode and make it difficult to remain open. Mr. Gilbreath opined that if the aforementioned niche providers enter the community, they will skim off the paying patients the hospital needs to keep its doors open. In conclusion, Mr. Gilbreath related his strong opposition to HB 287.

3:55:35 PM

CHAIR WILSON acknowledged the presence of a group of students observing the proceedings.

3:56:29 PM

DENNIS MURRAY, Chair, Alaska State Hospital and Nursing Home Association Legislative Committee, began by noting that he is the administrator of the Heritage Place Nursing Facility, although he isn't speaking in that capacity. He then said he would like to echo the remarks of Mr. Gilbreath. He then highlighted that community hospitals are available 24 hours a day, 7 days a week, 365 days a year. The aforementioned is jeopardized when health care is segmented. With regard to the comments about monopolies, Mr. Murray said that the CON doesn't create such but rather creates a process by which a community has input, through DHSS, upon which the department can determine whether there is sufficient need for a competitive environment or whether it would jeopardize the overall health care available in a particular community.

3:59:02 PM

JEREMY HAYES, Representative, Advanced Medical Centers of Alaska, testified in support of HB 287 and provided the following testimony:

> I support repealing our certificate of need laws as Alaska continues to see some of the most expensive health care in the country .... In 2006, depending on which study you cite, Alaska is either the first or second most regulated health care state in the country and has costs that are 40 percent higher than the national average. The stated purpose of the certificate of need program is to foster a health care

system that controls costs and meets changing conditions. Alaska's alarming health care costs proves CON has failed in controlling costs. And in a state experiencing growth and demographic change, the CON law prevents providers from adapting to the changing needs of the community effectively.

In states with no or less restrictive CON programs, hospitals are increasingly facing competition from ambulatory surgery centers, which offer minor surgical procedures that do not require an overnight stay. Hence, the 24/7 issue before. These facilities offer the same surgery as the 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 for the public. Established hospitals in heavily regulated 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. To give you an idea of the cost difference between ambulatory surgery centers and hospitals, a 2005 Medicare study found that hospitals' outpatient claims totaled $4.4 billion where the total for the same claims in a surgery center would cost about $2.8 billion, a difference of nearly $1.6 billion. In other words, taking only outpatient procedures into account: if procedures in a hospital setting were instead performed in a surgery center, Medicare would have saved $1.6 billion in 2005. Of the nearly $5 million [in] claims studied in 2005, they averaged $891 in the hospital versus $571 in a surgery center - a difference of $320 less per claim. A separate but similar study published by the Journal of Health Care Compliance in 2005 found that payments for procedures in hospital outpatient department and ambulatory surgery centers indicate that for the same surgical services, the hospital is reimbursed significantly more resulting in an estimated $1.1 billion in additional Medicare payments. After payment rate comparisons of 424 different procedure codes in '05, it was found that 66 percent for 279 of those procedures reimbursed more in the hospital compared to a surgery center. For these 279 procedure codes, the median difference was $282.

MR. HAYES continued:

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 continue to raise costs by restricting the entry of more cost effective providers into the market. Multi-state econometric studies demonstrated no significant lower cost with CON and the repeal of CON had no significant subsequent effect on hospital costs. In fact, hospitals in states with CON regulation have costs that are approximately 20.6 percent higher than non-CON states. Hospitals in more competitive markets have demonstrated to have average costs below those who have competitive markets. Healthy competition appears to work in giving economic power to the patients and payers by creating choices for consumers and raising quality standards as providers compete for patient loyalty.

Alaska's certificate of need department regulates the most services equipment and facilities of any state in the country. Interestingly, state health care data from the Kaiser [Family] Foundation also shows Alaska to be the most expensive in the country for outpatient care. So, I don't think it's coincidence that Alaska is the most regulated CON state in the country and just happens to also be the most expensive in the country. Additionally, our number one ranking cannot simply be attributed to the high cost of living as Hawaii ranks 28 in hospital care expense but is number four in cost of living. Alaska's not even in the top 10 for cost of living, but remains the most expensive health care services in the country. In contrast, Alaska spent only 8.3 of its general fund on Medicaid, with only five states in the Union spending less. Therefore, high health care costs are not a result of high indigent or charity care spending by the state as the hospitals have argued. Although the cost of services remains high in the state of Alaska, the CON department has created a substantial impediment to healthy competition. And, in effect, represents a state government supported department of anti-trade and hospital monopolies that keeps health care prices

high. These high health care costs support the thesis that Alaska's CON department contributes to increased patient expenses.

