ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
March 27, 2019
1:31 p.m.

MEMBERS PRESENT

Senator David Wilson, Chair
Senator John Coghill, Vice Chair
Senator Gary Stevens
Senator Cathy Giessel
Senator Tom Begich

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE BILL NO. 1
"An Act repealing the certificate of need program for health care facilities; making conforming amendments; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 1
SHORT TITLE: REPEAL CERTIFICATE OF NEED PROGRAM
SPONSOR(s): SENATOR(s) WILSON

01/16/19	(S)	PREFILE RELEASED 1/7/19
01/16/19	(S)	READ THE FIRST TIME - REFERRALS
01/16/19	(S)	HSS, FIN
03/27/19	(S)	HSS AT 1:30 PM BUTROVICH 205

WITNESS REGISTER

GARY ZEPP, Staff
Senator David Wilson
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Presented the sectional analysis of SB 1 on behalf of the sponsor.

DAVID GRABOWSKI, Ph.D., Professor
Department of Health Care Policy
Harvard Medical School
Boston, Massachusetts
POSITION STATEMENT: Testified in favor of repealing Certificate of Need laws.

DAN GILMAN, Attorney Advisor
Office of Policy Planning
Federal Trade Commission (FTC)
Washington, D.C.
POSITION STATEMENT: Testified in favor of repealing Certificate of Need laws.

MATTHEW MITCHELL, Ph.D., Senior Research Fellow
Director of the Equity Initiative
Mercatus Center
George Mason University
Arlington, Virginia
POSITION STATEMENT: Testified in favor of repealing Certificate of Need laws.

ACTION NARRATIVE

1:31:10 PM
CHAIR DAVID WILSON called the Senate Health and Social Services Standing Committee meeting to order at 1:31 p.m. Present at the call to order were Senators Coghill, Giessel, Begich, Stevens, and Chair Wilson.

SB 1-REPEAL CERTIFICATE OF NEED PROGRAM

1:31:22 PM
CHAIR WILSON announced the only order of business would be SENATE BILL NO. 1, "An Act repealing the certificate of need program for health care facilities; making conforming amendments; and providing for an effective date."

CHAIR WILSON made opening remarks.

1:31:48 PM
CHAIR WILSON solicited a motion to adopt the proposed committee substitute (CS) for SB 1.

1:31:55 PM

SENATOR COGHILL moved to adopt the Committee Substitute (CS) for SB 1, work order 31-LS0001\M, Marx, 3/8/19, as the working document.

SENATOR GIESSEL objected for purposes of discussion.

1:32:08 PM
CHAIR WILSON reviewed the changes made to SB 1 from Version A to Version M:

The changes made in the work draft pertain to the effective date on page 5, line 9:

- Section 8 reads: This act takes effect on July 1, 2024.

The change in the effective date from July 1, 2020, to July 1, 2024, enables a step-down approach to allow certificate-of-need recipients and newly approved applicants to:

- plan for the change over the course of five years
- re-engineer their business model
- and re-coup their investment
- allow the department to revise regulations

1:33:01 PM
SENATOR BEGICH asked how existing regulations would be affected if the Certificate of Need (CON) program was eliminated. He said if the [department] spends four or five years working on regulations, what would the legislature need to ensure the regulations still apply and do not disappear with the bill. He asked if the committee could request a legal opinion for clarification.

CHAIR WILSON said the bill would repeal the statute. He said he hoped the department would develop new regulations to help strengthen what could be a better process. He noted that last year the committee heard from many providers who were in agreement that the process was not perfect. Even the department stated that the process for applying for a certificate of need (CON) is not a good one. The [department and stakeholders] would like to make the process better and the bill will allow them to do so without the CON law in effect.

SENATOR BEGICH asked if eliminating the statute would also eliminate the authority for regulation.

CHAIR WILSON offered to request a legal opinion from the Legislature Legal Services on the matter.

1:34:54 PM
SENATOR GIESSEL removed her objection.

There being no further objection, CSSB 1, Version M, was adopted.

1:35:04 PM
CHAIR WILSON explained that SB 1 repeals Alaska's Certificate of Need program and provides for a five-year delayed effective date. The CON programs were first mandated nationally by the federal government in 1974. Since the mandate was repealed by the federal government in 1987, 12 states have repealed their CON laws, three states have a regulatory oversight method, and 35 states still have CON laws and require approval for certain facilities and services.

CHAIR WILSON said that CON programs were originally intended to restrain health care costs and improve access to care for the poor and the underserved populations. However, four decades of data and studies show CON laws have not controlled costs, improved quality and outcomes or increased access to health care for the poor or underserved.

CHAIR WILSON offered his belief that CON laws have established health care monopolies. This has resulted in barriers to new or expanded medical facilities and limited health care choices or innovations for consumers. Studies have shown that a well-functioning health care market improves access, quality, and outcomes. Further, a well-functioning health care market will incentivize innovations from new entrants and lower the cost of health care services. Repealing Alaska's Certificate of Need program would benefit Alaskans by fostering competition in the health care markets.

1:36:53 PM
GARY ZEPP, Staff, Senator David Wilson, Alaska State Legislature, Juneau, said that most of the sections for CSSB 1 are conforming. He presented the sectional analysis:

> Sections 1-3: makes conforming amendment to AS 18.20.400 and AS 18.20.499 to eliminate references to AS 18.07.111, which is repealed under sec. 5 of the bill.

MR. ZEPP explained that the conforming amendments were to limitations on nursing overtime under AS 18.20.400, to definitions in AS 18.20.499. It would remove references to definitions in AS 18.07.11, which is repealed under Section 5 of the bill. He reviewed Section 4.

> Section 4: makes conforming amendments to AS 18.26.220 by removing references to repealed sections of law.

MR. ZEPP said these conforming amendments were to facility compliance with health and safety laws and licensing requirements. He continued his sectional analysis.

> Section 5: repeals all of AS 18.07, which describes the certificate of need program for health care facilities, and AS 21.86.030(c)(1), AS 44.64.030(a)(18), and AS 47.80.140(b), which also relate to the certificate of need program.
>
> Section 6: repeals a section of uncodified law, sec. 4, ch. 275, SLA 1976, which provided a transition to allow medical facilities in existence or under construction before July 1, 1976 to obtain certificates of need.

MR. ZEPP said this statute was the original creation of the CON program in Alaska in 1976. He reviewed Section 7.

> Section 7: provides that the Department of Health and Social Services may not take any action to revoke, enforce, or modify a certificate of need issued to a health care facility before the effective date of the Act.
>
> Section 8: provides that the Act takes effect July 1, 2020.