MR. HAYES continued:

> The CON's chief goal is to reduce health care costs, something the numbers tell us it has been horrific in accomplishing. There has been no evidence that CON regulations lower the cost of health care in Alaska, but significant data from respected agencies showing we're the most expensive in the country. A fact, which alone should be sufficient reason to repeal a law specifically designed to control costs. This bill, if passed, would have tremendous economic effect on the residents of Alaska in the form of huge health care savings. We feel with time Alaskans are given an answer to their quest for affordable medical care.
>
> In conclusion, I just would like to leave you guys with some additional statistics from the 2005 Henry J. Kaiser [Family] Foundation study on Alaska's current health care environment. Number one, in 2003 Alaska ranks number one in the U.S. in average expenses per inpatient day at $1,952. In comparison, Hawaii ranks 28. In 2004 Alaska ranks 45th in total Medicaid spending, confirming that the majority of the states in this country spend more indigent and charity care. In 2003 Alaska spent 8.3 percent of the state general fund expenditures on Medicaid. Only five states in the U.S. spent less. Currently, Alaska's hospital care is the highest as compared with any other state, with the exception of the District of Columbia.

4:06:09 PM

MR. HAYES, in response to comments that service centers would not be open 24 hours 7 days a week, pointed out that emergency rooms care for patients requiring acute care and emergency services. However, surgery centers perform outpatient services and perform procedures that aren't life and death procedures and thus there wouldn't be a need for a surgery center to be open 24 hours a day. There is a difference between emergency rooms and ambulatory surgery centers, he said. With regard to Mr. Powers' testimony that only one pain management physician is necessary in the Fairbanks area, Mr. Hayes pointed out that the Fairbanks area already supports five pain management physicians. The

hospital doesn't support more than one. Furthermore, the four pain management physicians not allowed to see patients at the hospital in Fairbanks are fellowship trained and double board certified, which is the case for the hospital pain staff.

4:07:43 PM

REPRESENTATIVE GATTO agreed that eliminating the CON would reduce prices, but he questioned whether the state wants to have a few years of cheaper costs and lose the hospital. He opined that of most concern are hospitals such as Bartlett Regional Hospital, which is located in an area where there is no other alternative for that kind of care.

MR. HAYES pointed out that the physicians who want to compete with hospitals for some services have a vested interest in keeping the hospital running because most physicians who work outside of the hospital also work for the hospital and provide inpatient care at the hospital. He opined that Fairbanks Memorial Hospital, with its $100 million in the bank, can afford to have some healthy competition. Perhaps such would increase the efficiency of services and increase the level of technology and innovation.

4:10:55 PM

CHARLIE FRANZ, CEO, South Peninsula Hospital, recalled the sponsor saying that free market forces should be allowed to work in health care and repeal the CON law. Mr. Franz disagreed and pointed out that health care is not in a free market as it's highly regulated and very different than other businesses. He asked the committee to think of another business or profession in which someone else decides how much one will be paid for the service provided. With regard to the testimony that specialty facilities can provide services at a lower cost than hospitals, Mr. Franz agreed. However, he pointed out that specialty facilities target the most lucrative services provided by hospitals, such as imaging or surgery. The aforementioned are major profit centers, which help hospitals offset the cost of providing unprofitable services 24 hours a day 365 days a year to anyone. "Community hospitals serve the community, specialty facilities are businesses," he said. Last year the CON law was changed by adding clarity and new requirements in order to qualify to add a service, build a new facility, or make major changes. Those new rules should be allowed to operate for a period of time in order to determine whether it creates a better situation. Nothing in the current CON statute or regulation

prevents anyone from submitting a CON application and demonstrating the need for services or the ability to provide those services in a more cost-effective manner. Therefore, Mr. Franz asked the committee to do what is right and maintain the current CON law.