1:40:28 PM
MR. ZEPP began his presentation on CSSB 1 by showing a video from George Washington University-Mercatus Center explaining the Certificate of Need program. The video made the following points:

> Before someone can open or expand the operations of a health care facility, CON laws require them to prove to a regulator that their community needs the new

services. The original goal was to control costs by reducing spending on unnecessary treatments and equipment. The CON laws have not been a panacea for controlling costs. Obtaining a CON is a pain. CON laws make it hard for new health care providers to compete with established ones. Congress stopped encouraging states to adopt CON laws in 1987. Since then, 14 states have repealed them. Repealing CON laws is one of the first steps a state can take to make its health care market more competitive.

1:43:53 PM
MR. ZEPP said that the state's CON programs are administered by statutes and regulations controlling market entry for regulated facilities, services, and equipment, hospitals, nursing homes, some free-standing clinics, home health agencies, and ambulatory care service centers.

He reviewed slide 3 of the PowerPoint on Senate Bill 1 – "An Act repealing the Certificate of Need (CON) program for health care facilities" dated March 27, 2019.

CON laws are state-level statutory laws that require healthcare entities to obtain permission to make significant expenditures or to construct or expand facilities and services, based on the an application fee and the theory that controlling the supply of facilities, equipment, and services is the best method to restrain rising healthcare costs and prevent over-expansion of healthcare facilities.

The certificate of need laws originally were created to contain healthcare costs, prevent an over-supply of medical services and infrastructure, and improve access to care for the indigent or to the underserved population.

The basic assumption underlying Certificate of Need is excess capacity stemming from the overbuilding of healthcare facilities which results in healthcare price inflation and overcapacity.

MR. ZEPP reviewed slide 4, "National History of Certificate of Need."

1974: National Health Planning Resources Development Act (NHPRDA) required all states seeking federal funding for health programs to establish oversight agencies for the submission of proposals for any major capital spending on health care, i.e. a Certificate of Need program.

1974-1982: Health care costs continue to rise nationwide despite almost 100% state participation in NHPRDA.

1982: Congress initiates a review of Certificate of Need programs and the Congressional Budget Office study doesn't offer a recommendation but reports that problems with NHPRDA has limited the program's success in achieving cost savings. 1983-1985: Five states abandon Certificate of Need even though NHPRDA is still in effect.

1987-Present: Congress repeals NHPRDA. Following the U.S. repeal, 13 states have now terminated their Certificate of Need programs.

MR. ZEPP said that in 1974, if a state did not develop oversight agencies it would lose federal funding. By 1987, the CON programs throughout the country were not working. CON laws did not constrain health-care costs, provide access, or increase indigent care or underserved populations, he said.

1:45:21 PM
MR. ZEPP referred to maps on slides 5-9 that showed the evolution of CON in the U.S. in 1974, 1980, 1990, 2000, and 2017. By 1980 every state except Louisiana adopted CON programs. From 1990-2017, states gradually repealed their CON programs, and by 2017 a total of 15 states had repealed its CON programs. Since then, Arizona has introduced a variation of the program, and Indiana reinstated its program, although its state medical association does not support the CON laws.

1:46:21 PM
MR. ZEPP reviewed slide 10, "Alaska's Legislative History of Certificate of Need."

The following is a past summary of enacted legislation passed by the Alaska Legislature regarding the Certificate of Need program:

1976: HB 665 (Ch. 275, SLA 1976), which repealed and replaced all of AS 18.07 to establish the CON program and regulation of healthcare facilities.

1982: HB 591 (Ch. 59, SLA 1982), covered a temporary but non-emergency CON for a health care facility and added a definition of certificate of need dealing with the issuance of certificates.

1982: HB 591 (Ch. 25, SLA 1981), clarified that Pioneer Homes are not subject to CON.

1983: SB 85 (Ch. 95, SLA 1983), added a $1.0 million floor for requiring a CON.

1990: HB 85 (Ch. 85, SLA 1990), provided authorization to Dept. of Health & Social Services to charge a fee for the CON.

1991: SB 86 (Ch. 21, SLA 1991), deleted the federal statutes and changed the title section.

1996: HB 528 (Ch. 84, SLA 96), Placed a moratorium on nursing home beds and established a legislative working group on long-term care.

2004: HB 511 (Ch. 48, SLA 04), Included Residential Psychiatric Treatment Centers.

1:46:43 PM

MR. ZEPP briefly reviewed slide 11, "Alaska's Certificate of Need Program." He said he would not read the slide but noted that the program is broad.

Certificate of Need approval is required in Alaska for any expenditures totaling more than $1.5 million dollars for:

Construction of a health care facility;
Alteration of the bed capacity of a health care facility; Addition of a category of health services provided by the health care facility; and,
Conversion of a building or a part of a building to a nursing home.

Non-Refundable Applications & Fees:

Activity valued at $2.5 million dollars or less, the cost would be $2,500.00 to apply; and,

Activity valued more than $2.5 million dollars, a fee equal to .1% of the estimated cost is applied, up to a maximum of $75,000.00.

MR. ZEPP briefly reviewed slide 12, "Alaska's Certificate of Need Program."

Time Standards for review of applications for Certificate of Need:

The department has up to 60 days to review a completed application and to allow concurrent applications/proposals for a similar activity in the same geographic area.

Proceedings for modification, suspension, and revocation:

The department, a member of the public who is substantially affected by activities authorized by the certificate, or another applicant for a Certificate of Need may initiate a hearing conducted by the Office of Administrative Hearings to obtain a modification, suspension, or revocation of an existing Certificate of Need by filing an accusation, THE Commissioner has authority to do this as prescribed under AS 44.62.360.

Definition:

Health care facility means a private, municipal, state, or federal hospital, psychiatric hospital, independent diagnostic testing facility, residential psychiatric treatment center, tuberculosis hospital, skilled nursing home facility, kidney disease treatment center, intermediate care facility, and ambulatory surgery facility.

1:47:31 PM

MR. ZEPP reviewed slide 13, "CON Exemptions."

An operational ambulatory surgical facility may expend any amount of money, to relocate the facility to a new site within the same community without seeking a CON

approval. As long as the neither the bed capacity nor the number of categories of health care services remains the same.

Exempt Entities:
- The Alaska Pioneers' Homes
- The Alaska Veterans' Home
- Offices of private practice physicians or dentists whether in individual or group practice
- US Indian Health Services Facilities
- Alaska Tribal Healthcare entities.

MR. ZEPP explained that Alaska has three categories of health care providers with CON. Some on the forefront with exemptions, incumbents in the middle were existing and operational, and new entrants were those who are not able to gain entrance to Alaska because of CON laws.

1:48:40 PM
MR. reviewed slide 14, "Healthcare is complicated!"

- Our current healthcare system is a highly fragmented.
- Data is siloed with no sharing, because "proprietary" patient data can be profitable.
- Insurance is bought mostly by employers and the patient is removed from the purchasing process.
- Government laws and regulations require unnecessary administrative efforts for healthcare providers.
- The government dictates what health care facilities, providers, and services are allowed and not allowed into your community.
- The freedom of selecting your healthcare services is dictated and controlled by government.

MR. ZEPP pointed out that repealing CON will not solve all of Alaska's health care issues, but it is a great start to open up the markets for new entrants and increased access to new services, technology, and most importantly, competition.

MR. ZEPP reviewed slide 15, "Repealing Alaska's CON is only a piece of the puzzle."

- Over 100 million Americans in twelve states (31% of the U.S. population) live without CON.

- 40 years of studies very clearly show that non-CON states have better access, lower costs, higher quality outcomes, and lower mortality rates than CON states.
- Proponents of CON would have you believe that if CON was repealed, there would chaos in our communities: small hospitals would close, Medicaid/Medicare costs would rise, and hospitals would be unable to provide EMTALA for the indigent care
- CON states and non-CON states have very similar levels of indigent care, whether you have a con or not, this is based on actual research!

1:49:36 PM
MR. ZEPP reviewed slide 16, "Our healthcare providers are cherished and valued members of our communities!"

> Attempts to repeal Alaska's Certificate of Need program is not meant in any way, shape, or form to dishonor, disrespect, or minimize how important our healthcare providers are to Alaskans! They are our friends, family members, and neighbors.

He said that [SB 1] is a policy discussion and not an attack on health care providers.

1:50:02 PM
MR. ZEPP reviewed slide 17, "Consequences of CON failures."

> We believe Alaska's CON laws have:
- Stifled competition, prevented innovation, and prevented new technology;
- Failed to increase access for indigent care or the underserved populations;
- Created barriers for new entrants;
- Protected incumbent hospitals and created monopolies;
- And increased healthcare costs, especially in a restrained market like Alaska.

> Result: We have the highest healthcare costs in the world!

1:50:37 PM
MR. ZEPP reviewed slide 18, "Why competition is important in health care markets."

"Competition is essential to ensure that providers and health plans are subject to the market forces that drive them to attract patients and subscribers by offering low prices and high quality. If market powers are concentrated among providers or plans, they are insulated from those forces."

"Material, lasting improvement to our healthcare system requires harnessing private sector innovation and competition to benefit of all. When ingenuity and capital are focused on what we most value, we see incredible innovation and productivity gains. Enabling competition requires alignment of the incentives of all stakeholders with what we value: sufficient transparency and appropriate regulations that further benefit Alaskans."

"Reform must address the underlying drivers of costs and cost increases, including the current lack of value-based competition in our healthcare delivery system (e.g., hospitals, medical service providers, and pharmaceuticals."

1:51:18 PM
MR. ZEPP reviewed slide 19, "Why is competition important?"

"Reduced competition among clinicians leads to higher prices for healthcare services, reduces choice, and negatively impacts overall healthcare quality and the efficient allocation of resources."

"State polices that restrict entry into provider markets can stifle innovation and more cost-effective ways to provide care while limiting choice and competition."

MR. ZEPP said that the quotations were from "A Bipartisan Blueprint for Improving Our Nation's Health System Performance," signed by Governors John Hickenlooper, John Kasich, Bill Walker, Tom Wolf, and Brian Sandoval, pointing out that Alaska's Governor Bill Walker had been one of the signees of the blueprint.

1:51:49 PM
MR. ZEPP reviewed slide 20, "Competition is Important."

The quotes you see are from research, studies and data regarding how CON laws have stifled competition:

"Competition creates choices for consumers and raises quality standards as providers compete for patient loyalty. A 1993 study found that hospitals in more competitive markets had average costs below those of less competitive markets."

"Market competition in healthcare delivery provides economic empowerment to patients and payors by providing access, encouraging innovation and the investment of capital in overall cost saving technologies, and creating choices for consumers which, in turn, encourages providers to raise quality standards as they compete for patient loyalty. When patient choice is diminished, decisions about appropriate pricing/costs, access, quality, and beneficial outcomes become the sole purview of the elite groups of oligopoly decisionmakers who, in the absence of healthy competition, are free to ignore market demands and patient needs. This circumstance is what drives the acceleration of costs."

Written Testimony to the Senate Labor & Commerce Committee on April 6, 2017 – Robert J. Cimasi (page 7 & 8) + "California Providers Adjust to Increasing Price Controls, J Zwanziger, G. Melnick, A. Bamezai, Health Policy Reform – 1993 (Pages 241-58); Written testimony to the Senate Labor & Commerce Committee on April 6, 2018 – Matthew D. Mitchell, PhD, Mercatus Center-George Mason University (page 17).

He said that these studies span over 30 years, but the data trends have not changed.

1:52:15 PM
MR. ZEPP reviewed slides 21-22, two slides stating that CON laws prevent innovation and new technologies.

Example, this applies to Alaska as well due to our CON law restrictions if you're a new entrant and costs exceed $1.5 million!

Dr. Singh, of North Carolina, cannot purchase a new MRI machine because of CON laws in North Carolina, the law that applies here.

On average, an MRI at a North Carolina hospital costs upwards of $2,000. Dr. Singh's charges run from $500 to $700 but he has to use a mobile scanner instead of a fixed MRI scanner because of the CON laws.

"The answer lies in the powerful lessons business has learned over the past two decades about the imperatives of competition. In industry after industry, the underlying dynamic is the same; competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in health care, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less that the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care – two equally undesirable results."

1:53:00 PM
MR. ZEPP reviewed slide 22, "How CON Laws Prevent Innovation and New Technologies."

"The misguided assumption underlying much of the debate about health care reform is that technology is the enemy. By assuming that technology drives up costs, reformers neglect the central importance of innovation or, worse yet, attempt to slow its pace. In fact, innovation driven by rigorous competition is the key to successful reform. Although health care is unique in some ways, in this respect, it is no different than any other industry."