4:14:58 PM

JOHN BRINGHURST, CEO, Petersburg Medical Center, began by relating his opposition to HB 287. He noted that his testimony is based primarily on his experience in joint ventures with a physician center in another area. He expressed concern that specialty facilities hurt existing providers who provide 24-hour service in a community. Furthermore, Mr. Bringhurst related his belief that the specialty facilities may increase the overall cost of health care. Also, there is a disproportionate share of uninsured and underinsured patients who are treated by [specialty] facilities. The aforementioned increases the average cost of care for existing providers, he opined. Moreover, [specialty] facilities take patients with less critical needs, and thus leave fewer cases for existing providers as well as cases with a higher average cost. Mr. Bringhurst then related his experience that surgery centers have increased the number of procedures performed in a community. Although there is evidence that rates can be lower in an outpatient surgery center, there's also evidence that the number of cases treated increases. He recalled that within a short period of time the surgery center with which he was involved began to see 40 patients a week. However, the hospital only suffered 15-20 cases per week of a loss and thus he questioned from where the other 20-25 cases came. Mr. Bringhurst opined that when a physician has a larger financial interest at stake, sometimes the physician's objectivity in referring patients can be challenged. In such situations, the patients lose. Therefore, Mr. Bringhurst urged defeat of HB 287.

4:18:03 PM

ELIZABETH RIPLEY, Director, Marketing and Public Relations, Mat-Su Regional Medical Center, stated opposition to HB 287. Ms. Ripley opined that the current CON isn't preventing growth in Alaska's health care infrastructure as Mat-Su Regional Medical Center is the newest and most modern medical facility in the state. Ms. Ripley acknowledged the benefits of fair competition, but highlighted that [hospitals] are legally and ethically bound to serve all patients, regardless of the patient's ability to pay. Ms. Ripley said that there are

documented decreases related to free-standing imaging centers in the Mat-Su area. She clarified that Mat-Su Regional Medical Center is a private business that doesn't receive assistance from the Mat-Su Borough government, which has limited health care powers as a second class borough. She noted that the Mat-Su Regional Medical Center directly competes with the Anchorage providers. Ms. Ripley concluded by reiterating the need to allow the CON modifications passed last year a chance to work for evaluation.

4:21:47 PM

REPRESENTATIVE GATTO, recalling that the cost of the Mat-Su Regional Medical Center was $101 million, asked if it was more expensive to build the hospital with the CON in place than it would've been had the CON been repealed.

MS. RIPLEY said that she didn't believe there would be a difference, although she acknowledged that there was a cost to move through the CON process.

4:22:44 PM

REPRESENTATIVE GATTO noted that an imaging center is being built close to Mat-Su Regional Medical Center. He surmised that the imaging center will cause the hospital to lower its rates for imaging.

MS. RIPLEY began by commenting that this new hospital will help all the hospitals in the area perform at a higher level and provide better care. She related her belief that there are loop holes in the current CON law, and thus there is still concern that there isn't a level playing field. In further response to Representative Gatto, the imaging center, to the Ms. Ripley's understanding, didn't go through the CON process. Therefore, Mat-Su Regional Medical Center has petitioned the state to investigate the matter and determine whether a CON is necessary. This determination should be forthcoming. This is an example of how hospitals that are very familiar with the CON laws find ways in which to capitalize on the lucrative areas of health care.

REPRESENTATIVE GATTO inquired as to what happens if the imaging facility, currently being constructed, doesn't obtain a CON.

MS. RIPLEY answered that construction would have to cease and desist.

4:25:40 PM

PAUL FUHS, Lobbyist, Alaskans for Medical Choice and Competition, stated support for HB 287. He informed the committee that he is also the sponsor of an initiative that would [eliminate the CON]. He noted that originally the initiative was filed as HB 287 because hospitals in large communities can afford competition. He acknowledged that the smaller hospitals [in smaller areas] can't afford competition, which is why HB 287 only applies to communities with populations over 25,000 and facilities that aren't designated as a critical access hospital. Mr. Fuhs surmised from much of the testimony that the hospitals believe that they are the only ones that should be able to supply services and that the CON is holding costs down. However, if that's the case, why does Alaska have a crisis in every aspect of health care, he asked.