"CON repeal would remove unnecessary and irrational constraints and costly regulatory barriers to innovation; to investment in new technologies; to quality services; and, to cost-effective improvements, which as the technology advances, offer the true and valid opportunity to provide cost-effective quality healthcare to Alaska's citizens."

"Systematically review and rationalize federal and state regulations that may inhibit innovation and

competition (e.g., credentialing, clinical trials, and prescription drug import regulations)."

1:53:39 PM
MR. ZEPP reviewed slide 22, "CON laws create barriers for new entrants."

"Government-erected barriers to entry that can lead to a highly-concentrated and inefficient market."

"Under normal market conditions, high prices and/or high profit margins attract new producers and sellers. This increased supply leads to lower prices and higher quality over time. Without the possibility of new entrants and real competition, however, existing producers can use market power to keep prices high and quality low."

"Denial of patient choice in Alaska is because of the barrier to entry posed by CON. New Medical providers, no matter how efficiently and creatively they might contribute to higher quality, more beneficial outcomes, and lower overall healthcare costs, must receive permission and can be challenged by incumbents and this limits competition for Alaskans and their families."

"On average, application fees are $32,000; however, total costs associated with the process to obtain regulatory permission to provide the medical services requested can exceed $5 million for a single application (Conley and Valone 2011), which exceeds the average price of a magnetic resonance imaging (MRI) machine. The costs include consulting fees as well as review and appeal fees, and the process can take up to three years."

1:54:13 PM
MR. ZEPP reviewed slide 23, What About EMTALA?"

EMTALA is a federal law that requires Medicare-participating hospitals with emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay--this law has been an unfunded mandate since it was enacted in 1986.

> CON laws have failed to increase access for indigent care or the underserved populations.

He said he wanted to bring Emergency Medical Treatment and Labor Act (EMTALA) because it has come up the last several years when discussing CON in committee.

1:54:54 PM
MR. ZEPP reviewed slide 24, "Is EMTALA-related care the driver of Rising Healthcare Costs.

> Emergency care in America is just 2 percent of all U.S. medical costs.

He said he would say no, because according to the American College of Emergency Physicians, emergency care in America is just two percent of all U.S. medical costs. He reminded members that CON has been in effect for over four decades and the effectiveness and burdens of CON regulatory policy have been studied extensively by federal and state governments, academic institutions, and other researchers and organizations.

1:55:32 PM
MR. ZEPP reviewed slide 26, which contained quotes:

> "Although advocates of CON laws might seek to promote indigent care, the evidence does not show that CON laws advance that goal."
>
> "Most noticeable in all of the results is a lack of any statistically significant evidence for the cross subsidization hypothesis. The data provides no statistically significant evidence that increased competition leads to reductions in charity care. The claim that hospitals will use market power to increase services to the poor is largely unsupported by this data."

He said that by limiting competition, CON laws allow incumbent healthcare providers to earn greater profits by charging higher prices for private health insurance and financing indigent care. It is cross-subsidization. That is the concept behind CON, he said.

1:56:08 PM
MR. ZEPP reviewed slide 27, "Contemplate the Following."

"The huge enterprises that U.S. hospitals have become are largely unaccountable for the amounts of revenue they raise or the uses to which they put that money. Indeed, they are major contributors to ever-rising healthcare costs."

"Competition is the best way both to limit dominant hospitals' claims on gross domestic product (GDP) and to restore voters and their representatives the power to decide just what extras are worth paying for."

"Early analysis of the Medicare Care Report data shows national declines in uncompensated care, especially in expansion states, although the data do not permit reliable estimates of trends in Medicaid payment amounts."

"Almost all states make Medicaid Disproportionate Share Hospital (DHS) payment are made to hospitals serving high proportions of Medicaid or low-income patients."

What is Disproportional Share Hospital payments?
Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Approximately 3,109 hospitals receive this adjustment.

1:56:41 PM
MR. ZEPP reviewed slide 28, "Medicaid Disproportionate Share Hospital (DSH) payments in 2018 for Alaska."

Who or where was the funding distributed to? What healthcare entities/facilities?

4 Hospitals have had ongoing agreements with the department to receive DSH for many years.

- Alaska Psychiatric Institute (by regulation API receives their facility specific maximum allowable by law)
    - FY2018-$14.7 million
    - FY2017-$14.6 million
    - FY2016-$14.1 million

- Fairbanks Memorial Hospital- note the decline resulting from falling uncompensated care
  - FY2018-$258.9 thousand
  - FY2017-$660.5 thousand
  - FY2016-$1.3 million
- Bartlett Regional Hospital - note the decline resulting from falling uncompensated care
  - FY2018-$302.5 thousand
  - FY2017-$274.5 thousand
  - FY2016-$1.8 million
- Providence Alaska Medical Center - $2,531,019 annually.
  - FY2018-$2.5 million
  - FY2017-$2.5 million
  - FY2016-$2.5 million

1:57:07 PM
MR. ZEPP reviewed slide 29, "Final Considerations on EMTALA."

How do other states deal with EMTALA?

Example: New Jersey requires Ambulatory Surgery Centers not owned by a hospital to pay a 3.5% tax of up to $200,000 on the facility's annual gross revenue. The tax helps fund the uncompensated care through the Health Care Subsidy Fund.

There are methodologies to help level the playing field for EMTALA in Alaska for those healthcare providers who are mandated to provide EMTALA. It's not an all or nothing proposition and certainly not a reason to retain CON laws in Alaska.

1:57:59 PM
SENATOR BEGICH referred to [slide 28] on Disproportionate Share Hospital (DSH) payments. He noted the API numbers are significantly higher than others and read, "… by regulation API receives their facility specific maximum allowable by law." Under EMTALA API receives the Medicaid disproportionate share funds. He asked if the state privatizes API, whether that regulation would still apply.

MR. ZEPP answered that he did not know.

SENATOR BEGICH said that he would like the committee to look into that at some point.

1:58:59 PM
MR. ZEPP reviewed the quote on slide 30.

> "Let's examine the data of Alaska's high health care costs."

MR. ZEPP reviewed slide 31, "Inflation vs. Skyrocketing Healthcare Prices."

> The average overall rate of inflation in Alaska was 1.22% from 2013 – 2017.
>
> Healthcare had a rate of inflation of 10.0% over the same five-year period.

MR. ZEPP said to remember that in 1974, one of the main points was that health care costs were rising rapidly with an 11 percent inflation rate that year. According to the Department of Labor's data, Alaska's health care costs are anywhere from 45 to 53 percent higher than the U.S. average for health care.

1:59:46 PM
MR. ZEPP reviewed slide 33,"Milliman reports." He presented the key conclusions from 2011:

- Hospital operating margins in Alaska were 13.4% on average in 2010, compared with 5.7% for the comparison states (or in other words, average hospital margins in Alaska are 233% of those in the comparison states) Margins for hospitals in rural areas were similar to the comparison states. Margins for hospitals in urban areas were 16.2%, driven largely by high margins in two for-profit hospitals.
- Commercial hospital reimbursement is approximately 137% of the average in the comparison states.
- Average hospital costs are approximately 138% of the average in comparison states.
- Overall health care utilization rates for Medicare patients are similar to the comparison states.

2:00:36 PM
SENATOR BEGICH asked how the repeal of CON laws would impact this.

MR. ZEPP explained the process he used to make the conclusions, including using 22 studies to prepare this presentation, that he

reviewed many other studies in the last three years, and held numerous discussions with people nationwide.

He reiterated that CON was created to contain health care costs, prevent an oversupply of medical services and infrastructure, and improve access for indigent care and underserved populations. He gave an example to illustrate how a new provider of dialysis, cannot work in Alaska unless the state of gives permission, but a sole incumbent provider could get involved and help prevent another company from working in Alaska.

SENATOR BEGICH expressed an interest in knowing the expectations if the legislature eliminates the CON laws. Referring to his example, he said that the assumption is that a company holds the price at a certain point and because of the barriers to entry, other entities cannot offer that same product at a lower price. He asked if that was the fundamental theory.

2:02:45 PM
CHAIR WILSON said that he will discuss the goals later on. The slide reviewed the original reasons for CON laws, which was to help contain and control health care costs and expenditures. However, Alaska is still paying the same inflation rates as it did the 70s, he said. It has not changed.

SENATOR BEGICH said his point was that identifying the figures on the slide does not indicate causation. He would like to see how the two are related and connect.

2:03:43 PM
SENATOR GIESSEL said that the Milliman reports, which were done for the Health Care Commission are very helpful. She said that one recommendation by Milliman was to repeal CON laws.

She related a scenario to illustrate how CON works. Two years ago, one Eagle River hospital requested permission for a stand-alone emergency room. This community serves a large population and is about a 30 minute drive from Anchorage and 45 minutes from the Mat-Su Valley. The commissioner of Department of Health and Social Services (DHSS), the person who makes the CON decision, denied the CON even though the stand-alone emergency room in Eagle River would serve a large population. Instead, emergency room facility increases were approved at Providence Hospital in Anchorage.

She offered her belief that the rationale was non-existent in this decision. Not only did it increase costs by suppressing

competition, it limits access to health care. She expressed frustration that even though more people reside in the Eagle River area than in Bethel, this community was denied a stand-alone emergency room.

2:05:24 PM
SENATOR BEGICH said that the two scenarios get right to the point of connecting the figures on the slide, which is what he sought.

MR. ZEPP reviewed slide 33, "Data from the Milliman Report from November 2016, which included a bar chart that showed hospital margins by area from FY 2012 to FY 2014, comparing hospital margins in Alaska to other locations in the nation. It included these statements:

> Hospital margins in Alaska are generally higher than those in the rest of the country. Within Alaska, hospital margins in Anchorage are the highest. Figure 10 sows the Alaska average at 15.6% comes in about five points higher than San Francisco, which is the highest of the comparison areas at 10.3%. Anchorage facilities lead the pack with 20.3% margin. Alaska hospitals outside of Anchorage are consistent with the high end of the comparison areas.

MR. ZEPP said that when health care markets have a restrained market, the incumbents create monopolies and control prices.

2:06:33 PM
SENATOR STEVENS asked why the chart shows the hospital margins in Fairbanks as so low.

MR. ZEPP related his understanding that Fairbanks is a smaller hospital. He offered to research it and respond back to the committee.

SENATOR STEVENS commented that it was remarkable that the Fairbanks hospital has the same margins as Vermont.

2:07:05 PM
SENATOR GIESSEL said another factor is who owns the hospital. This slide refers to hospital margins or profits and it would include the Providence Medical Center complex, which is the highest margin facility in the Providence network. She reminded members that Providence Medical covers most of the West Coast

and noted that the Anchorage Providence hospital has an extremely high margin of profitability.

2:07:48 PM
MR. ZEPP reviewed slide 34, "An Example - Milliman Report on Colonoscopy from November 2016," which consisted of a graph that showed the average unit cost for physician colonoscopy with biopsy. He said that Anchorage costs are significantly higher than the other eight cities listed. This is consistent with the data throughout the Milliman report. He concluded that with CON laws, prices are set by the competitors. This is especially true in Alaska because it has a small population and a restrained market, he said.

MR. ZEPP reviewed slide 35, "Milliman Reports Key Findings - 2016."

- Commercial provider payment levels in Alaska are 76% higher than levels nationwide;
- Physician payment levels are 148% higher in Alaska;
- Hospital payment levels are 56% higher;
- Commercial provider payment levels have grown faster in Alaska than in comparison areas over the last five years, with the Alaska physician payment level growing by an excess of 15% and the hospital payment levels by an excess of 6%. Combined, this resulted in an additional 10% medical cost growth in Alaska versus the comparison areas over the five-year period;
- Hospital margins in Anchorage, at 20.6% are high relative to the nationwide average at 6.9%/

2:08:58 PM
MR. ZEPP reviewed slide 36, "Alaska's high health care costs are driving citizens out of the state for medical care."

> Companies such as the state of Alaska, Premera, General Communication, Inc. (GCI), and the Mat-Su Borough have programs that send employees south for medical care because of the high healthcare costs in Alaska.

He explained that these entities use third-party vendors to schedule appointments. The covered costs usually include the airfare, hotel, per diem, for the patients and their spouses and the program still save tens of thousands of dollars. A 2018

report for the state of Alaska shows that the carrier rate for repairing a hernia was $17,434. The cost to have the surgery performed in Seattle, using SurgeryPlus, a third-party vendor that provides travel arrangements, was $9,558. This results in a savings of $7,876 or 45.2 percent, including the travel costs of $2,000, he said.

SENATOR GIESSEL said that the Teamsters also send its beneficiaries to the Lower 48 as do many school districts since the districts can no longer afford to have care provided in Alaska.

MR. ZEPP said that the point of the slide is that the state needs competition CON prevents competition.

MR. ZEPP said that 12 states have repealed their CON laws. Over 100 million Americans, or about 31 percent of the U.S. population, live without CON programs. Theses still have licensing and regulation, but the states have open competition.