MR. FUHS then referred the committee to what he considered to be the best source of data: the U.S. Department of Justice and the Anti-Trust Division of the Federal Trade Commission (FTC). The FTC published a study of CON last July that showed in states without CON health costs are 20 percent lower. With regard to the General Motors Daimler Benz (ph) Study that was mentioned earlier, the Michigan Department of Health has completely debunked that study. Mr. Fuhs then related that he was a consumer representative on the first state health board meeting [on CON] back in the 1970s. In those days, a statewide system of reporting financial and other operating data as well as a current health plan for the state was required. At this point, the department is deficient in the aforementioned areas. He indicated that the aforementioned is partially due to the fact that there is only one employee who deals with CONs, which is in stark contrast to the 25 employees who performed the work when it was "a real program." The data is not being collected to provide the information. He then drew attention to charts provided to the committee that relate nationwide data that specify health care price increases across the country and which sectors are responsible. Hospitals, the most protected by CONS, are 53 percent of the cost increases in the country. The aforementioned data isn't available for Alaska. Moreover, he related that when he contacted the Division of Workers' Compensation within the Department of Labor & Workforce Development (DLWD) to obtain some of the data it collects, he was told that it was proprietary information since the department contracts with a company to gather the data. Therefore, he questioned what's going on with the aforementioned since workers' compensation is a public program. Without any

data or oversight, decisions are being made on a political basis, he opined. The aforementioned isn't a good way to make decisions for health care.

MR. FUHS agreed that the state does allow the creation of monopolies such as with phone service. However, he pointed out that with such monopolies there are regulated rates, which isn't the case with hospitals. Mr. Fuhs recalled hearings on the CON regulations last year when he discovered that cost isn't one of the criteria for granting a CON. Furthermore, quality isn't a criteria for judging a CON application. Therefore, he questioned upon what the CON bases its decisions. He then suggested that hospitals should be able to illustrate through financial data that they are losing money [without the CON]. He said that he has a financial report on Fairbanks Memorial Hospital and Providence Hospital, which presents that Fairbanks Memorial Hospital made $11 million in profits and has $214 million in the bank while Providence Hospital, as a nonprofit, made $23 million in profit last year.

MR. FUHS then turned the committee's attention to the $28 million fiscal note on HB 287, which the sponsor has challenged the department to justify. However, the department has yet to do so. He drew attention to information that related that independent ambulatory surgical centers cost the patient less than a hospital. If the committee does take action on HB 287, Mr. Fuhs urged the committee to address the fiscal note, which he said is too high.

4:35:45 PM

REPRESENTATIVE GATTO pointed out that the $214 million that Mr. Fuhs said Fairbanks Memorial Hospital has in the bank refers to the hospital's net assets or fund balances at the end of the year. Therefore, the $214 million seems to refer to the total sum of Fairbanks Memorial Hospital's assets.

MR. FUHS replied no, and related his understanding that the $214 million is the money, stocks, and bonds of Fairbanks Memorial Hospital not the hospital's physical assets.

CHAIR WILSON related her understanding that the [Fairbanks Memorial Hospital] foundation is separate from the hospital and it raises funds. Therefore, she opined that the foundation funds couldn't be included in the hospital's profits.

MR. FUHS specified that he has seen tax years in which [Fairbanks Memorial Hospital has earned a profit] of $20 million, which is then placed into the foundation. He disagreed with the notion that the foundation is raising funds for the hospital because when the hospital added a $120 million addition, the hospital obtained financing from the Alaska Industrial Development and Export Authority (AIDEA). In response to Representative Gatto, he suggested that the hospital probably owes most of that recent funding from AIDEA. If the hospital is taking funds from what it charges patients to pay the loan and maintains $11 million in the foundation, the foundation isn't being used rather it's building the foundation.

4:39:45 PM

REPRESENTATIVE GATTO asked if the amount the hospital is paying back would be a deduction and the hospital would still have an $11 million profit.

MR. FUHS answered that it's after all payments have been made. He offered to provide the committee with the financial records for a representative year.

4:41:23 PM

MR. FUHS, in response to Representative Gardner regarding whether there are other stakeholders than medical personnel, specified that Alaskans For Medical Choice and Competition are behind this effort and the organization consists of consumers, small businesses, individuals, nurses, and physicians.