2:11:05 PM
MR. ZEPP presented the slide 37, "Why repeal Alaska's Certificate of Need?"

Four decades of research show that CON Laws Have:

- Prevented Access;
- Not increased the levels of indigent care in CON states versus Non-CON states;
- Created barriers to new entrants;
- Enriched incumbent healthcare providers;
- Contributed to high healthcare costs in Alaska;

Alaskans are paying the highest healthcare prices in the world and they continue to increase!

Repealing Alaska's CON program will provide Alaskans with choice and spur competition.

2:11:42 PM
MR. ZEPP presented slide 39, "No better time to repeal Alaska's CON program."

The fundamental premise of our systems is that consumer welfare is maximized by open competition and consumer choice! Healthcare development should be left

to the economics of a well-functioning healthcare system for Alaskans.

Alaska's CON law remains a major hurdle for new entrants, existing providers seeking to expand, modernize or reshape their service capabilities. Now is the right time!

Alaskans are paying the highest healthcare prices in the world!

MR. ZEPP said that with a delayed, five-year implementation date, the repeal provides Alaska health care providers an opportunity to prepare and the state of Alaska to develop meaningful regulations.

2:12:17 PM
MR. ZEPP presented slide 40, "Healthcare is multifaceted."

Healthcare markets contain many elements that are in need of review, including:

- Escalating costs and care provider shortages;
- Public health and various payer programs;
- Lack of accurate and reliable cost information to consumers;
- Medicaid reforms and implementation challenges;

"When healthcare markets operate properly, competition will determine the appropriate prices for medical services, the appropriate organizational forms for healthcare financing and delivery, and the appropriate range and availability of cost/quality/service trade-offs."

MR. ZEPP concluded saying the sponsor believes that based on the research and studies spanning over 30 years, that 31 percent of Americans live without CON laws. These states thrive because competition is good for consumers in all industries, including health care. He urged the committee to open Alaska to competition.

2:13:28 PM
SENATOR STEVENS said that this is a complex issue. He stated that he is the only committee member from rural Alaska. He said he feels fortunate that Kodiak has a wonderful hospital and emergency room. He expressed concern about what this this really means. He said he understands that the sponsor believes that repealing CON laws will spur competition. However, he expressed

concern that the Kodiak hospital might not survive. He said he will cautiously consider this measure. He pointed out that the legislature has considered repealing the CON statutes, but it lacked support to do so.

MR. ZEPP responded that no one wants to see small, rural hospitals close. He referred members to three different studies, including one from the federal U.S. General Accounting Office, the Chartis group, and from the North Carolina Rural Health Commission. All of these entities studied small rural hospital closures and determined hospitals close due to economics and not competition. The Mercatus Center studies have shown that in states that repealed CON statutes, it has had little effect on hospitals. In 2017 and 2018, rural hospital closures occurred in 17 of 22 states with CON laws and in five without CON laws. He offered his belief that the extensive research concludes it these closures did not have anything to do with the certificate of need requirements.

2:16:02 PM
SENATOR STEVENS said that his district has small hospitals in Kodiak, Cordova, and Homer. The Cordova hospital is always on the verge of closing, he said. He expressed an interest in hearing from the hospital administrators for their perspective. He estimated that approximately one-third of the health care in his community is covered by the Kodiak Area Native Association (KANA). The KANA is a nonprofit corporation exempt from CON requirements since the KANA has an exemption from the federal rules.

CHAIR WILSON said, in terms of profitability margins, the small hospitals in Seward and Kodiak are owned by a large entity, [Providence Health & Services]. He offered his belief that Providence Health & Services seems to send its profits out of state instead of investing in Alaska infrastructure and needs. For example, it added a large California hospital to its portfolio. That group suggests that the CON laws stifle new hospital beds, which are always based on cost. However, the department {DHSS) says that CON laws do not account for the specific acuity of Alaskan situations. Prior committee testimony about the need for more nursing home beds indicates that CON laws are not the issue. Today, the [DHSS] deputy commissioner said that skilled nursing home facilities need more ventilator-type systems. However, only St. Elias [Specialty] Hospital in Anchorage operates ventilator systems for patients who need specialized skilled nursing level care. He said that current CON laws do not allow new entrants into the market because of the

type of facility, not based on the needs of Alaskans who suffer. This is one example of how CON laws have stifled treatment for vulnerable populations in Alaska.

SENATOR STEVENS stated that the Kodiak Island Borough owns the Kodiak Island Medical Center and building and every five years the borough contracts for services. He noted that he served on the KIB Assembly when the bid went to Providence Health.

2:19:12 PM
SENATOR GIESSEL offered her belief that the supply and demand concept has worked for coffee and bagels and it will work for health care. The health care system will respond to the demand if it is allowed to do so. She referred to the slide in the PowerPoint that showed the states without any CON requirements and to the Milliman report that compared Idaho and North Dakota to Alaska. The Milliman report showed these two states have significantly lower health care costs than Alaska. These states are also rural states with small communities, she said. While it could be argued that North Dakota and Idaho have road systems and Kodiak does not, those two states repealed their CON requirements and allowed competition to work. She offered her belief that the CON statutes suppress innovation, particularly in stand-alone surgery centers and in orthopedics. She has held discussions with many surgeons who would like access to innovative facilities that can provide lower-cost care. However, new clinics cannot open due to government restrictions on the market, she said.

2:21:40 PM
DAVID GRABOWSKI, Ph.D., Professor, Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts, testified in favor of repealing certificate of need laws. He said his research has focused on nursing home CON, so his remarks will address that area. He asked members to imagine if Alaska limited the number of hotels in communities. Instead of the market dictating the number of hotel beds, a regulatory body would set the number of hotel beds. He explained that this would quickly distort competition. As demand grew, new hotels could not easily open, which would result in higher hotel occupancy and fewer available beds. Hotels would not need to provide good service or invest in capital improvements since customers would pay higher prices for limited hotel bed. Yet many other states have similar rules for nursing homes in the form of certificate of need laws. These laws constrain nursing home bed growth in Alaska by employing a needs-based evaluation of all applications for new construction.

[Connection with Dr. Grabowski was lost.]

2:23:40 PM
DAN GILMAN, Attorney Advisor, Office of Policy Planning, Federal Trade Commission (FTC), Washington, D.C., testified in favor of repealing Alaska's certificate of need (CON) laws. He pointed out that he also submitted prepared remarks that reviewed the effects of CON laws issued jointly by the two federal competition authorities, the FTC and the Antitrust Division of the U.S. Department of Justice (DOJ), referred to as "the agencies". In April 2017, these agencies commented on Senate Bill 62, discussing their general views on CON laws and the likely impact of that bill on Alaska's health care competition. In February 2018, the agencies summarized those comments and the FTC's continued concerns about CON to the Senate Labor and Commerce Committee. The FTC has continued to follow the economic and policy related to CON laws and remains concerned about the impact of CON laws on health care competition and health care consumers. These agencies have extensive experience with health care competition, including several decades of law enforcement, research, and policy regarding the effects of provider concentration and CON laws. However, his comments do not necessarily reflect the views of the FTC, any individual commissioner, or the Department of Justice (DOJ), he said.

2:25:39 PM
MR. GILMAN offered his belief that initial goal of certificate of need laws was to reduce health care costs and improve access to care. However, it has become apparent that CON laws do not provide these benefits. In fact, CON laws can undermine some of the very policy goals the laws originally intended to advance. The empirical data from numerous studies do not generally find that CON laws have succeeded in controlling costs, improving quality, or increasing access to health care, he said.

MR. GILMAN said he has identified at least three serious problems with CON laws. First, CON laws create barriers to entry and expansion, which can increase prices, limit consumer choice, and stifle innovation. Second, incumbent firms can use CON laws to thwart or delay market entry or expansion by new or existing competitors. Third, as illustrated by the FTC's own experience in the Supreme Court [Federal Trade Commission vs.] Phoebe Putney, CON laws can deny consumers the benefit of an effective remedy following the consummation of an anticompetitive merger. For these reasons, last year he suggested Alaska repeal its CON laws, which he still maintains, he said.

MR. GILMAN said CON laws create barriers to entry and expansion, potentially depriving consumers of the benefits of health care competition. CON laws, including Alaska's law, require new entrants and incumbent providers to obtain state-issued approval before constructing new facilities or offering certain health care services. These aren't basic health and safety standards but are entry requirements. By interfering with market forces that normally determine the supply of services and facilities, CON laws can suppress increases in supply and misallocate resources, he said. These CON laws also shield incumbent health care providers from competition by new entrants and innovations in health care delivery, which means consumers lose these benefits. He urged the committee to consider all the ways that CON laws may harm health care consumers and to consider how patients and public and private payers might benefit if new facilities and services could enter the market more easily. He suggested that the credible threat of entry or expansion alone typically restrains health care prices, improves quality of care, incentivizes innovation, and improves access to care.

MR. GILMAN said that entry restrictions tends to raise costs and prices and limit opportunities for providers to compete, not just on price, but also on non-price aspects, like quality and convenience for patients. Impeding new entry into health care markets can be especially harmful in rural or other underserved areas since CON laws may delay or block the development of facilities and services in areas services are needed most. CON laws potentially reinforce market power that incumbent providers may enjoy in already concentrated areas, he said.

MR. GILMAN said that incumbent providers may exacerbate the competitive harm from these entry barriers by taking advantage of the CON process to protect their revenues. The strategic use of the CON process by competitors can divert scarce resources away from health care innovation and delivery as potential entrants incur legal, consulting, and lobbying expenses. The FTC's found in FTC vs. Phoebe Putney that CON laws can entrench anticompetitive mergers by limiting the ability of antitrust enforcers to implement effective structural remedies to consummated transactions.

MR. GILMAN said that empirical evidence does not show that CON laws have achieved their goals. States originally adopted CON law programs over 40 years ago as a way to control health care costs and mitigate the incentives created by a cost-plus health care reimbursement system. Although this type of reimbursement

has disappeared, CON laws remain in force in a number of states. The CON proponents continue to raise cost control as a justification, arguing that CON laws improve health care quality while increasing access. The evidence suggests otherwise, he said. Empirical evidence on competition in health care markets generally has demonstrated that more competition leads to lower prices. FTC scrutiny of hospital mergers has been particularly useful in understanding concentrated-provider markets and retrospective studies of provider-consolidation by FTC's staff and independent researchers. He quoted from "The Impact of Hospital Consolidation" by economists Martin Gaynor and Robert Town that "increases in hospital market concentration lead to increases in the price of hospital care." All sources and citations of his empirical points can be found in the 2017 joint statement by FTC and DOJ, he said.

2:31:49 PM
MR. GILMAN said that the best empirical evidence also suggests that greater competition incentivizes providers to become more efficient. Recent work shows that hospitals faced with a more competitive environment have better management practices and also that narrowing or repealing CON laws can reduce per patient cost of health care.

2:32:10 PM
MR. GILMAN said he has found no empirical evidence that CON laws have successfully restricted so-called overinvestment. CON laws can, however, limit investments that would lower costs in the long run. Several studies directly analyzed the impact of changes in CON laws on health care outcomes. The weight of this research has found that repealing or narrowing CON laws is unlikely to lower quality. It may, in fact, improve the quality of certain types of care.

MR. GILMAN said that CON proponents concede that CON laws allow incumbent providers to earn greater profits that the providers would in a competitive environment. Proponents argue that incumbents could use those extra profits to cross-subsidize charity care. He acknowledged providing charity care is important. However, he urged the committee to consider less costly and more effective ways to provide it. The charity care rationale is at odds with the cost control rationale, he said. If the idea is that CON-protected incumbents will use their market power and profits to cross-subsidize charity care, that implies that providers will charge more for non-charity care, he said. Such pricing can harm Alaska's health care consumer and hurt low-income or underinsured patients who are ineligible for

charity care. Also, because CON programs impede entry and expansion, these programs impede access to care for all patients, including the indigent and other low-income patients.

MR. GILMAN said that although advocates of CON laws might seek to promote charity care, the evidence simply does not show that CON laws advance that goal. In fact, there is some research suggesting that safety-net hospitals are not financially stronger in CON states than in non-CON states. Moreover, some empirical evidence contradicts the notion that dominant providers use their market power to cross-subsidize charity care. A paper from Professor Christopher Garmon found a "complete lack of support for the cross-subsidization hypothesis," he said. The FTC recognizes that states must weigh a variety of policy objectives when considering health care legislation, but CON laws raise considerable competitive concerns and do not appear to achieve their intended benefits for health care consumers. CON laws have failed to demonstrate success at delivering on any of their policy goals in over 40 years. He respectfully asked that the legislature consider whether Alaskan citizens are well served by CON laws and if not, whether Alaskans would benefit from the repeal of those laws.