4:41:54 PM

REPRESENTATIVE GATTO asked if there is an organization on the other side of this issue as he expressed interest in the belief of consumers.

MR. FUHS said that's why he tried to provide the committee with data regarding the impact to the consumer.

4:43:03 PM

LAURIE HERMAN, Regional Director, Government Affairs, Providence Health & Services - Alaska, provided the following testimony [original punctuation provided]:

Providence does not believe that this piece of legislation should be enacted into law. In 2004 the legislature made significant changes to state law governing this program. And during the legislative debate there was a message heard loud and clear that the legislature felt that the regulations surrounding CON needed review and revision where appropriate. As a result, the department embarked upon a lengthy public process and in fact, updated those regulations and they were completed in December of last year and they've been in effect since January of this year. And we believe that we need to give these new regulations a chance to work. Let's see if things are better as a result of this latest effort. As you've heard today several times, health care does not fit the free market enterprise mold. Gratefully, our society stipulates that no one will be denied medical care due to the lack of financial resources. Only certain facilities, primarily hospitals, are subject to a federal mandate that all patients will be seen regardless of the ability to pay. As a result, hospitals have essentially become insurance for the uninsured. Care to the poor and vulnerable is a very important piece of the Providence mission and we provide these services willingly every day. Last year alone, we provided over $30 million in charity care and an additional $40 million was written off in bad debt. Important revenue streams that are used to underwrite unprofitable services like our emergency departments -- the place where the poor and vulnerable go for care -- are provided by high margin services that are attractive for those who do not use the profits to ensure the survival for critical care in our communities. They can easily under price and still collect windfall profits, given that they are not mandated to see all patients nor do they provide a full spectrum of care 24 hours a day, 365 days a year. What does their delivery model do for the uninsured mother who needs care?

In Alaska we have a strong system of nonprofit hospitals that offset their losses in charitable care and bad debt through profitable services like ambulatory surgery and imaging. Without a CON program, more niche providers will likely open service boutiques to provide only these specific services. When niche providers skim the profitable business from

local community hospitals, hospitals can't offset the expense of charitable care, bad debt, or emergency room cases. Remember, this is mandated care we're talking about -- care for those who lack the ability to pay. If hospitals fail and emergency rooms close, this is the population that will have nowhere to turn for medical care. Certificate of need is not about government control of health care, it is about providing a process for communities to have a say in the evolution of the health care systems that they've financed and that are an essential component of the infrastructure in their community. Whether in a large community or small, hospitals must have profitable service lines in order to offer the full range of services a community needs. If niche providers are allowed to come into an area without demonstrating that there's a need and primarily serve the high pay, low risk population, community-based hospitals could be at risk of failing. Those who cannot pay for care are then left without treatment options. I urge committee members not to move this bill forward.

4:48:13 PM

MS. HERMAN then acknowledged that in 2005 Providence did have a significant amount of net income and every penny stays in the state. In fact, over 2005-2007 Providence is putting $100 million into medical facilities in Anchorage. Additionally, Providence spends about $30 million a year on infrastructure and information technology upgrades.

REPRESENTATIVE GATTO turned to the facility Providence is building in Palmer that doesn't have a CON.

MS. HERMAN specified that a medical office building is being built in Palmer, which will be leased to a physician practice. She said that medical office buildings don't require a CON.

REPRESENTATIVE GATTO asked if the Palmer facility is an imaging center.

MS. HERMAN reiterated that it's a physician practice. She related her understanding that one of the physicians involved is a radiologist. She offered to have the physicians in that practice talk with the committee regarding the nature of the practice.

4:51:10 PM

ROD BETIT, President, Alaska State Hospital and Nursing Home Association (ASHNHA), began by clarifying that testimony that all physicians in Juneau oppose [eliminating] the CON isn't the case. Regarding transparency of medical data, Mr. Betit said that ASHNHA would like to have better medical data analysis. In fact, Mr. Betit noted that he sits on a task force created by the legislature to review the following: workers' compensation, why costs are higher, and how much of the costs are related to medical care versus the kinds of injuries and rehabilitation utilized. For a year, such information has been requested and it's still not available. The aforementioned is part of the reason Senator Seekins requested an extension of the task force. Therefore, it's premature, he opined, to draw conclusions with regard to why costs are increasing in areas such as workers' compensation.