2:35:30 PM
MATTHEW MITCHELL, Ph.D., Senior Research Fellow, Director of the Equity Initiative, Mercatus Center, George Mason University, Arlington, Virginia, testified in favor of repealing the certificate of need (CON) statutes. He said that for the last several years he and his colleagues have been studying CON laws. He highlighted some misconceptions about CON laws, such that CON laws are not quality gates. CON laws require permission from the state to open or expand a health care facility, add a hospital bed or offer a neonatal intensive care unit. The process does not asses the provider's quality, safety record or certifications, which is addressed by other regulatory measures. Instead, the CON process assesses whether the community needs the services, which is typically decided by the market. Economists tend to view CON laws as being anticompetitive restrictions to supply, which is why antitrust authorities at the FTC and the DOJ are skeptical of them, he said.

DR. MITCHELL said that the 1974 National Health Planning and Resources Development Act mandated that states pass CON laws in order to receive matching funds. This federal law laid out a number of rationales for CON laws. Since then 15 states have repealed CON laws and 38 percent of the U.S. population lives in one of those states. Alaska can predict the effect of repealing

its CON laws from the experiences of the other states. Alaska can also use sophisticated econometric techniques to examine differences in outcomes in CON and non-CON states and control for other factors, such as demographics and underlying economics of the community.

DR. MITCHELL said that substantial research focuses on the rationales offered in the National Health Planning and Resources Development Act in 1974, including the goal to ensure an adequate supply of health care. However, the CON laws place restrictions on supply. Research finds that relative to non-CON states, CON states offer a more limited supply of dialysis clinics, hospice care, fewer hospitals per capita, and beds per capita. CON states also have fewer hospitals offering MRIs and fewer CT, MRI, PET scans. Patients in CON states seek more out-of-county and out-of-state care as compared to ones in states without CON. Based on his research of other states that eliminated CON laws, he estimated that Alaska's 25 hospitals would increase to approximately 36 hospitals.

DR. MITCHELL said the second goal of the federal law is to ensure rural access to care. However, states with CON laws have 30 percent fewer rural hospitals and fewer hospitals overall. Rural areas have less access to hospice care, experience longer travel distances in order to obtain care, and are more likely to seek out-of-county care. He and his colleagues estimate that if Alaska repealed the CON statutes, it would have 25 rural hospitals instead of 17 rural hospitals.

2:41:32 PM
DR. MITCHELL reiterated that the CON process itself does not attempt to assess quality. Under the CON process, states would have fewer hospitals and doctors would perform more procedures, so these doctors should become more skilled. However, quality tends to rise with competition. Research suggests that CON laws do not achieve this goal. In fact, states with CON laws have higher mortality rates following heart failure, pneumonia, and heart attacks. Hospitals in these states also have higher rates of postsurgery complications and lower levels of patient satisfaction, he said. He and his colleague estimated patient satisfaction in Alaska would be 4.8 percent higher and postsurgery complications would be about 5.6 percent lower without CON laws.

2:43:00 PM
DR. MITCHELL said the next goal of the CON process is to promote charity care. He and his colleagues reviewed the levels of

uncompensated care or indigent care in CON versus non-CON states and did not find any evidence that charity care increased. He and his colleagues also found greater racial disparity in the provision of care in CON states relative to non-CON states.

The final goal of the federal law requiring the CON process was to promote hospital substitutes. However, under CON laws 18 states, including Alaska, limit any hospital substitutes, such as ambulatory surgery centers. He and his colleagues found that these states have fewer hospitals and approximately 14 percent fewer ambulatory surgery centers. While CON laws limit new hospitals and nonhospital providers, these laws do not seem to limit existing providers. He recalled earlier testimony that indicated an existing provider was awarded a CON whereas a new entrant was not, which is consistent with the broader evidence. It also helps explain why CON laws persist because these laws provide protection to incumbent providers. He and his colleagues estimated that Alaska would have more ambulatory surgery centers than it currently does if it repealed its CON laws.

2:43:29 PM
DR. MITCHELL said the final goal for the advocates of CON is to restrict cost. However, the evidence shows that restrictions on supply tend to raise prices. He said he surveyed 20 peer-reviewed academic studies and the preponderance of evidence supported this. However, he and his colleagues did not find any evidence to show that CON laws reduce per unit costs. Instead, CON laws increased per unit costs and increase overall patient spending, he said. He highly recommended Dr. Grabowski's study to the committee.

2:45:52 PM
SENATOR BEGICH asked if Idaho and North Dakota lost any rural hospitals when these rural states repealed their CON laws.

DR. MITCHELL said he was unsure. After reviewing all rural communities with and without CON laws, he found evidence that CON laws are associated with fewer rural hospitals. His home state is New Mexico, which is a low-income, rural state that does not have a CON law. However, it has decent measures of access of care, he said.

SENATOR BEGICH said that type of information can help alleviate some of Senator Steven's concerns. He asked why Indiana reinstated its CON law last year.

DR. MITCHELL replied that he was unsure. Those who benefit from CON are the incumbent providers who tend to be very politically organized. Many patients often are often unaware that CON exists. He surmised that providers hoping to start up facilities and apply via the certificate of need process tend not to be very politically organized.

2:48:34 PM
At ease.

2:48:38 PM
CHAIR WILSON said the committee must examine the many studies to answer questions that arose during public testimony. He said the topic of certificate of need laws has been analyzed by federal administrations under four presidents. These federal administrations concluded the certificate of need laws are ineffective and recommended that states seek other methodologies to regulate their health care facilities. He remarked that he studied CONs when he worked to obtain his master's degree in health service administration.

CHAIR WILSON encouraged the committee and the public to research whether certificate of need laws work. He said that it was difficult to find studies by proponents of CON laws that were not written by hospital associations or other hospital entities. His office has boxes of empirical data and research, but he has tried to provide the most relevant research to the committee. He has worked to educate the public on more innovative health care systems for the state of Alaska. He reiterated the problems his district faced when an Anchorage clinic applied for a certificate of need to open an office in the Mat-Su, which resulted in a lawsuit that has adversely affected his community.

CHAIR WILSON offered his belief that the public testimony in opposition to certificate of need (CON) applicants are most likely to come from their competitors. He remarked that significant funds are spent on opposing changes to CON laws in Alaska, which would be better spent on indigent care. That is the reason this bill is so important, he said.

[CHAIR WILSON held SB 1 in committee.]

2:54:34 PM
There being no further business to come before the committee, Chair Wilson adjourned the Senate Health and Social Services Standing Committee at 2:54 p.m.