MR. BETIT then recalled testimony that Medicaid only makes up 8.3 percent of the general fund and the state doesn't spend enough. Drawing on his prior experience as Medicaid director in Alaska, all states spend far too much on Medicaid. Alaska has had an almost 60 percent federal match rate whereas other states have had 50 percent. Furthermore, a large number of those eligible for Medicaid are Alaska Natives and those who use a Indian health service facility or tribal program are reimbursed 100 percent by the federal government. Therefore, he opined that it's not a good indicator as to whether too little or too much is being spent on the Medicaid population.

MR. BETIT, speaking to the document he provided the committee, said there are seven key themes regarding whether the CON is a good or bad program. He specified the following: health care isn't a conventional market; CON is an important health policy tool that balances community need with growth; the lack of a federal mandate for CON doesn't mean such laws are unnecessary. In fact, when the federal government left the CON in the hands of the state government, it was a political decision based on the belief that states should marshal the health care environment in the state. Therefore, he didn't interpret the absence of the federal government as an indication that it doesn't support CON.

MR. BETIT, regarding whether CON is preventing growth, related that since the CON regulations were finalized and the CON application process reopened, there has been a flurry of activity. Although ASHNHA members aren't particularly excited

about some of the decisions, it's an environment in which rational and fair decisions are being applied. Furthermore, there is an appeal process for those who don't believe a fair process occurred. He then provided the committee with a sampling of applications that have come before the department. The process attempts to balance the needs in the community with the projects that come forward, he said. Regarding whether CON is a good health tool or not, Mr. Betit opined that the health care system in a geographic area can be built up and not provide what is truly needed, create over supply, and lead to some critical damage to a health care system. He recalled his time in Utah as a state health director when Utah had lifted the CON in some areas. Immediately following, eight psychiatric facilities were built, all of which disappeared over the course of the next three years. During this time, the long-term care system in Utah had 25 percent vacancy rate and 20 out of 100 facilities were in some kind of financial distress. The aforementioned led to an emergency rule forbidding any more building of Medicaid beds in Utah without approval from the department. The aforementioned moratorium remains today. Mr. Betit opined that there is ample evidence that if health policy and planning isn't approached in a very deliberative manner, very significant unintended consequences can result. Therefore, if HB 287 moves forward he suggested that it will have results similar to those in Utah.

5:02:36 PM

REPRESENTATIVE KOHRING interpreted empty facilities as the result of a market process caused by facilities not providing services the public wants. Deciding whether facilities should be built or not isn't the government's role, he opined.

MR. BETIT noted his strong disagreement. He explained that the reason for the vacancies didn't have to do with whether someone wanted to be in a nursing home. He reminded the committee that most of the nursing home business is funded by Medicaid with only about 25 percent of the nursing home population being privately funded because people can't afford it and don't have insurance for it. Ultimately, people lose enough assets and income to qualify for Medicaid. He explained the differences in this market. He recalled that when Utah [eliminated its CON in certain areas] there was a 300 percent increase in confirmed patient harm and complaints during the period of escalation of vacant beds, the state was paying the same amount per day for nursing home beds that it paid before the new beds were built, and operators were forced to fund overhead and basic expenses

and thus didn't meet the need of patients. Therefore, the moratorium in Utah changed that. However, that change occurred because the state stepped in since the market doesn't have such a correcting ability.

5:06:10 PM

CHAIR WILSON pointed out that the testimony on this issue has brought forth much contradictory information that requires further inquiry. Therefore, she announced that HB 287 would be held.

5:09:53 PM

REPRESENTATIVE CISSNA noted that she made a copy of the Institute of Social and Economic Research (ISER) report regarding the cost of health care for the committee's review. The report essentially says, "But for now we want to emphasize that the answer to what is driving health care costs is not simple and finding solutions won't be simple either." Additionally, Common Wealth North's study provided a number of recommendations, of which none touched CON. Representative Cissna stressed her belief that this is a matter for which the state is responsible.

5:11:32 PM

CHAIR WILSON announced that although the [House] isn't [placing any House Bills on the floor calendar], the committee will continue to hear legislation that address health care costs in the state.

5:12:30 PM

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 5:12 p.m.